BSc (Hons) Nursing
Dip HE Nursing

Nursing Adults in the Community Setting

NRMW 2201

Continuous Assessment of Practice (CAP)

School of Nursing & Midwifery
Faculty of Health and Life Sciences
Student Name:  
**Pre Registration Branch Programme**  
Clinical Assessment of Practice  

*Semester 6,7 or 8 rotating: Summative*  
*NRMW 2201*  
*Nursing Adults in the Community Setting*  

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<th>Student Nurse:</th>
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<td>Programme:</td>
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<td>Module Dates:</td>
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<td>Personal Tutor:</td>
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<td>Named Mentor:</td>
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Guidance and Completion Advice

Continuous Assessment Practice
The Continuous Assessment of Practice document is an essential element of your portfolio of experience, evidence and achievement. The Branch Programme, continuous assessment of practice documents include proficiencies that are essential for the successful completion of that module.
You will be expected to complete this element of your portfolio as you progress through the module. Your progression will be closely monitored by your Mentor/ Second Mentor and Personal Tutor.

Make sure you complete the Continuous Assessment Practice document either in black ink or use a word processor and keep a photocopy before you hand it in.
After the Continuous Assessment of Practice document has been moderated and presented to the examination board, you can collect it from student services in Mallard House at Charles Frears. It can then form part of your more general professional portfolio.

Standards of proficiency for pre-registration nursing education (2004)
You are required to submit evidence for all standards of proficiency identified for the module.

Reflection
You are required to provide evidence of achievement for each of the statements of proficiency. In order to achieve you must reflect upon the evidence you have used.

Evidence can take a number of forms but it should be focussed and specific to the proficiency statement. In addition to your practice mentor observing your performance, evidence may include care plans, case studies, protocols, teaching programmes/plans, health promotion materials, video/audio tapes and critical incident analyses. It is not expected that you include this type of evidence in your portfolio but that you reflect upon this towards the achievement of that specific proficiency. These reflections form an essential collection of material within your portfolio. Please keep your portfolio safe as a percentage of students’ evidence will be audited each year, by the University Assessment Board.

The Role of the Mentor
Your Mentor should be a qualified nurse, midwife, / social / allied health professional who feels competent to act as your mentor, supervisor and assessor for this module. The Mentor should have a level of expertise that you are able to draw upon as you progress through your module. They should be someone with whom you can develop a supportive, professional relationship. You should have one Mentor who takes overall responsibility for your experience, supervision and assessment. A second Mentor may be identified to assist in this. These mentors would normally be from your own professional background. However, there may be occasions when an individual from another profession may be the most suitable person to undertake this role. This will be discussed and agreed with your module leader.
Mentors Comments & Verification
The comments that the practice mentor makes will verify the overall achievement that the student has made regarding, each proficiency. If at the mid module review, the mentor and the student feel that the student is not making satisfactory progress and may fail to provide evidence of completion of any of the proficiencies, then the mentor and student should contact the module leader / nominated team member and arrange a meeting to discuss this.

Assessment Process

- Initial meeting of student and mentor – **Action plan from previous placement to be discussed. To facilitate this, it is a requirement that the OAR be presented to the mentor within the first five days of the placement.**
- Mid module review with mentor
- It is advised that all aspects are completed and **verified by the mentor before the last day of the placement and an Action Plan for next placement be produced and agreed**

The completed Continuous Assessment Practice document should be submitted via the established submission route on the date clearly indicated in the Module Guide. Late submissions will not be accepted, unless accompanied by the agreed extension form. Late submissions (without an extension form) and non submissions will be deemed a FAIL. There should be a signed student cover sheet on the front.

Pass / Fail Criteria

Your practice mentor needs to confirm that each of the proficiency statements meet the following criteria:

1. Your evidence is relevant to the proficiency
2. You have demonstrated reflection on and analysis of aspects of practice
3. You have demonstrated integration of theory and practice

If by the end of your module, you have not achieved the proficiencies required for progression, then you will be reported to the examination board as having failed this aspect of the module. Your progression and non achievement will be discussed by the Progression and Award Board.

