Critical Care Network-National Nurse Leads

National Competency Framework

For

Registered Nursing Associates

in Adult Critical Care

Working Version- October 2021

Learner Name:	**Signature:**

Lead Assessor/ Mentor Name:	**Signature:**

Registered Nursing Associates (NA) Critical Care Competencies

Name of Nursing Associate	
Clinical Area:	
Division:	
First date of employment:	
Start Date of Competencies:	
Due date for Completion:	
Name of Assessor:	

These competencies have been designed to provide you with the core skills required to care for critically ill patients under the supervision of a registered nurse. You will need to be able to demonstrate a fundamental underpinning knowledge in relation to all the competency statements outlined and you are advised to keep a record of any supportive evidence and reflective practice to assist you during progress and assessment reviews, these competencies will form part of your development in the Band 4 Critical Care Nursing Associate role.

These competencies are mapped to the core domains outlined in the Critical Care National Nurse Leads (CC3N) Step one competencies.

Contents

Foreword

All Nursing Associate (NA) step 1 competencies have been designed to provide you with the core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of the registered nurse (RN) which may also be your supervisor, mentor, Practice Assessor and/or Practice Educator. For the purpose of this document, we will use the term Lead Assessor for the RN that will be responsible for your assessment, you may be allocated to a different RN on a daily basis.

You will need to be able to demonstrate a fundamental underpinning knowledge in relation to all the competency statements outlined and you are advised to keep a record of any supportive evidence and reflective practice to assist you during progress and assessment reviews and to inform your Nursing and Midwifery Council (NMC) Revalidation.

It is anticipated that the NA Step 1 Competencies will form the first part of your development in critical care, and may be included as part of a local Preceptorship programme. It is expected that these NA Step 1 competencies be completed within 12 months of appointment as a Nursing Associate in critical care; however, this timeframe will be agreed locally by your line manager and will be dependent on your previous knowledge and experience, your hours and pattern of work and local service needs.

You will receive a supernumerary period, this will be agreed locally depending on your circumstances, however all newly registered Nursing Associates or new Nursing Associates to Critical Care will need a minimum of 6 weeks. The shaded competencies (highlighted blue) have been identified for completion within your supernumerary period.

Nursing Associates are encouraged to develop further skills and knowledge beyond their initial qualification and training. This may include but not be limited to intravenous medication administration, intravenous fluid administration, and blood and blood product administration. Training and the application of further skills and knowledge will be in accordance with local patient need as well as being compliant with organisational policies and training pathways. Other complementary competency or proficiency packs may therefore form part of these competencies for the nursing associate in critical care.

On starting your critical care development, you will be required to complete a Learning Contract with your Lead Assessor and Unit Manager; this will provide the foundations for your individual commitment to learning, your assessors' commitment to the supervision and support you will require and your managers' commitment to providing designated time and opportunities to learn.

We acknowledge the work of Imperial College Healthcare NHS Trust in developing this document from the original Registered Nurse Step One competencies and Nicola Witton, Lecturer in Nursing at Keele University for cross referencing these competences to the Step One Competences.

Competence is defined throughout this document as:

'The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions'

- You, the learner, should read the competency standards within this document and reflect on your current knowledge and understanding of the theories which underpin the competency statement and standards. It is important that you meet regularly with your Lead Assessor discuss your self-assessment.

- Competence must be demonstrated through **observation** of your practice against the competency statements outlined. Your Lead Assessor may however use a combination of the following techniques to support their decision.

    - Discussion & probing questions
    - Simulation
    - Completion of associated workbook
    - Reflective practice
    - Portfolio
    - Record of achievements

The Lead Assessor

The lead assessor is the person responsible for making the decision on whether the Nursing Associate has met the standards. The assessor must be occupationally competent in the standards they are assessing. All Registered Nurses (RNs) can support the assessment process. You are should complete these competencies within one year of joining intensive care, these can be used to support your personal development plan and annual appraisal.

Assessment Process

- **The Formative assessment** comes first. The learner should complete the self-assessment using the "Clinical Competencies Assessment Tool". This should be done after completing the 1st week of working supernumerary. Your assessor will use this opportunity to discuss your self-assessment scores, and provide you with constructive feedback for the criteria where you may not have demonstrated competency, and so assist you to achieve competency in **all** criteria at the Summative assessment
- **The Midpoint assessment**. The midpoint assessment will enable you to discuss your progress and to check if you need to be assigned more time to specific areas.
- **The Summative assessment** is the final assessment at the end of the period of learning and this must be completed if you have not achieved the competency for all the criteria in the Formative assessment. You must pass **all** sections of the Summative assessment to demonstrate your competence.

Evidence of Assessment must be:

Valid – relevant to the standards for which competence is claimed

Authentic - produced by the learner

Current – sufficiently recent for assessors to be confident that the learner still has that same level of skills or knowledge

Reliable – genuinely representative of the learner's knowledge and skill

Sufficient – meets in full all the requirements of the standards

Signing a Competency
If the assessor finds that teaching, rather than assessment is taking place then the competency assessment should cease. Competence can be reassessed when the learner has acquired the necessary knowledge, skills and behaviours relating to each competence standard. The "comments" box provides space for evidence of discussion feedback and action planning.

Clinical Competencies Assessment Tool

The following competency scores should be used by the learner and the assessor to indicate the level of competence at the formative stage of the competency assessment and, where required, at the summative stage of the competency assessment *(if your assessor scores you at 3 or above at the formative stage you will not need to complete the summative assessment).*

Action required:

1) Learner to complete self- assessment within 1 month of receiving the competency assessment document
2) Document 'evidence to support competency' section to demonstrate competency score
3) Set timescales with your supervisor for completion of the formative assessment
4) Complete action plan following formative assessment where required
5) Complete summative self-assessment where required
6) Set timescales for completion of the summative assessment where required

Score	Level of Competency	
1	The individual has no knowledge or technical skills in this area and needs step-by-step guidance in every aspect.	Not yet competent
2	The individual has some knowledge and is beginning to link this to practice and needs specific direction and demonstration in new skills.	
3	The individual can give simple explanations for actions and can perform technical skills safely and competently without direct supervision. The individual knows when to ask for guidance for more complex cases.	Competent
4	The individual is able to relate theory to practice and provide a sound rationale for actions. The individual is able to carry out technical skills independently with speed and consistency. The individual is able to teach and supervise others at a basic level. The individual knows when to ask for guidance from the clinical expert for the most complex cases.	
5	The individual is able to consider options, relate theory to practice and provide a sound rationale for actions. The individual is able to carry out technical skills independently with speed, consistency and confidence. The individual is able to teach and supervise others at a more advanced level. The individual is able to participate in decision making with others regarding complex cases and groups of patients.	
6	The individual is a recognised clinical expert, in terms of knowledge and skills, and is able to demonstrate sound problem solving/decision making and perform the technical task with confidence in a complex case. ~~T.~~ The individual is able to supervise and takes the lead in teaching others and delivering innovative care. However, as a NA they are aware that a dialogue must take place with a RN regarding decision making and changes to care.	

A score of 3 or more should be achieved in all criteria of the summative assessment. If a score of 3 is achieved in all criteria of the formative then there is no need to repeat that assessment.

Learning Contract

The following Learning Contract applies to the Individual Learner, Lead Assessor/supervisor and 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

LEARNERS RESPONSIBILITIES
As a learner I intend to:

• Take responsibility for my own development
• Successfully complete a period of induction/preceptorship as locally agreed
• Form a productive working relationship with supervisors and assessors
• Deliver effective communication processes with patients and relatives, during clinical practice
• Listen to colleagues, supervisors and assessors advice and utilise coaching opportunities
• Use constructive feedback positively to inform my learning
• Meet with my Lead Assessor 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 competencies in the agreed time frame
• Use this competency development programme to inform my annual appraisal, development needs and NMC Revalidation
• Report lack of mentorship/supervision or support directly to the Lead Assessor and escalate to the Clinical Educator/Unit Manager or equivalent if not resolved.

Learner Name (Print) .....

Signature ..... Date: .....

LEAD ASSESSOR RESPONSIBILITIES
As a Lead Assessor I intend to:

• Meet the standards of regularity bodies (NMC, 2008)
• Demonstrate on-going professional development/competence within critical care
• 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 nursing associates 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

Lead Assessor Name (Print) .....

Signature ..... Date: .....

CRITICAL CARE LEAD NURSE/MANAGER
As a critical care service provider I intend to:
• Facilitate a minimum of 40% of learners' clinical practice hours with their mentor/assessor and/or Practice Educator or delegated appropriate other within the multidisciplinary team
• Provide and/or support clinical placements to facilitate the learners' development and achievement of the core competency requirements
• Regulate and quality assure systems for supervision and standardisation of assessment to ensure validity and transferability of the nurses' competence

Lead Nurse/Manager Name (Print) .....

