Procedural Competency Evaluation

STUDENT: **DATE:**

MEDICAL RECORD REVIEW

Evaluator: ☐ Peer ☐ Instructor **Setting:** ☐ Lab ☐ Clinical Simulation

Equipment Utilized: **Conditions (Describe):**

Performance Level:

S or ✓= Satisfactory, no errors of omission or commission
U = Unsatisfactory error of omission or commission
NA = Not applicable

Performance Rating:

5 **Independent:** Near flawless performance; minimal errors; able to perform without supervision; seeks out new learning; shows initiative; A = 4.7–5.0 average

4 **Minimally Supervised:** Few errors, able to self-correct; seeks guidance when appropriate; B = 3.7–4.65

3 **Competent:** Minimal required level; no critical errors; able to correct with coaching; meets expectations; safe; C = 3.0–3.65

2 **Marginal:** Below average; critical errors or problem areas noted; would benefit from remediation; D = 2.0–2.99

1 **Dependent:** Poor; unacceptable performance; unsafe; gross inaccuracies; potentially harmful; F = < 2.0

Two or more errors of commission or omission of mandatory or essential performance elements will terminate the procedure, and require additional practice and/or remediation and reevaluation. Student is responsible for obtaining additional evaluation forms as needed from the Director of Clinical Education (DCE).

	PERFORMANCE LEVEL	PERFORMANCE RATING
EQUIPMENT AND PATIENT PREPARATION		
1. Obtains and verifies correct chart or electronic medical record		
2. Informs nurse or unit secretary if removing chart from the nurses' station		
3. Ensures compliance with HIPAA regulations regarding personal health information		
ASSESSMENT AND IMPLEMENTATION		
4. Locates and evaluates:		
A. Patient demographics		
B. Chief complaint/diagnosis		
C. History of present illness		
D. Smoking history (pack/years)		
E. Past medical history		
F. Allergies		
G. Current medications		
H. Psychosocial history		
I. Occupational history and exposures		
J. Family history		
5. Locates and evaluates the physician's orders or protocols		
6. Reviews physical examination results		
7. Reviews results of current diagnostic procedures including CXR, EKG, PFT, ABGs, labs		
8. Reads and evaluates most recent progress notes		
9. Charts procedure performed or shift note including all pertinent data		
10. Signs note with appropriate credential and has preceptor/instructor countersign		
FOLLOW-UP		
11. Develops and documents SOAP, APIE, and care plan		
12. Returns chart to proper location and/or closes electronic record		

SIGNATURES Student: Evaluator: Date: