FUNDAMENTALS of NURSING PROCEDURES CHECKLISTS



College of Nursing
Hawler Medical University

FUNDAMENTALS of NURSING

PROCEDURES CHECKLISTS

This manual has been prepared to assist nursing students of the College of Nursing at Hawler Medical University in learning Fundamentals of Nursing procedures.

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College of Nursing
Hawler Medical University

	HAWLER MEDICAL UNIVERSITY	
	COLLEGE OF NURSING	
Department	Nursing	
Subject	Fundamentals of Nursing	
Section	Laboratory Practice	
Year	Second	
Semester	1,2	
Hours	Semester 1 (60 hrs.) /Semester 2 (30 hrs.)	
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PROCI	EDURE:		Code	01-01								
No.				Skill	steps						Not achieved	Achieved
1	Prepared procedu	ire equipment:										
	Patient n	nedical record										
	□ Vital sign											
	=	notes including			_							
	-	bracelet with pa	atient det	ails (lab	el or writ	tten)						
	• .	racelet (red)										
		neter, mercury	or electro	onic								
		omanometer										
	☐ Stethosc											
	☐ Gauze											
		ing solution										
	☐ Hand rub	-										
2	☐ Plastic tray Identified the patient using two identifiers (name, date of birth, address).											
3	Performed greeting			1		-						
4	Provided privacy.	<u> </u>										
5	Explained the pro	cedure to the p	atient an	d answe	ered any	question	S.					
6	Checked patient's	details on the	medical r	ecord.								
7	Checked patient's		=									
8	Applied identity b			wrist.								
9	Asked the patient about allergies.											
10	Applied the allerg				patient	does not	have all	ergies - \	erbal re	eport)		
11	Oriented the patie											
12	Oriented the patie											
13 14	Introduced the pa Explained the hos	•				admini	tration	f modic	ations o	to \		
15	Performed admiss				ina time	, auminis	stration C	n medica	ations e	(C.)		
16	Assessed patient's				report)							
17	Assessed patient's	-	-			+\						
18	Assessed patient's					ι,						
19	Assessed patient's											
	·	<u> </u>	FUIN IAD -	- verbar	report)							
20	Assessed patient's											
21	Assessed patient's											
22	Checked doctor's					mmedia	tely (FoN	- verbai	report)	•		
23	Explained the initi	-			are.							
24	Checked patient u											
25 26	Asked the patient Explained to the p				if noodo	d /sall ba	511\					
27	Assessed patient's			ie iiurse	ппееце	u (can be	zii).					
28	Reassured the pat		/1 L.									
29	Returned equipme		cated are	a.								
30	Informed the doct				mitted (v	erbal rei	oort).					
					ILL EVA	•						
Steps	0 1-3	4-6 7-9	10-12	13-15	16-18	19-21	22-24	25-27	28-30	Skill steps	achieved	
Points	0 6	12 18	24	30	36	42	48	54	60	Skill points		
Level	·	F			U	N	S	С	ı	Skill level a	chieved	

	2. PROCEDURE ASPECTS EVALUATION 40%											
Rationa	ale 10%		Patient F	ocus 10% Profession			Manner :	10%	Time	Time 10%		
Failed		5	Failed		5	Failed	Failed 5			+10	5	
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory	Unsatisfactory	6				
Novice		7	Novice		7	Novice 7			Novice	+6	7	
Supervised	ervised 8 Supervised				8	Supervised	Supervised	+4	8			
Competent	mpetent 9 Competent				9	Competent	Competent	+2	9			
Independent		10	Independent		10	Independent 10			Independent	10		
Notes:									Time allowed	(TA)	60	
									Time achieved			
									Aspects points achi	ieved		
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 100	%				
≤50	51-6	0	61-70	71-	-80	81-90	91-1	.00	Total points achie	eved		
Failed	Unsatisfa	actory	Novice	Super	vised	Competent	Indepe	ndent	Total level achiev	/ed		
Student			•	Signati	ure							
Teacher				Signati	ure	Actual Mar			Actual Mark/O	ut of		
Clinical Area				Date								

	HAWLER MEDICAL UNIVERSITY			
	COLLEGE OF NURSING	ION		
	LABORATORY AND CLINICAL EDUCAT FUNDAMENTALS OF NURSING	IUN		
	ADMISSION NURSING ASSESSM	IENT		
Patient Name				
Date of Birth		Gender:	Male	Female
Address				
Family member				
(name & mobile number)				
Date of Admission				
Reason for admission				
Present health problems (signs & symptoms)				
(signs & symptoms)				
Past health problems				
(illnesses, operations)				
Present medications				
Allergies	T			
Allergies				
Height & weight	Height:	Weig	ht:	
Nursing student				
(name & signature)				
(marrie & signature)				

PROCE	EDURE:				Hospita	alizatio	n – tran	sterrin	g a pati	ent			Code	01-02
No.						Skill	steps						Not achieved	Achieved
1	Prepare	d proce	dure equ	ipment:										
	□ Patient medical record													
			g transfe	r form										
		Hand r				<u> </u>				• • •				
2							ocation, t	ime and	special c	onsidera	itions.			
3	Prepared patient documentation for the transfer. Filled in the pursing transfer form correctly													
4	Filled in the nursing transfer form correctly. Performed hand byging correct technique													
5	Performed hand hygiene using correct technique.													
6 7	Identified the patient using two identifiers. Performed greating introduction and permission procedure (GLP)													
8	Performed greeting, introduction and permission procedure (G.I.P). Provided privacy.													
9				out trans	for and	ncworo	d any gu	octions						
10	Informed the patient about transfer and answered any questions. Contacted transfer unit to determine the best time for transfer.													
11							ing assist							
12							ted the p		mily if n	eeded				
13							the belor							
14							erbal rep)			
15							·		cereman		,			
16	Covered the patient to provide warmth and protect dignity. Transferred the patient to the transfer unit with assistance.													
17	On arrival to the transfer unit informed the nurse in charge f the transfer.													
18				he alloca										
19				o the oth										
20							ive manr	ner.						
21				e using co										
22						allocate	d nurse.							
23		-					tion to th	ne alloca	ted nurse	2.				
24	On retu	rn to the	e unit, in	formed a	ppropria	ite depai	rtments o	of transfe	r (kitche	n, diagno	ostic			
							ns or trea							
25	Arrange	ed for the	e bed of	the trans	sferred p	atient to	be prepa	ared for t	he new	admissio	n.			
26							sfer has		npleted.					
27	Informe	ed the fa	mily that	t the pati	ient was		red and v							
				T	T	1	KILL EV							
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps		
Points Level	0	6	12	18	24	30	36 U	42 N	48	54	60	Skill points Skill level a		
Levei				<u> </u>	2 D	ROCEDI	JRE ASP	N FCTS FV	S	C ON 40º	<u> </u>	Skill level a	criieveu	
	Rationa	le 10%				ocus 10%				Manner:			Time 10%	
Failed		10 10/0	5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	ctory+8	6
Novice											+6	7		
Supervi	ervised 8 Supervised 8 Supervised 8 Supervised +4											8		
•	npetent 9 Competent 9 Competent +2										9			
Indeper	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ		10
wotes:												Time allo	wed (TA)	30
												Time achie	ved	
												Aspects poin	ts achieved	

	3. COMPLETE PROCEDURE EVALUATION 100%											
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved						
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved						
Student			Signature									
Teacher			Signature			Actual Mark/Out of						
Clinical Area			Date									

		EDICAL UNIVE										
COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION												
		NTALS OF NU										
	PATIENT 1	RANSFER I	ORM									
	PATIE	NT DETAIL	S									
Name												
Date of Birth				Gender:	Male	Female						
Address												
Telephone number												
	CLINI	CAL DETAIL	S									
Diagnosis												
Medications												
iviculcations												
Present condition												
Tresent condition												
	TRANSF	ERRED FRO	M:									
Organization												
Department												
Doctor arranging	Name:											
transfer												
Contact details	Tel:		Email:									
	TRAN	SFERRED TO	D:									
Organization												
Department												
Doctor accepting	Name:											
transfer												
Contact details	Tel:		Email:									
	TRAN	SFER DETAI	LS									
Name & Signature:		Date:										

No. Skill steps Prepared procedure equipment: Patient medical record Nursing referral form Hand rub gel Checked doctor's order for referral. Performed hand hygiene using correct technique. Identified the patient using two identifiers (name, date of birth, address). Performed greeting, introduction and permission procedure (G.I.P). Provided privacy. Informed the patient about the referral and answered any questions. Filled in the referral form correctly. Contacted the health professional the patient was referred to discuss the referral. Sent the referral form by fax, e-mail, hospital mail system, porter or post to the appropriate health professional. Gave the form to the patient/family if no other option is available and arranged the appointment on the phone. Documented referral in the patient documentation. Returned equipment to the dedicated area. Performed hand hygiene using correct technique.											
No. Skill steps Achieved Achieved											
Patient medical record Nursing referral form Hand rub gel Checked doctor's order for referral. Performed hand hygiene using correct technique. Identified the patient using two identifiers (name, date of birth, address). Performed greeting, introduction and permission procedure (G.I.P). Provided privacy. Informed the patient about the referral and answered any questions. Filled in the referral form correctly. Contacted the health professional the patient was referred to discuss the referral. Sent the referral form by fax, e-mail, hospital mail system, porter or post to the appropriate health professional. Gave the form to the patient/family if no other option is available and arranged the appointment on the phone. Documented referral in the patient documentation. Returned equipment to the dedicated area.											
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11 Documented referral in the patient documentation. 12 Returned equipment to the dedicated area.											
12 Returned equipment to the dedicated area.											
Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60%											
Steps 0 1 2 3 4 5-6 7-8 9-10 11 12 13 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved											
Level F U N S C I Skill level achieved											
2. PROCEDURE ASPECTS EVALUATION 40%											
Rationale 10% Patient Focus 10% Professional Manner 10% Time 10%											
Failed 5 Failed 5 Failed +10 5											
Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6											
Novice 7 Novice 7 Novice 7 Novice +6 7											
Supervised 8 Supervised 8 Supervised 8 Supervised +4 8											
Competent 9 Competent 9 Competent 9 Competent +2 9											
Independent10Independent10Independent10IndependentTA10											
Notes: Time allowed (TA) 30											
Time achieved											
Aspects points achieved											
3. COMPLETE PROCEDURE EVALUATION 100%											
≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved											
Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved											
Student Signature											
Teacher Signature Actual Mark/Out of											
Clinical Area Date											

LABORATORY AND CLINICAL EDUCATION FUNDAMENTALS OF NURSING												
		PAT	TIENT REF	ERRAL FOR	M							
			PATIENT	DETAILS								
Name												
Date of Birth						Gender:	Male	Female				
Address												
Telephone number												
			CLINICAL	DETAILS								
Diagnosis												
Medications												
Present condition												
Doctor												
	T		REFERF	RED BY:								
Name												
Organization												
Job					T							
Contact details	Tel:				Email:							
	I		REFERR	RED TO:								
Nieman												
Name												
Organization												
Job	Tole				Email:							
Contact details	Tel:		REFERRA	L DETAILS	Email:							
			ILLILINA	LULIAILS								
Name & Signature:				Date:								

PROCE	EDURE:				Hospita	alizatio	n – disc	charging	g a pati	ent			Code	01-04
No.						Skill	steps						Not achieved	Achieved
1	Prepare	-	dure equ	-										
			medical											
				rge sumn	nary									
			g dischar											
					nation a	nd post-o	discharge	e instruct	ions acco	ording to	the dia	ignosis		
			tient's co	ondition										
		Medica												
2	Checked	Hand r		for disch	arge, disc	charge ti	me and s	special co	nsiderat	ions.				
3	Checked that all the medical orders, tests and treatments have been completed.													
4	Informed the family of discharge if not present (verbal report).													
5	Performed hand hygiene using correct technique.													
6	Identified the patient using two identifiers.													
7				oduction	and per	mission	procedu	re (G.I.P)	•					
8		d privac	•											
9		•						uestions	•					
10						lications.								
11	Gave the patient instructions about the diet, rest and activity, hygiene.													
12	Explained to the patient how to recognise complications and what to do if they occur. Gave the patient instructions about the follow - up appointments.													
13		-				•								
14							•	nt answe			ıs.			
15			-	-				and inst						
16 17								oatient/fa						
18								ort if wh			1)			
19							•	ge summa			•	201		
20				•				ositive m	•	ing discin	arge pro	aii <i>j</i>		
21						•		r, nursing		nt)				
22							- ''	al report)		10,				
23			-	-				ared for a		ndmissio	n			
24								e has bee			···			
					<u> </u>			ALUATIO	•					
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С		Skill level a	chieved	
		1 400/		.				ECTS EV				T	T : 400/	
Failed	Rationa	le 10%	-	Failed	atient F	ocus 10%	6 5	Failed	essional I	Vlanner	10% 5	Failed	Time 10% +10	
Unsatis	factory		5 6		factory		6	Unsatis	factory		6	Unsatisfa		5 6
Novice	idetory		7	Novice	nactory		7	Novice	ractory		7	Novice	+6	7
Supervi	sed		8	Supervi	ised		8	Supervi	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	ved (TA)	30
												Time achie	ved	
												Aspects poir		

3. COMPLETE PROCEDURE EVALUATION 100%												
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved						
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved						
Student			Signature									
Teacher			Signature			Actual Mark/Out of						
Clinical Area			Date									

					Proced	lure Eva	aluatio	n Docur	nent (P	ED)				
PROCI	EDURE:			Infectio	n cont	rol - ha	nd was	hing us	ing soa	p and v	water		Code	02-01
No.						Skill	steps						Not achieved	Achieved
1	Stood i	n front o	f sink, ke	eping ha	nds and	uniform	away fro	om sink s	urface.					
2	Turned	on the v	vater.	· · ·			•							
3	Regula	ted flow	and tem	perature	(warm)	of the wa	ater.							
4		l hands a ows duri			ghly und	er runnir	ng water	keeping	hands ar	d forear	ms low	er than		
5				of soap,	lathering	thorous	ghlv.							
6				•			•	t 15 seco	nds.					
7		d hands p												
8					palm of c	ther han	d with f	ingers int	erlaced.					
9	1			ith finge				0						
10		•	•				th finger	s interlo	ked.					
11														
12	Rubbe	Rubbed each thumb clasped in opposite hand using a rotational movement. Rubbed tips of fingers in opposite palm in a circular motion. Cleaned fingernails with the finge of the other hand if needed.												
13	Rubbe	d each w	rist with	opposite	hand.									
14	Rinsed hands and wrists thoroughly, keeping hands down and elbows up, water flowing towards fingertips.													
15	Dried h dryer.	ands tho	roughly	from fing	gers to w	rists witl	h a pape	r towel, s	ingle-use	e cloth, c	r warn	n air		
16	Discard	led pape	r towel,	if used, ii	n a lined	waste bi	n.							
17	Turned	off hand	d faucet,	using cle	an, dry p	paper tov	vel.							
18	Avoide	d touchir	ng handl	es with h	ands.									
						1. SI	CILL EVA	ALUATIO	N 60%					
Steps	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	I	Skill level a	achieved	
				1				ECTS EV				T		
F 11 1	Ration	ale 10%			Patient F	ocus10%			essional	Manner:		F 11 1 44	Time10%	
Failed											5	Failed+10		5
Novice	sfactory		6 7	Novice			6 7	Novice	ractory		6 7	Unsatisfa Novice	+6	6 7
Supervi			8	Superv			8	Superv	sod		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:								-1				Time allov		10
												Time achie		
												Aspects poir	nts achieved	

	3. COMPLETE PROCEDURE EVALUATION 100%												
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved							
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved							
Student			Signature										
Teacher			Signature			Actual Mark/Out of							
Clinical Area			Date										

					Proced	lure Eva	aluatio	n Docui	ment (F	PED)				
PROC	EDURE:			Infection	on con	trol - ha	and wa	shing u	sing ha	nd rub	gel		Code	02-02
No.						Skill	steps						Not achieved	Achieved
1	Checke	d the pro	oduct lab	elling fo	r correct	amount	of produ	uct neede	ed.					
2	Applied	the cor	rect amo	unt of pr	oduct to	the palr	n of one	hand.						
3	Rubbed	l hands p	oalm to p	alm.										
4	Rubbed	back of	each ha	nd with p	oalm of c	ther han	d with f	ingers int	erlaced.					
5	Rubbed	d palm to	palm w	ith finger	s interla	ced.								
6	Rubbed	d with ba	ck of fing	gers to o	pposing	palms wi	th finger	s interlo	cked.					
7	Rubbed	d each th	umb clas	sped in o	pposite l	hand usir	ng a rota	tional m	ovement					
8		•	s of fingers in opposite palm in a circular motion. Cleaned fingernails with the fingernails r hand if needed.											
9	Rubbed	l each w	rist with	opposite	hand.									
10	Rubbed	l hands t	ogether	until the	y were d	ry.								
						1. Sł	CILL EVA	ALUATIO	N 60%					
Steps	0	1	2	3	4	5	6	7	8	9	10	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С		Skill level a	achieved	
				Т				ECTS EV				<u> </u>		
- · · ·	Rationa	ale 10%	-		Patient F	ocus10%			essional	Manner		Failed+1	Time10%	-
Failed	sfactory		5 6	Failed Unsatis	factory		5 6	Failed	factory		5 6	Unsatisfa		5 6
Novice			7	Novice	iactory		7	Novice			7	Novice	+6	7
Superv			8	Supervi	ised		8	Superv			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Indepen	dent TA	10
Notes:												Time allo	wed (TA)	5
												Time achie	eved	
												Aspects poi	nts achieved	
						MPLETE	PROCEI	OURE EV	ALUATI	ON1009	<u>% </u>			
≤!	50	51	-60	61-	-70		-80	81	-90	91-	100	Total point	s achieved	
	iled	Unsatis	factory	Nov	/ice		rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signat						_		
Teach						Signat	ure					Actual M	ark/Out of	
Clinica	l Area					Date								

Procedure Evaluation Document (PED) Infection control- donning and removing sterile gloves Code 02-03

PROCE	ROCEDURE: Infection control- donning and removing sterile gloves												Code	02-03
No.		Skill steps epared procedure equipment:												Achieved
1	Prepar	-	-	uipment:										
		Sterile	_											
		Hand r												
2		d the wo					ion.							
3		d the cor												
4		ned hand												
5								parating			t the sid	les.		
6								surface a		evel.				
7							surface	of the w	rapper.					
8	Identifi	ed right a	and left ខ្	gloves (ve	erbal rep	ort)								
9		d glove fo												
10	With thumb and first two fingers of non-dominant hand, grasped glove for dominant hand by touching only the glove's inside folded surface.													
11	Carefully pulled glove over dominant hand, leaving it cuffed, and ensured that the cuff did not rol													
	up the wrist. Ensured that thumb and fingers were in proper spaces.													
12	With gloved dominant hand, slipped fingers underneath the second glove's cuff.													
13				-				king care	not to a	llow the	gloved			
		nt hand			•									
14	After d	onning th	ne secon	d glove, i	nterlock	ed hand:	s togethe	er.						
15	Kept ha	ands abo	ve waist	level.										
16	To remo	ve the glo	oves, gras	ped the o	utside of	one cuff v	with the o	ther glove	ed hand; a	voided to	ouching v	vrist.		
17	Pulled (glove off,	, turning	it inside	out and	placed it	in glove	d hand.						
18	Tucked	the finge	ers of the	e bare ha	nd insid	e the ren	naining g	love cuff	. Peeled	glove of	f inside	out and		
	over th	e previo	usly remo	oved glov	/e.									
19	Discard	ed both	gloves in	the line	d waste	bin.								
20	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. SKILI	L EVALU	ATION (50%					
Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				=			U	N	S	С	I	Skill level a	chieved	
								PECTS EV						
	Rationa	ale 10%			Patient F	ocus10%			essional	Manner:			Time10%	
Failed	•		5	Failed			5	Failed	•		5	Failed+10		5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa		6
Novice	la a al		7	Novice			7	Novice	la a d		7	Novice	+6	7
Supervi Compe			8 9	Supervi Compe			8	Supervi Compe			8	Supervise Compete		8 9
Indepe			10	•			10				10	Independ		10
Notes:	toe									Time allow		5		
												Time achie	ved	
												Aspects poir	nts achieved	
								DURE E						
≤5	50	51-	-60	61-	70	71	-80	81-	-90	91-1	100	Total points	achieved	
Fai	led	Unsatis	factory	Nov	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								

PROCI	EDURE:		Infectio	n conti	rol- don	ining st	terile g	own an	d glove	es – ope	en met	hod	Code	02-04
No.						Skill	steps						Not achieved	Achieved
1	Prepare	ed proce	dure equ	ipment:										
		Sterile	_											
		Sterile												
2	Cleaned	d the wo	rking are	a with a	disinfect	ing solut	ion.							
3	Perforn	ned hand	d hygiene	e using co	orrect ted	chnique.								
4	Selecte	d the ap	propriate	e size and	d type of	sterile g	loves.							
5	Selecte	d the ap	propriate	e size of	sterile su	rgical go	wn.							
6	Checke	d that pa	ackages a	re intact	and dry									
7	Checke	Checked the expiry dates of the packages.												
8	Asked t	he scrub	person	or the cir	rculating	nurse to	open th	e sterile	gown an	d glove ¡	oackage	s on a		
	clean, c	dry, flat s	surface. P	referabl	y on a sm	nall table	separat	e from th	ne sterile	field co	ntaining	the		
			ents and s											
9	Perforn	ned surg	ical hand	l antisep:	sis.									
10	Dried h	ands tho	roughly.											
11	Picked	up the g	own fron	n the ste	rile packa	age, gras	ping the	inside su	urface of	the gow	n at the	collar.		
12	Lifted t	he folde	d gown d	lirectly u	pward, a	nd stepp	ed back,	away fro	om the t	able.				
13	Located neckba	_	wn neckb	and; wit	h both ha	ands, gra	sped the	inside f	ront of t	he gown	just bel	ow the		
14	Keeping	g the gov	wn at arn	n's lengtl	h from th	e body,	allowed	the gowi	n to unfo	ld with t	he insid	e of the		
	gown fa	acing the	body.											
15	With ha	ands at s	houlder	level, slip	ped both	n arms ir	nto the a	rmholes	simultan	eously.				
16	Had the	e circulat	ting nurse	e pull the	e gown o	ver the s	houlders	by reac	hing insid	de the ar	m seam	S.		
17	Extende	ed hands	s through	the cuff	s.									
18	Opened	d inner p	ackage o	f the glo	ves, keep	ing glov	es on the	e inside s	urface o	f the wra	apper.			
19	Identifi	ed right	and left g	gloves (v	erbal rep	ort)								
20	Donnec	d glove fo	or domin	ant hand	l first.									
21				_	of non-d		t hand, g	rasped g	love for	dominan	t hand	ру		
22					nant han		g it cuffe	d, and e	nsured tl	hat the c	uff did r	not roll		
	up the	wrist. En	sured th	at thumb	and fing	gers wer	e in prop	er space	s.					
23					ped finge									
24				-	er non-do			_	not to a	llow the	gloved			
					posed no			d.						
25					h" the go									ļ
26	-				paper tab									
27	Passed the sterile paper tab to a member of the sterile surgical team or to a non-sterile team member.													
28	Kept the gown tie in the right hand. The circulating nurse stood still as the scrub person turned.													
29		g a marg ed gown		ety, turn	ed to the	left one	e-half tur	n, which	covered	the bacl	k with th	ne		
30			•	from the	circulati	ng nurse	, and sec	cured bo	th ties in	place.				
						<u> </u>								
						1. SI	(ILL EVA	LUATIO	N 60%					1
Steps	0	1-3	4-6	7-9	10-13	14-15	16-19	20-22	23-25	26-28	29-30	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60		s achieved	
Level				=			U	N	S	С	I	Skill level		

			2. PR	OCEDU	RE ASPI	ECTS EVALUATION	ON 40%			
Rationa	ale 10%		Patient F	ocus10%	6	Professional	Manner1	L0%	Time10%	
Failed		5	Failed		5	Failed		5	Failed+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory+8	6
Novice	Novice		7	Novice		7	Novice +6	7		
Supervised		8	Supervised		8	Supervised		8	Supervised +4	8
Competent		9	Competent		9	Competent		9	Competent +2	9
Independent 10 Independent 10 Independent TA										10
Notes:									Time allowed (TA)	10
									Time achieved	
									Aspects points achieved	
			3. CON	APLETE	PROCEI	OURE EVALUATI	ON 100%	6		
≤50	51-	-60	61-70	71-	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatis	factory	Novice	Super	rvised	Competent	Indepe	ndent	Total level achieved	
Student			•	Signati	ure		-			
Teacher			Signati	ure				Actual Mark/Out of		
Clinical Area				Date						

No. Skill steps Achieved Prepared procedure equipment:		Procedure Evaluation Document (PLD)		
No. Skill steps Achieved Achieved Achieved Prepared procedure equipment: Packaged sterile drape Syringes Needles Packaged sterile container for solutions Sterile gloves Solution Non-sterile gloves Disinfecting solution Disinfecting solution Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Performed hand hygiene using correct technique. Put on non-sterile gloves. Performed hand hygiene using correct technique. Put on non-sterile gloves. Performed hand hygiene using correct technique. Put on non-sterile gloves. Put on non-sterile gloves. Put on non-sterile gloves. Put on non-sterile drape (verbal report). Put on non-sterile drape to strile drape (verbal report). Put on non-sterile drape to unfold, away from your body and any other surface of the sterile drape (verbal report). Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put on non-sterile drape, lifting it carefully by its corners. Put o	PROCI	EDURE: Infection control- creating sterile field using packaged sterile drape	Code	02-05
Packaged sterile drape Syringes Needles Packaged sterile container for solutions Sterile gloves Solution Non-sterile gloves Disinfecting solution Disinfecti	No.	Skill steps		Achieved
Syringes Needles Packaged sterile container for solutions Sterile gloves Solution Non-sterile gloves Disinfecting solution Disinfecting solution Disinfecting solution Derformed hand hygiene using correct technique. Put on non-sterile gloves. Held away from body and above the waist and work surface. Opened the outer covering of the drape. Removed sterile drape, lifting it carefully by its corners. Held away from body and above the waist and work surface. Ocntinued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Avoided touching any other surface or object with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Avoided touching the surface or other items or dropping items onto the 1-inch border. Avoided touching the surface or other items or dropping items onto the 1-inch border.	1	Prepared procedure equipment:		
Needles Packaged sterile container for solutions Sterile gloves Solution Non-sterile gloves Disinfecting solution Non-sterile gloves Hand rub gel Disinfecting solution Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Checked expiration date of the sterile drape (verbal report). Popened the outer covering of the drape. Removed sterile drape, lifting it carefully by its corners. Pled away from body and above the waist and work surface. Ocntinued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Positioned the drape on the work surface with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. Avoided touching the surface or other items or dropping items onto the 1-inch border. Decked expiration date of the solution for adding to the sterile field. Placed additional atterile items or other items or dropping items onto the 1-inch border. Placed expiration date of the solution for adding to the sterile field. Placed additional sterile items or other items or dropping items onto the 1-inch border. Placed expiration date of the solution for adding to the sterile field. Placed additional sterile items or other items or dropping items onto the 1-inch border. Placed additional sterile items or other items or dropping items onto the 1-inch border. Placed additional sterile items or other items or dropping items onto the 1-inch border. Placed additional sterile items or other items or dropping items onto the 1-inch border. Placed additional sterile items or other items on the sterile field. Placed additional sterile items or other items or dropping items onto the 1-inch border. Place		☐ Packaged sterile drape		
Packaged sterile container for solutions Sterile gloves Solution Non-sterile gloves Hand rub gel Disinfecting solution 2 Cleaned the working area with disinfecting solution. 3 Performed hand hygiene using correct technique. 4 Put on non-sterile gloves. 5 Checked that the sterile pack is dry and unopened (verbal report). 6 Checked expiration date of the sterile drape (verbal report). 7 Opened the outer covering of the drape. 8 Removed sterile drape, lifting it carefully by its corners. 9 Held away from body and above the waist and work surface. 10 Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. 11 Avoided touching any other surface or object with the drape. 12 Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. 13 Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. 14 Avoided touching the surface or other items or dropping items onto the 1-inch border. 15 Checked expiration date of the solution for adding to the sterile field.		□ Syringes		
Sterile gloves Solution Non-sterile gloves Hand rub gel Disinfecting solution 2 Cleaned the working area with disinfecting solution. 3 Performed hand hygiene using correct technique. 4 Put on non-sterile gloves. 5 Checked that the sterile pack is dry and unopened (verbal report). 6 Checked expiration date of the sterile drape (verbal report). 7 Opened the outer covering of the drape. 8 Removed sterile drape, lifting it carefully by its corners. 9 Held away from body and above the waist and work surface. 10 Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. 11 Avoided touching any other surface or object with the drape. 12 Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. 13 Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. 14 Avoided touching the surface or other items or dropping items onto the 1-inch border. 15 Checked expiration date of the solution for adding to the sterile field.				
Solution Non-sterile gloves Hand rub gel Disinfecting solution Ceaned the working area with disinfecting solution. Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Checked expiration date of the sterile drape (verbal report). Opened the outer covering of the drape. Removed sterile drape, lifting it carefully by its corners. Held away from body and above the waist and work surface. Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Avoided touching any other surface or object with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. Avoided touching the surface or other items or dropping items onto the 1-inch border. Checked expiration date of the solution for adding to the sterile field.		☐ Packaged sterile container for solutions		
Non-sterile gloves Hand rub gel Disinfecting solution Cleaned the working area with disinfecting solution. Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Checked expiration date of the sterile drape (verbal report). Opened the outer covering of the drape. Removed sterile drape, lifting it carefully by its corners. Held away from body and above the waist and work surface. Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Avoided touching any other surface or object with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. Avoided touching the surface or other items or dropping items onto the 1-inch border. Checked expiration date of the solution for adding to the sterile field.		☐ Sterile gloves		
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Disinfecting solution Cleaned the working area with disinfecting solution. Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Checked expiration date of the sterile drape (verbal report). Checked expiration date of the drape. Removed sterile drape, lifting it carefully by its corners. Held away from body and above the waist and work surface. Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Avoided touching any other surface or object with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. Avoided touching the surface or other items or dropping items onto the 1-inch border. Checked expiration date of the solution for adding to the sterile field.				
Cleaned the working area with disinfecting solution. Performed hand hygiene using correct technique. Put on non-sterile gloves. Checked that the sterile pack is dry and unopened (verbal report). Checked expiration date of the sterile drape (verbal report). Dened the outer covering of the drape. Removed sterile drape, lifting it carefully by its corners. Held away from body and above the waist and work surface. Continued to hold only by the corners. Allowed the drape to unfold, away from your body and any other surface. Avoided touching any other surface or object with the drape. Positioned the drape on the work surface with the moisture proof side down. This would be the shiny or blue side. Placed additional sterile items on field – syringes, needles, gloves holding each item 6 inches above the surface of the sterile field and dropping it onto the field. Avoided touching the surface or other items or dropping items onto the 1-inch border. Checked expiration date of the solution for adding to the sterile field.		•		
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14 Avoided touching the surface or other items or dropping items onto the 1-inch border. 15 Checked expiration date of the solution for adding to the sterile field.	13			
15 Checked expiration date of the solution for adding to the sterile field.				
	14	Avoided touching the surface or other items or dropping items onto the 1-inch border.		
16 Placed cap on table away from the field with edges up.	15	Checked expiration date of the solution for adding to the sterile field.		
	16	Placed cap on table away from the field with edges up.		

													•	10
17		ottle outs e to pour		•					acing the	e palm o	f your h	and and		
18		he bottle												
19	Avoide	d splash	ing any l	iquid.										
20	Touch	ed only tl	ne outsio	de of the	lid when	recappi	ng.							
21	Labelle	ed solution	n with d	late and	time of c	pening.								
22	Remov	ed glove	S.											
23	Perforr	ned hand	hygiene	e using co	orrect te	chnique.								
						1. Sł	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-17	18-19	20-21	22-23	Skill steps achieve	ed	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achiev	red	
Level			ı	F			U	N	S	С	I	Skill level achieve	d	
								CTS EV	ALUATIO	ON 40%				
	Ration	ale 10%			Patient F	ocus10%			essional	Manner	10%		10%	
Failed			5	Failed			5	Failed			5	Failed+10		5
	factory		6	Unsatis	factory		6	1	factory		6	Unsatisfactory		6
Novice			7	Novice			7	Novice			7	Novice +6	_	7
Superv			<u>8</u> 9	Superv			8	Superv			8 9		+4	8 9
Compe Indepe			10	Compe Indepe			9 10	Compe Indepe			10	Competent +2 Independent		10
Notes:	nuent		10	шиере	ilueilt		10	пиере	nuent		10	•		
												Time allowed (T	A)	15
												Time achieved		
												Aspects points achie	eved	
					3. CON	MPLETE	PROCE	URE EV	ALUATI	ON1009	%			
≤!	50	51-	-60	61-	-70	71	-80	81	-90	91-3	100	Total points achie	ved	
Fai	led	Unsatis	factory	Nov	/ice	Supei	vised	Comp	etent	Indepe	ndent	Total level achieve	ed	
Studer	nt					Signat	ure							
Teach	er					Signat	ure					Actual Mark/O	ut of	
Clinica	l Area					Date								

PROCE	DURE: Comfort, rest and sleep – making an unoccupied bed	Code	03-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Gloves		
	Plastic apron		
	Hand rub gel		
	Clean bed linen		
	Laundry bag or hamper		
2	Performed hand hygiene using correct technique.		
3	Adjusted the height of the bed.		
4	Placed the bed in a flat position.		
5	Put on gloves.		
6	Put on plastic apron.		
7	Check bed linens for patient's personal items and any other objects.		
8	Loosened all linen moving around the bed, from the head of the bed on the far side to the head of		
	the bed on the near side.		
9	Folded reusable linens, such as sheets, blankets, or spread in fourths and hang them over a clean		
	chair.		

	ı												1	
10	Rolled	all the so	iled line	n inside 1	the botto	m sheet	and plac	ced direc	tly into tl	he laund	ry ham	oer.		
11	Did not	place th	e soiled	linen on	floor or	furniture	l.							
12	Did not	hold the	e soiled l	inens aga	ainst the	uniform.	•							
13	Shifted	mattres	s up to h	ead of b	ed.									
14	Cleane	d and dri	ed the m	natrass b	efore ap	plying ne	w sheet	s.						
15	Remov	ed glove:	S.											
16	Placed	the botto	om shee	t with its	center f	old in the	e center	of the be	d.					
17	Pulled t	the botto	om sheet	over the	e corners	at the h	ead and	foot of tl	ne mattr	ess or tu	cked th	e corners		
			ass using											
18							l in the c	enter of	the bed a	and with	the her	n even		
					<u>id unfold</u>									
19		-		with top	blanket	or spread	d, placin	g the upp	er edge	about 15	cm bel	ow the		
20	-	he sheet					C.I. I	1 11						
20		•		u bianke	t under t	ne toot d	or the be	d on the	near side	е.				
21		d the cor		C.I										
22					-			read and						
23	Moved to the other side of the bed and follow the same procedure for securing top sheets under													
24	the foot of the bed and making a cuff. Desired side valls if used and lawared the bad.													
25		Raised side rails, if used and lowered the bed.												
		Disposed of soiled linens in appropriate area.												
26		Returned equipment to the dedicated area. Performed hand hygiene using correct technique.												
27	Perforn	ned hand	hygiene	e using c	orrect te									
		4.2	2.5		0.11			LUATIO		22.25	26.27	l		
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level			1	F			U	N	S	С	ı	Skill level a	achieved	
					2. PR	OCEDUI	RE ASPE	CTS EV	ALUATIO	ON 40%				
	Rationa	ale 10%		ı	Patient F	ocus 10%	6	Profe	essional I	Manner	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
-	factory		6		factory		6		factory		6	Unsatisfa	actory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Superv			8	Superv			8	Superv			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe Notes:	naent		10	Indepe	naent		10	Indepe	nuent		10		dent TA	10
Notes.												Time allo	wed (TA)	20
												Time achie	eved	
												Aspects poi	nts achieved	
				3	B. CON	1PLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61	-70	71-	-80	81	-90	91-1	L00	Total point	s achieved	
Fai	led	Unsatis	factory	No	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt			•		Signati	ure							
Teach	er					Signati						Actual M	ark/Out of	
Clinica						Date						1		
	- •-							<u> </u>				1		

PROCE	DURE: Comfort, rest and sleep – making an occupied bed	Code	03-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:	acilieveu	
	☐ Gloves ☐ Plastic apron		
	☐ Hand rub gel		
	☐ Clean bed linen		
	☐ Large towel or bath blanket		
	☐ Laundry bag or hamper		
2	Performed hand hygiene using correct technique.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed.		
8	Placed the bed in a flat position unless contraindicated.		
9	Put on gloves.		
10	Put on plastic apron.		
11	Check bed linens for patient's personal items and any other objects.		
12	Placed a bath blanket over patient.		
13	Asked the patient to hold onto bath blanket while you reach under it and remove top linens.		
14	Discarded soiled linen in laundry bag or hamper (not on the floor or furniture).		
15	Did not hold the soiled linens against the uniform.		
16	If possible, and another person was available to assist, grasped the mattress securely and shifted it up to head of bed.		
17	Assisted the patient to turn toward opposite side of the bed with the rail up, if possible.		
18	Repositioned the pillow under patient's head.		
19	Loosened all bottom linens from head, foot, and side of bed.		
20	Fan-fold soiled linens as close to patient as possible.		
21	Placed the bottom sheet with its center fold in the center of the bed.		
22	Opened the sheet and fan-fold to the center, positioning it under the old linens.		
23	Raised side rail, if possible.		
24	Assisted the patient to roll over the folded linen in the middle of the bed toward the student.		
25	Moved to other side of the bed and lowered the side rail if raised.		
26	Loosened and removed all bottom linen.		
27	Discard soiled linen in laundry bag or hamper.		
28	Pull the bottom sheet taut and secure at the corners at the head and foot of the mattress.		
29 30	Assisted the patient to turn back to the center of bed.		
	Removed pillow and changed pillowcase.		
31 32	Applied the top linen, sheet and blanket, if desired, so that it is centered.		
33	Folded the top linens over at the patient's shoulders to make a cuff.		
34	Asked the patient to hold on to top linen and removed the bath blanket from underneath. Secured top linens under foot of mattress and mitered corners.		
35	Returned the patient to a position of comfort.		
36	Raised side rails, if used and lowered the bed.		
37	Disposed of soiled linens in appropriate area.		
		I	Ī

38	Remov	ed glove:	s and pla	stic apro	n.									
39	Return	ed equip	ment to	the dedi	cated are	ea.								
40	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-13	14-18	19-20	21-25	26-30	31-34	35-38	39-40	Skill steps ad	chieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points a	chieved	
Level			ı	F			U	N	S	С	I	Skill level ac	hieved	
					2. PR	OCEDUI	RE ASPE	CTS EVA	ALUATIO	ON 40%				
	Rationa	ale 10%		F	Patient F	ocus 10%	6	Profe	essional	Manner	10%	٦	ime 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfac	tory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Superv	ised		8	Superv	ised		8	Superv	ised		8	Supervised	d +4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Competen	t +2	9
ndepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independe	ent TA	10
Notes:												Time allowe	ed (TA)	30
												Time achieve	ed	
												Aspects points	achieved	
				3	. COM	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61-	-70	71	-80	81-	-90	91-1	100	Total points	achieved	
Fai	led	Unsatis	factory	Nov	vice	Super	vised	Comp	etent	Indepe	ndent	Total level ad	chieved	
Studer	nt					Signat	ure							
Teach	er					Signat	ure					Actual Mar	k/Out of	
Clinica	l Area					Date								

PROCE	DURE: Vital signs – assessing axillaries temperature	Code	04-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Vital signs chart		
	Thermometer, mercury or electronic		
	Gauze		
	Disinfecting solution		
	Hand rub gel		
	Plastic tray		
2	Identified patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of the bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted patient to supine or sitting position.		
9	Prepared the thermometer for the measurement:		
	mercury thermometer, shook down and cleaned		
	Electronic, placed the cover, and turned on.		
10	Inserted the thermometer into center of axilla.		
11	Placed patient's arm across the chest.		
12	Left the thermometer in axilla for 5-7 minutes (mercury thermometer), or until a signal is heard		
	(electronic thermometer.		

														22
13	Read th	ne measu	ırement.											
14	Cleane	d the the	rmomet	er (merc	ury therr	nometer	r), or disc	arded th	e probe	(electror	nic			
	thermo	meter).												
15	Restore	ed patien	nt to a co	mfortabl	e positio	n.								
16	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
17	Docum	ented th	e result i	in the vit	al signs c	hart.								
18	Inform	ed the pa	atient or	relative i	f approp	riate of	the resul	t.						
19	Return	ed equip	ment to	the dedi	cated are	ea.								
20	Reporte verball		mal find	ings to th	ne appro	priate he	ealth care	e provide	r (studer	nt report	ed this	action		
		•				1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level			1	F			U	N	S	С	1	Skill level a	chieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	N 40%				
	Rationa	ale 10%	•		Patient F	ocus 10%			essional I	Manner	10%		Time 10%	
ailed			5	Failed			5	Failed			5	Failed	+10	5
	factory		6		factory		6		factory		6	Unsatisfa	-	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Superv			8	Superv			8	Superv			8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9 10
ndepe Notes:	naent		10	Indepe	naent		10	Indepe	naent		10	Independ		
10163.												Time allov	ved (TA)	10
												Time achie	ved	
												Aspects poir	nts achieved	
				3	. COM	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61-	-70	71	-80	81-	-90	91-1	L00	Total points	sachieved	
Fai	led	Unsatis	factory	Nov	/ice	Supe	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date]		

PROCE	DURE: Vital signs - assessing tympanic temperature	Code	04-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
2	Identified the patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted patient to a comfortable position with head turned to one side.		
9	Put the probe cover in place and turn the thermometer on.		
10	Straighten the ear canal by pulling the external ear up and back (adults), and down and back (children).		

														23
11	Left the	thermon	neter in p	lace until	the signa	was hear	rd.							
12	Read th	e measur	ement.											
13	Discarde	ed the pro	be.											
14	Restore	d patient	to a comf	ortable p	osition.									
15	Perform	ed hand l	hygiene u	sing corre	ct technic	que.								
16	Docume	ented the	result in t	he vital si	gns chart	•								
17	Informe	d the pati	ient or rel	lative if ap	propriate	of the re	sult.							
18	Returne	d equipm	ent to the	e dedicate	ed area.									
19	Perform	ed hand l	hygiene u	sing corre	ct technic	que.								
20	Reporte	d abnorm	nal finding	s to the a	ppropriat	e health o	are provi	der (stude	nt report	ed this ac	tion ver	bally).		
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	Skill steps a		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points a		
Level				F			U	N	S	С	I	Skill level ac	hieved	
		1 1001		1 -				CTS EVA				1 -		
T-:1I	Rationa	ale 10%	-		Patient F	ocus 10%			essional I	Manner			Time 10%	_
Failed	factory		5 6	Failed Unsatis	factory		5 6	Failed Unsatis	factory		5 6	Failed Unsatisfac	+10	5 6
Novice			7	Novice	nactory		7	Novice	iactory		7	Novice	+6	7
Superv			8	Superv	ised		8	Superv	sed		8	Supervise		8
Compe			9	Compe			9	Compe			9	Competer		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independe	ent TA	10
Notes:												Time allow	ed (TA)	10
												Time achiev	ed	
												Aspects points	sachieved	
						1PLETE I	PROCED	URE EV	ALUATIO					
≤!	50	51-	-60	61-	-70	71	-80	81-	90	91-1	100	Total points	achieved	
	led	Unsatis	factory	Nov	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level a	chieved	
Studer	nt					Signat	ure							
Teach	her Signature Actual Mark/Out of													
Clinica	l Area					Date								

PROC	EDURE: Vital Signs – assessing oral temperature	Code	04-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment. Vital signs chart Thermometer, mercury or electronic Disposable probe cover Gauze Disinfecting solution Hand rub gel Plastic tray		
2	Identified patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of the bed.		
7	Performed hand hygiene using correct technique.		

