كلية العلوم الطبية التطبيقية
Faculty of Applied Medical Science
جامعة تبوك
University of Tabuk
قسم التمريض
Department of Nursing

Clinical Training Committee

Student Manual 2015-2019

M E S S A G E F R O M T H E D E A N

On behalf of the Faculty of Applied Medical Sciences – Department of Nursing, it is with great pleasure to present this Nursing Students' Clinical Manual, as a result of collaborative efforts among the faculty members of the department driven by their passion for teaching and nursing as a profession.

The ultimate goal of this manual is to assist students steer through their transition from theory to clinical practice. Acquisition of nursing skills is essential in the nursing practice. Therefore, student nurses are expected to fulfill their duty of care to be able to deliver effective process of nursing care as part of their preparation as future professional nurses. This manual outlines the basic nursing skills required of a novice nurse to be able to consistently perform psychomotor skills with competency within the safety practice standards. Further, this will help facilitate a simulation of actual or possible scenarios in the clinical area to guide students' safety engage in the clinical practice.

To keep abreast with the theoretical foundation of this nursing students' manual, scientific rationale of every nursing intervention is integrated to provide sound clinical judgment for the nursing students and practitioners encompassing the various domains emphasized in the national and international standards in promoting teaching and learning such as knowledge, cognition, interpersonal, communication and psychomotor skills in carrying out nursing procedures in various health care settings.

More so, the editors of this manual are self-reliant that this contribution will substantiate to be valuable, practical and useful learning resources for undergraduate nursing students towards their learning experience in becoming globally competitive professional nurses.

DR. HAMAD AL AMER
Dean
Faculty of Applied Medical Sciences
University of Tabuk

PREFACE

The Clinical Training Experience Committee created the Clinical Student Manual for the nursing students to be able to fulfill the Mission and Vision of the Department Nursing and for them to be able to possess quality of a competent nurse in the future. Its focus is to develop, refine and apply classroom knowledge and skills in managing care as part of an inter professional team in a clinical setting

This manual will enable the student to be versed in the significance of the clinical/practical view of the nursing as a profession. This will also serve as their guide pertaining to the rules, guidelines and policies of the Department of Nursing and to all affiliating institutions for them to follow with compassion.

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

CLINICAL TRAINING COMMITTEE

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INTRODUCTION

The Department of Nursing geared towards continuous improvement in preparation for globalization of their graduates. We believed that our students will make a great impact in the society that will reflect positively for the University of Tabuk.

The **Clinical Learning Experience (CLE)** is a vital component of the Nursing Program and it complements the theoretical aspects of the curriculum. The nursing students are assigned in different hospital facilities and community areas to acquire, develop, and enhance their knowledge, skills and attitudes in the care and management of clients in varied settings and ages. Nursing students are constantly supervised by the university faculty staff with the assistance of the hospital field teaching staff.

The Nursing Curriculum requires a specific number of hours for CLE from the major nursing subjects. Each student is expected to complete and pass the CLE requirements before they are promoted to the next level and eventually granted the degree of Baccalaureate in Nursing.

The Clinical Training Committee must ensure sufficient clinical placements across a range of practice settings and across the continuum of care. Placements must be safe, supportive, and conducive for groups of students to practice and to develop their professional roles within defined scopes of practice.

VISION AND MISSION

UNIVERSITY OF TABUK

VISION الرؤية

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

MISSION الرسالة

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.

DEPARTMENT OF NURSING

VISION AND MISSION

VISION الرؤية

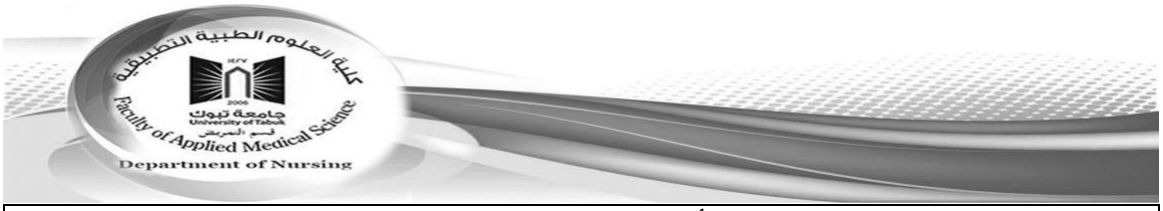
التميزفي تعليم التمريض والبحث العلمي و خدمة المجتمع.

Excellence in nursing education, research, and community services.

MISSION الرسالة

تخريجممرضينأكفاءقادرينعلىتعزيزالرعايةالصحيةمنخلالمعاييرتعليميةعاليةالجودةوأبحاثمبتكرةتلبيالاحتياجاتالصحيةللم
جتمع.

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



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 increase 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 Teamwork 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

CLINICAL TRAINING COMMITTEE

GOALS, OBJECTIVES, DUTIES AND RESPONSIBILITIES

GOAL: To provide quality Clinical Learning Experience to the nursing students

OBJECTIVES:

1. To coordinate with the prospects Hospital institution for possible affiliation
2. To provide a venue for the students for clinical area that is conducive for learning
3. To provide educational materials in the clinical area

Duties and Responsibilities

1. To coordinate and network with hospitals and other institutions to forge understanding (MOA) for student trainings and exposures.
2. Place plans and evidence regarding clinical training.
3. Follow-up student performance in clinical training to ease procedures and solve problems related to training.
4. Evaluate students and receive performance reports from hospitals and training centers.
5. Raise performance reports to the head of the department at the end of each semester.
6. To develop master plan for students' clinical learning experience
7. To coordinate with Student Advisory Council in relation to the clinical rotation of the students

8. To conduct General Orientation every 1st week of semester to the students and clinical instructors regarding the requirements, policies, guidelines, field experience specifications and among others that is related to clinical set up.
9. Monitor the clinical performance of the students regularly (attendance, evaluation and attitude)
10. Ensure that the training facilities is align with the concepts in the theory.
11. Make a unified format for NCP, Case Study, Drug study and other requirements pertaining to their exposure.
12. Propose unified clinical competency evaluation criteria for all of the requirements in the clinical area.
13. To assess the students' performance in the clinical area.

Roles of a Clinical Instructor

DEFINITION:

Clinical instructors (C.I.) is an academic appointment made to guide, mentor, supervise and evaluatenursing students during their respective clinical rotations in any health care facilities such as hospital and health dispensaries in academic settings..

The clinical instructions are mainly based from the Field Experience Specifications. Typically, the students received classroom instruction from a different lecturers, while the Clinical Instructor facilitates the clinical or skills laboratory portion. The CI is responsible for connecting the classroom material and its real-life application and for accommodating the varied learning styles and paces of clinical students.

Roles of a Clinical Instructor	
Outcome	**Strategies**
1. Prepares student for the clinical experience	• Plan and coordinates with the assigned lecturer of the course/subject in preparation for Field Experience Specifications, Course Syllabus Typical Format (CSTF), Course Syllabus and Clinical Teaching Plan for each semester. • Provides orientation to the students about the assigned unit. • Collaborates with the unit manager and staff • Ensures that studentsunderstands university and hospital policies • Review and guide the students to all clinical assessment forms, requirements and grading system
2. Maintains current knowledge base which serves as a resource for the students	• Understands novice behavior. • Knows clinical teaching. • Knows questions to ask to facilitate student learning in increasingly independent nursing practice.
3. Models professional practice	• Ensures student accessing pertinent resources, eg. Literature, professional. • Facilitates conflict resolution and unusual circumstances.**(See appendix F: Conflict Resolution)** • Facilitates development of problem solving and critical thinking skills.

4. Engages in regular communication with the student to facilitate a productive working relationship	• Is available to the student both on a regular and emergency basis.
5. Must conduct formal student performance evaluations	• Provide timely evaluation of the students • Ensures students signature in each forms
6. Coordinate with the Clinical Training Committee and Student Advisorship Committee	• In case of **absenteeism**, must prepare and submit reports to the Level Adviser • Report any unusual circumstances **(See Appendix F: Conflict Resolution)**
7. Completion of Course File	• Must be submitted at the end of each semester

GUIDELINES FOR THE CLINICAL LEARNING EXPERIENCE

As a curricular requirement, 1 credit unit/hour of CLE is equivalent to three (3) actual hours. Pre-clinical exposure will be done in the skills facility and simulation area within the University.

Clinical areas for the student are based on the curricular offerings per level. The distribution of students are based on their enrolled Nursing subject that requires CLE.

A. Clinical facilities and learning resources for the Clinical Learning Experience

It is the policy of the University to provide the students with quality instruction and clinical experiences aimed to develop their professional skills needed for the profession. Along this line, the University has established quality affiliations with the following hospitals and community facility:

1. King Khaled Civilian Hospital
2. King Salman Armed Forces Hospital in Northwestern Region
3. King Fahad Specialist Hospital
4. Maternal and Child Hospital
5. Psychiatric Government Hospital (Al Amal Mental Health Center)
6. Different Health Care Center/Dispensary

7. Social Affairs Rehabilitation Hospital

Rules, Policies and Guidelines

I. Attendance and Punctuality

To develop and improve professionalism among the students, they are expected to practice and appreciate the importance of attendance and punctuality in their profession as Nurses.

A. Students are expected to read all announcements, schedules and Clinical student groupings posted in the bulletin board to avoid confusion for the students.

B. Actual Rotation Plan for students should be sent by the advisers through group email.

C. Students are also expected to determine and visit their clinical area or hospital of assignment prior to the day of the schedule of duty. This will avoid being late in reporting to duty.

D. Students are expected to report on their respective areas of assignment **15 minutes** before the start of the scheduled duty. The student must have her/his attendance checked by the assigned Clinical Instructor for each schedule of duty.

The checking time:

7:45 AM to 8:00AM on site.

E. ABSENCES AND TARDINESS

ABSENT

Any student who failed to report on his/her clinical duty in any circumstances will be considered absent

TARDINESS/LATE

Any student/s who report**15 minutes** after the scheduled time shall be marked **LATE**. While students who report **30 minutes** after the call time will be marked as **1 unexcused absence**.

Students who have acquired **more than the allowable absence of 25%** in the entire 15 week rotation in each CLE subject will be considered **Dropped** and will be marked Denial of Entry in the system since the student will not be allowed to take the Final Examination in the course where he/she is being dropped.

Table 1: Computation of the Allowable 25% absences

Number of Weeks	Number of Hours / week Days/week	Total number of hours/week Days/15 weeks	Allowable absent (25%)
15 weeks	1 unit = 3 hours /Week 1 day/week	45 hours / 15 weeks 15 days/ 15 weeks	11.25 hours 3.75 days
15 weeks	2 units = 6 hours 1 day/Week	90 hours/15weeks 15 days/15weeks	22.5 hours 3.75 days
15 weeks	3 units = 9 hours / week 2 Days / Week	135 hours/15 weeks 30 days / 15 weeks	33.75 hours 7.5 Days

II. Uniform and Grooming

The uniforms prescribed by the University for the Department of Nursing are designed in accordance with the standards of modesty commonly upheld in their respective profession. It must be worn with neatness and cleanliness. Any deviation from the official design and university logo is not allowed. The clinical uniform must always adhere to the custom, tradition, culture and religion of the Muslim community.

1. The University uniform must be worn when attending classes and clinical duty; and when attending professional meeting & conferences.

2. Use the prescribed clinical uniform must always be clean, well-pressed, unstained and in good condition. Incomplete uniform will mean a demerit in the clinical performance.

For Female:

- White undershirt and white scrub pants, no tight leggings and colored ones' is **NOT** allowed.
- Long (ankle level) white Lab coat with University logo on the left arm. The lab coat should not be tight fitting.
- If Lab coat shorter than the ankle level, student should wear a skirt underneath.
- Head cover and *"burka"* should be black in color and the length should be below the chest area, not exposing it.

For Male:

- White undershirt and white top with university logo on the left arm.
- White loose pants.

3. University ID should be worn at all times.
4. White Shoes and white socks must be worn all throughout the clinical exposure.
5. Wristwatch with second hand, ballpen and pocket notebook are required to each students as part of their paraphernalia.
6. Nails should be well – trimmed; **Female students. *Nail polish is not allowed***.
7. For female: Wearing of make-up is prohibited.
8. Failure to comply with the above guidelines would be considered against the students' individual performance in the clinical area. Basis of markings will reflect in the Students Evaluation Performance

III. Snacks / Coffee Break

1. Snack break should not exceed 30 minutes
2. The Clinical Instructor is responsible in monitoring the students whereabouts
3. Students who failed to return on the time given by the Clinical instructor will be marked as absent on the following conditions:
   A. More than the break time but not exceeding 15 minutes: The Clinical Instructor will mark the student as warning.
   B. Exceeding 15 minutes: The student will be considered absent

IV. Student Conduct and Behavior

1. Student should have deep regard & concern for all individual patients and show due respect to hospital personnel.
2. Students should always knock before entering any room, unless otherwise specified; and should respect the patient's privacy and feeling of modesty.
3. Students should always observe silence and speak in a modulated voice. Eating, giggling and chatting in the clinical area and hospital corridors are not allowed.
4. Mobile phones and cameras must be turned off during duty hours.
5. Taking pictures of patients and patient records is **strictly prohibited**.
6. Students should stay in the clinical area only during the official CLE time
7. Students should show polite behavior and thoughtfulness not only to faculty members, doctors and nurses, medical technologist & hospital personnel, but also to patients, their families, visitors and other persons working for the patients.
8. Students should treat information received from patients or obtained from patient's records as confidential.

9. Students should use hospital supplies properly and wisely and use them for their intended purpose.
10. Sitting on patient's bed is prohibited except when caring for pediatric or psychiatric patients (for nursing student).
11. When errors or accidents occur, the CI concerned must be notified at once. If the C.I. is not available, staff nurses, or Senior Nurse or Supervisor must be notified.**(See Appendix F: Conflict Resolution)**
12. In situations where a student has an appointment and wanted to leave the clinical area without finishing the hours of duty, the student should present the appointment slip or if none, must write that she/he is leaving the area and state the reason/s.
13. This must be given to the clinical instructor in charge of her/ him as a documentation.
14. For female student: the clinical instructor should escort the student to the service car that she will use and the clinical instructor should take a photo of the ID of the driver.
15. If the student leaves the hospital before 12noon, the student will be marked absent for that day.
16. In situations where clinical instructor cannot immediately decide on the situation, she/ he should immediately inform the clinical coordinator through a phone call and wait for further instruction/s.
17. It is the responsibility of the clinical instructor to make a written report regarding this matter and address the report to the clinical coordinator.
18. Hospital Conduct must be read and discussed to the student without fail prior to every start of the clinical rotation.

OFFENSES

Students who will violate the clinical guidelines:

- **First Offense**: Verbal reprimand from the instructor & consultation report.
- **Second Offense**: Verbal reprimand with written report addressed to the adviser and a furnished copy to the CTC.
- **Third Offense**: Violation slip should be accomplished.

DEPARTMENT OF NURSING

Grading System

I. Competency Evaluation, Performance Skills, Requirements and Equivalent Markings

Skills Laboratory & Laboratory Grading System

Criteria	NUR 203/NUR 306_Male & NUR 309_Male MLTN 202/ANTN 202		Remarks	Note:
Midterm Examination Written OSCE/Moving Exam	10 15	25	30 items (written exam) OSCE (2 scenarios)	No repetition of previous questions
Final Examination Written OSCE	15 25	40	50 items (written) OSCE (3 scenarios from all of the procedures)	No repetition of previous questions
Quizzes		5	At least 2 quizzes	At least 10 items each and No repetition of previous questions.
Practical Demonstration Practical Exercises (Micro & Ana)		25	With rubrics	Ready for review
Attendance		5	Below 0% - 5%= 5 6% - 10%= 4 11%- 15%=3 16% - 20% =2 21% - 25% =1	
Total	100%			

Criteria	NUR 303/NUR 406/NUR 411/CHN NUR 306 (F), NUR 309 (F)		NUR 408		NUR 404		Remarks
Midterm Examination Written OSCE/Moving Exam	5 10	15	NONE		10		30 items (written exam) for 10 marks 20 items (written exam) for 5 marks OSCE (2 scenarios)
Final Examination Written OSCE	15 25	40	25 15 LNM Activity	40	20 20	40	50 items (written) for 25 marks 40 item for 20 marks 30 items for 15 marks OSCE (3 scenarios from all of the procedures)
Quizzes	5		20		5		Maximum 2 quizzes for 5 marks At least 5 quizzes for 20 marks
Professional Competencies	10		15		15		With rubrics
Requirements	10		20		25		With rubrics
Return Demo	15		None				
Attendance	5		5		Below 0% - 5%= 5 6% - 10%= 4 11%- 15%=3 16% - 20% =2 21% - 25% =1		
Total	100%		100%		100%		

(See Appendix E) : Rubric for Oral and Written Case Study, Health Education and NCP)

1. For each clinical area of assignment, a standard evaluation tool is utilized. An individual conference between the Clinical Instructor and student will be made prior to the finalization of the student's clinical performance evaluation.

2. Competency Evaluation Checklist in the CLE area is done by Clinical Instructors/ Preceptors. Factors to be taken into consideration includes Clinical Competency Attitude and Behavior, ***(See Appendix A,B,C,D,E Competency Evaluation Checklist)***

II. Grading System and Grade Point Average (G.P.A.)

Summary for Grading System and Codes			
Mark	**Weight**	**Grade**	**Course Grade**
95-100	5.00	**A+**	Excellent Plus
90 less than 95	4.75	**A**	Excellent
85 less than 90	4.50	**B+**	Very Good Plus
80 less than 85	4.00	**B**	Very Good
75 less than 80	3.50	**C+**	Good Plus
70 less than 75	3.00	**C**	Good
65 less than 70	2.50	**D+**	Pass Plus
60 less than 65	2.00	**D**	Pass
Less than 60	1.00	**F**	Failed

1. The final mark achieved by each student for a given course will be scored out of a hundred.
2. Each grade included in GPA calculations is given a weight.

3. Students who did not complete all requirements to take a grade for a specific course will be given an “In-Complete” temporary grade, code “IC” for that course.
4. Students must complete the requirements of that specific course no later than the end of the following semester. Otherwise, the “Fail” grade, code “F” will be automatically assigned. This will be calculated within the semester and the GPA.
5. Students who are taking a course that takes more than one semester to complete its requirements will be given an “In-Progress” temporary grade, code “IP” for that course.
6. When a student drops the semester, all registered courses will be given “Withdrawn” grade, code “W”.
7. Cumulative GPA: Total courses points of all semesters / Total courses credits of all semesters.
8. Semester GPA and Cumulative GPA are out of five.
9. The overall graduation grade, assigned according to the last cumulative GPA, is out of five and can be described as a “grade” according to the following classification:

A - “EXCELENT” for GPAs 4.50 and above.
B - “VERY GOOD” for GPAs from 3.75 to less than 4.50.
C - “GOOD” for GPAs from 2.75 to less than 3.75.
D - “SATISFACTORY” for GPAs from 2.00 to less than 2.75.

PERFORMANCE SKILLS CHECKLISTS

The Performance Skills Checklist are list of procedures that the Clinical Instructor must check every time the student is assigned to his/her area. The Clinical Instructor must help the students to perform whatever available procedures needed to perform by the students based on the checklist. In addition, the Clinical Instructor must check and write his/her name with attached signature on all the procedures that the student either observe or perform. **(See Appendix A,B,C,D: PERFORMANCE SKILLS CHECKLISTS)**

APPENDIX A

FIRST SEMESTER

3RD YEAR / LEVEL 5

1. **ADULT HEALTH NURSING 1 PRACTICAL (NUR 303)**
2. **MATERNAL HEALTH NURSING PRACTICAL (NUR 306)**

COMPETENCY EVALUATION CHECKLISTS

and

PERFORMANCE SKILLS CHECKLISTS

COMPETENCY EVALUATION CHECKLIST
ADULT HEALTH NURSING 1 (NUR 303) and 2 (NUR 304) PRACTICAL

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 isconsistently ineffective and inefficient

I. UTILIZATION OF THE NURSING PROCESS (12%)	**3**	**2**	**1**	**0**
1. Obtains comprehensive client's information through the following: a. Reviewing the chart				
b. Interviewing patient.				
c. Performing physical assessment.				
d. Reviewing laboratory tests/ diagnostic examinations results.				
e. Reviewing doctor's order/s.				
f. Reviewing progress notes.				
2. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems				
3. Prioritizes from the identified problems				
4. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses				
5. Performs safe and effective nursing care.				
6. Implements appropriate nursing interventions based on identified needs.				
7. Evaluates nursing care.				
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**
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 and bedside 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.				
7. Assist in endorsement of patient and other patient related handover cases.				
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**
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.				
TOTAL: _____/_____= ___* 12%= ____				
IV. VALUES AND ATTITUDE (8%)	**3**	**2**	**1**	**0**
1. Wears complete uniform: A. ID				
B. head cover				
C. shoes and socks				
C. lab gown with patch and piping				
D. 2-hand watch				
E. clinical kit				
2. Is well-groomed at all times: A. trimmed nails				
B. no nail polish				
C. no jewelries				
D. no make-up				
E. contact lenses				
F. no perfume				
3. Follows the policies, procedures and guidelines of the a. Department and University				
b. Affiliating agencies (hospital)				
4. Demonstrates honesty and accountability				
5. Changes behavior in response to constructive criticism/s				
6. Reports for duty A. On time				
B. Regularly				
5. Submits requirements on time.				
6. Demonstrate effective time management.				
7. Observes bedside manners and courtesies				
8. Displays caring attitude in professional manner.				
9. Shows initiative in accepting responsibilities and accountabilities.				
TOTAL: _____/_____= ___* 8%= ____				
OVERALL: Clinical Performance Evaluation: _____/12% **Values &Attitude_____/8%** **Total: _____/20%**				

PERFORMANCE SKILLS CHECKLISTS

SURGICAL SCRUBBING, APPLYING STERILE GOWN and GLOVES

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____**Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Steps follow foroxygen therapy
Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
***0** – Unable to perform even under maximum supervision*
***1**– Performs with maximum supervision*
***2** – Performs correctly with minimal supervision*
***3** – Performs correctly without supervision/independently*

No.	*Goal: Completes surgical scrub, applies sterile gown and glovesvia closed method.*	*3*	*2*	*1*	*0*	*Remarks*
Surgical Scrub Procedure						
1	Use a deep sink with side or foot pedal.Have two surgical scrub brushes and nail file. Remove rings, watches, and bracelets.(Note: Sterile field has been created by Instructor already)					
2	Apply surgical shoe covers and cap to cover hair and ears completely and mask.					
3	Stand in front of sink, being careful that uniform does not touch sink during washing procedure.					
4	Turn on warm water; wet hands under flowing water, beginning at tips of fingers, to forearms—keeping hands at level above elbows. Prewash hands and forearms to 2 inches above the elbow.					
5	Apply a liberal amount of soap onto hands, and rub hands and arms to 2 inches above elbows.					
6	Using nail file under running water, clean under each nail of both hands, and drop file into sink when finished.					
7	Open prepackaged scrub brush if available. If not, wet and apply soap to scrub brush. With brush in dominant hand, in circular motion, scrub nails and all skin areas of nondominant hand and arm-- 10 strokes to nails; palm of hand, and anterior side of fingers.					
8	Rinse brush thoroughly, and reapply soap.					
9	Continue to scrub of nondominant arm with a circular motion for 10 strokes each to the lower, middle, and upper arm; drop brush into the sink.					
10	Maintain hands and arms above elbow level, place fingertips under running water, and thoroughly rinse fingers, hands, and arms (allow water to run off elbows into the sink); take care not to get uniform wet.					
11	Take the second scrub brush and repeat Actions 7-10 on dominant hand and arm.					
12	Keep arms flexed and proceed to operating or procedure room with sterile items.					
13	Secure sterile towel by grasping it on one edge, opening the towel, full length, making sure it does not touch uniform.					

14	Dry each hand and arm separately; extend one side of the towel around fingers and hand, and dry in a rotating motion up to the elbow.					
15	Reverse the towel and repeat the same action on the other hand and arm, thoroughly drying the skin.					
16	Discard the towel into a linen hamper.					
	Total Score:					
Applying Sterile Gown and Gloves						
1	Open the package of sterile gloves. Remove the outer wrap from the sterile gloves and leave the gloves in their inner sterile wrap on the sterile field. (The sterile gown is folded inside out.)					
2	Grasp the gown inside the neckline, step back, and allow the gown to open in front of you; keep the inside of the gown toward you; do not allow it to touch anything.					
3	Put your hands inside the shoulders of the gown without touching the outside of the gown.					
4	With hands at shoulder level, slip both arms into the gown; keep your hands inside the sleeves of the gown.					
5	With hands still inside the gown sleeves, open the inner wrapper of the gloves on the sterile gown field.					
6	With nondominant sleeved hand, grasp the cuff of the glove for the dominant hand and lay it on the extended dominant forearm; with palm up, place the palm of the glove against the sleeved palm, with fingers of the glove pointing toward elbow.					
7	Manipulate the glove so the sleeved thumb of dominant hand is grasping the cuff; with nondominant hand, turn the cuff over the end of dominant hand and gown's cuff.					
8	With sleeved nondominant hand, grasp the cuff of the glove and the gown's sleeve of the dominant hand; slowly extend the fingers into the glove, making sure the cuff of the glove remains above the cuff of the gown's sleeve.					
9	With the gloved dominant hand, repeat Actions 7 and 8.					
10	Interlock gloved fingers; secure fit.					
	Total Score:					

Surgical Scrubbing:

Total Score/Total Points (48): _____ x ____ marks = _____

Applying Sterile Gown and Gloves

Total Score/Total Points (30): _____ x ____ marks = _____

Comments:

_____

_____

Student's signature over printed name: _____ Date/ Time: _____

Clinical Instructor's signature over printed name: _____ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

INITIATING & DISCONTINUING INTRAVENOUS INFUSION

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **initiating and discontinuing an IV infusion**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstratesrequired level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: Access device is inserted using sterile technique on the first attempt.	**3**	**2**	**1**	**0**	**REMARKS**
INITIATING					
1. Verify prescription for IV therapy, check solution label, and identify patient. Check for allergies (i.e., latex, iodine).					
2. Explain the procedure to patient.					
3. Prepare IVF bag and tubing: a. Check solution for discoloration or particulate matter.					
b. Label the IV solution container with the patient's name, date, and own initials.					
c. Place a time tape on the solution container with the prescribed infusion rate, time the infusion began, and the time of completion.					
d. Take the administration set from the package, labels the tubing with the date and time, and then closes the roller clamp.					
e. Remove the protective cover from the IV solution container port.					
f. Remove the protective cover from the spike on the IV administration set, making sure the spike remains sterile. Place the spike into the port of the solution container.					
g. Make certain the tubing is clamped; hang the IV solution container on an IV pole.					
h. Lightly compress the drip chamber and allow it to fill up halfway. If using extension tubing, attach it to the end of the administration set.					

i. Prime the tubing by opening the roller clamp and allow the fluid to slowly fill the tubing.					
j. Inspect the tubing for air. If air bubbles remain in the tubing, flick the tubing with a fingernail to mobilize the bubbles. Recap end of tubing firmly.					
4. Locate a vein for inserting the IV catheter. Select the most distal vein on the hand or arm. Avoid using an arm or hand that contains a dialysis graft or fistula or the affected arm of a mastectomy patient.					
5. Place a linen-saver pad under the patient's arm. Places the patient's arm in a dependent position and applies a tourniquet 4 to 6 inches above the selected site.					
6. Palpates the radial pulse; if no pulse is present, loosens the tourniquet and reapplies it with less tension.					
7. Palpates the vein and presses it downward, making sure that it rebounds quickly. If the vein is not adequately dilated, has the patient open and close his fist, applies heat (e.g., a warm towel), lightly taps the vein site, or strokes the extremity from distal to proximal below the selected venipuncture site.					
8. After selecting the vein, gently releases the tourniquet.					
9. Apply procedure gloves.					
10. Choose an appropriate IV catheter based on the size of the vein and the solution to be infused.					
11. Using aseptic technique, open the catheter package.					
12. Gently reapply the tourniquet and cleanse the site, using an antiseptic swab that contains 2% tincture of iodine, alcohol, or chlorhexidine. (Avoid using chlorhexidine in infants under age 2 months.)					
13. Cleanse the area using a circular motion starting at the site and work outward several inches.					
14. Allow the antiseptic to dry on the skin.					
15. Using the nondominant hand, stabilize the vein by stretching the skin over the vein, making sure not to contaminate the insertion site.					
16. Inform the patient that he is about to insert the catheter and that it may be uncomfortable.					
17. Pick up the catheter. Grasp the catheter by the hub, using the thumb and forefinger of the dominant hand—bevel up.					
18. Holding the catheter at a 20- to 30-degree angle, pierce the skin.					
19. Lower the catheter so that it is parallel to the skin and advance the catheter into the vein. Watch for a flashback of blood into the chamber of the catheter or the tubing of the winged catheter.					

20. Advance the catheter to half its length. Withdraw the needle while advancing the catheter fully into the vein.					
21. While holding the catheter in place with one hand, release the tourniquet with the other hand.					
22. Quickly connect the administration set adapter to IV catheter, using aseptic technique.					
23. Still stabilizing the catheter, slowly open the roller clamp and allow the IV fluid to flush the catheter. Adjust the flow rate according to the physician's order.					
24. Cover the insertion site with a sterile semipermeable transparent dressing. If the site isn't clean and dry, clean the site with an antiseptic swab and allow it to dry before applying the dressing.					
a. Open the package containing the dressing. Using aseptic technique, remove the protective backing from the dressing making sure not to touch the sterile surface.					
b. Cover the insertion site and the hub or winged portion of the catheter with the dressing. Does not cover the tubing of the administration set.					
c. Gently pinch the transparent dressing around the catheter hub to secure the hub.					
d. Smooth the remainder of the dressing so that it adheres to the skin.					
25. Loop the administration tubing and place a piece of tape over the catheter tubing connection, and looped section of tubing.					
26. Label the dressing with the date and time of insertion, catheter size, and own initials.					
27. If the insertion site is located near a joint, place an arm board under the joint and secures it with tape.					
DISCONTINUING					
1. Assist the client to a comfortable position.					
2. Place a linen-saver pad under the extremity that contains the IV catheter.					
3. Apply procedure gloves.					
4. Close the roller clamp on the administration set.					
5. Carefully remove the IV dressing and tape that is securing the tubing.					
6. Apply a sterile 2×2 gauze pad above the IV insertion site and gently remove the catheter, directing it straight along the vein. Do not press down on the gauze pad while removing the catheter.					

7. Immediately apply firm pressure with the gauze pad over the insertion site. Hold pressure for 2 to 3 minutes; longer if bleeding persists.					
8. Check the IV catheter if complete.					
9. Remove the soiled 2×2 gauze pad and replaces it with a sterile 2×2 gauze pad. Secures it with a piece of 1-inch tape.					
10. Dispose of the IV catheter in the appropriate sharps container.					
11. Discard the IV tubing, linen-saver pad, IV solution container, and gloves in the appropriate trash container, according to agency policy.					
TOTAL SCORE					

Initiating:

Total Score/Total Points (81): _____ x ___ marks = _____

Discontinuing:

Total Score/Total Points (33): _____ x ___marks = _____

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

ADMINISTERING OXYGEN

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow foroxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: The patient will exhibit an oxygen saturation level within acceptable parameters.	***3***	***2***	***1***	***0***	***Remarks***
1. Verify the prescribing practitioner's order.					
2. Perform hand hygiene, put on PPE (if indicated).					
3. Identify the patient.					
4. Gather equipment on overbed table. • Oxygen source • Oxygen delivery device (i.e. nasal cannula, face mask) • Oxygen flow meter • Oxygen humidifier • Distilled water or normal saline • Pulse oxymeter					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain what you are going to do and the reason for doing it to the patient. Review safety precautions necessary when oxygen is in use.					
7. Connect the appropriate oxygen delivery device to oxygen setup with humidification. Set-up humidification as needed.					
A. Administer oxygen **by nasal cannula:**					
8. Adjust flow rate as ordered. Check that oxygen is flowing out of prongs. Place prongs in patient's nostrils. Keep flange against upper lip.					
9. Place tubing over and behind each ear with adjuster comfortably under chin. Place gauze pads at ear beneath the tubing, as necessary.					
10. Adjust the fit of the cannula, as necessary. Tubing should be snug but not tight against the skin.					
11. Encourage patients to breathe through the nose, with the mouth closed.					
B. Administer oxygen **by oxygen mask:**					
8. Start the flow of oxygen at the specified rate. For a mask with a reservoir, be sure to allow oxygen to fill the bag before proceeding to the next step.					
9. Position face mask over the patient's nose and mouth.					
10. Adjust the elastic strap so that the mask fits snugly but comfortably on the face.					

11. If patient reports irritation, or you note redness, use gauze pads under the elastic strap at pressure points.					
12. Reassess patient's respiratory status (respiratory rate, effort, and lung sounds); any signs of respiratory distress (tachypnea, nasal flaring, use of accessory muscles, or dyspnea).					
13. Remove PPE, if used. Perform hand hygiene.					
14. (nasal cannula): Put on clean gloves. Remove and clean the cannula an assess nares at least every 8 hrs. Check nares for evidence of irritation or bleeding. (mask): Remove the mask and dry the skin every 2-3 hrs if oxygen is running continuously. Do not use powder around mask.					
TOTAL SCORE:					

Total Score/Total Points (**42 points**):_____ x ____ marks = _____

Comments:

_____

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROVIDING CARE OF A CHEST TUBE DRAINAGE SYSTEM

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow foroxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: The patient does not experience any complications related to the chest drainage system or respiratory distress.	***3***	***2***	***1***	***0***	***Remarks***
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Assemble equipment on overbed table.					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain what you are going to do and the reason for doing it to the patient.					
7. Assess the patient's level of pain. Administer prescribed medication, as needed.					
8. Put on clean gloves.					
Assessing the Drainage System					
9. Move the patient's gown to expose the chest tube insertion site. Keep the patient covered as much as possible, using a bath blanket to drape the patient, if necessary. Observe the dressing around the chest tube insertion site and ensure that it is dry, intact, and occlusive.					
10. Check that all connections are securely taped. Gently palpate around the insertion site, feeling for subcutaneous emphysema, a collection of air or gas under the skin. This may feel crunchy or spongy, or like "popping" under your fingers.					
11. Check drainage tubing to ensure that there are no dependent loops or kinks. Position the drainage collection device below the tube insertion site.					
12. If the chest tube is ordered to be suctioned, note the fluid level in the suction chamber and check it with the amount of ordered suction. Look for bubbling in the suction chamber. Temporarily disconnect the suction to check the level of water in the chamber. Add sterile water or saline, if necessary, to maintain correct amount of suction.					

