Chapter 3E

Specialty Nursing Competencies- Platypus Ward

The Royal Children's Hospital Melbourne

Nursing Competency Workbook, 10th Edition

The Royal Children's Hospital (RCH) Nursing Competency Workbook is a dynamic document that will provide you with direction and assist you in your professional development as a nurse working at the RCH. The workbook also provides a record of your orientation and competency obtainment.

Chapter 1
Includes resources for nurses and is complemented by the Royal Children's Hospital (RCH) New Starter Pack, Hospital Orientation and Nursing Orientation day, to provide an introduction to nursing at the RCH.

Chapter 2
Generic Nursing Competency Assessment Forms

Chapter 3
Specialty Nursing Competency Assessment Forms

Appendix 1
Unit / Department Nursing Orientation

All chapters and appendices are downloadable as pdfs from the Nursing Education Website.

The RCH Nursing Competency Workbook developed by Nursing Education with input from specialist nurses at the RCH.

For further information contact:
Melody Trueman
Director, Nursing Education
T: (03) 9345 6716 | E: melody.trueman@rch.org.au

Workbook Edition 10, January 2018

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Burns – Assessment & Fluid Management

Competency Statement:
The nurse demonstrates sound knowledge and assessment skills for patients with burns

RCH references related to this competency: RCH Clinical Practice Guidelines: Burns; RCH Intranet: Surgery – Clinical Information - Burns

COMPETENCY ELEMENTS	
K	1. Locate and read: Nursing Management of Burn Injuries clinical practice guideline 2. State the rationale for assessing the patient with a burn injury 3. Discuss the signs, symptoms & associated complications of an inhalational burn injury 4. State the first aid requirements for a burn & the timeframe it may be used in 5. Discuss how to calculate total burn surface area (TBSA) for various age groups using the Lund & Browder Chart as a guide 6. Identify a circumferential burn & state the associated risk it presents 7. Discuss the implications for assessment requirements for the patient with a a. circumferential burn b. facial burn, c. perineal burn, d. burns over a joint e. superficial burn f. partial thickness burn g. full thickness burn 8. Discuss the challenges in assessing fluid status in the burns patient 9. Explain circulatory shock 10. Discuss fluid needs and criteria for fluid resuscitation in the burns patient 11. Discuss the allocation of the percentage of fluids i.e.: resuscitation and maintenance 12. Identify the formula used to calculate resuscitation fluids in burns patients 13. Discuss the importance of time of the burn injury in regard to resuscitation fluids 14. Discuss the rationale for insertion of a nasogastric tube in a patient with a burn injury 15. State the expected urinary output in the patient receiving fluid resuscitation after a burn injury.
S	1. Accurately perform & document ABCD assessment for a patient with a burn injury-within EMR using the 'Primary Assessment' tab in the Flowsheets Activity 2. Correctly document the time of burn & mechanism of injury-in the notes activity in the EMR 3. Assess colour, presence/absence of blisters, capillary refill time & sensation to determine burn depth. 4. Perform a calculation of resuscitation fluids in a patient weighing 10kg with 20% TBSA who presented to ED 2 hrs post the burn injury-use the Burns/Management of Burns Wounds Clinical Practice Guideline as a resource 5. Demonstrate accurate documentation of fluid resuscitation within the 'Fluid Balance' section in the Flowsheets Activity

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in this competency. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio.

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Burns Dressing Changes

Competency Statement:
The nurse discusses the principles of wound care in relation to a burn. The nurse demonstrates a holistic & structured approach towards burn wound care.

