Skills/Experience Checklist
Hospice Registered Nurse (RN)

- This form is a self-assessment of your current skills and abilities.
- This form is also used to document skill demonstration

EMPLOYEE PROFILE			
Last Name	First Name	Middle Initial	Employee Number
Direct Supervisor (Name)	Date Form Initiated	RN	
CPR Card – expiration date			

Sections designated with to be completed by employee. Sections designated with to be completed by supervisor or preceptor.

Previous Experience (Sections RN Must Complete)	**Instruction, Review or Skill Demonstration** (Sections Supervisor or Preceptor Must Complete)
Clinician: Place "X" in the appropriate column using the key below: **A** = I am competent to supervise this skill **B** = I am competent to perform this skill without supervision **C** = I need to review this skill **D** = I need additional instruction on this skill **E** = I have never performed this skill	**Supervisor:** Indicates whether or not a review of policies/procedures or instruction is required then document completion in the appropriate columns. If C or D is selected, review of instruction and possibly the skills demonstration is required prior to assignment to applicable patients. **Preceptor:** Documents completion of skills demonstration or indicates NA as applicable. A date and initials in the Skill Demonstration column indicates competency has been achieved. Do not date or initial until competency is achieved. An additional column is provided for repeat demonstrations. **Complete the signature section at the end of this form.** ***All RNs must demonstrate competencies for items in bold text and marked with an asterisk (*) prior to the first assignment.***
	How Competency Demonstrated **DO** Direct observation **V** Verbalization **S** Simulation **CR** Chart Review **Preceptor/Manager:** Place # of competency and corresponding letter identifying how competency was demonstrated in appropriate column(s).

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Infection Control						1. Institute Standard Precautions at all times 2. Perform proper bag technique 3. Perform hand washing per CDC guidelines 4. Use Personal Protective Equipment (PPE) appropriately 5. Properly handle bio-hazardous materials 6. Demonstrate proper sharps disposal 7. Understand Exposure Control Plan and related responsibilities 8. Understand responsibility to report patient infections and communicable diseases 9. Demonstrate location of Infection Control Policies 10. Demonstrate aseptic and sterile technique appropriately				
Bag Technique						1. Bag contains at least the following: a. Hand washing equipment – skin cleanser and paper towels b. Blood pressure equipment: Stethoscope/sphygmomanometer c. Tape measure for wounds 2. Disposable Items are not expired 3. Bag is placed on a clean surface in the car and in the home. a. If this is not possible, a barrier is placed under the bag 4. Prior to administering care, skin cleanser and paper towels are removed and hands are washed a. Supplies are left at sink for hand washing at end of visit 5. After hand washing, the supplies and/or equipment needed for the visit are removed from the bag				

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Bag Technique (continued)						6. After the visit, reusable equipment is cleaned using all approved disinfectant and/or soap and water as appropriate, hands are washed, and equipment and supplies are returned to the bag 7. Hands are washed prior to returning clean equipment to bag 8. Paper towels/newspapers used as protective barrier for bag placement in the patient/s home are disposed of				
Hand Washing Technique						1. With hands angled downward under the faucet, adjusts the water temperature until it's comfortably warm 2. Works up a generous lather by scrubbing vigorously for at least 20 seconds (Takes care to clean beneath fingernails, around knuckles, and along the sides of fingers and hands) 3. Rinses hands completely to wash away suds and microorganisms 4. Pats dry with a paper towel 5. To prevent recontamination, covers each faucet handle with a dry paper towel when turning off the water				
Sterile Technique						1. Inspect all packaging (Did not use if packaging is wet/damaged) 2. Inspected all bottles or solution bags for signs of contamination 3. Took extreme care to make sure the inside did not touch anything on the outside when opening package 4. Did not touch any sterile items with his/her hands 5. Always wear sterile gloves before touching sterile items				

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Sterile Technique (continued)						6. Always place sterile items only on a sterile surface (May be a separate sterile cloth or the inside of the sterile packaging if it has not touched a non-sterile item) 7. When changing the sterile dressing, wear one pair of gloves to remove the soiled dressing 8. Removed the soiled gloves 9. Used a pair of sterile gloves to cleanse wound and apply sterile dressing 10. Cleansed area in circular motion (center to wound edge)				
Aseptic Technique						1. Work area is kept clean with appropriate disinfecting or cleaning solution 2. Wiped the area with alcohol or the disinfectant solution 3. Cleaned the area after the procedure 4. Washed hands before and after the procedure 5. Kept traffic in the area to a minimum, if possible 6. Avoided direct currents on the area from open windows, doors, heat or air conditioning vents 7. If he/she was not sure if an item was clean, he/she threw it out or cleaned it prior to use				
Base Line Data						1. Accurately measure a Mid-Arm Circumference (MAC) 2. Accurately calculate Basil Metabolic Index (BMI) 3. Assess and accurately calculate a Palliative Performance Scale (PPS) 4. Assess and accurately calculate a Functional Assessment of Staging for Alzheimer's Disease (FAST) 5. Assess and accurately calculate New York Heart Association Classification (NYHA)				

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Base Line Data (continued)						6. Utilize approved scales in the Hospice Eligibility Toolbox (HETB)				
Vital Signs						1. Accurately take an apical pulse for one minute 2. Identify abnormalities in heart rate and rhythm 3. Accurately take temperature (oral, ear, rectal/auxiliary) 4. Record vital signs at a minimum with each visit and document accurately 5. For Blood Pressure (see Cardiac)				
Neurological						1. Assess Level of Consciousness and orientation 2. Identify seizure activity and take appropriate precautions 3. Assess sensation, memory, perception and judgment 4. Utilize approved scales in the Hospice Eligibility Toolbox (HETB)				
Respiratory						1. Assess breath sounds anteriorly and posteriorly by correctly placing stethoscope 2. Identify normal and abnormal breath sounds 3. Identify and document changes in position, i.e. HOB elevated or additional pillows required for comfort or improved breathing 4. Suctioning a. Identify and document indications for suctioning b. Able to suction secretions (oral, nasal, intratracheal) using proper techniques 5. Tracheostomy Care a. Able to inflate and deflate cuff when indicated b. Able to maintain patient airway c. Provide tracheostomy care per procedure 6. Oxygen administration				

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Respiratory Assessment (continued)						7. Administer nebulizer treatment per order 8. Identify potential and actual problems and appropriate interventions 9. Document assessment, interventions, and evaluation of effectiveness and discuss with RN the need for a Plan of Care update				
Cardiac						1. Demonstrate proper technique of taking a BP and identify abnormalities (i.e. pulse pressure) 2. Assess adequate circulation including pulses, capillary refill, skin temperature, skin color and edema and accurately document 3. Identify signs and symptoms of fluid retention 4. Identify postural hypotension 5. Identify pacemaker/internal cardiac defibrillator 6. Understand Pacemaker/Internal Cardiac Defibrillator deactivation 7. Able to monitor Left Ventricular Assist Device * 8. Able to monitor Inotropic Drug Infusion * 9. Identify potential and actual problems and appropriate interventions, evaluate effectiveness and update Plan of Care 10. Assess and accurately calculate New York Heart Association Classification (NYHA)				
Skin/Wound						1. Perform skin assessment using Norton Pressure Score Risk Assessment in HETB 2. Demonstrate ability to properly stage pressure ulcer I-IV 3. Identify potential and actual problems and appropriate interventions by type of wound 4. Perform diabetic skin/foot/nail assessment and teaching				

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Skin/Wound (continued)						5. Document wound assessment and wound(s) appearance, interventions at each visit and update Plan of Care				
Gastrointestinal/ Nutrition						1. Assess and document swallowing status 2. Assess and document oral and dental status 3. Assess and document percentage of intake/changes in intake 4. Able to complete nutritional screening/assessment 5. Identify quantity and quality of bowel sounds 6. Identify potential and actual problems and appropriate interventions including consulting dietitian 7. Initiate bowel program in response to opioid therapy 8. Manage fecal impactions appropriately 9. Nasogastric tube a. Able to change Nasogastric tube b. Assesses tube for placement and patency c. Properly per form irrigation 10. Gastrostomy Tube a. Able to change Gastrostomy tube b. Assess tube for placement and patency c. Properly perform irrigation d. Maintain site 11. Jejunostomy tube a. Assess and document swallowing status b. Maintain site 12. Administer continuous and Bolus tube feedings per Plan of Care safely 13. Ostomy Management a. Able to change appliance b. Maintain skin integrity				

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Gastrointestinal/ Nutrition (continued)						14. Document patient appearance as related to intake, i.e. sunken cheeks, cachectic 15. Identify potential and actual problems and appropriate interventions, evaluate effectiveness discuss with RN the need for a Plan of Care update				
Diabetic Management						1. Monitor blood glucose 2. Identify patients at risk for hypo and hyperglycemic reactions 3. Know signs and symptoms of hypo and hyperglycemia 4. Identify patient knowledge patient and caregiver knowledge deficits, provide education and document patient/caregiver understanding 5. Communicate changes to the physician appropriately and update Plan of Care				
Genitourinary						1. Assess urine output for quality and quantity 2. Assess for urinary continence 3. Foley Catheter a. Able to insert using proper procedure b. Routinely assess tube for placement and patency c. Properly perform irrigation d. Maintain catheter and insertion site 4. Suprapubic catheter care a. Assess tube for placement and patency b. Properly perform irrigation c. Maintain catheter and insertion site 5. Nephrostomy tube management and irrigation 6. Incontinence Management a. Understand brief fitting and educates Hospice Aide				

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Genitourinary (continued)						7. Assess urine for signs and symptoms of UTI 8. Understand and evaluate related clinical changes with UTI i.e. VS, behavior, intake 9. Identify potential and actual problems and interventions and update Plan of Care				
Functional Status						1. Able to complete functional status assessment 2. Identify potential and actual problems and appropriate interventions including need for Hospice Aide services 3. Able to accurately complete and communicate the Hospice Aide assignment 4. Identify potential and actual problem and appropriate interventions including consulting PT and OT as appropriate 5. Positioning a. Able to properly align body b. Support joints and limbs c. Float pressure points 6. Identify actual and potential problems and appropriate interventions 7. Document assessment, interventions, and evaluation of effectiveness and update Plan of Care				
Psychosocial						1. Able to accurately assess the patients and caregivers coping mechanism, adjustment and risk factors 2. Perform pre-bereavement assessment 3. Identify potential and actual problems and appropriate inerventions including use of volunteer services in collaboration with the Medical Social Worker 4. Meet psychosocial needs in collaboration with the MSW when patient refuses social worker visit				

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Spiritual						1. Able to accurately assess patient spiritual/religious preferences and needs 2. Identify potential and actual problems and appropriate interventions in collaboration with the Spiritual Care Coordinator 3. Meet spiritual needs in collaboration with the Spiritual Care Coordinator (SCC) when patient refuses SCC visit				
Infusion Therapy Competency Peripheral IV Insertion (INS Manual Chapter 5) Vascular Access Device (VAD) Procedure						1. Review the Physician's order 2. Verify the patient's identity using 2 independent identifiers 3. Peripheral Catheters a. Explain the procedure to the patient b. Place patient in recumbent position, as tolerated c. Wash Hands d. Gather Supplies e. Assess the upper extremities for an appropriate venipuncture site f. Prepare insertion site i. If visibly soiled, cleanse with antiseptic soap and water ii. Remove excess hair, if necessary g. Wash hands / don non-sterile gloves h. Cleanse insertion site with antiseptic solution; allow to dry completely i. Chlorhexidine solution (preferred): apply using a back-and-forth motion for at least 30 seconds ii. Povidone-iodine: apply using swab sticks in a concentric circle beginning at the catheter insertion site, then moving outward; it must				

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						remain on the skin for at least 2 minutes or longer to completely dry for adequate antisepsis j. Apply a tourniquet above the intended venipuncture site k. Stabilize the selected vein below the intended venipuncture site l. Insert the VAD according to manufacturer's directions for use m. Release the tourniquet n. Attach connector; flush catheter with primed saline flush, or attach primed administration set. i. Observe the site for signs of swelling, or patient complaints of discomfort or pain, removing VAD if present o. Stabilize the VAD with sterile tape, surgical strips, or a stabilization device p. Apply a transparent dressing over the insertion site q. Discard used supplies in the appropriate receptacles r. Remove gloves/wash hands s. Label dressing: i. Date and time of insertion ii. Gauge and length of VAD iii. Initials of inserter t. Document procedure in the patient's electronic medical record. Include: VAD size/length; site of insertion; infusion fluids connected or flush used; how patient tolerated procedure; patient instructions provided				

