

National Competency Framework for
Registered Practitioners:

Level 1

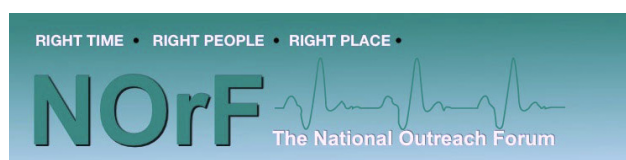
Patients and Enhanced Care Areas



Learner Name	Signature
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Lead Assessor /Mentor Name	Signature
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Foreword

I am delighted to introduce the National Competency Framework for Registered Practitioners: Level 1 Patients and Enhanced Care Areas, which is the outcome of collaboration between the National Outreach Forum (NORF) and the Critical Care National Network Nurse Leads Forum (CC3N).

This document outlines the latest evidence based competencies for registered practitioners working in enhanced care areas and with Level 1 patients on general wards. The framework acknowledges the increasing complexity of patients' conditions and interventions in non-critical care areas.

Achieving the competency framework will allow practitioners to strengthen their professional development, knowledge and skills in caring for acutely ill patients and the early recognition and management of the deteriorating patient.

This educational initiative is proposed as an addition to existing resources in individual organisations, moreover facilitating an essential standardisation on the assessment of these competencies. This consistent approach for assessing competence will help to decrease variability and to increase transferability of skilled practitioners.

I firmly believe that education and training empowers the individual, and in the healthcare setting contributes to the provision of high quality care and enhances patient safety. As a clinician working in the acute setting with multidisciplinary teams, I most welcome this document.

Dr Isabel Gonzalez LMS MRCP FRCA Cert ClinEd EDIC FFICM

Chair National Outreach Forum

Medical Lead - North of England Critical Care Network



Towards Excellence in Level 1 Patient Care

Healthcare teams in hospitals have been recognising the vulnerability of the deteriorating patient in acute care settings for over 20 years. UK national organisations such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), the National Patient Safety Association (NPSA) and the National Institute for Health and Care Excellence (NICE) have identified this in numerous documents. Following the publication of Comprehensive Critical Care (Department of Health, 2000), the Intensive Care Society (ICS) published definitions of levels of care in 2002 to better understand the needs of acutely ill and critical patients. These definitions were later updated in 2009 (ICS, 2009) and are used to describe the levels of care required by critically ill patients including the care required by patients who may deteriorate and follow the approach of allocating levels of care to patients according to their clinical needs irrespective of geographical location.

The National Outreach Forum (NOrF) and the Critical Care Network National Nurse Leads Forum (CC3N) have gathered a wide group of key stakeholders to develop competencies for practitioners who care for Level 1 patients. These are an extension to the three levels of the National Competency Framework for Adult Critical Care Nurses. The group has worked in collaboration with numerous professional bodies in the development of this document.

The focus of the competencies is to:

- Provide and maintain a current, nationally transferable competency package
- Provide standardisation in assessment of competency attainment
- Provide Practice Educators, Higher Education Institutes (HEIs) and other education providers with core clinical competencies/skills to support Level 1 or 'enhanced care area' educational programmes
- Provide a supportive strategy and tool to assist learners with competency attainment.

The competencies have been designed to support safe, kind and effective care and treatment to Level 1 patients within acute provider organisations. These competencies are not an exhaustive list of all skills required to treat and care for patients requiring Level 1 care. They aim to provide you with the core generic skills required to safely and professionally care for the patient requiring Level 1 care. They can be used in an enhanced care unit or a general ward, under the supervision and support of your mentor, lead assessor and/or practice educator. You will need to be able to demonstrate a fundamental underpinning knowledge in relation to all the competency statements outlined that are specific and relevant to your scope of practice and workplace. You are advised to keep a portfolio of any supportive evidence and reflective practice that might assist you during your progress and assessment reviews. It will also provide evidence to inform your Nursing and Midwifery Council (NMC) or Health and Care Professionals Council (HCPC) at revalidation.

This document is intended to complement local Trusts' existing educational programmes and competency-based training packages, to provide an evidenced based framework to assess the performance of registered nurses and allied health professionals (AHPs) with regular exposure to caring for Level 1 patients.

Alison Dinning RGN BSc (Hons)

Chair Working Group

Past Chair National Outreach Forum

Endorsements

Endorsement from the Faculty of Intensive Care Medicine

What happens to those patients who do not require Level 2 support but are not well enough to be safely cared for on a ward, frequently identified as Level 1/1+? We know from Critical Futures: A report on the First Wave Survey, The Faculty of Intensive Care Medicine (FICM) publication in 2017, that many of these patients are managed in a Level 2 facility, reducing availability of this scarce resource for those sicker patients who require it. Some patients will remain on a ward, perhaps with support from Critical Care Outreach, but this can be stressful for staff responsible for providing a higher level of care in the ward environment. In some institutions an ad hoc development of Enhanced Care areas has occurred in an attempt to ensure that these Level 1/1+ patients receive safe, high quality care outside of a critical care facility. FICM has established a multi professional working party to address this unmet need and warmly welcomes this document as an important framework supporting those currently caring for the sick patient either in the ward or a specific facility designed for this purpose.

The National Outreach Forum (NORF) and the Critical Care National Network Nurse Leads Forum (CC3N) have gathered together key stakeholders to produce this excellent document which, although not intended to be mandatory, does establish a standard to support organisations, and individuals, in delivering safe, high quality care which will maintain public confidence in the service being provided. The framework is intended to supplement educational resources already in place and to support educators and learners in the clinical arena. The FICM's intention is to incorporate this into our Enhanced Care outcomes and we acknowledge the work put into this document by the group, expertly chaired by Alison Dinning. I cannot recommend it highly enough to the critical care community.

Alison Pittard MB ChB MD FRCA FFICM

Vice Dean

Faculty of Intensive Care Medicine

Endorsement from the Society for Acute Medicine

On behalf of the Society for Acute Medicine (SAM) I am more than happy to give our endorsement to these guidelines. Traditionally Acute Medical Units (AMUs) have cared for some of the sickest patients admitted to hospital most frequently with the full support of critical care teams.

In the annual audit of our practice (Society for Acute Medicine Benchmarking Audit (SAMBA, 2017) full data was collected around the acuity of people admitted to our units. In June 2017, approximately 10% of all patients admitted to AMU were classified as Level 1 with 30% of these being admitted to Level 2 care, and 6% of these being admitted to Level 3 care within 72hrs. In addition, a further 25% of them were reviewed by a critical care outreach team and 15.5% were seen by an ICU doctor but deemed not for escalation beyond ward based care.

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Endorsements Continued

Endorsement from the Society for Acute Medicine Continued

The ward structure to support this showed that only 11 of our hospitals has Level 2 beds within their AMUs. These competencies will provide an ideal framework for ward nurses and other allied health professionals to work from. Essentially, they will be able to demonstrate competence in looking after these sick individuals as and when they are admitted to hospital. SAM are proud to have contributed to developing these and fully support their implementation.

Dr Nick Scriven FRCP

Consultant Acute and General Medicine

President Society for Acute Medicine

Endorsement from Association of Chartered Physiotherapists in Respiratory Care

We welcome the publication of a National Competency Framework for Level 1 and Enhanced Care Areas by NOF and CC3N.

This framework will not only supplement existing systems in place to aid the recognition and management of the deteriorating ward patient but will support improvements in collaborative multi-disciplinary practice and quality of clinical assessments utilising the A-E approach.

This is the first framework of its kind which inclusively brings together nursing and AHP practice. We commend NOF and CC3N in recognising the role physiotherapists may play in the acute ward setting and as a 'core responder' to the acutely ill patient.

Ian Culligan

Chair

Association of Chartered Physiotherapists in Respiratory Care (ACPRC)

Introduction

The Level 1 competencies outlined in this framework have been developed in a healthcare culture that has been recognising the vulnerability of the deteriorating patient in acute care for over 20 years (Lee et al, 1995). It was first reported by McQuillan et al (1998) that a considerable number of patients were admitted to intensive care as a result of their deterioration not being recognised or acted upon. This notion was later endorsed by UK national organisations such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2005), the National Patient Safety Association (NPSA, 2007) and the National Institute for Health and Care Excellence (NICE, 2007). As a result, there has been considerable clinical interest and service innovation in optimising the recognition and management of the deteriorating and acutely ill patient.

Following the publication of Comprehensive Critical Care (Department of Health (DH), 2000), the ICS published definitions of levels of care in 2002 to better understand the needs of acutely ill and critical patients; these definitions were later updated in 2009 (ICS, 2009) (Figure 1). The focus of the competencies outlined in this framework are for Level 1 patients, and the definitions can be found on page 2 of this document.

In order to support the patients that need Level 1 care on the general wards, and improve the recognition and management of deterioration, Rapid Response Systems (RRS) have been developed and implemented, which include referral to response teams with critical care skills (DeVita et al, 2006). Various models of RRSs have been adopted in different countries - Medical Emergency Team (MET) in Australia, and Rapid Response Team (RRT) in the USA, but in the UK these teams are commonly termed Critical Care Outreach Teams (CCOT) and consist mainly of nurses and physiotherapists with advanced critical care skills (ICS, 2002).

While there has been debate in the literature about the effectiveness of Rapid Response Teams (RRTs), there is a strong feeling they make intuitive sense. Winters et al (2002) conclude that RRTs are effective in the reduction of cardiac arrests, and there is a favourable trend in reducing mortality. The initial trigger for activating the RRT involves the utilisation of an early warning scoring (EWS) system. The EWS system consists of a set of pre-agreed physiological parameters that, when breached, prompts the bedside clinician to refer the patient to the RRT for assessment and/or further management. More recently, the Royal College of Physicians (2017) published the National Early Warning Score 2 (NEWS2) for use in acute settings which has been endorsed by NHS England and NHS Improvement.

Level 1 Criteria

■ Patients recently discharged from a higher level of care ■ Patients requiring a minimum of 4 hourly observations

Patients in need of additional monitoring/clinical interventions, clinical input or advice such as those requiring:

- Continuous oxygen therapy ■ Boluses of intravenous fluid (need not be determined by CVP)
- Epidural analgesia or Patient Controlled Analgesia (PCA) ■ Parenteral nutrition
- Administration of bolus intravenous drugs through a Central Venous Catheter (CVC)
- Postoperative observations ■ Tracheostomy or Laryngectomy care ■ Chest drain care
- A minimum of 4 hourly GCS assessment ■ Continuous infusion of insulin
- Observation for risk of aspiration pneumonia ■ Intermittent renal support
- Respiratory physiotherapy to treat or prevent respiratory failure
- Frequent (> 2x day) Peak Expiratory Flow rate measurement for clinical reasons

Implementation Strategy

This suite of multi-professional competencies has been designed to support safe, compassionate and effective care and treatment to Level 1 patients. They are intended to complement local Trusts' existing educational programmes and training packages, to provide an evidenced based framework. They aim to develop the knowledge, skills and behaviours of registered nurses and Allied Health Professionals (AHPs) with regular exposure to Level 1 patients.

The framework is intended for all areas that regularly care for Level 1 patients. This will differ across organisations, but may include (not exhaustive):

- Acute Medical Units (AMUs)
- Acute Assessment Units
- Emergency Assessment Units
- Surgical Admission Units
- Coronary Care Units
- Surgical Care Units
- Enhanced Care Units (including respiratory, cardiac etc.)
- Dialysis Units
- Acute Ward Areas.

To support the implementation of the framework The National Outreach Forum (NOoF) and The Critical Care Network National Nurse Leads (CC3N) recommend that the following local infra-structure will be required:

1. Corporate competency lead: identify a person who will take overarching responsibility for the launch, implementation and evaluation of the programme
2. Corporate practice educator support: to provide an outline of the support available and how assessors, mentors and learners can access this
3. A Level 1 competency database: to provide a database with identified ward areas, professional groups, start dates and dates of completion. This database will need to have the capability to run compliance reports to inform the wider corporate education and training strategy
4. A positive learning environment and experience.

It is further recommended that the framework is introduced using a structured approach to fully engage all stakeholders and consider available resources.

Learning Contract

The following learning contract applies to the individual learner, lead assessor/mentor and ward/unit manager/lead nurse and should be completed before embarking on this competency development programme. It will provide the foundations for:

- Individual commitment to learning
- Commitment to continuing supervision and support
- Provision of time and opportunities to learn.

Learner Responsibilities

As a Learner I intend to:

- Take responsibility for my own development
- Form a productive working relationship with mentors and assessors
- Deliver effective communication with patients, relatives and healthcare professionals during clinical practice
- Listen to colleagues, mentors and assessors' advice and utilise coaching opportunities
- Use constructive feedback positively to inform my learning
- Meet with my lead assessor/mentor at least 3 monthly
- Adopt a number of learning strategies to assist in my development
- Put myself forward for learning opportunities as they arise
- Complete all the competencies in the agreed timeframe
- Use this competency development programme to inform my annual appraisal, development needs and NMC/HCPC revalidation
- Report lack of mentorship/supervision or support directly to the lead assessor/mentor and escalate to the clinical educator/unit manager or equivalent if not resolved.

Print name (Learner)

Signature

Date:

Lead Assessor/Mentor Responsibilities

As a Lead Assessor/Mentor I intend to:

- Meet the standards of regulatory bodies (NMC/HCPC)
- Demonstrate on-going professional development/competence within the Level 1 / enhanced care environment
- Promote a positive learning environment
- Support the learner to expand their knowledge and understanding
- Highlight learning opportunities • Set realistic and achievable action plans
- Complete assessments within the recommended timeframe
- Bring to the attention of the education lead and/or manager concerns related to the individual nurses/AHPs learning and development
- Plan a series of learning experiences that will meet the individuals defined learning needs
- Prioritise work to accommodate support of learners within their practice roles
- Provide feedback about the effectiveness of learning and assessment in practice.

Print name (Lead Assessor/Mentor)

Signature

Date:

As a Level 1/enhanced care service lead I intend to:

- Provide and/or support clinical placements to facilitate the learners' development and achievement of the core/essential competency requirements
- Regulate and quality assure systems for mentorship and standardisation of assessment to ensure validity and transferability of the nurses'/AHPs competence

Print name (Lead Nurse/Manager)

Signature

Date:

[illegible]

Authorised Signature Records Continued

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Introduction to assessing the Level 1 ward patient

A standardised, systematic approach to assessing the deteriorating ward patient is recommended and well represented in the literature, in order for the multi-professional team to recognise deterioration and provide prompt clinical interventions; thereby improving outcome. The Airway, Breathing, Circulation, Disability, Exposure (ABCDE) method of assessment is taught by many healthcare providers, and is endorsed by the Resuscitation Council (2015), AIM™ (2003), ALERT™, IMPACT™ and CCRISP™ training programmes.

A systematic approach identifies any changes in patient's physiology to provide immediate, timely clinical care, in order to stabilise and improve the patient's condition. If performed effectively, this reduces the risk of cardio-respiratory arrest and allows time for assessment by more experienced practitioners to diagnose and identify a clear management and escalation plan. If intervention is not prompted, a clear reason for non-escalation must be documented in the patients notes (NCEPOD, 2012).

Using ABCDE assessment standardises practice so that all healthcare providers fully understand a structured assessment process, develop their situational awareness and improve communication skills between all team members.

The underlying principles are:

- For all professionals in both primary and secondary healthcare settings to use the ABCDE approach to assess and treat the patient in a timely way.
- To treat and resolve problems before moving to the next stage of the assessment.
- To enable a complete primary assessment and then re-assess regularly to ensure optimisation of care.
- To enable and promote recognition for teams when they will need additional support such as the critical care outreach team (CCOT), or senior specialist nurses, doctors or physiotherapists.
- To empower clinicians when calling for appropriate help to communicate effectively – using Situation, Background, Assessment, Recommendation (SBAR) or Reason, Story, Vital signs, Plan (RSVP) approach.

The competencies in this document are based on the ABCDE approach and describe in detail the knowledge and skills expected for practitioners working in Level 1 areas or in wards where patients are acutely ill or at risk of deterioration. It is expected that these competencies will underpin the care provided by the registered practitioner in the acute care environment.

Patients with different clinical conditions will require different treatment plans according to clinical and operational need. It is acknowledged that monitoring and therapeutic interventions will vary depending on individual National Health Service (NHS) providers, and some patients may be managed in ward areas rather than Level 1 areas or enhanced care areas e.g. Non-invasive ventilation (NIV). Where this is a possibility, the clinical competencies will be inserted into grey boxes.

The National Early Warning Score

Background

In 2012 the Royal College of Physicians (RCP) published the first iteration of the National Early Warning Score (NEWS). It was developed to improve the detection of and response to clinical deterioration in patients with acute illness with the aim of standardising the process of recording, scoring and responding to changes in routinely measured physiological parameters. The NEWS was founded on the premise that (i) early detection, (ii) timeliness and (iii) competency of the clinical response comprise a triad of determinants of clinical outcome in people with acute illness.

A number of EWS systems are in use across the NHS; however, the approach is not standardised. This variation has arguably resulted in a lack of familiarity with local systems as staff move between clinical areas/hospitals and impedes attempts to embed training in the detection and response to acute illness in a consistent way, across the NHS workforce. Put simply, when assessing acutely ill patients using various scores, staff are not speaking the same language, which leads to a lack of consistency in the detection of and response to acute illness.

Evaluation of NEWS

During its original development, the NEWS was evaluated against a variety of other EWS scoring tools in use at the time. The NEWS was shown to be as good at discriminating risk of serious clinical deterioration and acute mortality as the best existing systems and better than most (Smith et al, 2013). Furthermore, at the recommended trigger level for an urgent clinical response (NEWS score of 5 or more), the NEWS was more sensitive and specific than most existing systems (Smith et al, 2013). Thus, the NEWS provided an enhanced level of surveillance of patients, with greater specificity in identifying those at risk of serious clinical deterioration.

National Early Warning Score (NEWS) 2

Following substantial peer-reviewed evidence of effectiveness by the NEWS Review Group and feedback from users, in December 2017 the RCP published the 'National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party'. NEWS2 pays particular attention to four important themes:

- Determining how the NEWS2 could be used to better identify patients likely to have sepsis who are at immediate risk of serious clinical deterioration and require urgent clinical intervention
- Highlighting that a NEWS2 score of 5 or more is a key threshold for an urgent clinical alert and rapid response
- Introduction of a 2nd dedicated SpO₂ scoring scale (Scale 2) and improving the recording of the use of oxygen therapy in patients with known hypercapnic respiratory failure (most often due to COPD)
- Recognising the importance of new-onset confusion, disorientation, delirium or any acute reduction in the Glasgow Coma Scale (GCS) score as a sign of potentially serious clinical deterioration, by including new confusion as part of the AVPU scoring scale (which becomes ACVPU).

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The National Early Warning Score Continued

Physiological parameter	3	2	1	Score 0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO ₂ Scale 1 (%)	≤91	92–93	94–95	≤96			
SpO ₂ Scale 2 (%)	≤83	84–85	86–87	88–92 ≤93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Six physiological parameters form the basis of the scoring system:

- 1 Respiratory Rate
- 2 Oxygen Saturation (Scale 1 or Scale 2)
- 3 Systolic Blood Pressure
- 4 Pulse Rate
- 5 Level of Consciousness or New Confusion*
- 6 Temperature

* If the patient has new-onset confusion, disorientation and/or agitation, where previously their mental state was normal – this may be significant. The patient may respond to questions coherently, but if there is some confusion, disorientation and/or agitation (even subtle) it needs to be acknowledged. This would score 3 or 4 on the GCS (rather than the normal 5 for verbal response), and subsequently scores 3 on the NEWS2 system.

A score is allocated to each parameter as they are measured, with the magnitude of the score reflecting how extremely the parameter varies from the physiological norm. The score is then aggregated. The score is augmented by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation. This is a pragmatic approach, with a key emphasis on system-wide standardisation. It uses physiological parameters that are already routinely measured in NHS hospitals and in prehospital care, that are recorded on a standardised electronic or paper chart.

The National Early Warning Score Continued

As these observations are routinely recorded in hospital and as part of pre-hospital assessment they can tell the practitioner how well a patient is and when they are heading towards a critical condition. They also inform when a patient is becoming unwell before they reach a critical condition. This is when clinicians are more likely to rescue the patient and prevent cardiac arrest and death. Studies have shown that staff fail to recognise this period between a well patient and a crisis situation soon enough to make a positive difference (NPSA, 2007). Repeated observations and the use of NEWS2 allows clinicians to define a trend which can highlight deterioration or improvement in a patient's condition.

Note: NEWS2 may not identify clinician concern (a low score with concern should still warrant escalation). Clinical judgment about a patient's condition should always override the NEWS2 if the attending healthcare professional considers it necessary to escalate care.

NHS England and NEWS2

NHS England (NHSE) and NHS Improvement (NHSI) have approved and endorsed the use of the NEWS2 as the recommended early warning scoring system for use in adults across the NHS in England, to standardise the approach to detecting and grading the severity of acute illness. The NEWS2 has also been endorsed as the recommended early warning system to detect acute clinical illness/deterioration due to sepsis in patients at risk of or with infection.

NEWS2 and Training and Education

NEWS2 provides the basis for standardising the training and credentialing of all staff engaged in the care of patients in acute hospitals. The use of NEWS2 will improve the assessment of acute illness, improve the detection of clinical deterioration, and get the right treatment from the right person at the right time to our patients.

NEWS2 is supported by an accredited online training module and certification of completion of training at (<http://tfinews.ocbmedia.com>)

1. Emergency Assessment

1.1 Rapid ABCDE

The following competency statements relate to emergency assessment and management of the deteriorating patient and are designed to be used in conjunction with other chapters within this document. Detailed patient assessment takes time and in life-threatening situations patient outcomes can be time-critical; therefore, an abbreviated version of assessment is required. Each process is explored in more depth in its corresponding competency chapter. Privacy and dignity must be maintained at all times. Always practice within one's own scope of competence.

1.1.1	Emergency assessment	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: The indications for performing a rapid ABCDE assessment of a patient. The importance of timely patient assessment including: • Completion of a FULL emergency assessment • Treatment escalation plans, treatment limitations already in place, ReSPECT documentation or similar • Resuscitation status • Timely referral for medical intervention • Consequences of delayed recognition and treatment of a medical emergency The importance of using a standardised, structured approach to patient assessment for example, ABCDE (Resuscitation Council UK, 2015). The appropriate escalation process for the management of the patient following rapid ABCDE assessment including: • Shouting for help • Referral to senior medical team • Calling the cardiac arrest team (or equivalent) • Continuation to thorough ABCDE assessment • Referral to CCOT (or equivalent) • Activation of major haemorrhage protocol if appropriate		
	I can demonstrate through practice: Provision of emotional reassurance and support to patient during emergency assessment.		

