My Placement, ***NAPAD***

This electronic resource guide is intended to support learners in completing their practice document (NAPAD) and to provide general information and tips for practice throughout the trainee nursing associate programme. This guide may also be helpful for practice assessors, practice supervisors and academic assessors.

We recommend that learners view this guide electronically as updates will be made as needed, this will ensure learners are accessing up-to-date information.

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1. What is the Trainee Nurse Associate PAD? (NAPAD)

The NAPAD has been developed in collaboration with HEE Regions across England involving a range of stakeholders including universities and practice partners. The Practice Assessment Document has been developed from the Pan London Practice Assessment Document for pre-registration nursing that was developed by the Pan London Practice Learning Group (PLPLG). This collaborative assessment document aims to support trainee nurse associates to achieve the criteria set out in the: Standards of Proficiency for Nursing Associates, (NMC 2018). (https://www.nmc.org.uk/standards/standards-for-nursing-associates/standards-of-proficiency-for-nursing-associates/)

The NAPAD is **your** document and provides evidence of your learning and development in practice throughout the duration of your programme. It is essential that you are familiar with this document and your requirements for practice as completion of your NAPAD is **your** responsibility. **Assessment in practice is mandatory and is a requirement to progress through each stage of your programme.**

This guide has been designed as a brief overview to support you to understand your NAPAD requirements for practice and has been broken down into smaller sections for ease of reference. This guide is not intended to talk through the technical aspects of using the NAPAD and further guides for this can be found on the PebblePad Guidance webpage. Further and more detailed guidance is available within the NAPAD on the Help & Support page.

2. How do I complete my NAPAD?

The NAPAD document has various sections that need to be completed to demonstrate your understanding and progression in practice. The NAPAD breaks down the NMC requirements and there are detailed guides within the NAPAD itself. This document covers the main aims / requirements of the NAPAD as a useful guide for you to understand each section.

2.1 What can I expect in my initial interview?

The initial interview can be completed with your Practice Assessor (PA) or Practice Supervisors (PS) and there are subheadings within this section to help you to complete this. Generally the initial interview is an opportunity for you to discuss: what you hope to achieve during your placement, any areas that require additional support, planning for completion of your NAPAD and practice requirements including how you will achieve your protected learning time hours. You can discuss opportunities about appropriate spoke placements and how to access these. The initial interview should be completed within the first week of placement.

(Note: if your initial interview is completed with a PS this will need discussion and confirmation from your PA).

2.2 What are professional values?

Learners are required to demonstrate high standards of professional conduct at all times during their placements. Professional values reflect a number of the requirements of Nurses, Midwives and Nursing Associates as set out in 'The Code' and learners should work within the ethical and legal frameworks, and be able to articulate the underpinning values of The Code (NMC, 2018). You should familiarise yourself with these requirements as these will be assessed throughout each practice area.

Professional values will need to be assessed at midpoint interview and you will also receive feedback on your progress. The Professional Values are summatively completed at the final interview. In order to pass the stage you will need to be compliant with **all** professional values. If you are identified as not achieving any of the professional values, an action plan should be implemented to support you to meet these values.

Professional values should be assessed and completed by your PA. A Practice Supervisor who is a registered health professional can sign off your formative (midpoint) professional values, however this must be in discussion with your PA.

2.3 What is an Episode of Care (EOC)?

When looking at your NAPAD, you will see that the EOC assessments are split into 'formative' and 'summative' assessments. The formative assessment can be completed with your PA or PS's, however your summative assessment **must** be completed with your PA. Each stage of the programme will have different advice for episodes of care, please see further guidance on EOC assessments which can be found at the top of the page within the NAPAD. The aim of the EOC assessment is for learners to demonstrate underpinning knowledge of an area of care to a patient/ family/ group of patients **appropriate to the learners stage in the programme**.

Learners should discuss and agree an EOC assessment with their PA to identify an appropriate care intervention. The formative assessment will provide you with feedback on your EOC ready for your summative assessment with your PA. The summative EOC should be completed towards the end of year 1 and again at the end of year 2, when you have had time to practise and understand the underpinning knowledge of the EOC assessment that you have identified.

The EOC that you choose will usually be the same for your formative and summative assessment depending on your stage of training. Undertaking the same EOC for your summative assessment allows you to work on any formative feedback and demonstrate your knowledge and skills in this area. The EOC is an essential part of your placement assessment, if you do not meet the summative EOC requirements an action plan will be implemented **(For further information on action plans see section 2.11)**.

