T-LEVELS | Institute for Apprenticeships & Technical Education

T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Midwifery Team

Assignment 1 - Case study - Distinction

Guide standard exemplification materials

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T Level Technical Qualification in Health
Occupational specialism assessment

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Supporting the Midwifery Team

Assignment 1

Contents

Introduction

The material within this document relates to the Supporting the Midwifery Team occupational specialism sample assessment. These exemplification materials are designed to give providers and students an indication of what would be expected for the lowest level of attainment required to achieve a pass or distinction grade.

The examiner commentary is provided to detail the judgements examiners will undertake when examining the student work. This is not intended to replace the information within the qualification specification and providers must refer to this for the content.

In assignment 1, the student must interrogate and select relevant information to respond to the tasks in ways typical to the workplace. By adopting a problem-based inquiry approach, the student is placed at the centre of decision making regarding an individual's care in a scenario designed to be as realistic as possible.

After each live assessment series, authentic student evidence will be published with examiner commentary across the range of achievement.

Task 1: assessment of the patient/situation

Scenario

You have an hour-long appointment booked with Lucy, the aim of which is to ascertain a thorough history, assess her needs and then advise, educate, plan, and refer as needed.

Task

For this task, you are involved in completing:

- the highlighted gaps in the booking notes (item B), including calculating the body mass index (BMI) and ticking the venous thromboembolism (VTE) assessment
- the highlighted gaps in the booking summary (item C)
- the observations that you have available in the first column of the MEOWS chart (item D) which will provide a baseline for the rest of the pregnancy

You must then identify 3 risk factors from the documentation and explain:

- how the risk factors are relevant to Lucy
- what advice you would give Lucy based on these risk factors

You can use online resources: Tommy's Pregnancy Hub, BMI calculator, NHS UK Stop smoking in pregnancy, NHS UK Start4Life – Pregnancy, Antenatal Results and Choices – Tests explained, NHS UK Start4Life – Breastfeeding (item A) to support your answer.

Student evidence

I complete all paperwork in small, neat, legible print, writing in black ink.

Item B:

- page 7: I tick 1 for smoker and 1 for BMI; I score Lucy's VTE as 2 and I circle the box on the VTE assessment that says lower risk
- page 8: I complete BMI 31 and name and unit number

Item C:

- page 9: I copy EDD as 11/1/24, P0, BMI 31
- page 10: I write 'none' in medication and allergies. I complete name and unit number at bottom of page

MEOWS chart:

- I complete patient name/unit number
- I complete date and time
- I write 13 in the 11 to 15 box for respiratory rate
- temperature of 36.8 – I mark a small dot in correct area, and I write 36.8 underneath
- I mark pulse as 73 with a small dot and neatly written 73 underneath
- I mark the BP marked at 95/58
- I identify 1 yellow score and I initial result

One of the reasons for the booking appointment is to carry out various risk assessments, to see whether Lucy may need additional support or medical input during the pregnancy.

Based on the booking information given, I will outline 3 risk factors specific to Lucy that have been identified.

Firstly, Lucy has disclosed that she is still a smoker. Her CO reading confirms this. A score of 4 or more would indicate a smoker and her score was 10, a high score.

Smoking increases risks when pregnant. The carbon monoxide in the cigarettes can deprive the baby of oxygen, leading to problems such as poor growth and stillbirth.

Smoking is also the biggest risk factor for sudden infant death syndrome or cot death after birth.

I give Lucy this information but in a sensitive way so that she does not feel she is being judged, which is likely to make her disengage from any discussions and behaviour change.

I ask her about her understanding of the effects of smoking on pregnancy which would allow us to dispel any myths, such as a small baby might be easier to birth.

I emphasise how addictive nicotine is and give her praise if she has tried or is thinking of quitting. I discuss the benefits of quitting for her baby and for her in terms of better health and more money available. I explain that evidence suggests people are much more likely to quit with support and discuss referral to a smoking cessation service: her partner could also go to with her if he smokes to make it more likely both would quit.

I also offer CO monitoring at every contact so that she could see any improvements quickly if she quit or even cut down, which would make her more likely to continue.

Secondly, Lucy's BMI is raised at 31. It is known that a BMI above 30 in pregnancy increases the risk of complications such as pre-eclampsia, gestational diabetes and DVT.

Weight can be a very sensitive issue for women, and it is important that this is considered when discussing the risks of BMI.

