Chapter 3G

Specialty Nursing Competencies – Kelpie Ward

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 9, January 2018

Table of Contents

Assessment (Adolescent Psychosocial)

Competency Statement:
The nurse safely and effectively undertakes an adolescent psychosocial assessment

RCH references related to this competency: RCH Clinical Practice Guidelines: Engagement & assessment of the adolescent patient

COMPETENCY ELEMENTS	
K	1. Locate and read adolescent psychosocial assessment resources 2. Explain the purpose of an adolescent psychosocial assessment 3. Define the six (6) elements of a H.E.A.D.S.S. assessment 4. Discuss the importance of confidentiality during the assessment of an adolescent 5. Discuss the importance of positive reinforcement during the assessment 6. Describe how and where to document findings from an adolescent psychosocial assessment 7. Describe actions required following identification of significant risk and protective factors 8. Discuss professional responsibilities regarding mandatory reporting
S	Not Applicable

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Blood Sampling from Central Venous Access Devices

ALERT*: *The Central Venous Access Device Management Competency should be completed prior to or in conjunction with this competency

Competency Statement:
The nurse can safely and effectively collect a blood sample from a Central Venous Access Device (CVAD)

RCH references related to this competency: RCH Policies & Procedures: Central Venous Access Device Management; RCH Intranet: CVAD - Education

COMPETENCY ELEMENTS	
K	1. Describe the circumstances when bloods might need to be taken from a CVAD 2. Identify: a. Blood tests frequently taken from CVADs b. Tubes required for tests identified above c. Volumes required 3. Discuss when gloves would be worn for blood sampling from CVADs and why 4. Discuss safe handling procedures of blood specimens 5. Discuss the correct size syringe to take blood from a CVAD 6. With regards to discarding blood, discuss: a. When a volume of blood should be discarded prior to the blood specimen being collected and why b. How much blood should be discarded c. In what circumstances a discard sample would be returned to the patient
S	1. Demonstrate education of the patient/family/carer regarding blood collection from a CVAD 2. Assemble correct equipment for the collecting a blood specimen from a CVAD 3. Demonstrate the procedure for taking blood from a single lumen CVAD 4. Demonstrate the procedure for taking blood from a multi lumen CVAD 5. Demonstrate 'Collect and Print' using a rover when taking a blood specimen 6. Demonstrate correct labelling of blood specimens

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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 Guidelines: Chest Drain (Intercostal Catheter) Insertion, Chest Drain Management

COMPETENCY ELEMENTS	
K	1. Describe the anatomy of the chest including the lining of the lungs 2. Identify the mechanics of breathing including negative intrapleural space 3. Identify the location of the proximal end of the chest drain 4. Describe the function of the 3 chamber UWSD apparatus 5. Provide rationales for insertion of UWSD chest drain 6. Explain the specific safety precautions required for the patient with an UWSD 7. Describe the correct procedure for securing the chest drain and dressing the insertion site 8. 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 9. Outline the correct procedure for measuring chest drainage 10. Discuss the nursing management for chest drainage losses 11. Describe the indications and procedure for changing the UWSD unit 12. Describe the precautions required for transporting a patient with an UWSD 13. Outline the complication of a chest drain and UWSD
S	14. 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) 15. Using the UWSD apparatus identify how you would determine if the patient has an ongoing air leak 16. Demonstrate the correct method of documenting the chest drainage activity and drainage 17. Demonstrate the correct method for obtaining a specimen from the UWSD unit

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Nurse Name: Signature: Date:

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Central Venous Access Device (Blocked)

ALERT*: *The Central Venous Access Device Management Competency should be completed prior to this competency

Competency Statement:
The nurse can safely attempt to unblock a central venous access device (CVAD)

RCH references related to this competency: RCH Clinical Practice Guidelines: Central Venous Access Device Management; RCH Policies & Procedures: Anticoagulation Therapy Guidelines

COMPETENCY ELEMENTS	
K	1. Locate and read the Anticoagulation Therapy Clinical Practice Guideline 2. List possible causes of CVAD occlusion 3. Discuss CVAD management to minimise the risk of occlusion 4. Describe a Fibrin Sheath? 5. Discuss rationale for syringe size selection in flushing CVADs 6. Discuss the steps to be taken in attempting to unblock a CVAD that has a. A blood related blockage b. A chemical related blockage 7. State the length of time TPA should be left in the line 8. State the documentation / communication required to alert others that TPA is in the line 9. Describe the potential side effects of TPA and HCl 10. Discuss management of a blocked CVAD in which initial attempts to clear the blockage have failed
S	Not Applicable

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Nurse Name: Signature: Date:

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Chemotherapy (Management & Supportive Care Theory)

Competency Statement:
The nurse has the requisite knowledge to provide supportive care to a patient receiving cytotoxic therapy

RCH references related to this competency: RCH Clinical Practice Guideline: Cytotoxic Drugs- Management of

ALERT	**This competency is required for all nurses who care for a child receiving or who has received chemotherapy**

COMPETENCY ELEMENTS	
K	1. Identify resources available to access for information regarding cytotoxic agents (drug information and supportive care) 2. Describe the key elements of the chemotherapy protocol 3. Describe where the chemotherapy protocol can be located on the EMR (including treatment plan and oncology communication) 4. Outline the pre chemotherapy investigations required 5. Discuss side effects of administered cytotoxic agents 6. Outline management for potential immediate side effects 7. Summarise antiemetic options for the patient receiving cytotoxic agents. 8. Discuss nursing precautions, care and monitoring for a patient receiving chemotherapy including a. monitoring of urine output b. pre and post hydration c. line set up d. observations e. other medications (e.g. mesna, folinic acid) 9. Identify relevant tests patient may require whilst receiving cytotoxic agents 10. Discuss the management of cytotoxic drug extravasation 11. Summarise family understanding of treatment being delivered and areas for education
S	Not Applicable

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Chemotherapy (Safe Handling)

Competency Statement:
The nurse safely and effectively handles cytotoxic agents and disposes of cytotoxic waste.

RCH references related to this competency: RCH Clinical Practice Guidelines: Cytotoxic drugs- Management of

COMPETENCY ELEMENTS	
K	1. Discuss safe transport and storage of cytotoxic agents from pharmacy to patient 2. Discuss correct use of personal protective equipment (PPE) required to a. administer cytotoxic agents b. dispose of cytotoxic waste i. equipment ii. excess cytotoxic agents iii. contaminated lined and clothing iv. patients personal waste (vomit, urine, faeces and blood) 3. State action required if personal contamination with a cytotoxic agent occurs 4. Outline correct procedure to manage a cytotoxic spill 5. Discuss safe management/disposal of cytotoxic waste a. equipment b. excess cytotoxic agents c. contaminated linen and clothing d. patients personal waste (vomit, urine, faeces and blood) 6. Summarise information provided to children and families in regards to safe handling, including resources available
S	7. Demonstrate set up of a safe working environment

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Nurse Name: Signature: Date:

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Diabetes (Surgery)

Competency Statement:
The nurse will safely and effectively care for the patient with diabetes pre and post surgery and anaesthesia

RCH references related to this competency: RCH Clinical Practice Guideline: Diabetes Mellitus and Surgery, Fasting Guidelines

COMPETENCY ELEMENTS	
K	1. Locate and read the diabetes and surgery clinical practice guideline 2. Discuss guidelines regarding initiation of fasting, BSL (including frequency of testing) and insulin administration – sub cut and IV 3. State the considerations for a diabetic patient who is fasting. 4. Outline management of post-operative recovery regarding blood sugar monitoring, insulin administration and re-introduction of diet 5. Discuss criteria to be met prior to discharge of patient
S	Not Applicable

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Nurse Name: Signature: Date:

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Diabetes Mellitus

ALERT*: *This competency should be completed in conjunction with the insulin administration competency

Competency Statement:
The nurse safely and effectively cares for children / young people with diabetes and their families.

RCH references related to this competency: RCH Clinical Guidelines: Diabetes Mellitus

COMPETENCY ELEMENTS	
K	1. Locate and read the diabetes mellitus clinical practice guideline 2. Describe the signs and symptoms that might indicate a diagnosis of diabetes mellitus 3. Describe the significance of blood glucose levels (BGL); normal range, why, when and how they should be monitored 4. Discuss the management of low and high BGL 5. Discuss ways in which ketone levels can be determined and when ketone levels should be checked 6. Discuss the management of ketoacidosis 7. State what basic 'hypo management' entails and the time frame in which this should be completed 8. Discuss the basic principles of dietary management of diabetes 9. Describe the role of the Dietician in educating the child and family about the food plan 10. Discuss the role of the Diabetes Nurse Educator 11. Describe the role of the ward nurse in the absence of the Diabetes Nurse Educator 12. Discuss types of insulin used including their onset and duration of action 13. Locate and read the nursing clinical guideline 'Subcutaneous catheter devices management of insuflon and BD safTIntima devices'
S	14. Demonstrate collection of a capillary BGL 15. Demonstrate teaching the child and family: a. to perform blood glucose testing b. to draw up and administer insulin c. about key principles of dietary management d. about identification and management of low and high BGL 16. Demonstrate ordering a 'Point of Care Test' on the EMR 17. Demonstrate documenting a BGL on the EMR 18. Demonstrate insertion of an insuflon device

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Nurse Name: Signature: Date:

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Eating Disorders

Competency Statement:
The nurse safely and effectively cares for a young person with an eating disorder

RCH references related to this competency: RCH Clinical Practice Guidelines: Anorexia Nervosa;
RCH Intranet: Centre for Adolescent Health – Health Services – Eating Disorders Program

COMPETENCY ELEMENTS	
K	1. Locate and read the Kelpie Eating Disorders Resource Folder 2. Describe the two main types of eating disorders requiring admission to RCH 3. Discuss the reasons/goals for admitting a young person with an eating disorder to RCH 4. Define and discuss refeeding syndrome 5. Explain the need for lying and standing observations 6. Discuss the protocol for cardiac monitoring and identify the rationale for monitoring 7. Describe responses to a young person who challenges their supplied meal 8. Locate and read the resources available to staff and families 9. Describe the differences between the four recovery phases 10. Describe the differences between the four supervision levels involved in the management of a young person with an eating disorder at RCH 11. Discuss the nurse's role in meal support therapy (pre meal, during meal, post meal) 12. Describe the roles of the multidisciplinary team a. Dietitian b. Mental Health c. Clinical Nurse Consultants d. Adolescent Medicine Team e. Allied Health Team (activity program) 13. Discuss the role of family based therapy
S	14. Demonstrate fluid balance chart documentation on the EMR for protocol meals

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Nurse Name: Signature: Date:

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Eczema (Wet dressings and topical treatment)

Competency Statement:
The nurse safely and effectively performs wet dressings and applies topical treatments for patients with Eczema

RCH references related to this competency: RCH Clinical Practice Guidelines: Eczema; RCH intranet: Dermatology – Eczema – Wet Dressing Instructions

COMPETENCY ELEMENTS	
K	1. Locate and read the a. RCH Eczema clinical practice guideline b. wet dressing instructions – elasticated tubular bandage 2. Describe the signs and symptoms of Eczema a. Mild b. Moderate c. Severe 3. Describe the signs and symptoms of infected Eczema 4. Describe the topical process for treating bacterial infected Eczema 5. Discuss what causes Eczema to flare 6. State how the following conditions can alter a patient's treatment a. Infected Eczema b. Herpes Simplex Virus 1 Eczema 7. Discuss the rationale for the use of bleach baths 8. Discuss the rationale for wet dressings 9. Discuss the rationale for the use of topical steroids 10. State which topical steroids should be applied to what part of the body and how a. Hydrocortisone 1% ointment b. Elocon ointment c. Advantan fatty ointment
S	1. Demonstrate accurate completion of an Equipment Distribution Centre Card for supplies 2. Demonstrate accurate completion of an Eczema Treatment Plan 3. Demonstrate assessment of a child's Eczema 4. Demonstrate accurate application of wet dressings, topical steroids and moisturisers

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Nurse Name: Signature: Date:

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Febrile Neutropenia

Competency Statement:
The nurse safely and effectively cares for a patient with febrile neutropenia

RCH references related to this competency: RCH Clinical Practice Guidelines: Fever Neutropenia and Septic shock

