A Practical Guide to Competency Assessment

Jill M. Sheehan
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A PRACTICAL GUIDE TO COMPETENCY ASSESSMENT

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

ADULT AND CORPORATE INSTRUCTIONAL MANAGEMENT PROGRAM
SCHOOL OF EDUCATION

BY

JILL M. SHEEHAN

CAROL STREAM, ILLINOIS

OCTOBER 1994
This manual is dedicated to
the health and wellness of all the customers
EHS Health Care serves.

Manual developed and written by Jill M. Sheehan, M.A., Senior Education Specialist, EHS University, EHS Health Care.

Program developed by Nancy Luehrs, R.N., B.S.N., Manager, Clinical Education, EHS Good Shepherd Hospital in conjunction with the EHS Good Shepherd Nursing Education and Research Council.

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PREFACE

Fairy tales teach us that everyone can open doors to great treasures if they have the "magic key." Competence is no different; it prevails as the door beyond which flourishes personal and professional excellence. And in competency assessment, YOU ARE THE KEY to helping your staff open the door to new levels of competence and confidence on your unit. Open Sesame!

This manual serves as a practical guide and resource book for competency assessment. It provides:

- the rationale for and methodology of competency assessment,
- a template for the identification, development and assessment of competencies,
- a comprehensive collection of tools, examples and resources, and
- a systematic process to identify and address developmental needs.

PURPOSE OF THIS MANUAL

The Adult and Corporate Instructional Management (ACIM) program is designed to teach its students the required sets of complex skills and knowledge to meet the specific needs of the corporate trainer, educator and instructional designer. Therefore, the program stresses application of the design and educational skills necessary to function in a training and development setting. Moreover, it teaches students to synthesize these skills in order to develop educational material appropriate to their organization's employee population.

As merited by the nature of the ACIM program, the development of a competency assessment manual as a thesis project was approved. This manual was developed at the request of the Professional and Clinical Education Department of EHS University as a result of the need for a clinical competency assessment program. This program is required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It was completed in partnership with Nancy Luehrs, EHS Good Shepherd Hospital's Manager of Clinical Education.
METHOD OF RESEARCH

This manual required the research of clinical competency models, investigation and analysis of current models used within the organization, partnering with internal customers, and obtaining customer feedback. A detailed literature search was conducted to research all aspects of clinical competency assessment including identification of various models, best practices, successes and failures. Joint Commission standards were also researched and identified. Then, internal models were investigated and the current model in the process of successful implementation at EHS Good Shepherd Hospital in Barrington, Illinois was analyzed. A partnership was formed with the manager of Clinical Education, and the Professional and Clinical Education Department of EHS University. Feedback was obtained from these internal customers in regards to format, content, and thoroughness as the manual was being completed.

ACKNOWLEDGEMENTS

Special thanks to:

Nancy Luehrs, RN, BSN, Manager, Clinical Education and Research, EHS Good Shepherd Hospital. Nancy's unyielding energy for and dedication to professional competence and learning was the vehicle that helped create this manual. Sincere appreciation is also given to Nancy and the other individuals at EHS Good Shepherd who designed the competency assessment process and the self-learning module tools included in this manual.

In addition, special thanks to the other individuals who made this manual possible:

- Kathie Blanchfield, PhD, RN, Director, Professional and Clinical Development, EHS University
- Char Bock, Coordinator, Professional and Clinical Development, EHS University
- Terri Holden, RN, BSN, Nurse Manager, Medical ICU, Loyola University Medical Center
- Janice Muzynski, RN, MS, Associate Director, Professional and Clinical Development, EHS University

Jill M. Sheehan, M.A.
"COMPETENCY"

In order to be able to assess the competency of individuals at EHS Health Care, there must first be a common understanding or a definition of competency. In recent years, hundreds of definitions have been published. However, for all practical purposes, "competency" can be defined "in its most generic form as any underlying characteristic an individual possesses and uses which leads to successful performance in a life role" (Dubois, 5).

Competency, therefore, is the knowledge, skills, ability, attitudes, behavior and "intellectual strategies, such as problem solving and the ability to deal with ambiguity" (Stephens, 7) necessary to meet performance expectations or "function well in a given situation" (Joint Commission Tape Library, Lecture).

As Callahan states, "A competency is a single, observable or definable skill" (Callahan, 387-88). "The concept of skill involves perceptual, motor, manual, intellectual and social aspects" (Parkes, 7). "In traditional programs the question is . . . what should the person know to do the job? . . . In competency-based programs the question is...what does a competent performer do in this job" (Grey, 128A)?

"COMPETENCY ASSESSMENT"

Competency assessment means "to examine critically the necessary conditions which make a person fit for a job, task or function in order to acquire or obtain those privileges" (Luehrs).

Competency assessment, therefore, is "a method of assessing an individual's ability to perform an identified behavior according to specified cognitive and/or psychomotor criteria" (Feeney, 269).

The components involve the "identification of knowledge and skills necessary for achievement of the competency" and then the demonstration of that behavior (Kawczak Hagerty, 157).
PURPOSE AND VALUE

Journal articles and books have been published worldwide regarding the importance of and need for competency assessment in health care. The rationale for developing competencies is well documented:

"The value of evaluating competency is three-fold:

1) it promotes the delivery of consistent, quality care [and service] by ensuring that all [employees] are able to perform at a competent level;

2) provides objective data for use in employee performance appraisal and counseling; and

3) provides documentation (in the event of legal action) that management has defined and evaluated the clinical competence of individual[s]" (Feeney, 369).

Competency assessment involves taking ownership for one's own self-directed learning and thus has several advantages or benefits. First, it increases cognitive learning; secondly, integrates knowledge and skills; and lastly produces consistent and predictable practice (Luehrs). Del Bueno describes competency orientation as a model that:

1. promotes individualized assessment of the nurses' learning needs;
2. emphasizes defined performance outcomes; and
3. allows for varied learning opportunities to achieve the outcomes with time flexibility" (Kawczak Hagerty, 157).

It "cannot be assumed that all experienced staff are clinically competent by virtue of their work experience alone" (Houge, 102). As a result, the Joint Commission states that "there must be a process to ensure competence by explicit specification rather than by implicit assumption" (Callahan, 388).

In addition, health care organizations must legally ensure the competence of their staff. As cited by Scrima,

"Legal aspects of professional practice also demand that institutional mechanisms exist. The hospital may be held liable for negligent acts of staff members. Moreover, persons in positions of management may be held liable if an individual in their employ fails to exercise competent practice. These factors mandate that minimum measures to ensure competency must be developed and documented. This process should ensure that the new employee be restricted from performing specific tasks without supervision and provide a mechanism for repeated evaluation" (Scrima, 42).
Also, "Because hospitals are legally responsible for their employees' actions, it is essential that minimum requirements be set and that programs be developed and documented to ensure staff competency" (McGregor, 79).

Documented effects can be astonishing:

"The negative outcomes of the system can be measured statistically. They are both impressive and disturbing. If even half of the 20-25% of hospital admissions estimated to be iatrogenic or medically caused, and even half of the estimated 10,000 deaths per year attributed to unnecessary surgery are so caused, we have an epidemic of health care that is compromising the public's health as well as affecting the economy" (Sultz, 275).

Thus, health care managers and organizations have "a continuing obligation to assure that competencies consistent with the current state of the art are maintained" (275). Two reasons warrant this view. The first is that:

"... the health care system is not populated by charlatans, incompetents, and crooks. With rare exception, health care providers who use technology inappropriately, who misuse and abuse the considerable array of therapeutic drugs, who fail to diagnose correctly, who fail to treat appropriately when the diagnosis is accurate, who misinform or are unable to inform patients do so out of ignorance of the requisite knowledge and, perhaps more important, of a professional value system that demands self-inspection and self-discipline. The remedy for ignorance is education ...

The second reason that [health care organizations] have an obligation to assist in the maintenance of competence, although more pragmatic, should be equally persuasive: no other agency or institution has the capacity to provide the needed education" (275).

Once developed, competency assessment tools can be used for the formation of job descriptions, staff orientations, performance reviews, "staff development and peer review" (Callahan, 388).
COMPETENCY APPLICATION IN HEALTH CARE: CORE VS ANNUAL COMPETENCIES

At EHS Health Care, two sets of competencies have been identified: core competencies and annual competencies.

Core competencies are those basic sets of skills and knowledge required in order to perform at a minimally competent level. Core competencies are assessed and documented during a new employee's general and unit-specific orientation. Core competencies can be unit-specific or housewide. For example:

- Core competency, housewide: Guidelines for Documentation
- Core competency, unit-specific: Enteral Fluid Requirements

During the initial implementation of this program, seasoned employees will need to be assessed as documentation of core competency assessment.

Annual competencies are those basic sets of skills and knowledge required of all employees in order to perform at a minimally competent level. Annual competencies can be unit-specific, but more often are housewide. For example:

- Annual competency, housewide: CPR; Fire Safety; Electrical Safety
- Annual competency, unit-specific: TPN Order Calculations

At EHS Health Care, each unit manager is responsible for ensuring that core and annual competencies have been met by each member of her/his staff. If a manager is in need of assistance or direction, several resources are available: the EHS Corporate Education Committee, the specialty councils, EHS University: Department of Professional and Clinical Development, clinical specialists and clinical educators at any of the other units or EHS facilities.
THE NEED FOR COMPETENCY ASSESSMENT AT EHS HEALTH CARE

Ensuring the competence of staff is not just a nice thing to do! It is essential to maintain the quality of care and service for patients and other customers of EHS Health Care. The reasons for ensuring competency are many. They include Continuous Quality Improvement, Joint Commission, management accountabilities, performance review, cross training and customer focus.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

Continuous improvement in the way employees work, how they serve their customers and how well they do their job is the focus of EHS Health Care and countless other organizations today. CQI requires all employees to hold up the magnifying glass and take a critical look at how they can become even more successful.

With the implementation of CQI, EHS is able to assess and continue to increase the competence of all individuals within the organization. This will help to provide even higher quality of care and service to patients, families, and all other customers of EHS Health Care.

JOINT COMMISSION (JCAHO)

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the implementation of competency assessment. In addition, the Joint Commission will be looking for the assessment of competencies at a nursing and allied health level during its reviews.

"In the 1991 Accreditation Manual for Hospitals (AMH), the Joint Commission introduced standards requiring each nurse's competency to be evaluated throughout his or her association with the hospital. These requirements are found in standards NC.2 through NC.2.4.1.1 in the 1993 AMH. In addition, all staff who provide patient care services are expected to demonstrate competencies appropriate to their responsibilities. These expectations can be found in standards SE.4 through SE.4.4 in the 1993 AMH" (Joint Commission Tape Library, Participant's Guide, 1).
"Relevant Joint Commission Standards

NC.2 All nursing staff members are competent to fulfill their assigned responsibilities.

NC.2.1 Each nursing staff member is assigned clinical and/or managerial responsibilities based on educational preparation, applicable licensing laws and regulations, and an assessment of current competence.

NC.2.1.1 An evaluation of each nursing staff member's competence is conducted at defined intervals throughout the individual's association with the hospital.

NC.2.1.1.1 The evaluation includes an objective assessment of the individual's performance in delivering patient care services in accordance with patient needs.

NC.2.1.1.2 The process for evaluating competence is defined in policy and procedure.

NC.2.1.2 Nursing care responsibilities are assigned to a nursing staff member in accordance with

NC.2.1.2.1 the degree of supervision needed by the individual and its availability; and

NC.2.1.2.2 the complexity and dynamics of the condition of each patient to whom the individual is to provide services and the complexity of the assessment required by each patient, including

NC.2.1.2.2.1 the factors that must be considered to make appropriate decisions regarding the provision of nursing care, and

NC.2.1.2.2.2 the type of technology employed in providing nursing care.

NC.2.2 The determination of a nursing staff member's current clinical competence and the assignment of nursing care responsibilities are the responsibility of registered nurses who have the clinical and managerial knowledge and experience necessary to competently make these decisions.

NC.2.3 If a nursing staff member is assigned to more than one type of nursing unit or patient, the staff member is competent to provide nursing care to patients in each unit and/or to each type of patient.
Documented evidence of licensure and current clinical competence in assigned patient care responsibilities are reviewed and approved by the hospital before nursing personnel from an outside source(s) engage in patient care activities.

The performance of these nursing personnel in the hospital is evaluated.

Responsibility for this evaluation is defined in hospital policy.

