Competencies for Recognising and Responding to Acutely Ill Patients in Hospital

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Document Purpose	Consultation/Discussion		
ROCR Ref:		**Gateway Ref:**	9633
Title	Care of the Acutely Ill patient in hospital - Competency Framework		
Author	DH / Emergency Care Team / Adult Critical Care		
Publication Date	25 Mar 2008		
Target Audience	Medical Directors, Directors of Nursing, Allied Health Professionals		
Circulation List			
Description	This consultation document sets out a framework of competencies for recognising and responding to acutely ill patients in hospital. Comments are invited on the document content and framework of competencies.		
Cross Ref	NICE clinical guideline 50.		
Superseded Docs	N/A		
Action Required	N/A		
Timing	**Consultation ends 17 June 2008.**		
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For Recipient's Use			

Care of the Acutely Ill Patient in Hospital

Competency Framework - Consultation

Prepared by

The Commissioning and System Management Directorate in collaboration with representatives from the Intensive Care Society, the Royal College of Anaesthesia, the Royal College of Nursing, the Royal College of Physicians, the Royal College of Surgeons of England and acute care clinical experts.

First published 25 March 2008
Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications

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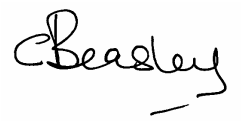
Foreword by Christine Beasley

The increasing complexity of healthcare, the ageing population and shorter length of stay, means that patients in hospital today need a higher level of care than ever before. It is essential therefore, that Hospital staff are equipped to recognise and manage deterioration confidently and competently. This is an area we know needs attention. There is a strong body of evidence showing that delays in recognising deterioration or inappropriate management can result in late treatment, avoidable admissions to intensive care and in some cases, unnecessary deaths (1, 2). Studies show that Hospital staff may not understand the disturbances in physiology affecting the sick patient; frequently ignore signs of clinical deterioration (despite being regularly charted) (1); and lack skills in the implementation of oxygen therapy, assessment of the adequacy of respiration and management of fluid balance (2, 3, 4). There are of course many other factors influencing a patient's ability to receive appropriate and timely care including the failure to seek advice, poor communication between professional groups, and a lack of clinical supervision for all staff in training (8).

I therefore welcome this framework of competences wholeheartedly. It provides a flexible and comprehensive tool that can be used in many ways to support safe high quality care in complex care environments. It shows clearly that the management of acutely ill patients in hospital is not just the responsibility of doctors and nurses – it is a team effort and one in which everyone (including patients and carers), has a part to play.



Chris Beasley

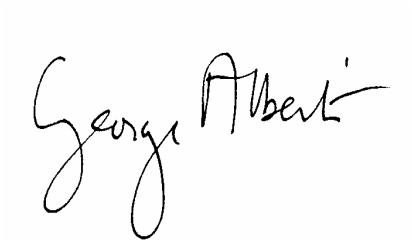
Chief Nursing Officer
for England

Forward by Sir George Alberti

Patients who are admitted to hospital believe that they are entering a place of safety. They feel confident that they will receive timely and effective care throughout their illness and should their clinical condition deteriorate, this will be recognised and acted on.

Unfortunately, there is evidence to the contrary [1,2,3] with a failure to recognise clinical deterioration and a failure to respond effectively being recurring themes. Professional organisations have recognised these clinical challenges and as a result, undergraduate and post-graduate curriculum has been amended accordingly.

All doctors will acquire basic competencies to recognise deterioration and respond appropriately to acute illness during of the training they receive during their Foundation years. However, this is merely a platform on which to build further expertise through core and specialist training programmes that will equip them to respond at a secondary or tertiary level. This Framework describes the competencies required by staff acting in each role and will complement the NICE guidance "Acutely ill patients in hospital" which was published earlier this summer. Taken together, organisations will be able to redesign clinical services to ensure that failure to recognise and failure to respond no longer feature in the NHS's drive to enhance patient safety.



Sir George Alberti

Clinical Director for Service Design

1. Introduction

This document sets out a framework of competences for recognising and responding to acutely ill patients in hospital. It responds to recommendations made in NICE Guidelines (CG50 Acutely ill patients in hospital: NICE guidance) and will support their implementation in healthcare organisations. You are invited to comment on the content of this document and the framework of competences.

2. Background

Patients in hospital are often at risk of becoming acutely ill. Unfortunately, there is a body of evidence showing that the recognition of deteriorating health by staff is often delayed or managed inappropriately resulting in late treatment, avoidable admissions to intensive care and unnecessary deaths. The NCEPOD Report (1) for example identified that suboptimal ward care contributed to 33% of deaths in a medical population who were ultimately admitted to Critical Care. Suboptimal care before intensive care admission ultimately will be associated with a higher intensive care unit or hospital mortality (2).

Within the United Kingdom, the magnitude of the problem has been clearly defined (1,2). Evidence suggests that some general ward staff are unfamiliar with the full range of disturbances in physiology affecting the sick patient. As a result, signs of clinical deterioration are frequently ignored (despite being regularly charted on a patient's clinical records for hours preceding either late referral to Intensive Care or a Cardiopulmonary arrest)(1);and lack skills in the implementation of oxygen therapy, assessment of the adequacy of respiration and management of fluid balance (2, 3, 4). Other factors, which influence a patient's ability to receive appropriate and timely intervention, include failure to seek advice, poor communication between professional groups, and a lack of clinical supervision for all staff in training (8).

In order to tackle this problem, The National Institute of Clinical Excellence (NICE) (9) has published a short guideline addressing the recognition and response to acute illness in adults in hospital. They recommend:

- Hospitals deliver a graded response to the acutely ill adult patient. This response should match the competencies of doctors, nurses and support staff to an individual patient's needs in a clearly defined period. The graded strategy should grade the risk of clinical deterioration into three levels and the urgency of response should reflect the risk of deterioration.

- The risk of deterioration should be assessed using either a multiple parameter or an aggregated weighted scoring system. Such systems permit a patient's physiology to be tracked over time.

- Staff caring for patients in any acute hospital setting should have competences in monitoring, measurement, and interpretation of vital

signs, equipping them with the knowledge to recognise deteriorating health and respond effectively to acutely ill patients, appropriate to the level of care they are providing.

- Education and training should be provided to develop staff competences and competence should be assessed.

The framework of competences described in this document will support healthcare organisations meeting these requirements.

3. Origins of the competences

The work was led by the Department of Health in conjunction with a multidisciplinary group of expert practitioners and training providers. Existing competences developed by the European Society of Intensive Care Medicine (ESICM) COBaTrICE Framework (10), the Foundation Programme for year 1 and 2 post-registration doctors (11), the ACUTE Initiative (12)) (13), and the Core Competency Framework for Critical Care (14) have informed the work. In addition, the group has employed consensus agreement for some competencies. Appendix 1 documents membership of the group.

4. Underlying principles

The competences are built around the 'Chain of Response' described by NICE (9). The Chain of Response reflects escalating levels of intervention in the care of a patient who becomes acutely ill, and corresponds to low, medium and high 'track and trigger scores' and correlates with primary, secondary and tertiary responses.