COMPETENCY ELEMENTS	
K	1. Locate and read the following clinical practice guidelines a. Fever Neutropenia and b. Septic Shock 2. State the normal values a. Haemoglobin b. Platelets c. White Blood count d. Neutrophils 3. Describe the function of neutrophils 4. Define the term febrile neutropenia 5. Discuss the observations required during an admission for neutropenia 6. Locate and read the following clinical practice guidelines a. Fever Neutropenia and b. Septic Shock 7. State the normal values a. Haemoglobin b. Platelets c. White Blood count d. Neutrophils 8. Describe the function of neutrophils 9. Define the term febrile neutropenia 10. Discuss the observations required during an admission for neutropenia 11. Discuss the actions to be taken where observations are outside the normal range for the child's age 12. Discuss the use of paracetamol and Ibuprofen in the care of children who have febrile neutropenia 13. Explain the rationale for the following investigations as part of a septic work up a. Blood cultures b. Swabs – nose / throat / CVAD c. Urine d. Stool 14. Explain which blood cultures need to be taken and how much blood you would take for a 20kg child 15. Discuss/Demonstrate collection of blood cultures from a Central Venous Access Device- 16. Discuss CVAD line set up for administration of antibiotics for the child with febrile neutropenia? 17. Discuss the management of suspected febrile neutropenia on presentation to emergency 18. Discuss the management provided in the first 72 hours of admission for febrile neutropenia 19. State the antibiotics and dosages used as first line treatment for febrile neutropenia. What is the expected timeframe that the first dose of antibiotics should be given and why? 20. Describe the process of activating the febrile neutropenia pathway on the EMR 21. Discuss treatment options for patients with unresolved fever 22. State the signs and symptoms of septic shock 23. Identify potential sources/portals/causes of infection in patients with neutropenia and discuss ways to minimise the risk 24. Demonstrate education of children and families about neutropenia and describe the key points that you would educate a family about febrile neutropenia. 25. List ways in which staff / parents and children can help prevent infection
S	Not applicable

Nurse competency statement on next page

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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 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. Differentiate between the types of gastrostomy tubes, including time frames for tube changes 9. Discuss the role of the dietician in the management of feeding via a gastrostomy tube 10. Describe the process for administering feeds via a gastrostomy tube including the types of feeding methods 11. Describe the process for administering medications via a gastrostomy tube 12. Discuss the care required for the stoma site 13. State common problems with a gastrostomy and discuss nursing interventions required 14. State the immediate management of a patient with a dislodged gastrostomy tube
S	1. Demonstrate venting of a gastrostomy tube

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Nurse Name: Signature: Date:

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Mucositis

Competency Statement:
The nurse safely and effectively cares for a child with cancer at risk or with mucositis

RCH references related to this competency: RCH Clinical Practice Guidelines: Mouth Care – Oral Care of the paediatric oncology patient and hematopoietic stem cell transplant patient, perianal care for the paediatric oncology patient

COMPETENCY ELEMENTS	
K	1. Define "Mucositis" 2. Discuss potential causes of Mucositis for children with cancer 3. Discuss the signs and symptoms the patient may present with when experiencing mucositis 4. Discuss the Oral Assessment Guide score 5. Discuss oral hygiene measures to reduce the risk of oral mucositis 6. Discuss management to reduce the risk of perianal mucositis 7. Discuss the management of a patient with mucositis a. Oral b. gastrointestinal c. perineal d. pain relief 8. Discuss the link between recovering neutrophil count and resolution of mucositis 9. Demonstrate discussion with children / parents regarding mucositis and care including care at home
S	1. Demonstrate assessment of a patient's mouth and accurate documentation of results 2. Demonstrate assessment of a patient's perineum and accurate documentation of results

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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. Glasgow 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. Explain the Cushing Reflex 7. State the actions required if a patient has deterioration in neurological status
S	8. Assemble the equipment required to perform neurological observations 9. 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 10. Demonstrate documentation of neurological observations on the EMR 11. List the signs and symptoms of raised ICP and how these change as the infant/child gets older

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Nurse Name: Signature: Date:

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Neurovascular Assessment

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

RCH references related to this competency: RCH Clinical Practice Guidelines- 'Neurovascular Assessment'

COMPETENCY ELEMENTS	
K	1. Explain the importance of neurovascular assessment 2. Discuss the criteria to determine whether a patient required neurovascular observations 3. Discuss frequency of neurovascular assessment a. Commencing & RPAO b. Frequency c. Ceasing 4. Discuss abnormal and potential complications of findings 5. Discuss what action is required if abnormal neurovascular observations are assessed
S	1. Demonstrates a neurovascular assessment on a patient and record findings on correct hospital documentation a. Colour b. Warmth c. Movement d. Sensation e. Swelling f. Ooze g. Pulses h. Venous Return i. Pain Score 2. Demonstrate provision of information and confirmation of understanding with families 3. Demonstrate documentation of neurovascular observations on the EMR

