



# Core Competency Framework

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*For Band 5 Registered Nurses Community Setting*

**Name:**

**Department:**

**Start Date:**

**End Date:**

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# Introduction

This document identifies generic skills and competencies expected of all Registered Nurses working at Band 5 within a Community setting for Walsall Healthcare NHS Trust.

On completion, this document should be kept by the Nurse for their personal portfolio; a copy of the final sign-off declaration should be submitted to the Locality Lead and retained in their personal file.

## The Code

The NMC code requires that each Registered Nurse:

- Must deliver care based on the best available evidence or best practice.
- Must have the knowledge and skills for safe and effective practice when working without direct supervision.
- Must keep knowledge and skills up to date throughout your working life.
- Must take part in appropriate learning and practice activities that maintain and develop your competence and practice.

Nursing & Midwifery Council (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*

## Core skills

This identifies the range of skills which may be required of any Registered Nurse working within the Trust. The individual is expected to perform the skills safely, consistently and to the required standard, following all relevant Trust policies in order to be deemed competent. In addition they must demonstrate that they have the underpinning theoretical knowledge necessary to provide the rationale for performing a specific task.

The Trust recognises that, where a skill is not relevant to a clinical setting individuals may lose competence over time. However, it is expected that the individual should take steps to refresh their knowledge and competence in order to undertake these skills should they become relevant to their clinical practice in future.

## Guidance Notes

All of the skills identified within this document must be carried out in line with:-

- Current Trust policies, procedures and protocols
- Current legislation
- NMC guidelines

The Registered Nurse undertaking these competences must also ensure that they:-

- Use all equipment appropriately and safely
- Provide the patient with emotional and physical support throughout
- Maintain the health and safety of the patient, their colleagues and themselves
- Seek appropriate advice and support if unsure of the action to take

## *Assessment*

Staff completing this Competency document will be assessed by a competent trained Staff Member. It is the responsibility of the Individual to ensure that they have a competent Assessor, who will be identified in conjunction with the Locality Lead.

A Registered Nurse is expected to demonstrate a minimum of Level 4 of Steinaker and Bell's taxonomy as identified below (Page 5) in all competences. Beyond the preceptorship period Registered Nurses are expected to be demonstrating competence at Level 5 in most areas.

Where Assessors feel a particular skill is demonstrated at Level 5, this should be noted within the assessment.

The Assessor must ensure that each outcome is reviewed, signed and dated indicating achievement or non-achievement.

The Assessor will:

- Meet with the RN regularly, review competencies and set realistic timescales for achievement.
- Accurately and honestly assess the Candidate against the competence criteria. Identify any competencies not being met and provide constructive feedback and guidance to support and enable the RN to become competent.
- Review progress midway through the programme and escalate to the Ward Manager if timescales are not being achieved or other concerns identified.

Where a competence cannot be demonstrated because that element of care is not delivered in a particular clinical setting this should be documented in this booklet by the Manager of that clinical area. The Registered Nurse is expected to ensure any competencies omitted because the opportunities are not available, are achieved within a timely manner – usually 4-8 weeks - should they move to a clinical area where that skill is required.

## *Failure to progress*

Where areas of concern are identified or the RN fails to achieve competence in a timely manner this should be escalated to the Locality Lead at the earliest opportunity. The individual, Locality Lead and Assessor must agree clear action plans to facilitate achievement within a defined timescale. These plans must be documented in the Individual's personal file and progress regularly reviewed. Further failure to progress should then be managed under the Trust's Capability or Conduct Procedures.

## *Relevant Contact Details:*

These competencies have been developed by the Faculty of Research and Clinical Education with consultation from Trust senior nursing staff and the Trust Competency Group. The FORCE team may be able to offer support or identify appropriate training opportunities to Locality Leads or Assessors for individual nurses who are failing to demonstrate competence and can be contacted as below:

- Faculty of Research and Clinical Education Phone – Ext 5794
- Faculty of Research and Clinical Education Email – [force@walsallhealthcare.nhs.uk](mailto:force@walsallhealthcare.nhs.uk)

## *Assessment Taxonomy*

The following taxonomy developed by Steinaker and Bell (1979) describes the sequence of levels of skills acquisition which individuals progress through as they learn and develop competence in a skill.