Signature ..... Date: .....

Authorised Signature Records

Print Name	Signature	Designation	PIN No:	Organisation

Step 1: Tracker Sheet

The following table allows the tracking of NA Competencies and should be completed by Lead Assessors and/or Practice Educators (or equivalent) as the individual achieves each competency statement. This provides an easy and clear system to review and/or audit progress at a glance.

Competency Statement	Date Achieved	Assessors Signature
Supernumerary competencies successfully obtained and completed		
1.1 Promoting a positive patient experience		
1.1.1 Promoting psychosocial wellbeing		
1.1.2 Visiting in Critical Care		
1.2 Respiratory System		
1.2.1 Anatomy & Physiology		
1.2.2 Respiratory Assessment, Monitoring & Observation		
1.2.3 Non-Invasive Ventilation		
1.2.4 Intubation		
1.2.5 Invasive Ventilation		
1.2.6 Tracheostomy Care		
1.2.7 Chest Drains		
1.2.8 Associated Pharmacology		
1.3 Cardiovascular System		
1.3.1 Anatomy & Physiology		
1.3.2 Assessment, Monitoring & Observation		
1.3.3 Arterial Access		
1.3.4 Central Venous Access		
1.3.5 Managing Fluid Replacement		
1.3.6 Shock		
1.3.7 Cardiac Rhythms		
1.3.8 Associated Pharmacology		
1.4 Renal System		
1.4.1 Anatomy & Physiology		

1.4.2 Assessment, Monitoring & Observation		
1.4.3 Renal Replacement Therapy (RRT)		
1.5 Gastrointestinal System		
1.5.1 Anatomy & Physiology		
1.5.2 Assessment and Management of Patients with GI conditions		
1.5.3 Nutrition in Critical Illness		
1.5.4 Associated Pharmacology		
1.6 Neurological System		
1.6.1 Anatomy & Physiology		
1.6.2 Assessment, Monitoring & Observation		
1.6.3 Sedation & Delirium Assessment and Management		
1.6.4 Pain Control		
1.7 Integumentary System		
1.7.1 Anatomy & Physiology		
1.7.2 Skin Integrity		
1.7.3 Joint Positioning & Range of Movement		
1.7.4 VTE Assessment		
1.7.5 Mouth and Eye Care		
1.8 Medicines Administration		
1.8.1 Regulations		
1.8.2 Administration		
1.9 Admission & Discharge		
1.9.1 Admission to Critical Care		
1.9.2 Discharge from Critical Care		
1.10 End of Life Care		
1.10.1 End of Life Requirements		
1.10.2 Assessment, Decision Making and Initiation of End-of-Life Care		
1.11 Intra & Inter Hospital Transfer		
1.11.1 Assisting in the preparation and transfer of the critically ill		

1.12 Rehabilitation		
1.12.1 Rehabilitation Initial Assessment and Referral		
1.13 Communication & Teamwork		
1.13.1 Communicating with Critical Care Patients		
1.13.2 Communication & Team Working		
1.13.3 Communicating in Difficult Situations		
1.14 Infection Prevention & Control		
1.14.1 Infection Prevention & Control		
1.15 Evidenced Based Practice		
1.15.1 Evidenced Based Practice		
1.16 Professionalism		
1.16.1 Maintaining Professionalism		
1.17 Defensible Documentation		
1.17.1 Documentation		
1.18 Mental Capacity		
1.18.1 Mental Capacity & Safeguarding Adults		
1.19 Leadership		
1.19.1 Demonstrating Personal Qualities		
1.19.2 Working with Others		

1.1 Promoting a positive patient experience.

The following competency statements are about the psychosocial needs of a patient during a critical care stay, the competencies outlined need to be applied to all care and treatment undertaken by the registered nurse in the critical care environment**.**

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):
Concept of holistic care and how it can be incorporated into your practice:

1: 1 Promoting psychological wellbeing	**Assessment**									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1.1.1 Holistic Care										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): **Concept of holistic care and how it can be incorporated into your practice:** • Physical • Psychological • Social and family • Spiritual and cultural										
Common feelings experienced by patients 'Waking up' in critical care to include: • Feelings of dehumanisation • Feelings of loss of self • Feelings of loss of control • Feelings of loss of time • Feelings of loss of hope • Feelings of loss of worth • Feelings of loss of reality • Feelings of loss of choice										
Impact of the following on the psychological wellbeing of critical care patients: • Sensory overload • Sleep deprivation • Pain • Confusion										

• Disorientation • Anxiety • Fear • Night terrors • Hallucinations										
Importance of developing the following with critical care patients: • A trusting relationship • Effective ways of communicating • Contribute to the development of Individualised family centred care plans under supervision of the RN										
Assisting patients to: • Regain control as far as possible • Be involved and empower patients to make decisions about their own care and treatment • Promote acceptance of the situation • Move through the grieving process Importance of giving patients and families clear explanations about care and treatment, always seeking consent before approaching patients to undertake tasks										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Always act as the patients advocate • Demonstrate kindness and compassion in all care undertaken • Promote a holistic approach to all care undertaken • 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 the patient can understand and repeat these explanations as often as needed										

• Adopt appropriate communication aids • Encourage and motivate patients to achieve independence in relevant tasks • Support in the development of care plans with patients and the family regarding treatment choices • Be open and honest with patients and families and demonstrate empathy towards their situation • Encourage family members to bring in pictures, familiar music and toiletries • Encourage patient to accept the situation they find themselves in and promote acceptance wherever possible • Respect cultural and spiritual needs • Promote normal sleep patterns • Reduce sensory overload (particularly during the night) • Give explanations for loss of time, consider use of patient diaries • Reassure patients that many patients experience similar problems during and following a critical care stay • liaise with RN regarding referral for solution focused therapy or psychological support from relevant multi-disciplinary team members if appropriate • Where used keep a clear and accurate account of the patients progress in their diary • Encourage patients and their relatives to discuss their experiences of being in critical care, for staff to learn from this • Provide patients and relatives with written information • Signpost patients and relatives to support groups and/or forums (i.e., ICU Steps)										
1.1.2 Visiting in Critical Care										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Importance of visiting and protected rest periods										

• Local units visiting policy, including children visiting in critical care, refreshments and availability of accommodation (consider ICU Steps resources for children visiting ICU) • Needs of the visitor including what information & facilities are required • Awareness of situations of when to discourage visiting or refuse entry to visitors and how to manage these situations, through conflict resolution and who to refer them to • Awareness of patient consent/ data protection, local policy/ professional guidance around the use of photography and social media										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support for patients and their families for all aspects of care • Establish a main person who acts as a point of contact for other family members • Communicate information clearly taking into account the needs of the relatives/visitor, providing written information if necessary, being aware of what information can be given over the phone • Ensure that the environment is conducive for effective communication • Document appropriate communication 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/ visitor's experience										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1.2 Respiratory System

You must be able to demonstrate through discussion and **practice** essential knowledge of patients with impaired respiratory function.

1.2 Respiratory System	**Assessment**									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:2.1 Anatomy and Physiology										
The anatomy and physiology involved in respiration: • the components of breathing: nose, pharynx, larynx, lungs, bronchi • role and function of the components of the respiratory system • gas exchange • VQ mismatch and patients at risk										
Risk factors for developing respiratory failure: Type I and Type II respiratory failure and give examples from practice • Signs & symptoms of respiratory failure • The following conditions: o COPD o Asthma o ARDs o Pneumonia and Ventilator Associated Pneumonia (VAP) o Pulmonary Embolism										
2.2 Respiratory assessment, monitoring and observation.										

You must be able to demonstrate through discussion essential knowledge of and its application to your supervised practice • Normal parameters for respiratory observations • Rate/Depth/ pattern of respiration • Heart rate • Skin Colour, peripheral and central cyanosis • Indications for, and limitations of pulse oximetry • Use of accessory muscles • Sputum assessment • End tidal Carbon dioxide ($EtCO_2$) • Able to sample ABG from arterial line and recognise normal values, and basic analysis of respiratory, metabolic acidosis/ alkalosis and escalate findings to RN										

Able to implement *(under indirect supervision by an RN)* actions to:
• Restore respiratory function in response to observations including:
  ○ Oxygen therapy
• Indications for potential complications:
  ○ Signs & symptoms of oxygen toxicity
• Various methods of oxygen delivery
• Patient positioning
• Deep breathing exercises
• Effective coughing (including cough assist if available)
• Liaise with therapy team (under direction of RN)
• Humidification
• Patient positioning
• Deep breathing exercises
• Effective coughing
• Safely perform ABG sampling and discuss results to RN										

Able to assemble relevant equipment and administer oxygen therapy via: ○ A simple face mask ○ A venturi system ○ Nasal cannulae ○ Reservoir mask • Set up and use humidification methods • Set up and use pulse oximetry ○ Appropriately select probe site ○ Check CRT & proximal pulses • Provide appropriate intervention for patients experiencing airway problems: ○ Position ○ Head tilt/chin lift/jaw thrust ○ Insertion of airway ○ Manual ventilation										
1.2.3 Non-Invasive Ventilation										
You must be able to demonstrate through discussion essential knowledge of and its application to your supervised practice • Care and management of the patient requiring Non-Invasive ventilation (NIV) ○ Indications ○ Describe contra-indications ○ Modes/settings used • Use of capnography										
You must be able to undertake the following in a safe and professional manner: Under supervision and with appropriate support, manage the patient who requires: • Non-invasive ventilation: • Accurately monitor & document ventilator observations • Seek support & advice as appropriate • **Under direct supervision from the RN** -Set alarm limits appropriately for specific patients										
1.2.4 Intubation										
You must be able to demonstrate through discussion essential knowledge of (and its application to your										

supervised practice): Indications for intubation Potential complications of intubation Process of intubation, including equipment Preparation of the patient Discuss procedure for application of cricoid pressure Causes for emergency reintubation										
You must be able to undertake the following in a safe and professional manner • Complete ABCDE assessment of the patient about to undergo a rapid sequence induction • Prepare medications for which you are competent • Assist during procedure • Applies cricoid pressure • Secure ETT/tracheostomy tube • Check and confirm position of tube • Document length and position of tube • Check cuff pressure										
1.2.5 Invasive Ventilation										
You must be able to demonstrate through discussion essential knowledge of (and its application to supervised practice): • Care and management of a patient requiring mechanical ventilation (to include basic modes of mechanical ventilation): • Modes of ventilation used in the clinical area including: o Spontaneous modes o Pressure controlled ventilation o Volume or time cycled ventilation o Methods of humidification • Normal parameters of ventilation including: o Rate o Tidal volume o Minute volume o Set pressures o PEEP										

○ I:E Ratio ○ Pressure support ○ Triggers • Indications for weaning and extubation • Management of Secretions including: ○ Physiotherapy ○ Indications for suctioning ○ Appropriate monitoring and observations during the procedure • Potential complications associated with suctioning ○ Correct pressure ○ Correct sized suction catheter ○ Correct procedure ○ Sub-glottic suctioning • Aware of the effects of prolonged bed rest on respiratory function										
You must be able to undertake the following in a safe and professional manner: Under supervision and with appropriate support, manage the patient who requires invasive ventilation: • Provide emotional reassurance and support • Accurately monitor & document ventilator observations • Seek support & advice as appropriate • Set alarm limits appropriately for specific patients • Adhere to ventilator care bundle • Perform appropriate oral hygiene to reduce the risk of ventilator associated pneumonia • **Under direct supervision of RN** be able to hand ventilate a patient • **Under direct supervision from the RN Set alarm limits** appropriately for specific patients • Monitor Et CO_2 • Implement weaning **under supervision by the RN** • **Assist the RN** with extubation										

• Care for the patient post extubation • Suctioning: ○ Select appropriate suction pressures ○ Select appropriate catheter size ○ Suction using the correct technique via: ▪ Naso-oropharyngeal ▪ ET tube ▪ Tracheostomy ○ Monitor the patient prior to, during and after suctioning ○ Accurately monitor & chart findings ○ Inform/liaise with relevant MDT members ○ Practice in a manner that will minimise cross infection ○ Correctly and safely dispose of container/contents/suction equipment as per local policy										
1:2.6 Tracheostomy Care										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Anatomical position of tracheostomy • Indications for insertion of a tracheostomy • Types of tracheostomies ○ Percutaneous tracheostomy ○ Surgical tracheostomy ○ Mini tracheostomy • Knowledge of tracheostomy care bundle and NCEPOD best practice standards • Importance of: ○ Securing tube safely ○ Changing/cleaning inner-tube ○ Checking cuff pressures ○ Wound care management • Tracheostomy emergency algorithm and best practice standards, including bedside safety equipment, escalation for blocked tube, unplanned decannulation (Refer to national and local guidelines)										

You must be able to undertake the following in a safe and professional manner • Provide emotional reassurance and support • Care for the stoma site • Clean and change the inner tube • Appropriately monitor the patient following tracheostomy insertion • Observe a decannulation • Appropriately monitor the patient following decannulation • Appropriately implement care in line with national/local guidelines • Knowledge of associated swallowing assessments processes and difficulties How to refer patients to Speech and Language Therapy (SLT)										
1.2.7 Chest Drains										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Indications for chest drain insertion including: o Pneumothorax o Haemo-pneumothorax o Pleural effusion o Empyema • General care and management: o Indications for use of chest drain clamps o Drainage o Swinging o Bubbling o Bottle changes o Dressings o Removal • Application of low thoracic suction to a chest drain • Potential complications associated with chest drains										

You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Observe and assist with chest drain insertion • Perform routine respiratory observations **Escalate and changes or concerns to RN** • Effectively manage the drain: o Position of bottle o Appropriate/cautionary use of drain clamps, in line with local guidance o Dressings o Changing/disposal of bottles o Monitoring drainage o Application of low suction										
1.2.8 Associated Pharmacology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Commonly used medications for respiratory care; o Bronchodilators/Nebulisers o Steroids o Sedation/paralysing agents o Antibiotics o Analgesia										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Safely prepare and administer medications as above to support the respiratory system within sphere of competence • Monitor effects of medication										

In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards

I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally.

Signature of Learner: …… Print name: …….. Date: ……

1.3 Cardiovascular System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired cardiovascular system

1.3 Cardiovascular System	**Assessment**									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1.3.1 Anatomy & Physiology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Structure and function of the heart (include chambers and valves) • Identify major/minor blood vessels • Oxygenated/deoxygenated blood flow • Determinants of the normal cardiac cycle • Determinants of blood pressure (BP= COxSVR) • Determinants of central venous pressure • Cardiac Conditions: o Hypertension o Peripheral Vascular Disease o Angina (stable/unstable) o Myocardial Infarction o Left Ventricular Failure o Cardiomyopathy o Acute Coronary Syndrome										
1.3.2 Assessment, Monitoring & Observation										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Indications for haemodynamic monitoring in relation to the critically ill adult: o Invasive o Non-Invasive • Sepsis identification criteria: o Sepsis criteria o Red Flag Sepsis criteria										

(non-laboratory sepsis criteria + HR, RR or ACVPU) **You must be able to undertake the following in a safe and professional manner:** • Provide emotional reassurance and support • monitor the patient requiring cardiovascular support • Accurately perform and correctly document a full cardiovascular assessment including: o Pulse/ECG o Blood pressure including MAP o Temperature o Urine output o Fluid therapies o Capillary refill time o Skin turgor o Limb temperature o Blood results and the effect of abnormal results o Biochemical markers recognise when a result in outside of normal limits and escalate to RN Vascular observations including pulses, colour and perfusion										
1.3.3 Arterial Access										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Choice of arterial cannula sites • Associated hazards and complications of arterial cannulas/lines • Reasons for the removal of an arterial cannula										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Prepare for and assist in the safe insertion of an arterial cannula • Correctly prepare and prime a transducer										

system • Correctly attach a transducer to an arterial cannula • Correctly zero a transducer system • Correctly set appropriate alarm limits under indirect supervision by an RN • Apply an appropriate dressing in accordance with local policy • Correctly obtain a blood sample from the arterial cannula • Safely remove an arterial cannula										
1.3.4.Central Venous Access										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Choice of sites for central venous access • Associated hazards and complications of central venous catheters and systems • Reasons for the removal of a central catheter										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Aware that line position must be checked before use in accordance with local policy • Correctly prime a transducer system • Correctly attach a transducer to a central venous catheter • Correctly zero a transducer system • Correctly set appropriate alarm limits and discuss with an RN • Apply an appropriate dressing in accordance with local policy • Correctly obtain a venous sample from the central line • **Under direct supervision by a RN** Safely remove a central line										