Ongoing Achievement Record

From Semester 3 onwards, the mentor should also complete the Ongoing Achievement Record (OAR). It is the student’s responsibility to maintain their OAR. They should:

- **Discuss the OAR with the mentor within the first five days of the placement** and identify any outstanding issues from their previous module(s) which may require action planning.
- **Present the OAR near the end of the module and ask the mentor to complete it.**

Full instructions for this process are contained within the OAR, therefore they are not repeated here.
EVALUATION OF PROFESSIONAL PRACTICE

Introduction

There is an expectation that all students undertaking courses of study in nursing demonstrate standards of behaviour compatible with the principles of ‘The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC 2008).’

This is an essential criterion for achieving ‘fitness for practice’ and therefore becoming eligible to be recommended for entry to the NMC’s professional register.

To manage this process of evaluation, a standard approach, which utilises a standard set of criteria, has been introduced to all pre-registration nursing and midwifery courses. This facilitates equity for all students and provides a ‘transparent process’ to monitor, assess and summatively evaluate professional development and professional conduct.

Key points relating to the assessment of professional conduct

Professional behaviour is an integral part of all practice assessments and is a considered component of a student’s performance. This should be reflected appropriately, in comments related to the achievement of specific learning outcomes or competencies, both verbally and within the student’s Continuous Assessment of Practice document.

Throughout a practice placement, practice Mentors monitor students’ professional development and conduct, providing feedback to the student at appropriate intervals. Where a student demonstrates inappropriate professional behaviour, the practice Mentor should discuss this with the student and together, they should devise an action plan to support professional development. This should also be discussed with the lecturer visiting the student, or module leader as appropriate.

Assessments of the stated learning outcomes throughout the placement, aggregate to form a focused, summative evaluation of professional conduct, which should be recorded on the dedicated Professional Conduct Evaluation page of the Continuous Assessment of Practice document. This should be completed by the student’s Practice Mentor. It is emphasised that the behaviours listed on the Professional Conduct Evaluation page, are examples only and not exhaustive. Practice Mentors and Professional Heads in practice, will exercise professional judgement regarding a student’s performance.

4 The outcome of the summative, professional conduct evaluation will be reported to the School of Nursing and Midwifery’s Assessment Board, as a component of the practice assessment for the module undertaken, and subsequently, will be entered on each student’s assessment record.

5 Where a student fails to meet a satisfactory standard of professional conduct the Assessment Board will decide the appropriate action, for example, that the student:

- Fails the module – due to lack of progress in professional development
  (e.g. – is uncooperative/ unreliable in time keeping)
• Is dismissed from the course - **in cases of serious professional misconduct**
  (e.g. – abuse of clients or patients/ theft/ fraud)

Professional conduct evaluations throughout the course will contribute to an objective recommendation to the NMC for students to be admitted to the professional register, as well as, references to prospective employers.

Copies of the following are included overleaf for information and guidance:

• **The Professional Conduct Evaluation page** - which is included in each Continuous Assessment of Practice document.

• **Guidance for monitoring and assessment of Professional Conduct of pre-registration nursing and midwifery students** – which provides a quick reference guide.

• **A Flow Chart**: dealing with unsatisfactory professional behaviour in students undertaking pre-registration nursing and midwifery courses – which outlines the process to be followed in managing the assessment of professional conduct.
Flow Chart: Process for dealing with unsatisfactory professional behaviour in students undertaking pre-registration nursing and midwifery courses

**Professional behaviour is unsatisfactory in practice**

### Serious misconduct
*Practice Mentor reports to Professional Head in practice, Visiting Tutor & Programme Leader*

- Student immediately removed from patient contact (decision made by Professional Head)
- Student remains on placement, but written action plan agreed
- Investigation by Programme Leader
- Report submitted to Head of School and Personal Tutor informed
- Action Plan implemented & reviewed
- No improvement by end of placement student deemed **UNSATISFACTORY PROFESSIONAL CONDUCT**
- Potential Fitness to Practise Procedure

#### Lack of progress in professional development
*Student interviewed by Practice Mentor & Visiting Tutor or Personal Tutor*
*Action Plan agreed*
*Module Leader and Personal Tutor or Programme leader and LME (midwifery) as relevant to be informed*
*Action Plan implemented & reviewed*
*No improvement by end of placement student deemed **UNSATISFACTORY PROFESSIONAL CONDUCT***

#### Nursing and Midwifery Assessment Board

- Student deemed **FAIL at 1st attempt** in practice
- Student proceeds to 2nd attempt under supervision and monitoring
- No improvement during subsequent practice placement

#### Updated 27 Feb 08 PMN
Student deemed: **FAIL at 2\textsuperscript{nd} attempt in practice and Discontinued**
Nursing Midwifery Council Proficiencies

These proficiencies are assessed throughout the Branch Programme and evidence that you have achieved them will be contained within your portfolio. For each module of the branch programme a number of these proficiencies will be achieved in order to ensure that by the end of the programme you are eligible for registration.

Student nurses need to achieve the NMC (2004) proficiencies listed below in order to be eligible for registration:

Professional and Ethical Practice

1 Manage oneself, one’s practice, and that of others, in accordance with The NMC code of professional of conduct: standards for conduct, performance and ethics, recognising one’s own abilities and limitations
1.1 Practise in accordance with The NMC code of professional of conduct: standards for conduct, performance and ethics
1.2 Use professional standards of practice to self-assess performance
1.3 Consult with a registered nurse when nursing care requires expertise beyond one’s own current scope of competence
1.4 Consult other health care professionals when individual or group needs fall outside the scope of nursing practice
1.5 Identify unsafe practice and respond appropriately to ensure a safe outcome
1.6 Manage the delivery of care services within the sphere of one’s own accountability

2 Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality
2.1 Demonstrate knowledge of legislation and health and social policy relevant to nursing practice
2.2 Ensure the confidentiality and security of written and verbal information acquired in a professional capacity
2.3 Demonstrate knowledge of contemporary ethical issues and their impact on nursing and health care
2.4 Manage the complexities arising from ethical and legal dilemmas
2.5 Act appropriately when seeking access to caring for patients and clients in their own homes

3 Practise in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups
3.1 Maintain, support and acknowledge the rights of individuals or groups in the health care setting
3.2 Act to ensure that the rights of individuals and groups are not compromised
3.3 Respect the values, customs and beliefs of individuals and groups
3.4 Provide care which demonstrates sensitivity to the diversity of patients and clients
Care Delivery

4. Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills
   4.1 Utilise a range of effective and appropriate communication and engagement skills
   4.2 Maintain and, where appropriate, disengage from professional caring relationships that focus on meeting the patient's or client's needs within professional therapeutic boundaries

5. Create and utilise opportunities to promote the health and well-being of patients, clients and groups
   5.1 Consult with patients, clients and groups to identify their need and desire for health promotion advice
   5.2 Provide relevant and current health information to patients, clients, and groups in a form which facilitates their understanding and acknowledges choice / individual preference
   5.3 Provide support and education in the development and / or maintenance of independent living skills
   5.4 Seek specialist / expert advice as appropriate

6. Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities
   6.1 Select valid and reliable assessment tools for the required purpose
   6.2 Systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observations and measurement
   6.3 Analyse and interpret data accurately to inform nursing care and take appropriate action

7. Formulate and document a plan of nursing care, where possible, in partnership with patients, clients, their carers and family and friends, within a framework of informed consent
   7.1 Establish priorities for care based on individual or group needs
   7.2 Develop and document a care plan to achieve optimal health, habilitation, and rehabilitation based on assessment and current nursing knowledge
   7.3 Identify expected outcomes, including a time frame for achievement and / or review in consultation with patients, clients, their carers and family and friends and with members of the health and social care team

8. Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe and effective nursing practice
   8.1 Ensure that current research findings and other evidence are incorporated in practice
   8.2 Identify relevant changes in practice or new information and disseminate it to colleagues
   8.3 Contribute to the application of a range of interventions which support and optimise the health and well-being of patients and clients
   8.4 Demonstrate the safe application of the skills required to meet the needs of patients and clients within the current sphere of practice
   8.5 Identify and respond to patients and clients' continuing learning and care needs
8.6 Engage with, and evaluate, the evidence base that underpins safe nursing practice

9. **Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences**
   9.1 Identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care

10. **Evaluate and document the outcomes of nursing and other interventions**
    10.1 Collaborate with patients and clients and, when appropriate, additional carers to review and monitor the progress of individuals or groups towards planned outcomes
    10.2 Analyse and revise expected outcomes, nursing interventions and priorities in accordance with changes in the individual’s condition, needs or circumstances

11. **Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts**
    11.1 Use evidence based knowledge from nursing and related disciplines to select and individualise nursing interventions
    11.2 Demonstrate the ability to transfer skills and knowledge to a variety of circumstances and settings
    11.3 Recognise the need for adaptation and adapt nursing practice to meet varying and unpredicted circumstances
    11.4 Ensure that practice does not compromise the nurse’s duty of care to individuals or the safety of the public

**Care Management**

12. **Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies**
    12.1 Apply relevant principles to ensure the safe administration of therapeutic substances
    12.2 Use appropriate risk assessment tools to identify actual and potential risks
    12.3 Identify environmental hazards and eliminate and / or prevent where possible
    12.4 Communicate safety concerns to a relevant authority
    12.5 Manage risk to provide care which best meets the needs and interests of patients, clients and the public
13. Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team

13.1 Establish and maintain collaborative working relationships with members of the health and social care team and others
13.2 Participate with members of the health and social care team in decision-making concerning patients and clients
13.3 Review and evaluate care with members of the health and social care team and others

14. Delegate duties to others, as appropriate, ensuring that they are supervised and monitored

14.1 Take into account the role and competence of staff when delegating work
14.2 Maintain one’s own accountability and responsibility when delegating aspects of care to others
14.3 Demonstrate the ability to co-ordinate the delivery of nursing and health care

15. Demonstrate key skills

15.1 Literacy – interpret and present
15.2 Numeracy – accurately interpret numerical data and their significance for the safe delivery of care
15.3 Information technology and management – interpret and utilise data and technology, taking account of legal, ethical and safety considerations, in the delivery and enhancement of care
15.4 Problem-solving – demonstrate sound clinical decision-making which can be justified even when made on the basis of limited information

Personal and Professional Development

16. Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice

16.1 Identify one’s own professional development needs by engaging in activities such as reflection in, and on, practice and lifelong learning
16.2 Develop a personal development plan which takes into account personal, professional and organisational needs
16.3 Share experiences with colleagues and patients and clients in order to identify the additional knowledge and skills needed to manage unfamiliar or professionally challenging situations
16.4 Take action to meet any identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice.

17. Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching

17.1 Contribute to creating a climate conducive to learning
17.2 Contribute to the learning experiences and development of others by facilitating the mutual sharing of knowledge and experience
17.3 Demonstrate effective leadership in the establishment and maintenance of safe nursing practice.
Initial meeting of student and mentor

Action Plan (Identify how you are going to meet the proficiencies including resources – people / places, areas of practice, formal & informal teaching, supervision. Include a realistic review date. Note: To include review of OAR, written agreed goals for further development and learning from previous placement)

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<tr>
<th>Action Plan</th>
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OAR seen  Yes ☐ No ☐

Mentor’s signature  Date

Student’s signature  Date
Mid Module Review

Student’s comments reflecting progress in achieving proficiencies and action plan. Identify any areas that still need to be achieved. Are there any outstanding issues raised by the OAR? Has the action plan been achieved?

Signature of student       Date

Mentor’s comments identifying any areas that you feel that the student may have difficulty in achieving by the end of the module. Consider if you need to contact the module leader for any advice.

Signature of mentor       Date
Final Evaluation (this should be completed during last week of practice)

Student’s comments reflecting progress in achieving proficiencies and action plan.

