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** |
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### **Section 1: General Knowledge- Severe Dysphagia**

**To be completed by the Support Worker**

**Please indicate you 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 this support.

|  |  |  |  |
| --- | --- | --- | --- |
| **I UNDERTSAND:** the basic anatomy and physiology of the swallowing process  | **Yes** | **No** | **N/A** |
| **I UNDERSTAND:** dysphagia and what causes severe dysphagia  |  |  |  |
| **I UNDERSTAND:** the role and responsibility when it comes to supporting a participant with dysphagia |  |  |  |

**Section 3: Severe Dysphagia Skills Descriptors**

**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 this support.

|  |
| --- |
| **Prepare and Deliver Severe Dysphagia Supports**  |
| 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: understand the current support plan/ mealtime management plan and check the participant’s specific support requirements Eg. food or fluid needs, preparation techniques, safe feeding strategies and feeding equipment. |  |  |  |
| 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 devices and/or methods. |  |  |  |
| I KNOW TO: communicate with the participant using participant-specific communication strategies, communication aids, devices, or resources, including resources in the participant’s preferred language. |  |  |  |
| I KNOW TO: support the participant to explore ways to enjoy mealtime and feeding, for example, timing, frequency, choice of environment and social company. |  |  |  |
| I KNOW TO: check that required equipment and consumables are available and ready for use. |  |  |  |
|  |  |  |  |
| **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: Follow hygiene and infection control procedures and safe food handling. |  |  |  |
| I KNOW TO: Support the participant with menu and meal planning. |  |  |  |
| I KNOW TO: Support the participant to position themselves for feeding and check they are ready for their meal. |  |  |  |
| I KNOW TO: Support the participant to enjoy their meal safely, using techniques such as use of feeding equipment and assistive technologies or other strategies for safe eating documented in the support plan, and providing reminders about safe rate of eating, or a safe amount of food in each mouthful if required. |  |  |  |
| I KNOW TO: Identify and immediately inform a Team Leader of risk indicators such as swallowing or breathing difficulties during mealtimes.  |  |  |  |
| I KNOW TO: Apply first aid in the event of a choking incident |  |  |  |
| I KNOW TO: Support the participant with oral hygiene consistent with the support plan. |  |  |  |
| I KNOW TO: Monitor and record information required by the support plan. |  |  |  |
| I KNOW TO: Work collaboratively with others to ensure continuity and effective delivery of support.  |  |  |  |
| I KNOW TO: Actively involve the participant in their support, as outlined in their support plan and to the extent they choose. |  |  |  |
|  |  |  |  |
| **Review Support**  |
| I KNOW TO: Check with the participant to discuss any changes needed to the dysphagia 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. |  |  |  |

**Support Worker 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:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**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 Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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