Chapter 3J

Specialty Nursing Competencies – Rosella 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.

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Admission (Rosella Ward/PICU)

Competency Statement:
The nurse prepares the required bed space and equipment for the safe and systematic admission of a patient to PICU

RCH references related to this competency: RCH Intranet: PICU – Guidelines – Admitting a patient; Basic patient room setup; Working with families in single rooms in Rosella; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. State the necessary information that will be required to prepare a bed space for patient admission a. Monitor patient admission 3. Identify how the admission source and patient type will determine the bed space requirements a. PETS b. NETS c. Ward d. Theatre e. Interstate transfer 4. Outline the additional equipment required to admit a. A child with respiratory failure b. A child with neurological compromise c. A neonatal admission 5. State the variations that the weight of the child will have on requirements a. <10kg b. <15kg c. <25kg d. 30 – 50kg e. >50kg 6. Outline the initial nursing assessment required on admission to PICU Discuss the nursing priorities of care on patient arrival on PICU 7. Discuss how the principles of Family Centered Care should be applied when the child is admitted to the PICU, identifying key responsibilities towards parents and care giver
S	1. Demonstrate the necessary equipment and preparation required for a basic bed space 2. Demonstrate accurate nursing documentation in the ADT Navigator on the EMR when admitting 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:

Admission to Rosella Ward (PICU) post cardiac surgery

Competency Statement:
The nurse competently prepares for admission and provides nursing care the child following cardiac surgery

RCH references related to this competency: RCH Intranet – PICU – Guidelines – Cardiac post-operative patient reception to PICU; Cardiac setup for PICU; Cardiac post-operative problems and arrhythmias; Working with families in single rooms in Rosella ward; Invasive Haemodynamic Monitoring; Investigations of chylothorax in infants after cardiac surgery; Labile Pulmonary Vascular Resistance after surgery; Monitoring arterial lactate and central venous oxygen saturation after cardiac surgery; Management of infants having Blalock-Taussig (BT) shunt; Heparin infusion protocol for PICU; Anticoagulation in PICU following cardiac surgery; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Safe Transfer of Patients & Materials

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the correct anatomy and physiological understanding for the patient condition and the surgical repair undertaken 3. Identify the appropriate post – operative management and prioritize care to maintain cardiovascular stability according to the 'Cardiac post-operative problems & arrhythmias' guideline and addressing; a. preload b. afterload c. contractility d. heart rate 4. Discuss the role of the family in the post – operative care and provide support for the family and child.
S	1. Collect and assemble the correct equipment and prepares the bed-space according to the 'Cardiac set up for PICU' guideline. 2. Accurately receive the patient incoming call from the operating theatre and completes documentation within EMR 3. Ensures medical staff have completed cardiac order set on EMR. 4. Systematically receive handover and assess the patient on arrival, attending to all admission requirements according to the 'Cardiac post-operative patient reception to PICU' guideline. 5. Integrates COW with AVEA ventilator and Phillips monitor upon patient arrival. 6. Accurately recognize and respond to the potential complications post – operatively e.g.: a. Low Cardiac Output b. Respiratory Failure c. Fluid and Electrolyte imbalance d. Arrhythmias e. Excessive chest drain losses and bleeding f. Cardiac Tamponade g. Pain and Anxiety

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Nurse Name: Signature: Date:

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Arterial Line

Competency Statement:
The nurse safely and effectively prepares for and provides care for the child or infant with an intra – arterial line

RCH references related to this competency: RCH Intranet – PICU – Guidelines – Invasive Haemodynamic Monitoring; Drug Infusions & Maintenance fluid in PICU; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the indications for invasive arterial line placement 3. Identify the correct infusion to prime and maintain patency of the arterial line a. For infant <2kg & Liver transplant post-operative b. For neonates and children 4. Correctly interpret the monitoring and waveform to identify normal waveforms and irregular recordings a. Waveform scale b. Systolic, Dichotic notch, Diastolic Pressures c. Cardiac cycle and ECG interpretation d. Respiratory Effect 5. Identify the potential complications of intra-arterial line placement and continuous monitoring
S	1. Demonstrate safe practice in the care and maintenance of the arterial line transducer and infusion a. Cannula security b. Prevention of infection c. Prevention of air and debris emboli d. Prevention of bleeding e. Circulation checks 2. Correctly assemble the equipment required to insert line and establish monitoring a. Cannula and lines b. Transducer and cables c. Monitor 3. Accurately zero and level the transducer 4. Demonstrate gaining an accurate pressure reading from the monitoring system 5. Demonstrate correct procedure for taking a blood sample from the arterial line a. Dead space b. Technique return blood c. Sample accuracy d. Aseptic technique 6. Provide correct care for the IA insertion site and cannula a. Securing the cannula b. Limb immobilisation c. Labelling d. Periphery perfusion e. Exposure of insertion site 7. Demonstrate the ability to troubleshoot and problem solve technical problems with transducer and pressure measurement 8. Demonstrate safe removal of arterial line 9. Document assessment of the arterial line access point in the LDA Assessment flowsheet on the EMR. 10. Ensure IAL infusion is correct and document this in the MAR of the EMR.

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Nurse Name: Signature: Date:

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Blood Gas Analysis

Competency Statement:
The nurse safely and effectively performs and interprets the analysis of a blood gas specimen

RCH references related to this competency: PICU intranet – Invasive haemodynamic Monitoring. RCH Policies & Procedures – Specimen Collection; ANTT.

COMPETENCY ELEMENTS	
K	1. Locate & read RCH online references related to this competency. 2. Identify the following components measured in arterial blood gas analysis and state their normal ranges: a. pH b. pCO2 c. p02 d. BE e. HCO3 3. Identify the normal variables for the a. Venous sample b. Capillary sample c. Arterial sample 4. State the possible indications for a taking a blood gas sample 5. State the causes of a. Respiratory acidosis b. Respiratory alkalosis c. Metabolic acidosis d. Metabolic alkalosis 6. Discuss compensation in acid – base status 7. Articulate considerations for patients with mixed circulation when performing blood gas analysis 8. Identify the correct management of the patient with altered blood gas analysis
S	1. Demonstrate the correct procedure to obtain a: a. Arterial blood gas sample b. Venous blood gas sample c. Capillary blood gas sample 2. Demonstrate how to order blood gas test on EMR. 3. Demonstrate a step by step process to interpret the blood gas analysis 4. Identify a. Respiratory acidosis b. Respiratory alkalosis c. Metabolic acidosis d. Metabolic alkalosis

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Blood Sampling from Central Venous Access Devices (CVAD)

ALERT: 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; Specimen Collection; Aseptic Technique; Documentation: Electronic Medical Records (EMR) ; RCH Intranet - Microbiology: Specimen collection details

COMPETENCY ELEMENTS	
K	1. Locate & read RCH online references related to this competency. 2. Describe the circumstances when bloods might need to be taken from a CVAD 3. Identify a. blood tests frequently taken from CVADs b. tubes required for tests identified above c. volumes required 4. Discuss when gloves would be worn for blood sampling from CVADs and why 5. Discuss safe handling procedures of blood specimens 6. Discuss the correct size syringe to take blood from a CVAD 7. 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. Demonstrate the procedure for taking blood from a single lumen CVAD 3. Demonstrate the procedure for taking blood from a multi lumen CVAD 4. Assemble correct equipment for the collecting a blood specimen from a CVAD 5. Demonstrate correct labeling of blood specimens 6. Demonstrate the correct ordering and releasing process required for active pathology requests within EMR

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Nurse Name: Signature: Date:

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Brainz monitoring (aEEG monitoring)

Competency Statement:
The nurse safely and effectively cares for a neonate requiring Brainz monitoring

RCH references related to this competency: RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Explain what aEEG is 2. State 2 reasons why aEEG is used 3. State when needle electrodes should not be used
S	1. Demonstrate set up of the Brainz monitor 2. Demonstrate the correct placement and attachment of Brainz electrodes- both needle & gel electrodes. 3. Demonstrate commencement of recording 4. Demonstrate checking signal from electrodes 5. Demonstrate marking events and explain what events should be marked 6. Demonstrate recognition of sleep / wake cycles on Brainz 7. Demonstrate recognition of: a. Continuous normal voltage b. Discontinuous normal voltage c. Burst suppression – high burst density d. Burst suppression – low burst density e. Continuous low voltage f. Isoelectric or flat trace g. Seizures h. Artefact 8. Demonstrate explanations and confirmation of understanding with parents 9. Discuss and demonstrate ways in which parents can be involved in the care of their child with Brainz monitoring in situ

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Nurse Name: Signature: Date:

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Cardiac Tamponade

Competency Statement
The nurse can recognise a patient with tamponade and safely and effectively provide emergency nursing care

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Cardiac call out; Cardiac post-operative problems and arrhythmias; Anticoagulation in PICU following cardiac surgery; RCH Policies & Procedures - Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate & read RCH online references related to this competency 2. Define cardiac tamponade 3. Explain the pathophysiology of cardiac tamponade including early and late compensation mechanisms 4. Outline the potential causes of tamponade 5. Describe assessment findings with rationales for a patient who are developing a tamponade 6. Explain the presentation and significance of pulsus paradoxus for a. the patient who is spontaneously breathing b. the patient who is ventilated. 7. State the diagnostic test that can be performed on a patient thought to have a tamponade 8. Discuss the emergency nursing management for the patient who has a cardiac tamponade 9. Identify the two emergency procedures that may be performed for a patient with tamponade
S	Not Applicable

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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 – Nursing – Chest Drain Management; Procedural Pain Management; External website: Atrium Medical – Chest Drainage – Education (accessed via Chest Drain Management guideline); RCH Policies & Procedures: Aseptic Technique; Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Describe the anatomy of the chest including the lining of the lungs 3. Identify the mechanics of breathing including negative intra pleural space 4. Identify the location of the proximal end of the chest drain 5. Describe the function of the 3 chamber UWSD apparatus 6. Provide rationales for insertion of UWSD chest drain 7. Explain the specific safety precautions required for the patient with an UWSD 8. Describe the correct procedure for securing the chest drain and dressing the insertion site 9. Describe the ongoing patient assessment required when a patient has chest drain with UWSD including: a. Start of shift checks and documentation within the LDA flowsheet of the EMR b. Vital signs c. Pain d. Drain insertion site 10. Using the USWD apparatus identify how you would determine if the patient has an ongoing air leak 11. Outline the correct procedure for measuring chest drainage 12. Discuss the nursing management for chest drainage losses 13. Describe the indications and procedure for changing the UWSD unit 14. Describe the precautions required for transporting a patient with an UWSD 15. Outline the complication of a chest drain and UWSD
S	1. 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. Dry suction unit (Atrium Oasis) 2. Demonstrate the correct method of documenting the chest drainage activity and drainage in the fluid balance flowsheet of the EMR. 3. Demonstrate the correct method for obtaining a specimen from the UWSD unit

