Using the new Nursing Practice Assessment Document

UNIVERSITY OF LINCOLN

Introducing the Nursing Practice Assessment Documentation and Ongoing Achievement Record

The new Practice Assessment Documentation (PAD) and Ongoing Achievement Record (OAR) has been designed following consultation with academics, external advisors, staff from practice in partner organisations, students, mentors and service users/patients.

The documents were validated by the NMC in May 2016 to be used as part of the new curriculum for undergraduate nursing programmes delivered by the University of Lincoln beginning in September 2016.

What's New?

- One PAD per placement which contains all the paperwork needed for that placement
- Competencies and essential skills are listed under 5 headings relating to the 4 P's of *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC 2015) and Medicines Management
- The Episode of Care - A graded assessment of nursing skills and competencies, delivered during an 'Episode of Care' with a patient and assessed by the mentor. This means students get credit for practice
- There are no bondy levels. Instead a 1-6 grading scale based on what is expected of students in that year
- There is no requirement to generate a portfolio of evidence
- Service user feedback on student's care delivery
- An OAR will capture three years of information relating to progression. The student will make this available to all mentors on request.

How to use the PAD

On pages 2-4, 9 & 21 of each PAD there are guidelines on the contents of the document and requirements of the mentor and student.

There is a guidance document which mentors can access from www.nursingplacement.blogs.lincoln.ac.uk or request from their PST link.

There is a brief page by page guide to explain what you need to do to complete the document.

Guidance for Completion

The student will take ownership of their PAD and OAR and work with their mentor to ensure its completion.

The mentor will ensure they see these two documents at the start of the placement, complete the orientation using the checklist, complete the preliminary, intermediate and final interviews, grade the student against all competencies under the 5 headings, and complete an Episode of Care summative assessment.

Mentors can contact their link lecturer or the University if they feel they need support with the documents Uolpractice.support@Lincoln.ac.uk .

Students will also be working towards their EU requirements and these are documented in their PAD and recorded in the OAR. They must also complete summative assessments with mentors on the specific ESCs in the PAD (discussed later) with advice to complete early on in the year.

Who is able to undertake student assessments?

The NMC standards for pre-registration nurse education (2010) state that **all summative judgments** regarding student competence **must be made by a suitably qualified mentor**

A mentor is a qualified nurse or allied health professional who has successfully undertaken an NMC approved mentorship course

- Year one – can be **any qualified mentor/AHP** (must be a registered nurse from any field at progression point)
- Year 2 – any qualified **nurse mentor** (a nurse from the same field at progression point)
- Year 3 – any qualified **same field nurse mentor** (**sign-off** for final placement).

Other members of the MDT can inform the mentor of their observations to aid assessment

The mentor or associate mentor complete the documentation

A sign-off mentor must be allocated to third year students in their final placement to assess competency, fitness to practice and progression to enter the register

Front Page

PRE-REGISTRATION BSc (Hons) NURSING (ADULT) - Placement 1A

Student name:	ANN SMITH	Student ID Number	12389403	Cohort:	0916
Personal Tutor:	JOHN BROWN	Module Code:	1020M	9 weeks/337.5	
Hours completed:	338	Hours sick/absent:	15 (MADE UP)	Occasions of sickness/absence:	2 DAYS

Name of placement:	6A PILGRIM	Placement dates:	From: 5TH DECEMBER 16	To: 19TH FEBRUARY 2017
Type of placement:	FEMALE OLDER ADULTS	Contact Telephone:	01205	445 661
Mentor name:	JANE JONES	Mentor signature:	J. Jones	
Associate mentor/assessor:	TOM LEWIS	Associate mentor/assessor signature:	TL	
Link Lecturer name:	ALISON THOMAS	Link Lecturer signature:	A. Thomas	

Action plan completed (if appropriate)	(Yes)	N/A	Follow up by Link Lecturer/personal tutor:	(Yes)	No
Cause for concern submitted (if appropriate)	Yes	(N/A)	Name of person following up:	—	

For completion by module team – Action required if checklist criteria not met					
Assessment criteria			Checklist	Circle (action if 'no')	
Has achieved at least a '3' in all Part A criteria	(Yes/No)		Front page fully completed?	(Yes)	No
Has achieved at least a '3' in Part B criteria	(Yes/No)		All criteria assessed?	(Yes)	No
Has achieved all required practice hours	(Yes/No)		All necessary signatures completed?	(Yes)	No
• Episode of Care (insert grade)	2:1		Interim and final assessments complete?	(Yes)	No
Overall Grade	2:1		Action plan completed & actioned?	If no to any of the above initiate or refer to action plan	
			Cause for concern completed & actioned?		

Students will populate the front page of each PAD inputting their details and that of their placement. This page will then be completed by the academic tutor at the end of the placement.

Mentors must sign the front page.

Orientation

Placement 1A. Orientation	Student Signature/Date:	Mentor Signature/Date:
The following activities must be met within the first day of placement:		
An orientation to the practice placement setting has been undertaken including shift patterns, breaks, meal times, placement profile, nature of service, awareness of user group, intended interventions and clinical outcomes.	A Smith 5.12.16	J. Jones 5/12/16
Placement specific fire procedures have been explained and student is aware of exit, alarms and fire safety equipment locations.	A Smith 5.12.16	J. Jones 5/12/16
The student and mentor are aware of the university and trust escalation process and support mechanisms	A Smith 5.12.16	J. Jones 5/12/16
The student understands and adheres to dress code, infection prevention and control and promotes a professional image	A Smith 5.12.16	J. Jones 5/12/16
The student is aware of how to summon assistance in the case of emergency.	A Smith 5.12.16	J. Jones 5/12/16
Resuscitation policy and procedures have been explained and the location and use of necessary equipment has been shown.	A Smith 5.12.16	J. Jones 5/12/16
Information governance protocol including data protection, record keeping and confidentiality	A Smith 5.12.16	J. Jones 5/12/16
The student is aware of where to find key policies and protocols for safe practise: • Health and safety • Incident reporting • Infection prevention and control • Safeguarding and escalation of concerns • Lone working (as applicable) • Sickness and absence policy and reporting procedure • Supply/administration/destruction/surrender of controlled drugs	A Smith 5.12.16	J. Jones 5/12/16
Practical arrangements such as: • Security access to practice area • Access to computer and learning resources • Storage of personal belongings • Break periods	A Smith 5.12.16	J. Jones 5/12/16
The placement interface with other services or agencies and opportunities for inter-professional learning to inform opportunities, insight visits and learning plan.	A Smith 9.12.16	J. Jones 9/12/16
Risk assessment and reasonable adjustments have been discussed and considered relating to disability/learning/pregnancy needs (where disclosed)	A Smith 5.12.16	J. Jones 5/12/16
The following criteria must be met prior to student use:		
Any moving and handling equipment used in the practice area must be demonstrated in terms of safe use for student and service user/patient.	A Smith 10.12.16	J. Jones 10/12/16
The student has had a demonstration of any medical devices and practices used in the practice area.	A Smith 10.12.16	J. Jones 10/12/16

It is important that students are orientated to each clinical area prior to undertaking any clinical activity.

