First Shift Checklist/Time Sheet

Competency Assessment/Performance Evaluation

Employee Name: _____ Signature: _____ Facility: _____

Time Sheet: Supervisor must sign, verifying time is correct and initial if no break was available.
Date: _____ Unit/Floor Worked: _____
Orientation Start Time: _____ End Time: _____ Total Time: _____
Shift Start Time: _____ End Time: _____ No Break (Initial): ___Total Time: _____

Orientation: Complete Prior to providing care, treatment, or services. Please ensure all areas have been addressed and complete. (JC HR.3 (10))

Facility staff please initial each topic completed or place NA if not applicable.

- ❑ Tour of unit(s) working
- ❑ Review of Emergency Protocol/Codes
- ❑ Review of physical layout of facility
- ❑ Orientation to policies/procedures
- ❑ Facility Specific Orientation
- ❑ Infection Control Policy
- ❑ Documentation (Computer, Charting, Paperwork, Restraint, etc.)
- ❑ Medication Administration (Orientation, Documentation, Protocols)
- ❑ Review Emergency Evacuation Procedures (Fire, Tornado, etc.)
- ❑ Equipment to be used by HCP (Glucomete, IV Pumps, etc.)
- ❑ Other: _____

Competency Assessment/Performance Evaluation: To assist with our evaluation process, we would appreciate your assessment of the performance of this person. Please check the appropriate boxes and make additional comments you feel may be of assistance in our ongoing quality assurance program. Thank you! (JC HR.4 (3) and HR.6 (1)).

Expectation Ratings: E=Exceeds, M=Meets, D=Does Not Meet, N=Not Applicable (Please circle)

• Prioritizes assignments based on patient condition	E	M	D	N
• Conducts assessments per standard of care	E	M	D	N
• Plans care in collaboration with healthcare team	E	M	D	N
• Carries out physicians orders accurately and timely	E	M	D	N
• Performs nursing interventions per standard of care	E	M	D	N
• Documents per policy completely and accurately	E	M	D	N
• Maintains confidentiality	E	M	D	N
• Works within Scope of Practice	E	M	D	N
• Performs Skills and duties assigned competently	E	M	D	N

Additional Comments:

Facility Representative Name/Title: _____

Facility Representative Signature: _____

3100 S Lakeport St
Sioux City, IA 51106
Phone: 800.727.1912
Fax: 712-277-4547