NAME OF

PATIENT CARE SERVICES

ORIENTATION/COMPETENCY INVENTORY (OCI)

Patient Care Technician, Critical Care Services (1-18)

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:

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

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

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

Validation:

RD = Return demonstration.

V = Verbalizes.

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)		
0	**1**	**2**		**RD**	**V**	**NA**
			1. Discuss Hospital Safety Procedures: 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 and MSDS).			
			g. Radiation Safety.			
			h. Patient call system.			
			i. Code Blue Responsibilities.			
			j. Current BLS-Healthcare Provider.			
			2. Departmental Overview: a. Tour of department(s)/unit(s).			
			b. Mechanism for tracking time and attendance (Kronos).			
			c. Telephone system; etiquette.			
			d. Page operator; beepers.			
			e. Hospital/departmental manuals/resource texts.			
			f. Departmental staff meetings.			
			g. Role of the Resource Nurse and Administrative Supervisor.			
			h. Standard of professional attire.			
			i. Ethics committee role and access.			
			3. Participate in Caring for Patient's Mental Health and Social Needs: a. Determines level or orientation.			
			b. Identifies behaviors exhibited by patients with psychological and/or emotional needs.			
			c. Describes appropriate techniques of behavior management.			
			4. Engage in Effective Communication: a. Identifies types of effective communication: verbal and non verbal.			
			b. Identifies alternate methods of communication for patients with special needs.			

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0	1	2		RD	V	NA
			c. Describes characteristics of therapeutic communication.			
			d. Describes barriers to effective communication.			
			e. Recognizes and reports important observations to the appropriate member of the health care team.			
			f. Discusses the importance of collaboration and communication with all members of the health care team.			
			g. Documents the following in the patient's medical record: 1) Intake and output. 2) Vital signs. 3) Capillary blood glucose testing. 4) Calorie counts.			
			h. Identifies acceptable medical abbreviation terminology using current approved list.			
			5. Apply Healthcare Asepsis Techniques: a. Defines the term medical asepsis.			
			b. Describes common mechanisms of hospital-acquired infections.			
			c. Identifies measures to prevent infections: 1) Demonstrates proper handwashing.			
			2) Separates clean and dirty items.			
			3) Disinfects supplies and equipment.			
			4) Properly handles food.			
			5) Properly handles linen.			
			6) Properly disposes body fluids/waste.			
			7) Maintenance of own health.			
			8) Identification of visitor illness.			
			d. Identifies isolation procedures, including signage: 1) Standard precautions.			
			2) Transmission-based: a) Airborne precautions.			
			b) Droplet precautions.			
			c) Contact precautions.			
			3) Portable Hepafilter.			
			4) Identifies negative pressure rooms.			

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0	1	2		RD	V	NA
			6. <u>Apply Comfort, Safety, and Emergency Measures</u>: a. Restraint Management. 1) Articulates legal and ethical considerations of restraint application.			
			2) Articulates devices not classified as restraints.			
			3) Collaborates with the nurse to ensure appropriate medical order is in place, including time limit.			
			4) Articulates indications/contraindications of restraint application.			
			5) Collaborates with the nurse and implements alternatives to restraint application.			
			6) Educates the patient/significant other regarding purpose of the restraints, and necessity for use.			
			7) Correctly applies the following restraints: a) Vest restraint. b) Limb restraints. c) Leather restraints.			
			8) Assesses, at a minimum every two (2) hours: a) Circulation. b) Condition of skin. c) Hygiene and toileting needs. d) Comfort and safety. e) Nutritional needs.			
			9) Removes restraint devices every two (2) hours for 10 minutes, and a) Performs ROM on extremity(ies). b) Repositions patient. c) Reapplies restraint, if indicated.			
			10) Documents on restraint flowsheet.			
			11) Articulates indications for removal of restraints.			
			b. Prevention of Accidents. 1) Responds to emergency calls.			
			2) Follows plan of care at all times.			
			3) Answers call lights promptly.			

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0	1	2		RD	V	NA
			4) Verifies accurate identification of patient prior to performing procedure(s).			
			5) Uses wheel locks on beds, lifts, stretchers, and wheelchairs.			
			6) Uses side rails when indicated; maintains bed in low position..			
			7) Cleans up spills immediately.			
			8) Removes sharps and disposes according to policy.			
			9) Prevents and removes hallway clutter.			
			10) Identifies, labels, reports and removes unsafe equipment.			
			c. Body Mechanics. 1) "Plans prior to doing."			
			2) Provides explanations to patients and/or significant other frequently.			
			3) Identifies tasks requiring assistance.			
			4) Uses appropriate body alignment techniques, e.g., wide base of support, avoid reaching, etc.			
			5) Uses appropriate positioning techniques: a) Side-Lying or Lateral.			
			b) Lying prone.			
			c) Lying supine.			
			d) Sitting in bed: High/Semi-Fowler's.			
			e) Trendelenburg: Operation of bed.			
			f) Reverse Trendelenburg: Operation of bed..			
			g) Sitting in chair.			
			d. Transfer Measures: 1) Collaborates with the nurse to ensure medical order is in place, develops a plan for transfer and explains to patient.			
			2) Identifies assistive devices needed.			
			3) Assisted Sitting: Chair to bed, bed to chair, chair to chair.			
			4) Assisted Lying: Bed to stretcher, stretcher to bed.			
			a) Uses lift shift.			

