

• HEALTHCARE · GUIDE

The skills matrix *for* *healthcare teams*

In healthcare, capability is not a productivity question; it is a patient-safety one. A skills matrix shows, clearly and defensibly, who is signed off to practise each clinical skill unsupervised, who is still developing under supervision, and where a shift might be left without the competence it needs. This is how to build one that protects patients and stands up to inspection.



Dr Alex J. Martin-Smith

CMGR · MBA · LLM · DBA

Reading time 12 min · **Method** Upleashed 0 to 5 capability framework · **Updated** May 2026

THE SHORT ANSWER

A healthcare skills matrix maps clinical staff against the competencies their roles require, with a level in each cell and a required floor, usually the level at which someone is signed off to practise unsupervised. It shows who has met that floor, who is still developing under supervision, and where cover for a competency is thin. In short: **it makes clinical competence visible and defensible, so every shift is safely staffed and every sign-off is evidenced.**

KEY TAKEAWAYS

- **Competence is a safety issue.** Research links clinical competence to patient-safety culture, so visibility of capability protects patients directly.
- **Set a required floor.** The key line is the level at which someone may practise a skill unsupervised; below it means supervised practice.
- **Below the floor is often correct.** A preceptee practising under supervision is not a failing; it is exactly how developing staff should work.
- **Mind the skill-mix.** The matrix shows whether each shift has the competencies it needs, not just enough bodies.
- **Currency matters.** Competence is not permanent; revalidation and refreshers keep it current, which the framework builds in.

— START HERE

Where competence *means safety*

In most settings a skills matrix improves performance. In healthcare it does that too, but its first job is patient safety. Mapping clinical competence is how a team ensures that every task is carried out by someone genuinely competent to do it, and that developing staff are properly supervised until they are.

The required floor is the heart of it

A healthcare skills matrix turns on one idea: the **required floor**, the level at which a person is signed off to practise a competency unsupervised. For most clinical skills that is Level 3, capable and working to standard without supervision. Someone at or above the floor may practise alone; someone below it works under supervision until they reach it. This single line, drawn clearly on the matrix, is what keeps practice safe and accountable, and it is exactly what the 0 to 5 scale is built to express.

Below the floor is not a failing

An important and often misunderstood point: being below the floor is frequently the **correct and expected** state. A newly qualified nurse on preceptorship, or a member of staff learning a new competency, should be practising under supervision until signed off. The matrix does not shame that; it documents it, so everyone knows who needs supervising on what, and the developing member of staff has a clear, visible path to sign-off. The flag is a safeguard, not a criticism.

It is built for accountability

Healthcare runs on demonstrable competence. Professional regulation expects practitioners to work within their competence and to keep it current, and inspectors expect to see the evidence. A skills matrix is the natural record: a dated, scored, signed-off view of who is competent to do what, ready to support **revalidation, supervision decisions and inspection** alike. It turns "we are confident our staff are competent" into something you can actually show.

— WHY IT MATTERS NOW

An unseen competence gap is a *safety risk*

When it is not clear who is signed off for what, two dangers follow: a task done by someone not yet competent, or a developing member of staff left unsupported. Both are patient-safety risks. Making competence visible is the first line of defence, and the data on capability visibility is sobering.

8%

GARTNER, 2024

of organisations have reliable workforce skills data, so most rely on memory for who is competent at what.

39%

WEF, 2025

of workers' core skills are expected to change by 2030, as clinical practice, technology and guidance evolve.

63%

WEF, 2025

of employers call skills gaps the biggest barrier to change, and in care those gaps carry the highest stakes.

Peer-reviewed research links the level of clinical competence to the strength of a team's patient-safety culture: more competent teams sustain safer practice and miss less care. Yet competence is precisely what most organisations cannot see clearly, which means supervision and rostering decisions are too often made on assumption. A healthcare skills matrix changes that. It makes the **line between signed-off and supervised explicit**, so the right person is matched to each task, developing staff are properly

supported, and the whole picture is current and ready to evidence, before a gap becomes an incident.