1.1.1	Emergency assessment	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued		
	Full, rapid ABCDE assessment using standardised approach, to include: Maintaining safety of myself and my team. How to identify signs of illness by using the LOOK, LISTEN, FEEL approach in the ABCDE assessment: Airway and Breathing: • Asking the patient how they are feeling • LOOK and FEEL for air flow at patient's mouth and nose (for non-responsive patients) • LOOK for chest rise and fall, symmetry, paradoxical movements, use of accessory muscles • LISTEN for additional breath sounds if trained • Count respiratory rate (for one full minute) • If monitoring and help available, ask for oxygen saturations Circulation (concurrent with Airway and Breathing assessment in non-responsive patients): • Palpation of a central pulse (commence Basic Life Support if absent) • Palpation of peripheral pulse rate, rhythm and volume (for patients with circulation and breathing) • Monitoring temperature (peripheral and central) / skin colour • Capillary refill time (CRT) centrally and peripherally • If monitoring and help available request for blood pressure (BP) and electrocardiogram (ECG) medical devices. • Consider using defibrillator to monitor ECG in the critically unstable patient • Observation of intravenous line positioning and patency, current intravenous therapy, and urine output over past 24 hours Disability: • How to check for consciousness using ACVPU method as per NEWS2 (RCP, 2017) • How to check blood glucose level • How to measure temperature • How to check medication chart for drugs recently administered • How to check pupils for abnormal reactions • How to assess pain levels • How to identify seizures		

1.1.1	Emergency assessment	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice: Continued		
	Exposure: Top to toe assessment to include: • Looking for rash / wounds / cellulitis • Checking calves for redness / signs of DVT • Identifying signs of sepsis • Looking for obvious signs of bleeding (internal & external) • Identification of any abnormal findings • Provision of appropriate interventions based on emergency assessment including; Airway and Breathing: • Head tilt, chin lift, jaw thrust • Airway adjunct insertion: nasopharyngeal, oropharyngeal, supraglottic airways (i.e. iGel) • Manual ventilation and mask positioning (Bag Valve Mask) • Suction for oral secretions using either 'Yankauer' or oral suction catheters • Application of oxygen therapy as per the British Thoracic Society Guidelines (BTS) (2017) • Repositioning of patient to maximise effective ventilation and gas exchange Circulation: • Effective chest compressions • Ensuring vascular access has been established • Administration/ discontinuation of intravenous fluids or medications • Measuring and observing BP, heart rate, heart rhythm, CRT, urine output • Venepuncture for venous blood gas, full blood screen +/- blood cultures • Arterial Blood Gas for metabolic, respiratory, electrolyte, lactate assessment within competence Disability: • Warming/ cooling patient • Commencement of emergency blood glucose management protocol as per Trust policy • Consideration of reversal agent for any medications recently administered i.e. Naloxone for opioid reversal • Rapid referral onwards for new neurological insult or control of seizures if present • Commencement of seizure monitoring chart • Commencement of analgesia as per prescription or escalation to acute pain experts (Acute pain team or anaesthetists)		

1.1.1	Emergency assessment	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued		
	Exposure: • Administration of adrenaline for anaphylaxis • Implementation of sepsis protocol • Stemming of obvious flow of bleeding • Commencement of major haemorrhage policy as per Trust policy • Management of abnormal findings appropriately by escalating to most appropriate grade of professional Demonstrate understanding of the consequence in delayed assessment and intervention for acutely unwell patients. Methods of correct referral for urgent escalation of care using a systematic approach for example: • SBAR • RSVP		

2. Airway and Breathing

The following competency statements relate to the assessment and management of the patient's airway and respiratory systems. The competency comprises anatomy and physiology, patient assessment, and approaches to management for each body system. Additional focus is given to tracheostomies and laryngectomies, chest drains and for those working in relevant clinical areas, non-invasive ventilation.

2.1 Airway

2.1.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The structures of the upper airways from mouth and nose to larynx. The role and function of the components of the upper airway system • Air warming • Air filtering • Air moistening • Mucociliary system • Irritant 'sneeze' receptors • Epiglottis		

2.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Common causes of airway obstruction • Anaphylaxis • Choking Visual and auditory clues to airway compromise such as: • Additional sounds • Paradoxical movement • Tracheal tug • Tracheal deviation		
	I can demonstrate through practice:		
	Early recognition and escalation for appropriate help.		
2.1.3	Management		
	I can demonstrate through practice:		
	Actions I would take to restore airway patency using the LOOK, LISTEN and FEEL assessment approach: • Airway management including: - Head tilt, chin lift, jaw thrust - Airway adjuncts- oropharyngeal, nasopharyngeal - Manual ventilation – Bag Valve Mask • Oral and deep suctioning – indications and methods, potential complications, monitoring and observations, catheter selection and suction pressure • Bronchodilators – delivery method using inhalers, nebuliser and intravenous therapy • Provision of emotional reassurance and support Appropriate reassessment strategies post intervention.		

2.1.4	Management - Tracheostomy/Laryngectomy Care	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The anatomical position of tracheostomy and laryngectomy: • Indications for insertion Types of stoma: • Percutaneous tracheostomy • Surgical tracheostomy • Mini tracheostomy • Permanent and temporary tracheostomy • Laryngectomy Types and choice of tracheostomy tubes: • Cuffed tube • Un-cuffed tube • Fenestrated tube • Non-fenestrated tube • Flexible flange • Subglottic aspiration port • Tubes with inner cannula • Mini-trach Potential complications of tracheostomy/ laryngectomy • Immediate complications • On-going complications • Late complications Knowledge of tracheostomy care bundle and NCEPOD best practice standards (NCEPOD, 2014). The importance of: • Securing tube safely • Changing/cleaning inner-tube • Checking cuff pressures • Wound care and stoma management • Humidification • Adequate hydration • Safe suction Knowledge of: • Tracheostomy/ laryngectomy emergency algorithm • First line intervention for a blocked tube • Unplanned displacement or decannulation (refer to national and local guidelines) • Bedside safety equipment • Using speaking valves or speaking aids		

2.1.4	Management - Tracheostomy/Laryngectomy Care	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Roles of multidisciplinary team (MDT) to deliver safe effective tracheostomy and laryngectomy management: • Physiotherapists • Ear, nose and throat team (ENT) • CCOT • Speech and language therapists (SALT) • Dietitian		
	I can demonstrate through practice:		
	Provision of emotional reassurance and support. The safe use of respiratory support therapies with tracheostomy/laryngectomy including: • Oxygen • Suction • Ventilation • Humidification • Nebulisers Care for the stoma site. Cleaning and changing the inner tube, dressing and securing tapes. Safe suction technique. Tracheostomy cuff pressure monitoring (where applicable) and appropriate referral for an incompetent cuff. Correct placement and monitoring of speaking valves. How to prepare, assist and monitor the patient pre-and-post decannulation.		

2.2 Breathing

2.2.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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I can demonstrate through discussion:			
The components of the lower respiratory system: • Lower respiratory tract: - Trachea to alveoli • Lung anatomy: - Pleural membrane/ cavity/ fluid - Lobes/ fissures The role and function of the components of the respiratory system in normal respiration: • Ribs, intercostal muscles and diaphragm (expansion and recoil) • Relationship between lung volume and pressure • Passive role of the lung • Thoracic wall compliance Three stages of respiration: • Ventilation • External respiration • Internal respiration Causes of respiratory failure: • Type I respiratory failure • Type II respiratory failure Signs and symptoms of respiratory inadequacy including: • Skin colour (peripheral/ central/ oral mucosa) • Altered physiological observations • Respiratory depth, pattern, symmetry and accessory muscle use • Added sounds (e.g. wheeze/crackles/secretions) • Cough strength/ability to expectorate How the following might affect respiratory function: • Sepsis • Cardiovascular (CVS) disorders • Inadequately treated pain • Overdose of opiate medications • Post anaesthesia The effects of poor ventilation and oxygenation on other systems including: • Cardiac • Renal • Gastrointestinal • Neurological • Skin			

2.2.2	Assessment and Investigations	Self Assessment	Competence Fully Achieved
		Learner Sign and Date	Assessor Sign and Date
	I can demonstrate through discussion:		
	The importance of on-going assessments and investigations relating to respiratory assessment and management: • Normal parameters for respiratory observations - Respiratory rate and pattern - Peripheral oxygen saturations (SpO₂) • Trends in observation charts • Arterial blood gas (ABG)/ venous blood gas (VBG) • ECG (3, 5 and 12 lead) • Chest/ Abdominal X-Ray • Computerised tomography (CT)/ magnetic resonance imaging (MRI)/ computerised tomography pulmonary artery (CTPA)/ Ultrasound Thorax • Microbiology • Clinical laboratory The rate and depth of breathing including: • Normal • Abnormal (fast and slow rates) • Use of accessory muscles • Symmetry of tidal breathing Additional sounds: • Wheeze • Crackles • Quiet / silent chest Skin colour: • Peripheral cyanosis • Central cyanosis Cough Strength: • Effective and ineffective • Ability to expectorate vs retention • Sputum assessment Indications for and limitations of pulse oximetry: • Probe site • Capillary refill time (CRT) and proximal pulses Prescribed target saturations oxygen ranges (BTS, 2017) • For patients not at risk of hypercapnic respiratory failure • For patients at risk of hypercapnic respiratory failure Indications and methods for oxygen therapy in line with BTS Emergency Oxygen Guidelines (2017). Risks, signs and symptoms of hyperoxia and hypercarbia (include narcosis).		

2.2.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Basic ABG/VBG • Normal values • Respiratory/Metabolic, Acidosis/Alkalosis Indications and methods for escalation of respiratory support. Requirement for further information. History taking to include: • Baseline considerations • Co-morbidities • Exercise tolerance • Long term oxygen therapy/ home ventilation • Drug history • Social history Signs and symptoms of respiratory inadequacy including the following common conditions: • Chronic Obstructive Pulmonary Disease (COPD) • Asthma • Pulmonary oedema • Pneumonia - community acquired - hospital acquired - aspiration • Pulmonary Embolism (PE)		

2.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	<i>(Refer to section 1.1.1 for emergency management using the LOOK, LISTEN and FEEL assessment approach)</i> The appropriate use of interventions including: • Oxygen therapy: - High concentration mask with reservoir - Fixed performance oxygen devices - Simple face mask and nasal cannulae - High Flow Nasal Oxygen (HFNO) cannulae - Humidification methods • Patient positioning: - Maximising ventilation - Postural drainage positioning • Deep breathing exercises/ testing procedures: - Incentive spirometry - Peak flow/ cough peak flow		

2.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Secretion clearance/ suctioning • Effective coughing and expectoration • Indications and methods • Potential complications • Monitoring and observations • Catheter selection and suction pressure Escalation for higher level of respiratory support • Recognition of level of care requirements • Knowledge of escalation procedures Multidisciplinary Team roles: • CCOT • Dietician • Ear, Nose and Throat (ENT) • Parent team • Physiotherapists • Respiratory Specialist Nurses • Speech and Language Therapy (SALT)		

2.3 Non-Invasive Ventilation

2.3.1	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	If relevant to your area: Care and management of a patient requiring Non-invasive ventilation (NIV) as per BTS NIV (2016) and Emergency Oxygen (2017) guidelines: • High Flow Nasal Oxygen (HFNO) • Continuous Positive Airway Pressure (CPAP) • Bi Level Positive Airway Pressure (BiPAP) With reference to the: • Indications • Cautions/ contra-indications • Physiological and psychological effects • Trouble shooting		

2.3 Non-Invasive Ventilation

2.3.1	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	Normal parameters and function for each modality where applicable: • Flow • Fraction of inspired oxygen (FiO₂) • Humidification and temperature • Positive End Expiratory Pressure (PEEP) • Inspiratory Positive Airway Pressure (IPAP) • Expiratory Positive Airway Pressure (EPAP) • Tidal Volume • Leak tolerance Indications for escalation, weaning or cessation.		
	I can demonstrate through practice:		
	Care and management of a patient requiring HFNO, CPAP or BiPAP: • Provision of emotional reassurance and support • Explanation of specific therapy and procedures • Correct assembly and application of circuits/ equipment • Selection and correct sizing of interface for relevant modality • Setting of patient specific alarm limits • Interpretation of observational and clinical investigations • Adjustment of settings within scope of practice and recognise need to refer to expert • Recognition and troubleshooting of equipment • Accurate monitoring and documentation of modality, settings and observations • Recognition of required breaks from therapy when appropriate and safe • Monitoring of pressure areas around interface • Regular mouth care • Seeking support and advice as appropriate		

2.4 Care of the patient with a chest drain

2.4.1	Indications	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Indications for chest drain insertion including: • Pneumothorax • Haemothorax • Pleural Effusion • Empyema		

2.4.2	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	If relevant to your area: Provision of emotional reassurance and support. Preparation of equipment required for chest drain insertion. Observation of patient and assistance with chest drain insertion. Management of a patient with a chest drain in situ: • Immediately post insertion • Respiratory observations including rate depth and pattern • Identification of surgical emphysema • Application of prescribed thoracic suction (high volume, low pressure) to a chest drain Effective management of a chest drain: • Positioning and handling of the drain bottle(s) • Wound care/dressings • Changing/ disposal of bottles • Monitoring drainage General care and management regarding: • Indications for use of chest drain clamps • Drainage / fluid level • Swinging/ bubbling • Bottle changes • Dressings • Removal of drain and closure of wound where applicable		

2.4 Care of the patient with a chest drain

2.4.2	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Recognition and management of potential complications: • Infection • Acute respiratory distress • Pain • Surgical emphysema • Drain blockage or displacement • Air leakage from stoma • Bubbling stops • Underwater seal is lost • Tension pneumothorax develops		

2.4.3	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Commonly used medications for respiratory care: • Bronchodilators - nebulisers/intravenous • Steroids • Antibiotics • Analgesia • Fluid resuscitation • Diuretics • Mucolytics • Anxiolytic/anxiety reducing drugs • Magnesium		
	I can demonstrate through practice:		
	Provision of emotional reassurance and support. Safe preparation and administration of medications used for respiratory care. An ability to monitor the effects of medication.		