														24
8	Assisted	patient t	o supine	or sitting	position.									
9		d the the				ent:								
		thermon				ned								
10		ic, placed												
10		•						and did no		within las	t 15 min	ts.		
11	Inserte	d the ther	mometer	under th	e tongue	in the pos	sterior sub	o-lingual p	ocket.					
12		he patien												
13	Left the		neter in p	lace for 3	-5 minute	s (mercur	y thermo	meter), or	until the	signal is l	neard (el	ectronic		
14	Read th	e measure	ement.											
15	Cleaned	the therr	nometer(mercury	, or disca	rd the pro	be (elect	ronic)						
16	Restore	d patient	to comfo	rtable pos	ition.									
17		ed hand l				que.								
18	Docume	ented the	result in t	he vital si	gns chart									
19	Informe	d the pati	ient or rel	ative if ap	propriate	of the re	sult.							
20	Returne	d equipm	ent to the	e dedicate	ed area.									
21	Reporte	d abnorm	nal finding	s to the a	ppropriat	e health o	care provi	der (stude	ent report	ed this ac	tion ver	bally).		
						1.	SKILL EV	/ALUAT	ION 609	%				
Steps	0	1-2	3-4	5-6	7-8	9-10	11-13	14-15	16-17	18-19	20-21	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	s achieved	
Level				F			U	N	S	С	- 1	Skill level	achieved	
					2. F	PROCED	URE AS	PECTS E	VALUAT	ION 40	1%			
	Rationa	ale 10%		ı	Patient F	ocus 10%	6	Profe	essional	Manner	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisf	actory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8	Superv			8	Superv			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compet		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Indepen	dent TA	10
Notes:												Time allo	wed (TA)	10
												Time achie	eved	
												Aspects po	ints achieved	
					3. CC	MPLET	E PROCI	EDURE E	VALUA					
≤5	50	51-	-60	61	-70	71	-80	81-	-90	91-1	100	Total poin	ts achieved	
Fai	led	Unsatis	factory	No	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual M	lark/Out of	
Clinica														

PROC	EDURE: Vital Signs – assessing rectal temperature	Code	04-04
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Vital signs chart		
	Thermometer, rectal		
	Gauze		
	Disinfecting solution		
	Lubricant		
	Non-sterile gloves		
	Hand rub gel		
	Plastic tray		

	1													
2	Identifi	ed patie	nt using	two ider	ntifiers.									
3	Perforr	ned gree	ting, into	roductio	n and pe	rmission	procedu	re (G.I.P)).					
4	Provide	ed privac	у.											
5	Explain	ed the p	rocedure	e to the	patient a	nd answe	ered any	question	ıs.					
6	Adjuste	ed the he	eight of t	he bed.										
7	Perforr	ned hand	d hygien	e using o	correct te	chnique.								
8	Put on	gloves.												
9	Assiste	d patient	t to the p	osition	on side v	vith the u	pper leg	slightly f	flexed at	the hip a	and kne	е.		
10						urement								
		-				cleaned								
						nd turned	on.							
11		ted patie												<u> </u>
12					of therm									<u> </u>
13					um (adu	lt -5cm, c	:hild -2.5	cm, infar	nt – 1.250	cm)				<u> </u>
14		ne measu					-\ !!	and 12			l			
15		d the the meter).	ermomet	er (mer	cury tner	mometer	r), or also	araea tr	ie probe	cover (e	iectroni	C		
16			cant and	l any sto	ol from a	around th	no nation	t's roctuu						
17		ed glove:		i arry sto	OI II OIII 8	around tr	ie patien	t 3 rectui						1
18				mfortah	ole positio	nn .								
19		•			•	chnique.								
20					tal signs		<u>'</u>							
21						priate of	the resul	t.						
22		•			icated ar									
23						priate he	ealth car	e provide	er (stude	nt report	ed this	action		
	verball	y).												
						1.	SKILL EV	/ALUAT	ION 60	%				
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-17	18-19	20-21	22-23	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F	2.	PROCED	U	N DECTS E	S	C C	 	Skill level a	acnieved	
	Pation	ale 10%				Focus 109				Manner		Ī	Time 10%	
Failed	Nation	ale 1076	5	Failed	ratienti	Tocus 107	5	Failed	essionai	iviaiiilei	5	Failed	+10	5
	factory		6		sfactory		6	1	sfactory		6	Unsatisfa		6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi	ised		8	Superv	/ised		8	Superv	ised		8	Supervise	ed +4	8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	endent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	wed (TA)	10
												Time achie		
											2251	Aspects poir	nts achieved	
		F.4	60			OMPLET		1		1			1	
	50		-60		L-70		-80	-	-90	91-:		•	s achieved	
	led	Unsatis	factory	No	vice	· ·	rvised	Comp	oetent	Indepe	ndent	Total level	achieved	<u> </u>
Studer						Signat						A a 4 1 8 a	ouls/0	
Teache Clinica						Signat Date	ure					Actual IVI	ark/Out of	
Cililica	ı Ared					Date		1						<u> </u>

Note	PROCE	DURE:				Vital Si	gns – a	ssessin	g perip	nerai p	ulse			Code	04-05
Vital signs chart	No.						Skill	steps							Achieved
Hand watch or clock	1	Prepare	ed proce	dure equ	ipment.										
Identified patient using two identifiers.			Vital si	gns chart	:										
2 Identified patient using two identifiers. 3 Performed greeting, introduction and permission procedure (G.I.P). 4 Provided privacy. 5 Explained the procedure to the patient and answered any questions. 6 Asked the patient if he/she was inactive for at least 5 minutes. 7 Adjusted the height of the bed. 8 Performed hand hygiene using correct technique. 9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingertip on the patient's radial artery. 12 Counted pulsations for 30 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 2 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 15 Failed 5 Failed 5 Failed 5 Failed 10 Skill level achieved Points 0 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 7 Novice 7 Novice 6 Novice 6 Novice 6 Novice 6			Hand v	vatch or	clock										
Performed greeting, introduction and permission procedure (G.I.P). 4 Provided privacy. 5 Explained the procedure to the patient and answered any questions. 6 Asked the patient if he/she was inactive for at least 5 minutes. 7 Adjusted the height of the bed. 8 Performed hand hygiene using correct technique. 9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingerty on the patient's radial artery. 12 Counted pulsations for 30 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 2 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 2 4 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 2 4 30 36 42 48 54 60 Skill points achieved Points 0 6 5 Failed 10 Skill iseled achieved Points 0 6 Unsatisfactory 7 Novice 7 Novice 7 Novice 7 Novice 6 7 Novice 7 Novice 7 Novice 7 Novice 7 Novice 7 Novice 7 N			Hand r	ub gel											
Performed greeting, introduction and permission procedure (G.I.P). 4 Provided privacy. 5 Explained the procedure to the patient and answered any questions. 6 Asked the patient if he/she was inactive for at least 5 minutes. 7 Adjusted the height of the bed. 8 Performed hand hygiene using correct technique. 9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingerty on the patient's radial artery. 12 Counted pulsations for 30 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 2 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 2 4 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 2 4 30 36 42 48 54 60 Skill points achieved Points 0 6 5 Failed 10 Skill iseled achieved Points 0 6 Unsatisfactory 7 Novice 7 Novice 7 Novice 7 Novice 6 7 Novice 7 Novice 7 Novice 7 Novice 7 Novice 7 Novice 7 N															
Provided privacy			•												
Explained the procedure to the patient and answered any questions. Asked the patient if he/she was inactive for at least 5 minutes.					oductior	n and per	mission	procedu	re (G.I.P)						
Asked the patient if he/she was inactive for at least 5 minutes. 7 Adjusted the height of the bed. 8 Performed hand hygiene using correct technique. 9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingertlip on the patient's radial artery. 12 Counted pulsations for 30 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved 19 Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved 19 Points 0 6 12 2 18 24 30 36 42 48 54 60 Skill points achieved 19 Points 0 6 12 5 Failed 5 Failed 5 Failed 5 Failed 10 Skill steps achieved 19 Points 0 1 0 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 8 6 Unsatisfactory 6 Unsatisfactory 8 Supervised 10 Independent 10 Independent 10 Independent 11 Independent 11 Independent 12 Independent 12 Independent 12 Independent 13 Independent 14 Independent 14 Independent 15 Independent 17				·											
7 Adjusted the height of the bed.		•	•					•	•	S.					
8 Performed hand hygiene using correct technique. 9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingertip on the patient's radial artery. 12 Counted pulsations for 30 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds regular full fulled by a second rate or feature in pulse rate or feature rate or		Asked t	he patie	nt if he/s	he was i	nactive f	or at leas	st 5 minu	ites.						
9 Assisted patient to supine or sitting position. 10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingertip on the patient's radial artery. 12 Counted pulsations for 30 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 5 Failed 5 Failed 5 Failed 410 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 8 6 Supervised 8 Supervised 8 Supervised 8 Supervised 48 Supervised 49 Independent 10 Independent 1		Adjuste	d the he	ight of th	ne bed.										
10 Ensured the patient's arm was supported. 11 Placed the first, second and third fingertip on the patient's radial artery. 12 Counted pulsations for 30 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 SKILL EVALUATION 60% Steps 0 1 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill joints achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill level achieved Level F UN S C I Skill level achieved Patient Focus 10% Professional Manner 10% Time 10% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 4 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 9 Competent 9 Competent 9 Competent 9 Competent 9 Competent 10 Independent 10 Independent 11 Independent 11 Independent 12 9 Independent 12 9 Independent 12 9 Independent 12 10 Independent 14 10 Independent 14 10 Independent 15 Independent 16 Independent 17 Independent		Perforn	ned hand	d hygiene	using co	orrect te	chnique.								
Placed the first, second and third fingertip on the patient's radial artery.	9		_ •			<u> </u>									
Counted pulsations for 30 seconds if pulse was regular (multiplied the result by 2 to get the correct pulse rate) or for 60 seconds if irregular or in patients with cardiovascular disease. Restored patient to a comfortable position. Performed hand hygiene using correct technique. Documented the result in the vital signs chart. Informed the patient or relative if appropriate of the result. The returned equipment to the dedicated area. Steps 0 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 5 Failed 5 Failed 5 Failed +10 5 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 9 Competent 9 Competent 9 Competent 4 9 Competent 9 Competent 4 9 Competent 10 Independent TA 10 Notes: Student Novice Supervised Competent Independent Total level achieved 10 Total points achi	10		•												
Pulse rate) or for 60 seconds if irregular or in patients with cardiovascular disease. 13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 Skill EVALUATION 60%	11							-		-					
13 Restored patient to a comfortable position. 14 Performed hand hygiene using correct technique. 15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 Performed hand hygiene using correct technique. 18 Returned equipment to the dedicated area. 18 Performed hand hygiene using correct technique. 19 Returned equipment to the dedicated area. 19 Returned equipment to the dedic	12		•			•			•		•	get the	correct		
Performed hand hygiene using correct technique.	12	•				_	•	ents with	cardiova	ascular d	isease.				
15 Documented the result in the vital signs chart. 16 Informed the patient or relative if appropriate of the result. 17 Returned equipment to the dedicated area. 18 Skill EVALUATION 60% 19 Steps 0 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved 19 Points 0 6 12 18 24 30 36 42 48 5-6 60 Skill points achieved 10 N S C I Skill level achieved 10 N S C I Skill level achieved 10 Novice F U N S C I Skill level achieved 10 Rationale 10% Patient Focus 10% Professional Manner 10% 10 Failed S Failed S Failed S Failed 10 S 11 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 8 6 12 Novice 7 Novice 7 Novice 6 7 13 Supervised 8 Supervised 8 Supervised 8 Supervised 4 8 14 Competent 9 Competent 9 Competent 9 Competent 2 9 15 Independent 10 Independent 10 Independent 10 Independent 10 16 Notes:			•			•									
16							•								
The notation Time 10															
Skill EVALUATION 60%								the resul	t.						
Steps 0 1 2 3-4 5-6 7-8 9-10 11-12 13-14 15-16 17 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved Exercise Colspan="8">Supervised Professional Manner 10% Time 10% Failed Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised 8 Supervised 10 Independent 10 Ind	17	Return	ed equip	ment to	the dedi	cated are									
Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved Bationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Time achieved Aspects points achieved Supervised 81-90 91-100 Total po						T = -							01:11 -4		
F													-		
2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 10 5 Failed 410 4 8 4 8 5 Professional Manner 10% 10		U	6			24	30					60			
Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory+8 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 10 Time allowed (TA) 10 Time achieved Aspects points achieved Aspects points achieved 10 ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of Actual Mark/Out of Actual Mark/Out of	Levei					2 [POCED					10/	Skill level a	ichieveu	
Failed 5 Failed 5 Failed 5 Failed 410 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 4 7 Supervised 8 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 9 Competent 2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 10 10 Time allowed (TA) 10 10 10 Time achieved Aspects points achieved 10 10 Supervised Sale -90 91-100 Total points achieved 10 Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Supervised		Rationa	ale 10%											Time 10%	
Unsatisfactory 6	Failed	Nationi	1070	5		ducitie	ocus 107			233101141	viailiei		Failed		5
Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent 10 Independent TA 10 Notes: 3. COMPLETE PROCEDURE EVALUATION 100% Time achieved Aspects points achieved Aspects points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total points achieved Student Signature Actual Mark/Out of Actual Mark/Out of Actual Mark/Out of		factory				factory				factory					
Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 10 Time achieved Aspects points achieved Actual Mark/Out of										-					
Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 10 Time achieved Aspects points achieved Aspects points achieved Aspects points achieved Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of	Supervi	sed		8	Superv	ised		8	Superv	ised		8	Supervise	ed +4	8
Notes: Time allowed (TA) 10				9	Compe	tent		9	Compe	tent		9	Compete	ent +2	9
Time achieved Aspects points achieved Signature Time achieved Aspects points achieved Source Supervised Competent Independent Total level achieved Signature Failed Signature Teacher Signature Actual Mark/Out of	Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Aspects points achieved 3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of	Notes:												Time allov	wed (TA)	10
3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Signature Teacher Signature Actual Mark/Out of													Time achie	ved	
≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of													Aspects poir	nts achieved	
Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of						3. CC	MPLET	E PROCE	DURE E	VALUA	TION 10	00%			
Student Signature Ceacher Signature Actual Mark/Out of	≤5	50	51-	-60	61-	-70	71-	-80	81	-90	91-1	L00	Total points	s achieved	
Teacher Signature Actual Mark/Out of			Unsatis	factory	Nov	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Clinical Area								ure					Actual Ma	ark/Out of	
Cililical Area	Clinica	l Area					Date								

PROCE	DURE:				Vita	al signs -	assessi	ing apica	al pulse				Code	04-06	
No.							Skill ste	eps					Not achieved	Achieved	
1	Prepare	-	dure equ	· · ·											
	•		gns char	t											
	•	Stetho	-												
	•		vatch or	clock											
2	•	Hand r													
2				two iden											
3				oduction	and pe	rmission	procedu	re (G.I.P)							
4		d privac	•												
5					atient a	nd answe	ered any	question	IS.						
6			ight of t												
7				e using co		chnique.									
8		•													
9		Assisted patient to supine or sitting position. Asked if the patient had been active in the last 20 minutes, if yes, waited 5 to 10 minutes before assessing the pulse.													
10				moking,	waited 2	20 minut	es before	e assessir	ng the pu	ılse.					
11	Found	the angle	of Louis	just bel	ow the s	upra-ste	rnal notc	h betwee	en the st	ernal boo	dy and	the			
	manub														
12		ly moved y to the l) and												
13				of the st			palm of	hand.							
14							•	imum im	npulse (P	MI) at th	e fifth I	CS, at			
			-	the diag	_	-			. ,	,		,			
15	If the a	pical rate	e was reg	gular, cou	ınted for	30 seco	nds and	multiplie	d by two	(verbal	report (of the			
				rement).											
				_				ing cardio easureme		medica	tion, co	unted			
16				mfortabl			ir the me	asar ciric	21107.						
17		•		e using co	•										
18				in the vit											
19				relative i			the resul	+							
20				the dedi			ine resur	ι.							
21							alth care	e provide	r (studer	nt renort	ed this	action			
21	verbally		mai mia	11163 to ti	іс арріо	priace ric	aitii cait	c provide	i (staaci	пстероге	ca tilis	action			
				T				ALUAT							
Steps	0	1-2	3-4	5-6	7-8	9-10	11-13	14-15	16-17	18-19	20-21	Skill steps			
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points			
Level				F		DC 6==	U	N DECTC F	S	C	1	Skill level a	achieved		
	D-4:	-I- 400/		I -				PECTS E					Ti 400/		
Fails -	Rationa	iie 10%	-		atient F	ocus 109		-	essional I	vianner	1	Fails -	Time 10%	1	
Failed	factor		5	Failed	factori		5	Failed	factori		5	Failed Unsatisfa	+10	5	
Unsatis Novice	iactory		6 7	Novice	factory		6 7	Novice	sfactory		6 7	Novice	+6	6 7	
Supervi	ised		8	Supervi			8	Superv			8	Supervise		8	
Compe			9	•			9	· ·			9	Compete		9	
•	ppetent 9 Competent 9 Competent +2 competent 10 Independent 10 Independent TA													10	
Notes:												Time allov		10	
	Time achie												ved		
												Aspects poir	nts achieved		

Time achieved

Aspects points achieved

		3. CC	OMPLETE PROCE	DURE EVALUA	TION 100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION

PROCE	DURE:				Vita	l signs -	assessi	ng respi	rations				Code	04-07
No.							Skill st	eps					Not achieved	Achieved
1	Prepar	ed proce	-	-										
	•		gns char											
	•		watch or											
2	Identif													
3	Perforr													
4	Provide													
5	Didn't	Explain t	he proce	dure to t	he patie	nt, and a	nswered	l any que	stions.					
6	Adjuste	ed the he	eight of t	he bed.										
7	Performed hand hygiene using correct technique.													
8		•	•		<u> </u>									
9		Assisted patient to supine or sitting position. While fingers are still in place after counting the pulse rate, counted patient's respirations. (student's verbal report after the measurement).												
10	Counte	d numbe	er of resp	oirations	for a mir	nimum of	f 30 seco	nds. Mul	tiplied 30)-second	d measu	irement		
	Counted number of respirations for a minimum of 30 seconds. Multiplied 30-second measurement by 2 for respiratory rate per minute.													
	Counted respirations for at least 1 full minute if respirations are abnormal													
11	Restored patient to a comfortable position.													
12	Performed hand hygiene using correct technique.													
13	Docum	ented th	e result i	in the vit	al signs o	hart.								
14	Inform	ed the pa	atient or	relative i	fapprop	riate of t	the resul	t.						
15	Return	ed equip	ment to	the dedi	cated are	ea.								
16	Report verball		rmal find	ings to th	ne appro	priate he	ealth care	e provide	r (studer	it report	ed this	action		
						1.	SKILL E	/ALUAT	ON 60%	6				
Steps	0	1	2	3-4	5-6	7-8	9-10	11-12	13-14	15	16	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С		Skill level a	achieved	
		1 400/		1 -				PECTS E				I	T : 400/	
Failed	Rationale 10% Patient Focus 10						1	Failed	ssional I	vlanner		Time 10%		-
	d 5 Failed tisfactory 6 Unsatisfactory						5 6	Unsatis	factory		5 6	Failed +10 Unsatisfactory+8		5 6
Novice			7	Novice	iactory		7	Novice	iactory		7	Novice	+6	7
Superv			8	Supervi	ised		8	Superv	sed		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:														

	3. COMPLETE PROCEDURE EVALUATION 100%													
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved								
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved								
Student			Signature											
Teacher	acher		Signature			Actual Mark/Out of								
Clinical Area			Date											

PROCE	PROCEDURE: Vital signs – assessing blood pressure Code 04-08											
No.	Skill steps	Not achieved	Achieved									
1	Prepared procedure equipment:											
	Vital signs chart											
	Sphygmomanometer											
	Stethoscope											
	Hand rub gel											
	Plastic tray											
2	Identified patient using two identifiers.											
3	Performed greeting, introduction and permission procedure (G.I.P).											
4	Provided privacy.											
5	Explained the procedure to the patient and answered any questions.											
6	Adjusted the height of the bed.											
7	Performed hand hygiene using correct technique.											
8	Assisted patient to supine or sitting position.											
9	Asked if patient is in pain or has just exercised, unless it is urgent to obtain blood pressure.											
10	Selected appropriate arm for application of the cuff.											
11	Selected appropriate size cuff for the client.											
12	Exposed the area of brachial artery by removing garments or moving sleeve.											
13	Centered bladder of cuff over brachial artery approximately midway on arm, so lower edge of cuff											
	was about 2.5–5 cm (1–2 inches) above inner aspect of elbow.											
14	Wrapped cuff smoothly and snugly around arm.											
15	Student verbally informed checking that mercury manometer is in a vertical position and mercury is											
	within the zero area with gauge at eye level.											
16	Palpated pulse at brachial or radial artery.											
17	Tighten the screw valve on air pump.											
18	Inflated the cuff while continuing to palpate artery, and verbally informed the point when the pulse											
	disappeared.											
19	Deflated cuff and waited 15 seconds.											
20	Placed stethoscope earpieces in ears											
21	Placed stethoscope bell or diaphragm firmly but with as little pressure as possible over brachial											
22	artery 20 years the description of the second size											
22	Pumped the pressure 30 mm Hg above point at which systolic pressure was palpated and estimated.											
23	Slowly turned the screw valve on the air pump and let mercury fall slowly while noticing first clear sound (systolic pressure) and the last clear sound (diastolic pressure).											
24	Restored the patient to a comfortable position.											
25	Performed hand hygiene using correct technique.											
26												
27	Documented the result in the vital signs chart.											
	Informed the patient or relative if appropriate, of the result											
28	Returned equipment to the dedicated area.											
29	Reported abnormal findings to appropriate health care provider (student should verbally report this action).]										

						1.	SKILL E\	/ALUAT	ION 609	%			
Steps	0	1-3	4-6	7-9	10-12	13-14	15-18	19-21	22-24	25-27	28-29	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level				F			U	N	S	С	1	Skill level achieved	
					2. I	PROCED	URE AS	PECTS E	VALUAT	TION 40	%		
Rationale 10% Patient Focus 10% Professional Manner 10% Time 10%													
Failed 5 Failed							5	Failed			5	Failed +10	5
Unsatisfactory 6			6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory+8	6
Novice	Novice 7			Novice			7	Novice			7	Novice +6	7
Superv	ised		8	Supervised			8	Supervised			8	Supervised +4	8
Compe	tent		9	Competent			9	Competent			9	Competent +2	9
Indepe	ndent		10	Indepe	ndent		10	Independent			10	Independent TA	10
Notes:												Time allowed (TA)	15
												Time achieved	
												Aspects points achieved	
					3. CC	MPLET	E PROCE	DURE E	VALUA	TION 10	00%		
≤5	50	51	-60	61	-70	71	-80	81	-90	91-1	L00	Total points achieved	
Fai	Failed Unsatisfactory		factory	Nov	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level achieved	
Studer	Student		Signatu		ure								
Teach	Teacher		Signatu			ure					Actual Mark/Out of		
Clinica	Clinical Area				Date								

PROCE	PROCEDURE: Vital signs- assessing oxygen saturation										
No.	Skill steps	Not achieved	Achieved								
1	Prepared procedure equipment.										
	Vital signs chart										
	 Pulse oximeter 										
	 Alcohol swabs or gauze and disinfecting solution 										
2	Hand rub gel										
2	Identified patient using two identifiers.										
3	Performed greeting, introduction and permission procedure (G.I.P).										
4	Provided privacy.										
5	Explained the procedure to the patient and answered any questions.										
6	Adjusted the height of the bed.										
7	Performed hand hygiene using correct technique.										
8	Assisted patient to supine or sitting position.										
9	Selected proper site for the sensor, patient's index, middle or ring finger, toe or earlobe.										
10	Cleansed the selected area with the alcohol swab or gauze and allowed the area to dry.										
11	Applied probe securely to skin.										
12	Turned the oximeter on and waited for the result.										
13	Removed sensor and cleaned it with an alcohol swab.										
14	Restored patient to a comfortable position.										
15	Performed hand hygiene using correct technique.										
16	Documented the result in the vital signs chart.										
17	Informed the patient or relative, if appropriate of the result.										
18	Returned equipment to the dedicated area.										
19	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).										

						1.	SKILL EV	/ALUAT	ION 609	%				
Steps	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18-19	Skill steps achi	eved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points ach	Skill points achieved	
Level				F			U	N	S	С	I	Skill level achie	ved	
					2. I	PROCED	URE AS	PECTS E	VALUAT	TION 40	%			
Rationale 10% Patient Focus 10% Professional Manner 10% Time 10%														
Failed							5	Failed			5	Failed	+10	5
Unsatisfactory 6 Unsatisfacto				factory		6	Unsatis	factory		6	Unsatisfacto	ry+8	6	
Novice 7 Novice						7	Novice			7	Novice	+6	7	
Superv	Supervised 8 Supervise				ised	8 Supervised			8	Supervised	+4	8		
Compe	tent		9	Compe	tent		9	Compe	tent		9	Competent	+2	9
Indepe	ndent		10	Indepe	ndent		10	Independent 1				Independen	t TA	10
Notes:												Time allowed	(TA)	10
												Time achieved		
												Aspects points a	chieved	
					3. CC	MPLET	E PROCI	EDURE E	VALUA	TION 10	00%			
≤!	50	51	-60	61-	-70	71-	-80	81	-90	91-1	100	Total points act	nieved	
Fai	Failed Unsatisfactory		Nov	/ice	Super	rvised	Comp	etent	Indepe	ndent	Total level achi	eved		
Studer	Student			Signature										
Teach	Teacher			Signature						Actual Mark/	Out of			
Clinica	Clinical Area					Date								

Vital Signs Chart

PROCEDURE: Activity – assisting a patient with turning in bed Code C										
No.	Skill steps	Not achieved	Achieved							
1	Prepared procedure equipment:									
	Patient medical record									
	Friction-reducing sheet									
	Hand rub gel									
	Plastic tray									
2	Reviewed the physician's orders and nursing plan of care for patient activity, identifying any									
	movement limitations and the ability of the patient to assist with turning.									
3	Performed hand hygiene using correct technique.									
4	Identified the patient using two identifiers.									
5	Performed greeting, introduction and permission procedure (G.I.P).									
6	Provided privacy.									
7	Explained the procedure to the patient and answered any questions.									
8	Adjusted the height of the bed.									
9	Assess for tubes, IV lines, incisions, or equipment that may alter the turning procedure.									
10	Positioned at least one nurse on the other side of the bed to assist.									
11	Positioned a friction-reducing sheet under the patient.									
12	Using the friction-reducing sheet, move the patient to the edge of the bed, opposite the side to									
	which he or she will be turned.									
13	Raised the side rails if possible.									
14	If the patient is able, asked the patient to grasp the side rail on the side of the bed toward which he									
	or she is turning.									
	Alternately, place the patient's arms across his or her chest and cross his or her far leg over the leg									
15	nearest you. Asked the nurse on the side of the bed toward which the patient is turning to stand opposite the									
13	patient's center with his or her feet spread about shoulder width and with one foot ahead of the									
	other.									
16	Asked the nurse on the side of the bed toward which the patient is turning to position his or her									
	hands on the patient's shoulder and hip, assisting to roll the patient to the side.									
17	Instructed the patient to pull on the bed rail at the same time.									
18	Used the friction-reducing sheet to gently pull the patient over on his or her side.									
19	Used a pillow or other support behind the patient's back.									
20	Made the patient comfortable and position in proper alignment, using pillows or other supports									
	under the leg and arm, as needed.									
21	Readjusted the pillow under the patient's head or elevate the head of the bed as needed for									
	comfort.									
22	Placed the bed in the lowest position, with the side rails up.									
23	Made sure the call bell and other necessary items are within easy reach.									
24	Performed hand hygiene using correct technique.									
25	Documented the procedure in the patient's notes if record of turning the patients is needed.									
26	Returned equipment to the dedicated area.									

						1.	SKILL E\	/ALUAT	ION 609	%			
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-24	25-26	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level			1	F			U	N	S	С	I	Skill level achieved	
					2. I	PROCED	URE AS	PECTS E	VALUA1	TION 40)%		
	Ration	ale 10%		F	Patient F	ocus 10%	6	Profe	essional	Manner	10%	Time 10%	
Failed							5	Failed			5	Failed +10	5
· · · · · · · · · · · · · · · · · · ·				Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory+8	6
Novice 7			7	Novice			7	Novice			7	Novice +6	7
Supervised 8			8	Supervised			8	Supervised			8	Supervised +4	8
Compe	Competent 9			Competent			9	Competent			9	Competent +2	9
Indepe	ndent		10	Indepe	ndent		10	Independent			10	Independent TA	10
Notes:												Time allowed (TA)	10
												Time achieved	
												Aspects points achieved	
					3. CC	MPLET	E PROCE	EDURE E	VALUA	TION 1	00%		
≤5	50	51	-60	61-	-70	71	-80	81	-90	91-2	100	Total points achieved	
Fai	Failed Unsatisfactory		factory	Nov	/ice	Super	rvised	Comp	etent	Indepe	ndent	Total level achieved	
Studer	Student					Signat	ure						
Teach	Teacher			Signatur							Actual Mark/Out of		
Clinica	Clinical Area		Date										

PROCE	DURE: Activity – moving a patient up in bed	Code	05-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	Hand rub gel		
	Plastic tray		
2	Reviewed the physician's orders and nursing plan of care for conditions that may influence the patient's ability to move or to be positioned.		
3	Performed hand hygiene using correct technique.		
4	Identified the patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed to the lowest position.		
9	Raised the head of the bed to a sitting position, or as the patient can tolerate.		
10	Assessed for tubes, IV lines, incisions, or equipment that may alter the positioning procedure.		
11	Checked the bed brakes are locked		
12	Put the chair next to the bed bracing it against a secure object.		
13	Positioned himself/herself with legs shoulder width apart, with one foot near the head of the bed, slightly in front of the other foot.		
14	Assisted the patient to sit up on the side of the bed; helping the patient to swing his or her legs over the side of the bed.		

														35		
15	Asked t	he patie	nt about	any bala	nce prob	olems or	complaiı	nts of diz	ziness.							
16	Assiste	d the pat	ient to p	ut on a r	obe, as r	necessary	y, and no	n-slip fo	otwear.							
17	Stood f	acing the	e patient	with fee	t about s	houlder	width ap	art and f	lexed hi	os and kr	nees.					
18	Asked t	he patie	nt to slid	le his or h	ner butto	cks to th	ne edge c	of the bed	d until th	e feet to	uch the	floor.				
19	Assiste	d the pat	tient to s	tand up v	with the	help of a	nother r	urse if n	eeded.							
20		•		alance ar	nd leg sti	ength. If	the pati	ent was	too weal	or unst	eady, re	eturned				
	•	ient to b														
21	Assisted the patient to turn until the patient feels the chair against his or her legs. Asked the patient to use an arm to steady him- or herself on the arm of the chair while slowly															
22	lowering to a sitting position.															
23	Assess the patient's alignment and comfort in the chair.															
24	Covered the patient with blanket.															
25	Made sure the call bell and other necessary items are within easy reach.															
26	Performed hand hygiene using correct technique.															
27	Returned equipment to the dedicated area.															
	1. SKILL EVALUATION 60%															
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	6 17-19 20-22 23-25 26-27 Skill steps			Skill steps ach					
Points	0	6	12	18	24	30	36	42	48	54	60		Skill points achieved			
Level				F	2 22	005011	U	N CTC F) (4	S	C	I	Skill level ach	ieved			
	Dations	J- 100/						CTS EVA								
Failed	Rationa	ile 10%	5	Failed	atient F	ocus 10%	6 5	Failed	ssionai	Manner	5	Failed	me 10% +10	5		
	factory		6	Unsatis	factory		6	Unsatisfactory		6	Unsatisfact		6			
Novice	nactor y		7	Novice	ractory		7	Novice	ractory		7	Novice	+6	7		
Supervi	ised		8	Supervi	sed		8	Supervi	sed		8	Supervised		8		
Compe			9	Compe			9	Compe			9	Competent		9		
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independe	nt TA	10		
Notes:												Time allowe	d (TA)	15		
												Time achieved	d			
												Aspects points	achieved			
3. COMPLETE PROCEDURE EVALUATION 100%																
	≤50 51-60 61-70				-80	81-	-90	91-100 1		Total points a						
	ailed Unsatisfactory Novice Supervised Competent Independent				ndent	Total level ach	nieved									
Studer				Signature												
Teache	er					Signati	ure					Actual Mark	/Out of			
Clinica	l Area					Date										

PROCE	EDURE: Activity – transferring patient from bed to a chair	Code	05-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	Hand rub gel		
	Plastic tray		
2	Reviewed the physician's orders and nursing plan of care for conditions that may influence the		
	patient's ability to move or to be positioned.		
3	Performed hand hygiene using correct technique.		

4	1-1	4			: -1 +: ::: :									
5		ed the pa						(C D)						
_				oductioi	n and pe	rmission	proceau	re (G.I.P)	•					
6		ed privacy	•											
7	•					nd answe	•	question	S.					
8			_			est posit								
9						sition, o	•							
10						equipme	nt that m	ay alter	the posi	ioning p	rocedur	e.		
11		d the bed												
12						gainst a s			.		1 6.1			
13					_	lder wid	th apart,	with one	e foot ne	ar the he	ad of th	ie bed,		
14	slightly in front of the other foot. Assisted the patient to sit up on the side of the bed; helping the patient to swing his or her legs over													
14	the side of the bed.													
15														
16	Asked the patient about any balance problems or complaints of dizziness. Assisted the patient to put on a robe as pecessary, and pon-slip footwear.													
17	Assisted the patient to put on a robe, as necessary, and non-slip footwear. Stood facing the patient with feet about shoulder width apart and flexed hips and knees.													
18												floor		
19														
20	Assisted the patient to stand up with the help of another nurse if needed. Assessed the patient's balance and leg strength. If the patient was too weak or unsteady, returned													
	Assessed the patient's balance and leg strength. If the patient was too weak or unsteady, returned the patient to bed.													
21	Assisted the patient to turn until the patient feels the chair against his or her legs.													
22	Assisted the patient to turn until the patient feels the chair against his or her legs. Asked the patient to use an arm to steady him- or herself on the arm of the chair while slowly													
	lowering to a sitting position.													
23	Assess the patient's alignment and comfort in the chair.													
24														
25														
26	Perforn	ned hand	hygiene	e using c	orrect te	chnique.								
27	Returne	ed equip	ment to	the dedi	cated are	ea.								
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps a	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	I	Skill level a	chieved	
				ı		OCEDU						T		
	Rationa	ale 10%			Patient F	ocus 109			essional	Manner			Time 10	
Failed	· ·		5	Failed	<u> </u>		5	Failed	<u> </u>		5	Failed	+10	5
Unsatis	tactory		6 7		sfactory		6 7		factory		6	Unsatisfa	•	6
Novice Supervi	cod		8	Novice Superv			8	Novice Superv			7 8	Novice Supervise	+6 ed +4	7 8
Compe			9	Compe			9	Compe			9	Compete		+
Indepe			10	Indepe			10	Indepe			10	Independ		
Notes:												Time allow		10
														10
												Time achiev	ved	
	3. COMPLETE PROCEDURE EVALUATION 100%													
	≤50 51-60 61-70			71-80 81-90 91-100				Total points						
	Failed Unsatisfactory Novice			Supervised Competent Independent				ndent	Total level a	achieved				
Studen					Signature									
Teache						Signat	ure					Actual Mark/Out of	of	
Clinica	ı Area					Date								

PROCE	DURE: Exercise – performing range of motion exercises	Code	06-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	• Gloves		
	Hand rub gel		
	Plastic tray		
2	Review the physician's orders and nursing plan of care for patient activity.		
3	Performed hand hygiene using correct technique.		
4	Identified the patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Identified the patient's learning needs by asking about level of knowledge and previous experience		
	with range of motion exercises.		
9	Encouraged the patient to do as many of these exercises by him- or herself as possible.		
10	Adjusted the height of the bed.		
11	Stand on the side of the bed where the joints are to be exercised.		
12	Put on gloves.		
13	Exercise 1: Move the chin down to rest on the chest and return the head to a normal upright		
	position.		
14	Exercise 2: Tilt the head as far as possible toward each shoulder.		
15	Exercise 3: Move the head from side to side, bringing the chin toward each shoulder.		
16	Exercise 4: Lift the arm forward to above the head and return the arm to the starting position at the		
	side of the body.		
17	Exercise 5: With the arm back at the side, move the arm laterally to an upright position above the		
	head, return it to the original position and move it across the body as far as possible.		
18	Exercise 6: Raise the arm at the side until the upper arm is in line with the shoulder. Bend the elbow		
	at a 90-degree angle and move the forearm upward and downward, then return the arm to the side.		
19	Exercise 7: Bend the elbow and move the lower arm and hand upward toward the shoulder. Return		
	the lower arm and hand to the original position while straightening the elbow.		
20	Exercise 8: Rotate the lower arm and hand so the palm is up. Rotate the lower arm and hand so the		
21	palm of the hand is down.		
21	Exercise 9: Move the hand downward toward the inner aspect of the forearm. Return the hand to a neutral position even with the forearm. Then move the dorsal portion of the hand backward as far		
	as possible.		
22	Exercise 10: Bend the fingers to make a fist, and then straighten them out. Spread the fingers apart		
	and return them back together. Touch the thumb to each finger on the hand.		
23	Exercise 11: Extend the leg and lift it upward. Return the leg to the original position beside the other		
	leg.		
24	Exercise 12: Lift the leg laterally away from the patient's body. Return the leg back toward the other		
	leg and try to extend it beyond the midline.		
25	Exercise 13: Turn the foot and leg toward the other leg to rotate it internally. Turn the foot and leg		
	outward away from the other leg to rotate it externally.		
26	Exercise 14: Bend the leg and bring the heel toward the back of the leg. Return the leg to a straight		
	position.		
27	Exercise 15: At the ankle, move the foot up and back until the toes are upright. Move the foot with		
	the toes pointing downward.		
28	Exercise 16: Turn the sole of the foot toward the midline. Turn the sole of the foot outward.		
29	Exercise 17: Curl the toes downward, and then straighten them out. Spread the toes apart and bring		
	them together.		

														30
30	Repeat	ed these	exercise	s on the	other sid	de of the	body.							
31	Checke	d that th	e patien	t is comf	ortable.									
32	Remov	ed glove:	S.											
33	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
34	Docum	ented th	e proced	lure in th	e patien	t's notes								
35	Returne	ed equip	ment to	the dedi	cated are	ea.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-33	34-35	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level F							U	N	S	С	- 1	Skill level a	achieved	
					2. PR	OCEDUI	RE ASPE	CTS EVA	LUATIO	N 40%				
	Rationale 10% Patient Focus 10% Professional Manner							10%						
Failed			5	Failed			5	Failed			5	Failed +10		5
	factory		6		factory		6	Unsatis	factory		6	Unsatisfa	6	
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8	Superv			8	Supervi			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Indepen	dent TA	10
Notes:												Time allov	wed (TA)	20
												Time achie	eved	
												Aspects poi	nts achieved	
				3	. CON	IPLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤5	50	51-	-60	61	-70	71-	-80	81-	90	91-1	L00	Total points achieved		
Fai	led	Unsatis	factory	Nov	vice	Super	vised	Comp	etent	Indepe	ndent	Total level achieved		
Studer	nt					Signat	ure							
Teache	er					Signatu						Actual M	ark/Out of	
Clinica	l Area					Date								

PROCE	EDURE: Exercise – performing leg exercises	Code	06-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	• Gloves		
	Hand rub gel		
	Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Checked the patient's chart for the type of surgery and reviewed the medical orders.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Put on gloves.		
8	Explained the procedure to the patient and answered any questions.		
9	Identified the patient's learning needs by asking about level of knowledge and previous experience with leg exercises.		
10	Adjusted the height of the bed.		
11	Assisted the patient to sitting (semi-Fowler's) position or asked the patient to sit up.		
12	Explain to the patient that you will first demonstrate, and then coach him/her to exercise one leg at		
	a time.		

Straightened the patient's knee, raised the foot, extended the lower leg, and hold this position for a few seconds and lowered the entire leg.															33
Assisted or asked the patient to point the toes of both legs toward the foot of the bed, then relax them.	13						e foot, e	xtended	the lowe	er leg, an	d hold th	nis posit	ion for a		
Assisted or asked the patient to point the toes of both legs toward the foot of the bed, then relax them. 16 Assisted or asked the patient to flex or pull the toes toward the chin. 17 Assisted or asked the patient to keep legs extended and to make circles with both ankles, first circling to the left and then to the right. 18 Instructed the patient to repeat these exercises three times. 19 Checked the patient to repeat these exercises three times. 20 Asked the patient to give a return demonstration. 21 Asked the patient to give a return demonstration. 22 Encouraged the patient to practice the activities and ask questions, if necessary. 23 Restored patient to a comfortable position. 24 Removed gloves. 25 Performed hand hygiene using correct technique. 26 Returned equipment to the dedicated area. 27 SKILL EVALUATION 60% Steps 0 1-2 3-5 6-8 9-11 12-13 14-16 17-19 20-22 23-24 25-26 Skill steps achieved 28 Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved 29 Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved 19 Level F U N S C I Skill level achieved 20 PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 5 Failed 5 Failed 5 Failed 5 Failed 10 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 7 Novice 7 Novice 7 Novice 46 7 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 10 Independent 10 Independent 10 Independent 10 Independent 10 Independent 11 Indepe		few sec	onds and	d lowere	d the en	tire leg.									
The complete compl	14														
Assisted or asked the patient to flex or pull the toes toward the chin. 17 Assisted or asked the patient to keep legs extended and to make circles with both ankles, first circling to the left and then to the right. 18 Instructed the patient to repeat these exercises three times. 19 Checked the patient understands the information. 20 Asked the patient to give a return demonstration. 21 Asked the patient to give a return demonstration. 22 Encouraged the patient to practice the activities and ask questions, if necessary. 23 Restored patient to a comfortable position. 24 Removed gloves. 25 Performed hand hygiene using correct technique. 26 Returned equipment to the dedicated area. 1 SKILL EVALUATION 60% Steps 0 1-2 3-5 6-8 9-11 12-13 14-16 17-19 20-22 23-24 25-26 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved 1 SKILL EVALUATION 40% Patient Focus 10% Professional Manner 10% Time 10% Patient Focus 10% Professional Manner 10% Time 10% Failed S Failed S Failed S Failed S Failed 15 Failed 10 Independent 10 Independent 10 Independent 10 Independent 10 Independent 11 In	15	Assiste	d or aske	d the pa	tient to p	ooint the	toes of I	both legs	s toward	the foot	of the be	ed, ther	relax		
Assisted or asked the patient to keep legs extended and to make circles with both ankles, first circling to the left and then to the right. 18															
Circling to the left and then to the right.						-									
Instructed the patient to repeat these exercises three times.	17			-			extende	ed and to	make ci	rcles wit	h both a	nkles, fi	rst		
Checked the patient understands the information. 20 Asked the patient to give a return demonstration. 21 Asked the patient if he or she has any questions. 22 Encouraged the patient to practice the activities and ask questions, if necessary. 23 Restored patient to a comfortable position. 24 Removed gloves. 25 Performed hand hygiene using correct technique. 26 Returned equipment to the dedicated area. 27 Skill EVALUATION 60% 28 26 Returned equipment to the dedicated area. 28 Steps 29 Skill steps achieved 20	10														
Asked the patient to give a return demonstration. 21									es.						
Asked the patient if he or she has any questions. 22 Encouraged the patient to practice the activities and ask questions, if necessary. 3 Restored patient to a comfortable position. 3 Restored patient by a Restored			•												
Steps			•												
Restored patient to a comfortable position.			•												
24 Removed gloves. Sepriormed hand hygiene using correct technique. SKILL EVALUATION 60% 26 Returned equipment to the dedicated area. SKILL EVALUATION 60% Steps 0 1-2 3-5 6-8 9-11 12-13 14-16 17-19 20-22 23-24 25-26 Skill steps achieved Skill steps achieved Points 0 6 12 18 24 30 36 42 48 8 5 C 1 Skill level achieved Level F		and all the patients to produce the determined and determined the													
Performed hand hygiene using correct technique. 26 Returned equipment to the dedicated area.					mfortabl	e positio	n.								
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Skeps O															
Steps 0 1-2 3-5 6-8 9-11 12-13 14-16 17-19 20-22 23-24 25-26 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill level achieved Level F U N S C 1 Skill level achieved Extractory Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 7 Novice 4 8 Competent 9 Competent 9 Competent 9 Competent 10 Independent 7A 10 Notes: 3 COMPLETE PROCEDURE EVALUATION 100 Total points achieved <td>26</td> <td colspan="12"></td> <td></td>	26														
Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved	-	I			T							1 25 26	1 01 111 1		
Level F U N S C I Skill level achieved Rationale 10% PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 1A 10 Notes: 3 COMPLETE PROCEDURE EVALUATION 100% 15 15 15 15 15 15 15 15 15 15 15 15 15 15 15 15 15 10 10															
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Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 15 Time allowed (TA) 15 Time achieved Aspects points achieved 15 Time achieved Aspects points achieved ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of	Levei				<u> </u>	2 DD	OCEDIII		1			'	Skill level a	acnieved	
Failed 5		Pations	lo 10%											Time 10%	
Unsatisfactory 6	Failed	Nationi	10/0	5		atienti	ocus 107			.331011a1 1	viaililei		Failed		5
Novice 7 Novice 7 Novice 4 8 Supervised 8 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 2 9 Independent 10 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 15 Time achieved Aspects points achieved Aspects points achieved Actual Mark/Out of		factory				factory				factory			1		
Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 15 Time achieved Aspects points achieved Aspects points achieved Actual Mark/Out of		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				,				,				-	
Independent 10 Independent 10 Independent 10 Independent Table 10 Notes: Time allowed (TA) 15 Time achieved Aspects points achieved Actual Mark/Out of	Supervi	ised		8	Superv	ised		8	Superv	ised		8	Supervis	ed +4	8
Notes: Time allowed (TA) Time achieved Aspects points achieved Competent Independent Total points achieved Signature Signature Teacher Signature Actual Mark/Out of	Compe	tent		9	Compe	tent		9	Compe	tent		9	Compete	ent +2	9
Time achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of	Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Aspects points achieved 3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of	Notes:												Time allow	wed (TA)	15
Aspects points achieved 3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of													Time achie	eved	
3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of															
≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Signature Student Teacher Signature Signature Actual Mark/Out of					3	. CON	1PLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
Student Signature Actual Mark/Out of	≤5	50	51-	-60	61-	-70	71-	-80	81	-90	91-1	100	Total point	s achieved	
Teacher Signature Actual Mark/Out of	Fai	led	Unsatis	factory	Nov	/ice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
	Studer	nt					Signati	ure							
Clinical Area Date	Teache					Signati	ure					Actual M	ark/Out of		
	Clinica	l Area					Date								

PROCE	EDURE: Immobilization - applying an arm sling	Code	07-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	Arm sling		
	Gauze pad		
	Hand rub gel		
	Plastic tray		
2	Identified patient using two identifiers.		

														40
3	Perforn	ned gree	ting, inti	oduction	n and per	mission	procedu	re (G.I.P)						
4	Provide	ed privac	у.											
5	Explain	ed the p	rocedure	e to the p	atient ar	nd answe	ered any	question	s.					
6	Adjuste	ed the he	ight of t	he bed.										
7	Perforn	ned hand	d hygien	e using co	orrect te	chnique.								
8	Assiste	d patient	to a sitt	ing posit	ion.									
9	Placed	the patie	ent's fore	earm acro	oss the c	hest with	the elbo	ow flexed	and the	palm ag	gainst th	ne chest.		
10	Enclose	ed the ar	m in the	sling, ma	aking sur	e the elb	ow fits ir	nto the c	orner of	the fabri	c.			
11			•	tient's ba			e shoulde	er opposi	te the in	jury, the	n down	the		
				the end										
12				der the	•		•							
13	Checked that the sling and forearm are slightly elevated and at a right angle to the body (verbal report).													
14	Restored the patient to a comfortable position.													
15	Checked the patient's level of comfort, arm positioning, and neurovascular status of the affected													
16	limb every 4 hours (verbal report). Assessed the axillary and cervical skin frequently for irritation or breakdown (verbal report).													
17	Performed hand hygiene using correct technique.													
18	Documented the procedure in the patient's notes.													
19	Returned equipment to the dedicated area.													
	Return	eu equip	ment to	the deal	cateu are		/III E\/A	LUATIO	N 60%					
Steps	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18-19	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F	I.	I	U	N	S	С	I	Skill level a		
					2. PR	OCEDUI	RE ASPE	CTS EV	LUATIO	N 40%				
	Rationa	ale 10%		F	Patient F	ocus 10%	6	Profe	essional	Manner	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed +10		5
Unsatis	factory		6	1	factory		6	Unsatis	factory		6	Unsatisfa	actory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Superv			8	Superv			8	Superv			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe Notes:	naent		10	Indepe	naent		10	Indepe	naent		10	Indepen		10
Notes.												Time allo	wed (TA)	10
												Time achie	eved	
												Aspects poi	nts achieved	
						IPLETE F	PROCED	URE EV						
≤!	≤50 51-60 61-70		-70	71-	-80	81	-90	91-1	100	Total point	s achieved			
Fai	Failed Unsatisfactory Novice			vice		rvised	Comp	etent	Indepe	ndent	Total level	achieved		
	itudent				Signat	ure								
	Teacher					Signature						Actual M	ark/Out of	
01: :		Area Date												

PROCE	EDURE: Immobilization – assisting a patient with ambulation using crutches	Code	07-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Patient medical record		
	Crutches		
	Hand rub gel		
	Plastic tray		

2					d nursing	plan of	care for	condition	s that m	ay influe	nce the	!		
2		•		and aml										
3					orrect ted	chnique.								
4		•		two iden				(0.1.0)						
5				roduction	n and per	mission	procedu	re (G.I.P)	•					
6		ed privac	•											
7					atient an			-						
8					and previo				the use	of crutch	es.			
9				•	e size crut									
10	Assessed for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation. Decided how far to walk.													
11														
12	Asked the patient to report any feelings of dizziness, weakness, or shortness of breath while walking.													
13	Assisted the patient to stand erect, face forward in the tripod position - the patient holds the crutches 12 inches (25cm) in front of and 12 inches (25cm) to the side of each foot.													
14											move t	he left		
 	Four-point gait: asked the patient move the right crutch forward 12 inches and then move the left foot forward to the level of the right crutch, then asked the patient move the left crutch forward 12 inches and then move the right foot forward to the level of the left crutch. or													
	inches or	then to r	nove the	stronge	nt move r leg forw	ard to t	he level (of the cru	utches.					
	at the s	_	e and th	en to mo	t to move ove the rig				_			12 inches eft		
	or	at the 3d	ine time	•										
	-	o gait: A	sked the	patient	move bot	th crutch	nes forwa	ard abou	t 12 inch	es, then	lift the	legs and		
	_	_		-	porting hi							J		
15	Continu	ued with	ambulat	tion for tl	he planne	ed distar	ice and t	ime.						
16		•			or chair b	pased on	the pati	ent's tole	erance ai	nd condit	tion, en	suring		
17		e patient					tale to		_					
18					cessary it			asy reaci	1.					
19					orrect ted	•								
					ne patient									
20	Return	ed equip	ment to	the dedi	cated are		=							
Chama		4.2	2.4					LUATIO		17.40	19-20	Skill steps	ashiovad	
Steps Points	0	1-2 6	3-4 12	5-6 18	7-8 24	9-10	11-12 36	13-14 42	15-16 48	17-18 54	60	Skill points		
Level	U	О	l	F 18	24	30	U	N N	48 S	54 C	1	Skill level a		
Levei				<u> </u>	2. PRO	OCEDIII		L		ON 40%		Skill level a	icilieveu	
	Pations	ale 10%		Ι .	Patient Fo					Manner			Time 10%	
Failed	Nation	A.C 10/0	5	Failed	aucii F	JUG 10/	5	Failed		· · · · · · · · · · · · · · · · · · ·	5	Failed	+10	5
	sfactory		6		sfactory		6		factory		6	Unsatisfa		6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8	Superv			8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
	ependent 10 Independent					10	Indepe			10	Independ		10	
Notes:	Notes:											Time allov	wed (TA)	30
												Time achie	ved	
												Aspects poir	nts achieved	
								1		ON 100				
	50	51	-60	61	-70		-80		-90	91-1		Total points	s achieved	
Fai	led	Unsatis	factory	Nov	vice	Supe	vised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signate	ure	1				Actual Ma	ark/Out of	

Teacher	Signature	
Clinical Area	Date	

PROCI	EDURE: Elimination – assisting with the use of a bedpan	Code	08-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:	acilieveu	
	Bedpan		
	Powder		
	Waterproof pad		
	• Gloves		
	Plastic apron		
	Container with warm water or a toilet tissue		
	Wash basin with water		
	Soap Tanadananahanala		
	Towel or paper towels		
	Hand rub gel Trolloy		
2	Trolley Performed hand hygiene using correct technique.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Put on gloves.		
8	Put on plastic apron.		
9			
10	Unless contraindicated, applied powder to the rim of the bedpan. Placed the bedpan and cover on chair next to bed.		
11	Adjusted bed to comfortable working height		
12	Placed the patient in a supine position.		
13			
14	Made the head of the bed elevated about 30 degrees, unless contraindicated.		
15	Folded top linen back just enough to allow placement of bedpan.		
	Placed a waterproof pad under patient's buttocks before placing bedpan.		
16	Asked the patient to bend the knees and lift his or her hips upward helping if needed.		
17	Slipped the bedpan into place under the patient.		
18	Ensured that bedpan is in proper position.		
19	Raised the head of bed as near to sitting position as tolerated, unless contraindicated.		
20	Covered the patient with bed linens.		
21	Placed the call bell and toilet tissue within easy reach.		
22	Removed gloves and plastic apron.		
23	Performed hand hygiene using correct technique.		
24	Left the patient if it is safe to do so.		
25	After returning to the patient, performed hand hygiene using correct technique.		
26	Put on gloves.		
27	Put on apron.		
28	Lowered the head of the bed, if necessary, to about 30 degrees.		
29	Removed the bedpan in the same manner in which it was offered, being careful to hold it steady		
	and covered it.		
30	Assisted the patient with hygiene of the perineal area, if needed.		
31	Offered the patient supplies to wash and dry his or her hands, assisting as necessary.]

