FP7Y 04 (PCS7) Assist the registered practitioner in the delivery of perioperative patient care

About this Unit

This standard covers carrying out delegated care activities that are within your own sphere of competence to assist the registered practitioner in the delivery of perioperative patient care. This will involve assessment, planning, implementation, monitoring and evaluation of perioperative patient care.

Users of this standard will need to ensure that practice reflects up to date information and policies.

Your **knowledge and understanding** will be specifically related to legal requirements and codes of practice and conduct applicable to your job, and the NHS Knowledge and Skills Framework. This will relate to your work activities; the job you are doing, and the setting, eg in hospital and community, domiciliary, residential care, and the individuals you are working with.

Values — the values underpinning this Unit are embedded within the 2009 NHS Code of Conduct for Health Care Support Workers. These are stated in full within the Assessment Strategy and Guidance document for the awards.

Key Words and Concepts — a glossary of definitions, key words and concepts used in this Unit is contained in the Assessment Strategy and Guidance document.

In occupational standards it is quite common to find words or phrases used which you will be familiar with, but which, in the detail of the standards, may be used in a very particular way. **You should read the Assessment Strategy and Guidance document before you begin working with the standards and refer to it if you are unsure about anything in the Unit.**

Specific Evidence Requirements for the Unit
It is essential that you adhere to the Evidence Requirements for this Unit

SPECIFIC EVIDENCE REQUIREMENTS FOR THIS UNIT
Simulation:
♦ Simulation is **NOT** permitted for any part of this Unit.
♦ **The following forms of evidence ARE mandatory:**
♦ **Direct Observation:** Your assessor or expert witness must observe you in real work activities. Their confirmation of your practice will provide evidence for a significant amount of the performance criteria in this Unit. **For example**, maintaining the confidentiality of patient information and protecting the patient's dignity and privacy. ♦ **Professional discussion:** Describes your actions in a particular situation and reflect on the reason(s) why you practice that way. **For example**, you could explain which members of the team should be made aware of any allergies the patient may have and the effect this may have on the plan of care.
Competence of performance and knowledge could also be demonstrated using a variety of evidence from the following:
♦ **Reflective Account:** These are written pieces of work which allow you to reflect on the course of action you took in a specific situation to identify any learning from the piece of work and to describe what you might do differently in the light of your new knowledge. ♦ **Questioning/professional discussion**: May be used to provide evidence of knowledge, legislation, policies and procedures which cannot be fully evidenced through direct observation or reflective accounts. In addition your assessor/mentor or expert witness may also ask questions to clarify aspects of your practice. ♦ **Expert Witness**: A designated expert witness, eg a senior member of staff, may provide a direct observation of your practice, or record a professional discussion they have held with you on a specific piece of practice. ♦ **Witness Testimony**: Can be a confirmation or authentication of the activities described in your evidence which your assessor or mentor has not seen. ♦ **Products:** These can be any record that you would normally use within your normal role, eg you should not put confidential records in your portfolio; they can remain where they are normally stored and be checked by your assessor and internal verifier. ♦ **Prior Learning:** You may be able to use recorded prior learning from a course of training you have attended within the last two years. Discussion on the relevance of this should form part of your assessment plan for each Unit. ♦ **Simulation:** There may be times when you have to demonstrate you are competent in a situation that does not arise naturally through your work role, eg dealing with violent or abusive behaviour. The Evidence Requirements in each Unit provide specific guidance regarding the use of simulation.
GENERAL GUIDANCE
♦ Prior to commencing this Unit you should agree and complete an assessment plan with your assessor which details the assessment methods you will be using, and the tasks you will be undertaking to demonstrate your competence. ♦ Evidence must be provided for ALL of the performance criteria, ALL of the knowledge. ♦ The evidence must reflect the policies and procedures of your workplace and be linked to current legislation, values and the principles of best practice within the Health Care sector. This will include the National Service Standards for your areas of work. ♦ All evidence must relate to your own work practice.

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KNOWLEDGE SPECIFICATION FOR THIS UNIT

Competent practice is a combination of the application of skills and knowledge informed by values and ethics. This specification details the knowledge and understanding required to carry out competent practice in the performance described in this Unit.

When using this specification **it is important to read the knowledge requirements in relation to expectations and requirements of your job role**.

You need to provide evidence for ALL knowledge points listed below. There are a variety of ways this can be achieved so it is essential that you read the 'knowledge evidence' section of the Assessment Guidance.

You need to show that you know, understand and can apply in practice:		**Enter Evidence Numbers**
1	The current European and National legislation, national guidelines, organisational policies and protocols in accordance with clinical/corporate governance which affect your work practice in relation to assisting the registered practitioner in the delivery of perioperative patient care.	
2	Your responsibilities and accountability in relation to the current European and National legislation, national guidelines and local policies and protocols and clinical/corporate governance.	
3	The duty to report any acts or omissions in care that could be detrimental to yourself, other individuals or your employer.	
4	The importance of working within your own sphere of competence when assisting in the care of patients in the perioperative environment and seeking advice when faced with situations outside your sphere of competence.	
5	The principles of the care process.	
6	The meaning of a 'professional approach' in relation to patients, relatives, friends and staff within and outside the operating department team.	
7	The importance of applying standard precautions and the potential consequences of poor practice.	
8	Specific care needs of the patients that you work with, for example, adults, pregnant women, children, people with learning difficulties, perioperative death, and how to meet those needs.	
9	The importance of taking patients' expressed wishes and needs into account during the development of plans of care, and the situations in which it may not be possible to meet patients' wishes.	
10	How a patient's care needs may change according to the stage of the procedure, including pre-operative; operative; post-operative.	
11	The principles of patient advocacy, and effective ways of representing and safeguarding patients' interests.	
12	The effect of anxiety on the emotional state and behaviour of patients and how to recognise signs of patient distress.	
13	Methods of monitoring patients' ongoing care needs, safety and wellbeing.	

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	You need to show that you know, understand and can apply in practice:	Enter Evidence Numbers
14	Methods of providing support and reassurance to patients who are undergoing clinical procedures.	
15	The care provided to patients who die during clinical procedures.	
16	Sources of information and how to access and use them.	
17	Collating and assessing information from a number of sources to determine patients' care needs.	
18	Methods for checking and confirming the accuracy, validity and reliability of information.	
19	How plans of care may vary for day case/in patients and non-scheduled, for example, emergency, trauma and non-elective patients.	
20	How to identify and access appropriate resources for the delivery of patient care.	
21	Sources of information and advice that are available if there are any problems or uncertainty regarding plans of care.	
22	The importance of following agreed plans of care, and of reporting significant deviations from them.	
23	Circumstances which may require plans of care to be revised	
24	The purpose of providing feedback to the registered practitioner to assist in the evaluation of perioperative care plans.	
25	The process for revising perioperative plans of care.	
26	The importance of keeping accurate and up to date records.	
27	The importance of immediately reporting any issues which are outside your own sphere of competence without delay to the relevant member of staff.	
28	The reasons for recording care needs.	
29	Methods and procedures for communicating perioperative plans of care to colleagues and patients.	
30	Methods and procedures for working within a multi-disciplinary team in the assessment, planning, implementation, monitoring and evaluation of perioperative care.	
31	How multi-disciplinary teams communicate effectively.	
32	Requirements that colleagues have for specific information relating to all stages of perioperative care.	

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Performance Criteria	DO	RA	EW	Q	P	WT	PD
1 Apply standard precautions for infection prevention and control and other relevant health and safety measures.							
2 Obtain information on the care needs of the patient from the appropriate sources, identifying when you need to confirm or clarify information and take the appropriate action.							
3 Enable the patient to express their needs, beliefs and preferences.							
4 Maintain: (a) confidentiality of patient information (b) the patient's privacy and dignity as much as possible							
5 Identify when you are unsure of any aspect of the process, or one that is outside your current competence, and inform the registered practitioner why this part of the process has not been completed.							
6 Collect sufficient valid and reliable information to assist the registered practitioner to assess the care needs of the patient and make clear, accurate and complete records of the care needs of the patient that you have identified.							
7 Feedback information you have collected to the registered practitioner at the agreed time.							
8 Agree delegated aspects of the perioperative care plan with the registered practitioner which are within your current competence.							
9 Use the perioperative care plan to identify the timing/frequency of your activities to meet the identified care needs of the patient.							
10 Provide care to the patient that is consistent with the agreed perioperative plan of care.							
11 Explain your actions to the patient in a manner appropriate to their needs and abilities and confirm their agreement.							
12 Answer any questions and concerns from the patient clearly and appropriately and pass on anything you are unable to deal with to the registered practitioner.							

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Performance Criteria	DO	RA	EW	Q	P	WT	PD
13 Promptly seek advice from the appropriate member of the care team where you have queries or difficulties in carrying out your delegated activities.							
14 Record the outcomes of the activities you have carried out clearly, accurately and legibly in the correct documentation and sign and date each entry.							
15 Monitor the effects of your activities and promptly identify, and report changes in the patient's wellbeing/status to the relevant member of the care team and document in the care plan.							
16 Assist in the review of the perioperative care plan.							

DO = Direct Observation *RA = Reflective Account* *Q = Questions*
EW = Expert Witness *P = Product (Work)* *WT = Witness Testimony*
PD = Professional Discussion

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To be completed by the candidate
I SUBMIT THIS AS A COMPLETE UNIT

Candidate's name: ……………………………………………

Candidate's signature: ………………………………………..

Date: ……………………………………………………………..

To be completed by the assessor
It is a shared responsibility of both the candidate and assessor to claim evidence, however, it is the responsibility of the assessor to ensure the accuracy/validity of each evidence claim and make the final decision.

I CERTIFY THAT SUFFICIENT EVIDENCE HAS BEEN PRODUCED TO MEET ALL THE ELEMENTS, PCS AND KNOWLEDGE OF THIS UNIT.

Assessor's name: …………………………………………….

Assessor's signature: ………………………………………….

Date: ……………………………………………………………..

Assessor/Internal verifier feedback

To be completed by the internal verifier if applicable
This section only needs to be completed if the Unit is sampled by the internal verifier

Internal verifier's name: ……………………………………………

Internal verifier's signature: ………………………………………..

Date: …………………………………..…………………………..