****

**CERTIFIED NURSING ASSISTANT SKILLS CHECKLIST**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Self** | **Rating Key:** |
| **0** | **No experience** (please print) |
| **1** | **Minimal experience/works with supervision** |
| **2** | **Independent/works without supervision in most cases** |
| **3** | **Senior/works at a supervisory or teaching level** |

**Has knowledge of and can provide care and assist patients with the following tasks:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **0** | **1** | **2** | **3** |
| **AMBULATION** |  |  |  |  |
| 1. Crutches |  |  |  |  |
| 2. Walker |  |  |  |  |
| 3. Cane |  |  |  |  |
| 4. Gait belt |  |  |  |  |
| **PERSONAL CARE x** |  |  |  |  |
| 1. Bath: |  |  |  |  |
| a. Bed |  |  |  |  |
| b. Tub |  |  |  |  |
| c. Shower |  |  |  |  |
| 2. Skin Care: |  |  |  |  |
| a. Back rub |  |  |  |  |
| b. Decubitus prevention/care |  |  |  |  |
| 3. Dress: |  |  |  |  |
| a. Assist as needed |  |  |  |  |
| b. Use of assistive devices |  |  |  |  |
| 4. Hair Care |  |  |  |  |
| 5. Nail Care (fingers & toes) |  |  |  |  |
| a. Clean/file/trim with clippers |  |  |  |  |
| 6. Oral Hygiene: |  |  |  |  |
| a. Mouth care |  |  |  |  |
| b. Brush teeth |  |  |  |  |
| c. Denture care |  |  |  |  |
| 7. Shaving: Safety razor/electric razor |  |  |  |  |
| **NUTRITION / HYDRATION x** |  |  |  |  |
| 1. Feeding techniques |  |  |  |  |
|  | **0** | **1** | **2** | **3** |
| 2. Assist with eating |  |  |  |  |
| 3. Use of feeding assistive devices |  |  |  |  |
| 4. Measure & record intake |  |  |  |  |
| 5. Encourage fluids |  |  |  |  |
| **BASIC INFECTION CONTROL PROCEDURESx** |  |  |  |  |
| 1. Hand washing |  |  |  |  |
| 2. Universal precautions |  |  |  |  |
| 3. Use of warm & cool applications |  |  |  |  |
| **ASSISTING OR CARE OF PATIENT WITH BOWEL & BLADDER ELIMINATIONx** |  |  |  |  |
| 1. Bedpan / urinal |  |  |  |  |
| 2. Bedside commode |  |  |  |  |
| 3. Care of incontinent patient |  |  |  |  |
| 4. Stoma care |  |  |  |  |
| 5. Bowel / bladder training |  |  |  |  |
| 6. Measure & record output |  |  |  |  |
| **URINARY CATHETER CARE** |  |  |  |  |
| 1. Perineal hygiene |  |  |  |  |
| 2. Foley catheter |  |  |  |  |
| 3. Supra pubic catheter |  |  |  |  |
| **TRANSFER TECHNIQUES x** |  |  |  |  |
| 1. Use of transfer gait belt |  |  |  |  |
| 2. Weight bearing |  |  |  |  |
| 3. Non-weight bearing |  |  |  |  |
| 4. Mechanical lift |  |  |  |  |
| 5. Wheelchair |  |  |  |  |
| **TURNING / POSITION PATIENT** |  |  |  |  |
| 1. Supine |  |  |  |  |
| 2. Side-lying |  |  |  |  |
| 3. In chair |  |  |  |  |
| 4. In bed |  |  |  |  |
| 5. Use of lift sheet |  |  |  |  |
| **COMMUNICATION x** |  |  |  |  |
| 1. Verbal |  |  |  |  |
| 2. Non-verbal with cognitively impaired patients |  |  |  |  |
| **RANGE OF MOTION EXERCISES x** |  |  |  |  |
| 1. Active |  |  |  |  |
| 2. Passive |  |  |  |  |
| 3. Combination |  |  |  |  |
| **TAKE & RECORD VITAL SIGNS** |  |  |  |  |
| 1. Temperature |  |  |  |  |
| a. Oral |  |  |  |  |
| b. Rectal |  |  |  |  |
| c. Ear canal |  |  |  |  |
| 2. Pulse: |  |  |  |  |
| a. Apical |  |  |  |  |
| b. Radial |  |  |  |  |
| c. Pedal |  |  |  |  |
|  | **0** | **1** | **2** | **3** |
| 3. Respirations |  |  |  |  |
| 4. Blood Pressure |  |  |  |  |
| 5. Height |  |  |  |  |
| 6. Weight |  |  |  |  |
| a. Standing |  |  |  |  |
| b. Bed scale |  |  |  |  |
| c. Chair scale |  |  |  |  |
| **SAFETY DEVICES** |  |  |  |  |
| 1. Vest restraint |  |  |  |  |
| 2. (Soft) wrist / ankle restraint |  |  |  |  |
| 3. Padded side rail |  |  |  |  |
| 4. Side rails |  |  |  |  |
| **MENTAL HEALTH & SOCIAL SERVICE NEEDS x** |  |  |  |  |
| 1. Demonstrates principles of behavior management |  |  |  |  |
| 2. Provides emotional support to patient |  |  |  |  |
| 3. Encourages family support |  |  |  |  |
| 4. Encourages patients to make personal choices |  |  |  |  |
| 5. Respects patient’s rights & dignity, including privacy & confidentiality |  |  |  |  |
| 6. Encourages self-care as ability allows |  |  |  |  |
| 7. Knowledge of adult, child and elder abuse reporting statutes |  |  |  |  |
| 8. Knowledge of domestic violence and violent injury reporting statues |  |  |  |  |
| **SAFETY / EMERGENCIES** |  |  |  |  |
| 1. Recognizes & reports safety hazards |  |  |  |  |
| 2. Recognizes & reports emergencies and responds appropriately |  |  |  |  |
| 3. Handles 02 safely |  |  |  |  |
| 4. Observes, reports & documents changes in body functions, behavior |  |  |  |  |
| **CARE OF PROSTHETIC DEVICES x** |  |  |  |  |
| 1. Limbs |  |  |  |  |
| 2. Eye glasses |  |  |  |  |
| 3. Hearing aids |  |  |  |  |
| **SPECIMEN COLLECTION x** |  |  |  |  |
| 1. Urine |  |  |  |  |
| 2. Stool |  |  |  |  |
| 3. Sputum |  |  |  |  |
| **UNDERSTAND AND CAN PERFORM x** |  |  |  |  |
| 1. Binders & Bandages |  |  |  |  |
| a. ACE bandages |  |  |  |  |
| b. Support stockings |  |  |  |  |
| 2. Care of the deceased |  |  |  |  |
|  | **0** | **1** | **2** | **3** |
| **ASSIST THE CARE OF PATIENT WITH x** |  |  |  |  |
| 1. Diabetes |  |  |  |  |
| 2. Cancer |  |  |  |  |
| 3. Heart Disease |  |  |  |  |
| 4. 02 therapy |  |  |  |  |
| 5. Respiratory disease |  |  |  |  |
| 6. Terminal |  |  |  |  |
| 7. Infectious diseases |  |  |  |  |

To the best of my knowledge, information provided on this CNA Skills Checklist is true and accurate. My

signature indicates that I have read this document in its entirety and understand its contents.

Print Name:

Signature:

Date: