KINGDOM OF SAUDI ARABIA
MINISTRY OF EDUCATION

جامعة الإمام عبد الرحمن بن فيصل
IMAM ABDULRAHMAN BIN FAISAL UNIVERSITY

College of Nursing Internship Program Manual

Intern name: _____

Batch: _____ Group: _____

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Welcome Message

Dear Nursing Interns:

Welcome to the internship period, and big congratulations for the achievement of the academic requirements in the College of Nursing, at Imam Abdulrahman Bin Faisal University.

During your internship, you will be able to expose to different clinical settings and practice lots of nursing procedures which are efficient and vital for your carrier.

It is a pleasure for us in the Clinical Affair presented by Internship Unit to support you and guide your practical journey.

Thanks a lot, and Kind Regards

Vice-Dean Clinical Affairs

INTRODUCTION TO INTERNSHIP PROGRAM

Introduction:

Following successful completion of the four years in the undergraduate nursing program, the student must spend 52 weeks of hospital based internship period in a recognized hospital, that can offers a proper training areas to meets the objectives of the internship program.
This period of practical managerial and theoretical experience will enable the graduate to acquire more competency and experience to perform as an independent nurse specialist (per Saudi council for health specialties accreditation) and as a first level nursing manager, and will enable student to adjust to the real practical life in different units in the hospital settings.
By the successful completion of this internship period, the graduate is expected to fulfill the objectives of the program and will be awarded the certificate.

Vision

To be an innovative cornerstone of nursing education nationally, regionally and internationally through the use of technology within a caring context.

Mission

To offer a dynamic, comprehensive and innovative educational experience that will enable students to expand their nursing knowledge and enhance their professional skills in order to meet the health care needs of the community within the context of Islamic culture, beliefs and values.

Goals

1. Provide quality education in nursing for Saudi nurses who graduate with high scientific and clinical competencies.
2. Utilize concepts from the humanities and behavioral sciences in the nursing practice.
3. Practice legal and ethical standards of the nursing profession.
4. Develop professional knowledge and practice through a problem-solving approach and evidence-based learning.
5. Utilize electronic administration and health information resources.
6. Apply leadership and managerial skills to attain quality care.
7. Focus on the commitment to the principle of “lifelong learning”.

Values

- Comply with and incorporate Islamic and community beliefs with the ethics of the profession.
- Quality performance.
- Development of confidence.
- Transparency.
- Pursuit of self-education.

Objectives

The graduates will be able to:

- Provide competent and culturally sensitive nursing services in response to the changing needs of the society and in accordance with both legal and ethical standards.

- Communicate effectively with clients, family and other health professionals.
- Use critical thinking, problem solving and scientific inquiry in the practice of nursing and in monitoring and ensuring the quality of health care.
- Use their nursing knowledge and skills in partnership with clients and families in order to maintain and promote health and wellbeing as well as provide care and support during illness.
- Implement the Standards of Nursing Practice.
- Use different approaches to assess, protect and promote the health of the community.
- Meet challenges produced by ongoing changes in the provision of health care.
- Participate in the preventive, promotive, curative, rehabilitative and supportive services.
- Demonstrate care by utilizing theory and evidence based nursing interventions.
- Collaborate with clients and other health professionals to provide culturally sensitive nursing care.
- Appreciate how specific environments and socio-political, cultural and historical conditions affect health behavior, professional practice and public policy.
- Apply leadership and managerial skills to attain quality care for clients and quality of the working environment for co-workers.
- Engage in self-directed, life-long learning, reflective and evidence-based practice.

Practice Competencies

1. Uses advanced comprehensive assessment, diagnostic, treatment planning, implementation and evaluation skills
2. Documents assessment diagnosis, management and monitors treatment and follow-up care in partnership with the patient
3. Uses applicable communication, counseling, advocacy and interpersonal skills to initiate, develop, and discontinue therapeutic relationships
4. Refers to and accept referral from other health care professionals to maintain continuity of care.
5. Practices independently where authorized and the regulatory framework allows in the interest of the patients, families, and communities
6. Works in collaboration with health team members in the interest of the patient
7. Develops a practice that is based on current scientific evidence and incorporated into the health management of patient, families, and communities
8. Uses research to produce evidence-based practice to improve the safety, efficiency and effectiveness of care.
9. Engages in ethical practice in all aspects of the registered nurse role responsibility.
10. Creates and maintains a safe therapeutic environment through the use of risk management strategies and quality improvement.

11. Assume leadership and management responsibilities in the delivery of efficient practice nursing services in a changing health care system
12. Introduce tests, evaluates, and manages evidence-based practice.
13. Acts as an advocate for patients in the health care system and in the development of health policies that promote and protect the individual patient, family and community.

ORIENTATION PROGRAM

Overall purpose:

To provide new interns with **one-week General hospital orientation which offered by hospital staff and internship unit in the college** to practice nursing care in a safe environment, which is in accordance with the goals and objectives of the nursing internship program.

Objectives:
On completion of the orientation program each intern is expected to understand the following regulations about:

The Hospital:

1. Recognize the overall physical setting of the hospital and specify the work areas to which he is trained.
2. Be aware of the mission, vision, and policies of the hospital
3. Understand the organizational structure of the hospital
4. Recognize the intradepartmental communication process (e.g. computer, intercommunication systems, forms, procedures).
5. Identify the functions of departments other than nursing and the nurse's relationship with them.

Scope of Orientation:

All newly interns are entitled to be oriented to the hospital as a total institution and specifically to the nursing service.

- **General Orientation**:

  - ✓ **Orientation to the hospital**:

    It includes a tour of the facilities; a description of the organizational structure; a discussion of different departmental functions; a presentation of the philosophy, goals, and standards; an interpretation of administrative policies and procedures; and possibly an explanation of hospital relationships with the community.

- ✓ **Orientation to the nursing service:**

  It Includes Interdepartmental relationships, departmental organization, administrative controls, philosophy, goals. Policies, procedures, and job description.

- ✓ **Orientation for specific Areas**:

The new interns will need a tour of the selected units for training so that he knows the location of supplies, equipment, and policy and procedure books.
Information about how the unit is run, specific methods of practice, and communication system is important and Introduction to the nursing personnel

Orientation activities:

1. Orientation through Internship unit explain all rules and regulation for internship program
2. Interns Health Screening and Vaccination
3. Explain Hospital and Departmental Organizational Charts
4. Hospital Physical Setting and Map (Tour)
4. Patients' and their Families Rights & Responsibilities
5. General Hospital Policies & Procedures, Mission & Vision
6. Mission, vision, Philosophy of Nursing Department
7. Standard of Nursing Care and Code of conduct
8. General & Specific Dress Code
9. Job description of Nursing Interns
10. Documentation Guidelines and Practical workshop
11. Medication and Pharmacy workshop, Course and Test
12. Intravenous therapy Course and Test
13. Introduction to Quality Management: OVR Documentation
14. Risk Management
15. The Use of Ulti-care System/ Computer
16. Environmental and Safety Lectures
17. Fire Drill and Disaster Drill Lectures
18. Code Protocol / crash cart
19. CPR Course
20. Infection Control Lecture

RULES AND REGULATION

ATTENDANCE REGULATION:

Late in duty:

The allowed time for nursing intern to be late is **ONLY 5 Minutes in attendance>**

Excuses:

Each intern is allowed to **excuse maximum 2 hours**. Compensate at the same day or next day in the same rotation. Total number of excuses per year is 6 times with submitted of documents. Two requests will be approved in each rotation from total number of interns.

Governmental holiday:

Each intern is entitled to the National Holidays (**Ramadan Eid, Hajj Eid,National Day and founding day**) throughout **the entire year of training these days will be included in the total exposure weeks** of training. However, **the number of days allocated for each holiday will depend on hospital regulation.**

Emergency leave:

- An intern is entitled to have a maximum (10) days emergency leave.
- An intern should contact the hospital internship coordinator when there is an emergency immediately.

Sick leave:

- The intern is entitled to absent due to illness for a maximum (5) days during the entire internship year.
- If the intern need more than five days as sick leave, it has to be compensated.
- A medical report should be attached with the sick leave request and must be submitted to the office of Clinical Affairs..

Educational leave:

- An intern is allowed to have **(5) days of educational leave** to attend or participate in symposium, workshops or conferences.
- Request for attendance must be **submitted 2 weeks** in advance to the hospital internship coordinator and internship supervisor.
- An attendance certificate is required.

Absent without valid excuse:

- If the intern is absent without call or given justified reason the intern will receive penalty of repeating double the missed days.
- If the intern is absence 25% from the rotation intern will repeat the same rotation.
- If the intern is absence 25% from the total internship period intern will repeat the whole year.
- The intern is subjected to a disciplinary action by the internship supervisor for any absent without a valid excuse depending on the report submitted to the vice dean of clinical affairs office.
- Any absent day should be compensated at the end of the internship year.

Maternity leaves:

- Maternity leave is **two (2) weeks for normal delivery and four (4) weeks for cesarean section (with compensation)**
- The assigned rotation during the maternity leave should be repeated at the end of the internship year.
- The allowable number of excused pre-natal check-up will not exceed five (5) visits to her attending physician for the whole 9-month of pregnancy.

Marriage leave: **2 weeks with compensation.**

INTERNSHIP ROTATION

Male Rotation		Female Rotation	
Medical 8 wks.	2 wks. Haemodialysis 2wks.MICU/CCU/ cath.lab. 4 wks. Medical unit	Medical 7 weeks	2 wks. Haemodialysis 2 wks. CCU/cath.lab 3 wks. Medical unit
Surgical 8 wks.	2 wks. OR /Burn 2 wks. SICU 4 wks. Surgical unit	Surgical 7 weeks	2 wks. ER/SICU 2 wks. OR 3 wks. surgical unit
Paediatric 4 weeks	2 wks. PICU 2 wks. OPD paediatric	Paediatric 7 weeks	2 wks. PICU 2 wks. NICU 3 wks. Paediatric Unit
Emergency Room	6 weeks	OB/GYN 7 weeks	DR 2 wks. 2 wks. Postpartum 2 wks. Antenatal 1 wk. OB/GYN ER
Nursing Management	2 wks. Medical 2 wks. Surgical	Nursing Management	2 wks. Medical 2 wks. Surgical
PHC 4 weeks	4 weeks	Primary Health Care	4 weeks
Area of choice (Elective)	18 weeks	Area of choice (Elective)	16 weeks
Total number of weeks	**52 weeks**	**Total number of weeks**	**52 weeks**

KEYS:

CCU: Coronary care unit
MICU: Medical intensive care unit
OR: Operating room
SICU: Surgical intensive care unit
ER: Emergency room
PICU: Pediatric intensive care unit
NICU: Neonatal intensive care unit
DR: Delivery Room
PHC: primary health care
OB/GYN: Obstetrics and gynaecology

Area of choice (Elective):

Nursing interns are required to give their preference for elective subject prior to the elective rotations at the orientation period. This is organized by the nursing department.
Selected areas of choice are:

For Male	For Female
Intensive Care Units: MICU, SICU, PICU	Intensive Care Units: MICU, SICU, PICU
Cardiac Care Unit (CCU) and Cath lab	Cardiac Care Unit (CCU) and Cath lab
Operating Room (OR) and Recovery Room	Operating Room (OR) and Recovery Room
Hemodialysis (HD) and Peritoneal Dialysis Unit	Hemodialysis (HD) and Peritoneal Dialysis Unit
Psychiatry	Delivery Room (DR)
Endoscopy Unit	Emergency Room (ER)
	Endoscopy Unit
	Psychiatry

The selected hospital for nursing interns must involve the following criteria:

1. Being accredited either JCI or CBAHI and promote compliance with regulations, statutes, and accreditation requirements
2. Emphasize a safe environment with high standard of safe and effective practice setting.
3. To meet the objectives of the training for our students and interns in order to gain practical experience
4. Conduct training courses in order to improve the staff. Or Encourage professional self-development.
5. To be a governmental hospitals
6. Evaluate and develop all procedures that benefit training to achieve better performance for trainees
7. Comply with the hospital accreditation requirements of the Saudi Commission for Health Specialties
8. Standardize practices across multiple entities within a health system.
9. Develop of research, seminars and seminars, which helps to Presents medical equipment at world levels and high quality,
10. Ensure training skills by Evaluate the effectiveness of training programs

JOB DESCRIPTION

Job Title:
(Nursing Intern)

Qualification:
Graduate of 4 years BSN degree of nursing course in the Kingdom of Saudi Arabia.

Organizational Relationship:

- The nurse intern shall report to the head nurse or unit manager of the assigned unit on arrival. In the absence of the head nurse reports to the Unit in-charge.
    - The nurse intern shall report all clinical matters to the head nurse or unit manager.
    - The nurse intern shall report administrative matters to the Hospital Nursing Coordinator for the Internship Program or to the assigned Nursing College In-charge for the internship program.

Duties and Responsibilities of Nursing Intern:

- Sign Promissory form
- The nurse intern is responsible for assessing patient needs, Nursing care plan, implementing of nursing care plan, and evaluating results of such care in accordance with the policies and standards of the nurse works under the direction of the Head Nurse or her/his designee; and in conjunction with other health care professionals and paraprofessionals contributing to patient care.
- To report on duty (according to the shifts) and to leave the area when "handover" is completed.
- To receive a "handover" shift report from the outgoing nurse of “allocated patients".
- To participate in the unit/patient care activities (e.g. bed making, morning care, drug administration).
- To prepare and administer medication or narcotic drug under staff nurse supervision and according to hospital policy and make relevant observation to drug side effects.
- To maintain a clear and legible patient's documents of assigned patient’s records according to hospital documentation policy.
- To follow-up and carry out changes of orders in the patient's file.
- To report any unusual incidents occurrence in the duty, according to hospital policy.
- To be available in the unit all the time on duty except on break time.

- To give a "hand-over" shift report to the in- coming nurses before leaving the unit.
- To adhere to the internship regulations of the hospital.
- All nursing interns are expected to have a watch with second hand, a stethoscope, and a small pocket torch to aid in physical assessments of the patient.
- To participate in the activities those, promote and develop the nursing profession.
- To attend and participate in educational programs within the hospital that will foster professional growth and development (i.e. in-service committee, case conferences, continuing education)
- To follow guidelines/practices of infection control.
- To participate in disaster drill.
- To carry out nursing care plan on assigned patients according to patient's needs and prioritize and in line with the hospital policy

SAUDI NURSING LICENSING EXAM COMMITTEE

INTRODUCTION:

The purpose of the Saudi Nursing Licensing Exam Committee is to assure that the graduating nursing students of CON, IAU successfully pass the Saudi Nursing Licensing Exam (SNLE) mandated by the Saudi Commission for Health Specialties (SCHS). Main objectives of the Committee are (a) Plan and conduct a self – study of the current practices at the CON, IAU with respect to preparing students for SNLE (b) Adoptbest practices in national and international universities in the same domain and (c) Prioritize recommendations to improve CON, IAU practices for SNLE.