1.3.5 Managing Fluid Replacement										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Clinical indications that necessitate fluid intervention • Differences between colloids, crystalloids and blood products • Provide emotional reassurance and support • Accurately record fluid balance according to local policy										
1.3.6 Shock										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Classifications, signs and symptoms and treatment of: o Cardiogenic Shock o Hypovolemic Shock o Distributive Shock including: - Septic Shock - Neurogenic Shock - Anaphylactic Shock										
You must be able to undertake the following in a safe and professional manner: Provide emotional reassurance and support Recognise, report, interpret (under supervision) the signs and symptoms of the above Implement the prescribed treatments (within your remit of administration and local policy) and interventions and escalate concern appropriately										
1.3.7 Cardiac Rhythms										
You must be able to demonstrate through discussion essential knowledge of (and its application to supervised practice): Normal conductive pathway Monitoring of 3 lead / 5 lead ECG Normal sinus rhythm Life threatening cardiac dysrhythmias and										

their management • Atrial fibrillation • Ventricular tachycardia • Ventricular fibrillation • Asystole • Pulseless Electrical Activity (PEA) Your role within a cardiac arrest team Key resuscitation equipment • Location • Application of use										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Correctly attach the patient to a cardiac monitor • Correctly check 'emergency' equipment including defibrillator • Correctly identify and respond to o Bradycardia o Tachycardia o Ectopic beats o Atrial fibrillation o Atrial flutter • Correctly identify and follow BLS guidelines										
1.3.8 Associated Pharmacology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Indications for and the basic effects of the following medications o Diuretics • Indications for choice and the following fluid challenges: o Crystalloids o Colloids o Blood products **<u>Do not administer</u>, but monitor and understand the effects of** o Inotropes o Vasopressors o Vasodilators										

o Anti-arrhythmic o Anti-hypertensive										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Safely prepare and administer medications used to support the cardiovascular system within your scope of professional practice.										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in **all of the Standards**										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1.4 Renal System

You must be able to demonstrate through discussion and **practice** essential knowledge of patients with impaired renal function

1.4 Renal	**Assessment**									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1.4.1 Anatomy and Physiology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Renal System anatomy and physiology • Functions of the kidney • Production of urine • Control of fluid and electrolyte balance • Renal blood supply • Causes of acute kidney injury o Pre-renal - Volume depletion - Dehydration - Sepsis - Heart Failure o Intra-Renal (intrinsic kidney failure) - Glomerular disease - Toxins (inc. nephrotoxic drugs) - Contrast Medium - Untreated pre-renal failure o Post–renal (obstruction) - Blocked urinary catheter - Stones - Enlarged prostate Difference between acute renal injury and chronic renal failure Aware of negative effects of prolonged bed rest on renal function										
1.4.2 Assessment, Monitoring & Observation										
You must be able to demonstrate through discussion essential knowledge of (and its										

application to your supervised practice): • Methods of measuring and recording fluid output: o Urine output o Fluid loss from drains o GI loss (including vomit, naso-gastric drainage, faeces) o Problems recording loss during operative procedures o Bleeding (external and internal) o Insensible loss (different routes and specific patients at risk) • Methods and techniques for monitoring the fluid status and balance including: • Maintenance of fluid balance charts • Patient weight • Urine output relative to weight • Urinalysis Understands which bloods relate to renal profile and when these are required • Basic considerations in renal injury/ failure: o Nephrotoxic drugs o Drug dose adjustments in renal injury/ failure o Fluid overload o Hyperkalaemia										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Demonstrate the ability to accurately measure and record fluid balance and report abnormalities to the RN • Can describe the normal parameters of Urea & Creatinine, Potassium, Chloride, Sodium, Bicarbonate, Haemoglobin and escalates out of range results to the RN • Identify factors which may affect the assessment of renal function (e.g. blocked catheters and urinary retention) • Administer appropriate care to the patient with a urinary catheter (according to national guidelines and local policy) • Utilise locally available equipment o Catheterisation equipment o Urometers • Weigh patients routinely in line with local policy										

• Record hemodynamic parameters as directed • Appropriately seek help in the presence of abnormal physiological/pathological results										
1.4.3 Renal Replacement Therapy (RRT)										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • the difference between renal dialysis and CRRT The indications for RRT o Fluid overload o Hyperkalaemia o Metabolic acidosis o Toxin clearance										
You must be able to undertake the following in a safe and professional manner: • Identify the main alarm categories and their relevance how to appropriately dispose of waste products according to local infection prevention guidelines • Clean and store filtration machine in line with local policy and store as appropriate										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1.5 Gastrointestinal System

You must be able to demonstrate through discussion and **practice** essential knowledge of patients with impaired gastrointestinal function

1.5 Gastrointestinal System	Assessment									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:5.1 Anatomy & Physiology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Gastrointestinal tract and metabolism: o Oral cavity and swallowing o Oesophagus o Stomach o Small bowel o Large bowel o Appendix o Rectum • Pancreas: o Function and production of insulin o Role of pancreatic enzymes Liver & biliary system: o Liver o Gall Bladder o Common bile ducts o Spleen • Causes of gastrointestinal dysfunction: o Obstruction o Inflammation o Perforation o Infection o Ulceration o Factors that may affect motility (sympathetic and parasympathetic, drugs, surgery) • Causes of pancreatic dysfunction: o Pancreatitis o Obstruction o Diabetes (Type 1 and 2)										

o Cystic Fibrosis • Causes of Liver or biliary dysfunction: o Obstruction o Inflammation o Infection (biliary sepsis) o Perforation Cirrhosis/ acute liver disease (distinction of acute and chronic)										
1.5.2. Assessment and management of Patients with GI Conditions										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): Normal and absent bowel sounds Nutritional assessment tools appropriate for use in critical care										
1.5.3. Nutrition in Critical Illness										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Factors contributing to nutritional impairment in critical illness • Nutritional assessment tools appropriate for use in critical care • Local nutritional care bundles in critical illness • Different types of feeding and the indications for use: o Nasogastric/NJ /gastrostomy (PEG /RIG) o Parental nutrition o Oral • Stomach/intestinal fluid aspiration: o Normal appearance and content of stomach/intestinal fluid o Potential abnormal appearance and content of stomach/intestinal fluid depending on the individuals presenting medical condition										

Nasogastric insertion in critical care • Correct placement of nasogastric tubes (local policy & NPSA guidance) • Prevention and of blocked enteral feeding tubes • Care of enteral feeding tubes • Types and benefits of various feeding tubes Complications of nasogastric feeding in critical illness • Care of parenteral nutrition lines • Complications of parenteral nutrition • Management of bowel function in critical care • Nutritional needs of adults and how to maintain a healthy gut: o Food groups required o Calorific intake o Normal blood sugar Types of nasogastric feed										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support in relation to assessing the patients nutritional requirements • Perform an assessment of the patient's nutritional status using an appropriate tool or local protocol • Manage the care of a patient with a nasogastric tube including: • Method of Insertion (depending on tube type) o Correct positioning of patient o Confirming placement by pH testing (understanding normal values) o Correct external measurement o When to x-ray o Absorption and aspiration • Administration of medication: o Correct anchoring of NG device o Monitoring for pressure sore prevention o Correct size and appropriate tube selection										

• Assessment of bowel sounds										
You must be able to undertake the following in a safe and professional manner: • Manage the care of a patient with a naso-jejunal tube; insertion, position and care of tube • On-going assessment of nutritional needs • Liaise with the MDT where appropriate • Monitor patients during nutritional support • Monitor blood glucose in critically ill patients according to local policy, escalate measurements to RN to and implement care as directed. • Recognition and management of the patient experiencing hypo/hyperglyceaemia • Record bowel opening accurately and monitor for diarrhoea and constipation • **Under direction of the RN** implement appropriate measures to manage constipation and diarrhoea, including: o Fluid management o Pharmacological management o Tissue viability issues o Patient dignity o Utilise local bowel management protocols appropriately (faecal collection systems) o Adheres to local guidelines for managing constipation o Adheres to local guidelines for management of C-Diff • Identify at risk/high/severe risk re feeding patients in line with local guidance • Replace electrolytes and follow reduced calorific nutrition as directed Provide emotional reassurance and support in relation to assessing the patients nutritional requirements • Accurately measure and record nutritional status and report										

abnormalities to the RN • Follow guidelines in the management of blood glucose control and feeding regimes • Monitor patient's biochemistry and haematology results, escalate abnormal findings to the RN • Administer appropriate care to the patient with enteral and parental devices (according to national guidelines and local policy) • Weigh patients routinely in line with local policy • Manage stoma and/or drains in accordance with national and local policy and guidelines • Monitor and document stoma site appearance (such as colour, positioning, functioning) and escalate any concerns										
1:5.4 Associated Pharmacology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Commonly used medications for GI management: o Prokinetics & motility o Laxatives o Anti-stimulants o Probiotics • Discuss when the above are unsuitable and/or contraindicated										
Do not administer but monitor and understand the effect of • Insulin/ hypoglycaemic agents • Safely prepare and administer medications used to support the gastrointestinal system within the scope of your professional practice										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1.6 Neurological System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired neurological function.

