Insulin administration clinical competencies

Name:	Role:
Base:	Date initial training completed:

Competency Statement:

The participant demonstrates clinical knowledge and skill in drug administration without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Registered Nurse who can demonstrate competence at level 4 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to:				
1.**Demonstrate knowledge of the management and administration of insulin by Subcutaneous injection (SC)**				
a) Can identify an appropriate site for subcutaneous injection, including ability to describe why it is important to: i) inspect site for lipohypertrophy (fatty lump) ii) change injection sites regularly iii)avoid injecting into areas of lipohypertrophy or bruising	Questioning / observation			
b) Can explain why INSULIN is prescribed and how it works	Questioning			
c) Can describe the signs and symptoms of hypoglycaemia and how to treat hypoglycaemia, and what preparations could be prescribed	Questioning			
d) Can describe signs and symptoms of hyperglycaemia and actions to be taken should this occur	Questioning			
f) Can describe when to monitor a patient's blood sugar and where to record readings. Can state normal glucose levels.	Questioning			
g) Can explain why on medication charts the word 'UNITS' and not 'U' must be clearly written next to the dose and what action to take if	Questioning			

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
prescription not written as units, or the prescription and dose are not written clearly				
h) Can describe the correct storage and preparation of INSULIN (e.g. re-suspension of cloudy insulin).	Questioning			
2. Demonstrate practical skill in administration of subcutaneous injection (SC)				
a) Wash hands and prepare necessary equipment	Observation			
b) On prescription\administration chart check: • That prescribed insulin has not already been given • Name of patient/service user • Name of medication • Strength • Route • Prescribed Dose • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength with information on packaging	Observation			
c) On insulin pen / Penfill • Visual check of cartridge (e.g. clear insulin is clear) and that it has not been tampered with or cracked • Check medicine was stored as recommended, e.g. refrigerator	Observation			
d) Blood glucose level checked and within safe range for INSULIN administration (if applicable refer to target glucose range on care plan)	Observation			

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
e) Service user fully consulted, consent maintained & person given opportunity to ask questions/raise concerns.	Observation			
f) Ensure therapeutic environment is considered for administration.	Observation			
g) Appropriate site chosen, area clean and good technique used. Equipment disposed of safely. Hand hygiene performed	Observation			
h) Documents all care given in accordance with Trust policy & procedures	Observation			
i) Check/ ensure appropriate monitoring & care plan/ support plan in place and identify need for updating or review	Observation / Questioning			

Date all elements of Competency Tool completed to level 3________

Name ______________ Signature _______________Status ___________ Date _______

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in insulin administration

Assessor______________ Signature _______________ Status ___________ Date _______

Review Dates:	Competent Yes / No	Registered Nurse Signature	Verifier signature	Comments

Appendix 9. Standard Operating Procedure (SOP) for Administration of Low Molecular Weight Heparin (LMWH) by Non-Registered Practitioners and Paid carers to Adults

Objective	To ensure that LMWH administered by non-registered practitioners and paid carers is in accordance with recommended practice. Medicines Policy (SH CP01), Medicines Matters (SPS 2018).
Scope	This SOP applies to administration of LMWH by non-registered practitioners and paid carers to a patient in their own home, residential care settings and day care services.
Authority	This SOP is issued as part of Southern Health SH CP 96 Delegation of Administration of Medicines Policy
Risk Assessment	There must be documentary evidence that a risk assessment has been undertaken by the registered practitioner who will take responsibility for delegating the task, before a decision is made to allow the administration of LMWH by non-registered practitioners and paid carers. The assessment must be completed for each patient, non-registered practitioner and/or paid carer and task required. The risk assessment must include identification of the use of LMWH for either prophylaxis or treatment and the monitoring requirements around their use.
Who can Administer	Only non-registered practitioners and paid carers who are qualified to a minimum of NVQ Level 2 or can demonstrate previous learning / experience and have received initial training and have been assessed as competent can undertake administration of LMWH to a named patient
Monitoring and audit	The registered practitioner who has delegated this task is responsible for the initial and continued assessment of the a) Patient on a monthly basis unless a concern arises before this and therefore an earlier visit is required. b) Non-registered practitioner or paid carer's competence on a six monthly basis unless a concern arises before this and therefore an earlier reassessment is required. Reassessment of competence will be by direct observation of the non-registered practitioner and completion of the competencies for LMWH administration. In situations where the patient transfers for example to another team the accountability for the assessment of the non-registered practitioner or paid carer's competence lies with the Registered Nurse who will have ongoing responsibility for the delegation of care to the non-registered practitioner or paid carer. Where the Registered Nurse leaves his/her post the responsibility

	for assessment/ reassessment of the non-registered practitioner or paid carer transfers to the Registered Nurse who has ongoing responsibility for the delegation of care to the non-registered practitioner or paid carer.

