

# T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

## Supporting Healthcare

Assignment 2 - Practical activities part 1

Assignment brief

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### Assignment brief

Assignment 2

Practical activities part 1

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# Assignment brief cover sheet

This assessment is for the following occupational specialism:

Supporting Healthcare

## Date

[date]

## Time allowed

1 hour 25 minutes

## Paper number

[paper number]

## Materials

For this assessment you must have:

- a black or blue ball-point pen

## Student instructions

- this assessment requires you to demonstrate the 3 practical activities 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 60

## Submission form

Please complete the detail below clearly and in BLOCK CAPITALS.

Student name	
Provider name	

Student number		Provider number	
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SAMPLE

# Practical activity scenario 1

This practical activity scenario requires you to:

CPA5: Move and handle individuals safely when assisting them with their care needs, using moving and handling aids.

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 20 minutes.

## Brief

A 74-year-old individual has been admitted to hospital due to pain in their knees and hips from their osteoarthritis.

They are currently sat in a chair in their private hospital room and have requested to move to a chair in the day room so that they can watch television.

## Task

Using information from the individual's care plan (Item A) you will support the individual to:

- move safely, using an appropriate moving and handling aid, from the chair in their private room to a chair in the day room
- document actions taken in the individual's daily care log (Item B)

[16 marks]

Plus marks for underpinning skills – duty of care, candour and person-centred care, communication and health and safety.

## Supporting information

This practical activity scenario involves role play. The individual will be played by a member of staff.

## Resources

You have been given an extract of the individual's care plan (item A) and a daily care log (item B).

## Equipment

You have access to the following equipment:

- a simulated hospital room
- a simulated day room
- 2 chairs with armrests
- handwashing equipment
- standard walking frame

## Performance outcomes (POs)

This practical activity scenario assesses:

PO1: Assist with an individual's overall care and needs to ensure comfort and wellbeing.

PO2: Assist registered health professionals with clinical or therapeutic tasks and interventions.

SAMPLE

## Item A: extract of individual's care plan

<b>Name</b>	Individual
<b>Date of birth (DOB)</b>	08/05/1949
<b>Home address</b>	1 The Avenue Old Village New Town
<b>Next of kin</b>	Son
<b>Name of GP</b>	Dr Jones
<b>Social history</b>	Lives alone
<b>Occupation</b>	Retired
<b>Smoking</b>	Non-smoker
<b>Alcohol</b>	Does not drink alcohol
<b>Exercise taken</b>	Unable to exercise due to condition
<b>Diet</b>	Vegetarian
<b>Additional information</b>	<ul style="list-style-type: none"><li>• individual has osteoarthritis</li><li>• admitted due to pain in knees and hips</li><li>• has been using a standard walking frame to aid in mobility for 3 days</li><li>• full risk assessment has been completed on walking aid</li></ul>

<b>Care needs</b>	<ul style="list-style-type: none"><li>• individual is able to consent to treatment/care support required</li><li>• individual can support own weight to stand for a couple of minutes but requires a standard walking frame to walk and can walk a short distance with this aid independently, requires encouragement sometimes to look up and face forward when using as sometimes looks at feet</li><li>• individual does not want to use a wheelchair to be mobile</li><li>• individual can sit up/down from a chair with arm rest to a standing position independently</li></ul>
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SAMPLE



## Item B: daily care log

Name		Home address	DOB
Individual		1 The Avenue Old Village New Town	08/05/1949
Date	Time	Actions taken	Signatures

## Practical activity scenario 2

This practical activity scenario requires you to:

CPA8: Assist in obtaining an individual's history and offer brief advice on health and wellbeing, recognising and responding as 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

An individual has recently moved to the area and has registered with a local general practice (GP) surgery. The individual has attended the surgery for a new patient wellbeing check. You are working as a supporting healthcare assistant within the surgery and have been asked to undertake a health and wellbeing assessment, prior to their appointment with the nurse.

The receptionist has informed you that the individual has arrived for the appointment.

### Task

Appropriately meet the individual and escort them from simulated waiting area to the room for the appointment.

Gather appropriate information by completing the health and wellbeing form (item C).

Offer brief advice relating to physical and mental wellbeing according to the information gathered.

On completion of the appointment appropriately escort the individual to the simulated waiting area, and report verbally any issues and deteriorations in health and wellbeing, to the nurse in the appointment room.

