Critical Care Networks-National Nurse Leads

National Competency Framework for

Registered Nursing Associates

in Adult Critical Care

V2 04.24

Foreword

Welcome to version 2 of the Nursing Associate (NAR) competencies. This document aligns to CC3N Best Practice Guidelines for Registered Nursing Associates in Adult Critical Care Units (2024).

These competencies have been designed to provide you with the core knowledge and skills required to care for critically ill patients safely and professionally in a general adult critical care unit under the supervision and with support of a registered nurse (RN). You will need to demonstrate fundamental underpinning knowledge in relation to all the competency statements and you are advised to keep a record of any supportive evidence and reflective practice to assist you during progress and assessment reviews. These competencies will form part of your development as a Band 4 Critical Care Nursing Associate registrant (NAR).

This document uses the term Practice Assessor for the RN that will be responsible for your assessment, you may be allocated to a different RN daily to supervise your practice.

It is anticipated that these NAR competencies will form part of your development in critical care and may be included as part of a local preceptorship programme. It is expected that these NAR competencies are completed within 12 months of appointment as a Nursing Associate in critical care, however, this timeframe will be agreed locally by your line manager and will be dependent on your previous knowledge and experience, your hours and pattern of work and local service needs. You will receive a supernumerary period, this will be agreed locally depending on your experience, however all newly registered Nursing Associates or new Nursing Associates to Critical Care will need a minimum of 6 weeks.

Nursing Associates are encouraged to develop further skills and knowledge beyond their initial qualification and training. This may include but not be limited to intravenous medication administration, intravenous fluid administration, and blood and blood product administration. Training and the application of further skills and knowledge will be in accordance with local patient need as well as being compliant with organisational policies and training pathways. Therefore additional, complementary competency or proficiency packs may form part of any additional training and education to support the further education of the registered nursing associate in critical care.

On starting your critical care development, you will be required to complete this Learning Contract with your Lead Assessor and Unit Manager. This will provide the foundations for your individual commitment to learning, your assessors' commitment to the supervision and support you will require and your managers' commitment to providing designated time and opportunities to learn.

Nursing and Midwifery Council (2024) Role Differences between Nursing Associates and Nurses

Nursing Associate (NAR) (4 Platforms)	**Registered Nurse (RN) (7 platforms)**
Be an Accountable Professional	Be an Accountable Professional
Promoting Health and Preventing Ill health	Promoting Health and Preventing Ill health
Provide and **MONITOR** care.	Provide and **EVALUATE** care.
Working in teams	**LEADING AND MANAGING** Patient Care. Working in teams
Improving safety and quality of care.	Improving safety and quality of care.
CONTRIBUTING TO integrated care	**COORDINATING** care
	ASSESSING NEEDS AND PLANNING CARE

Learner Name PRINT	SIGNATURE
Lead Assessor/Mentor Name PRINT	SIGNATURE

Contents

Assessment

Competence is defined throughout this document as:

'The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions' (1)

You, the learner, should read the competency standards within this document and reflect on your current knowledge and understanding of the theories which underpin the competency statement and standards. It is important that you meet regularly with your Practice Assessor discuss your self-assessment.

Competence must be demonstrated through **observation** of your practice against the competency statements outlined. Your Practice Assessor may however use a combination of the following techniques to support their decision:

- Discussion & probing questions
- Simulation
- Completion of associated workbooks
- Reflective practice
- Portfolio
- Record of achievements

The Practice Assessor

The practice assessor is the person responsible for making the decision on whether the Nursing Associate has met the standards. The assessor must be occupationally competent in the standards they are assessing. All Registered Nurses (RNs) can support the assessment process. You should complete these competencies within one year of joining critical care, these can be used to support your personal development plan and annual appraisal.

Assessment Process

The learning contract is completed first followed by the initial interview. This is an opportunity for you and your Practice Assessor to identify initial, key objectives for completion and the date for the mid-point assessment.

The Midpoint assessment. The midpoint assessment will enable you to discuss your progress, identifying your next objectives and to check if you need to be assigned more time to specific areas.

The Summative assessment is the final assessment at the end of the period of learning. You must pass **all** sections of the summative assessment to demonstrate your competence.

Learning Contract

The following Learning Contract applies to the Individual Learner, Lead Assessor/supervisor and Unit Manager/Lead Nurse and should be completed before embarking on this competency development programme. It will provide the foundations for:

- Individual commitment to learning
- Commitment to continuing supervision and support
- Provision of time and opportunities to learn

Learners Responsibilities

As a learner I intend to:

- Meet the standards of regularity bodies (NMC, 2018)
- Take responsibility for my own development
- Successfully complete a period of induction/preceptorship as locally agreed
- Form a productive working relationship with supervisors and assessors
- Deliver effective communication processes with patients and relatives, during clinical practice
- Listen to colleagues, supervisors and assessors advice and utilise coaching opportunities
- Use constructive feedback positively to inform my learning
- Meet with my Lead Assessor at least 3 monthly and attend the initial, midpoint and final summative meetings
- Adopt several learning strategies to assist in my development
- Put myself forward for learning opportunities as they arise
- Complete all competencies in the agreed time frame
- Use this competency development programme to inform my annual appraisal, development needs and NMC Revalidation
- Report lack of mentorship/supervision or support directly to the Practice Assessor and escalate to the Clinical Educator/Unit Manager or equivalent if not resolved.

Learner Name (Print) .....

Signature ..... Date: .....

Practice Assessor Responsibilities

As a Practice Assessor I intend to:

- Meet the standards of regularity bodies (NMC, 2018)
- Demonstrate on-going professional development/competence within critical care
- Promote a positive learning environment
- Support the learner to expand their knowledge and understanding
- Highlight learning opportunities
- Set realistic and achievable action plans
- Complete assessments within the recommended timeframe
- Bring to the attention of the Education Lead and/or Manager concerns related to the individual nursing associates learning and development
- Plan a series of learning experiences that will meet the individuals defined learning needs
- Prioritise work to accommodate support of learners within their practice roles
- Provide feedback about the effectiveness of learning and assessment in practice

Lead Assessor Name (Print) .....

Signature ..... Date: .....

Critical Care Lead/ Manager

As a critical care service provider, I intend to:

- Provide and/or support clinical placements to facilitate the learners' development and achievement of the core competency requirements
- Regulate and quality assure systems for supervision and standardisation of assessment to ensure validity and transferability of the nurses' competence

Lead Nurse/Manager Name (Print) .....

Signature ..... Date: .....

Record of Assessment Interviews

Initial Assessment Interview:

Practice Assessor: Nursing Associate: Date:

Midpoint Assessment Interview:

Practice Assessor: Nursing Associate: Date:

Summative Assessment Interview:

Practice Assessor: Nursing Associate: Date:

Authorised Signature Records

Print Name	Sample Signature	Designation	PIN No:	Organisation

Nursing Associate in Critical Care: Tracker Sheet

The following table allows the tracking of NAR Competencies and should be completed by Lead Assessors and/or Practice Educators (or equivalent) as the individual achieves each competency statement. This provides an easy and clear system to review and/or audit progress at a glance.

Competency Statement	Date Achieved	Practice Assessor Signature
1 Promoting a positive patient experience		
1.1 Promoting psychosocial wellbeing		
1.2 Visiting in Critical Care		
2 Respiratory System		
2.1 Anatomy & Physiology		
2.2 Respiratory Assessment, Monitoring & Observation		
2.3 Non-Invasive Ventilation		
2.4 Intubation/Extubation		
2.5 Tracheostomy Care		
2.6 Chest Drains		
2.7 Associated Pharmacology		
3 Cardiovascular System		
3.1 Anatomy & Physiology		
3.2 Assessment, Monitoring & Observation		
3.3 Arterial Access		
3.4 Central Venous Access		
3.5 Managing Fluid Replacement		
3.6 Shock		
3.7 Cardiac Rhythms		
3.8 Associated Pharmacology		
4 Renal System		
4.1 Anatomy & Physiology		
4.2 Assessment, Monitoring & Observation		
4.3 Renal Replacement Therapy (RRT)		

