My Placement, ***MYEPAD*** (BSc / MNurs)

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

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

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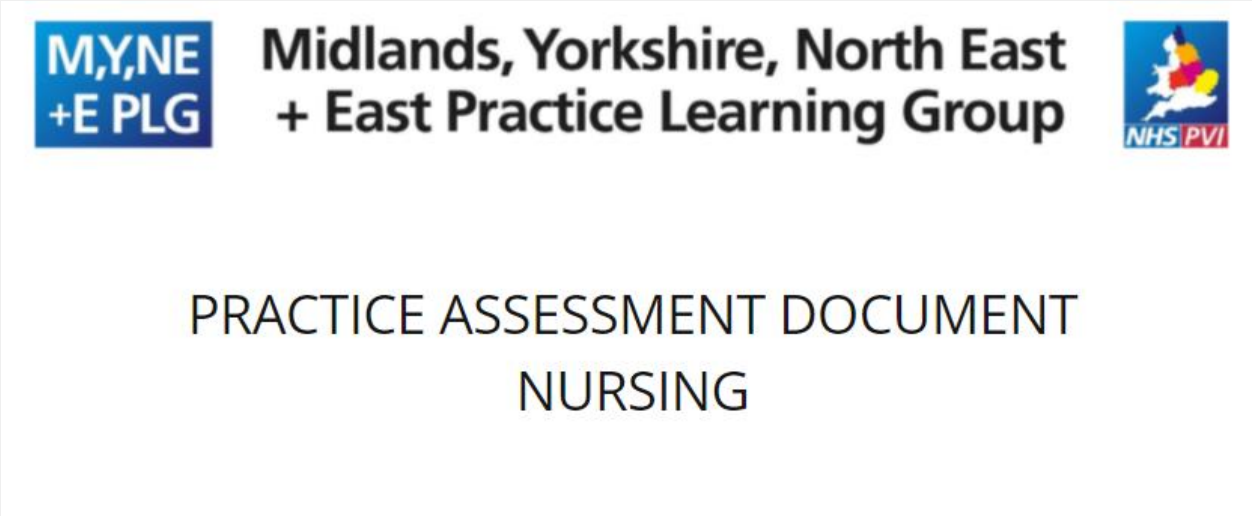
1. What is the MYEPAD?

"The Midlands, Yorkshire and East Practice Assessment Document (MYEPAD) has been developed by the Pan London Practice Learning Group in collaboration with practice partners, assessors, academic staff, students and service users across London, the Midlands, Yorkshire and the East of England regions. This collaborative assessment document aims to support nursing students to achieve the criteria set out in the Future Nurse: Standards of Proficiency for Registered Nurses, (NMC 2018)." (https://myeweb.ac.uk/mye-practice-assessment-document-mye-pad/)

MYEPAD is **your** document and provides evidence of your learning and development in practice throughout the duration of your nursing programme. It is essential that you are familiar with this document and your requirements for practice as completion of your MYEPAD 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 MYEPAD 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 PebblePad and further guides for this can be found on the Student PebblePad Guidance webpage. Further and more detailed guidance is available within the MYEPAD on the Help & Support page.



2. How do I complete my MYEPAD?

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

2.1 Academic Assessor Interview

Preparing for Practice:
Prior to starting on your placement you should have met with your Academic Assessor to talk through about your forthcoming placement; what possible learning opportunities there may be, setting of goals, consideration of any previous learning and any other questions you may have. This discussion should be recorded in the Academic Assessor Interview page.

2.2 What is the orientation?

The practice orientation is an essential requirement for practice to ensure that you are welcomed into your clinical area and that you are aware of key safety information to keep yourself and others safe. You will see that these are broken down into 'orientation base' and 'orientation spoke'. Orientation should be completed in each practice area on your pre-placement induction (if completed) or your first day. If you are not given an orientation at the start of your first day, please speak with the area manager/ nurse-in-charge.

2.3 What can I expect in my initial interview?

The initial interview is designed to ensure that you feel supported and welcomed into the practice area. 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 previous placement experience you have, any areas that require additional support, planning for completion of your MYEPAD and practice requirements and the opportunity to find out more about appropriate static spokes and how to access these. This is also a great opportunity to discuss the Episode of Care (EOC) assessment **(See section 2.5)** and make a plan for the formative completion of this. 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).

