Procedural Competency Evaluation

STUDENT: **DATE:**

PATIENT INTERVIEW AND HISTORY

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. Common Performance Elements Steps 1–8 (Refer to Appendix B)		
2. Limits distractions; performs in quiet location		
ASSESSMENT AND IMPLEMENTATION		
3. Common Performance Elements Steps 9 and 10 (Refer to Appendix B)		
4. Utilizes therapeutic communication skills to determine level of consciousness and sensorium, orientation to person, place, time		
5. Assesses ability to follow directions and level of cooperation		
6. Evaluates emotional status, level of dyspnea, nutritional status, and tolerance of activities of daily living (ADLs)		
7. Asks patient chief complaint: onset, duration, frequency, severity (quantity), character (quality), location, radiation, aggravating factors, alleviating factors, associated manifestations		
8. Asks about history of present illness		
9. Determines smoking history (pack years)		
10. Inquires about allergies and current medications		
11. Asks the patient questions to ascertain specific pulmonary symptoms: dyspnea on exertion or rest, orthopnea, platypnea, pleurodynia		
12. Asks about nature of cough		
13. Inquires about sputum production: amount, color, consistency, odor, taste, presence of blood		
14. Inquires about chest pain: quality, location, radiation, aggravating factors, alleviating factors, and associated manifestations		
15. Inquires about past medical history, major illnesses, injuries, and surgeries		
16. Performs psychosocial assessment as applicable:		
A. Birthplace F. Highest education level		
B. Race G. Alcohol intake		
C. Religion H. Sexual activity		
D. Culture I. Drug use		
E. Language(s) spoken J. Home situation		
17. Asks questions about occupational history and exposures		
18. Performs review of systems (ROS) to ensure all pertinent information has been obtained		
19. Asks the patient questions to determine current comfort level or needs		
FOLLOW-UP		
20. Common Performance Elements Steps 11–16 (Refer to Appendix B)		

SIGNATURES Student: Evaluator: Date: