STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

June 18, 2020

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'the OCO investigation into the death of an incarcerated individual at Mission Creek Correction Center for Women' completed by the Office of Corrections Ombuds.

Recommendation	Response
Ensure oversight of the physician assistants and nursing staff at camps. DOC should implement a clear policy and procedure requiring recurring, documented oversight of physician assistants (10% of the physician assistant's working time, per Department of Health) and nursing staff at the camps.	The Department of Corrections adheres to the medical oversight process that is approved by the Department of Health on continuing education and oversight of medical staff. Additionally, the department created a Coordinated Quality Improvement Program (CQIP) that was built to review current processes for recommendations on updating current practices. This program was tasked to review oversight of the nursing staff and a plan was created by the Health Services 2020 effort for implementation of nursing staff oversight. Please see Attachment A and B
Require a practitioner evaluation after every declared medical emergency. DOC should implement a clear policy and procedure that requires an evaluation by a physician or advanced practitioner after a declared medical emergency.	Nursing staff can perform the referral function in OMNI-HS by creating a nursing encounter and referring the patient to the medical practitioner. One of the department's health service administrators and health services managers are working on a training curriculum for nursing staff to train/update them, through Skype training sessions, on creating Internal Referrals to the practitioner after a patient has returned to the Emergency Room (ER). The referral will be to see the patient within 24-48 hours after an ER visit.
Revise Outpatient Services policy to clarify that transfer from camp to major facility	This protocol was revised in the Offender Health Care Plan under *Authorization for*

clinic is not required in a medical emergency. DOC should implement a policy and procedure that clearly instructs the direct transfer from a camp to the emergency room in cases of medical emergency.	*Medically Necessary Care.* The Chief Medical Officer distributed a memo to Health Services Staff on June 9, 2020, noting of this update and new procedure that was implemented.
Improve kite responses. DOC should implement a clear policy and procedure that ensures an appointment for every patient who requests one.	Health services has fully implemented a new medical kite tracking protocol at all major facilities. The process update includes a detailed tracking tool, daily retrieval, daily clinical triage and daily follow up. All triaged emergent or urgent kites are immediately addressed for follow up by health services staff with the reporting patients. All routine requests are forwarded to the appropriate discipline for response and action. The agency expectation is that all routine kites will be responded to within five business days. Each facility specific leadership is tasked to conduct periodic audits to ensure time lines are met, clinical triage is appropriate, and the quality of responses, and to ensure staff are attempting to remedy at the lowest level as appropriate. The goal is to provide a rapid response and remediation of issues to avoid delays where possible and avoid a protracted grievance process. This allows critical staff to spend more time on patient care and support and lessens excessive administrative activities. In an effort to utilize the resources as effectively as possible, not all medical kites require an appointment and will be addressed per the new tracking protocol and routinely reviewed for quality assurance.
Provide training on the evaluation of the adult with a non-traumatic headache. Training should be required for all medical and nursing staff.	This specific case was added to the cases used for continuing education of health care staff pertaining to responding to non-traumatic headache concerns at future morbidity and mortality conferences. All medically licensed staff are required, per the Department of Health, to participate in continuing education to remain compliant with practicing medical

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	services. The Department of Corrections has a policy for continuing education cost reimbursement to encourage staff to continue with their education.
Ensure regular testing of 911 emergency call system. The system should have a regular testing schedule, with documented plan for backup with cell phone in the event the regular call system fails.	In the year of 2018, the Department of Corrections updated the telephone security compliance process which allowed for 911 dedicated phones to be placed throughout all DOC facilities and requires regular routine maintenance and testing.
Reassess whether the remaining staff involved in the patient's care should be investigated for failure to provide care or appropriately respond in a timely manner.	The Department of Corrections reviewed this case and has ensured that individuals involved in the care of this incarcerated individual were evaluated for accountability and received training on proper responses to the incident. In addition, all nursing staff that are employed through the Department of Corrections are now receiving annual competency reviews by supervising staff.

The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's facilities is a fair and safe space for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections

Attachment A

CQIP Documentation Quality Checklist

Date of Review	Practitioner
Click here to enter date.	Click here to enter text.