I explain why we are interested in her weight and what the additional risks were. I also explain though, that just because there is a risk, it doesn't mean it will happen and that she can still help the situation with her behaviour during the pregnancy.

I ask her about her lifestyle in terms of diet and exercise and work with her to think about improvements she could make. I ensure she understands that during pregnancy, dieting is not recommended, but trying to stabilise weight and prevent large gains is. I discuss healthy eating and the value of staying active, and explore where she could fit exercise, even walking, into her life.

Lastly, Lucy is a pregnant teenager with an unplanned pregnancy. It has been recorded that she does feel supported by her partner, but we do not know how long they have been in a relationship or how stable it is.

There can be stigma in society attached to teenage pregnancy and so Lucy may feel some shame or embarrassment about being pregnant; this can sometimes be a barrier to young mothers accessing support they may need. She might not know other young mothers either and so could feel quite isolated.

She does not yet have full-time permanent work and so there may also be some financial concerns, which may affect her ability to look after both herself and the baby during pregnancy and post birth.

I think it is important to congratulate her on the pregnancy, as she may have had some negative feedback in relation to the news of the pregnancy from family members/friends.

I discuss the support available and try to build trust and rapport with her so that she feels able to open about her

concerns/questions.

She could be referred to the teenage pregnancy midwife who can give specialist support, tailor education to her needs and help her develop support networks with other teenage mothers.

A referral to local Sure Start centres/services could be helpful as well, to help her access parenting groups and things like baby massage after birth, to encourage bonding, parenting confidence and friendship groups.

Task 2: goals/patient outcomes/planned outcomes

Scenario

You are assisting with an appointment for Lucy in her last trimester. Lucy is still undecided about her options regarding place of her birth and is considering a water birth.

Task

For this task, you have to produce notes for a lesson around choosing a place of birth: home, midwifery-led unit or consultant unit.

In these notes, explain the advantages and drawbacks of each birthing environment. You should also include the practical information that parents need to consider when preparing for birth in each setting.

Student evidence

Lucy is considered a low-risk pregnancy so she has the following place of birth options: home birth, midwifery-led unit or consultant-led unit at hospital, and so the pros and cons of all places of birth should be outlined to her.

This should be done in a person-centred way, finding out from her and her partner what is important to them and giving them a chance to ask questions. For example, Lucy has shown interest in having a water birth and so this may be an important aspect of care to her that will be given a higher priority when making her decision.

I am also aware that she was considering a home birth at booking and so I would start by asking her what had attracted her to a home birth and finding out what she understood about her options.

Home birth:

Advantages:

- it can support a more natural, physiological birth experience with fewer interventions and because it is in your own environment, it can make you and your partner feel more relaxed, which can make it more likely labour will progress well
- in your own environment, you are also more likely to eat and drink when you want and to move around the house, an active labour and good hydration can help contractions and encourage the baby into a good position
- you can have Entonox for pain relief from the midwives and can also use things like a TENS machine if you want
- you can hire a pool if you want to, providing the opportunity for a water birth. This can also help with pain relief
- you are more likely to know your midwife at a home birth, which can be very reassuring and there will always be 2 midwives with you

Disadvantages:

- if there are any complications with labour progress, for example, being very slow, the mother (bleeding or raised BP), or the baby (such as heart rate decelerations in labour or breathing problems after birth), you would need to be transferred into the hospital in an ambulance.
- there is not the option for other pain relief at home such as pethidine, diamorphine or epidural, although less likely to be needed at home

Practical information to consider:

- at a home birth, you will need to plan things like ordering a pool and thinking about how to set it up, fill/empty it, keep the water warm and clean it
- you will need to think about where in the house to deliver and get plastic sheets to cover carpets or the bed
- you need the house to be warm and provide warm towels for the baby
- the midwives will need an uncluttered area with good light to set up oxygen for the baby if needed

Midwifery-led unit (MLU):

Advantages:

- these provide a more homely environment than the consultant-led unit and look less clinical so can again make you feel more relaxed and they are set up to encourage active physiological births with equipment like pools, birthing balls and beanbags
- it can feel safer than a home birth because you are closer to the doctors if you or the baby needs them
- some MLUs are 'alongside' the main hospital so transfer can be much quicker if necessary
- as well as Entonox, you can have other pain relief like water papule injections, pethidine or diamorphine
- birthing pools are generally available

Disadvantages:

- if there are problems in labour, you would still need to be transferred to main hospital unit. If the MLU is a stand-alone unit, this could still result in long delays
- you cannot have an epidural there and would need to transfer to consultant unit if this was wanted
- you might not get a pool if they are full