13. Observe the water-seal chamber for fluctuations of the water level with the patient's inspiration and expiration (tidaling). If suction is used, temporarily disconnect the suction to observe for fluctuation. Assess for the presence of bubbling in the water-seal chamber. Add water, if necessary, to maintain the level at the 2-cm mark, or the mark recommended by the manufacturer.					
14. Assess the amount and type of fluid drainage. Measure drainage output at the end of each shift by marking the level on the container or placing a small piece of tape at the drainage level to indicate date and time. The amount should be a running total, because the drainage system is never emptied. If the drainage system fills, it is removed and replaced.					
15. Remove gloves. Assist patient to a comfortable position. Raise the bed rail and place the bed in the lowest position, as necessary.					
16. Remove additional PPE, if used. Perform hand hygiene.					
Changing the Drainage System					
1. Obtain two padded Kelly clamps, a new drainage system,and a bottle of sterile water. Add water to the water-sealchamber in the new system until it reaches the 2-cm markor the mark recommended by the manufacturer. Followmanufacturer's directions to add water to suction system ifsuction is ordered.					
2. Put on clean gloves and additional PPE, as indicated.					
3. Engage the clamp on drainage tubing. Alternately apply Kelly clamps1.5 to 2.5 inches from insertion site and 1 inch apart, going in opposite directions.					
4. Remove the suction from the current drainage system.Unroll or use scissors to carefully cut away any foam tapeon the connection of the chest tube and drainage system.Using a slight twisting motion, remove the drainage system. Do not pull on the chest tube.					
5. Keeping the end of the chest tube sterile, insert the endof the new drainage system into the chest tube. Remove Kelly clamps. Reconnect suction, if ordered. Apply plasticbands or foam tape to chest tube/drainage system connectionsite.					
6. Assess the patient and the drainage system as outlined in Steps 9–16 "Assessing the Drainage System".					
7. Remove additional PPE, if used. Perform hand hygiene.					
Total Score					

Assessing the Drainage System

Total Score/Total Points (**48 points**): _____ x ____ marks = _____

Changing the Drainage System

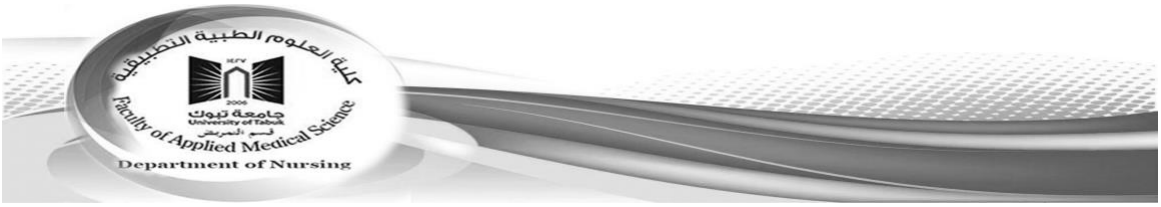
Total Score/Total Points (**21 points**): _____ x ____ marks = _____

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ASSISTING WITH REMOVAL OF CHEST TUBE

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow foroxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: The chest tube is removed with minimal discomfort to the patient and the patient remains free of respiratory distress.	***3***	***2***	***1***	***0***	***Remarks***
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Assemble equipment on overbed table.					
5. Administer pain medication, as prescribed. Premedicate patient before the chest tube removal, at a sufficient interval to allow for the medication to take effect, based on the medication prescribed.					
6. Close curtains around bed and close the door to the room, if possible.					
7. Explain what you are going to do and the reason for doing it to the patient. Explain any nonpharmacologic pain interventions the patient may use to decrease discomfort during tube removal.					
8. Explain that patient will be required to take and hold a deep breath or exhale during removal. Instruct on taking deep breaths and holding them. Alternately, patient may be asked to take a deep breath and hum during removal.					
9. Put on clean gloves.					
10. Provide reassurance to the patient while the physician removes the dressing and then the tube.					
11. After physician has removed chest tube and secured the occlusive dressing, assess patient's lung sounds, vital signs, oxygen saturation, and pain level.					
12. Anticipate an order for a chest x-ray.					
13. Dispose of equipment appropriately.					
14. Remove gloves and additional PPE, if used. Perform hand Hygiene.					
15. Continue to monitor the patient's cardiopulmonary status and comfort level. Monitor the site and dressing.					
Total Score:					

Total Score/Total Points (**45 points**): _____ x ____ marks = _____

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

OBTAINING AN ELECTROCARDIOGRAM (ECG)

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow foroxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: ECG is obtained without any complications and the patient demonstrates an understanding of the need for and about the ECG.	***3***	***2***	***1***	***0***	***Remarks***
1. Verify order for an ECG in patient's health record.					
2. Gather all equipment.					
3. Perform hand hygiene, put on PPE if indicated.					
4. Identify patient.					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain the procedure to the patient; that the test records the heart's electrical activity, and it may be repeated at certain intervals. *Emphasize that no electrical current will enter his or her body*; and that the test takes about 5 minutes. Ask about allergies to adhesive.					
7. Place ECG machine close to the patient's bed, and plug the power cord into the wall outlet.					
8. If the bed is adjustable, raise it to a comfortable working height, usually elbow height of the caregiver.					
9. Position patient supine in the center of the bed with arms at the sides. *Raise the head of the bed to semi-Fowler's position if necessary.* Expose the patient's arms and legs, and drape appropriately. Encourage the patient to relax the arms and legs. Make sure wrists do not touch the waist; and the feet do not touch the bed's footboard.					
10. Prepare skin for electrode placement. If an area is excessively hairy, clip the hair. **Do not shave hair.** Clean excess oil or other substances from the skin with soap and water and dry it completely.					
11. Apply RA lead electrode.					
12. Apply LA lead electrode.					
13. Apply RL lead electrode.					
14. Apply LL lead electrode					
15. Connect the limb lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright.					
16. Expose the patient's chest.					
17. Apply the precordial lead electrode V1					
18. Apply the precordial lead electrode V2					
19. Apply the precordial lead electrode V3					
20. Apply the precordial lead electrode V4					

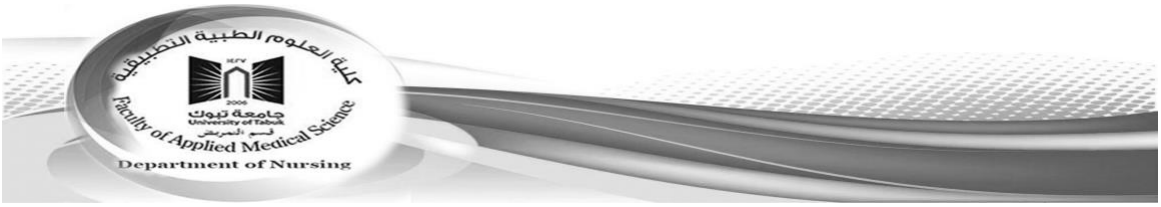
21. Apply the precordial lead electrode V5					
22. Apply the precordial lead electrode V6					
23. Connect the precordial lead wires to the electrodes.					
24. Ask the patient to relax and breathe normally. Instruct the patient to lie still and not to talk while you record the ECG.					
25. Press the AUTO button. Observe the tracing quality.					
26. Remove the electrodes and clean the patient's skin, if necessary, with adhesive remover for sticky residue.					
27. Return the patient to a comfortable position. Lower bed height and adjust the head of bed to a comfortable position.					
28. Clean ECG machine per facility policy. Label the ECG with the patient's name, date of birth, location, date and time of recording, and other relevant information, such as symptoms that occurred during the recording.					
29. Remove additional PPE, if used. Perform hand hygiene.					
TOTAL:					

Total Score/Total Points (**87 points**):_ **_____** x ____ marks = _____

Comments:_____
_____

Student's Signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROVIDING COLOSTOMY CARE

Name of Student: _____ Section:_____

Student ID: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow foroxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Goal: The stoma appliance is applied correctly to the skin to allow stool to drain freely.	***3***	***2***	***1***	***0***	***Remark***
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient. Encourage the patient to observe or participate, if possible.					
5. Assemble equipment on overbed table.					
EMPTYING AN OSTOMY APPLIANCE					
6. Assist patient to a comfortable sitting or lying position in bed (or a standing or sitting position in the bathroom). Place waterproof pad under patient at stoma site.					
7. Put on gloves. Remove clamp and fold end of pouch upward like a cuff.					
8. Empty contents into bedpan, toilet, or measuring device.					
9. Wipe the lower 2 inches of the appliance or pouch with toilet tissue					
10. Uncuff edge of appliance or pouch and apply clip or clamp, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body. Remove gloves. Assist patient to a comfortable position.					
CHANGING AN OSTOMY APPLIANCE					
11. Place disposable pad on work surface. Set up washbasin with warm water and the supplies. Place a trash bag within reach.					
12. Put on clean gloves. Place waterproof pad under the patient at the stoma site. Empty appliance.					
13. Put on gloves. Start at top of appliance and keep abdominal skin taut. Gently remove pouch from skin by pushing skin from appliance.					

14. Place appliance in trash bag. Use toilet tissue to remove any excess stool from stoma. Cover stoma with gauze pad. Clean skin around stoma with skin cleanser and water. Remove all old adhesive from skin.					
15. Gently pat area dry. Make sure skin around stoma is thoroughly dry. Assess stoma and condition of surrounding skin.					
16. Apply skin protectant to a 2-inch (5 cm) radius around the stoma, and allow it to dry completely, which takes about 30 seconds.					
17. Lift the gauze squares for a moment and measure the stoma opening, using the measurement guide. Replace the gauze.					
18. Trace the same-size opening on the back center of the appliance. Cut the opening 1/8 inch larger than the stoma size. Using a finger, gently smooth the wafer edges after cutting.					
19. Remove the backing from the appliance. Quickly remove the gauze squares and ease the appliance over the stoma. Gently press onto the skin while smoothing over the surface. Apply gentle pressure to appliance for 30 seconds.					
20. Close bottom of appliance or pouch by folding the end upward and using the clamp or clip that comes with the product, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body.					
21. Remove gloves. Assist the patient to a comfortable position. Cover the patient with bed linens. Place the bed in the lowest position.					
22. Put on clean gloves. Remove or discard equipment and assess patient's response to procedure.					
TOTAL SCORE:					

Total Score/Total Points (**66 points**):_____ x ____ marks = _____

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

COMPETENCY EVALUATION CHECKLIST

MATERNAL HEALTH NURSING (NUR 306)

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

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

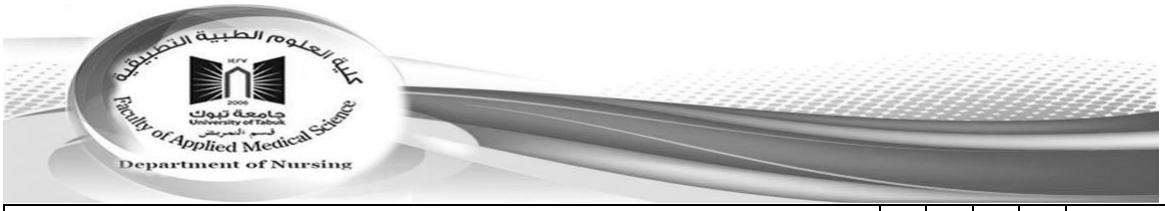
Area of Exposure: _____ **Inclusive Dates:** _____

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
2. Obtains comprehensive client's information by thorough checking of the client's chart.					
3. Interviews the client and/or significant others to gather history and subjective data					
4. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
5. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
6. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
7. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
8. Develops a comprehensive patient care plan					
9. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
10. Implements appropriate nursing interventions based on identified needs					
1. Evaluates nursing care outcomes based on formulated objectives, allowing for the revision of actions and goals.					
2. 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					
▯ endorsement to OR/DR					
C. INTRA-PARTAL CARE					
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					
F. 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 hemorrhage, 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.					

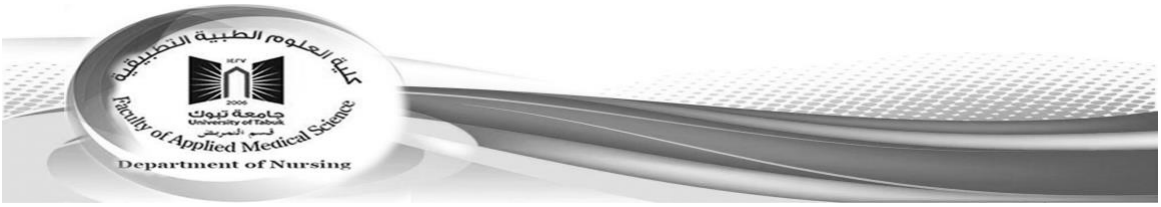
TOTAL MARK: _____

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

_____ _____

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

Date: _____ Date: _____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING STEPS IN PRENATAL CARE (FIRST VISIT)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

STEPS IN PRENATAL CARE (FIRST VISIT)	3	2	1	0	Remarks
1. Immediate assessment for emergency signs. Ask about warning symptoms.					
2. Make the woman comfortable.					
3. Register the client and issue antenatal record form/book).					
4. Assess the pregnant woman:					
a. Age					
b. Past Medical History					
Obstetric History					
c. Use of alcohol, drugs and/or cigarette smoking					
d. Ask about or check for prior pregnancies					
e. Check duration of pregnancy					
f. Perform general examination:					
i. Check client's height and weight.					
ii. Check V/S. Check for hypertension/pre-eclampsia.					
iii. Check for conjunctival or palmar pallor and anemia (check hemoglobin level). Ask about getting tired easily or shortness of breath during routine work.					
Auscultate heart and lungs sounds.					
Examine breast and nipples.					
Check for presence of gestational diabetes.					
Look for edema.					
Check for burning sensation on urination and abnormal vaginal discharge.					
g. Do Leopold's maneuver					
h. Determine fundic height and compare findings to Bartholomew's rule					
i. Auscultate for fetal heart tone					
j. Assist in ultrasonography					
k. Ask for bleeding/danger signs during the current pregnancy					
5. Prepare birth and emergency plan					
6. Ask patient if she has other concerns					
7. Give education and counseling on family planning and breastfeeding					
8. Get baseline laboratory information of the woman					
9. Immunize against tetanus.					
10. Give iron and folate supplementation					
11. Provide health education and advice.					
12. Advise on danger signs.					
13. Encourage the woman to come for return visits.					
14. Document all procedures done and findings.					
	Total Score				

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING STEPS IN PRENATAL CARE (RETURN VISIT)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing the Steps in Prenatal Care (Return Visits). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

STEPS IN PRENATAL CARE (RETURN VISITS)	*3*	*2*	*1*	*0*	*Remarks*
1. Immediate assessment for emergency signs. Ask about warning symptoms.					
2. Make the woman comfortable.					
3. Assess the pregnant woman:					
a. Check duration of pregnancy					
b. Weigh the client					
c. Check V/S. Check for hypertension/pre-eclampsia.					
d. Check for conjunctival or palmar pallor and anemia (check hemoglobin level). Ask about getting tired easily or shortness of breath during routine work.					
e. Check for presence of gestational diabetes.					
f. Look for edema.					
g. Check for burning sensation on urination and abnormal vaginal discharge.					
h. Do Leopold's maneuver					
i. Determine fundic height and compare findings to Bartholomew's rule					
j. Auscultate for fetal heart tone					
k. Ask for bleeding/danger signs during the current pregnancy					
4. Prepare birth and emergency plan					
5. Ask patient if she has other concerns					
6. Give education and counseling on family planning and breastfeeding					
7. Get baseline laboratory information of the woman (if not taken on the first visit)					
8. Immunize against tetanus.					
9. Give iron and folate supplementation					
10. Provide health education and advice.					
11. Advise on danger signs.					
12. Encourage the woman to come for return visits.					
13. Document all procedures done and findings.					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments: _____
Student's signature over printed name/ Date/ Time: _____
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN MEASURING FUNDIC HEIGHT & AUSCULTATING FHT

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Measuring the Fundic Height & Auscultating Fetal Heart Tone.. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

STEPS IN MEASURING FUNDIC HEIGHT	***3***	***2***	***1***	***0***	***Remarks***
1. Wash and dry hands and explain procedure of the examination to the patient.					
2. Feel for the fundus of the uterus					
a. Gently palpate from the lower end of the sternum. Continue to palpate down the abdomen until the fundus is reached.					
b. Make sure that you have reached the highest point of the fundus. If the uterus is rotated away from the midline, the highest point will be to the left or to the right of the midline.					
3. Having marked the fundic height, hold the end of the tape measure at the top of symphysis pubis.					
4. Lay the tape measure over the curve of the uterus to the point marking the top of the fundus. If uterus does not lie in the midline, then the distance to the highest point of the uterus must still be measure without moving the uterus into the midline.					
5. Having determined the height of fundus, you need to assess whether the height of the fundus corresponds to the patient's AOG. (Bartholomew's rule)					
STEPS IN AUSCULTATING FETAL HEART TONE					
1. Wash and dry hands and explain procedure of the examination to the patient.					
2. Help the patient assume comfortable position that provides access to the abdomen.					
3. Palpate the maternal abdomen using Leopold Maneuvers to identify the fetal position to aid in obtaining the location of the fetal heart tones. Note that the fetal heart tones are heard most loudly over the fetal back.					

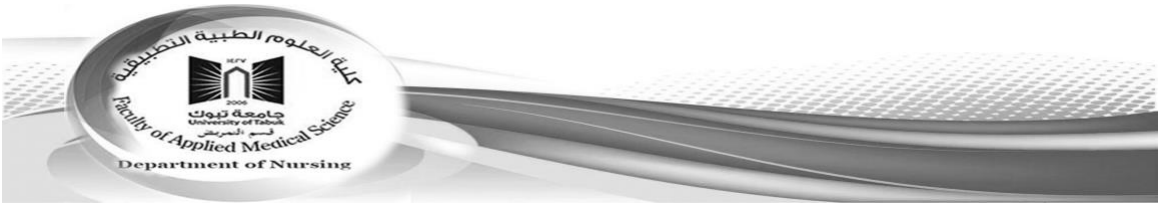
4. Palpate the fundus of the uterus for the presence of uterine contractions. At the end of a uterine contraction, place the fetoscope/Doppler or stethoscope over the location of the fetal back. Adjust the fetoscope /Doppler/stethoscope if necessary to obtain a clearly audible FHR. Depending on fetal position, the fetal heart sounds may be soft and muffled or loud and clear.					
5. Listen for audible fetal heart sounds. Note that two distinctly different sounds can be heard: fetal heart tomes that result from blood moving through the placenta and umbilical cord (fundic soufflé) and the uterine soufflé which is the same rate as the maternal pulse.					
6. Palpate the maternal radial pulse to ensure that the auscultated fetal heart sounds are at different rate than the maternal pulse.					
7. Auscultate the fetal heart sounds for the rate and rhythm, The greatest accuracy for assessment of the fetal heart rate occurs when listening for 1 minute					
8. Count the FHR for 1 full minute between contractions to determine the baseline rate.					
9. Let the OB-Gyne interpret the fetal heart rate: is the baseline normal between 110-160 bpm? Is there tachycardia(>160 bpm)? Or bradycardia (<120 bpm)- when baby is active?					
10. Repeat the procedure as indicated according to agency policy.					
11. Inform the patient of the findings.					
12. Document the fetal heart rate according to agency policy.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN ASSISTING IN PERFORMING THE INTRAPARTAL VAGINAL EXAMINATION/INTERNAL EXAMINATION (IE)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing the intrapartal vaginal examination/internal examination (IE) Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

ASSISTING IN PERFORMING THE INTRAPARTAL VAGINAL EXAMINATION/INTERNAL EXAMINATION (IE)	***3***	***2***	***1***	***0***	***Remarks***
1. Wash and dry your hands. Explain the procedure and purpose of the examination to the patient.					
2. Assess for latex allergies.					
Ensure privacy.					
Assemble necessary equipment including clean gloves (if the membranes are intact) or sterile examination gloves (if the membranes are ruptured), sterile lubricant, antiseptic solution (if required).					
Position the patient in a supine position with a small pillow or towel under her hip to prevent supine hypotension. Instruct the patient to relax and position herself with her thighs flexed and abducted.					
Don sterile gloves (clean gloves may be used if the membranes are intact).					
Inspect the perineum for any redness, irritation, or vesicles.					
Using the nondominant hand, spread the labia majora and continue assessment of the genitalia. Note the presence of any discharge including blood or amniotic fluid.					
Gently insert the lubricated gloved index andthird fingers into the vagina in the direction ofthe posterior wall until they touch the cervix.The uterus may be stabilized by placing thenondominant hand on the woman's abdomen.					
Assess the cervix for effacement and the amount of dilation.					
Assess for intact membranes; if fluid is expressed, test for amniotic fluid.					
Palpate the presenting part.					
Assess fetal descent and station by identifying the position of the posterior fontanel.					
Withdraw the fingers. Assist the patient in wiping her perineum from front to back to remove lubricant or secretions. Help her to resume a comfortable position.					
Inform the patient of the findings from the examination.					
Wash hands.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ASSESSING FOR AMNIOTIC FLUID

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in assessing for amniotic fluid. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

ASSESSING FOR AMNIOTIC FLUID	***3***	***2***	***1***	***0***	***Remarks***
Wash and dry hands and explain the procedure and purpose of the examination to the patient, noting what she will experience, and what the results will indicate.					
2. Assess for latex allergies.					
Ask the patient if she has noticed any leakage of fluid from her vagina.					
Assess for the presence of amniotic fluid before other tests that require the use of lubricant (such as vaginal examination).					
Don sterile gloves. With one hand, spread the labia to expose the vaginal opening. With the other hand, place a 2-inch (5 cm) piece of Nitrazine tape against the vaginal opening, ensuring contact with enough fluid to wet the tape. Alternately, a sterile cotton-tipped applicator may be used to obtain fluid from the vagina. The applicator is then touched to the Nitrazine tape.					
Remove the tape. Compare the color of the tape with the color guide on the Nitrazine tape container. If the tape turns blue-green, gray or deep blue, amniotic fluid is present. If the tape remains beige, no amniotic fluid has been detected.					
When the Nitrazine test has not confirmed the presence of amniotic fluid, the nurse may insert a speculum and sterile cotton swab to collect a sample of fluid from the posterior vagina. The swab is smeared on a glass slide and allowed to dry. The glass slide is then placed on the microscope. The presence of a ferning pattern confirms the presence of amniotic fluid. The fern test is often indicated if premature rupture of the membranes (PROM) is suspected.					
Document the findings on the admission or labor record.					
Inform the patient of the finding					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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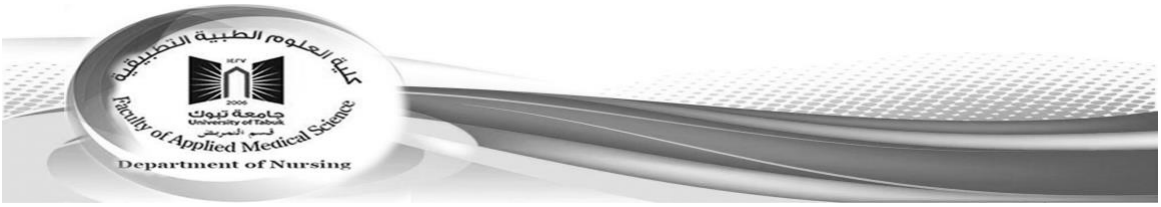
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN ASSISTING IN LABOR AND DELIVERY AND IDENTIFYING OB INSTRUMENTS

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in assisting in labor and delivery and identifying OB instruments. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

IDENTIFYING OB INSTRUMENTS	***3***	***2***	***1***	***0***	***Remarks***
Prepare the woman. Routinely check for crowing, cervical dilation and effacement (Done by Ob-Gyne through IE).					
When crowning, and cervical dilation and effacement complete put the mother in the birthing table.					
3. Position the mother in lithotomy					
Clean the perineum with warm antiseptic solution					
Identify the equipments correctly a. Mayo Scissor					
b. Kelly clamp (curve)					
c. Kelly clamp (straight)					
d. Rubber suction bulb					
e. Suction Machine					
f. Gauze					
g. Mayo table					
h. Metzenbaum					
i. Needle holder					
j. Tissue forceps					
k. Suture					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
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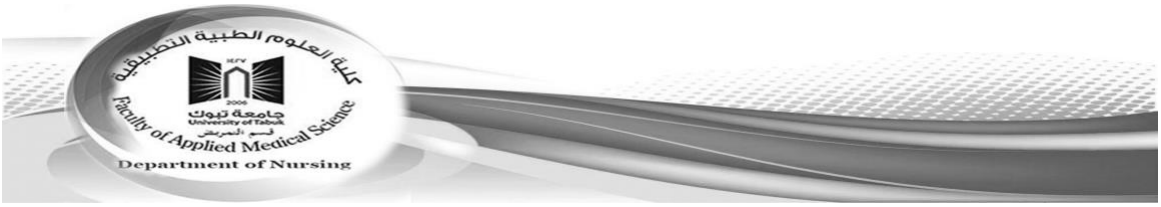
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN AUSCULTATION OF THE FETAL HEART TONES DURING LABOR



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in auscultation of the fetal heart tones during labor. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

AUSCULTATION OF THE FETAL HEART TONES DURING LABOR	***3***	***2***	***1***	***0***	***Remarks***
Wash and dry hands and explain procedure and purpose of the examination to the patient.					
Help the patient assume a comfortable position that provides access to the abdomen.					
Palpate the maternal abdomen using Leopold maneuvers to identify the fetal position to aid in obtaining the location of the fetal heart tones. Note that the fetal heart tones are heard most loudly over the fetal back.					
Palpate the fundus of the uterus for the presence of uterine contractions. At the end of a uterine contraction, place the fetoscope or Doppler over the location of the fetal back. Adjust the fetoscope or Doppler if necessary to obtain a clearly audible FHR. Depending on fetal position, the fetal heart sounds may be soft and muffled or loud and clear.					
Listen for audible fetal heart sounds. Note that two distinctly different sounds can be heard: fetal heart tones that result from blood moving through the placenta and umbilical cord (funic souffl é) and the uterine souffl é, which is the same rate as the maternal pulse.					
Palpate the maternal radial pulse to ensure that the auscultated fetal heart sounds are at a different rate than the maternal pulse.					
Auscultate the fetal heart sounds for the rate and rhythm. The greatest accuracy for assessment of the fetal heart rate occurs when listening for 1 minute. ***Note:*** During active labor, 30-second intervals may be more feasible.					
Count the FHR for 30–60 seconds between contractions to determine the baseline rate.					
Let the Ob-gyne interpret the fetal heart rate: Is the baseline normal between 110 and 160 bpm? Is there tachycardia (baseline _160 bpm) or bradycardia (baseline 110/bpm)?					
Repeat the procedure as indicated according to agency policy.					
11. Inform the patient of the findings.					
12. Document the fetal heart rate according to agency policy					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

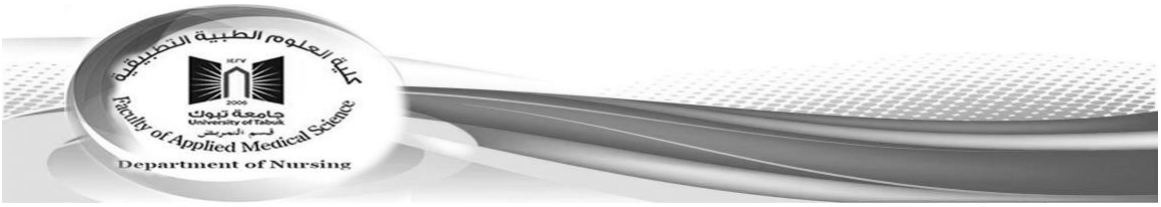
Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN BIRTH OF THE NORMAL PLACENTA

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in birth of the normal placenta. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

BIRTH OF THE NORMAL PLACENTA	***3***	***2***	***1***	***0***	***Remarks***
1. Placing the ring forceps, after the birth, on the portion of the umbilical cord that is just outside the introitus and letting it hang down by its own weight.					
Placing your hand over the uterus through the abdominal wall (inside a folded sterile towel) to note when the uterus contracts into a hard globular ball which rises slightly under your hand.					
Requesting the mother to tell you, after the delivery of the baby, when she next has contractions or "cramps."					
Noting whether there is a small gush of blood and/or lengthening of the cord. This may not always be readily apparent.					
Noting the time of the birth of the baby so you know how long you have waited for separation of the placenta. Many placentas do not separate within the first 10 minutes and you should check for separation at that time, unless it is apparent before					
When the mother feels a contraction, or a gush of blood or cord lengthening or a change in the uterine firmness is noted, or ten or more minutes have elapsed, ask the mother to bear down at the same time that you: Provide some firm pressure against the fundus of the uterus with your cupped hand, and your thumb placed just above the pubic bone to keep the uterus from entering the pelvis and a) causing spurious cord lengthening or other false evidence of separation, or b) even inverting the uterus.					
7. Provide some steady cord traction to note whether there is a sense of "give" as the placenta moves into the vagina and the cord lengthens, or conversely, does not progress --- in which case you cease your maneuvers and wait.					
8. Assess the placental surface if it is clean or the surface is not smooth and glossy there is a possibility of retained placental fragments.					
9. If you are uncertain whether the placenta has actually separated, you may also follow the cord with your hand in the vagina, up to the cervix, to determine if the placenta is trapped in the cervical os, or whether the cord disappears into the uterus.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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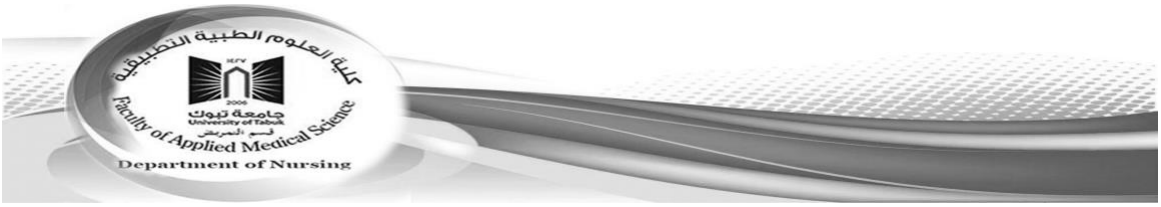
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN ASSESSMENT OF PLACENTAL SURFACE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in assessment of placental surface. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

ASSESSMENT OF PLACENTAL SURFACE	*3*	*2*	*1*	*0*	*Remarks*
Start with the fetal surface since that is the most common presentation of the placenta at birth, e.g., "shiny Schultz" or Duncan (dirty). Correctly Identify the placenta type					
Note the placement of the cord insertion on the placenta and note the umbilical vessel. It should contain 3 vessels inside.					
Turn the placenta over to the maternal surface. Pull the membranes up gently to identify the location of the hole which resulted from the rupture of the membranes. A hole near the center of the membranes indicates a placenta attached in the upper portion of the uterus. A hole near an edge of a placenta indicates a low-lying placenta, e.g., one attached in the lower uterine segment closer to the cervical os.					
After noting whether there are any tears in the membranes or blood vessels passing through them, pull the membranes completely back to expose the maternal surface of the placenta. Note the cotyledons which make up a normally thick, red surface and ensure that there is not a missing section. Look for infarctions (white, thickened areas), or a pale overall color. These signs may indicate an aging placenta, or one that has not had a healthy maternal/fetal transfer unit. Run your finger around the edge of the placenta to determine whether there are any vessels or succinturiate lobes in the membranes.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
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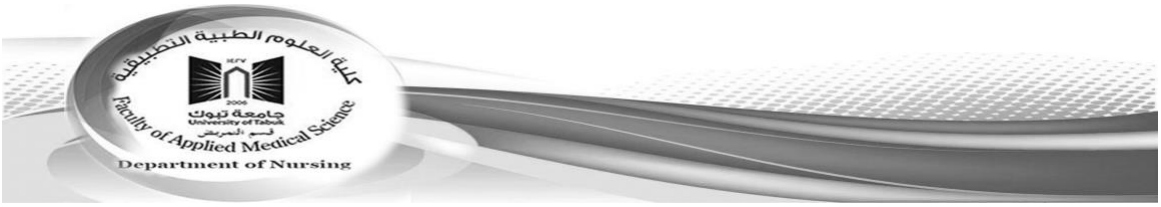
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN THE FIRST AND SECOND STAGE OF LABOR

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in assessment of placental surface. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

SKILLS IN THE FIRST AND SECOND STAGE OF LABOR	***3***	***2***	***1***	***0***	***Remarks***
1. Assess Progress of labor.					
2. Transports clients safely while providing privacy					
3. Places mother in lithotomy position					
3. Performs perineal care using sterile technique correctly					
4. Performs proper hand scrub					
5. Assess urinary output. Palpate bladder at least every hour during labor if epidural is in place and at least every two hours without epidural anesthesia.					
6. Prevent the client from straining or bearing down.					
7. Place the cardiotocograph on the mother. Obtain Vital signs.					
8. Monitor progress of labor/uterine contractions as to: Frequency, Duration, Intensity and Interval					
9. Assist in reinforcing breathing and relaxation exercises.					
10. Once crowning prepare the delivery set.					
11. Observe for the timely rupture of membrane					
12. Prepare the suction machine and warmer.					
13. Provide emotional support and reassurance as is feasible.					
14. Put on gown and mask. Assist doctor in gowning.					
15. Ask the client to gently blow out with each breath.					
16. Assist the doctor as he drapes and cleans the perineum with antiseptic solution; as the perineum distends, (an episiotomy will be done). Perform Ritgen's Maneuver					
17. Ask the client to gently blow out with each breath in order to avoid pushing.					
18. Open and hold the lidocaine ampoule for withdrawal by the doctor.					
19. Put on sterile gloves to receive the baby					
20. After crowning, allow the head of the baby to gradually extend under your hand.					
21. The doctor will gently feel around the baby's neck for the cord.					
22. If the cord is around the neck, but loose, he will slip it over the baby's head.					

