T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Adult Nursing Team

Assignment 1 - Case study stimulus materials

Assignment brief insert

v1.3: Specimen assessment materials
21 November 2023
603/7066/X

Internal reference: HLTH-0003-03

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Assignment brief insert

Assignment 1

Case study stimulus materials

Contents

Item A: Mike's care plan

Nursing care plan - ward 7 C (care of the elderly)

Patient: Mike Smith

Care plan initiated by: senior sister ward 7 C. To be updated every 2 weeks

Date: Initial plan on admission - 27 June 2019 Update: 27 April 2020

Nursing assessment	Goals and outcomes	Nursing interventions	2 week plan
Admitted following multiple unwitnessed falls at home, resulting in a fractured neck of femur, broken wrist and bruised ribs. Patient reports usually good mobility. He lives alone and has social and family relationships nearby. Paramedics reported some disorientation and confusion about how he fell in the latest incident. A community pharmacist usually manages medication and patient was admitted without his home stock. Ward pharmacy technician is aware. The A&E transfer nurse noted Mike was disorientated and distressed and initially hostile. He has no restrictions under the mental health act/mental capacity act (MHA/MCA) and has not been assessed for a liberty protection safeguards (LPS) order. Patient provided consent to contact next of kin. Patient's next of kin, his son, has been informed of his admission. He states the family has been trying to persuade Mike to move into an independent living facility, as they are worried about some signs of frailty. The patient is resistant to this plan.	Mike has a long-term goal to return home and resume the same quality of life and independence he had before hospital admission. He accepts this may be an ambitious outcome and has an intensive therapy plan with the allied health professional team to rebuild mobility. Mike has a weekly review from the pharmacy technician to review his compliance with prescribed medicines. Our view of his home stock and discussion with his GP found he regularly missed doses. We have set medicine optimisation as a key plan moving forward. Mike's primary goal on discharge is to maintain independence. This includes living alone and being able to resume his daily routine, which included seeing his friends, going to the local pub quiz and daily walks. Mike has a dim view of any sort of living arrangement that includes on-site care staff. His main goal is to return home, but his son is concerned about the family's ability to provide homecare should his condition deteriorate.	Mike is not clinically dependent and remains an inpatient awaiting a decision on a community transfer. His consultant does not consider it safe for him to return home and he remains hospitalised whilst we stabilise his pain, psychological condition and mobility. Nursing interventions are minimal and most are carried out by healthcare assistants or a nurse associate: • personal care • mobilising to attend activities and physiotherapy • medication prompts • nutritional support • general care The pharmacy technician reviews Mike's medication on a weekly basis. Nurses complete his MAR chart for every dose of medicine. Mike remains under observation, but there is no immediate concerns that care needs to take place under the MCA or LPS. Senior sister FC maintains regular contact with Mike's son and ward staff record daily summaries of the care given. This helps his family to understand any change in his condition and needs.	Daily allocated nurse to maintain observations and document notable changes for shift handovers. Mike's fall risk has been increased following a recent incident and a nurse or healthcare assistant must monitor him during mobilisation. Any missed meals should be documented, Any missed medication should be documented in the medication administration record (MAR) chart. Mike is usually coherent, articulate and aware of his surroundings. He can become disorientated and confused if woken too early and occasionally experiences frustration when trying to mobilise. Document any changes in his mental health. Encourage him to attend activities and social opportunities. Duty nurse to provide Mike's son with a brief daily summary of his care and any notable change or progression. Please note any new concerns related to frailty.

Multi-disciplinary care plan

Patient: Mike Smith

Care plan initiated by: senior sister ward 7 C.

Date: w/c 20 April 2020

Assessment of need	Diagnosis	Goals and outcomes	MDT interventions	Summary	Date
Reduced mobility and dexterity.	Muscle atrophy and age-related osteoarthritis.	Improve mobility and reduce the rate of muscle degradation.	Physiotherapy 3 times weekly. 30 minutes in the therapy gym.	Mike continues to engage fully in his physiotherapy sessions, with minimal encouragement. Today he was motivated and managed 2 weight-bearing exercises on the leg-strengthening machine.	20 April 2020
Low mood and boredom.	Mild depression and social isolation caused by lack of stimulation and long-term environment.	Support to maintain hobbies and build social opportunities.	Activities volunteer visits Mike daily, Monday to Friday. They support him to access the activities lounge and take part in group social sessions.	Mike has joined several groups this week, including the film club and daily coffee and cake chats. He has made a new friend who is a patient in a neighbouring ward. They are able to safely meet in the activities room without supervision.	21 April 2020
Appears to be in pain when moving around.	Awaiting assessment by the pain team.	Pain management and reduction.	Referred to the pain team 19 April 2020.	Nursing notes: Mike appears to grimace when getting out of bed and getting in and out of the shower. He is unwilling to talk about this today.	24 April 2020
Mike was placed on a NEWS2 chart in April 2020 following an acute deterioration of condition. This identified his pain was worse than previously assessed.	Arthritis and depression were found to be the key causes of Mike's pain.	Further explore pain needs and establish a management plan.	The pain CNS attended Mike and carried out an acute pain assessment.	The source of Mike's pain was not related to the acute episode and is non-life threatening. The pain CNS has prescribed medicine to manage the physical manifestation of the pain.	26 April 2020

Mike's Measurements at 4pm

Taken at 4pm on 27th.

	Measurement at 4pm
Respirations	22
Oxygen Saturation (SpO2)	93%
Air or oxygen?	Air
Blood pressure (mmHg)	108/80
Pulse	115
Consciousness	Alert
Temperature (ºC)	37.5

Item B: Mike's NEWS2 chat

NEWS key				FULL NAME: Mike Smith	
0	1	2	3	DATE OF BIRTH: 12/03/43	DATE OF ADMISION: 27/6/19

	DATE	27	27																											DATE
	TIME	12	14																											TIME
A+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
A+B **SpO_2 Scale 1** Oxygen saturation (%)	≥96																													
	94–95													1																
	92–93													2																
	≤91													3																
SpO2 Scale 2 Oxygen saturation (%) Use scale 2 if target range is 88–92% eg in hypercapnic respiratory failure	≥97 on O_2													3																≥97 on O_2
	95–96 on O_2													2																95–96 on O_2
	93–94 on O_2													1																93–94 on O_2
	≥93 on air																													≥93 on air
	88–92																													88–92
	86–87													1																86–87
*ONLY use Scale 2 under the direction of a qualified clinician	84–85													2																84–85
	≤83%													3																≤83%
Air or oxygen?	A = Air																													A = Air
	O_2 L/min													2																O2 L/min
	Device																													Device
C **Blood pressure mmHg** Scores 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													3																81–90
	71–80																													71–80
	61–70																													61–70
	51–60																													51–60
	≤50																													≤50
C **Pulse** Beats/min	≥131													3																≥131
	121–130													2																121–130
	111–120													2																111–120
	101–110													1																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													3																31–40
	≤30													3																≤30

D **Consciousness** Score for the NEW onset of confusion (no score if chronic)	Alert																										Alert
	Confusion													3														Confusion
	V													3														V
	P													3														P
	U													3														U
E **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°													3														≤35°
NEWS TOTAL		1	1																									**TOTAL**

Monitoring frequency	2	2																									Monitoring
Escalation of care Y/N	N	N																									Escalation
Initials	AA	AA																									Initials

The NEWS2 scoring system

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

National Early Warning Score (NEWS) 2 © Royal College of Physicians 2017

Item C: Treating pressure ulcers (pressure sores)

Treatments for pressure ulcers (sores) include regularly changing your position, using special mattresses to reduce or relieve pressure, and dressings to help heal the ulcer. Surgery may sometimes be needed.

Changing position

Moving and regularly changing your position helps to relieve the pressure on ulcers that have already developed. It also helps prevent pressure ulcers form.

After your care team has assessed your risk of developing pressure ulcers, they'll draw up a repositioning timetable. This states how often you need to move, or be moved if you're unable to do so yourself.

For some people, this may be as often as once every 15 minutes. Others may need to be moved only once every 2 to 4 hours.

