Southern Health NHS
NHS Foundation Trust

Wound assessment, management and dressing selection clinical competencies

Name:	Role:
Base:	Date initial training / E mot completed:

Competency Statement:

The participant demonstrates clinical knowledge and skill in wound assessment and dressing selection 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 3 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to:				
1. Demonstrate the knowledge and skill in wound assessment and dressing selection				
a) Demonstrate knowledge of the Trust Wound Formulary and Leg Ulcer Guidelines	Questioning			
b) Describe the need for a holistic patient assessment in conjunction with a wound assessment	Questioning			
c) Explain the different wound types and the stages of healing	Questioning			
d) Identify slough, necrotic, granulating and epithelial tissue	Observation			
e) Demonstrate the ability to perform a wound swab including; i) describe when taking a wound swab is appropriate (e.g. for MRSA) ii) describe the indications for use of a wound swab iii) describe what information is required by the pathology lab iv) demonstrate how to take a swab according to the protocol v) describe how to access the result	Questioning/ observation			
f) Know what dressings are in the Trust formulary	Questioning			
g) Undertake a wound assessment completing the relevant assessment form	Observation			
e) Identify which types of dressings are suitable for which wound types and or symptoms	Questioning			

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
f) Explain to the patient the rationale for the chosen treatment regime	Observation			
g) Demonstrate the need to gain consent and maintaining privacy and dignity throughout the wound assessment and procedure	Observation			
h) Discuss when an aseptic or clean technique is used	Questioning			
i) Identify what solutions should be used to clean acute and chronic wounds	Questioning			
j) Identify what dressings are single use only and should be disposed of after use.	Questionning			
k) Discuss the indication and contraindication are for foams, hydrocolloids, hydrogels, films, carbon dressings, films and antimicrobial dressings	Questioning			
l) Demonstrate to apply and remove each dressing according to manufacturers' recommendation to avoid trauma and discomfort	Observation			
m) Identify which dressings may alleviate pain or odour	Questioning			
n) Discuss how long a treatment regime should be adhered to before the treatment is stopped or changed	Questioning			
o) Discuss how to identify a clinical infection	Questioning			
p) Describe the difference between contamination, colonisation and infected	Questioning			
q) Identify when to initiate and stop antimicrobial dressings	Questioning			
r) Demonstrate how to treat and protect skin surrounding a wound	Observation			
2. Demonstrate the ability to remove would closure devices				
a) Demonstrate the ability to remove sutures	Observation			

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
b) Demonstrate the ability to remove clips	Observation			
c) Demonstrate the ability to remove wound drains	Observation			
d) Demonstrate the ability to follow infection control guidelines in all procedures	Observation			
e) Describe the contraindications / precautions when removing a wound closure device	Questioning / observation			
3. Demonstrate the ability to use wound management medical devices				
a) Demonstrate the ability to apply and remove a wound drainage bag	Observation			

Source: Tissue Viability wound Formulary 2013. Infection Prevention and Control Policy SH CP 10 (2013)

Date all elements of Competency Tool completed _____

Name _____ Signature _____Status_____ Date _____

For Assessor

I confirm that I have assessed the above named Registered Nurse and that he/she has demonstrated an overall competence in continence assessment at level _____

Assessor _____ Signature _____ Status_____ Date _____

For Self Assessment

I confirm that I have assessed my overall competence in continence assessment at level _____

Name _____ Signature _____Status_____ Date _____

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