— WHAT IT PROTECTS

Four things a healthcare matrix safeguards

A clinical skills matrix is not paperwork for its own sake; it protects four things a care team cannot compromise on. Each is a direct contribution to safe, accountable practice.

PROTECTS 01

Patient safety

By ensuring each clinical task is done by someone competent to do it, and that developing staff are supervised, the matrix puts capability where patient safety depends on it.

PROTECTS 02

Regulation & revalidation

A dated, evidenced record of competence supports practising within one's scope, professional revalidation, and the documentation inspectors expect to see.

PROTECTS 03

Safe skill-mix per shift

It shows whether each shift has the specific competencies it needs, not just enough staff, so a rota is never quietly left without a critical skill.

PROTECTS 04

Supervision of new staff

It makes clear who is still below the floor and needs supervising on what, giving preceptees support and a visible, structured path to sign-off.

These four share a single thread: **the right competence, in the right place, evidenced.** A care setting can be fully staffed by numbers and still be unsafe if the people on shift are not collectively competent in the skills the shift demands, or if a developing member of staff is left unsupervised. The matrix is the instrument that makes that distinction visible, turning a vague confidence in the team into a clear, defensible picture of who can safely do what, right now.

— THE SCALE BEHIND THE SCORES

The 0 to 5 capability framework

A clinical matrix needs a clear, shared scale, so a level means the same across the team and over time. This framework, developed by Dr Alex J. Martin-Smith, provides it, and its Level 3 line, capable and unsupervised, is exactly the floor most clinical competencies are set at.

-
- 0** **Not in scope / not required** EXCLUDED
- The competency is outside this person's role or professional scope, for example a task a healthcare assistant is not registered to perform. It is excluded from their score, not counted as a gap.
-
- 1** **In training / Trainee** WEIGHTING 25%
- Learning the competency under direct supervision. Up to 75% trained and does not yet fully understand the quality and safety requirements. Must not practise unsupervised.
-
- 2** **Developing capabilities** WEIGHTING 50%
- More than 75% trained. Can perform the competency, but consistent, safe practice is not yet evidenced, so it is carried out under supervision and checked.
-
- 3** **Capable** WEIGHTING 75% · THE USUAL FLOOR
- Fully trained, consistently safe and to standard, signed off to practise the competency unsupervised. For most clinical skills this is the required floor.
-
- 4** **Subject Matter Expert / Trainer** WEIGHTING 100%
- Prolonged, expert practice; can assess and train others and act as a preceptor or practice educator. If a competency is unused for a period, drop back to Level 3 to reconfirm currency.
-
- 5** **Strategic ownership / Leadership** WEIGHTING 100%
- Sets clinical standards, defines competency requirements and leads practice across the service. The purple flag marks clinical leads and practice educators who own how a skill is done.

The floor, and why currency matters

Each competency has a required floor, the level needed to practise it unsupervised, usually Level 3. Anyone at or above it is signed off; anyone below works under supervision. The proficiency weightings, Level 1 = 25%, 2 = 50%, 3 = 75%, 4 and 5 = 100%, with 0 excluded, also roll a person's row into an overall capability figure. Crucially, competence is not permanent: a skill unused for a period drops back toward the floor and needs reconfirming, which mirrors how professional revalidation keeps practice current.

A worked example. Who may practise Catheterisation unsupervised, where the floor is Level 3?

Catheterisation scores Sister 3, Nurse A 3, Nurse B 2, Preceptee 1, HCA 0 (out of scope), Bank 2
at or above floor (L3) → **Sister and Nurse A** may practise unsupervised
below floor → **Nurse B, Bank** supervised · **Preceptee** supervised
· **HCA** out of scope.