Examples of an EOC may include, but are not limited to; care planning, a nursing procedure or assessment, a patient admission, discharge planning.

The EOC must be in agreement with your PA to ensure a stage appropriate assessment has been identified.

Please see Appendix 1 for Examples of how Episodes of Care should be written. These episodes of care were written by University of York 1st year students in their MYEPADs (Included in this document with their permission).

2.4 What can I expect in my midpoint interview?

The midpoint interview should be completed with your PA. The subheadings within the NAPAD will support your discussion. The midpoint interview is used to identify areas of strength and to support further learning and development for the remainder of the

placement. The midpoint interview should also include a review and sign off of your professional values, any proficiencies you have met so far **(See sections 2.2 & 2.6),** review of progress with protected learning time hours **(See section 2.8)** and sign off your formative EOC **(See section 2.3).** Your midpoint interview is an opportunity to discuss what learning opportunities you can gain in your external spoke placements and the remainder of the placement and identify any proficiencies to be completed. It is also a good opportunity to think about any static spokes that you may need to arrange in order to develop further knowledge and skills.

2.5 How do I demonstrate / document my feedback and progress? (Record of working with and learning from others)

As you are aware, you will be allocated a Practice Assessor to oversee your learning in practice and complete your summative assessments. You will also spend time with a range of Practice Supervisors who will support your day-to-day learning and feedback in practice. In order to demonstrate to your PA that you have being developing your knowledge and skills, and to understand areas of strength and development in yourself, learners are required to gain written feedback from the PS's they work alongside. This can be done under the record of working with and learning from others / interprofessional working section of your NAPAD. Here you should reflect on your time spent working with your PS's, including what you have learnt, what could have been improved and any evidence of the proficiencies you may have gained or worked towards.

Your PS can then provide their feedback on your performance, your professionalism and any skills gained towards your proficiencies at base or on external placement.

PS's should have access to PebblePad, however access to IT devices in practice isn't always easy and learners may find it **helpful to print off some feedback pages** which can be later uploaded as a supplementary piece of evidence.

During your time on your base or external placements you may work with non-registered staff and other allied health professionals (AHP's) who will provide evidence/feedback to support your professional values and proficiency sign-off. This evidence/feedback should be written in the record of working with others section.

It is essential that learners gather feedback and evidence of their learning as PA's are required to review feedback from PS's in order to make an informed decision of progress.

Learners who do not provide evidence of feedback may find that their PA is unable to pass their placement due to lack of evidence to support their objective assessment.

2.6 What are proficiencies?

The proficiency outcomes are based on the NMC Standards of Proficiency (2018). They reflect what the public can expect nursing associates to know and be able to do in order to deliver safe, compassionate and effective nursing care (NMC, 2018).

These skills are split into communication and management skills (annex A) and nursing procedures (annex B) (NMC, 2018). Learners must demonstrate that they understand and have gained exposure to these skills and must meet the required proficiencies in each stage of the programme. There are 34 proficiencies per year to be completed in practice.

Please familiarise yourself with your proficiencies, consider and discuss with your PA and PS which proficiencies you will be able to achieve in your base and which you will work towards during your external placements. Your PA/ PS's can support you with this.

Please note: Non-registered staff supporting learners in practice should not directly sign off proficiencies. Instead these staff contribute to proficiency sign off by providing evidence/ feedback to your practice assessor under the 'record of working with others' section of your NAPAD. Non-registered staff may include healthcare assistants, care support workers, phlebotomists, teachers.

Top tip: It is helpful to print your proficiencies and have these signed as you go. This can support your written feedback as evidence and provide a quick reference to know what you have achieved and which are outstanding.

You may need to discuss an appropriate spoke with your PA/PS to meet your proficiencies if these are not achievable from your base or allocated external placement. The proficiency can also be obtained through simulation/reflection/discussion with a practice supervisor or assessor that is up to date and proficient in that particular proficiency.

It is key that you get your proficiencies signed off and know which are outstanding, **you will not be able to progress onto the next stage of the programme without meeting all of the stage required proficiencies.**

When a PS/PA signs off a proficiency, this does not mean you are competent/ proficient. It signifies that you have built up understanding and knowledge. Competency can only truly be achieved after qualification and with continuous practice of that particular skill to ensure you are a safe practitioner.

