LISMORE BASE HOSPITAL
CRITICAL CARE
NURSING COMPETENCIES
Critical Care Competencies

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Critical Care Competencies

Model for Competency Assessment

The tool that has been designed for use in the NCAHS combines two key components. These have been combined to give a model that can assess both the overall level of functionality and effectiveness of the Critical Care Nurse as well as their skills and knowledge in specific clinical domains. The two components are:

1. Clinical Performance Assessment Tool (CPAT). The Australian College of Critical Care Nurses (ACCCN) has identified key clinical criteria for a Clinical Performance Assessment Tool (CPAT), this tool is used by Queensland Health as part of its assessment of Critical Care Nurses. (Queensland Health (1990) “Transition to Intensive Care Nurse Education Program”)

2. A selection of clinically based competencies that have been identified as the basis of which a safe and competent Critical Care clinician would be expected to be competent in performing in the above role.

General Information

Who is expected to undergo these assessments?
All nursing staff that are rostered to work predominantly in Critical Care will be expected to complete an initial competency assessment. This will include a Clinical Performance Assessment Tool (CPAT), assessment of both the identified 15 core Critical Care competencies and the 9 additional competencies.

When are staff expected to undergo the assessments?
- Due to the large number of staff required to undergo these assessments nursing management within the Unit will allocate assessments over a period of approximately 6 - 12 months.
- The date and shift that the CPAT and core competencies are to be commenced is to be negotiated between yourself, the NUM and your assessor. For rostering and planning purposes this date may be chosen several weeks in advance.
- Your assessor will be allocated by the NUM. Please discuss any issues you may have regarding your allocated assessor directly with your NUM.

Timeframe for Completion

Within what timeframe are staff expected to undertake the competency assessments?
- Competency assessment will commence with a Clinical Performance Assessment Tool (CPAT) undertaken during one shift within the first 3 months from initial orientation. This assessment will be performed whilst providing care for a ventilated and haemodynamically monitored patient. Core Competencies will be included in this assessment.
- Timeframe for further assessments will be identified following evaluation and discussion of the initial program. It would normally be expected that the Core
Competencies would be achieved within 3 months of commencement of the program and additional Competencies within 6 months.

- There may be some competencies that are not as frequently seen in the Intensive Care / Coronary Care / High Dependency Unit (ICU/CCU/HDU) unit, such as pulmonary artery catheters (PAC). The completion of these can be negotiated with your assessor.

**Expected Level of Performance**

*What Level of Performance is expected?*

- If you have more than 2 years critical care experience and/or hold Critical Care qualifications, your expected level of CPAT performance is at a “supervised / independent” level.
- If you have less than 2 years experience in Critical Care your expected level of CPAT performance is at “assisted / supervised” level.
- Staff are expected to complete core and additional competencies within the prescribed time frame, eventually achieving a goal of “competent” in all individual competencies.

**Not Yet Competent Results or Expected Level of Performance Not Met**

*What happens if the required level of practice is not met?*

- Staff who are identified as ‘not yet competent’ in individual competencies will be supported with additional learning strategies. These strategies will be developed individually in association with the staff member, the Clinical Nurse Educator (CNE), Clinical Nurse Consultant (CNC) and Nursing Unit Manager (NUM).
- Further clinical assessment no later than 6 months from commencement of the competencies will then occur.
- If after this assessment the staff member is still identified as ‘not yet competent’ the staff member will be referred to Nursing Management (NUM in the first instance) where performance management processes will be put in place. These processes are established and outlined in the performance management section of the NCAHS Human Resource Manual.

**Right of Appeal**

*What right of appeal is there?*

- It is acknowledged that some staff may find this process threatening. If this is the case please discuss your feelings with your NUM, CNC or CNE prior to the assessment process.
- If any staff member feels that they are being assessed in a manner that is unjustified, or the result of assessment is not valid the initial appeal process is,
  - The staff member can ask the assessor to stop at any point during the assessment.
  - The staff member can write to the NUM and outline the reasons that they do not wish the assessment to continue.
  - The NUM can then ask that a different assessor be assigned to the staff member if it is deemed appropriate.
- If the staff member feels there is still no satisfactory resolution to this then they should consult with their Director of Nursing and/ or the New South Wales Nurses & Midwives Association (NSWNMA).
Standards for Assessment

What are the standards used to assess from?

- The assessments will be attended using the following,
  - The CPAT assessment will be attended over one full shift. It will utilize the CPAT assessment guidelines incorporating ACCCN competency standards. These are outlined on pages viii, ix and x. An assessment will be determined from the modified Bondy Score sheet (see pages xi and xii)
  - The Clinical Competencies (Core and Additional) will be assessed using the enclosed Clinical Competency sheets. These sheets outline the Elements of the competency that are required and the performance criteria involved. These Competency Sheets will be available to both the staff member and the assessor before and throughout the assessment phase.
  - Practice guidelines from the Unit are also to be used in conjunction with the Clinical Competency sheets.

Assessors

Who will perform the Assessments?

- The Clinical Nurse Educator (CNE), Clinical Nurse Consultant (CNC) and Clinical Nurse Specialists (CNS) are currently the designated resource people for the CPAT and competency assessments. Some of these staff have achieved NSW Vocational Education and Training Accreditation Board (VTAB) certification to plan, conduct and review assessments for other staff. It is accepted by management of the ICU that all assessors will not have these qualifications.

Storage of Assessments Documents

Where will the assessments be stored?

- Staff will need to have their assessment records available at all times during the assessment phase. Therefore the individual staff member is responsible for storing this record during this time. Staff will be given a folder with the complete document in it. It is expected that the folder be kept in the individual staff’s locker or the unit’s education cupboard to enable assessment when appropriate clinical situations arise.

Access to Records and Documents

Who will have access to the records of my assessments?

- Individual staff will have the right to access their own records at any time.
- The nominated assessors will also enter information into this record during the active phase of assessment
- On completion the CNE, CNC and NUM will have authority to access the assessment records. This will be arranged via the CNE.

Frequency of Assessments

How often will I have to undergo competency assessment?

- Staff will only have to complete their full competency assessment once.
- Once this process is completed there will be an annual revision of three individual competencies. The individual and the NUM will identify these competencies during performance appraisal.
- As new equipment and procedures/practice guidelines are introduced into the Critical Care Unit staff may be required to undergo an associated competency assessment.
Comprehensive Competency Assessments

- Competencies will only be undertaken within your clinical workload in coordination with your resource person ensuring patient care is not compromised.
- Where difficulties are encountered in achieving these competencies discussion should be sought with the NUM, CNC or CNE as soon as possible to arrange alternatives / additional support.
- Core competencies are to be successfully completed within three months of commencement.

CLINICAL PERFORMANCE ASSESSMENT TOOL (CPAT)

INTRODUCTION

The Australian College of Critical Care Nurses (ACCCN) has identified key clinical criteria for a Clinical Performance Assessment Tool (CPAT).

RATING SYSTEM AND ASSESSMENT

The evaluation system is based on a modified Bondy scale of 1-5, with 5 being the highest achievable grading.

The assessment will incorporate five major areas:

1. Safety
2. Assessment
3. Planning
4. Implementation of the Care Plan
5. Evaluation

A staff member who is deemed to be a competent practitioner will incorporate the following abilities throughout the assessment:

- Demonstrate a sound level of knowledge commensurate with the level of experience;
- Demonstrate a competent level of clinical practice commensurate with the level of experience;
- Demonstrate the ability to integrate knowledge with clinical practice;
- Demonstrate the ability to justify clinical practice based on research;
- Demonstrate the ability to constantly evaluate the patient’s response; and
- Practice within the guidelines of the Workplace Health and Safety, Infection Control and Policy & Procedure Guidelines of the employing institution.

ASSESSMENT GUIDELINES

1. SAFETY 1,6,9,11,12,13,14,18,

Performs a safety check of the bedside at the commencement of each shift

- Checks all emergency equipment. This includes the re-breathing bag and suction equipment - operational and within easy access.
- Appropriately sets the alarm parameters on monitors and any other equipment.
- Checks the ventilator settings with the written orders, checks and appropriately sets the alarm parameters and apnoea settings (if appropriate)
- Checks the orders for intravenous infusions against the fluids currently infusing.
- Demonstrates the knowledge of evacuation procedure for the unit.
• Ensures that the floor is clear of fluid spills, all electrical cords are off the floor or secured to avoid tripping and there are no obstacles in case of the need for emergency access to the bedside.
• Demonstrates knowledge of location and use of the Emergency Resuscitation Trolley.

2. ASSESSMENT 1,2,3,4,6,8,11,12,13,14.
Performs a comprehensive physical assessment of the patient using a Systems Approach.
• Utilises other information related to the patient’s condition e.g.
  - Biochemistry, ABG, Haematology, Microbiology.
  - Chest and any other X-rays, CT/MRI scans.
  - History: the patient’s oral history if possible, information obtained from the patient’s Unit Record, patient’s family members, information given at Nursing Handover.
• Documents Physical Assessment as a baseline for the shift.
• Is able to interpret the data collected and directly relate it to the patient’s clinical condition.
• Is able to differentiate between normal and abnormal findings.
• Reports any relevant abnormal findings to the Team Leader and/or Medical Officer

3. PLANNING 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17.
Formulates an individualised Plan of Nursing Care incorporating the following:
• Includes the patient in the formulation of the Plan of care if possible.
• Uses assessment data as a basis for the Plan.
• Formulates a predicted outcome.
• Takes into account any specific uniqueness of the patient that may impact on patient care e.g. religious and cultural beliefs.
• Identifies potential problems that may adversely affect the patient.
• Identifies nursing interventions to address potential problems. Provides rationale.
• Anticipates changes that may be required e.g. titration of inotropes or ventilation changes and provides the rationale for same.
• Contributes to and participates in decision making on the ward round.
• Includes other members of the Health Care Team e.g. Physiotherapist, Social Worker, Dietitian, Stomal Therapist or Occupational Therapist.
• Structures nursing interventions / activities to enable the patient to have rest periods.
• Formulates criteria for evaluation of predicted outcomes.
• Recognises own abilities and incorporates other nursing staff to assist or provide guidance if necessary.

4. IMPLEMENTING THE PLAN OF CARE 1,2,3,4,5,6,7,9,10,11,12,13,14,16,17,18,20.
Implements care for the patient in an effective and efficient manner
• Manages therapeutic interventions
• Demonstrates accountability for own actions at all times.
• Communicates with the patient before commencing any nursing interventions.
• Constantly monitors for changes in the patient’s condition.
• Responds effectively to any changes. Able to give rationale for response.
• Alters parameters of equipment as required e.g. infusion rates, ventilator and monitor alarms.
• Utilises other team members as identified in the planning stage.
- Demonstrates knowledge of pharmacology relating to sedation, muscle relaxants and other drug therapies for the patient.
- Demonstrates efficient and effective use of material and human resources.
- Completes correct, precise documentation of all aspects of care.
- Involves family members in the patient’s care if applicable.
- Communicates and supports the patient’s family members / significant others.
- Reports any deterioration or improvement in the patient’s condition to the Team Leader and/or Medical Officer.
- Enables continuity of care by giving a comprehensive handover to the Team Leader of the current shift and the primary care nurse on the next shift.

5. EVALUATION 1,2,3,4,9,10,11,12,13,14,15,19,20.

Evaluates the response of the patient and the outcome of the Plan of Care
- Evaluates the actual outcome in comparison to the predicted outcome.
- Identifies areas for improvement and provides rationale.
- Documents the actual outcome and the patient’s response to planned care.
- Identifies the need to return to the Planning stage and makes adjustments if necessary.