— SEE IT ON A REAL TEAM

A clinical competency matrix, *with the floor drawn in*

Here is a skills matrix for a six-person clinical team, read the way healthcare needs it. Every competency has a required floor of Level 3, the line for unsupervised practice. Cells at or above it are signed off; cells below are flagged for supervision; out-of-scope tasks are greyed. The right-hand column shows how many competencies each person is signed off for.

	Medication admin	IV cannulation	Wound care	Catheterisation	Tracheostomy	ECG interp.	Signed off (of 6)
REQUIRED FLOOR	L3	L3	L3	L3	L3	L3	–
Sister CHARGE NURSE	4	4	4	3	3	4	6 / 6
Nurse A STAFF NURSE	3	3	3	3	2	3	5 / 6
Nurse B STAFF NURSE	3	3	4	2	3	2	4 / 6
Priya NEWLY QUALIFIED	2	1	2	1	1	1	Preceptee
Sam HCA	2	–	2	–	–	1	Scope-limited
Bank nurse	3	2	3	2	2	2	2 / 6
SIGNED OFF (L3+)	4	3	4	2	2	2	–

■ at or above floor · signed off
 ■ below floor · supervised practice
 out of professional scope

3

specialist competencies thinly covered (catheterisation, tracheostomy, ECG)

2

staff developing under supervision, exactly as they should be

Illustrative clinical team on the Upleashed 0 to 5 framework. The floor is Level 3, the line for unsupervised practice. Pink marks supervised practice; grey marks tasks outside scope.

WHAT THIS MATRIX TELLS THE WARD SISTER

- **Who is safe to practise alone.** Reading a row, the Sister is signed off across all six competencies; Nurse A on five, with tracheostomy still to complete. The floor makes every sign-off explicit.
- **Supervision is documented, not implied.** Priya, newly qualified, sits below the floor on every competency, exactly right for a preceptee, so the matrix records who must supervise her, and her path to sign-off.
- **Scope is respected.** The healthcare assistant's greyed cells are tasks outside professional scope, not gaps, so they never count against the team's competence.
- **Thin cover stands out.** Reading the bottom row, catheterisation, tracheostomy and ECG are each signed off for only two staff, so a single absence could leave a shift without that competence, the priority for training.

— EVIDENCING IT

Five ways to confirm clinical competence

A level on a healthcare matrix should rest on evidence, not assertion. These are the established ways clinical competence is confirmed before someone is signed off above the floor, and where each fits best.

Method	Best for	Watch out for
Supervised practice & sign-off	Confirming a competency through observed practice with a preceptor or assessor	Signing off on a single occasion rather than consistent practice
Simulation / OSCE	Safely assessing high-risk or rare skills before live practice	Assuming simulated competence always transfers fully to the ward
Direct observation	Checking real practice against the standard, in the moment	The observer effect; people perform differently when watched
Portfolio & revalidation	Evidencing ongoing competence and reflection for professional revalidation	Treating a portfolio as a one-off task rather than living evidence
Audit & feedback	Confirming competence holds at scale, across records and colleagues	Using audit punitively, which discourages the honest reporting it needs

In practice these combine. A new competency might be taught in simulation, confirmed through supervised practice and a sign-off, then sustained and re-evidenced through portfolio, observation and audit over time. The matrix is where the result of all of it lands: a single, current level for each person on each competency, backed by whichever evidence confirmed it. That is what lets a sign-off withstand scrutiny, and what keeps competence honest rather than assumed.

— AVOID THESE

Six mistakes on a healthcare matrix

MISTAKE 01

No clear floor

Without a defined level for unsupervised practice, "competent" is a judgement call. Set the floor explicitly for each competency.

MISTAKE 02

Treating below-floor as failure

A preceptee practising under supervision is correct, not deficient. The flag documents support needed, it does not shame.

MISTAKE 03

Confusing scope with gaps

A task outside someone's professional scope is not a missing skill. Mark it out of scope, so it never counts as a gap.

MISTAKE 04

Ignoring currency

Competence fades when a skill is unused. A sign-off from two years ago is not evidence of competence today; reconfirm it.

