Assessment of Outcomes and Standards of Proficiency

Introduction
The assessment strategy within all nursing courses is intended to extend students’ personal development and professional learning and to serve as a means of recording their level of proficiency thereby reflecting the multiple demands made on registered nurses. In order to ensure that the students acquire the standards of proficiency required for registration with the NMC an outcomes led framework has been developed.

Essential components of this framework are:

a) Theoretical assessments.

b) Achievement of NMC Standards of Proficiency

c) Objective Structured Examinations (OSCE’s); see section on Teaching and Learning.

d) Evidence based portfolios.

e) Self assessment by the student.

What is Assessment?1

Assessment strategies are designed to:

a) Enable the learner to identify their strengths and areas for development.

b) Provide a way of knowing when a learner is proficient to practice.

Therefore, assessment in the nursing practice settings should:

a) Provide a clear picture of the progress of the learner.

b) Enable the learner to be aware of their progress in each nursing practice experience.

---

1 Some of the information in this section has been adapted with permission for the Pre-Registration, BSc Hons in Midwifery guidelines for mentors
Principles of assessment

a) Judgements should be made using the agreed criteria for assessment.

b) Learners must be aware of the criteria on which they are being assessed.

Assessment is a continuous process and in the final analysis a single incident should not be allowed to 'make or mar' a learner's reputation.

Assessment is a continuous process of learning in which the learner is equally involved with their assessors. Within this process there is both FORMATIVE and SUMMATIVE assessment.

Formative assessment is diagnostic in nature and is concerned with the development of the student, with identifying strengths and weaknesses, and with providing the student with feedback on their progress during the learning process.

Summative assessment is a final assessment that occurs at the end of an experience and is decision making in nature.

Who Assesses?

Assessment throughout the programme is essentially a team activity involving mentors, other health and social care practitioners, the student and their personal tutor.

The student's responsibility is to:

a) Keep the Assessment of Practice Record / Continuity of Practice Assessment Record (CPAR) in a safe place and ensure it is available when discussions are held with their mentor.

b) Develop an action plan to provide the starting point for discussion with their mentor at the beginning of the nursing practice placement.

c) Reflect on their progress and provide evidence to support achievement of their outcomes / standards of proficiency. They should be encouraged to achieve this through portfolio activity.

d) Arrange meetings with their mentor to discuss their progress at designated points during each nursing practice experience.

e) Take their Assessment of Practice Record / Continuity of Practice Assessment Record (CPAR) and portfolio to their Personal Tutor on completion of the placement for ratification of the results in their Personal Academic Record documentation.

The mentor's responsibility is to:

a) Designate time to discuss the student's progress.

b) Provide the student with formative feedback on the progress that they are making towards achievement of the outcomes / standards of proficiency.

c) Document whether or not the student has achieved the outcomes / standards of proficiency following discussion with the student and verification of the supporting evidence provided by the student.

d) Sign the Assessment of Practice Record / Continuity of Practice Assessment Record (CPAR) Results NCR sheet to confirm whether or not they believe that the student has the potential to be a safe competent practitioner.

e) Inform the student's personal tutor or a member of the Practice Learning Team if at any time during the placement there is concern about the student's progress, attitudes.
and/or attendance, and/or if the student fails to achieve any of the outcomes/standards of proficiency.

The personal tutor's responsibility is to:

a) Assist the student to reflect on their learning and develop a portfolio of learning whilst in placement.

b) Ratify that the student has achieved the requisite outcomes/standards of proficiency and record the results in the student's Personal and Academic Record.

c) If a student fails to achieve one or more outcomes/standards of proficiency they must validate the decision made by the mentor, in discussion with the mentor and the student.

d) Inform the Assessment Clerk of student's progress at the end of each year, so that the Examinations Board can receive results for progression on the course.

e) Provide support and advice for both mentor and student when and as required.
**The Process of Assessment**

**At the beginning of each placement**
All students will be provided with an Assessment of Practice Record at the beginning of each new placement. On the first day of the placement, a preliminary discussion should take place between the learner and the mentor. For those students in Cohorts from October 2007 onwards the mentor will be able to review the students Continuity of Practice Assessment Record for comments and action plans from previous placements. Key things to discuss and document in the student’s assessment of practice record are:

- **a) The level of proficiency so far.**
- **b) Any specific learning needs that are likely to warrant specific emphasis.**
- **c) Learning opportunities that are available in the placement area.**
- **d) Orientation and Health and safety procedures and other policies relevant to that placement.**

**During the placement**
Part way through the placement the student and mentor **must** designate time to discuss the progress the student has made towards achievement of the outcomes / standards of proficiency and to review the Action Plan developed at the beginning of the placement. The results of this meeting are recorded in the Assessment of Practice Record as an Intermediate Interview.

At any time during the placement, the student and mentor may record achievement of an outcome/ standard of proficiency. Students are expected to provide sufficient evidence of learning to enable effective dialogue to take place in relation to their capabilities. A portfolio of evidence of learning is important and should not just be a record of what has been undertaken. Students **must** present sufficient written and observational evidence from their portfolio for the mentor to be able to make an assessment decision.

If at any time there is concern that the student is not achieving the outcomes / standards of proficiency, or is making slow progress in spite of the learning opportunities and discussion, or is unsafe, this **must** be discussed with the student and recorded in their documentation. Then the student’s personal tutor or a member of the Practice Learning Team **must** be contacted. Please **Do Not** wait until the final interview before discussing it.

