



SUPERVISOR REPORT
for Registered Nurses and APRN's
(Please duplicate this form for future use)

Date: _____ Licensee: _____ Department: _____

Employer: _____ Position: _____

Is a Regulatory License Required for this Position: Yes No License Required: _____

Report for the period beginning _____ and ending _____ Month submitted for: _____

Please attach explanations for any answers you feel necessary. Please attach a current job description with the first report and with changes to the job description.

- | True | False | |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. This licensee is employed in a capacity for which a license is required by statute. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. The licensee is working _____ (number of) hours per week. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Supervision is provided by a licensed registered nurse who has no license restrictions. A physician may be considered a Supervisor for APRN's. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. The supervisor will notify the Nursing Peer Health Assistance / Nurse Alternative to Discipline Program by telephone within 72 hours after termination of employment at 303-369-0039. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. In the supervisor's opinion, this licensee is practicing consistent with standards of practice. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. This licensee is dispensing/administering narcotics or mind altering drugs (e.g., benzodiazepines, narcotics or opiates) that are prone to abuse. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Supervisor received copy of the SBON Stipulation (if applicable). |

Please describe the duties and responsibilities to be carried out by the Licensee: _____

Please describe the type of direct supervision provided: _____

WORK PERFORMANCE GUIDELINES - Please complete the following section of this report evaluating whether or not the registered nurse or APRN is meeting the standard criteria listed.

Assessment

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Collects data in a systematic and ongoing process as the position requires |
| <input type="checkbox"/> | <input type="checkbox"/> | Involves supervisor and/or co-workers, as appropriate, in data collection |
| <input type="checkbox"/> | <input type="checkbox"/> | Prioritizes data collection activities based on the immediate anticipated needs of the job/task or situation |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses appropriate evidence-based assessment techniques and instruments in collecting pertinent data when necessary |
| <input type="checkbox"/> | <input type="checkbox"/> | Documents relevant data in a retrievable form as needed |

Planning

- | Yes | No | |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Develops an individualized care plan for patient as needed |
| <input type="checkbox"/> | <input type="checkbox"/> | Develops the plan in conjunction with supervisor and/or co-workers as appropriate |
| <input type="checkbox"/> | <input type="checkbox"/> | Includes strategies within the plan that address each of the identified issues |
| <input type="checkbox"/> | <input type="checkbox"/> | Incorporates an implementation pathway |

Implementation

- | Yes | No | |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Implements the plan in a safe and timely manner |
| <input type="checkbox"/> | <input type="checkbox"/> | Documents implementation and any modifications of the identified plan |
| <input type="checkbox"/> | <input type="checkbox"/> | Utilizes nursing skills to implement the plan |
| <input type="checkbox"/> | <input type="checkbox"/> | Collaborates with colleagues and others during implementation |
| <input type="checkbox"/> | <input type="checkbox"/> | Appropriately delegates aspects of the plan according to company policies and guidelines |

Evaluation

- | Yes | No | |
|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Evaluates the effectiveness of the planned strategies and the attainment of the expected outcomes |
| <input type="checkbox"/> | <input type="checkbox"/> | Documents the results of the evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | Uses ongoing assessment data to revise and implement the plan and outcomes as needed |

Ethics

- | Yes | No | |
|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Integrates ethical provisions in all areas of practice |
| <input type="checkbox"/> | <input type="checkbox"/> | Demonstrates a commitment to practicing self-care, managing stress, and connecting with self and others |

BEHAVIORAL PERFORMANCE GUIDELINES - All employees, at some time, display job performance problems. An isolated incident of coming to work late need not be a cause for alarm. However, when a Licensee *displays a pattern of repeated job performance decline*, the supervisor needs to take notice and report it to the Nursing Peer Health Assistance / Nurse Alternative to Discipline Program. Use the checklist below to determine if there are job performance problems or patterns.

Decline in Job Efficiency

- | Yes | No | |
|--------------------------|--------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Decrease in overall work quality |
| <input type="checkbox"/> | <input type="checkbox"/> | Inconsistent work quality (periods of high and/or low productivity) |
| <input type="checkbox"/> | <input type="checkbox"/> | Errors in judgment |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased period of confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Unrealistic excuses for lowered work quality |
| <input type="checkbox"/> | <input type="checkbox"/> | Missed deadlines |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased carelessness/mistakes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tasks taking excessive time to complete or never being completed |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty handling complex tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory |

Inconsistent Work Patterns

- | Yes | No | |
|--------------------------|--------------------------|------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Becoming or has become less dependable |
| <input type="checkbox"/> | <input type="checkbox"/> | Doing minimal or substandard work in comparison with peers |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent requests for help with assignments |

Absenteeism/Tardiness

- | Yes | No | |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pattern of absenteeism centering around scheduled days off |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tardiness (Monday and Friday) or after days off |
| <input type="checkbox"/> | <input type="checkbox"/> | Leaving work early |
| <input type="checkbox"/> | <input type="checkbox"/> | Repeated absenteeism due to vaguely defined illnesses, "not feeling well," "cold," "headache" |
| <input type="checkbox"/> | <input type="checkbox"/> | Improbable reasons for absenteeism |
| <input type="checkbox"/> | <input type="checkbox"/> | Unauthorized leave |
| <input type="checkbox"/> | <input type="checkbox"/> | Last minute request for leave or excessive use of sick leave |
| <input type="checkbox"/> | <input type="checkbox"/> | Shows up when not scheduled for shift |
| <input type="checkbox"/> | <input type="checkbox"/> | Takes extended breaks, sometimes without telling colleagues and without explanation |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained disappearances on the job |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive breaks, trips to bathroom or to water fountain |
| <input type="checkbox"/> | <input type="checkbox"/> | "Absent" while present on job |

