T-LEVELS | Institute for Apprenticeships & Technical Education

T Level Technical Qualification in Health

Occupational specialism assessment (OSA)

Supporting the Adult Nursing Team

Assignment 1 - Case study - Distinction

Guide standard exemplification materials

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Supporting the Adult Nursing Team

Assignment 1

Contents

Introduction

The material within this document relates to the Supporting the Adult Nursing 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 that 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.

Scenario

You are supporting the adult nursing team on ward C at New Town Hospital. Ward C provides care on an inpatient basis for those with conditions relating to ageing, frailty, and dementia. The hospital is a district general facility in a suburban area. Many inpatients on ward C spend several months in the ward due to a lack of community adult social care beds.

Mike is a 77 year old inpatient and has been there for 10 months awaiting a community bed. Mike was admitted following an unwitnessed fall at home in which he suffered a fractured neck of femur. This followed several months in which Mike's family were concerned about him living alone. He seemed to be experiencing the symptoms of increasing frailty, although he would not see his GP about this. During this admission, the multidisciplinary team felt it would be unsafe for Mike to return home to live by himself and helped him to make the decision to move into an assisted living facility. These are in short supply in his local area, and he is on a long waiting list.

The case study you have been provided with includes a number of documents:

- item A: Mike's care plan
    - nursing care plan
    - multi-disciplinary care plan
- item B: Mike's NEWS2 chat
- item C: healthy skin project guidance
- item D: Roper-Logan-Tierney's model of nursing based on a model of living
- item E: photograph of a grade 3 pressure ulcer
- item F: blue sheet patient goals form
- item G: wound assessment chart
- item H: discharge plan

Task 1: assessment of the patient/situation

Scenario

You are assisting a staff nurse in carrying out a weekly review of Mike's care documentation. Mike appears reasonably alert but looks physically unwell and you think his condition has deteriorated although there does not appear to be a need for urgent care.

The ward team use the NEWS2 tool to monitor Mike's condition because they are concerned about potential deterioration, including the issue of pressure sores.

You find the following areas of concern in your review:

- the nurse looking after Mike has not calculated his NEWS2 score for the 16 June to 18 June 2020 (item B)
- whilst reading Mike's care plan and activities risk assessment, you note he sometimes complains of pain when moving around (item A)
- Mike has not been referred to a pain specialist because he becomes agitated when nurses ask him questions about it
- you decide from your observations that Mike is experiencing pain that he does not want to talk about

Task

Calculate Mike's NEWS2 score. Explain your answer and decide whether or not you would escalate his care. Make recommendations based on the case study and what you know about best practice. You should think about what can influence a NEWS2 score and pain management and the consequences of not acting on changes.

Student evidence

The total NEWS2 score on 16 April 2020 is 9. The total NEWS2 score on 17 April 2020 is 12. The total NEWS2 score on 18 April 2020 is 7.

The NEWS2 score is to detect acute illness severity by calculating total scores from the vital signs of respirations, pulse oximetry, blood pressure, pulse, conscious level and body temperature.

NICE and the RCP set a NEWS2 score of 7 for urgent escalation. As Mike's scores are above this, I would escalate his care immediately to the critical care outreach team.

Missed opportunities for care interventions means that Mike's condition way be worse than expected and a consultant should be involved in his care. There is evidence of his respiratory rate being above the normal levels and this could be a sign of a lung or cardiac condition, which could put Mike at risk of cardiac or respiratory arrest.

Mike's oxygen saturation has also decreased and with the raised respiratory rate it shows that Mike has to breathe more rapidly in order to have sufficient oxygenation to his blood supply and body.

His body temperature is low which suggests he is struggling to keep warm. This can be associated with his frailty, malnutrition or can be an early warning sign of sepsis when taken in conjunction with other physiological indicators, such as increased respiratory rate.

Mike's systolic blood pressure has dropped to dangerously low levels.Low blood pressure can also be an indicator of sepsis or some other type of shock, (for example, hypovolaemic shock) as a result of internal bleeding.

Mike's pulse is raised which shows that his heart has to work harder to pump oxygenated blood around his body. This could be for several reasons, possibly linked to the respiratory levels but also maybe because he is experiencing pain on movement. He could be anxious about the pain, including thinking about the causes or what the implications of pain are for him (for example, how it influences his independence).