**At the end of the placement**
During the last week of the placement, the learner and mentor **must** have designated time to discuss and to complete the Assessment of Practice Record / Continuity of Practice Assessment Record, document outcomes/standards of proficiency achieved and discuss progress to date. Continuous feedback is a vital part of this process and if this has been happening throughout the placement there should be a fairly good match between the learner’s self assessment and the evidence they provide to support achievement, and the mentor’s assessment. Record of achievement or not **must** be recorded on the appropriate sheets either India Tagged to the Assessment of Practice Record or contained in the Continuity of Practice Assessment Record.
Key issues that will contribute to the student's learning on subsequent placement experiences **must** be documented as part of the 'ongoing record of achievement' [NMC Circular 33/2007]. These will be used to help the student to develop an action plan identifying how they are going to build on their achievements in this placement and the outcomes/standards of proficiency they wish to develop further in subsequent placements.

**Failure to make progress**

If at the end of the placement the student has failed to provide sufficient and/or appropriate evidence to support achievement of one or more of the specified outcomes/standards of proficiency then the PLT Representative or the student's personal tutor **must** be notified immediately so that the decision can be discussed with and validated by a member of academic staff.
**The Assessment of Practice Record**

The Assessment of Practice Record contains three elements.

a) Outcomes or Standards of Proficiency

b) Portfolio of evidence supporting achievement of Outcomes or Standards of Proficiency

c) Documentation and verification of achievement of Outcomes or Standards of Proficiency. [India Tagged to back of documentation for Cohorts up to 07.05; for Cohorts 07.10 onwards Continuity of Practice Assessment Record]

**Nursing and Midwifery Council Standards of Proficiency**

These were introduced by the NMC in February 2004 and have been validated for use in all pre-registration nursing curricula from September 2005. Throughout the course, pre-registration nursing students will be continuously assessed against the NMC Standards of Proficiency (see page 44). In the foundation programme they are used to specify the standard of practice proficiency to be achieved by the student by the end of the foundation programme for progression to the branch. During this period they are referred to as outcomes that must all be achieved at the appropriate level for progression to the branch programmes. In the branch programmes the standards of proficiency are used to specify the level to be achieved by the end of the year and for admission to the professional register.

The Standards of Proficiency are progressive. As student’s progress through their course their standard of proficiency is expected to increase in line with the published NMC Standards of Proficiency and against the escalator of progression in practice. These standards cover the types of behaviours which students might demonstrate and the principles of care students may utilise rather than focusing on specific psychomotor skills.

For students non branch experience there will be one Assessment of Practice Record identifying common and specific outcomes to be achieved over the whole period of the student’s non-branch placements.
Collecting the evidence for the Portfolio

When judgements are being made about a student’s progress it is important that the student is actively involved. The collection of a portfolio of evidence to support achievement of outcomes and standards of proficiency is one way in which this might be achieved. The aims of asking students to develop a portfolio of evidence are to encourage students to accept responsibility for their own learning and to assist them to learn how to reflect on their own progress and to review where they are going. This process entails them setting targets and action planning, i.e., identifying the learning opportunities, and the amount of supervised practice they are likely to require. These personal skills are important ‘key skills’ that underpin the development of all nursing practice skills. Therefore, this process is an essential component of achievement in practice assessment. The strengths of using a portfolio of evidence to show evidence of achievement of proficiency are;

a) Establishing the principle of student participation and self-assessment
b) Increasing student motivation through the recognition of personal achievement.
c) Providing a focus for diagnosis of achievements and learning needs.
d) Placing assessment of practice at the centre of the learning process.
e) Assisting students to reflect critically on and to accept responsibility for their own learning.

In the early stages of the course many students will have little experience of using portfolios to support their learning. Your role as a mentor and our role within the School of Nursing will be to help the students to select the most appropriate evidence to support their claims for achievement of proficiency through the development of a portfolio.
Assessing the quality of the evidence

Reliability and sufficiency: How much evidence does a student need to produce to show that they have achieved the stated outcome or standard of proficiency? There is no easy answer to this question, as the nature of the evidence that the student provides to demonstrate achievement of specific outcomes and standards of proficiency will be very dependant on the nature of the nursing care they are providing, and the needs of individual patients and clients. Therefore, the broader the type of evidence, and the context and the number of occasions on which the students produce this evidence, the more likely it will be that student is able to demonstrate that they have reliably achieved the level of proficiency.

Validity: This requires that you get as close as possible to the student’s actual performance. It also requires that you ensure that the evidence that the student is producing is recent and that it belongs to particular student. Consequently, it will be important to ensure that students produce new evidence to support achievement of each outcome or standard of proficiency on each placement.

Documentation and verification
If satisfied that there is sufficient evident to support achievement of the outcome or standard of proficiency then this should be verified on the results sheets tagged to the Assessment of Practice Record or in the Continuity of Practice Assessment Record. If the outcome or standard of proficiency is not achieved then the mentor should decide whether this is because:

a) There has been no opportunity [minimal use where possible]

b) The evidence presented is insufficient or inadequate to fully achieve the outcome or standard of proficiency.

c) The student has demonstrated poor or unsafe practice.

In the case of non-achievement for any reason the mentor must discuss this with the student and record it on the appropriate sheet. Both student and mentor should sign this. The student’s personal tutor must be contacted so that they can verify the decision that has been made. An action plan should be made for transfer to next placement.

The mentor should ensure that they sign each outcome/ standard of proficiency on the result sheet i.e. a number of outcomes/standards of proficiency should not be grouped together with one signature.

It is very important that the mentor considers the significance of, and their accountability for, their decisions. If there are any concerns at all about the decisions that are being made either the mentor or student can seek support and advice from the School of Nursing.