Evaluates the effectiveness of own practice
- Uses reflective practice and self-appraisal to examine own clinical performance and identify areas of strength and areas for improvement.
- Uses peer appraisal to identify areas of strength and areas for improvement.
- Identifies contingency plan to assist in the correction of any areas for improvement and to enhance self-professional development.
### Critical Care Competencies
#### MODIFIED BONDY SCORE REFERENCE SHEET

<table>
<thead>
<tr>
<th>Performance Skills</th>
<th>Knowledge</th>
<th>Communication</th>
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</thead>
<tbody>
<tr>
<td><strong>INDEPENDENT</strong></td>
<td></td>
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<tr>
<td>• Demonstrates safe clinical practice each time observed, while functioning within the hospital’s guidelines for Policy &amp; Procedures, Workplace Health &amp; Safety and Infection Control</td>
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<tr>
<td>• Functions as an independent practitioner with no supportive or directive cues</td>
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<td>• Demonstrates effective time management with no wasted energy</td>
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<tr>
<td>• Demonstrates a high level of proficient &amp; coordinated clinical practice</td>
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<td>• Consistently uses theoretical knowledge to validate clinical practice.</td>
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<td>• Demonstrates awareness of research to validate clinical practice.</td>
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<tr>
<td>Consistently communicates effectively by:</td>
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<tr>
<td>• Focusing on the client</td>
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<tr>
<td>• Using therapeutic touch</td>
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<tr>
<td>• Awareness/use of alternate means of communication</td>
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<tr>
<td>• Using listening skills when interacting with the patient and family</td>
<td></td>
<td></td>
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<tr>
<td>• Clarifying information where necessary</td>
<td></td>
<td></td>
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<tr>
<td>• Interacting effectively with all members of the health care team</td>
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</table>

| **SUPERVISED**     |           |               |
| • Demonstrates safe clinical practice each time observed, while functioning within the hospital’s guidelines for Policy & Procedures, Workplace Health & Safety and Infection Control |
| • Functions as an independent practitioner with no supportive but some directive cues |
| • Demonstrates effective time management with little evidence of wasted energy. |
| • Demonstrates a sound level of proficient & coordinated clinical practice |
| • Often uses theoretical knowledge to validate clinical practice. |
| • Demonstrates some awareness of research to validate clinical practice. |
| Often communicates effectively by: |
| • Focusing on the client |
| • Using therapeutic touch |
| • Awareness/use of alternate means of communication |
| • Using listening skills when interacting with the patient and family |
| • Clarifying information where necessary |
| • Interacting effectively with all members of the health care team |

<p>| <strong>ASSISTED</strong>        |           |               |
| • Demonstrates safe clinical practice each time observed, while functioning within the hospital’s guidelines for Policy &amp; Procedures, Workplace Health &amp; Safety and Infection Control |
| • Functions as an independent practitioner but requires occasional supportive and directive cues. |
| • Demonstrates effective time management with frequent evidence of wasted energy. |
| • Requires assistance to achieve a sound level of proficient &amp; coordinated clinical practice |
| • Occasionally uses theoretical knowledge to validate clinical practice. |
| • Demonstrates some awareness of research to validate clinical practice. |
| Occasionally communicates effectively by: |
| • Focusing on the client |
| • Using therapeutic touch. |
| • Awareness/use of alternate means of communication |
| • Using listening skills when interacting with the patient and family |
| • Clarifying information where necessary |
| • Interacting effectively with all members of the health care team |</p>
<table>
<thead>
<tr>
<th>PERFORMANCE SKILLS</th>
<th>KNOWLEDGE</th>
<th>COMMUNICATION</th>
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</thead>
<tbody>
<tr>
<td><strong>MARGINAL</strong></td>
<td><strong>Seldom uses theoretical knowledge to validate clinical practice.</strong></td>
<td>Seldom communicates effectively by:</td>
</tr>
<tr>
<td>• Demonstrates safe clinical practice under supervision while functioning within the hospital’s guidelines for Policy &amp; Procedures, Workplace Health &amp; Safety and Infection Control</td>
<td>• Demonstrates limited awareness of research to validate clinical practice.</td>
<td>• Focusing on the client</td>
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<tr>
<td>• Limited ability to function as an independent practitioner, requires frequent supportive and directive cues</td>
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<td>• Using therapeutic touch</td>
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<tr>
<td>• Demonstrates little evidence of effective time management with evidence of wasted energy.</td>
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<td>• Awareness/use of alternate means of communication</td>
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<td>• Demonstrates a limited level of proficient &amp; coordinated clinical practice</td>
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<td>• Using listening skills when interacting with the patient and family</td>
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<tr>
<td><strong>DEPENDENT</strong></td>
<td><strong>No evidence of theoretical knowledge to validate clinical practice.</strong></td>
<td>Never communicates effectively by:</td>
</tr>
<tr>
<td>• Unable to demonstrate safe clinical practice. Does not function within the hospital’s guidelines for Policy &amp; Procedures, Workplace Health &amp; Safety and Infection Control</td>
<td>• No evidence of awareness of research to validate clinical practice.</td>
<td>• Focusing on the client</td>
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<tr>
<td>• Unable to function as an independent practitioner, requires continuous supportive and directive cues</td>
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<td>• Using therapeutic touch</td>
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<td>• Demonstrates no evidence of effective time management with evidence of wasted energy.</td>
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<td>• Awareness/use of alternate means of communication</td>
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<tr>
<td>• Is unable to perform at a basic level of proficient &amp; coordinated clinical practice</td>
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<td>• Using listening skills when interacting with the patient and family</td>
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</table>

For references see reference list *
### Critical Care Competencies
#### Clinical Performance Assessment Tool (CPAT)

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<td>Safety</td>
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<td>Implementation</td>
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<td>Evaluation</td>
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**Candidates Comments:**

**Assessor Comments:**

**Candidates Signature:** _____________________________  **Assessor Signature:** _____________________________
# Lismore Base Critical Care Core Competencies

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<th>Date Achieved</th>
<th>Assessor Signature</th>
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<td>12-Lead ECG and Interpretation</td>
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<td>Arterial Blood Gas Machine</td>
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<td>Central venous catheters</td>
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<td>Managing continuous infusions of drugs</td>
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<td>Removal of pleural drains</td>
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<td>Non invasive ventilation CPAP - CF800</td>
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<td>PiCCO catheters management and monitoring</td>
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<td>Synchronized Cardioversion</td>
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<td>Transoesophageal Echocardiogram (T.O.E)</td>
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<td>CRRT</td>
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## Critical Care Competencies

**Demonstrates competence in:** PHYSICAL ASSESSMENT

- **Statement of performance criteria:** MBS = Modified Bondy Score
- **Procedure or policy components:** I = Independent, A = Assisted

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
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</table>
| 1. Safe environment established               | - Checks and adjusts safe working and patient environment.  
  - Emergency ventilation bag attached to high flow O₂ and checked according to unit guidelines ready for use  
  - Suction equipment correctly assembled, tested and ready for use with yankauer sucker or in-line suction catheter attached  
  - Bed rails raised (unless GCS 15 and patient cooperative)  
  - Patient identification band present with correct information  
  - Ventilator/BiPAP connected to uninterrupted power supply (UPS)  
  - Safe alarm settings on monitor (and ventilation equipment) at 10% above and below patients parameters  
  - Current / updated manual handling, pressure area assessment and APACHE data forms  
  - PC powered up and logged into EMR  
  - Unobstructed working area.                                                                                                                                  |     |                         |
| 2. Patients past and present bio-psychosocial history reviewed | - Outline patient history, incorporating the following:  
  - Patient hospital presentation, signs and symptoms  
  - Presenting diagnosis, including diagnostic findings  
  - Current working diagnosis, including problems currently being treated  
  - Relevant past medical history  
  - Identified psychosocial needs (identified coping / situation, family support and perception of current situation)  
  - Identified needs of relatives / significant others.                                                                                                         |     |                         |
| 3. Patient Prepared for Physical Assessment.   | - Provided an explanation to the patient and family.  
  - Demonstrated an ability to utilise a systematic approach and adapt to unexpected events.  
  - Position patient for each section of the assessment.  
  - Privacy and dignity of patient maintained throughout procedure.                                                                                           |     |                         |
## Critical Care Competencies

### Demonstrate competence in: PHYSICAL ASSESSMENT CONTINUED

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
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<th>Further Action Required</th>
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</table>
| **4. Patients Neurological Status assessed** | ❖ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings.  
❖ Documented patients neurological assessment using Glasgow Coma Scale.  
❖ Eyes (4), verbal (5) and motor (6) responses documented separately.  
❖ Inspected and discussed the relevance of pupil size with use of torch.  
❖ Assess pupil size, equality, reaction to light and consensual reflex  
❖ Identifies possible reasons for size and reaction changes.  
❖ Neuromuscular function assessed.  
❖ Strength testing each limb separately, and together.  
❖ Assesses and records sensory responses, testing each limb separately.  
❖ Patient’s attitude, affect, mood and appropriateness of response and delirium are assessed.  
❖ Asses non speaking patients with the CAM ICU  
❖ Assessed verbal responses by questioning both short and long term memory  
❖ Listened for quality, quantity, and organisation of speech and thought  
❖ Listened for relevance and organisation of thoughts.  
❖ Assesses pain and sedation scores according to unit assessment scoring systems  
❖ Measures temperature  
❖ Identify and discuss neurological interventions and their effect | I | A |
| **5. Patients Respiratory status assessed** | ❖ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings.  
❖ Inspects:  
❖ Anatomy of chest wall (e.g. barrel chest)  
❖ Symmetrical chest wall movement  
❖ Breathing pattern and work of breathing  
❖ Skin, mucosal membranes for colour and moisture.  
❖ Tracheal position.  
❖ Identify size and length of endotracheal tube (ETT) at teeth/gums or size of tracheostomy tube  
❖ ETT / Tracheostomy cuff pressure  
❖ Auscultates lung fields systematically:  
❖ Describe air entry and breath sounds findings and anomalies (e.g. R=L, added sounds)  
❖ Palpates neck and thorax systematically:  
❖ Describe and discuss findings and anomalies (e.g. subcutaneous emphysema)  
❖ Percusses chest wall systematically:  
❖ Describe and discuss findings and anomalies (e.g. tympany) | | |
<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 5. Patients Respiratory status assessed continued | ❖ Review and discuss investigative data  
❖ SpO₂ monitoring  
❖ Identify normal values for arterial blood gases and findings where taken  
❖ Identify the carina and ETT tip on chest x-ray  
❖ ETCO₂ monitoring  
❖ Identify and discuss respiratory interventions and their effect (e.g ventilation / O₂ therapy) | | |
| 6. Patients Cardiovascular status assessed | ❖ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings.  
❖ Inspects:  
❖ Skin colour, capillary return, warmth, moisture, diaphoresis, turgor  
❖ Peripheral / sacral oedema  
❖ Auscultates heart sounds:  
❖ Describes S₁, S₂ and any additional sounds  
❖ Palpates pulses:  
❖ Peripheral (e.g pedal, radial) and central (e.g femoral, carotid)  
❖ Reviews investigative data  
❖ Describe and discuss systematic review of vital signs (e.g. HR, BP, Temp)  
❖ Describe and discuss systematic review of rhythm strip  
❖ Describe and discuss systematic review of 12-lead ECG  
❖ Describe and discuss Haematology findings  
❖ Describe and discuss Biochemistry findings  
❖ Describe and discuss fluid status  
❖ Describe and discuss haemodynamic pressures (if monitoring in place)  
❖ Identifies patient weight (actual or estimated)  
❖ Identifies and discusses supportive therapies (e.g continuous vasoactive infusions) | | |
## Critical Care Competencies

### PHYSICAL ASSESSMENT CONTINUED

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>7. Patients Gastrointestinal system assessed</td>
<td>✅ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings. ✅ Inspects abdomen: ◆ Describe and discuss findings and anomalies (bruising, distension, wounds) ✅ Auscultates abdomen systematically: ◆ Describe four quadrants ◆ Describe bowel sound frequency and quality ✅ Palpates abdomen: ◆ Describe and discuss findings and anomalies (eg guarding, distension, tenderness) ✅ Percusses abdomen: ◆ Describes areas of density variation and discusses findings ✅ Reviews patient’s gastric intake and losses. ✅ Reviews patient’s bowel activity including stool frequency and quality. ✅ Reviews investigative data ✅ Describes and discuss pathology findings</td>
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</tr>
<tr>
<td>8. Patients Genito-urinary status assessed</td>
<td>✅ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings. ✅ Reviews and discusses fluid balance and urine specifications ◆ Amount and frequency of urine ◆ Urine consistency including urinalysis where indicated, colour and sedimentation ✅ Inspects genitalia: ◆ Describes and discusses findings and anomalies including discharge and menses</td>
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</table>
### Critical Care Competencies

**Demonstrates competence in: PHYSICAL ASSESSMENT CONTINUED**

<table>
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</thead>
</table>
| 9. Patients Integumentary system assessed | ❖ Identified underlying pathophysiology, disease processes and/or injury that may result in abnormal findings.  
❖ Inspects patients skin condition:  
❖ Describes and discusses any wounds and their management  
❖ Identifies drainage sites, amount and consistency of drainage  
❖ Identifies and discusses pressure area wounds size, location and management.  
❖ Ensures appropriate paper work (wound or pressure area chart) is attended and up to date  
❖ Identifies intravascular lines, drains and catheters ensuring all are adequately secured, functional and site inspected.  
❖ Describes and discusses management of pressure area relief | I A | ☐ |
❖ Interventions planned to address assessment findings.  
❖ Evaluations of interventions. | ☐ | ☐ |

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** _______________________ **Date:** __________ **Candidates Signature:** _______________________ **Date:** __________
**Critical Care Competencies**

**Demonstrates competence in:** 12-LEAD ECG RECORDING and INTERPRETATION

- Statement of performance criteria  MBS = Modified Bondy Score
- Procedure or policy components  I = Independent, A = Assisted

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</thead>
</table>
| 1. Patient assessed to determine the need for 12-lead ECG performance | - Identifies and discusses indications for 12-lead ECG performance e.g.  
  - Rhythm changes  
  - Chest pain  
  - Pre/post-operative  
  - Serial investigations | I   |                         |
| 2. Quality 12-lead ECG obtained | - Attends to 12-lead ECG in accordance with clinical practice guidelines.  
  - Identifies anatomical landmarks for correct lead placement.  
  - Ensures baseline drift minimised.  
  - Ensures all 12 leads recorded. | I   |                         |
| 3. Interprets and notifies findings | - Identifies and discusses the following:  
  - Rhythm interpretation and process  
  - ECG changes reflecting actual / potential ischaemia, injury and infarction.  
  - Initiates nursing interventions in response to 12-lead ECG findings.  
  - Identifies findings that require Medical review / intervention. | I   |                         |
| 4. Documents | - Accurately documents relevant information regarding 12-lead ECG.  
  - Labels 12-lead ECG adequately.  
  - Date and time of performance  
  - Patient identification  
  - Reason for performance.  
  - Demonstrates an awareness of legal implications pertaining to documentation | I   |                         |

**Assessment Decision:**  □ Independent  □ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

Assessors Signature: ____________________ Date: ___________ Candidates Signature: ____________________ Date: ___________
**Critical Care Competencies**

**Competency:**

<table>
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</table>
| 1. Patient assessed to determine the need for arterial monitoring | - Identified indications for arterial line insertion.  
  - Close monitoring of haemodynamics  
  - Regular arterial blood specimens.  
  - Identified potential insertion sites and explained the benefits and limitations of each.  
  - Radial, Brachial, Pedal, Femoral or axilla.  
  - Identifies the components and principles of transducer pressure monitoring systems. | I   | A   | |
| 2. Maintained accuracy of arterial monitoring and troubleshooting | - Checked arterial monitoring is set up and connected as per unit protocol.  
  - Identifies and ensures the correct placement for transducer.  
  - Discussed the importance of maintaining correct positioning and zeroing of the transducer.  
  - Fast flush test / square wave assessment.  
  - Identified normal range and waveform of arterial monitoring.  
  - Outlined potential causes of a changed waveform.  
  - Explained the nursing management of a changed waveform.  
  - Re-zero; check line, flush line, redress, reposition, use of arm board (if required).  
  - Explained and demonstrated setting of appropriate alarm limits.  
  - Discussed alternative methods of blood pressure monitoring and identified indications for use. | I   | A   | |
| 3. Potential complications of arterial monitoring explained | - Identified potential complications of arterial pressure monitoring including:  
  - Haemorrhage  
  - Infection  
  - Disruption to distal circulation  
  - Reduced patency including cannula obstruction, vessel embolisation, vasospasm  
  - Unplanned removal  
  - Measurement inaccuracy (e.g. over dampening / under dampening).  
  -Outlined proactive nursing interventions to prevent complications from occurring. | I   | A   | |
## Critical Care Competencies

### Demonstrates competence in: ARTERIAL CATHETERS

<table>
<thead>
<tr>
<th>Elements of Competency</th>
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</table>
| 4. Performed arterial line dressing | ❖ Assessed patient for need of arterial line dressing outlined by unit protocol.  
❖ Gathered equipment to dress insertion site and change lines following infection control standards.  
❖ Maintains safe environment in the delivery of care.  
❖ Performed dressing and line change maintaining infection control standards.  
❖ Disposed of contaminated equipment correctly. | | |
| 5. Performs arterial blood sampling and identifies potential complications | ❖ Patient is assessed to determine the need for blood sampling.  
❖ Pathology blood specimen required (routine / change of condition)  
❖ Arterial blood gas required (routine / change of condition).  
❖ Demonstrated safe blood sampling following OH & S and Infection Control guidelines.  
❖ Re-establishes effective haemodynamic monitoring.  
❖ Identified potential complication of blood sampling.  
❖ Disposed of contaminated equipment correctly. | | |
| 6. Analyses and interprets blood results | ❖ Systematically analysed and interpreted blood results.  
❖ Identifies normal ranges  
❖ Discusses findings with appropriate staff and implements appropriate changes to care. | | |
| 7. Proficient management of sample | ❖ Utilises PPE  
❖ Patient is assessed to determine the need for blood sampling.  
❖ Pathology blood specimen required (routine / change of condition).  
❖ Consider minimum blood volumes required for requested test.  
❖ Ensures ABG sample processed by competent staff member in ICU | | |
| 8. Documents | ❖ Accurately documents relevant information regarding care and management of arterial line.  
❖ Demonstrates an awareness of legal implications pertaining to documentation | | |

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

Assessors Signature: ___________ Date: ___________ Candidates Signature: _______________ Date: ___________
## Critical Care Competencies

**Demonstrates competence in:** The Use of the Arterial Blood Gas Machine

- **Statement of performance criteria**
  - MBS = Modified Bondy Score
- **Procedure or policy components**
  - I = Independent, A = Assisted

<table>
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</table>
| 1. Shows proficiency and safety in Obtaining and transport of sample | ✤ Identifies correct equipment required.  
  ◦ Appropriate use of PPE.  
  ◦ Self-filling pre heparinised arterial syringe.  
  ✤ Explains correct use of self-filling pre heparinised arterial syringe.  
  ◦ Retract plunger of syringe for passive arterial collection. Closed plunger, rear-cap syringe - for active venous collection.  
  ◦ Collect a minimum 0.3 mL (prefer 0.5mL) to allow for 0.1mL discard  
  ◦ Expel any air and cap syringe. (Remove needle using blue safety square).  
  ✤ Describes correct method for transport of specimen,  
  ◦ Invert and Roll sample between fingers repeatedly to mix heparin  
  ◦ Need for storage in ice slurry if expecting processing delay of greater than 20min.  
  *NB: Ice slurry contraindicated for use with Istat | | |
| | | | |
  ◦ Explains requirement for PIN number/ bar code swipe entry.  
  ◦ Describes how to touch the red Hand icon to interrupt machine self-maintenance if urgent.  
  ◦ Identifies that membrane lights all green means machine is functional.  
  ✤ Demonstrates sample entry requirements  
  ◦ Expel 0.1mL blood into tissue to check for clotting (if so discard sample)  
  ◦ Draw back plunger so blood is at hub to prevent overflow  
  ◦ Lift sampling door port.  
  ◦ Attach syringe and allow passive sampling by machine.  
  ◦ Select Blood gas or K+ only.  
  ◦ Enter Patient MRN as minimum details.  
  ◦ Select Arterial, or Venous. (defaults to Arterial)  
  ◦ Remove syringe as machine indicates and close sampling door.  
  ◦ Discard syringe and tissue into clinical waste bin.  
  ◦ Newborns are entered under MRN provided. Unknown person MRN is 999999  
  ◦ Logout after use.  
  ◦ Printed results to be logged with Patient notes until formal result available. | | |
## Critical Care Competencies

### Demonstrates competence in: The Use of the Arterial Blood Gas Machine

<table>
<thead>
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</thead>
</table>
| 3. Understands and Interprets messages | ❖ Demonstrates or discussed appropriate response to sample error messages  
   ♦ Remix sample, check sample for clots, re-enter sample.  
   ♦ Collect new sample.  
   ♦ Activate 1 or 2 point calibration.  
   ♦ Activate "cleaning" function. (Especially if clot seen in membranes).  
   ♦ Contact ICU TL or Pathology for further assistance. | I | |
| 4. Identifies and understands correction of errors | ❖ Demonstrates method of correcting errors in data entry.  
   ♦ Enter Data Log- patient result Log- results-ID. Change required field and reprint.  
   ♦ Discuss when error correction form is required to be completed  
   ♦ Discuss implications of using MRN 999999 | I | |
| 5. Demonstrates Machine Maintenance | ❖ Demonstrate or discuss correct Change of Paper and Waste/Rinse bottles procedure.  
   ♦ Open paper trap. Release used paper roll, insert new paper roll and re-clamp.  
   ♦ Remove cover. Remove empty rinse bottle. Barcode read new rinse bottle and connect to machine.  
   ♦ Remove cover. Remove old waste bottle- cap and discard into clinical waste. Connect new waste bottle.  
   ♦ Contact ICU TL or Pathology for unresolved concerns. | I | |

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ___________________________ Date: ___________ **Candidates Signature:** ___________________________ Date: ___________
### Critical Care Competencies

