INITIAL SKILL/EQUIPMENT COMPETENCY CHECKLIST (CLINICAL/NON-CLINICAL)

Associate_____ **Department**_____

Job Title **LPN** **Evaluation Period**_____

Instructions: Record each activity to be evaluated. Assessment of "Meets Expectations" indicates the individual meets the performance expectations for the skill/competency. A rating of "Does Not Meet" requires documentation of an action plan for correction, a repeat evaluation, and a competency demonstration within 30-90 days. Note any relevant comments in the adjacent column.

SKILL/PROCEDURE/EQUIPMENT	DATE OBSERVED/ REVIEWED BY** (Initials)	M = MEETS EXPECTATIONS DNM = DOES NOT MEET EXPECTATIONS R = REVIEWED, ABLE TO FIND RESOURCES N/A = NOT APPLICABLE	COMMENTS/ACTION PLAN
I. VERBALIZES/DEMONSTRATES THE NURSING PROCESS:			
A. Data Collection/Interventions of Assigned Patients 1. Provides care based on: a. Physical data collection b. Psychosocial data collection c. Spiritual data collection d. Changes in patient's condition 2. Completes Population Served & Patient Rights Competency Checklist (located in pathways)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
B. Participates with RN in ongoing development and modification of the plan/strategy of care (on SNF with MDS Coordinator)		M DNM R N/A	
C. Collects evaluative data related to patient outcomes.		M DNM R N/A	
D. Provides patient education based on plan of care		M DNM R N/A	
II. COMMUNICATES AND DIRECTS PERTINENT INFORMATION TO THE HEALTH CARE TEAM:			
A. Interacts with patients, visitors, physicians, co-workers, Nurse Managers and interdisciplinary team in professional manner utilizing the AIDET® communication model.		M DNM R N/A	
B. Reports changes in patient's condition to RN, charge nurse/team leader, supervisor, and MD		M DNM R N/A	
C. Reports changes in patient's condition to charge nurse/team leader, supervisor, and MD		M DNM R N/A	

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D. Rapid Response Team: 1. Identifies when and how to call 2. Instructs family on initiation of Rapid Response		 M DNM R N/A M DNM R N/A	
E. Code Blue Policy/Procedure: 1. Identifies when and how to call 2. Completes Code Blue Update 2015 CBL		 M DNM R N/A M DNM R N/A	
F. Stroke Order Sets (unit specific) 1. SEH ED Stroke 2. SEH IP Neuro Stroke T-PA 3. SEH IP Neuro Hemorrhagic Stroke Nursing protocol 4. SEH IP Neuro Hemorrhagic Stroke Orders 5. SEH IP Neuro Ischemic Stroke/TIA Routine 6. SEH IP Neruo Ischemic Stroke/TIA Routine Nursing Protocol 7. SEH IP Neuro Inpatient Code Stroke		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
G. Communication: 1. Utilizes SBAR model when giving report to a member of the healthcare team 2. Utilizes AIDET model in daily interactions with patients, customers, and associates. 3. Participates in bedside reporting at change of shift involving patient and incorporating the care plan. 4. Utilizes Ticket to Ride 5. Delegates appropriately 6. Utilizes Bedboard System effectively		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
III. <u>DEMONSTRATES PROFESSIONAL RESPONSIBILITY UTILIZING VISION & VALUES BY OBSERVING:</u>			
A. Chain of command		M DNM R N/A	
B. Charge Nurse/Team Leader Role (aware of role)		M DNM R N/A	
C. Confidentiality 1. Disclosure of protected health information (PHI) 2. Disposal of PHI 3. Limited EPIC access to business based reasons		 M DNM R N/A M DNM R N/A M DNM R N/A	
D. Dress Code		M DNM R N/A	

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E. P.I. studies 1. Identifies unit based and organization-wide studies.		M DNM R N/A	
F. HCAHPS 1. Identifies unit specific and system wide efforts related to customer satisfaction.		M DNM R N/A	
G. Professional Practice 1. Accepts accountability for care of the patients. 2. Recognizes how the Forces of Magnetism apply in the work environment. 3. Incorporates the Dynamic Caring Model in every aspect of patient care. 4. Able to discuss the SEH Councilor Model of Shared Leadership. 5. Identifies Patient Care Delivery Model (unit specific) 6. Articulates the method of making assignments as related to acuity and competency. 7. Recognizes Nurse Sensitive Quality Indicators.		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
H. Core Measures (as appropriate for pt): 1. Perinatal 2. Acute MI 3. SCIP 4. Influenza 5. VTE 6. Stroke 7. ED Throughput 8. Tobacco/Screening/Counseling/Treatment		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
I. StaffingGuidelines		M DNM R N/A	
J. Ethics Committee (purpose and process)		M DNM R N/A	
IV. LOCATES AND UTILIZES:			
A. Policy (Compliance 360)		M DNM R N/A	
B. Procedures (Mosby's Skills)		M DNM R N/A	
C. Time Clock Processes		M DNM R N/A	
D. Staff Meetings		M DNM R N/A	
E. Unit Specific Reference Materials		M DNM R N/A	

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F. Outlook		M DNM R N/A	
G. Pneumatic Tube System		M DNM R N/A	
H. Imprivata		M DNM R N/A	
I. Intranet Access for: 1. Diet Manual 2. ICARE 3. MedEx Forms 4. Netlearning 5. Pathways 6. Self Serve 7. Success Factors 8. Midas RDE 9. Corporate Compliance 10. oneSOURCE (manufacturer's document site) 11. Employee Injury Report 12. OPIM Exposure Incident Report 13. Biomed/Clinical Engineering Work Request Application		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
V. <u>DEMONSTRATES PROPER USAGE, APPLICATION, & TROUBLESHOOTING EQUIPMENT:</u>			
A. Phone System		M DNM R N/A	
B. Intercom/Nurse Call/Pocket Pagers/Wireless Phones		M DNM R N/A	
C. Kangaroo Pump		M DNM R N/A	
D. Oxygen Delivery Systems: 1. O_2 Flowmeter 2. Nasal Cannula 3. High flow 4. Venturi Mask 5. Non Rebreather Mask 6. Bi-Pap/CPAP Model _____ 7. Bag Valve Mask (BVM)		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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E. Respiratory Equipment 1. Pulse Oximeter Spot check – Model _____ Continuous – Model _____ 2. Incentive Spirometry Model_____ 3. Flutter Valve 4. Spacer 5. Emergency O2 Tank		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
F. Heat Therapy System Model: _____		M DNM R N/A	
G. Athrombic Pump (Sequential Compression Devices) Model: _____		M DNM R N/A	
H. Antiembolism Stockings		M DNM R N/A	
I. I.V. Pump		M DNM R N/A	
J. PCA Pump (select meds only) (Review procedure)		M DNM R N/A	
K. Ambit Pump/On Q for pain (monitoring)		M DNM R N/A	
L. Foley Catheter 1. Insertion Male 2. Insertion Female 3. Securement device 4. Leg Bag 5. Emptying Foley Drainage Bag 6. Removal (Urinary Catheter Removal Protocol)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
M. Continuous/Intermittent Bladder Irrigation		M DNM R N/A	
N. Suprapubic Catheter		M DNM R N/A	
O. Nephrostomy Tube		M DNM R N/A	
P. Suction 1. Wall 2. Portable		M DNM R N/A M DNM R N/A	

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Q. Restraint Use & Documentation in collaboration with RN (Violent/Self-Destructive & Non-violent/Non-Self-Destructive)			
1. Alternatives & preventative strategies attempted		M DNM R N/A	
2. Utilizes & documents protective devices (not a restraint) per policy/procedure		M DNM R N/A	
3. Handcuffs (not a restraint) documented under peripheral vascular assessment		M DNM R N/A	
4. Restraints:			
a. Side Rails X4		M DNM R N/A	
b. Soft Hand Mitts		M DNM R N/A	
c. Joint Immobilizers		M DNM R N/A	
d. Disposable Quick Release Limb Holder		M DNM R N/A	
e. Body Holder		M DNM R N/A	
f. Twice as Tough (wrist/ankle) (unlocked)		M DNM R N/A	
g. Physical Hold (violent/self-destructive)		M DNM R N/A	
h. 3or4 point (unlocked – violent/self-destructive)		M DNM R N/A	
i. BH Only			
1) 3or4 point (locked)		M DNM R N/A	
2) Swedish belt (locked)		M DNM R N/A	
3) Twice as Tough (wrist/ankle) (locked)		M DNM R N/A	
R. Feeding Tube/ NG Salem Sump/ Mark IV Moss Tube/PEG/J tube			
1. Continuous vs Bolus orders		M DNM R N/A	
2. Irrigation & Residual/Placement Check		M DNM R N/A	
3. Routine Tubing & Feeding Change		M DNM R N/A	
4. Suction		M DNM R N/A	
5. Removal (NG Salem Sump/Keofed)		M DNM R N/A	
S. SMART Mobility Equipment data collection, usage, and documentation			
1. Maxi Slide		M DNM R N/A	
2. Stedy		M DNM R N/A	
3. Sara Plus		M DNM R N/A	
4. Maxi Move		M DNM R N/A	
a. Repositioning bar		M DNM R N/A	
5. Maxi Sky 600/1000		M DNM R N/A	
6. Tenor		M DNM R N/A	

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T. Assistive Devices		M DNM R N/A	
U. Fluid/Blood Warmers		M DNM R N/A	
V. Doppler Model: _____		M DNM R N/A	
W. Precision Meter		M DNM R N/A	
A. Blood Pressure Cuff a. Automatic Model: _____ b. Manual		M DNM R N/A M DNM R N/A	
B. Pyxis		M DNM R N/A	
C. BearHugger		M DNM R N/A	
D. Drains 1. Surgivac/Hemovac 2. Jackson Pratt 3. T-Tube 4. PleurX 5. Other _____		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
E. Tracheostomy 1. Disposable Inner Cannula 2. Trach Care kit/cleaning		M DNM R N/A M DNM R N/A	
F. Chest Tubes 1. Drainage System 2. Suction 3. Heimlich Valve		M DNM R N/A M DNM R N/A M DNM R N/A	
G. Bed Operation Type of Bed: _____ Type of Bed: _____ 1. Bed Positioning 2. Code Blue position 3. Specialty Bed & instructions manual 4. Bed Alarm 5. Overhead frame with Trapeze 6. Traction		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
H. Scales 1. In Bed Scale/Zeroing 2. SMART equipment scales 3. Standing scale 4. Other (specify) _____		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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I. Telemetry (unit specific) 1. Box 2. Leads		 M DNM R N/A M DNM R N/A	
J. Thermometer: Type/Model: _____/_____ Type/Model: _____/_____		 M DNM R N/A M DNM R N/A	
K. Assistive Listening Device Model: _____		M DNM R N/A	
L. Additional unit equipment: 1. Other (specify) _____ 2. Other (specify) _____		 M DNM R N/A M DNM R N/A	
VI. COMPLETES DOCUMENTATION PER POLICY/PROCEDURE			
A. Admission navigator 1. PTA Meds a. Document per patient/family input b. Verify addressed by MD 2. Advanced Directives 3. Valuables		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
