Creation and Development of Staff Competencies for the Acute Care Setting

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Objectives:

- Define clinical competence and identify benefits of assessing competence
- Identify areas of practice that can be assessed for clinical competence
- List potential criteria for clinical validators
- Establish systems for monitoring continued competence
- Review clinical competency examples
Henry Ford Health System

- 4 Acute Care Hospitals
  - Henry Ford Hospital Detroit: 877 beds
  - Henry Ford Wyandotte: 401 beds
  - Henry Ford Macomb: 353 beds
  - Henry Ford West Bloomfield: 191 beds
- 3 Inpatient Rehab Units
- 2 Psychiatric Hospitals
- 25 Outpatient Rehab Clinics

Henry Ford Hospital

- 877-bed tertiary care hospital, education and research complex
- 130 ICU beds
- Recognized for clinical excellence and innovation in the fields of cardiology and cardiovascular surgery, neurology and neurosurgery, orthopaedics and sports medicine, organ transplants, and treatment for prostate, breast, and lung cancers.
- Level I trauma center
HFH Rehab Department

- 17+ PT FTEs
- 15+ OT FTEs
- 47 total clinicians
- Active student program, >30 yearly
- The community hospitals include an additional 50+ clinicians and students

Introduction

- Review of acute care environment
- Complexity/novelty of patient cases
- Minimum standard of care and knowledge.
- Delivery of safe and effective physical therapy services.
- Higher sense of confidence in clinicians
Introduction

- How do you know when your patient is appropriate to see?
- Without competencies:
  - Therapists may rely solely on nursing report or physician order to determine appropriateness for skilled therapy
  - Therapists may not feel comfortable progressing patients
  - Possibly unsafe interventions or overconfidence

What is clinical competence?

- Entry level skill set
- Areas of focus available in acute care
- Discrepancies
What are the benefits of establishing a competency program?

- **Benefits for the clinician**
  - Increased confidence
  - Improved skill set
  - Provides mentorship
  - Possibility for assist in licensure renewal

- **Benefits for the facility**
  - Confidence in clinician skill set/work force
  - Establishes site as seeking excellence
  - Meets accreditation requirements

What are the benefits of establishing a competency program?

- **Benefits for the validator**
  - Reinforces pride in system
  - Refreshes knowledge

- **Benefits for patients**
  - Improved confidence in clinicians and facility
  - Patients receive a standard level of care

- **Enforced levels of precautions and safety**
Creating Competencies

Plan: Identify areas of practice

- Definable scope
- Contains objective components
- Applicable to high and low incidence
- Examples:
  - Clinical competence (general)
  - Lab values
  - ICU
  - Stroke
  - AFMS (Acute Functional Measure Scale)
  - Neonatal ICU
  - Cardiac rehab, VAD
  - High Risk Pregnancy
Plan: Identifying knowledge to be included

- Incorporate inter-professional recommendations and knowledge
  - Physicians, surgeons, PTs (APTA), OTs, anesthesiologists, etc
- Involvement of highly experienced clinicians
- Knowledge that relates specifically to population
- Evaluating and including evidence-based research
- Topics that can impact or be impacted by therapy intervention

Plan: Identify test material

[Diagram showing Bloom's Taxonomy]

- Remembering: Recalling relevant knowledge from long-term memory
- Understanding: Making sense of what you have learnt
- Applying: Use the knowledge gained in new ways
- Analysing: Breaking the concept into parts and understand how each part is related to one another
- Evaluating: Making judgements based on a set of guidelines
- Creating: Putting information together in an innovative way

http://juletosar.edublogs.org/files/2011/05/bloom-taxonomy-1k4es.jpg
Plan: Writing Test Questions

- Recognition:
  - Multiple choice, matching
  - Define/describe

- Comprehension/Understanding:
  - Multiple choice (advanced), short answer
  - Explain, provide example, predict

Plan: Writing Test Questions

- Application:
  - Requires learner to use >1 steps to arrive at answer.
  - Apply, prepare, demonstrate, modify information or idea
  - Short answer, multiple choice, T/F with modification, paper patients, oral quizzes, practical check offs
Plan: Writing Test Questions

- **Analysis:**
  - Discussion of topics, ideas
  - Breakdown into components
  - Compare & contrast

- **Evaluation:**
  - Judgment of an idea or situation
  - Story problems, paper patients, simulation, real patients

Plan: Selection of validators

- Experience in population
  - Minimum number of hours
- Experience with mentoring, education
- Familiarity with competency program
- Willingness
- Availability to the mentee
- Not exempt from re-validation
- Consider limiting number of validators to increase consistency and validity
Plan: Training validators

- Expectations of validator and mentee
- Familiarize with materials for competency
- Coaching and providing appropriate feedback to mentee
- Regular validator forums via email and regular meetings usually twice a year or PRN
- Mentee feedback for Validator/Mentor

Do: Mentee feedback for Mentor

<table>
<thead>
<tr>
<th>PART I</th>
<th>Always (A)</th>
<th>Frequently (F)</th>
<th>Infrequently (I)</th>
<th>Rarely (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My mentor/mentee:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Communicated with me in a respectful, positive manner.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>2. Provided me with opportunities to get feedback from them.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>3. Kept to agreed upon timelines.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>4. Accepted constructive feedback and advice openly and easily.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>5. Followed through with plans and maintained focus on their goals.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>6. Maintained a positive attitude throughout the entire mentoring process.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>7. Was organized and prepared for arranged opportunities.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>8. Listened attentively to my suggestions and utilized them as able.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>9. Was able to see how their growth in specific areas would be a positive for the department.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>10. Demonstrated initiative and a desire to meet their goals.</td>
<td>A</td>
<td>F</td>
<td>I</td>
<td>R</td>
</tr>
</tbody>
</table>

PART II:
Mentor's/Mentee's strengths.
Implementing Competencies

1. Plan
   - Identify the problem and develop the plan for improvement.

2. Do
   - Implement the plan on a test basis.

3. Study/Check
   - Assess the plan; is it working?

4. Act
   - Institutionalize improvement; continue the cycle.

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Do: Delivery of knowledge

- Expectations and check list
- Provide time line and schedule formal mentoring times.
- Written materials provided in advance
- Review of research: Provide resources
Do: Utilize Mentoring Program

- HFHS Mentoring Program provides structured mentoring on clinical or leadership topics in general
- Provides Structured time frames
- Program and Mentee feedback forms

Do: Use of Simulation Lab

- For demonstration and practice
- SimMan®: a fully computer operated total body simulator.
Do: Delivery of knowledge

- Observation of experienced clinicians
- Group education; inservices; journal review
- Journaling/Self assessment

Do: Assessing Competence

- Written exam
  - Review and discuss incorrect answers
- Oral quiz
- Practical check off
  - OSCE model based on objective data rather than subjective
Do: Remediation

- Have re-tests available that have different questions
- Consider clinician's learning style
- Consider mentor's teaching style

Check

1. Plan
   Identify the problem and develop the plan for improvement.

2. Do
   Implement the plan on a test basis.

3. Study/Check
   Assess the plan, is it working?

4. Act
   Institutionalize improvement, continue the cycle.
Check: Monitoring ongoing competence

- Determine re-competency cycle
  - ie: annually, every 2 years
- Consider minimum level of continued involvement in population
- Re-competency exam that is different from initial exam

Act: Process Improvement

1. Plan
   - Identify the problem and develop the plan for improvement.
2. Do
   - Implement the plan on a test basis.
3. Study/Check
   - Assess the plan, is it working?
4. Act
   - Institutionalize improvement, continue the cycle.
Act: Process Improvement

- Review / Revise every 2-3 years or sooner if a clinical question or problem arises
  - Maintain dialogue with experts
  - Reevaluate evidence-based research
- Add additional competencies as necessary