Instructions:

Briefly review the chart before assessing for the following attributes in the note assessed:

Attribute	Score 1 (not at all) 2 (poorly) 3 (sufficiently) 4 (satisfactorily) to 5 (exceptionally)										Description of Ideal Note
Up-to-date											Contains most recent test results and recommendations
Accurate											Free of incorrect information
Thorough											Complete; documents all issues of importance to the patient
Useful											Extremely relevant; provides valuable information and/or analysis
Organized											Well-formed; structured in a way that helps reader understand clinical course
Comprehensible											Clear, without ambiguity or sections that are difficult to understand
Succinct											Brief, to the point; without redundancy
Synthesized											Reflects author's understanding of patient's status and ability to develop a plan of care
Internally consistent											Does not ignore or contradict any other sections of note
Target: 31-45	0	0	0	0	0	0	0	0	0	0	All charts found to have a majority of the positive attributes

Comments:
Click here to enter text.

Click here to enter text.		Click here to enter date.
Reviewer Name	**Reviewer Signature**	**Date Signed**
Click here to enter text.		Click here to enter date.
Practitioner Name	**Practitioner Signature**	**Date Signed**

CQIP Direct Observation Checklist

Date(s) of Observation	Practitioner Name
Click here to enter a date.	Click here to enter text.

History Component	Check if performed adequately during each observed encounter				
Chief complaint					
HPI					
Began with open-ended questions					
Asked appropriate directed questions					
Obtained pertinent historical information PMH/PSH/FH					
Obtained pertinent SH					
Reviewed medications					

Exam Component	Check (or N/A) if performed adequately during each observed exam				
Vital signs					
HEENT					
Cardiovascular					
Lungs					
Abdomen					
Rectal or pelvic					
Extremities and/or skin					
Neurologic					
Musculoskeletal					

Clinician-Patient Interaction	Check if demonstrated during each encounter				
Introduction/rapport					
Professional approach					
Conveyed plan and asked patient to repeat back understanding					
Solicited patient questions					
Reviewed prevention needs					
Updated Problem List					

Additional Comments

Click here to enter text.

Click here to enter text.

Reviewer Name	Reviewer Signature
Click here to enter text.	
Practitioner Name	**Pracctitioner Signature**

CQIP Practitioner Performance Enhancement Scorecard

Reviewer: Click here to enter text.	Position: Click here to enter text.
Pracitioner: Click here to enter text.	Position: Click here to enter text.
Facility: Click here to enter text.	Period of review: Click here to enter text.

Review based upon (select all that apply):	
☐ Chart review	Number of charts reviewed: Click here to enter text.
☐ Direct observation	Number of cases observed: Click here to enter text.
☐ Case management discussion	Number of cases discussed: Click here to enter text.

Instructions for completing the review:

Complete the CQIP Performance Enhancement Scorecard at least annually for each employee under clinical supervision. Use this form to document after performing:

1) **10** formal chart reviews at a minimum for each period of review.
2) **5** direct observations of clinical care for each period of review.

Documentation and direct observation checklists should be used as worksheets to track findings. Comments, findings, and feedback should be shared in discussion between supervisor and supervisee.

Rating definitions:

1. **Needs Improvement -** Frequently or consistently performs below expectations in exhibiting clinical skills and/or professional standards of practice.

    - For more severe deficits, a rating at this level may require immediate intervention/training or temporary restriction from performing a specific task or tasks independently until performance improves. If restriction is necessary the Health Care Manager, Chief Medical Officer/designee, and Appointing Authority will be notified.

    - This rating requires that training or mentoring occur over the course of the next review period. A concerning trend should prompt notification to the Health Services Manager and Chief Medical Officer, along with sharing of improvement plans.

2. **Meets Expectations**- Consistently meets expectations in exhibiting clinical skills and professional standards of practice.

    - Performs in accordance with expectations and established clinical standards.

    - Has room to improve to achieve performance above established standards.

3. **Exceeds Expectations-** Often or consistently exceeds expectations and may exhibit exceptional clinical skills and professional standards of practice.

    - Often or consistently performs above established standards of clinical performance and professionalism.

- May serve as a role model to peers

NOTE to Reviewer: An explanation and plan for improvement in the "Comments" section is required for all ratings not meeting expectations.

Direct Observation	**RATING***	**COMMENTS**
History-taking		Click here to enter text.
Physical Examination		Click here to enter text.
Diagnostic testing selection, interpretation, response		Click here to enter text.
Assessment		Click here to enter text.
Treatment Planning and Follow-up		Click here to enter text.
Chart Review	**RATING***	**COMMENTS**
Organized		Click here to enter text.
Comprehensible		Click here to enter text.
Up-to-date		Click here to enter text.
Accurate		Click here to enter text.
Complete, including signature and date		Click here to enter text.
Overall Clinical Approach	**RATING***	**COMMENTS**
Clinical Rapport with patient		Click here to enter text.
Seeks consultation when needed		Click here to enter text.
Clinical knowledge base		Click here to enter text.
Professionalism with patients and staff		Click here to enter text.
Appropriate application of guidelines and protocols		Click here to enter text.
Clinical supervision skills (only if applicable)		Click here to enter text.
Average rating (goal 2-3)		Click here to enter text.