RCH references related to this competency: RCH Clinical Practice Guidelines: Burns; Procedural Pain Management & Sedation- Procedural Sedation: Ward & Ambulatory Areas
RCH Intranet: Surgery – Clinical Information – Burns Unit

COMPETENCY ELEMENTS	
K	1. Locate and read: • –Nursing Management of Burn Injuries clinical practice guideline • Clinical Information on the RCH Burns Unit Webpage http://www.rch.org.au/burns/clinical/index.cfm?doc_id=2012 • Procedural Pain Management clinical practice guideline 2. Discuss Burns Wound Assessment in relation to: • Depth- appearance, sensation, circulation and colour • Location- considerations for perineal, face and hand burns • Size- total body surface area • Healing- effectiveness of dressing product used 3. Explain patient and family preparation prior to a burns dressing 4. Discuss the considerations for the patient undergoing a burns dressing • Pain management • Play therapy & distraction • Environment preparation 5. Discuss the overall aims of burns wound management in relation to: • Healing environment • Pain relief • Prevention of infection • Dressing removal, wound preparation (cleaning) and the presence of blisters 7. Explain the range of burns dressing products commonly used at RCH: • Acticoat- different types, activation & application • Intrasite Conformable- considerations when applying to a burn • Mepilex Ag- the use of foam dressings on different areas of the body • Xeroform & Kenacomb ointment- when is this applied • Bactigras- low adherent dressing application • Securing tapes & Tubigrip/Tubifast application • Vaseline & Sorbolene creams- their role in burn healing
S	1. Demonstrate a burns dressing change requiring: a) **Simple Analgesia**- oral analgesia used b) **Multimodal Analgesia**- oral analgesia plus sedation (i.e. nitrous or oral sedation) c) **General Anaesthetic**- anaesthetic involvement 2. Demonstrate accurate documentation within EMR following the completion of the burns dressing change- using the 'LDA Assessment' tab in the Flowsheets Activity & completion of a progress note within the Notes activity.

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Bowel Washout

Competency Statement:
The nurse safely and effectively cares for a child requiring a bowel washout

RCH references related to this competency: RCH Clinical Practice Guidelines: Neonatal Bowel Washout (Rectal)

COMPETENCY ELEMENTS	
K	1. Locate and read Bowel Washout (Rectal) Clinical Practice Guideline 2. State the rationale for a performing bowel washout on a patient 3. Collect all equipment required
S	4. Perform a bowel washout 5. Demonstrate accurate documentation utilising the Bowel Washout section within EMR in the 'Fluid Balance' tab in the Flowsheets activity 6. Educate the family on the procedure and the rationale as appropriate 7. Effectively discharges a child who requires bowel washouts into the community

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Nurse Name: Signature: Date:

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Chest Drain & Underwater Seal Drain (UWSD) Management

Competency Statement:
The nurse safely and effectively cares for the child who has a Chest Drain with an Underwater Seal Drain (UWSD)

RCH references related to this competency: RCH Clinical Practice Guideline: Chest Drain Management

COMPETENCY ELEMENTS	
K	1. Locate and Read: a. RCH Clinical Practice Guideline: Chest Drain Management 2. Describe the anatomy of the chest including the lining of the lungs 3. Identify the mechanics of breathing including negative intrapleural space 4. Provide rationales for insertion of UWSD chest drain 5. Explain the specific safety precautions required for the patient with an UWSD 6. Describe the correct procedure for securing the chest drain and dressing the insertion site 7. Describe the ongoing patient assessment required when a patient has chest drain with UWSD including a. Start of shift checks b. Vital signs c. Pain d. Drain insertion site 8. Describe the indications and procedure for changing the UWSD unit 9. Describe the precautions required for transporting a patient with an UWSD 10. Outline the complications of a chest drain and UWSD
S	11. Demonstrate the correct assembly of the UWSD apparatus for connection to the chest drain, and suction (if ordered) a. Correct pressure b. Connecting one unit to suction c. Connecting 2 units to suction (splitting) d. Wet suction unit (Atrium Ocean) e. Dry suction unit (Atrium Oasis) 12. Using the UWSD apparatus identify how you would determine if the patient has an ongoing air leak 13. Demonstrate the correct method of documenting the chest drainage activity utilising the Chest Drain section within the 'LDA Assessment' tab in the Flowsheets Activity in the EMR 14. Demonstrate the correct method for obtaining a specimen from the UWSD unit