2.4 What are professional values?

Students 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 students 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 placement 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.

2.5 What is an Episode of Care (EOC)?

When looking at your MYEPAD, you will see that the EOC assessments are split into 'formative' and 'summative' assessments. The episodes of care assessments **must** be completed with your PA. Each stage of training 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 MYEPAD. The aim of the EOC assessment is for students to demonstrate underpinning knowledge of an area of care to a patient/ family/ group of patients appropriate to the students stage in the programme. Students 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 your placement experience, where 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 2.13)**. **Examples of an EOC may include, but are not limited to;** care planning, a nursing procedure or assessment, a patient admission. **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).

2.6 What can I expect in my midpoint interview?

The midpoint interview should be completed with your PA and should be ideally completed before you access your allocated spoke experience. The subheadings within MYEPAD 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 2.4 & 2.8),** review of progress with practice hours **(See section 2.10)** and sign off your formative EOC **(See section 2.5).** Your midpoint interview is ideally placed before your allocated spoke experience so that you can also identify any proficiencies to complete during your spoke. It is also a good opportunity to think about what learning opportunities you can gain during your spoke to enhance your knowledge overall.

2.7 How do I demonstrate/ document my feedback and progress? (Record of working with 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, students are required to gain written feedback from the PS's they work alongside. This can be done under the record of working from others/ interprofessional working section of your MYEPAD. Here you should reflect on your time spent working with your PS's, what you have learnt, what could have been improved and evidence of the proficiencies you may have gained. Your PS can then provide their feedback on your performance and of professional values maintained and skills gained towards your proficiencies. PS's should have access to PebblePad, however access to IT devices in practice isn't always easy and students 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 spoke 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 students gather feedback as PA's are required to review feedback from PS's in**

order to make an informed decision of progress. Students 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.

2.8 What are proficiencies?

The proficiency outcomes are based on the NMC Future Nurse Standards (2018) and "specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses 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). Students must demonstrate that they understand and have gained exposure to these skills and must meet the required proficiencies in each stage of the programme. Proficiencies can be achieved over the stage (year). Some proficiencies can be achieved between stage 1 & 2 or stage 2 & 3 and these are clearly identified in your MYEPAD.

Please familiarise yourself with your proficiencies before going into your placement. If this is the first placement of your stage you may consider which proficiencies you will be able to achieve in your base and which you will work towards during your spoke - your PA/ PS's can support you with this.

Please note: Non-registered staff supporting students 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 MYEPAD. 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.

If this is the second placement block of the stage you will need to review which proficiencies are outstanding and ensure that you meet these during your base or spoke. You may need to discuss an appropriate static spoke with your PA/PS to meet your proficiencies if these are not achievable from your allocated base or spoke area. 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 students 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.

Top tip: The Clinical Teaching Fellows hold clinical workshops and proficiency drop in sessions to support students in meeting these outcomes. These do not replace any experience that can be gained in practice and should be used primarily to enhance learning and knowledge. Please see section 3.6 of this booklet for more information on how the Clinical Teaching Fellows can support your learning.

2.9 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 MYEPAD medicine management assessment **should only be completed by the PA and in one assessment episode (i.e this assessment can not be completed across your placements or with a number of staff)**. 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. If you feel you have not had sufficient time to practise these skills, or you do not feel confident to undertake this assessment, you may wish to wait until your even numbered placement to complete it (2, 4 or 6). Prior to your summative assessment, PS's will provide feedback for learning and development.
Please note that students should only administer medications under direct supervision.

There are a few placements where medicine administration does not take place, if this is your base placement please discuss this with your Practice Assessor, Academic Assessor or Practice Learning Link (PLL) team (dohs-pll@york.ac.uk) who will be able to support you.