Additional Reviewer Comments and Improvement Plan:
Click here to enter text.

Practitioner Feedback and Self-Assessment

In which clinical subject areas can your clinical leadership assist you in acquiring more training, education, or experience during the upcoming period of review?

Click here to enter text.

Which practice quality parameters from page 1 would you like to improve during the upcoming period of review?

Click here to enter text.

Click here to enter text.		Click here to enter a date.
Reviewer Name	**Reviewer Signature**	**Date**
Click here to enter text.		Click here to enter a date.
Practitioner Name	**Practitioner Signature**	**Date**

Completed/signed original document should be maintained in the practitioner's education file, protected under CQIP.

Department of Corrections WASHINGTON STATE	**DOC Nursing Standards Manual**
TITLE: COMPETENCY ASSESSMENT OF NURSING PERSONNEL	
AUTHORIZATION: _____ Chief Nursing Officer	**STANDARD:** Protocol N-8001

PERSONNEL: RN, LPN, CAN, MA

COMPETENCIES: Ability to assess skills and learning needs in relation to the nursing department policies, procedures and protocols.

DESIRED OUTCOME:

PATIENT: Receives care from nursing staff that are qualified, oriented and skilled to perform the assigned functions

NURSING: Delegates care to persons capable of performing assigned aspects of care according to regulatory standards and DOC Nursing Standards (procedures and protocols)

SUPPORTIVE DATA: A commitment to employ nursing staff occurs after a determination has been made that the applicant meets desired qualifications and credential requirements. The credentialing review is based upon, but not limited to, verification of current Washington State licensure in good standing (i.e. RN, LPN), Washington State Background Authorization and other evidence indication that the applicant has the applicable certificates, degrees or credentials as requested to demonstrate adequate preparation for the work functions.

The RN3/RN4 interviews applicants referred from for vacant nursing positions. The job description is reviewed during the interview process. The selection of the applicant for the job is based upon their skills and abilities.

Once hired, nursing employees must attend an orientation program prior to assigned duties. Orientation includes orientation to specific aspects of care on the assigned unit, as well as additional education and training, such as OMNI and CIPS for licensed staff.

Position descriptions, clinical oversight evaluation tools, performance expectations and competency validation tools define competency.

SUPPORTIVE DATA: (Continued)

Competency Assessment identifies and evaluates skills needed to initiate and maintain competent delivery of nursing care interventions. Competencies are a collection of skills, abilities and performance elements needed during orientation, the first six months to one year of employment, annually and ongoing.

Competency Assessment interfaces with improving organizational performance and assists in monitoring what is truly needed so that skills and issues are not missed.

All nursing personnel are expected to participate in the Nursing Department's ongoing competency assessment process. As the organization changes, so will skills and knowledge needed/required for the job. Nursing Supervisors are expected to schedule attendance at relevant training.

Performance shall be directly observed and evaluated by an RN Supervisor. Monthly supervisory conferences will be completed with each staff member. Performance of nursing responsibilities and clinical functions will be assessed through chart audits, documentation review and observations of staff and patient interactions. Performance evaluations are provided annually.

Initial Competencies are completed within 30 days of hire.

Ongoing Competencies involve periodic assessment after the initial competencies have been met, and reflect new, changing or problematic aspects of the job as it evolves over time (example: new procedures, changes in technologies, changes in policies, identified improvement areas from performance improvement data, etc.).

Annual Competencies are mandatory as determined by DOC and nursing leadership and involve aspects such as Safety, Infection Prevention, HIPPA Compliance, etc.

FORMS: All forms can be accessed on the DOC Nursing SharePoint.