32	Restore	ed the pa	tient to	a comfor	table po	sition.								
33		ed the be												
34		ned hand	· ·											
	,					-		LUATIO	N 60%				1	
Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-32	33-34	Skill steps ac	hieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points ac	chieved	
Level	Level F U N S C I Skill level act								Skill level ach	nieved				
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	N 40%				
	Rationa	ale 10%		F	Patient F	ocus 10%	6	Profe	essional I	Manner	10%	Т	ime 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfact	6	
Novice			7	Novice			7	Novice			7	Novice	7	
Superv	ised		8	Superv	ised		8	Superv	ised		8	Supervised	+4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Competent	t +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independe	nt TA	10
Notes:												Time allowe	d (TA)	15
												Time achieve	d	
												Aspects points	achieved	
				3	. COM	1PLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61	-70	71	-80	81	-90	91-1	100	Total points a	chieved	
Fai	led	Unsatis	factory	Nov	/ice	Supe	rvised	Comp	etent	Indepe	ndent	Total level achieved		
Studer	nt					Signat	ure							
Teacher			Signat	ure					Actual Marl	k/Out of				
Clinica	l Area					Date						1		

PROCE	DURE: Elimination – assisting with the use of a bedside commode	Code	08-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Bedside commode		
	• Gloves		
	Plastic apron		
	 Container with warm water or a toilet tissue 		
	Wash basin with water		
	 Soap 		
	Towel or paper towels		
	Hand rub gel		
	Trolley		
2	Performed hand hygiene using correct technique.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Put on gloves.		
8	Put on plastic apron.		
9	Placed the commode close to, and parallel with, the bed.		
10	Assisted the patient to a standing position and then help the patient pivot to the commode.		
11	Assisted the patient to lower himself/herself slowly onto the commode seat.		

														44
12	Covere	d the pat	tient witl	h a blank	et.									
13	Placed	call bell a	and toile	t tissue o	r a conta	ainer wit	h warm v	water wi	thin easy	reach.				
14	Remov	ed glove:	s and pla	stic apro	n.									
15	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
16	Left the	patient	if it was	safe to d	lo so.									
17	After re	eturning	to the pa	atient, pe	rformed	hand hy	giene us	ing corre	ct techn	ique.				
18	Put on	gloves.												
19	Put on	apron.												
20	Assiste	d the pat	tient to a	standing	g positio	n to get o	off the co	ommode.						
21	Return	ed the pa	atient to	the bed	or chair.									
22	Offered	the pat	ient supp	olies to w	ash and	dry his o	r her hai	nds, assis	ting as n	ecessary	<i>'</i> .			
23	Restore	ed the pa	tient to	a comfor	table po	sition.								
24	Return	ed the co	ommode	to the de	edicated	area.								
25	Perforn	ned hand	d hygiene	e using co	orrect te	-								
			T					LUATIO		T	1	T		
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level F U N S C I Skill level achieved 2. PROCEDURE ASPECTS EVALUATION 40%														
	Rationa	No 10%		l c		ocus 10%						I	Time 10%	
Failed	Nationa	ile 10/6	5	Failed	atient r	ocus 107				5	Failed	+10	5	
	sfactory		6	Unsatis	factory		6	Unsatisfactory		6	Unsatisfa	= *	6	
Novice	· · ·		7	Novice	,		7	Novice	,		7	Novice	+6	7
Superv	ised		8	Supervi	ised		8	Superv	ised		8	Supervise	ed +4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Compete	ent +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	wed (TA)	20
												Time achie	ved	
												Aspects poir	nts achieved	
						IPLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50 51-60 61-70		71-	-80	81-	-90	91-1	100	Total points	s achieved				
Fai	iled	Unsatis	factory	Nov	/ice	Super	rvised	Comp	etent	Indepe	ndent	dent Total level achieved		
Studer						Signati	ure							
Teach						Signati	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROC	EDURE: Elimination – applying a condom catheter	Code	08-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Condom catheter		
	Urinary catheter bag		
	• Gloves		
	Plastic apron		
	Wash basin with water		
	Soap		
	Towel or paper towels		
	Hand rub gel		
	Trolley		

2	Perforr	ned hand	d hygien	e using o	orrect te	chnique.								
3		ed patie				<u>qu.o.</u>								
4					n and pe	rmission	procedu	re (G.I.P)						
5		ed privac					1	- (-)						
6		· ·	·	to the	patient a	nd answe	ered any	question	ıs.					
7		•			allergies,		•	•						
8	Put on	•		•		•	•							
9	Put on	plastic a _l	pron.											
10	Positio	ned the p	patient o	n his ba	ck with th	nighs slig	htly apar	t.						
11	Slid wa	terproof	pad und	er patie	nt.									
12	Draped	patient	so that o	nly the	area arou	und the p	enis is e	xposed.						
13	Asked t	he patie	nt to cle	an the g	enital are	a if poss	ible, oth	erwise as	sisted w	ith the w	ash.			
14					ard onto									
15					inant hand es (2.5 to 5									
16					e base of									
17	Connec	ted the	condom	sheath t	o drainag	ge setup	avoiding	kinking o	or twistir	ng draina	ge tubi	ng.		
18	Remov	ed glove:	s.											
19	Secure drainage tubing to the patient's inner thigh with Velcro leg strap or tape, leaving some slack in tubing for leg movement.													
20	Assisted the patient to a comfortable position.													
21														
22	Secured drainage bag below the level of the bladder.													
23														
24														
25	Charles the patient supplies to make any me of her hands, assisting as necessary.													
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F	3 00	OCEDIU	U U	N CTC F)//	S	C		Skill level a	achieved	
	Dation	ala 100/		l		OCEDUI				אנ 40% Manner		l	Time a 100/	
Failed	Kationa	ale 10%	5	Failed	Patient F	ocus 109	5	Failed	essionai	wanner	5	Failed	+10	5
	factory		6		sfactory		6		factory		6	Unsatisfa		6
Novice	,		7	Novice	· · · · · · · · · · · · · · · · · · ·		7	Novice			7	Novice	+6	7
Supervi	ised		8	Superv	/ised		8	Superv	ised		8	Supervise	ed +4	8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	endent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	wed (TA)	15
Time achieved														
3. COMPLETE PROCEDURE EVALUATION 100%														
									l -					
	≤50 51-60 61-70			-80		-90	91-1		Total points					
Fail					Indepe	ndent	Total level	achieved						
				Signature				0.04	and (October					
Teache						Signat	ure					Actual M	ark/Out of	
Clinica	ı Area					Date								

PROCE	DURE: Elimination – administering a small volume cleansing enema	Code	08-04
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: • Patient medical record		
	Small volume enema		
	Lubricant		
	Small bowl of warm water		
	Bedpan or commode if bathroom not used		
	Powder		
	Waterproof pad		
	• Gloves		
	Plastic apron		
	Wash basin with water		
	Washcloth Soon		
	SoapTowel or paper towels		
	Hand rub gel		
	• Trolley		
2	Verified the order for the enema.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Discussed where the patient would defecate (a bedpan, commode, or nearby bathroom).		
9	Put on gloves.		
10	Put on plastic apron.		
11	Adjusted bed to comfortable working height.		
12	Positioned the patient on the left side (Sims' position), as dictated by patient comfort and condition.		
13	Folded the top linen back just enough to allow access to the patient's rectal area.		
14	Placed a waterproof pad under the patient's hip.		
15	Removed the cap and generously lubricated end of rectal tube 2 to 3 inches (5 to 7 cm).		
16	Lifted buttock to expose anus and slowly and gently inserted the rectal tube 3 to 4 inches (7 to 10		
47	cm) for an adult without forcing the entry of the tube.		
17	Asked the patient to take several deep breaths.		
18	Compressed the container administering all the solution in the container.		
19	After solution was given, removed tube, keeping the container compressed.		
20 21	Had paper towel ready to receive tube as it is withdrawn. Encouraged the patient to hold the solution until the urge to defecate is strong, usually in		
21	about 5 to 15 minutes.		
22	Removed gloves.		
23	Returned the patient to a comfortable position.		
24	Checked that the linens under the patient are dry.		
25	Covered the patient with bed linens.		
26	Lowered the bed.		
27	Removed plastic apron.		
28	Performed hand hygiene using correct technique.		
29	Placed the call bell within easy reach.		
30	Left the patient if it is safe to do so.		

														47
31	On retu	urn to the	e patient	, perforn	ned hand	d hygiene	using co	orrect te	hnique.					
32	Put on	gloves.					_		-					
33	Put on	plastic a _l	pron.											
34	After th	ne patien	t was rea	ady to de	fecate, a	assisted t	o use be	dpan, co	mmode	or bathro	oom.			
35	Assiste	d the pat	ient with	n washin	g if need	ed.								
36	Restore	ed the pa	tient to	a comfor	table po	sition en	suring he	e/she is c	lean, dry	and cor	nfortab	le.		
37	Return	ed equip	ment to	the dedi	cated are	ea.								
38	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-17	18-19	20-24	25-28	29-32	33-36	37-38	Skill steps a		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	- 1	Skill level a	chieved	
				r -		OCEDUI								
F - 111	Rationa	ale 10%	-		Patient F	ocus 109			ssional	Manner			Time 10%	-
Failed	factory		5 6	Failed Unsatis	factori		5 6	Failed Unsatis	factori		5 6	Failed Unsatisfa	+10	5 6
Novice	stactory		7	Novice	ractory		7	Novice	ractory		7	Novice	+6	7
Supervi	ised		8	Supervi	sed		8	Superv	sed		8	Supervise		8
Compe			9	Compe			9	Compe			9	Competer		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:				-								Time allow	ved (TA)	30
												Time achiev	/ed	
												Aspects poin	ts achieved	
				3	. CON	1PLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	≤50 51-60 61-70		-70	71	-80	81	90	91-1	100	Total points	achieved			
Fai	led	Unsatis	factory	Nov	/ice	Super	vised	Comp	etent	Indepe	ndent	Total level achieved		
Studer	nt					Signat	ure							_
Teach	er					Signat	ure					Actual Ma	rk/Out of	
Clinical Area						Date								

PROCE	DURE: Hygiene – assisting a patient with shower	Code	09-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	• Gloves		
	Plastic apron		
	• Towels		
	Bath mat		
	Washcloth		
	Soap or skin cleanser		
	Comb or hairbrush		
	Clean clothes		
2	Performed hand hygiene using correct technique.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Explained the procedure to the patient and answered any questions.		
6	Assisted patient to the bathroom	·	

Performed hand hygiene using correct technique. Put on gloves. Put on apron. 10 Turned on the water. 11 Adjusted the temperature of the water. 12 Assisted the patient into the shower. Offered a chair to sit on, if the patient was unsteady. 13 Helped the patient wash body areas that are difficult. 14 Put towel on commode or chair. 15 Assisted the patient out of the shower and into the chair. 16 Let the patient dry themselves, assisted if needed. 17 Helped the patient put on a clean gown. 18 Helped the patient to groom their hair, teeth as necessary. 19 Removed gloves and plastic apron. 20 Assisted the patient to return to the bedside. 21 Performed hand hygiene using correct technique. 22 Returned the equipment to appropriate location. Steps 0 1-2 3-4 5-6 7-9 10-11 12-14 15-16 17-18 19-20 21-22 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 18 24 30 36 42 48 54 50 Skill steps achieved Points 0 6 12 18 18 24 30 36 42 48 54 50 Skill steps achieved Points 0 6 19 Skill steps achieved Points 0 6 19 Skill steps achieved Patient Focus 10% Professional Manner 10% Skill steps achieved Patient Focus 10% Professional Manner 10% Imme 10% Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 7 Novice 7 Novice +6 7 Novice 7 Novice 7 Novice 7 Novice +6 7 Novice 7 Novice +6 7 Novice 9 Competent 9 Competent 9 Competent 10 Independent TA 10 Notes: 3 COMPLETE PROCEDURE EVALUATION 100% S≤50 \$1-60 61-70 71-80 81-90 91-100 Total points achieved Ageas points achieved Student Signature Student Signature Signature															. •
9 Put on apron. 10 Turned on the water. 11 Adjusted the temperature of the water. 12 Assisted the patient into the shower. Offered a chair to sit on, if the patient was unsteady. 13 Helped the patient wash body areas that are difficult. 14 Put towel on commode or chair. 15 Assisted the patient out of the shower and into the chair. 16 Let the patient put on a clean gown. 18 Helped the patient put on a clean gown. 18 Helped the patient to groom their hair, teeth as necessary. 19 Removed gloves and plastic apron. 20 Assisted the patient to return to the bedside. 21 Performed hand hygiene using correct technique. 22 Returned the equipment to appropriate location. 15 SKILL EVALUATION 60% Steps 0 1-2 3-4 5-6 7-9 10-11 12-14 15-16 17-18 19-20 21-22 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F PACCEDURE ASPECTES VALUATION 40% Falled 5 Failled 5 Failled 5 Failled 10 Supervised 5 Failled +10 5 Supervised 6 Unsatisfactory 7 Novice +6 Novice Novi	7	Perforn	ned hand	d hygiene	e using c	orrect te	chnique.								
Turned on the water.	8	Put on	gloves.												
Adjusted the temperature of the water.	9	Put on	apron.												
Assisted the patient into the shower. Offered a chair to sit on, if the patient was unsteady.	10	Turned	on the v	vater.											
Helped the patient wash body areas that are difficult.	11	Adjuste	d the te	mperatu	re of the	water.									
14	12	Assiste	d the pat	tient into	the sho	wer. Offe	ered a ch	air to sit	on, if the	e patient	was uns	teady.			
Assisted the patient out of the shower and into the chair. 16 Let the patient dry themselves, assisted if needed. 17 Helped the patient put on a clean gown. 18 Helped the patient to groom their hair, teeth as necessary. 19 Removed gloves and plastic apron. 20 Assisted the patient to return to the bedside. 21 Performed hand hygiene using correct technique. 22 Returned the equipment to appropriate location. 10 SKILL EVALUATION 60% Steps 0 1-2 3-4 5-6 7-9 10-11 12-14 15-16 17-18 19-20 21-22 Skill steps achieved Points 0 6 12 18 24 30 64 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved Level F U N S C I Skill level achieved Professional Manner 10% Time 10% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Rationale 10% Patient Focus 10% Professional Manner 10% Supervised Supervis	13	Helped	the pati	ent wash	n body ar	eas that	are diffic	cult.							
16	14	Put tow	el on co	mmode	or chair.										
17	15	Assiste	d the pat	tient out	of the sh	nower an	d into th	e chair.							
18	16	Let the	patient (dry them	iselves, a	ssisted if	needed								
19	17	Helped	the pati	ent put c	n a clea	n gown.									
20	18	Helped	the pati	ent to gr	oom the	ir hair, te	eeth as n	ecessary	·						
21	19	Remove	ed glove	s and pla	stic apro	n.									
Steps 0	20	Assiste	d the pat	tient to r	eturn to	the beds	ide.								
Skeps O	21	Perforn	ned hand	d hygiene	e using c	orrect te	chnique.								
Steps O	22	Returne	ed the ed	quipmen	t to appr	opriate l	ocation.								
Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved 2. PROCEDURE ASPECTS EVALUATION 40% Tailed Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed 5 Failed 10 5 Failed 10 5 Failed 40 5 Failed 410 8 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 9 Competent 9 Competent 10 Independent															
F													-		
2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 9 Competent 2 9 Independent 10 Independent 10 Independent 10 Independent TA 10 Notes: 3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent </td <td></td> <td>0</td> <td>6</td> <td>l</td> <td></td> <td>24</td> <td>30</td> <td></td> <td></td> <td></td> <td></td> <td>60</td> <td>•</td> <td></td> <td></td>		0	6	l		24	30					60	•		
Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed +10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 4 7 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 9 Competent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 30 30 Time allowed (TA) 30 30 **Time achieved	Level				F	2 22	005011						Skill level a	achieved	
Failed 5		D-4'	-I- 100/						1					Time - 100/	
Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice 7 Novice 4 7 Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 9 Competent 10 Independent 10 Independent 10 Independent Tallowed (TA) 30 Notes: 3 COMPLETE PROCEDURE EVALUATION 100% Time achieved 30 3 COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of	Failed	Rationa	ile 10%	5		Patient F	ocus 109								5
Novice 7 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 30 Time achieved Aspects points achieved Aspects points achieved Aspects points achieved Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Signature Actual Mark/Out of		factory				factory			+	factory					
Supervised 8 Supervised 8 Supervised 4 8 Competent 9 Competent 9 Competent 4 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 30 Time achieved Aspects points achieved Aspects points achieved Aspects points achieved Time achieved Aspects points achieved Time achieved Aspects points achieved Total points achieved Signature Total level achieved Signature Total level achieved Actual Mark/Out of		idetory								nactory				-	
Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) 30 Time achieved Aspects points achieved Aspects points achieved Actual Mark/Out of		sed						8	+	ised			+		
Notes: Time allowed (TA) 30 Time allowed (TA) 30 Time achieved Aspects points achieved Aspects points achieved Actual Mark/Out of				9				9	1			9	-		9
Time achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Aspects points achieved Signature Teacher Time achieved Aspects points achieved Aspects points achieved Fotal points achieved Total level achieved Actual Mark/Out of	Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Indepen	dent TA	10
3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of	Notes:												Time allow	wed (TA)	30
3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of													Time achie	eved	
≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of		Aspects points achieved											nts achieved		
Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of	3. COMPLETE PROCEDURE EVALUATION 100%														
Student Signature Teacher Signature Actual Mark/Out of	≤5			71-	-80	81	-90	91-3	100	-					
Teacher Signature Actual Mark/Out of	Fail	led	Unsatis	factory	No	vice	Super	rvised	Comp	etent	Indepe	endent Total level achieved		achieved	
	Studen	nt					Signati	ure							
Clinical Area	Teache	cher							Actual M	ark/Out of					
- Dutc	Clinica	cal Area Date													

PROCE	PROCEDURE: Hygiene – bed bath								
No.	Skill steps	Not achieved	Achieved						
1	Prepared procedure equipment:								
	• Gloves								
	Plastic apron								
	• Towels								
	Bath blanket								
	Washcloth								
	Soap or skin cleanser								

														49
	•	Basing	with wa	rm wate	r									
	•	Comb	or hairbr	ush										
	•	Clean l	bed linen	1										
	•	Laundı	ry bag or	hamper										
2	Perforr	ned han	d hygien	e using c	orrect te	chnique.								
3	Identifi	ed patie	nt using	two iden	tifiers.									
4	Perforr	ned gree	eting, intr	roductio	n and pe	rmission	procedu	re (G.I.P)						
5	Provide	ed privac	cy.											
6	Explain	ed the p	rocedure	e to the p	oatient a	nd answe	ered any	question	ıs.					
7	Adjuste	ed the he	eight of t	he bed.										
8	Perforr	ned han	d hygien	e using c	orrect te	chnique.								
9	Put on	gloves.												
10	Put on													
11		•	t to sittin	ng positio	n.									
12			n with w	<u> </u>		washclo	th, towel	s, comb	within th	e easy re	each.			
13			e patient							· · ·				
14		_	ient put o			<u> </u>								
15	•		ed linen i			hange wa	as not ne	eded. st	raightene	ed the be	ed linen			
16			ient to a					, , , , , , ,	. 0					
17		•	s and pla											
18			d hygien	•		chniaue.								
19	Returned equipment to the dedicated area.													
	1. SKILL EVALUATION 60%													
Steps	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18-19	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	- 1	Skill level a	achieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%	1			
	Rationa	ale 10%		1	Patient F	ocus 109	%	Profe	essional	Manner	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed +10		5
	factory		6		sfactory		6		factory		6	Unsatisfa		6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Superv			8	Superv			8	Superv			8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe Notes:	naent		10	Indepe	nuent		10	Indepe	naent		10	-	dent TA	10
Notes.												Time allo	wed (TA)	30
												Time achie	eved	
												Aspects poi	nts achieved	
		1				1		URE EV						
	≤50 51-60 61-70			-80	81	-90	91-:	100	-	s achieved				
	Failed Unsatisfactory Novice			Supe	rvised	d Competent Independent			ndent	Total level	achieved			
Studer	Student			Signature										
Teacher		Signat	ure					Actual M	ark/Out of					
Clinica	l Area					Date								

• () • F • T • E • \(\) • G • G • G • G • G • G • G • G • G • G	Skill steps procedure equipment: Gloves Plastic apron Towels Bath blanket Washcloth Soap or skin cleanser Basing with warm water Comb or hairbrush Clean bed linen	Not achieved	Achieved
• () • F • T • E • \(\) • G • G	Gloves Plastic apron Towels Bath blanket Washcloth Goap or skin cleanser Basing with warm water Comb or hairbrush		
• F • T • E • \	Plastic apron Towels Bath blanket Washcloth Soap or skin cleanser Basing with warm water Comb or hairbrush		
• T • E • \ • \ • \ • \ • \ • \ • \ • \ • \ • \	Fowels Bath blanket Washcloth Boap or skin cleanser Basing with warm water Comb or hairbrush		
• E	Bath blanket Washcloth Soap or skin cleanser Basing with warm water Comb or hairbrush		
• \\ • <u>9</u> • E	Washcloth Soap or skin cleanser Basing with warm water Comb or hairbrush		
• S	Soap or skin cleanser Basing with warm water Comb or hairbrush		
• E	Basing with warm water Comb or hairbrush		
• (Comb or hairbrush		ļ
• (
	Liean bed iinen		
	Laundry bag or hamper		
2 Performe	d hand hygiene using correct technique.		
	patient using two identifiers.		
4 Performe	d greeting, introduction and permission procedure (G.I.P).		
5 Provided			
	the procedure to the patient and answered any questions.		
	the height of the bed.		
-	d hand hygiene using correct technique.		
9 Put on glo			
10 Put on ap			
·	atient bedpan or urinal (If used removed gloves and put on clean gloves).		
· · · · · · · · · · · · · · · · · · ·	patient to supine position.		
-	top covers and removed all except the top sheet.		
	th blanket over patient and then remove top sheet while patient holds bath blanket in		
place.			ļ
15 Placed lin	en that will be re-used on the chair.		
16 Placed so	iled linen in a laundry bag or hamper without touching uniform.		
17 Removed	the patient's gown and kept bath blanket in place.		
18 Checked t	the temperature of the water.		
19 Put a tow	rel across patient's chest and on top of bath blanket.		
	cleanser on the washcloth, wiped one eye from the inner part of the eye, near the nose, to		
the outer	part.		
21 Rinsed or	turned the washcloth before washing the other eye.		
22 Added ski	in cleanser to the water.		
23 Bathed pa	atient's face, neck, and ears.		
24 Exposed p	patient's far arm and place towel lengthwise under it.		
25 Using firm	strokes, washed hand, arm, and axilla, lifting the arm as necessary to access axillary region.		
26 Rinsed, if	necessary, and dried.		
27 Placed a f	folded towel on the bed next to the patient's hand and put basin on it.		
28 Soaked th	ne patient's hand in basin.		
29 Washed,	rinsed if necessary, and dried hand.		
30 Repeated	steps 25-29 for the other arm.		
31 Lowered	bath blanket to patient's umbilical area.		
32 Washed,	rinsed, if necessary, and dried chest keeping the chest covered with a towel.		
	bath blanket to the perineal area.		
	rinsed, if necessary, and dried abdomen.		
	bath blanket to original position and expose far leg.		

36 37		towel un	der far l												
-			iaci iai i	eg.											
20	Using fi	rm strok	es, wash	ed, rinse	d, if nec	essary, a	nd dried	leg from	ankle to	knee an	d knee	to groin.			
38	Washed	d, rinsed	if necess	sary, and	dried th	e foot.									
39	Repeat	ed steps	37 and 3	88 for the	other le	g and fo	ot.								
40	Made s	ure the p	oatient w	as cover	ed with l	bath blar	nket.								
41	Change	d the wa	ater.												
42	Assisted	d the pat	ient to p	rone or s	side-lying	gposition	า.								
43	Position	ned bath	blanket	and tow	el to exp	ose only	the back	and but	tocks.						
44	Washed	d, rinsed,	, if neces	sary, and	dried b	ack and b	outtocks	area.							
45	Change	d the wa	iter.												
46	Assisted	d the pat	ient to t	urn on th	e back.										
47	Set pati	ent up s	o that he	or she c	an comp	lete peri	ineal self	-care or	perform	ed perine	eal care	if			
	patient	was una	ble to do) so.											
48	•	•	•	n a clear											
49				h towel a	nd groo	med pati	ient's ha	ir.							
50	Change	d bed lin	en as ne	eded.											
51		-		oatient to		ortable p	osition.								
52	Remove	ed gloves	s and pla	stic apro	n.										
53	Performed hand hygiene using correct technique.														
	1. SKILL EVALUATION 60% s 0 1-6 7-12 13-18 19-24 25-26 27-33 34-39 40-45 46-51 52-53 Skill steps achieved														
Steps	0	1-6	7-12	13-18	19-24	25-26	27-33	34-39	40-45	46-51	52-53	-			
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points			
Level				-	2 22	0.65011	U	N OTC FY	S	C	ı	Skill level a	achieved		
	Datiana	J- 100/						CTS EVA				I	Time = 100/		
Failed	Rationa	iie 10%	5	Failed	atient F	ocus 10%	6 5	Professional Manner 10% Failed 5			Failed +10		5		
Unsatisf	factory		6	Unsatis	factory		6		factory		6	Unsatisfa	+10	6	
Novice	iactory		7	Novice	ractory		7	Novice	stactory		7	Novice	+6	7	
Supervis	sed		8	Supervi	sed		8	Superv	ised		8	Supervise		8	
Compet			9	Compe			9	Compe			9	Compete		9	
Indepen			10	Indepe			10	Indepe			10	Independ		10	
Notes:				•							•	Time allov	wed (TA)	60	
												Time achie	eved		
													nts achieved		
3. COMPLETE PROCEDURE EVALUATION 100%															
≤5	≤50 51-60 61-70		71-	-80	81	-90	91-1	100	Total points	s achieved					
Faile	ailed Unsatisfactory Novice		Super	vised	Comp	etent	Indepe	ndent	Total level	achieved					
Studen	lent			Signati	ure										
Teache	eacher			Signature				Actual M	ark/Out of						
1	Area					Date									

PROCE	PROCEDURE: Hygiene - oral care for a dependent patient								
No.	Skill steps	Not achieved	Achieved						
1	Prepared procedure equipment:								
	toothbrush								
	• toothpastes								
	lip lubricant (Vaseline, lip balm)								
	suction unit and suction catheter								

	•	water												
	•	irrigati	on syring	ge or bull	o syringe									
	•	emesis	basin											
	•	towel	or water	proof pac	b									
	•	gloves												
	•	plastic	-											
	•	plastic	•											
2	Identifi	ed the p	atient us	ing two i	dentifier	S.								
3	Provide	ed privac	у.											
4		d the he												
5	Perforn	ned hand	d hygien	e using co	orrect te	chnique.								
6	Put on	gloves.												
7	Put on	plastic a _l	pron.											
8	Positio	ned the d	client on	the side	with the	head tilt	ted forwa	ard.						
9	Placed	a towel b	beneath	the head	and acr	oss the c	hest.							
10	Put em	esis basi	n under	the chin.										
11	Gently	opened t	the patie	ent's mou	ith by ap	plying pr	ressure t	o lower j	aw at th	e front of	f the mo	outh,		
	remove	ed dentu	res if pre	esent.										
12	Spread	toothpa	stes ove	r the moi	istened t	ooth bru	sh.							
13	Brushe	d the tee	eth and g	gums care	efully wit	h toothb	rush and	d paste.						
14	Lightly	brushed	the tong	gue.										
15	Inserte	d the rub	ber tip o	of the irri	gating sy	ringe or	bulb syr	inge into	the pati	ent's mo	uth and	rinsed		
	· ·			unt of wa										
16		-		head to	allow for	return o	of water	or used s	uction a	pparatus	to rem	ove the		
		rom oral												
17				efore rep										
18	<u> </u>			ient's lips	5.									
19	Remov	ed wet to	owel.											
20	Restore	ed patien	nt to com	fortable	position									
21	Perforn	ned hand	d hygien	e.										
22	Docum	ented th	e proced	dure.										
23	Returne	ed equip	ment to	the dedi	cated are	ea.								
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-17	18-19	20-21	22-23	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	I	Skill level a	achieved	
								CTS EV				I		
	Rationa	ale 10%			Patient F	ocus 109		-	essional	Manner	1		Time 10%	
Failed			5	Failed	· ·		5	Failed	· ·		5	Failed	+10	5
	factory		6		factory		6		factory		6	Unsatisfa	•	6
Novice	isad		7	Novice Superv			7	Novice			7	Novice	+6	7
Superv			8	Compe			8	Superv Compe			8	Supervise		8
Compe Indepe			10	Indepe			10	Indepe			10	Compete Independ		10
Notes:	nuciit		1 10	I muche	nuciit		1 10	Imache	nuciil		1 10			
												Time allov		30
												Time achie	ved	
												Aspects poir	nts achieved	
								URE EV		1				
-	50		-60	1	-70		-80		-90	91-1		Total points		
-	led	Unsatis	sfactory	No	vice		rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signat								
Teach						Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								

PROCE	DURE:				Fluid ba	alance -	- calcula	iting flu	id balan	ce			Code	10-01
No.							Skill	steps					Not achieved	Achieved
1	Prepare	ed proce	dure equ	ipment:										
	•		t medical											
	•		alance cl	narts										
	•	Hand r												
	•	Plastic	tray											
2	Review	ed patie	nt medic	al record	for orde	ers regar	ding fluic	d balance	measur	ement.				
3					whole ho	our, i.e. 9	am, 10a	m, 11am	etc.					
4		•	nt using 1											
5				oduction	and per	mission	procedu	re (G.I.P)						
6	Provide	d privac	у.											
7		•			atient ar		ered any	question	S.					
8					orrect tec	•								
9					st fluid ba				-		t's chart).		
10					orded the									
11					the type						s hour.			
12					ed the N	G feed ir	put for t	he previ	ous hour	•				
13			otal hou	•										
14			ne outpu	ıt (meası	uring jug	or urina	ry cathet	er) and r	ecorded	urine ou	itput foi	r the		
4.5	previou					, ,								
15					in drain/									
16					f vomit, N	NG aspira	ate, diarr	hea, sto	ma outpi	ut.				
17			hourly f											
18					(fluid ba	lance ca	lculation	chart), c	alculated	d total 24	fluid ir	iput.		
19			24 fluid	•										
20				-	e) betwe			ut and o	utput.					
21					field in t									
22			as positi it with		bigger),	marked	it +sign,	if the ba	lance wa	s negativ	e (outp	ut		
23					nderstand	ling of the	e importa	nce of co	rect reco	rding of o	ral intak	е.		
24					glass, cup									
25					orrect ted			· · · · · ·						
26					cated are	-								
27	Reporte	d abnorm	nal finding	s to the a	ppropriate	e health c	care provi	der (stude	ent report	ed this ac	tion ver	bally).		
						1. SK	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	C		Skill level a	achieved	
		1 4551						CTS EV				ı		
F-:! !	Rationa	ale 10%			Patient Fo	ocus 109		-	essional	Manner		E-il I	Time 10%	
Failed	footows		5	Failed	footo::::		5	Failed	footow		5	Failed	+10	5
	sfactory		6 7		factory		6 7	Novice	factory		6 7	Unsatisfa Novice		6 7
Novice Supervi			8	Novice Superv			8	Superv			8	Supervis	+6 ed +4	8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
														ı –-

Notes:						Time allowed (TA)	30
						Time achieved	
						Aspects points achieved	
		3. CON	IPLETE PROCED	URE EVALUATI	ON 100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area			Date				

Fluid Balance Chart

No. Skill steps Prepared procedure equipment. Patient medical record Vital signs chart Oxygen mask with tubing Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P).	Achieved
 Patient medical record Vital signs chart Oxygen mask with tubing Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P). 	
 Vital signs chart Oxygen mask with tubing Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P). 	
Oxygen mask with tubing Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P).	
Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P).	
 Gauze pads Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P). 	
 Hand rub gel Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P). 	
 Plastic tray Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P). 	
Checked the medical order for oxygen administration. Identified the patient using two identifiers. Performed greeting, introduction and permission procedure (G.I.P).	
3 Identified the patient using two identifiers. 4 Performed greeting, introduction and permission procedure (G.I.P).	
Performed greeting, introduction and permission procedure (G.I.P).	
Terrormed greening, increased and permission procedure (em.).	
5 Dravidad privacy	
5 Provided privacy. 6 Explained the procedure to the patient and answered any questions.	
and the processing to the patient and another any questions.	
Terrormed manual rigidate damage served teaming at	
9 Assisted patient to comfortable position.	
Assessed and recorded patient's respirations and oxygen saturation (student's verbal report).	
11 Checked the central oxygen port or portable oxygen cylinder for any problems in delivering oxygen.	
12 Checked humidification bottle for any problems and for the amount of water.	
13 Attached face mask to the oxygen source with humidification.	
14 Adjusted flow rate as ordered.	
Positioned face mask over the patient's nose and mouth.	
Adjusted the elastic strap so that the mask fits snugly but comfortably on the face.	
17 Placed gauze pads under the elastic strap at pressure points.	
18 Encouraged the patient to breathe through the nose, with the mouth closed.	
19 Reassessed and documented patient's respiratory status (student verbal report).	
20 Performed hand hygiene using correct technique.	
21 Documented the procedure and result in patient's nursing notes.	
22 Return equipment to the dedicated area.	
Reported abnormal findings to appropriate health care provider (student verbal report).	
1. SKILL EVALUATION 60%	
Steps 0 1-2 3-4 5-6 7-9 10-11 12-14 15-17 18-19 20-21 22-23 Skill steps achieved	
Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved	
Level F U N S C I Skill level achieved	
2. PROCEDURE ASPECTS EVALUATION 40%	10/
Rationale 10%Patient Focus 10%Professional Manner 10%Time 1Failed5Failed5Failed5	
Failed 5 Failed 5 Failed 5 Failed +10 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory	5 6
Novice 7 Novice 7 Novice 7 Novice +6	7
Supervised 8 Supervised 8 Supervised 8 Supervised 4	8
Competent 9 Competent 9 Competent 9 Competent +:	9
Independent 10 Independent 10 Independent To Independent Independe	10
Notes: Time allowed (TA)	15
Time achieved	
Aspects points achieve	

		3. CON	IPLETE PROCED	URE EVALUATION	ON 100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area			Date				

PROCE	DURE:			Oxyg	enatior	ı - admi	nisterin	g oxyge	n – nasa	al cannu	ıla		Code	11-02
No.							Skill ste	eps					Not achieved	Achieved
1	Prepare	ed proce	dure equ	iipment.										
	•		t medical											
	•		gns chart	t										
	•		cannula	12 1	/·c .									
	•		le oxyger	n cylinde	r (if cent	ral oxyge	en are no	ot availab	le)					
		Gauze Hand r	-											
		Plastic	_											
		riastic	c. a y											
2			edical ord				tion.							
3		•	atient us	_										
4			ting, intr	oduction	and pe	rmission	procedu	re (G.I.P)						
5		ed privac	•											
6	Explain	ed the p	rocedure	to the p	atient aı	nd answe	ered any	question	S.					
7	Adjuste	ed the he	eight of th	he bed.										
8	Perforn	ned hand	d hygiene	e using co	orrect te	chnique								
9		•	t to comf											
10			ecorded p		•							-		
11			ntral oxy								livering	oxygen.		
12			ification						t of wate	er.				
13	Attache	ed nasal	cannula t	to the ox	ygen sou	irce with	humidif	ication.						
14	Adjuste	ed flow ra	ate as or	dered.										
15			d prongs i											
16		_	ver and b	oehind ea	ach ear v	vith adju	ster com	fortably	under ch	in or arc	ound the	head		
17		the nostr												
17			ads at ear						,					
18			patient			_								
19			l docume	· ·		•		student v	erbal re	port).				
20			d hygiene											
21			e proced			patient	s nursing	notes.						
23			ent to the			4 - I IVI					+\			
	керогі	ed apnor	rmal findi	ings to a	propria	te neaitr	care pro	oviaer (si	uaent ve	erbai rep	ort).			
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps				F C	7-9	10-11	12-14	15-17	18-19	20-21	22-23	Skill steps	achieved	
	0	1-2	3-4	5-6	, ,									
Points	0	1-2 6	3-4 12	18	24	30	36	42	48	54	60	Skill points		

			2. PR	OCEDUI	RE ASPE	CTS EVALUATION	N 40%				
Rationa	ale 10%		Patient F	ocus 10%	6	Professional	Manner :	10%	Tim	e 10%	
Failed		5	Failed		5	Failed		5	Failed	+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactor	γ+8	6
Novice		7	Novice		7	Novice		7	Novice	+6	7
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8
Competent		9	Competent		9	Competent		9	Competent	+2	9
Independent		10	Independent		10	Independent		10	Independent	TA	10
Notes:									Time allowed ((TA)	15
									Time achieved		
									Aspects points acl	hieved	
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 100	%			
≤50	51-6	50	61-70	71-	-80	81-90	91-1	.00	Total points achi	ieved	
Failed	Unsatisf	actory	Novice	Super	rvised	Competent	Indepe	ndent	Total level achie	ved	
Student			•	Signati	ure						
Teacher				Signati	ure				Actual Mark/0	Out of	
Clinical Area				Date					1		

PROCE	DURE: Suctioning - nasopharyngeal	Code	11-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	Patient medical record		
	 Vital signs chart 		
	 Portable suction unit if wall unit not available. 		
	 Sterile suction package – gauze, suction catheter, container 		
	Normal saline		
	Lubricant		
	• Gloves		
	Sterile gloves		
	Oxygen mask with tubing		
	 Portable oxygen cylinder (if central oxygen are not available) 		
	Gauze pads		
	Hand rub gel		
	Towel or waterproof pad		
	Plastic tray		
2	Checked the medical order for suctioning.		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Reassured the patient you will interrupt the procedure if he or she indicates respiratory difficulty.		
8	Adjusted the height of the bed.		
9	Performed hand hygiene using correct technique		
10	Assisted patient to comfortable position.		
11	Placed towel or waterproof pad across the patient's chest.		
12	Adjusted suction to appropriate pressure:		
	For a wall unit for an adult: 100–120 mm Hg, adolescents: 80–120 mm Hg		
	For a portable unit for an adult: 10–15 cm Hg, adolescents: 8–10 cm Hg.		

13	Put on a disposable, clean glove.	
14	Occluded the end of the connecting tubing to check suction pressure.	
15	Open sterile suction package using aseptic technique.	
16	Used opened sterile package wrapper as a sterile field to hold other supplies.	
17	Poured normal saline into a sterile container	
18	Opened a wrapper of a sterile suction catheter and let catheter fall onto sterile field.	
19	Placed a small amount of water-soluble lubricant on the sterile field, taking care to avoid touching	
	the sterile field with the lubricant package.	
20	Increased the patient's supplemental oxygen level or applied supplemental oxygen.	
21	Put on face shield or goggles and mask.	
22	Put on sterile gloves.	
23	With dominant gloved hand, picked up sterile catheter.	
24	Picked up the connecting tubing with the non-dominant hand and connected the tubing and	
	suction catheter.	
25	Moistened the catheter by dipping it into the container of sterile saline.	
26	Occluded Y-tube to check suction with non-dominant hand.	
27	Encouraged the patient to take several deep breaths.	
28	Applied lubricant to the first 2 to 3 inches of the catheter, using the lubricant that was placed on the	
	sterile field.	
29	Remove the oxygen with non-dominant hand.	
30	Gently inserted the catheter through the naris and along the floor of the nostril toward the trachea	
	without applying the suction.	
31	Rolled the catheter between the fingers to help advance it.	
32	Advanced the catheter approximately 12-15cm to reach the pharynx.	
33	Applied suction by intermittently occluding the Y-port on the catheter with the thumb of your non-	
34	dominant hand and gently rotating the catheter as it was being withdrawn.	
35	Suctioned for 10 to 15 seconds at a time.	
	Withdrew the catheter.	
36 37	Replaced the oxygen delivery mask using non-dominant hand.	
-	Asked the patient take several deep breaths and cough.	
38	Flushed the catheter with saline.	
40	Assessed effectiveness of suctioning and repeated two more times if tolerated by the patient.	
	Alternated the nares when doing more than one pass.	
41	Allowed at least a 30-second to 1-minute interval between suction passes.	
43	Did not make more than three suction passes per suctioning episode.	
44	Wrapped the suction catheter around dominant hand between attempts. When suctioning is completed, removed glove from the dominant hand over the coiled catheter,	
44	pulling them off inside out.	
45	Removed glove from the non-dominant hand and dispose of gloves, catheter, and container with	
	solution in the appropriate lined waste bin.	
46	Removed face shield or goggles and mask.	
47	Turned off suction.	
48	Assisted the patient to a comfortable position.	
49	Performed hand hygiene using correct technique.	
50	Offered oral hygiene after suctioning.	
51	Reassessed and documented patient's respiratory status (student verbal report).	
52	Documented the procedure and result in patient's nursing notes.	
	1. SKILL EVALUATION 60%	
Steps	0 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 51-52 Skill steps	
Points	0 6 12 18 24 30 36 42 48 54 60 Skill points	
Level	F U N S C I Skill level a	achieved

			2. PR	OCEDUI	RE ASPE	CTS EVALUATION	N 40%				
Rationa	ale 10%		Patient F	ocus 10%	6	Professional	Manner :	10%	Tim	e 10%	
Failed		5	Failed		5	Failed		5	Failed	+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactor	ry+8	6
Novice		7	Novice		7	Novice		7	Novice	+6	7
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8
Competent		9	Competent		9	Competent		9	Competent	+2	9
Independent		10	Independent		10	Independent		10	Independent	TA	10
Notes:									Time allowed ((TA)	60
									Time achieved		
									Aspects points acl	hieved	
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 100	%			
≤50	51-6	60	61-70	71-	-80	81-90	91-1	.00	Total points ach	ieved	
Failed	Unsatisf	actory	Novice	Super	rvised	Competent	Indepe	ndent	Total level achie	eved	
Student				Signati	ure						
Teacher				Signati	ure				Actual Mark/0	Out of	
Clinical Area				Date					1		

PROCE	DURE: Suctioning - oral	Code	11-04
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	Patient medical record		
	Vital signs chart		
	 Portable suction unit if wall unit not available. 		
	 Sterile suction package – gauze, Yankauer suction catheter, container 		
	Normal saline		
	Lubricant		
	• Gloves		
	Sterile gloves		
	Oxygen mask with tubing		
	 Portable oxygen cylinder (if central oxygen are not available) 		
	Gauze pads		
	Hand rub gel		
	Towel or waterproof pad		
	Plastic tray		
2	Checked the medical order for suctioning.		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Reassured the patient you will interrupt the procedure if he or she indicates respiratory difficulty.		
8	Adjusted the height of the bed.		
9	Performed hand hygiene using correct technique		
10	Assisted patient to comfortable position.		
11	Placed towel or waterproof pad across the patient's chest.		
12	Adjusted suction to appropriate pressure:		
	For a wall unit for an adult: 100–120 mm Hg, adolescents: 80–120 mm Hg		
	For a portable unit for an adult: 10–15 cm Hg, adolescents: 8–10 cm Hg.		

