General Nursing Orientation

Day 2

RN/GN

Name:_____

Unit/Site: _____

Date: _____

IV Push Skill Demonstration-
RN/GN/RPN/GRPN

Adults: You will be preparing one of the following medications for J.R Smith:

- Order: Furosemide (Lasix) 15 mg IV Push (10 mg/mL ampule)
- Order: Diphenhydramine (Benadryl) 12.5 mg IV push. (50 mg/mL ampule)
- Order: Heparin 750 u IV push (10000 u/10 mL vial)

Pediatrics: Prepare one of the following medications for Jay Green:

- Order: Heparin 250 units IV push – 100 units/mL vial
- Order: Ampicillin 500 mg IV push. Ampicillin vials – reconstitute by adding 10 mL sterile water = 50 mg/mL
- Order: Furosemide 10 mg IV Push (10 mg/mL)

STEPS	Initial	Questions/Concerns
1. Review the order & drug monograph: Can this drug be given IV push?_____ If no, what would you do?_____ Does this medication require dilution? _____ Over how long will you give the drug? _____ What are the monitoring requirements?_____		
2. Calculate the correct amount of medication you will draw up, show your work:		
3. Draw up your medication		
4. Label the medication		
5. Get your partner to do an independent double check of the medication		
6. Demonstrate how you will administer the drug		
7. Discuss documentation		
8. Discuss assessment & follow-up		

REVIEW QUIZ

Administering IV Push/Direct Medications Quiz

1. Which method of administering a medication is not considered to be IV Push/Direct?
   a) medication is given into a Central line over 3 minutes
   b) medication is given into a saline lock
   c) Medication is given through the secondary port of the IV pump
   d) Medication is given through the y-site of the IV tubing

2. The IV Reference Manual is a resource used to: (circle all that apply):
   a) check for therapeutic dose ranges for different ages of the population
   b) check if the drug needs to be diluted before giving
   c) find out information on the recommended monitoring for the drug
   d) find out if the medication is on the Saskatchewan Formulary

3. Your patient is exhibiting respiratory depression. Naloxone (Narcan) is ordered 0.1 mg IV Push (supplied 0.4mg/ml ampule). How many mls will you draw up?
   a) 2.5 mls
   b) 0.025 mls
   c) 0.25 mls
   d) 4 mls

4. True or False (circle the correct answer):

   T F Flush IV line before and after medication administration with 0.9% Sodium Chloride or D5W (NICU) if incompatibilities exist.

   T F When using a Y-site, the flush following medication administration must be delivered at the same rate as the medication injection.

   T F Signs of infection in an IV can include: pain, edema, purulent discharge, fever.

5. What is Speed shock?
   a) medication is given without enough dilutent
   b) medication is given too fast
   c) medication is given too slow
   d) medication is given with too small a syringe causing pressure or "shock"

6. How can you prevent speed shock?
   a) Good hand washing prior to accessing IV
   b) Use appropriate size syringe for medication
   c) Infuse medication and flush at prescribed rate and dilution
   d) Assess IV site for infiltration

7. What is extravasation?
   a) patient has pain in his IV site
   b) patient experiences some pain when medication is infused
   c) vesicant or irritant medication was given
   d) Medication in the subcutaneous tissue that can cause damage to the tissue

8. What is one way nurses can help decrease the chances of extravasation?

a) Use aseptic technique during administration
b) ensure patency and position of IV prior to infusion
c) Change IV site before administering any IV push drug
d) Ensure medication and IV solution are compatible

9. Your patient requires Digoxin by IV push. The order is for 0.0625 mg. Digoxin is supplied in a 0.25mg/ml ampule. How many mls will you draw up?
    a) 4mls
    b) 0.4 mls
    c) 2.5 mls
    d) 0.25 mls

10. It is 0530; you have just received an admission from ER. Your patient has an order for IV antibiotics for an infected wound. His IV won't flush. What is the appropriate next step?

    a) Call Pharmacy and see if they can send the oral form of the antibiotic
    b) Leave it for the next shift to deal with
    c) Discontinue the IV , insert a new one, so the antibiotic can be given IV
    d) Try giving the antibiotic through the IV anyway

