

**Stroke Competency Document for Registered Nurses**

**ASSESSMENT OF PRACTICE**

**CLINICAL COMPETENCY DOCUMENT**

**PRINT NAME ..................................................… SIGNATURE ..............................................……**

**DATE COMMENCED ..........................……….. EXPECTED COMPLETION DATE …………….**

**ACTUAL COMPLETION DATE ……………………………………………………………….**

**MENTOR NAME ………………………………… SIGNATURE …………….......... INITIALS.....……**

**MENTOR NAME ………………………………… SIGNATURE …………….......... INITIALS.....……**

**Stroke Competency Document for Registered Nurses**

This document is to be used in conjunction with the agreed trust policies for the relevant procedures. Preceptors should ensure that the relevant trust policies and procedures are referred to during the course of their preceptorship. The learning resources available on the unit should be used in the completion of this pack. Additional evidence to support competence may be attached.

Any required scope packages should be given out after the supernumerary period after discussion with the appropriate Team Leader and in conjunction with the Band Progression Framework.

New staff should demonstrate the ability to correctly document all pertinent information relating to these competencies in the appropriate places during their supernumerary period.

**How to use this document**

This document should be completed during the registered nurses first year in the stroke service**. It is the responsibility of the Registered Nurse to ensure this document is completed with the help of the nurses they work with during this period.**

The document consists of a number of Competency Themes. Each theme is sub-divided into a number of competency statements, which need to be completed before competence can be achieved. If necessary, further learning needs identified by the learner and the preceptor as being needed to complete a learning outcome can be made note of on the continuation sheet at the back of this document. Each learning outcome should be signed by the learner and the nurse they are working with. *Only when both are happy that the learner will be able to carry out the task safely and independently should an outcome be signed.*

**It is suggested that the learner and the nurse they are working with identify a few outcomes they can work on during each shift. The learner should ensure that some of their pack is signed off on a daily basis.**

**OUTLINE**

This Competency document is designed to be used by all staff being assessed in practice, irrespective of experience. The assessment of clinical ability comprises of a series of competencies. The timescale for completion of competencies will vary according to grade and relevant experience. However, as a guideline, expected completion time will be in the first year of your employment in the stroke service.

**AIMS**

* To demonstrate an increase in competence
* To develop self and others
* To achieve quality care through evaluation and research
* To provide a profile of evidence

**PROCESS**

* The registered nurse will be responsible for their own development. They will acknowledge, recognise and arrange opportunities for learning and assessment.
* Assessors should work with the registered nurse to enable assessment to take place and verification of competence to be observed. The nurse will be responsible for arranging a mutually agreed time with an experienced member of staff, mentor or clinical educator to perform their assessments
* Registered nurses should self-assess all aspects in the initial (formative) category within two weeks of commencing the specified competencies – a programme of development should be discussed with your team leader/ward manager
* Registered nurses must provide evidence for the compulsory category in each competency and should indicate in the box provided which additional method is used and the page number in their profile where this evidence can be found
* Ideally you will provide 2 forms of evidence for each competency.
* The verifiers should sign and date the document when the competencies are assessed (as per rating criteria).

**NB Self-assessments must be completed before mentor/verifier ratings.**

**Each practitioner must have both an initial (formative) and a final (summative) assessment**

**OUTCOMES**

* The nurse will complete all pre-set competencies.
* Patient care will improve with the nurses increased competence and confidence
* The nurses theory practice gap will be reduced
* A portfolio of evidence will be produced to demonstrate competence

**GUIDELINES FOR USING THE COMPETENCY MEASUREMENT TOOL**

The framework describes four levels of competence. Competence is defined as “the skills, knowledge, experience, attributes and behaviours required by an individual in order to perform the job effectively” (Royal College of Nursing 2002).

The criteria for achievement are divided into three areas:-

* STANDARD
* QUALITY OF PERFORMANCE
* ADVICE ASSISTANCE CUES

Each of these 3 areas must be considered to determine the level of competence (level). The level that is awarded will relate to the lowest of the 3 areas achieved.

**TERMINOLOGY USED IN ASSESSMENT OF COMPETENCE**

* Safety - Performance includes both physical and psychological aspects. The criterion for safety is that behaviour does not cause harm by action or omission.
* Accuracy is assessed by the extent to which the knowledge base is used during the performance.
* Effectiveness refers to the achievement of stated objective.
* Effectiveness refers to the manner with which the behaviour is performed.
* Cues. This refers to the amount and type of assistance required. Cues can be directive or supportive and may be verbal or practical. They refer to what is necessary to maintain or promote the performance.

**EVIDENCE REQUIRED**

Evidence should be collected using one of the evidence methods identified in the table below

At least one form of evidence should be used for assessment of practice, ideally two

Evidence should then be put into the practitioner’s portfolio this will allow for verification of competence during the Appraisal process and provide the practitioner with evidence of learning