23. If the cord is loose but cannot be slipped over the baby's head, the doctor will slacken the cord so that it can slip backwards over the baby's shoulders as they emerge.					
24. If the cord is tight around the baby's neck, the doctor will clamp the cord with two artery forceps, placed 3 cm apart, and cut the cord in between the two clamps.					
25. Cut the cord using a sterile scissors.					
26. Note the gender, time of delivery of the baby.					
27. Palpate the mother's abdomen.					
28. Wait for the third stage of labor for delivery of the placenta					
TOTAL SCORE					

Total Points: Actual Score / Possible Score X Marks = ___ X Mark (__) = Final Mark_____

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN THE THIRD STAGE OF LABOR

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in the third stage of labor. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

SKILLS IN THE THIRD STAGE OF LABOR	3	2	1	0	Remarks
1. Delivers baby and placenta carefully • Checks and manages cord recoil correctly • Clamps and cuts the cord correctly • Identifies signs of placental separation • Checks the characteristics/completeness of the placenta					
2. Assesses the amount of blood loss (normal:<500ml)					
3. Employs intervention to achieve and maintain a well-contracted uterus to prevent/control hemorrhage • Uterine massage • Correct administration of oxytocin or methylergometrine • Cold compress					
4. Assesses presence and degree of laceration					
5. Assists in episiorrhapy					
6. Checks size, consistency and location of uterus					
7. Performs perineal care and applies pad correctly					
8. Provides emotional support to the mother throughout the labor and delivery					
9. Evaluates patient's condition and records pertinent data accordingly					
10. Prepares patient for transfer to recovery room/ward.					
11. Documents accurately relevant data about the client					
12. Maintains an organized system of filing and keeping records of the client					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING FUNDAL MASSAGE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Performing Fundal Massage. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

PERFORMING FUNDAL MASSAGE	*3*	*2*	*1*	*0*	*Remarks*
Pre examination Preparation **1.** Wash and dry hands, explain the procedure and its purpose to the patient; ensure privacy.					
2. Assemble necessary equipment, including clean examination gloves, disposable cleansing wipes, and clean peripads.					
3. Ask the patient to void, unless fundal massage must be performed immediately due to excessive bleeding.					
4. Assist the woman to a supine position with the knees flexed and the feet placed together.					
Steps during Procedure **1.** Don gloves, remove the peripad, and inspect the perineum. Observe the character and amount of drainage on the pad and the presence of clots. Apply a clean peripad.					
2. Place one hand on the abdomen, just above the symphysis pubis.					
3. Place the other hand around the top of the fundus.					
4. With the lower hand maintained in a stable position, rotate the upper hand and massage the uterus until it is firm. Avoid over massaging the uterus.					
5. Once the uterus has become firm, *gently* press the fundus between the hands. Apply a slight downward pressure against the lower hand.					
6. Observe the perineum for the passage of clots and the amount of bleeding.					
7. Once the uterus remains firm, cleanse the perineum and apply a clean peripad. Dispose of the soiled gloves and pads according to institutional policy.					
8. Document the findings. Continue to assess the fundus and vaginal drainage according to institutional protocol. Alert the physician or nurse midwife if the fundus does not remain contracted or if bleeding persists.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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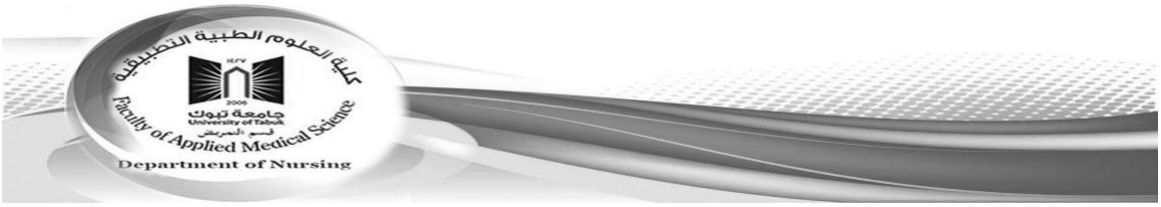
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN WOUND CARE FOR EPISIOTOMY

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Performing wound Care for Episiotomy Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

WOUND CARE FOR EPISIOTOMY	***3***	***2***	***1***	***0***	***Remarks***
1. Prepare the client, and assemble the equipment.					
2. Assist the client to a dorsal recumbent position in which the wound can be readily exposed. Expose only the wound area, using a bath blanket to cover the client, if necessary.					
3. Make a cuff on the moisture-proof bag for disposal of the soiled dressings, and place the bag within reach.					
4. Put a face mask, if required.					
5. Set up the sterile supplies. Put on sterile gloves.					
6. Clean the wound, using your gloved hands or forceps and gauze swabs moistened with cleaning solution.					
7. If using forceps, keep the forceps tips lower than the handles at all times.					
8. Clean the incision from inner to outer motion. Use a separate swab for each stroke, and discard each swab after use. Put the swab gauze in moisture-proof bag.					
9. Dry the surrounding skin with dry gauze swabs as required. Do not dry the incision or wound itself.					
10. Apply the ordered powder or ointment. Apply peripads if patient has lochia					
11. Remove gloves put in moisture-proof bag and dispose them off properly.					
12. Document the procedure and the status of the incision.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
_____
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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PREPARING A HOT SITZ BATH

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Preparing a Hot Sitz Bath. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

SKILLS IN PREPARING A HOT SITZ BATH	*3*	*2*	*1*	*0*	*Remarks*
1. Wash your hands, identify the patient, and explain the procedure.					
2. Assess the patient to confirm that she is able to ambulate to the bathroom.					
3. Assemble equipment (washtub or basin, hot water, warm blanket, towels, washcloth and small bowl of cool water) and ensure that all equipment is clean.					
4. Raise the toilet seat in the patient's bathroom.					
5. Insert the sitz bath apparatus into the toilet. The overflow opening should be directed toward the back of the toilet. Alternate method: Use any basin that can accommodate the buttocks of the women					
6. Fill the collecting bag with water or saline, as directed, at the appropriate temperature (105°F [41°C]).					
7. Test the water temperature. It should feel comfortably warm on the wrist.					
8. If prescribed, add medications to the solution.					
9. Hang the bag overhead to allow a steady stream of water to flow from the bag, through the tubing, and into the reservoir.					
10. Assist the ambulating patient to the bathroom. Help with removal of the perineal pad from front to back. Assist the patient to sit in the basin. The buttocks and upper thighs should be soaked in the water but not including legs.					
11. Instruct the patient to use the tubing clamp to regulate the flow of water. Ensure that the patient is adequately covered with a robe or blankets to prevent chilling.					
12. Verify that the call bell is within reach and provide for privacy.					
13. Encourage the patient to remain in the sitz bath for approximately 20 minutes.					
14. Provide assistance with drying the perineal area and applying a clean perineal pad by grasping the pad by the ends or bottom side.					
15. Assist the patient back to the room.					
16. Assess the patient's response to the procedure. Reinforce teaching about continued perineal care at home.					
17. Record completion of the procedure, the condition of the perineum, and the patient's tolerance.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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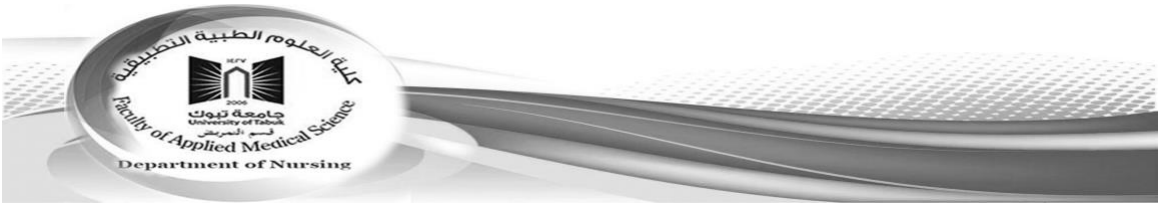
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROVIDING PERINEAL- GENITAL WASH

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in providing Perineal-Genital Wash. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

SKILLS IN PROVIDING PERINEAL- GENITAL WASH	***3***	***2***	***1***	***0***	***Remarks***
1. Gather necessary equipment. Place the equipment tray on stable surface adjacent to the bed					
2. Wash your hands. Put on clean gloves.					
3. Explain what you are going to do and remove the bed cover					
4. Wash and dry hands					
5. Put on the disposable gloves					
6. Assist client to back-lying or side-lying position; place bed protector or bedpan under hips/hips					
7. Using the dominant hand put on the mitt (using the cloth) and squeezed on soapy water					
8. With the non-dominant hand separate the labia. Clean 1 side first stroking from top to bottom. Then squeeze the mitt on soapy water and clean the other side. Clean the mitt again and stroke the middle area. Discard the mitt and pat dry the vulva with dry towel.					
9. Put the patient in side lying position. To make the patient more comfortable clean the anus and perineum. Use the second cloth as mitt and soaks in soapy water. Separate the buttocks and stroke from top to bottom. Do not touch the previously washed area.					
10. Dry the area carefully with the towel.					
11. Remove the bed protector under the patient thigh.					
12. Remove gloves and discard them in moisture resistant bag or receptacle/ sealable plastic storage bag and put them in the garbage bag					
13. Take the equipment tray and return them to proper place.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROVIDING POSTPARTUM CARE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in providingpostpartum care. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

SKILLS IN PROVIDING POST PARTUM CARE	***3***	***2***	***1***	***0***	***Remarks***
1. Identify patient.					
2. Check patient records: complications and treatment done during delivery.					
3. Explain the procedure to the patient and make the patient feel comfortable.					
4. Ask when her last urination was or check if bladder is full. If bladder is full, let the patient urinate before the examination.					
5. Provide privacy to the patient.					
6. Perform handwashing.					
7. Assess the patient's vital signs. Assess every 15 minutes in the first 4 hours, every 30 minutes for 2 hours then every 4 hours thereafter. Pay particular attention to the patient's body temperature. Temperature of 38ºC is normal for the first 24 hours.					
8. Perform postpartum assessment and care: **BREAST** a) Assess the patient's breast: Is she wearing supportive bra, inspect and palpate the breasts and nipples and take note for presence of discomforts.					
b) Teach patient about management of breast engorgement and sore nipples.					
c) Teach patient on breastfeeding. Assess good sucking. Observe for 4 minutes. Is there any difficulty breastfeeding? Observe how mother breastfeeds for at least 4 minutes. ▪ Is baby positioned well? ▪ Is baby able to attach to the nipples well? ▪ Is baby sucking effectively? If the baby does not suck try to stroke the side of the chin of the baby to initiate Rooting reflex.					
d) Help mother position baby to the breast (latch on). Pillows or a folded blanket under the mother's head may help. Or the mother can roll to one side and tuck the baby next to her.					

UTERUS-FUNDUS					

a) Position patient to supine or flat position. Support uterus with one hand under and palpate with other hand. Assess the relation of fundus to umbilicus, if it is in the midline or displaces and palpate for uterine firmness. Be gentle in palpating. For C-section delivery, also check the surgical incision.					
b) Describe the expected anatomic position of the fundus of the uterus: 1-2 hours, 12 hours, 2 days and 7 days after delivery. Check fundal height regularly.					
c) Do fundal massage as necessary.					
d) Teach patient about process of involution					
BOWEL a) Assess pattern of defecation and ask patient for concerns and discomforts.					
b) Teach patient on measures to prevent constipation.					
BLADDER a) Assess patient's voiding pattern. Palpate and assess for distension of bladder, presence of boggy or displaced uterus.					
b) Teach patient regarding importance of prevention of bladder distention and fluids after delivery.					
LOCHIA a) Monitor lochia (color, amount, consistency), and also assess for odor, size of clots and presence of foul odor. Ask the mother to call the nurse every time the peripad is replaced/tell patient to save the peripads.					
b) Do pad count every day. Count and weigh sanitary pads if lochia is heavy to evaluate amount of bleeding.					
c) Teach patient on the expected changes, onset of menses and on resumption of sexual activity.					
LEGS a) Press down gently on the patient's knee (legs extended flat on bed) and ask her to flex her foot (dorsiflex). Assess for presence of Homan's sign, edema on legs, and redness, warmth and tenderness on the patient's calf.					
b) Positive Homan's Sign is pain on the calf muscle (gluteus maximus). Negative is when no pain and edema noted. If positive inform the doctor immediately. Redness, warmth and tenderness on patient's calf should also be reported.					
c) Teach patient on signs and symptoms of Deep Vein Thrombosis (DVT) and on prevention of DVT.					
EPISIOTOMY/PERINEUM					
a) Have woman lay on her side, lift her leg and bring it forward. Assess the perineum for "REEDA" Redness Ecchymosis Erythema Drainage/Odor Suture approximation; And also assess for presence of hemorrhoids and evaluate effectiveness of comfort measures.					
b) Teach patient regarding episiotomy and care of episiorrhapy site.					
EMOTIONS a) Assess patient regarding patient's attitude, feelings of competence, support systems, fatigue level and ability to accomplish task					

b) Teach patient regarding effects of hormonal changes, importance of rest and available resources.					
EARLY ATTACHMENT a) As soon as the baby is delivered, place the baby skin-to-skin against the mother. Assess for the presence of early attachment: presence of engrossment to newborn, eye contact to newborn, nurturing behavior of the mother, consistency, sensitivity and enjoyment.					
PAIN a) Assess location, type, and quality of pain to direct intervention. Explain to the woman the source and reasons for the pain, its expected duration and treatments.					
b) Teach patient regarding comfort measures and provide interventions to provide pain relief.					
9. Do handwashing.					
10. Teach patient about danger signs/reportable signs and symptoms.					
11. Counsel patient regarding nutrition, birth spacing and family planning.					
12. Ask the patient for concerns/issues.					
13. Explain the findings to the patient. Abnormal findings should be referred to physician promptly.					
14. Inform patient about schedule of return visits.					
15. Document findings, care provided and responses of the patient.					
TOTAL SCORE					

Total Points: Actual Score / Possible Score X Marks = ___ X Mark (__) = Final Mark_____

Comments:

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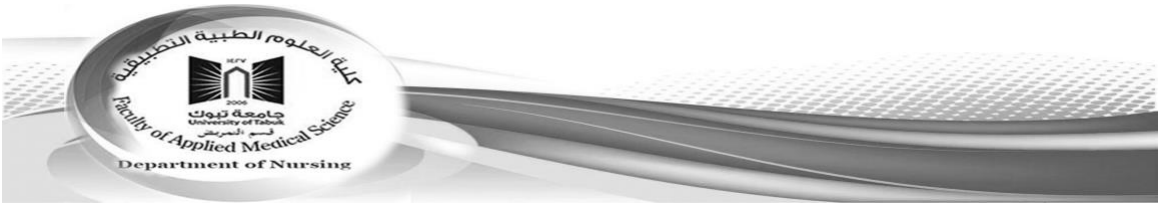
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in immediate care of the newborn. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

SKILLS IN IMMEDIATE CARE OF THE NEWBORN	3	2	1	0	Remarks
1. Assess the infant for oral secretions.					
2. Position the infant's head to the side or downward if he is vomiting or gagging.					
3. Compress the bulb syringe.					
4. Insert the bulb syringe approximately 1 inch into one side of the infant's cheek. Avoid contact with the roof of the mouth and the back of the throat.					
5. Gently release compression of the bulb syringe and allow it to fill with oral secretions.					
6. Gently remove the bulb syringe; expel drainage into a tissue.					
7. Repeat the process on the other side of the infant's cheek.Repeat as needed.					
B. Steps for Nasal Suctioning **1.** Assess the infant for nasal congestion.					
2. Position the infant's head to the side or downward if he is vomiting or gagging.					
3. Compress the bulb syringe.					
4. Insert the bulb syringe into the tip of the infant's nostril. Avoid obstructing the nasal passageway. .					
5. Gently release the compression of the bulb syringe to allow it to fill with mucus or nasal drainage.					
6. Gently remove the bulb syringe; expel drainage into a tissue.Repeat as needed.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
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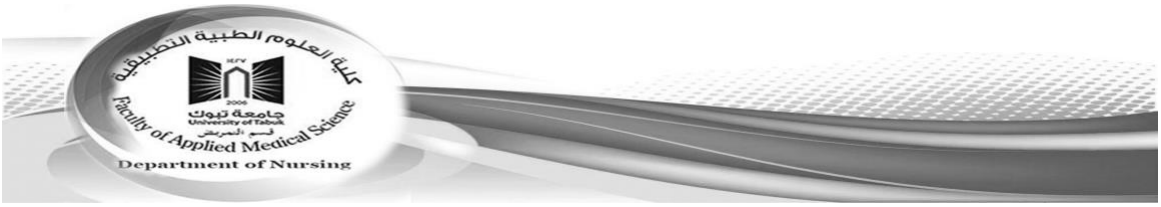
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (APGAR)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in immediate care of the newborn (APGAR). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (APGAR)	***3***	***2***	***1***	***0***	***Remarks***
Note: The Instructor will give the scenario and the condition of the baby. The student will give the APGAR score at the end of the return demo. **A. Assess heart rate** 1. Get the heart rate when the baby is not crying					
2. Warm the bell of the stethoscope with the palm of the hand prior to placing it in the chest of the baby.					
3. Place the stethoscope on the left side of the chest or where the heart beat is loud					
4. Record the heart rate in one full minute					
B. Assess the respiratory effort 5. Observe the respiratory effort of the baby, listen to the cry. A normal cry will be shrill and vigorous. Observe the rise and fall of the chest and abdomen. If the baby is not crying the nurse can perform the tangential foot slap. This is tapping with the nurse's finger the sole of the foot to stimulate crying.					
6. Count the number of rise and fall of chest and abdomen for 1 full minute.					
C. MUSCLE TONE 7. Observe the posture and muscle tone of the newborn. Normal newborn has some flexion of extremities and body					
8. Gently pull the babies leg and arm and note if there is some resistance felt (normal finding)					
9. Put the baby in prone position in the arm or hand (If you can support the baby's weight)					
D.REFLEX IRRITABILITY 10. While the baby is being suctioned observe for reflex irritability					
E. Color 11. Lastly observe for the babies skin color..					
12. Score the baby and be guided by the interpretation of score below. Report to the doctor if the score is 6 and below.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (BABY BATH)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in immediate care of the newborn (Baby bath). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

IMMEDIATE CARE OF THE NEWBORN (BABY BATH)	3	2	1	0	Remarks
1. Assemble all equipment. Do not leave the baby alone on the bath area.					
2. Wear gloves until initial bath is completed.					
3. Fill the basin with warm water and add some liquid soap. Check the temperature with your elbow					
4. Prepare the towel (fold towel on the edge under the baby's head) on the table and undress the baby. Put oil all over the body with cotton balls. And gently remove some of the vernix caseosa of the baby but do not remove entirely. Do this in a quick manner. Wrap the baby with towel.					
5. Hold the baby with one hand and use the other hand to scoop water in the head carefully not splashing water in the face.					
6. Then wipe the baby's head with the wrap towel (use the folded part to do this).					
7. Remove the towel and soaked the baby on to the basin of warm water. Hold the baby securely on its upper back. Maintain baby's head above the water level. Careful not to put any water in its ear.					
7. Towel dry the infant. Careful not to scrub the skin so much with the towel instead use a pat motion to dry the baby. Take special care with their creases and under the chin, under groin, and axilla.					
8. Put some baby oil on the skin especially increases and under the chin, under groin, and axilla. Dress and comb the baby					
9. Assemble all equipment. Do not leave the baby alone on the bath area.					
10. Wear gloves until initial bath is completed.					
11. Fill the basin with warm water and add some liquid soap. Check the temperature with your elbow					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (CORD CARE)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in immediate care of the newborn (Cord Care). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

IMMEDIATE CARE OF THE NEWBORN (CORD CARE)	3	2	1	0	Remarks
Initial Cord Care (Day 1):					
1. Gather all necessary equipment and put the baby in supine position.					
Clamp 0.5 – 1 inch above umbilical base. Milking the cord towards the baby is not allowed.					
Leave the umbilical stump uncovered.					
With the use of forceps, cleanse the cord stump with betadine antiseptic or solution.					
Using a circular motion going out outside the stump					
Succeeding Cord Care (Day 2):					
1. Assess for any odor, discharge, bleeding, or skin inflammation around the cord.					
2. Cleanse the cord and the skin around the base around the cord with cotton swabs and prescribed preparation (Alcohol 70% Isopropyl).					
3. The clamp is removed when the cord is dry (about 24-48 hours).					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN
(ANTHROPOMETRIC MEASUREMENTS)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in anthropometric measurements. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (ANTHROPOMETRIC MEASUREMENTS)	3	2	1	0	Remarks
A. Weight 1. Weigh the newborn without any dress					
2. Put clean paper on the scale					
3. Balance the scale zero as directed by the manufacturer					
4. Wash hands and put on gloves if you haven't bath the neonate yet					
5. Place the neonate in the middle of the scale tray without any dress. Note the neonate's weight. Keep one hand poise over him all times. Work quickly.					

6. Measure the newborn using a tape measure					
Head Circumference: 7. Measure the head at the greater diameter or occipito-frontal circumference (33-35 cm).					
8.Slide tape measure under the neonate's head at the occiput and draw tape snugly around, just above the eyebrow					
Chest Circumference:9. Measure the nipple line (30-33 cm) which is lower in 1-2 cm than head circumference.					
10. Place the tape around the back and wrap it snugly around the chest at the nipple line.					
11.Take the measurement after the neonate inspires and before it begins to exhale.					
Length: 1. Place the infant on a paper-covered flat surface.					
2. Fully extend the infant's body by holding the head midline.					
3. Gently grasp the knees and place them together.					
4. Push down gently on the knees until they are fully extended and fl at against the table surface.					
5. Measure the crown-to-heel recumbent length by placing the paper tape measure beside the infant with the 0 end of the tape at the top of the head. Keep the infant's body in alignment and carefully extend one leg. Ensure that the tape measures remain straight. Note the length and record it in the infant's chart **(normally 47-50 cm)**. As an alternate measurement method, make a slash mark with a pen at the end points by the top of the infant's head and the heels of the foot. While providing continuous support, gently roll the infant to the side and measure between the two points with a paper tape measure that has increments designated in tenths.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN IMMEDIATE CARE OF THE NEWBORN

(VITAMIN K ADMINISTRATION)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Vitamin K administration. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

VITAMIN K ADMINISTRATION	*3*	*2*	*1*	*0*	*Remarks*
Do hand washing and assemble all necessary equipment					
Aspirate 2mg in *0.2*m solution of Vit K. Replace a new needle for injection recap and set aside. Put the *1*% silver nitrate solution on the tray.					

Place the newborn on a firm surface. Open the eyelids and put ointment from inner to outer canthus at the lower conjunctiva.					
Expose the thigh of the infant and assess the location of vastus lateralis. Insert needle at a 90° angle to the skin with a quick thrust and pull back on the syringe plunger after needle insertion. Put gauze and tape it on to the skin of the client.					
5. Return the baby's cover					
Return the equipment and dispose the syringe and needle in the non-punctured container.					
TOTAL SCORE					

Comments:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

SKILLS IN IMMEDIATE CARE OF THE NEWBORN
(Attachment to Warmth-Radiant Warmer)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in attachment to warmth-radiant warmer. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

SKILLS IN IMMEDIATE CARE OF THE NEWBORN (Attachment to Warmth-Radiant Warmer)	***3***	***2***	***1***	***0***	***Remarks***
1. Wash hands and make sure that the baby is dry keeping close attention to axilla, under the chin, and groin.					
2. Place the sheet on a firm table and lay down the baby on top of it.					
3. Cover the baby					

Step 1					
Step 2					
Step 3					
Step 4					
4. Put the baby on the radiant warmer and make sure to check every 30 minutes. Turn the baby regularly to make sure all aspect their body is equally warm.					
TOTAL SCORE					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score

Comments:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

APPENDIX B

SECOND SEMESTER

3RD YEAR / LEVEL 6

1. **ADULT HEALTH NURSING 2 PRACTICAL(NUR 304)**

2. **CHILD HEALTH NURSING PRACTICAL (NUR 309)**

COMPETENCY EVALUATION CHECKLISTS

and

PERFORMANCE SKILLS CHECKLISTS

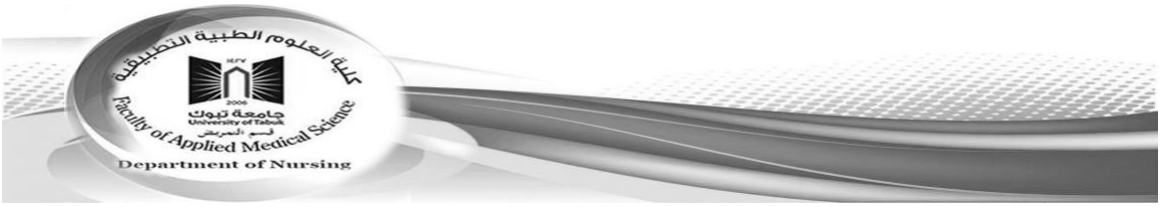
COMPETENCY EVALUATION CHECKLIST
ADULT HEALTH NURSING 1 (NUR 303) and 2 (NUR 304) PRACTICAL

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 isconsistently ineffective and inefficient



I. UTILIZATION OF THE NURSING PROCESS (12%)	**3**	**2**	**1**	**0**
8. Obtains comprehensive client's information through the following: g. Reviewing the chart				
h. Interviewing patient.				
i. Performing physical assessment.				
j. Reviewing laboratory tests/ diagnostic examinations results.				
k. Reviewing doctor's order/s.				
l. Reviewing progress notes.				
9. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems				
10. Prioritizes from the identified problems				
11. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses				
12. Performs safe and effective nursing care.				
13. Implements appropriate nursing interventions based on identified needs.				
14. Evaluates nursing care.				
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**
8. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others				
9. Establishes and maintains effective working relationships within an interdisciplinary team.				
10. Utilizes proper channels of communication.				
11. Participates actively during pre, post and bedside conferences.				
12. Documents data on client care clearly, concisely, accurately, and in a timely manner				
13. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.				
14. Assist in endorsement of patient and other patient related handover cases.				
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**
17. Ensure proper identification of patient.				
18. Assesses and monitors LOC, vital signs, including pulse and respiratory rates, temperature, pulse oximetry, BP, and 3-lead EKG, I & O, and pain.				
19. Assess and maintain patency of contraptions (IVF, BT, catheters, drainage).				
20. 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.				
21. Provides appropriate individual comfort measures such as hygiene maintenance, positioning, touching, bed making, and non-pharmacologic management of pain.				
22. Applies infection control measures. Wears prescribed attire according to department policies and isolation precautions.				
23. Transfer patients safely. Raise side rails when needed.				

24. Identify and prepare correct equipment/materials/instruments prior to performance of procedures while maintaining sterility as needed.				
25. Observe and perform techniques and principles of specimen collection techniques.				
26. Provides teaching about assessed and identified learning needs. (e.g. diet restriction as ordered, prior diagnostic and nursing or medical procedures, medications etc.).				
27. Provides emotional, physical and psychological and spiritual support as needed.				
28. 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.				
29. Performs ongoing assessment and identify deviations from standards.				
30. Refer untoward signs of complications and any deviations from normal and standards.				
31. Performs after care of materials/instruments/equipment used.				

32. Ensure proper disposal of hospital waste.				
TOTAL: _____/_____= ___* 12%= ____				
IV. VALUES AND ATTITUDE (8%)	**3**	**2**	**1**	**0**
10. Wears complete uniform: B. ID				
B. head cover				
C. shoes and socks				
G. lab gown with patch and piping				
H. 2-hand watch				
I. clinical kit				
11. Is well-groomed at all times: G. trimmed nails				
H. no nail polish				
I. no jewelries				
J. no make-up				
K. contact lenses				
L. no perfume				
12. Follows the policies, procedures and guidelines of the c. Department and University				
d. Affiliating agencies (hospital)				
13. Demonstrates honesty and accountability				
5. Changes behavior in response to constructive criticism/s				
6. Reports for duty C. On time				
D. Regularly				
14. Submits requirements on time.				
15. Demonstrate effective time management.				
16. Observes bedside manners and courtesies				
17. Displays caring attitude in professional manner.				
18. Shows initiative in accepting responsibilities and accountabilities.				
TOTAL: _____/_____= ___* 8%= ____				
OVERALL: Clinical Performance Evaluation: _____/12% **Values &Attitude_____/8%** **Total: _____/20%**				

Comments:

_____

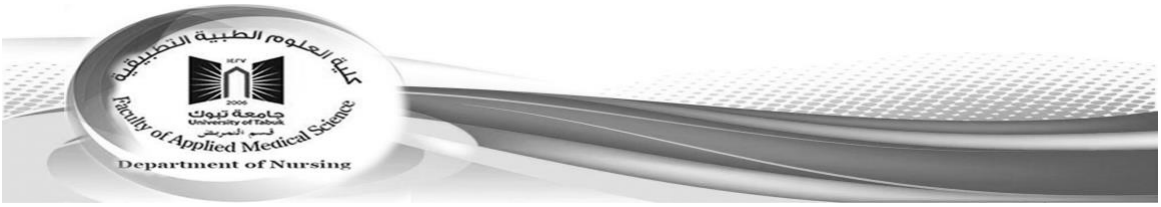
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN OBTAINING A CAPILLARY BLOOD SPECIMEN AND MEASURING BLOOD GLUCOSE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *obtaining a capillary blood specimen & measuring blood glucose.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	Steps in Obtaining a Capillary Blood Specimen and Measuring Blood Glucose	***3***	***2***	***1***	***0***	***Remarks***
1	Ensure you have all necessary equipment for the procedure: - gloves - an alcohol wipe - a glucose monitor test strips - spring loaded lancet - cotton wool					
2.	Introduce yourself and explain the procedure to the					
3.	Wash your hands and put on your gloves.					
4	Turn on the glucose monitor and ensure that it has been calibrated. If not, insert the calibration strip and allow it to calibrate.					
5	If necessary, assist the patient with washing and drying of the finger / hand with warm water.					
6	If there is any possibility that there may have been contact with substances such as fruit juice, the finger should be cleaned with warm water and dried before pricking. Do not use alcohol for cleaning the hands					
7	Before pricking, clean the tip of one of the patient's fingers with an alcohol, wipe and allow it to dry.					
8	Prepare the test strip, ensuring that it is still in date.					
9	Load it into the glucose monitor.					
10	Open the lancet carefully.					
11	Prick the side of the patient's finger with the lancet and squeeze the finger. Preferably, avoid using thumb or					
12	Wipe away the first drop of blood and squeeze the finger again to form another drop.					
13	Place this drop on the test strip					
14	Ensure that blood covers the strip entirely.					
15	Give the patient a piece of cotton wool to stop the bleeding					

16	Thank the patient, take note of the reading from the glucose monitor and turn it off.					
17	Decontaminate hands					
18	Record all actions, observations and results in nursing records.					
19	Explain results to patient and any necessary action/s needed to change current treatment plan and by when, if required. Document all actions in patient's record.					
20	Check for orders for sliding scale insulin based on capillary blood glucose results.					
21	Administer insulin as prescribed.					