Administration of LMWH Procedure	
Action	***Rationale***
1. Read care plan and check prescription details ensuring the right patient is identified. Check the patient's name, NHS number or date of birth, prescriber's signature, approved medicine name, dose and frequency of administration, date and route of administration.	1. Care plan will explicitly identify care required. LMWH must be administered only in accordance with the written directions of a suitably qualified prescriber. Administration procedure should not continue if this is incomplete or incorrect.
2. Explain procedure to the patient and ask for and record verbal consent	2. To inform the patient and obtain evidence of informed consent
3. Check a)patient has not already had or self-administered medication b)that the LMWH is due for administration at that time c)site of administration of last dose	3. To prevent medication error / overdose To ensure site rotation (same site is not used twice in a row)
4. Clean own hands and apply a clean pair of non-sterile gloves	4. To prevent cross infection and contamination by following Trust Infection Prevention and Control Policy and Hand Hygiene Procedure
7. Ensure the area for medicine preparation is suitable and assemble all materials and equipment	7. The preparation area should be clean, uncluttered, and free from interruption and distraction. Ideally in a dedicated area to minimise risk of error in dose preparation
8. Prepare the dose to be given against the prescription, carefully checking that all details on the prescription record chart below correspond to the LMWH supplied Drug Name.	8. General good practice procedures for the preparation and administration of medications should be followed to minimise the risk of medication error. Refer to the Medicines Policy (SH CP 01)

Dose/ Strength/ Formulation Expiry date Route	
9. Check the care plan, prescription and patient's name, NHS number or date of birth corresponds to the patient before administration	9. To ensure right patient is identified if medication is prepared away from patient
10. Administer LMWH in accordance with the Manufacturer's instructions and the Medicines Policy (SH CP01)	10. To ensure that the product is used as licensed. Always refer to the current summary of product characteristics (SPC) and patient information leaflet
11. Dispose of used equipment and sharps immediately after use at the point of care.	11. To prevent cross infection, contamination and sharps injury by following Trust infection control and Sharps Inoculation and Management Policy.
12. Remove gloves and clean own hands	12. To prevent cross infection and contamination by following Trust Infection Prevention and Control Policy and Hand Hygiene Procedure
13. Document administration in patient's notes ensuring there is no duplication of drug administration records when care is shared between different services	13. To comply with the NMC record keeping standards and avoid any risk of medication error. A clear, accurate and immediate record of each administration should be kept in the relevant patient clinical notes, using the approved drug administration form. These records should specify the date, time, strength, presentation and form of administration, dose administered as well as the name and occupation of the person administering it. Ensure that there is no duplication of drug administration records when care is shared between different services in order to prevent administration errors

Training	The registered practitioner providing training to a non-registered practitioner or paid carer must demonstrate evidence of knowledge, skills and competency in the

	task being taught. All non-registered practitioners and paid carers authorised to administer LMWH must have a thorough knowledge of this SOP, and must have completed initial training and assessment in accordance with the Delegation of Medicines Administration
Reporting an incident	Priority must be given to patient safety. Incidents must be reported to the non-registered practitioner or paid carer's line manager and to the registered nurse who has delegated the care, who will report the incident following the SHFT Policy for Managing Incidents. Adverse drug reactions or suspected reactions must be reported to the non-registered practitioner or paid carer's line manager who will report to the General Practitioner and Registered Practitioner. Both practitioners are encouraged to consider reporting the reaction to the MHRA on a Yellow card.
Authorisation	This SOP is issued as part of the Southern Health Administration of medicines training policy for non-registered practitioners and paid carers
Review date	3 years from implementation date
Written by	S Coopey / S Mennear

