WEST COAST NURSING Home Health Agency

West Coast Nursing Ventura, Inc.

2955 E. Hillcrest Dr. Ste.121 Thousand Oaks, CA 91362 Tel: (805) 496-0900 Fax: (805) 496-0906
Website: www.wcnventura.com Email: wcnv@wcnventura.com

Employee Name: ______________________________

Dear Applicant,

Please bring with you the following at the time of interview:

☐ Professional License	Expires: ________	☐ Confidentiality Form	☐ Resume
☐ Auto Insurance	Expires: ________	☐ Abuse Form	☐ Application
☐ C.P.R	Expires: ________	☐ Hepatitis B Form	☐ I-9 Form
☐ Drivers License	Expires: ________	☐ W4 form	☐ Job Description
☐ Physical Exam	Expires: ________	☐ Universal Precautions	☐ Safety in the community
☐ TB Test	Expires: ________	☐ Social Security Card	☐ Driver license or ID card
☐ Prof. Liability Ins.	Expires: ________	☐ Bag technique	☐ 3 References
☐ U.S Passport or Birth Certificate, Green Card or Naturalization Certificate			☐ Conflict of Interest

Reviewed on: ______________________________

Reviewed by: ______________________________

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(Pre-Employment Questionnaire) (An Equal Opportunity Employer)

PERSONAL INFORMATION

Date: ______________

Name: ______________________________ SSN# ______________

Present Address: ______________________________

Permanent Address: ______________________________

Phone No: ______________ Are you 18 years or older? ☐ Yes ☐ No

Are you either a U.S. Citizen or an Alien Authorized to Work in the United States? ☐ Yes ☐ No

EMPLOYMENT DESIRED

Position: ______________ Date Available: ______________ Salary Desired: ______________

Are you currently employer? ______________ If yes, may we inquire of your present employer? ______________

Ever applied to this company before? ______________ Where? ______________ When? ______________

Referred By: ______________________________

EDUCATION	NAME AND LOCATION OF SCHOOL	NO. OF YEARS ATTENDED	YEAR GRADUATED	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL

Certification and License: ______________________________

____

Languages Spoken: ______________________________

Special Skills: ______________________________

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN OF ITS MEMBERS.

U.S. MILITARY OR NAVAL SEVICE ______________ RANK ______________ PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES ______________

** The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age.**

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE FMONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
From To				
From To				
From To				
From To				

WHICH OF THESE JOBS DID YOU LIKE BEST? ______________________

WHAT DID YOU LIKE MOST ABOUT THIS JOB? ______________________

REFERENCES: GIVE THE NAMES OF THREE PERSON NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	PHONE NO.	YEARS ACQUAINTED
1			
2			
3			

IN CASE OF EMERGENCY, A PERSON TO CONTACT

NAME	ADDRESS	PHONE NO.	RELATIONSHIP
1		Home ______ Work	
1		Home ______ Work	

"I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL".

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE. AND RELEASE ALL PARTIES FROMALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM FURNISHING SAME TO YOU.

I UNDERSTAND AND AGREE THAT, IF HIRED, MY EMPLOYMENT IS FOR NO DEFINITE PERIOD AND MAY, REGARDLESS OF THE DATE OF PAYMENT OF MY WAGES AND SALARY, BE TERMINATED AT ANYTIME WITHOUT PRIOR NOTICE AND WITHOUT CAUSE.

SIGNATURE: ______________________ Date: ______________

DO NOT WRITE BELOW THIS LINE

INTERVIEW BY: ______________________ DATE: ______________

REMARKS: ______________________

NEATNESS: ______________________ ABILITY: ______________

HIRED: ______________ POSITION: ______________ DEPT. ______________

SALARY/WAGE OFFERED: ______________ DATE REPORTING TO WORK ______________

APPROVED	1 GENERAL MANAGER	2 DIRECTOR OF PATIENT CARE	3 ADMINISTRATOR

This form has been designed to strictly comply with State and Federal fair employment practice laws prohibiting employment discrimination. This application for employment form is to be used for West Coast Nursing Ventura, Inc.

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Date: ____________________

Attn: ____ Tel: ____________________

____ Fax: ____________________

Name of Company

____

Address

____

City State Zip Code

RE: ☐ Request for Information/ Reference

Please release the information requested on this form under my authorization. Thankyou.

____

Signature of applicant

________________________ ,SS# ________________________ is applying for a position with our organization

The applicant states he/she was employed with you as a ________________________ We would appreciate your answering the following questions to help us evaluate this person's qualifications.The information you provide will be held in confidence.

