T-LEVELS | Institute for Apprenticeships & Technical Education

T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Adult Nursing Team

Assignment 2 – Practical activities part 2

Assignment brief

V1.0
P001991
02 May – 26 May 2023
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NCFE CACHE

T Level Technical Qualification in Health
Occupational specialism assessment (OSA)

Supporting the Adult Nursing Team

Assignment brief

Assignment 2

Practical activities part 2

Contents

Assignment brief cover sheet

This assessment is for the following occupational specialism:

- Supporting the Adult Nursing Team

Date

2 May to 26 May 2023

Time allowed

2 hours 10 minutes

Paper number

P001991

Materials

For this assessment you must have:

- a black or blue ballpoint pen

Student instructions

- this assessment requires you to demonstrate the 4 practical activity scenarios contained within this booklet
- the practical activity scenarios within this booklet have been set up at different stations; you will move between these stations during the assessment
- you have up to 5 minutes when you get to a station to prepare for the practical activity scenario; you should use this time to carefully read each practical activity scenario, including any supporting information, and familiarise yourself with the station
- you will have a maximum amount of time to complete the practical activity scenario – the time available is written at the beginning of each practical activity scenario – if you go over this time you will be asked by the assessor to move on to the next station
- fill in the boxes at the top of the next page

Student information

- the marks available for each practical activity scenario are shown in brackets
- the marks for this assessment are broken down into scenario specific skills and underpinning skills:
- 16 marks are available for scenario specific skills – you will be awarded a scenario specific skills mark for your performance in each practical activity scenario you demonstrate
- 12 marks are available for underpinning skills – you will be awarded an underpinning skills mark for your performance across the practical activity scenarios you demonstrate
- the maximum mark for this assessment is 76

Submission form

Please complete the details below clearly and in BLOCK CAPITALS.

Student name	
Provider name	

Student number		**Provider number**	

Practical activity scenario 1

This practical activity scenario requires you to:

OPA11: Support or enable individuals to maintain good personal hygiene, involving carers where appropriate

You have up to 5 minutes to carefully read through the following scenario and familiarise yourself with the station.

The total amount of time available for this practical activity scenario, including the 5 minutes reading time, is 25 minutes.

Brief

Jeff is an adolescent male living with a moderate cognitive impairment that also affects his mobility. He has access to a walking stick for some mobility support but is not confident in using it.

He lives at home with his parents who usually do daily tasks for him, such as washing and dressing.

You are working as a healthcare support worker within a community multidisciplinary team. You have joined a district nurse to visit Jeff at home because his community healthcare team want him to develop some independence.

Task

Item A is an observation template.

You should:

- undertake a discussion with Jeff about his support needs and encourage him to take responsibility for his own health and mobility
- update the observation template with any advice provided or agreed actions
- support Jeff to walk to the sink and wash his hands and offer constructive support

(16 marks)
plus marks for underpinning skills – person-centred care and service frameworks, communication and health and safety

Supporting information

This practical activity scenario involves role play. The district nurse and the service user (Jeff) are played by 2 members of staff.

You have been given an observation template (item A).

You have access to the following equipment:

- a walking stick
- personal hygiene equipment:
  - a bowl of water or a sink
  - soap
  - towel
- table

- 2 chairs

Performance outcomes (POs)

This practical activity scenario assesses:

PO2: Support individuals to meet activities of daily living

Item A: observation template

Task	Requires no assistance	Some assistance needed	Complete assistance needed	Support needs identified
Bathing				
Dressing				
Oral care				
Toileting				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				

Using the phone				
Housework				
Laundry				
Driving				
Totals				

Practical activity scenario 2

This practical activity scenario requires you to:

OPA6: Check skin integrity using appropriate assessment documentation and inform others

You have up to 5 minutes to carefully read through the following scenario and familiarise yourself with the station.

The total amount of time available for this practical activity scenario, including the 5 minutes reading time, is 45 minutes.

Brief

You are working in an acute hospital on the elderly care ward and assisting a staff nurse with a 78 year old female patient named Maddy.

