**Adult Registered Nurse Orientation Tool**  
**Competency based tool**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Hire:</th>
<th>Unit:</th>
<th>Validation Method</th>
<th>Validator’s Initials/Date</th>
</tr>
</thead>
</table>

### Learning Objective

**Assessment: Initial/Ongoing**

1. Provides ongoing assessment of nursing care to a group of patients.
2. Considers population-served characteristics in the assessment of all patients.
3. Admits patients & documents history on all admission database forms.
4. Performs a functional assessment on each patient admitted.
5. Conducts an initial and ongoing assessment and documents assessment data on appropriate documentation tool.
6. Prepares patient and family for transfer.
7. Documents all aspects of care and initiates discharge planning through the electronic medical record.
8. Assesses patient’s understanding / wishes regarding end of life care.
   a. Determines and documents if the patient has or wishes to have an Advanced Directive.

### Implementation: Planning of Care

1. Develops and implements care plan according to established priorities and revises as needed.
   a. Documents correctly in the electronic medical record and carries out orders related to the plan of care.
2. Incorporates population-served information in development of plan of care.
3. Evaluates progress toward identified outcomes and documents appropriate patient progress note to reflect the patient’s changes.
4. Implements health care provider orders and communicates relevant patient information or change in patient status by using the SBAR format.
   a. Utilizes electronic medical record to communicate complete and accurate patient information.
5. Promotes patient-family centered care at all times and collaborates with patient, family, and interdisciplinary team in the completion of White Board information.

### Evaluation of Nursing Process:

1. Organizes nursing care for assigned patients.
   a. Delegates/negotiates nursing responsibilities within scope.
   b. Establishes priority for care and provides rationale for clinical decisions.
   c. Revises and updates plan of care.

---

**Self-Assessment Level Key:**
1= No experience  
2= Needs review  
3= Functions independently

**Validation Method Key:**
V - Verbal response  
WE - Written exam  
DO - Direct observation  
RD - Return demonstration  
O – Other (explain)
The nurse will safely administer medications via all routes per order and policy/procedure.

<table>
<thead>
<tr>
<th>Self-Assessment</th>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
<th>Validation Method</th>
<th>Validator’s Initials/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Evaluates care of patients.
   a. Documents patient’s physical and psychosocial response to care.
   b. Evaluates response to care to desired outcomes.

**Implementation: Medication**

1. Demonstrates understanding of medication to be administered and safely administers via all routes as prescribed.
   a. Ensures infection prevention by washing hands and cleaning clave ports before accessing the line.
   b. Participates with narcotic counts within the medication administration system.
   c. Correctly uses the medication administration system / MAR patient verification.
   d. Implements medication alerts into administration practices.
   e. Validates positive patient identification during administration through scanning all medications and co-signing for high risk medications.
   f. Utilizes Micro Medex and Lexicomp for medication information verification.

2. Verbalize location of medication administration policy.
   a. Adheres to policy and procedure for care of patients receiving IV therapy while initiating/maintaining IV therapy per orders.

3. Provides care for a patient with a peripheral, midline, and extended dwell intravenous catheters according to the Venous Access Policy.
   a. Demonstrates PIV catheter insertion.

4. Provides care for a patient with an external non-tunneled and tunneled central intravenous catheters according to the Venous Access Policy.

5. Provides care for a patient with an implanted port according to the Venous Access Policy.


7. Uses IV pump safely, by utilizing Smart Pump drug library and correctly documents in MAR and CPOE.
   a. Sets up primary and secondary IV tubing administration sets
   b. Administers/changes IV bags and tubing
   c. Administers bolus infusion
   d. Administers specialty infusions (blood products, parenteral nutrition, etc.)

8. Correctly labels IV tubing and bags.
   a. All tubing should be labeled with date and time when hung and when it should be discontinued as well as the medication infusing.
   b. If medication is added to a bag outside of pharmacy, the orange label should be completed and placed on the front of the bag.