- Orientation to Duty Checklist
- Clinical Competency Checklist
- Clinical Oversight
- Monthly Supervisor Conference
- Specific Facility Orientation (if applicable)
- Performance and Development Plan

CORRELATES WITH:

- DOC 850.110 Performance and Development Plans

STEPS and KEY POINTS:

A. Orientation Upon Hire

1. RN4 Nurse Manager or designee schedules orientation for new employee
   - Orientation programs are critically important in preparing nursing staff for patient care responsibilities. The orientation period serves to assess the individual's abilities, knowledge and skills
2. RN3 Supervisor and new employee meet to review expectations and sign documents including:
   - Orientation to Duty Work Station Checklist
   - PD and PDP expectations
   - Pertinent policies and procedures (i.e. attendance, dress code, PREA, etc.)
   - Schedule and rotation assignments
3. RN3 Supervisor to assign all licensed staff to receive onboarding training to include OMNI, CIPS and CORE

B. Ongoing Competency Review and Clinical Oversight

1. RN3 Supervisor and employee meet to:
   - Review/complete Orientation to Duty Checklist with any change in assignments to ensure staff are familiar with their working environment
   - Review/discuss competency checklist with any changes to procedures, protocols or equipment
   - Review/discuss Clinical Oversight Checklist with every monthly Supervisory conference to include:
     - Staff observations
     - Chart audits
     - Training assignments completed as expected (i.e. LMS review)
   - Review/complete staff engagement tools
     - 30 and 90 day reviews completed
     - Monthly rounding with each staff
   - Review/discuss facility specific orientation if applicable (i.e. agency nurse, temporary assignment)
2. The employee's education file is kept by supervisor for ongoing record of staff's training.
3. RN3 Supervisor to complete annual evaluation for each staff member using clinical oversight checklist, monthly supervisory conference information and LMS data.

REFERENCES:

Eliza Schub, H. H. (2016, June 24). Clinical Competencies: Assessing. Retrieved October 24, 2017, from ebscohost.com:https://www.ebscohost.com/assetssamplecontent/NRCPlus_AssessingClinicalCompetencies_NPS_SC.pdf

DATE ISSUED: March 2020

DATE REVIEWED:

DATE REVISED:

CQIP Clinical Oversight Review Form	
Supervisor Name: Click here to enter text.	Position: Click here to enter text.
Staff Name: Click here to enter text.	Position: Click here to enter text.
Facility: Click here to enter text.	Type of review: Click here to enter text.

Review based upon (select all that apply):	
☐ Chart review	Number of charts reviewed: Click here to enter text.
☐ Direct observation	Number of cases observed: Click here to enter text.
☐ Case management discussion	Number of cases discussed: Click here to enter text.

Instructions for completing the review

Complete the CQIP Clinical Oversight Review Form **monthly** for each employee under clinical supervision. This form is meant to document annual trends after performing:

- **10** formal chart reviews at a minimum (1 per month) and
- **5** direct observations of clinical care (1 every other month)

Rating Scale:

1. **Needs Improvement -** Frequently or consistently performs below expectations in exhibiting clinical skills and/or professional standards of practice.

    - For more severe deficits, a rating at this level may require immediate intervention/training or temporary restriction from performing a specific task or tasks independently until performance improves. If restriction is necessary the Health Care Manager, Chief Nursing Officer, and Appointing Authority will be notified.
    - This rating requires that training or mentoring occur over the course of the next review period.

2. **Meets Expectations**- Consistently meets expectations in exhibiting clinical skills and professional standards of practice.

    - Performs in accordance with expectations and established clinical standards.
    - Has room to improve to achieve performance above established standards.

3. **Exceeds Expectations-** Often or consistently exceeds expectations and may exhibit exceptional clinical skills and professional standards of practice.

    - Often or consistently performs above established standards of clinical performance and professionalism.
    - May serve as a role model to peers

***NOTE: Any rating score below a 2 requires an explanation in the "Comments" section.**

Direct Observation	**RATING***	**COMMENTS**
Assessments		Click here to enter text.
Medication & Treatment Administration		Click here to enter text.
Clinical Skills & Interventions		Click here to enter text.
Theraupeutic Communication		Click here to enter text.
Patient Education		
Delegates tasks appropriately		Click here to enter text.
Chart Review	**RATING***	**COMMENTS**
MAR and Chart documentation accurate		Click here to enter text.
Comprehensible (Legible, understandable)		Click here to enter text.
Up-to-date (*Contains the most recent results*)		Click here to enter text.
Nursing Care Plan in place		Click here to enter text.
Complete, including signature and date (all issues of importance are documented)		Click here to enter text.
Overall Clinical Approach	**RATING***	**COMMENTS**
Patient Centered Care		Click here to enter text.
Seeks consultation when needed		Click here to enter text.
Clinical knowledge base		Click here to enter text.
Professionalism with patients and staff		Click here to enter text.
Appropriate application of guidelines and protocols		Click here to enter text.
Critical Thinking Skills		Click here to enter text.
Average rating (goal 2-3)		Click here to enter text.

