Chapter 2
Generic Nursing Competencies

The Royal Children's Hospital Melbourne

Nursing Competency Workbook, 9th 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 resources, 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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Introduction to Chapter 2

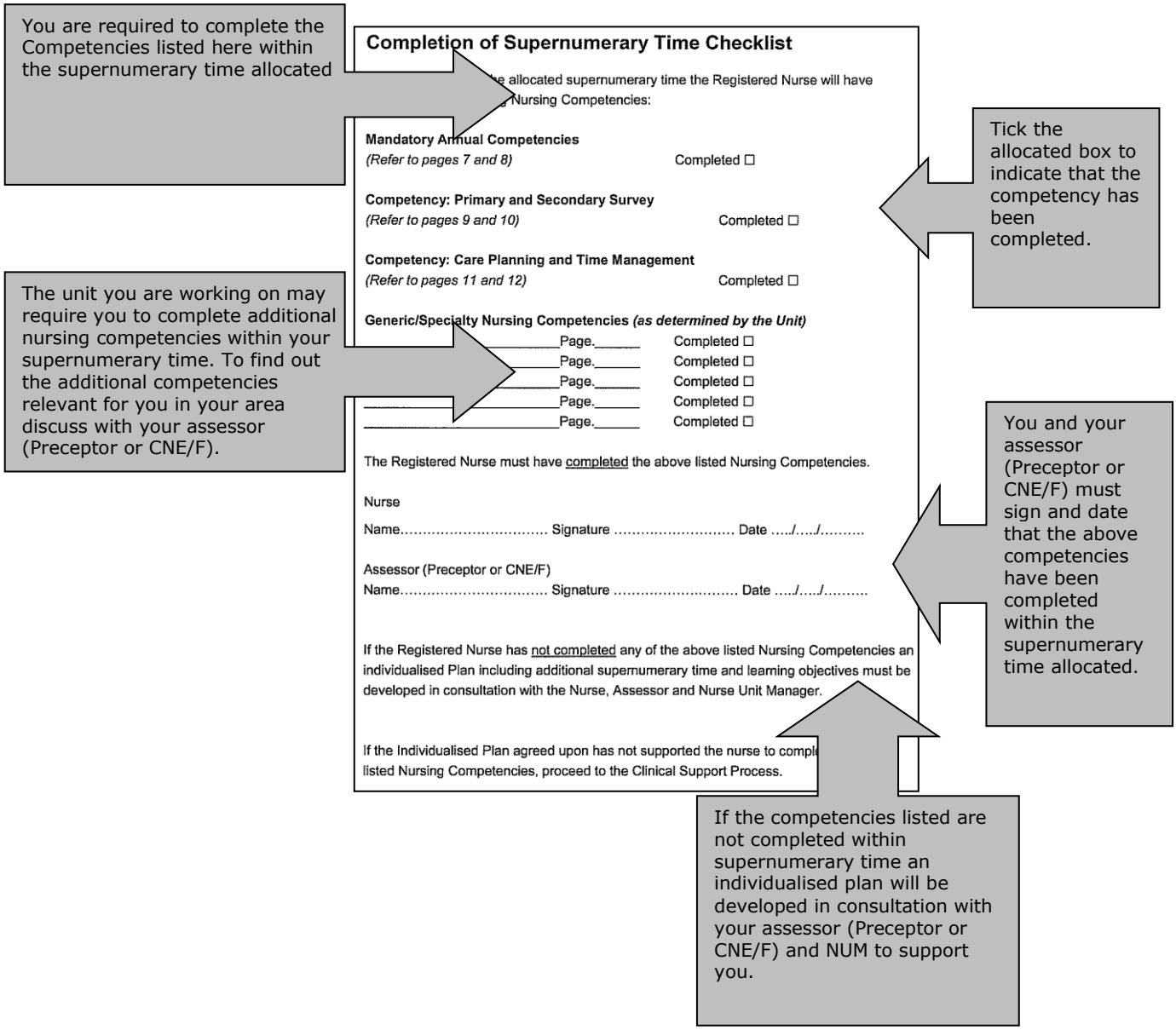
Chapter 2 contains forms for the use of all nurses commencing work at the Royal Children's Hospital (RCH) to assist in the attainment and demonstration of competence. By clearly setting expectations for the standards of care at RCH, the use and successful completion of these forms will assist in guiding safe neonatal, child and adolescent nursing practice. Detailed below is the purpose and function of each form including an example of how to complete the form.

Due to conditions of employment, progress through Chapter 2 for BARO staff will be different to what is outlined here. Please refer to Appendix 1V, The RCH Nursing Competency Framework for BARO staff.

Completion of Supernumerary Time Checklist

This completion of supernumerary time checklist provides an outline of the competencies you are expected to complete within your supernumerary time. If you have not completed these competencies within the timeframe stipulated, an individualised plan including additional supernumerary time and learning objectives must be developed in consultation with your assessor and Nurse Unit Manager (NUM)/Manager. Figure 1 contains of an example of how to use the completion of supernumerary time checklist.

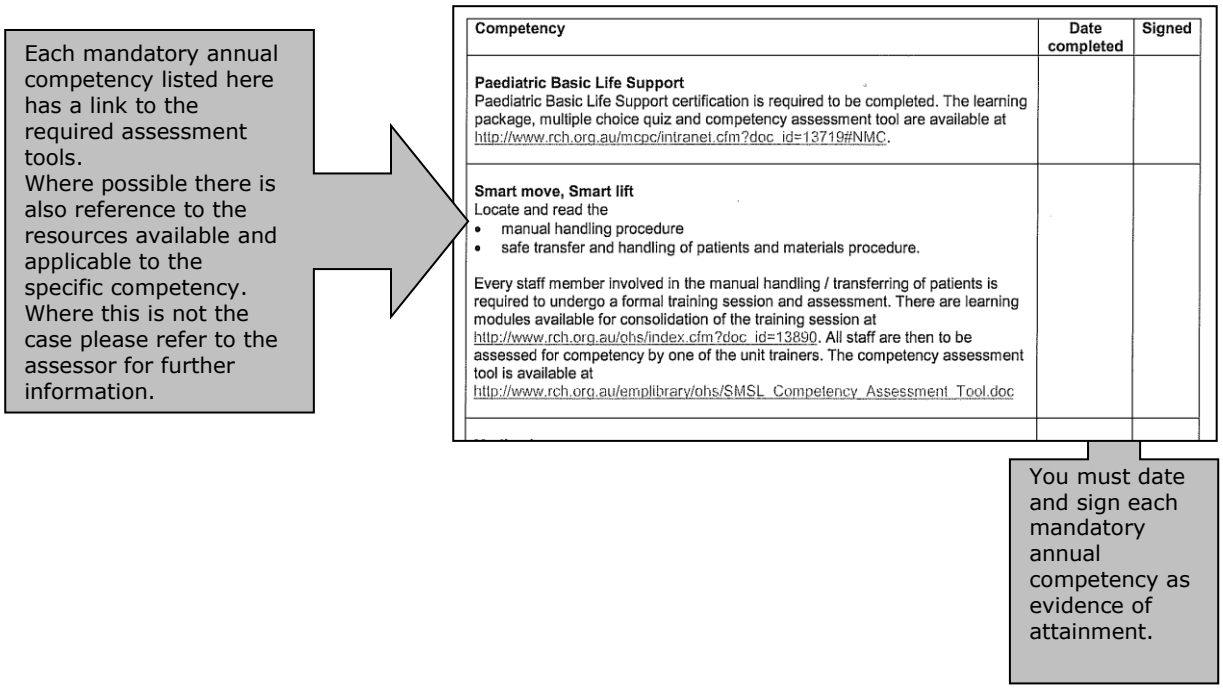
Figure 1: Example of Completion of Supernumerary Time Checklist form



RCH Mandatory Annual Competencies

The mandatory annual competencies must be completed as soon as practical upon commencement of employment (preferably within your first month). These competencies are assessed within your unit by the Clinical Nurse Educator/Facilitator (CNE/F) or another nurse who is trained to conduct specific assessments. This will be communicated to you during your unit orientation. It is your professional responsibility to liaise with this individual to arrange the assessments recorded in this chapter. Once completed you must date and sign that competence has been attained. Mandatory competencies are completed on an annual basis thereafter. Figure 2 provides an example of the mandatory annual competencies form.