10. Demonstrates correct administration of blood/blood products, including:
<table>
<thead>
<tr>
<th>Self-Assessment</th>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
<th>Validation Method</th>
<th>Validator's Initials/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Verifying consent or refusal of blood products.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Collects and sends type and cross specimen correctly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Validates utilizing TypeNex CheckDigit Blood Band competency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Initiates and monitors patient during transfusion of products per policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Recognize transfusion reactions and follow treatment protocols.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation: Diagnostic Data</td>
<td>1. Correctly collects, labels, and sends lab specimens.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Correctly performs capillary blood glucose monitoring.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Recognizes and responds to abnormal laboratory values and diagnostic procedure reports.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Identifies which diagnostic findings require physician interventions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Demonstrates Critical Result Notification documentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Obtains vital signs, height and weight per orders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment: Pain</td>
<td>1. Assesses patient’s level of comfort and use the appropriate pain scale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Assesses pain with vital signs and as indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Documents patient’s pain level according to policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Documents reassessment of pain level and further action, if required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Assess factors that might influence the patient’s pain and their expression of their pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Assess for barriers that might influence the nursing assessment and treatment of pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implementation: Pain</td>
<td>1. Provides acceptable pain management care for patients based on their needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Provides and documents appropriate pain management interventions according to policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Provides and documents appropriate patient education related to pain and pain medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Demonstrates ability to use PCA pumps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Demonstrates ability to use Epidural pumps.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Collaborates with healthcare team to evaluate and treat pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment: Psychosocial</td>
<td>1. Assesses patient’s psychosocial status (level of orientation, sleep patterns, anxiety, grief) and support systems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Identifies psychosocial issues.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Responsibilities & Performance Criteria

**Assessment: Pulmonary System**
1. Performs a pulmonary assessment and documents findings appropriately.
   - a. Identifies normal and adventitious lung sounds.
2. Assesses need for oxygen therapy.
3. Accurately interprets early warning system data.

**Implementation: Pulmonary System**
1. Provides care for patient using the correct oxygen therapy necessary for care.
   - a. Applies oxygen therapy devices correctly.
   - b. Demonstrates correct use and storage of O₂ tank.
2. Provides care for patient with respiratory insufficiency and instability.
   - a. Recognizes pulmonary instability and initiates appropriate interventions.
   - b. Activates RRT when appropriate.
   - a. Suctions airway adjuncts appropriately.
   - b. Uses pulse oximeter correctly.
4. Provides and documents patient education on modifiable risk factors, diagnostic tests, and medication.

**Assessment: Chest Tubes**
1. Assesses dressing and area around insertion site for any drainage or other abnormal findings.
2. Assesses drainage in the tube/drainage device.

**Implementation: Chest Tubes**
1. Manages chest tube by applying suction as ordered.
2. Monitors tube drainage system for air leaks, patency, negative pressure fluctuation, bubbling, and drainage.
3. Verbalizes emergency interventions if chest tube becomes dislodged from patient or drainage system.
4. Performs specimen collection appropriately.
5. Performs routine exchange of drainage system.

**Assessment: Tracheostomy Care**
1. Assesses patency of tracheostomy.
2. Assesses stoma site and secretions, if applicable.
**Self-Assessment Level Key:**
1= No experience  
2= Needs review  
3= Functions independently

<table>
<thead>
<tr>
<th>Self-Assessment</th>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
<th>Validation Method</th>
<th>Validator's Initials/Date</th>
</tr>
</thead>
</table>
| 1 2 3            | The nurse will provide care to manage the patient with a tracheostomy. | 3. Continuously assesses patient’s respiratory status for potential dislodgement.  
**Implementation: Tracheostomy Care**  
1. Demonstrates tracheostomy care to maintain airway.  
2. Maintains sterile technique during tracheostomy suction and cleaning.  
3. Changes tracheostomy ties as needed with second healthcare provider.  
4. Ensures proper emergency equipment is available at beside and proper signage is posted, if applicable. | | |
| 1 2 3            | The nurse will provide care to manage and protect the patient’s cardiac status. | **Assessment: Cardiovascular System**  
1. Performs cardiovascular assessment and documents finding appropriately.  
   a. Identifies normal and abnormal cardiovascular assessment findings  
2. Review Acute Coronary Syndrome flowchart.  
   a. Activates Code Heart Team when necessary.  
3. Correctly obtains 12-lead ECG.  
**Implementation: Cardiovascular System**  
1. Provides care for patient with abnormal cardiovascular function.  
   a. Recognizes cardiac instability and initiates appropriate interventions.  
2. Provides care for patient on telemetry monitoring.  
3. Demonstrates ability to setup telemetry at central monitoring station and patient’s portable monitor.  
4. Attaches electrodes in a lead designated by unit protocol (i.e. EASI lead placement).  
5. Initiates basic monitoring to include setting alarm limits according to monitor preset or as appropriate to patient condition.  
6. Troubleshoots telemetry equipment and resolves problems as necessary.  
7. Provides and documents post-cardiac catheterization care.  
8. Utilizes Doppler correctly.  
9. Provides and documents patient education on modifiable risk factors, diagnostic tests, and medications.  
10. Correctly sizes and applies TED hose or SCDs as ordered. | | |
| 1 2 3            | The nurse will provide care to manage and protect the patient’s neurologic status. | **Assessment: Neurological System**  
1. Performs neurological assessment and recognizes normal & abnormal findings.  
2. Utilizes Glasgow Coma Scale accurately.  
**Implementation: Neurological System**  
1. Provides care for patients with neurological deficits.  
2. Provides care for patients with spinal cord injuries.  
3. Recognizes neurological/neurovascular instability and initiates appropriate interventions.  
   a. Verbalizes how and when to activate “Code Stroke”. | | |

Rev: 3/2019
### Responsibilities & Performance Criteria

- b. Ensures NIHSS is completed by certified healthcare provider, if applicable.
- c. Initiates Stroke quality measure.
- 4. Provides care for patients with seizure disorders.
- 5. Provides and documents patient education on modifiable risk factors, diagnostic tests, and medications.

#### Assessment: Renal, Endocrine, and Hematologic Systems

1. Recognizes abnormal renal/endocrine/hematological assessment findings and documents appropriately.
   - d. Accurately interprets diagnostic exams and lab values.
3. Assesses intake and output, correlates findings to daily weight.
4. Assesses laboratory values for hematologic functions.
5. Assesses laboratory values for indications of endocrine dysfunction.

#### Implementation: Renal, Endocrine, and Hematologic Systems

1. Provides care for patient with renal dysfunction and/or renal failure.
2. Recognizes patients at risk for and/or experiencing acute renal failure/renal insufficiency.
4. Provides care for patient with endocrine dysfunction (SIADH, DI, DKA, thyroid disorders).
5. Completes urinary catheter insertion, maintenance, and removal while assessing and documenting appropriately.
   - a. Validates utilizing the BARD SureStep Foley Tray System competency.
   - b. Removes catheter utilizing the nurse driven removal protocol.
6. Provides care for patient with hematologic dysfunction.
7. Recognizes appropriate treatment, medications, and potential complications.
8. Provides and documents patient education on modifiable risk factors, diagnostic tests, and medications.

#### Assessment: GI/Nutritional System

1. Performs abdominal assessment and demonstrates ability to collect assessment data related to nutritional needs.
2. Recognizes abnormal GI assessment findings through inspection and auscultation of bowel sounds, and documents appropriately.
3. Accurately interprets lab data as related to nutritional status, to include patient’s weight.
4. Recognizes GI instability and potential complications and initiates appropriate interventions.
5. Assesses patency of various GI tubes.

---

**Validation Method Key:**
- V - Verbal response
- WE - Written exam
- DO - Direct observation
- RD - Return demonstration
- O – Other (explain)
### Responsibilities & Performance Criteria