Appendix 10 Competencies for Administration of LMWH by Non-Registered Practitioners and Paid carers to Adults

Name:	Role:
Base:	Date initial training completed:

Competency Statement:

The participant demonstrates clinical knowledge and skill in administration of LMWH without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Registered Nurse who can demonstrate competence at level 4 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to:				
1. Demonstrate an understanding of the principles of LMWH administration and the correct injection procedure				
a) Obtains informed consent from patient	Observation			
b) Demonstrates knowledge of common side effects and knows how to raise concerns with registered practitioner	Discussion			
c) Demonstrates appropriate selection of site	Observation			
d) Demonstrate correct injection technique (observed on at least 3 occasions)	Observation			
e) Follows infection control guidelines	Observation			
f) Dispose of sharps safely and correctly, knows when and how to report in the event of needle stick injury	Observation			
g) Demonstrates correct storage of LMWH, check expiry dates and appearance of LMWH	Observation			
h) Documents administration accurately and immediately, and reports to manager in charge at handover	Observation			

Date all elements of Competency Tool completed to level 3________

Name ______________ Signature _______________Status ___________ Date _______

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in administration of LMWH

Assessor______________ Signature _______________ Status ___________ Date _______

Review Dates:	Competent Yes / No	Registered Nurse Signature	Verifier signature	Comments

Appendix 11 Medicines administration clinical competencies for non-registered practitioners

These should be used in conjunction with the core skills framework and where appropriate to support role and job description

Name:	Role: **Band 3 and 4**
Base:	Date initial training completed:

Competency Statement:

The participant demonstrates clinical knowledge and skill in drug administration without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Registered Nurse who can demonstrate competence at level 4 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to:				
1. Demonstrate the knowledge of principles and theory of drug administration required to meet the patient's medication needs				
a) Identify the principles of accountability and responsibility for medicines administration	Questioning			
b) Describe the purpose of a Standard Operating Procedure (SOP)	Questioning			
c) Identify the differences between administering a medicine from a patient prescription (Patient Specific Direction) and from a Patient Group Direction (PGD)	Questioning			
d) Identify the situation in which a verbal order may be used	Questioning			
e) Demonstrate knowledge and understanding of the Professional Guidance on the Administration of Medicines in Healthcare Settings (RPS and RCN 2019)	Questioning			
f) Can accurately describe whose responsibility it is to check that a medication is prescribed correctly	Questioning			

prior to administration				
g) Can explain what to do if asked to administer medication: • At dose exceeding BNF recommendation OR • Through route not specified in BNF for drug	Questioning			
h) Can explain what to do if asked to leave a prepared injection or pot of medication unsupervised	Questioning			
i) Can explain how to report and record a near miss or drug error	Questioning			
j) Can explain how to obtain up to date information about any medication	Questioning			
k) Can describe the symptoms and management of anaphylactic shock	Questioning			
2.1 Demonstrate knowledge of the management and administration of oral drugs				
a) Can discuss alternative strategies for medication administration should a person be unable to swallow tablets	Questioning			
b) Can describe the distinguishing features of tablets which cannot be cut or crushed	Questioning			
c) (If drug used in clinical area) Can describe what you should do before administering DIGOXIN	Questioning			
d) (if drug used in clinical area)Can explain why WARFARIN is prescribed at a variable dose, and where this is recorded. Evidence that the staff member knows: 1. Target INR 2. Latest INR result 3. Latest dose 4. Date of next test	Questioning			

5. Blood test – date and latest result.				
e) (if used in own area) Can describe how to order monitored dosages systems/compliance aids, e.g. Dosett & NOMAD boxes	Questioning			
f) Can name a medication that can be administered at the discretion of nurses and where to record that it has been given	Questioning			
2.2 Demonstrate practical skill in administration of oral drugs				
a) Wash hands and prepare necessary equipment	Observation			
b) On prescription chart check: • That prescribed drug dose has not already been given at the time due • Name of patient/service user • Name of medication • Strength • Route • Prescribed Dose • Calculation if any • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on blister pack against information on label • For PRN check amount & time previous dose administered	Observation			
c) On medicine label/blister pack check: • Drug name • Drug strength • Dose (if not stock) • Patient name (if not stock)	Observation			

• Expiry date • Any additional instructions				
d) Prepare and record correctly	Observation			
e) Administer correctly to service user checking identity, obtaining consent and respecting dignity before moving on to next patient	Observation			
f) Appropriate disposal of medicines (if necessary) or other equipment used	Observation			
3.1 Demonstrate knowledge of the management and administration of drugs by Subcutaneous injection (SC) including insulin				
a) Can describe an appropriate site for subcutaneous injection	Questioning			
b) Can explain why INSULIN might be prescribed and its method of action	Questioning			
c) Can describe the symptoms of hypoglycaemia and hyperglycaemia and actions needed should this occur. Should include normal ranges.	Questioning			
d) Can describe when to monitor a patient's blood sugar and where to record readings.	Questioning			
f) Can explain why on medication charts the word 'UNITS' and not 'U' must be clearly written next to the dose and what action to take if prescription not written as units.	Questioning			
g) Can describe the correct storage and preparation of INSULIN.	Questioning			
h) What information should be discussed in handover if an insulin dependent diabetic patient is on the ward?	Questioning			
i) If a patient is prescribed insulin what other preparations may also be prescribed as PRN?	Questioning			

3.2 Demonstrate practical skill in administration of subcutaneous injection (SC)				
a) Wash hands and prepare necessary equipment	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route • Prescribed Dose • Calculation if any • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on container against information on label • For PRN check amount & time previous dose administered	Observation			
c) On vial &container check: • Patient name (if not stock) • Drug name & strength • Route & expiry date • Visual check of vial/ampoule that it has not been tampered with • Check medicine was stored as recommended, e.g. refrigerator	Observation			
d) Injection drawn up correctly (including correct needle selection, vial opened safely, bubbles removed)	Observation			
e) Blood sugar level checked and within safe range for INSULIN administration (if applicable)	Observation			

f) Patient /service user fully consulted, consent maintained & person given opportunity to ask questions/raise concerns.	Observation			
g) Ensure therapeutic environment is considered for administration.	Observation			
h) Appropriate site chosen, area clean and good technique used. Equipment disposed of safely.	Observation			
i) Check/ ensure appropriate monitoring & care plan in place.	Observation			
4.1 Demonstrate knowledge of the management and administration of medication rectally (PR)				
a) Can describe why enemas and suppositories might be given and their method of action	Questioning			
b) Can describe how to reduce the risk of discomfort to the person and/or damage to the bowel wall during administration of any of the above	Questioning			
c) Can describe appropriate disposal of equipment after use	Questioning			
d) Can describe how to protect the dignity and privacy of service users during administration	Questioning			
4.2 Demonstrate practical skill in rectal administration of medication				
a) Applies standard precautions for infection control and adheres to hand hygiene policy.	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any.	Observation			

• Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on blister pack against information on label • For PRN check amount & time previous dose administered				
c) On medicine label/blister pack check: • Drug name • Drug strength • Dose (if not stock) • Patient name (if not stock) • Expiry date • Any additional instructions	Observation			
d) Ensures the privacy and dignity of the individual is maintained.	Observation			
e) Prepares necessary equipment including lubricant.	Observation			
f) Uses correct administration method in line with best practice & manufacturers guidelines.	Observation			
g) Monitor's and records the response to the medication administered & takes any necessary action.	Observation			
5.1 Demonstrate knowledge of the management and administration of vaginal medication				
a) Can describe why vaginal medicines (e.g..pessaries, creams, rings) might be given and their method of action	Questioning			
b) Can describe appropriate disposal of equipment after use	Questioning			
c) Can describe how to protect the dignity and privacy of service users during administration	Questioning			