The final part of the process is the completion of the final interview sheet and record of Professional Progress. [In future this will be part of the Continuity of Practice Assessment Record]. This summarises the discussion about the achievement of the NMC outcomes / standards of proficiency and, importantly reviews the student’s action plan and identifies key areas of learning for the next placement.
### NMC Outcomes to be achieved for entry to the Branch Programme

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Professional and Ethical Practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Discuss in an informed manner the implications of professional regulation for nursing practice.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td></td>
</tr>
<tr>
<td>1.1.1</td>
<td>Demonstrate a basic knowledge of professional regulation and self-regulation.</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Recognise and acknowledge the limitations of one’s own abilities.</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Recognise situations that require referral to a registered practitioner</td>
</tr>
</tbody>
</table>

| 1.2  | Demonstrate an awareness of the NMC code of professional conduct: standards for conduct, performance and ethics. |
| **Outcome** |  
| 1.2.1 | Commit to the principle that the primary purpose of the registered nurse is to protect and serve society. |
| 1.2.2 | Accept responsibility for one’s own actions and decisions |

| 1.3  | Demonstrate an awareness of, and apply ethical principles to, nursing practice. |
| **Outcome** |  
| 1.3.1 | Demonstrate respect for patient and client confidentiality. |
| 1.3.2 | Identify ethical issues in day to day practice. |

| 1.4  | Demonstrate an awareness of legislation relevant to nursing practice. |
| **Outcome** |  
| 1.4.1 | Identify key issues in relevant legislation relating to mental health, children, data protection, manual handling and health and safety, etc. |

<p>| 1.5  | Demonstrate the importance of promoting equity in patient and client care by contributing to nursing care in a fair and anti-discriminatory way. |
| <strong>Outcome</strong> |<br />
| 1.5.1 | Demonstrate fairness and sensitivity when responding to patients, clients and groups from diverse circumstances. |
| 1.5.2 | Recognise the needs of patients and clients whose lives are affected by disability, however manifest. |</p>
<table>
<thead>
<tr>
<th>Domain 2</th>
<th>Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td>Discuss methods of barriers to, and the boundaries of, effective communication and interpersonal relationships.</td>
</tr>
</tbody>
</table>

**Outcome**

2.1.1 Recognise the effect of one’s own values on interactions with patients and clients and their carers, families and friends.
2.1.2 Utilise appropriate communication skills with patients and clients.
2.1.3 Acknowledge the boundaries of a professional caring relationship.

**2.2** | Demonstrate sensitivity when interacting with and providing information to patients and clients. |

**Outcome**

2.2.1 Demonstrate sensitivity when interacting with and providing information to patients and clients.

**2.3** | Contribute to enhancing the health and social well-being of patients and clients by understanding how, under the supervision of a registered practitioner, to |

**Outcome**

2.3.1 Contribute to the assessment of health and needs.
2.3.2 Identify opportunities for health promotion.
2.3.3 Identify networks of health and social care services.

**2.4** | Contribute to the development and documentation of nursing assessments by participating in comprehensive and systematic nursing assessment of the physical, psychological, social and spiritual needs of patients and clients. |

**Outcome**

2.4.1 Be aware of assessment strategies to guide the collection of data for assessing patients and clients and use assessment tools under guidance.
2.4.2 Discuss the prioritisation of care needs.
2.4.3 Be aware of the need to reassess patients and clients as to their needs for nursing care.

**2.5** | Contribute to the planning of nursing care, involving patients and clients and, where possible, their carers; demonstrating an understanding of helping patients and clients to make informed decisions. |

**Outcome**

2.5.1 Identify care needs based on the assessment of a patient or client.
2.5.2 Participate in the negotiation and agreement of the care plan with the patient or client and with their carer, family or friends, as appropriate, under the supervision of a registered nurse.
2.5.3 Inform patients and clients about intending nursing actions, respecting their right to participate in decisions about their care.

**2.6** | Contribute to the implementation of a programme of nursing care, designed and supervised by registered practitioners. |

**Outcome**

2.6.1 Undertake activities that are consistent with the care plan and within the limits of one’s own abilities.
### 2.7
**Demonstrate evidence of a developing knowledge base which underpins safe and effective nursing practice.**

- **2.7.1** Access and discuss research and other evidence in nursing and related disciplines.
- **2.7.2** Identify examples of the use of evidence in planned nursing interventions.

### 2.8
**Demonstrate a range of essential nursing skills, under the supervision of a registered nurse, to meet individuals’ needs, which include:**

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.8.1</strong> Maintaining dignity, privacy and confidentiality; effective communication and observation skills, including listening and taking physiological measurements; safety and health, including moving, and handling and infection control; essential first aid and emergency procedures; administration of medicines; emotional, physical and personal care, including meeting the need for comfort, nutrition and personal hygiene.</td>
</tr>
</tbody>
</table>

### 2.9
**Contribute to the evaluation of the appropriateness of nursing care delivered.**

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.9.1</strong> Demonstrate an awareness of the need to assess regularly a patient’s or client’s response to nursing interventions.</td>
</tr>
<tr>
<td><strong>2.9.2</strong> Provide for a supervising registered practitioner, evaluative commentary and information on nursing care based on personal observations and actions.</td>
</tr>
<tr>
<td><strong>2.9.3</strong> Contribute to the documentation of the outcomes of nursing interventions.</td>
</tr>
</tbody>
</table>

### 2.10
**Recognise situations in which agreed plans of nursing care no longer appear appropriate and refer these to an appropriate accountable practitioner.**

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.10.1</strong> Demonstrate the ability to discuss and accept care decisions.</td>
</tr>
<tr>
<td><strong>2.10.2</strong> Accurately record observations made and communicate these to the relevant members of the health and social care team.</td>
</tr>
</tbody>
</table>
### Domain 3. Care Management

<table>
<thead>
<tr>
<th>3.1</th>
<th>Contribute to the identification of actual and potential risks to patients, clients and their carers, to oneself and to others, and participate in measures to promote and ensure health and safety.</th>
</tr>
</thead>
</table>

**Outcome**

3.1.1 Understand and implement health and safety principles and policies
3.1.2 Recognise and report situations that are potentially unsafe for patients, clients, oneself and others.

<table>
<thead>
<tr>
<th>3.2</th>
<th>Demonstrate an understanding of the role of others by participating in inter-professional working practice.</th>
</tr>
</thead>
</table>

**Outcome**

3.2.1 Identify the roles of the members of the health and social care team.
3.2.2 Work within the health and social care team to maintain and enhance integrated care.

<table>
<thead>
<tr>
<th>3.3</th>
<th>Demonstrate literacy, numeracy and computer skills needed to record, enter, store, retrieve and organise data essential for care delivery.</th>
</tr>
</thead>
</table>

**Outcome**

3.3.1 Demonstrate literacy, numeracy and computer skills needed to record, enter, store, retrieve and organise data essential for care delivery.

### Domain 4. Personal and Professional Development

<table>
<thead>
<tr>
<th>4.1</th>
<th>Demonstrate responsibility for one’s own learning through the development of a portfolio of practice and recognise when further learning is required.</th>
</tr>
</thead>
</table>

**Outcome**

4.1.1 Identify specific learning needs and objectives.
4.1.2 Begin to engage with, and interpret, the evidence base which underpins nursing practice.

<table>
<thead>
<tr>
<th>4.2</th>
<th>Acknowledge the importance of seeking supervision to develop safe and effective nursing practice.</th>
</tr>
</thead>
</table>

**Outcome**

4.2.1 Acknowledge the importance of seeking supervision to develop safe and effective nursing practice.
# Standards of Proficiency to be achieved, in branch programme, for entry to the NMC Register.

<table>
<thead>
<tr>
<th>Domain 1.</th>
<th>Professional and Ethical Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>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.</td>
</tr>
</tbody>
</table>

## Standards of Proficiency

1.1.1 Practice in accordance with The NMC code of professional conduct; standards for conduct, performance and ethics.
1.1.2 Use professional standards of practice to self-assess performance.
1.1.3 Consult with a registered nurse when nursing care requires expertise beyond one’s own current scope of competence.
1.1.4 Consult other health care professionals when individual or group needs fall outside the scope of nursing practice.
1.1.5 Identify unsafe practice and respond appropriately to ensure a safe outcome.
1.1.6 Manage the delivery of care services within the sphere of one’s own accountability.

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

## Standards of Proficiency

1.2.1 Demonstrate knowledge of legislation and health and social policy relevant to nursing practice.
1.2.2 Ensure the confidentiality and security of written and verbal information acquired in a professional capacity.
1.2.3 Demonstrate a knowledge of contemporary ethical issues and their impact on nursing and health care.
1.2.4 Manage the complexities arising from ethical and legal dilemmas.
1.2.5 Act appropriately when seeking access to caring for patients and clients in their own homes.

1.3 Practice in a fair and anti-discriminatory way, acknowledging the differences in beliefs and cultural practices of individuals or groups.

