Chapter 3Q

Specialty Nursing Competencies- Emergency Department

The Royal Children's Hospital Melbourne

Nursing Competency Workbook, 10th Edition

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

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

Chapter 2
Generic Nursing Competency Assessment Forms

Chapter 3
Specialty Nursing Competency Assessment Forms

Appendix 1
Unit / Department Nursing Orientation

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

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

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

Workbook 10th edition, January 2018

Table of Contents

Abdominal Pain (Emergency Department)

Competency Statement:
The nurse safely and effectively cares for a child presenting with abdominal pain

RCH references related to this competency: RCH Clinical Practice Guideline: Abdominal Pain

COMPETENCY ELEMENTS	
K	1. Locate and read the Abdominal Pain - RCH Clinical Practice Guideline 2. Discuss common diagnoses and symptoms associated with abdominal pain a. Gastroenteritis b. Urinary Tract Infection (UTI) c. Constipation d. Appendicitis e. Intussusception 3. What investigations may be required for a child with abdominal pain? a. abdominal xray b. abdominal ultrasound 4. Discuss differential diagnoses of abdominal pain
S	1. Discuss and demonstrate an assessment of a patient with abdominal pain considering a. Pain Score b. Analgesia c. Nausea / vomiting d. Diarrhoea / constipation e. Fever f. Vital Sign's g. Urinary symptoms h. Bare weight 2. Demonstrate collection of. a. Urine M/C/S b. Faecal M/C/S c. BHCG 3. Demonstrate appropriate documentation of a patient with abdominal pain 4. Demonstrate education to families and caregivers regarding abdominal pain management and fasting consideration 5. Demonstrate access of Parent Fact Sheets for Children with particular abdominal conditions e.g.: UTI, Constipation

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:

Anaphylaxis

Competency Statement:
The nurse safely and effectively cares for a child at risk of or experiencing anaphylaxis

RCH references related to this competency: RCH Clinical Practice Guideline: Anaphylaxis

Element Exemptions: RCH@Home (K9a-d, S3a-c)

COMPETENCY ELEMENTS	
K	1. Locate and read Anaphylaxis - RCH Clinical Practice Guideline 2. Define anaphylaxis 3. Discuss the pathophysiology of anaphylaxis 4. Identify common causes of anaphylaxis in children 5. Describe the signs and symptoms associated with anaphylaxis 6. Discuss management of the following for a child experiencing anaphylaxis a. Airway b. Breathing c. Circulation d. Skin e. Gastrointestinal system 7. State the drug used as first line treatment for anaphylaxis 8. Identify suitable locations for administration of IM injections 9. Discuss the planning required for discharge a. Medications b. Action Plan c. Referrals d. Resources 10. Discuss specific precautions required for a child admitted to hospital with a latex allergy
S	1. Demonstrate or discuss a. Correct calculation b. Correct drawing up c. Route of administration d. When to give e. How often to give 2. Demonstrate correct administration of an EPIPEN trainer 3. Demonstrate discussion with families the use of a. an anaphylaxis plan b. EPIPEN administration c. Care of an EPIPEN e.g. Expiry date, temperature control

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:

Blood Sampling from Central Venous Access Devices

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

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

RCH references related to this competency: RCH Clinical Practice Guideline: CVAD Insertion and Management

COMPETENCY ELEMENTS	
K	1. Locate and read The Central Venous Access Device Insertion and management Clinical Practice Guideline. 2. Locate and read the Blood Culture Clinical Practice Guideline. 3. Describe the circumstances when bloods might need to be taken from a CVAD 4. Identify a. blood tests frequently taken from CVADs b. tubes required for tests identified above c. volumes required 5. Discuss when gloves would be worn for blood sampling from CVADs and why 6. Discuss safe handling procedures of blood specimens 7. Discuss the correct size syringe to take blood from a CVAD 8. 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 9. Discuss 'hep-lock' of the CVAD
S	1. Demonstrate education of the patient / family / carer regarding blood collection from a CVAD 2. Assemble correct equipment for the collecting a blood specimen from a CVAD 3. Demonstrate the procedure for taking blood from a single lumen CVAD 4. Demonstrate the procedure for taking blood from a multi lumen CVAD 5. Demonstrate correct labelling of blood specimens 6. Demonstrate correct completion of pathology forms

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:

Burns - Assessment

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

RCH references related to this competency: RCH Clinical Practice Guideline: Burns

COMPETENCY ELEMENTS	
K	1. Locate and read the Burns - Clinical Practice Guideline. 2. State the rationale for assessing the patient with a burn injury 3. Discuss the signs, symptoms & associated complications of an inhalational burn injury 4. State the first aid requirements for a burn & the timeframe it may be used in 5. Discuss how to calculate total burn surface area (TBSA) for various age groups using the Lund & Browder Chart as a guide 6. Discuss the skin's healing potential in relation to depth of burn 7. Discuss the implications for assessment requirements for the patient with a: a. circumferential burn b. facial burn, c. perineal burn, d. burns over a joint e. superficial burn f. partial thickness burn g. full thickness burn
S	1. Accurately perform & document ABCD assessment for a patient with a burn injury 2. Correctly document the time of burn & mechanism of injury 3. Assess colour, presence / absence of blisters, capillary refill time & sensation to determine burn depth. 4. Identify a circumferential burn & state the associated risk it presents

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:

Cubicle Care (Emergency Department)

ALERT: The nurse should complete the ED cubicle minimum standards in conjunction with this competency

Competency Statement:
The nurse safely and effectively cares for a child in the cubicle area of the emergency department.