Figure 2: Example of Mandatory Annual Competencies form

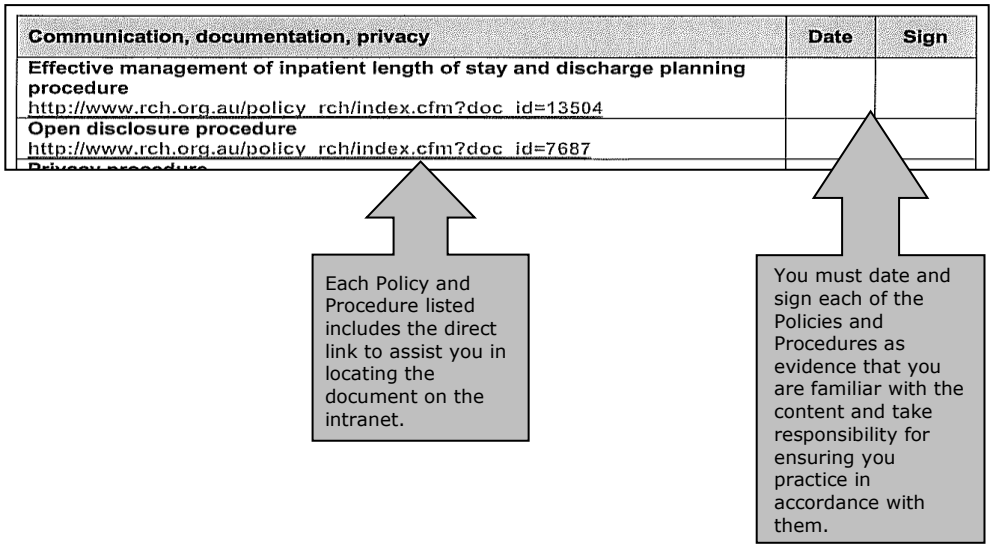


Essential Policies and Procedures

The essential policies and procedures are listed in this chapter for your reference. By the end of your 10 week familiarisation period it is expected that you be familiar with the content of the listed policies and procedures. When you date and sign alongside each policy or procedure you are taking responsibility for ensuring you practice in accordance with these. Evidence of this will be apparent in your Professional Practice Portfolio (PPP) and Performance and Development Assessment Program (PDAP).

Please note that there are a number of essential policies and procedures that relate directly to competencies. Where this is the case those policies and procedures have been included in the relevant nursing competency assessment form. Figure 3 describes how to complete the essential policies and procedures form.

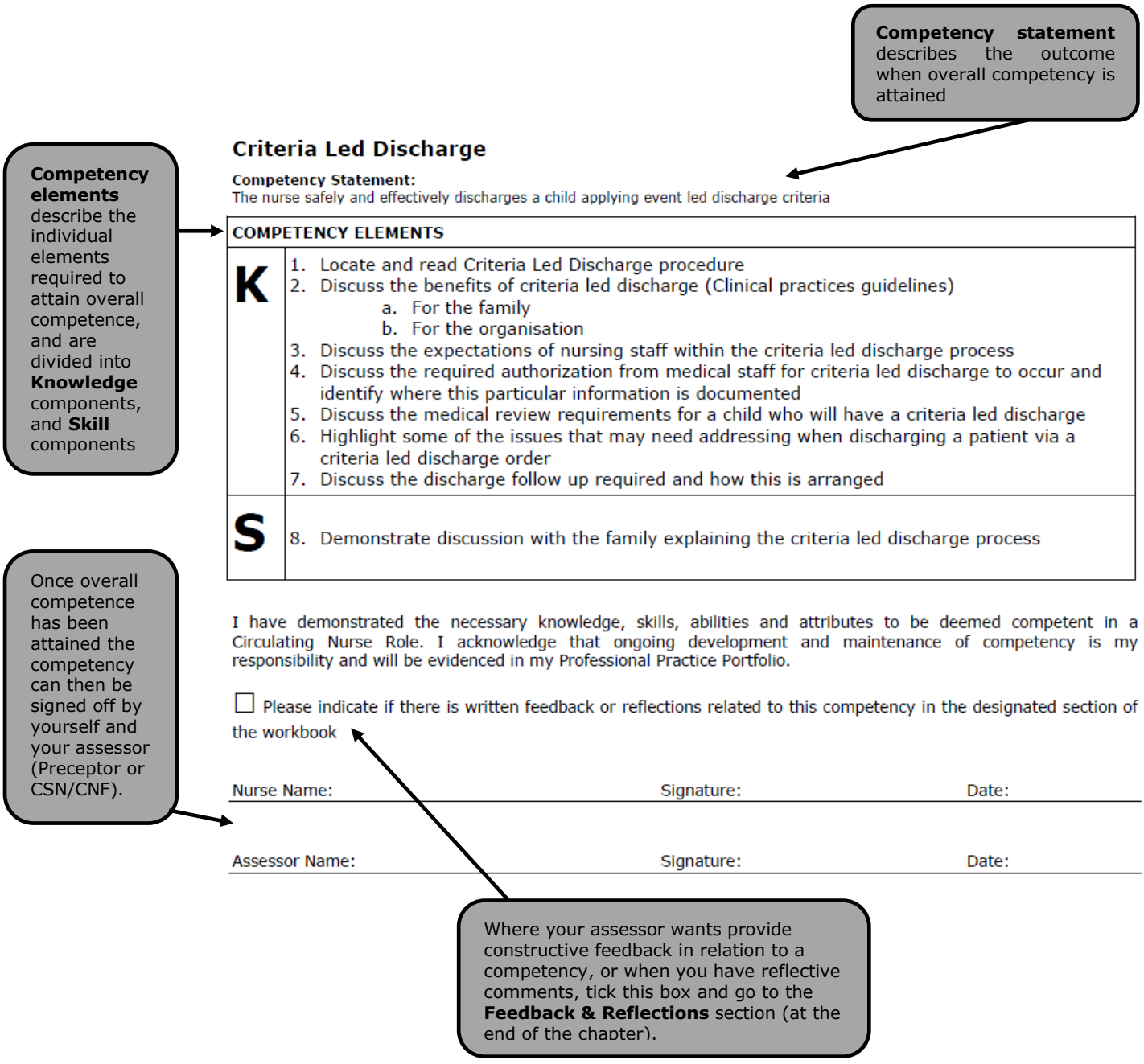
Figure 3: Example of Essential Policies and Procedures form



RCH Generic Nursing Competencies

The RCH Generic Nursing Competencies focus on skills, knowledge, attitudes, values and abilities relevant for all nurses working in direct patient care and clearly set the standard of practice at the RCH. They are classified according to the timeframe within which they are required to be achieved; 10 weeks and 12 months. Competence may be attained sooner than the timeframe stipulated based on individual experience. Some units may require you to attain competence earlier than identified here (Please refer to the CNE/F aligned with your unit). Generally, there is no specific order in which to progress through the generic nursing competencies. There are a small number of competencies for which nurses working in some units may be exempt. If this is the case, details of any exceptions will be noted on the competency. Figure 4 describes how to use and complete the generic nursing competency assessment forms.

Figure 4: Example of Generic Nursing Competency form



Feedback and Reflections

Each of the nursing competency chapter has a specific section for feedback and reflections. Your assessor can document constructive feedback relating to specific elements of the competency here. You can also capture evidence of reflection on your own practice as it relates to each of the competencies.

Figure 5: Example of Feedback and Reflections form

Competency name and element number(s) [e.g. K1 or S3a-c] should be documented in each instance.

If your assessor has provided any feedback each of you MUST sign and date below to document this has been discussed and agreed upon. This may or may not include any self-reflective comments.

When you are documenting your reflections, remember to note the competency, and to sign and date.

No signature from your assessor is necessary.

Competency Name:	Patient Discharge		
Element(s):	S2		
Assessor Feedback:	Valerie was concerned about giving the going home envelope to her patient's family today however I observed her to explain the envelope in a clear manner and responded appropriately to the questions the family had. With time and practice, Valerie's confidence will increase.		
Self-Reflection:	I provided a family with the Going Home envelope on admission and explained how it's used to help them organise a smooth discharge. I was not very confident but I received positive feedback from my preceptor which was encouraging.		
Assessor [sign and date]	[illegible] 2/2/14	**Nurse** [sign and date]	V.J 2/2/14

Competency Name:	Medication Administration		
Element(s):	K4		
Assessor Feedback:	Valerie was able to very competently explain what an adverse drug reaction is and the role of the nurse without any prompts. She was also able to clearly explain the nurses' responsibility in the event of an adverse reaction.		
Self-Reflection:			
Assessor [sign and date]	[illegible] 15/2/14	**Nurse** [sign and date]	V.J 15/2/14

Competency Name:	Wound Management		
Element(s):			
Assessor Feedback:			
Self-Reflection:	This competency was really challenging for me as I had little prior knowledge of wound care beyond using non-touch technique to perform a dressing. I feel like I am now confident to use the CPG and the wound care assessment and treatment plan to help me identify exactly how frequently wound care should occur and what products to use. I am going to challenge myself to fill out one assessment and treatment plan on a chronic and on a surgical wound each month until I feel more confidently in my practice.		
Assessor [sign and date]		**Nurse** [sign and date]	V.J 19/3/14

Completion of Supernumerary Time Checklist[1]

Upon completion of the allocated supernumerary time the registered nurse will have completed the following competencies:

Mandatory Annual Competencies
(Refer to pages 12 and 13) Completed ☐

Competency: Primary and Secondary Survey
(Refer to pages 14 and 15) Completed ☐

Competency: Care Planning and Time Management
(Refer to pages 16 and 17) Completed ☐

Competency: Medication Administration
(Refer to pages 16 and 17) Completed ☐

Generic/Specialty Nursing Competencies *(as determined by the unit)*
_____Page._____ Completed ☐
_____Page._____ Completed ☐
_____Page._____ Completed ☐
_____Page._____ Completed ☐
_____Page._____ Completed ☐

The Registered Nurse must have <u>completed</u> the above listed nursing competencies.

