

School of Healthcare Sciences

Ysgol y Gwyddorau Gofal Iechyd

#### Supporting Documentation

#### Supporting documentation is necessary for admission as a Postgraduate student to the following modules:

#### Advanced Clinical Practice Portfolio (HCT 353)

#### Advanced Clinical Assessment for Healthcare Professionals (HCT181)

* Musculoskeletal Advanced Practice First Contact Practitioner Module **(HCT 348)**
* Advanced Assessment of the Child and Young Person **(HCT372)**

We want to process your application as quickly as possible.

It is essential for all relevant sections of this document to be completed, and please complete in capital letters using black ink.

Please make sure that you have also completed/submitted the following for us:

* Module Application form (this is electronically submitted)

Completed supporting documentation should be emailed to the following address:

**hcarepgtadmissions@cardiff.ac.uk**

General Data Protection Regulation (GDPR) 2018

The General Data Protection Regulation (GDPR) was introduced in the UK from 25 May 2018 along with a new Data Protection Act. <https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection/student-data-protection-notice>

**APPLICANT PERSONAL DETAILS**

Title (Mr/Mrs/Miss/Ms/Dr):

Surname/Family Name:
Forenames:
Please specify any other names known as:

(Please ensure that the name on this form matches the name on your passport)

Date of Birth:

Contact Number:
Email Address:

Please indicate which module you are applying for:

(Please tick as appropriate)

  Advanced Clinical Practice Portfolio (HCT 353)

  Foundations Clinical Assessment for Health care Professionals (HCT181)

  Musculoskeletal Advanced Practice First Contact Practitioner (HCT 348)

 Advanced Assessment of the Child and Young Person (HCT372)

Please indicate whether you are a Nurse or AHP: (Please tick as appropriate)

 Nurse

 AHP

Please indicate how the module will be funded: (Please tick as appropriate)

 Self-funded

 Health Board

 HEIW

 Other, please name

**APPLICANT EMPLOYMENT DETAILS**

Job Title:

Grade/band:

Work Address:

Work Telephone Number:
Work Email Address:

NMC/HCPC/ Professional Body Registration Number:
NMC/HCPC/ Professional Body Registration Date:

**APPLICANT STATEMENT**

I give permission for my supporting organisation (i.e. Health Board, GP Practice, Health Ministry) and my employer (if different), to have access to information relating to my attendance and academic progress on this module.

I declare that to the best of my knowledge all the information on this form is correct and the questions have been answered truthfully.

Signature:
Date:

We would like to add your contact details to our student database. Your details would be shared with past and future students to encourage peer support.

Please tick the box if you are happy for us to do so:

THIS SECTION NEEDS TO BE COMPLETED BY THE APPLICANT’S LINE MANAGER.

**LINE MANAGER DETAILS**

Name:

Job Title:

Organistation:

Work Address:

Work Telephone Number:
Work Email Address:

**Please confirm the suitability of the Organisation and practice placement:**

(Please tick all that apply)

Health and Safety regulations are adhered to within the applicant’s clinical learning and practice environment.

A clinical governance framework is in place.

The applicant will be made aware of available learning opportunities and arrangements have been made that allow the applicant to be released for training and future CPD.

The applicant has access to the internet and local policies and procedures.

There is an equal opportunities and anti-discriminatory policy in place to which the applicant has access.

**Please confirm the applicant’s suitability of undertaking the module.**

(Please tick all that apply)

 I can confirm that a service has been identified where the chosen

 module will benefit the patient and the NHS/ Health Organisation.

I can confirm that the relevant clinical lead(s) in my organisation have agreed to support the introduction of Advanced Clinical Practice OR Advanced Clinical Assessment OR Service Improvement and Evaluation for this group of patients.

I can confirm that the employer is aware that they may be held vicariously liable for the applicant’s actions.

 I am confident that the applicant is a safe practitioner.

I can verify that this applicant’s Enhanced DBS Disclosure or equivalent has been checked and meets the required standard. An Enhanced DBS Disclosure must be no more than 3 years old.

For the section below, please only complete the section (**A, B, C, or D**) that is relevant for the applicant.

**A. Advanced Clinical Practice Portfolio (HCT 353)**

I can confirm that the applicant is working at a band 6 and has at least 3 years clinical experience within their current field.

I can confirm that the applicant is working a minimum of 3 days a week as a traineeAdvanced Practitioner within their clinical field.

I can confirm that they will have access to appropriate clinical support and supervision for the development of knowledge and skills to an advanced level.

**B. Foundations Clinical Assessment for Health Care Professionals module (HCT181**)

I can confirm that the applicant has at least 3 years clinical experience in their current

post/field.

**C. Musculoskeletal Advanced Practice First Contact Practitioner Module (HCT 348)**

 I can confirm that the applicant has at least 3 years clinical experience in their current post/field.

**D Advanced Assessment of the Child and Young Person** **(HCT372)**

I can confirm that the applicant has at least 3 years clinical experience in their current post/field.

**LINE MANAGER DECLARATION OF SUPPORT**

 I agree to support

(Name of Line Manager)

for this module.

(Name of Applicant)

Signature:
Date:

*Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the module. Evidence may be requested and external audit may be undertaken. You will be given adequate notice of this.*

THIS SECTION NEEDS TO BE COMPLETED BY THE APPLICANT'S EDUCATION MANAGER.

**EDUCATION MANAGER DETAILS**

Name:

Job Title:

Organistation:

Work Telephone Number:
Work Email Address:

**EDUCATION MANAGER DECLARATION OF SUPPORT**

 I agree to support

(Name of Education Manager)

for this module.

(Name of Applicant)

Signature:
Date:

*Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the module. Evidence may be requested and external audit may be undertaken. You will be given adequate notice of this.*

THIS SECTION NEEDS TO BE COMPLETED FOR ANY APPLICATIONS WISHING TO UNDERTAKE THE FOLLOWING MODULES:

* **HCT353** Advanced Clinical Practice Portfolio dissertation
* **HCT181** Foundations Clinical Assessment for Health care Professionals
* **HCT348** First Contact Practitioner
* **HCT372** Advanced Assessment of the Child and Young Person

IT NEEDS TO BE COMPLETED BY THE APPLICANT'S PRIMARY DESIGNATED SUPERVISING PRACTITIONER (DSP), ADVANCED PRACTITIONER (AP) OR DESIGNATED SUPERVISING MENTOR (DSM).

**THE DSP / AP / DSM ROLE**

The DSP/AP/DSM (mentor) has a crucial role in educating and assessing. It is anticipated that the mentor will only supervise one student at any one time. Please contact module organisers to discuss any issue that may arise with this.

## Feedback collected from mentors’ shows that they find this a rewarding role that contributes to their own Continuing Professional Development.

The role involves:

* Developing the applicant’s role.
* Establishing a learning contract with the applicant.
* Planning a learning programme, which will provide the opportunity for the student to meet their learning objectives and gain competency.
* Facilitating learning by encouraging critical thinking and reflection, and application of evidence.
* Supporting the applicant to develop an awareness of their limitations within their role.
* Providing dedicated time and opportunities for the applicant to observe how the mentor conducts a consultation or interview with patients or carers and develops a management plan.
* Allowing opportunities for the applicant to carry out consultations and suggest clinical management which are then discussed with the mentor.
* Taking opportunities to allow in-depth discussion, analysis of clinical management and integration of theory with practice.
* Assessing and verifying that, by the end of the module that the applicant is competent.

**MENTOR DETAILS**

Name:

Job Title:

Organisation:

Health Board:

Work Address:

Work Telephone Number:
Work Email Address:

NMC/HCPC/GMC Registration Number:
NMC/HCPC/GMC Registration Date:

For the section below, please answer ALL questions.

 (Please tick yes or no)

**1.** Are you a registered Medical Practitioner, Advanced Practitioner or Registered Nurse who has had a least 3 years recent clinical experience for a group of patients / clients in the relevant field of practice?

Yes No

**2.** Are you currently within a GP practice and either vocationally trained or in possession of a certificate of equivalent experience from the Joint Committee for Post-Graduate Training in General Practice Certificate?

Yes No

OR

Are you a specialist registrar, clinical assistant or a consultant within a NHS Trust or other NHS employer?

Yes No

**3.** Do you have the support of the employing organisation or GP practice to act as the Designated Supervising Medical Practitioner (DSMP), Advanced Practitioner (AP) or Designated Supervising Mentor (DSM) who will provide supervision, support and opportunities to develop competence in the relevant area of practice?

Yes No

**4.** Have you got some experience of training and/or supervision in practice?

Yes No

**5.** Have you previously assessed an Objective Structure Clinical Examination?

Yes No

If yes, how frequently?

**6.** Have you acted in the capacity of DSP previously?

Yes No

If yes, for which institution?

**7.** Would you like to attend the training session (the date is yet to be confirmed)?

Yes No

For the section below, please only complete the section (A, B, C or D) that is relevant for the applicant.

**MENTOR DECLARATION OF SUPPORT**

#### HCT 353 Advanced Clinical Practice module

#### I agree to act as the mentor in their advanced practice role.

#### I am prepared to establish a role and scope of practice.

#### I am prepared to agree a learning contract.

#### I am prepared to develop a plan for and facilitate regular practice-based learning at an Advanced level (allowing for co-supervision by suitably qualified healthcare professions).

#### I am prepared to meet the applicant at least monthly, to establish progress with their development

#### I am prepared to attend a mentor study session (usually half a day, or in special circumstances, can attend a meeting with a module tutor and the student to prepare for my role).

#### I am prepared to make the applicant aware of the available learning opportunities at the commencement of the module.

#### I am prepared to support the applicant and be willing to share expertise to enhance the learning experience.

#### I am prepared to ensure that risk assessment / risk management is evident in respect of the applicant.

I **am prepared to write an OSCE for the students’ final assessment and source a suitable**  **examiner.**

**MENTOR DECLARATION OF SUPPORT**

I understand that it is my responsibility to assess and verify that, by the end of the module, the trainee is competent to assume the Advanced Clinical Practitioner role.

Signature:
Date:
 *Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the module. Evidence may be requested, and external audit may be undertaken. You will be given adequate notice of this.*

#### HCT181 Foundations Clinical Assessment for Health care Professionals

####  I agree to act as the Mentor in their role for a period of learning in practice.

####  I am prepared to establish a role and scope of practice.

 I am prepared to agree a learning contract.

#### I am prepared to develop a plan for and facilitate a minimum of 45 hours of practice (allowing for co-supervision by suitably qualified healthcare professions).

#### I am prepared to meet the applicant at the least monthly, to establish progress with their development.

#### I am prepared to attend a mentor study session (usually half a day, or in special circumstances, can attend a meeting with a module tutor and the applicant to prepare for my role).

#### I am prepared to make the applicant aware of the available learning opportunities at the commencement of the module.

#### I am prepared to support the applicant and be willing to share expertise to enhance the learning experience.

#### I am prepared to ensure that risk assessment / risk management is evident in respect of the applicant.

**MENTOR DECLARATION OF SUPPORT**

I understand that it is my responsibility to assess and verify that, by the end of the module, the trainee is competent to assume the Advanced Clinical Practitioner role.

Signature:
Date:
 *Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the module. Evidence may be requested, and external audit may be undertaken. You will be given adequate notice of this.*

#### HCT348 First Contact Practitioner

####  I agree to act as the Mentor in their role for a period of learning in practice.

 I am prepared to establish a role and scope of practice.

#### I am prepared to agree a learning contract.

#### I am prepared to develop a plan for and facilitate a minimum of 30 hours of practice (allowing for co-supervision by suitably qualified healthcare professions).

#### I am prepared to meet the applicant at the least monthly, to establish progress with their development.

#### I am prepared to attend a mentor study session (usually half a day, or in special circumstances, can attend a meeting with a module tutor and the applicant to prepare for my role).

#### I am prepared to make the applicant aware of the available learning opportunities at the commencement of the module.

#### I am prepared to support the applicant and be willing to share expertise to enhance the learning experience.

#### I am prepared to ensure that risk assessment / risk management is evident in respect of the applicant.

**MENTOR DECLARATION OF SUPPORT**

I understand that it is my responsibility to assess and verify that, by the end of the module, the trainee is competent.

Signature:
Date:
 *Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the Module. Evidence may be requested, and external audit may be undertaken. You will be given adequate notice of this.*

**HCT372 Advanced Assessment of the Child and Young person**

####  I agree to act as the Mentor in their role for a period of learning in practice.

####  I am prepared to establish a role and scope of practice.

#### I am prepared to agree a learning contract.

#### I am prepared to develop a plan for and facilitate a minimum of 45 hours of practice (allowing for co-supervision by suitably qualified healthcare professions).

#### I am prepared to meet the applicant at the least monthly, to establish progress with their development.

#### I am prepared to attend a mentor study session (usually half a day, or in special circumstances, can attend a meeting with the module lead and the applicant to prepare for my role).

#### I am prepared to make the applicant aware of the available learning opportunities at the commencement of the module.

#### I am prepared to support the applicant and be willing to share expertise to enhance the learning experience.

#### I am prepared to ensure that risk assessment / risk management is evident in respect of the applicant.

**MENTOR DECLARATION OF SUPPORT**

I understand that it is my responsibility to assess and verify that, by the end of the module, the trainee is competent.

Signature:
Date:
 *Please note that all statements must be confirmed. Failure to do so may result in non-acceptance to the module Evidence may be requested, and external audit may be undertaken. You will be given adequate notice of this.*