**Demonstrates competence in managing CENTRAL VENOUS CATHETERS**

<table>
<thead>
<tr>
<th>Elements of Competency</th>
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</thead>
</table>
| 1. Patient assessed to determine the need for central venous catheter monitoring | - Identified indications for CVC insertion.  
- Central venous pressure monitoring  
- Medication delivery  
- Fluid delivery  
- Unobtainable peripheral access.  
- In conjunction with PICCO  
- Identified potential insertions sites and explained the benefits and limitations of each.  
- Subclavian, Internal jugular, Femoral, Brachial.  
- Identified and explained the factors that influence central venous pressure monitoring.  
- Fluid status, haemodynamic status, ventilation, patient position, transducer position.  
- Identifies normal values for CVP | | |
| 2. Maintained accuracy of central venous catheter monitoring | - Checked central venous monitoring is set up and connected as per unit protocol.  
- Identified the phlebostatic axis and places the transducer correctly as per unit protocol.  
- 4th intercostal space mid-axilla / thorax.  
- Discussed the importance of maintaining correct positioning and zeroing of the transducer.  
- Fast flush test / square wave assessment.  
- Identified normal range and waveform of central venous monitoring.  
- Outlined potential causes of a changed waveform.  
- Explained the nursing management of a changed waveform.  
- Check for infusions through pressure line  
- Re-zero, check line pressure and connections, catheter placement and dressing (i.e. kinked line or line displacement)  
- Explained and demonstrated setting appropriate alarm limits.  
- Responds appropriately to changes in central venous pressure monitoring. | | |
<table>
<thead>
<tr>
<th>Demonstrates competence in managing</th>
<th>CENTRAL VENOUS CATHETERS</th>
</tr>
</thead>
</table>
| 3. Potential complications of central venous catheter explained | Identified potential complications of central venous catheter including:  
  - Malpositioning/ unplanned removal  
  - Haemorrhage  
  - Infection  
  - Pneumothorax / tension pneumothorax  
  - Blockage / clotting / embolus / air embolus  
  - Arrhythmias  
  - Measurement inaccuracy (e.g. dampening / over reading / shooting).  
  - Outlined nursing interventions to prevent complications. |
| 4. Performed central venous dressing | Assessed patient for need of central venous dressing as outlined by unit protocol.  
  - Gathered equipment to dress insertion site and change lines  
  - Maintains safe environment in the delivery of care.  
  - Performed dressing and line changes maintaining infection control standards.  
  - Disposed of contaminated equipment correctly. |
| 5. Performs venous blood sampling and identifies potential complications | Patient is assessed to determine the need for blood sampling.  
  - Pathology blood specimen required (routine / change of condition).  
  - Demonstrated safe blood sampling following WHS and Infection Control CPG  
  - Ensure adequate pre-sample aspiration and post sample flush.  
  - Re-establishes effective central venous pressure monitoring.  
  - Identified potential complication of blood sampling.  
  - Disposed of contaminated equipment correctly. |
| 6. Performs safe removal of the CVC and identifies potential complications | Order for removal of CVC is confirmed  
  - Patient is assessed to determine ability to follow instruction - inhale, hold breath etc. and to be positioned supine / head down  
  - Assembles appropriate equipment as per relevant CPG  
  - Performs 5 moments of hand hygiene during procedure  
  - Removes CVC safely as per CPG instructions  
  - Discusses and observes for potential CVC complications and management of these |
| 7. Documents | Accurately documents relevant information regarding care and management of central venous pressure monitoring.  
  - Demonstrates an awareness of legal implications pertaining to documentation, |

Assessment Decision: □ Independent □ Assisted

Further Action/Training Required & Details of Feedback to Candidate:

Details of Feedback from Candidate:

Assessors Signature: __________________ Date: __________ Candidates Signature: __________________ Date: __________
## Critical Care Competencies

### Demonstrates competence in: MANAGING CONTINUOUS INFUSIONS OF DRUGS

- **Statement of performance criteria**
  - MBS = Modified Bondy Score
- **Procedure or policy components**
  - I = Independent, A = Assisted

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<thead>
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</table>
| 1. Safe environment for infusions of drugs | Identifies general principles in relation to safe management of infusions of drugs in Critical Care  
- Infusions must be changed every 24 hours  
- Identifies drugs that have shorter expiry time (e.g. Propofol, Perfalgan)  
- All infusions to be checked and signed by two RN's  
- Type of infusion solutions and sets must be suitable for drug infused (refer to drug infusion protocols)  
- All infusions must be delivered by volumetric pump or syringe driver and correctly labelled  
- Identifies correct methods of disposal of infusions when completed | | |
| 2. Provides safe and effective nursing care for a patient receiving an infusion of Vasoactive drugs | Identifies the actions indications, precautions and preparation guidelines of each of the following vasoactive drugs.  
- Adrenaline  
- Noradrenaline  
- Dobutamine.  
- Dopamine  
- Metaraminol  
- Vasopressin  
- Isoprenaline  
- Levosimendan  
- GTN  
- Recognises the importance of administering Alpha 1 receptor adrenergic receptor agonists via a central line. | | |
| 3. Provides safe and effective nursing management for patients receiving sedatives / analgesic agents used in the participants ICU | Identifies the actions indications, precautions and preparation guidelines of each of the following analgesic/ sedation agents.  
- Morphine  
- Midazolam  
- Propofol  
- Ketamine  
- Fentanyl  
- Oxycodone  
- Dexmedetomidine  
- Demonstrates the ability to perform a nursing assessment assessing the effectiveness of sedation / analgesic agents in the intensive care / high dependency patient.  
- Using sedation protocol (e.g. MAAS) and pain scoring tools. | | |
## Critical Care Competencies

### MANAGING CONTINUOUS INFUSIONS OF DRUGS

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</table>
| 4. Provides safe and effective nursing management for a patient receiving muscle relaxants used in the participants ICU | ✗ Identifies the actions indications, precautions and preparation guidelines of each of the following muscle relaxants. And where they are stored  
   ◦ Non depolarising muscle relaxant e.g. Rocuronium  
   ◦ Depolarising muscle relaxant e.g. Suxamethonium  
   ✗ Recognises the need for sedation/analgesia in patients receiving muscle relaxants.  
   ✗ Expiry date of drugs once removed from fridge for the Rapid Response trolley | | |
| 5. Provides safe and effective nursing management for a patient receiving continuous or intermittent doses of anti-arrhythmic agents | ✗ Identifies the actions indications, precautions and preparation guidelines of each of the following anti-arrhythmic agents.  
   ◦ Amiodarone  
   ◦ Adenosine  
   ◦ Lignocaine  
   ◦ Beta Blockers | | |
| 6. Documents the procedure performed | ✗ Accurately documents relevant information regarding care and management of continuous infusion.  
   ◦ Additive label correctly completed  
   ◦ Infusion expiry sticker on the infusion bag  
   ◦ Drug lines labeled appropriately as per practice guideline  
   ◦ Drug prescribed on NIMC  
   ◦ Drug infusion hourly amount recorded on flow chart  
   ◦ Awareness of CPG re cessation of infusion and locking of unused CVC lumen  
   ✗ Demonstrates an awareness of legal implications pertaining to documentation | | |

### Assessment Decision: ☐ Independent  ☐ Assisted

### Further Action/Training Required & Details of Feedback to Candidate:

### Details of Feedback from Candidate:

**Assessors Signature:** __________________________  **Date:** __________  **Candidates Signature:** __________________________  **Date:** __________
## Critical Care Competencies

### Demonstrates competence in the use of PHYSICAL RESTRAINTS

<table>
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</table>
| 1. Patient assessed for the need for physical restraints | - Discusses legal issues relating to restraint of patients.  
- Performs delirium score  
- Identified medical order for restraint.  
- Identified the conditions in which restraints may be required.  
  - Confused or agitated patient  
  - Non-compliant patient.  
- Patient regularly assessed for the need to continue restraints as per unit policy. | I |  |
| 2. Restraint types identified | - Analysed various types of restraints.  
- Method of restraint required for patient is determined.  
  - Wrist restraints  
  - Ankle restraints. | I |  |
| 3. Potential complications of physical restraints explained | - Psychological effects of restraints.  
  - Informs patient and relatives/Next of Kin of the reasons for and policy of the use of restraints. Consideration of relative/Next of Kin input.  
- Identified and explained potential complications of physical restraints.  
  - Decreased patient mobility  
  - Can increase patient agitation  
  - Can cause pressure areas if not checked regularly. | I |  |
| 4. Patient closely observed while restraints in place | - Identified responsibilities in monitoring patients.  
  - Regular skin checks assessing for redness, pressure, circulation and swelling  
  - Security of areas restrained. | I |  |
| 5. Documentation of restraints | - Discusses appropriate documentation of restraint in the integrated notes.  
  - E.g Time the restraint is applied, Type of restraint, Skin integrity checks | I |  |

Assessment Decision: □ Independent □ Assisted

Further Action/Training Required & Details of Feedback to Candidate:

Details of Feedback from Candidate:

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</table>
| 1. Proficient Set up of Equipment | Identifies necessary equipment.  
- Use of appropriate of PPE  
- Hotline fluid Warmer.  
- Bottle of distilled water (water for irrigation) for reservoir  
- Hotline tubing set and IVI extension set  
- IV giving set  
Demonstrates correct assembling of equipment  
- Reservoir filled with distilled water to between Hi and Lo marks  
- Power Cord plugged in  
- Hotline tubing prongs fully inserted into side of Hotline with IV tubing upward  
- IV giving set and IV extension set attached to Hotline tubing set. | | |
| 2. Safe management of Hotline. | Demonstrates use of Hotline  
- Water level in reservoir is between Hi and Lo marks.  
- Hotline tubing correctly inserted so front green light comes on when power on.  
- Power switch on.  
- No water out of tubing end identifies intact circuit.  
- IV Giving set then connected to IV port of Hotline tubing and primed to end including IV extension set.  
- Understands the risk from the weight of the tubing and need for securing of IV line | | |
| 3. Ability to understand and response to messages. | Discusses appropriate response to error messages  
- Top Green light means Tubing in correctly and machine functioning.  
- 2nd light red means tubing not inserted correctly. Check insertion.  
- 3rd light red means reservoir level low. Add distilled water.  
- 4th light red means thermostat malfunction. Remove Hotline from Patient and send to maintenance | | |
| 4. Safe disposal of equipment | Demonstrates or discusses appropriate removal and disposal of equipment  
- Machine switched off  
- Hotline IV tubing Clamped  
- Hotline tubing removed from IV giving set and IV extension set  
- Hotline Tubing ends connected together  
- Hotline tubing disposed of into either clinical waste or general waste depending on its use. | | |
Critical Care Competencies

Demonstrates competence in: The Use of the Hotline Fluid Warmer

<table>
<thead>
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<tbody>
<tr>
<td>5. Machine storage and Maintenance</td>
<td>Discusses safe care and maintenance of machine.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>• Hotline water level checked and topped up accordingly</td>
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<tr>
<td></td>
<td>• Hotline orange keeper plug inserted into tubing entry.</td>
<td></td>
<td></td>
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<td></td>
<td>• Hotline Machine wiped over with mild detergent wipes and put in store room.</td>
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<tr>
<td></td>
<td>• Hotline reservoir drained and refilled with distilled water each month</td>
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</tbody>
</table>

Assessment Decision: ☐ Independent ☐ Assisted

Further Action/Training Required & Details of Feedback to Candidate:

Details of Feedback from Candidate:

Assessors Signature: ___________________ Date: _________ Candidates Signature: ___________________ Date: _________
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<tbody>
<tr>
<td>1. Dry seal drain</td>
<td>Indicates criteria for Dry Seal Drain (DSD).</td>
<td></td>
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</tr>
<tr>
<td>Correctly set up</td>
<td>Able to explain concepts for safe care for a patient with an UWSD</td>
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<tr>
<td>Correctly and safely.</td>
<td>Bottle lower than patient</td>
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<td></td>
<td>Correct use of blue slide clamp on Oasis UWSD tubing.</td>
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<tr>
<td></td>
<td>DSD Water level</td>
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<tr>
<td></td>
<td>Required observations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checked equipment is set up and connected safely, as per unit protocol.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical order</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DSD bottle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Water syringe (supplied)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tubing to attach to wall suction canister (if suction required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dressing intact</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Correct position of 2 or 3 way tap if Pleura-cath in use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Applied the</td>
<td>Described the indications for suction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correction amount of</td>
<td>Described the recommended values for suction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>suction.</td>
<td>Described the correct setup for applying suction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connect suction port of DSD via canister to wall suction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dial correct amount of suction on DSD bottle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure orange bellow is visible in compartment E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For an order of suction 19cmH₂O ≤ bellow just need to be visible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For an order of suction 20cmH₂O ≥ bellows must be to the delta mark</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Drainage system</td>
<td>Patient is assessed to determine:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>is maintained.</td>
<td>Respiratory stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drainage system – air, drainage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swing cannot be determined on suction, briefly remove suction for assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>System vented to air if suction is ceased or not required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bottle below chest level</td>
<td></td>
<td></td>
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<tr>
<td>4. Patient is</td>
<td>Ensured system connections remained intact and patent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>observed for potential</td>
<td>Identified strategies to manage complications such as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>complications.</td>
<td>Disconnection</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Blockage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tipping over of DSD bottle</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Critical Care Competencies