Nurse
Name…… Signature …… Date …../…../…….

Assessor (Preceptor or CNE/F)
Name…… Signature …… Date …../…../…….

If the registered nurse has <u>not completed</u> all of the above listed nursing competencies an individualised plan including additional supernumerary time and learning objectives must be developed in consultation with the Nurse, Assessor and Nurse Unit Manager.

If the individualised plan agreed upon has not supported the nurse to complete the above listed nursing competencies, proceed to the Clinical Support Process.

[1] Completion of Supernumerary Time Checklist does not apply for Nursing & Administration Workforce staff. For more information on what is required during your first shift or supernumerary time please refer to Appendix 1V.

MANDATORY COMPETENCIES

Basic Life Support (RCH Level 2) Competency

Annual Requirement *Successful completion of both the online and practical components are required annually

COMPETENCY ELEMENTS	
K	Successful completion of online learning- **RCH Resuscitation eLearning Modules:** 1. **Basic Life Support - Infant &child eLearning module** ❑ **Date:**
S	**Skills Assessment** ❑ **Date:** Enables participants to practice their Basic Life Support skills as a team • review ARC/ APLS Basic Life Support Guidelines • review bag-valve mask ventilation (infant and child) • review cardiac compression technique (infant and child) **Simulation** ❑ **Date:** The First Three Minutes Simulation program enables participants to practice as a team to respond effectively to a collapsed and unresponsive patient in the first three minutes before help (MET team) arrives • Managing a 'collapsed and unresponsive' patient appropriate to the clinical setting

Medication Awareness & Competency-

All nurses new to the RCH required to administer medications are expected to complete both the online and practical components.

COMPETENCY ELEMENTS	
K	1. Locate & read the Medication Management Policy & Medication Management Procedure 2. Locate and utilize Medicines Information to complete online learning • AMH Children's Dosing Companion • Paediatric Injectable Guidelines • Peadiatric Pharmacopeia • MIMS Online • Drug Location Guide After Hours 3. Successful completion of online learning: • **RN's/Medication Endorsed EN's:** RCH Medication Awareness Package ❑ **Date:** • **Non IV Endorsed EN's & Mental Health Nurses:** RCH Medication Awareness Package ❑ **Date:** without Intravenous Medications 4. Unit Specific Medication Awareness Package (at the discretion of the employing unit)
S	Completion of a practical assessment of Medication Administration Competency as outlined in the RCH Nursing Competency Workbook ❑ **Date:** **Nurses are required to have all medications double checked until they have successfully completed the medication competency.**

Smart Move Smart Lift

Annual Requirement *Successful completion of both the online and practical components is required annually

COMPETENCY ELEMENTS	
K	1. Locate and read the RCH Manual Handling Procedure 2. Locate and utilise the intranet based Smart Move Smart Lift Training Resources covering the core competencies 3. Successful completion of online learning: **SMSL Patient Manual Handling** ❑ **Date:**
S	Completion of a practical assessment of Patient Manual Handling Competency as outlined by the RCH SMSL Competency Assessment Tool ❑ **Date:**

Emergency Procedures

Annual Requirement

COMPETENCY ELEMENTS	
K	1. Locate and read Emergency Management Policy and Emergency Procedures 2. Successful completion of online learning:**Emergency RACE Response and Management of Clinical Aggression** ❑ **Date:**
S	There may be some opportunity to be involved in ward based evacuation drills coordinated by the Emergency Management Coordinator

Infection Control- Hand Hygiene

Annual Requirement

COMPETENCY ELEMENTS	
K	1. Locate and read the Hand Hygiene Procedure 2. Locate and utilize the 'Wash Up' Hand Hygiene resources on the intranet to complete online learning 3. Successful completion of online learning: **Infection Control: Hand Hygiene** ❑ **Date:**
S	Consistently demonstrate effective hand hygiene and participate in monthly unit specific auditing

Electronic Medical Record (EMR)

All nurses new to the RCH required to complete EMR training and pass the assessment before accessing the patient record.

COMPETENCY ELEMENTS	
K	1. Attend EMR training **2.** Successful completion of online learning/assessment ❑ **Date:**
S	Consistently demonstrate department specific workflows (completed with a competent EMR user)

Primary and Secondary Survey (Recognition of the Unwell Child)

Competency Statement:
The nurse is able to safely and effectively conduct a primary and secondary survey, identifying management of abnormal findings

RCH references related to this competency: RCH intranet **-** Division Surgery**-** Surgery Resources

Element Exemptions: Banksia (K2a-c), ACE Program (K1b-c, S3)

COMPETENCY ELEMENTS	
K	1. Locate and read a. *Clinical observations procedure* b. *Medical Emergency Team Response procedure* c. *MET criteria clinical practice guideline* d. *Observation & Continuous Monitoring Clinical Guideline* e. *Nursing Assessment Clinical Guideline* f. *Escalation of Care & Modification Process Flowchart* 2. State the normal physiological values for a child: a. Less than one year of age b. One to four years of age c. Five to twelve years of age d. Twelve years of age and over 3. Discuss examples of management when there is compromise to: a. Airway b. Breathing c. Circulation d. Disability and Discomfort 4. Discuss examples of management when there are abnormal findings as the result of a Secondary Survey.
S	1. Demonstrate a Primary Survey including assessment of: a. Airway b. Breathing c. Circulation d. Disability and Discomfort 2. Demonstration correct documentation of observations on the observation Flowsheet in EMR 3. Demonstrate ability to review trends in ViCTOR graph 4. Identify abnormal findings as a result of conducting a Primary Survey including a. Nurse or parent "worried about patient" b. Observations in the "Orange Zone" c. Observations in the "Purple Zone" 5. Document evidence of Primary Survey on Primary assessment Flowsheet in EMR 6. Demonstrate a Secondary Survey including: a. Exposure b. Further history c. Get vitals, including glucose d. Head to toe, front to back 7. Identify abnormal findings as a result of conducting a Secondary Survey 8. Document evidence of a Secondary Survey on Focused assessment flowsheet in 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:

Care Planning & Time Management

Competency Statement:
The nurse will effectively plan care and manage time efficiently to attend to the care needs of patients.

COMPETENCY ELEMENTS	
K	1. Discuss resources available within the unit to assist in care planning 2. Discuss nursing care requirements and identify expectations of care for patients admitted to RCH
S	1. Create a time plan to attend to identified care requirements 2. Prioritise care to manage competing demands 3. Modify time plan to attend to changes in care requirements 4. Complete time critical care requirements on time 5. Ask for assistance when required and delegate as appropriate 6. Accept assistance when offered 7. Demonstrate accessing "Worklist" in the EMR to assist with care planning

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:

Medication Administration

Competency Statement:
The nurse demonstrates safe administration of medication.

COMPETENCY ELEMENTS	
K	1. Identify the indication for the medication prescribed using the appropriate resource 2. Select the medication prescribed in the correct form as determined by the prescribed route 3. Describe the process for self (patient or family) administration of medication 4. Explain what an adverse drug reaction is and the nurse's role and responsibility in the event that one occurs 5. State the six rights of medication safety including nurses, family and patients right to refuse
S	1. Demonstrate that dosage for the medication prescribed is correct using the appropriate resource 2. Demonstrate medication calculations and preparation for the liquid (oral/enteral) medication prescribed to ensure that the correct amount of medication is prepared 3. Demonstrate medication calculations and preparation for the injectable medication prescribed to ensure that the correct amount of medication is prepared 4. Demonstrates checking of the patient in accordance with the Patient Identification Procedure against the medication prescribed on MAR. 5. Discuss with patient and/or family what medication is being administered, why it is being administered and the potential side effects 6. Demonstrate negotiation of who will administer the medication with the patient and/or family 7. Administer the following medications in accordance with the Medication Management Procedure: a. Oral/ Enteral/ Topical medication b. Injectable medication c. Scheduled eight medication 8. Document administration of the medication prescribed in accordance with the Medication Management Procedure on MAR in EMR 9. Describe how to identify that the medication prescribed has been withheld or missed in accordance with the Medication Management Procedure on MAR

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:

Essential Policies & Procedures

By the end of your 10 week familiarisation period it is expected that you have read the listed policies and procedures, and will apply these to your nursing practice. When you date and sign alongside each policy or procedure you are taking responsibility for ensuring you practice in accordance with these. Please note that there are a number of essential policies and procedures that relate directly to competencies. Where this is the case those policies and procedures have been included in the relevant competency assessment tool.

