WORKING RECORD OF CLINICAL OUTCOMES

Semester Nine

Dip He/BSc Nursing
(Adult, Child, Mental Health, Learning Disabilities)

NRMW 2202/2302/2402/2500
Consolidating Professional Practice/Transition to Practice

Semester Nine

Evidence of experience, exploration and achievement

Student Nurse:	
Course:	
Module Date:	**Start:** **Finish:**
Module Leader:	
Clinical Base:	
Named Mentor:	
Second Mentor:	
As Named Mentor for this student, I can confirm that I am recorded on my Trust/ Employer/ University Register of Mentors **Signature and Date:** ***or*** ***Semester 9 Sign Off Mentors*: I can confirm that I am recorded on my Trust/ Employer/ University Register of Mentors as a Sign Off Mentor** **Signature and Date:**	
Submission Date:	

De Montfort University Personal Tutor Contact Details

Name	
☎ Telephone Number	
💻 E mail address	

Guidance and Completion Advice

Working Record of Clinical Outcomes

This document is an essential element of your portfolio of experience, evidence and achievement. There are three main components to your practice experience within this module; the completion of a management assessment, drug assessment and the formulation of a personal development plan leading to an action plan which will form the basis of your Preceptorship programme once registered. In addition to these main components, outstanding NMC Proficiencies that have not been completed in the previous module will need to be achieved in order to be eligible for registration.

You will be expected to complete this part 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 Working Record of Clinical Outcomes document either in black ink or use a word processor and keep a photocopy before you hand it in. After the document has been moderated and presented to the examination board, you can collect it from student services; Mallard House at Charles Frears. It can then form part of your more general professional portfolio, and provide evidence of achievement to prospective employers.

Reflection

You are required to provide evidence of achievement for each of the module components. 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 component. 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 is 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. Other people may contribute to your placement that would normally be from your own professional background. However, only your mentor can sign the assessed elements of this book.

Mentors Comments & Verification
The comments that the mentor makes will verify the overall achievement that the student has made. If at the mid module review, the mentor and/or the student feel that satisfactory progress is not being made, the mentor/student should contact the Module leader / personal tutor and arrange a meeting to discuss this.

Assessment Process

- Initial meeting of student and mentor – ***Action plan and outstanding NMC proficiencies from previous placement to be discussed***
- 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 future learning within the Preceptorship period be agreed***

The completed Working Record of Clinical Outcomes 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 an agreed Extension to Coursework Application form (PC 1675). Late submissions (without an agreed extension) and non submissions will be deemed a FAIL. There should be a signed student cover sheet on the front.

Pass / Fail Criteria
Your mentor needs to confirm that each of the module components meets the following criteria:

1. Your evidence is relevant
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 standard required for registration, 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.

EVALUATION OF PROFESSIONAL PRACTICE

PRE-REGISTRATION NURSING AND MIDWIFERY STUDENTS

There is an expectation that students undertaking courses of study in nursing or midwifery demonstrate standards of behaviour compatible with the principles of The Code Standards of Conduct, Performance and Ethics for Nurses and Midwives[1]. 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

1. **Professional behaviour is an integral part of all practice assessments and is 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.**

2. **Throughout a practice placement, practice Mentors (formerly referred to as 'assessors') 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.**

3. **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. <u>It is emphasized that the behaviour listed on the Professional Conduct Evaluation page, are examples only and not exhaustive. Practice Mentors and Professional Heads in practice, will exercise professional judgment regarding a student's performance.</u>**

4. **The outcome of the summative, professional conduct evaluation will be reported to the Single Tier Assessment Board, as a component of the practice**

[1] The Code Standards of Conduct, Performance and Ethics for Nurses and Midwives – Nursing and Midwifery Council (NMC) 2008

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 Single Tier 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/patients; theft; fraud)

6. **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 practice document (at the back of the Working Record of Clinical Outcomes document)**

