

Employee Name: _____

Date of Report: _____

1. Did the employee 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 employee complete nursing documentation according to policy and standards of nursing practice in the last month?
_____ Yes _____ No If No, please describe:

3. Did the employee 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 employee 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 employee 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 employee 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 employee 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 employee administered medications during the last month? If so, what types of medication were given? (e.g., non-narcotics, narcotics, etc.)

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

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9. Has this employee 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 employee was or might have been involved?
_____ Yes _____ No If Yes, please describe:

11. Has this employee 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 employee been received in the last month?
_____ Yes _____ No If Yes, please describe:

13. Has this employee received any performance counseling in the last month?
_____ Yes _____ No If Yes, please describe:

(Also attach copy of the performance counseling documentation.)

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

(Also attach copy of the performance evaluation.)

15. During the past month how many hours did this employee work each week?

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

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16. On which shift(s) did the licensee work? Day _____ Evening _____ Night _____

17. Please discuss any attendance problems in the last month:

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

19. Additional comments, questions, or problems:

Signature of Nursing Supervisor

____/____/____
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)