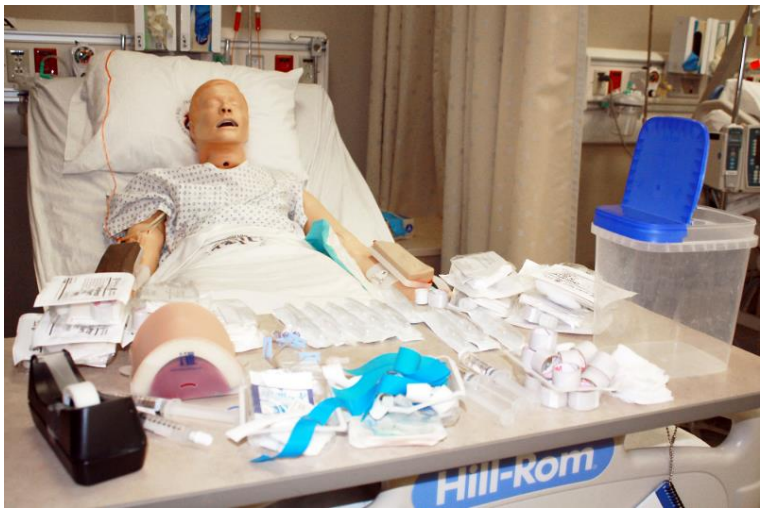
FUNDAMENTALS of NURSING PROCEDURES CHECKLISTS



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

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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.)	
SEMESTER 1		
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Procedure Evaluation Document (PED)

PROCEDURE:	**Hospitalization – admitting a patient**	**Code**	**01-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Nursing notes including admission nursing assessment □ Identity bracelet with patient details (label or written) □ Allergy bracelet (red) □ Thermometer, mercury or electronic □ Sphygmomanometer □ Stethoscope □ Gauze □ Disinfecting solution □ Hand rub gel □ Plastic tray		
2	Identified the patient using two identifiers (name, date of birth, address).		
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	Checked patient's details on the medical record.		
7	Checked patient's details on the identity bracelet.		
8	Applied identity bracelet on the patient's wrist.		
9	Asked the patient about allergies.		
10	Applied the allergy bracelet if allergies present. (If patient does not have allergies - verbal report)		
11	Oriented the patient to the ward environment.		
12	Oriented the patient to the room environment.		
13	Introduced the patient to other patients in the room.		
14	Explained the hospital and ward routine (ward round time, administration of medications etc.)		
15	Performed admission nursing assessment.		
16	Assessed patient's temperature. (FoN lab – verbal report)		
17	Assessed patient's blood pressure. (FoN lab – verbal report)		
18	Assessed patient's pulse. (FoN lab – verbal report)		
19	Assessed patient's respirations. (FoN lab – verbal report)		
20	Assessed patient's height.		
21	Assessed patient's weight.		
22	Checked doctor's orders for any treatments to be started immediately (FoN - verbal report).		
23	Explained the initial plan of medical and nursing care.		
24	Checked patient understands the plan of care.		
25	Asked the patient if he/she has any questions.		
26	Explained to the patient how to contact the nurse if needed (call bell).		
27	Assessed patient's level of comfort.		
28	Reassured the patient.		
29	Returned equipment to the dedicated area.		
30	Informed the doctor that the patient has been admitted (verbal report).		

1. SKILL EVALUATION 60%

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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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ADMISSION NURSING ASSESSMENT

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)		
Past health problems (illnesses, operations)		
Present medications		
Allergies		
Height & weight	Height:	Weight:
Nursing student (name & signature)		

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Procedure Evaluation Document (PED)

PROCEDURE: **Hospitalization – transferring a patient**		**Code**	**01-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Nursing transfer form □ Hand rub gel		
2	Checked the medical order for transfer, transfer location, time and special considerations.		
3	Prepared patient documentation for the transfer.		
4	Filled in the nursing transfer form correctly.		
5	Performed hand hygiene using correct technique.		
6	Identified the patient using two identifiers.		
7	Performed greeting, introduction and permission procedure (G.I.P).		
8	Provided privacy.		
9	Informed the patient about transfer and answered any questions.		
10	Contacted transfer unit to determine the best time for transfer.		
11	Obtained necessary staff for transfer (porter, nursing assistant)		
12	Prepared patient's belongings for transfer or assisted the patient/family if needed.		
13	Checked with the patient and family that none of the belongings are missing.		
14	Transferred the client to the wheelchair if used (verbal report if wheelchair not used)		
15	Covered the patient to provide warmth and protect dignity.		
16	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	Brought the patient to the allocated location.		
19	Introduced the patient to the other patients.		
20	Terminated the therapeutic relationship in a positive manner.		
21	Performed hand hygiene using correct technique.		
22	Gave oral report about the patient to the allocated nurse.		
23	Gave nursing transfer letter and other documentation to the allocated nurse.		
24	On return to the unit, informed appropriate departments of transfer (kitchen, diagnostic departments if patient has scheduled investigations or treatment).		
25	Arranged for the bed of the transferred patient to be prepared for the new admission.		
26	Informed the doctor and nurse in charge that transfer has been completed.		
27	Informed the family that the patient was transferred and where.		

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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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PATIENT TRANSFER FORM

PATIENT DETAILS		
Name		
Date of Birth		Gender: Male Female
Address		
Telephone number		
CLINICAL DETAILS		
Diagnosis		
Medications		
Present condition		
TRANSFERRED FROM:		
Organization		
Department		
Doctor arranging transfer	Name:	
Contact details	Tel:	Email:
TRANSFERRED TO:		
Organization		
Department		
Doctor accepting transfer	Name:	
Contact details	Tel:	Email:
TRANSFER DETAILS		
Name & Signature:	Date:	

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Procedure Evaluation Document (PED)

PROCEDURE: **Hospitalization – referring a patient**		**Code**	**01-03**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Nursing referral form □ Hand rub gel		
2	Checked doctor's order for referral.		
3	Performed hand hygiene using correct technique.		
4	Identified the patient using two identifiers (name, date of birth, address).		
5	Performed greeting, introduction and permission procedure (G.I.P).		
6	Provided privacy.		
7	Informed the patient about the referral and answered any questions.		
8	Filled in the referral form correctly.		
9	Contacted the health professional the patient was referred to discuss the referral.		
10	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.		
11	Documented referral in the patient documentation.		
12	Returned equipment to the dedicated area.		
13	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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PATIENT REFERRAL FORM

PATIENT DETAILS			
Name			
Date of Birth		Gender: Male Female	
Address			
Telephone number			
CLINICAL DETAILS			
Diagnosis			
Medications			
Present condition			
Doctor			
REFERRED BY:			
Name			
Organization			
Job			
Contact details	Tel:	Email:	
REFERRED TO:			
Name			
Organization			
Job			
Contact details	Tel:	Email:	
REFERRAL DETAILS			

Name & Signature:	Date:

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Procedure Evaluation Document (PED)

PROCEDURE:	**Hospitalization – discharging a patient**	**Code**	**01-04**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Medical discharge summary □ Nursing discharge plan □ Written discharge information and post-discharge instructions according to the diagnosis and patient's condition □ Medications □ Hand rub gel		
2	Checked doctor's order for discharge, discharge time and special considerations.		
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	Performed greeting, introduction and permission procedure (G.I.P).		
8	Provided privacy.		
9	Informed the patient about discharge and answered any questions.		
10	Explained to the patient how to take medications.		
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.		
13	Gave the patient instructions about the follow - up appointments.		
14	Completed discussion about discharge plan with the patient answering any questions.		
15	Checked and completed any written discharge information and instructions.		
16	Prepared patient's belongings for transfer or assisted the patient/family if needed.		
17	Checked with the patient and family that none of the belongings are missing.		
18	Transferred the client to the wheelchair if used (verbal report if wheelchair not used)		
19	Gave patient/ family appropriate documentation (discharge summary, nursing discharge plan)		
20	Terminate therapeutic relationship with the patient in a positive manner.		
21	Obtained necessary staff assistance for the transfer (porter, nursing assistant)		
22	Informed appropriate departments of the discharge (verbal report).		
23	Arranged for the bed of the discharged patient to be prepared for another admission.		
24	Informed the doctor and nurse in charge that the discharge has been completed.		

1. SKILL EVALUATION 60%

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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Infection control - hand washing using soap and water**	**Code**	**02-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Stood in front of sink, keeping hands and uniform away from sink surface.		
2	Turned on the water.		
3	Regulated flow and temperature (warm) of the water.		
4	Wetted hands and wrists thoroughly under running water keeping hands and forearms lower than the elbows during washing.		
5	Applied a small amount of soap, lathering thoroughly.		
6	Worked soap in to lather and generate friction for at least 15 seconds.		
7	Rubbed hands palm to palm.		
8	Rubbed back of each hand with palm of other hand with fingers interlaced.		
9	Rubbed palm to palm with fingers interlaced.		
10	Rubbed with back of fingers to opposing palms with fingers interlocked.		
11	Rubbed each thumb clasped in opposite hand using a rotational movement.		
12	Rubbed tips of fingers in opposite palm in a circular motion. Cleaned fingernails with the fingernails of the other hand if needed.		
13	Rubbed each wrist with opposite hand.		
14	Rinsed hands and wrists thoroughly, keeping hands down and elbows up, water flowing towards fingertips.		
15	Dried hands thoroughly from fingers to wrists with a paper towel, single-use cloth, or warm air dryer.		
16	Discarded paper towel, if used, in a lined waste bin.		
17	Turned off hand faucet, using clean, dry paper towel.		
18	Avoided touching handles with hands.		

1. SKILL EVALUATION 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 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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Infection control - hand washing using hand rub gel**	**Code**	**02-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Checked the product labelling for correct amount of product needed.		
2	Applied the correct amount of product to the palm of one hand.		
3	Rubbed hands palm to palm.		
4	Rubbed back of each hand with palm of other hand with fingers interlaced.		
5	Rubbed palm to palm with fingers interlaced.		
6	Rubbed with back of fingers to opposing palms with fingers interlocked.		
7	Rubbed each thumb clasped in opposite hand using a rotational movement.		
8	Rubbed tips of fingers in opposite palm in a circular motion. Cleaned fingernails with the fingernails of the other hand if needed.		
9	Rubbed each wrist with opposite hand.		
10	Rubbed hands together until they were dry.		

1. SKILL EVALUATION 60%												
Steps	0	1	2	3	4	5	6	7	8	9	10	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	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)	**5**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Infection control- donning and removing sterile gloves**	**Code**	**02-03**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Sterile gloves - Hand rub gel		
2	Cleaned the working area with a disinfecting solution.		
3	Selected the correct size and type of gloves.		
4	Performed hand hygiene using correct technique.		
5	Removed the outer glove package wrapper by carefully separating and peeling apart the sides.		
6	Grasped the inner package, and laid it on a clean, dry, flat surface at waist level.		
7	Opened the package, keeping gloves on the inside surface of the wrapper.		
8	Identified right and left gloves (verbal report)		
9	Donned glove for dominant hand first.		
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 roll 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	Carefully pulled second glove over non-dominant hand, taking care not to allow the gloved dominant hand to contact the exposed non-dominant hand.		
14	After donning the second glove, interlocked hands together.		
15	Kept hands above waist level.		
16	To remove the gloves, grasped the outside of one cuff with the other gloved hand; avoided touching wrist.		
17	Pulled glove off, turning it inside out and placed it in gloved hand.		
18	Tucked the fingers of the bare hand inside the remaining glove cuff. Peeled glove off inside out and over the previously removed glove.		
19	Discarded both gloves in the lined waste bin.		
20	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	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	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	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)	**5**
Time achieved	
Aspects points achieved	

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		**Actual Mark/Out of**	
Teacher		Signature			
Clinical Area		Date			

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Procedure Evaluation Document (PED)

PROCEDURE: **Infection control- donning sterile gown and gloves – open method**		**Code**	**02-04**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Sterile gloves - Sterile gown		
2	Cleaned the working area with a disinfecting solution.		
3	Performed hand hygiene using correct technique.		
4	Selected the appropriate size and type of sterile gloves.		
5	Selected the appropriate size of sterile surgical gown.		
6	Checked that packages are intact and dry.		
7	Checked the expiry dates of the packages.		
8	Asked the scrub person or the circulating nurse to open the sterile gown and glove packages on a clean, dry, flat surface. Preferably on a small table separate from the sterile field containing the sterile instruments and supplies.		
9	Performed surgical hand antisepsis.		
10	Dried hands thoroughly.		
11	Picked up the gown from the sterile package, grasping the inside surface of the gown at the collar.		
12	Lifted the folded gown directly upward, and stepped back, away from the table.		
13	Located the gown neckband; with both hands, grasped the inside front of the gown just below the neckband.		
14	Keeping the gown at arm's length from the body, allowed the gown to unfold with the inside of the gown facing the body.		
15	With hands at shoulder level, slipped both arms into the armholes simultaneously.		
16	Had the circulating nurse pull the gown over the shoulders by reaching inside the arm seams.		
17	Extended hands through the cuffs.		
18	Opened inner package of the gloves, keeping gloves on the inside surface of the wrapper.		
19	Identified right and left gloves (verbal report)		
20	Donned glove for dominant hand first.		
21	With thumb and first two fingers of non-dominant hand, grasped glove for dominant hand by touching only the glove's inside folded surface.		
22	Carefully pulled glove over dominant hand, leaving it cuffed, and ensured that the cuff did not roll up the wrist. Ensured that thumb and fingers were in proper spaces.		
23	With gloved dominant hand, slipped fingers underneath the second glove's cuff.		
24	Carefully pulled second glove over non-dominant hand, taking care not to allow the gloved dominant hand to contact the exposed non-dominant hand.		
25	Turned glove ends down to "catch" the gown cuffs.		
26	Grasped the sterile front flap or paper tab with gloved hands, and untied it.		
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	Allowing a margin of safety, turned to the left one-half turn, which covered the back with the extended gown flap.		
30	Retrieved the sterile tie from the circulating nurse, and secured both ties in place.		

1. SKILL EVALUATION 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 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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE: **Infection control- creating sterile field using packaged sterile drape**		**Code**	**02-05**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Packaged sterile drape - Syringes - Needles - 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.		
16	Placed cap on table away from the field with edges up.		

17	Held bottle outside the edge of the sterile field with the label side facing the palm of your hand and prepare to pour from a height of 4 to 6 inches (10 to 15 cm).		
18	Tip of the bottle did not touch a sterile container or field.		
19	Avoided splashing any liquid.		
20	Touched only the outside of the lid when recapping.		
21	Labelled solution with date and time of opening.		
22	Removed gloves.		
23	Performed hand hygiene using correct technique.		

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%

Rationale 10%		**Patient Focus**10%		**Professional Manner**10%		**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)	**15**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

10	Rolled all the soiled linen inside the bottom sheet and placed directly into the laundry hamper.		
11	Did not place the soiled linen on floor or furniture.		
12	Did not hold the soiled linens against the uniform.		
13	Shifted mattress up to head of bed.		
14	Cleaned and dried the matrass before applying new sheets.		
15	Removed gloves.		
16	Placed the bottom sheet with its center fold in the center of the bed.		
17	Pulled the bottom sheet over the corners at the head and foot of the mattress or tucked the corners under the matrass using triangular fold.		
18	Place the top sheet on the bed with its center fold in the center of the bed and with the hem even with the head of the mattress and unfolded.		
19	Follow same procedure with top blanket or spread, placing the upper edge about 15cm below the top of the sheet.		
20	Tucked the top sheet and blanket under the foot of the bed on the near side.		
21	Mitered the corners.		
22	Folded the upper 15cm of the top sheet down over the spread and make a cuff.		
23	Moved to the other side of the bed and follow the same procedure for securing top sheets under the foot of the bed and making a cuff.		
24	Raised side rails, if used and lowered the bed.		
25	Disposed of soiled linens in appropriate area.		
26	Returned equipment to the dedicated area.		
27	Performed hand hygiene using correct technique.		

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 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	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)	**20**
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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Comfort, rest and sleep – making an occupied bed**	**Code**	**03-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ 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	Assisted the patient to turn back to the center of bed.		
30	Removed pillow and changed pillowcase.		
31	Applied the top linen, sheet and blanket, if desired, so that it is centered.		
32	Folded the top linens over at the patient's shoulders to make a cuff.		
33	Asked the patient to hold on to top linen and removed the bath blanket from underneath.		
34	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.		

38	Removed gloves and plastic apron.												
39	Returned equipment to the dedicated area.												
40	Performed hand hygiene using correct technique.												
1. SKILL EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

13	Read the measurement.		
14	Cleaned the thermometer (mercury thermometer), or discarded the probe (electronic thermometer).		
15	Restored patient to a comfortable position.		
16	Performed hand hygiene using correct technique.		
17	Documented the result in the vital signs chart.		
18	Informed the patient or relative if appropriate of the result.		
19	Returned equipment to the dedicated area.		
20	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	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	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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Vital signs - assessing tympanic temperature**	**Code**	**04-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • Vital signs chart • Tympanic thermometer with disposable probe cover. • Hand rub gel • 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 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).		

11	Left the thermometer in place until the signal was heard.		
12	Read the measurement.		
13	Discarded the probe.		
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	Performed hand hygiene using correct technique.		
20	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	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	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)	**10**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

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	Asked that the patient did not eat or drink anything hot or cold, and did not smoke within last 15 mints.		
11	Inserted the thermometer under the tongue in the posterior sub-lingual pocket.		
12	Asked the patient to hold the thermometer with the lips closed.		
13	Left the thermometer in place for 3-5 minutes (mercury thermometer), or until the signal is heard (electronic thermometer).		
14	Read the measurement.		
15	Cleaned the thermometer(mercury), or discard the probe (electronic)		
16	Restored patient to comfortable position.		
17	Performed hand hygiene using correct technique.		
18	Documented the result in the vital signs chart.		
19	Informed the patient or relative if appropriate of the result.		
20	Returned equipment to the dedicated area.		
21	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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)	**10**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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		

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	Put on gloves.		
9	Assisted patient to the position on side with the upper leg slightly flexed at the hip and knee.		
10	Prepared the thermometer for the measurement: mercury thermometer, shook down and cleaned electronic, placed on the probe cover, and turned on.		
11	Instructed patient to breathe deeply.		
12	Applied the lubricant on the tip of thermometer.		
13	Inserted thermometer into rectum (adult -5cm, child -2.5cm, infant – 1.25cm)		
14	Read the measurement.		
15	Cleaned the thermometer (mercury thermometer), or discarded the probe cover (electronic thermometer).		
16	Wiped the lubricant and any stool from around the patient's rectum.		
17	Removed gloves.		
18	Restored patient to a comfortable position.		
19	Performed hand hygiene using correct technique.		
20	Documented the result in the vital signs chart.		
21	Informed the patient or relative if appropriate of the result.		
22	Returned equipment to the dedicated area.		
23	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

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%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Vital Signs – assessing peripheral pulse**	**Code**	**04-05**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. □ Vital signs chart □ Hand watch or clock □ 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	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 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.		

1. 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	

2. PROCEDURE ASPECTS EVALUATION 40%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Vital signs - assessing apical pulse**	**Code**	**04-06**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. • Vital signs chart • Stethoscope • Hand watch or clock • 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	Asked if the patient had been active in the last 20 minutes, if yes, waited 5 to 10 minutes before assessing the pulse.		
10	If the patient had been smoking, waited 20 minutes before assessing the pulse.		
11	Found the angle of Louis just below the supra-sternal notch between the sternal body and the manubrium.		
12	Carefully moved fingers down the left side of the sternum to the fifth intercostal space (ICS) and laterally to the left mid-clavicular line (MLC).		
13	Warmed the diaphragm of the stethoscope in the palm of hand.		
14	Placed the stethoscope's diaphragm over the point of maximum impulse (PMI) at the fifth ICS, at the left MCL (point 4 on the diagram bellow) and started counting.		
15	If the apical rate was regular, counted for 30 seconds and multiplied by two (verbal report of the student after the measurement). If the apical rate was irregular, or if the patient was receiving cardiovascular medication, counted for a full minute (verbal report of the student after the measurement).		
16	Restored patient to a comfortable position.		
17	Performed hand hygiene using correct technique.		
18	Documented the result in the vital signs chart.		
19	Informed the patient or relative if appropriate of the result.		
20	Returned equipment to the dedicated area.		
21	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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)	**10**
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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Vital signs - assessing respirations**	**Code**	**04-07**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. • Vital signs chart • Hand watch or clock		
2	Identified patient using two identifiers.		
3	Performed greeting, introduction and permission procedure (G.I.P).		
4	Provided privacy.		
5	Didn't Explain 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	While fingers are still in place after counting the pulse rate, counted patient's respirations. (student's verbal report after the measurement).		
10	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	Documented the result in the vital signs chart.		
14	Informed the patient or relative if appropriate of the result.		
15	Returned equipment to the dedicated area.		
16	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

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 artery		
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	Documented the result in the vital signs chart.		
27	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 EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Vital signs- assessing oxygen saturation**	**Code**	**04-09**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. ▪ Vital signs chart ▪ Pulse oximeter ▪ Alcohol swabs or gauze and disinfecting solution ▪ 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 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	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	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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

Vital Signs Chart

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Procedure Evaluation Document (PED)

PROCEDURE:	**Activity – assisting a patient with turning in bed**	**Code**	**05-01**
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 nearest you.		
15	Asked the nurse on the side of the bed toward which the patient is turning to stand opposite the 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 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	

2. PROCEDURE ASPECTS EVALUATION 40%								
Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

15	Asked the patient about any balance problems or complaints of dizziness.		
16	Assisted the patient to put on a robe, as necessary, and non-slip footwear.		
17	Stood facing the patient with feet about shoulder width apart and flexed hips and knees.		
18	Asked the patient to slide his or her buttocks to the edge of the bed until the feet touch the floor.		
19	Assisted the patient to stand up with the help of another nurse if needed.		
20	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	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	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	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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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	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.		
15	Asked the patient about any balance problems or complaints of dizziness.		
16	Assisted the patient to put on a robe, as necessary, and non-slip footwear.		
17	Stood facing the patient with feet about shoulder width apart and flexed hips and knees.		
18	Asked the patient to slide his or her buttocks to the edge of the bed until the feet touch the floor.		
19	Assisted the patient to stand up with the help of another nurse if needed.		
20	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	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	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	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	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	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)	**10**
	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		**Actual Mark/Out of**	
Teacher		Signature			
Clinical Area		Date			

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 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	Repeated these exercises on the other side of the body.		
31	Checked that the patient is comfortable.		
32	Removed gloves.		
33	Performed hand hygiene using correct technique.		
34	Documented the procedure in the patient's notes.		
35	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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)	**20**
						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			**Actual Mark/Out of**
Teacher			Signature			
Clinical Area			Date			

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PROCEDURE:	**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.		

13	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.		
14	Practiced this exercise with the other leg.		
15	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 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.		

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	

2. PROCEDURE ASPECTS EVALUATION 40%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**15**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE:	**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.		

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 a sitting position.		
9	Placed the patient's forearm across the chest with the elbow flexed and the palm against the chest.		
10	Enclosed the arm in the sling, making sure the elbow fits into the corner of the fabric.		
11	Run the strap up the patient's back and across the shoulder opposite the injury, then down the chest to the fastener on the end of the sling.		
12	Placed the gauze pad under the strap, between the strap and the patient's neck.		
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 limb every 4 hours (verbal report).		
16	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.		

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	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	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)	**10**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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	Reviewed the medical record and nursing plan of care for conditions that may influence the patient's ability to move and ambulate.		
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	Assess the patient's knowledge and previous experience regarding the use of crutches.		
9	Determined that the appropriate size crutch has been obtained.		
10	Assessed for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation.		
11	Decided how far to walk.		
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	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 Three-point gait: asked the patient move the affected leg and both crutches forward about 12 inches then to move the stronger leg forward to the level of the crutches. or Two-point gait: Asked the patient to move the left crutch and the right foot forward about 12 inches at the same time and then to move the right crutch and left leg forward to the level of the left crutch at the same time. or Swing-to gait: Asked the patient move both crutches forward about 12 inches, then lift the legs and swing them to the crutches, supporting his or her body weight on the crutches.		
15	Continued with ambulation for the planned distance and time.		
16	Returned the patient to the bed or chair based on the patient's tolerance and condition, ensuring that the patient is comfortable.		
17	Made sure call bell and other necessary items are within easy reach.		
18	Performed hand hygiene using correct technique.		
19	Documented the procedure in the patient's notes.		
20	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	19-20	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	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. 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**	

Teacher		Signature			
Clinical Area		Date			

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PROCEDURE:	**Elimination – assisting with the use of a bedpan**	**Code**	**08-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • Bedpan • Powder • Waterproof pad • 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	Unless contraindicated, applied powder to the rim of the bedpan.		
10	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	Made the head of the bed elevated about 30 degrees, unless contraindicated.		
14	Folded top linen back just enough to allow placement of bedpan.		
15	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	Restored the patient to a comfortable position.												
33	Returned the bedpan to the dedicated area.												
34	Performed hand hygiene using correct technique.												
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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

12	Covered the patient with a blanket.		
13	Placed call bell and toilet tissue or a container with warm water within easy reach.		
14	Removed gloves and plastic apron.		
15	Performed hand hygiene using correct technique.		
16	Left the patient if it was safe to do so.		
17	After returning to the patient, performed hand hygiene using correct technique.		
18	Put on gloves.		
19	Put on apron.		
20	Assisted the patient to a standing position to get off the commode.		
21	Returned the patient to the bed or chair.		
22	Offered the patient supplies to wash and dry his or her hands, assisting as necessary.		
23	Restored the patient to a comfortable position.		
24	Returned the commode to the dedicated area.		
25	Performed hand hygiene using correct technique.		

