A puzzle piece in a shape of a map

Description automatically generated

Health Care Support Worker Competency Passport

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

This Passport belongs to:

Contents:

Page 2 - 24 hour Ambulatory Blood Pressure Monitoring

Page 5 - Blood Glucose Testing

Page 7 - Blood Pressure Monitoring

Page 10 - Brief Smoking Cessation Advice

Page 12 - Diabetic Foot Checks

Page 15 - Ear Care and Irrigation

Page 18 - Electrocardiogram Recording

Page 21 - Health Checks

Page 24 - Intramuscular Injections

Page 28 - INR monitoring

Page 31 - Peak Flow Recording

Page 33 - Phlebotomy

Page 36 - Suture and Clip Removal

Page 39 - Urinalysis

Page 42 - Wound Care

Page 45 - Wound Swabs

| Areas of Competency: 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   * Initialise monitor as per manufacturer instructions * 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 points 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 of monitor and remove at correct time the next day before returning monitor to GP surgery * Document consultation in patient notes using correct template |  |  |  |  |
| Post Procedure:   * Download results to correct patients records as per manufacturer instructions * Alert requesting clinician that results are available to view * Check and clean equipment as per policy |  |  |  |  |
| Notes:  Update training record: |  |  |  |  |

| **Areas of Competency: BLOOD GLUCOSE TESTING** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * 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 * Check identity of patient * Gain consent * Gather equipment to hand [blood glucose meter, cotton wool, gloves, glucose test strips, lancet, sharps box] * Wash hands |  |  |  |  |
| During Procedure:   * Insert test strip into meter [do not touch testing area] * Apply gloves * Apply lancet to side of patients finger and use as instructed 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 and plaster * Note result * Dispose of test strip into sharps box |  |  |  |  |
| Post Procedure:   * Document results in patient records using correct template * Report abnormal results to clinician |  |  |  |  |
| 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 Update Record |  |  |  |  |

| **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 and reecord [If AF to inform clinician and book patient for ECG] * Explain procedure and gain consent * Wash hands |  |  |  |  |
| During Procedure:   * Ensure patient is relaxed and sitting down * Locate brachial artery * Apply cuff correctly to arm * 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 * \*if using automatic blood pressure monitor refer to 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 |  |  |  |  |
| 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:** record at least annually in patients without history of hypertension or renal disease.   **Or every:**   * 1 month if blood pressure is higher than 150/90 mmHg * 2 months if blood pressure is higher than 140/80 mmHg * 2 months if blood pressure is higher than 130/80 mmHg and there is kidney, eye or cerebrovascular damage. * Once stable monitor ever 4-6 months therafter * 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/> |  |  |  |  |
| Training Update Record |  |  |  |  |

| **Areas of Competency: BRIEF SMOKING CESSATION ADVICE** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| 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 * Has attended Making Every Contact Count Training every 2 years |  |  |  |  |
| During Procedure:   * Ask questions about current and past smoking behaviour * Offer verbal and written information on smoking risks and benefits in stopping * Advise patient of various options for stopping * Refer to local stop smoking service/pharmacist if they wish * 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 patient |  |  |  |  |
| Notes:  Reference: https://cks.nice.org.uk/smoking-cessation#!topicsummary |  |  |  |  |
| Updates: |  |  |  |  |

| **Areas of Competency : DIABETIC FOOT CHECKS** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * Gain Consent * Wash hands – apply gloves |  |  |  |  |
| During Procedure:   * 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 * Palpate foot pulses [dorsalis pedis and posterior tibial pulses] * Check temperature and blood flow * Check sensation using monofilament and document risk level * Ask patient if they have noticed any foot problems |  |  |  |  |
| 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 |  |  |  |  |
| Notes:  **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   **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     Training Update Record |  |  |  |  |

| **Areas of Competency : EAR CARE/IRRIGATION** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * **Ear irrigation is one of the highest areas of litigation – make sure you are indemnity covered to perform this 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 * Able to identify wax in ear using auriscope * Check safe to proceed with ear irrigation as per NICE guidelines\* * Knows when not to irrigate as per NICE guidelines\* or to refer to nurse or GP for review/advice * GP/Nurse to check ear prior to irrigation on the day of procedure |  |  |  |  |
| 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 auriscope 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 * Clean machine as per manufacturer’s instructions at the end of each days use. |  |  |  |  |
| Notes:  References  https://cks.nice.org.uk/earwax#!management |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Training update record |  |  |  |  |

| **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:   * Request patient removes clothing above the waist * Correctly position patient on couch lying approximately at a 45 degree angle with arms supported * 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 with GP/nurse to discuss results * Check and clean machine/electrodes as per protocol |  |  |  |  |
| Notes: Ref: [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 |  |  |  |  |
| Training Update Record: |  |  |  |  |