REQUESTED PERSONNEL INFORMATION

Position Held: ________________________ Employment Dates: ______________ to ______________

Eligible for rehire? ☐ Yes ☐ No If No, please explain: ________________________________

____

____

	Above Average	Average	Below Average		Above Average	Average	Below Average
Job Knowledge	(☐)	(☐)	(☐)	Attitude	(☐)	(☐)	(☐)
Quality of Work	(☐)	(☐)	(☐)	Character	(☐)	(☐)	(☐)
Appearance	(☐)	(☐)	(☐)	Emotional Maturity	(☐)	(☐)	(☐)
Attendance	(☐)	(☐)	(☐)	Initiative	(☐)	(☐)	(☐)
Cooperation	(☐)	(☐)	(☐)	Dependability	(☐)	(☐)	(☐)
Interpersonal	(☐)	(☐)	(☐)	Judgement	(☐)	(☐)	(☐)
Relationships	(☐)	(☐)	(☐)				

Comments: ____

____

Signature: ________________________ Title: ____________________ Date: ______________

Job Title/Position: Registered Nurse (RN)

Reports To: Clinical Supervisor

JOB DESCRIPTION SUMMARY

The registered nurse plans, organizes and directs home care services and is experienced in nursing, with emphasis on community health education/experience. The professional nurse builds from the resources of the community to plan and direct services to meet the needs of individuals and families within their homes and communities.

ESSENTIAL JOB FUNCTI ONS/RESPONSIBILITIES

Patient Care

1. Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es).
2. Regularly re-evaluates patient nursing needs.
3. Initiates the plan of care and makes necessary revisions as patient status and needs change.
4. Uses health assessment data to determine nursing diagnosis.
5. Develops a care plan, which establishes goals based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions.Includes the patient and the family in the planning process.
6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician.
7. Counsels the patient and family in meeting nursing and related needs.
8. Provides health care instructions to the patient as appropriate per assessment and plan of care.
9. Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient.
10. Acts as Case Manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned case load.

Communication

1. Prepares clinical notes and updates the primary physician when necessary and at least every sixty days.

Job Title/Position: Registered Nurse (RN)

2. Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required.

3. Communicates with community health related persons to coordinate the care plan.

Additional Duties

1. Participates in on-call duties as defined by the on-call policy.

2. Ensures that arrangements for equipment and other necessary items and services are available.

3. Instructs, supervises and evaluates home health aide care provided every two (2) weeks.

POSITION QUALIFICATIONS

1. Graduate of an accredited school of nursing. One to two years of recent acute care experience in an institutional setting.

2. Current licensure in State, CPR certification and valid drivers license.

3. Bachelor's degree, with one year of home health care experience preferred.

4. Management experience not required. Responsible for supervising home health aides.

5. Excellent observation, verbal and written communication skills, problem solving skills, basic math skills; nursing skills per competency checklist.

6. Prolonged or considerable walking or standing. Able to lift, position or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling or crouching. Visual acuity and hearing to perform required nursing skill.

Employee Name: ____

Employee Signature: ______________________________________ Date: _____________________

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Interview Worksheet

Name: ______________________ Date: ____________

Position Applying For: ______________________ Position Offer: ____________

Skill / Experiences:

Geographic Area / Availability:

Mon	Tue	Wed	Thu	Fri	Sat	Sun
☐	☐	☐	☐	☐	☐	☐

Appearance / People Skill:

Remark / Recommendation:

Interview By: ______________________ Date of Interview: ____________

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CONFIDENTIALITY STATEMENT

I have been formally instructed in maintaining the confidentiality of the medical records and I understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency, (except as needed to conduct the business of the day.) I understand that no medical records are to be removed from the home health agency, unless a "release of information" form has been completed and signed by the patient. It is my understanding that such discussion or release of information is cause for dismissal.

Employee Signature: ______________________________ Date: ____________

Name: ______________________________

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Subject: **Universal Precautions**

Purpose: To promote a safe working environment for patients and staff and decrease the potential for exposure to communicable and infection disease process.

Policy: Agency staff will assume that every direct contact with Blood and body fluids are to be considered potentially infectious material. Potentially infectious materials include:

- Blood
- Body fluids such as semen, vaginal secretions, pleural fluid, synovial fluid, pericardial fluid, amniotic fluid, saliva in dental procedures and any other fluid visibly contaminated with blood.
- Tissues . organs
- HIV and HBV cultures.

Note: Other body substances, including feces, urine and vomitus are not included unless contain visible blood.

Procedure:

1. Gloves must be worn at all times when direct contact with the blood or other potentially infectious body fluids is likely to occur (i.e. urine, stool, suctioning, or performing invasive procedures or treatments).

2. Mask or protective eye wear may be worn if possibility of aerosolization or spattering of blood or body fluids is considered likely to occur. Such attire is not required for routine patient care.

3. Gowns, aprons and other protective clothing may be required when: *Aerosolization or spattering of blood or other body fluids is considered likely to occur.

4. Good hand washing techniques must be practice before and after use of gloves or when hand and skin surfaces have been contaminated with blood or body fluids.
   NOTE: The use of gloves does not preclude the necessity of hand washing.

