

NAME OF
PATIENT CARE SERVICES
ORIENTATION/COMPETENCY INVENTORY (OCI)

Registered Nurse, Critical Care Services (1-16)

During orientation, you will be required to validate with your preceptor, administrative supervisor and/or department director established competencies for the above referenced position through either return demonstration or verbalizing the procedure, skill or criteria. Your preceptor, administrative supervisor and/or department director will date and initial each competency as they are satisfactorily completed. **THIS OCI MUST BE COMPLETED BEFORE YOU CAN BE RELEASED FROM ORIENTATION AND WORK WITHOUT A PRECEPTOR.** (Based on individual circumstances an employee may be released prior to completion of the OCI due to lack of opportunity for return demonstration. However, that procedure, skill or criteria may not be performed independently by the employee until s/he has been evaluated by the appropriate individual). At the conclusion of your orientation this OCI should be fully completed and will be reviewed by yourself, your preceptor and department director. This OCI will become a part of your Human Resources file.

Name of Employee: _____ Date of Hire: _____

Unit(s) Assignment: _____ Orientation Dates: _____ to _____

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

Department Director Signature: _____ Date: _____

KEY:

Self-Assessment:

Validation:

0 = No knowledge and/or experience.
(No competence).

RD = Return demonstration.

1 = Limited knowledge and/or experience.
(Some competence).

V = Verbalizes.

2 = Knowledgeable and feels confident.
(Complete competency).

NA = Not applicable to area or no
experience required.

Developed by: _____ Name of Developer
Approved by: _____ Name of Approver

SELF-ASSESSMENT (Orientee Initials)			COMPETENCIES The orientee will be able to:	VALIDATION (Preceptor, Administrative Supervisor, Department Director, Date and Initials)		
				RD	V	NA
0	1	2				
			1. <u>Hospital Safety Procedures:</u>			
			a. Internal Disaster (Fire [including RACE] & Electrical Safety, Bomb Threat).			
			b. External Disaster (Emergency Preparedness).			
			c. Infection Control: Bloodborne Pathogens and Tuberculosis Exposure Control Plans.			
			d. Body Mechanics.			
			e. Domestic Violence/Reporting of Suspected Abuse.			
			f. Risk management (including Hazardous Materials, MSDS).			
			g. Radiation Safety.			
			h. Patient call system.			
			i. Code Blue Management.			
			j. Restraint Management.			
			k. Current BLS-Healthcare Provider.			
			l. Current ACLS Provider.			
			2. <u>Departmental Overview:</u>			
			a. Tour of department(s)/unit(s):			
			1) Patient room/bed numbers.			
			2) Location of waiting rooms.			
			3) Location of conference rooms.			
			4) Medication carts.			
			5) Linen closets.			
			6) Utility rooms: Clean and soiled.			
			7) Examining rooms.			
			8) Supply room: Charging, ordering, obtaining.			
			9) Location of emergency equipment.			
			10) Charting areas.			
			b. Mechanism for tracking time and attendance (Kronos).			
			c. Telephone system; etiquette.			
			d. Page operators; beepers.			
			e. Departmental staff meetings.			
			f. Standard of professional attire.			
			h. Role of the resource nurse.			
			i. Ethics committee role and access.			

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				RD	V	NA
0	1	2				
			3. <u>Management of Information:</u>			
			a. Maintenance of patient records.			
			b. Confidentiality; facsimile of information.			
			c. Initial patient assessment.			
			d. Patient progress record (nurse's notes).			
			e. Patient/significant other education.			
			f. Advance directives.			
			g. Transcription of physician orders.			
			h. Use of SMS Invision computer system.			
			i. Methods of assignment.			
			j. Shift change reporting system: Walking rounds.			
			k. Hospital/departmental manuals:			
			1) Administrative.			
			2) Patient Care Standards.			
			3) Human Resources.			
			4) Infection Control.			
			l. Reporting defective medical equipment.			
			m. Incident reporting mechanism:			
			1) General form.			
			2) Medical Device Incident Report form.			
			n. Completion of informed consent forms.			
			o. Physician telephone and consultation log..			
			p. Patient kardex.			
			4. <u>Assessment of Patients:</u>			
			a. Initiate assessment of vital signs, orientation to room/smoking policy, allergies and notification of MD within 30 minutes of arrival.			
			b. Assess each patient's physical, psychosocial, and social status.			
			1) Determines the scope and intensity of further assessment based on the patient's diagnosis, the patient's desire for care, and the patient's response to any previous care.			
			2) Assesses nutritional and functional status when warranted by the patient's needs or condition.			

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0	1	2		RD	V	NA
			3) Determines the needs for discharge planning.			
			4) Identifies possible victims of abuse using preestablished hospital criteria.			
			c. Integrate all information through completion of the initial patient assessment document within 24 hours of arrival.			
			d. Reassess each patient every 8 hours at a minimum or when there is a change in patient's condition and/or diagnosis.			
			e. Integrate information from various assessments of the patient in order to identify and assign his or her care needs.			
			f. Independently perform a thorough physical assessment on admission, to include:			
			1) General appearance.			
			2) Respiratory.			
			3) Cardiac.			
			4) Neurological.			
			5) Gastrointestinal.			
			6) Genitourinary.			
			7) Musculoskeletal.			
			8) Integumentary.			
			9) Psychosocial.			
			g. Document assessment findings on the initial patient assessment (IPA) tool.			
			h. Take appropriate action on abnormal findings.			
			i. Assess allergies according to standard:			
			1) Documents in MAR, front of medical record, computer and on patient kardex.			
			2) Applies red allergy bracelet, if applicable.			
			5. <u>Patient education</u> :			
			a. Assess patient/significant other's educational needs.			
			b. Assess patient/significant other's educational readiness, barriers to learning, and preferred methods of learning.			
			c. Document the effectiveness of patient/significant other education provided.			

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0	1	2				
			d. Involve all of the necessary disciplines including physicians, in the education process.			
			6. <u>Perform and document the following admissions/transfers/ discharges:</u>			
			a. Patient admission from the emergency department.			
			b. Patient admission from the PACU.			
			c. Patient transfer to another med/surg unit.			
			d. Patient transfer to telemetry or ICU.			
			e. Patient transfer to another facility, including EMTALA regulations.			
			f. Patient discharge: routine, AMA, inmate.			
			g. Patient expiration: routine.			
			h. Patient expiration: medical examiner case.			
			i. Implements patient valuables policy.			
			7. <u>Accurately measure vital signs:</u>			
			a. Temperature (oral, axillary, rectal, tympanic).			
			b. Pulse (apical, dorsalis pedis, femoral, popliteal, radial); Able to use Doppler.			
			c. Respirations:			
			1) Rate and quality.			
			2) Auscultation of breath sounds.			
			3) Recognizes abnormal respiratory patterns.			
			d. Blood pressure:			
			1) Sphygmomanometer; continuous blood pressure monitoring.			
			2) Brachial.			
			3) Pulses paradoxes.			
			e. Height and weight; uses standing scale and bed scale.			
			8. <u>Monitoring:</u>			
			a. Intake and output: Strict and routine.			
			b. Circulation, Motor, Sensory (CMS) monitoring.			
			c. Neurological monitoring: Glasgow Coma Scale.			

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				RD	V	NA
0	1	2				
			d. Abdominal girth.			
			e. Extremity circumference.			
			9. <u>Activities of Daily Living:</u>			
			a. Bathing: Self, Partial, Complete, Shower.			
			b. Linen change: policy on utilization.			
			c. Elimination: Bedpan/fracture, urinal, assist to bathroom, external condom catheter care.			
			d. Skin/back care.			
			e. Perineal care: Male and female.			
			f. Hair care.			
			g. Oral care: Conscious, unconscious, immobilized jaw and intubated patient.			
			h. Eye care.			
			i. Foot care.			
			j. Siderail safety.			
			k. Positioning/turning/proper patient alignment/body mechanics:			
			1) Supine.			
			2) Prone.			
			3) Fowler's: High and Semi.			
			4) Sim's.			
			5) Trendelenburg			
			6) Reverse Trendelenburg.			
			7) Dorsal recumbent.			
			l. Stretcher; wheelchair.			
			10. <u>Feeding:</u>			
			a. Receiving and returning of food trays.			
			b. Ordering and changing of diet orders.			
			c. Spoon feed/assist.			
			d. Enteral feedings.			
			e. Calorie counts.			
			11. <u>Peripheral I.V. Therapy:</u>			
			a. Initiate I.V. therapy.			
			1) Verifies physician's order.			
			2) Prepares appropriate I.V. and PPE.			
			3) Verifies patient identity, allergy(ies) and explains procedure.			
			4) Identifies site for venipuncture.			
			5) Identifies catheter size to be inserted.			