Communication, documentation, privacy
Effective management of inpatient length of stay and discharge planning procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=13504
Open disclosure procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=7687
Privacy procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6357
Personal information – access procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6349
Personal information – confidentiality procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6354
Personal information – security procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6355
Personal information – use and disclosure procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6347
Email usage procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6336
Internet usage procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=12577
Professional conduct
Code of behaviour procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=10192
Code of conduct procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=9190
Dress code – all RCH procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6300
Identification badges procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6338
OHS
Risk management policy http://www.rch.org.au/policy_rch/index.cfm?doc_id=8939
Risk management procedure – for staff http://www.rch.org.au/policy_rch/index.cfm?doc_id=12325
Occupational health and safety procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6416
Occupational health and safety issue resolution procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6461
OHS risk (hazard) management procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=6429
Dangerous goods and hazardous substances procedure http://www.rch.org.au/policy_rch/index.cfm?doc_id=8938
Emergency procedures http://www.rch.org.au/emergencyprocedures/
Emergency procedures – Code Grey http://www.rch.org.au/emergencyprocedures/code_greybrunarmed_confrontation/Code_Grey/
Emergency procedures – Code Black http://www.rch.org.au/emergencyprocedures/code_blackbrarmed_confrontation/Code_Black/

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:

Admission (Nursing)

Competency Statement:
The nurse safely and effectively admits patients and families.

RCH references related to this competency: RCH intranet: Division Surgery**-** Surgery Resources, Operations- Admission into the Neonatal Care Unit;
Banksia Ward Procedures: Admission to the Banksia Adolescent Inpatient Unit

Competency Exemptions: Outpatients, Theatres, Cardiac Theatres, Recovery

Element Exemptions: Day Medical, Emergency Department & RCH@Home (K1, S1); Banksia (S1, S3a & S3e)

COMPETENCY ELEMENTS	
K	1. Discuss the purpose of providing "Preparing for home" envelope on admission 2. Discuss how different referrals would be made for patients and families to allied health teams and other support services based on the findings of a discharge risk screen
S	1. Provide families with the "Preparing for home" envelope on admission 2. Demonstrate and document a nursing admission including: a. Completion of admission assessment & care plan in ADT navigator on EMR b. Obtain personal / contact details c. Patient identification bracelet (or equivalent as per procedure) d. Identify presenting condition e. Conduct and record nursing assessment on admission f. Complete the admission checklist in ADT Navigator 3. Demonstrate orientation of patient and family to the environment

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:

Consent

Competency Statement:
The nurse demonstrates knowledge of the process for obtaining consent and applies that knowledge in practice.

RCH references related to this competency: RCH Policies & Procedures – Consent – Informed, Procedural Safety-correct Patient, correct procedure, and correct site

COMPETENCY ELEMENTS	
K	1. Locate and read the *Consent – informed* 2. Discuss when a documented consent is required 3. Define informed consent 4. Define implied consent 5. Define what material risks are 6. Identify the purpose of obtaining written consent 7. Define the term "minor" in Victoria 8. Discuss the notion of a "mature minor" 9. Explain who can SEEK and who can GIVE consent 10. Identify the requirements of a valid consent 11. Outline the actions you would take if you were concerned that the consent was not valid 12. Identify how long a consent is valid for 13. Summarise the information that must be provided in seeking consent 14. Discuss requirements for obtaining consent when there is a language barrier 15. Outline the actions required when consent cannot be obtained or is refused 16. Discuss when a court order is required 17. Discuss situations where consent is not required 18. Discuss how a situation in which consent has not been provided would be resolved 19. State the location of consent forms in your department and their location in the EMR once scanned.
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:

Discharge

Competency Statement:
The nurse demonstrates safe and effective discharge of a patient.

Competency Exemptions: Outpatients, Theatres, Cardiac Theatres, Recovery

Element Exemptions: Banksia (K2 & S5b); Day Medical (K1-2); Emergency Department (K1-2 & S3) & RCH@Home (K1-2 & K5a-b);

COMPETENCY ELEMENTS	
K	1. Locate the Effective Management of Inpatient Length of Stay and Discharge Planning Procedure on the intranet 2. Explain to families how to use the "Preparing for home" envelope 3. Discharge plans are clearly communicated and documented utilising white boards 4. Discuss the cleaning and preparation of the bed space including Infection Control Guidelines 5. Discuss proves involved regarding criteria led discharge and when this can be effectively utilised in the clinical environment.
S	1. Complete the following elements of discharge planning / and document on the Discharge tab of the ADT navigator ensuring that: a. Confirm GP details are correct utilising EMR b. Patient and family education is provided c. Follow up appointments are arranged d. Post discharge services are in place e. Discharge equipment and /supplies are ready f. Patient and family understand use and storage of equipment/ supplies g. Discharge medications are organised h. Patient and family understand medications i. "After visit summary" is given to family j. Discharge/Summary been organised to be given to family 2. Complete discharge entry in progress notes 3. Discharge patient from IBA 4. Demonstrate appropriate cleaning of bed space and preparation of oxygen and suction supplies and equipment

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:

Documentation: Admission to Discharge

Competency Statement:
The nurse demonstrates awareness of documentation standards and is able to write comprehensive, timely and relevant nursing notes that meet these standards.

RCH references related to this competency: RCH Policies and Procedures – Documentation: Medical Records; Clinical Practice Guideline: Nursing Documentation; Clinical Practice Guidelines: Nursing Assessment

Element Exemptions: Banksia (S1e-f)

COMPETENCY ELEMENTS	
K	1. Locate and read the *Documentation: Nursing Documentation*
S	1. Demonstrate Patient plan of care in EMR a. Parent education / involvement b. Observations c. Fluid balance d. Medication plan e. Wound care f. Pressure ulcer risk management g. Falls risk assessment h. ADL care needs i. Planned procedures j. Discharge planning k. Holistic care 2. Documentation captured in patient's progress notes in 'real time' 3. Demonstrate that nursing documentation meets the required standards, i.e.: a. Each EMR progress note entry should follow ISBAR philosophy with a focus on four points of Assessment; Action ; Response; Recommendation b. Entries are made as close to the time of an event occurring c. All other paper documents are correctly identified with patient labels or a minimum of patient's full name, date of birth and UR e. entries have electronic signature f. abbreviations used within the medical record are only those that are on the approved RCH Abbreviations List g. additional / late entries are identified as a "Late Entry" or "Additional Note" h. content includes a purpose of entry (e.g. admission note, progress note) i. content is objective, precise, accurate and factual, and sufficiently detailed to enable another clinician to assume the care of the patient 4. Demonstrates evidence of nursing assessment in entries to clinical records 5. Demonstrates evidence of evaluation of care provided

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:

Family Centred Care

Competency Statement:
The nurse discusses and applies the principles of Patient and Family Centred Care in practice.

RCH references related to this competency: RCH intranet: People & Culture – Patient and family-centred care; Medical Services-Patient Family Centred Care;
RCH website: Knowing what to expect

COMPETENCY ELEMENTS	
K	1. Locate and read a. *Care planning and implementation policy* b. *Clinical handover procedure* c. *Child, family and community participation procedure* d. *Consumer focused care policy* e. *Patient and family centred care procedure* f. *Culturally responsive care policy* g. *Interpreter and NESB services procedure* h. *Services to aboriginal people procedure* 2. Identify the core principles that underpin the provision of patient and family centred care 3. Explain resources available to patients and families at the RCH
S	1. Introduce self to patient and family 2. Identify who is part of the patient's family 3. Undertake a family assessment 4. Ensure patient and family dignity is preserved 5. Treat all patients and families with respect 6. Provide information in a way that is meaningful for patients and families 7. Obtain information from patients, where able, and families to ensure that care is well informed and consistent with patient and family needs 8. Enable patients and families to participate to the level to which they choose 9. Collaborate with patients and families to improve care and practise

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:

Growth & Development of the Neonate (0-4 weeks)

Competency Statement:
The Nurse discusses the growth and development of neonates aged 0–4 weeks and applies knowledge in practice.
Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Locate and Read Clinical Practice Guideline jaundice in Early Infancy 2. Identify the normal range of vital sign for neonates 3. Describe the normal sleep / wake patterns of the neonate 4. Discuss the following reflexes: a. Root reflex b. Suck reflex c. Moro reflex d. Palmer / Grasp reflex e. Step reflex f. Tonic Neck reflex g. Planter / Babinski's reflex 5. Discuss the physiology of thermoregulation in the neonate 6. Discuss / demonstrate umbilical cord care & management including the natural process of separation 7. Discuss signs of cord infection 8. Describe early signs of neonatal jaundice 9. Explain the management of physiological jaundice 10. Identify other causes of jaundice in the neonate 11. Identify risks to maternal / infant bonding 12. Discuss / demonstrate strategies to enhance maternal / infant bonding 13. State the immunisation and screening process due in the first week of life
S	1. Apply knowledge of growth and development to undertake a nursing assessment of the neonate 2. Apply knowledge of growth and development to carry out a procedure with a neonate 3. Document the growth and development needs of a neonate on the nursing care plan 4. Summarise/demonstrate education of parents regarding sleeping positions in line with SIDS guidelines

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:

Growth and Development of the Infant (5 - 52 weeks)

Competency Statement:
The nurse discusses the growth and development of infants aged 5 - 52 weeks and applies knowledge in practice.
Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Identify the normal range of vital signs for the infant 2. Describe key physical / motor changes occurring during normal infant development 3. Describe key cognitive / language changes occurring during normal infant development 4. Describe key social / emotional changes occurring during normal infant development 5. Identify risks to infant development of illness and hospitalisation 6. Discuss strategies to minimise risk to infant development of illness and hospitalisation 7. Explain the purpose of the Victorian Child Health Record (blue book) 8. List the immunisations that are due in infancy
S	1. Apply knowledge of growth and development to undertake a nursing assessment of an infant 2. Apply knowledge of growth and development to carry out a procedure with an infant 3. Document the growth and development needs of an infant on the nursing care plan

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:

Growth and Development of the Pre-schooler (1 - 4 years)

Competency Statement:
The nurse discusses the growth and development of toddlers/pre-schoolers aged 1 - 4 years and applies knowledge in practice.