Although Mike was not confused on 18 April 2020, he has been on the previous 2 days. Acute confusion can be a sign that the individual is developing an acute illness. In Mike's case there is information that he experienced an episode of confusion before admission and today he is not confused. This change from being alert and then confused should be investigated by a doctor.

Mike has been in hospital for 10 months and because there has been no escalation of his vital sign anomalies it means that we cannot confidently assume that there have not been other absences of information sharing (for example, a fall that could explain pain) and that would need investigating for potential traumatic injury.

It is not clear where Mike is experiencing pain. The nature of the pain, the site, duration, when it occurs, what triggers it and what reduces it, is essential. This can be monitored using a pain assessment tool. Mike should be assessed by a doctor or pain specialist to investigate the potential causes of his pain.

The staff nurse should report the missing NEWS2 score calculations to the nurse in charge or ward manager who will act based on local policy. This will likely include an incident report and investigation. From the information given this does not seem like a safeguarding incident but the senior nurse may choose to consider it as such.

Mike should be kept informed of his condition and the reason for escalation. The nurse in charge should follow local protocol in relation to the duty of candour and explain to Mike what has happened.

Task 2: goals/patient outcomes/planned outcomes

Scenario

As part of your care documentation review, the ward manager asks you to read Mike's care plan and identify opportunities to improve his wellbeing and general happiness as an inpatient.

Mike's nursing care plan and the Roper-Logan-Tierney's model of nursing (item D) includes 11 key activities of daily living (ADL). This model is often used to ensure care planning is evidence-based and is in the patient's best interest. The ward uses the blue sheet documentation for patient goals to help staff understand what patients want from their care (item F).

The ward manager has asked you to work with Mike to ensure he achieves his ADL. Refer to the guidance in the Roper-Logan-Tierney model of nursing and the information provided in Mike's care plan.

Task

Complete the blue sheet documentation part II discussion content and the symptom management section of part III for patient goals (item F). You can use information from Mike's care plan to complete the form. You should record the information on a word processor with the sections clearly labelled.

Using your understanding of patient goals and the ADLs, recommend a course of action to support Mike to achieve good outcomes. Refer explicitly to ADLs relevant to Mike and justify your answer by considering the information in the care plan and your completion of the blue sheet.

Student evidence

Blue form for patient Mike (surname not supplied)

Discussion participants:

- Mike
- his son (name not supplied)

Family/social networks include:

- lives alone independently and wishes to remain doing so
- support networks include friends who he meets at the pub to do a quiz with several times a week

SDM and POA

There is no current substitute decision maker as Mike does not lack capacity, but a discussion should be had for him to make decisions around lasting power of attorney and substitute decision making while he has capacity in order to validate his decisions should he lack capacity in the future. This is not necessarily a goal that Mike currently has but good nursing requires discussion so that his future goals can be met in accordance with his preferences.

Medical/nursing team

Ward C at Newtown Hospital (ward sister)

Allied health professionals

- physiotherapist and awaiting psychology assessment
- pain assessment specialist referral
- activities volunteer

Part II discussion content

Patients understanding of his medical condition and values, priorities, and expectations.

Osteoarthritis and muscle wasting – his goal is to undertake intensive physiotherapy in order that he can resume living at home because he wishes to resume former social contacts and activities, including a daily walk and attending the pub quiz. Mike knows his son and others are concerned that he is frail and at risk of falling but he is very against supported living arrangements at this time, but it is not clear why he feels this way. He expects to be discharged back home when his rehabilitation is completed.

Part III discussion outcomes

Symptom management – the nurse suspects that there is an underlying pain that is not being managed and should sensitively explore the nature of the pain and the reasons why Mike is reluctant to discuss it. It may help to start by asking about the relationship between pain and achieving his goals and the extent to which pain may be influencing the frustration he experiences when trying to walk. It may be that stress is also influencing the pain he experiences when walking.

Task 3: care/treatment/support plan

Scenario

You are asked to take part in daily shift handovers with your mentor and the nursing team.

During a handover, your mentor is told about a patient, Anita, who has a grade 3 pressure ulcer on their left heel. A nurse discovered this during the night. Item E includes a photograph of the pressure ulcer and a skin physiology diagram.