Supervisor Comments & Follow Up Action Items:

Staff Comments & Follow Up Action Items:

Staff Self-Assessment
In which areas can your supervisor assist you in acquiring more training, education, or experience? Which areas would you like to improve upon?

Click here to enter text.		Click here to enter a date.
Supervisor Name	**Supervisor Signature**	**Date**
Click here to enter text.		Click here to enter a date.
Staff Name	**Staff Signature**	**Date**

Instructions for filing the review
• After the review is completed and signed by both the supervisor and the staff member, the original document should be maintained in the supervisor's educational file protected under CQIP file. • The information collected from the clinical oversight nursing form will be used for periodic and annual supervisory evalutions (PDPs). • If there is a concerning trend that needs attention, it is recommended that the Health Services Manager, Nurse Manager and the Chief Nursing Officer are notified of the performance improvement plan.

Competency Skills Reassessment Checklist to be completed by staff and supervisor as needed to maintain and monitor competency. Any items that are noted below *competent* require action to move staff member to competency level.

Assessment Key: A
C= Competent, requires little or no supervision
N= Need assistance, requires moderate supervision
Z= Zero experience, requires close supervision

Method of Instruction Key: MOI
P=Procedure Review
E=Education Session
S=Self Learning Package
C=Clinical Practice
D=Demonstration

Method of Evaluation Key: MOE
O=Observation (clinical Setting)
RD= Return Demonstration
T= Written Test
VR= Verbal Review

Computerized records and software	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	A	MOE	Date	MOI	Date
Setting up Outlook ***Checklist***							
DOC Mail Messages							
DOCSharePoint							
OMNI-HS/Clinical Dashboard - *appointments, encounters, referrals; review queue,consults, census*							
CIPS - *order status, allergies, refills, medication reports/MARs*							
Public disclosure							
HIPAA in Corrections							
Infection Prevention	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	

	A	Date	MOI	Date	Intls	Date	MOE
Identify risk factors for infection transmission ***Checklist***							
Isolation precaution/types - *verbalize types of isolation*							
* Gown/gloves/mask - *verbalize/demonstrate application, removal, and disposal*							
Hand washing technique - *demonstrate, verbalize frequency and rationale*							
Aseptic technique - *describe/demonstrate*							
Sterile technique - *describe/demonstrate, gloves, field*							
Disposal of sharps, equipment							
BBP - *describe exposure risks, preventative measures, disposal of contaminated materials (red bag)*							
Biohazardous material -							
PPD/Administer/Read/Documentation							
Documentation and OMNI HS							

Emergency Response	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Understands the Emergency Response Nursing Protocols and Policy DOC 890.620							
Radio training/radio check/Emergency Response Questions ***Checklist***							
Red Bag - *contents & utilization* ***Checklist***							
* medication module - *Epi-pen, glucagon, Narcan, ASA, nitroglycerin*							
* use of adjunct airways - *verbalize/demonstrate on mannequin*							
* Ambu-bag - *verbalize/demonstrate on mannequin*							
* identify contents and location, verbalize usage							
AED-*using trainer, demonstrate pad placement and utilization* ***Checklist***							
C-collar/backboard - *verbalize/demonstrate* ***Checklist***							
Activate EMS 911 - *verbalize process*							
OMNI HS Emergency Encounter/Consult - *additional documentation to be completed PER, 13-440*							

EKG	**Self-Assessment**	**Supervisor Assessment**	**Action Plan**

	A	Date	MOI	Date	Intls	Date	MOE
Verifies patient identity and practitioner order ***Checklist***							
Provides patient education and obtains consent for procedure							
Patient preparation- *patient removes clothing above the waist, ensure patient warm, comfortable*							
Skin preparation - *dries skin, removal of excess body hair, alcohol wipe at electrode site*							
Power on machine, enter patient data							
Correct application of electrodes - *do not allow electrodes to touch each other (diagram)*							
Apply leads - *ensure appropriate placement, secure*							
Pacemaker - *if pacemaker, select appropriate indicator*							
Acquire rhythm - *check quality/leads, practitioner review, removal of electrodes, educate patient*							
Documentation and OMNI HS							
Vital Signs - *Will demonstrate knowledge, clinical application and ability to obtain vital signs*	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Hand hygiene and gloves donned prior to procedure(s)							
Blood Pressure - will accurately obtain manual blood pressure ***Checklist***							
Identify patient, explain procedure and obtain consent							
Position patient - *sitting, feet flat on floor, arm supported at heart level*							
Appropriate cuff size and placement - *lower cuff edge 1 inch above AC space*							
Apply bell of stethoscope over brachial artery - *do not touch tubing or cuff*							
Inflate cuff to maximum inflation, release slowly - *2-3mm Hg/second*							
Identify systolic reading - *Korotkoff's phase 1, record only even numbers*							
Identify diastolic reading - *Korotkoff's phase 5, record only even numbers*							
Deflate, remove cuff							
Documentation and OMNI HS - *indicate arm used and results*							
Orthostatic blood pressure							
Temperature - will accurately obtain temperature, identify variances							
Determine appropriate method - *axillary, tympanic, oral, temporal*							
Identify normal temperature for method used - *oral 98.6, axillary/forehead lower, tympanic higher*							
Documentation - *indicate method and results*							
Pulse Oximetry - will accurately obtain O2 saturation of hemoglobin; unrealiable in cardiac arrest, severe anemia							

Site selection - *skin warm, good circulation, no injury or amputation*							
Placement - *ensure probe securely placed, circulation not restricted by position/restraints,or BP cuff*							
Documentation - *indicate extremity used and results*							
Pulse- will accurately obtain manual pulse by palpation							
Site selection - *no IV, fistula; circulation not restricted by position/restraints, or BP cuff*							
Position patient- *if sitting bend at 90˚, supine at side or across body*							
Palpate- *place pads of first 3 fingers over radial artery, compress until strong pulse felt,*							
Determine strength, rate and irregularity - *if irregular measure full 60 seconds and note pattern*							
Documentation - *indicate extremity used and results*							
IV skills - *will demonstrate knowledge, clinical application, and correct use of intravenous therapy. Must successfully demonstrate IV start.*	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Short Peripheral Catheter Checklist							
Confirm orders and rationale for IV - *vesicant medication, duration, vein status*							
Checks allergies/name/DOC#							
Educates patient on prescribed therapy and obtains consent							
Appropriate vein selection based on medication, access, contraindications							
Hand hygiene, gloves							
Gather supplies - *flush add-on devices*							
Site preparation, aseptic technique - *verbalize, two attempts per clinician, max 4 attempts/24 hrs*							
Catheter advancement, patency, dressing							
Documentation - *site, catheter gauge/length, attempts, patency, patient response*							
Medication administration - *initial dose*							
Flushing and locking, maintenance - *changing administration sets, aspirate/flush*							
Dressing change - *frequency, technique, TSM q 5-7 days if patent, no redness, warmth*							
Assessment for patency, infection, infiltration - *verbalize findings, intervention, documentation*							
DC IV Site - *verbalize technique, documentation, note catheter intact , location*							
Peripherally Inserted Central Catheter - PICC pending							

Implanted Ports ***pending***								
Changes site, bag, tubing according to INS standards								
Label bags, tubing and sites appropriately								
Compounding - *use of vial adaptors, closed system*								
Immediate use compounding - *provide example, describe technique*								
IV Push -								

LAB -	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Performing Point of Care testing							
* Urinalysis dip ***Checklist***							
* Glucometer ***Checklist***							
* Guaiac FOBT ***Checklist***							
* FIT							
Specific equipment for POC/CLIA waived testing - *iStat, Piccolo,*							
Performing Venapuncture - *verbalize site selection, technique*							
Order of draw - *verbalize order of draw when collecting multiple specimens, explain rationale*							
Transfer specimens/ pipette etc							
Proper Labeling of specimens							
Proper storage of specimens							
Documentation in medical record, required logs							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							
Critical lab values - explain process of notification, internal referral							

Intensive Management Unit (IMU)	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Nursing Assessment of Patient placed in Secure Housing DOC 13-432							
Wellness checks and documentation DOC 05-091							
Restrained Patient Assessment DOC 13-418 Policy 420.250							

Use of Force Nursing Responsibilities							
Medical Risk Evaluation for OC, CS and EID Use DOC 13-473							
Conditions of Confinement DOC 13-393							
Oxygen Therapy Skills	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Set up and administration of O2 via: ***Checklist***							
*Nasal Cannula							
*Mask							
*Non-rebreather mask							
Humidifier -							
Oxygen Tank - *regulator, Grab 'n' Go,*							
Concentrator - *max L/min, continuous/pulse flow*							
Maintenance - Δ *cannula q 2 weeks, tubing q 30 days or prn*							
Assess patient oxygenation - *pulse oximetry, color, respirations*							
Incentive Spirometry - *patient education, rationale, demonstration*							
Nebulizer - *single/dual therapy, patient education, rationale, demonstration*							
Documentation - *provide/verbalize example of documentation in medical record, treatment record*							
Respiratory Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Assesses respiratory rate, rhythm, depth, symmetry, and recognizes abnormal findings ***Checklist***							
Auscultation - *anterior/posterior, pattern, diaphragm vs. bell*							
Recognizes abnormal breath sounds - *identify breath sounds and verbalize significance of findings*							
* Rhonchi - *Loud, low-pitched, ↑*w/*expiration; - fluid/mucus*							
* Crackles - *fine, medium, course; common in bases, not cleared w/coughing*							
* Wheezes - *high-pitched, usually louder w/expiration, narrowed/obstructed bronchus*							
* Absent/decreased - *obstruction, pneumothorax, pleural effusion*							

Productive - *cough, sputum, nasal discharge*							
Documentation - *provide/verbalize example of documentation of assessment* in medical record							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Cardiac Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify auscultatory areas - *refer to guide* ***Checklist***							
S1 - *mitral,* S2 - *pulmonic, murmurs*							
JVD assessment - *HOB 30-45˚*							
Capillary refill assessment in seconds							
Carotid artery palpataion/auscultation - *sitting, lying, use bell,*							
Palpate and measure peripheral pulses according to the 1-4 +scale							
Assess for pitting edema - *1-4+ scale, 5 seconds - indicate location*							
Recognizes age-specific normal vital signs							
Identify indicators of cardiac output - *LOC, U/O, HR, P, BP, skin temp and color*							
Assesses pain using a rating scale and non-verbal findings specific to the patients age							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

GI-Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for gastrointestinal assessment - *intake, elimination, infection, injury* ***Checklist***							
Verbalize rationale for following steps of assessment							
Inspection - *note incisions, scars, distention, discoloration, symmetry*							
Identify the abdominal quadrants and underlying organs - *in relation to s/sx*							
Auscultate bowel sounds - *all quadrants, hyper, hypo, absent, identify differential dx*							
* Diaphragm- *normal, high-pitched, friction rub*							
* Bell - *bruits(turbulence)*							
Percussion- *tympany, resonance, dullness*							
Palpate - *recognizes rigidity, tenderness, guarding, light to deep, McBurney's*							

Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

GU Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for genitourinary assessment - *alteration in elimination, infection, injury* ***Checklist***							
Identify location for kidneys, bladder - *may be asssessed during GI assessment*							
Palpate right flank at inspiration - *enlargement, pain,*							
Palpate bladder - *pain w/palpation , distention (need to void)*							
Ascertain difficulty/pain voiding, incontinence, hematuria							
Understands causes of hematuria - *infection, trauma,viral illness*							
Differential diagnosis for bladder, kidney and flank pain - *UTI, nephrolithiasis,*							
Ascertain if any discharge, swelling, lesions - *potential STI, trauma*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Musculoskeletal Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for musculoskeletal assessment - *ROM, mobility, self care, fall risk* ***Checklist***							
Ascertain any past/current injuries, surgeries or neurological concerns							
Palpate - *areas of concern, heat, tenderness, swelling, deformity*							
ROM - *observation of patient, identify limitations, restricting movements, dexterity*							
Gait - *mobility, age related, pregnancy related, fall risk*							
Neurological - *loss of sensation, disease process, balance*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Neurological Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE

Identify rationale for neurological assessment - *impact on patient care, self-care* ***Checklist***							
Level of consciousness - *alert, disoriented, lethargic, obtunded, acute confusion*							
* Mood /affect - *appropriate, crying*							
* Language - *communicate appropriately, effectively*							
* Thought process - *logical train of thought, follows direction*							
* Perception- *aware of surroundings/objects*							
Measure pupil size, equality and reaction to light							
Movement - *incorporate with musculoskeletal assessment, consider neurological factors*							
Symmetry- *facial symmetry*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Mental Health Assessment	**Assessment**		**Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Suicide prevention and response							
Identify self-harm/attempted suicide behavior -							
* Assess method/extent of injury - life threatening, *medically stable*							
* Emergent - *CPR/AED, control bleeding, maintain airway, stabilize for transport - 911*							
* Stable - *appropriately treat injuries, do not leave patient alone*							
* COA Admission - *contact MH provider, conditions of confinement*							
* DOC 13-557/556 Close Observation Nursing Assessment/continuing assessment							
Identify 5 risk factors for possible suicide attempt - *past/recent attempt, anniversaries, 1st incarceration*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of changes - *explain method of notification, subsequent documentation*							

