

Competency Verification Record

UVA Health

Removal of Central Line Catheter (Central Vascular Access Device)

Employee Name: _____ Employee ID #: _____ Date: _____

Successful completion is documented on the Annual Competency Record (ACR) or Department Specific Competency Form using the following competency statement(s):

Competency Statement(s): *Demonstrates removal of central line catheter (central vascular access devices)*

Evaluator(s): RNs qualified to sign the competency statement on ACR or Department Specific Competency Forms

Method of validation (circle one):

DO	Direct Observation – Return demonstration or evidence of daily work.
T	Test: Written or oral assessments, surveys or worksheets, passing grade on a CBL test.
S	Simulation
C	Case Study/ Scenarios: Create/share a story of a situation then ask questions that capture the nature of the competency that is being referenced.
D	Discussion: Identify questions related to a competency and ask orientee to provide an example of their real-life experiences.
R	Reflection: A debriefing of an actual event or a discussion of a hypothetical situation.
QI	Quality Improvement Monitoring: Audits or compliance checks on actual work or documentation to ensure the competency is completed.
N/A	If the specific product or process step is not used in the respective area or by the respective role, then this step is deemed N/A.

Note: This Competency Verification Record is **not** a required part of the permanent personnel record. This form is to be used as a guide for competency check off only; **the Annual Competency Record is used to document competency.** (If competency validation occurs away from the unit, this form can be completed by the validator; the signed form can then be presented to the unit NEC or manager as evidence of competency. The Annual Competency Record is then signed indicating that the competency was validated).

Instructions: Bolded steps are required critical elements for competency

Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	Evaluator's Initials
<ul style="list-style-type: none"> • Verifies plan of care with LIP and obtains order for removal of central line. 		
<ul style="list-style-type: none"> • Reviews appropriate labs (i.e. coagulation labs) 		
<ul style="list-style-type: none"> • Verifies/places alternative IV access if necessary 		
<ul style="list-style-type: none"> • Performs hand hygiene and Dons non-sterile gloves 		
<ul style="list-style-type: none"> • Prepares supplies: sterile scissors or suture removal kit; sterile gauze; absorbent pad 		
<ul style="list-style-type: none"> • Positions patient to minimize risk of venous air embolus (flat or slight Trendelenburg's) 		
<ul style="list-style-type: none"> • Minimizes risk of infection: positions patients head away from insertion site if not contraindicated 		
<ul style="list-style-type: none"> • Transfers/discontinues IV infusions as indicated 		
<ul style="list-style-type: none"> • Removes central line dressing and discards into regular trash 		