Some orientation activity must take place on the first day of a placement, other activities may be completed within the first week.

The nurse who undertakes the orientation activity must sign and date the appropriate box.

Preliminary Interview

Placement 1A: Preliminary interview and learning agreement

This interview takes place within the first week of placement. A development plan, including learning outcomes to be achieved should be drawn up with reference to each criteria.	
Prioritise people:	I will actively engage with the patients on this ward whilst respecting each individuals needs and wants. I will explore the barriers to communication for this patient group.
Practice effectively:	I will read examples of records and ensure I keep these updated. I will introduce myself to the different members of the team and work with them throughout the placement. I will be actively involved in delivering the fundamentals of care.
Preserve safety:	I will ensure I will follow instructions given and ask for help when needed, working within my limitations. I will develop an understanding of risk factors.
Promote professionalism and trust:	I will attend each shift dressed appropriately and always act in a professional manner. I will actively seek feedback and use this to reflect on my performance and identify ways to progress.
Medicines management:	I will research the medications typically used for this client group and on this ward. I will take part in drugs rounds to improve communication about drugs.
Mentor signature/date:	[illegible] 10/12/16
Student signature/date:	A Smith 10.12.16
Agreed date for intermediate interview:	13th January 2017
Agreed date for final interview:	17th February 2017

Mentors will meet with their student in the first week of placement to complete their preliminary interview including how the student aims to meet the competencies under the 5 headings.

A date to practice the Episode of Care should be discussed.

Intermediate Interview

Placement 1A: Intermediate Interview

To be completed mid-way through practice experience. Learning outcomes can be reviewed and changed as a result of this discussion. Any concerns about the student's progress must be communicated to the academic link lecturer as soon as possible. **The early warning checklist should be used to identify any concerns with the student's performance (p 31).**

Practice Mentor's Comments. Agree new learning objectives as appropriate (continue on separate page if necessary) set date for part B assessment

ANN IS PROGRESSING WELL AND MEETING THE COMPETENCIES.

OBJECTIVES: BE MORE CONFIDENT IN WRITING IN PATIENTS NOTES TO INCREASE WRITTEN COMMUNICATION SKILLS

: UNDERSTAND THE INTERACTION BETWEEN THE TYPICAL MEDICATIONS AND DISCUSS WITH ME

DATE FOR EoC: 27TH JANUARY 2017

Student's Comments (continue on separate page if necessary)

I feel I am working towards my competencies well and enjoy working on the ward. I feel part of the team and enjoy working with everyone. I have learnt a lot of communication skills and how to care for an older patient. I am getting used to the medications but need to look at this more.

Summarise feedback from patients/relatives/carers/service users on the student's performance.

THE PATIENTS RESPOND WELL TO ANN AND ENJOY THE TIME SHE SPENDS TALKING TO THEM.

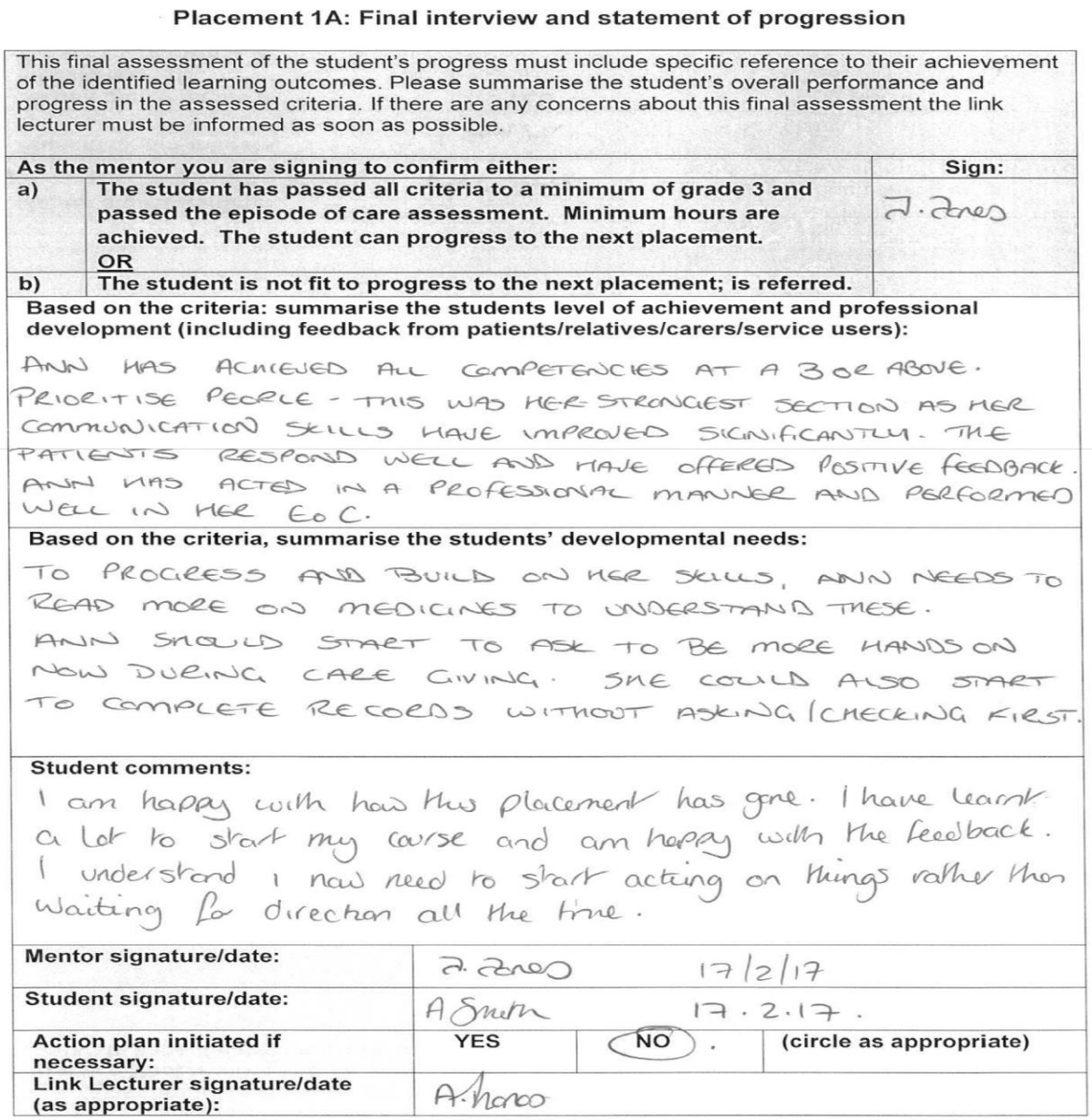
Mentor signature/date:	J. Jones 13/1/17	
Student signature/date:	A Smith 13.1.17	
Action plan initiated if necessary: (circle as appropriate)	(YES)	N/a

