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**Worked Assessment Examples**

Worked examples of key assessment forms from the Pan London Practice Assessment Document

*March 2025*

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Note: This document is a work-in-progress and further sections will be added as more examples become available.

# Introduction

This document contains examples of key forms from the Nursing PLPAD 2.0 and the England Nursing Associate PAD that need to be completed as part of the student assessment.

Whether the forms are the responsibility of the Practice Supervisor (e.g. initial interview) or Practice Assessor (e.g. action plan), these examples will be of value to any staff member involved in learning and assessment.

A number of forms also require documented input from students, such as reflection on professional values, episodes of care or interviews and these are included in order to provide the PS or PA with guidance so that they can advise the student and have a better understanding of the level of reflection expected of students.

Student reflections will vary greatly, depending on the level and experience of the student. The key message for the PS and PA is to ensure that they review any reflection/comment made by students, ensure their accounts are supported with evidence from their practice and use Q&A to explore student understanding. At times, the PS or PA may need to direct the student to rewrite their reflection.

# Professional Values

**Example of Student Reflection on Professional Values**

**End point: Student reflection on meeting Professional Values**

**Choose one example from your practice on this placement to demonstrate how you practice within the NMC Code (ensure confidentiality is maintained). For each placement, please select a different section of The Code to reflect on.**

In this reflection I am focusing on the first area of the Code ‘Prioritise People’

My example relates to Professional Value No.4‘. **The student is caring, compassionate and sensitive to the needs of others.**

When caring for a very confused patient with dementia I initially found it hard to monitor her vital signs. When I approached her she immediately pulled away from me and would not allow me to complete these. I was also conscious of the time I was taking to record her vital signs and I was worried that my practice supervisor would feel that I was taking too long.

After doing some reading and speaking to one of the dementia specialists I was encouraged to speak to the patients relatives to find out a bit more about her background, her family and things she was interested in, for example, films, books, hobbies and this helped me communicate better and create a more relaxed environment.

I began to understand that my anxiety was possibly making this patient more irritable and if I was more relaxed then that would also help her. When I approached her after that I was careful to initially seek her consent and take my time to explain what I was doing and talking about things of interest to her. These strategies worked well on most occasions and I was pleased that I seemed to be making a difference. I also spoke to my practice supervisor and reflected on how I was feeling and the learning I gained and was given positive feedback about my actions.

**Student Name: Signature**

Student Name: Signature: Date: Final assessment - please add comments on Final Interview Page

**Final assessment - please add comments on Final Interview Page**

**Practice Assessor Name: Signature: Date**:

# Initial Interview

This can be completed by a Practice Supervisor or Practice Assessor. If completed by the PS they must discuss and agree with the PA. This meeting should take place within the first week of the placement.

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| **Student to identify learning and development needs (with guidance from the PS)** |
| 1. To develop my knowledge and understanding of undertaking vital signs and practice safely and confidently
2. To develop communication and interpersonal skills when supporting people with dementia
 |
| **Outline of Learning Plan** | **How will learning plan be achieved?** |
| 1.To support Martha in gaining practice of undertaking vital signs under supervision and being able to provide an explanation of the readings, the underpinning physiology and document accurately by end of week 2.2. Martha to gain understanding of how different people present with dementia, their physical and psychosocial needs and feel more confident in communicating a plan of care with individuals and their families under supervision by week 4  | 1.Current knowledge and understanding to be reviewed and advice/guidance/resources provided. Opportunities to practice and document T,P,R B/P supported with demonstration, Q&A. Review progress weekly.2. Provide guidance /learning resource to support understanding. Allow Martha to shadow PS who will role model best practice prior to allocating 2 patients for Martha to care for with support. Closely observe her practice, facilitate reflection, provide ongoing feedback and review of progress weekly. |

# Action Plan

**Background and Context**

Lianne is a Year 2 student is in the 4th week of an 8 week placement in a 24 hour service. The student’s practice supervisor has raised some concerns regarding her competence with some proficiencies following several opportunities working with Lianne.

**The proficiencies are:**

* **Proficiency No 7**. Maintains accurate, clear and legible documentation of all aspects of care delivery using digital technologies where required.
* **Proficiency No 23**. Undertakes assessments using appropriate diagnostic equipment in particular blood glucose monitors and can interpret findings.

The practice supervisor is a nurse who has been qualified for 18 months and has supervised other students. The PS has worked 4 shifts with Lianne. The PS has assessed these proficiencies and documented that Lianne has “not achieved” proficiencies 7 and 23 due to inaccurate recording of blood glucose levels and failing to interpret and report the findings to an appropriate member of staff. The practice supervisor reports this to the practice assessor who arranges to meet with Lianne for the midpoint interview. It was decided that an action plan needed to be implemented to ensure Lianne understood areas for improvement and what support mechanisms would be in place to help her succeed

**Example of completed Action Plan**

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| **Placement Name: Date action plan initiated:12.02.24** |
| **Nature of Concern.****Refer to Professional Value(s), Proficiency and/or Episode of Care (Specific)** | **What does the student need to demonstrate; objectives and measure of success (Measurable, Achievable and Realistic)** | **Support available and who is responsible** | **Date for Review****(Timed)** | **Review/****Feedback** |
| Lianne has demonstrated inaccurate recording of blood glucose levels and failed to interpret and report the findings to an appropriate member of staff (Part 2 proficiencies 7 &23) and therefore not meeting requirements for safe practice, | Lianne will need to:1.Demonstrate understanding of normal ranges of blood glucose levels2.Be assessed by safely undertaking blood glucose monitoring and assessment of 5 service users3.Be able to identify signs of deterioration into hypo/hyper glycemia4.Safely interpret results and how when to escalate5.Accurately document findings6. Complete a 500 word reflective account on knowledge and skills gained as well as the role of the nurse | 1.Match shifts with the PS for supervision, support and coaching (PA)2. Provide local policy and direct to NMC guidance on record keeping (PS)3. Refer to relevant guidance/reading and NICE guidelines4.Provide an opportunity to work with the Diabetes Specialist Nurse5. Observe Lianne whilst undertaking monitoring of 5 service users (PS)6.Encourage reflection on practice and test understanding with Q&A (PS)7.Review reflective account (PA) | **To be completed in 4 shifts** **By 16.01.24** | **Date:****Comments**:**Practice Assessor’s Name:****Signature** |
| **Student’s Name: Signature: Date:****Practice Assessor’s Name: Signature: Date:****Academic Assessor’s Name: Signature: Date:** |