3. Circulation

The following competency statements relate to the assessment and management of the patient's cardiovascular and renal systems. Additional focus is given to sepsis and acute kidney injury. The competency comprises anatomy and physiology, patient assessment and approaches to management for each body system. Competency statements for the interpretation of 12 lead ECGs and care of central venous catheters are included for those that work in relevant clinical areas.

3.1 Cardiovascular System

3.1.1.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The structure and function of the heart including: • Chambers • Endocardium, Myocardium, Pericardium • Mediastinum • Coronary blood supply • Valves The structure of the blood vessels • Arteries • Capillaries • Veins Valves within the heart and the systemic circulation. Vasoconstriction and vasodilation- control of and possible causes. Normal blood flow including coronary, systemic and pulmonary circulation. Normal cardiac cycle including diastole and systole. Blood pressure control and influencing factors including: • Baroreceptors • Central nervous control • Hormonal control Components of blood pressure including reference to the following: • Circulating volume • Cardiac output (CO) • Heart rate (HR) • Mean arterial pressure (MAP) • Stroke volume (SV) • Systemic vascular resistance (SVR) • Preload • Afterload • Contractility/force of contraction		

3.1 Cardiovascular System

3.1.1.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Normal electrical conduction pathway as represented on an electrocardiogram (ECG) or rhythm strip, and the corresponding mechanical responses. Including: • P wave • PR interval • QRS complex • T Wave • How sinus rhythm is defined Composition of blood and associated tests that detect abnormalities including: • Haemoglobin • Red blood cells • White blood cells • Platelets • Plasma proteins • Electrolytes including potassium, calcium, sodium and magnesium • Clotting studies • Creatinine and glomerular filtration rate (GFR) • Cardiac enzymes e.g. Troponin The physiology of shock including: • Hypovolaemic shock • Cardiogenic shock • Obstructive shock • Distributive shock (sepsis will be covered in more detail in section 4.3)		

3.1.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	Correct monitoring and recording of HR and an ability to find/ check other peripheral and central pulses. Correct recording of BP (lying and standing where required) using a manual sphygmomanometer. Correct capillary refill assessment. Continuous ECG monitoring (using a portable defibrillator if this is not available in your practice area).		

3.1 Cardiovascular System

3.1.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice: Continued		
	Essential cardiac rhythm recognition to include: • Normal sinus rhythm • Bradycardia • Tachycardia • Rhythms associated with cardiac arrest - Asystole - Ventricular tachycardia (VT) - Ventricular Fibrillation (VF) - Pulseless electrical activity (PEA) Accurate fluid balance monitoring. Detection of oedema/ fluid overload. Consider pulmonary, peripheral, ascites and jugular venous pressure (JVP). Detection of fluid insufficiency/ dehydration. Effective basic life support including the use of the following emergency resuscitation equipment: • Bag-valve-mask • Suction apparatus • Automated External Defibrillator (AED) • Resuscitation trolley and contents • Local policy and emergency number Effective intermediate / advanced life support if trained to do so (use simulations where necessary). Cannulation (if trained to do so). Venepuncture (if trained to do so). How to obtain blood cultures (if trained to do so).		

3.1.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The 4 H's and 4T's to be considered and eliminated during peri arrest / cardiac arrest situations.		

3.1 Cardiovascular System

3.1.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	The recommended treatment for the following arrhythmias: • Asystole • Bradycardia • Tachycardia • Ventricular Tachycardia (VT) • Ventricular Fibrillation (VF) • Pulseless Electrical Activity (PEA) The recommended treatment for the following conditions (following local protocols / guidance): • Acute coronary syndrome • Cardiogenic shock including left ventricular Failure • Hypo and hypertension • Pulmonary oedema • Sepsis (see section 3.3 for more detail) When an Echocardiogram (Echo) may be required and what it shows.		

3.1.1.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Local policy and considerations for the following types of drug administration. • Intravenous (IV) infusion • Bolus IV injection • Intra muscular (IM) injection • Subcutaneous (S/C) injection Fluid management pertinent to cardiovascular support including: • Crystalloids (isotonic, hypertonic, hypotonic) • Colloids • Blood products including albumin		

3.1 Cardiovascular System

3.1.1.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	Commonly used drugs in use that predominantly affect the cardiovascular system. These may include drugs to treat (but not exclusive): • Acute coronary syndromes including angina • Cardiac arrest and severe heart failure cardiac arrhythmias • Cardiac failure • Coagulation disorders • Electrolyte disturbances • Hyperlipidaemia • Hypertension • Hypotension • Myocardial ischaemia		

3.1.2. 12 Lead ECG interpretation

3.1.2.1	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	If relevant to your area: 12 lead ECG recording and interpretation to include: • Asystole • Bradycardia • Tachycardia • Supraventricular tachycardia • Atrial Fibrillation • Atrial flutter • Heart Blocks (1st, 2nd and 3rd degree) • VT • VF • PEA • ST segment changes		

3.1.3. Care of the patient with a central venous catheter

3.1.3.1	Indications	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	If relevant to your area: Indications for the use of CVC's • Venous access • Administration of potent drugs / TPN • Central venous pressure (CVP) monitoring Monitoring CVP • How CVP is measured and what it represents • Interpretation of waveform (if transduced) • Factors that influence CVP readings in relation to individual patient Signs and symptoms of CVC infection.		

3.1.3.2	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	Care of a patient with a CVC • Set up for insertion and be able to assist • Obtaining an accurate waveform reading • Safe use and change of needle free ports • Use of aseptic non-touch technique (ANTT) • Selection of appropriate dressing • Monitoring of line site according to local policy and reporting of concerns Safe removal of a CVC line.		

3.2 Renal System

The following competency statements are about the safe and effective assessment of renal function, monitoring of fluid balance and care of the patient at risk of acute kidney injury (AKI) or those patients who have developed AKI.

3.2.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The key structures of the renal system: • Kidneys • Ureters • Bladder • Urethra • Blood supply The key structures of the kidney including: • Glomerular capillaries • Bowman's capsule • Afferent and Efferent arterioles • Nephrons and components within How the above structures influence: • Filtration • Reabsorption • Secretion • Excretion The main functions of the kidney to include: • Urine formation • Regulation of concentration and volume • Regulation of electrolyte balance • Regulation of acid/base balance • Blood pressure control • Erythropoietin • Vitamin D		

3.2.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The rationale for the following investigations: • Urea and electrolytes • Estimated glomerular filtration rate (eGFR) • Full blood count • Liver function tests • Bone profile continued next page		

3.2 Renal System

3.2.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	• C reactive protein (CRP) • Urinalysis • Urine dipstick • Urine osmolarity • Bladder scan • Weighing of patients • Urine culture • Chest x-ray • ECG • Blood gas • Renal ultrasound • Cystoscopy • Renal biopsy The pathophysiology of Acute Kidney Injury (AKI). The use of urine output measurement as a marker for AKI. The biochemical markers to identify AKI. Baseline risk factors of those at risk of developing AKI. Acute risks factors for developing AKI as per NICE CG 169 (2013). The following definitions and causes of: • Pre-renal AKI • Renal AKI • Post renal AKI Knowledge of the stages of AKI. Local AKI screening tools and their use.		
	I can demonstrate through practice:		
	How to perform: • Accurate fluid balance monitoring • Urinalysis • Urine dipstick • Bladder scan • Accurate weighing of patient • A 12 lead ECG		

3.2 Renal System

3.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: The expected volume of urine for the individual patient. The importance of measuring fluid balance and examples of when to commence. When to consider bladder scanning. The possible causes of: • Anuria • Oliguria • Polyuria When appropriate to escalate concerns to the doctor and/or CCOT or equivalent. Factors which may complicate the assessment of fluid balance monitoring i.e. insensible losses. The importance of optimising fluid status. Key elements in preventing AKI. A clear management plan for the patient in AKI. An understanding of sodium and potassium balance and why is it important to treat promptly. The ECG changes associated with hyper/hypokalaemia. The treatment options for managing hyper/hypokalaemia. The importance of measuring blood sugar following treatment. Approaches to fluid management in renal care and the potential impact on other body systems. The importance of a timely referral to the renal physicians/urologists. An understanding of chronic kidney disease and acute-on-chronic renal failure.		
	I can demonstrate through practice: The ability to accurately measure and record fluid balance. Assessment of fluid status by measuring: • Pulse • BP • CRT • Peripheral limb temperature • Urine output, colour and consistency • Jugular venous pressure (JVP)		

3.2 Renal System

3.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice: Continued		
	Assessment and documentation of peripheral oedema. Administration of appropriate care to the patient with a urinary/suprapubic catheter (according to local policy). Utilisation of locally available equipment including: • Catheter types • Urometers The management of a blocked catheter. Weighing of patients in line with local policy and can understand the significance.		

3.2.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	A clear understanding of the basic differences between: • Crystalloids and colloids • Isotonic fluids • Hypotonic fluids • Hypertonic fluids Common nephrotoxic drugs. The rationale for administering: • Sodium bicarbonate • Insulin and dextrose • Calcium gluconate/chloride • Calcium resonium • Salbutamol nebuliser • Diuretics		

3.3 Sepsis

The following competency statements are related to sepsis – the challenge of sepsis, its pathophysiology, identification and management. The competencies need to be applied to all care and treatment undertaken by the registered nurse/AHP in the acute care environment.

3.3.1	Pathophysiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	An understanding of: • The pathophysiology of sepsis • The common sites for sepsis • The common causative organisms including how these organisms may gain access to the body The role of lactate in the diagnosis of sepsis. An ability to define the differences between: • Inflammatory response • Infection • Sepsis The role and importance of antibiotic stewardship. The definition of neutropenic sepsis and an understanding of the pathophysiology of neutropenic sepsis. The differences between: • Sepsis • Neutropenic sepsis Knowledge of septic shock and its pathophysiology including: • An understanding of the definition of septic shock • An understanding of the pathophysiology of septic shock • Knowledge of those patients at greater risk of developing sepsis		

3.3.2	Identification of Sepsis	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The importance of screening when there is a suspicion of sepsis. An understanding of local screening tools and how to use them in practice, including: • NEWS2 • quick Sequential Organ Failure Assessment (qSOFA) • Red flags		

3.3 Sepsis

3.3.2	Identification of Sepsis	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	An understanding of NEWS2: • Including identification of the NEWS2 threshold for screening for sepsis (RCP, 2017) An understanding of the altered vital signs in the identification of sepsis (NICE Clinical Guideline 51, 2017) with reference to: • Respiratory Rate • HR • Systolic BP • Temperature less than 36°C • Reduced urine output in the past 12 – 18 hours (catheterised patients 0.5 – 1.0 ml/Kg) • Altered behaviour or mental state		

3.3.3	Identification of Sepsic Shock	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	An understanding of the process for the identification of septic shock with reference to the: • Respiratory rate • Heart rate • Systolic blood pressure • Urine output • New altered mental state • Mottled or ashen appearance/ non-blanching rash • Cyanosis of skin, lips or tongue		

3.3 Sepsis

3.3.4	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: The importance of the “Sepsis Six”. Effective communication with key professionals regarding the delivery of the “Sepsis Six” interventions: • High flow oxygen • IV antibiotics • Lactate • IV fluid (crystalloid) • Blood cultures • Fluid balance Additional actions that might be required including: • Senior review • Full blood count, urea and electrolytes, C-Reactive Protein (CRP) and coagulation screen • Consider more frequent observations than local policy dictates e.g. 15-30 minutes • Critical care and/or CCOT referral • Imaging e.g. CT • Source control e.g. Surgery		

4. Disability

The following competency statements relate to the assessment and management of the neurological, endocrine and gastrointestinal systems. Additional focus is given to the patient in pain. Each competency comprises anatomy and physiology, patient assessment and approaches to management for each body system.

4.1 Neurological System

4.1.1.	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: The normal function of the neurological system. The major structures of the central and peripheral nervous system. The protective layers of the brain and spinal cord.		