Signature of student       Date

Mentor’s comments reflecting students progress in achieving proficiencies and action plan. Strengths and Weakness identified for the next placement

Signature of mentor       Date

A summary of the end of module evaluation must be made by the mentor in the student’s Ongoing Achievement Record, together with recommendations for the student’s future development, where necessary.
Principles for Placement Visits to Students

Aims of the visits:

Personal Tutors in the CFP and Lecturers from Module teaching teams (Visiting Tutors), in the Branch, have allocated hours to visit students during their placements. Placement visits are arranged to enhance the learning process of students during practice weeks.

- The timing of placement visits might not be crucial but if problems arise, they should be as soon as possible. Visits are performed to monitor learning so normally, a reasonable time for settling into a placement should occur before the first visit.

- It is the responsibility of students to negotiate a date for meeting with their Visiting Tutor when their Mentor is also on duty. *This should enable a tripartite discussion about the development of skills, knowledge and attitude.*
  - *Visiting Tutor could identify potential dates for visits to students at the beginning of a semester.*

- The Standard agenda should be used and retained within the CAP book so Personal Tutors can view the records at the end of each semester during tutorials.

- Students must have their CAP booklet available for their meeting. *This will focus the discussion on learning in practice and identify further potential learning opportunities.*

- Discussions should predominantly be about development of skills, knowledge and attitudes in practice.

- Academic support could be provided during visits. This is possible only if the Visiting Tutor is also the student’s Personal Tutor (in semesters 1-3) or a member of the respective Module Teaching Team (in semesters 4-9).

- The Visiting Tutor should give feedback to the mentor following the visit.

- During the CPF, Personal Tutors will be giving advice to students and mentors regarding the progress of the completion of the Evidence –based Diary, Clinical Skills Record, and CAP book. Notes should be made on the Student’s Placement Visit Record.

- Likewise, during the Branch, Visiting Tutors will be giving advice to students and mentors regarding the progress of the completion of the Clinical Skills Record, and CAP book. Notes should be made on the Visiting Tutor’s Record of Visit.

- Notes should be made in the event that a student and or a mentor do not attend the planned meeting. Likewise, if a Visiting Tutor fails to attend a planned meeting, this should be recorded and the reasons should be stipulated.
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<tr>
<th>Visiting Tutor’s Record of Visit</th>
<th>Comments on progress of each issue - if relevant</th>
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<td>Learning opportunities and achievements</td>
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<td>Student’s comments</td>
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<td>Any other comments including reason for non-attendance of student or mentor</td>
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<td>Discussion with mentor</td>
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Student’s Signature: __________________________|

Visiting Tutor’s Signature: ___________________________ Date: ___________
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Student’s Signature: ________________________________

Visiting Tutor’s Signature: _________________________ Date: ____________
Professional and Ethical Practice

Critically review the underpinning evidence relating to the Proficiency indicated below:

Professional and Ethical Practice

1 Manage oneself, one’s practice, and that of others, in accordance with The NMC code of professional conduct: standards for conduct, performance and ethics, recognising one’s own abilities and limitations

Guidance

• Explore the meaning of the concept “unsafe practice” in relation to community nursing
• Discuss with your mentor examples of unsafe practice
• Identify the actions and responsibilities of the student nurse in response to one of these examples

Summary of evidence used (to be completed by student)

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**Professional and Ethical Practice**

*Critically review the underpinning evidence relating to the Proficiency indicated below:*

2. Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality

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<th>2.5 Act appropriately when seeking access to caring for patients and clients in their own homes</th>
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<td><strong>Guidance</strong></td>
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<tr>
<td>• Act at all times as an invited guest in the client’s home</td>
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<td>E.g. Introduce yourself when seeking access to client’s home</td>
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<td>• Respects values, beliefs and customs if individuals in their own homes</td>
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<td>E.g. Seek consent when giving care</td>
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<td>• Discuss the different ways in which you might meet the needs of clients in a professional and sensitive manner</td>
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<td>E.g. Consider the different needs of individuals</td>
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**Care Delivery**