The Chain of Response should be effective, timely and seamless. A team approach with input from a range of staff with varying backgrounds and differing skills will be essential. Organisations must ensure that their "team" possess the following overall competencies:

- Accurate *recording* and *documentation* of vital signs on all adult wards
- *Recognition* of abnormal values and the ability to *interpret* these values in the context of individual patients
- Have the competence to *assess* the patient and institute clinical *intervention* in a timeframe that reflects the risk of further clinical deterioration and at a level that is determined by the patient's clinical condition. This must encompass three levels of intervention as described by the NICE document (9). These levels are referred to in this document as *primary, secondary* and *tertiary*.
- Each level must recognise when a higher level of assistance is required
- Have the necessary communication skills to convey the urgency of the situation and get immediate help from clinicians with appropriate knowledge and skills to ensure that the patient receives optimum care

In order to respect local diversity and support service flexibility and responsively, there are no assumptions about ideal service delivery models and competences along the Chain of Response. Consequently the competencies have not been assigned to any staff group; grade; level or banding. However because the competencies are *cumulative* and *advance significantly in complexity, responsibility and clinical risk*, the staff operating at each level should be in possession of the necessary qualifications, certified training and designated authority to carry out the competences safely and independently. It is however envisaged that staff with Critical Care expertise will undertake the tertiary response. Readers should note that Critical Care competencies are not the subject of this document and have been defined in the following: (i) the Intercollegiate Board for Training in Intensive Care Medicine competency based training documents 2007. The Curriculum for the CCT in Intensive Care Medicine. For latest version, please visit www.rcoa.ac.uk/ibticm or the PMETB website www.pmetb.org.uk. : (ii) The National Practitioner Programme National Education and Competence Framework for the Advanced Critical Care Practitioners National Practitioner Programme, Critical Care Programme Board. Draft remains available on Department of Health Website Download from: www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Emergencycare/Modernisingemergencycare/DH_4063826; (iii) the COBaTRICE programme developed by the CoBaTrICE Collaboration 2006. Competency Based Training programme in Intensive Care Medicine for Europe and other world regions. www.cobatrice.org.

5. Understanding the Framework

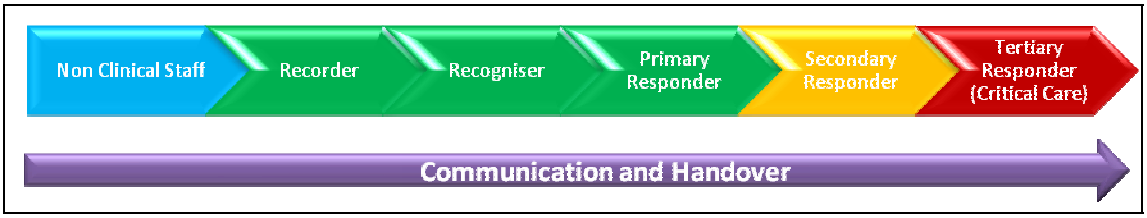
Scope of the competences

The competences are targeted at hospital-based staff involved in the care of acutely ill patients in hospital but may be adapted for use in other settings or across sectors.

Structure of the competences

The competences define the knowledge skills and attitudes required for safe and effective treatment and care along the Chain of Response (See figure 1).

Fig 1



It is likely that one staff group or banding will cover more than one role in the chain (e.g. the recogniser may also primary responder or on occasions may fulfil the recorder role).

- **Non- Clinical supporter** who may also be the ‘alerter’ and may include the patient or visitor

- **The recorder** who takes designated measurements, records observations and information**.**

- **The recogniser** who monitors the patients’ condition; interprets designated measurements, observations and information and adjusts the frequency of observations and level of monitoring.

- **The primary responder** who goes beyond recording and further observation by interpreting the measurements and initiating a clinical management plan e.g. commencing oxygen therapy; insertion of airway adjuncts; selection of Intravenous fluids and administration of a bolus.

- **The secondary responder** who is likely to be called to attend when the patient fails to respond to the primary intervention, or continues to ‘trigger’ or ‘re-trigger’ a response. This individual will assess the clinical effect of the primary intervention; formulate a diagnosis; refine the management plan, initiate a secondary response and will have the knowledge to recognise when referral to Critical Care is indicated.

- **Tertiary responder.** This role will be undertaken by staff possessing appropriate Critical Care competences such as advanced airway management, resuscitation, and clinical examination and interpretation of critically ill patients.

The competences focus primarily on the clinical and technical aspects of care and the delivery of effective patient management but are not exclusive. They assume the possession and application at every level of complementary generic competences such as record keeping, team working interpersonal skills and clinical decision-making. Of particular note in this context is the ability to rapidly access hospital information systems and retrieve patient information such as blood results and x-rays.

The case studies below help to portray the concepts described.

Case study 1

Mr P is a 79 year old male who has been admitted into a Trust with Acute Abdominal Pain. His current management plan includes Nil by Mouth Intravenous maintenance fluid, and analgesia.

Recorder

Mr P observations were recorded by the health care assistant on the ward. Each time a complete set of observations were recorded and the Track and Trigger score was calculated.

Recogniser

Staff Nurse on duty was responsible for reviewing the observations that had been recorded by the Health Care Assistant. As Mr P's observations had deteriorated the track and trigger score was now 4. Mr P's frequency of observations were increased as per local Trust Policy and the Outreach Team were contacted for a review that was to take place within 30 minutes.

Primary Responder

A member of the outreach team attended within the allocated time and undertook a systematic review of Mr P. Mr P was given a fluid challenge, had his oxygen concentration increased and a set of blood samples taken and sent to the laboratory. Initially Mr P condition stabilised. An arterial blood gas (ABG) sample was also obtained. Again the frequency of observations was increased, findings documented in the notes and a new clinical management plan was documented and communicated. The primary responder agreed to review Mr P in one hour to assess his condition and review the results of his blood tests. Mr P continued to deteriorate with his trigger score increasing to 5. His blood tests showed abnormalities. The primary responder and the nursing staff on the ward agreed a further review from a secondary responder was necessary.

Secondary Responder

The Surgical Registrar (ST3) was contacted and a detailed history of Mr P management and condition shared. An urgent review of Mr P condition was agreed and 10 minutes later the registrar arrived on the ward. Again Mr P had a systematic assessment undertaken and further intervention was prescribed including further fluid challenges and a review of his current medication. Mr P condition improved following the fluid challenges. The registrar again documented his finding and actions in the medical notes and communicated a management plan to the outreach nurse and the ward team. Mr P condition stabilised and the improved with the new management plan and his early warning score reduced to normal values.

Case study 2

Mrs S is a 72 year old female admitted to hospital with community acquired pneumonia. Following admission her condition has continued to deteriorate.

Recorder and Recogniser

Mrs S observations were recorded by the Staff Nurse on the ward and track and trigger score calculated. These showed continuing deterioration in Mrs. S's condition, therefore frequency of observations were increased, continuous monitoring commenced and the Foundation Year 1 doctor called as per local protocol for her Track and trigger score of 6. A full and detailed history was given by the Staff Nurse to the doctor and it was agreed that an immediate review was required.