**NUH ASSESSMENT OF PRACTICE / COMPETENCY MEASUREMENT TOOL**

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| --- | --- | --- | --- |
| **SCALE/ LEVEL OF ACHIEVEMENT** | **STANDARD** | **QUALITY OF PERFORMANCE** | **ADVICE ASSISTANCE CUES** |
| **Proficient**  **(PRO)** | Safe, accurate and effective with appropriate affective manner. Applies theory to practice and judges its appropriateness | Performance demonstrates expertise. Pro-active and flexible approach. Acts as a role model for practice, stimulates and informs others. Client/patient centred. | Freely offers cues to others |
| **Independent**  **(I)** | Safe, accurate and effective at all times. Applies theory to practice | Skilful and co-ordinated performance. Confident and economical use of time. Able to focus primarily on the client/patient. | Self-directing |
| **Supervised**  **(S)** | Safe, accurate and effective performance. Some potential for omissions or inaccuracies. Can relate theory to practice most of the time | Skilful and co-ordinated performance in some key aspects. Some degree of confidence but spends excess time in achieving objectives. Focuses on the client/patient but is distracted when the skill is more complex. | Frequent directive and supportive cues. |
| **Unskilled**  **(U)** | Unsafe practice when unsupervised. Some potential for omissions or inaccuracies. Limited ability to relate theory to practice | Unskilled in some aspects. Lacks confidence.  Spends considerable time in achieving objectives. Unable to focus on the client/patient, but concentrates on the skill. | Continuous directive and supportive cues. |

Adapted from K. N Bondy (1983) Criterion-Referenced definitions for rating scales in clinical evaluation Journal of nursing Education 22 (9) 376-382

**EVIDENCE METHOD:**

**O =Naturalistic Observation**

Observation of the candidate by the assessor at work

**WT = Witness Testimony**

As the named assessor cannot always be present and /or available to for assessment, the written testimonies of others are valuable. The candidate or an approved mentor/assessor/other may write a witness testimony. It is an account of the candidates’ performance that is signed by an approved assessor with the relevant skills and knowledge e.g. a physio may sign for respiratory competencies.

**WP = Work Product**

Various products of the candidates work may be used as supporting evidence towards a competency. These may include competency documents, care plans, observation charts, WINW packages, reflective diaries, study days, portfolios and teaching packages.

**PA = Project or Assignment**

In depth exploration / learning contract of a specific area related to work, this may be of any length providing that sufficient evidence is shown to achieve the actual competency, it should contain evidence and/or research. Examples include literature reviews, essay, projects and assignments (undertaken within last 5 years) providing that the candidate can show clear evidence of up- to- date knowledge and /or skills.

**WQ = Written questions**

Assessors may wish to give the candidate a list of written questions to answer to assist them in achieving the competency; the candidate and assessor should then go through the questions to ensure they are accurate and both should sign.

**S = Simulation**

Occasionally it may be necessary for the assessor to watch a simulation when a situation is unlikely to happen regularly in real life. For an example, resuscitation skills are often assessed in this way using a manikin and a basic scenario. When a simulation is used, the candidate is required to reflect on the simulation; outlining what skills and learning have been demonstrated. This is then signed by the assessor and submitted as evidence.

**CE = Candidate Explanation**

The assessor and candidate discuss/ and demonstrate the competency. The candidate explains their understanding of the competency and gives work related examples of their knowledge and skills being used in practice. The assessor may clarify the candidates understanding and abilities by asking questions about the subject, probing for additional information.

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**Please note whichever method is used the evidence must be signed and dated by both the registered nurse and the verifier**

### Core Competency Theme 1: Equipment & Environment

**Aim: The learner is able to safely and competently prepare and check a bed space ready for an admission/transfer, an**

**existing patient, to include equipment and infusions**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Can safely perform a bed area check |  | Safely assesses a bed space for an admission/ongoing care of a patient;   * Clutter removed * Infection control adhered to/hand gel available * Patient board at the back of the bed fully completed with relevant patient details (observe confidentiality) * Oxygen and suction available and ready for use at allocated bed spaces * Bed space ready to receive admission/transfer – as above + * Equipment availability   + See check list in Assessment Bay on Berman1   + Pump & infusion checks   + Monitor alarms | **I** |  |  |  |  |
| Ensures appropriate equipment is available and functioning |  | * Able to locate emergency equipment   + Cardiac Arrest trolley   + Suction   + Spare oxygen cylinder * Demonstrates knowledge of the equipment on the cardiac arrest trolley, its use, checking procedure and completion of checking chart * Is familiar with ward layout & storage of equipment * Able to check bedside and unit emergency equipment is working correctly * Demonstrates awareness of procedure for reporting faulty equipment and return of equipment to the ward from MESU * Has completed the Trust Health and Safety Staff Induction Checklist | **I** |  |  |  |  |

**Core Competency Theme 2: Respiratory Assessment and Management**

**Aim: The learner is able to safely and competently assess a patient’s respiratory status and optimise gas exchange**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Demonstrates a knowledge of the normal anatomy and physiology of the respiratory system |  | * Identifies basic structures within the respiratory system * Can describe the normal physiology of inspiration/expiration * Has a basic understanding of gaseous exchange | **I** |  |  |  |  |
| Can carry out a full respiratory assessment |  | * Can discuss pre-existing respiratory function * Is able to identify patients at risk of respiratory deterioration * Identifies the signs and symptoms that indicate a patient's respiratory function is deteriorating or improving * Is able to accurately recognise, monitor and document the significance of the following clinical signs: * Respiratory rate * Respiratory depth * Use of accessory muscles * Flaring of nostrils * Pulse rate * Colour * Posture * Oxygen Saturation * Recognises normal and abnormal ABG results. (Band 6) | **I** |  |  |  |  |
| Can demonstrate and discuss the safe use of nebulisers |  | * Demonstrates the correct use of nebulisers * Can give a basic explanation of the following drugs in a nebuliser:   + Salbutamol   + Ipratropium   + Normal saline | **I** |  |  |  |  |