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

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

GUIDELINES INDICATING AN AUTOMATIC FAILURE FOR UNSAFE PRACTICE IN BOTH PRACTICE AND ACADEMIC ASSESSMENT

Rationale for the Guideline

All students (pre and post-registration) are expected to be familiar with the principles of safe practice and are expected to perform in accordance with these requirements. Whilst it is usually the case that students recognise safe practice issues in placements experiences this is not always reflected in academic work. Feedback from external examiners indicates that there are variations in the application of judgements regarding the demonstration of unsafe practice in assessments. It is important to ensure, as far as is possible, equity of decision making in respect of assessments. Thus this guideline will apply to assessments in practice as well as for academic assessments.

This guideline is intended as a supplement to and not a replacement for the University's marking criteria. It is not possible to construct strict rules regarding what constitutes unsafe practice in all circumstances and professional judgement still has a role to play. The guideline is aimed at assisting in making judgements and providing a basis for resolving cases where a difference of opinion might occur.

Definition of Unsafe Practice

Unsafe practice is described as a "… behaviour that places the client or staff in either physical or emotional jeopardy. Physical jeopardy is the risk of causing physical harm. Emotional jeopardy means that the student creates an environment of anxiety or distress which puts the client or family at risk for emotional or psychological harm. Unsafe clinical practice is an occurrence or pattern of behaviour involving unacceptable risk" (Scanlan et al 2001 p1).

Unsafe practice includes:

- An act or behaviour of the type which violates the Nursing and Midwifery Council's The Code Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2008) or the Health Professions Council's Standards of Conduct, Performance and Ethics (2003);
- An act or behaviour which threatens or has the potential to threaten the physical, emotional, mental or environmental safety of the client, a family member, or substitute familial person, another student, a university member or other health care provider;
- An act or behaviour (commission or omission) which constitutes practice for which a student is not authorised or educated at the time of the incident.

In addition in respect of academic assessments unsafe practice includes:

- Expressing practice that if acted on would constitute unsafe practice as identified above.
- Omission of an essential element of care in an academic piece of work that if the omission occurred in practice would constitute unsafe practice as identified above.
- Failure to recognise or acknowledge an act or behaviour that has been recounted in an academic assessment constitutes unsafe practice.

Consequences of the Demonstration of Unsafe Practice in Assessments

Any student judged to have demonstrated unsafe practice in an assessment will be judged to have failed that complete assessment. Thus where, for example, an unseen written examination has a requirement for several questions to be answered the **demonstration of unsafe practice in a single question will result in a fail for the whole examination**. Where a student is judged to have demonstrated unsafe practice for a single outcome in a practice assessment a fail is recorded for the practice element of the module. The student will consequently be required to retrieve the failed outcome in a subsequent placement.

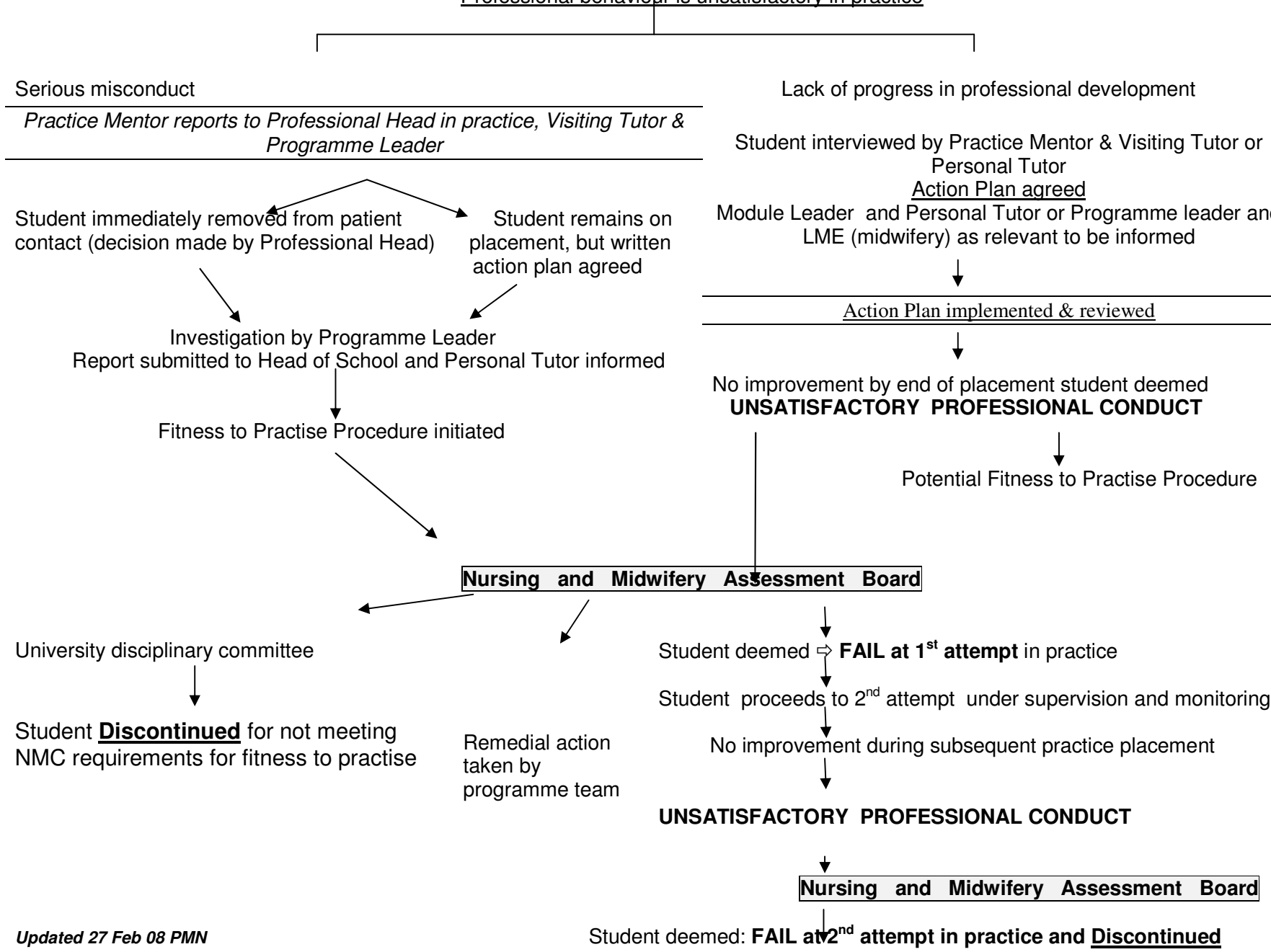
References

Health Professions Council (2003) Standard of conduct, performance and ethics: Your duties as a registrant. HPC, London.

Nursing and Midwifery Council (2008) The NMC Code of Professional Conduct. NMC, London.

Scanlan, J, Care WD, Gessler, GS (2001) Dealing with the unsafe student in clinical practice. Nurse Educator 26 (1); 23-27

Flow Chart: Process for dealing with unsatisfactory professional behaviour in students undertaking pre-registration nursing and midwifery courses



Updated 27 Feb 08 PMN

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 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 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, rehabilitation, 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 practise

Mentor Signatures

All registrants who sign in the Working Record of Clinical Outcomes (WROCO) document must indicate their details below. **The signature is also confirmation that the mentor is currently recorded on their Trust/Employer/University Register of mentors**

Name (Please Print)	Specimen signature	Place of work	Position / Title	Date of signature

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 registrants who have contributed significantly to this process.

