 

**Health Care Support Worker (HCSW)**

**Competency Passport**

This competency passport has been produced by Ealing CEPN to provide a framework for health care support workers (HCSWs) and their employers to use as a guide for competency assessment in general practice.

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| **This Passport belongs to:** |  |
| **Start Date:** |  |

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| **Areas of Competency****24 Hour Ambulatory Blood Pressure Monitoring (ABPM)** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure**ABPM is the most accurate method for confirming a diagnosis of hypertension and its use should reduce unnecessary treatment in people who do not have true hypertension. ABPM has also been shown to be superior to other methods of multiple blood pressure measurement for predicting blood pressure-related clinical events.’(NICE 2015)* Check identity of patient
* Have completed relevant training and competency
* Knows normal blood pressures ranges
 |  |  |  |  |
| **During Procedure*** Open correct patient in SystmOne and initialise monitor as per manufacturer instructions
* Tick blue box on SYSTMONE under auto consultation ABPM
* Ask patient to remove top piece of clothing
* Switch on monitor
* Show patient on/off switch
* Place in pouch
* Place appropriately sized cuff on non-dominant arm unless clinically unable e.g. lymphedema
* Line arrow with brachial artery
* Advise patient how to adjust cuff if required
* Pull Velcro to ensure firm fit
* Place tubing around back of neck and down arm to attach to monitor
* Patient can redress
* Check 1-2 readings in surgery to ensure working
* Attach monitor to belt around waist ensuring no kinks in the tubing
* Check recordings are set for 30 minutes during the day and 60 minutes at night (adjust if patient works night shifts)
* If ‘error’ occurs check ABPM manual
* Give patient both verbal and written instructions on procedure for when they go home and briefly reiterate important point’s i.e keeping arm still when recording/night time etc.
* Ask patient to keep a diary of activities performed throughout the 24 hours
* Advise patient how to turn off monitor and remove at correct time the next day before returning monitor to GP surgery
* Document consultation in patient notes using correct template
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| **Areas of Competency****24 Hour Ambulatory Blood Pressure Monitoring (ABPM)** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Post Procedure*** Download results to correct patients records in SystmOne as per manufacturer instructions
* Alert requesting clinician that results are available to view
* Check and clean equipment as per policy
 |  |  |  |  |
| **Notes****Reference**<https://www.welchallyn.com/content/dam/welchallyn/documents/upload-docs/Training-and-Use/Quick-Reference-Guide/quickguide_20071114_abpm6100.pdf>**Training Attended**

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| **Areas of Competency****Blood Glucose Testing** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Learning Outcome*** Able to identify an abnormal blood glucose result and when to immediately inform a clinician
* Knows when and how to perform quality control test on meter
* Check why Blood Glucose testing has been requested
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| **Pre Procedure**Check identity of patientGain consentGather equipment to hand (blood glucose meter, cotton wool, gloves, glucose test strips, lancet, sharps box)Wash hands |  |  |  |  |
| **During Procedure*** Apply gloves
* Insert test strip into meter (do not touch testing area)
* Apply lancet to side of patients finger to obtain blood sample
* Dispose of lancet in sharps box
* Gently press (milk) finger to bring blood to surface
* Apply test strip to blood and allow to draw into testing area
* Apply cotton wool to finger
* Note result
* Dispose of test strip into clinical waste
 |  |  |  |  |
| **Post Procedure*** Document results in patient records using correct template
* Report abnormal results to clinician
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| **Areas of Competency****Blood Glucose Testing**  |
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| **Notes**:Typical blood glucose results for a diabetic patient would be:* Before meals: 4 to 7 mmol/L
* 90 minutes After meals: less than 10 mmol/L
* Before going to bed: 8 mmol/L.

**Reference**<http://rcnhca.org.uk/clinical-skills/observation/blood-glucose-testing/>**Training Attended**

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| **Areas of Competency****Blood Pressure Monitoring** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** Check why BP is being monitored
* Identify correct patient
* Check if patient is taking any BP medication
* Check pulse to exclude atrial fibrillation (AF) and record (If AF to inform clinician and book patient for ECG)
* Explain procedure and gain consent
* Wash hands
 |  |  |  |  |
| **During Procedure**Manual Reading:* Ensure patient is relaxed and sitting down
* Locate brachial artery
* Apply cuff correctly to arm lining arrow with brachial artery
* Place stethoscope diaphragm over brachial artery
* Inflate cuff to approximately 30mmHg above estimated systolic pressure
* Slowly deflate cuff listening for regular ‘beats’ to start and note reading (systolic reading)
* Keep deflating cuff carefully noting when ‘beats’ stop (diastolic reading)
* Remove cuff
* Wash hands and clean equipment as per policy