All Registered Nurses are expected to demonstrate skills at a minimum of Level 4 of the taxonomy to be deemed competent. Beyond the preceptorship period Registered Nurses are expected to be demonstrating competence at Level 5 in most areas. Where assessors feel a particular skill is demonstrated at Level 5, this may be noted within the document.

<b>Taxonomy level</b>	<b>Learners performance</b>	<b>Criteria for accepted performance</b>	<b>Implications for mentors / assessors</b>
Level 1 (L1)	Exposure	Gain understanding through exposure of the knowledge, skills and attitudes needed for professional competence.	Selects and presents information. Demonstrates appropriate task. Acts as a motivator to reduce anxiety and maintain confidence. Observes trainees willingness to learn.
Level 2 (L2)	Participation	Completes competence only with substantial supervision and support. Student is unable to relate theory to practice	Offers guidance and supportive feedback. Questions the trainees understanding. Promote further thought and learning from situation. Observes level of learner participation.
Level 3 (L3)	Identification	Perform competency safely with minimal supervision / support, is able to relate theory to practice.	Less supervision and intervention. Provides advice and feedback. Reinforces good practice. Asks questions of the trainee, relating theory to practice.
<b>Level 4 (L4)</b>	<b>Internalisation</b>	<b>Able to explain the rationale for nursing action, is able to transfer knowledge to new situations. Seeks and applies new knowledge and research findings.</b>	<b>Requires less supervision whilst caring for a group of patients/clients, demonstrates ability to use problem solving skills, critical analysis and evaluation.</b>
Level 5 (L5)	Dissemination	Capable of independent nursing practice. Advises others, teaches junior colleagues and demonstrates ability to manage care delivery by junior staff.	Requires minimal supervision to plan, implement and evaluate care for a group of patients. Demonstrates critical analysis, evaluation and decision-making skills

Steinaker, N. and Bell, M (1979), *The Experiential Taxonomy: A New Approach to teaching and learning.*

## *Band 5 Registered Nurse Core Skills*

These are the core skills at which all Registered Nursing staff are expected to be able to demonstrate competence and to undertake where they are appropriate to their clinical area. See notes above.

Skill	Examples of evidence of competence	Date Achieved	Assessor Signature
Manual vital signs recording and accurate documentation of pulse, blood pressure, respiratory rate.	<ul style="list-style-type: none"> <li>Completion of Royal College of Physicians NEWS2 E-Learning.</li> <li>Observed clinical observations in practice.</li> </ul>		
Electronic vital signs recording and accurate documentation of pulse, blood pressure, oxygen saturations and temperature.	<ul style="list-style-type: none"> <li>Observed electronic observations in practice</li> </ul>		
Blood glucose monitoring	<ul style="list-style-type: none"> <li>Point of Care Team trainer or Diabetic Link Nurse Trainer</li> <li>Completion of competency document</li> </ul>		
Administration of Intravenous drugs	<ul style="list-style-type: none"> <li>Administration of Intravenous Therapies training course and completion of competency document</li> <li>Completion of competency document</li> </ul>		
Peripheral Cannulation, care and management of intravenous devices. <i>NB – Only for CIT in Community</i>	<ul style="list-style-type: none"> <li>Cannulation of theory training session</li> <li>Completion of clinical competency training</li> </ul>		
Care and Management of Central Venous Access Devices	<ul style="list-style-type: none"> <li>Attendance at theory training session</li> <li>Completion of clinical competency document</li> </ul>		
Venepuncture	<ul style="list-style-type: none"> <li>Attendance of the venepuncture theory session</li> <li>Completion of the clinical competency document</li> </ul>		
Bladder scanning	<ul style="list-style-type: none"> <li>Attendance at theory training session</li> <li>Completion of clinical competency document</li> </ul>		
Female Urethral Catheterisation	<ul style="list-style-type: none"> <li>Attendance at theory training session</li> <li>Completion of clinical competency document</li> </ul>		
Male Urethral Catheterisation	<ul style="list-style-type: none"> <li>Trust Male Catheterisation training</li> <li>Completion of the clinical competency document</li> </ul>		

Supra Pubic Catheterisation	<ul style="list-style-type: none"> <li>• Trust Supra Pubic Catheterisation training</li> <li>• Completion of the clinical competency document</li> </ul>		
Bowel Care	<ul style="list-style-type: none"> <li>• Trust DRE/DRF training session</li> <li>• Completion of clinical competency document</li> </ul>		
Aseptic Technique and Wound Dressing	Completion of the relevant course		
Removal of Wound Closures	Clinical observation by preceptor and sign off		
Recording a 12-Lead ECG <i>NB - Not an essential community competency</i>	<ul style="list-style-type: none"> <li>• Attendance at Trust Theory session</li> <li>• Completion of clinical competency document</li> </ul>		
Care and Management of a Nasogastric tube or PEG	<ul style="list-style-type: none"> <li>• Attendance at theory training session</li> <li>• Completion of clinical competency document</li> </ul>		
Care and Management of a Stoma	<ul style="list-style-type: none"> <li>• Attendance at theory training session</li> <li>• Completion of clinical competency document</li> </ul>		
Syringe Pump	<ul style="list-style-type: none"> <li>• Attendance at theory training session</li> <li>• Completion of clinical competency document</li> </ul>		
Compression Bandage	<ul style="list-style-type: none"> <li>• Attendance at theory training session</li> <li>• Completion of clinical competency document</li> </ul>		
Doppler Assessment	<ul style="list-style-type: none"> <li>• Attendance at theory training session</li> <li>• Completion of clinical competency document</li> </ul>		
Tracheostomy Care	<ul style="list-style-type: none"> <li>• Complete on line e-learning (tracheostomy.org.uk)</li> <li>• Completion of clinical competency document</li> </ul>		
Nephrostomy Care	<ul style="list-style-type: none"> <li>• Attendance at theory session</li> <li>• Completion of clinical competency document</li> </ul>		
Ear Irrigation	<ul style="list-style-type: none"> <li>• Attendance at theory session</li> <li>• Completion of clinical competency document</li> </ul>		

## *Competency Statements of Practice*

*Statement of Practice One: The registered nurse consistently delivers safe, effective, high quality care and demonstrates the ability to maintain patient safety and a safe environment at all times.*

	<b>Date and Level achieved. Assessor Signature</b>	<b>Assessor comments</b>
<i>Organisational Competence</i>		
Statutory, mandatory and risk management training is up to date in accordance with Trust Statutory, Mandatory and Risk Management Training policy.		
Local induction checklist has been completed and is documented.		
Demonstrates knowledge of location of fire alarms, exits, assembly points and fire equipment within local area and awareness of emergency evacuation procedures.		
Demonstrates knowledge of location, use and checking procedures for all emergency equipment.		
Demonstrates ability to locate Trust policies and procedures and any local guidelines, such as the ones identified below:		
Demonstrates awareness of Trust Major incident plan and can discuss local responsibilities.		
Completes incident/near miss reports in accordance with Trust Incident reporting policy.		
Demonstrates ability to manage and escalate staffing issues according to Trust policy.		
Demonstrates an understanding of clinical governance and can describe how it is applied locally.		



Demonstrates ability to respond appropriately to address simple complaints and can discuss methods of reducing complaints within own clinical area.		
Demonstrates awareness of local and national initiatives to improve patient safety, how they are being implemented within own clinical area and implications for own practice.		
<i>Behavioural Competence</i>		
Demonstrates ability to identify and report equipment fault or failure and escalate concerns regarding an unsafe environment.		
Demonstrates ability to discuss situations where it may be necessary to disclose information to maintain safety and in accordance with the law.		
Acts without delay to address any situation which may put a person at risk.		
Escalates appropriately concerns regarding any factors which prevent the nurse working in accordance with the NMC Code, national guidance or Trust policies.		
Identifies appropriate actions to take when concerned regarding patient safety or possible abuse/neglect, including completion of appropriate safeguarding alert.		
<i>Clinical Competence – Knowledge / Skills</i>		
Consistently ensures the environment is clean, clutter free and appropriately prepared for clinical care.		
Demonstrates ability to appropriately prepare a bed or working space for a patient; ensuring all equipment required is clean and in good working order and discussing any safety checks required.		
Demonstrates ability to identify a vulnerable patient and take appropriate steps to maintain their safety.		

Demonstrates ability to identify a patient who requires assessment for Deprivation of Liberty Safeguards and identifies who to contact for assessment.		
Demonstrates an understanding of the Mental Capacity Act.		
Demonstrates an understanding of the roles of the members of the multidisciplinary team and refers patients appropriately.		
Understands the competency levels and limitations of other staff, delegates tasks appropriately and provides effective supervision.		
Demonstrates the ability to co-ordinate and prioritise the delivery of nursing care to a group of patients based on sound clinical decision making.		
Contributes to continuous quality improvement (QI) changes by applying approved QI methodology.		
Demonstrates awareness of Ward/Department quality data, understands the implications for patients and works with the Matron/Manager and other staff to constantly improve and maintain quality standards.		
<i>Action Plan to Achieve Statement of Practice One</i>		

### *Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

### *Statement of Practice Two: The nurse consistently demonstrates professional behaviour in accordance with the NMC Code.*

	<b>Date and level achieved. Assessor Signature</b>	<b>Assessor comments</b>
<i>Behavioural Competence</i>		
Consistently maintains a smart and professional appearance, adhering to Trust Uniform policy.		
Consistently demonstrates professional behaviour when interacting with others and acts as a role model for other staff.		
Acts as an advocate for the patient and/or their family/carer when required.		
Develops and maintains a portfolio of practice which demonstrates on-going clinical competence and professional development.		
Provides evidence of involvement in clinical supervision.		
Evidence of reflection is present in portfolio of practice.		

Consistently ensures high standards of clinical care by challenging or reporting unacceptable standards of practice in an appropriate manner.		
Demonstrates ability to respect cultural diversity by providing care which reflects an individual patient's choices.		
Consistently demonstrates effective time management through punctuality and good attendance.		
<i>Clinical Competence – Knowledge / Skills</i>		
Demonstrates an understanding of professional responsibilities regarding delegation and delegates care in line with Trust policies and NMC Code.		
Follows Trust policy and procedure at all times.		
Treat all people as individuals, with dignity, consideration and without discrimination.		
Consistently delivers quality care to the best of their ability to patients, relatives and carers.		
Always practices within the scope of own competence, seeks advice and support when required and takes steps to appropriately develop clinical knowledge and experience.		
Consistently meets all Trust Mandatory Training requirements.		
<i>Action Plan to Achieve Statement of Practice Two</i>		

*Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

*Statement of Practice Three: The nurse demonstrates the ability to work collaboratively within a team and communicate effectively at all times, including emergency and distressing situations, using a variety of different methods.*

	Date and level achieved. Assessor Signature	Assessor comments
<i>Behavioural Competence</i>		
Consistently demonstrates effective verbal and written communication skills when communicating with patients, visitors, family/carers and other members of the multidisciplinary team.		
Establishes and maintains collaborative working relationships with members of the multidisciplinary team and others.		
Maintains confidentiality in line with NMC and Caldicott guidelines.		
Identifies how to recognise signs of stress in self and others and discusses how this may affect communication.		

Demonstrates ability to access interpreting services where required and knowledge of use and availability of dual language phone facilities.		
Demonstrates ability to recognise and avoid potential conflict situations and identifies varied strategies to diffuse and manage conflict should it arise.		
Demonstrates proficiency in accessing and using Trust IT systems effectively including: Trust Intranet and email systems, Patient information systems.		
<i>Clinical Competence – Knowledge / Skills</i>		
Demonstrates ability to use Trust telephone systems to access other wards, departments and members of the multidisciplinary team.		
Consistently demonstrates concise, timely and accurate documentation of care using appropriate Trust documentation.		
Demonstrates the ability to both give and receive a concise and accurate handover using SBAR techniques to the rest of the multidisciplinary team, both 1:1 and in a group.		
<i>Action Plan to Achieve Statement of Practice Three</i>		

*Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

*Statement of Practice Four: The nurse consistently demonstrates the ability to appropriately assess the patient, plan, implement and evaluate individualised quality care in conjunction with the patient, their family/carers and the multidisciplinary team and adjusts this care in order to respond quickly and effectively to changes in the patient’s condition.*

	<b>Date and level achieved. Assessor Signature</b>	<b>Assessor comments</b>
<i>Behavioural Competence</i>		
Demonstrates ability to Identify the potential psychological effects of illness on a patient and their family and discuss how these can be addressed.		
Maintains the patient’s privacy and dignity at all times.		
Consistently demonstrates the ability to support and encourage patient autonomy and independence.		