B. Manage Orders (if RN not available) 1. Verifies correct order mode (per protocol co-sign vs no co-sign required) 2. Verifies correct ordering/authorizing provider		M DNM R N/A M DNM R N/A	
C. Acknowledges Orders		M DNM R N/A	
D. Utilizes Sidebar in flowsheets to view information from Index page		M DNM R N/A	
E. Skin integrity 1. Braden Scale – only after completing the "Braden Scale" CBL 2. Wound Care protocols a. Add LDA for wound		 M DNM R N/A M DNM R N/A M DNM R N/A	
F. Mobility data collection & scoring		M DNM R N/A	
G. Care Plan (collaborates with RN) 1. To individualize care plan – addressing 3 initial questions 2. To enter only actual pt specific problems & interventions 3. To evaluate end date 4. To evaluate outcomes for each goal		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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H. Education 1. Completes learning data collection 2. Utilizes teachback 3. Utilizes patient education resources (Mosby & Medex)		 M DNM R N/A M DNM R N/A M DNM R N/A	
I. Flowsheets		M DNM R N/A	
J. IV MAR		M DNM R N/A	
K. Progress Notes		M DNM R N/A	
L. MAR: 1. Dual sign-off of medications 2. Medication override 3. MAR linking		 M DNM R N/A M DNM R N/A M DNM R N/A	
M. Pain Assessment		M DNM R N/A	
N. Pre-Op Checklist (collaborates)		M DNM R N/A	
O. Discharge Navigator		M DNM R N/A	
P. Transfer Forms: 1. Interhospital Transfer Form 2. Transfer Document		 M DNM R N/A M DNM R N/A	
Q. AMA Document		M DNM R N/A	
R. Meaningful use (collaborates with RN who completes discharge summary) – 1. Ensures Provider & Locations entered in Next Level of Care 2. Notifies IS if provider/location not in system 3. Ensures completion of Continuity of Care flowsheet (if applicable) 4. Medication Reconciliation a. Collaborates with RN who checks for duplication of meds before printing AVS b. Collaborates with RN who completes all info on AVS electronically (no handwritten information) before printing c. Encourages e-prescribing of DC meds 5. Encourages patient use of MyChart		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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S. Code Narrator (for rapid responses & codes)		M DNM R N/A	
T. Crash Cart/Defibrillator Checklist		M DNM R N/A	
U. Consent Forms		M DNM R N/A	
V. Calorie counts		M DNM R N/A	
W. Critical Lab Note/Process		M DNM R N/A	
X. Downtime Process		M DNM R N/A	
Y. DNR Treatment Plan/Orders		M DNM R N/A	
VII. OBSERVES SAFETY BY COMPLYING WITH POLICY/PROCEDURE & RELATED INTERVENTIONS FOR:			
A. Smoking Regulations		M DNM R N/A	
B. Verifies two patient identifiers – when performing tasks/procedures		M DNM R N/A	
C. Seizure Precautions		M DNM R N/A	
D. Disaster Procedures		M DNM R N/A	
E. Fall Protection Program 1. Reviews Policy 2. Utilizes alarms as indicated for patient safety a. Bed alarm b. Chair alarm c. Toilet alarm d. Other		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
F. Behavioral Precautions Observation Record (Reviews Policy)		M DNM R N/A	
G. Handling & Disposal of Sharps		M DNM R N/A	
H. Spill Kits 1. Cytotoxic (from security or 2AO) 2. Formalin (from security) 3. Other_____		 M DNM R N/A M DNM R N/A M DNM R N/A	
I. Readback & Verify phone orders		M DNM R N/A	
J. "Time Out"		M DNM R N/A	

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VIII. <u>OBSERVES INFECTION CONTROL PRACTICES:</u>			
A. Hand Hygiene 1. When hands are visibly dirty 2. Before eating & after using a restroom 3. Before direct contact with a patient 4. After contact with a patient's intact skin 5. Before donning sterile gloves 6. After removing gloves or other PPE 7. After contact with body fluids or secretions, mucous membranes, non-intact skin and wound dressings 8. When moving from a contaminated body site to a clean body site during patient care 9. After contact with inanimate objects in the immediate vicinity of the patient (e.g. items likely to be touched by the patient)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
B. Standard Precautions		M DNM R N/A	
C. Contact Precautions		M DNM R N/A	
D. Droplet Precautions		M DNM R N/A	
E. Airborne Precautions		M DNM R N/A	
F. Cleaning of Equipment		M DNM R N/A	
IX. <u>PROVIDES SAFE INTERVENTIONS FOLLOWING POLICY/PROCEDURE:</u>			
A. Sterile Dressing Change		M DNM R N/A	
B. Staple Removal		M DNM R N/A	
C. Suture Removal		M DNM R N/A	

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D. Wound Care Protocols and plan of care followed as appropriate: 1. Nutrashield: a. Foam cleanser b. Moisture Barrier c. Calazime 2. Desenex Powder 3. Barrier prep 4. Mepitel silicone dressing 5. Hydrogel 6. Mepilex foam 7. LiquiCell nasal CPAP cushions 8. Heelift boots 9. Repositioning Wedges 10. Redistribution cushion (chair/wheel chair) 11. Covidien premium underpad (skin open to air) in place of briefs while in bed 12. Hill-rom bed - chair and other features as available my model 13. Turns/reposition every 2hrs (including alignment/extremity support to avoid pressure areas)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
E. VAC Dressings		M DNM R N/A	
F. Ostomies		M DNM R N/A	
G. Enemas		M DNM R N/A	
H. Collecting, Labeling, Documenting Specimens		M DNM R N/A	
1. Urine a. Routine b. CCMS c. Straight Cath d. Foley e. 24 hour urine f. Straining for renal calculi g. Chain of Custody for Drug Screen		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
2. Stool a. Blood/WBC/C-Dif b. O & P c. Culture		M DNM R N/A M DNM R N/A M DNM R N/A	
3. Sputum a. C&S		M DNM R N/A	

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4. Wound Culture a. Anaerobic b. Aerobic		 M DNM R N/A M DNM R N/A	
5. Blood Draw (peripheral)		M DNM R N/A	
I. Suction 1. Oral 2. Nasal 3. Tracheostomy		 M DNM R N/A M DNM R N/A M DNM R N/A	
J. Peripheral IV Care 1. Catheter insertion 2. Flush Protocol 3. Monitor every 2hrs and prn 4. Tubing changes 5. D/C IV		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
K. Central Vascular Access Device (CVAD) 1. Sorbaview Contour (securement device) for jugular lines 2. Dualcap (port caps) (all ports of CVAD & peripheral when Central line in place) 3. Dressing Change 4. Monitor fluid/flush PICC 5. Monitor fluid/flush Port-a-Cath		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
L. Blood Product Administration (collaborates with RN who initiates) 1. Consent 2. Barcode scanning 3. Documentation (after 1st 15 min) a. EPIC b. Transfusion Document 4. Refusal 5. Reactions		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
X. <u>PROVIDES SAFE MEDICATION ADMINISTRATION</u>:			
A. Barcode Med Administration (BCMA) 1. Uses two patient identifiers 2. Uses scanner/rover for all meds 3. Maintains the Six Rights of Medication Safety 4. Administers time critical meds within 30 min of scheduled time		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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B. IV Fluid Administration 1. Maintenance 2. IVPB 3. IVP (see permitted section of LPN guidelines) 4. Vesicants a. Frequency of checking site b. Extravasation algorithms c. MIDAS reporting for infiltrates		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
C. Peripheral Parenteral Nutrition (PPN)		M DNM R N/A	
D. Hyperalimentation (TPN) 1. Central Parenteral Nutrition 2. Lipid/Amino Acid Administration		 M DNM R N/A M DNM R N/A	
E. Intradermal Skin Test		M DNM R N/A	
F. IM		M DNM R N/A	
G. Subcutaneous		M DNM R N/A	
H. NG		M DNM R N/A	
I. PEG		M DNM R N/A	
J. PO meds		M DNM R N/A	
K. Use of Safety Needles		M DNM R N/A	
L. Pyxis Discrepancy Report		M DNM R N/A	
M. Clinician Hold		M DNM R N/A	
N. Insulin 1. Telcor 2. Blood Glucose Algorithm/Basal Prandial Orders 3. Dose double checked 4. Diabetes Education		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
O. Pre-procedure/Pre-surgical 1. Meds administered 2. Signed & Held Orders reviewed		 M DNM R N/A M DNM R N/A	
P. Post-procedure/Post-surgical 1. Signed & Held Orders		M DNM R N/A	

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*Skills specific to licensure are to be reviewed by someone of like discipline.