MAT/MOUD	**Assessment**		**Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Verbalize understanding of medication assisted treatment within DOC ***Checklist***							
* Opioid addiction as a disease							
* Continuation of violators							
* Induction prior to release							
* Continuation of prisoners (pending)							

Verbalize knowledge of medication options and limitations							
* Buprenorphine							
* Vivitrol							
* Methadone - restrictions							
Medication administration for MAT/MOUD							
Verbalize symptoms of opioid withdrawal							
Verbalize rationale and demonstrate appropriate COWS assessment							
Verbalize symptoms of opioid overdose and appropriate interventions							
Verbalize rationale for providing narcan at release							

Facial Trauma Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for assessment of facial trauma - *emergent risk factors* ***Checklist***							
Facial Anatomy - *skeletal, soft tissue, ocular, dental*							
Primary assessment - ABC's							
* Airway/Breathing - *patent,c-collar/backboard precautions, oxygen, airways (no NG)*							
* Circulation - *perfusion, mental status, radial pulse, control bleeding (neck)*							
* Head trauma - *LOC, C-spine, VS*							
Secondary assessment							
* Eyes - *ocular movement, vision, facial fx, foreign body, injury, orbital fx*							
* Ears - *CSF, battle sign,soft tissue, hearing*							
* Nose - *CSF, fx, septal hematoma*							
* Mouth - *airway, bite, instability, mandibular fx*							
Transport- *injury impact on stabilization and transport*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Orthopedic Injury Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for assessment of orthopedic injuries/emergencies - *limb threatening injuries, Cspine*							
Primary assessment - ABC's ***Checklist***							
* Airway/Breathing - *patent,c-collar/backboard precautions, oxygen, airways (no NG)*							
* Circulation - *perfusion, mental status, radial pulse, hemorrhage, pulseless limb, impingement*							

* Head trauma - *LOC, C-spine, VS*							
Secondary assessment - *focused*							
* Inspection - *bleeding, deformity, abrasions, skin changes*							
* Palpate - *for tenderness, crepitus, swelling*							
* Neurovascular - *assess for compromise, parathesias, ↓pulses, weakness, symmetry, cap refill*							
* Mobility/ROM - *limitations, fracture, sprain,*							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							
Interventions - *transport, admission, splint/stabilize, sling*							
Transport- *injury impact on stabilization and transport*							

Integumentary/Skin Assessment	**Self-Assessment**		**Supervisor Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Identify rationale for skin assessment - *disease process, nutrition, circulation, injury* ***Checklist***							
Identify risk factors - *mobility, nasal cannula, trach, catheter, dressings, cast/splint , medication*							
Inspect/palpate -							
* Changes in pigmentation - *erythema, pallor, cyanosis, jaundice*							
* Temperature - *use back of hand, equal temperature - hyper/hypothermia*							
* Moisture - *perspiration, excess moisture in skin folds, maceration*							
* Dryness - *dehydration, cracked, xerosis,*							
* Thickness - *uniformity, callus, thin/shiny*							
* Edema - *swelling, unilateral/bilateral, anasarca*							
* Mobility/Turgor - *elasticity, tenting*							
* Bruising - *location, stage(s), color, pain*							
Nails - *linear streaks, bands, hemorrhages, thick/brittle, clubbing, refill 1-2 seconds*							
Identify changes associated with aging							
Documentation - *provide/verbalize example of documentation of assessment in medical record*							
Notify practitioner of any abnormal findings - *explain method of notification, subsequent documentation*							

Communication Skills	**Assessment**		**Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE

Demonstrates effective interpersonal communication skills - *verbal and written*							
Demonstrates effective conflict resolution - *lowest level between staff*							
Demonstrates effective communication with nursing supervision							
Demonstrates effective communication with other disciplines							
Demonstrates effective and professional communication with patients							

Leadership Skills	**Assessment**		**Assessment**			**Action Plan**	
	A	Date	MOI	Date	Intls	Date	MOE
Verbalizes understanding of leadership role and responsibilities							
Demonstrates appropriate delegation of tasks/responsibilities							
Completes monthly supervisory conferences on all staff supervised							
Completes annual evaluations on all staff supervised							
Demonstrates integrity in leadership							

Signature/Initials

Evaluator/Initials