Automated Blood Pressure Machine* Apply cuff correctly to arm lining arrow with brachial artery
* Monitor and record blood pressure as per manufacturer instructions
* If patient has atrial fibrillation must use manual BP machine to monitor BP

**Post Procedure** * Record results in patient records using correct template
* Inform GP/nurse of any abnormal readings – see notes
* Give brief advice regarding blood pressure and lifestyle
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| **Areas of Competency****Blood Pressure Monitoring** |
| **Notes*** **Normal** blood pressure is between 90/60 mmHg and 120/80 mmHg
* **High** blood pressure is above 140/90 mmHg
* **Low** blood pressure is below 90/60 mmHg
* **Between** 120/80 mmHg and 140/90 mmHg - at risk of developing hypertension if patient does not take steps to control BP now
* Diabetic BP parameters are under 140/80 mmHg

**References:*** NICE Guidelines: Managing blood pressure in adults with type 2 diabetes
* <http://rcnhca.org.uk/clinical-skills/observation/blood-pressure/>
* <https://www.nhs.uk/common-health-questions/lifestyle/what-is-blood-pressure/>

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| **Areas of Competency****Brief Smoking Cessation Advice** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Learning Outcome*** Attend Making Every Contact Count Training every 2 years

**Pre Procedure*** Take every opportunity to sensitively ask patients if they smoke
* Make sure there are stop smoking advice and service leaflets to hand
* Gain consent to offer some very brief advice (VBA) if patient smokes
* According to NICE guidelines (March 2018) this advice should take no longer than 30 seconds
 |  |  |  |  |
| **During Procedure*** Ask questions about current and past smoking behaviour
* Offer verbal and written information on smoking risks and benefits
* Advise patient of various options for stopping
* Offer local stop smoking service/pharmacist if available
* Refer to GP/Nurse for further advice if decline smoking cessation referral but wish to stop smoking
* For people who do not wish to stop smoking encourage them to consider this option and return if they change their mind
* Consider reducing the amount they smoke
 |  |  |  |  |
| **Post Procedure*** Record smoking status in notes using correct template and document conversation
* Refer to smoking cessation services if consent was given
* Book appointment with GP/Nurse for further support
* Encourage and commend patient
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| **Areas of Competency****Brief Smoking Cessation Advice** |
| **Notes****References:** <https://cks.nice.org.uk/smoking-cessation#!topicsummary>**Training Attended**

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| **Areas of Competency****Diabetic Foot Checks** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Learning Outcome*** Undertake risk classification for diabetic feet

**Risk Classification*** **Low risk**: no risk factors present except callus (hard area of skin).
* **Moderate risk**: deformity or numbness/weakness (neuropathy) or poor blood supply (non-critical limb ischemia)
* **High risk:**
	+ previous ulceration/amputation
	+ diabetic foot problems
	+ renal replacement therapy
	+ numbness/weakness + callus/deformity
	+ poor blood supply + callus/deformity

**Pre Procedure*** Gain Consent
* Wash hands – apply gloves
 |  |  |  |  |
| **During Procedure*** Ask patient if they have noticed any foot problems
* Ask patient to be remove all foot wear so they are bare foot
* Observe foot wear – is it suitable?
* Check the whole foot including nails for any abnormalities or skin discolouration
* Check temperature and blood flow
* Palpate foot pulses (dorsalis pedis and posterior tibial pulses)
* Check sensation using monofilament and document risk level
 |  |  |  |  |
| **Post Procedure*** Wash hands
* Advise patient of your findings
* Give foot care advice for home
* Document findings in patient records using correct template
* Inform GP or nurse of any foot abnormalities
 |  |  |  |  |

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| **Areas of Competency****Diabetic Foot Checks** |
| **Notes**Active diabetic foot problem* ulceration/spreading infection
* critical limb ischaemia/gangrene
* suspicion of an acute Charcot arthropathy ( fractures and dislocations of bones which occur with little or no known trauma),
* unexplained hot, red, swollen foot

**References:** * Diabetic foot problems - Prevention and management NICE guideline, published: 26 August 2015 nice.org.uk/guidance/ng19
* Diabetes UK 2018