5. Needles will be disposed of in a puncture proof, leak resistant sharp container.
   - Sharps containers are not to be overfilled
   - Sharps containers will be disposed of according to OSHA guidelines.

6. Sharps container must be closable, puncture proof and leak resistant on sides and bottom of container.

7. Resuscitation bags and pocket masks will be accessible and will be provided and used by agency personnel.

8. Infectious waste from invasive procedures (i.e., dressing changes, and Foley changes) will be double bagged and may discarded in regular trash.

REMINDER PROTECT YOURSELF

Health care workers whose jobs involve contact with patients or with blood or other body fluid from patients should take precautions to avoid exposure to hepatitis B virus, human immunodeficiency virus, the virus that causes AIDS, and other blood borne pathogens. While there is no evidence to suggest that HBV or AIDS virus is transmitted at work through casual contact, such as, eating meals in common lunch room facilities or with common eating utensils, breathing the same air, sharing bathroom and drinking fountain facilities, using the same telephone and other office or work equipment or supplies, there is a risk of infection if exposed to infected blood or blood components or other body fluids.

Historically, Home Health Agencies have followed the Centers for Disease Control Recommendations for Prevention's of HIV Transmission in Health Care Setting. In addition, the Occupational Safety and Health Association (OSHA) has issued its Final Standard on Blood borne Pathogens requiring written occupational exposure - control procedures for health care workers. Because of the increased prevalence of AIDS, there is an increased risk that health care workers will be exposed to blood or body fluids from infected patients.

Although the risk of infection is remote, the health and safety of employees will be protected by the following precautions, which are required of all employees.

All employees are required to follow the following OSHA mandated procedures in the care of all patients.

- All employees will routinely use appropriate protective clothing to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient that is anticipated.
- Gloves should be worn for to uching blood and body fluids, mucous membranes, or non intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, for performing venipuncture and other vascular access procedures, and giving injections.
- Gloves will be changed after contact with each patient.
- Masks or protective eye wear or face shields will be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes.
- Impervious gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids
- Hands and other skin surfaces will be washed immediately and thoroughly if contaminated with blood or other body fluids.
- Hands will be washed immediately after gloves are removed.
- All health care workers will take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures: when cleaning used instruments: during disposal of used needles, and when handling sharp instruments after procedures.
- Disposable syringes and needles, scalpel blades, and other sharp items will be placed in puncture resistant containers for disposal.
- Registered Nurses giving injections to patients must carry a sharp container. It must not be left at the patient's home.
- Contaminated needles and other contaminated sharps will not be bent, recapped, or removed except as noted below.
- Worker, you should immediately contact your supervisor/ or the Director of Patient Care Services.

I have read and understand the information outlined on Universa l Precautions.

_______________________________________ _______________

Supervisor Signature Date

_______________________________________ _______________

Employee Name Witness

REPORTING OF CHILD, DEPENDENT, ADULT AND/OR DEVELOPMENTALLY DISABLED ABUSE

Please read the following and then acknowledge that you have done so by signing this form in the space provided, The Statement concerns your duty under the law to report instances of dependent adult abuse and developmentally disabled abuse that come to your attention in your professional capacity. the agency will be happy to provide you with more information about the reporting requirements and assist you in reporting any known abusive situation, should it be required.
California Welfare and Institution Code Section 15632, requires Home Health Agencies to provide 'dependent child / adult care custodians" and "health practitioners" who are employees as of January 1, 1986, (both continuing and new employees), with the following statement.The legal definition of "care custodians' includes all employed of a hospital. California Law requires that this statement be signed as prerequisite to employment to be retained by the home health agency.

In summary : Section 15630 of the Welfare and Institution Code, requires any child care custodians, health practitioner, or employee of an adult protective services agency or a local law enforcement agency who has knowledge of or observes a dependent adult in his or her professional capacity or within the scope of his or her employment who he or she knows has been a victim of physical abuse, or who has injuries under circumstances which are consistent with abuse where the dependent adult's statement indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse had occurred, to report the known or suspected instance of physical abuse to the adult protective services or a local law enforcement agency immediately or as soon as practically possible by telephone and to prepare and send a written report ther of within 36 hours of receiving the information concerning the incident.

In summary: Section 11166 of the Penal Code, requires any child care custodian, medical practitioner , non-medical practitioner, or employee of a child protective agency who has knowledge of or observed a child in his or her professional capacity or within the scope of his/her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.
I understand the Dependent Adult Abuse and Child Abuse reporting requirements and will comply with them.

Supervisor Signature ______________________ Date ______________

Employee Name ______________________

BAG TECHNIQUE

POLICY

All staff who visit multiple patients, take equipment and supplies from patient to patient, and provide direct patient care will practice bag technique.

PURPOSE

To establish basic practices of infection control for caregivers who transport and use equipment and supplies with multiple patients.

SPECIAL INSTRUCTIONS

1. Place the bag on a clean, solid surface. Placing the bag on a barrier is preferable to avoid contaminating the outside of the bag. Do not place the bag on stuffed furniture or at a level where children or pets can gain access to the bag.Never place the bag on the floor.

2. Select material that will be used to discard contaminated disposable equipment, such as a paper or plastic bag.

3. Wash hands using the soap and paper towels in your bag. It is best to use your own soap and towels unless the patient has paper towels for your use.Do not use a cloth towel unless the patient has one for your use only.

4. After washing your hands, you may enter the bag and take out equipment needed for the visit. Place the equipment on a barrier, such as a clean paper towel.

5. During the visit, discard dirty disposable equipment into the paper or plastic bag. If there is an unusually large and/or contaminated dressing, another bag will be needed for double bagging as a precaution.

6. When the visit is completed, clean the used equipment, such as the stethoscope, and wash your hands before replacing the equipment in the bag.Never re-enter the bag unless you have washed your hands.

7. Close the bag and leave it in a clean area until you leave the home.

REMINDERS

Keep the bag out of sight when traveling in the car.

Do not leave the bag in the car at the end of the day. Extremes in temperature may damage some equipment.

Avoid bringing the bag into particularly dirty or insect-infested homes.Instead, prepare a small bag with the specific equipment you will need and a container for your cleaned equipment.

Use the patient's equipment as much as possible.

Signature: ______________________ Date: ______________

Name: ______________________

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Safety In The Community

- All Agency Personnel, Including Contract Personnel, shall be provided with photo identification (ID) name tags with first names only. All field personnel entering the Patient's home should be wearing WCNV Identification name tag.

- All field staff should communicate their visit schedules to the clinical supervisor or designated personnel as early as the day they are scheduled to visit patients.

- When driving, keep purses, cellular telephones and other valuable items on the floor, not on the passenger seat.

- Only those items that are crucial for the tasks of the particular day should be on the staff member's person.

- Before exiting the automobile, the immediate area should be surveyed to make sure there is no one around that might cause personal harm. Should staff members feel at all uneasy, they should not exit the automobile. The employee should drive to a safe area that has a telephone or use their cellular telephone, and call West Coast Nursing, Inc. office as well as the police to request an escort if necessary.

- Car doors should always be kept locked when driving and when exiting the automobile.

- Car should be parked facing the street in a well-lit area as close to the patient's home. escape routes for the patient and the employee should be identified.

- Information about potentially unsafe patient residences, i.e. animals in the home, history of violence, substance abuse, gang violence, should be documented in the patient's record and communicated to all health care team members.Staff will be provided with an escort, i.e. law enforcement, when necessary.

- Any, and all unsafe situations are to be reported to administration.

Clinicians Signature: ______________________________

Clinicians Name: ______________________________ Date: ______________

HEPATITIS B

DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials I maybe at risk of acquiring hepatitis B virus (HBV) infection.I understand that west Coast Nursing Ventura Inc.will provide to me at no cost to me the Hepatitis B vaccination series.However,I decline hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be risk of acquiring Hepatitis B. a serious disease I also understand that i may change my decision at any-time and may request the vaccine series at a later date.

Employee Name: ____

Title: ____

Employee Signature: ____ Date: ________________

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Conflict of Interest Statement

PURPOSE

To ensure that all organization personnel, as well as members of the Governing Body and advisory boards, adhere to conflict of interest guidelines.

POLICY

West Coast Nursing Ventura, Inc. personnel and Governing Body are expected to disclose and avoid affiliations or situations that may pose an apparent or implied conflict of interest.

PROCEDURES

1. All employees and Governing Body members will sign a conflict of interest document upon employment or appointment indicating that they have read and understood the relevant policies and that they will observe them.
2. All employees and Governing Body members will:
   A. Act in the course of their duties solely in the best interests of the organization without consideration to the interests of any other agency, organization, or association with which they are associated, and refrain from taking part in any transaction where such person(s) do not believe in good faith that they can act with undivided loyalty to West Coast Nursing Ventura, Inc.
   B. Disclose any material, financial, or other beneficial interest to any entity engaged in the delivery of goods or services to the organization or its members.
   C. Disclose any transactions with the organization that would result in any benefit to themselves, their immediate family/caregivers, or any entity in which they hold a significant financial ownership or other interests,and refrain from participation in any action on such matters, except upon approval of the Governing Body after full and frank disclosure.
   D. Refrain from utilizing any inside information as to the business activities of the organization for the benefit of themselves, their immediate families, or any entity with which they may be associated.
   E. Agree to devote their best efforts to the organization and not directly or indirectly be engaged in or connected with any other commercial pursuits whatsoever without written authorization of the organization.
   F. Engage in private practice of a service similar to that provided by the organization within the geographic area serviced by the organization, without the written permission of the Executive Director/Administrator. Persons violating this policy will be subject to probation or termination.
3. Disclosure of a potential employee conflict and the Executive Director/Administrator's decision regarding actions taken will be noted in a log file kept by the Executive Director/Administrator.
4. In the event that a situation arises whereby a member of the Governing Body could use confidential or privileged agency information for personal gain, he/she is obligated to report that potential to the Governing Body.
5. The Governing Body will render a decision of that member's eligibility to be part of voting, if applicable.
6. Disclosure of a potential conflict and the Governing Body's decision regarding voting will be noted in the minutes of the meeting.