1.6 Neurological System	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:6.1 Anatomy & Physiology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Gross structures of the nervous system • Pupil responses o How they are regulated o Abnormal responses and possible causes including focal and generalised deficit										
1.6.2 Assessment, Monitoring & Observation										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Purpose of neurological assessment tools: o ACVPU tool o GCS tool • Recommended frequency of GCS assessment and escalation of frequency • Logical steps to assess each component • Scoring system for eye opening: o Correct method of assessment of eye opening to voice and painful stimulus o Correct type of painful stimulus to assess for eye opening o Correct method for assessing pupil response to light including direct and consensual light reflexes as an adjunct to GCS • Scoring system for verbal/sound response: o Correct method of assessing orientation and verbal/sound response o Focal verbal deficit such as aphasia,										

receptive and expressive dysphasia • Scoring system for motor response: o Recording of best limb response from arms o How to identify the ability to obey commands o Comparing left to right to identify focal deficit o Differentiating between normal power, mild weakness and severe weakness o Use of correct method of painful stimulus when assessing limb response o Reflex arc o Correct use of trapezius pinch o Contra-indications to orbital pressure and sternal rub o Correctly identify ability to localise o Correctly identify flexion o Correctly identify abnormal flexion o Correctly identify extension o Correctly identify no response										
Limitations of the GCS as an assessment tool: o Assessment of vital signs to ensure there is a complete data set: o ACVPU score for assessing conscious level compared to GCS assessment o Adjuncts to the GCS for detecting deterioration in clinical condition such as NEWS2 or local track and trigger tool • Intracranial and extracranial reasons for deteriorating GCS										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Accurately assess ACVPU or GCS and record it • Identify deterioration and seek appropriate advice and guidance • Identify focal deficits such as; gag and swallow reflexes, pupil, verbal and limb responses and correlate with anatomy and physiology										

1:6:3 Sedation & Delirium Assessment and Management										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Relevant best practice, care bundle and NICE guidance: o Strategies to prevent, recognise and treat delirium o Screening for risk factors on admission o Person centred care o Mental Capacity Act o Importance of accurate assessment/ recording and communication between care teams, patient and family • Characteristics of delirium: o Changes in mental state o Inattention o Disorganised thinking o Altered consciousness • Three clinical subtypes of delirium and their presentation: o Hyperactive o Hypoactive o Mixed • Assessment of delirium using appropriate tool e.g., CAMICU • Treatment options if delirium is diagnosed • Sedation and indications for use • Assessing the adequacy of sedation using a sedation scoring tool • Different sedation scoring systems available • Strategies for administering sedation • Types of sedation used in the context of critical care and their effects • Importance of sedation holds • Confirm the desired sedation level for the patient • Correctly assess patients' sedation level using the local sedation scoring system • Accurately record sedation levels at the recommended time intervals in line with local guidance •Escalate to the RN if desired sedation levels										

cannot be achieved • Undertake delirium risk assessment										
Do not administer but monitor and know the effects of common sedation agents your area.										
• Care for the sedated patient in relation to: o Airway protection o Mechanical ventilation o Hygiene needs o Pressure area care o Nutritional needs o Privacy and dignity • Inform medical and senior nursing staff of changes in desired sedation level										
1:6:4 Pain Control										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Anatomy and physiology relating to pain perception • Concept of pain as the 5th vital sign • Basic pain categories: o Chronic pain o Acute pain o Break through pain o Withdrawal pain o Neuropathic pain • Methods of pain assessment and non-verbal signs of pain: o Utilisation of a pain measurement tool • Importance of excluding causes of agitation such as: o Constipation o Full bladder and/or blocked urinary catheter o Hypoxia o Poor positioning Incontinence										

Pharmacological treatment options for different types of pain: Non-opioid medications o Adjunct medications such as amitriptyline o Non-steroidal anti-inflammatory drugs o Anticonvulsants such as gabapentin and carbamazepine o Analgesic skin patches										
Do not administer but monitor and understand the effects of o Opioid medications o Patient controlled analgesia (PCA) and Epidurals as per Local Trust Training requirements										
Utilise Non-pharmacological strategies for pain control: o Deep breathing exercises o Use of heat and cold o Reassurance and control of environmental stimulus o Positioning for comfort • Use of relaxation and diversion, limiting the noise and lighting										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support Assess pain score using local scoring system and document findings clearly • Assess and document of physiological signs of pain • Escalate to the RN if unable to resolve pain. • Use positioning and posture to maximise patient comfort • Ensure good communication between the patient and MDT										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1:7 Integumentary System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired integumentary system

1.7 Integumentary System	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:7:1 Anatomy & Physiology										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Skin: o Layers of the skin o Accessory organs o Functions of the skin • loss of muscle tone o Identification of joints										
1:7:2 Skin Integrity										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Risk assessments and the nursing responsibilities related to patients at risk of pressure damage • High risk areas of the body for pressure damage • Grades 1- 4 pressure damage (using the European Pressure Ulcer Advisory Panel – EPUAP) • Differences between: o Pressure damage o Moisture lesions o Shear and/or friction force damage • Practice required to prevent pressure damage: o Surface o Keep moving										

o Incontinence / moisture management o Nutrition • Various pressure relieving devices available locally and the agreed Various pressure relieving devices available locally and the agreed pathway for accessing these • Local reporting system for pressure related damage • Importance of collecting and auditing data on pressure area damage in order to improve pressure area care within the clinical area • Associated costs of pressure damage: o Cost to the patient in terms of delayed rehabilitation and pain o Financial costs										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Surface management: o Risk assess the patient's skin using an appropriate risk assessment tool escalate concerns to the RN o Determine the appropriate surface for the identified risk under indirect supervision by the RN o Assess correct use of devices / equipment and that they are in good working order (in accordance with local policy) o Ensure regular visual checks of at risk areas are carried out *o* Encourage the patient to change their position or be repositioned o Manage people and equipment resources in order to achieve positioning objectives, such as the maximum length of time a patient is sitting out in a chair o Regularly reposition unconscious										

patient in line with local policy or skin bundle o Minimise shear and/or friction damage with correct use of manual handling devices o Increased moisture damage and incontinence management: - Identify moist or wet skin - Treat dry skin with moisturisers - Cleanse the skin at the time of soiling and use topical agents that act as moisture barriers - Identify incontinence associated dermatitis, and differentiate this from pressure damage - Offer toileting opportunities based on identified individual need - Instigate any incontinence device in line with local policy • Nutrition: *o* Report any pressure damage in line with local policy o Measure the reliability of the care delivered within the clinical area by measuring both pressure damage outcomes and compliance with processes o Prevent pressure damage from endotracheal tube holders, by either repositioning as needed, or using commercial products that avoid pressure o Refer patients to other members of the MDT when specialist input is needed: - Tissue viability - Dietician - physiotherapy - occupational therapy										
1:7:3 Joint Positioning & Range of Movement										

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Concept of 'range of movement' and the anatomical structures that could be damaged by poor joint positioning • Joints that are most at risk of damage • Concept of foot drop										
You must be able to undertake the following in a safe and professional manner: • Undertake a full range of passive exercises for the patient at the time intervals specified, as directed by the RN or other registered professional • Position patient's ankles to reduce the risk of foot drop • Apply any appropriate ankle/foot splint for patients at high risk of foot drop under supervision of the RN or other registered professional • Identify patients at high risk of joint damage (e.g. long stay, oedematous) • Position shoulders to prevent excessive joint stretch when lying a patient on their side										
1:7:4 VTE Assessment										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Importance and need to assess all patients admitted to hospital against the VTE assessment • Importance of assessing the patients level of mobility • Need for all patients (both surgical and medical patients) with significantly reduced mobility to be further VTE risk assessed • Understand local and NICE										

guidance • Types of thromboprophylaxis: o Pharmacological o Mechanical • Complications of pharmacological VTE prophylaxis										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Identifies and documents risks identified to the individual patient • Instigates mechanical prophylaxis in line with local policy, under indirect supervision for the RN • Safely administers prescribed pharmacological prophylaxis • Involves patient in prevention of thrombosis as appropriate Reviews VTE risk assessment in line with local policy										
1:7:5 You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):										
The importance of the following: • Eye Care • Mouth care o Describe mouth care assessment tools o Describe risks to patient from VAP o Differentiates between care requirements for ventilated and self-ventilating patients o Identifies local mouth care products and when to use them o Identifies specific risks to sedated patients need for eye assessment and care										

You must be able to undertake the following in a safe and professional manner: Performs and documents mouthcare as per local guidance on: an intubated and ventilated patient self-ventilating patient Performs assessment and documents (under supervision and guidance of the RN) appropriate eye care										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1.8 Medicines Administration

