Chapter 30

Specialty Nursing Competencies- Medical Imaging

The Royal Children's Hospital Melbourne

Nursing Competency Workbook, 7th Edition

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

Chapter 1

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

Chapter 2

Generic Nursing Competency Assessment Forms

Chapter 3

Specialty Nursing Competency Assessment Forms

Appendix 1

Unit / Department Nursing Orientation

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

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

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Workbook Edition, January 2015

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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 Guidelines: Anaphylaxis

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

COMPETENCY ELEMENTS	
K	1. Locate and read Anaphylaxis 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.

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Angiography - Digital Subtraction Angiography (DSA)

Competency Statement:
The nurse will effectively and efficiently set up a basic procedure trolley for a Cardiac Catheter and Radiology Intervention cases.

COMPETENCY ELEMENTS	
K	1. Describe some different Radiological Interventional cases 2. Describe some different Cardiology Interventional cases 3. Identify the location of the folder required for an ICD implant procedure 4. Discuss the documentation required for devices implanted in patients 5. Locate the Balloon Atrial Septostomy trolley and the frequency of checking and restocking
S	1. Locate the Defibrillator and Temporary Pacemaker and demonstrate how to check it 2. Assemble the equipment required for the following procedures a. Cerebral Angiogram b. Oesophageal Dilatation c. Liver Biopsy d. Sclerotherapy Injection 3. Assemble the equipment required for a a. Right and Left Heart Cardiac Catheter b. Endomyocardial Biopsy and Coronary Artery Angiography c. Electrophysiology Study d. ICD Implantation

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Nurse Name: Signature: Date:

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Chest Opening (Emergency)

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

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

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

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

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Nurse Name: Signature: Date:

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Circulating Nurse Role

Competency Statement:
The nurse effectively performs as a circulating nurse in the operating theatre

RCH references related to this competency: RCH Policies & Procedures: Consent, Manual Handling; Patient Identification; Procedural Safety Checks; RCH Intranet: Division of Surgery - Sterile Equipment 8211 Final Surgical Check

COMPETENCY ELEMENTS	
K	1. Discuss the role of the Circulating Nurse 2. Discuss the hospital policy and procedures and the ACORN Standards of a Circulating Nurse 3. Describe the surgical procedure **4.** Discuss the Circulating Nurse's role in verification and tracking of instrumentation and equipment used within the sterile field (TDOC is completed) **Setting up** 5. Discuss the process of reporting and recording of items that do not comply with processing standards **Intra-Operative** 6. Explain the recommended distance away from the sterile field when presenting sterile supplies and instruments to the sterile field 7. State why no waste and linen bags should be removed from the theatre until the final count is complete and correct 8. Describe the role of the circulating nurse at the completion of the procedure
S	1. Prepare equipment, instruments and supplies for surgical case 2. Confirm that the prepared equipment, instruments and supplies are appropriate and present for the procedure **Communication** 3. Consult the surgeon preference book to set up for the procedure 4. Consult the surgeon and/or experienced nurses on equipment and instruments required if unsure 5. Consult the surgeon and anaesthetist on the order of the list and individual patient needs 6. Introduce self to the surgical team 7. Ensure all members of the surgical team are recorded on ORMIS and on the white boards in theatre 8. Demonstrate correct completion of ORMIS, including Time Out and Consent **Setting Up** 9. Ensure instruments, equipment and supplies are at hand, in good working condition and ready for use 10. Check internal sterility indicators and integrity before opening and before using sterile items. Discard items that do not comply with standards and takes correct measures in the event of contamination 11. Demonstrate how to setup a theatre for a procedure ensuring all surfaces, floor and operating lights are clean and free of dust and fluids 12. Select correct trolley for procedure 13. Demonstrate correct placement of sterile bundles and supplies 14. Demonstrate correct technique when opening sterile packs, steri-peel and instrument trays 15. Demonstrate correct use of the T-Doc scanner to scan the tracking stickers **Intra-Operative** 16. Demonstrate correct movement around sterile fields 17. Confirm liquid type, strength and date of expiry before pouring into the correct bowls from a discrete distance 18. Demonstrate the Procedural Safety Checks 19. Accurately documents the consent is complete and "Time out" performed on ORMIS 20. Accurately documents the surgical count on the "Intra Operative Record Sheet, MR17A" ensuring form is complete and accurate 21. Discuss and demonstrate the correct connection of surgical equipment (eg: diathermy, camera, light lead, head lights, air tools, etc) 22. Demonstrate the safe transfer a patient from a trolley to the operating table 23. Accurately documents actions and interventions as they occur 24. Document and perform the correct "Sign Out" procedure 25. Demonstrate sending for the next patient