The student will complete their review of the competencies prior to this interview and discuss this with their mentor who will complete their assessment.

A date for the summative attempt at the Episode of Care will be agreed.

Any concerns that competencies won't be met at a 3 or above, will be discussed with student, an action plan should be initiated and link lecturer informed who will monitor this with the mentor.

Final Interview



Placement 1A: Final interview and statement of progression

This final assessment of the student's progress must include specific reference to their achievement of the identified learning outcomes. Please summarise the student's overall performance and progress in the assessed criteria. If there are any concerns about this final assessment the link lecturer must be informed as soon as possible.

As the mentor you are signing to confirm either:		Sign:
a)	The student has passed all criteria to a minimum of grade 3 and passed the episode of care assessment. Minimum hours are achieved. The student can progress to the next placement. OR	J. Jones
b)	The student is not fit to progress to the next placement; is referred.	

Based on the criteria: summarise the students level of achievement and professional development (including feedback from patients/relatives/carers/service users):

ANN HAS ACHIEVED ALL COMPETENCIES AT A 3 OR ABOVE. PRIORITISE PEOPLE - THIS WAS HER STRONGEST SECTION AS HER COMMUNICATION SKILLS HAVE IMPROVED SIGNIFICANTLY. THE PATIENTS RESPOND WELL AND HAVE OFFERED POSITIVE FEEDBACK. ANN HAS ACTED IN A PROFESSIONAL MANNER AND PERFORMED WELL IN HER EoC.

Based on the criteria, summarise the students' developmental needs:

TO PROGRESS AND BUILD ON HER SKILLS, ANN NEEDS TO READ MORE ON MEDICINES TO UNDERSTAND THESE. ANN SHOULD START TO ASK TO BE MORE HANDS ON NOW DURING CARE GIVING. SHE COULD ALSO START TO COMPLETE RECORDS WITHOUT ASKING/CHECKING FIRST.

Student comments:

I am happy with how the placement has gone. I have learnt a lot to start my course and am happy with the feedback. I understand I now need to start acting on things rather than waiting for direction all the time.

Mentor signature/date:	J. Jones	17/2/17	
Student signature/date:	A Smith	17.2.17.	
Action plan initiated if necessary:	YES	NO.	(circle as appropriate)
Link Lecturer signature/date (as appropriate):	A. Harco		

The University will have been informed if the student is not going to pass this assessment, and if their attendance is required at this meeting.

The student will again review their competencies and discuss with their mentor. The mentor will highlight areas of development and achievement and sign off the competencies.

How are Students Assessed?

Below expectations Refer/Fail **1**	Requires development Refer/Fail 2	Satisfactory Meets all of the criteria and is safe in practice 3	Good Meets all of the criteria to a standard higher than expected 4	Very good Meets all of the criteria to a high standard 5	Excellent Meets all of the criteria to an exceptionally high standard 6

Students are assessed for competence and the episode of care on a scale of 1-6.

1 & 2 are a fail which would result in an action plan to improve with the University being informed. 3 is satisfactory, competent and safe to progress.

Each assessment is relevant to year of study the student is in. They are able to achieve grades across the scale.

The new scale supports students who perform very good, or excellent, for their year of study to be acknowledged and rewarded.