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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE:	**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	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	Asked the patient if he has any allergies, especially to latex.		
8	Put on gloves.		
9	Put on plastic apron.		
10	Positioned the patient on his back with thighs slightly apart.		
11	Slid waterproof pad under patient.		
12	Draped patient so that only the area around the penis is exposed.		
13	Asked the patient to clean the genital area if possible, otherwise assisted with the wash.		
14	Rolled the condom sheath outward onto itself.		
15	Grasped penis firmly with non-dominant hand and applied condom sheath by rolling it onto penis with dominant hand, leaving 1 to 2 inches (2.5 to 5 cm) of space between tip of penis and end of condom sheath.		
16	Applied pressure to sheath at the base of penis for 10 to 15 seconds.		
17	Connected the condom sheath to drainage setup avoiding kinking or twisting drainage tubing.		
18	Removed gloves.		
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	Cover the patient with bed linens.		
22	Secured drainage bag below the level of the bladder.		
23	Changed the water in the basin.		
24	Offered the patient supplies to wash and dry his or her hands, assisting as necessary.		
25	Performed hand hygiene using correct technique.		

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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE:	**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 • Soap • Towel 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 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	Had paper towel ready to receive tube as it is withdrawn.		
21	Encouraged the patient to hold the solution until the urge to defecate is strong, usually in 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.		

31	On return to the patient, performed hand hygiene using correct technique.		
32	Put on gloves.		
33	Put on plastic apron.		
34	After the patient was ready to defecate, assisted to use bedpan, commode or bathroom.		
35	Assisted the patient with washing if needed.		
36	Restored the patient to a comfortable position ensuring he/she is clean, dry and comfortable.		
37	Returned equipment to the dedicated area.		
38	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE:	**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		

7	Performed hand hygiene using correct technique.		
8	Put on gloves.		
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 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.		

1. 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	
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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE:	**Hygiene – bed bath**	**Code**	**09-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • Gloves • Plastic apron • Towels • Bath blanket • Washcloth • Soap or skin cleanser		

	• Basing with warm water • Comb or hairbrush • Clean bed linen • 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	Performed hand hygiene using correct technique.		
9	Put on gloves.		
10	Put on apron.		
11	Assisted patient to sitting position.		
12	Placed the basin with warm water, soap, washcloth, towels, comb within the easy reach.		
13	Encouraged the patient to wash, assisting when needed.		
14	Helped the patient put on a clean gown.		
15	Changed any bed linen if needed, if the change was not needed, straightened the bed linen.		
16	Helped the patient to a comfortable position.		
17	Removed gloves and plastic apron.		
18	Performed hand hygiene using correct technique.		
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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Hygiene – giving a bed bath**	**Code**	**09-03**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • Gloves • Plastic apron • Towels • Bath blanket • Washcloth • Soap or skin cleanser • Basing with warm water • Comb or hairbrush • Clean bed linen • 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	Performed hand hygiene using correct technique.		
9	Put on gloves.		
10	Put on apron.		
11	Offered patient bedpan or urinal (If used removed gloves and put on clean gloves).		
12	Assisted patient to supine position.		
13	Loosened top covers and removed all except the top sheet.		
14	Placed bath blanket over patient and then remove top sheet while patient holds bath blanket in place.		
15	Placed linen that will be re-used on the chair.		
16	Placed soiled linen in a laundry bag or hamper without touching uniform.		
17	Removed the patient's gown and kept bath blanket in place.		
18	Checked the temperature of the water.		
19	Put a towel across patient's chest and on top of bath blanket.		
20	With no 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 skin cleanser to the water.		
23	Bathed patient's face, neck, and ears.		
24	Exposed 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 folded towel on the bed next to the patient's hand and put basin on it.		
28	Soaked the 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.		
33	Lowered bath blanket to the perineal area.		
34	Washed, rinsed, if necessary, and dried abdomen.		
35	Returned bath blanket to original position and expose far leg.		

36	Placed towel under far leg.		
37	Using firm strokes, washed, rinsed, if necessary, and dried leg from ankle to knee and knee to groin.		
38	Washed, rinsed if necessary, and dried the foot.		
39	Repeated steps 37 and 38 for the other leg and foot.		
40	Made sure the patient was covered with bath blanket.		
41	Changed the water.		
42	Assisted the patient to prone or side-lying position.		
43	Positioned bath blanket and towel to expose only the back and buttocks.		
44	Washed, rinsed, if necessary, and dried back and buttocks area.		
45	Changed the water.		
46	Assisted the patient to turn on the back.		
47	Set patient up so that he or she can complete perineal self-care or performed perineal care if patient was unable to do so.		
48	Helped the patient put on a clean gown.		
49	Protected the pillow with towel and groomed patient's hair.		
50	Changed bed linen as needed.		
51	Restored or helped the patient to a comfortable position.		
52	Removed gloves and plastic apron.		
53	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 60%

Steps	0	1-6	7-12	13-18	19-24	25-26	27-33	34-39	40-45	46-51	52-53	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	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)	**60**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE:	**Hygiene - oral care for a dependent patient**	**Code**	**09-04**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • toothbrush • toothpastes • lip lubricant (Vaseline, lip balm) • suction unit and suction catheter		

	• water • irrigation syringe or bulb syringe • emesis basin • towel or waterproof pad • gloves • plastic apron • plastic tray		
2	Identified the patient using two identifiers.		
3	Provided privacy.		
4	Adjusted the height of bed.		
5	Performed hand hygiene using correct technique.		
6	Put on gloves.		
7	Put on plastic apron.		
8	Positioned the client on the side with the head tilted forward.		
9	Placed a towel beneath the head and across the chest.		
10	Put emesis basin under the chin.		
11	Gently opened the patient's mouth by applying pressure to lower jaw at the front of the mouth, removed dentures if present.		
12	Spread toothpastes over the moistened tooth brush.		
13	Brushed the teeth and gums carefully with toothbrush and paste.		
14	Lightly brushed the tongue.		
15	Inserted the rubber tip of the irrigating syringe or bulb syringe into the patient's mouth and rinsed gently with a small amount of water.		
16	Positioned the patient's head to allow for return of water or used suction apparatus to remove the water from oral cavity.		
17	Cleaned the dentures before replacing.		
18	Applied lubricant to patient's lips.		
19	Removed wet towel.		
20	Restored patient to comfortable position.		
21	Performed hand hygiene.		
22	Documented the procedure.		
23	Returned equipment to the dedicated area.		

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%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Fluid balance – calculating fluid balance**	**Code**	**10-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: • Patient medical record • Fluid balance charts • Hand rub gel • Plastic tray		
2	Reviewed patient medical record for orders regarding fluid balance measurement.		
3	Performed the procedure at the whole hour, i.e. 9am, 10am, 11am etc.		
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	Performed hand hygiene using correct technique.		
9	Checked the patient details in the first fluid balance chart (laboratory-empty, clinical – patient's chart).		
10	Checked the iv fluid rate and recorded the iv fluid input for the previous hour.		
11	Checked the oral intake recorded the type of fluid and amount in ml for the previous hour.		
12	Checked the NG feed and recorded the NG feed input for the previous hour.		
13	Calculated the total hourly fluid intake.		
14	Checked the urine output (measuring jug or urinary catheter) and recorded urine output for the previous hour.		
15	Checked the amount of drainage in drain/s and recorded drainage output.		
16	Checked the recorded amount of vomit, NG aspirate, diarrhea, stoma output.		
17	Calculated total hourly fluid output.		
18	In the second fluid balance chart (fluid balance calculation chart), calculated total 24 fluid input.		
19	Calculated total 24 fluid output.		
20	Calculated the difference (balance) between total fluid input and output.		
21	Recorded balance in the balance field in the chart.		
22	If the balance was positive (input bigger), marked it +sign, if the balance was negative (output bigger), marked it with – sign.		
23	Checked the patient's and family's understanding of the importance of correct recording of oral intake.		
24	Checked that correct container (glass, cup) with known capacity is being used for oral fluids.		
25	Performed hand hygiene using correct technique.		
26	Returned equipment to the dedicated area.		
27	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

Fluid Balance Chart

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Procedure Evaluation Document (PED)

PROCEDURE:	**Oxygenation - administering oxygen - oxygen mask**	**Code**	**11-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	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		
2	Checked the medical order for oxygen administration.		
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 comfortable position.		
10	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.		
15	Positioned face mask over the patient's nose and mouth.		
16	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.		
23	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%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**15**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Oxygenation - administering oxygen – nasal cannula**	**Code**	**11-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. • Patient medical record • Vital signs chart • Nasal cannula • Portable oxygen cylinder (if central oxygen are not available) • Gauze pads • Hand rub gel • Plastic tray		
2	Checked the medical order for oxygen administration.		
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 comfortable position.		
10	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 nasal cannula to the oxygen source with humidification.		
14	Adjusted flow rate as ordered.		
15	Carefully placed prongs in patient's nostrils.		
16	Placed tubing over and behind each ear with adjuster comfortably under chin or around the head and in the nostrils.		
17	Placed gauze pads at ear beneath the tubing.		
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.		
23	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%							
Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**15**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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-dominant hand and gently rotating the catheter as it was being withdrawn.		
34	Suctioned for 10 to 15 seconds at a time.		
35	Withdrew the catheter.		
36	Replaced the oxygen delivery mask using non-dominant hand.		
37	Asked the patient take several deep breaths and cough.		
38	Flushed the catheter with saline.		
39	Assessed effectiveness of suctioning and repeated two more times if tolerated by the patient.		
40	Alternated the nares when doing more than one pass.		
41	Allowed at least a 30-second to 1-minute interval between suction passes.		
42	Did not make more than three suction passes per suctioning episode.		
43	Wrapped the suction catheter around dominant hand between attempts.		
44	When suctioning is completed, removed glove from the dominant hand over the coiled catheter, 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 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	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 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 • 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	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-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 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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).		

19	Instructed the patient to inhale and exhale through the nose three times.		
20	Asked the patient to take a deep breath and hold it for 3 seconds and then cough out three short breaths.		
21	Asked the patient to take a breath through the mouth and strongly cough again two times.		
22	Instruct the patient that he or she should perform these actions every 2 hours when awake after surgery.		
23	Checked patient's understanding of information by asking the patient to give a return demonstration.		
24	Asked the patient if he or she has any questions.		
25	Encourage the patient to practice the activities and ask questions, if necessary.		
26	Restored patient to a comfortable position.		
27	Performed hand hygiene using correct technique.		
28	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Peri-operative care – applying anti-embolic stockings**		**Code**	**12-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Anti-embolic stockings with manufacturer's instructions □ Powder or lotion □ Gloves □ Hand rub gel □ Plastic tray		
2	Reviewed the medical record and medical orders to determine the need for anti-embolism stockings.		
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	Checked manufacturer's instructions for application of stockings.		
9	Performed hand hygiene using correct technique.		
10	Put on gloves.		
11	Assisted the patient to supine position.		
12	If patient has been sitting or walking, have him or her lie down with legs and feet well elevated for at least 15 minutes before applying stockings (verbal report).		
13	Exposed legs one at a time.		
15	Applied powder or lotion to the skin if recommended by manufacturer.		
16	Stood at the foot of the bed.		
17	Placed hand inside stocking and grasped heel area securely.		
18	Turned the stocking inside-out to the heel area, leaving the foot inside the stocking leg.		
19	With the heel pocket down, eased the stocking foot over the patient's foot and heel.		
20	Checked that patient's heel is centered in heel pocket of stocking.		
21	Using fingers and thumbs, carefully grasped edge of stocking and pull it up smoothly over ankle and calf, toward the knee.		
22	Pulled forward slightly on toe section.		
23	Adjusted the stocking to ensure material is smooth.		
24	- If the stockings are knee-length, make sure each stocking top is 1 to 2 inches below the patella. - If applying thigh-length stocking, continued the application flexing the patient's leg and stretching the stocking over the knee until the top is 1 to 3 inches below the gluteal fold.		
25	Restored patient to a comfortable position.		
26	Removed gloves.		
27	Performed hand hygiene using correct technique.		
28	Documented the result in the vital signs chart.		
29	Informed the patient or relative if appropriate of the result.		
30	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Pre-operative care - immediate**	**Code**	**12-03**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	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		
2	Checked the patient's chart for the type of surgery and review the medical orders.		
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	Checked that preoperative consent forms were signed, witnessed, and correct and that the patient's chart is in order.		
9	Assessed and documented blood pressure.		
10	Assessed and documented pulse.		
11	Assessed and documented respirations.		
12	Assessed and documented oxygen saturations.		
13	Assessed and documented temperature.		
14	Notified appropriate staff of any pertinent changes in vital signs or general condition (e.g., rise or drop in blood pressure, elevated temperature, cough, symptoms of infection) – verbal report.		
15	Ensured patient had shower and oral care.		
16	Assess for loose teeth and caps.		
17	Remind patient of food and fluid restrictions before surgery.		
18	Instructed the patient to remove all personal clothing, including underwear, and put on a hospital gown.		
19	Asked the patient to remove cosmetics, jewelry, nail polish, and prostheses.		
20	If possible, gave valuables to family member or place valuables in appropriate area, if this was not possible.		
21	Asked the patient to empty bladder and bowel before surgery.		
22	Asked the patient regarding the location of the operative site.		
23	Administer preoperative medication as prescribed by physician/anesthesia provider.		
24	Complete preoperative checklist and record of patient's preoperative preparation.		
25	Provided safe environment with bed in low position and rails up if possible.		
26	Instructed the patient to remain in bed or on stretcher.		
27	Put call bell within patient's reach, if available.		
28	Asked the patient if he/she is comfortable.		
29	Performed hand hygiene using correct technique.		
30	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE: **Post-operative care - immediate**		**Code**	**12-04**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	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		
2	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 blood pressure.		
16	Assessed and documented pulse.		
17	Assessed and documented respirations.		
18	Assessed and documented oxygen saturations.		

19	Assessed and documented temperature.		
20	Assessed skin colour (verbal report).		
21	Provide for warmth, using heated or extra blankets, as necessary.		
22	Checked dressings for colour, odor, presence of drains, and amount of drainage.		
23	Turned the patient to assess visually under the patient for bleeding from the surgical site.		
24	Marked the drainage on the dressing by circling the amount, and include the time.		
25	Checked that all the tubes and drains are patent and equipment is operative.		
26	Checked and documented the amount of drainage in collection device or Foley's catheter bag.		
27	Checked and maintained IV infusion at correct rate.		
28	Assessed the patient for pain.		
29	Checked the recovery record for analgesics administered in recovery and arranged pain relief if appropriate.		
30	Provided safe environment with bed in low position and rails up if possible.		
31	Put call bell within patient's reach, if available.		
32	Asked the patient if he/she is comfortable.		
33	Performed hand hygiene using correct technique.		
34	Documented the result in the vital signs chart.		
35	Returned equipment to the dedicated area.		
36	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Post-operative care - continuing**		**Code**	**12-05**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Thermometer, mercury or electronic □ Sphygmomanometer and stethoscope		

	□ Pulse oximeter □ Visual analogue scale □ Gauze □ Disinfecting solution □ Hand rub gel □ Plastic tray		
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	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed.		
8	Assessed neurological status: • patient is awake • alert • oriented • responds to commands		
9	Checked that patient can move all extremities.		
10	Assessed and documented blood pressure.		
11	Assessed and documented pulse.		
12	Assessed and documented respirations.		
13	Assessed and documented oxygen saturations.		
14	Assessed and documented temperature.		
15	Assessed pain using visual analogue scale.		
16	Assessed skin colour (verbal report).		
17	Assessed nail beds for signs of cyanosis.		
18	Assessed for return of peristalsis by auscultation.		
19	Assessed for presence of nausea or vomiting.		
20	Encourage fluid intake when recommended by a physician.		
21	Checked dressings for colour, odour, presence of drains, and amount of drainage.		
22	Checked that all the tubes and drains are patent and equipment is operative.		
23	Checked and documented the amount of drainage in collection device or Foley's catheter bag.		
24	Checked and maintained IV infusion at correct rate.		
25	Checked administration of oxygen if used.		
26	Encouraged patient to perform deep breathing exercises.		
27	Encouraged patient to perform frequent position changes.		
28	Encouraged patient to perform early ambulation when recommended by the physician.		
29	Provided safe environment with bed in low position and rails up if possible.		
30	Put call bell within patient's reach, if available.		
31	Asked the patient if he/she is comfortable.		
32	Provided emotional support and encouragement.		
33	Performed hand hygiene using correct technique.		
34	Documented the result in the vital signs chart.		
35	Returned equipment to the dedicated area.		
36	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

19	Encouraged the patient to perform incentive spirometry 5 to 10 times every 1 to 2 hours, if possible.		
20	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	Performed hand hygiene using correct technique.		
26	Returned equipment to the dedicated area.		
27	Documented the procedure in the patient's medical record.		

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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 diagnosis and patient's condition(written or leaflets) ☐ Hand rub gel		
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	Provided privacy.		
6	Reviewed patient's medical record and nursing notes.		
7	Determined risk factors for discharge: □ Elderly age group □ Multisystem disease process □ Major surgical procedure □ Chronic or terminal illness □ Emotional or mental instability □ Inadequate or inappropriate living arrangements □ Lack of transportation □ Financial insecurity □ Unsafe features at home (for example stairs, no heating)		
8	Informed the patient about discharge planning and answered any questions.		
9	Evaluate the extent to which the patient educational plan was implemented.		
10	Checked that patient knows how to do deep breathing exercises.		
11	Checked that patient knows how to do range of motion exercises.		
12	Explained to the patient how to take medications.		
13	Explained to the patient how to care for their surgical wound,		
14	Gave the patient instructions about the diet, rest and activity, hygiene.		
15	Explained to the patient how to recognise complications and what to do if they occur.		
16	Gave the patient instructions about the follow - up appointments.		
17	Completed discussion about discharge plan with the patient answering any questions.		
18	Checked and completed discharge plan form correctly.		
19	Checked and completed discharge instructions or provided leaflets.		
20	Identified appropriate support needed after discharge (verbal report).		
21	Made referrals (one for evaluation purposes) filling the referral form.		
22	Documented the procedure in the patient documentation.		

1. 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
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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Pain management – assessment**	**Code**	**13-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Medication chart □ Pain assessment chart □ 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	Performed hand hygiene using correct technique.		
7	Assisted the patient to a comfortable position.		
8	Prepared pain assessment chart by filling in the patient details.		
9	Checked and documented the sites of pain.		
10	Checked and documented the onset of pain.		
11	Checked and documented the characteristics of pain.		
12	Checked and documented the radiation or shifting of pain.		
13	Checked and documented other sensations or feelings associated with pain.		
14	Checked and documented the timing of pain.		
15	Checked and documented the exacerbating factors of pain.		
16	Checked and documented the alleviating factors of pain.		
17	Checked and documented the severity of pain using 0-10 pain scale.		
18	Asked the patient to provide any additional information about their pain.		
19	Checked current analgesia prescription in the medication chart		
20	Provided pain relief if needed and appropriate according to the medical order (verbal report).		
21	Performed hand hygiene using correct technique.		
22	Documented the result in the vital signs chart.		
23	Informed the patient or relative if appropriate of the result.		
24	Returned 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	19-20	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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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	Performed hand hygiene using correct technique.		
28	Documented the result in the patient's notes.		
29	Informed the patient or relative if appropriate of the result.		
30	Returned equipment to the dedicated area.		
31	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 ☐ 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 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 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.		
	Put on sterile gloves.		
20	Placed the fine-mesh gauze into the basin and pour the ordered solution over the mesh to saturate 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	Dried the surrounding skin with sterile gauze dressings.		
24	Squeezed 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	Documented the result in the patient's notes.		
33	Informed the patient or relative if appropriate of the result.		
34	Returned equipment to the dedicated area.		
35	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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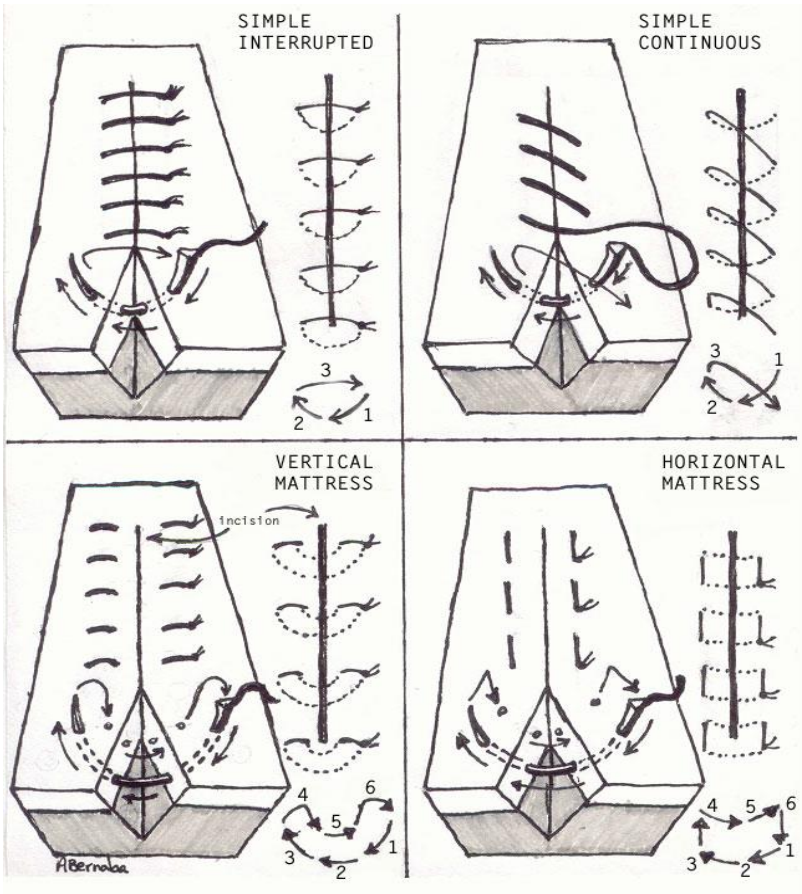
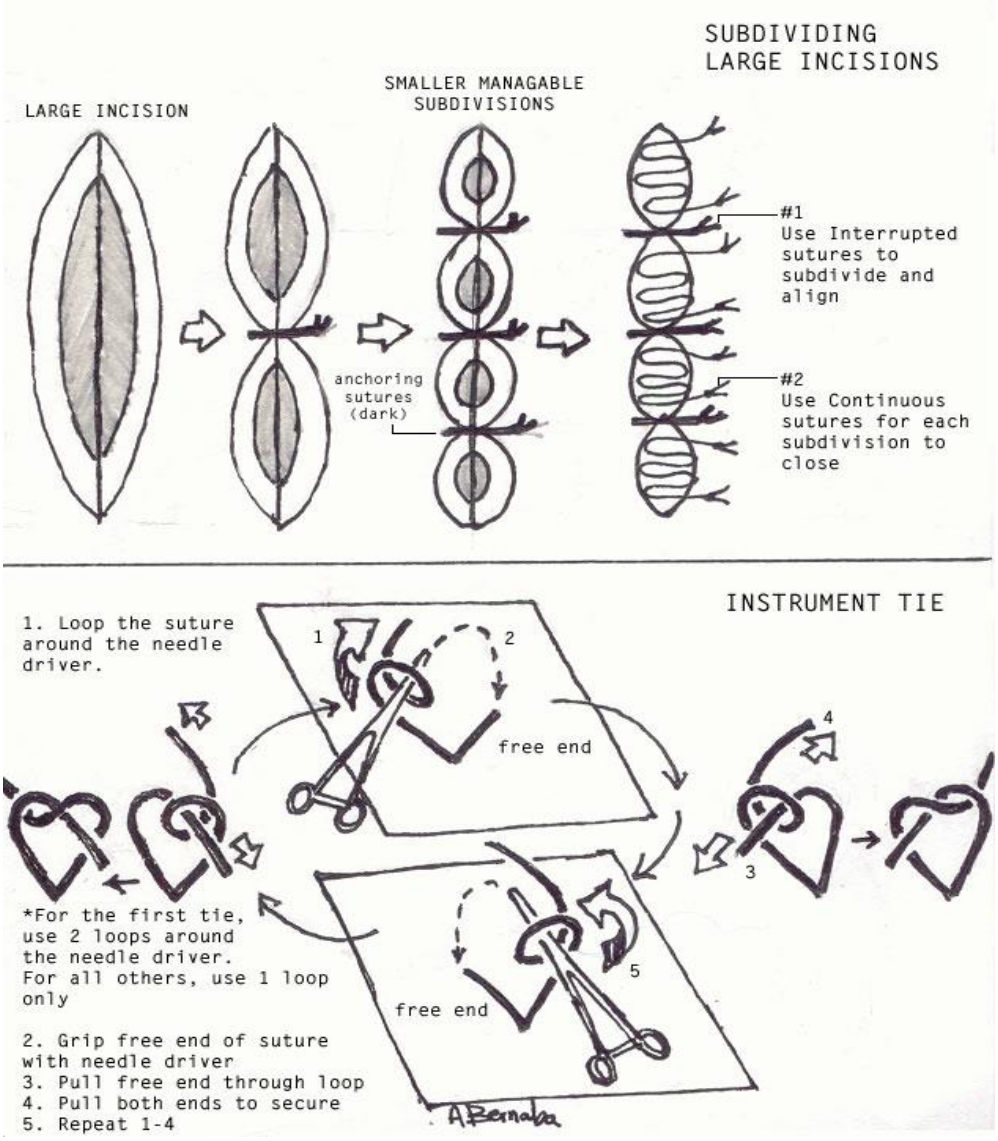
Procedure Evaluation Document (PED)

PROCEDURE:	**Wound care - suturing**	**Code**	**14-03**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ☐ Patient medical record ☐ Lidocaine ☐ Syringes, 18gauge, 25 gauge ☐ Needles ☐ 500 cc Normal saline and 50cc syringe for flushing the wound ☐ Waterproof pad ☐ Non-sterile gloves ☐ Sterile gloves ☐ Chlorhexidine antiseptic solution or Betadine ☐ Basin Sterile kit with: ☐ sterile drape ☐ sterile gloves ☐ sterile gauze ☐ needle holder ☐ forceps with teeth ☐ suture scissors ☐ Suturing needles ☐ Suturing material ☐ Gauze ☐ Antibacterial cream ☐ Bandage ☐ Tape ☐ Hand rub gel ☐ Sharps container ☐ 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%

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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

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. 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	

2. PROCEDURE ASPECTS EVALUATION 40%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Wound care - removing staples**		**Code**	**14-05**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ☐ Patient medical record ☐ Surgical staples remover ☐ Scissors ☐ Normal saline ☐ Gauze ☐ Disinfecting solution ☐ Gloves ☐ Tape ☐ Hand rub gel ☐ Sharps box ☐ Waterproof pad ☐ Plastic tray		
2	Reviewed the medical orders for suture removal.		
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	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	Firmly grasped the staples remover and positioned it under the staple to be removed.		
16	Firmly closed the staple remover to bend the staple in the middle and pull it up out of the skin.		
17	Removed every other staple first to be sure the wound edges were healed.		
18	Discarded the staples in the sharps box.		
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.		
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. 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

2. PROCEDURE ASPECTS EVALUATION 40%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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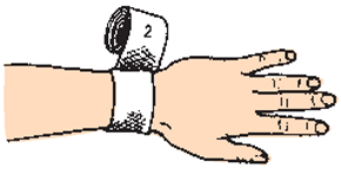
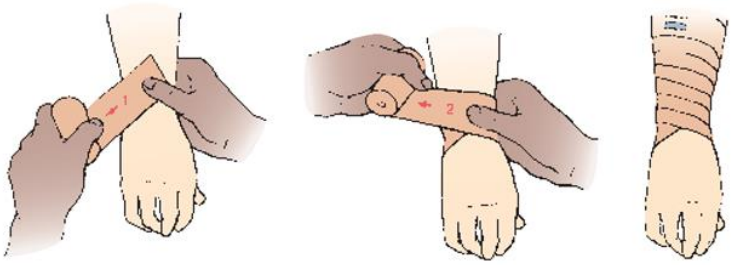
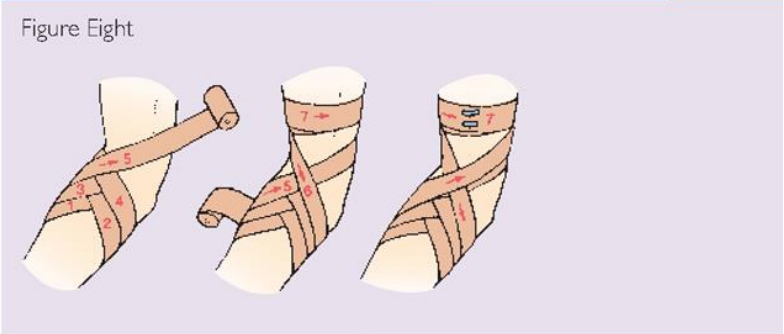
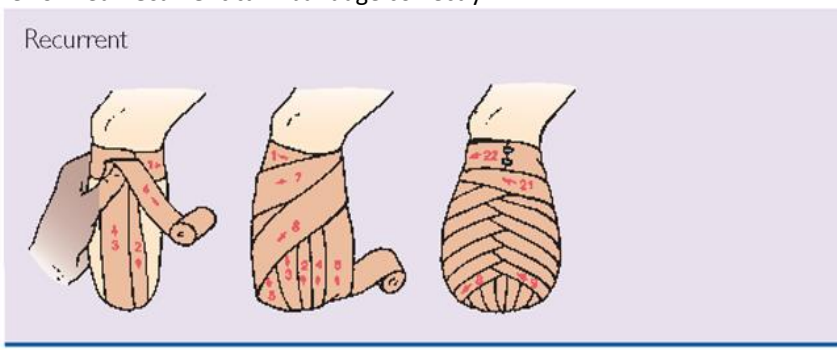
Procedure Evaluation Document (PED)

PROCEDURE:	**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: Circular 		
11	Performed **Spiral turn** bandage correctly. Spiral 		
12	Performed **Figure-of-eight** turn bandage correctly. Figure Eight 		

13	Performed **Recurrent turn** bandage correctly. 		
14	Assessed the limb for: ☐ Skin colour ☐ Finger or toe motion ☐ Sensation in fingers or toes ☐ Distal pulses ☐ Capillary refill ☐ Oedema or swelling ☐ Pain ☐ Severe pressure or tightness ☐ Skin temperature		
15	Asked the patient to report any of the above symptoms.		
16	Performed hand hygiene using correct technique.		
17	Documented the result in the patient's notes.		
18	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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 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 wound.		
27	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.		
32	Restored patient to a comfortable position.		

33	Performed hand hygiene using correct technique.		
34	Documented the result in the patient's notes.		
35	Informed the patient or relative if appropriate of the result.		
36	Returned equipment to the dedicated area.		
37	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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	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	Discarded soiled dressings into the plastic bag.		
19	Removed gloves.		
20	Discarded gloves into the plastic bag.		
21	Observed the wound for: (verbal report) □ presence, amount, colour, odour of drainage □ signs of infection □ pain □ signs of healing		
22	Performed hand hygiene using hand rub gel.		
23	Put on sterile gloves.		
24	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 circular motion away from the drain.		
26	Cleaned the drain site with sterile gauze and Normal Saline in a circular motion away from the drain.		
27	Advanced the drain if ordered (if not ordered, verbal report): □ Pulled the drain out ordered number of centimetres using sterile forceps □ Repositioned the safety pin so it was at the level of the skin □ Cut off excess tubing with sterile scissors to leave 5cm on the outside.		
28	Cut the slit in the sterile gauze with sterile scissors.		
29	Placed the sterile gauze around the drain.		
30	Applied dry sterile gauze pads (or ABD pads) over drain.		
31	Secured the gauze pads with the tape.		
32	Label the dressing with the date and time of dressing.		
33	Closed the plastic bag with the soiled dressings and discarded.		
34	Removed gloves.		
35	Restored the patient to a comfortable position.		
36	Performed hand hygiene using correct technique.		
37	Documented the procedure and the results (including the length of exposed tube).		
38	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 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 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	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)	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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 ☐ Sterile container in the sterile package if available ☐ 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	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	Discarded soiled dressings into the plastic bag.		
19	Removed gloves.		
20	Discarded gloves into the plastic bag.		
21	Observed the wound for: (verbal report) □ presence, amount, colour, odour of drainage □ signs of infection □ pain □ signs of healing		
22	Performed hand hygiene using hand rub gel.		
23	Put on sterile gloves.		
24	Cleaned the drain site with sterile forceps and sterile gauze and antiseptic solution moving in a circular motion away from the drain.		
25	Cleaned the drain site with sterile gauze and Normal Saline in a circular motion away from the drain.		
26	Removed the drain in a smooth motion and discarded into the plastic bag.		
27	Cleaned the wound with sterile gauze and Normal Saline in a circular motion away from the wound.		
28	Placed the sterile gauze on the wound.		
29	Applied dry sterile gauze pads (or ABD pads) over drain.		
30	Secured the gauze pads with the tape.		
31	Label the dressing with the date and time of dressing.		
32	Closed the plastic bag with the soiled dressings and discarded.		
33	Removed gloves.		
34	Restored the patient to a comfortable position.		
35	Performed hand hygiene using correct technique.		
36	Documented the procedure and the results (including the length of exposed tube).		
37	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE:	**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 ulcers - History of pressure ulcer		
11	Performed the risk assessment using Norton Scale.		
12	Assessed physical condition correctly.		
13	Assessed mental condition correctly.		
14	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 report).		
18	Assessed condition of patient's skin over regions of pressure. - 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		

	☐ Indwelling urinary drainage (Foley) catheter ☐ Orthopaedic and positioning devices		
20	Observed patient for preferred positions when in bed or chair (verbal report).		
21	Encouraged the patient to change position frequently to relieve pressure areas.		
22	Observed ability of patient to initiate and assist with position changes.		
23	Assessed patient/caregiver understanding of risks for the development of pressure ulcers.		
24	Restored the patient to a comfortable position.		
25	Performed hand hygiene using correct technique.		
26	Documented the procedure and the results (including the length of exposed tube).		
27	Returned the equipment to the dedicated area.		

NORTON SCALE

Name	Date	Physical condition	Mental condition	Activity	Mobility	Incontinent	Total score
		Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk/help 3 Chair-bound 2 Stupor 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasionally 3 Usually/urine 2 Doubly 1	

Norton Scale Interpretation

>18 - low risk

14-17 - medium risk

10-13 - high risk

<10 - very high risk

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 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	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. 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**	
Teacher		Signature			
Clinical Area		Date			

HAWLER MEDICAL UNIVERSITY
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Procedure Evaluation Document (PED)

PROCEDURE: **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	Assisted the patient to a position that will allow dressing to be performed.		
11	Exposed the pressure ulcer area keeping the remaining body parts draped.		
12	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: □ 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.		

21	Put on plastic apron.		
22	Opened sterile pack without contaminating the sterile field.		
23	Poured cleansing solution into the container.		
24	Donned sterile gloves correctly.		
25	Cleansed the area around pressure ulcer thoroughly with normal saline or a prescribed wound-cleansing agent.		
26	Cleansed the pressure ulcer thoroughly with normal saline or a prescribed wound-cleansing agent.		
27	Applied topical medication (hydrogel) or special dressings (calcium alginate dressing) if prescribed.		
28	Placed a gauze dressing directly over the pressure ulcer, and taped it in place.		
29	Removed gloves.		
30	Performed hand hygiene using correct technique.		
31	Encouraged the patient to change position frequently to relieve pressure areas.		
32	Observed ability of patient to initiate and assist with position changes.		
33	Assessed patient/caregiver understanding of risks for the development of pressure ulcers.		
34	Restored the patient to a comfortable position.		
35	Documented the procedure and the results (including the length of exposed tube).		
36	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 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 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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - administering oral medications**	**Code**	**15-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient's medical record □ Medication chart □ 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.		
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 bottles or boxes (and individual strips).		
14	Checked the expiration dates of all medications.		
15	Checked the dosages and performed medication calculation if necessary.		
16	Put the medications in disposable or plastic cups without touching tablets with hands.		
17	Explained the purpose of each medication to the patient.		
18	Offered water or other permitted fluids to take with medications.		
19	Remained with the patient until each medication is swallowed.		
20	Restored patient to comfortable position.		
21	Performed hand hygiene.		
22	Documented the procedure in the medication chart immediately after the procedure.		
23	Returned the equipment to the dedicated area.		

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%

Rationale 10%		**Patient Focus**10%		**Professional Manner**10%		**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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - administering topical medications - skin**	**Code**	**15-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ☐ Patient's medical record ☐ Medication chart ☐ Medication container (tube or jar) if in the fridge ☐ Tongue blade ☐ Gloves ☐ Hand rub gel ☐ Soap ☐ Basin with warm water ☐ Gauze ☐ Tape ☐ 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	Put on gloves.		
16	Cleaned the skin site with the soap and water and dried well.		
17	Squeezed the medication from tube or used a tongue blade to take cream from the container.		
18	Spread small quantity of medication smoothly and evenly with gloved hand over the patient's skin following directions of hair follicles.		
19	Applied dry gauze dressing if indicated.		
20	Labelled dressing with date, time and initials.		
21	Removed gloves.		
22	Restored the patient to a comfortable position.		
23	Performed hand hygiene using correct technique.		
24	Documented the administration in the medication chart immediately after the procedure.		
25	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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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	Removed the covering on the patch without touching the medication surface.		
25	Applied the patch to the patient's skin.		
26	Used the palm of hand to press firmly for about 10 seconds without massaging the patch.		
27	Removed gloves.		
28	Restored the patient to a comfortable position.		
29	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

12	Asked the patient about any allergies and check the allergy bracelet if available.		
13	Read the medication chart and selected the proper medication from the patient's medication drawer or unit stock.		
14	Checked the labels on the medications.		
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	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 ceiling.		
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.		
34	Returned equipment to the dedicated area.		
35	Documented the administration in the medication chart immediately after the procedure.		

1. SKILL EVALUATION 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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - administering ear medications**	**Code**	**15-05**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. □ Patient medical record □ Medication chart □ Gloves □ Cotton balls or gauze □ Hand rub gel □ 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 labels on all medications.		
14	Checked the expiration dates of all medications.		
15	Checked the dosages and performed medication calculation if necessary.		
16	Put on gloves.		
17	Cleansed external ear of any drainage with cotton ball or gauze moistened with normal saline.		
18	Placed the patient on his or her unaffected side in bed, or, if ambulatory, have patient sit with head well tilted to the side so that affected ear is uppermost.		
19	Straightened the auditory canal by pulling cartilaginous portion of pinna up and back.		
20	Held dropper in the ear with its tip above the auditory canal.		
21	Allowed drops to fall on the side of the canal.		
22	Released pinna after instilling drops		
23	Gently pressed on the tragus a few times.		
24	If needed, loosely insert a cotton ball into the ear canal.		
25	Removed gloves.		
26	Restored patient to a comfortable position.		
27	Performed hand hygiene using correct technique.		
28	Documented the administration in the medication chart immediately after the procedure.		
29	Returned the equipments to dedicated area.		
30	Reported abnormal findings to appropriate health care provider.		

1. SKILL EVALUATION 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 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	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)	**10**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

23	Asked the patient to remain in the position with the head tilted back for a few minutes.		
24	Removed gloves.		
25	Restored the patient to a comfortable position.		
26	Performed hand hygiene.		
27	Documented the administration in the medication chart immediately after the procedure.		
28	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

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 bottles or boxes (and individual strips).		
14	Checked the expiration dates of all medications.		
15	Checked the dosages and performed medication calculation if necessary.		
16	Put the medications in disposable or plastic cups without touching tablets with hands.		
17	Explained the purpose of each medication to the patient.		
18	Asked the patient to place the medication (if help is needed, used gloves to assist the patient): - under the tongue - between upper or lower molars and cheek		
19	Instructed the patient not to chew or swallow the tablet and wait until it is completely dissolved before drinking.		
20	Restored patient to comfortable position.		
21	Performed hand hygiene.		
22	Documented the procedure in the medication chart immediately after the procedure.		
23	Returned the equipment to the dedicated area.		

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%

Rationale 10%		**Patient Focus**10%		**Professional Manner**10%		**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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering medications using inhaler**		**Code**	**15-08**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ☐ Patient's medical record ☐ Medication chart ☐ Inhaler with spacer if needed ☐ Gloves ☐ Hand rub gel ☐ 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 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 all medications.		
14	Checked the expiration dates of 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 place the inhaler's (spacer's) mouthpiece into mouth, grasping securely with teeth and lips.		
20	Asked the patient to breathe normally.		
21	Asked the patient to depress the canister, releasing one puff into the mouth (spacer), then inhale slowly and deeply through the mouth.		
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 inhaler from the spacer and replaced the caps on both.		
25	Asked the patient gargle and rinsed the mouth with tap water after using an inhaler.		
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%

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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 □ Oxygen □ Hand rub gel □ 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 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 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 has 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	Documented the administration in the medication chart immediately after the procedure.		
31	Returned equipment to dedicated area.		

1. SKILL EVALUATION 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	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	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)	**20**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

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 being inserted.		
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 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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering vaginal medications**		**Code**	**15-11**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient's medical record □ Medication chart □ Hand rub gel □ Gloves □ Basin with warm water □ Washcloth □ 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 of medication.		
16	Put on gloves.		
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	Provided adequate light to visualize the vaginal opening.		
20	Spread labia with fingers, and cleansed area at vaginal orifice with washcloth and warm water, using a different corner of the washcloth with each stroke.		
21	Wiped from above the vaginal orifice downward toward the sacrum		
22	Removed gloves and put on new gloves.		
23	Filled vaginal applicator with prescribed amount of cream.		
24	Lubricated applicator with the lubricant,		
25	Spread the labia with your non-dominant hand and introduced applicator with your dominant hand gently, in a rolling manner, while directing it downward and backward.		
26	Pushed the plunger to its full length and then gently remove applicator with plunger depressed.		
27	Told patient to remain in the supine position for 5 to 10 minutes after insertion.		
28	Disposed of applicator in appropriate receptacle		
29	Removed gloves		
30	Restored patient to comfortable position.		
31	Performed hand hygiene.		
32	Documented the procedure and result,		
33	return the equipments to dedicated area		
34	Reported abnormal findings to appropriate health care provider.		

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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - preparing medications using vials**		**Code**	**15-12**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. □ Patient medical record □ Medication chart □ Syringes and needles □ Gauze □ 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 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 center 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 needle past the fluid into the air space to re-inject air bubble into the vial.		
18	After the correct dose was withdrawn, removed the needle from the vial and carefully replaced the 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	Performed hand hygiene.		

1. SKILL EVALUATION 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	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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - preparing medications using ampules**		**Code**	**15-13**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. □ Patient medical record □ Medication chart □ Syringes and needles □ Gauze □ 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 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	Withdrew the syringe and tapped it to expelled the air carefully by pushing on the plunger.		
15	Carefully replaced the needle cover.		
16	Checked the amount of medication in the syringe with the medication dose and discarded any surplus.		
17	Discarded the ampule in a sharps box.		
18	Performed hand hygiene.		

1. SKILL EVALUATION 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 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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **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 the vial over and then removed needle from vial.		
18	Checked that there are no air bubbles in the syringe.		
19	Checked the amount of medication in the syringe with the medication dose and discarded any surplus.		
20	Calculated the endpoint on the syringe for the combined insulin amount by adding the number of units for each dose together.		
21	Inserted the needle into the modified vial and inverted it, taking care not to push the plunger of the syringe.		
22	Inverted vial of modified insulin.		
23	Held the vial in one hand and use the other to withdraw the medication		
24	Drew up the prescribed amount of medication while holding the syringe at eye level and vertically.		
25	Turn the vial over and then removed needle from vial.		
26	Checked the amount of medication in the syringe with the medication dose.		
27	Labelled the vials with the date and time opened, and store the vials containing the remaining medication.		
28	Performed hand hygiene.		
29	Proceeded with administration, based on prescribed route.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

HAWLER MEDICAL UNIVERSITY
COLLEGE OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

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

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	Provided privacy.		
6	Explained the procedure to the patient.		
7	Adjusted the height of the bed if possible.		
8	Assisted the patient to a comfortable position.		
9	Inspected the possible sites of insertion and selected the most suitable site.		
10	Applied a tourniquet 5 to 10 cm above the vein that would be used.		
11	Cleaned the skin with disinfecting solution or an alcohol swab starting at the center of the site moving outwards 5-10cm.		
12	Allowed the antiseptic to dry.		
13	Put on gloves.		
14	Stretched and stabilized the vein and soft tissue about 5cm below the intended site of entry by thumb.		
15	Positioned the cannula with the bevel up and at approximately a 45 angle above the vein.		
16	Warned the patient before inserting the needle.		
17	After observing blood , advanced the needle about 4-6mm.		
18	Withdrew the needle slightly so that the tip stayed within the catheter.		
19	Slided the catheter into the vein until only the end can be seen.		
20	Release the tourniquet.		
21	Applied the pressure over the internal tip of the catheter.		
22	Secured the catheter by crisscrossing a piece of tape from beneath the tubing or used a cannula dressing.		
23	If tape used, covered cannula with a piece of gauze and secured with tape.		
24	Wrote the date, time gauge of catheter on the outer piece of tape.		
25	Restored patient to comfortable position.		
26	Performed hand hygiene using correct technique.		
27	Documented the procedure and the result.		
28	Returned equipment to the dedicated area.		
29	Reported abnormal findings to appropriate health care provider.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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	Restored patient to comfortable position.												
35	Performed hand hygiene using correct technique.												
36	Documented the procedure in the medication chart immediately after the procedure.												
1. SKILL EVALUATION 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 achieved	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level	Returned the equipment to the dedicated area.						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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

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	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 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 dedicated area.		

1. SKILL EVALUATION 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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - administering intramuscular injection**	**Code**	**15-18**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. ☐ Patient medical record ☐ Medication chart ☐ Prepared medication for intramuscular 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	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 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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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 □ 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 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	Withdrew the syringe and tapped it to expelled the air carefully by pushing on the plunger.		
15	Carefully replaced the needle cover.		
16	Checked the amount of medication in the syringe with the medication dose and discarded any surplus.		
17	Discarded the ampule in a sharps box.		
18	Diluted the medication with the appropriate IV fluid as prescribed.		
19	Transported medications and equipment to the patient's bedside carefully, keeping them in sight at all times.		
20	Performed hand hygiene using correct technique.		
21	Identified patient using two identifiers.		
22	Performed greeting, introduction and permission procedure (G.I.P).		
23	Provided privacy.		
24	Explained the procedure to the patient and answered any questions.		
25	Adjusted the height of the bed.		
26	Assisted patient to supine or sitting position.		
27	Put on gloves.		
28	Assessed IV site for presence of inflammation or infiltration.		
29	Flushed the IV cannula with half of the Normal Saline flush.		
30	Connected syringe with the medication to the IV cannula.		
31	Injected medication at the recommended rate.		
32	Flushed the cannula with the other half of Normal Saline flush.		
33	Discarded syringe with the needle into the sharps box.		
34	Replaced IV cannula dressing.		
35	Removed gloves.		
36	Document the administration of the medication immediately after administration.		
37	Returned the equipment to the dedicated area.		
38	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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 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	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)	**20**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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 needle past the fluid into the air space to re-inject air bubble into the vial.		
18	After the correct dose was withdrawn, removed the needle from the vial and carefully replaced the 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.		

30	Put on gloves.		
31	Assessed IV site for presence of inflammation or infiltration.		
32	Flushed the IV cannula with half of the Normal Saline flush.		
33	Connected syringe with the medication to the IV cannula.		
34	Injected medication at the recommended rate.		
35	Flushed the cannula with the other half of Normal Saline flush.		
36	Discarded syringe with the needle into the sharps box.		
37	Replaced IV cannula dressing.		
38	Removed gloves.		
39	Document the administration of the medication immediately after administration.		
40	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering intravenous fluid infusion – intermittent-continuous**		**Code**	**15-21**
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 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	Performed hand hygiene using correct technique.		