The practising of any proficiencies will be dependent on placement area. If that organisation's policies state that learners are unable to perform any kind of procedures, that policy must be adhered to and the proficiency must be practised/obtained through simulation/reflection/discussion.

2.7 What is the medicine management assessment?

You must be able to demonstrate safe and effective medicine administration in each stage of the programme. You should take opportunities to undertake medicine administration where possible, ensuring that you work under the supervision of your PS's or PA at all times. The NAPAD medicine management assessment **should only be completed by the PA and in one assessment episode (i.e this assessment can not be complete across your placements)**. This assessment will be completed once per stage of the programme and is pass/ fail. It is strongly recommended that you plan to complete the medicine assessment towards the end of your placement block when you have had sufficient time to practise these skills. Prior to your summative assessment, PS's will provide feedback for learning and development.

Please note that learners should only administer medications under direct supervision (unless this is part of your HCA role).

There are a few placements where medicine administration does not take place, if this is your base placement please discuss with your Academic Assessor or PA where you will be able to carry out this assessment.

2.8 How do I get my hours signed off?

Protected learning time

Any protected learning time completed at base must be documented in the NAPAD on the placement hours page. You can add in any time you have spent in practice gaining new learning (outside your role as a HCA). These hours need to be verified by your PA at the end of each placement.

External placement hours

When you are on your external placement, you will need to share your NAPAD with your external practice supervisor, so they are able to verify your hours on the external hours page. If your PS does not have access to NAPAD then **you** must print off a paper timesheet that can be found on the 'Placement Hours' page in your NAPAD. Complete this timesheet, and get your practice supervisor from your external placement to sign off these hours to confirm attendance, then upload this timesheet on to the 'External Placement Hours' page in the relevant section. You must also complete a timesheet for any spoke placements away from your base and upload these in the 'Spoke placement hours' section of the external practice hours page. This evidence enables your practice assessor to verify all your Protected Learning Time (PLT) and external hours at the end of your placement.