Practical considerations:

- at the MLU, you might need to bring in snacks for you and your partner
- you might want to bring in your own music
- think about what you would wear in the pool
- make sure your partner knows where the unit is and parking arrangements before you are full-term

Consultant-led unit:

Advantages:

- obstetricians and theatres available on site if any problems/emergencies, so prevents transfer and delays
- still mainly looked after by a midwife, so doctors may not have to get involved if there are no concerns
- other staff always available, such as anaesthetists for epidural pain relief and neonatal doctors for any problems with the baby; this might make some women feel safer and more able to relax
- can have all pain relief options from Entonox to epidural

Disadvantages:

- you might not be able to have a pool
- you might not feel as relaxed in the environment which can look and feel more medicalised, and this can interrupt the flow of oxytocin and slow labour progress or lead to more requests for pain relief
- rooms often focussed on hospital bed and so do not encourage active birth as much, particularly if the baby's heart is being auscultated continuously on CTG
- your partner may not be able to stay over if you go to a postnatal ward afterwards

Practical considerations:

- in the consultant-led unit, think about who your birth partners will be as likely only allowed 2 birth partners
- good to stay active in labour so if you need to be on a CTG, ask the midwife about using a birthing ball close to the monitor, or putting the bed into upright seating position, rather than lying flat on your back
- also, try to make the room more relaxing for you with your own music, pillows, birthing ball, and low lighting where possible
- ensure your partner knows about where to park in the hospital, where maternity is, and that he has change for parking, which can sometimes be expensive

Once I have gone through all the options, I check whether the couple has any questions and help answer or get answers to the questions. I let Lucy know that even if she makes a decision now, she can always change her mind.

Task 3: care/treatment/support plan

Scenario

You accompany the community midwife to Lucy's first home visit on day 3. Lucy tells you that she is not sure if her baby is getting enough milk.

Task

Referring to the breastfeeding photograph (item E), the breastfeeding tool answers (item F) and the Start4Life breastfeeding website (item A), document your discussion with Lucy. You should analyse Lucy's breastfeeding, considering signs of effective feeding and potential problems.

Write a breastfeeding plan, outlining the steps that could help Lucy, considering Lucy's wishes and needs as well as breastfeeding mechanics.

Student evidence

18/01/2024 – day 3, 10.00h

Lucy exclusively breastfeeding, but she is unsure as to whether baby getting enough milk.

Breastfeeding assessment carried out; see completed breastfeeding tool and breastfeed observed during the visit:

I gave Lucy encouragement and praise that she is breastfeeding as she is finding it difficult at the moment. We discussed the fact that breastfeeding can be difficult to initially establish but that with support, it can often quickly become easier and has many benefits for mother and baby.

We discussed why Lucy wanted to breastfeed and she said that it was because she knew it was best for baby and to help with bonding. Lucy admits that she does feel closer to the baby and that it is a 'lovely feeling' when baby is breastfeeding well. I discussed benefits of breastfeeding, such as giving antibodies to baby and fewer stomach and ear infections, and less likelihood of things like obesity and diabetes in later life. Also, I explained the financial benefits for Lucy (no cost compared to formula) and less chance of breast cancer and osteoporosis for her.

Lucy feels these reminders might help her persevere over the next couple of days until feeding improves and she feels more confident.

We discussed positive signs of her feeding currently:

Lucy is dedicated to breastfeeding and has not given any formula, which could interfere with her milk production, and introducing a bottle could also cause difficulties such as 'nipple-teat confusion.'

Lucy is not using a dummy, which at this early stage can cause parents to miss early feeding cues and miss feeds.

Lucy reports that once baby is on the breast, he is calm and relaxed, not fighting or agitated, suggesting there is some milk transfer, and he will settle between feeds.

However, there are signs that Lucy may be right in that baby may not be getting enough milk yet as shown in the feeding assessment tool:

Ideally, for babies to stimulate the breasts enough to encourage good milk production and to gain enough calories, babies need to feed at least 8 times in a 24-hour period. Baby currently feeds less frequently than this, although Lucy feels it is difficult to count exactly how many feeds baby is having as he often feeds for 1-2 hours at a time,

sometimes with a short break between breasts so she is unsure whether this counts as 1 or 2 feeds. I discussed optimum feed lengths between 5 and 40 minutes and that if baby is consistently feeding for longer, it suggests he may be working hard to get the milk, suggesting poorer milk transfer.

