Training & Competency Assessment Documentation

 **[ ] Annual [ ] Semi-Annual [ ] Initial Training**

## (Use a new record for each competency assessment cycle.)

**Employee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Skill:** **Identifying Pathogenic Flora from Normal Flora in Specimens/Body Sites** | **\*Method(s) of Assessment****Circle code (DO, RR, etc) and enter****document used / record involved** | **Trainer**By signing this form, I certify that I have trained these skills as outlined below.**Assessor**By signing this form I certify that I have assessed this individual for competency in the skills listed. I deem this individual competent to perform this (these) skill(s). |
| **\*Specimen Site** | **Assessment or Training Completion:** **Date Initial**  | **Assessors or Trainers Signature:** |
| **Prenatal Strep Screens** |  |  |  |
| **Vaginal** |  |  |
| **CSF** |  |  |
| **Skin** |  |  |
| **Ear** |  |  |
| **Eye****Gro** |  |  |
| **Lower Respiratory Cultures** |  |  |
| **Groin, Rectal, Perianal, Buttock** |  |  |
| **Stool** |  |  |
| **Nasal and Sinus****D** |  |  |
| **Sterile Sites** |  |  |
| **Upper Respiratory**  |  |  |
| **Blood** |  |  |
| **Urine** |  |  |
| **\*Write in “N/A” if not applicable.**  | **Example Specimen Site:** |
| **DO** |  | **UCMI0002 Normal Flora vs. Pathogens 02/2013** |  |
| **RR**  |  |
| **ST**  |  |
| **PS** |  |

By signing this form I acknowledge that I have been trained, if applicable, and my competency has been assessed for these skill(s). I have discussed my questions with a trainer, as needed, and I understand that I am now accountable for being in compliance. If I need further assistance, I am to request it. A trainer or supervisor will assist me.

|  |
| --- |
| Employee Signature & Date: |

**Supervisor signature (or designee):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**Medical Director Signature (If required):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**\*Method(s) of Assessment**

**DO: Direct Observation**

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| --- |
| * Record the Direct Observation Checklist ID # or SOP, e.g. “DO, DOC HR22(04/11)” or “DO, SOP HR2200”
 |

**RR: Record Review**

|  |  |
| --- | --- |
| * calibrations, instrument or reagent
 | * temperature, cleaning, or other logs
 |
| * maintenance logs and reports
 | * proficiency testing records
 |
| * quality control logs/records/reports
 | * technical/clerical reviews
 |
| * test worksheets/results
 | * other reports, e.g. error reports, root cause analyses
 |

**ST: Skills Testing** (Keep source documents.)

|  |  |
| --- | --- |
| * blind samples
 | * proficiency testing
 |
| * practical exams
 | * oral exams
 |

**PS: Problem Solving & Recall** (Keep source documents.)

|  |  |
| --- | --- |
| * case studies
 | * written tests (other than SOP Cn tests)
 |
| * instrument/assay trouble shooting
 | * oral tests or DAPs
 |
| * practical exams
 | * proficiency testing failure follow up
 |
|  |  |