You may also be given training and advice about:

- correct sitting and lying positions
- how you can adjust your sitting and lying positions
- how best to support your feet to relieve pressure on your heels
- any special equipment you need and how to use it

Mattresses and cushions

If you're at risk of getting pressure ulcers or have a minor ulcer, your care team will recommend a specially designed static foam or dynamic mattress.

If you have a more serious ulcer, you'll need a more sophisticated mattress or bed system, such as a mattress connected to a pump that delivers a constant flow of air into the mattress.

There is also a range of foam or pressure-redistributing cushions available. Ask your carer about the types most suitable for you.

However, the National Institute for Health and Care Excellence (NICE) says there's limited evidence about what types of pressure-redistributing devices are best for the relief and prevention of pressure ulcers in different places, such as heels or hips.

Dressings

Specially designed dressings can be used to protect pressure ulcers and speed up the healing process.

These include:

- **alginate dressings** – these are made from seaweed and contain sodium and calcium, which are known to speed up the healing process
- **hydrocolloid dressings** – contain a gel that encourages the growth of new skin cells in the ulcer, while keeping the surrounding healthy skin dry
- **other dressing types** – such as foams, films, hydrofibres/gelling fibres, gels and antimicrobial (antibiotic) dressings may also be used

Ask your carer about which type of dressing they're using to manage your pressure ulcer.

Gauze dressings are not recommended for either the prevention or treatment of pressure ulcers.

Creams and ointments

Topical antiseptic or antimicrobial (antibiotic) creams and ointments are not usually recommended for treating pressure ulcers.
But barrier creams may be needed to protect skin that's been damaged or irritated by incontinence.

Antibiotics

Antibiotics may be prescribed to treat an infected ulcer or if you have a serious infection, such as:

- blood poisoning (sepsis)
- bacterial infection of tissues under the skin (cellulitis)
- infection of the bone (osteomyelitis)

Diet and nutrition

Eating a healthy, balanced diet that contains enough protein and a good variety of vitamins and minerals can speed up the healing process.
If your diet is poor, you may need to see a dietitian. They can draw up a suitable dietary plan for you.
It's also important to drink plenty of fluids to avoid dehydration, because being dehydrated can slow down the healing process.

Removing damaged tissue (debridement)

It may sometimes be necessary to remove dead tissue from the pressure ulcer to help it heal. This is known as debridement.
If there's a small amount of dead tissue, it may be removed using specially designed dressings.
Larger amounts of dead tissue may be removed using:

- high-pressure water jets
- ultrasound
- surgical instruments, such as scalpels and forceps

A local anaesthetic should be used to numb the area around the ulcer so debridement (if not being treated with a dressing) does not cause you any pain.

Source: https://www.nhs.uk/conditions/pressure-sores/treatment/

Item D: Roper-Logan-Tierney's model of nursing based on a model of living

The Roper-Logan-Tierney Model for nursing is a theory of nursing care based on activities of daily living, which are often abbreviated ADL.

The purpose of the theory is as an assessment used throughout the patient's care. In the United Kingdom, it has been reduced to being used simply as a checklist. It is often used to assess how the life of a patient has changed due to illness, injury, or admission to a hospital rather than as a way of planning for increasing independence and quality of life.

The theory attempts to define what living means. It categorises the discoveries into activities of living through complete assessment, which leads to interventions that support independence. The goal of the assessment and interventions is to promote maximum independence for the patient.

The activities of daily living should be viewed 'as a cognitive approach to the assessment and care of the patient, not on paper as a list of boxes, but in the nurse's approach to and organisation of their care', and that nurses deepen their understanding of the model and its application.

The activities of living are:

- maintaining a safe environment
- communication
- breathing
- eating and drinking
- elimination
- washing and dressing
- controlling temperature
- mobilisation
- working and playing
- sleeping

The list also includes death and sexuality as activities of daily living, but these are often disregarded depending on the setting and situation for the individual patient.