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Dressing Change Procedures (INS Manual-Chapter 6) Short Peripheral Catheter						1. Review the Physician's order 2. Verify the patient's identity using 2 independent identifiers 3. Short Peripheral Catheter a. Wash Hands b. Gather Supplies c. Explain procedure to patient d. Apply gloves e. Assess insertion site for redness, tenderness, swelling, or drainage f. Remove existing dressing, beginning at device hub and gently pulling the dressing perpendicular to the skin toward the insertion site g. Remove stabilization device h. Cleanse skin with antiseptic solution; allow to dry completely i. Chlorhexidine solution (preferred): apply using a back-and-forth motion for at least 30 seconds ii. Povidone-iodine: apply using swab sticks in a concentric circle beginning at the catheter insertion site, moving outward; it must remain on the skin for at least 2 minutes or longer to dry completely for adequate antisepsis i. Apply stabilization device, surgical strips, or sterile tape j. Apply transparent dressing (or gauze and tape) dressing to insertion site k. Discard used supplies in appropriate receptacles l. Remove gloves and discard				

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						m. Wash hands n. Label dressing with date, time, and initials of nurse performing procedure o. Document procedure in patient's permanent medical record				
Dressing Change Procedures (INS Manual-Chapter 6) Central Venous Access Device; PICC or Midline Catheter						1. Review the Physician's order 2. Verify the patient's identity using 2 independent identifiers 3. Central Venous Access Device; PICC or Midline Catheter a. Wash Hands b. Gather Supplies c. Explain procedure to patient d. Don mask e. Assess insertion site for redness, tenderness, swelling or drainage f. Remove existing dressing, beginning at device hub and gently pulling the dressing perpendicular to the skin toward the insertion site g. Remove stabilization device, if applicable h. Remove gloves i. Wash hands j. Don sterile gloves k. Measure external length of CVAD or midline catheter l. Cleanse skin with antiseptic solution; allow to dry completely i. Chlorhexidine solution (preferred): apply using a back-and-forth motion for at least 30 seconds ii. Povidone-iodine: apply using swab sticks in a concentric circle beginning at the catheter				

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						insertion site, moving outward; it must remain on the skin for at least 2 minutes or longer to dry completely for adequate antisepsis m. Discard used supplies in appropriate receptacles n. Remove gloves and discard o. Wash hands p. Label dressing with date, time, initials of nurse performing the procedure q. Document procedure in patient's permanent medical record				
Infusion Flushing Procedure for Vascular Access Devices (VACs)						1. Review the Physician's order 2. Verify the patient's identity using 2 independent identifiers 3. Infusion Flushing Procedure for Vascular Access Devices (VAC) a. Wash hands b. Gather supplies c. Don gloves d. Disinfect needless connector with antiseptic wipe using friction and a scrubbing motion; allow to dry completely e. Attach syringe of preservative-free 0.9% sodium chloride (USP) to needleless connector while maintaining the sterility of the syringe tip f. Open VAD clam, if present g. Slowly aspirate until brisk blood return is obtained h. Slowly inject preservative-free 0.9% sodium chloride (USP) into VAD, noting any resistance or sluggishness of flow i. Never inject against resistance				

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						ii. VAD will require further evaluation if unable to flush freely i. Remove syringe and discard j. Document flush solution; site status-patency; patient's tolerance to procedure k. If MD orders to keep patency with Hep-Lock: i. Flush with saline ii. Instill Hep-Lock iii. Document procedure l. Implanted vascular access ports are accessed using only a non-cording needle m. Power injection will be performed only with implanted vascular access ports and non-coring needles identified as power-injection compatible n. When administering an infusion via an implanted port, the non-coring needle is replaced at least every 7 days o. The implanted port should be accessed, flushed, and locked every 4 weeks or per MD orders				
Procedure for Port Access						1. Wash hands 2. Verify the patient's identify using two independent identifiers 3. Explain procedure to patient 4. Gather Supplies a. Mask b. Gloves, sterile c. Antiseptic solution d. Non-coring needle with extension set e. Needleless connector f. Preservative-free 0.9% sodium chloride (USP) prefilled syringe g. Gauze and tape, sterile				