<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
</tr>
</thead>
</table>
| **The nurse will provide care to manage and protect the patient’s GI/Nutritional status.** | 6. Correctly places and secures nasogastric (NG) tube.  
7. Confirms patency and position of NGT, jejunostomy, and other gastric feeding tubes.  
8. Assesses volume and characteristics of gastric secretions.  
**Implementation: GI/Nutritional System**  
1. Provides care for patient with GI instability (GI bleed, hepatic failure, diverticulitis, pancreatitis, etc.).  
2. Administers supplemental nutrition, enteral nutrition via bolus, or continuous feeding methods appropriately, as needed.  
3. Provides appropriate ostomy care and patient education.  
4. Provides and documents patient education on modifiable risk factors, diagnostic tests, and medication. |
| |  
| **The nurse will provide care to manage and protect the patient’s integumentary status.** |  
**Assessment: Integumentary System**  
1. Performs integumentary assessment, in order to assess patient for skin irritation/breakdown.  
a. Recognizes normal/abnormal integumentary assessment findings and documents appropriately.  
b. Evaluates patient for skin breakdown.  
c. Utilizes Braden scale accurately.  
d. Performs (2) RN skin check at each admission and transfer.  
e. Appropriately places Nurse Referral for WOCN.  
2. Recognizes common skin conditions and effects of aging on skin.  
**Implementation: Integumentary System**  
1. Provides care for patient with skin breakdown.  
2. Collaborates with wound care team for wound maintenance and pressure injury staging.  
3. Provides care for patient with postoperative wounds.  
4. Recognizes patient at risk for integumentary instability and initiates appropriate interventions.  
5. Determines need for and utilizes appropriate pressure reduction beds.  
6. Differentiates between types of specialty beds and identifies bed type to best meet patient’s needs.  
7. Completes dressing changes.  
8. Demonstrates maintenance and troubleshooting of wound vac therapy.  
9. Provides and documents patient education on prevention techniques, diagnostic tests, treatments, and medications.  
**Assessment: Musculoskeletal System**  
1. Performs musculoskeletal assessment. |

### Validation Method Key:
- V - Verbal response
- WE - Written exam
- DO - Direct observation
- RD - Return demonstration
- O – Other (explain)
<table>
<thead>
<tr>
<th>Self-Assessment Level Key:</th>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
<th>Validation Method</th>
<th>Validator’s Initials/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1= No experience</td>
<td>The nurse will provide care to manage and protect the patient’s musculoskeletal status.</td>
<td><strong>Implementation: Musculoskeletal System</strong>&lt;br&gt;1. Provides care to the patient in C-Spine immobilization or full spinal precautions.&lt;br&gt;2. Provides care to the patient in traction.&lt;br&gt;   a. Skeletal&lt;br&gt;   b. Halo&lt;br&gt;   c. C-Collar&lt;br&gt;3. Provides care to the patient with an external fixator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2= Needs review</td>
<td>The nurse will ensure patient care is delivered in an optimal healing environment.</td>
<td><strong>Facilitates optimal patient environment.</strong>&lt;br&gt;1. Maintains clean and safe environment.&lt;br&gt;2. Controls patient environment in relation to: sleep, visitors, privacy, noise, other staff, etc.&lt;br&gt;3. Adheres to Hand Hygiene policy.&lt;br&gt;4. Cleans and returns all equipment to designated area after patient care.&lt;br&gt;5. Incorporates and educates patients and family per the Family Presence policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3= Functions independently</td>
<td>The nurse will provide safe transportation and transfer of care throughout the patient’s admission.</td>
<td><strong>Transports patient to other departments.</strong>&lt;br&gt;1. Provides for safe transport.&lt;br&gt;2. Utilizes SBAR communication tool to provide handoff to destination department.&lt;br&gt;3. Identifies supplies needed for transport.&lt;br&gt;4. Communicates with patient and family to better facilitate transport.&lt;br&gt;5. Locates emergency equipment, if needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The nurse will ensure all care is completed before surgery and provides post-operative care to optimizes patient outcomes.</td>
<td><strong>Prepares patient for surgical procedures.</strong>&lt;br&gt;1. Witnesses consent form for procedure and separate blood consent in presence of patient and physician.&lt;br&gt;2. Completes and performs all activities of preoperative surgical checklist.&lt;br&gt;3. Prepares patient and family for procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The nurse will collaborate with the healthcare team to properly manage and transfer the patient to morgue.</td>
<td><strong>Cares for the post-operative patient.</strong>&lt;br&gt;1. Assesses vital signs on arrival to unit and as ordered by physician.&lt;br&gt;2. Monitors and treats pain according to physician orders.&lt;br&gt;3. Assess and maintains surgical site/dressing and drains, if applicable.&lt;br&gt;4. Ensures incentive spirometry is completed hourly.&lt;br&gt;5. Advance diet and activity per Progressive Mobility parameters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Cares for patient and family after patient’s death.</strong>&lt;br&gt;1. Contacts charge nurse and/or nursing supervisor of patient’s impending death for potential organ donation per policies.&lt;br&gt;2. Provides and documents post mortem care.&lt;br&gt;3. Collaborates with medical team to complete/submit post mortem forms.&lt;br&gt;4. Notifies additional agencies providing care to patient (i.e. Hospice, LifeLink, Georgia Eye and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The nurse will follow all policy and protocols to ensure hospital safety standards are met.

