UNIVERSITY OF TABUK

Faculty of Applied Medical Sciences

Department of Nursing

Nursing Internship Manual

Second Edition

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C O N T R I B U T O R S

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INTRODUCTION

The Internship Program is designed to provide the Nurse Interns with the necessary clinical and practical experiences obtained from working and being trained in a hospital setting with in-patient and ambulatory care departments. The nurse intern will enable to perform the practical skills experience to be able to acquire more competency and experience to perform as an independent nurse specialist (as per Saudi Commission for Health Specialties).

This manual is designed as a guide for the nurse interns during their internship program. This includes description, policies and guidelines, duties and responsibilities, and lists of major procedural checklists to ensure that the nurse interns will be able to perform well all the required procedures and be able to achieve the clinical objectives of each specific ward.

The internship program is a one -year comprehensive clinical practicum designed for the fifth year nursing students to complete the Baccalaureate Program.

The primary objective of the Internship Program is to provide the student the opportunity to enhance their competencies to the practice of the nursing profession. This is an intensive hands-on clinical training that enables the nurse intern to have an actual understanding of the health-care delivery system, executes confidence in providing nursing care in a variety of illnesses, applies critical thinking in making ethical and clinical decisions, and integrates professional roles in the provision of nursing care.

The Internship Program is carried out in selected health care institutions duly recognized by the government and the university. It is carefully designed to be able to provide opportunity for the students to be extensively exposed in the different areas in the hospital setting to augment and enhance previous clinical exposure during their third and fourth years of nursing education. It further develops their terminal competencies to be able to function as staff nurses in both general and specialty areas in the hospital, and to be able to develop as beginning nurse practitioner, beginning nurse researcher, and beginning nurse manager.

The nurse intern completes four (4) years of general education and professional courses as a requirement before they can be in the Internship Program. The nurse intern is required to render one (1) year for the Internship Program completion to be able to obtain the Baccalaureate degree in Nursing.

Upon successful completion of the internship program, the nurse intern shall be awarded the Certificate of Completion.

UNIVERSITY OF TABUK VISION AND MISSION

Visionالرؤية

"A distinguished university in education, research and community service"

Missionالرسالة

To offer a distinguished university education that prepares university graduates with the knowledge, capabilities, and skills needed by the community and developmental projects in the Tabuk region within an exceptional education and administrative environment that promotes innovative research.

FACULTY OF APPLIED MEDICAL SCIENCE VISION AND MISSION

Visionالرؤية

Educational and research excellence in the field of applied medical sciences to contribute to the service of community.

Missionالرسالة

To provide outstanding education and innovative research in applied medical sciences to produce qualified graduates who will contribute to the service of community.

DEPARTMENT OF NURSING

Vision الرؤية

Excellence in nursing education, research, and community services.

التميز في تعليم التمريض والبحث العلمي و خدمة المجتمع.

Mission الرسالة

To graduate competent nurses who are able to enhance healthcare services through high quality educational standards and innovative research that addresses the health needs of the community.

تخريج ممرضين أكفاء قادرين على تعزيز الرعاية الصحية من خلال معايير تعليمية عالية الجودة وأبحاث مبتكرة تلبي الاحتياجات الصحية للمجتمع.

Goals الأهداف

1. To achieve excellence in nursing education through an advanced educational environment that promotes creativity and innovation. 2. To enhance faculty members capacity and professional development. 3. To achieve national and international accreditation. 4. To establish partnership with national and international institutions to enhance nursing education. 5. To conduct research relevant to the health care. 6. To provide educational activities that increases awareness towards health promotion and prevention of illnesses and its complications.	1. تحقيق التميز في تعليم التمريض من خلال بيئة تعليمية متقدمة تعزز الإبداع والابتكار. 2. تعزيز القدرات والتطور المهني لأعضاء هيئة التدريس. 3. تحقيق الاعتماد الوطني والدولي. 4. إقامة شراكة مع المؤسسات الوطنية والدولية لتعزيز تعليم التمريض. 5. إجراء البحوث المتعلقة بالرعاية الصحية. 6. توفير الأنشطة التعليمية التوعوية من أجل تعزيز الصحة والوقاية من الامراض ومضاعفاتها

Values القيم

1. Quality and Distinction 2. Creativity and Innovation 3. Leadership and Team work 4. Loyalty and Commitment 5. Transparency and Accountability 6. Fairness and Honesty 7. Confidentiality and Respect	1. الجودة والتميز 2. الإبداع والابتكار 3. القيادة والعمل الجماعي 4. الولاء والانتماء 5. الشفافية والمساءلة 6. النزاهة والامانة 7. السرية والاحترام

GOAL OF INTERNSHIP PROGRAM

The Internship Program is designed to provide the nurse intern with the necessary clinical and practical experiences to reinforce competence in the care and management of patients with health problems in varied settings.

PROGRAM LEARNING OUTCOMES

1. Knowledge
   1.1 Describe the knowledge and concepts of basic health and nursing sciences
   1.5 Describe the nursing process in all concepts of nursing services
2. Skills
   2.1 Apply the nursing process to provide holistic care in variety of health care levels
   2.2 Incorporate concepts of health promotion and prevention in providing care
   2.3 Apply evidence based nursing practice
3. Competency
   3. 1 Comply with ethical and legal standards governing the performance of nursing professionals
   3.2 Communicate effectively with patients, families and other healthcare professionals
   3.3 Utilize leadership and managerial competencies in nursing practice under guidance and autonomously

COURSE LEARNING OUTCOMES

Learning Outcomes for Field Experience in Domains of Learning, Assessment Methods and Teaching Strategy			
	NQF Learning Domains and Learning Outcomes	**Teaching Strategies**	**Assessment Methods**
1.0	By the end of the internship, given actual or simulated situations/conditions , the students will be able to: **Knowledge**		
1.1	Integrate the theoretical foundations, knowledge and concepts for core nursing interventions and skills in area of assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 1.1 (*Describe the knowledge and concepts of basic health and nursing sciences*)	Self-directed learning Self-study modules Debriefing Bedside micro teaching, conference and post conference Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Attendance in each assigned unit
1.2	Describe the importance of holistic nursing care in handling different cases in each assigned unit assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading	Self-directed learning Self-study modules Debriefing	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Attendance in each

	criteria; @ PLO 1.5 (*Describe the nursing process in all concepts of nursing services)*	Bedside micro teaching, conference and post conference Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion	assigned unit
2.0	**Skills**		
2.1	Utilize nursing process as a framework for delivery of care in every assigned unit, as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 2.1 (*Apply the nursing process to provide holistic care in variety of health care levels).*	Hands on practice Nursing Rounds Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance
2.2	Provide health education to individuals, family and community in every assigned unit, as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 2.2 (*Incorporate concepts of health promotion and prevention in providing care).*	Hands on practice Health education delivery Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance
2.3	Evaluate research evidence that will guide professional nursing practice in each area of assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 2.3 *(Apply evidence based nursing practice)*	Hands on practice Health education delivery Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion with evidence based integration	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance

3.0	**Competency**		
3.1	Incorporate professional values including ethical and legal aspects of nursing care in each area of assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 3.1 *(Comply with ethical and legal standards governing the performance of nursing professionals).*	Professionalism related guidelines and policies Professional counseling Role modeling Confidentiality Agreement Hands on practice Health education delivery Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion with evidence based integration	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance
3.2	Communicate effectively using therapeutic verbal and non-verbal communication to assigned patient, family and in relating with other healthcare professionals in each area of assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 3.2 *(Communicate effectively with patients, families and other healthcare professionals)*	Hands on practice Health education delivery Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Electronic and mobile learning resources Case Studies/ Case- or Scenario-Based discussion with evidence based integration	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance
3.3	Demonstrate effective and efficient nursing leadership skills in each area of assignment as exhibited by obtaining a mark of 60% and above in all the components of the grading criteria; @ PLO 3.3 *(Utilize leadership and managerial competencies in nursing practice under guidance and autonomously).*	Role modeling Bedside micro teaching, conference and post-conference Self-directed learning Self-study modules Reflection Acts as an in charge in the unit Attendance in unit meetings Participation in unit quality and safety related projects	Rubrics for Performance Checklist per unit Rubrics for Case Study Rubrics for Attitude Summary of Attendance

INTERNSHIP ROTATION

FEMALE ROTATION

AREAS OF ASSIGNMENT	NUMBER OF WEEKS	AREAS OF ASSIGNMENT	NUMBER OF WEEKS
KING KHALID HOSPITAL		**KING FAHAD SPECIALIST HOSPITAL**	
Medical Ward	4	Medical Ward	4
Surgical Ward	4	Surgical Ward	4
Operating Room	3	Operating Room	3
Recovery Room	3	Recovery Room	3
Intensive Care Unit	8	Intensive Care Unit	4
Emergency Room	4	Coronary Care Unit	4
Paediatric Ward	4	Emergency Room	4
Maternity Ward	4	Pediatric Ward	4
Psychiatric Unit	4	Maternity Ward	4
Health Center /OPD	4	Psychiatric Unit	4
Elective (Intern's Choice)	6	Health Center /OPD	4
TOTAL WEEKS	**48**	Elective (Intern's Choice)	6
		TOTAL WEEKS	**48**

MALE ROTATION

AREAS OF ASSIGNMENT	NUMBER OF WEEKS	AREAS OF ASSIGNMENT	NUMBER OF WEEKS
KING KHALID HOSPITAL		**KING FAHAD SPECIALIST HOSPITAL**	
Medical Ward	6	Medical Ward	6
Surgical Ward	6	Surgical Ward	6
Operating Room	3	Operating Room	3
Recovery Room	3	Recovery Room	3
Intensive Care Unit	8	Intensive Care Unit	4
Emergency Room	4	Coronary Care Unit	4
Psychiatric Unit	6	Emergency Room	4
Health Center/OPD	6	Psychiatric Unit	6
Elective (Intern's Choice)	6	Health Center/OPD	6
TOTAL WEEKS	**48**	Elective (Intern's Choice)	6
		TOTAL WEEKS	**48**

INTERNSHIP PROGRAM

Qualifications for Admission in the Internship Program:

- GPA not lower than 2.0
- Completed and passed all academic subjects.
- Completed needed documents for internship.
- Passed the BLS provider course.
- Should take the pre and post Internship Assessment Examinations.
- Should attend General Orientation given by the Internship Committee, Department of Nursing and of the Host Institution.