Assessment Rubrics

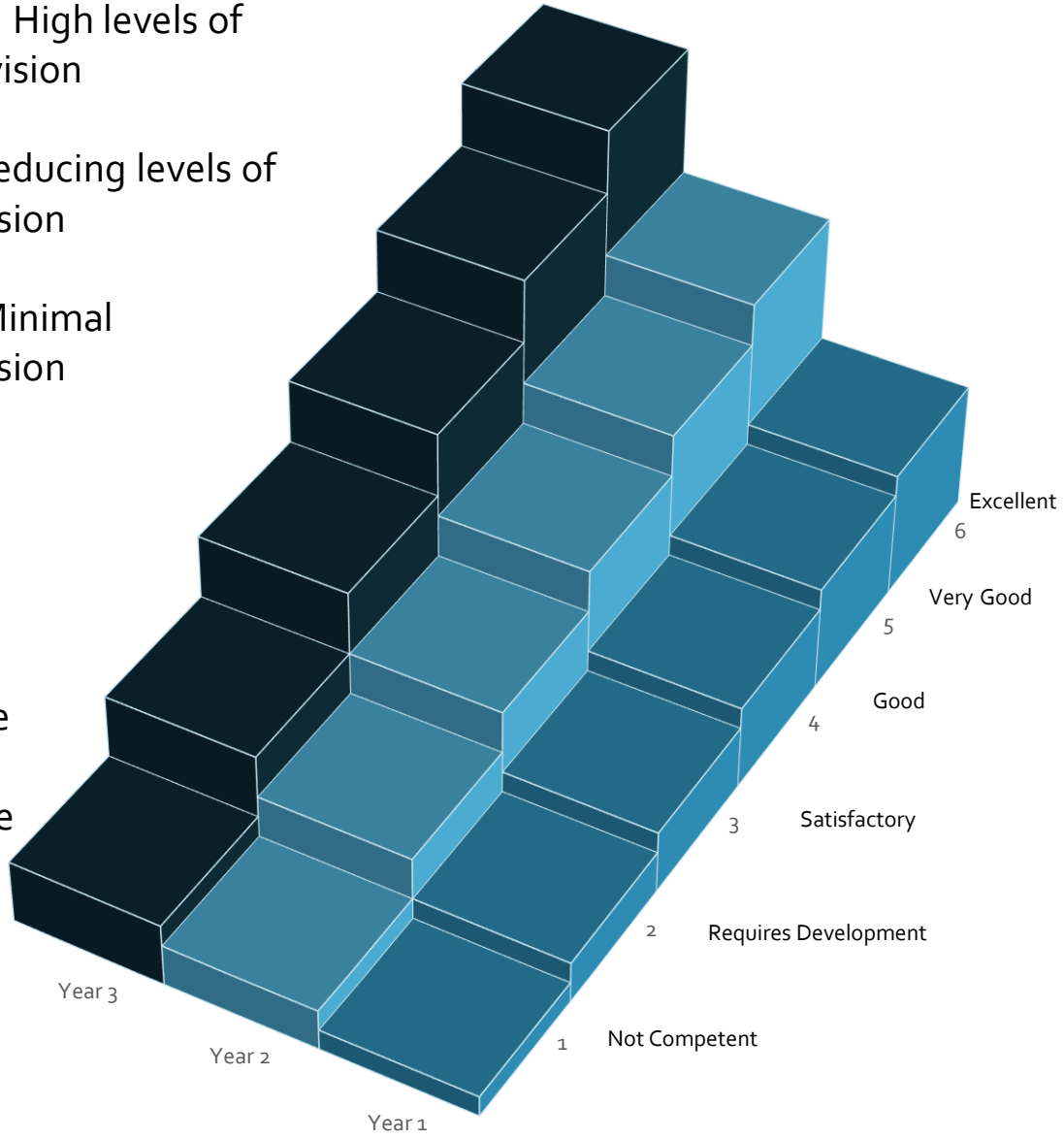
- If the mentor considers that any aspect of the student's performance falls within the 'unsatisfactory' band then they must award the 'unsatisfactory' descriptor overall on that competency.
- At the intermediate interview, this will enable the student to reflect on their performance and help them to identify areas for development before the final interview.
- The Link Lecturer should be contacted and an action plan completed to enable the student to focus on specific development requirements.
- This will be monitored to support achievement either on placement or insight visits prior to final interview.

Year 1 – Assimilating. High levels of directions and supervision

Year 2 – Engaging. Reducing levels of direction and supervision

Year 3 – Impacting. Minimal direction and supervision

This escalator shows how students are assessed on the scale and that they can score across the scale in each year due to the expectations changing as they progress.



Competencies

Criterion 2 – Practice Effectively					
Below expectations Refer/Fail 1	Requires development Refer/Fail 2	Satisfactory Meets all of the criteria and is safe in practice 3	Good Meets all of the criteria to a standard higher than expected 4	Very good Meets all of the criteria to a high standard 5	Excellent Meets all of the criteria to an exceptionally high standard 6

Student and Mentor: Please insert indicative grade for intermediate and final grade		Intermediate	Final
1. Takes a person-centred approach to care, recognising the individual while promoting health, self-management of conditions, or delivering interventions, empowering people to make informed choices about their care	Self	3	4
	Mentor	3	4
2. Promotes well-being, prevents ill health and practices in a non-judgemental manner, ensures privacy and dignity is maintained and is responsive, sensitive and compassionate towards patients/service users and their carers	Self	3	4
	Mentor	3	4
3. Ensures clear and accurate records are kept, relevant to scope of practice, are countersigned, transferred appropriately and maintains confidentiality aligned to information governance	Self	2	3
	Mentor	2	3
4. Links knowledge of anatomy, physiology, sociology & psychology to assessment, care planning and care provision	Self	3	3
	Mentor	3	3
5. Communicates effectively with colleagues and seeks advice from appropriate sources where there is a concern or uncertainty, for example changing patient/service user status, risk or safeguarding issue	Self	3	5
	Mentor	3	4
6. Refers to best available evidence and uses and interprets relevant data when undertaking a range of assessments linked to fundamentals of care	Self	3	3
	Mentor	3	3
7. Is aware of reporting mechanisms and raising concerns process, sharing information with care professionals as appropriate, seeks advice/supervision as appropriate	Self	3	4
	Mentor	3	4
8. Demonstrates increasing confidence and competence in communication, listening and recording information, utilising manual assessment and recording including technology, taking into account emotional and physiological responses when engaging in care delivery	Self	4	5
	Mentor	4	6
9. Ensures care assessment, intervention and communication is undertaken without undue delay, recognising limitations of own knowledge, skills and competence, seeking assistance where necessary	Self	3	3
	Mentor	3	4
10. Delivers the fundamentals of care, undertakes, measures and documents a range of observations, vital signs and diagnostics	Self	3	4
	Mentor	4	4

The competencies are aligned to the NMC essential skills clusters and domains.

The student should self assess prior to intermediate and final interviews. The mentor should complete their assessment at each interview.

If any competency is assessed as below a 3, an action plan must be completed and the University contacted.

The student may grade across the scale and a discussion should be held if student and mentor assessments differ.

Comments

Criterion 2 – Practice Effectively- Intermediate interview feedback			
Student reflection on their learning (use specific examples):		**Mentor statement/summary of progress (use specific examples):**	
I feel I am working well towards practicing effectively but I do need to be more confident with record keeping and understanding what to write.		ANN IS PRACTICING EFFECTIVELY IN THIS PLACEMENT AGAINST THE MAJORITY OF POINTS. SHE NEEDS TO BECOME FAMILIAR WITH RECORDS, WHAT TO WRITE AND HOW SO AN ACTION PLAN HAS BEEN INITIATED TO ADDRESS THIS.	
Student signature & date:	A Smith 13.1.17	**Mentor signature & date:**	T. Jones 13/1/17

Practice Effectively – Final interview feedback			
Student reflection on their learning (use specific examples):		**Mentor statement/summary of progress (use specific examples):**	
I have worked on record writing and followed my action plan. I now feel more confident and led the recording of notes for Mrs C today which Jane checked and said was good.		I AM HAPPY WITH THE PROGRESS MADE BY ANN FOR THIS CRITERION. SHE HAS FOLLOWED HER ACTION PLAN WHICH HAS DEVELOPED HER SKILL IN RECORD KEEPING. SHE ENGAGES WELL IN HER CARE DELIVERY AND PATIENTS RESPOND WELL TO THIS.	
Student signature & date:	A Smith 17.2.17	**Mentor signature & date:**	T. Jones 17/2/17

The comments boxes allows both student and mentor to record progress towards meeting the criterion at each interview and ways to improve.

Specific Essential Skills

Specific Essential Skills The student is required to achieve these specific skills by the progression point stated below, but they can attempt them at any stage of the programme		Achieved safely
At least by the end of year 2: • Measures and accurately documents TPR and BP	Self	
	Mentor	
• Accurately measures height, weight and BMI.	Self	
	Mentor	
• Accurately monitors dietary and fluid intake and output, recognises signs of dehydration and takes steps to correct.	Self	
	Mentor	
At least by the end of year 3: • Comprehensive assessment of patients'/service user needs in relation to nutrition identifying – MUST	Self	PASS
	Mentor	PASS
• Can identify signs of dehydration and acts to correct these in accordance with local policy	Self	
	Mentor	
• Administers and, where necessary, prepares medication safely under direct supervision, including orally and by injection, safely disposes of equipment used in the administration of medicines	Self	
	Mentor	
• Administer enteral feeds safely	Self	
	Mentor	
• Monitor and assess patients / clients receiving intravenous fluids	Self	
	Mentor	

Please refer to ESC assessment guidance provided separately.

These are the ESCs the student must achieve across the programme and before the stated progression points.

Students are expected to practice the skills before undertaking a summative attempt. They are to be observed by their mentor and outcome is recorded in the PAD.

Refer to guidance and checklist of clinical activity required to achieve these skills, provided separately.

Episode of Care

Structured Situated Assessment: An Episode of Care

Not competent Refer/Fail	Requires development Refer/Fail	Satisfactory Meets the criteria and is safe in practice	Good Meets the criteria to a standard higher than expected	Very good Meets the criteria to a high standard	Excellent Meets the criteria to an exceptionally high standard
1	2	3	4	5	6

Mentor, please enter grade against each descriptor in the associated box
Assessment can be either direct observation or indirect where privacy and dignity may be compromised

Prioritise People; Practice Effectively; Prioritise Safety; Promote Professionalism and Trust; Medicines Management	The student promotes a professional image, acts within professional boundaries, values and understands the role of the multi-disciplinary team and interacts effectively when delegated work, providing accurate and comprehensive written and verbal communication relevant to the episode of care.	5
	The student is aware of the reason for referral, is prepared for undertaking the episode of care and understands the medication prescribed, potential effect and side effects, interactions and monitoring requirements for the individual when medication is prescribed.	3
	The student introduces themselves appropriately, aware of the impact of self on others and of the individual's emotional and physical responses.	6
	Maintains infection prevention and control and moving and handling requirements, for example according to local policy. Is aware of reporting mechanisms and raising concerns process.	4
	The student engages in such a way as to preserve privacy, dignity and facilitates partnership approaches to care planning and decision making, recognising the right to refuse care.	6
	The student nurse treats the individual and their carers' in a person centred, non-judgmental, sensitive and respectful way.	6
	The student demonstrates an understanding on how religion, culture, gender, age, disability, sexuality, spiritual beliefs for example can impact on health, illness and recovery.	5
	The student explains the purpose of their involvement, gains consent, respects confidentiality, communicates effectively with appropriate listening, responding and questioning, offering information and reassurance as appropriate within their sphere of knowledge.	5
	The student uses ways to maximise communication with individuals in their care, when factors such as hearing loss, cognitive impairment, confusion, anxiety, vision or ability to speak or understand is compromised.	5
	Essential care may focus on: emotional and psychological health, nutrition, infection prevention and control, pain management, provides adequate and appropriate personal care, assesses effect of medication, side effects, recovery or deterioration. Ensures nutrition and hydration are adequate at all times if the patient is unable to manage this themselves, recognises mobility and communication factors, assesses risk; maintains patient safety.	4
	Student reflects on own preparation, interactions and interventions and mentor and student assess. Further discussion may include: Who needs to be involved in decisions around care, what professionals, agencies, services, assessments, treatment options and accessibility?	4
	Mentor: Consider the quality of the care delivered during the episode of care and to what level professional values, communication and compassion and decision making appropriate to the needs of the individual?	5
	To what extent did the student act within their sphere of competence and skills, using initiative and evidence relevant to patient need? Has the student demonstrated insight into areas for future development and skills acquisition and the opportunities for this to occur?	5
	Patient/Service User feedback of experience and recommendations to support assessment and future development – not graded	

A pre-negotiated date to undertake the summative assessment of an Episode of Care will be set.

The mentor will assess the student against competencies listed and grade their competence based on the same 1-6 scale.

If any descriptor attracts below 3 (satisfactory), this would be an overall fail. This will necessitate referral to the University.

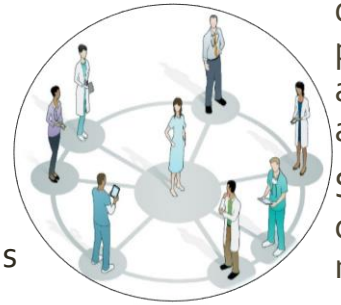
Episode of Care

1. Episode of Care Preparation: negotiate a suitable patient. Assess the student's ability to: Respect the person as an individual: know if communication needs tailoring, read notes, care plans, prescriptions, know name and reason for need for services, how the condition affects the person, and how the person's circumstances and experiences affect their condition and treatment

2. Communication: confident approach, eye contact, introduction, checks identity, respects confidentiality, explains reasons for interaction, gains consent, listens to and addresses any health beliefs, concerns and preferences that the patient has, respect views, offer support, reassures, asks relevant questions

3. Patient centred, home and social issues, ie isolation, family, carer, information and decisions around condition, care and interventions, including knowledge of prescribed medication, side effects/effect, within sphere of knowledge and recognizing limitations; treat patients with respect, kindness, dignity, compassion, understanding, sensitivity and honesty.