| **Areas of Competency: HEALTH CHECKS [HC]** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * Ensure you have adequate appointment time [20-30 minutes] * 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 Health Check template**:- * Cardiovascular risk assessment * Smoking status * Family History of coronary heart disease [CHD] - **\* see notes** * Body Mass Index [BMI] * Cholesterol Test – *if above 7.5mmol/l refer to GP* * 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 10 questions long, follow pathway* * Diabetes Risk Assessment - **\* see notes** * Give dementia awareness advice/leaflet * Every patient having a HC must be told their BMI, cholesterol level, blood pressure, AUDIT score and CVD risk score. * 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 |  |  |  |  |
| 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   <file:///C:/Users/haisus/Downloads/20160226%20Best%20Practice%20Guidance%20FINAL%20(2).pdf>   * Making every contact count information:   **http://www.makingeverycontactcount.co.uk/** |  |  |  |  |
| Training Update Record: |  |  |  |  |

| **Areas of Competency : INTRAMUSCULAR INJECTIONS** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * **HCSW are only allowed to administer the following injections in General Practice: Influenza, B12, Shingles,** **Pneumococcal** * Has a record of attendance and is up to date with annual immunisation training   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 plaster if required * Wash hands * Advise of next injection date and book appointment |  |  |  |  |
| Post Procedure:   * Record results in patient notes using correct templates * Give post injection advice * Check stock * Scan 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 [Only to be done if the injection site is the dorsogluteal muscle] * Attend annual anaphylaxis and basic life support training * Attend annual immunisation training * *Adhere to Practice policy regarding home visits for flu vaccination [make sure 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 Update Record: |  |  |  |  |

| **Areas of Competency: INR MONITORING [International Normalized Ratio]** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * Has completed and passed appropriate anticoagulation training and updates   [minimum BMJ module – see notes]   * Trained and competent at using computerised dosing support system [usually INR STAR] * Trained and competent at performing quality control checks * 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 when bleeding has stopped * Note INR result and enter onto INR STAR * If the warfarin dose requires changing a clinician will need to sign PSD to confirm they are happy with new dose. * 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 |  |  |  |  |
| Notes:  References:  <https://learning.bmj.com/learning/module-intro/maintaining-patients-on-anticoagulants--how-to-do-it.html?moduleId=5004429> |  |  |  |  |
| Training Update Record: |  |  |  |  |

| **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:   * Have a peak flow meter with one way valve mouthpiece to hand 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 peak flow dairy. [if the 2 largest PEF are not within 40 l/min of each other you will need to perform further blows] * Clean peak flow monitor as per protocol   Post Procedure:   * Record results in patient records using correct template * Inform GP/nurse of any abnormal readings |  |  |  |  |
| Notes:  References:  British Thoracic Society Guidelines 2018  NICE Asthma Guidelines 2018 |  |  |  |  |
| Training Update Record: |  |  |  |  |

| **Areas of Competency: PHLEBOTOMY** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * Able to identify which sites/areas one would not take blood sample from * Print request form * Identify patient * Explain procedure * Gain consent * Gather supplies – appropriate blood collection tubes, sterile swab, cotton wool, tourniquet, gloves, blood drawing needle, sharps box, plaster. |  |  |  |  |
| 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 plaster 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 |  |  |  |  |
| Notes:  References:  <https://nurse.org/articles/how-nurses-professionally-draw-blood/>  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. |  |  |  |  |
| Training Update Record |  |  |  |  |

| **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 * Gain consent * Inspect wound for signs of infection or complications * Prepare dressing trolley with dressing pack, suture removal blade or clip removers and forceps * Make sure patient is comfortable and address any concerns * Ensure sufficient light * Wash hands and apply gloves |  |  |  |  |
| 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 * Continue to 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 * Continue to 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 including number of stitches/staples removed in patient records using correct template * Give patient post suture/clip wound advice * Inform GP/Nurse of any concerns |  |  |  |  |
| 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. |  |  |  |  |
| Updates: |  |  |  |  |

| **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 * Obtain patient consent |  |  |  |  |
| During Procedure:   * Wear gloves prior to procedure * Confirm correct identification of patient sample with request label * Check expiry date of test strips * 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 and send to laboratory on the day of sample collection  * Dispose of items as per policy * Wash hands |  |  |  |  |
| Post Procedure:   * Record results in patient notes using correct templates |  |  |  |  |
| 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 * **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 Update Record |  |  |  |  |

| **Areas of Competency : WOUND CARE** | **Working Towards** | **Competent** | **Evidence Collated** | **Assessor Sign Off** |
| --- | --- | --- | --- | --- |
| Pre Procedure:   * **Nurse or GP must assess all wounds prior to care being delegated to HCSW and review weekly** * Gain consent * How and when did wound occur * Are you confident to dress? * Check correct dressings are in stock * Wash hands |  |  |  |  |
| 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…] |  |  |  |  |
| Post Procedure:   * Check patient comfort * Dispose of dressing pack in clinical waste bin * Disinfect clinical trolley * Check stock * Inform Nurse/GP of any dressings that need to be prescribed and issued * Document in patient records using correct template * Book next appointment if required * Inform Nurse/GP of any deterioration or concerns |  |  |  |  |
| Notes: References:Wound 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 2016http://www.practicenurse.co.uk/index.php?p1=a-z&p2=wounds-and-wound-care |  |  |  |  |
| Training Update Record: |  |  |  |  |

| **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 * 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 |  |  |  |  |
| Notes: |  |  |  |  |
| Training Update Record: |  |  |  |  |