

WAHIAWA GENERAL HOSPITAL

PROFESSIONAL PROFILE

Print Name and Level: \_\_\_\_\_

1. Past unit assignment(s) \_\_\_\_\_

Position as:      \_\_\_ Staff Nurse      \_\_\_ Head Nurse      \_\_\_ LPN (LVN)  
                         \_\_\_ Other (Please specify): \_\_\_\_\_

2. Last Employment: \_\_\_\_\_

3. Total Nursing Experience: \_\_\_\_\_

\_\_\_ Less than 6 months                      \_\_\_ 1-5 years  
\_\_\_ 6 months to 1 year                      \_\_\_ 6 or more years

4. What was your usual patient assignment (number): \_\_\_\_\_

The following pages contain lists of tasks/interventions which are common in nursing. It is important for us to know if you are, or are not, familiar with a task/intervention so that we can provide the most relevant orientation possible. Please use the rating scale as noted on the pages.

PLEASE REFER TO THE RATING SCALE BELOW AS YOU ANSWER THE QUESTIONS:

- 0: No familiarity at all with the task/intervention.
- 1: Class, lab and/or self-instructional program experience only.
- 2: Practice in clinical setting with supervision only.
- 3: Performed competently in the past, but now need reteaching/supervision.
- 4: Completely comfortable with task/intervention. Need no help.

	<u>SCALE</u>
1. ASSESSING NUTRITIONAL NEEDS AND ASSISTING PATIENTS ON THE FOLLOWING REGIMES TO OBTAIN OPTIMAL NUTRITION:	
a. Food restricted diets (e.g., low sodium, ADA)	0 1 2 3 4
b. Fluid restricted diets	0 1 2 3 4
c. Tube feedings (NG tubes):	
1) Assessing tube placement	0 1 2 3 4
2) Aspiration precautions	0 1 2 3 4
d. Tube feedings (gastrostomy tubes)	0 1 2 3 4
e. Measurement of accurate intake and output	0 1 2 3 4
2. ASSESSING A PATIENT'S OUTPUT AND INTERVENING TO MAINTAIN SATISFACTORY ELIMINATION AND TOTAL BODY BALANCE:	
a. Assessment and management of gastrointestinal output:	
1) Insertion of NG tube	0 1 2 3 4
2) Auscultation for bowel sounds	0 1 2 3 4
3) Enema administration	0 1 2 3 4
4) Care of patient with colostomy:	
a) Irrigation	0 1 2 3 4
b) Colostomy equipment	0 1 2 3 4
5) Care of patient with gastrostomy	0 1 2 3 4
6) Care of patient with ileostomy:	
-- Ileostomy equipment	0 1 2 3 4
7) Care of patient with a sump tube:	
a) Irrigation	0 1 2 3 4
b) Use of the air vent	0 1 2 3 4
c) Intermittent suction	0 1 2 3 4

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SCALE

- |                                                                                           |   |   |   |   |   |
|-------------------------------------------------------------------------------------------|---|---|---|---|---|
| 8) Care of the patient with a T-tube                                                      | 0 | 1 | 2 | 3 | 4 |
| 9) Care of the patient with a Jackson Pratt/Hemovac                                       | 0 | 1 | 2 | 3 | 4 |
| 10) Care of the patient with a jejunostomy tube                                           | 0 | 1 | 2 | 3 | 4 |
| 11) Use of a rectal tube                                                                  | 0 | 1 | 2 | 3 | 4 |
| b. Assessment of the genitourinary output:                                                |   |   |   |   |   |
| 1) Insertion of a bladder catheter:                                                       |   |   |   |   |   |
| a) Male                                                                                   | 0 | 1 | 2 | 3 | 4 |
| b) Female                                                                                 | 0 | 1 | 2 | 3 | 4 |
| 2) Care of a patient with a foley catheter:                                               |   |   |   |   |   |
| a) Intermittent irrigation                                                                | 0 | 1 | 2 | 3 | 4 |
| b) Continuous irrigation                                                                  | 0 | 1 | 2 | 3 | 4 |
| 3) Application and care of a condom catheter                                              | 0 | 1 | 2 | 3 | 4 |
| 4) Palpation for bladder distention                                                       | 0 | 1 | 2 | 3 | 4 |
| 3. SPECIMEN COLLECTION AND DIAGNOSTIC PROCEDURES WITH ACCURATE INTERPRETATION OF RESULTS: |   |   |   |   |   |
| a. Culture collection:                                                                    |   |   |   |   |   |
| 1) Urine (clean voided)                                                                   | 0 | 1 | 2 | 3 | 4 |
| 2) Urine (catheterized)                                                                   | 0 | 1 | 2 | 3 | 4 |
| 3) Urine (foley needle aspirant)                                                          | 0 | 1 | 2 | 3 | 4 |
| 4) Wound                                                                                  | 0 | 1 | 2 | 3 | 4 |
| 5) Throat                                                                                 | 0 | 1 | 2 | 3 | 4 |
| 6) Sputum (routine)                                                                       | 0 | 1 | 2 | 3 | 4 |
| 7) Sputum (tracheal aspirate)                                                             | 0 | 1 | 2 | 3 | 4 |