Critically review the underpinning evidence relating to the Proficiency indicated below:

4 Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills

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<tr>
<th>4.2 Maintain and, where appropriate, disengage from professional caring relationships that focus on meeting the patient’s or client’s needs within professional therapeutic boundaries</th>
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<tr>
<td><strong>Guidance</strong></td>
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<tr>
<td>• Acknowledge and maintain professional boundaries in relation to developing a therapeutic relationship for patients/clients receiving long term care</td>
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<td>E.g. Recognise when it is appropriate to use therapeutic touch within a professional relationship</td>
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<td>• Demonstrate how you have been able to complete an episode of care and discharge a patient</td>
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Care Delivery
Critically review the underpinning evidence relating to the Proficiency indicated below:

6. Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities

6.2 Systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observations and measurement

Guidance
- Demonstrate effective interviewing and observational skills to carry out a holistic and accurate patient assessment including the patient’s home and community environment.
  E.g. Identify sources of health and social care data to determine health needs within the community

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Care Delivery

Critically review the underpinning evidence relating to the Proficiency indicated below:

7. **Formulate and document a plan of nursing care, where possible, in partnership with patients, clients, their carers and family and friends, within a framework of informed consent**

<table>
<thead>
<tr>
<th>7.1 Establish priorities for care based on individual or group needs</th>
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<td><strong>Guidance</strong></td>
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<tr>
<td>• Examine the identified health needs of both individuals and groups in your community.</td>
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<td>• Reflect with your mentor on caseload management and identify priorities for care delivery</td>
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<td>E.g. Referral activity to other agencies</td>
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Care Delivery

Critically review the underpinning evidence relating to the Proficiency indicated below:

9. Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences

9.1 Identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care

Guidance

- Specific to your community, show an awareness of other services which contribute to enhancing health outcomes e.g. education, housing, leisure etc.
- Consider the allocation of resources within your community in relation to equity of care for individual clients and communities.

E.g. Consider the implications of nurse prescribing in relation to utilisation of resources

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</tbody>
</table>
**Care Delivery**

Critically review the underpinning evidence relating to the Proficiency indicated below:

10. **Evaluate and document the outcomes of nursing and other interventions**

10.1 Collaborate with patients and clients and, when appropriate, additional carers to review and monitor the progress of individuals or groups towards planned outcomes.

**Guidance**

- Contribute to discussion as part of community nurse team meetings to evaluate patient care.
- Participate in the implementation and evaluation of a negotiated package of care.
- Acknowledge the contribution of patients/clients, carers and other agencies in managing planned outcomes of care.

**Summary of evidence used (to be completed by student)**

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Care Delivery

Critically review the underpinning evidence relating to the Proficiency indicated below:

10. Evaluate and document the outcomes of nursing and other interventions

10.2 Analyse and revise expected outcomes, nursing interventions and priorities in accordance with changes in the individual’s condition, needs or circumstances

Guidance
- Participate in the evaluation of care by assessing the effectiveness of expected outcomes in conjunction with the client and family.
- Respond appropriately to changes in a client’s condition or needs
  E.g. Contribute to changing a package of care in response to the deterioration of a terminally ill patient

**Summary of evidence used (to be completed by student)**

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Care Management

Critically review the underpinning evidence relating to the Proficiency indicated below:

12 Contribute to public protection by creating and maintaining a safe environment of care through the use of quality assurance and risk management strategies

12.4 Communicate safety concerns to a relevant authority

Guidance
- Demonstrate an understanding of potential and actual unsafe situations
- Identify with your mentor an awareness of hazards and risks in the home and community environment
- Communicate concerns to the relevant appropriate authority

E.g. Recognise the potential of a client to fall, complete a falls assessment and liaise with an appropriate professional for ongoing care

Summary of evidence used (to be completed by student)

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**Care Management**

**Critically review the underpinning evidence relating to the Proficiency indicated below:**

**13 Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team**

<table>
<thead>
<tr>
<th>13.2 Participate with members of the health and social care team in decision-making concerning patients and clients</th>
</tr>
</thead>
</table>