5 Gastrointestinal System		
5.1 Anatomy & Physiology		
5.2 Assessment and Management of Patients with GI conditions		
5.3 Nutrition in Critical Illness		
5.4 Associated Pharmacology		
6 Neurological System		
6.1 Anatomy & Physiology		
6.2 Assessment, Monitoring & Observation		
6.3 Sedation & Delirium Assessment and Management		
6.4 Pain Control		
7 Integumentary System		
7.1 Anatomy & Physiology		
7.2 Skin Integrity		
7.3 Joint Positioning & Range of Movement		
7.4 VTE Assessment		
7.5 Mouth and Eye Care		
8 Medicines Administration		
8.1 Regulations		
8.2 Administration		
9 Admission & Discharge		
9.1 Admission to Critical Care		
9.2 Discharge from Critical Care		
10 End of Life Care		
10.1 Assessment, Decision Making and Initiation of End-of-Life Care		
11 Intra & Inter Hospital Transfer		
11.1 Assisting in the preparation and transfer of the critically ill		
12 Rehabilitation		
12.1 Rehabilitation Initial Assessment and Referral		
13 Communication & Teamwork		
13.1 Communicating with Critical Care Patients		
13.2 Communication & Team Working		

13.3 Communicating in Difficult Situations		
14 Infection Prevention & Control		
14.1 Infection Prevention & Control		
15 Evidenced Based Practice		
15.1 Evidenced Based Practice		
16 Professionalism		
16.1 Maintaining Professionalism		

1 Promoting a positive patient experience

The following competency statements are about the psychosocial needs of a patient during a critical care stay, the competencies outlined need to be applied to all care and treatment undertaken by the nursing associate registrant in the critical care environment.

1.1 Promoting psychological wellbeing	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Concept of holistic care and how it can be incorporated into your practice: • Physical • Psychological • Social and family • Spiritual and cultural	
Common feelings experienced by patients 'waking up' in critical care to include: • Feelings of dehumanisation • Feelings of loss of self • Feelings of loss of control • Feelings of loss of time • Feelings of loss of hope • Feelings of loss of worth • Feelings of loss of reality • Feelings of loss of choice	
Impact of the following on the psychological wellbeing of critical care patients: • Sensory overload • Sleep deprivation • Pain • Confusion • Disorientation • Anxiety • Fear • Night terrors • Hallucinations	
Importance of developing the following with critical care patients: • A trusting relationship • Effective ways of communicating	
Contribute to the development of Individualised family centred care plans under supervision of the RN	
Assisting patients to: • Regain control as far as possible • Promote acceptance of the situation • Move through the grieving process • Importance of giving patients and families clear explanations about care and treatment, always seeking consent before approaching patients to undertake tasks	

1.1 Promoting psychological wellbeing continued	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Always act as the patients advocate	
Demonstrate kindness and compassion in all care undertaken	
Promote a holistic approach to all care undertaken	
Orientate patients to time, place and physical location	
Alleviate fear, stress and anxiety	
Ensure the patient is comfortable and pain free	
Promote reality where the opportunity arises	
Empower patients to regain self-concept and self-control	
Give adequate explanations regarding care and treatment in a language the patient can understand and repeat these explanations as often as needed	
Adopt appropriate communication aids	
Encourage and motivate patients to achieve independence in relevant tasks	
In conjunction with the RN, contribute to development of care plans including patients and the family in treatment choices	
Be open and honest with patients and families and demonstrate empathy towards their situation	
Encourage family members to bring in pictures, familiar music and toiletries	
Encourage patient to accept the situation they find themselves in and promote acceptance wherever possible	
Respect cultural and spiritual needs	
Promote normal sleep patterns	
Reduce sensory overload (particularly during the night)	
Give explanations for loss of time, consider use of patient diaries	
Reassure patients that many patients experience similar problems during and following a critical care stay	
Liaise with RN regarding referral for solution focused therapy or psychological support from relevant multi-disciplinary team members if appropriate	
Where used keep a clear and accurate account of the patients progress in their diary	
Encourage patients and their relatives to discuss their experiences of being in critical care, for staff to learn from this	
Provide patients and relatives with written information	
Signpost patients and relatives to support groups and/or forums (i.e., ICU Steps)	

1.2 Visiting in critical care	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Importance of visiting and protected rest periods	
Local units visiting policy, including children visiting in critical care, refreshments and availability of accommodation (consider ICU Steps resources for children visiting ICU)	
Needs of the visitor including what information & facilities are required	
Awareness of situations of when to discourage visiting or refuse entry to visitors and how to manage these situations, through conflict resolution and who to refer them to	
Awareness of patient consent/ data protection, local policy/ professional guidance around the use of photography and social media	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support for patients and their families for all aspects of care	
Establish a main person who acts as a point of contact for other family members	
Communicate information clearly taking into account the needs of the relatives/visitor, providing written information if necessary, being aware of what information can be given over the phone	
Ensure that the environment is conducive for effective communication	
Document appropriate communication to relatives /visitors in line with local policy (e.g., care plan/case notes/communication folder	
Assist with any areas for improvement that would enhance the relatives/ visitor's experience	

2 Respiratory System

You must be able to demonstrate through discussion and **practice** essential knowledge of patients with impaired respiratory function.

2.1 Anatomy and Physiology	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
2:1. The anatomy and physiology involved in respiration: • Components of the respiratory system • Role & function of the components of the respiratory system in normal respiration • Gas exchange • VQ Mismatch and patients at risk	
Risk factors for developing respiratory failure: • Type I and Type II respiratory failure and give examples from practice	
Signs & symptoms of respiratory failure	
The following conditions: • Chronic Obstructive Pulmonary Disease (COPD) • Asthma • Acute Respiratory Distress Syndrome (ARDS) • Pneumonia and Ventilator Associated Pneumonia (VAP) • Pulmonary Embolism	

2.2 Respiratory assessment, monitoring, and observation	
You must be able to demonstrate through discussion, essential knowledge of:	
• Normal parameters for respiratory observations • Rate/Depth/ pattern of respiration • Heart rate • Skin Colour, peripheral and central cyanosis • Indications for, and limitations of pulse oximetry • Use of accessory muscles • Sputum assessment • End tidal Carbon dioxide (EtCO2)	

2.2 Respiratory assessment, monitoring, and observation continued	
You must be able to undertake the following in a safe and professional manner under direct supervision by an RN, actions to restore respiratory function in response to observations Including:	
Oxygen therapy • Indications for • Potential complications • Signs & symptoms of oxygen toxicity • Various methods of oxygen delivery including high flow nasal oxygen	
Able to sample ABG from arterial line and recognise normal values, and basic analysis of respiratory, metabolic acidosis/ alkalosis and escalate findings to RN	
Patient positioning	
Deep breathing exercises	
Effective coughing (including cough assist if available)	
Liaise with therapy team (under direction of RN)	
Humidification	
Deep breathing exercises	
Effective coughing	
Safely perform ABG sampling and discuss results to RN	
Be able to demonstrate through discussion when to escalate respiratory deterioration.	
Able to assemble relevant equipment and administer oxygen therapy via: • A simple face mask • A venturi system • Nasal cannula • Reservoir mask	
Care of a patient receiving high flow nasal oxygen (HFNO) • Indications for • Contraindications • Modes and settings used – difference between flow and FiO2 • Nasal prong fitting • Pressure are care/ Oral care/ nutrition and hydration • Humidification • Documentation of settings/ observations • Psychological care • Under direct supervision of a RN discuss rationale, seek support and advice and change settings in accordance with clinical condition/ ABG/ target SPO2	
Set up and use humidification methods	
Set up and use pulse oximetry • Appropriately select probe site • Check CRT & proximal pulses	
Provide appropriate intervention for patients experiencing (and when to notify RN) airway problems: • Position • Head tilt/chin lift/jaw thrust • Insertion of airway • Manual ventilation	

2.3 Non-invasive ventilation (NIV)	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
• Care of a patient receiving non-invasive ventilation Including mask-fitting, pressure area care, oral care, nutrition and hydration and psychological care • Indications for NIV • Contraindications to NIV • Modes and setting used • Normal parameters of ventilation including rate, tidal volume, minute volume, set pressures, PEEP, I:E ratio, Leak • Management of secretions including positioning, physiotherapy, indications for suctioning, indications for heated humidification • Potential complications associated with suctioning including correct pressure, correct catheter size, correct procedure	
You must be able to undertake the following in a safe and professional manner:	
Accurately monitor and document ventilator observations	
Under the direct supervision of the RN set alarm limits appropriately for specific patients	
Seek support and advice as appropriate	