Training Period:

- All nursing interns in regular Baccalaureate Program are expected to work **40 hours** a week in 12 Gregorian months.
- Internship Program will commence as determined by the host Institution.

The Internship Coordinator from the Department of Nursing in collaboration with the Training Coordinator of the identified hospital is responsible for providing proper training area to meet the objectives of the internship program.

Each intern will present a case study on the **6th month and 12th month** of training that will be identified by the Internship Coordinator of the University, Department of Nursing and such activity will be held at the University Campus.

The Interns are expected to seek educational opportunities such as attending to seminars, workshops, lectures, and in-service educational programs. This is to promote their professional growth and seek continuing education. Nursing Interns are given by the host institution certain days as educational leave to fulfill this expectation.

DEPARTMENT OF NURSING RESPONSIBILITIES

The Department of Nursing, Internship Committee have a crucial role to play in the planning, development and implementation, monitoring, evaluation towards the success of the program.

The Department of Nursing, Internship Committee will have direct responsibilities for the following:

1. Plans & organizes the internship program.
2. Coordinates with host institution.
3. Follows up the implementation of the policies and guidelines of the nursing internship program.
4. Maintains an accurate personal data and files of the interns.
5. Coordinates counselling of nurse interns if needed.
6. Acts as a resource person for any inquiries related to the internship program.
7. Collaborates and coordinates the implementation and appraisal of the internship program with the Hospital Nursing Coordinator

Roles of a Preceptor/ Head Nurse	
Outcome	**Strategies**
1. Provides an orientation for the student	Develops and implements an orientation plan to include: • Location of equipment, physical layout of the unit, the process to acquire supplies, location of the client record, the charting process, shift scheduling, and staff rotation, and explanation of nursing unit routines. • Orientation of student to facility emergency and special code procedures.
2. Maintains a current knowledge base which serves as a resource nurse role.	• Explains policies and procedures to intern highlighting interpretation and key points. • Coach the intern in solving clinical problems, recognizing and differentiating between the novice and expert learning curve. • Recognizes novice practice in the development of expertise. • Directs the intern to appropriate resources in seeking additional problem-solving information. • Observes the intern in demonstrating clinical skills and facilitates student's development of skill competencies.

	• Incorporates principles of adult learning by explaining plans for assignments and soliciting student feedback on progress. • Explains unit philosophy and incorporates application into unit operation and client care assignment.
3. Models professional nursing practice	• Demonstrates application of clinical procedures and coaches the intern in the execution of complex skills. • Provides direction in problem-solving, advising on information generating and examining alternatives, while considering all resources available. • Assists the intern to set priorities which may include delegation of tasks. • Guides and coaches the intern in providing verbal and written communication by questioning and explaining relevance of required information. • Participates in the socialization process introducing the intern to situations which will establish interpersonal/collegial relationships. • Demonstrates professional accountability by explaining rationale for decisions and client care outcomes. • Demonstrates dependability by being available to student and providing constructive support. • Coach's the intern in the art of acquiring peer respect.
4. Provides clinical supervision	• Constructs a daily assignment, in collaboration with the intern. • Provides learning activities appropriate to intern's abilities. • Constructs a learning environment to facilitate achievement of the intern's goals and objectives. • Assist the intern to complete the procedure checklist
5. Assists the student to adapt to the new role inherent in professional practice.	• Provides a forum to reduce anxiety inherent in adjusting to new professional role. • Schedules meetings to review the intern's progress and exchange constructive feedback. • Accepts feedback from the intern by collaborating in each other's professional development.
6. Contributes to the evaluative system which measures the student's progress.	• Reviews progress and outcomes on identified intern's goals and objectives. • Observes the intern in completing nursing care considering knowledge and utilization of nursing knowledge and experience. • Submits a written evaluation of intern's performance according to program standards and criteria.

	• Recognizes importance of on-going collaborative communication with the intern to determine progress towards experience expectations.
7. Communicates with the Internship Coordinator and intern to facilitate the functioning of the preceptorship experience.	• Understands the process for contacting the Internship Coordinator, as the need arises.

NURSE INTERN'S RESPONSIBILITIES

1. Reports to the Head Nurse /Preceptor and ask for permission before leaving the assigned area for breaks, lunch, pray, or a meeting.
2. Accepts patient assignments which complement the nursing internship clinical objectives.
3. Provides quality nursing care to patients applying the nursing process.
4. Participates in the unit/patient care activities.
5. Takes larger caseloads and work with decreasing levels of supervision as the internship progresses.
6. Performs nursing procedures safely and confidently.
7. Participates in Endorsement shift report from the outgoing and incoming nurse on duty of allocated patients.
8. Reports any unusual incidents/occurrence in the duty, according to hospital policy.
9. Stays in the unit all the time on duty except when on break time.
10. Adheres to the internship regulations of the hospital.
11. Displays professional and positive attitudes at all times.
12. Attends mandated in-service programs related to nursing.
13. Follows the working hours and working procedures of the host institution.
14. Attends orientation program.
15. Endorsement should be made to her/ his designated preceptor about all patients under her care prior to leaving the clinical area.
16. Demonstrates honesty, punctuality, courtesy, cooperative attitude, good grooming habits, and willingness to learn.

ASSESSMENT & EVALUATION

The assessment and evaluation will be done after each area of assignment on the following assessment criteria and corresponding percentage with a total of 100%:

Assessment Criteria	Percentage
Attendance	10%
Behaviour	10%
Requirements (Case Study Presentation)	10%
Competency	70%
TOTAL	**100%**

APPENDICES

1. Terms and conditions of Internship student in Health Facilities and Hospitals of the Ministry of Health in Tabuk
2. Expectations
3. Policies and Regulations
4. Holidays/Leave
5. Competency Checklists
6. Self-Assessment of Nursing Skills Inventory

TERMS AND CONDITIONS OF INTERNSHIP STUDENT IN HEALTH FACILITIES AT HOSPITALS OF THE MINISTRY OF HEALTH IN TABUK

1. The Nursing intern will be treated as an employee in terms of attendance and leave of absences in accordance to the official working hours as scheduled by the affiliating host.
2. The Nursing intern must show commitment to the training plan prepared by the Department of Academic Affairs and Training in Tabuk Health.
3. The Nursing intern must spend the training period continuously without interruption and in case of discontinuation of training without an official excuse for five days, the student will be suspended by the Nursing Education Training Office. Training will only resume when an official letter of excuse from the Internship Coordinator of the Department of Nursing, University of Tabuk is given to the Nursing Education Training Office.
4. The Nursing intern must follow the instructions and policies given by the Nursing Education and Training Office.
5. The Nursing intern must exhibit commitment to wear uniforms (gray mid-leg lab coat) and identification card in all facilities.
6. The Nursing intern are strictly forbidden to wear jeans for male students.
7. The Nursing intern (Female) must consider the decency of wearing the designated hospital uniform
8. The Nursing intern must not smoke inside health facilities and take care of the general appearance.
9. The Nursing intern must undergo a blood test and take the necessary immunizations.
10. The Nursing interns are strictly prohibited on using mobile phones during duty hours as well as Taking photos and/or videos inside the facility is not allowed.
11. In case problem arises during duty hours, the nurse intern should make a report and submit to the Nursing Education and Training Office for documentation purposes.
12. The nurse intern should render full commitment to the rules and regulations of the affiliating host.

EXPECTATIONS:

1. Nursing department of the host institution and the Nurse Intern are all sharing a joint accountability to provide safe quality patient and family care.
2. The Nurse Intern will function under supervision of the designated preceptor/ Head Nurse during the entire Internship Program.
3. The Nurse Intern will not function outside the scope of her practice. Should this happen he/she will accept all consequences of his/her action(s).
4. The Nurse Intern will follow patterns of behaviour which follow the standards for nursing practice.
5. The Nurse Intern will accept personal responsibility for being able to provide safe quality nursing care, and for knowledge and skill necessary to provide this care.
6. The Nurse Intern is expected to meet performance criteria and achieve each clinical placement's specific objectives and competencies by the end of each clinical rotation.
7. The Nurse Intern will participate in the role responsibilities of the Team Leader, Charge Nurse and Head Nurse of the designated area, particularly as it relates to planning of care, assignment of staff, scheduling and work organization.
8. The Nurse Intern will progress to take on larger caseload and work with decreasing levels of supervision as the Internship progresses.
9. The Nurse Intern will work day shifts only during the first three months of the program, but subject to changes in accordance to the Hospital policy

POLICIES AND REGULATIONS

1. Working Hours
   1.1 Adhere to shift schedule of host institution.
   1.2 Break times during assigned duty:
      1.2.1 30 minutes for lunch break
      1.2.2 15 minutes for prayer time
      1.2.3 And /or according to host institution policy.
   1.3 Report to work on or before 7:00 am and leaves after the shift endorsement.
   1.4 Sign in and sign out in the attendance log book
2. Mobile phones and other electronic devices may be used in accordance to hospital policy
3. Dress Code - Student shall dress in accordance to hospital policy.
4. Attending lectures/ seminars depends on the policy of the host institution.

HOLIDAYS/ LEAVE

1. National Holidays

1.1 Each Nurse intern is entitled to the national Holidays (Ramadan Eid, Hajj Eid and national holiday)
1.2 Number of days (Eid Al Fitr " five days", Eid Al Adha "five days", The National Holiday "1 day")
1.3 Holiday/s leave will be in accordance to the host Institution

2. Leave of Absence/s

2.1. This will be in accordance to the host Institution.

3. Tardiness/ Late/ Absences

3.1. Coming late for duty and able to incur 5 late will be equivalent to 1 unexcused absence, thus the intern should have a 1 day make-up.

3.2. Intern will be subjected to disciplinary action for the numbers of unauthorized absences incurred.

3.3. Incurred 25% of unexcused absences will cause to repeat her/ his whole clinical duty in the same area/unit, without deprivation of his actual grades or the grades he incurred for that rotation. Repetition of the clinical duty will be done after the Internship Program.

4. Maternity Leave

4.1 Maternity leave as per policy of host institution.
4.2 The assigned rotation during which the maternity leave comes in should be repeated at the end of the internship year.

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Nursing Internship Competency Checklists

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Surgical Nursing

SURGICAL WARD COMPETENCY CHECKLIST

Name of Student: _____ **Student Number: _____**

Year Level: _____ **Section/Group #: _____**

Area of Exposure: _____ **Inclusive Dates: _____**

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Implements appropriate nursing interventions based on identified needs					
8. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
9. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Provide discharge teaching to patient and family members.					
6. Documents data on client care clearly, concisely, accurately, and in a timely manner					
7. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
8. Assist in patient handover (endorsement) procedures					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
1. Ensure proper identification of patient.					
2. Assesses and monitors LOC, vital signs, including pulse and respiratory rates, temperature, pulse oximetry, BP, and 3-lead EKG, I & O, and pain.					

3. Assess and maintain patency of contraptions (IVF, BT, catheters, drainage).					
4. Performs Physical assessment (focused or comprehensive); Cranial nerves assessment, Neurovascular Circulation Observations (Pain, Pulse, Pallor, Paresthesia and Paralysis), OR Safety checklist and Aldrete scoring in PACU.					
5. Provides appropriate individual comfort measures such as hygiene maintenance, positioning, touching, bed making, and non-pharmacologic management of pain.					
6. Applies infection control measures. Wears prescribed attire according to department policies and isolation precautions.					
7. Transfer patients safely. Raise side rails when needed.					
8. Identify and prepare correct equipment/materials/instruments prior to performance of procedures while maintaining sterility as needed.					
9. Observe and perform techniques and principles of specimen collection techniques.					
10. Provides teaching about assessed and identified learning needs. (e.g. diet restriction as ordered, prior diagnostic and nursing or medical procedures, medications etc.).					
11. Provides emotional, physical and psychological and spiritual support as needed.					
12. Performs nursing procedures (perioperative care, CBG, insulin and other therapeutic drugs administration, tubes, irrigations and contraptions care like IV, BT, IFC, CTT; CPT, oxygen therapy, spirometer, suctioning, ECG, wound dressing and mobility techniques, including ROM, transferring, ambulating, and use of assistive devices) efficiently and effectively.					
13. Performs ongoing assessment and identify deviations from standards.					
14. Refer untoward signs of complications and any deviations from normal and standards.					
15. Performs after care of materials/instruments/equipment used.					
16. Ensure proper disposal of hospital waste.					
17. Document accurately.					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE : _____× ___% = _____					

TOTAL MARK: _____

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

_____

_____

_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date: _____**

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Medical Nursing

MEDICAL WARD COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Implements appropriate nursing interventions based on identified needs					
8. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
9. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Provide discharge teaching to patient and family members.					
6. Documents data on client care clearly, concisely, accurately, and in a timely manner					
7. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
8. Assist in patient handover (endorsement) procedures					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
1. Ensure proper identification of patient.					
2. Assesses and monitors LOC, vital signs, including pulse and respiratory rates, temperature, pulse oximetry, BP, and 3-lead EKG, I & O, and pain.					
3. Assess and maintain patency of contraptions (IVF, BT, catheters, drainage).					
	3	**2**	**1**	**0**	**REMARKS**

4. Performs Physical assessment (focused or comprehensive); Cranial nerves assessment, Neurovascular Circulation Observations (Pain, Pulse, Pallor, Paresthesia and Paralysis), OR Safety checklist and Aldrete scoring in PACU.					
5. Provides appropriate individual comfort measures such as hygiene maintenance, positioning, touching, bed making, and non-pharmacologic management of pain.					
6. Applies infection control measures. Wears prescribed attire according to department policies and isolation precautions.					
7. Transfer patients safely. Raise side rails when needed.					
8. Identify and prepare correct equipment/materials/instruments prior to performance of procedures while maintaining sterility as needed.					
9. Observe and perform techniques and principles of specimen collection techniques.					
10. Provides teaching about assessed and identified learning needs. (e.g. diet restriction as ordered, prior diagnostic and nursing or medical procedures, medications etc.).					
11. Provides emotional, physical and psychological and spiritual support as needed.					
12. Performs nursing procedures (perioperative care, CBG, insulin and other therapeutic drugs administration, tubes, irrigations and contraptions care like IV, BT, IFC, CTT; CPT, oxygen therapy, spirometer, suctioning, ECG, wound dressing and mobility techniques, including ROM, transferring, ambulating, and use of assistive devices) efficiently and effectively.					
13. Performs ongoing assessment and identify deviations from standards.					
14. Refer untoward signs of complications and any deviations from normal and standards.					
15. Performs after care of materials/instruments/equipment used.					
16. Ensure proper disposal of hospital waste.					
17. Document accurately.					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE : _____× _____% = _____					

TOTAL MARK: _____

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

_____

_____

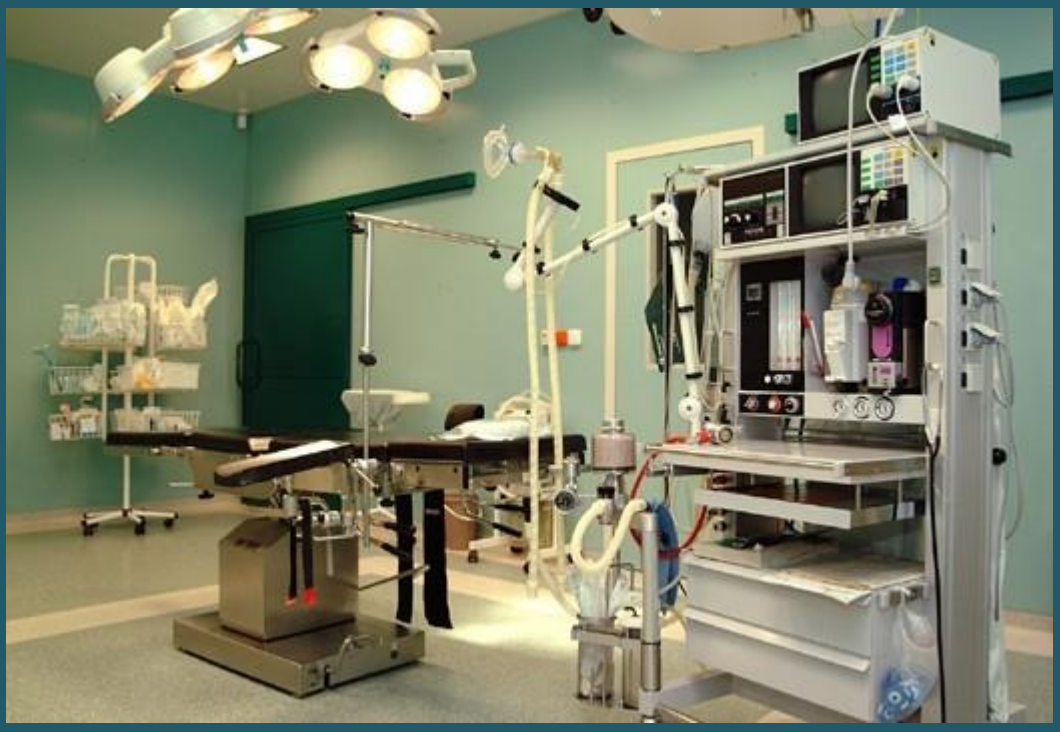
_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date: _____**

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Operating Room



OPERATING ROOM COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
8. Implements appropriate nursing interventions based on identified needs					
9. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
10. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
A. OPERATING ROOM					
1. Correctly identifies and follows the OR policies					
2. Wears the prescribed attire (Scrub Nurse/ Circulating Nurse)					
3. Surgical scrubbing done following correct technique and time frame					

	3	2	1	0	REMARKS
4. Performs sterile gowning and gloving adeptly and confidently (Scrub Nurse)					
5. Observe high regards for sterility without constant reminder from the Clinical Instructor					
Demonstrates knowledge and or skills in:					
6. Preparation of OR table, sheets and instruments (Circulating Nurse)					
7. Maintaining the sterility of supplies, equipment and area at all times (Circulating Nurse)					
8. Anticipating, providing and properly arranging the needed supplies and equipment for the operation and moves with confidence and foresight (Circulating Nurse)					
9. Keeping track of instruments as to location and numbers religiously (Scrub Nurse/Circulating Nurse)					
10. Constantly keeping track of the whereabouts of sponges and instruments in use (Scrub Nurse/Circulating nurse)					
11. Observing Sterile Technique in the preparation of sterile packs and instruments					
During the Operation					
12. Anticipates the needs of the surgeon and the surgical team with confidence (Scrub Nurse/Circulating Nurse)					
13. Anticipates, provides for and arranges properly the needed supplies and equipment for the operation and moves with confidence and foresight (Circulating Nurse)					
14. Accurately counts and promptly records sponges and instruments before and after cutting time, and closing time.					
After the Operation					
15. Accurately counts and promptly records sponges and instruments before and after cutting time, and before closing time (Scrub Nurse/Circulating Nurse)					
16. Helps in the application of dressing and previous immediate post op care, methodical and surefooted in his/her action.					
17. OR suite/theatre is thoroughly cleaned after use, paying close attention to hooks and crannies, in preparation for the next use.					
18. Displays initiatives to assist in cleaning and arranging OR suite for the next case.					
IV. VALUES AND ATTITUDE	**4**	**3**	**2**	**1**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behaviour in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE on SKILLS: _____× 100 × ___% = _____					

TOTAL MARK: _____
INSTRUCTOR'S REMARKS AND SUGGESTIONS: _____
_____

_____
Student's Signature over Printed Name:
Date: _____

_____
Clinical Instructor's Signature over Printed Name:
Date: _____

RECOVERY ROOM COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
8. Implements appropriate nursing interventions based on identified needs					
9. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
10. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
RECOVERY ROOM (RR)/ POST-ANESTHESIA CARE UNIT (PACU)					
1. Prepares stretcher and appropriate medical equipment needed by the incoming patient.					
2. Safely transfers the patient from the operating room to the recovery room.					

