UCLA Health

# DEPARTMENT OF NURSING INITIAL COMPETENCY VALIDATION CHECKLIST: ORIENTATION: RN

**POSITION TITLE:**_____ **UNIT:**_____ **EMPLOYEE NAME:**_____

The above staff member has demonstrated the knowledge, skills, and attitudes necessary to provide care appropriate to the age of the patients served on his or her assigned unit. The individual has demonstrated knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's status and interpret the appropriate information needed to identify each patient's requirements relative to his or her age specific needs.

**Preceptors:** Please sign your initials and date each competency in the appropriate column as they are completed. Then, sign your full name and initials below for reference.

| AGES SERVED – CHECK AGE GROUPS SERVED | |
|---|---|
| ☐ A – NEONATES (<30 DAYS) | ☐ E – ADULTS (>=18 YEARS & <65 YEARS) |
| ☐ B – INFANTS (>=30 DAYS & <1 YEAR) | ☐ F – GERIATRICS (>=65 YEARS) |
| ☐ C – PEDIATRICS (>=1 YEAR & <13 YEARS) | ☐ O – NOT APPLICABLE |
| ☐ D – ADOLESCENTS (>=13 YEARS & <18 YEARS) | |

| COMPETENCY ASSESSMENT CRITERIA | VALIDATION OF COMPETENCY | |
|---|---|---|
| | INITIALS | DATE |
| **A. PATIENT/FAMILY CENTERED CARE** | | |
| 1. Nursing Process | | |
| a. Assessment-Adult | | |
| 2. Patient Education | | |
| 3. Patient Experience | | |
| 4. Pain Management and Pain Service | | |
| a. Equipment: Curlin Pain Smart Pump (PCA/PCEA) | | |
| 5. Patient/Family Communication | | |
| a. Interpreter Services | | |
| 6. Advance Directives | | |
| 7. End of Life Care | | |
| 8. Palliative Care | | |
| **B. TEAMWORK COLLABORATION** | | |
| 1. Communication-Handoff/Handover Process | | |
| 2. Delegation | | |
| 3. Chain of Command | | |

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| | | |
|---|---|---|
| 4. Care Coordination | | |
| 5. Patient Admission | | |
| 6. Patient Discharge | | |
| 7. Patient Transfer: | | |
| a. Patient Transfer Within The Facility | | |
| b. Patient Transfer Outside The Facility | | |
| **C. EBP (EVIDENCE BASED PRACTICE)** | | |
| 1. Evidence Based Practice | | |
| **D. QUALITY IMPROVEMENT** | | |
| 1. Quality Improvement | | |
| 2. Core Measures: | | |
| a. Immunization Screening in Adults | | |
| b. Sepsis | | |
| c. Venous Thromboembolism (VTE) Prophylaxis and anticoagulation | | |
| i. Equipment: VTE Devices | | |
| ii. Equipment: Foot Pump | | |
| 3. Nurse Sensitive Indicators: | | |
| a. Adult Fall Prevention: Post fall and Post Fall Head Injury Care | | |
| b. Infection Prevention: Catheter Associated Urinary Tract Infection (CAUTI) Prevention | | |
| i. Equipment: Bladder Scanner | | |
| c. Infection Prevention: Central Line-associated Bloodstream Infection (CLASBI) Prevention | | |
| d. Skin Care and Wound Management | | |
| **E. SAFETY** | | |
| 1. Blood/Blood Product Administration | | |
| 2. Central Venous Catheters | | |
| 3. Cardiopulmonary Monitoring | | |
| a. Equipment: EKG | | |
| b. Equipment: Pulse Oximetry | | |
| c. Equipment: Doppler | | |
| d. Equipment: Vital Sign Device | | |
| 4. EKG | | |
| a. Equipment: Lead Placement | | |
| b. Equipment: 12 Lead Recording | | |

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| | | |
|---|---|---|
| c. Equipment: Analysis | | |
| d. Equipment: Storage | | |
| e. Equipment: Central | | |
| f. Equipment: Mirrored Monitor Station | | |
| 5. **Disruptive Behavior:** Constant Observation Aide (COA), suicide assessment and precautions, de-escalation process, and Code Gray, medical incapacity | | |
| 6. Changing Patient Condition: Rapid Response, Code Stroke, and Code Blue | | |
| a. Equipment: Zoll: AED, Defibrillator, Cardiovert, Pacer, and ETCO2 | | |
| b. Equipment: Emergency Cart: Code Cart Contents and Location | | |
| 7. Glycemic Management | | |
| a. Equipment: Accu-Chek Inform II | | |
| b. Equipment: Insulin Pen | | |
| 8. Infection Prevention | | |
| 9. Infusion Therapy: | | |
| a. Intravenous Insertion and Venipuncture | | |
| i. Equipment: Vein Finder AV400 | | |
| ii. Equipment: Infusion Pump (Sigma) | | |
| 10. Lab and Specimen Handling | | |
| 11. Medication Management and Administration | | |
| 12. Procedural Sedation | | |
| 13. Respiratory Management and Oxygen Administration | | |
| a. Equipment: Oxygen Delivery Devices | | |
| 14. Restraints | | |
| 15. Safe Patient Mobilization | | |
| 16. Temperature Management | | |
| 17. Cooling Devices | | |
| a. Warming Devices | | |
| b. Universal Protocol | | |
| **F. INFORMATICS** | | |
| 1. Documentation Standards and Audits | | |

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In signing this competency assessment, I agree I have been oriented as documented above. I recognize my own limitations, will seek resources when I am unsure of a planned action and agree to perform according to UCLA Health policy/procedures, Nurse Practice Act and Professional Standards of Practice.

Signature of Employee:_____ Employee Number:_____ Date:_____

| PRECEPTOR SIGNATURE | PRECEPTOR EMPLOYEE NUMBER | PRECEPTOR UNIT | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Signature of Educator/Manager: _____ Employee Number_____ Date:_____

**One Staff = "Init Comp"**