Guidance Document

ASSESSING AND SUPERVISING NMC STANDARDS OF PROFICIENCY (2018)

Pre-Registration Nursing Students in Community Care Placements – District Nursing.

Year 1 student proficiencies.

UNIVERSITY OF PLYMOUTH

	PROFICIENCY	SUGGESTIONS FOR SKILL/ACTIVITY	SUGGESTED EVIDENCE
Participates in assessing needs and planning person-centred care			
1.	Demonstrate and apply knowledge of commonly encountered presentations to inform a holistic nursing assessment including physical, psychological and socio-cultural needs	• First visit assessments • Continual use of assessment documentation and risk assessments in all visits • Completion of wound care plans •	Assessment Documentation. Patient notes. Staff/Service User Feedback. Q&A.
2.	Demonstrates understanding of a person's age and development in undertaking an accurate nursing assessment.	• History Taking. • Patient Documentation. • Obtaining informed valid consent. • TEPS • Single point assessment	Documentation. Patient notes. Relevant Assessment documentation. Staff/Service User Feedback. Q&A.
3.	Accurately processes all information gathered during the assessment process to identify needs for fundamental nursing care and develop and document person-centred care plans	• Referral to other services and members of the MDT linked to completed assessments • Telephone consultations with GP	Referral Documentation. Staff/Service User Feedback. Reflection. Q&A.
	Participates in providing and evaluating person-centred care		
4.	Work in partnership with people, families and carers to encourage shared decision-making to manage their own care when appropriate	• Clinic activity and care provision • Patient review meetings. • Recording of online consultations/telephone consultations with informed consent. • Accurate documentation of clinical care • Accurate	Patient notes. Minutes. Staff feedback. Q&A.

		documentation of telephone discussions. • Documentation of referrals. •	
5.	Demonstrates an understanding of the importance of therapeutic relationships in providing an appropriate level of care to support people with mental health, behavioural, cognitive and learning challenges	• Referral to other services. • Continuity of visits • Health promotion advice • Patient education- self help.	Staff/Service User Feedback. Patient Notes. Q&A.
6.	Provides person centred care to people experiencing symptoms such as anxiety, confusion, pain and breathlessness using verbal and non-verbal communication and appropriate use of open and closed questioning	• Mental Health Checks. • Review of Medications. • Providing care for patients with Dementia • Providing care for patients with cognitive impairment • Providing care to Patients at End of Life • Same day contact with patients • Referral to appropriate services	Assessment Documentation. Patient Notes. Referral Process. Staff/Service User Feedback. Reflection. Q&A.
7.	Takes appropriate action in responding promptly to signs of deterioration or distress considering mental, physical, cognitive and behavioural health	• Health Promotion, Smoking Cessation. • Complete appropriate assessments e.g clinical observations, NEWS 2 • Sepsis screeing • Referral to appropriate services • Telephone consultations with services • Discuss with N.O.K with consent	Staff/Service User Feedback. Reflection. Q&A.
8.	Assesses comfort levels, rest and sleep patterns demonstrating understanding of the specific needs of the person being cared for	• Medication reviews. • Visiting and providing care for all patients but particular those at End of Life • Documentation of appropriate care plans and risk assessments • Referral to other	Patient notes. Staff Feedback External Assessor Feedback.

		services • Telephone consultations with GP	
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9.	Maintains privacy and dignity in implementing care to promote rest, sleep and comfort and encourages independence where appropriate	• Care provision in patients home • Health promotion • Educating the patient and family	External Assessor Feedback. Reflection.
10.	Assesses skin and hygiene status and determines the need for intervention, making sure that the individual remains as independent as possible.3	• Regular skin assessments completed • Regular risk assessments completed • Completion of Wound care plans • Act on results of assessments • Refer to specialist services such as continence or Tissue Viability • Consider referral to OT for specialist equipment • Spend time with other members of MDT	Documentation Q+A Assessor and/or supervisor feedback Direct observation
11.	Assists with washing, bathing, shaving and dressing and uses appropriate bed making techniques 3	• Care provision for EOL patients. • (Not a usual element of care within Community Nursing)	Documentation Q+A Assessor and/or supervisor feedback Direct observation
12.	Supports people with their diet and nutritional needs, taking cultural practices into account and uses appropriate aids to assist when needed 5	• Regular Nutritional assessments with all patients • Making appropriate referrals to other MDT members e.g dietician, GP • Consider referral to OT • Health Promotion • Educating patients and carers • Care of patient with PEG	Documentation Q+A Assessor and/or supervisor feedback Direct observation Patient feedback
13.	Can explain the signs and symptoms of dehydration or fluid retention and accurately records fluid intake and output 5	• Care of patient with cardiac history • Care of patient with kidney disease • Medication reviews • Care provision for patients in a	Q+A Assessor and/or supervisor feedback Documentation