	3	2	1	0	REMARKS
3. Observes proper positioning during the immediate post-operative period					
4. Raises the side rails.					
5. Assesses for level of consciousness					
6. Provides care of the respiratory system, including chest physiotherapy, Oxygen therapy, resuscitation, spirometry, and suctioning.					
7. Attaches patient to the cardiac monitor.					
8. Performs initial assessment of the patient's vital signs and oxygen saturation.					
9. Assesses the patient's pain scale.					
10. Provides comfort and pain reduction measures including positioning and therapeutic touch.					
11. Assesses the patient's operative site and manages wounds, including irrigation, application of dressings, and suture/staple removal.					
12. Carries out the doctor's orders correctly.					
13. Assesses, monitors and regulates intravenous therapies.					
14. States the different principles of drug administration during the immediate post-operative period.					
15. Keeps patient on NPO, as necessary.					
16. Remove oral airways as necessary.					
17. Performs accurate intake and output calculations and recording.					
18. Performs intravenous therapy (Initiating, maintaining, monitoring and discontinuing)					
19. Monitors clients who are undergoing Transfusion of Blood and Blood Products					
20. Provides appropriate individual hygiene maintenance.					
21. Applies infection control measures					
22. Performs ongoing assessment of patient's vital signs and oxygen saturations.					
23. Refers to the doctor for any untoward signs of complications					
24. Assesses the patient's Post-Anesthesia Recovery Score					
25. Prepares the patient for transfer to the Surgical Floor/ Ward					
26. Endorses the patient to the Surgical Ward Nurse					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					

TOTAL SCORE on SKILLS: _____× 100 × ____% = _____

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Emergency Nursing

FIRST AID AND EMERGENCY NURSING COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____

Year Level: _____ **Section/Group #:** _____

Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
8. Implements appropriate nursing interventions based on identified needs					
9. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates appropriate and correct assessment in the care of patients admitted at ER					
• Cardiovascular Problems					
• Pulmonary Problems					
• Neurological Problems					
• Orthopedic Problems					
• Gastrointestinal Problems					
• Renal/ Genitourinary Problems					
• Endocrine/ Metabolic Problems					

• Other diseases encountered.					
2. Demonstrates knowledge and understanding of common Emergency medications. • Observes and monitors for possible adverse effects.					
3. Demonstrates correct skill/ technique in performing different ER procedures					
• Taking Vital Signs					
• Assists with insertion and set up of IV line.					
• Monitoring of other devices a. Cardiac monitor b. Infusion pumps					
• Placement of ECG leads					
• Neurologic Assessment (based on hospital policy)					
• Oxygen Therapy Administration					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE on SKILLS: _____× 100 × ____% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____

_____
Student's Signature over Printed Name:
Date: _____

_____
Clinical Instructor's Signature over Printed Name:
Date: _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Maternal Health Nursing

MATERNAL HEALTH NURSING COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Develops a comprehensive patient care plan					
8. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
9. Implements appropriate nursing interventions based on identified needs					
10. Evaluates nursing care outcomes based on formulated objectives, allowing for the revision of actions and goals.					
11. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS CARE OF THE MOTHER	**3**	**2**	**1**	**0**	**REMARKS**
A. ANTE-PARTAL CARE					
1. Demonstrates knowledge of pregnancy on					
▯ signs of pregnancy					
▯ physiological changes					
▯ EDC (expected date of confinement)					

▯ AOG (Age of Gestation)					
▯ psychological signs					
2. Demonstrates the ability to perform full health assessment related to pregnancy such as:					
▯ VS and weight					
▯ last menstrual cycle					
▯ history of past medical					
▯ number of pregnancies (gravida, para, term, preterm, abortion, living children and multiple birth)					
▯ fundal height& compare to Bartholomew's rule					
▯ Leopold's maneuver					
▯ auscultation of fetal heart beat					
▯ testing of urine, CBC and other laboratory and diagnostic tests					
▯ assist in ultrasonography					
▯ discomforts of pregnancy					
▯ danger signs of pregnancy (burning sensation, edema, hypertension, anemia, abnormal heart/lung sounds, bleeding)					
3. Demonstrates the ability to teach the pregnant client in relation to prenatal care.					
4. Demonstrates knowledge of complications associated with pregnancy such as (DM, Eclampsia, Ectopic pregnancy and others)					
5. Demonstrates the ability to teach the client about complications of pregnancy, counseling on Family Planning and breastfeeding					
6. Gives health teachings on medications such as ferrous sulfate, folic acid and tetanus toxoid.					
B. EMERGENCY OBSTETRIC CARE					
1. Performs focused assessment					
▯ true signs of labor and birthing process					
▯ danger signs of pregnancy					
▯ emergency nursing needs					
2. Demonstrates ability to perform full health assessment and specialized admission specific to maternal nursing such as:					
▯ awareness of risk factors					
▯ vital signs					
▯ assist in UTZ and auscultation of fetal heart					
▯ consents					
▯ delivery record					
▯ last menstrual cycle					
▯ previous pregnancies (gravida, para)					
3. Demonstrates skills in carrying out doctor's orders promptly and properly.					
4. Performs nursing procedures effectively and safely					
▯ admission					
▯ Blood examination/investigation					
▯ IVF insertion					
▯ Medication administration					
▯ catheterization					
▯ Non-Stress Test/Contraction Stress Test					
▯ Oxygen administration					
▯ Prepare patient for OR					

C. INTRA-PARTAL CARE	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains obstetrical history including GPTPAL, LMP, EDC, AOG, BOW and onset of true labor					
2. Demonstrates ability to assist authorized professional during management of labor:					
applies external fetal heart monitor/CTG					
assists with ongoing monitoring throughout labor (duration, interval, frequency and intensity of contraction)					
reports and documents as required.					
comfort measures (perineal care, positioning, exercise)					
coaching mother on breathing and pushing techniques					
3. Demonstrates ability to test appropriate specimens during labor such as glucometer, urine & amniotic fluids using litmus paper / kits.					
4. Provides privacy					
5. Demonstrates ability to assist authorized professional with invasive procedures such as:					
vaginal exams					
artificial rupture of membranes					
insertion of internal mode fetal monitoring					
epidural anesthesia / analgesia					
induction					
obtaining consents if applicable.					
6. Demonstrates ability to use non-pharmacological techniques to assist client in managing pain during labor and delivery.					
7. Demonstrates ability to administer medications to client in labor as per agency policy.					
8. Demonstrates ability to use sterile techniques to set-up delivery suite (, performs hand scrub, wears gown and gloves)					
9. Demonstrates ability to use equipment for safe delivery.					
10. Demonstrates ability to assist authorized professional in delivery process.					
assist in episiotomy					
identifies maneuvers in delivering the fetus (Ritgen's)					
assist in delivery of placenta, serves clamps					
identifies maneuvers in delivering the placenta (Crede's and Brandtt Andrew maneuvers)					
identifies signs of placental separation and shows ability to assess placenta					
assess amount of blood loss					
employs interventions to achieve and maintain a well-contracted uterus					
assess presence and degree of laceration					
assist in episiorrhaphy					
check size and consistency of uterus					
11. Perform perineal care and applies pad correctly					
12. Provides emotional support to the mother throughout labor and delivery					
13. Prepares client for transfer in the observation room					

C. POST-PARTAL CARE					
1. Demonstrates ability to perform assessment and on-going assessment of post-delivery client such as:					
▯ Vital signs.					
▯ breasts / nipples					
▯ fundus					
▯ bowel movement/ hemorrhoids					
▯ bladder/ voiding					
▯ lochia					
▯ caesarean section incision/ episiotomy					
▯ Homan's sign					
▯ Emotion					
▯ Pain					
2. Demonstrates ability to recognize post-delivery complications such as *boggy fundus, passing large clots or tissue, difficulty voiding or distended bladder, displaced fundus, edema (hands and feet), high blood pressure, postpartum haemorrhage, seizure activity*.					
3. Demonstrates ability to provide appropriate and safe nursing interventions.					
4. Observe aseptic technique in all procedures.					
5. Demonstrates ability to recognize physiological changes such as: *after pains, cervical closure, constipation, decreased perineal muscle tone, diuresis, involution of uterus, lactation, ovulation / menstruation, vital sign changes, diaphoresis, weight loss.*					
6. Demonstrates the ability to teach and support client in ongoing postpartum care such as: *breast feeding / bottle feeding, changes in family dynamics, nutrition and exercise, importance of rest, involution, newborn care, perineal hygiene, personal hygiene, physiological changes, and psychological changes.*					
7. Demonstrates ability to safely use equipment needed in the postpartum period.					
8. Demonstrates the ability to assist mother with breast feeding.					
9. Demonstrates ability to provide discharge teaching to mother, father and / or significant other.					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform & is well-groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE on SKILLS: _____× 100 × ____% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS: _____