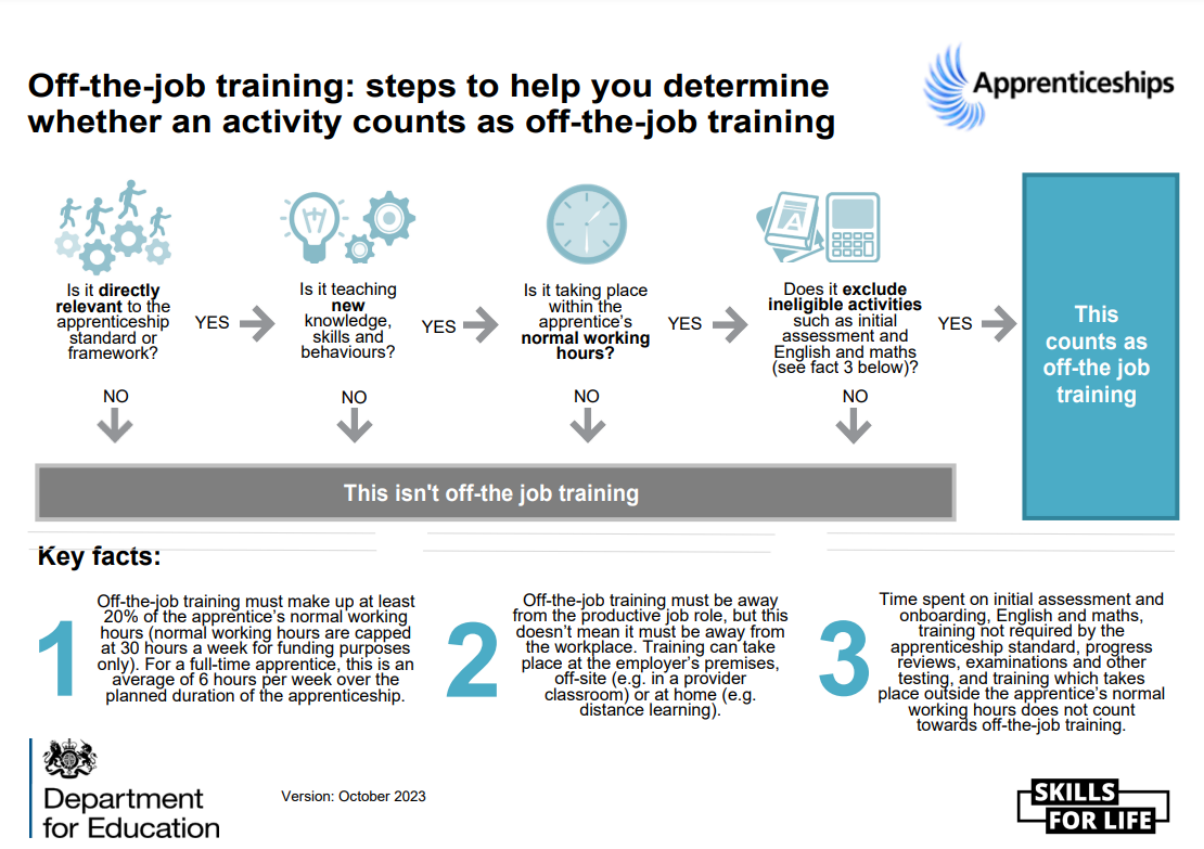
Off the job hours

Off-the-job training is defined as learning which is undertaken outside of day-to-day work duties and leads towards the achievement of the apprenticeship. This training takes place within the apprentice's normal (contracted) working hours.

The off-the-job training must be directly relevant to the apprenticeship.

The minimum off the job training for a full-time apprentice is an average of 6 hours per week. The off-the-job training provides the time to focus and develop the required skills, knowledge and behaviours to achieve the apprenticeship. There are lots of activities that can contribute to off-the-job training. The key thing to remember is that it must be relevant to the apprenticeship.

You can find out more about off-the-job training on the infographic below



2.9 What is the record of communication section for?

The record of communication section can be used by learners, PAs, PS's and AA's to document any meetings or conversations of relevance. For example, your PA/ PS can document here any concerns that they may have about performance, any ad hoc meetings of support and the conversations between you and your PA/PS. It may also be used by your Academic Assessor to document any meetings of support.

2.10 What is the patient / service user/ child / young person/ carer feedback section?

Learners should gather 2 pieces of feedback from patients/ service users/ children/ young persons or carers per stage. There are various forms that you can use to gather feedback depending on the person being asked to complete the form. This feedback is not formally assessed, however it is best practice for you to gain an insight into your performance and development of learning. **You should not ask for this feedback yourself, you should discuss this with your PS who can ask on your behalf.** These feedback forms can be printed and uploaded as evidence. Your AA or PA will need to confirm evidence of these.

2.11 What is an action plan?

An action plan is a supportive measure designed to assist learners in meeting the required areas of the programme. As with any module, practice is an essential part of the trainee nursing associate programme and learners must be able to demonstrate safe and effective practice. You may be put onto an action plan based on unsafe practice, lack of demonstration of professional values, failure to meet proficiencies by the end of the stage, failure of EOC or medicine management assessments or if the required protected learning time has not been achieved by the summative point in year 2. Where an action plan is required, you should be fully informed of the reasons for this. The action plan will be developed using SMART goals and you should clearly understand what is expected from you to achieve this. Action plans will be implemented with the learner, PA and Academic Assessor. Action plans should be regularly reviewed and a timeframe for completion of the action plan will be established.

2.12 What is the final interview for?

The final interview takes place at the end of stage 1 and at the end of stage 2. It concludes the placement and provides an opportunity for you and your PA to reflect on the placement, progress made and areas for development. The final interview should include:

- PLT Hours verified
- External placement hours signed off and verified
- All interviews completed
- All proficiencies signed off
- Midpoint and final Professional values in practice completed
- Confirmation of Summative EOC assessment
- Confirmation of Medicines Management assessment
- Review of patient / service user/ child/ young person/ carer feedback forms
- Discussion on feedback from external / PS's and any learning points
- Any action plans completed
- Completion of the On-going achievement record

2.13 What is the on-going achievement record (OAR)?

The Ongoing Achievement Record (OAR) summarises your achievements in each stage and within the Practice Assessment Document (NAPAD), it provides a comprehensive record of professional development and performance in practice. The purpose of this document is to provide evidence from your stage one practice assessor to your stage two practice assessor regarding your progress, highlighting any areas for development throughout the programme. Your practice assessor and academic assessor must have

access to this document at all times during your placement and it should be made available on request. It is your responsibility to ensure it is completed on each placement.

It is the Practice Assessor's responsibility to ensure that the OAR is completed at the end of each stage, this must be verified by the learner and the AA.

The Academic Assessor will work in partnership with the practice assessor in relation to learner achievement in practice. The academic assessor confirms in the OAR learner completion and recommends progression for each part of the programme. Please note: Academic Assessors will have oversight of learner assessments throughout each of their placement experiences.

2.14 What is the criteria for assessment?

The criteria of assessment is intended to guide the level of supervision that you should be working within throughout each stage of the programme. Please note: the level of supervision required will be assessed individually for each learner. The below is an example of the Stage 1 criteria for assessment which can be found in your NAPAD. You should review the guidance on the criteria for assessment for each new stage of your programme. You should work alongside your PA and PS's to ensure you are meeting your stage required criteria for assessment.
Overall Framework; these criteria should be achieved by the end of each year.

'Achieved' must be obtained in all three criteria by the learner.

PAD 1:
Guided participation in Care.

Achieved	Knowledge	Skills	Attitude and Values
Yes	Is able to identify the appropriate knowledge base required to deliver safe, person-centred care under some guidance.	In commonly encountered situations is able to utilise appropriate skills in the delivery of person-centred care with some guidance.	Is able to demonstrate a professional attitude in delivering person-centred care. Demonstrates positive engagement with own learning.
No	Is not able to demonstrate an adequate knowledge base and has significant gaps in understanding, leading to poor practice.	Under direct supervision is not able to demonstrate safe practice in delivering care despite repeated guidance and	Inconsistent professional attitude towards others and lacks self-awareness. Is not asking questions nor engaging with own learning needs

		prompting in familiar tasks.	

PAD 2:

Provides and monitors care with minimal guidance and increasing confidence

Achieved	Knowledge	Skills	Attitude and Values
Yes	Has a sound knowledge base to support safe and effective practice and provide the rationale to support decision making.	Utilises a range of skills to provide and monitor safe, person-centred and evidence care with increased confidence and in a range of contexts.	Demonstrates an understanding of professional roles and responsibilities within the multidisciplinary team. Maximises opportunities to extend own knowledge.
No	Has a superficial knowledge base and is unable to provide a rationale for care, demonstrating unsafe practice.	With supervision is not able to provide safe care and is unable to perform the activity and/or follow instructions despite repeated guidance.	Demonstrates lack of self awareness and understanding of professional role and responsibilities. Is not asking appropriate questions nor engaged with their own learning.

3. What is a tripartite review?

A tripartite review must take place between the learner, the PA and the AA every 12 weeks throughout the programme. At the tripartite review the learners progress will be discussed in relation to theory and practice progress. There is an opportunity to discuss your progress and all elements of the NAPAD.

Progress Plan: The aim of your progress plan is to plan small goals in order to keep your learning individualised to your specific needs and to keep you moving forward with learning. This should be reviewed and updated at the time of each tripartite review.

Part A is completed by your personal supervisor prior to each tripartite review following their meeting with you.

Part B of the tripartite review must be completed by the learner before the tripartite takes place.

Part C of the tripartite is completed during the tripartite meeting. There are separate sections for the Learner, Academic Assessor and Practice Assessor to complete. This should include a review of hours and progress and a brief summary of the meeting

It is the learners responsibility to make sure that the tripartite is booked in a timely manner.

There are 8 or 9 tripartite reviews throughout the programme, it is important that these take place no more than 12 weeks apart in order to maintain compliance with the Education Skills Funding Agency (ESFA) guidelines for apprenticeship provision.

4. Useful placement information

4.1 What elements of my NAPAD should I complete in base and in my allocated external placement?

The tables below outline a quick guide of what learners should have achieved during their base and external placements . AA's will be checking your documentation throughout your practice experiences.

Nursing Associate Practice 1:

Base placement	★ Initial interview ★ Midpoint interview ★ Midpoint professional values in practice ★ Final interview ★ Final professional values in practice ★ Upload feedback from PS and external PS ★ All proficiencies to be achieved by end of NAP1 ★ Record of PLT hours documented & verified on the placement hours page ★ Formative & Summative Episode of Care ★ Medicines Management Assessment ★ OAR for PAD1 to be completed
External placements 1 & 2	★ Any proficiencies achieved signed off ★ Practice hours recorded & verified ★ Feedback gained from PS

Nursing Associate Practice 2:

Base placement	★ Initial interview ★ Midpoint interview ★ Midpoint professional values in practice ★ Final interview ★ Final professional values in practice ★ Upload feedback from PS and external PS ★ All proficiencies to be achieved by end of NAP1 ★ Record of PLT hours documented & verified on the placement hours page ★ Formative & Summative Episode of Care ★ Medicines Management Assessment ★ OAR for PAD2 to be completed
External placements 3 & 4	★ Any proficiencies achieved signed off ★ Practice hours recorded & verified ★ Feedback gained from PS

