Assessment of Competency:
Practical Application of Compression Bandaging: UrgoK-Four System

Name:.....	There is an expectation with all competencies that you will be able to articulate underpinning anatomy and physiology including compression theory.			
Competency	**Date of lower limb training**	**Date application observed**	**Date application supervised**	**Date application supervised in practice (if required)**
Attended Skin Integrity Lower Limb session or Wound Care Alliance Training and achieved >80% in post- course questionnaire within past 3 years.				
Demonstrates knowledge of the significance of limb assessment prior to application of compression and is able to clearly explain this.				
Demonstrates knowledge of limb reshaping or additional protection if required within the UrgoKFour systems: 1) required limb shape 2) areas requiring protection eg. tendons at joint of lower leg and foot				
Demonstrates knowledge of significance of measuring the ankle circumference, to include position, when to measure, anatomical landmarks and subsequent regularity.				
Demonstrates knowledge of appropriate Urgo K-Four system to use, once limb has been assessed appropriate lower leg assessment and ABPI.				
Demonstrates knowledge of ideal limb position required in order to apply the compression bandage e.g. foot flexed to 90 degrees and the issues of manual handling.				
Demonstrates an ability to accurately apply K-Plus layer to include positioning, overlap, technique and tension applying at 50% stretch and with 50% overlap in figure of 8.				
Demonstrates an ability to accurately apply Ko-Flex to include positioning, overlap, technique and tension with 50% stretch with 50% overlap.				

Declaration of Competence

I declare that I have undertaken a period of supervised practice with a suitably qualified practitioner. I have demonstrated a clear ability to apply the Urgo K-Four compression system safely identifying the underpinning theoretical knowledge.

Mentee:.....

Date:.....

Mentor:.....

Date:.....

Approved Competence:

Name of SIT Nurse:.....

Signature of SIT Nurse:.....

Date:.....

3 year review date:.....

Developed by The Skin Integrity Team, Tissue Viability and Lymphoedema Service and RDaSH community Practice Educators.