The role of the Committee involves the responsibility of carrying out student review, assessment and SNLE preparation services. Passing the SNLE for Saudi nursing graduates promises a bright opportunity in gettingadmission for Postgraduate Nursing Program at the Saudi Commission for Health Specialties or practicing a nursing profession in the academic or hospital background.

Unit Charges:

1. Orient graduating students on the Saudi Nursing Licensing Exam applicant guide to ensure properguidance on the step by step application SNLE process.
2. Explain and ensure full understanding of graduating students on the guide, policies and procedurescontained in the SNLE Applicant Guide.
3. Provide Consultation Services and professional presentation/Content development related toconsultation topics/modules on SNLE.
4. Develop virtual and on-site workshops with a focus on SNLE preparations/review.
5. Represent the CON, IAU for any meeting(s), conference or workshops initiated by the SNLE Central Committee who continually reviews the outline ensuring the content of SNLE Examinationis relevant to the nursing practice. Arrange orientation sessions / workshops regarding SNLE for CON, IAU Students
6. Contribute to the standard setting for the Saudi Nursing Licensure Examination in achieving an acceptable level of performance of the CON, IAU graduates that represents the institution as a whole.
7. Review the curriculum periodically for appropriateness of SNLE content and recommend changesin the curriculum accordingly for approval.
8. Align learning outcomes with SNLE.
9. Track statistics of the college graduates who have passed the SNLE (first timers and repeaters).
10. Recommend collaborative agreements between the College/University and local professional examination bodies (Saudi Commissions for Health Specialist).

GRADUATE ATTRIBUTES

1. Uses advanced comprehensive assessment, diagnostic, treatment planning, implementation and evaluation skills in monitoring the treatment and following-up care in partnership with the patient
2. Uses applicable communication, counseling, advocacy and interpersonal skills to initiate, develop, and discontinue therapeutic relationships
3. Refers and works in collaboration with health team members in the interest of the patient to maintain continuity of care
4. Practices independently where authorized and the regulatory framework allows in the interest of the patients, families, and communities and engages in ethical practice in all aspects of the registered nurse role responsibility.
5. Develops a practice that produces evidence-based practice to improve the safety, efficiency and effectiveness of care.
6. Creates and maintains a safe therapeutic environment with risk management strategies and quality improvement.
7. Assume leadership and management responsibilities in the delivery of efficient practice nursing services in a changing health care system.
8. Acts as an advocate for patients in the health care system and in the development of health policies that promote and protect the individual patient, family and community

Personal Information

نموذج تعريف شخصي

Intern Name:	**الاسم:**
Batch#: **Group#:**	**الدفعة:** **المجموعة:**
ID #:	**الرقم الجامعي:**
Nationality:	**الجنسية:**
Email:	**البريد الإلكتروني:**
Home Address:	**عنوان السكن:**
Home Telephone Number:	**رقم هاتف المنزل:**
Mobile Telephone Number:	**رقم الجوال:**
Emergency Contact Number:	**رقم الاتصال في حالة الطوارئ:**
مستشفى التدريب : 1- **2-**	

Promissory Form

تعهد

أنا طالب/ طالبة الامتياز الموقعة أدناه أتعهد بالتالي:
أن جميع المعلومات التي كتبتها صحيحة.

- إنني تلقيت التوجيه الصحيح وجميع الاستفسارات المتعلقة بالسياسات والإرشادات السريرية الحالية لبرنامج التدريب الداخلي

- أن ألتزم بالقوانين المكتوبة في كتيب التعريف والزي الرسمي الموحد و الالتزام بالدوام الرسمي و عدم التغيب من غير عذر رسمي.

- أن أحترم وألتزم بقوانين الممارسة التمريضية وأخلاقيات مهنة التمريض.

- أن ألتزم بحسن المعاملة وأخلاقيات المهنة السليمة مع رؤساء و زملاء العمل.

- أن أحافظ على نظافة وسلامة الملف الشخصي وإعادته لمكتب إدارة التمريض عند الانتهاء من فترة - الامتياز (عند ضياع الملف يتوجب دفع الغرامة المالية المحددة من قبل إدارةالتمريض)

I am the nursing intern hereby promise:

- That all my information's written are correct.
- I have received proper orientation and all queries regarding the existing clinical policies and guidelines of the internship program.
- I will adhere to the regulations stated in the orientation manual, dress code and attendance performance.
- I will respect the code of conduct of the nursing services & the ethics.
- I will maintain a professional behavior when dealing with colleagues and other coworkers.
- I will maintain the cleanliness of my personal file and return to the nursing office at the end of the internship year (in case of lost I will pay the penalty fees).

Intern Signature:	**التوقيع المتدرب/ المتدربة:**
Date:	**التاريخ:**

CLINICAL OBJECTIVES FOR GENERAL UNITS

SURGICAL UNITS

General Objectives:

Upon the completion of this training period in surgical units, the intern student will be able to:

1. Fulfill all the requirements for patient's admission.
2. Use nursing process as a frame work for care of patients with surgical problems
3. Perform comprehensive pre-operative assessment
4. Apply aseptic technique principles while caring for surgical patient
5. Implement pre-operative nursing measures that decrease the risk for infection & other post-operative complications
6. Examine surgical patient physically, psychologically & mentally immediately before surgery
7. Utilize health teaching to promote patient's recovery from anesthesia & surgery thus preventing post-operative complications
8. Endorse the patient to Operating Room (OR) following hospital policy
9. Receive the patient from OR following the criteria according to hospital policy
10. Identify common post-operative problems& their management
11. Perform post-operative assessment for early detection of post-operative need and complications through early detection and their nursing management.
12. Demonstrate the following procedures:
    a. Wound dressing
    b. O_2 therapy
    c. I. V. therapy
    d. Medication administration
    e. NGT insertion, feeding irrigation and removal, gavage and lavage
    f. Insert / maintain catheter, straight and indwelling
    g. Suctioning techniques
13. Monitor & document the following:
    a. Vital signs
    b. Skin status
    c. Pain
    d. Level of consciousness
    e. Surgical site & wound drainage system. Drainage Tubes
    f. I.V. Sites
    g. Urine Output
14. Evaluate patient's condition & outcome
15. Utilize information to patient & family before discharge.
16. Exhibit behavior that is based on ethical and moral conduct of professional nursing.

MEDICAL UNITS

General objectives:

Upon completion of this training period in the medical units, the intern student will be able to:

1. Fulfill all the requirements for patient's admission
2. Use nursing process as a framework for care of patients with medical problems
3. Assess patient's needs & problems
4. Plan nursing actions to meet patients need & solve patient's problems
5. Implement nursing skills related to patient's care safely & efficiently
6. Evaluate & modify the plan of care based on observable responses of patients & attainment of patient's goals
7. Provide health education to patients & their families
8. Prepare and Administer medication safely & correctly
9. Perform the following nursing procedures:
    a. IV therapy
    b. Blood extraction
    c. O_2 therapy
    d. Nebulization
    e. Capillary testing of glucose
    f. Suctioning techniques
    g. NGT insertion, feeding & removal
    h. Female urethral catheterization (if allowed)
    i. Carryout prescribed treatment
10. Exhibit behavior that is based on ethical & moral conducts of professional nursing
11. Documentation of nursing notes
12. Follow guidelines of infection control to guard against potentially of transmission.

PEDIATRIC UNITS

General Objectives:

1. Perform physical assessment of pediatric patients
2. Management of pediatric patient with respiratory problems:
    a. Airways (oral and nasal)
    b. Tracheostomy
    c. Suctioning (oral, nasal, and tracheostomy)
3. Initiate and maintain oxygen therapy using:
    a. Face mask
    b. Nasal cannula
    c. Oxyhood
    d. Oxygen tent / croupette
    e. Oxygen humidifier
4. Initiate and maintain Cardio-Pulmonary Resuscitation (CPR)
5. Maintain nutritional status:
    a. Bottle feeding
    b. Syringe feeding
    c. Tube feeding (nasogastric)
    d. Gastrostomy feeding
6. Calculate dosage of and administer medication to the pediatric patient including vaccines, e.g. PPD:
    a. Oral
    b. Parenteral
    c. Push using voluntrol
7. Utilize knowledge of communicable diseases
8. Assist with special procedure (Diagnostic or therapeutic)
9. Care of pediatric surgical patient pre-and post op including cases with:
    a. Chest tube
    b. Wound drainage device, e.g. hemovac
    c. Suprapubic catheter
    d. Gastric drainage
    e. Skin and skeletal traction
10. Care of pediatric diabetic patient including diabetic teaching
11. Apply knowledge of isolation techniques/universal precautions
12. Monitor L V. using control device, e.g. ivac
13. Manage TPN using line for hyperalimentation
14. Administer blood and blood products
15. Administer and/or monitor administration of chemotherapy drugs
16. Assist with bone marrow aspiration Care of chronically disable child.

OBSTETRICS AND GYNECOLOGY UNITS

General Objectives:

1. Recognize need to initiate and maintain CPR
2. Provide pre-and post op teaching to OB/Gyne Patient
3. Participate in diabetic teaching
4. Participate in discharge planning / teaching
5. Assist/ instruct mothers with breast care and breast feeding
6. Prepare patient for diagnostic / therapeutic procedures/ e.g. (Amniocentesis, U/S)
7. Insert / maintain catheter, straight and indwelling
8. Administer blood and blood product
9. Maintain I.V. using infusion control devices
10. Initiate current infection control techniques including isolation
11. Perform venipuncture for blood sampling
12. Detect fetal heart using sonic aid or cardiomographic monitor (CTG) Or Doppler
13. Care of post critical patients
14. Promote infant / parent' bonding
15. Perform fetal monitoring techniques
16. Assessment and management of the newborn
17. Perform Apgar scoring of the newborn
18. Apply emergency resuscitation of the newborn.
19. Management of initial critical newborn.

Ante Partum Care:

1. Estimate gestational age
2. Palpate abdomen
3. Locate fetal heart tones

Care of Patient in Labor:

1. Assist in Vaginal Exam
2. Monitor progress
3. Assist in artificial rupture of membrane
4. Care of patient with internal fetal electrode
5. Assist in epidural insertion
6. Care of patient under epidural anesthesia

Care During and After Delivery:

1. Positioning patient
2. Conducting/ assisting delivery (normal spontaneous delivery, forceps, vacuum, etc.)
3. Checking funds, massage
4. Observe lochia
5. Assess of postpartum
6. Care of episiotomy

PRIMARY HEALTH CARE SERVICES

Family and Community Health Center (FAMCO)

General Objectives:

To identify the services provided by PHC.

Specific objectives:

By the end of this experience in the primary health care center, nursing intern will be able to:

1. Explain the importance of primary health care (PHC)
2. Apply health education to client/family according to their needs
3. Demonstrate nursing care and health teaching for patient attending clinic with endemic disease or infectious diseases.
4. Practice maternal and child health services care including family planning.
5. Apply the principle of evidence-based nursing practice in problem solving and decision making.

Maternal and Child Health (MCH):

General Objectives:

To recognize the role of MCH in Women and children health.

Specific objectives:

1. Describe MCH program.
2. Identify the MCH services for maternal care during premarital care, prenatal, antenatal and postnatal care.
3. Identify high risk pregnant mothers.
4. Define the health problems & needs related to children less than 5 years.
5. Monitor growth and development of children aged newborn – 5 years.
6. Conduct the nursing assessment, intervention & health teaching for well and sick child.
7. Apply the immunization according to the MOH schedule.
8. Identify incidence & prevalence of health problems in the community.
9. Discuss the role of family and community health nurse in MCH center.

CLINICAL OBJECTIVES FOR NURSING MANAGEMENT

AS A HEAD NURSE

Aim:

Participate in maintain quality and standards of nursing care in the unit.

Patient Care Management:

Participate in providing total, comprehensive, individualized patient care in the unit.

Staff Management:

Participate and evaluates performance of personnel in the unit.

1. Participates of orientation of new employees.
2. Monitors quality of nursing activities.
3. Conduct nursing rounds, conferences, & demonstrations.
4. Attend with nursing staff medical rounds.
5. Establish harmonious relationship with staff.
6. Shares in committee and attends meeting.

Unit Management:

1. Participate in managing adequate supplies and equipment in the unit.
    a. Utilize the procedure for managing equipment and supplies.
    b. Controlling the use of supplies and equipment.
    c. Utilize the inventory list correctly.
    d. Fill different formats for ordering supplies and equipment.
    e. Report and follow maintenance needs.
    f. Maintain a stable standard for equipment and supplies for emergency use.
2. Participate in documenting unit information.
    a. Write shift report.
    b. Write census report.
    c. Maintain patient clinical record complete and accurate.
    d. Perform unit statistics.
    e. Write an incident report.
3. Maintain safe and clean environment.
    a. Provide safety measures.
    b. Provision of clean environment.
    c. Teach personnel, patients and relatives about the safety measures.
4. Coordination of patient care services, coordination with other departments (serving units) such as laboratory, physiotherapy, etc.

AS A NURSING SUPERVISOR

Aim:

The Nursing Supervisor is the nursing leader and manager of the assigned nursing unit and are responsible for the direct supervision, and management of patient care services/activities and nursing personnel within the designated nursing unit.

Patient Care Management:

1. Ensures the effective delivery of patient-focused, competent, compassionate and efficient nursing care, which is consistent with the philosophy, goals and objectives of the Department of Nursing Services, Conduct and Ethics.
2. Attends morning and evening shift handover reports in the assigned units.
3. Conducts regular patient rounds and continuously re-evaluates the clinical situation.
4. Monitors and evaluates clinical performance of nursing personnel on assigned unit.
5. Accepts the 24-hour Patient's Report (Supervisor's Report) at the beginning of the shift and submits the report to the evening off- shift supervisors at the end of the shift after reviewing the patient-care information entered by the Head Nurse.
6. Attends to patient complaints **personally** and follows up on events which occurred during the off-shift.

Staff Management:

1. Maintains close and continuous communication with the Nursing Services administrators on every matter concerning staffing and assigned nursing personnel.
2. Monitors and adjusts staffing patterns to improve unit productivity.
3. Reports all leaves (absences, sick leaves, planned emergency leaves, etc.) direct to the Nursing Services administrators
4. Prepares the monthly duty schedule for nursing personnel of the designated unit.
5. Prepares the annual vacation plan.
6. Prepares all staff evaluations for assigned nursing personnel on an annual basis.
7. Conducts regular monthly staff meetings with the unit staff.
8. Maintains minutes of staff meetings.
9. Encourage professional self-development within assigned nursing personnel.

Unit Management:

1. Ensures that all supply par levels are always satisfied.
2. Determines the unit requirements for equipment or materials.
3. Ensures that infection control measures are understood by nursing personnel..
4. Ensures that the overall environment is conducive to the safety of patients, visitors and personnel.
5. Personally oversees incident reporting procedures, countersigns the report

CLINICAL OBJECTIVES FOR ELECTIVE UNITS

HEMODIALYSIS AND PERITONEAL DIALYSIS UNITS

Aim:

To obtain a clinical experience in assessing, planning and evaluating the outcomes conservative and renal replacement therapies in acute and chronic renal failure and to understanding the special needs of these patients

General Objectives (hemodialysis unit)

1. Understanding the principles of HD machines.
2. Evaluating the dialysate and dialyzers needed for specific patients.
3. Overall pre-dialysis assessment:
    a. Physical assessment
    b. Blood pressure
    c. Concept of "Dry weight"
    d. Psychological needs
    e. Laboratory data
4. Planning the HD treatment according to the patient's needs.
5. Assessment of the patient's vascular access for HD.
6. Observing the process of cannulation and connection to the HD machine.
7. Performing ongoing patient monitoring and surveillance during the dialysis session.
8. Understanding the required auditing methods used in the nephrology unit.
9. Recognizing all the common complementary (medical, nutritional etc.) treatment given to the patient before, during and after the dialysis treatment.
10. Observing the process of disconnection from dialysis treatment.
11. Monitoring and evaluating dialysis treatment outcomes.
12. Assessing the patient's quality of life.
13. Considering rehabilitation factors in the patient's everyday activities.

General Objectives (Peritoneal dialysis unit):

1. Recognizing the contraindications to PD (why PD may not be suitable for some patients)
2. Learning the different peritoneal access methods.
3. Understanding the principles of peritoneal dialysis.
4. Recognizing the variety of PD methods (acute, IPD, CAPD, APD)
5. Assessing the PD method of choice to the patient's needs.
6. Understanding the PD patient education program.
7. Recognizing the variety of PD solutions and their suitability to patient need.
8. Performing assessment of the patient's "dry weight", blood pressure, edema, laboratory findings, and nutritional status.
9. Assessing the exit site and tunnel for signs of infection.
10. Assessing the drained fluids for signs of infection, bleeding or any other complication.

11. Learning the differential diagnosis of peritonitis or any other complications .
12. Learning the unit protocol for treating peritonitis.
13. Evaluating treatment outcomes.
14. Assessing the patient’s quality of life.
15. Considering rehabilitation factors in the patient's everyday activities.

CLINICAL OBJECTIVES FOR EMERGENCY ROOM

Purpose:

To provide the graduate nurse interns with the opportunity to increase his basic nursing skills when applying the nursing process to the care of patients in emergency situations.

General Objectives:

By the end of this placement the nurse intern will be able to:

1. Acquire competency in assessing patients in emergency (complete a primary survey and secondary survey).
2. Demonstrate skills in performing physical assessment of patients in emergency situations.
3. Intervene in situations where life support systems are threatened and provide emergency care in compliance with unit regulatory policies and practice.
4. Perform nursing interventions appropriate to patients in emergency situations.
5. Demonstrate a level of communication appropriate for emergency room functioning and practices.
6. Identify different ER area /rooms and the responsibility of the nurse in each room.
7. Perform complete physical assessment for any emergency case.
8. Triage the patients according to the type of severity of their presenting manifestation using the universal five levels scale
9. Recognize life-threatening problems and know how to intervene accordingly.
10. Apply strict guidelines of infection control to guard against potentially disease transmission.
11. Perform emergency room procedures and care under the direct supervision of the charge nurse.
12. Identify common ER medication, their action, indications, contraindications, adverse effects and nursing consideration for each one.
13. Identify ER equipment and supplies and the location of them in each ER area.
14. Determine the Crash Cart's contents and their uses.
15. Identify the nurse's roles in Code 99 and the principle of CPR.
16. Identify the different types of intravenous fluids and their indications.
17. Perform ECG for emergency patients and recognize major abnormalities in it.
18. Observe and assist the physicians and ER nurses in surgical sutures and casts under supervision of the charge nurse.
19. Perform wound dressing and assessment
20. Administer ER medication under the direct supervision of the charge nurse.
21. Give instructions and health education for emergency patient

CRITICAL CARE UNITS

Purpose:

To provide the nurse intern with the opportunity to increase his basic nursing skills when applying nursing process to the care of patients in critical care settings.

General Objectives:

By the end of this experience, the nurse intern will be able to:

1. Acquire competency in performing complete physical assessment of patients in critical care unit.
2. Perform appropriate nursing interventions to patients in critical care units.
3. Demonstrate competency in performing special procedures required in the critical care unit.
4. Identify critical care unit protocols in performing procedures and administering medications.
5. Communicate appropriately with patients and critical care team.
6. Apply protocol by nurse intern for patient with the following requirements:
    a. Oxygen therapy
    b. Arterial blood gases analysis
    c. Endotracheal / Nasotracheal intubation
    d. Endotracheal / Nasotracheal suctioning
    e. Tracheostomy care
    f. Mechanical ventilation
    g. Chest tube
    h. Continuous cardiac monitoring
    i. Cardiac arrhythmia interpretation
    j. Alternative management therapies in cardiac care
    k. Hemodynamic monitoring
    l. Arterial pressure monitoring
    m. Pulmonary artery pressure monitoring
    n. Central venous pressure monitoring
    o. Cardiac output determination
    p. Intra cranial pressure monitoring
    q. Patient controlled analgesia
    r. An epidural catheter

OPERATING ROOM

Purpose:

To provide the graduate nurse intern with the opportunity to develop basic competency and implement the technical aspects of preoperative care.

General Objectives:

At the end of this experience the nurse intern will be able to:

1. Demonstrate skills and knowledge pertinent to the operating room techniques and practices.
2. Demonstrate skills in arranging sterile setups for various types of surgeries including preparation of instruments, equipment, material and supplies.
3. Apply operating room nursing interventions appropriate to the care of patients during preoperative period.
4. Perform efficiently assigned duties related to circulating and/or scrubbing nursing roles.
5. Demonstrate skill in the safety use and handling of equipment, materials and supplies during the intra operative period.
6. Monitor and maintain the quality of the environment according to operating theatre policies and practices.
7. Become aware of the legal responsibilities involved in administering care to the patient undergoing surgical interventions.

Appendix I
Attendance sheet,evaluation forms and clinical competency

Attendance sheet

Intern Name:

Unit: Batch#: Group#:

1. Medical Rotation

Attendance Sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	wed						
	Thu						
2	Sun						
	Mon						
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3	Sun						
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4	Sun						
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6	Sun						
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	Thu						
7	Sun						
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8	Sun						
	Mon						
	Tue						
	wed						
	Thu						

Note: No interns can leave the hospital premises during the break time.

Intern Name:

Unit: Batch#: Group#:

2. Surgical Rotation

Attendance Sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	wed						
	Thu						
3	Sun						
	Mon						
	Tue						
	wed						
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4	Sun						
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6	Sun						
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	Thu						
7	Sun						
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8	Sun						
	Mon						
	Tue						
	wed						
	Thu						

Note: No interns can leave the hospital premises during the break time.

3.PEDIATRIC ROTATION

Intern Name:

Unit: Batch#: Group#:

Attendance sheet

Week #	Date	Time In	Time Out	Break Time		Signature of Intern	Signature of Preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	Wed						
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3	Sun						
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7	Sun						
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8	Sun						
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	Wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

Intern Name:

Unit: Batch#:

4. OB/GYN ROTATION

Attendance sheet

Week #	Date	Time In	Time Out	Break Time		Signature of Intern	Signature of Preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
3	Sun						
	Mon						
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4	Sun						
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6	Sun						
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	Thu						
7	Sun						
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	Thu						
8	Sun						
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	Wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

5. ER Rotation (Male)

Attendance sheet

Intern Name:

Unit: Batch#:

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
2	Sun						
	Mon						
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3	Sun						
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8	Sun						
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	Wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

6. **Primary Health Care Rotation**

Intern Name:

Unit: Batch#: Group#:

Attendance Sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	wed						
	Thu						
3	Sun						
	Mon						
	Tue						
	wed						
	Thu						
4	Sun						
	Mon						
	Tue						
	wed						
	Thu						

Note: No interns can leave the clinical area during the break time

7. MANAGEMENT ROTATION

Intern Name:

Unit: Batch#: Group#:

Attendance sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
3	Sun						
	Mon						
	Tue						
	Wed						
	Thu						
4	Sun						
	Mon						
	Tue						
	Wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

8. ELECTIVE (1) ROTATION

Intern Name:

Unit: **Batch#:** **Group#:**

Attendance Sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	wed						
	Thu						
2	Sun						
	Mon						
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3	Sun						
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	Thu						
7	Sun						
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	Thu						
8	Sun						
	Mon						
	Tue						
	wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

9. ELECTIVE (2) ROTATION

Intern Name:

Unit: Batch#: Group#:

Attendance Sheet

Week #	Date	Time In	Time Out	Break Time		Signature of intern	signature of preceptor
				Out	In		
1	Sun						
	Mon						
	Tue						
	wed						
	Thu						
2	Sun						
	Mon						
	Tue						
	wed						
	Thu						
3	Sun						
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6	Sun						
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	Thu						
7	Sun						
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	Thu						
8	Sun						
	Mon						
	Tue						
	wed						
	Thu						

Note: No interns can leave the hospital premises during the break time

Medical rotation

Patient Diagnosis

#No.	Date	Patient Diagnosis	Intern Signature	Preceptor Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (Chief complain, Present,past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
▪ for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for Medical Rotation

Intern Name:

Unit: Batch#: Group#:

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Clinical competency for Medical / Surgical Care

Key" Write the date, intern's signature, preceptor signature &rotation .
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
d. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following :			
• The routine admission transfer and discharge of a patient			
• The care of a patient valuable			
10. Diagnostic Investigation & Procedures The Nurse Intern is able to assist with safe preparation, and post procedural care of the patient for following procedures			
• X-ray procedure			
• Upper GI Series Barium Swallow			
• Lower GI Series Barium Enema			
• IVP/ Excretory Urography			
• Cholecystography			
• CT Scan			
• MRI			
• ERCP			
• Endoscopy			
• ESWL procedures			
• Fluoroscopy			

• Ultrasound			
• Nuclear medicine			
• Angiogram			
• Renogram			
Biopsies			
• Lumber puncture			
• Sternal Puncture			
• Liver			
• Bone Marrow aspiration			
• Breast FN biopsy			
11. Diabetes Management			
• Insulin Therapy			
- Single type			
- Mixed insulin			
- Insulin infusion			
- Diabetic diet			
• Glucose monitoring			
- Blood glucose devices (e.g. glucometer)			
- Urinary glucose & ketone testing			
• Foot care			
• Patient/family teaching			
12. Cardiac Management The Nurse Intern is able to discuss the policy & competently complete the following activities			
• ECG recording/interpretation			
• Cardiac monitor			
• Performing basic rhythm strip measurements			
• Recognizing basic and life threatening dysrhythmias			
• Care of patient with pacemaker			
• Use of dopplers			
• Defibrillation			
• Cardioversion			
• Cardiac medications			
• Administration of Nitrates (oral, topical)			
• Administration of Anti arrhythmias (oral)			
• Administration of Anti-hypertensive			
• Pre & Post-operative care			
• Patient and family teaching			
13. Oncology/ Haematology Care The Nurse Intern is able to discuss the policy & competently complete the following activities			
Blood transfusion			
• The requirements related to the initiation of a transfusion			
• The actions & documentation required in the incidence of blood transfusion reaction			
• Patient Teaching			
Able to administer			
• PRBs			

• Whole Blood			
• Platelets			
• Fresh Frozen Plasma			
• Cryoprecipitate			
• Heparin Sodium/Side effects/Contraindications			
• Antidote – Protamine Sulphate & its action			
• Coumadin (Warfarin)/Side Effects/ Contraindications			
• Antidote – Vitamin K & its action			
• Heparin therapy			
• Chemotherapy medications/Administration of Cytotoxic Agents			
• Patient Teaching			
14. Neuro Management The Nurse Intern is able to demonstrate the following activities			
• Assessing level of consciousness			
• Using the Galscow Coma Scale			
• Neuro-vascuar nursing			
- Colour			
- Warmth			
- Movements			
- Sensations			
• Seizure Precautions & Observation			
• Administering anticonvulsants drugs			
• Management of the unconscious patient			
• Care of patient with			
- CVA			
- Spinal cord injury			
- Neuromuscular diseases			
- Pre & Post-operative care			
15. Renal/Urologic Management The Nurse Intern is able to discuss the policy & demonstrate the following activities:			
• Insertion of an indwelling catheter (female only)			
• Continuous care of an indwelling catheter			
• Care of patient with an ileal conduit			
• Maintenance of continuous bladder irrigation			
• Bladder Ultrasonography			
Care of Patient with peritoneal/ haemodialysis			
• The Pre & Post-operative care of AVF & AVG			
• Care and maintenance of exit sites for peritoneal dialysis			
• Preparation of a patient for haemodialysis			
• Testing the haemodialysis machine for safety alarm			
• Checks prior to dialyzing a patient			
• Patient monitoring during dialysis			
16. Orthopedic Nursing care The Nurse Intern is able to discuss the policy & competently complete the following activities:			
• Maintenance and care of tractions			

• Maintenance and care of splints			
• Plaster Cast Care: - Equipment - Implementation - Nursing Care			
• Application of bandages			
• Internal and External fixation care			
• Pin Care/external fixatures			
• Care of patient with "POP"			
• Application of bandages			
17. Pre-operative Management The Nurse Intern can discuss the policy and demonstrate the following:			
• Pre-operative skin preparation			
• Patient teaching			
• Specific preparation			
• Organizing a pre-chest x-ray, ECG, & blood work (Pt's file)			
• Pre-operative checklist			
• Transfer patients too OR and from the recovery room			
18. Post-Operative Management			
• Immediate post-operative care			
• Positioning			
• Ambulation			
19. Surgical Dressing The Nurse Intern is able to discuss the policy and can demonstrate the following techniques:			
• Set up of surgical field			
• Wound Care: assessment, implementation, equipment, nursing care, documentation			
- Type of stress			
- Evaluating of wound			
- Changing dressing aseptically			
- Packing a wound and irrigation wound			
- Selecting of appropriate dressing material(s)			
- Care of drains/hemovac			
- Removal of sutures			
- Removal of staples			
- Removal of chest drains			
- Pressure ulcer care			
• Care of "Osteotomies"			
- Application of appliances (bags/ wax bath)			
- Cleaning of the stoma			
- Recording of condition of stoma			
- Educating patient/parent			

Surgical rotation

Patient Diagnosis

No.	Date	Patient diagnosis	Intern signature	Preceptor signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
10. History on Admission (Chief complain, Present,past)	**1**	
11. Medical Diagnosis (initial and final)	**0.5**	
12. Physical Examination (general to Specific)	**1**	
13. Laboratory and Diagnostic Study	**1**	
14. Medication (Dose, Route, Frequency & Action)	**1**	
15. All Nursing Diagnosis	**2**	
16. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
▪ for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
17. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good

(10) 90% &Above – Excellent

Intern Name:

Unit: Batch#: Group#:

Evaluation Form for Surgical Rotation

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Pediatric rotation

Patient Diagnosis

No.	Date	Patient Diagnosis	Intern signature	Preceptor signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (chief complain, present, past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
• for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum.