2.10 How do I get my hours signed off?

You will complete a weekly timesheet on TMS (Time Management System) and get this verified by your practice assessor on base or by your practice supervisor**.** TMS is accessed by logging into POW (Placements On the Web), selecting the 'binoculars' icon on the left hand side of the placement you wish to add practice hours for and clicking the 'Timesheets' button. You then add a Practice Assessor by clicking the 'Add a Practice Assessor' button and filling in their details. You must add the **approved work email address of your practice assessor**. If the practice assessor is not on the system, the practice education support team (PEST) will be notified and will either approve or reject the email address so it is important that the email address is correct and is an approved work email.

You then complete your timesheet including your shift pattern, start time, end time and any breaks (Breaks are now included in your practice hours, TMS will automatically work out your hours, once you have inputted them). Any absence time is also recorded here. If you are absent you must also report this to your practice placement and the Student Services Team at the University by phone (01904 321 321) or email (dohs-student-experience@york.ac.uk).

Once you have completed your timesheet, you must submit this to your practice assessor. This then sends an email to your practice assessor for them to either verify your hours or to reject either part or all of the timesheet. If the timesheet is approved you will receive a notification to say your hours have been approved. If part or all of the timesheet has been rejected, you will receive a notification to say that part or all of the timesheet has been rejected and will include some notes from your practice assessor with the details of why and actions you need to take.

If your spoke supervisors cannot access the TMS system you must print off a paper timesheet that can be found on the 'Placement Hours - TMS Guidance' page within your UoY MYEPAD workbook in PebblePad. You must complete this timesheet, and get your practice supervisor from your spoke placement to verify the hours, then add this timesheet evidence on to the 'Placement Hours - TMS Guidance' page. You must also complete a timesheet on TMS and submit this to your practice assessor at your base placement to approve. The practice assessor at your base can then access this paper

timesheet from your spoke and see that it has been verified by the practice supervisor on your spoke, and they can then verify the hours on TMS.

The student must complete their timesheets weekly and will receive notifications if this is not completed within 14 days.

Please remember that all hours should be inputted to your Timesheet and approved. Only Hours verified through the Time Management System will be counted toward the student's Placement hours.

For Sept 23 Cohort onwards
At the end of each year (stage) you must have no more than 150 practice hours outstanding.
If you have more than 150 hours outstanding by the end of the 4 week retrieval period you will have to take a leave of absence.

If you are absent from practice this should be documented within the TMS. **You** must inform your placement area as soon as possible and the SASS team. Further information on recording absence can be found in **section 3.5.**

As well as all practice hours, some of your clinical skills hours (Completed at University) need to be added on to POW, however if the session does not appear on the list to be added, an academic will add these clinical skills hours to your hours log. You can add your clinical skills hours to POW by logging into POW and clicking the 'Clinical Skills' button at the top of the page. You would then select the required clinical skill and fill in the date of when you attended the clinical skill session. The hours for this session will then be populated automatically. Once you have checked the information is correct, click 'Submit'. This will then add this clinical skill and the allocated hours to your record.

2.11 What is the record of communication section for?

The record of communication section can be used by students, 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 or PLL team to document any meetings of support.

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

Students should gather 5 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 PS or PA will need to sign and confirm evidence of these.

2.13 What is an action plan?

An action plan is a supportive measure designed to assist students in meeting the required areas of the programme. As with any module, practice is an essential part of the nursing programme and students 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 and failure of EOC or medicine management assessments. 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 student, PA and Academic Assessor. The PLL team may also be involved to support you with this. Action plans should be regularly reviewed and a timeframe for completion of the action plan will be established.
Please note: Actions plans may be formative or summative. Formative action plans may be used where there are exceptional circumstances. Students should discuss their individual circumstances with their Academic Assessor.

2.14 What is the final interview for?

The final interview concludes the placement and provides an opportunity for you and your PA to reflect on the placement, progress made and areas for development in your future placements. The final interview should ensure that all relevant placement assessments are completed including:

- Hours signed off
- Interviews completed

- Relevant proficiencies signed off
- Professional values completed
- Summative EOC completed
- Medicine management assessment signed off (as appropriate - once per stage)
- patient / service user/ child/ young person/ carer feedback forms signed
- Any action plans completed

Failure to complete summative assessments by the end of the placement will result in an action plan to take forward into the next placement or mandatory use of the retrieval period. Failure to meet the requirements of the action plan may result in programme failure. Please see the action plan section above for more information.