4. Fundamentals of care including emotional/psychological, nutrition, infection control, pain management and personal needs: Provides adequate and appropriate personal care, assesses, manages pain or deterioration. Ensures nutrition and hydration are adequate at all times, if the patient is unable to manage this themselves, recognises mobility and communication factors, assesses risk; maintains patient safety; documents in records.



5. Post Episode of Care discussion

Student reflects on own preparation, interactions and interventions and mentor and student assess. Further discussion may include:

Who needs to be involved in decisions around care, what professionals, agencies, services, assessments, treatment options and accaccessibility?

Student acts within sphere of competence and skills required, relevant to patient need.

6. Patient Feedback

Service user feedback form

Patient/service user feedback form

A Mentor will approach service users in receipt of care to obtain consent and will be aware of the right to decline to participate

We are interested in your views about the way the student nurse has been looking after you and/or your carer. Your feedback will help the student nurse to learn and any feedback offered will not change or impact on the way you are looked after. **Thank you**

Tick if you are: A patient/service user ☑ A carer or relative ☐

How happy are you with the way the student nurse.....	Very Happy	Happy	I'm not sure	Unhappy	Very unhappy
Cared for you?	○	●	○	○	○
Listened to you?	●	○	○	○	○
Talked to you?	●	○	○	○	○
Preserved privacy and dignity?	●	○	○	○	○
Demonstrated respect?	●	○	○	○	○
Undertook care assessment and delivery?	○	●	○	○	○

What did the student nurse do well? THEY LISTENED TO ME AND MY NEEDS THEY SPOKE TO ME THROUGHOUT.

What could the student nurse have improved on? THEY COULD HAVE BEEN MORE CONFIDENT IN WHAT THEY WERE DOING AS THEY SEEMED NERVOUS.

Mentor signature: J. Jones Date: 27/1/17

Student signature: A Smith Date: 27.1.17.

Within each Episode of Care there is a page for students to receive feedback directly from someone they have cared for or their relative.

The mentor that works with the student should approach the patient/service user to seek consent and ask for feedback

Mentors may complete the form on behalf of the service user and ask them to sign or initial to verify the information.

Mentors are also asked to sign on completion for verification purposes.

EU Requirements

Mentor, please list specific skills and competence related to the care episode:

Examples: Oral hygiene; wound care, catheter care; height, weight and BMI measurement; blood pressure; fluid input and output; dietary requirements; temperature; enteral feeds; harm minimisation; education and self-management; therapeutic interventions; team working

- BLOOD PRESSURE
- EMOTIONAL WELLBEING
- DIETARY PREFERENCES
- MEDICATION DISCUSSION
- SELF HELP FOR ELEVATING MOOD.

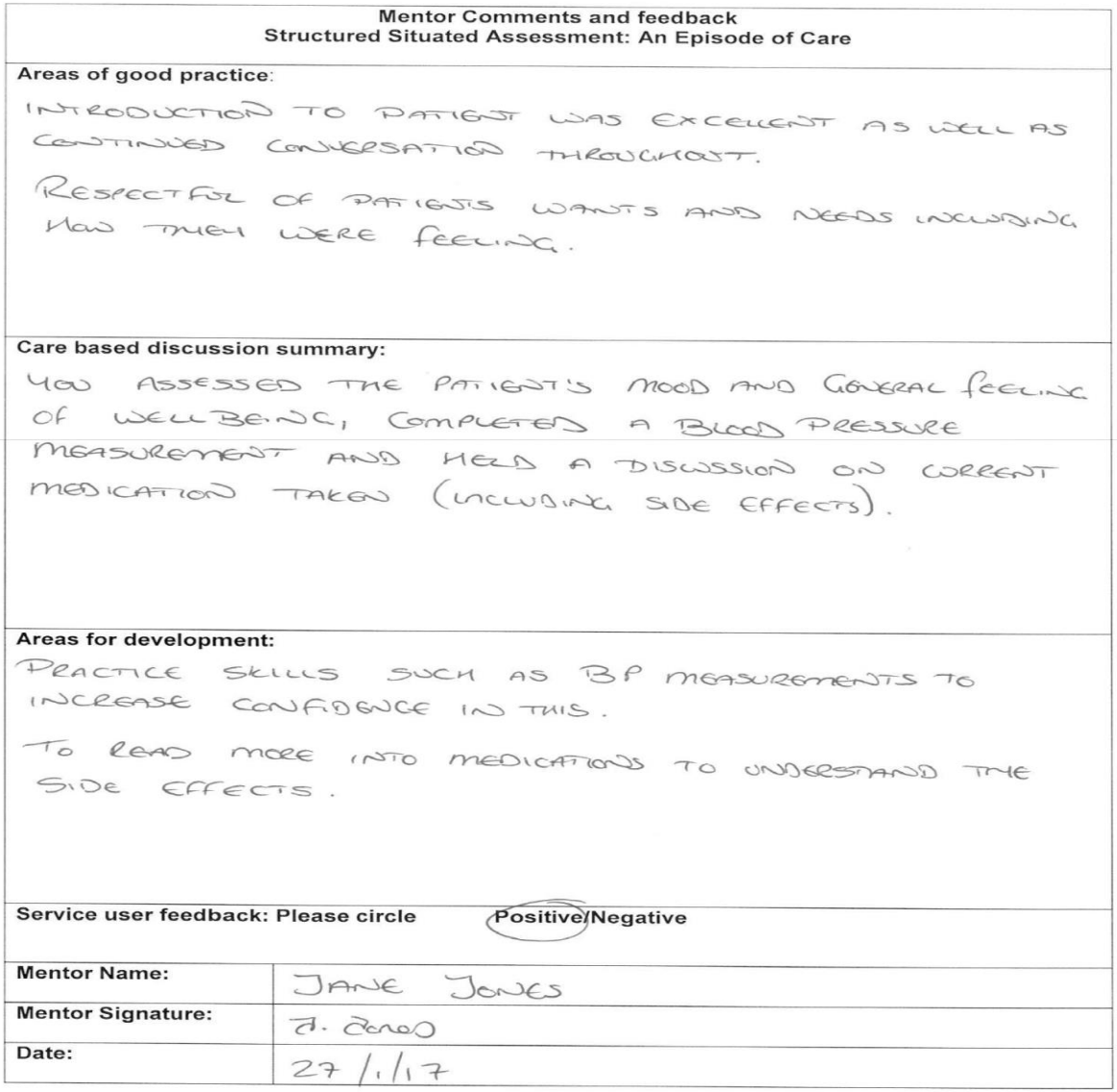
Mentor: please list range of insight visits and learning opportunities with reference to other fields and specialties of nursing (Acute care; new born, paediatric and adolescent care; maternal care; long term care; general internal medicine and surgery; mental health and psychiatric illness; disability and care for disabled people; geriatrics and care for the elderly; primary health care, community care; palliative care, end of life and pain management)

