

## **Clinical Performance Evaluation (CPE) Student Checklist**

This checklist is designed to help you understand the expectations for each skill demonstration. Use it to guide your practice and ensure you're following proper procedures before performing the skill in front of an evaluator.

### **Medication Administration – Medication Room**

- Hand Hygiene (HH) In – Perform hand hygiene upon entering the medication room.
- Check Orders – Verify physician's orders for accuracy and completeness.
- Clean Medication Drawer – Wipe down surfaces before accessing medications.
- Apply Gloves – Wear gloves as needed for medication preparation.
- Second Medication Check – Perform a second check of the medication against the MAR.
- Hand Hygiene (HH) Out – Remove gloves (if used) and perform hand hygiene before leaving.
- Label Medications – Ensure all medications are properly labeled before transport.

### **Medication Administration – Patient Room**

- Hand Hygiene (HH) In – Perform hand hygiene before entering the patient's room.
- Introduction – Introduce yourself and explain the purpose of the visit.
- Identify the Patient – Use two patient identifiers (name, DOB, wristband).
- AIDET – Follow the AIDET framework (Acknowledge, Introduce, Duration, Explanation, Thank You).
- Assess Allergies – Confirm medication and cleaning agent allergies with the patient.
- Scan Patient – Scan the patient's wristband to verify identity.
- Third Medication Check – Perform a final check before administration.
- Clean Equipment – Sanitize any equipment that will be used.
- Teach Medication – Explain the medication name, purpose, and side effects to the patient.
- Teach Procedure – Explain any necessary steps involved in administration.
- Fall Bundle – Ensure patient safety measures are in place (bed low, call light, non-slip socks, etc.).
- Administer Medication – Follow proper administration protocols.
- Document Medication – Record the administration in the MAR.
- Document Procedure – Note any additional procedures performed.
- Document Assessment – Include patient response and any necessary follow-up.
- Hand Hygiene (HH) Out – Perform hand hygiene before leaving the room.
- Demonstrate Human Caring – Show respect, empathy, and professionalism throughout.
- Professional Role – Maintain professional communication and demeanor.

## **Injection Administration**

- Clean Medication Vial – Wipe the vial stopper with alcohol before drawing medication.
- Prepare Medication – Draw up the correct dose.
- Select Correct Syringe & Needle Size – Choose the appropriate gauge and length.
- Prepare Medication – Draw up the correct dose.
- Hand Hygiene/ Don Gloves – Perform hand hygiene before preparing the injection.
- Scan Medication – Scan the barcode for verification.
- Select Injection Correct Site – Intramuscular, Subcutaneous
- Assess Injection Site – Inspect for redness, swelling, or contraindications.
- Clean Injection Site – Use alcohol swab in a circular motion.
- Administer Injection – Follow the proper technique for intradermal, subcutaneous, or intramuscular injections.
- Verify 7 Rights – Right patient, medication, dose, route, time, reason, and documentation.
- Dispose of Sharps Properly – Place used needle in the sharp's container immediately.

## **IV Push (IVP) Administration**

- Check Compatibility – Ensure the medication is compatible with IV fluids.
- Clean Vial – Wipe with alcohol before access.
- Select Correct Syringe Size – Choose the appropriate syringe for administration
- Prepare Medication – Draw up the correct amount in the syringe.
- Hand Hygiene/Don Gloves – Perform hand hygiene before preparing the medication.
- Scan Medication – Verify the medication against the MAR.
- Assess IV Site – Check for infiltration, phlebitis, or complications.
- Clean IV Port– Wipe with alcohol before access. (15 Seconds)
- Aspirate
- Pre-Flush – Flush the IV before medication administration
- Clean IV Port– Wipe with alcohol before access. (15 Seconds)
- Administer at Correct Rate – Inject the medication over the recommended time.
- Clean IV Port– Wipe with alcohol before access. (15 Seconds)
- Post-Flush – Flush the IV after medication administration.
- Cap Port
- Clamp
- Dispose of Sharps Properly – Place used syringes in the sharps container.
- Verify 7 Rights – Ensure correct patient, medication, dose, route, time, reason, and documentation.

## **IV Piggyback (IVPB) Administration**

- Hand Hygiene/Don Gloves – Perform hand hygiene before preparing the medication.
- Check Compatibility – Verify the IVPB medication is compatible with current IV fluids.
- Spike Medication Bag – Insert the tubing spike into the IVPB bag.
- Prime IV Tubing – Remove air bubbles from the secondary tubing.
- Scan Medication – Ensure the correct medication and dosage.
- Clean IV Port– Wipe with alcohol before access. (15 Seconds)
- Attach Secondary Tubing – Connect the IVPB tubing to the primary line.
- Lower Primary IV Fluid (IVF) Bag – Ensure proper backflow for piggyback infusion.
- Set Pump Correctly – Program the IV pump with the correct infusion rate
- Unclamp Tubing – Ensure proper medication flow.
- Confirm Dripping – Verify medication is infusing properly.
- Verify 7 Rights – Ensure correct patient, medication, dose, route, time, reason, and documentation.

## **Patient Assessment**

### **Cardiac Assessment**

- Hand Hygiene (HH)– Perform hand hygiene before beginning assessment.
- Clean Stethoscope – Wipe down with alcohol before use.
- Assess Pain – Ask the patient if they are experiencing any chest pain or discomfort.
- Inspect Skin – Check for pallor (paleness) or cyanosis (bluish discoloration).
- Auscultate Heart Sounds (4 Locations) – Listen for normal heart sounds (S1 & S2, “lub-dub”). Aortic, Pulmonic, Tricuspid, Mitral
- Apical Pulse (1 Minute) – Count the apical pulse for a full 60 seconds.

### **Respiratory Assessment**

- Hand Hygiene (HH)– Perform hand hygiene before beginning assessment.
- Clean Stethoscope & O2 Sensor – Wipe down before use.
- Inspect Breathing Effort – Observe the patient’s work of breathing, including rate, depth, and accessory muscle use.
- Assess Respiratory Rate (RR) – Count breaths per minute.
- Measure SPO2 – Check oxygen saturation with a pulse oximeter.

- Auscultate Anteriorly (7 Locations) – Listen to breath sounds in the front.
- Auscultate Posteriorly (10 Locations) – Listen to lung sounds in the back.

### **Peripheral Nervous System (PNV) Assessment**

- Hand Hygiene (HH) – Perform hand hygiene before assessment.
- Assess Pain – Ask the patient about any discomfort, tingling, or numbness.
- Inspect for Pallor – Observe for skin color changes in extremities.
- Evaluate Peripheral Pulses – Assess pulse strength in upper and lower extremities
- Assess for Paresthesia – Check for abnormal sensations (numbness or tingling).
- Assess for Paralysis – Determine if there is any loss of motor function.
- Check for Poikilothermia – Compare temperature differences between limbs.

### **Abdominal (ABD) Assessment**

- Hand Hygiene (HH) – Perform hand hygiene before beginning assessment.
- Clean Stethoscope – Wipe down before auscultation.
- Inspect Abdomen – Look for distention, asymmetry, or abnormal skin findings.
- Auscultate Bowel Sounds (4 Quadrants) – Listen for presence, absence, or abnormalities.
- Auscultate Additional Sites (Epigastric)
- Palpate Abdomen – Assess for tenderness, guarding, or masses.

## **Procedure Skills**

### **Catheterization (Indwelling/Straight) Checklist**

- Hand Hygiene (HH) In – Perform hand hygiene before beginning the procedure.
- Check Allergy to Betadine – Confirm patient does not have an allergy to betadine or other cleaning agents.
- Prepare the Patient – Explain the procedure, provide privacy, and position the patient appropriately.
- Assess & Pre-Clean Perineal Area – Perform perineal care and assess for abnormalities.
- Open Sterile Kit & Apply Sterile Gloves – Maintain sterility throughout the procedure.
- Drape the Patient – Place the sterile drape under and around the patient as indicated.
- Prepare the Catheter Tray – Arrange supplies in an aseptic manner.
- Cleanse Urethral Meatus (x3) – Use sterile technique, cleaning from meatus outward.
- Insert Catheter – Advance catheter correctly while maintaining sterility.

- Secure Catheter – Inflate balloon (if indwelling) and secure tubing properly.
- Verbalize Proper Cleaning & Aftercare – Explain how to maintain cleanliness and prevent infection.
- Hand Hygiene (HH) Out – Perform hand hygiene after completing the procedure.

### **Central Venous Access Device (CVAD) Dressing Change Checklist**

- Check Allergy to Chloraprep – Confirm with the patient before proceeding.
- Perform Hand Hygiene (HH) In – Clean hands before starting the procedure.
- Apply Mask & Turn Patient’s Head – Prevent contamination by reducing airborne exposure.
- Apply First Pair of Gloves – Wear clean gloves for the initial steps.
- Inspect CVAD Site – Look for redness, drainage, or signs of infection.
- Palpate Around the Site – Assess for tenderness or swelling.
- Remove Old Dressing – Carefully remove the dressing without dislodging the catheter.
- Open Sterile Drape – Set up a sterile field for the new dressing application.
- Apply Second Pair of Sterile Gloves – Maintain sterility for the rest of the procedure.
- Clean the CVAD Site – Use the appropriate cleaning agent (e.g., Chloraprep) in a back-and-forth motion (30 secs) then down the lumens
- Apply Sterile Dressing – Secure the catheter site with a sterile dressing, ensuring proper adhesion.
- Perform Hand Hygiene (HH) Out – Clean hands after completing the procedure.

### **Critical Elements – Must Pass**

Failure to perform any of the following may result in an unsuccessful CPE attempt:

- Second Medication Check
- Third Medication Check
- Verify Allergies (Medication & Cleaning Agents)
- Multiple Missed Hand Hygiene (HH) Steps
- Failure to Identify Patient
- Contamination of Sterile Field/Supplies
- Failure to Scan Patient & Medications
- Incorrect Dose or Volume
- Failure to Document Administration or Assessment
- Unsuccessful Sterile Procedure