REVIEW QUESTIONS

Chemotherapy Drugs (Oral) For Cancer & Non-Cancer Treatment
Chemotherapy Drugs (Injectable) For Non-Cancer Treatment

Name: _____ Site: _____ Unit_____ Date: _____

1. Chemotherapy works by:
   a. damaging a cell's DNA
   b. interfering with a cell's growth and proliferation
   c. not interfering with any healthy, normal cells
   d. suppressing the abnormal autoimmune response
   e. a, b & d
   f. all of the above

2. In which phase of the cell cycle is chemotherapy most effective?
   a. G0
   b. G1
   c. G2
   d. S
   e. all of the above

3. Match these drugs with the related descriptions:

____ Cyclophosphamide	a. higher risk of developing Tumor Lysis Syndrome
____ Mitoxantrone	b. give Leukovorin rescue & vigorous hydration
____ Methotrexate	c. adequate hydration to prevent hemorrhagic cystitis
____ Hydroxyurea	d. cardiac and malignancy screening

4. Drug Calculation:
   Mr Plasma is a 54yr old man with Multiple Myeloma who has been prescribed Melphalan 9mg/m^2 PO once daily x 4 days as part of his chemotherapy regimen. Mr Plasma weighs 85kg and is 180cm tall.

   What is Mr Plasma's BSA(*show calculations*)?

   What is Mr Plasma's Melphalan dose?

   What is Mr Plasma's actual dose being that Melphalan is supplied in 2mg capsules and is rounded to the nearest 2mg?

5. Match these side effects with the related descriptions:

____ Neutropenia	a. protect scalp from cold & sun
____ Thrombocytopenia	b. eat applesauce & bananas
____ Mucositis	c. avoid spicy foods & alcohol; use saline mouthwashes
____ Anorexia	d. Increased caloric and protein supplements
____ Hand-Foot Syndrome	e. prophylactic antiemetics
____ Alopecia	f. may be treated with G-CSF
____ Diarrhea	g. painful burning & tenderness of palms & soles
____ Nausea & Vomiting	h. avoid invasive treatments

6. Match these oncologic emergencies with their symptoms or management:

_____ Septic Shock	a. pathological fractures, muscle weakness, restlessness

_____ Spinal Cord Compression	b. back pain, paralysis, diminished pain sensation
_____ Hypercalcemia	c. allopurinol & sodium bicarbonate; hydration
_____ DIC	d. colloid therapy, antibiotics & oxygen therapy
_____ Tumor Lysis Syndrome	e. spontaneous bleeding & clot formation

7. When administering a liquid chemotherapy drug and disposing of the drug waste you must wear:
   a. nitrile gloves (double)
   b. eye/face protection
   c. impervious cuffed gown
   d. all of the above

8. The liquid chemotherapy you are administering splashes on the floor. Listed are 5 things you should do. Number them in the correct order.

   ___ Contain the spill from the outer edges to the center with absorbent pads.
   ___ Complete Acute Care Safety report and notify MON or Charge Nurse.
   ___ Alert persons in the immediate area. Don't leave the area unattended. Have someone else bring the spill kit.
   ___ Wash & rinse the area well with supplied detergent and water 3 times.
   ___ Don PPE and attend to anyone exposed to the spill.

9. If a chemotherapy agent in intravenous solution remains in the IV bag you should:
   a. drain the solution in the sink and dispose of the IV bag and tubing in the garbage.
   b. drain the solution in the sink and dispose of the IV bag and tubing in the appropriate biohazardous waste container.
   c. leave the solution in the bag and dispose of the IV bag and tubing in the appropriate Chemotherapy Drug Sharps & Fluid Resistant Waste Container.

10. True or False
    T F your patient is receiving chemotherapy drugs and has soiled the linen with urine. You are sending all linen to Central laundry. You should process the linen using strict isolation precautions.

    T F items being returned to SPD should be soaked in bleach first.