2.4 Intubation/Extubation	
You must be able to demonstrate through discussion essential knowledge of Intubation	
• Indications for intubation • Potential complications of intubation	
Process of intubation: • Including equipment • Preparation of the patient	
Discuss procedure for application of cricoid pressure and understand why it is necessary	
Causes for emergency reintubation	
The importance of an ABCDE approach of the patient about to undergo a rapid sequence induction	
Medications used for intubation	
You must be able to undertake the following in a safe and professional manner:	
Assist (only) in preparing the patient for intubation	
Prepare the equipment for intubation	
Assist (only) the RN with extubation	

2.5 Tracheostomy Care	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Anatomical position of tracheostomy	
Indications for insertion of a tracheostomy	
Types of tracheostomies • Percutaneous tracheostomy • Surgical tracheostomy • Mini tracheostomy	
Knowledge of tracheostomy care bundle and NCEPOD best practice standards	
Importance of: • Securing tube safely • Changing/cleaning inner-tube • Checking cuff pressures • Wound care management	
Management of secretions including: • Physiotherapy • Indications for suctioning • Appropriate monitoring and observations during the procedure	
Potential complications associated with suctioning • Correct pressure • Correct sized suction catheter • Correct procedure for sub-glottic suctioning	
Knowledge of associated swallowing assessments processes and difficulties	
How to refer patients to Speech and Language Therapy (SLT)	
You must be able to undertake the following in a safe and professional manner:	
Suctioning: • Select appropriate suction pressures • Select appropriate catheter size • Monitor the patient prior to, during and after suctioning • Accurately monitor & chart findings • Inform/liaise with relevant MDT members • Practice in a manner that will minimise cross infection • Correctly and safely dispose of container/contents/suction equipment as per local policy	

2.6 Chest Drains	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Indications for chest drain insertion including: • Pneumothorax • Haemo-pneumothorax • Pleural effusion • Empyema	
General care and management: • Indications for use of chest drain clamps • Drainage • Swinging • Bubbling • Bottle changes • Dressings • Removal	
Application of low thoracic suction to a chest drain	
Potential complications associated with chest drains	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Observe chest drain insertion	
Perform routine respiratory observations and escalate and changes or concerns to RN	
Effectively manage the drain: • Position of bottle • Appropriate/cautionary use of drain clamps, in line with local guidance • Perform change of dressings under the supervision of a RN • Changing/disposal of bottles • Monitoring drainage • Application of low suction under the supervision of a RN	

2.7 Associated Pharmacology	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Commonly used medications for respiratory care, • Bronchodilators/Nebulisers • Steroids • Sedation/paralysing agents • Antibiotics • Analgesia	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Safely prepare and administer medications as above to support the respiratory system within your Trust policy and scope of accepted practice.	
Monitor effects of medication	

3 Cardiovascular System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired cardiovascular function

3.1 Anatomy and Physiology	
You must be able to demonstrate through discussion, essential knowledge of:	
• Structure and function of the heart (include chambers and valves) • Identify major/minor blood vessels • Oxygenated/deoxygenated blood flow	
Determinants of the normal cardiac cycle	
Determinants of blood pressure (BP= CO x SVR)	
Determinants of central venous pressure	
Cardiac Conditions: • Hypertension • Peripheral Vascular Disease • Angina (stable/unstable) • Myocardial Infarction • Left Ventricular Failure • Cardiomyopathy • Acute Coronary Syndrome	

3.2 Assessment, Monitoring & Observation	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Indications for haemodynamic monitoring in relation to the critically ill adult: • Invasive • Non-Invasive	
Sepsis identification criteria: • Sepsis criteria • Red Flag Sepsis criteria • (non-laboratory sepsis criteria + HR, RR or ACVPU)	

3.2 Assessment, Monitoring & Observation continued	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Monitor the patient requiring cardiovascular support	
Cardiovascular monitoring including: • Pulse/ECG • Blood pressure including MAP • Temperature • Urine output • Fluid therapies • Capillary refill time • Skin turgor • Limb temperature • Blood results and the effect of abnormal results • Biochemical markers recognise when a result in outside of normal limits and escalate to RN • Vascular observations including pulses, colour and perfusion	
Report abnormal results to a RN	

3.3 Arterial Access	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Choice of arterial cannula sites	
Associated hazards and complications of arterial cannulas/lines	
Reasons for the removal of an arterial cannula	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Prepare for and assist in the safe insertion of an arterial cannula	
Correctly prepare and prime a transducer system following assessment of competence and in line with local policy	
Correctly attach a transducer to an arterial cannula following assessment of competence and in line with local policy	
Correctly zero a transducer system	
Correctly set appropriate alarm limits under indirect supervision by an RN	
Apply an appropriate dressing in accordance with local policy	
Correctly obtain a blood sample from the arterial cannula	
Safely remove an arterial cannula following competence assessment in line with local policy	

3.4 Central Venous Access	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Choice of sites for central venous access	
Associated hazards and complications of central venous catheters and systems	
Reasons for the removal of a central catheter	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Aware that line position must be checked before use in accordance with local policy	
Correctly prime a transducer system following assessment of competence and in line with local policy	
Correctly attach a transducer to a central venous catheter following assessment of competence and in line with local policy	
Correctly zero a transducer system	
Correctly set appropriate alarm limits and discuss with an RN	
Apply an appropriate dressing in accordance with local policy	
Correctly obtain a venous sample from the central line	
Under direct supervision by a RN Safely remove a central line following competence assessment in line with local policy	

3.5 Managing Fluid Replacement	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Clinical indications that necessitate fluid intervention	
Differences between colloids, crystalloids and blood products	
Provide emotional reassurance and support	
Accurately record fluid balance according to local policy	

3.6 Shock	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Classifications, signs and symptoms and treatment of: • Cardiogenic Shock • Hypovolemic Shock • Distributive Shock including: Septic Shock Neurogenic Shock Anaphylactic Shock	
You must be able to undertake the following in a safe and professional manner:	
Recognise and report the signs and symptoms of the above	
Implement the prescribed treatments (within your remit of administration and local policy) and interventions and escalate concern appropriately	

3.7 Cardiac Rhythms	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Normal conductive pathway	
Monitoring of 3 lead / 5 lead ECG	
Normal sinus rhythm	
Life threatening cardiac dysrhythmias and their management • Atrial fibrillation • Ventricular tachycardia • Ventricular fibrillation • Asystole • Pulseless Electrical Activity (PEA)	
Your role within a cardiac arrest team	
Key resuscitation equipment • Location • Application of use	
You must be able to undertake the following in a safe and professional manner:	
Correctly attach the patient to a cardiac monitor	
Correctly check 'emergency' equipment including defibrillator	
Correctly identify, respond and escalate to the RN signs of • Bradycardia • Tachycardia • Ectopic beats • Atrial fibrillation • Atrial flutter	
Correctly identify and follow BLS guidelines	

3.8 Associated Pharmacology	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Indications for and the basic effects of the following medications • Diuretics	
Indications for choice and the following fluid challenges: • Crystalloids • Colloids • Blood products	
Understand the effects of • Inotropes • Vasopressors • Vasodilators • Anti-arrhythmic • Anti-hypertensive	
You must be able to undertake the following in a safe and professional manner:	
Safely prepare and administer medications used to support the cardiovascular system within your scope of professional practice.	
Monitor patients undergoing ONE of the following therapies: • An established single low dose inotrope or vassopressor • A single IV antiarrhymia infusion • A single IV antihypertensive infusion	

4 Renal System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired cardiovascular system

4.1 Anatomy and Physiology	
You must be able to demonstrate through discussion, essential knowledge of:	
• Functions of the kidney • Production of urine • Control of fluid and electrolyte balance • Renal blood supply	
Causes of acute kidney injury • Pre-renal (Volume depletion, Dehydration, Sepsis, Heart Failure) • Intra-Renal /intrinsic kidney failure- (Glomerular disease, Toxins inc. nephrotoxic drugs, contrast medium, untreated pre-renal failure) • Post–renal /obstruction – (Blocked urinary catheter, Stones, Enlarged prostate)	
Difference between acute renal injury and chronic renal failure	