COMPETENCY ELEMENTS	
K	1. Discuss documentation requirements including a. Timing of Assessments b. Relevance c. Assessment findings and interventions 2. Discuss effective communication with the Emergency Multidisciplinary 3. Discuss safe transport of patients from cubicles to other area within the department and other areas of the hospital 4. Discuss the importance of providing parents with education
S	5. Discuss and demonstrate the location, assembly and use of oxygen and suction in the cubicle and location of related and spare equipment including nearest bag and mask location 6. Discuss and demonstrate the use of the Philips MP30 monitor including a. Setting/adjusting alarm parameters b. Yellow, red and blue alarms c. Changing the patient profile d. Selecting the appropriate sized BP cuff and leads to obtain a blood pressure e. Changing to an automatic, interval cycle for BP monitoring f. Changing the size of the ECG complexes on the screen g. Turning the QRS complex sound on/off h. Turning off/on appropriate waveform monitoring as per patient requirements i. Correctly attaching 3 lead monitoring to patient and rational for lead selection 7. Plan and conduct interventions as indicated for the patient 8. Ensure all patients wearing correct ID label and placed in correct cubicle 9. Demonstrate recognition of changes in patient condition and alerts appropriate staff 10. Discuss and demonstrate providing accurate handover of patients to members of the multidisciplinary team

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:

Diabetes Mellitus

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

RCH references related to this competency: RCH Clinical Practice Guideline: Diabetes Mellitus

COMPETENCY ELEMENTS	
K	1. Locate and read the Diabetes Mellitus RCH Clinical Practice Guideline 2. Describe the signs and symptoms that might indicate a diagnosis of diabetes mellitus 3. Describe the significance of blood glucose levels (BGL); normal range, why, when and how they should be monitored 4. Discuss the management of low and high BGL 5. Discuss ways in which ketone levels can be determined and when ketone levels should be checked 6. Discuss the management of ketoacidosis 7. Discuss the basic principles of dietary management of diabetes 8. Describe the role of the Dietician in educating the child and family about the food plan 9. Discuss the role of the Diabetes Nurse Educator 10. Describe the role of the Emergency nurse in the absence of the Diabetes Nurse Educator
S	1. Demonstrate collection of a capillary BGL 2. Demonstrate teaching the child and family a. to perform blood glucose testing b. to draw up and administer insulin c. about key principles of dietary management d. about identification and management of low and high BGL

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:

Eczema (Wet dressings and topical treatment)

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

RCH references related to this competency: RCH Clinical Practice Guideline: Eczema

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

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:

Febrile Illness

Competency Statement:
The nurse safely and effectively cares for a child with a febrile illness

RCH references related to this competency: RCH Clinical Practice Guideline: Febrile Child, Sepsis – assessment and management

COMPETENCY ELEMENTS	
K	1. Locate and read the febrile child Clinical Practice Guideline 2. Locate and read the Sepsis – assessment and management Clinical Practice Guideline. 3. State an acceptable temperature range for neonates and children 4. Discuss the significance of low temperature recordings in infants under 3 months 5. Discuss the significance of high temperature recordings in neonates 6. Discuss the significance of high temperature readings in children who are immuno-compromised 7. Provide examples of investigations that may be undertaken to determine the cause of fever a. Under 3 months b. 2 year old with abdominal pain and fever c. 3 year well, not distressed with runny nose d. Child who is immunocompromised 8. Discuss the use of antipyretics in the care of a child with a febrile illness
S	1. Demonstrate a primary assessment of a child who is febrile a. Airway b. Breathing c. Circulation d. Disability e. Exposure 2. Demonstrate the different methods used to obtain a temperature and describe the benefits and disadvantages of each a. Tympanic b. Per Axilla c. Per Rectal 3. Demonstrate education to families and caregivers regarding fever management and the use of antipyretics including fever handout education 4. Provide families / caregivers with accurate information regarding febrile convulsions 5. Display reassurance to distressed families and caregivers about their child with a febrile illness

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:

Febrile Neutropenia

ALERT: The blood sampling from central venous access device competency should be completed in conjunction with this competency

Competency Statement:
The nurse will safely and effectively care for a patient with Febrile Neutropenia

RCH references related to this competency: RCH Clinical Practice Guideline: Febrile Neutropenia, Sepsis – assessment and management