4	Checked expiry date on the IV fluid bag. and the condition of the fluid		
5	Checked the condition of the iv bag and the iv fluid.		
6	Hanged the IV fluid bag on the IV stand.		
7	Opened the iv administration set wrapping.		
8	Clamped the tubing on IV administration set.		
9	Removed plastic port cap on the iv bag.		
10	Inserted spike of IV set into the port of IV bag while squeezing the drip chamber.		
11	Released pressure on the drip chamber until it is half full.		
12	Removed protective cap at the end of iv set tubing.		
13	Opened the clamp to prime the iv set.		
14	Closed the clamp when the iv set was primed.		
15	Checked that no air is present in the tubing.		
16	Transported the prepared equipment to the patient' bedside carefully.		
17	Identified patient using two identifiers.		
18	Performed greeting, introduction and permission procedure (G.I.P).		
19	Provided privacy.		
20	Explained the procedure to the patient and answered any questions.		
21	Adjusted the height of the bed.		
22	Put on gloves.		
23	Inspected the IV access site for signs of any inflammation.		
24	Flushed the IV cannula with saline flush to check patency if the cannula has not been used. (if used – verbal report)		
25	Connected IV set to IV cannula.		
26	Changed the cannula dressing if necessary.		
27	Calculated the drop rate correctly.		
28	Started the infusion regulating the correct drop rate with the clamp on IV set.		
29	Asked the patient to report any pain or discomfort at the venous access site.		
30	Removed gloves.		
31	Documented starting IV infusion in the medication chart.		
32	Documented starting IV infusion in the fluid balance chart if used (if not used- verbal report).		
33	Returned the equipment to the dedicated area.		
34	Performed hand hygiene using correct technique.		

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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering intravenous 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 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	Performed hand hygiene using correct technique.		
4	Preparing secondary infusion		
5	Checked expiry date on the IV fluid bag. and the condition 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.		
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 while squeezing the drip chamber.		
12	Released pressure on the drip chamber until it is half full.		
13	Removed protective cap at the end of iv set tubing.		
14	Opened the clamp to prime the iv set.		
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 patient' bedside carefully.		
18	Identified patient using two identifiers.		
19	Performed greeting, introduction and permission procedure (G.I.P).		
20	Provided privacy.		
21	Explained the procedure to the patient and answered any questions.		
22	Adjusted the height of the bed.		
23	Put on gloves.		
24	Administering secondary infusion		
25	Inspected the IV access site for signs of any inflammation.		
26	Hanged the secondary iv fluid bag on the iv pole above the primary running infusion.		
27	Attached needle or needless adapter to the secondary infusion set.		
28	Cleaned the port on the primary infusion with disinfecting solution or alcohol swab.		
29	Inserted needle or needless adapter to the port of the primary iv set.		
30	Locked (secured) connection.		
31	Calculated the drop rate correctly.		
32	Started the secondary infusion regulating the correct drop rate with the clamp on IV set.		
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.		

36	Documented starting IV infusion in the fluid balance chart if used (if not used- verbal report).											
37	Returned the equipment to the dedicated area.											
38	Performed hand hygiene using correct technique.											
1. SKILL EVALUATION 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 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	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)	**25**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE: **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 □ Tape □ 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.		

10	Hanged the IV fluid bag on the IV stand		
11	Filled the volume-control administration set with the prescribed amount of IV fluid by opening the clamp between IV fluid and the volume-control administration set.		
12	Primed the volume-control set		
13	Checked to make sure the air vent on the volume-control administration set chamber is open.		
14	Put on gloves.		
15	Inspected the IV access site for signs of any inflammation or infiltration.		
16	Flushed the IV cannula with saline flush to check patency if the cannula has not been used (if used – verbal report).		
17	Connected the volume-control set to IV cannula.		
18	Changed the cannula dressing if necessary (if not necessary-verbal report).		
19	Calculated the drop rate according to the prescription.		
20	Used roller clamp to set prescribed rate or placed the volume-control set on an infusion pump and programmed the pump.		
21	Removed gloves.		
22	Documented the starting the infusion in medication chart.		
23	Documented the starting the infusion in fluid balance chart.		
24	Returned the equipment to the dedicated area.		
25	Performed hand hygiene using correct technique.		

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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering intravenous fluid infusion - infusion pump**	**Code**	**15-24**
No. **Skill steps**	**Not achieved**	**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!		
1 Prepared procedure equipment: ☐ Medication chart ☐ IV fluid		

	□ IV fluid administration set □ Infusion 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.		
4	Prepared IV infusion as per medical order using correct procedure including priming the 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 pump is plugged in (plugged it in if it was not).		
11	Hanged the IV fluid bag on the IV stand.		
12	Checked that all the air is expelled from the set.		
13	Opened the door pump and loaded the iv set through the guide channel.		
14	Closed pump door.		
15	Opened iv set clump completely.		
16	Put on gloves.		
17	Inspected the IV access site for signs of any inflammation.		
18	Flushed the IV cannula with saline flush to check patency if the cannula has not been used. (if used – verbal report)		
19	Connected IV set to IV cannula.		
20	Changed the cannula dressing if necessary.		
21	Removed gloves.		
22	Turned the pump on by pressing ON/OFF key.		
23	Set primary flow rate in ml/hr by pressing RATE (PRI RATE) key.		
24	Set primary volume to be infused by pressing VOLUME (PRI VTBI) key.		
25	Checked the programmed information before starting the pump.		
26	Started the pump by pressing START key.		
27	Documented the starting the infusion in medication chart.		
28	Documented the starting the infusion in fluid balance chart.		
29	Performed hand hygiene using correct technique.		
30	After completion of the infusion pressed STOP key.		
31	Closed IV set clump.		
32	Opened pump door and removed the IV set.		
33	Turned the pump off by pressing ON/OFF key.		
34	Performed hand hygiene using correct technique.		
35	Put on gloves.		
36	Disconnected the IV set from IV cannula.		
37	Removed gloves.		
38	Documented the volume infused in the fluid balance chart.		
39	Returned the equipment to the dedicated area.		
40	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering intravenous infusion - syringe pump**		**Code**	**15-25**
No.	**Skill steps**	**Not 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!			
1	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.		
4	Prepared IV infusion as per medical order using correct procedure including priming the 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).		
11	Mount the syringe on the pump by pulling the plunger driver , releasing the barrel clamp, placing the syringe in the cradle and closing barrel clamp firmly.		
12	Turned the syringe pump on by pressing the ON key.		

13	Used the arrow keys to programme the rate of administration.		
14	Used the arrow keys to programme the volume to be infused.		
15	Purged the syringe and tubing to prime the set using PURGE START key.		
16	Stopped purging the syringe by pressing PURGE STOP key.		
17	Put on gloves.		
18	Inspected the IV access site for signs of any inflammation.		
19	Flushed the IV cannula with saline flush to check patency if the cannula has not been used. (if used – verbal report)		
20	Connected IV set to IV cannula.		
21	Changed the cannula dressing if necessary.		
22	Removed gloves.		
23	Checked the programmed information before starting the pump.		
24	Started the pump by pressing START key.		
25	Documented the starting the infusion in medication chart.		
26	Documented the starting the infusion in fluid balance chart.		
27	Returned the equipment to the dedicated area.		
28	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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	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	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)	**20**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **Medication - administering intravenous infusion with IV medication (ampule) using infusion pump**	**Code**	**15-26**

No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment. ○ Medication chart ○ Medication ○ IV fluid ○ Saline flash – Normal Saline Ampule, 5ml syringe and needle. ○ Syringes and needles		

	○ Antimicrobial swabs or disinfecting solution ○ Gauze ○ IV infusion set ○ Additive labels ○ Infusion pump ○ Hand rub gel ○ Sharps box ○ 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.		

43	Flashed the cannula with saline flush.		
44	Checked that infusion set is primed and there are no air bubbles in the set.		
45	Attached the infusion set to the cannula.		
46	Inserted infusion set into the infusion pump according to the type of the pump.		
47	Opened the clamp of the infusion set.		
48	Programmed the pump to the appropriate rate and began infusion.		
49	Checked that patient is in a comfortable position.		
50	Documented the procedure in the medication chart.		
51	Returned the equipment to dedicated area.		
52	Performed hand hygiene using correct technique.		

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 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	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)	**25**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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.		

9	Checked the IV fluid container expiry date.		
10	Closed the roller clamp of the infusion set or stopped the infusion device.		
11	Removed the empty solution container from suspension hook with the tubing still attached.		
12	Inverted the empty solution container and pulled the spike free.		
13	Removed the seal from the replacement solution container.		
14	Inserted the spike in to the port of new container.		
15	Removed the air with in the tubing.		
16	Readjust the roller clamp or reprogrammed the infusion device.		
17	Deposited the empty iv container in a lined waste bin.		
18	Checked that patient is in a comfortable position.		
19	Documented the procedure in the medication chart.		
20	Returned the equipment to dedicated area.		
21	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - changing IV infusion set**	**Code**	**15-28**
No.	**Skill steps**	**Not 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.		

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	Prepared the gauze and tape for changing dressing.		
7	Opened the new package containing the tubing and stretched the tubing.		
8	Tightened the roller clamp.		
9	Removed the solution container from suspension hook with the tubing still attached.		
10	Inverted the solution container and pulled the spike free.		
11	Secured the spike to the IV pole with strips of previously torn tape.		
12	Inserted the spike from the new tubing in to container of solution.		
13	Squeezed the drip chamber to fill it half full.		
14	Opened the roller clamp, purged the air from the tubing without spilling the fluid.		
15	Removed the tape and dressing from the iv cannula site.		
16	Put on gloves.		
17	Tightened the roller clamp on the expired tubing.		
18	Stabilized the iv cannula and separated the tubing from it.		
19	Removed the cap from the end of the new tubing and attached it to the end of cannula.		
20	Released the roller clamp on the new tubing.		
21	Replaced the dressing on the vinepuncture site, and secured tubing.		
22	Readjusted the rate flow.		
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	Removed gloves.		
26	Performed hand hygiene using correct technique.		
27	Documented the procedure and result.		
28	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medication - discontinuing iv infusion**	**Code**	**15-29**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Medication chart □ Gloves □ Gauze □ Tape □ Scissors □ 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	Clamped the tubing and removed the tape that holds the dressing and iv cannula in place.		
7	Put on gloves.		
8	Pressed the gauze square gently over the site where iv cannula entered the skin.		
9	Removed the iv cannula.		
10	Applied pressure to the site for 30 to 45 seconds while elevating the forearm.		
11	Secured the gauze with tape.		
12	Disposed the iv cannula in a sharps container.		
13	Removed gloves.		
14	Performed hand hygiene using correct technique.		
15	Documented the procedure and the result.		
16	Reported abnormal findings to appropriate health care provider.		

1. SKILL EVALUATION 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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Medications – drug calculations**	**Code**	**15-30**
No.	**Skill steps**	**Not achieved**	**Achieved**
Dosage calculations			
1	A patient requires ( ) mg of Morphine IVI. Morphine is available as 10mg/ml. How many mls will you draw up?		
2	Gentamycin ( ) mg is prescribed. Gentamycin is available as 80mg/2ml. How many mls will you draw up?		
3	Haloperidol ( ) mg IVI is charted. Haloperidol is available as 5mg/ml. How many mls is required?		
4	Frusemide ( ) mg IVI is charted. Stock dose is 20mg/ml. How many ml would you give?		
Metric conversions			
5	Atropine 0.6 mg = ? mcg		
6	Gentamycin 360mg = ? gm		
7	Digoxin 125mcg = ? mg		
8	Prescribed dose – ( ) mg/kg Patient's weight – 79 kg What is the dose required?		
Infusion flow rates			
9	A 1L bag is to be infused over ( ) hours. Calculate how many mls per hour the patient will receive.		
10	A 1L bag is to be infused over ( ) hours. Calculate how many mls per hour should the patient receive.		
11	How many ml/hr would a patient receive if they were to have 500ml of fluid infused over ( ) hours?		
12	The patient is prescribed 15mg/kg/day. The patient weighs ( ) kg. a) How much is the total dose per 24 hours? b) How much will the patient receive every 8 hours?		
Drop per minute calculations			
13	Your patient is prescribed a 1000ml infusion of 5% Glucose to be given over ( ) hours. Using a standard giving set (20 drops per minute), calculate the drops per minutes he will receive.		
14	Your patient is prescribed a 500 ml blood transfusion to be given over 4 hours. Using a blood giving set (15 drops per minute), calculate the drops per minutes he will receive.		
15	Your patient is prescribed a 1000ml infusion of Sodium Chloride 0.9% with 40 mmols of Potassium to be given over ( ) hours. Using a micro giving set (60 drops per minute), calculate the drops per minutes he will receive.		