Initials	Signature	Title

Initials	Signature	Title

Date:_____ **Associate Signature:**_____

Date:_____ **Manager Signature:**_____

ONGOING COMPETENCIES &
POPULATION SERVED/PATIENT RIGHTS COMPETENCIES
(CLINICAL/NON-CLINICAL)

Associate_____ **Department**_____

Job Title LPN **Evaluation Period** 1/1/14-12/31/14

Instructions: Record each activity to be evaluated. Assessment of "Meets Expectations" indicates the individual meets the performance expectations for the skill/competency. A rating of "Does Not Meet" requires documentation of an action plan for correction, a repeat evaluation, and a competency demonstration within 30-90 days. Note any relevant comments in the adjacent column.

Age Specific Populations:				
Neonate/Infant ☐	**Child** ☐	**Adolescent** ☐	**Adult** ☐	**Geriatric** ☐

POPULATION SERVED COMPETENCIES	**DATE OBSERVED/ REVIEWED BY** (Initials)**	**M = MEETS EXPECTATIONS DNM = DOES NOT MEET EXPECTATIONS R = REVIEWED, ABLE TO FIND RESOURCES N/A = NOT APPLICABLE**	**COMMENTS/ACTION PLAN**
A. Uses equipment that is validated as effective for age &/or weight ranges.		M DNM R N/A	
B. Adapts communication techniques/approaches to population served.		M DNM R N/A	
C. Administers individualized, population specific care that supports physical/psychosocial function.		M DNM R N/A	
D. Applies both population specific and disease specific considerations in all aspects of service/care delivery.		M DNM R N/A	
E. Promotes self-care abilities of clients per stage of growth and development.		M DNM R N/A	
F. Completes Age-Related Newsletters as assigned by Manager (may use Grown Up/Growing Up With Us Series)		M DNM R N/A	
Diverse Populations:			
A. Uses statements and body language that convey awareness of cultural differences and respect for the rights of others.		M DNM R N/A	
B. Provides service/care based on the values of the St Elizabeth Healthcare.		M DNM R N/A	
C. Adapts the delivery and management of health care/service for diverse populations.		M DNM R N/A	
D. Applies unit/departments specific diversity and age specific population modifications to care (give examples): 1. _____ 2. _____ 3. _____		M DNM R N/A M DNM R N/A M DNM R N/A	

ONGOING COMPETENCIES &
POPULATION SERVED/PATIENT RIGHTS COMPETENCIES
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E. CBL Completion: 1. Our Model for Diversity 2. Obesity: Understanding, Awareness/Sensitivity 3. Other: _____		M DNM R N/A M DNM R N/A M DNM R N/A	
F. Able to locate and use patient related resources: 1. Language – Assistance Service (Interpreter) 2. Culture and Clinical Care 3. Dual set headphones 4. Printed materials in languages other than English a. Patient Handbook b. Mosby's patient teaching sheets 5. Able to use additional unit based/department based resources for diverse patient types (list) a. _____ b. _____		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
G. Organizational Resources: 1. Culture & Diversity Leaf (Pathways/St Elizabeth University) 2. Connection Corner 3. Diversity Council 4. Patient Experience Department (language services)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
Patient Rights & Responsibilities:			
A. Inform patient of identity and professional status of individual (s) providing care. Wears name badge in area visible to patient.		M DNM R N/A	
B. Provides patients with considerate and respectful care without discrimination.		M DNM R N/A	
C. Provides patient every consideration of privacy.		M DNM R N/A	
D. Treats patient health care records as confidential.		M DNM R N/A	
E. Informs patient of hospital policies and practices that relate to patient care, treatment and responsibilities.		M DNM R N/A	
F. Informs patient of available resources for resolving disputes, grievances, and conflicts such as ethics committee, patient representatives or other mechanisms available in the institution.		M DNM R N/A	