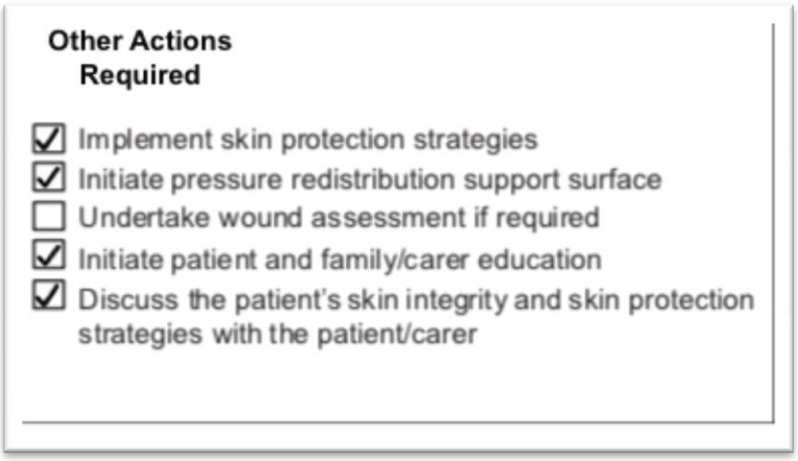
The hospital uses the healthy skin project care plan guidance to support good skin health and prevent pressure ulcers amongst inpatients. Staff complete a wound assessment chart when they find evidence of a breakdown in skin integrity.

Task

You assist the staff nurse in the completion of the wound assessment chart (item G). Complete the 'other actions required' section by marking the actions you believe should be taken next.

Using the appropriate healthy skin project care plan guidance (item C) and your selections in the wound assessment chart, briefly evaluate the effectiveness of different options to prevent further pressure ulcers in this patient. In your answer, consider the possible causes of the pressure ulcer and its grade.

Student evidence



The student completes the Other Actions Required section as follows:

The grade of the pressure ulcer is 3. A grade 3 pressure ulcer is unlikely to have formed overnight without some evidence of being in other stages of 1 and 2 undetected because her skin has not been assessed. This means it is a safeguarding issue due to neglect. Anita should have been assessed using a standard document, such as Waterlow score, and the outcome of this would have identified her as high risk. This means that she should have had interventions in place to prevent her skin integrity breaking down, for example, a pressure relieving mattress. We do not have this score, but if we did, we would know what the contributing factors are to the pressure ulcer formation in Anita's case.

If we find out if Anita has diabetes, we will know if this impacted on her risk of getting a pressure ulcer and her ability to heal because diabetes effects the circulation and the nervous system in the long term.

Her nutritional status is important because if someone has poor nutrition the skin cells in the tissues of the epidermis, dermis and subcutaneous layer will not get enough nutrients to maintain skin integrity which puts her at risk of more pressure sores. It also means that the sore she has will be difficult to heal, and she may need nutritional supplements if she is not getting the right balance of macro and micro-nutrients.

Any medication will be important because all medicines have side effects and those that do have high scores on the Waterlow assessment, for example, cytotoxic drugs and steroids.

Referral to safeguarding is necessary because it will prompt an investigation and determine the reasons why this pressure ulcer was not detected at an earlier stage and therefore prevented. This is important because if it is something that the organisation or the individuals within it are responsible for, it could prevent it from happening again if it is investigated fully and actions are taken.

Knowing which allergies Anita has will be important for deciding the treatment for a grade 3 pressure ulcer. The wound has moderate exudate and is smelling and has slough, so a wound dressing may have compounds that the person is allergic to and it may be necessary to give antibiotics. However, if Anita was allergic to the antibiotics, she would be at risk of a reaction such as anaphylaxis, which is life threatening.

We also need to know how well she is mobilising because if she cannot move herself, she will need to be supported to move and the surface that she sits or lies upon may need to be specialist for pressure ulcer prevention, such as an airflow mattress or roho cushion.

Task 4: evaluation/monitoring effectiveness/clinical effectiveness

Scenario

Informal care givers play a key role in ensuring people with care needs achieve their long-term care and treatment goals. These can often be different to the goals or milestones prioritised by the clinical team.

Mike is increasingly frustrated with his inpatient spell and has become more positive about the MDT plan to find him a community supported living facility. He has given this a lot of thought and thinks he can be happy and safe there. He has told staff that 2 of his friends will help to look after him. The ward manager needs to complete a full assessment of needs to be able to decide if this would be a safe course of action.