1. SKILL EVALUATION 60%

Steps	0	1	2	3	4-5	6-7	8-9	10-11	12-13	14	15	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	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)	**10**
	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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 bag ☐ Hand 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	Identified patient using two identifiers.		
7	Performed greeting, introduction and permission procedure (G.I.P).		
8	Provided privacy.		
9	Explained the procedure to the patient and answered any questions.		
10	Advised patient to report any chills, itching, rash, or unusual symptoms.		
11	Adjusted the height of the bed.		
12	Obtained baseline set of vital signs before beginning transfusion.		
13	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	Connected three-way stop-cock to the cannula.		
20	Started normal saline infusion.		
21	Asked another nurse to compare and validate the following information with the medical record, patient identification band, and the label of the blood product: □ Medical order for transfusion of blood product □ Informed consent □ Patient identification number □ Patient name □ Blood group and type □ Expiration date □ Inspection of blood product for clots		
22	Closed the clamp on the Normal Saline administration set.		
23	Prepared blood transfusion administration set (inserting spike into the container).		
24	Primed the blood administration with blood.		
25	Squeezed drip chamber until the in-line filter was saturated.		
26	Connected the blood administration set to the three-way stop-cock.		
27	Started administration slowly (no more than 25 to 50 ml for the first 15 minutes).		
28	Stayed with the patient for the first 5 to 15 minutes of transfusion.		
29	Calculated the drop rate to infuse the blood over maximum time of 4 hours!		
30	Adjusted the correct drop rate on the blood set.		
31	Inspected the insertion site for signs of infiltration or discomfort.		
32	Observed the patient for flushing, dyspnoea, itching, hives or rash, or any unusual comments (verbal report).		
33	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	After completion of the transfusion of blood, clamped the blood administration set.		
37	Restarted Normal Saline infusion.		
38	Disconnected the blood transfusion set from the three-way stop-cock and capped.		
39	Put empty blood product bag and set to the plastic bag.		
40	Assessed patient's vital signs (4th hour).		
41	Discontinued and disconnected the Normal Saline infusion.		
42	Checked patient's comfort.		
43	Removed gloves.		
44	Put equipment in dedicated location.		
45	Sent the empty blood bag back into the laboratory/blood bank.		
46	Performed hand hygiene using correct technique.		

1. SKILL EVALUATION 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 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	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. 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**	
Teacher			Signature				
Clinical Area			Date				

Medication Chart 1

Medication Chart 2

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Procedure Evaluation Document (PED)

PROCEDURE:	**Collection of specimens – nasal swab**	**Code**	**16-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Gloves □ Disposable apron □ Nasal 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	Inserted the swab approximately 2-3cm into naris and rotated the swab.		
13	Removed the swab.		
14	Inserted the swab into the collection tube, taking care not to touch any other surface.		
15	Removed gloves and other PPE.		
16	Placed the specimen tube in a plastic bag without contaminating the outside of the bag.		
17	Performed hand hygiene using correct technique.		
18	Correctly filled in the laboratory request form/s or checked it if already filled.		
19	Ensured the specimen was transported to the laboratory immediately or kept the specimen in the fridge if not contraindicated. (student verbal report)		
20	Documented the result in the patient's notes.		
21	Returned equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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)	**10**
Time achieved	
Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Collection of specimens – sputum**	**Code**	**16-02**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ☐ Patient medical record ☐ Gloves ☐ Mask ☐ Goggles ☐ Sputum specimen container ☐ Laboratory request form ☐ Hand rub gel ☐ Plastic sealable bag for the specimen ☐ Plastic cup ☐ 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	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.		
7	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 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)		
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. 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	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

14	Placed the specimen container in a plastic bag without contaminating the outside of the bag.		
15	Performed hand hygiene using correct technique.		
16	Correctly filled in the laboratory request form/s or checked it if already filled.		
17	Ensured the specimen was transported to the laboratory immediately or kept the specimen in the fridge if not contraindicated. (student verbal report)		
18	Documented the result in the patient's notes.		
19	Returned equipment to the dedicated area.		
20	Reported abnormal findings to the appropriate health care provider (student verbal report).		

1. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Collection of specimens – urine specimen - catheter**	**Code**	**16-04**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared 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	Reviewed the medical orders for collection of urine specimen from catheter.		
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 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	Put on gloves.		
10	Clamped the catheter drainage tubing or bent it back on itself distal to the port. If an insufficient amount of urine is present in the tubing, allow the tubing to remain clamped up to 30 minutes, to collect a sufficient amount of urine, unless contraindicated		
11	Removed the lid from specimen container, keeping the inside of the container and lid free from contamination.		
12	Cleaned the aspiration port with alcohol wipe.		
13	Allowed the port to air dry.		
14	Inserted the needle and syringe into the port, or attached the syringe to the needleless port.		
15	Slowly aspirated 10ml of urine for specimen.		
16	Removed the needle or syringe from the port.		
17	If a needle was used on the syringe, removed from the needle carefully and disposed the needle in the sharps box.		
18	Slowly injected urine into the specimen container.		
19	Replaced the lid on container		
20	Disposed of the syringe in the lined waste bin.		
21	Placed the container in a plastic sealable bag without contaminating outside of the bag.		
22	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	Documented the result in the patient's notes.		
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	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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 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. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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.		

16	Removed gloves and other PPE.		
17	Placed the specimen tube in a plastic bag without contaminating the outside of the bag.		
18	Performed hand hygiene using correct technique.		
19	Correctly filled in the laboratory request form/s or checked it if already filled.		
20	Ensured the specimen was transported to the laboratory immediately or kept the specimen in the fridge if not contraindicated. (student verbal report)		
21	Documented the result in the patient's notes.		
22	Returned equipment to the dedicated area.		

1. 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
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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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		

	number, time specimen was collected, route of collection, identification of the person obtaining the sample.		
9	Put on gloves.		
10	Asked the patient to turn head to the side.		
11	Removed the swab from the collection tube without touching any surface.		
12	Inserted the swab into ear canal.		
13	Rotated the swab to collect inner ear drainage.		
14	Removed the swab.		
15	Inserted the swab into the collection tube, taking care not to touch any other surface.		
16	Removed gloves.		
17	Placed the specimen container in a plastic bag without contaminating the outside of the bag.		
18	Performed hand hygiene using correct technique.		
19	Correctly filled in the laboratory request form/s or checked it if already filled.		
20	Ensured the specimen was transported to the laboratory immediately or kept the specimen in the fridge if not contraindicated. (student verbal report)		
21	Documented the result in the patient's notes.		
22	Returned equipment to the dedicated area.		

1. 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	
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	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)	**10**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Collection of specimens – wound culture**	**Code**	**16-8**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Patient medical record - Wound culture swab - 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 □ Plastic bag for the wound culture specimen □ Waterproof pad □ Surgical trolley		
2	Reviewed the medical orders for wound culture.		
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	Twisted the cap to loosen the swab on the wound culture tube.		
21	Carefully inserted the swab into the wound.		
22	Pressed and rotated the swab several times over the wound surfaces.		
23	Placed the swab back in the culture tube.		
24	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.		
25	Once the wound is cleaned, dried the area using sterile gauze in the same way.		
26	Reapplied the dry sterile gauze dressing.		
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	Labelled the specimen and placed it in a plastic bag.		
31	Restored patient to a comfortable position.		
32	Performed hand hygiene using correct technique.		
33	Documented the result in the patient's notes.		
34	Informed the patient or relative if appropriate of the result.		
35	Returned equipment to the dedicated area.		
36	Reported abnormal findings to the appropriate health care provider (student reported this action verbally).		

1. SKILL EVALUATION 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 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	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)	**20**
						Time achieved	
						Aspects points achieved	

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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE: **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 □ Plastic tray		
2	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	Cleaned the venipuncture site with an alcohol swab moving in a circular motion out from the site approximately 5 cm (2 inches).		
19	Allowed the site to dry completely.		
20	Removed the needle cover and maintained sterility of the needle.		
21	Informed the patient that he or she would feel a stick.		
22	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.		
23	Held Vacutainer needle at a 15- to 30-degree angle from the patient's arm with the bevel up.		
24	Slowly inserted the needle into the vein.		
25	Grasped the Vacutainer securely, and advanced specimen tube into the needle of the holder (did not advance the needle in the vein).		
26	After the specimen tube was filled to the correct level, grasped Vacutainer firmly and removed the specimen tube. Inserted additional specimen tubes as needed.		
27	If tubes contained additives, gently inverted back and forth immediately. Did not shake.		
28	Just before filling the last specimen tube, released the tourniquet.		
29	Filled last tube and removed it from Vacutainer.		
30	Applied gauze pad over the puncture site without applying pressure, and quickly but carefully withdrew the needle with Vacutainer from the vein.		
31	Immediately applied pressure over the venipuncture site with gauze until bleeding stopped.		
32	Inspected puncture site for bleeding, and applied adhesive tape with gauze or a plaster.		
33	Checked collection tubes for any sign of external contamination with blood. Decontaminated with 70% alcohol if necessary.		
34	Filled the label on the tube with all requested details.		
35	Put the blood samples and request form into a plastic, sealable bag.		
36	Ensured that blood samples were sent to laboratory as soon as possible (student verbal report).		
37	Restored patient to a comfortable position.		
38	Performed hand hygiene using correct technique.		
39	Documented the procedure and result in patient's notes.		
40	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 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	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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**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 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) to the Vacutainer holder.		
31	Removed the second blood culture bottle from the holder.		

32	Applied gauze pad over the puncture site without applying pressure, and quickly but carefully withdrew the needle with Vacutainer from the vein.		
33	Immediately applied pressure over the venipuncture site with gauze until bleeding stopped.		
34	Inspected puncture site for bleeding, and applied adhesive tape with gauze or a plaster.		
35	Checked collection tubes for any sign of external contamination with blood. Decontaminated with 70% alcohol if necessary.		
36	Filled the label on the tube with all requested details.		
37	Put the blood samples and request form into a plastic, sealable bag.		
38	Ensured that blood samples were sent to laboratory immediately (student verbal report).		
39	Restored patient to a comfortable position.		
40	Performed hand hygiene using correct technique.		
41	Documented the procedure and result in patient's notes.		
42	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 60%

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
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	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. 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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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Procedure Evaluation Document (PED)

PROCEDURE:	**Death - performing post-mortem care**	**Code**	**17-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared 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 sheets □ Hand rub gel □ Equipment trolley		
2	Checked patient medical record to confirm that the patient has been pronounced dead by the physician.		
3	Checked that the family of the patient has been notified or provide time for the family to see the patient if appropriate.		
4	If there are other patients or visitors in the room, carefully explained the situation and asked them to leave the room temporarily if possible.		
5	Informed relevant staff and departments of the patient's death.		
6	Contacted mortuary and arranged the time for collection of the body.		
7	Contacted any staff/departments involved in organ transplant procurement (verbal report).		
8	Asked the family in a sensitive manner to leave the room to enable preparation of the body for the transfer to the mortuary/out of the hospital.		
9	Pulled the curtains around the bed.		
10	Transferred equipment to the room.		
11	Put on gloves.		
12	Put on apron.		
13	Determine that the client is dead by assessing breathing and circulation.		
14	Placed the body in supine position with the arms extended at the sides.		
15	Removed all medical equipment (iv lines, catheters, drains..)		
16	Removed hairpins or clips.		
17	Closed the eyelids.		
18	Placed or kept dentures in the mouth.		
19	Placed the small rolled towel under the chin to keep the mouth closed.		
20	Cleaned secretions and drainage from the body or washed all the body if soiled.		
21	Removed the bed sheet.		
22	Applied disposable pads between the legs and under the buttocks.		
23	Checked the details on the identification tags with the patient's ID band.		
24	Attached identification tags to the ankle and the wrist.		
25	Wrapped the body in the shroud.		
26	Attached the identification tag to the shroud.		
27	Covered the body with a clean sheet.		
28	Packed all the patient's belongings.		
29	Tidied the bedside.		
30	Removed gloves and apron.		
31	Washed hands.		
32	Returned patient's belongings to the family.		
33	Provided psychological support to the family and answered any questions		
34	Arranged the transport of the body to the mortuary/out of the hospital.		
35	When the room was empty, arranged the cleaning of the room.		
36	Documented the procedure in patient's medical record.		

1. SKILL EVALUATION 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 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	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)	**60**
						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			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				