**Skills Training and Evaluation**

(At the completion of training session, the operator should be able to complete these tasks and successfully conduct Fecal Occult Testing)

|  |  |  |
| --- | --- | --- |
|  | Met\* | Unmet |
| 1. Reviews procedure, “Hemoccult”. | □ | □ |
| 1. Describes purpose of test. | □ | □ |
| 1. Demonstrates compliance with Standard Precautions; wears gloves | □ | □ |
| 1. Describes proper sample collection and application procedure. | □ | □ |
| 1. Waits 3-5 minutes before applying developer directly over each smear. | □ | □ |
| 1. Reads test results within 60 seconds | □ | □ |
| 1. Develop the “On Slide Performance Monitor” by applying one drop of developer between the positive and the negative Performance Monitor areas on the back of the slide. | □ | □ |
| 1. Reads the slide within 10 seconds | □ | □ |
| 1. Interprets On Slide Performance Monitor correctly (should be blue in the (+) area, no blue in the (-) area). | □ | □ |
| 1. Takes appropriate action based on results on the “On Slide Performance Monitor. | □ | □ |
| 1. If Performance monitor results are as expected, records results in appropriate log or record | □ | □ |
| 1. If Performance Monitor results are not as expected, takes appropriate action (repeats using new card, or card from new box, and/or developer; knows whom to notify) | □ | □ |

\*All skills parameters must be “met” in order to become an authorized user of this product.

**Individual Information**

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| \*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Employee ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Department/Cost Center:  □ RN:  □ LPN:  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Date of Training: \_\_\_ / \_\_\_ / \_\_\_  Training Status:  □ New/initial  □ Recertification  \*Required Fields |

The trainer’s signature attests that the trainee has (a) successfully completed the program and scored 80% or better on the quiz, and (b) demonstrated successful skill in performing this procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ / \_\_\_ / \_\_\_

Trainer Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trainer Position/Dept

Please send a copy of this form to the laboratory, attention Point of Care Coordinator.