### Demonstrates competence in: MANAGEMENT OF PLEURAL DRAINS DRY / SEAL DRAIN

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 5. Change of Drainage bottle. | ❖ Described the indications for changing the bottle.  
❖ Described or performed the procedure for changing the bottle on:  
❖ Ventilated - do not clamp, change during inspiration (or end expiration for PSV)  
❖ Non-ventilated – change during breath-holding and valsalva or end expiration | I A | |
| 6. Accurate observations for safe maintenance of DSD. | ❖ Describes and records the observations of the DSD system accurately  
❖ Site  
❖ Bubbling  
❖ Swing  
❖ Drainage  
❖ Suction. | I | |
| 7. Documents accurately. | ❖ Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol.  
❖ Accurately documents relevant information regarding care and management  
❖ DSD observations documented on DSD observation sheet. | I | |

**Assessment Decision:** ☐ Independent  ☑ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** __________________________ Date: __________ **Candidates Signature:** __________________________ Date: __________
# Critical Care Competencies

## Demonstrates competence in: REMOVAL OF PLEURAL DRAIN

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Describe the indications for removal of chest drains. | Provided a comprehensive rationale and demonstrates understanding of pathophysiological indications for removal of chest drains:  
- Absence of air leak (off suction), swing, drainage.  
- Respiratory improvement.  
Patient is assessed to determine readiness for drain removal following unit protocol:  
- CXR review  
- Documented MO order.  
- Anticoagulation withheld 12 hours prior to I/O or R/O ICC | | |
| 2. Procedure is explained and the patient is prepared for drain removal. | Implemented strategies to assess patient's understanding of and involvement in intended procedure:  
- Ascertains that patient can hold a breath and perform valsalva.  
- Assessed patient's requirements for analgesia prior to performing procedure. | | |
Identified and obtains resources for dressing as per unit protocol. | | |
| 4. Chest drains are removed safely. | Explained and demonstrated knowledge of the technique to prevent air entering the pleural space when removing chest drain.  
Removed drain maintaining aseptic principles and following unit protocol:  
- Disconnects suction.  
- Remove or un-tie suture (purse string) if present.  
- Removal of drain with continuous motion. Non-Ventilated -with patient holding breath or end expiration. Ventilated - inspiration or end expiration for PSV.  
- Grasp skin edges together.  
- Re-tie purse string or Pinch skin for approx one minute. Then apply steri-strips, vas-gauze and occlusive dressing.  
- Ensure airtight seal to site is maintained. | | |

Note:  
- MBS = Modified Bondy Score  
- Procedure or policy components:  
  - I = Independent, A = Assisted
## Critical Care Competencies

### Demonstrates competence in: REMOVAL OF PLEURAL DRAIN CONTINUED

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 5. Patient observations/parameters are within safe limits post drain removal. | ♦ Describes and observes patient’s respiratory effort and function  
♦ Assess air-entry, respiratory rate, chest expansion and respiratory muscles, $	ext{SaO}_2$, Pain assessment.  
♦ Assess site for bleeding, intact dressing.  
♦ Assessed repeat chest x-ray post removal. | | |
| 6. Documents accurately. | ♦ Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol.  
♦ Accurately documents relevant information regarding care and management in patient notes and on flow chart.  
♦ Time of removal of chest drains  
♦ Condition of Wound  
♦ Patient respiratory assessment. | | |

**Assessment Decision:** □ Independent □ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ______________________ Date: ___________ **Candidates Signature:** ______________________ Date: ___________
## Critical Care Competencies

**Demonstrates competence in: HIGH FLOW NASAL CPAP**

- Statement of performance criteria: MBS = Modified Bondy Score
- Procedure or policy components: I = Independent, A = Assisted

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>Elements Achieved</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Assessment of patients ventilation requirements | - Performed a respiratory physical assessment  
- Ensures that the patient is suitable for High flow nasal (CPAP):  
  - Pathological process  
  - Arterial blood gases/ SpO2  
  - Patient respiratory rate  
  - Level of consciousness  
  - Respiratory effort.  
- Assesses for contraindications:  
  - Non-compliant patient  
  - Inadequate spontaneous breathing  
  - Unable to clear secretions  
  - Unable to maintain patent airway  
  - Acute sinusitis  
  - Nasal/nose injuries | Yes | No |
| 2. Identifies and assembles appropriate equipment | - Provided a rationale for the selected non-invasive ventilation mode;  
  - HFN (CPAP)  
- Assembled HFN (O2) circuit correctly as per CPG, ensuring infection control standards are met.  
  - Assembles and connects circuit appropriately: Tubing, bacterial filter, heating wire, temp probe and fluid bag. | Yes | No |
| 3. Configures machine and sets ventilation parameters effectively | - Checked HFN (CPAP) set up and connected as per unit protocol, ensuring infection control standards are met:  
  - Sets and checks parameters/settings  
  - Calibrates O2 sensor  
  - Sets appropriate alarm.  
  - Ensures temp probe is wiped down with tuffie 5.  
- Described assessment of ventilation parameters, including:  
  - High flow air settings  
  - FiO2 settings  
  - Respiratory rate  
  - Air and Oxygen flow rates. | Yes | No |
### Critical Care Competencies

**Demonstrates competence in: HIGH FLOW NASAL CPAP**

| 4. Patient assessed for adequate safe ventilation commencement maintenance | ❖ Safely commences patient on HFN (CPAP)  
❖ Performed a respiratory physical assessment following commencement of HFN (CPAP)  
❖ Ensured the patient NIV safely by assessing:  
❖ Rise and fall of chest wall including symmetry, auscultate lung fields, patients/ventilator respiratory rate.  
❖ Determine if patient is a CO₂ retainer (Low flow O₂ may be more appropriate)  
❖ Patient respiratory and ventilator observations documented as per CPG including:  
❖ Patient’s haemodynamic and respiratory status  
❖ Patient assessed for ability to tolerate ventilation  
❖ Oral hygiene needs are met.  
❖ Patient position optimised to facilitate ventilation  
❖ Accurately interprets ABG. |
|---|---|
| 5. Potential ventilation emergencies are recognised | ❖ Recognised patient signs and symptoms indicating an emergency situation  
❖ Cyanosis, agitation, excessive sweating, increased respiratory rate/apnoea, inability to maintain airway.  
❖ Identified strategies for dealing with NIV emergencies.  
❖ E.g. Detach patient form NIV and maintain oxygenation.  
❖ Seeks assistance of other staff members. |
| 6. Patient psychological and psychosocial needs are met. | ❖ Promotes as near normal activities of daily living (ADL) i.e. sleep patterns, use of music, reading etc.  
❖ Ensured patient and family receive information/ explanations of the patients care plan/ condition and are involved where appropriate.  
❖ Ensured patient has access to buzzer |

**Assessment Decision:** ☐ Independent  ☐ Assisted

**Further Action/Training Required and feedback to candidate:**

**Feedback from Candidate:**

**Assessors Signature:_______________ Date:______**  
**Candidates Signature: ________________ Date:______**
### Critical Care Competencies

**Demonstrates competence in:** MANAGEMENT OF CPAP

- **Statement of performance criteria**
  - MBS = Modified Bondy Score
- **Procedure or policy components**
  - I = Independent, A = Assisted

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Assessment of patients ventilation requirements | - Performed a respiratory physical assessment.  
- Ensures that the patient is suitable for CPAP by assessing:  
  - Pathological process  
  - Arterial blood gases / SpO₂  
  - Patient respiratory rate  
  - Level of consciousness  
  - Respiratory effort.  
- Assesses for contraindications:  
  - Non compliant patient  
  - Inadequate spontaneous breathing  
  - Unable to clear secretions  
  - Unable to maintain patent airway  
  - Acute sinusitis  
  - Risk of aspiration of gastric contents  
  - Facial injuries  
  - Profound hypotension. | | |
| 2. Identifies and assembles appropriate equipment | - Provided a rationale for the selected non-invasive ventilation mode;  
  - CPAP  
- Assembled non-invasive ventilator circuit correctly as per CPG ensuring infection control standards are met  
  - Assembles and connects circuit appropriately: tubing, bacterial filter, peep valve, proximal pressure line | | |
| 3. Configures machine and sets ventilation parameters effectively | - Checked CPAP set up and connected as per unit protocol, ensuring infection control standards are met  
  - Plugs into uninterrupted power supply (UPS) and turns machine on  
  - Sets and checks parameters / settings as per medical order  
  - Sets appropriate alarm limits for patient needs.  
- Described assessment of ventilation parameters, including  
  - CPAP settings  
  - FiO₂ settings  
  - Respiratory rate  
  - Air and Oxygen flow rates  
- Described assessment for mask size | | |
## Critical Care Competencies

### Demonstrates competence in: MANAGEMENT OF CPAP

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 4. Patient assessed for adequate safe ventilation commencement and maintenance | - Safely commences patient NIV.  
- Performed a respiratory physical assessment following commencement of NIV.  
- Ensured the patient NIV safely by assessing:  
  - Rise & fall of chest wall including symmetry, auscultate lung fields, patient/ventilator respiratory rate.  
  - Patient respiratory and ventilator observations documented as per CPG, including.  
    - Patient’s haemodynamic and respiratory status  
    - Patient assessed for ability to tolerate ventilation e.g. sedation.  
    - Oral hygiene needs are met.  
- Patient position optimised to facilitate ventilation.  
- Accurately interprets ABG.  
- Demonstrated knowledge of the effect of ventilation on altering blood gas values. | I | A |
| 5. Potential ventilation emergencies are recognised | - Recognised patient signs and symptoms indicating an emergency situation  
  - Cyanosis, agitation, excessive sweating, increased respiratory rate/apnoea, inability to maintain own airway.  
- Identified strategies for dealing with NIV emergencies.  
  - E.g. Detach patient from NIV and maintain oxygenation  
  - Seeks assistance of other staff members | | |
| 6. Patient psychological and psychosocial needs are met | - Promoted as near normal activities of daily living (ADL) i.e. sleep patterns, use of music, reading etc.  
- Ensured patient and family receive information / explanations of the patients care plan / condition and are involved where appropriate.  
- Ensured patient has access to buzzer | | |
| 7. Patient ventilation weaning strategies are identified | - Demonstrated understanding of NIV weaning principles.  
- Usefulness of CPAP for chest physiotherapy post extubation  
- Management plan/goals by medical team reviewed | | |

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

Assessors Signature: __________________ Date: __________ Candidates Signature: __________________ Date: ________
## Critical Care Competencies

**Demonstrates competence in:** MANAGEMENT OF BiPAP

- **Statement of performance criteria**
  - MBS = Modified Bondy Score
- **Procedure or policy components**
  - I = Independent, A = Assisted