You must be able to demonstrate through discussion and **practice** essential knowledge of the following. This should be completed in conjunction with local

1.8 Medicines Administration	Assessment									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:8:1 Regulations										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • National and local legislation, guidelines, protocols and policies for the administration of medication: o Medicines Act o Medication Compatibilities. o Misuse of Drugs Act o NMC Code of Professional Conduct o NMC Medicines Administration Standards • Health & Safety regulations relevant to medicines administration in critical care: o COSHH o Safe handling and disposal of sharps o Standard precautions & personal and protective clothing/equipment o Hand hygiene • Legal and ethical consideration of medication: o Legal requirements o Capacity Assessment o Informed consent o Acting in the patients best interest									

You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Take responsibility as an administrator under the listed guidance and as per scope of competency.										
1:8:1 Administration										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Process of administration in critical care and the importance of working within your own scope of practice: o Consent o Prescription checks o Preparation of medications o Administration of medications o Monitoring during administration o Safe discontinuation of medications under supervision o Monitoring post administration o Safe disposal of equipment o Supervision & training of others o Role and responsibility of prescribers.										
You must be able to undertake the following in a safe and professional manner: Provide emotional reassurance and support • Identify the correct patient always seeking positive confirmation of the individual's identity before starting the preparation of medicines in critical care, in both: o Conscious patients o Unconscious patients • Participate in critical care patient's medication history: o Allergies and sensitivities o Regular medications and their										

effects on critical illness and presenting condition o Critical care medications and their effects on pre-existing co-morbidities • Adherence to the following practices used in critical care to minimise the risk of harm to the individual or reduce the risk of error in medication and fluid administration: o Identity check o Prescription check o Weight check o Prescriber and administrators responsibilities o Required and/or continuous monitoring and observation during administration o Knowledge of the medication and the expected effects on the individual • Use the 5 R's when administering any medication: o Right patient o Right medication o Right dose o Right route o Right time • Prepare and use oral, intramuscular, subcutaneous and inhalation medications in critical care adhering to the following guidance: o NMC Code o NMC Medicines Administration Standards										
Apply local policy for infusion device competencies										
Consider the route of administration: o Oral o Sublingual o Nasogastric o Nasojejunal o Orogastric o Rectal o Topical o Intra muscular injection o Subcutaneous injection o Continuous intravenous infusion										

• Access information in relation to drug administration if you are unfamiliar with the prescribed medication: o Critical care pharmacist o On call pharmacist o Injectable medicines guide (MEDUSA) o Enteral medication guidelines o BNF o Online data sheet compendium o Manufactures instructions o Local administration guidance • When preparation of medications: o Demonstrate competence in mathematical calculations in line with local policy • Select the appropriate type of equipment to use in relation to the medication being administered and the route of administration prescribed: o Consumables, taking into account local policy for line changes o Oral syringes for enteral preparations o Gloves/lubricant for rectal • Identify and manage signs of anaphylaxis: o Early identification o Signs and symptoms o Emergency treatment o Communication with multidisciplinary team o Continuous monitoring and re evaluation o On-going treatment of anaphylaxis o Reporting of anaphylaxis, in line with local policy Review of regular prescriptions										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:9 Admission & Discharge

You must be able to demonstrate through discussion and **practice** essential knowledge of admission and discharge to ICU

1.9 Admission and Discharge	Assessment									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:9:1 Admission to Critical Care										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Indications and rationale for patient admission to the critical care setting • The nursing associate responsibilities related to patient admission processes • Significance of initial patient physical and psychological assessments Setting up a bedspace for admission and perform safety checks • Range of relevant trust, unit, network policy documents that support patient admission to critical care o Essential Trust Documentation o Operational Guidance for Critical Care Services o Outreach teams and/or other supportive structures • Importance of the nursing associates role associated with the support and providing information for accompanying family members/carers or patient representatives on admission										

• Importance of discussing the patients usual special needs or requirements with the family: (including but not exclusive to): o Hearing aids o Glasses o Mobility aids/equipment • Importance of providing the family with timely updates and explanations • Importance of providing families with the time and opportunity to ask questions and discuss any concerns • Importance of obtaining infection control status and performing relevant infection control screens, • The issues related to data protection and patient confidentiality										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Collate, prepare and complete appropriate documentation in electronic and paper formats for admission (inclusive of but not limited to): o Completion and use of handover documentation • Preparation of supportive equipment (inclusive of but not limited to): o Bed/mattress o Monitors o Oxygen, suction, re-breathing circuit, ventilator o Volumetric pumps o Disposables and PPE o Safety equipment • Demonstrate proficiency in receiving the patient, assessing, recognising and implementing the priorities associated with care activities (inclusive of but not limited to): o Physical and psychological										

assessment processes: o A,B,C,D,E assessment o Mental Capacity • Ascertain the patients infection risk and take appropriate step to isolate and instigate protective equipment as required • Safely handle the patient, equipment and the patient's property • Provide timely information to family/carers or patient representatives as appropriate and document the information you relayed										
1:9:2 Discharge from Critical Care										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Current national, network and local policies, protocols and guidelines in relation to the discharge of patients from a critical care area: o NICE CG 50 o NICE CG 83 o Outreach follow up • Roles and responsibilities of all MDT members involved in critical care patients discharge planning • Different requirements that need to be considered to support the patients personal and socio-cultural needs following a critical care stay • Importance of keeping the individual and family members informed, offering reassurance about what you are doing and any relevant aspects involved in the development of the discharge plan: Implement as directed the following procedures in preparation for discharge o Removal of lines o Removal of monitoring o Follow up/rehabilitation process										

• Importance of establishing that the patient has understanding, can recall and repeat information provided • MDT members responsible for each aspect of the individuals' care plan and rehabilitation needs, and how to appropriately contact them and inform them of the patients discharge from critical care • Types of information that must be recorded in relation to different aspects of the discharge plan: o Discharge summary of critical care stay o Condition at time of discharge (system based approach) o Continuing treatment and rehabilitation plans *o* Infection risk o Invasive lines/devices o Equipment required • The additional considerations you need to make when discharging a patient with a tracheostomy: o Tracheostomy passports/pathways o Safety equipment o Emergency algorithms o Designated wards o Ward staff capacity and capability to receive patients safely o Tracheostomy education & training o Decannulation o Time of discharge o AHP support										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support • Remove all invasive lines/device that are no longer required • Discontinue all appropriate monitoring • Obtain a full blood profile in line										

with local policy and NCEPOD • Obtain discharge NEWS2 or equivalent local track and trigger score • Complete all rehabilitation assessments require on discharge from critical care in line with local policy • Communicate appropriately with other MDT members during and following discharge regarding the condition, treatment plans and follow up arrangements: o Outreach services o Bed management teams/systems o Patient diary follow up teams • Provide discharge information and support to the individual and significant others • Organise any necessary medications, equipment and rehabilitation aids • Identify any reasons for delay in discharge and escalate to the RN • Record, monitor and escalate the following through the appropriate department in line with local policy: o Delayed discharge o Discharges out of hours o Privacy & Dignity/Single sex Accommodation										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:10 End of Life Care

You must be able to demonstrate through discussion and practice essential knowledge of end of life care

1.10 End of Life Care	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:10.2 Assessment, Decision Making and Initiation of an End-of-Life Care Plan										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Ethical dilemmas in caring for the critically ill patient nearing the end of life including organ and tissue donation • Concept of futility and prolonging life • Legal definitions of death • Stages a patient may pass through within the dying process • Role of the broader MDT in End-of-Life care: o Palliative Care Team o Bereavement Support o Pastoral Care o Specialist Organ Donation Nurse • Treatment algorithms as part of individualised End of Life Care planning o Pain o Nausea o Agitation o Dyspnoea o Respiratory Tract Secretions • Rapid discharge policies • Understand the benefits of organ and tissue donation for both donor										

families and recipients										
You must be able to undertake the following in a safe and professional manner: • Effectively communicate with patient and family throughout the end-of-life stages, • Identify any resources required • escalate and potential problems that can arise as individuals progress towards their End of Life • Implement aspects of the individualised End-of-Life care and treatment plan promptly, in the correct sequence, and at the earliest possible opportunity, • Demonstrate an understanding of the emotional and spiritual support the patient and family may require • Demonstrate understanding of the families religious and spiritual needs immediately following death (including but not limited to): o Assemble all relevant equipment and assisting with last offices o Relatives/carer time spend at the bedside • Following the death of a patient, facilitate processes after death (including but not limited to): o Collection of death certificate and patient property o Provision of support documents o Discussions with regards to tissue and/or organ donation										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1.11 Intra & Inter Hospital Transfer

You must be able to demonstrate through discussion and practice essential knowledge of

1.11 Intra & Inter Hospital Transfer	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:11.1 Assisting in the preparation and transfer of the critically ill										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Expected sequence of events • Importance and implications of time critical transfers Assist with preparation of the patient and equipment prior to transfer • Methods, procedures and techniques for the portable monitoring and the types of equipment required during transfer (outline the calibration requirements and battery life expectancy/expiry date of each): o Mechanical Ventilator o Oxygen supply (including flow rates and journey time) o Vital signs monitor o Invasive lines o Infusion devices/syringe pumps o Suction equipment o Transfer bag o Spinal board o Continuous ECG o Arterial blood pressure versus non - invasive blood pressure o SpO2 o Continuous capnography with wave form analysis o CVP										

o Temperature: o Contents of the local emergency/transfer bag and identify the situations in which it may be required o Process and sequence of communication required prior to, during and following transfer o Safe moving and handling of the individual and equipment being transferred o Needs of family for information about transfer • Documentation that needs to be completed for intra & inter hospital transfer: o Transfer form o Physiological observation chart o Reporting of clinical incidents o Audit tool										
You must be able to undertake the following in a safe and professional manner: • Provide emotional reassurance and support Assist in the physiological optimisation/stabilisation of the patient prior to transfer • Assist in the preparation of equipment and resources: o Airway management o Portable ventilation o Suction equipment o CV support o Vital sign monitoring o Fluid therapy & pharmacological requirements o Infusion devices/syringe drivers o Transfer bag o Psychological support • Assist in the location, calibration and safely set up monitoring and transfer equipment including: o Alarm parameters o Prepare electromechanical devices										

o Supplementary gases o Transportation • Assist in the care for the family of the patient being transferred										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
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1.12 Rehabilitation

You must be able to demonstrate through discussion and practice essential knowledge of

1.12 Rehabilitation	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:12.1 Rehabilitation Initial Assessment and Referral										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Relevant national guidance, policies and procedures relating to the rehabilitation needs of the critically ill: o NICE CG 83 o Trauma rehabilitation pathways o NICE CG 50 • The importance of rehabilitation being identified and started within 24 hours of admission to critical care • The importance of Rehabilitation prescription and/or plans o Rehabilitation pathways o Short clinical rehabilitation assessments o Nutritional assessment tools o Swallowing assessments o Pain assessment tools o Delirium assessments o Referral to relevant MDT members o Long term rehabilitation assessments o Rehabilitation goal setting o On-going reassessments of needs • Importance of regularly reviewing and screening the rehabilitation needs of									

the patient • Other equipment and resources that may benefit critical care patients with rehabilitation needs (including but not limited to): o Patient diaries o Mobility aids to promote independence o Communication aids o Family presence o Music therapy o Aromatherapy o Massage o Sleep therapy • Environment factors in critical care that may impact on rehabilitation needs: o Noise/alarms o Equipment o Level of activity o Disturbance for observation and care needs o Invasive treatments/devices o Isolation • Importance of the rehabilitation record and documentation being held separately from the case notes: o Patient needs access to documents										
You must be able to undertake the following in a safe and professional manner: • Implement as directed by the RN or registered professional a rehabilitation prescription or plan within 24 hours of admission • Identify all AHP support required for the patient • Assist in the completion of any nurse led assessments require in the first 24 hours: o Nutritional assessment o Delirium assessment • Follow planned therapy prescribed or recommended by the MDT members involved in the patients rehabilitation journey										

• Monitor the patients progress against set goals and feedback this progress to the relevant AHP groups • Reduce (where possible) the critical care environmental effects on the patient • Communicate rehabilitation needs and goals to the patient and their families in a clear and concise manner • Involve the patient and significant others in the rehabilitation process as appropriate and able										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:13 Communication & Teamwork

You must be able to demonstrate through discussion and practice essential knowledge of

1.13 Communication & Teamwork	Assessment									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:13.1 Communicating with Critical Care Patients										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • The importance of: o Focusing on the individual o Personal space and positioning when communicating o Body language and eye contact when communicating o Using the individual's preferred means of communication and language o Checking that you and the individuals understand each other o Adapting your communication skills to aid understanding o Active listening o Medications o Past medical history o Learning disability The difficulties that can arise with communication in the critical care environment: o Unconscious patient o Artificial airways o Disorientation o Confusion o Delirium o Withdrawal from communication										

o Addictions o Hallucinations o Sleep deprived patients • Methods and ways of communicating that allow for communication difficulties to be overcome (including but not limited to): o Nonverbal communication aids, such as picture boards, writing and electric devices • Support equality and diversity • The difficulties that may be experience in recognising and interpreting the patient's nonverbal communication (including but not limited to): o Signs of distress o Deterioration in patient understanding o Changes in mental capacity										
You must be able to undertake the following in a safe and professional manner: Provide emotional reassurance and support • Adopt any communication aids that are appropriate to the patient's needs: o Glasses o Hearing aids o Picture boards o White boards o Speaking valves o Interpreter o Electronic devices • Adapt your communication style to suit the situation & 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 critical care patient • Ensure written documentation reflects the needs of the patient and records any communication that has taken place										
1:13:2 Communicating and Team Working										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Importance of effective team working in critical care (Including but not limited to): Efficient and timely completion of workload o Working collaboratively o Achieving common goals o Team satisfaction o Supporting and valuing each other • Members of the extended MDT and the main roles and responsibilities of each in caring for the critically ill (including but not limited to): o Critical care doctors o Critical care nursing team o Critical care technicians o Specialist nurse o Physiotherapist o Dietician o Pharmacist o Occupational therapist o Speech & Language o Psychologist • Importance of referring or responding promptly and appropriately to each member of the MDT • Most effective and efficient way to communicate with the appropriate team member including • Emergency call • Verbal referral • Appropriate documentation										

• Principles of confidentiality, security and sharing of information about critical care patients • How your communication skills reflects on you and your team										
You must be able to undertake the following in a safe and professional manner: • Work as an effective critical care team member • Communicate information about your critical care patient in a logical and systematic manner • 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 RN and team leader • Focus all your actions on the safety of yourself, your patient and on other team members • Actively participate in the professional development of other team members • Records and documents any referral, actions and outcomes agreed by the team members										
1:13:3 Communicating in Difficult Situations										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Possible impact of all aspects of significant news on the patients and families well-being • Range of communication difficulties and resources available to aid communication • Importance of clear and direct communication										

• Importance of the individual's choice • Importance of establishing rapport • How to ask questions, listen carefully and summarise back • 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 • Importance of working within your own sphere of competence and seeking advice when faced with situations outside this situation										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:14 Infection Prevention & Control

You must be able to demonstrate through discussion and practice essential knowledge of

1.14 Infection Prevention & Control	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:14:1 Infection Prevention & Control										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Chain of infection • Infection process • Alert organisms and conditions • Body defence mechanisms • Specifically in relation to the critical care environment o Ventilator Associated Pneumonias (VAPs) o Influenza o Catheter Related Blood Stream Infections (CRBSIs) o MRSA o Clostridium Difficile o VRE o CPE Significance of microbiological results in line with other pathology results and the overall patient condition • Key legislation, national guidance outcomes/indicators related to the prevention and control of infection in the critical care environment: o Recent Health and Social Care Act o Communicable disease control o Prevention and management of										

injuries (including sharps) o Waste management o Safe water management o Decontamination of equipment used for diagnosis and treatment, inclusive of traceability of reusable medical devices o Environmental cleaning o Antimicrobial prescribing & stewardship • Effective engagement methods with patients, families/carers and visitors about their needs and priorities in relation to infection prevention and control • Effectiveness of existing policies and practices and identify possible areas for improvement • Feedback and reporting mechanisms associated with infection prevention and control issues • Ensure that suitable and sufficient communication of information on patients' infection status is provided, utilising guidance from the IPC Team: o On admission, discharge and transfer from one health care area or organisation to another o Between health care workers including displaying appropriate signage o To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets • Demonstrate effective and appropriate use of personal and protective equipment in minimising the risk of infection spread, on admission, discharge and transfer*:* o Between health care workers, including displaying appropriate signage o To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets										