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I. Required by Regulatory Agency			
A. Communication:			
1. Utilizes SBAR model when giving report to a member of the healthcare team		M DNM R N/A	
2. Utilizes AIDET model in daily interactions with patients, customers, and associates.		M DNM R N/A	
3. Participates in bedside reporting at change of shift involving patient and incorporating the care plan.		M DNM R N/A	
B. Documents & incorporates Core Measure interventions as appropriate including:			
1. Perinatal		M DNM R N/A	
2. Acute MI		M DNM R N/A	
3. SCIP		M DNM R N/A	
4. Influenza		M DNM R N/A	
5. VTE		M DNM R N/A	
6. Stroke		M DNM R N/A	
7. ED Throughput		M DNM R N/A	
8. Tobacco/Screening/Counseling/Treatment		M DNM R N/A	
C. Utilizes Restraints & Documents in collaboration with RN per policy/procedure (Violent/Self-Destructive & Non-violent/Non-Self-Destructive)			
1. Alternatives & preventative strategies attempted		M DNM R N/A	
2. Protective devices (not a restraint) utilized per policy/procedure		M DNM R N/A	
3. Handcuffs (not a restraint) documented under peripheral vascular assessment		M DNM R N/A	
4. Restraints:			
a. Side Rails X4		M DNM R N/A	
b. Soft Hand Mitts		M DNM R N/A	
c. Joint Immobilizers		M DNM R N/A	
d. Disposable Quick Release Limb Holder		M DNM R N/A	
e. Body Holder		M DNM R N/A	
f. Twice as Tough (wrist/ankle) (unlocked)		M DNM R N/A	
g. Physical Hold (violent/self-destructive)		M DNM R N/A	
h. 3or4 point (unlocked – violent/self-destructive)		M DNM R N/A	
i. BH Only		M DNM R N/A	
1) 3or4 point (locked)		M DNM R N/A	
2) Swedish belt (locked)		M DNM R N/A	
3) Twice as Tough (wrist/ankle) (locked)			

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D. Completes SMART mobility data collection and utilizes appropriate SMART Equipment for patient safe movement and protection of self from injury: 1. Maxi Slide 2. Stedy 3. Sara Plus 4. Maxi Move a. Repositioning bar 5. Maxi Sky 600/1000 6. Tenor		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
E. Completes Code Blue Update 2015 CBL		M DNM R N/A	
F. Completes Basic Annual Requirement (BAR) Netlearning Modules in first quarter.		M DNM R N/A	
G. Attends Annual Competency Assessment Day as mandated by SEH policy.		M DNM R N/A	
II. Changes in work, role, and/or setting			
A. Acts upon patient data collection and documentation of: 1. MEWS score to be aware of declining patient Condition. 2. CIWA for treatment of alcohol withdrawal. 3. Clinical Opiate Withdrawal Protocol for treatment of opiate withdrawal.		 M DNM R N/A M DNM R N/A M DNM R N/A	
B. Utilizes Bedside Reporting: 1. Documents in admission navigator patient's desire to be awakened for bedside report 2. Conducts report at the bedside 3. Utilizes SBAR report/ sticky note for patient information 4. Collaborates with RN to involve patient in plan of care 5. Verifies equipment settings at ordered rates		 M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
III. New technology, equipment, procedures			
A. Collects data & documents Mobility assessment & scoring		M DNM R N/A	
B. Cares for Central Vascular Access Device (CVAD) utilizing: 1. Sorbaview Contour (securement device) for jugular lines 2. Dualcap (port caps) (all ports of CVAD & peripheral when Central line in place)		 M DNM R N/A M DNM R N/A	

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C. Follows Wound Care Protocols and care plan as appropriate: 1. Nutrashield: a. Foam cleanser b. Moisture Barrier c. Calazime 2. Desenex Powder 3. Barrier prep 4. Mepilex foam 5. LiquiCell nasal CPAP cushions 6. Heelift boots 7. Repositioning Wedges 8. Covidien premium underpad (skin open to air) in place of briefs while in bed 9. Hill-rom bed - chair and other features as available my model 10. Turns/reposition every 2hrs (including alignment/extremity support to avoid pressure areas)		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	
D. Collaborates with RN to care for Vesicant IV Fluid Administration following policy/procedure: 1. Frequency of checking site 2. Extravasation algorithms 3. MIDAS reporting for infiltrates		M DNM R N/A M DNM R N/A M DNM R N/A	
E. Monitors/maintains "Bridle" securement device for NG tubes.		M DNM R N/A	
IV. Documentation			
A. Manages Orders (if RN not available) 1. Verifies correct order mode (per protocol co-sign vs no co-sign required) 2. Verifies correct ordering/authorizing provider		M DNM R N/A M DNM R N/A	
B. Utilizes "sidebar" in flow sheets to view information from Index page		M DNM R N/A	
C. Documents accurately in Code Narrator (for rapid responses & codes): 1. Event type 2. Event start 3. Even end 4. Event outcome 5. Rapid Response Onset including "Reason": a. Respiratory compromise b. Hemodynamic Compromise c. Other Reason for Call		M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A M DNM R N/A	