[16 marks]

Plus marks for underpinning skills– duty of care, candour and person-centred care, communication and health and safety.

### Supporting information

This practical activity scenario involves role play. The individual and nurse will be played members of staff. The member of staff playing the nurse will be in the room that the appointment took place when you return from escorting the individual back to the waiting area.

You have been provided with a health and wellbeing form (item C). Parts of the form have already been completed for you.

### Resources

You have been given a health and wellbeing form (item C). Parts of the form have already been completed.

## Equipment

You have access to the following equipment:

- a simulated waiting area
- a suitable simulated environment for the appointment such as a private, quiet and accessible area
- 2 chairs
- a table

## Performance outcomes (POs)

This practical activity scenario assesses:

PO1: Assist with an individual's overall care and needs to ensure comfort and wellbeing.

PO2: Assist registered health professionals with clinical or therapeutic tasks and interventions.

SAMPLE

## Item C: health and wellbeing assessment form

### Confidential patient record form – Health simulation centre.

<b>Date</b>	
<b>Name</b>	Individual
<b>Date of birth</b>	25/06/1998
<b>Home address</b>	1 The Place Somewhere UK
<b>Next of kin</b>	June Hill (Mother)
<b>Name of GP</b>	Dr Goode
<b>Social history</b>	
<b>Occupation</b>	
<b>Smoking (per day)</b>	
<b>Alcohol (units per week)</b>	
<b>Exercise taken</b>	
<b>Diet</b>	

<b>Children</b>	<b>Age</b>	<b>Age</b>	<b>Age</b>	<b>Age</b>	<b>Age</b>

<b>Medical history</b>	<b>Self</b>	<b>Family</b>
<b>Long-term conditions</b>		
<b>Mental health status</b>		
<b>Medication</b>		
<b>Allergies</b>		
<b>Signatures</b>	<b>Patient</b>	<b>Health professional</b>

## Practical activity scenario 3

This practical activity scenario requires you to:

CPA2: Undertake and record a range of physiological measurements, recognising deteriorations in physical health and escalating as 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 35 minutes.

### Brief

A 52-year-old individual with a history of chronic obstructive pulmonary disease (COPD) has been admitted to the hospital with a possible chest infection, and concerns about lack of hydration, urine elimination and nutrition, following a GP appointment.

At 4pm they had their physiological measurements taken at the GP surgery, these are provided on the physiological measurements form (Item D).

The individual is lying in a bed in a hospital room.

### Task

It is 6pm and you have been instructed by the nurse in charge to take the first set of physiological measurements on their admission to hospital. Currently they are not receiving any oxygen treatment and are currently alert and able to consent to physiological measurements being taken. Take the individual's current physiological measurements of:

- respiratory rate
- oxygen saturation (SpO<sub>2</sub> Scale 1)
- blood pressure
- heart rate (pulse)
- body temperature
- level of consciousness

Use the physiological measurements form (item D) to make notes in the second column, before recording them on the National Early Warning Score 2 (NEWS2) chart (item E).

Using the results, calculate the individual's NEWS2 score.

Report verbally the findings to the nurse in charge in accordance with criteria provided in item E and information provided from the GP readings in Item D.

Make verbal recommendations to the nurse about how the individual's urine elimination, nutrition and hydration should be monitored based on the information provided in the brief.

[16 marks]

Plus marks for underpinning skills— duty of care, candour and person-centred care, communication and health and safety.

## Supporting information

The individual in this practical activity scenario is played by a manikin. The nurse in charge is played by a member of staff. Another member of staff will act as the responsive manikin's voice, if required.

## Resources

You have been given a physiological measurements form (item D) and NEWS2 observation chart (item E).

## Equipment

You have access to the following equipment:

- a hospital bed
- a simulated hospital room
- table/cabinet for holding required equipment
- a manikin
- an automatic blood pressure (BP) machine
- a tympanic thermometer and disposable covers
- a pulse oximeter
- a watch with second hand/stopwatch
- handwashing equipment
- general cleaning equipment and products
- PPE (gloves, apron)

## Performance outcomes (POs)

This practical activity scenario assesses:

PO1: Assist with an individual's overall care and needs to ensure comfort and wellbeing.

PO3: Undertake a range of physiological measurements.

## Item D: physiological measurements form

Use this form to make notes. This will **not** be marked as part of your assessment.