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| Can select the appropriate oxygen device based on patient need and give rationale for decision |  | * Can explain advantages and disadvantages in the use of the following:   + Nasal cannula   + Non-rebreathe mask   + Fisher-Paykel humidifier (using high/low flow oxygen)   + High flow   + Dry or humidified oxygen | **I** |  |  |  |  |
| Demonstrates an understanding of the additional therapeutic interventions which can assist with gaseous exchange |  | * Demonstrates correct technique for chest auscultation * Identifies positions for optimal lung inflation. * Awareness of which staffs are able to provide further information regarding breathing exercises. * Discusses plan and assists physiotherapist. * Monitor the effectiveness of interventions and documents findings and results. | **I** |  |  |  |  |
| Demonstrate an awareness and understanding of associated stroke problems that may have an impact on the respiratory system |  | * Demonstrate an understanding of which stroke related problems may cause problems * How to Identify indicators of these at the earliest opportunity * Understanding of the correct escalation procedure and plan of care | **I** |  |  |  |  |

**Core Competency Theme 3: Neurological Assessment and Effects of Stroke**

**Aim: The learner is able to safely and competently assess a patient’s neurological status and respond to a changing neurological condition**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Demonstrates knowledge of the normal anatomy and physiology of the central nervous system |  | * Can label a diagram of the main structures of the brain * Can identify the structures in the brain and list the major functions of;   + Cerebrum - cortex and basal ganglia   + thalamus, hypothalamus and pineal gland   + Midbrain   + Pons   + Medulla   + Cerebellum * Can label the vascular circulation diagram in the brain and give a basic understanding | **I** |  |  |  |  |
| Demonstrates an understanding of the process and rationale for carrying out a neurological assessment |  | * Can competently complete a GCS assessment and documentation * Accurately monitors patient status, recognising the significance of the findings and seeks advice when needed * Be able to identify signs of raised intracranial pressure and describe appropriate treatments that can be used outside of the intensive care setting to reduce the occurrence and effects of this * Complete **STARS Core Competency Section 1** – Cause of Stroke | **I** |  |  |  |  |
| Demonstrate an understanding of the disabilities associated with stroke depending on the area of the brain affected |  | * Describe the probable disabilities associated with the following;   + Left hemispheric stroke   + Right hemispheric stroke * Complete **STARS Core Competency Section 2** – Effects of Stroke * Complete **STARS Core Competency Section 5** – Common effects of Stroke * Complete **STARS Core Competency Section 6** – Level of Consciousness * Complete **STARS Core Competency Section 10** – Loss of Feeling * Complete **STARS Core Competency Section 11** – Change of Vision | **I** |  |  |  |  |
| Define and explain the terms listed including where the damage may have originated in the brain |  | * Hemiplegia * Hemiparesis * Flexion and extension, withdrawal and localisation movements * Ataxia * Nystagmus * Dysphasia – expressive/receptive * Dysarthria | **I** |  |  |  |  |
| Essence of Care |  | * Has an understanding of the requirements for the End of Life care benchmark | **I** |  |  |  |  |

**Core Competency Theme 4: Cardiovascular Assessment and Management**

**Aim: The learner is able to safely and competently assess a patient’s cardiovascular system**

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| Demonstrates knowledge of the normal anatomy and physiology of the heart and cardiovascular system |  | * Labels structures within the heart diagram * Can discuss the physiology of a normal heart beat   + Conduction   + PQRST * Completes relevant learning worksheets:   + Have an understanding on how to perform a 12-Lead ECG * Attends the rhythm recognition workshop * Has completed the WINW’s ECG package by end of 1st year | **I**  **I** |  |  |  |  |
| Demonstrates an understanding of the process and rationale behind haemodynamic monitoring |  | * Can discuss the rationale for monitoring the following specifically in stroke patients: * Heart rate * Blood pressure * Respiratory rate * Temperature * Urine output * Level of consciousness/neurological observations * Can demonstrate an understanding of the EWS system for recognising the deteriorating patient * Is able to complete a full set of observations * Can accurately calculate the EWS * Demonstrates how to escalate an EWS of;   + 3   + 6     - 9 | **I** |  |  |  |  |
| Can demonstrate how to assess a patient without using usual equipment and describe a rationale for each observation |  | * Blood Pressure * Pulse including rate and regularity * Pedal pulses * Capillary refill * Respiratory rate * Skin perfusion and colour * Urine output | **I** |  |  |  |  |
| Has a basic understanding of the following;   * Septic shock * Neurogenic shock * Hypovolaemic shock |  | * Can define all of the shocks listed * Can identify the clinical features of each shock * Has an awareness of how and who to escalate to | **I** |  |  |  |  |
| Demonstrates an understanding of thermoregulation in relation to pyrexia |  | * Demonstrates the correct use of a tympanic thermometer – complete competency assessment * Can define both hypothermia and pyrexia * Can discuss the effects of pyrexia/hyperpyrexia on normal physiology * Can demonstrate care of a patient who has a pyrexia | **I** |  |  |  |  |

**Core Competency Theme 5: Management of a patient suffering a transient ischaemic attack**

**Aim: The learner is able to explain the care and management needs of a patient who has suffered a transient ischaemic attack (TIA)**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
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| The nurse gains an understanding of TIA |  | * Explain the signs and symptoms of TIA * Discuss the differences between a Transient Ischaemic Attack (TIA) and Stroke * Undertake an insight visit to the TIA clinic; observe the triaging of TIA patients, patient history taking, physical examination and the patient journey * Complete **STARS Core Competency Section 3 – Reducing the Risk of Stroke** | I |  |  |  |  |
| The nurse can describe the investigations required in making a diagnosis of TIA |  | * Describe how to triage a TIA patient, discuss the triage form and the use of the ABCD2 tool, explaining what is meant by high risk and how to accommodate them * Explain the investigations, interventions and treatments for TIA (e.g. imaging, vascular, medical, cardiac, and surgical) * Discuss the importance of ECG * Discuss  the indication for Carotid Doppler * Discuss the use of brain imaging in the TIA clinic * Explain carotid imaging and when referral to vascular surgery is required, discuss what surgical interventions are offered | I |  |  |  |  |
| The nurse is able to describe the management and treatment options available for TIA patients |  | * Discuss the management and treatment options for TIA;   + An awareness of the NICE /RCP guidelines | S |  |  |  |  |