4.2 Assessment, Monitoring & Observation	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Methods of measuring and recording fluid output: • Urine output (considering via methods, e.g. urethral catheter, suprapubic catheter, non-invasive urine collection device and ileal conduit) • Fluid loss from drains • GI loss (including vomit, naso-gastric drainage, faeces) • Problems recording loss during operative procedures • Bleeding (external and internal) • Insensible loss (different routes and specific patients at risk)	
Methods and techniques for monitoring the fluid status and balance including: • Maintenance of fluid balance charts • Patient weight • Urine output relative to weight • Cumulative fluid balance • Urinalysis	
Understands which bloods relate to renal profile and when these are required	
Basic considerations in renal injury/ failure: • Nephrotoxic drugs • Drug dose adjustments in renal injury/ failure • Fluid overload • Hyperkalaemia	

4.2 Assessment, Monitoring & Observation continued	
You must be able to undertake the following in a safe and professional manner:	
Demonstrate the ability to accurately measure and record fluid balance and report abnormalities to the RN	
Can describe the normal parameters of Urea & Creatinine, Potassium, Chloride, Sodium, Bicarbonate, Haemoglobin and escalates out of range results to the RN	
Identify factors which may affect the assessment of renal function (e.g. blocked catheters and urinary retention)	
Administer appropriate care to the patient with a urinary catheter (according to national guidelines and local policy)	
Utilise locally available equipment • Catheterisation equipment • Urometers	
Weigh patients routinely in line with local policy	
Record hemodynamic parameters as directed	
Appropriately seek help in the presence of abnormal physiological/pathological results	

4.3 Renal Replacement Therapy	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
The difference between Intermittent Haemodialysis, peritoneal dialysis and CRRT	
The indications for RRT • Fluid overload • Hyperkalaemia • Metabolic acidosis • Toxin clearance	
An awareness of different types of venous access used for RRT and advantages and potential complication of each • Vas cath • AV fistula	
You must be able to undertake the following in a safe and professional manner:	
Identify the main alarm categories and their relevance	
How to appropriately dispose of waste products according to local infection prevention guidelines	
Clean and store filtration machine in line with local policy and store as appropriate	

5 Gastrointestinal System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired gastro-intestinal system system

5.1 Anatomy and Physiology	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	
Gastrointestinal tract and metabolism: • Oral cavity and swallowing • Oesophagus • Stomach • Small bowel • Large bowel • Appendix • Rectum	
Pancreas: • Function and production of insulin • Role of pancreatic enzymes	
Liver & biliary system: • Liver • Gall Bladder • Common bile ducts • Spleen	
Causes of gastrointestinal dysfunction: • Obstruction • Inflammation • Perforation • Infection • Ulceration • Factors that may affect motility (sympathetic and parasympathetic, • drugs, surgery)	
Causes of pancreatic dysfunction: • Pancreatitis • Obstruction • Diabetes (Type 1 and 2) • Cystic Fibrosis	
Causes of Liver or biliary dysfunction: • Obstruction • Inflammation • Infection (biliary sepsis) • Perforation	
Cirrhosis/ acute liver disease (distinction of acute and chronic)	

5.2 Assessment and management of Patients with GI conditions	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Normal and absent bowel sounds	
Nutritional assessment tools appropriate for use in critical care	
Weigh patients routinely in line with local policy	
Manage stoma and/or drains in accordance with national and local policy and guidelines	
Monitor and document stoma site appearance (such as colour, positioning, functioning) and escalate any concerns	

5.3 Nutrition in Critical Illness	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Factors contributing to nutritional impairment in critical illness	
Nutritional assessment tools appropriate for use in critical care	
Local nutritional care bundles in critical illness	
Different types of feeding and the indications for use: • Nasogastric/NJ /gastrostomy (PEG /RIG) • Parental nutrition • Oral	
Stomach/intestinal fluid aspiration: • Normal appearance and content of stomach/intestinal fluid • Potential abnormal appearance and content of stomach/intestinal fluid depending on the individuals presenting medical condition	
Nasogastric insertion in critical care • Correct placement of nasogastric tubes (local policy & NPSA guidance) • Prevention and of blocked enteral feeding tubes • Care of enteral feeding tubes • Types and benefits of various feeding tubes	
Complications of nasogastric feeding in critical illness	
Management of bowel function in critical care	
Nutritional needs of adults and how to maintain a healthy gut: • Food groups required • Calorific intake • Normal blood sugar	
Types of nasogastric feed	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support in relation to assessing the patients nutritional requirements	
Perform an assessment of the patient's nutritional status using an appropriate tool or local protocol	
Manage the care of a patient with a nasogastric tube including: • Method of Insertion (depending on tube type) • Correct positioning of patient • Confirming placement by pH testing (understanding normal values) • Correct external measurement • When to x-ray • Absorption and aspiration	

5.3 Nutrition in Critical Illness continued	
Administration of medication: • Correct anchoring of NG device • Monitoring for pressure sore prevention • Correct size and appropriate tube selection	
Assessment of bowel sounds	
Manage the care of a patient with a naso-jejunal tube; insertion, position and care of tube	
On-going assessment of nutritional needs	
Liaise with the MDT where appropriate	
Monitor patients during nutritional support	
Monitor blood glucose in critically ill patients according to local policy, escalate measurements to RN to and implement care as directed	
Recognition and management of the patient experiencing hypo/hyperglycaemia	
Record bowel opening accurately and monitor for diarrhoea and constipation	
Contribute to the care of managing constipation and diarrhoea, including: • Fluid management • Pharmacological management • Tissue viability issues • Patient dignity • Utilise local bowel management protocols appropriately (faecal collection systems) • Adheres to local guidelines for managing constipation • Adheres to local guidelines for management of C-Diff	
Identify at risk/high/severe risk re feeding patients in line with local guidance	
Replace electrolytes and follow reduced calorific nutrition as directed	
Provide emotional reassurance and support in relation to assessing the patients nutritional requirements	
Accurately measure and record nutritional status and report abnormalities to the RN	
Follow guidelines in the management of blood glucose control and feeding regimes	
Monitor patient's biochemistry and haematology results, escalate abnormal findings to the RN	
Administer appropriate care to the patient with enteral and parental devices (according to national guidelines and local policy)	

5.4 Associated Pharmacology	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Commonly used medications for GI management: • Prokinetics & motility • Laxatives • Anti-stimulants • Probiotics	
Discuss when the above are unsuitable and/or contraindicated	
Monitor and understand the effect of Insulin/ hypoglycaemic agents (as per local policy)	
Safely prepare and administer medications used to support the gastrointestinal system within the scope of your professional practice	

6 Neurological System

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient with impaired neurological system

6.1 Anatomy & Physiology	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Gross structures of the nervous system	
Pupil responses • How they are regulated • Abnormal responses and possible causes including focal and generalised deficit	

6.2 Assessment, monitoring and observation	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Purpose of neurological assessment tools: • ACVPU tool • GCS tool	
Recommended frequency of GCS assessment and escalation of frequency	
Logical steps to assess each component	
Scoring system for eye opening: • Correct method of assessment of eye opening to voice and painful stimulus • Correct type of painful stimulus to assess for eye opening • Correct method for assessing pupil response to light including direct and consensual light reflexes as an adjunct to GCS	
Scoring system for verbal/sound response: • Correct method of assessing orientation and verbal/sound response • Focal verbal deficit such as aphasia, receptive and expressive dysphasia	
Scoring system for motor response: • Recording of best limb response from arms • How to identify the ability to obey commands • Comparing left to right to identify focal deficit • Differentiating between normal power, mild weakness and severe weakness • Use of correct method of painful stimulus when assessing limb response • Reflex arc • Correct use of trapezius pinch • Contra-indications to orbital pressure and sternal rub • Correctly identify ability to localise • Correctly identify flexion • Correctly identify abnormal flexion • Correctly identify extension • Correctly identify no response	

6.2 Assessment, monitoring and observation continued	
Limitations of the GCS as an assessment tool: • Assessment of vital signs to ensure there is a complete data set: • ACVPU score for assessing conscious level compared to GCS assessment • Adjuncts to the GCS for detecting deterioration in clinical condition such as NEWS2 or local track and trigger tool	
GCS Intracranial and extracranial reasons for deteriorating GCS	
You must be able to undertake the following in a safe and professional manner:	
Accurately assess ACVPU or GCS and record it and discuss findings with RN	
Identify deterioration and escalate to RN for appropriate advice and guidance	
Have knowledge of focal deficits such as; gag and swallow reflexes, pupil, verbal and limb responses and correlate with anatomy and physiology	