Primary Responder

The foundation 1 doctor reviewed Mrs S within 10 minutes. A systematic review of Mr S was undertaken, oxygen therapy was increased, the rate of intravenous fluids increased. A range of tests were ordered , including arterial blood gas, blood cultures and a Chest X-Ray The doctor then called his senior, the medical registrar for further advice,.

Secondary Responder

The medical registrar (ST3) reviewed Mrs S within 15 minutes and following a further systematic review and interpretation of test results decided to refer Mrs S onto the Critical Care team. Oxygen therapy was maximised to deliver high concentrations of oxygen and fluid challenges were commenced, as Mrs S was hypotensive.

Tertiary Team

The critical Care team immediately reviewed Mrs S. They found Mrs S to be hypoxic and hypotensive despite the interventions carried out by the primary and secondary responders. A decision was made to transfer Mrs S to the Intensive Therapy Unit for advanced intervention and management.

6. Using the Competences

The competences provide consistent standards for hospital and ward staff involved in the care and management of the acutely ill patient in hospital. By setting out what people and teams should be able to do, they can enhance accountability at all levels; inform service planning; and guide all aspects of workforce and performance development. These include...

- Service reviews

- Workforce design and profiling
- Role design
- Appraisal and staff development
- Education training and development
- Education commissioning, planning and provision
- Design of Professional and Vocational Qualifications
- Clinical supervision
- Professional revalidation/registration

7. Workforce Development

Hospitals have a responsibility to ensure staff are deemed competent in the early recognition of acutely ill and deteriorating patients and are able to perform the initial resuscitation of such patients. There are a number of nationally and certified courses available to support workforce development in this area. (See Appendix 3). In addition to these resources, local teaching initiatives, acute care sessions at clinical simulation centres and some e-learning packages are also being developed. This document supports all such efforts to improve knowledge, particularly where multidisciplinary team working is emphasised and promoted. Future care should be improved because of the use of these educational resources and staff should be encouraged and assisted to take full advantage of them wherever possible.

8. Links to Knowledge and skills framework

All NHS staff (excluding medical personnel) work within the Knowledge and Skills Framework (KSF).

The framework of competences support the KSF by providing more detailed criteria against which staff involved in the care of the acutely ill patient can be reviewed and developed. Following consultation, these competences will be mapped by Skills for Health to the National Occupational Standards and the KSF.

9. Implementing the competences

Implementing the competences will require a system wide approach with effective leadership and rigorous change management from board through to ward. This may include the following:

- Identifying a designated clinical and managerial lead and implementation team who will also secure training provision
- Monitoring outcomes at all levels with board reporting and intervention
- Critical Incident analysis and peer supervision
- The incorporation of recommendations for education/training and assessment of competence into induction and ongoing provision, as well as into formal performance review and development processes.
- Making sure that resources are in place such as equipment.
- Adapting local policies to support people meeting the competences and clarifying levels of authority and responsibility.

- Developing team working, assertiveness and inter-professional working relationships. It is essential that staff have confidence in the competence of colleagues; are willing to challenge and to be challenged.

See Appendix 4 for a worked exemplar

10. Updating and monitoring the competences

Following consultation, the competences will become part of the wider suite of competences held by Skills for Health who will oversee monitoring and updating. They will ensure continuity of approach.

11. Responding to the consultation

The Department of Health Minister of State for Health Services has agreed that there should now be a limited consultation on the Framework within the wider clinical community caring for acutely ill patients.

Clinical colleagues and professional organisations are now invited to comment on the draft competences within this Framework.

You should consider the following:

- Is purpose of the competences clear?
- What might hinder the competences achieving their purpose?
- Is the layout clear and usable?
- Is language clear and understandable to those staff involved in care of the acutely ill?
- Is there sufficient information about the competences and how they might be used (suggested additions?)
- Do you agree with the structure and principles of the competences?
    - Built around the chain of response
    - The decision to avoid specifying staff group, grade banding level and minimal qualifications
    - The focus on minimal standards of technical and clinical competence
    - Not specifying generic/complementary competences
- Your comments on specific competencies.
- During the preparation of this Framework no equality issues have been identified that need to be addressed; however, we would welcome views from respondents on this.
- Any recommended additions.

To respond to the consultation please complete the attached questionnaire and return to keith.young@dh.gsi.gov.uk **by the 24 June 2008**

12. What Happens Next

This consultation will end on 24 June 2008.

- At the end of the consultation, we will publish a feedback document that details the responses we have received to the questions asked.
- All the responses received will help to inform the shape and contents of the final Competency Framework.
- All responses will be confidential and any references to responses will be anonymised.
- We anticipate that the final framework will be published by 31 August 2008.

13. References

1. NCEPOD 2005: “An Acute Problem”

2.NPSA 2007: Safer Care for the acutely ill patient: learning from serious incidents

3.McQuillan P, Pilkington S, Allan A, Taylor B, Short A, Morgan G, Nielsen M, Barrett D, Smith G, Collins CH Confidential inquiry into quality of care before admission to intensive care. BMJ 1998;316:1853-1858

4. McGloin H, Adam SK, Singer M Unexpected deaths and referrals to intensive care of patients on general wards. Are some cases potentially avoidable? J R Coll Physicians Lond 1999;33:255-259

5. Soar J, Perkins GD, Harris S, Nolan J The immediate life support course. Resuscitation 2003;57:21-26

6. Smith GB, Osgood VM, Crane S ALERT--a multi-professional training course in the care of the acutely ill adult patient. Resuscitation 2002; 52:281-286

7.Greater Manchester Acute Illness Management Course (GAIM). Critical Care Skills Institute, Trafford General Hospital.

8. Vincent C, Neale G, Woloshynowych M Adverse events in British hospitals: preliminary retrospective record review. BMJ 2001; 322:517-519

9. National Institute for Health and Clinical Excellence. Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital 2007 (NICE guideline no 50).

10.COBaTrICE framework.www.cobatrice.org.

