



Perfusor[®] Space Syringe Pump

TRAINING RECORD

Hospital:.....

Ward:.....

Role:.....

Name:.....

The submission of personal data or business data (names) is done on an explicitly voluntary basis. This data will not be transmitted to B. Braun Medical Ltd or any third party unless you explicitly indicate that this is your wish. The data collected will be stored in line with your NHS Trust Privacy Policy.

TRAINING RECORD

COMPETENCY STATEMENT

Perfusor® Space Syringe Pump

These competences are to aid the participant in demonstrating a practical knowledge and appropriate clinical use of the Perfusor® Space Pumps.

These competences have been designed to help support the NHSLA Risk Management Standards for Acute Trusts (2006).

STEP ONE: First Line Training

This Training session will be carried out by a B. Braun Clinical Education Specialist or your B. Braun Super User.

The training session will comprise of a demonstration session and some practice scenarios. This is to help ensure you have acquired the relevant knowledge and skills to commence using the infusion pumps within your clinical setting.

STEP TWO: Clinical Application

Using the training received, continue to complete the practice scenarios to reinforce the knowledge gained during your training session. Use the reference material provided for further support.

STEP THREE: Review: 3 Month/Annually

To ensure competence is being maintained your trainer will undertake an assessment. Following this you may be required to attend annual training updates and reviews.

YOUR FIRST LINE TRAINER WAS

NAME: _____

ORGANISATION: _____

SIGNATURE: _____

DATE: _____

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COMPETENCY SELF ASSESSMENT

Self-assessment of competence should be measured against the following statements:

These statements are designed to indicate competence to use this device. Responsibility for use remains with the user, so if you are in any doubt regarding your competence to use the Perfusor® Space Syringe Pumps, you should seek education to bring about improvement. This should be completed through self-directed learning and coaching. Training resources available include: instructions for use, practice scenarios, medical devices ward file, the intranet, discussion with colleagues, medical device coordinator or the B. Braun Super User.

Questions to ask yourself: Can you...	Sign:	Date:
<ol style="list-style-type: none">1. State the clinical application of the Perfusor® Space Syringe Pumps2. Explain the safety checks and precautions to be taken prior to use including safely attaching and detaching the power cable3. Securely fasten the pump by using the pole clamp and attaching to an IV pole4. State the functions of the keys and indicators on the front panel5. Demonstrate how to clear the infusion data and how start a new therapy6. Demonstrate the correct insertion of the disposables7. Initiate and start a prescribed infusion8. Explain the information displayed on the screen whilst the pump is running9. Demonstrate the ability to change the rate once the infusion has started10. Demonstrate the activation, application and deactivation of the Data Lock anti-tamper facility (if applicable)11. Demonstrate the correct administration of a prescribed bolus (if applicable) by<ol style="list-style-type: none">a. delivering a manual purged bolusb. delivering a pre selected hands free bolus12. Demonstrate how to check the pumps battery status13. Explain why the pressure indicator is important and demonstrate how to check and adjust the pressure level14. Explain the difference between a AMBER and a RED alarm, and give an example of each15. Demonstrate how to set the standby mode and resume operation16. Demonstrate the correct way to remove the syringe from the pump17. Turn the pump off and explain the correct cleaning and storage procedures		

I certify that I am aware of my professional responsibility for continuing professional development and realise that I am accountable for my actions. With this in mind I make the following statement:

I am competent to use the Perfusor® Space Pump, and I am aware of the support material available to me.

Print: _____ Signed: _____ Date: _____

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PERIODICAL REVIEWS

This form is to be completed by you and your assessor during your assessments.

The assessment is designed to establish that self-competence has been achieved within your clinical practice.

Review Date	Assessor Signature	Record Owner Signature	Notes/Training Update Required