Comments:

_____

_____

Student's signature over printed name/ Date/ Time:

_____

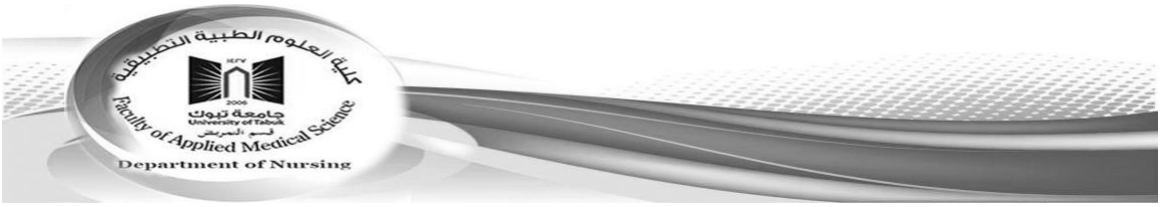
Clinical Instructor's signature over printed name/ Date/ Time:

_____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING INSULIN ADMINISTRATION

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing insulin administration.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	Steps in Insulin Administration	***3***	***2***	***1***	***0***	***Remarks***
1	**Preparation:** **Assemble equipment and supplies:** **11.** Insulin syringe **2.** Medication-Insulin **3.** Gloves **4.** Alcohol wipe **5.** Tissue or cotton ball **6.** Sharps container or disposal plan					
	Procedure					
2	Introduce yourself and verify the client's identity. Explain to the client what you are going to do, why it is necessary, and how the client can cooperate.					
3	Perform hand hygiene and observe other appropriate infection control procedures					
4	Provide for client privacy.					
5	Gather the equipment.					
6	Check 6 Rights of medication administration Right Patient Right time Right medication Right dose Right route Right documentation					
7	Check insulin expiration date and appearance- clear, colorless and free of clumps					
8	First time vial is used remove cap					
9	Clean rubber stopper with alcohol					
10	Remove needle cap					
11	Pull plunger back to pull air into syringe until the tip of the plunger is at the line for the number of units required for the dose					
12	Push the needle through the rubber stopper-making sure the tip of the needle is not in the insulin					

13	Press the plunger to push air into the vial of insulin.					
14	Turn the vial and syringe upside down so that the tip of the needle is in the insulin					
15	Holding the vial with one hand, pull back on the plunger to pull insulin into the syringe until has reached the line of the proper dose					
16	Check for large air bubbles-if there is push insulin back into the syringe and repeat step					
17	Double check if plunger at line marking of proper dose					
18	Selecting site-rotate (change) sites					
19	If using alcohol pad, clean selected site and allow to dry					
20	Pinch a large area of skin and push the needle straight into the skin all the way, at a 90 degree angle					
21	Push the plunger all the way down to inject insulin					
22	Release pinched skin, and count to 5 slowly, and pull the needle straight out					
23	Safely dispose of used needle and syringe in sharps container					
24	Remove gloves and wash hands					
	Post Procedure					
25	Inspect area for blood spills and follow district/program protocols for cleaning					
26	Put insulin and supplies away					
27	Document procedure-including date, time, site of injection and amount of insulin administered. Sign/initial documentation					

Comments:

_____

_____

Student's signature over printed name/ Date/ Time:

_____

Clinical Instructor's signature over printed name/ Date/ Time:

_____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN DONNING AND DOFFING (REMOVAL) OF PERSONAL PROTECTIVE EQUIPMENT (PPE's)

Name of Student: _____ **Section:** _____ **Group:**_____

Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *donning & doffing of PPE* . Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

Steps in Donning and Doffing (Removal) of Personal Protective Equipment (PPE's)		*3*	*2*	*1*	*0*	*Remarks*
A	***Donning of Personal Protective Equipment (PPE's)***					
1.	Review patient's file and identify the appropriate type of infection control precaution.					
2.	Gather needed PPEs. Select appropriate type and size of: Gloves					
3.	Gown					
4.	Face mask					
5.	Face shield or eye goggles					
6.	Do hand hygiene.					
7.	Pick up gown by shoulders; allow to fall open without touching any contaminated surface.					
8.	Slip arms into the sleeves; fasten/tie at the neck and then waist properly					
9.	Pick up mask with the top ties or ear loops.					
10.	Identifies the filter and the top edge of the mask by locating the thin metal strip.					
11.	Place metal strip over bridge of nose and ties upper ties or slips loops around ears.					
12.	Place lower edges of mask below chin and ties lower ties.					
13.	Press metal strip so it conforms to the bridge of the nose.					
14.	Don face shield by placing shield over eyes, adjusting metal strip over bridge of nose, and tucking the lower edge below the chin. Secures straps behind head.					
15.	Don safety glasses or goggles by setting them over the top edge of the face mask.					
16.	Don on gloves.					
17.	Make sure that the gloves cuff extends over the cuff of the gown.					

B	***Doffing (Removal) of Personal Protective Equipment (PPE's)***					
18.	Remove gloves first.					
19.	Grasp the outside of the glove at the wrist with the other hand					
20.	Ball the glove up in the fist of the gloved hand.					

21.	Grasp the remaining glove inside the wrist, and slowly pull it					
22.	Dispose of the gloves in a proper receptacle.					
23.	Remove the goggles and place them in an area to be					
24.	Untie the gown from the waist then neck.					
25.	Remove the gown by pulling it off from the neckline, so that the sleeves end up turned inside out.					
26.	Ball the gown and place it into an appropriate receptacle.					
27.	Remove the face mask and place it into the correct trash container.					
28.	Carefully wash your hands including wrists.					

Comments: _____

Student's signature over printed name/ Date/ Time:

_____

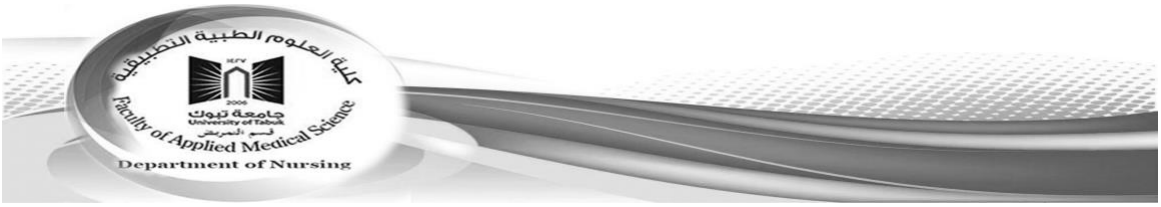
Clinical Instructor's signature over printed name/ Date/ Time:

_____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ASSISTING A PATIENT IN AMBULATION USING A WALKER

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *assisting a patient is ambulation using a walker*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*

STEPS IN ASSISTING A PATIENT WITH AMBULATION using walker	***Raw Score 0,1,2,3***	***Remarks***
ASSESSMENT		
1. Review the medical record and nursing plan of care for conditions. Identify activity ordered.		
2. Identify patient's capabilities. Check previous level of activity, assistive devices used previously and patient's knowledge regarding the use of assistive device.		
3. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation.		
4. Take vital signs and perform pain assessment.		
PLANNING		
5. Prepare equipment. • Assistive device needed (walker, crutches, cane) • Nonskid shoes or slippers • Nonsterile gloves and/or other personal protective equipment (PPE), as indicated • Additional staff for assistance, as needed • Stand-assist device and gait belt, as necessary, if available		
IMPLEMENTATION		
6. Perform hand hygiene. Put on PPE, if indicated.		
7. Identify the patient.		
8. Explain the procedure to the patient.		
9. Obtain robe and shoes and clear floor of litter or spills. Place the bed in the lowest position, if the patient is in bed.		
10. Encourage the patient to move to the side of the bed (make use of a stand-assist aid); or assist the patient to the side of the bed. Assess for dizziness or lightheadedness.		
11. Assist the patient to put on footwear and a robe, if desired. Wrap the gait belt around the patient's waist, if needed.		

12. Carry out specific procedure (using a walker, crutches, or cane). **Using a walker:** • Standing: *Teach patient to do the following:* Place walker in front of seat.		
Put both hands on arms of chair.		
Move hands to walker one at a time.		
• Gait pattern for pick-up walker: *Teach patient to do the following:* Move walker and weak leg ahead 6-8 inches.		
Place weight on arms with some weight on weak leg if permitted.		
Move strong leg forward.		
Repeat pattern.		
• Stand behind and slightly to side of patient		
13. Ensure patient's safety throughout the procedure. Nurse stands to side of and behind patient.		
14. Return patient to bed and position for comfort. Remove gait belts. Clean transfer aids per facility policy.		
15. Remove gloves and any other PPE, if used. Perform hand hygiene.		
16. Make sure call bell and other necessary items are within easy reach.		
EVALUATION		
17. Recheck vital signs and compare vital signs.		
18. Check fatigue level. Find out how patient feels.		
DOCUMENTATION		
19. Document the activity, any other pertinent observations, the patient's ability to use the walker, the patient's tolerance of the procedure, and the distance walked.		
20. Document the use of transfer aids and number of staff required for transfer.		
Total Score:		

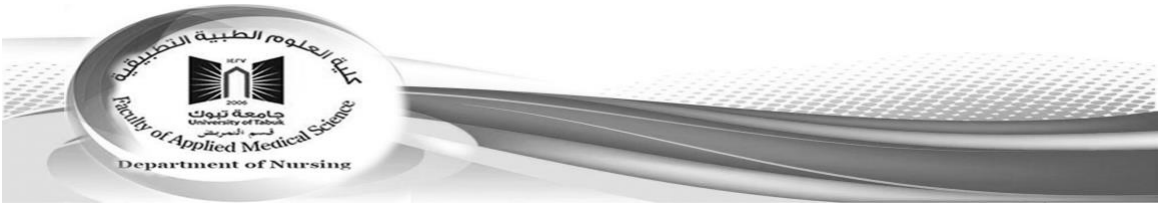
Comments: _____

Student's Signature over printed name: _____ Date/ Time: _____

Clinical Instructor's signature over printed name: _____ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ASSISTING A PATIENT WITH AMBULATION USING AXILLARY CRUTCHES



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *assisting patient with ambulation using axillary crutches.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R):
Based on the student's performance
***0** – Unable to perform even under maximum supervision*
***1** – Performs with maximum supervision*
***2** – Performs correctly with minimal supervision*
***3** – Performs correctly without supervision/independently*

STEPS IN ASSISTING A PATIENT WITH AMBULATION using axillary crutches	***Raw Score*** ***0,1,2,3***	***Remarks***
ASSESSMENT		
1. Review the medical record and nursing plan of care for conditions. Identify activity ordered.		
2. Identify patient's capabilities. Check previous level of activity, assistive devices used previously and patient's knowledge regarding the use of assistive device.		
3. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation.		
4. Take vital signs and perform pain assessment.		
PLANNING		
5. Prepare equipment. • Assistive device needed (walker, crutches, cane) • Nonskid shoes or slippers • Nonsterile gloves and/or other personal protective equipment (PPE), as indicated • Additional staff for assistance, as needed • Stand-assist device and gait belt, as necessary, if available		
IMPLEMENTATION		
6. Perform hand hygiene. Put on PPE, if indicated.		
7. Identify the patient.		
8. Explain the procedure to the patient.		
9. Obtain robe and shoes and clear floor of litter or spills. Place the bed in the lowest position, if the patient is in bed.		
10. Encourage the patient to move to the side of the bed (make use of a stand-assist aid); or assist the patient to the side of the bed. Assess for dizziness or lightheadedness.		
11. Assist the patient to put on footwear and a robe, if desired. Wrap the gait belt around the patient's waist, if needed.		
12. Using crutches: Assist the patient to stand erect, face forward in the tripod position.		

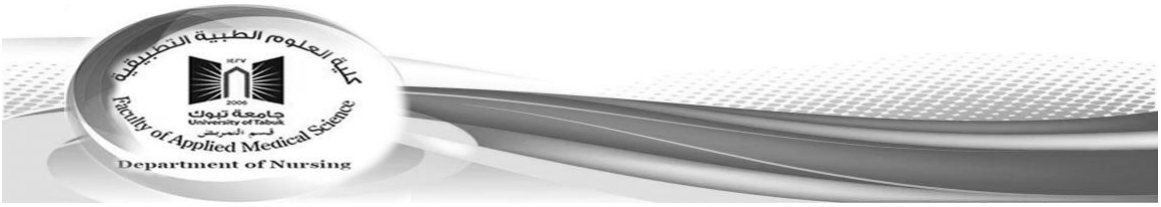
• Demonstrate the crutch-foot sequence of FOUR-POINT GAIT to the client. Move the right crutch		
Move the left foot		
Move the left crutch		
Move the right foot		
• Demonstrate the crutch-foot sequence of THREE-POINT GAIT to the client. Two crutches support the weaker extremities		
Balance weight on the crutches		
Move both crutches and affected leg forward		
Move unaffected leg forward		
• Demonstrate the crutch-foot sequence of TWO-POINT GAIT to the client. Advance the right foot and left crutch simultaneously		
Advance the left foot and right crutch simultaneously		
• Demonstrate the crutch-foot sequence of SWING-TO or SWING THROUGH GAIT to the client. Move both crutches forward		
Swing-to gait: lift legs and swing the body to the crutches		
Swing-through gait: lift legs and swing the body past the crutches		
Repeat		
• Demonstrate the crutch-foot sequence of GOING UP STAIRS to the client. Start with the crutches and unaffected extremity on the same level.		
Put weight on the crutch handles and lift the unaffected extremity onto the first step of the stairs.		
Put weight on the unaffected extremity and lift other extremity and the crutches to the step.		
Repeat.		
• Demonstrate the crutch-foot sequence of GOING DOWN STAIRS to the client. Start with weight on the unaffected leg and crutches on the same level.		
Put crutches on the first step.		
Put weight on the crutch handles and transfer unaffected extremity to the step where crutches are placed.		
Repeat.		
13. Ensure patient's safety throughout the procedure. Nurse stands to side of and behind patient.		
14. Return patient to bed and position for comfort. Remove gait belts. Clean transfer aids per facility policy.		

15. Remove gloves and any other PPE, if used. Perform hand hygiene.		
16. Make sure call bell and other necessary items are within easy reach.		
EVALUATION		
17. Recheck vital signs and compare vital signs.		
18. Check fatigue level. Find out how patient feels.		
DOCUMENTATION		
19. Document the activity, any other pertinent observations, the patient's ability to use the walker, the patient's tolerance of the procedure, and the distance walked.		
20. Document the use of transfer aids and number of staff required for transfer.		
Total Score:		

Comments:_____

Student's Signature over printed name: _____ Date/Time_____

Clinical instructor's signature over printed name: _____ Date/ Time:_____



PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ASSISTING A PATIENT IN AMBULATION USING A CANE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *assisting a patient in ambulation using a cane*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

STEPS IN ASSISTING A PATIENT WITH AMBULATION using cane	*Raw Score 0,1,2,3*	*Remarks*
ASSESSMENT		
1. Review the medical record and nursing plan of care for conditions. Identify activity ordered.		
2. Identify patient's capabilities. Check previous level of activity, assistive devices used previously and patient's knowledge regarding the use of assistive device.		
3. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation.		
4. Take vital signs and perform pain assessment.		
PLANNING		
5. Prepare equipment. • Assistive device needed (walker, crutches, cane) • Nonskid shoes or slippers • Nonsterile gloves and/or other personal protective equipment (PPE), as indicated • Additional staff for assistance, as needed • Stand-assist device and gait belt, as necessary, if available		
IMPLEMENTATION		
6. Perform hand hygiene. Put on PPE, if indicated.		
7. Identify the patient.		
8. Explain the procedure to the patient.		
9. Obtain robe and shoes and clear floor of litter or spills. Place the bed in the lowest position, if the patient is in bed.		

10. Encourage the patient to move to the side of the bed (make use of a stand-assist aid); or assist the patient to the side of the bed. Assess for dizziness or lightheadedness.		
11. Assist the patient to put on footwear and a robe, if desired. Wrap the gait belt around the patient's waist, if needed.		
12. Using cane: • Standing: *Teach patient to do the following:* Hold cane in hand opposite weak side.		
Move hips forward in chair.		
Grasp arms of chair.		
Push to standing position.		
Gain balance.		
• Sitting: *Teach patient to do the following:* Turn around and back to chair.		
Grasp arm of chair.		
Lower self into chair.		
• Gait pattern: *Teach patient to do the following:* a) Hold cane 4-6 inches ahead.		
b) Move weak leg ahead, opposite cane.		
c) Put weight on weak leg and cane.		
d) Move strong leg ahead.		
e) Repeat sequence.		
13. Ensure patient's safety throughout the procedure. Nurse stands to side of and behind patient.		
14. Return patient to bed and position for comfort. Remove gait belts. Clean transfer aids per facility policy.		
15. Remove gloves and any other PPE, if used. Perform hand hygiene.		
16. Make sure call bell and other necessary items are within easy reach.		
EVALUATION		
17. Recheck vital signs and compare vital signs.		
18. Check fatigue level. Find out how patient feels.		
DOCUMENTATION		
19. Document the activity, any other pertinent observations, the patient's ability to use the walker, the patient's tolerance of the procedure, and the distance walked.		
20. Document the use of transfer aids and number of staff required for transfer.		
Total Score:		

Comments:_____

Student's Signature over printed name: _____ Date/Time_____

Clinical instructor's signature over printed name: _____ Date/ Time:_____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING CRANIAL NERVE ASSESSMENT

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing cranial nerve assessment.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	Steps in Cranial Nerve Assessment	***3***	***2***	***1***	***0***	***Remarks***
1	Introduce yourself					
2	Wash hands					
3	Briefly explain to the patient what the examination involves					
4	Identify the correct equipment					
I. Olfactory: smell						
5	Instruct client to close both eyes and one naris.					
6	Place a strong smelling item under each nostril individually and ask the person to identify it.					
II. Optic: vision						
7	Ask the patient to look at 20 feet (6 meters) from the					
8	Ask the patient look at hand-held card or **Jaeger or Rosenbaum chart** at distance of 14 inches (about 30 cm) to assess near vision					
III. Oculomotor, IV. Trochlear, VI. Abducens						
9	**Extraocular Movements**					
	Explain the need to keep the head still while following a pen that you will move in several directions to form a star in front of the client's eyes.					
10	Place an object (usually pen) in the front of the patient about 10 cm from the his/her nose.					
11	Instruct the patient to follow the pen as you move it in front of him. Make sure that the objects moves far enough out and up/down. Always return the pen to the centre before changing direction.					

12	Kook at patient's eyes to see all appropriate eye movements as you do the procedure.					
13	Always return the pen to the center before changing direction.					
14	**Accommodation**					
	Hold an object about 10 cm from the client's nose.					
15.	Note the convergence of the eyes and pupillary constriction.					
16	**Direct and consensual pupillary reaction to light test**					
	Using a penlight, starting from the lateral side, swing the light back and forth to one eye every 2-3 seconds.					
17	Note the changes on the pupils of the eye shone with light.					
18	Note the changes on the pupils of the opposite eye (not shone with					
V. Trigeminal						
19	Bilaterally palpate temporal and masseter muscles while patient clenches teeth					
20	**To test for sensation:** Ask client to close his eyes and test forehead, each cheek, and jaw on each side for sharp or dull (use a cotton swab) sensation. Direct the client to say 'now' every time the cotton is felt					
21	**To test for Reflex:** With the individual's eyes open and looking upward, the practitioner takes a strand of cotton, approaches the cornea from the side, and touches it with the cotton. This should initiate a blink response. Both eyes should be tested					
VII. Facial						
22	Ask the client to close both eyes and keep them closed. Try to open them by retracting the upper and lower lids simultaneously					
23	Ask patient to raise eyebrows, show teeth, grimace, smile, puff both cheeks (Assess face for asymmetry, abnormal movements)					
24	Use the sweet, salty, sour and bitter items to test taste (Between each solution the mouth needs to be rinsed with water)					
VIII. Acoustic						
25	**Weber's test::** Strike the tuning fork and place the base of the vibrating tuning fork on the patient's forehead (or the top of the head). Ask if the tone is louder in the left ear, the right ear or					
26	**Rinne's test:** Strike the tuning fork. Using a vibrating tuning fork, place the base of the tuning fork on the client's mastoid process. Ask patient to tell you when the sound is no longer heard. Immediately move the fork in front the external auditory meatus (1-					
27	**Romberg Test:** Patient should stand with feet together on level ground, arms at their sides, and eyes open The examiner should stand facing the patient with their arms out, without touching them, to catch the patient if they fall. Observe the patient for about 20 seconds. Note any swaying or falling. Ask the patient to close both eyes for 20 seconds. Note the patient's ability to maintain an					
IX. Glossopharyngeal and X. Vagus						
28	Ask the client to open the mouth, depress the client's tongue with the tongue blade, ask the client to say "ah" . Usually, *the soft palate raises and the uvula remains in the midline*					
29	Observe the patient swallowing.					
30	Press the back of the tongue using a tongue blade to test gag reflex, warning patient first.					

31	Ask the client to open the mouth, depress the client's tongue with the tongue blade, ask the client to say "ah" . Usually, the soft palate raises and the uvula remains in the midline					
XI. Spinal Accessory						
32	Test the **Trapezius muscle:** have the client shrug the shoulders while you resist with your hands					
33	Ask the client to try to touch the right ear to the right shoulder without raising the shoulder. Repeat with the left shoulder					
XII. Hypoglossal						
34	Ask patient to protrude tongue and move it side to side. Assess for symmetry, atrophy.					
35	Discuss the findings to the patient and document findings.					

Comments:

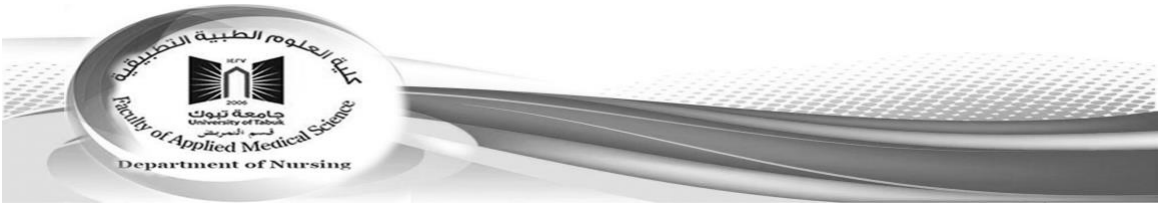
_____

_____

Student's signature over printed name/ Date/ Time:

Clinical Instructor's signature over printed name/ Date/ Time:

COMPETENCY EVALUATION CHECKLIST



CHILD HEALTH NURSING – Practical (NUR 309)

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**
15. Obtains comprehensive client's information by thorough checking of the client's chart.					
16. Interviews the client and/or significant others to gather history and subjective data					
17. Performs Physical Assessment and/ or Neurological Assessment competently and correctly to assess for objective data					
18. Utilizes result/s of laboratory tests/ diagnostic examinations in the analysis of the client's problems/ diagnosis.					
19. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
20. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
21. Performs age-specific nursing interventions/ comfort measures (e.g. oral care, AM care, changing of bed linen).					
22. Implements appropriate nursing interventions based on identified needs					
23. Evaluates nursing care outcomes, allowing for the revision of actions and goals.					
24. Engages in creative problem solving.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
15. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
16. Establishes and maintains effective working relationships within an interdisciplinary team.					
17. Utilizes proper channels of communication.					
18. Participates actively during pre & post conferences					
19. Documents data on client care clearly, concisely, accurately, and in a timely manner					
20. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					

III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**

A. <u>Ability to assess child condition:</u> - Obtain accuratehealth history - Perform physical assessment. - Record data of assessment with accurately					
B. <u>Recognize patient and family needs.</u> - Set priorities for the needs. - Set goals for the care. - Nursing actions to meet child's needs.					
C. Implementation of the plan - Follow aseptic technique. - Give health education according to child/family needs. - Evaluate the care given.					
- Ability to feed the baby accurately (Bottle feeding or gavage feeding)					
- Ability to perform nursing procedures accurately, safely, and comfortably.					
- Vital signs for children and compare the results with normal average according to child age					
- Growth Measurements (Wt., L., HC., CC.)					
- Baby bathing & Diaper care for neonate .					
- Eye care & cord care for neonate.					
- 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. -					
- Compute IV fluids rate and drug dose					
V. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
19. Wears complete uniform C. ID					
B. head cover					
C. shoes and sacks					
J. lab gown with patch and piping					
K. 2-hand watch					
L. clinical kit					
20. Is well-groomed at all times M. (trimmed nails,					
N. no nail polish,					
O. no jewelries,					
P. no make-up					
Q. contact lenses					
R. no perfume					
21. Follows the policies, procedures and guidelines of the e. Course department, university and the affiliating agencies.					
f. Affiliating agencies.					

22. Demonstrates honesty and accountability					

5. Changes behavior in response to constructive criticism/s					
6. Reports for duty E. On time					
F. regularly					
1. Submits requirements on time.					
2. Demonstrate effective time management.					
3. Observes bedside manners and courtesies					
4. Displays caring attitude in professional manner.					
5. Shows initiative in accepting responsibilities and accountabilities.					

Comments:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING BATHING AN INFANT OR SMALL CHILD

(Attachment to Warmth-Radiant Warmer)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in attachment to warmth-radiant warmer. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	3	2	1	0	REMARKS
• Prepare the equipment's & instruments *Basin with warm water * Mild soap *Cotton balls * Soft washcloth *Diaper * Dry clean clothing * Blanket * No sterile gloves * Alcohol pad (If care for umbilical cord care is indicated) * Comb * Baby lotion * Towel					
• Explain the procedure to the patient and family . • Assemble the Equipment at the bedside.					
• Wash hands					
• Assess the child					

• Take & record temperature, pulse and respiration					
• Wash the child from head to feet. Dry washed areas with a towel, giving added emphasis to skin folds					
• Moisten a cotton ball with water and wipe eyes from inner canthus to outer canthus. repeat with a clean cotton ball on the other eye					
• Wet washcloth & wring. Gently wash one side of the face from forehead to chin, going around the nose and mouth. Repeat on other side of the face. Do not use soap on the face					
• Dry infant's face with towel					
• To clean the baby's scalp, pick up baby securely by sliding hand under the baby until the head is well supported in the palm of the hand. Cover ears with thumb and middle finger. Hold baby's head over the basin. Soap and rinse head and dry with towel					
• Continue washing ears and neck, giving particular attention to the skin folds of the neck, behind the ears, and the external part of the ears. Wipe washed areas repeatedly to rinse off soap					
• Remove infant's shirt. Wash trunk and arms. Wash between fingers. Turn infant one on side to wash back					
• Cover infant with a blanket. Rinse and wring washcloth, then wipe away soap. Repeat to ensure removal of soap					
• Dry area with towel. Cover trunk after drying					
• Wash and rinse the infant’s chest and abdomen					
• Use an alcohol wipe to clean gently around the edge of the umbilical cord. Dry the baby, and keep her body covered with a towel.					
• Remove diaper, exposing lower half of body. Keep upper half of body covered with blanket					
• Work down each leg to the foot, using long stroking motions. Wash between toes. give special attention to the area between the toes					
• Wash genitalia with cotton balls. Spread apart the female's labia and clean between folds, using a front to back motion. use each cotton ball for one stroke only					
• The male genitalia should be washed with cotton balls from penis to anus. Do not retract the foreskin of the penis					
• Next wash the anus and between the gluteal fold and buttocks					

• Dry lower half of body. Apply mild baby oil or lotion to skin, don't apply powder to prevent dermatitis and protect skin from inflammation.					
• Re-diaper .Redress and position the infant in the isolate or bassinet					
• Clean the finger nail& toe nail cut if necessary ,Brush and comb hair					
• Document any abnormalities in the skin surface in the medical record					
• Document the infant's tolerance of the bath process					
• Replace equipment's					
• Wash hands					

REMARKS:

_____

_____

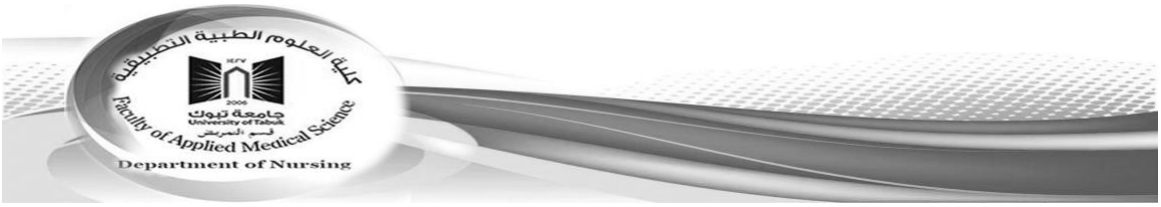
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN CARE OF THE INCUBATOR AFTER DISCHARGE OF THE BABY

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in the *care of the incubator after discharge of the baby.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	3	2	1	0	REMARKS
Wash hands.					
Put on disposable gloves.					
Switch the electricity off from the incubator and the wall socket.					
Remove all detachable parts and soaks it in a soapy solution and warm water for 1 hour.					
Inspect the mattress cover for tears.					
Wash mattress with soap and water, dry it well.					
Wash the inside walls, the floor, and the outside walls of the incubator with soapy solution and warm water then dry it well.					
Wipe the inside and outside wall, floor, mattress of the incubator with Chloride solution 0.5% diluted 10ml/L and let it to dry well.					
Wipe the incubator with distilled water, dry it well.					
After the incubator dry completely, reassembles all the removed parts.					
Remove gloves and discard it.					
Wash hands.					
Document the date and the time of incubator care.					

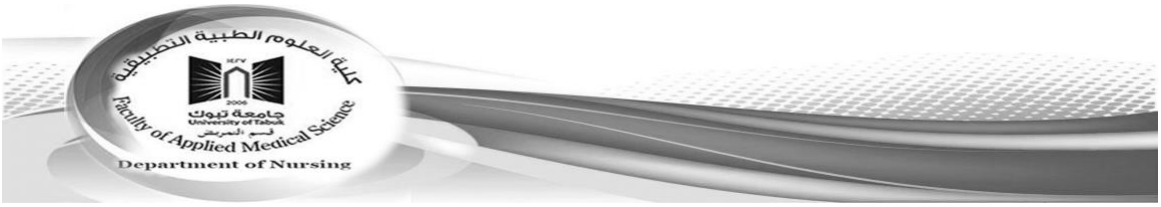
REMARKS:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN CLEANING AND STERILIZATION OF THE INCUBATOR

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *cleaning & sterilization of the incubator.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	3	2	1	0	REMARKS
Wash hands.					
Move the incubator to a suitable area of the nursery.					
Remove all movable parts.					
Soak all the parts in a detergent solution for 1 hour.					
Wipe both the inside and the outside walls of the hood and the base of the incubatorwith a detergent solution. Make sure that all dirt is removed.					
Allow the incubator to dry completelybefore re-assembling it.					
Document the date and time of incubator care.					

REMARKS:

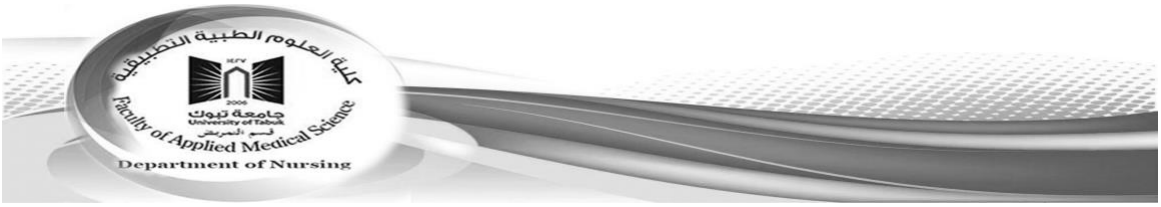
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING DAILY CARE OF THE INCUBATOR



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *daily care of the incubator.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
***0** – Unable to perform even under maximum supervision*
***1** – Performs with maximum supervision*
***2** – Performs correctly with minimal supervision*
***3** – Performs correctly without supervision/independently*

	3	2	1	0	REMARKS
Wash hands.					
Put on disposable gloves.					
Clean the mattresses with warm water using a clean towel or paper tissues then dry it.					
Clean the inside walls of the incubator with a warm water then dry it.					
Cover the mattress with a sheet and tuck it under the sides.					
Fill the humidity reservoir with distilled water.					
Clean the outside walls of the incubator with a warm water or using disinfectant solution (Chlorine 0.5% diluted in 10ml/l).					
Check that temperature is between 28-35°C.					
Check that humidity is between 55-65%.					
Monitor oxygen flow rate and concentration as prescribed.					
Remove gloves and discard it.					
Wash hands.					

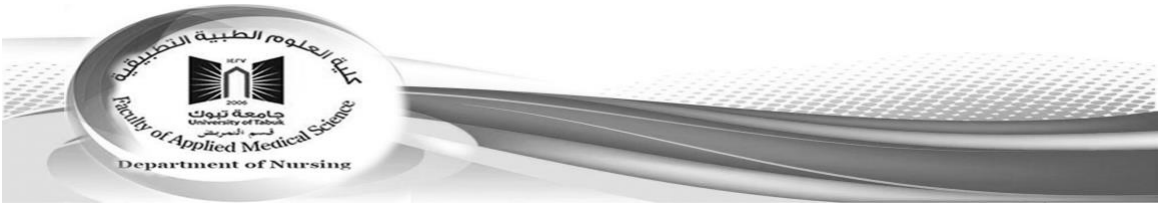
REMARKS:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PREPARING THE INCUBATOR FOR A NEW BABY



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *preparing the incubator for a new baby checklist.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
Wash hands.					
Warm and oxygenate the incubator.					
Check the physician's order as regarding adjustment.					
Cover the mattress with a sheet and tuck it under the sides.					
Explain the needs of incubator care to the parents of neonate.					
Adjust the incubation parameters and maintain, follow the chart.					
Remove the cloths of the neonate and place inside the incubator.					
Provide meticulous care as long neonate remains inside.					
Continue care through port hole.					
Report to the doctor if baby is not maintaining the normal temperature.					
Do not bring the neonate out without justifiable cause.					
Document time and condition of the neonate.					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN OBTAINING A URINE SPECIMEN FOR ANALYSIS

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *obtaining a urine specimen for urine analysis*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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 isconsistently ineffective and inefficient

	3	2	1	0	REMARKS
1.Prepare the equipment's * Sterile container * Urine collection bag * Label specimen clearly * Deliver specimen immediately to the lab (Bacteria may grow at room temperature)					
2.Explain the procedure a. Apply newborn and pediatric urine collection * The skin must be clean and perfectly dry * Avoid oils, baby powder & lotion soap * Application must begin on the tiny area of skin between the anus and genitals * The narrow bridge on the adhesive patch keep feces from contaminating the specimen and help position the collector correctly b. Put the child on his back, spread the legs and wash each skin fold in genital area c. Do not use a scrub soap solution d. Wash the anus last, allow a few moments for air drying e. Remove protective paper from the bottom half of the adhesive patch g. For girl, stretch the perineum to separate the skin folds and expose the vagina h. For boys, begin between the anus and the base of scrotum i. Press adhesive firmly against the skin and avoid wrinkles, remove paper from the upper portion of adhesive patch					
3. Use a sterile container or apply a urine collection device					
4. If a bag is used, Secure the diaper over the bag					
5. Check bag every 20 to 30 minutes					
6. Label all specimens clearly and attach the proper laboratory slip, collected specimens should be transported in plastic bag (check institution policy)					

7.Document procedure					

REMARKS: _____

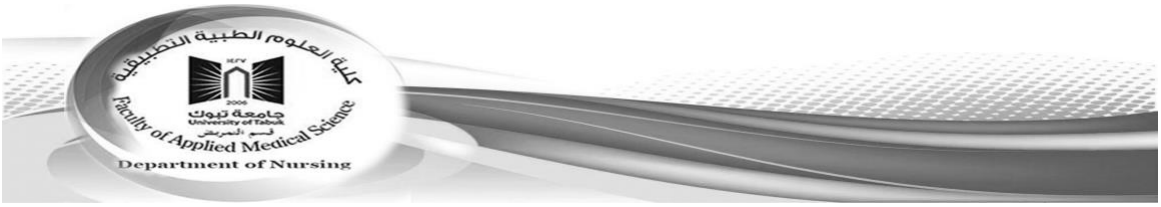
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN OBTAINING THROAT CULTURE

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *obtaining throat culture*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
• Prepare the equipment's * Throat swab * Tongue depressor * Media culture					
• Explain the procedure to the woman & describing the sensation to expect					
• Gather equipment					
• Wash hand, wears gloves					
• Have child stick out tongue and say "ah"					
• Depress anterior half of tongue with tongue depressor if necessary					
• Swab area with exudates or redness, one time only per swab (Avoid teeth, tongue, cheeks, lips & palate					
• Be sure parents or nurse comfort child					
• Label, obtain requisition					
• Transport to laboratory					
• Document procedure, including description of pharyngeal area if you can see it					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____

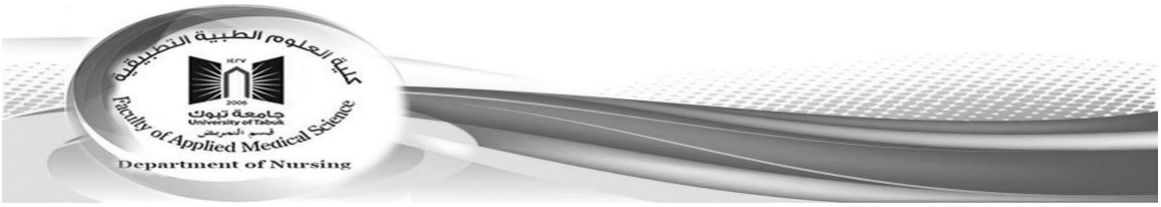
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING OXYGEN THERAPY

Name of Student: _____ **Section:** _____ **Group:**_____

Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing oxygen therapy*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
• Prepare the equipment's & instruments					
• Explain the procedure to the child and allow him or her to feel the equipment and the oxygen flowing through the tube, mask					
• Maintain a clear airway by suctioning, if necessary					
• Measure oxygen concentration every 1-2hours when a child is receiving oxygen through incubator hood or tent ✓ Measure when the oxygen environment is closed ✓ Measure the concentration close to the child's airway ✓ Record oxygen concentrations and simultaneous measurements of pulse & respiration					
• Observe the child response to oxygen					
• Organize nursing care so that interruption of therapy is minimal					
• Periodically check all equipment during each tour of duty					
• Clean equipment daily and change it at least once each week					
• Keep combustible materials & potential sources of fire away from oxygen therapy Pt teaching: • Avoid using oil or grease around oxygen connections • Do not use alcohol or oils on a child in an oxygen tent • Do not permit any electrical devices in or near an oxygen tent • Avoid the use of wool blankets and those made from some synthetic fiber because of the hazards resulting from static electricity • Prohibit smoking in areas where oxygen is being used • Have a fire extinguisher available					
Terminate oxygen therapy gradually a. Slow reduce liter flow b. Open air events in incubators Continually monitor the child's response during weaning.					

a. Observe for restlessness b. Increase pulse rate c. Observe respiratory distress, cyanosis					
Oxygen by mask 1. Choose an appropriate size mask that cover the mouth and nose but no the eye 2. Use a mask that is capable of delivering the desired oxygen concentration 3. Place the mask over the child, s mouth and nose so that it fits securely. Secure the mask with an elastic head grip 4. Remove the oxygen mask at hourly intervals, wash the face & dry Do not use masks for comatose infant or children					
Face tent 1. Face tent are available in the adult size only 2. A flow of 8-10 L should be to flush the system and provide a stable oxygen concentration					
Incubator oxygen therapy 1. The incubator is used to provide a controlled environment for the neonate 2. Adjust the oxygen flow to achieve the desired oxygen concentration a. An oxygen limiter prevents the oxygen concentration inside the incubator from exceeding 40% b. Higher concentrations (up to 85%) may be obtained by placing the red reminder flag in the vertical position					

3. Secure a nebulizer to the inside wall of incubator if mist therapy is desired 4. Keep sleeves of incubator closed to prevent loss of oxygen 5. Periodically analyze the incubator atmosphere					
Oxygen hood					

1. *Warmed, humidified oxygen is supplied through a plastic container that fits over the child's head 2. *Continuously monitor the oxygen concentration, temperature & humidity inside the hood 3. Open the hood or remove the baby from its infrequently as possible 4. Several different designs are available for use. The manufacture's direction should be carefully followed					

REMARKS:

_____

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROMOTING POSTURAL DRAINAGE IN PEDIATRIC PATIENT

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *promoting postural drainage in pediatric patient.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
Preparatory phase 1. Assess the child's respiratory status a. Obtain a baseline respiratory rate b. Observe for respiratory distress retraction, nasal flaring, and so forth					
2. Identify the involved portions of the lung by auscultation, percussion or review of the x ray report					
3. Explain the procedure to the child or the parent					
4. Make the child comfortable a. Remove constricting clothes b. Flex the child's knee and hips c. Have tissue and an emesis basin available d. Have several pillows available					
5.Provide bronchodilator or nebulization therapy prior to the procedure if indicated					
Performance phase 1. Place the child in asides of appropriate position a. Thereat to be drained should be elevated The spine should be as straight as possible to permit optimal expansion of the rib cage					
2. Unless contraindicated, cup the chest wall for 1-2 minutes					
3. Have the child inhale deeply, then, as he exhales, vibrate the chest wall during three to five exhalation					
4. Encourage the child to cough					
5. Allow the child to rest for a minute, then repeat cupping vibration and coughing until no more mucus is produced or the child, s condition indicates that the procedure should be stopped					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING RESTRAINT

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing restraint.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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 isconsistently ineffective and inefficient

	3	2	1	0	REMARKS
Equipment • Jacket (For jacket restraint) • Large dressing, gauze bandage, adhesive tape and stoknette if available (For mitt restraint) • A commercially prepared mitt (For mitt restraint) • Safety pins (For elbow restraint) • Elbow restraint					
Jacket Restraint 1.Check physician's order and agency policy regarding use of restraints.					
2. Gather equipment.					
3. Wash hands					
4. Explain purpose of restraints to child and parents. Reassure child that restraint is not a punishment					
5. Place the jacket on the patient gown and tie it from back					
6. Ensure that patient's gown and jacket are not wrinkled					
7.Secure each tie to unmovable portion of the bed , using half bowknot which is easily removed					

8.Secure shoulder straps to head of the bed					

9.Secure abdomen straps on either sides					
Mitt or hand restraint 1.Place a large folded dressing in patient's palm • Separate the fingers with a piece of large dressing • Put a padded dressing around the wrist • Place two large dressings over the hand, one is first placed from the back of the hand over the fingers to the palm and the other is then wrapped from side to side around the hand • Cover these dressing by placing stoknette dressings over the hand or elastic bandage, using the recurrent pattern • Secure the stoknette or elastic bandage with adhesive tape					
*2. Apply commercially made restraints • a. If mitts are worn for several days remove them at least every twelve hours, wash, exercise the hand and reapply again					
Elbow restraint 1. Check the restraints to make sure that the tongue depressors are intact and in place					
2. Apply elbow restraint over gown sleeves					
3. Make sure the end of the tongue depressors are covered by padded material					
4. Place elbow in the center of restraint					
5. Warp the restraint smoothly around the arm					
6. Secure the restraint, using safety pins, ties or strings					
7. Ensure that it is not too tight so not to occlude blood					

Clove hitch restraint 1. prepare the equipment • Bandage 5-8 cm wide and 90 –120 cm long • Cotton • Commercially made restraint					

2. Apply 2-3 layers of cotton around ankle or wrist					
3. Make 2 loop forming finger of 8					
4. Pick up the two loops					
5. Make sure that the loops are small to fit patient hands					
6. Using half – bow knot attach the end of restraint to the end of the bed spring					
7. Check every two hours and readjust accordingly					
Mummy restraint 1. Prepare the equipment • Blanket or sheet • Safety pins or adhesive tape					
2. Lay the blanket or sheet on flat dry surface					
3. Fold down one corner of the blanket and place the baby on it the supine position, make sure that the infant shoulder touches the upper border of the blanket					
*4. Fold the right side of the blanket over the infant's body and tuck it under his back leaving the left arm free					
Crip net restraint 1. prepare the equipment * A stretch net with long strap					
2. Place the net over sides and ends of the Crip					
3. Secure the tie to bed frame					
4. Tie the strap in half –bow knot					

REMARKS: _____

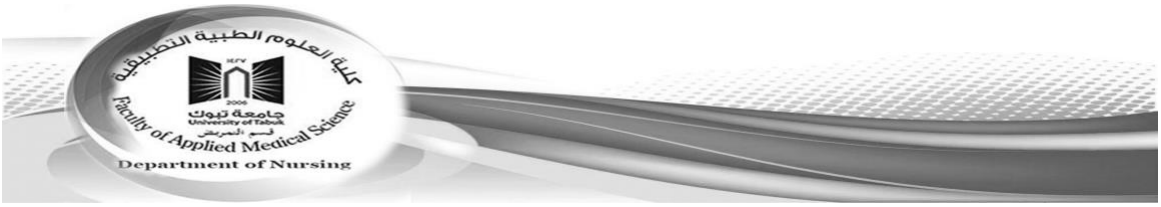
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN ADMISNITERING FEEDINGS THROUGH GASTRIC TUBES

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *administering feedings through gastric tubes.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
Administering Feedings Through Gastric and Enteric Tubes					
1. Determines type of feeding, rate of infusion, and frequency of feeding.					
2. Checks expiration date of the feeding formula.					
3. Warms formula to room temperature (for continuous feedings, keeps formula cool but not cold).					
4. Shakes the feeding formula to mix well.					
5. Elevates head of the bed at least 30°.					
6. Places a linen saver pad under the connection end of the feeding tube.					
7. Dons procedure gloves.					
8. For the first feeding, verifies tube placement by: a. Aspirating stomach contents and measuring pH. b. Confirms findings by asking the patient to speak. c. For NG and NE tubes, but not for gastrostomy or jejunostomy tubes, can also confirm by injecting air into the tube and auscultating					
9. For subsequent feedings, aspirates and measures gastric residual (except for jejunostomy tubes). a. Connects syringe to the proximal end of the feeding tube. b. Measures volume of aspirated contents using syringe (if volume is more than 60 mL, uses graduated container). c. Reinstalls aspirate unless the volume is more than the formula flow rate for 1 hour (or alternatively, a total of 150 mL). If the aspirate volume is more than the formula flow rate for 1 hour or 150 mL, notifies the physician.					
11. Flushes the feeding tube with 30 mL of tap water.					
• ***Beginning the Feeding***					
If Using Open System and Syringe:					
• a. Clamps or pinches off the end of the feeding tube.					

• b. Attaches the syringe to the proximal end of the feeding tube.					
• c. Fills the syringe with the prescribed amount of formula.					
• d. Releases tube clamp or "pinch," and elevates the syringe. Does not elevate syringe >18 inches above the tube insertion site.					
• e. Allows feeding to flow slowly (if too fast, lowers the syringe).					
• f. When the syringe is 3/4 empty, clamps tube or holds it above the level of the stomach; refills syringe; unclamps and continues feeding until prescribed amount is administered.					
Ending Feeding					
• When feeding is infused, clamps or pinches off the proximal end of the feeding tube. If an infusion pump was used, turns off the pump before pinching off the proximal end of the feeding tube.					
• Disconnects the syringe or administration tubing from the feeding tube. Flushes the feeding tube with 30 mL of tap water. If administering a continuous feeding, flushes the tube with the prescribed amount of water (typically 50 to 100 mL) every 4 to 6 hours.					
• Caps the proximal end of the feeding tube.					
• Changes tube feeding bag, administration set, and syringes every 24 hours (or according to agency policy).					
• Keeps head of patient's bed elevated at least 30° for 1 hour after administering the feeding.					

REMARKS: _____

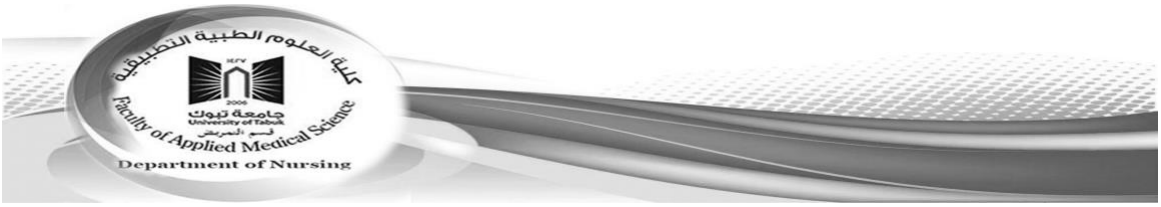
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN WEIGHTING & MEASURING THE NEWBORN

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____



DIRECTIONS: Below is a list of criteria to evaluate the student's skill in ***weighing & measuring the newborn.*** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	**2**	**1**	**0**	**REMARKS**
Prepare the equipment's & instruments					
• Scale					
• Cover sheets					
• Paper tape measure					
Weighting					
1. Place cover sheet on scale					
2. Wear gloves if newborn has not been bathed					
3. Adjust the scale balances to 0, or push the appropriate pads on the digital scales, using a protective barrier on your hand					
4. Record weight on baby's chart. Weight baby at the same time					
Measuring the length					
• 1. To measure length, place the newborn in supine position on the crib mattress, with the hand against the top of crib					
• 2. Place the paper tape measure beside the infant, with the 0 end of the tape against the top of the crib					
• 3. Wear gloves if the newborn has not been bathed					
• 4. Hold the newborn's head straight with one hand, and extended one leg, with the other hand					
• 5. Watch that the tape measures remain straight					
• 6. Note the length and record it in the infant's chart					
• 7. Compare your finding with the normal range, most infants are 48 to 53 cm in length					
Measuring the head circumferences					
• 1. Place the paper tape under the newborn's head to measure head Circumferences. Compare your finding with the normal range, most infants are 32-37 cm.					

• 2. Wrap the tape around the newborn's head, measuring just above the eyebrows so that the largest area of the occiput is included					
• 3. Record your finding in the infant's chart					
To measure chest circumference					
• 1.Place the paper tape under the newborn's chest, at nipple level					
• 2. Wrap the tape around the chest, at the nipple line					
• 3. Note the circumference and record it in the infant's chart. Chest circumference is measured at the nipple line, average chest circumference is 30.5 to 33 cm					

REMARKS:

_____

_____

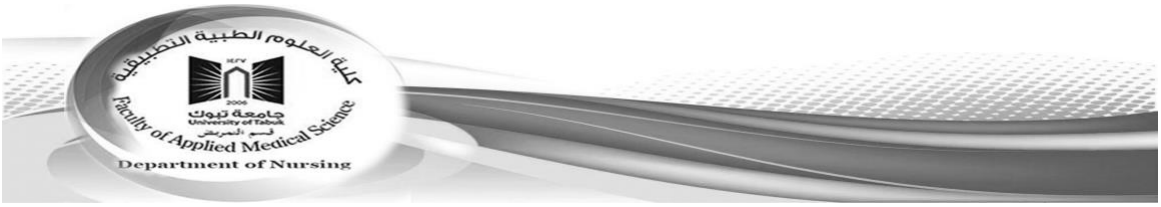
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN TEMPERATURE TAKING

Name of Student: _____ **Section:** _____ **Group:**_____



Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *temperature taking.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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 isconsistently ineffective and inefficient

	3	2	1	0	REMARKS
Prepare the equipment's & instruments *Thermometer 1. Oral bulb 2. Rectal or stubby bulb 3 Electronic (Interchangeable oral and rectal probes) 4. Tympanic probe 5. Gloves					
Explain the procedure to the patient and family y. assemble the Equipment at the bedside.					
Oral determination a. Wash hand b. Select an instrument (oral, stubby or electric) c. If the thermometer has been stored in chemical solution, rinse it with water and wipe it dry with a soft tissue d. Shake a glass thermometer until the mercury is below the 35.5 c mark. Firmly hold the non-bulb end of the thermometer and briskly snap the hand at the wrist. If using an electronic thermometer, remove from charger and slide cover over probe e. Place the bulb under the right side of the child tongue. Have the child close mouth around the thermometer (If the child is over the age of 6 years) f. Leave the thermometer under the tongue for 3-5 minutes. Stay with the child while thermometer is in place					

g. *If an electronic thermometer is used, use the oral probe with a disposable plastic probe cover. The thermometer will signal when the peak temperature has been reached h. Remove the thermometer from the mouth and read the temperature • After use, wipe thermometer with soft tissue, rinse in cold water, and store according to policy					
Rectal determination a. Wash hand b. Select an instrument (Rectal /stubby or electric) and provide privacy for the child c. Rinse, wipe and shake the rectal thermometer as in oral temperature. If an electronic thermometer is used, remove from charger and slide cover over probe d. Lubricate the bulb with a water-soluble gel Infant **1.** place infant prone, spread the buttocks with one hand and insert the thermometer slowly and gently with other hand **2.** Insert the bulb into the rectum about 1/4 -1/2. **3.** If resistance is felt, remove thermometer and choose another route					
Older child • Position child on side, separate buttocks to expose the anal opening • Gently insert the thermometer into the rectum about 1- 11/2 • Hold thermometer in place for 3-4 minutes or until electronic thermometer signal is heard • Never leave child alone with a rectal thermometer in place • Remove the thermometer in a straight line • Wipe it off with a soft tissue. If an using an electronic thermometer • Insert probe into base and store in charger • Read the temperature • Reposition child in a comfortable position and clean thermometer according to the policy					

Axillary determination • Wash hand • Select instrument – follow institution policy concerning whether to use a rectal or oral thermometer • Rinse, wipe and shake the thermometer as suggested in the procedure for obtaining an oral temperature. If an electronic thermometer is used, remove from charger and place cover on probe • Place the bulb under the arm, well up into the armpit. Bring the child's arm down close to the body and hold in place • Leave in place 10 minutes or until electronic thermometer signal is heard					

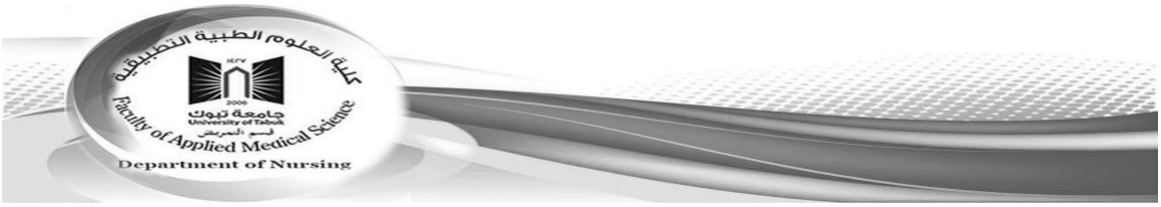
REMARKS:

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN TAKING RESPIRATION



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *taking respiration*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
Approach the child in a quiet, non – threatening manner					
In the infant, note the rise and fall of the abdomen with each inspiration and expiration					
In the older child, note the rise and fall of the chest with each inspiration and expiration					
Using a watch with a sweep hand, count the respiration for 30 -60 seconds, depending on the age of the child					
Compare to the average rates at rest					
Record the findings according to policy					

TOTAL SCORE on SKILLS: ____/____ pts
TOTAL SCORE EQUIVALENT:

- Add all scores divided by total number of items observed, multiply by 100

REMARKS:

_____

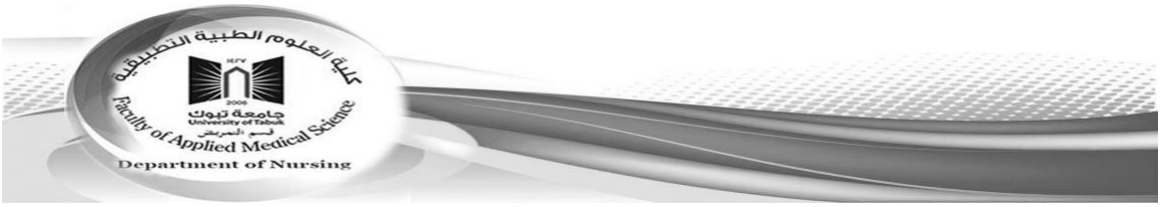
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING PULSE TAKING



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *taking a pulse*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

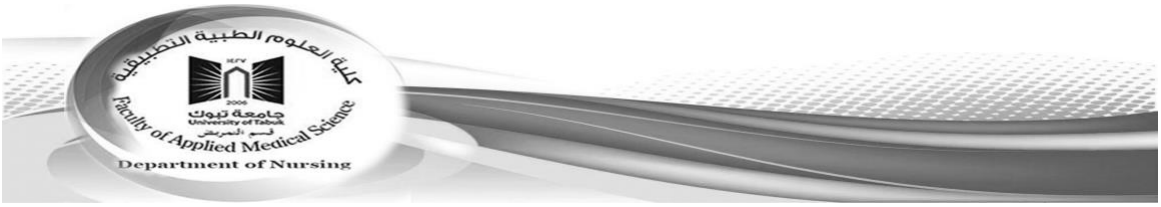
	3	2	1	0	REMARKS
Infant & young child and all cardiac patients – Apical rate 1.Take the apical rate before any other vital sign measurement is attempted					
2.Place the stethoscope between the left nipple and sternum					
3.Count the beats for 1 minute					
Older child – Radial rate 1.Place the first, second or third finger along the child's radial artery and press gently against the radius.					
2.Rest the thumb in opposition to the fingers on the back of the child's wrist					
3.Apply only enough pressure so that the child's pulsating artery can be felt					
4.Count the arterial pulsations for 30 seconds and multiply by 2 to calculate the rate for one minute. If the pulse rate is abnormal, palpate the pulse for 1 full minute					
5.Assess rhythm (Regularity versus irregularity), amplitude (Strength of pulsation), & elasticity of the vessel (Distension of vessel) while counting the rate					
6.Accurately record the following in the medical record a. Rate b. Quality of the pulse c. Location felt d. Regularity or irregularity of rate e. Activity of child at time pulse is taken					
7. Report any changes in pulse characteristics to the physician immediately					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING BLOOD PRESSURE TAKING



Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *blood pressure taking*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

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

	3	2	1	0	REMARKS
Prepare the equipment's & instruments					
• Stethoscope					
• Appropriate size cuff					
• Sphygmomanometer					
Auscultation: brachial Artery					
• 1. Place the infant or child in a sitting or recumbent position. The forearm is supinated and slightly flexed					
• 2. Remove all clothing from the upper extremity					
• 3. Demonstrate the equipment and procedure to the child using appropriate terminology.					
• 4. Check equipment for connection and function					
• 5. Place the correct size cuff around the upper arm with the inflatable portion centered over the blood vessel. The lower edge should be 3 cm above the antecubital fossa					
• 6. Locate the artery by palpation at the antecubital fossa					
• 7. Close the air valve and rapidly inflate the cuff to 30 mm Hg above the expected systolic pressure or until the radial pulse disappears					
• 8. Place the stethoscope gently over the artery					
• 9. Slowly release the air valve, permitting the column of mercury to fall at a rate of 2-3 mm per heartbeat					
• 10. After readings have been made, the cuff is deflated and removed from the arm					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____
Clinical Instructor's signature over printed name/ Date/ Time: _____

APPENDIX C

FIRST SEMESTER

4TH YEAR / LEVEL 7

1. **Mental Health Nursing Practical (NUR 404)**
2. **Community Health Nursing Practical (NUR 402)**

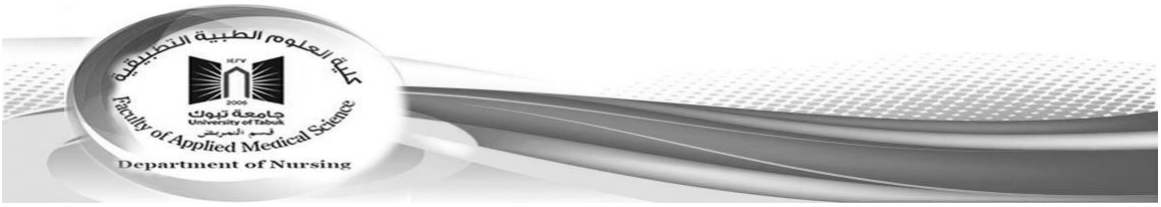
COMPETENCY EVALUATION CHECKLISTS

and

PERFORMANCE SKILLS CHECKLIST

COMPETENCY EVALUATION CHECKLIST

MENTAL HEALTH NURSING – Practical (NUR 404)



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

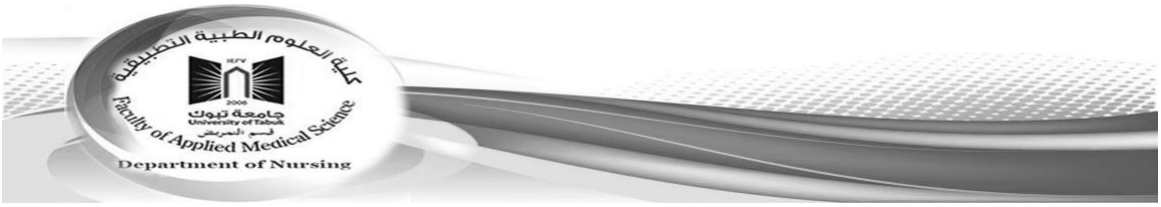
I. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
• Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
• Establishes and maintains effective working relationships within an interdisciplinary team.					
• Utilizes proper channels of communication.					
• Participates actively during pre & post conferences					
• Documents data on client care clearly, concisely, accurately, and in a timely manner					
• Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
II. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
• Demonstrates knowledge and ability to properly assess mental status:					
○ A – PPEARANCE					
○ B- EHAVIOUR					
○ C-OGNITION					
• Demonstrates ability to communicate and collaborate with the health care team within mental health environment.					
III. TREATMENTS AND INTERVENTIONS	**3**	**2**	**1**	**0**	**REMARKS**
• Demonstrates knowledge and ability to implement psychosocial/ therapeutic interventions.					
• Demonstrates appropriate use of communications techniques during patient interaction.					
• Documents correct MSE assessment					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
• Wears complete uniform & is well-groomed at all times.					
• Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
• Demonstrates honesty and accountability					
• Changes behavior in response to constructive criticism/s					
• Reports for duty on time.					
• Submits requirements on time.					
• Demonstrate effective time management.					
• Observes bedside manners and courtesies.					

REMARKS: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN PERFORMING MINI MENTAL STATUS EXAMINATION

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing *Mini Mental Status Examination*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

MINI MENTAL STATUS EXAMINATION CHECKLIST	3	2	1	0	*Remarks*
1. Explains the procedure briefly to the patient.					
2. Checks patient's orientation by asking: • 'What is the year, season, month, day, date?' • 'Where are we: country, province, city, hospital, room?'					
3. Checks patient's memory – registration • Names three unrelated objects, taking 1 second to say each. • Then asks the patient to repeat all three. (Rehearses the answers if needed until the patient has learnt all three).					
4. Checks patient's attention and calculation 2 methods acceptable here: • Asks patient to count backwards by 7s, starting with 100 (93, 86, 79, 72, 65). Stops patient after these 5. OR • Asks the patient to spell the word 'world' backwards.					
5. Checks patient's memory – recall • Asks the patient to repeat the names of the three objects learned in question 3 above.					
Checks patient's language – naming • Points to a pencil and a watch, asks the patient to name them as s/he points					
Checks patient's language – repetition • Asks patient to repeat after her/ him (one trial lonely allowed): 'No ifs, ands or buts'.					
6. Checks patient's language – 3 stage command • Tells the patient, once only: 'Take this paper in your right hand. Fold the paper in half. Put the paper on the floor.'					
7. Checks patient's language – reading • Writes large on a piece of paper: 'Close your eyes'; asks patient to read and carry out instruction.					

8. Checks patient's language – writing • Asks patient to write a sentence of his/ her choice. Check if the sentence has a subject and a verb and make sense (spelling not important)					
9. Checks patient's ability to copy Asks patient to copy a design provided (it is on the table). Check the point if all 5 sides are preserved and if the intersecting sides form a diamond shape					
10. Communicates the examination findings briefly to the patient					

Remarks:

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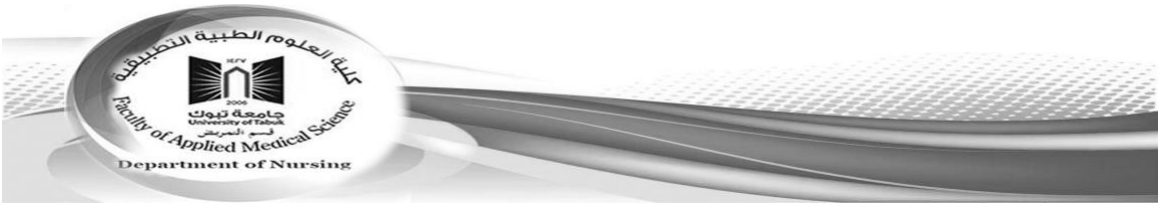
Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN PERFORMING NURSE-PATIENT INTERACTION

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing nurse patient interaction*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	3	2	1	0	Remarks
1.Address patient by name; introduced self and role; used clear, specific communication.					
2. Assess patient's need, coping strategies, defenses, and adaptation styles.					
3. Assess patient language, ability to speak, literacy level and patient's ability to hear, ensured patient hears and understand words.					
Orientation Phase					
4. Create a climate of warmth and acceptance, was aware of non-verbal cues, provided comfort and support.					
5. Use appropriate non-verbal behavior					
6. Observe patient non-verbal behaviors, sought clarification if necessary.					
7. Explain purpose of interaction when information was being shared.					
8. Use active listening					
9. Interview patient about health status, lifestyle, support system, patterns of health and illness, and strengths and limitation.					
10. Encourage patient to ask clarification at any time.					
Working Phase					
11. Use therapeutic communication techniques when interacting with patient.					
12. Help patient express needs and feeling.					
13. Use question carefully and appropriately, asked one question at a time' used direct question, used open-ended statements as much as possible					
14. Avoid communication barriers or non-therapeutic communication technique					
15. Observe patients verbal and non-verbal responses and willingness to share information and concerns					
16. Note your response to patient and patient's response to you, reflected on effectiveness of technique.					

Termination Phase					
17. Use therapeutic communication skills to discuss discharge or termination issues, guided discussion to patient changes in thoughts and behavior					
18. Summarize with patient what was discussed during interaction and restated goals, reinforced patient strengths, outlined issues requiring work, develop an action plan.					

Remarks:

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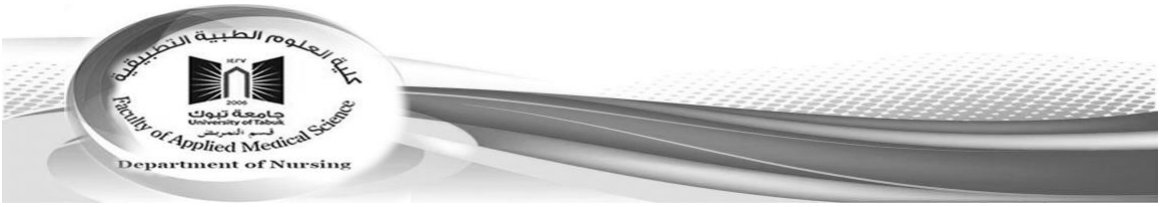
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN PERFORMING MUSIC & ART THERAPY

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing music & art therapy*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

	3	2	1	0	Remarks
1. Prepare all the materials needed: bond paper, crayon, soft & slow music					
2. Gather the patients.					
3. The facilitator greets each other member of the group					
4. The facilitator says something positive to each person					
5. The facilitator gives his or her name and asked the patient to create a relaxed and comfortable atmosphere.					
6. The facilitator could also comment on the appearances' of the patients or could ask questions like the date or food at breakfast.					
7. Explain the mechanics of the activity: • Give the details about the activity (**Music therapy**). • The patient will listen to slow and fast music. • Then, while listening to the music they will draw whatever they remember or what they think when they hear slow or fast music. • Start first the slow music,(Let the patient draw ,do not interrupt the patient). • Next, they will listen to fast music.					
8. The patient will explain their drawing.					
9. The facilitator will ask questions about the drawing to gain more information about.					
10. Give appreciation by clapping hands.					
11. After the activity collect the drawing of the patient.					
12. After the activity check if all the materials are complete.					
13. Express appreciation of their participation for attending the activity.					

Remarks:
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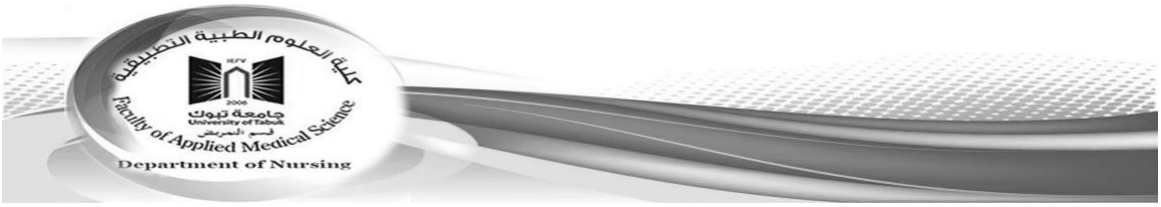
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS



SKILLS IN PERFORMING BIBLIOTHERAPY

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing *bibliotherapy*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

Material needed:

Visual aid_ Story Book

1.Prepare all the materials needed.					
2. Gather the patients.					
3. The facilitator greets each other member of the group.					
4. The facilitator says something positive to each person.					
5. The facilitator gives his or her name and asked the patient to create a relaxed and comfortable atmosphere					
6. The facilitator could also comment on the appearances' of the patients or could ask questions like the date or food at breakfast.					
7. Explain the mechanics of the activity to the patient: • Give the details of the activity (Bibliotherapy). • The facilitator will present the story using the prepared visual aids. (Make sure to avoid topics about violence, sex, crime, politics, religion and family problems) • Then the facilitator will ask questions about the story presented.					
8. Lastly the facilitator will ask each patient the moral lessons of the story.					
9. Give appreciation by clapping hands.					
10. Express appreciation of their participation for attending the activity.					