I have read and understood the above policy and procedure in regards to conflict of interest.

____ ____________________
Signature Date

____
Employee Name

ADDENDUM 3-002.E

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST

(Registered Nurse)

Key for Evaluation Method

(to be determined by organization):

Verbal Test	=	**V**
Written Test	=	**W**
Observation	=	**O**
Demonstration	=	**D**
Special Training	=	**ST**

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST
REGISTERED NURSE

Name: ____________________

Date of Employment: ____________________ Date Completed: ____________________

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	*		
☐	☐	☐	☐	1. Admission to organization			
☐	☐	☐	☐	a. Initiates assessment form	*		
☐	☐	☐	☐	b. Initiates care plan based on assessment	*		
☐	☐	☐	☐	c. Knowledge of nursing process	*		
☐	☐	☐	☐	d. Health history/physical exam	*		
☐	☐	☐	☐	e. Development of problem list and care planning	*		
☐	☐	☐	☐	f. Conducts complete initial evaluation	*		
☐	☐	☐	☐	2. Transfer of patient	*		
☐	☐	☐	☐	3. Care coordination/discharge planning	*		
☐	☐	☐	☐	a. Care planning	*		
☐	☐	☐	☐	b. Case conference	*		
☐	☐	☐	☐	c. 60 day summary	*		
☐	☐	☐	☐	d. Case management	*		
☐	☐	☐	☐	e. Adheres to POC	*		
☐	☐	☐	☐	f. Reports and documents key information to physician, DC planner, Case Manager, pharmacist, supervisor	*		
☐	☐	☐	☐	g. Coordinates community resources	*		
☐	☐	☐	☐	4. Documentation			
☐	☐	☐	☐	a. Medicare guidelines for documentation	*		