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			6) Facilitates vein engorgement.			
			7) Prepares site.			
			8) Inserts catheter and verifies flashback.			
			9) Advances catheter fully into vein.			
			10) Removes tourniquet.			
			11) Connects primed tubing or male adapter.			
			12) Applies dry sterile dressing and secures I.V. tubing as per standard.			
			13) Initiates accurate flow.			
			14) Completes documentation: catheter size; site; fluid infusing; rate; and date/time of insertion.			
			b. Identify types of I.V.: I.V. lock, continuous, intermittent.			
			c. Able to regulate flow rate, identify factors affecting flow rates and intervenes appropriately.			
			d. Able to calculate flow rate.			
			e. I.V. pump: Set-up, monitoring and troubleshooting.			
			f. Recognize complications of I.V. therapy.			
			g. Perform I.V. site assessment and documents.			
			h. Change peripheral I.V. sites and changes I.V. tubing every 72 hours and labels tubing with appropriate day change sticker.			
			i. Performs three (3) supervised peripheral I.V. punctures: 1) Date: Preceptor Signature: 2) Date: Preceptor Signature: 3) Date: Preceptor Signature:			
			12. <u>Central Venous Catheter Maintenance:</u> a. Verbalize understanding of policy on central venous catheter insertion, maintenance and discontinuation.			
			b. Assess need for dressing/tubing change as per standard.			
			c. Verify patient's identity and explains procedure.			

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0	1	2		RD	V	NA
			d. Assemble sterile equipment.			
			e. Dons mask and gloves.			
			f. Remove existing dressing without disturbing catheter.			
			g. Assess site for infiltration/infection.			
			h. Change all caps, connections and tubings.			
			i. Perform site care as per standard.			
			j. Apply transparent, occlusive dressing			
			k. Secure tubings.			
			l. Document date and time of dressing change on dressing, as well as initials.			
			m. Maintain accurate flow of I.V. fluids and ensures use of I.V. infusion pump.			
			n. Document date and time of dressing in nurse's notes.			
			o. Perform three (3) supervised central line dressing changes using aseptic technique: 1) Date: Preceptor Signature: 2) Date: Preceptor Signature: 3) Date: Preceptor Signature:			
			13. <u>Central Venous Catheter Removal and Culturing of Catheter Tip:</u> a. Verify physician order for removal.			
			b. Assemble sterile equipment, including sterile container/cup for catheter tip..	1		
			c. Verify patient's identity and explains procedure.			
			d. Remove dressing.			
			e. Remove sutures without cutting catheter.			
			f. Instruct patient to take a deep breathe, and bear down.			
			g. Remove catheter.			
			h. Apply betadine prepped dry, sterile dressing with pressure to site.			
			i. Place catheter in sterile cup, labels and sends to the laboratory.			

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0	1	2		RD	V	NA
			j. Record date, time and initials on outside of dressing.			
			k. Document procedure on flowsheet.			
			l. Report abnormalities to the physician.			
			14. <u>Drawing Blood from a Central Venous Catheter:</u>			
			a. Verify blood tests ordered by the physician.			
			b. Consult lab manual regarding any special handling techniques.			
			c. Gather necessary equipment.			
			d. Wash hands.			
			e. Identify patient.			
			f. Select proper lumen for blood drawing.			
			g. Don gloves.			
			h. Temporarily stop all infusions through the central venous catheter.			
			i. Ensure lumen is clamped.			
			j. Remove tubing and adapter from lumen, open clamp and flush lumen with 3 ml of NSS.			
			k. Change syringes and withdraw 6 ml of blood to waste.			
			l. Collects blood in proper collect tubes.			
			m. Flushes lumen with Heparin flush 3 ml (100 units/ml).			
			n. Recaps lumen with adapter.			
			o. Resumes any I.V. infusions.			
			p. Labels and bags specimens.			
			q. Ensures timely transport of specimens to the laboratory.			
			15. <u>Blood/Blood Products Administration:</u>			
			a. Verify physician's order including type of blood product.			
			b. Verify signed consent form is on medical record; includes patient signature, physician signature and witness signature.			
			c. Assess current I.V. access for patency and ability to infuse blood product.			