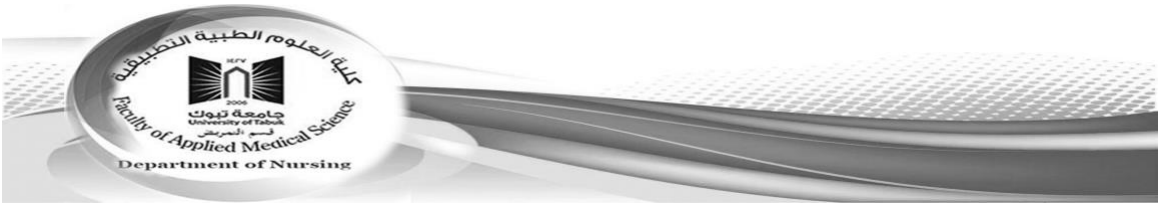
Remarks:
_____
_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

COMPETENCY EVALUATION CHECKLIST

COMMUNITY HEALTH NURSING – Practical (NUR 402)



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**
25. Obtains comprehensive client's information by thorough checking of the client's m. Chart					
n. Interview					
o. Performs Physical Assessment and/ or Neurological Assessment					
p. Laboratory tests/ diagnostic examinations					
26. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
27. Prioritizes from the identified problems					
28. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
29. Performs safe and effective nursing care.					
30. Implements appropriate nursing interventions based on identified needs					
31. Evaluates nursing care.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
21. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
22. Establishes and maintains effective working relationships within an interdisciplinary team.					
23. Utilizes proper channels of communication.					
24. Participates actively during pre, post and bedside conferences.					
25. Documents data on client care clearly, concisely, accurately, and in a timely manner					
26. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
27. Assist in endorsement of patient and other patient related handover cases.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
PROVISION OF BASIC HEALTH SERVICES					
A. ASSESSMENT					
a. 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 Analysis 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					
a. Formulates with the client a plan of care to address the health condition, needs, and problems based on priorities.					
b. Plan and integrate health promotion into all aspects of community health nursing.					
C. IMPLEMENTATION					
a. Performs hand washing before and after every procedure.					
b. Explain procedure in a comprehensive manner to the client and support system.					
c. 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.					
d. 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.					
e. Under Five/ Child Health Care:					
1. Performs Growth and Development Monitoring appropriately (height, weight and head circumference)					
2. Administer proper vaccine safely.					
3. Give appropriate health teaching.					
f. Chronic Care:					
1 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.					
2 Performs independent nursing care (such as: glucose monitoring test, wound care, first aid, TSB)					
3 Implements safe and quality nursing care during the pre -, intra - and post – diagnostic and treatment procedures.					
g. Conduct brief and concise health education for promote, preventive, curative and rehabilitative aspects of care.					
h. Uses strategies to encourage independence and enable clients to maintain their own health.					
D. EVALUATION					
a. Evaluates the response of the client regarding the effectiveness of nursing care based on the expected outcomes of the nurse – client working relationship.					
b. Documents client's responses to nursing care provided.					
c. Uses research and evaluation skills to improve the quality of community health.					
d. Evaluates with the client the effectiveness of nursing care based on the expected outcomes of the nurse – client working relationship.					

V. VALUES AND ATTITUDE	3	2	1	0	REMARKS
23. Wears complete uniform D. ID					
B. head cover					
C. shoes and sacks					
M. lab gown with patch and piping					
N. 2-hand watch					
O. clinical kit					
24. Is well-groomed at all times S. (trimmed nails,					
T. no nail polish,					
U. no jewelries,					
V. no make-up					
W. contact lenses					
X. no perfume					
25. Follows the policies, procedures and guidelines of the g. Course department, university and the affiliating agencies.					
h. Affiliating agencies.					
26. Demonstrates honesty and accountability					
5. Changes behavior in response to constructive criticism/s					
6. Reports for duty G. On time					
H. Regularly					
6. Submits requirements on time.					
7. Demonstrate effective time management.					
8. Observes bedside manners and courtesies					
9. Displays caring attitude in professional manner.					
10. Shows initiative in accepting responsibilities and accountabilities.					

INSTRUCTOR'S REMARKS AND SUGGESTIONS:

_____

_____

_____ _____

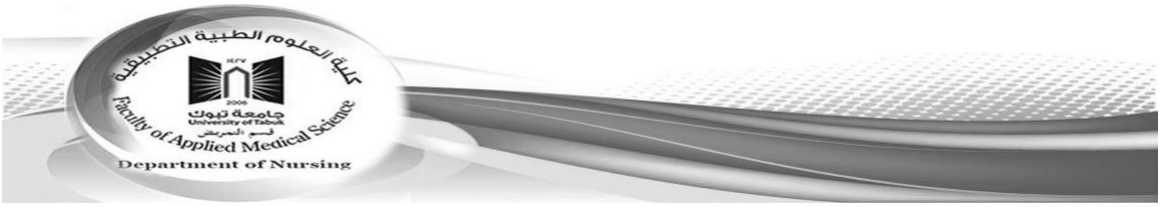
Student's Signature over Printed Name: **Clinical Instructor's Signature over Printed Name:**

Date: _____ **Date:** _____

PERFORMANCE SKILLS CHECKLISTS

ADMINISTERING VACCINE (General Procedure)

Name of Student: _____ **Section:** _____ **Group:**_____



Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in administering vaccine. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

ADMINISTERING VACCINE	3	2	1	0	Remarks
Greet client and make him/her comfortable.					
Obtain client's record and verify the immunization schedule.					
Ensure that the client is healthy before administering the vaccine. Screen for contraindications.					
Prepare needed materials. Select appropriate needle size.					
Obtain right vaccines needed from the refrigerator/storage box.					
Check for expiration date.					
Reconstitute according to the manufacturer's guidelines (if necessary).					
Choose the right route.					
Position patient so the administration site is accessible.					
Instruct the mother how to properly hold the baby.					
Locate the preferred site correctly.					
Cleanse injection site by circling from the center of the site outward.					
Allow the site to dry before administering the injection.					
Provide appropriate health teachings to the mother/guardian.					
Handwashing done before and after the procedure.					
Procedure is properly documented (if allowed)					

Comments:
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_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

ADMINISTERING VACCINE (Hexa 6, Hib 4, PCV,MCV, Hepa A)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in administering vaccine. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

ADMINISTERING VACCINE	**3**	**2**	**1**	**0**	**Remarks**
1. With nondominant hand, hold the skin taut.					
2. Insert needle at a 90° angle to the skin with a quick thrust by dominant hand.					
3. Stabilize syringe while pressing plunger to inject the vaccine.					
4. Inject the entire amount of vaccine.					
5. Remove the needle smoothly along the line of insertion.					
6. Apply dry cotton balls to injection site.					
7. Engage safety needle device, and disposes in biohazard container. If there is no safety device, places uncapped syringe and needle directly in biohazard puncture-proof container.					
8. Observed aseptic technique					
9. Ensured safety of patient					

Comments:
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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

ADMINISTERING VACCINE (Measles, MMR, Varicella)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in administering vaccine. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

ADMINISTERING VACCINE	3	2	1	0	Remarks
1. With nondominant hand, pinch up subcutaneous tissue.					
2. Insert needle at a 45° angle to the skin.					
3. Stabilize syringe while pressing plunger to inject the vaccine.					
4. Inject the entire amount of vaccine.					
5. Remove the needle smoothly along the line of insertion.					
6. Apply dry cotton balls to injection site.					
7. Engages safety needle device, and disposes in biohazard container. If there is no safety device, places uncapped syringe and needle directly in biohazard puncture-proof container.					
8. Observed aseptic technique					
9. Ensured safety of patient					

Comments:

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_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

ADMINISTERING VACCINE (OPV, Rotarix)

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in administering vaccine. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

ADMINISTERING VACCINE	3	2	1	0	Remarks
1. Remove the protective tip cap from the oral applicator.					
2. Position the infant in a nursing or feeding position.					
3. For Rotarix, administer the entire amount of the liquid slowly down one side of the inner mouth cheek (between the cheek and gum) toward the back of the infant's mouth and allow the infant to swallow the vaccine.					
4. For OPV, administer 2 drops.					
5. Ensure that the tip of the container does not touch the infant's mouth (OPV).					
6. Ensure that the vaccine is swallowed and retained.					
7. Administer single replacement dose if the infant spits out, fails to swallow, or regurgitates most of the vaccine dose					
8. Discard the empty applicator and cap in approved biological waste container.					
9. Observed aseptic technique					
10. Ensured safety of patient					

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

Well-Baby Clinic Visit

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in well-baby clinic visit. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

Well-baby Clinic Visit	3	2	1	0	Remarks
Greet client and make him/her comfortable.					
Obtain client's record and gather needed information.					
Check for body temperature and record.					
Assess for baby's weight.					
Assess for baby's height.					
Assess for baby's head circumference.					
Record height in growth chart.					
Record weight in growth chart.					
Record head circumference in growth chart.					
Interpret assessment findings.					
Provide health teachings to the mother/guardian.					
Observed aseptic technique					
Ensured safety of patient					

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING HEIGHT MEASUREMENT

Name of Student: _____Section:_____ Group:____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *height measurement* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– (progress unacceptable) Unable to perform even under maximum supervision*
1 *– (needs improvement) Performs with maximum supervision*
2 *– (progress acceptable) Performs correctly with minimal supervision*
3 *– (competent) Performs correctly without supervision/independently*

Height measurement	3	2	1	0	REMARKS
1. Explain procedure for children and her mother					
2. Gather equipment					
3. Wash hand					
4. Remove the child's shoes and socks.					
5. Stand as tall and straight as possible with head in midline and the line vision parallel to the floor.					
6. The child's back should be to the vertical flat surface with hells, buttocks and back of the shoulder touching the surface.					
7. Any flexion of the knees, lumping of the shoulders or raising of heels of the feet is checked and corrected.					
8. Move the board on the top of the head.					
9. Read and record.					
Height using measuring tape: **1.** Explain procedure for children and her mother					
2. Gather equipment					
3. Wash hand					
4. Attach a measuring tape to the wall					
5. Place the child adjacent to the tape.					
6. Place a three dimensional object, such as thick book or box on the top of the head.					
7. The side of the book must rest firmly against the wall to form a right angle.					
8. Length or stature is measured to the nearest 1ml.					
9. Record.					

Comments:

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Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

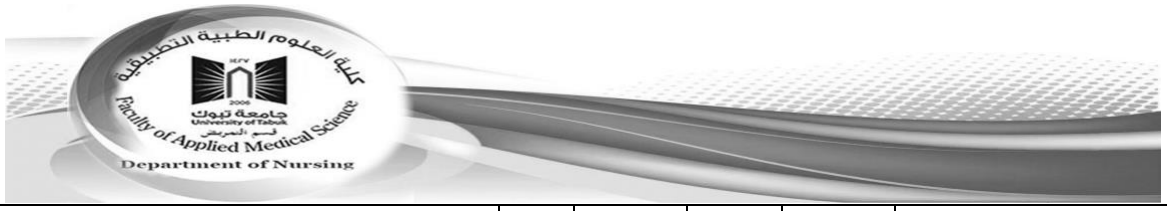
PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING WEIGHT MEASUREMENT

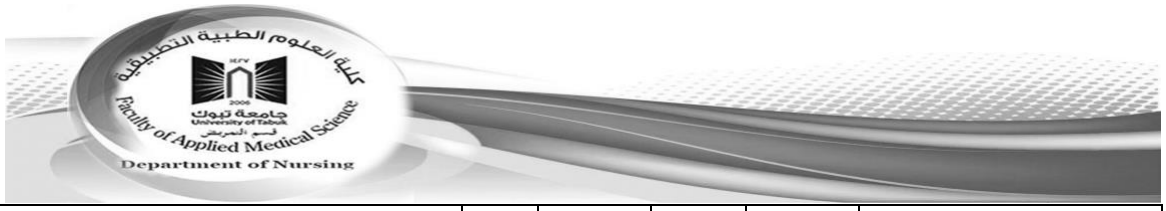
Name of Student: _____Section:_____ Group:____
Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *weight measurement* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*



Weight measurement	**3**	**2**	**1**	**0**	**REMARKS**
1. Explain procedure for children and mother					
2. Gather equipment					
3. Wash hand					
1. Place the scale horizontally.					
2. Check to see that scale is balanced by sitting it to the zero, and noting if the balance registers exactly in the middle of the mark.					
3. Make the patient room warm.					
4. Wipe the scale with cotton with alcohol.					
5. Remove the infant clothing.					
6. Put a scale paper on the scale.					
7. Gently lift the infant from the bed and place him in the scale basket.					
8. For safety, hold hand over the body of the infant.					
9. Adjust the weight to balance the scale by right hand.					
10. Read the scale when the infant is lying still.					
11. Remove and dispose the scale paper.					
12. Record the weight.					
13. Report any abnormalities					
<u>Weight for older children</u>: 1. Explain procedure for children and mother					
2. Gather equipment					
3. Wash hands					
4. Balance the scale.					
5. Place a paper towel on the scale for the child to stand on.					
6. Keep child privacy.					



7. Child usually weighed while wearing their underpants or light gown.					
8. Remove shoes of the child.					
9. Read and record.					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING NEBULIZATION

Name of Student: _____Section: _____ Group:_____
Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Nebulization. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R):
Based on the student's performance
0 *– (progress unacceptable) Unable to perform even under maximum supervision*
1 *– (needs improvement) Performs with maximum supervision*
2 *– (progress acceptable) Performs correctly with minimal supervision*
3 *– (competent) Performs correctly without supervision/independently*

NEBULIZATION	3	2	1	0	REMARK
1. Interprets order correctly					
2. Identifies and gathers supplies					
3. Washes hands					
4. Positions the patient appropriately					
5. Attaches tubing to air compressor					
6. Measures medication accurately					
7. Opens nebulizer cup, instills medicine, closes cup and attaches the tubing					
8. Turns on power switch, checks mist.					
9. Starts treatment, placing mouth piece in mouth or mask over nose and mouth/trach					
10. Allows all medication to be used before ending treatment, flicking nebulizer cup to restart if necessary					
11. Encourage the patient to cough, suction if needed					
12. Wash hands					
13.Proceed with aftercare					
14. Document					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

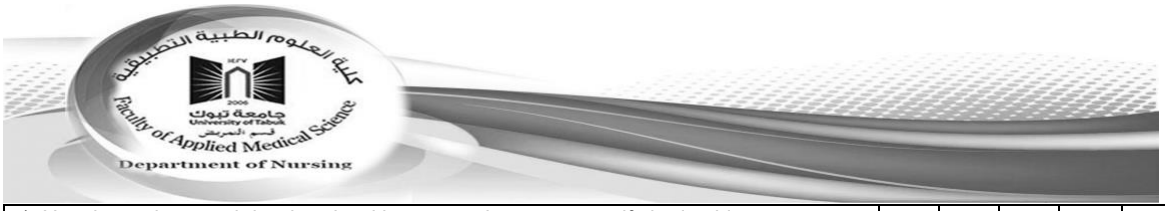
CHECKING FINGERSTICK (CAPILLARY) BLOOD GLUCOSE LEVELS

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Checking Fingerstick (Capillary) Blood Glucose levels**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

CHECKING FINGERSTICK (CAPILLARY) BLOOD GLUCOSE LEVELS	3	2	1	0	Remarks



1. Has the patient wash her hands with soap and warm water, if she is able.					
2. If patient is in bed, assists to semi-Fowler's position if possible.					
3. Turns on the glucose meter. Calibrates according to manufacturer's instructions.					
4. Checks expiration date on the container or reagent strips.					
5. Removes a reagent strip, then tightly seals container.					
6. Checks that the reagent strip is the correct type for the monitor being used.					
7. Dons procedure gloves.					
8. Selects a puncture site on the lateral aspect of a finger (heel or great toe for an infant).					
9. Positions the finger in a dependent position and massages toward the fingertip.					
10. For infants, older adults, and people with poor circulation, places a warm cloth on the site for about 10 minutes before obtaining the blood sample.					
11. Cleanses the site with an antiseptic pad, or according to facility policy, and dries it with a gauze pad.					
12a. Engages the sterile lancet and removes the cover.					
12b. Places the back of the hand on the table, or otherwise secures the finger so it does not move when pricked.					
12c. Positions the sterile lancet firmly against the skin, perpendicular to the puncture site. Pushes the release switch, allowing the needle to pierce the skin.					
13. If there is no injector, uses a darting motion to prick the site with the lancet.					
14. Lightly squeezes the patient's finger above the puncture site until a droplet of blood has collected.					
15. Wipes away the first drop and squeezes again to form another droplet.					
16. Places reagent strip test patch close to the drop of blood. Allows contact between the drop of blood and the test patch until blood covers the entire patch. Does not "smear" the blood over the reagent strip.					
17. Allows the blood sample to remain in contact with the reagent strip for the amount of time specified by the manufacturer.					
18. Using a gauze pad, gently applies pressure to the puncture site.					
19. Places the reagent strip into the glucose meter. (Some manufacturer's instructions require you to first wipe the reagent strip with a cotton ball so that no blood remains on the test patch. Follows individual manufacturer instructions.)					
20. After the meter signals, reads the blood glucose level indicated on the digital display.					
21. Turns off the meter and disposes of the reagent strip, cotton ball, gauze pad, paper towel, alcohol pad, and lancet in the proper containers.					
22. Removes the procedure gloves and disposes of them in the proper container.					

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN REMOVING AND APPLYING DRY DRESSING

Name of Student: _____ **Section:** _____ **Group:**_____
Student no.:_____ **Date:** _____ **Score:**_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Removing and Applying Dry Dressing. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

PERFORMING REMOVING AND APPLYING DRY DRESSING	3	2	1	0	Remarks
Places the patient in a comfortable position that provides easy access to the wound.					
Washes hands and applies clean gloves.					

Loosens the edges of the tape of the old dressing. Stabilizes the skin with one hand while pulling the tape in the opposite direction.					
Beginning at the edges of the dressing, lifts the dressing toward the center of the wound.					
If the dressing sticks, moistens it with 0.9% (normal) saline before completely removing it.					
Assesses the type and amount of drainage present on the soiled dressing.					
Disposes of soiled dressing and gloves in a biohazard bag.					
Removes the cover of a tray of sterile 4×4 gauze. Moistens the gauze with sterile saline.					
Applies clean gloves.					
Gently cleanses the wound with the saline-moistened gauze by lightly wiping a section of the wound from the center toward the wound edge.					
Discards the gauze in a biohazard receptacle and repeats in the next section, using a new piece of gauze with each wiping pass.					
Discards gloves and soiled gauze into a biohazard bag.					
Washes hands.					
Opens sterile gauze packages on a clean, dry surface.					
Applies clean gloves.					
Applies a layer of dry dressings over the wound; if drainage is expected, uses an additional layer of dressings.					
Removes gloves, turning them inside out, and discards in a biohazard receptacle.					
Places strips of tape at the ends of the dressing and evenly spaced over the remainder of the dressing. Uses strips that are sufficiently long to secure the dressing in place.					

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING ADMINISTERING OXYGEN THERAPY

Name of Student: _____ Section:_____ Group:____

Student no.: _____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for oxygen therapy**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Based on the student's performance
0 *– Unable to perform even under maximum supervision*
1 *– Performs with maximum supervision*
2 *– Performs correctly with minimal supervision*
3 *– Performs correctly without supervision/independently*

Steps to follow for Administering Oxygen	3	2	1	0	Remarks
12. Verify the prescribing practitioner's order.					
13. Perform hand hygiene, put on PPE (if indicated).					
14. Identify the patient.					
15. Gather equipment on overbed table. • Oxygen source • Oxygen delivery device (i.e. nasal cannula, face mask) • Oxygen flow meter • Oxygen humidifier • Distilled water or normal saline • Pulse oxymeter					
16. Close curtains around bed and close the door to the room, if possible.					
17. Explain what you are going to do and the reason for doing it to the patient. Review safety precautions necessary when oxygen is in use.					
18. Connect the appropriate oxygen delivery device to oxygen setup with humidification. Set-up humidification as needed.					
C. Administer oxygen **by nasal cannula:**					
19. Adjust flow rate as ordered.Check that oxygen is flowing out of prongs.Place prongs in patient's nostrils. Keep flange against upper lip.					
20. Place tubing over and behind each ear with adjustercomfortably under chin. Place gauze pads at ear beneath the tubing, as necessary.					
21. Adjust the fit of the cannula, as necessary. Tubingshould be snug but not tight against the skin.					
22. Encourage patients to breathe through the nose, with the mouth closed.					
D. Administer oxygen **by oxygen mask:**					
8. Start the flow of oxygen at the specified rate. For a mask with a reservoir, be sure to allow oxygen to fill the bag before proceeding to the next step.					
15. Position face mask over the patient's nose and mouth.					
16. Adjust the elastic strap so that the mask fits snugly but comfortably on the face.					

17. If patient reports irritation, or you note redness, use gauze pads under the elastic strap at pressure points.					
18. Reassess patient's respiratory status (respiratory rate, effort, and lung sounds); any signs of respiratory distress (tachypnea, nasal flaring, use of accessory muscles, or dyspnea).					
19. Remove PPE, if used. Perform hand hygiene.					
20. (nasal cannula): Put on clean gloves. Remove and clean the cannula an assess nares at least every 8 hrs. Check nares for evidence of irritation or bleeding. (mask): Remove the mask and dry the skin every 2-3 hrs if oxygen is running continuously. Do not use powder around mask.					
TOTAL SCORE:					

Comments:

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

APPENDIX D

SECOND SEMESTER

4TH YEAR / LEVEL 8

Critical Care Nursing Practical (NUR 406)

1st Aid and Emergency Nursing Practical (NUR 411)

Nursing Leadership and Management Practical (NUR 408)

COMPETENCY EVALUATION CHECKLISTS

and

PERFORMANCE SKILLS CHECKLIST

COMPETENCY EVALUATION CHECKLISTS

CRITICAL CARE NURSING PRACTICAL (NUR 406)

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					
Interview					
Performs Physical Assessment and/ or Neurological Assessment					

Laboratory tests/ diagnostic examinations					
2. Formulates nursing diagnosis (actual, risk, and potential) based on the gathered nursing problems					
3. Prioritizes from the identified problems					
4. Sets attainable and measurable objectives appropriate to the identified nursing diagnoses					
5. Performs safe and effective nursing care.					
6. Implements appropriate nursing interventions based on identified needs					
7. Evaluates nursing care.					
II. COMMUNICATION AND DOCUMENTATION	**3**	**2**	**1**	**0**	**REMARKS**
8. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
9. Establishes and maintains effective working relationships within an interdisciplinary team.					
10. Utilizes proper channels of communication.					
11. Participates actively during pre, post and bedside conferences.					
12. Documents data on client care clearly, concisely, accurately, and in a timely manner					
13. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
14. Assist in endorsement of patient and other patient related handover cases.					
III. TECHNICAL SKILLS	**3**	**2**	**1**	**0**	**REMARKS**
15. Ability to assist in preparing all of the equipment needed					
16. Wears Personal Protective Equipment (PPE) accordingly					
17. Uses aseptic technique during the whole procedure as necessary					
18. Draws the possible causes for the alarm conditions of the machines being used (dialysis machine, mechanical ventilator etc.)					
19. Monitors possible complications using appropriate assessment technique (bleeding, infection, tube disconnections etc.)					
20. Demonstrates competence in preforming basic ICU nursing skills: A. Assesses patient's Glasgow Coma Scale (GCS) B. Examine the ECG tracing in the Cardiac Monitor					
21. Demonstrates competence in performing nursing skills for: **a. Central lines** A. Assist in the care of patients with CVP					
B. Discusses the normal parameters and chest landmarks for CVP measurement					
C. Determines and records CVP using a water manometer and pressure monitor					
7.2 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: _____					
22. Monitors patients receiving common cardiac medications					
V. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
23. Wears complete uniform E. ID					
B. head cover					
C. shoes and sacks					
D. lab gown with patch and piping					
E. 2-hand watch					
A. clinical kit					

24. Is well-groomed at all times (trimmed nails,					
no nail polish,					
no jewelries,					
no make-up					
contact lenses					
no perfume					
25. Follows the policies, procedures and guidelines of the i. Course department, university and the affiliating agencies.					
j. Affiliating agencies.					
26. Demonstrates honesty and accountability					
27. Changes behavior in response to constructive criticism/s					
28. Reports for duty On time					
Regularly					
29. Submits requirements on time.					
30. Demonstrate effective time management.					
31. Observes bedside manners and courtesies					
32. Displays caring attitude in professional manner.					
33. Shows initiative in accepting responsibilities and accountabilities.					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING CARE FOR A PATIENT ON A MECHANICAL VENTILATOR

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *care of patient on mechanical ventilator*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

STEPS in CARE FOR A PATIENT ON A MECHANICAL VENTILATOR	3	2	1	0	Remarks
1. Verifies ventilator settings with the physician's order.					

2. Wear PPE					
3. Identify patient					
4. Prepare equipment					
5. Prepares a resuscitation bag: Attaches a flow meter to one of the oxygen sources; attaches an adapter to the flow meter; and connects the oxygen tubing to the adapter.*Note: The respiratory therapy department is responsible for setting up mechanical ventilators in most agencies*.					
6. Checks the ventilator alarm limits. Makes sure they are set appropriately.					
7. Attaches the ventilator tubing to the endotracheal or tracheostomy tube.					
8. Places the ventilator tubing in the securing device.					
9. Prepares the suction equipment					
10. Checks the ventilator tubing frequently for condensation.					
11. Checks the ventilator tubing frequently for condensation.					
12. Never drains the fluid into the humidifier.					
13. Checks ventilator settings regularly.					
14. Provides the patient with an alternate form of communication, such as a letter board or white board.					
15. Repositions regularly, being careful not to pull on the ventilator tubing.					
16. Provides frequent oral care, moistens the lips with a cool, damp cloth and water-based lubricant.					
17. Ensures that the call light is always within reach and answers call light and ventilator alarms promptly.					
18. Document					
Total items **18 items**					

Comments: _____

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

Evaluator's Signature over

Date: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING CENTRAL VENOUS PRESSURE MONITORING USING HEMODYNAMIC MONITORING (TRANSDUCER)

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *CVP Monitoring using Hemodynamic*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

STEPS in CVP Monitoring Using Hemodynamic	3	2	1	0	Remarks
1. Perform hand hygiene					
2. Explain the procedure to the patient					

3. Check all connectors on tubing as they may be loose. Ensure all connections are secure					
4. Before attaching the system to the patient, remove air and prime the line by opening the stopcock to room air and flushing saline through the line.Be sure to eliminate all air bubbles as they can be a main factor affect the waveform .					
5. Insert the IV bag into the pressure bag on the IV pole and inflate the pressure bag.					
6. Connect transducer directly to CVC port					
Beginning procedure					
7.Attached the CVC to intravenous fluid within a pressure bag. Ensure that the pressure bag is inflated up to 300mmHg.					
8. Place the patient flat in a supine position if possible. Alternatively, measurements can be taken with the patient in a semi-recumbent position. The position should remain the same for each measurement taken to ensure an accurate comparable result.					
1. Find the three-way tap that leads from the fluid bag to the CVC. Catheters differ between manufacturers, however, the white or proximal lumen is suitable for measuring CVP.					
2. Tape the transducer to the phlebostatic axis or as near to the right atrium as possible. OR Insert transducer into the transducer holder that mounts onto the IV pole					
11. Turn the tap off to the patient and open to the air by removing the cap from the three-way port opening the system to the atmosphere.					
12. Press the zero button on the monitor and wait while calibration occurs. When 'zeroed' is displayed on the monitor, replace the cap on the three-way tap and turn the tap on to the patient.					
13. Observe the CVP trace on the monitor. The waveform undulates as the right atrium contracts and relaxes, emptying and filling with blood. (light blue in this image)					

14. Document the measurement and report any changes or abnormalities.					
Post procedure					
15. check the patient's vital signs every 2 hours or more frequently if the patient's condition indicates					
16. 2-Continue monitoring of the CVP waveform if using the hemodynamic monitoring system.					
17. 3-Measure the CVP every 2 hours and as needed if using the water manometer method					
18. Document Patients tolerance of the procedure, Cardiopulmonary assessment and Assess and labeled CVP waveform, if appropriate					

Comments:

_____

_____

Student's Signature over Printed Name
Date: _____

Evaluator's Signature over Printed Name
Date: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING GLASGOW COMA SCALE MONITORING

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *Glasgow coma scale monitoring*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

STEPS IN GLASGOW COMA SCALE	3	2	1	0

1. Identify the patient and explain the procedure.				
2. Wash hands				
3. Use appropriate PPE.				
4. Provide privacy.				
5. Check level of consciousness • **Full Consciousness-** Check for patient's alertness, attentiveness and ability to follow command. If asleep, she responds promptly to external stimulation and once awake remains attentive				
• Lethargy- Check if patient is drowsy. She will answer questions & follow commands, b do so slowly & inattentively				
• **Obtundatio**n- Check patient if she/he is difficult to arouse and needs constant stimula in order to follow a simple command. Patient may respond verbally with one or two words, bu drift back to sleep between stimulation				
• **Stupor-** Elicit pain (nail bed pressure, supraorbital notch pressure), patient arouses to vigorous & continuous stimulation, patient may moan briefly but does not follow commands, Patient attempt to withdraw from or remove the painful stimulus.				
• **Coma**- Patient does not respond to continuous or painful stimuli, does not move excep possibly, reflexively & does not make any verbal sounds				
6. Eye Opening • E4 – (Spontaneous) Observe the patient's eyes. Patient opens eyes spontaneously, give score of 4.				
• E3 – (Opens To speech) ask the patient loudly and clearly to open eyes. If patient responds by opening eyes, give score of 3.				
• E2 – (To pain). Apply nail bed pressure, patient opens eyes after pressure, give score of 2.				
• E1 - (No response) Apply nail bed pressure, if patient has no response give 1.				
• Record **C** if eyes closed by swelling				

7. Verbal Response • V5 – Oriented to TIME, PLACE, and PERSON. Ask the patient to answer "What day is today? "Where are you at this moment?" If patient answers correctly, give 5.				
• V4 - (Confused). Ask the patient to answer "What day is today? "Where are you at this moment?", if the patient appears slightly confused or disoriented during conversation, give 4.				
• V3 – (Inappropriate words). If patient has random or muddled speech without exchange of info during conversation, give 3.				
• V2 – (Incomprehensible words). If patient is making sounds but is unable to formulate words, give 2.				
• V1 – (No response). IF patient is unable to produce sounds, give1. Don't confused this with aphasia due to laryngeal injury or airway obstruction.				
Record **E** if endotracheal tube is in place, **T** if tracheostomy tube is in place				

8.	Motor Response • M6 – (Obeys command). Shake the patient's hand upon arrival. A patient responds and does what you ask, give 6.				
	• M5 – (Localized pain) elicit a pain (Supraorbital notch, or nailbed pressure), if patient purposefully attempts to remove the stimulus or pushes away your hand away from pain, give 5.				
	• M4 – (Flex to withdraw from pain). Elicit a pain (Supraorbital notch, or nailbed pressure), if patient pulls away from stimulus, give 4.				
	• M3 – (Abnormal flexion). Elicit a pain (Supraorbital notch, or nailbed pressure), if patient's arms moves toward their chest, their fingers and wrist flex on their chest and they point their toes, and assumes decorticate position, give 3.				
	• M2 – (Abnormal extension). Elicit a pain (Supraorbital notch, or nailbed pressure), if patient's arms and legs extend, wrist rotate away from their body and they point their toes, and assumes decerebrate position, give 2.				
	• M1 – (No response). Patient does not have motor response, give 1.				
9.	Give the total GCS **Eye - ___/4 +** **Verbal= ___/5 +** **Motor= /6 =** **____/15**				
10.	Interpret the results of total GCS GCS 15 : NORMAL GCS 13-14 : minor depression of consciousness GCS 9-12 : moderate depression of consciousness GCS 3-8 : COMA				
11.	Pupillary Assessment • P-upils- Let the patient sit in a dimly lit room. Assess pupils if they are at the center of the iris, which is the colored part of the eyes. Pupils dilates and constricts when light enters the eyes.				
	• E-qually- Check for the same size of the pupils.				
	• R-ound- Check for the perfect round shape of the pupils.				
	• R-eactive to Light.- Move a penlight to the patient's eyes back and forth every two distance and ask patient to look at a distance, check both pupils react to light at the same time.				

