Registered Nurse Medical Surgical & Observation Unit Orientation Checklist

Associate Name: _____ Completed Telemetry Training: _____
Unit: _____ Completed MyPath: _____
Initiation Date: _____ Completed Policy Review: _____
Completion Date: _____

Self-Assessment (*SA):

Prior to starting orientation, the associate will complete the self-assessment portion using the following guidelines:

0 – Novice: I have little to no knowledge/experience in this area

1 – Competent: I am competent in this area

2 – Proficient: I can perform well in this area

3 – Expert: I excel in this area

Preceptor Assessment of Skill Competency Levels:

Initial and date the appropriate column on the checklist based on your assessment of the orientee's level of performance using the levels described:

Observed: Simulation of skill performed

Performed: Skill performed with supervision

Competent: Skilled performed competently

Exempt: Skill not performed on patient population

Preceptor Initials/Signature:

_____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____

Associate Comments: **Preceptor Comments:**

Associate Signature: _____ **Date:** _____

Manger/Director Signature: **Date:**

*SA	Nursing Practice Orientation	Observed	Performed	Competent	Exempt
P1	**ursing Fundamentals**				
	Intranet – Policy Review, Procedure Review, E-mail, Nursing Webpage				
	Scheduling Software (Clocking, PTO, Exception Log)				
	Event Reporting System				
	Electronic Health Record (EHR)				
	Security				
	Call Bell System				
	Emergency Response – Rapid Response/Code Team				
	Unit fire plan – locate emergency exit routes				
	Floor Orientation (Clean/Dirty Utility, Kitchen, Pt Rooms, Code Cart(s), etc.)				
	Nursing Standards of Care				
	Nursing Code of Ethics				
	Resuscitation Quality Improvement Program (RQI)				
	Professional Advancement System (PAS)				
	Pharmacy				
	HIPPA/Patient Confidentiality				
P1	**ltural Diversity/Patient Communication**				
	Respect the patient's cultural and personal values, beliefs, and preferences				
	Effectively communicates with patient/family/visitors when providing care, treatment, & services				
P1	**fection Control/Universal Precautions**				
	Demonstrates Proper Hand Hygiene				
	Donning & Doffing of Personal Protective Equipment				
	Types of Isolation: Initiation/Discontinuation				
	Healthcare Associated Infection Prevention				
	Central Line Associated Bloodstream Infection (CLABSI)				
	Catheter Associated Urinary Tract Infections (CAUTI)				
	Clostridium Difficile (C. Diff)				
	Multiple Drug-Resistant Organism (MDRO)				
	Surgical Site Infections (SSI)				
P1	**fe Patient Handling & Mobility**				
	Bed positioning				
	Gait Belt				
	Non-Friction Devices				
	Total Mechanical Lift				
	Sit-Stand Mechanical Lift				
	Manual Stand Aid				
	Ambulating/Positioning/Transferring				
P2	**inical Care**				
P2	**eneral Assessment**				
	Assessment Types (Admission, Shift Assessment, Reassessment)				
	Implementing Education/Care Plan				
	Allergies				
	Falls Precautions (BMAT, Morse Fall Scale)				
	Alarm Management (Chair, Bed)				
	Virtual Patient Safety Observation				

*SA	Nursing Practice Orientation	Observed	Performed	Competent	Exempt
Clinical Care (cont.)					
P2	**eview of Systems**				
P2	**astrointestinal**				
	Abdominal Assessment Bowl Sounds/Flatus				
	Colostomy/Ileostomy				
P2	GI Tube (NGT, PEG, J-tube, G-Tube) Medication Administration Enteral Feeding				
	Rectal Tube				
P2	**rdiovascular**				
	Heart Sounds				
	Pacemaker				
	Edema				
	CMS Checks				
P3	**dvanced Cardiac Care**				
	Cardiac Monitoring				
	Implementing/Discontinuing Telemetry				
	Alarm Management (Setting Limits, Measurements)				
	Troubleshooting monitor/leads				
	Defibrillator & AED				
	Defibrillation Using Multifunction Electrode Pads				
	Synchronized Cardioversion				
	Transcutaneous Pacing				
	Code Cart Checks	1.	2.	3.	
	Pacemakers (Single, Dual, Defibrillator)				
	Laboratory Studies (Troponins, CK, BNP, etc.)				
	Orthostatic Blood Pressure				
	Echocardiogram (TTE, Stress Test, Bubble Study, Definity)				
	Weights (Daily, Admit)				
	Strict Intake & Output				
	EKG (3 Successful EKGs)	1.	2.	3.	
P2	**espiratory**				
	Breath Sounds				
	Cough				
	Incentive Spirometer				
	Continuous Monitoring Pulse Oximeter				
P3	**dvanced Respiratory Care**				
	Supplemental Oxygen				
	Nasal Canula				
	Non-Rebreather Mask				
	Oxymask				
	Oral Suctioning				
	Tracheostomy Care				
	Care of Plastic Tracheostomy Tube with Inner Cannula				
	Tracheostomy Suctioning				
	Aerosol Mask, Tracheostomy				
	Chest Tube				
	Respiratory Medications (inhaled therapies, nebulizer therapies) Assessment/Reassessment and Documentation				

*SA	Nursing Practice Orientation	Observed	Performed	Competent	Exempt
Clinical Care (cont.)					
Review of Systems (cont.)					
P2	**EENT (Head, Eyes, Ears, Nose, Throat)**				
	Aspiration Precautions				
	Special Communication Needs (Hearing, Language, Vision)				
P2	**eurological**				
	Glasgow Coma Scale (GCS)				
	Neuro Checks				
	Delirium Assessment				
P2	**roke Care**				
	Assessment – Neurological Deficits, VS, Cardiac Monitoring				
	Activating Stroke Alert – Stroke Team & Code LVO				
	NIHSS				
	Dysphagia Screening/Modified Diets				
	Types of testing – CT, CTA, MRI, Labs, BG				
	Antiplatelet/Anticoagulants				
	DVT Prophylaxis				
P2	**usculoskeletal**				
	Range of Motion (ROM) & Muscle Strength				
P2	**enitourinary**				
	Urinary Bladder Catheterization (Straight/Foley)				
	Nephrostomy				
	Urostomy				
P2	**tegumentary**				
	Skin Integrity				
	Wound Care				
P2	**ychosocial**				
	Social Determinants of Health (SDoH)				
	Mental Health, Relationships, & Coping Mechanisms (including interventions)				
P3	**ecialty Care**				
P3	**RS/Sepsis**				
	NEWS/Sepsis Score & BPA				
	RR, O2 Sat., Supplemental O2, Temp., SBP, HR, LOC				
	Treatment (Bolus, ABX., VS, Labs, T & S, BC, Cultures)				
	SIRS (Systemic Inflammatory Response Syndrome)				
P3	**in Management**				
	Pain Assessment/Reassessment and Documentation				
	Pain Medications (Prescribed and Over the Counter)				
	Alternative Therapies				
P3	**anging Patient Condition - Deterioration**				
	SBAR				
	Initiating Advanced Care (6666)				
	Rapid Response (RR), Code Team, Stroke Alert, MI Alert				
	Use of the Code Narrator/RR Narrator				
	Reporting Critical Values				
P3	**d Of Life**				
	Organ donation				
	Advanced Directives				
	Comfort Care/Hospice/Palliative				
	Postmortem Care and Documentation				

*SA	Nursing Practice Orientation	Observed	Performed	Competent	Exempt
Clinical Care (cont.)					
Specialty Care (cont.)					
P3	**st-Operative Hernia**				
	Vital Signs (Q2hrs for 12hrs. then Q4hrs.)				
	Continuous Oxygen Saturation				
	Continuous Telemetry				
	Patient Education & Care Plan				
P3	**st-Operative Orthopedic**				
	Vital Signs				
	CMS Check (Q2hrs. until full sensation, Q4hrs. until POD1 2000, then Q8hrs.)				
	Pain (Q4hrs for 24hrs. then Q8hrs.)				
	Incentive Spirometry (Q8hrs.)				
	IVF (D/C POD1 0600 with good oral intake)				
	Drains				
	Foley Catheter (D/C POD1 0600)				
	Surgical Site Care				
	Patient Education & Care Plan				
P4	**travenous (IV) Access**				
Peripheral IV Access					
	IV Catheter Insertion (3 Successful Insertions – Date/Initials)	1.	2.	3.	
	IV Catheter Removal				
	IV Catheter Maintenance (Assessment, Flushing, Dressing Change)				
P4	**ntral Venous Access (CVC)**				
	Non-Tunneled Catheters (Hohn, Triple/Double Lumen)				
	Tunneled Catheters (Hickman, Groshong, Broviac)				
	Implanted Ports (Medi port, Port-A-Cath, Power Port)				
	Peripherally Inserted Central Cath (PICC, Power PICC)				
	CVC Maintenance (Assessment, Flushing, Dressing Change)				
P4	**ood/Blood Product Administration**				
	Pre-Transfusion				
	Intra-Transfusion				
	Post-Transfusion				
	Transfusion Reaction				
	Pre-Transfusion				
P4	**aris IV Pump**				
	Primary Infusion/Secondary Infusion				
	Patient Controlled Analgesia Pump				
	Initiation				
	Documentation (2 RN cosign)				
	ETCO2 Pump				
	Inititation (Set up & ETCO2 tubing)				
	Troubleshooting/Alarms				
P4	**renteral Nutrition**				
	Total Parenteral Nutrition (TPN)				
	Lipids				

*SA	Nursing Practice Orientation	Observed	Performed	Competent	Exempt
Clinical Care (cont.)					
P4	**edication Administration**				
	Pyxis Tutorial and Pyxis Usage Guidelines				
	6 Rights of Medication Administration				
	Positive Patient Identification (PPI)				
	Patient Specific Medications				
	Review Prior to Arrival (PTA) Medications				
	Wasting Medications				
	Vaccinations				
	Review of Historical Vaccine Data & Assessment in EMR				
	Administration/Documentation of Vaccines in EMR				
	Education: Printing VIS from EMR & Documentation				
	Medication Administration Record (MAR)				
	Barcode Scanning				
	Override & Linking Medications				
P4	**Medication Route**				
	Rectal (Suppository, Enema)				
	Transdermal				
	IV Drip (Primary/Secondary)				
	IV Push Injection				
	Intramuscular Injection				
	Subcutaneous Injection				
	Oral/Enteral				
	Sublingual				
	Ocular (Eye)				
	Otic (Ear)				
P4	**Medication Type**				
	Insulin Administration Sub-Q Insulin Nomogram & sliding scale				
	Insulin Administration IV				
	Anticoagulation Therapy SQ (Heparin/Lovenox) Oral (Coumadin, Xarelto, Eliquis)				
	Heparin/Bivalirudin Drips				
	Antibiotic Therapy				
	Peaks & Troughs				
	Antibiotic Resistance (MDRO, VRE, MRSA, CRE, ESBL, C. Diff)				

****Once Complete please submit <u>BOTH</u>**

Clinical Orientation Checklist &

Department-Specific Orientation Checklist

to your Nursing Director**