Program Evaluation

- Mentee provides feedback for competency
  - Did this program offer you the opportunity to grow professionally?
  - Did you feel your mentor had the necessary knowledge, resources, experience, etc to help you meet your goals?
- Suggestions for improvement
Clinical Competency Examples

Competency Development Timeline
- First competencies in the mid 1990's
- Estimated man hours for creation of a new competency may be up to 100 or more hours over multiple weeks.
- Recent HFH Revision estimates: ICU: 20 hours over 8 weeks (3 clinicians); Lab Values: 100 hours over course of 6 months for team of 5 therapists
HFHS Competency Table

<table>
<thead>
<tr>
<th>Competency</th>
<th>Cycle</th>
<th>Brief description</th>
<th>Validators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Competency</td>
<td>Once</td>
<td>Mandatory for all employees effective August 2011, practical check off</td>
<td>Supervisors, identified mentor, or supervisor</td>
</tr>
<tr>
<td>Lab Values/Vital Signs guidelines</td>
<td>Q 2 years</td>
<td>Mandatory for all employees within first 30 days, written test</td>
<td>Lab values, Supervisors</td>
</tr>
<tr>
<td>JC Accredited Stroke Unit</td>
<td>Q 2 years</td>
<td>Completed within 6 months of employment, written and practical check off</td>
<td>1. Permanent Neurorehab Team Member for one year, 2. Minimum of 100 hours of Stroke Unit experience, 3. Must have taken at least 1 Stroke Rehab related CE course in the last 3 years</td>
</tr>
<tr>
<td>Spinaling</td>
<td>Q 2 years</td>
<td>Mandatory for OTs only, started after first 90 days, written and practical check off</td>
<td>Practical: Paula Kant OTR/L</td>
</tr>
<tr>
<td>High Risk Pregnancy</td>
<td>Q 2 years</td>
<td>Mandatory for permanent med surg therapists only (written component); practical component completed by select # of therapists at a time due to low consults from this patient population</td>
<td>Jenny Zhang, PT, Adele Myszenski, PT</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Once</td>
<td>Completed during Medicine/Surgery rotation. Includes observation and check off</td>
<td>Barbara Michon, PT</td>
</tr>
<tr>
<td>ICU (vented and non-vented)</td>
<td>Q 2 years</td>
<td>Non-Vented: Eligible to train after 1 year of employment with HFH or 6 months if employee has previous acute care experience. Vented: Eligible after approximately 6 months of non-vented experience. Oral, written and practical check off</td>
<td>Jacqueline Scully, PT, Adele Myszenski, PT, Kristy Stain, PT, Jenny Tempa, PT, Dharmin Singh, PT, Kara Luplow, OTR/L, Paula Kawa, OTR/L, Danielle Leoppi, OTR/L</td>
</tr>
<tr>
<td>LVAD</td>
<td>Q year</td>
<td>Joint Commission requirement for therapists working with LVAD patients.</td>
<td>Barbara Michon, FT, Heather Boyd, FTA, Daniella Lupida, OTR/L</td>
</tr>
</tbody>
</table>

New Employee Timeline

- Initial Orientation 2-3 weeks
- Within 30 days: Lab Values, Vital Signs, AFMS, Clinical Competency
- Within 180 days: Stroke unit competency
- Clinical Rotations: Ortho, Neuro, Med/Surg
  - 3 months each with orientation provided
  - Specialty competencies PRN
- > 1 year: ICU Non-Vented
- > 6-12 months after Non-vent: Vented
Clinical Competency
New Employee

Name: ____________________________

REHABILITATION THERAPY SERVICES
CLINICAL COMPETENCY EVALUATION GUIDE:

COMPETENCY STATEMENT: Occupational and physical therapists who work with acute care patients will demonstrate the understanding and deliver effective and safe treatment of these patients to enhance mobility, functional outcomes and overall recovery.

CRITICAL BEHAVIORS: Key: ✓ = Satisfactory, X = Unsatisfactory
2 sessions: Evaluation of treatment(s) completed with satisfactory behavior demonstrated before independent patient intervention.