6.3 Delirium Assessment & Management	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Relevant best practice, care bundle and NICE guidance: • Recognise Strategies to prevent and treat delirium – while escalating to RN changes. • Screening for risk factors on admission • Person centred care • Mental Capacity Act • Importance of accurate assessment/ recording and communication between care teams, patient and family	
Characteristics of delirium: • Changes in mental state • Inattention • Disorganised thinking • Altered consciousness	
Three clinical subtypes of delirium and their presentation: • Hyperactive • Hypoactive • Mixed	
Assessment of delirium using appropriate tool e.g., CAMICU	
Treatment options if delirium is diagnosed	

6.4 Pain Control	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Anatomy and physiology relating to pain perception	
Concept of pain as the 5th vital sign	
Basic pain categories: • Chronic pain • Acute pain • Break through pain • Withdrawal pain • Neuropathic pain	
Methods of pain assessment and non-verbal signs of pain: • Utilisation of a pain measurement tool	
Importance of excluding causes of agitation such as: • Constipation • Full bladder and/or blocked urinary catheter • Hypoxia • Poor positioning • Incontinence	
Have knowledge of Pharmacological treatment options for different types of pain (practice within your trust drug policy): • Non-opioid medications • Adjunct medications such as amitriptyline • Non-steroidal anti-inflammatory drugs • Anticonvulsants such as gabapentin and carbamazepine • Analgesic skin patches	
Monitor and understand the effects of • Opioid medications • Patient controlled analgesia (PCA) • Epidurals as per Local Trust Training requirements	
Utilise Nonpharmacological strategies for pain control: • Deep breathing exercises • Use of heat and cold • Reassurance and control of environmental stimulus • Positioning for comfort • Use of relaxation and diversion, limiting the noise and lighting	
You must be able to undertake the following in a safe and professional manner:	
Assess and document pain score using local scoring system and document findings clearly	
Escalate to the RN if unable to resolve pain	
Use positioning and posture to maximise patient comfort	
Ensure good communication between the patient and MDT	

7 Integumentary System

The following competency statements are about maintaining skin integrity and positioning patients in the critical care environment.

7.1 Anatomy & Physiology	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Skin: • Layers of the skin • Accessory organs • Functions of the skin	
Muscular Skeletal: • Major skeletal muscles and their structure • Associated connective tissues • Loss of muscle tone • Identification of joints	

7.2 Skin Integrity	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Risk assessments and the nursing responsibilities related to patients at risk of pressure damage	
High risk areas of the body for pressure damage	
Grades 1- 4 pressure damage (using the European Pressure Ulcer Advisory Panel – EPUAP)	
Differences between: • Pressure damage • Moisture lesions • Shear and/or friction force damage	
Practice required to prevent pressure damage: • Surface • Keep moving • Incontinence / moisture management • Nutrition	
Various pressure relieving devices available locally and the agreed pathway for accessing these	
Local reporting system for pressure related damage	
Importance of collecting and auditing data on pressure area damage to improve pressure area care within the clinical area	
Associated costs of pressure damage: • Cost to the patient in terms of delayed rehabilitation and pain • Financial costs	

7.2 Skin Integrity continued	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Surface management: • Risk assess the patient's skin using an appropriate risk assessment tool • Determine the appropriate surface for the identified risk and to locate the correct surface • Assess correct use of devices/equipment and that they are in good working order (in accordance to local policy) • Ensure regular visual checks of at risk areas are carried out	

Keep moving:
• Encourage the patient to change their position or be repositioned
• Manage people and equipment resources to achieve positioning objectives, such as the maximum length of time a patient is sitting out in a chair
• Regularly reposition unconscious patient in line with local policy or skin bundle
• Minimise shear and/or friction damage with correct use of manual handling devices
• Increased moisture damage and incontinence management: - Identify moist or wet skin
  ○ Treat dry skin with moisturisers
  ○ Cleanse the skin at the time of soiling and use topical agents that act as moisture barriers
  ○ Identify incontinence associated dermatitis, and differentiate this from pressure damage
  ○ Offer toileting opportunities based on identified individual need
  ○ Instigate any incontinence device in line with local policy	

Nutrition:
• Report any pressure damage in line with local policy
• Measure the reliability of the care delivered within the clinical area by measuring both pressure damage outcomes and compliance with processes
• Prevent pressure damage from endotracheal tube holders, by either repositioning as needed, or using commercial products that avoid pressure
• Refer patients to other members of the MDT when specialist input is needed:
  ○ Tissue viability
  ○ Dietician
  ○ Speech and language therapy
  ○ Occupational therapy
  ○ Physiotherapy	

7.3 Joint Positioning & Range of Movement	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Concept of 'range of movement' and the anatomical structures that could be damaged by poor joint positioning	
Joints that are most at risk of damage	
Concept of foot drop	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Undertake a full range of passive exercises for the patient at the time intervals specified	
Position patients ankles to reduce the risk of foot drop	
Apply any appropriate ankle/foot splint for patients at high risk of foot drop	
Identify patients at high risk of joint damage (e.g. long stay, oedematous)	
Position shoulders to prevent excessive joint stretch when lying a patient on their side	

7.4 VTE Assessment	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Importance and need to assess all patients admitted to hospital against the VTE assessment	
Importance of assessing the patient's level of mobility	
Need for all patients (both surgical and medical patients) with significantly reduced mobility to be further VTE risk assessed	
Need to review the patient-related factors identified on the risk assessment against thrombosis risk	
Why any patient at risk of thrombosis should receive thromboprophylaxis in accordance with NICE guidance and local policy	
Types of thromboprophylaxis: • Pharmacological • Mechanical	
Complications of pharmacological VTE prophylaxis	
You must be able to undertake the following in a safe and professional manner:	
Provide emotional reassurance and support	
Identifies and documents risks identified to the individual patient	
Instigates mechanical prophylaxis in line with local policy	
Safely administers prescribed pharmacological prophylaxis	
Involves patient in prevention of thrombosis as appropriate	
Reviews VTE risk assessment in line with local policy	

7.5 Mouth and Eye Care	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Eye Care:	
Identifies local eye care policy and assessment tools	
Identifies specific risks to sedated patients	
Identifies local eye care products and when to use them	
Mouth Care:	
Describe mouth care assessment tools	
Describe risks to patient from VAP	
Differentiates between care requirements for ventilated and non- ventilated patient's	
Identifies local mouth care products and when to use them	
You must be able to undertake the following in a safe and professional manner:	
Assesses, performs and documents mouthcare as per local guidance on (under guidance of the RN) • Intubated and ventilated patient • Non-intubated, self-ventilating patient	
Demonstrates assessment and documents (under guidance of the RN) appropriate eye care	

8 Medicines Administration

You must be able to demonstrate through discussion and **practice** essential knowledge of the following. This should be completed in conjunction with your local policy

8.1 Regulations	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
National and local legislation, guidelines, protocols and policies for the administration of medication: • Medicines Act • Medication Compatibilities • Misuse of Drugs Act • NMC Code of Professional Conduct	
Health & Safety regulations relevant to medicines administration in critical care: • COSHH • Safe handling and disposal of sharps • Standard precautions & personal and protective clothing/equipment • Hand hygiene	
Legal and ethical consideration of medication: • Legal requirements • Capacity Assessment • Informed consent • Acting in the patient's best interest	
You must be able to undertake the following in a safe and professional manner:	
Take responsibility as an administrator under the listed guidance and as per scope of competency.	