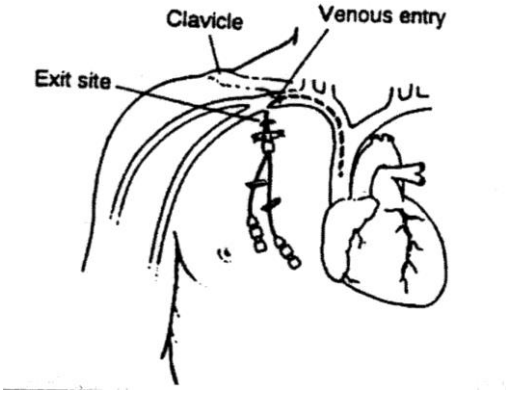
    T F a urine soaked blue pad could be disposed of in the Chemotherapy Drug Soft Sided Waste Container or appropriate Chemotherapy Drug Sharps & Fluid Resistant Waste Container.

    T F a chemotherapy drug has been spilled on your uniform. You should damp sponge the area with a wet facecloth.

11. Body fluid waste precautions will be followed _____hours post infusion of last chemotherapy dose.

Central Venous Catheters Review Quiz

1. **Name that Line:** A central venous catheter (CVC) is a catheter that is inserted or threaded into a large central vein with the tip placed outside the right atrium, usually in the superior vena cava. Match the central venous catheter type with the appropriate description (below) and label pictures:



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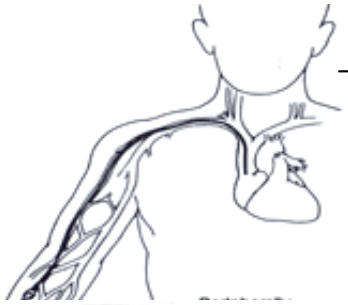

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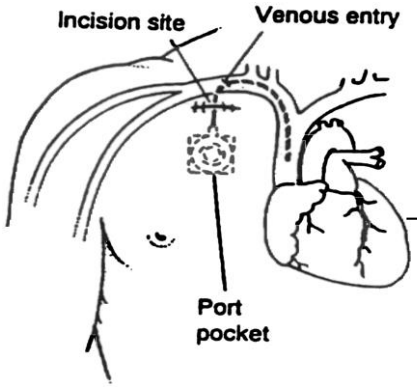

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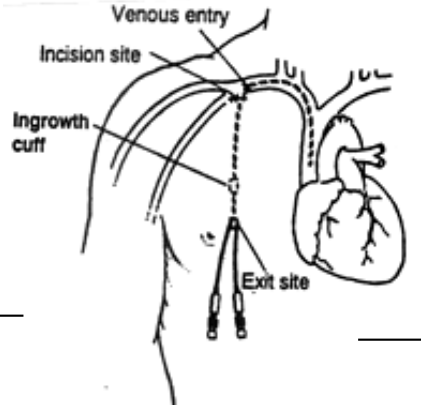


_____

A. Short Term (percutaneous)
B. Tunneled
C. Peripherally Inserted
D. Implanted

____ inserted above the elbow in radiology

____used only in acute care because of the increased risks of accidental removal and infection

____ the port is sutured to underlying tissue to prevent rotation in the subcutaneous pocket

____ a tissue ingrowth cuff on the catheter secures it in the subcutaneous tract

2) The tip of any type of central venous catheter (CVC) is placed in the:
   a. superior vena cava , outside of the right atrium
   b. subclavian vein
   c. internal jugular vein
   d. external jugular vein

3) A CVC is used for the following: (choose all the correct answers)
   a. blood sampling
   b. PN
   c. blood products
   d. emergency resuscitation
   e. arterial blood gases

4) The smallest syringe size used for CVC flushing is:
   a. 3 mL
   b. 5 mL
   c. 10 mL
   d. 20 mL

5) Choose all the correct CVC procedures:
   a. Change needleless adapters every week
   b. Change gauze dressings every 48 hours; transparent dressings every 5-7 days
   c. Change tubing used for Parenteral Nutrition every 24 hours
   d. Place a needleless adapter on all the unused CVC lumens

6) The nurse assesses the CVC for: (choose all the correct answers)
   a. length of CVC visible from exit site
   b. intact dressing
   c. signs of infection at insertion site
   d. signs of pneumothorax