13	Put on a disposable, clean glove.	
14	Occluded the end of the connecting tubing to check suction pressure.	
15	Open sterile suction package using aseptic technique.	
16	Used opened sterile package wrapper as a sterile field to hold other supplies.	
17	Poured normal saline into a sterile container	
18	Opened a wrapper of a sterile suction catheter and let catheter fall onto sterile field.	
19	Placed a small amount of water-soluble lubricant on the sterile field, taking care to avoid touching	
19	the sterile field with the lubricant package.	
20	Increased the patient's supplemental oxygen level or applied supplemental oxygen.	
21	Put on face shield or goggles and mask.	
22	Put on sterile gloves.	
23	With dominant gloved hand, picked up sterile catheter.	
24	Picked up the connecting tubing with the non-dominant hand and connected the tubing and	
24	suction catheter.	
25	Moistened the catheter by dipping it into the container of sterile saline.	
26	Occluded Y-tube to check suction with non-dominant hand.	
27	Encouraged the patient to take several deep breaths.	
28	Applied lubricant to the first 2 to 3 inches of the catheter, using the lubricant that was placed on the	
	sterile field.	
29	Remove the oxygen with non-dominant hand.	
30	Inserted catheter through in the the mouth and carefully suctioned the mouth cavity.	
31	Applied suction by intermittently occluding the Y-port on the catheter with the thumb of your non-	
	dominant hand and gently rotating the catheter as it was being withdrawn.	
32	Suctioned for 10 to 15 seconds at a time.	
33	Withdrew the catheter.	
34	Replaced the oxygen delivery mask using non-dominant hand.	
35	Asked the patient take several deep breaths and cough.	
36	Flushed the catheter with saline.	
37	Assessed effectiveness of suctioning and repeated two more times if tolerated by the patient.	
38	Alternated the nares when doing more than one pass.	
39	Allowed at least a 30-second to 1-minute interval between suction passes.	
40	Did not make more than three suction passes per suctioning episode.	
41	Wrapped the suction catheter around dominant hand between attempts.	
42	When suctioning is completed, removed glove from the dominant hand over the coiled catheter,	
	pulling them off inside out.	
43	Removed glove from the non-dominant hand and dispose of gloves, catheter, and container with	
11	solution in the appropriate lined waste bin.	
44	Removed face shield or goggles and mask.	
45	Turned off suction.	
46	Assisted the patient to a comfortable position.	
47	Performed hand hygiene using correct technique.	
48	Offered oral hygiene after suctioning.	
49	Reassessed and documented patient's respiratory status (student verbal report).	
50	Documented the procedure and result in patient's nursing notes.	
51	Returned equipment to the dedicated area.	
52	Arranged for the portable suction unit or the container of the wall suction to be cleaned and	
	decontaminated (verbal report).	
	1. SKILL EVALUATION 60%	
Steps	0 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 51-52 Skill steps	achieved
Points	0 6 12 18 24 30 36 42 48 54 60 Skill points	
Level	F U N S C I Skill level a	

			2. PR	OCEDU	RE ASPE	CTS EVALUATION	N 40%				
Rationa	ale 10%		Patient F	ocus 10%	6	Professional	Manner :	10%	Tim	e 10%	
Failed		5	Failed		5	Failed		5	Failed	+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactor	′y+8	6
Novice		7	Novice		7	Novice		7	Novice	+6	7
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8
Competent		9	Competent		9	Competent		9	Competent	+2	9
Independent	1	10	Independent		10	Independent		10	Independent	TA	10
Notes:									Time allowed	(TA)	60
									Time achieved		
									Aspects points ac	hieved	
			3. COM	IPLETE F	PROCED	URE EVALUATION	ON 1009	%			
≤50	51-60		61-70	71-	-80	81-90	91-1	.00	Total points ach	ieved	
Failed	Unsatisfact	tory	Novice	Super	vised	Competent	Indepe	ndent	Total level achie	eved	
Student				Signati	ure						
Teacher		•		Signati	ure		•	•	Actual Mark/0	Out of	
Clinical Area				Date							

PROCE	DURE: Suctioning - oropharyngeal	Code	11-05
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment. Patient medical record Vital signs chart Portable suction unit if wall unit not available. Sterile suction package – gauze, suction catheter, container Normal saline Lubricant Gloves Sterile gloves Oxygen mask with tubing Portable oxygen cylinder (if central oxygen are not available) Gauze pads Hand rub gel Towel or waterproof pad		
2	Plastic tray Checked the medical order for suctioning.		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Reassured the patient you will interrupt the procedure if he or she indicates respiratory difficulty.		
8	Adjusted the height of the bed.		
9	Performed hand hygiene using correct technique		
10	Assisted patient to comfortable position.		
11	Placed towel or waterproof pad across the patient's chest.		
12	Adjusted suction to appropriate pressure: For a wall unit for an adult: 100–120 mm Hg, adolescents: 80–120 mm Hg For a portable unit for an adult: 10–15 cm Hg, adolescents: 8–10 cm Hg.		

13	Put on a disposable, clean glove.	
14	Occluded the end of the connecting tubing to check suction pressure.	
15	Open sterile suction package using aseptic technique.	
16	Used opened sterile package wrapper as a sterile field to hold other supplies.	
17	Poured normal saline into a sterile container	
18	Opened a wrapper of a sterile suction catheter and let catheter fall onto sterile field.	
19	Placed a small amount of water-soluble lubricant on the sterile field, taking care to avoid touching	
	the sterile field with the lubricant package.	
20	Increased the patient's supplemental oxygen level or applied supplemental oxygen.	
21	Put on face shield or goggles and mask.	
22	Put on sterile gloves.	
23	With dominant gloved hand, picked up sterile catheter.	
24	Picked up the connecting tubing with the non-dominant hand and connected the tubing and suction	
	catheter.	
25	Moistened the catheter by dipping it into the container of sterile saline.	
26	Occluded Y-tube to check suction with non-dominant hand.	
27	Encouraged the patient to take several deep breaths.	
28	Applied lubricant to the first 2 to 3 inches of the catheter, using the lubricant that was placed on the	
20	sterile field.	
29	Remove the oxygen with non-dominant hand.	
30	Inserted catheter through the mouth, along the side of the mouth toward the trachea, advancing the catheter 7-10cm to reach the pharynx.	
31	Applied suction by intermittently occluding the Y-port on the catheter with the thumb of your non-	
31	dominant hand and gently rotating the catheter as it was being withdrawn.	
32	Suctioned for 10 to 15 seconds at a time.	
33	Withdrew the catheter.	
34	Replaced the oxygen delivery mask using non-dominant hand.	
35	Asked the patient take several deep breaths and cough.	
36	Flushed the catheter with saline.	
37	Assessed effectiveness of suctioning and repeated two more times if tolerated by the patient.	
38	Alternated the nares when doing more than one pass.	
39	Allowed at least a 30-second to 1-minute interval between suction passes.	
40	Did not make more than three suction passes per suctioning episode.	
41	Wrapped the suction catheter around dominant hand between attempts.	
42	When suctioning is completed, removed glove from the dominant hand over the coiled catheter,	
	pulling them off inside out.	
43	Removed glove from the non-dominant hand and dispose of gloves, catheter, and container with	
4.4	solution in the appropriate lined waste bin.	
44	Removed face shield or goggles and mask.	
45	Turned off suction.	
46 47	Assisted the patient to a comfortable position.	
	Performed hand hygiene using correct technique.	
48	Offered oral hygiene after suctioning.	
49	Reassessed and documented patient's respiratory status (student verbal report).	
50 51	Documented the procedure and result in patient's nursing notes.	
52	Returned equipment to the dedicated area. Arranged for the portable suction unit or the container of the wall suction to be cleaned and	
52	decontaminated (verbal report).	
	accontanimated (versus report).	
	1. SKILL EVALUATION 60%	
Steps	0 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 51-52 Skill steps a	achieved
Points	0 6 12 18 24 30 36 42 48 54 60 Skill points	
Level	F U N S C I Skill level a	
		•

			2. PR	OCEDUI	RE ASPE	CTS EVALUATION	N 40%					
Rationa	ale 10%		Patient F	ocus 10%	6	Professional	Professional Manner 10% Time 10%					
Failed		5	Failed		5	Failed		5	Failed	5		
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactor	ry+8	6	
Novice		7	Novice		7	Novice		7	Novice	+6	7	
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8	
Competent		9	Competent		9	Competent		9	Competent	+2	9	
Independent		10	Independent		10	Independent		10	Independent	TA	10	
Notes:									Time allowed ((TA)	60	
									Time achieved			
									Aspects points acl	hieved		
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 100	%				
≤50	51-6	60	61-70	71-	-80	81-90	91-1	.00	Total points ach	ieved		
Failed	Unsatisf	actory	Novice	Super	rvised	Competent	Indepe	ndent	Total level achie	eved		
Student				Signati	ure							
Teacher				Signati	ure				Actual Mark/0	Out of		
Clinical Area				Date					1			

PROC	EDURE: Peri-operative care – deep breathing exercises, coughing and splinting	Code	12-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Written instructions about deep breathing exercises, coughing and splinting.		
	☐ Hand rub gel		
	□ Plastic tray		
2	Reviewed the medical record for the type of surgery and reviewed the medical orders.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Provided patient with written instructions about deep breathing exercises, coughing and splinting.		
8	Adjusted the height of the bed.		
9	Identified the patient's learning needs -level of knowledge regarding deep breathing exercises, coughing, and splinting of the incision.		
10	Asked the patient about previous experience with surgery and deep breathing exercises, coughing, and splinting of the incision.		
	To teach patient deep breathing exercises assisted or asked the patient to sit up (semi- or high- Fowler's position).		
11	Instructed the patient to place the palms of both hands along the lower anterior rib cage.		
12	Instructed the patient to exhale gently and completely.		
13	Instructed the patient to breathe in through the nose as deeply as possible and hold breath for 3 seconds.		
15	Instructed the patient to exhale through the mouth, pursing the lips like when whistling.		
16	Asked the patient to practice the breathing exercise three times.		
17	Instructed the patient that this exercise should be performed every 1 to 2 hours for the first 24 hours after surgery.		
18	For learning how to cough and splint, apply a folded bath blanket or pillow against the part of the body where the incision will be (e.g., abdomen or chest).		

														65
19	Instruc	ted the p	atient to	inhale a	nd exha	e throug	the no	se three	times.					
20	Asked to	•	nt to tak	e a deep	breath a	nd hold	it for 3 s	econds a	nd then	cough ou	it three	short		
21	Asked t	he patie	nt to tak	e a breat	h throug	h the mo	outh and	strongly	cough a	gain two	times.			
22	Instruc	t the pati	ient that	he or sh	e should	perform	these a	ctions ev	ery 2 hou	ırs when	awake	after		
	surgery													
23		d patient stration.	t's under	rstanding	g of infor	mation b	y asking	the patie	nt to giv	e a retur	'n			
24	Asked t	he patie	nt if he c	or she ha	s any que	estions.								
25	Encour	age the p	oatient to	o practice	e the act	vities an	d ask qu	estions, i	f necess	ary.				
26	Restore	ed patien	t to a co	mfortabl	e positio	n.								
27	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
28	Return	ed equip	ment to	the dedi	cated are	ea.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-3	4-6	7-9	10-12	13-14	15-17	18-20	21-23	24-26	27-28	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level		F U N S C I Skill level achieved 2. PROCEDURE ASPECTS EVALUATION 40%												
				1 -										
F-111	Rationa	ale 10%	-		Patient F	ocus 109			essional	Manner			Time 10%	1
Failed	factory		5 6	Failed	factory		5 6	Failed Unsatis	factory		5 6	Failed Unsatisfa	+10	5 6
Novice	sfactory		7	Novice			7	Novice	ractory		7	Novice	+6	7
Superv			8	Superv			8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:												Time allo	wed (TA)	60
												Time achiev	ved	
												Aspects poin	ts achieved	
								URE EV	ALUATIO					
≤!	50		-60	61	-70		-80	81		91-1	L00	Total points	achieved	
Fai	led	Unsatis	factory	No	vice		rvised	Comp	etent	Indepe	ndent	Total level a	achieved	
Studer						Signat								
Teach						Signat	ure					Actual Ma	rk/Out of	
Clinica	l Area					Date								

PROCI	EDURE:	Peri-operative care – applying anti-embolic stockings	Code	12-02
No.		Skill steps	Not achieved	Achieved
1	Prepare	d procedure equipment:		
		Patient medical record		
		Anti-embolic stockings with manufacturer's instructions		
		Powder or lotion		
		Gloves		
		Hand rub gel		
		Plastic tray		
2	Review	ed the medical record and medical orders to determine the need for anti-embolism		
	stocking	ŢS.		
3	Identifi	ed patient using two identifiers.		
4	Perform	ned greeting, introduction and permission procedure (G.I.P).		

г	Drovii d	d p=1	.,											1
5 6		ed privac) to the :	nationt c	ad answer	arod and	aucstic-	· C					
					oatient ar	na answe	ered any	question	is.					
7			eight of the			11								
8					tions for			ckings.						
9			d hygiene	e using c	orrect te	chnique.								
10	Put on	_												
11			tient to s											
12	-			_	king, hav ing stock				n legs an	d feet we	ell eleva	ted for		
13	Expose	d legs on	ne at a tir	ne.										
15	Applied	l powder	r or lotio	n to the	skin if red	commen	ded by m	nanufacti	urer.					
16	Stood a	t the foc	ot of the	bed.										
17	Placed	hand ins	ide stock	ing and	grasped	heel area	securel	y.						
18					o the hee			•	side the	stocking	leg.			
19					ed the sto									
20		· ·			ntered ir									
21					ully grasp	· ·			ull it up :	smoothly	over a	nkle and		
		ward the		,	, 0 P	0-		G = P						
22	Pulled 1	forward s	slightly o	n toe se	ction.									
23	Adjuste	d the sto	ocking to	ensure	material	is smoot	h.							
24	-	If the s	tockings	are kne	e-length,	make su	re each s	stocking	top is 1 t	o 2 inche	es belov	the		
		patella	_											
	-			_	stocking				_	-	_			
					over the		til the to	o is 1 to 3	3 inches	below th	e glutea	l fold.		
25				mfortab	le positio	n.								
26	Remov	ed gloves	S.											
27	Perforn	ned hand	d hygiene	e using c	orrect te	chnique.								
28	Docum	ented th	e result i	in the vit	tal signs o	hart.								
29	Inform	ed the pa	atient or	relative	if approp	riate of t	the resul	t.						
30	Return	ed equip	ment to	the dedi	icated are	ea.								
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-3	4-6	7-9	10-13	14-15	16-19	20-22	23-25	26-28	29-30	Skill steps	s achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	ı	Skill level a	achieved	
				ı			RE ASPE							
	Rationa	ale 10%	ı		Patient F	ocus 109			essional	Manner			Time 10%	
Failed	•		5	Failed	•		5	Failed			5	Failed	+10	5
	factory		6		sfactory		6		factory		6	Unsatisfa	-	6
Novice	icod		7 8	Novice			7	Novice			7	Novice Supervise	+6	7
Supervi			9	Superv Compe			8	Superv Compe			8 9	Compete		8 9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:			1 10	macpe	aciit		1 10	macpe			1 10	·		
												Time allo	owed (TA)	15
												Time achie	ved	
												Aspects poir	nts achieved	
							PROCED							
≤5	50	51-	-60	61	-70	71	-80	81	-90	91-1	100	Total points	s achieved	
Fai	led	Unsatis	factory	No	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								
					_									

PROCE	DURE:			Pre-	operat	ive car	e - imm	ediate				Code	12-03
No.					Skill	steps						Not achieved	Achieved
1	Prepared proced	dure equ	ipment:										
		medical											
	-	gns chart											
			=	or electro									
			meter an	d stethos	scope								
		ximeter											
	☐ Gauze	otina solu	ıtion										
	☐ Disinfed☐ Hand ru	cting solu	ution										
	☐ Plastic t	_											
		cray											
2	Checked the pat					y and rev	iew the	medical (orders.				
3	Performed hand				hnique.								
4	Identified patien												
5	Performed greet		oduction	and peri	mission	procedu	re (G.I.P)						
6 7	Provided privacy Explained the pr		to the n	ationt an	d answer	rod any	anostica	· C					
8	Checked that pro						•		act and t	hat the	nationt's		
8	chart is in order.	•	ve conse	1110111113	WCIC 318	siicu, wii	illesseu,	and com	ect and t	inat the	patient 3		
9	Assessed and do		ed blood	pressure	<u>).</u>								
10	Assessed and do	cumente	ed pulse.										
11	Assessed and do	cumente	ed respir	ations.									
12	Assessed and do	cumente	ed oxyge	n saturat	ions.								
13	Assessed and do												
14	Notified appropr												
4.5	drop in blood pr			•		ugh, sym	ptoms o	f infectio	n) – verl	al repo	rt.		
15	Ensured patient			oral care	•								
16	Assess for loose		· ·		b.ef.								
17 18	Remind patient of the						-	r and nut	t on a hor	nital gov	un.		
19	Asked the patier							-		pitai gov	VII.		
20	If possible, gave					-				if this w	as not		
_0	possible.	· aradole		,	o. p.	ruide			ar cu,	٧٧	~J 1.00		
21	Asked the patier	nt to emp	pty blado	der and b	owel be	fore surg	gery.						
22	Asked the patier												
23	Administer preo									•			
24	Complete preop				•	•	•		ration.				
25	Provided safe en				-		ils up if	oossible.					
26	Instructed the pa					tcher.							
27	Put call bell with												
28	Asked the patier												
29	Performed hand Returned equipr												
30	neturnea equipr	nent to t	ine dedic	Lateu are		ILL EVA	LLIATIO	N 60%					
Steps	0 1-3	4-6	7-9	10-13	14-15	16-19	20-22	23-25	26-28	29-30	Skill stens	achieved	
Points	0 6	12	18	24	30	36	42	48	54	60	Skill points		
Level		F				U	N	S	С	I	Skill level a		

			2. PR	OCEDUF	RE ASPE	CTS EVALUATION	N 40%				
Rationa	ale 10%		Patient F	ocus 10%	6	Professional	Manner 1	10%	Tim	e 10%	
Failed		5	Failed		5	Failed		5	Failed	+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactor	′y+8	6
Novice		7	Novice		7	Novice		7	Novice	+6	7
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8
Competent		9	Competent		9	Competent		9	Competent	+2	9
Independent		10	Independent		10	Independent		10	Independent	TA	10
Notes:	<u>.</u>								Time allowed ((TA)	60
									Time achieved		
									Aspects points acl	hieved	
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 1009	%			
≤50	51-60	0	61-70	71-	-80	81-90	91-1	.00	Total points ach	ieved	
Failed	Unsatisfa	ctory	Novice	Super	vised	Competent	Indepe	ndent	Total level achie	ved	
Student				Signati	ure						
Teacher				Signati	ure				Actual Mark/0	Out of	
Clinical Area				Date							

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

Prepared procedure equipment: Patient medical record Vital signs chart Thermometer, mercury or electronic Sphygmomanometer and stethoscope Pulse oximeter Gauze Disinfecting solution Hand rub gel Plastic tray Performed hand hygiene using correct technique. 3 Collected the patient from recovery unit and received verbal handover and patient documentation from the recovery staff. 4 Adjusted the height of the bed. 5 Transferred the patient from the stretcher to the bed safely and with assistance. 6 Placed the patient in safe position (semi- or high Fowler's or side-lying). 7 Noted level of consciousness by asking patient how he/she feels. 8 Identified patient using two identifiers. 9 Performed greeting, introduction and permission procedure (G.I.P). 10 Provided privacy. 11 Explained the procedure to the patient and answered any questions. 12 Performed hand hygiene using correct technique. 13 Checked prescribed frequency of vital signs measurements in medical record. 14 Verbally reported that usual frequency of checking vital signs would be every 15 minutes the first hour, every 30 minutes the next 2 hours, every hour for 4 hours, and finally every 4 hours. 15 Assessed and documented pulse. 17 Assessed and documented pressure.	PROC	EDURE: Post-operative care - immediate	Code	12-04
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·	16	Assessed and documented pulse.		
10 Assessed and decumented evigen seturations	17	Assessed and documented respirations.		
18 Assessed and documented oxygen saturations.	18	Assessed and documented oxygen saturations.		

														69
19	Assesse	ed and do	ocument	ed temp	erature.									
20	Assesse	ed skin co	olour (ve	rbal repo	ort).									
21	Provide	for war	mth, usir	ng heate	d or extra	a blanket	ts, as nec	essary.						
22	Checke	d dressir	ngs for co	olour, od	or, prese	nce of d	rains, an	d amoun	t of drair	nage.				
23	Turned	the pati	ent to as	sess visu	ally unde	er the pa	tient for	bleeding	from the	e surgica	ıl site.			
24	Marked	d the dra	inage on	the dres	sing by c	ircling th	ne amour	nt, and ir	clude th	e time.				
25	Checke	d that al	l the tub	es and di	rains are	patent a	ınd equip	ment is	operative	Э.				
26	Checke	d and do	cumente	ed the an	nount of	drainage	e in colle	ction dev	ice or Fo	ley's cat	heter b	ag.		
27	Checke	d and ma	aintained	d IV infus	ion at co	rrect rat	e.							
28	Assesse	ed the pa	itient for	pain.										
29	Checked	the reco	very reco	rd for ana	lgesics ad	ministere	ed in recov	very and a	rranged p	ain relief	if appro	priate.		
30	Provide	ed safe ei	nvironm	ent with	bed in lo	w positio	on and ra	ails up if p	ossible.					
31	Put call	bell with	hin patie	nt's reac	h, if avail	able.								
32	Asked t	he patie	nt if he/s	she is cor	mfortable	2.								
33	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
34	Docum	ented th	e result i	in the vit	al signs c	hart.								
35	Return	ed equip	ment to	the dedi	cated are	ea.								
36	Reporte	d abnorm	nal finding	s to the a	ppropriat	e health c	care provi	der (stude	ent report	ed this ac	tion ver	bally).		
						1. SK	(ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36		s achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	- 1	Skill level	achieved	
				1 -				CTS EVA				1		
F '1 1	Rationa	ale 10%	-		Patient F	ocus 109			essional I	Manner	1	F 11 1	Time 10%	-
Failed	factory		5	Failed	factori		5	Failed	factori		5	Failed	+10	5
Novice	factory		6 7	Novice	factory		6 7	Unsatis Novice	ractory		6 7	Unsatisfa Novice	+6	6 7
Superv	isad		8	Supervi	h		8	Superv	isad		8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
											dent TA	10		
Notes:							1				•	Time all	owed (TA)	60
												Time achie	eved	
												Aspects poi	nts achieved	
				3	. CON	IPLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61-	-70	71	-80	81-	-90	91-1	100	Total point	s achieved	
Fai	led	Unsatis	factory	Nov	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	dent					Signature								
												7		ı
Teach	er					Signat	ure					Actual M	ark/Out of	

COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION **Procedure Evaluation Document (PED)** Post-operative care - continuing 12-05 PROCEDURE: Code Not No. Skill steps Achieved achieved 1 Prepared procedure equipment: ☐ Patient medical record ☐ Vital signs chart ☐ Thermometer, mercury or electronic Sphygmomanometer and stethoscope

HAWLER MEDICAL UNIVERSITY

	☐ Pulse oximeter													
	☐ Visual analogue scale													
		Gauze												
			ecting sol	ution										
			rub gel											
		Plastic	tray											
2	Perform	ned hand	d hygiene	using co	rrect tec	hnique								
3			atient usi											
4		•	ting, intr	_			procedu	re (G.I.P)	_					
5		d privac			and per		p. 000a.a.	· · · (• · · · ·)						
6		•	•	to the p	atient an	ıd answe	ered anv	auestion	S.					
7	Explained the procedure to the patient and answered any questions. Adjusted the height of the bed.													
8	Assessed neurological status:													
	•	patient	t is awake	9										
	•	alert												
	•	oriente	ed											
	•	respon	ds to cor	nmands										
9			atient car											
11			ocumento ocumento		•	2.								
12			ocument											
13			ocument			tions.								
14			ocument											
15			sing visua			_								
16		•	olour (vei			-								
17			eds for sig	•	-									
18			turn of pe			ltation.								
19			esence of		•									
20		•	intake w			_	hysician							
21			ngs for co				•		nt of dra	inage.				
22			I the tube		•									
23	Checke	d and do	cumente	d the an	nount of	drainage	e in colle	ction dev	ice or Fc	ley's cat	heter b	ag.		
24	Checke	d and ma	aintained	l IV infus	ion at co	rrect rat	e.							
25	Checke	d admini	istration	of oxyge	n if used.									
26	Encoura	aged pat	ient to p	erform d	eep brea	thing ex	ercises.							
27	Encoura	aged pat	ient to p	erform fr	equent p	osition	changes.							
28	Encoura	aged pat	ient to p	erform e	arly amb	ulation v	when rec	ommend	led by th	e physic	ian.			
29			nvironme			-	on and ra	ils up if p	ossible.					
30			hin patier											
31		•	nt if he/s											
32			onal supp											
33			d hygiene			•								
34			e result i										-	
35			ment to t				alth sam	nrovid-	r /ctdc.	at rono	ad this	oction		
36	verbally		mal findi	iigs to tr	ie approp	oriate ne	aith Care	: provide	ı (studer	ıı report	eu this a	aCHON		
	verbuny	· · ·												
						1 6	/II I E\ / ^	LLIATIO	N COO					
Steps	0	1-4	5-8	9-12	13-16	1. SK	19-22	LUATIO 23-26	N 60% 27-30	31-34	35-36	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level	5		<u> </u>		۷-	- 50	U	N N	S	C	I	Skill level a		
									_		i -			

			2. PR	OCEDUF	RE ASPE	CTS EVALUATION	N 40%					
Rationa	ale 10%		Patient Fo	ocus 10% Professional			Manner:	10%	Time 10%			
Failed 5			Failed		5	Failed		5	Failed	+10	5	
Unsatisfactory	6	U	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory+8		6	
Novice	7	N	Vovice		7	Novice	Novice 7		Novice	+6	7	
Supervised 8			Supervised		8	Supervised 8			Supervised	+4	8	
Competent 9			Competent		9	Competent 9			Competent	+2	9	
Independent 10			Independent		10	Independent		10	Independent	TA	10	
Notes:	·								Time allowed	(TA)	30	
										Time achieved		
										Aspects points achieved		
			3. COM	IPLETE F	PROCED	URE EVALUATION	ON 100	%				
≤50	51-60	61-70	71-80		81-90	91-100		Total points achieved				
Failed	Unsatisfactory		Novice	Supervised		Competent	Independent		Total level achieved			
Student		•		Signati	ure							
Teacher				Signature				•	Actual Mark/Out of			
Clinical Area			Date									

PROC	EDURE: Pre - operative care - teaching patient to use incentive spirometry	Code	12-06
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Incentive spirometer		
	☐ Hand rub gel		
	☐ Plastic tray		
2	Reviewed chart for any health problems that would affect the patient's oxygenation status.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Assisted patient to an upright or semi-Fowler's position.		
9	Assessed the patient's level of pain and administer pain medication if appropriate.		
10	If patient has recently undergone abdominal or chest surgery, placed a pillow or folded blanket over a chest or abdominal incision for splinting.		
11	Demonstrated how to steady the device with one hand and hold the mouthpiece with the other hand, assisting if necessary.		
12	Instructed the patient to exhale normally and then place lips securely around the mouthpiece.		
13	Instructed the patient to inhale slowly and as deeply as possible through the mouthpiece without using nose (if desired, a nose clip may be used).		
15	Told the patient that when he/she cannot inhale anymore, he/she should hold his or her breath and count to three.		
16	Checked the position of gauge to determine progress and level attained.		
17	Instructed the patient to remove lips from mouthpiece and exhale normally.		
18	Told the patient that if he/she becomes light-headed during the process, he/she should stop and		
	take a few normal breaths before resuming incentive spirometry.		

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19	Encouraged the patient to perform incentive spirometry 5 to 10 times every 1 to 2 hours, if possible.															
20	Cleaned	Cleaned the mouthpiece with water and shook it to dry.														
21	Checked patient understands of information by asking the patient to give a return demonstration.															
22	Asked the patient if he or she has any questions.															
23	Encourage the patient to practice the activities and ask questions, if necessary.															
24	Restored patient to a comfortable position.															
25	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.										
26	Returne	ed equip	ment to	the dedi	cated are	ea.										
27	Docum	ented th	e proced	lure in th	e patien	t's medio	cal record	d.								
1. SKILL EVALUATION 60%																
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps achieved				
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points				
Level				F			U	N	S	C		Skill level achieved				
				Г				CTS EV				I				
Rationale 10% Patient F				Patient F					Time 10%							
			Failed			5	Failed Unsatisfactory			5	Failed +10 Unsatisfactory+8		5			
Unsatisfactory 6 Novice 7			Unsatisfactory Novice		6 7	Novice	tactory		6 7	Novice	+6	6 7				
Novice Supervi			8	Supervised			8				8	Supervised +4		8		
Compe			9	Competent		9	Competent		9	Competent +2		9				
Indepe			10	Indepe			10	· · ·			10	Independent TA		10		
Notes:				•			l					·	owed (TA)	30		
												Time achieved				
												Aspects poir	nts achieved			
								URE EV				ı				
	50	51-60 61-70			71-80		81-90 91-1		-100 Total poin		s achieved					
	iled	Unsatisfactory Novice		Supervised		Competent Independ		ndent	dent Total level achieved							
Student				Signature												
Teacher				Signature						Actual Ma	ark/Out of					
Clinica	ıl Area					Date										

	Procedure Evaluation Document (PED)							
PROCE	EDURE: Post-operative care – discharge planning	Code	12-07					
No.	Skill steps	Not achieved	Achieved					
1	Prepared procedure equipment: Patient medical record Medical discharge summary Nursing notes Nursing discharge plan form Referral form Written discharge information and post-discharge instructions according to the diagnost and patient's condition(written or leaflets) Hand rub gel	sis						
2	Performed hand hygiene using correct technique.							
3	Identified the patient using two identifiers.							
4	Performed greeting, introduction and permission procedure (G.I.P).							

5	Provide	d privac	у.												
6	Review	ed patie	nt's med	ical reco	rd and n	ursing no	otes.								
7	Determ	ined risk	factors	for disch	arge:										
		Elderly	age gro	up											
		Multisy	ystem di	sease pro	ocess										
		Major	surgical _l	orocedur	e										
				ninal illne											
				ental ins	-										
				napprop	riate livii	ng arrang	gements								
			ftranspo												
			ial insecu	•		_									
							airs, no h						 		
8							id answe						<u> </u>		
9					-		nal plan	-	emente	d.			<u> </u>		
10							thing exe						<u> </u>		
11			d that patient knows how to do range of motion exercises. ed to the patient how to take medications.												
12	-		ed to the patient how to care for their surgical wound,												
13	•	ed to the patient how to care for their surgical wound, ne patient instructions about the diet, rest and activity, hygiene.													
14													<u> </u>		
15	Explain	ed to the	e patient	how to I	recognise	e compli	cations a	nd what	to do if t	hey occu	ır.		<u></u>		
16	Gave th	Explained to the patient how to recognise complications and what to do if they occur. Gave the patient instructions about the follow - up appointments.													
17	Comple	npleted discussion about discharge plan with the patient answering any questions.													
18	Checke	ked and completed discharge plan form correctly.													
19	Checke	d and co	mpleted	discharg	ge instru	ctions or	provided	leaflets							
20	Identifi	ed appro	priate si	upport n	eeded af	ter disch	arge (vei	bal repo	rt).						
21	Made r	eferrals	(one for	evaluatio	on purpo	ses) fillir	ng the ref	erral for	m.						
22	Docum	ented th	e proced	lure in th	e patien	t docum	entation.	1							
			-		-	1. SI	KILL EVA	LUATIO	N 60%						
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-16	17-18	19-20	21-22	Skill steps a	achie	ved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achie	eved	
Level				F			U	N	S	С	I	Skill level a	chiev	red	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%					
	Rationa	ale 10%			Patient F	ocus 109			essional	Manner			Tim	e 10%	
Failed			5	Failed			5	Failed			5	Failed		+10	5
	factory		6		factory		6		factory		6	Unsatisfa	ctor	y+8	6
Novice			7	Novice			7	Novice			7	Novice	<u> </u>	+6	7
Supervi			8	Superv			8	Superv			8	Supervise		+4	8
Compe			9	Compe			9	Compe			9	Compete		+2	9
Indepe	naent		10	Indepe	naent		10	Indepe	naent		10	Independ			10
Notes.												Time allov	/ed (TA)	60
												Time achiev	ved		
												Aspects poin	ts ach	nieved	
							PROCED	URE EV	ALUATION						
≤5	50	51	-60	61	-70	71	-80	81-	-90	91-1	100	Total points	achi	eved	
Fai	led	Unsatis	factory	No	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level a	achie	ved	
Studer	nt					Signat	ure]			
Teache	er					Signat	ure					Actual Ma	rk/C	Out of	
Clinica	l Area	Signature Actual Mark/Out of													

PROCE	EDURE:				Pain	manag	ement	asses	sment				Code	13-01
No.							Skill ste	ps					Not achieved	Achieved
1														
	Prepare		dure equ											
			t medica											
			ation cha ssessmer											
			ssessinei rub gel	it Cilait										
		Plastic	_											
		riastic	. ti ay											
2			nt using t											
3				oduction	and per	mission	procedui	re (G.I.P)	•					
4		d privac	•	A - Al	-4:4									
5 6		•					ered any	question	S.					
7			d hygiene											
8			tient to a		•		atient de	taile						
9		•	cumente				atient de	taiis.						
10			cumente		•									
11			cumente				ain							
12						•	g of pain.							
13								ociated v	vith pain					
14			cumente							-				
15							rs of pain							
16			cumente											
17	Checked	d and do	cumente	ed the se	verity of	pain usi	ng 0-10 p	ain scale	·.					
18	Asked t	he patie	nt to pro	vide any	addition	al inforn	nation ab	out thei	r pain.					
19	Checked	d curren	t analges	ia prescr	iption in	the med	dication o	hart						
20	Provide	d pain re	elief if ne	eded an	d approp	riate aco	cording to	o the me	dical ord	er (verba	al repor	t).		
21	Perform	ned hand	d hygiene	using co	orrect te	chnique.								
22	Docume	ented th	e result i	n the vit	al signs c	hart.								
23		•					the resul	t.						
24	Returne	ed equip	ment to	the dedi	cated are									
Ctono	0	1.2	2.4	F 7	0.10			LUATIO		24.22	23-24	Skill steps	achiovad	
Steps Points	0	1-2 6	3-4 12	5-7 18	8-10 24	11-12 30	13-15 36	16-18 42	19-20 48	21-22 54	60	Skill points		
Level	0	U	l .	:	24	30	U	N N	S	C	I	Skill level a		
					2. PR	OCEDU		CTS EV						
	Rationa	le 10%		ı	Patient F	ocus10%	ó	Profe	essional	Manner:	10%		Time10%	
Failed			5	Failed			5	Failed			5	Failed+10)	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	•	6
Novice			7	Novice			7	Novice	1		7	Novice	+6	7
Supervi Compe			8 9	Supervi			8 9	Supervi Compe			8 9	Supervise Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:				асрс				чере				Time allov		30
												Time achie		
												Aspects poir		
												ווטק טוט בקבו		

		3. COI	MPLETE PROCEE	URE EVALUATI	ON 100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area			Date				

PROC	EDURE: Wound care – applying dry gauze dressing	Code	14-01
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: Patient medical record Sterile pack containing gauze, solution container, basin Normal saline or other irrigating solution as per medical order Clean gloves Sterile gloves Syringes Tape Hand rub gel Plastic bag for waste Waterproof pad Surgical trolley		
2	Reviewed the medical orders for applying dry dressing if given.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		
9	Assisted the patient to a comfortable position that provides easy access to the incision area.		
10	Placed a waste plastic bag at a convenient location for use during the procedure.		
11	Placed waterproof pad under the incision area.		
12	Put on clean gloves.		
13	Carefully and gently removed the soiled dressings, used sterile normal saline to help loosen the dressing if needed.		
14	Noted the condition of the wound and presence, amount, type, colour and odour of any drainage. (student verbal report).		
15	Discarded the dressing into the waste plastic bag.		
16	Removed gloves.		
17	Performed hand hygiene using correct technique.		
18	Opened the sterile pack using aseptic technique.		
19	Put on sterile gloves.		
20	Cleaned the wound from top to bottom and from the centre to the outside using new gauze for each wipe and discarding the used gauze into the waste plastic bag.		
21	Once the wound is cleaned, dried the area using sterile gauze in the same way.		
22	Reapplied the dry sterile gauze dressing.		
23	Removed and discarded the gloves.		
24	Secured the dressing with the tape.		
25	After securing the dressing, labelled the new dressing with date and time.		
26	Restored patient to a comfortable position.		

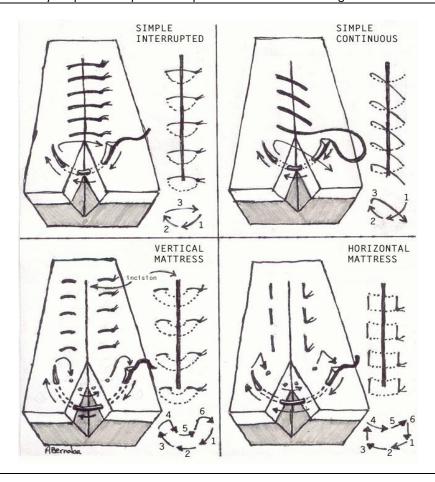
27	Perform	ed hand l	nygiene u	sing corre	ct technic	que.								
28	Docume	ented the	result in t	he patien	t's notes.									
29	Informe	d the pati	ent or rel	ative if ap	propriate	of the re	sult.							
30	Returne	d equipm	ent to the	e dedicate	ed area.									
31	Reporte	d abnorm	al finding	s to the a	ppropriat	e health c	are provi	der (stude	nt report	ed this ac	tion verl	oally).		
	L					1. Sł	(ILL EVA	LUATIO	N 60%					
Steps	0	1-3	4-6	7-9	10-13	14-15	16-19	20-23	24-26	27-29	30-31	Skill steps	achieved	
Points	0											Skill points	achieved	
Level												Skill level a	chieved	
					2. PR	OCEDUI	RE ASPE	CTS EV	LUATIO	ON 40%				
	Rationa	ale 10%		l	Patient F	ocus 10%	6	Profe	essional I	Manner	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory		6	Unsatisfa	6		
Novice			7	Novice			7	Novice			7	Novice	7	
Supervi	ised		8	Superv	ised		8	Superv	sed		8	Supervise	ed +4	8
Compe			9	Compe	tent		9	Compe	tent		9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10
Notes:												Time allov	ved (TA)	30
												Time achie	ved	
												Aspects poir	ts achieved	
				3	B. CON	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤5	50	51-	-60	61	-70	71	-80	81-	-90	91-1	100	Total points	achieved	
Fai	led	Unsatisfactory Novice Su		Supe	vised	Comp	etent	Indepe	ndent	Total level	achieved			
Studer	Student			Signat	ure									
Teache	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area		•	•	•	Date	•		•	•	•			

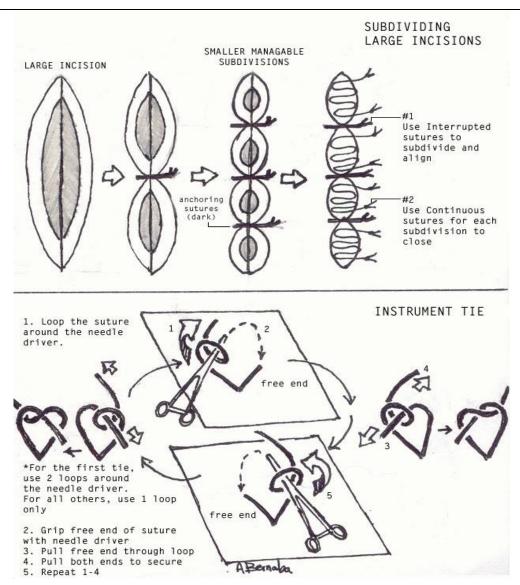
PROCI	DURE: Wound care – applying wet dressing	Code	14-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Sterile pack containing gauze, solution container, basin		
	☐ Normal saline and/or other irrigating solution as per medical order		
	☐ Clean gloves		
	☐ Sterile gloves		
	□ Syringes		
	□ Таре		
	☐ Hand rub gel		
	☐ Plastic bag for waste		
	☐ Waterproof pad		
	☐ Surgical trolley		
2	Reviewed the medical orders for applying dry dressing if given.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		

9	Assiste	d the pat	ient to a	comfort	table pos	ition tha	t provide	es easy a	ccess to	the incisi	on area			
10					onvenien		n for use	during t	he proce	dure.				
11	Placed	waterpro	oof pad u	ınder the	e incision	area.								
12	Put on	gown, m	ask and	eye prot	ection if	needed.								
13	Put on	clean glo	ves.											
14		ly and ge g if need		oved the	e soiled o	dressings	, used st	erile nori	mal salin	e to help	loosen	the		
15		the condi it verbal		he wour	nd and pr	esence, a	amount,	type, col	our and	odour of	any dra	ainage.		
16	Discard	ed the di	ressing i	nto the v	waste pla	stic bag.								
17	Remov	ed gloves	5.											
18	Perforn	ned hand	hygiene	using c	orrect te	chnique.								
19	Opened	d the ster	rile pack	using as	eptic tec	hnique.								
	Put on sterile gloves.													
20	Placed it.													
21		Cleaned the wound from top to bottom and from the centre to the outside using new gauze for each wipe and discarding the used gauze into the waste plastic bag.												
22		Oried the surrounding skin with sterile gauze dressings.												
24		ueezed excess fluid from the gauze dressing. Unfolded the dressing.												
25		Gently pressed the gauze to loosely pack the moistened gauze into the wound.												
26		Applied several dry, sterile gauze pads over the wet gauze.												
27	Removed and discarded the gloves.													
28	Secured the dressing with the tape.													
29	After securing the dressing, labelled the new dressing with date and time.													
30	Restored patient to a comfortable position.													
31	Performed hand hygiene using correct technique.													
32					tient's no									
33		-			if approp		the resul	t.						
34					cated are									
35	Reporte verbally		mal find	ings to tl	he appro	priate he	ealth care	e provide	r (studei	nt report	ed this	action		
						1. SI	KILL EVA	LUATIO	N 60%			,		
Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-33	34-35	Skill steps a		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				=	2 55	0050111	U	N STC F) (S	C		Skill level a	chieved	
	Dations	-l- 100/						CTS EVA					Time a 100	
Failed	Rationa	10%	5	Failed	Patient F	ocus 109	5	Failed	essionai	Manner	5	Failed	Time 109 +10	5
	factory		6		sfactory		6	Unsatis	factory		6	Unsatisfa		6
Novice			7	Novice	-		7	Novice			7	Novice	+6	7
Supervi			8	Superv			8	Superv	ised		8	Supervise		8
Compe	tent		9	Compe	etent		9	Compe			9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	ent TA	10
Notes:												Time allow	ved (TA)	30
												Time achiev	/ed	
												Aspects poin		
					3. CON	1PLETE I	PROCED	URE EV	ALUATI	ON 100	%			
	50	51-	-60	61	-70	71	-80	81-	-90	91-1	100	Total points	achieved	
Fai	Failed Unsatisfactory Novice		vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level a	achieved			
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual Ma	rk/Out of	
Clinica	l Area					Date								

PROC	EDURE: Wound care - suturing	Code	14-03
No.	Skill steps	Not achieved	Achieved
1 1	Prepared procedure equipment:		Achieved
	□ Trolley		
2	Checked the medical record for the medical order for wound suturing.		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed.		
8	Ensured good lighting of the area.		
9	Assisted patient to a comfortable position.		
10	Put waterproof pad under the area with wound.		
11	Performed hand hygiene using correct technique.		
12	Put on non-sterile gloves		
13	Drew up the anaesthetic with a 10cc syringe and a 25gauge needle.		
14	Cleansed the area that would be anaesthetised.		
15	Used 18 gauge needle to inject the anaesthetic aspirating before infusing (to make sure the needle is not in a vein).		
16	Prepared the Normal saline flush.		
17	Flushed the wound with Normal saline to remove all the foreign bodies.		-
18	Cleansed the skin around the wound (size of the drape) with Chlorhexidine antiseptic solution in three circular motions using sterile gauze.		

19	Removed gloves.	
20	Opened the sterile kit and prepared sterile field correctly.	
21	Put on sterile gloves.	
22	Loaded the needle holder with the needle.	
23	Loaded the needle with suturing material.	
24	Closed the wound by simple interrupted or simple continuous stiches using instrument tie knots.	





25	Applied antimicrobial cream if prescribed.							
26	Applied sterile gauze to cover the wound.							
27	Secured the gauze with tape.							
28	Applied bandage on the affected area.							
29	Restored patient to a comfortable position.							
30	Performed hand hygiene using correct technique.							
31	Documented the procedure in the patient record.							
32	Informed the patient or relative about the care of the wound.							
33	Informed the patient or relative about where and when to go for suture removal.							
34	Returned equipment to the dedicated area.							
	1. SKILL EVALUATION 60%							

	1. SKILL EVALUATION 60%												
Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-32	33-34	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level			l	=			U	N	S	С	I	Skill level achieved	

		2. PROCEDU	RE ASPI	ECTS EVALUATION 40%	/ 0		
Rationale 10%		Patient Focus 109	6	Professional Manner	Time 10%		
Failed	5	Failed	5	Failed	5	Failed +10	5
Unsatisfactory	6	Unsatisfactory	6	Unsatisfactory	6	Unsatisfactory+8	6
Novice	7	Novice	7	Novice	7	Novice +6	7
Supervised	8	Supervised	8	Supervised	8	Supervised +4	8
Competent	9	Competent	9	Competent	9	Competent +2	9
Independent	10	Independent	10	Independent	10	Independent TA	10

Notes:						Time allowed (TA)	30
						Time achieved	
						Aspects points achieved	
		3. CO	MPLETE PROCED	URE EVALUATI	ON 100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area			Date				

PROC	EDURE: Wound care - removing sutures	Code	14-04
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: Patient medical record Forceps Scissors Normal saline Gauze Disinfecting solution Gloves Tape Hand rub gel Plastic bag for waste Plastic tray		
2	Reviewed the medical orders for suture removal.		
3	Identified patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Described the sensation of suture removal as a pulling or slightly uncomfortable experience.		
8	Placed a waste plastic bag at a convenient location for use during the procedure.		
9	Adjusted the height of the bed.		
10	Assisted the patient to a comfortable position that provides easy access to the incision area.		
11	Placed waterproof pad under the incision area.		
12	Put on clean gloves.		
13	Carefully and gently removed the soiled dressings, used sterile normal saline to help loosen the dressing if needed.		
14	Cleaned the incision using normal saline and gauze.		
15	Using the forceps, grasped the knot of the first suture and gently lifted the knot up off the skin.		
16	Using the scissors, cut one side of the suture below the knot, close to the skin.		
17	Grasped the knot with the forceps and pull the cut suture through the skin avoiding pulling the visible portion of the suture through the underlying tissue.		
18	Removed every other suture first to be sure the wound edges are healed.		
19	Reapplied the dry gauze dressing.		
20	Removed and discarded the gloves.		
21	Restored patient to a comfortable position.		
22	Performed hand hygiene using correct technique.		

														02
23	Docum	ented th	e result i	n the pa	tient's no	otes.								
24	Inform	ed the pa	itient or	relative i	f approp	riate of t	he resul	t.						
25	Return	ed equip	ment to	the dedi	cated are	ea.								
26	Report	ed abnor	mal find	ings to th	ne appro	priate he	alth care	provide	r (studer	nt report	ed this	action		
20	verball	y).												
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-24	25-26	Skill steps a	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	I	Skill level a	chieved	
					2. PR	OCEDUI	RE ASPE	CTS EVA	LUATIO	N 40%				
	Rationale 10% Patient Focus 10% Professional Manner 10%									Time 10%				
Failed			5	Failed			5	Failed		5	Failed	5		
Unsatis	sfactory		6	Unsatis	factory		6	Unsatisfactory		6	Unsatisfa	6		
Novice			7	Novice			7	Novice			7	Novice	7	
Superv			8	Superv	ised		8	Supervised		8	Supervise	8		
Compe			9	Compe	tent		9	Competent		9	Compete	nt +2	9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10
Notes:												Time allov	ved (TA)	20
												Time achie	ved	
												Aspects poin	ts achieved	
				3	. COM	IPLETE F	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61-	-70	71-	-80	81-	-90	91-1	L00	Total points	achieved	
Fai	led	Unsatis	factory	Nov	/ice	Super	vised	Comp	etent	Indepe	ndent	Total level		
Studer	nt					Signati	ure							
Teach	Teacher			Signature						Actual Ma	rk/Out of			
Clinica	l Area					Date								

		HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING		
		LABORATORY AND CLINICAL EDUCATION		
		Procedure Evaluation Document (PED)		
PROCI	EDURE:	Wound care - removing staples	Code	14-05
No.		Skill steps	Not achieved	Achieved
1	Prepare	ed procedure equipment:		
		Patient medical record		
		Surgical staples remover		
		Scissors		
		Normal saline		
		Gauze		
		Disinfecting solution		
		Gloves		
		Таре		
		Hand rub gel		
		Sharps box		
		Waterproof pad		
		Plastic tray		
2	Review	ed the medical orders for suture removal.		
3	Perforn	ned hand hygiene using correct technique.		
4	Identifi	ed patient using two identifiers.		
5	Perforn	ned greeting, introduction and permission procedure (G.I.P).		

6	Provide	d privacy	у.											
7	Explain	ed the pi	rocedure	to the p	atient ar	nd answe	ered any	question	S.					
8	Placed	a waste p	plastic ba	ag at a co	onvenien	t locatio	n for use	during t	he proce	dure.				
9	Adjuste	d the he	ight of tl	ne bed.										
10	Assiste	d the pat	ient to a	comfort	able pos	ition tha	t provide	es easy a	ccess to	the incisi	ion area			
11	Placed	waterpro	oof pad ι	ınder the	e incision	area.								
12	Put on	clean glo	ves.											
13		ly and ge g if need	-	oved the	e soiled c	lressings	, used st	erile norı	mal salin	e to help	loosen	the		
14		Cleaned the incision using normal saline and gauze.												
15	Firmly 8	Firmly grasped the staples remover and positioned it under the staple to be removed.												
16	Firmly	losed th	e staple	remover	to bend	the stap	le in the	middle a	nd pull i	t up out	of the s	kin.		
17	Remov	ed every	other st	aple first	to be su	re the w	ound ed	ges were	healed.	<u> </u>				
18	Discard	ed the st	taples in	the shar	ps box.									
19					·									
20	Reapplied the dry gauze dressing. Removed and discarded the gloves.													
21	Restore	ed patien	it to a co	mfortab	le positio	n.								
22	Restored patient to a comfortable position. Performed hand hygiene using correct technique.													
23	Documented the result in the patient's notes.													
24	Informed the patient or relative if appropriate of the result.													
25	Returned equipment to the dedicated area.													
26	Reported abnormal findings to the appropriate health care provider (student reported this action													
	verbally).													
						1. Sł	KILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-24	25-26	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	1	Skill level a	achieved	
				T			RE ASPE					T		
	Rationa	ale 10%			Patient F	ocus 109	1		essional	Manner			Time 10%	
Failed	<u> </u>		5	Failed	· ·		5	Failed	· ·		5	Failed +10		5
	sfactory		6		factory		6	Unsatis	tactory		6	Unsatisfa	·	6
Novice Supervi			7 8	Novice Superv			7 8	Novice Superv	icad		7 8	Novice Supervise	+6 ed +4	
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:											1	Time allow		20
														20
												Time achie		
				-		IDI ETE 1		LIDE EV	\ \T	ON 100	10/	Aspects poir	nts achieved	
	50	51	-60		3. CON		-80		-90	91-:		Total point	a achieved	
	≤ 50 51-60 61-70 Failed Unsatisfactory Novice											Total points		
	•						rvised	Comp	etent	Indepe	riaent	Total level	acilieved	
Studer						Signature Signature			Actual Mark/Out of					
Teache							ure					Actual Ma	ark/Out of	
Clinica	ı Area					Date								

PROCE	EDURE: Wound care – bandaging	Code	14-06
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: Patient medical record Bandages Hand rub gel Plastic tray		
2	Identified patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of the bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted patient into a comfortable position.		
9	Elevated and supported the limb.		
10	Performed Circular turn bandage correctly:		
11	Performed Spiral turn bandage correctly. Spiral		
12	Performed Figure-of-eight turn bandage correctly. Figure Eight		

13	Perforn	ned Rec u	urrent tu	ı rn banda	age corre	ectly.									
	Recu	irrent													
		ssessed the limb for:													
14	Assesse	ed the lin	nb for:												
		Skin co	lour												
		Finger	or toe m	otion											
		□ Sensation in fingers or toes													
		Distal p													
			ry refill	lling											
		Pain	na or swe	ening											
		-	evere pressure or tightness												
			Skin temperature												
15	Asked t	d the patient to report any of the above symptoms.													
16	Perforn	ned hand	d hygiene	e using c	orrect te	chnique.									
17	Docum	ented th	e result i	in the pa	tient's n	otes.									
18	Return	ed equip	ment to	the dedi	cated are										
6.	T -			1	T	1		LUATIO		1		Oldill atoms	a alai a ca al		
Steps Points	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18	Skill steps			
Level	0	6	12	18 F	24	30	36 U	42 N	48 S	54 C	60	Skill points Skill level a			
Level				<u> </u>	2. PR	OCEDUI					'	OKIII IEVEI A	icilieveu		
	Rationa	ale 10%		1		ocus 109				Manner			Time 10%		
Failed			5	Failed			5	Failed			5	Failed	+10	5	
	factory		6	-	sfactory		6		factory		6	Unsatisfa		6	
Novice			7	Novice			7	Novice			7	Novice	+6	7	
Supervi			8	Superv			8	Superv			8	Supervise		8	
Compe			9	Compe			9	Compe			9	Compete		9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ		10	
Notes:												Time allov	ved (TA)	15	
												Time achie	ved		
												Aspects poir	nts achieved		
						IPLETE I									
	50		-60	†	-70		-80		-90	91-3		Total points			
	Failed Unsatisfactory Novice				-	rvised	Comp	etent	Indepe	ndent	Total level	achieved			
Student				Signature						1					
Teache									ark/Out of						
Clinica	ı Area					Date									

PROC	EDURE: Wound care – irrigating a wound	Code	14-07
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Sterile pack containing gauze, solution container, basin		
	☐ Normal saline or other irrigating solution as per medical order		
	☐ Clean gloves		
	□ Sterile gloves		
	□ Syringes		
	☐ Tape		
	☐ Hand rub gel☐ Plastic bag for waste		
	□ Waterproof pad		
	□ Surgical trolley		
2	Reviewed the medical orders for irrigating a wound.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		
9	Assisted the patient to a comfortable position that provides easy access to the incision area.		
10	Placed a waste plastic bag at a convenient location for use during the procedure.		
11	Placed waterproof pad under the incision area.		
12	Put on gown, mask and eye protection if needed.		
13	Put on clean gloves.		
14	Carefully and gently removed the soiled dressings, used sterile normal saline to help loosen the		
45	dressing if needed.		
15	Noted the condition of the wound and presence, amount, type, colour and odour of any drainage. (student verbal report).		
16	Discarded the dressing into the waste plastic bag.		
17	Removed gloves.		
18	Performed hand hygiene using correct technique.		
19	Opened the sterile pack using aseptic technique.		
20	Pour warmed sterile irrigating solution into the sterile container.		
21	Opened the sterile packs with syringes and let the fall onto the sterile field		
22	Put on the sterile gloves.		
23	Drew the sterile solution into syringes.		
24	Positioned the sterile basin below the wound to collect the irrigation fluid.		
25	Using a non-dominant hand, gently applied pressure to the basin against the skin below the wound		
	to form a seal with the skin.		
26	Irrigated the wound with the sterile solution, keeping the tip of the syringe at least 3cm above the		
27	wound. Dried the surrounding skin with sterile gauze.		
28	Reapplied the dry sterile gauze dressing.		
29	Removed and discarded the gloves.		
30	Secured the dressing with the tape.		
31	After securing the dressing, labelled the new dressing with date and time. Restored patient to a comfortable position.		
5 2	nestored patient to a connoctable position.		

33						chnique.								
34	Docum	ented th	e result i	n the pa	tient's no	otes.								
35	Informe	ed the pa	atient or	relative i	f approp	riate of t	he resul	t.						
36	Returne	ed equip	ment to	the dedi	cated are	ea.								
37	Reporte	ed abnor	mal find	ings to th	ne appro	priate he	alth care	provide	r (student	reported t	his action	verbally).		
						1. Sł	(ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-16	17-18	19-23	24-27	28-31	32-35	36-37	Skill steps	achieved	
Points	nts 0 6 12 18 24 30 36 42 48 54 60 Skill points										Skill points	achieved		
Level												Skill level a	chieved	
2. PROCEDURE ASPECTS EVALUATION 40%														
	Rationale 10% Patient Focus 10% Professional Manner 10%												Time 10%	
Failed	5 Failed 5 Failed				Failed 5			Failed	+10	5				
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	ctory+8	6
Novice			7	Novice			7	Novice			7	Novice	7	
Supervi	ised		8	Superv	ised		8	Supervi	sed		8	Supervise	ed +4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10
Notes:												Time allov	ved (TA)	30
												Time achie	ved	
												Aspects poin	ts achieved	
				3	. COM	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤5	≤50 51-60 61-70			71	-80	81-	90	91-1	100	Total points	achieved			
Fai	Failed Unsatisfactory Novice Supervised			rvised	Comp	etent	Indepe	ndent	Total level	achieved				
Studer	Student					Signat	ure							
Teacher				Signature						Actual Ma	rk/Out of			
Clinica	linical Area Date													

PROCI	EDURE: Wound care – care of a wound with open drain (Penrose drain)	Code	14-08
No.	Skill steps	Not achieved	Achieved
1	Prepared the equipment:		
	□ Patients medical record		
	□ Non-sterile gloves		
	□ Sterile gloves ¬		
	□ Sterile scissors		
	□ Sterile forceps		
	☐ Sterile safety pin ☐ in the sterile package if available		
	☐ Sterile gauze		
	□ Sterile container □		
	☐ Sterile Normal saline		
	☐ Antimicrobial cleansing solution if prescribed		
	☐ ADB (abdominal) pads		
	□ Tape		
	☐ Plastic bag for soiled dressing		
	□ Waterproof pad		
	☐ Hand rub gel		
	☐ Plastic tray or trolley		
2	Verified the medical order and nursing care plan for care of the wound with drain.		
3	Performed hand hygiene using correct technique.		
4	Identified the patient using two identifiers.		

5	Perforn	ned Gree	eting, Int	roductio	n and Pe	rmission	procedu	re (GIP).						
6	Provide	d privac	у.											
7	Explain	ed the p	rocedure	to the p	atient ar	nd answe	red any	question	S.					
8		•			elbow h		· · ·							
9			_			_	ow the a	ccess to t	he wour	nd.				
10					orrect tec									
11							r the wo	und site.						
12					rt of the				'					
13		•	•	•	contamir	•								
14	_	-							a tha sta	rile field.				
15									g the ste	me neid.				
16					by pullin	ig toward	as incisio	n.						
17	Put on non-sterile gloves. Removed soiled dressings.													
18				gs into th	ne plastic	bag.								
19	Removed gloves.													
20	Discarded gloves into the plastic bag. Observed the wound for: (verbal report)													
21	Observ			•										
		-			ur, odou	r of draii	nage							
		_	of infecti	ווכ										
		pain signs c	of healing	7										
22					and rub g	TO!								
23		sterile gl		using in	allu lub į	<u>zei.</u>								
24							عماعاتنا	منام مانم	£	/:f t		-1		
25	If the safety pin on the drain was crusted, replaced with sterile pin carefully (if not used, verbal report).													
25	Cleaned the drain site with sterile forceps and sterile gauze and antiseptic solution moving in a													
26	circular motion away from the drain. Cleaned the drain site with sterile gauze and Normal Saline in a circular motion away from the drain.													
27	Cleaned the drain site with sterile gauze and Normal Saline in a circular motion away from the drain. Advanced the drain if ordered (if not ordered, verbal report):													
27	Advanc			-			-	res using	sterile f	orcens				
								of the ski		лесрэ				
	П	-		-	-			5cm on		de.				
28	Cut the				ith sterile									
29					he drain.		"							
30			_		r ABD pa		drain							
31		•		with the	•	43) 0 0 0	araiii.							
32			•		and time	of drace	ing							
33			_		oiled dres		_	404						
34		· ·		1011 0118 50	med ures	osiiigs dli	u uiscai (icu.						
35		ed gloves		2 ccmf	+abla	cition								
36		•			table pos									
37					orrect tec		dina +1	longth of	- OVDGES	1+11651				
38			•				anig the	length of	exposed	i tube).				
36	Keturne	ea the ea	uipmen	to the c	ledicated		/III E\/^	LLIATIO	N 600/					
Stone	0	1 /	ГС	0.12	12 17			LUATIO		22.20	37-38	Skill steps	achieved	
Steps Points	0	1-4 6	5-8 12	9-12 18	13-17 24	18-19 30	20-24 36	25-28 42	29-32	33-36 54	60	Skill points		
Level										C 54	ı	Skill level a		
LEVEI					2. PR	OCEDIU		L	L	N 40%	1	OMII IEVEI A	IOTHO V G U	
	Rationa	le 10%			Patient F					Manner:	10%		Time 10%	
Failed	Mativile	C 10/0	5	Failed	acient F	CC43 10/	5	Failed	.331U11a1	VIUIIICI .	5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6		factory		6	Unsatisfa		6
Novice	,		7	Novice			7	Novice			7	Novice	+6	7
Supervi	ised		8	Superv	ised		8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10				10				10			10
	endent 10 Independent 10 Independent TA 10													

Notes:						Time allowed (TA)	40					
						Time achieved						
						Aspects points achieved						
	3. COMPLETE PROCEDURE EVALUATION 100%											
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved						
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved						
Student			Signature									
Teacher			Signature			Actual Mark/Out of						
Clinical Area			Date									

	Procedure Evaluation Document (PED)		
PROC	EDURE: Wound care – drain removal (Penrose drain)	Code	14-09
No.	Skill steps	Not achieved	Achieved
1	Prepared the equipment:		
	☐ Patients medical record		
	□ Non-sterile gloves		
	□ Sterile gloves		
	□ Sterile forceps		
	☐ Sterile gauze in the sterile package if available		
	Sterile Container		
	☐ Sterile Normal saline☐ Antimicrobial cleansing solution if prescribed		
	 ☐ Antimicrobial cleansing solution if prescribed ☐ ADB (abdominal) pads 		
	☐ Tape		
	☐ Plastic bag for soiled dressing		
	☐ Waterproof pad		
	☐ Hand rub gel		
	☐ Plastic tray or trolley		
	Months of the great discharge and according to a second of the control of the days.		
2	Verified the medical order and nursing care plan for care of the wound with drain.		
3	Performed hand hygiene using correct technique.		
4	Identified the patient using two identifiers.		
5	Performed Greeting, Introduction and Permission procedure (GIP).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed to elbow height.		
9	Assisted the patient to appropriate position to allow the access to the wound.		
10	Performed hand hygiene using correct technique.		
11	Put plastic bag for soiled dressings on the bed near the wound site.		
12	Put waterproof pad under the part of the body with the wound.		
13	Opened sterile package without contaminating the sterile field.		
14	Pour sterile Normal saline into the container without contaminating the sterile field.		
15	Remove tape from patient's skin by pulling towards incision.		
16	Put on non-sterile gloves.		
17	Removed soiled dressings.		

18	Discard	lad sailar	d dressin	ac into th	ho plactic	c hag								
19		ed glove:		gs into ti	ie piasti	. Dag.								
20					.									
21			es into the round for											
21	Observ			•		ır of drai	nage							
		-	of infecti		ar, odoc	ii Oi ai ai	ilage							
		pain	or infectiv	511										
		•	of healing	g										
		- 0		,										
22	Perforr	ned hand	d hygiene	e using h	and rub	gel.								
23	Put on	sterile gl	oves.											
24	Cleane	d the dra	in site w	ith steril	e forceps	s and ste	rile gauz	e and an	tiseptic s	olution r	noving	n a		
	circular	motion	away fro	m the di	rain.									
25	Cleane	d the dra	in site w	ith steril	e gauze a	and Norn	nal Saline	e in a circ	ular mo	tion awa	y from t	he drain.		
26								the plas						
27		Cleaned the wound with sterile gauze and Normal Saline in a circular motion away from the wound. Placed the sterile gauze on the wound.												
28														
29	Applied	d dry ster	rile gauze	pads (o	r ABD pa	ds) over	drain.							
30	Secure	d the gau	ıze pads	with the	tape.									
31	Label tl	he dressi	ng with t	he date	and time	of dress	sing.							
32	Closed the plastic bag with the soiled dressings and discarded.													
33	Removed gloves.													
34	Restored the patient to a comfortable position.													
35	Perforr	ned hand	d hygiene	e using c	orrect te	chnique.								
36	Docum	ented th	e procec	lure and	the resu	lts (inclu	ding the	length of	expose	d tube).				
37	Return	ed the ed	quipmen	t to the c	dedicated	d area.								
						1. Sk	(ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-16	17-18	19-23	24-27	28-31	32-35	36-37	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С		Skill level a	achieved	
	- ··	1 400/		г .				CTS EV					T : 400/	
Failed	Kationa	ale 10%		Failed	Patient F	ocus 109			essionai	Manner	1	Failed	Time 10%	Е
	factory		5 6		factory		5 6	Failed Unsatis	factory		5 6	Unsatisfa	+10 actory+8	5 6
Novice	nactory		7	Novice			7	Novice	ractory		7	Novice	+6	7
Supervi	ised		8	Superv			8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
	ependent 10 Independent 10 Independent TA											10		
Notes:							•					Time allow	wed (TA)	20
												Time achie		
												Aspects poir		
				3	B. CON	1PLETE I	PROCED	URE EV	ALUATIO	ON 100	%	Loherig holl	no achieveu	
<	50	51	-60		-70		-80	81-		91-1		Total points	s achieved	
Fai			factory		vice		rvised		etent	Indepe		Total level		
Studer			•	<u> </u>		Signat								
Teache						Signat						Actual Ma	ark/Out of	
Clinica													-	
		Area Date												

PROCI	EDURE: Pressure ulcers – risk assessment	Code	14-10
No.	Skill steps	Not achieved	Achieved
1	Prepared the equipment:		
	☐ Patient medical record		
	☐ Norton Scale for pressure ulcer risk assessment		
	□ Non-sterile gloves		
	☐ Hand rub gel		
2	Performed hand hygiene using correct technique.		
3	Identified the patient using two identifiers.		
4	Performed Greeting, Introduction and Permission procedure (GIP).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed to elbow height.		
8	Assisted the patient to supine position.		
9	Performed hand hygiene using correct technique, put on gloves if needed.		
10	Identified any patient characteristics that might be risk factors for pressure ulcer formation.		
	☐ Paralysis, or immobilization caused by restrictive devices		
	☐ Sensory loss (e.g., hemiplegia, spinal cord injury)		
	☐ Circulatory disorders (e.g., diabetes mellitus)		
	□ Fever		
	□ Anaemia		
	☐ Malnutrition		
	□ Incontinence		
	 Heavy sedation and anaesthesia 		
	□ Age		
	□ Dehydration		
	□ Oedema		
	Existing pressure ulcersHistory of pressure ulcer		
11	Performed the risk assessment using Norton Scale.		
12	Assessed physical condition correctly.		
13			
14	Assessed mental condition correctly.		
	Assessed activity correctly.		
15	Assessed mobility correctly.		
16	Assessed incontinence correctly.		
17	Obtained risk score, and evaluate its meaning based on patient's unique characteristics (verbal		
18	report). Assessed condition of patient's skin over regions of pressure.		
10	☐ Inspected for:		
	-skin discoloration (redness in light-tone skin; purplish or bluish colour in darkly pigmented skin)		
	-tissue consistency (firm or boggy feel)		
	-abnormal sensations		
	☐ Palpated discoloured area for blanching.		
	☐ Inspected for pallor and mottling.		
	☐ Inspected for absence of superficial skin layers		
19	Assess patient for additional areas of potential pressure.		
	□ Nares: nasogastric (NG) tube, oxygen cannula		
	☐ Tongue and lips: oral airway, endotracheal tube		
	☐ Ears: oxygen cannula, pillow		
	□ Drainage tubes		
	☐ Wound drainage		

																1	T
			elling urin	-			ter										
			opaedic ar	•													
20		•	ient for pr						•		•	•					
21	Encour	aged t	he patient	to chan	ge positi	on freque	ntly t	o re	elieve pr	essure	e ar	eas.					
22	Observ	ed abi	lity of pation	ent to in	tiate an	d assist w	ith po	siti	on chan	ges.							
23	Assess	ed pati	ent/caregi	ver und	erstandir	ng of risks	for th	ne c	developn	nent c	of p	ressure ι	ulcer	s.			
24	Restor	ed the	patient to	a comfo	rtable p	osition.											
25	Perform	ned ha	ınd hygien	e using o	orrect to	echnique.											
26	Docum	ented	the proced	dure and	the resu	ults (inclu	ding t	he l	length of	fexpo	sed	l tube).					
27	Return	ed the	equipmen	t to the	dedicate	ed area.											
					NOR	TON SC	ALE									Norto	n Scale
			Physical	М	ental										7	Interpr	etation
			condition	cor	dition	Activit	y		Mobility	y		Incontiner	ıt			>18 - low	risk
				4 Alert		Ambulant	4	Fu		4	No		4	ĺ		14 17	مادات مدادات
				3 Apati 2 Conf		Walk/help Chair-boun	3 d 2		ightly limite ery limited	d 3		casionally sually/urine	3 2	Tota	.	14-17 - M	edium risk
	Name	Date		1 Stupe		Stupor	1		mobile	1		oubly	1	score	1	10-13 - hig	gh risk
															1	<10 - very	high risk
											Г				7		
							-				Г				1		
						1. Sk	(III F	VΔ	LUATIO	N 60	<u> </u>						
Steps	0	1-2	3-5	6-8	9-11	12-13	14-1	-	17-19	20-2		23-25	26-2	27 5	Skill steps	achieved	
Points	0	6	12	18	24	30	36		42	48		54	60			s achieved	
Level		0		<u>г 10 </u>] 30	IJ	,	N N	S	,	C	ı		•	achieved	
				<u> </u>	2. PI	ROCEDUI		SPF		L	TIO				JAMII 10 VOI	domorou	
	Ration	ale 109	<u></u>			Focus 109						Manner	10%			Time 10%	
Failed	- Tution	u.c 107	5	Failed		. 0000 107	5		Failed	200.01			5	-	ailed	+10	5
	sfactory		6		sfactory		6		Unsatis	facto	rv		6			actory+8	6
Novice			7	Novice			7		Novice				7		Novice	+6	7
Superv	ised		8	Superv	vised		8		Superv	ised			8	9	Supervis	sed +4	8
Compe	tent		9	Comp	etent		9		Compe	tent			9	(Compet	ent +2	9
Indepe	ndent		10	Indepe	endent		10)	Indepe	ndent	t		10) [ndepen	dent TA	10
Notes:														1	ime allo	wed (TA)	30
														-	Time achi	eved	
																ints achieved	
					3. COI	MPLETE I	PROC	ΈD	URE EV	ALUA	TIC	ON 100	%		.spooto po		
<u><</u> !	50	5	51-60	•	70	1	-80			-90		91-1		1	Total poin	ts achieved	
	iled		tisfactory	1	vice		rvised			etent		Indepe			•	l achieved	
Studer						Signat						•					
Teach						Signat								\dashv	Actual M	lark/Out of	
	ıl Area					Date								ऻ ॔		,	
2	, ca	l				2000			l					I			<u> </u>

PROCI	EDURE: Pressure ulcers – care	Code	14-11
No.	Skill steps	Not achieved	Achieved
1	Prepared the equipment:		
	☐ Patient medical record		
	□ Non-sterile gloves		
	☐ Plastic apron		
	☐ Sterile gloves		
	☐ Sterile pack – gauze, container, forceps		
	☐ Sterile cotton tip applicator		
	☐ Sterile Normal saline		
	☐ Antiseptic cleaning solution		
	☐ Prescribed topical medication or dressing		
	☐ Measuring tape or ruler		
	□ Towel		
	☐ Plastic bag		
	☐ Hand rub gel		
2	Performed hand hygiene using correct technique.		
3	Identified the patient using two identifiers.		
4	Performed Greeting, Introduction and Permission procedure (GIP).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Assessed the patient's level of comfort and need for pain medication.		
8	Determined if the patient is allergic to topical agents, especially silver products, or to latex.		
9	Adjusted the height of the bed to elbow height.		
10			
11	Assisted the patient to a position that will allow dressing to be performed.		
12	Exposed the pressure ulcer area keeping the remaining body parts draped.		
	Put on non-sterile gloves.		
13	Removed the dressing and dispose in plastic bag.		
14	Removed gloves and disposed in aplastic bag.		
15	Performed hand hygiene using correct technique.		
16	Put on non-sterile gloves.		
17	Assessed the pressure ulcer according to the stage.		
	Stage 1 : A reddened area on the skin that, when pressed, does not turn white. This is a sign that a		
	pressure ulcer is starting to develop.		
	Stage 2 : The skin blisters or forms an open sore. The area around the sore may be red and irritated.		
	Stage 3 : The skin now develops an open, sunken hole called a crater. There is damage to the tissue		
	below the skin. Stage 4: The pressure ulcer has become so deep that there is damage to the muscle and bone, and		
	sometimes to tendons and joints.		
18	Noted the condition of the skin around the pressure ulcer:		
10	colour		
	□ temperature		
	□ level of oedema		
	amount of moisture		
	□ drainage		
19	Measured the pressure ulcer's:		
	□ length		
	□ width		
	□ depth		
20	Performed hand hygiene using correct technique.		
	יון די	n l	i i

													94
21	Put on	plastic a	pron.										
22	Opene	d sterile _l	pack with	nout con	taminati	ng the st	erile fiel	d.					
23	Poured	l cleansin	g solutio	n into th	e contai	ner.							
24	Donne	d sterile į	gloves co	rrectly.									
25	Cleans	ed the ar	ea aroun	id pressu	re ulcer	thorough	nly with	normal sa	aline or a	prescrib	ed wou	ınd-	
	cleansi	ng agent											
26	Cleans	ed the pr	essure u	lcer thor	oughly w	ith norn	nal saline	or a pre	scribed v	vound-c	eansing	g agent.	
27	Applied	d topical	medicati	on (hydr	ogel) or	special d	ressings	(calcium	alginate	dressing	;) if pres	scribed.	
28	Placed	a gauze (dressing	directly o	over the	pressure	ulcer, a	nd taped	it in plac	e.			
29	Remov	ed glove:	S										
30	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.							
31	Encour	aged the	patient	to chang	e positio	n freque	ntly to r	elieve pre	essure ar	eas.			
32	Observ	ed ability	of patie	nt to ini	tiate and	assist w	ith posit	ion chan	ges.				
33	Assess	ed patien	ıt/caregi	ver unde	rstandin	g of risks	for the	developn	nent of p	ressure	ulcers.		
34	Restor	ed the pa	tient to	a comfor	table po	sition.							
35	Docum	ented th	e proced	lure and	the resu	lts (inclu	ding the	length of	exposed	d tube).			
36	Returned the equipment to the dedicated area.												
						1. Sk	(ILL EVA	LUATIO	N 60%				
Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36	Skill steps achieve	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieve	
Level			l	F			U	N	S	С	I	Skill level achieved	1
				<u> </u>				CTS EVA				T	
F '1 1	Ration	ale 10%			Patient F	ocus 109	1		essional	Manner		Time	1
Failed	·f+		5	Failed	· f t		5	Failed	.f		5	Failed +1	
Novice	factory		6 7	Novice	factory		6 7	Unsatis Novice	ractory		6 7	Unsatisfactory+ Novice +	+8 6 -6 7
Supervi	ised		8	Superv	ised		8	Superv	ised		8		4 8
Compe			9	Compe			9	Compe			9	-	+2 9
Indepe			10	Indepe			10	Indepe			10	Independent	
Notes:				· · ·								Time allowed (TA	
												,	7 20
												Time achieved	
				9	B. CON	IDI ETE I	DRUCED	URE EV	ΛΙΙΙΛΤΙ	DN 100	%	Aspects points achieve	ved
< 0	50	51.	-60		-70		-80	1	-90	91-1		Total points achiev	har
												Total level achieve	
Studer	ailed Unsatisfactory Novice						Supervised Competent Independent Signature				iiueiit	Total level achieve	u
Teach						_		 				Actual Mark/Our	t of
Clinica												. 01	
Cittica	I AI Ed					Date		<u> </u>				J	

		Procedure Evaluation Document (PED)		
PROC	EDURE:	Medication - administering oral medications	Code	15-01
No.		Skill steps	Not achieved	Achieved
1	Prepare	d procedure equipment:		
		Patient's medical record		
		Medication chart		
		Hand rub gel		
		Disposable or plastic cups for medications		
		Plastic tray		

2	Identifi	ed patie	nt using	two iden	tifiers.									
3	Perforr	ned gree	ting, intr	oduction	n and pe	rmission	procedu	re (G.I.P)	•					
4	Provide	ed privac	у.											
5	Explain	ed the p	rocedure	to the p	atient a	nd answe	ered any	question	ıs.					
6	Adjuste	ed the he	eight of b	ed.										
7	Perforr	ned hand	d hygiene	e using c	orrect te	chnique.								
8	Assiste	d the pat	tient to a	ın uprigh	t or late	al position	on.							
9	Checke	d the me	edication	chart fo	r patient	details.								
10	Checke	d the me	edication	chart fo	r allergie	!S.								
11	Asked t	the patie	nt about	any alle	rgies and	l check tl	he allerg	y bracele	t if availa	ble.				
12	Read th	ne medic	ation cha	art and s	elected t	he prope	er medic	ation fro	m the pa	tient's m	edication	on		
		or unit s												
13	Checke	d the lab	els on th	ne medic	ation bo	ttles or b	oxes (an	d individ	ual strips	s).				
14		d the ex												
15		d the do		•					•					
16	1	medicat		-	-	·		ouching	tablets v	vith hand	ds.			
17	Explain	ed the p	urpose o	f each m	edicatio	n to the _l	patient.							
18	Offered	d water c	or other p	permitte	d fluids t	o take w	ith medi	cations.						
19	Remair	ned with	the patie	ent until	each me	dication	is swallo	wed.						
20	Restore	ed patien	nt to com	fortable	position									
21	Perforr	Performed hand hygiene.												
22	Docum	ented th	e proced	lure in th	ne medic	ation cha	art imme	diately a	fter the p	rocedur	e.			
23	Return	ed the ed	quipmen	t to the o	dedicate	d area.								
	1	T	T	1	1	1. SI		LUATIO	N 60%	Ī	•	T		
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-17	18-19	20-21	22-23	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F	2 DE	OCEDII	U U	N CTC EV	S	C	I	Skill level a	icnieved	
	Dation	ale 10%		1		ocus109		ECTS EV	essional			I	Time10%	
Failed	Kation	ale 10%	5	Failed	Patient F	ocus ₁₀ 7	5	Failed	essionai	ivianner	5	Failed+10		5
	sfactory		6		sfactory		6		sfactory		6	Unsatisfa		6
Novice	•		7	Novice	•		7	Novice	•		7	Novice	+6	7
Superv			8	Superv			8	Superv			8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	wed (TA)	10
												Time achie	ved	
												Aspects poir		
					3. COI	MPLETE	PROCE	OURE EV	/ALUATI	ON 100°	%	7 topodio poli	no domovou	
</td <td>50</td> <td>51</td> <td>-60</td> <td></td> <td>-70</td> <td></td> <td>-80</td> <td></td> <td>-90</td> <td>91-</td> <td></td> <td>Total points</td> <td>s achieved</td> <td></td>	50	51	-60		-70		-80		-90	91-		Total points	s achieved	
	ailed Unsatisfactory Novice						rvised		etent	Indepe		Total level		
Studer	<u> </u>					Signat								
Teach						Signat						Actual Ma	ark/Out of	
Clinica							_						,	
Ciica	, cu	Area Date												

PROCE	OCEDURE: Medication - administering topical medications - skin										Code	15-02		
No.						Skill	steps						Not achieved	Achieved
1	Prepar	ed proce	edure eq	uipment:										
		Patient	t's medic	al record										
		Medica	ation cha	ırt										
				itainer (t	ube or ja	r) if in th	e fridge							
		Tongue	e blade											
		Gloves												
		Hand r	ub gel											
		Soap												
			vith warr	n water										
		Gauze												
		Tape												
		Plastic	•											
3				ing two i			n ro co d u	10 (C I D)						
4		d privac		oduction	i and per	mission	procedu	re (G.I.P)	•					
5		•	•	to the p	atient an	ıd answe	red anv	auestion	s.					
6			ight of b					1						
7	Perforn	rformed hand hygiene using correct technique.												
8	Assisted	Assisted the patient to a comfortable position.												
9	Checke	Checked the medication chart for patient details.												
10		Checked the medication chart for allergies.												
11		•			_				elet if ava					
12				art and se	elected th	ne prope	er medica	ation from	n the pat	ient's m	edication	on		
		or unit s												
13				ne medica										
14	Checke	d the exp	piration (date on t	he medio	cation.								
15	Put on	gloves.												
16	Cleaned	d the skir	n site wit	the so	ap and w	ater and	dried w	ell.						
17	•						_		cream f					
18	-	-	-			othly and	evenly	with glov	ed hand	over the	e patien	t's skin		
				air follicl										
19				ng if indi										
20				ate, time	and initi	ials.								
21		ed gloves												
22		•		a comfor										
23 24				e using co		•			. l £4 4	l				
25							cnart in	imediate	ely after t	ne proce	edure.			
23	Returne	Returned the equipment to the dedicated area. 1. SKILL EVALUATION 60%												
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps	achieved	
Points												Skill points		
Level	-	-	•	F			U	N	S	C	I	Skill level a		
	2. PROCEDI							CTS EV						
	Rationa	le 10%		F	atient Fo	ocus 10%	6	Professional Manner 10%					Time 10%	
Failed			5	Failed			5					+10	5	
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	ctory+8	6
Novice	7 Novice 7 Novice 7 Novice									Novice	+6	7		

Supervised	8	Supervised		8	Supervised		8	Supervised +4	8
Competent	9	Competent		9	Competent		9	Competent +2	9
Independent	10	Independent		10	Independent		10	Independent TA	10
Notes:	·				•			Time allowed (TA)	15
								Time achieved	
								Aspects points achieved	
		3. COI	MPLETE F	PROCE	OURE EVALUATI	ON 1009	%		
≤50	51-60	61-70	71-	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatisfactory	Novice	Super	vised	Competent	Indepe	ndent	Total level achieved	
Student			Signati	ure					
Teacher			Signati	ure				Actual Mark/Out of	
Clinical Area			Date					1	

PROCI	EDURE: Medication - administering transdermal medications	Code	15-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient's medical record		
	☐ Medication chart		
	□ Gloves		
	☐ Hand rub gel		
	□ Soap		
	☐ Basin with warm water		
	□ Plastic tray		
2	Identified the patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted the patient to a comfortable position.		
9	Checked the medication chart for patient details.		
10	Checked the medication chart for allergies.		
11	Asked the patient about any allergies and checked the allergy bracelet if available.		
12	Read the medication chart and selected the proper medication from the patient's medication		
	drawer or unit stock.		
13	Checked the labels on the medication.		
14	Checked the expiration date on the medication.		
15	Checked the dosage and performed medication calculation if necessary.		
16	Put on gloves.		
17	Selected the site for the new patch that is clean, dry and hair free (student's verbal report).		
18	Assessed the patient's skin where patch is to be placed, looking for any signs of irritation or		
	breakdown (student's verbal report).		
19	Removed any old transdermal patches from the patient's skin.		
20	Folded the old patch in half with the adhesive sides sticking together and discarded.		
21	Gently washed the area where the old patch was with soap and water.		
22	Removed the patch from its protective covering.		
23	Wrote the date and time of administration and nurse's initials on the label side of the patch.		

24	Remov	ed the co	overing o	n the pa	tch with	out touch	ning the	medication	on surfac	ce.			
25			ch to the										
26	Used th	ne palm (of hand t	o press f	irmly for	about 10	0 second	s withou	t massag	ging the p	oatch.		
27		ed glove		•	•								
28				a comfor	table po	sition.							
29		· ·			orrect te								
			78				(ILL EVA	LUATIO	N 60%				
Steps	0	1-3	4-6	7-9	10-12	13-14	15-18	19-21	22-24	25-27	28-29	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level			1	F			U	N	S	С	I	Skill level achieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%			
	Rationa	ale 10%			Patient F	ocus10%	, 0	Profe	essional	Manner	10%	Time10%	
Failed 5				Failed			5	Failed 5			5	Failed+10	5
Unsatisfactory 6			6	Unsatis	factory		6	Unsatisfactory			6	Unsatisfactory+8	6
Novice			7	Novice			7	Novice			7	Novice +6	7
Superv	ised		8	Supervised			8	Superv	ised		8	Supervised +4	8
Compe			9	Compe			9	Competent		9	Competent +2	9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independent TA	10
Notes:												Time allowed (TA)	15
												Time achieved	
												Aspects points achieved	
					3. CON	IPLETE	PROCE	URE EV	ALUATI	ON1009	%		
≤50 51-60 61-70						71	-80	81-	-90	91-1	100	Total points achieved	
Failed Unsatisfactory		No	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level achieved			
Student				Signat	ure								
Teacher				Signat	ure					Actual Mark/Out of			
Clinica	l Area					Date							

PROCI	EDURE: Medication - administering eye medications	Code	15-04
No.	Skill steps	Not achieved	Achieved
1	Checked each medication order against the original order in the medical record.		
2	Prepared procedure equipment:		
	☐ Patient chart		
	☐ Medication chart		
	□ Gloves		
	☐ Cotton balls, or gauze squares		
	□ Normal saline solution.		
	☐ Hand rub gel		
	□ Plastic tray		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed.		
8	Performed hand hygiene using correct technique.		
9	Assisted patient to a comfortable position.		
10	Checked the medication chart for patient details.		
11	Checked the medication chart for allergies.		

Asked the patient about any allergies and check the allergy bracelet if available. Asked the patient about any allergies and check the allergy bracelet if available.		i												, , , , , , , , , , , , , , , , , , , ,	
drawer or unit stock. 14 Checked the labels on the medications.	12	Asked the patient about any unergies and theoretic anergy bracelee in available.													
14 Checked the labels on the medications. 15 Checked the dosages and performed medications. 16 Checked the dosages and performed medication calculation if necessary. 17 Put on gloves. 18 Offered tissue to patient. 19 Cleansed the eyelids and eyelashes of any drainage with cotton balls, or gauze squares moistened with normal saline solution. 20 Used each area of the cleaning surface once, moving from the inner toward the outer canthus. 21 Tilted the patient's head back slightly if sitting, or place the patient's head over a pillow if lying down. 22 Removed the cap from the medication bottle, being careful not to touch the inner side of the cap. 23 Asked the patient to look up and focus on something on the celling. 24 Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and exert pressure downward over bony prominence of cheek. 25 Held dropper close to eye, but avoided touching eyelids or lashes. 26 Squeeze container and allowed prescribed number of drops to fell in lower conjunctival sac. 27 Released lower lid after eye drops are instilled. 28 Asked the patient to close eyes gently. 29 Applied gentle pressure over inner canthus to prevent drops to enter tear duct. 30 Told the patient not to rub an affected eye. 31 Removed gloves. 32 Restored the patient to to dedicated area. 33 Restored the patient to the dedicated area. 34 Returned equipment to the dedicated area. 35 Documented the administration in the medication chart immediately affer the procedure. 38 In the dedicated eye and the patient to a comfortable position. 39 Performed hand hygiene using correct technique. 30 Told the patient to a Comfortable position. 31 Removed gloves: 32 Restored the patient to a Comfortable position. 33 Performed hand hygiene using correct technique. 34 Returned equipment to the dedicated area. 35 Documented the administration in the medication chart immediately affer the procedure. 36 Love the patient of the dedicated area. 37 Failed	13				art and s	elected t	he prope	er medica	ation fro	m the pa	tient's m	edication	on		
15 Checked the expiration dates of all medications. 16 Checked the dosages and performed medication calculation if necessary. 17 Put on gloves. 18 Offered tissue to patient. 19 Cleansed the eyelids and eyelashes of any drainage with cotton balls, or gauze squares moistened with normal saline solution. 20 Used each area of the cleaning surface once, moving from the inner toward the outer canthus. 21 Titled the patient's head back slightly if sitting, or place the patient's head over a pillow if lying down. 22 Removed the cap from the medication bottle, being careful not to touch the inner side of the cap. 23 Asked the patient to look up and focus on something on the ceiling. 24 Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and exert pressure downward over borny prominence of check. 25 Held dropper close to eye, but avoided touching eyelids or lashes. 26 Squeeze container and allowed prescribed number of drops to fell in lower conjunctival sac. 27 Released lower lid after eye drops are instilled. 28 Asked the patient to close eyes gently. 29 Applied gentle pressure over inner canthus to prevent drops to enter tear duct. 30 Told the patient not or buth an affected eye. 31 Removed gloves. 32 Restored the patient to to the an affected eye. 33 Restored the patient to the dedicated area. 34 Returned equipment to the dedicated area. 35 Documented the administration in the medication chart immediately after the procedure. 2															
15 Checked the dossages and performed medication calculation if necessary.	14	Checke	d the lab	els on th	ne medic	ations.									
17 Put on gloves. 18 Offered tissue to patient. 19 Cleansed the eyelids and eyelashes of any drainage with cotton balls, or gauze squares moistened with normal saline solution. 20 Used each area of the cleaning surface once, moving from the inner toward the outer canthus. 21 Titled the patient's head back slightly if sitting, or place the patient's head over a pillow if lying down. 22 Removed the cap from the medication bottle, being careful not to touch the inner side of the cap. 23 Asked the patient to look up and focus on something on the ceiling. 24 Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and evert pressure downward over bony prominence of cheek. 25 Held dropper close to eye, but avoided touching eyelids or lashes. 26 Squeeze container and allowed prescribed number of drops to fell in lower conjunctival sac. 27 Released lower lid after eye drops are instilled. 28 Asked the patient to olose eyes gently. 29 Applied gentle pressure over inner canthus to prevent drops to enter tear duct. 30 Told the patient not to rub an affected eye. 31 Removed gloves. 32 Restored the patient to a comfortable position. 33 Performed hand hygiene using correct technique. 34 Returned equipment to the dedicated area. 35 Documented the administration in the medication chart immediately after the procedure. 2	15	Checke	d the exp	piration (dates of	all medic	ations.								
18 Offered tissue to patient. 19 Cleansed the eyelids and eyelashes of any drainage with cotton balls, or gauze squares moistened with normal saline solution. 20 Used each area of the cleaning surface once, moving from the inner toward the outer canthus. 21 Tilled the patient's head back slightly if sitting, or place the patient's head over a pillow if lying down. 22 Removed the cap from the medication bottle, being careful not to touch the inner side of the cap. 23 Asked the patient to look up and focus on something on the ceilling. 24 Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and exert pressure downward over bony prominence of cheek. 25 Held dropper close to eye, but avoided touching eyelids or lashes. 26 Squeeze container and allowed prescribed number of drops to fell in lower conjunctival sac. 27 Released lower lid after eye drops are instilled. 28 Asked the patient to close eyes gently. 29 Applied gentle pressure over inner canthus to prevent drops to enter tear duct. 30 Told the patient not to rub an affected eye. 31 Removed gloves. 32 Restored the patient to a comfortable position. 33 Performed hand hygiene using correct technique. 35 Documented the administration in the medication chart immediately after the procedure. 36 Squeeze container and allowed prescribed area. 37 Socumented the administration in the medication chart immediately after the procedure. 38 Performed hand hygiene using correct technique. 39 Performed hand hygiene using correct technique. 30 Performed hand hygiene using correct technique. 31 Removed gloves. 32 Restored the patient to a comfortable position. 33 Performed the administration in the medication chart immediately after the procedure. 39 Documented the administration in the medication chart immediately after the procedure. 39 Position to the dedicated area. 30 Squeeze container and hygiene using correct technique. 30 Position to the dedicated area. 31 Position to the dedicated area. 32 Performed hand hy	16	Checke	d the do	sages an	d perfor	med med	dication o	calculatio	n if nece	essary.					
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Tilted the patient's head back slightly if sitting, or place the patient's head over a pillow if lying down.															
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Asked the patient to look up and focus on something on the ceiling.	21		he patier	nt's heac	l back sli	ghtly if si	tting, or	place the	e patient	's head o	ver a pil	low if ly	ing		
Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and exert	22														
Pressure downward over bony prominence of cheek.	23														
Sequence container and allowed prescribed number of drops to fell in lower conjunctival sac.	24	Placed thumb or two fingers near margin of lower eyelid immediately below eyelashes, and exert													
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29 Applied gentle pressure over inner canthus to prevent drops to enter tear duct.	27	Release	ed lower	lid after	eye drop	os are ins	tilled.								
Told the patient not to rub an affected eye.	28														
Removed gloves.	29														
Restored the patient to a comfortable position. 33	30	Told the patient not to rub an affected eye.													
33	31														
34 Returned equipment to the dedicated area.	32	 													
Steps O	33														
Steps O	34	Return	ed equip	ment to	the dedi	cated are	ea.								
Steps 0	35	Docum	ented th	e admini	stration	in the m	edicatior	n chart in	nmediate	ely after	the proce	edure.			
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Total points achieved F	Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-33	34-35	Skill steps	achieved	
2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus10% Professional Manner10% Time 10% Failed 5 Failed 5 Failed+10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent 10 Independent 10 Notes: Time achieved 7 10 Time achieved 10 10 3. COMPLETE PROCEDURE EVALUATION100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved	Points	0	6			24	30					60			
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Failed					T										
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3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Actual Mark/Out of															
Student Signature Signature Signature Signature Signature Signature Signature Actual Mark/Out of						2 661	ADI ETE	DDCCE	NIDE E	(411147	ON4000	1/	Aspects poi	nts achieved	
Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of		-0	Га	60					1		1		Total and 1	Inia	
Student Signature Actual Mark/Out of									-						
Teacher Signature Actual Mark/Out of			Unsatis	stactory	No	vice			Comp	etent	Indepe	ndent	i otal level	acnieved	
									-					1.6	
Clinical Area Date	-							ure					Actual M	ark/Out of	
	Clinica	ı Area					Date		<u> </u>						

Procedure Evaluation Document (PED) Medication - administering ear medications

PROCI	ROCEDURE: Medication - administering ear medications									Code	15-05			
No.							Skill ste	eps					Not achieved	Achieved
1	Prepar	-	-	uipment.										
			medical											
			ition cha	rt										
		Gloves		~~										
		Hand r	balls or	gauze										
	П	Plastic												
2				ing two i	dentifier	 S.								
3							procedu	re (G.I.P)						
4	Performed greeting, introduction and permission procedure (G.I.P). Provided privacy.													
5			•	to the p	atient an	d answe	red any	question	S.					
6	Adjuste	d the he	ight of tl	ne bed.										
7	Perform	ned hand	hygiene	e using co	orrect ted	hnique.								
8	Assisted	the pat	ient to a	comfort	able pos	tion.								
9	Checke	d the me	dication	chart fo	r patient	details.								
10	Checke	d the me	dication	chart fo	r allergie	S.								
11					rgies and									
12				art and se	elected tl	ne prope	er medica	ation from	n the pa	tient's m	edication	on		
12		or unit s												
13				l medica										
14 15					all medic			:6						
16			sages an	a perfori	med med	ication c	alculatio	n if nece	essary.					
17	Put on §		al aar af	any drai	nogo wit	h sattan	hall ar a		istopodi	uith nor	mal cali	•		
18					nage wit inaffecte									
10		-			cted ear			ii aiiibai	atory, me	ive patie	iic sic w	itii iicaa		
19					oy pulling			rtion of p	oinna up	and bac	k.			
20					ip above									
21					of the ca		<u>, </u>							
22	Release	d pinna	after ins	tilling dro	ops									
23	Gently	oressed (on the tr	agus a fe	w times.									
24	If need	ed, loose	ly insert	a cotton	ball into	the ear	canal.							
25	Remove	ed gloves	5.											
26	Restore	d patien	t to a co	mfortabl	e positio	n.								
27	Perform	ned hand	l hygiene	e using co	orrect ted	hnique.								
28	Docume	ented the	e admini	stration	in the me	edication	chart in	nmediate	ely after t	the proc	edure.			
29					icated ar									
30	the service of the Control of the service of the se													
_	1. SKILL EVALUATION 60%											T		
Steps	0	1-3	4-6	7-9	10-13	14-15	16-19	20-22	23-25	26-28	29-30	Skill steps		
Points Level	0	6	12	18	24	30	36	42 N	48 S	54 C	60	Skill points		
revei						OCEDIU	U RF ASPF	<u> </u>				Skill level a	icilieveu	
	Rationale 10% Patient Focus 10						DURE ASPECTS EVALUATION 40% 10% Professional Manner10%						Time10%	
Failed		10/0	5	Failed	- attent		5					5		
Unsatis	factory		6		factory		6	Unsatis	factory		6			6
Novice			7	Novice			7	Novice			7	Novice	+6	7

Supervised	8	Supervised		8	Supervised		8	Supervised +4	8
Competent	9	Competent		9	Competent		9	Competent +2	9
Independent	10	Independent		10	Independent		10	Independent TA	10
Notes:								Time allowed (TA)	10
								Time achieved	
								Aspects points achieved	
		3. CON	MPLETE PR	ROCEL	URE EVALUATI	ION100%	,)		
≤50	51-60	61-70	71-80)	81-90	91-1	00	Total points achieved	
Failed	Unsatisfactory	Novice	Supervis	sed	Competent	Indeper	ndent	Total level achieved	
Student			Signatur	е					
Teacher			Signatur	е				Actual Mark/Out of	
Clinical Area			Date						

PROC	EDURE: Medication - administering nasal medications	Code	15-06
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: Patient's medical record Medication chart Hand rub gel Gloves Paper tissues Plastic tray		
2	Identified the patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted the patient to a comfortable position.		
9	Checked the medication chart for patient details.		
10	Checked the medication chart for allergies.		
11	Asked the patient about any allergies and checked the allergy bracelet if available.		
12	Read the medication chart and selected the proper medication from the patient's medication drawer or unit stock.		
13	Checked the label on the medication.		
14	Checked the expiration date on the medication.		
15	Checked the dosage and performed medication calculation if necessary.		
16	Put on gloves.		
17	Provided patient with paper tissues and told patient to blow his or her nose.		
18	Asked the patient to sit up with the head tilted well back. If patient is lying down, to tilt head back over a pillow.		
19	Opened the bottle.		
20	Told the patient to breathe through the mouth.		
21	Held the tip of nose up and placed dropper just above naris.		
22	Instilled the prescribed number of drops in one naris and then the other without touching the naris.		