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D. Meaningful use (collaborates with RN who completes discharge summary) –			
1. Ensures Provider & Locations entered in Next Level of Care		M DNM R N/A	
2. Notifies IS if provider/location not in system		M DNM R N/A	
3. Ensures completion of Continuity of Care flowsheet (if applicable)		M DNM R N/A	
4. Medication Reconciliation			
a. Collaborates with RN who checks for duplication of meds before printing AVS		M DNM R N/A	
b. Collaborates with RN who completes all info on AVS electronically (no handwritten information) before printing		M DNM R N/A	
c. Encourages e-prescribing of DC meds		M DNM R N/A	
5. Encourages patient use of MyChart		M DNM R N/A	
E. Care Plan (collaborates with RN)			
2. To individualize care plan – addressing 3 initial questions		M DNM R N/A	
3. To enter only actual pt specific problems & interventions		M DNM R N/A	
4. To evaluate end date		M DNM R N/A	
1. To evaluate outcomes for each goal		M DNM R N/A	
F. Documents in Education section by:			
1. Completing the learning data collection		M DNM R N/A	
2. Utilizing teachback		M DNM R N/A	
3. Utilizing patient education resources (Mosby & Medex)		M DNM R N/A	
G. Completes appropriate occurrence reporting:			
a. Employee Injury Report on intranet for all staff injuries only.		M DNM R N/A	
b. OPIM Exposure Incident Report in addition to injury report for exposure.		M DNM R N/A	
c. MIDAS RDE for patient and visitor occurrence reporting only.		M DNM R N/A	
V. Patient Safety			
A. Utilizes Bar Code Med Administration (BCMA):			
1. Uses two patient identifiers		M DNM R N/A	
2. Uses scanner/rover for all meds		M DNM R N/A	
3. Maintains the Six Rights of Medication Safety		M DNM R N/A	
4. Administers time critical meds within 30 min of scheduled time		M DNM R N/A	

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B. Performs Hand Hygiene:			
1. When hands are visibly dirty		M DNM R N/A	
2. Before eating & after using a restroom		M DNM R N/A	
3. Before direct contact with a patient		M DNM R N/A	
4. After contact with a patient's intact skin		M DNM R N/A	
5. Before donning sterile gloves		M DNM R N/A	
6. After removing gloves or other PPE		M DNM R N/A	
7. After contact with body fluids or secretions, mucous membranes, non-intact skin and wound dressings		M DNM R N/A	
8. When moving from a contaminated body site to a clean body site during patient care		M DNM R N/A	
9. After contact with inanimate objects in the immediate vicinity of the patient (e.g. items likely to be touched by the patient)		M DNM R N/A	
C. Follows Fall Protection Program			
1. Reviews Policy		M DNM R N/A	
2. Utilizes alarms as indicated for patient safety			
a. Bed alarm		M DNM R N/A	
b. Chair alarm		M DNM R N/A	
c. Toilet alarm		M DNM R N/A	
d. Other		M DNM R N/A	
VI. Performance Improvement involvement (individual/department)			
A. Can state unit PI initiative and personal role in attaining unit goals.		M DNM R N/A	
		M DNM R N/A	

*Skills specific to licensure are to be reviewed by someone of like discipline.

Initials	Signature	Title

Initials	Signature	Title

Date:_____ **Associate Signature:**_____
Date:_____ **Manager Signature:**_____
To be completed yearly at the time of performance appraisal.

"I am still currently up-to-date on the skills/procedures/equipment identified on the Initial Skills/ Equipment Competency Checklist."

Date:_____ **Associate Signature:**_____
Date:_____ **Manager Signature:**_____