### Hospital Safety Standards

1. Recognizes and is able to verbalize or respond appropriately to Code system.
   a. Code Red
   b. Code Blue
   c. Code Triage
   d. Code Orange
   e. Code Grey
   f. Code Green
   g. Code White
   h. Code Pink
   i. Code Black
   j. Code Gold
   k. Code Strong

2. Activates emergency response/Code Blue: locates and transports code cart and defibrillator to patient’s room, accepts assigned role during code.
   a. Performs BLS correctly.
   b. Correctly documents Code Blue.
   c. Performs code cart and defibrillator check.

3. Locates fire alarm and fire extinguishers.
   a. Locates and verbalizes how to shut off oxygen, if required.

4. Verbalizes how to activate the panic button alert system.

5. Verbalizes emergency contact phone numbers.

The nurse will recognize and implement care related to quality measures to ensure high level patient care.

### Quality

1. Implements and complies with Cerner Core Quality Measures and discern notifications.
   a. Assesses, initiates, and verbalizes understanding of the Core Quality Measures plans:
      i. Chest Pain / AMI
      ii. Heart Failure
      iii. Stroke
      iv. Pneumonia
      v. SCIP
      vi. VTE
      vii. Sepsis

2. Implements appropriate interventions to comply with the management of nursing quality

### Responsibilities & Performance Criteria

- Tissue Bank, Coroner.
- Coordinates and prepares the body for transport to the morgue to include proper covering and labeling.

### Validation Method Key:
- V - Verbal response
- WE - Written exam
- DO - Direct observation
- RD - Return demonstration
- O – Other (explain)
<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The nurse will recognize and implement care related to quality measures to ensure high level patient care.</strong></td>
<td>Correctly interprets and implements appropriate interventions for discern notifications:</td>
</tr>
<tr>
<td></td>
<td>a. Sepsis Alert</td>
</tr>
<tr>
<td></td>
<td>b. VTE Alert</td>
</tr>
<tr>
<td></td>
<td>c. CAUTI Alert</td>
</tr>
<tr>
<td></td>
<td>d. CLABSI Alert</td>
</tr>
<tr>
<td></td>
<td>3. Correctly verbalizes protocols associated with each nursing quality indicator:</td>
</tr>
<tr>
<td></td>
<td>a. CLABSI</td>
</tr>
<tr>
<td></td>
<td>b. CAUTI</td>
</tr>
<tr>
<td></td>
<td>c. Pressure injury</td>
</tr>
<tr>
<td></td>
<td>d. Falls</td>
</tr>
<tr>
<td></td>
<td>e. Positive Patient Identification (PPID)</td>
</tr>
<tr>
<td><strong>Implements infection control precautions.</strong></td>
<td>1. Correctly demonstrates/implements transmission-based precautions:</td>
</tr>
<tr>
<td></td>
<td>a. Contact</td>
</tr>
<tr>
<td></td>
<td>b. Expanded contact</td>
</tr>
<tr>
<td></td>
<td>c. Enteric contact</td>
</tr>
<tr>
<td></td>
<td>d. Droplet</td>
</tr>
<tr>
<td></td>
<td>e. Airborne</td>
</tr>
<tr>
<td></td>
<td>f. Neutropenic</td>
</tr>
<tr>
<td></td>
<td>2. Provides and documents patient and family education.</td>
</tr>
<tr>
<td></td>
<td><strong>Provides care for the Cystic Fibrosis patient population</strong></td>
</tr>
<tr>
<td></td>
<td>1. Locates on the unit and able to reference CF Admission Playbook, provided and updated by CF Coordinator.</td>
</tr>
<tr>
<td></td>
<td>2. Reviews and adheres to Cystic Fibrosis Adult PowerPlan orders in the EMR.</td>
</tr>
<tr>
<td></td>
<td>3. Follows the contact care path for inpatient needs to include the appropriate member of the multidisciplinary team.</td>
</tr>
<tr>
<td></td>
<td>4. Observes CF-specific transmission-based precautions:</td>
</tr>
<tr>
<td></td>
<td>a. Verbalizes appropriate staffing pattern for patient assignments when multiple CF patients are on the unit.</td>
</tr>
<tr>
<td></td>
<td>b. Verbalizes importance of strict infection control related to organismal transmission.</td>
</tr>
<tr>
<td></td>
<td>c. Places patient on contact isolation precautions.</td>
</tr>
<tr>
<td></td>
<td>d. Uses a patient-dedicated vital signs machine throughout inpatient admission.</td>
</tr>
</tbody>
</table>

*Self-Assessment Level Key:*
1= No experience  
2= Needs review  
3= Functions independently

*Validation Method Key:*
V - Verbal response  
WE - Written exam  
DO - Direct observation  
RD - Return demonstration  
O – Other (explain)
<table>
<thead>
<tr>
<th>Self-Assessment</th>
<th>Learning Objective</th>
<th>Responsibilities &amp; Performance Criteria</th>
<th>Validation Method</th>
<th>Validator's Initials/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>e. Educates patient and visitors on infection control procedures:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Patients and visitors must perform hand hygiene before leaving their room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. Patients must wear a mask and gown when leaving their room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. Notifies CF Coordinator for issues with patient/visitor compliance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. Ensures patient room is terminally cleaned after discharge and collaborates with charge nurse regarding unique patient bedding issues with multiple CF patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.</td>
<td>Performs standing weight for all CF patients on admission and per ordered frequency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6.</td>
<td>Performs medication reconciliation by comparing medications listed by patient to most recent clinic visit note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Verbalizes protocol for using patient’s home supply of vitamins/enzymes, when not available on hospital formulary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.</td>
<td>Collects on ensures that RT collects a sputum culture on admission, if not done within the week prior to admission. This should be ordered as a “CF culture”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.</td>
<td>Collaborates with medical team to advocate for patient’s intravenous access needs, if long-term antibiotics are necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9.</td>
<td>Provides patient with hospital-approved refrigerator to remain in-room during admission:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Consults CF registered dietitian for all CF patient admissions and for weight changes during the inpatient stay.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Follows CF-Related Diabetes (CFRD) algorithm to determine frequency of blood glucose checks and/or the need for an Endocrine consult.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.</td>
<td>Coordinates respiratory care for the CF patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Collaborates with CF-specific respiratory therapist to ensure airway clearance therapy and inhaled medications are administered appropriately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Ensures pulmonary function tests (PFTs) are performed on admission and at appropriate intervals to monitor treatment response.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Observes infection control procedures related to multiple CF patients receiving PFTs on the same day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11.</td>
<td>Coordinates physical therapy for the CF patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Ensures every CF patient has a PT consult on admission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. If available, places a stationary exercise bicycle in the CF patient’s room, as part of the PT plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Cleans exercise bicycle before placing in CF patient’s room and after discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12.</td>
<td>Collaborates with CF coordinator for discharge planning needs and follow-up appointments.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rev: 3/2019
Self-Assessment Level Key:
1= No experience
2= Needs review
3= Functions independently

Validation Method Key:
V - Verbal response
WE - Written exam
DO - Direct observation
RD - Return demonstration
O – Other (explain)

Employee Signature/Initials: ______________________

Comments:

Preceptor Signature/Initials: ______________________

Preceptor Signature/Initials: ______________________

Preceptor Signature/Initials: ______________________

Preceptor Signature/Initials: ______________________

Recommendation(s):