		residential setting • Completion of continence assessments	
14.	Assists with toileting, maintaining dignity and privacy and managing the use of appropriate aids including pans, bottles & commodes 5	• Continence team referral • Complete appropriate assessments to determine need for equipment.	Referral Documentation. Local Policy/Protocol. Staff/Service User Feedback. Reflection. Q&A.
15.	Selects and uses continence and feminine hygiene products, for example, pads, sheaths and appliances as appropriate 5	• Referral to Continence service • Spend time with Continence service • Care provision patients at EOL	Q+A Documentation Direct observation
16.	Assesses the need for support in caring for people with reduced mobility and demonstrates understanding of the level of intervention needed to maintain safety and promote independence	• Competing regular risk assessments • Referral to physio and/or OT • Education to patient and carers • Fall assessments • Referral to other services if deemed appropriate	Student Presentation/Project Work. Audit Documentation. Staff Feedback. Q+A Documentation Direct observation
Participates in procedures for the planning, provision and management of person-centred care			
17.	Uses a range of appropriate moving and handling techniques and equipment to support people with impaired mobility.	• Care provision across patient group • Complete relevant risk assessments • Identify need to refer patients.	Q&A Compilation of Staff Chart Full Understanding Of Relevant MDT roles. Staff Feedback. Direct observation
18.	Consistently utilises evidence based hand washing techniques 2	• Across all patient visits • Educating others	Staff/Service User Feedback. Reflection. Q&A. Direct observation
19.	Identifies potential infection risks and responds appropriately using best practice guidelines and utilises personal protection equipment appropriately. 2	• Across all patient visits • Care provision particularly in regards to Catheter care, Wound care • Use of aseptic technique • Use of clean technique • How to maintain a clean environment within a patients home • Understanding Appropriate use of	Documentation. Q&A. Staff Feedback. Direct observations Practice Assessor/supervisor feedback Episode of care

		PEE	
20.	Demonstrates understanding of safe decontamination and safe disposal of waste, laundry and sharps 2	• Care provision when completing all types wound care, catheterisation, catheter care, pleural drain management, • Management of different types of waste, correct removal of waste products • Completion of sub cutaneous and Intra muscular injections • Understanding sharps policy • Needle stick injury protocol	Policies and protocols Direct observation Q+A Feedback
21.	Effectively uses manual techniques and electronic devices to take, record and interpret vital signs, and escalate as appropriate. 2	• Completion of all clinical observations • Completion of blood glucose monitoring • NEWS 2 • Escalation of deterioration • Sepsis markers- how to detect • Research evidence based practice – •	Policies and protocols Direct observation Q+A Feedback Documentation
22.	Accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinical significance of high/low readings 2	• Completion of assessments • Indicate referral to other MDT service if appropriate • Health Promotion • Educating patients	Direct observation Q+A Feedback Documentation
23.	Collect and observe sputum, urine and stool specimens, undertaking routine analysis and interpreting findings 6	• Completion of assessments • Correct use of equipment • Use of PPE • Research evidence based practice – • Protocols	Direct observation Q+A Feedback Documentation
Participates in improving safety and quality of person-centred care.			
24.	Accurately undertakes person centred risk assessments proactively using a range of evidence based assessment and improvement tools	• Infection Prevention. • Hand Washing. • Audit Result reviews. • Self limiting and health prevention patient facing online resources • Health promotion tools • Risk assessments used during single point	Audit Documentation. Staff Feedback. Q&A.

		assessment and first visits	
25.	Applies the principles of health and safety regulations to maintain safe work and care environments and proactively responds to potential hazards	• Significant event reporting and process. • Understand incident reporting procedure • Completion of lone working assessment • First visit assessments • Consider hazards in the workplace	Assessment Documentation. Q&A. Staff Feedback. Health and safety policy Lone working policy
26.	Demonstrate an understanding of the principles of partnership, collaboration and multi-agency working across all sectors of health and social care.	• Escalating concerns protocol. • Whistleblowing. • Safeguarding. • Spend time with other members of the teams linked with District Nursing	Q&A. Staff Feedback.
27.	Demonstrate an understanding of the challenges of providing safe nursing care for people with co- morbidities including physical, psychological and socio-cultural needs misses, critical incidents or major incidents.	• Significant event reporting and protocol. • Safeguarding • Consent • Capacity • Compliance management • Best interests • Self help • Informed choices	Documentation. Staff Feedback. Q&A. Policies and Protocol
28.	Understand the principles and processes involved in supporting people and families so that they can maintain their independence as much as possible	• Relevant referrals. • Collaborative working across the organisation and primary care • Informed choice • Self help groups • Health promotion and prevention •	Feedback from External Assessors. Reflection. Q&A.
29.	Provides accurate, clear, verbal, digital or written information when handing over care responsibilities to others.	• . • Family/Friends Test. • . • Take part in handover • Attend training to use the IT system • Document accurately • Telephone referrals	Documentation. Q&A. Staff/Service User Feedback. Wider Patient Engagement Activity. Training day

Proficiencies with a green numbered dot indicates that the subject is covered in Clinical Skills. This does not confirm proficiency. The skills need to be assessed in practice placement.