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Identify the normal range of vital signs for the toddler /pre-schooler 2. Describe key physical / motor changes occurring during normal toddler/pre-schooler development 3. Describe key cognitive / language changes occurring during normal toddler/pre-schooler development 4. Describe key social / emotional changes occurring during normal toddler/pre-schooler development 5. Identify risks to toddler/pre-schooler development of illness and hospitalisation 6. Discuss strategies to minimise risk to toddler/pre-schooler development of illness and hospitalisation 7. Explain the purpose of the Victorian Child Health Record (blue book) 8. List the immunisations that are due between the ages of 1 and 4
S	1. Apply knowledge of growth and development to undertake a nursing assessment of a toddler/pre-schooler 2. Apply knowledge of growth and development to carry out a procedure with a toddler/pre-schooler 3. Document the growth and development needs of a toddler/pre-schooler within the nursing care plan

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Growth and Development of the School Aged Child (5 - 11 years)

Competency Statement:
The nurse discusses the growth and development of school aged children aged 5 - 11 years and applies knowledge in practice.

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Identify the normal range of vital signs for the school aged child 2. Describe key physical / motor changes occurring during normal school aged child development 3. Describe key cognitive / language changes occurring during normal school aged child development 4. Describe key social / emotional changes occurring during normal school aged child development 5. Identify risks to school aged child development of illness and hospitalisation 6. Discuss strategies to minimise risk to school aged child development of illness and hospitalisation 7. List the immunisations that are due between the ages of 5 and 11
S	1. Apply knowledge of growth and development to undertake a nursing assessment of a school aged child 2. Apply knowledge of growth and development to carry out a procedure with a school aged child 3. Document the growth and development needs of a school aged child within the nursing care plan

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Growth and Development of the Adolescent (12+ years)

Competency Statement:
The nurse discusses the growth and development of adolescents aged 12 years plus and applies knowledge in practice.

Competency Exemptions: Banksia (K7). All areas except Banksia (K8)

COMPETENCY ELEMENTS	
K	1. Locate and Read Clinical Practice Guideline "Engaging with and assessing the Adolescent patient 2. Identify the normal range of vital signs for the adolescent 3. Describe key physical / motor changes occurring during normal adolescent development 4. Describe key cognitive / changes occurring during normal adolescent development 5. Describe key social / emotional changes occurring during normal adolescent development 6. Identify risks to adolescent development of illness and hospitalisation 7. Discuss strategies to minimise risk to adolescent development of illness and hospitalisation 8. Explain the HEADSS assessment tool 9. List the immunisations that are due between the ages of 12 and 18
S	1. Apply knowledge of growth and development to undertake a nursing assessment of an adolescent 2. Apply knowledge of growth and development to carry out a procedure with an adolescent 3. Document the growth and development needs of an adolescent within the nursing care plan

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Hydration - altered (Basic)

Competency Statement:
Provide safe and effective nursing care for patients with altered hydration.

RCH references related to this competency: RCH Clinical Practice Guidelines: Intravenous Fluids, Fluid Management in Meningitis, & Gastroenteritis, Nursing Assessment, Surgery – Perioperative Services-118 Fluid Management, Operations-Clinical Support Services-Pharmacy-Pharmacopoeia -Neonatal Intravenous (IV) Fluid Requirements, Division of Medicine-General Medicine-Clinical Practice Guidelines-Dehydration

Element Exemptions: Banksia (K1, K10-14a-b), ACE Program (K1, K7, K12, K14)

COMPETENCY ELEMENTS	
K	1. Locate and read a. RCH intravenous fluids clinical practice guideline b. Dehydration clinical practice guideline 2. Describe the signs and symptoms of dehydration (mild, moderate, severe) 3. Describe the signs and symptoms of over hydration 4. Discuss how water gains can be measured 5. Discuss how sensible water losses can be measured 6. Identify causes of increased insensible losses 7. State at least three conditions that can alter a patient's hydration status 8. Describe how the conditions stated above alter a patient's hydration status 9. Discuss rationale for oral/nasogastric versus IV rehydration 10. State the calculations (daily and hourly) for normal maintenance IV fluid rates for a. Children 3 to 10kg b. Children 10-20kg c. Children > 20kg 11. Calculate the daily and hourly maintenance IV fluid rates for a child weighing a. 4kg b. 12kg c. 37kg 12. Discuss examples in which normal maintenance rates may be altered 13. State the recommended intravenous fluid to be used as maintenance for well children with normal hydration 14. State the minimum expected urine output in mls/kg/hr for a a. Infant b. Toddler/pre-schooler c. School age child d. Adolescent 15. State the fluid and calculation of bolus administration for hypovolaemia (e.g. in an emergency situation)
S	1. Demonstrate assessment of a child's hydration status and documentation of assessment findings 2. Demonstrate accurate documentation of intake and output on a fluid balance Flowsheet 3. Review the Fluid balance activity tab to review the patients progressive totals

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Hygiene

Competency Statement:
The nurse identifies safe and effective care to meet the personal hygiene needs of infants, young children and adolescents.

RCH references related to this competency: RCH Policy & Procedure Manual - Hand Hygiene;
RCH Clinical Guidelines: Mouth Care –Oral Care of the paediatric oncology patient and haematopoietic stem cell transplant patient, Wash Up Competency Package (see Hand Hygiene Quiz);
RCH Clinical Resources: Hand Hygiene Quiz;
RCH Intranet: Kids Health Info - Hand Hygiene – why is it so important?

PICU Intranet Guideline: Bathing patients in PIC, Oral Care in PICU Guideline

Element Exemptions: Banksia (K2)

COMPETENCY ELEMENTS	
K	1. Discuss importance of attending to personal hygiene for children while they are hospitalised 2. Describe personal hygiene care requirements of the neonate, infant, toddler/pre-schooler, child and adolescent 3. Identify equipment needed to attend to personal hygiene care 4. Identify potential barriers to providing personal hygiene care and give examples of strategies 5. Identify strategies for maintaining privacy and dignity of the patient while attending to personal hygiene
S	1. Demonstrate negotiation of personal hygiene care with patient and family 2. Demonstrate accurate documentation of hygiene requirements and provision of hygiene care

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Infection Prevention

Competency Statement:
The nurse is aware of and compliant with the strategies/procedures in place at RCH to minimise the risk of transmission of infection between patients, staff and visitors

Please note – that the following procedures are not addressed in this competency: Healthcare Workers with Infectious Diseases; Staff Immunisation - Prevention of Vaccine Preventable Diseases; Needle stick Injuries and Blood-Body Fluid Exposures

RCH references related to this competency: RCH Policy & Procedure Manual: Infection Control

COMPETENCY ELEMENTS	
K	1. Locate and read: a. Standard precautions – infection control procedure b. Transmission based precautions – infection control procedure c. Multi resistant organisms d. Consumables in patient rooms e. Cleaning, disinfection and sterilisation of reusable medical equipment f. Linen management g. Toys, play and educational equipment – Cleaning of h. Infection Control Principles-Clinical staff attire i. Hand Hygiene j. Events related sterility k. Clinical waste and sharps management 2. Locate infection prevention and control webpage: a. Staff and family resources b. Table of infectious diseases 3. Describe the modes of transmission and precautions required for the management of a patient with a known or suspected infection
S	1. Demonstrate the principles of standard precautions, appropriate Personal Protective Equipment (PPE), Hand Hygiene, equipment cleaning and waste management 2. Demonstrate the principles of aseptic technique in practice

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Intravenous Cannula Management - Peripheral

Competency Statement:
The nurse demonstrates assistance with insertion of, and ongoing care of, peripheral intravenous cannulae.

RCH references related to this competency: RCH Clinical Practice Guidelines: Intravenous access – Peripheral, Intravenous Fluids, Peripheral Intravenous (IV) Device Management;
RCH intranet: Surgery – Perioperative – 118 Fluid Management

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	*1.* Locate and read the *Peripheral Intravenous (IV) Device Management clinical practice guideline* 2. Identify suitable sites for insertion of peripheral IVs 3. Apply local anaesthetic cream to insertion site 4. Assemble correct equipment for peripheral IV insertion 5. Assist in the insertion of a peripheral IV cannula 6. State the frequency and criteria for replacement of a peripheral IV cannula 7. Describe the management of a peripheral IV cannula that does not have fluids running through it
S	1. Demonstrate securing and dressing of peripheral IV cannula 2. Demonstrate peripheral IV cannula inspection and document in LDA flowsheet 3. Demonstrate removal of a peripheral IV cannula

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Intravenous Fluid Management

Competency Statement:
The nurse demonstrates safe management of children receiving intravenous fluids.

RCH references related to this competency: RCH Clinical Practice Guidelines: Intravenous access – Peripheral, Intravenous Fluids, Peripheral Intravenous (IV) Device Management;
RCH intranet: Surgery – Perioperative – 118 Fluid Management

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Locate and read the a. RCH intravenous fluids clinical practice guideline b. RCH Paediatric Injectable Guidelines (PIG) c. peripheral intravenous device management clinical practice guideline 2. Differentiate between "Hard" and "Soft" limits when using Guardrails system 3. Identify the type of IV transfusion lines available within the hospital (minimum volume extension line, SmartSite, Infusion Set, Burette Gravity Macro-Dropper set, Rapid Transfusion Pump Set) 4. Summarise IV bag and line change requirements when a. No additives b. Additives c. TPN/Lipid d. Central Line vs Peripheral line 5. Discuss the monitoring requirements for a child receiving IV fluids
S	1. Demonstrate checking procedure at the start of a new bag/syringe/rate change 2. Demonstrate labelling for all IVs fluids & medications using RCH medication labels 3. Demonstrate labelling of infusions with NO additives 4. Demonstrate labelling of infusions WITH additives 5. Demonstrate procedure for indicating the flush of an additive through a line 6. Demonstrate procedure for administering bolus/loading doses using Alaris Guardrails system 7. Demonstrate ability to select correct program for department setting when using Guardrails system 8. Demonstrate ability to perform IV fluid additive calculations 9. Prime a giving set with intravenous fluid 10. Commence an intravenous infusion via an Alaris syringe driver and Alaris IV pump 11. Demonstrate checking and documentation of a. IV sites b. Rate c. Infused volume

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Monitoring (Basic)

Competency Statement:
The nurse demonstrates ability to safely and effectively monitor a patient.

RCH references related to this competency: RCH Clinical guidelines: Nursing Assessment, Observation and Continuous Monitoring;
RCH Intranet: Division of Medicine – Monitoring the Acute Patient

Competency Exemptions: Banksia (K9-11)

COMPETENCY ELEMENTS	
K	1. Identify the types of monitors available within the hospital (Philips IntelliVue and Nellcor SpO_2) 2. State instances when a patient will require cardio respiratory monitoring and/or saturation monitoring 3. Identify reasons for false alarming and discuss troubleshooting 4. Discuss dangers associated with silencing alarms 5. Identify suitable pulse oximetry probe sites 6. State how often the pulse oximetry probe site should be assessed and changed 7. State instances when a patient will require blood pressure measurements 8. Describe selection of the correct size cuff 9. Identify suitable sites for blood pressure measurement 10. Describe sinus rhythm 11. Identify common causes of artefact and their associated trouble shooting 12. Discuss common paediatric arrhythmias and the response required
S	1. Demonstrate effective respiratory and saturation monitoring 2. Demonstrate setting of alarm parameters 3. Demonstrate placement of leads for a patient requiring 3 lead ECG monitoring

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Enteral Feeding

Competency Statement:
The nurse safely and effectively cares for a patient with a nasogastric or orogastric tube.
RCH references related to this competency: RCH Policies & procedures: Insertion of Nasogastric Tube policy: Clinical Guideline: Enteral Feeding and Medication Administration.
RCH Intranet: Kids Health Info- Nasogastric tube - insertion of

Element Exemptions: ACE Program

COMPETENCY ELEMENTS	
K	*1.* Locate and read *Enteral Feeding and Medication Administration Clinical Guideline* Identify reasons why child may have an enteral tube and the location of following a. Orogastric tube b. Nasogastric tube c. Nasojejunal tube d. Gastrostomy tube (gastrostomy-Button, Percutaneous Endoscopic Gastrostomy, Temporary Balloon Device) e. Percutaneous Endoscopic jejunostomy 2. Discuss methods for securing and Enteral Tube 3. Describe what equipment is required to check the position of an Enteral Tube 4. Discuss the frequency for checking the placement of an Enteral Tube for a. bolus feeds b. continuous feeds 5. Describe the documentation process for continuous enteral feeds 6. Discuss the care of a feeding set and how often they should be changed. 7. Discuss the potential complications for Enteral Tubes 8. Discuss when flushing and venting of Enteral Tubes may be required
S	1. Demonstrate methods of securing an Enteral Tube nasogastric or orogastric tube 2. Demonstrate how to withdraw a gastric aspirate required to check the placement of a nasogastric or orogastric tube, and identify the volume required 3. Demonstrate how to test the pH of a gastric aspirate Demonstrate how medications are administered via an Enteral Tube 4. Demonstrate how to heat an enteral feed 5. Demonstrate administration of a. bolus feeds b. continuous feeds

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Nutritional Requirements

Competency Statement
The nurse provides safe and effective care to meet the nutritional needs of unwell infants and children.

RCH references related to this competency: RCH Intranet: Division of Medicine-Dietary Management Of Chronic Renal Failure, Division of Medicine- Nutrition In Acute Renal Failure, Division of Medicine- Nutrition after renal transplant Surgery-Nutritional management for burn patients; Neonatal Medicine-Parenteral Nutrition in the Newborn Intensive Care Unit
RCH intranet Kids Health Info-Breastfeeding a baby in hospital, breastfeeding at The Royal Children's Hospital
RCH Clinical Guidelines: Breastfeeding support and promotion, Parental Nutrition PN

Element Exemptions: Banksia (K1b, K5-8, K10-11)

COMPETENCY ELEMENTS	
K	1. Locate and read a. *breast feeding support and promotion clinical guideline (hospital)* b. *parenteral nutrition (PN) clinical guideline (hospital)* 2. Obtain and document nutrition history and requirements-documentation conducted on nursing admission 3. Give examples of when patients might have special dietary requirements 4. Describe the process for referral to a dietician 5. Discuss the facilities and resources available to support breast feeding mothers 6. Explain the following in relation to expressed breast milk: a. labelling requirements b. storage c. checking procedure of EBM d. location of central formula room and expressing rooms on units 7. Identify how to order and store: a. bottles and teats b. standard infant formulas c. enteral feeds or specialised/modified infant formulas 8. Explain the process for ordering patient meals 9. State the indications for the commencement of PN 10. Outline the steps for ordering PN 11. Outline the resources available for management of PN in the clinical environment 12. Documentation of PN
S	1. Demonstrate documentation of nutritional intake ~~2.~~ Document assessment of patient nutrition and hydration 3. Fluid balance recording 4. Checking of PN solution, connection/running of intravenous PN Infusions 5. Monitoring of Patient on PN solution

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Oxygen Therapy

Competency Statement:
The nurse safely and effectively administers oxygen therapy.

RCH references related to this competency: RCH Clinical guidelines: Oxygen delivery, Oxygen Saturation SpO2 Level Targeting - Premature Neonates;
High Flow Nasal Prong HFNP guideline

Element Exemptions: ACE Program (K8, K9, K11, K12, S3, S5)

COMPETENCY ELEMENTS	
K	Locate and read the RCH clinical guidelines: • Oxygen delivery • Oxygen Saturation SpO2 Level Targeting-Premature Neonates; • High Flow Nasa prong (HFNP therapy) Sugar glider, E.D., Koala only 1) Describe and differentiate the mechanisms of ventilation, diffusion, and respiration. 2) Define Peak Inspiratory Flow Rate 3) State the normal SpO2 range for a) Children/adults b) Neonates (premature or less than 28 days of age) nursed in oxygen c) Cyanotic heart disease 4) Describe the signs and symptoms of hypoxia 5) State the aims of oxygen therapy 6) State potential complications and hazards associated with oxygen therapy 7) Identify factors taken into consideration in selecting oxygen delivery methods 8) Differentiate between High flow and Low flow oxygen delivery systems 9) State minimum and maximum flow rates deliverable via: a) Simple face mask b) Nasal prongs for children less than 2 years and children older than 2 years, c) Humidified nasal prongs for children less than 2 years and children older than 2 years. 10) Describe the process for initiating or altering oxygen delivery 11) Describe the application and maintenance of a non re breather mask for emergencies
S	1. Demonstrate application and maintenance of each of the following for a child receiving oxygen therapy via: a. Nasal prongs-wall b. Simple face mask 2. Demonstrate set up and application of humidified oxygen therapy via Airvo, for: a. Humidified nasal prong oxygen b. Humidified face mask oxygen 3. Demonstrate clinical assessment of a patient receiving oxygen therapy 4. Document assessment of a patient receiving oxygen therapy 5. Evaluate patient response to oxygen therapy 6. Assemble equipment for portable oxygen delivery

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Pain assessment and management (basic)

Competency Statement:
The nurse will effectively assess and take all steps to manage pain.