Name (please print)	Place of work	Position/Title	Outcomes/areas contributed to

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

Transitional Personal Development Plan

Guidance for Students/Mentors

This component requires the student to formulate a development plan for their practice placement experience and for the initial preceptorship period following registration. Students should be able to assess the ability to recognise deficits and weaknesses in their knowledge/skills and identify a variety of strategies to meet their learning needs during their placement and for the first six months following registration.
Students must initially identify how they are going to meet the assessed components for the module- specifically the management assessment, drug assessment and personal development plan/ completion of branch outcomes, plus any outstanding NMC proficiencies from previous modules (if applicable). There may be additional areas for development that will be required, and will therefore need to be included on the PDP. Specific resources needed e.g. – people / places, areas of practice, formal & informal teaching and supervision and a realistic review date must be included. Post registration objectives should be set according to KSF/local appraisal systems.

Initial meeting of Student and Mentor

Initial Meeting	Review date
discussion of how practice requirements can be achieved	

Student's signature …….. Date …….

Mentor's Signature…….. Date ….....

TRANSITIONAL PERSONAL DEVELOPMENT PLAN- PRACTICE EXPERIENCE-Semester Nine

What do I want to achieve?	How am I going to achieve it?	What resources will I need?	What date?	What has happened?
ACTIONS FROM PREVIOUS PLACEMENT: **Including: OUTSTANDING NMC PROFICIENCIES FROM MODULE…… (where applicable):**				
ACTIONS FOR THIS PLACEMENT: **MANAGEMENT ASSESSMENT:**				

DRUG ASSESSMENT: **ADDITIONAL AREAS FOR DEVELOPMENT (Please identify)**				

Mid Module Review

Student's comments

Reflection of progress in achieving the module components/personal development plan following the initial meeting. Identify any areas that still need to be achieved. Has the expected progress been achieved?

Signature of student…….. Date ……

Mentor's comments identify 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 advice.

Signature of mentor…….. Date……

Final Meeting

Student feedback:

Mentor feedback:

Student's signature…… Date……..

Mentor's signature…… Date……..

What do I want to achieve?	How am I going to achieve it?	What resources will I need?	When do I want to achieve this by?	What has happened?
ACTION PLAN DURING PRECEPTORSHIP PERIOD:				

Student Signature…… Date……

Mentor Signature…….. Date……

Principles for Placement Visits to Students

Aims of the visits:

Personal Tutors (in CFP) and Lecturers from Module teaching teams (Visiting Tutors), in the Branch, have allocated hours to visit students during their placements. Within Semester Nine, Personal Tutor's and/or Visiting Tutors may conduct placement visits. 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/Personal Tutor when their Mentor is also on duty. *This should enable a tripartite discussion about the development of skills, knowledge and attitude.*

- Visiting/Personal 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 Working Record of Clinical Outcomes so Visiting/Personal Tutors can view the records at the end of each semester during tutorials.

- Students must have their Working Record of Clinical Outcomes 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.

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

- During the Branch, Visiting/Personal Tutors will be giving advice to students and mentors regarding the progress of the completion of the Clinical Skills Record, and Working Record of Clinical Outcomes 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/Personal Tutor fails to attend a planned meeting, this should be recorded and the reasons should be stipulated.

Visiting/Personal Tutor's Record of Visit

	Comments on progress of each issue - if relevant
Learning opportunities and achievements	
I Integration of theory and practice	
Academic issues	
Professional / behavioral issues	
Practice skills	
Student's comments	
Any other comments Including reason for non-attendance of student or mentor	

Student's Signature: …… Date……
Visiting/Personal Tutor's Signature…… Date……...

Visiting/Personal Tutor's Record of Visit

	Comments on progress of each issue - if relevant
Learning opportunities and achievements	
I Integration of theory and practice	
Academic issues	
Professional / behavioral issues	
Practice skills	
Student's comments	
Any other comments Including reason for non-attendance of student or mentor	

Student's Signature: …… Date……
Visiting/Personal Tutor's Signature…… Date……...