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b. Specimen testing:	
1) Urine (chemstrip)	0 1 2 3 4
2) Bedside glucose	0 1 2 3 4
3) Hemocult	0 1 2 3 4
4. MONITORING THE FOLLOWING TYPES OF PHYSIOLOGICAL PARAMETERS:	
a. TPR/BP	0 1 2 3 4
b. Neurologic and coma scale	0 1 2 3 4
c. Hemodynamic status	0 1 2 3 4
d. Estimation of blood loss	0 1 2 3 4
e. Orthostatic vitals	0 1 2 3 4
f. Fluid and electrolyte balance	0 1 2 3 4
g. Paradoxical blood pressure	0 1 2 3 4
h. Basic cardiac arrhythmia interpretation	0 1 2 3 4
5. PARENTERAL FLUID ADMINISTRATION:	
a. Starting IV's	0 1 2 3 4
b. Care and maintenance of:	
1) Peripheral IV lines	0 1 2 3 4
2) Central IV lines	0 1 2 3 4
c. Maintain and monitor multiple IV lines	0 1 2 3 4
d. Calculation of IV rates	0 1 2 3 4
e. Monitoring the patient receiving blood and blood products	0 1 2 3 4
f. Administer albumin	0 1 2 3 4
g. Maintain and monitor TPN	0 1 2 3 4

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	<u>SCALE</u>				
	0	1	2	3	4
h. Familiarity with different IV solutions (e.g., D5W, lactated ringer's)	0	1	2	3	4
i. Infusion pumps (please indicate which):					
1) Volume controllers	0	1	2	3	4
2) Use of filters	0	1	2	3	4
3) PCA	0	1	2	3	4
4) Other (please specify):	0	1	2	3	4
6. ASSISTING PATIENTS TO MAINTAIN OPTIMUM MOBILITY:					
a. Range of motion exercises	0	1	2	3	4
b. Turning/positioning	0	1	2	3	4
c. Bed to chair	0	1	2	3	4
d. Turn, cough, deep breathe	0	1	2	3	4
e. Maintenance of good body mechanics	0	1	2	3	4
f. Other (please specify): _____	0	1	2	3	4
7. ASSISTING PATIENTS WITH THE FOLLOWING DAILY HYGIENIC PROCEDURES:					
a. Nails, skin, hair	0	1	2	3	4
b. Mouth:					
--- Special mouth care (i.e., the comatose or intubated patient, etc.)	0	1	2	3	4
c. Perineal care	0	1	2	3	4
d. Diabetic foot care	0	1	2	3	4
e. Decubitus prevention	0	1	2	3	4
8. PREVENTION OF NOSOCOMIAL INFECTIONS AND PREVENTION OF THE SPREAD OF INFECTION:					
a. Aseptic technique	0	1	2	3	4

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b. Isolation technique:	
1) Universal precaution	0 1 2 3 4
2) Category specific	0 1 2 3 4
9. RESPIRATORY CARE:	
a. Chest physiotherapy	0 1 2 3 4
b. Airway insertion	0 1 2 3 4
c. Care of the patient with an endotracheal tube	0 1 2 3 4
d. Care of the patient with a tracheostomy	0 1 2 3 4
e. Suction:	
1) Nasopharyngeal	0 1 2 3 4
2) In-line	0 1 2 3 4
3) Tracheal	0 1 2 3 4
f. Care of the patient with chest tubes (closed drainage):	
--- Closed drainage system	0 1 2 3 4
g. Care of the patient on a ventilator*	0 1 2 3 4
h. Care of the patient on:*	
1) Positive End Expiratory Pressure (PEEP)	0 1 2 3 4
2) Continuous Positive Airway Pressure (CPAP)	0 1 2 3 4
3) Intermittent Mandatory Ventilation (IMV)	0 1 2 3 4
i. Oxygen delivery via:	
1) Mask	0 1 2 3 4
2) Venti-Mask	0 1 2 3 4