4.2 What is a retrieval Placement?

An additional placement, titled 'retrieval placement' in the NAPAD may be required if a learner has been unable to gain experience in all fields of practice during their external placements. Or if there have been other circumstances that have meant that practice assessment is not complete or there is a deficit in hours. However, this is unusual, and all practice requirements should be completed in the allocated placements. If this is required, it will be arranged by your AA and the allocation team and will be up to a 4 week period taking place within the last 8 weeks of the stage 1 and stage 2 of the programme. We recommend that you do not take A/L in this period (as highlighted on the course plan).

4.3 What do I do if I need support?

There are a number of options for support:

Pastoral Support - You would contact your personal supervisor

Placement Support - Firstly discuss any issues with your Practice Assessor, the Nurse in Charge or your manager. You can also contact your Academic Assessor. Each employer also has a practice education team who help to support the learner in practice e.g:
York NHSFT - practiceeducationteam@york.nhs.uk
TEWV - tewv.professionalnursingandeducation@nhs.net

Wellbeing General Support:
Contact the Student Services team (dohs-student-experience@york.ac.uk).

Student Services webpages:
https://www.york.ac.uk/healthsciences/student-intranet/support/student-services/

Apprenticeship related queries, contact the apprenticeship unit at:
apprenticeships@york.ac.uk

4.4 Recording sickness / absence in the NAPAD.

All sickness and absence must be recorded in the NAPAD on the placement hours page whether or not you are absent from University, base placement or external placement. It is important that this is documented so that we can ensure the learner is meeting all requirements of their Apprenticeship.

If you are absent or sick during an external placement you must let the external placement know before the start of the shift, also let your base placement manager know you are absent from your external placement.

Sickness from base placement must be reported as per your local employer policy. For all sickness reporting procedures please refer to the Trainee Nursing Associate handbook.

5. Terms

Base Placement
Your base placement is your place of employment where you will spend the majority of your time whilst on the TNA programme.

External placements
External placements are allocated for 5 or 6 week periods, twice per year during each stage of the programme. This is to enable you to encounter a broad range of experiences across all fields of practice and across the lifespan. Your progress will be monitored by named Practice Supervisors to develop your knowledge and understanding. These placements will offer you a range of experiences to develop transferable skills. Whilst on an external placement you must maintain and uphold your professional values, work towards achieving any proficiencies that are available in that particular area. Record and have signed off the placement hours that you have worked.

Spoke placements

Spoke placements can be arranged from your base or from your external placement. They are short placements from a few hours to a few days and can be arranged with your PA or PS. They are used to give you further learning experiences in different practice areas and can be linked to your base area i.e. if on a cardiology ward, the learner could go for a day or two on a spoke to coronary care unit. Spokes can also be arranged by the staff in the external placement area if they have links to other areas that would enhance your learning.

Practice Supervisor

Practice Supervisors are responsible for contributing to your education through monitoring and recording of your achievement of learning outcomes and professional values. Their feedback on your conduct, proficiency and learning will inform decisions about your progression made by the Practice Assessor. Learners will work alongside a range of Practice Supervisors throughout their placement experiences.

Practice Assessor

Each learner will be assigned a Practice Assessor at their base placement. For each stage of the programme the learner will be assigned a different Practice assessor. A Learner is not able to keep the same Practice assessor across the whole of their programme.

The Practice Assessor has an overview of your placement progression and works in partnership with Practice Supervisors and other relevant individuals to confirm placement achievement. The Practice Assessor is responsible for assessing your achievement of professional values, proficiencies across a year of the programme, summative episode of care, medicines management and completing the OAR section.

Academic Assessor

The Academic Assessor is a member of academic staff from the Department who collates and confirms achievement of proficiencies and programme outcomes (In the OAR section). They work in partnership with the Practice Assessor and Practice Supervisors. The academic assessor will deal with any concerns about your development whilst on placement, they will initiate action plans in conjunction with the practice assessor as required. For each stage of the programme the learner will be assigned a different Academic assessor. A Learner is not able to keep the same Academic assessor across the whole of their programme.