RCH references related to this competency: RCH Intranet: Surgery-Acute Pain Management CPMS, Surgery-Chronic Pain Management CPMS, Surgery-Links - Anaesthesia Pain Management, Surgery- Parent Info - Anaesthesia Pain Management

COMPETENCY ELEMENTS	
K	1. Locate and read the a. RCH pain assessment module and clinical practice guideline b. Completion of Opioid primary & other pain service e-learning competencies (assigned based on area requirements) 2. Discuss cultural and past experiences that may affect a child's pain 3. Discuss the impact of untreated or inadequately managed pain 4. Describe the pain assessment tools used in paediatrics at RCH 5. Identify which pain assessment tools are most useful for different developmental stages and children with developmental disabilities 6. Discuss appropriate language when assessing pain 7. Discuss options for pharmacological management of pain 8. Discuss options for non-pharmacological management of pain 9. Discuss nursing actions to take if pain escalates 10. Identify resources available to assist in pain management
S	1. Demonstrate assessment of pain during: a. rest b. activity c. post-operative d. procedures 2. Demonstrate family inclusion in pain assessment and decision making 3. Demonstrate documentation of pain assessment in observation flowsheet

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Preparation for Surgery and Pre-Anaesthetic Care

Competency Statement:
The nurse will safely and effectively prepare and care for a patient pre surgery/ anaesthetic.

RCH references related to this competency: RCH Intranet: Division of Medicine-General Medicine-Clinical Practice Guidelines-Fasting Guidelines, Surgery-Intranet Resources - Anaesthesia Intranet Only, Surgery-Parent Info - Anaesthesia Pain Management

Element Exemptions: Banksia (K3a)

COMPETENCY ELEMENTS	
K	1. Explain the required paperwork for a patient prior to an anaesthetic 2. Summarise the baseline observations required prior to an anaesthetic 3. Outline fasting guidelines for a. Breast milk b. Clear fluids c. Other liquids d. Solids 4. Outline patient and parent education and preparation for theatre a. Discuss the process for escorting patients to theatre b. State the appropriate attire for patients presenting for theatre c. Discuss parents role in accompanying and supporting child throughout anaesthetic and recovery process 5. Outline common premedications given and monitoring required 6. Discuss what medications should/shouldn't be withheld prior to anaesthetic/ surgery
S	1. Demonstrate baseline assessment and documentation within the ADT navigator 2. Demonstrate completion of preoperative checklist 3. Demonstrate transport and handover to a pre-operative nurse 4. Demonstrate how to locate and read the theatre list and time line

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Procedural Pain Management (Basic)

Competency Statements:
The nurse assesses and implements basic non pharmacological and pharmacological strategies to minimise anxiety, distress and pain as part of routine procedure care.
The nurse educates and models developmentally appropriate strategies that enable the parent and child to develop positive coping skills for routine procedure.

RCH references related to this competency: RCH Clinical guidelines: Sedation - Procedural Sedation Guideline - Ward and Ambulatory Areas

Please note that there are specialty nursing competencies for IV sedation and Nitrous oxide administration

COMPETENCY ELEMENTS	
K	**General:** 1. Locate and read a. Procedural Pain Management procedure b. Procedural Pain Management clinical guideline c. Procedural Sedation clinical guideline 2. Discuss the nurse's role in advocacy for procedures 3. Discuss the Educational Play Therapist role for procedures 4. Discuss management of a. unresolved/untreated pain and anxiety and b. the number of procedural attempts **Pharmacology Strategies:** 5. State the differences between administration of same agents for: a. Procedural b. Nocturnal c. Pre medication **Non pharmacology Strategies:** 6. State the resources available to assist children/families and health care staff to manage procedural pain, fear and distress 7. List department and RCH services available to support children who are moderately or extremely distressed during procedures 8. Discuss non pharmacological strategies available for procedural pain management 9. Describe the role of parental and child decision making for procedures including coping strategies 10. State differences between a procedural explanation and preparation of the child/family for procedures 11. Describe the preparation required for procedures that are common in your department 12. Discuss the use of sucrose for procedural pain management including: d. Dosage e. Site selection f. Duration g. Documentation
S	**Pharmacology Strategies:** 1. Demonstrate the appropriate and safe use of topical and local anaesthetic agents including: a. Dosage b. Site selection c. Duration d. Documentation 2. Demonstrate the appropriate and safe use of oral procedural sedation agents including: a. Dosage b. Route c. Duration d. Documentation **Non-Pharmacology Strategies:** 3. Demonstrate the use of positioning and distraction strategies for common procedures in your department

Competency Declaration over page

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Nurse Name:	Signature:	Date:

Assessor Name:	Signature:	Date:

Post-Sedation/-Anaesthetic Care

Competency Statement:
The nurse will safely and effectively care for a patient post sedation or anaesthetic.
RCH references related to this competency: RCH Clinical Guidelines: Sedation - Procedural Sedation Guideline - Ward and Ambulatory Areas;
RCH Intranet: Kids Health Info-Sedation for procedures 1: About sedation, Surgery-Links - Anaesthesia Pain Management, Surgery-Intranet Resources - Anaesthesia Intranet Only

Competency Exemptions: Banksia (K1-7 & S1-4)

COMPETENCY ELEMENTS	
K	1. Discuss the patient's surgery/procedure 2. Outline type, frequency and duration of post sedation/anaesthetic observations 3. Discuss rationale for intravenous fluid orders, oral intake 4. Explain potential impact of procedure on output 5. Summarise the pain management plan for a child post procedure, including analgesic infusions, wound catheters, epidural and local anaesthetic techniques 6. Identify factors that contribute to post procedure nausea and vomiting and its management and appropriate intervention 7. Identify potential post procedure complications
S	1. Demonstrate bedside checks 2. Demonstrate assessment and documentation of observations, fluid status and relevant surgical assessment 3. Demonstrate pain assessment post procedure 4. Demonstrate wound assessment and documentation

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Risk Screening & Management

Competency Statement:
The nurse maintains a safe and healthy environment when caring for patients.

RCH references related to this competency: RCH Policies & Procedures: Clinical Waste and sharps management, Code Grey Procedure, Incident/Injury/Hazard Reporting, Incident Reporting and Management, Needle stick injuries and blood/body fluid exposures procedure, Occupational violence procedure, Patient Identification, Procedural Safety – Correct Patient, Correct Procedure, Correct Site

Please note that pressure ulcer prevention and management is addressed in skin integrity competency tool and infection prevention is addressed in the infection prevention competency tool.

COMPETENCY ELEMENTS	
K	1. Locate and read a. *Patient identification procedure* b. *Incident / Injury / Hazard reporting procedure* c. *Falls prevention procedure* d. *Vulnerable children policy* e. *Child protection procedure* f. *Code of behaviour procedure* g. *Code grey procedure* h. *Occupational violence procedure* i. *Clinical waste and sharps management* j. *Sharps handling procedure* k. *Needle stick injuries and blood / body fluid exposures procedure* 2. Identify and act upon potential safety hazards in the environment 3. Describe the process of "procedure matching" as per the patient identification procedure 4. Describe the rationale and documentation for recording information about allergies and reactions 5. Summarise the identification and management of vulnerable children 6. List the RCH expectations of staff in compliance with the Code of behaviour procedure 7. Discuss the responsibility of clinical staff in the event of clinical aggression 8. Summarise the procedure for sharps disposal 9. Outline the procedure for managing a needle stick injury 10. Describe the process for incident reporting via VHIMS
S	11. Demonstrate care consistent with falls prevention procedure 12. Undertake a safety check of bedside equipment 13. Demonstrate correct positive patient identification technique

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:

Skin Integrity

Competency Statement:
The nurse provides safe and effective care for a patient at risk of or with existing skin breakdown.

RCH references related to this competency: RCH Clinical Guideline: Environmental Humidity for Premature Neonates, Perianal care for the Paediatric Oncology Patient, Pressure Injury Prevention and Management, Tracheostomy Tube Ties - procedure for changing

COMPETENCY ELEMENTS	
K	1. Locate and read the Pressure Ulcers Prevention and Management guideline 2. Define a pressure ulcer 3. Discuss when a patient should be assessed for risk of pressure ulcer development 4. Identify risk factors for the development of pressure ulcers 5. Describe preventative strategies used to reduce the likelihood of pressure ulcer development 6. Describe the role of positioning in the prevention of pressure ulcers 7. Identify areas of skin at increased risk for pressure ulcer development including the rationale 8. State the initial signs of pressure ulcer development 9. Discuss the process for management of a patient with a pressure ulcer 10. List pressure relieving devices appropriate for patients at: a. Low to moderate risk of developing a pressure ulcer b. High to very high risk of developing a pressure ulcer and without existing skin breakdown c. High to very high risk patients with existing skin breakdown, immobile and high, perspiration
S	1. Demonstrate a pressure ulcer risk assessment using the Glamorgan Scale 2. Demonstrate a Falls risk assessment using the Little Schmidy Scale 3.

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Nurse Name: Signature: Date:

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Transfer of Patients

Competency Statement:
The nurse safely and effectively transfers patients within the hospital and to external organisations.