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	b. Corrections to the clinical record	*		
☐	☐	☐	☐	c. Accident/incident reports	*		
☐	☐	☐	☐	d. Clinical notes, flow charts	*		
☐	☐	☐	☐	5. Other			
☐	☐	☐	☐	a. Supervision of ancillary personnel			
☐	☐	☐	☐	b. Supply requisition & management			
☐	☐	☐	☐	**B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:**			
☐	☐	☐	☐	1. Pulmonary System			
☐	☐	☐	☐	a. Pulmonary Assessment			
☐	☐	☐	☐	b. Tracheostomy care			
☐	☐	☐	☐	c. Oxygen administration			
☐	☐	☐	☐	d. Pharyngeal suction			
☐	☐	☐	☐	e. Use of oral/nasal inhalers			
☐	☐	☐	☐	f. Oxymeter			
☐	☐	☐	☐	g. CPAP			
☐	☐	☐	☐	h. Oxygen mask, nasal cannula, concentrator, portable oxygen			
☐	☐	☐	☐	i. Airway insertion			
☐	☐	☐	☐	j. SVN/Nebulizer treatment			
☐	☐	☐	☐	k. Home ventilator management			
☐	☐	☐	☐	l. Foreign body airway obstruction			
☐	☐	☐	☐	m. Breathing exercises/incentive spirometry			
☐	☐	☐	☐	n. Other			
☐	☐	☐	☐	2. Cardiovascular System			
☐	☐	☐	☐	a. Cardiovascular assessment			
☐	☐	☐	☐	b. Pulses (apical, radical, femoral, pedal)			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	c. Edema assessment and management			
☐	☐	☐	☐	d. Supine and orthostatic blood pressure			
☐	☐	☐	☐	e. NTG use, inhaler use			
☐	☐	☐	☐	f. CPR			
☐	☐	☐	☐	g. Energy conservation techniques			
☐	☐	☐	☐	h. Other			
☐	☐	☐	☐	3. Neurologic System			
☐	☐	☐	☐	a. Neurologic assessment			
☐	☐	☐	☐	b. Aphasia care			
☐	☐	☐	☐	c. Mental status exam			
☐	☐	☐	☐	d. Seizure precautions			
☐	☐	☐	☐	e. Spinal cord injuries care			
☐	☐	☐	☐	f. Head injury care			
☐	☐	☐	☐	g. Other			
☐	☐	☐	☐	4. Gastrointestinal System			
☐	☐	☐	☐	a. Gastrointestinal assessment			
☐	☐	☐	☐	b. NG tube insertion/care			
☐	☐	☐	☐	c. Jejunostomy tube caret			
☐	☐	☐	☐	d. Gastrostomy tube care			
☐	☐	☐	☐	e. Enteral feedings			
☐	☐	☐	☐	f. Suction machine(s)			
☐	☐	☐	☐	g. Ostomy care			
☐	☐	☐	☐	h. Dysphagia precautions			
☐	☐	☐	☐	i. Impaction removal			
☐	☐	☐	☐	j. Enema			
☐	☐	☐	☐	k. Bowel training			
☐	☐	☐	☐	l. Other			
☐	☐	☐	☐	5. Genitourinary System			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
☐	☐	☐	☐	a. GU assessment			
☐	☐	☐	☐	b. Urinary catheterization insertion and care (male and female)			
☐	☐	☐	☐	c. Irrigation of catheters			
☐	☐	☐	☐	d. Obtaining specimens			
☐	☐	☐	☐	e. Removal of urinary catheter			
☐	☐	☐	☐	f. Care of supra-pubic catheter			
☐	☐	☐	☐	g. Care of urostomy			
☐	☐	☐	☐	h. Bladder training			
☐	☐	☐	☐	i. Nephrostomy tubes			
☐	☐	☐	☐	j. Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
☐	☐	☐	☐	k. Ileostomy care			
☐	☐	☐	☐	l. Incontinence care			
☐	☐	☐	☐	m. GU post op care			
☐	☐	☐	☐	n. Other			
☐	☐	☐	☐	6. Integumentary/Wounds/Dressings			
☐	☐	☐	☐	a. Assessment of skin/wound			
☐	☐	☐	☐	b. Measurement of wounds			
☐	☐	☐	☐	c. Wound irrigation			
☐	☐	☐	☐	d. Wet to dry dressing(s)			
☐	☐	☐	☐	e. Decubitis care:			
☐	☐	☐	☐	1. Assessment and staging			
☐	☐	☐	☐	2. Prevention			
☐	☐	☐	☐	3. Various treatments (hydrocollid, calcium alginate, transparent films)			
☐	☐	☐	☐	4. Documentation/pictures			
☐	☐	☐	☐	f. Ace wrap,cast care,compresses			
☐	☐	☐	☐	g. Hemovac			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	h. Sterile dressing change			
☐	☐	☐	☐	i. Suture/staple removal			
☐	☐	☐	☐	7. Musculoskeletal System			
☐	☐	☐	☐	a. Assessment			
☐	☐	☐	☐	b. Range of motion (ROM)			
☐	☐	☐	☐	c. TED hose			
☐	☐	☐	☐	d. Total knee care			
☐	☐	☐	☐	e. Total hip care			
☐	☐	☐	☐	f. Cast assessment and care			
☐	☐	☐	☐	g. Devices:			
☐	☐	☐	☐	1. Walker			
☐	☐	☐	☐	2. Wheelchair			
☐	☐	☐	☐	3. Transfer board			
☐	☐	☐	☐	4. Hoyer lift			
☐	☐	☐	☐	h. Pain assessment			
☐	☐	☐	☐	i. Transfers			
☐	☐	☐	☐	j. Other			
☐	☐	☐	☐	8. Pain assessment and management			
☐	☐	☐	☐	a. Conducts pain evaluation which includes location, onset, intensity, duration, alleviating factors	*		
☐	☐	☐	☐	b. Utilizes a pain rating scale to collect data	*		
☐	☐	☐	☐	c. Knowledgeable about types of pain (neuropathic, viseral, bone, smooth muscle, psychologic)	*		
☐	☐	☐	☐	d. Knowledgeable about drug therapies indication and dosing			
☐	☐	☐	☐	1. NSAIDS	*		
☐	☐	☐	☐	2. Steroids	*		
☐	☐	☐	☐	3. Benzodiazipines	*		
☐	☐	☐	☐	4. Tricylic antidepressants	*		