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### Evaluation

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Session 2</th>
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</thead>
<tbody>
<tr>
<td>Gathers pertinent data from available sources (medical record, patient/family, other health care professionals) to include diagnoses, PM/Ex Hx, restrictions/precautions and appropriate vital signs as needed.</td>
<td></td>
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<tr>
<td>Examines patient’s cognitive/psychological ability to participate in treatment.</td>
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<tr>
<td>Appropriately completes subjective/objective components of assessment.</td>
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<tr>
<td>Prepares the patient for maximum participation through verbal education about the role of therapy/purpose of intervention.</td>
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</table>

### Implementation

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<tbody>
<tr>
<td>Arranges equipment appropriately to ensure intact state with movement and transfers.</td>
</tr>
<tr>
<td>Provides a safe and energy efficient set up for the treatment, minimizing re-work or excess expenditure.</td>
</tr>
<tr>
<td>Monitors the patient’s vital signs and/or tolerance to intervention throughout the treatment session and can explain why changes are occurring if indicated.</td>
</tr>
<tr>
<td>Performs mobility and transfer techniques independently; keeps all lines arranged to allow for greatest patient participation; asks for assistance as needed.</td>
</tr>
<tr>
<td>Leaves the patient in a safe, comfortable position with appropriate supports, restraints and with call bell in reach (as appropriate).</td>
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### Standards of Excellence

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<tr>
<td>Adheres to HFHE Standards of Excellence throughout the patient interaction (e.g. utilizes AIDET)</td>
</tr>
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</table>

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Lab Values

- Referenced evidence-based literature prior to APTA development
- Periodic Review of new literature and APTA guidelines
- Internal input from expert HFHS physicians
- Review Lab Values Manual

"It is important to understand that this manual is a source of guidance and that some patients may have test results that fall outside of the "normal" parameters for any given lab value. As such, some patients may continue to receive therapeutic interventions from rehab therapy staff.

It is expected that the treating therapist will utilize this manual in addition to critical reasoning, discussions with physicians and written clarification in the patient's chart in order to begin or continue interventions on patients whose lab values are outside of normal ranges. In addition, all therapists are expected to follow guidelines for vital signs when providing care to patients."

Lab Values
Lab Values

HEMOGLOBIN

Hemoglobin is the red, iron-based pigment in the blood that carries oxygen. Hemoglobin levels may be low if a patient is:
- anemic
- iron deficient
- after surgery or after trauma

Low hemoglobin levels may cause:
- decreased exercise tolerance
- increased fatigue
- tachycardia

When the blood has low oxygen-carrying capacity, there are limited levels of oxygen available to the tissues.

To get oxygen to the tissues, heart rate and cardiac output will increase, thus causing increased work on the myocardium.

This is why it is important to monitor the vitals and record objective symptoms of a patient with hemoglobin levels between 7.1 and 7.9 before, during, and after treatment.

Refer to hemoglobin policy for specifics.

NORMAL RANGES: 12 – 16 g/dl for women
13.5 – 17 g/dl for men

Values differ in men and women due to body size and muscle mass.

Lab Values

Patients with hemoglobin levels of 8.0 or above will receive routine Occupational and Physical Therapy that day.

Patients with hemoglobin levels 7.0 and below will receive no Occupational or Physical Therapy that day.

The following guidelines will be observed for patients with hemoglobin levels 7.1 – 7.9:

- Activity orders must be clarified with the patient’s primary physician prior to treatment.
- The patient’s heart rate and blood pressure must be monitored pre-, mid-, and post-treatment.
- Oxygen saturation levels must be ≥90% prior to treatment.
- Treatment will be terminated if any of the following symptoms are observed:
  - Numbness or tingling in any body part
  - Dizziness not resolved within 30 seconds of obtaining upright
  - Nausea
  - Blurred vision
  - Dilated pupils
  - Increase in patient’s heart rate of >30 bpm over baseline
  - A change in the patient’s systolic blood pressure of 30 mmHg or a change in diastolic blood pressure of 10 mmHg
  - Anginal pain
  - Shortness of breath
### Lab Values