Nurse Declaration on next page

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Nurse Name:	Signature:	Date:

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Instrument Nurse's Role

Competency Statement:
The nurse safely and effectively performs the role of the Instrument Nurse

RCH references related to this competency: RCH Policies & Procedures: Aseptic Techniques, Sharps Handling; RCH Intranet – Division of Surgery – Checking process for surgical implants, Incorrect Surgical Count; Perioperative Attire; Surgical Count; RCH Clinical Guidelines (Nursing) - Routine Post Anaesthetic Observation Guideline: ACORN Accreditation;

COMPETENCY ELEMENTS	
K	**Preparation:** 1. Locate and read references related to this competency 2. Discuss hospital policy and procedures and the ACORN Standards of an Instrument Nurse 3. Describe the surgical procedure **Setting up** 4. Describe sterile field 5. Describe the principles for setting up a trolley **Intra-Operative** 6. State the location of countable items during the operation
S	**Preparation** 1. Prepare equipment, instruments and supplies for surgical case 2. Identify sources of support when unfamiliar with the procedure 3. Asks for assistance and instruction from experienced staff members 4. Demonstrate the care and handling of instruments and equipment a. Sharps management b. Fluids c. Identifying the logical lay out of instruments d. Passing the surgical instruments **Communication** 5. Consult the surgeon preference book to set up for the procedure 6. Contribute in the team meeting prior to the surgical list 7. Introduce yourself to the surgical team and all members of the team are recorded on ORMIS and on the white boards in theatre **Setting up** 8. Ensure instruments, equipment and supplies are at hand, in good working condition and are ready for use 9. Check internal sterility indicators before starting to set up trolley and before using sterile items. Discards items that do not comply with standards and takes appropriate measures in the event of contamination 10. Demonstrate draping trolley / trolleys in a manner that ensures integrity of the sterile field 11. Demonstrate maintenance of sterility at all times 12. Ensure fluids and wet supplies are only contained in the correct receptacles 13. Demonstrate correct set up of a trolley 14. Demonstrate containment of all sharps in the appropriate receptacles and handled in a safe manner **Prepping and Draping** 15. Demonstrate the correct movement around the sterile field 16. Demonstrate correct process for surgical draping **Intra-Operative** 17. Demonstrate efficient and safe delivery of surgical instruments and items to surgeon or assistant 18. Anticipate and select the instrument required 19. Demonstrate correct loading of a. Raytec on a sponge holder, "swab on a holder" b. Peanut swab c. Clip applicator d. Blade and suture 20. Demonstrate maintenance of the sterile field (cleaning instrumentation as required) and ensuring items remain sterile and can be immediately located 21. Initiate the surgical count ensuring preparation for application of dressings are attended to 22. Demonstrate correct sharps and waste disposal 23. Demonstrate correct removal of gown and gloves 24. Demonstrate accurate completion of the Intra-Operative record and data recorded on ORMIS 25. Participate in the safe movement of the unconscious patient onto trolley on the completion of the procedure.

Nurse Declaration on next page

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Nurse Name:	Signature:	Date:

Assessor Name:	Signature:	Date:

Medical Imaging Procedures

Competency Statement:
The nurse safely and effectively cares for the patient and their family while they undergo an investigation or procedure in the Medical Imaging Department