According to the model, there are 5 factors that influence the activities of living. The incorporation of these factors into the theory of nursing makes it a holistic model. If they aren't considered, the resulting assessment is incomplete and flawed. The factors are used to determine the individual patient's relative independence in regards to the activities of daily living.

They are: biological, psychological, sociocultural, environmental, and politico economic.

Roper herself objects to the model being used as a checklist. She states that if nurses are uncomfortable discussing certain factors, they assume the patients are, as well. This leads to the nurses attributing the lack of assessment to the patient's preference, when in reality, the patient's preferences were not addressed.

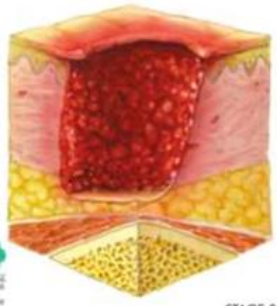
Her assertion leads to the conclusion that rather than deleting or disregarding activities of daily living, it can benefit the individual being assessed if the nurse uses the model more thoroughly and assesses the patient using the 5 factors in conjunction with the activities of daily living, regardless of the area in which the care is being received.

Taken from: https://nursing-theory.org/theories-and-models/roper-model-for-nursing-based-on-a-model-of-living.php

Item E: photograph of a grade 3 pressure ulcer

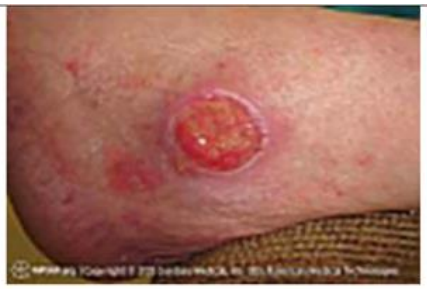
Stage 3

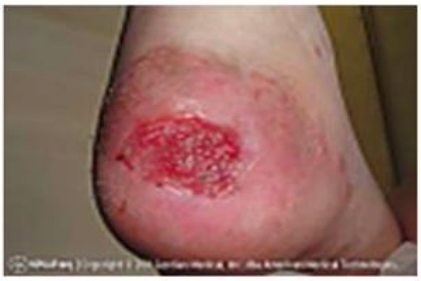
The wound extends through the dermis (second layer of skin) into the fatty subcutaneous (below the skin) tissue. Bone, tendon and muscle are not visible. Look for signs of infection (redness around the edge of the ulcer, pus, odour, fever, or greenish drainage from the ulcer) and possible necrosis (black, dead tissue).



STAGE 3

Healing time: approximately 4 weeks-6 months





Item F: patient goals form

Date of goal setting	_ _/ _ _/ _ _	Review Date	_ _/ _ _/ _ _
Patient diagnosis: (Include details relating to current and expected time as inpatient)			
Patient Values, Fears and Expectations			
Inpatient Primary/Short Term Goal(s)			
Long Term Goal(s)			
Opportunities to support Activities of Daily Living as an Inpatient			
Referrals needed (e.g. Medication, Therapies, Social Support, Other)			