\*CCU RN's only

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3) Nasal prongs	0	1	2	3	4
4) One-Way valve and mask	0	1	2	3	4
5) Ambu bag	0	1	2	3	4
10. NURSING PROCESS:-					
a. Data collection, assessment and analysis, and documentation	0	1	2	3	4
b. Planning of nursing care:					
1) Nursing orders/action	0	1	2	3	4
2) Referral process/discharge planning	0	1	2	3	4
3) Patient education	0	1	2	3	4
c. Implementation of care plan	0	1	2	3	4
d. Evaluation of interventions	0	1	2	3	4
11. PROFESSIONAL RESPONSIBILITIES:					
a. Report giving	0	1	2	3	4
b. Charge:					
1) Days	0	1	2	3	4
2) Evenings	0	1	2	3	4
3) Nights	0	1	2	3	4
c. Transcribing and implementing orders	0	1	2	3	4
d. Participating in the orientation of new personnel	0	1	2	3	4
e. Supervising and instructing ancillary personnel	0	1	2	3	4
f. Communication with physicians	0	1	2	3	4

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12. METHOD OF PATIENT CARE DELIVERY:

SCALE

a. Modular (team) nursing:

- 1) Member 0 1 2 3 4
- 2) Leader 0 1 2 3 4

b. Primary nursing (please describe): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. MEDICATION ADMINISTRATION:

- a. By mouth (PO) 0 1 2 3 4
- b. Sublingual (SL) 0 1 2 3 4
- c. Intramuscular (IM) 0 1 2 3 4
- d. Topical 0 1 2 3 4
- e. Z-tract 0 1 2 3 4
- f. Subcutaneous 0 1 2 3 4
- g. Rectal (R) 0 1 2 3 4
- h. Nebulization 0 1 2 3 4
- i. IV medication:
  - 1) IV bolus 0 1 2 3 4
  - 2) Saline lock 0 1 2 3 4
  - 3) Piggy-back 0 1 2 3 4
- j. Pharmaceutical system:
  - 1) Unit dose 0 1 2 3 4
  - 2) Floor stock 0 1 2 3 4
  - 3) Performed as "medication nurse" 0 1 2 3 4

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SCALE

- k. Observation and documentation of response to medication 0 1 2 3 4
- l. Accountability for controlled substance 0 1 2 3 4

What is the greatest number of patients you have administered medication to at one time? \_\_\_\_\_

What is the average number of patients to whom you have delivered medications? \_\_\_\_\_

14. SPECIAL EQUIPMENT:

- a. Cardiac monitor/defibrillator 0 1 2 3 4
- b. Pacemakers:
  - 1) External 0 1 2 3 4
  - 2) Transvenous 0 1 2 3 4
- c. Hypothermia blanket 0 1 2 3 4
- d. Bed scale (specify): \_\_\_\_\_ 0 1 2 3 4
- e. Anti-thrombolytic boots 0 1 2 3 4
- f. Non-invasive BP machine 0 1 2 3 4
- g. 12-Lead EKG 0 1 2 3 4
- h. Others (please specify): \_\_\_\_\_ 0 1 2 3 4
- i. Pulse Oximeter 0 1 2 3 4
- j. Patient Lifts 0 1 2 3 4
- k. Fetal monitor 0 1 2 3 4
- l. Computer 0 1 2 3 4

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15. ASSISTING PHYSICIAN:

SCALE

- |                                       |   |   |   |   |   |
|---------------------------------------|---|---|---|---|---|
| a. Pelvic exam                        | 0 | 1 | 2 | 3 | 4 |
| b. PAP smear                          | 0 | 1 | 2 | 3 | 4 |
| c. Chest tube insertion/thoracentesis | 0 | 1 | 2 | 3 | 4 |
| d. Spinal tap                         | 0 | 1 | 2 | 3 | 4 |
| e. Central line insertion             | 0 | 1 | 2 | 3 | 4 |
| f. Swan-Ganz catheter*                | 0 | 1 | 2 | 3 | 4 |
| g. Arterial line*                     | 0 | 1 | 2 | 3 | 4 |
| h. Pacing catheter*                   | 0 | 1 | 2 | 3 | 4 |
| i. Suturing                           | 0 | 1 | 2 | 3 | 4 |
| j. Casting                            | 0 | 1 | 2 | 3 | 4 |
| k. Bone marrow aspiration             | 0 | 1 | 2 | 3 | 4 |

16. ORTHOPEDIC EQUIPMENT AND CARE:

- |                                               |   |   |   |   |   |
|-----------------------------------------------|---|---|---|---|---|
| a. Use of crutches                            | 0 | 1 | 2 | 3 | 4 |
| b. Use of walker                              | 0 | 1 | 2 | 3 | 4 |
| c. Care of a patient in traction              | 0 | 1 | 2 | 3 | 4 |
| d. Care of the patient in cast                | 0 | 1 | 2 | 3 | 4 |
| e. Care of the patient in balanced suspension | 0 | 1 | 2 | 3 | 4 |
| f. Care of the patient with pillow suspension | 0 | 1 | 2 | 3 | 4 |

17. CARDIOPULMONARY RESUSCITATION (According to American Heart Association standards and guidelines):

- |                                 |   |   |   |   |   |
|---------------------------------|---|---|---|---|---|
| a. Maintenance of patent airway | 0 | 1 | 2 | 3 | 4 |
| b. Compression                  | 0 | 1 | 2 | 3 | 4 |

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SCALE

c. Defibrillation 0 1 2 3 4

d. Other definitive care (e.g., drugs): \_\_\_\_\_  
\_\_\_\_\_ 0 1 2 3 4

18. DEATHS:

a. Post-mortem care 0 1 2 3 4

b. Others (please specify): \_\_\_\_\_  
\_\_\_\_\_ 0 1 2 3 4

APPLICANT'S STATEMENT:

I attest to the validity of my level of competency in the above skills as rated by me. I also acknowledge my responsibility for obtaining appropriate instructions prior to performing any activity with which I am not familiar or have not actually performed.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

WAHIAWA GENERAL HOSPITAL  
**WORK PREFERENCE**  
(WGH-OFC-350)

\_\_\_\_\_  
PRINT NAME AND LEVEL

It is understood that:

1. All regular part-time, part-time and call-in employees shall be required to be available for at least two (2) different shifts. However, consideration will be given to requests for permanent night shift assignments.
2. Whenever possible, consistent with patient needs, the work preference expressed on this form will be given every consideration, but cannot be guaranteed.
3. Preferences expressed on this form shall not be construed as a guarantee of work hours per day or per week or number of work days per week.
4. Regular part-time and part-time employees will be pre-scheduled as needed, based upon full-time employees' work schedules. They may also be called on a PRN basis.
5. Call-in employees are generally not pre-scheduled. However, during the preparation of work schedules, if it is known that part-time staff will not be available and availabilities of call-in staff known, the call-in staff may be pre-scheduled.
6. Call-in employees are expected to be available at least one work shift per week including one weekend out of four. If a call-in is not available for work for four consecutive weeks, he/she will be considered to have terminated employment unless prior notification for non-availability is submitted to the nursing office in writing. Non-availability will not exceed (30) thirty days at any given time or frequency of more than every four months.  
EXCEPTION: Long term disability, including pregnancy.

MY WORK PREFERENCE IS AS FOLLOWS:

STATUS:  Regular Part-time                       Part-time                       Call-in  
SHIFT:  7-3:30                                       3-11:30                       11-7:30

NO. OF DAYS PER WEEK: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

NOTE:

1. Changes in availability may be requested thru Nursing Office.
2. Providing operational needs can be met, employee preference will be given consideration by bargaining unit seniority, but cannot be guaranteed.
3. Questions and/or concerns about work schedules are to be directed to the Nursing Office.

_____ Manager Signature
_____ Title and Date

\_\_\_\_\_  
Employee Signature & Level: (RN, LPN, NA)

\_\_\_\_\_  
Date