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Nurse Name: Signature: Date:

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Chest Opening (Emergency)

Competency Statement:
The nurse provides safe and effective emergency nursing care to facilitate the chest opening procedure

RCH references related to this competency: RCH intranet – PICU – Guidelines: Cardiac call out; ECLS protocols; Cardiac post-operative problems and arrhythmias; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

Element Exemptions: Medical Imaging (K5, K6-7)

COMPETENCY ELEMENTS	
K	1. Locate and read online reference related to this competency 2. Discuss reasons why a child may require an emergency chest opening, including specific post-operative reasons 3. Describe the nursing assessment of a patient who is at risk of imminent cardiac arrest 4. Detail the emergency nursing management for child requiring immediate chest opening 5. Explain the procedure for calling out the cardiac team for a chest opening 6. Outline the emergency preparation for the chest opening procedure a. ICU environment b. team members c. child d. family 7. Outline the post – procedure nursing responsibilities for the child who has a chest opening 8. Describe the important nursing management issues for the child nursed with an open chest in the ICU 9. Outline the documentation required on EMR during and following the chest opening procedure
S	1. Describe and demonstrate participation in the emergency chest opening procedure and the roles of the medical and nursing teams a. Preparation of the environment and equipment required for emergency chest opening. i. Emergency instrumentation trolley ii. Diathermy machine and accessories iii. Surgical headlight iv. PICU defibrillating machine and correct size pads v. PICU chest drain trolley vi. Pacing cables storage vii. Surgical CHG 4% hand scrub (pink) viii. Sterile surgical suction available and connected at time of incision b. scrub role and requirements for establishing ECLS c. Maintenance of all aspects of Australian College of Operating Room Nurses [ACORN] standards in non-theatre and critical care environment

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Nurse Name: Signature: Date:

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Carbon Dioxide Monitoring: End Tidal & Transcutaneous

Competency Statement:
The nurse safely and effectively cares for a patient requiring non-invasive Carbon Dioxide (CO_2) monitoring

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Nursing management of the patient with invasive mechanical ventilation in PICU; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

Element Exemptions: Rosella (K7)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. State rationale for performing non – invasive monitoring of CO_2 3. State the normal arterial range of CO_2 ($PaCO_2$) 4. Describe the relationship between $PaCO_2$, Transcutaneous CO_2 ($tcCO_2$) and End Tidal CO_2 ($EtCO_2$) 5. Describe how the normal CO_2 range can deviate in chronic lung disease 6. Describe how the normal CO_2 range can deviate in the ventilated patient 7. State the roles of the Respiratory Consultant, Respiratory Fellow, Respiratory Nurse and staff nurses in preparing, monitoring and completing a sleep study 8. State equipment required for both $tcCO_2$ and $EtCO_2$ monitoring 9. Describe patient safety issues during $EtCO_2$ and $tcCO_2$ monitoring 10. Describe the components of a normal $EtCO_2$ waveform
S	1. Demonstrate functional use of MP30, MP50, MP70 and MX800 monitors in non – invasive monitoring of CO_2 2. Demonstrate the correct procedure for a. Calibration of $tcCO_2$ monitor b. Reapplying membrane $tcCO_2$ electrode c. Application of $tcCO_2$ electrode d. Documentation on the EMR during $tcCO_2$ monitoring e. Trouble shooting $tcCO_2$ electrode, MP 30, MP50, MP70 and MX800 monitor, calibration unit. 3. Demonstrate the correct procedure for a. Application and maintenance of $EtCO_2$ side stream device b. Trouble shooting $EtCO_2$ side stream device c. Troubleshooting $etCO_2$ sensor d. Documentation on EMR during $EtCO_2$ monitoring

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Nurse Name: Signature: Date:

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CPAP (Nasopharyngeal)

Competency Statement:
The nurse provides safe and effective care for the child receiving Nasopharyngeal CPAP

RCH references related to this competency: RCH Intranet- PICU – Guidelines: Non-invasive respiratory support in PICU; Fixation of Endotracheal Tubes ETT in PICU; Artificial airway suctioning; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the anatomical location of a nasopharyngeal tube and the mechanism of its support for respiratory function 3. Discuss the indications for the clinical application of nasal CPAP 4. Identify components of nasal CPAP and assemble correctly for the a. AVEA (including tube calibration) b. VIP Bird c. Machine settings and alarms d. Circuit e. Humidification f. Oxygen and analysis g. Tube cut down measurement, size and length 5. Outline the process for preparation of the patient and correct placement of a nasopharyngeal tube 6. Discuss the specific nursing measures for the patient with nasopharyngeal CPAP including a. Respiratory assessment b. Strategies to enhance maintenance of effective ventilation c. Tube security and airway patency d. Suction and hand – ventilation e. Trouble shooting ventilator f. Demonstrate start of shift assessment of a nasopharyngeal tube and document this in the LDA flowsheet of the EMR. 7. Identify the emergency management for a blocked nasopharyngeal CPAP tube 8. Outline the complications associated with the delivery of nasopharyngeal CPAP 9. Identify the signage and correct documentation of nasal CPAP on the EMR. 10. Discuss how family centered care can be provided when the child is receiving nasal CPAP
S	Not Applicable

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Nurse Name: Signature: Date:

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Drug Dispensing from PYXIS Machine

Competency Statement:
The nurse is able to accurately and safely obtain a medication from the PYXIS machine for patient administration

RCH references related to this competency: RCH Policies & Procedures

COMPETENCY ELEMENTS	
K	1. Identify the groups of drugs kept in the locked PYXIS machine 2. Discuss the correct procedure for a drug discrepancy in the PYXIS 3. Identify the correct method to check, prepare and administer the drug from the PYXIS to the patient 4. State the correct procedure for disposal of any unused drug not required for patient administration 5. Outline the correct documentation required when dispensing a drug from the PYXIS machine
S	1. Demonstrate the correct process for removing a Schedule 5 and Schedule 8 drug from the PYXIS machine for patient administration 2. Demonstrate the correct process for returning a drug to the PYXIS

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Nurse Name: Signature: Date:

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ECG Atrial

Competency Statement:
The nurse accurately measures and interprets an atrial electrocardiogram (ECG)

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Atrial ECG – How to do; ECG how to perform; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate & read RCH online references related to this competency 2. Define an ECG lead a. Unipolar lead and its associated waveform b. Bipolar lead and its associated waveform 3. Identify the indications for conducting an Atrial ECG (AEG) 4. Provide an accurate interpretation of the AEG a. Comparison of AEG and ECG b. Identifies the location of atrial electrical activity
S	5. Locate and identify the equipment required to obtain an AEG 6. Demonstrate obtaining a standard ECG 7. Demonstrate obtaining an AEG via the bedside monitor a. Correct atrial pacing wire connection b. Identify lead to obtain bipolar AEG c. Identify leads to obtain unipolar AEG d. Correct ordering of ECG on the EMR 8. Demonstrate obtaining an AEG via the 12 lead ECG machine e. Correct atrial wire placement f. Correct placement of remaining electrodes g. Identify leads to obtain unipolar AEG h. Identify lead to obtain bipolar AEG 9. Accurately review the rhythm strips at commencement of shift and when rhythm changes occur

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Nurse Name: Signature: Date:

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Endotracheal Tube (Re-strapping)

Competency Statement:
The nurse safely and securely re straps the endotracheal tube (ETT) of the intubated child

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Fixation of Endotracheal Tubes ETT in PICU; Intubation of the patient in PICU-Nursing Management; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate & Read RCH online references related to this competency 2. Outline the experience and process required for a nurse to become competent in re-strapping the ETT 3. Identify the rationale for secure ETT strapping for the intubated child 4. State the patient assessment criteria that indicate the ETT requires re-strapping 5. Outline the preparation of the personnel and environment for procedure a. Identify patient groups that nurses cannot perform re-strapping procedure on b. Patient care requirements for the room c. Identify number of personnel required d. Notification of medical personnel 6. Discuss the preparation of the patient and family for procedure a. Explanation and reassurance b. Checking chest x-ray and tube position c. Documenting tube size and length within LDA flowsheet of the EMR d. Positioning, warmth and comfort e. Monitoring 7. State which patient age and categories will have an oral re-strapping using the "oral ETT securing device" 8. Identify the post procedure care required a. Repositioning and comfort b. Confirmation of ETT position and effective ventilation c. Mouth care d. Documentation of procedure within notes of the EMR e. Routine cuff checks 9. Discuss the complications and nursing considerations to minimise the risks for re-strapping the patients ETT
S	1. Assemble the equipment required to conduct re-strapping a. Face mask and hand bagging circuit b. Intubation trolley and tubes c. Tapes cut and correct size, or oral device d. Skin protection 2. Demonstrate the procedure for re-strapping the nasal ETT a. Removal old tapes b. Skin preparation c. Correct placement and taping sequence d. Checking skin integrity e. ETT direction 3. Demonstrate the procedure for re-strapping the oral ETT a. Removal of oral securing device b. Maintaining tube security during procedure c. Checking skin integrity d. Replacing device and securing tube

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Nurse Name: Signature: Date:

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External Ventricular Drains & Intracranial Pressure Monitoring

Competency Statement:
The nurse safely and effectively cares for a patient with an External Ventricular Drain (EVD) and/or Intracranial Pressure (ICP) monitor

RCH references related to this competency: RCH Clinical Practice Guidelines – Nursing: External Ventricular Drains and Intracranial Pressure Monitoring (including link to Medtronic: Exacta- external drainage and monitoring system – quick reference guide); RCH Policies & Procedures – Aseptic Technique; Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify patient groups which require an EVD/ ICP monitoring 3. List daily care requirements and considerations for a patient with EVD 4. Explain the actions required in the event a. The EVD becomes disconnected from the line b. The EVD is accidently removed 5. State the procedure required when transporting a patient with an EVD 6. Discuss the removal of EVD including the nurse's role during the procedure 7. State the normal ICP ranges for infants and children 8. Explain how ICP is measured using an EVD 9. List the nursing considerations for a patient having ICP monitoring
S	1. Demonstrate hourly check required for EVD care including: a. leveling of EVD to patient tragus of the ear b. checking dressing site c. checking line for oscillating CSF d. checking volume and colour of CSF drainage e. Documentation of all care within EMR. 2. Demonstrate collection of CSF specimen using sterile technique. 3. Discuss how to view medical order and print pathology form from the EMR 4. Demonstrate ability to zero monitor with ICP transducer.