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Nurse Name: Signature: Date:

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Cleft Lip and Palate Repair

ALERT*: *The pain competencies should be completed in conjunction with this competency

Competency Statement:
The nurse safely and effectively cares for a child post cleft lip repair

RCH references related to this competency: RCH Intranet: Surgery – Plastic & Maxillofacial Surgery

COMPETENCY ELEMENTS	
K	1. Locate and read Cleft Lip and Palate question and answer booklet. 2. Describe the expected colour / consistency of oral ooze post cleft lip and/or cleft palate repair 3. State the rationale for use of nasal stents in some patients post cleft lip repair 4. Discuss the differences in mouth care of patients post cleft lip repair with a. Sutures b. Dermabond 5. Provide rationale for use of a Nasopharyngeal Airway (NPA) in some patients post cleft palate repair 6. State frequency & type of observations necessary for patients with an NPA 7. State rationale for use of a Swedish Nose on an NPA 8. State the rationale for mouth care post cleft palate surgery & describe when mouth care is necessary
S	9. Ensure bedside safety checks complete & necessary equipment is available at the bedside 10. Demonstrate discussion with patients and caregivers with regard to the importance of a. Mouth care b. Nasal Stent care 11. Demonstrate correct technique in performing mouth care & stent care for a patient post cleft palate surgery 12. Demonstrate discharge education of caregivers regarding the correct technique in performing mouth care & stent care

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Nurse Name: Signature: Date:

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Craniofacial Surgery

ALERT*: *The urinary catheter, and central venous access device management and pain competencies are closely associated with this competency

Competency Statement:
The nurse demonstrates sound knowledge and is able to provide safe care for the patient post craniofacial surgery

COMPETENCY ELEMENTS	
K	1. Describe the Cranial Vault Remodelling procedure 2. Describe actions to be taken in the event of any bleeding or haemoserous ooze leaking from the dressing 3. Provide a rationale for frequency and type of observations necessary from the immediate post-operative period through to day 4 post op. 4. Describe how to perform neurological observations on a patient whose eyes are swollen shut 5. Discuss the fluid management for patients post craniofacial surgery and provide rationales 6. State when it is appropriate to remove head dressing
S	1. Demonstrate correct preparation of the room and equipment prior to receiving patient from recovery 2. Demonstrate correct patient positioning post craniofacial surgery and provide rationale 3. Perform eye care with correct solution 4. Demonstrate hair washing, suture care and related caregiver education when head dressing is off 5. Demonstrate discharge education to caregivers

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Nurse Name: Signature: Date:

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Free Flap Transfer & Digital Reimplantation / Revascularisation

ALERT*: *The surgical drains, IDC care, IV fluids, pain management & CVAD competencies should be completed in conjunction with or prior to this competency

Competency Statement:
The nurse will safely and effectively care for a patient with a free flap

COMPETENCY ELEMENTS	
K	1. Demonstrates correct room preparation & ensures all necessary equipment is available 2. State indications for digital replantation / revascularisation 3. Discuss the type & frequency of observations to be taken for: a. The first 24 hours post-op b. Day two c. Day three d. Day four 4. Able to identify normal flap/digit observation findings from abnormal: a. venous congestion b. arterial insufficiency 5. States actions to be taken in the event of abnormal flap/digit observations 6. Provide the rationale for keeping a strict fluid balance for this patient group 7. State expected urine output for this patient group & actions to be taken in the event of insufficient urine output 8. State any dietary restrictions for these patients & provide rationale for these restrictions.
S	1. Demonstrate accurate documentation of observations utilising the Flap/Digital reimplantation section of the 'LDA Assessment' tab in the Flowsheets activity within the EMR 2. Demonstrate/state correct patient positioning for: a. Limb flaps b. Facial flaps c. Affected limb