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0	1	2		RD	V	NA
			b) Uses log rolling technique.			
			5) Assists with ambulation. a) Demonstrates use of cane.			
			b) Demonstrates use of walker.			
			c) Demonstrates appropriate crutch walking procedure.			
			d) Demonstrates use of mechanical lift device, including safety measures.			
			e. Range of Motion Excercises (ROM). 1) Identifies the purpose of ROM.			
			2) Identifies patient populations at risk for complications of immobility related to the musculoskeletal system.			
			3) Educates patients on techniques of active ROM.			
			4) Demonstrates correct techniques of passive ROM, to include flexion, extension, abduction and adduction of appropriate joints.			
			5) Identification and Reporting of Emergent Situations: a) Evidence of pain.			
			b) Skin changes (pale, flushed, cyanotic, diaphoretic, temperature, etc.).			
			Respiratory changes: c) Shortness of breath/noisy breathing and coughing.			
			d) Change in respiratory rate $\pm$ 4 breaths/minute.			
			Digestive changes. e) Nausea, vomiting (with description).			
			f) Change(s) in stool color, consistency.			
			g) Difficulty swallowing.			
			h) Changes in appetite.			
			Urinary changes. i) Difficulty in urinating.			
			j) Changes in amount or color.			
			Musculoskeletal changes. k) Cannot move arms and/or legs.			
			l) Seizure activity/seizure precautions.			

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0	**1**	**2**		**RD**	**V**	**NA**
			Neurological changes. m) Changes in orientation status.			
			n) Changes in level of consciousness.			
			o) Restlessness.			
			Cardiovascular changes: p) Chest pain and/or discomfort.			
			q) Changes in pulse ± 10 beats/minute and/or blood pressure ± 20 mm Hg systolic or diastolic.			
			7. Apply Personal Care Needs: a. Articulates changes in skin related to age, disease process, bedrest nutrition, hydration and/or health status.			
			b. Identifies areas (bony prominences) that are prone to skin breakdown.			
			c. Inspects the skin and reports any signs of: 1) Irritation.			
			2) Texture change.			
			3) Color change.			
			4) Growth.			
			5) Injury.			
			6) Pressure sores.			
			7) Drainage.			
			d. Performs skin care interventions: 1) Ensures skin cleanliness.			
			2) Stimulates circulation.			
			3) Repositions patients at frequent intervals.			
			4) Ensures hydration and nutrition as per plan of care.			
			e. Demonstrates the appropriate use of pressure-relieving devices: 1) Sheepskin.			
			2) Protective elbow and heel pads.			
			3) Bed cradle.			
			4) Overlay mattress.			
			f. Provides hygienic care: 1) Bath: Self, partial, complete.			
			2) Shave (except eyebrows).			

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0	1	2		RD	V	NA
			3) Oral care; including denture care; conscious and unconscious.			
			4) Hair care.			
			5) Perineal care: Male and female.			
			6) Foot care (except for nail cutting unless ordered by physician).			
			7) Postmortem care.			
			8) Makes bed: a) Occupied/Unoccupied.			
			b) Head to toe.			
			c) Postoperative.			
			g. Prosthesis Care (Limb):			
			1) Washes prosthesis.			
			2) Identifies pressure areas under prosthesis.			
			3) Apply prosthesis properly, including stockinet.			
			4) Report to nurse if prosthesis needs repair.			
			h. Applies the following devices: 1) Bandages.			
			2) Slings.			
			3) Antiembolic stockings (including measurement).			
			8. <u>Participate in Caring for the Patient's Nutrition and Fluid Needs</u>: a. Identifies the following diets: 1) Regular.			
			2) Clear liquids.			
			3) Full liquids.			
			4) Puree or mechanical soft.			
			5) Diabetic or calorie controlled.			
			6) Low sodium.			
			7) NPO; places appropriate sign over patient's bed.			
			b. Identifies foods to avoid on the above diets.			
			c. Distinguishes signs and symptoms of dehydration/overhydration/edema.			
			d. Assists with menu selection, meal preparation, and feeding.			