Principles of Management Assessment

Guidance for Mentors and Students

This component draws upon the student's previous knowledge and skills in order to be able to effectively manage a group of patients/clients within an identified area whilst under supervision from their mentor. It is expected that students will be expected to reach the level of INTERNALISATION/DISSEMINATION in order to pass this component of the practice assessment

The criteria by which practice is assessed are based on those defined by **Steinaker and Bell (1979):**

- ***Exposure***
- ***Participation***
- ***Identification***
- ***Internalisation***
- ***Dissemination***

Exposure

To achieve this level the student must have had the opportunity to be exposed to a situation that reflects the identified learning outcomes. **This is not a passive state** and the student must be able to actively show how participation in a given situation could be achieved and apply their mentor's practice to their own understanding. For example, when observing a patient's admission, the student would be expected to observe the mentor and understand the rationale behind the process of admission.

Participation

The student moves from being an observer to actively participating in the experience. The mentor will decide when the student is ready and will choose appropriate opportunities through discussion with the student. For example, the student will begin to develop the skills of assessing patients and participate in undertaking aspects of care with support from their mentor. Exposure and Participation would be expected from students during their **first year**.

Identification

At this level, the student becomes able to take more responsibility for their participation by initiating appropriate action. The student will be able to provide a rationale for their action and begin to evaluate consequences. For example, the student will be able to undertake on-going assessment of patients on their own initiative.

Internalisation
The student will act as an autonomous practitioner within the context of safe practice. The student must be able to make informed decisions based on a range of information available. For example, the student will be able to initiate the necessary actions if patient observations demonstrate deterioration of their clinical condition. Identification and Internalisation would be expected from students during their **second and third years**.
Dissemination
Students will be expected to share their knowledge with others and to critically analyse their own performance. For example, the student will be able to explain the rationale for their care practices to others. Dissemination would be expected from students during their **third year**. It is important when assessing a student that the mentor clearly identifies the particular programme that the student is taking, the stage within the programme and the specific learning outcomes for the module during each placement.
Mentor comments on overall performance of the students management assessment

Component Achieved **Mentor Signature:** **Date:**	**Component Not Achieved** **Mentor Signature:** **Date:**

Outcome One: Facilitation and assessment of learning

i. Demonstrates the ability to communicate effectively during the teaching of others
ii. Acts as a positive role model
iii. Demonstrates the ability to assess the effectiveness of teaching and learning

Summary of evidence used (to be completed by student)

Outcome Two: Establishing effective working relationships

i. Can describe own role within the team, and can acknowledge own limitations and boundaries
ii. Identifies potential barriers to effective team working and strategies to resolve them
iii. Involves patients/clients in decision making processes
iv. Develops successful working relationships with all members of the team

Summary of evidence used (to be completed by student)

Outcome Three: Quality and risk

i. Can identify areas of risk and how to implement the risk assessment process
ii. Demonstrates an understanding of the mechanisms in place to address concerns of poor standards of care
iii. Demonstrates the ability to manage queries, concerns and complaints

Summary of evidence used (to be completed by student)

1. Outcome Four: Organisation and management of care:

i. Can organise and co-ordinate the delivery of safe and effective care
ii. Is able to prioritise care delivery, own workload/workload of others and can respond appropriately to changes
iii. Appropriately reports and records all aspects of care delivery during a span of duty
iv. Can delegate, supervise and monitor as appropriate to relevant members of staff

Summary of evidence used (to be completed by student)

Drug Administration Assessment

Guidance for Mentors and Students

Please note that throughout this assessment, all participants should practice in line with the NMC (2007) Standard 18, 'student nurses must never administer/supply medicinal products without direct supervision'.
Not all outcomes may be encountered during Semester 9. If this is the case students should draw on previous experience and knowledge to satisfy their mentor that they can practice safely.
It is expected that students will actively participate with the administration of medicines within their placement area, which may include administering (For example) oral, depot and subcutaneous medicines. If a practical experience cannot be encountered within the placement area, tripartite discussions between the student, mentor and visiting tutor will need to be arranged so that practice may be obtained elsewhere.