	• and Accomodation. Tell patient to focus on a pen or index finger. Move it towards and away from patient, and side to side, check if pupils can properly focus. The pupils constricts when watching an object that's shifting perspectives.				
12.	Interpret Pupil Assessment. Pupils are PERRLA. Pupils are equally round, and reactive to light and accommodation.				
13.	Document findings				
	TOTAL				

Comments:
_____

_____ _____

Student's Signature over Printed Name **Evaluator's Signature over Printed Name**

Date: _____ Date: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING TRACHEOSTOMY CARE

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing tracheostomy care*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

PERFORMING **TRACHEOSTOMY CARE**	**3**	**2**	**1**	**0**	**Remarks**
1. Identify patient					
2. Identify equipment needed: Sterile gloves, Hydrogen peroxide, Normal saline solution or sterile water, Cotton-tipped applicators-Q tips, Dressing, Twill tape, Type of tube prescribed, if the tube is to be changed					
3. A cuffed tube air is injected into cuff) is required during mechanical ventilation. A low-pressure cuff is most commonly used. Patients requiring long term use of a tracheostomy tube and who can breathe spontaneously commonly on uncuffed, metal tube.					
4. Inspect the tracheostomy dressing for moisture or drainage.					
5. Perform hand hygiene.					
6. Explain procedure to patient and family as appropriate.					
7. Places the patient in semi-Fowler's position.Places a towel or linen-saver pad over the patient's chest.					
8. Put on clean gloves, remove & discard the soiled dressing in a biohazard container.					
9. Prepare sterile supplies. Pours hydrogen peroxide into one of the sterile solution containers and pours normal saline solution into the other one.					
10. Opens three 4×4 gauze packages; wets the gauze in one package with hydrogen peroxide; wets the gauze in another package with normal saline; keeps the third package dry.					
11. Opens 2 cotton-tipped applicator packages. Wets the applicators in one package with normal saline solution and wets the applicators in the other package with hydrogen peroxide.					
12. Opens the package containing a new disposable inner cannula, if available.					
13. Opens the package of Velcro tracheostomy ties or cuts a length of twill tape long enough to go around the patient's neck two times. Makes sure to cut end of the tape on an angle.					
14. Dons sterile gloves (or sterile on dominant and clean on non-dominant hand); keeps the glove on the dominant hand sterile. Handles the sterile supplies with the dominant hand only.					
15. With the non-dominant hand removes the oxygen source, if the patient has been receiving supplemental oxygen.					
16. Unlocks and removes the inner cannula with the non-dominant hand and cares for it accordingly: a. Disposable Inner Cannula: Disposes of the inner cannula in the biohazard receptacle according to agency policy.					
b. Reusable Inner Cannula: Places the inner cannula into the basin filled with hydrogen peroxide.					
17. Attaches the oxygen source to the outer cannula, if possible.					
18. Removes the oxygen source, using non-dominant hand, (if the patient requires supplemental oxygen) and reinserts the inner cannula into the patient's tracheostomy in the direction of the curvature.					
19. Reattaches the oxygen source, if indicated.					
20. Cleans the stoma under the faceplate with the cotton-tipped applicators saturated with hydrogen peroxide, using a circular motion from the stoma site outward.					
21. Uses each applicator only once and then discards it.					

22. Cleans the top surface of the faceplate and the skin around it with the gauze pads saturated with hydrogen peroxide. Uses each gauze pad only once, and then discards it.					
23. Repeats steps 20, 21, and 22, using the cotton-tipped applicators and gauze pads saturated with normal saline.					
24. Dries the skin and outer cannula surfaces by patting them lightly with the remaining dry gauze pads.					
25. Removes soiled tracheostomy stabilizers: a. Variation: Velcro Tracheostomy Holder: With an assistant stabilizing the tracheostomy tube, disengages the Velcro on both sides of the soiled holder and removes it gently from the eyes of the faceplate. Discards the Velcro holder in the nearest biohazard receptacle.					
b. Variation: Twill Tape Tracheostomy Ties: With the assistant stabilizing the tracheostomy tube, cuts the soiled tracheostomy ties using bandage scissors. Avoids cutting the tube of the tracheostomy balloon. Removes the ties gently from the eyes of the faceplate and discards them in the nearest biohazard receptacle.					
26. Has the patient flex his neck and applies new tracheostomy stabilizers.					
a. Using Twill Tape: 1) Threads one end of the twill tape into one of the eyelets on the tracheostomy faceplate; continues to thread the twill tape through the eyelet, bringing both ends of the tape together.					
2) Brings both ends of the twill tape around the back of the patient's neck.					
3) Threads the end of the twill tape that is closest to the patient's neck through the back of the eyelet on the faceplate.					
4) Has the assistant place one finger under the tape while tying the two ends together in a square knot.					
27. Inserts a precut, sterile tracheostomy dressing under the faceplate and new tracheostomy stabilizers.					
28. Disposes of used equipment/supplies in the appropriate biohazard receptacle, according to agency policy.					
Total					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

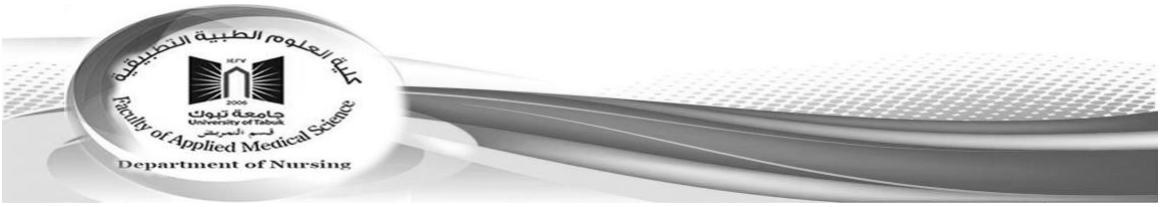
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING SUCTIONING

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *suctioning*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*



PERFORMING TRACHEAL SUCTIONING	**3**	**2**	**1**	**0**	**Remarks**
1. Positions the patient in semi-Fowler's position, unless contraindicated.					
2. Places a linen-saver pad or towel on the patient's chest.					
3. Puts on a face shield or goggles.					
4. Turns on the wall suction or portable suction machine and adjusts the pressure regulator according to agency policy (typically 100 to 120 mm Hg for adults, 95 to 110 mm Hg for children, and 50 to 95 mm Hg for infants).					
5. Tests the suction equipment by occluding the connection tubing.					
6. Opens the suction catheter kit or the gathered equipment if a kit is not available.					
7. Dons sterile gloves. Considers the dominant hand sterile and the non-dominant hand nonsterile.					
8. Pours sterile saline into the sterile container, using the non-dominant hand.					
9. Picks up the suction catheter with the dominant hand and attaches it to the connection tubing.					
10. Puts the tip of the suction catheter into the sterile container of normal saline solution and suctions a small amount of normal saline solution through the catheter. Applies suction by placing a finger over the suction control port of the suction catheter.					
11. Hyper-oxygenates the patient according to agency policy: a. Patient Requiring Mechanical Ventilation: Presses the 100% O_2 button on the ventilator or attaches the resuscitation bag to the endotracheal tube or tracheostomy tube and manually hyper-oxygenates the patient by compressing the resuscitation bag 3 to 5 times as the patient inhales. Removes the resuscitation bag and places it next to the patient when finished. b. Patient Not Requiring Mechanical Ventilation: Attaches the resuscitation bag to the tracheostomy or endotracheal tube and hyper-oxygenates the patient by compressing the resuscitation bag 3 to 5 times. Removes the resuscitation bag and places it next to the patient when finished.					
12. Lubricates the suction catheter tip with normal saline.					
13. Using the dominant hand, gently but quickly inserts the suction catheter into the endotracheal tube or tracheostomy tube.					
14. Advances the suction catheter, with suction off, gently aiming downward and being careful not to force the catheter.					
15. Applies suction while withdrawing the catheter.					
16. Does not apply suction for longer than 10 seconds.					
17. Repeats suctioning as needed, allowing at least 30-second intervals between suctioning.					
18. Hyper-oxygenates patient between each pass.					
19. Replaces the oxygen source, if the patient was removed from the source during suctioning.					
20. Coils the suction catheter in the dominant hand (alternatively, wraps it around the dominant hand). Pulls the sterile glove off over the coiled catheter.					

21. Discards the glove and catheter in a water resistant receptacle designated by the agency.					
22. Using the non-dominant hand, clears the connecting tubing of secretions by placing the tip into the container of sterile saline.					
23. Provides mouth care.					
TOTAL					

Comments:
_____
_____

Student's signature over printed name/ Date/ Time: _____

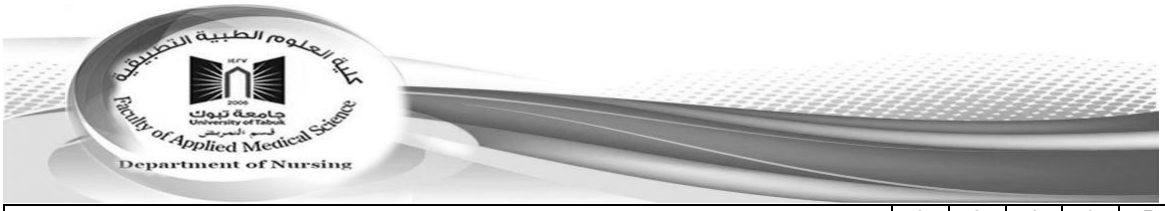
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PROVIDING CARE TO A CLIENT UNDERGOING HEMODIALYSIS

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *providing care to a client undergoing hemodialysis*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*



STEPS IN Providing Care to a Client Undergoing Hemodialysis	3	2	1	0	Remarks
Pre- Dialysis Care					
1. Identify the patient. Explain procedure.					
2. Weight. Determine amount of fluid to be removed.					
3. Assess VS especially BP					
4. Assess Potassium level in dialysate. Review laboratory results.					
5. Review medications. Hold drugs that passes through the dialysis membrane (like folic acid, piperacillin other water soluble vitamins). Hold antihypertensive especially if systolic pressure is <100					
6. Review need for blood products					
7. Wear PPE and Check access site a. Assess fistula or graft					
b. Assess circulation in distal portion of the extremity					
c. Auscultate for bruit					
d. Palpate for thrill					
e. No IV or blood draws in that arm					
f. No BP in that arm					
During Dialysis					
1. Identify the patient.					
2. Explain procedure to the patient.					
3. Prepare all equipment.					
4. Wear proper PPE					
5. Cannulate and connect to the HD machine by ensuring strict sterile technique and closed system					
6. Continuously monitor hemodynamic status. Watch for hypotension, muscle cramps, n/v, headache, itching. Monitor BP.					
7. Watch for bleeding					
8. Assess access site for bruit, thrill, exudate and signs of infection, bleeding					
9. Give missed meds as ordered.					
10. Dry weight the patient after HD and compare from pre-HD weight.					
11. Dispose used materials to biohazard receptacle.					
12. Remove PPE. Wash hands					
13. Document Findings					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

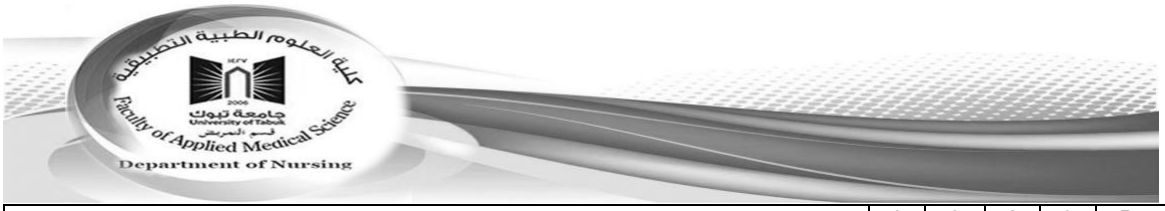
Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN INTERPRETING AN ELECTROCARDIOGRAPH

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in interpreting an ECG. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*



STEPS in Assessing & Interpreting ECG	3	2	1	0	Remarks
1. Check the ECG rhythm if it is regular or irregular.					
a. Check sinus rhythm showing standard waves, segments and intervals.					
b. Identify the R waves using a six second strip, measure the R to R intervals between QRS complex and determine if the rhythm is regular or irregular					
c. Interpret the rhythm. Tell if it is regular or irregular.					
2. Calculate the Heart Rate					
a. Use the 1500 method-for regular rhythm- Count the number of small boxes within an R-R interval and divide 1500 by that number					
b. R-R method for irregular rhythm-count the number of RR intervals in 6 seconds and multiply it by 10 (if it is a 6 seconds ECG paper), multiply 10 seconds by 6 (if it is a 10 seconds ECG paper)					
c. Use the formula: 300(1 big box between R-R, 150(2 big boxes), 75(3 big boxes), 60 (4 big boxes, and 50(5 big boxes)					
d. Tell the heart rate value. Interpret if it is normal, bradycardia or tachycardia.					
3. Find the P waves					
a. Check for the presence of P waves					
g. Check if the P waves is upright					
h. Check if it followed by a QRS complex					
i. Describe the P wave (missing, barrowed, waveform, fibrillatory wave, etc.)					
4. Measure the PR interval					
a. Check if it is 0.12-0.20 seconds or 3-5 small boxes on the ECG graph					
b. Tell the duration. Interpret if it is normal, shortened or prolonged.					
5. Measure the QRS complex/segment					

STEPS in Assessing & Interpreting ECG	3	2	1	0	Remarks
a. Check for the 3 graphical deflections, the negative wave (Q wave); the positive wave above the isoelectric line (R wave) and the negative wave after the positive wave (S wave)					
c. Check time duration is 0.06-0.10 seconds. Write the QRS time.					
d. Describe QRS. Tell if it is normal, wide narrow or fibrillatory in form.					
6. Interpret the overall condition- Normal Sinus rhythm or what type of dysrhythmia					
7. Document findings					

Comments:

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PUNCTURE PROCEDURE in ABG

DIRECTIONS: Below is a list of criteria to evaluate the student's *skill in puncture procedure in ABG*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

STEPS in<u>Puncture procedure in ABG</u>	<u>3</u>	<u>2</u>	<u>1</u>	<u>0</u>	<u>Remarks</u>
1. Check Doctor's order					
2. Prepare equipment a. Commercially available blood gas kit or: b. 2 or 3 ml. syringe c. 23 or 25 gauge needle d. 1 ml syringe with gauge 25 or 27 needle (for neonates and children) e. 0.5 ml. syringe of sodium heparin (1:1000) f. Stopper no cap g. Anesthetic agent 1% ***(optional)*** h. Sterile germicide (Povidone, isopropyl alcohol 70%) i. Cup, plastic bag or kidney basin with crushed ice/ **Patient label** j. Gloves					
3. Introduce yourself and ask patient their name & Check patient I.D					
4. Explain the procedure & if patient refuses, notify physician					
5. Record patient's inspired oxygen concentrations.					
6. Take patient's temperature					
7. Heparinized the 2 ml. or 1 ml. syringe if commercial blood gas kit is not available					
8. Expel excess heparin and air bubbles from the syringe					
9. Wash hands thoroughly and wear gloves					
10. Palpate the radial, brachial or femoral artery if puncturing the radial artery, perform the Allen test					
In a conscious and cooperative patient: 11. Compress ulnar and radial arteries at wrist to obliterate pulse. Ask patient to clench and release until hand blanches. With radial still compressed, release pressure on ulnar artery. watch for pinkness to return should "pink up "**<u>within 5 – 15 second</u>**					
In an unconscious: 12. Compress ulnar and radials. Elevate hand above head, squeeze hard. Release ulnar and lower hand below heart-Maximal pulse. The one with the stronger pulse will be your site of entry.					
13. Prepare chosen site with germicide					
14. Drape the bed and stabilize the wrist (hyper-extended, using a rolled up towel if necessary)					
15. Holding the heparin-coated ABG needle & syringe like a pen between your thumb and index finger, insert it at around **<u>45º angle</u>** to the skin, approximately 1 cm distal (away from) the index figure (radial sample)					
16. Once the artery is punctured, arterial pressure will push up the hub of the syringe and pulsating flow blood will full the syringe.					
17. After blood is obtained, withdraws needle and apply firm pressure over the punctured site with a dry sponge. **pressure on the puncture site for at least 5 minutes. More than 5 if the patient is on anticoagulant therapy**					
18. Blood gas analysis should be done immediately once sample is extracted					
19. Inspect the puncture site, and assess cold hand, numbness, tingling or discoloration.					

20. Change ventilation setting of the respiratory therapy equipment indicated by the results and as ordered by the doctor.						
21. Record the time of sampling, the site of puncture, the length of time pressure was applied to control bleeding and the type and amount of oxygen therapy the patient was receiving						
TOTAL						

Comments:

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING CVP MONITORING

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *CVP monitoring*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

STEPS in CVP Monitoring	3	2	1	0	Remarks
1. Perform hand hygiene					
2. Identify the patient. Explain procedure to patient					
3. Place the patient in the supine position with the head of the bed from 0 to 45 degrees. Position the zero point of the CVP line at the level of the right atrium. Usually this is at the Mid Axillary Line, 4th Intercostal Space.					
4. Attach the water manometer to the CVP tubing system, and flush the tubing with normal saline solution while the system is off to the patient.					
5. Line up the manometer arm with the phlebostatic axis ensuring that the bubble is between the two lines.					
6. Move the manometer scale up and down to allow the bubble to be aligned with the zero the scale. Referred as zeroing the manometer.					
7. Turn the three-way tap off to the patient and open to the manometer.					
8. Open the IV fluid bag and slowly fill the manometer to a level higher than the expected CVP.					
9. Turn off the flow from the fluid bag and open the three-way tap from the manometer to the patient.					
10. Observe the fluid column closely. It should fluctuate with the patient's respiratory cycle. Kneel down so that you can take the reading at eye level.					
11. *The fluid column should fall quickly and then fluctuate gently at the point at which the fluid column equalizes with the RAP.* Measure the CVP reading at end-expiration.					
12. When the fluid stops falling the CVP measurement can be read. If the fluid moves with the patient's breathing, read the measurement from the lower number.					
13. Turn the water manometer stopcock open to the flush solution and the patient, and reestablish the IV fluid infusion.					
14. Perform hand hygiene.					
15. Document the measurement and report any changes or abnormalities.					
TOTAL					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

COMPETENCY EVALUATION CHECKLISTS

FIRST AID AND EMERGENCY NURSING PRACTICAL (NUR 411)

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	**4**	**3**	**2**	**1**	**REMARKS**
10. Demonstrates therapeutic communication skills during assessment, intervention, evaluation, and teaching when dealing with clients and their significant others					
11. Establishes and maintains effective working relationships within an interdisciplinary team.					
12. Utilizes proper channels of communication.					
13. Participates actively during pre & post conferences					
14. Maintains privacy and confidentiality in the safekeeping of records and other information gathered.					
III. TECHNICAL SKILLS	**4**	**3**	**2**	**1**	**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	4	3	2	1	REMARKS
15. Wears complete uniform & is well-groomed at all times.					
16. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
17. Demonstrates honesty and accountability					
18. Changes behavior in response to constructive criticism/s					
19. Reports for duty on time.					
20. Submits requirements on time.					
21. Demonstrate effective time management.					
22. Observes bedside manners and courtesies.					
23. Reports to duty regularly.					
					Total Mark:

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING PRIMARY AND SECONDARY SURVEY

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing primary & secondary survey*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

PRIMARY SURVEY	3	2	1	0
A. Scene size up				

1. Verbalizes body substance isolation and wear PPE				
2. Scene safety • Safety of the Health Care Team • Safety of the patient • Safety of bystanders				
3. Identify the Mechanism of Injury or Nature of Illness				
4. Number of patients involved and need for additional help				
B. Initial Assessment				
1. <u>Check for Responsiveness</u> • Is the patient **A**lert? • Respond to **V**erbal stimuli • Respond to **P**ain stimuli • Is the patient **U**nresponsive				
2. <u>Airway</u> • Assess and open the airway o Head tilt-chin lift for medical patient o Jaw thrust for trauma patient				
• Insert airway adjuncts o Oropharyngeal airway (without gag reflex) o Nasopharyngeal airway (with gag reflex)				
3. <u>Assess breathing</u> • Look-chest rise and fall • Listen-breath sound • Feel-breathing/air				
• Evaluate rate, rhythm and quality				
• Check for symmetry of chest movement				
• Observe any usage of accessory muscles				
• Auscultate lungs for presence of bilateral breath sounds				
• Initiates appropriate oxygen therapy				
4. <u>Circulation</u> • Check for major bleeding				
• Check for perfusion o Capillary refill				

o Skin color ▪ Normal-pink ▪ Abnormal-cyanotic, pale, jaundice, flushed skin o Skin Temperature ▪ Normal-warm ▪ Abnormal-Hot and cold				
• Evaluate Pulse o Quality o Rhythm o Rate				
5. <u>Disability</u> • Assess for Level of Consciousness using GCS				
• Assess pupil size and reactivity				
• Assess for speech (if patient is conscious)				
• Assess for motor function				

6. Expose • Expose patient to check for additional cues/injuries that are hidden (whenever necessary)				
SECONDARY SURVEY	**3**	**2**	**1**	**0**
7. TRAUMA PATIENT				
SAMPLE HISTORY Accurate assessment of history/ mechanism of injury incorporating: • A – allergies • M- medications • P - past medical & surgical history • L – last oral intake • E - events leading to illness or injury				
HEAD TO TOE ASSESSMENT				
HEAD • Inspects mouth, nose, and assesses facial area • Inspects and palpates scalp and ears				
NECK • Checks position of trachea • Checks jugular veins • Palpates cervical spine				
CHEST • Inspects chest • Palpates chest • Auscultates chest				
ABDOMEN/PELVIS • Inspects and palpates abdomen • Assesses pelvis • Verbalizes assessment of genitalia/perineum as needed				
LOWER EXTREMITIES • Inspects, palpates, and assesses motor, sensory, and distal circulatory functions				

UPPER EXTREMITIES • Inspects, palpates, and assesses motor, sensory, and distal circulatory functions				
POSTERIOR THORAX, LUMBAR AND BUTTOCKS • Inspects and palpates posterior thorax • Inspects and palpates lumbar and buttocks area				
Manages secondary wounds and Injuries				
MEDICAL PATIENT				
HISTORY OF PRESENT ILLNESS • O-nset • P-rovocation • Q-uality • R-adiation/region • S-everity				

• T-ime				
SAMPLE HISTORY Accurate assessment of history/ NATURE OF ILLNESS incorporating: • A – allergies • M- medications • P - past medical & surgical history • L – last oral intake • E - events leading to illness or injury				
8. Check Vital signs				

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING TRIAGE

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing triage*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

PRIMARY SURVEY	3	2	1	0
Scene size up				

1.Verbalizes body substance isolation and wear PPE				
2. Scene safety • Safety of the Health Care Team • Safety of the patient • Safety of bystanders				
3. Call for assistance and start triaging				
4. Able to sort patients • Separate walking wounded and uninjured from others				
5. Identify patient/s with minor injury (green category)				
RESPIRATION				
6. Able to assess the respiration of the patient/s and identify life threats • Present ○ Under 30 cpm ○ over 30 cpm • Absent ○ Reposition the airway and LLF				
7. Categorize patient/s correctly based on the assessment of respiration (immediate, delayed or dead)				
PERFUSION				
8. Able to assess perfusion(radial pulse and/or capillary refill) of the patient/s and identify life threats • Radial pulse (present or absent) • Capillary refill (over 2 seconds or under 2 seconds)				
9. Categorize patient/s correctly based on the assessment findings (immediate or delayed)				
MENTAL STATUS				
10. Able to assess mental status of the patient/s and identify life threats • Follow simple commands • Can't follow simple commands				
11. Categorize patient/s correctly based on the assessment findings (immediate or delayed)				

Remarks: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING BASIC LIFE SUPPORT (ADULT) 1 RESCUER

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing BLS 1 rescuer*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

	3	2	1	0

1. Body substance isolation/Wear Personal Protective Equipment				
2. Check scene safety				
3. Establish unresponsiveness				
4. Activate medical assistance				
5. Locate and check carotid pulse (5-10 seconds)				
Evaluator must state that the patient has no pulse				
6. Start CPR • *30 compressions:2 breaths, depth 5-6 cm/ at least 2 inches at a rate of 100-120 compressions per minute*				
7. Open airway using head tilt chin lift or jaw thrust maneuver and deliver rescue breaths				
8. Continue CPR until 5cycles is finished.				
9. Recheck pulse *Note: patient still no pulse, repeat procedure 6-9*				
Evaluator must state that the patient has pulse and good breathing				
10. Place patient in recovery position				

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING AIRWAY MANAGEMENT

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing airway management*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

HEIMLICH MANEUVER **Conscious victim:**	**3**	**2**	**1**	**0**

1. Ask person who appears to have choked but who is not coughing, “Are you choking?”				
2. Determine that victim cannot expel object on own and state that you will help.				
3. Stand behind victim.				
4. Wrap arms around victim’s waist.				
5. Clench fist, keeping thumb straight.				
6. Place clenched fist, thumb side in, against abdomen between navel and tip of sternum.				
7. Grasp clenched fist with opposite hand.				
8. Push abdomen forcefully with upward thrusts until object is removed, victim starts to cough, or becomes unconscious.				
Chest thrusts for obese victim:				
1. Stand behind victim.				
2. Place arms around victim directly under armpits.				
3. Form fist and place thumb side of fist against sternum, level with armpits.				
4. Grasp fist in opposite hand and administer thrusts, pulling straight back, until object is removed, victim starts to cough, or becomes unconscious.				
Unconscious victim with obstructed airway:				
1. Place victim on back.				
2. Activate EMS system.				

3. Finger sweep mouth to remove object.				
4. If unsuccessful, open airway with head-tilt/chin-lift maneuver.				
5. Try to ventilate; if still obstructed, reposition head and try to ventilate again.				
6. If ventilation unsuccessful, give five abdominal thrusts: a. straddle victim’s thighs or kneel next to victim b. place heel of one hand on abdomen above navel c. place other hand in same position over first d. keep elbows straight and thrust inward and upward five times				
7. If unsuccessful, finger sweep mouth.				

8. Repeat steps 4 –7 until effective or EMS arrives.				
Head-Tilt/Chin-Lift				
1. Places one hand on casualty's forehead and presses with palm of hand to tilt head back.				
2. Places fingertips of other hand under tip of casualty's jaw and lifts. jaw forward				
Jaw Thrust				
1. Rests elbows on surface on which casualty is lying.				
2. Grasps angles of casualty's jaw (one hand on each side) and lifts jaw forward.				
3. Checks casualty for breathing (looks for chest rising and falling, listens for sounds of breathing, and feels with cheek for air flow).				
4. Seals nostrils closed and seals mouth over casualty's mouthwhile maintaining open airway. One hand maintains pressure on the casualty's forehead.				
5. Administers two full breaths.				
6. Releases casualty's nostrils and breaks seal over mouth.				
7. If chest does not rise and fall, repositions airway and administers two breaths again.				
8. If airway still blocked, administers finger sweep and appropriate manual thrusts.				

Finger Sweep				
1. Grasps tongue and lower jaw between thumb and index finger and lifts jaw open.				
2. Inserts index finger of other hand along inside of cheek to base of tongue and uses a hooking motion to remove any visible obstruction.				

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING BANDAGING

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing bandaging*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

	3	2	1	0
1. Assemble equipment.				

2. Explain procedure and obtain permission. Wash hands. Provide privacy.				
3. Expose part to be bandaged, making sure it is clean and dry.				
4. Hold bandage so that roll is up and loose end is on bottom.				
5. Apply bandage to smallest part of extremity to be bandaged.				
6. Make two circular turns around extremity, and proceed with the applicable bandaging and end with two circular turns.				
7. Apply bandage smoothly with firm, even pressure.				
8. Pin, tape, or clip end of bandage to hold in place, making sure pin or clip is not under body part.				
9. Check extremity for symptoms of cyanosis. Instruct to report complaints of pain, numbness, or tingling. Remove bandage if symptoms present and report immediately.				
10. Wash hands.				
11. Record actions and report any abnormal observations				

Comments:

_____

__

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING SPLINTING

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing triage*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

	3	2	1	0

	Guidelines for Splinting				
1.	Support the injured area above and below the site of the injury, including the joints.				
2.	If possible, splint the injury in the position that you find it.				
3.	Don't try to realign bones or joints.				
4.	After splinting, check for proper circulation (warmth, feeling, and color).				
5.	Immobilize above and below the injury.				
	6 Ways To Use Triangular Bandages				
1.	Folded as a thick rectangle of cloth, the cravat can be placed over a large wound. In this case, it functions like a trauma pad, absorbing blood and helping to stop bleeding.				
2.	One folded cravat can be used as a trauma pad, and a second cravat can be used to wrap the wound and trauma pad. In this usage, it functions like first-aid tape, to hold the trauma pad in place.				
3.	If a victim has an injured arm, a triangular bandage can be used as a sling, to support the arm in a bent position over the chest. A second cravat (folded as a long band) can be used around the torso as a swathe, to immobilize the arm against the chest. This technique is called a sling and swathe. Dedicated sling and swathe kits are available for purchase. But the advantage of the triangular bandage is that a few compact bandages serve multiple purposes. This allows a smaller first aid kit to do more.				
4.	If a victim has a broken leg, the leg can be immobilized with a blanket between the legs and a couple of cravats to tie the legs together, firmly but not so tight as to restrict circulation.				
5.	If a victim has a sprained ankle or wrist, a cravat can be used like an Ace bandage to wrap and support the appendage. Always remember, when wrapping, bandaging, or taping any wound, to avoid restricting circulation.				
6.	In the case of a head wound, a triangular bandage can be wrapped over the forehead and around the top of the head to cover the wound. Do not use bandages over the eyes, nose, or mouth. Do not use bandages of any kind around the neck, because you might restrict circulation to the head.				

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

PERFORMANCE SKILLS CHECKLISTS

SKILLS IN PERFORMING CODE BLUE

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *performing code blue*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R): *Based on the student's performance*
0 *–* ***(Progress Unacceptable)*** *- Unable to perform even under maximum supervision*
1 *–* ***(Needs Improvement)*** *- Performs with maximum supervision*
2 *–* ***(Progress Acceptable)*** *- Performs correctly with minimal supervision*
3 *–* ***(Competent)*** *- Performs correctly without supervision/independently*

	3	2	1	0
1. Initiate CPR unless DNR; Call For HELP.				

2.	Page Code Blue.				
3.	Bring Crash cart– place backboard, begin to assist with CPR. Check the RBS of every coded patient at the beginning of Code Blue.				
4.	Ensure airway is patent – insert oral airway, suctioning and Bag Valve Mask , O2 administration, prepare ET tube, prepare the laryngoscope & remove the head board				
5.	Clear the area				
6.	Institute IV therapy (14-18G)				
7.	Attach monitoring equipment				
8.	Monitor Heart rate & rhythm & document				
9.	Prepare & label the following drugs: • Epinephrine • Amiodarone • Magnesium sulfate • Vasopressin • Lidocaine • Atropine sulfate • Sodium bicarbonate				
10.	Complete documentation is needed, using the resuscitation record.				

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

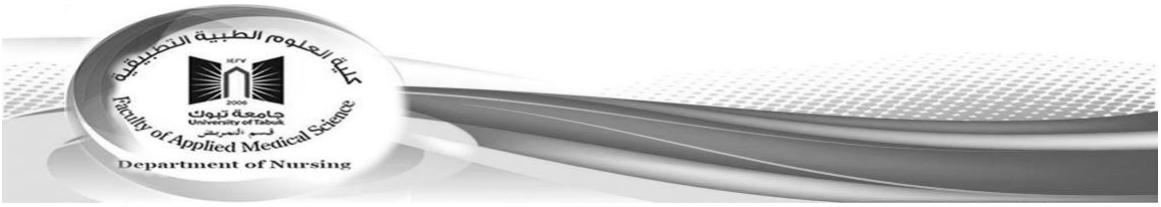
COMPETENCY EVALUATION CHECKLIST

NURSING LEADERSHIP AND MANAGEMENT PRACTICAL (NUR 408)

LEADERSHIP & MANAGEMENT IN NURSING - CLINICAL (NUR 408)
(Head Nursing)

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. PLANNING	**3**	**2**	**1**	**0**	**REMARKS**
12. Conducts a pre and post -conference with his/her staff to discuss the objectives and activities for the day, helps subordinates formulate strategies in accomplishing assigned tasks, address questions pertaining to accomplishment of tasks.					
13. Identify the Vision, Mission, Philosophy, Goals & Objectives of the hospital					
14. Gathers data on physical set-up, organizational chart, performance evaluation of student staff, ward rules, regulations and standard operating procedures, channel of communication, records and reports.					
15. Schedules meetings/individual conferences.					
16. Reviews nursing standards, policies & procedures.					
II. ORGANIZING	**3**	**2**	**1**	**0**	**REMARKS**
17. Identify the different organizational structure: a. Hospital b. Unit					
18. Recognize the staffing ratio & schedule utilized in each unit.					
19. Demonstrate the job description of a Head Nurse.					
III. DIRECTING	**3**	**2**	**1**	**0**	**REMARKS**
1. Distributes patient assignment evenly.					
2. Delegates tasks to student staff nurses.					
3. Utilizes the existing chain of command in implementing activities.					
4. Coordinates and collaborates with other members of the health team and other administrative units in the attainment of objectives.					