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						h. Transparent Semipermeable membrane (TSM) dressing 5. Place patient in comfortable position with head turned away from implanted port 6. Assess skin over and around implanted port; palpate port to locate septum 7. Assemble supplies on sterile field 8. Don mask and sterile gloves 9. Cleanse implanted port access site; allow to dry completely 10. Attach needleless connector to non-coring needle with extension set, and prime set with preservative-free 0.9% sodium chloride (USP) 11. With non-dominant hand, palpate and stabilize the implanted port 12. Insert non-coring needle perpendicular to the skin through septum of the port until the needle tip comes in contact with the back of the port 13. Aspirate for blood to confirm device patency and flush with preservative-free 0.9% sodium chloride (USP) 14. Stabilize non-coring needle with sterile tape; place sterile gauze to support wings of non-coring needle if present, making sure gauze does not obscure needle insertion site 15. Apply Transparent Semipermeable Membrane (TSM) dressing 16. Initiate infusion therapy as ordered 17. Discard used supplies in appropriate receptacles 18. Remove gloves and wash hands 19. Document procedure in the patient's permanent medical record				

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Procedure for Port De-access						1. Wash hands
						2. Verify the patient's identify using two independent identifiers
						3. Explain procedure to patient
						4. Gather Supplies
						  1. Gloves, non-sterile
						  2. Preservative-free 0.9% sodium chloride (USP) prefilled syringe
						  3. Heparin 100 units/ml, 3-5 ml prefilled syringe
						  4. Gauze and tape, sterile
						  5. Transparent Semipermeable Membrane (TSM) dressing
						5. Apply non-sterile gloves
						6. Flush port with 5-10 ml of preservative-free 0.9% sodium chloride (USP) and lock port with heparin as prescribed
						7. Remove dressing, noting any drainage, redness, or swelling and discard
						8. Stabilize port using thumb and forefinger of non-dominant hand. Grasp needle with dominant hand and remove device, engaging safety mechanism; discard into sharps container
						9. Apply gauze dressing to site if bleeding occurs
						10. Discard used materials in appropriate receptacles
						11. Remove gloves and wash hands
						12. Document procedure in patient's permanent medical record				

Procedure for Vascular Access Device Removal						1. Wash hands 2. Verify the patient's identify using two independent identifiers 3. Explain procedure to patient				

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Procedure for Vascular Access Device Removal (continued)						4. Gather Supplies a. PPE as indicated b. Gloves, non-sterile c. Suture removal set, as needed d. Gauze, sterile e. Petroleum based ointment, sterile f. Transparent Semipermeable Membrane (TSM) dressing 5. Explain procedure to patient a. Educate patient in Valsalva's maneuver for a CVAD removal procedures b. If a Valsalva's maneuver is contraindicated, have the patient exhale during the procedure 6. Don gloves 7. Place patient in sitting or recumbent position 8. Discontinue administration of all infusates 9. Remove dressing from insertion site 10. Remove stabilization device or sutures, if present 11. Inspect catheter-skin junction 12. Apply gauze to insertion site. With dominant hand, slowly remove catheter using gentle, even pressure a. Use extreme caution when removing central non-tunneled catheters to prevent the occurrence of air embolism b. Discontinue removal if resistance is met, and notify MD 13. Apply pressure to site with gauze for a minimum of 30 seconds, or until hemostasis is achieved 14. Apply petroleum-based ointment to exit site, cover with gauze and transparent dressing 15. Patient should remain in sitting or recumbent position for 30 minutes post CVAD removal				

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Procedure for Vascular Access Device Removal (continued)						16. Change dressing every 24 hours until exit site is healed 17. Assess integrity of removed catheter. Compare length of catheter to original insertion length to ensure entire catheter is removed 18. Document procedure in patient's permanent medical file				
Patient Safety						1. Able to accurately calculate a Fall Risk Assessment Score using the HETB appropriately 2. Able to accurately complete an environmental risk assessment including oxygen safety as appropriate 3. Identify potential and actual problems, appropriate interventions using the Patient Family Handbook and discuss with the RN the need for a Plan of Care 4. Assess patient caregiver knowledge deficit, ability to learn and how each learns 5. Provide education and document patient caregiver understanding 6. Utilize principles of proper body mechanics				
State Specific										
Other										

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Initials	Print Name	Signature/Title	Date