4.1 Neurological System

4.1.1.	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	The principles of raised intracranial pressure including: • Cerebral perfusion pressure (CPP) • Mean arterial blood pressure (MAP) • Intracranial Pressure (ICP) • Cushing's triad		

4.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The correct use of neurological assessment tools and when to escalate any concerns. These include: • ACVPU tool • Glasgow coma scale (GCS) • Distinction between confusion, new confusion and delirium • Delirium screening tools Limitations of the GCS as an assessment tool: • Assessment of vital signs must also be recorded on the same chart to ensure there is a complete data set • Neurological conditions that can affect GCS • ACVPU score for assessing conscious level compared to GCS assessment • Adjuncts to the GCS for detecting deterioration in clinical condition such as pupil reaction Types of seizures • Convulsive/generalised • Focal/absent • Non-epileptic seizures Common conditions and their associated pathophysiology (this list is not exhaustive): • Alzheimer's/dementia • Parkinson's disease • Stroke/cerebrovascular accident (CVA)/intracranial haemorrhage • Subarachnoid haemorrhage • Traumatic brain injury • Encephalitis • Meningitis • Neuromuscular disorders • Motor neurone disease • Multiple sclerosis (MS) • Myalgic Encephalomyelitis (ME) • Guillain Barré syndrome		

4.1 Neurological System

4.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	How to 'assess and score' eye opening: • Correct method of assessment of eye opening to voice • Correct use of trapezius pinch How to assess pupil response to light including direct and consensual light reflexes as an adjunct to GCS How to assess and score the best verbal/ sound response: • Correct method of assessing orientation and verbal/ sound response • Recognise and distinguish between vocal verbal deficit such as aphasia, receptive and expressive dysphasia How to assess and score for the best motor response: • Correctly identify and record - ability to localise to pain - flexion - abnormal flexion - extension - no response • Contra-indications to orbital pressure and sternal rub • Comparing left to right to identify focal deficit • Differentiating between normal power, mild weakness and severe weakness		

4.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Responsibilities in the care of patients having seizures. • Maintain patient safety • Preservation of patient's dignity and privacy Treatment options: • Anticonvulsants • Metabolic disorders and treatment		
	I can demonstrate through practice:		
	An ability to: • Assess the type of seizure • Maintain an accurate seizure chart • Monitor and care for the patient during seizure activity • Monitor and care for the patient after seizure activity • Consider referral to the neurologist/specialists		

4.2 Endocrine and Gastrointestinal Systems

4.2.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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I can demonstrate through discussion:			
Knowledge of the anatomy and physiology of the normal gastrointestinal (GI) and endocrine systems including detailed function of the following: • Mouth - Dentition - Saliva production and action • Oesophagus - Varices and causes • Stomach - Gastric enzymes- production and action - Ulceration • Small bowel - Digestive enzymes-production and action - Carbohydrate digestion and metabolism - Protein digestion and metabolism - Fat digestion and metabolism - Resection/ ileostomy procedures - Ileus - Ulceration • Large bowel and appendix - Role of bacteria - Resection/colostomy procedures - Ischaemia - Perforation • Rectum and anus - Fissures - Haemorrhoids • Liver - Blood supply including portal system - Metabolic functions - Excretion functions - Synthetic functions • Gall Bladder and common bile duct - Bile production and action • Pancreas - Exocrine functions and secretions - Endocrine functions and secretions • Spleen			

4.2 Endocrine and Gastrointestinal

4.2.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The following investigations and their related significance in relation to a patient requiring GI and/ or endocrine support. • Abdominal x-ray • Blood glucose • Biopsy • Clotting studies • Colonoscopy • Computerised tomography (CT) scan • Endoscopy • Full blood count • Lactate • Liver function tests including albumin • Pancreatic enzymes • Stool specimen tests • Tests for viral disorders e.g. viral hepatitis • Toxicology tests • Ultrasound of abdomen and biliary tract • Urea and electrolytes		

4.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Care of the patient requiring GI/ endocrine support including: • Assistance with feeding where required • Administration of tube feeds as per local policy • Assisting diabetic patient to maintain healthy blood glucose levels • Assistance with bowel care where required e.g. administration of aperients, stoma care etc The possible causes and their associated care and management: • Diabetes - Non-insulin dependant - Insulin dependant - Diabetic ketoacidosis (DKA) Continued on next page		

4.2 Endocrine and Gastrointestinal

4.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion: Continued		
	• Pancreatitis - Acute - Chronic • Cholecystitis - Obstruction - Inflammation • Hepatic Failure - Acute conditions e.g. overdose - Chronic conditions e.g. Cirrhosis - Clotting abnormalities including Disseminated Intravascular Coagulation (DIC) • Oesophagus - Oesophagostomy - Varices-hepatic portal hypertension - Surgical procedures for varices - Sengstaken/Minnesota tubes • Ulcerative colitis • Crohn's Disease • Perforated appendix / bowel and sepsis risk • Refeeding syndrome • Bowel Surgery including: - Hartmann's procedure - Antero-Posterior (AP) resection - Formation of an ileostomy - Formation of a colostomy The management of nutrition in an acutely unwell patient including: • A critique of a nutritional assessment tool and how it might be/ is currently used with your patient group • Measurement and recording of weight and body mass index (BMI) • The role and use of the dietician in the MDT • Definition of catabolism and anabolism • Different routes for nutrition, their implications, associated care and contraindications including (refer to local guidelines for management of feeding tubes): - Oral - Nasogastric (NG) tube - Nasojejunal (NJ) tube - Gastrostomy tube - Percutaneous endoscopic gastrostomy (PEG) tube - Radiologically inserted gastrostomy tube - Parenteral nutrition		

4.2 Endocrine and Gastrointestinal

4.2.3	Management	Self Assessment	Competence Fully Achieved
		Learner Sign and Date	Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	An awareness of the different needs pertaining to elimination including reference to: • Causes and complications of diarrhoea • Causes and complications of constipation • Change of bowel habit • Stool chart and abnormalities including melena, fresh blood, steatorrhea and pale stool The causes of raised intra-abdominal pressure and possible management. The different types of diabetes, how they might present and how they are managed. Refer to the following terms: • Type I diabetes • Type II diabetes • Oral agent control • Short acting insulin • Long acting insulin • Continuous insulin infusions Hyperglycaemia and hypoglycaemia including: • Causes • Signs • Symptoms • Treatment		
	I can demonstrate through practice:		
	A comprehensive nutritional and GI patient assessment including: • Nutritional status and requirement • Assessment of absorption and gut function when tube feeding is in place • Importance of digital rectal examination • Assessment of bowel function • Assessment of stoma function / viability • Interpretation of associated tests and investigations (see above)		

4.2 Endocrine and Gastrointestinal

4.2.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Possible usage and actions of the following medications: • Antacids • Antibiotics • Anti-inflammatory drugs • Anti-motility / anti-spasmodic drugs • Aperients and laxatives • Corticosteroids (steroids) • H2-receptor antagonists • Iron preparations • Nutritional supplements / specialist feeds • Pancreatic drugs (bullets) • Prokinetic drugs • Vitamins and minerals		

4.3 Pain

4.3.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Anatomy and physiology relating to pain. The different pain categories including: • Acute pain • Chronic pain • Neuropathic pain • Break-through pain • Withdrawal pain • Post-operative pain • Referred pain • Phantom pain Where patients' pain can originate from. The importance of ensuring adequate pain relief to prevent respiratory complications for example: • Post-operative pain • Chest trauma		

4.3 Pain

4.3.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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I can demonstrate through discussion: Continued			
	Knowledge about the different types of pain and ways in which to describe and assess it: • Pain assessment tools • Terms to help describe and understand the type of pain e.g. radiating • Terms to help describe the source/origin of the pain • Functional pain syndrome • When to seek specialist intervention (e.g. pain team/ medical team) Knowledge of how pain might manifest in patients who are unable to verbally express their pain: • Constipation • Full bladder/urinary retention • Poor positioning • Inability to settle/wandering with no purpose Knowledge of different strategies to control pain without using pharmacology: • Deep breathing/relaxation exercises • Using hot or cold compresses/pads • Reassurance • Optimal positioning • Exercises e.g. Yoga • Distraction techniques Knowledge of the many different pharmacological options for the different categories of pain: • Non-opioid • Opioid • Non-steroidal anti-inflammatory • Analgesic skin patches • Adjunct medications Knowledge of the different types of Patient Controlled Analgesia (PCA): • Morphine • Oxycodone Knowledge of different analgesia infusions: • Epidural • Direct wound infusion • Different types of nerve blocks The use of combined drug therapy and use of appropriate escalation of pain preparations e.g. the analgesic ladder.		

4.3 Pain

4.3.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	How to perform a pain assessment including: • Recognising the physiological signs of pain • Use of a pain assessment tool • Documentation of the pain assessment and plan in patients records • Evaluation of all pharmacological and non-pharmacological methods of pain relief An ability to communicate with the patient's team with regards to pain symptoms and the effectiveness of pain relief e.g. functional pain and pre-and post-analgesia. When to escalate if pain control is ineffective and who to contact both in and out of office hours. How to position patients and make them as comfortable as possible.		

4.2.5	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Knowledge of the many different pharmacological options for the different categories of pain: • Non-opioid • Opioid • Non-steroidal anti-inflammatory • Analgesic skin patches • Alternate routes of administration for specific pain types (i.e. suppository, sub-cutaneous, intravenous vs oral) • Adjunct medications Knowledge of different strategies to control pain without using pharmacology: • Deep breathing • Distraction techniques • Using heat or cold • Reassurance • Positioning		

4.3 Pain

4.2.5	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	The following should be completed as per Trust policy and with attendance to the appropriate study days. Education and safe management of patients using patient controlled analgesia (PCA) Effective and safe care of a patient receiving the following forms of analgesia: • Rectus sheath catheter • Paravertebral block • Other wound blocks • Lidocaine infusion • Epidural • Transcutaneous electrical nerve stimulation (TENS)		

5. Exposure

The following competency statements relate to the assessment and management of the integumentary (skin) and musculoskeletal systems. Additional focus is given to venous thromboembolism. The competency comprises of anatomy and physiology, patient assessment and approaches to management for each body system.

5.1 Skin

5.1.1.	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Layers of the skin: • Epidermis, dermis and hypodermis Accessory organs: • Hair, nails, sebaceous (oil) glands, sweat glands Functions of the skin including: • Protection (Chemical/physical barriers and biological defence) • Homeostasis and temperature regulation • Stimuli (touch, pressure, pain, heat and cold) • Excretion • Synthesis of vitamin D • Blood reservoir		

5.1 Skin

5.1.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Awareness of common investigations such as: • Skin swabs (screening/ bacterial/ viral/ fungal) • Mycology (skin tests/ scrapings) • Blood tests (e.g. immunology for connective tissue disorders and vasculitis) • Skin biopsies and tissue cultures		
5.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The importance of adequate exposure to perform a thorough head to toe, front and back examination (see section 2.1.2) including consideration for the importance of nutrition, body mass index (BMI) and the maintenance of skin integrity (see section 5). Risk assessments and the nursing responsibilities related to patients at risk of pressure damage. Knowledge of high risk areas of the body for pressure damage. Grades 1- 4 pressure damage (using the European Pressure Ulcer Advisory Panel (EPUAP) guidelines, 2014). The differences between: • Pressure damage • Moisture lesions • Shear and/ or friction force damage The practice required to prevent pressure damage: • Surface beneath the patient • Keep moving • Incontinence/ moisture management • Nutrition and hydration Various pressure relieving devices available locally and the agreed pathway for accessing these. The importance of collecting and auditing data on pressure area damage to improve pressure area care within the clinical area and the local reporting system used.		