## Standards of Proficiency

1.3.1 Maintain, support and acknowledge the rights of individuals or groups in the health care setting.
1.3.2 Act to ensure that the rights of individuals and groups are not compromised.
1.3.3 Respect the values, customs and beliefs of individuals and groups.
1.3.4 Provide care which demonstrates sensitivity to the diversity of patients and clients.
<table>
<thead>
<tr>
<th>Domain 2.</th>
<th>Care Delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standards of Proficiency</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2.1</strong></td>
<td>Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills.</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Utilise a range of effective and appropriate communication and engagement skills.</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Maintain and, where appropriate disengage from professional caring relationships that focus on meeting the patient’s or client’s needs within professional therapeutic boundaries.</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td>Create and utilise opportunities to promote the health and well-being of patients, clients and groups.</td>
</tr>
<tr>
<td><strong>Standards of Proficiency</strong></td>
<td></td>
</tr>
<tr>
<td>2.2.1</td>
<td>Consult with patients, clients and groups to identify their need and desire for health promotion advice.</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Provide relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice/individual preference.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Provide support and education in the development and/or maintenance of independent living skills.</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Seek specialist/expert advice as appropriate.</td>
</tr>
<tr>
<td><strong>2.3</strong></td>
<td>Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities.</td>
</tr>
<tr>
<td><strong>Standards of Proficiency</strong></td>
<td></td>
</tr>
<tr>
<td>2.3.1</td>
<td>Select valid and reliable assessment tools for the required purpose</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observation and measurement.</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Analyse and interpret data accurately to inform nursing care and take appropriate action.</td>
</tr>
<tr>
<td><strong>2.4</strong></td>
<td>Formulate and document a plan of nursing care, were possible, in partnership with patients, clients, their carers and family and friends, within a framework of informed consent.</td>
</tr>
<tr>
<td><strong>Standards of Proficiency</strong></td>
<td></td>
</tr>
<tr>
<td>2.4.1</td>
<td>Establish priorities for care based on individual or group needs.</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Develop and document a care plan to achieve optimal health, habilitation, and rehabilitation based on assessment and current nursing knowledge.</td>
</tr>
<tr>
<td>2.4.3</td>
<td>Identify expected outcomes, including a time frame for achievement and/or review in consultation with patients, clients, their carers and family friends and with members of the health and social care team.</td>
</tr>
<tr>
<td><strong>2.5</strong></td>
<td>Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe and effective nursing practice.</td>
</tr>
<tr>
<td>Standards of Proficiency</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>2.5.1 Ensure that current research findings and other evidence are incorporated in practice.</td>
<td></td>
</tr>
<tr>
<td>2.5.2 Identify relevant changes in practice or new information and disseminate it to colleagues.</td>
<td></td>
</tr>
<tr>
<td>2.5.3 Contribute to the application of a range of interventions which support and optimise the health and well-being of patients and clients.</td>
<td></td>
</tr>
<tr>
<td>2.5.4 Demonstrate the safe application of the skills required to meet the needs of patients and clients within the current sphere of practice.</td>
<td></td>
</tr>
<tr>
<td>2.5.5 Identify and respond to patients and client’s continuing learning and care needs.</td>
<td></td>
</tr>
<tr>
<td>2.5.6 Engage within, and evaluate, the evidence base that underpins safe nursing practice.</td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td><strong>Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences.</strong></td>
</tr>
<tr>
<td>Standards of Proficiency</td>
<td></td>
</tr>
<tr>
<td>2.6.1 Identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care.</td>
<td></td>
</tr>
<tr>
<td>2.7</td>
<td><strong>Evaluate and document the outcomes of nursing and other interventions.</strong></td>
</tr>
<tr>
<td>Standards of Proficiency</td>
<td></td>
</tr>
<tr>
<td>2.7.1 Collaborate with patients and clients and, when appropriate, additional carers to review and monitor the progress of individuals or groups towards planned outcomes.</td>
<td></td>
</tr>
<tr>
<td>2.7.2 Analyse and revise expected outcomes, nursing interventions and priorities in accordance with changes in the individual’s condition, needs or circumstances.</td>
<td></td>
</tr>
<tr>
<td>2.8</td>
<td><strong>Demonstrate sound clinical judgement across a range of differing professional and care delivery contexts.</strong></td>
</tr>
<tr>
<td>Standards of Proficiency</td>
<td></td>
</tr>
<tr>
<td>2.8.1 Use evidence based knowledge from nursing and related disciplines to select and individualise nursing interventions.</td>
<td></td>
</tr>
<tr>
<td>2.8.2 Demonstrate the ability to transfer skills and knowledge to a variety of circumstances and settings.</td>
<td></td>
</tr>
<tr>
<td>2.8.3 Recognise the need for adaptation and adapt nursing practice to meet varying and unpredictable circumstances.</td>
<td></td>
</tr>
<tr>
<td>2.8.4 Ensure that practice does not compromise the nurse’s duty of care to individuals or the safety of the public.</td>
<td></td>
</tr>
</tbody>
</table>
## Domain 3. Care Management.

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

**Standards of Proficiency**

- 3.1.1 Apply relevant principles to ensure the safe administration of therapeutic substances.
- 3.1.2 Use appropriate risk assessment tools to identify actual and potential risks.
- 3.1.3 Identify environmental hazards and eliminate and/or prevent where possible.
- 3.1.4 Communicate safety concerns to a relevant authority.
- 3.1.5 Manage risk to provide care which best meets the needs and interests of patients, clients and the public.

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

**Standards of Proficiency**

- 3.2.1 Establish and maintain collaborative working relationships with members of the health and social care team and others.
- 3.2.2 Participate with members of the health and social care team in decision-making concerning patients and clients.
- 3.2.3 Review and evaluate care with members of the health and social care team and others.

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

**Standards of Proficiency**

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

### 3.4 Demonstrate Key Skills.

**Standards of Proficiency**

- 3.4.1 Literacy – interpret and present information in a comprehensible manner.
- 3.4.2 Numeracy – accurately interpret numerical data and their significance for the safe delivery of care.
- 3.4.3 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.
- 3.4.4 Problem-solving – demonstrate sound clinical decision-making which can be justified even when made on the basis of limited information.
<table>
<thead>
<tr>
<th>Domain 4.</th>
<th>Personal and Professional Development.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.1</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| Standards of Proficiency | 4.1.1 Identify one’s own professional development needs by engaging in activities such as reflection in, and on, practice and lifelong learning.  
4.1.2 Develop a personal development plan which takes into account personal, professional and organisational needs.  
4.1.3 Share experiences with colleagues, patients and clients in order to identify the additional knowledge and skills needed to manage unfamiliar or professionally challenging situations.  
4.1.4 Take action to meet any identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice. |
| **4.2**  | Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching. |
| Standards of Proficiency | 4.2.1 Contribute to creating a climate conducive to learning.  
4.2.2 Contribute to the learning experiences and development of others by facilitating the mutual sharing of knowledge and experience.  
4.2.3 Demonstrate effective leadership in the establishment and maintenance of safe nursing practice. |
Mentors Guide to Portfolio Assessment

PREPARED BY THE SURGICAL PRACTICE LEARNING TEAM, CITY HOSPITAL, NOTTINGHAM
Updated May 2008.

Introduction
The aim of this guide is to assist mentors to support students in practice with evidence collection for their portfolio, and to advise on the portfolio assessment of a student’s practice evidence.
A student’s overall portfolio will demonstrate their ongoing learning throughout the course, in academic and practice learning environments as well as reflection by the student on their learning. In practice you will see their current portfolio evidence and assignment work related to this placement only and not the overall portfolio the student will have collected through the whole of their course. As a mentor your role will focus on the practice assessment of the student.