She also reports baby often falls asleep at the breast mid-feed and can be quite lethargic, which can suggest he is not feeding effectively and getting the calories he needs to give him the energy to be alert/awake to feed effectively. Baby also mildly jaundiced. I explained that this can be a normal physiological process but that it is something to monitor if we have concerns about feeding as it can also make the baby sleepy and further affect feeding.

In the last 24 hours, baby has had 2 wet nappies and 1 stool that she feels is beginning to change colour. Shown that for day 3, we would ideally see slightly more output, as Lucy's milk 'comes in' and volumes increase. Again, this is a sign that baby may not be getting enough milk.

Lucy reports that her nipples are cracked and sore. I explained that this is usually a sign of positioning and attachment problems. If the baby does not have a wide gape, he will just have the end of the nipple in his mouth, which will rub against the hard palate at the front of his mouth, causing pain and trauma to the nipple.

Lucy has noticed pinched, misshapen nipples after feeds which does suggest a poor latch. She also reports pain throughout the feed, suggesting poor attachment but thought this was normal for the early days of breastfeeding.

Observing a breastfeed confirmed problems with positioning and attachment, which are likely to cause poorer milk transfer, the longer feeds and reduced nappy output.

Baby was not held in close to mother. Lucy tried to line the baby's mouth with her nipple, resulting in the baby latching just to the nipple. Lucy was shown the signs of this, that we could see the baby did not have a wide open-mouthed gape, but just his lips were around the nipple, with a small mouth. Other signs were shown to Lucy, such as we could not see baby's whole jaw moving as he sucked and his cheeks sucked in instead and did not stay nice and full, suggesting he didn't have a large mouthful of breast tissue. I helped Lucy achieve a better latch during the appointment. Lucy can see and feel the difference.

One thing Lucy finds difficult is sitting for extended periods to feed as she had stitches after birth and is uncomfortable. I discussed different feeding positions that could help her, and helped to try these, such as lying down and biological nurturing, leaning back to take pressure off her perineum.

Feeding plan initiated:

- feed to early cues. Feed at least 8 times in 24 hours
- use skin to skin to encourage feeding behaviours
- CHIN principles discussed to encourage good positioning and attachment and so Lucy can recognise when it is right, as Lucy did not feel confident with how to latch baby well:
  - close to mum
  - head free – baby's weight supported on his shoulders mainly with head free so that he can move his head back to obtain wide gape and good attachment
  - in line – head and body lined up so baby not twisting to feed, so he is comfortable and more likely to sustain good latch
  - nose to nipple – line nipple up with nose to prevent him sucking in only the nipple, but encourage him to tip head back and point nipple towards back of his mouth and soft palate
- to try different feeding positions for comfort
- to take baby off breast if uncomfortable/poor latch recognised, by putting little finger in corner of baby's mouth to break the vacuum and re-position
- to offer both breasts at each feed

- if baby is lethargic and not feeding or has not latched and fed well, then Lucy to express after feeds and to offer top-up of expressed breast milk via cup to continue to stimulate breast so that milk supply will establish and to ensure baby gets calories needed. Cup less likely than bottle to cause future problems latching to breast.
- to weigh day 5 – I explained that up to 10% weight loss is acceptable and is another sign of how breastfeeding is progressing.

I checked Lucy understood and is happy with the plan. I provided her with hand pump and feeding cups and I showed how to use them. I gave her breastfeeding leaflets with photos of positions/signs of good attachment. I gave her some sachets of nipple cream to aid healing. She is aware she can still breastfeed while using this.

I also discussed possible signs of deterioration in the baby and when to seek medical advice, for example, if becoming more lethargic and difficult to get to feed, worsening jaundice, or further reduced wet and dirty nappies.

Finally, I gave Lucy breastfeeding support contact information and contact numbers for the midwives in case she has any concerns before the next visit.

Task 4: evaluation/monitoring effectiveness/clinical effectiveness

Scenario

You are one of the midwifery support workers (MSW) on the infant feeding team running the regular drop-in sessions. Lucy comes to have her baby weighed on day 8 and opens up to you about a number of issues that she is experiencing (item J).

Task

Referring to the day 3 breastfeeding tool (item F), extract from labour notes (item G), day 5 postnatal notes (items H and I) and day 8 conversation transcript (item J), write a confidential email to her community midwife to evaluate:

- how Lucy is recovering from the birth physically and adapting to parenthood emotionally
- how breastfeeding has been since day 3

Student evidence

Dear Emma,

I saw Lucy Potter today when she came to the drop-in feeding session and I'm writing to give you some feedback about her progress.