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Assessment of patients ventilation requirements | - Performed a respiratory physical assessment.  
- Ensures that the patient is suitable for NIV by assessing:  
  - Pathological process  
  - Arterial blood gases / SpO₂  
  - Patient respiratory rate  
  - Level of consciousness  
  - Respiratory effort.  
- Assesses for contraindications:  
  - Non compliant patient  
  - Inadequate spontaneous breathing  
  - Unable to clear secretions  
  - Unable to maintain patent airway  
  - Acute sinusitis  
  - Risk of aspiration of gastric contents  
  - Facial injuries  
  - Profound hypotension. | | |
| 2. Identifies and assembles appropriate equipment | - Provided a rationale for the selected non-invasive ventilation mode;  
  - BiPAP.  
- Assembled non-invasive ventilator circuit correctly as per hospital protocols ensuring infection control standards are met  
  - Assembles and connects circuit appropriately (connection, bacterial filter, pressure line) | | |
| 3. Patient assessed for adequate safe ventilation commencement and maintenance | - Safely commences patient ventilation.  
- Performed a respiratory physical assessment following commencement of ventilation.  
- Ensured the patient ventilated safely by assessing:  
  - Rise & fall of chest wall including symmetry, auscultate lung fields, tidal volume, patient/ventilator respiratory rate.  
  - Described assessment of ventilation parameters, including  
  - Tidal volume, respiratory rate and alarm settings where available.  
  - Patient respiratory and ventilator observations documented as per unit protocol, including.  
  - Patient’s haemodynamic and respiratory status  
  - Patient assessed for ability to tolerate ventilation e.g. sedation.  
  - Oral hygiene needs are met. | | |
Demonstrates competence in: **MANAGEMENT BiPAP CONT’D**

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.</strong> Patient assessed for adequate safe ventilation commencement and maintenance continued</td>
<td>❖ Patient position optimised to facilitate ventilation. ❖ Accurately interprets ABG. ❖ Demonstrated knowledge of the effect of ventilation on altering blood gas values.</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td><strong>4.</strong> Potential ventilation emergencies are recognised</td>
<td>❖ Recognised patient signs and symptoms indicating an emergency situation  ♦ Cyanosis, agitation, excessive sweating, increased respiratory rate/apnoea, inability to maintain own airway. ❖ Identified strategies for dealing with ventilator emergencies.  ♦ Eg Detach patient from NIV and maintain oxygenation  ♦ Seeks assistance of other staff members</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td><strong>5.</strong> Patient psychological and psychosocial needs are met</td>
<td>❖ Promoted as near normal activities of daily living (ADL) i.e. sleep patterns, use of music, reading etc. ❖ Ensured patient and family receive information / explanations of the patients care plan / condition and are involved where appropriate. ❖ Ensured patient has access to nurse call bell</td>
<td>I</td>
<td>A</td>
</tr>
<tr>
<td><strong>6.</strong> Weaning strategies are identified</td>
<td>❖ Demonstrated understanding of ventilator weaning principles. ❖ Usefulness of BiPAP for chest physiotherapy post extubation ❖ Management plan/goals by medical team reviewed</td>
<td>I</td>
<td>A</td>
</tr>
</tbody>
</table>

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

Assessors Signature: ___________________________ Date: ___________ Candidates Signature: ___________________________ Date: ___________
## Critical Care Competencies

**Competency:**

**Demonstrates competence in** MANAGEMENT OF INVASIVE VENTILATION

- Statement of performance criteria
  - MBS = Modified Bondy Score
- Procedure or policy components
  - I = Independent, A = Assisted

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
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<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Assembles ventilator and circuit | Performs pre use safety checks as per Hospital clinical practice guideline  
- Assembled ventilator circuit correctly as per Unit guidelines, ensuring infection control standards are met  
  - Appropriate PPE  
  - Correct attachment tubing, expiratory valve, Flow sensor, filter, ETT connector, in-line suction device, HME  
  - Attachment to the UPS  
  - Must be left on in standby while not in use to charge internal battery | I | |
| 2. Sets ventilator parameters to meet patients needs | Provided and discussed a rationale for setting various parameters  
  - Tidal volume, respiratory rate, inspiratory time, rise time, trigger, FiO₂, high pressure limit, PEEP, pressure support, apnoea parameters, alarm limits. | A | |
| 3. Patient assessed for adequate safe ventilation | Ensure ETT/Trache secure  
  - As per relevant clinical practice guideline  
  - Safely attaches patient to ventilator  
  - Disconnects manual resuscitator or transport ventilator using appropriate PPE  
  - Attaches patient’s ETT to connector tube securely  
  - Performs a respiratory physical assessment and ensures the patient ventilated safely by assessing:  
    - ETT length and cuff pressures at shift commencement  
    - Rise and fall of chest wall including symmetry, auscultate lung fields, tidal volume, arterial blood gases, patient/ventilator respiratory rate.  
  - Describe assessment of ventilation parameters including:  
    - Mode, peak inspiratory pressure, waveforms, auto PEEP and alarm settings | I | |
| 4. Patients ventilation maintained over time | Patient ventilation observed to be effective using visual prompts and assessment of ventilation parameters  
  - Respiratory rate and rhythm, chest movement, SpO₂  
  - Ventilation information- TV, pressures, etc.  
  - Haemodynamic status- BP, HR, CVP, etc  
  - Patient assessed for ability to tolerate ventilation e.g. Sedation  
  - Patient position optimized to facilitate ventilation  
  - Considers disease process involved and discusses relationship of ventilation and perfusion and how positioning of patient’s influence this.  
  - Patent airway maintained by suctioning and assessment of humidification | A | |
**Critical Care Competencies**

**Demonstrates competence in MANAGEMENT OF INVASIVE VENTILATION**

<table>
<thead>
<tr>
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<th>Further Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Ventilation assessed utilising analysis of investigations</td>
<td>✧ Accurately interprets patient’s arterial blood gas values. ✧ Demonstrated knowledge of the effect of ventilation on altering blood gas values. ✧ Demonstrates knowledge of End Tidal CO₂ values on ventilation ✧ Assessed patient’s oxygenation with non invasive SaO2 monitoring.</td>
<td></td>
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<tr>
<td>6. Potential ventilation emergencies are recognised</td>
<td>✧ Recognised patient signs and symptoms indicating an emergency situation  ♦ Cyanosis, Agitation, Excessive Sweating, Patient fighting ventilator, increased respiratory rate/apnoea. ✧ Identified strategies for dealing with ventilator emergencies:  ♦ Detach patient from ventilator and manually ventilate with 100% O₂  ♦ Check ETT or Trache tube for signs of obstruction  ♦ Check correct size of inline suction catheter  ♦ Check patient for unequal chest movement – Auscultation / Palpation. ✧ Seeks assistance of experienced staff member.</td>
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<tr>
<td>7. Patient psychological and psychosocial needs are met</td>
<td>✧ Promoted an environment that minimises patient risk of sensory deprivation i.e. noise, lighting, social contact. ✧ Promoted as near normal activities of daily living (ADL) i.e. sleep patterns, use of music, reading etc. ✧ Ensured patient and family receive information / explanations of the patients care plan / condition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Patient ventilation weaning strategies are identified</td>
<td>✧ Demonstrated understanding of principles of ventilator weaning  ♦ Discussion as to appropriate ways to manage weaning and to assess whether weaning is effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Documents management</td>
<td>✧ Accurately documents relevant information regarding care and management goals ✧ Documents physical assessment using ICU physical assessment form ✧ Patient respiratory and ventilator observations documented as per unit guideline.  ♦ Demonstrates an awareness of legal implications pertaining to documentation, as per unit guidelines.</td>
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</tbody>
</table>

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ___________________ **Date:** __________ **Candidates Signature:** ___________________ **Date:** __________
## Critical Care Competencies

**Demonstrates competence in:** **ENDOTRACHEAL TUBE SECUREMENT**

<table>
<thead>
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<th>Further Action Required</th>
</tr>
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</table>
| 1. Patient assessed for need for changing of ETT security                            | - Identified the need for the ETT tape or Endotracheal Tube Attachment Device (ETAD) to be changed  
  - Tape is loose  
  - ETAD is lifting  
  - To change length or position of tube  
  - To perform as required for personal hygiene  
  - Pressure relief / reposition (L-R) once per shift for tape only  
  - Reposition ETT 2-3 hourly for ETAD device                                                                                                               |     |                         |
| 2. Methods of securing ETT identified, advantages and disadvantages explained         | - Identified the various methods for securing an ETT and explained the advantages and disadvantages of each method including:  
  - ETAD  
  - Cotton / adhesive tape  
    - Venous congestion  
    - Facial hair  
    - Pressure areas  
    - Burns                                                                                                                                                |     |                         |
| 3. Procedure is explained to patient.                                                 | - Explained procedure to patient.  
  - Provided pain relief or sedation if required.  
  - Communication occurred with patient throughout procedure.                                                                                               |     |                         |
| 4. Resources and equipment prepared and utilised                                       | - Prepared equipment and utilised resources to maintain patient safety  
  - Two registered nurses  
  - Emergency Equipment available  
  - Scissors  
  - Tape/ETAD                                                                                                                                             |     |                         |
| 5. Performs ETT tape change maintaining patient safety and comfort                    | - ETT/ETAD tapes secured and patient safety and comfort maintained throughout the procedure  
  - Tapes/ETAD are changed with two registered nurses  
  - ETT is positioned on opposite side of mouth to previous position 2nd hourly  
  - Length of ETT is correct at teeth or gums as per medical or nursing documentation  
  - ETT secured  
  - Chest auscultated to confirm bilateral air entry.                                                                                                     |     |                         |
## Critical Care Competencies

**Demonstrates competence in:** **ENDOTRACHEAL TUBE SECUREMENT CONTINUED**

<table>
<thead>
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<th>Further Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Identifies complications of changing tapes</td>
<td>❖ Explains situations that may lead to pressure areas when securing tapes</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Not repositioned for pressure relief</td>
<td>A</td>
<td></td>
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<tr>
<td></td>
<td>♦ Not changing position of tube against mouth.</td>
<td></td>
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<tr>
<td></td>
<td>❖ Explains risks of tube movement</td>
<td></td>
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<tr>
<td></td>
<td>♦ Loss of secure airway</td>
<td></td>
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<tr>
<td></td>
<td>♦ Migration down into lung</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>♦ Tube movement further into upper respiratory tract</td>
<td></td>
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<tr>
<td></td>
<td>♦ Kinked tubing/pilot tube tied into tapes.</td>
<td></td>
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<tr>
<td>7. Documents the procedure performed</td>
<td>❖ Procedure is documented in patient notes and on flow chart</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ Date and time of securing tube</td>
<td>A</td>
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<tr>
<td></td>
<td>♦ Tube placement (measurement at the teeth or gums)</td>
<td></td>
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<td></td>
<td>♦ Pressure areas or other abnormalities under tapes</td>
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<td></td>
<td>♦ Further interventions that may be required.</td>
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</tbody>
</table>

**Assessment Decision:** ☑ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ______________________ Date: ____________  **Candidates Signature:** ______________________ Date: ____________
## Critical Care Competencies

### Demonstrates competence in: ENDOTRACHEAL / TRACHEOSTOMY TUBE SUCTIONING

<table>
<thead>
<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
<th>MBS</th>
<th>Further Action Required</th>
</tr>
</thead>
</table>
| 1. Patient is assessed for indications and type of suction device required. | Described indications for tracheal suction  
- Patient has potential airway obstruction evidenced by increase in secretions, increase in PIP (volume preset modes of ventilation /decreased TV (Pressure Support / PCV), decreased air entry or check patency of tube).  
- Preparing patient for extubation.  
- Described types of suction equipment and circumstances in which they are used  
  - Closed suction systems  
  - Open methods  
  - Risks associated with each of these methods | | |
| 2. Procedure is explained to patient. | Demonstrated an understanding of the importance of patient psychological preparation.  
- Patient understands intended procedure. | | |
| 3. Appropriate equipment / resources are prepared. | Gathered equipment outlined by the unit protocol  
- Sterile suction pack, correct sized / length suction catheter, or  
- Closed suction catheter system and saline for cleaning.  
- Appropriate PPE | | |
| 4. Pre Suction: Ensures observations/parameters are within acceptable limits. | Ensured patient’s blood pressure, saturation and ECG monitoring are within acceptable limits – as per Unit guideline. | | |
| 5. Suctioning of patient. | Explained the technique for open or closed suction as outlined in unit protocol  
- Suction catheter advanced through ETT/TRACHE and suction applied as catheter is withdrawn  
- Suction applied no longer than 10 seconds  
- Ensured sufficient break between suction. (respiratory effort returns to normal)  
- Assessed the need for oropharynx suctioning.  
- Cleans or discards contaminated suction equipment following infection control guidelines  
- Suction tubing is rinsed at the completion of suctioning. | | |
## Critical Care Competencies

**Demonstrates competence in:** **ENDOTRACHEAL / TRACHEOSTOMY TUBE SUCTIONING**

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</table>
| 6. Patient observations/parameters are stable post suctioning. | ❖ Patient assessed for changes in ECG, BP and saturation's.  
❖ Assessed effectiveness of patient ventilation | | |
| 7. Documents procedure | ❖ Procedure documented in nursing notes or nursing flow chart, included  
❖ Time of suctioning  
❖ Sputum: amount, colour, and consistency  
❖ Patency of ETT / Trache tube  
❖ Size of ETT/Trache  
❖ Suction catheter due date of change  
❖ Any complications throughout procedure. | | |

**Assessment Decision:** ☐ Independent  ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ___________________  **Date:** __________ **Candidates Signature:** ___________________  **Date:** __________
## Critical Care Competencies

**Competency:**

**Demonstrates competence in:** **EXTUBATION**

- **Statement of performance criteria:** MBS = Modified Bondy Score
- **Procedure or policy components:** I = Independent, A = Assisted

<table>
<thead>
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<th>Elements of Competency</th>
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</table>
| **1. Patient assessed to determine readiness for extubation.** | Performed a respiratory assessment and applied accurate knowledge of extubation criteria, covering:  
  - Documented medical order for extubation  
  - Patient has stable ABG's, with minimum FiO\textsubscript{2} and PEEP requirements  
  - Haemodynamic stability, evidenced by normotensive, HR, ECG rhythm  
  - Respiratory stability, equal air entry, adequate TV, RR < 30 /min, an ability to maintain patent airway and cough / gag reflex  
  - Adequate conscious level / sedation ceased  
  - Strength / level of fatigue assessed  
  - Ceased NG feeds prior to extubation / aspirates stomach contents.  
  - Discussed observations and readiness for extubation.  
  - Provided an explanation of potential complications post extubation.  
  - Provides a comprehensive rationale and demonstrates understanding of pathophysiological principles for extubation on full inspiration. | I |  |

| **2. Procedure is explained to patient.** | Provided relevant, accurate and comprehensive information to the patient.  
  - Utilises appropriate communication methods  
  - Establishes patient understanding of extubation procedure.  
  - Demonstrates understanding of the importance of patient psychological preparation. | I |  |

| **3. Equipment/resources and safe environment are prepared.** | Demonstrated a prepared environment and managed equipment to ensure a safe patient outcome.  
  - Ensures emergency re-intubation equipment available at bedside  
  - Ensures that skilled medical officer is aware of imminent extubation and available to re-intubate if required.  
  - Identifies and obtains appropriate resources as per unit protocols:  
    - Standard Precautions and appropriate PPE  
    - Suction equipment  
    - 10ml syringe  
    - Scissors  
    - Oxygen mask and tubing to deliver required FiO\textsubscript{2}  
    - Blue protective sheet. | I |  |
### Critical Care Competencies

<table>
<thead>
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<th>Elements of Competency</th>
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</table>
| 4. Patient is safely extubated | - Patient extubated following unit protocol.  
  - Apply appropriate PPE  
  - Places patient in an upright position  
  - Obtains assistant if required to facilitate safe extubation procedure  
  - Aspirates NG tube  
  - Suction patients oropharynx  
  - Suction patient ETT and deflate cuff whilst maintaining suction  
  - Cut white tape or remove velcro ties from ETAD  
  - Instruct patient to take a large breath  
  - Remove ETT on expiration following full inspiration  
  - Instruct patient to cough following removal of ETT  
  - Suction airway if required and support spontaneous airway clearance  
  - Administers concentration of oxygen post extubation to maintain SaO₂  
  - Encourage deep breathing and coughing post extubation. | I | A | |
| 5. Patient observations post extubation | - Described and observed patient's respiratory effort and function  
  - Assess air-entry, RR, chest expansion and respiratory muscles  
  - Described and observed patient monitor for SpO₂, ECG, BP.  
  - Demonstrated an understanding of gas exchange, and ensures adequate oxygenation  
  - Discusses assessment or need to perform and assessed ABG post extubation if ordered or clinical required | I | A | |
  - Identified clinical signs and symptoms of laryngospasm, stridor or respiratory compromise following patient extubation.  
  - Provided accurate rationales for treatment of complications post extubation  
  - Clean, setup and check ventilator ASAP | I | A | |
| 7. Documents procedure | - Accurately documents relevant information regarding care and management.  
  - Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol  
  - Ensures procedure is documented in nursing notes and on flow chart, including:  
    - Time of extubation  
    - Patient respiratory assessment. | I | A | |

**Assessment Decision:**  
- [ ] Independent  
- [ ] Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ______________________  **Date:** __________  **Candidates Signature:** ______________________  **Date:** __________
Demonstrates competence in: MANAGEMENT OF A TRACHEOSTOMY

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</table>
| 1. Knowledge of the indications for patients who require a tracheostomy tube | Identified conditions for which tracheostomy tube is required  
   - Eg Long term ventilation, upper airway obstruction, facial injuries, to facilitate suctioning. | I | |
| 2. Maintains patency and integrity of tracheostomy | Identified strategies to ensure patency of tracheostomy tube is maintained  
   - Physical Assessment performed  
   - Suction's tracheostomy tube.  
   - Demonstrated cleaning of the inner cannula, if used, following unit protocol  
     - 4th - 8th hourly and as necessary removal and cleaning of inner cannula as per care of tracheostomy CPG  
     - Assessed humidification requirements based on respiratory assessment and sputum amount and type.  
     - Changes HME as required.  
     - Demonstrated cleaning and dressing of the stoma following unit protocol  
     - 4th - 8th hourly / PRN cleaning of stoma with normal saline and redressed with a product relevant to stoma need. | I | |
| 3. Patient is observed for potential complications of the tracheostomy tube | Identified potential complications and explained the management of them  
   - Accidental Extubation, occlusion, hypoxia, infection, aspiration, aspiration pneumonia, bleeding, stoma breakdown.  
   - Monitor cuff pressure and ensure that cuff pressure is maintained at safe level.  
   - Demonstrated location and checking of the emergency equipment and explains the indications for use.  
     - Spare tracheostomies; same size and 1 size smaller, Tracheal dilators  
     - Suction equipment, manual resuscitation bag, appropriate sized face mask. | I | |
Demonstrates competence in: MANAGEMENT OF A TRACHEOSTOMY

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</table>
| 4. Maintains open communication with patient and family | ❖ Provided relevant, accurate and comprehensive information about the patient’s condition to the patient and family members.  
❖ Identified potential communication strategies to enhance understanding, eg alphabet boards etc.  
❖ Mandatory EMR referral to: “Trache Team Consult” |     |                         |
| 5. Documents management | ❖ Accurately documents relevant information regarding care and management  
❖ Physical assessment findings  
❖ Tracheostomy: redness, discharge, swelling, patency, oxygenation, regularity of suction required, description of sputum  
❖ Changes to dressing and inner cannula.  
❖ Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol. |     |                         |

Assessment Decision: □ Independent  □ Assisted

Further Action/Training Required & Details of Feedback to Candidate:

Details of Feedback from Candidate:

Assessors Signature: ______________________ Date: __________ Candidates Signature: ______________________ Date: __________
## Critical Care Competencies

**Demonstrates competence in:** SAFE TRANSPORT OF THE CRITICALLY ILL PATIENT

- **Statement of performance criteria**
  - MBS = Modified Bondy Score
- **Procedure or policy components**
  - I = Independent, A = Assisted

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</table>
| 1. Identifies the need for transport. | - Discusses the possible needs for and appropriate methods of patient transport  
  - Inter / intra hospital transfers  
  - Diagnostic imaging, treatments unavailable at current site.  
  - Identifies and discusses risks and potential complications of transporting the critically ill  
  - Unplanned extubation / decannulation  
  - Ongoing treatment during treatment  
  - Physiological reserves of patient  
  - Equipment failure  
  - Insufficient support / infrastructure  
  - High risk procedures e.g. transfer bed to bed / trolley / table. | | |
| 2. Identifies resources required for safe patient transport. | - Identifies minimum standards for patient transport as per policy and clinical practice guidelines  
  - Equipment, drugs, staffing, communication (checklist where available).  
  - Assess patient for sedative / muscle relaxant requirements. | | |
| 3. Prepares patient and environment. | - Communicates with destination source to confirm estimated time of arrival and confirm bookings for planned diagnostic procedures.  
  - Ensures relatives / significant others aware of transport.  
  - Liaise with Medical staff to ensure adequate skill level of escorting Medical Officer.  
  - Prepares and tests transport equipment.  
  - Gathers, tests and checks contents of emergency transport equipment  
  - Emergency drug box  
  - Resuscitation equipment (manual ventilation bag and intubation equipment)  
  - Portable suction  
  - Monitor / Defibrillator / end tidal CO₂ monitor (ETCO₂).  
  - Prepares adequate volumes of drug infusions to last length of transport journey.  
  - Empty all drainage bags and secure all invasive lines  
  - Maintains effective ventilation during transport and must include ETCO₂ monitoring  
  - Establish patient stability and equipment reliability  
  - Ensures transport items are not placed on patient.  
  - Ensures required documentation is completed and gathered to accompany patient. | | |
### Critical Care Competencies

**Demonstrates competence in:** **SAFE TRANSPORT OF THE CRITICALLY ILL PATIENT**

<table>
<thead>
<tr>
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</thead>
</table>
| **4. Safely escorts patient throughout transport.** | ❖ Maintains a standard of care during transport  
❖ Ensures patient comfort, warmth, privacy, dignity  
❖ Maintains adequate analgesia and sedation  
❖ Continues haemodynamic monitoring and documents at regular intervals. | I A | | |
| **5. Safely terminates transport process.** | ❖ Ensures adequate patient information and documentation communicated to destination staff.  
❖ Safely returns patient to unit based equipment.  
❖ Cleans, removes and restocks transport equipment. | I A | | |
| **6. Documents management.** | ❖ Accurately documents relevant information regarding transport process  
❖ Time of procedure performed, complications, adverse events.  
❖ Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol. | I A | | |

**Assessment Decision:** ☐ Independent  ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

Assessors Signature: ______________________ Date: ___________ Candidates Signature: ______________________ Date: ___________
### Critical Care Competencies

**Demonstrates competence in:** PiCCO MONITORING

- **Statement of performance criteria**
  - MBS = Modified Bondy Score

- **Procedure or policy components**
  - I = Independent, A = Assisted

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 1. Prepares for PiCCO monitoring. | - Describes the indications for the PiCCO monitoring.  
- Sets up the PiCCO monitor according to CPG  
  - Correctly enters patient variables (i.e. height, predicted body weight, ID), catheter codes, and CVP into the PiCCO monitor  
  - Correctly zero’s the arterial transducer  
  - Level’s the transducer to the phlebostatic axis  
- Provides a description of each of the following parameters and their relevance to the management of a patient with PiCCO monitoring:  
  - ITBV(I) / GEDV(I)  
  - SVV / PVV  
  - CCO / CCI  
  - SVR / SVR(I)  
  - EVLW (I). | | |
| 2. Thermodilution technique. | - Describes the indications for a thermodilution measurement  
  - At least once per shift, as ordered, or change in clinical condition  
  - Lists the parameters attained through intermittent thermodilution and the continuous parameters derived from the thermodilution measurement.  
- Performs a thermodilution measurement according to unit policy and practice guideline  
  - Uses cold saline <8°  
  - Injects saline on a stable base line when indicate by "inject now" signal, within 5 seconds in a continuous and reproducible manner  
  - Performs at least three measurements and obtains an average  
  - Reviews and discards unacceptable curves. | | |
Critical Care Competencies