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Gastrostomy Tubes

Competency Statement:
The nurse safely and effectively cares for a child with a gastrostomy tube

RCH references related to this competency: RCH Clinical Practice Guidelines: Gastrostomy – acute replacement of displaced tubes, Gastrostomy – common problems

COMPETENCY ELEMENTS	
K	1. Locate and read a. Gastrostomy – common problems clinical practice guideline b. Gastrostomy – acute replacement of displaced tubes clinical practice guideline. 2. Discuss the reasons why a gastrostomy tube might be inserted 3. Describe a gastrostomy tube including all the key parts 4. Discuss post-operative care of gastrostomy tube post insertion 5. Discuss immediate use of gastrostomy tube post insertion 6. Discuss rotating or turning the gastrostomy tube 7. Discuss the daily care requirements for a child with a gastrostomy tube 8. Discuss the role of the dietician in the management of feeding via a gastrostomy tube 9. Describe the process for administering feeds via a gastrostomy tube including the types of feeding methods 10. Discuss the care required for the stoma site 11. State common problems with a gastrostomy and discuss nursing interventions required 12. State the immediate management of a patient with a dislodged gastrostomy tube
S	1. Demonstrate: • venting of a gastrostomy tube • medication administration • administration of enteral feeds • care of the gastrostomy site

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Nurse Name: Signature: Date:

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Hip Spica Cast

Competency Statement:
The nurse safely and effectively cares for a patient with a hip spica cast.

RCH references related to this competency: RCH Intranet: Kids Health Info – Fact Sheets – Hip Displacement, Hip spica plaster 1, Hip spica plaster 2

COMPETENCY ELEMENTS	
K	1. Locate and read the Hip Spica Nursing Care Clinical Guideline & Hip Spica Resource folder 2. Discuss the reasons for Hip Spica application 3. Discuss assessment and initial nursing management required when caring for a hip spica plaster cast 4. Identify the process for equipment hire from the Equipment Distribution Centre a. Documentation required b. After-hours access 5. Discuss the information, including discharge education, that should be provided to the family/carers when caring for a child in a Hip Spica Cast a. Preparation for a hip spica- Kids health Info "What to expect in Hospital b. Car seating/pram/wheelchair (equipment hire / indemnity & medical letters) c. Cast care both in hospital- scotching and sleeking at at home- Kids Health Info "Care at home" d. Pain Management e. Toileting options f. Positioning and pressure area care g. Lifting/Handling h. Diet i. Family centred care
S	1. Demonstrate the nursing care required of a patient with a Hip Spica Cast a. Pain assessment b. Neurovascular assessment c. Toileting & Hygiene d. Pressure area care & Positioning e. Cast Care (scotching and sleeking) f. Lifting/Handling 2. Demonstrate the safe fitting of the patient in an appropriate car seat and pram / wheelchair a. Use of padding b. Provision of correct indemnity paperwork for car seating utilising the 'Communication' Activity within the EMR 3. Demonstrate discharge planning and provision of parent education

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Nurse Name: Signature: Date:

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Neurological Observations

Competency Statement:
The nurse accurately and effectively performs neurological observations on paediatric patients

COMPETENCY ELEMENTS	
K	1. State the difference between performing neurological observations and a neurological assessment 2. Discuss each component of neurological observations and how they assist in determining a patient's neurological condition a. Glascow Coma Scale b. Pupils c. Limb strength d. Vital signs 3. Identify the preferred method of painful stimuli 4. Describe decorticate and decerebrate posturing and what causes them 5. Discuss how acquired or developmental intellectual impairment will affect the collection of accurate neurological observations 6. List the signs and symptoms of raised ICP and how these change as the infant/child gets older 7. State the actions required if a patient has deterioration in neurological status
S	1. Assemble the equipment required to perform neurological observations 2. Demonstrate neurological observations on paediatric patients in the following age groups: a. Infant (<1year) b. 1 – 4 year c. 5 - 12 year d. 12 + years