11.Foundation Programme 2007 revised version

12. Acute Care Undergraduate Teaching (ACUTE) initiative – consensus development of core competencies in acute care for undergraduates in the United Kingdom. Int Care Med 2005;31:1627-1633

Appendix 1 - Working Group Members

Jane Eddleston (Chair)	-	Clinical Advisor, Adult Critical Care Services, DH. Central Manchester and Manchester Children's University Hospital Trust
Iain Anderson	-	Royal College of Surgeons. Salford Royal Hospital, Faculty member Care of the Critically Ill Surgical Patient (CCrISP)
Carol Ball	-	Royal Free Hampstead NHS Trust and City University.
Anna M Batchelor	-	President Intensive Care Society. Royal Victoria Hospital, Newcastle.
Julian F Bion	-	University Hospital Birmingham NHS Trust. European Board for Intensive Care Medicine. CoBaTrICE framework for training in Intensive Care Medicine. Contributor to Foundation Programme.
Ian Bullock	-	Royal College of Nursing Institute. National Collaborating Centre for Nursing and Supportive Care.
Emma Carberry	-	City Hospital Birmingham
Liz Carpenter	-	Ipswich Hospital.
Peter Featherstone	-	Portsmouth Hospitals NHS Trust. Faculty member ALERT and IMPACT courses.
Nancy Fontaine	-	Whipps Cross University Hospital
Magnus Garrioch	-	Central Manchester and Manchester Children's University Hospital Trust. IMPACT National Chairman
Mike Jones	-	Society of Acute Medicine, Edinburgh Royal Infirmary
Ros Moore	-	Nursing Office, DH
Pamela Munro	-	Whipps Cross University Hospital, South Bank University
Peter Murphy	-	AIM course. Critical Care Nursing Forum

		National Outreach Forum Salford Royal Hospital.
Robert Standfield	-	West Midlands SHA and Skills for Health
Gary Smith	-	Portsmouth Hospitals NHS Trust. Faculty member ALERT course
Sam Waddy	-	Intensive Care Society (Trainee Doctors Section). Derriford Hospital, Plymouth
Keith Young	-	Department of Health

Appendix 2

The Consultation Process

Criteria for consultation

This consultation follows the 'Cabinet Office Code of Practice', in particular, we aim to:

- consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses;
- ensure that our consultation is clear, concise and widely accessible;
- ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- monitor our effectiveness at consultation including through the use of a designated consultation co-ordinator; and
- ensure our consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The full text of the code of practice is on the Cabinet Office website at:

http://bre.berr.gov.uk/regulation/consultation/code/index.asp

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact

Consultations Coordinator
Department of Health
2N16, Quarry House
Leeds
LS2 7UE

e-mail Mb-dh-consultations-coordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Appendix 3

Educational initiatives to aid the management of the acutely ill.

Many educational initiatives are available that address shortcomings that have been identified in some areas in the delivery of acute care. This document does not endorse or promote any particular one of these initiatives, but supports all efforts to educate staff to improve the care of acutely ill patients. Three main types of resources are available

- National one/two day courses developed and peer reviewed by the medical and nursing professions.
- Clinical simulation centres.
- Local educational initiatives including University degree courses, e-learning programmes and clinical skills facilities.

These resources promote best practice and all clinical staff should be encouraged to enhance their skills by one or more of these methods.

National professional courses.

These differ in complexity and emphasis (see Table 1). The primary focus of all is to prevent or manage cardiac arrests, reduce intensive care unit (ICU) admissions and in-hospital deaths by early intervention and treatment. Table 1 is followed by brief explanation of what each course offers. Those courses outlined in blue are intended for all hospital staff (including non-clinical staff), those in green are intended largely for recorders, recognisers and first responders and those in yellow for secondary responders.

Table 1.

Themes	Airway Breathing Circulation ethos	Cardiac arrest procedures	Neurological assessment	Multi disciplinary	Team working and leadership.	Advanced medical management	Advanced surgical management
BLS	X			X			
ALERT	X		X	X	X		
AIM	X		X	X	X		
ILS	X	X		X			
ALS	X	X		X	X		
IMPACT	X		X	X	X	X	
CCrISP	X		X	Doctors only	X		X
MedicALS	X		X	Doctors only		X	

BLS. Basic Life Support can be taught locally within Trusts and is mandatory for all hospital employees. Algorithms are endorsed by the Resuscitation Council UK www.resusc.org.uk

ALERT (Acute Life–threatening Events — Recognition and Treatment) is a one day multi-professional course, using a structured and prioritised system of patient assessment and management to assist treating the acutely unwell.

www.alert-course.com

AIM (Acute Illness Management) is a one-day inter-professional course standardising the clinical approach to recognition, assessment and management of acutely ill adult patients.
www.gmskillsinstitute.nhs.uk

ILS (Immediate Life Support) is a one day course. It develops skills in cardiopulmonary resuscitation, simple airway management and safe defibrillation. It is designed for first responders, who on arrival of a cardiac arrest team may also participate as members of that team.
ILS is administered by the Resuscitation Council UK. www.resusc.org.uk

ALS (Advanced Life Support) is a two day course. It develops skills in effective management of peri-arrest situations and cardiorespiratory arrest. It prepares senior members of a multidisciplinary team to treat the patient until transfer to a critical care area is possible.
ALS courses are administered by the Resuscitation Council UK. www.resusc.org.uk and the Advanced Life Support group www.alsg.org/

IMPACT (Ill Medical Patients Acute Care and Treatment) is a two day inter-professional course designed to teach advanced principles and practice of acute general medical care to doctors at ST1/2 level and senior nurse practitioners. It is sponsored by the Federation of Royal Medical Colleges and the Royal College of Anaesthetists. www.impactmedical.org

CCrISP (Care of the Critically Ill Surgical Patient) is a two-and-a-half day course designed to advance the practical, theoretical and personal skills necessary for the care of critically ill surgical patients. It is sponsored by the Royal College of Surgeons of England and is aimed at surgeons and those dealing with surgical patients who are in specialist training.
www.rcseng.ac.uk/education/courses

MedicALS (Medical Advanced Life Support) is a three day advanced course teaching the management of medical emergencies. It is administered by the advanced life support group (ALS-G). www.alsg.org

In addition to these professional courses there are a number of clinical simulation centres throughout the UK where advanced medical scenarios have been or are being developed. These allow real time complex physiological interactions to be simulated in a controlled environment with advanced mannequins and equipment. Individual simulation centres can be contacted about the acute care packages they may offer or develop.

Appendix 4

Embedding the Competences in Practice

Leadership

There is Board level sponsor for implementation of the competences.

Responsibility for implementation is clearly allocated with accountability mechanisms in place

FT Governors are informed, involved and reports are presented.

Capability gaps are monitored, reported and fed into strategic workforce force development plans and funding priorities

Directors secure time and resources for learning needs analysis and training is provided

People

There is designated clinical and educational lead for implementation.

People to train, supervise and assess competence are available.

People are clear about their individual & collective responsibilities and levels of authority for action.

People have the designated authority to demonstrate the competences at each level

Policy and Strategy

An implementation plan has been developed with stakeholders

KSF profiles are reviewed and mapped across to the competencies

Escalation and other policies are reviewed to ensure coherence with the competency sets.

Partnerships & resources

Partnerships with external education provider ensure competences are mapped to current & future provision.

Any new educational materials are commissioned.

Partnerships are in place with the PCT to monitor impact

Technical resources are provided

Processes

There is a clear Implementation process with measurable goal and progress is monitored and evaluated .

The NICE Guidelines and Competences are launched effectively to staff and readily accessible to staff.

A Learning needs analysis drives training provision.

There is a high quality relevant and targeted education training and development at the start addressing technical, personals and team (whole team events) with learning materials or opportunities to support ongoing updating and development induction onwards for all identified staff

Competence is monitored and developed through performance management

Clinical /patient results

The introduction & use of the competences have a measurable impact on patient outcomes.