COMPETENCY ELEMENTS	
K	1. Locate and read the following clinical practice guidelines a. Febrile Neutropenia b. Sepsis – assessment and management 2. State the normal values a. Haemoglobin b. Platelets c. White Blood count d. Neutrophils 3. Describe the function of neutrophils 4. Define the term febrile neutropenia 5. Discuss the observations required during an admission for neutropenia 6. Discuss the actions to be taken where observations are outside the normal range for the child's age 7. Discuss the use of paracetamol and Ibuprofen in the care of children who have febrile neutropenia 8. Explain the rationale for the following investigations as part of a septic work up a. Blood cultures b. Swabs – nose / throat / CVAD c. Urine d. Stool 9. Explain which blood cultures need to be taken and how much blood you would take for a 20kg child 10. Discuss CVAD line set up for administration of antibiotics for the child with febrile neutropenia? 11. Discuss the management of suspected febrile neutropenia on presentation to emergency 12. Discuss the management provided in the first 72 hours of admission for febrile neutropenia 13. State the antibiotics and dosages used as first line treatment for febrile neutropenia 14. Discuss treatment options for patients with unresolved fever 15. State the signs and symptoms of septic shock 16. Identify potential sources/portals/causes of infection in patients with neutropenia and discuss ways to minimise the risk 17. List ways in which staff / parents and children can help prevent infection
S	1. Discuss/Demonstrate collection of blood cultures from a Central Venous Access Device 2. Demonstrate education of children and families about neutropenia

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:

Fractures (Limb)

ALERT: The neurovascular assessment competency should be completed in conjunction with this competency

Competency Statement:
The nurse safely and effectively cares for a child in the ED with a limb fracture
RCH references related to this competency: RCH Clinical Practice Guideline: Biers Block, Pain Management – Intranasal Fentanyl;
RCH Intranet: Kids Health Info – Plaster Care Fact Sheet

COMPETENCY ELEMENTS	
K	1. Locate and read the Paediatric Fracture Guideline - RCH Clinical Practice Guideline. 2. Locate and read the Pain Management – Intranasal Fentanyl Clinical Practice Guideline. 3. Locate and read the Biers Block Clinical Practice Guideline. 4. Locate and read Plaster care – Kids Health Info Fact Sheet. 5. Define fracture 6. Discuss analgesia for different fracture types a. Oral b. Intranasal c. IV opioids d. Regional nerve blockage 7. Discuss the indications for use of plaster 8. Discuss the principles of plaster care 9. Identify the frequency of neurovascular observation post plaster application 10. Explain compartment syndrome 11. Discuss the prevention of compartment syndrome 12. Discuss discharge education for patient and family
S	13. Demonstrate assisting with LAMP a. What does LAMP stand for? b. Describe the procedure. c. Identify the number of staff that need to be present. d. Preparing the child e. Nursing observation requirements including monitoring f. Tourniquet checks g. Cuff inflation minimum time h. Identifying need for nitrous oxide i. Identifying need for intravenous access j. Use of Lignocaine 14. Demonstrate the application of plaster & explain indications for use 15. Demonstrate provision of information for parents for care of the patient at home a. Limb elevation b. Neurovascular observations c. Use of sling for immobilisation d. Skin Care e. Plaster Care f. Pain management, g. Analgesia 16. Discuss and demonstrate organisation of follow up appointment at fracture clinic

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:

Ingestion / Overdose (Emergency Management)

Competency Statement:
The nurse effectively and safely manages and cares for a patient presenting to the Emergency Department post ingestion/overdose

RCH references related to this competency: RCH Clinical Practice Guideline: Ingestion/Overdose

COMPETENCY ELEMENTS	
K	1. Locate and read the Poisoning RCH Clinical Practice Guidelines 2. Discuss possible clinical considerations regarding the patient who has presented with ingestion/overdose 3. Identify any other resources available to staff/patients regarding clinical information and possible treatment relating to the patient presenting with ingestion / overdose 4. Identify and discuss available treatment options for the following common ingestion/ overdose presentations a. Paracetamol b. Benzodiazepines c. Opioids d. Salicylates e. SSRI, TCAs f. Beta blockers, anti-hypertensives 5. Discuss the use of charcoal in the Emergency Department setting in regards to overdoses 6. Discuss the complications and management of potential in-hospital medication errors: a. Insulin b. Heparin c. Potassium d. Morphine
S	Not Applicable

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:

Invasive Procedures (Emergency Department)

Competency Statement:
The nurse effectively and safely cares for children requiring invasive procedures in the Emergency Department (ED)

RCH references related to this competency: RCH Clinical Guidelines: Indwelling urinary catheter – insertion and ongoing care, IV insertion, Lumbar puncture, Suprapubic Aspirate;
RCH Policies & Procedures: Consent

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH hospital policy and procedure regarding 'consent' 2. Locate and read the following clinical practice guidelines a. IV insertion b. Suprapubic Aspirate Guideline c. Indwelling urinary catheter – insertion and ongoing care d. Lumbar puncture guideline. 3. Discuss invasive procedures commonly performed in the ED 4. Explain the procedure to the patient using age appropriate language and cues 5. Discuss the role and involvement of play therapist in invasive procedures in the ED 6. Identify situations when procedural sedation may need to be used 7. Identify which procedural sedation agents are used in the ED and discuss any clinical, pharmacological and medico legal considerations relating to their usage
S	1. Demonstrate the obtaining of parental / caregiver consent for procedure prior to commencement 2. Discuss and demonstrate effective use of the following during invasive procedure a. Language b. Positioning c. Distraction 3. Discuss and demonstrate inclusion and involvement of parents during invasive procedures 4. Demonstrate correct set up for the following invasive procedures a. Intravenous Cannulation b. Blood Sampling c. Supra pubic aspiration d. In out catheter e. Lumbar puncture 5. Demonstrate effective assistance/performance of procedures (according to RCH policies and procedure, and guidelines): a. Intravenous Cannulation b. Blood sampling c. Suprapubic aspiration d. In out catheter e. Lumbar puncture 6. Demonstrate accurate documentation of invasive procedure