**Guidance**
- Under supervision liaise with different members of the primary healthcare team and/or other agencies.
- Contribute to multi-disciplinary meetings, case conferences, multi-agency care package planning
  
  E.g. Meet with the GP to discuss patient care
  E.g. Attend a case conference to organise a discharge package of care

**Summary of evidence used (to be completed by student)**

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</table>
**Care Management**

**Critically review the underpinning evidence relating to the Proficiency indicated below:**

13 Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team

13.3 Review and evaluate care with members of the health and social care team and others

<table>
<thead>
<tr>
<th>Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participate in the day to day caseload management meeting</td>
</tr>
<tr>
<td>• Explore the contribution of members of the health and social care team to the care of clients on the caseload</td>
</tr>
<tr>
<td>E.g. Spend time with Macmillan nurse, practice nurse, podiatrist, GP, Red Cross etc</td>
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**Summary of evidence used (to be completed by student)**

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</table>
Care Management

Critically review the underpinning evidence relating to the Proficiency indicated below:

15. Demonstrate key skills

15.3 Information technology and management – interpret and utilise data and technology, taking account of legal, ethical and safety considerations, in the delivery and enhancement of care

Guidance
- Demonstrate an awareness of the Data Protection legislation
- Be aware of and understand your own limitations and develop alternative strategies to ensure safe practice
  E.g. Use a calculator to calculate drug dosages
- Access the internet to source information to examine the healthcare profile of your community eg Blackboard
  E.g. Meet with the practice nurse to discuss the Practice profile

Summary of evidence used (to be completed by student)

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Date | Date
Personal and Professional development

16. Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice

16.2 Develop a personal development plan which takes into account personal, professional and organisational needs

Guidance
- Reflect on your practice to examine your future learning needs from a personal, professional and organisational perspective.
- Identify specific areas of learning which will enhance your practice development
- Examine resources which may be available to you in your placement where you may enhance your professional development

Summary of evidence used (to be completed by student)

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<td>Date</td>
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</table>
**GUIDANCE FOR PROFESSIONAL PRACTICE**

<table>
<thead>
<tr>
<th>Student performance - as set out in Practice Assessment document</th>
<th>Behaviours reflecting Satisfactory professional conduct</th>
<th>Behaviours reflecting Unsatisfactory professional conduct</th>
<th>Guidelines for unsatisfactory evaluations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work in accordance with The Code: Standards of Conduct, Performance and ethics for Nurses and Midwives (NMC 2008)</td>
<td>Student demonstrates awareness of The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008) for example, in practice the student:</td>
<td>Student lacks awareness of The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008) for example, in practice the student:</td>
<td>1. All assessments will be decided by DMU Assessment Board</td>
</tr>
<tr>
<td>a) Treat people as individuals</td>
<td>Is considerate, sensitive and responsive to patients'/clients' needs Treats all patients/clients with dignity at all times</td>
<td>Is inconsiderate, insensitive and unresponsive to clients' needs Does not treat patients/clients with dignity at all times</td>
<td>2. Failure due to gross professional misconduct (which for example places clients at risk) will result in immediate dismissal</td>
</tr>
<tr>
<td>b) Respect people's confidentiality</td>
<td>Maintains patient/client confidentiality Respects patients/clients, their property and the environment Behaves in a responsible, positive and co-operative manner</td>
<td>Breaches patient/client confidentiality Is disrespectful to patients/clients, their property and the environment Is irresponsible, uncooperative and displays negative attitudes</td>
<td>3. A second failure of Professional Conduct will result in dismissal from their studies and practice.</td>
</tr>
<tr>
<td>c) Uphold the reputation of your profession</td>
<td>Time keeping and timely completion of shift activities are good. Dresses appropriately for the place of work Safeguards clients' well-being Acknowledges own limitations and accepts constructive criticism</td>
<td>Time keeping and adherence to shift activities are poor Dresses inappropriately for the place of work Places patients'/clients' well-being at risk Lacks insight into own limitations and does not accept constructive criticism</td>
<td></td>
</tr>
<tr>
<td>d) Work effectively as part of a team</td>
<td>Is respectful, co-operative and makes positive contributions within the team Is reliable, communicates and works collaboratively in the team Takes appropriate due regard to health &amp; safety measures Adheres to all relevant policies and procedures</td>
<td>Is disrespectful, uncooperative and reluctant to contribute to the team effort Is unreliable, fails to communicate appropriately and does not work well in the team Lacks insight into appropriate health &amp; safety measures Disregards relevant policies and procedures</td>
<td></td>
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</tbody>
</table>
**Mentor’s Pages**: These three pages contain a summary of the student’s progress in clinical placement. It is used to confirm that the student has completed all components of the CAP book, or to identify outstanding components at the end of the placement. Individual components such as NMC outcomes and Progress Reviews must still be completed.