Maddy was admitted yesterday from a residential care facility, due to stomach pain and loss of weight. She has had restricted mobility due to feeling unwell and cannot get out of bed or move herself. She has been complaining of pain on her left foot.

Task

Using the tools and resources available to you, you should:

- talk to Maddy about her discomfort
- assess the current state of Maddy's foot (item B)
- assess the situation by completing the Braden risk assessment (item C) and the SSKIN Bundle (item D)
- provide immediate pressure relief
- complete a brief care plan (item E) to recommend the appropriate course of action

(16 marks)

plus marks for underpinning skills – person-centred care and service frameworks, communication and health and safety

Supporting information

This practical activity scenario involves role play. The staff nurse and the service user (Maddy) are played by 2 members of staff.

You have been given a photograph of Maddy's foot (item B), a Braden risk assessment (item C), a SSKIN bundle (item D) and a care plan template (item E).

You have access to the following equipment:

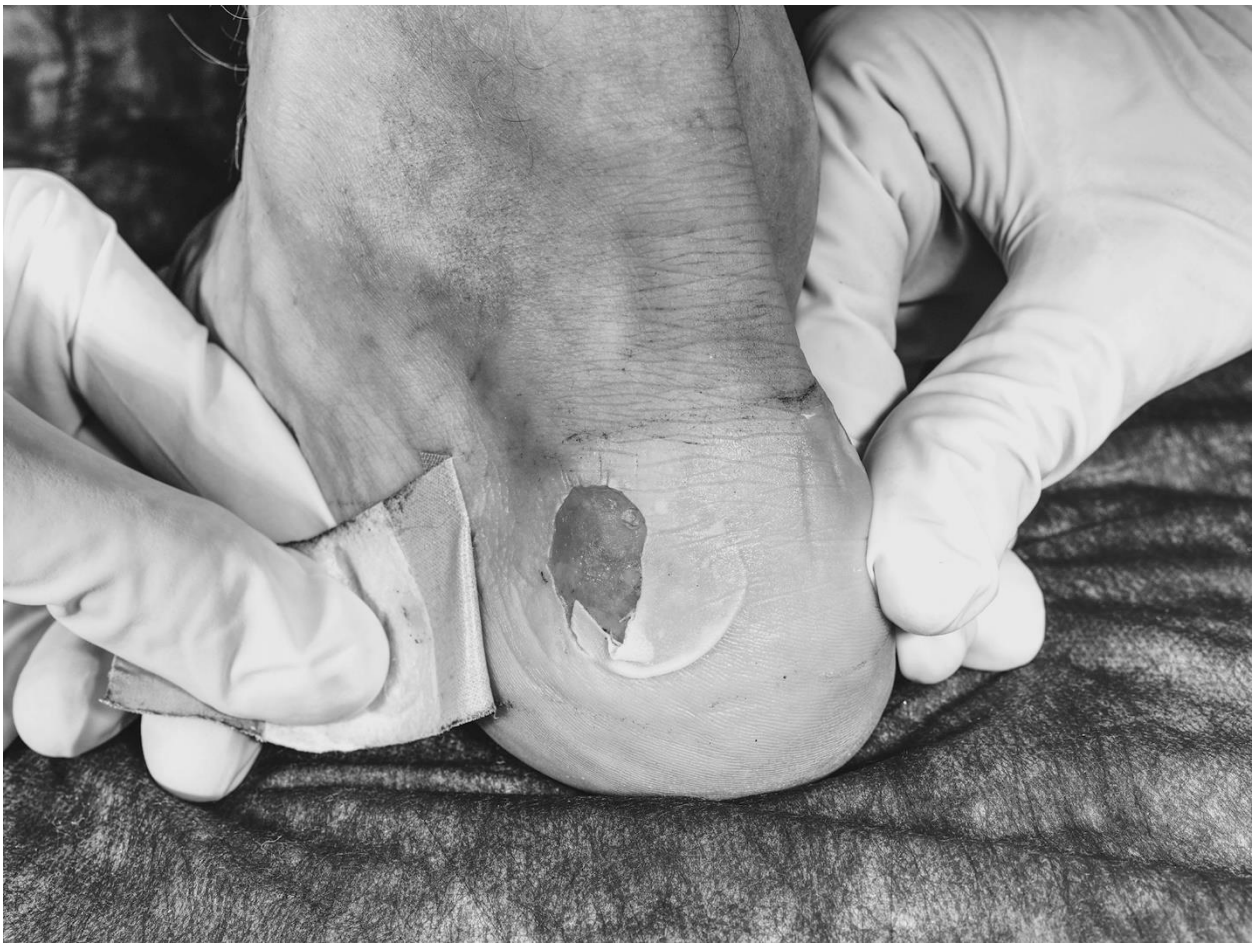
- personal protective equipment (PPE) – gloves, aprons, antibacterial hand gel
- pressure relieving support tool – cushion
- bed or suitable surface
- bedside table or suitable surface
- chair

Performance outcomes (POs)

This practical activity scenario assesses:

PO3: Assist with skin integrity assessments and with the care and treatment of skin conditions

Item B: photograph of Maddy's foot



Item C: Braden risk assessment

Braden risk assessment chart

Individuals with a total score of 16 or less are considered at risk:

15–16 = low risk, 13–14 = moderate risk, 12 or less = high risk.

Undertake and document risk assessment within 6 hours of admission or on first home visit. Reassess if there is a change in individual's condition and repeat regularly according to local protocol.

Date:

Sensory perception Ability to respond meaningfully to pressure related discomfort	**1. Completely limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	**2. Very limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort	**Score**
Moisture-Degree to which skin is exposed to moisture	**1. Constantly moist** Skin is kept moist almost constantly by perspiration/urine. Dampness is detected every time service user is moved or turned.	**2. Very moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist** Skin is usually dry. Linen only requires changing at routine intervals.	**Score**
Activity Degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of	**4. Walks frequently** Walks outside the room at least twice a day and inside the room every 2 hours during waking hours.	**Score**

			each shift in bed or chair.		
Mobility Ability to change and control body position	**1. Completely immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No limitations** Makes major and frequent changes in position without assistance.	**Score**
Nutrition Usual food intake pattern	**1. Very poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is nothing by mouth (NPO) and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over ½ of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered OR is on a tube feeding or total parenteral nutrition (TPN) regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	**Score**
Friction and shear	**1. Problem** Requires moderate to maximum assistance in moving.	**2. Potential problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against	**3. No apparent problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good		**Score**

		sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	position in bed or chair at all times.		
Indicate appropriate number and add for total score **Total score:**					

Adapted from Healthcare Improvement Scotland (2019). Braden risk assessment tool. Available at: www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/braden_risk_assessment_tool.aspx (Accessed: 11 January 2022).

Item D: SSKIN bundle

Pressure ulcer classification (adapted from EPUAP, 2009)

Grade 1: Non-blanching erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, bluish tinge. Grade 1 may be difficult to detect in individuals with dark skin tones. May indicate an "at risk" persons.

Grade 2: Partial thickness

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. **Note that bruising may indicate deeper tissue injury**. This stage should not be used to describe skin tears, tape burns, moisture lesions, maceration or excoriation.

Grade 3: Full thickness

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. The depth of a Grade 3 pressure ulcer varies by anatomical location. The ear, occiput and malleolus do not have fatty tissue and Grade 3 ulcers can appear shallow. In contrast, fatty areas appear deeper. Bone/tendon is not visible or directly palpable.

Grade 4: Full thickness

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a Grade 4 pressure ulcer varies by anatomical location as for Grade 3. Grade 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis likely to occur. Exposed bone/muscle is visible or directly palpable.

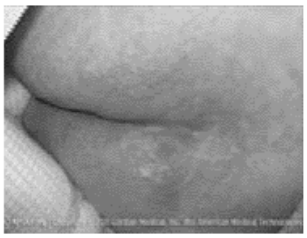
Ungradeable ulcer

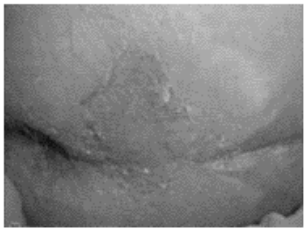
Any pressure ulcer where depth cannot be discerned.

Purple localised area of discoloured intact skin or blood-filled blister due to damage of underlying soft tissue from pressure **and/or shear**. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. A thin blister may develop over a dark wound bed. The wound bed may become obscured by slough or eschar. Changes may be rapid exposing additional layers of tissue despite optimal treatment.

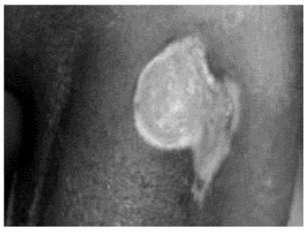
Moisture Lesion: not a pressure ulcer

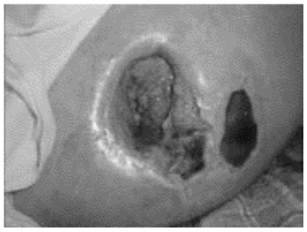
Redness or partial thickness skin loss involving the epidermis, upper dermis or both. Caused by excessive moisture to the skin from urine, faeces or sweat. This is not a pressure ulcer and must not be confused with a Grade 2 pressure ulcer which is caused by pressure not moisture.



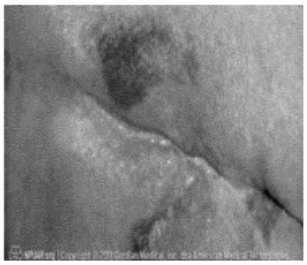


SUPERFICIAL

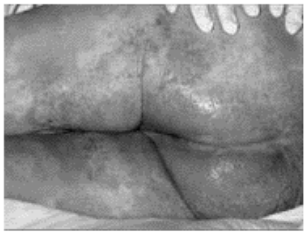




DEEP



UNGRADEABLE



MOISTURE

Adapted from Isle of Wight NHS Trust (year unknown). SSKIN Bundle. Available at: www.iow.nhs.uk/Publications/sskin-bundle.htm (Accessed: 11 January 2022).

Item E: care plan

Patient name……Date of plan……..

Patient need	Action	Review date

Practical activity scenario 3

This practical activity scenario requires you to:

OPA10: Support or enable individuals to maintain good nutrition by promoting current healthy nutrition and hydration initiatives to support individuals to make healthy choices, recording details using food and drink charts and nutritional plans and involving carers where appropriate

You have up to 5 minutes to carefully read through the following scenario and familiarise yourself with the station.

The total amount of time available for this practical activity scenario, including the 5 minutes reading time, is 30 minutes.

Brief

You are assisting a practice nurse in a busy city centre GP surgery. The nurse is running a nutrition clinic for patients with health problems relating to their diet.

Your first patient is István, a computer programmer for a local tech firm. István is experiencing low energy, mood swings and was recently diagnosed with type 2 diabetes following a number of warnings from his GP about his weight. He is currently not taking medication for his diabetes. He moved to the UK from Hungary 3 years ago to start his new job.

Task

You should have a discussion with István so you can:

- complete the nutrition assessment document (item F) using the tools available to you
- make recommendations to the patient to improve their diet, record these on the recommendations page

(16 marks)
plus marks for underpinning skills – person-centred care and service frameworks, communication and health and safety

Supporting information

This practical activity scenario involves role play. The practice nurse and the service user (István) are played by 2 members of staff.

You have been given a nutrition assessment document (item F), a BMI scoring chart (item G) and an eat well guide (item H).