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Nurse Name: Signature: Date:

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Neurovascular Assessment

Competency Statement:
The nurse safely and effectively performs a neurovascular assessment on a patient

COMPETENCY ELEMENTS	
K	1. Locate and read Neurovascular Observations Clinical Guideline 2. Explain the importance of neurovascular assessment 3. Identify patient groups that require neurovascular observations 4. Discuss frequency of neurovascular assessment a. Commencing & RPAO b. Frequency c. Ceasing 5. Discuss abnormal and potential complications of findings 6. Discuss what action is required if abnormal neurovascular observations are assessed
S	1. Demonstrate and document a neurovascular observations on a patient utilising the Neurovascular section of the 'Observations' tab within the Flowsheets activity of the EMR 2. Educate families on rationale for neurovascular assessment.

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Nurse Name: Signature: Date:

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Nutrition (Parenteral)

ALERT: The CVAD management competency should be completed in conjunction with this competency

Competency Statement:
The nurse safely and effectively administers Parenteral Nutrition

Element Exemptions: Koala and Cancer Care Unit (K6a-b and S2b)

COMPETENCY ELEMENTS	
K	1. Locate & read the a. Parenteral Nutrition Clinical Guideline b. Parenteral Nutrition (PN) Cue Card 2. State the general indications for use of PN 3. Identify members of the multidisciplinary team involved in the care of this patient group. 4. Identify at least five components which can be found in the PN solution 5. State the ideal IV access for patients receiving a. Low dextrose nutrient solutions b. High dextrose nutrient solutions 6. Discuss the following a. TPN fluid prescription and documentation b. Preparation & administration 7. Discuss the ongoing care requirements and management of patients receiving PN a. commencing b. ceasing c. weaning d. frequency of monitoring: i. Bloods ii. Weight iii. CVAD 8. Discuss how to administer non-compatible IV antibiotics to a patient receiving high dextrose PN solution 9. Discuss the correct action to be taken in the event that the nutrient solution finishes prior to the next bag being delivered from pharmacy
S	1. Demonstrate checking of IV medication compatibility with PN prior to medication administration utilising available medication resources 2. Demonstrate appropriate checking, scanning and documentation of TPN administration utilising the MAR within the EMR 3. Demonstrate IV line assembly & priming for the patient receiving 4. Demonstrate programming of IV pumps for all stages of weaning on & off PN

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Nurse Name: Signature: Date:

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Pin Site Care

Competency Statement:
The nurse safely and effectively cares for a patient with an external fixator requiring pin site care

RCH references related to this competency: RCH Intranet: Surgery – Limb Reconstruction (LR)

COMPETENCY ELEMENTS	
K	1. Locate and read the Clinical Practice Guideline- Pin Site Care for the Child with an External Fixator 2. Discuss the rationale for performing pin site care 3. Identify the correct dressing for frame locations: a. Femoral- MONOLATERAL frame b. Tibial- CIRCULAR frame & MONOLATERAL frame 4. Discuss the frequency of dressing changes required for: a. Femoral- MONOLATERAL frame b. Tibial- CIRCULAR frame & MONOLATERAL frame 5. Discuss the preparation required prior to performing pin site care: a. Patient and family preparation b. Time management & staffing resources c. Analgesia requirements d. Environment 6. Discuss the discharge planning process for patients with external fixators requiring pin site care to be performed at home a. Obtaining correct dressing supplies from EDC (Equipment Distribution Centre) b. Wallaby referral c. Discharge medications d. Additional resources-Platypus Care Coordinators/ Limb Reconstruction Nurse
S	1. Locate and set up dressing stock in preparation for pin site dressing 2. Prepare patient and family, explain the procedure 3. Demonstrate appropriate pin site care technique for: • Femoral- MONOLATERAL Frame • Tibial- CIRCULAR & MONOLATERAL Frame

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Nurse Name: Signature: Date:

Downloadable Oximetry

Competency Statement:
The nurse safely and effectively cares for a patient requiring overnight oximetry.

