Connecticut Valley Hospital
RN Clinical Orientation Nurse Evaluation

The Division Nurse Supervisor is responsible for ensuring completion of these shift evaluations

<table>
<thead>
<tr>
<th>RN Name: ___________________________ Unit______ Shift: ____ Evaluation # ______</th>
<th>Satisfactory</th>
<th>Needs Improvement</th>
<th>Unsatisfactory</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency RN__     CVH RN____</td>
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</tbody>
</table>

1. Reports to work on time
2. Works with staff to insure that unit assignments are carried out
3. Makes sound Nursing Assessments, i.e., patients at risk for self-harm and/or a danger to others, PRN meds, restraints, seclusion, and other patient care assignments
4. Accurately transcribes MD, PA, APRN orders
5. Administers medications in an accurate and timely manner
6. Documents legibly and according to policies & procedures
7. Provides accurate report to Charge Nurse or on-coming shift
8. Interacts therapeutically with patients
9. Knowledge of policies and procedures evident in practice
10. Presents a professional attitude and appearance
11. Recognizes reportable events and notifies appropriate authority
12. Accepts direction and utilizes supervisory staff as necessary and appropriate

Comments:________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Supervising CVH RN_________________________________________ Date: ___________
Orienting Nurse Signature_______________________________________ Date____________________

**Overall Evaluation**
To be completed as of 10th shift worked during orientation and/or until Competency to assume Charge Nurse Responsibilities is reached.

(Please check one)

- [ ] Competent to assume Charge Nurse responsibilities
- [ ] Competent to assume Staff Nurse responsibilities
- [ ] Continues to require ongoing Supervision to carry out assignments

Shift Supervisor Review – Signature: _________________________________ Date: __________

Original Copy to Divisional Chief of Patient Care Services