Marshall and Luffingham (1998) argued that greater role definition is achieved through introducing core competencies. Competence is job related, being a description of an action, behaviour or outcome that a person should demonstrate in their performance.

On the other hand, competency and competencies are person orientated, referring to the person’s underlying characteristics and qualities that lead to an effective and/or superior performance in a job. According to Woodruffe (1993), competence concerns an aspect of a job that an individual can perform, while competency concerns an individual’s behaviours underpinning competent performance. In other words, competence covers something a person is or should be able to do. Its focus is more on performance than on knowledge and it is concerned more with what people can do than what they know.

Performance criteria provide assessors with statements by which judgements about a person’s ability to perform a specified activity to an acceptable level can be made (Manley and Garbett, 2000).

Wolf (1989) pointed out that competence cannot be observed directly and can only be inferred from performance (cited by McMullan et al, 2003). Hence, under a performance-based assessment system, assessors will judge from evidence based on performance whether a person meets criteria specified in competence standards. The benefits of this approach are the ability to identify learning needs, provide insight into areas of professional practice and allocate educational resources for training.

A list of pre-specified skills that have to be ticked off to show that competence has been achieved does not solve the difficulty of ensuring consistency of interpretation, but it is a relatively easy way to ensure that a basic level of competency is achieved. Therefore, the assessment of HCAs’ competency had to be holistic; it had to contain a mixture of different types of assessment.

The workbook uses a list to assess HCAs, which can be ticked for certain competencies, such as changing a urine drainage bag or taking a urine sample. It also contains self-assessment strategies such as a questionnaire for pressure ulcer prevention and workshop-based questions on nutrition. HCAs’ knowledge, values, attitudes on privacy and dignity, and general nutrition skills will be assessed within the yearly context of the performance appraisal and personal development plan by their managers. This will provide evidence of their developmental needs as well as support and continuing education needs. On completing the workbook, HCAs can progress through the KSF.

THE WORKBOOK’S THREE AREAS OF PRACTICE

Urinary catheter care

Urinary catheterisation is vital in both nursing and medical care, but carries the risk of serious complications, such as urinary tract infections, trauma, stricture formation, encrustation, bladder calculi, urethral perforation and carcinoma of the bladder (Pomfret, 2000). Healthcare professionals’ primary clinical considerations in daily practice are patients’ care requirements and the intended function of the urinary catheter and drainage system. Urethral catheterisation is a common clinical intervention in acute care settings. A recent survey identified that the urinary tract is the most common source of nosocomial infection, particularly when the bladder is catheterised (Tenke et al, 2007).

Pratt et al (2007) reported that urinary tract infections are the second largest single group of healthcare-associated infections in the UK, accounting for 20% of all hospital-acquired infections. The presence of a urinary catheter and its duration are risk factors for the development of a UTI.

HCAs need to gain an understanding and develop competence in the clinical practice of caring for a urethral catheter. The workbook’s section on catheter care focuses on attaching and disconnecting an overnight drainage bag, changing a drainage leg bag, the procedure for emptying a drainage leg bag (Fig 1) and collecting a catheter specimen of urine.

Nutrition and hydration

Good nutrition is essential in order to maintain physical and mental well-being, including growth and tissue repair and energy to function in daily activity. Food not only influences health but also provides structure and social interaction to the day in hospital settings, in the community or at home.

The DH (2001) raised awareness of the issue of poor nutrition in all areas of health care. Evidence from more recent government documents (DH, 2007) suggests that there is still some way to go in order to meet patients’ needs.

Age Concern’s (2003) Hungry to be Heard campaign identified some important evidence (see Box 1, p12). The charity also highlighted some of the concerns raised by older people and their carers/relatives and friends, especially inappropriate food and lack of assistance with eating at mealtimes in hospital.

In our trust, HCAs are trained and involved in the initial screening process of patients’ nutritional status on admission, using the malnutrition universal screening tool (MUST), which incorporates weight, height and BMI. They report any adverse scores to the relevant healthcare professional in the team, who uses the information when planning and implementing the patient’s care.