Demonstrates awareness of how to access support for patients, families and carers both within the Trust and externally.		
<i>Clinical Competence – Knowledge / Skills</i>		
Demonstrates the ability to accurately assess a patient on admission or at initial referral using a systematic approach and including accurate recording of all appropriate vital signs. Accurately documents this assessment using correct paperwork and completing all appropriate risk assessments.		
Effectively documents individualised plans of care based on the initial assessment, identifying appropriate evaluation and reassessment dates including required frequency of on-going monitoring and vital signs recording.		
Demonstrates ability to make appropriate referrals to other members of the multidisciplinary team based upon the patient assessment.		
Demonstrates the involvement of the patient, family/carers in the planning, provision and evaluation of care where appropriate.		
Demonstrates awareness of the importance of effective discharge planning by identifying estimated discharge date and potential barriers to discharge at the point of initial assessment.		
Effectively provides, or delegates provision of planned care, continually evaluating the quality and effectiveness of care provided.		
Demonstrates the ability to quickly and effectively recognise and respond to deterioration in a patient's condition, escalating care where required and in accordance with Trust guidelines.		
Demonstrates the ability to initiate appropriate interventions in response to abnormal observations or changes in patient condition e.g. ECG recording, blood glucose monitoring, neurological observations.		
Demonstrates ability to accurately assess a patient's skin condition and risk of developing pressure-related damage and takes required steps to maintain skin integrity, including provision of appropriate equipment.		



Demonstrates ability to assess wounds, evaluate healing and treat appropriately.		
Demonstrates ability to accurately monitor and assess a patient's fluid status, identifying and initiating appropriate intervention when required.		
Demonstrates and discusses strategies available to ensure patients receive adequate nutrition and hydration, including MDT referrals.		
Effectively maintains protected mealtimes within wards/departments.		
Demonstrates effective assessment of an individual's mental capacity and awareness of how to escalate concerns.		
Delivers compassionate, appropriate and effective care to the dying patient and their family/carers, involving other members of the MDT and external agencies where appropriate.		
Demonstrates safe, timely and effective planning and implementation of both simple and complex discharges, maintaining good communication with all involved throughout and documenting effectively.		
Identifies normal ranges of the following blood results: full blood count, urea, electrolytes, creatinine, liver function tests plus any additional blood tests commonly used within a specific ward/department. Escalates abnormal results appropriately.		
<i>Action Plan to Achieve Statement of Practice Four</i>		

*Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

*Statement of Practice Five: The nurse consistently demonstrates the ability to ensure every patient receives their medications safely, effectively and by the most appropriate route.*

	Date and level achieved. Assessor Signature	Assessor comments
<i>Behavioural Competence</i>		
Provides annual evidence of ability to accurately calculate drug dosages.		
Consistently provides patients, their families and carers with the information they require to make informed decisions regarding their medicines.		
Involves patients and their families/carers in discussions and choices regarding their medicines.		
<i>Clinical Competence – Knowledge / Skills</i>		
Demonstrates proficient practice in the administration of medicines by the following routes in accordance with Trust Medicines Management Policy: oral, subcutaneous injection and infusion, intramuscular injection, inhalation, intravenous injection and infusion, rectal, vaginal, and topical.		

Demonstrates awareness of the indication, dosage and common side-effects of any medication being administered and can discuss whether it is appropriate for a specific patient.		
Identifies appropriate sources of information regarding drug administration and demonstrates how to use these effectively.		
Demonstrates ability to accurately ascertain and document a patient's medication history.		
Ensures availability of medications through monitoring, timely ordering and maintenance of ward stocks, effective liaison with the pharmacy department and safe and robust transfer of medication between departments where appropriate.		
Identifies circumstances when it would be appropriate to omit a medication. Demonstrates actions to be taken where a drug is omitted, including appropriate documentation and identifies steps to be taken to avoid future omissions.		
Demonstrates ability to educate the patient and families/carers good medicines administration techniques including; inhaler/spacer technique, subcutaneous injections.		
Demonstrates ability to ensure patients/family/carers have appropriate supplies of all required medications on discharge, understand their safe storage and use and knows where to obtain further advice if required.		
<i>Action Plan to Achieve Statement of Practice Five</i>		

### *Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_

### *Statement of Practice Six: The nurse consistently demonstrates good infection control practices in all aspects of care.*

	<b>Date and level achieved. Assessor Signature</b>	<b>Assessor comments</b>
<i>Behavioural Competence</i>		
Consistently demonstrates good hand hygiene and infection control techniques within clinical practice.		
<i>Clinical Competence – Knowledge / Skills</i>		
Consistently uses personal protective equipment, e.g. gloves, aprons appropriately in clinical practice.		
Identifies the correct procedures for decontamination of equipment and ensures all equipment is cleaned appropriately.		
Challenges others where appropriate to ensure everyone within the clinical setting follows Trust infection control policies.		