**Core Competency Theme 6: Care of a patient following a diagnosis of stroke**

**Aim: The learner is able to safely and competently care for a patient who has suffered a stroke**

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| Be able to describe the following neurological disorders |  | * Ischaemic stroke * Haemorrhagic stroke * Mimics | **I** |  |  |  |  |
| Demonstrate how to carry out an initial neurological assessment and be able to describe a rationale for each aspect |  | * Vital signs/GCS * NIHSS (BSU1) * Modified Rankin * Barthel * STAT | **I** |  |  |  |  |
| Discuss the investigations that take place to aid the making of a diagnosis |  | * CT scan * MRI scan * Cerebral angiography * Blood tests * ECG * Urinalysis * Carotid Doppler | **I** |  |  |  |  |
| Demonstrate knowledge of the treatment options available following a diagnosis of stroke |  | * Anticoagulation * Thrombolysis * Surgical intervention | **I** |  |  |  |  |
| Understand the requirement for specialist care in designated centres |  | * Complete **STARS Core Competency Section 4 – Specialist Care** | **I** |  |  |  |  |

**Core Competency Theme 7: Mobility**

**Aim: The learner is able to safely and competently care for a patient who requires support with their movement and mobility**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
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| Demonstrate how to plan, deliver and evaluate the care of an individual’s needs who suffers with impaired mobility |  | * Identifies patients at risk of hazards associated with immobility in relation to all aspects of daily living * Complete **STARS Core Competency Section 7 – Limb Weakness** * Complete **STARS Core Competency Section 14 – Preventing Pressure Ulcers** * Identifies benefits to patients of sitting in a chair and of standing /walking. * Can discuss the use of therapeutic beds * Can discuss how to order additional equipment for the patients’ needs * Shows awareness of the contact details and location of the ergonomics manager and team * Complete **STARS Core Competency Section 8 and 17 – Moving, Handling and Safety** | **I** |  |  |  |  |
| Demonstrate the delivery of therapeutic care |  | * Is proactive in getting patients out of bed/mobilising * Demonstrates how the nurse can continue with planned programmes of rehabilitation and therapeutic care in the absence of the physiotherapist * Is able to facilitate self-practice or management by the patient to continue with their rehabilitation outside of therapy sessions e.g. Use of the communication folder | **I** |  |  |  |  |
| Show an understanding of the role of physiotherapy in the patients recovery |  | * Discuss the role of the physiotherapist * Shadow the physiotherapist for at least one shift (to be negotiated with the learner, ward manager and physiotherapist) * Can discuss the benefits of preserving mobility and range of movement in bed bound patients * Has an understanding of the effect of exercise and repetition on neuroplasticity and therefore recovery * Demonstrate the required skills to be able to position a patient, post stroke, in order to optimise the recovery of mobility;   + Positioning in bed     - Supine     - Long sitting     - Side lying   + Moving forward in a chair   + Moving backward in a chair   + Positioning in a wheelchair   + Lying to sitting   + Sitting to lying   + Sit to stand with the assistance of one person (front side)   + Sit to stand with the assistance of two people (side)   + Step round transfer with assistance of one person   + Step round transfer with the assistance of two people   + Care of upper limbs   + Care of lower limbs * Optimal handling and positioning of the hemiplegic   + Recognises the different approach in handling and positioning for patients with high and low tone Upper and lower limbs   + Able to handle an impaired upper limb effectively for functional tasks such as washing and dressing, eating and drinking and mobilising * Educates and encourages patients, and their families, to perform their exercises * Introduces families and patients to the rehabilitation folders to aid with communication and adherence to exercise programmes * Discusses the plan of care with and assists physiotherapist. * Reassesses the effectiveness of interventions, documents findings and results and discusses with the physiotherapist | **S** |  |  |  |  |
| Can competently use the required equipment to move a patient safely |  | Demonstrates the safe and correct use of the following manual handling aids for patients with or without a hemiplegic upper limb;   * Pat slide * Sliding sheets * Emergency lifting sheet * Rotunda * Rota-stands * Arjo Standing hoist * Hoist   + Arjo hoist and slings   + Sara Plus standing hoist   + Opera full hoist * Able to use the following mobility aids with the patients under guidance of the therapists:   + Walking stick   + Tripod stick   + Wheeled zimmer frame   + Gutter frame * Has completed the wheelchair competency:   + Tilt and space wheelchair and Hydrotilt     - In relation to the safe application and removal of:       * Trunk side supports       * Bexhill arm rests       * Head rest * Able to report any problems/repairs re these wheelchairs to the ward manager | **I** |  |  |  |  |
| Able to competently complete assessment of patients skin |  | * Able to identify the differences between hospital acquired pressure damage and community acquired pressure damage and /or moisture lesions. * Competently completed the wound assessment booklet and Datix incident * Is able to complete a referral to Tissue Viability Nurses on Notis | **I** |  |  |  |  |

**Core Competency Theme 8: The Role of Occupational Therapy**

**Aim: The learner is able to safely and competently care for a patient requiring rehabilitation and support with the activities of daily living**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
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| Demonstrate the delivery of therapeutic care using a 24 hour approach |  | * Demonstrates how the nurse can continue with planned programmes of rehabilitation and therapeutic care in the absence of the occupational therapist * Complete **STARS Core Competency Section 19 - Rehabilitation** * Is proactive in facilitating the patient to do as much for themselves as possible | **I** |  |  |  |  |
| Can competently use the required equipment |  | * Demonstrates what ADL equipment is safe to use and when it might be needed * Complete **STARS Core Competency Section 9 – Activities of Daily Living** * Can fit and adapt ADL equipment accordingly for each patient   + Raised toilet seat   + Free standing Toilet frame   + Mowbray   + Perching stool * Has an awareness of why splints are applied to the upper limb and lower limb * Demonstrates the correct fitting of upper and lower limb splints, and can identify any limitations or contra-indications for the use of these and what factors may affect safe use and/or effectiveness of the splint:   + Palm protector   + Off the shelf functional splint   + Thermoplastic mid-line resting splint   + Podus boot   + Pillow splint * Is able to follow splinting instructions and records the donning and doffing correctly | **S/I** |  |  |  |  |
| Show an understanding of the role of occupational therapy in the patients recovery |  | * Discuss the role of the occupational therapist * Shadow the occupational therapist for a shift * Can discuss the benefits of preserving/re-establishing independence and self-care for patients * Is proactive in facilitating patients to relearn the skills required to undertake everyday activities such as washing, dressing, feeding themselves, going to the toilet * Demonstrates therapeutic washing and dressing, including clinical reasoning for grooming and top half washing and dressing tasks * Attend a home visit / Access Visit with an occupational therapist * Show an awareness/understanding of visual problems and how this can impact on function:   + Acuity   + Diplopia   + Hemianopia * Show an awareness/understanding of cognition /perceptual problems and how this can impact on function;   + Attention   + Information Processing   + Apraxia   + Neglect   + Memory   + Executive function * Shows an awareness/understanding of insight and how this can impact of function and capacity to make a decision * Educates and encourages patients in self-practice tasks * Discusses the plan of care with the OT and assists in delivering this * Reassesses the effectiveness of interventions, documents findings and results and discusses with the OT | **S** |  |  |  |  |
| Has an understanding of the risks associated with visual, and cognitive/perceptual impairment following a stroke |  | * Demonstrates an awareness of the risks associated with vision/perception/cognitive impairment in hospital and for discharge. And is able to apply management strategies to these. | **S** |  |  |  |  |

**Core Competency Theme 9: Communication and Dysphagia**

**Aim: The learner is able to safely and competently care for a patient who has difficulty with communication and/or a swallowing difficulty**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Demonstrates an understanding of the issues that can impair a patient’s ability to communicate |  | * Can discuss limitations to effective communication after a stroke * Adopts a range of alternative methods of communication including; non verbal * Has an understanding of the communication benchmark * Can discuss the role of Speech and Language Therapy/Therapist in the patients plan of care and recovery * Complete **STARS Core Competency Section 12** – Communication | **I** |  |  |  |  |
| Demonstrates the skills required to be able to communicate with a patient who has aphasia, dysarthria or apraxia following stroke. |  | Attendance on the Speech and Language Therapy (SLT) run “Supported Conversation Skills” workshop This will provide the following:   * Understanding of the role of the SLT with patients who have a communication impairment * Understanding of the terminology used and awareness of different types of communication disorders which may result from a stroke e.g. dysarthria, apraxia, aphasia, dysphonia * Knowledge and experience of supported conversation skills to assist a patient with both their expression and comprehension using writing, gesture, drawing, facial expression …. * Ability to engage a patient with aphasia in conversation using patient’s communication book * Some understanding and insight into the impact of an acquired communication disability on social and psychological functioning, and on everyday life for the patient and family. | **S** |  |  |  |  |
| Consolidation of newly acquired skills |  | Observation of an SLT or SLTA carrying out a communication session with a patient who has aphasia   * Consolidate knowledge gained from supported conversation training workshop   Observed by SLT while using supported conversation with a patient who has aphasia | **I** |  |  |  |  |
|  |  | * Knowledge of how to refer a patient to SLT | **I** |  |  |  |  |
| Basic Level |  | Attendance on ward-based Dysphagia awareness course (these take place monthly)(check with LE)   * The role of the SLT * Awareness of SLT recommendations and strategies and how to follow them * Complete **STARS Core Competency Section 13 - Swallowing** * Understanding of the need for thickened fluids and how to prepare different consistencies * Understanding of the need for different diet consistencies and know why they are used * Awareness of the different signs of aspiration * Awareness of safe feeding practice and how to implement * Understanding of the optimum environment for feeding a patient in terms of positioning, utensils, techniques and monitoring. * Knowledge of how to refer to SLT or to seek immediate advice and assistance. * Observation of SLT carrying out a dysphagia assessment | **I** |  |  |  |  |

**Core Competency Theme 10: Nutrition**

**Aim: The learner is able to safely and competently care for a patient at risk of malnutrition**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Demonstrates knowledge and understanding of the screening process and of the needs of a patient requiring dietetic intervention. Can plan, deliver and evaluate the care needed appropriately |  | * Comprehensively and accurately completes assessment documentation (MUST score) – has completed the Trust MUST competency assessment * Is able to identify patients at risk of malnutrition * Is aware of dietetic referral criteria * Is able to make referrals to the relevant agencies – including the ward Dietician and Nutrition Specialist Nurse * Can discuss the risk factors for malnutrition specific to patients who have suffered a stroke and the need for nutrition support in these patients * Plans and delivers care in accordance with Trust policies on nutrition * Has an understanding of the Food and Drink benchmark | **I** |  |  |  |  |
| Demonstrate a basic definition of the effects of electrolyte imbalance on the patient |  | * Hypernatraemia * Hyponatraemia * Hypokalaemia * Hyperkalaemia * Hypercalcaemia * Hypocalcaemia * Hypophosphataemia * Hypomagnesaemia   (Sheet to be provided) | **I** |  |  |  |  |
| Can discuss the adverse effects and demonstrate the care required by a patient who is suffering from: |  | * Dehydration * Under nutrition * Starvation   + Definition   + Causes   + Treatment   + Prevention | **I** |  |  |  |  |
| Shows an awareness of the different methods of tube feeding, and able to demonstrate the care required by patients receiving their nutrition via the following methods |  | * NG tube (fine bore)   + Passing the tube - to have completed the WINW training package and study day   + To have completed competency training on NG tube position checking   + Able to discuss the ongoing care of the NG tube   + Able to describe potential complications relating to initial placement, the tube feed and the patients themselves, and able to show knowledge of how these might be prevented/managed   + Understands the policy and procedure for the use of mittens and nasal bridles in stroke patients * Gastrostomy   + Understanding of the procedure for caring for a new gastrostomy tube and the post-gastrostomy feeding procedure and documentation   + Care of gastrostomy tubes and stoma sites (including care of balloon gastrostomy tubes) | **I**  **S/I** |  |  |  |  |
| Demonstrates competence in the care of a patient requiring enteral nutrition |  | * Able to demonstrate the correct administration of a pump feed * Able to demonstrate the correct administration of a bolus feed * Understands how to position the patient during tube feeding and how to administer feed safely * Demonstrates safe blood glucose monitoring and an awareness of when to refer to Diabetes Specialist Nurse. * Able to demonstrate knowledge of how to care for stoma sites and identify if a stoma site is infected. Knows what action to take if the site is infected. * Understands the basic principles of refeeding syndrome, including some of the risk factors and possible differences in nutritional treatment of these patients (both enteral and oral nutrition support) * Able to discuss potential causes of loose stools (other than the enteral feed) * Able to describe the management of complications that can be related to enteral feeding, including diarrhoea, constipation, nausea, vomiting and suspected aspiration * Able to list common drug-feed interactions | **I** |  |  |  |  |
| Demonstrates the safe administration of medication via an enteral feeding tube |  | * Adheres to trust policy on the use of syringes to administer flushes, feed and medication via the enteral route in adults * Able to demonstrate correct preparation of medications * Understands the issues re: crushing medication * Understands potential issues re: fluid balance * Able to show correct administration of flushes and able to discuss occasions when feeding tubes require flushing * Demonstrates safe and appropriate administration of the medications * Demonstrates safe and appropriate use and disposal of equipment * Has undertaken the Trust competency assessment for the administration of medication via an enteral feeding device | **I** |  |  |  |  |

**Core Competency Theme 11: Management of Pain**

**Aim: The learner is able to safely and competently care for a patient who is experiencing pain**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Can assess the needs of a patient in pain and offer suitable analgesia. |  | * Performs a comprehensive assessment to determine the level of pain.   + Demonstrates the use of the trust pain score tool * Recognises verbal and non-verbal signs of pain * List the analgesics commonly used to alleviate pain, describe how they work and their common side effects * Describe the methods of administration of analgesia * Safely and appropriately administer prescribed analgesia * Record effects and any undesirable side effects of prescribed treatment * Demonstrate an awareness of pain assessment tools including PAINAD * Is aware of the requirements of the Pain Benchmark * Has completed the trust pain management training :dates to follow | **I** |  |  |  |  |

**Core Competency Theme 12: Elimination**

**Aim: The learner is able to safely and competently care for a patient requiring support with elimination**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Demonstrates knowledge and is safe when caring for patients with potential renal impairment. |  | * Label the basic anatomy and physiology of the renal system * Describe the reasons/causes of Acute Kidney Injury * Discuss the rationale for accurate monitoring of fluid and electrolyte balance * List the first line treatments for renal failure * Can discuss treatments that may have an adverse effect on renal function | **I** |  |  |  |  |
| Demonstrates care of a patient with urinary incontinence |  | * Can carry out a continence assessment * Is able to plan care to support the continence needs of a patient * Can demonstrate how this plan is applied in practice * Ensures that the plan and the patients’ needs are communicated to the team * Complete **STARS Core Competency Section 15 - Incontinence** * Can recognise the need for, and devise, a toileting regimen that takes into account the individual needs of the patient * Where a patient requires catheterisation, the nurse can demonstrate appropriate care, infection control measures and documentation regarding this intervention * Has completed the male catheterisation WINW’s Package | **I** |  |  |  |  |
| Essence of Care requirements |  | * Shows an understanding of the Bladder, Bowel and Continence Care Benchmark | **S** |  |  |  |  |
| Plans, delivers and evaluates care regarding bowel management. |  | * Can label the basic anatomy and physiology of gastro-intestinal tract ( Diagram) * Can assess a patients normal bowel habits * Recognises the importance of the effects of diet and fluid intake on bowel function * Has knowledge of the factors that may have an adverse effect on the digestive tract; * Treatments * Drugs * Disease process * Has knowledge and can demonstrate the correct procedure for performing digital rectal examination * Describes the commonly used laxatives and their effect on the intestinal tract | **I** |  |  |  |  |