RCH references related to this competency: RCH Intranet: FRACP – FRACP Resources,

COMPETENCY ELEMENTS	
K	1. State rationale for performing downloadable oximetry. 2. State rationale for oximeter probe site rotation
S	1. Prepare oximeter for test: a. Deletion of previous data b. Setting of high/low oximetry alarms c. Setting of high/low heart rate alarms d. Probe selection and application 2. Accurately record observations required of a patient requiring overnight oximetry within the EMR utilising the 'Observations' tab of the Flowsheets activity. 3. Demonstrate how to download and print oximetry data.

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Nurse Name: Signature: Date:

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Plaster Care

Competency Statement:
The nurse safely and effectively cares for a child with a plaster cast.

COMPETENCY ELEMENTS	
K	1. Discuss the indications for use of plaster 2. Discuss the principles of plaster care 3. Identify the location and use of different plaster tools a. Plaster scissors b. Spreader c. Plaster saw
S	1. Demonstrate the application of Scotchcast (fibreglass) to plaster & explain indications for use 2. Demonstrate positioning of patient with plaster. 3. Discharge and educate family on plaster care.

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Nurse Name: Signature: Date:

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Spinal Immobilisation & Log Rolling

Competency Statement:
The nurse safely and effectively cares for a patient requiring spinal immobilisation

RCH references related to this competency: RCH Clinical Practice Guidelines: Cervical Spine Assessment

Element Exemptions: Medical imaging (K2-5, K8-10, S3-4)

COMPETENCY ELEMENTS	
K	1. Locate and read the cervical spine assessment clinical practice guideline 2. Identify the patients that require cervical collar application and immobilisation 3. Discuss the rationale for log rolling a patient requiring spinal precautions 4. Discuss the nursing care for a patient with spinal immobilisation a. Observations b. Documentation c. Radiology d. Hygiene and collar care e. Pressure area care including frequency and sequence f. Transfer 5. Identify the correct process for clearing the spinal column and removing the collar 6. When should an airway pad be used to assist in maintaining neutral alignment of the paediatric spine 7. Discuss and demonstrate spinal immobilisation education to patients and families / caregivers
S	1. Demonstrate how to immobilise a patient with cervical collar, ensuring correct collar fitting 2. Demonstrate how to log roll a patient with a suspected spinal injury 3. Demonstrate maintenance of neutral alignment when the collar is removed for hygiene, examination, or airway management 4. Demonstrate how to tilt the bed on a patient who is having spinal precautions

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Nurse Name: Signature: Date:

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Spinal Surgery – Post Operative Care

Competency Statement:
The nurse safely and effectively cares for patients post spinal surgery

COMPETENCY ELEMENTS	
K	1. List the indications for spinal surgery in the paediatric population 2. Discuss the different types of spinal surgery performed at RCH a. Anterior Spinal Release b. Posterior Spinal Fusion c. Accelerated Pathway 3. Discuss the rationale for the ward nurse to assess the spinal patient post operatively in Recovery prior to transfer to the ward 4. Explain the rationale for lying the patient post spinal surgery flat for 4 hrs after transfer from theatre 5. Discuss possible complications of spinal surgery
S	6. Explain & demonstrate the management of the patient post spinal surgery in regard to a. Respiratory assessment b. Circulatory assessment (fluid management, intake / output) c. Neurovascular assessment d. Wound assessment e. Pressure area assessment f. Document appropriately within the EMR using the Flowsheets Activity 7. Demonstrate proper patient positioning post spinal surgery 8. Demonstrate patient mobilisation post spinal surgery a. sitting up b. standing c. sitting out of bed

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Nurse Name: Signature: Date:

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Stomal Care

Competency Statement:
The nurse will safely and effectively care for a child with a stoma