													102
23	Asked t	he patie	nt to ren	nain in th	ne positio	n with tl	he head	tilted bad	k for a fe	ew minu	tes.		
24	Remov	ed glove	s.										
25	Restore	ed the pa	tient to	a comfor	table po	sition.							
26	Perforn	ned hand	d hygiene	2.									
27	Docum	ented th	e admini	stration	in the m	edication	chart in	nmediate	ly after t	the proce	edure.		
28	Returne	ed the ed	quipment	t to the o	dedicated	d area.							
						1. Sk	(ILL EVA	LUATIO	N 60%			·	
Steps	0	1-3	4-6	7-9	10-12	13-14	15-17	18-20	21-23	24-26	27-28	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level				F			U	N	S	С	ı	Skill level achieved	
	2. PROCEDURE ASPECTS EVALUATION 40%												
	Rationale 10% Patient Focus 10% Professional Manner 10% led 5 Failed 5 Failed 5 Failed+10											Time10%	
Failed					Failed			Failed			5	Failed+10	5
	factory		6		factory		6	Unsatis	factory		6	Unsatisfactory+8	6
Novice			7	Novice			7	Novice			7	Novice +6	7
Supervi			8	Superv		8 Supervised 8				Supervised +4	8		
Compe			9	Compe			9	Compe			9	Competent +2	9
Indepe	naent		10	Indepe	naent		10	Indepe	naent		10	Independent TA	10
Notes.												Time allowed (TA)	10
												Time achieved	
												Aspects points achieved	
					3. CON	//PLETE	PROCE	OURE EV	ALUATI	ON1009	%		
≤5	≤50 51-60 61-70						-80	81-	90	91-1	L00	Total points achieved	
Fai	Failed Unsatisfactory Novice				vice	Super	rvised	Comp	etent	Indepe	ndent	Total level achieved	
Studer	nt					Signati	ure						
Teache	er					Signati	ure					Actual Mark/Out of	
Clinica	l Area												

PROCI	EDURE: Medication - administering sublingual and buccal medications	Code	15-07
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient's medical record		
	☐ Medication chart		
	□ Non-sterile gloves		
	☐ Hand rub gel		
	☐ Disposable or plastic cups for medications		
	☐ Plastic tray		
2	Identified patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted the patient to an upright or lateral position.		
9	Checked the medication chart for patient details.		
10	Checked the medication chart for allergies.		
11	Asked the patient about any allergies and check the allergy bracelet if available.		

														103
12	Read th	ne medic	ation cha	art and s	elected t	he prope	er medic	ation fro	m the pa	tient's m	edication	on		
		or unit s												
13	Checke	d the lab	els on th	ne medic	ation bo	ttles or b	oxes (an	ıd individ	ual strips	s).				
14	Checke	d the exp	oiration (dates of	all medic	cations.								
15				•				on if nece	•					
16				-				touching	tablets w	vith hand	ds.			
17	Explain	ed the p	urpose o	of each m	edicatio	n to the p	patient.							
18	Asked t	under	the tong	gue		n (if help and che		ed, used _{	gloves to	assist th	e patie	nt):		
19 20	Instructed the patient not to chew or swallow the tablet and wait until it is completely dissolved before drinking. Restored patient to comfortable position.													
21	·													
21	70													
	Documented the procedure in the medication chart immediately after the procedure.													
23														
Ctono	1. SKILL EVALUATION 60% 0 1-2 3-4 5-6 7-9 10-11 12-14 15-17 18-19 20-21 22-23 Skill steps achieved													
Steps Points	0	1-2 6	3-4 12	5-6 18	7-9 24	10-11 30	12-14 36	42	18-19 48	20-21 54	60	Skill points		
Level	0	U		<u> 10 </u>	24	30	U	N N	S	C	I	Skill level a		
					2. PR	ROCEDU	RE ASPI	ECTS EV	ALUATIO	ON 40%				
	Ration	ale 10%		ı	Patient F	ocus10%	6	Prof	essional	Manner	10%		Time10%	
Failed			5	Failed			5	Failed			5	Failed+10)	5
	factory		6	1	factory		6		factory		6	Unsatisfa	actory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8 9	Superv Compe			8	Superv Compe			8	Supervise Compete		8
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:				аоро								Time allow		10
												Time achie	ved	
												Aspects poir	nts achieved	
				:	3. COI	MPLETE	PROCEI	DURE EV	'ALUATI	ON 1009	%			
≤5	50	51-	-60	61	-70	71-	-80	81	-90	91-2	100	Total points	s achieved	
	led	Unsatis	factory	Nov	vice		rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signat	ure							
Teache						Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								

PROCI	PROCEDURE: Medication - administering medications using inhaler							
No.		Skill steps	Not achieved	Achieved				
1	Prepare	ed procedure equipment:						
		Patient's medical record						
		Medication chart						
		Inhaler with spacer if needed						
		Gloves						
		Hand rub gel						
		Plastic tray						
2	Identifi	ed the patient using two identifiers.						

3 Performed greeting, introduction and permission procedure (G.I.P).														1	
Sepalared the procedure to the patient and answered any questions.	3	Perforn	ned gree	ting, intr	oduction	and pe	rmission	procedu	re (G.I.P)						
Agiusted the height of bed Agiusted Agiusted the height of bed Agiusted the height of bed Ag	4	Provide	d privac	у.											
8 Assisted patient to a comfortable position. 9 Checked the medication chart for patient details. 10 Checked the medication chart for allergies. 11 Asked the patient about any allergies and checked the allergy bracelet if available. 12 Read the medication chart for allergies. 13 Checked the labels on all medications. 14 Checked the labels on all medications. 15 Checked the dosages of all medications. 16 Put on gloves. 17 Removed the mouthpiece cover from the inhaler and attached to the spacer if used. 18 Shook the inhaler (and spacer) well. 19 Asked the patient to breathe normally. 20 Asked the patient to breathe normally. 21 Asked the patient to breathe normally. 22 Told patient to hold his or her breath for 5 to 10 seconds, or as long as possible, and then to exhale slowly through pursed lips. 23 Waited 1 to 5 minutes, as prescribed, before administering the next puff. 24 Asked the patient to replace the cap on the inhaler or remove the linhaler from the spacer and replaced the caps on both. 25 Asked the patient to replace the cap on the inhaler or remove the linhaler. 26 Cleaned the inhaler. 27 Removed gloves. 28 Performed hand hygiene. 29 Documented the administration in the medication chart immediately after the procedure. 1 Skill EVALUATION 60% 10 6 12 18 24 30 36 42 48 54 60 Skill joined achieved lips. 10 5 Chart of the inhaler of the inhale	5	Explain	ed the pi	rocedure	to the p	atient a	nd answe	ered any	question	ıs.					
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PROCE	EDURE: Medication - administering medications using nebulizer	Code	15-09
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient's medical record		
	☐ Medication chart		
	□ Nebulizer		
	□ Gloves		
	☐ Hand rub gel		
2	□ Plastic tray		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P). Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of bed.		
7	-		
8	Performed hand hygiene using correct technique. Assisted patient to a comfortable position.		
9	Checked the medication chart for patient details.		
10	Checked the medication chart for patient details. Checked the medication chart for allergies.		
11	Asked the patient about any allergies and checked the allergy bracelet if available.		
12	Read the medication chart and selected the proper medication from the patient's medication		
	drawer or unit stock.		
13	Checked the labels on the medication.		
14	Checked the expiration dates of the medication.		
15	Checked the dosage and performed medication calculation if necessary.		
16	Put on gloves.		
17	Removed the nebulizer cup from the device and open it.		
18	Placed premeasured unit-dose medication in the bottom section of the cup or used a dropper to)	
	place a concentrated dose of medication in cup and add prescribed diluent.		
19	Screwed the top portion of the nebulizer cup back in place if needed and attached the cup to the nebulizer.	!	
20	Attached one end of tubing to the stem on the bottom of the nebulizer cuff and the other end to	,	
	the air compressor or oxygen source.		
21	Turned on the air compressor or oxygen.		
22	Checked that a fine medication mist is produced by opening the valve.		
23	Told the patient to place mouthpiece into mouth and grasp securely with teeth and lips.		
24	Told the patient to inhale slowly and deeply through the mouth.		
25	Told the patient to continue this inhalation technique until all medication in the nebulizer cup ha	S	
	been aerosolized (usually about 15 minutes).		
26	Cleaned the nebulizer.		
27	Removed gloves.		
28	Restored the patient to a comfortable position.		
29	Performed hand hygiene using correct technique.		
30 31	Documented the administration in the medication chart immediately after the procedure.		
<u> </u>	Returned equipment to dedicated area. 1. SKILL EVALUATION 60%		
Steps		steps achieved	
Points		points achieved	
Level		level achieved	

			2. PR	OCEDU	RE ASPI	ECTS EVALUATION	ON 40%			
Rationa	ale 10%		Patient F	ocus10%	6	Professional	Manner1	L0%	Time10%	
Failed	5		Failed		5	Failed		5	Failed+10	5
Unsatisfactory	6		Unsatisfactory		6	Unsatisfactory 6			Unsatisfactory+8	6
Novice	7		Novice		7	Novice		7	Novice +6	7
Supervised	8		Supervised		8	Supervised		8	Supervised +4	8
Competent	9		Competent		9	Competent		9	Competent +2	9
Independent	Independent		10	Independent		10	Independent TA	10		
Notes:									Time allowed (TA)	20
									Time achieved	
									Aspects points achieved	
			3. CON	MPLETE	PROCEI	DURE EVALUATI	ON 100%	6		
≤50	51-60		61-70	71-	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatisfacto	ry	Novice	Super	rvised	Competent	Indepe	ndent	Total level achieved	
Student				Signat	ure					
Teacher				Signat	ure				Actual Mark/Out of	
Clinical Area				Date						

PROCE	EDURE: Medication - administering rectal medications	Code	15-10
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient's chart		
	☐ Medication chart		
	☐ Hand rub gel		
	□ Gloves		
	☐ Toilet tissue paper		
_	□ Plastic tray		
2	Identified the patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Explained the procedure to the patient and answered any questions.		
6	Adjusted the height of the bed.		
7	Performed hand hygiene using correct technique.		
8	Assisted the patient to a comfortable position.		
9	Checked the medication chart for patient details.		
10	Checked the medication chart for allergies.		
11	Asked the patient about any allergies and checked the allergy bracelet if available.		
12	Read the medication chart and selected the proper medication from the patient's medication drawer or unit stock.		
13	Checked the label on the medication.		
14	Checked the expiration date on the medication.		
15	Checked the dosage.		
16	Put on gloves.		
17	Assisted the patient to his or her left side in a Sims' position.		
18	Draped the patient to only expose the buttocks.		
19	Removed the suppository from its wrapper.		
20	Applied lubricant to the rounded end of the suppository.		
21	Lubricated the index finger of the dominant hand.		

														107
22 Separated the buttocks with the non-dominant hand.														
23	Told the patient to breathe slowly and deeply through his or her mouth while the suppository was													
		nserted.												
24	Using the index finger, inserted the suppository,													
25	Used toilet tissue to clean any stool or lubricant from around the anus.													
26	Released the buttocks.													
27	Told the patient to remain on his or her side for at least 5 minutes.													
28	Removed gloves.													
29	Restored the patient to a comfortable position.													
30	Performed hand hygiene.													
31	Documented the administration in the medication chart immediately after the procedure.													
32	Returned the equipment to the dedicated area.													
	1. SKILL EVALUATION 60%													
Steps	0	1-3	4-6	7-10	11-14	15-16	17-20	21-24	25-27	28-30	31-32		Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
F U N S C I Skill level achieved 2. PROCEDURE ASPECTS EVALUATION 40%												achieved		
				T .								I		
Fail and	Rationa	ale 10%	-		Patient F	ocus10%		Professional Manner10%				Time10% Failed+10		
Failed Unsatis	factory		5 6	Failed	factory		5 6	Failed 5 Unsatisfactory 6				Unsatisfactory+8		5 6
Novice	пастогу		7	Unsatisfactory Novice		7	Novice			7	Novice +6		7	
		Supervised		8	Supervised			8	Supervised +4		8			
Compe			9	Compe			9	Competent			9	Competent +2		9
Independent 10 Independent					10	•				Independent TA		10		
Notes:											Time allov	wed (TA)	10	
												Time achie	eved	
Aspects po											nts achieved			
					3. CON	APLETE	PROCE	OURE EV	ALUATI	ON1009	%			
≤50 51-60 61-70						71-80		81-90 91-3		1-100 Total poin		s achieved		
Fai	led	Unsatis	factory	No	vice	Supervised		Competent Independ		ndent	Total level	achieved		
Studer	nt					Signat	ure							
Teache	er					Signature						Actual M	ark/Out of	
Clinical Area Date														

PROCI	EDURE:	Medication - administering vaginal medications	Code	15-11
No.		Skill steps	Not achieved	Achieved
1	Prepare	ed procedure equipment:		
		Patient's medical record		
		Medication chart		
		Hand rub gel		
		Gloves		
		Basin with warm water		
		Washcloth		
		Plastic tray		
2	Identifi	ed the patient using two identifiers.		
3	Perforn	ned greeting, introduction and permission procedure (G.I.P).		
4	Provide	d privacy.		
5	Explain	ed the procedure to the patient and answered any questions.		

	1														
6	Adjusted the height of bed.														
7	Performed hand hygiene using correct technique. Assisted the patient to a comfortable position.														
8	Assiste	d the pat	tient to a	comfort	able pos	ition.									
9	Checke	d the me	edication	chart fo	r patient	details.									
10	Checke	d the me	edication	chart fo	r allergie	.s.									
11	Asked the patient about any allergies and checked the allergy bracelet if available. Read the medication chart and selected the proper medication from the patient's medication														
12				art and s	elected t	he prope	er medic	ation fro	n the pa	tient's m	edicati	on			
		or unit s													
13				e medica											
14				date on t		cation.									
15			sage of r	medicatio	n.										
16	Put on gloves. Told the nation to yold before inserting the medication														
17	Told the patient to void before inserting the medication.														
18	Positioned the patient so that she is lying on her back with the knees flexed.														
19				t to visua											
20	Spread labia with fingers, and cleansed area at vaginal orifice with washcloth and warm water,														
21	using a different corner of the washcloth with each stroke. Wiped from above the vaginal orifice downward toward the sacrum														
21						wnward	ioward t	ne sacru	11						
			•	it on new	_		<u> </u>								
23				with pre		amount c	of cream.	1							
24				ith the lu					l:+	dala	d !				
25	-		-					uced app nd backw		ith your	aomina	ant nand			
26								ve applic		nlungo	donro	scod			
27								inutes af			uepre	sseu.			
28				n approp	•		10 10 11	illutes ai	ter inser	tion.					
29		•		п арргор	mate rec	ертасте									
30		ed glove:		nfortable	nosition										
31		•			position	•									
32		ned hand			rocult										
33			•	dure and											
34				o dedica ings to a				ovidor.							
34	кероги	eu abiioi		_			-	ALUATIO	N 60%						
Steps	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-32	33-34	Skill stens	achieved		
Points	0	6	12	18	24	30	36	42	48	54	60	·	s achieved		
Level		<u> </u>	l	F = 0	27	30	U	N	S	C	1	Skill level			
					2. PR	OCEDU	RE ASPI	ECTS EV							
	Rationa	ale 10%		ı	Patient F	ocus10%	6	Prof	essional	Manner	10%	Time10%			
Failed			5	Failed			5	Failed				Failed+10		5	
Unsatis	factory		6	Unsatisfactory			6	Failed 5 Unsatisfactory 6				Unsatisfactory+8		6	
Novice 7			Novice			7	Novice 7				Novice +6		7		
				Supervised			8	Supervised 8				Supervised +4		8	
	Competent 9 Competent					9	Competent 9				Competent +2		9		
•	Independent 10 Independent				ndent	10 Independent 10					Independent TA		10		
Notes:	:es:								Time allo	wed (TA)	15				
									Time achieved						
											Aspects po	ints achieved			
3. COMPLETE PROCEDURE EVALUATION 100%															
≤5	≤50 51-60 61-70				71	-80	81-90 91-100			100	Total points achieved				
Fai	Failed Unsatisfactory Novice			Super	rvised	Competent Independent			Total level achieved						
Student					Signat	ure			· 						
Teacher						Signature					Actual M				
Clinical Area Date											<u></u>				

PROCE	DUKE:			ivie	aicatio	n - prep	paring r	nedica	tions us	sing via	IS		Code	15-12
No.						:	Skill ste	ps					Not achieved	Achieved
1	Prepar	ed proce	edure equ	uipment.										
		Patient	t medical	l record										
		Medica	ation cha	ırt										
		Syringe	es and ne	eedles										
		Gauze												
		Disinfe	cting sol	ution or	alcohol s	wab								
		Hand r	ub gel											
		Sharps	box											
		Plastic	•											
2				e using co			w madia	tion from	m +h o no	tiont's m	odicati			
3		or unit s		art and se	elected ti	ne prope	rmedica	וטוו ווטו	п те ра	uent s m	edicatio	ווו		
4			els on th	ne vial.										
5	Checke	d the ex	piration (date on t	he vial.									
6				l perform			alculation	n if neces	ssary.					
7				lastic cap										
8				with the	e gauze a	nd disinf	ecting so	olution o	r an alco	hol swab				
9			ber top											
10				the syring										
11			-	he needl		_	_							
12			mount of	f air into	the syrin	ge that i	s equal t	o the spe	ecific dos	e of med	lication	to be		
	withdra													
13				rface. Pie										
14				ir into th					ıt injectir	ng air int	o the so	lution.		
15	Inverte	d the via	l. Kept th	ne tip of t	the need	le below	the fluid	l level.						
16				d and use										
17								-	_	-	-	e level. If		
	•			ated in t o the air						sharply	and mo	ved the		
18				as withd						ıd carefu	lly repla	ced the		
		ver the r			, ,						, -1-			
19	Checke	d the am	ount of	medicati	on in the	syringe	and disc	arded an	y surplus	5.				
20	If a sing	le-use vi	ial was u	sed, disc	arded the	e vial into	o sharps	box.						
				used, lab		vial with	the date	e and tin	ne opene	d, and st	ored th	e vial		
				g medica	tion.									
21	Perforn	ned hand	d hygiene	2		4 61	E		21.600/					
Stone	0	1 2	2.4	ГС	7.0	1. Sk	11-13	14-15		10 10	20-21	Skill steps	achieved	
Steps Points	0	1-2 6	3-4 12	5-6 18	7-8 24	30	36	42	16-17 48	18-19 54	60	Skill points		
Level	U	- 0		F 10	24	30	U	N N	S S	C	I	Skill level a		
					2. PR	OCEDUI		L	ALUATIO		'	Skiii lovol d	5.70 V G G	
	Rationa	le 10%		1	Patient F				essional		10%		Time10%	
Failed		-	5	Failed			5	Failed			5	Failed+10		5
Unsatis	factory		6	Unsatis	factory		6		factory		6	Unsatisfa		6
Novice	•		7	Novice	•		7	Novice	•		7	Novice	+6	7
Supervi	sed		8	Supervi	sed		8	Superv	ised		8	Supervise	ed +4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10

Notes:						Time allowed (TA)	15
						Time achieved	
						Aspects points achieved	
		3. COI	MPLETE PROCEI	OURE EVALUAT	ION100%		
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved	
Student			Signature				
Teacher			Signature			Actual Mark/Out of	
Clinical Area		_	Date				

							aluatio				_			
PROC	EDURE:			Medic	ation -	prepai	ring me	dicatio	ns usin	g ampu	les		Code	15-13
No.							Skill st	eps					Not achieved	Achieved
1	Prepar	ed proce	dure equ	iipment.										
		Patient	t medica	l record										
			ation cha											
			es and ne	eedles										
		Gauze												
			ecting sol	ution or	alcohol s	swab								
		Hand r	•											
		Sharps												
		Plastic	tray											
2	Perforr	med hand	d hygien	e, using o	orrect te	echnique).							
3				art and s	elected t	he prop	er medica	ation fro	m the pa	tient's m	nedicati	on		
		or unit s												
4		d the lab												
5	Checke	d the ex	piration	date on t	the ampu	ıle.								
6							alculation							
7	•			•			quickly wl		ing the a	mpule ve	ertically			
8							ne ampul							
9		snapping ne body.	g motion	to breal	off the	top of th	ne ampule	e along t	he score	d line at i	its neck	away		
10		ed the ne	eedle to	syringe.										
11					le by pul	ling it str	raight off							
12			•				d inverte		pule. Ke	ot the ne	edle ce	ntered		
	and no	t touchir	ng the sic	les of the	e ampule									
13	Withdr	ew requi	ired amo	unt of m	edicatio	n into sy	ringe.							
14	Withdr	ew the s	yringe ar	nd tappe	d it to ex	pelled th	ne air car	efully by	pushing	on the p	lunger.			
15	Carefu	lly replac	ed the n	eedle co	ver.									
16			nount of	medicati	on in the	e syringe	with the	medicat	ion dose	and disc	carded a	any		
	surplus													
17		ded the a	•		s box.									
18	Perform	med hand	d hygien	e										
							KILL EVA		1					
Steps	0	1	2-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С	I	Skill level	achieved	

		2. P	ROCEDU	RE ASP	ECTS EVALUATION	ON 40%			
Rationa	ale 10%	Patient	Focus10%	6	Professional	Manner1	L0%	Time10%	
Failed	5	Failed		5	Failed		5	Failed+10	5
Unsatisfactory	6	Unsatisfactory	,	6	Unsatisfactory		6	Unsatisfactory+8	6
Novice	7	Novice		7	Novice		7	Novice +6	7
Supervised	8	Supervised		8	Supervised		8	Supervised +4	8
Competent	9	Competent		9	Competent		9	Competent +2	9
Independent	10	Independent		10	Independent		10	Independent TA	10
Notes:					•			Time allowed (TA)	15
								Time achieved	
								Aspects points achieved	
		3. CO	MPLETE	PROCE	DURE EVALUAT	ION 1009	6		
≤50	51-60	61-70	71	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatisfactor	/ Novice	Supe	rvised	Competent	Indepe	ndent	Total level achieved	
Student			Signat	ure					
Teacher			Signat	ure				Actual Mark/Out of	
Clinical Area			Date						

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROC	EDURE: Medication – mixing medications (vials) in one syringe - insulin	Code	15-14
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	☐ Patient medical record		
	☐ Medication chart		
	☐ Syringes and needles		
	☐ Gauze square		
	☐ Disinfecting solution or alcohol swab		
	☐ Hand rub gel		
	□ Sharps box		
	☐ Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Read the medication chart and selected the correct medications.		
4	Checked the expiration dates on the medications.		
5	Checked the dosages and performed calculations if needed.		
6	Mixed the suspension in the vial by rolling and shaking.		
7	Removed the protective caps that protect the rubber stopper at each vial.		
8	Cleansed the rubber tops with antimicrobial swabs.		
9	Removed the cap from the needle and drew back an amount of air into the syringe that is equal to		
	the dose of modified insulin to be withdrawn.		
10	Held the modified insulin vial on a flat surface.		
11	Pierced the rubber stopper in the center with the needle tip and injected the measured air into the		
	space above the solution. Did not inject air into the solution. Withdrew the needle.		
12	Drew back an amount of air into the syringe that is equal to the dose of unmodified insulin to be		
	withdrawn.		
13	Held the unmodified vial on a flat surface.		
14	Pierced the rubber stopper in the center with the needle tip and injected theme assured air into the		
	space above the solution. Did not inject air into the solution. Kept the needle in the vial.		
15	Inverted vial of unmodified insulin.		
16	Held the vial in one hand and use the other to withdraw the prescribed amount of medication while		
	holding the syringe vertically at the eye level.		

17	Turn th	ne vial ov	er and t	hen rem	oved nee	dle from	ı vial.						
18	Checke	d that th	nere are	no air bu	ubbles in	the syrin	ige.						
19	Checke surplus		nount of	medicat	tion in the	e syringe	with the	e medica	tion dose	and dis	carded	any	
20	units fo	r each d	ose toge	ther.	syringe fo								
21	syringe	•			dified vial	l and inv	erted it,	taking ca	re not to	push th	e plung	er of the	
22	Inverte	d vial of	modified	insulin.									
23	Held th	ne vial in	one han	d and us	se the oth	ner to wit	thdraw t	he medio	ation				
24	Drew u	p the pre	escribed	amount	of medic	ation wh	ile holdi	ng the sy	ringe at	eye level	and ve	rtically.	
25	Turn th	e vial ov	er and th	nen remo	oved need	dle from	vial.						
26					ion in the								
27	Labelle medica		ls with th	he date a	and time	opened,	and stor	e the via	ls contai	ning the	remaini	ng	
28	Perforn	ned hand	d hygiene	е.									
29	Procee	ded with	<u>ո admini</u> s	stration,	based or	n prescrik	oed rout	e.					
						1. Sł	KILL EVA	LUATIO	N 60%				
Steps	0	1-3	4-6	7-9	10-12	13-14	15-18	19-21	22-24	25-27	28-29	Skill steps achieve	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achiev	
Level				F			U	N	S	С	<u> </u>	Skill level achieve	d
								ECTS EV					
- 11 1	Rationa	ile 10%		-	Patient F	ocus10%			essional	Manner	1	Time	
Failed	.f		5 6	Failed	-f+		5	Failed	.f		5	Failed+10	5 7+8 6
Novice	factory		7	Novice	sfactory		6 7	Unsatis Novice	ractory		6 7	Unsatisfactory Novice +6	
Supervi	h		8	Superv			8	Superv	hazi		8		+4 8
Compe			9	Compe			9	Compe			9	Competent +2	9
Indepe			10	Indepe			10	Indepe			10	Independent	
Notes:												Time allowed (T	
												Time achieved	
												Aspects points achie	eved
					3. CON								
	50	51-	-60	-	-70		-80	81	-90	91-1	100	Total points achie	
Fail	led	Unsatis	factory	No	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level achieve	ed
Studen						Signat	ure						
Teache	er					Signat	ure					Actual Mark/Ou	ıt of
Clinica													

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROC	EDURE: Medication - insertion of intravenous cannula	Code	15-15
No.	Skill steps	Not achieved	Achieved
1	Prepared equipment:		
	o Intravenous cannula		
	o Tourniquet		
	o Gloves		
	o Gauze		
	o Tape or cannula dressing		
	 Scissors if tape used 		
	 Alcohol swabs or disinfecting solution 		
	o Hand rub gel		

Clinica	ı Area					Date								
Teache						Signat	ure					Actual M	ark/Out of	
Studer						Signat								
Fai		Unsatis	factory	No	vice		rvised	Comp	etent	Indepe	ndent	Total level	achieved	
	50	51-		†	-70		-80	-	-90	91-1		-	ts achieved	
								OURE EV						
					_							Aspects po	ints achieved	
												Time achie	eved	
wores:												Time allo	wed (TA)	15
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10		dent TA	10
Compe			9	Compe			9	Compe			9	Compet		9
Supervi			8	Superv			8	Superv			8	Supervis		8
Novice			7	Novice			7	Novice			7	Novice	+6	7
Unsatis	factory		6	1	sfactory		6	1	factory		6	Unsatisf	actory+8	6
Failed			5	Failed			5	Failed			5	Failed+1	0	5
	Rationa	le 10%			Patient F				essional		10%		Time10%	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%				
Level		-		F = 0	<u> </u>		U	N N	S	C	I	Skill level		
Points	0	6	12	18	24	30	36	42	48	54	60		s achieved	
Steps	0	1-3	4-6	7-9	10-12			19-21		25-27	28-29	Skill steps	achieved	
23	reporte	u aunur	ınaı IIIIQ	iiigs to a	phrohug			ALUATIO	N 60%					
29					ppropria		n caro ne	ovidor						
28					cated are								+	
27					the resu								+	
26		-			orrect te								+	
25				_	position		ter piece	oi tape.					+	
24								of tape.					+	
23	dressing		vered ca	nnula wi	ith a niec	e of gain	ze and co	ecured w	ith tane				+ -	
22			neter by	crisscros	ssing a pi	ece of ta	pe trom	beneath	the tubi	ng or use	ed a can	nula		
21		-			ternal tip			1						
20		the tou	•											
19				the vein	until onl	y the end	d can be	seen.						
18								the cath	eter.					
17					the nee									
16					ting the i									
15							pproxim	ately a 4!	5 angle a	bove the	vein.			
	thumb.													
14	Stretch		tabilized	the vein	and soft	tissue a	bout 5cn	n below t	the inten	ded site	of entr	y by		
13	Put on													
12			iseptic to											
11			ds 5-10cr		_b Joiutio	OI all a		vuo stai t		c center	or tile :			
11								vab start		e center	of the	site		
10	•	•						nost suit						
9					table pos		tad tha s	nost suit	ahle site					
7 8	-				possible									
6	-			to the p										
5		d privacy	•											
4				oduction	n and per	rmission	procedu	re (G.I.P)						
3					identifier									
2					orrect te	•								
	1													

PROC	EDURE: Medication - administering intradermal injection	Code	15-16
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	☐ Patient medical record		
	☐ Medication chart		
	□ Prepared medication for intradermal administration		
	Syringes and needles		
	☐ Gauze square☐ Disinfecting solution or alcohol swab		
	☐ Hand rub gel		
	□ Sharps box		
	□ Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Checked the medication chart and compared the label of prepared medication with the		
	prescription.		
4	Checked the expiration date on the used ampule or vial.		
5	Checked the dosage of medication and medication calculation if necessary.		
6	Transported the equipment on the tray to the patient in a safe manner, keeping the medication in sight at all times.		
7	Identified the patient using two identifiers.		
8	Performed greeting, introduction and permission procedure (G.I.P).		
9	Provided privacy.		
10	Explained the procedure to the patient and answered any questions.		
11	Adjusted the height of the bed.		
12	Performed hand hygiene using correct technique.		
13	Assisted the patient to the supine or sitting position.		
14	Checked the medication chart for patient details.		
15	Checked the medication chart for allergies.		
16	Asked the patient about any allergies and check the allergy bracelet if available.		
17	Put on clean gloves.		
18	Selected an appropriate administration site.		
19	Draped the patient as needed to expose only the area to be used.		
20	Cleansed the site with alcohol swab or gauze with disinfecting solution while wiping with a firm,		
	circular motion and moving outward from the injection site.		
21	Allowed the skin to dry.		
22	Removed the needle cap with the non-dominant hand by pulling it straight off.		
23	Used the non-dominant hand to spread the skin taut over the injection site.		
24	Held the syringe in the dominant hand, between the thumb and forefinger with the bevel of the needle up.		
25	Held the syringe at a 5- to 15-degree angle from the site.		
26	Place the needle almost flat against the patient's skin, bevel side up, and inserted about 3mm of the		
	needle into the skin.		
27	Slowly injected the agent while watching for a small wheal or blister to appear.		
28	Withdrew the needle quickly at the same angle.		
29	Did not recap the used needle.		
30	Did not massage the area after removing needle.		
31	Told patient not to rub or scratch the site.		
32	Applied dry gauze square on site of injection.		
33	Discarded the syringe and needle in the sharps box.		

34	Restore	ed patien	it to com	fortable	position									
35	Perforn	ned hand	d hygiene	using co	orrect te	chnique.								
36	Docum	ented th	e proced	ure in th	e medica	ation cha	rt imme	diately a	fter the p	rocedur	e.			
						1.	SKILL E	VALUAT	ION 60%	6				
Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level	Returne	ed the ed	quipmen	t to the d	ledicated	d area.	U	N	S	С	I	Skill level a	chieved	
					2. I	PROCED	URE AS	PECTS E	VALUA	FION 40	%			
	Rationa	ale 10%		ı	Patient F	ocus10%	0	Prof	essional	Manner	10%		Time10%	
Failed			5	Failed			5	Failed			5	Failed+10)	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory+8		6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8	Supervi	sed		8	Superv	ised		8	Supervis		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allow	wed (TA)	10
												Time achie	ved	
												Aspects poir	nts achieved	
					3. C	OMPLET	E PROC	EDURE I	EVALUA	TION10	0%			
≤5	50	51	-60	61-	-70	71-	-80	81	-90	91-	100	Total points	s achieved	
Fai	led	Unsatis	factory	Nov	/ice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teache	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date						1		

	, , , , , , , , , , , , , , , , , , , ,		
PROCI	EDURE: Medication - administering subcutaneous injection	Code	15-17
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Medication chart		
	☐ Prepared medication for subcutaneous administration		
	☐ Syringes and needles		
	☐ Gauze square		
	☐ Disinfecting solution or alcohol swab		
	☐ Hand rub gel		
	□ Sharps box		
	☐ Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Checked the medication chart and compared the label of prepared medication with the		
	prescription.		
4	Checked the expiration date on the used ampule or vial.		
5	Checked the dosage of medication and medication calculation if necessary.		
6	Transported the equipment on the tray to the patient in a safe manner, keeping the medication in		
	sight at all times.		
7	Identified the patient using two identifiers.		
8	Performed greeting, introduction and permission procedure (G.I.P).		
9	Provided privacy.		
10	Explained the procedure to the patient and answered any questions.		

Adjusted the height of the bed. Aglisted the patient to the supine or sitting position. Assisted the patient to the supine or sitting position. Assisted the patient to the supine or sitting position. Assisted the medication chart for patient details. Assisted the patient about any allergies and check the allergy bracelet if available. Assisted the patient about any allergies and check the allergy bracelet if available. Assisted the patient about any allergies and check the allergy bracelet if available. Put on clean gloves. By the on clean gloves. By the one c															
Assisted the patient to the supine or sitting position. Checked the medication chart for aptient details. Checked the medication chart for aptient details. Checked the medication chart for aptient details. Asked the patient about any allergies and check the allergy bracelet if available. Put on clean gloves. Selected an appropriate administration site. Draped the patient as needed to expose only the area to be used. Cleansed the site with alchord swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. Cleansed the site with alchord swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. Cleansed the site with alchord swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. Cleansed the site with alchord swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. Cleansed the site with alchord swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. Cleansed the site with a dominant hand between the throw and forefinger. Injected the needle si in place, released the tissue ensuring that the needle stayed in place as the skin was released. Moved the needle si in place, released the tissue ensuring that the needle stayed in place as the skin was released. The surface of the place of the symple and the dominant hand to the device of the symple and the dominant hand to the device of the symple and the dominant hand to the device of the symple and the dominant hand to the symple and the dominant hand to the surface of the symple and the symple in the symple and the symple and the symple in the symple and the symple and the symple in the symple and the symp	11	Adjuste	ed the he	ight of tl	ne bed.										
14 Checked the medication chart for patient details. 15 Checked the medication chart for allergies. 16 Asked the patient about any allergies and check the allergy bracelet if available. 17 Put on clean gloves. 18 Selected an appropriate administration site. 19 Draped the patient as needed to expose only the area to be used. 20 Cleansed the site with alcohol swab or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. 21 Grasped and bunch the area surrounding the injection site. 22 Held the syringe in the dominant hand between the thumb and forefinger. 23 Injected the needle guickly at a 45 to 90-degree angle. 24 After the needle is in place, released the tissue ensuring that the needlestayed in place as the skin was released. 25 Moved the non-dominant hand to steady the lower end of the syringe and the dominant hand to the end of the plunger. 26 Injected the medication slowly (at a rate of 10 sec/mL). 27 Withdraw the needle quickly at the same angle at which it was inserted, while supporting the surrounding tissue with non-dominant hand. 28 Used a gauze square, apply gentle pressure to the site after the needle was withdrawn. 29 Did not massage the site. 30 Did not recap the used needle. 31 Discarded the needle and syringe in the sharps box. 32 Restored the patient to a comfortable position. 33 Performed hand hygiene using correct technique. 34 Documented the procedure in the medication chart immediately after the procedure. 35 Returned the equipment to dedicate area. 36 Rationale 10% Patient Focusion Patient Focusion (Professional Manner 10% Skill steps achieved Points 0 6 12 18 24 30 30 36 42 88 54 60 Skill points achieved Points 0 6 12 18 Skill steps achieved Points 0 6 12 18 Skill steps achieved Points 0 6 12 18 Skill steps achieved Points 0 6 12 Skill steps achieved Points 0 6 12 Skill steps achieved Points 0 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 7 Novice 7 Novice 6 7 Novice 6 7 Novice 6 7	12	Perforr	ned hand	d hygiene	e using c	orrect te	chnique.								
Asked the medication chart for allergies.	13	Assiste	d the pat	ient to t	he supin	e or sitti	ng positi	on.							
16	14	Checke	d the me	dication	chart fo	r patient	details.								
17 Put on clean gloves.	15	Checke	d the me	dication	chart fo	r allergie	es.								
18 Selected an appropriate administration site. 19 Draped the patient as needed to expose only the area to be used. 20 Cleansed the site with alcohol swalp or gauze with disinfecting solution while wiping with a firm, circular motion and moving outward from the injection site. 21 Grasped and bunch the area surrounding the injection site. 22 Held the syringe in the dominant hand between the thumb and forefinger. 23 Injected the needle quickly at a 45- to 90-degree angle. 24 After the needle is in place, released the tissue ensuring that the needle stayed in place as the skin was released. 25 Moved the non-dominant hand to steady the lower end of the syringe and the dominant hand to the needle of the plunger. 26 Injected the medication slowly (at a rate of 10 sec/ml.). 27 Withdraw the needle quickly at a the same angle at which it was inserted, while supporting the surrounding tissue with non-dominant hand. 28 Used a gauze square, apply gentle pressure to the site after the needle was withdrawn. 29 Did not massage the site. 30 Did not recap the used needle. 31 Discarded the needle and syringe in the sharps box. 32 Restored the patient to a comfortable position. 33 Performed hand hygiene using correct technique. 34 Rotored the patient to a comfortable position chart immediately after the procedure. 35 Returned the equipment to dedication chart immediately after the procedure. 36 Steps 0 1:3 4-7 8-11 12-15 16-17 18-21 22-5 8-29 30-33 30-33 34-35 Skill stops achieved 27 PROCEDURE ASPECTS EVALUATION 60% 28 Procedure the procedure in the medication chart immediately after the procedure. 39 Patient Focusion Professional Manner 10% Failed 10% Skill points achieved 4 Supervised 5 Failed 5 Failed 5 Failed 7 Novice 7 Novice 6 7 Novice 6 7 Novice 6 7 Novice 7 Novice 7 Novice 7 Novice 7 Novice 6 7 Novice 7 N	16	Asked t	he patie	nt about	any alle	rgies and	d check tl	he allerg	y bracele	t if availa	ıble.				
Draped the patient as needed to expose only the area to be used.	17	Put on	clean glo	ves.											
Draped the patient as needed to expose only the area to be used.	18	Selecte	d an app	ropriate	adminis	tration s	ite.								
circular motion and moving outward from the injection site.	19							area to b	e used.						
Held the syringe in the dominant hand between the thumb and forefinger.	20	Cleanse	ed the sit	e with a	lcohol sv	vab or ga	uze with	disinfec	ting solu	tion whil	e wiping	with a	firm,		
Held the syringe in the dominant hand between the thumb and forefinger.		circular	motion	and mov	ing outv	ward fron	n the inje	ection sit	e.						<u> </u>
After the needle quickly at a 45- to 90-degree angle.	21	Graspe	d and bu	nch the	area sur	rounding	the inje	ction site	·						
After the needle is in place, released the tissue ensuring that the needle stayed in place as the skin was released. 25 Moved the non-dominant hand to steady the lower end of the syringe and the dominant hand to the end of the plunger. 26 Injected the medication slowly (at a rate of 10 sec/mt). 27 Withdraw the needle quickly at the same angle at which it was inserted, while supporting the surrounding tissue with non-dominant hand. 28 Used a gazue square, apply gentle pressure to the site after the needle was withdrawn. 29 Did not massage the site. 30 Did not recap the used needle. 31 Discarded the needle and syringe in the sharps box. 32 Restored the patient to a comfortable position. 33 Performed hand hygiene using correct technique. 34 Documented the procedure in the medication chart immediately after the procedure. 35 Returned the equipment to dedicated area. 1 SKILL EVALUATION 60% Steps 0 1-3 4-7 8-11 12-15 16-17 18-21 22-25 12-29 30-33 34-35 Skill steps achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F UN N S C I Skill level achieved Points 0 6 15 3 Failed S Failed	22	Held th	e syringe	e in the d	lominan	t hand be	etween t	he thuml	b and for	efinger.					
Was released.	23	Injecte	d the nee	edle quic	kly at a	45- to 90	-degree a	angle.							
Moved the non-dominant hand to steady the lower end of the syringe and the dominant hand to the end of the plunger.	24	After th	ne needle	e is in pla	ice, relea	ased the	tissue en	suring th	nat the n	eedle sta	yed in pl	ace as t	he skin		
Time 1															
Very competent of the medication slowly (at a rate of 10 sec/mL). Withdraw the needle quickly at the same angle at which it was inserted, while supporting the surrounding itssue with non-dominant hand.	25				nt hand	to steady	the low	er end of	f the syri	nge and	the domi	inant ha	ind to		
Withdraw the needle quickly at the same angle at which it was inserted, while supporting the surrounding tissue with non-dominant hand.															
Surrounding tissue with non-dominant hand.		_													<u> </u>
Used a gauze square, apply gentle pressure to the site after the needle was withdrawn.	27			•	•		_	which it	was inse	erted, wh	ile supp	orting tl	ne		
29 Did not massage the site.	20														
30 Did not recap the used needle.						le pressu	re to the	site afte	er the nee	edle was	withdra	wn.			<u> </u>
Discarded the needle and syringe in the sharps box.	-														
Restored the patient to a comfortable position.			•												
33 Performed hand hygiene using correct technique.								X.							
34 Documented the procedure in the medication chart immediately after the procedure.			•			•									<u> </u>
Steps O															<u> </u>
Steps O				•				art imme	diately a	fter the p	rocedur	e.			<u> </u>
Steps 0	35	Return	ed the ed	quipmen	t to dedi	cated are									
Points 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill points achieved Cannow a proper to the count of the		Т			Т	T	1		1				T =		
Patient Pat							-								
2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus10% Professional Manner10% Time10% Failed 5 Failed 5 Failed+10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory+8 6 Novice 7 Novice 7 Novice +6 7 Supervised 8 Supervised 8 Supervised +4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent 10 Notes: Time allowed (TA) 10 10 Time achieved Aspects points achieved Aspects points achieved 5 50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Signature Signature Actual Mark/Out of		0	6		l .	24	30	†				60			
Rationale 10% Patient Focus10% Professional Manner10% Time 10% Failed 5 Failed 5 Failed+10 5 Unsatisfactory 6 Unsatisfactory+8 6 0	Levei				<u> </u>	2 00	OCEDII			L		I	Skill level ad	nieved	
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Notes: Time allowed (TA) 10															
Time achieved Aspects points achieved Solution 100% Solution 250 Solution 250 Solution 250 Solution 250 Novice Supervised Competent Independent Student Signature Teacher Signature Signature Signature Time achieved Aspects points achieved Solution 250 Solution					<u> </u>										
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3. COMPLETE PROCEDURE EVALUATION100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Signature Teacher Signature Actual Mark/Out of															
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Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved Student Signature Teacher Signature Actual Mark/Out of		=0	E1	-60			1		1				Total points	achicuad	
Student Signature Actual Mark/Out of							-		-				•		
Teacher Signature Actual Mark/Out of			Unsatis	iactory	INO	vice	-		Comp	есепт	inaepe	nuent	rotarievera	cilleved	
									1				A	al. /out	
Clinical Area Date								ure	1				Actual Mai	rk/Out of	
	Ciinica	ı Area					Date		<u> </u>						<u> </u>

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROCI	EDURE: Medication - administering intramuscular injection	Code	15-18
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	☐ Patient medical record	<u> </u>	
	☐ Medication chart	 -	
	☐ Prepared medication for intramuscular administration	ļ	
	☐ Syringes and needles	ļ	
	☐ Gauze square	 -	
	☐ Disinfecting solution or alcohol swab	ļ	
	☐ Hand rub gel	ļ	
	☐ Sharps box	 -	
2	□ Plastic tray		
	Performed hand hygiene using correct technique.		
3	Checked the medication chart and compared the label of prepared medication with the prescription.		
4	Checked the expiration date on the used ampule or vial.		
5	Checked the dosage of medication and medication calculation if necessary.		
6	Transported the equipment on the tray to the patient in a safe manner, keeping the medication in sight at all times.	 -	
7			
8	Identified the patient using two identifiers.		
9	Performed greeting, introduction and permission procedure (G.I.P).		
10	Provided privacy.		
	Explained the procedure to the patient and answered any questions.		
11	Adjusted the height of the bed.		
12	Performed hand hygiene using correct technique.		
13	Assisted the patient to the supine or sitting position.		
14	Checked the medication chart for patient details.		
15	Checked the medication chart for allergies.		
16	Asked the patient about any allergies and check the allergy bracelet if available.		
17	Put on clean gloves.		
18	Selected an appropriate administration site.		
19	Draped the patient as needed to expose only the area to be used.		
20	Cleansed the site with alcohol swab or gauze with disinfecting solution while wiping with a firm,	ļ	
21	circular motion and moving outward from the injection site.		
21	Allowed the skin to dry.		
22	Removed the needle cap with the non-dominant hand by pulling it straight off.		
23	Held the syringe like a dart and pierce the skin at a 90° angle.		
24	Steadied the syringe and aspirated to observe for blood.		
25	Instilled the drug if no blood appeared.		
26	Withdrew the needle at the same angle.		
27	Applied gentle pressure at the site of injection with a dry gauze.		
28	Discarded the uncapped needle and syringe in a sharps box.		
29	Restored the patient to a comfortable position.		
30	Performed hand hygiene using correct technique.		
31	Documented the procedure in the medication chart immediately after the procedure.		
32	Returned the equipment to the dedicated area.		
	1. SKILL EVALUATION 60%		
Steps	0 1-3 4-6 7-10 11-14 15-16 17-20 21-24 25-27 28-30 31-32 Skill steps a		
Points	0 6 12 18 24 30 36 42 48 54 60 Skill points a		
Level	F U N S C I Skill level ac	cnieved	

			2. PR	OCEDU	RE ASPI	ECTS EVALUATION	ON 40%			
Rationa	ale 10%		Patient F	ocus10%	, 5	Professional	Manner1	.0%	Time10%	
Failed	5	Faile	ed		5	Failed		5	Failed+10	5
Unsatisfactory	6	Uns	satisfactory		6	Unsatisfactory		6	Unsatisfactory+8	6
Novice	7	Nov	/ice		7	Novice		7	Novice +6	7
Supervised	8	Sup	ervised		8	Supervised		8	Supervised +4	8
Competent	9	Con	npetent		9	Competent		9	Competent +2	9
Independent	10	Inde	ependent		10	Independent		10	Independent TA	10
Notes:									Time allowed (TA)	15
									Time achieved	
									Aspects points achieved	
			3. CON	MPLETE	PROCEI	DURE EVALUATI	ON 100%	6		
≤50	51-60		61-70	71-	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatisfactor	У	Novice	Super	vised	Competent	Indepe	ndent	Total level achieved	
Student				Signati	ure					
Teacher				Signati	ure		•		Actual Mark/Out of	
Clinical Area				Date						

	Procedure Evaluation Document (PED)		
PROC	EDURE: Medication - administering intravenous medication (ampule) - bolus	Code	15-19
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Medication chart		
	☐ IV fluid for dilution		
	☐ Syringe		
	□ Needles		
	☐ Disinfecting solution or alcohol swab		
	□ Normal Saline flush (10ml of Normal Saline in a syringe)		
	☐ Gauze or cannula dressing		
	Паре		
	□ Non-sterile gloves		
	☐ Sharps box		
	☐ Hand rub gel		
	☐ Plastic tray		
2	Performed hand hygiene, using correct technique.		
3	Read the medication chart and selected the proper medication from the patient's medication		
	drawer or unit stock.		
4	Checked the labels on the ampule.		
5	Checked the expiration date on the ampule.		
6	Checked the dosage and performed medication calculation if necessary.		
7	Taped the stem of the ampule or twist the wrist quickly while holding the ampule vertically.		
8	Wrapped a small gauze pad around the neck of the ampule.		
9	Used a snapping motion to break off the top of the ampule along the scored line at its neck away from the body.		
10	Attached the needle to syringe.		
11	Removed the cap from the needle by pulling it straight off.		
12	Inserted the tip of the needle into the ampule and inverted the ampule. Kept the needle centered		
	and not touching the sides of the ampule.		
13	Withdrew required amount of medication into syringe.		

