8.

Fareham and Gosport NHS
Primary Care Trust

COMPETENCY OBJECTIVES

NAME: SN C ROBINSON

MENTOR: SISTER H RUSSELL

Signature: _____

Signature: _____

COMPETENCE	KEY OBJECTIVES	ACHIEVE BY	MEASUREMENT CRITERIA	ABLE TO DISCUSS RATIONALE DATE & SIGN	DEMONSTRATES UNDER SUPERVISION DATE & SIGN	DEMONSTRATES INDEPENDENT SAFE PRACTICE DATE & SIGN
Professional Accountability	Management of the patient	3 months	• Promote & safeguard the patients interest and well being • Ensure no act or omission is detrimental to the interests, condition or safety. • Work in an open, co-operative manner. Actively work within a multi-discipline framework. • Recognise the uniqueness and dignity of each patient. • Protect all confidential information, make disclosures only with consent, where required by court order, or where justified by wider public interest			
	Management of the relatives/carers	3 months	• Work in an open, co-operative manner. • Protect all confidential information, make disclosure only with consent, where required by court order, or where justified by wider public interest.			
	Management of colleagues	3 months	• Work in a collaborative & co-operative manner with colleagues and other health care professionals. • Recognise and respect other contributions within the team. • Protect all confidential information, make disclosure only with consent, where required by court order, or where justified by wider public interest. • Assist others in the care team, including informal carers, to ensure safety to their appropriate roles.			

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Professional accountability	Professional development	3 months	• Demonstrate effective use of time management by prioritising workload. • Acknowledge any limitations in knowledge or competency. • Perform any duties or responsibilities in a safe & skilled manner. • Maintain & improve professional knowledge and competence. • Consistently demonstrate research based practice.			
Documentation	Clear concise, informative admission summary	6 months	• All assessments completed. • All sections completed. • One care plan per problem. • Care plans identify current problems and discussed with patient. • Care plans identify desired outcomes of care. • Evidence provided of care being evaluated against desired outcomes. • Care plan & summary compliment each other. • All entries in black ink. • All entries signed, dated and legible. • All entries by unqualified staff countersigned by a Registered Nurse. • Alteration/errors have a single line through and are signed. • Trust approved only abbreviations used. • Store in secure location in line with ward practice.			

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Documentation	Clear & accurate documentation of all nursing g/clinical interventions	6 months	• Summary sheet shows chronology of care responding to changing need. • All entries in black ink. • All entries by unqualified staff countersigned by a Registered Nurse. • Alterations/errors have a single line through and are signed. • Trust approved only abbreviations used. • Store in secure location in line with ward practice.			
Documentation	All communications recorded	6 months	• Clear information recorded including: • Name of person communicated with • Content of discussion/information • Nature of communication i.e. phone, in person • Location i.e. bedside, office etc • All entries in black ink • All entries signed, dated and legible • All entries by unqualified staff countersigned by a Registered Nurse • Alterations/errors have a single line through & signed • Store in secure location in line with ward practice			
Documentation	Evidence of discharge planning (if appropriate)	6 months	• Evidence of clear structured planning. • All sections of the check list completed by a Registered Nurse and filed in notes.			

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Documentation	Evidence of discharge planning (if appropriate) (continued)	6 months	• Alterations/errors have a single line through and are signed. • Store in secure location in line with ward practice.			
Communication	Effective verbal & written communication	3 months	• Promotes effective verbal communication. • Promotes effective non-verbal communication. • Promotes effective written communication. • Promotes effective telephone communication. • Communicates effectively with:- • Patients, Relatives/Carers. • Internal Agencies/Departments. • External Agencies/Departments. • Participates in ward rounds. • Participates in case conferences. • Communicates effectively with other members of the multi-disciplinary team. • Effectively uses telephone bleep system. • Activates emergency calls. • Attends Communication Skills Workshop. • Demonstrates the correct use of Referral Form to multi-disciplinary team and outside agency			

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Administration of medicines	Establish competency	3 months	• Questions appropriateness of prescription , or container if information is illegible, unclear, ambiguous or in complete. • Able to ascertain patients identity. • Demonstrates an understanding of common usage drugs and those particular to clinical area. • Demonstrates an understanding of how those drugs interact with human, physiological, biochemical and metabolic processes. • Able to administer safely a range of medication in a variety of ways. • Able to administer safely controlled drugs. • Able to state the action to be taken in the event of a drug or dosage error. Able to describe the signs and symptoms and management of anaphylactic shock. • Demonstrate knowledge of the national and local policy in relation to nurse prescribing. • Able to make clear accurate & contemporaneous records of medicines administered or withheld. • Demonstrates an understanding of under which circumstances a refusal to administer medication should be made and the appropriate action. • Demonstrates an understanding of the appropriate course of action if the prepared medication cannot be administered: a. at the prescribed time b. directly to the patient			