8.2 Administration	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Process of administration in critical care and the importance of working within your own scope of practice: • Consent • Prescription checks • Preparation of medications • Administration of medications • Non-administration of medication • Monitoring during administration • Safe discontinuation of medications under supervision • Monitoring post administration • Safe disposal of equipment • Supervision & training of others • Role and responsibility of prescribers. • Knowledge of the medication and the expected effects on the individual	

8.2 Administration continued	
Use the 5 R's when administering any medication: • Right patient • Right medication • Right dose • Right route Right time	
Prepare and use medications in critical care adhering to the following guidance: • NMC recommendation set out in the proficiencies for medicine administration • Local policy	
Discuss an awareness of the following routes of administration (in relation to local policy): • Oral • Sublingual • Buccal • Inhaled • Nasogastric • Nasojejunal • Orogastric • Rectal • Topical • Intramuscular injection • Subcutaneous injection • Intravenous	
You must be able to undertake the following in a safe and professional manner:	
Identify the correct patient always seeking positive confirmation of the individual's identity before starting the preparation of medicines in critical care, in both: • Conscious patients • Unconscious patients	
Participate in critical care patient's medication history: • Allergies and sensitivities • Regular medications and their effects on critical illness and presenting condition • Critical care medications and their effects on pre-existing co-morbidities	
Adherence to the following practices used in critical care to minimise the risk of harm to the individual or reduce the risk of error in medication and fluid administration: • Identity check • Prescription check • Weight check • Prescriber and administrators responsibilities • Required and/or continuous monitoring and observation during administration	
Prepare and use oral, intramuscular, subcutaneous and inhalation-medications in critical care adhering to the following guidance: • NMC Code • Local policy	
Demonstrate an awareness of their scope of practice if infusions devices need attention	

8.2 Administration continued	
Access information in relation to drug administration if you are unfamiliar with the prescribed medication: • Critical care pharmacist • On call pharmacist • Injectable medicines guide (MEDUSA) • Enteral medication guidelines/policy • BNF • Online data sheet compendium • Manufactures instructions • Local administration guidance	
When preparation of medications: • Demonstrate competence in mathematical calculations in line with local policy	
Select the appropriate type of equipment to use in relation to the medication being administered and the route of administration prescribed: • Consumables, taking into account local policy for line changes • Oral syringes for enteral preparations • Gloves/lubricant for rectal	
Identify and manage signs of anaphylaxis: • Early identification • Signs and symptoms • Emergency treatment • Communication with multidisciplinary team • Continuous monitoring and re evaluation • On-going treatment of anaphylaxis • Reporting of anaphylaxis, in line with local policy	
Review of regular prescriptions	

9 Admission & Discharge

You must be able to demonstrate through discussion and **practice** essential knowledge of admission and discharge to Critical Care

9.1 Admission to Critical Care	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Indications and rationale for patient admission to the critical care setting	
The nursing associate responsibilities related to patient admission processes	
Significance of initial patient physical and psychological assessments	
Setting up a bedspace for admission and perform safety checks	
Range of relevant trust, unit, network policy documents that support patient admission to critical care: • Essential Trust Documentation relating to admissions to and discharges from critical care • Operational Guidance for Critical Care Services • Outreach teams and/or other supportive structures	
Importance of the nursing associates role associated with the support and providing information for accompanying family members/carers or patient representatives on admission	
Importance of discussing the patients usual special needs or requirements with the family: (including but not exclusive to): • Hearing aids • Glasses • Mobility aids/equipment	
Importance of providing the family with timely updates and explanations	
Importance of providing families with the time and opportunity to ask questions and discuss any concerns	
Importance of obtaining infection control status and performing relevant infection control screens	
The issues related to data protection and patient confidentiality	
You must be able to undertake the following in a safe and professional manner:	
Collate, prepare and complete appropriate documentation in electronic and paper formats for admission (inclusive of but not limited to): • Completion and use of handover documentation	
Preparation of supportive equipment (inclusive of but not limited to): • Bed/mattress • Monitors • Oxygen, suction, re-breathing circuit, ventilator • Volumetric pumps • Disposables and PPE • Safety equipment	

9.1 Admission to Critical Care continued	
Demonstrate proficiency in receiving a level 2 planned admissions (e.g., surgical pathways, elective surgery) • Assess, recognise and implement the priorities associated with care activities under supervision from the RN: • Physical and psychological assessment processes • A, B,C,D,E assessment • Mental Capacity	
Ascertain the patients infection risk and take appropriate step to isolate and instigate protective equipment as required	

9.2 Discharge from Critical Care	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Current national, network and local policies, protocols and guidelines in relation to the discharge of patients from a critical care area: • NICE CG 50 • NICE CG 83 • Outreach follow up	
Roles and responsibilities of all MDT members involved in critical care patients discharge planning	
Different requirements that need to be considered to support the patients personal and socio-cultural needs following a critical care stay	
Importance of keeping the individual and family members informed, offering reassurance about what you are doing and any relevant aspects involved in the development of the discharge plan	
Implement as directed the following procedures in preparation for discharge of a step-down level 1 patient • Removal of lines • Removal of monitoring • Follow up/rehabilitation process	
Importance of establishing that the patient has understanding, can recall and repeat information provided	
MDT members responsible for each aspect of the individuals' care plan and rehabilitation needs, and how to appropriately contact them and inform them of the patients discharge from critical care	
Types of information that must be recorded in relation to different aspects of the discharge plan: • Discharge summary of critical care stay • Condition at time of discharge (system based approach) • Continuing treatment and rehabilitation plans • Infection risk • Invasive lines/devices • Equipment required	

9.2 Discharge from Critical Care continued	
The additional considerations you need to make when discharging a patient with a tracheostomy: • Tracheostomy passports/pathways • Safety equipment • Emergency algorithms • Designated wards • Ward staff capacity and capability to receive patients safely • Tracheostomy education & training • Decannulation • Time of discharge • AHP support	
You must be able to undertake the following in a safe and professional manner:	
Remove arterial lines that are no longer required under the direct supervision of a RN	
Discontinue all appropriate monitoring	
Obtain a full blood profile in line with local policy and NCEPOD	
Obtain discharge NEWS2 or equivalent local track and trigger score	
Complete all rehabilitation evaluation as required on discharge from critical care in line with local policy	
Communicate appropriately with other MDT members during and following discharge regarding the condition, treatment plans and follow up arrangements: • Outreach services • Bed management teams/systems • Patient diary follow up teams	
Provide discharge information and support to the individual and significant others	
Organise any necessary medications, equipment and rehabilitation aids	
Identify and report reasons for delay in discharge to the RN	
Record, monitor and escalate the following through the appropriate department in line with local policy: • Delayed discharge • Discharges out of hours • Privacy & Dignity/Single sex Accommodation	

10 End of Life

You must be able to demonstrate through discussion and **practice** essential knowledge of end-of-life care in Critical Care

10.1 Assessment, decision making and initiation of an end-of-life care plan	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Ethical dilemmas in caring for the critically ill patient nearing the end of life including organ and tissue donation	
Concept of futility and prolonging life	
Legal definitions of death	
Stages a patient may pass through within the dying process	
Local withdrawal of life sustaining treatment guidelines	
Role of the broader MDT in End-of-Life care: • Palliative Care Team • Bereavement Support / service • Pastoral Care	
Role of Organ donation in end-of life care in accordance with UK guidance: • Role of Specialist Nurse for Organ Donation (SNOD) • Types of organ donation – DCD, DBD, tissue donation • Human tissue act • How to contact SNOD • Ethical dilemmas around organ donation • Religious practices and organ donation • Understand the benefits of organ and tissue donation for both donor families and recipients	
Treatment algorithms as part of individualised End of Life Care planning • Pain • Nausea • Agitation • Dyspnoea • Respiratory Tract Secretions	
Rapid discharge policies	
Awareness of local withdrawal of life sustaining treatment (WoLST) policy/ guideline	
Awareness of Gold Standard Framework (GSF) • GSF Red • GSF Amber • GSF Green	
Follow up services/ bereavement services offered by critical care/ hospital trust	
You must be able to undertake the following in a safe and professional manner:	
Effectively communicate with patient and family throughout the end-of-life stages,	
Identify any resources required	
Escalate and potential problems that can arise as individuals progress towards their End of Life	
Implement aspects of the individualised End-of-Life care and treatment plan promptly, in the correct sequence, and at the earliest possible opportunity	

10.1 Assessment, decision making and initiation of an end-of-life care plan continued	
Demonstrate an understanding of the emotional and spiritual support the patient and family may require	
Demonstrate understanding of the families religious and spiritual needs immediately following death (including but not limited to): • Assemble all relevant equipment and assisting with last offices • Relatives/carer time spend at the bedside	
Following the death of a patient, facilitate processes after death (including but not limited to): • Last offices • Collection of death certificate and patient property • Provision of support documents • Local follow-up/bereavement services	

11 Intra & Inter Hospital Transfer

You must be able to demonstrate through discussion and **practice** essential knowledge of intra and inter hospital transfer

11.1 Assisting in the preparation and transfer of the critically ill	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Expected sequence of events	
Importance and implications of time critical transfers	
Assist with preparation of the patient and equipment prior to transfer	
Methods, procedures and techniques for the portable monitoring and the types of equipment required during transfer (outline the calibration requirements and battery life expectancy/expiry date of each): • Mechanical Ventilator • Oxygen supply (including flow rates and journey time) • Vital signs monitor • Invasive lines • Infusion devices/syringe pumps • Suction equipment • Transfer bag • Spinal board • Continuous ECG • Arterial blood pressure versus non -invasive blood pressure • SpO2 • Continuous capnography with wave form analysis • CVP • Temperature: • Contents of the local emergency/transfer bag and identify the situations in which it may be required • Process and sequence of communication required prior to, during • and following transfer • Safe moving and handling of the individual and equipment being transferred • Needs of family for information about transfer	
Documentation that needs to be completed for intra & inter hospital transfer: • Transfer form • Physiological observation chart • Reporting of clinical incidents • Audit tool	

