BCHS Competency-Based Orientation

This document will be used by staff for orientation and should be completed in collaboration with the orientee, role model, and/or Clinical Manager. Competencies will vary according to the individual's respective regulatory/non regulatory college.
Any required actions (Needs Improvement or Unsatisfactory) should be included in comments and/or addressed through a development plan.

Competency Evaluation Levels	Satisfactory (S)	Needs Improvement (NI)	Unsatisfactory (U)	Not Applicable (NA)

Satisfactory- Safe; accurate each time; skillful in all actions; efficient, coordinated; confident, focuses on patient outcomes; appropriate effective knowledge and behavior; minimal constructive feedback required

Needs Improvement- Safe; accurate each time; skillful in some actions; focuses more on skill rather than the patient; inefficient, some knowledge and behavior gaps; frequent verbal and/or physical directive cues in addition to supportive cues necessary; moderate constructive feedback required in several areas

Unsatisfactory-Failure to achieve the competency; safe or unsafe, needing constant reminders; not always accurate; disruptive or omitting actions; inefficient; focuses on skills rather than the patient; lacks effective knowledge and behaviour; continuous verbal and/or physical cues required, unable to function independently

Standards of Patient Care

PURPOSE:

The purpose of the Standards of Patient Care is to incorporate evidence based practice and define excellence in nursing care at the Brant Community Healthcare System (BCHS). Each Nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships. All Nurses must continue to use clinical judgment, knowledge and critical thinking to ensure patient needs are met and optimal care is provided (CNO, 2014).

These Standards of Patient Care are required of Personal Support Workers (PSW) according to the PSW scope of practice as defined by BCHS; for example, meeting patients' nutrition and elimination needs and the PSW participation in hourly rounding.

POLICY STATEMENT:

The Standards of Patient Care define the minimum expectations that all patients at the BCHS can expect to receive from nursing staff. In addition to the corporate service standards outlined in this policy, each clinical area has additional Standards specific to the needs of the patients in these areas. Nurses will provide the Standard of Patient Care reflective of BCHS values to every patient, every shift. Documentation and communication is required if nursing staff are unable to meet any aspect of the standards of care.

DEFINITION (S):

Nurse – A Registered Nurse (RN) or Registered Practical Nurse (RPN)
Shift – A health care professional's scheduled hours of work on a unit

PROCEDURE:

1. Nurses practice in accordance with the College of Nurses of Ontario (CNO) Standards of Practice, and the policies and procedures of the BCHS. These include, but are not limited to scope of practice, medication, consent, confidentiality, documentation, ethics and professional standards.
    - Nurses must practice within one's competencies related to knowledge, skill, and judgement to deliver care to assigned patients.
    - Nurses are accountable for their own actions.
    - Nurses will seek guidance where appropriate and will work in collaboration with other health care providers to deliver optimal care to patients

2. Patient and family involvement is supported and encouraged for the development of a comprehensive care plan and discharge arrangements throughout the hospital experience. The patient defines their family. Family includes any person identified by the patient (or substitute decision maker) as important in their life. Nurses optimize communication with the patient and family by providing on-going support as appropriate during the hospital stay.

3. Every Nurse is responsible to ensure information is exchanged at every point of transfer of care. This includes patient transfers within BCHS, discharge to another facility or site, shift reports, and when care is being transferred to another provider.

4. The Nurse shares accountability with pharmacy to ensure the best possible medication history (BPMH) is obtained from every patient (or substitute decision maker) as outlined in Policy N-IV-1267 – Medication Reconciliation Admission.

5. The Nurse will identify the need for infection prevention and control precautions and will practice in accordance with BCHS Infection Control Manual to reduce potential exposure to bodily fluids and the spread of infection.
    - Personal Protective Equipment (PPE) will be worn in accordance with BCHS Policy ICMAN 1018 – Donning and Doffing of PPE

6. Rounding on patients occurs every hour or more frequently as the patient's condition warrants. This includes a "critical look" of the patient (airway, breathing, and circulation) and responding to any emotional/physical needs. Hourly rounding is accomplished by observing and/or interacting with the patient while assessing safety needs and interventions that are in place.

7. The Nurse will monitor the patient by completing assessments and appropriately responding to significant findings. The Nurse will document all significant findings in the health record and communicate these significant findings to the appropriate health care professional.

8. Nursing staff will follow professional and BCHS documentation standards (Policy N-IV-352 Documentation – Interdisciplinary Documentation Overview) when recording all assessments, treatments, medications and evaluations of outcomes including the patient/family response.

9. The nurse will complete assessments of peripheral venous access device(s) (PVAD) and/or central venous access device(s) (CVAD) every hour for tenderness, discolouration, inflammation or infiltration.

10. The Nurse will monitor intake and output at a minimum of every shift and more frequently as required by patient's condition.

11. Patient (and family or substitute decision maker) education and discharge instructions are provided according to the patient and family needs, considering readiness and capacity. Nurses will evaluate and document the effectiveness of education provided, accommodating teaching methods and adjusting the learning plan as required.

12. If patient is unable to perform activities of daily living independently, the patient will receive:
    - Assistance with oral hygiene at least every 8 hours;
    - Assistance with personal hygiene at least every 24 hours;
    - Assistance with meals, including but not limited to hand hygiene and set up;
    - Assistance with ambulation according to patient needs;
    - The opportunity for toileting every 2 hours;
    - Skin care and, if required, turning and repositioning, every 2 hours.

13. All patients will have vital signs assessed on admission and then according to unit specific Standards and/or Physician orders. Vital signs include temperature (T), heart rate (HR), respiratory rate (RR), blood pressure (BP), and oxygen saturation (SpO2).

14. All patients will be assessed for pain as part of Hourly Rounding and formally at a minimum of every shift, utilizing the appropriate pain scale. Documentation will include the assessment, intervention and outcome; refer to BCHS Policy N-IV-352 Documentation – Interdisciplinary Documentation Overview.

15. Actual measured height and weight will be obtained on admission. If unable to obtain an actual height and weight, documentation should reflect why these values were unable to be obtained.

16. The Nurse will complete a bedside safety check (refer to BCHS Policy N-IV-1908 – Transfer of Accountability – SBAR). Bedside safety check must be in the presence of the registered staff assuming care and the registered staff transferring care and include the patient and or family members. Information to review includes, but is not limited to:
    - Armband with 2 Patient Identifiers (refer to Identification Patient, N-IV-802)
    - IV solutions reconciled with EMR/Physician Order
    - Allergies
    - Monitor alarms on, call bell functional and within the patient's reach as appropriate
    - Risk issues such as, falls, restraints, high risk medications
    - Ask patient if he or she has any concerns related to his / her safety
    - Updating the white board in the patient's room where available

17. Falls assessments and documentation will be completed according to BCHS Policy N-IV-510 – Best Practice – Falls and Fall Injuries – Preventing.

18. Braden Scale will be completed according to BCHS Policy N-IV-180 – Braden Scale, at time of admission for all patients with the exception of newborns and repeated as defined by the following risk score(s):
    - High Risk Score – every 24 hours;
    - Moderate Risk Score – every 72 hours;
    - At Risk – weekly (with the exception Inpatient Mental Health where it is done on admission and with change in patient status).

19. The Nurse will provide skin care and pressure ulcer prevention and management according to BCHS Policy N-IV-1801 – Skin and Wound Care Prevention and Management Program. This will include, at a minimum the assessment, planning, interventions, discharge, transfer of care, and documentation.

20. The Nurse will initiate accurate and ongoing assessment of physical, psychosocial and spiritual needs of patients.

21. In addition to the preceding Standards, the BCHS recognizes the unique needs and criteria for different clinical settings. The following minimum Standards of Patient Care will be provided to all patients in the specified practice settings.

