



ADVANCED PRACTICE RN
CERTIFIED RN ANESTHETIST
WORK PERFORMANCE EVALUATION

Board of Registered Nursing Probation Monitor: _____

INSTRUCTIONS: As required by the Board of Registered Nursing (BRN) decision and order, a probationary Certified RN Anesthetist (CRNA) must have their practice evaluated and written reports submitted to the BRN on a periodic basis throughout the entire term of their probation. The frequency of the evaluation is monthly unless you have been notified otherwise. The evaluation must address all areas of practice and should be sufficient to determine if the CRNA is safe and competent in his/her practice. This form should be filled out in collaboration with the Board approved work site monitor(s) who are California CRNA(s) with no current disciplinary action against their license, unless an alternative method of supervision is approved(i.e. MD)

Please note: Probationary CRNAs must abide by their current job approval and may NOT change the scope of their job unless a written request for modification has been approved.

ANSWER EACH SECTION COMPLETELY AND ACCURATELY AS IT APPLIES TO THE PROBATIONARY CRNA

REPORTING PERIOD

NOTE: Your report is for the previous timeframe (month or quarter), not for the future.

MONTHLY REPORTING: List the month & year you are reporting: _____

OR

QUARTERLY REPORTING: [check applicable quarter & indicate the year]

Jan. 1 – Mar. 31, _____ due between 4/1-4/10

Jul. 1 – Sept. 30 _____ due between 10/1-10/10

Apr. 1 – Jun. 30, _____ due between 7/1-7/10

Oct. 1 – Dec. 31, _____ due between 1/1-1/10

CRNA's NAME: _____ **RN LIC. #** _____

REGULAR HOURS WORKED/WEEK: _____ **OVERTIME HOURS PER WEEK** _____

1. What is the current required level of supervision? Maximum- Moderate- Minimum- Other (circle one)

Have you provided that level of supervision? YES NO (circle one) If no, explain:

2. Have you disciplined the probationary CRNA in any manner during this reporting period?

ie. warnings, counseling, suspension, etc.? YES NO (circle one) If yes, explain:

WORK PERFORMANCE RATING

Use this scale to answer the following questions and evaluate the CRNA's practice :

- 3..... Exceeds position expectations on a regular basis.
- 2..... Meets position expectations for a safe and competent Certified RN Anesthetist
- 1..... Does NOT meet expectations: Improvement needed- See Action Plan Section.
- N/A ...Not Assessed or Does not apply to the position.

All areas rated as a "1" MUST be addressed in the Action Plan Section.

PROFESSIONALISM	3	2	1	N/A
DEMEANOR: Demonstrates a caring attitude even in unexpected &/or uncomfortable situations. Respects & preserves the basic rights of the patient.				
RESPONSIBILITY: Dependable, punctual attendance. Incorporates professional and legal standards into clinical practice.				
COMMUNICATION: Listens to & respects wishes of patient/family. Adjusts communication level/style as needed.				
COMPETENCIES: Updates knowledge & skills and keeps certificates current. Specifically regarding Specialty practice standards, National & State Certifying Boards, & 3 rd Party Payers				
DOCUMENTATION: Charting is accurate, complete, legible, & timely				
COLLABORATION: Seeks advice & input when needed & in order to improve quality of anesthesia care.				
PRACTICE AREAS	3	2	1	N/A
SAFETY:				
Adheres to safety precautions established within the practice setting to minimize the risks of fire, explosion, electrical shock & equipment malfunction. Ensures equipment is present & in proper working order & audible alarms are turned on & in use.				
Verifies Infection control policies & procedures exist & adheres to them.				
ASSESSMENT:				
Performs & documents a thorough pre-anesthesia assessment & evaluation.				
Identifies health & psychosocial risk factors & obtains consultation & diagnostic studies as needed				
Obtains & documents informed consent for the planned anesthetic intervention.				
Educates patients & families re: anesthetic plan & expected outcomes based on individualized needs. Involves the patient with all aspects of their care.				
PLANNING:				
Demonstrates an understanding of age-specific physiology in these populations(circle all that apply)				
INFANT CHILD ADOLESCENT ADULT GERIATRIC				
Accurately analyzes collected data to formulate a patient specific plan for anesthetic care				

PRACTICE AREAS Cont.	3	2	1	N/A
INTERVENTION:				
Initiates timely consultation &/or referrals based on anesthetic plan.				
Selects & initiates the planned anesthetic technique that may include general, regional, or local anesthesia, & intravenous sedation				
Demonstrates technical competence in performing procedures.				
Monitors, evaluates, & documents patient's physiologic condition as appropriate for the type of anesthesia & specific patient needs in an ongoing fashion.				
Oxygenation:				
Ventilation:				
Cardiovascular				
Thermoregulation				
Neuromuscular				
Positioning & Protective measures				
Maintains the patient's physiologic homeostasis & corrects abnormal responses to anesthesia or surgery by selecting, obtaining, &/or administering drugs & fluids as necessary				
Pain Relief: Order, initiate, or modify pain relief therapy to maintain the patient in optimal physiologic condition.				
Manages emergence & recovery from anesthesia by selecting, obtaining, ordering, or administering medications, fluids, or ventilatory support in order to maintain homeostasis or provide relief from pain or anesthesia side effects.				
Safely transports patient to post-anesthesia care area				
Responds to Emergencies by providing airway management, administering drugs or fluids, & using basic or advanced cardiac life support techniques				
EVALUATION:				
Evaluates the patient's status & determines when it is safe to transfer care. Accurately report patient's condition to receiving qualified healthcare provider in a manner that assures continuity of care & patient safety.				
Releases patients from post-anesthesia care area & provide follow-up evaluation & care related to anesthesia side effects or complications.				

RESULTS OF AUDITS: Please specify type of audit & results. If none, indicate none.

COMMENTS: _____

ACTION PLAN: (Address all areas that are listed as 1s)

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EVALUATOR NAME _____ **AND** _____ **TITLE:** _____

_____ **PHONE** _____ **NUMBER:** _____

_____ **EMAIL:** _____

EVALUATOR SIGNATURE: _____ **DATE:** _____

****EVALUATIONS MUST BE COMPLETED AFTER THE REPORTING PERIOD
AND CANNOT BE SUBMITTED EARLY.***

**FORMS MAY BE RETURNED BY MAIL, FAX OR SCANNED & E-MAILED DIRECTLY TO THE
PROBATION MONITOR.**

**Board of Registered Nursing
Attn: Probation Unit
Po Box 944210
Sacramento, CA 94244-2100
Fax: (916) 574 - 8636**