## **Procedural Competency Evaluation**

STUDENT:		DATE	:		
CASE STUDY PRESENTATION					
Evaluator:	Peer Instructor	Setting: 🗌 La	b 🗌 Clinical Simula	tion	R
Equipment Uti	ilized:	Conditions (Des	ribe):	ut new learning:	RF
Performance Level:					DRN
S or √= Satisfactorγ, no errors of omission or commission U = Unsatisfactorγ error of omission or commission NA = Not applicable					PERFORMANCE F
Performance	Rating:				Â
s	<b>ndependent:</b> Near flawless performanc shows initiative; A = 4.7–5.0 average	· · ·	•	at new rearring,	RATING
4 <b>Minimally Supervised:</b> Few errors, able to self-correct; seeks guidance when appropriate; B = 3.7–4.65					
<b>Competent:</b> Minimal required level; no critical errors; able to correct with coaching; meets expectations; safe; C = 3.0–3.65					
<ul> <li>Marginal: Below average; critical errors or problem areas noted; would benefit from remediation; D = 2.0–2.99</li> <li>Dependent: Poor; unacceptable performance; unsafe; gross inaccuracies; potentially harmful; F = &lt; 2.0</li> </ul>					
<i>Two or more errors of commission or omission of mandatory or essential performance elements will terminate the proce-</i>					
C	dure, and require additional practice an evaluation forms as needed from the Di	d/or remediation and reeva	luation. Student is responsible for a		
EQUIPMENT AND PATIENT PREPARATION					
1. Common Performance Elements Steps 1–8 (Refer to Appendix B)					
ASSESSMENT AND IMPLEMENTATION					
2. Common Performance Elements Steps 9 and 10 (Refer to Appendix B)					$\square$
3. Interviews patient and collects history					
4. Performs physical examination					
5. Ensures patient comfort and safety					
ORAL CASE PRESENTATION					
6. Identifies self to audience					
7. Maintains patient confidentiality					
8. Relates patient information including: age, gender, race, height, and weight					
9. Relates advances directive status (full code, DNR)					
10. States chief complaint concisely					
11. States history of present illness (tells the story)					
12. States past medical history including major illnesses, injuries, and surgeries					
13. States psychosocial history					
14. Identifies employment history including present and past employment					
15. Identifies family history					
16. Identifies result of review of systems (ROS)					
17. Identifies results of physical examination including date and time performed					
18. Presents case in chronological order (tells the story)					
19. Presents discussion and summary					
20. Presents complete care plan					
21. Maintains poise and composure throughout presentation					
22. Speaks clearly and loudly enough so audience can hear and comprehend					
23. Answers questions of audience and instructors in reasonable time frame					
24. Correlates theory to case presentation					
25. Completes presentation in reasonable time frame (15 to 30 minutes)					
26. Prepares and	submits written case according to inst	ructions			