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
☐	☐	☐	☐	5. Anticonvulsants	*		
☐	☐	☐	☐	6. Narcotics	*		
☐	☐	☐	☐	7. Other			
☐	☐	☐	☐	e. Non-pharmacologic methods:	*		
☐	☐	☐	☐	1. Relaxation (guided imagery, meditation, massage)	*		
☐	☐	☐	☐	2. Psychologic (biofeedback, therapy)	*		
☐	☐	☐	☐	3. Neurologic (TENS)	*		
☐	☐	☐	☐	4. Ice/heat	*		
☐	☐	☐	☐	f. Patient/family teaching			
☐	☐	☐	☐	1. Drug use, side effects	*		
☐	☐	☐	☐	2. Management of constipation	*		
☐	☐	☐	☐	3. Addiction vs. tolerance	*		
☐	☐	☐	☐	4. Other			
☐	☐	☐	☐	9. Metabolic			
☐	☐	☐	☐	a. Assessment			
☐	☐	☐	☐	b. Diabetic assessment and teaching			
☐	☐	☐	☐	1. Insulin types and teaching			
☐	☐	☐	☐	2. Use, care and teaching of glucose monitoring system			
☐	☐	☐	☐	3. Diet, exercise and sick day teaching			
☐	☐	☐	☐	4. Signs and symptoms of Hypo-Hyperglycemic reactions			
☐	☐	☐	☐	5. Foot and skin care			
☐	☐	☐	☐	c. Coumadin therapy			
☐	☐	☐	☐	d. Other			
☐	☐	☐	☐	10. Behavioral Assessment			
☐	☐	☐	☐	a. Psychosocial Status			
☐	☐	☐	☐	b. Suicide precautions			
☐	☐	☐	☐	c. Psychotropic drugs			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	d. Care of the demented patient			
☐	☐	☐	☐	e. Other			
☐	☐	☐	☐	11. Miscellaneous Skills			
☐	☐	☐	☐	a. Vital signs			
☐	☐	☐	☐	b. Intake and output			
☐	☐	☐	☐	c. Caring for immuno-compromised patients			
☐	☐	☐	☐	d. eye/ear irrigation			
☐	☐	☐	☐	e. Post mortem care			
☐	☐	☐	☐	f. Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
☐	☐	☐	☐	g. Concepts of death and dying			
☐	☐	☐	☐	1. Normal vs. abnormal	*		
☐	☐	☐	☐	2. Cultural attitudes toward death	*		
☐	☐	☐	☐	3. Values of patient/family	*		
☐	☐	☐	☐	4. Denial and coping mechanisms	*		
☐	☐	☐	☐	5. Grief and family, children and others	*		
☐	☐	☐	☐	6. Anticipatory grief	*		
☐	☐	☐	☐	7. Other			
☐	☐	☐	☐	**C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.**			
☐	☐	☐	☐	1. Medication Administration Techniques			
☐	☐	☐	☐	a. Oral			
☐	☐	☐	☐	b. Intra muscular			
☐	☐	☐	☐	c. Intravenous-bolus/push			
☐	☐	☐	☐	d. Subcutaneous			
☐	☐	☐	☐	e. Total Parenteral Nutrition			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	f. Suppositories			
☐	☐	☐	☐	g. Ear, eye, nose drops			
☐	☐	☐	☐	h. Heparin administration			
☐	☐	☐	☐	i. Insulin administration,site rotation			
☐	☐	☐	☐	j. Assessment for side effects, adverse reactions, therapeutic response			
☐	☐	☐	☐	2. Intravenous Therapy			
☐	☐	☐	☐	a. Technique and care of:			
☐	☐	☐	☐	1. Venipuncture			
☐	☐	☐	☐	2. Butterfly			
☐	☐	☐	☐	3. Over the needle catheter			
☐	☐	☐	☐	4. Regulation of IV flow rate, use of infusion pumps			
☐	☐	☐	☐	b. Other			
☐	☐	☐	☐	3. Central Venous Access Devices			
☐	☐	☐	☐	a. Drawing blood from			
☐	☐	☐	☐	b. Site care			
☐	☐	☐	☐	c. Flushing			
☐	☐	☐	☐	d. Cap change			
☐	☐	☐	☐	e. Needleless system			
☐	☐	☐	☐	f. Other			
☐	☐	☐	☐	**D. Infection Control**			
☐	☐	☐	☐	1. Hand washing technique	*		
☐	☐	☐	☐	2. Aseptic technique	*		
☐	☐	☐	☐	3. Proper bag technique	*		
☐	☐	☐	☐	4. Safe needle technique	*		
☐	☐	☐	☐	5. Personal protective equipment	*		
☐	☐	☐	☐	6. Exposure control plan	*		

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Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
☐	☐	☐	☐	7. TB exposure control plan	*		
☐	☐	☐	☐	8. Reporting of infections for patient and personnel	*		
☐	☐	☐	☐	9. Standard precautions	*		
☐	☐	☐	☐	**E. EquipmentI**			
☐	☐	☐	☐	1. Displays knowledge of the following:			
☐	☐	☐	☐	a. Electric bed			
☐	☐	☐	☐	b. Special beds			
☐	☐	☐	☐	c. Alternating pressure mattress			
☐	☐	☐	☐	d. Infusion pumps			
☐	☐	☐	☐	e. Ambulatory infusion devices			
☐	☐	☐	☐	2. Home Glucose Monitoring:			
☐	☐	☐	☐	a. Verbalizes purpose of test	*		
☐	☐	☐	☐	b. Specimen collection	*		
☐	☐	☐	☐	c. Instrument calibration	*		
☐	☐	☐	☐	d. Quality control process	*		
☐	☐	☐	☐	e. Test correctly performed and interpreted	*		
☐	☐	☐	☐	3. Other			
☐	☐	☐	☐	**F. Safety**			
☐	☐	☐	☐	1. Restraints, indications and policy			
☐	☐	☐	☐	2. Fire extinguishers			
☐	☐	☐	☐	3. Emergency preparedness			
☐	☐	☐	☐	4. Hazardous materials			
☐	☐	☐	☐	5. Assessment of patient safety risks and home safety			
☐	☐	☐	☐	**G. Patient Education**			
☐	☐	☐	☐	1. Determine patient and family learning needs	*		
☐	☐	☐	☐	2. Sets measurable objectives	*		