5. Establishes rapport.					
6. Generates suggestions and recommendations for the resolution of identified problems.					
7. Implements plan of action.					
IV. EVALUATING	**3**	**2**	**1**	**0**	**REMARKS**

1. Evaluates performance of staff & the unit as a whole through the use of reports, records, observations, interviews & conferences.					
2. Develops alternative courses of action.					
3. Evaluates if objectives are met.					
4. Identifies & troubleshoots as the necessity arises.					
5. Requires incident reports as necessary, keeps the clinical instructor informed & updated					
IV. VALUES AND ATTITUDE	**3**	**2**	**1**	**0**	**REMARKS**
20. Wears complete uniform and is well groomed at all times.					
21. Follows the policies, procedures and guidelines of the course, department, university and the affiliating agencies.					
22. Demonstrates honesty and accountability					
23. Changes behavior in response to constructive criticism/s					
24. Reports for duty on time.					
25. Submits requirements on time.					
26. Demonstrate effective time management.					
27. Observes bedside manners and courtesies.					
28. Reports to duty regularly.					
TOTAL MARK: _____					

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Leadership and Management in Nursing Clinical: Grading Student Staff Nurse Rubric

Name of Student: _____ Section: _____ Group:_____

Student no.:_____ Date: _____ Score:_____

	4	3	2	1	

1. Given the correct formula	Meet s all the criteria	Meets 2 out of 4 criteria	Meets 1 out of 4 criteria	Did not meet any of the criteria	
2. Completely label and give the data.	Meet s all the criteria	Meets 2 out of 4 criteria	Meets 1 out of 4 criteria	Did not meet any of the criteria	
3. Grades given was fair.	Meet s all the criteria	Meets 2 out of 4 criteria	Meets 1 out of 4 criteria	Did not meet any of the criteria	
4. Calculated the correct grades	Meet s all the criteria	Meets 2 out of 4 criteria	Meets 1 out of 4 criteria	Did not meet any of the criteria	

Clinical Instructor's Feedback:

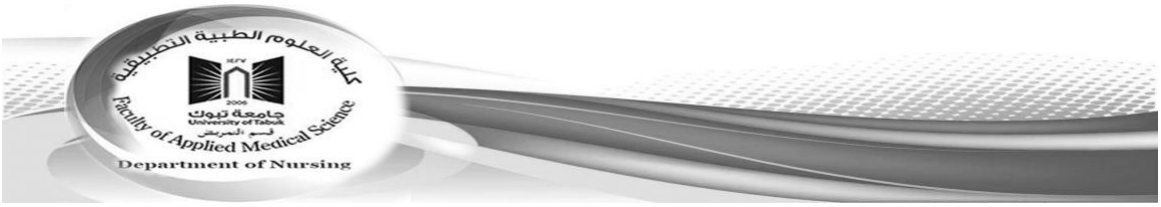
_____

_____

_____ _____

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

Date: _____ **Date:** _____



APPENDIX E

(RUBRICS/FORMS AND FORMAT)

NURSING CARE PLAN

DRUG STUDY

CASE STUDY FORMAT

CASE STUDY FORMAT (Written & Presentation)

ORAL AND WRITTEN RUBRICS

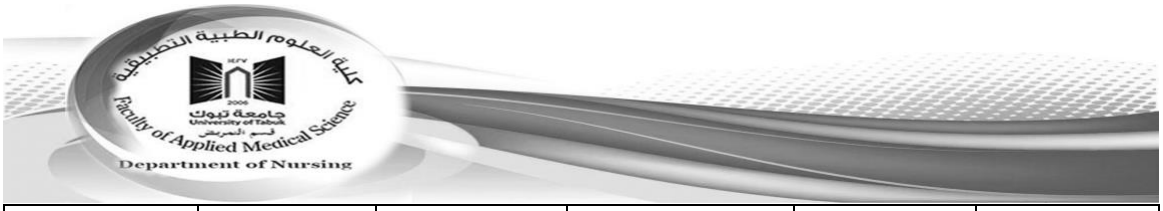
LEARNING INSIGHTS FOR STUDENTS

PERFORMANCE APPRAISAL TOOL

NURSING CARE PLAN

Name of Student: _____Student Number: _____
Name of Patient: _____ Age:_____ Medical Diagnosis:
_____
Ward/Unit :_____Room/ Bed No.:_____ Date of Assessment: _____

Assessment	Nursing Diagnosis	Goal	Interventions	Rationale	Evaluation



Subjective Cues: Objective Cues:		Goal Statement: Objectives: Long Term Objectives: Short Term Objectives	Independent: Dependent: Collaborative:		Fully Met: Partially Met: Unmet:

Date Submitted: _____ Faculty Name & Signature: _____

Name of Student:_____ Date: _____

Student Number:_____ Score: _____

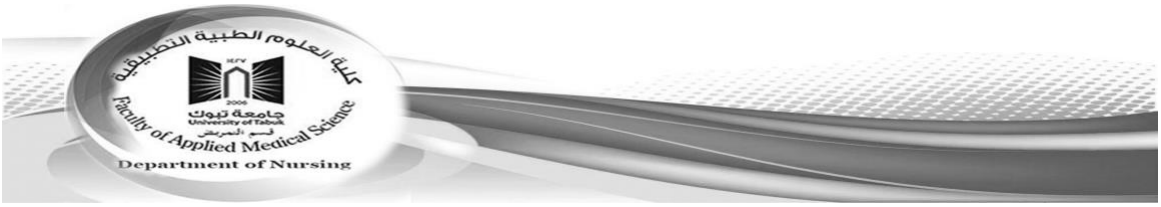
NURSING CARE PLAN RUBRIC

CRITERIA	GOOD 4	FAIR 3	POOR 2	INCOMPLETE 1	SCORE
Assessment	*(Meets all the criteria)* - Includes relevant subjective data - Includes sufficient objective data - Subjective assessment supports the nursing diagnosis - Objective assessment supports the nursing diagnosis - Includes client history related to the identified problem - Presents laboratory and diagnostic findings *(if applicable)*	Includes all pertinent data related to nursing diagnosis but also includes data not related to nursing diagnosis. (Meets 4 out 5 in the criteria)	Does not include all pertinent data related to nursing diagnosis. May also include data that does not relate to nursing diagnosis. (Meets 3 out 5 in the criteria)	Assessment portion is incomplete. Meets 2-1 out of 5 in the criteria)	
Nursing Diagnosis	*(Meets all the criteria)* - Presents priority nursing problem - Problem identified is relevant to patient's condition - Nursing diagnosis is derived from NANDA - States correct nursing diagnosis *(presented as P, PE depending on the identified problem)*	Diagnosis is appropriate for patient & ordinal level & diagnosis is NANDA approved, but does not include all parts or information is listed in wrong part of diagnosis.	Diagnosis is not appropriate for patient & ordinal level. May also not be NANDA & may not include all parts.	Diagnosis portion is incomplete.	
Goal	*(Meets all the criteria)* - Derives goal from problem statement of nursing diagnosis - Demonstrated direct resolution of the problem - Presentation of LTO & STO is guided SMART (specific, measurable, attainable, realistic and time – bounded)	Goal statement is patient or family centered & contains at least 1 measurable criteria or a target date/time.	Goal statement is not patient or family oriented & may not have measurable criteria or a target date/ time.	Goal portion is incomplete.	
Intervention with Rationale	*(Meets all the criteria)* - Presents client – centered interventions - Interventions properly categorized as dependent, independent and collaborative - Includes assessment, preventive, promotive, curative and rehabilitative care (if applicable) - Interventions accurately supported by rationale	Intervention portion contains adequate number of interventions to help patient/ family meet goal, but interventions may not be specific, labeled or listed with rationales.	Intervention portion does not include adequate number of interventions to help patient/family meet goal. Interventions may also not be specific, labeled or listed with rationales.	Intervention portion is incomplete.	
Evaluation	*(Meets all the criteria)* - Includes evaluation statement whether goal was met, partially met, or not met - Evaluation is coherent with the outcome listed in goal statement - Evidence/s is listed to support evaluation statement - Identifies factors which prevent goal from being accomplished	Evaluation portion does not contain data that is listed as criteria in goal statement, but does not describe goal as met, partially met or not met. May also not include revision or new evaluation date/time.	Evaluation portion does not contain data that is listed as criteria in goal statement. May also not describe goal as met, partially met or not met. May also not include revision or new evaluation date/time.	Evaluation portion is incomplete.	
				TOTAL: 20/ 20	

Faculty Name & Signature: _____

DRUG STUDY

Name of Student: _____Student Number: _____
Name of Patient: _____Age:_____Medical Diagnosis: _____
Ward/Unit :_____Room/ Bed No.:_____Date of Assessment: _____



DRUG NAME	MECHANISM OF ACTION AND INDICATION	CONTRAINDICATIONS	SIDE EFFECTS	NURSING RESPONSIBILITIES
GENERIC NAME: **BRAND NAME:** **CLASSIFICATION:** **DOSAGE:** **ROUTE:** **FREQUENCY:**	**MECHANISM OF ACTION:** **INDICATION:**			

Date Submitted: _____ Faculty Name & Signature: _____

Name of Student:_____ Date: _____

Student Number:_____ Score: _____

DRUG STUDY RUBRIC

CRITERIA	GOOD	FAIR	POOR	INCOMPLETE	SCORE

	4	3	2	1	
Generic Name/ Brand Name/ Classification/ Dosage/Route/ Frequency/	Includes all pertinent data related to the drug being studied and does include data that is not related to the drug being studied.	Includes all pertinent data related to the drug being studied but also include data that is not related to the drug being studied.	Does not include all pertinent data related to the drug. May also include data that does not relate to the drug.	Unable to include pertinent data about the drug.	
Mechanism of Action / Drug Indication	Accurately identifies all critical elements of the mechanism of action of the drug. Describes the priority reasons this medication would be prescribed. Accurately states why the patient is receiving this medication	Identifies most critical elements of the mechanism of action of the drug. Accurately identifies 3-4 main uses for this medication and why the patient is receiving the medication	Identifies some all critical elements of the mechanism of action of the drug. Identifies 2 main uses for this medication and why the patient is receiving the medication.	Unable to identify any critical elements of the mechanism of action of the drug. Unable to identify uses for this medication and why the patient is receiving the medication.	
Contraindication	Accurately describes all the most common contraindications that could affect the plan of management.	Partially describes the most common contraindications that could affect the plan of management.	Minimally describes common contraindications that could affect the plan of management.	Unable to describe common contraindications that could affect the plan of management.	
Side Effects	Accurately prioritizes all the side effects of the drug.	Inaccurately prioritizes most of the side effects of the drug.	Inaccurately prioritize some side effects of the drug.	Unable to prioritize the side effects of the drug.	
Nursing Responsibilities	Accurately prioritizes the nursing considerations to monitor while patient is on medication.	Inaccurately prioritizes most of the nursing considerations to monitor while patient is on medication.	Inaccurately prioritizes some of the nursing considerations to monitor while patient is on medication.	Unable to prioritize the nursing considerations to monitor while patient is on medication.	
				TOTAL: 20/ 20	

Faculty Name & Signature: _____

CASE STUDY FORMAT

I. Introduction

a. Short definition of the case

b. Background of the study: statistics(incidence and prevalence)

II. Patient/Case Presentation

a. Assessment(IPPA, Cephalo-caudal), neurological if needed

b. Demographics

c. Lifestyle

d. Family history

e. Medical History:

b.1. Past history

b.2. Present history (including admission)

III. Anatomy and Physiology

a. Book base (schematic diagram/ concept mapping)

b. Client base (schematic diagram/ concept mapping)

IV. Medical Management I Interventions

a. Medications (Drug Study)

b. Medical interventions: (doctors' orders, progress notes, including Surgery if any)

c. Diagnostic and laboratory tests

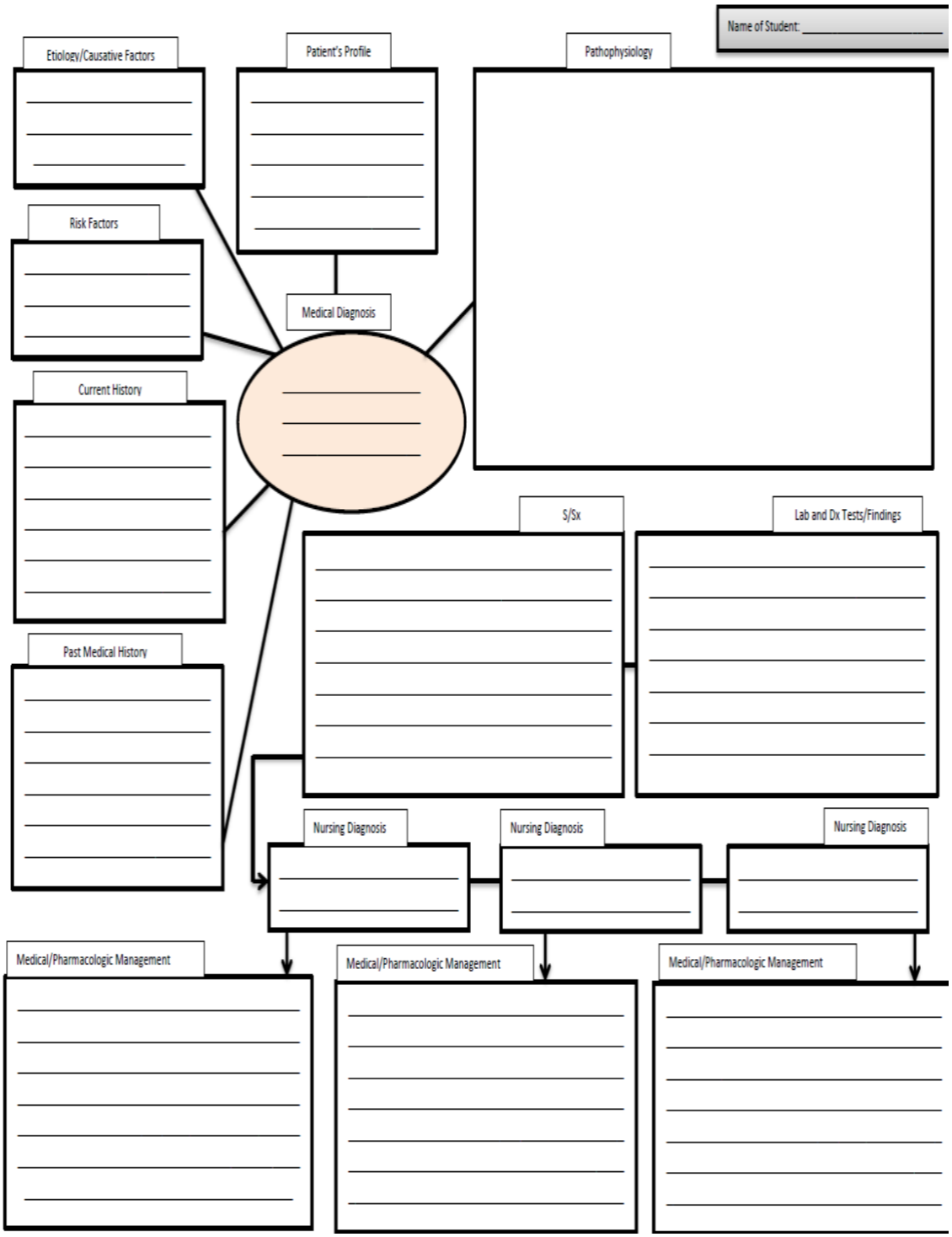
V. Nursing Interventions

a. NCP

V. Conclusion & Recommendation

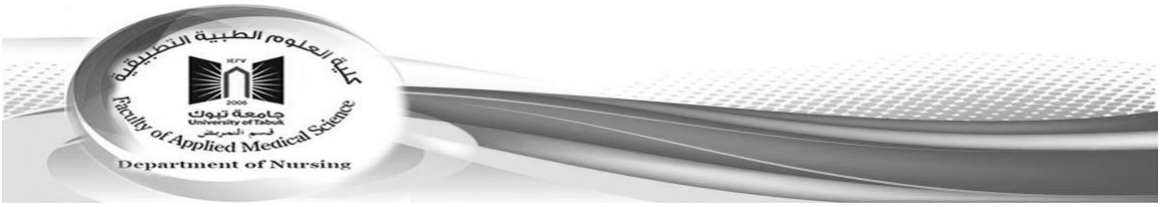
VI. References

CONCEPT MAP



Name of Members: _____

Case Title: _____ Date Submitted: _____



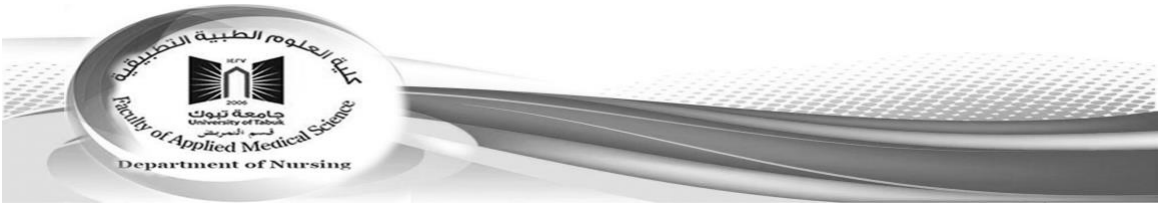
Name of Rater: _____ Signature: _____

Date: _____

CASE STUDY RUBRIC (WRITTEN)					
	Exceptional 4	**Satisfactory 3**	**Unacceptable 2**	**Consider Remediation 1**	**SCORE**
1. Patient's Past Medical History a. History	History is complete and is appropriate with the age, gender and chief complaint. It is written in logical format.	History is age/gender appropriate and contains pertinent information. However, it is missing some vital points relating to the chief complaint.	History is scant. The majority of vital information is missing relating to the chief complaint.	The work in this category is far below what is expected to be presented.	
2. Assessment and Plan a. Anatomy and Physiology	Anatomy & Physiology is presented based on the signs and symptoms and risk factors presented by the patient.	Anatomy & Physiology is presented utilizing the risk factors of the patient towards the disease process.	The majority of the risk factors presented in the anatomy & physiology is missing relating to the identified problem	The work in this category is far below what is expected to be presented.	
b. Physical Assessment	Physical exam has been completed as instructed, is age/gender appropriate, relates to the chief complaint, and pertinent findings.	Physical exam is appropriate for the chief complaint but there are pertinent systems or special tests missing.	Appropriate physical examination is incomplete. The information obtained would not be sufficient to support the diagnosis.	The work in this category is far below what is expected to be presented.	
c. Plan of Care	Student outlines a complete and effective plan of care for selected patient	Student outlines an effective care plan for selected patient, with one or two missing components	Plan of care is incomplete, with several components that are missing or not relative to the selected patient's condition.	The work in this category is far below what is expected to be presented.	
c. Laboratory Diagnostic tests	All appropriate labs and diagnostic tests are recorded and rationalized	The majority of the appropriate tests have been ordered. There are one or more missing.	The majority of the appropriate tests are missing.	The work in this category is far below what is expected to be presented.	
3. Treatment overview	There is a complete discussion of the actual treatment including rationale for each aspect of treatment.	The summary of treatment is adequate with some facts omitted.	The summary of treatment is poor and many facts are omitted.	The work in this category is far below what is expected to be presented	
4. Organization	The paper is well-written in a logical, organized manner	The paper relays information but is slightly disorganized	The paper does not relay adequate information on the subject, is disorganized and difficult to follow.	The work in this category is far below what is expected to be presented.	
5. Content	The length of the paper is appropriate to communicate the ideas presented professionally.	There are topics throughout the paper which should have been explained more thoroughly.	The paper is poorly written with incomplete data and communication of thought.	The work in this category is far below what is expected to be presented	
				TOTAL: 32/ 32	

ORAL CASE PRESENTATION RUBRIC

Case Title: _____ Date Presented: _____



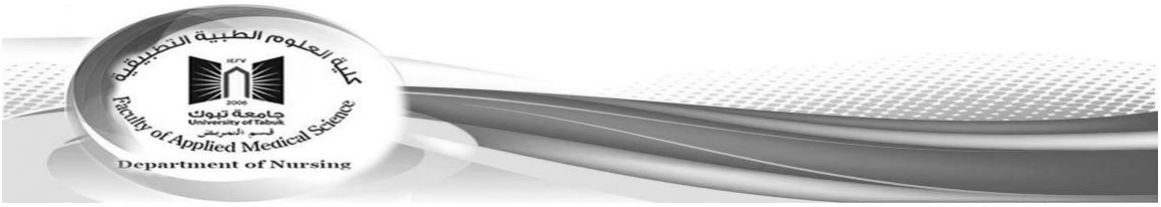
CRITERIA	4 Excellent	3 Good	2 Fair	1 Poor	Name:	Name:	Name:	Name:
Content	In-depth and thorough discussion of assigned topics spontaneously without referring to notes or slides	Majority of the topics are thoroughly discussed and given in-depth discussion while occasionally refers to notes and slides	Only some topics are thoroughly discussed and given in-depth discussion while constantly referring to slides	Limited analysis of data, interpretation and correlation				
	Student demonstrates full knowledge (more than required) by answering all class questions with explanation.	Student is at ease with expected answers to all questions, but fails to elaborate.	Student is uncomfortable with information & is able to answer only rudimentary questions.	Student does not have grasp of information: student cannot answer questions about subject.				
	Student presents information in logical, interesting sequence which audience can follow.	Student presents information in logical, sequence which audience can follow.	Audience has difficulty following presentation because student jumps around.	Audience cannot understand presentation because there is no sequence of information.				
Delivery	Relaxed, self-confident.	Demonstrates quick recovery from minor mistakes	Difficult to recover from minor mistakes	Nervous				
	Shows natural body movements that develop enthusiasm and affects audience positively	Possesses body movements that enhance presentation	Body movements and gestures enhance presentation to a limited extent	Self-conscious				
	Voice projection fluctuates in volume and inflection and sustains interest	Voice projection is satisfactorily varied in volume and inflection	Voice projection is fairly varied in volume and inflection	Voice projection is monotonous				
	Very good articulation and communicative	Good articulation and communicative	Grasps for words sometimes	Inarticulate most of the time				
Presentation Aids	AV materials are well done and are used to make the presentation more interesting and meaningful	Makes use of AV materials that enhances the presentation to a good extent	Makes use of some AV materials that enhances the presentation to a limited extent	Makes use of AV materials but does not enhance the presentation				
Time Management	Finishes within the prescribed time with appropriate pacing	Finishes within the time frame but failed to give emphasis on some topics	Hurriedly finished on time	Did not finish on time				
				TOTAL: 36/ 36				

Name of Rater: _____ Signature: _____

Date: _____

Name: _____ **Student # : _____**

Grade: _____



Leadership and Management Clinical: Learning Insight Rubric

Directions: The learning insights will be graded based on this rubric.

Criteria	4	3	2	1	Score
Focus & Details	There is one clear, well-focused topic. Main ideas are well supported by detailed and accurate information.	There is one clear, well-focused topic. Main ideas are clear but are not well supported by detailed information.	There is one topic. Main ideas are somewhat clear.	The topic and main ideas are not clear.	
Organization	The introduction is inviting, states the main topic, and provides an overview of the paper. Information is relevant and presented in a logical order. The conclusion is strong.	The introduction states the main topic and provides and overview of the paper. A conclusion is included.	The introduction states the main topic. A conclusion is included.	There is no clear introduction, structure, or conclusion.	
Writing	The author's purpose of writing is very clear, and there is strong evidence of attention to audience. The author's extensive knowledge and/or experience with the topic is/are evident.	The author's purpose of writing is somewhat clear, and there is some evidence of attention to audience. The author's knowledge and/or experience with the topic is/are evident.	The author's purpose of writing is somewhat clear, and there is evidence of attention to audience. The author's knowledge and/or experience with the topic is/are limited.	The author's purpose of writing is unclear.	
Word Choice	The author uses vivid words and phrases. The choice and placement of words seems accurate, natural, and not forced.	The author uses vivid words and phrases. The choice and placement of words is inaccurate at times and/or seems overdone.	The author uses words that communicate clearly, but the writing lack variety.	The writer uses a limited vocabulary jargon or cliché's may be present and detract from the meaning.	

Sentence Structure, Grammar, Mechanics & Spelling	All sentences are well constructed and have varied structure and length. The whole content met the 50-100 words requirement. The author makes no errors in grammar, mechanics, and/or spelling.	Most sentences are well constructed and have varied structure and length. The whole content is within the 50-100 words requirement. The author makes a few errors in grammar, mechanics, and/or spelling, but they do not interfere with understanding.	Most sentences are well constructed, by they have a similar structure and/or length. The whole content is less than 50 words requirement. The author makes several errors in grammar, mechanics, and/or spelling that interfere with understanding.	Sentences sound awkward, are distractingly repetitive, or are difficult to understand. The whole content is less than 50 words requirement. The author makes numerous errors in grammar, mechanics, and/or spelling that interfere with understanding.	

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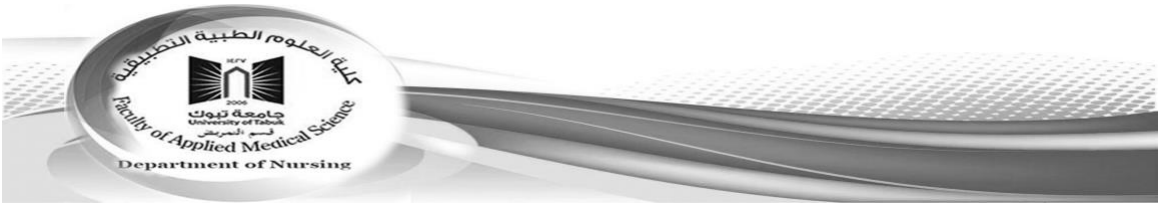
Clinical Instructor and Signature: _____

Date: _____

Nursing Leadership & Management Clinical (NUR 408)

LEARNING INSIGHT FORM



Date Submitted: _____

Head Nurse:	Student Number:	Signature:
Staff Nurses:		

Topic:

Guide Questions:

1.
_____

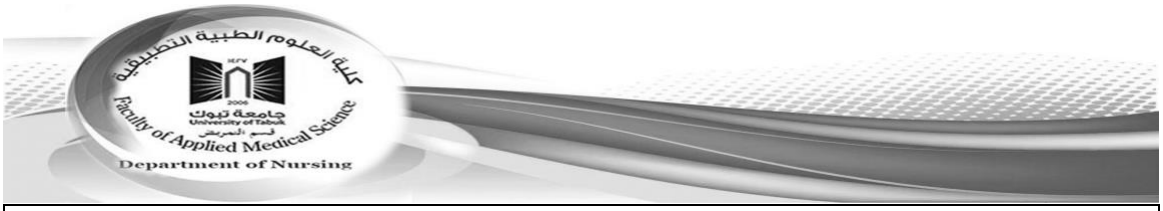
2._____
__

3._____
__

4.
_____

Learning Insights:

Feedback of Clinical Instructor:



Clinical Instructor: _____

Date: _____

Name of Student:_____ Date: _____

Student Number:_____ Score: _____

Rubrics for Performance Appraisal Tool

Parameters/ Elements	**4**	**3**	**2**	**1**	***Actual Score***
OBJECTIVITY AND RELIABILITY	**Activities:** a. Correctly follows all directions in completing the appraisal form. b. Gives appropriate score to student-staff nurse c. Able to rationalize or justify given score/s.	Unable to perform 1 task	Unable to perform 2 tasks	Absence of performance in all the required task	
CONTENT VALIDITY	Complete data for evaluation were presented. a. Kardex b. List of absences c. Post Conference activities	Some data are incomplete (1-3 items) for evaluation were presented	Major data are incomplete (4-6 items) for evaluation were presented	All data are incomplete.	
TIMELINESS OF SUBMISSION	Able to submit requirement on time	Late by 1 meeting	Late by 2 meetings	Late by 3 meetings or more	
NUMERACY SKILLS	Attain correct computation value, Without mistakes	Commits 1 mistake in computation	Commits 2 mistakes in computation	All computations are Incorrect	
Total marks			**16/16**		

Clinical Instructor's Feedback:

_____

_____

_____

Clinical Instructor's Signature over Printed Name:

Date: _____

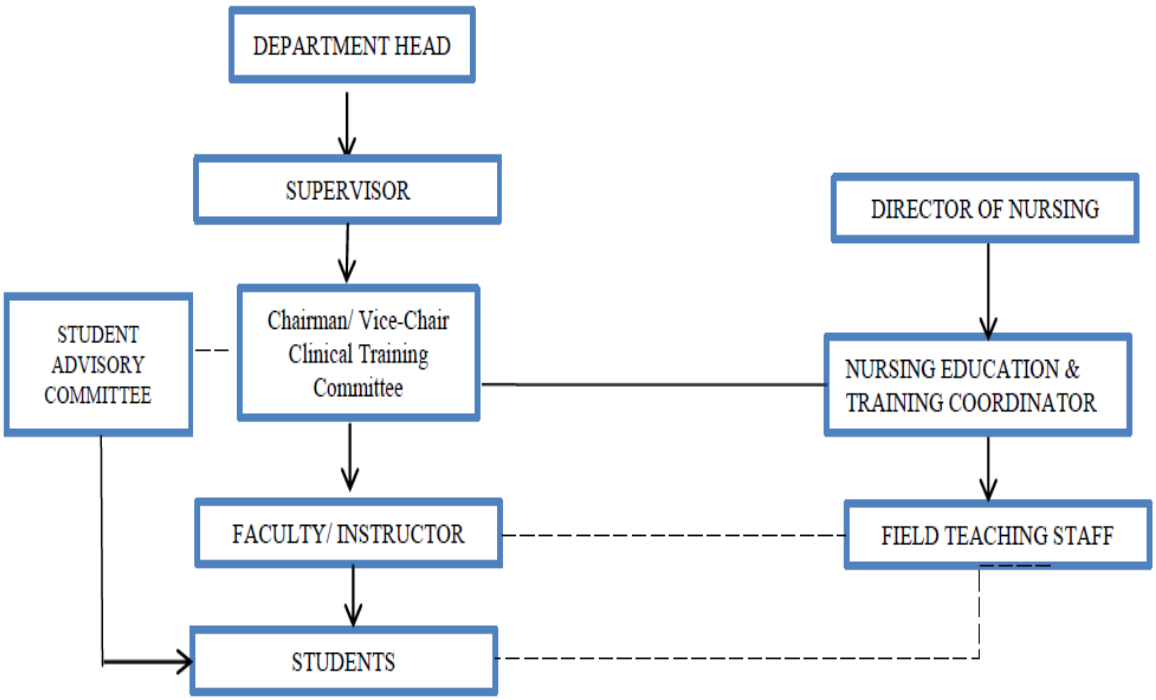
APPENDIX F

FLOW CHART OF FIELD EXPERIENCE RESPONSIBILITY

AND

GUIDELINES IN DEALING WITH ALL TYPES OF CONFLICT RESOLUTION

FLOW CHART OF FIELD EXPERIENCE RESPONSIBILITY



Feedback ----
Two-way communication _____
Direct Communication ⟶

GUIDELINES IN DEALING WITH ALL TYPES OF CONFLICT RESOLUTION

1. It is the sole responsibility of the assigned Faculty/Instructor (F.I.) to report all types of conflict during the clinical training of the student
2. The F.I. will provide feedback about any incident to the Field Teaching Staff (FTS) and must directly report the issue to the Chairman and/or Vice Chairman of the Clinical Training Committee CTC).
3. The student and the FI must write an incident report immediately and submit it to CTC
4. The CTC must provide feedback to the Student Advisorship Committee either the conflict is resolve or not for proper documentations and updating the students file.

Documents required:

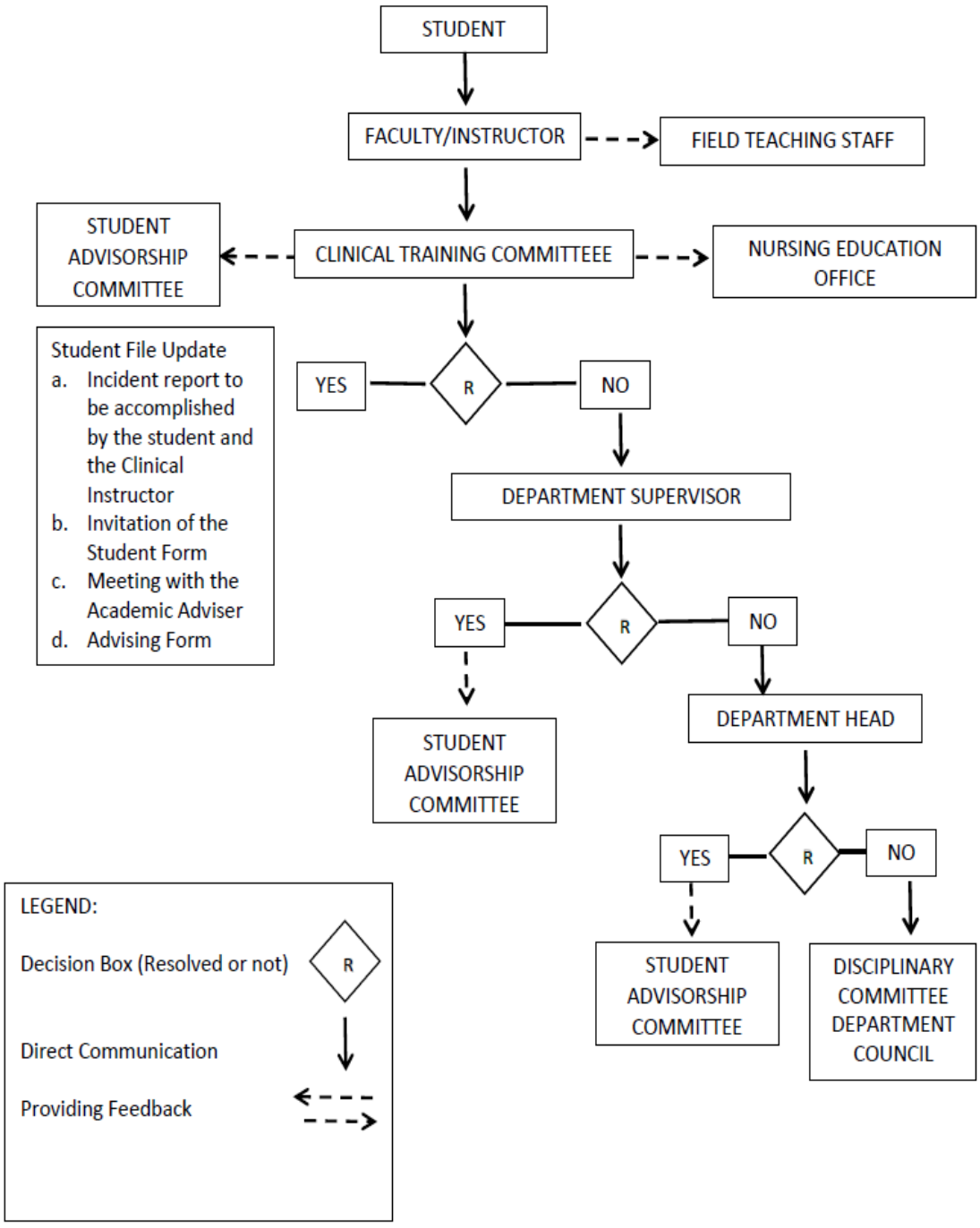
A. Incident report to be accomplished by the student and the Clinical Instructor
B. Student Violation report form
C. Invitation of the Student Form
D. Meeting with the Academic Adviser
E. Advising Form

5. **Unresolved conflicts** must be elevated to the Department Supervisor. The Department Supervisor must review the following reports prior to giving of feedback to the Department Head.

Necessary documents needed f:

A. Updated Student file/record
B. Incident report
C. Invitation of the Student Form
D. Meeting with the Academic Adviser
E. Advising Form

6. Any serious violations must be elevated to the Department Council for proper disciplinary actions



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