Each individual in the organization is competent, as appropriate to his/her responsibilities, in the knowledge and skills required to perform his/her responsibilities; effective and safe use of all equipment used in his/her activities; prevention of contamination and transfer of infection; and cardiopulmonary resuscitation and other lifesaving interventions" (3).

"...it is necessary to identify specific tasks needed to perform job functions and the required qualifications expected of the staff performing those job functions. Competency requirements will need to be updated since work processes many change as a result of quality assessment and improvement activities; new developments in health care management, science, and technology; and changing patient care needs" (Joint Commission, Accreditation Manual, 11).

MANAGEMENT ACCOUNTABILITIES

One of the key accountabilities of managers is and will continue to be the competence of their staff. As a result, managers will need the tools to determine and ensure ongoing competence of staff. Self-learning modules, competency assessment, and developmental plans all contribute to the ongoing effectiveness of a department or unit and thus has a reflection on the effectiveness of its manager.
PERFORMANCE REVIEW

In order to effectively evaluate an individual's performance, managers or peer reviewers must have documentation of the employee's performance. Documentation from competency assessment provides reviewers with some of the vital documentation they need to assess individuals' competence, provide positive feedback, and discuss future developmental plans.

CROSS TRAINING

Today and in the future, health care organizations will need to have a flexible workforce that can adapt quickly to the changing needs of its environment. As a result, cross training has become a widely used vehicle. Throughout the process of cross training, standards and competencies are used to identify training needs, set objectives, assess knowledge and skills, and guide the developmental plan. The road to ensuring competence begins by first identifying competence and providing opportunities for competence to be achieved.

CUSTOMER FOCUS

As health care becomes more and more competitive, focusing on the needs and expectations of customers becomes crucial to an organization's viability and success. Patients, families, physicians and macro buyers will be examining more closely the practices and competence of staff in determining where to bring their business. Assessing and documenting competency, then, is a key component to remaining competitive and maintaining the interest of future customers.
FOR WHOM DOES COMPETENCY ASSESSMENT APPLY?

Every job requires a certain set of skills and knowledge in order to be effective and perform competently. Thus, every person regardless of job title or level within an organization, health care or otherwise, must have a set of competencies in order to meet standards and expectations.

If this is true, every individual at EHS Health Care can be assessed according to the competencies of their position. This includes:

- Nursing Staff
- Allied Health Staff
- Ancillary Staff
- Non Clinical and Support Staff
- Supervisors and First-Line Management
- Middle Management
- Senior Management

It is suggested that competency assessment begin with Nursing and Allied Health professionals as these individuals make up the largest population of EHS Health Care and have the greatest impact on the well being of our customers.

It is then suggested that competency assessment be shared throughout the remainder of the organization to ensure that each individual at every level has the skills and knowledge necessary for competent performance.
HOW TO DEVELOP A COMPETENCY ASSESSMENT PROGRAM

HOW TO IDENTIFY AND PRIORITIZE COMPETENCIES

The careful, accurate identification and then prioritization of competencies for the unit is essential for meaningful competency assessment. There are three tools that can be used to identify and prioritize competencies. These are the:

• Competency Needs Assessment - 3 Star Method
• Orientation Skill Checklist
• Department Summary Record of Staff Competencies

Each of these tools provides information to identify critical core and annual competencies. In addition, the needs assessment allows for the prioritization of these competencies according to specific criteria. Identification and development of a competency assessment program should be a collaborative effort between the manager, experienced staff and clinical preceptors.
COMPETENCY NEEDS ASSESSMENT - 3 STAR METHOD

WHAT IS IT?

The Competency Needs Assessment provides a method to identify and prioritize skills/knowledge that are essential to competent job performance. It is an all-inclusive checklist of job accountabilities and responsibilities from which competencies are determined. The three criteria used are:

- High Risk
- Problem Prone
- Seldom Used/Frequently Used

There is no specific number of competencies that need to be chosen. In fact, your guideline should instead be to choose those competencies that are high priority, whether there are three or ten!

WHEN TO USE?

The needs assessment should be developed based on each job description/accountabilities and then reevaluated on a yearly basis.

HOW TO USE?

1. Working from the Job Description, identify housewide and unit-specific job accountabilities and responsibilities. List these skills/knowledge in the Skills Checklist column. The list will include both core and annual competencies.

2. Next, review each item on the list. Place a "star" in the appropriate box for each item if the following criteria is met:

   - High Risk: If the accountability is associated with a potential problem or high risk for the patient, the employee, or the facility.

   - Problem Prone: If there has been a history of difficulties with the accountability or if there is evidence that it is already a problem. Be sure to utilize quality indicators, patient dissatisfiers, your CQI plan and incident reports as resources.
• Seldom Used: If the accountability is not done often. Nursing may want to review the DRG's to identify those that are seldom done.

• Frequently Used: If the accountability is done very often and it is high risk.

3. To prioritize the accountabilities, count the number of stars in each row, adding them across.

3 ★ For those accountabilities with 3 stars, place a "3" in the Priority column. These are your most important priorities!

2 ★ For those accountabilities with 2 stars, place a "2" in the Priority column. These are your next most important priorities.

1 ★ For those accountabilities with only 1 star, place a "1" in the Priority column. These are your third most important priorities.

Congratulations! By using this three star method, you have identified and prioritized competencies for your unit.

See the example on page 15 for more detail.
### SKILL CHECKLIST FOR CLINICAL DIETICIAN

<table>
<thead>
<tr>
<th>Skill</th>
<th>High Risk</th>
<th>Problem Prompt</th>
<th>Seldom Used</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritize patient load</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Patient Assessments</td>
<td>★</td>
<td>★</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Nutritional recommendations</td>
<td>★</td>
<td>★</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Educational resource selection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of patient knowledge</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Diet calculations</td>
<td></td>
<td></td>
<td>★</td>
<td>1</td>
</tr>
<tr>
<td>TPN order calculations</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Enteral formulas</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Baby formulas</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Skinfold measurement</td>
<td></td>
<td></td>
<td>★</td>
<td>1</td>
</tr>
<tr>
<td>Renal, complicated</td>
<td></td>
<td></td>
<td>★</td>
<td>2</td>
</tr>
<tr>
<td>Diabetic, complicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetarian (Strict)</td>
<td>★</td>
<td>★</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Kosher</td>
<td></td>
<td></td>
<td>★</td>
<td>2</td>
</tr>
<tr>
<td>Failure to Thrive assessment</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Anorexia evaluation</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Drug/Nutrient Interactions, Primary</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Instruction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid Requirements, Adult</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Fluid Requirements, Child</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Visual Nutrition Assessment</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
</tbody>
</table>

*1993, EHS Good Shepherd Hospital Clinical Education/Competency Assessment Program*
ORIENTATION SKILL CHECKLIST

WHAT IS IT?

The Orientation Skill Checklist is a tool to assist managers and preceptors in the development and assessment of new employees' competencies during the initial orientation on the unit. It serves as an outline and checklist to help formulate the major topics, skills and knowledge of the unit-specific orientation. When this tool is completed, you will have written documentation of core competencies, skills and knowledge for each new employee on the unit.

WHEN TO USE?

After it has been developed, the checklist is used during orientation to evaluate new employees' core competencies, skills and knowledge when beginning work on a unit. The checklist is used by new employees for their self assessment and by the preceptor for documentation during employee orientation.

HOW TO USE?

1. List all the accountabilities and skills/knowledge identified from the Competency Needs Assessment onto the Orientation Skill Checklist. Also list the major steps or skills involved under each accountability.

2. Identify those items that are higher priority competencies (identified as priority 3 or 2) under the Comments column.

3. When a new employee arrives on the unit, she/he should complete the self evaluation section. This allows the new employee to do a self assessment and identify learning needs. It also enables the preceptor to individualize the orientation process to meet these needs.

4. During the orientation process, the preceptor will use the Preceptor Evaluation section to document the following:

   ■ Reviewed: When material has been reviewed with or given to the employee.

   ■ Verbalizes Understanding: When the employee can verbalize knowledge acquired.

   ■ Demonstrates Skill: When the employee performs the skill observed by the preceptor or reviewer.
Documentation in this section is especially important if the new employee will be oriented by more than one preceptor or reviewer.

See the example on page 18 for more detail.
### EHS GOOD SHEPHERD HOSPITAL
Barrington, Illinois

**NAME:**

**TITLE:** Clinical Dietician

**UNIT:** Food Service

<table>
<thead>
<tr>
<th>SELF EVALUATION</th>
<th>CLINICAL DIETICIAN</th>
<th>PRECEPTOR</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent</td>
<td>Orientation Skill Checklist</td>
<td>Reviewed</td>
<td>Verbalizes Understanding</td>
</tr>
<tr>
<td>Additional Education Needed</td>
<td>(outline of competency requirements)</td>
<td>(date/initial)</td>
<td>(date/initial)</td>
</tr>
<tr>
<td>Additional Experience Needed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Prioritize patient load
2. Patient assessment
3. Makes appropriate nutritional recommendation
4. Selects appropriate educational materials
5. Assessment of patient knowledge
6. Prepares accurate diet calculations
7. Calculates TPN orders for cals, C, P, F.
8. Knowledge of appropriate enteral formulas
9. Knowledge of baby formulas
10. Skin fold measurement
11. Complicated renal
12. Complicated diabetic
13. Vegetarian (strict)
14. Kosher
15. Failure to thrive assessment
16. Appropriate evaluation/recommendations
17. Primary knowledge of drug/nutrient interactions
18. When is it appropriate to instruct?
19. Fluid requirements (adult)
20. Fluid requirements (child)
21. Visual/physical assessment for malnutrition

Orienteer's Signature: ____________________________
Preceptor's Signature: ____________________________

Date: ____________________________ © 1993. EHS Good Shepherd Hospital Clinical Education/ Competency Assessment Program
DEPARTMENT SUMMARY RECORD OF STAFF COMPETENCIES

WHAT IS IT?

The Department Summary Record of Staff Competencies is a tool for managers to document individuals' compliance with required competencies. Thus, it is a record of all competencies completed on the unit by each individual employee.

WHEN TO USE?

This record is maintained on an ongoing basis and updated as competencies are completed by employees. New records are kept for each calendar year.

HOW TO USE?

1. List each employee's name down the left-hand column.

2. List annual housewide and unit-specific competencies required for that year across the top row. These are the top priorities identified from the Competency Needs Assessment.

3. Throughout the year, record the date in the appropriate box when an individual has successfully completed a competency.

4. At the end of the year, document the percentage of compliance on the bottom of each column for distribution to Human Resources and the Safety Committee. Note that JCAHO requires 100% compliance.

5. Post the Summary Record form in the department to maintain employee awareness of compliance. In addition, department assignment decisions should be based on this documentation.

See the example on page 20 for more detail.
<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>ANNUAL SAFETY COMPETENCIES</th>
<th>P.T.R ORDER CALCULATIONS</th>
<th>ENTERAL FORMULAS</th>
<th>BAY FORMULAS</th>
<th>FAILURE TO THERAPE</th>
<th>ANOREXIC EVALUATION</th>
<th>FLUID REQUIREMENTS (ADULT)</th>
<th>FLUID REQUIREMENTS (CHILD)</th>
<th>NUTRITION ASSESSMENT (VISUAL)</th>
<th>% COMPLIANCE</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Calendar Year: 1994
DEVELOPMENT OF SELF-LEARNING MODULES FOR COMPETENCY ASSESSMENT

Competencies are created for each item identified as a priority on the Competency Needs Assessment. The developer of the competency should be someone with expertise in that area, whether it be:

- The unit manager,
- A unit preceptor,
- A staff member,
- A clinical specialist, or
- Another person outside of the unit.

TOOLS:

There are several tools used to create a competency and its study guide. They include:

- Cover Page
- Written Competency
- Guidelines for Written Competency
- Guidelines for Skill Competency
- Evaluation Form
- Answer Key for Written Competency

The study guide provides the learners with material and resources to help them successfully achieve the competency. Once developed, it will allow employees to prepare themselves independently and at their own pace for the competency assessment. It also provides the manager or preceptor with guidelines to assess employees' skill competencies.
COVER PAGE FOR SELF-LEARNING MODULE

WHAT IS IT?

In order to develop a competency and a study guide for that competency, the objectives must first be determined. The Cover Page For Self-Learning Module allows you to identify the target audience, the behavioral objectives or desired outcomes and all resource materials required to complete the self-learning module.

WHEN TO USE?

This page is to be developed when creating a competency. It serves as a cover page for the independent study guide of the specific competency.

HOW TO USE?

When creating a cover page for a self-learning module, the following steps are followed:

1. Prepared by - Identify the author or preparer of the study guide. Include her/his degrees and title. This serves to give credibility to the competency and also identify a resource person.

2. Abstract - Identify the target audience and a sentence or two introducing the module.

3. Objectives - Identify the main objectives or desired outcomes of the competency in behavioral terms. An objective or desired outcome is what specifically and in behavioral terms you want the learner to know or do upon completion of the module.

   For example, "Upon completion of this module, the employee will be able to . . . list the equipment requiring electrical safety testing." See Appendix IV for The Process of Writing Objectives.

4. Resources - List the resource materials required to complete the self-learning module and necessary for successful validation of the competency. This may include reading materials, journal articles, policies and procedures and video tapes. In choosing materials, consideration should be given to the accessibility and practicality of using these methods. In addition, list the competencies required for the completion of this module (written and/or skill).
See the example on pages 24 for more detail.
EHS Good Shepherd Hospital

Competency Assessment Program

ENTERAL FLUID REQUIREMENTS

Foods & Nutrition Department

ABSTRACT:

The following is a competency for Clinical Dieticians for determining fluid requirements in infants, children, adults and tube fed patients.

OBJECTIVES:

Upon completion of this module, the employee will be able to:

1) Calculate fluid requirements for infants, children, adults and stressed adults.
2) Assess fluid adequacy in the tube fed patient.
3) Identify appropriate free water recommendation for tube fed patients.

RESOURCES:

Materials required to complete the self learning packet include:

A) Table I: Fluid Requirements, Infant-Adult (attached)
B) Good Shepherd Hospital enteral formulary
C) Calculator
D) Written Competency

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Competency Assessment Program
RESOURCE MATERIALS

WHAT ARE THEY?

Resource materials that will assist staff in gaining the knowledge and skills needed to meet the competency are to be included in the study guide.

HOW TO USE?

Include any written materials that will assist staff in gaining the knowledge and skill needed to meet the competency in the study guide. Other forms of learning such as books and video tapes should be listed as resources on the Cover Page For Self Learning Module. Considerations when selecting materials:

1. Is there a current policy and procedure or protocol regarding this competency? Does one need to be developed?

2. Is the policy and procedure or protocol current practice or does it need to be revised?

3. Is the material clear, readable, and easily understood?

4. Can the competency be successfully achieved through the use of these materials and other resources chosen?

5. Is there enough learning material included to allow the reader to easily reach the objectives?

6. Is there too much material included so that the reader may become overwhelmed?

7. How often or to what extent will these materials need to be updated?

8. Have I obtained necessary permission for copyrighting written materials or video tapes?

See the example on pages 26-27 for more detail.
<table>
<thead>
<tr>
<th>AGE</th>
<th>FLUID ml/kg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants &amp; Children</td>
<td></td>
</tr>
<tr>
<td>&lt; 750 g. infant</td>
<td>180-200</td>
</tr>
<tr>
<td>Infant</td>
<td>120-180</td>
</tr>
<tr>
<td>1-3 yr.</td>
<td>125</td>
</tr>
<tr>
<td>4-6 yr.</td>
<td>100</td>
</tr>
<tr>
<td>7-12 yr.</td>
<td>75</td>
</tr>
<tr>
<td>13-15 yr.</td>
<td>50</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Young adults with large muscle</td>
<td>40</td>
</tr>
<tr>
<td>Adults 18-55</td>
<td>35</td>
</tr>
<tr>
<td>Vent and elderly without major cardiac/ renal disease</td>
<td>30</td>
</tr>
<tr>
<td>Renal &amp; Heart patient</td>
<td>25</td>
</tr>
</tbody>
</table>

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### GOOD SHEPHERD HOSPITAL NUTRITIONAL FORMULARY

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>ADMINISTRATION</th>
<th>CALORIE (F.S.)</th>
<th>PROTEIN gms/scoop</th>
<th>OSMOLALITY</th>
<th>FREE H₂O</th>
<th>USES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure*</td>
<td>Primarily P.O.</td>
<td>1 cal/cc</td>
<td>37.2</td>
<td>470</td>
<td>844/l</td>
<td>An all purpose, low residual supplement or enteral feeding</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure Plus*</td>
<td>Primarily P.O.</td>
<td>1.5 cal/cc</td>
<td>55.0</td>
<td>670</td>
<td>769/l</td>
<td>Nutrient dense, high protein, high calorie, enteral feeding or oral</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Ensure* Pudding</td>
<td>P.O.</td>
<td>250 cal/5 oz</td>
<td>10.9/5 oz</td>
<td>—</td>
<td>—</td>
<td>Nutrient dense supplement ideal for patients with impaired swallowing</td>
</tr>
<tr>
<td>Hepatic Aid</td>
<td>Primarily P.O.</td>
<td>1.18 cal/cc</td>
<td>44.1</td>
<td>560</td>
<td>820/l</td>
<td>A mixture of essential and non-essential amino acids. CHO, fat, for</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>patients with chronic liver disease</td>
</tr>
<tr>
<td>Jevity*</td>
<td>T.F. or P.O.</td>
<td>1 cal/cc</td>
<td>44.4</td>
<td>300</td>
<td>835/l</td>
<td>Fiber containing enteral formula to maintain normal bowel function</td>
</tr>
<tr>
<td>Osmolite*</td>
<td>Primarily T.F.</td>
<td>1 cal/cc</td>
<td>37.2</td>
<td>300</td>
<td>841/l</td>
<td>Low residue enteral feeding or oral feeding for patients with altered</td>
</tr>
<tr>
<td></td>
<td>or P.O.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>taste</td>
</tr>
<tr>
<td>Pulmocare*</td>
<td>T.F. or P.O.</td>
<td>1.5 cal/cc</td>
<td>62.6</td>
<td>490</td>
<td>785/l</td>
<td>High fat, low CHO enteral formula to ~ CO₂ production for patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>with COPD or respiratory disease</td>
</tr>
<tr>
<td>Pellarin*</td>
<td>T.F. or P.O.</td>
<td>1 cal/cc</td>
<td></td>
<td>310</td>
<td>840/l</td>
<td>Oral or enteral feeding for 1-8 year olds</td>
</tr>
<tr>
<td>ProMod*</td>
<td>Add to T.F. or P.O.</td>
<td>28 cal/scoop</td>
<td>5 gms/scoop</td>
<td>—</td>
<td>—</td>
<td>Concentrated protein that can be added to oral supplements or enteral</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>TF</td>
</tr>
<tr>
<td>Replena*</td>
<td>T.F. or P.O.</td>
<td>2 cal/cc</td>
<td>30</td>
<td>615</td>
<td>712/l</td>
<td>Ready to use high calorie, low protein, low electrolyte and low fluid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>formula for renal patients</td>
</tr>
<tr>
<td>Vivean TEN</td>
<td>T.F. or flavored P.O.</td>
<td>1 cal/cc</td>
<td>38.2</td>
<td>630</td>
<td>845/l</td>
<td>Elemental formula for patients with impaired GI function</td>
</tr>
<tr>
<td>CIB</td>
<td>P.O.</td>
<td>280 cal/scoop</td>
<td>22.1</td>
<td>—</td>
<td>—</td>
<td>High calorie, high protein, diet supplement, high patient acceptance</td>
</tr>
<tr>
<td>CIB Shake</td>
<td>P.O.</td>
<td>550 cal/scoop</td>
<td>26.1</td>
<td>—</td>
<td>—</td>
<td>Very high calorie, high protein diet supplement, high patient acceptance</td>
</tr>
</tbody>
</table>

*Confer with dietitians for recommendation of appropriate feedings.

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GUIDELINES FOR SKILL COMPETENCY

WHAT IS IT?

The Guidelines for Skill Competency is a step by step outline of the skill or procedure being assessed. Often it is resourced from the policies and procedures manual. The Skill Competency is assessed by the preceptor through specific criteria observed. Note, however, that every competency may not require a skill assessment.

WHEN TO USE?

The guidelines are to be developed when creating criteria to assess cognitive understanding and psychomotor skills for a specific competency.

HOW TO USE?

Outline the specific performance criteria for the particular skill competency. Often it can be resourced from policies and procedures, standards of care or recommended guidelines/protocols. The successful completion of each step will be the criteria by which the preceptor will assess the skill competency.

See the example in Appendix II, page 64 for more detail.
WRITTEN COMPETENCY

WHAT IS IT?

The Written Competency is a list of questions which evaluate critical thinking skills, judgement and decision-making abilities for a specific competency. It is an assessment tool that captures the major points of knowledge for the competency. This evaluation may be incorporated into the Skill Competency tool.

WHEN TO USE?

The Written Competency is to be developed when creating questions to assess cognitive ability/knowledge for a specific competency.

HOW TO USE?

1. Write a series of questions that will assess the learners' ability to utilize appropriate resources as well as their cognitive ability. Each question should relate to the initial competency objectives and the key concepts presented in the resource materials. Knowledge acquisition can be identified through several methods, including multiple choice, true/false, and fill-in-the-blank questions. All questions should pertain to the knowledge identified in the stated objectives.

See the example on page 30 for more detail.
ENTERAL FLUID REQUIREMENTS

Written Competency

1. Calculate the fluid requirements for a 6-month-old baby weighing 15 lb.

2. Calculate the fluid requirements of a 14-year-old child weighing 102 lb.

3. Calculate the fluid requirements for a 72-year-old ventilated patient weighing 178 lb.

4. The above patient is on a tube feeding of 60 cc/hr. full strength PulmoCare. Calculate the amount of free water from the tube feeding and make recommendations for additional free water if needed.

5. An 85-year-old patient weighing 135 lb. has congestive heart failure and is on a tube feeding of full strength Jevity at 75 cc/hr. Calculate total fluid requirements and make recommendations for additional fluid if appropriate.
GUIDELINES FOR WRITTEN COMPETENCY

WHAT IS IT?

These guidelines are the "answer key" to the Written Competency questions. They describe each question as a correct statement to provide learners the answer in a written explanation. This tool allows learners to receive the immediate feedback they need by reviewing what was learned, assessing and correct themselves. In this way, learners will evaluate the effectiveness of their responses while reviewing the material.

WHEN TO USE?

This is to be utilized for staff to conduct a self-evaluation for immediate feedback.

HOW TO USE?

1. Using the series of questions that were developed in the Written Competency section, restate each question as a correct statement. The statements in this "answer key" should provide a comprehensive explanation of each answer.

See the example on page 32 for more detail.
1. Using 120-180 ml/kg/day:
   
   15 lb  2.2 lb/kg = 6.8 kg.  
   
   6.8 kg. x 120-180 ml/kg = 818-1224 ml H₂O/day

2. Using 50 ml/kg/day:
   
   102 lb  2.2 lb/kg = 46.4 kg  
   
   46.4 kg x 50 ml/kg = 2318 ml H₂O/day

3. Using 30 ml/kg/day:
   
   178 lb  2.2 lb/kg = 81 kg  
   
   81 kg x 30 ml/kg = 2427 ml H₂O/day

4. Pulmocare is 785 cc free water per liter (see EHS enteral formulary)
   
   60 cc/hr x 24 hr = 1440 cc Pulmocare  
   
   1440 cc x .785 cc free water/cc = 1130 cc free water
   
   Patient needs 2427 cc free water - 1130 cc from TF = 1297 cc extra free water needed
   
   Could give 432 cc H₂O q shift or 216 cc H₂O q 4 hr.

5. For fluid needs, use 25 cc/kg/day:
   
   135 lb + 3.3 lb/kg = 61 kg  
   
   61 kg x 25 cc/kg = 1534 cc fluid/day

   Jevity at 75 cc/hr x 24 hr x .835 cc free H₂O/cc = 1503 cc/day
   
   Tube feeding meeting fluid needs, very little additional water should be added.

* 1993. EHS Good Shepherd Hospital Clinical Education/Competency Assessment Program
WHAT IS IT?

The Answer Key for Written Competency is an optional time saver if the manager or preceptor will be assessing the written competency. It is the true "answer key" giving just enough information so that answers to the written competency can be assessed accurately. It is different from the "Guidelines for Written Competency" in that the guidelines are used for the learners' self-assessment and development, thus it requires depth of explanation. This answer key, however, simply requires enough information to quickly and accurately assess the learners' answers to the questions.

WHEN TO USE?

This answer key is developed only when someone other than the learner will be assessing the written competency.

HOW TO USE?

1. Look back at the questions asked in the Written Competency.

2. For each question, write only the correct answer as concisely as possible.

See the example in Appendix II, page 82 for more detail.
EVALUATION FORM

WHAT IS IT?

The evaluation form provides you with feedback from learners regarding how well the competency and study guide meet their needs. Based on the feedback, you will be able to make changes to improve their effectiveness.

WHEN TO USE?

The Evaluation Form is to be developed when completing the development of a competency and study guide.

HOW TO USE?

1. Using the evaluation format provided, write in each of the competency objectives to complete section I. These can be found on the Cover Page For Self-Learning Module.

2. To the right of each objective just listed, create an "() Achieved / () Not achieved" column as in the sample form.

3. The remainder of the evaluation form can be copied, retyped or changed to suit the unit's needs.

See the example on page 35 for more detail.
EHS Good Shepherd Hospital
Competency Assessment Program

EVALUATION FORM

ENTERAL FLUID REQUIREMENTS

Please assist us in evaluating this independent study program and planning future programs by completing this evaluation form. Thank you.

I. As a result of this program, I feel I have achieved the following objectives.

   A. Calculate fluid requirements for infants, children, adults and stressed adults. ( ) Achieved ( ) Not Achieved

   B. Assess fluid adequacy in the tube fed patient. ( ) Achieved ( ) Not Achieved

   C. Identify appropriate free water recommendation for tube fed patients. ( ) Achieved ( ) Not Achieved

II. Rate the effectiveness of the methods used

   Excellent  Good  Fair  Poor
   4    3     2     1

III. Rate the relevance of the content to the program objectives.

   4    3     2     1

IV. Document the amount of time required to complete this offering: ____________

V. Please comment on suggestions for future programs.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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erflldqym.cpp
There are three methods to evaluate competencies: written assessment, direct observation and simulated testing stations.

Written Assessment

Cognitive knowledge is assessed through a Written Competency. Staff learn from the available resources including the materials in the study guide, read and answer the identified questions, and use the Guidelines for Written Competency to assess their knowledge. This self-learning process provides the individuals with immediate feedback and direction to gain the knowledge needed.

Direct Observation

If the learning objectives of the competency are skill based, it can be assessed by a preceptor or manager through one of two methods. The first is through direct observation of skill performance on the job. The individual is observed by the preceptor and assessed according to the skills/procedure criteria listed in the Guidelines for Skill Competency.

New employees who are going through orientation with their preceptor to be checked off on their core competencies generally participate in this on-the-job method. However, when first developing and formally assessing core competencies on the unit, the manager will have to initially assess all seasoned employees on the core competencies to ensure competence and proper documentation.

Advantages:

- Allows direct, on-the-job observation of an individual in a real situation
- Takes less planning and coordination than in testing stations

Disadvantages:

- Can assess one individual or a limited number at one time
- The availability of "real life" assessment situations is unpredictable, especially for competencies that are seldom used
HOW TO DEVELOP:

Many of the skill competencies can be assessed during the normal course of work on the unit. Usually during orientation:

1. The preceptor works with a new employee for several weeks and assesses the individual during routine procedures they encounter using the Guidelines for Skill Competency.

2. The preceptor or evaluator uses the Orientation Skill Checklist to ensure that all competencies have been successfully achieved.

3. For those that have not been achieved, continuing education and coaching is provided to the employee.

4. The employee is then assessed again until competence is reached.

Simulated Testing Stations

Skill competency can also be assessed by a preceptor or manager through a set of testing stations. These are simulated situations where an individual must perform a series of skills to demonstrate a competency or several competencies. Simulation can be used when there is little occasion to use the skills on the unit in a real situation. The individual is observed by the preceptor according to the skills/procedure listed in the Guidelines for Skill Competency.

Seasoned staff who have already been checked off on their core competencies generally participate in this simulated lab to assess their annual competencies.

Advantages:

- Can assess a number of competencies for a number of individuals at one time
- Can plan a time when specific competencies will be assessed
- Can provide a focused environment free from distractions

Disadvantages:

- Does not allow for on-the-job observation in a true situation
- Takes more planning and coordination than in direct observation
HOW TO DEVELOP:

1. Acquire any necessary equipment and supplies that will be needed.

2. Reserve a room for the number of days assessment will occur. It is recommended that assessments be conducted on consecutive days so that set up and break down of equipment will only occur once.

3. Ensure that the preceptor has the Guidelines for Skill Competency which outlines the steps in the competency.

4. Determine at what points in the process the staff should begin and end the simulation. This will need to be communicated to staff and equipment should be set up accordingly.

5. Determine the level of detail expected for a competency to be assessed as successfully performed.

6. Provide staff with the competency and study guide prior to their assessments. This may include a copy of equipment usage from a product manual.

7. Create an atmosphere of support and development. This situation may feel stressful or intimidating for some staff. Explaining the purpose of the testing stations, helping people understand what is expected of them, helping staff prepare, and providing a relaxed, nurturing environment will help to ensure the success of this type of assessment.

8. Determine the preceptors or people who will do the assessments and prepare them with assessment criteria, their responsibilities, etc.

9. Determine the number of people to go through the stations at one time and how long each station should take. Then, set aside a specific time for staff to attend and oversee the scheduling process.

10. After the first series, obtain feedback from staff and evaluators regarding what went well and what might be done differently to make the assessment process more effective in the future.

DOCUMENTATION:

No matter what method of assessment is chosen, when the competency has been completed and successfully achieved, the preceptor will complete the Employee Continuing Education Record - Competency Validation form. Each employee on the unit should have her/his own record and it should be kept up to date with each new competency achieved.
See the example on page 40 for more detail.
EHS EMPLOYEE CONTINUING EDUCATION RECORD

<table>
<thead>
<tr>
<th>RECORD OF COMPETENCY ASSESSMENT</th>
<th>WRITTEN/ SKILL (C)</th>
<th>OBJECTIVES MET (✓)</th>
<th>ACTION PLAN</th>
<th>DATE/ INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACK SAFETY</td>
<td>W</td>
<td>S</td>
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<td>ELECTRICAL SAFETY</td>
<td>W</td>
<td>S</td>
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<td>FIRE SAFETY</td>
<td>W</td>
<td>S</td>
<td></td>
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<tr>
<td>INFECTION CONTROL</td>
<td>W</td>
<td>S</td>
<td></td>
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</tr>
<tr>
<td>M.S.D.S.</td>
<td>W</td>
<td>S</td>
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<tr>
<td>O.S.H.A.</td>
<td>W</td>
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<tr>
<td>S.M.D.A.</td>
<td>W</td>
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<tr>
<td>CPR CERTIFICATION (If applicable)</td>
<td>W</td>
<td>S</td>
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</tr>
</tbody>
</table>

Signature of Evaluator(s)  Initials  Signature of Evaluator(s)  Initials

* 1993. EHS Good Shepherd Hospital Clinical Education Competency Assessment Program

ORIGINAL  Manager  COPY  Human Resources
HOW TO IDENTIFY AND TARGET
DEVELOPMENTAL NEEDS

Developmental needs are those skills and/or knowledge lacking in order for an individual to achieve a competency. This may be determined through several methods:

- An employee’s self-assessment
- The results of a written assessment
- The observations made during an assessment of a skill competency

When developmental needs have been identified, a developmental plan should be created by the manager and employee with the assistance of the preceptor to devise a strategy to assist the employee in meeting those needs.

HOW TO CREATE A DEVELOPMENTAL PLAN

A developmental plan is used to address and correct an individual’s developmental needs. It is a plan to set in motion a series of activities to decrease or remove the gap between the current and desired knowledge or behavior. This plan is created jointly with the employee.

DEVELOPING "THE PLAN"

Using the information and resources for identifying developmental needs, schedule time with the individual employee to sit down and create a Developmental Plan.

Guidelines for creating a Developmental Plan:

1. Discuss and mutually agree upon developmental needs.

2. List each of the developmental needs as "Improvement Objectives".

3. Ask the employee or brainstorm together activities that will address the developmental need.
4. Agree upon the best activity/activities and list them under "Developmental Activities".

5. Discuss the potential barriers as well as the support and resources needed by the employee in order to complete this plan successfully.

6. Lastly, list the date when the activity is to be accomplished and a follow up date for a progress review.

See the example on page 43 for more detail.
## DEVELOPMENTAL PLAN

<table>
<thead>
<tr>
<th>Improvement Objective</th>
<th>Developmental Activities</th>
<th>Obstacles Anticipated</th>
<th>Help Needed &amp; From Whom</th>
<th>Benefit Expected</th>
<th>Progress Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</tbody>
</table>

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ROLES AND RESPONSIBILITIES

MANAGER

The role and responsibilities of the manager are to:

- Identify core and annual competencies for the unit with the assistance of the preceptors.
- Identify individuals on staff who have expertise in a particular competency. These individuals may or may not be preceptors.
- Provide the resources and tools for staff to achieve the competencies. This may include time, materials, support, and other resources.
- Determine where to keep the competency materials and develop a "check out" system.
- Oversee the competency assessment process. This includes:
  - Delegating the creation of a competency and study guide to the most appropriate person.
  - Approving the final format of each competency.
  - Ensuring the implementation and compliance of competency assessment.
  - If someone is unable to successfully complete a competency, developing an action plan for continuing education and on-going support, and providing resources to ensure her/his competency, and
  - Evaluating the effectiveness of the competency program on an ongoing basis. This includes evaluating outcomes, conducting an annual Needs Assessment to identify new core and annual competencies, and reevaluating the competency assessment program on a yearly basis.
- Ensure the competence of each individual staff member through follow up with the preceptor/evaluator and ongoing documentation of department/unit compliance on the Department Summary Record of Staff Competency.

PRECEPTOR/EVALUATOR

For purposes of this manual, the term "preceptor" has been used as the individual who creates and assesses competencies on the unit. Traditionally the preceptor role has been found primarily in Nursing units and was the person who did most of the education. Today, however, preceptors and other "evaluators" are beginning to appear throughout the organization on many units as primary
assessors of staff competency.

In any case staff members should be identified as evaluators who will develop and assess competencies on the unit. The individuals may or may not be preceptors, but will certainly have expertise in the specific competency to be developed. Therefore, individuals creating competencies will vary depending on their expertise.

The role and responsibilities of the preceptor/evaluator are to:

- Develop those competencies and a study guide for which she/he has expertise
- Implement and assess staff competencies
- Document or "validate" staff competencies on the Employee Continuing Education Record
- Identify additional training/educational needs of those staff unable to achieve a particular competency
- Develop an action plan with the employee to enable her/him to achieve the competency
- Assist the manager with the creation of a developmental action plan and resources for employees as needed
- Act as a role model, demonstrating competent performance and exhibiting model behaviors
- Be available as a resource person for staff, the manager and others throughout the organization

Criteria and Qualifications of an Evaluator:

- Has the expertise, experience and qualifications in a particular area
- Is seen as credible in her/his field
- Has knowledge of the operating unit's standards/current practice and policies and procedures
- Occupies a staff position for at least a minimum of hours determined by the manager per week
- Demonstrates an interest in professional growth and development

- Demonstrates the following skills effectively:
  - Verbal and written communication
  - Listening
  - Providing feedback and positive reinforcement
  - Teaching ability
  - Organizational skills / prioritizing
  - Interpersonal skills including facilitation, honesty, enthusiasm, approachability, and creating a non-threatening environment
  - Leadership
  - Flexibility

**STAFF**

The role and responsibilities of the staff are to:

- Learn and be assessed on the required competencies. Staff are to be held accountable for their compliance

- Document their compliance on their individual Employee Continuing Education Record

- For those with particular expertise, help develop competencies for the unit

- For those that meet the qualifications and criteria, become preceptors/evaluators for the unit
CONCLUSION

There is a sense of urgency for the managers of EHS Health Care to spearhead the process of competency assessment in their departments and on their units today. Thus, "preparation should develop both the skills for lifelong learning and the expectation that the exercise of those skills is a continuing individual obligation. Further [professionals] must understand that they are individually accountable and that they have a moral and ethical obligation to assess their competence to perform in a manner compatible with current practice" (Sultz, 276).

To be successful, it will take tenacity, a strong belief in and commitment to competence, and the pooling of expertise that already exists on the unit. However, ensuring the competence of staff is an investment in the quality of care and service EHS provides to its patients, residents, and community. Thus it is an investment in the livelihood of EHS Health Care in the future.
APPENDIX I

DIETARY EXAMPLE: EXTERNAL FLUID REQUIREMENTS

JOB DESCRIPTION - CLINICAL DIETICIAN ....................... 49
COMPETENCY ASSESSMENT - 3 STAR METHOD ..................... 52
ORIENTATION SKILL CHECKLIST ................................ 53
DEPARTMENT SUMMARY RECORD OF STAFF COMPETENCIES ...... 54
COVER PAGE FOR SELF-LEARNING MODULE ....................... 55
RESOURCE MATERIAL ........................................ 56
WRITTEN COMPETENCY ....................................... 58
GUIDELINES FOR WRITTEN COMPETENCY ......................... 59
EVALUATION FORM .......................................... 60
**Job Title:** Clinical Dietitian (RD1092)

**Unit/Department:** Food & Nutrition

**Location:** Good Shepherd

**Immediate Supervisor's Title:** Patient Services Supervisor

**Effective Date:** 10/92

**Job Code:**

**Written By:** JG

---

**Immediate Supervisor's Title:** Pt. Ser. Supervisor

**Date:** 10/92

**Reviewing Supervisor:** Mat. Services Mgr.

**Date:** 10/92

---

**General Instructions**

- This questionnaire, when completed and approved, will constitute the job description. Answer all inquiries as completely and concisely as possible.
- Important: This must be a description of the job — not the personal qualifications or performance of the employee now on the job.

**Purpose:** Describe briefly the overall purpose of this job, i.e. Why does it exist?

Provides cost effective and efficient quality nutritional care to patients.

Provides nutritional expertise to departments and other health care professionals.

---

**Accountabilities and Job Activities:** Begin by writing an accountability statement (a sentence describing an end-result the incumbent is held accountable for achieving). Immediately below the accountability statement, write activity statements describing how the incumbent goes about accomplishing each accountability, including what authority the incumbent has in carrying out the action. Place an asterisk (*) in front of any non-essential job activities, that is, activities which are performed either infrequently or could be performed by others without altering the underlying reason the job exists. Using the format described above, go on to list additional job accountabilities followed by job activity statements. Once all the job accountabilities are listed, go back and place a percentage estimate of time spent performing each accountability, directly before the activity statement.

1. Verification of physician's diet orders for appropriateness of diet and assesses/monitors patients' nutritional needs.
   - a. Prioritizes patient load by reviewing cardcases daily to evaluate diet order, diagnosis, length of stay, NPO/CI status and requests.
   - b. Reviews medical record for pertinent data (i.e.: med hx, H & P, labs, meds, data base) and discusses the nutritional care plans with nursing and medical staff as necessary.
   - c. Visits patients for diet history, food preferences and diet counseling.
   - d. Recommends diet orders (as appropriate), diet changes, need for nutritional support, cal levels, TF formulas based on nutritional assessment.
   - e. Writes nutrition orders at MD's request.

2. Responsible for nutrition counseling to patients and significant others.
   - a. Visits patient to schedule counseling appointment to include significant others, if possible.

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Accountabilities and Job Activities Continues:

b. Counsels patient and significant others on diet rationale, dietary restrictions and meal planning and provides written materials of diet for home.

c. Assesses patient knowledge and understanding of counseling by obtaining pertinent verbal feedback or written meal plan.

3. Nutritional expert/liaison to department, hospital and community through effective communication.

a. Participates in various committees as assigned by the Patient Services Supervisor or department manager.

b. Serves as a resource to physicians regarding nutrition and researches nutrition related topics for them.

c. Attends unit patient rounds.

* d. Participates as an active member of the Good Shepherd Speaker's Bureau by conducting community as well as professional presentations.

* e. Provides in-patient nutrition education classes as appropriate.

* f. Develops and presents educational inservices to Food Service staff and Hospital staff.

g. Provides nutritional consulting services to non-hospital facilities which includes preparation of appropriate reports, inservices, and attendance of meetings.

4. Responsible for supervision and direction of diet office personnel, and students.

a. Ensures follow through of diet orders, menu modifications and checking of modified diets by providing accurately calculated diet patterns, appropriate diet plans and periodic quality checks.

b. Conducts bimonthly diet office meetings to address employee concerns and disseminates information.

c. Supervises students to obtain clinical experience; coordinates activities with class instructor.

d. Prepares employee performance reviews, counseling sessions as necessary and student evaluations.

e. Schedules flex pool RD staff as identified by special projects or workload and approved by the Patient Services Supervisor.

f. Monitors flex pool activities to ensure acceptable standards of performance and productivity.

5. Responsible for providing assistance to the Patient Services Supervisor in development of department goals, and review of Policy and Procedure.

a. Prepares clinically related department goals annually and assists in achievement of goals.

b. Reviews the Patient Services and Diet Therapy sections of the Policy and Procedure manual (and other sections as appropriate) annually.

c. Prepares new policies and procedures as appropriate.

6. Responsible for providing assistance to manager and Patient Services Supervisor in planning and implementing the department's QOI/QA plan.

a. Reviews department QOI/QA plan annually with Patient Services Supervisor

b. Identifies target areas, high risk areas, problem areas etc. for necessary monitoring.
Accountabilities/Job Activities continued:

c. Provides input to those areas needing plans of corrective action.
d. Maintains data collection information and reports data at weekly management meetings.
e. Prepares monthly CQI/QA reports and attends QA meetings as appropriate.
f. Maintains records on periodic tests and all pertinent data for QA documentation.

7. Maintenance of Clinical/Supervisory skills and knowledge.

a. Keeps abreast of current standards of care via literature, educational events, internal/external resources and internal/external networking.
b. Maintains ADA registration status.
## COMPETENCY NEEDS ASSESSMENT

★★★ Three Star Priorities ★★★

### SKILL CHECKLIST FOR CLINICAL DIETICIAN

<table>
<thead>
<tr>
<th>Skill</th>
<th>High Risk</th>
<th>Problem PRONE</th>
<th>Seldom / Freq. Used</th>
<th>Priority</th>
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</thead>
<tbody>
<tr>
<td>Prioritize patient load</td>
<td></td>
<td>★</td>
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<td>1</td>
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<tr>
<td>Patient Assessments</td>
<td>★</td>
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<td>2</td>
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<tr>
<td>Nutritional recommendations</td>
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<td>★</td>
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<tr>
<td>Educational resource selection</td>
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<tr>
<td>Assessment of patient knowledge</td>
<td>★</td>
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<tr>
<td>Diet calculations</td>
<td>★</td>
<td></td>
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<tr>
<td>TPN order calculations</td>
<td>★</td>
<td>★</td>
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<td>3</td>
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<tr>
<td>Enteral formulas</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
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<tr>
<td>Baby formulas</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
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<tr>
<td>Skinfold measurement</td>
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<tr>
<td>Renal, complicated</td>
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<tr>
<td>Diabetic, complicated</td>
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<td>Vegetarian (Strict)</td>
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<td>Kosher</td>
<td>★</td>
<td>★</td>
<td>★</td>
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<tr>
<td>Failure to Thrive assessment</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>3</td>
</tr>
<tr>
<td>Anorexia evaluation</td>
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<td>Drug/Nutrient Interactions, Primary</td>
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<td>Patient Instruction</td>
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<td>Fluid Requirements, Adult</td>
<td>★</td>
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<td>Fluid Requirements, Child</td>
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<td>Visual Nutrition Assessment</td>
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</tbody>
</table>

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**Priority:**
- 3 = High
- 2 = Medium
- 1 = Low
<table>
<thead>
<tr>
<th>ORIENTATION SKILL CHECKLIST</th>
<th>CLINICAL DIETICIAN</th>
<th>PRECEPTOR</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(outline of competency requirements)</td>
<td>Reviewed (date/time)</td>
<td>Verbalizes Understanding (date/time)</td>
<td>Demonstrates Skill (date/time)</td>
</tr>
<tr>
<td>1. Prioritize patient load</td>
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<tr>
<td>2. Patient assessment</td>
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<tr>
<td>3. Makes appropriate nutritional recommendation</td>
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<tr>
<td>4. Selects appropriate educational materials</td>
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<td>5. Assessment of patient knowledge</td>
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<tr>
<td>6. Prepares accurate diet calculations</td>
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<td>7. Calculates IPN orders for cats, C.P.F.</td>
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<tr>
<td>8. Knowledge of appropriate enteral formulas</td>
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<td>9. Knowledge of baby formulas</td>
<td>See Written competency</td>
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<td>10. Skin fold measurement</td>
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<td>11. Complicated renal</td>
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<td>12. Complicated diabetic</td>
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<td>13. Vegetarian (strict)</td>
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<td>14. Kosher</td>
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<td>15. Failure to thrive assessment</td>
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<td>16. Anorexia evaluation/recommendations</td>
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<tr>
<td>17. Primary knowledge of drug/nutrient interactions</td>
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<td>18. When is it appropriate to instruct?</td>
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<td>19. Fluid requirements (adult)</td>
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<td>20. Fluid requirements (child)</td>
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<td>21. Visual physical assessment for malnutrition</td>
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## SUMMARY RECORD OF STAFF COMPETENCY

**Department/Unit:** Clinical Dietician

**Calendar Year:** 1994

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<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>ANNUAL SAFETY COMPETENCIES</th>
<th>TPN ORDER CALCULATIONS</th>
<th>ENTERAL FORMULAS</th>
<th>BARNY FORMULAS</th>
<th>FAILURE TO THRIVE</th>
<th>AMENITY EVALUATION</th>
<th>FLUID REQUIREMENTS (ADULT)</th>
<th>FLUID REQUIREMENTS (CHILD)</th>
<th>NUTRITION ASSESSMENT (Mental)</th>
<th>% COMPLIANCE</th>
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ABSTRACT:
The following is a competency for Clinical Dieticians for determining fluid requirements in infants, children, adults and tube fed patients.

OBJECTIVES:
Upon completion of this module, the employee will be able to:

1) Calculate fluid requirements for infants, children, adults and stressed adults.
2) Assess fluid adequacy in the tube fed patient.
3) Identify appropriate free water recommendation for tube fed patients.

RESOURCES:
Materials required to complete the self learning packet include:

A) Table I: Fluid Requirements, Infant-Adult (attached)
B) Good Shepherd Hospital enteral formulary
C) Calculator
D) Written Competency
## TABLE I - FLUID REQUIREMENTS - INFANCY - ADULT

<table>
<thead>
<tr>
<th>AGE</th>
<th>FLUID ml/kg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants &amp; Children</td>
<td></td>
</tr>
<tr>
<td>&lt; 750 g. infant</td>
<td>180-200</td>
</tr>
<tr>
<td>Infant</td>
<td>120-180</td>
</tr>
<tr>
<td>1-3 yr.</td>
<td>125</td>
</tr>
<tr>
<td>4-6 yr.</td>
<td>100</td>
</tr>
<tr>
<td>7-12 yr.</td>
<td>75</td>
</tr>
<tr>
<td>13-15 yr.</td>
<td>50</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Young adults with large muscle</td>
<td>40</td>
</tr>
<tr>
<td>Adults 18-55</td>
<td>35</td>
</tr>
<tr>
<td>Vent and elderly</td>
<td></td>
</tr>
<tr>
<td>without major cardiac/renal disease</td>
<td>30</td>
</tr>
<tr>
<td>Renal &amp; Heart patient</td>
<td>25</td>
</tr>
<tr>
<td>PRODUCT</td>
<td>ADMINISTRATION</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
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<tr>
<td>Ensure*</td>
<td>Primarily P.O.</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
</tr>
<tr>
<td>Ensure Plus*</td>
<td>Primarily P.O.</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
</tr>
<tr>
<td>Ensure Pudding</td>
<td>P.O.</td>
</tr>
<tr>
<td>Hepatic Aid</td>
<td>Primarily P.O.</td>
</tr>
<tr>
<td></td>
<td>also T.F.</td>
</tr>
<tr>
<td>Jevity*</td>
<td>T.F. or P.O.</td>
</tr>
<tr>
<td>Osmolite*</td>
<td>Primarily T.F.</td>
</tr>
<tr>
<td></td>
<td>or P.O.</td>
</tr>
<tr>
<td>Pulmocare*</td>
<td>T.F. or P.O.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Pedlasure*</td>
<td>T.F. or P.O.</td>
</tr>
<tr>
<td>ProMod*</td>
<td>Add to T.F. or</td>
</tr>
<tr>
<td></td>
<td>P.O.</td>
</tr>
<tr>
<td>Replena*</td>
<td>T.F. or P.O.</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>Vivenex TEN</td>
<td>T.F. or flavored</td>
</tr>
<tr>
<td>CIB</td>
<td>P.O.</td>
</tr>
<tr>
<td>CIB Shake</td>
<td>P.O.</td>
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*Confer with dietitians for recommendation of appropriate feedings.

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1. Calculate the fluid requirements for a 6-month-old baby weighing 15 lb.

2. Calculate the fluid requirements of a 14-year-old child weighing 102 lb.

3. Calculate the fluid requirements for a 72-year-old ventilated patient weighing 178 lb.

4. The above patient is on a tube feeding of 60 cc/hr. full strength Pulmocare. Calculate the amount of free water from the tube feeding and make recommendations for additional free water if needed.

5. An 85-year-old patient weighing 135 lb. has congestive heart failure and is on a tube feeding of full strength Jevity at 75 cc/hr. Calculate total fluid requirements and make recommendations for additional fluid if appropriate.
1. Using 120-180 ml/kg/day:

\[ 15 \text{ lb} \times \frac{2.2 \text{ lb/kg}}{} = 6.8 \text{ kg} \]
\[ 6.8 \text{ kg} \times 120-180 \text{ ml/kg} = 818-1224 \text{ ml} \text{ } H_2O/\text{day} \]

2. Using 50 ml/kg/day:

\[ 102 \text{ lb} \times \frac{2.2 \text{ lb/kg}}{} = 46.4 \text{ kg} \]
\[ 46.4 \text{ kg} \times 50 \text{ ml/kg} = 2318 \text{ ml} \text{ } H_2O/\text{day} \]

3. Using 30 ml/kg/day:

\[ 178 \text{ lb} \times \frac{2.2 \text{ lb/kg}}{} = 81 \text{ kg} \]
\[ 81 \text{ kg} \times 30 \text{ ml/kg} = 2427 \text{ ml} \text{ } H_2O/\text{day} \]

4. Pulmocare is 785 cc free water per liter (see EHS enteral formulary)

\[ 60 \text{ cc/hr} \times 24 \text{ hr} = 1440 \text{ cc} \text{ Pulmocare} \]
\[ 1440 \text{ cc} \times 0.785 \text{ cc free water/cc} = 1130 \text{ cc free water} \]

Patient needs 2427 cc free water - 1130 cc from TF = 1297 cc extra free water

Could give 432 cc H_2O q shift or 216 cc H_2O q 4 hr.

5. For fluid needs, use 25 cc/kg/day:

\[ 135 \text{ lb} \times \frac{3.3 \text{ lb/kg}}{} = 61 \text{ kg} \]
\[ 61 \text{ kg} \times 25 \text{ cc/kg} = 1534 \text{ cc fluid/day} \]
\[ \text{Jevity at 75 cc/hr} \times 24 \text{ hr} \times 0.835 \text{ cc free H}_2\text{O/cc} = 1503 \text{ cc/day} \]

Tube feeding meeting fluid needs, very little additional water should be added.
Please assist us in evaluating this independent study program and planning future programs by completing this evaluation form. Thank you.

I. As a result of this program, I feel I have achieved the following objectives.

A. Calculate fluid requirements for infants, children, adults and stressed adults. ( ) Achieved ( ) Not Achieved

B. Assess fluid adequacy in the tube fed patient. ( ) Achieved ( ) Not Achieved

C. Identify appropriate free water recommendation for tube fed patients. ( ) Achieved ( ) Not Achieved

II. Rate the effectiveness of the methods used

IV. Document the amount of time required to complete this offering: 

V. Please comment on suggestions for future programs.

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APPENDIX II

NURSING EXAMPLE: ELECTIVE CARDIOVERSION

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EHS Good Shepherd Hospital
Competency Assessment Program

ELECTIVE CARDIOVERSION

Developed by: Bonnie Schleder, Critical Care Clinical Specialist
Policies developed by: Roseanne Niese, Interim Manager, MSICU
Critiqued by: Shana Schiemann, RN
Rosie Jeretina, RN

Approved for 1.2 contact hours by I.N.A.

EHS Program #295-2200-248
EHS Good Shepherd Hospital
Competency Assessment Program

ELECTIVE CARDIOVERSION

PREPARED BY: Bonnie Schleder, MS, RN, Critical Care Clinical Specialist

ABSTRACT:

This independent study describes the elective cardioversion procedure at Good Shepherd Hospital. It includes physiology, indications/contraindications, pre-procedure and post-procedure nursing responsibilities.

OBJECTIVES:

Upon completion of this module, the professional nurse will be able to:

1. Describe the physiological mechanism of cardioversion.
2. Identify the indications/contraindications for cardioversion.
3. Discuss patient/family teaching for cardioversion.
4. Describe the scheduling process for cardioversion.
5. Explain pre-procedure preparation of the patient and environment.
6. Demonstrate safety measures for the patients undergoing elective cardioversion.
7. Discuss post-procedure assessments of the cardioversion patient.

RESOURCES:

Materials required to complete this module include:

A) Elective Cardioversion Summary
B) Flow Chart for Elective Cardioversion
C) Patient Instructions
D) Pre and Post procedure orders

EHS Good Shepherd Hospital Nursing Services Policies:

E) Cardiac Services: Scheduling  C 1.65
F) Elective Cardioversion  EPS 2.95

EHS Good Shepherd Hospital Critical Care Policy:

G) Elective Cardioversion; Procedure
EHS Good Shepherd Hospital

Guidelines for Skill Competency

ELECTIVE CARDIOVERSION

OBJECTIVE

1. Demonstrates safety measures for the patient requiring synchronized cardioversion.
   A. Assembles the necessary equipment for synchronized cardioversion.
   B. Ensures that the Crash Cart & suction equipment are at the bedside.
   C. Attaches leads from the defibrillator to the patient and ensures that the ECG tracing produces a tall QRS complex and small T wave without artifact.
   D. Verifies that the defibrillator is in the synchronized mode.
   E. Prepares defibrillator paddles and demonstrates correct placement.
   F. Rechecks monitor for patient’s ECG rhythm and proper R-wave synchronization. (Adjusts amplitude of QRS complex.)
   G. Adheres to electrical safety precautions.
   H. Immediately assesses ECG rhythm, confirms presence of a pulse and identifies potential complications.
   I. Assesses respiratory status, identifying potential complications.
   J. Demonstrates nursing actions for patients in cardiopulmonary arrest.

OBJECTIVES MET (✔)

ACTION PLAN if Objective Not Met

NAME: ______________________________ DATE COMPLETED: ______________________________

SIGNATURE OF EVALUATOR: ____________________________________________
EHS Good Shepherd Hospital

ELECTIVE CARDIOVERSION

Written Competency

Name: __________________________

Please return the following test and evaluation form to obtain CEUs.

1) Why is synchronization necessary for elective cardioversion?

________________________________________________________________________

2. List three contraindications to elective cardioversion.

________________________________________________________________________

________________________________________________________________________

3. Which laboratory tests will you review prior to cardioversion?

________________________________________________________________________

________________________________________________________________________

4. Scheduling for cardioversions is coordinated through what department? ________________ When this department is closed, who is to be called for scheduling? __________________________

5. In instructing your patient, how long should the patient be NPO?

________________________________________________________________________

6. Name three things the registered nurse can do to ensure a safe environment during cardioversion.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7. What patient assessments are required post-procedure?

________________________________________________________________________
ELECTIVE CARDIOVERSION

Cardioversion is the delivery of a synchronized direct current to the myocardium. If the impulse is strong enough, it causes the cardiac cells to depolarize simultaneously, interrupting the current rhythm and allowing the normal sinus impulse to resume control. The shock is synchronized with the patient's QRS complex. Synchronization prevents accidental discharge during repolarization, the vulnerable phase of the cardiac cycle. Repolarization is represented by a T-wave on the ECG. An unsynchronized shock landing on the T-wave may precipitate ventricular tachycardia or fibrillation. Synchronization allows the impulse to be triggered by the R-wave of the QRS complex with energy being delivered immediately after the R wave when the myocardial cells are completely refractory.

With cardioversion, discharge is synchronized to fall just after the R wave (arrow, top strip), converting atrial flutter to regular sinus rhythm. With defibrillation, discharge may fall instead on the T wave (arrow, bottom strip), which occasionally results in ventricular tachycardia.

Cardioversion is indicated for treatment of several dysrhythmias including atrial fibrillation, atrial flutter, supraventricular tachycardia and symptomatic ventricular tachycardia. Contraindications to cardioversion may include hypokalemia, a grossly enlarged left atrium such as occurs in chronic mitral valve disease or prolonged congestive heart failure and long-standing or recurrent atrial fibrillation or flutter. Even though many people can function well with controlled atrial fibrillation, it is preferable to convert the rhythm to sinus thereby preventing long-term complications such as thromboemboli.
Since there may be a period of electrical instability post countershock, it is necessary to eliminate factors that enhance electrical instability. These include hypoxia, hypokalemia and electrolyte abnormalities to name a few. Therefore, assessment of the patient and laboratory results, including ordered blood levels, prior to the procedure is crucial. Physical assessment includes vital signs, level of consciousness and skin color. The current cardiac rhythm and 12-lead ECG should also be reviewed and labelled "precardioversion." Any abnormalities must be immediately reported to the physician.

The patient is NPO for at least eight hours prior to the procedure. Assess the patient's current medication regimen and review these medications with the cardiologist. Cardioversion is usually safe for patients on digitalis and diuretic therapy, however, if the patient is clinically digitalis toxic, cardioversion is postponed until toxicity subsides if possible since cardioversion during this time may result in ventricular fibrillation. Clinical signs and symptoms of digitalis toxicity include dysrhythmias, conduction defects, gastrointestinal upset, visual disturbances, headache, fatigue and restlessness.

It is also important to determine the patient's level of understanding of the procedure. Avoid using fearful terms such as "electrical shock." Instead terms such as "small electrical impulses" or a "signal to the heart" may be more readily received. Once the patient has been informed by his physician and demonstrates understanding, a surgical consent is signed, a patent IV is started and dentures and nail polish are removed.

The room is prepared with emergency equipment including the crash cart, defibrillator, oxygen, bag-valve mask device (ambu bag), suction set up, oximetry, non-invasive BP, external cardiac pacemaker and emergency drugs. The patient is placed in a supine position and connected to the defibrillator monitor. When applying the leads, careful attention to proper skin preparation including shaving of hair is necessary. Assess the monitor for clarity and obtain the lead with a tall R wave. Lead II or V\textsubscript{3} are recommended. Adjust amplitude of the QRS so other waves such as T waves are not triggering the rate sensor. The room should also be observed for any water or moisture (on the floor or the patient) to reduce the risk of electrical hazards.
Once the anesthesiologist and cardiologist arrives the patient is given oxygen, sedated and provided manual ventilations as necessary. The defibrillator synchronizer switch is turned on, assuring a spike is present on each R wave. Apply the electrode pads in the standard (anterolateral position) or anterior-posterior position to decrease skin resistance to the flow of current. The cardiologist will perform the cardioversion using a specific number of joules individualized to the patient. If unsuccessful the initial level may be increased as needed. The role of the registered nurse during the cardioversion includes assuring a safe environment, running an ECG rhythm strip, noting patient response and recording time of defibrillations and joules administered.

Post procedure includes close observation for 2-3 hours of the patient's respiratory status, vital signs, level of consciousness, oxygen saturation, skin color and cardiac rhythm. A 12-lead ECG is also obtained postprocedure. Ectopic beats are common but rarely require antiarrhythmic therapy. The patient is also observed for postprocedure complications. These include embolic episodes, transient hypotension (especially if the patient has been in long-standing atrial fibrillation), and local skin irritation. Burns may result from the cardioversion and are best treated by a topical steroid.

Once the patient has recovered, he/she should be reoriented and reunited with his family. The success of the procedure should be explained by the physician to the patient/family. The need for close observation postprocedure should also be explained.