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| **Areas of Competency****Ear Care/Irrigation** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Learning Outcome*** Ear irrigation is one of the highest areas of litigation – make sure you are indemnity covered to perform this procedure.
* Has read and understood the CEPN statement on ear irrigation (Appendix 1)
* Able to identify wax in ear using auriscope
* Knows when not to irrigate as per NICE guidelines\* or to refer to nurse or GP for review/advice

**Pre Procedure*** Check patient records to confirm GP/nurse has referred for ear irrigation
* Check patient has been using ear drops for correct time prior to procedure
* Check safe to proceed with ear irrigation as per NICE guidelines\*
* GP/Nurse to check ear prior to irrigation **on the day** of procedure
* Patient has understood and signed consent form (**Appendix 2)**
 |  |  |  |  |
| **During Procedure*** Use an electronic ear irrigator (safety, maintenance, cleaning, infection control)
* Prepare all equipment
* Use correct water temperature (around body temperature) and recommended amount per ear
* Use jet tip correctly
* Inspect ear canal with otoscope to review effectiveness of procedure
* Check patient safety and comfort throughout procedure
* Post ear irrigation inspection, able to identify normal/abnormal Tympanic Membrane
* Perform aural toilet
 |  |  |  |  |
| **Post Procedure*** Able to identify and act upon any presenting risk factors
* Give post procedure ear care advice
* Document clearly and correctly in patient notes
* Scan signed consent form to patient notes
* Clean machine as per manufacturer’s instructions at the end of each days use.
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| **Areas of Competency****Ear Care/Irrigation** |
| **Notes****References** <https://cks.nice.org.uk/earwax#!management>**Training Attended**

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| **Areas of Competency** **Recording a Standard 12 Lead Electrocardiogram (ECG)**  | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure** * Check why ECG has been requested
* Identify correct patient
* Explain procedure and gain consent
* Offer a chaperone
* Check expiry dates of electrodes
* Standard calibration of the ECG is 10mm/mV – check this is the default position prior to taking ECG (follow manufacturer’s instructions to set this)
* Wash hands
 |  |  |  |  |
| **During Procedure*** Open correct patient in SystmOne and initialise monitor
* Request patient removes clothing above the waist
* Correctly position patient on couch lying approximately at a 45 degree angle
* Clean skin **if required** with soap and water and dry thoroughly
* Employ correct technique for locating chest electrode positions:

<https://www.youtube.com/watch?v=0gAOy7f2-Gs> * Apply electrodes correctly
* If unable to apply electrodes due to chest hair, remove hair from area using a single use razor with patient consent
* Dispose razor in sharps bin
* Cover patient to preserve modesty
* Record ECG correctly according to manufacturer instructions
* After recording remove all electrodes from the patient and dispose in clinical waste
* Advise patient to redress
* Wash hands

**Post Procedure** * Record in notes using correct template
* Ensure requesting GP or nurse sees ECG results that same day (or any available GP if requesting clinician is not on duty)
* Advise patient to make appointment as per practice policy with GP/nurse to discuss results
* Check and clean machine/electrodes as per protocol
 |  |  |  |  |
| **Areas of Competency** **Recording a Standard 12 Lead Electrocardiogram (ECG)**  |
| **Notes****References*** [Recording a standard 12-lead electrocardiogram: an approved method by the Society for Cardiological Science and Technology](http://www.scst.org.uk/resources/SCST_ECG_Recording_Guidelines_20171.pdf)
* 01 September 2017 - Publisher: Society for Cardiological Science and Technology
* **Access online at:**

<http://www.scst.org.uk/resources/SCST_ECG_Recording_Guidelines_20171.pdf>* ECG electrode/lead placement 3 minute video:
* <https://www.youtube.com/watch?v=0gAOy7f2-Gs>

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| **Areas of Competency****Health Checks (HC)** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure** * Check age of patient (40-74 years of age)
* Check exclusion criteria (see NICE guidelines)
* Arrange for patient to get pre HC bloods taken approximately 2 weeks prior to appointment
* Explain procedure to patient
* Gain Consent
 |  |  |  |  |
| **During Procedure*** **Use correct NHS Health Check template**:-
* Cardiovascular risk assessment
* Smoking status
* Family History of coronary heart disease (CHD) - **\* see notes**
* Waist Circumference
* Body Mass Index (BMI)
* Cholesterol Test – *if above 7.5mmol/l refer to GP for familial hypercholesterolemia testing*
* If QRISK is over 10%, refer to nurse / GP for advice re statin
* Blood pressure check– *If above/below normal limits refer to GP*
* Check pulse rhythm - *if irregular refer to GP*
* Physical Activity Assessment – *if inactive sign post to local services*
* Alcohol Risk Assessment – *AUDIT questionnaire if above sensible limits*
* Diabetes Risk Assessment - **\* see notes**
* Give dementia awareness advice/leaflet
* Discuss all results with patients
* MECC (making every contact count) – lifestyle advice
* Answer questions or sign post to GP/Nurse
* Give appropriate supporting leaflets
 |  |  |  |  |
| **Post Procedure** * Document consultation and advice given in patient records using correct template.
* Inform GP/nurse of any abnormal findings or any concerns
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| **Areas of Competency****Health Checks (HC)** |
| **Notes*** **CHD** - Family history of coronary heart disease in first-degree relative under 60 years. First-degree relative means father, mother, brother or sister.
* **BMI** – A blood glucose test is required where the individual’s BMI is greater than 27.5 for people from black, Asian and other ethnic groups or BMI is greater than 30 rest of population – refer to GP/Nurse
* **Diabetes risk assessment** –A blood glucose test is required if BMI is greater than 27.5 for people from black, asian and other ethnic groups or greater than 30 (rest of population) OR blood pressure is at or above 140/90mmHg – refer to GP/Nurse

**References*** Public Health England - NHS Health Check Best practice guidance March 2016
* Making every contact count information:

[**http://www.makingeverycontactcount.co.uk/**](http://www.makingeverycontactcount.co.uk/) **Training Attended**

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| **Areas of Competency****Inhaler Technique** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** Check identity of patient
* Gain consent
* Check patient has had an full asthma review in the past 6/12 months with a clinician, if not arrange a review
* Check you are familiar with the type of inhalers prescribed, if not speak to clinician prior to seeing patient
* Ask about any concerns
 |  |  |  |  |
| **During Procedure*** Check patient has correct inhalers as prescribed
* Check how often they are using inhalers, if not using as prescribed refer to clinician

Seven Basic Steps to using an inhaler device: 1. Prepare inhaler device
2. Prepare/load the dose
3. Breathe out, fully and gently, but not into the inhaler
4. Place inhaler mouthpiece in the mouth and seal the lips around the mouthpiece
5. Depress or click inhaler to release the dose of medication
6. Breathe in: • Metered Dose Inhaler (MDI): Slow and steady

 • Dry Powder Inhaler (DPI): Quick and deep 1. Remove inhaler from the mouth and hold the breath for up to 10 seconds
2. Wait for 30+ seconds then repeat as necessary
3. Have a drink to rinse mouth and throat
 |  |  |  |  |
| **Post Procedure*** Advise patient on care, maintenance and storage of inhalers and any spacers if used.
* Sign post patient to access further information on inhaler technique (see references)
* Arrange to see patient again within 1 month if technique is moderate/poor or if a new type of inhaler has been prescribed
* Document consultation in patient notes
* Report any concerns to clinician
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| **Areas of Competency:** **Inhaler Technique** |
| **Notes****References*** <https://www.rightbreathe.com/>
* <https://www.respiratoryfutures.org.uk/media/69774/ukig-inhaler-standards-january-2017.pdf>
* <https://www.asthma.org.uk/advice/inhaler-videos/>
* [BTS/SIGN Asthma Guideline Quick Reference Guide 2016](https://www.brit-thoracic.org.uk/document-library/guidelines/asthma/btssign-asthma-guideline-quick-reference-guide-2016/)

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| **Areas of Competency****Intramuscular Injections** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| * HCSW can only administer the following injections in General Practice: Influenza, B12, Shingles, Pneumococcal for patients over 18 years of age
* Must attend annual immunisation training

**Pre Procedure**Check* Correct Patient
* When last dose was given
* Correct Drug
* Correct Time
* Correct Dose
* Correct Route
* Expiry date
* Make sure patient specific direction (PSD) signed by clinician
* Wash hands
 |  |  |  |  |
| **During Procedure*** Check identity and gain consent
* Check allergies
* Draw up medication as prescribed (unless using pre-filled syringe) selecting correct size needle
* Disperse air bubbles (some flu injections do not require bubbles to be dispersed, follow individual manufacturer’s instructions)
* Change needle – dispose of old needle in sharps bin
* Use tray to transport injection to patient
* Ensure patient is sitting (consider laying down if history of fainting)
* Locate correct site
* Gently stretch skin
* Insert needle at 90 degrees holding like a dart
* Depress plunger slowly
* Wait 10 seconds prior to removing
* Dispose of sharps immediately
* Apply pressure with cotton wool
* Apply plaster if required
* Wash hands
* Advise of next injection date and book appointment
 |  |  |  |  |
| **Areas of Competency:****Intramuscular Injections** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Post Procedure:*** Record results in patient notes using correct templates
* Give post injection advice
* Check stock
* Ensure evidence of PSD to patient notes
 |  |  |  |  |
| **Notes:*** Swab skin **only** if patient is immunocompromised or skin is unclean
* Wear gloves **only** if the skin is not intact
* Do not aspirate
* Attend annual anaphylaxis and basic life support training
* Attend annual immunisation training
* *Adhere to Practice policy regarding home visits for flu vaccination (Ensure you carry an anaphylactic kit and sharps box with you and transport vaccines in appropriate cool box)*

**References:** Shepherd E**(2018) Injection technique 1: administering drugs via the intramuscular route. *Nursing Times* (online); 114: 8, 23-25****Training Attended**

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| **Areas of Competency****INR Monitoring (International Normalised Ratio)** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Learning Outcomes:*** HCSW has completed and passed appropriate anticoagulation training and updates
* Trained and competent at using computerised dosing support system (usually INR STAR)
* Trained and competent at performing quality control checks

**Pre Procedure:*** Confirm that oral vitamin K is kept in the fridge and is in date
 |  |  |  |  |
| **During Procedure*** Identify patient and select in INR star
* Switch on Coaguchek machine and follow instructions
* Check expiry date of code test strips and insert into machine
* Check code on machine matches with strip code
* Check if patient has changed dose, started new medicines or missed any warfarin doses prior to testing and document accordingly on INR STAR
* Prick patients finger using lancet
* Dispose of used lancet in sharps box
* Apply drop of blood correctly to test strip ensuring enough is applied to draw up strip
* Apply cotton wool to patients finger and then plaster if required when bleeding has stopped
* Note INR result and enter onto INR STAR
* If INR out of range refer to clinician
* If the warfarin dose requires changing a clinician will need to sign INR star documents to confirm they are happy with new regime.
* Print summary dosing record from INR star for patient
* Record regime in patients yellow anticoagulation booklet and ensure patient understands
* Record results in patients records using correct template
* Remind patient of red flags prior to leaving
 |  |  |  |  |
| **Post Procedure:*** Clean machine as per manufacturer’s instructions
* Make sure quality control testing is being performed weekly and documented on INR star
* Make sure NEQUAS is being performed every quarter
* Check there are enough test strips for future appointments
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| **Areas of Competency****INR Monitoring (International Normalised Ratio)** |
| **Notes****Reference**<https://learning.bmj.com/learning/module-intro/maintaining-patients-on-anticoagulants--how-to-do-it.html?moduleId=5004429>**Training Attended**

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| **Areas of Competency****Peak Flow Monitoring** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Peak expiratory flow (PEF) monitoring is an easy and quick test to monitor the maximum amount of air a person can exhale forcefully after full inspiration.****Pre Procedure*** Check why peak flow is being monitored
* Identify correct patient
* Check if patient is taking any asthma medication
* Gain consent
 |  |  |  |  |
| **During Procedure**To perform peak expiratory flow recordings the person will: * Ensure peak flow meter has a one way valve mouthpiece with marker to zero
* Sit or stand
* Take full inspiration through the mouth and place mouth and teeth around the mouthpiece
* Make a forced powerful hard short blow into the peak flow meter, note where marker is.
* Return marker to zero
* Leave 2 seconds between further blows
* Repeat 3 times with acceptable blows and record the highest recording in notes (if the 2 largest PEF are not within 40 l/min of each other you will need to perform further blows)
* Discard disposable mouth piece
* Clean peak flow monitor as per protocol
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| **Post Procedure*** Record results in patient records using correct template

Inform GP/nurse of any abnormal readings |  |  |  |  |

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| **Areas of Competency****Peak Flow Monitoring** |
| **Notes****References**British Thoracic Society Guidelines 2018NICE Asthma Guidelines 2018**Training Attended**