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0	1	2				
			d. Addressograph and completes appropriate requisition and obtains product from blood bank.			
			e. Verify patient identity using ID bracelet, blood bracelet and transfusion slip; confirms accuracy of information (patient name, room number, bed number, hospital number, blood number and blood/Rh type) with another RN.			
			f. Complete information on transfusion slip prior to initiation of transfusion.			
			g. Measure vital signs (temperature, pulse, respirations and blood pressure) prior to initiating transfusion.			
			h. Initiate transfusion according to standard.			
			i. Measure vital signs 15 minutes after transfusion initiation.			
			j. Monitor patient for signs and symptoms of transfusion reaction.			
			k. Initiate the following in the event of a transfusion reaction: 1) Immediately stops transfusion.			
			2) Infuses normal saline.			
			3) Measures vital signs.			
			4) Notifies the physician.			
			5) Completes transfusion reaction form.			
			6) Obtains appropriate lab specimens.			
			7) Documents reaction in medical record.			
			l. Place transfusion slip in medical record.			
			m. Document transfusion activities in the medical record.			
			n. Able to transfuse the following blood products: 1) Whole blood.			
			2) Packed red blood cells.			
			3) Platelets.			
			4) Fresh frozen plasma (FFP).			
			5) Albumin.			
			6) Cryoprecipitate.			
			o. Blood warmer: Assembly and use.			

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0	1	2		RD	V	NA
			16. <u>Medication Administration:</u>			
			a. Administer medications via the following route(s):			
			1) Ear: Instillation and irrigation.			
			2) Eye: Instillation and irrigation.			
			3) Intradermal.			
			4) Intramuscular.			
			5) Intramuscular: Z-track.			
			6) Intraosseous.			
			7) Nasal.			
			8) Oral.			
			9) Rectal.			
			10) Subcutaneous			
			11) Sublingual.			
			12) Topical.			
			13) Vaginal.			
			14) Side-arm nebulizer.			
			b. Administer the following special medications according to standard:			
			1) Cytotoxic medications: Administration and disposal.			
			2) Heparin therapy protocol.			
			3) Insulin.			
			4) Potassium salts: I.V.			
			5) Dilantin.			
			c. Identify and report adverse drug reactions.			
			d. Identify medications with automatic stop orders.			
			e. Follow the controlled substances protocol.			
			f. Document on the medication administration record.			
			g. Identify the procedure for storing medications brought to the hospital by a patient.			
			h. Identify and report medication errors and adverse drug reactions.			
			i. State the procedure for patients to self-administer medications.			

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0	1	2				
			j. Identify the hospital policy on standardized continuous I.V. medication concentrations.			
			k. Demonstrate skill to administer/medications: 1) Verbalizes knowledge of medications being administered.			
			2) Uses appropriate reference materials.			
			3) Demonstrates ability to follow the 5 rights of medication administration.			
			4) Documents on the MAR accurately, including omitted medications and patient's response to PRN medications.			
			17. <u>Specimen Collection:</u>			
			a. Accurately obtain urine specimen(s): 1) Urine, voided.			
			2) Urine, clean-catch.			
			3) Urine, indwelling (Foley).			
			4) Urine, straight catheter.			
			5) 24 hour urine collection.			
			6) Notes completion of specimen collection on overbed sign.			
			b. Accurately obtain stool specimen(s): 1) Stool for culture/sensitivity.			
			2) Stool for occult blood.			
			3) Stool for clostridium difficile.			
			4) Stool for ova and parasites,			
			5) Notes completion of specimen collection on overbed sign.			
			c. Accurately obtain the following specimens: 1) Nasal.			
			2) Rectal swab.			
			3) Sputum: Spontaneous and via suction; Lukens trap.			
			4) Throat swab.			
			5) Wound/orifice: Aerobic and anaerobic.			

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0	1	2		RD	V	NA
			d. Able to perform the following point of care testing: 1) Capillary blood glucose testing (see separate OCI).			
			2) Stool for occult blood testing.			
			3) Urine dipstick testing.			
			4) Gastric secretions.			
			18. <u>Pulmonary/Respiratory Care</u> :			
			a. Able to assess presence or absence of symmetrical chest expansion.			
			b. Able to assess lung/breath sounds.			
			c. Able to assess for signs and symptoms of hypoxia/hypoxemia.			
			d. Manages airway:			
			1) Maintains a patent airway.			
			2) Encourages coughing and deep breathing; uses incentive spirometry if appropriate.			
			3) Identifies types of oral/nasal airways.			
			4) Provides frequent oral care to prevent aspiration.			
			5) Maintains HOB elevated to promote lung expansion.			
			6) Positions patient minimally every 2 hours.			
			e. Interpret arterial blood gases (ABGs):			
			1) Determines reason for ABG.			
			2) States appropriate patient considerations:			
			a) Site(s) used for blood drawing.			
			b) Observation of site post draw.			
			3) States normal ranges of the following ABG parameters:			
			a) PaO ₂ .			
			b) SaO ₂ .			
			c) pH.			
			d) pCO ₂ .			
			e) HCO ₃ .			
			f) Base excess.			

