Transition to Nurse Residency Program (TNRP)
Skills Assessment

Resident Name: Preceptor Name:

Program Start Date: Program End Date:

Instructions

Resident Self-assessment
The skills assessment helps to individualize and guide your competency development as a new to practice professional nurse. Read each item, rate your level of independence performing each skill using the rating scale below (0 = no experience; 3 = competent in performing the skill), and write-in the number that best reflects your ability.

Preceptor/Coach/Nursing Professional Development Practitioner/Faculty
Review and discuss the ratings for each of the skills with the nurse resident. Using preferably hands-on patient experiences or high/low fidelity simulation, observe and coach the nurse resident to perform each skill. Rate and initial each skill indicating level of competence. At the end of the TNRP, rate any remaining skills and complete the feedback section. Review ratings and feedback with the resident.

0 = No experience
1 = Limited experience
2 = Performed skill; still needs guidance
3 = Competent in performing the skill
N.A. = Not applicable

Fundamental Skills	Pre-Orientation Assessment (Resident Self-Assessment)		Post-Orientation Assessment (Coach/Preceptor Assessment)	Coach / Preceptor Feedback
Isolation Precautions				
• Handling Soiled Equipment				
• Don and Doff PPE				
Hand Hygiene				
Vital Signs				
Point of Care Tests				
• Glucometer				
Handling Specimens				
Sharps Safety				
Patient Hygiene				

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• Make Bed (with/without patient)				
• Bath				
• Toilet				
• Foley Care				
Ambulate/Transfer Patients				
• Foley Care				
Communication Skills	**Pre-Orientation Assessment (Resident Self-Assessment)**		**Post-Orientation Assessment (Coach/Preceptor Assessment)**	**Coach / Preceptor Feedback**
Communicate with Patients				
• Introduce Self				
• Patient Identification/ Identifiers				
• Verbal/Nonverbal Behaviors				
Patient Education				
• Initiate and Update Plan of Care				
• Set Goals with Patient				
Communicate with Family				
• Communication of Plan of Care				
• Basic End of Life				
Communicate with Staff				
• Shift Report (Handoff)				
• Transfer of Care				
• Delegation				
Communicate with Other Disciplines				
• Report Patient Condition to Provider				
• Call Provider - SBAR				
Phone use & etiquette				
Documentation in EMR				

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Assessment Skills	Pre-Orientation Assessment (Resident Self-Assessment)		Post-Orientation Assessment (Coach/Preceptor Assessment)	Coach / Preceptor Feedback
• Accurate Data Entry (i.e., intake and output)				
• Professional Writing				
Basic Communication with an Escalating Patient/Family				
Situational Awareness				
• Safety/Room Environment				
• Recognize an Escalating Patient/ Family				
• Recognize When to Seek Help				
Room Set-up & Use				
• O2				
• Suction				
• Bed Alarm				
• IV Pump				
• Other				
Recognize Changing Patient Condition				
Physical Assessment				
Systems Assessment (head-to-toe)				
Skin Assessment				
• Wound Care				
Falls Risk				
PIV Site Care				
• Discontinue PIV				
• Sharps Safety				
Medication Administration				
• Topical Medication Application				

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• Oral Medications (P.O.)				
• I.M. and SubQ Injections				
• IV Medications				
• Antibiotic Administration (IV/PO)				
○ On Time				
○ Lab Protocols				
• NG/PEG Tube Medications				
• Insulin Administration				
Policy / Protocols				
Awareness/Location of Organization Policies and Access				
Professional Appearance and Attire				
Chain of Command				