MISTAKE 05

Counting bodies, not competencies

A fully staffed shift can still lack a critical skill. Read the matrix for skill-mix, not just headcount.

MISTAKE 06

Signing off without evidence

A level that rests on assumption will not withstand scrutiny. Back every sign-off above the floor with real evidence.

The method is free. A ready-made matrix just makes the floor and the *sign-offs clear.*

Everything here works in a blank spreadsheet, and that is a fine place to start. A purpose-built template simply makes the clinical view effortless. Score each competency on the 0 to 5 scale, set the required floor, and the matrix shows at a glance who is signed off, who is supervised, and where cover is thin, with every level dated and ready to evidence for supervision decisions and revalidation.



The Advanced Excel Skills Matrix shows competence against the required floor and coverage per skill at a glance, so signed-off, supervised and thinly-covered competencies are obvious, all on the same 0 to 5 framework used throughout this guide.

TRY IT FREE

£0

The online 5x5 builder maps a small team in your browser, with no sign-up. A fast way to map a clinical team.

MOST POPULAR

£199

The full Excel template: heat map, required floors, coverage and currency views, up to 30 people and 30 skills. One-off, yours forever.

WHEN YOU ARE READY

£1

Upgrade to PulseAI in your first year for a living, web and mobile version with AI skill suggestions and reminders.

— COMMON QUESTIONS

Quick *answers*

Q What is a skills matrix in healthcare?

It is a grid mapping clinical staff against the competencies their roles require, with a level in each cell and a required floor, the level needed to practise unsupervised. It shows who is signed off, who is developing under supervision, and where cover for a competency is thin, supporting safe staffing and accountability.

Q What is the "required floor"?

It is the level at which a person is signed off to practise a competency unsupervised, usually Level 3 (capable, consistently safe, to standard). At or above the floor, a person may practise alone; below it, they work under supervision until they reach it. The floor is the safety line of a healthcare matrix.

Q Is it a problem if staff are below the floor?

Often not. A newly qualified nurse on preceptorship, or anyone learning a new competency, should be below the floor and practising under supervision, that is exactly how it should work. The matrix documents who needs supervising on what and gives them a clear path to sign-off; the flag is a safeguard, not a criticism.

Q How does it support revalidation and inspection?

It provides a dated, scored, signed-off record of who is competent at what, backed by evidence. That supports practitioners practising within their competence, contributes to the evidence individuals keep for professional revalidation, and gives inspectors the clear documentation of competence they expect to see.

Q How do I keep clinical competence current on the matrix?

Treat competence as time-limited. Reconfirm a competency when a skill has been unused for a period, when mandatory training is due, or at revalidation points, dropping a level back toward the floor until it is re-evidenced. Building currency in keeps the matrix honest rather than a record of who was once competent.

Q Do I need special software for a clinical skills matrix?

No. A well-built spreadsheet with required floors and dated sign-offs works well, and is where most teams should start. Software helps when you want competence tracked live across wards and sites, with renewal and revalidation reminders and skill-mix views that update automatically.

— ABOUT THE AUTHOR



Dr Alex J. Martin-Smith

CMGR · MBA · LLM · DBA

Alex is the creator of the Upleashed capability framework that powers Skills Matrix Template, the award-winning Excel skills matrix. A Chartered Manager with an MBA, an LLM and a doctorate in business administration, he has spent more than two decades helping operations, HR and quality teams turn capability from a gut feel into something they can measure, manage and prove.

Connect on LinkedIn: [linkedin.com/in/alexmartinsmith](https://www.linkedin.com/in/alexmartinsmith)

A handwritten signature in black ink that reads "Alex J. Martin-Smith".

Dr Alex J. Martin-Smith

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Know who is *signed off*.

You now have the clinical method. The quickest way to start is to list your team's key competencies this week, set the floor for unsupervised practice, and score everyone honestly. The matrix will show you who is signed off, who needs supervising, and where the next sign-off matters most.

[Try the free 5x5 builder →](#)

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