

Pan-London Adult Critical Care Intravenous Medication Competency Document

Practical Assessment

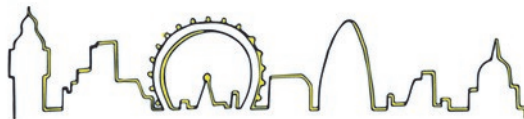
Version 1.0

Name		Pin	
Hospital/unit			
Lead assessor			
Started		Completed	



Assessment process

1. This document is the practical assessment section of the Pan-London Critical Care Intravenous Medication Competency document. When all sections are completed, the PLCCIV competency shows that the theory and knowledge, calculation ability and practical skills of the holder have been assessed as demonstrated in the document. This indicates that the holder is competent to safely administer intravenous medication in Critical Care areas. It is not exhaustive, and covers basic safety principles for some commonly used drugs. Specifically, it does not cover the use of blood products, total parenteral nutrition, epidurals and patient controlled analgesia or anticoagulation for extracorporeal circuits.
2. Before starting to work on this document, the holder should:
 - a. Have been assessed as competent within the hospital they are working to give intravenous medication in non-critical care areas.
 - b. Be competent in the use of all administration devices that will be used in their critical care area
3. In order for the PLCCIV competency to be fully signed off, the holder will also need to have passed a drug calculations exam, have completed section 1.8 (pages 37-40) of the National Step 1 Critical Care Competency Framework, and passed the practical assessment section of the PLCCIV competency. The process through which these activities are completed will vary according to local policy and will be directed by the lead assessor in each area.
4. This document was developed by three Critical Care Networks in London, and the Pan-London Critical Care Practice Development Group, working with CapitalNurse.



Practical Assessment Criteria

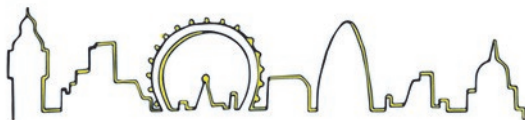
For each episode of medication administration candidate demonstrates the following:

Review of prescription and patient

- Checks the prescription for completeness and clarity
- Checks the '5 Rs', allergies and specifically identity of unconscious patient
- Checks appropriateness of prescription for patient in relation to drug history and condition
- Knowledge of the drug being administered, expected effects, side effects and reversal agents if appropriate
- Selects appropriate route and delivery method
- Checks compatibility of drug (if necessary with other infusions, via Y-site)
- Assesses the IV site (peripheral / central using a scoring system if unit policy)

Preparation

- ANTT in the preparation of the IV injection
- Correct mixing of drug and diluent – any special reconstitution requirements i.e. filter/storage after reconstitution – using sources of knowledge as above
- Correct calculation of volume, rate and dosage
- Correct storage of drugs
- Obtains second check appropriately



Administration

- Uses ANTT / follows local policy in the administration of the injection / infusion
- Correct use of equipment / devices / lines
- Administration of the drug at the correct rate
- Observation of the patient
- Safe disposal of waste/sharps etc
- Does not leave medication unattended

Documentation

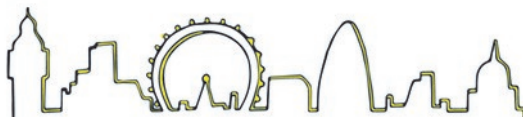
- Correctly record drug administration – including withheld or refused
- Demonstrates correct completion of any additive labels attached to bags/ bottles/ syringes

Monitoring

- Monitors response to drug and titrates dose with regard to specific targets e.g RASS, CPOT, MAP

The holder should carry out the named procedures below and those indicated by the lead assessor. Each procedure / medication administration should be satisfactorily completed on two occasions – 1st assessment and 2nd assessment

Optional procedures would be assigned by the lead assessor in each unit, i.e. they are optional for the unit, if assigned the holder must be assessed as competent.

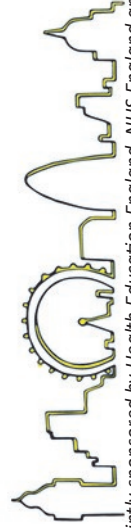


Signature record

Name	Signature	Post	PIN	Initials	Date of signing this record

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Record of Practical Assessment

Procedure	Practice / formative assessment under supervision (optional – assessor to initial and date if used)			1 st Assessment satisfactorily completed	2 nd Assessment satisfactorily completed
1. Set up and initiate a noradrenaline Infusion.			Assessor initials Date	Assessor initials Date	
2. Change a noradrenaline infusion according to local policy			Assessor initials Date	Assessor initials Date	
3. Set up and initiate a continuous opiate infusion.			Assessor initials Date	Assessor initials Date	
4. Set up and initiate a sedative Infusion			Assessor initials Date	Assessor initials Date	

<p>5. Give a fluid bolus for hypovolaemia</p>					<p>Assessor initials Date</p>	<p>Assessor initials Date</p>
<p>6. Optional (specify)</p>					<p>Assessor initials Date</p>	<p>Assessor initials Date</p>
<p>7. Optional (specify)</p>					<p>Assessor initials Date</p>	<p>Assessor initials Date</p>
<p>8. Optional (specify)</p>					<p>Assessor initials Date</p>	<p>Assessor initials Date</p>
<p>9. Optional (specify)</p>					<p>Assessor initials Date</p>	<p>Assessor initials Date</p>



Record of Action Plan (if applicable)

Feedback provided to the holder during completion of this assessment document	Date / initials

Date / initials	Feedback provided to the holder during completion of this assessment document

Assessment of Practice for:

Name:

Hospital / trust:

Pin:

Outcome

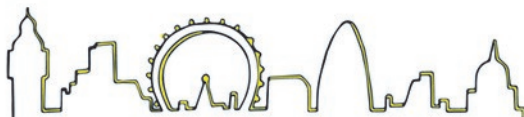
Assessment of practice passed

Practical assessment documented as complete by:

Signature:

Date:

Print Name:



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