

Name: _____

NursePro

Registered Nurse Competency/Skills Assessment Evaluation

SELF-ASSESSMENT

EVALUATION SUMMARY

| <i>Directions: for each procedure listed, the new employee will answer the two questions indicated. Competence means "the ability to perform the procedures safely, correctly, effectively and legally."</i> | | | <i>Directions: The evaluator/preceptor certifies that the nurse has demonstrated the ability to perform the skill within acceptable standards.</i> | | | | |
|--|---------------------------------|----|--|----|---------------------------|------------------------|----------|
| Procedure | Have you ever done this before? | | Are you competent performing? | | Date Competency Validated | Signature of Evaluator | Comments |
| | Yes | No | Yes | No | | | |
| I. Safety/Infection Control | | | | | | | |
| A. Hand Washing Procedures 1. Aseptic technique | | | | | | | |
| B. Standard Precautions | | | | | | | |
| C. Tb Precautions | | | | | | | |
| D. MRSA Precautions | | | | | | | |
| E. Electrical Safety | | | | | | | |
| F. Preventing falls | | | | | | | |
| G. Fire Safety | | | | | | | |
| H. Medication Safety | | | | | | | |
| I. Sharps Disposal | | | | | | | |
| II. Assessment | | | | | | | |
| A. ENT | | | | | | | |
| B. Neurological | | | | | | | |
| C. Cardiac | | | | | | | |
| D. Respiratory | | | | | | | |
| E. GI/Nutrition | | | | | | | |
| F. GU | | | | | | | |
| G. Integumentary | | | | | | | |

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| | Yes | No | Yes | No | | | |
| H. Pain | | | | | | | |
| I. Ability to learn | | | | | | | |
| J. Vital Signs | | | | | | | |
| K. Height and Weight | | | | | | | |
| III. Monitoring | | | | | | | |
| A. Patient Education | | | | | | | |
| B. Taking verbal orders | | | | | | | |
| C. Inventory: expiration dates, stocking, ordering | | | | | | | |
| D. Deliveries | | | | | | | |
| E. Care Planning | | | | | | | |
| 1. Development | | | | | | | |
| 2. Revisions/Updates | | | | | | | |
| 3. Discharge/Transfer | | | | | | | |
| F. Medication Profiles | | | | | | | |
| 1. Initial | | | | | | | |
| 2. Allergy History | | | | | | | |
| 3. Revisions | | | | | | | |
| 4. Discharge | | | | | | | |
| G. Venipuncture/labwork | | | | | | | |
| IV. Accesses | | | | | | | |
| A. Peripheral Insertion | | | | | | | |

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| | Yes | No | Yes | No | | | |
| B. PICC | | | | | | | |
| C. Midline | | | | | | | |
| D. Tunneled Catheters | | | | | | | |
| E. Port-a-Caths | | | | | | | |
| F. Nontunneled Catheters | | | | | | | |
| G. Care & Flushing | | | | | | | |
| H. Other | | | | | | | |
| V. Other Procedures | | | | | | | |
| A. Wound Care | | | | | | | |
| 1. Dry | | | | | | | |
| 2. Wet to Dry | | | | | | | |
| 3. Wound Care Products | | | | | | | |
| 4. Ace Wraps & pressure drsgs | | | | | | | |
| B. Routine Skin Care | | | | | | | |
| C. Catheterization | | | | | | | |
| 1. Male | | | | | | | |
| 2. Female | | | | | | | |
| D. Medication Admin. | | | | | | | |
| 1. Oral | | | | | | | |
| 2. Subcutaneous | | | | | | | |
| 3. IM | | | | | | | |

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| | Yes | No | Yes | No | | | |
| 4. Ocular | | | | | | | |
| 5. Aerosolized | | | | | | | |
| 6. IV | | | | | | | |
| a. Gravity | | | | | | | |
| b. Elastomeric | | | | | | | |
| c. Add-vantage | | | | | | | |
| d. Rate controlled tubing | | | | | | | |
| E. Care of Cardiac pt. | | | | | | | |
| F. Care of AIDS pt | | | | | | | |
| G. Care of Oncology pt | | | | | | | |
| VI. Therapies | | | | | | | |
| A. Antibiotics | | | | | | | |
| 1. First dose/ANA kits | | | | | | | |
| B. TPN - 3:1 | | | | | | | |
| C. Chemotherapy | | | | | | | |
| 1. Vesicant | | | | | | | |
| 2. Non Vesicant | | | | | | | |
| 3. Chemo Spill Kit | | | | | | | |
| D. IgG | | | | | | | |
| E. Hydration | | | | | | | |
| F. Enteral | | | | | | | |

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| | Yes | No | Yes | No | | | |
| G. Inotropics | | | | | | | |
| H. Pain Management | | | | | | | |
| I. Other | | | | | | | |
| VII. Pumps | | | | | | | |
| A. Ambulatory | | | | | | | |
| 1. Type _____ | | | | | | | |
| 2. Type _____ | | | | | | | |
| 3. Type _____ | | | | | | | |
| 4. Type _____ | | | | | | | |
| B. Pole Mounted | | | | | | | |
| 1. Type _____ | | | | | | | |
| 2. Type _____ | | | | | | | |
| C. Enteral | | | | | | | |
| D. Other | | | | | | | |
| VIII. Performance Improvement | | | | | | | |
| A. Participation in | | | | | | | |
| 1. Customer Satisfaction | | | | | | | |
| 2. Chart Audits | | | | | | | |
| 3. Infection Control | | | | | | | |
| 4. Teams | | | | | | | |

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| | Yes | No | Yes | No | | | |
| IX. General Knowledge | | | | | | | |
| A. Case Management | | | | | | | |
| B. Authorizations | | | | | | | |
| C. Interdisciplinary Communication | | | | | | | |
| D. On Call | | | | | | | |
| E. DNR Status | | | | | | | |
| F. Advanced Directives | | | | | | | |
| G. HIPAA | | | | | | | |
| H. References | | | | | | | |
| X. Other | | | | | | | |
| A. | | | | | | | |
| B. | | | | | | | |
| C. | | | | | | | |

Date: _____

Evaluator Signature: _____

Evaluator Signature: _____

RN Signature: _____

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