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
☐	☐	☐	☐	3. Develops/implements teaching plan	*		
☐	☐	☐	☐	4. Evaluates effectiveness of teaching	*		
☐	☐	☐	☐	5. Revises teaching plan based on patient needs	*		
☐	☐	☐	☐	6. Documents response to teaching	*		
☐	☐	☐	☐	7. Provides instruction in the following:			
☐	☐	☐	☐	a. Emergency care	*		
☐	☐	☐	☐	b. Diet and nutrition	*		
☐	☐	☐	☐	c. Medications	*		
☐	☐	☐	☐	1. Route, dosage, frequency, side effects, adverse reactions, safe storage, labeling, indications, drug/food interactions, home monitoring program, therapeutic blood levels	*		
☐	☐	☐	☐	8. Provides instruction about advance directives and patient rights			
☐	☐	☐	☐	9. Other			

Comments:

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Employee Signature ______________________ Date ______________

Supervisor Signature ______________________ Date ______________

Preceptor(s) ______________________ Date ______________

Preceptor(s) ______________________ Date ______________

Preceptor(s) ______________________ Date ______________

2955 E. Hillcrest Dr. Ste.121 Thousand Oaks, CA 91362 Tel: (805) 496-0900 Fax: (805) 496-0906
Website: www.wcnventura.com Email: wcnv@wcnventura.com

Annual Exam Form
To be filled out by Physician

I have examined (Mr. / Mrs. / Ms.) ____________________ ____________________
Last Name First Name

who is applying for the position of ______________________________

and I have found no condition that appears to prevent him / her from performing the duties of the position applied for, with the exception or possible exception of the following:

____

____

Further, I have found no indication of any condition which might represented possible hazard to the health of patients or other employees of this facility .

EXAMINATION

Height: __________ Weight: __________ Blood Pressure: __________

Test	Date Performed	Result
PPD:		
Chest X-RAY		
Hepatitis Vaccine B		

☐ Yes ☐ No The applicant is free from health conditions which would interfere with his/her ability to perform assigned duties.

☐ Yes ☐ No The applicant / employee is free from symptoms of infectious disease.

______________________________ ______________
MD Signature Date:

____
Physicians Name (Please print)

Address: ____
City State Zip

Phone: ____________________

West Coast Nursing Ventura, Inc.

2955 E. Hillcrest Dr. Ste.121 Thousand Oaks, CA 91362 Tel: (805) 496-0900 Fax: (805) 496-0906
Website: www.wcnventura.com Email: wcnv@wcnventura.com

ORIENTATION CHECKLIST

1 ☐ Overall Agency Purpose / Functions
2 ☐ Personnel Information
  ☐ a. Employee Handbook ☐ b. Keys, Name Tag, Business Cards, Staff Roster, Birthday List
3 ☐ Performance Evaluations
4 ☐ Job Description
5 ☐ Organizational Chart
6 ☐ How to Complete Time Cards
7 ☐ Mileage and Expense Reports
8 ☐ Tour of Physical Set-up
9 ☐ Introduction to Staff
10 ☐ Policy Manual
11 ☐ Agency Mission and Philosophy
12 ☐ Agency Image and Marketing
13 ☐ State Licensing Regulations
14 ☐ Medicare Regulations
15 ☐ Forms and Documentation
  ☐ a. SOC Assessment ☐ b. Case Management ☐ c. Discharge
  ☐ d. Recertification ☐ e. Coordination of services
16 ☐ Utilization Review Responsibilities
17 ☐ Employee Ethics
18 ☐ Confidentiality
19 ☐ Infection Control / Safety / Acc. / Inc.
20 ☐ Quality Assurance Responsibilities
21 ☐ Acceptable Abbreviations / Symbols
22 ☐ Office Flow and Billing
23 ☐ Equipment Issued Responsibilities
24 ☐ Nursing Bag Procedure
25 ☐ Case Presentation (optional)
26 ☐ Mediation Policy & Procedure (RN & LVN)

To be completed and signed during orientation.

Employee Signature: ______________________ Date: __________

Director of Professional Services: ______________________ Date: __________