7) Which of these signs or symptoms could indicate a serious complication IMMEDIATELY following insertion of a CVC? (choose all the correct answers)

   a. sharp shoulder pain
   b. sharp chest pain
   c. blurred vision
   d. tachycardia or irregular pulse

8) Appropriate nursing actions for a suspected infected CVC include:
   a. checking patient's temperature
   b. assessing CVC for signs and symptoms of infection (redness, swelling, warmth, purulent drainage)
   c. obtaining blood C&S and swab site for C&S
   d. sending blood for PTT and INR

9) Which of the following is an appropriate nursing action for the management of phlebitis related to a PICC?
   a. apply warm compresses to the PICC insertion site
   b. apply topical steroid cream to arm
   c. apply ice pack to arm
   d. keep arm positioned below the level of the heart

10) The three GREATEST risks for patients with a Short Term central venous catheter are:
    a. hemorrhage, fluid overload, infection
    b. fluid overload, cracked catheter, air embolus
    c. infection, hemorrhage, air embolus
    d. cardiac arrhythmia, hemorrhage, fluid overload

11) Signs and symptoms of venous thrombosis include choose all the correct answers):
    a. swelling of the neck, face, shoulder and arm
    b. mild to moderate neck pain
    c. external jugular distension
    d. labored respiratory effort

12) Any type of central vein catheter (CVC) is flushed using the following technique.
    a. remove cap, attach syringe to line and use positive pressure flush technique, clamp during last portion of flush
    b. cleanse needleless adapter, attach syringe, flush using turbulent start/stop method, clamp during last portion of flush
    c. scrub needleless adapter, attach syringe with normal NS, flush using a turbulent start/stop method, remove syringe and and if needed, flush with Heparin and clamp
    d. attach syringe to needleless adapter, flush with NS and clamp

13) In Adults the following types of Central Venous Catheters are flushed with Sodium Chloride 0.9% and Locked with Heparin Flush Solution (choose all that apply):
    a. PICC lines
    b. Short Term Lines
    c. Tunneled Lines
    d. Implanted Ports

14) In Pediatrics the following types of Central Venous Catheters are flushed with Sodium Chloride 0.9% and locked with Heparin Flush Solution (choose all that apply):
    a. PICC lines
    b. Short Term Lines
    c. Tunneled Lines
    d. Implanted Ports

15) Central Venous Catheters are flushed with a stop and start motion because:
    a. the motion helps prevent infection from developing in the line
    b. the motion helps to prevent catheter occlusion
    c. the motion helps decrease the pressure from building up in the line
    d. the motion helps decrease the side effects of certain medications

16) Describe the needleless adapter (Microclave) as used with the central venous catheters (choose the one right answer):
    a. used on all CVC connections, maintains positive pressure in the line
    b. used on all intermittently accessed CVC lines and provides neutral pressure
    c. used on all PICC lines and provides negative pressure in the line
    d. used on Implanted Ports as they require a specialized needle to access

17) A special non-coring needle is always used:
    a. to draw blood specimens from tunneled central venous catheters
    b. to access an implanted port
    c. by the physician to anaesthetize the patient's skin prior to insertion of a CVC
    d. to flush the distal lumen of a multilumen catheter

18) A client who lives in the community receives chemotherapy through an Implanted port as an out-patient. He is now hospitalized. What can you use his port for? (Choose all that apply).
    a. blood products
    b. blood sampling
    c. IV antibiotics
    d. PN
    e. Chemotherapy

19) Prior to removing a Short Term line the patient should be positioned:
    a. Supine with head of bed flat (as tolerated)
    b. flat with arm at a 90 degree angle to the body
    c. Lying flat or on left side
    d. flat with full sterile drapes

20) Following the Short Term Central Line removal assess site for signs of bleeding:
    a. after 5 minutes then every hour X 2
    b. every 15 minutes X 2 then in 1hour
    c. every 15 minutes X2 then every 30 minutes X 2 then 1 hour later
    d. every 15 minutes X 2 then every 1 hour X 2 then after 2 hours