6. Useful Resources

Department of Health Sciences Student Experience webpages:
https://www.york.ac.uk/healthsciences/student-intranet/support/student-services/sis-where/

Department of Health Sciences Apprenticeship webpages:
https://www.york.ac.uk/students/new/apprenticeships/

7. Appendix 1: Examples of Episodes of Care from Uni of York students

(These are real episodes of care from students who were 1st years at the time, they have given permission for their EofC to be used)

Example 1
Student Reflection on an Episode of Care

Within your reflection, describe the episode of care and how you assessed, planned, delivered and evaluated care.

I was assessed in UVB light therapy appointments. I first read the patients notes to see if they had any previous reactions or erythema during their light therapy treatments. I also checked to see what stage in their treatment they were and what they were needing light therapy for. I then retrieved the patient from the waiting area. I conversed with the patient whilst we walked to the treatment room, asking if it would be okay for me to lead their appointment. I gained their consent and introduced my assessor when we got into the room. I confirmed the patient's date of birth and first line of their address to ensure I had the correct patient. I asked the patient how their skin had been since their last treatment, asking if they had any redness, soreness or irritation, when the patient confirmed they hadn't, I asked if they felt happy with where their skin is at, because this was their last treatment. The patient explained to me that they had felt some plaques coming back already. I advised them to get in touch with their doctor's secretary to arrange a follow up appointment and advised to continue utilising their creams at home until then. I then let them get ready to use the UVB machine. I calculated the correct dose for the machine and filled in their booklet to the appointment and dose we would be giving them. I then ensured the patient was wearing the correct clothing and equipment for the machine. I asked if the patient needed the air conditioning on to try to circulate

the hot air. I ensured the patient was in a central position in the machine. Whilst they were in there I ensured they were okay and comfortable, due to them being on the maximum dose. They assured me they were. Once the treatment had ended, I checked the patient's skin to check the areas they weren't happy with, which was the chest and knee areas. I asked if they had the secretary's number and if they knew who to call, they assured me they did. The patient then left and bidding goodbye, I asked my assessor for some help with the discharge documentation, as I hadn't done this before. I then documented the appointment in the patient notes and ensured CPD had been updated.

What did you do well?

I think the communication I had with the patient was good, I retrieved all the relevant information needed to assess the patient and provide the appropriate after care. I believe the appointment went smoothly, ensuring all steps were done. I think the way I documented was informing, ensuring that the patient's appointment was documented in the correct place and felt it was clear and concise, which meant that if the patient returned, the next person would understand where the patient was the last time they came for light treatment. I think I provided appropriate aftercare, offering the patient the correct pathway to ensure they knew they had options and advised them to continue on their cream treatment in the meantime. I knew the correct dose for the machine and filled in their booklet correctly calculating their lifetime dose. I felt I was considerate of my patient's needs by ensuring they were comfortable in the machine and if they wanted the air conditioning on, as I didn't want them feeling too hot. I wiped down the areas once the patient had left and ensured a clear changing room and machine ready for the next patient.

What would you have done differently?

I wasn't confident in doing the discharge documentation for the patient, I think with more practice this would come with time, but I am happy with how the appointment went and felt my confidence had improved since my last episode of care

Example 2
Student Reflection on an Episode of Care

Within your reflection, describe the episode of care and how you assessed, planned, delivered and evaluated care.

For my summative episode of care, I performed the administration of insulin to a type 2 diabetic patient. This patient also had dementia so when entering the home I introduced myself and my role to make her feel at ease. I got out the insulin box and sharps bin and got out the prescription chart. I made sure the glucometer had been calibrated before entering the house. Then got the glucometer out and put a strip in, got a lancet out of the insulin box and asked the patient which finger they would like me to use. Then wiped the finger with a wet tissue to make sure there was no food on the finger that could effect the reading. Then twisted the top of the lancet and pinched the side of the finger and pricked it. Then squeezed the finger gently to ensure there was enough blood, and got the blood on the strip. I then waited for the glucometer to produce a reading of the BM. I then documented the reading and checked on the prescription chart that this reading was within range; which it was. I then made sure the insulin pen was the correct one prescribed and that it was in date, and documented the batch number and expiry date. I then checked with the patient of their name and date of birth to solidify that it was the correct patient. Then I made sure to shake the pen so the insulin was all combined and attached a safety needle to the insulin pen, after I primed the needle with 2 units of insulin I drew up the correct dose stated on the prescription chart. I then checked which side of the abdomen I was injecting into and pinched the skin, warned the patient of a sharp scratch and inserted the needle. I then pushed the pen and left the needle in for 10 seconds to ensure all the insulin had been injected into the body. I then removed the needle and documented the injection had been made on the prescription chart. I then said goodbye to the patient and left.