**Demonstrates competence in: PiCCO MONITORING CONTINUED**

<table>
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<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
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</thead>
</table>
| 3. Manages the patient with PiCCO monitoring. | ✤ Discusses the possible complications of arterial line / PiCCO monitoring.  
✥ Identifies relevant nursing observations for a patient with an arterial line placed in a brachial, femoral or axilla artery.  
✥ Discusses troubleshooting methods of the PiCCO monitoring system.  
✥ Discusses PiCCO decision tree | I   | A                        |
| 4. Documents accurately. | ✤ Demonstrates an awareness of legal implications pertaining to documentation, as per unit protocol.  
✥ Accurately documents relevant information regarding care and management  
✦ CI/CO documented on flow chart  
✦ Print out “Hemo Review” when thermodilution occurs  
✦ Arterial line dressing, line and site changes and observations. | I   | A                        |

**Assessment Decision:** ☐ Independent ☐ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ____________________________ Date: __________ Candidates Signature: ____________________________ Date: __________
<table>
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</thead>
</table>
| 1. Maintains a safe environment | ☑ Consent gained  
☑ Considers safe environment prior to defibrillation.  
♦ Completion of TOE procure checklist  
♦ Ensure patient fasted for 6 hours  
♦ Must be done in a critical care environment  
♦ Cardioversion may only be performed by an ALS accredited staff member (or by staff member under direct supervision of an ALS accredited staff member)  
♦ Anaesthesia must be administered by an Anaesthetist  
♦ Considers manual handling issues relating to the movement and positioning of an unconscious patient  
♦ Time out must be performed by the senior clinician documented on the time out sticker | | |
| 2. Appropriate preparation of patient | ☑ 12 lead ECG pre and post procedure  
☑ Check INR and electrolytes  
☑ Appropriate monitoring in place  
♦ Continuous Cardiac monitoring, SpO₂, NIBP and CO₂  
☑ IV access  
☑ Ensures appropriate level of sedation prior to procedure occurring (MAAS score) | | |
| 3. Correct application of MFE pads | ☑ Prepares patient.  
♦ Removes clothing from patients chest  
♦ If excessive hair – clip/shave  
♦ Dry chest with towel or cloth if necessary.  
☑ Attach pads in the position as shown on package/ practice guideline  
☑ Ensure MFE pads are in good contact with the skin and not covering existing ECG electrodes.  
☑ MFE applied appropriately as per Cardiologist  
♦ Sternal/ apex or,  
♦ Anterior (right chest)/ Posterior (beneath left scapula) (discuss advantages of each) | | |
## Critical Care Competencies

**Demonstrates competence in: SYNCHRONISED CARDIOVERSION CONTINUED**

<table>
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<tr>
<th>Elements of Competency</th>
<th>Performance Criteria</th>
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<th>A Further Action Required</th>
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</thead>
</table>
| 4. Performs Defibrillation / Cardioversion procedure | ♦ Selects appropriate joules for Cardioversion (50-100j) as per medical orders  
♦ Ensure ECG leads from Zoll also attached to patient to allow sensing for Cardioversion  
♦ Selects “synchronise” for Cardioversion  
♦ Ensures safety is considered prior to defibrillating.  
♦ Dry area  
♦ Calls “ALL CLEAR – SYNCH ON” then observes that no-one is in contact with patient prior to defibrillating  
♦ O₂ turned off or removed away from defibrillator MFE.  
♦ Defibrillates patient. | | |
| 5. Observes outcome | ♦ Observation and interpretation of patient’s rhythm.  
♦ If required repeats defibrillation  
♦ Generally do not exceed 150 joules.  
♦ Remove MFE pads prior to patient waking  
♦ Observe and recover patient as appropriate following anaesthetic as per clinical guideline | | |
| 6. Documents the procedure performed | ♦ Procedure is documented in patient medical records  
♦ Time out performed  
♦ Rhythm strips secured in medical records | | |

**Assessment Decision:** ☐ Independent ☑ Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** __________________________ Date: __________ **Candidates Signature:** __________________________ Date: __________
## Critical Care Competencies

**Competency:** Demonstrates competence in: **TRANSOESOPHAGEAL ECHOCARDIOGRAM**

- Statement of performance criteria: MBS = Modified Bondy Score
- Procedure or policy components: I = Independent, A = Assisted

<table>
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</table>
| 1. Maintains Safe environment | Ensures Consent is obtained  
Ensures Resuscitation Trolley immediately available  
Correct use of PPE  
Attend TOE procedure check list  
Time out must be performed by the senior clinician documented on the time out sticker  
Considers Manual Handling Issues related to movement and reposition of sedated patient |
| 2. Appropriated Preparation of TOE Probe | Ensures TOE Probe disinfection process attended to as per CPG  
Attaches disinfection cycle log to anaesthetic chart |
| 3. Patient Observations | Pre procedure 12 Lead ECG  
Monitoring must include continuous Cardiac monitoring, SpO2, NIBP and EtCO2  
Carries out patient observations and care as per CPG and hospital policy and procedure |
| 4. Cleaning of TOE Probe | Has knowledge of precautions regarding handling of and cleaning of probe  
Ensures Probe is cleaned appropriately  
Signage sheets are correctly filled out  
Probe cleaned with matrix wipes  
Tip guard insitu, new tip guard for probe post disinfection |
| 5. Post procedure Care of patient | Patient Observations  
5 min observation  
Sip test  
Maintains patient privacy and care as per MO orders  
Patient education provided  
Maintains patient records and documents all aspects of the procedure |

**Assessment Decision:**  
- [ ] Independent  
- [ ] Assisted

**Further Action/Training Required & Details of Feedback to Candidate:**

**Details of Feedback from Candidate:**

**Assessors Signature:** ______________________  
**Date:** __________  
**Candidates Signature:** ______________________  
**Date:** __________
### Critical Care Competencies

**Competency:** Demonstrates competence in **CONTINUOUS RENAL REPLACEMENT THERAPY (CRRT)**

- **Statement of performance criteria**
- **Procedure or policy components**
  - I = Independent, A = Assisted

<table>
<thead>
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</table>
| 1. Demonstrates the ability to set up CRRT. | - Prepares Prismaflex (CRRT machine)  
  - Ensures connection to UPS  
  - Maintains sterility of patient connections  
  - Setup and primes the circuit in accordance with manufacturers guidelines and unit policies  
  - Ensures all air is removed from the circuit ready for connection.  
  - Discusses priming the blood circuit advantages and disadvantages of heparinised saline. |
| 2. Prepares the Patient and vascular access | - Prepares vascular access maintaining asepsis as per guideline  
  - Aspirates 5 mL of blood from HD catheter lumens (removing heparin lock)  
  - Flushes HD catheter lumens with 10mL NaCl 0.9% assessing flow resistance. |
| 3. Commences CRRT. | - Administers heparin bolus as ordered.  
  - Connects patient to CRRT machine maintaining asepsis.  
  - Observes and responds appropriately to changes in haemodynamics and takes corrective action when required.  
  - Inspects set for air  
  - Observes and adjusts De-airation chamber  
  - Hangs new bag of NaCl 0.9% with Y connecter  
  - Discusses optimization of blood flow to enhance filter life. |
| 4. Observations | - Discusses appropriate recording of observations  
  - Pressures  
  - Flow  
  - Fluid removal  
  - De-airation chamber  
  - Haemodynamics  
  - Circuit |

**MBS**

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<tbody>
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<td>Performance Criteria</td>
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<tr>
<td>5. Recirculation</td>
<td>- Prepares pt for recirculation&lt;br&gt;- Dons adequate PPE&lt;br&gt;- Initiates procedure according to manufacturers instructions and unit clinical guideline&lt;br&gt;- Maintains clean environment and connections&lt;br&gt;- Flushes and heparin locks HD catheter as per unit guideline&lt;br&gt;- Sets appropriate rate for recirculation&lt;br&gt;- Discusses repriming of circuit every 2 hours&lt;br&gt;- Initiates reconnection of pt to Prismaflex at appropriate time</td>
</tr>
<tr>
<td>6. End treatment</td>
<td>- Discusses the indications for removal of therapy&lt;br&gt;  - Clotting filter&lt;br&gt;  - Membrane rupture.&lt;br&gt;- Discusses the indications and technique for blood return.&lt;br&gt;- Dons adequate PPE&lt;br&gt;- Demonstrates disconnection of a patient from CRRT in an aseptic manner, according to unit guideline.&lt;br&gt;- Flushes and heparin locks HD catheter as per unit guideline&lt;br&gt;- Disposal of set in appropriate waste management</td>
</tr>
</tbody>
</table>

Assessment Decision: ☐ Independent ☑ Assisted

Further Action/Training Required & Details of Feedback to Candidate:

Details of Feedback from Candidate:

Assessors Signature: ___________________________ Date: ___________ Candidates Signature: ___________________________ Date: ___________
Critical Care Competencies

Acknowledgment

We acknowledge the Intensive Care Nursing Department, Royal North Shore Hospital for the permission to use their Orientation Package in the development of this tool, 2005.

Developed

2005  NCAHS Critical Care Competencies, R. Butcher, R. Fyfe & M. McLennan

Reviewed

2008  M. McLennan
2008/9  M. Frogley & Di Goldie
2015  M. McLennan, Di Goldie and M. Frogley

Revised Edition

2013  D. Goldie, M. McLennan & M. Frogley

References

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Critical Care Competencies


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Critical Care Competencies


**APPENDIX 1**

**The Australian College of Critical Care Nurses (ACCCN)**

**Competency Standards for Specialist Critical Care Nurses (2002)**

**ENABLING**

Standards 1:
Maintains a physical and psychological environment, which promotes safety, security and optimal health.

Standards 2:
Acts to enhance the dignity and integrity of individuals.

Standards 3:
Facilitates informed decision-making by individuals.

Standards 4:
Employs the skills of effective communication to guide and achieve optimal outcomes.

Standards 5:
Effectively manages and coordinates the care of a variety of individuals.

Standards 6:
Anticipates, plans for and utilizes human and physical resources.

Standards 7:
Manages therapeutic interventions and regimes.

**CLINICAL PROBLEM SOLVING**

Standards 8:
Integrates comprehensive patient assessment and interpretive skills to achieve optimal patient outcomes.

Standards 9:
Evaluates and responds effectively to changing situations.

Standards 10:
Develops and manages a plan of care to achieve desired outcomes.

**PROFESSIONAL PRACTICE**

Standards 11:
Functions in accordance with legislative and common law affecting critical care nursing practice.

Standards 12:
Protects the rights of patients and their significant others.

Standards 13:
Demonstrates accountability for nursing practice.

Standards 14:
Demonstrates and contributes to effective, ethical decision-making.

**REFLECTIVE PRACTICE**

Standards 15:
Recognises own abilities and level of professional competence.

Standards 16:
Engages in and contributes to evidence based critical care practice.

**TEAMWORK**

Standards 17:
Collaborates with the critical care team to achieve desired outcomes.

Standards 18:
Creates a supportive environment for nursing colleagues and other members of the critical care team.

**LEADERSHIP**

Standards 19:
Acts to enhance the professional development of self and others.

Standards 20:
Demonstrates effective leadership qualities in relationships.