While in practice mentors are assessing students against the NMC standards of proficiency. These are national standards all student nurses must achieve in practice during their course and have been developed by the Nursing and Midwifery Council.

The proficiencies are stated in the assessment of practice record each student brings with them onto placement. The records are different for each year of the course, to enable the student to demonstrate their progression in ability and proficiency. The student should use the initial interview to identify the skills and learning they wish to achieve during the placement. Practice learning can then be planned and specific evidence identified. The student should ensure all learning opportunities are recorded. Towards the end of the placement a final interview will be conducted with the mentor who will review the quality of all evidence presented to that point and discuss their assessment decisions with the student and record these in the Assessment of Practice Record / Continuity of Practice Assessment Record.

In order to show their mentor what knowledge skills and attitudes they have the student is asked to collect evidence, referenced against the NMC standards. You will then assess if this evidence is acceptable and meets the standards as the student claims. It is acceptable and good practice, for you to give the student time within their shift where possible for them to record and develop their practice evidence.

When assessing a student you must always remember their level of training. Their knowledge shown in practice should match this. You are not only assessing their practical skills, but their knowledge levels and attitudes which underpin their practice.
In order for you to be able to do this you need to be clear on what evidence can be collected, and how you check this against the NMC standards of proficiency. This guide aims to help you with this aspect of assessment.
What is acceptable evidence?
There are many ways a student can show their mentor what they do and know in practice.

Direct Observation (DO) is when a mentor observes a student performing an activity / skill under supervision. You would observe that the student is working to the correct and appropriate standard for their level of training. You may observe them on more than one occasion to ensure they consistently work at this level. Observations should take place as part of the normal working activity.
Direct Observation is recorded in the student’s assessment of practice record as DO and would be dated and then signed by you to verify the student had been seen delivering this care / activity.

Questions and Answer sessions (QA) can be used by the mentor to assess a student’s underpinning knowledge. This is usually done as you work alongside the student and ask them questions as you work about the activities and skills you observe. This would be recorded as QA, dated and then signed by you to verify the student had answered sufficiently to show their knowledge appropriate to their level of training. It may be useful to note the focus of the topic of questioning.

Reflective Discussion (RD) between the mentor and student would be used to explore issues and knowledge of the student about current issues, in care delivery, skills and attitudes. They are also used to discuss a student’s progress. These are recorded as RD, dated and then signed by you to verify this discussion took place and the student showed an appropriate level of knowledge.

Insight Visit/ Record of Observed Learning statement (OL) A Observed Learning statement can be obtained from a member of health and social care staff (other than the mentor) the student has worked with, as evidence of their observed performance and skills. The student must write the statement and the witness sign it. It should link directly to the NMC outcomes / standards of proficiency that the student is working towards. It should be a statement of learning with supporting evidence outside of normal placement experience. If the statement is achieved as part of an Insight Visit then aims for the visit should be agreed beforehand and recorded on the record. When students are learning from staff working on other professions, then the record of Interprofessional Learning should also be completed.
Patients in exceptional circumstances may be approached, but only after initial discussion with the Mentor. All Observed Learning Records / Insight Visit statements must provide sources of evidence in support of achieving outcomes/ standards of proficiency.

Reflective writing. (RW) Following a particular incident or episode of learning / care delivery a student may write an account of this and use a model of reflection to analyse their learning experience. They may then present this as evidence against NMC standards. As the mentor assessing this you are checking the evidence is valid, that the incident or learning did occur during this placement, and that the standards are met. They may ask you for some support with the structure of this account when using a reflective model. Accounts should be signed by the mentor when accepted as evidence and can incorporate supporting evidence in the form of literature, policies, standards or protocols.
Anonymous nursing documentation. During care delivery students will complete documentation that they may wish to add as evidence of their achievement. Documentation must be anonymous and not identify the client or placement area. Photocopies of documents or blank documents completed for simulated patients are acceptable.

Clinical Skills Book. This book can be completed by the student and those they are working with as they acquire their clinical skills in practice. The book itself is not assessed but if these skills are backed up by explanation then you could assess those. Do not take the skills book alone as evidence of proficiency. The associated explanation can be verbal or written as long as the student gives information to show their skill, knowledge and the context of this skill in their care delivery.

Other forms of acceptable evidence are;
  a) Evidence based literature
  b) SWOT analyses
  c) Computer learning packages
  d) Inter-professional learning activities
Any evidence submitted should demonstrate what the student has learnt. Therefore copies of policies or journal articles are inappropriate; you need to know whether the student has read them and how the learning has contributed to their practice. A portfolio should not consist of leaflets and photocopies from the practice area.

Students may also present you with:

Action plans. In addition to the plan you will agree with them at the start of the placement, the student should have a plan for identified learning for this placement that they have negotiated with their personal tutor. This may highlight outstanding proficiencies they need to achieve, or if there are specific learning opportunities they want to achieve whilst in this placement. Any action plan should clearly identify deadlines and dates of review.

Evidence of key skills development. Whilst producing evidence of their practice experience students are also demonstrating they meet certain key skills in communication, application of number and improving own learning. This may mean that they highlight certain evidence as key skill evidence as well as meeting standards of proficiency. The assessment of key skills takes place in school, but mentors are expected to have awareness of these skills. It would help students if you can support them in producing evidence that shows they can communicate, use numerical skills and improve their learning by the evidence generated in practice settings. An example of this would be evidence based on drug calculations using application of number.