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for Pediatric Rotation

Intern Name:

Unit: Batch#: Group#:

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and family's questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Clinical competency for Pediatric Care

Key" Write the date, intern's signature, preceptor signature &rotation .
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals(IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The nurse intern is able to demonstrate the following:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. Measuring & recording of			
• **Vital Signs & Related Observations**			
- Oral thermometer			
- Axillary thermometer			
- Rectal thermometer			
• Use of IVAC Thermometer			
• Palpating & Recording of			
- Radial Pulse			
- Brachial Pulse			
- Apical Pulse			
• Blood Pressure			
- Using Mercury Sphygmomanometer			
- Using Dynamap			
• Pulse Oximetry Set-up & Reading			
• Respiratory Rate			

I. Taking & recording Patient			
1. Height			
2. Weight			
3. Length (pediatric)			
4. Head Circumference (pediatric)			
11. Performance of Physical Health Assessment			
• Cardiovascular			
• Respiratory			
• Gastro-intestinal			
• Genito-urinary			
• Musculo-Skeletal			
• Integumentary			
• Neurological			
12. Admission & Discharge			
13. Patient Sensitivity			
14. Documentation & Verbal report			
15. Positioning Patients, Lifting, Transport			
16. Patient Safety			
• Using bedrails appropriately			
• Using "restraints" when required			
17. Patient hygiene			
18. Patient comfort			
19. Infection Control			
• Applying hospital infection control policy in relation to			
- "Principles of Asepsis"			
- Isolation principles according to			
- Disposal of waste materials			
20. IV therapy			
• Care of IV Heplock/cannula (including "flushing" of cannula			
• Use of IV pump operational set-up			
21. Food & Fluids			
• Inserting/removing an NGT			
• Administering Enteral Feeding…			
- Gravity			
- Pump			
• Administering TPN/PPN			
22. Oxygen Administration/Respiratory Therapy			
• Simple face mask			
• Venturi marsk			
• Nasal Cannula			
• Head box			
• Tracheostomy mask			
• Incentive spirometry			
• Suctioning			
- Tracheal			
- Oropharyngeal			
- Nasopharyngeal			
• Using ambu-bagging: Pediatric/Neonate			
• Inserting of oral airway			
• Performing chest physiotherapy			
23. Blood sugar monitoring			
• Correct use of glucometer			
• Urine testing			
24. Diagnostic Preparation			

• Follow the protocol as the preparation for various diagnostic procedures			
25. Surgical Nursing Care			
• Pre-operative care			
• Post-operative care			
• Care of wound			
- Caring of drains			
- Removal of sutures, staples			
• Care of "Osteotomies"			
• Educating Patient/Parent			
26. Transfusion of blood & blood products			
27. Orthopedic Nursing Care			

OB/GYN rotation

Patient Diagnosis

No.	Date	Patient Diagnosis	Intern signature	Preceptor signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (chief complain ,present, past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
▪ for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for OB/GYN Rotation

Intern Name:

Unit: Batch#: Group#:

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Clinical competency for OB/GYN Nursing Skills

Key" Write the date, intern's signature, preceptor signature &rotation .
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals(IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarizes unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as, crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine …etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. Ante Natal			
• Admit Ante- Natal Patient			
• Measuring vital signs			
• Measuring & recording weight, height			
• Palpate abdomen			
• Measure & record fetal heart rate using pinard & Doppler			
• Test urine			
• Observe & recognize P.V. loss			
11. Monitoring of Fetal Heart Values			
• CTG – applying CTG Machine			
• Interpreting CTG reading/reporting abnormalities & providing care as indicated			
12. Care of High-Risk Patient's …			
• Elective LSC – preparing for elective CS			
• Provide Pre & Postoperative Care			
• Observing vaginal bleeding			

• Changing dressing			
• Assisting with Prostin insertion			
• Testing blood sugar using Glucometer			
• Collecting cord blood sample			
13. Post Natal Routine Care			
• Monitoring vital signs			
• Checking uterus & lochia			
• Monitoring pain level			
• Providing breast care			
• Educating mothers on breast care			
14. Documentation Nursing note			
1. Admission Procedure			
• **Perform Obstetric examination (under supervision)**			
• **Measuring & recording fetal heart rate**			
• **Perform physical health assessment**			
2. Care of Patient with Hypermesis Gravidarum			
• **Urine Dipstick for Ketones & Proteins**			
3. Care of Patients with Diabetes in Pregnancy			
4. Care of Gynecology Oncology Patient			
• **Care of patient undergoing Radiation Therapy**			
• **Care of patient undergoing Chemotherapy**			
5. Pre-Operative Care…			
• **Pre-operative shaving**			
• **Inset Catheterizatioon**			
6. Post – Operative OB/Gyne care			
• **Changing dressing**			
• **Removal of vaginal pack**			
• **Removal of urinary catheter**			
• **Dilatation & curettage**			
• **Vaginal/Abdominal hysterectomy**			
• **Anterior/Posterior repair**			
• **Tubal ligation (Abdominal & laparoscopic)**			
• **Fistula repair**			
• **Bartholin's cyst**			
• **Ovarian Cyst**			
• **Cervical Cerclage**			
• **Ectopic pregnancy**			
• **Pelvic Inflammatory Disease**			
• **Hydatidiform Mole**			
• **Abortions (Threatened, inevitable, complete, incomplete, missed)**			
7. IUDF (Intrauterine Fetal Death)			

Clinical competency for Labor Room Skills

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Ante Natal			
• Admit Ante- Natal Patient			
• Measuring vital signs			
• Measuring & recording weight, height			
• Palpate abdomen			
• Measure & record fetal heart rate using pinard & Doppler			
• Test urine			
• Observe & recognize P.V. loss			
2. Monitoring of Fetal Heart Values			
• CTG – applying CTG Machine			
• Interpreting CTG reading/reporting abnormalities & providing care as indicated			
3. Care of High-Risk Patient's …			
• Elective LSC – preparing for elective CS			
• Provide Pre & Postoperative Care			
• Observing vaginal bleeding			
• Changing dressing			
• Assisting with Prostin insertion			
• Testing blood sugar using Glucometer			
• Collecting cord blood sample			
4. Post Natal Routine Care			
• Monitoring vital signs			
• Checking uterus & lochia			
• Monitoring pain level			
• Providing breast care			
• Educating mothers on breast care			
5. Documentation Nursing note			
8. Admission Procedure			
• Perform Obstetric examination (under supervision)			
• Measuring & recording fetal heart rate			
• Perform physical health assessment			
9. Care of Patient with Hyperemesis Gravid arum			
• Urine Dipstick for Ketones & Proteins			

10. Care of Patients with Diabetes in Pregnancy			
11. Care of Gynecology Oncology Patient			
• Care of patient undergoing Radiation Therapy			
• Care of patient undergoing Chemotherapy			
12. Pre-Operative Care…			
• Pre-operative shaving			
• Inset Catheterization			
13. Post – Operative OB/Gyne care			
• Changing dressing			
• Removal of vaginal pack			
• Removal of urinary catheter			
• Dilatation & curettage			
• Vaginal/Abdominal hysterectomy			
• Anterior/Posterior repair			
• Tubal ligation (Abdominal & laparoscopic)			
• Fistula repair			
• Bartholin's cyst			
• Ovarian Cyst			
• Cervical Cerclage			
• Ectopic pregnancy			
• Pelvic Inflammatory Disease			
• Hydatidiform Mole			
• Abortions (Threatened, inevitable, complete, incomplete, missed)			
14. IUDF (Intrauterine Fetal Death)			

ER rotation (Male)

Patient Diagnosis

No.	Date	Patient Diagnosis	Intern signature	Preceptor signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (chief complain ,present, past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
▪ for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Case Presentation or Project Evaluation (Male)

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for ER Rotation (Male)

Intern Name:

Unit: Batch#: Group#:

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					

III. Documentation		**1**	**2**	**3**	**4**
Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

CLINICAL COMPETENCY EMERGENCY ROOM

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG).			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, Doppler, skin thermometer…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following :			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. Performance of Physical Heath Assessment- Adult/Pediatric/Neonate			
• A, B, C, D, E for trauma patient			
11. Triage System…			
• Demonstrate understanding re criteria for prioritizing patient management			
12. Admission Procedure…			
• ICU			
• In-patient			
• Direct to OR			
• Labor & Delivery			
13. Police Case			
• Aware of clinical situations which should be reported to the police			
14. Respiratory / Oxygen therapy			
• Ambu-bagging: Adult			
: Pediatric			
• Insertion of Oral Airway			
15. Mother in Labor…			
• Assessment of contractions			
• FHR			

• Obstetric examination			
16. Multi-Trauma Patient			
• Care of patient with suspected cervical fracture			
• Stabilization of fractures with splints			
• Care of the Head Injury Patient			
17. Burn Patient…			
• Fluid resuscitation			
• Dressings			
18. Documentation / verbal reporting			
• Follows hospital admission procedure			
• Follows hospital discharge procedure			
• Reviews physician orders on a regular basis			
• Documents accurately on hospital forms			
• Reports information accurate in-patient nurses notes according to hospital protocol			

Primary health care rotation

Client Diagnosis

#No.	Date	Reason for Visit	Intern Signature	Preceptor Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Intern Name:

Unit: **Batch#:** **Group#:**

Topic Presentation Evaluation Form

#	Content	Ideal	Actual
1.	**Section I : Written:**	**2**	
2.	• Frontal page • Outlines		
	• Introduction		
	• Content		
	• Summary		
	• Questions		
	• Reference		
3.	**Initial draft** • Submitted one week before the presentation day to preceptor.	**(1.5)** **0.5**	
	• Complete, organize and accurate content.	**0.5**	
	• Use updating references	**0.5**	
4.	**Final draft** • Content: Clear, neat, readable, accurate and appropriate to the level of clients understanding.	**0.5**	
	• Complete includes bibliography & summery	**0.5**	
	• Prepare appropriate audio-visual aid. (Real objects or posters or pamphlets)	**0.5**	
5.	**Section II: Oral Presentation**	**3**	
	Introduce himself	**0.5**	
	Ability to keep attention maintain eye contact, provide motivation, interest and hold the class without interruption	**1**	
	Appropriate use of audiovisual material.	**1**	
	Make summary, asking questions and encourage audience participation.	**0.5**	
6.	**Total**	**8**	

Supervisor Comments:

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum.

Case Presentation or Project Evaluation (Male

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for Health care center

Intern Name:
Unit: Batch#: Group#:

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Understanding the patient diagnosis, drug therapy and other therapeutic measures.					
2. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning the patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the health center.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the health center.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Topic presentation		2	4	6	8
1. Perform topic presentation.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Intern Name:

Unit: **Batch#:** **Group#:**

Evaluation Form for Health Education

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Understanding the patient diagnosis, drug therapy and other therapeutic measures.					
2. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning the patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the hospital.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the hospital.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					

4. Responds appropriately to patients and family's questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**
Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Topic presentation		2	4	6	8
1. Perform topic presentation.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

Clinical competency for Primary Health Care

Key" Write the date, intern's signature, preceptor signature &rotation . 1-Procedure done for the 1st time (Beginner) 2-Procedure done for the 2nd time (Advanced Beginner) 3-Procedure done for the 3rd time (Competent)	Intern Name: Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
d. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG).			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarizes unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following :			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. Diagnostic Investigation & Procedures The Nurse Intern is able to assist with safe preparation, and post procedural care of the patient for following procedures (Under observation)			
• **Ante Natal Care**			
- History taking			
- Measuring vital signs			
- Measuring & recording weight, height			
- Testing blood sugar using Glucometer			
- Test urine			
- Perform physical health assessment			
- Perform Obstetric examination (under supervision)			
- Abdominal maneuver			
- Measure & record fetal heart rate using pinard & Doppler			
- Observe & recognize P.V.loss			
- Health education			

- Documentation Nursing note			
• **Post Natal Routine Care**			
- History taking			
- Monitoring vital signs			
- Perform physical health assessment			
- Perform Obstetric examination (under supervision)			
- Checking level of fundus & lochia			
- Monitoring pain level			
- Providing breast care			
- Health education			
- Documentation Nursing note			
• **Family Planning**			
- History taking			
- Health education			
- Give complete attention to the client			
- Use simple understandable language			
- Encourage the client to ask questions			
- Answer question clearly			
- Provide complete accurate information about all options			
- Help the client to take decision			
- Explain the procedure			
- Use appropriate instructional media in explaining			
- Explain the warning signs that require immediate return			
- Discuss when the patient needs to return for follow up			
- Documentation Nursing note			
• **New born care**			
- Assessment of new born and identification high risk babies.			
- Gestational assessment.			
- Check vital signs			
- Assess growth: weight , height			
- Cord care			
- Health education			
- Documentation Nursing note			
• **Well Child Clinic**			
- History taking			
- Perform physical health assessment			
- Assess development			
- Intellectual			
- Motor			
- Social			
- Communication			
- Health education			
- Documentation Nursing note			
• **Integrated management of childhood illness: Assess danger signs include:**			
- Cough or difficult breathing			
- Diarrhea			
- Fever			
- Ear problem			

- Malnutrition			
- Immunization status			
• **Medical and Surgical clinics**			
- History taking			
- Perform physical health assessment			
- Measuring & recording weight, height			
- Testing blood sugar using Glucometer			
- Test urine			
- X-ray procedure			
- Health education			
- Documentation Nursing note			
• **Surgical Dressing**			
- The nurse intern is able to discuss the policy and can demonstrate the following techniques:			
- Set up surgical field			
- Wound care: assessment, implementation, equipment, nursing care, documentation.			
- Types of dressing			
- Evaluating of wound			
- Changing dressing aseptically			
- Selecting of appropriate dressing materials			
- Removal of sutures			
- Removal of staples			
• **Health education:**			
- Give complete attention to the client			
- Use simple understandable language			
- Encourage the client to ask questions			
- Answer question clearly			
- Provide complete accurate information about all options			
- Make summary, asking questions and encourage audience participation			
- Help the client to take decision			
- Explain the procedure			
- Use appropriate instructional media in explaining			
- Explain the warning signs that require immediate return			
- Discuss when the patient needs to return for follow up			

Management rotation

Topic Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

#	Content	Ideal	Actual
1.	**Section I: Written:**	**2**	
2.	• Frontal page • Outlines		
	• Introduction		
	• Content		
	• Summary		
	• Questions		
	• Reference		
3.	**Initial draft** • Submitted one week before the presentation day to preceptor.	**(1.5)** **0.5**	
	• Complete, organize and accurate content.	**0.5**	
	• Use updating references	**0.5**	
4.	**Final draft** • Content: Clear, neat, readable, accurate and appropriate to the level of clients understanding.	**0.5**	
	• Complete includes bibliography & summery	**0.5**	
	• Prepare appropriate audio-visual aid. (Real objects or posters or pamphlets)	**0.5**	
5.	**Section II: Oral Presentation**	**3**	
	Introduce himself	**0.5**	
	Ability to keep attention maintain eye contact, provide motivation, interest and hold the class without interruption	**1**	
	Appropriate use of audiovisual material.	**1**	
	Make summary, asking questions and encourage audience participation.	**0.5**	
6.	**Total**	**8**	