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

The Ongoing Achievement Record (OAR) summarises your achievements in each placement and within the Practice Assessment Document (MYEPAD), it provides a comprehensive record of professional development and performance in practice. The purpose of this document is to provide evidence from one practice assessor to another 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.

The Practice Assessor needs to ensure that the placement record for their placement is completed in OAR and the progression statement at the end of the Part is signed. i.e. If you are at the end of Part 1 your PA on placement 2 needs to complete the OAR for Part 1- Placement 2 and the End of Part 1 section. This will be the same for End of Part 2 and Part 3. It is also the PA's responsibility to confirm which of the identified proficiencies have been achieved in Part 2 /Part 3.

Stage 4, M Nurse - The OAR will need completing in Part 4 - Placement 7 and for the End of Programme.

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

2.16 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 student. There are certain tasks that you should never do unsupervised, for example, medicine administration. The below is an example of the Stage 1 criteria for assessment which can be found in your MYEPAD. 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 Parts 1-4 to be achieved by the end of the part

The decision on the level of supervision provided for students should be based on the needs of the individual student. The level of supervision can decrease with the student's increasing proficiency and confidence (NMC, 2018, p5). 'Achieved' must be obtained in all three criteria by the student.

Part 1:
Guided participation in care and performing with increased confidence and competence.

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 prompting in familiar tasks.	Inconsistent professional attitude towards others and lacks self-awareness. Is not asking questions nor engaging with own learning needs

Part 2:
Active participation in care with minimal guidance and performing with minimal guidance and with increased confidence and competence.

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 deliver safe, person centred and evidence based 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 demonstrate safe practice 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.

Part 3:

Practising independently with minimal supervision and leading and coordinating care and confidence.

Achieved	Knowledge	Skills	Attitude and Values
Yes	Has a comprehensive knowledge-base to support safe and effective practice and can critically justify decisions and actions using an appropriate evidence base.	Is able to safely, confidently and competently manage person-centred care in both predictable and less well recognised situations, demonstrating appropriate evidence based skills.	Acts as an accountable practitioner in responding proactively and flexibly to a range of situations. Takes responsibility for own learning and the learning of others.
No	Is only able to identify the essential knowledge-base with poor understanding or rationale for care. Is unable to justify decisions made leading to unsafe practice.	With minimal supervision is not able to demonstrate safe practice despite guidance.	Demonstrates lack of self awareness and professionalism. Does not take responsibility for their own learning and the learning of others.

Part 4:

Work effectively as a leader and coordinator of care and apply enhanced theoretical knowledge to practice.

Achieved	Knowledge	Skills	Attitude and Values
Yes	Aligned with theory modules, applies enhanced theoretical knowledge to their practice.	Demonstrates leadership skills and coordinates complex care situations with minimal supervision.	Professional values and proficiencies are maintained in line with NMC standards. Demonstrates commitment to development of own nursing practice.
No	Is not able to demonstrate an adequate understanding of the evidence base for their practice.	Is unable to describe characteristics of leadership or demonstrate ability to coordinate complex care despite repeated guidance and prompting in familiar settings.	Inconsistent maintenance of professional values and proficiencies*, and not engaging with development of personal nursing practice.

*If any concerns are raised about maintenance of professional values or proficiencies these should be discussed with the Academic Assessor as referral to fitness to practice may be required.

3. Useful placement information

3.1 What elements of my MYEPAD should I complete in base and in my allocated spoke?

The tables below outline a quick guide of what students should have achieved during their placement blocks. AA's will be checking your documentation throughout your practice experiences.