Attitude/Mood

- | Yes | No | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dramatic mood shifts |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to isolate |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Secretiveness/suspiciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Crying |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflexibility |

Physical/Emotional Problems or Impairments

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in physical/emotional condition during shift |
| <input type="checkbox"/> | <input type="checkbox"/> | Marked nervousness on the job |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweating |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors of hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of attention to personal cleanliness or grooming |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports to duty despite physical/emotional contraindication |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol-like odor on breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular breathing pattern (e.g., labored, shallow) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stumbles/staggers while walking (gait/balance) |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in speech pattern (e.g., slurred, fast, slow) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fumbles/drops equipment (manual coordination) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pupils dilated/constricted |
| <input type="checkbox"/> | <input type="checkbox"/> | Jerky body movements |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports difficulty sleeping |
| <input type="checkbox"/> | <input type="checkbox"/> | Nodding off while on duty or eyes shut for extended period |

Impaired Interpersonal Relationships

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent arguments with co-workers |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive blaming of others |
| <input type="checkbox"/> | <input type="checkbox"/> | Unwillingness to cooperate with co-workers or inability to compromise |
| <input type="checkbox"/> | <input type="checkbox"/> | Over-reactions to co-workers |
| <input type="checkbox"/> | <input type="checkbox"/> | Wide swings in mood from isolation to angry outbursts |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids contact |
| <input type="checkbox"/> | <input type="checkbox"/> | Complaints by co-workers of irritability, physical roughness, or verbal abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Exhibits aggression or hostility towards patients and/or coworkers |
| <input type="checkbox"/> | <input type="checkbox"/> | Responds defensively or aggressively when provided performance feedback |
| <input type="checkbox"/> | <input type="checkbox"/> | Inappropriate sharing of personal information with patients |
| <input type="checkbox"/> | <input type="checkbox"/> | Communicates with flat affect in tone of voice |

Difficulty in Concentration/Cognitive Impairment

- | Yes | No | |
|--------------------------|--------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Assignment takes more time (despite skill/experience) |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in assigning priorities |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant increase in error ratios |
| <input type="checkbox"/> | <input type="checkbox"/> | Omitted, illogical, incomplete, or illegible written communications |
| <input type="checkbox"/> | <input type="checkbox"/> | Deteriorating handwriting during shift or deteriorating performance |
| <input type="checkbox"/> | <input type="checkbox"/> | Errors in taking verbal or written instructions |
| <input type="checkbox"/> | <input type="checkbox"/> | Overlooking daily standard job tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | Forgets how to complete simple tasks or makes mistakes (memory/concentration) |
| <input type="checkbox"/> | <input type="checkbox"/> | Makes inaccurate judgments regarding patient care (judgment) |
| <input type="checkbox"/> | <input type="checkbox"/> | Exhibits confusion (e.g., about directions or instructions) |
| <input type="checkbox"/> | <input type="checkbox"/> | Unable to accurately communicate specific patient information with staff and/or patients |
| <input type="checkbox"/> | <input type="checkbox"/> | Inaccurate or incomplete patient care documentation |
| <input type="checkbox"/> | <input type="checkbox"/> | Consistent inability to improve performance or conduct even with training or counseling |

Drug Diversion

- | Yes | No | |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loiters around medicine supply |
| <input type="checkbox"/> | <input type="checkbox"/> | Insists on performing narcotic counts alone |
| <input type="checkbox"/> | <input type="checkbox"/> | Waits until alone to access narcotics cupboard and/or to draw up medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports medication being wasted when the medication not wasted |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports wasting more of a drug than seems likely |
| <input type="checkbox"/> | <input type="checkbox"/> | Inconsistencies between narcotic records and administration record |
| <input type="checkbox"/> | <input type="checkbox"/> | Has no reasonable explanation for Pyxis withdrawals |
| <input type="checkbox"/> | <input type="checkbox"/> | Patients consistently complain that pain is not improving after receiving pain medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports lost or wasted medications frequently |
| <input type="checkbox"/> | <input type="checkbox"/> | Fails to ensure observation or co-signing for narcotic wastage |
| <input type="checkbox"/> | <input type="checkbox"/> | Asks others to withdraw narcotics for his/her patients |
| <input type="checkbox"/> | <input type="checkbox"/> | Offers to cover other nurses' breaks to administer medications to their patients |
| <input type="checkbox"/> | <input type="checkbox"/> | PRN medications for a patient administered at higher frequency than other shifts |

Other Areas

- | Yes | No | |
|--------------------------|--------------------------|------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive time spent making personal telephone calls |
| <input type="checkbox"/> | <input type="checkbox"/> | Physically threatening |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive talkativeness |
| <input type="checkbox"/> | <input type="checkbox"/> | Grandiosity (exaggerated self-importance) |

Licensee: _____

Comment on any areas checked: _____

Please note in narrative form any changes that you have observed in this employee since they have participated in the Nursing Peer Health Assistance / Nurse Alternative to Discipline Program: _____

Any knowledge or concern regarding this licensee's inability to practice with reasonable skill and safety must be reported to Nursing Peer Health Assistance / Nurse Alternative to Discipline Program **within 24 hours** at 303-369-0039.

Supervisor Signature

Date

Supervisor Name (Please Print)

Employer

Address

City, State, Zip

Phone #

E-Mail Address:

Reports may be submitted via:

Email: reports@peerassist.org

Fax: Last name A-L 720.213.1007
Last Name M-Z 720.213.0002

Mail: Peer Assistance Services
2170 S. Parker Road, Suite 229
Denver, CO 80231

In Person: Peer Assistance Services, Inc.
2170 S. Parker Road, Suite 229
Denver, CO 80231

or Peer Assistance Services, Inc.
200 Grand Avenue, Suite 270
Grand Junction, CO 81501