Employee name:		Signature:	
Patient name:		Date:	_ _/ _ _/ _ _

Item G: wound assessment chart

n/a

undernutrition referred to dietician

n/a

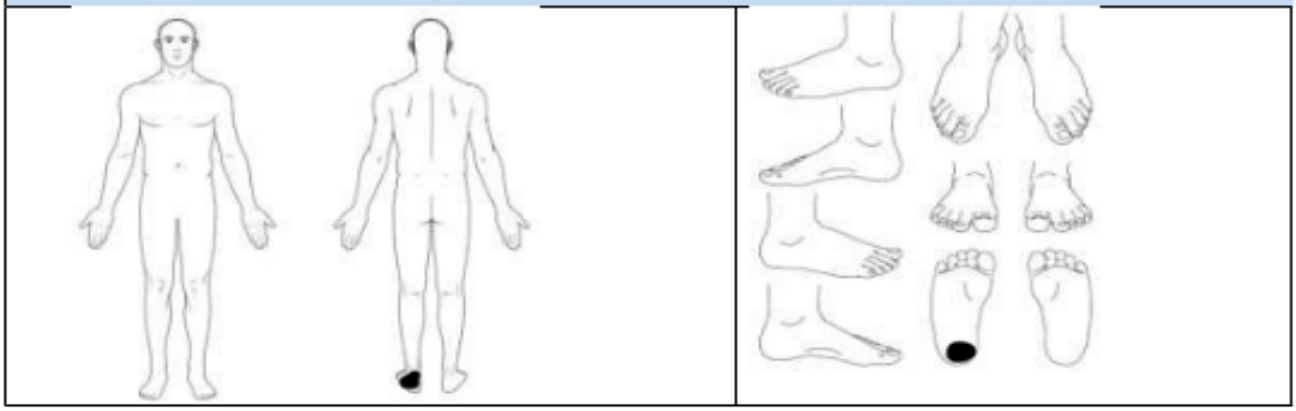
n/a

n/a

Residents Name: Anita Smith				Date of first assessment: 12/06/20
Background information				
Duration of wound (PleaseTick)	Acute (<6 weeks)		Chronic (>6 weeks)	
Type of wound (Please Tick)				
Pressure ulcer ✓	Burn/scald	Skin tear/ laceration	Moisture lesion	Leg ulcer
Diabetic foot ulcer	Sinus/fistula	Traumatic wound	Surgical wound	Other
If pressure ulcer, what category?	1	2	3 ✓	4

Factors affecting wound healing:		
	Comments	Actions
Diabetes		
Nutritional Status		
Medications		
Other		
Allergies including dressings and tapes:		

Location of wound:



	Initial assessment	Review	Review	Review
Date:				
Wound size:				
Max. length (cm)	3			
Max. width (cm)	2			
Max. depth (cm)	1			
Undermining/tracking?	No			
Wound bed:				
Necrotic (black)				
Slough (yellow/brown)	✓			
Granulating (red)				

Dry/cracked	✓			
Scaly	✓			
Erythema				
Macerated				
Oedematous				
Excoriated				
Skin nodules				
Skin stripping				
Other (state)				
Exudate level:				
None				
Low				
Moderate	✓			
High				
Increasing?				
Decreasing?				
Odour:				
None				
Slight	✓			
Moderate				
Strong				
Bleeding:				
None	✓			
Slight				
Moderate				
Heavy				
At dressing change				
Infection suspected?				
Swab taken? (Y/N)	✓			
Signature/designation of assessor	[signature]			

Other actions required (insert date completed)				
Photograph taken				
Pressure relieving equipment in place				
MUST reviewed				
Waterlow reviewed				
Pain assessment completed				
Wound management care plan completed				
Family and care staff informed				
Reported to CQC				
Reported to safeguarding				
Duty of candour required?				
Referrals required? E.g. TVN, podiatry, dietician, other				
Reason for referral				
Signature/designation				

Item H: discharge plan

Planned date of discharge:	_ _/ _ _/ _ _	Start of care:	_ _/ _ _/ _ _

Patient diagnosis:	

Type of diagnosis:			
☐	Revocation	☐	Patient refusing service
☐	Moving from service area	☐	Extended prognosis
☐	Transfer to non-contracted hospital	☐	Unsafe environment
☐	Change in hospice	☐	Other

Patient/family involvement:

Problems/needs for continued care (symptom control):

Referrals needed (other hospice, home help, community resources, etc):

Continuing needs:	
Equipment:	
Medical supplies:	
Instructions:	

Communication with the following staff:			
☐ RN	☐ Spiritual counsellor	☐ Bereavement counsellor	☐ Volunteer
☐ Social worker	☐ Attending physician	☐ Hospice physician	☐ Other

Employee name:		Signature:	
Patient name:		Date:	_ _/ _ _/ _ _

Document information

The T Level Technical Qualification is a qualification approved and managed by the Institute for Apprenticeships and Technical Education.

Owner: Head of Assessment Design

Change History Record

Version	Description of change	Approval	Date of Issue
v1.0	Post approval, updated for publication.		January 2021
v1.1	NCFE rebrand		September 2021
v1.2	OS review Feb 23		February 2023
v1.3	Sample added as a watermark	November 2023	21 November 2023