The purpose of this form is to assess worker competency in providing high-intensity support, in line with the **NDIS Practice Standards: High Intensity Supports Skill Descriptors**. Competency will be reviewed on an annual basis to ensure that workers maintain the necessary skills and knowledge to meet these standards.

Workers are required to complete training tailored to the specific needs of the participants they support and must demonstrate proficiency in the high-intensity skill descriptors.

In addition to the annual review, a competency reassessment may be conducted whenever there is a change in the participant’s support plan to ensure the worker’s skills are aligned with any new or updated requirements. The Training Officer will track and monitor the worker’s annual review date via the **Sentrient Workflow** system.

**Support Worker Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Review**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **High Intensity Participant Name(s) currently being supported by the worker** | **Supports Provided by worker to the participant** | |
|  | **Bowel Care** | **Catheter Care** |
|  |  |  |
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### **Section 1: General Knowledge- Bowel Care**

**To be completed by the Support Worker.**

**Please indicate your competency by ticking the appropriate option:**

* **Yes** – As the Support Worker I demonstrates understanding and competency in this area with confidence.
* **No** – As the Support Worker I do not demonstrate understanding and competency in this area.
* **N/A** – I do not provide Bowel Care Support.

|  |  |  |  |
| --- | --- | --- | --- |
| **I UNDERTSAND:** the basic anatomy of the digestive system, importance of regular bowel care and understanding of stool characteristics indicating healthy bowel functioning | **Yes** | **No** | **N/A** |
| **I UNDERSTAND:** basic conditions including autonomic dysreflexia; symptoms/indications of need for intervention and when to refer to health practitioner e.g. overflow, impaction, perforation; infection, understanding of intervention options and techniques including |  |  |  |
| **I UNDERSTAND:** how to administer laxatives, enemas or suppositories according to procedure and identify when to seek health practitioner advice. |  |  |  |

**Support Worker Comment: (Optional)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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### **Section 2: General Knowledge- Catheter Care**

**To be completed by the Support Worker**

**Please indicate your knowledge and competency by ticking the appropriate option:**

* **Yes** – As the Support Worker I demonstrates understanding and competency in this area with confidence.
* **No** – As the Support Worker I do not demonstrate understanding and competency in this area.
* **N/A** – I do not provide Catheter Care Support.

|  |  |  |  |
| --- | --- | --- | --- |
| **I UNDERTSAND:** the basic urinary system for males and females; hydration and the different types of catheters; | **Yes** | **No** | **N/A** |
| **I UNDERSTAND:** procedures and challenges in inserting catheters in males and females (intermittent catheters only); common complications associated with using different types of catheters, |  |  |  |
| **I KNOW:** how to identify indicators of complications that require intervention and understanding when to involve a health practitioner. |  |  |  |

**Support Worker Comment: (Optional)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Section 3: Support Worker Acknowledgment**

**To be completed by the Support Worker**

**Please indicate the support worker’s level of understanding for each statement by selecting the appropriate option:**

* **Yes** – as the Support Worker I has a clear understanding and competency in this area.
* **No** – as the Support Worker I do not currently have an understanding or competency in this area.
* **N/A** – This is not applicable to my current responsibilities.

**Please note that the following statements apply equally to both bowel care and catheter support.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Prepare and Deliver for Bowel and Catheter Care** | | | |
| Have you, the worker, had a 3-month break from working with any of the high intensity participants listed above?  (if you answer yes, refresher training will be required for the specific participant) | **Yes** | **No** | **N/A** |
| I KNOW TO: read and understand the participant’s current support plan and procedures before providing supports. |  |  |  |
| I KNOW TO: check with the participant on their expectations, capacity and preferences for being involved in the delivery of support. |  |  |  |
| I KNOW TO: check with the participant on their preferences for communication, including the use of aids, devices and/or methods. |  |  |  |
| I KNOW TO: communicate with the participant using participants preferred manner |  |  |  |
| I KNOW TO: prepare for and follow hygiene and infection control procedures including hand washing, disinfecting the environment and wearing gloves. |  |  |  |
| I KNOW TO: check that the required equipment and consumables are available and ready for use. |  |  |  |
| I KNOW TO: recognise the intensely personal nature of this type of support and make sure the participant is ready to receive support. |  |  |  |
|  |  |  |  |
| **Implement the Support Plan** | | | |
| I KNOW TO: check with the participant for any specific factors or adjustments needed at the time support is provided. | **Yes** | **No** | **N/A** |
| I KNOW TO: Deliver support that meets timing, frequency and type of support required. |  |  |  |
| I KNOW TO: deliver support in ways that are least intrusive or restrictive and that fit into the participant’s daily routines and preferences |  |  |  |
| I KNOW TO: use reference guides such as the Bristol Stool Form Scale to observe and record bowel motions, and identify any changes that require action. This includes the recording of bladder user and hydration where required. |  |  |  |
| I KNOW TO: Check that the participant has no perianal or other skin irritations around the rectum or catheter site. |  |  |  |
| I KNOW TO: recognise and respond/report to blockages and/or dislodged catheters. |  |  |  |
| I KNOW TO: identify and immediately inform the Team Leader who will inform an appropriate health practitioner in response to signs of poor bowel or bladder function or related problems as well as any deterioration of health or infection of the participant. |  |  |  |
| I KNOW TO: work collaboratively with others to ensure continuity and effective delivery of support. |  |  |  |
|  |  |  |  |
| **Stoma Care** | | | |
| *For workers who support participants with a stoma (opening with a collection bag):*  • Support the participant to clean and maintain healthy condition of the stoma site.  • Replace and dispose of ileostomy and colostomy bags as required.  • Monitor and record information required by the support plan such as outputs, hydration, and appearance of the stoma.   * Identify and respond to problems such as blockages and immediately inform Team Leader and an appropriate health practitioner in response to indicators of deteriorating health condition of the participant.   • Actively involve the participant in their support, as outlined in their support plan, and to the extent they choose | **Yes** | **No** | **N/A** |
|  |  |  |  |
| **Review Supports** | | | |
| I KNOW TO: check with the participant to discuss any changes needed to the bowel care support they are receiving. | **Yes** | **No** | **N/A** |
| I KNOW TO: identify, document and report information where a support plan is not meeting a participant’s needs. |  |  |  |
| I KNOW TO: support the participant to provide feedback and request changes to their support plan as required. |  |  |  |

**Employee’s Comments (Optional):**  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Summary and Action Plan**

**To be completed by Manager/ Training Officer**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes /no** | **Required Training** | **When and how will this occur?**  **Eg. Health practitioner, shadow shift, Sentrient E-Learning** |
| Is refresher training required due to a 3 month or more absence from any listed participant? |  |  |  |
| Is any specific training required to address gaps in knowledge and/ or skills? |  |  |  |

**Manager/ Training Officer comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Use:**

* Worker has added time taken to complete this form on Carelink (at home 30 mins, group meeting with team leader 1 hour)
* Return form to training officer who will organise relevant training if required and record completion of CCF-37 and relevant training on Sentrient
* CCF-37 has been filed - workers electronic file and the locked filing cabinet

**Manager/ Team Leader Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Manager/ Team Leader Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next Skills Review Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_