Licensed Nurse Competency Checklist and Self-Evaluation

This tool is used to determine your training needs during your orientation. Please evaluate yourself in the following areas by using a **"1" for excellent competency (no training or practice needed)**, a **"2" for fair competency (some training to review standards)**, and a **"3" (need training related to overall standards and practice).**

Competency Main Area	Specific Competency	Self-Rating (1,2,3)	Comments
General:	Blood Glucose Monitoring (Performing, Charting, and Cleaning)		
	Ear Irrigations		
	Post Surgical Hip Precautions		
	Drawing Labs		
	CPR		
	Heimlich		
	Medication Pass Procedures		
	Isolation Procedures		
Documentation	Systems Assessment in General: Respiratory, Gastric, Integumentary, Cardiac, Urinary, GI, Neurological, Musculoskeletal, Other:		
	Alert Charting for Condition Changes		
	Minimum Data Set		
	Care Planning		
	Using the SBAR for notifying physicians		
Gastric Tubes	Checking Placement		
	Naso/gastric Tube Insertion		
	Administering Meds via T/F		
GI	Apply Ostomies		
	Large Enemas and Small Enemas		
Injections	Intradermal / SQ / IM		
IV	IV Standards in General		
	Starting IV's		
	Discontinuing IV's		
Central Caths	Attaching Needleless Devices		
	Drawing blood from central catheters		
	Flushing central catheters		
	Sterile dressing changes for central catheters		
	Removing central catheters		
Pumps / Devices	Baclofen Pumps (Care of, Monitoring, Alarms)		
	Pacemakers (Monitoring)		

Competency Main Area	Specific Competency	Self-Rating (1,2,3)	Comments
Wounds	Assessing and Documenting		
	Dressing changes (non-sterile)		
	Removing staples / sutures		
Respiratory	Administering Nebulizer Medications		
	Applying Oxygen (cannula, mask)		
	Incentive Spirometry		
	Oropharyngeal Suctioning		
	CPAP and BIPAP		
	Tracheostomy Care		
Urinary	Collecting a specimen from a closed system		
	Inserting a retention catheter / Female		
	Inserting a retention catheter / Male		
	Irrigating a closed system		
	Catheter Care in general / Precautions		
	Removing a retention catheter		
	Supra-pubic catheter care		
	Hemodialysis Care		
Other Misc. Facility Specific Skills (list):			

Additional comments:_____

Employee Signature_____ **Date**_____

Interviewee Signature_____ **Date**_____

QUALITY IMPROVEMENT TOOL

INTERACT II
Interventions to Reduce Acute Care Transfers

The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Section 1: BACKGROUND INFORMATION

Resident's Last Name	First Name	Age	Unit/Room #
_____	_____	_____	_____

a. Date of ***most recent*** admission to nursing home: _____/_____/_____

b. Resident hospitalized in the past 12 months? ☐ No ☐ Yes **If yes, list dates and reasons below:**

_____

_____

_____

_____

Section 2: DESCRIBE THE ACUTE CHANGE IN CONDITION THAT LED TO TRANSFER

Date the change in condition first noticed: _____/_____/_____

a. **Check *all* that apply:**

CHANGE IN:
☐ Appetite/intake
☐ Behavior
☐ Function
☐ Skin or a wound

NEW CONDITION:
☐ Bleeding
☐ Breathing difficulty or SOB
☐ Constipation
☐ Diarrhea
☐ Fall
☐ Pain (new or worsened)
☐ Other (specify)
_____

NEW SYMPTOM(S)/SIGNS OF:
☐ Altered mental status
☐ Congestive heart failure
☐ Dehydration
☐ Fever
☐ Lower respiratory infection
☐ Urinary tract infection

OTHER CHANGE:
☐ Abnormal lab value(s)
☐ Abnormal vital signs
☐ Family concern
☐ Other (specify)
_____

b. Briefly describe the symptom, sign or change in condition that led to the transfer:

_____

_____

_____

_____

Section 3: EVALUATION AND MANAGEMENT

a. **Check *all* that apply:**

TOOLS USED:
☐ Stop and Watch
☐ SBAR Progress Note
☐ Care Path
☐ Change in Condition Cards

MEDICAL EVALUATION:
☐ Telephone only
☐ On-site visit - MD
☐ On-site visit - NP or PA

TESTING:
☐ Blood tests
☐ Urinalysis or culture
☐ Xray
☐ Other (specify)

INTERVENTIONS:
☐ New medication
☐ IV or SC fluids
☐ Other (specify)

b. Briefly describe how the symptoms, signs, or change was evaluated and managed before hospital transfer:

_____

_____

c. Was advanced care planning (e.g. DNR, DNH, palliative or hospice care) discussed? ☐ No ☐ Yes

d. Was the resident transferred to the hospital? ☐ No **(skip to Section 5)** ☐ Yes **(complete Sections 4 and 5)**

Section 4: TRANSFER INFORMATION

Date of transfer: _____/_____/_____ Day (circle): M T W Th F Sa Sn Time of transfer: _____:____ a.m./p.m.

MD authorizing transfer: ☐ Primary MD ☐ Covering MD ☐ Other (_____)

a. What contributed to the transfer? **(Check *all* that apply)**:

☐ Abnormal vital signs
☐ Abnormal lab(s)
☐ Injury
☐ Worsening condition despite intervention
☐ MD insisted on transfer
☐ Resident preference or insistence
☐ Family preference or insistence
☐ Other (specify)

b. Briefly describe the main reason(s) for transfer:

_____

_____

Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement? ☐ No ☐ Yes **If yes, describe briefly**

_____

_____

_____

b. In retrospect, does your team think this transfer might have been prevented?

☐ No ☐ Yes **If yes, check all that apply and describe briefly**

☐ The new sign, symptom, or other change might have been detected earlier
☐ The condition might have been managed safely in the facility without transfer
☐ Advance directives and/or palliative or hospice care could have been discussed
☐ Other (specify)

_____

_____

_____

_____ _____/_____/_____

Name of person completing form **Date of completion**

Name of Nursing Home:_____
Contact Person and Title:_____
Phone:_____Email:_____

Available on Site*

Emergency interventions	Yes/No	Interventions	Yes/No
CPR – basic only		*Drains and catheters*	
Diagnostic Testing		Epidural catheters	
Stat EKG (within 4-6 hrs)		Suprapubic catheters	
Stat Xray (within 4-6 hrs)		Urostomy	
Stat lab work (within 4-6 hrs)		Surgical drains	
Bladder ultrasound		*Pulmonary*	
Cardiac Echo		O2 management	
Venous duplex		Suction q2hr	
Physician/NP Services		Suction q4hr	
7 day/wk visits		Suction q shift	
5 day/wk visits		Tracheostomy management	
1-2x/wk visits		Nebulizer treatments	
Consultation		CPAP	
Psychiatry		*Wound care program*	
One on one		VAC dressings	
Therapies		Debridement	
Physical therapy		*IV capabilities*	
Occupational therapy		PICC insertion	
Speech therapy		PICC management	
Isolation		IV Fluids	
VRE, MRSA, c. diff		IV antibiotics	
		Q4 hrs	
Typical turnaround time when new Meds are ordered:	____hrs	Q 8 hrs	
Nursing Services		Q 12 hrs	
		IV meds – other (e.g., furosemide)	
		CAD pumps	
Vital sign monitoring Q 2 hrs		*Other*	
Vital sign monitoring Q 4 hrs		G/J tube feeding	
O2 saturation monitoring		NG tube feeding	
Peak flow		TPN	
Glucose monitoring at least Q 6 hrs			

**Availability of certain equipment/services may have changed since this form was updated. Please contact the nursing home directly at the number provided for the most up to date information.*

Nursing Home would be able to accept resident back under the following conditions:

INTERACT II
Interventions to Reduce Acute Care Transfers

ACUTE CARE TRANSFER DOCUMENT CHECKLIST

RESIDENT NAME _____

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

_____ Resident Transfer Form
_____ Face Sheet
_____ Current Medication List or Current MAR
_____ Advance Directives
_____ Care limiting Orders
_____ Out of hospital DNR
_____ Bed hold policy

Send these documents IF INDICATED:

_____ SBAR/Nurse's Progress Note
_____ Most Recent History & Physical and any recent hospital discharge summary
_____ Recent MD/NP/PA Orders related to Acute Condition
_____ Relevant Lab Results
_____ Relevant X-Rays
_____ PERSONAL BELONGINGS SENT WITH RESIDENT:
_____ Eyeglasses _____Hearing Aid ___ Dental Appliance
_____ Other (specify)

Signature of ambulance staff accepting envelope:_____

(Please make a copy and keep this for your records in the nursing home)