

WAHIAWA GENERAL HOSPITAL

NURSES AIDE PROFILE

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

The following questionnaire is designed to provide us with an assessment of your orientation needs. It consists of a series of nursing tasks or interventions with which you may or may not currently be familiar.

What we would like to know is the following: What is your level of familiarity or experience with each tasks?

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

Position as:     \_\_\_Nurses Aide

                  \_\_\_Other (please specify): \_\_\_\_\_

2. Date of 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 list 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. There are no right or wrong answers, or right or wrong levels.

A scale is provided that describes the various levels of familiarity/experience. For each of the items in the following pages, please circle the one level that best describes your current level of experience for the task provided. Please use the rating scale as noted on the pages and make any comments as necessary.

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

- 0: No familiarity at all with the task/intervention.
- 1: Practice in clinical setting with supervision only.
- 2: Performed competently in the past, but now need reteaching/supervision.
- 3: Completely comfortable with task/intervention. Need no help.

	<u>SCALE</u>
12. SPECIAL EQUIPMENT: (Set up, Use, Clean)	
a. Ice Bags	0 1 2 3
b. K-Pads (aqueous thermal pads)	0 1 2 3
c. Air-Fluidize Beds (clinitron, flexicare)	0 1 2 3
d. Pressure Relieving Mattress (Geomat)	0 1 2 3
e. Patient Bed/Upright Scale	0 1 2 3
f. Patient Lifter	0 1 2 3
g. Patient Roller	0 1 2 3
h. Intermittent/Continuous Suction Machines (e.g., Gomco)	0 1 2 3
13. REPORTING OF:	
a. Unsafe Conditions	0 1 2 3
b. Broken/Malfunctioning Equipment	0 1 2 3
14. GENERAL INFORMATION:	
-- What has been the average number of patients to who you were assigned to give care in an eight hour shift? _____	
15. COMMUNICATION WITH:	
a. Patients:	
1) Hearing Impaired	0 1 2 3
2) Visually Impaired	0 1 2 3
3) Cognitively Impaired	0 1 2 3
b. Healthcare Team:	
1) Shift Report	0 1 2 3
2) Reporting Abnormal Signs and Symptoms	0 1 2 3
3) Chain of Command	0 1 2 3
4) Abuse of Patients	0 1 2 3
5) Telephone Etiquette	0 1 2 3

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	<u>SCALE</u>
1. ASSISTING WITH NUTRITIONAL NEEDS OF PATIENTS TO OBTAIN OPTIMAL NUTRITION:	
a. Accurate intake and output	0 1 2 3
b. Checking special diet trays (e.g., low sodium, diabetic)	0 1 2 3
c. Fluid restricted diets	0 1 2 3
d. PM/HS snacks	0 1 2 3
2. ASSISTING RN/LPN WITH PATIENT'S OUTPUT AND INTERVENTION TO MAINTAIN SATISFACTORY ELIMINATION AND TOTAL BODY BALANCE:	
a. Enema:	
1) Tap water	0 1 2 3
2) Soap suds	0 1 2 3
3) "Fleet"	0 1 2 3
4) Oil retention	0 1 2 3
b. Care of Patient with Colostomy:	
--- Colostomy care	0 1 2 3
c. Rectal Tube	0 1 2 3
d. Care of Patient with Foley	
1) Taping	0 1 2 3
2) Catheter care	0 1 2 3
3) Measuring out from foley bag	0 1 2 3
e. Application of Condom Catheter/Skin Care	0 1 2 3
f. Blood Loss Measurement	
--- Hemovac	0 1 2 3
g. Use of Adult Incontinent Briefs	0 1 2 3
h. Use of Disposable Bed Liners (blue pads/chux)	0 1 2 3

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SCALE

3. SPECIMEN COLLECTION AND DIAGNOSTIC PROCEDURES:

a. Special Collection:

- 1) Urine (clean catch/mid-stream voided) 0 1 2 3
- 2) Urine (catheter) with needle 0 1 2 3
- 3) Sputum (routine) 0 1 2 3
- 4) Stool 0 1 2 3
- 5) 24 hours urine collection 0 1 2 3
- 6) Other (please specify): \_\_\_\_\_ 0 1 2 3

b. Special Testing:

- 1) 3-glass cycle 0 1 2 3
- 2) Other (please specify): \_\_\_\_\_ 0 1 2 3

4. MONITORING:

a. TPR:

- 1) Radial pulse 0 1 2 3
- 2) Apical pulse 0 1 2 3

b. Blood Pressure:

- 1) Lying 0 1 2 3
- 2) Sitting 0 1 2 3
- 3) Standing (orthostatic blood pressure) 0 1 2 3