COMPETENCY ELEMENTS	
K	1. Identify the location of the Department Procedure folder 2. Describe the individual modalities that make up the Medical Imaging Department 3. State the precautions that should be taken for patients having the following scans a. CT b. Nuclear Medicine c. Fluoroscopy d. Ultrasound e. MRI 4. Discuss MRI safety checks 5. Discuss the types of procedures performed throughout the department 6. Identify the situation in which Omnipaque would be used instead of Barium 7. Discuss the difference between an MRI scan and a CT scan 8. Discuss the care of patients when administered with the following medications a. Chloral Hydrate b. Midazolam 9. Discuss the process required when organising a sedation booking 10. Discuss the information that is required for families post sedation prior to discharge 11. Describe the preparation of patients attending nuclear medicine for the following investigations a. MIBG scan b. Bone scan c. Mag3 scan 12. Describe the preparation and care of a patient in fluoroscopy having a a. MCU b. Barium swallow c. Barium Meal d. Barium Enema e. NJ insertion f. Gastrostomy Tube Change g. PICC Line h. Bronchogram 13. List the preparation required for CAP or a patient requiring either IV / oral contrast in CT 14. List the nursing care required for patients having a a. Crohns Study b. MRU 15. State the types of access that are suitable for a a. Pressure injection in CT b. Hand injection in CT 16. Discuss the emergency management of a child having a seizure during an interictal scan 17. Discuss the process involved when undertaking a General Anaesthetic list
S	Not Applicable

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Nasojejunal Tube Insertion & Management

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

Element Exemptions: Medical Imaging (S6 & S8)

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

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Nurse Name: Signature: Date:

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Peri-Operative Attire

Competency Statement:
The nurse wears the correct attire when entering the Peri-Operative area

RCH references related to this competency: RCH Intranet – Division of Surgery –Perioperative Attire; RCH Clinical Guidelines (Nursing) - Routine Post Anaesthetic Observation Guideline: ACORN Accreditation;

COMPETENCY ELEMENTS	
K	1. Discuss the hospital policy and ACORN standard on Peri-Operative attire 2. Discuss why finger nails are to be kept sort, clean and free of nail polish and artificial nails 3. Discuss when a surgical mask is required to be worn
S	4. Demonstrate the wearing of correct Peri-Operative attire 5. Demonstrate the correct wearing of protective eye wear and surgical mask 6. Demonstrate adherence to hand hygiene principles

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Nurse Name: Signature: Date:

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Peri-Operative Nursing Principles of Care

Competency Statement:
The nurse demonstrates adherence to Peri-Operative nursing principles of care to achieve optimal patient outcomes

RCH references related to this competency: RCH Policies & Procedures: Blood transfusion, Consent

Element Exemptions: Medical Imaging (K5, S10-11)

COMPETENCY ELEMENTS	
K	1. Explain the rationale for a quiet environment during patient induction 2. Explain the significance of providing temperature management devices 3. Explain the strategies to prevent hypothermia 4. Discuss potential complications of incorrect positioning 5. State patient considerations when using a diathermy such as cochlear implant, metal, skin integrity 6. Explain the observations for blood loss and actions to be taken when loss is excessive. 7. Discuss blood storage and retrieval processes
S	1. Prioritises identified health needs using a problem solving and critical thinking approach 2. Demonstrates collaboration with team members to ensure pre-operative care and orders have been completed 3. Demonstrate maintenance of respect and dignity of the peri-operative patient 4. Demonstrate verification of correct procedure including correct site / side according to protocols 5. Demonstrate correct patient identification procedure takes place 6. Demonstrate correct measures taken to manage a patient with a latex sensitivity 7. Demonstrate correct positioning of the patient 8. Demonstrate application of the principles of standard precautions 9. Demonstrates adherence to the principles of asepsis 10. Demonstrate correct placement and checking of the diathermy plate and site 11. Demonstrate correct use of the diathermy machine and equipment including foot pedals

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Nurse Name: Signature: Date:

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Post Anaesthetic Care (Immediate)

ALERT*: *This competency should be completed in conjunction with the post anaesthetic nursing principles of care competency

Competency Statement:
The nurse safely and effectively cares for a patient in the immediate post anaesthetic period

COMPETENCY ELEMENTS	
K	**General** 1. Discuss life threatening complications and management including advanced life support **Airway** 2. Describe airway assessment 3. Discuss the importance of correct patient positioning to maintain airway and identify complications or poor positioning 4. Describe techniques for airway support under anaesthesia 5. Describe indications for oxygen delivery via a. Face mask b. T piece c. LMA 6. Identify signs and symptoms of Laryngospasm 7. Discuss treatment and intervention for Laryngospasm **Cardiovascular** 8. Identify the risks for impaired cardiovascular status in the immediate post-operative period 9. Discuss nursing management of impaired cardiovascular status in the immediate post-operative period **Neurological** 10. Identify indications for assessment of neurological status immediately post anaesthetic 11. Identify potential neurological complications following surgical intervention 12. Discuss nursing management of impaired neurological status in the immediate post anaesthetic period **Pain** 13. Discuss nursing management of pain in PACU 14. Discuss opioid agents commonly used in PACU including dose / kg calculations 15. Describe types and use of adjunct analgesics **Neurovascular** 16. Identify indications for assessment of neurovascular status immediately post anaesthetic 17. Identify potential neurovascular complications following surgical intervention 18. Discuss nursing management of impaired neurovascular status in the immediate post anaesthetic period **Temperature** 19. State the normal temperature ranges for neonates and children 20. Identify signs and symptoms of Malignant Hypothermia and notifies medical staff of abnormal or rapid changes in temperature
S	**General** 1. Discuss and demonstrate correct patient monitoring 2. Discuss and demonstrate individualised planning for patients based on a. Assessment b. Procedure c. Underlying conditions 3. Demonstrate accurate patient assessment and documentation of findings post anaesthetic a. Airway/Respiratory b. Cardiovascular c. Neurological d. Pain e. Neurovascular f. Temperature g. Surgical wound / drains 4. Demonstrate correct connection of defibrillator paddles

Skill competencies continued and Nurse Declaration on next page

S	**Airway** 5. Demonstrate correct obstructive airway interventions and discuss rationales for different age groups 6. Recall indications for use of a guedel airway and demonstrate correct size selection and insertion technique 7. Describe indications for oxygen delivery via d. Face mask e. T piece f. LMA **Cardiovascular** 8. Describe and demonstrate and the correct technique for removal of an arterial cannula **Neurological** 9. Demonstrate reporting of deviations from baseline or change in neurological status in a timely manner **Pain** 10. Demonstrate the use of non-pharmacological methods of pain control 11. Demonstrate reporting of unrelieved pain to the medical staff **Temperature** 12. Describe and demonstrate techniques to improve and / or maintain temperature that is within normal limits **Wounds & Drains** 13. Discuss and demonstrate management of surgical wounds and drains in PACU **Emergence Delirium** 14. Discuss and demonstrate management of the child with emergency delirium

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Nurse Name: Signature: Date:

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Post Anaesthetic Nursing Principles of Care

ALERT*: *This competency should be completed in conjunction with the post anaesthetic care (immediate) competency

Competency Statement:
The nurse safely and effectively performs the role of the post anaesthetic care (PACU) nurse

RCH references related to this competency: RCH Clinical Guidelines (Nursing) - Routine Post Anaesthetic Observation Guideline: ACORN Accreditation;

COMPETENCY ELEMENTS	
K	1. Describe the role of the PACU Nurse 2. Discuss hospital policy and procedures and the ACORN Standards of a PACU nurse 3. Discuss why and how modes of anaesthesia are used a. IV b. Inhalational c. Rapid Sequence Induction d. Total Intravenous Anaesthesia 4. Discuss the intra-operative procedure 5. Discuss key elements that should be communicated with the anaesthetic team on receiving the patient in PACU 6. Identify factors to be considered in calling family into recovery
S	1. Demonstrate safety checks a. Defibrillator and Internal Adaptor b. Resuscitation Trolley c. Oxygen and Suction / Portable Oxygen and Suction d. Drugs and Addiction Book e. Laerdal Bag and Mask 2. Demonstrate use of intercom systems if applicable 3. Demonstrate communication of accurate information to a. Anaesthetists b. Surgeons 4. Demonstrate inclusion of families in post anaesthetic care 5. Demonstrate use of the Lanpage system for post anaesthetic care 6. Accurately enter Post operative data into the ORMIS system 7. Accurately complete documentation for the patient in the PACU including a. Anaesthesia Medical Record (MR800/A) b. Fluid Balance and Treatment Orders (MR730/A) c. Medicine Chart (MR690/A) d. PONV Attachment e. Opioid Infusion attachment f. Patient Controlled Analgesia (PCA) attachment

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Nurse Name: Signature: Date:

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Procedural Sedation nitrous oxide accreditation – skill

ALERT*: *This competency should follow the procedural sedation nitrous oxide accreditation – theory competency. 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 procedure.