5.1 Skin

5.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	The associated costs of pressure damage: • Cost to the patient in terms debility, low self-esteem, delayed rehabilitation and pain • Financial costs to the wider NHS		
	I can demonstrate through practice:		
	An ability to identify and manage: • Pressure ulcers (grades 1-4) • Cellulitis • Allergies (urticarial rash/hives) • Atopic dermatitis/eczema • Sweat rash • Thrombophlebitis • Psoriasis • Shingles • Purpuric rash • Necrotising fasciitis An ability to provide emotional reassurance and support. Management of the patient at risk of skin damage by: • Performing a risk assessment of the patient's skin using an appropriate risk assessment tool • Determining the appropriate surface (e.g. pressure relieving mattress) for the identified risk and to be able to locate it • Selecting the most appropriate devices/equipment and ensuring that they are in good working order (in accordance to local policy) • Ensuring that regular visual checks of at risk areas are carried out Promotion of the concept of 'keep moving' by: • Encouraging the patient to change their position or be repositioned • Managing people and equipment resources to achieve positioning objectives, such as the stating the maximum length of time a patient is sitting out in a chair • Regularly repositioning the unconscious patient in line with application of local policy or skin bundle • Minimising shear and/or friction damage with correct use of manual handling devices		

5.1 Skin

5.1.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued		
	Manage damage cause by increased moisture by: • Identifying moist or wet skin • Treating dry skin with moisturisers • Cleaning the skin at the time of soiling and applying topical agents that act as moisture barriers • Identifying incontinence associated dermatitis and differentiating this from pressure damage Offering of toileting facilities based on individual need. Report any pressure damage in line with local policy. Measure the quality of the care delivered within the clinical area by measuring both pressure damage outcomes and compliance with processes. Refer patients to other members of the MDT when specialist input is needed including: • Tissue viability • Dietetics • Occupational therapy • Physiotherapy		
5.1.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Knowledge of when the following are indicated: • Anti-infective creams • Antibacterial/anti-fungal • Steroids • Barrier creams • Anti-inflammatories • Anti-histamines		

5.2 Musculoskeletal

5.2.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Knowledge of musculoskeletal anatomy including: • Overview of the skeletal system • Muscle location, shape, size and direction • How muscles connect to overlying fascia/tendons • Composition of muscle • Composition of bone		
	Knowledge of physiology of the musculoskeletal system including: • Role of the skeleton in supporting shape, movement and protection • Role of tendons and joints • Muscle voluntary control – posture and locomotion • Agonist/antagonistic role of muscles • Motor neurone control of muscle • Muscle protein filaments and contraction • Slow and fast muscle fibres • Generation of body heat • Importance of muscle tone • Range of movement		

5.2.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Awareness of common investigations such as: • Blood tests e.g. creatinine kinase (CK) and erythrocyte sedimentation rate (ESR) • Bone density tests • Nerve conduction studies • X-ray, CT, MRI and ultrasound • Bone scan An understanding of the significance of local, symmetrical or asymmetrical: • Muscle weakness/atrophy • High and low muscle tone		

5.2 Musculoskeletal

5.2.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	The importance of adequate exposure to perform a thorough head to toe, front and back examination (see section 2.1.2) including an appreciation of the importance of determining symmetry of muscle power and movement. Identification of patients at increased risk of skeletal injury (e.g. cachexic, poor bone density) and an appreciation of how this impacts on the respective Trust's falls risk assessment. An ability to identify patients at high risk of joint damage (e.g. long stay, oedematous). Positioning of shoulders to prevent excessive joint stretch when laying a patient on their side. Careful application of range of movement to avoid damage by poor joint positioning. Application of any appropriate splints or orthosis for patients with identified needs. Provision of emotional reassurance and support. Identification and management of: • Muscle atrophy following significant bed-rest • Myopathies • Rhabdomyolysis • Osteoarthritis • Rheumatoid arthritis • Osteoporosis		
5.2.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Knowledge of when the following are indicated: • Non-opioid and opioid analgesic and their impact on skeletal muscle pain (see section 5.3) • Muscle relaxants (e.g. Baclofen) • Bisphosphonates (e.g. Alendronate) to improve bone density		

5.3 Venous Thromboembolism

5.3.1	Anatomy and Physiology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Anatomy of veins and how veins in the lower extremities give rise to venous thromboembolisation (VTE). The difference between a thrombus and an embolus. The impact of VTE on: • Pulmonary vasculature • Deep muscle		

5.3.2	Assessment and Investigations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The importance of adequate exposure to perform a thorough head to toe, front and back examination (see section 2.1.2) including assessment of the patient for signs and symptoms of DVT/ PE (see 6.2.5). Awareness of common investigations such as: • D Dimer • Coagulation screen • Ultrasound scan • Ventilation/ perfusion scan • Pulmonary angiography		

5.3.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	An ability to recognise the signs and symptoms of, and manage the care of a patient with a: • Deep vein thrombosis (DVT) (calf and thigh) • Pulmonary embolism (PE) The importance and need to assess all patients admitted to hospital against the VTE risk screening tool including the: • Importance of assessing the patients level of mobility and the need for all patients with significantly reduced mobility to be further VTE risk assessed		

5.3 Venous Thromboembolism

5.3.3	Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice: Continued		
	An ability to review VTE risk assessments in line with local policy. Why any patient at risk of thrombosis should receive thromboprophylaxis in accordance with NICE CG 92 (2015) and local policy, and can: • Instigate mechanical prophylaxis in line with local policy (e.g. elastic compression stockings and encourage ambulation) • Safely administer pharmacological prophylaxis and/or treatment (see 6.2.4) An ability to provide emotional reassurance and support and involve the patient in prevention of thrombosis as appropriate.		

5.3.4	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Knowledge of when the following are indicated and the associated monitoring and complications: • Heparin (low molecular weight heparin (LMWH) or unfractionated heparin) • Oral anticoagulants • Pharmacological thrombolysis • Electronic compression devices e.g. Flowtron therapy • Anti-embolism stockings Complications of pharmacological VTE prophylaxis. An awareness of additional treatment options including endovascular and surgical interventions.		

6. Safe Patient Transfer (intra-hospital)

The following competency statements relate to the safe transfer of an acutely unwell patient. Transfer of patients has been recognised as an intervention during which patients may be exposed to increased risk. These competencies are not intended to replace any local transfer training course, but rather should remind staff of the principles pertaining to intra hospital transfers; e.g. to the X-ray department or another ward.

6.1	Safe Patient Transfer	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	The key principles when transferring a patient to another department • The most appropriate person(s) to escort the patient including portering staff if applicable • The skills required of such person(s) e.g. level of life support training • The local procedure to follow when arranging the transfer of a patient to another department • The equipment to accompany the patient including: - The platform for transfer as per local policy e.g. the patients bed or a trolley - Emergency drugs/patient specific drugs - Emergency suction equipment - Emergency bag and contents (according to local guidelines) - Monitoring equipment according to local guidelines - Portable oxygen cylinders required including knowledge of how to calculate oxygen required for duration of transfer and how to open/close cylinders - Appropriate documentation according to local guidelines including the monitoring and recording of observations and transfer documentation - Medical and nursing notes • Knowledge of what treatment might be temporarily discontinued for the duration of the transfer e.g. use of feed pumps • Knowledge of local procedure to follow if patient deteriorates during transfer and how to/who to call for help • Knowledge of local electronic systems that need to be completed when patient transfers permanently to another department or ward.		

6.1	Safe Patient Transfer	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice:		
	Preparation of the patient for transfer including: • Discussion of the impending transfer with the patient (and/or family) including reason for transfer • A patient assessment using the ABCDE approach • Stabilisation of the patient at risk during transfer e.g. hypotension under the guidance of the medical staff • Application of any appropriate monitoring if required and how to record and document observations during the transfer • Application of supplementary oxygen if required and an ability to monitor and document its effect • Ability to check all equipment and contents of transfer bag ensuring everything that might be required is present and working according to local policy. Support of the patient during transfer including: • Ability to transfer patient safely with all required equipment including portable oxygen and suction • Ability to attend to any patient needs including emergencies (including competency in life support) • Ability to support medical staff with administration of emergency drugs • Ability to complete transfer documentation and/ or observations during the transfer according to local Trust policy • Ability to handover the patient clearly and safely to another department/ ward if not returning patient back to same ward after a procedure Return of the patient back to the ward/ department (if applicable) after the transfer including: • Ability to return patient to bed space ensuring comfort • Reinstatement of all treatment and monitoring that might have been discontinued e.g. nasogastric (NG) feeding • Return of equipment, ensuring it is cleaned, checked and that bags/drugs/oxygen cylinders are restocked according to local policy • Ability to document any effects of the transfer and see that these are made known to the MDT • Return all notes/documentation including investigation reports to the appropriate place • Completion of any required local electronic systems especially if patient not returned to same ward or department.		

7. Holistic Care

The following competency statements relate to holistic care of acutely unwell patients. Comprising concepts of psychosocial care, the physiological impact of acute illness and communication, they encompass approaches to assessment and management which promote the patient experience.

7.1 Promoting a positive patient experience

7.1.1	Knowledge of Psychosocial Wellbeing	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: The concept of holistic care and how it can be incorporated into practice with reference to the following aspects: • Physical needs • Psychological needs • Social needs and those of the family • Spiritual and cultural needs The impact of the following on the psychological wellbeing of acutely ill patients: • Sensory overload • Sleep deprivation • Pain • Confusion • Disorientation • Anxiety • Fear • Night terrors • Hallucinations The importance of developing the following with acutely ill patients: • A trusting relationship • Effective ways of communicating • Individualised family centred care plans Assisting patients to: • Regain control as far as possible • Become more involved and empower them to make decisions about their own care and treatment • Develop acceptance of the situation • Move through the grieving process where applicable The importance of giving patients and family's clear explanations about care and treatment, always seeking consent before approaching patients to undertake tasks The visitation needs of acutely unwell patients.		

7.1 Promoting a positive patient experience

7.1.1	Knowledge of Psychosocial Wellbeing	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Provide emotional reassurance and support. Act as the patients advocate. Demonstrate kindness and compassion in all aspects of care given. Promote a holistic approach when giving care. Orientate patients to time, place and physical location. Alleviate fear, stress and anxiety. Ensure the patient is comfortable and pain free. Promote reality where the opportunity arises. Empower patients to regain self-concept and self-control. Give adequate explanations regarding care and treatment in a language that the patient can understand and be willing to repeat these explanations as often as needed. Adopt appropriate communication aids. Encourage and motivate patients to achieve independence in relevant tasks. Include patients and family in the development of care plans and treatment choices. Be open and honest with patients and families and demonstrate empathy towards their situation. Encourage family members to bring in items that might make the patient feel more relaxed e.g. family photographs, familiar clothing, personal music choices and/or toiletries. Help the patient to accept the situation they find themselves in and provide support to do this. Respect any cultural and/or spiritual needs. Promote the restoration of normal sleep patterns which may include: • Reducing noise and light disturbance (sensory overload) • Having designated rest times • Offering milky drinks • Limiting the amount of nursing activity during the night/ rest periods • Offering earplugs and/or eye masks		

7.1 Promoting a positive patient experience

7.1.1	Knowledge of Psychosocial Wellbeing	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through practice: Continued		
	Reduce unnecessary sensory overload such as prompt attention to call bells and alarms (at all times but particularly during the night). Give explanations for loss of time. Reassure patients that many patients experience similar problems during and following a period of acute illness. Refer for solution focused therapy or psychological support from relevant multi-disciplinary team members if appropriate. Encourage patients and their relatives to discuss their experiences of acute illness, for staff to learn from this. Provide patients and relatives with written information.		

7.1.2	Delirium Assessment and Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
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	I can demonstrate through discussion:		
	Three clinical subtypes of delirium and their presentation: • Hyperactive • Hypoactive • Mixed The characteristics of delirium: • Altered consciousness • Fluctuating mental status • Inattention • Disorganised thinking Knowledge of NICE CG 103 (2010) including: • Strategies for delirium prevention • Screening for risk factors on admission and during daily observations • Indicators of delirium • Diagnosis – Confusion Assessment Method (CAM) • Treatment – interventions and pharmacological agents		

7.1 Promoting a positive patient experience

7.1.2	Delirium Assessment and Management	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	Prevention of delirium by: • Ensuring that people at risk of delirium are cared for by healthcare professionals who are familiar to the person at risk • Avoiding moving people within and between wards or rooms unless absolutely necessary • Assessing people at risk for clinical factors that might contribute to delirium • Providing a multicomponent intervention tailored to the person's individual needs and care The initial management of a delirious patient including: • Identification and management of the underlying cause(s) • Ensuring effective communication and reorientation takes place • The provision of reassurance • Consideration of involving family, friends and carers • Provision of a safe and suitable care environment		
7.1.3	Pharmacology	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The main medications used in the pharmacological management of delirium.		
	I can demonstrate through practice:		
	An ability to: Safely prepare and administer medications as above to treat delirium: • Starting with a low dose • Titrating drugs cautiously according to symptoms Monitor the effects of medication according to the: • Desired outcome • Side effects		

7.1 Promoting a positive patient experience

7.1.4	Visiting needs of acutely ill patients	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Provide emotional reassurance and support. Establish a main person who acts as a point of contact for other family members. Communicate information clearly considering the needs of the relatives/ visitor, providing written information if necessary. Be aware of what information can be given over the phone. Ensure that the environment is conducive for effective communication. Document appropriate communication given to relatives/ visitors in line with local policy (e.g. care plan/case notes/ communication folder). Assist with any areas for improvement that would enhance the relatives/visitors visiting experience.		

7.2 Physiological changes due to acute illness

7.2.1	Promoting independence through function	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The physiological impact of reduced physical function/ immobility on the body's systems: • Cardiovascular • Respiratory • Gastrointestinal • Endocrine • Musculoskeletal The psychological impact of reduced physical function/ immobility. Awareness of how acute and chronic medical conditions impact on a patient's physical functional ability.		

7.2 Physiological changes due to acute illness

7.2.1	Promoting independence through function	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	Clinical presentation of patients who are recovering from an acute illness and may be deconditioned/suffering with muscle wasting and/or fatigue including: • Loss of joint range of movement • Decreased/ altered sensation • Decreased exercise tolerance Strategies for promoting independent function within a Level 1 environment. Awareness of when patients are too medically unstable to engage in functional activities. An enhanced recovery programme for post-operative patients. Knowledge of NICE CG 83 (2009) including: • Causation of acquired weakness post critical illness • Physiological impact following episode of acute or critical illness • Strategies to prevent, recognise and treat physical and non-physical sequela following critical illness		
	I can demonstrate through practice:		
	Accurate social history taking to establish previous level of function. A comprehensive risk assessment including: • Moving and handling • Falls Patient orientation to unfamiliar surroundings. Encouragement of independent function by: • Ensuring a safe environment • Limiting constraints such as catheters, drips etc. • Management of pain Encouragement and involvement in care. Education of patients and relatives of the benefits of maintaining independent function. An ability to follow instructions provided by other MDT specialists outlining safe moving and handling, equipment requirements and strategies to achieve 24-hour approach to rehabilitation. Referrals to relevant multi-disciplinary team members if strategies to promote independent function are unsuccessful or patient is not at baseline level of function.		

7.3 Communication

7.3.1	Communication	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The importance of focusing on the individual, including: • Personal space and positioning when communicating • Body language and eye contact when communicating • Using the individual's preferred means of communication and language • Checking that you and the individuals understand each other • Adapting your communication skills to aid understanding • Active listening • Awareness of medications that may affect communication • Knowing patients past medical history • Considering any learning disability and adapting communication accordingly The difficulties that can arise with communication in the acute care environment including: • Altered conscious level • Physical barriers to communication e.g. tracheostomy • Clinical condition e.g. stroke and aphasia • Dementia • Disorientation • Confusion • Delirium • Withdrawal from communication • Addictions • Hallucinations • Sleep deprivation • Sensory impairment Methods and ways of communicating that allow for communication difficulties to be overcome (including but not limited to): Nonverbal communication aids, such as picture boards, writing and electric devices. Ways in which to support equality and diversity. The difficulties that may be experienced in recognising and interpreting the patient's nonverbal communication (including but not limited to): • Signs of distress • Deterioration in patient's ability to understand i.e. changes to their mental capacity		

7.3 Communication

7.3.1	Communication	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Provide emotional reassurance and support. Communicate clearly whilst considering the needs of the patient. Select the most appropriate method of communication for the patient. Identify any communication barriers with the individual and take the appropriate action to overcome these: • Appropriate language and terminology • Patient's usual communication aids (see list below) Provide adequate pain relief. Relieve any anxiety and/or stress. Adopt any communicate aids that are appropriate to the patient's needs: • Spectacles • Hearing aids • Picture boards • White boards • Pen and paper • Interpreter • Electronic devices Adapt my communication style to suit the situation and the patients' needs. Ensure that the environment for communication is as conducive as possible for effective communication. Clarify points to check that the patient understands what is being communicated. Actively listen and respond appropriately to any questions and concerns raised during communication with the acutely ill patient. Ensure written documentation given to the patient reflects their needs and that accurate legible records are kept of any communication that has taken place.		

7.3 Communication

7.3.2	Communication and Team Working	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The importance of effective team working in acute care (Including but not limited to): • Efficient and timely completion of workload • Working collaboratively • Achieving common goals • Team satisfaction • Supporting and valuing each other Knowledge regarding the members of the extended MDT and the main roles and responsibilities of each in caring for the acutely ill (including but not limited to): • Acute care doctor • Parental team doctor • Acute care nursing team • Acute care technician • Specialist nurse • Physiotherapist • Dietician • Pharmacist • Occupational therapist • Speech and Language Therapy (SALT) • Psychologist The importance of referring or responding promptly and appropriately to each member of the MDT. The most effective and efficient way to contact and communicate with the appropriate team member including: • Emergency call/bleep • Non-urgent call/bleep • Verbal referral (face to face) • Written referral • Email/local electronic system • Fax • Appropriate documentation Identification of when a difficulty or problem arises with a MDT member. Strategies and mechanisms for positively resolving difficulties. Knowledge of appropriate communication tools, including Situation, Background, Assessment, Recommendation (SBAR) and Reason, Story, Vital Signs, Plan (RSVP). The principles of confidentiality and security and the sharing of information about patients. How communication skills reflect on both myself and my team.		

7.3 Communication

7.3.2	Communication and Team Working	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Work as an effective acute care team member. Refer as appropriate to other members of the MDT, ensuring all referrals documented appropriately together with agreed outcomes and escalation plans if outcomes are not met. Give an effective handover using appropriate communication tools for example: • SBAR • RSVP Maintain confidentiality as appropriate to do so. Acknowledge and respond to communication promptly. Assist and support other team members. Deliver shift goals as set by the team leader. Focus my actions on the safety of the patient, myself and on other team members. Actively participate in the professional development of other team members.		

7.3 Communication

7.3.3	Communicating in Difficult Situations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The management of emotional distress in patients, families and colleagues. The potential impact of all aspects of significant news on the patients and family's well-being. The range of communication difficulties and resources available to aid communication. The importance of clear and direct communication. The importance of the individual's choice. The importance of establishing rapport.		

7.3 Communication

7.3.3	Communicating in Difficult Situations	Self Assessment	Competence Fully Achieved
		Learner Sign and Date	Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	How to ask questions, listen carefully and summarise back. The importance of encouraging individuals and families to ask questions. How to negotiate effectively with individuals, families and other professionals. How to manage own feelings and behaviour when communicating with patients and families. The importance of working within my own sphere of competence and seeking advice when faced with situations outside of this.		
	I can demonstrate through practice:		
	An ability to: Provide emotional reassurance and support. Maintain a professional attitude when participating in difficult discussions. Choose or create an appropriate environment. Communicate with individuals and their families/ significant others at a pace and level appropriate to their understanding. Review the individual's notes and all supporting information and consult with colleagues so that you clearly understand the individual's current situation prior to the discussion. Explore the individual's perceptions and feelings about the current situation. Use questions to assess what information the individual wants to know. Provide open and honest information to patients and families at an appropriate level and pace. Establish the patient and families understanding of any information provided. Summarise the information using different words, phrases or expressions to assist the individuals understanding.		

7.3 Communication

7.3.3	Communicating in Difficult Situations	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued		
	Provide opportunities for the patient and family to ask questions and express their concerns and emotions. Discuss options with the individual and agree the next steps. Record the consultation and any agreed outcomes as per national and local policies.		

8. Professional Competencies

The following competency statements relate to your professional development as a registered practitioner in the acute care environment. The competency comprises of core concepts in evidence-based practice, professional development planning and the acquisition of leadership skills through the recognition of human factors in healthcare.

8.1 Ethical and Legal issues

8.1.1	Ethical and legal issues	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	The importance of Duty of Candour. The importance of defensible documentation. The role of the healthcare professional involved in decision making practices in relation to: • Mental capacity • Deprivation of Liberty (DoLS) • Safeguarding • Advanced decisions Understanding of the roles: • Independent mental capacity advocate (IMCA) • Lasting Power of Attorney (LPA) • Court appointed deputy		

8.1 Ethical and Legal issues

8.1.1	Ethical and legal issues	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Keep accurate, timely and legible records in line with local policy and professional standards. Minimise potential sources of harm to the vulnerable individual. Undertake risk assessments and report findings, including the application of the two-stage mental capacity assessment. Make appropriate DoLS applications. Follow local guidelines and policies related to Health, Safety and Security. Demonstrate effective communication measures with the patients, families and/or carers and the wider MDT members, on issues relating to diminished mental capacity.		

8.2 Evidence Based Practice

8.2.1	Policy and Benchmarking	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	An understanding of local, regional and national policy and guidance that underpins my practice. The value of clinical audit and its contribution to practice. The importance of conducting benchmarking exercises against appropriate national and professional guidance to demonstrate local compliance and performance. The importance of critical appraisal of new resources, developments and research that is relevant to acute care to: • Establish an evidence base for practice • Develop clinical guidelines • Identify key professional resources • Identify key resources for patients and relatives • Facilitate my own professional development and promote professional development of others		

8.2 Evidence Based Practice

8.2.1	Policy and Benchmarking	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice:		
	An ability to: Apply existing local, regional and national policy and guidance to my practice. Contribute to clinical audit. Build and maintain my personal portfolio demonstrating my competence and professional development. Complete any required benchmarking exercises accurately and in the timeframe outline		

8.3 Developing Self and Others

8.3.1	Developing Self and Others	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	An awareness and understanding of: The Nursing and Midwifery Council (NMC), Health and Care Professionals Council (HCPC), or other professional bodies and their associated standards of practice and behaviour.		
	I can demonstrate through practice:		
	Self-awareness including: • Setting my own achievable development goals • Using feedback to improve my performance • Using reflection to learn from previous experiences • Utilising appraisals and clinical supervision sessions to inform and guide my development Working with others and an ability to: • Prioritise tasks and duties and delegate where appropriate • Provide emotional reassurance and support • Build effective relationships and rapport with team members • Involve other relevant team members in problem solving and decision making		

8.3 Developing Self and Others

8.3.1	Developing Self and Others	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued		
	• Challenge others constructively when required • Make the most of any learning opportunities that might arise • Completing appropriate knowledge and clinical based competences • Reading relevant peer reviewed journals/websites/forums • Keep abreast of current / contemporary developments within my clinical area of work • Share my learning with others and support an environment that is conducive to learning		

8.4 Human Factors

8.4.1	Human Factors	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Knowledge of Human Factors including an ability to: • Define human factors • Discuss the impact of human factors on team working and patient safety Knowledge of the supportive mechanisms to speaking up such as the Concern, Unsure, Safety, Stop (CUSS) or Probe, Alert, Challenge and Emergency (PACE) approaches. Knowledge of safety and occurrence reporting including: • Evaluation of human factors issues in occurrence and safety reports • Understanding the effectiveness of reporting systems • Understanding the significance of safety culture		
	I can demonstrate through practice:		
	An ability to: Complete a risk assessment for any identified issue and escalate accordingly in line with local policy. Report critical incidents or near misses in line with local policy/systems. Act on safety reports in line with local policies/systems. Act in a manner which supports a safety culture and encourage others to do so. Work with other members of the MDT to promote awareness of human factors and a safety culture.		

9. End of Life Care

The following competency statements relate to end of life care in the acute care environment.

9.1 End of Life Care

9.1.1	End of Life Care planning	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Awareness of current national and local policies, protocols and guidelines in relation to End of Life (EoL) care including: • Capacity, care planning and advance care planning in life limiting illness • EoL Care Strategy • Leadership Alliance for the Care of Dying People including: engagement with patients, families, carers and professionals. • Gold Standard Framework • Preferred Priorities of Care • One Chance to Get It Right • Amber Care Bundle Knowledge of the five priorities of care with the end of life patient and family including: • Recognition that death may be imminent and this is communicated clearly to all involved and documented • Open and honest communication with the patient and family • Involvement of the dying person and those important to them in decisions and treatment plans • Recognising that the needs of the family and significant others are met where ever possible • An individualised plan of care which includes food and drink, symptom control and social, psychological and spiritual support is created, agreed and delivered Knowledge of ethical dilemmas in caring for the acutely ill patient nearing the end of life including tissue donation. An understanding of the concept of futility and prolonging life. The stages a patient may pass through within the dying process. Application of clinical decision-making models within the acute care setting.		