5. ASSISTING PATIENTS TO MAINTAIN OPTIMUM MOBILITY:

- a. Range of Motion Exercises 0 1 2 3
- b. Turning/Positioning 0 1 2 3
- c. Transfer from Bed to Chair and Back 0 1 2 3
- d. Use of Gait Belt 0 1 2 3
- e. Ambulation 0 1 2 3

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	<u>SCALE</u>
f. Use of Walker	0 1 2 3
g. Patient Transport:	
1) By wheelchair	0 1 2 3
2) By stretcher	0 1 2 3
h. Other (please specify): _____	0 1 2 3
 6. ASSISTING PATIENTS WITH THE FOLLOWING DAILY HYGIENIC PROCEDURES:	
a. Nail Care	0 1 2 3
b. Skin	
1) Bed bath	0 1 2 3
2) Tub bath	0 1 2 3
3) Use of shower chair	0 1 2 3
4) Shower patients who are supine (e.g., bird bath)	0 1 2 3
c. Hair (shampoo)	0 1 2 3
d. Mouth:	
1) Brushing patient's teeth	0 1 2 3
2) Care of dentures	0 1 2 3
e. Perineal Care	0 1 2 3
f. Douche	0 1 2 3
g. Sitz Bath	0 1 2 3
h. Other (please specify): _____	0 1 2 3
 7. SAFETY:	
a. Aspiration Precautions	0 1 2 3
b. Skin Precautions	0 1 2 3
c. Seizure Precautions	0 1 2 3
d. Fall Precautions	0 1 2 3

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SCALE

e. Suicide Precautions	0	1	2	3
f. Patient Use of Restraints:				
1) Wrist/vest/belt/mitten	0	1	2	3
2) Wheelchair/pelvic	0	1	2	3
3) Crib nets	0	1	2	3
4) Bed alarm	0	1	2	3
5) Use of positioning devices (i.e., wedges)	0	1	2	3
6) Side rails	0	1	2	3
g. Staff Performance Safety:				
1) Turning and repositioning patient	0	1	2	3
2) Transfer patient from bed to chair and back	0	1	2	3
3) Proper body mechanics	0	1	2	3
4) Evacuation of patients	0	1	2	3
h. Others (please specify): _____	0	1	2	3
8. CARE OF PATIENT WITH:				
a. IV/Saline Lock	0	1	2	3
b. Fracture/Cast	0	1	2	3
c. NG / G Tubes	0	1	2	3
d. Telemetry Monitoring	0	1	2	3
e. Tracheostomy	0	1	2	3
CARE OF PEDIATRIC PATIENT:				
a. Taking Weight	0	1	2	3
b. Emotional care such as play, offering comfort measures for family	0	1	2	3
c. Prosthesis (i.e., hearing aid, artificial limbs)	0	1	2	3
d. Others (please specify): _____	0	1	2	3

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	<u>SCALE</u>			
	0	1	2	3
9. POST-MORTEM CARE	0	1	2	3
10. PREVENTION OF THE SPREAD OF INFECTION:				
a. Strict Isolation:				
1) Admission	0	1	2	3
2) Care of patient in strict isolation	0	1	2	3
3) Discharge	0	1	2	3
4) Transportation out of unit	0	1	2	3
b. Protective Isolation:				
1) Admission	0	1	2	3
2) Care of patient in protective isolation	0	1	2	3
3) Discharge	0	1	2	3
4) Transportation out of unit	0	1	2	3
c. Respiratory Isolation:				
1) Admission	0	1	2	3
2) Care of patient in respiratory isolation	0	1	2	3
3) Discharge	0	1	2	3
4) Transportation out of unit	0	1	2	3
d. Contact Isolation:				
1) Admission	0	1	2	3
2) Care of patient in contact isolation	0	1	2	3
3) Discharge	0	1	2	3
4) Transportation out of unit	0	1	2	3
11. RESPIRATORY CARE:				
a. Set-up O <sub>2</sub> /Suctioning	0	1	2	3
b. Use of Portable O <sub>2</sub> Tanks	0	1	2	3

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SCALE

c. Documentation:

1) TPR Graphics	0	1	2	3
2) ADL (as applicable)	0	1	2	3
3) Kardex (weights in kgms/lbs)	0	1	2	3
4) Incident Reports	0	1	2	3

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: \_\_\_\_\_

CURRENT CERTIFICATIONS

Please list any current certifications which you have earned (e.g., ANA specialty specification, AACN certification, AHA-CPR certification, etc.)

<u>Certification</u>	<u>Organization</u>	<u>Date of Last Certification or Recertification</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. Basic Life Support	_____	_____
6. Advanced Life Support	_____	_____
7. Instructor - BLS	_____	_____
8. Instructor/Trainer: BLS-Heart Association	_____	_____

Please list any additional behavior/skill which you bring to your role which has not been listed above but which you feel is important to nursing practice:

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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/Date: \_\_\_\_\_

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

\_\_\_\_\_  
Date