11.1 Assisting in the preparation and transfer of the critically ill continued	
You must be able to undertake the following in a safe and professional manner:	
Assist in the physiological optimisation/stabilisation of the patient prior to transfer	
Assist in the preparation of equipment and resources: • Airway management • Portable ventilation • Suction equipment • CV support • Vital sign monitoring • Fluid therapy & pharmacological requirements • Infusion devices/syringe drivers • Transfer bag • Psychological support	
Assist in the location, calibration and safely set up monitoring and transfer equipment including: • Alarm parameters • Prepare electromechanical devices • Supplementary gases • Transportation	
Assist in the care for the family of the patient being transferred	

12 Rehabilitation

You must be able to demonstrate through discussion and **practice** essential knowledge of the patient and the role of rehabilitation in Critical Care

12.1 Rehabilitation initial assessment and referral	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Relevant national guidance, policies and procedures relating to the rehabilitation needs of the critically ill: • NICE CG 83 • Trauma rehabilitation pathways • NICE CG 50	
The importance of rehabilitation being identified and started within 24 hours of admission to critical care	
The importance of Rehabilitation prescription and/or plans • Rehabilitation pathways • Short clinical rehabilitation assessments • Swallowing assessments • Referral to relevant MDT members • Long term rehabilitation assessments • Rehabilitation goal setting • On-going reassessments of needs	
Importance of regularly reviewing and screening the rehabilitation needs of the patient	
Other equipment and resources that may benefit critical care patients with rehabilitation needs (including but not limited to): • Patient diaries • Mobility aids to promote independence • Communication aids • Family presence • Music therapy • Aromatherapy • Massage • Sleep therapy	
Environment factors in critical care that may impact on rehabilitation needs: • Noise/alarms • Equipment • Level of activity • Disturbance for observation and care needs • Invasive treatments/devices • Isolation	
Importance of the rehabilitation record and documentation being held separately from the case notes: • Patient needs access to documents	

12.1 Rehabilitation initial assessment and referral continued	
You must be able to undertake the following in a safe and professional manner:	
Implement as directed by the RN or registered professional a rehabilitation prescription or plan within 24 hours of admission	
Identify all AHP support required for the patient	
Follow planned therapy prescribed or recommended by the MDT members involved in the patient's rehabilitation journey	
Monitor the patients progress against set goals and feedback this progress to the relevant AHP groups	
Reduce (where possible) the critical care environmental effects on the patient	
Communicate rehabilitation needs and goals to the patient and their families in a clear and concise manner	
Involve the patient and significant others in the rehabilitation process as appropriate and able	

13 Communication & teamwork

You must be able to demonstrate through discussion and **practice** essential knowledge of communication in Critical Care

13.1 Communicating with Critical Care Patients	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
The importance of: • Focusing on the individual • Personal space and positioning when communicating • Body language and eye contact when communicating • Using the individual's preferred means of communication and language • Checking that you and the individuals understand each other • Adapting your communication skills to aid understanding • Active listening • Medications • Past medical history • Learning disability	
The difficulties that can arise with communication in the critical care environment: • Unconscious patient • Artificial airways • Disorientation • Confusion • Delirium • Withdrawal from communication • Addictions • Hallucinations • Sleep deprived patients	
Methods and ways of communicating that allow for communication difficulties to be overcome (including but not limited to): • Nonverbal communication aids, such as picture boards, writing and electric devices	
Support equality and diversity	
The difficulties that may be experience in recognising and interpreting the patient's nonverbal communication (including but not limited to): • Signs of distress • Deterioration in patient understanding • Changes in mental capacity	

13.1 Communicating with Critical Care Patients continued	
You must be able to undertake the following in a safe and professional manner:	
Adopt any communication aids that are appropriate to the patient's needs: • Glasses • Hearing aids • Picture boards • White boards • Speaking valves • Interpreter • Electronic devices	
Adapt your communication style to suit the situation & the patients' needs	
Ensure that the environment for communication is as conducive as possible for effective communication	
Clarify points to check that the patient understands what is being communicated	
Actively listen and respond appropriately to any questions and concerns raised during communication with the critical care patient	
Ensure written documentation reflects the needs of the patient and records any communication that has taken place	

13.2 Communicating and Teamworking	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Importance of effective team working in critical care (Including but not limited to): • Efficient and timely completion of workload • Working collaboratively • Achieving common goals • Team satisfaction • Supporting and valuing each other Members of the extended MDT and the main roles and responsibilities of each in caring for the critically ill (including but not limited to): • Critical care doctors • Critical care nursing team • Professional nurse advocate • Critical care technicians • Specialist nurse • Physiotherapist • Dietician • Pharmacist • Occupational therapist • Speech & Language • Psychologist	
Importance of referring or responding promptly and appropriately to each member of the MDT	
Most effective and efficient way to communicate with the appropriate team member including • Emergency call • Verbal referral • Appropriate documentation	
Principles of confidentiality, security and sharing of information about critical care patients	
How your communication skills reflect on you and your team	

13.2 Communicating and Teamworking continued	
You must be able to undertake the following in a safe and professional manner:	
Work as an effective critical care team member	
Communicate information about your critical care patient in a logical and systematic manner	
Maintain confidentiality as appropriate to do so	
Acknowledge and respond to communication promptly	
Assist and support other team members	
Deliver shift goals as set by the RN and team leader	
Focus all your actions on the safety of yourself your patient and on other team members	
Actively participate in the professional development of other team members	
Records and documents any referral, actions and outcomes agreed by the team members	

13.3 Communicating in Difficult Situations	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Possible impact of all aspects of significant news on the patients and families well-being	
Range of communication difficulties and resources available to aid communication	
Importance of clear and direct communication	
Importance of the individual's choice	
Importance of establishing rapport	
How to ask questions, listen carefully and summarise back	
Importance of encouraging individuals and families to ask questions	
How to negotiate effectively with individuals, families and other professionals	
How to manage own feelings and behaviour when communicating with patients and families	
Importance of working within your own sphere of competence and seeking advice when faced with situations outside this situation	

13.4 Teamworking	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Importance of effective team working in critical care (Including but not limited to): • Efficient and timely completion of workload • Working collaboratively • Achieving common goals • Team satisfaction • Supporting and valuing each other Members of the extended MDT and the main roles and responsibilities of each in caring for the critically ill (including but not limited to): • Critical care doctors • Critical care nursing team • Professional nurse advocate • Critical care technicians • Specialist nurse • Physiotherapist • Dietician • Pharmacist • Occupational therapist • Speech & Language • Psychologist	
Importance of referring or responding promptly and appropriately to each member of the MDT	
Most effective and efficient way to communicate with the appropriate team member including • Emergency call • Verbal referral • Appropriate documentation	
Principles of confidentiality, security and sharing of information about critical care patients	
How your communication skills reflect on you and your team	
You must be able to undertake the following in a safe and professional manner:	
Work as an effective critical care team member	
Assist and support other team members	
Deliver shift goals as set by the RN and team leader	
Focus all your actions on the safety of yourself your patient and on other team members	
Actively participate in the professional development of other team members	
Records and documents any referral, actions and outcomes agreed by the team members	

14 Infection Prevention and Control (IPC)

You must be able to demonstrate through discussion and practice essential knowledge of IPC in Critical Care

