

Vermont Board of Nursing

NURSING PROGRAM MONTHLY REPORT
For Conditioned Licensees

This report is due in the Board Office by the 7th of every month reporting on the licensee's performance for the previous month. Please print and include detail sufficient for review and evaluation of the areas of concern delineated in the Board Order. Specifically note adherence to standards of nursing practice.

Student/Licensee: _____ M _____
(First and Last Name) (Case Number)

Program: _____
(Program Name) (Degree/Certificate)

(Program Address) (Date of Enrollment)

Program Director: _____
(First and Last Name) (Telephone #)

Clinical Faculty/Instructor: _____
(First and Last Name) (Telephone #)

(Credential) (E-mail Address)

This report reflects performance during: _____
Month Year

Indicate the level of supervision provided on every shift worked by the licensee:

_____ **On-site supervision** (Requires monitoring of the licensee's practice by a nurse on the premises of the facility. The individual(s) must understand that they are providing supervision to the licensee and have read their Order).

- _____ **Provided by RN faculty/instructor**
- _____ **Provided by RN preceptor**
- _____ **Other**

_____ **Direct supervision** (Requires that supervision and direction is given by a nurse physically present on the unit. The individual(s) must understand that they are providing supervision to the licensee and have read their Order).

- _____ **Provided by RN faculty/instructor**
- _____ **Provided by RN preceptor**
- _____ **Other**

(Note: The level of supervision necessary for the licensee is identified in the Board Order)

Student/Licensee Name: _____

Date of Report: _____

1. Did the licensee consistently provide patient/resident care according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

2. Did the licensee complete nursing documentation according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

3. Did the licensee obtain and/or carry out physician/APRN orders according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

4. Did the licensee develop and/or follow patient care plans according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

5. Did the licensee complete medication administration according to policy and standards of nursing practice in the last month?

_____ N/A _____ Yes _____ No If No, please describe:

6. Did the licensee communicate with patients/residents according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

7. Did the licensee communicate with colleagues and/or other staff according to policy and standards of nursing practice in the last month?

_____ Yes _____ No If No, please describe:

8. Has this licensee administered medications during the last month?

_____ Yes _____ No If Yes, please note types:

_____ Non-narcotics _____ Controlled drugs _____ Over the counter _____ PRN

Student/Licensee Name: _____

Date of Report: _____

9. Has this licensee made any medication errors in the last month?
_____ Yes _____ No If yes, please describe:

(Also attach copy of error/incident report.)

10. Have there been any controlled drug count discrepancies this past month where this licensee was or might have been involved?
_____ Yes _____ No If Yes, please describe:

11. Has this licensee made any errors in practice, judgment or decision making in the last month?
_____ Yes _____ No If Yes, please describe:

(Also attach copy of error/incident report.)

12. Have any patient/family complaints about this licensee been received in the last month?
_____ Yes _____ No If Yes, please describe:

13. Has this licensee received any clinical performance improvement feedback in the last month?
_____ Yes _____ No If Yes, please describe:

14. Has this licensee had a clinical evaluation in the last month?
_____ Yes _____ No If Yes, please describe:

(Also attach copy of the clinical evaluation.)

15. During the past month how many hours did this licensee attend clinical each week?

Week 1 _____ Week 2 _____ Week 3 _____ Week 4 _____

Student/Licensee Name: _____

Date of Report: _____

16. On which shift(s) did the licensee attend clinical?

Day ____ Evening ____ Night ____

17. Has this licensee successfully completed the required classroom content in the last month?

____ Yes ____ No If No, please describe:

18. Please describe the licensee's classroom performance:

19. Please discuss any attendance problems (classroom and/or clinical) in the last month:

20. Please describe improvements in practice observed in the last month:

21. Additional comments, questions, or problems:

Signature of Program Director

____/____/____
Date

Signature of Clinical Faculty/Instructor

____/____/____
Date

Thank you for your commitment to this licensee and to the protection of the public.

Please submit this evaluation form by the 7th of every month to the Board of Nursing Office

Fax: 802-828-2484

E-mail: sandy.swenson@sec.state.vt.us

Mail: Vermont Board of Nursing, National Life Building – North, FL2, Montpelier, VT 05620
(Attention: Sandy Swenson)