**Core Competency Theme 13: Psychological Care**

**Aim: The learner is able to safely and competently care for a patient requiring support psychological support**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
|  | **PAGE NUMBERS IN PROFILE** |  |  | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** | **SELF RATING DATE & SIGN** | **VERIFIER RATING DATE & SIGN** |
| Plans delivers and evaluates care to promote psychological wellbeing |  | * Shows an awareness and understanding of the Respect and Dignity Benchmark * Recognises why a hospital environment can be stressful and describe emotional reactions to this environment * Is able to describe signs of stress in a patient * Can discuss how cultural, spiritual and social factors may affect the perception of illness * Demonstrates knowledge of the importance of sleep and rest * Is aware of how emotions such as anxiety and fear may affect behaviour * Complete **STARS Core Competency Section 18 - Emotions** * Deals constructively and sensitively with difficult behaviour * Complete **STARS Core Competency Section 16 and 20 – Thinking Processes and Behaviour** * Builds trusting relationships with patient and visitors, allowing for the expression of anxieties and concerns * Documents communications with relatives in the nursing records * Can recognise and show an understanding of the role of clinical psychology in the patients treatment plan | **I** |  |  |  |  |
| Provides individualised care, being responsive and adaptable to the needs of relatives, |  | * Understands the requirements of the Promoting Self Care and Well-Being benchmark * Ensures visitors are aware of the wards facilities and information that is available for them to read * Involves family in care, and discussions about care, at a level appropriate to the patients’ needs (with the patients consent) * Prepares visitors for what to expect, helps and encourages them to relate appropriately to patients. * Ensure that family are given opportunity to discuss the diagnosis and prognosis so that they understand what has happened and how they can contribute to the patients recovery where appropriate * Is able to complete the SAD-QH * Has an awareness of when to refer to clinical psychology and is able to make this referral independently * Can sign post carers to the Stroke Association for support and advice | **I** |  |  |  |  |
| Can assess a patient for delirium |  | * Is able to describe the causes and symptoms of delirium * Takes measures to try to reduce the incidence of delirium * Demonstrates how the care and treatment of a patient with delirium has to be adapted to suit their changing needs | **I** |  |  |  |  |
| Demonstrates an awareness of mental capacity |  | * Demonstrates an understanding of capacity and the processes involved under the Mental Health Act and how cognition can affect this * Attends safeguarding of vulnerable people training * Understands the Safety of Vulnerable People benchmark * Has completed trust wide Dementia Awareness training * Demonstrates an awareness of when to action a Deprivation of Liberty Screen (Dols) * How to complete a Dols assessment   (Including documentation and referral process) | **I** |  |  |  |  |

**Core Competency Theme 14: Hygiene and Infection Prevention and Control**

**Aim: The learner is able to safely and competently care for the hygiene needs of a patient and has a full understanding of their role in the prevention and control of infection**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
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| Demonstrates the ability to assess patients hygiene needs and provide individualised care |  | * Is sensitive to patients’ individual needs * Maintains privacy and dignity at all times * Administers correct/appropriate mouth and eye care as required * Has an understanding of the ‘Privacy and Dignity’ benchmark * Provides care, which is appropriately carried out, for patients that involves;   + Eye care   + Mouth care   + Washing of hair   + Shaving – male and female needs considered   + Bathing/showering * Understands the requirements of the Personal Hygiene benchmark | **I** |  |  |  |  |
| Demonstrates an understanding of the infection prevention requirements in a clinical setting |  | Demonstrates an understanding of how infections are transmitted  and how to prevent or limit the spread of infection   * Can demonstrate understanding of infection control issues and the impact on care delivery. Specifically demonstrates (or explains where not possible) * Collection of specimens (Sputum, Urine, Blood, Faeces) * Use of the MRSA pathway, screening and prophylaxis/treatment options * Identification of single use items * Recording of microbiology results * Able to identify the correct preventative measures for patients : * CRE * C-DIFF * MRSA * Has an awareness and knowledge of the Trust Infection and prevention control colour coded cards relating to infections and precautions * Is able to document any contraindications to adhering to all Trust barrier procedures * Completed trust hand hygiene osce | **I** |  |  |  |  |

**Core Competency Theme 15: Transfer of Care**

**Aim: The learner is able to safely and competently care for the needs of a patient who is being prepared for the transfer of their care needs be that to their home environment or to another healthcare provider**