Framework adapted from Standards for Medicines Management (Nursing and Midwifery Council, 2007)

Mentors comments on overall performance of Drug Assessment:

Component Achieved **Mentor Signature:** **Date:**	**Component Not Achieved** **Mentor Signature:** **Date:**

Outcome One **You must correctly confirm the identity of the person to whom the medicine is being administered**
Guidance for students/mentors that MUST be considered: What safety precautions are in place to help you make sure that you have the right person What would you do if you could not identify the person List at least four reasons why a medication might be given to the wrong person What would you do if a colleague or visitor asked for some medication
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Two **You must check that the person is not allergic to the medicine before administering it**
Guidance for students/mentors that MUST be considered: Where should allergies be recorded Identify the differences between an allergy, side effect and sensitivity to a medication How would you recognise a severe anaphylactic reaction What actions would you take if a person was having a severe reaction and what actions would you take What information would you give to a person that has had an allergic response
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Three **You must know the therapeutic uses of the medication to be administered, its normal dosage, side effects, precautions and contraindications**
Guidance for Students/Mentors that MUST be considered: What resources are available for you to find out this information Within your placement area who/what is available to help you clarify a medication dose Has gained the opportunity to practice the procedure of administering medications under supervision of a Registered Practitioner Demonstrate your knowledge of the common medicines used within your placement area, using the table on the next page as a reference guide
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Table to identify the common medications used within the clinical area

(Complete and use as a reference guide. Photocopy this page as necessary))

Medication Name, Dose and Route	Mechanism of Action	Clinical Indications	Contra indications	Side Effects	Nursing Care and monitoring

Medication Name, Dose and Route	Mechanism of Action	Clinical Indications	Contra indications	Side Effects	Nursing Care and monitoring

Outcome Four **You must check that the prescription and medicine label is clearly written, including the expiry date**
Guidance for students/mentors that MUST be considered: What would you do if you could not read any of the information on the medication/prescription chart Identify who can legally prescribe medications What should you do if you are unable to read the name/expiry date on the medication packet/container What steps should you take to ensure that you have the correct medication
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Five

You must have considered the medication:
-dosage
-weight (where appropriate)
-method of administration
-route
-timing

Guidance for students/mentors that MUST be considered:
Identify at least one medication that should be given before food, with food and after food, including the rationale for this
What would you do if the person asked for additional medication in between the prescribed times
Describe the safety aspects and rationale for a range of administration routes (e.g. PO/PR/NG/SC/IM/TOP/INH)

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

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Six **You must administer or withhold the medication in the context of the patients condition and co-existing therapies e.g. physiotherapy**
Guidance for students/mentors that MUST be considered: Identify reasons why a patient may be unable to take their medication and describe what actions you would take List reasons why a medication maybe omitted and identify what steps you would take What would you do if a patient were unable to give consent to the medication being given What do you understand about the term covert administration, and how does this apply to your practice. Are there any circumstances in which covert administration is acceptable
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Seven

You must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the person, ensuring that the signature is clear and legible. Where the medication is not given the reason for doing so must be recorded.

Guidance for students/mentors that MUST be considered:

When administering medication, at what point do you sign for it, and where?
What might be the consequences of failing to do this

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

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Eight **Where self administration of medicines is in practice, identify ways to share the responsibility for safe administration of medicines**
Guidance for students/mentors: What is the process for self administration within your placement area. If this is not applicable, draw upon your previous experiences to discuss the principles involved What do you do if you suspect that the person is not adhering to the proposed regime
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Nine

In the event of a medication error, identify the appropriate action to prevent any potential harm

Guidance for students/mentors that MUST be considered:
What would you regard as a medication error
What are your responsibilities if you make a medication error
What are your responsibilities when you discover that someone else has made a medication error
What documentation needs to be completed when a medication error has been discovered
How is a medication error investigated and followed up

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

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Ten **Demonstrate knowledge of national/local Medication Administration policies. Identify the differences between the role of the student and Registrant Nurse**
Guidance for students/mentors that MUST be considered: What medications are covered by the Misuse of Drugs Act (1971) How these medications are stored How should stock levels of Controlled Drugs be checked What would you do if you discovered a discrepancy in the Controlled Drugs Register How are Controlled Drugs managed in your placement What does the term accountability mean when applied to the administration of medications What do you understand by the term vicarious liability Discuss the policies relevant to your placement area
Summary of evidence used (to be completed by the student)