### Mentor’s Page 1: Professional Practice Confirmation

<table>
<thead>
<tr>
<th>Student’s Name:………………………………………</th>
<th>Practice Mentor’s Name: …………………………………………</th>
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</thead>
<tbody>
<tr>
<td>Professional Conduct Satisfactory - Mentor’s Signature: …………………………………………</td>
<td>Date…………………………..</td>
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<tr>
<td>Or</td>
<td></td>
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<tr>
<td>Professional Conduct Unsatisfactory - Mentor’s Signature: …………………………………………</td>
<td>Date…………………………..</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student performance</th>
<th>Guidance for Practice Mentors</th>
<th>Student’s comments on professional behaviour</th>
<th>Practice Mentor’s comments on professional behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work in accordance with The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008)</td>
<td>Student demonstrates awareness of The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008) <strong>for example</strong>, in practice the student:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| a) Treat people as individuals | Is considerate, sensitive and responsive to patients’/clients’ needs  
Treats all patients/clients with dignity at all times | | |
| b) Respect people’s confidentiality | Maintains patient/client confidentiality  
Respects patients/clients, their property and the environment  
Behaves in a responsible, positive and co-operative manner | | |
| c) Uphold the reputation of your profession | Time keeping and timely completion of shift activities are good.  
Dresses appropriately for the place of work  
Safeguards clients’ well-being  
Acknowledges own limitations and accepts constructive criticism | | |
| d) Work effectively as part of a team | Is respectful, co-operative and makes positive contributions within the team  
Is reliable, communicates and works collaboratively in the team  
Takes appropriate due regard to health & safety measures  
Adheres to all relevant policies and procedures | | |
Mentor’s Page 2: Evidence

<table>
<thead>
<tr>
<th>Evidence Provided By Student</th>
<th>Achieved</th>
<th>Not Achieved</th>
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<tbody>
<tr>
<td>The evidence provided by the students is relevant to the module</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is demonstration of reflection on and analysis of aspects of practice</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is demonstration of integration of theory and practice</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>All proficiencies have been achieved</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>OAR has been reviewed and completed</td>
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<td>☐</td>
</tr>
</tbody>
</table>

I confirm that I am currently recorded on my Trust/ Employer/ University Register of Mentors

Signed by Mentor: ......................................................

Reliability of Assessment
In practice, mentors commonly discuss a student’s progress with fellow registered staff. This is seen as a positive activity and helps support the reliability of the assessment of the student’s progress and behaviour.
As named mentor, please list all registered staff who have contributed significantly to this process.

<table>
<thead>
<tr>
<th>Name (Please Print)</th>
<th>Place of work</th>
<th>Position / Title</th>
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</table>

NB: It is recognised that there are a number of clinical areas where only the mentor will have worked with the student, if this is the case, please leave this table blank.
Mentor's Page 3: Signatures

All practitioners who sign in the Continuous Assessment Practice document must indicate their details below.

<table>
<thead>
<tr>
<th>Name (Please Print)</th>
<th>Specimen signature</th>
<th>Place of work</th>
<th>Position/ Title</th>
<th>Date of signature</th>
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</table>
Supplementary sheets for comments (1)
Supplementary sheets for comments (2)
Carbonated Attendance record