Consistently demonstrates correct procedures for safe segregation, handling, storage and disposal of waste.		
Consistently ensures correct procedures for management of sharps.		
Demonstrates appropriate care and management of patients with known or suspected communicable infections, including consideration of psychological care.		
Demonstrates good practice in labelling and transport of clinical specimens.		
Educates colleagues, patients, relatives and carers where appropriate on effective methods of infection control.		
<i>Action Plan to Achieve Statement of Practice Six</i>		
<p><i>Statement of Competence</i></p> <p>I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.</p> <p>Signature of Registered Nurse: _____ Date: _____</p> <p>I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.</p> <p>Signature of Assessor: _____ Date: _____</p>		

*Statement of Practice Seven: The nurse consistently works to develop a culture of learning throughout the organisation through his/her own personal and professional development and by supporting the development of others.*

	Date and level achieved. Assessor Signature	Assessor comments
<i>Behavioural Competence</i>		
I Identifies and facilitates access to appropriate learning opportunities for self and others		
Following appropriate training and education, acts as an effective mentor to student nurses and preceptor to new registrants.		
Ensures that Trust mentor status is maintained by meeting NMC requirements of annual updating, maintaining a portfolio of mentorship evidence and undertaking triennial review.		
Provides written evidence of learner achievement where appropriate through completion of practice/competency documents.		
Escalates any concerns regarding learner performance appropriately, e.g. concerns re student to Practice Placement team.		
Ensures University requirements for assessment of learners on Trust placements are met in a timely manner.		
<i>Clinical Competence – Knowledge / Skills</i>		
Consistently strives to ensure that all care provided is current and evidence-based, questioning and challenging practice where appropriate and contributes to dissemination of new knowledge and practice within the clinical area.		
Ensures that all learners are supported to provide care which is safe and effective through appropriate supervision and delegation.		

Demonstrates the ability to teach and support learners through delivery of formal teaching sessions using equipment and IT as appropriate.		
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*Action Plan to Achieve Statement of Practice Seven*

*Statement of Competence*

I declare that I believe I have demonstrated competence in this Statement of Practice. I understand that I am required to ensure that I maintain this level of competence and practice in accordance with Trust policies and procedures.

Signature of Registered Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have assessed the above individual against this Statement of Practice and found them to be competent according to the above criteria and in accordance with Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_ Date: \_\_\_\_\_





## *Final Competency Sign-Off*

I declare that I have assessed the above individual and found them to be competent in all the above Statements of Practice as judged by the above criteria and in accordance with current Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

I declare that I have read and understood relevant Trust policies/guidelines and I am competent in all the above Statements of Practice within my role within Walsall Healthcare NHS Trust.

I understand that it is my professional responsibility to ensure I maintain on-going competence through appropriate clinical development.

Signature of Registered Nurse: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

The following page - Final Competency Sign-Off (Locality Lead Copy) - should be completed and given to the Locality Lead as evidence of Competence. The Locality Lead should sign for receipt of this copy below.

**I confirm that I have received the Final Competency Sign-Off (Locality Lead Copy)**

Signature of Locality Lead: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_



# *Final Competency Sign-Off- Locality Lead Copy*

**Candidate Name (Print):** \_\_\_\_\_

**Clinical Area:** \_\_\_\_\_

**Induction Completion Date:** \_\_\_\_\_

I declare that I have assessed the above individual and found them to be competent in all the above Statements of Practice as judged by the above criteria and in accordance with current Trust policies and procedures.

Signature of Assessor: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

I declare that I have read and understood relevant Trust policies/guidelines and I am competent in all the above Statements of Practice within my role within Walsall Healthcare NHS Trust.

I understand that it is my professional responsibility to ensure I maintain on-going competence through appropriate clinical development.

Signature of Registered Nurse: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

***PLEASE RETURN A SCANNED COPY OF THIS PAGE ONLY TO THE FORCE FACULTY  
AT EMAIL:***

**Force@walsallhealthcare.nhs.uk**