KANP 1, 3, 5:

Field specific **base** placement (first 4 weeks of placement block)	★ Initial interview ★ Episode of Care identified & formative undertaken ★ Midpoint interview (pre-spoke) ★ Midpoint professional values (pre- spoke) ★ Any proficiencies achieved signed off (proficiencies to be achieved on spokes identified at midpoint interview)
Spoke placement (3 weeks - any field) ** KANP5 spoke is the elective practice experience	• Students will collect evidence on their professional values & proficiencies (documented under 'record of working with others') & have their practice hours signed
Base placement return (between 3-4 weeks depending on stage)	★ Episode of Care summative ★ Final professional values ★ Final interview

	★ Any proficiencies achieved signed off ★ Medicines Management (if completed in this placement) ★ Practice hours checked & signed ★ OAR completed

KANP 2, 4, 6:

Field specific **base** placement (first 4 weeks of placement block)	★ Initial interview ★ Episode of Care identified & formative undertaken ★ Midpoint interview (pre-spoke) ★ Midpoint professional values (pre- spoke) ★ Any proficiencies achieved signed off (proficiencies to be achieved on spokes identified at midpoint interview)
Spoke (3 weeks - any field)	• Students will collect evidence on their professional values & proficiencies (documented under 'record of working with others') & have their practice hours signed
Return to field specific **base** (between 2 - 5 weeks depending on stage)	★ Episode of Care summative ★ Final professional values ★ Final interview ★ Medicines Management completed (If not completed in placements 1, 3 or 5) ★ Any proficiencies achieved signed off ★ Practice hours checked & signed ★ OAR completed ★ OAR confirmed

KANP 7 & 8

Field specific **base**	★ Initial interview ★ Episode of Care identified & formative undertaken ★ Midpoint interview ★ Midpoint professional values ★ Episode of Care summative ★ Final professional values ★ Final interview ★ Medicines Management completed ★ Practice hours checked & signed ★ OAR completed ★ OAR confirmed (Inc: End of Programme)

3.2 What do I need to do now my placement is finished?

You should check your MYEPAD and ensure all sections have been fully completed by yourself, your practice supervisor(s) and your practice assessor.
You must contact your academic assessor and inform them of any circumstances that are affecting your ability to complete your MYEPAD within the assessment schedule as soon as possible. You must work within assessment deadlines, as with any theory module. You may also contact the Practice Learning Link team (dohs-pll@york.ac.uk) for advice if you are unable to complete your MYEPAD on time.

3.3 What is a retrieval Placement and how do I access it?

Retrieval placement is located in the first 4 weeks of your summer break on the course plan. **Should you fail to meet the stage requirements for practice (i.e medicine management assessment, stage required proficiencies, professional values or episode of care assessments) mandatory use of the retrieval period will be required. Students are therefore recommended not to book leave in this period as failure to complete stage required assessments will result in you being unable to progress to the next stage of your programme.**

Should the retrieval period be required, students will access this 4 week period with an agreed action plan implemented by the Academic Assessor and Practice Assessor. Retrieval will always take place in the same placement as the even numbered placements (only in exceptional circumstances would this change).

Retrieval placements can be used to make up a deficit of hours but this has to be with agreement as summative requirements will take priority for retrieval placements. You should aim to complete your required practice hours within your KANP blocks.

3.4 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 of that area or the manager for that area. You can also contact your Academic Assessor or the PLL team (dohs-pll@york.ac.uk)
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/

How to raise a concern in practice:
https://www.york.ac.uk/healthsciences/practice-ed-support/practice-concerns/

3.5 What if I am absent from placement?

All sickness and absence from theory or practice must be reported to the Student Services Team on 01904 321 321 preferably before 09.30am on the morning of your first day of sickness. You **must also call the practice area** to inform them as soon as possible. This should be carried out in plenty of time prior to the start of your placement shift. **Failure to notify the placement area in a timely fashion can take placement staff away from caring for patients/clients to chase up your whereabouts and may affect the assessment of your professional values.**

Absence should also be reflected in the TMS system for recording practice hours.
For all students, sickness lasting four to seven days; a self-certification form should be completed. The original certificate must also be sent to the Student and Academic Support Service. If you are a sponsored student by your employer, the original of this certificate goes to the Student and Academic Support Service and you need to send a photocopy to your employer. From the eighth day of sickness a doctor's certificate is required and again should be sent to the appropriate office as above.