Supervisor Comments: ----------

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Topic Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for Management Rotation

Intern Name:
Unit: Batch#: Group#:

Performance Items		P	S	G	VG	E
1. Communicate effective thru:		4	8	12	16	20
a) Reporting pertinent information to the appropriate health care professionals						
b) Liaise with other hospital department						
c) Relates appropriately within the hospital administrative structures.						
2. Carry out activities related to Nursing Quality Institute (NQI)		2	4	6	8	10
3. Participate in activities relevant to staff allocation on the basis of patient need and workload.		2	4	6	8	10
4. Participation in the management of special condition		4	8	12	16	20
5. Participate in or initiate actions that promote professional self-development.		2	4	6	8	10
6. Develop awareness with the responsibilities of a Head Nurse /Supervisor as specified in the checklist.		2	4	6	8	10
7. Professionalism.		2	4	6	8	10
a) Adheres to professional conduct & ethical standards while dealing with patients and members of the health team.						
b) Maintains punctual attendance to work						
c) Shows professional appearance.						
8. Performs case presentation in nursing management topics		2	4	6	8	10
Total Grade						**100**

Total percentage: ----------%

Remarks:

Intern signature: ----------
Unit Manager Signature: ---------- **Supervisor signature: ----------**
Faculty Evaluator Signature: ----------

Note:
P (Poor) =Less than 60% S (Satisfactory) =60-69%
G (Good) =70-79% VG (Very good) =80-89%
E (Excellent) =90% & Above

Clinical competency for Nurse Manager

As a Head Nurse:

Key" Write the date, intern's signature, preceptor signature &rotation .
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	LEVEL 1	LEVEL 2	LEVEL 3
1. Receive patient reports from night duty staff. Gives shift report to afternoon duty nurse.			
2. Assess staffing requirements, and allocation in relation to patient care workload & implement changes as required			
3. Liaise with other departments e.g. Supply, C.S.S.D., Pharmacy, Social work dietary. X-ray. Physiotherapy.			
4. Participate in staff evaluation procedures.			
5. Participate in NQI activities			
6. Participate in an Emergency/Code Blue situation.			
7. Attend Nursing Supervisor rounds and report on all patients.			
8. Participate in Doctor's round			
9. Plan and organize unit meeting and / or In- service activities			
10. Provide patient reports and report unit activities to assigned nursing supervisor.			
11. Read understand and discuss Head Nurse responsibilities for:			
• Management of an emergency e.g. code Blue fire & evacuation			
• Infection control policies			
• Nursing policies & procedures.			
• Procedure for reporting unusual occurrences e.g. Security, Catering, Laundry, Supply.			
• Police Case (procedures).			
• Patient death (procedures)			
• VIP accommodation and other requests			
• Out of Hours visitors.			
• Watchers e.g. parents			
• Admission, Discharge and transfer (procedures)			
• Ambulance escort.			
• Planning for leaves e.g. Application for leave, Absence, Comp time etc.			
• Incident reporting.			
• Patients/Relatives Complaints.			
• Patients/Relatives Complaints			
• Absconding patient			
• Discharge against Medical Advice.			
• Out-on-pass.			
• Informed Consent: General / High-risk /Emergency			

As a Supervisor

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Receive Unit based patient reports form night duty nursing Supervisor			
2. Assess staffing requirement in relation to patient care workload initiate and implement changes where required in consultation with the Assistant Director of Nursing- Clinical Services.			
3. Visit the Units regularly each shift, liaise with Head Nurses and provide support and assistance.			
4. Receive Unit based patient reports from the Unit Head Nurse and note those patients with significant changes or seriously ill.			
5. Participate in NQA activities e.g. Unit-based Monitoring; Nursing Documentation.			
6. Attend and mange and emergency/Code Blue situation.			
7. Receive patients/relatives complains investigate and report.			
8. Receive Incident reports, investigate and report			
9. Provide Unit-based patient report to Evening Shift supervisor.			
10. Read, Understand and Discuss Nursing Supervisor Responsibilities for:			
• Management of an emergency station e.g. Code Blue			
• Infection Control policies.			
• Nursing Policies and Procedures			
• Procedure for reporting unusual occurrences			
• Mortuary (procedures)			
• Police Case (procures)			
• VIP-accommodation and other requests.			
• Out-of-hours visitors			
• Watchers			
• Admission, Discharge and Transfer(procedures)			
• Ambulance escort.			
• Administrator On-call.			
• Personnel procedures e.g. Application of leave			
• Unit schedules.			
• Absconded patient procedure.			
• Discharge against medical Advice			
• Informed consent; General /High-risk /Emergency			

Elective (1) Rotation

Patient Diagnosis

No.	Date	Patient diagnosis	Intern signature	Preceptor signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (chief complain, present, past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
• for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum.

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Intern Name:

Unit: Batch#: Group#:

Evaluation Form for Elective (1) Rotation

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and families questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:			
P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

ELECTIVE (2) ROTATION

Patient Diagnosis

No.	Date	Patient diagnosis	Intern signature	Preceptor signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Case Presentation Evaluation Form

Intern Name:

Unit: Batch#: Group#:

Out Line	Ideal	Marks
1. Demographic data:		
• Pt.'s Age	0.5	
• Sex and Nationality	0.5	
• Date of Admission	0.5	
Total	**1.5**	
2. History on Admission (chief complain, present, past)	**1**	
3. Medical Diagnosis (initial and final)	**0.5**	
4. Physical Examination (general to Specific)	**1**	
5. Laboratory and Diagnostic Study	**1**	
6. Medication (Dose, Route, Frequency & Action)	**1**	
7. All Nursing Diagnosis	**2**	
8. Nursing Care Plan. (At least 2 Ng. Diagnosis)		
• for each Nursing Process:		
• Assessment (need & problems)	(1.5) 3	
• Ng Diagnosis (Actual & Potential)	(1.5)	
• Objectives	(1.5)	
• Nursing Intervention	(1.5) 3	
• Evaluation	(1.5) 3	
Total	**12**	
9. Presentation Skills:		
• Proper selection of case	0.5	
• Understandable	0.5	
• Fluent English	0.5	
• Eye to eye Contact	0.5	
• Organized	0.5	
• Appropriate tone of voice	0.5	
• Follow correction of draft	0.5	
• Submit final on time	0.5	
Total	**4**	
Total Score	**24**	
Average	**8**	
Supervisor comments:		
	Signature	

The presentation will be done using PowerPoint and must observe the following:

1. A clear and concise introduction to the topic.
2. Aims and outcomes of the presentation.
3. Clear, readable English writing and grammar.
4. Conclusions and recommendations.
5. Current evidence from research (references and proper citation).
6. Presentation time is 15 minutes minimum and 20 minutes maximum

Case Presentation or Project Evaluation

Topic: ----------

Method of Presentation: ----------

(Indicate: lecture, demonstration, case presentation, bedside conference, reading journal, film showing, etc,)

Note: Each specialty should have its own presentation; the topic should be submitted in the **first week** of the specialty rotation and presented in the **last week** of orientation, a written proposal or a copy should be submitted one week prior to the presentation to the concerned area manager.

ATTENDANCE:

1.	Score=
2.	Score=
3.	Score=
4.	Score=
5.	Score=
6.	Score=
7.	Score=
8.	Score=
9.	Score=
10.	Score=

Average score=----------

Scoring indicators:

(2) Less than 60% - Poor **(4)** 60-69% - Satisfactory **(6)** 70-79% – Good

(8) 80-89% - Very good **(10)** 90% &Above – Excellent

Evaluation Form for Elective (2) Rotation

Intern Name:

Unit: **Batch#:** **Group#:**

Performance Items		P	G	VG	E
I. Application of scientific knowledge and principle		1	2	3	4
1. Demonstrates knowledge of nursing process in delivering patient care by: **a**. Assessing patient needs.					
b. Setting goals to meet the needs.					
c. Planning patient care based on priorities.					
d. Implementing the developed plan.					
e. Evaluating out comes and reassessing the patient.					
2. Integrating knowledge of physiological, psychological and sociological into patient care.					
II. Quality of work		**1**	**2**	**3**	**4**
1. Work within standards of nursing care practices, policies and procedures and established protocols for the unit.					
2. Performs independent nursing action according to patient needs.					
3. Priorities the patient care in consideration with the overall assignments in the units.					
4. Demonstrates confidence and safety in the performance of nursing procedures.					
II. Communication skills		**1**	**2**	**3**	**4**
1. Maintains good interpersonal relationship with the co-workers.					
2. Accepts constructive feedback from preceptor and other staff.					
3. Request assistance of preceptor or designee when faced with managerial or clinical problem.					
4. Responds appropriately to patients and family's questions, concerns, and request.					
III. Documentation		**1**	**2**	**3**	**4**

Demonstrates competence in documenting patient care, and maintain a Complete, accurate and concise.					
IV. Professionalism		1	2	3	4
1. Adheres to professional and ethical standards when dealing with patients and health care team members.					
2. Punctuality: Reports to work on time, maintains good attendance record and completes given assignment on time.					
3. Adheres to dress code and maintain professional appearance.					
4. Demonstrate positive attitude toward nursing care.					
5. Shows initiative to learn and seek new learning opportunities.					
V. Health Education		1	2	3	4
1. Promotes positive environment for health teaching.					
2 Provides effective education based on needs.					
3. Evaluate the effectiveness of teaching.					
VI. Case presentation		2	4	6	8
1. Performs case presentation within the framework of nursing process.					
Total Grade					100

Total percentage---------- %

Evaluation panel comment & recommendation if any:

Nursing intern comment:

Note:

P (Poor)	=Less than 60%	S (Satisfactory)	=60-69%
G (Good)	=70-79%	VG (Very good)	=80-89%
E (Excellent)	=90% & Above		

Nursing intern Signature: ---------- **Date:** ----------

Preceptor Signature: ---------- **Date:** ----------

Unit Manager Signature: ---------- **Date:** ----------

Faculty evaluator signature: ---------- **Date:** ----------

CLINICAL COMPETENCY FOR CRITICAL CARE UNITS

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Critical Lines The Nurse Intern is able to demonstrate the following:			
• Collection of equipment for insertion of Central Line			
• Discuss the normal parameters of CVP			
• Determines and records CVP using a water manometer and cardiac monitor			
• Identifies chest landmarks for CVP measurement			
• The administration of drugs and fluids			
• The "flushing" of a Central Line			
• Aseptically change Central IV Lines			
• Setting up a transducer system			
• Aseptically changing a Central IV site dressing			
• The safe removal of Central Lines			
• Use of Porta-caths & Hickman catheter			
• Risks & complications of Central Lines			
• Interventions/troubleshoot complications of Central Lines			
2. Pulmonary Artery Catheters & Arterial Lines in Critical Care Nursing The Nurse Intern is able to discuss and constantly demonstrate the following:			
• Take appropriate action to prevent or resolve complications of PA Catheters & Arterial Lines			
• Setting up a single and multiple transducer system			
• Identify a PA and Arterial trace on the cardiac monitor			
• Zeroing of a PA & Arterial Lines			
• The purpose for performance of an Allen's test			
• Correct technique for drawing blood from an PA Catheter & Arterial Line			
• Supervised performance of a PAWP			

CLINICAL COMPETENCY OPERATING ROOM

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILL/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
d. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG).			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as, crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, skin thermometer…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. knowledge of specialized equipment in OR			
• OR Tables (General/ Specialized)			
• Electrocute Devices (Diathermy)			
• Hypo/Hyperthermia Devices			
11. knowledge of Aseptic Technique, Application of Universal Precautions in OR			
12. knowledge of Sterilization Techniques in OR			
13. Knowledge of Care of Instruments/Equipment.			
14. General Introduction to these Surgical specialty			
• General / Abdominal			
• Orthopedics			
• Urology			

• Gynecology			
• Obstetrics			
• Ophthalmic			
• Ear/ Nose / Throat			
• Maxillofacial			
• Dental			
• Cardiac			
• Thoracic			
• Vascular			
• Neurosurgery			
• Plastic / Reconstructive			
• Pediatric			
15. **Attended and Participated in these Procedure** General / Abdominal Surgery Procedures:			
• Abdominal- Perineal Resection			
• Adrenalectomy			
• Anal Fissurectomy			
• Appendicectomy			
• Basal Cell Carcinoma Excision			
• Bone marrow Harvest			
• Breast Biopsy			
• Bowel Resection			
• Cholecystectomy, Cholangiogram			
• Choledocoscopy			
• Colectomy			
• Colostomy lleostomy, Closure of			
• Decubitus-Debridement, Closurfe of			
• Diverticulectomy			
• Drainage of Abdominal Abscess			
• Exploratory Laparotomy			
• Gastrectomy			
• Gastrostomy Feeding Tube			
• Hemorrhoidectomy			
• Herniorrhaphy			
• Lipoma, Excision of			
• Laparoscopy-General			
• Lymph Node Dissection			
• Mastectomy			
• Pancreatectomy			
• Pilonidal Cystectomy			
• Splenectomy			
• Vagotomy-Pyloroplasty			
• Whipple Procedure			
Plastic/ Reconstructive Surgery Procedures:			
• Blepharoplasty			
• Burn Surgery			
• Derabrasion			
• Laceration Repair			
• Mammoplasty- Augmentation, Reduction			
• Pedicle Grafts			
• Scare Revision			
• Skin Grafting- Split Thickness			
Ophthalmology/ ENT/Dental Procedures:			
• Cataract Extraction with Lens Implant			

• Chalazion			
• Dacrocystorhinostomy			
• Ectropion of Lids			
• Enucleation			
• Glaucoma Filtering			
• Iridectomy			
• Orbital Floor Fracture, Repair of			
• Pterygiuim Repair			
• Ptosis of Lids			
• Rectus Resection			
• Strqabismus Repair			
• Adenoidectomy			
• Bronchoscopy Rigid Flexible			
• Esophagoscopy			
• Ethoidmoidectomy			
• Laryngoscopy, Microlaryngoscopy			
• Laryngectomy			
• Lesions of Mouth Soft or Hard Palate			
• Mastoidectomy			
• Mediastinoscopy			
• Myringotomy			
• Parathyroidectomy			
• Radical Neck Dissection			
• Rhinoplasty			
• Stapedectomy			
• Submucosal Resection/ Turbinectomy			
• Thyroidectomy			
• Tonsillectomy			
• Tracheostomy			
• Tympanoplasty			
• Closed Reduction Fracture			
• Extraction of Teeth			
• Open Reduction Fracture			
Vascular /Thoracic Procedures:			
• IV Pacemaker Insertion			
• Pneumonectomy			
• Segmental Resection			
• Thoracentesis			
• Thoracotomy			
• Thymectomy			
Genito-Urinary/ Gynaecology Procedures:			
• Caesarean Section			
• Cervical Cone			
• Hysterectomy			
• Ectopic Pregnancy			
• Vaginectomy			
• Ectopic Pregnancy			
• Colporrhaphy A & P			
• Cystocele/Rectocele Repair			
• D & C			
• Laparoscopy. Diagnostic, Tubal Ligation			
• Marshall-Marchetti			
• Marsupialization Barthol			
• Myomectomy			

• Ovarian Cystectomy			
• Removal of Veneral Warts			
• Salpingectomy			
• Salpingooophorectomy			
• Salpingoplasty			
• Shirodkar Procedure			
• Suction Curettage			
• Tubal Ligation			
Urology Procedures:			
• Circumcision			
• Cystectomy			
• Cystoscopy			
• Hydrolectomy			
• Insertion of Ureteral Catheter			
• Kidney Harvest			
• Inguinal Exploration Retroperitoneal			
• Pelvic Lymphadenectomy			
• Epididymectomy			
• Needle Biopsy, prostate			
• Flexible Nephroscopy			
• Ureteroscopy			
• Percutaneous Nephrolithotomy			
• Reimplantation Ureters Neocystostomy			
• Pelvic Exploration			
• Repair Ureter-Vaginal Fistula			
• Meatotomy			
• Nephrectomy			
• Nephroscopy			
• Nephrostomy Tube Insertion			
• Orchidectomy			
• Orchiopexy			
• Prostatectomy			
• Pyelolithotomy			
• Pyeloplasty			
• Stone Manipulation			
• TURP & TURBT			
• Urethral Dilatation			
• Ureterolithotomy			
• Ureteral-lleum			
• Suprapublic Cystostomy			
• Penile Prosthesis			
Orthopedic/Neurology/Podiatry procedures:			
• Amputations			
• Above Knee			
• Below Knee			
• Fingers			
• Hip Disarticulation			
• Toes			
• Achilles Tendon Repair			
• Arthroscopy			
• Fusion with Bone Graft			
• Open Reduction Internal Fixation			
• Osteotomy			
• Excision Olecranon Bursa			

• ORIF			
• Discectomy			
• Harrington Rod			
• Laminectomy			
• Menongocele Repair			
• Spinal Fusion with lilac Bone Graft			
• Fracture / Dislocation			
• Brachial Plexus Exploration and Graft			
• Temporal Artery Biopsy			
• Insertion Subarachnoid Screw			
• Ulnar Nerve Exploration			
• Cranioromy			
• Hypophysectomy, Transphenoidal			
• Discectomy			
• AV-malformation			
• Spinal Fusion with Harrington Rod			
• Meningocele Repair			
• Chemonucleolysis			
• Laminecotomy			
• Fasciotomy			
• Hemiarthroplasty			
• Thomoson			
• Fracture Wiring			
• Tibial Wiring			
• Open Reduction Internal Fixation			
• Carpal Tunnel Release			
• Ganglion Excision			
• Nerve Repair			
• Reimplantation			
• Insertion VP Shunt			

CLINICAL COMPETENCY FOR HEMODIALYSIS

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: Batch#: Group#:

CLINICAL SKILLS/TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international safety goals (IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as otoscope, ophthalmoscope, crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine …etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission ,Transfer and discharge: The Nurse Intern is able to demonstrate the following:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. Examining Vascular Access Integrity The Nurse Intern is able to demonstrate the following:			
• Observes previous needle sites and stage of healing			
• Observes for dryness			
• Observes for bruises			
• Checks for bleeding below the surface of the skin			
• Checks for ballooning of a weak spot in vessel wall			
• Checks for presence of any enlargement or expansion of blood vessel			
• Assess for ischemia of the hand and fingers			
• Feels for presence of pulse			
• Listens with stethoscope for bruit			
• Uses the Doppler ultrasound machine to assess for bruit in case of its absence with the stethoscope			
• Checks that vascular access is free from infection by absence of: *Redness			

*Tenderness *Swelling *Warmth *Serous Drainage *Pus Drainage			
11. Preparing Vascular Access (AV Fistula, AV Graft) The Nurse Intern is able to demonstrate the following:			
• Prepares venipuncture access sites: - Asks the patient to wash his fistula arm with liquid soap and dry with paper towel - Prepares the needle insertion sites with betadine for a full 10 minutes using a circular motion or a downward motion - Allows area to dry			
• Selects puncture sites: - Palpate over the entire length of the fistula - Occludes vessel with finger – feel for pulse - Avoids the access surgery Scars, Aneurysms, scar tissue, hematomas, inflamed or infected areas, or skin lesions of any kind			
- Keeps a distance of 3-5 cm between arterial and venous needle sites			
- Inserts arterial needle first, at least 3 cm away from the site of the arteriovenous (AV) anastomosis			
- Ensures the arterial needle clamp is closed, inserts the needle with bevel up, at a 45-degree angle and against the blood stream			
• **Insert venous needle** - Occludes vessel with finger-feels for pulse - Keeps a distance of 3-5 cm between arterial and venous needle sites - Inserts venous needle at least 3 cm away from the site of the arteriovenous (AV) anastomosis - Ensures the venous needle clamp is closed, inserts the needle with bevel up, at a 45-degree angle and in the direction of blood stream - Connects arterial needle to the arterial line and venous needle to the venous line - Applies dry dressing, secures tubes with tape			
12. **Preparing Vascular Access (Percutaneous Venous Access)**			
• **Prepares vascular access site** - Removes the dressing using alcohol swab at the edges - Prepares the access insertion site and the arterial and venous lines with betadine for a full 10 minutes using a circular motion or a downward motion - Allows area to dry			
• Recaps the arterial and venous catheters, ensures that the catheters are clamped			
• Connects the arterial catheter to the 10 cc-syringe aspirates and assesses backflow of blood, pushes the normal saline and detects resistance			
• Connects the venous catheter to the 10 cc-syringe aspirates and			

assesses backflow of blood, pushes the normal saline and detects resistance			
• Connects the arterial catheter to the arterial line and the venous catheter to the venous line			
• Unclamps the catheters			
• Applies dressing, secures tubes with tape			
• **Initiating Hemodialysis:** • Sets the dialysis machine to perform the following functional safety alarms checks pre-dialysis: - Arterial pressure high/low alarms - Venous pressure high/low alarms - Air detector - Conductivity high/low alarms - Dialysate temperature high/low alarms - Dialysate flow alarms			
• Uses dialysis concentrate and dialyzer as prescribed.			
• Primes dialyzer and tubing with normal saline			
• Chicks all tubing connections			
• Inter dialysis machine monitoring: dialysis machine functional alarms are checked for safe operation			
• Vital signs and pre dialysis assessments have been completed and recorded			
• Needles have been properly inserted and taped into position securely.			
• Heparin bolus order is infused before initiating dialysis through the venous needle			
• Connects the arterial line to the arterial needle and venous line to the venous needle			
• Removes the arterial and venous blood line clamps and turn the blood pump on to allow blood to enter the extracorporeal circuit			
• **Before leaving the patient, ensure that:** - The arterial and the venous lines are secure - The patient is comfortable - The machine is in dialysis mode - Anticoagulation has been commenced - At least 500 ml saline is attached to the circuit for emergency use - The correct fluid loss had been programmed into the machine - Nursing documentation has been completed - Used dressing pads have been discarded - The patient has access to a nurse call system if not visible to nursing staff.			
• **Patient monitoring during dialysis:** - Observes for signs and symptoms of hypotension - Increased pulse rate - Nausea and/or vomiting - Dizziness - Sweating - Yawning - Warmth			

- Blurred vision - Drop in patient's normal pressure - Loss of consciousness			
• **Observes patient for signs and symptoms of:** - Itching - Flushing - Shortness of breath - Pain and discomfort - Apprehension or nervousness - Irritability - Sleepiness - Restlessness or confusion - Fever and chills			
• **Machine monitoring inter dialysis:** - Chicks equipment safety - Inspect the dialyzer and bloodlines for air - Watches the blood leaks - Checks for clotting - Checks pressure alarms - Checks monitor blood and dialysate flow rates - Checks dialysate temperature, conductivity, and PH - Checks the correct rate of heparin infusion every 30 min - Checks tubing connections			
• Inspects venipuncture site and taping			
• Checks blood flow rate			
• **Post –dialysis Patient Care:**			
• **Discontinues dialysis:** - Checks pressure and pulse just before discontinuing dialysis (usually 5 min before termination) - Turns off heparin pump several minutes to an hour before the end of treatment - Reduces blood flow rate and negative pressure - Rinses the dialyzer and blood lines with normal saline - Clamps arterial and venous lines			
• **Remove the needles:** - Un-tapes and removes the venous needle - Applies gentle pressure to the puncture site - Un-tapes and remove the arterial needles - Applies moderate direct pressure to the puncture site be hand until the bleeding stops - Cleans and dresses the access following sterile technique, dressing is applied securely			
• **Perform post dialysis assessment:** - Chicks post weight - Chicks blood pressure (sitting, lying, and standing) - Measure temperature - Measure pulse rate - Checks access for bruit and patency - Listens to compliance and observes behavior of the patient post dialysis			
• **Documents information about patient's medical care in the**			

medical record including: - Medications include saline administration during dialysis - Amount of saline needed to return the patient's blood at the end of dialysis - Evaluation of the patient's access (infection, patency, bruit/thrill) - Amount of heparin given during the treatment - Estimate any blood loss that occurred (rupture or clotted dialyzer, Prolonged bleeding after treatment, clots, or fibrin rings in drip champers) - Complications occurring in the dialysis machine or patient - Vital signs - Update medication order in the patient chart - Any special instructions given to the patient - Ensures the patient's general condition is satisfactory before discharge from the dialysis unit			
• **Post-dialysis Machine Care:**			
• Applies blood and body fluid precautions when handling hemodialysis machine components			
• Removes dialyzer and bloodlines from the dialysis machine and discards them in the blood and body fluids container (red containers)			
• Discards needles in the sharp container			
• Removes clamps and other non-disposable items and disinfect according to unit procedure before using for another patient			
• Cleans the outer surface of the machine with a disinfectant solution after each treatment			
• Disinfects the dialysis machine between patient's by heat and chemicals used in the unit			

CLINICAL COMPETENCY FOR CATHETERIZATION LABORATORY

Key" Write the date, intern's signature, preceptor signature &rotation (compulsory units)
1-Procedure done for the 1st time (Beginner)
2-Procedure done for the 2nd time (Advanced Beginner)
3-Procedure done for the 3rd time (Competent)

Intern Name:

Unit: **Batch#:** **Group#:**

CLINICAL SKILL / TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
d. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Checking the crash cart			
8. Daily checking for the instrument and equipment such as IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, Doppler, skin thermometer…etc. are available and in good condition with updated PPM (planned preventive maintenance			
9. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
10. Physicians & other health professionals on call roster board schedule of beeper listening			
11. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following :			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable/ belongings			
General Nursing Skills The Nurse Intern is able to complete the following activities:			
12. Measuring & recording of:			
• Vital signs:			
- Temperature			
- Pulse Rate			
- Respiratory Rate			
- Blood Pressure			
• Pulse Oximetry Set-up & Reading			
• Height& Weight			
13. Cardiac Bedside, Transport monitor and Central Desk EKG Monitoring:			
a. Aware of the location of Monitor Manual.			
b. Prepares skin and appropriately attaches electrodes and EKG cable leads.			
c. Sets rate alarm limits appropriately.			
d. Changes Lead selection for appropriate wave form.			
e. Changes size of ECG waveform.			
f. Correctly clears history of alarms on central monitor			
g. Troubleshoots alarms/error codes appropriately.			
h. Documentation of Pt. vital signs, oxygen saturation by using cardiac			

monitor.			
14. Medication Administration The Nurse Intern is observed to consistently demonstrate high level of care & maintenance to the policy related to the administration of medications by the following routes			
- Subcutaneous injections			
- Intradermal injections			
- Intramuscular injections			
- Intravenous injections			
- IV Push/ Bolus			
- Inhalers			
- Nebulizer			
• Follow hospital policy for Documentation of drug administration			
• Consult appropriate sources for the necessary information regarding unfamiliar medications e.g. Direct vasodilator, Beta agents			
The Nurse intern is able to describe the following:			
• The supply of drugs to the wards/unit			
• The safe keeping of ward stock drugs in the drug cupboard and refrigerator			
• The correct checking & administration of all medication administration			
• The appropriate documentation related to medication administration			
• The supply of medication to patients being discharged			
• Documentation related to Drug errors			
15. Controlled & Narcotic Drugs The Nurse Intern is able to discuss & competently demonstrate the following activities			
• The procedure for incidents of Narcotic & Control Drug breakages or errors			
• The administration of a controlled or narcotic medication to a patient			
• The correct procedure in dispensing a controlled or narcotic drug using the narcotic drug register			
16. IV Therapy (Cannulation/Lines/Burettes) The Nurse Intern is able to demonstrate the appropriate techniques of the following			
• Insertion of an IV Cannula, maintaining an IV cannula/Heplock			
• Measuring & documenting input and output readings			
• Regulating IV			
• Changing an IV site dressing			
Demonstrate ability to use IV devices: • Set up and regulation of IV infusion pumps			
- The calculation of proper concentration and rate of infusion			
- The dilution strength of fluids and the time required for infusions			
17. Able to response to code and function as a cardiac arrest team			
18. Patient Hygiene			
19. Infection Control The Nurse Intern will be able to:			
• Demonstrate appropriate hand washing technique (as Indicated by WHO "Five Moment")			
• Apply principles of aseptic techniques in performing - Dressing change			
- IV cannulation			
• The Nurse Intern will be able to discuss:			
- Universal/standard precautions			
- The Post Mortem Policy			
• Disposes waste/Materials appropriately			
20. Invasive hemodynamic monitoring set up: The Nurse Intern is able to demonstrate the appropriate techniques of the following:			
• A-line/CVP: demonstrate set up of an arterial pressure and connect the system to			

a patient.			
• Demonstrate proper techniques for obtaining blood sample from an arterial catheter			
• Recognize variability of pressure reading obtained with catheter (aortic,femoral,axillary)			
• Recognize variability of pressure reading obtained with peripheral catheter (radial,ulner,brachial,dorsal,dorsal pedis,posthiobital sets)			
• Demonstrate techniques used to remove arterial catheter			
• Pulmonary artery pressure monitor			
21. **Scrub Nurse Role and Responsibilities:** The Nurse Intern is able to demonstrate the appropriate techniques of the following			
1. Assists the operator/cardiologist with diagnostic and interventional procedures.			
▪ Demonstrates knowledge in different Cath Lab procedures:			
- Cardiac Catheterization			
- Temporary Pacemaker Insertion			
- Intra-aortic Balloon Pump Insertion			
- Right Heart Catheterization			
2. Addresses the team for surgical time-out prior to the procedure.			
3. Recognizes the importance of maintaining sterility peri-operative:			
▪ Performs surgical handwashing prior to the procedure.			
▪ Wears the gown and gloves aseptically.			
▪ Prepares the operative site by cleaning with appropriate skin preparations (povidone iodine, chlorhexidine)			
▪ Drapes the patient aseptically.			
▪ Assorts and brings used instruments in the washing area cleaned and separated accordingly.			
4. Observes proper techniques in handling catheters, sheaths, guidewires, balloons, stents and other devices:			
▪ Flushes the catheters, sheaths, guidewires and other devices.			
▪ Prepares the balloons and stents and performs inflation at proper pressure and time.			
▪ Handles the supplies properly to avoid accidental splashes of blood and water to the team			
▪ Assists in application of closure device after sheath removal.			
▪ Performs radial sheath removal and applies Transradial band properly.			
▪ Performs femoral artery compression after sheath removal and properly applies pressure dressing			
5. Notifies the circulating nurse of any needs during the procedure:			
▪ Check the completeness of the preparation and all the items are sterile.			
▪ Keep special instruments and supplies ready and informs the circulating nurse of any lacking materials.			
22. **Circulating Nurse Role and Responsibilities:** The Nurse Intern is able to demonstrate the appropriate techniques of the following			
1. Assesses the patient upon receiving the patient and prior to the procedure:			
▪ Identifies the patient correctly using two identifiers (Name, Medical Record Number)			
▪ Asks the patient for any allergies and informs the physician of it.			
▪ Checks the patient's vital signs prior to the procedure.			

▪ Assesses the cardiovascular, pulmonary, neurological, renal and vascular status of the patient.			
▪ Checks the patient's laboratory results			
▪ Informs the physician immediately if there are any problems or critical information in regard to the patient			
2. Administers proper preparation and interventions pre-operative:			
▪ Prepares the procedure room appropriately for the procedure.			
▪ Tests the operation of light, suction machine, cardiac monitors, defibrillator, piped-in oxygen and tank.			
▪ Ensure availability of intubation gadgets, pacemaker devices, supplies, and other equipment to be used.			
▪ Prepares the procedure table and provides appropriate supplies thus minimizing wastage.			
▪ Promotes physical comfort and safety when transporting, lifting and positioning patient.			
▪ Positions the patient appropriately on the table while observing fall risk precautions and optimal skin protection for skin integrity.			
▪ Attaches patient to the cardiac monitor:			
▪ Demonstrates management of pain during and immediately after Cath Lab procedure.			
▪ Demonstrates knowledge and competency in use of medications including emergency drugs, sedatives and reversal agents.			
▪ Applies proper assessment and interventions if the patient is sedated in accordance to the sedation course manual.			
▪ Operate the defibrillator when needed in emergency situations, prepare external pacemaker device as needed.			
▪ Prepares the materials for sheath removal and assists scrub nurse in sheath removal. Applies pressure dressing if needed.			
▪ Transfer the patient to the recovery room after properly fixing the patient's gown and assuring patient is stable for transfer.			
3. Reviews the patient's status during the case:			
▪ Performs surgical time-out prior to and after every procedure.			
▪ Gives relevant information about the patient's status and call other nurse's attention to any special endorsement or medications.			
▪ Observes the importance of maintaining sterility of the field and the unit.			
▪ Prepares the operative site properly with the use of povidone iodine and chlorhexidine.			
▪ Re-shave skin hair if needed and remove sticky adhesive or extra clothing if present.			
4. Notifies the physician of any status changes from the patient and administer appropriate care:			
▪ Identifies risks (Air embolism, catheter rupture, over volume injection, contrast reaction etc.) during procedure and applies appropriate interventions.			
▪ Physically monitors patient's status during the procedure and reports and change in status, ECG and hemodynamics.			
▪ Monitors intravenous fluids, vital signs, effects of sedatives and reports any untoward data, signs and symptoms.			
▪ Demonstrates appropriate assessment and treatment in accordance with the ACLS during Code Blue.			
23. **Documentation Nurse Role and Responsibilities:** The Nurse Intern is able to demonstrate the following: (according to the policy):			
1. Assesses patient chart for appropriate pre-procedure data and interventions:			

▪ Checks the patient's laboratory result.			
▪ Checks the medications and interventions administered to the patient prior to the procedure.			
▪ Reviews the completeness of the consent and the chart during endorsement.			
▪ Receives endorsement from the Unit Nurse using SBAR method.			
2. Assesses patient's knowledge base/needs in regard to age, education and level of consciousness:			
▪ Identify cultural and religious needs, language barriers, physical and psychological limitations and education barriers			
▪ Explains to the patient prior to the procedure what is expected inside the Cath Lab.			
▪ Provides appropriate health teachings to the patient/family after the procedure.			
3. Reviews the patient's status during the surgical time-out together with the team.			
4. Observes the importance of maintaining sterility of the field.			
5. Notes all information and interventions done to patient and documents it on the chart.			
▪ Documents patient data and outcomes, pre, intra and post-catheterization.			
▪ Documents all interventions and management done on patients pre, intra and post-catheterization.			
▪ Endorses the patient properly to the Unit Nurse using SBAR method.			
24. Recovery Room Nurse Role and Responsibilities: The Nurse Intern can demonstrate the appropriate techniques of the following			
1. Assesses patient's condition post procedure:			
▪ Monitors patient's vital signs			
- Attach the patient to cardiac monitor			
▪ Check for any signs and symptoms of:			
- Potential respiratory dysfunction			
- Alterations in cardiac output			
- Alterations/changes in hydration status			
- Alterations in core temperature			
- Altered LOC			
- Presence of pain			
- Presence of contrast allergic reactions			
2. Answers patient's questions regarding the procedure and provides information or health teachings related to the procedure:			
3.Reports any changes in patient's dressing site or operative site:			
▪ Check for the presence of bleeding or hematoma			
▪ Performs compression of the artery and reinforces the dressing or pressure pack for femoral puncture site			
▪ Checks the transradial band for signs of bleeding and adjusts the inflation of the band until bleeding stops.			
4. Observes for any changes in patient's status and provides appropriate treatment and interventions needed.			
▪ Provides appropriate pain management post procedure			
▪ Applies proper Advance Cardiac Life Support during Code Blue			
▪ Delivers interventions for patients with vasovagal attacks during femoral compression			
25. Documentation & Verbal Report The Nurse Intern is able to demonstrate the following: (according to the policy)			
• Complete the Kardex accurately			
• Updates Nursing Care Plan			
• Reports/records information accurately according to hospital policy			

CLINICAL COMPETENCY FOR NICU

Key" Write the date, intern's signature, preceptor signature &rotation.

1. Procedure done for the 1st time (Beginner)
2. Procedure done for the 2nd time (advanced beginner)
3. Procedure done for the 3rd time. *(Competent)*

Intern Name:

Unit: Batch#: Group#:

Clinical skills /Task	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Physician's room			
d. Stock room			
e. Treatment room			
2. Read and understand policies & procedures including job description			
3. Familiarize with IPSG including:			
▪ Using incubator &Phototherapy			
▪ Using restrain – when required			
▪ Radiant warmer			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarizes unit disaster plan with its roles and responsibilities.			
6. Familiarizes unit protocols of the following: Cardiac Arrest, Seizure……etc.			
7. Checking the crash cart			
8. Daily checking for the instrument and equipment such as IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, Doppler …etc. are available and in good condition with updated PPM (planned preventive maintenance			
9. Knows how to locate the attendance sheet, duty ROTA, vacation plan, telephone directory			
10. Physicians & other health professionals on call roster board schedule of beeper listening			
11. Admission, transfer procedures			
12. Infection control			
• Applying hospital infection control policy in relation to:			
a. Principals of Asepsis			
b. Isolation principals			
c. Disposal of waste materials			
13. Diagnostic preparation- follows protocol for various diagnostic procedures.			

14. Daily nursing care:			
▪ Patient hygiene			
▪ Assess the newborn generally			
▪ Assess gestational age			
▪ Length and weight			
▪ Neonate vital signs			
15. Neurology			
a. Assessment of the neurological system:			
b. Fontanel and cranial sutures			
c. Level of consciousness			
d. Motor response e. Reflexes: ▪ Rooting ▪ Sucking ▪ Swallowing ▪ Moro Tonic Neck ▪ Grasp ▪ Babinski Stepping ▪ gaging ▪ Blinking			
f. posturing			
g. Pupil reactivity			
h. Head circumference			
16. Cardiovascular:			
i. Assessment of the cardiovascular system:			
▪ Heart sounds			
▪ Skin color/temperature			
▪ Pulses			
▪ Capillary refill			
▪ Edema			
▪ **Cardiac Bedside, Transport monitor and Central Desk EKG Monitoring**			
i. Aware of the location of Monitor Manual.			
j. Prepares skin and appropriately attaches electrodes and EKG cable leads.			
k. Sets rate alarm limits appropriately.			
l. Distinguishes artifact and electrical interference from the patient's rhythm.			
m. Correctly clears history of alarms on central monitor			
n. Troubleshoots alarms/error codes appropriately.			
o. Documentation of Pt. vital signs, oxygen saturation by using cardiac monitor.			
▪ Use of the defibrillator			
▪ Care of the cardiac surgery patient (pre/post-op)			
▪ Care of patient with shock			
▪ Care of the cardiac surgery patient (pre/post-op)			
▪ Administration of blood and blood products			
▪ Care of a patient receiving exchange transfusion			
17. PULMONARY			

a. Chest circumference			
b. Breath sounds			
c. Breathing pattern/effort			
d. Skin/nail bed color			
e. Respiratory secretions (color/character)			
f. RDS Score			
g. Administering and Monitoring 02 Therapy : ▪ Nasal cannula, hood, endotracheal tube ▪ Pulse oximetry ▪ Head box ▪ Venture mask ▪ Assisting with intubation/extubation ▪ Proper use of CPAP and ▪ Ambu-bag			
h. Care of the intubated patient Securing ETT			
i. Suctioning: duration and depth, hyperventilation			
j. Surfactant replacement therapy			
k. Performing chest physiotherapy			
l. Ventilators (use, mode, and alarm complications)			
18. GASTROINTESTINAL/RENAL			
m. Assessment of bowel sounds			
n. Abdominal circumference/ Abdominal girth			
o. Appearance/character of urine and stool			
p. Fluid and electrolyte balance			
q. Umbilical cord care			
r. Taking and recording patient:			
▪ TPN			
▪ Gavage feeding			
▪ NEC			
▪ GI Abnormalities			
▪ Ostomy			
▪ Care of the patient with tube feedings:			
▪ Checking placement and residuals on tube feedings			
▪ Feeding intolerance			
▪ Gastrostomy tube			
▪ Care of infant in acute/chronic renal failure			
▪ Care of infant on peritoneal dialysis			
▪ Care of infant requiring bladder catheterization			
▪ Breast feeding (pumping, collection, storage)			
19. Collection of specimen (urine,blood,wound,CSF)			
20. Pediatric laboratory result			
21. Performance of physical health assessment and nursing management			
▪ Premature neonate and Low birth infant			

▪ Term neonate			
▪ Congenital anomalies (cardiac, respirator, gastric, neurological, urinary tract and Hydrocephalus)			
▪ Dawn syndrome			
▪ Communicable disease			
▪ Respiratory disease			
▪ Post-natal disorder			
▪ Jaundice			
▪ Infant of diabetic mother			
22. Medication administration **The Nurse intern is observed to consistency demonstrate high level of care &maintenance to the policy related to the administration of medication by the following routes**			
a. Introps, vasopressor			
b. Prostaglandin			
c. Per NGT			
d. S.C.injection			
e. Intradermal injection			
f. I.V.Injection			
g. Eye drops			
h. Ear drops			
i. Inhaler			
j. nebulizer			
• Follow hospital policy for documentation of drug administration			
• Consult appropriate sources for necessary information regarding unfamiliar drugs			
The Nurse intern is able to describe the following:			
a. The supply of drugs to the wards/unit			
b. The safe keeping of ward stock drugs in the drug cupboard and refrigerator			
c. The correct checking & administration of all medication administration			
d. The administration of specific medications			
e. The appropriate documentation related to medication administration			
f. The supply of medication to patients being discharged			
23. Follow hospital policy for discharge procedures			
24. Post-Mortem Care			
25. Follow hospital policy for documentation			

CLINICAL COMPETENCY FOR PICU

Key" Write the date, intern's signature, preceptor signature &rotation

1. Procedure done for the 1st time (Beginner)
2. Procedure done for the 2nd time (advanced beginner)
3. Procedure done for the 3rd time. *(Competent)*

Intern Name:

Unit: **Batch#:** **Group#:**

CLINICAL SKILL / TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
c. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with international patient safety goals (IPSG)			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, Doppler, skin thermometer… etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern is able to demonstrate the following:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
The Nurse Intern is able to demonstrate the following:			
10. General Nursing Skills			
- **Measuring & recording of:**			
• Vital Signs & related Observations:			
- Temperature			
- Pulse Rate			
- Respiratory Rate			
- Blood Pressure			
• Pulse Oximetry Set-up & Reading			
• Height& Weight			
11. Cardiac related equipment			
• Aware of the location of monitor manual			
• Prepare skin and appropriately attaches electrodes and ECG			
• Sets rate alarm limits appropriately			

• Changes lead selection for appropriate waveform			
• Correctly clears history of alarms on central monitor			
12. Respiratory care			
- Maintain Basic airway:			
a. Insert correct size airway appropriately:			
• Oral airway			
• Nasopharyngeal airway			
• Laryngeal mask			
b. Perform effective bag-mask breathing			
- Basic oxygen therapy			
• Identify indications for oxygen therapy , devices for oxygen administration:			
• Nasal Cannula			
• Simple face mask			
• Non-rebreathing mask			
• Tracheostomy mask			
- Care of chest tubes/drainage system			
- **Suctioning**			
• Oral-pharyngeal			
• Nasal-Pharyngeal			
13. Medication Administration The Nurse Intern under observation consistently demonstrate high level of care & adhere to the policy related to the administration of medications by the following routes			
- Subcutaneous injections			
- Intradermal injections			
- Intramuscular injections			
- Intravenous injections			
- IV Push/ Bolus			
- Nebulizer			
• Consult appropriate sources for the necessary information regarding unfamiliar medications e.g. Direct vasodilator, Beta agents			
The Nurse intern is able to describe the following:			
• The supply of drugs to the wards/unit			
• The safe keeping of ward stock drugs in the drug cupboard and refrigerator			
• The correct checking & administration of all medication administration			
• The appropriate documentation related to medication administration			
• The supply of medication to patients being transferred			
• Documentation and report related to Drug errors			
14. Controlled & Narcotic Drugs The Nurse Intern is able to discuss & competently demonstrate the following activities			
• The procedure for incidents of Narcotic & Control Drug breakages or errors			
• The administration of a controlled or narcotic medication to a patient			
• The correct procedure in dispensing a controlled or narcotic drug using the narcotic drug register			
15. IV Therapy (Cannulation/Lines) The Nurse Intern is able to demonstrate the appropriate techniques of the			

following			
• Insertion of an IV Cannula, maintaining an IV cannula/Heplock			
• Measuring & documenting input and output			
• Regulating IV			
• Changing an IV site dressing			
Demonstrate ability to use IV devices: • Set up and regulation of IV infusion pumps			
- The calculation of proper concentration and rate of infusion			
- The dilution strength of fluids and the time required for infusions			
16. Identify needs for communication with other facilities e.g. OPD clinics, wards-ray dep., OR.			
17. Able to response to code and function as a cardiac arrest team			
18. Infection Control The Nurse Intern will be able to:			
• Demonstrate appropriate hand washing technique (as Indicated by WHO "Five Moment")			
• Apply principles of aseptic techniques in performing - Dressing change			
- IV cannulation			
- Universal/standard precautions			
- The Post Mortem Policy			
• Disposes waste/Materials appropriately			
19. Locate patient room equipment /supplies			
• Emergency call button			
• Oxygen flowmeter			
• Suction regulator/Bottles			
• lights			
• Supply drawers/cart			
20. Forms and Documentation requirements:			
• Shift change report using SBAR			
• Admission assessment/daily assessment flowsheet			
• Consent forms			
• Pre, intra& post-operative e forms			
• Incident/Occurrence report (OVR)			
• Nursing kardex			
• Nursing care plan and clinical pathway			
• Transfer summery			
• Discharge summery			
• Post-mortem Care			
21. Assigned with one patient with regular ICU staff nurse			
- Start to do basic bedside care:			
• Head to toe assessment, do charting			
• Give medications do documentation			
• Laboratory specimen labels and results			
• Suctioning (oral, nasal, ET, tracheostomy)			
• NGT insertion and removal			
• Observe central line insertion			