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| **Areas of Competency:****Phlebotomy** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** Gather supplies – appropriate blood collection tubes, sterile swab, cotton wool, tourniquet, gloves, blood drawing needle, sharps box, tape.
* Able to identify which sites/areas are suitable for venesection
* Print request form
* Identify patient
* Explain procedure
* Gain consent
 |  |  |  |  |
| **During Procedure*** Wash hands and apply gloves
* Rest patients arm appropriately
* Identify the vein **\*see notes**
* Clean area with sterile swab and allow to dry for 30 seconds
* Apply tourniquet to about 3-4 inches above vein site
* Do not allow tourniquet to be left on for more than 2 minutes
* Observe arm throughout procedure for signs that the tourniquet might be too tight
* Holding patient’s lower arm pull skin taut to stop vein from rolling.
* Insert needle attached to vial at 15-30 degrees into the vein
* Collect blood sample as per blood collection tube instructions
* Remove tourniquet as soon as the last sample is collected
* Remove needle gently and apply pressure using cotton wool
* Dispose of sharps in sharp box
* Label blood collection tubes and put into labelled transport specimen bag
* Apply cotton wool and tape to puncture site and give advice on post phlebotomy care
 |  |  |  |  |
| **Post Procedure*** Document procedure in patients records using correct template
* Make sure specimens are delivered to the laboratory on the day of collection
* Advise patient re practice procedure to obtain results
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| **Areas of Competency****Phlebotomy** |
| **Notes:**Adult patients: Most common vein for drawing blood from the elbow crevice is the median cubital vein in the antecubital fossa. Other veins commonly used are the cephalic vein and the basilic vein.**References:**<https://nurse.org/articles/how-nurses-professionally-draw-blood/>**Training Attended**

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| **Areas of Competency****Suture and Staple/Clip Removal** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** Check in patient notes recommended suture/clip removal date
* Prepare dressing trolley with dressing pack, suture removal blade or clip removers and forceps
* Gain consent
* Make sure patient is comfortable and address any concerns
* Ensure sufficient light
* Wash hands and apply gloves
* Inspect wound for signs of infection or complications
 |  |  |  |  |
| **During Procedure**Sutures* Gently lift stitch knot with forceps and cut one side of stitch closest to the skin
* Pull stitch out and place removed stitch on gauze
* To ensure wound is fully healed remove sutures alternately until all sutures have been removed
* Dispose of sharps immediately

Staples/clips* Place bottom clip blade under staple and close (this will lift staple edges from patients skin for you to fully remove)
* Place removed staple into sharps bin
* To ensure wound is fully healed remove staples alternately until all staples have been removed
* Dispose of clip remover into sharps bin after use
* If any concerns, stop procedure and seek advice from GP/Nurse
* Check wound for any open areas or any unseen sutures/clips
* Apply dry dressing if required
* Wash hands
 |  |  |  |  |
| **Post Procedure*** Document procedure in patient records using correct template
* Give patient post suture/clip wound advice
* Inform GP/Nurse of any concerns
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| **Areas of Competency****Suture and Staple/Clip Removal** |
| **Notes****References**Nursing 2018 Removing sutures and staples* PULLEN, RICHARD L. JR. RN, EdD Nursing2003: [October 2003 - Volume 33 - Issue 10 - p 18](https://journals.lww.com/nursing/toc/2003/10000) CLINICAL DO'S & DON'TS.

**Training Attended**

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| **Areas of Competency****Urinalysis** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure:*** Confirm reason for urinalysis request
* Print or locate request label if sending to laboratory
* Check expiry date of test strips
* Obtain patient consent
 |  |  |  |  |
| **During Procedure:*** Wear gloves prior to procedure
* Confirm correct identification of patient sample with request label
* Dip test strip in urine correctly then rest on paper towel or hold
* After allocated time check results against bottle
* Inform requesting nurse/GP as soon as possible of any abnormal results - (note any strong smell/colour/consistency of urine)
* Send sample correctly labelled in correct specimen bottle if requested:
1. Use **red topped** boric acid container for all urine samples (except for diabetic ACR) and send to laboratory within 24 hours of sample collection
2. Use **white topped** urine specimen pot for all diabetic ACR urine tests, ensure first urine of the day and send to laboratory on the day of sample collection
* Dispose of items as per policy
* Wash hands
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| **Post Procedure:*** Record results in patient notes using correct template
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| **Areas of Competency****Urinalysis** |
| **Notes**Findings from the reagent strip might include:* **Glucose** – suggestive of diabetes
* **Bilirubin** – may indicate liver damage
* **Ketones** – sign of high blood sugar or not eating/vomiting.
* **Specific gravity** – concentration of urine.
* **Blood** – present in kidney disease, kidney stones, tumours, infections and trauma
* **pH** – shows acidity, normal urine has a pH of 4.5 to 8.00
* **Protein** – possible infection

*Notes Cont’d** **Urobilinogen** – higher may indicate liver disease, lower may indicate gallstones
* **White blood cells** - kidney or bladder infections

**References:**First Steps for Health Care Assistants Royal College of Nursing <http://rcnhca.org.uk/clinical-skills/observation/urine-testing>**Training Attended**

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| **Areas of Competency****Wound Care** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** How and when did wound occur
* Are you confident to dress?
* Check correct dressings are in stock
* Gain consent
* Wash hands
* **Nurse or GP must assess all wounds prior to care being delegated to HCSW and review weekly and as needed**
 |  |  |  |  |
| **During Procedure*** Irrigate and dress wound appropriately selecting correct dressings using an aseptic technique

Assess: * Wound size
* Wound site
* Wound bed
* Periwound area
* Signs and symptoms of infection ?swab
* Wound edges
* Wound odour
* Wound exudate
* Wound management (dressings and frequency of redressing)
* Wound pain
* Is wound healing? If not refer to GP/nurse
* Any contraindications/allergies?
* Check patient comfort throughout procedure
* Give correct holistic wound care advice to patient (red flags/dressing care/nutrition etc.)
* Inform Nurse/GP of any deterioration or concerns
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| **Areas of Competency****Wound Care** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Post Procedure*** Check patient comfort
* Dispose of dressing pack in clinical waste bin
* Disinfect clinical trolley
* Check stock

*Post Procedure Cont’d** Inform Nurse/GP of any dressings that need to be prescribed and issued
* Book next appointment if required
* Document in patient records using correct template
 |  |  |  |  |
| **Notes**ReferencesWound assessment and treatment in primary care Independent Nurse: Written by: [Edwin Chamanga](http://www.independentnurse.co.uk/site/contact-form.aspx?to=3QmKEaAqN91zx5QV/2NDrQFLi9Es0X5wQwxFCWzVn+OYBK27FSLi/3U1f28/8Ie+34P6rXl7mquZ7BMVRZwmuA==) | Published: 23 March 2016<http://www.practicenurse.co.uk/index.php?p1=a-z&p2=wounds-and-wound-care>**Training Attended**

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| **Areas of Competency****Wound Swabs** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| **Pre Procedure*** Check why wound swab has been requested
* Print/obtain request label
* Identify correct patient

Gain consent |  |  |  |  |
| **During Procedure*** Wash hands
* Set up sterile field and select correct swab
* Apply gloves
* Remove any wound dressings
* Irrigate wound with normal saline to remove pus/exudate
* Rotate wound swab over wound applying just enough pressure to release wound exudate for 5 seconds
* Wet swab with normal saline if dry wound prior to procedure
* Return swab to container (culture medium) immediately without contamination, closing lid fully
* Redress wound
 |  |  |  |  |
| **Post Procedure:** * Wash hands
* Label and securely package wound swab
* Must be transported to laboratory at room temperature within 24 hours
* Document in patient records using correct template
* Advise GP/nurse that swab has been taken
* Observe patient records frequently for results
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| **Areas of Competency****Wound Swabs** |
| **Notes**ReferencesWound assessment and treatment in primary care Independent Nurse: Written by: [Edwin Chamanga](http://www.independentnurse.co.uk/site/contact-form.aspx?to=3QmKEaAqN91zx5QV/2NDrQFLi9Es0X5wQwxFCWzVn+OYBK27FSLi/3U1f28/8Ie+34P6rXl7mquZ7BMVRZwmuA==) | Published: 23 March 2016<http://www.practicenurse.co.uk/index.php?p1=a-z&p2=wounds-and-wound-care>**Training Attended**

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Appendix 1

 

**A Statement on Ear Irrigation in General Practice**

November 2018

It is with some reservation that Ealing CEPN have included ear irrigation as a competency within the HCSW passport due to concerns over the risks of perforation and litigation. We have therefore issued a statement to advise practices on current advice so they may make an informed decision whether to offer this service or indeed delegate it to a HCSW.

Latest guidance from NICE (June 2018) state that ‘GP surgeries or community clinics should offer to remove earwax if a build-up is contributing to someone’s hearing loss’ and not referred to ENT.

However, GP practices are under no obligation to offer this service under the GMS contract, nor receive any reimbursement as it is not part of the Ealing Standard.

Wessex LMC advise that ‘practices need to take into consideration their resources, competency of staff, training needs, safety and risk of litigation’.

Recommendations from the RCN, The Rotherham NHS Foundation Trust, Medical Defence Organisations and the BMA is that the GP and/or registered nurse **remain responsible** for any ear irrigation delegated to an unregistered practitioner (HCSW).

We advise that if you choose to offer this service and expect it to be delivered by your HCSW that it is performed by a competent and experienced HCSW and that the patient’s ear is examined and assessed by a GP or nurse immediately prior to any irrigation.