Organisational results

Practices adhere to NICE guidelines at all times

Governance data shows continuous improving.

People results

Staff work within NICE Guidelines and express confidence in this areas through staff surveys

There is a measurable impact on staff performance.

Staff understand their contribution demonstrate the competence consistently in all settings an the right standard & level

Enablers

Results

Appendix 5

The Acutely Ill Competency Framework

Airway, Breathing, Ventilation and Oxygenation

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Description of group role	Calls for help	Records and interprets within T&T protocol	Recognises and interprets observations in the context of the patient	Delivers a primary response and intervention	Delivers a secondary response and intervention	Delivers a tertiary response and intervention
NICE Response Level		**Low Risk**	**Low Risk**	**Low Risk**	**Medium Risk**	**High Risk**
Respiratory Rate	Recognises Respiratory Arrest and calls 2222.	Measures respiratory rate. Records result and assigns trigger score for respiratory rate. Has knowledge of what constitutes an abnormal value.	Interprets trigger in context of patient and responds in accordance with local escalation protocols. Adjusts frequency of observations in keeping with trigger.	Identifies inadequate respiratory effort and institutes clinical management therapies.	Evaluates effectiveness of treatment, refines treatment plan if necessary, formulates a diagnosis and recognises when referral to Critical Care is indicated.	Refer to critical care competencies as defined by the CoBaTrICE framework and mirrored in the Intercollegiate Board's training framework for Intensive Care Medicine in the United Kingdom
Oxygen Saturation		Measures oxygen saturation. Records result and assigns trigger score. Has knowledge of limitations of pulse oximetry and recognises abnormal result.	Interprets measurements in context and intervenes with basic measures in accordance with local escalation protocols including oxygen and airway support. Adjusts frequency of observations in keeping with trigger.	Identifies possible cause of hypoxia, prescribes oxygen therapy and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	

Competency Group	Non-Clinical Staff	"Recorder"	"Recogniser"	"Primary Responder"	"Secondary Responder"	Critical Care
Assessment of adequacy of ventilation and oxygenation	Recognises Respiratory Arrest and calls 2222.	Measures respiratory rate, and oxygen saturation. Assesses pattern of ventilation. Records measurements, has knowledge of abnormal values.	Interprets measurements in context and intervenes with basic measures in accordance with local protocols including oxygen and airway support. Adjusts frequency of observations in keeping with trigger.	Identifies inadequate ventilation and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	
Common causes of breathlessness			Describes the common causes of breathlessness. Recognises when a patient is breathless.	Identifies cause of breathlessness and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	
Tension Pneumothorax		Measures respiratory rate, and oxygen saturation. Assesses pattern of ventilation. Records measurements, has knowledge of abnormal values.	Describes the common causes of breathlessness. Recognises when a patient is breathless.	Identifies tension pneumothorax as a possible cause of breathlessness. Has knowledge of the management of a tension pneumothorax.	Formulates a diagnosis for and confirms the presence of a tension pneumothorax. Performs chest drain insertion and directs subsequent management.	
Peak Flow, Spirometry	Identifies equipment and seeks advice if unclear, transports equipment to ward.	Supervises patient performing peak expiratory flow measurement and records result.	Interprets reading in context, can undertake bedside spirometry when instructed to do so.	Has knowledge of which additional diagnostic tests are appropriate, institutes them and formulates a clinical management plan.	Reviews diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when	

Competency Group	Non-Clinical Staff	"Recorder"	"Recogniser"	"Primary Responder"	"Secondary Responder"	Critical Care
					referral to Critical Care is indicated.	
Use of airway adjuncts and suction	Identifies equipment and seeks advice if unclear, transports equipment to ward.	Same as Non-Clinical staff.	Uses adjuncts and suction.	Same as "recogniser".	Same as "recogniser".	
Arterial blood gas sampling	Transports sample according to local protocol.	Collects equipment and transports sample.	Assists operator in performing task.	Undertakes arterial blood gas sampling and measurement. Has knowledge of and can interpret arterial blood gas measurement.	Recognises need for assistance from Critical Care.	
High flow and controlled oxygen therapy	Identifies and collects medical gases if designated.	Identifies and uses masks /nasal cannulae/venturi adapters at appropriate oxygen flow rates. Records oxygen concentration/flow.	Follows oxygen prescription. Understands the context when controlled oxygen is required and applies high flow oxygen effectively in emergencies.	Prescribes oxygen and evaluates effectiveness.	Has detailed knowledge of the use of controlled and high flow oxygen therapy. Evaluates effectiveness of oxygen therapy and revises treatment accordingly.	
Administration of drugs via nebuliser	Identifies and collects medical gases if designated.	Recognises nebuliser devices and can use under supervision.	Uses nebuliser device and administer therapy using correct driving gas as prescribed.	Prescribes nebulisers including appropriate driving gas.	Reviews effectiveness of nebuliser therapy and revises treatment accordingly.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Continuous Positive Airway Pressure (CPAP) and/or Non-Invasive Ventilation (NIV)	Identifies equipment and seeks advice if unclear, transports equipment to ward.	Identifies and transports equipment to the patient.	Uses CPAP and NIV therapy. Identifies the risks associated with CPAP and NIV therapy.	Has knowledge of indications for CPAP and NIV.	Prescribes, uses CPAP and/or NIV, evaluates effectiveness of treatment and revises accordingly. Recognises need for assistance from Critical Care.	
Urgent endotracheal intubation	Identifies and transports emergency equipment to the patient.	Recognises endotracheal tube and laryngoscope.	Assists with urgent intubation.	Same as "recogniser".	Same as "recogniser".	
Chest Radiograph				Requests and interprets Chest Radiograph.	Same as primary responder.	
Chest Drain	Recognises that transferring a patient with a chest drain needs clinical assistance.	Recognises drain presence. Has knowledge of the use of a chest drain. Records output from drain and/or position (swinging and bubbling).	Prepares equipment for and assist with insertion of drain. Manages a patient with a chest drain.	Same as "recogniser".	Inserts chest drain using either seldinger or traditional technique.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Description of group role	Calls for help	Records and interprets within T&T protocol	Recognises and interprets observations in the context of the patient	Delivers a primary response and intervention	Delivers a secondary response and intervention	Delivers a tertiary response and intervention
NICE Response Level		**Low Risk**	**Low Risk**	**Low Risk**	**Medium Risk**	**High Risk**
Measurement of Heart Rate		Measures heart rate, records measurement, assigns trigger score and has knowledge of what constitutes an abnormal value.	Interprets trigger in context of patient and responds in accordance with local escalation protocols. Adjusts frequency of observations in keeping with trigger.	Identifies abnormal heart rate (tachyarrhythmias and bradyarrhythmias) and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	Refer to critical care competencies as defined by the CoBaTrICE framework and mirrored in the Intercollegiate Board's training framework for Intensive Care Medicine in the United Kingdom

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
ECG monitoring and recording of trace	Identifies equipment and seeks advice if unclear, transports equipment to the patient or ward as appropriate.	Recognises ECG machine.	Uses machine to perform 12 lead ECG. Knowledge of local equipment eg refilling paper/toner.	Has knowledge of common abnormalities and can interpret ECG in the context of the patient. Responds in accord with local protocols and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	
Measurement of Blood Pressure		Measures blood pressure, records measurement, assigns trigger score and has knowledge of what constitutes an abnormal value.	Interprets trigger in context of patient and responds in accordance with local escalation protocols. Adjusts frequency of observations in keeping with trigger.	Has knowledge of causes of an abnormal blood pressure, and which diagnostic investigations are appropriate. Institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Arterial catheter		Recognises arterial catheter as distinct from venous catheter.	Understands principles of invasive arterial pressure measurement and has knowledge of technique for insertion, use and removal of catheter.	Samples from catheter under supervision.	Inserts arterial catheter, manages independently, displays and interprets arterial pressure waveform.	
Assessment of cardiac output		Has knowledge of how to assess adequacy of cardiac output clinically using colour of skin, capillary refill, temperature of skin, presence of sweating and level of consciousness. Alerts senior staff if assessment indicates inadequate cardiac output.	Interprets assessment in the context of the patient and responds in accord with local protocols.	Identifies low cardiac output and institutes diagnostic investigations and a clinical management plan.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Fluid status and balance assessment		Records input and output.	Interprets fluid balance status.	Identifies when clinical intervention is required and institutes diagnostic investigations and a clinical management plan.	Formulates diagnosis and evaluates effectiveness of treatment, refines treatment plan if necessary and recognises when referral to Critical Care is indicated.	
Urinary catheter		Collects and prepares equipment.	Inserts catheter.	Same as "Recogniser".	Same as "Recogniser".	
Nasogastric tube		Recognises tube, can record input and output.	Inserts tube in awake, uncomplicated patient and understands local protocol for checking position. Can use for drainage, drug administration and enteral feed administration.	Same as "Recogniser".	Inserts tube in unconscious non-intubated patients.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Peripheral Venous Cannula		Recognises peripheral cannula.	Assesses potential sites for peripheral IV access and inserts cannula in "simple" cases.	Inserts IV cannula in "difficult" cases.	Same as primary responder.	
Intravenous fluid maintenance and resuscitation	Recognises infusion equipment (eg in relation to patient transport).	Retrieves correct IV fluid, volume and infusion device.	Administers fluid as prescribed and in accord with local protocols.	Identifies need for, and initiates fluid challenge for resuscitation and institutes clinical management plan. Prescribes maintenance fluids.	Evaluates effectiveness of treatment, and refines treatment plan if required**.** Recognises when invasive monitoring is required and referral to Critical Care is indicated.	
IV infusions (giving sets and pumps)	Recognises presence of IVI and safely transfer patients with IVI's.	Assists patient to manoeuvre with IVI running. Calculate and record hourly fluid input. Has knowledge of how to use device.	Prepares infusion device for use and administers fluids and drugs as prescribed.	Prescribes intravenous fluids and drugs.	Administers larger range of drugs and infusions.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Hypodermic needles and syringes	Recognises and understands safety issues.	Has knowledge of safe practice for use and disposal of hypodermic needles and syringes.	Same as "recogniser".	Same as "recogniser".	Same as "recogniser".	
Care of peripheral venous access	Recognises presence of IV access.	Undertakes and records observation of IVI in situ in accordance with local protocol.	Identifies extravastated IVI and infected IV site. Removes infected IV cannula.	Identifies need for replacement.	Same as" primary" responder.	
Alternatives to peripheral venous access		Recognition of a Central Venous Catheter.	Has knowledge of when central venous access may be required and can assist in preparing equipment.	Performs central venous access under supervision.	Inserts central venous catheter in accord with NICE guideline and local protocol. Competent in the use of Ultrasound and Landmark techniques.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Central venous catheter		Recognises a Central Venous Catheter.	Has knowledge of when Central Venous Access may be required, understands risk/benefit associated with Central Venous Catheter and uses catheter including the administration of drugs.	Performs Central Venous Access under supervision.	Inserts central venous catheter in accord with NICE guideline and local protocol. Competent in the use of Ultrasound and Landmark techniques.	
Ultrasound machine	Identifies and transports equipment to the patient.	Recognises machine.	Has Knowledge of common indications for use.	Uses ultrasound under supervision for insertion of central venous catheter.	Uses ultrasound independently for insertion of central venous catheter.	
External haemorrhage	Recognises overt blood loss.	Same as "Non-Clinical Staff".	Assesses severity of overt blood loss and interprets loss in the context of the patient. Initiates first aid management eg compression, dressing.	Identifies source of bleeding, clinical impact and initiates definitive management. Commences resuscitation.	Evaluates effectiveness of resuscitation**,** management of haemostasis and appropriate use of blood products. Refines treatment plan if necessary and recognises when referral to specialist services and/or Critical Care is indicated.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Administration of blood products including warming	Collects blood products according to local protocols.	Documents administration of Blood Products.	Administers products including the use of a blood warmer. Ensures adherence to traceability protocol.	Has knowledge of indications for, and risks associated with, blood products. Prescribes blood products.	Same as "primary" responder.	
Blood sampling equipment	Transports samples according to local protocols.	Same as "Non-Clinical Staff".	Has knowledge of which tests are required in an emergency, can perform venesection.	Has knowledge of which tests are required in both elective and emergency situations. Can request test/s, performs venesection.	Same as "primary" responder.	
Collapsed/unresponsive patient	In hospital resuscitation according to local policy.	Same as "Non-Clinical Staff".	Same as "Non-Clinical Staff".	Identifies potential causes relevant to the individual patient.	Advanced life support with a broad approach to finding information and treatment of specific causes of collapse.	
External chest compressions	Recognises when cardio-pulmonary resuscitation is in progress.	In hospital resuscitation.	In hospital resuscitation.	In hospital resuscitation.	Advanced life support.	
Cardiac arrest rhythms (VF, pulseless VT, PEA and asystole)	Recognises when cardio-pulmonary resuscitation is in progress.	In hospital resuscitation.	In hospital resuscitation.	In hospital resuscitation.	Advanced life support.	