14	Withdr	ew the s	yringe ar	nd tappe	d it to ex	pelled th	ne air car	efully by	pushing	on the p	lunger.				
15		ly replac				•		•	<u> </u>	•					
16	Checke surplus		ount of	medicat	ion in the	syringe	with the	medicat	ion dose	and disc	carded a	nny			
17	Discard	led the a	mpule in	a sharp	s box.										
18		the med													
19	-		dication	s and eq	uipment	to the p	atient's k	oedside c	arefully,	keeping	them in	n sight at			
	all time														
20		ned hand				chnique.									
21		ed patie													
22	Perforr	ned gree	ting, inti	oduction	n and pei	rmission	procedu	re (G.I.P)							
23	Provide	ed privac	у.												
24	Explain	ed the p	rocedure	e to the p	oatient ar	nd answe	ered any	question	S.						
25	Adjuste	ed the he	ight of t	he bed.											
26	Assiste	d patient	to supir	ne or sitt	ing posit	ion.									
27	Put on	gloves.													
28	Assesse	ed IV site	for pres	ence of i	inflamma	ition or i	nfiltratio	n.							
29	Flushed	d the IV c	annula v	vith half	of the No	ormal Sa	line flush	١.							
30	Connec	ted syrin	ge with	the med	ication to	o the IV	cannula.								
31	Injecte	d medica	tion at t	he recon	nmended	d rate.									
32	Flushed	the can	nula wit	h the oth	ner half o	f Norma	l Saline f	lush.							
33	Discard	Flushed the cannula with the other half of Normal Saline flush. Discarded syringe with the needle into the sharps box.													
34	Replaced IV cannula dressing.														
35	Remov	ed glove:	S.												
36	Docum	ent the a	dministi	ration of	the med	ication ir	nmediat	ely after	administ	ration.					
37		ed the ed													
38		ned hand													
			70					LUATIO	N 60%						
Steps	0	1-4	5-8	9-12	13-17	18-19	20-24	25-28	29-32	33-36	37-38	Skill steps	achiev	ed	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achiev	/ed	
Level				F			U	N	S	С	I	Skill level a	chieve	:d	
					2. PR	OCEDU	RE ASPE	CTS EVA	LUATIO	N 40%	,				
	Rationa	ale 10%		I	Patient F	ocus 10%	6	Profe	essional	Manner	10%		Time	10%	
Failed			5	Failed			5	Failed			5	Failed		10	5
Unsatis	factory		6		sfactory		6		factory		6	Unsatisfa	ctory	/ +8	6
Novice			7	Novice			7	Novice			7	Novice		+6	7
Supervi			8	Superv			8	Superv			8	Supervise		+4	8
Compe			9	Compe			9	Compe			9	Compete		+2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ			10
Notes:												Time allov	ved (T	A)	20
												Time achie	ved		
												Aspects poir	its achie	eved	
					B. CON	1PLETE I	PROCED	URE EV	ALUATION	ON 100	%				
≤5	50	51-	-60	61	-70	71	-80	81-	90	91-2	100	Total points	achie	ved	
Fai	led	Unsatis	factory	No	vice	Supervised Competent Independent					ndent	Total level	ed		
Studer	nt					Signat	ure								
Teache	er					Signat	ure					Actual Ma	ark/O	ut of	
												4			

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROC	EDURE: Medication - administering intravenous medication (vial) - bolus	Code	15-20
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Medication chart		
	☐ IV fluid for dilution		
	□ Syringe		
	□ Needles		
	□ Disinfecting solution or alcohol swab		
	□ Normal Saline flush (10ml of Normal Saline in a syringe)		
	☐ Gauze or cannula dressing		
	☐ Tape		
	□ Non-sterile gloves□ Sharps box		
	☐ Hand rub gel		
	□ Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Read the medication chart and selected the proper medication from the patient's medication		
	drawer or unit stock.		
4	Checked the labels on the vial.		
5	Checked the expiration date on the vial.		
6	Checked the dosage and performed medication calculation if necessary.		
7	Removed the metal or plastic cap on the vial.		
8	Swabbed the rubber top with the gauze and disinfecting solution or an alcohol swab.		
9	Allowed the rubber top to dry.		
10	Attached the needle to the syringe.		
11	Removed the cap from the needle by pulling it straight off.		
12	Drew back an amount of air into the syringe that is equal to the specific dose of medication to be		
	withdrawn.		
13	Held the vial on a flat surface. Pierced the rubber stopper in the centre with the needle tip.		
14	Injected the measured air into the space above the solution without injecting air into the solution.		
15	Inverted the vial. Kept the tip of the needle below the fluid level.		
16	Held the vial in one hand and use the other to withdraw the medication.		
17	Drew up the prescribed amount of medication while holding the syringe vertically and at eye level. If		
	any air bubbles accumulated in the syringe, tapped the barrel of the syringe sharply and moved the		
18	needle past the fluid into the air space to re-inject air bubble into the vial. After the correct dose was withdrawn, removed the needle from the vial and carefully replaced the		
10	cover over the needle.		
19	Checked the amount of medication in the syringe and discarded any surplus.		
20	If a single-use vial was used, discarded the vial into sharps box. If a multi-dose vial was used, labelled		
_•	the vial with the date and time opened, and stored the vial containing the remaining medication.		
21	Dilute the medication with the appropriate IV fluid as prescribed.		
22	Transported medications and equipment to the patient's bedside carefully, keeping them in sight at		
	all times.		
23	Performed hand hygiene using correct technique.		
24	Identified patient using two identifiers.		
25	Performed greeting, introduction and permission procedure (G.I.P).		
26	Provided privacy.		
27	Explained the procedure to the patient and answered any questions.		
28	Adjusted the height of the bed.		
29	Assisted patient to supine or sitting position.		

														121	
30	Put on	gloves.													
31	Assesse	d IV site	for pres	ence of i	nflamma	tion or i	nfiltratio	n.							
32	Flushed	the IV c	annula v	vith half	of the No	ormal Sal	ine flush	١.							
33	Connec	ted syrir	nge with	the med	ication to	the IV o	annula.								
34	Injected	d medica	ition at t	he recon	nmended	l rate.									
35	Flushed	I the can	nula witl	h the oth	er half o	f Normal	Saline f	lush.							
36	Discard	ed syring	ge with t	he needl	e into th	e sharps	box.								
37	Replace	ed IV can	nula dre	ssing.											
38	Remov	moved gloves. cument the administration of the medication immediately after administration.													
39	Docum	ent the a	ndministr	ration of	the med	ication ir	nmediat	ely after	administ	ration.					
40	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.									
						1. SK	ILL EVA	LUATIO	N 60%						
Steps	0	1-4	5-8	9-13	14-18	19-20	21-25	26-30	31-34	35-38	39-40	Skill steps ad			
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points a			
Level				F		222211	U	N	S	C	ı	Skill level ac	hieved		
		1 400/		I .				CTS EV							
r-th-d	Rationa	ale 10%	-		Patient F	ocus 109			essional	Manner	10% 5		ime 10%		
Failed	factory		5 6	Failed Unsatis	factory		5 6	Failed	factory			Failed Unsatisfac	+10	5 6	
Novice			7	Novice			7	Novice	Unsatisfactory		7	Novice	+6	7	
Supervi			8	Superv			8	Superv	sed		8	Supervised +4		8	
Compe			9	Compe			9	Compe			9	Competent +2		9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independe	ent TA	10	
Notes:												Time allowe	ed (TA)	20	
												Time achieve	ed		
												Aspects points	achieved		
				3	B. COM	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%				
≤5	50	51-	-60	61	-70	71	-80	81-	90	91-1	L00	Total points	achieved		
Fai	led	Unsatis	factory	No	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level ad	chieved		
Studer	nt					Signat									
Teache						Signat	ure					Actual Mar	k/Out of		
Clinica	l Area					Date									

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)

PROC	EDURE:	Medication - administering intravenous fluid infusion – intermittent-continuous	Code	15-21
No.		Skill steps	Not achieved	Achieved
1	Prepare	d procedure equipment:		
		Medication chart		
		IV fluid		
		IV fluid administration set		
		Normal Saline flush (5-10ml of Normal Saline in a syringe)		
		Antiseptic solution		
		Gauze or cannula dressing		
		Tape		
		IV stand		
		Non-sterile gloves		
		Hand rub gel		
		Plastic tray		
2	Checked	medication chart for the IV infusion prescription.		
3	Perform	ed hand hygiene using correct technique.		

	1													
4								of the fl	uid					
5					ag and t	he iv flui	d.							
6				on the IV										
7					wrappir	_								
8					istration	set.								
9		•	•	p on the										
10		•		•			•	zing the	drip char	nber.				
11	Release	ed pressu	ire on th	e drip ch	amber u	ntil it is h	nalf full.							
12					nd of iv s	et tubin	g.							
13	· ·			ime the i										
14			•		t was prii									
15	Checke	d that no	o air is pr	esent in	the tubir	ng.								
16	Transpo	orted the	e prepare	ed equip	ment to t	the patie	nt' beds	ide caref	ully.					
17	Identifi	ed patie	nt using	two iden	tifiers.									
18	Perforr	ned gree	ting, intr	oduction	n and per	rmission	procedu	re (G.I.P)						
19		d privac	•											
20					atient ar	nd answe	ered any	question	S.					
21	_		eight of t	he bed.										
22	Put on	gloves.												
23					igns of ar	-								
24			annula v	vith salin	e flush to	o check p	oatency i	f the can	nula has	not beei	n used.	(if used –		
	verbal													
25			et to IV c											
26		hanged the cannula dressing if necessary.												
27		Calculated the drop rate correctly. Started the infusion regulating the correct drop rate with the clamp on IV set.												
28														
29		•	•	ort any p	oain or di	iscomfor	t at the v	enous a	cess site	! .				
30		ed glove:												
31					in the m									
32							ce chart	if used (i	f not use	d- verba	l report	:).		
33					dedicated									
34	Perforn	ned hand	d hygiene	e using c	orrect te	-								
		4.0			10.15			LUATIO		20.22	22.24	01:11 -4	a alaba ya d	
Steps Points	0	1-3	4-7	8-11	12-15	16-17	18-21	22-25	26-29	30-32	33-34	Skill steps		
Level	0	6	12	18 F	24	30	36 U	42 N	48 S	54 C	60 I	Skill points Skill level a		
Level				<u> </u>	2. PR	OCEDIII		CTS EV				OKIII IEVEI (acilieveu	
	Rationa	ale 10%			Patient F			1	essional				Time 10%	
Failed		10/0	5	Failed	2301161	_ = = = = = = = = = = = = = = = = = = =	5	Failed			5	Failed	+10	5
	factory		6		factory		6	-	factory		6	Unsatisf		6
Novice			7	Novice	•		7	Novice			7	Novice	+6	7
Superv	ised		8	Superv	ised		8	Superv	ised		8	Supervis	ed +4	8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Indepen	dent TA	10
Notes:												Time allo	wed (TA)	20
												Time achie	eved	
													nts achieved	
				3	. CON	1PLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61	-70	71	-80	81	90	91-1	100	Total point	s achieved	
Fai	led	Unsatis	factory	No	vice	Supe	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teach						Signat	ure					Actual Mark/Out of		
Clinica						Date								
		Ü				L								

PRO	OCEDURE: Medication - administering intrave	nous fluid infusion – secondary intermittent	Code	15-22
No.		Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:			
	☐ Medication chart			
	□ IV fluid			
	□ IV fluid administration set			
	☐ Normal Saline flush (5-10ml of Normal Sa	aline in a syringe)		
	☐ Antiseptic solution			
	☐ Gauze or cannula dressing			
	☐ Tape			
	□ IV stand□ Non-sterile gloves			
	☐ Non-sterile gloves☐ Hand rub gel			
	□ Plastic tray			
2	Checked medication chart for the IV infusion preso	crintion		
3	Performed hand hygiene using correct technique.	in paid.		
4	Preparing secondary infusion			
5	Checked expiry date on the IV fluid bag, and the co	andition of the fluid		
6	Checked the condition of the iv bag and the iv fluid			
7	Hanged the IV fluid bag on the IV stand.	4.		
8	Opened the iv administration set wrapping.			
9	Clamped the tubing on IV administration set.			
10	Removed plastic port cap on the iv bag.			
11	Inserted spike of IV set into the port of IV bag whil	e squeezing the drip chamber		
12	Released pressure on the drip chamber until it is h			
13	Removed protective cap at the end of iv set tubing			
14	Opened the clamp to prime the iv set.	5 .		
15	Closed the clamp when the iv set was primed.			
16	Checked that no air is present in the tubing.			
17	Transported the prepared equipment to the patien	at' hadaida carafully		
18	Identified patient using two identifiers.	it bedside carefully.		
19	Performed greeting, introduction and permission	aracadura (C.I.D.)		
20		orocedure (G.I.P).		
21	Provided privacy. Explained the procedure to the patient and answe	rad any guartians		
22	·	red any questions.		
23	Adjusted the height of the bed. Put on gloves.			
24	Administering secondary infusion			
25	Inspected the IV access site for signs of any inflam	mation		
26	Hanged the secondary iv fluid bag on the iv pole a			
27	, , , , ,			
28	Attached needle or needless adapter to the secon	•		
29	Cleaned the port on the primary infusion with disi			
	Inserted needle or needless adapter to the port of	the primary iv set.		
30 31	Locked (secured) connection.			
	Calculated the drop rate correctly.	and allow water with the element of the t		
32	Started the secondary infusion regulating the corn			
33	Asked the patient to report any pain or discomfort	at the venous access site.		
34	Removed gloves.			
35	Documented starting IV infusion in the medication	chart.		

26	I _													
36				infusion			ce chart	if used (i	f not use	d- verba	l report).		
37	Returne	ed the ed	quipmen	t to the c	ledicated	d area.								
38	Perforn	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-17	18-19	20-24	25-28	29-32	33-36	37-38	Skill steps achieve	d	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieve	ed	
Level			1	=			U	N	S	С	- 1	Skill level achieved		
					2. PR	OCEDUI	RE ASPE	CTS EVA	LUATIO	N 40%				
	Rationa	ale 10%		F	Patient F	ocus 109	6	Profe	essional I	Manner	10%	Time	10%	
Failed			5	Failed			5	Failed			5	Failed +1	.0	5
Unsatis	Unsatisfactory 6 Novice 7				Unsatisfactory			Unsatisfactory 6			6	Unsatisfactory+	-8	6
Novice	ovice 7				Novice			Novice			7	Novice +	6	7
Superv	ised		8	Supervi	sed		8	Superv	ised		8	Supervised +	-4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Competent -	+2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independent 7	ГА	10
Notes:												Time allowed (TA	۸)	25
												Time achieved		
												Aspects points achieve	ved	
				3	. CON	IPLETE I	PROCED	URE EV	ALUATIO	ON 100	%			
≤!	50	51-	-60	61-	70	71	-80	81-	-90	91-2	100	Total points achiev	ed	
Fai	led	Unsatis	factory	Nov	/ice	Supe	rvised	Comp	etent	Indepe	ndent	Total level achieve	d	
Studer	nt					Signat	ure							
Teach	Teacher				Signat	ure					Actual Mark/Ou	t of		
Clinica	l Area					Date								

	Procedure Evaluation Document (PED)		
PROC	EDURE: Medication - administering intravenous fluid infusion – volume-control set	Code	15-23
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Medication chart		
	□ IV fluid		
	□ Volume control set		
	□ Normal Saline flush (5-10ml of Normal Saline in a syringe)		
	☐ Gauze or cannula dressing		
	□ Таре		
	□ IV stand		
	□ Non-sterile gloves		
	☐ Hand rub gel		
	☐ Plastic tray		
2	Checked medication chart for the IV infusion prescription.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		
9	Inserted the spike of volume-control set into the IV fluid bag without contaminating the spike.		

														123
10	Hanged	the IV f	luid bag	on the IV	' stand									
11	Filled t	he volum	e-contro	ol admini	stration	set with	the pres	cribed ar	nount of	IV fluid	by open	ing the		
	clamp l	oetween	IV fluid a	and the v	olume-c	ontrol ac	dministra	ition set.						
12	Primed	the volu	me-cont	rol set										
13	Checke	d to mak	e sure th	ne air ver	nt on the	volume-	-control	administ	ration se	t chamb	er is ope	en.		
14	Put on	gloves.												
15	Inspect	ed the IV	/ access :	site for si	igns of a	ny inflam	mation o	or infiltra	tion.					
16	Flushed	the IV c	annula v	vith salin	e flush t	o check p	oatency i	f the can	nula has	not bee	n used (if used –		
	verbal	report).												
17	Connec	ted the	volume-d	control se	et to IV c	annula.								
18	Change	d the ca	nnula dr	essing if	necessar	y (if not i	necessar	y-verbal	report).					
19	Calcula	ted the c	lrop rate	accordi	ng to the	prescrip	tion.							
20			-	=	ed rate c	or placed	the volu	me-cont	rol set o	n an infu	sion pu	mp and		
		mmed th												
21	Remov	ed glove:	5.											
22						medicatio								
23	Docum	ented th	e startin	g the info	usion in f	fluid bala	nce char	t.						
24	Return	ed the ed	quipmen	t to the c	dedicated	d area.								
25	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps achi		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points ach		
Level				F			U	N	S	С	I	Skill level achie	eved	
	-			I		OCEDUI						T .		
	Ration	ale 10%			Patient F	ocus 109			essional	Manner	1		ne 10%	
Failed	.CL		5	Failed	· C		5	Failed	f t		5	Failed	+10	5
	factory		6		factory		6 7	Unsatis	tactory		6	Unsatisfacto	•	6
Novice Superv	icad		7 8	Novice Superv	icad		8	Novice Superv	icod		7 8	Novice Supervised	+6 +4	7 8
Compe			9	Compe			9	Compe			9	Competent	+4	9
Indepe			10	Indepe			10	Indepe			10	Independen		10
Notes:	naciic		10	тисрс	naciic		10	тасрс	ilaciit		10	Time allowed		20
														20
												Time achieved		
				_								Aspects points a	chieved	
		T				IPLETE F						T		
	50		-60		-70		-80	81	-90	91-3		Total points ac		
	led	• •		vice		rvised	Comp	etent	Indepe	ndent	Total level achi	eved		
Studer						Signat								
Teach						Signature			Actual Mark/	Out of				
Clinica	l Area					Date								

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION **Procedure Evaluation Document (PED)** Medication - administering intravenous fluid infusion - infusion pump PROCEDURE: Code 15-24 Not No. **Skill steps** Achieved There are differences between the operational instructions of different types of infusion pumps. It is necessary to consult manufacturer's manual to use the pump correctly! Prepared procedure equipment: Medication chart IV fluid

				stration s										
					ion stand		-1: :							
				-	10ml of N	ormal S	aline in a	a syringe)						
			ptic solu											
			or canni	ula dress	ing									
		Tape	terile glo	VOC										
		Hand	_	ves										
		Plastic	_											
2				rt for the	e IV infus	ion nres	crintion							
3					orrect tec	•								
4					cal order			ocedure	including	nriming	the set			
5			· · · · · · · ·	two iden		using co	orrect pr	occuarc	meraame	5 Prinning	, the set	•		
6		•			and per	mission	nrocedu	re (G I P)						
7		ed privac		oddetioi	rana per	1111331011	procedu	10 (0.1.1)	•					
8		•	•	to the n	atient an	d answe	ared any	auestion	10					
9		•	ight of th		atient an	u answe	cied arry	question	13.					1
10					(plugged	lit in if i	t was no	+1						1
11				on the IV		10 111 11 1	t was no	ι).						1
12					d from th	no sot								-
13				•	ed the iv		ugh tho	guido ch	annol					-
14	•	pump do		anu ioau	eu the iv	set till t	ugii tile	guide cii	aillei.					1
15				npletely.										1
16	Put on		idilip coi	пріссету.										-
17			/ 200000	sita for si	igns of an	v inflam	mation							1
18								f the can	nula has	not beer	n used	(if used –		1
10	verbal r		armaia v	vicii saiiii	e masm te	, circuit b	Jacciley 1	i tire cari	maia mas	not been	ii uscu.	(II doca		
19			et to IV ca	annula.										
20	Change	d the ca	nnula dr	essing if	necessary	/.								
21	Remove	ed glove:	S.											
22	Turned	the pum	np on by	pressing	ON/OFF	key.								
23	Set prin	nary flov	v rate in	ml/hr by	pressing	RATE (F	RI RATE	key.						
24	Set prin	nary volu	ume to b	e infused	by press	ing VOL	.UME (PF	RI VTBI) k	ey.					
25	Checke	d the pro	ogramme	ed inform	nation be	fore sta	rting the	pump.						
26	Started	the pun	np by pre	essing ST	ART key.									
27	Docum	ented th	e startin	g the info	usion in n	nedicati	on chart.							
28	Docum	ented th	e startin	g the infu	usion in fl	uid bala	nce char	t.						
29	Perforn	ned hand	d hygiene	e using co	orrect tec	hnique.								
30	After co	mpletio	n of the	infusion	pressed S	STOP key	y .							
31	Closed	IV set clι	ımp.											
32	Opened	d pump o	door and	removed	d the IV s	et.								
33	Turned	the pum	np off by	pressing	ON/OFF	key.								
34	Perforn	ned hand	d hygiene	e using co	orrect tec	hnique.								
35	Put on	gloves.												
36	Disconr	nected th	ne IV set	from IV	cannula.									
37	Remove	ed glove:	S.											
38	Docum	ented th	e volume	e infused	in the flu	uid balar	nce chart	<u> </u>						
39	Returne	ed the ed	quipmen	t to the c	dedicated	area.								
40	Perforn	ned hand	d hygiene	e using co	orrect tec	hnique.								
						•		LUATIO	N 60%					
Steps	0	1-4	5-8	9-13	14-18	19-20	21-25	26-30	31-34	35-38	39-40	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60		s achieved	
Level			l	F			U	N	S	С	I	Skill level	achieved	

			2. PR	OCEDUI	RE ASPE	CTS EVALUATION	ON 40%				
Ration	ale 10%		Patient F	ocus 10%	6	Professional	Manner :	10%	Tin	ne 10%	
Failed		5	Failed		5	Failed		5	Failed	+10	5
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfacto	ry+8	6
Novice		7	Novice		7	Novice		7	Novice	+6	7
Supervised		8	Supervised		8	Supervised		8	Supervised	+4	8
Competent		9	Competent		9	Competent		9	Competent	+2	9
Independent		10	Independent		10	Independent		10	Independent	t TA	10
Notes:						•			Time allowed	(TA)	20
									Time achieved		
									Aspects points ac	chieved	
			3. COM	1PLETE F	PROCED	URE EVALUATION	ON 100	%			
≤50	51-	60	61-70	71-	-80	81-90	91-1	.00	Total points ach	nieved	
Failed	Unsatisf	factory	Novice	Super	vised	Competent	Indepe	ndent	Total level achie	eved	
Student				Signat	ure						
Teacher				Signat	ure				Actual Mark/	Out of	
Clinical Area				Date					1		

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION **Procedure Evaluation Document (PED)** 15-25 PROCEDURE: Code Medication - administering intravenous infusion - syringe pump Not No. Skill steps Achieved achieved There are differences between the operational instructions of different types of syringe pumps. It is necessary to consult manufacturer's manual to use the pump correctly! Prepared procedure equipment: Medication chart ☐ Luer-lock 50-60ml syringe with administration set Needles □ Prescribed medication □ IV fluid for dilution ☐ Syringe pump on infusion stand □ Normal Saline flush (5-10ml of Normal Saline in a syringe) Antiseptic solution ☐ Gauze or cannula dressing □ Tape ☐ Non-sterile gloves ☐ Hand rub gel Plastic tray 2 Checked medication chart for the IV infusion prescription. 3 Performed hand hygiene using correct technique. Prepared IV infusion as per medical order using correct procedure including priming the 4 administration set. 5 Identified patient using two identifiers. 6 Performed greeting, introduction and permission procedure (G.I.P). 7 Provided privacy. 8 Explained the procedure to the patient and answered any questions. 9 Adjusted the height of the bed. 10 Checked that syringe pump is plugged in (plugged it in if it was not). Mount the syringe on the pump by pulling the plunger driver, releasing the barrel clamp, placing 11 the syringe in the cradle and closing barrel clamp firmly. 12 Turned the syringe pump on by pressing the ON key.

														128
13	Used th	ne arrow	keys to	program	me the r	ate of ad	ministra	tion.						
14	Used th	ne arrow	keys to	program	me the v	olume to	be infu	sed.						
15	Purged	the syrir	nge and t	tubing to	prime tl	ne set us	ing PUR	GE START	key.					
16	Stoppe	d purgin	g the syr	inge by p	oressing I	PURGE ST	TOP key.							
17	Put on	gloves.												
18	Inspect	ed the I\	/ access	site for s	igns of a	ny inflam	mation.							
19	Flushed	the IV c	annula v	vith salin	e flush t	o check p	oatency i	if the can	nula has	not bee	n used.	(if used –		
	verbal													
20	Connec	ted IV se	et to IV c	annula.										
21	Change	d the ca	nnula dr	essing if	necessar	у.								
22		ed glove:												
23	Checke	d the pro	ogramme	ed inforn	nation be	efore star	rting the	pump.						
24	Started	the pun	np by pre	essing ST	ART key.									
25	Docum	ented th	e startin	g the inf	usion in ı	nedicatio	on chart	•						
26	Docum	ented th	e startin	g the inf	usion in 1	fluid bala	nce cha	rt.						
27	Return	ed the ed	quipmen	t to the o	dedicated	d area.								
28	Perforn	ned hand	d hygien	e using c	orrect te	chnique.								
								LUATIO			1			
Steps	0	1-3	4-6	7-9	10-12	13-14	15-17	18-20	21-23	24-26	27-28	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	C	l	Skill level a	ichieved	
		1 400/		1 .				ECTS EV				I	-: 100/	
ادعانعا	Rationa	ale 10%	-		Patient F	ocus 109	ı		essional	Manner		Failed.	Time 10%	
Failed	factory		5 6	Failed	sfactory		5 6	Failed	factory		5 6	Failed Unsatisfa	+10	5 6
Novice			7	Novice			7	Novice	iactory		7	Novice	+6	7
Superv			8	Superv			8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:							II.					Time allov		20
												Time achie		
				-	S COM	1DI FTF I	PROCEC	URE EV	ΔΙΙΙΔΤΙ	ON 100	%	Aspects poir	its acriieveu	
<1	50	51.	-60		-70		-80		-90	91-1		Total points	s achieved	
	led		factory	†	vice		rvised		etent	Indepe		Total level		
Studer		0.154113		1		Signat		20111		асре		1010110101		1
Teach						Signat						Actual Ma	ark/Out of	
Clinica						Date	ui C					Actualivi	and Out Of	
Cirrica	i Ai Ca					Date		<u> </u>				<u> </u>		L

	11000410 1141441011 200411011 (1.12)		
PROC	EDURE: Medication - administering intravenous infusion with IV medication (ampule) using infusion pump	Code	15-26
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		

		123
	Antimicrobial swabs or disinfecting solution	
	Gauze IV infusion set	
	Additive labels	
	o Infusion pump	
	Hand rub gelSharps box	
	o Plastic tray	
2	Performed hand hygiene using correct technique.	
3	Read the medication chart and selected the correct medication.	
4	Checked the medication chart for any allergies.	
5	Checked expiration dates.	
6	Checked dosages and performed calculations if needed.	
7	Taped the stem of the ampule.	
8	Wrapped a small gauze pad around the neck of the ampule.	
9	Broke the top of the ampule away from the body.	
10	Attached the needle to the syringe and removed the cap.	
11	Withdrew medication from the ampule in ordered amount touching the plunger at the knob only.	
12	Withdrew the needle from the syringe and tapped it to collect the air at the top.	
13	Expelled the air from the syringe by pushing on the plunger.	
14	Removed the needle.	
15	Discarded the needle in the sharps box.	
16	Attached a new needle on the syringe.	
17	Re-checked the medication name and dosage on the ampule.	
18	Discarded the ampule in the sharps box.	
19	Checked the name and expiration date of IV fluid.	
20	Uncovered the port of iv bag or cleaned it with antimicrobial swab or gauze with disinfecting solution.	
21	Inserted the medication from the syringe into IV fluid bag's port.	
22	Withdrew the syringe and discarded the syringe and needle into the sharp's box.	
23	Correctly prepared the additive label and attached it to the IV bag.	
24	Inverted the IV bag a few times to distribute the medication in IV fluid.	
25	Inserted infusion set into the IV bag.	
26	Primed the infusion set with the IV solution.	
27	Prepared a saline flash by withdrawing 5ml of Normal Saline into a syringe.	
28	Put all the equipment on the tray or the trolley.	
29	Cleaned the working area.	
30	Transported the prepared infusion and equipment to the patient's bedside safely.	
31	Identified the patient using two identifiers.	
32	Performed greeting, introduction and permission procedure (G.I.P).	
33	Provided privacy.	
34	Explained the procedure to the patient.	
35	Adjusted the height of the bed.	
36	Assisted patient to a comfortable position.	
37	Checked the medication chart for patient's details with the patient and an ID bracelet if possible.	
38	Compared the medication chart with the additive label on the infusion.	
39	Asked the patient about any allergies.	
40	Performed hand hygiene, using correct technique.	
41	Assessed the IV site for the presence of inflammation or infiltration.	
42	Cleaned the injection port on the cannula with a disinfecting solution.	

													130
Flashe	d the car	nula wit	h saline t	flush.									
Checke	d that in	fusion se	t is prim	ed and t	here are	no air bı	ubbles in	the set.					
Attach	ed the in	fusion se	et to the	cannula.	•								
Inserte	d infusion	set into t	he infusio	n pump a	according	to the typ	e of the p	ump.					
Opened	the clam	p of the ir	nfusion se	t.									
Prograi	nmed th	e pump	to the ap	propriat	e rate ar	nd began	infusion						
Checked	that pati	ent is in a	comforta	able posit	ion.								
Docume	nted the	procedur	e in the m	edication	chart.								
Returne	d the equ	ipment to	o dedicate	d area.									
Perform	ed hand l	nygiene u	sing corre	ct technic	que.								
					1. SI	(ILL EVA	LUATIO	N 60%					
0	1-6	7-12	13-18	19-24	25-26	27-32	33-38	39-44	45-50	51-52	Skill steps	achieved	
0	6	12	18	24	30	36	42	48	54	60			
												achieved	
				2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%				
Ration	ale 10%		ı	Patient F	ocus10%	6	Prof	essional	Manner	10%			
		5				5				5			5
				factory				factory					6
													7
		_					_ •				•		8
													9 10
nuent		10	Пиере	iluelit		10	Писре	iluelit		10			25
													25
				s con	ADI ETE	DROCEI	NIRE EV	ΛΙΙΙΛΤΙ	ON 1009	%	Aspects poi	nts achieved	
50	51	-60					1				Total point	s achieved	
led													
nt			1		-								
er											Actual M	ark/Out of	
l Area					Date						1		
	Checke Attach Inserted Opened Program Checked Docume Returne Perform 0 0 Rationa factory sed tent ndent	Checked that in Attached the in Inserted infusion Opened the clam Programmed th Checked that pati Documented the Returned the equ Performed hand I 0 1-6 0 6 Rationale 10% factory sed tent Indent 50 51- Ied Unsatis	Checked that infusion set Attached the infusion set Inserted infusion set into the Inserted	Checked that infusion set is prim Attached the infusion set to the Inserted infusion set into the infusion Opened the clamp of the infusion se Programmed the pump to the ap Checked that patient is in a comforta Documented the procedure in the m Returned the equipment to dedicate Performed hand hygiene using corre 0 1-6 7-12 13-18 0 6 12 18 F Rationale 10% F Rationale 10% F Rationale 10% S Failed factory 6 Unsatis 7 Novice sed 8 Supervi tent 9 Competent 10 Independent 10 Independent 10 Independent	Attached the infusion set to the cannular Inserted infusion set into the infusion pump at Opened the clamp of the infusion set. Programmed the pump to the appropriate Checked that patient is in a comfortable posity Documented the procedure in the medication Returned the equipment to dedicated area. Performed hand hygiene using correct technical set of the procedure in the medication Returned the equipment to dedicated area. Performed hand hygiene using correct technical set of the procedure in the medication Returned the equipment to dedicated area. Performed hand hygiene using correct technical set of the procedure in the medication of the procedure in the medication of the procedure in the medication in the medication of the medication of the medication of the procedure in the medication of the procedure in the procedure in the infusion set in the	Checked that infusion set is primed and there are Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according Opened the clamp of the infusion set. Programmed the pump to the appropriate rate are Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. Performed hand hygiene using correct technique. 1. Si 0 1-6 7-12 13-18 19-24 25-26 0 6 12 18 24 30 F 2. PROCEDU Rationale 10% Patient Focus10% 5 Failed factory 6 Unsatisfactory 7 Novice sed 8 Supervised tent 9 Competent Indent 10 Independent 3. COMPLETE 50 51-60 61-70 71 Independent Signater Signater Signater	Checked that infusion set is primed and there are no air but Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVA 25-26 27-32 0 6 12 18 24 30 36 F U 2. PROCEDURE ASPER Rationale 10% Patient Focus 10% Failed 5 Failed 5 Failed 5 Failed 5 Failed 5 Sed 8 Supervised 8 Supervised 8 Supervised 8 Supervised 8 Supervised 10 Independent 10 Independent 10 Independent 10 Signature 8 Signature Signature Signature	Checked that infusion set is primed and there are no air bubbles in Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the properties of the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATIO 1. SKILL EVALUATIO 1. SKILL EVALUATIO 2. PROCEDURE ASPECTS EVALUATIO 3. PROCEDURE ASPECTS EVALUATIO 4. Patient Focus 10% Profit 5. Failed 5. Failed 5. Failed 5. Failed 5. Failed 6. Unsatisfactory 6. Unsatisfactory 6. Unsatisfactory 7. Novice 8. Supervised 8. Supervised 8. Supervised 9. Competent 9. C	Checked that infusion set is primed and there are no air bubbles in the set. Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the pump. Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion. Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60% 0 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 0 6 12 18 24 30 36 42 48 F UNN S 2. PROCEDURE ASPECTS EVALUATION Rationale 10% Patient Focus10% Professional 5 Failed 5 Failed factory 6 Unsatisfactory 6 Unsatisfactory 7 Novice sed 8 Supervised 8 Supervised tent 9 Competent 9 Competent ndent 10 Independent 10 Independent 3. COMPLETE PROCEDURE EVALUATION O 51-60 61-70 71-80 81-90 led Unsatisfactory Novice Supervised Competent other Signature Signature	Checked that infusion set is primed and there are no air bubbles in the set. Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the pump. Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion. Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60% 1. SKILL EVALUATION 60% 0 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 0 6 12 18 24 30 36 42 48 54 F U N S C 2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus10% Professional Manner: 5 Failed 5 Failed 5 Failed 5 Failed 5 Failed 6 Unsatisfactory 7 Novice Sed 8 Supervised 10 Independent 3. COMPLETE PROCEDURE EVALUATION 1009 10 51-60 61-70 71-80 81-90 91-19 11 Signature 12 Signature 13 Signature 14 Signature	Checked that infusion set is primed and there are no air bubbles in the set. Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the pump. Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion. Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60% 1. SKILL EVALUATION 60% 1. SKILL EVALUATION 60% 1. SKILL EVALUATION 60% 2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus10% Patient Focus10% Professional Manner10% Rationale 10% Patient Focus10% Professional Manner10% Sed 8. Supervised 9. Competent 9. Competent 9. Independent 10. Independent	Checked that infusion set is primed and there are no air bubbles in the set. Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the pump. Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion. Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60% O 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 51-52 Skill steps of the pump of the infusion set. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Set I skill level at the procedure of the pump of the pump. Double of the pump to the appropriate rate and began infusion. Checked that infusion set into the infusion set. Programmed the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump to the appropriate rate and began infusion. Skill pump to the pump t	Checked that infusion set is primed and there are no air bubbles in the set. Attached the infusion set to the cannula. Inserted infusion set into the infusion pump according to the type of the pump. Opened the clamp of the infusion set. Programmed the pump to the appropriate rate and began infusion. Checked that patient is in a comfortable position. Documented the procedure in the medication chart. Returned the equipment to dedicated area. Performed hand hygiene using correct technique. 1. SKILL EVALUATION 60% O 1-6 7-12 13-18 19-24 25-26 27-32 33-38 39-44 45-50 51-52 Skill steps achieved O 6 12 18 24 30 36 42 48 54 60 Skill points achieved F U N S C I Skill level achieved F V D N S C I Skill level achieved Rationale 10% Patient Focus10% Professional Manner10% Time10% Rationale 10% Patient Focus10% Professional Manner10% Failed-10 factory 6 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory-8 Supervised 8 Supervised 8 Supervised 8 Supervised 19 Competent 9 Competent 4 Supervised 10 Independent 10 Independent TA Time allowed (TA) Time achieved 3. COMPLETE PROCEDURE EVALUATION 100% 4. COMPLETE PROCEDURE EVALUATION 10

	rocedure Evaluation Document (1 25)		
PROCI	EDURE: Medication - changing IV infusion containers	Code	15-27
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Medication chart		
	☐ New iv fluid container		
	☐ Hand rub gel		
	□ Plastic tray		
2	Identified the patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Explained the procedure to the patient and answered any questions.		
5	Performed hand hygiene using correct technique		
6	Checked the medication chart for patient details.		
7	Checked the iv fluid prescription in the medication chart.		
8	Checked the IV fluid container label.		

														121
9	Checke	d the IV	fluid con	itainer ex	piry date	e.								
10	Closed	the rolle	r clamp (of the inf	usion se	t or stop	ped the i	infusion (device.					
11	Remov	ed the er	mpty sol	ution cor	ntainer fr	om susp	ension h	ook with	the tubi	ng still a	ttached	•		
12	Inverte	d the em	pty solu	tion cont	tainer an	d pulled	the spike	e free.						
13	Remov	ed the se	eal from	the repla	cement	solution	containe	er.						
14	Inserte	d the spi	ke in to t	the port	of new c	ontainer.								
15	Remov	ed the ai	r with in	the tubi	ng.									
16	Readju	st the ro	ller clam	p or repr	ogramm	ed the in	fusion d	evice.						
17	Deposi	ted the e	mpty iv	containe	r in a line	ed waste	bin.							
18	Checke	d that pa	atient is i	in a comf	ortable _l	position.								
19	Docum	ented th	e proced	dure in th	e medic	ation cha	irt.							
20	Return	ed the ed	quipmen	t to dedi	cated are	ea.								
21	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.								
						1. Sł	KILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-8	9-10	11-13	14-15	16-17	18-19	20-21	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				<u>F</u>			U	N	S	С	ı	Skill level a	chieved	
		1 100/		1				ECTS EV			4.00/	T .	= 100/	
Failed	Rationa	ale 10%	-	Failed	Patient F	ocus10%	1	Failed	essional	Manner:		Failed+10	Time10%	
	factory		5 6		factory		5 6	Unsatis	factory		5 6	Unsatisfa		5 6
Novice	stactory		7	Novice	nactory		7	Novice	nactory		7	Novice	+6	7
Superv	ised		8	Superv	ised		8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:												Time allov	wed (TA)	15
												Time achie	ved	
												Aspects poir	nts achieved	
				;	3. COI	MPLETE	PROCE	OURE EV	ALUATI	ON 1009	%			
≤5	50	51-	-60	61	-70	71	-80	81	-90	91-1	100	Total points	s achieved	
Fai	led	Unsatis	factory	Nov	vice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer	nt					Signat	ure							
Teach	er					Signat	ure					Actual Ma	ark/Out of	
Clinica	l Area					Date								

COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION **Procedure Evaluation Document (PED)** PROCEDURE: Medication - changing IV infusion set Code 15-28 Not No. **Skill steps** Achieved achieved 1 Prepared procedure equipment. Medication chart New IV infusion set Gloves Gauze Tape Hand rub gel Plastic tray 2 Identified the patient using two identifiers.

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3	Perforn	ned gree	ting, intr	oductio	n and per	rmission	procedu	re (G.I.P)							
4	Explain	ed the pi	rocedure	e to the p	oatient ar	nd answe	ered any	question	S.						
5	Perforn	ned hand	hygiene	e using c	orrect te	chnique									
6	Prepare	ed the ga	uze and	tape for	changin	g dressin	g.								
7	Opened	the nev	v packag	e contai	ning the	tubing a	nd stretc	hed the t	ubing.						
8	Tighter	ed the ro	oller clar	np.											
9	Remov	ed the so	lution co	ontainer	from sus	pension	hook wi	th the tul	oing still	attached	ł.				
10	Inverte	d the sol	ution co	ntainer a	and pulle	d the spi	ke free.								
11	Secure	d the spil	ke to the	IV pole	with strip	os of pre	viously to	orn tape.							
12	Inserte	d the spil	ke from	the new	tubing in	to cont	ainer of s	solution.							
13	Squeez	ed the di	rip cham	ber to fi	ll it half f	ull.									
14	Opened	the roll	er clamp	, purged	l the air f	rom the	tubing w	ithout sp	illing the	e fluid.					
15	Remov	ed the ta	pe and c	dressing	from the	iv cannu	ıla site.								
16	Put on	gloves.													
17	Tighter	ed the ro	oller clar	np on th	e expired	tubing.									
18	Tightened the roller clamp on the expired tubing. Stabilized the iv cannula and separated the tubing from it. Removed the cap from the end of the new tubing and attached it to the end of cannula.														
19	Remov	ed the ca	p from t	he end o	of the nev	w tubing	and atta	ched it to	the en	d of canr	ıula.				
20	Released the roller clamp on the new tubing. Replaced the dressing on the vinepuncture site, and secured tubing.														
21															
22															
23	Wrote the date, time on the tape and attached it to the tubing.														
24	Disposed of the expired tubing in a lined waste bin.														
25	Disposed of the expired tubing in a lined waste bin. Removed gloves.														
26	Perforn	ned hand	d hygiene	e using c	orrect te	chnique.									
27	Docum	ented th	e procec	dure and	result.										
28	Return	ed equip	ment to	the dedi	cated are	ea.									
						1. SI	KILL EVA	LUATIO							
Steps	0	1-3	4-6	7-9	10-12	13-14	15-17	18-20	21-23	24-26	27-28	Skill steps			
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points			
Level				F	2 00	OCEDII	U U	N CTC FV	S	C		Skill level a	ichieved		
	Rationa	alo 109/		1	2. PR Patient F			CTS EV		Manner		I	Time10%		
Failed	Nationi	ile 1076	5	Failed	ratientr	ocus ₁₀ /	5	Failed	essional	IVIAIIIIEI	5	Failed+10		5	
Unsatis	factory		6	-	sfactory		6		factory		6	Unsatisfa		6	
Novice			7	Novice			7	Novice			7	Novice	+6	7	
Supervi	ised		8	Superv	ised		8	Superv	ised		8	Supervise	ed +4	8	
Compe			9	Compe			9	Compe	tent		9	Compete	nt +2	9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10	
Notes:												Time allov	ved (TA)	15	
												Time achie	ved		
												Aspects poir	nts achieved		
					3. CON	MPLETE	PROCEI	OURE EV	ALUATI	ON1009	%				
≤5	3. COMPLETE PROCEDURE EVALUATION 100% ≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved														
Fai	Failed Unsatisfactory Novice Supervised Competent Independent Total level achieved														
Studer	nt					Signat	ure								
Teache	er					Signat	ure					Actual Ma	ark/Out of		
Clinica	l Area					Date									

PROCE	DURE:				Medic	ation -	discont	inuing	iv infus	ion			Code	15-29
No.							Skill ste	eps					Not achieved	Achieved
1	Prepare	ed proce		-										
				ation cha	ırt									
			Gloves											
			Gauze											
			Tape											
			Scissor											
			Hand r Plastic	_										
2	Identifi	ed the pa			dentifier	·S.								
3		ned gree					procedu	re (G.I.P)						
4	Explain	ed the pi	rocedure	to the p	atient ar	nd answe	ered any	question	S.					
5	Perforn	ned hand	l hygiene	using co	orrect te	chnique.								
6	Clampe	d the tul	oing and	removed	the tap	e that ho	olds the	dressing	and iv ca	nnula in	place.			
7	Put on	gloves.												
8	Pressec	the gau	ze squar	e gently	over the	site whe	ere iv car	nula ent	ered the	skin.				
9	Remov	oved the iv cannula.												
10	Applied	l pressur	e to the	site for 3	0 to 45 s	econds v	while ele	vating th	e forearr	n.				
11	Secure	d the gau	ze with t	tape.										
12	Dispose	ed the iv	cannula	in a shar	ps conta	iner.								
13	Remov	ed gloves	5.											
14		ned hand		using co	orrect te	chnique.								
15		ented th												
16		ed abnor	•				care pro	ovider.						
								LUATIO	N 60%					
Steps	0	1	2	3-4	5-6	7-8	9-10	11-12	13-14	15	16	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level			F	=			U	N	S	С	I	Skill level a	chieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%				
	Rationa	ale 10%		ı	Patient F	ocus10%	<u></u>	Profe	essional	Manner:	10%		Time10%	
Failed			5	Failed			5	Failed			5	Failed+10		5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	ctory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi	sed		8	Supervi			8	Superv			8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10
Notes:												Time allov	ved (TA)	10
												Time achie	ved	
											.,	Aspects poir	ts achieved	
			60			1		OURE EV						
<u>≤</u> 5		51-		61-			-80	81-		91-1		Total points		
Fail		Unsatis	iactory	Nov	rice		rvised	Comp	etent	Indepe	naent	Total level	acnieved	
Studer						Signat		-				A	l./0	
Teache						Signati	ure	1				Actual Ma	ark/Out of	
Clinica	ı Area					Date]						

					Proced	ure Eva	luation	1 Docur	nent (P	ED)				
PROCE	DURE:				Med	dicatio	ns – dr	ug calc	ulation	าร			Code	15-30
No.						SI	kill step	s					Not achieved	Achieved
Dosage	calculat	ions												
1	A patier you dra	nt require w up?	es () mg of N	1orphine	IVI. Mor	phine is	available	as 10mg	g/ml. Hov	w many	mls will		
2	Gentam draw up) mg is	prescrib	ed. Gent	amycin i	s availab	le as 80n	ng/2ml. H	How mar	ny mls v	vill you		
3	Haloper	idol () mg IV	l is charte	ed. Halop	peridol is	available	e as 5mg,	/ml. How	many m	nls is re	quired?		
4	Frusem	ide () mg IVI	is charte	d. Stock	dose is 2	0mg/ml.	How ma	ny ml wo	ould you	give?			
Metric	conversi	ons												
5	Atropin	e 0.6 mg	= ? mcg	5										
6	Gentarr	ycin 360)mg = ? g	gm										
7		125mcg												
8		ed dose		mg/kg										
		s weight		<i>0,</i> 0										
		the dose	_	ed?										
Infusio	n flow ra	tes												
9	A 1L ba	g is to be	infused	over () hours	. Calculat	e how m	any mls	per hour	the pati	ent will	receive.		
10		g is to be			-			nany mls						
11			r would	a natient	receive	if they w	ere to h	ave 500n	ol of fluid	Linfused	over () hours?		
12				d 15mg/k						imasca	0,00	/ Hours:		
	-	-		l dose pe		-	it weight	, , , , ,						
				tient rec			·s?							
Drop pe	er minute					7								
13				d a 1000	ml infusi	on of 5%	Glucose	to be giv	ven over	() hc	ours.			
	-	-						e the dro			e will re	ceive.		
14		-						e given ov ne drops			ill rocoi	VΔ		
15								oride 0.9						
13	-	ven over		ours.		011 01 00	u.u c	01140 013	70 111611	0 11111013		a331a111		
	_				s per mir	nute). cal	culate th	ne drops	oer minu	tes he w	ill recei	ve.		
	<u> </u>		<u> </u>	<u> </u>	<u>'</u>			LUATIO						
Steps	0	1	2	3	4-5	6-7	8-9	10-11	12-13	14	15	Skill steps a	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level			ſ	F		I	U	N	S	С	I	Skill level a		
					2. PR	OCEDU	RE ASPE	CTS EVA	LUATIO	N 40%				
	Rationa	le 10%		F	Patient F	ocus 10%	6	Profe	ssional I	Manner :	10%		Time 10%	
Failed			5	Failed			5	Failed			5	Failed	+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa	ctory+8	6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi	sed		8	Supervi	ised		8	Supervi	sed		8	Supervise	ed +4	8
Compe	tent		9	Compe			9	Compe	tent		9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	lent TA	10
Notes:												Time allov		10
												Time achie	ved	
												Aspects poin	ts achieved	

		3. CON	IPLETE PROCED	URE EVALUATION	ON 100%						
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved					
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved					
Student			Signature								
Teacher			Signature			Actual Mark/Out of					
Clinical Area											

PROC	EDURE: Medication - Blood transfusion	Code	15-31
No.	Skill steps	Not achieved	Achieved
1	☐ Patient medical record		
	☐ Vital signs chart		
	☐ Thermometer		
	☐ Sphygmomanometer		
	☐ Stethoscope		
	☐ Blood transfusion form		
	☐ Blood product		
	□ Normal Saline		
	☐ IV fluids administration set		
	☐ Blood administration set		
	☐ 16-20 gauge cannula		
	□ Normal saline flush (syringe with 5-10ml of Normal Saline_		
	☐ Alcohol swab or disinfecting solution		
	Gauze		
	☐ Tape or iv cannula dressing		
	☐ Tourniquet		
	☐ Three way stop-cock		
	□ Non-sterile gloves		
	Plastic bag for empty blood product bagHand rub gel		
	□ Plastic tray		
2	Verified the medical order for transfusion of a blood product.		
3	Verified the completion of informed consent documentation in the medical record.		
4	Verified any medical order for pre-transfusion medication.		
5	Performed hand hygiene using correct technique.		
6	· · · · · · · · · · · · · · · · · · ·		
7	Identified patient using two identifiers.		
8	Performed greeting, introduction and permission procedure (G.I.P).		
9	Provided privacy.		
10	Explained the procedure to the patient and answered any questions.		
11	Advised patient to report any chills, itching, rash, or unusual symptoms.		
12	Adjusted the height of the bed.		
13	Obtained baseline set of vital signs before beginning transfusion.		
	Documented the vital signs in the vital signs chart.		
14	Put on gloves.		
15	Prepared Normal saline administration set correctly.		
16	Connected three-way stop-cock to the iv fluid administration set and primed the set.		
17	Checked the venous access site for any signs of inflammation or infection.		
18	Checked the type of the iv cannula. If the cannula is too small (should be 16-20 gauge, ideally 18),		

	replaced the cannula using correct procedure.													
19	Connec	ted thre	e-way sto	op-cock t	o the ca	nnula.								
20	Started	normal	saline inf	fusion.										
21	Asked a	nother r	nurse to	compare	and vali	date the	followin	g inform	ation wit	h the me	dical re	cord,		
	patient	identific	ation ba	nd, and t	he label	of the bl	ood prod	duct:						
			□ M	edical or	der for t	ransfusio	n of blo	od produ	ct					
				formed c										
			□ Pa	itient ide	ntificatio	on numb	er							
				itient nai	_									
				ood grou	-	pe								
	☐ Expiration date ☐ Inspection of blood product for clots													
22	61 1					•		5						
23			•	Normal				-: :	46	-:\				
24				istration			serting sp	oike into	the cont	ainer).				
25				until the			caturata							
26									,					
27							•	stop-cock or the firs		utos)				
28				for the fi					St 13 IIIII	utesj.				
29			•					n time of	. A hours					
30			•	p rate or			maximur	n time oi	4 nours	!				
31							di	ft						
32	•			ite for si	_				or any II	nusual co	mmont	ts (verbal		
32	report).	-	atient ioi	ilusiilig	, uyspiic	ea, ittiii	iig, iiives	Oi Tasii,	or arry u	ilusuai CC	Jiiiiieiii	is (verbar		
33			l signs af	ter 15 m	inutes fr	om starti	ng the ir	nfusion a	nd everv	15 minu	tes afte	r for the		
	Reassessed vital signs after 15 minutes from starting the infusion and every 15 minutes after for the first hour.													
34	Reassessed vital signs and patient's condition every hour at 2nd, 3rd, 4th hour (verbal report).													
35	Notified medical staff if any transfusion reaction occurred (verbal report).													
36	The state of the s													
37	Restart	ed Norm	al Saline	infusion										
38	Disconr	nected th	ne blood	transfusi	on set fr	om the t	hree-wa	y stop-co	ck and c	apped.				
39	Put em	pty blood	d produc	t bag and	set to t	he plasti	c bag.							
40	Assesse	d patien	t's vital s	signs (4 th	hour).									
41	Discont	inued ar	nd discon	nected t	he Norm	al Saline	infusion							
42	Checke	d patient	t's comfo	ort.										
43		ed gloves												
44				ited locat	tion.									
45	Sent th	e empty	blood ba	ng back ir	nto the la	boratory	y/blood l	oank.						
46	Perforn	ned hand	d hygiene	using co	orrect te	chnique.								
						1. SK	ILL EVA	LUATIO	N 60%					
Steps	0	1-5	6-10	11-15	16-21	22-23	24-29	30-34	35-39	40-44	45-46	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level			F	=			U	N	S	С	ı	Skill level a	chieved	
				_				CTS EVA						
T-il-d	Rationale 10% Patient Focus 10% Professional Manner 10%									E-UI	Time 10%	-		
Failed							5	Failed	.ft		5	Failed	+10	5
Novice	ractory		6 7	Novice	ractory		6 7	Novice	factory		6 7	Unsatisfactory+8 Novice +6		6 7
Supervi	sed		8	Supervi	sed		8	Superv	ised		8	Supervise		8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:												Time allov		30
												Time achie		
												Aspects poir		

	3. COMPLETE PROCEDURE EVALUATION 100%												
≤50	≤50 51-60 61-70 71-80 81-90 91-100 Total points achieved												
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved							
Student			Signature										
Teacher			Signature			Actual Mark/Out of							
Clinical Area			Date										

Medication Chart 1

Medication Chart 2

PROCI	EDURE: Collection of specimens – nasal swab												Code	16-01
No.							Skill ste	eps					Not achieved	Achieved
1	Prepare	d proced	dure equ	ipment:										
		Patient	medical	record										
		Gloves												
		Disposa	able apro	on										
		Nasal s	wab in a	collection	n tube									
		Labora	tory requ	uest form	า									
		Hand r												
		Plastic	sealable	bag for t	he speci	men								
		Plastic	tray											
2	Review	ed the m	edical o	rders for	collectio	n of sput	tum snec	rimen						
3						-	tum spec							
4	Performed hand hygiene using correct technique. Identified patient using two identifiers.													
5	Performed greeting, introduction and permission procedure (G.I.P).													
6	Explained the procedure to the patient and answered any questions.													
7	Provided privacy.													
8	Labelled the specimen tube with a label that contained patient's name and identification number, time specimen was collected, route of collection, identification of the person obtaining the sample.													
9						lection, i	identifica	ation of t	ne perso	n obtain	ing the	sampie.		
10				sable apr		a ck								
11	Asked the patient to tip his or her head back. Removed the swab from the collection tube without touching any surface.													
12														
13				ximatery	2-3011111	ILO Halis	and rota	iteu tile :	swab.					
14														
15			and oth		tion tube	e, taking	care not	to touch	any our	ersuriac	е.			
16					astic hag	without	contami	nating th	na outsid	of the	haσ			
17					orrect te		Containi	mating ti	ie outsiu	e or the	Jag.			
18							r chackar	d it if alre	adv fille	4				
19		-									snacim	en in the		
13		-			ident ver		-	iiiiiieaie	ately of f	cept the	эреспп	en in the		
20					tient's no		,							
21				•	cated are									
		<u> </u>					(ILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-4	5-6	7-8	9-10	11-13	14-15	16-17	18-19	20-21	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				=			U	N	S	С	I	Skill level a	chieved	
								CTS EV				T		
	Rationa	le 10%			Patient F	ocus10%			essional	Manner:			Time10%	
Failed							5	Failed	<u> </u>		5	Failed+10		5
	Insatisfactory 6 Unsatisfactory Iovice 7 Novice						6		factory		6	Unsatisfa		6
Novice	icod		8	Novice	icod		7 8	Novice	icad		7	Novice Supervise	+6	7 8
Supervi			8 9	Supervi Compe			9	Supervi Compe			8 9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:				асре								Time allow		10
												Time achie		
												Aspects poir	its achieved	

	3. COMPLETE PROCEDURE EVALUATION 100%												
≤50	51-60 61-70 71-80 81-90 91-100 Total points achieved												
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved							
Student			Signature										
Teacher			Signature			Actual Mark/Out of							
Clinical Area			Date										

PROC	EDURE: Collection of specimens – sputum	Code	16-02
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	□ Gloves		
	□ Mask		
	☐ Sputum specimen container		
	☐ Laboratory request form		
	☐ Hand rub gel		
	☐ Plastic sealable bag for the specimen		
	□ Plastic cup		
	Plastic tray Povious of the modical orders for collection of courtum specimen		
2	Reviewed the medical orders for collection of sputum specimen.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Labelled the specimen container with a label that contained patient's name and identification		
	number, time specimen was collected, route of collection, identification of the person obtaining the		
7	sample.		
	Provided privacy.		
8	Explained the procedure to the patient and answered any questions.	 	
9	Adjusted the height of the bed.		
10	Assisted the patient to a semi-Fowler's position		
11	Put on gloves, mask and goggles if appropriate		
12	Asked the patient to clear nose and throat and rinse mouth with water before beginning procedure.		
13	Instructed the patient to inhale deeply two or three times and cough with exhalation.		
14	When the patient produced sputum, opened the lid to the container and asked the patient to		
4.5	expectorate the specimen into container.		
15	Closed the lid to container.		
16	Offered oral hygiene to the patient.		
17	Restored patient to a comfortable position.		
18	Removed gloves and other PPE.		
19	Placed the specimen container in a plastic bag without contaminating the outside of the bag.		
20	Performed hand hygiene using correct technique.		
21	Correctly filled in the laboratory request form/s or checked it if already filled.		
22	Ensured the specimen was transported to the laboratory immediately or kept the specimen in the		
	fridge if not contraindicated. (student verbal report)	<u> </u>	
23	Documented the result in the patient's notes.		
24	Returned equipment to the dedicated area.		
25	Reported abnormal findings to the appropriate health care provider (student verbal report).]

						1. Sł	KILL EVA	LUATIO	N 60%				
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level				F			U	N	S	С	I	Skill level achieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%			
Rationale 10% Patient Focus 10% Professional Manner 109							10%	Time10%					
Failed			5	Failed			5	Failed			5	Failed+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory+8	6
Novice 7 Novice						7	Novice			7	Novice +6	7	
Supervi	ised		8	Superv	ised		8 Supervised			8 Supervised		8	
Compe	tent		9	Compe	tent		9	Compe	tent		9	Competent +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independent TA	10
Notes:												Time allowed (TA)	10
												Time achieved	
												Aspects points achieved	
					3. CON	MPLETE	PROCE	OURE EV	/ALUATI	ON1009	%		
≤5	50	51	-60	61	-70	71-	-80	81	-90	91-1	100	Total points achieved	
Fai	Failed Unsatisfactory Novice Supervised Competent Independe		ndent	Total level achieved									
Studer	Student			Signature									
Teache	Гeacher			Signature				Actual Mark/Out of					
Clinica	Clinical Area				Date								

PROC	EDURE: Collection of specimens – stool	Code	16-03
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	□ Gloves		
	☐ Disposable apron		
	☐ Stool specimen container		
	☐ Laboratory request form		
	☐ Hand rub gel		
	☐ Plastic sealable bag for the specimen		
	□ Plastic tray		
2	Reviewed the medical orders for collection of sputum specimen.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Explained the procedure to the patient and answered any questions.		
7	Labelled the specimen container with a label that contained patient's name and identification		
	number, time specimen was collected, route of collection, identification of the person obtaining the		
	sample.		
8	Provided privacy if bedpan used or helped the patient to the bathroom (commode)		
9	Put on gloves and disposable apron.		
10	Asked the patient to pass urine first.		
11	When the patient produced stool, opened the lid to the container and obtained the sample with the		
	plastic spoon attached to the lid of the container.		
12	Closed the lid to container.		
13	Removed gloves and other PPE.		

														143
14	Placed	the spec	imen cor	ntainer ir	a plasti	c bag wit	hout cor	ntaminati	ng the o	utside of	the ba	g.		
15	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.								
16	Correct	ly filled i	n the lab	oratory	request 1	form/s o	r checke	d it if alre	ady fille	d.				
17		•			•		•	immedia	itely or l	cept the	specim	en in the		
	fridge i	f not con	traindica	ated. (stu	dent ver	rbal repo	rt)							
18	Docum	ented th	e result i	in the pa	tient's no	otes.								
19	Return	ed equip	ment to	the dedi	cated are	ea.								
20	Report	ed abnor	mal find	ings to th	ne appro	priate he	alth care	e provide	r (studer	nt verbal	report)			
1. SKILL EVALUATION 60%														
Steps												Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F			U	N	S	С		Skill level a	chieved	
2. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus10% Professional Manner10% Time10%														
				Patient F	ocus10%			essional	Manner:		F '1 1 4	Time10%		
Failed	£+		5	Failed	f+		5	Failed	f		5	Failed+10		5 6
Novice	sfactory		6 7	Unsatis Novice	ractory		6 7	Unsatis Novice	ractory		6 7	Unsatisfa Novice	+6	7
Supervi	ised		8	Supervi	sed		8	Superv	sed		8	Supervise	<u> </u>	8
Compe			9	Compe			9	Compe			9	Compete		9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:							·				·	Time allov	ved (TA)	10
												Time achie	ved	
												Aspects poir	nts achieved	
					3. CON	MPLETE	PROCE	URE EV	ALUATI	ON1009	%			
≤5	50	51-	-60	61-	-70	71-	-80	81-	90	91-1	L00	Total points	achieved	
Fai	niled Unsatisfactory Novice		/ice	Super	rvised	Comp	etent	Indepe	ndent	Total level	achieved			
Studer	ent				Signat	ure						<u>-</u>		
Teach	cher				Signature						Actual Ma	ark/Out of		
Clinica	l Area	Area Date												

	Procedure Evaluation Document (PED)											
PROCE	DURE:	Collection of specimens – urine specimen - catheter	Code	16-04								
No.		Skill steps	Not achieved	Achieved								
1												
	Prepare	d procedure equipment:										
		Patient medical record										
		Gloves										
		Urine specimen container										
		Clamp										
		10ml syringe and needle										
		Sharps box										
		Alcohol swabs or gauze and disinfecting solution										
		Laboratory request form										
		Hand rub gel										
		Plastic sealable bag for the specimen										
		Plastic tray										
2	Review	ed the medical orders for collection of urine specimen from catheter.										
3	Performed hand hygiene using correct technique.											
4	Identifi	ed patient using two identifiers.	·	·								

5							procedu							
6		-				-						pecimen		
	was co	llected, r	oute of o	collection	n, identif	ication o	f the per	son obta	ining the	sample.				
7		ed privac	•											
8			rocedure	e to the p	oatient a	nd answe	ered any	question	ıs.					
9	Put on													
10	-			_	_		oack on it		-					
			•		•		e tubing		n clampe	d up to 3	30 minu	ites, to		
11							indicated		0.000401		id fraa i			
11		ed the iid nination.	•	becimen	containe	я, кеерп	ig the ins	side or tri	e contan	ier and i	iu iree i	TOTTI		
12			oiration p	ort with	alcohol	wine								
13			rt to air o		alconor	wipe.								
14					into the	nort or a	attached	the syrin	ge to the	needlel	ess nor			
15	Inserted the needle and syringe into the port, or attached the syringe to the needleless port. Slowly aspirated 10ml of urine for specimen.													
16	Removed the needle or syringe from the port.													
17				· -		•	n the ne	edle care	fully and	disnosa	d the n	edle in		
''	If a needle was used on the syringe, removed from the needle carefully and disposed the needle in the sharps box.													
18			urine int	o the sp	ecimen c	ontainer	·.							
19			d on cont	·										
20	•				ed waste	e bin.								
21	Disposed of the syringe in the lined waste bin. Placed the container in a plastic sealable bag without contaminating outside of the bag.													
22	Placed the container in a plastic sealable bag without contaminating outside of the bag. Removed gloves.													
23	Performed hand hygiene using correct technique.													
24	Correctly filled in the laboratory request form/s or checked it if already filled.													
25	Ensured the specimen was transported to the laboratory as soon as possible or kept the specimen in													
	the fridge if not contraindicated. (student verbal report)													
26			e result											
27	Return	ed equip	ment to	the dedi	cated ar	ea.								
						1. SI	KILL EVA	LUATIO	N 60%					
Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	- 1	Skill level a	chieved	
				1			RE ASPE							
	Rationa	ale 10%	T		Patient F	ocus109			essional	Manner	1		Time10%	
Failed	•		5	Failed	•		5	Failed			5	Failed+10		5
Unsatis	factory		6	1	sfactory		6		factory		6	Unsatisfa	•	6
Novice	isad		7	Novice Superv			7	Novice			7	Novice	+6	7
Supervi Compe			8	Compe			8	Superv Compe			8	Supervise Compete		<u>8</u> 9
Indepe			10	Indepe			10	Indepe			10	Independ		10
Notes:	- Ideiit		10	шасре	inaciic		10	тасре			10	Time allow		15
														13
												Time achie		
	3 60						DDCCE	אווסר בי	/AII!AT	ON4.000	1/	Aspects poir	its achieved	
					PROCEI					Tatal	a a bizzzz			
	≤50 51-60 61-70 Failed Unsatisfactory Novice			ļ	80		-90	91-2		Total points				
		Unsatis	stactory	No	vice	•	rvised	Comp	etent	Indepe	naent	Total level	acnieved	
Studen					Signat		1				A street Marris (Out of			
Teache						Signat	ure	-				Actual Mark/Out of		
Ciinica	cal Area Date													

PROCI	EDURE: Collection of specimens – urine specimen - midstream	Code	16-05
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment: Patient medical record Gloves Urine specimen container Laboratory request form Hand rub gel Plastic sealable bag for the specimen Basin with water if procedure performed by the bedside Washcloths or disposable wipes Plastic tray		
2	Reviewed the medical orders for collection of sputum specimen.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Prepared the label for the specimen container with the patient's name and identification number, time specimen was collected, route of collection, identification of the person obtaining the sample.		
7	Provided privacy.		
8	Explained the procedure to the patient and answered any questions.		
9	Assisted the patient to the bathroom or onto the bedside commode or bedpan.		
10	Gave the following instructions to the female patient: - Wash the genital area with washcloth. - Clean each side of urinary meatus (opening) with disposable wipes, one wipe for each side. - Clean over the urinary meatus (opening) with a new disposable wipe. - Void small amount of urine into toilet, commode or bedpan and stop. - Void 10-20ml of urine into a container and stop. - Finish voiding into the toilet, commode or bedpan. - Do not touch the inside of the container or a lid. Gave the following instructions to the male patient: - Wash tip of the penis in circular motion away from urinary meatus (opening) - Uncircumcised patients should retract the foreskin before the cleaning the area. - Void small amount of urine into toilet, commode or bedpan and stop. - Void 10-20ml of urine into a container and stop. - Finish voiding into the toilet, commode or bedpan. - Do not touch the inside of the container or a lid.		
11	Placed the lid on container.		
12	Placed the label on the container.		
13	Placed the container in plastic, sealable bag.		
14	Assisted the patient from the bathroom, off the commode, or off the bedpan.		
15	Removed gloves.		
16	Performed hand hygiene using correct technique.		
17	Correctly filled in the laboratory request form/s or checked it if already filled.		
18	Ensured the specimen was transported to the laboratory as soon as possible or kept the specimen in		
10	the fridge if not contraindicated. (student verbal report)		
19	Documented the result in the patient's notes.		
20	Returned equipment to the dedicated area.		
21	Reported abnormal findings to the appropriate health care provider (student verbal report).		

						1. Sł	KILL EVA	LUATIO	N 60%				
Steps	0	1-2	3-4	5-6	7-8	9-10	11-13	14-15	16-17	18-19	20-21	Skill steps achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level				F			U	N	S	С	I	Skill level achieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%			
	Rationa	ale 10%			Patient F	ocus10%	6	Prof	essional	Manner	10%	Time10%	
Failed			5	Failed			5	Failed			5	Failed+10	5
Unsatis	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfactory+8	6
Novice			7	Novice			7	Novice			7	Novice +6	7
Supervi	ised		8	Superv	ised		8	Superv	ised		8	Supervised +4	8
Compe	tent		9	Compe	tent		9	Competent		9	Competent +2	9	
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independent TA	10
Notes:												Time allowed (TA)	15
												Time achieved	
												Aspects points achieved	
					3. CON	MPLETE	PROCE	OURE EV	'ALUATI	ON1009	%		
≤5	50	51	-60	61	-70	71	-80	81	-90	91-1	100	Total points achieved	
Fai	led	Unsatis	factory	No	/ice	Supe	rvised	Comp	etent	Indepe	ndent	Total level achieved	
Studer	nt					Signat	ure	_			-		
Teache	er					Signat	ure					Actual Mark/Out of	
Clinica	l Area					Date							

_	Procedure Evaluation Document (PED)		
PROCI	EDURE: Collection of specimens – throat swab	Code	16-06
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	□ Gloves		
	☐ Disposable apron		
	☐ Throat swab in a collection tube		
	☐ Laboratory request form		
	☐ Hand rub gel		
	☐ Plastic sealable bag for the specimen		
	□ Plastic tray		
2	Reviewed the medical orders for collection of sputum specimen.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Explained the procedure to the patient and answered any questions.		
7	Provided privacy.		
8	Labelled the specimen tube with a label that contained patient's name and identification number,		
	time specimen was collected, route of collection, identification of the person obtaining the sample.		
9	Put on gloves and disposable apron.		
10	Asked the patient to tip his or her head back.		
11	Removed the swab from the collection tube without touching any surface.		
12	Asked the patient to open mouth and inserted the swab into mouth.		
13	Carefully swabbed the tonsilar pillars as the sampling may cause difficulty breathing or retching.		
14	Removed the swab.		
15	Inserted the swab into the collection tube, taking care not to touch any other surface.		

														17/	
16	Remov	ed glove:	s and oth	ner PPE.											
17	Placed	the spec	imen tub	e in a pla	astic bag	without	contami	nating th	e outsid	e of the	bag.				
18	Perforr	ned hand	d hygiene	e using co	orrect te	chnique.									
19	Correct	ly filled i	n the lab	oratory	request 1	form/s o	r checked	d it if alre	ady fille	d.					
20	Ensure	d the spe	ecimen v	vas trans	ported t	to the lal	ooratory	immedia	ately or I	cept the	specim	en in the			
	fridge i	f not con	traindica	ated. (stu	dent ver	rbal repo	rt)								
21	Docum	ented th	e result i	n the pa	tient's no	otes.									
22	Return	ed equip	ment to	the dedi	cated are	ea.									
						1. Sł	(ILL EVA	LUATIO	N 60%						
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-16	17-18	19-20	21-22	Skill steps a			
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points			
Level	1 0 11 0 11 0 11										chieved				
				1	2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%			Time10%		
	Rationa	ale 10%			Patient F	ocus10%		_	essional	Manner			5		
Failed	_		5	Failed			5	Failed			5		Failed+10		
	factory		6	Unsatis	factory		6	Unsatis	factory		6	Unsatisfa		6	
Novice	:d		7	Novice			7	Novice	in a d		7	Novice	+6	7	
Supervi			8 9	Supervi			8	Supervi Compe			8 9	Supervise Compete		8	
Indepe			10	Indepe			10	Indepe			10	Independ		10	
Notes:	nuent		10	шиере	ilueilt		10	шиере	ilueilt		10			15	
												Time allov		12	
												Time achie	ved		
												Aspects poin	ts achieved		
						MPLETE						T			
	50	51-	-60	61-	-70	71-	-80	81-	-90	91-1	100	Total points	achieved		
Fai	led	Unsatis	factory	Nov	/ice	Super	vised	Comp	etent	Indepe	ndent	Total level	achieved		
Studer	nt					Signat	ure								
Teache	er					Signat	ure					Actual Ma	rk/Out of		
Clinica	l Area					Date									

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	Procedure Evaluation Document (PED)		
PROC	EDURE: Collection of specimens – ear swab	Code	16-07
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	□ Gloves		
	☐ Ear swab in a collection tube		
	☐ Laboratory request form		
	☐ Hand rub gel		
	☐ Plastic sealable bag for the specimen		
	□ Plastic tray		
2	Reviewed the medical orders for collection of sputum specimen.		
3	Performed hand hygiene using correct technique.		
4	Identified patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Explained the procedure to the patient and answered any questions.		
7	Provided privacy.		
8	Labelled the specimen container with a label that contained patient's name and identification		

														140
	numbe	r, time s	oecimen	was coll	ected, ro	ute of co	ollection	, identific	ation of	the pers	on obta	aining the		
	sample	•												
9	Put on	gloves.												
10				n head to										
11	Remov	ed the sv	vab from	the coll	ection tu	be witho	out toucl	ning any s	surface.					
12	Inserte	d the swa	ab into e	ar canal.										
13	Rotated	d the swa	ab to col	lect inne	r ear dra	inage.								
14	Remov	ed the sv	vab.											
15	Inserte	d the swa	ab into t	he collec	tion tube	e, taking	care not	to touch	any oth	er surfac	e.			
16	Remov	ed gloves	S.											
17	Placed	Placed the specimen container in a plastic bag without contaminating the outside of the bag.												
18	Perforn	ormed hand hygiene using correct technique.												
19								d it if alre						
20		ured the specimen was transported to the laboratory immediately or kept the specimen in the												
				ated. (stu			rt)							
21				in the pa										
22	Returne	ed equip	ment to	the dedi	cated are									
				ı	T	ı — — — — — — — — — — — — — — — — — — —		ALUATIO		T	1	1	<u></u>	1
Steps	0	1-2	3-4	5-6	7-9	10-11	12-14	15-16	17-18	19-20	21-22	Skill steps		
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points		
Level				F	2. PR	OCEDII	U U	N ECTS EV	S	C		Skill level a	cnieved	
	Rationa	do 10%		Ι .		ocus10%			essional				Time10%	
Failed	Nationa	ile 10/6	5	Failed	ratient	ocus ₁₀ /	5	Failed	essionai	iviaiiiei	5	Failed+10		5
	sfactory		6		factory		6	Unsatis	factory		6	Unsatisfa		6
Novice	-		7	Novice	nactor y		7	Novice	, accory		7	Novice	+6	7
Superv			8	Superv	ised		8	Superv	ised		8	Supervise	ed +4	8
Compe	tent		9	Compe	tent		9	Compe	tent		9	Compete	nt +2	9
Indepe	ndent		10	Indepe	ndent		10	Indepe	ndent		10	Independ	dent TA	10
Notes:												Time allov	ved (TA)	10
												Time achie	ved	
												Aspects poir	nts achieved	
						1		DURE EV						
	50		-60	†	-70		-80		-90	91-		Total points		
-	iled	Unsatis	factory	Nov	vice	_	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signat						1		
Teache						Signature			Actual Ma	ark/Out of				
Clinica	Il Area					Date								

HAWLER MEDICAL UNIVERSITY COLLEGE OF NURSING LABORATORY AND CLINICAL EDUCATION **Procedure Evaluation Document (PED)** PROCEDURE: Collection of specimens - wound culture Code 16-8 Not No. Skill steps Achieved achieved 1 Prepared procedure equipment: Patient medical record Wound culture swab Sterile pack containing gauze, solution container, basin

		Norma	ıl saline c	or other i	rrigating	solution	as per n	nedical o	rder					
		Clean g	gloves											
		Sterile	_											
		Syringe	es											
		Tape												
		Hand r	_											
			bag for v											
				he woun	d culture	e specim	en							
			proof pag	a										
2	Poviou		al trolley	rders for	wound	rulturo								
3														
4				e using co		cnnique.								
		•		two iden				(C D						
5				oduction	and per	mission	proceau	re (G.I.P	<u>. </u>					
6		ed privac	•											
7	-	-		to the p	atient ar	nd answe	ered any	question	is.					
8	_		eight of th		-1-1	:4: 4l	A			ula a dia adai				
9				comfort							ion area	9.		
10			-	ag at a co			n for use	during t	he proce	dure.				
11				under the	incision	area.								
12		clean glo												
13		-	-	noved the	soiled c	Iressings	, used st	erile nor	mal salin	e to help	loosen	the		
1.4		g if need		he woun	4 004 00	252222	amaunt	tuno co	امین ممط	- d	f any dr	oinaga		
14		the cond nt verbal		ne woun	a ana pr	esence,	amount,	type, co	iour and	odour o	r any dr	ainage.		
15				nto the w	zste nla	stic hag								
16		ed glove		into the w	raste pia	otic bag.								
17				e using co	orrect to	chnique								
18				using ase										
_	-	sterile gl		using ast	eptic tec	illique.								
19				n +h o ou	ah an +h		l audtura	+b.o						
20				n the sw			culture	tube.						
21				vab into t				l£						
22				swab se		es over 1	tne wour	na surtac	es.					
23				the cultu		1.6								
24				n top to b						using ne	ew gauz	e for		
25		•		g the use ned, dried										
-						a using s	terne ga	uze III tii	e same v	vay.				
26			•	gauze d										
27				the glove										
28				th the tap				1 .						
29				ing, label				n date an	d time.					
30				nd place	-		ig.							
31		•		mfortabl	•									
32				e using co		•								
33				in the pat										
34				relative i			the resul	t.						
35	Return	ed equip	ment to	the dedic	cated are	ea.								
36	Report	ed abnor	mal find	ings to th	ne appro	priate he	ealth care	e provide	er (studei	nt report	ed this	action		
	verball	y).												
						1. SI	KILL EVA	ALUATIO	N 60%					
Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36	Skill steps	s achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill point	ts achieved	
Level				F			U	N	S	С	I	Skill level	achieved	

			2. PR	OCEDU	RE ASPI	ECTS EVALUATION	ON 40%			
Rationa	ale 10%		Patient F	ocus10%	6	Professional	Manner1	L0%	Time10%	
Failed		5	Failed		5	Failed	5 Failed+10			
Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory		6	Unsatisfactory+8	6
Novice		7	Novice		7	Novice		7	Novice +6	7
Supervised		8	Supervised		8	Supervised		8	Supervised +4	8
Competent		9	Competent		9	Competent		9	Competent +2	9
Independent		10	Independent		10	Independent		10	Independent TA	10
Notes:									Time allowed (TA)	20
									Time achieved	
									Aspects points achieved	
			3. CON	MPLETE	PROCEI	OURE EVALUATI	ON 100%	6		
≤50	51-	60	61-70	71-	-80	81-90	91-1	.00	Total points achieved	
Failed	Unsatisf	factory	Novice	Super	rvised	Competent	Indepe	ndent	Total level achieved	
Student			•	Signati	ure					
Teacher				Signati	ure				Actual Mark/Out of	
Clinical Area				Date						

PROC	EDURE: Collection of specimens - blood - venipuncture	Code	16-09
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	☐ Patient medical record		
	☐ Vacutainer needle		
	☐ Vacutainer holder		
	□ Tourniquet		
	☐ Alcohol swab or gauze and disinfecting solution		
	□ Tubes		
	☐ Gauze and tape or plaster		
	□ Plastic sealable bag		
	□ Sharps box		
2	□ Plastic tray		
	Checked the medical record for the medical order for collection of blood specimen/s.		
3	Filled the request form with all appropriate details.		
4	Identified the patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		
9	Performed hand hygiene using correct technique.		
10	Assisted patient to supine or sitting position.		
11	Asked the patient about preferred site for the procedure based on previous experience.		
12	Assessed the patient for contraindicated sites and risks associated with venipuncture.		
13	Put on gloves.		
14	Assessed the vein using inspection and palpation.		
15	Selected the venipuncture site.		
16	Applied the tourniquet with sufficient pressure to impede venous circulation, but not arterial blood		
	flow.		
17	Located the vein.		

18			nipunctu		ith an ald	cohol swa	ab movin	g in a cir	cular mo	tion out	from th	e site		
			5 cm (2 ir											
19			e to dry c											
20			eedle co					needle.						
21			atient tha											
22			r forefin											
			he patier											
23			r needle			gree ang	le from tl	he patier	nt's arm v	with the	bevel u	р.		
24	•		the nee											
25			cutainer e needle			vanced s	pecimen	tube into	o the nee	edle of th	ie holde	er (did		
26			nen tube			correct	lovol gra	spod Va	cutainor	firmly an	d romo	yod tho		
20			Inserted						Julanier	illilliy all	u remo	veu trie		
27			ed addit						iately Di	d not sh	ako			
28			ng the las		-				lately. Di	u 110t 311	akc.			
29			and remo				i the tou	inquet.						
30			oad over				annlying	nressur	e and di	ıickly hu	t carefu	llv		
			eedle wi	-				, אי כיייטוו	c, and qu	alenty Du	. carera	,		
31			oplied pr					with gau	ze until h	leeding	stoppe	1.		
32			ture site									•		
33			tion tube									ed with		
			necessary	-	- 0									
34	Filled t	ne label o	on the tu	be with	all reque	sted det	ails.							
35			amples a					lable bag	ζ.					
36			ood sam			•				ıdent ve	rbal rep	ort).		
37			nt to a co					<u> </u>						
38		•	d hygiene		•									
39			ie proced											
40			quipmen			•								
			1- 1-				KILL EVA	LUATIC	N 60%					
Steps	0	1-4	5-8	9-13	14-18	19-20	21-25	26-30	31-34	35-38	39-40	Skill steps	achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	achieved	
Level				F			U	N	S	С	ı	Skill level a	achieved	
					2. PR	OCEDU	RE ASPE	CTS EV	ALUATIO	ON 40%				
	Ration	ale 10%	_		Patient F	ocus10%	1		essional	Manner			Time10%	Ī
Failed			5	Failed			5	Failed			5	Failed+10		5
	factory		6		sfactory		6		sfactory		6	Unsatisfa		6
Novice			7	Novice			7	Novice			7	Novice	+6	7
Supervi			8	Superv			8	Superv			8	Supervis		8 9
Compe			9	Compe Indepe			9	Compe Indepe			9	Compete Independ		10
Notes:	nuent		10	шиере	iluelit		10	шиере	nuent		10			
												Time allow		15
												Time achie	eved	
					_							Aspects poi	nts achieved	
							PROCEE							
≤5			-60		-70	1	-80		-90	91-:		Total point		
Fai		Unsatis	sfactory	No	vice	-	rvised	Comp	etent	Indepe	ndent	Total level	achieved	
Studer						Signat						_		
Teache						Signat	ure					Actual M	ark/Out of	
Clinica	l Area					Date								

PROC	EDURE: Collection of specimens - blood - blood cultures	Code	16-10
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment.		
	☐ Patient medical record		
	☐ Vacutainer holder		
	☐ Butterfly needle		
	☐ Blood cultures bottles – aerobic and anaerobic		
	□ Tourniquet		
	☐ Alcohol swab or gauze and disinfecting solution		
	Gauze and tape or plaster		
	□ Plastic sealable bag□ Sharps box		
	□ Plastic tray		
2	Checked the medical record for the medical order for collection of blood specimens for blood		
_	cultures.		
3	Filled the request form with all appropriate details.		
4	Identified the patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Explained the procedure to the patient and answered any questions.		
8	Adjusted the height of the bed.		
9	Performed hand hygiene using correct technique.		
10	Assisted patient to supine or sitting position.		
11	Asked the patient about preferred site for the procedure based on previous experience.		
12	Assessed the patient for contraindicated sites and risks associated with venipuncture.		
13	Put on gloves.		
14	Assessed the vein using inspection and palpation.		
15	Selected the venipuncture site.		
16	Attached the butterfly needle extension tubing to the Vacutainer holder.		
17	Moved collection bottles to a location close to arm, with bottles sitting upright on table top.		
18	Applied the tourniquet with sufficient pressure to impede venous circulation, but not arterial blood		
	flow.		
19	Located the vein.		
20	Cleaned the venipuncture site with an alcohol swab moving in a circular motion out from the site		
	approximately 5 cm (2 inches).		
21	Allowed the site to dry completely.		
22	Removed the butterfly needle cover and maintained sterility of the needle.		
23	Informed the patient that he or she would feel a stick.		
24	Placed thumb or forefinger of non-dominant hand 2.5 cm (1 inch) below the site, and gently pulled		
	and stretched the patient's skin distal to the patient until it was taut and the vein was stabilized.		
25	Held Vacutainer needle at a 15- to 30-degree angle from the patient's arm with the bevel up.		
26	Slowly inserted the needle into the vein.		
27	Grasped the Vacutainer securely, and advanced anaerobic blood culture bottle into the needle of		
20	the holder (did not advance the needle in the vein).		
28	Removed the tourniquet as soon as blood flows adequately into the bottle.		
29	When the sufficient amount of blood entered the bottle, removed it from the holder.		
30	Continued to hold the butterfly needle in place in the vein and inserted the second bottle (aerobic)		
21	to the Vacutainer holder.		
31	Removed the second blood culture bottle from the holder.		

														122		
32	Applied	l gauze p	ad over	the punc	ture site	without	applying	pressur	e, and qu	ickly but	carefu	lly				
	withdre	ew the ne	eedle wit	th Vacuta	iner fro	n the ve	in.									
33	1			essure ov								d.				
34				for bleed												
35				s for any	sign of e	xternal o	contamin	ation wi	th blood.	Deconta	aminate	ed with				
26		ohol if n	•													
36				be with a												
37			· · ·	nd reque		•										
38				ples were			ry imme	diately (s	student v	erbal re	oort).					
39				mfortabl												
40				e using co		•										
41				lure and		•	notes.									
42	Return	ed the ed	quipmen	t to the c	ledicated	l area.										
				ı				LUATIO		ı	T	1		1		
Steps	0-5	6-9	10-13	14-17	18-21	22-25	26-29	30-33	34-37	38-41	42		Skill steps achieved Skill points achieved			
Points	0	6	12	18	24	30	36	42	48	54	60					
Level				F			U	N	S	C		Skill level ac	hieved			
		1		Ι .				CTS EV				1				
F-111	Rationa	ale 10%	_		Patient F	ocus10%		Professional Manner10%			Failed+10	Time10%				
Failed	sfactory		5 6	Failed Unsatis	factory		5 6		Failed Unsatisfactory		5 6	Unsatisfac	rtonu 0	5 6		
Novice			7	Novice	iactory		7	Novice	iactory		7	Novice	+6	7		
Superv			8	Supervi	sed		8	Superv	ised		8	Supervise		8		
Compe			9	Compe			9	Compe			9	Competer		9		
Indepe			10	Indepe			10	Indepe			10	Independe		10		
Notes:				-								Time allow	ed (TA)	15		
												Time achiev	ed			
												Aspects points	s achieved			
						/IPLETE	PROCE			ON1009						
≤!	50	51-	-60	61-	·70	71	-80	81	-90	91-1	L00	Total points	achieved			
Fai	iled	Unsatis	factory	Nov	/ice	Supe	rvised	Comp	etent	Indepe	ndent	Total level a	chieved			
Studer	nt					Signat	ure									
Teach	Teacher					Signature						Actual Mai	rk/Out of			
Clinica	l Area					Date										

PROCEDURE: Death - performing post-mortem care							
FNOC	LDONL.	Death - performing post-morteni care	Code	17-01			
No.		Skill steps	Not achieved	Achieved			
1	Prepare	ed procedure equipment:					
		Patient medical record					
		Non-sterile gloves					
		Plastic apron					
		Wash basin					
		Gauze or wash cloth					
		Soap					
		2 Towels (one small one big)					
		Disposable pads					
		Shroud (paper covering of the body)					
		3 Identification tags					

		2 Bed s												
		Hand r	_											
			nent trol											
2	Checke physici	-	t medica	I record t	to confir	m that th	ne patien	it has be	en prono	unced de	ead by t	he		
3			-	of the pa	atient ha	s been n	otified o	r provide	e time foi	the fam	ily to se	e the		
4	patient if appropriate. If there are other patients or visitors in the room, carefully explained the situation and asked them to leave the room temporarily if possible. Informed relevant staff and departments of the patient's death.													
5							atient's c	death.						
6	Contac	ted mort	uary and	d arrange	d the tin	ne for co	llection o	of the bo	dy.					
7									curemen	t (verbal	report)			
8	Asked t	he famil	y in a ser	nsitive m	anner to	leave th	e room t	o enable	e prepara	tion of th	he body	for the		
	transfe	r to the r	nortuary	/out of t	he hospi	tal.								
9	Pulled	the curta	ins arou	nd the be	ed.									
10	Transfe	erred equ	ipment 1	to the ro	om.									
11	Put on	gloves.												
12	Put on	apron.												
13	Determ	nine that	the clier	nt is dead	by asses	ssing bre	athing a	nd circul	ation.					
14	Determine that the client is dead by assessing breathing and circulation. Placed the body in supine position with the arms extended at the sides.													
15	Remov	ed all me	edical equ	uipment	(iv lines,	cathete	rs, drains	5)						
16	Removed all medical equipment (iv lines, catheters, drains) Removed hairpins or clips.													
17	Closed	the eyeli	ds.											
18	Placed	or kept o	dentures	in the m	outh.									
19						hin to ke	ep the m	outh clo	sed.					
20									oody if so	iled.				
21		ed the be				<u> </u>								
22					n the leg	s and un	der the b	uttocks						
23	Applied disposable pads between the legs and under the buttocks. Checked the details on the identification tags with the patient's ID band.													
24				ags to th			-							
25														
26	Wrapped the body in the shroud. Attached the identification tag to the shroud.													
27				clean sh		Juu.								
28			-											
29	Packed all the patient's belongings. Tidied the bedside.													
30				ron										
31	Removed gloves and apron. Washed hands.													
32			nt's helor	ngings to	the fam	ilv								
33	Returned patient's belongings to the family. Provided psychological support to the family and answered any questions													
34				• •		•								
35	Arranged the transport of the body to the mortuary/out of the hospital. When the room was empty, arranged the cleaning of the room.													
36				lure in pa				00111.						
30	Docum	enteu tii	e proced	iure iii pa	itient s n		(ILL EVA	LLIATIC	N 60%					
Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36	Skill ston	s achieved	
Points									_					
Level	0	0 6 12 18 24 30 36 42 48 54 60 Skill points achieved F U N S C I Skill level achieved												
					2. PR	OCEDU			ALUATIO					
	Rationa	ale 10%		F									Time 10%	
Failed	ailed 5 Failed 5 Failed 5 Failed						+10	5						
	factory		6		factory		6		sfactory		6		actory+8	6
Novice 7 Novice 7 Novice 7						7	Novice	+6	7					
Supervi	ised		8	Superv	ised		8	Superv	/ised		8	Supervis	ed +4	8
Compe			9	Compe			9	Compe		-	9	Compet		9
Indepe	Independent 10				ndent		10	Indepe	endent		10	Indepen	10	

Notes:	Time allowed (TA)	60								
						Time achieved				
3. COMPLETE PROCEDURE EVALUATION 100%										
≤50	51-60	1-60 61-70 71-80 81-90 91-100		91-100	Total points achieved					
Failed	Unsatisfactory	Novice	Supervised	Competent	Independent	Total level achieved				
Student			Signature		•					
Teacher			Signature		Actual Mark/Out of					
Clinical Area			Date							