Task

Complete the discharge plan (item H) to indicate what will be needed for Mike to leave the hospital safely and what he will need in the community.

Consider the information in Mike's multidisciplinary care plan. Evaluate the effectiveness of informal support that caregivers in the community would be able to give. In your answer you should make a recommendation about his request for discharge.

Student evidence

See attached discharge form.

Recommendations about Mike's request for discharge

Mike got frustrated with waiting for formal support to go home and it sounds as though he has given up waiting and feels he has no choice but to accept assisted living arrangements if he wants to get out of hospital. This is not really supporting his rights to make his own choices and he may feel he has not been supported to achieve his goals even though he has done what was asked of him by doing the rehabilitation.

He will need a social worker to support his discharge even into an assisted living facility.

The hospital will need to let his GP, a pharmacy and his family know about his plans for discharge and there may be other equipment or resources he needs and may require an occupational therapist for this.

He may need some social prescribing for activities in the community but also, he needs to go and view any options for supported living facilities so that he chooses a place that meets his needs and preferences.

Evaluation of effectiveness of informal support

Informal support is different to formal support because there is no need to be trained and they are not accountable for their actions or inactions.

Informal support can be good at supporting the work of professionals and lots of people rely on informal support to meet most of their needs.

They can provide companionship; they can spot changes and alert authorities to any concerns. Provide social support, emotional wellbeing, and friendship.

They can help improve mood and motivation and encourage participation in preferred activities

They can help maintain the persons usual preferences and standards, for example, clothing, hygiene, housekeeping.

They can remind Mike to do things like pay bills, take medicines or go shopping. They can help to advocate for Mike's best interests.

They do not have the same duty of care as formal carers, so there can be risk with things, such as safeguarding from abuse, data protection, optimising care and treatment depending on the knowledge, circumstances and involvement levels of informal carers.

It can mean that the individual feels obligated to them or the informal carer can be put under pressure and stress.

They may not have knowledge about what is in Mike's best interest.

Informal care can be really valuable to helping people be independent, but it is not fair on them or the people they care for if this is not supported because there is a risk of harm to both parties.

On the whole, a combination of formal and informal care will work best, especially initially, as Mike has to adapt to new circumstances and has been away from home for a very long time and might have forgotten how to do many tasks. This will also reassure Mike's family who have said they are not available to provide care. It will also provide better continuity for Mike's wellbeing because they know him better than formal carers.

Examiner commentary

Links between person-centred care and maintaining safety meaningfully contributed to patient outcomes throughout each scenario. The student proficiently explained the principles of such areas of work in areas relevant to adult nursing and adapted these to individuals. The student had very good awareness of codes of conduct, duties of care and the duty of candour in the scenarios that require safeguarding acumen and an understanding of safeguarding risks that is individualised, empathetic and evidence based. The student applied a very good understanding of resources and equipment required to work in safeguarding scenarios safely and appropriately.

The student understood their scope of practice and confidently identified strengths, weaknesses and opportunities for learning in the context of their own experience and in application with specific scenarios. The student understood the markers of clinical deterioration, including actions they could take to reduce risk and the documentation needed, with named examples of policies and care pathways.

The student accurately and effectively reviewed documentation to make recommendations that positively influenced patient care and outcomes, with a clear evidence base. Their recommended support was well justified with relevant evidence and in line with named guidance. They identified the fluid nature of recommendations and applied these as a tool to continuously review and monitor patient progression as part of a broader nursing team.

They communicated relevant knowledge of the scope and limitations of their healthcare role. They clearly understood the purpose of gathering information and maintaining records in line with legislation and maintaining individuals' rights within broader data management contexts, including named legislation.

The student communicated reliable information on physiological states because of their very good understanding of the correct use of equipment to monitor and calculate scores and differentiate and escalate results appropriately under supervision and guidance.

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, the threshold competence requirements of the role and have been validated with employers within the sector to describe achievement appropriate to the role.

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, by 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 the 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, 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 individual's 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 correct monitoring processes o calculating scores, reporting and differentiation of normal and abnormal results to the relevant

Grade	Demonstration of attainment
	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, 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 needs to a satisfactory standard, including maintaining individual's 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 an individual's rights ○ maintaining a record of professional development to develop knowledge, skills, values and behaviours consistent with the 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

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	Published final version.		June 2021
v1.1	NCFE rebrand		September 2021