Emergency drugs		Recognises situations when emergency drugs are used.	Selects drug when instructed.	Understands rationale for therapeutic intervention and can administer drugs according to in hospital resuscitation standard.	Advanced life support.	
Automated external defibrillator	Recognises equipment and +/- in hospital resuscitation according to local policy.	In hospital resuscitation.	In hospital resuscitation.	In hospital resuscitation.	Advanced life support.	
Non-automated external defibrillation	Recognises equipment.	In hospital resuscitation.	In hospital resuscitation.	In hospital resuscitation.	Advanced life support.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Description of group role	Calls for help	Records and interprets within T&T protocol	Recognizes and interprets observations in the context of the patient	Delivers a primary response and intervention	Delivers a secondary response and intervention	Delivers a tertiary response and intervention
NICE Response Level		**Low Risk**	**Low Risk**	**Low Risk**	**Medium Risk**	**High Risk**
Patient handling equipment + beds	Recognizes equipment.	Uses in accord with local protocols.	Identifies need for specialist bed and handling requirements.	Same as "recognizer".	Same as "recognizer".	**Refer to critical care competencies as defined by the CoBaTrICE framework and mirrored in the Intercollegiate Board's training framework for Intensive Care Medicine in the United Kingdom**
Portable suction	Can identify equipment and seeks advice if unclear, transports equipment to the ward.	Uses in accord with local protocols.	Uses equipment and adjuncts (e.g. yakeur sucker and suction catheters).	Same as "recognizer".	Same as "recognizer".	
Portable monitoring		Identifies and transports equipment to the patient.	Assists in setting up of the equipment.	Uses portable monitoring equipment to measure heart rate, oxygen saturation, respiratory rate and blood pressure.	Same as "primary responder".	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Description of group role	Calls for help	Records and interprets within T&T protocol	Recognizes and interprets observations in the context of the patient	Delivers a primary response and intervention	Delivers a secondary response and intervention	Delivers a tertiary response and intervention
NICE Response Level		**Low Risk**	**Low Risk**	**Low Risk**	**Medium Risk**	**High Risk**
Unconsciousness	Calls for help.	Recognizes the danger of airway obstruction and takes remedial action.	Has knowledge of common causes of unconscious state, eliminates these, provides in hospital resuscitation, and institutes local protocol for assistance.	Identifies the cause of reduced consciousness and institutes clinical management therapies.	Evaluates diagnosis and effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated.	Refer to critical care competencies as defined by the CoBaTrICE framework and mirrored in the Intercollegiate Board's training framework for Intensive Care Medicine in the United Kingdom
Blood Glucose measurement and interpretation	Identifies equipment and seeks advice if unclear, transports equipment to the patient or the ward.	Supervises patient to undertake own blood glucose measurement.	Performs blood glucose measurement. Has knowledge to interpret blood glucose value in context of the patient. Initiates local protocol for hypoglycaemia.	Identifies when clinical intervention is required and institutes clinical management therapies including the prescription of insulin or intravenous bolus of 50% glucose if the patient is hypoglycemic.	Evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Acute confusional states		Recognizes that confusion may be marker of illness.	Understands importance of these signs as markers of pathology, performs additional tests such as capillary blood glucose, checks for hypoxia.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated.	
Acute sudden onset headache		Recognizes severe sudden onset headache as a problem.	Understands that severe sudden headache, temperature and stiff neck needs further urgent intervention.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Differentiates meningitis/encephalitis from other causes of severe sudden onset headache such as subarachnoid hemorrhage. Institutes appropriate interventions and investigations including lumbar puncture if appropriate. Refers for specialist neurological advice.	
Altered motor / sensory function		Recognizes new weakness as abnormal.	Interprets clinical signs in context of the patient and responds in accord with local protocol.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Reviews diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care or specialist neurology is indicated.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Swallowing difficulties		Understands clinical implications of oral intake.	Interprets clinical signs in context of the patient and responds in accord with local protocol.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Reviews diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care, Speech and Language Therapist or specialist neurology is indicated.	
Seizures		Recognizes and records seizures. Understands basic practical procedures that need to be done to maintain the safety of the patient e.g. posture, airway.	Confirms seizure activity, initiates airway protection, oxygen and positioning and responds further in accord with local protocol.	Has knowledge of the causes of seizures, eliminates hypoglycaemia and hypoxia as causes and responds in accord with local protocol.	Reviews diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care or specialist neurology is indicated.	
AVPU Scale (Awake and responsive, Responds to verbal commands, Responds to painful stimuli, Unresponsive)		Measures, records, assigns trigger score and has knowledge of what constitutes an abnormal value.	Interprets trigger in context of patient and understands clinical importance of an abnormal score. Responds in accordance with local escalation protocols.	Has knowledge of the diagnostic and clinical therapies that are indicated in the context of an abnormal score. Refers to "secondary responder".	Initiates definitive diagnostic and clinical treatment strategies and recognizes when referral to Critical Care or specialist neurology is indicated.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Assessment of pupillary size and light reflex		Measures size of pupils, assesses light reflex and has knowledge of what constitutes an abnormal reaction and pupil size.	Interprets pupillary size and response to light in context of patient Understands clinical significance of either abnormal pupil size or response to light reflex. Responds in accordance with local escalation protocols.	Has knowledge of the diagnostic and clinical therapies that are indicated in the context of an abnormal pupil size or light reflex. Refers to "secondary responder".	Initiates definitive diagnostic and clinical treatment strategies and recognizes when referral to Critical Care or specialist neurology is indicated.	
Glasgow Coma Score		Measures, and records score and has knowledge of what constitutes an abnormal value.	Interprets score in context of patient and understands clinical importance of an abnormal score. Responds in accordance with local escalation protocols.	Has knowledge of the diagnostic and clinical therapies that are indicated in the context of an abnormal score. Refers to "secondary responder".	Initiates definitive diagnostic and clinical treatment strategies and recognizes when referral to Critical Care or specialist neurology is indicated.	
Cervical spine protection	Recognizes not to move patient after major trauma unless instructed by clinical staff.	Maintains spinal immobilization once initiated.	Assesses risk for spinal immobilization. Initiate spinal immobilization procedures.	Identifies the indications for requesting imaging and when to request senior assistance.	Interprets cervical spine radiograph and recognizes when referral for specialist advice required.	
Computerised Tomography (CT) Scan of Head			Recognizes that CT scan may be needed.	Identifies indications and priorities for requesting imaging.	"Simple" interpretation of CT scan and recognizes when referral for specialist advice required.	
Lumbar Puncture	Transports samples according to local protocols.	Assists with patient positioning.	Prepares equipment and labels samples.	Performs lumbar puncture under supervision.	Independently performs lumbar puncture.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Recovery Position	Places patient in recovery position.	Same as "Non-Clinical Staff".	Same as "Non-Clinical Staff".	Same as "Non-Clinical Staff".	Same as "Non-Clinical Staff".	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Description of group role	Calls for help	Records and interprets within T&T protocol	Recognizes and interprets observations in the context of the patient	Delivers a primary response and intervention	Delivers a secondary response and intervention	Delivers a tertiary response and intervention
NICE Response Level		**Low Risk**	**Low Risk**	**Low Risk**	**Medium Risk**	**High Risk**
Call for help: patient sick, or cause for concern	Communicates need for help in accord with local policy.	Same as "Non-Clinical Staff".	Interprets and documents patient condition, adjusts frequency of observations and level of monitoring in accord with local protocol.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated.	Refer to critical care competencies as defined by the CoBaTrICE framework and mirrored in the Intercollegiate Board's training framework for Intensive Care Medicine in the United Kingdom
Call for help: arrested or unconscious patient	Communicates need for help in accord with local policy.	Initiates in hospital resuscitation. Dials 2222.	Performs resuscitation to "in hospital" standard..	Recognition of potential causes pertinent to the individual patient.	Advanced life support with a broad approach to finding information and treatment of specific causes of unconsciousness or cardiac arrest.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
Patient not improving		If aware or informed by patient that they are not improving, calls for help in accord with local policy and records communication pathway.	Interprets clinical deterioration in the context of the patient, adjusts frequency of observations and level of monitoring and initiates management strategies in accord with local protocols.	Identifies when clinical intervention is required. Initiates diagnostic tests and institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated.	
Need for management plan		Communicates to appropriate staff.	Recognizes lack of plan.	Documents plan request and / or formulates management plan.	Reviews management plan and refines if necessary.	
Breaking bad news		Supports patients and/or those close to them.	Identifies need to inform primary responder. Contacts friends or relatives, if time, to be with receiver of bad news.	Informs senior clinician and may deliver bad news. Documents discussion. Liaises with carers.	Breaks bad news and documents discussion in the notes.	

Competency Group	*Non-Clinical Staff*	*"Recorder"*	*"Recogniser"*	*"Primary Responder"*	*"Secondary Responder"*	*Critical Care*
End of shift handover		Undertakes handover to next shift. Receives information. Documents and communicates appropriately to other members of the multi -disciplinary team.	Communicates frequency of observations and ongoing management plans for all patients who have reached the low, medium or high trigger and also for those where there is clinical concern.	Same as "recognizer".	Evaluates clinical progress in conjunction with the ongoing management plans for all patients who have reached medium or high trigger and also for those where there is clinical concern. Communicates to next shift.	
Documentation		Produces clear, legible documentation of the event. E.g. Note of event, date, time, which is signed, name printed and contact bleep number given.	Writes a structured note of the event including a referral plan.	Incorporates within the documentation a management plan and timescale for reassessment. Identifies when referral to the secondary responder will be indicated.	Incorporates situations when referral to critical care is appropriate and timescale for reassessment after secondary intervention.	
Team working						

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
a) Provides information in a structured format that conveys clinical urgency	Professional and respectful in approach. Actively listens. Gives clear information.	Communicates with patient/carers. Documents discussion in notes. Informs senior staff.	Gives clear instructions and communicates with senior staff when appropriate. Feedback given to junior members of the team.	Recognizes when secondary responder needs to be informed .	Evaluates effectiveness of communication. Recognizes when referral to Critical Care is indicated.	
b) Participation in whole team review and reassessment		Participates in review ,documents actions and communicates to senior staff.	Communicates to primary responder after review. Feedback given to junior members of the team.	Examines patient, gives clear instructions and communicates with secondary responder.	Leads the team, including giving feedback to all members of the team.	
c) Personal Responsibility and Accountability		Is aware of accountability.	Complies with code of professional conduct, complies with local policies.	Recognizes leadership role within the team and responsibility to refer to secondary responder.	Acknowledges overall responsibility for the care of a patient.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
d) Decision Making		Is aware of policies, complies with policies.	Interprets observations, adjusts frequency of observations and level of monitoring, provides nursing intervention and communicates with primary responder when escalation of care is required. Feedback given to junior members of the team. Recognizes own limitations.	Identifies when clinical intervention is required. Initiates treatment ,monitors patient response, recognizes limitations. Communicates with secondary responder when further escalation or de-escalation of care is indicated.	Formulates diagnosis if not already done. Evaluates effectiveness of management plan, refines where appropriate and communicates with critical care when further escalation of care is needed. Recognizes when de-escalation of care is appropriate and the patient requires palliative care in-put. Communicates decisions with team.	
e) Leadership			Adopts leader or follower role as appropriate.	Same as "recognizer"	Reviews team working, develop local teams, identify and work to resolve problems.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Ethics/ medico-legal		Has an awareness of concepts. Acknowledges limitations.	Works within established hospital procedures. Acknowledges limitations.	Same as "recognizer"	Works independently, can review and agree plan. Seeks advice or second opinion as needed.	
Patient Safety:						
a) Electrical Safety	Recognizes basic electrical safety and associated clinical risk. Communicates concerns to ward staff and instigates appropriate action to avoid patient harm.	Recognizes and documents clinical risk associated with the equipment on which training has been given**.** Communicates risk to senior staff and initiates appropriate action.	Assesses, quantifies and documents risk in the workplace. Initiates appropriate action to minimize clinical risk and communicates risk to primary responder.	Quantifies individual risk, acts to prevent or minimize it.	Manages risk-benefit across groups of patients e.g. triage.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
b) Moving and Handling	Recognizes clinical risk associated with moving and handling. Communicates concerns to ward staff and instigates appropriate action to avoid patient and personal harm.	Recognizes and documents clinical risk associated with the equipment for moving and handling on which training has been given**.** Communicates risk to senior staff and initiates appropriate action.	Assesses, quantifies and documents risk in the workplace. Initiates appropriate action to minimize clinical risk and communicates risk to primary responder.	Quantifies individual risk, acts to prevent or minimize it.	Manages risk-benefit across groups of patients e.g. triage.	
c) Falls	Recognizes clinical risk associated with falls. Communicates concerns to ward staff and instigates appropriate action to avoid harm.	Recognizes and documents clinical risk associated with falls**.** Communicates risk to senior staff and initiates appropriate action.	Assesses, quantifies and documents risk in the workplace. Initiates appropriate action to minimize clinical risk and communicates risk to primary responder.	Quantifies individual risk, acts to prevent or minimize it.	Manages risk-benefit across groups of patients e.g. triage.	
d) Applies infection control policies to minimize risk of Hospital Acquired Infections	Adheres to Trust's infection control policy.	Documents infection-related hazards and communicates such hazards to all staff.	Provides leadership on the ward for Hospital Acquired infections (HAI).	As per "Recogniser".	Implements measures in collaboration with infection control staff.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
Blood culture	Can transport samples according to local protocols.	Identifies and transports equipment to the patient.	Recognizes when a blood culture is appropriate and identifies equipment required and procedure to undertake the intervention.	Performs blood cultures according to local aseptic policy.	As per "Primary Responder".	
Microbiology samples	Transports samples according to local protocols.	Performs microbiological sampling under supervision	Independently performs microbiological sampling as requested.	Has knowledge of which microbiological samples are required.	Same as "primary "responder.	
Measurement of Temperature		Measures temperature, records result and has knowledge of what constitutes an abnormal value.	Interprets trigger in context of patient and responds in accord with local protocols.	Identifies abnormal temperature and recognizes when clinical intervention is required. Institutes clinical management therapies.	Formulates diagnosis**,** evaluates effectiveness of treatment, refines treatment plan if necessary and recognizes when referral to Critical Care is indicated.	

Competency Group	***Non-Clinical Staff***	***"Recorder"***	***"Recogniser"***	***"Primary Responder"***	***"Secondary Responder"***	***Critical Care***
End of Life Care	Respects patient's dignity and privacy.	Ensures clear documentation of events.	Facilitates expression of a patient's and their family wishes. Provides holistic care.	Determines a patient and their family wishes. Communicates end of life wishes to all staff.	Institutes appropriate end of life care to comply with the patient's wishes and regularly reviews decisions and plan. Recognizes when to refer for palliative care.	