COMPETENCY ELEMENTS	
K	1. State the difference between an Ileostomy and Colostomy 2. Locate available resources for post-operative management and care following formation of an ileostomy or colostomy 3. Discuss nursing considerations for post – operative care 4. Discuss the differences between the amount and consistency of output expected from an a. Ileostomy b. Colostomy 5. State actions if stoma output is excessive 6. Discuss the role of the stomal therapist 7. Discuss members of the multidisciplinary team and their roles in the care of patients with stomas 8. Discuss potential complications of stomas and their management 9. Discuss resources available for patients and families
S	1. Demonstrate accurate documentation of stoma output within the EMR utilising the Output section of the 'Fluid Balance' tab of the Flowsheets Activity. 2. Demonstrate application of a stoma dressing 3. Demonstrate accurate documentation of procedures associated with stoma care within the EMR utilising the 'LDA Assessment' tab of the Flowsheets Activity

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Nurse Name: Signature: Date:

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Surgical Drains

Competency Statement:

The nurse safely and effectively cares for a patient with a surgical drain

COMPETENCY ELEMENTS	
K	1. Identify reasons why a surgical drain might be inserted 2. Identify the following surgical drains a. Jackson-Pratt b. Redivac c. Mini-Vac d. Penrose 3. State how it would be evident if each of the above drains was on suction 4. State how frequently a surgical drain should be measured and / or emptied 5. Discuss potential complications of surgical drains 6. Discuss the procedure for removal of a surgical drain
S	1. Demonstrate emptying a Jackson Pratt and Mini-Vac Drain 2. Demonstrate emptying a Mini–Vac drain 3. Demonstrate correct procedure for obtaining an accurate measurement of a Redivac drain

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Nurse Name: Signature: Date:

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Tracheostomy Management

Competency Statement:
The nurse safely and effectively cares for the infant / child with a Tracheostomy Tube Exlusions – everyone but NICU/PICU 27 onwards

RCH references related to this competency: RCH Clinical Practice Guidelines: Tracheostomy Management

Element Exemptions: Banksia, Cockatoo, Dolphin, Emergency, Kelpie, Koala, Kookaburra, Medical Imaging, Perioerative, Platypus, Possum, RCH@Home, Sugar Glider (K21-23, S7)

COMPETENCY ELEMENTS	
K	1. Locate and read the Tracheostomy Management Guidelines CPG 2. Watch the RCH Tracheostomy Care Video 3. Describe the basic anatomy of the trachea 4. State 3 underlying principles for which a tracheostomy tube is inserted 5. Describe 3 clinical conditions for which a tracheostomy tube is inserted 6. State essential aspects of the upper airway that are bypassed when a tracheostomy tube is inserted 7. Identify the different tracheostomy tubes used at RCH and discuss their management 8. Identify the different tracheostomy tapes used at RCH and discuss age related safety issues 9. State immediate and long term complications following insertion of a tracheostomy tube 10. Discuss the process for transition of a recently tracheostomied patient from PICU / NICU to a ward 11. Discuss patient safety when transporting within hospital 12. Discuss nursing supervision requirements of a patient with a tracheostomy tube 13. State the signs that indicate when suctioning is required an demonstrate correct suctioning technique 14. Describe the different secretions that may be observed and what each might indicate 15. State what a granuloma is, why they occur and how they are resolved 16. State options available for providing humidification via a tracheostomy tube and demonstrate their application 17. State options available for providing oxygen via a tracheostomy tube and demonstrate their application 18. Describe signs and symptoms of a blocked tracheostomy tube and state interventions required 19. Identify and discuss safety issues in relation to a. Bathing b. Feeding c. Travel d. Clothing e. Play 20. Discuss discharge planning for family / caregivers including: routine care and procedures, emergency procedures, community support and supplies 21. Discuss the post-operative nursing management (<7days) of a newly established tracheostomy a. availability of tracheostomy set or airway dilators at bedside b. availability of spare tracheostomy tubes at bedside c. timing 1st tube change d. personnel 1st tube change e. procedure for soiled ties f. assessment of stoma g. routine for changing trachy dressing h. airway clearance and tube patency 22. Discuss the rationale for stay – sutures 23. Discuss the process for transition of a recently tracheostomied patient from PICU / NICU to a ward
S	1. Demonstrate the procedure for changing tracheostomy ties 2. Demonstrate recommended bedside setup / transport kit / emergency kit 3. Demonstrate correct procedure for stoma care 4. Assemble equipment and demonstrate procedure for routine tracheostomy tube change 5. Demonstrate emergency management of a tracheostomy tube with respect to a. Blockage b. Accidental decannulation 6. Demonstrate care of a patient undergoing planned decannulation 7. Demonstrate management of a percutaneous tracheostomy tube

Nurse Declaration on next page

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in this competency. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio.

☐ Please indicate if there is written feedback or reflections related to this competency in the designated section of the workbook

Nurse Name:	Signature:	Date:

Assessor Name:	Signature:	Date:

Traction

Competency Statement:
The nurse safely and effectively cares for a patient in traction

RCH references related to this competency: RCH Policies & Procedures: Management of Halo Traction

COMPETENCY ELEMENTS	
K	1. Locate and Read: a. Traction Resource Folder (Located on Platypus/Possum Wards) b. Policy and Procedures: Management of Halo Traction 1. Explains the principles of traction and counter traction 2. Discuss three objectives of traction 3. Discuss three different types of traction and indications for use
S	1. Demonstrate nursing care of a patient in traction a. Pressure area care b. Pain management c. Pin site care if applicable d. Positioning e. Diversion and distraction techniques age appropriate 2. Demonstrate safety checks of patients in traction a. Check traction set up b. Assess skin integrity once per shift 3. Identify equipment, assemble and apply Slings and Springs 4. Identify equipment, assemble and apply skin traction (Bucks traction) 5. Identify equipment, assemble and apply Halo Femoral Traction

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in this competency. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio.

☐ Please indicate if there is written feedback or reflections related to this competency in the designated section of the workbook

Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Urinary Catheters

Competency Statement:
The nurse will safely and effectively care for a child with a urinary catheter

COMPETENCY ELEMENTS	
K	1. Define urinary catheterisation 2. State the reasons why a urinary catheter would be required 3. Describe the position of the following types of catheters a. Indwelling catheter (IDC) b. Suprapubic Catheter (SPC) c. Ureteric Catheter d. Nephrostomy Tube 4. State the frequency that urine output should be measured based on the child's condition 5. State the expected urine output in ml/kg/hr for the post-operative patient 6. Discuss the catheter care for different types of catheters 7. Discuss potential causes of a non – draining catheter 8. State actions if a nephrostomy or ureteric catheter has stopped draining and discuss for why urine output may have stopped 9. Discuss the resources and education required for children and families when a child is to be discharged with a urinary catheter in situ
S	1. Demonstrate accurate documentation of urine output within the EMR ultilising the 'Fluid Balance' tab in the Flowsheets Activity 2. Demonstrate how an IDC should be taped

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in this competency. I acknowledge that ongoing development and maintenance of competency is my responsibility and will be evidenced in my Professional Practice Portfolio.

☐ Please indicate if there is written feedback or reflections related to this competency in the designated section of the workbook

Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Competency Feedback & Reflection

This section is used to document constructive feedback relating to specific elements of any competency from assessors, and also provides space to document reflection on your own practice (either in direct relation to the feedback, or separately).

Competency Name:			
Element(s):			
Assessor Feedback:			
Self-Reflection:			
Assessor [sign and date]		**Nurse** [sign and date]	

Competency Name:			
Element(s):			
Assessor Feedback:			
Self-Reflection:			
Assessor [sign and date]		**Nurse** [sign and date]	

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Assessor [sign and date]		**Nurse** [sign and date]	

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