

PROCEDURE/INSTRUMENT: Hemochron Signature Elite Low Range Activated Clotting Time

Competency Assessment Record

Initial Competency Semi-annual Competency Annual Competency (CY: _____) Follow up

Name:		Title:	
License Number:		Location:	
	Assessment Performed	Competency Assessment Method	Assessor's Findings (To be completed by Technical Supervisor)
1	<input type="checkbox"/> Direct observation <u>or</u> <input type="checkbox"/> Skills demonstration of routine patient test performance, including: patient preparation, specimen collection, handling, processing, and testing. (attach record) Date performed: _____ MRN: _____	Directly observe test performance, including patient preparation, specimen handling, processing and testing. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:
2	Review of patient record for monitoring, recording and reporting of test results. (attach record) Date Reviewed: _____	Monitor the recording and reporting of test results. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:
3	Review Quality Control (LQC) documentation. (attach record) Date reviewed: _____	Review of intermediate test results or worksheets, QC records, PT results and preventive maintenance records. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:
4	<input type="checkbox"/> Direct observation of EQC testing <u>or</u> <input type="checkbox"/> Skills demonstration (looking up EQC value when performed automatically by the instrument). Date performed: _____	Directly observe performance of instrument maintenance, function checks and calibration. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:
5	Performance of PT (CAP survey) or blind sample (LQC). (attach record) Date and time performed: _____	Assess test performance using previously analyzed samples. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:
6	Score 100% on the written quiz to demonstrate appropriate problem-solving skills.	Assessment of problem solving skills. Trainer/Observer Initials: _____	Expectation(s) met: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: Assessor's Initials:

(FOR INITIAL COMPETENCY or FOLLOW UP ONLY)

EMPLOYEE: I feel competent in the subjects/tasks/competencies noted above: YES or NO

I feel I need additional training with the following subjects/tasks/competencies:

 EMPLOYEE'S SIGNATURE: _____ DATE: _____

I, _____ (Employee's Initials), have read and understand the applicable policy(ies) and procedure(s) and changes therein. Last Competency assessment date: _____

Laboratory Director or Technical Supervisor: I have reviewed all six methods of competency in the above named procedure/instrument and determined that the employee is competent to work in these areas.

 Laboratory Director or Technical Supervisor (print/signature)

 Date