14.1 Infection Prevention & Control	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
Chain of infection	
Infection process	
Alert organisms and conditions	
Body defence mechanisms	
Specifically in relation to the critical care environment • Ventilator Associated Pneumonias (VAPs) • Influenza • Catheter Related Blood Stream Infections (CRBSIs) • MRSA • Clostridium Difficile • VRE • CPE	
Significance of microbiological results in line with other pathology results and the overall patient condition	
Key legislation, national guidance outcomes/indicators related to the prevention and control of infection in the critical care environment: • Recent Health and Social Care Act • Communicable disease control • Prevention and management of injuries (including sharps) • Waste management • Safe water management • Decontamination of equipment used for diagnosis and treatment, inclusive of traceability of reusable medical devices • Environmental cleaning • Antimicrobial prescribing & stewardship	
Effective engagement methods with patients, families/carers and visitors about their needs and priorities in relation to infection prevention and control	
Effectiveness of existing policies and practices and identify possible areas for improvement	
Feedback and reporting mechanisms associated with infection prevention and control issues	
Ensure that suitable and sufficient communication of information on patients' infection status is provided, utilising guidance from the IPC Team: • On admission, discharge and transfer from one health care area or organisation to another • Between health care workers including displaying appropriate signage • To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets	
Demonstrate effective and appropriate use of personal and protective equipment in minimising the risk of infection spread, on admission, discharge and transfer*:* • Between health care workers, including displaying appropriate signage • To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets	

14.1 Infection Prevention & Control continued	
Demonstrate best practice in the care of patients' requiring: • Source Isolation • Protective isolation	
Understanding of local surveillance, outbreak or incident information and how this would be communicated to the team	
You must be able to undertake the following in a safe and professional manner:	
Demonstrate best practice in environmental tidiness & cleanliness (including but not limited to): • Appropriate level of cleaning to instigate on patient discharge • Cleaning and disinfection of items that come into contact with the patient and/or their environment that are not invasive (e.g. beds, commodes, hoists)	
Safe disposal of waste (including sharps and linen)	
Safe storage of food and medical equipment	
Bedside damp dusting regime	
Demonstrate best practice in decontamination of reusable medical devices, following manufacturer guidance and local policy related to: • Processes for cleaning, disinfection, sterilisation • Specifically but not limited to decontamination of: Ventilators/Infusion pumps, Renal Replacement Therapy (RRT) machines, Humidification equipment, Endoscopic, equipment, such as bronchoscopes, Diagnostic equipment	
Demonstrates best practice in the use of disposable medical devices, following manufacturer guidance and local policy, applying knowledge of 'single use' and 'single patient use'	
Demonstrates best practice in obtaining, packaging, handling, labelling and transport of biological samples, with reference to local pathology guidance	
Demonstrates safe management of invasive devices and applies safe practices to prevent device related infections	
Participates in audit and surveillance activities (including but not limited to): • Department of Health, Saving Lives High Impact Intervention (HII) • Care bundle audits • Environmental cleanliness audits	
Aware of local statistics on the prevalence of alert organisms, outbreaks, serious untoward incidents and action plans to deal with occurrences of infection,	
Acts upon any risks identified including: • Recognition of the signs and management of infection & sepsis • Safe practice in administration of oral antimicrobial drugs, with reference to local formulary	
Takes appropriate actions to escalate concerns when safety and quality are compromised	
Ensure safe practice in the event of occupational exposure	

15 Evidence Based Practice

The following competency statement is about applying evidence-based practice to the activities you undertake in critical care, it also includes audit conducted within the critical care setting and the importance of benchmarking against evidence-based quality standards.

15.1 Evidence Based Practice	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
How you integrate evidence-based practice into your daily work	
Importance of keeping up to date with developments and new resources relevant to critical care	
Key professional and critical care resources that are available to you to ensure you are abreast of any developments	
Importance of conducting audit exercises against the following quality standards to demonstrate local compliance, within scope of practice e.g. audit	

16 Professionalism

The following competency statement relates to maintaining professionalism in critical care

16.1 Maintaining Professionalism	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
NMC Standards of proficiency for nursing associates (2018) standards-of-proficiency-for-nursing-associates.pdf (nmc.org.uk) • Scope of practice for nursing associate • Clear role boundaries between the NAR and the RN • Awareness of how to raise concerns (patients, public, self and peers)	
CC3N Best Practice Guidelines for the Nursing Associate registrant (NAR)	
You must be able to undertake the following in a safe and professional manner:	
Prioritise people: • Treat people as individuals and uphold their dignity • Listen to people and respond to their preferences and concerns • Make sure that peoples physical, social and psychological needs are assessed and responded to • Act in the best interests of people at all times • Respect people's right to privacy and confidentiality	
Practice Effectively: • Practice in line with the best available evidence within the scope of one's own professional practice • Communicate clearly • Work collaboratively • Share your, skills, knowledge and experience with colleagues for the benefit of people receiving care • Keep clear and accurate records relevant to your practice • Be accountable for your decisions to delegated tasks and duties	
Preserve Safety: • Recognise and work within the limits of your competence • Be open and candid with all service users about aspects of care and treatment, including where mistakes or harm have occurred • Act without delay if you believe there is a risk to patient safety or public protection • Raise concerns immediately if you believe that there is a vulnerable person at risk • Reduce (as far as possible) any potential for harm associated with your practice	
Promote Professionalism & Trust: • Uphold the reputation of your profession at all times • Respond to any compliant	

17 Defensible Documentation

This competency statement is about the legal and accountable aspects of documentation within the critical care environment

17.1 Documentation	
You must be able to demonstrate through discussion, essential knowledge of (and its application to your supervised practice):	
The impact of the NMC record keeping guidance (2009) on the registered nursing Associates legal responsibility in written documentation: • Clear • Accurate • Purposeful • Contemporaneous • Author of entry – printed, signed and professional PIN number	
Your accountability in relation to: • Statute law • Case law • Civil law • Criminal law	
The reasons for accessing and maintaining health care records: • Helping to improve accountability • Showing how decisions related to patient care were made • Supporting the delivery of services • Supporting effective clinical judgements and decisions • Supporting patient care and communications • Making continuity of care easier • Providing documentary evidence of services delivered • Promoting better communication and sharing of information between • members of the multi-professional healthcare team, patients and families • Helping to identify risks, and enabling early detection of complications • Supporting clinical audit, research, allocation of resources and • performance planning • Helping to address complaints or legal processes	
Your responsibility in relation to maintaining health care records • Use of electronic tracking systems for health care records • Privacy and confidentiality of patient information • Caldecott guidelines	
You must be able to undertake the following in a safe and professional manner:	
Complete an accurate admission profile of your patient	
Provide an accurate, concise, timely and contemporaneous record of your patient's treatment and events, utilising appropriate systems as required	
Maintain an accurate, concise, timely and contemporaneous record of communication between the MDT and patient and relatives	
Complete the necessary care plans, risk assessments and evaluations	
Accurately file patient information utilising the health care records systems in place	

Abbreviation List & glossary of terms

ABG	Arterial Blood Gas
BP	Blood Pressure
CO	Cardiac Output
ECG	Electrocardiogram
HR	Heart Rate
ICU	Intensive Care Unit
MAP	Mean Arterial Pressure
MDT	Multidisciplinary team
NAR	Nursing Associate Registered
NCEPOD	National Confidential Enquiry into Perioperative Deaths
PCA	Patient Controlled Analgesia
RN	Registered Nurse
RR	Respiratory Rate
SVR	Systemic Vascular Resistance
VQ	Ventilation perfusion

Acknowledgements

This Nursing Associate competency document has been developed in partnership with a range of stakeholders from practice and academia within the Critical Care community across England, Wales and Northern Ireland. Thanks are extended to all contributors specifically the following:

Nicky Witton	Keele University
Karen Wilson	Lead Nurse Cheshire and Mersey Critical Care Network and chair of CC3N
Mindy Dawes	University Hospitals Birmingham
Lisa Enoch	Cambridge University Hospitals NHS Foundation Trust
Elizabeth Farney	Dudley Group Hospitals NHS Foundation Trust
Elaine Morley	Cornwall partnership NHS Trust
Claire Partridge	Bolton NHS FT

We would also like to acknowledge the work of Imperial College Healthcare NHS Trust, for the initial development.

For any queries in relation to these competencies:
www.cc3n.org.uk/contact-us.html

References

Critical Care Networks National Nurse Leads (CC3N) (2024) CC3N Best Practice Guidelines Registered Nursing Associates in Adult Critical Care Units V2.

Nursing and Midwifery Council (2018) Standards of Proficiency for Nursing Associates. Retrievef from: standards-of-proficiency-for-nursing-associates.pdf (nmc.org.uk) (Accessed on 14/5/2024)

Nursing and Midwifery Council (2020) We regulate nursing associates. Retrieved from: Nursing Associates - The Nursing and Midwifery Council (nmc.org.uk) (Accessed on 16/7/2023)

Notes

Critical Care Networks-National Nurse Leads (CC3N) 2015