• Foley catheter insertion, empties Foley collection bag, urinal and removal			
• Record output on flow sheet (NGT,wound drain, Chest tube drain)			
• Perform /assists with patient bed bath, shower			
- **Pain management:**			
• Reports patient pain to physician /pain management nurse			
• Assists patient with pain management			
• Use acute pain assessment form			
- **Skin care**			
• Identifies risk factors, prevention strategies			
• Management of abnormal skin conditions and pressure ulcers			
• Report abnormal skin conditions			
- **Blood /Blood products administration**			
• Monitoring blood/blood products			
- **Swab culture**			
• Abdominal fluid			
• Anaerobic cultures			
• Wound cultures			
- **Suctioning**			
• Oral-pharyngeal			
• Nasal-Pharyngeal			
• Tracheostomy			
- **Assist with basic procedures:**			
• Lumber puncture			
• Thoracentesis/paracentesis			
• Dressing change			
- Blood and blood products transfusion:			
- Familiarize with:			
• Infusion pump			
• Intubation tray			
• Epidural pump			
• Feeding pump			
• ICP monitor			
• Ventilator			

CLINICAL COMPETENCY FOR DAY SURGERY

Key" Write the date, intern's signature, preceptor signature &rotation.

1. Procedure done for the 1st time (Beginner)
2. Procedure done for the 2nd time (advanced beginner)
3. Procedure done for the 3rd time. *(Competent)*

Intern Name:

Unit: **Batch#:** **Group#:**

CLINICAL SKILL / TASK	1	2	3
1. Familiarize with the physical set up of the unit specifically the rooms of the following with their checklists:			
a. Staff locker			
b. Male/Female changing rooms			
d. Stock room			
2. Read and understand policies & procedures including job description.			
3. Familiarize with IPSG.			
4. Knows the location of the fire evacuation plan, fire extinguishers and fire alarm and to respond thru RACE and PASS			
5. Familiarize with unit disaster plan with its roles and responsibilities			
6. Familiarize with unit KPI: Patient Fall Prevention and Nurse turn over.			
7. Daily checking for the instrument and equipment such as crash cart IVAC (portable IV pump), glucometer, TCOM (transcutaneous oximetry) machine, , skin thermometer…etc. are available and in good condition with updated PPM (planned preventive maintenance).			
8. Knows how to locate the attendance sheet, duty ROTA, telephone directory			
9. Admission, Transfer and discharge: The Nurse Intern can demonstrate the following:			
• The routine admission transfer and discharge of a patient			
• The care of a patients valuable			
10. General Nursing Skills The Nurse Intern is able to complete the following activities:			
- Measuring & recording of **:**			
• **Vital Signs & related Observations**:			
- Temperature			
- Pulse Rate			
- Respiratory Rate			
- Blood Pressure			
• Pulse Oximetry Set-up & Reading			
• Height& Weight			
• Documentation of Pt. vital signs, oxygen saturation, height and weight.			
11. Medication Administration The Nurse Intern is observed to consistently demonstrate high level of care & maintenance to the policy related to the administration of medications by the following routes			
- Subcutaneous injections			
- Intradermal injections			
- Intramuscular injections			
- Intravenous injections			

- IV Push/ Bolus			
- Nebulizer			
• Follow hospital policy for Documentation of drug administration			
• Consult appropriate sources for the necessary information regarding unfamiliar medications e.g. Direct vasodilator, Beta agents			
The Nurse intern is able to describe the following:			
• The supply of drugs to the wards/unit			
• The safe keeping of ward stock drugs in the drug cupboard and refrigerator			
• The correct checking & administration of all medication administration			
• The appropriate documentation related to medication administration			
• The supply of medication to patients being transferred			
• Documentation related to Drug errors			
12. Controlled & Narcotic Drugs The Nurse Intern is able to discuss & competently demonstrate the following activities			
• The procedure for incidents of Narcotic & Control Drug breakages or errors			
• The administration of a controlled or narcotic medication to a patient			
• The correct procedure in dispensing a controlled or narcotic drug using the narcotic drug register			
13. IV Therapy (Cannulation/Lines) The Nurse Intern is able to demonstrate the appropriate techniques of the following			
• Insertion of an IV Cannula, maintaining an IV cannula/Heplock			
• Measuring & documenting input and output readings			
• Regulating IV			
• Changing an IV site dressing			
Demonstrate ability to use IV devices: • Set up and regulation of IV infusion pumps			
- The calculation of proper concentration and rate of infusion			
- The dilution strength of fluids and the time required for infusions			
14. Identify needs for communication with other facilities e.g. OPD clinics, wards-ray dep., OR.			
15. Able to response to code and function as a cardiac arrest team			
16. Infection Control The Nurse Intern will be able to:			
• Demonstrate appropriate hand washing technique (as Indicated by WHO "Five Moment")			
• Apply principles of aseptic techniques in performing - Dressing change			
- IV cannulation			
• The Nurse Intern will be able to discuss:			
- Universal/standard precautions			
- The Post Mortem Policy			
• Disposes waste/Materials appropriately			
17. Circulating Nurse Role and Responsibilities: The Nurse Intern is able to demonstrate the appropriate techniques of the following			
▪ Check OR list for procedures of the day			
▪ Receive patient and check his identity with ID Band and file.			
▪ Assesses the cardiovascular, pulmonary, neurological, renal and vascular status of the patient.			
▪ Checks the patient's laboratory results			
▪ Informs the physician immediately if there are any problems or critical information in regard to the patient			

- Administers proper preparation and interventions pri-operative:			
▪ Prepares the procedure room appropriately for the procedure.			
▪ Tests the operation of light, suction machine, cardiac monitors, defibrillator, additional monitor &defibrillator, ECG machine.			
▪ Ensure availability of Intubation tray: Oral, nasal airways/laryngoscope handle/blades., pacemaker devices, supplies, and other equipment to be used.			
▪ Promotes physical comfort and safety when transporting, lifting and positioning patient.			
▪ Operate the defibrillator when needed in emergency situations, prepare external pacemaker device as needed.			
▪ Assists the anesthetist with intubation.			
▪ Assist, observe the scrub nurse in setting sterile instruments in the mayo table			
▪			
▪ Transfer the patient to the recovery room after properly fixing the patient's gown and assuring patient is stable for transfer.			
▪ Cleaning and disinfection of RR stretchers in between patients.			
▪ Prepare supplies & patients files for the following day.			
▪ Preparation of patient's files for the following day.			
18 . Scrub Nurse Role and Responsibilities			
▪ Proper gowning, gloving			
▪ Reviews the patient's status during the case:			
▪ Gives relevant information about the patient's status and call other nurse's attention to any special endorsement or medications.			
▪ Basic knowledge of surgical instruments, supplies, drapes, gown etc. in the working table			
▪ Observes the importance of maintaining sterility of the field and the unit.			
▪ Prepares the operative site properly with the use of povidone iodine and chlorhexidine (as order).			
▪ Prepare the instruments and equipment's are used for procedures/OR &when they are needed.			
- Notifies the physician of any status changes from the patient and administer appropriate care:			
▪ Identifies risks (Air embolism, over volume injection etc.) during procedure and applies appropriate interventions.			
▪ Inform any untoward signs to the surgeon e.g. bleeding, hematoma.			
▪ Monitors intravenous fluids, vital signs, effects of sedatives and reports any untoward data, signs and symptoms.			
▪ Count all sponges, instruments, needles and other tools before &after surgery &inform surgeon of the count.			
▪ Prepare the pt. to transfer him to the recovery room			
▪ Packing of instruments before sending to CSSD			
18. Recovery Room Nurse Role and Responsibilities: The Nurse Intern is able to demonstrate the appropriate techniques of the following			
1. Assesses patient's condition post procedure:			
▪ Monitors patient's vital signs			
- Attach the patient to cardiac monitor (as needed)			
▪ Check for any signs and symptoms of:			
- Potential respiratory dysfunction			
- Alterations in cardiac output			
- Alterations/changes in hydration status			
- Alterations in temperature			
- Altered LOC			
- Presence of pain			
2. Answers patient's questions regarding the procedure and provides information or health			

teachings related to the procedure:			
3.Reports any changes in patient's dressing site or operative site:			
▪ Check for the presence of bleeding or hematoma			
4. Observes for any changes in patient's status and provides appropriate treatment and interventions needed.			
▪ Provides appropriate pain management post procedure			
▪ Applies proper Advance Cardiac Life Support during Code Blue			
▪ Familiarization on RR documents used for effective recording and reporting			
Transfer pt. back to ward with the preceptor and to be oriented with proper reporting of post-operative patient.			
19.Documentation Nurse Role and Responsibilities: The Nurse Intern is able to demonstrate the following: (according to the policy)			
1. Assesses patient chart for appropriate pre-procedure data and interventions:			
▪ Receives endorsement from the Unit Nurse using SBAR method.			
2. Assesses patient's knowledge base/needs in regard to age, education and level of consciousness:			
▪ Explains to the patient prior to the procedure what is expected inside OR.			
▪ Provides appropriate health teachings to the patient/family after the procedure.			
3. Reviews the patient's status during the surgical time-out together with the team.			
5. Notes all information and interventions done to patient and documents it on the chart.			
▪ Documents patient data and outcomes, pre, intra and post-operative.			
▪ Documents all interventions and management done on patients pre, intra and post-operative.			
▪ Endorses the patient properly to the Nurse in recovery room using SBAR method.			
▪ Complete the Kardex accurately			
▪ Familiarization on HIS (health information System) of the hospital			

APPENDEX II: FORMS

NURSING INTERNSHIP PROGRAM

Anecdotal Record

Intern Name: ----------
Batch #---------- Unit: ----------
Evaluation period: ----------

Date	Comments	Preceptor

COLLEGE OF NURISNG

INTERNS LEAVE REQUEST FORM

SECTION I: TO BE COMPLETED BY THE INTERN:

Intern Name _____	**Group**	**Date of Request**
Contact No:	Email Address:	
Start Date of Leave:	End Date of Leave:	
Place of Training:		
REASON FOR LEAVE	**SUPPORTING DOCUMETNS REQUERED**	
☐ Sick Leave	Medical Report	
☐ Maternity Leave		
☐ Marriage Leave	Marriage Certificate	
☐ Excuse ☐ No.of Hour-------- ☐ Time of compensation ---------- ☐ Date of compensation----------	Formal Request Form Any Special document(e.g appointment slip….etc)	
☐ Emergency Leave	Formal Request Form	

Interns signature _____ Date: _____

SECTION II: TO BE COMPLETED BY NURING SERVICES DEPT.

☐ Request Approved	☐ Request Denied	Comment

Signature nursing Interns coordinator in the training hospital _____

Date: _____

Signature college coordinator clinical & internship affairs _____
Date: _____

CC:

- Original to intern manual book
- Copy to nursing education office
- Copy to Internship Unit (CON)

Educational Leave Application
نموذج طلب إذن بحضور دورة تدريبه
رقم ( )

Name:	**الاسم:**
I.D#	**الرقم الجامعي:**
Batch ( ) Group ( )	**المجموعة ( ) الدفعة ( )**
Present area Orientation:	**القسم الذي تتدرب فيه حالياً:**
Request Date:	**تاريخ الطلب:**
Title of Symposium/ lecture/education:	**عنوان المؤتمر/ المحاضرة/ الدورة التعليمية:**
Place of Symposium:	**المكان:**
From Date	**يبدأ في تاريخ:**
To Date:	**تنتهي في تاريخ:**
Intern Remarks & Signature:	**ملاحظة وتوقيع المتدرب:**
Approval of the Nursing Department **موافقة المسئولة عن طلبة الامتياز بالمستشفى**	**Approval of Nursing College** **موافقة المسئول عن طلبة الامتياز بالكلية**

- Request should be submitted 2 weeks before Activity date
- يجب تقديم الطلب أسبوعين قبل تاريخ الدورة التعليمية
- Each intern is allowed for a maximum of 6 Educational Activity to be approved by the administration
- لكل طالب الحق بحضور 6 دورات تعليمية خلال فترة الامتياز فقط لا غير بموافقة الإدارة
- Only 30% of the group can attend and the priority to those who register first
- فقط 30% من المجموعة تستطيع حضور الدورة التعليمية والأولوية بأسبقية التسجيل
- Please submit the approved request to the unit manager to be kept in the file and as a notification of approval
- الرجاء تسليم نموذج الموافقة إلى القسم كإشعار بموافقة الإدارة ومن ثم يحفظ في الملف
- Copy of Educational Activity Certificate should be submitted to the unit after attendance otherwise it will be considered as absent without excuse
- تزويد القسم بصورة من شهادة حضور الدورة التعليمية و إلا سيحتسب هذه الأيام غياب بدون عذر

Nursing Internship program
Warning letter

Date: _____

Warning NO. ( )

Name of Intern: _____ Batch: _____

ID#:_____ Group: _____

Rotation: _____

You are counseled to the following:

- ☐ Not adhering to dress code
- ☐ Unprofessional attitude or behavior
- ☐ Going out without prior approval
- ☐ Absences more than 25% of the rotation
- ☐ Falsification (for evaluation or absences)
- ☐ Not follow the instruction
- ☐ Other

_____

Also, be informed that after receiving one counseling letter the second will be a warning letter resulting in below disciplinary action:

- ☐ First warning letter: 2 days compensation.
- ☐ Second warning letter: Reduce days of emergency leave
- ☐ Third warning letter: Repeat one rotation
- ☐ Forth warning letter: Referred to College Council

Nursing intern signature: _____
Coordinator Clincial & Internship Affairs: _____
Vice Dean College of Nursing: _____

GOOD LUCK