3.6 What clinical skills I can undertake when out on placement?

It is important to note that local policies and procedures must always be followed and that these will always take precedence over the advice offered below.
It is also important that students are properly prepared before undertaking any aspect of direct patient care and receive appropriate supervision

Please follow this Link for Clinical Skills Guidance

3.7 Who are the Clinical Teaching Fellows and how can they support me?

Clinical Teaching Fellows' (CTF) hold a dual role whereby they split their time 60/40 between (University of York/ Partnered NHS Trust). They are registered nurses by background and hold a contemporary stance on clinical practice. They are a great resource to support you in meeting your proficiencies. Molly is based at Foss Park Hospital and supports with building skills and knowledge specific to mental health. Claudia is based at York Hospital within paediatrics, supporting students with increasing

their knowledge and confidence around skills and interventions within this environment. Sarah is also based at York Hospital, covering all adult nursing areas. Sarah is able to support with improving skills and knowledge, and has good links with various hospital areas, which may be beneficial for students seeking out specific learning opportunities.

The team:

Molly Crosland - molly.crosland@york.ac.uk / molly.crosland@nhs.net

Sarah Kelly - s.kelly@york.ac.uk / sarah.kelly105@nhs.net

Claudia Viglianti-Pinches - claudia.viglianti-pinches@york.ac.uk

CTF's support students in practice by offering bespoke learning opportunities, and a student-centred approach to teaching in clinical settings that is aligned with NMC requirements of the programme. Currently they offer clinical workshops, proficiency support, and pastoral support. For further information please see available resources which will be signposted to on the VLE, alongside email reminders from the team themselves.

Please note: The Clinical Teaching Fellows will provide evidence that you have attended the skills sessions and the hours achieved. Students attending a skills session during placement shift time can not claim duplicate hours for these sessions.

4. Terms

Base Placement
Main placement in the student's field of practice.

Allocated Spokes
Allocated Spoke placements – During Stages One, Two and Three of the programme, you will rotate through allocated spoke placements where your progress will be monitored by named Practice Supervisors. Spoke placements are planned to offer you a range of experiences and develop your knowledge and understanding. Spoke placements will offer you a range of experiences to develop transferable skills. Spoke placements will be in any field of practice. Whilst on a spoke placement you must maintain and uphold your professional values, work towards achieving any proficiencies

that are available on that particular spoke. Record and have signed off the placement hours that you have worked.

Static Spokes

Static Spokes can be arranged between you and your PA on base placement, they are used to give you further learning experiences in different practice areas and can be linked to your base area i.e. a student on placement on a cardiology ward, the student could go for a day or two on a static spoke to coronary care unit. Static spokes can also be arranged by the staff in the spoke placement area if they have links to other areas that would enhance the student's learning. A static spoke is only for a couple of days at the most; they can be very useful in achieving your proficiencies and medicines management assessments.

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. Students will work alongside a range of Practice Supervisors throughout their placement experiences.

Please note: Non-registered staff supporting students 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 MYEPAD. Non-registered staff may include healthcare assistants, care support workers, phlebotomists, teachers.

Practice Assessor

Each student will be assigned a Practice Assessor during their base placement. 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 Part (Stage or Year) of the programme, summative episode of care, as appropriate 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 student 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.

5. Useful Resources

Resource on mapping proficiencies to primary care:
https://myeweb.ac.uk/wp-content/uploads/2021/12/Proficiencies-for-Primary-Care-Nursing.pdf

Examples for meeting adult proficiencies:
https://myeweb.ac.uk/wp-content/uploads/2021/06/achievement-of-proficiencies-adult-mapping-version-field-specific-examples-mapping.pdf

Examples for meeting MH proficiencies:
https://myeweb.ac.uk/wp-content/uploads/2021/06/achievement-of-proficiencies-mental-health-field-specific-examples-mapping.pdf

Examples for meeting Child proficiencies:
https://myeweb.ac.uk/wp-content/uploads/2021/06/achievement-of-proficiencies-child-mapping-field-specific-examples-mapping.pdf

Information about student nurse placements within the wider health & social care sector, examples of learning opportunities:
https://www.skillsforcare.org.uk/Regulated-professions/Nursing/Student-nurse-placements.aspx

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

Practice Support webpages:
https://www.york.ac.uk/healthsciences/practice-ed-support/student-practice-info/

6. 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.

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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.