Physically, her recovery is largely as would be expected for day 8 postnatally. Her breasts and nipples are continuing to improve and are much less painful, even from day 5 when you saw her.

There are no concerns with her lochia, suggesting her uterus remains well contracted and she is passing urine normally and opening her bowels without difficulty.

There are no signs of DVT in her legs, such as swelling or pain, and no signs of PE, such as breathlessness.

The main physical problem for her remains perineal pain, following her episiotomy from the forceps delivery. I know you examined her stitches at home on day 5 but today she reported that they are feeling worse and are so sore, she can't sit comfortably again. I have suggested that she sees the GP in case she has an infection and needs some antibiotics. I hope that was ok.

Apart from her stitches, my concerns after today are more about Lucy's emotional wellbeing and how she's adapting to parenthood.

I have no concerns about Lucy's parenting in terms of how she is looking after her baby or bonding with the baby. The baby appears well cared for and Lucy has demonstrated appropriate concern, for example, in relation to feeding and his weight gain, and she was pleased that he was back to his birth weight. She interacts well with him, but I think puts a lot of pressure on herself, feeling that she doesn't know what she's doing most of the time and I think she feels a bit overwhelmed. She appears to easily blame herself, for example, she wondered whether her baby not feeding well meant 'he didn't like her', and today she is still expressing thoughts that she 'failed' by not achieving her home birth and maybe she should have 'tried harder'.

I think this is making her feel she needs to somehow prove herself as a worthy parent, so she is reluctant to ask for help from her parents, although they seem willing to help and support her. This is definitely making her more tired,

which will not help her low mood.

She remains very tearful even now 8 days postnatally and I think she would benefit from some additional support to monitor her mood, to look for signs of postnatal depression. I think she would like another visit from you to discuss things.

She does not appear to be getting much support from James, which is also likely to be contributing to her low mood and tearfulness, but Lucy did repeat how difficult he found witnessing the birth and she is worrying about him. She also acknowledged that she still thinks a lot about the birth too and I think birth reflections could be useful for them to go to as a couple. It might encourage them to talk to each other too about the experience and their concerns now.

In terms of breastfeeding, I think there have been significant improvements.

Lucy is no longer sore when feeding and her nipple trauma is healing, suggesting positioning and attachment have improved.

She has followed the feeding plan well. The baby had 6% of its birthweight at day 5, which was within normal limits, and today he has regained that loss and is back to birthweight.

The baby is having much more appropriate wet and dirty nappy output now, suggesting better milk transfer, and he is more alert, waking to feed around 2 times hourly from day 5, and the jaundice is resolving.

I have advised her to feed solely by responsive breastfeeding now and that there is no further indication for expressing and top-up unless she wants to. Hopefully, knowing that feeding is going better will remove some stress from her as well as the burden of expressing, which may also allow her to rest more.

I have documented everything in Lucy's notes but if you need any more information, please let me know.

Thank you.

Signed

Examiner commentary

The student has demonstrated excellent midwifery knowledge and skills in relation to the task demands, providing well thought through precise, coherent, logical and detailed responses, with consistent use of appropriate terminology apparent.

The student has made extensive use of their knowledge and evidence-based practice, pulling together medical, social and psychological approaches and considerations, giving breadth and depth to responses.

The student has been adept at identifying relevant information from a range of sources and made exceptional use of stimuli material to provide well-reasoned, sensitive and well-contextualised person-centred recommendations throughout the assessment, demonstrating an ability to respond to novel situations and problems.

The student has demonstrated excellent awareness of professional issues and engagement with all relevant standards, codes of conduct and health and safety considerations.

Overall grade descriptors

The performance outcomes form the basis of the overall grading descriptors for pass and distinction grades.

These grading descriptors have been developed to reflect the appropriate level of demand for students of other level 3 qualifications and the threshold competence* requirements of the role and have been validated with employers within the sector to describe achievement appropriate to the role.