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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 (Hospital 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, including each member's role 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 differences between hospital PN & Baxter PN for the following a. 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. Urine iii. Weight iv. CVAD v. Documentation 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 13.State the maximum amount of potassium to be placed in a PN bag
S	4. Demonstrate checking of IV medication compatibility with PN prior to medication administration 5. Demonstrate IV line assembly & priming for the patient receiving a. Hospital PN Solution b. Baxter PN Solution 6. Demonstrate programming of IV pumps for all stages of weaning on & off PN 7. Demonstrate the process of double checking parenteral nutrition using the EMR 8. Demonstrate documentation of parenteral nutrition in flow charts on the EMR

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Nurse Name: Signature: Date:

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Pain (Analgesia Infusion)

Competency Statement:
The nurse will safely and effectively administer analgesia infusions

RCH references related to this competency: RCH Intranet: Surgery – Acute Pain Management CPMS – Ketamine Infusion, Surgery – Acute Pain Management CPMS – Opioid Infusion

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH a. Opioid Infusion Guidelines b. Ketamine Infusion Guidelines 2. Describe the pharmacokinetics of the analgesia infusion 3. Discuss the potential side effects of analgesia infusions 4. State the minimal clinical observations required for a patient receiving an analgesia infusion 5. Discuss reportable parameters 6. Discuss nursing actions to take if pain escalates 7. Discuss when to give analgesia boluses and when to increase analgesia infusions 8. State when, why and how much naloxone should be given for opioid induced pruritus, sedation and respiratory depression 9. Locate and complete the opioid primary competency quiz
S	10. Demonstrate pain assessment with an understanding of child development, language and appropriate pain assessment tools 11. Demonstrate accurate documentation of observations and assessment on the EMR 12. Demonstrate correct set up of analgesia infusion pumps 13. Demonstrate explanation, answering questions and confirmation of understanding with family

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Pain (Epidural / Regional Analgesia)

Competency Statement:
The nurse safely and effectively administer epidural or regional infusions

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH Epidural and Regional Analgesia Guidelines 2. Describe the pharmacokinetics of the local anaesthetic and additives 3. Discuss the potential side effects of the local anaesthetic and explain the signs and symptoms 4. Describe the components of epidural / regional lines 5. Discuss the importance of the markings of the epidural / regional catheters 6. State the minimum observations for a patient receiving an epidural 7. Discuss reportable parameters 8. Explain the potential complications of an epidural 9. Discuss the importance of pressure care for patients with an epidural 10. Discuss the nursing actions to take is pain escalates 11. Discuss the relevance of a high or low epidural sensory blockade 12. Describe the removal of the epidural / regional catheter, observations during the procedure and where and what to document 13. Locate and complete the epidural primary competency quiz
S	1. Demonstrate set up and programming on the epidural / regional pump 2. Demonstrate how and when to assess and document dermatomes and bromage 3. Demonstrate accurate documentation of observations and assessment 4. Demonstrate explanation, answering questions and confirmation of understanding with the family

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Pain (Patient Controlled Analgesia)

Competency Statement:
The nurse will safely and effectively administer patient controlled analgesia (PCA)

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH Patient Controlled Analgesia Guidelines 2. Describe the pharmacokinetics of the opioid analgesia used 3. Discuss the potential side effects of PCA 4. Describe the PCA pump program and demonstrates where the prescribed program is documented 5. State the minimum observations for a patient receiving a PCA and recognizes reportable parameters 6. Discuss the nursing actions to take if pain escalates 7. Explain when, why and how much naloxone should be given for opioid induced pruritus, sedation and respiratory depression 8. Discuss how to transition from a PCA to oral analgesia 9. Locate and complete the PCA primary competency quiz
S	1. Demonstrate a pain assessment 2. Demonstrate accurate documentation of PCA use on the EMR 3. Demonstrate explanation, answering of questions and confirmation of understanding with family

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Post Traumatic Amnesia (PTA)

Competency Statement:
The nurse will safely and effectively care for a child experiencing post traumatic amnesia

COMPETENCY ELEMENTS	
K	1. Explain PTA, including why a patient may experience PTA, and the behaviour that is commonly seen in patients 2. List the nursing considerations for a patient with PTA 3. Discuss the education that may need to be provided to the child and family
S	4. Demonstrate PTA testing for a patient

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:

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 2. Demonstrate application of a stoma appliance 3. Demonstrate application of a stoma dressing 4. Demonstrate accurate documentation of procedures associated with stoma care

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Spinal Injury (Acute)

Competency Statement:
The nurse will safely and effectively care for a patient with an acute spinal cord injury

COMPETENCY ELEMENTS	
K	1. Locate and read a. RCH Acute Spinal Injury Guideline b. Cue Card – Acute Spinal Injury Define an acute spinal injury 2. Define an acute spinal injury 3. Differentiate between primary and secondary spinal cord injury 4. Differentiate between complete and incomplete spinal cord injury 5. Define SCIWORA 6. Identify the aims of nursing care for a child with an acute spinal cord injury 7. Differentiate between spinal shock and neurogenic shock 8. Identify the nursing care for the patient with an acute spinal injury a. Neurological assessment b. Vital signs (and loss of autonomic control) c. Spinal immobilisation: i. 1st 24hr ii. Ongoing d. Positioning & Pressure Area Care e. Bladder management f. Bowel management g. Psychological care 9. Discuss autonomic dysreflexia: a. Definition b. Causes c. Signs and symptoms d. Management 10. Discuss the complications of acute spinal cord injury in children a. Postural hypotension b. Pulmonary complications c. Hip dysplasia d. Joint contractures e. Spinal scoliosis
S	1. Discuss and demonstrate the difference between a full spinal precaution roll and a log roll

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

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 3. State how it would be evident if each of the above drains was on suction 4. Explain the correct procedure to address a Redivac which is not patent 5. State how frequently a surgical drain should be measured and / or emptied 6. Discuss two potential complications of surgical drains 7. List four signs indicating infection of a surgical drain site 8. Discuss the rationale for removal of a surgical drain
S	1. Demonstrate emptying a Jackson Pratt 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:

Assessor Name: Signature: Date:

Tracheostomy Management

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

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

Element Exemptions: Banksia, Cockatoo, Dolphin, Emergency, 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 8. Demonstrate associated documentation on the EMR

Nurse Declaration on next page

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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 mls/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	10. Demonstrate the correct emptying of the urinary catheter bag 11. Demonstrate accurate documentation of urine output 12. Demonstrate how an IDC should be taped for a. Boys b. Girls 13. Perform catheter care

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Ventilation – Non Invasive

Competency Statement:
The nurse safely and effectively cares for the child receiving CPAP, BIPAP and Negative Pressure Ventilation

RCH references related to this competency: RCH Clinical Practice Guidelines: Continuous Positive Airway Pressure (CPAP) and Non Invasive Ventilation (NIV);
RCH Intranet: Kids Health Info – Continuous Positive Airway Pressure (CPAP)

COMPETENCY ELEMENTS	
K	1. Discuss the indications and application for Non invasive positive pressure ventilation (NPPV) 2. Discuss the indications and application of Negative pressure ventilation (NPV) 3. Differentiate between the mechanisms of the following ventilation strategies a. CPAP b. BIPAP c. NPV 4. Identify components of the NPPV circuit and assemble correctly: a. Vision b. VPAP 111 ST-A c. Avea d. Remstar Pro e. Machine settings and alarms f. Circuit g. Circuit CO2 exhalation port h. Masks: i. Nasal ii. Face iii. Full Facial 5. For single or dual circuit a. Humidification b. Oxygen and analysis 6. Identify components and state function of NPV equipment a. Chamber including collar, chamber access and pressure gauge: b. Connecting hose c. Motor settings and alarms 7. Differentiate between the modes of BIPAP available a. Spontaneous (S) b. Spontaneous Timed (S/T) c. Timed (T) 8. Discuss the specific nursing management of the patient requiring non-invasive ventilation: a. Monitoring and Respiratory assessment b. Ventilation assessment c. Airway clearance and patency d. Hygiene and Pressure care e. Complications f. Trouble shooting g. Psychological support 9. Identify the correct documentation of NPPV / NPV in the paediatric patient 10. Discuss how Family Centred Care can be provided when the child is receiving NPPV
S	Not Applicable

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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]	

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