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			4) Recognizes the following abnormalities: (based on ABG results and patient symptoms):			
			a) Respiratory acidosis.			
			b) Respiratory alkalosis.			
			c) Metabolic acidosis.			
			d) Metabolic alkalosis.			
			5) Correlates ABG results and patient symptoms to abnormalities in: potassium, sodium, drug levels, BUN, creatinine, magnesium, blood sugar, etc.			
			6) Notifies physician as appropriate.			
			f. Demonstrate knowledge of safety measures in oxygen administration.			
			g. Identify oxygen shut off valve on unit.			
			h. Administer oxygen via the following modalities:			
			1) Nasal cannula.			
			2) Rebreather mask.			
			3) Non-rebreather mask.			
			4) Simple face mask.			
			5) Ventimask.			
			6) T-piece with aerosol.			
			7) Trache collar with aerosol.			
			8) Continuous positive airway pressure (CPAP) and BiPAP.			
			9) Ventilator.			
			10) Bag-valve mask (ambu bag).			
			i. Able to use flow meter with humidification; able to use portable oxygen tank with regulator.			
			j. Able to administer respiratory treatment via side arm nebulizer (SAN).			
			k. Able to use pulse oximeter to measure SpO ₂ :			
			1) Attaches probe to patient appropriately.			
			2) Operates machine according to manufacturer's directions.			

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			3) Has knowledge of abnormal SpO ₂ readings and intervenes appropriately.			
			4) Troubleshoots alarms and general malfunctions.			
			5) Documents measures			
			l. Able to use intermittent suction apparatus for respiratory suctioning: Wall and portable.			
			m. Demonstrate the following suctioning techniques:			
			1) Oropharyngeal.			
			2) Nasopharyngeal.			
			3) Tracheostomy.			
			4) Endotracheal.			
			n. Demonstrate ability to perform tracheostomy/laryngectomy care:			
			1) Assesses condition of stoma prior to care.			
			2) Performs suctioning of the trachea and oropharynx prior to trache care.			
			3) Provides trache care at least every 8 hours and PRN to include:			
			a) External cleansing of the stoma.			
			b) Cleaning and/or replacement of the inner cannula.			
			c) Replacement of trache stoma dressing.			
			d) Changing of the tie tapes.			
			4) Documents trache care on flowsheet.			
			o. Demonstrate competency in the care of the patient with a chest tube(s):			
			1) States the purpose and function of water seal chest drainage system (Pleur-Evac).			
			2) Assesses drainage system:			
			a) Verifies patency and ensures suction.			
			b) Observes connections to ensure there aren't any kinks in the tubing or loose connections.			
			c) Verify fluid fluctuations; identify reason(s) for absence of fluctuations.			
			d) Assess for air leaks.			

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0	1	2				
			3) Assesses patient for signs/symptoms of distress.			
			4) Assesses chest tube site for drainage and/or signs/symptoms of infection.			
			5) Maintains 2 large smooth, rubber-tipped Kelly clamps and petroleum gauze at the bedside in case of dislodgment/removal.			
			6) Demonstrates proper transportation of a patient with chest tube(s).			
			7) Demonstrate proper changing of Pleur-Evac collection/drainage system.			
			8) Performs Pleur-Evac Collection System Set-up.			
			p. Able to care for the patient with:			
			1) COPD.			
			2) Pneumonia.			
			3) ARDS.			
			4) Status asthmaticus.			
			19. <u>Cardiac Care:</u>			
			a. Able to assess heart sounds: Presence of audible S ₁ and S ₂ .			
			b. Measure capillary refill.			
			c. Assist with defibrillation/cardioversion.			
			d. Able to care for the patient with:			
			1) Abdominal aortic aneurysm (post acute phase)..			
			2) Angina (post acute phase).			
			3) Arteriosclerosis			
			4) Cardiac catheterization: Pre and post care.			
			5) Carotid endarterectomy (post acute phase).			
			6) CHF.			
			7) CVA.			
			8) Femoral/popliteal bypass.			
			9) MI (post acute phase).			
			10) Open heart (post acute phase).			
			11) Permanent pacemaker (post acute phase).			