5.2 Demonstrate practical skill in vaginal administration of medication				
a) Applies standard precautions for infection control and adheres to hand hygiene policy.	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on blister pack against information on label • For PRN check amount & time previous dose administered	Observation			
c) On medicine label/blister pack check: • Drug name • Drug strength • Dose (if not stock) • Patient name (if not stock) • Expiry date • Any additional instructions	Observation			
d) Ensures the privacy and dignity of the individual is maintained.	Observation			
e) Prepares necessary equipment	Observation			
f) Uses correct administration method in line with best practice &	Observation			

manufacturers guidelines.				
g) Monitor's and records the response to the medication administered & takes any necessary action.	Observation			
6.1 Demonstrate knowledge of the management and administration of topical medication e.g. eye, ear and nasal preparations				
a) Can describe common reasons for eye preparations, nasal preparations & ear preparations being prescribed.	Questioning			
b) Can explain expiry date for eye preparations once in use.	Questioning			
c) Can explain when it is necessary to have separate containers for each eye and when and if one is needed.	Questioning			
d) Can explain the time delay needed if patient receives more than one type of eye preparation at the same time.	Questioning			
e) Can describe standard precautions which should be taken when administering any of the above	Questioning			
f) Can explain where and how to store eye preparations, nasal sprays and ear preparations and how to check if unsure	Questioning			
6.2 Demonstrate practical skill in administration of topical medication				
a) Apply standard precautions for infection control	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route.	Observation			

• Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on container against information on label. • For PRN check amount & time previous dose administered				
c) Service user fully consulted & consent sought	Observation			
d) Applies medication in a sensitive and dignified way, and one which minimises pain or discomfort.	Observation			
e) Use correct technique in application of creams, ointments, eye drops, nasal sprays and ear drops.	Observation			
f) Respond appropriately to any adverse reaction.	Observation			
7.1 Demonstrate knowledge of the management and administration of inhaled medication e.g. nebulisers and inhalers				
a) Can explain why metered-dose inhalers and nebulisers might be prescribed	Questioning			
b) Can describe the correct technique for using various types of metered dose inhaler in line with the equipment guidelines.	Questioning			
c) Can discuss alternative strategies which could be used if a service user is unable to effectively operate a metered-dose inhaler	Questioning			
d) Can describe the correct technique for the administration of medication via a nebuliser	Questioning			
e) Can describe the correct use and purpose of a spacer device and how to maintain it.	Questioning			

7.2 Demonstrate practical skill in administration of inhaled medication				
a) Is able to set up equipment correctly in preparation for administration.	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on blister pack against information on label • For PRN check amount & time previous dose administered	Observation			
c) On inhaler/ nebuliser solution check: • Drug name & strength • Patient name (if applicable) • Expiry date	Observation			
d) Correct dosage delivered, with any necessary assistance or advice to service user given.	Observation			
e) Nebuliser used in accordance with operating instructions (if used in own area)	Observation			
8.1 Demonstrate knowledge of the management and administration of buccal medication e.g. Midazolam				
a) Can describe situations where use of buccal Midazolam is required.	Questioning			

b) Can describe the method of action for buccal Midazolam	Questioning			
c) Can demonstrate knowledge of potential side effects.	Questioning			
d) Can explain the correct storage and recording of Midazolam.	Questioning			
e) Can describe the correct method of administration in line with manufacturer and best practice guidelines.	Questioning			
8.2 Demonstrate practical skill in administration of buccal medication				
a) Is able to assess the service users need and identify when buccal medication should be administered.	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on container against information on label • For PRN check amount & time previous dose administered	Observation			
c) On medicine label/blister pack check: • Drug name • Drug strength	Observation			

• Dose (if not stock) • Patient name (if not stock) • Expiry date • Any additional instructions				
d) Prepares equipment correctly and safely.	Observation			
e) Administers Midazolam in line with manufacturer and best practice guidelines.	Observation			
f) Disposes of equipment safely.	Observation			
g) Monitors and records the response to the medication administered & takes any necessary action/emergency response as indicated.	Observation			
9.1 Demonstrate knowledge of the management and administration of transdermal medication				
a) Can explain why transdermal patches might be prescribed	Questioning			
b) Can describe safety precautions for the use of Fentanyl patches	Questioning			
c) Can describe a common side effect which might occur	Questioning			
d) Can describe appropriate sites for the application of transdermal patches and the importance of site rotation	Questioning			
e) Can explain why gloves should be used when handling transdermal patches	Questioning			
f) Can describe the how patches should be disposed of	Questioning			
9.2 Demonstrate practical skill in the application of transdermal medication				
a) On prescription chart check: • That prescribed drug has not already been given	Observation			

• Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength on container against information on label • For PRN check amount & time previous dose administered				
b)) On medicine label / container pack check: • Drug name • Drug strength • Dose (if not stock) • Patient name (if not stock) • Expiry date • Any additional instructions	Observation			
c) Communicates with the service user: • Information regarding the medication being administered • Potential adverse reactions/side effects • Action to be taken should an adverse reaction occur.	Observation			
d) Uses correct technique for applying transdermal patches (including selecting appropriate site & using gloves) or supervises service user doing this.	Observation			

e) Ensure appropriate removal and disposal of old patch.	Observation			
f)) Monitor's and records the response to the medication administered & takes any necessary action.	Observation			
10.1 Demonstrate knowledge of the management and administration of bladder irrigation				
a) Discuss the indications for bladder irrigation	Questioning			
b) Can describe appropriate disposal of equipment after use	Questioning			
c) Can describe how to protect the dignity and privacy of service users during administration	Questioning			
10.2 Demonstrate practical skill in bladder irrigation				
a) Applies standard precautions for infection control and adheres to hand hygiene policy.	Observation			
b) On prescription chart check: • That prescribed drug has not already been given • Name of patient/service user • Name of medication • Strength • Route. • Prescribed Dose. • Calculation if any. • Time of administration • Expiry date • Allergies • Any additional instructions • Drug name and strength against information on label • For PRN check amount and previous dose administered	Observation			

c) On medicine label/ pack check: • Drug name • Drug strength • Dose (if not stock) • Patient name (if not stock) • Expiry date • Any additional instructions	Observation			
d) Ensures the privacy and dignity of the individual is maintained.	Observation			
e) Prepares necessary equipment	Observation			
f) Uses correct administration method in line with best practice &manufacturers guidelines.	Observation			
g) Monitor's and records the response to the medication administered & takes any necessary action.	Observation			
11.1 Demonstrate knowledge of enteral feeding				
a) Discuss the indications for enteral feeding	Questioning			
b) Identify range of methods for nutritional support	Questioning			
c) Describe how patients are screened and assessed for nutritional support	Questioning			
d) Discuss the legal and ethical implications of nutritional support	Questioning			
e) Describe three methods of delivery for feeding	Questioning			
f) List the recommendations for giving medications through a feeding tube	Questioning			
g) Identify the main feeding routes for enteral feeding	Questioning			

11.2. Demonstrate practical skill in enteral feeding				
a) Demonstrate ability to commence enteral feeding	Observation			
b) Demonstrate ability to maintain hygiene and apply infection control principles throughout procedure	Observation			
c) Monitor feeding to ensure: i) nutritional needs of the patient are met ii) to assess the effectiveness of treatment iii) to allow early detection of complications	Observation			
d) Demonstrate ability to maintain good mouth hygiene	Observation			
e) State what information must be documented	Questioning / observation			

Date all elements of Competency Tool completed to level 3________

Name ___________________ Signature _______________ Status ___________ Date _______

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in drug administration

Assessor______________ Signature _______________ Status ___________ Date _______

Review Dates:	**Competent Yes / No**	**Registered Nurse Signature**	**Verifier signature**	**Comments**

Levels of competency Rating Scale

	Level of achievement	Level
Novice	Cannot perform this activity satisfactorily to the level required in order to participate in the clinical environment	0
↓	Can perform this activity but not without constant supervision and assistance	1
	Can perform this activity with a basic understanding of theory and practice principles, but requires some supervision and assistance	2
Competent Practitioner	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision	3
↓	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice At this level competence will have been maintained for at least 6 months and/or is used frequently (2-3 times /week) The practitioner will demonstrate confidence and proficiency and show fluency and dexterity in practice **This is the minimum level required to be able to assess practitioners as competent**	4
	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. At this level the practitioner will be able to adapt knowledge and skill to special/ novel situations where there may be increased levels of complexity and/or risk	5
Expert	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. Demonstrate initiative and adaptability to special problem situations, and can lead others in performing this activity At this level the practitioner is able to co-ordinate, lead and assess others who are assessing competence. Ideally they will have a teaching and /or mentor qualification	6

Adapted from: Herman GD, Kenyon RJ (1987) Competency-Based Vocational Education. A Case Study, Shaftsbury, FEU, Blackmore Press, cited in Fearon, M. (1998) Assessment and measurement of competence in practice, *Nursing Standard* 12(22), pp43-47.