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Outcome Eleven

You must ensure that all medicinal products are stored/transported/ordered and disposed of correctly

Guidance for students/mentors that MUST be considered:

Can demonstrate an understanding of:

- Who is responsible for the safe storage/transport of medicines
- How they are stored/transported
- Local policies and procedures
- How patients own medications should be managed within the placement area
- Describe the process of safe disposal of unwanted and contaminated medicines
- Discusses the issues surrounding the ordering of medications within the placement area

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

Outcome Achieved **Mentor Signature** **Date**	**Outcome not achieved** **Mentor Signature** **Date**

Medicines Administration Assessment
Completion Statement

Assessment Criteria	Name/Signature of Mentor/Assessor Date
• All twelve theoretical outcomes within the Working Record of Clinical Outcomes are answered satisfactorily	
• The student has been provided with the opportunity to practice the procedure of medication administration under supervision	
• The student has been assessed as competent in both the practical medication and theoretical elements of medicines administration	

I understand that I have now reached the standard required to administer medicines as demonstrated by the completion of the practical medicine administration procedure and the completion of the theoretical outcomes. However, until I am registered with the Nursing and Midwifery Council (NMC), I recognise that I cannot perform this procedure independently and may have to undergo a further assessment in accordance with my employer

Student Name	Signature	Date

PROFESSIONAL PRACTICE FORM

Student's Name: **Practice Mentor's Name:** …….

Professional Conduct Satisfactory ☐ **Practice Mentor's Signature:** …….

Professional Conduct Unsatisfactory ☐ **Date**……..

Student performance	Guidance for Practice Mentors	Student's comments on professional behaviour	Practice Mentor's comments on professional behaviour
Work in accordance with the Code of Professional Conduct (NMC 2008): Demonstrates appropriate individual professional behaviour	Student demonstrates awareness of the Code of Professional Conduct (NMC 2008) and **for example**, through practice: • Behaves in a responsible, positive and co-operative manner • Adheres to relevant policies & procedures • Acknowledges own limitations and accepts constructive criticism • Time keeping and related action are appropriate and fulfils on-duty requirements on placement • Dresses appropriately for the place of work		
Professional behaviour is appropriate when working with clients/patients	❑ Maintains client confidentiality ❑ Respects clients, their property and the environment ❑ Safeguards clients' well-being ❑ Is considerate, sensitive and responsive to clients' needs ❑ Treats all patients/clients with dignity at all times		
Professional behaviour is appropriate when working within the care 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		

(NB please see guidance notes on page 5 for information)

Working Record of Clinical Outcomes
Semester Nine Consolidation of Professional Practice

FINAL COMPLETION STATEMENT

I confirm that (insert Student Name) **…… has completed the areas identified to the required standard as specified within the Working Record of Clinical Outcomes document:**

- **Personal Development Plan** **ACHIEVED/NOT ACHIEVED**
- **Portfolio of NMC Proficiencies completed** **ACHIEVED/NOT ACHIEVED**
- **Principles of Management Assessment** **ACHIEVED/NOT ACHIEVED**
- **Drug Administration Assessment** **ACHIEVED/NOT ACHIEVED**
- **Professional Conduct** **ACHIEVED/NOT ACHIEVED**

(NB All elements must be successfully completed in order to achieve an overall PASS for the Working Record of Clinical Outcomes practice document)

Overall Achievement of Working Record of Clinical Outcomes (to be completed by Mentor):

PASS/FAIL

Mentor Signature…….. Date……..

Student Signature…… Date……

(for academic staff only):

Document checked by Semester Nine Academic Staff for Presentation to DMU Single Tier Assessment Board (STAB)

NAME……
SIGNATURE……..
DATE……..