You have access to the following equipment:

- weighing scales
- a tape measure or stadiometer
- table
- 2 chairs

Performance outcomes (POs)

This practical activity scenario assesses:

PO1: Assist the adult nursing team with clinical tasks

PO2: Support individuals to meet activities of daily living

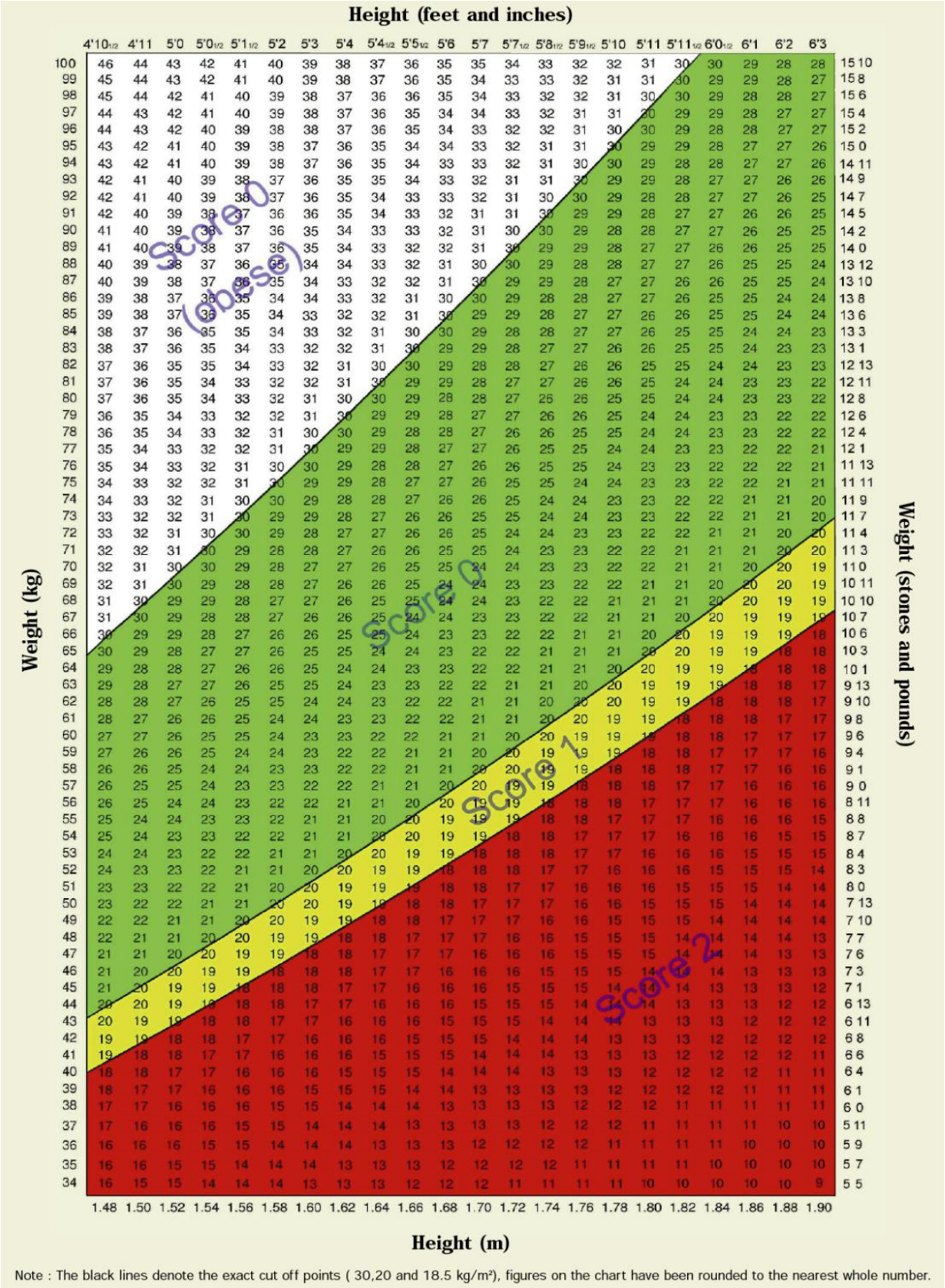
Individual's notes

Use this page to note your recommendations.

Item F: nutrition assessment document

Name	Individual	
Date of birth	01/01/1984	
Step 1 (a)	Measure height and weight.	
	Height	
	Weight	
Step 1 (b)	Calculate BMI score using the details given below and the chart provided.	
	Height	1.80m
	Weight	94kg
	BMI	

Item G: BMI scoring chart



Note : The black lines denote the exact cut off points (30,20 and 18.5 kg/m²), figures on the chart have been rounded to the nearest whole number.

Item H: Eatwell Guide

Practical activity scenario 4

This practical activity scenario requires you to:

OPA2: Perform first line calibration on clinical equipment

You have up to 5 minutes to carefully read through the following scenario and familiarise yourself with the station.

The total amount of time available for this practical activity scenario, including the 5 minutes reading time, is 30 minutes.

Brief

You are working in a day clinic within City Hospital. It is the beginning of a shift on a Monday morning. It is normal practice to calibrate clinical equipment before patients arrive. This morning the clinical manager has asked you to calibrate 3 items:

- pulse oximeter
- weighing scales
- an automatic blood pressure monitor

Task

Use the standard operating procedures (item H) to:

- calibrate each item in turn and record either a success or failure
- write your checks on the equipment preparation checklist (item I)
- explain to your colleague what you are doing and why

(16 marks)

plus marks for underpinning skills – person-centred care and service frameworks and communication

Supporting information

This practical activity scenario involves role play. The clinical manager is played by a member of staff.

You have been given standard operation procedures (item H) and an equipment preparation checklist (item I).

You have access to the following equipment:

- pulse oximeter
- digital weighing scales
- cup (the weight of the cup will need to be measured in advance of task and recorded with the cup so the student knows the expected weight to support with the weighing scales standard operating procedure (SOP))
- an automatic blood pressure monitor
- a table

Performance outcomes

This practical activity scenario assesses:

PO1: Assist the adult nursing team with clinical tasks

Item H: standard operating procedures

Pulse oximeter

1. Check the general integrity of the device and that the batteries are appropriately inserted
2. Turn on the pulse oximeter
3. Place the pulse oximeter onto the index finger of either hand
4. Ensure that the entirety of the pulse oximeter monitor covers the finger tip
5. Record the reading
6. Place the pulse oximeter onto the finger of your opposite hand
7. Record the reading
8. Remove the pulse oximeter and compare the readings – the readings are the same and within 1% of one another, and the pulse oximeter is functioning and can be used
9. If the readings are different, press the reset button and return to step 1

Digital weighing scales

1. Check the general integrity of the device and that the batteries are appropriately inserted
2. Place scales on a flat, hard surface
3. Power on the scales
4. Ensure the scales are pre-set at zero
5. Ensure the display reads the appropriate measurement (‘g’, ‘kg’)
6. Place the cup in the centre of the scale (it is important that they are not placed around the edges)
7. Wait for the scale to measure the weight
8. Remove the cup
9. Record the reading – if the weight displayed on the screen is correct with the cup placed on the scales, record the check as complete; if the weight displayed on the screen differs from the actual weight of the cup, record the check as failed

Automatic blood pressure monitor

1. Complete a visual check of the equipment to ensure there is no damage
2. Check the batteries are inserted correctly
3. Turn on and inflate the cuff
4. Check integrity of cuff and connecting tube, once inflated, for any signs of leakage
5. Ensure the cuff remains inflated for a minimum of 3 seconds
6. Record the outcome

Item I: equipment preparation checklist

HOSPITAL:				
WARD:				
Date:		**Time:**		
Device	**Pulse oximeter**	**Digital weighing scales**	**Automatic blood pressure monitor**	**Success or failure**
Checks completed				
PLEASE ENSURE ANY FAULTY EQUIPMENT IS REPORTED AND APPROPRIATE ACTION IS TAKEN				
PRINT NAME:				
SIGNATURE:				

Adapted from the NHS Greater Glasgow and Clyde (year unknown). Cleaning of Near Patient Equipment: Bed Space Checklist. Available at: www.nhsggc.org.uk/media/266429/appendix-3a-bedspace-checklist-amended-apr-21.doc (Accessed: 11 January 2022).

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