What did you do well?

I think I did well at communicating with the patient. The patient had dementia so it was important to communicate well as, even though she has her insulin each day, she may have forgotten or get it confused and that may be scary for the patient. I made sure she knew what I was doing while doing it as well as warning her before the needle went in, of a sharp scratch so it wasn't a surprise to her.

I also think I documented my work well. I made sure the batch number and the expiry date was documented clearly and checked that the amount of pens left in the fridge was correct. I also documented the side of the abdomen I injected into on the prescription chart and at what time it was injected, as well as signing once it had been injected.

What would you have done differently?

Next time I would ensure I had all my equipment ready, such as my strip in the glucometer before pricking the finger so I was ready to get the blood when I

squeezed it out. So next time I wouldn't rush anything so what I was doing was more effective.

Example 3
Student Reflection on an Episode of Care

Within your reflection, describe the episode of care and how you assessed, planned, delivered and evaluated care.

About half way through my placement we had a Patient who came into the clozapine clinic which is a regular Clinic for monitoring Clozapine Therapy which involves taking blood samples, blood pressures, height, weight and checking for side effects and any physical health problems. Me and the other Nurse introduced ourselves to the Patient and explained to the Patient that we needed a blood sample, blood pressure and weight. The Nurse asked the Patient if they consent to me doing some of the procedures. The Patient agreed and consented to it, so I started to wash my hands and put on my PPE while the Nurse asked for the patient's details. I asked the Patient to take anything out of their pockets before stepping onto the weighing scales, after I got the readings I let the Nurse know of the readings and they started to document them onto their system. I let the Patient sit down to do the blood pressure, the same process again I let the Nurse know of the readings and they document it onto their system. Then the Nurse took over in taking the patient's blood sample. So I sat beside the Patient comforting them while they had the injection. I asked open-ended questions for example how was their weekend so that they are able to respond back to my question. Once the blood sample was completed, we provided the Patient with another monthly date for the next check up. After the Nurse showed me how to document the information onto their system. A few weeks later we had a review meeting with the same Patient to see how they are feeling and the different strategies they could use to to change their diet for example adding more vegetables to their meals or having fruit in-between each meal, limit the amount of fast food takeaways that the Patient has and different strategies to lose weight for example walking somewhere instead of going on the Bus.

What did you do well?

Assessing needs and Planning care- Within the review meeting we explained the different side effects medications can have on the Patient's weight and diet. We provided the Patient websites and leaflets for them to have a more understanding of what side effects medications can have. After the Nurse showed me how to document the information onto their system.

Providing and Evaluating Care- By providing care in small amounts for example sitting beside the Patient and asking questions to the Patient to take their mind off the pain from the injection which made the Patient feel less distress and anxious about having the injection. Both me and the Nurse made sure that the Patient gave consent to me that I could do some of the observations.

Promoting Health and Preventing illness- When both me and the Nurse introduced ourselves we explained the procedure to the Patient what was going to happen. When the Patient gave consent to the Nurse that I could do parts of the procedure I made sure that I washed my hands before the procedure started and put on my PPE. Within the review meeting we explained the different ways for the patient to change their diet and their weight so it will benefit the patients overall Health.

Improving Safety and Quality of Care- When I was doing the procedure I put on my PPE so that I am minimising the risk of infection when doing the procedure and for the safety of the Patient. After the procedure was completed the Nurse showed me how to document the procedure onto their system.

Coordinating Care- When both me and the Nurse explained the procedure to the patient the Nurse made sure that the Patient gave consent so that I was able to do part of the observations. I communicated to the Patient when doing the weighing scales to take any items out of their pockets and when the Patient was having the injection I made sure that I tried to communicate and ask open-ended questions to the Patient. The Nurse made sure that I understood my roles and responsibilities within the clozapine clinic and not to do any Observations that I have little to no knowledge of.

What would you have done differently?

The things that I need to improve on is being able to be more confident when speaking to the Patient for example asking more open-ended questions to the Patient. To do this I will have more practice in the future which will make me more confident when speaking to other Patients in the future. Another thing to improve on for the future is to have a more of an understanding on how to document procedures that have happened onto the Trusts system. I have made flashcards and notes on how to document notes onto their system.