EDTNA/ERCA
European Dialysis & Transplant Nurses Association/ European Renal Care Association

ASSESSOR'S GUIDELINES FOR COMPETENCY FRAMEWORK BOOKLET

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ASSESSMENT LEVELS RELATED TO THE FRAMEWORK PROPOSED BY BENNER (1984)				
Level	**Standard**		**Quality of performance**	**Supervision and assistance**
Expert	- Safe - Accurate - Effective - Affective	**- All of the time**	• Intuitive grasp of each situation • Problems focused rapidly and problem solving well developed • Draws upon professional experience • Proactive in relation to change • Proposes professional development	Collaborative discussions with colleagues
Proficient	- Safe - Accurate - Effective - Affective	**- All of the time**	• Skilful, co-ordinated and confident • Perceives caring situations in their entirety • Draws upon professional experience • Responds to change • Uses problems solving approach and knowledge which has been analysed and critically evaluated • Reflects upon professional role	Collaborative discussions with colleagues
Competent	- Safe - Accurate - Effective - Affective	**- All of the time**	• Skilful and co-ordinated • Confident • Focuses on individual and responds to subtle cues • Identifies long range goals • Seeks occasional supervision and direction appropriately	Occasional supervision and directive cues
Advanced beginner	- Safe - Accurate	**- All of the time**	• Skilful and co-ordinated • Confident • Focuses on individual, but distracted if activity is complex	Frequent supervision and some directive cues
	- Effective - Affective	**- Some of the time**		
Novice	**Some at risk performances**		• Considerable time required to complete activity • Some degree of confidence • Beginning to focus upon the individual and their needs	Frequent supervision and directive cues
	- Accurate - Effective - Affective	**- Some of the time**		

Safe = Activity does not cause harm by action or omission
Accurate = Demonstrates in relation to: knowledge base and application, verbal, non verbal and written communication
Effective = Intended purpose of activity achieved
Affective = Attends to the feelings/emotions of individuals involved in the situation

Table adapted from City University Assessment Guidelines.

WHY HAVE ASSESSOR GUIDELINES:

This booklet has been produced to assist both the renal nurses and their assessors to use the competency framework booklet accurately, so to get the best of the booklet.

AN EXAMPLE OF HOW TO USE THE COMPETENCY DOCUMENT:

Nurse “Maria” has been working on the medical renal ward for six months her first competence assessment was in February 2008 and now she is due for her six month assessment review. “Camilla” has been mentoring her to the ward since she commenced in January 2008 as this is her first experience of working in the renal area. Maria now needs to be assessed by a senior member of the nursing team and Camilla has been chosen to do this as she has supported Maria throughout her orientation to the renal unit.

Camilla commenced undertaking these competencies for the first time in February 2008 and both Camilla and Maria feel that she is now ready to undertake the competency **“Assess and monitor a patient with chronic kidney disease”** for the second time in August 2008**.** Camilla and Maria sit down in an office off the ward for a half hour discussion and Camilla asks Maria to talk her way through the different aspects of the competency, determining if Maria mentions the aspects from the “**criteria for consideration”**. Maria has been looking after a male stage three Chronic renal failure patient on the ward for the past five shifts and so is able to explain what care she has provided for this patient and what she has learnt from this experience and how it has developed her learning.

Prior to this discussion Camilla should have thought about from her previous experience of what expectations she would have of Maria and what she should have been able to achieve in this three months she has been working on the ward. Camilla could also be thinking about what previous knowledge that Maria may have from her prior ward areas.

At Maria’s three month assessment in February 2008 she believed that she was an advanced beginner within **“work an individual plan and look after patient’s blood results”** within the overall competence of **“Assess and monitor a patient with chronic kidney disease”.** Camilla had disagreed and believed that she was still a novice as although Maria could identify the different blood tests that need to be reviewed, she found it difficult to determine what the expected levels should be for a “renal” patient. Maria could do basic patient assessments to identify how members of the multi disciplinary team could work with her identified patient, but could not explain about the importance of anaemia management, prevention of complications. Overall her general

communication with both patients and families was good, but she had difficulty explaining some renal information to relatives and friends.

After their discussion they worked out some future objectives and Camilla booked Maria onto a renal study day where an overall general introduction to renal care and its many facets would be discussed and a take home workbook would be provided to continue their learning. This three month assessment provided evidence of criteria that Maria both knows and does not know. It also allowed for discussion on how she plans to increase her knowledge of the criteria so that when Camilla reviews her again in three months time she has been able to improve this competence.