RCH references related to this competency: RCH Policies & Procedures: Non-Emergency Patient Transport, Non-Emergency patient transport (NEPT) webpage-wizard flowchart: Nursing documentation (clinical guidelines)

COMPETENCY ELEMENTS	
K	1. Locate and read the patient transport resources available 2. Identify equipment necessary to ensure safety of patient during transfer 3. Discuss documentation necessary to accompany patient transferring to: a. An inpatient unit b. An appointment in another department c. Theatre d. Another organisation 4. Discuss the relevant OHS considerations when transferring a patient within the hospital 5. Identify transport options for patient transfer to an external organisation
S	1. Arrange date and time for transfer with area receiving patient 2. Demonstrate how you prepare a patient for transfer 3. Ensure privacy and dignity of the patient and family are maintained during transfer

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Nurse Name: Signature: Date:

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Wound Assessment & Management

Competency Statement:
The nurse provides safe and effective care for a patient requiring wound care.

RCH references related to this competency: RCH Clinical Guideline: Wound Care; RCH Policy: Antiseptic technique

COMPETENCY ELEMENTS	
K	1. Locate and Read the Wound Care clinical Guideline 2. Describe the three phases of wound healing 3. Discuss the considerations for wound assessment, including: • Wound bed • Wound measurement • Wound edges • Exudate • Infection • Pain • Surrounding skin 4. Discuss factors delaying wound healing 5. State the objectives of acute and ongoing wound management 6. Describe the differences in aseptic technique used in wound management • Standard Aseptic Technique • Surgical Aseptic Technique 7. Discuss considerations when choosing dressing products
S	1. Demonstrate a wound dressing requiring: • Standard Aseptic Technique • Surgical Aseptic Technique 2. Appropriately document: • Wound assessment in LDA flowsheet • Dressing products used • Analgesia required • Multidisciplinary team involvement (e.g. play therapy, stomal therapy) • Plan for further wound care and management

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

CVAD Management

Competency Statement:
The nurse safely and effectively cares for a patient with a central venous access device (CVAD).

RCH references related to this competency: RCH Policies & Procedures: Central Venous Access Device Management; RCH Intranet: Division of Medicine-Guidelines for the Management Blocked Central Venous Lines

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Locate and read the CVAD clinical guideline 2. Locate and complete the CVAD education package and quiz 3. Differentiate between a peripheral IV access device and a CVAD 4. Discuss the indications for central venous access 5. Identify possible routes and devices for central venous access 6. Differentiate between standard aseptic technique and surgical aseptic technique 7. State which technique to use when performing dressing and smart site change on a CVAD 8. State which technique to use when preparing and administering drugs via a CVAD 9. State which technique to use when changing IV administration sets connected to a CVAD 10. State indications for dressing change and smart site change of CVAD 11. Discuss the correct blood sampling technique 12. Discuss potential complications associated with CVADs and appropriate management 13. Discuss the management of a blocked CVAD and anticoagulant guidelines
S	1. Demonstrate CVAD site inspection 2. Demonstrate correct standard aseptic technique when preparing medications for administration via a VCAD 3. Demonstrate correct surgical aseptic technique for CVAD dressing and /or smart site change 4. Demonstrate correct surgical aseptic technique for port cannulation 5. Demonstrate access of CVAD for medication administration using standard aseptic technique 6. Demonstrate correct disinfection of smart site prior to accessing it 7. Demonstrate CVAD line change 8. Demonstrate disconnection of lines and flushing of a CVAD 9. Demonstrate correct blood sampling technique from a CVAD 10. Document CVAD management on the LDA flowsheet

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Haematology and Biochemistry (Basic)

Competency Statement:
The nurse is able to identify normal basic biochemistry results, the causes of abnormal results and is able to respond appropriately.

RCH references related to this competency: RCH Intranet: Division of Medicine – Intranet Resources – Haematology, Operations – Laboratory Services

COMPETENCY ELEMENTS	
K	1. Identify reasons for monitoring basic biochemistry for patients common to your clinical area 2. Identify reasons for monitoring basic haematology for patients common to your clinical area 3. State the normal reference ranges for a. Haemoglobin b. Platelets c. White blood cells d. Neutrophils 4. Identify potential causes of high or low a. Haemoglobin b. Platelets c. White blood cells d. Neutrophils 5. State the normal reference ranges for a. Creatinine b. Urea c. Sodium d. Potassium e. Chloride f. Bicarbonate g. Glucose 6. Identify potential causes of high or low a. Creatinine b. Urea c. Sodium d. Potassium e. Chloride f. Bicarbonate g. Glucose 7. Discuss action required when results fall outside the normal reference range
S	1. Demonstrate use of "Results review" activity tab in EMR to review biochemistry results

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Tube Insertion

Competency Statement:
The nurse is able to safely insert, secure & confirm positioning of a nasogastric tube.

RCH references related to this competency: RCH Intranet: Kids Health Info – Nasogastric tube – insertion of;
RCH Policies & Procedures: Insertion of Nasogastric Tube

COMPETENCY ELEMENTS	
K	1. Locate and read the "Insertion of Naso-Gastric Tube" procedure 2. Identify the reasons why a patient may require a nasogastric tube (NGT) 3. Discuss the differences including frequency of tube changing and rationale for insertion between long term and short term NGT 4. Identify the anatomical position of where the tip of the NGT is placed 5. Discuss how confirmation of tube position is obtained 6. Describe the methods for securing a NGT for patients with: a. intact skin b. neonates c. eczema d. burns 7. Discuss management of possible complications that may occur during NGT insertion 8. Discuss appropriate resources available in preparing the patient and family for tube placement 9. Discuss patient types and groups where nasogastric and orogastric tubes should be inserted by medical personnel
S	1. Select equipment for insertion, testing & securing of NGT 2. Demonstrate how to measure the length of tube to be inserted 3. Demonstrate insertion of a NGT 4. Demonstrate testing of NGT placement 5. Demonstrate securing of a NGT 6. Complete accurate documentation of NGT insertion in LDA flowsheet

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Specimen Collection

Competency Statement:
The nurse safely and effectively collects specimens, checks results and responds appropriately.

RCH references related to this competency: RCH Intranet: Operations – Laboratory Services – Specimen collection details, Operations – Specimen Collection; RCH Policies & Procedures ; Collection of Capillary Blood samples; Clinical Practice Guidelines: Lumbar puncture, NPA, Newborn Screening Test, Supra Pubic Aspirate, Urinary tract infection.

COMPETENCY ELEMENTS	
K	1. Locate the RCH specimen collection handbook 2. Locate and read the RCH specimen collection policy 3. List the information required on a specimen collection request slip 4. Discuss common pre-analytic specimen problems (PASP's) and the prevention strategies 5. Differentiate between the following urine specimen collection techniques: a. Clean Catch b. Mid-Stream Urine c. Supra Pubic Aspirate d. Catheter Specimen 6. Describe the capillary blood specimen collection 7. Describe faecal specimen collection 8. Describe the four different respiratory virus PCR collection methods available 9. Differentiate between viral and bacterial specimen collection equipment 10. Explain rationale for plating swabbed specimens 11. Discuss actions when abnormal results are obtained 12. Describe indications for lumbar puncture 13. Describe and demonstrate the nurse's role when assisting with an LP 14. Discuss correct order of draw when collecting blood samples
S	1. Demonstrate application of urine specimen bag 2. Demonstrate 'dip-stick' testing of urine and interpretation of results 3. Demonstrate correct capillary blood specimen collection by finger prick and heel prick 4. Demonstrate correct specimen labelling requirements 5. Demonstrate use of "Results review" activity tab in EMR to review pathology results 6. Demonstrate correct technique for Newborn Screening test 7. Demonstrate correct technique for samples transported on ice 8. Demonstrate correct technique for venepuncture

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Transfusion Management (Red Blood Cell)

Competency Statement:
The nurse will safely administer red cell red blood cells according to best practice guidelines.

RCH references related to this competency: RCH Intranet: Operations – Laboratory Services – Adverse effects of transfusion, Division of Medicine – General Medicine – Clinical Practice Guidelines-Blood product transfusion

Competency Exemptions: Banksia

COMPETENCY ELEMENTS	
K	1. Locate and read the a. *blood transfusion procedure* b. *blood product transfusion clinical practice guideline* c. *blood transfusion – consent and consumer information clinical guideline (Hospital)* 2. Define the normal range for Haemoglobin 3. Describe the signs and symptoms of anaemia 4. Discuss supportive management for the symptoms of anaemia 5. Explain why some patients receive blood products that are: a. Irradiated b. CMV negative 6. Identify how soon after release from blood bank the transfusion of a product should commence 7. Identify over what period of time a blood transfusion must be completed once a bag is spiked 8. State the formula for calculating the transfusion volume 9. Identify when filters should be changed 10. Summarise the monitoring requirements of a patient during a blood transfusion 11. Describe the signs and symptoms of a blood transfusion reaction 12. Discuss the steps in recognising and managing a transfusion reaction
S	1. Demonstrate correct collection and labelling of pre transfusion sample 2. Correctly fill in a blood bank release order 3. Demonstrate the correct pre transfusion check a. Patient preparation b. Patient identification c. Blood product identification d. Blood Group e. Expiry date f. Inspection of product g. Documentation 4. Select the correct filter for the transfusion

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Competency Feedback & Reflection

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

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

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

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