<table>
<thead>
<tr>
<th>Lab Test</th>
<th>Normals</th>
<th>Cause of Increase</th>
<th>Cause of Decrease</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin Hgb</td>
<td>Men 13.5-17</td>
<td>Exercise tolerance</td>
<td>Exercise insufficiency</td>
<td>&lt;8 follow guidelines</td>
</tr>
<tr>
<td></td>
<td>Women 12-16</td>
<td></td>
<td></td>
<td>7 or less no tx.</td>
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<tr>
<td>Dehydration</td>
<td></td>
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<tr>
<td>Polycythemia</td>
<td></td>
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<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Trauma</td>
<td></td>
<td></td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron insufficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>3.5-3.6 mmol/L</td>
<td></td>
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<td></td>
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<tr>
<td>PI</td>
<td>(18-33)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td>1.5-17.5 mg/dL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thromboplastin PTT</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>20-60 sec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4-10 meq)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INR</td>
<td>0.9-1.5</td>
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</tbody>
</table>

### Lab Values Test

9. Per Vital Signs Guidelines, what are considered to be the normal/treatable ranges at rest? **Circle the correct answer:** (4 pts)

   a) Heart Rate: 60-100 bpm  50-120 bpm  40-110 bpm
   b) Systolic BP: 80-180 mmHg  90-140 mmHg  60-120 mmHg
   c) Diastolic BP: 60-120 mmHg  80-180 mmHg  40-110 mmHg
   d) SaO2: 94-100%  90-100%  80-100%

4. A patient receiving a blood transfusion can be mobilized as soon as the blood has been started. (2 pts)
   **TRUE _____  FALSE _____**  (**_______**)
Lab Values Test

Mr. X comes into the hospital after being involved in an MVA. He has a large, infected wound on his left leg, which is being treated with IV antibiotics. He also has a broken left femur. He has been in the ICU for 3 days and PT and OT services have been requested to mobilize him out of bed and begin working on gait and ADL’s.

His lab values are as follows:
- a) Hemoglobin = 8.4
- b) WBC count = 12,000
- c) PTT = 30
- d) CPK = 340 (CPK-MB is less than 5% of total CPK)

12. What issues might the therapist have to deal with when treating this patient because of his Hemoglobin level? (Please list 3 examples) (3 pts)

13. Why might his WBC count be elevated? (1 pt)

14. What is the normal range for this patient for PTT levels? (1 pt)

15. Why might this patient’s CPK be elevated? (1 pt)

ICU Competency

- Mentoring process
  - Demonstration in SIM Lab
  - Comprehensive ICU Manual
  - Evidenced based literature review
  - Observation hours with validator
  - Practice with validator present
ICU Competency - manual

- Identifying equipment in the ICU
  - Specialty beds
  - Drains
  - Possible locations of invasive lines
  - Relevance of lines
  - Placement, use, and normal readings of telemetry
  - Vented competency: ventilator settings, vent weaning

ICU Competency – Completion Check List

A. ___ Six hours of observation and education (material in log attached)

B. Required Reading:
   1. “Identifying Equipment in the Intensive Care Unit”
   2. “Mobility in the Critical Care Unit: Pain, Pathophysiology, and Treatment”
   3. “Managing the Critical Care Patient”
   4. “Providing Occupational Therapy in an Intensive Care Unit”
   5. “Managing the Patient on Mechanical Ventilation in ICU: Early Mobility and Weaning Program”

C. Observation Check List:
   - Telemetry Unit
   - Ventilator
   - Cannulae
   - Arterial Line
   - Central Line
   - NPO
   - Foley
   - Ventilator (Vent Competency)

D. Two sessions of the following observed and checked off by the subscriber:
   - General Evaluation
   - Exercise Treatment
   - Transfers with Non-ventilated Patient
   - Transfers with Ventilated Patient (left, right, and both)
   - Appropriate care written in all intervention sessions

E. Competency Check Off
   - Oral Quiz
   - Written Quiz
   - Transfers with Non-ventilated patient
   - Ventilated lift and pivot
ICU Competency – Oral Exam

Indicate the arterial line on the patient. Where else could the arterial line be located? What does the arterial line measure?