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			12) Vascular surgery.			
			e. Able to perform 12-Lead ECG:			
			1) Verbalizes knowledge of electrical activity of the heart.			
			2) Places electrodes on the extremities and chest precordium as per standard.			
			3) Operates machine according to manufacturer's instructions.			
			4) Properly labels ECG with patient information.			
			5) Able to verbalize indications for obtaining an ECG.			
			20. <u>Neurological/Neurovascular/Orthopedic Care:</u>			
			a. Able to assess level of consciousness: Glasgow Coma Scale.			
			b. Able to assess pupils: Size and reaction.			
			c. Able to assess strength of extremities and grade.			
			d. Able to document neurological assessment on neurological monitoring record.			
			e. Able to assess pain according to standard.			
			f. Able to administer Patient Controlled Analgesia via pump.			
			g. Document PCA on appropriate flowsheet.			
			h. Perform neurovascular assessment:			
			1) Assesses each extremity:			
			a) Temperature: Warm or cool to touch.			
			b) Color.			
			c) Capillary refill.			
			d) Peripheral pulses: Presence, absence, and quality (grade).			
			i. Able to care for the patient with:			
			1) Seizure activity:			
			a) Maintains bed in low position.			
			b) Maintains siderails in an upright position; pad with pillows as appropriate.			
			c) Removes restrictive clothing.			
			2) Maintains an oral airway at the bedside.			

SELF-ASSESSMENT (Orientee Initials)			COMPETENCIES The orientee will be able to:	VALIDATION (Preceptor, Administrative Supervisor, Department Director, Date and Initials)		
				RD	V	NA
0	1	2				
			3) Able to assess type of seizure and duration.			
			4) Implements medication administration as ordered; verbalizes understanding of medical management including therapeutic blood levels of anticonvulsants.			
			5) Documents seizure activity, including precipitating events, presence of aura, nursing/medical interventions implemented and patient's response.			
			j. Able to care for patients with orthopedic compromise:			
			1) Traction:			
			a) States the purpose of traction.			
			b) Identifies the type of traction to be applied.			
			c) Demonstrates knowledge of potential complications of traction (infection, skin breakdown, pneumonia, DVT, constipation, UTI, and/or renal calculi).			
			d) Assesses affected extremity for pain, deformity, swelling, motor and sensory function, and circulatory status.			
			e) Assesses skin condition of affected extremity and all bony prominences throughout the body.			
			f) Minimizes the effects of immobility:			
			1) Prevention of footdrop.			
			2) Encourage deep breathing.			
			3) Encourage increased fluid intake: 2,000 to 2,500 ml/day.			
			4) Provide adequate nutrition.			
			g) Provides preventative skin care:			
			1) Keep linens and clothing free of wrinkles.			
			2) Use heel/elbow protectors, if indicated.			

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				RD	V	NA
0	1	2				
			3) Use overlay mattress, if indicated.			
			h) Able to care for patient's in the following traction:			
			1) Trapeze.			
			2) Skin.			
			3) Cervical.			
			4) Pelvic.			
			5) Buck's.			
			6) Russell's.			
			7) Balanced suspension.			
			i) Assesses traction for safety and effectiveness:			
			1) Ropes and pulleys are in alignment.			
			2) The pull is in line with the long axis of the bone.			
			3) Weights hang freely.			
			4) Ropes are unobstructed.			
			5) Patient is repositioned frequently.			
			6) Neurovascular assessments every 4 hours and prn.			
			j) Provides external pin site care:			
			1) Assesses site for signs/symptoms of infection.			
			2) Cleanse pin site with betadine every 8 hours.			
			2) Head trauma; increased intracranial pressure.			
			3) Cerebral aneurysm.			
			4) Spinal cord injury.			
			5) Laminectomy, cervical and lumbar.			
			6) Neuromuscular disease.			
			7) DT's.			
			8) Post-craniotomy.			
			9) Post-orthopedic surgical procedure:			
			a) Uses appropriate positioning: Hip and knee.			
			b) Assesses for signs/symptoms of infection.			

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0	1	2		RD	V	NA
			c) Promotes early mobility.			
			d) Assesses for signs/symptoms of thromboembolism.			
			10) Total knee replacement.			
			11) Total hip replacement.			
			j. Crutches: Crutch walking.			
			k. Cast care.			
			l. Ace wrap.			
			m. Stump wrapping.			
			n. Application of arm sling.			
			o. Splinting: Arm and leg.			
			p. CPM machine.			
			q. Pneumatic compression device: Sequential and intermittent.			
			r. Aqua K pad: Moist heat; adjusts to appropriate setting.			
			21. <u>Gastrointestinal/Enteral Nutrition:</u>			
			a. Assess abdomen and bowel sounds.			
			b. Care for enteral feeding tubes.			
			1) Nasogastric tube: Verifies placement, residuals.			
			2) Flexible feeding tube.			
			3) Salem sump tube with anti-reflux valve.			
			4) Gastrostomy tube.			
			5) Percutaneous endoscopic gastrostomy tube (PEG) tube.			
			6) Jejunostomy tube.			
			7) Enteral feeding pump.			
			c. Perform ostomy care:			
			1) Colostomy.			
			2) Ileostomy.			
			3) Irrigation of ostomy.			
			d. Disimpaction.			
			e. Care for patient with:			
			1) GI bleeding: Upper and lower.			
			2) Inflammatory bowel disease.			
			3) Pancreatitis.			
			4) Hepatitis.			
			5) GI surgery.			

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0	1	2		RD	V	NA
			f. Administer the following types of enemas: 1) Fleet's: Regular and oil retention.			
			2) Tap water enema (Harris flush).			
			3) Soap suds enema.			
			4) High colonic enema.			
			5) Kayexalate enema.			
			22. <u>Genitourinary/Renal Care:</u>			
			a. Perform an assessment of the GU system.			
			b. Perform urinary catheterization/care for various urinary catheters:			
			1) Indwelling (Foley) catheter: Male and female.			
			2) Straight catheterization: Male and female.			
			3) Three-way Foley catheter: Intermittent irrigation and continuous bladder irrigation (CBI).			
			4) Suprapubic tube.			
			5) Catheter bag: Regular and urimeter.			
			6) External condom catheter (Texas): Male.			
			7) Leg bag.			
			c. Care for a patient with a fistula/shunt.			
			d. Care for the patient with renal failure: Acute and chronic.			
			e. Care for the patient receiving dialysis:			
			1) Hemodialysis.			
			2) Peritoneal dialysis: Regular and CAPD.			
			23. <u>Integumentary Care:</u>			
			a. Perform a skin assessment.			
			b. Perform a wound/pressure ulcer risk assessment: Initial using Braden Scale and daily.			
			c. Perform wound dressing care: Application of sterile dressing(s).			
			d. Care for a patient with a surgical drain:			
			1) Jackson Pratt (bulb, manual).			
			2) Hemovac.			
			3) Penrose.			

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0	1	2		RD	V	NA
			e. Operate a hospital bed: 1) Operation: Trendelenburg, reverse trendelenburg, locking of wheels.			
			2) Specialty (including bariatric devices), overlay mattresses.			
			3) Ordering, set-up, discontinuing.			
			24. <u>Miscellaneous:</u> a) Care for the hearing impaired: AT&T Language Line.			
			b) Care for the speech impaired.			
			c) Assist the physician with: 1) Lumbar puncture.			
			2) Paracentesis.			
			3) Thoracentesis.			
			d) Set-up and monitor cold application: Purpose, duration, and safety.			
			e) Set-up and monitor heat application: Purpose, duration, and safety.			
			f) Care for the patient with TB.			
			g) Care for the patient with AIDS or HIV+ status.			
			h) Care for the patient with an eye prosthesis.			
			25. <u>Hemodynamic Monitoring:</u> a. Demonstrate use of cardiac monitor.			
			1) Apply electrodes: LII, MCL1, MCL6.			
			2) Set alarm limits.			
			3) Troubleshoot heart rate alarms.			
			4) Transfer patient with monitor.			
			5) Verbalizes standing dysrhythmia orders.			
			b. Set-up and assist with:			
			1) Single, double, and triple lumen catheters.			
			2) Pulmonary artery catheter.			
			3) Pacer port pulmonary artery catheter.			
			c. Balance and calibrate system.			
			d. Record readings during insertion, including PCWP.			
			e. Able to measure and record routine CVP (RA), PA systolic and diastolic, PCWP, CO, and SVO2 readings.			