Competency-Based orientation Checklist

	Date & Assessment Level	Supervisor Assessment	Comments
Addresses learning needs for continued competency development past the probationary period			
Locates all items on orientation checklist For example but not limited to: • Bathrooms • Break schedule • Lunch room			
Engages in Interprofessional Collaborative Practice principles For example but not limited to: • Daily huddles • Rounding (PEEP) • Standard work			
Demonstrates responsibility for own learning by assessing their own learning needs and seeking out activities and resources to meet identified needs • Creation of a smart learning plan • Collaborate with Clinical Manager/Role Model			

Uses self-reflection in practice and seeks resources accordingly • Aware of own role and responsibility within unit, organization and profession • Seeks and accepts assistance and feedback as necessary • Seeks resources and clarification during decision-making and problem solving situations			
Demonstrates sensitivities to need of other team members • Ensures the right care provider for patient care needs by demonstrating and applying the knowledge, skill and judgement related to the different roles of the interprofessional care team members • Collaborates with interprofessional care team when a patient's care needs have changed in order to identify the human resources required to meet the change in patient status • Shares knowledge and experience • Shows willingness to support other team members			
Knowledge of how to access and the process as it relates to the following: • Electronic Documentation • Schedule/Rotor • Electronic Lab Manual (ELM) • Lippincott Procedures • Up-to-date • Medworxx • Halogen • Pharmacy Folder • S drive • Bnet - Policy and Procedure • Important contact information			

• Helpdesk			
• Describes procedure for sick call-in, shift change, vacation request and scheduling practices			
Attends and completes mandatory in-service orientation education and e-learning For example but not limited to: • WHMIS • Hand Hygiene • Respectful Workplace • Customer Service Excellence • Patient Confidentiality • Dress Code • AODA • Domestic Violence • Injury Reporting • Donning and Doffing • FIPPA			
Maintains certificate in BLS			
Familiar with emergency procedures in real or simulated situation, and able to locate policies and procedures • Code Blue • Code Pink • Code Yellow • Code White • Code Red • Code Burgundy • Code Purple • Code Black • Code Green • Code Orange • Code Brown • Code Grey			
Describes the procedure for reporting patient incidents, near misses and errors using RiskPro			

Describes the procedure for reporting staff incidents or injury using Parklane			
Communicates significant patient information to appropriate team members in the circle of care in a timely manner through: For example but not limited to: • TOA unit to unit, shift to shift and facility to facility where appropriate (SBAR) • Bedside safety check • Verbal communication • Written/electronic documentation • Telephone • Participation in interprofessional rounds			
Understands and demonstrates use of technology systems as it relates to your specific role. For example and not limited to: • MEDITECH applications – PCS (e-doc), BMV (med. admin) • PICIS (OR, Dietary, ER Tracking Board) • PACS (imaging) • Baxter Sigma Spectrum (IV pumps)			
Operates unit specific communication equipment For example but not limited to: • Call bell response system • Code Blue response • Telephones • Physician paging/notification • Notification of other staff			

Documents care according to BCHS and regulatory body standards • Documents and updates all information as soon as possible without compromising patient safety • Applies BCHS principles of charting by exception and the DAR format • Maintains professional accountability of charting			
Performs an integrated initial assessment For example but not limited to: • Admission to the unit • Discharge process • Code status • Allergy status • Smoking status • Identify interprofessional consultation needs (e.g. SW, nurse, DCP, SLP, PT/OT) • Patient orientation to the care plan e.g. (COPD, CHF, Pneumonia)			
Provides care based on the principles of patient and healthcare safety For example but not limited to: • Least restraint use • Falls risk assessment • Minimal lift • Mandatory reporting of child and elder abuse, domestic violence • Wound care prevention			
Maintains infection prevention and control standards For example but not limited to: • Routine practices • Donning and doffing PPE • Appropriate isolation signage			