Who is working harder? Patient A on CMV or Patient B on CPAP?

Mrs. Brown has an arterial line in her left arm, a central line on her right side, and the telemetry attached to the monitor on her right. The patient is weaker on their left side. Which side of the bed would you transfer the patient to and why? Where would you position their lines?

ICU Competency – Written Exam

Give 2 examples when a high pressure alarm may sound.

What does CMV stand for?

If a patient had been on CPAP all day and they had just been put back onto AC with a PEEP of 8 and PSV of 6, give 1 reason why you could work with this patient at this time and give 1 reason why you might want to defer your treatment at this time.
ICU Competency - Practical

REFERENCES:


Questions?

Discussion

Contact Information

- Adele Myszsenski, PT
  - amyszen1@hfhs.org
- Krissy Stein, PT
  - kstein1@hfhs.org
- Jenny Trimpe, PT
  - jtrimpe1@hfhs.org
Additional Examples

Acute Care Functional Measures Scale

- Developed to ensure consistent scoring of functional mobility
Vitals Signs

Name ___________________ Date ___________ Time ______

All ReStaff Services staff must be able to demonstrate the proper technique and accuracy in taking a blood pressure and pulse rate.

**Critical Behaviors:** (Must achieve 100% to pass these critical behaviors)

**Blood Pressure:**
1. Blood pressure cuff is placed above the antecubital fossa. YES NO
2. The brachial artery is palpated. YES NO
3. The systolic blood pressure is auscultated properly. YES NO
4. The diastolic blood pressure is auscultated properly. YES NO

**Pulse Rate:**
1. The radial pulse is palpated. YES NO
2. The pulse rate is counted correctly. YES NO

**Oral Questions:** (Must achieve 80% to pass, each question worth 1 point)
1. When would you choose to take a manual BP rather than an electronic BP?
   - [ ] If the cuff is too small
   - [ ] If the BP register is inaccurate higher or lower

3. Describe where you will place the patient arm when taking blood pressure.

4. What instruction would you give to a patient when taking a blood pressure using an electronic cuff?
   - [ ] How long should you wait before re-inflating the cuff between pressures?

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VAD Initial

**OBSERVE** two VAD session in ICU with a Trainer (Eval, or Treatment) (ideally, different patient if possible)

<table>
<thead>
<tr>
<th>#1</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>#2</td>
<td>Date</td>
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</tbody>
</table>

**OBSERVE** two VAD sessions on ICU with a trainer (likely treatments) (ideally, different patient if possible)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>#2</td>
<td>Date</td>
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</table>

**CHECK OFF** session with Simulator – One Hour Session – See Check sheet

**CHECK OFF** on floor: Trainee performs two VAD sessions with instructor shadowing (ideally, different patient if possible)

<table>
<thead>
<tr>
<th>#1</th>
<th>Date</th>
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<tr>
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<td>Date</td>
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</table>

Includes applying stabilization device (LVAD Binder or Abdominal Binder) or ensure it is in place prior to mobilization, managing VAD lines: OT, don’t lift binder and holster for batteries.
# VAD Annual

<table>
<thead>
<tr>
<th>Skill</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of Annual VAD Update Information</td>
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</tbody>
</table>

**HeartMate II**
- Review new HM II Pocket System controller
- Change from battery-powered to power base unit operation
- Change from power base unit to battery-powered operation
- Demonstrate securement and release of Paralock
- Identify what to do if a patient has a red heart alarm

**HeartWare**
- Change from AC/DC to battery-powered operation

**General Points of Care**
- Take a Doppler blood pressure reading (HMI)
- Determines BSA and appropriate flow rate for therapeutic intervention for patient

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*For other devices, VAD Coordinator must be contacted and training will occur on a case to case basis.*