• Demonstrate best practice in the care of patients' requiring: o Source Isolation o Protective isolation • Understanding of local surveillance, outbreak or incident information and how this would be communicated to the team										
You must be able to undertake the following in a safe and professional manner: • Demonstrate best practice in environmental tidiness & cleanliness (including but not limited to): o Appropriate level of cleaning to instigate on patient discharge o Cleaning and disinfection of items that come into contact with the patient and/or their environment that are not invasive (e.g. beds, commodes, hoists) • Safe disposal of waste (including sharps and linen) • Safe storage of food and medical equipment • Bedside damp dusting regime • Demonstrate best practice in decontamination of reusable medical devices, following manufacturer guidance and local policy related to: o Processes for cleaning, disinfection, sterilisation o Specifically but not limited to decontamination of: o Ventilators/Infusion pumps o Renal Replacement Therapy (RRT) machines o Humidification equipment o Endoscopic equipment, such as bronchoscopes o Diagnostic equipment • Demonstrates best practice in the use of disposable medical devices, following manufacturer guidance and										

local policy, applying knowledge of 'single use' and 'single patient use' • Demonstrates best practice in obtaining, packaging, handling, labelling and transport of biological samples, with reference to local pathology guidance • Demonstrates safe management of invasive devices and applies safe practices to prevent device related infections • Participates in audit and surveillance activities (including but not limited to): o Department of Health, Saving Lives High Impact Intervention (HII) o Care bundle audits o Environmental cleanliness audits • Aware of local statistics on the prevalence of alert organisms, outbreaks, serious untoward incidents and action plans to deal with occurrences of infection, • Acts upon any risks identified o Recognition of the signs and management of infection & sepsis o Safe practice in administration of oral antimicrobial drugs, with reference to local formulary • Takes appropriate actions to escalate concerns when safety and quality are compromised • Ensure safe practice in the event of occupational exposure										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

	Assessment									
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			Evidence/Method of assessment
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
n orrder to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										

I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy.
A copy of this page should be given to the Learner's line manager and held locally.
gSignature of Learner: …… Print name: …….. Date: …….

1:15 Evidenced Based Practice

The following competency statement is about applying evidence-based practice to the activities you undertake in critical care, it also includes audit conducted within the critical care setting and the importance of benchmarking against evidence-based quality standards

1.15 Evidence Based Practice	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:15.1 Evidenced Based Practice										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • How you integrate evidence-based practice into your daily work • Importance of keeping up to date with developments and new resources relevant to critical care • Key professional and critical care resources that are available to you to ensure you are abreast of any developments • Importance of conducting benchmarking exercises against the following quality standards to demonstrate local compliance: o Care Bundles o NICE guidance										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:16 Professionalism

The following competency statement is about maintaining professionalism in critical care nursing practice

1.16 Profesionalism	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:16.1 Maintaining Professionalism										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • NMC code (2015) Professional standards of practice and behaviour for nursing associates										
You must be able to undertake the following in a safe and professional manner: • Prioritise people: o Treat people as individuals and uphold their dignity o Listen to people and respond to their preferences and concerns o Make sure that peoples physical, social and psychological needs are assessed and responded to o Act in the best interests of people at all times o Respect people's right to privacy and confidentiality • Practice Effectively: o Practice in line with the best available evidence o Communicate clearly o Work collaboratively o Share your, skills, knowledge and										

experience with colleagues for the benefit of people receiving care o Keep clear and accurate records relevant to your practice o Be accountable for your decisions to delegated tasks and duties • Preserve Safety: o Recognise and work within the limits of your competence o Be open and candid with all service users about aspects of care and treatment, including where mistakes or harm have occurred o Act without delay if you believe there is a risk to patient safety or public protection o Raise concerns immediately if you believe that there is a vulnerable person at risk o Reduce (as far as possible) any potential for harm associated with your practice • Promote Professionalism & Trust: o Uphold the reputation of your profession at all times o Respond to any compliant										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:17 Defensible Documentation

This competency statement is about the legal and accountable aspects of documentation within the critical care environment

1.17 Evidence Based Practice	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1.17.1 Documentation										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • The impact of the NMC record keeping guidance (2009) on the registered Nursing Associates legal responsibility in written documentation: o Clear o Accurate o Purposeful o Contemporaneous o Author of entry – printed, signed and professional PIN number • Your accountability in relation to: o Statute law o Case law o Civil law o Criminal law • The reasons for accessing and maintaining health care records: o Helping to improve accountability o Showing how decisions related to patient care were made o Supporting the delivery of services o Supporting effective clinical										

judgements and decisions o Supporting patient care and communications o Making continuity of care easier o Providing documentary evidence of services delivered o Promoting better communication and sharing of information between members of the multi-professional healthcare team, patients and families o Helping to identify risks, and enabling early detection of complications o Supporting clinical audit, research, allocation of resources and performance planning o Helping to address complaints or legal processes • Your responsibility in relation to maintaining health care records o Use of electronic tracking systems for health care records o Privacy and confidentiality of patient information o Caldecott guidelines										
You must be able to undertake the following in a safe and professional manner: • Provide an accurate, concise, timely and contemporaneous record of your 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 and relatives • Accurately file patient information utilising the health care records systems in place										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										

I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally.

Signature of Learner: …… Print name: …….. Date: …….

1.8 Mental Capacity & Safeguarding Adults

This competency statement is about the legal and accountable aspects of mental capacity and safeguarding adults within the critical care environment

1.18 Mental Capacity & Safeguarding Adults	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:18.1 Mental Capacity & Safe Guarding Adults										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): Explain the role of the Nursing Associate as a patient advocate Completed mental capacity mandatory training Understand the underlying principles of assessing mental capacity Mental Capacity Legislation specifically: The definition of 'capacity' Key principles of the legislation and their relevance to the critical care patient. Understand the definition of a vulnerable adult' or 'adult at risk and groups of people covered by the legislation Understand them meaning										

of 'best interests'. Understand issues surrounding consent Explain indications of types of abuse Awareness of risk assessments & reporting procedures Demonstrate practices that ensure safety for self, patient and colleagues Recognize limitations of competence in relation to mental capacity and Safeguarding Adults management Awareness of Advance decisions and lasting power of attorney • Deprivation of Liberty safeguards - Code of Practice for those individuals who lack the capacity to consent to treatment or care • Strategies and tools available for assessing and recording mental capacity • Procedures available for referral of patients presenting with diminished mental capacity Implications of diminished mental capacity for critical care practice and in emergency situations • Demonstrate effective communication measures with the patient, families and/or carers and the wider MDT members, on issues related to diminished mental capacity Range of strategies may include Handover o Team meetings o Written records										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

1:19 Followership

The following competency statements are about developing leadership styles and skills throughout your professional development in critical care.

1.19 Followership	Assessment									Evidence/Method of assessment
	Formative Date			Mid-Point Date			Summative (only undertake if the learner scored 1 or 2 in Formative) Date			
	Score Learner	Score Assessor	Assessor Initials	Score Learner	Score Assessor	Assessor Initials	Score Assessor	Score Assessor	Assessor Initials	
1:19.1 Demonstrating Personal Qualities										
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice): • Self awareness • Managing yourself • Continuing professional development • Acting with integrity										
You must be able to undertake the following in a safe and professional manner: • Identify and reflect on personal strengths and weaknesses • Effectively fulfil your role • Maintain routine critical care practice • Maintain Health & Safety • Recognise personal stress • Manage time constructively										

• Use feedback to improve performance • Set own achievable development goals • Make effective use of learning opportunities • Use reflection to learn from previous experiences • Apply ethical issues, debates and principles to your practice • Recognise when ethical issues may conflict with your personal views • Effectively communicate with patients, families and multi professional team members • Build effective relationships and rapport with team members • Recognise and value others • Challenge constructively when your viewpoint differs to others • Effectively work with a diverse team regardless of social, educational, cultural and sexual orientation differences										
In order to demonstrate competency, the Learner must be scored as Competent (Proficiency Score of 3 - 5) by the Assessor in all of the Standards										
I have been assessed as competent in all these objectives and am willing to assume responsibility to ensure I consistently demonstrate competency and abide by Trust policy. A copy of this page should be given to the Learner's line manager and held locally. Signature of Learner: …… Print name: …….. Date: …….										

Final Competency Assessment
Date |

This meeting is to identify that all the competencies have been achieved and that the nurse is considered a safe competent practitioner as a Band 4 Nursing associate I critical care.

COMPETENCY STATEMENT:
The nursing associate has been assessed against the competencies within this document and measured against the definition of competence below by critical care colleagues, mentors and assessors and is considered a competent safe practitioner within the critical care environment:

"The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions".

As part of quality assurance the nurse is expected to maintain a portfolio of practice as part of NMC 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 revalidation. Where necessary objectives will be set to further develop any emerging competency required to work in safety within the critical care.

Critical Care Networks - National Nurse Leads, (2015) National Competency Framework for Registered Nurses in Adult Critical Care version 2. Available at hhtp://www.cc3n.org.uk (Accessed Oct 27th 2015)

This document has been produced with support from these organisations. and will be available through their websites.