Occupational specialism overall grade descriptors:

Grade	Demonstration of attainment
Pass	A pass grade student can: • communicate the relationship between person-centred care and health and safety requirements in healthcare delivery, by: o demonstrating working in a person-centred way, taking relevant and sufficient precautions to protect the safety and physical and mental wellbeing of individuals o recognising and responding to relevant healthcare principles when implementing duty of care and candour, including demonstrating sufficient knowledge of safeguarding individuals and maintaining confidentiality o following standards, codes of conduct and health and safety requirements/legislation to maintain a sufficiently safe working environment o demonstrating use of an adequate range of techniques, equipment and resources safely to promote sufficient levels of cleanliness and decontamination required for satisfactory infection prevention and control • communicate knowledge of national and local structures, definitions of clinical interventions, and the scope and limitations of their healthcare role within it, by: o adequately following current best practice and codes of conduct across relevant boundaries, relevant to assisting with scenario specific, clinical and therapeutic interventions o working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individuals' privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users' views to maintain effective provision of services o gathering sufficient evidence, contributing to, following and recording information in care plans/records relevant to tasks and interventions, structuring these sufficiently to allow understanding in line with local and national legislation and policies, preserving individuals' rights o maintaining a record of professional development with evidence of using feedback to develop knowledge, skills, values and behaviours consistent with sufficient ability to reflect on practice and thereby improve performance adequately • communicate sufficiently reliable levels of knowledge of the physiological states that are commonly measured by healthcare support workers, including why, when and what equipment/techniques are used by: o working as part of a team to use relevant equipment effectively and safely and following

Grade	Demonstration of attainment
	correct monitoring processes ○ calculating scores, reporting and differentiation of normal and abnormal results to the relevant registered professional ○ applying knowledge of policy and good practice techniques when undertaking all physiological measurements, checking when uncertain and consistent with instructions and guidance
Distinction	A distinction grade student can: • communicate adeptly the relationship between person-centred care and health and safety requirements in healthcare delivery, by: ○ demonstrating flexible and constructive person-centred care, taking appropriate precautions reliably, making sound decisions to protect the safety and physical and mental wellbeing of individuals ○ alertness and responsiveness to relevant healthcare principles when implementing duty of care and candour, including the demonstration of exceptional sensitivity and accurate knowledge of safeguarding individuals and maintaining confidentiality ○ commitment to following all required standards, codes of conduct and health and safety requirements/legislation decisively to maintain a safe, healthy working environment ○ demonstrating proficient use of an extensive range of techniques to promote optimum levels of cleanliness and decontamination required for effective infection prevention and control • communicate knowledge of national and local structures, definitions of clinical interventions, and the scope and limitations of their healthcare role within it, by: ○ following current best practice and agreed ways of working highly relevant to assisting with scenario specific, care-related tasks consistently and reliably, whilst fully supporting individuals to meet their care and needs, including maintaining the individual's privacy and dignity to a high standard ○ working adequately as part of a team to assist registered health professionals with delegated tasks and interventions, supporting individuals to meet their care and needs to a satisfactory standard, including maintaining individuals' privacy and dignity and communicating effectively, contributing to handovers, seeking help, advice and information, and responding sufficiently to service users' views to maintain effective provision of services ○ gathering extensive evidence consistently, interpreting, contributing to, following and recording information in care plans/records highly relevant to tasks and interventions, structured accurately and legibly and in line with local and national policies, while preserving and promoting individuals' rights ○ maintaining a record of professional development to develop knowledge, skills, values and behaviours consistent with ability to reflect on practice enthusiastically, using the feedback to initiate new learning and personal practice development to improve performance with developing proficiency • communicate exceptional levels of knowledge of the physiological states that are commonly measured by healthcare support workers, including why, when and what equipment/techniques are used, by: ○ working as part of a team to use relevant equipment accurately and safely and consistently

Grade	Demonstration of attainment
	following correct monitoring processes ○ calculating scores, reporting and differentiation of normal and abnormal results adeptly, consistently and reliably to the relevant registered professional ○ applying knowledge of policy and good practice techniques proficiently when undertaking all physiological measurements, checking when uncertain, solving problems, and following instructions and guidance with energy and enthusiasm

* ‘threshold competence’ refers to a level of competence that:

- signifies that a student is well placed to develop full occupational competence, with further support and development, once in employment
- is as close to full occupational competence as can be reasonably expected of a student studying the TQ in a classroom-based setting, for example, in the classroom, workshops, simulated working and (where appropriate) supervised working environments
- signifies that a student has achieved the level for a pass in relation to the relevant occupational specialism component

Document information

Owner: Head of Assessment Design

Change History Record

Version	Description of change	Approval	Date of Issue
v1.0	Published final version.		June 2021
v1.1	NCFE rebrand		September 2021