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| Can safely transfer a patient to the ward |  | * Liaise with shift co-ordinator regarding the time of transfer. * Prepares the patient for transfer; * Assembles belongings including patients own drugs, notes and nursing records * Ensures that all relevant documentation is completed and filed appropriately * Ensures patient identification bands are present and correct * Prepares the patient for transfer. Informs family/carer of transfer and new ward contact details. * Provides a clear and concise hand-over to the receiving nurse * Ensures details are transferred off the electronic handover. | **I** |  |  |  |  |
| Demonstrates safe implementation of discharge plan |  | * Able to demonstrate how family / caregivers needs are assessed and can explain how they are kept informed and what information can be given to them. * Has NOTIS access * Where possible to spend a day while on induction with the Discharge co-ordinator (DISCO) | **I** |  |  |  |  |
| Demonstrates the safe preparation of a patient for their discharge |  | * Demonstrates ability to effectively handover/feedback accurate information during board rounds, family meetings and case conference. This is to include; * The 24 hour care needs of the patient * Diet & feeding needs * Continence/toileting * Safety issues such as use of bed rails * Medication and ability to self- administer medications * Pressure area care * The patient’s psychological care needs * Any caregiver needs that may also need to be addressed. * Able to maintain up to date records on the ward electronic handover. * Able to demonstrate knowledge of the patients discharge plans within the accountability handover * Able to demonstrate accurate completion of all information charts including: * Bed rail trials chart * Stroke discharge booklet * 24hr intervention chart * Self- administration of medicines assessment * SADHQ and mood assessments * Demonstrates ability to complete the required social services documentation including;   + The IHSCT Section two,   + IHSCT Section five   + CHNC checklist   + Can demonstrate how to make the relevant referrals required   + Can also explain the process of the Section two and Section five, giving relevant time frames for these two assessments. * Has an understanding of why we need to know how the patient will manage in the community over a 24 hour period, and is able to independently complete a detailed 24 hour care chart when appropriate to do so. * Is proactive in the instigation of conducting a care package simulation and feeding back the results of this to the MDT * Is able to explain why we need to know how the patient will manage medications on discharge and independently implements a self- medication assessment in a timely manner, taking into account swallow and dexterity problems that may be encountered. * Is able to teach family and/or carers and is able to assess their competence in the administration of medications for the patient on discharge. * Has an understanding of the risks associated with the use of bed rails in the community and independently completes the risk assessment tool for a trial without bed rails in hospital in a timely manner, and informs the family if a trial without bedrails is to commence. | **I** |  |  |  |  |
|  |  | * Is able to demonstrate completion of capacity assessments around bed rails to facilitate a discharge plan. * Is able to demonstrate an understanding of continence on discharge plans from hospital, and promotes independent toileting where able (e.g. bed side commode / female urinal). * Able to complete capacity assessments around continence needs to facilitate a discharge plan * Has an understanding of the risks associated with pressure care needs on discharge and proactively plans for discharge from hospital e.g. trials of reduced turns at night, consideration of reduced bed mobility - to simulate home and pressure relieving equipment that will be needed on discharge * Is able to feedback to family and the MDT the outcome of the above assessments appropriately | **I** |  |  |  |  |

**Additional Competency;**

**Aim: The learner is able to:**

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**Additional Competency;**

**Aim: The learner is able to:**

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| **COMPETENCY / Outcome** | **EVIDENCE METHOD USED +** | **Criteria for practice assessment** | **MIN LEVEL**  **tO ACHIEVE** | **INITIAL**  **LEVEL** | | **FINAL**  **LEVEL** | |
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**Additional Competency;**

**Aim: The learner is able to:**

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**RECORD OF SUPERVISED / ASSESSED PRACTICE**

**🖉** Developing my Competence Practitioner Name ……………………………………

By signing the discussed/assessed/competent sections of the statements both the preceptor/mentor/assessor and learner are stating that the

Learner is competent to carry out the associated tasks safely and independently according to Trust and Stroke policy and procedures.

In line with Trust policy new staff must be trained and have competency statements for medical devices relevant to the Stroke Wards/Clinic.

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| **Date** | **Objective** | **Strengths** | **Development Areas Identified** | **Actions Agreed** | **Practitioner/ Learner**  **Initials** | **Mentor/ Verifier**  **Initials** |
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| **Date** | **Objective** | **Strengths** | **Development Areas Identified** | **Actions Agreed** | **Practitioner/ Learner**  **Initials** | **Mentor/ Verifier**  **Initials** |
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| **Date** | **Objective** | **Strengths** | **Development Areas Identified** | **Actions Agreed** | **Practitioner/ Learner**  **Initials** | **Mentor/ Verifier**  **Initials** |
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**Medical Device Training/Competency Record**

The table below is a list of the most common medical devices used in your area. You have to be trained to use each of the devices listed and then competency assessed to ensure that you are safe to continue the use of the equipment for direct patient care.

As you will see, the second column gives you space to name the trainer who works in your area who will provide the training and conduct the competency assessment.

You need to undergo this assessment ***every three years*** for each piece of equipment unless otherwise stated.

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| **Medical Device** | **Name of trainer** | **Training complete** | **Competency assessment complete** | **Date when next due** |
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**Mandatory Training**

All staff undertake annual mandatory training which is delivered in the form of a Trust DVD or on-line training in the month of your birthday.

The current DVD covers the following aspects of your mandatory training requirements:

* Infection prevention and control
* Conflict resolution
* Health and safety
* Values and behaviours

The DVD is then followed by a session on Safeguarding Vulnerable People – this session covers your needs for safeguarding both adults and children.

In addition to the above training you will need:

* To have basic life support training – carried out locally with resuscitation link professionals in your area
* A manual handling assessment – carried out locally by manual handling competency assessors
* Fire training – carried out locally after your area has undergone a risk assessment by the fire prevention team

All of the above mentioned subjects are updates to the initial training that you receive when commencing employment with the trust. For this reason it is imperative that you attend both the corporate and nursing induction sessions within 2 months of stating your job.

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| **Aspect of Mandatory training** | **Date due** | **Date completed** | **Aspect of Mandatory training** | **Date due** | **Date completed** |
| Mandatory training DVD |  |  |  |  |  |
| Safeguarding Session |  |  |  |  |  |
| Fire |  |  |  |  |  |
| AHLS |  |  |  |  |  |
| Manual Handling Competency Assessment |  |  |  |  |  |

**Record of Training**

The table below provides an opportunity for you to record other training that you receive or courses that you attend.

Your Ward Sister/Charge Nurse will also have a record of this learning.

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| **Training/Course undertaken** | **When required?** | **Date completed** | **Comments** |
| Corporate Induction | In the first 2 months |  |  |
| Nursing induction | In the first 2 months |  |  |
| IV drug administration package | In the first 3 months |  |  |
| Stroke Foundation Course | In the first 6 months |  |  |
| Critical skills training for RN’s | In the first year |  |  |
| Dysphagia training | In the first year |  |  |
| Dying to communicate | In the first year |  |  |
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**Notes**

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