SMART PUMP REVIEW QUESTIONS

1. When running continuous drug infusions such as Heparin or Insulin, Line B should always be used.

   ☐ True ☐ False

2. If there were concerns of patient tampering, and you want to set the "Lock" on a pump, you would
   - ☐ a. Use toggle switch located at the back of the machine beneath the volume control switch
   - ☐ b. Enter the "numeric code" to enable the lock
   - ☐ c. Note that the only key that will work with it locked is the STOP key and an alarm will sound when it is pushed to remind you the device is locked.
   - ☐ d. All of the above
   - ☐ e. b & c

3. Piggyback infusion will delay Line A and infuse Line B until complete, then Line A takes over.

   ☐ True ☐ False

4. When Pump Pressure alarms appear on the display screen, circle all that apply:
   - ☐ a. Pumps in pediatric areas are defaulted to 2 PSI
   - ☐ b. Pumps in NICU will alarm at 1.4 PSI
   - ☐ c. Pumps in adult units will alarm at 6 PSI
   - ☐ d. Checking the pump pressure is required for pediatrics
   - ☐ e. All of the above

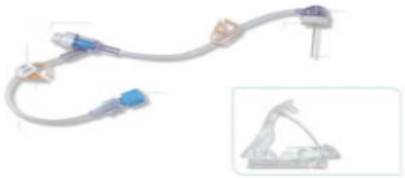
5. Tubing changes should be done every 96 hours:

   ☐ True ☐ False

6. Always perform a visual check of pump settings before leaving the patient's room to prevent accidental double keying errors.

   ☐ True ☐ False

7. Verification of pump settings/independent double checks should be done:
   - ☐ a. at shift change
   - ☐ b. transfer of care
   - ☐ c. When establishing heparin drip
   - ☐ d. When changing insulin orders
   - ☐ e. When administering narcotics
   - ☐ f. All of the above



Insertion of a Gripper Micro needle into an Implanted Port

RNSP Certification Skills Checklist

Demonstrates Proper Technique of the following	Yes	No	Certifier Initials
Insertion of the Gripper Micro			
• Chooses appropriate needle gauge and length for client			
• Prepares client for needle insertion			
• Prepares and flushes set (needle, tubing and needleless adapter)			
• Cleans insertion site with chlorhexidine/alcohol and allows to dry			
• Dons sterile gloves			
• Removes needle guard from needle			
• Inserts Gripper micro needle into the port at a 90° angle			
Removal of the Gripper Micro Inserter			
• From the back of the inserter, places fingers on each side of the inserter, presses tab in and lifts the safety arm straight back to the lock position until audible “click” is heard			
• Disposes of used inserter in a sharps container			
Preparation of the Gripper Micro infusion site			
• Verifies correct placement by aspiration of blood			
• Applies a sterile transparent semi-permeable dressing over the infusion site			
Removal of the Gripper Micro Infusion set			
• Flushes and locks port as appropriate			
• Places fingers on each side of the infusion site and while stabilizing the port with the other hand, lifts the infusion site straight up, discards in sharps container			
• Documents on the procedure and reports any issues to the physician			

Signature of Certifier_____ Date_____

Signature of RN/GN _____ Date _____

Insertion of a Gripper Plus needle into an Implanted Port
RNSP Certification Skills Checklist

Demonstrates Proper Technique of the following	Yes	No	Certifier Initials
Insertion of the Gripper Plus			
• Chooses appropriate needle gauge and length for client			
• Prepares client for needle insertion			
• Prepares and flushes set (needle, tubing and needleless adapter)			
• Cleans insertion site with chlorhexidine/alcohol and allows to dry			
• Dons sterile gloves			
• Removes needle guard from needle			
• Inserts Gripper Plus needle into the port at a 90° angle			
Preparation of the infusion site			
• Verifies correct placement by aspiration of blood			
• Removes and discards safety needle tab			
• Applies a sterile transparent semi-permeable dressing over the infusion site			
Removal of the Gripper Plus Infusion set			
• Flushes and locks port as appropriate			
• Places fingers on each side of the base while gently pressing down to secure portal. From behind the needle, lifts the safety arm straight back to the lock position until audible "click" is heard • Disposes of used needle in sharps container			
• Documents on the procedure and reports any issues to the physician			