_____

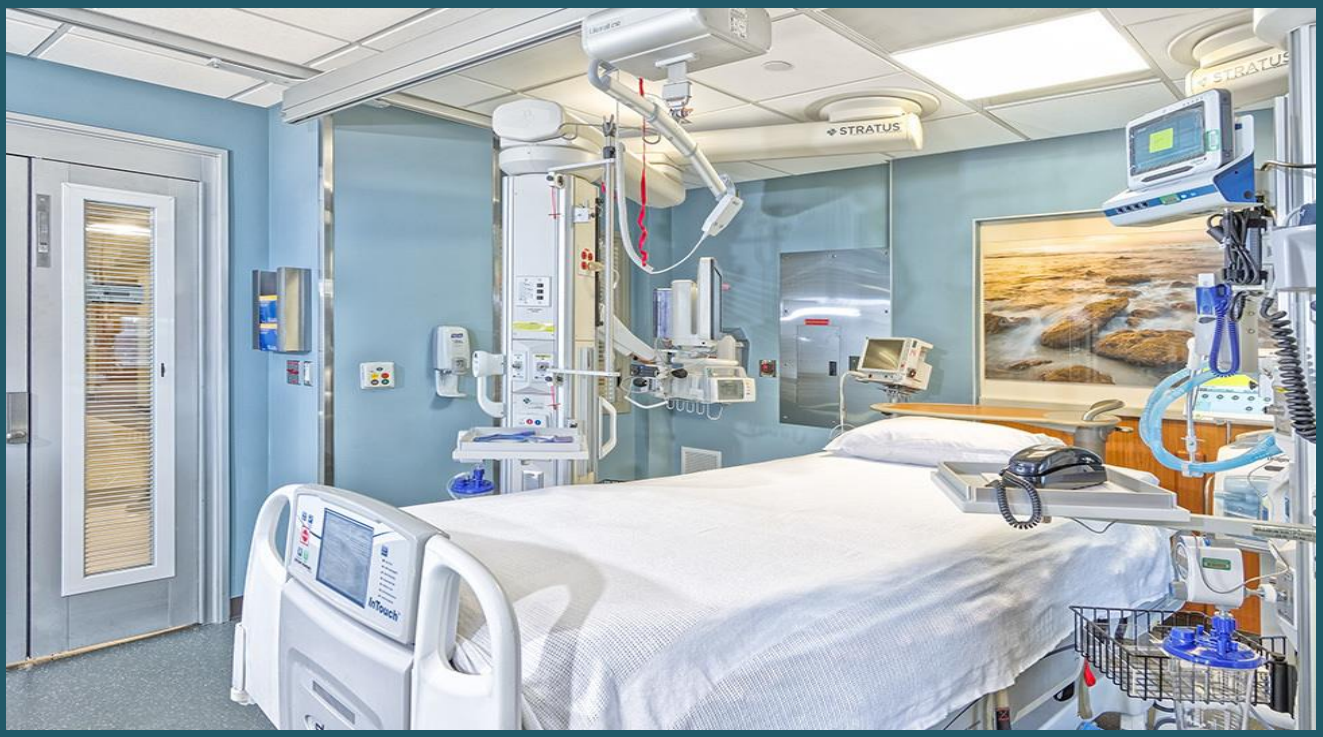
_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Intensive Care Nursing



CORONARY CARE UNIT/ ADULT INTENSIVE CARE UNIT (CCU/ AICU)
COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data.					
3. Performs Physical Assessment and/or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses.					
7. Performs age-specific comfort measures (e.g. oral care, AM care, changing of bed linen).					
8. Implements appropriate nursing interventions based on the needs being identified.					
9. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre and post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner.					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
1. Prepares all of the equipment needed					
2. Wears Personal Protective Equipment (PPE) accordingly					
3. Uses aseptic technique during the whole procedure as necessary					

4. Draws the possible causes for the alarm conditions of the machines being used (dialysis machine, mechanical ventilator etc.)					
5. Monitors possible complications using appropriate assessment technique (bleeding, infection, tube disconnections etc.)					
6. Demonstrates competence in perfoming basic ICU nursing skills:					
6.1 Assesses patient's Glasgow Coma Scale (GCS)					
6.2 Examine the ECG tracing in the Cardiac Monitor					
6.3 Demonstrates competence in performing nursing skills for:					
7.1 Air way management:					
7.1.3 Demonstrates care of Tracheostomy					
a. Provides care for patients with air way tube					
7.1.4 Performs Suctioning					
7.1.5 Performs Chest Physiotherapy					
7.2. Central lines					
a. Discusses the normal parameters and chest landmarks for CVP measurement					
b. Determines and records CVP using a water manometer and pressure monitor					
7.3 Nursing care and Management of:					
a. Post-Intracranial surgeries					
b. With Cerebrovascular Accident					
c. With Myocardial Infarction/Unstable angina					
d. With Congestive heart failure					
e. With End Stage Renal Failure					
f. With Burns					
g. Others: _____					
8. Monitors patients receiving common cardiac medications					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform and is well groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE: _____× __% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Pediatric Nursing

CHILD HEALTH NURSING COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Obtains comprehensive client's information by thorough checking of the client's chart.					
2. Interviews the client and/or significant others to gather history and subjective data					
3. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
4. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
5. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
6. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
7. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
8. Implements appropriate nursing interventions based on identified needs					
9. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
10. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**4**	**3**	**2**	**1**	**REMARKS**
A. <u>Ability to assess child condition:</u> 1. Obtain accurate health history **2.** Perform physical assessment. **3.** Record data of assessment with accurately					
B. <u>Recognize patient and family needs.</u> 1. Set priorities for the needs.					

2. Set goals for the care. 3. Nursing actions to meet child's needs.					
C. Implementation of the plan 4. Follow aseptic technique. 5. Give health education according to child/family needs. 6. Evaluate the care given.					
7. Ability to feed the baby accurately (Bottle feeding or gavage feeding)					
8. Ability to perform nursing procedures accurately, safely, and comfortably.					
9. Vital signs for children and compare the results with normal average according to child age					
10. Growth Measurements (Wt., L., HC., CC.)					
11. Baby bathing & Diaper care for neonate .					
12. Eye care & cord care for neonate.					
13. Familiarized with Pediatric procedures (hand washing , oral feeding , turning the child , bathing , suctioning with a bulb syringe , obtaining a specimen for urinalysis and stool . obtaining a throat culture, gastrostomy tube feeding . administration an enema , suctioning the tracheostomy. -					
14. Compute IV fluids rate and drug dose					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform and is well groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE: _____× ___% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Mental Health Nursing

MENTAL HEALTH NURSING COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
2. Establishes and maintains effective working relationships within an interdisciplinary team.					
3. Utilizes proper channels of communication.					
4. Participates actively during pre & post conferences					
5. Documents data on client care clearly, concisely, accurately, and in a timely manner					
6. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
II. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
1. Demonstrates knowledge and ability to properly assess mental status:					
A – PPEARANCE					
B- EHAVIOUR					
C-OGNITION					
2. Demonstrates ability to communicate and collaborate with the health care team within mental health environment.					
TREATMENTS AND INTERVENTIONS					
3. Demonstrates knowledge and ability to implement psychosocial/ therapeutic interventions.					
4. Collaborates with client support system and the multidisciplinary team in developing, implementing and evaluating the plan of care. (IF APPLICABLE)					
KNOWLEDGE AND AWARENESS OF SAFE PREPARATION AND ADMINISTRATION OF MEDICATIONS	**3**	**2**	**1**	**0**	
5. Demonstrates awareness of the standard procedures in medication preparation:					
a. Checking on the medications to be administered three times before administration.					
b. Avoiding interruptions during the preparation and administration of medication.					
c. Performing the 2-patient identifier checks before administering the medication.					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
1. Wears complete uniform and is well groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					

6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE: _____× ___% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____
Student's Signature over Printed Name:
Date: _____

_____
Clinical Instructor's Signature over Printed Name:
Date: _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Community Health Nursing

COMMUNITY HEALTH NURSING COMPETENCY CHECKLIST

Name of Student: _____ **Student Number:** _____
Year Level: _____ **Section/Group #:** _____
Area of Exposure: _____ **Inclusive Dates:** _____

3	**Competent**	Student performs consistently in an effective and efficient manner
2	**Progress Acceptable**	Performance is usually effective and efficient but not always
1	**Needs Improvement**	Progress in performance is too slow to judge satisfactorily, task performance is not done properly majority of the time
0	**Progress Unacceptable**	No progress in performance has been demonstrated, and/or performance is consistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS	**3**	**2**	**1**	**0**	**REMARKS**
PROVISION OF BASIC HEALTH SERVICES					
A. ASSESSMENT					
1. Assesses with the client (individual, family, population group, and/or community) one's health status thru:					
a.1 Interview utilizing appropriate data gathering methods and tools guided by the type of setting requisites.					
a.2 Vital Signs, height, weight and BMI					
a.3 Analyzes data gathered.					
a.4 Enumerates identified health needs of the client using the typology of health care.					
a.5 Identify priority learning needs of the client.					
B. PLANNING					
1. Formulates with the client a plan of care to address the health condition, needs, and problems based on priorities.					
2. Plan and integrate health promotion into all aspects of community health nursing.					
C. IMPLEMENTATION					
1. Performs hand washing before and after every procedure.					
2. Explain procedure in a comprehensive manner to the client and support system.					
3. Apply safety principles, evidence based – practice and appropriate protective devices when providing nursing care to prevent injury to client, self and other health care team.					
4. Implement safe and quality nursing intervention with the client to address the health need/s, problem/s or condition/s utilizing appropriate and available resources.					
5. Maternal Health Care:					
a. Address with respect actual concern of pregnant mother.					
b. Fill out maternal care book properly and accurately					
c. Compute EDC and AOG correctly and accurately					
d. Administer tetanus toxoid to the pregnant mother with appropriate route and dosage.					
e. Give appropriate health teaching.					
6. Under Five/ Child Health Care:					

a. Performs Growth and Development Monitoring appropriately (height, weight and head circumference)					
b. Administer proper vaccine safely.					
c. Give appropriate health teaching.					
7. Chronic Care:					
a. Decides and implement an appropriate nursing care based on the client's actual situation in accordance with the nursing standards which includes health promotion, disease prevention, health maintenance and restoration, rehabilitation and palliative care.					
b. Performs independent nursing care (such as: glucose monitoring test, wound care, first aid, TSB)					
8. Implements safe and quality nursing care during the pre -, intra - , and post – diagnostic and treatment procedures.					
9. Conduct brief and concise health education for promotive, preventive, curative and rehabilitative aspects of care.					
10. Uses strategies to encourage independence and enable clients to maintain their own health.					
D. EVALUATION					
1. Evaluates with the client the effectiveness of nursing care based on the expected outcomes of the nurse – client working relationship.					
2. Documents client's responses to nursing care provided.					
3. Uses research and evaluation skills to improve the quality of community health.					
II. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	REMARKS
1. Wears complete uniform and is well groomed at all times.					
2. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
3. Demonstrates honesty and accountability					
4. Changes behavior in response to constructive criticism/s					
5. Reports for duty on time.					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies.					
9. Reports to duty regularly.					
TOTAL SCORE: _____× ___% = _____					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

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_____

_____ _____

Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

University of Tabuk
Faculty of Applied Medical Sciences
Department of Nursing

Nursing Internship Self-Assessment of Nursing Skills Procedures

SELF-ASSESSMENT OF SURGICAL NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1. The nurse intern is able to discuss the policy and demonstrate the following: 1.1 Preoperative skin preparation					
1.1.1. Patient teaching					
1.1.2. Specific preparation					
1.1.3. Organization of chest x ray, ECG and blood works					
1.1.4. Preoperative check list					
1.1.5. Transfer patient to OR and from recovery room					
1. 2. Postoperative management					
1.2.1. Immediate post-operative care					
1.2.2. Positioning					
1.2.3. Ambulation					
1.3. Surgical dressing					
1.3.1. Set up of surgical field					
1.3.2. Performing surgical dressing					
1.4. Wound care					
1.4.1. Evaluation of wound					
1.4.2. Changing the dressing					
1.4.3. Packing the wound					
1.4.4. Selecting appropriate dressing material					
1.4.5. Care of drains					
1.4.6. Removal of sutures					
1.4.7. Removal of staples					
1.4.8. Removal of chest drains					

SELF-ASSESSMENT OF MEDICAL NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1. Vital Sign 1.1. Axillary temperature					
1.2. Use of IVAC thermometer					
1.3. Palpation & recording of radial pulse					
1.4. Palpation & recording of brachial pulse					
1.5. Recording of apical pulse					
1.6. Pulse amplitude					
1.7. Recording of respiration rate					
1.8. Recognition of respiration character / pattern					
1.9. Blood Pressure 1.9.1. Mercury sphygmomanometer					
1.10. Recognition of vital signs ranges 1.10.1 Adult					
1.10.2. Adolescent					
1.10.3. >10 years					
1.10.4. 2 - 10 years					
1.10.5. 3 months - 2 years					
1.10.6. Newborn - 3 months					
1.11. Use of Pulse Oximetry 1.11.1. Set–up					
1.11.2. "Acceptable values"					
1.11.3. Significance of waveforms					
1.12. Glasgow coma scale 1.12.1. Adult					
1.12.2. Paediatric					
1.12.3. Neurovascular / Circulation Observations (colour, warmth, movement, sensation)					
1.13. Recording of patient 1.13.1. Height					
1.13.2. Weight					
Performance of Physical Health Assessment					
2. Medication Administration 2.1 Documentation : Hospital Medication Chart 2.1.1 Oral					
2.2.2. I / D					
2.2.3. S / C					
2.2.4. IM					
2.2.5. IV Push / Bolus					
2.2.6. Per NGT					
2.2.7. Per Rectum					
2.3.8. Topical					
2.3.9. Eye / Nasal Drops					
2.3.10. Nebulization					
2.2. Hospital narcotic / Controlled substance Protocol & administration of such					
2.2.1. Epidural Anaesthesia / Analgesia					

2.2.2. Local anaesthetics					
2.2.3. Narcotics					
2.2.4. Continuous infusions					
2.2.5. Hospital forms					
2.2.6. Side-effects / Standing orders					
3. Infection Control					
3.1. Follows "Principles of Asepsis"					
3.2. Demonstrates appropriate "hand-washing" Technique					
3.3. Demonstrates "Isolation Principles" 3.3.1. Gloves					
3.3.2. Apron / gown					
3.3.3. Face mask					
3.3.4. Hospital Protocol					
3.4. Disposes of waste materials appropriately 3.4.1. Contaminated linens					
3.4.2. Contaminated clinical wastes					
3.4.3. Domestic wastes					
3.4.4. Chemotherapy wastes					
3.4.5. Isolation wastes					
4. Blood Sugar Monitoring 4.1. Ability to prepare correct equipment					
4.2. Correct use of glucometer					
4.3. Ability to analyse test result: "Normal vs. Abnormal" values					
4.4. Random Blood Sugar Protocol					
4.5. Fasting Blood Sugar Protocol					
4.6. Urine testing					
5. Oxygen Administration / Respiratory Therapy 5.1. Simple Face Mask - Application & Rationale					
5.2. Venturi Mask - Application & Rationale					
5.3. Nasal Cannula - Application & Rationale					
5.4. Oxygen Tent - Application & Rationale					
5.5. Head Box - Application & Rationale					
5.6. Tracheotomy Mask - Application & Rationale					
5.7. Incentive Spirometry - Application & Rationale					
5.8. Nebulization - Application & Rationale					
5.9. Humidification - Principles & Rationale					
5.10. Suctioning 5.10.1. Indications					
5.10.2. Potential complications					
5.10.3. Aseptic technique					
5.10.4. Selection of equipment					
5.10.5. Oropharyngeal					
5.10.6. Tracheal					
5.10.7. Nasopharyngeal					
5.11. Ambo - bagging					
5.12. Insertion of oral airway					
5.13. Ability to identify "hypoxemia"					
5.14. Postural drainage / Chest physiotherapy					
6. Specimen Collection 6.1. Urine					
6.2. Blood					
6.3. Stool					

6.4. Sputum					
6.5. Drainage Fluid					
6.6. Swabs: Ear, Nose, Throat, Wound					
6.7. Vomitus					
6.8. Identification of correct specimen containers & Hospital Labels					
7. Food & Fluids 7.1 Ability to order a patient's diet					
7.2. Reference to dietitian when appropriate					
7.3. Ability to maintain a patient on NPO					
Feeding of "dependent patients"					
7.4. Monitoring / documents nutritional intake					
7.5. Accurately monitoring fluid balance					
7.7. Inserting & removing an NGT safely					
7.8. Administering Enteral Feeding 7.8.1. Checks NGT position					
7.8.1. Preparing Feeding Aseptically					
7.8.2. Continuing Infusion Feeding					
7.8.3. Intermitting Feeding					
7.9. Administration of T.P.N. / P.P.N. 7.9.1. Indications					
7.9.2. Potential Complications					
7.9.3. Hospital Protocol					
7.10. Administration of Intralipids 7.10.1. Indications					
7.10.2. Hospital Protocol					
7.10.3. Potential Complications					
8. I.V. Therapy 8.1. Maintaining an IV Heplock / cannula					
8.2. Discontinuing an IVI safely					
8.3. Discontinuing an IV Heplock safely					
8.4. Documenting IVT Appropriately					
8.5. Use IVAC pumps correctly					
8.6. Use Abbott pumps correctly					
8.7. Use Syringe pumps correctly					
9. Positioning Patients					
9.1. Identifying "bed controls"					
9.2. Using a sheepskin appropriately					
9.3. Using "incontinence pads" appropriately while maintaining patient dignity					
9.4. Using "ripple overlays" appropriately					
9.5. Ability to position the patient comfortably & Appropriately					
9.6. Safely lifting a patient when necessary					
9.7. Transporting patients safely on a stretcher					
9.8. Transporting patients safely in a wheel chair					
9.10. Using a "draw sheet" effectively					
9.11. Demonstrating an understanding of "Body Mechanics"					
10. Bed Making 10.1. Showing ability to make an unoccupied bed					
10.2. Showing ability to make an occupied bed					
10.3. Showing ability to make up a cot					
10.4. Showing ability to make up a post-operative bed					
11. Patient Safety					

11.1. Using bedrails appropriately					
11.2. Using "restraints" when indicated					
12. Patient Comfort 12.1. Showing ability to assess pain accurately					
12.2. Showing ability to manage pain non-pharmacologically					
12.3. Administering appropriate analgesia					
12.4. Evaluating the "effectiveness" of analgesia					
13. Patient Hygiene 13.1. Performing bed-bath safely & with dignity					
13.2. Assisting with wash / shower					
13.3. Showing ability to wash a Paediatric / neonate safely					
13.4. Performing Perineal care when indicated					
13.5. Performing Eye care when indicated					
13.6. Performing Oral care when indicated					
13.7. Showing ability to wash a bed ridden patient's hair					
14. Crash Cart 14.1 Showing ability to check the "crash cart" contents & accurately reporting any discrepancies					
14.2. Showing ability to test the defibrillator safely					
15. Documentation					
15.1. Completing Kardex accurately & as required					
15.2. Following Hospital Admission Procedure					
15.3. Following Hospital Discharge Procedure					
15.4. Reporting information accurately in Patient Nurses Notes					
15.5. Documenting accurately on Forms					
16. Diagnostic Preparation					
16.1. Upper G.I. Series (barium swallows)					
16.2. Lower G.I. Series (barium enema)					
16.3. I.V.P. / Excretory urography					
16.4. Cholecystography					
16.5. C.T. Scan					
16.6. M.R.I.					
16.7. E.R.C.P.					
16.8. Endoscopy					
16.9. E.S.W.L. procedures					
16.10. Fluoroscopy					
16.11. Ultrasound					
16.12. Nuclear Medicine					
16.13. X-ray					
17. Care of the Following: 17.1. Orthopedic patients					
17.2. Urology patients					
17.3. Neurology patients					
18. Transfusion of Blood and Blood Products					
18.1. Administration according to hospital protocol					
18.2. Administration of PRBCs					
18.3. Administration of whole blood					
18.4. Administration of platelets					
18.5. Administration of cryoprecipitate					
18.6. Administration of fresh frozen plasma					

SELF-ASSESSMENT OF OPERATION ROOM NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1.Orientation to the OR suite or policies 1.1. Identifies the physical layout of the OR suite correctly with great degree of efficiency					
1.2.Correctly identifies the OR policies					
1.3. Always follows area/unit policies					
2. Application of nursing procedure and skills before the operation 2.1. Wearing prescribed uniform (Scrub Nurse/Circulating Nurse)					
2.2. Preparation of OR table, sheets and instruments (Circulating Nurse)					
2.3. Maintain sterility of supplies, equipment and area at all times (Circulating Nurse)					
2.4. Anticipates, provides and arranges properly the needed supplies and equipment for the operation and moves with confidence and foresight (Circulating Nurse)					
2.5. Adept and confident in performing sterile gowning and gloving (Scrub Nurse)					
2.6. Religiously keeps track of instruments as to location and numbers (Scrub Nurse/Circulating Nurse)					
2.7. Is oriented with regards to the whereabouts of sponges and instruments in use (Scrub Nurse/Circulating nurse)					
2.8. Surgical scrubbing done following correct technique and time frame					
2.9. Sterile technique is observed in the preparation of sterile packs and instruments					
2.10. Observe high regards for sterility without constant remainder from the Clinical Instructor					
3. During the operation 3.1. Anticipates the needs of the surgeon and the surgical team with confidence (Scrub Nurse/Circulating Nurse)					
3.2. Anticipates, provides for and arranges properly the needed supplies and equipment for the operation and moves with confidence and foresight (Circulating Nurse)					
3.3. Accurately counts and promptly records sponges and instruments before and after cutting time, and closing time.					
4. After the operation 4.1. Accurately counts and promptly records sponges and instruments before and after					

cutting time, and before closing time (Scrub Nurse/Circulating Nurse)					
4.2. Helps in the application of dressing and previous immediate post op care, methodical and surefooted in his/her action.					
4.3. OR suite/theatre is thoroughly cleaned after use, paying close attention to hooks and crannies, in preparation for the next use.					
4.4. Displays initiatives to assist in cleaning and arranging OR suite for the next case.					
4.5. Disposes waste material properly					

SELF-ASSESSMENT OF EMERGENCY NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1. Diagnostic Investigation & Procedures The nurse intern is able to assist with safe preparation and post procedural care of the patient for the following procedures					
1.1. X-ray procedures					
1.1.1.Upper GI Series Barium Swallow					
1.1.2. Lower GI Series Barium Enema					
1.1.3. IVP/ Excretory Urography					
1.1.4. Cholecystography					
1.2. CT Scan					
1.3. MRI					
1.4. ERCP					
1.5. Ultrasound					
1.6. Angiogram					
1.7. Biopsies					
1.8. Lumbar Puncture					
1.9. Bone Marrow Aspiration					
2. Diabetes Management					
2.1. Glucose Monitoring					
2.2. Blood Glucose device (e.g. glucometer)					
2.3. Urinary glucose & ketone testing					
2.4. Foot care					
2.5. Patient/family teaching					
3. Insulin Therapy					
3.1. Single Type					
3.2. Mixed Insulin					
3.3. Insulin Infusion					
4. Emergency Assessment					
4.1. Primary Assessment					
4.2. Secondary Assessment					
5. Triaging					
5.1. Able to demonstrate & assist in prioritizing patients management.					
6. Life Saving Interventions					
6.1. BLS					
6.2. CPR					
6.3. First Aid Measures					
6.4. Fluid Resuscitation					
7. Life Maintaining Procedures					
7.1. Airway Management					

SELF-ASSESSMENT OF MATERNITY NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1. Ante Natal					
1.1. Admit ante - natal patient					
1.2. Perform Obstetric Examination					
2. CTG Monitoring					
2.1. Machine set - up					
2.2. Interpretation					
2.2.1. Normal					
2.2.2. Abnormal					
3. Care of High Risk Patients					
3.1. Toxemia					
3.2. Ante partum haemorrhage(APH)					
3.3. Pre - eclampsia					
3.4. Essential HPN					
3.5. Multiple Pregnancy					
3.6. Diabetic Mother					
3.7. Gestational Diabetes					
3.8. Anaemia					
3.9. Cardiac History					
3.10. Renal History					
4. Complicated Pregnancy					
4.1. I.U.G.R.					
4.2. Premature Labour					
4.3. I.U.F.D.					
4.4. P.R.O.M.					
5. Post Natal: Post-delivery observations					
5.1. Fundus					
5.2. Lochia					
5.3. Perineum					
5.4. Vital signs					
5.5. Assisted delivery					
5.6. Caesarean section					
6. Mothercraft Teaching					
6.1. Routine newborn care & hygiene					
6.2. Establishment of breast feeding					
6.3. Milk Formula's					
6.3.1. Types & rationale					
6.3.2. Preparation					
6.3.3. Sterilization of bottles & teats					
6.4. Immunization schedule					
LABOR AND DELIVERY					
7. Admission of Patient in Labour					
7.1. Vital Signs					
7.2 Recording of F.H.R.					
7.3. Recording of CTG					
7.4. Assessment of Contractions					

7.5. Collection of Blood works					
7.6. Establishment of IV.					
8. Care of Patient in Labour					
8.1. Trolley Settings					
8.2. Partogram					
8.3. Vaginal Examination					
9. Administration of Analgesia 9.1. Narcotic					
9.2. Inhalation Analgesia (Entenox)					
10. Uncomplicated Labor					
11. Complicated Labour 11.1. Pre – Term					
11.2. Pre - eclampsia					
11.3. Fetal Distress					
11.4. Multiple Pregnancy					
12. Induction of Labour					
13. Third Stage of Labour 13.1. Management of 3rd stage					
13.2. Expulsion of Placenta & taking Of Cord Blood					
13.3. Obstetric Pharmacology 7.3.1. Syntocinon 7.3.2. Methergin					
14. Procedure for Normal Delivery 14.1. Set - up : Aseptic Technique					
14.2. Assist with Normal Delivery					
14.3. Assist with Episiotomy & Repair					
15. Assisted Delivery 15.1. Forceps					
15.2. Ventouse Extraction					
15.3. Vacuum Extraction Machine					
15.4. Breech Presentation					
15.5. Cesarean Section					
16. Emergency Interventions					
16.1. Cord Prolapse					
16.2. Ante - Natal hemorrhage					
16.3. Abruptio Placenta					
16.4. Placenta Previa					
16.5. Ruptured Uterus					
16.6. Eclampsia					
16.7. Fetal Distress					
16.8. Resuscitation of newborn					
17. Assessment of Newborn					
17.1. Apgar scoring					
17.2. Examination of newborn					
17.3. Lochia					
17.4. Uterus					
17.5. Documentation					
17.6. Collection of blood from umbilical cord					
17.7. Inspection of Placental Membranes					
18. Care of Mother					
18.1. Perineal - episiotomy care					
18.2. Recognition of post-partum haemorrhage					

18.3. Criteria for transfer to Obstetric Unit					
GYNECOLOGY					
19. Admission Procedure					
19.1. Admit Gynecological Patient					
19.2.Admit Ante - Natal Patient					
19.3.Perform Physical Health Assessment					
19.4.Perform Obstetric Examination					
20. Pre - Operative Care					
20.1.Hysterectomy Abdominal / Vaginal					
20.2.Pre - operative shaving					
20.3.Vaginal douching					
21. Post - Operative Care ……					
21.1.Dilatation & Curettage					
21.2.Anterior and posterior repair					
21.3.Hysterectomy Abdominal / Vaginal					
21.4.Tubal ligation (abdominal)					
21.5.Laparotomy					
21.6.Batholins cyst					
21.7.Fistula					
21.8.Removal of vaginal pack					
22. Care of Patients with					
22.1. Hyperemesis Gravidarum					
22.2. Ectopic pregnancy					
22.3. Pelvic Inflammatory Disease					
22.4. Abortions					
24.4.1 Threatened					
24.4.2. Inevitable					
24.4.3. Incomplete					
24.4.4. Missed					
22.5. Fetal heart monitoring					
22.6. CTG monitoring					
22.7. Secondary Post - partum hemorrhage					
22.8. Ovarian cyst					
22.9. Hydatiform mole					
22.10. Urinary Incontinence					
22.11. Gynecology Oncology					

SELF-ASSESSMENT OF CRITICAL CARE NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1- Basic ICU skill:					
1.1. Defibrillation /cardioversion					
1.2. Administration of thrombolytic therapy					
1.3. Temporary pacemaker transcutaneous/ transvenous					
2- Air way management:					
2.1. Mechanical ventilator					
2.2. Assist in initiating invasive & non-invasive mechanical ventilator					
2.3. Providing care for patient with mechanical ventilator					
2.4. Assist in weaning from MV Air way tube					
2.5. Assist in insertion of airway tube(endotracheal , tracheostomy, nasopharyngeal)					
2.6. Providing care of air way tube					
3- Central lines:					
3.1. Collection of equipment for insertion of central line					
3.2. Discuss the normal parameters for CVP measurement					
3.3. Determines and records CVP using a water manometer and pressure monitor					
3.4. Identifies chest landmarks for CVP Measurement					
3.5. The flushing of a central line					
3.6. The administration of drugs and fluids					
3.7. Aseptically change central IV lines					
3.8. Aseptically change central IV lines dressing					
3.9. Setting up a transducer systems					
3.10. The safe removal of central lines					
3.11. Use of Porta-caths & Hichman catheter					
3.12. Risks &complications of central lines					
3.13. Intervention/troubleshoot complication of					
4- Pulmonary artery catheters & arterial:					
4.1. Take appropriate action to prevent or resolve complications of PA catheters & arterial lines					
4.2. Sitting up a single and multiple transducer system					
4.3. Identify a PA and arterial trace on the cardiac Monitor					
4.4. Zeroing of PA & arterial lines					
4.5. The purpose for performance of an Allen's test					
4.6. Correct technique for drawing blood from PA catheter & arterial lines					
4.7. Supervised performance of a PAWP					
4.8. Identify normal reading and waveform					
4.9. Care of wound drains/graft area					
5- Chest physiotherapy/spirometry					

6- Feeding management:					
7.1. Administration TPN					
7.2.Administer tube feeding through tummy syringe					
7.3. Feeding pump					
7- Under water seal					
7.1 Assisting in insertion/removal of underwater seal Drainage					
8- Nursing care of patient:					
8.1 Post CABG					
8.2. Post valve reconstruction/replacement					
8.3. Post-operative bleeding					
8.4. Unconscious (general care to prevent of foot drop and contractures)					
8.5. Post PTCA					
8.6. Post cardiac catheterization					
9- Nursing care and Management of:					
9.1. Intracranial surgeries					
1.2. Fractures and osteoarthritis					
1.3. Biliary and pancreatic disorder					
1.4. MI/unstable angina					
1.5. Intestinal obstruction, colonic surgery.					
10- Room/bed preparation pre/post-cardiac surgery					
11- Administration of medications (vasopressors, antiarrhythmic, inotropes, anticoagulation)					
12- Use of electronic life support equipment					
12.1. Respiratory support					
12.2. Renal support					
12.3. Intravenous/ syringe pump					
12.4. Cardiac monitoring					
12.5. Non-invasive continuous cardiac output					
13- Recognition and interpretation of:					
13.1. dysrhythmias					
13.2. Critical patient signs and symptoms					
13.3. Laboratory findings					
15-Psychosocial support of patient and family (specific to critical care situation)					
16- Post mortem care					

SELF-ASSESSMENT OF PEDIATRIC NURSING SKILLS INVENTORY

NAME of Student: _____ **Student Number: _____**
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
1. Admission & Discharge Procedure					
2. Physical Assessment: Head – to - Toe Assessment for a Neonate 2.1. Cardiovascular					
2.2. Respiratory					
2.3. Gastrointestinal					
2.4. Genitor urinary					
2.5. Musculoskeletal					
2.6. Integumentary					
2.7. Neurological					
3. Assessment and nursing care to the following: 3.1. High risk infant					
3.2. Normal infant					
3.3. Toddler					
3.4. Preschool child					
3.5. School age child					
3.6. Adolescent					
3.7. Young adolescent					
4. Vital signs and related observations 4.1. Measuring and recording of temperature					
4.2. Palpating and recording of pulse & BP					
4.3. Pulse oximetry set up and reading					
4.4. Assessment and recording of respiratory rate					
4.5. Assessment of height, weight and head Circumference					
4.6. Measuring input and output					
5. Child safety and using restraints					
6. Documentation and verbal report					
7. Procedures 7.1 IV therapy					
7.1.1. Insertion of cannula					
7.1.2. Care of cannula					
7.2 Feeding					
7.2.1. Insertion of NG tube					
7.2.2. Feeding by NG tube					
7.3 Oxygen administration 7.3.1. Simple face mask					
7.3.2. Venture mask					
7.3.3. Nasal cannula					
7.3.4. Tracheotomy mask					
7.3.5. Incentive spirometry					
7.3.6. Using bag mask valve					
7.3.7. Inserting oral air way					
7.4 Suctioning 7.4.1 Tracheal					

7.4.2 Oro pharyngeal					
7.4.3 Nasopharyngeal					
7.5 Blood Sugar Monitoring 8.5.1. Use of glucometer					
8.5.2. Urine testing					
8. Diagnostic preparations 8.1 Preparations for various diagnostic procedures					
9. Surgical nursing care 9.1 Pre-operative care					
9.2 Post-operative care					
9.3 Care of wound					
9.4 Removal of sutures					
9.5 Transfusion of blood products					
10. Medication administration 10.1 Oral medication					
10.2. Intramuscular					
10.3 Intradermal					
10.4 Subcutaneous					
10.5 Intravenous					
10.6 Eye instillation					
10.7 Ear instillation					
10.8 Topical					
10.9 Nebuliser					
11. Positioning, lifting and transporting children					
12. Infection control practices 12.1. Disposal of waste material					
12.2. Principles of asepsis					
12.3. Isolation principles					
13. Phototherapy 13.1. Nursing considerations					
13.2. Laboratory values					
14. Temperature Regulation 14.1. Hypothermia : Radiant warmer					
15. Suctioning 15.1 Tracheal					
NEONATOLOGY					
16. Admission Procedure: 16.1 S.C.B.U.					
16.2 N.I.C.U.					
16.3 Nursery					
17. Physical Health Assessment 17.1. Head – to - Toe Assessment for a Neonate					
18. Assessment of Gestational Age 18.1. Premature					
18.2. Term					
18.3. Post-term / date					
18.4. I.U.G.R.					
18.5. V.L.B.W.					
18.6. L.G.A.					
19. Assessment of Respiratory System / Respiratory Monitoring 19.1. Auscultation of breath sounds					
19.2. Recognition of 19.2.1. Apnea					
19.2.2. Tachypnea					

19.2.3. Nasal Flaring					
19.2.4. Grunting					
19.2.5. Wheezing					
19.2.6. Chest Retractions					
19.2.7. Respiratory Distress					
20. Assessment of Cardiovascular System 20.1. Apical pulse					
20.2. Areas of cuff placement (re B.P.)					
20.3. Tissue perfusion / capillary refill					
20.4. Auscultation of heart sounds					
21. Assessment of Neurological System 21.1. Level of consciousness					
21.2. Assessment of anterior fontanelle					
21.3. Degree of "activity"					
21.4. Newborn reflexes (abnormal vs. normal)					
22. Assessment of G.I.T. 22.1. Abdomen					
22.2. Auscultation of bowel sounds					
22.3. Elimination pattern					
22.4. Meconium					
23. Assessment of Genito-Urinary System 23.1. Fluid balance considerations in the newborn					
23.2. Clinical presentation of infection / disorders / disease etc.					
24. Assessment of Integument 24.1. Skin turgor					
24.2. Temperature					
24.3. Presence of: Lanugo, Milia					
25. Assessment of Color					
26. Vital Sign Ranges 26.1. Pre-term					
26.2. Term					
27. Routine Newborn Care					
28. Pulse Oximetry					
29. Suctioning 29.1 Oropharyngeal					
29.2. Nasopharyngeal					
29.3. Endotracheal					
29.4. Ambo- bagging					
29.5. Aseptic technique					
29.6. Collection of a specimen					
30. Isolation Protocol					

SELF-ASSESSMENT OF PSYCHIATRIC NURSING SKILLS INVENTORY

NAME of Student: _____ Student Number: _____
Unit/Department assigned: _____

CLINICAL SKILLS	Pre-internship		Post-internship		Remarks
	Observed	Done	Observed	Done	
A. PSYCHIATRIC PATIENT					
1. Admit Psychiatric Patient					
1.1 Identify and handles Patient with Psychiatric D/O					
1.1.1 Anxiety and anxiety Disorder					
1.1.2 Schizophrenia					
1.1.3 Mood Disorder and Suicide					
1.1.4 Personality disorder					
1.1.5 Substance Abuse					
1.1.6 Eating Disorder					
1.1.7 Somatoform disorder					
1.1.8 Child and Adolescent disorder					
1.1.8.1 Autistic disorder					
1.1.8.2 ADHD					
1.1.8.3 Conduct disorder					
1.1.8.4 Pica					
1.1.8.5 Feeding disorder					
1.1.8.6 Separation Anxiety Disorder					
1.1.8.7 Mutism					
1.1.8.8 Cognitive disorder					
2. Perform Physical Examination (Head to Toe)					
2.1 Vital Signs recording					
2.2 collection of specimen (urine, blood, pregnancy test, sperm specimen for rape victim)					
3. Perform Mental Status and Neurological Examination					
3.1. Use of different psychological approach in identifying and assessing (cognitivist, behaviorist, psychodynamic, humanistic, social psych approach) Mental Status Monitoring					
4. Therapeutic Communication 3.1 Verbal communication					
3.1.1 Use Therapeutic Communication 3.1.2 Limit use of non- therapeutic communication					
3.2 . Non- verbal communication 3.2.1 Use of appropriate gestures 3.2.2 Use appropriate distance for pt. personal space					
5. Psychopharmacology 5.1 Make a Drug analysis of patient medication					
5.2 Identify the Action, Indication, contraindication, Adverse effect, other consideration)					
5.3 Identify the Nursing Implication needed					
6. Administration of Medication					
6.1 Controlled Medicine (Narcotics)					

6.2 Injections (Oral, IV, IM, SC, SL)					
7. Psychiatric Nursing Care Plan 7.1. Assessment 7.1.1 Subjective 7.1.2 Objective 7.2. Nursing Diagnosis 7.3. Planning 7.4. Psychiatric Intervention 7.5. Evaluation of Client response to treatment					
8. Treatment setting and Therapeutic Program 8.1 Different Psychotherapy					
9. Health Education 9.1. Discharge Plan					
9.2. Medication Follow-up					
9.3. Next check-up					
9.4 Important consideration					
10. Emergency Intervention 10.1. In case of fire (Vertical and Horizontal evacuation)					
10.2. P.A.S.S. – P.U.L.L.					
10.3. For assaultive patient					
10.4. Absconded Patient					
10.5. Restraint and isolation					
10.6 Electro-convulsive Therapy					

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ACKNOWLEDGEMENT

_____

(Date)

I, _____, bearing the student ID No. _____,

(Name)

a Nursing Internship student, am responsible in reading and understanding all the information

contained in the Nursing Internship Manual.

_____

Signature over Printed Complete Name

Conforme:

_____

Signature over Printed Complete Name of Parent/Guardian