Now three months later in August 2008, Maria is ready for her six month assessment. There is an improvement from the first assessment at three months. This is related to Maria being able to explain clearly the role of blood results and their impact on the renal patient and she feel more comfortable explaining issues with both patients and their extended families and assisting them to make appropriate choices with regard to future plans.

The competency framework has been able to assist Camilla and Maria to work together to determine what learning needs Maria had and then also to guide her learning and continuing development that has helped to improve her understanding and assist her to become a competent renal nurse over a six month period of time.

Please review this scenario within the following pages as an example of how this scenario developed.

Assess and monitor a patient with chronic kidney disease

This competence is about assessing and monitoring the progress of a patient with chronic kidney disease. It includes different phases of a process starting by giving information about chronic kidney disease; work out an individual patient plan, by consideration of blood results, state of health, diet, related complications, taking care for blood pressure, weight, hydration and prevention of renal bone disease. This also includes different health specialists supporting patient's needs and evaluate patient's plan with the patient.

	MANAGEMENT OF CARE									
1.7	COMPETENCIES	SE	AE	Date	SE	AE	Date	SE	AE	Date
	Interview and give the patient information look after social problems and motivate patients.	AB	AB	01/02/08	AB	C	01/08/08			
	Work an individual plan and look after patient's blood results.	AB	N	01/02/08	AB	C	01/08/08			
	Give support to patient during treatment to achieve a goal in the individual plan for the best quality of life.	N	N	01/02/08	AB	C	01/08/08			
	Ensure the patient understands information and modify the plan if necessary.	AB	AB	01/02/08	C	C	01/08/08			

Clinician Rating [N] [AB] [C] [P] [E]	Assessor Rating [N] [AB] [C] [P] [E]

CRITERIA FOR CONSIDERATION	
1.7	Interview the patient about kidney failure, different replacement therapies available, health status, how to adjust the diet to patient's blood results, it includes assessing the severity of kidney disease and its related complications, prevention of bone disease, identifying co-morbidities, taking care for blood pressure by regularly taking antihypertension therapy, look after weight, adequate body hydration, ensuring for the appropriate physical activity adjusted to patients condition such as fast walking. Look after social problems and try to motivate the patient to take over an active role in the process of health treatment.
	Consult the patient's blood results such as potassium, calcium, phosphorus and other results such as bone structure, weight and work out an individual plan by taking into management consideration different specialists like dieticians, social worker, dialysis nurse, and psychologist and include into planning a patients family. Identify, with patients regulation of anaemia with iron compounds or treatment with epoetin if necessary. Encourage the patient to express feelings and ask questions about considering the appropriate diet, health condition, and prevention of complications of chronic kidney disease. Respond to patient's actual and potential needs. Help the patient to understand the nature and significance of good of chronic kidney disease to other family members, and offer explanation if requested. Provide opportunities with team members to continue the discussion within the team. Record the patient discomfort about progressing chronic kidney disease and to adjust the plan to the new condition.
	Encourage the patient and family members to talk freely, ask questions about kidney failure, the possibilities of appropriate replacement therapy of chronic kidney disease. Share information with other members of the multidisciplinary team, and connect with at home nursing care if it is necessary. Encourage the discussion, participation and patient feedback reaction. Provide and connect with other specialists to achieve the goal in the individual plan for the best quality of life in spite of chronic kidney disease. Promote the benefits of stability of chronic kidney disease.
	Evaluate blood and other results together with the patient and modify the plan if necessary. Support the patient to measure blood pressure, look after bone disease, patient's psychophysical condition, which results in the patient's social status. Benefits of good patient s education give us the information of patient quality of life. Emotional support from other family member and good education patient gives the patient stability of chronic kidney disease. Provide continuing information and explanation regarding patient's health. Ensure that other members of multidisciplinary team are aware of patient s needs. Offer to arrange further psychological support if the patient or family members wishes it.

Date:	Competence number	Clinician's comments	Assessor's comments	Future Objectives.
01/02/08	1.7	I am struggling with blood interpretation, but feel confident with communicating with pts.	Maria has noted her areas to develop clearly.	Improve blood result interpretation and attend a introduction to renal study day in March 2008.
01/08/08	1.7	I feel more confident in my knowledge and abilities than six months ago.	Maria has improved vastly in her knowledge and in particular her blood result interpretation and discussions with patients about their choices is very good.	To time with the pre dialysis nurses and other members of the MDT so that Maria can continue to gain confidence with patient education and patient options.