Academic work the students have completed can also be added to support their practice evidence. This is good practice as it links the relevant academic and practice learning and demonstrates the student is able to integrate the two and transfer skills and knowledge. This work may be extracted from the student’s main portfolio and added to their assessment of practice evidence, or just provide relevant references in support of the application of theory to practice.
It is important to remember that each piece of evidence the student submits for assessment should clearly show;

a) What it is
b) By whom
c) When it was produced
d) When it was undertaken
e) What it intends to show
f) Which standard(s) it meets

Students should be aiming for quality of evidence not quantity where possible, so an account that covers many standards is seen to be more valuable as evidence than many pieces of evidence that only meet one standard each.

It is also good practice for the student to develop a system of tracking their evidence using page numbers, letters etc. in order that the correct evidence can be tracked to the standards they claim it meets. This becomes more valuable when they collect 10 different pieces of reflective writing for that placement for example.

Assess as you go!!!
It is useful to assess the student’s evidence as they progress through their placement, don’t leave it all until the final interview. This helps you and the students to identify which standards are outstanding and where further evidence is needed. It also reduces the time required for the final interview and gives opportunity for the student to receive feedback about their performance in practice so far. It can be really useful to plan and allocate time for the intermediate and final interview with the student in advance so that you both know when you are meeting again to discuss their progress.

Is there enough??
As you assess the evidence the student presents to you, you need to make an assessment decision on whether they have sufficient evidence for you to agree they are proficient. If you have not seen them achieve a particular standard of proficiency and they only have 1 piece of evidence for that standard you may decide this is insufficient and ask them to collect more evidence. If at the end of the placement they have insufficient evidence you can then record ‘inadequate evidence’ against that standard, which is not achieved.

It is important to remember you are assessing the student’s evidence in practice – if you are not happy with it for any reason of validity, sufficiency or lack of achievement of that standard you should explain this to the student and take appropriate action. More information about this can be found in the student’s assessment of practice record / Continuity of Practice Assessment Record. If you have any concerns about a student’s ability to achieve proficiency please speak to your PLT education representative as soon as possible. Action can then be taken whilst the student is in placement and has the opportunity to develop and improve.

PLT Mapping
In some areas practice learning teams have produced examples of evidence, which meet the standards of proficiency. Ask to see the ones for your placement area, if available, as they will help you to direct your student to the appropriate learning opportunities and evidence collection.

Further information can be found on line at;
www.nottingham.ac.uk/nursing/practice
Examples of Evidence.

Here are two examples of evidence from students.

**Year Two – Outcome 1.1;** Manage oneself, one’s practice and that of others, in accordance with the NMC code of professional conduct, recognising one’s own abilities and limitations.

1) **Written in Practice Assessment Record.**
During my first week on the ward I worked with my mentor and found out about health and safety and infection control in the placement to care for patients correctly. I understand about my role in practice in documentation and consent to practice like the NMC Code.

2) **Reflective Writing No.3.**
As this is an independent placement outside of the NHS, during my first week I found out about the relevant policies that affect my care delivery. I read the health and safety and fire policies and the infection control policy. I now know my role in the event of a fire on the premises and what precautions to take in the building. The fire alert system is quite different and I learnt it by heart in case I needed it. I also need to remember to sign in to the fire book when I go on and off duty. Health and safety follows the national guidelines but are adapted by the company for this placement. Specific policies relating to infection control influence admission as all admissions from the NHS or independent care have to have MRSA swabs taken on arrival. As all patients are nursed in single rooms the issue of isolation until the results are back is not a problem and equipment is not shared between patients. I read the notes from the monthly infection control meetings which helped me understand what the current issues and concerns are in this placement. Documentation and entries into patient notes have to be signed by a nurse. If I write in their notes it must be countersigned. My practice should always be at the required standard as dictated by the NMC Code of Professional Conduct (2004).

What do you think of the 2 accounts?
The second is clearly more detailed and explains how reading the policies has affected the students practice and knowledge in this placement. The first account is not detailed enough and the evidence is insufficient.

If you were assessing these do you think they are both acceptable as evidence? Maybe – but you would need to discuss the evidence with the first student before accepting it wouldn’t you?
Example of Observed Learning Statement

Student Name: Joanne Bloggs  Cohort: 05/03
Observer Name (Print): Debbie Abbott  Role: Staff Nurse Ward 14
Personal Tutor (Print): John Smith

Evidence to support learning (must include sources of evidence)

Working with Admissions Staff Nurse Abbott admitting patients from Emergency Admissions 07.00 – 12.00, 19th June 2006.

- Recognised importance of accurate record keeping (NMC 2005).
- Informing appropriate members of MDT to ensure implementation of full discharge planning (NMC 2004).
- Risk assessment of patients in relation to safety, dependency and nutritional status (Roper, Tierney and Logan, 2000).
- Recognise level of competence and seek support of Staff Nurse Abbott for clarification (NMC 2004).

Links to Outcomes and Standards of Proficiency (Competencies)

1.1, 1.3, 2.1, 2.3, 2.5, 2.7, 2.8, 3.2, 3.3

(Note: The best thing about this statement is that it relates to so many standards.)

In signing, I confirm that this is a true record of the performance of the above student.