Signature of Certifier_____ Date_____
Signature of RN/GN _____ Date _____

Removal of Short Term Line
RNSP Certification Skills Checklist

Demonstrates Proper Technique of the following	Yes	No	Certifier Initials
Checks for Physician order to remove short term catheter			
Gathers supplies			
Completes verification of client identification			
Completes client education of procedure and expectations			
Completes hand hygiene and dons PPE (gloves and mask/face shield)			
Remove dressing			
Clean insertion site with chlorhexidine/alcohol solution			
-- **For sutures**-clean as above before removing sutures			
-- For stabilization device: remove device prior to cleaning as above			
Hold gauze on insertion site and while client exhales gently pull out catheter and put pressure on area until bleeding stops for at least 5 minutes			
When bleeding stops place an occlusive dressing on site			
Check that catheter is intact			
Send tip for C &S if ordered or if there are signs of infection			
Completes checks of patient every 15 x 2, every 30 X 2 and then in one hour			
Documents on the procedure and reports any issues to the physician			

Signature of Certifier_____ Date_____
Signature of RN/GN _____ Date _____

RN/GN Certification Record: RN SPECIALTY PRACTICES

Name:_____ Site:_____ Unit:_____ Date Of Hire:_____

RN PROCEDURE		CERTIFICATION			RECERT		
		Date	Certifier	RN/GN	Date/ Initial	Date/ Initial	Date/ Initial
Cardiac (ECG) Monitoring - Adult	†						
	S						
Cardiac (ECG) Monitoring - Pediatrics	†						
	S						
Catheters – Hemodialysis -Access	†						
	S						
Central Venous Catheters-Implanted Ports – Accessing & Discontinuing Access	†						
	S						
Central Venous Catheters-Short Term – Removal	†						
	S						
Chemotherapy Bladder Instillation - Mitomycin – Assisting with & Care of Pt.	†						
	S						
Chemotherapy Drugs For Cancer Treatment – Admin. & Precautions	†						
	S						
Chemotherapy Drugs (Oral) for Cancer and Non-Cancer Treatment - Administration and Precautions	†						
	S						
Chemotherapy Drugs (Oral, Topical & Subcut) for Cancer Treatment	†						
	S						
Chemotherapy Drugs for Non-Cancer Treatment – Admin. & Precautions	†						
	S						
Cough Assist Therapy	†						
	S						
Endotracheal Tubes – Extubation	†						
	S						
Endotracheal Tubes – Securing, Care of	†						
	S						
Epidural - Catheter Removal	†						
	S						
Epidural/Intrathecal Analgesia – Care of Patients Receiving	†						
	S						
Femoral Arterial Sheath – Removal Post PCI/Angiogram	†						
	S						
Fetal Health Surveillance	†						
	S						

RN PROCEDURE		CERTIFICATION			RECERT		
		Date	Certifier	RN/GN	Date/ Initial	Date/ Initial	Date/ Initial
Gastrostomy Tube (Balloon Type) Adult and Pediatric: Replacement and Removal	t						
	s						
Hemodialysis– Central Venous Catheter – Accessing, Dressings and Blood Withdrawal	t						
	s						
Hemodialysis– Insertion of Access Needles	t						
	s						
Hemodialysis With a Dual Lumen Dialysis Catheter	t						
	s						
Intra-abdominal Pressure Monitoring via Bladder Catheter	t						
	s						
Peripheral Nerve Block (PNB) - Single Dose/ Continuous/Patient Controlled Analgesia - Care of Patient Receiving	t						
	s						
Peripheral Nerve Block (PNB) - Single Dose/ Continuous/Patient Controlled Analgesia - Removal of	t						
	s						
Peritoneal Dialysis	t						
	s						
Pessary Ring Changes	t						
	s						
Suctioning Non-Ventilated Patients with an Endotracheal Tube	t						
	s						
Suctioning Ventilated Patients	t						
	s						
Suprapubic Catheter Change – Established Stoma	t						
	s						
Tracheostomy Tubes – Change-Pediatrics	t						
	s						
Vaginal Examination	t						
	s						
Venipuncture (Phlebotomy)	t						
	s						
Ventilation-Chronic-Care of Mechanically Ventilated-Adult (Advanced RN Intervention)	t						
	s						
Venous Dialysis Catheter – Removal	t						
	s						

t = theory s = skills

Certifier indicates that the RN/GN has successfully completed the Educational Program.