Physiological measurement	GP physiological measurements results	Hospital admittance physiological measurement results
Blood pressure (mmHg)	130/80 mmHg	
Heart rate (pulse)	90 bpm	
Respirations	22 bpm	
Oxygen saturation (SpO2 Scale 1)	94%	
Body temperature (°C)	38.0°C	
Level of consciousness	Alert	



## Item E: NEWS2 observation chart

NEWS key		FULL NAME													
0 1 2 3		DATE OF BIRTH						DATE OF ADMISSION							
DATE TIME														DATE TIME	
<b>A+B</b> Respirations Breaths/min	≥25							3							≥25
	21–24							2							21–24
	18–20														18–20
	15–17														15–17
	12–14														12–14
	9–11							1							9–11
≤8							3							≤8	
<b>A+B</b> SpO <sub>2</sub> Scale 1 Oxygen saturation (%)	≥96							1							≥96
	94–95														94–95
	92–93							2							92–93
	≤91							3							≤91
<b>SpO<sub>2</sub> Scale 2†</b> Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure  †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O <sub>2</sub>							3							≥97 on O <sub>2</sub>
	95–96 on O <sub>2</sub>							2							95–96 on O <sub>2</sub>
	93–94 on O <sub>2</sub>							1							93–94 on O <sub>2</sub>
	≥93 on air														≥93 on air
	88–92														88–92
	86–87							1							86–87
	84–85							2							84–85
≤83%							3							≤83%	
<b>Air or oxygen?</b>	A=Air														A=Air
	O <sub>2</sub> L/min Device							2							O <sub>2</sub> L/min Device
<b>C</b> Blood pressure mmHg Score uses systolic BP only	≥220							3							≥220
	201–219														201–219
	181–200														181–200
	161–180														161–180
	141–160														141–160
	121–140														121–140
	111–120														111–120
	101–110							1							101–110
	91–100							2							91–100
	81–90														81–90
	71–80														71–80
	61–70														61–70
	51–60							3							51–60
≤50														≤50	
<b>C</b> Pulse Beats/min	≥131							3							≥131
	121–130														121–130
	111–120							2							111–120
	101–110														101–110
	91–100							1							91–100
	81–90														81–90
	71–80														71–80
	61–70														61–70
	51–60														51–60
	41–50							1							41–50
31–40														31–40	
≤30							3							≤30	
<b>D</b> Consciousness Score for NEWS onset of confusion (no score if chronic)	Alert														Alert
	Confusion														Confusion
	V							3							V
	P														P
<b>E</b> Temperature °C	≥39.1°							2							≥39.1°
	38.1–39.0°							1							38.1–39.0°
	37.1–38.0°														37.1–38.0°
	36.1–37.0°														36.1–37.0°
	35.1–36.0°							1							35.1–36.0°
≤35.0°							3							≤35.0°	
<b>NEWS TOTAL</b>															<b>TOTAL</b>
Monitoring frequency															Monitoring frequency
Escalation of care Y/N															Escalation of care Y/N
Initials															Initials

## The NEWS2 scoring system

Physiological parameter	Score						
	3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO <sub>2</sub> Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO <sub>2</sub> Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

National Early Warning Score (NEWS) 2

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## NEWS2 thresholds and triggers and clinical response to the NEWS2 trigger thresholds

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

\* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

\*\*The response team must also include staff with critical care skills, including airway management.

National Early Warning Score (NEWS) 2

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NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	<ul style="list-style-type: none"> <li>Continue routine NEWS monitoring</li> </ul>
Total 1–4	Minimum 4–6 hourly	<ul style="list-style-type: none"> <li>Inform registered nurse, who must assess the patient</li> <li>Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required</li> </ul>
3 in single parameter	Minimum 1 hourly	<ul style="list-style-type: none"> <li>Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary</li> </ul>
Total 5 or more Urgent response threshold	Minimum 1 hourly	<ul style="list-style-type: none"> <li>Registered nurse to immediately inform the medical team caring for the patient</li> <li>Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients</li> <li>Provide clinical care in an environment with monitoring facilities</li> </ul>
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	<ul style="list-style-type: none"> <li>Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level</li> <li>Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills</li> <li>Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU</li> <li>Clinical care in an environment with monitoring facilities</li> </ul>

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Owner: Head of Assessment Design

## Change History Record

Version	Description of change	Approval	Date of issue
v1.0	Additional sample material		01 September 2023
v1.1	Sample added as a watermark	November 2023	20 November 2023