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:

Mental Health Emergencies (Emergency Care)

Competency Statement:
The nurse can effectively and safely manage and care for a patient presenting to the Emergency Department with a Mental Health Emergency

RCH references related to this competency: RCH Clinical Practice Guidelines: Mental Health Examination, Restraint - Emergency Chemical Restraint, Restraint - Emergency Restraint and Sedation – Code Grey;
RCH Policies & Procedures: Emergency Behavioural Assessment Room (EBAR)

COMPETENCY ELEMENTS	
K	1. Locate and read the Mental State Examination Clinical Practice Guideline. 2. Locate and read Restraint – Emergency chemical restraint 3. Locate and read Restraint – Emergency restraint and sedation – Code Grey. 4. Locate and read Emergency Behavioural Assessment Room (EBAR) policy and procedure 5. Discuss the most common reasons a patient may present to ED and require mental health assessment and / or treatment 6. Discuss the role, location and availability of the following staff in relation to mental health assessment and / or treatment of patients in ED a. Psych triage liaison nurses b. Social work c. Psych registrars / fellows / consultants 7. Discuss the management of a patient presenting to ED with a mental health emergency who has: a. Physical injury or illness b. No physical injury or illness 8. Discuss when physical restraints are indicated 9. Identify commonly used chemical restraints in ED and discuss nursing considerations of a patient who is chemically restrained 10. Discuss what section 10 of mental health act relates to 11. Discuss nursing considerations of a patient who is brought in by police under section 10 mental health act.
S	1. Identify location of a. Safe room b. Safe room keys c. Code grey bag 2. Demonstrate correct application of physical restraints (shackles) and discuss nursing considerations of a patient who is physically restrained

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:

Metabolic Conditions

ALERT*: *Element 5 is only applicable for nurses working in the neurosciences ward

Competency Statement:
The nurse discusses care of a patient with a metabolic condition

RCH references related to this competency: RCH Clinical Practice Guidelines: Metabolic Disorders

COMPETENCY ELEMENTS	
K	1. Locate and read the Metabolic Disorders Clinical Practice Guideline. 2. Explain in basic terms what a metabolic condition is 3. Summarise catabolism and anabolism 4. List some of the metabolic conditions that are commonly seen at the Royal Children's Hospital 5. Discuss the main principles around sick day management for a patient with a metabolic condition 6. Identify who can check medications for a patient with a metabolic condition on CNC
S	1. Not applicable

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:

Assessment (neonates)

Competency Statement:

The nurse safely and effectively performs a comprehensive assessment on a neonate

RCH references related to this competency: RCH Clinical Practice Guideline: Neonates

COMPETENCY ELEMENTS	
K	1. Explain when a neonatal assessment should be performed 2. Describe the maternal history of the neonate being assessed 3. Describe the labour and delivery of the neonate being assessed
S	4. Performs a head to toe physical assessment of the neonate explaining the procedure using the following systems: a. Respiratory b. Cardiovascular c. Neurological d. Gastrointestinal e. Elimination f. Musculoskeletal 5. Accurately document findings from the neonatal assessment

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:

Fluid Management (Neonates)

Competency Statement:
The nurse is able to safely manage fluid requirements of a neonate

RCH references related to this competency: RCH Clinical Guideline: Neonatal intravenous fluid requirements

COMPETENCY ELEMENTS	
K	1. Locate and read the neonatal intravenous fluid requirements Clinical Practice Guideline 2. Explains neonatal fluid homeostasis a. Pre-diuretic phase b. Diuretic phase c. Post – diuretic phase 3. Identify expected fluid requirements for neonates a. Day 1 b. Day 2 c. Day 3 d. Beyond Day 3 4. Identify four clinical indications for commencing intravenous therapy 5. State rationale for choice of fluid selected for intravenous therapy 6. Describe the potential effects intravenous therapy may have on the neonates blood glucose levels and interventions that may need to be taken a. Identifies normal ranges for BSL and TBG 7. Identify interventions to minimise the risk of extravasations 8. Describe the physical signs that indicate the cannula is tissued 9. Discuss interventions to be taken if cannula is suspected of having tissued 10. With regards to replacement fluids a. Identify which fluid losses can be replaced b. Identify when to commence fluid replacement c. Identify what fluids are used for fluid replacement d. Identify when to cease fluid replacement e. Correctly documents fluid losses and replacement
S	1. Demonstrate a thorough physical assessment of the neonate's hydration status including a. Skin Turgor b. Mucous membranes c. Fontanelle d. Urine Output (states normal values) e. Fluid Balance f. Presence of oedema g. Vital Signs (states normal values) h. Electrolytes (states normal values) i. Weight 2. With regards to replacement fluids: a. Demonstrate accurate calculation of losses in ml / kg / day b. Demonstrate accurate calculation of required replacement c. Demonstrate setting of syringe driver intravenous pump with guardrails to required rate 3. Demonstrate explanation and confirms understanding with the 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.