The HCSW must be fully aware of NICE guidelines and advise the patient of the risks prior to this procedure so that the patient can make an informed decision. By ‘experienced and competent’ we would expect the HCSW to have at least 2 years experience working in general practice and be fully trained and assessed as competent in ear irrigation.

The Ear Bulb:

We would like to advise that there is growing evidence for alternatives to ear irrigation. Patients can self-treat at home with the ear bulb syringe. This can be purchased over the counter or from amazon for under £6 and the evidence thus far (be it limited) has shown it to be safe and significantly reduce the demand for appointments for ear irrigation. Please see link below for further information for a patient information leaflet.

Wessex LMC Ear Irrigation advice.

<https://www.wessexlmcs.com/lmcguidetoearcare>

RCN competencies

[file:///C:/Users/haisus/Downloads/PDF-006855%20(2).pdf](file:///C%3A/Users/haisus/Downloads/PDF-006855%20%282%29.pdf)

Rotherham Ear Care Centre

<http://www.earcarecentre.com/professionals/protocols/>

NICE 2018 Ear assessment and management.

<https://www.nice.org.uk/guidance/ng98/chapter/Recommendations#assessment-and-referral>

Ear Bulb information

<http://www.cityandhackneyccg.nhs.uk/Downloads/gp/Pathways/Ear%20Wax%20Bulb%20syringe%20pathway%20-%20Approved%20Dec%202014.pdf>

Appendix 2

**EAR IRRIGATION**

**PATIENT INFORMATION LEAFLET AND CONSENT FORM**



Ear wax is normal and provides protection from dust and infection. A build-up of ear wax is only a problem if it is causing deafness, pain or if the ear drum needs to be seen by a clinician but is obscured by wax

DO NOT use cotton buds or any other objects to remove wax as this can impact the wax or cause damage and trauma which may lead to infections.

If you have troublesome ear wax:

* Apply ear drops to affected ear for 5-7 days initially to soften wax and aid removal.
* Olive oil, or almond oil drops (unless nut allergy) can be used 3-4 times daily
* Lie down and allow drops to soak into the affected ear for a minimum of 10 minutes per ear
* Do not apply cotton wool afterwards as this acts as an absorbent
* Do the above for 2 weeks, if after 3 weeks you are still deaf please see the GP or nurse for a check up
* See the GP sooner if you are experiencing pain or discharge or your condition worsens

Ear irrigation is a **last resort** to removing ear wax and will only be offered if the ear remains completely blocked with ear wax AFTER the 2 week regime.

Ear irrigation also comes with the following risks:

* Failure to remove wax
* Pain, discomfort
* Dizziness, vertigo, nausea and vomiting
* Worsening of tinnitus
* Perforation of the ear drum, ear infection, deafness.

Ear irrigation is not an emergency procedure so you will be offered an available routine appointment for this procedure if indicated.

If you have any questions or are concerned about the risks please discuss this with the nurse at your appointment.

**EAR IRRIGATION CONSENT FORM**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you: Comments if applicable:

* Undergone 2 weeks of ear drops? Y / N ………………………………………………
* Had ear pain in the last 8 weeks? Y / N ………………………………………………
* Had an ear infection in past 8

weeks? Y / N ……………………………………………...

* Any unusual ear discharge? Y / N ………………………………………………
* History of ear perforation,

ear surgery or cleft palate? Y / N ………………………………………………

* Recent head injury? Y / N ………………………………………………
* Hearing in only one ear? - do not

Irrigate that ear. Y / N ………………………………………………

* Any previous ear irrigation

complications? Y / N ……………………………………………...

* Received post ear irrigation advice? Y / N ……………………………………………...

*I have received, read and understood the ear irrigation patient information leaflet. The Health Care Assistant/nurse/GP has explained the procedure to me and answered any questions.*

*I am fully aware of the risks of ear irrigation (failure to remove wax, dizziness, vertigo, nausea and vomiting, perforation, ear infection and deafness).*

*I am aware that ear irrigation is not a painful procedure and will inform the clinician immediately of any pain or discomfort, if I want them to stop or if I experience any dizziness or nausea.*

*If I experience any pain or discharge post procedure I will contact the GP.*

*I agree to have ear irrigation performed on me today*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* After irrigation keep ears dry for a few days to allow the protective wax layer to reform. If ear wax build up is a continuous problem for you try applying olive oil ear drops once a week to keep the wax sort and aid natural removal.