Marlette Regional Hospital
Acute Care Orientation for RN Clinical Performance Assessment

Name:_____

Complete the self-assessment tool prior to unit orientation and share with preceptor on your first day of orientation. It is the new employee's responsibility to request preceptor to validate performance during orientation with signatures.

This form must be returned to Acute Care Manager within 90 days of start date.

Start Date:_____ **Due Date: _____**

Self-Assessment

Key: 0 – No knowledge of Skill/Information
1 – Knowledge of Skill/Information. Never Performed/Utilized
2 – Minimal Experience
3 – Skill/Information mastered

SKILL/INFORMATION **SELF-ASSESS** **PERFORMANCE EVALUATION**

GENERAL INFORMATION	0	1	2	3	Discussed **Date/Initial**	Demonstrated **Date/Initial**	Performs Independently **Date/Initial**
1. Employee/Incident Reports on MRH Patient Safety Portal							
2. Shift Report-Location and Format							
3. Emergency Overhead Paging							
4. Nurse Call System							

a. Answering Lights							
b. Emergency System							

PATIENT CARE ASSESSMENT Conduct and Document Physical Assessment Per Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initial**			**Date/Initial**			**Date/Initial**		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
1. General Assessment													
a. Obtains Head to Toe Assessment Q shift, PRN, with Changes in Patient Condition and/or as Ordered													
b. Identifies Patients at Risks for Falls and Initiates Fall Risk Prevention As Appropriate													
c. Reviews Patient Medical History and Medications													
d. Reviews VS per procedure and PRN based on clinical needs/observations													
e. Identifies Problems/Potential Problems from Assessments and Address Appropriately													

f. Monitors Lab/ Radiology Results/Reports, Communicates Appropriately													
g. Educate Patient/Caregiver regarding Disease Process, Patient Needs													
h. Displays Effective Communication with Patients and Families													
i. Effective Communication with Physicians													
PATIENT CARE ASSESSMENT Conduct and Document Physical Assessment Per Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initial**			**Date/Initial**			**Date/Initial**		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
2. Neurological													
a. Assesses Mental Status and Orientation with Assessment													
b. Utilizes the Glasgow Coma Scale Appropriately													
c. Identifies any Abnormal Findings/ Changes in Assessment and Report to Appropriate Provider													

3. Cardiovascular													
a. Auscultation of Heart Sounds with Assessment-Identifies and Reports Abnormalities													
b. Palpates Peripheral Pulses. Utilize Doppler as appropriate													
c. Assesses Peripheral Perfusion													
d. Assesses Fluid Volume Status													
e. Identifies Abnormalities and Takes Appropriate Action													
f. Verifies VS prior to Cardiac Medication Administration													
g. Monitors Telemetry. Analyzes and Interprets Rhythms.													
PATIENT CARE ASSESSMENT Conduct and Document Physical Assessment Per Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initial**			**Date/Initial**			**Date/Initial**		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
4. Respiratory													
a. Assesses patency of Airway, Rate, Depth, Respiration													

Pattern, SPO2, Sputum Production													
b. Assess Need for Droplet Precautions													
c. Auscultates and Appropriately Identifies Breath Sounds with Assessment													
d. Recognizes S/S of Respiratory Distress and Responds Appropriately													
e. Proper Positioning of Patient for Optimal Oxygenation													
f. Initiates and Maintains O2 Delivery Device: NC, Mask, SPO2 Monitoring													
g. Collaborates with Respiratory Therapy													
h. Demonstrates Appropriate use of Suction: 1. Wall 2. Gomco													
PATIENT CARE ASSESSMENT	Self-Assess				Discussed			Demonstrated			Performs Independently		

Conduct and Document Physical Assessment Per Policy	0	1	2	3	Date/Initial			Date/Initial			Date/Initial		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
5. GI/GU													
a. Inspects, Auscultates, And Palpates Abdomen. Reports Abnormalities													
b. Assess Nutritional Status including oral intake and mucus membranes status.													
c. Assess/Monitor Drains/Tubes including placement and output													
d. Monitor Intake and Output. Appropriate Diet Order in place													
e. Evaluate for S/S of Infection, Obtain Samples as Ordered/Appropriate													
6. Integumentary													
a. Assess Skin at Admission and with each Assessment. Obtain Pictures As Appropriate													
b. Assess for Risk of Pressure Ulcer Development. Interventions as Appropriate:													

Air Mattress, Heel Boots, Turn Clock, etc.													
c. Assess Wounds for S/S of Infection and/or Healing													
d. Obtain Cultures as Needed													
PATIENT CARE ASSESSMENT Conduct and Document Physical Assessment Per Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initial**			**Date/Initial**			**Date/Initial**		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
e. Wound Care/ Dressing Changes as Ordered													
f. Monitor for signs/symptoms of healing, infection													
g. Documentation of Wound Status and any Changes As Appropriate													
7. Spiritual/Psychological													
a. Assess Spiritual and/or Religious Needs/Preferences in Relation to Care													
b. Respect Patients Religious/ Spiritual Needs/Preferences													