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Extra Corporeal Life Support

ALERT: In addition to satisfactory attainment of the knowledge and skill competency elements listed below completion of this competency includes satisfactory participation in the ECLS course, a minimum of six doubling shifts, a written examination and ten solo shifts. (See Additional Requirements)

Competency Statement:
The nurse safely and effectively cares for a patient requiring Extra Corporeal Life Support (ECLS)

RCH references related to this competency: RCH Intranet – PICU – Guidelines: ECLS; ECLS protocols; Epoprostenol administration guideline**;** RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH references related to this competency 2. Discuss policies and procedures pertinent to ECLS 3. Identify each component of the ECLS circuit and console and explain how each works, including any complications that may occur 4. Discuss role responsibilities during ECLS related emergencies. 5. Discuss where clots may develop, or air may enter the circuit, and management to prevent or correct these occurrences 6. Discuss the patient plan of care with the health care team and communicates effectively with all members of the health care team 7. Discuss the ongoing annual education requirements of this Advanced Practice role.
S	1. Demonstrate assisting in the commencement of ECMO support in an emergency situation, a. identifying the appropriate ECMO circuit and oxygenator in relation to the patient's weight, b. priming the circuit c. administering the appropriate medications. 2. Demonstrate the setting of appropriate alarm limits on the patient monitor and on all E.C.L.S. equipment. 3. Ensure all emergency equipment is functioning, and is within easy access to the patient's bedside. 4. Analyze clinical data, recognize abnormal parameters and respond in an appropriate manner. 5. Demonstrate appropriate manipulation of gas flow, Fio2 and circuit flows in relation to patient's oxygenation levels and haemodynamics. 6. Demonstrate maintenance of a physical and psychosocial environment which promotes safety, security and optimal health for both patient and family. 7. Demonstrate access of the circuit in a safe aseptic manner. 8. Eliminate or prevent environmental hazards whenever possible. 9. Demonstrate assessment and management of patient comfort needs a. monitoring b. analgesia c. sedation d. positioning e. hygiene 10. Demonstrate implementation of specific nursing interventions to reduce the potential for complications, such as bleeding, infection, and immobility 11. Demonstrate explanations and confirmation of understanding with parents 12. Discuss and demonstrate ways in which parents can be involved in the care of their child on ECLS 13. Demonstrate adherence to unit and hospital policies when administering therapeutic agents, including blood products 14. Effectively coordinate and manage the nursing care required. 15. Liaise with other health team members to ensure adequate resources. 16. Demonstrate teaching other members of the health care team the basic principles of E.C.L.S., equipment used and role of others in the case of emergencies

Additional Requirements and Nurse Declaration on next page

Additional Requirements	
	1. Satisfactory participation in ECLS Course 2. Doubling shifts x 6 3. Satisfactory completion of written exam (Min 80%) 4. Solo shifts x 10 5. Ongoing Annual education; a. Maintain annual accreditation for Advanced Paediatric Resuscitation, emergency procedures and PICU drug assessments b. Work at least 80 hours annually as an ECMO specialist caring for the patient on ECMO (balanced over the 12 month period) c. Attend 2 ECMO study days and 2 wetlabs. 6. Complete both written and practical assessments.

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:

Extubation (PICU)

Competency Statement:
The nurse safely and effectively cares for the patient requiring extubation

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Extubation of a patient in PICU; Nursing management of the patient with invasive mechanical ventilation in PICU; Artificial airway suctioning; Fasting in PICU; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH online references related to this competency 2. State the clinical indications of readiness for extubation a. Identify how it is determined if the intubated paediatric patient has a leak around the endotracheal tube b. Discuss the clinical risk factors for failing extubation 3. Describe the nursing assessment of the patient post extubation 4. Discuss potential complications of extubation 5. Identify the correct documentation following extubation 6. Discuss how Family Centered Care can be provided when the child is extubated
S	1. Discuss and demonstrate preparation for extubation a. Patient (physical and psychological) b. Monitoring c. Equipment d. Environment e. Personnel 2. Discuss and demonstrate the preparation of drugs and equipment for failed extubation 3. Document removal of ETT LDA flowsheet in the EMR

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:

High Frequency Oscillatory Ventilation (HFOV)

Competency Statement:
The nurse is able to safely and effectively care for infant requiring high frequency oscillatory ventilation (HFOV) using the SLE & Sensormedics ventilators.

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Intubation of the patient in PICU – Nursing Management; Fixation of Endotracheal Tubes ETT in PICU; Artificial airway suctioning; Cuff Management in Paediatric ETT and Tracheostomy Tubes; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)**Exemption:** Rosella (K5)

COMPETENCY ELEMENTS	
K	**General** 1. Locate & Read RCH online references relating to this competency 2. Describe the differences between the function of HFOV and conventional mechanical ventilation (CMV) 3. Identify 4 respiratory conditions which may require HFOV 4. Differentiate between the Sensormedics 3100A & Sensormedics 3100B & their indications for use. 5. Differentiate between the SLE and Sensormedics 3100A including a. Indications for use a. Safety precautions on initiation of oscillation b. Explain measurement of DCO_2 **Sensormedics** 6. Identify and explain the function of each of the following oscillator components a. Bellows b. Pressure limit (identify correct colour diaphragm) c. Dump (identify correct colour diaphragm) d. Mean pressure adjust (identify correct colour diaphragm) e. Water Trap 7. Identify and explain the function of each of the following oscillator controls a. Power On /Off b. Bias flow c. Mean pressure adjust d. Mean pressure limit e. Amplitude (Power) f. Frequency g. Percentage inspiratory time h. FiO_2 i. Start / Stop j. Reset k. Alarm silence l. Piston Centring m. Mean pressure alarms (upper and lower) 8. Explain how the following initial settings are usually determined a. Mean airway pressure (MAP) b. Amplitude c. Frequency d. Inspiratory time e. FiO_2 9. Identify the nursing care required for the child receiving HFOV discussing: a. Respiratory and adequacy of ventilation assessment b. Assessment for complications on initiating therapy c. Imaging and laboratory test required d. Maintaining the patency and position of the endotracheal tube i. head and tubing position ii. ventilator security iii. suction procedure, additional connections, precautions iv. emergency ventilation: Neopuff /hand ventilation safe use v. humidification e. Monitoring and maintaining haemodynamic stability f. Assessment of skin, providing pressure area care and patient positioning g. Appropriate alarm settings on HFOV and causes of activation i. pressure limit ii. dump valve

Competencies continued and nurse declaration on next page

K	10. Discuss and demonstrate ways in which parents can be involved in the care of their child on HFOV 11. Outline 4 possible complications of HFOV, including prevention and appropriate management 12. Discuss preparation for discontinuing HFOV a. assess patient readiness to discontinue b. use of the conventional ventilator at bedside and rationale
S	1. Demonstrate the pre use circuit check a. State rationale for circuit check b. Demonstrate the circuit check c. State 2 reasons why the circuit may not pressurise d. State 2 possible actions if the circuit does not pressurise e. State the procedure to be followed if circuit check fails 2. Accurately document assessment and care associated with HFOV in the EMR 3. Demonstrate explanations and confirmation of understanding with parents

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:

Hypothermia (Therapeutic)

Competency Statement:
The nurse will safely and effectively care for a neonate requiring therapeutic hypothermia

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Therapeutic hypothermia for patients in PICU; Oesophageal temperature probe insertion; Rectal temperature probe insertion; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Discuss the rationale and indications for inducing hypothermia 3. Identify the correct timeframes for inducing hypothermia 4. Outline the required nursing care for the paediatric patient requiring induced hypothermia a. Maintaining paralysis and sedation b. Haemodynamic monitoring and maintaining stability i. Fluid and electrolyte imbalances ii. Recognition of cardiovascular compromise iii. Arrhythmia recognition c. Temperature monitoring d. Blood test screening e. Pressure area care requirements f. Prevention of infection g. Feeding and nutrition management 5. Identify correct management of cooled status for when the patient requires intra-hospital transfer to CT or X-Ray 6. Outline the regime for rewarming the child with hypothermia a. Time Frame b. Detect haemodynamic instability c. Weaning of sedation and paralysis 7. Discuss 5 specific complications of induced hypothermia
S	1. Assemble and prepare the equipment for the patient who is to receive therapeutic hypothermia a. Monitoring and bedspace b. Cooling blanket c. Cooled Intravenous bolus d. Surface cooling 2. Demonstrate correct use of the cooling blanket and outline the required nursing care 3. Demonstrate correct procedure for cooled intravenous bolus fluid administration 4. Demonstrates correct procedure for cooled peritoneal dialysis fluid administration 5. Demonstrate correct procedure to induce surface cooling in the paediatric patient 6. Prepare the child and family and maintains communication with adequate explanations to enable understanding and allay anxiety of treatment 7. Demonstrates accurate documentation of cooling device temperature and patient temperature in the EMR.

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:

Intracranial Pressure Monitoring in the Critically Ill Child

Competency Statement:
The nurse safely and effectively cares for the critically ill patient who requires intracranial pressure (ICP) monitoring

RCH references related to this competency: RCH Clinical Practice Guidelines – Nursing: External Ventricular Drains and Intracranial Pressure Monitoring (including link to Medtronic: Exacta- external drainage and monitoring system – quick reference guide); RCH Policies & Procedures – Aseptic Technique; Learning hero; Learning package Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate & Read RCH online references related to this competency 2. Define: a. Intracranial Pressure b. Cerebral Perfusion Pressure (CPP) 3. Identify the normal age dependent ICP and CPP parameters 4. Identify how CPP is calculated 5. Outline the pathophysiology and reasons why a patient may have a raised ICP and the implications this may have for a patient 6. Outline the medical and nursing management for raised ICP 7. Outline the indications and advantages of the two invasive monitoring approaches: a. Codman device b. EVD 8. Describe the nursing management measures to minimise ICP fluctuations 9. Describe the nursing management of patient with the Codman device: a. Zeroing the monitor b. Cross checking reference codes c. Setting alarms d. Accurate pressure measurements documented in the EMR 10. Describe the nursing management for a patient with an EVD: a. Levelling the transducer b. Accurate measurement ICP c. Interpretation of ICP waveforms d. Documentation of CSF drainage e. Collection of CSF specimen f. Collection of pathology form from EMR g. Troubleshooting drains and monitoring safely h. Removal of drain
S	1. Demonstrate setting up the Codman's monitoring device in preparation for a patient's admission 2. Demonstrates setting up of the EVD monitoring device in preparation for a patient admission 3. Documentation of ICP in the observation flowsheet of the EMR 4. Documentation of removal in LDA flowsheet of the EMR

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:

Intubation – Nursing Management

Competency Statement:
The Nurse provides safe and effective care for the patient requiring intubation

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Intubation of the patient in PICU – Nursing Management; Fixation of Endotracheal Tubes ETT in PICU; Artificial airway suctioning; RCH Policies & Procedures – Documentation: Medical Records & Documentation – Medical Records

COMPETENCY ELEMENTS	
K	1. Locate and read RCH references related to this competency 2. State the indications for intubation of the paediatric patient 3. Discuss the drugs, actions and dosages for intubation a. Anticholinergic b. Atropine c. Muscle relaxant i. Suxamethonium ii. Vecuronium iii. Pancuronium d. Sedation / analgesic i. Midazolam ii. Morphine iii. Fentanyl iv. Ketamine v. Proprofol 4. Describe the indications for and process of Rapid Sequence Intubation (RSI) 5. Discuss the indications for and use of an inhalation anaesthetic for intubation 6. Outline how endotracheal tube placement is confirmed a. Interpret the chest x-ray 7. Describe the indications for and location of the 'difficult intubation' trolley 8. Describe the correct techniques for securing the ETT 9. Describe the potential complications of intubation 10. Identify the correct documentation within the EMR following the intubation procedure
S	1. Discuss and demonstrate the preparation of the patient for intubation a. Assessment b. Monitoring c. Intravenous access d. Psychological preparation e. Patient position f. Resuscitation equipment g. Environment h. Personnel 2. Describe and demonstrate the ETT selection a. Cuffed versus uncuffed b. Oral versus nasal c. Size calculation d. Length calculation 3. Demonstrate the application of cricoid pressure 4. Document ETT properties in LDA flowsheet of EMR.

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:

Magnetic Resonance Imaging – Conditional Infusion Pumps

Competency Statement:
The nurse should safely and effectively collect, program and use the B Braun Pefuser® Space Syringe Pump

RCH references related to this competency: RCH Intranet – PICU – Guidelines: MRI conditional pump guideline (including link to Perfusor Space pump manual); Intra hospital transport for PICU patients

COMPETENCY ELEMENTS	
K	1. Locate & Read RCH online references related to this competency. 2. State the clinical application of the Perfusor® Space Syringe Pump 3. Explain the safety checks and precautions to be taken prior to use 4. State the functions of the keys and indicators on the front panel 5. Explain the information displayed on the screen whilst the pump is running 6. Explain why the pressure indicator is important and demonstrate how to check and adjust the pressure level 7. Explain the difference between a Yellow (pre) and a Red (operational alarm), and give an example of each
S	1. Securely fasten the pump by a. Mounting in the Space Station b. Using the pole clamp and attaching to an IV pole 2. Demonstrate the correct insertion of the disposables 3. Initiate and start a prescribed infusion 4. Demonstrate the ability to change the rate once the infusion has started 5. Demonstrate the correct administration of a prescribed bolus (if applicable) by a. Delivering a manual purge bolus b. Delivering a pre-selected hands free bolus 6. Demonstrate how to check the pumps battery status 7. Demonstrate how to set the standby mode 8. Demonstrate the correct way to remove the disposables from the pump 9. Turn the pump off and explain the correct cleaning and storage procedures

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:

Medication Infusion – Continuous (Guardrails)

Competency Statement:
The nurse safely and effectively administers medications and infusions via Guardrails

RCH references related to this competency: RCH Intranet – Paediatric Injectable Guidelines; Paediatric Pharmacopoeia; PICU – Guidelines: Drug infusions and maintenance fluid in PICU; Vasoactive Drug Infusion Management; Heparin infusion protocol for PICU Clinical practice guidelines: Intravenous fluids; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Describe the correct procedure for administering a drug to a patient in the PICU identifying the 6 rights of medication administration 3. Outline the checking procedure for infusions that are ordered and in progress at shift commencement a. Checking prescribed orders within the MAR flowsheet of the EMR b. Checking dose and infusion rate calculation c. Checking Guardrails entry data and setting safe limits d. Checking route (central or peripheral) e. Checking compatibilities of multiple drugs infusing allergy checks 4. Identify the correct way to label drugs and infusions a. Clinical assessments b. Signs of allergy or reaction c. Serum blood levels 5. Discuss frequency which infusions should be changed according to the PICU, CVAD and Pharmacy recommendations 6. Discuss the correct practice in documenting infusion rate within the fluid balance flowsheet of the EMR (including the importance of clearing pumps hourly)
S	1. Demonstrate the loading, programming and troubleshooting of a drug infusion a. Into a Guardrails pump b. Into a Alaris pump 2. Demonstrate the correct procedure for accessing lines and commencing an infusion into a central or peripheral line a. Checking access vein patency b. Aseptic technique c. Grading up infusions d. Discontinuing infusions

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:

Monitoring (Advanced ECG)

Competency Statement:
The nurse safely and effectively monitors an acutely unwell child fully utilizing the capability of the bedside monitor, central monitoring station and telemetry unit (where utilised)

RCH references related to this competency: RCH Intranet – PICU – Guidelines: ECG how to perform; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Discuss common patient categories which require continuous cardiac monitoring 3. Describe what the ECG trace is representing 4. Discuss what defines a sinus rhythm 5. Recognise the following rhythms a. VT – Ventricular Tachycardia b. VF – Ventricular Fibrillation c. AF – Atrial Fibrillation d. Heart block e. SVT – Supraventricular Tachycardia Ventricular Ectopics
S	1. Demonstrate correct ECG dot placement for 3 and 5 lead monitoring and describe differing monitoring capabilities of each. 2. Demonstrate changing Phillips monitor to a paced setting and explain the rationale for this 3. Demonstrate changing lead trace (on monitor at bedside and telemetry) and discuss rationale for this 4. Demonstrate change size of ECG trace 5. Demonstrate how to calculate an ECG rate 6. Discuss how to order, record and review ECG within the EMR

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:

Monitoring (Invasive Haemodynamic)

Competency Statement:
The nurse maintains accurate monitoring and provides valid interpretation of invasive haemodynamic monitoring for the critically ill child

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Invasive Haemodynamic Monitoring; RCH Policies & Procedures – Documentation: Electronic Medical Records(EMR)

COMPETENCY ELEMENTS	
K	d. Locate and read RCH online references related to this competency e. Define Invasive Haemodynamic Monitoring (IHM) and identify the parameters that are monitored f. State the rationales for initiating IHM in the critically ill child g. Identify the principles of management of the monitor a. Patient identification b. Screen configuration c. Waveform display d. Monitoring scale e. Alarm setting f. Identify technical errors h. Identify the principles of management of transducers and lines a. Priming procedure and technique b. Maintaining line patency c. Tubing and connections d. Labelling and colour coding practice e. Demonstrate levelling and zeroing transducer f. Infection control principles and frequency of line changes g. Identify technical errors i. State the potential complications associated with invasive monitoring and identify preventative strategies j. Outline the specifics of nursing management of intra-arterial (IA) monitoring k. States indications for invasive arterial blood pressure monitoring l. List sites for arterial cannula placement m. Identify patients requiring .22 micron filter and correct placement in IA line set-up n. Correlating the waveform with ECG and cardiac cycle o. Identification dichotic notch p. Discuss pulsus paradoxus q. Identification of normal blood pressure values and trends r. Identify reasons for abnormal blood pressure readings s. Discuss where and how this information is documented within the EMR t. Outline the specifics of nursing management of Central Venous Pressure (CVP) lines u. States indications for central venous pressure monitoring v. List sites for central catheter w. Securing safely, dressing and labelling central lines x. Identify patients requiring .22 micron filter and correct placement in CVP line y. Checking dressing and insertion sites z. Correlating the waveform with ECG and Cardiac Cycle aa. Identification of normal CVP values and trends bb. Identify reasons for abnormal CVP readings cc. Identify complications central lines dd. Outline the specifics of nursing management of direct transthoracic cardiac lines ee. State the 3 lines and identify their locations ff. Outline the rationale for monitoring from each line gg. Discuss securing safely, traction dressing and labelling direct cardiac lines hh. Identify rationale for placement of .22micron filter in direct lines ii. Checking dressing and insertion sites jj. Correlating the waveform with ECG and Cardiac Cycle for each line kk. Identification of normal values and trends ll. Identify reasons for abnormal readings mm. State the complications and risk of direct lines nn. Identify precautions to prevent complications of direct lines oo. Discuss the removal of direct lines, identify the process and associated risk pp. Discuss how to document removal of direct lines within EMR

Skill elements and nurse declaration on next page

S	1. Collect and assemble the equipment to establish monitoring a. Central monitor b. Cables c. Transducer d. Line and infusion 2. Demonstrate the correct technique for obtaining an accurate pressure reading a. Patient positioning b. Pressure reading c. Waveform interpretation i. Normal waveform ii. Dampened waveform d. Recording and trend analysis within EMR 3. Demonstrate assessment of line in the LDA assessment flowsheet of the EMR

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:

Nasojejunal Tube Insertion & Management

Competency Statement:
The nurse safely and effectively inserts and manages a transpyloric feeding tube

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Nasojejunal Tube Insertion; Pain and Sedation PICU – Procedural pain and sedation; Policies and procedures: Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Outline the rationale for transpyloric tube feeding 3. List the contra-indications for placing a tube 4. Outline the post – insertion procedure requirements to be attended to 5. Describe how confirmation of tube placement will be determined 6. List the possible complications of tube insertion and use 7. Describe the rationale for the feeding method required with a tube in place 8. Describe the administration of medications via a tube 9. Outline the monitoring and ongoing care of the child with a tube in place
S	1. Demonstrate the preparation for inserting a tube a. Correct equipment assembled b. Patient prepared 2. Demonstrate the procedure for insertion of the tube 3. Demonstrate accurate documentation and assessment of Nasojejunal tube within the LDA flowsheet of the EMR

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:

Nitric Oxide (NO) Therapy

Competency Statement:
The nurse safely and effectively cares for the child receiving Nitric Oxide (NO) therapy

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Nitric oxide gas guideline; Nitric oxide protocols; Nursing management of the patient with invasive mechanical ventilation in PICU; Artificial airway suctioning; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the indications for the application of NO therapy 3. Describe the pathophysiology of Pulmonary Hypertension a. Primary b. Secondary 4. Explain NO under the following headings a. Action b. Dose c. Route 5. Outline the correct unit processes required prior to initiation of NO therapy 6. Describe the monitoring required and discuss how to a. Calibrate b. Set alarm limits c. Measure delivered NO & byproduct. 7. Describe specific nursing assessment and care requirements for the child receiving NO 8. Identify the haematological complication of NO therapy and discuss a. prevention b. monitoring blood levels i. acceptable ranges ii. frequency c. drug to counteract 9. Describe other potential complications of NO therapy and identify management 10. Outline management for weaning NO therapy and preventions of further complications
S	1. Demonstrate the technical set up for Nitric Oxide a. Positive pressure ventilators b. High Frequency Ventilators c. Hand ventilation circuit and scavenging 2. Demonstrate accurate documentation within the MAR and observation flowsheet in the EMR 3. Discuss assessment of the patient and equipment and the care associated with NO therapy 4. Demonstrate explanations of NO therapy to parents and confirmation of their understanding

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:

Pacing Wires – Temporary

Competency Statement:
The nurse safely and effectively cares for a non-paced patient with temporary pacing wires

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Cardiac post-operative problems and arrhythmias; Temporary Epicardial Pacing; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify need for and location of temporary pacing wires 3. Distinguish between and identify indications for use of: a. Non-redo and single (skin / redo) wires b. Atrial and ventricular wires c Dermal wires 4. Discuss precautions required to ensure electrical safety 5. Discuss the importance of pacing wires in an event of cardiac emergency 6. Discuss the relevance of temporary pacing wires for any permanent pacemaker procedures in theatres. 7. Describe the assessment required for the pacing wire site and dressings. 8. State the precautions prior to removal and rationale for removal on day 4-5 9. State three complications of removal of pacing wires and nursing actions to prevent or detect these 10. Discuss follow up of patient post removal of pacing wires
S	1. Demonstrate the correct way to insert pacing wire ends into the protectors and explain the rationale 2. Demonstrate removal of pacing wires, following Clinical Practice Guidelines 3. Demonstrate the documentation of wire and site assessment in the LDA assessment flowsheet of the EMR.

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:

Pacing Wires – Temporary Epicardial Pacing

Competency Statement:
The nurse safely and effectively cares for a paced patient with temporary pacing wires

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Temporary Epicardial Pacing; Atrial ECG – How to do; Ospyka 203H (pacemaker); Cardiac post-operative problems and arrhythmias; Cardiac setup for PICU; RCH Policies & Procedures – Documentation:Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify common reasons for temporary pacing 3. Distinguish between atrial, ventricular and skin wires 4. Discuss correct use of the temporary pacemaker Prescription sheet located within the order set in EMR 5. Define the terms "output" and "sensitivity" 6. Discuss commonly used pacing modes a. AOO b. DDD c. AAI d. VVI 7. State precautions necessary to be taken to ensure patient safety 8. Identify the start of shift checks required for the paced patient and how this is documented within EMR 9. Describe how to assess the effectiveness of pacing 10. Identify the following complications, stating the causes and appropriate actions for a. Failure to sense b. Failure to capture c. Failure to pace d. Competition 11. Describe nursing practice required when a pacing is being decreased or ceased
S	1. Demonstrate how you would set up a monitor for a patient being paced 2. Demonstrate accurate documentation within the EMR and observation of pacemaker use 3. Demonstrate a temporary pacemaker battery change

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:

Pain (Analgesia Infusion)

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

- **RCH references related to this competency:** RCH Intranet: Paediatric Injectable Guidelines; Surgery – Acute Pain Management CPMS – Ketamine Infusion, Surgery – Acute Pain Management CPMS – Opioid Infusion; Surgery – Post-operative Nausea Vomiting PONV; PICU – Guidelines: Pain and Sedation PICU; Drug infusion and maintenance fluid in PICU; Anaesthesia & Pain Management: Children Pain Management service CPMS; RCH Clinical Practice Guidelines – Analgesia and Sedation, Policies & Procedures: Documentation: Electronic Medical Records (EMR)

Element Exemptions: Rosella PICU (S5a); All other units (S5b)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 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. Discuss signs of withdrawal syndrome
S	1. Demonstrate pain assessment with an understanding of child development, language and appropriate pain assessment tools 2. Demonstrate accurate documentation of observations and assessment within EMR 3. Demonstrate correct set up of analgesia infusion pumps 4. Demonstrate the use of the Withdrawal Assessment Tool (WAT-1) in weaning of opioid and analgesia and how to control these symptoms a. Discuss where to locate this tool within the EMR 5. Demonstrate explanation, answering questions and confirmation of understanding with family 6. Locate and complete: a. The online learning Primary Opioid competency b. The online learning Rosella Pain & Sedation competency

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:

Pain – Epidural / Regional Analgesia

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

RCH references related to this competency: RCH Intranet: Surgery – Anaesthesia & Pain Management – Epidural infusion, Surgery – Anaesthesia & Pain Management – Regional Anaesthetic Infusion Blocks; RCH Policies & Procedures – Documentation: Electronic Medical Records(EMR)

Element Exemptions: Banksia, Butterfly, Cockatoo, Dolphin, Kelpie, Koala, Kookaburra, Medical Imaging, Platypus, Possum, Rosella, Sugar Glider (S1)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online the reference related to this competency 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 if pain escalates 11. Discuss the relevance of a high or low epidural sensory blockade 12. Describe the removal of the epidural / regional catheter and document this is in the LDA assessment flowsheet of the EMR
S	1. Demonstrate set up and programming on the epidural / regional pump 2. Demonstrate how and when to assess and document dermatomes and bromage within EMR 3. Demonstrate accurate documentation of observations and assessment within the EMR 4. Demonstrate explanation, answering questions and confirmation of understanding with the family 5. Locate and complete the online learning Epidural Primary Competency in Learning Hero.

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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)

RCH references related to this competency: RCH Clinical Guidelines: Patient Controlled Analgesia; Surgery – Acute Pain Management; Surgery – Patient Controlled Analgesia PCA; Surgery – Post-operative Nausea Vomiting PONV; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH references related to this competency 2. Describes 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. Discuss 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
S	1. Demonstrate a pain assessment including documentation in the EMR 2. Demonstrate explanation, answering of questions and confirmation of understanding with family 3. Locate and complete the online learning PCA primary competency

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Pain Management (Critically Ill Child)

Competency Statement:
The nurse identifies and discusses appropriate pain assessment and management with comfort measures for the critically ill child

RCH references related to this competency: RCH Intranet – Surgery – Acute Pain Management CPMS; PICU – Pain & Sedation in PICU (Incorporating all pain & sedation guidelines); RCH Policies & Procedures – Documentation: Electronic Medical Records

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify appropriate pain assessment tools for the following patients a. Extubated with developed verbal skills b. Ventilated and sedated patient c. Pre – verbal and cognitively impaired patients 3. Discuss the importance of incorporating behavioural and physiological assessments of pain in critically ill children 4. Discuss the reasons why physiological responses to pain are less reliable in the critically ill child a. Inotropes b. Sepsis c. Stress Response d. Paced 5. Identify the behavioural indicators of pain in the following age groups and identify why these might be altered in the critically ill child a. neonate b. infant c. preschooler d. school aged child e. adolescent 6. Identify nursing comfort measures for a. neonate b. infant c. preschooler d. school aged child e. adolescent
S	1. Demonstrate the application of comfort measures to reduce pain in the critically ill child 2. Demonstrate accurate, frequent (1 – 4 hourly) pain assessment on the observation, Comfort B or WAT flowsheet of the EMR 3. Demonstrate accurate documentation of interventions performed within EMR of: a. Nursing comfort measures b. Non – opioid analgesia c. Opioid analgesia (boluses or change in rate) 4. Demonstrate re – assessment and documentation of pain in a timely manner following intervention

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Peritoneal Dialysis (PD) - Manual

Competency Statement:
The nurse safely and effectively cares for patients who require manual peritoneal dialysis

RCH references related to this competency: RCH Intranet: Nephrology – Protocols – Index Peritoneal Dialysis Protocol Manual; PICU – Guidelines: Peritoneal dialysis in PICU post cardiac surgery; RCH Policies & Procedures – Aseptic Technique; Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate & read RCH online references related to this competency 2. Complete the PD learning package 3. Identify the rationale for manual PD 4. Discuss importance of maintaining accurate fluid balance 5. Discuss the correct technique for PD a. Warming bags b. Assembling equipment and priming the set c. Connecting and disconnecting patient to and from the set d. Performing a dialysis cycle e. Changing the bag f. Performing exit site care g. Administering medications to dialysate bags h. Collecting specimens 6. Discuss the rationale for monitoring patient electrolytes
S	1. Locate and assemble all necessary equipment 2. Demonstrate correct documentation within the fluid balance flow sheet of the EMR 3. Demonstrate documentation of PD catheter and insertion site assessment in LDA flowsheet of EMR. 4. Complete PD learning package

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Phototherapy

Competency Statement:
The nurse safely and effectively cares for a neonate requiring phototherapy

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Phototherapy Guidelines – NNU; Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify 4 risk factors for or causes of neonatal jaundice 3. State the difference in serum bilirubin (SBR) levels a. conjugated b. unconjugated 4. Discuss the action of phototherapy light in reducing SBR 5. Identify the major complication of hyperbilirubinaemia and state the signs and symptoms 6. State 2 methods available to deliver phototherapy 7. Discuss nursing care required including: a. assessment of jaundice and effect of blue light therapy b. response to therapy and specifics of blood specimen collection to monitor SBR c. temperature assessment and control under radiant warmer or incubator d. hydration status assessment and altered fluid requirements e. stooling pattern alteration and associated hygiene needs f. comfort and developmental needs of the neonate receiving phototherapy 8. Discuss and demonstrate ways in which parents can be involved in the care of their child receiving phototherapy
S	1. Correctly assess the indication for phototherapy based on acceptable SBR range for neonate's gestation and postnatal age, and correctly locate and plot SBR on graph in the EMR 2. Assemble and operate phototherapy lights safely and effectively a. position lights at correct height and provide rationale b. positioning the neonate to maximise light exposure 3. Accurately document assessment and care associated with phototherapy 4. Demonstrate explanations and confirmation of understanding with parents

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Potassium (Molar) Infusion

Competency Statement:
The nurse safely and effectively administers a concentrated (molar) potassium chloride infusion in the PICU

RCH references related to this competency: RCH Intranet – Pharmacy – Medicines Information: Paediatric Injectable Guidelines; MIMS Online; PICU – Guidelines: Concentrated Potassium Chloride infusion; Drug infusions and maintenance fluid in PICU; PRN electrolyte replacement; PICU – Guidelines: Paediatric Intensive Care Guidelines; Drug Doses; RCH Policies & Procedures – Central Venous Access Device Management; Documentation: Electronic Medical Records (EMR); RCH Library – Online Resources – Journal Search: White J, Veltri M, & Fackler J (2005). Preventing adverse events in the paediatric intensive care unit: Prospectively targeting factors that lead to intravenous potassium chloride order errors. Paediatric Critical Care Medicine, 6(1), 25-31

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH online references related to this competency 2. Identify normal serum potassium levels and define Hypokalaemia and Hyperkalaemia 3. Discuss the complications of Hypokalaemia and Hyperkalaemia 4. Discuss the factors which will alter the accurate measurement of serum potassium levels 5. Classify the 2 patient groups who may receive a molar potassium chloride infusion 6. State the indications and contraindications for administering a molar potassium chloride infusion 7. State the correct dosage, route, and line choice for administering molar potassium chloride infusion 8. Describe the 6 components that constitute a valid molar potassium chloride prescription order within the MAR in the EMR 9. Identify the complications of administering molar potassium chloride 10. State the elevated serum potassium level that requires treatment and identify this treatment
S	1. Complete Learning Hero PRN electrolyte replacement package 2. Demonstrate the correct checking procedure, documentation in the MAR of the EMR, and infusion preparation of a molar potassium chloride infusion

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Respiratory Assessment and Illness

Competency Statement:
The nurse safely and effectively performs a comprehensive paediatric respiratory assessment and discusses the pathophysiology and management of common paediatric respiratory illnesses.

RCH references related to this competency: RCH Clinical Practice Guidelines: Asthma, Bronchiolitis, Croup, Pertussis, Pneumonia; Nursing – Oxygen Delivery; RCH Emergency Department Respiratory Learning Package; RCH Intranet – PICU – Guidelines: Oxygen therapy in PICU: standing orders; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

Element exemption: Rosella (K13)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency: 1. Describe the anatomical & physiological differences between a paediatric and adult airway. 2. Describe the anatomical & physiological differences in relation to the respiratory system for a. infant b. small child c. older child 3. State the normal values for respiratory rates in an a. infant b. small child c. older child 4. Discuss preparation of the environment, equipment, and child for respiratory assessment 5. Identify and state significance of respiratory noises a. Wheeze b. Stridor c. Crackles: coarse / fine d. Grunting 6. State the signs and symptoms of mild, moderate, severe respiratory distress 7. Discuss oxygen saturation monitoring in relation to respiratory assessment and illness 8. Discuss the relationship between pulse oximetry and the oxygen-haemoglobin dissociation curve. 9. Describe the pathophysiology underlying common respiratory conditions: a. Asthma b. Bronchiolitis c. Pneumonia d. Croup e. Pertussis 10. Discuss interventions/management of common respiratory conditions: a. Asthma b. Bronchiolitis c. Pneumonia d. Croup e. Pertussis 11. Describe clinical indications and rationale for commencing oxygen therapy 12. Describe process for escalating care of a patient who develops an oxygen requirement 13. Describe observation regime for patients when weaning oxygen therapy.
S	1. Demonstrate effective respiratory assessment in relation to: a. Level of consciousness b. Inspection (Look) c. Auscultation (Listen) d. Palpation (Feel) e. History Taking f. Effort & Efficiency of breathing 2. Accurately document the findings of respiratory assessment on the EMR: a. Air entry b. Respiratory rate and character c. Rise and fall of chest wall d. Normal sounds on auscultation e. Work of breathing f. Landmarks and sequence for auscultation g. Use of accessory muscles 3. Demonstrate effective use of spacer for different age groups 4. Demonstrate asthma education to parents / caregivers

Nurse Declaration on next page

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Nurse Name:	Signature:	Date:

Assessor Name:	Signature:	Date:

Resuscitation – Advanced Paediatric

Competency Statement:
The nurse safely, efficiently and effectively performs advanced cardiopulmonary resuscitation on the infant and child

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Advanced Paediatric Resuscitation; Cardiac call out ED APLS Package (obtain from ED education); Learning Hero (ALS competencies and guidelines); RCH Clinical Practice Guidelines – Intraosseous Access; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency **Initial Assessment (DRS)** 2. Outline the process to raise an alert and activate a MET call **Airway and breathing (AB)** 3. Cite indications for use of the Guedel airway **Circulation (C)** 4. Discuss indications for commencing chest compressions 5. Discuss how you would identify if chest compressions are effective 6. Identify rhythms requiring chest compressions **Intubation** 7. Describe correct priorities for assisting at intubation 8. Identify correct procedure for confirming ETT placement **Medication administration** 9. Identify the primary resuscitation drug and preferred routes **Defibrillation** 10. Identify rhythms requiring defibrillation 11. Identify correct joules and sequence 12. Discuss the current Australian Resuscitation Council (ARC) guidelines for paediatric resuscitation 13. Discuss how family centred care can be provided when the child requires resuscitation
S	**Initial Assessment (DRS)** 1. Demonstrate initial assessment of the patients conscious state **Airway and breathing (AB)** 2. Perform manoeuvres to open the airway specific to the age group 3. Demonstrate assessment of airway 4. Demonstrate effective clearance of the airway 5. Demonstrate assessment of breathing using the "look, listen and feel" process 6. Provides effective bag and mask ventilation with a. Correct size mask b. Adequate oxygen flow c. Good chest inflation 7. Demonstrate reassessment of breathing. **Circulation (C)** 8. Demonstrate immediate provision of cardiac compressions 9. Demonstrate safe and effective cardiac compression technique a. Adequate rate and ratio b. Adequate depth in correct position c. Allowing full chest recoil d. Minimising interruptions e. Co-ordination of compressions and breaths f. Determines the effectiveness of compressions **Intubation** 10. Assemble the correct equipment and information to enable intubation a. Airway equipment b. Weight calculation c. Endotracheal tube (ETT) size and length **Medication administration** 11. Prepare the correct drugs and dosages for resuscitation 12. Prepare the correct fluid and volume to be administered 13. Demonstrate the correct calculation and preparation for infusions of Dobutamine and Noradrenaline **Defibrillation** 14. Demonstrate correct use of the manual biphasic defibrillator to safely and effectively deliver the electrical energy with minimal interruptions to compressions 15. Accurately document cardiopulmonary resuscitation **Documentation** 16. Demonstrate how to locate the resuscitation navigator within the EMR

	17.Demonstrate effective use and cessation of the resuscitation navigator throughout an emergency situation

Nurse Declaration on next page

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

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 Injury; Nursing – Spinal Cord Injury (Acute Management); RCH Intranet – PICU – Guidelines: Aspen collars; Occian airway pad; RCH Policies & Procedures – Documentation:Electronic Medical Records (EMR); Safe Transfer and Handling of Patients and Materials

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

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Describe the rationale for spinal immobilisation 3. Identify the patients that require cervical collar application and immobilisation 4. Discuss the difference between hard and soft collars and identify available hard and soft collars 5. State when a one piece hard collar should be replaced with an Aspen hard collar 6. Discuss the rationale for log rolling a patient requiring spinal precautions 7. 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 8. Identify the correct process for clearing the spinal cord and removing the collar 9. Describe the TED airway pad and when should it be used to assist in maintaining neutral alignment of the paediatric spine 10. Discuss and demonstrate spinal immobilisation education to patients and families / caregivers
S	1. Demonstrate how to immobilise a patient with cervical collar discussing limitations to immobilisations 2. Demonstrate how to log roll a patient with a spinal injury discussing limitations to immobilisations 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:

Assessor Name: Signature: Date:

Spinal Injury (Acute)

ALERT*: *The spinal immobilisation competency should be completed in conjunction with this competency

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

RCH references related to this competency: RCH Clinical Practice Guidelines: Acute Spinal Injury; Cervical Spine Assessment; Major paediatric trauma – The primary survey; Major paediatric trauma – The secondary survey; Nursing: Indwelling urinary catheter – insertion and ongoing care; Nursing: Spinal Cord Injury (Acute Management); Nursing: Pressure Injury Prevention and Management; RCH Policies & Procedures - Documentation: Electronic Medical Records (EMR); Safe Transfer and Handling of Patients and Materials PICU Intranet Aspen collars; TED airway pad.

COMPETENCY ELEMENTS	
K	1. Locate and read RCH references related to this competency 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 "spinal cord injury with radiographic abnormality" 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. First 24hrs 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 a safe full spinal precaution log roll.

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Spinal Surgery – Post-operative Care

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

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Pain & Sedation PICU; Nursing management of the patient with invasive mechanical ventilation in PICU; Spinal fusion surgery cue card; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Safe Transfer and Handling of Patients and Materials

Element exemption: Rosella (K4)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. List the indications for spinal surgery in the paediatric population 3. Discuss the different types of spinal surgery performed at RCH a. Anterior Spinal Release b. Posterior Spinal Fusion c. Other 4. Discuss the rationale for the ward nurse to assess the spinal patient post-operatively in Recovery prior to transfer to the ward 5. Explain the rationale for lying the patient post spinal surgery flat for 4 hrs after transfer from theatre 6. Identify the specific care required by the PICU nurse in preparation for transfer to the ward. 7. Discuss 5 possible complications of spinal surgery
S	1. 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. Skin assessment 2. Demonstrate proper patient positioning post spinal surgery 3. Demonstrate patient mobilisation post spinal surgery a. sitting up b. standing c. sitting out of bed

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Suction & Hand Ventilation

Competency Statement:
The nurse safely and effectively provides endotracheal suction and hand ventilation for the intubated patient

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Nursing management of the patient with invasive mechanical ventilation in PICU; Artificial airway suctioning; Cuff management in Paediatric ETT and Tracheostomy Tubes; Oxygen therapy in PICU – standing orders; Procedural Pain Management; RCH Policies & Procedures – Documentation: Electronic Medical Records Documentation (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. State the rationale for performing artificial airway suction 3. Identify two important principles of providing suction for the paediatric patient 4. Describe the indications for and frequency of performing airway suction 5. Outline the specific precautions for suctioning the child with a. HFOV b. Nitric Oxide c. Pulmonary hemorrhage d. Labile pulmonary hypertension 6. Discuss the specific techniques and precautions required for hand ventilation of the patient with a. Low ventilatory rate and spontaneously breathing b. Continuous positive airway pressure (CPAP) via ETT c. Upper airway obstruction who is breathing spontaneously via ETT d. Nasal CPAP 7. Outline when a normal saline lavage may be indicated during suction 8. Discuss the safety aspects of providing artificial airway suction 9. Discuss the possible complications of suction of the endotracheal tube
S	1. Demonstrate the preparation of the patient for the suctioning procedure 2. Describe and demonstrate preparation required for the suctioning procedure a. Personnel involved b. Bagging circuit size c. Catheter size d. Assembly and testing of the suction apparatus, including the suction pressure required e. Selection and insertion of the inline suction apparatus f. Testing and setting the blow off valve on the bagging circuit manometer 3. Describe and demonstrate the hand ventilation technique required during routine suction 4. Describe and demonstrate the suction procedure required for 10. Child <3kg 11. Child >3kg 5. Demonstrate correct documentation of suction within observation flowsheet of the EMR

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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

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Pain and Sedation PICU; Cardiac surgical wound dressings; RCH Clinical Practice Guidelines – Chest Drain (Intercostal Catheter) Insertion; Nursing: Chest Drain Management; RCH Policies & Procedures: Aseptic Technique; Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify reasons why a surgical drain might be inserted 3. Identify the following surgical drains a. Jackson – Pratt b. Redivac c. Mini – Vac d. UWSD 4. State how it would be evident if each of the above drains was on suction 5. Explain the correct procedure to address a Redivac which is not patent 6. State how frequently a surgical drain should be measured and / or emptied 7. Discuss two potential complications of surgical drains 8. List four signs indicating infection of a surgical drain site 9. Discuss the rationale for removal of a surgical drain
S	1. Demonstrate emptying a Jackson Pratt drain and accurate measuring 2. Demonstrate emptying a Mini – Vac drain 3. Demonstrate correct procedure for obtaining an accurate measurement of a Redivac drain 4. Demonstrate the re-application of suction to Redivac drain 5. Demonstrate the conversion from Redivac to UWSD 6. Demonstrate drain loses and properties in the fluid balance flowsheet of EMR

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Thermoregulation (Neonates)

Competency Statement:
The nurse provides safe and effective thermoregulation nursing care for neonates and infants.

RCH References related to this competency: RCH Clinical Practice Guidelines – Nursing: Neonatal & Infant Skin Care; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

Element Exemptions: Banksia, Cockatoo, Dolphin, , Kelpie, , Kookaburra, Medical Imaging, , Platypus, Possum, RCH@Home, Sugar Glider (K11); Rosella, Emergency, Perioperative, Koala (K11b) Banksia, Cockatoo, Dolphin, Emergency, Kelpie, Koala, Kookaburra, Medical Imaging, Perioperative, Platypus, Possum, RCH@Home, Rosella, Sugar Glider (K12, 17-21, S5-7)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency **Thermoregulation Overview** 2. State the normal range for axilla and rectal temperatures in a neonate or infant 3. State to correct technique for obtaining a rectal temperature in children under 3 months of age 4. Define neutral thermal environment (NTE) 5. Explain the four mechanisms of heat loss and state two strategies to prevent heat loss for each of the four mechanisms 6. State risk factors for temperature imbalance in neonates/infants 7. Discuss cold stress and impact this has on the critically ill neonate/infant 8. Outline the nursing management for hypothermia 9. Define hyperthermia and describe the assessment findings in the neonate/infant 10. Outline the nursing management for hyperthermia 11. Describe the advantages/disadvantages of a. Radiant warmer b. Incubator 12. Explain how nursing an extremely low birth weight neonate in humidity affects temperature balance **Radiant Warmers** 13. Explain the mechanism of "servo control" 14. State how often the temperature should be monitored when neonates are nursed on a radiant warmer a. identify how to manage the radiant warmer when the neonate is hypothermic b. identify how to manage the radiant warmer when the neonate is hyperthermic 14. Describe and demonstrate specific nursing assessment and care required of the neonate on a radiant warmer 15. State when it is appropriate to transfer a neonate to a. an incubator b. open cot 16. Describe the specific nursing care to maintain thermoregulation stability when transferring to an open cot. **Incubators** 17. State how often neonates temperature should be monitored when in an incubator and the procedure for increasing incubator temperature if needed 18. State why an incubator should not be turned off while a neonate is still being nursed in it 19. State the factors to be considered in weaning a neonate from an Incubator to an open cot 20. Describe procedure for weaning a neonate from an incubator to an open cot 21. Explain the mechanism of servo control in the incubator stating two reasons why this mode would be used
S	**Radiant Warmers** 1. Demonstrate the functions of a radiant warmer 2. Collect and prepare equipment to pre-warm the radiant heater 3. Position the infant correctly on the radiant warmer 4. Demonstrate correct application of the skin probe and a. discuss factors that can interfere with probe function b. discuss nursing interventions to rectify probe problems **Incubators** 5. Demonstrate how to set the NTE for two neonates of different gestation and weights in Incubators 6. Demonstrate how to set up servo control and what needs to be documented if the neonate is on servo control in the incubator explaining the rationale for this documentation 7. Accurately documents information within EMR related to thermoregulation of the neonate

Nurse Declaration on next page

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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

RCH references related to this competency: RCH Clinical Practice Guidelines: Tracheostomy Management; Nursing: Tracheostomy Video; Nursing: Tracheostomy De-cannulation; PICU Intranet Artificial airway suctioning, RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

Element Exemptions: Banksia, Cockatoo, Dolphin, Emergency, Kelpie, Koala, Kookaburra, Medical Imaging, Perioperative, Platypus, Possum, RCH@Home, Sugar Glider (K21-23, S7); Butterfly (K10)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 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 patient with a newly formed tracheostomy 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. 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 17. State options available for providing oxygen via a tracheostomy tube 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 first tracheostomy tube change d. personnel required for first tracheostomy tube change e. procedure for tracheostomy tube tie change f. assessment of stoma g. routine for changing tracheostomy dressing h. airway clearance and tube patency 22. Discuss the rationale for stay – sutures
S	1. Demonstrate the procedure for changing tracheostomy tube 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 de-cannulation 6. Demonstrate correct suctioning technique 7. Demonstrate application of humidification and oxygen via the tracheostomy tube. 8. Demonstrate care of a patient undergoing planned de-cannulation 9. Demonstrate management of a percutaneous tracheostomy tube 10. Demonstrate documentation of tracheostomy assessment in LDA assessment flowsheet of the EMR

Nurse Declaration on next page

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Transfer from Rosella Ward (PICU)

Competency Statement:
The nurse safely and effectively prepares and transfers the patient to the ward from PICU

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Discharge – Koala Inotropes; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Safe Transfer and Handling of Patients and Materials

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify which members of the multi-disciplinary team need to be contacted prior to discharge 3. Communicate effectively with all members of the multi-disciplinary team and the family to plan the transfer
S	1. Demonstrate patient assessment to determine that the patient is clinically stable for the intended transfer 2. Demonstrate preparation of the patient a. Correct intravenous infusions type, volume and strength for ward and loaded into ward infusion pumps and poles b. Accurate pain assessment and if appropriate referral made to Children's Pain Management Service (CPMS) c. Correct lines labelled, minimised and prepared d. Intra – arterial line removed e. Pressure monitoring discontinued f. CVC removed if not required g. Peripheral lines patent h. Dressings and drains attended to i. Removal of chest drains and pacing wires if indicated j. patient and bed is clean and all PICU hardware removed 3. Demonstrate preparation of the patient and family 4. Accurately complete documentation located within EMR prior to transfer including: a. Met criteria reviewed b. Documentation up to date – LDA flowsheet updated c. Medical orders optimised pre to discharge (including fluid orders and medications) 5. Demonstrate accurate handover of the patient

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Nurse Name: Signature: Date:

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Transplant (Post-operative cardiac)

Competency Statement:
The nurse safely and effectively cares for the child / young person post Cardiac transplant

RCH references related to this competency: RCH Intranet: Cardiology – Intranet Resources - Cardiology and Cardiac Surgery Protocols; Anticoagulation in PICU following cardiac surgery. PICU – Guidelines: Cardiac post-operative patient reception to PICU; Cardiac setup for PICU; Cardiac surgical would dressings; Chest drain management; Drug infusions and maintenance fluid in PICU; Vasoactive drug infusion management; Levosimendan PICU guide; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Aseptic Technique

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Describe the preparation of the allocated room, equipment, and bedspace for the patient post-operative cardiac transplant 3. Identify the post-operative nursing care priorities to maintain haemodynamic stability in PICU: a. Within first 24hours b. ongoing until transfer to the ward 4. State the nursing responsibilities in caring for the child/young person who has undergone cardiac transplantation and their family in relation to a. Room allocation b. Monitoring of vital signs and laboratory results c. Pain management d. Fluid requirements / balance e. Medications / Infusions f. Infection Control g. Discharge planning and family education 5. Describe the rationale for immunosuppressants and the possible complications and side effects associated with these medications 6. Describe the rationale for prophylactic medications 7. State the nurses responsibilities when caring for the immunosuppressed patient 8. Discuss the main surgical complications that may occur post cardiac transplant and their management 9. Discuss the multidisciplinary team members involved in the care of child post cardiac transplant and their role in a child's recovery 10. Describe the psychosocial impact cardiac transplantation may have on the child / young person and their family 11. Discuss the required follow up of children / young people post discharge
S	Not Applicable

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Transplant (Post-operative liver)

Competency Statement:
The nurse safely and effectively cares for the child / young person post liver transplant

RCH references related to this competency: RCH Intranet – PICU Intranet – Guidelines: Liver Transplant; Pain and Sedation PICU; Intestinal transplant – pre-operative preparation; Multi-resistant organism guideline for PICU; RCH Clinical Practice Guidelines – Nursing: Chest Drain Management; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Aseptic technique

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Discuss the following relevant to liver transplantation a. Whole, Split or cut down liver transplant b. Biliary Anastomosis c. Portal Vein, Hepatic vein and hepatic artery anastomosis d. Living donor. 3. Identify the post-operative care required in PICU / Ward relating to a. cardiovascular monitoring and haemodynamic stability b. renal function, fluid balance, electrolytes and glucose c. respiratory monitoring and support d. central nervous system functioning e. immunosuppression and infection control f. coagulopathy monitoring and control g. routine post-operative investigations h. medication administration / interactions i. wound management j. nutrition k. infection control l. documentation 4. State rationale for insertion and describe management of: a. Jackson Pratt tube b. T-tube 5. Discuss the following complications and their management a. Infection b. Renal dysfunction c. Ascites d. Haemorrhage e. Organ rejection f. Bile duct obstruction / leak g. Hepatic vein, portal vein and hepatic artery thrombosis / obstruction h. Post-transplant diabetes i. Abnormal LFT / FBE / U+E 6. Discuss the rationale for immunosuppression and state potential complications / side effects. 7. State the roles of the following multidisciplinary team members: a. Gastroenterology Consultant b. Liver Transplant Coordinator c. Pharmacist d. Physiotherapist 8. Describe the psychosocial management of liver transplantation on: a. Parent education / involvement b. ADL's c. Discharge planning d. Holistic care 9. Discuss the follow up of children / young people required post discharge
S	10. Demonstrate the preparation required for receiving the patient post liver transplant a. Cleaning and stocking the room b. Equipment, fluid and drug preparation c. Receiving the patient from theatre / PICU

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Nurse Name:	Signature:	Date:

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Transport of a Ventilated Patient – Intra-hospital

Competency Statement:
The nurse prepares for and provides safe and effective transport for the ventilated patient transported within the hospital

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Intra-hospital transport for PICU patients; Nursing management of the patient with invasive mechanical ventilation in PICU; PICU intra-hospital transport Patient Checklist; Ventilator and accessory selection guideline; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); Safe Transfer and Handling of Patients and Materials

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the reasons that a ventilated patient may require transport within the hospital 3. Discuss the associated risks with transporting the ventilated patient 4. Outline the time required and the persons to notify in preparation for transport 5. Discuss procedures to prepare and stabilise the patient prior to transport a. Airway patency i. Oxygen and suction ii. Tubes and intubation equipment iii. Critical airway precautions b. Breathing i. Hand ventilation requirements ii. Ventilator c. Circulation stability i. Monitoring I. Invasive II. Non-invasive ii. Access and line patency iii. Drugs and resuscitation dosages iv. Fluids v. Inotrope infusions vi. Thermoregulation 6. Describe the correct procedure to transfer the ventilated patient onto and from bed 7. Identify the personnel required and their specific roles during transport 8. Outline precautions to maintain patient stability during transport 9. Discuss the emotional preparation of the patient and family for the transport procedure 10. Explain the process for restocking and storage of equipment upon completion of transporting the ventilated patient
S	1. Demonstrate assembly, connection and working knowledge of the ventilator a. Elisee b. Baby Pac c. LTV 2. Demonstrate assembly, connection and working knowledge of the monitor a. Zoll b. Phillips Intellivue MP30 c. Phillips Intellivue MP50 d. Phillips Intellivue X2 e. Microstream Npb-75

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Vasoactive Drugs

Competency Statement:
The nurse safely and effectively cares for the patient receiving commonly used Vasoactive Drug Infusions

RCH references related to this competency: RCH Intranet: Pharmacy – Medicines Information – Paediatric Injectable Drug Guidelines; PICU – Guidelines: Vasoactive Drug Infusion Management; Drug infusions and maintenance fluid in PICU; Discharge – Koala Inotropes Policy and procedure Documentation; Electronic medical records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. State the action, usual dose, side effects and nursing responsibilities during administration of a. Inotropes i. Dobutamine ii. Dopamine iii. Adrenaline b. Vasodilators i. Sodium Nitroprusside ii. Glycerine Trinitrate c. Vasopressors i. Noradrenaline ii. Vasopressin d. Phosphodiesterase Inhibitors i. Milrinone 3. Discuss the correct placement of vasoactive drugs on a central line 4. Discuss the frequency with which infusions should be changed according to the PICU guidelines 5. Detail the labelling and correct documentation of vasoactive infusions in the MAR of the EMR
S	1. Describe and demonstrate how to calculate an infusion in a. Mg / kg / min b. Mcg / kg / min c. Units / kg / hr d. Nanograms / kg / min e. mmols / hr 2. Demonstrate and discuss the safe changing of vasoactive drug infusions using the "double pumping quick change" method

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Nurse Name: Signature: Date:

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Ventilation (Invasive)

Competency Statement:
The nurse safely and effectively cares for the child receiving invasive ventilation

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Intubation of the patient in PICU – Nursing Management; Fixation of Endotracheal Tubes ETT in PICU; Nursing management of the patient with invasive mechanical ventilation in PICU; Ventilator and accessory selection guideline; Ventilator Alarm Settings; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. State the clinical indications and aims for invasive ventilation of the paediatric patient 3. Explain the available ventilator breath types a. TCPL b. SIMV c. Assist Control d. Volume Control e. Pressure Control f. CPAP g. Pressure Support 4. Identify components of the ventilation circuit and state their function 5. Describe the nursing assessment of the ventilated patient including a. Adequacy of ventilation b. Adequacy of humidification 6. Discuss the nursing care of the patient receiving positive pressure ventilation a. Endotracheal / tracheostomy tube care b. Prevention of VAPS c. Optimizing ventilation d. Prevention of extubation / decannulation 7. Define 'flow trigger', demonstrate how to set this, and discuss how to recognize and manage 'auto cycling' 8. Define '% Flow cycling' and discuss how this mechanism operates for a. Mandatory breaths b. Assisted breaths 9. Describe the limitations of AVEA ventilator when providing nasopharyngeal continuous positive airway pressure (nCPAP). 10. Discuss alternative methods of nCPAP delivery 11. Describe the function of the background settings available (LTV Ventilator) 12. Discuss the risks and complications associated with mechanical ventilation and identify ways to minimize these 13. Outline how communication is facilitated with the ventilated patient 14. Discuss how family centered care can be provided when the child is ventilated.
S	1. Demonstrate correct assembly and checking of the ventilator circuit and tubing a. For an infant b. For a young child 2. Demonstrate the checks required of the ventilator and ventilation circuit a. Initial start of shift checks and alarm limits b. Hourly checks c. Devise integrate d. Documentation within EMR 3. Demonstrate a respiratory assessment of a ventilated patient 4. Demonstrate the correct setting and identify the function of the advanced settings available (Avea Ventilator) a. Machine volume b. Volume limit c. Bias flow d. Pressure trigger 5. Demonstrate how to change from IMV/SIMV to PS +CPAP, including setting of appropriate apnoea settings 6. Demonstrate how to setup nCPAP on AVEA ventilator, including calibration process 7. Demonstrate accurate documentation within EMR of ventilation settings.

Nurse Declaration on next page

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Nurse Name:	Signature:	Date:

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Ventilation: Mechanical (Basic Principles)

Competency Statement:
The nurse demonstrates a sound understanding of the principles of mechanical ventilation

RCH references related to this competency: RCH Intranet – PICU – Guidelines: Nursing management of the patient with invasive mechanical ventilation in PICU; Ventilator Alarm Settings; Artificial airway suctioning; Ventilator & accessory selection guide for PICU; Nitric oxide protocols; ED respiratory package (available from ED education) RCH Policies & Procedures – Documentation: Electronic Medical Records(EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Describe the physiology of normal spontaneous breathing 3. Discuss the lung characteristics of a. Airway resistance b. Lung compliance c. Tidal volume (VT) d. Minute volume (VE) e. Dead space f. Intrapulmonary shunt g. Inspiratory / Expiratory ratio (I:E ratio) h. Ventilation / Perfusion ratio (V:Q) 4. State the aims of mechanical ventilation 5. Define mechanical ventilation and explain a. Invasive ventilation b. Non-invasive ventilation c. Negative pressure ventilation d. Positive pressure ventilation e. High frequency ventilation 6. Distinguish the two main modes of ventilation and discuss their application in ventilating children a. Volume ventilation b. Pressure ventilation 7. State the clinical indications for initiation of mechanical ventilation for the paediatric patient with a. Acute respiratory failure b. Chronic respiratory failure 8. Explain the types of breaths that may be delivered by a ventilator a. Mandatory breaths b. Spontaneous: triggered, assisted, supported 9. Determine the difference between SIMV breaths and Assisted Control breaths 10. Identify the components of the ventilation circuit a. Inspiratory limb b. Expiratory limb c. Exhalation valve d. Humidifier e. Oxygen inlet and monitor 11. Define the ventilation parameters a. PIP / IPAP b. PEEP / EPAP c. Pressure support d. Assist sensitivity (Flow trigger) e. Inspiratory time f. Flow g. Minimum / Maximum inspiratory time (TiMin/ TiMax) h. $Fi0_2$ 12. State the causes of and appropriate response for a. Low pressure alarm b. High pressure alarm c. Low minute volume alarm 13. Provide a rational for the use of humidification and discuss a. Care of the humidifier and temperature probes b. Temperature setting c. Humidity control d. Troubleshooting
S	1. Demonstrate and discuss appropriate alarm settings for a. Pressure parameters b. Flow parameters

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Ventilation (Non-Invasive)

Non-Invasive positive pressure ventilation (NPPV) & Negative pressure ventilation (NPV)

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 Intranet: PICU Intranet – Guidelines: Non-invasive respiratory support in PICU; Ventilator and accessory selection guideline; High flow nasal prong NFNP oxygen therapy; PICU ventilation package (obtain from PICU education);Non-invasive BIPAP ventilation package (obtain from ED education) RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR)

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Discuss the indications and application for NPPV 3. Discuss the indications and application of NPPV 4. Differentiate between the mechanisms of the following ventilation strategies a. CPAP b. BiPAP c. Hi-Flow nasal prongs d. Negative pressure ventilation cuirass (vest) 5. 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 CO_2 exhalation port h. Masks i. Nasal ii. Face iii. Full facial iv. For single or dual circuit i. Humidification j. Oxygen and analysis k. Negative pressure cuirass 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 in the observation flowsheet of the EMR of NPPV / NPV 10. Discuss how family centered care can be provided when the child is receiving NPPV
S	Not Applicable

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Nurse Name: Signature: Date:

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Ventricular Access Device (VAD) – Long Term

Competency Statement:
The nurse safely and effectively cares for the child who is receiving therapy via a Berlin Heart Ventricular Assist Device (VAD)

RCH references related to this competency: RCH Clinical Practice Guidelines: Long Term Ventricular Assist Device VAD Anticoagulation Guidelines; RCH Intranet: Haematology – Intranet Resources – Anticoagulation, Kids Health Info – Resources; RCH Policies & Procedures – Documentation: Electronic Medical Records (EMR); VAD Pre-operative checklist, Long term VAD Anticoagulation guideline, Daily care plan for long term VAD patients, Long term VAD dressing procedure.

COMPETENCY ELEMENTS	
K	1. Locate and read RCH online references related to this competency 2. Identify the indications for a VAD 3. List the components of the VAD a. Cannula b. Blood pump head c. Pneumatic lead/ drive line d. Driver 4. Describe the cannula placement in VAD a. Left-sided VAD b. Right-sided VAD 5. Discuss the principles of VAD a. the role of pneumatics in the functioning of VAD b. the process and direction of blood flow from the patient into the VAD blood pump and returning to the patient circulation 6. Explain what is meant by fixed rate modes of VAD 7. Discuss the modes available with the Berlin Heart 8. Explain the clinical problems that can present during therapy on a VAD and discuss the potential causes of each problem (e.g. incomplete VAD output) 9. Attend the following sessions: a. Berlin Heart lecture b. Berlin Heart tutorial c. Heartware tutorial 10. Describe the ongoing patient assessment and documentation within EMR required when a patient is receiving VAD therapy including: a. Vital signs b. VAD Observations c. Pump head filling and emptying d. Signs of effective cardiac output e. Signs of the potential clinical problems f. VAD Circuit g. Cannula site dressing and pump head stabilisation h. Describe the correct procedure for securing the VAD cables i. Anticoagulation management j. Pain 11. Discuss the purpose of the insertion of the double lumen Broviac at the time of VAD implantation 12. Discuss points to consider when a patient is returning to theatre for a chest exploration in relation to: a. Timing of when to transfer to the operating theatre b. What can happen when muscle relaxants are given in the anaesthetic room to a patient on VAD (volume mode) c. What should be done to help prevent this occurring and to treat the problem. 13. Explain how to call for assistance when a patient on VAD is located a. On the Cardiac/Renal Unit and have a non-urgent query related to the patient or VAD **out** of hours b. On the Cardiac/Renal Unit and have an emergency related to the patient or VAD **in or out** of hours c. In PICU and there is an emergency with either the patient or VAD **in** hours d. In the Starlight Room **in** hours
S	1. Successfully complete the written competencies for Berlin Heart 2. Successfully complete the practical assessment for Berlin Heart 3. Complete supernumerary time with a nurse experienced in caring for a child on the Berlin Heart VAD 4. Articulate and demonstrate the correct start of shift checks for the Berlin Heart VAD and record accurately within EMR 5. Accurately document assessment of cannulas in LDA flowsheet of EMR. 6. Accurately document observations in observation flowsheet of EMR.

Nurse declaration on next page

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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).

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Self-Reflection:			
Assessor [sign and date]		**Nurse** [sign and date]	

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