☐ 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:

Neonates

Sepsis suspected (Neonates)

Competency Statement:
The nurse safely and effectively cares for a neonate with suspected sepsis.

COMPETENCY ELEMENTS	
K	1. Describe specific and non-specific signs that may indicate sepsis in the neonate 2. Identify risk factors that may make an individual neonate more vulnerable to sepsis including a. Relevant antenatal and material factors b. Postnatal history c. Invasive instrumentation and / or procedures 3. Identify risk factors for pneumothorax in neonates 4. State 5 tests commonly used to diagnose / exclude sepsis 5. Explain how each test assists in making a diagnosis of sepsis 6. Discuss 2 complications which may occur from each of the 5 tests commonly used
S	1. Assemble the equipment required to perform each of the tests 2. Discuss and demonstrate maintenance of patient safety during septic work up 3. Discuss and demonstrate implementation of effective patient comfort measures during septic work up 4. Demonstrate collection of specimens according to guidelines 5. Accurately labels samples and completes documentation 6. Demonstrates explanation and confirmation of understanding with the 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.

☐ 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:

Thermoregulation (Neonates)

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

Element Exemptions: Banksia, Cockatoo, Dolphin, Emergency, Kelpie, Koala, Kookaburra, Medical Imaging, Perioperative, Platypus, Possum, RCH@Home, Rosella, Sugar Glider (K10); Banksia, Cockatoo, Dolphin, Emergency, Kelpie, Koala, Kookaburra, Medical Imaging, Perioerative, Platypus, Possum, RCH@Home, Sugar Glider (S5-7)

COMPETENCY ELEMENTS	
K	**Thermoregulation Overview** 1. State the normal range for axilla and rectal temperatures in a neonate or infant 2. State to correct technique for obtaining a rectal temperature in children under 3 months of age 3. Define neutral thermal environment (NTE) 4. Explain the four mechanisms of heat loss and state two strategies to prevent heat loss for each of the four mechanisms 5. State risk factors for temperature imbalance in neonates/infants 6. Discuss cold stress and impact this has on the critically ill neonate/infant 7. Outline the nursing management for hypothermia 8. Define hyperthermia and describe the assessment findings in the neonate/infant 9. Outline the nursing management for hyperthermia 10. Describe the advantages/disadvantages of a. Radiant warmer b. Incubator 11. Explain how nursing an extremely low birth weight neonate is humidity affects temperature balance 12. Explain the mechanism of servo control **Radiant Warmers** 13. State how often the temperature should be monitored when neonates are nursed on a radiant warmer, and identify how to manage the radiant warmer when hypothermic 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 related to thermoregulation of the neonate

Nurse Declaration on next page

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

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

Nurse Name:	Signature:	Date:

Assessor Name:	Signature:	Date:

Neurological Observations

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

COMPETENCY ELEMENTS	
K	1. State the difference between performing neurological observations and a neurological assessment 2. Discuss each component of neurological observations and how they assist in determining a patient's neurological condition a. Glasgow Coma Scale b. Pupils c. Limb strength d. Vital signs 3. Identify the preferred method of painful stimuli in different age groups 4. Describe decorticate and decerebrate posturing and what causes them 5. Discuss how acquired or developmental intellectual impairment will affect the collection of accurate neurological observations 6. List the signs and symptoms of raised ICP in different age groups 7. Explain the Cushing Reflex 8. State the actions required if a patient has a deterioration in neurological status
S	1. Assemble the equipment required to perform neurological observations 2. Demonstrate neurological observations on paediatric patients in the following age groups: a. Infant (<1year) b. 1 – 4 year c. 5 - 12 year d. 12 + years

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:

Neurovascular Assessment

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

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

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:

Procedural Sedation Nitrous Oxide competency – theory

ALERT*: *This competency should precede the procedural sedation nitrous oxide competency – skill component. Completion of this competency in isolation does not indicate the nurse's competency to administer nitrous oxide

Competency statement: The nurse has the requisite knowledge to assess and prepare a child and family for nitrous oxide sedation and to safely and effectively administers nitrous oxide throughout the sedation period
RCH references related to this competency: RCH Website - Comfort Kids – For Health Professionals – nitrous oxide Accreditation Process RCH CPG Sedation-Procedural Sedation-Ward & Ambulatory areas and RCH CPG Procedural Pain Management. RCH Record of Sedation for procedure

COMPETENCY ELEMENTS	
K	1. Locate and read a. Sedation-Procedural Sedation-Ward & Ambulatory areas CPG b. Sedation Manual 5th edition Emergency Department c. Sedation – Analgesia & Sedation CPG d. Procedural Sedation learning guide for healthcare professionals 2. Discuss the role and responsibility of the procedure and sedation team 3. Describe the pharmacological effects of nitrous oxide 4. Outline the fasting guidelines for nitrous oxide and the consent process 5. Describe how to prepare a child/family for a nitrous oxide sedation event 6. Describe what considerations should be taken when administering nitrous oxide with another primary sedation agent or an opioid medication 7. State the appropriate gas flow rate (L/min) and reservoir bag size (L) for a child and adolescent 8. State what is required and the rationale for: a. Risk assessment b. Exclusion criteria c. Emergency equipment d. Monitoring - Baseline and ongoing observation of vital signs e. Continual assessment of sedation level and maintaining verbal contact f. Line of sight clinical observation and appropriate staffing g. Maintaining a quiet environment h. Falls prevention i. Time out and positive identification j. Occupational Health and Safety k. Post sedation discharge criteria l. Documentation and reporting of adverse events 9. State the action required for: a. Equipment faults b. Loss of nitrous oxide or oxygen gas flow c. Failure to sedate or adequate analgesic effect 10. Describe the management and possible prevention of: a. Patient who is combative – including loss of facemask seal b. Patient who complains of nausea or vomits c. Patient who desaturates, is apneic or respiratory depressed d. Patient who is distress from double vision or hallucinations e. Patient who is excessive drooling f. Patient who progresses to an unintended deeper level of sedation g. Patient who develops airway obstruction and laryngospasm 11. State the maximum time of administration (minutes) recommended for a nitrous oxide procedural sedation event 12. State the location of the emergency equipment in your area
S	Not Applicable

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:

Procedural Sedation Nitrous Oxide competency – skill

ALERT*: *This competency should follow the procedural sedation nitrous oxide competency – theory component. Nurses must attain the competency elements INDEPENDENTLY in order to be considered competent

Competency statement: The nurse assesses and prepares a child and family for a procedure and safely and effectively administers nitrous oxide throughout the sedation period

RCH references related to this competency: RCH Website - Comfort Kids – For Health Professionals – nitrous oxide Accreditation Process RCH CPG Sedation-Procedural Sedation-Ward & Ambulatory areas and RCH CPG Procedural Pain Management. RCH Record of Sedation for procedure

COMPETENCY ELEMENTS	
K	1. State when the sedation period starts and ends 2. State how to assess and maintain a patent airway for your patient 3. State the function of the nitrous oxide delivery unit, include all components 4. State the two built in safety features on the nitrous oxide delivery unit, include the rationale 5. Identify the appropriate time and support personnel to delivery nitrous oxide
S	6. Complete the "Prior to the sedation" section of the Record of sedation for procedure to: a. Identify risk and to meet the criteria for nitrous oxide administration b. Obtain informed verbal consent and provide information (fact sheet) c. Obtain an order for nitrous oxide+/-additional analgesic+/- Topical LA 7. Demonstrate patient assessment, including correct sizing of the facemask 8. Demonstrate preparation of the child and parent, prior to the sedation event 9. Demonstrate the safety checks for the nitrous oxide delivery unit and assemble the disposable components of the unit, prior to the sedation event 10. Demonstrate preparation of treatment area and emergency equipment as per the Record of sedation for procedure prior to the sedation event 11. Demonstrate how to turn on the scavenging system for the nitrous oxide gas and ensure compliance with Occupation Health and Safety standards 12. Demonstrate Time out or Positive Patient Identification 13. Demonstrate leadership in administering nitrous oxide " a. Clarify the roles of staff and family, prior to the sedation event b. State when the child is ready for the procedure to begin c. Direct staff and family, maintaining one leader and a calm environment 14. Demonstrate non pharmacological strategies, as part of the sedation event 15. Maintain line of sight and verbal contact throughout the sedation period 16. Demonstrate continuous monitoring of vital signs and sedation score, documenting as per the Record of sedation for procedure 17. Deliver nitrous oxide making adjustment to: a. the concentration of nitrous oxide based on anxiety, pain and sedation requirements b. the gas flows based on the patients age (child or adolescent), breathing pattern and volume of gas in the reservoir bag c. the facemask in order to maintain a seal over the nose and mouth 18. Demonstrate safe and timely management of side effects or adverse events 19. Monitor administration time and communicates timing with the person performing the procedure 20. Demonstrate delivery of oxygen post procedure for 3-5 minutes 21. Perform the "end of sedation period" assessment, include level of alertness and return to baseline vital signs 22. Demonstrate "recovery" positioning and handover of patient when indicated 23. Complete all documentation for the sedation event per the Record of sedation for procedure 24. Demonstrate debrief of child and parent, include positive reinforcement 25. Discuss post sedation care with family and child, include falls prevention 26. Discuss travel arrangements and supervision (for outpatients)

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in independently administering nitrous oxide. The minimum recommended number of supervised nitrous oxide events, achieving independent administration, was undertaken and documented below. 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:

Record of Nitrous Oxide Administration

The recommended number of supervised nitrous oxide sedation events is based on prior experience of nitrous oxide administration. Refer to-Comfort Kids Website-For health professionals - nitrous oxide accreditation process

Event *Number & Date*	**Feedback** *Prompts required Areas to improve*	**Outcome for Event** *Assisted - Repeat Independent - Competent*	**Assessor** *Signature & Designation*

Procedural Sedation Ketamine competency – theory

ALERT*: *This competency should precede the procedural sedation ketamine competency – skill component. Completion of this competency in isolation does not indicate the nurse's competency to administer ketamine

Competency statement: The nurse has the requisite knowledge to assess and prepare a child and family for nitrous oxide sedation and to safely and effectively administers ketamine throughout the sedation period
RCH references related to this competency: RCH Website - Comfort Kids – For Health Professionals – Ketamine Accreditation Process RCH CPG Sedation-Procedural Sedation-Ward & Ambulatory areas and RCH CPG Procedural Pain Management. RCH Record of Sedation for procedure

COMPETENCY ELEMENTS	
K	13. Locate and read e. Sedation-Procedural Sedation-Ward & Ambulatory areas CPG f. Sedation Manual 5th edition Emergency Department g. Sedation – Analgesia & Sedation CPG h. Procedural Sedation learning guide for healthcare professionals 14. Discuss the role and responsibility of the procedure and sedation team 15. Describe the pharmacological effects and action of Ketamine 16. Outline the fasting guidelines for Ketamine and the consent process 17. Describe how to prepare a child/family for a Ketamine sedation event 18. Describe what considerations should be taken when administering Ketamine and how it can be administered including dosing 19. State what is required and the rationale for: m. Risk assessment n. Exclusion criteria o. Emergency equipment p. Monitoring - Baseline and ongoing observation of vital signs q. Continual assessment of sedation level and maintaining verbal contact r. Line of sight clinical observation and appropriate staffing s. Maintaining a quiet environment t. Falls prevention u. Time out and positive identification v. Occupational Health and Safety w. Post sedation discharge criteria x. Documentation and reporting of adverse events 20. Describe the management and possible prevention of: h. Patient who complains of nausea or vomits i. Patient who desaturates, is apneic or respiratory depressed j. Patient who is distress from double vision or hallucinations k. Patient who is excessive drooling or hypersalvation l. Patient who progresses to an unintended deeper level of sedation m. Patient who develops airway obstruction and laryngospasm 21. Discuss the care of the patient post a ketamine procedure 22. State the location of the emergency equipment in your area
S	Not Applicable

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:

Procedural Sedation Ketamine competency – skill

ALERT*: *This competency should follow the procedural sedation ketamine competency – theory component. Nurses must attain the competency elements INDEPENDENTLY in order to be considered competent

Competency statement: The nurse assesses and prepares a child and family for a procedure and safely and effectively administers ketamine throughout the sedation period

RCH references related to this competency: RCH Website - Comfort Kids – For Health Professionals – Ketamine Accreditation Process RCH CPG Sedation-Procedural Sedation-Ward & Ambulatory areas and RCH CPG Procedural Pain Management. RCH Record of Sedation for procedure

COMPETENCY ELEMENTS	
K	27. State when the sedation period starts and ends 28. State how to assess and maintain a patent airway for your patient 29. Identify the appropriate sedation and procedure team and role allocations
S	30. Complete the "Prior to the sedation" section of the Record of sedation for procedure to: d. Identify risk and to meet the criteria for Ketamine administration e. Obtain informed verbal consent and provide information (fact sheet) f. Obtain an order for Ketamine 31. Demonstrate patient assessment prior to sedation 32. Demonstrate preparation of the child and parent, prior to the sedation event 33. Demonstrate the safety checks and preparation of emergency equipment 34. Demonstrate preparation of treatment area and emergency equipment as per the Record of sedation for procedure prior to the sedation event 35. Demonstrate Time out or Positive Patient Identification 36. Demonstrate non pharmacological strategies, as part of the sedation event 37. Maintain line of sight and verbal contact throughout the sedation period 38. Demonstrate continuous monitoring of vital signs and sedation score, documenting as per the Record of sedation for procedure 39. Demonstrate safe and timely management of side effects or adverse events 40. Monitor administration time and communicates timing with the person performing the procedure 41. Perform the end of sedation period assessment, include level of alertness and return to baseline vital signs 42. Demonstrate safe positioning and encourage a quiet environment for the patient 43. Demonstrate safe transfer of patient to non-acute area once safe for on-going observation 44. Complete all documentation for the sedation event per the Record of sedation for procedure 45. Demonstrate debrief of child and parent, include positive reinforcement 46. Discuss post sedation care with family and child, include falls prevention

I have demonstrated the necessary knowledge, skills, abilities and attributes to be deemed competent in independently administering nitrous oxide. The minimum recommended number of supervised nitrous oxide events, achieving independent administration, was undertaken and documented below. 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:

Record of Ketamine Administration *The recommended number of supervised nitrous oxide sedation events is based on prior experience of ketamine administration. Refer to-Comfort Kids Website-For health professionals - ketamine accreditation process*			
Event *Number & Date*	**Feedback** *Prompts required* *Areas to improve*	**Outcome for Event** *Assisted - Repeat* *Independent - Competent*	**Assessor** *Signature & Designation*

Rash Recognition

Competency Statement:
The nurse identifies common childhood rashes and implements safe and effective nursing management.

COMPETENCY ELEMENTS	
K	1. Locate and read the Department of Health guidelines for the control of infectious disease http://www.health.vic.gov.au/ideas/bluebook/ 2. Define the following terms in relation to rashes a. Macule b. Papule c. Vesicle d. Urticarial e. Petechial f. Purpura g. Pustule h. Erythema i. Blanching j. Non Blanching 3. Discuss the following common childhood conditions and nursing management of each a. Measles b. Chickenpox c. Impetigo d. Scabies e. Erythema infectiosum (slapped cheek) f. Coxsackie virus (hand foot and mouth disease) g. Eczema 4. Identify and discuss rashes linked to illness that require isolation 5. Identify the types of rashes that are associated with potentially life threatening illness 6. Accurately describe and document rash and rash location
S	1. Demonstrate provision of patient and family with education and handouts on rashes and management

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:

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; RCH Emergency Department Respiratory Learning Package

COMPETENCY ELEMENTS	
K	1. Locate and read a. RCH Emergency Department Respiratory Learning Package b. Asthma Clinical Practice Guideline c. Bronchiolitis Clinical Practice Guideline d. Croup Clinical Practice Guideline e. Pneumonia Clinical Practice Guideline f. Pertussis Clinical Practice Guideline 2. Describe the anatomical & physiological differences in relation to the respiratory system for a. infant b. small child c. older child d. adult 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: Course / fine d. Grunting 6. State the signs and symptoms of mild, moderate, severe respiratory distress 7. Discuss saturation monitoring in relation to respiratory assessment and illness 8. Describe the pathophysiology underlying common respiratory conditions a. Asthma b. Bronchiolitis c. Pneumonia d. Croup e. Pertussis 9. Discuss interventions / management of common respiratory conditions a. Asthma b. Bronchiolitis c. Pneumonia d. Croup e. Pertussis Describe clinical indications and rationale for commencing oxygen therapy
S	1. Demonstrate effective respiratory assessment in relation to n. Level of consciousness o. Inspection (Look) p. Auscultation (Listen) q. Palpation (Feel) r. History Taking s. Effort & Efficiency of breathing 2. Accurately document findings of respiratory assessment a. Air Entry b. Respiratory rate c. Rise and fall of chest wall d. Normal sounds on auscultation e. Work of breathing f. 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

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:

Seizures

Competency Statement:
The nurse discusses the care required for a patient during a seizure and with a seizure disorder

COMPETENCY ELEMENTS	
K	1. Locate and read Seizures & Status Epilepticus – RCH Clinical Practice Guideline 2. Explain the different types of seizures and how they can present 3. Define Status Epilepticus 4. List some of the investigations a child may need who presents with seizures 5. Discuss the emergency management of a child during a seizure a. Assessment b. Algorithm & drugs c. Investigations d. Parental support
S	1. Not Applicable

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:

Spinal Immobilisation, Log Rolling & Spinal cord Injury

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

COMPETENCY ELEMENTS	
K	1. Locate and read spine cord injury – acute management RCH Clinical Practice Guideline 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 process of fitting an Aspen collar and who is authorised to fit them 7. Discuss the rationale for log rolling a patient requiring spinal precautions 8. 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 9. Identify the correct process for clearing the spinal column and removing the collar 10. Describe an Airway pad and when should it be used to assist in maintaining neutral alignment of the paediatric spine 11. Identify the nursing care for the patient with an acute spinal injury 12. Differentiate between spinal shock and neurogenic shock 13. Differentiate between primary and secondary spinal cord injury
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 examination or airway management 4. Demonstrate how to tilt the bed on a patient who is having spinal precautions 5. Discuss and demonstrate spinal immobilisation education to patients and families / caregivers

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:

Tracheostomy Management

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

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

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

COMPETENCY ELEMENTS	
K	1. Locate and read the Tracheostomy Management Guidelines CPG 2. Watch the RCH Tracheostomy Care Video 3. Describe the basic anatomy of the trachea 4. State 3 underlying principles for which a tracheostomy tube is inserted 5. Describe 3 clinical conditions for which a tracheostomy tube is inserted 6. State essential aspects of the upper airway that are bypassed when a tracheostomy tube is inserted 7. Identify the different tracheostomy tubes used at RCH and discuss their management 8. Identify the different tracheostomy tapes used at RCH and discuss age related safety issues 9. State immediate and long term complications following insertion of a tracheostomy tube 10. Discuss patient safety when transporting within hospital 11. Discuss nursing supervision requirements of a patient with a tracheostomy tube 12. State the signs that indicate when suctioning is required an demonstrate correct suctioning technique 13. Describe the different secretions that may be observed and what each might indicate 14. State what a granuloma is, why they occur and how they are resolved 15. State options available for providing humidification via a tracheostomy tube and demonstrate their application 16. State options available for providing oxygen via a tracheostomy tube and demonstrate their application 17. Describe signs and symptoms of a blocked tracheostomy tube and state interventions required 18. Discuss the role of the hospital Tracheostomy nurse
S	1. Not applicable

Nurse Declaration on next page

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

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

Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Triage

Competency Statement:
The nurse will demonstrate understanding of the Australasian Triage Scale

COMPETENCY ELEMENTS	
K	1. Discuss the purpose of the Australasian Triage Scale (ATS) and what the waiting times are for: a. Cat 1 b. Cat 2 c. Cat 3 d. Cat 4 e. Cat 5 2. Discuss the patient flow from triage 3. Discuss medications and procedures which may be initiated by the Triage Nurse 4. Discuss the role of the waiting room nurse in Emergency Department
S	Not Applicable

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

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

Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Competency Feedback & Reflection

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

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

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

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

Competency Feedback & Reflection

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

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

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

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

Competency Feedback & Reflection

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

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

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

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

Competency Feedback & Reflection

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

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

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

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