Witness Signature: D Abbott  Date: 14/3/05
Student Signature: Joanne Bloggs  Date: 14/3/05

Accepted as Evidence
Mentor’s Signature:  Date:  

This is a ‘best practice’ example. Students may use fewer references in the earlier stages of their course.
### Example 1 – UNSATISFACTORY practice assessment record

#### Domain 2. Care Delivery

**2.1 Discuss methods of barriers to, and the boundaries of, effective communication and interpersonal relationships.**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Recognise the effect of one’s own values on interactions with patients and clients and their carers, families and friends</td>
<td>20/1/06 able to communicate with all clients. Know how to act professionally when talking to clients</td>
</tr>
<tr>
<td>2.1.2 Utilise appropriate communication skills with patients and clients</td>
<td>See above</td>
</tr>
<tr>
<td>2.1.3 Acknowledge the boundaries of a professional caring relationship</td>
<td>See above</td>
</tr>
</tbody>
</table>

**2.2 Demonstrate sensitivity when interacting with and providing information to patients and clients.**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Demonstrate sensitivity when interacting with and providing information to patients and clients</td>
<td>Admitted Mr B. with hepatitis, able to tell him and his partner about his care and infection risks privately during admission</td>
</tr>
</tbody>
</table>

**2.3 Contribute to enhancing the health and social well-being of patients and clients by understanding how, under the supervision of a registered practitioner, to**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1 Contribute to the assessment of health and needs</td>
<td>See above. And able to assess needs on all patients admitted to ward</td>
</tr>
<tr>
<td>2.3.2 Identify opportunities for health promotion</td>
<td>Ensure clients able to access health promotion leaflets in dayroom</td>
</tr>
<tr>
<td>2.3.3 Identify networks of health and social care services</td>
<td>Read notice board about different help available and gave leaflets to Mr Jackson</td>
</tr>
</tbody>
</table>

**2.4 Contribute to the development and documentation of nursing assessments by participating in comprehensive and systematic nursing assessment of the physical, psychological, social and spiritual needs of patients and clients.**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.1 Be aware of assessment strategies to guide the collection of data for assessing patients and clients and use assessment tools under guidance</td>
<td>Able to do risk assessment, tissue viability and nutritional assessment and refer as required. Completed all nursing documentation on admission of patients.</td>
</tr>
<tr>
<td>2.4.2 Discuss the prioritisation of care needs</td>
<td>Discussed with mentor on admissions</td>
</tr>
<tr>
<td>2.4.3 Be aware of the need to reassess patients and clients as to their needs for nursing care</td>
<td>Re assess care at start of each shift after handover according to daily changes.</td>
</tr>
</tbody>
</table>
Example 2 – SATISFACTORY completed practice assessment record

Domain 2. Care Delivery

### 2.1 Discuss methods of barriers to, and the boundaries of, effective communication and interpersonal relationships.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
</table>
| 2.1.1 Recognise the effect of one’s own values on interactions with patients and clients and their carers, families and friends | RD . P42  
DO .  
RW -diversity study day - P 53. |
| 2.1.2 Utilise appropriate communication skills with patients and clients | DO  
RW Communication p 59.  
OL p. 4 |
| 2.1.3 Acknowledge the boundaries of a professional caring relationship | RW - diversity study day P 53.  
OL p.4 |

### 2.2 Demonstrate sensitivity when interacting with and providing information to patients and clients.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
</table>
| 2.2.1 Demonstrate sensitivity when interacting with and providing information to patients and clients | DO  
RW Communication p 59  
OL p.4 |

### 2.3 Contribute to enhancing the health and social well-being of patients and clients by understanding how, under the supervision of a registered practitioner, to

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
</table>
| 2.3.1 Contribute to the assessment of health and needs | DO.  
RD with mentor after patient admission |
| 2.3.2 Identify opportunities for health promotion | DO.  
RD with mentor after patient admission |
| 2.3.3 Identify networks of health and social care services | RD with mentor after patient admission   
RW- diversity study day P 53. |

### 2.4 Contribute to the development and documentation of nursing assessments by participating in comprehensive and systematic nursing assessment of the physical, psychological, social and spiritual needs of patients and clients.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Type and Location of Evidence</th>
</tr>
</thead>
</table>
| 2.4.1 Be aware of assessment strategies to guide the collection of data for assessing patients and clients and use assessment tools under guidance | RD with mentor after patient admission  
DO.  
WP - care plan produced after admission. P47  
OL p. 4 |
| 2.4.2 Discuss the prioritisation of care needs | RD with mentor after patient admission  
OL p. 4 |
| 2.4.3 Be aware of the need to reassess patients and clients as to their needs for nursing care | DO  
OL p. 4  
RD with mentor after patient admission. |
Information to consider in the examples;
These are both drawn from the student’s practice assessment record. The boxes for recording evidence in this assessment record are small to encourage the students not to write mini evidence in there, or evidence so brief it’s difficult to remember the event – as in example one.

In example two the student clearly has additional evidence on pages in their portfolio, which are referenced here. This creates links for the mentor with a brief summary of the evidence and origins and then the detail for assessment of outcome / proficiency would be in the separate evidence. These are the skills of portfolio building we would like to encourage students to adopt. As you can see one piece of evidence has been referenced on more than one occasion to utilise it to the maximum effect.

Summary.
This guide has been written to help mentors with the skill of assessing evidence from practice using portfolios of evidence. If you have any further queries please contact your practice learning team representatives in practice or the School of Nursing, the Student’s personal tutor, or your local practice learning unit.

Remember when assessing students you are making decisions about their future practice and entry to the professional register. If you have concerns about their level of skill or knowledge don’t leave it to the last week to raise this but use evidence collected throughout their placement to show where they have weaknesses and seek support from other mentors in your team and the PLT when you can.

For Students a virtual portfolio tool, where they can see information on how to build their portfolio and generate quality evidence can be found at:  
www.nottingham.ac.uk/nursing/students/prereg-docs/portfolio/index.php

Take a look and see what guidance is contained there too.