Discharge may occur the same day as the procedure. Upon discharge, evaluate the patient's LOC, vital signs, cardiac rhythm and skin color. It is advisable that patients be driven home if the procedure is on the same day as discharge since anesthesia was administered.
Flow Chart for Elective Cardioversion

**OutPatient**

1. MDs office call Pre-Admitting
2. Pre-Admitting notifies Surgery Front Desk
3. Front Desk notifies Anesthesia Tech or Anesthesiology Scheduler
4. Physicians office calls the patient confirms date and time
5. PreAdmitting schedules patient for Cardioversion
6. PreAdmitting sends cardioversion schedule of Cardioversion to 4 East & Surgery
7. Unit Secretary informs charge nurse
8. Anesthesiologist begins paperwork, calls pt. for H&P
9. Pt. receives testing
10. Pt arrives at admitting and is admitted to 4E as OBS bed.
11. Nurse obtains data base

**InPatient**

1. MD writes order to schedule Cardioversion
2. Unit secretary notifies Pre-Admitting
3. PreAdmitting notifies Surgery Front Desk and obtains date and time
   Surgery Front Desk notifies Anesthesia Tech and or Anesthesia Scheduler
4. PreAdmitting notifies Unit Sec of date and time
5. Unit Sec notifies nurse as to date/time
6. Anesthesiologist completes paperwork and sees patient.
7. Preprocedure tests are completed

**Procedure Flow**

1. Nurse obtains preop and pre-procedure orders and performs pt teaching and interventions (ie. consent, meds, IV Equipment set up). Obtains old chart
   Equipment: Intubation Equipment, Anesthesia Bag Crash Cart, O2 Equipment Ambu bag, flow meter, mask, and Sao2 Monitor, Cardiac Monitor, Meds as Necessary B/P monitor, Nasal Airway, Suction Set up,
2. Nurse coordinates Cardioversion time with Cardiologist and Anesthesia
3. Anesthesia and Physician Arrive
4. Procedure Performed
5. Post procedure orders obtained and completed
6. Pt. charged for the procedure
7. Discharge teaching provided
8. Pt. discharged
EHS Good Shepherd Hospital

50 West Highway 22
Barrington, Illinois 60010
708.381.9600

CARDIOLOGY SERVICES

You have been scheduled as a patient at Good Shepherd Hospital in the "Outpatient Program." This means that you will be admitted to the hospital on the day of your procedure to avoid the cost and inconvenience of hospitalization the night before.

Your procedure is scheduled on _____________ at ______________. Please arrive at the Admitting Department/Satellite Admitting on the first floor at ________.

PREPARING FOR YOUR PROCEDURE

DO NOT EAT OR DRINK ANYTHING, EXCEPT FOR MEDICATIONS YOUR PHYSICIAN HAS INSTRUCTED YOU TO TAKE, INCLUDING CHEWING GUM OR WATER, AFTER MIDNIGHT the night before your procedure. If you are taking medications as directed by your doctor, take them only with sips of water. If you develop a fever, persistent cough, cold or flu, or any other health problem before your procedure, be sure to notify your doctor immediately, as your doctor may wish to postpone your procedure.

ON THE DAY OF YOUR PROCEDURE

Once again remember, DO NOT EAT OR DRINK, EXCEPT FOR SIPS OF WATER WITH MEDICATIONS. Before leaving home remove any jewelry, nail polish and/or make-up. DO NOT bring large amounts of money as we cannot be held responsible. Dentures and contact lenses will need to be removed in the hospital. Admitting will direct you to your room where the procedure will take place.

Before your procedure, you will be asked to sign a consent form; please bring your glasses if you need them for reading. A responsible family member will be asked to cosign for any adult patient unable to read or sign.

Prior to the procedure you will meet your Anesthesiologist and the nurse who will care for you. An intravenous line will be started to administer fluids and medications. You will be placed on a heart monitor. After the procedure, you will be closely observed for about one to two hours. Every effort will be made to keep your family informed and comfortable. Your Primary Nurse will be responsible for working with your physician and other members of the health care team to develop a written care plan with you.

If you have any questions about your procedure and wish to speak with a nurse, please call (708) 381-9600 Ext. 5038 Monday - Friday between the hours of 8:00 a.m. and 4:30 p.m. In the evening after 4:30 p.m., and on weekends and holidays, the operator will be glad to page the Nursing Supervisor who will be able to help you.

DISCHARGE INSTRUCTIONS

Depending on your particular situation, you may possibly be discharged on the day of your procedure. If this occurs please keep in mind that we require that you have someone drive you home.

EHS Health Care / Related to the United Church of Christ
Pre-Cardioversion Orders

1. NPO at least 8 hours prior to procedure.
2. Notify physician and anesthesia of patient's arrival and verify time of procedure.
3. Medications per Cardiologist.
4. Obtain consent for Elective DC Cardioversion.
5. CBC, lytes, CXR upon arrival, if not done pre admission. Notify physician of abnormal lab results.
6. EKG prior to procedure and label "Precardioversion."
7. Start IV of D5W, run at KVO.
8. Have the following at the bedside:
   - Crash cart with defibrillator
   - Ambu bag
   - Anesthesia box (airways)
   - Continuous wall suction with Yankauer device.
   - Nasal cannula & flowmeter set up
9. Pre-op:
   - NPO after 1:00 a.m.
   - No pre op medication
Post Cardioversion Orders

1. EKG

2. Monitor VS, skin color, level of consciousness, ECG rhythm and SAO2:
   every 10 minutes times 3, then
   every 15 minutes times 4, then
   every 1 hour times 2 or until stable.

3. Remain with patient until awake.

4. Resume diet when awake.
   Diet: ___________________________ Advance as tolerated.

5. Convert IV to Saline lock when stable, then discontinue when awake and tolerated diet.

6. Discharge patient at ________________

7. When stable, may be up with assistance the first time, then up ad lib.
PURPOSE:

To ensure proper scheduling and notification of cardiac procedures.

POLICY:

Scheduling is coordinated through the Pre-Admitting Department.

PROCEDURE:

I. Scheduling during Pre-Admitting hours - 0800 until 1600.

A. Inpatient

1. The Cardiologist writes the order for the cardiac procedures.
2. The Health Unit Secretary (HUS) then contacts Pre-Admitting with the order for the procedure and confirms the time of the procedure.
3. The Pre-Admitting Department notifies:
   A. Cardiac Catheterization: MedCath (1-800-771-4445) with information regarding the patient and the time of the catheterization.
   B. Cardioversion: Surgery Front Desk
4. The HUS or RN confirms the time of the procedure with the physician.
5. The Pre-Admitting Department notifies all pertinent departments of the scheduled procedure. (i.e., 4 East, MSICU, Nursing Supervisors, Medical Records, Hospital Cath Lab Supervisor, Admitting and Pharmacy).

B. Outpatient

1. The physician or physician office personnel contacts Pre-Admitting to schedule the procedure and confirms the time of the procedure.
2. The Pre-Admitting Department notifies:
   A. Cardiac Catheterization: MedCath (1-800-771-4445) with the information regarding the patient and the time of the catheterization.
   B. Cardioversion: Surgery Front Desk
3. Pre-Admitting notifies all pertinent departments of the scheduled procedures (See I. A. 6.).

II. Scheduling after Pre-Admitting hours - 1600 until 0800 and/or during holidays.

A. Inpatient

1. The Cardiologist writes the order for the cardiac procedure.
2. The HUS or the RN notifies the Nursing Supervisor about the procedure.
3. The Supervisor completes the "Admitting Reservation" form and puts it in the Pre-Admitting Mailbox.
4. The Supervisor and the HUS and/or RN coordinates the time of the procedure with the schedule received by the Pre-Admitting Department.
5. The HUS or the RN notifies Pre-Admitting via phone mail of the reservation (extension 5038).
6. The HUS and/or the RN notifies:
   A. For Cardiac Catheterization: MedCath of the patient reservation (1-800-771-4445).
   B. For Cardioversion: Surgery Front Desk at extension 5250.
7. The following information will be asked by MedCath:
   A. Procedure requested Time:
   B. Patient name
   C. Diagnosis
   D. Telephone number
   E. Birth date
   F. Insurance information
   G. Cardiologist
   H. Attending physician
8. The RN and/or HUS confirms the scheduled time of the procedure with the cardiologist and/or anesthesiologist.

B. Outpatient

1. The physician and/or office personnel will notify the nursing supervisor, HUS or RN of the patient.
2. If the HUS and/or RN is notified of the procedure she must then notify:
A. The Nursing Supervisor and
B. Cardiac Catheterization: MedCath of the catheterization (1-800-771-4445, See II. A. 7. a through h).
C. Cardioversion: Surgery Front Desk at extension 5250.
3. The Supervisor and the HUS and/or RN coordinates the time of the procedure with the schedule received by the Pre­Admitting Department.
4. The Supervisor completes the "Admitting Reservation" form and puts it in the Pre-Admitting Mailbox.
5. The Supervisors will notify 4 East and Admitting.
6. The physician's office will notify the patient of the scheduled cardiac procedure.
I. PURPOSE:

Elective cardioversion provides patients with efficient, professional and safe care during the performance of cardioversion.

II. PRE-SCREENING

Since the cases are considered elective, specific pre-cardioversion non-invasive screening tests should be performed. The screening tests will include history and physical examination, studies, static electrocardiograms, and, when applicable, exercise electrocardiograms, Holter monitoring, drug level analysis and routine laboratory studies as requested by the physician.

If on evaluation the patient is found to be at risk of adverse reaction from the elective cardioversion, the patient will require cardioversion in the MSICU.

III. PRE-CARDIOVERSION

After the physician determines the need for cardioversion, the Pre-Admitting Department will be notified and will schedule the patient for the cardioversion (See the Cardiac Services Scheduling Policy).

A. OUTPATIENT

1. The Pre-Admission Department schedules the Outpatient's laboratory studies, compiles the patient's folder and forwards it to the Outpatient Center.

2. Prior to obtaining laboratory specimens, the Outpatient Center staff will have the patient sign the appropriate release forms.

3. The patient's folder is forwarded to the Pre-Admission Department the night before the procedure.
4. The Health Unit Secretary from the unit receiving the patient will pick up the folder in the Admission Department satellite office.

5. Laboratory test results are reviewed by the Pre-Admission Department. Physicians will be notified of abnormal results as necessary.

IV. CARDIOVERSION

A. The procedure is performed during pre-scheduled times at Good Shepherd.

B. The physician who performs the cardioversion is present and responsible for the patient in the immediate post-cardioversion period.

C. Anesthesiology is present for airway maintenance.

D. The primary nurse is present to monitor and evaluate the results of the cardioversion procedure. (See Critical Care Policy: Elective Cardioversion; Procedure.)

E. During the actual cardioversion, every patient is continuously electrocardiographically monitored.

V. POST-CARDIOVERSION

A. Nursing is readily available during the immediate post-cardioversion period to evaluate the patient's status.

B. Post-cardioversion orders are written by the physician and/or anesthesiologist.

C. In every case, the physician will provide a final evaluation of the elective cardioversion.

VI. ORGANIZATIONAL MEETINGS

Problems and concerns regarding elective cardioversion will be discussed informally on an ongoing basis and formally at the MSICU Committee as necessary quarterly.
PURPOSE: Provide safe and effective care for the patient undergoing elective cardioversion.

EQUIPMENT:
- Defibrillator
- Paddles
- ECG Monitor with electrodes
- Defibrillation pads
- Code Blue Cart with Emergency Medications
- Suction set-up with Yankauer suction catheter attached
- Oxygen Flow Meter
- Pulse Oximetry
- Non-invasive BP Monitor
- External Cardiac Pacemaker
- Anesthesia medications (brought by anesthesia)
- Manual resuscitator (Ambu Bag) with various sized face masks
- Respiratory box (may contain some of the above)

PROCEDURE:
The primary nurse will:

1. Assess history, noting the following:
   a. No clinical s/s of digitalis toxicity.
   b. NPO for at least 8 hours or as ordered by the physician.

2. Obtain baseline assessment including; v/s, level of consciousness, skin color and ECG rhythm and document.

3. Assess laboratory test results and notify the physician of any abnormalities.

4. Determine patient's understanding of the procedure and reinforce information as needed.
ELECTIVE CARDIOVERSION: PROCEDURE

5. Obtain surgical consent.

6. Administer medications per Cardiology orders with sips of H20 only.

7. Notify cardiologist and anesthesia of patient’s arrival and verify time of the procedure.

8. Encourage patient to void.

9. Remove dentures.

10. Label baseline 12 lead ECG "precardioversion" if ordered.

11. Place Code Blue Cart, Emergency drugs, and respiratory box in the patient’s room.

12. Put up external cardiac pacer.

13. Set up oxygen with bag-valve mask.

14. Set up suction equipment with Yankauer.

15. Assure all respiratory box contents are present.

16. Assure equipment is properly functioning (i.e., defibrillator, suction, etc.).

17. Connect non-invasive BP monitor.

18. Assess IV line for patency.

19. Wipe perspiration from patient’s chest as needed.

20. Plug defibrillator into AC current if available or assure extra battery is present.

21. Connect patient leads to defibrillator monitor assessing monitor pattern for size and clarity of pattern.

22. Turn synchronizer switch on, noting spike on R wave downslope or during S wave on the ECG.
22. Apply conductive pads away from ECG leads.

23. Place patient in supine position upon arrival of the cardiologist and anesthesiologist. (Anesthesia to administer sedation.)

24. Remove headboard

25. Select energy dose per physician.


27. Assess ECG rhythm, respirations and start recorder.

28. Remain clear of the patient, bed or attached equipment.

29. Physician will perform the cardioversion.

30. Assess ECG rhythm, pulse, respiration and blood pressure.

31. Repeat cardioversion if necessary per physician.

32. Assess v/s and level of consciousness q 10 minutes x 3, then every 15 minutes x 4, then q 1 hour or until stable.

33. Obtain 12 lead ECG as ordered.

34. Maintain cardiac monitor for at least 2 hours, notify cardiologist of lethal arrhythmias.

35. Document all assessments in the patients record:
   a. Vital Signs
   b. Level of consciousness
   c. Oxygen saturation
   d. Pre & post cardioversion rhythm (include strips),
   e. Patient's response to the procedure
   f. Time of cardioversion
   g. Joules administered
   h. Medications administered
   i. Other resuscitative measures
ELECTIVE CARDIOVERSION

1. Synchronization is necessary for elective cardioversion in order to prevent accidental discharge during repolarization, the vulnerable phase of the cardiac cycle.

2. Contraindications to elective cardioversion include:
   - Hypokalemia
   - Grossly enlarged left atrium
   - Long standing or recurrent atrial fibrillation

3. Laboratory tests to be reviewed prior to cardioversion include:
   - Any ordered blood level
   - Digoxin level if ordered
   - Electrolytes
   - ABGs if ordered
   - CBC
   - EKG
   - Chest X-ray

4. Scheduling is coordinated through the Pre-admitting Department. When this department is closed, cardioversions are scheduled through the Nursing Supervisor.

5. The patient should be instructed to be NPO after midnight, or for 8 hours, or according to the physician's order.

6. The registered nurse can insure safety by:
   - Wiping off any moisture from the patient's chest
   - Removing water from the immediate environment (i.e., floor).
   - Remaining clear during defibrillation
   - Assuring others are clear during defibrillation

7. Patient assessments post-procedure include:
   - Vital signs
   - Level of consciousness
   - Oxygen saturation
   - Skin color
   - Cardiac rhythm
(Time saver in correcting written competency if the manager/supervisor will be correcting written competency.)

1. To prevent accidental discharge during repolarization, the vulnerable phase of the cardiac cycle.

2. Hypokalemia
   Grossly enlarged left atrium
   Long standing or recurrent atrial fibrillation

3. Any ordered blood level
   Digoxin level if ordered
   Electrolytes
   ABGs if ordered
   CBC
   EKG
   Chest X-ray

4. Pre-admitting Department
   Nursing Supervisor.

5. After midnight, or for 8 hours, or according to the physician's order

6. Wiping off any moisture from the patient's chest
   Removing water from the immediate environment (i.e., floor)
   Remaining clear during defibrillation
   Assuring others are clear during defibrillation

7. Vital signs
   Level of consciousness
   Oxygen saturation
   Skin color
   Cardiac rhythm
EHS Good Shepherd Hospital
Evaluation Form

TITLE OF PROGRAM: ELECTIVE CARDIOVERSION

Date of Presentation:
INA-CEAP#

Please assist us in evaluating this program and planning future programs by completing this evaluation form. Thank you.

1. As a result of this program, I feel I have achieved the following objectives:

A. Describe the physiological mechanism of cardioversion. ( ) Achieved ( ) Not Achieved
B. Identify the indications/contraindications for cardioversion. ( ) Achieved ( ) Not Achieved
C. Discuss patient/family teaching for cardioversion. ( ) Achieved ( ) Not Achieved
D. Describe the scheduling process for cardioversions. ( ) Achieved ( ) Not Achieved
E. Explain pre-procedure preparation of the patient and environment. ( ) Achieved ( ) Not Achieved
F. Demonstrate safety measures for patients undergoing cardioversion. ( ) Achieved ( ) Not Achieved
G. Discuss post-procedure assessments of the cardioversion patient. ( ) Achieved ( ) Not Achieved

II. Rate the effectiveness of the teaching methods used.

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III. Rate the relevance of the content to the program objectives.

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IV. How long did it take you to complete the program? ____________________________

V. Please comment on suggestions for future independent study programs.


APPENDIX III

SELF-LEARNING MODULE AND DOCUMENTATION TOOLS

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Date: ______________________________________

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DEPARTMENT
SUMMARY RECORD OF STAFF COMPETENCY

Calendar Year: __________

Form © 1993. EHS Good Shepherd Hospital Clinical Education/Competency Assessment Program
## SUMMARY RECORD OF STAFF COMPETENCY

**Department/Unit:**

**Calendar Year:**

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ABSTRACT:
(Identify the target audience and a sentence or two introducing the packet information)

OBJECTIVES: (State objectives/desired outcomes in behavioral terms - see objective sheet attached)

Upon completion of this module, the employee will be able to:

1) Relate …

2) Identify …

3) Demonstrate …

RESOURCES: - Identify all written, audio and video materials required to complete the offering.
- Identify written and/or skill competencies necessary for competency validation

Materials required to complete the self-learning packet include:

A)
B)
C)
GUIDELINES FOR SKILL COMPETENCY

(TITLE OF PACKET)

These focus on cognitive understanding in addition to skill demonstration. Identify objectives to be met and *outline performance criteria for clinical evaluation*, utilizing policies and procedures, standards of care or recommended guidelines/protocols at GSH.
Written Competency

(TITLE OF PACKET)

(This is a study/worksheet which addresses the key concepts presented through resource materials provided.

NOTE: Avoid lengthy, time consuming questions.
Limit the number of questions
Construct a section for each group of questions.
Do not jumble true/false, multiple choice and fill in the blank questions throughout the page.)
GUIDELINES FOR WRITTEN COMPETENCY

(TITLE OF PACKET)

(Restate the question as a correct statement. This enables the participant to evaluate the effectiveness of his/her responses while reviewing the material.)
EHS Good Shepherd Hospital
Barrington, Illinois

ANSWER KEY FOR WRITTEN COMPETENCY

(TITLE OF PACKET)

(Time saver in correcting written competency if the manager/supervisor will be correcting written competency.)
Please assist us in evaluating this independent study program and planning future programs by completing this evaluation form. Thank you.

I. As a result of this program, I feel I have achieved the following objectives.

A. Relate ... ( ) Achieved ( ) Not achieved

B. Identify ... ( ) Achieved ( ) Not achieved

C. Demonstrate ... ( ) Achieved ( ) Not achieved

II. Rate the effectiveness of the methods used.

III. Rate the relevance of the content to the objectives.

IV. Document the amount of time required to complete this offering: ___________

V. COMMENTS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for your evaluation. Upon completion of this packet, please return this form to a designated evaluator in your area.

NAME: ___________________ DEPT: _________
EHS EMPLOYEE CONTINUING EDUCATION RECORD

Name: ___________________ Title: _______________ Facility: ____________________

Department: _______________ Status: (√) FT __ PT __ 00/Flex Calendar Year: __________

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Signature of Evaluator(s) ___________________ Initials _______ Signature of Evaluator(s) ___________________ Initials _______

Facility: ____________________ 00/Flex Calendar Year: __________

ORIGINAl Manager COPY Human Resources

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Employee Signature: ___________________________ Date: _____________

Supervisor Signature: ___________________________ Date: _____________

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At first, writing objectives is difficult for most educators. With practice, however, and attention to the following points, the process of writing objectives becomes easier and less time consuming.

COMPONENTS OF AN OBJECTIVE

Each educational objective must contain two important components, a verb and the content.

The FIRST PART of each educational objective should contain a verb or action word (a word that describes an observable behavior) that states what the learner is to do to demonstrate achievement of the objective.

Verbs such as know, understand, or comprehend, although frequently used in some objectives, are poor terms because they are neither observable nor easily interpreted.

Terms such as identify, list, state, plan, and define, relate to more easily observable actions, have fewer interpretations, and thus are more useful to the learning program.

The following is a list of suggested verbs which may be used in the development of your objectives. This list is not meant to be all inclusive and limiting. Used properly, these behavioral verbs will prove acceptable.

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</tr>
<tr>
<td>Distinguish</td>
<td>Organize</td>
<td>Revise</td>
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</table>

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The SECOND PART of each educational objective is the content (in terms of knowledge, attitudes, or skills) that the learner will learn and subsequently demonstrate the ability to act upon. The content is the substance of the objective that meets the assessed learning need. Examples of the content part of objectives include:

1. "...contributing factors in coronary artery disease..."
2. "...signs and symptoms of postoperative infection..."
3. "...rationale for low residue diet..."
4. "...1800 calorie diabetic diet for 24 hours..."
5. "...peptic ulcer..."

By combining the two components (the verb and content), complete, observable objectives are written, for example:

1. Identify contributing factors in coronary artery disease.
2. List signs and symptoms of postoperative infection.
3. State the rationale for a low residue diet.
4. Plan an 1800 calorie diabetic diet for 24 hours.
5. Define peptic ulcer

THE UTILITY OF AN OBJECTIVE

Once an objective has been written, it must be examined for four qualities in order to certify its usefulness in a teaching/learning program. Objectives must be specific, inclusive, measurable, and realistic.

1. An objective is **specific** if it contains a singular idea. Although combining similar ideas into one objective may make a shorter list of objectives, it encumbers the teaching and evaluation stages, making more work for the educator later on.

2. The amount of information contained in an objective may also make it more **inclusive**. An objective must take all learning content into account.

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3. An objective becomes more easily measurable if the number of items in the content portion is mentioned. For example, "List the four E's contributing to a heart attack."

4. An objective is realistic only if it can be attained by the learner.

Adapted from:


APPENDIX V

COMPETENCY MEASUREMENT

EXAMPLES OF COMPETENCY MEASUREMENT .................. 103

COMPETENCY ASSESSMENT INDEX FOR GOOD SHEPHERD HOSPITAL AS OF MARCH 1994 ........................................ 104
1994 CQI PERFORMANCE MONITORING INDICATORS

The following competencies and indicators are examples of measurements within a competency assessment program.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>INDICATOR</th>
<th>BASELINE</th>
<th>GOAL</th>
<th>JAN</th>
<th>MAR</th>
<th>APRIL</th>
<th>MAY</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
<th>SEPT</th>
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<tr>
<td>Mammography Procedure</td>
<td>Pt. recall rate for mammography will be reduced.</td>
<td>1.5</td>
<td>1</td>
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<tr>
<td>Specimen Collection</td>
<td>Number of outpts. recalled due to improper specimen collection will be reduced</td>
<td>2%</td>
<td>0%</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Dispensation of medications</td>
<td>Pharmacy dispensing errors will not exceed established standard.</td>
<td>0.02%</td>
<td>0.01%</td>
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<td>Assembly of Surgical Trays</td>
<td>Appropriate tray content</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Insertion, care and maintenance of central lines</td>
<td>The number of central line infections will be reduced.</td>
<td>4%</td>
<td>1%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>Applications and maintenance of restraints</td>
<td>Patients will not experience complications from restraints</td>
<td>100%</td>
<td>60%</td>
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© 1993, EHS
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<td>Blood Administration</td>
<td>Education</td>
<td>4/93</td>
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<td>Blood Salvage</td>
<td>Emergency Blood Salvage (Cell Saver) Collection</td>
<td>OR</td>
<td>2/94</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>Cardiac Output</td>
<td>MSICU</td>
<td>10/93</td>
<td></td>
</tr>
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<td>Cardiac</td>
<td>Cardiac Catherization</td>
<td>4E</td>
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<td>Elective Cardioversion</td>
<td>4E</td>
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* 1993. EHS Good Shepherd Hospital Clinical Education Competency Assessment Program*
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Joint Commission Tape Library. "Nursing Competency Assessment: Regaining Control of the Process." Lecture on Videotape VHS.


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The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Arts.

[Signature]
December 1, 1994
Date

[Signature]
Director's Signature