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Administration of medicines	Establish competency	3 months	• able to describe/demonstrate the appropriate action if asked to: a. prepare substances for injection in advance of their immediate use b. administer a medication not prepared by him/her in him/her presence c. take over responsibility for the care of a continuous infusion d. educate patients with respect to their medication e. administer a medication on verbal instructions • Able to describe/demonstrate the appropriate action if a patient refuses medication. • Able to describe/demonstrate an appropriate action if doses or routes of administration are considered inappropriate or outside the product licence. • Able to account for responsibilities in law, as set out by the UKCC standards and local policies. • Able to describe responsibilities for safe storage. • Demonstrates a knowledge of routes of administration. • Demonstrates competent drug calculation. • Demonstrates an ability to scrutinise, understand and follow prescribed instructions. • Able to identify:- Dose Administration method Route Time			

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Administration of medicines (continued)	Establish competency	3 months	• Able to follow information on the relevant containers and check expiry dates. • Able to administer medication via: S/C I/M Syringe Driver NG/PEG • Able to demonstrate correct procedure for setting up: Syringe Driver Feeding Pump			
Tissue Viability		2 months	• Demonstrate effective use of aseptic required • Demonstrate an understanding of common dressings used on ward. • Demonstrate Wound Assessment using grading scale.			
Nutrition		2 months	• Demonstrate the correct use of Nutritional Assessment Tool. • Demonstrate actions following assessment. • Participate in referral to Dietician or SLT. • Able to insert NG/Feeding Tube. • Commence Feeding Regime.			
Personal Development	Attend Statutory Training	2 months	Attend:- BLS and AED Fire Manual Handling Food Hygiene			
Continence		2 months	• Demonstrate knowledge of continence pad sizes. • Able to catheterise female patient • " " " male patient • " " apply sheaths to male patient			

Fareham and Gosport NHS
Primary Care Trust

ADMINISTRATION OF MEDICINES
COMMUNITY HOSPITALS – ASSESSMENT FOR QUALIFIED NURSES

Measurement Criteria	Competent		Comments
	Yes	No	
Produce copy of NMC guidelines			
Show evidence of understanding of guidelines via questioning			
Show evidence of knowledge of what constitutes a legal prescription			
Outline checking procedures for non-controlled and controlled medicine			
Demonstrate evidence of knowledge of the side effects of commonly used drugs currently on the trolley			
Demonstrate evidence of knowledge of does and strength of commonly used drugs			
Identify sources of drug information			
Identify process to be followed in the event of a drug error			
Complete minimum of one supervised drug round without error			
Demonstrate knowledge of the safe storage of drugs			

Name: _____ ☐ Passed ☐ Failed

Date: _____

P.T.O.

Report

Name of Nurse: _____

Ward: _____

Date of Assessment: _____

Name of Assessor: _____

Signature of Assessor: _____

Name of Nurse: _____

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Measurement Criteria	Competent		Comments
	Yes	No	
Produce copy of UKCC guidelines	✓		
Show evidence of understanding of guidelines via questioning	✓		
Show evidence of knowledge of what constitutes a legal prescription	✓		
Outline checking procedures for non-controlled and controlled medicine	✓		
Demonstrate evidence of knowledge of the side effects of commonly used drugs currently on the trolley	✓		
Demonstrate evidence of knowledge of does and strength of commonly used drugs	✓		
Identify sources of drug information	✓		
Identify process to be followed in the event of a drug error	✓		
Complete minimum of one supervised drug round without error	✓		Has undertaken several drug rounds under supervision
Demonstrate knowledge of the safe storage of drugs	✓		

Name: ~~EDONA~~ DONNA ROBINSON (CHRISTINE) ☑ Passed ☐ Failed

Date: 21/12/03

P.T.O.

Report

Name of Nurse: DONNA ROBINSON

Ward: DRYAD WARD.

Date of Assessment: 24/12/03

S/N Robinson has successfully undertaken several drug rounds, she has learnt from the experience and always ensures that she reads the Drug Prescription effectively, thus being able to successfully complete a drug round without incident

If S/N Robinson is unable to identify a drug she can successfully find its use ect by using the resources available

Name of Assessor: H T Russell

Signature of Assessor: **Code A**

Name of Nurse: DONNA ROBINSON