COMPETENCY ELEMENTS	
K	1. State when a sedation period starts and ends 2. Describe the function of the Nitrous Oxide delivery unit components. 3. State the two built in safety features on the nitrous unit and rationale for these
S	4. Assemble the disposable equipment required for nitrous oxide administration 5. Demonstrate a safety check of the nitrous oxide and emergency equipment prior to the start of the procedure 6. Demonstrate preparation of the child and parent for the sedation event 7. Integrate non pharmacological strategies as part of sedation event 8. Maintain line of sight throughout the sedation episode 9. Deliver nitrous oxide including making adjustment to: a. the nitrous oxide concentration based on anxiety, pain and sedation requirements b. the gas flows based on patients needs. 10. Scavenge nitrous oxide gas in accordance with Occupation Health and Safety Standards 11. Summarise and demonstrate delivery of oxygen post sedation 12. Performs end of sedation period assessment including assessment of level of alertness and return to baselines vital signs. 13. Correctly document (MR 56S) the sedation event including all baseline observations, risk assessments, sedation summary and discharge criteri 14. Demonstrate discussion of post sedation care including falls prevention with family and child

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Procedural Sedation nitrous oxide – theory

ALERT*: *This competency should precede the procedural sedation nitrous oxide competency – skill. 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 the safe delivery of nitrous oxide during a procedure

RCH references related to this competency: RCH Clinical Practice Guidelines: Emergency Sedation, Procedural Pain; (Nursing) Sedation - Procedural Sedation Guideline - Ward and Ambulatory Areas

COMPETENCY ELEMENTS	
K	1. Locate and read references related to this competency 2. Complete online learning package and pre test 3. Discuss the role and responsibility of the "sedater" for a nitrous oxide sedation event including reporting of adverse event. 4. Describe pharmacological effects of nitrous oxide 5. Outline the differences between anaesthetic and procedural fasting guidelines and consent. 6. State the three RCH services available to provide procedural sedation advice/consultation. 7. Describe five ways to prepare a child/family for a nitrous oxide sedation event 8. State any specific variation to nitrous oxide sedation guideline that applies to your area 9. Describe what considerations should be taken when administering nitrous oxide with another primary sedation agent. 10. State the rationale for a. Risk assessment b. Baseline observations and ongoing observations c. Sedation scale d. Line of sight monitoring e. Post sedation discharge criteria for patients in your area f. Falls prevention g. Emergency equipment h. Occupational Health and Safety i. Nitrous oxide storage j. Documentation responsibilities 11. State the action required for a. Equipment faults b. Loss of nitrous or oxygen gas flow c. Failure to sedate 12. Describe the adverse events that might occur during administration of nitrous oxide and outline the actions required 13. Describe the actions required for the following side effects: a. Hallucinations b. Over sedation c. Vomiting 14. State the location of the emergency equipment
S	Not Applicable

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Nurse Name: Signature: Date:

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Procedure Safety Checks

Competency Statement:
The nurse safely and effectively performs a procedural safety check prior to theatre

RCH references related to this competency: RCH Policies & Procedures: Consent, Manual Handling; Patient Identification; Procedural Safety Checks; RCH Clinical Practice Guidelines – Fasting Guidelines

COMPETENCY ELEMENTS	
K	**ID & Allergy Bands** 1. State the action to be taken if ID and or allergy bands are incorrect or missing **Fasting** 2. Identify the importance of fasting times 3. Describe the actions to be taken if fasting is inadequate **Consent** 4. Identify all components of the consent that require checking 5. Discuss action to be taken if consent is incomplete or inaccurate 6. Discuss the action to be taken if there is a discrepancy between the written consent and the family's verbal understanding
S	**ID & Allergy Bands** 1. Demonstrate correct technique in checking ID bands and allergy bands **Consent** 2. Demonstrate consultation with family to discuss procedure and confirm family expectation matches written consent **General** 3. Demonstrate checking of the surgical site marking 4. Accurately document all information on the Procedure Safety Checks (MR805/A)

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Radiation Safety

Competency Statement:
The nurse effectively maintains radiation safety

COMPETENCY ELEMENTS	
K	1. Discuss the importance of a TLD badge and the frequency of changing it 2. List and discuss the factors that reduce radiation exposure 3. List the most radiosensitive parts of the body 4. Describe what scatter radiation is 5. List the regulatory annual dose limits a. occupational b. public c. pregnancy when declared 6. Discuss the radiation precautions required in a. Nuclear Medicine b. CT c. Fluoroscopy d. General X-Ray 7. 7. List the questions asked the patient prior to radiation exposure
S	Not Applicable

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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. Explain the different types of seizures and how they can present 2. Define epilepsy 3. Define refractory epilepsy 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. Pathway of treatment b. When do we treat a seizure? c. Oxygen use d. Drugs of choice
S	1. Demonstrate care of a patient during a seizure

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Specimen Collection Intra Operatively

Competency Statement:
The nurse safely and effectively collects specimen's Intra Operatively

RCH references related to this competency: RCH Policies & Procedures: Specimen Collection

COMPETENCY ELEMENTS	
K	1. Ask type of storage of specimen: a. Fresh b. Frozen c. Formalin 2. Discuss the process for delivering: a. Fresh Specimens b. Specimen in formalin
S	1. Determine whether the tissue is a specimen 2. Confirm the type of specimen 3. Demonstrate how to receive a specimen from the surgical field, utilising universal precautions and according to RCH policy and procedures 4. Demonstrate handing of specimen to the circulating nurse 5. Demonstrate receiving of specimen from the instrument nurse or surgeon 6. Demonstrate the correct specimen labelling requirements. 7. Correctly documents specimens collected in the Operating room specimen register, ORMIS and on the Intra Operative Record Sheet, MR17A

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

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 the cervical spine injury 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 Occian pad and when should it be used to assist in maintaining neutral alignment of the paediatric spine
S	1. Demonstrate how to immobilise a patient with cervical collar discussing limitations to immobilisations 2. Demonstrate how to log roll a patient with a spinal injury discussing limitations to immobilisations 3. Demonstrate maintenance of neutral alignment when the collar is removed for hygiene, examination, or airway management 4. Demonstrate how to tilt the bed on a patient who is having spinal precautions 5. Discuss and demonstrate spinal immobilisation education to patients and families / caregivers

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Spinal Injury (Acute)

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

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

RCH references related to this competency: RCH Clinical Practice Guidelines: Acute Spinal Injury

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

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Surgical Count

Competency Statement:
The nurse safely and effectively participates in counting of accountable items

RCH references related to this competency: RCH Intranet: Division of Surgery – Incorrect surgical count

COMPETENCY ELEMENTS	
K	1. Discuss the hospital policy and ACORN standard on the surgical count 2. Describe the correct procedure for initial and subsequent counts 3. Discuss the process for any discrepancy in the count
S	1. Identify an accountable item 2. Demonstrate correct counting technique for accountable items 3. Demonstrate correct use of the instrument tray list 4. Demonstrate correct documentation for additional items added onto the sterile field 5. Demonstrate the correct documentation of the count on the Intra-Operative Record MR17A 6. Demonstrate the process for a change over count where the scrub nurse is relieved or where the circulating nurse is permanently relieved 7. Demonstrate a closure count

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Nurse Name: Signature: Date:

Assessor Name: Signature: Date:

Surgical Scrub, Gowning and Gloving

Competency Statement:
The nurse effectively completes a surgical scrub and dons the correct surgical gown and gloves

COMPETENCY ELEMENTS	
K	1. Discuss; a. The rationale for the surgical scrub b. The expected outcomes of the surgical scrub c. The procedure for surgical scrub as per ACORN standards 2. Discuss the reason and demonstrate how to turn the surgical gown with the circulating nurse 3. Discuss the reason and demonstrate how to turn the surgical gown with a member of the scrub team
S	1. Demonstrate the correct preparation prior to the surgical scrub 2. Select approved antiseptic scrub solution 3. Perform a surgical scrub procedure according to the ACORN standards and guidelines a. First scrub of the day b. Subsequent scrubs 4. Assess gown pack 5. Demonstrate drying hands and arms 6. Demonstrate donning a surgical gown 7. Demonstrate the principles of standard precautions 8. Demonstrate donning of sterile gloves by using closed gloving technique 9. State which areas of the gown are considered sterile

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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]	

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

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