• ARI tool compliance • Patient and family education			
Establishes priorities for patient care in collaboration with the patient For example but not limited to: • Identifies existing or potential health problems • Documents care plan • Develops acceptable outcomes • Uses evidence-based principles to select and individualize interventions			
Collaborates with patient, family and health care team to implement a plan of care that will achieve a positive health outcome for the patient For example but not limited to: • Initiate BPMH where appropriate • Processes physicians orders appropriately • Safe medication administration practices where appropriate • Notifies and communicates with physicians and members of the health care team as necessary (lab values, changes in patient condition, abnormal assessment findings)			
Promote positive self concept and the principles of AODA (Accessibility for Ontarians with Disability Act) For example but not limited to: • Support cultural identity • Adapt plan of care to support cultural health beliefs while in hospital			

Operates equipment in a safe manner specific to the delivery of patient care For example but not limited to: • Glucometer • IV pumps • Automatic vital signs machine • Thermometers • Suction • Oxygen • Stretchers • Mechanical lifting devices • Beds • Wheelchairs/walkers • Diagnostic equipment • Computers on Wheels			
Engages in safe medication administration according to regulatory college standards via the following routes as appropriate: • Oral • Topical • Rectal • Vagina • Subcutaneous injection • Intramuscular injection • Intravenous • Intravenous below the drip chamber • Inhalation • Intestinal tube			
Identification, treatment, prevention and documentation of allergic responses to food, medications, contrast material or other substances			
Engages in appropriate narcotic procedures For example but not limited to: • Counting and documentation • Receiving from pharmacy • Wasting • Responsibility for the key			
Collaborates with health care team in			

discharge planning with the patient For example but not limited to: • Predictive discharge • Referral to appropriate internal and external resources for support • Facilitate transition of patient from hospital to discharge destination			
Performs thorough respiratory assessment, implementation and evaluation of care For example but not limited to: • Respiratory assessment • Use of oxygen (nasal prongs, masks and Ambubag and portable) • Oral/nasopharyngeal suctioning • Care and maintenance of chest tubes • Prevention or minimization of risk factors in the patient at risk for aspiration			
Performs thorough cardiovascular assessment, For example but not limited to: • Promotion of maximum functional activity level for a patient with impaired cardiac function • Promotion of arterial and venous circulation • DVT Prevention • Peripheral Circulation • Peripheral Edema			
Performs thorough gastrointestinal assessment, For example but not limited to: • Abdominal assessment • Nutrition assessment • Oral care			

• Accurate monitoring and documentation of elimination patterns • Insertion of nasogastric tube • Assessment, care and maintenance of nasograstic tube • Assessment, care and maintenance of gastrostomy/jejunostomy tubes • Delivering nutrients and water through a gastrointestinal tube • Assessment and care of ostomy			
Performs thorough genitourinary assessment, For example but not limited to: • Genitourinary assessment • Accurate monitoring and documentation of output • Insertion and/or removal of Foley or in and out catheter • Care and maintenance of urinary drainage equipment • Perform bladder scan			
Performs thorough neurological assessment, For example but not limited to: • Neurological assessment • Initiate the Stroke Alert Protocol • CAM, Behavior Observation Record			
Performs thorough musculoskeletal assessment, For example but not limited to: • Musculoskeletal assessment • Lifts and transfers • Early mobilization • ROM • Positioning			
Performs thorough integumentary			

assessment, For example but not limited to • Integumentary assessment • Braden Scale • Prevention of pressure ulcers • Wound care			
Performs thorough pain assessment, For example but not limited to: • Pain assessment • Pharmological interventions • Non-pharmological interventions			
Accurate interpretation of • Blood and urine tests • Biochemistry • Culture and sensitivity			
Promote adequate fluid balance and monitoring: For example but not limited to: • Initiate peripheral IVs • Regulate/maintain/change and hang peripheral IV fluids • Initiate blood transfusions/blood products • Removal of IV catheter • Conversion to saline lock • Flushing/accessing and de-accessing CVADs • Care and maintenance of CVADs • Administering TPN			
Promotion of physical comfort and psychological peace in the final stages of life For example but not limited to: • Stages of grief • Post-mortem care of the body • Providing support to the family • Accessing internal and external resources for patient and family support			