c. Assess Patient Mental Status for any S/S of Mental Illness, Difficulty Coping													
d. Assess Patient Verbalized Home Environment. Monitor for Potential S/S of Abuse and/or Neglect													
e. Social Worker Consult as Deemed Necessary													
f. Restraints will be used as a last resort when other interventions have failed per policy													
PATIENT CARE ASSESSMENT Conduct and Document Physical Assessment Per Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initial**			**Date/Initial**			**Date/Initial**		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
8. Musculoskeletal													
a. Assess Abnormalities including Gait, Numbness, Tingling, Weakness, Neurovascular Status													
b. Use of Assistive Devices													

c. History/Risk of Falls													

PATIENT CARE PROCEDURES Medication Administration Per MRH Policy	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	**1**	**2**	**3**	**Date/Initials**			**Date/Initials**			**Date/Initials**		
Medication Administration					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
1. Oral													
2. Intradermal													
3. Intramuscular													
4. Subcutaneous													
5. Intravenous													
a. IV Push													
b. IV Piggyback													
6. PCA Management for Pain Control													
Medication Management Guidelines													

1. Narcotics/Controlled Substances a. Med-Dispense b. MRH Policy							
2. Anti-Coagulant Therapy a. PO b. IV							
3. Insulin a. SQ b. IV							
4. TPN/PPN per Policy							

Patient Care Procedures and Equipment	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	1	2	3	Date/Initials			Date/Initials			Date/Initials		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
1. Peripheral IV Start Per MRH Policy													
2. Management/Access of Various Lines per MRH Policy:													
a. Peripheral													
b. Central													
c. PICC Line													
d. Mediport													

e. Midline													
3. Pump Operation:													
a. Hospira Plum													
b. Baxter's													
c. PCA													
4. Blood Product Administration Per MRH Policy:													
a. Consent Obtained.													
b. Follows MRH policy. Validates Blood Product with 2 RN's													
c. Tubing and Blood Set-up													
d. Monitoring													
e. Documentation													
f. Appropriate Nursing Care i.e. Transfusion Reaction Response													
5. Inpatient Surgical Patient													
a. Patient Prepared/Questions Answered													
b. Surgical Site Prepped/Patient Showered													

c. Chart Reviewed, Required Forms Present in Chart													
d. IV Site Patent/Appropriate for Procedure													
Patient Care Procedures and Equipment Continued	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	1	2	3	Date/Initials			Date/Initials			Date/Initials		
					Peds	Adult	Geriatric	Peds	Adult	Geriatric	Peds	Adult	Geriatric
e. Lab/Radiology Reports Reviewed as Appropriate													
6. Management of Drains/Tubes													
a. J.P.													
b. Hemovac													
c. Penrose													
d. Chest Tube													
Insertion & Set-up													
Management													
Discontinuation													
7. Naso-Gastric Tube													
a. Insertion													
b. Placement													
c. Patency													
d. Auscultation													

e. Residual													
f. Chest X-ray													
g. Tube Feeding Management													
h. Tube Feeding Pump													
i. Aspiration Precautions													
7. Tracheostomy Care													
a. Suction													
8. Catheter Care													
a. Straight Cath													
b. Foley Cath													
c. Suprapubic Management													
9. Urine Specimen Collection													
10. Sputum Specimen Collection													
11. Wound Specimen Collection													
12. Stool Specimen Collection O/P, C-diff													
13. SCD's													
14. TEDS													
Cardiac Monitoring	Self-Assess				Discussed			Demonstrated			Performs Independently		
	0	1	2	3	Date/Initials			Date/Initials			Date/Initials		

1. Telemetry Monitoring							
a. Set-up Patient							
b. Admission of Patient							
c. Set Limits							
d. Evaluate Alarms							
e. Pacemaker Function							
f. Run Strip							
g. ST Segment Function							
h. Add paper							
i. Discharge Patient							
2. SCU Monitor:							
a. Set-up and Admit patient							
b. Monitor Functions/Capability							
c. Discharge Patient							
Isolation Precautions							
1. Standard Precautions							
2. Droplet							

3. Contact							
4. Neutropenic							
Emergency Procedures							
1. Crash Cart/Emergency Equipment							
2. Calling/Paging a Code							
3. Code Meanings (Blue, Gray, Strong, etc.)							
4. Defibrillator/AED							
5. Cardioversion							
6. External Pacing							
7. Arrest Procedure/Documentation							

Death of Patient	0	1	2	3	Discussed	Demonstrated	Performs Independently
					Date/Initial	**Date/Initial**	**Date/Initial**
1. Post-Mortem Care							
2. Gift-of-Life							
3. Location of Paperwork							
DELEGATION/WORKING RELATIONSHIPS	**0**	**1**	**2**	**3**	**Discussed** **Date/Initial**	**Demonstrated** **Date/Initial**	**Performs Independently** **Date/Initial**

1. Physician On-Call List							
2. Demonstrates appropriate delegation of Patient Care							
a. CENA							
b. Ward Clerk							
3. Unit Chain of Command							

COMMENTS:_____

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New Employee Signature: _____ Initial:_____ Date: _____

Preceptor Signature: _____ Initial:_____ Date: _____

Preceptor Signature: _____ Initial:_____ Date: _____