9.1 End of Life Care

9.1.1	End of Life Care planning	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion: Continued		
	An understanding of the role of the broader MDT in EoL care including: • Palliative care team • Bereavement support • Pastoral care • Specialist tissue donation nurse Treatment algorithms as part of individualised EoL care planning with reference to: • Pain • Nausea • Agitation • Dyspnoea • Respiratory tract secretions An understanding of rapid discharge policies. An understanding of the benefits of tissue donation for both donor families and recipients. The procedure for deactivation of implantable cardiac devices for EoL care.		
	I can demonstrate through practice:		
	An ability to: Provide emotional reassurance and support. Agree with patients/relatives and/or significant others the EoL plan of care. Communicate effectively with patient and family throughout the EoL stages. Identify any resources required. Identify potential problems that can arise as the individual progresses towards their EoL. Implement aspects of the individualised EoL care and treatment plan promptly, in the correct sequence, and at the earliest possible opportunity, to achieve the best outcome for the individual.		

9.1 End of Life Care

9.1.1	End of Life Care planning	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: Continued Demonstrate an understanding of the emotional and spiritual support the patient and family may require with reference to: • Refusal of treatment • Advanced directives • Objection to certain procedures • Religious views and practices • Ensuring the safety of individuals as they progress towards their EoL Take prompt and effective action when there is deviation from the agreed care plan. Implement rapid discharge policies where appropriate to the preferred place of care. Review individualised care and treatment plans and update as necessary. Ensure death is certified by an appropriately trained professional. Demonstrate understanding of the families religious and spiritual needs immediately following death (including but not limited to): • Assembling all relevant equipment and assisting with last offices • Allowing relatives/carer time to spend time at the bedside • Respecting the need for privacy Facilitate the following processes after death (including but not limited to): • Collection of death certificate and patient property • Provision of support documents • Discussions with regards to tissue donation		

9.1 End of Life Care

9.1.2	Withholding and Withdrawing Treatment	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	Knowledge of legal constraints, the Mental Capacity Act and ethical principles of withdrawal or withholding treatment. The procedures for forming and recording agreements on withdrawal of treatment. The best practice procedures for early identification of potential tissue donation according to defined triggers. How to facilitate access to sources of support within the broader MDT e.g. bereavement support. The availability of care suitable for patients after withdrawal of treatment e.g. EoL care plan.		
	I can demonstrate through practice:		
	An ability to: Establish with MDT that further treatment for the patient is inappropriate and that, at some stage, active treatment should be withdrawn in the knowledge that this will result in the patient's death. Consider the patients and /or family's preference for where care will be delivered after withdrawal of treatment. Consider the patients and/or family's religious beliefs when delivering EoL care Review the EoL care options suitable for patients. Initiate a systematic timely referral for tissue donation according to best practice guidelines. Agree with colleagues, the patient (where possible) and their family an appropriate plan of care. Arrange resources for the delivery of the plan, including liaison with MDT and appropriate support teams.		

9.2 Defensible Documentation

9.2.1	Documentation	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through discussion:		
	An awareness and understanding of national and local guidance pertaining to consent for examination or treatment including: • Informed consent • Capacity • Verbal / non-verbal consent An awareness and understanding of information governance and NHS Litigation Authority Standards in relation to the registered professional's legal responsibility in written documentation. It must be: • Accurate • Purposeful • Contemporaneous • Inclusive of the author of entry – printed signed and, in some instances state the professional PIN number My accountability in relation to: • Statute Law • Case Law • Civil Law • Criminal Law The reason for accessing and maintaining health care records including: • Helping to improve accountability • Showing how decisions related to patient care are made • Supporting the delivery of services • Supporting effective clinical judgements and decisions • Supporting patient care and communications • Making continuity of care easier • Providing documentary evidence of services delivered • Promoting better communication and sharing of information between members of the multi-professional healthcare team, patients and families • Helping to identify risks, and enabling early detection of complications • Supporting clinical audit, research, allocation of resources and performance planning • Helping to address complaints or facilitate legal processes An awareness and understanding of my responsibility in relation to health care records including: • Use of electronic tracking systems • Privacy and confidentiality of patient information • Caldicott Guidelines		

9.2.1	Documentation	Self Assessment Learner Sign and Date	Competence Fully Achieved Assessor Sign and Date
	I can demonstrate through practice: An ability to: Provide an accurate, concise, timely and contemporaneous record of my patient's treatment and events, utilising appropriate systems as required. Maintain an accurate, concise, timely and contemporaneous record of communication between the MDT and patient. Complete the necessary risk assessments and care plans then be able to evaluate them after implementation. Accurately file patient information utilising the local health records systems in place.		

Assessment and Development Summary

[illegible]

Assessment and Development Summary

[illegible]

10. Assessment and Development

Assessment and Development Summary

Initial Assessment and Development Plan	
Date	Record this date on the Assessment and Development Summary
This meeting between Learner and Lead Assessor should take place during induction. It is to identify the learning needs of the practitioner during their supernumerary period and identify those competencies that should be attained within the first 3 months of the competency programme.	
Current Acute Care knowledge, understanding and skills	
Competencies to be achieved	
Specific supportive strategies required	
Learners Signature:	
Lead Assessors / Practice Educators Signature:	
Next agreed meeting date	

10. Assessment and Development

Assessment and Development Summary

On-going Assessment and Development Plan	
Date	Record this date on the Assessment and Development Summary
This meeting between Learner and Lead Assessor is to identify the progress made by the practitioner in achieving the competencies identified in the initial and/or previous meetings. It is here further SMART objectives will be set. On-going assessments should take place at least every 3 months. If the learner requires additional support a further action plan can be completed.	
Review of competencies achieved	
ON TARGET:	YES NO
If NO, which competencies have yet to be met	
Reasons for not achieving	
SMART objectives to achieve competence	
Key areas and additional competencies to be achieved before next meeting	
Learners Signature:	
Lead Assessors / Practice Educators Signature:	
Next agreed meeting date	

10. Assessment and Development

Assessment and Development Summary

Additional Action Planning	
Date	Record this date on the Assessment and Development Summary
This document should be used to set SMART objectives for the learner who requires additional support to achieve certain competencies (these will have been identified during the 3 monthly On-going Assessment and Development plan).	
Areas for further action planning	
Learners Signature:	
Lead Assessors / Practice Educators Signature:	
Next agreed meeting date	

10. Assessment and Development

Assessment and Development Summary

Final Competency Statement	
Date	Record this date on the Assessment and Development Summary
This meeting is to identify that all the Level 1 competencies have been achieved and that the practitioner is considered competent and safe. COMPETENCY STATEMENT: The practitioner has been assessed against the competencies within this document and measured against the definition of competence by Level 1/enhanced care colleagues, mentors and assessors and is considered a competent safe practitioner within the Level 1/enhanced care environment by demonstrating: “The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective practice in Level 1/enhanced care” As part of quality assurance, the practitioner is expected to maintain a portfolio of practice as part of NMC/HCPC regulations and revalidation to support on-going competence and declare any training and/or development needs to their line manager or appropriated other. Competency will be reviewed annually as part of staff personal development plans and evidence of this will be required for NMC/HCPC revalidation. Where necessary SMART objectives will be set to further develop any emerging competency required to work safely within the Level 1 environment.	
Lead assessors comments	
Learners comments	
Learners Signature:	
Lead Assessors / Practice Educators Signature:	
Next agreed meeting date	

10. Assessment and Development

Assessment and Development Summary

Annual Competency Review (To accompany local appraisal documentation)	
Date	Record this date on the Assessment and Development Summary
This record is a statement between the practitioner who has successfully completed the Level 1 competencies and their Appraiser. It should be used alongside local appraisal systems annually to ensure that the practitioner continues to demonstrate that they are competent and safe in the delivery of care in the Level 1 / enhanced care environment.	
OVERALL COMPETENCY MAINTAINED	YES ☐ NO ☐
If NO, which competencies require further development?	
SMART objectives to achieve competence	
Further Comments	
Learners Signature:	
Lead Assessors / Practice Educators Signature:	
Next agreed meeting date	

Continuing Personal Development and Learning**Reflective Account****Date**

Please fill in a page for each of your reflections, ensuring you do not include any information that might identify a specific patient or service user.

What was the nature of the CPD activity/ practice-related feedback?**What did you learn from the CPD activity and/or feedback?****How did you change or improve your work as a result?****How was this relevant to your profession?**

Learners Signature:

Continuing Personal Development and Learning**Reflective Account****Date**

Please fill in a page for each of your reflections, ensuring you do not include any information that might identify a specific patient or service user.

What was the nature of the CPD activity/ practice-related feedback?**What did you learn from the CPD activity and/or feedback?****How did you change or improve your work as a result?****How was this relevant to your profession?**

Learners Signature:

Continuing Personal Development and Learning**Reflective Account****Date**

Please fill in a page for each of your reflections, ensuring you do not include any information that might identify a specific patient or service user.

What was the nature of the CPD activity/ practice-related feedback?**What did you learn from the CPD activity and/or feedback?****How did you change or improve your work as a result?****How was this relevant to your profession?**

Learners Signature:

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Abbreviations

ACVPU	Alert, Confused, Verbal, Pain, Unresponsive
A,B,C,D,E	Airway, Breathing, Circulation, Disability, Exposure
ABG	Arterial Blood Gas
AF	Atrial Fibrillation
AHP	Allied Health Professional
AKI	Acute Kidney Injury
ANTT	Aseptic Non Touch Technique
BiPAP	Bi Level Positive Airway Pressure
BMI	Body Mass Index
BP	Blood Pressure
BTS	British Thoracic Society
CAM	Confusion Assessment Method
CBG	Capillary Blood Gas
CC3N	Critical Care Network National Nurse Leads
CCOT	Critical Care Outreach Team
CIS	Critical Illness Score
CK	Creatinine Kinase
CO	Cardiac Output
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure
CRP	C Reactive Protein
CRT	Capillary Refill Time
CT	Computerised Tomography
CTPA	Computerised Tomography Pulmonary Arteries

CVA	Cerebrovascular Accident
CVC	Central Venous Catheter
CVP	Central Venous Pressure
CVS	Cardiovascular
DIC	Disseminated Intravascular Coagulation
DKA	Diabetic Ketoacidosis
DH	Department of Health
DoLS	Deprivation of Liberty Safeguarding
DVT	Deep Vein Thrombosis
ECG	Electrocardiogram
EEG	Electroencephalogram
ENT	Ear, Nose, Throat
EoL	End of Life
EPAP	Expiratory Positive Airway Pressure
EPUAP	European Pressure Ulcer Advisory Panel
ESR	Erythrocyte Sedimentation Rate
EWS	Early Warning Score
FiO2	Fraction of Inspired Oxygen
GCS	Glasgow Coma Scale
GFR	Glomerular Filtration Rate
GI	Gastrointestinal
GCS	Glasgow Coma Scale
HCPC	Health and Care Professionals Council
HEI	Higher Education Institute

Abbreviations

HFNO	High Flow Nasal Oxygen
HHS	Hyperosmolar Hyperglycaemic State
HR	Heart Rate
ICP	Intracranial Pressure
ICS	Intensive Care Society
IMCA	Independent Mental Capacity Advocate
IPAP	Inspiratory Positive Airway Pressure
JVP	Jugular Venous Pressure
LMWH	Low Molecular Weight Heparin
LPA	Lasting Power of Attorney
MAP	Mean Arterial Pressure
MDT	Multidisciplinary Team
MET	Medical Emergency Team
MEWS	Modified/Medical Early Warning Score
MRI	Magnetic Resonance Imaging
NCEPOD	National Confidential Enquiry into Patient, Outcome and Death
NEWS2	National Early Warning Score2
NG	Nasogastric
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIV	Non Invasive Ventilation
NJ	Nasojejunal
NMC	Nursing and Midwifery Council
NOF	National Outreach Forum

NPSA	National Patient Safety Association
PACE	Probe, Alert, Challenge, Emergency
PARS	Patient at Risk Score
PCA	Patient Controlled Analgesia
PE	Pulmonary Embolism
PEA	Pulseless Electrical Activity
PEEP	Positive End Expiratory Pressure
PEG	Percutaneous Endoscopic Gastroscopy
PR	Per Rectum
qSOFA	quick Sequential Organ Failure Assessment
RCP	Royal College of Physicians
RRS	Rapid Response Systems
RRT	Rapid Response Team
RSVP	Reason, Story, Vital Signs, Plan
SALT	Speech and Language Therapy
SBAR	Situation, Background, Assessment, Recommendation
SEWS	Surgical Early Warning Score
SpO₂	Peripheral Oxygen Saturations
SV	Stroke Volume
SVR	Systemic Vascular Resistance
SVT	Supraventricular Tachycardia
USS	Ultrasound Scan
VF	Ventricular Fibrillation
VT	Ventricular Tachycardia
VE	Venous Thromboembolism

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