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0	1	2		RD	V	NA
			1) Ensures accurate identification of patient with diet; ensures patient is not NPO.			
			2) Ensures a pleasant environment.			
			3) Washes patient's hands.			
			4) Ensures comfort and proper positions, e.g., ↑ HOB.			
			5) Provides adaptive equipment, if appropriate.			
			6) Provides as much assistance as necessary to ensure proper nutrition.			
			7) Is alert to signs and symptoms of difficulty swallowing and/or choking.			
			f. Safety Precautions When Caring for Patient with an Indwelling Feeding Tube: 1) Does not pull or tug on tubing.			
			2) Maintains the skin around tube clean and dry.			
			3) Maintains HOB ↑ 30^{o} at all times for patients with a nasogastric tube/ gastrostomy, unless contraindicated.			
			4) Temporarily discontinue tube feedings when repositioning patient.			
			5) Report to the nurse any alterations with the tube and/or equipment.			
			g. Intake and Output: 1) Explains procedure to patient.			
			2) Records all liquid sources of intake.			
			3) Records only the amount taken in by the patient.			
			4) Records all fluids lost from the body.			
			5) Measures all output in a graduated device.			
			6) Reports to the nurse any blood/wound drainage or imbalances in intake and output .			
			9. <u>Participate in Caring for the Patient's Elimination Needs</u>: a. Describes factors interfering with normal elimination.			

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0	1	2		RD	V	NA
			b. Identifies characteristics used to describe urine.			
			c. Offers patient bedpan/fracture pan/ commode.			
			d. Identifies reasons for Foley catheter insertion.			
			e. Performs Foley care according to standard.			
			f. Applies condom catheter.			
			g. Accurately obtains urine specimens: 1) Routine urinalysis.			
			2) Clean-catch.			
			3) Foley catheter.			
			4) 24 hour urine.			
			5) Notes completion of specimen collection on appropriate overbed sign.			
			h. Performs urine dipstick point of care testing.			
			i. Accurately obtains stool specimens: 1) Stool for C & S.			
			2) Stool for O & P.			
			3) Stool for occult blood.			
			4) Stool for clostridium difficile			
			5) Notes completion of specimen collection on appropriate overbed sign.			
			j. Administers 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 (after prepared by the pharmacist and/or nurse).			
			k. Uses the following principles when administering an enema: 1) Verifies with nurse type and amount of enema to be administered.			
			2) Ensures proper fluid temperature ($105^{o}F$)			
			3) Dons gloves and places patient in left side-lying position.			
			4) Lubricates tip of rectal tube.			
			5) Clears air from enema tubing.			

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0	1	2		RD	V	NA
			6) Inserts rectal tube 3-4" and raises container of solution 12-18" over rectum.			
			7) Slowly administers solution; clamps tube if patient experiences cramping.			
			8) Asks patient to hold solution and assist to bathroom, bedpan or commode.			
			9) Places call light within reach.			
			10) Records and reports results.			
			10. Participate in Ostomy Care: 1) Independently cares for patients with ostomies greater than 2 months old and without complications.			
			2) Assesses and reports skin site surrounding stoma for reddness, open areas, drainage and/or ulcerations.			
			3) Observes color and amount of drainage from stoma.			
			4) Observes existing pouch for leakage.			
			5) Reports to nurse immediately any pain or changing at stoma site.			
			6) Changes stoma appliance only if necessary, e.g., leakage from stoma.			
			7) Empties appliance prn.			
			8) Implements stoma care and changing of pouch based on individual plan of care.			
			11. Measure Vital Signs: a. Temperature (oral, axillary, rectal, tympanic).			
			b. Pulse (apical and radial).			
			c. Respirations: 1) Rate and quality.			
			d. Blood pressure (brachial).			
			e. Recognizes, reports and records above.			
			f. Height and weight; uses standing scale and bed scale.			
			12. Use Equipment: a. Oxygen tank and regulator; "cracking tank."			
			b. Hospital bed; specialty beds: ordering, set-up, and discontinuing.			

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0	**1**	**2**		**RD**	**V**	**NA**
			c. Stretcher; wheelchair.			
			d . Sphygmomanometer.			
			e. Suction apparatus: Wall and portable.			
			f. Hypo/hyperthermia blanket.			
			g. Pulse oximeter.			
			h. Traction: Set-up, care and discontinuing.			
			i. Incentive spirometer.			
			j. Reports defective medical equipment.			
			13. Performs 12-Lead ECG.			
			14. Perform Venipuncture (see separate Phlebotomist OCI).			
			15. Perform Capillary Blood Glucose Testing and Quality Control Monitoring (see separate OCI).			
			16. Perform Unit Secretary Functions (see separate OCI).			
			17. Perform Cardiac Monitoring Functions (see separate ICAT).			

Orientation/Competency Inventory (OCI)
Patient Care Technician, Critical Care Services