

Competency Documentation

Students in the **Women's Health** specialty track must satisfactorily meet the following competencies by the completion of the program:

1. History & Physical Examination
2. Leopold's Maneuvers, Bony Pelvis, & Pelvic Examination

Students in the **Nurse Midwifery** specialty track must satisfactorily meet the following competencies by the completion of the program:

1. History & Physical Examination
2. Leopold's Maneuvers, Bony Pelvis, & Pelvic Examination
3. Intrapartum Skills
4. Newborn Examination

As evidence of competency achievement, students are responsible for having their clinical preceptors and/or specialty track core faculty document '**Satisfactory**' achievement of each competency component on the appropriate form (see following pages for Competency Forms). The preceptor / core faculty 'signing off' on a particular component of a competency must sign and date the area after the component.

Although competencies must be completed by program completion, **ALL students are expected to provide the core faculty with up-to-date competency forms at the end of each clinical quarter (i.e., during the N859 series)**. Individual students may also be asked to provide these forms at any time by the specialty track core faculty. Forms may be provided to appropriate core faculty either via: scanning and uploading to Carmen; faxing to the College of Nursing (614-292-4948) with a cover sheet addressed to an appropriate core faculty member; or copies left in the core faculty inbox on the 3rd floor of the College of Nursing. Students are responsible for maintaining the competency forms with all original documentation and signatures which must be turned into the specialty track core faculty at the end of the program and prior to graduation:

History & Physical Examination Competencies

Women's Health / Nurse Midwifery Specialty Tracks

The Ohio State University

Student _____ Date _____

Faculty _____

COMPONENT	Not yet Acceptable	Needs Improvement	Satisfactory
History: introduction			
Identifying data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CC: presenting problem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Past history			
General state of health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accidents/injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynecologic/obstetrical history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current health status			
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMPONENT	Not yet Acceptable	Needs Improvement	Satisfactory
Screening tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise/leisure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home/significant others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Important experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Religious beliefs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outlook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Review of Systems			
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination			
General with VS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMPONENT	Not yet Acceptable	Needs Improvement	Satisfactory
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose/sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior thorax/lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts/axillae, epitrochlear nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts (lying down)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anterior thorax/lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pap & cultures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bimanual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical pelvimetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic with DTRs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