Roche Glucose Meter Post Learning Assessment

Name_____ Employee#_____ Date_____

1. When you use your operator ID to do a glucose test on the meter, it means:

   a. You are responsible and accountable for that result
   b. Your operator ID is tied to that result
   c. If someone else uses your operator ID you are still accountable
   d. All of the above

2. Which statement(s) is/are true concerning the quality control (QC) solutions?

   a. QC should be run once every 24 hours, or if questioning accuracy of patient results
   b. QC ensures the meter is functioning properly
   c. QC should be run if meter dropped or damaged
   d. All of the above
   e. a and b only

3. The testing range of the Accu-Chek Inform II meter is:

   a. 1.2-25.2 mmol/L
   b. 0.6-33.3 mmol/
   c. 0.2-40.0 mmol/L
   d. None of the above

4. Once the test strip is inserted the blood sample is applied:

   a. On top of the test strip in the yellow sample application area
   b. On top of the test strip in the blue application area
   c. To the front edge of the test strip in the yellow sample application area
   d. To the front edge of the strip in the blue sample application area

5. Which of the following affects glucose testing?

   a. galactose
   b. hematocrit <10% or > 65%
   c. ascorbic acid
   d. hydration status
   e. all of the above

TRUE OR FALSE

6. The glucose test strips are not affected by heat or humidity and may be kept near open windows and heating elements. T_____ F_____
7. The test strip must be loaded in the meter before blood can be applied to the strip. T_____ F_____
8. QC solution vials must be dated on opening, as they outdate in 3 months, but test strips are good until the expiry date on the vial. T_____ F_____
9. After piercing the site, the first drop of blood is used for glucose meter testing. T_____ F_____
10. Extremes in Hematocrit (below 10% and above 65% for adults and below 23% and above 58% for neonates) can affect the test results. T_____ F_____

Accu-Chek - Inform II Glucose Meter

TRAINING CHECKLIST

RUH Fax to 306-655-2631

SPH/SCH/LTC/Rural Fax to 306-655-5667

Or scan and email to:**pointofcare@saskatoonhealthregion.ca**

Name-First/Last: Please Print	Site(s) Dept./Unit: list all units worked	Employee Number (ID) : Print Clearly

	YES	NO
1. Presses button to power meter on		
2. Knows how to reset meter		
3. Knows how to check battery status to ensure adequate power		
4. Enters operator/patient ID using manual keypad entry or by scanning barcode		
5. Describes storage requirements and expiration dates of QC vials and test strips		
6. Dates QC vials when opened		
7. Correctly scans test strip barcode and QC Lot info		
8. Correctly prepares the QC solution (mixes vial, wipes vial tip and discards first drop)		
9. Applies quality control testing (QC) solutions to the TIP of Strip. • Keeps meter horizontal, as possible, to prevent port contamination.		
10. Describes corrective action procedure when QC is out of range (add comment)		
11. Simulates patient sample testing: • Describes skin puncture procedure including proper location of puncture site • Use of appropriate lancet device • Use of soap & water to clean patient's hand and dries hand • Wipes away first drop of blood		
13. Identifies critical values and required follow-up action steps per policy		
14. Identifies when to initiate confirmatory laboratory glucose testing per policy		
15. Knows how to view previous patient and QC results		
16. Describes meter cleaning procedure		
17. Understands importance of proper placement of meter in base unit for transfer of Patient/QC data as well as recharging meter battery		
18. Disposes of bio-hazardous material appropriately		
19. Has passed Accu-Chek Inform II Quiz		

Employee Signature: _____ Date: _____

This staff member has successfully demonstrated competency for the Roche Accu-Chek Inform II skills checked above.

Instructor/Super User: (print name):_____ Phone #: _____

Instructor/Super User Signature: _____ Date: _____

Lab Use Only:

Point of Care Review Signature: _____Date: _____