- OLDER ADULT
- GENERAL MEDICINE
- LONG TERM CONDITION CARE
- MENTAL HEALTH CONDITIONS
- PAIN MANAGEMENT

The mentor is asked to make notes on how the student may have met specific EU requirements during placement as evidence to inform the students OAR.

Information about requirements can be found on page 2.

Feedback



Mentor Comments and feedback
Structured Situated Assessment: An Episode of Care

Areas of good practice:

INTRODUCTION TO PATIENT WAS EXCELLENT AS WELL AS CONTINUED CONVERSATION THROUGHOUT.

RESPECTFUL OF PATIENTS WANTS AND NEEDS INCLUDING HOW THEY WERE FEELING.

Care based discussion summary:

YOU ASSESSED THE PATIENT'S MOOD AND GENERAL FEELING OF WELLBEING, COMPLETED A BLOOD PRESSURE MEASUREMENT AND HELD A DISCUSSION ON CURRENT MEDICATION TAKEN (INCLUDING SIDE EFFECTS).

Areas for development:

PRACTICE SKILLS SUCH AS BP MEASUREMENTS TO INCREASE CONFIDENCE IN THIS.

TO READ MORE INTO MEDICATIONS TO UNDERSTAND THE SIDE EFFECTS.

Service user feedback: Please circle Positive/Negative

Mentor Name:	JANE JONES
Mentor Signature:	J. Jones
Date:	27/1/17

Mentors will complete the feedback form after the Episode of Care to help the student progress, reflect and learn from the experience.

The overall grade for the assessment will be interpreted by the academic team once the student submits their PAD to University by an agreed deadline.

Moderation

University of Lincoln Moderation
Structured Situated Assessment: An Episode of Care

Notes:

I moderated the assessment and felt the awarded grades were accurate.

The student performed well throughout the Episode of Care.

The mentor gained service user feedback after gaining consent.

The mentor provided feedback in a positive and constructive manner to the student highlighting areas for improvement.

The mentor spoke with me after assessment to gain feedback and confirm grades.

No concerns.

Moderator Name:	ALISON THOMAS
Moderator Signature:	A. Thomas
Date:	27/1/17
Grade Agreed: Yes	YES
No: Action Required	—

The University link lecturers will randomly select a sample of students and observe these assessments for moderation purposes.

If you would specifically like the link lecturer to moderate your assessments, please make contact with them.

Evidence of Additional Learning

Evidence of additional learning experience/activity and/or inter-professional learning

- So as to capture the range of opportunities students should briefly outline any visits or experience that they or their mentor have arranged to complement their practice experience. This will include visits to observe procedures or therapies conducted away from the allocated experience, time spent with specialist nurses and/or working with and learning from members of other professions.
- Students should name the experience and identify the purpose of that experience
- Student should summarise the activities of learning, give brief evidence of the learning and how this can be applied elsewhere. This may be detailed as bullet points.
- Should there be nothing of note to record, it is not mandatory during each placement, however is recommended that you seek alternative, inter-professional learning across each year within insight or pathway placements to complement your learning.
- This record should be kept with the practice learning assessment documentation (PAD) and should be used to contribute to discussion during the final assessment. It may also be used to contribute to the student's Ongoing Achievement Record.

Type of visit/experience and dates:	ST BARNABAS HOSPICE @ HOME BOSTON 20/12/16
Student to identify purpose of learning experience.	To explore end of life care in the community as some patients are referred to this service.
Activities of learning. How can this be applied elsewhere?	I shadowed the nurse on her visits to patients and watched her engagement with individuals. I asked about medications and also mental health/wellbeing and how this is dealt with. I now have a better knowledge of End of life care services.
Comments from supervisor of learning experience (to include professionalism, knowledge, attitudes, behaviour and skills).	Ann spent a day with me going to patients homes. She was very professional and respectful of the patients. She engaged well with them and asked a lot of questions regarding care and medication.

Supervisor signature: K. Fuller	**Student signature:** A. Smith	**Hours completed:** 7.5

There are several forms in each PAD that a student will complete as part of attending an "insight" or "care pathway" visit.

This allows the mentor to see what learning the student gained from this visit and the student a chance to record their experience and possible evidence for EU requirements.

A member of staff at this visit must sign the form and hours completed to inform the mentor.

Action Plan

Action Plan template

This action plan is for use by mentors in practice with support from the University and should be completed if the student has received less than "satisfactory" grade in any criteria. Actions should be specific, measurable, achievable, relevant and timely. Where an action plan has been provided by an academic it must be attached to this document. Please use cause for concern early warning checklist to formulate the action plan. Use additional pages as necessary.

ACTION PLAN

PAD criteria	Action	Resources/support	Date for review
2.	SPEND TIME READING PATIENT RECORDS / NOTES. SHADOW THE INPUT OF THIS. INPUT YOUR OWN NOTES / OBSERVATIONS & WITH MENTOR TO ASK QUESTIONS INPUT YOUR OWN NOTES WITH MENTOR TO SIGN.	CURRENT NOTES / RECORDS ON THE WARD ALL STAFF ON THE WARD. MENTOR.	28/1/17
ESC HOURS	PRACTICE + RESIT BP ESC MAKE UP THE 2 DAYS SICK (15 HOURS) BY: 15/1/17 – 12 HOUR SHIFT FROM 7.5 21/1/17 – 12 HOUR SHIFT FROM 7.5 24/1/17 – 7.5 EXTRA SHIFT 28/1/17 – 8.5 HOUR SHIFT FROM 7.5	MENTOR MENTOR + CO-MENTOR.	

Student name: Ann Smith	Mentor name: JANE JONES
Signature: A Smith	Signature: J. Jones
Date: 13.1.17	Date: 13/1/17

If an action plan is needed, the template for this is included towards the end of the document.

The mentor and student will complete this together along with a link lecturer if needed.

Cause for Concern

Cause for Concern Early Warning Checklist

If concerns are identified at any stage, these statements can be used to formulate an action plan in the template provided. Indicate a yes against those statements best describing concerns; asterisk if individual. Where concerns differ from examples, document within action plan.

PAD Criteria	Early warning concern	Yes	Comments
Practice Effectively	• Has no insight into weakness so unable to change following constructive feedback • Practical interpersonal and communication skills are not appropriate to their level of experience • Demonstrates inability to deal with difficult situations for their level of experience • Poor written record keeping • Lacks insight into the impact of their communication on others • Demonstrates a lack of empathy, respect, dignity and caring towards clients/carers and colleagues		
Prioritise People	• Is preoccupied with personal issues • Is not motivated and shows lack of interest • Does not respond appropriately to feedback • Is unable to effectively work within the team • Shares personal experiences with patients and clients inappropriately • Lacks insight into their behaviour towards others		
Preserve Safety	• Demonstrates inconsistent clinical performance to their level of experience • Has demonstrated unsafe clinical practice • Is unable to demonstrate preparation and organisational skills to their level of experience • Is unable to relate actions to potential risks re self, patients and colleagues • Misuse of IT and/or electronic patient records		
Promote Professionalism and Trust	• Demonstrates poor professional behaviour and is unaware of professional boundaries • Is unreliable – i.e. persistent lateness/absence/sickness • Evidence of breaching confidentiality, of patients, peer group, placement or university staff • Evidence of inappropriate use of social media • Uses mobile phone to text while in clinical area • Does not adhere to uniform policy • Inappropriate use of electronic mail, text messaging and social network sites • Does not demonstrate respect for all members of the team		
Medicines Management	• Does not have required knowledge for their level of experience • Has little or no ability to translate numerical calculations into drug administration • Unable to apply theory to practice • Does not meet the required level of competencies for their level of experience • Is unsafe in recognising need for storing, recording or monitoring side effects of medications for example • Appears to have little understanding of legislation around medicines management, legal and ethical frameworks • Does not use initiative in knowledge acquisition around drugs associated with patient profile for placement area, routes of administration, side effects, adverse reactions for example		

The early warning checklist is included to help mentors identify if there is a cause for concern early on with a student in relation to the 5 areas of competence.

These points should aid early identification of problems to speed up resolution and initiate developmental action plans.

Authorised Signatures

List of Supervisor and mentor signature samples

Name (Please print)	Signature	Date of last mentor update	Designation	Placement
JANE JONES	J. Jones	11/10/16	STAFF NURSE	GA PILGRIM
TOM LEWIS	Thews TL	2/2/16	SISTER	GA PILGRIM
KAREN FULLER	K. Fuller	22/5/16	SPECIALIST NURSE	ST BARNABAS BOSTON

Anyone who writes in the student's PAD or OAR should record their signature and details at the back of the PAD.

This includes mentors, co-mentors, associate mentors, mentors in training, supervisors from insight visits, etc.

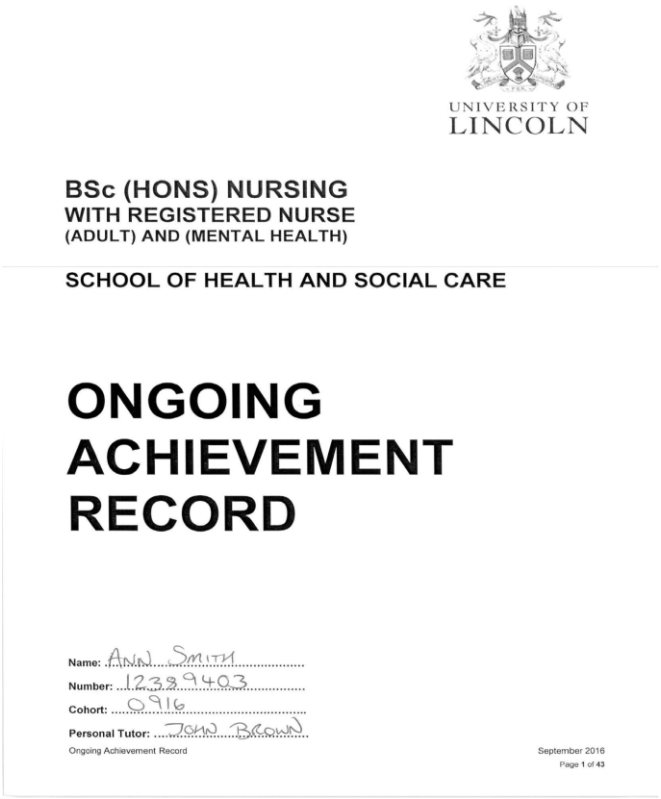
The Ongoing Achievement Record (OAR)

Contents

The OAR contains the student's tutorial records (both one to one and group), evidence towards EU requirements, summary and interview pages of previous PADs, action plans and cause for concern forms. This document covers the full three years of the programme.

Mentors may wish to review the student's OAR to understand prior learning, at preliminary interview

This is an electronic document and students will either show you an electronic version or they may choose to print and present this in a file.


UNIVERSITY OF LINCOLN

BSc (HONS) NURSING
WITH REGISTERED NURSE
(ADULT) AND (MENTAL HEALTH)

SCHOOL OF HEALTH AND SOCIAL CARE

ONGOING ACHIEVEMENT RECORD

Name: ANN SMITH
Number: 12338403
Cohort: 0916
Personal Tutor: JOHN BROWN

Ongoing Achievement Record

September 2016
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Records of Practice Hours

Students will be recording their hours on PEMS which is an electronic timesheet.

Mentors will need to verify the hours recorded on these sheets by viewing them and entering a unique pin number to agree the hours (or ask the student to amend if needed and then agree).

Mentors will be assigned a pin number through PEMS and they will find this on their dashboard when they log in.

This pin will be active for your linked students only and for the period of the placement only.

https://pems.lincoln.ac.uk/Login.aspx

Students will have university specific information regarding how this information is submitted, reported and recorded.