










Hospice Skills/Experience Checklist—LPN/LVN

 Previous Experience						 Guidelines to Evaluate Competency	 Instruction, Review or Skill Demonstration			
<input type="checkbox"/> Required for all Nurses	A	B	C	D	E		Review or Instruction Needed (Y/N/NA)	Review or Instruction Completed Date/Initial/How Competency Demonstrated	Repeat Skills Demo Date/Initial/How Competency Demonstrated	Manager/Preceptor's Comments
Vital Signs						1. Accurately takes an apical pulse for one minute 2. Identifies abnormalities in heart rate and rhythm 3. Accurately takes temperature (oral, ear, rectal/ auxiliary). 4. Records vital signs at a minimum with each visit and documents accurately				
Neuro						1. Assesses Level of Consciousness and orientation 2. Identifies seizure activity and takes appropriate precautions 3. Assesses sensation, memory, perception and judgment 4. Utilizes approved scales in the Hospice Eligibility Toolbox (HETB)				
Respiratory Assessment						1. Assess breath sounds anteriorly and posteriorly by correctly placing stethoscope 2. Identifies normal and abnormal breath sounds 3. Identifies and documents changes in position i.e. HOB elevated or additional pillows required for comfort or improved breathing 4. Suctioning a. Identifies and documents indications for suctioning b. Able to suction secretions (oral, nasal, intracheal) using proper techniques 5. Tracheostomy Care a. Able to inflate and deflate cuff when indicated b. Able to maintain patent airway c. Provides tracheostomy care per procedure 6. Oxygen administration a. Properly applies and regulates oxygen via mask, cannula, CPAP, BiPAP b. Understands Oxygen % and related treatment protocols 7. Administers nebulizer treatment per order Identifies potential and actual problems and appropriate interventions 8. Documents assessment, interventions, and evaluation of effectiveness and updates plan of care				




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Cardiac						1. Demonstrates proper technique of taking a BP and identifying abnormalities (i.e. pulse pressure) 2. Assesses adequate circulation including pulses, capillary refill, skin temperature, skin color and edema and accurately documents 3. Identifies signs and symptoms of fluid retention 4. Identifies postural hypotension 5. Identifies pacemaker/internal cardiac defibrillator 6. Understands Pacemaker/Internal Cardiac Defibrillator deactivation 7. Able to monitor Left Ventricular Assist Device * 8. Able to monitor Inotropic Drug Infusion * 9. Identifies potential and actual problems and appropriate interventions, evaluates effectiveness and updates plan of care 10. Assesses and Accurately calculates New York Heart Association Classification (NYHA)				
Skin/Wound						1. Performs skin assessment using Norton Pressure Score Risk Assessment in HETB 2. Demonstrates ability to properly stage pressure ulcers I-IV 3. Identifies potential and actual problems and appropriate interventions by type of wound 4. Performs diabetic skin/foot/nail assessment and teaching 5. Documents wound assessment and wound(s) appearance, interventions at each visit and updates the plan of care				




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Gastrointestinal/Nutrition						1. Assesses and documents swallowing status 2. Assesses and documents oral and dental status 3. Assesses and documents percentage of intake/changes in intake 4. Able to complete nutritional screening/assessment 5. Identifies quantity & quality of bowel sounds 6. Identifies potential and actual problems and appropriate interventions including consulting dietitian 7. Initiates bowel program in response to opioid therapy 8. Manages fecal impactions appropriately 9. Nasogastric tube a. Able to change Nasogastric tube b. Assesses tube for placement and patency c. Properly performs irrigation 10. Gastrostomy Tube a. Able to change Gastrostomy tube b. Assesses tube for placement and patency c. Properly performs irrigation d. Maintains site 11. Jejunostomy tube a. Assesses tube for placement and patency b. Maintains site 12. Administers continuous and Bolus tube feedings per plan of care safely 13. Ostomy management a. Able to change appliance b. Maintains skin integrity 14. Documents patient appearance as related to intake i.e. sunken cheeks, cachectic 15. Identifies potential and actual problems and appropriate interventions, evaluates effectiveness and updates plan of care				

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Diabetic Management						1. Monitors blood glucose 2. Identifies patients at risk for hypo and hyperglycemic reactions 3. Knows signs and symptoms of hypo and hyperglycemia 4. Identifies knowledge patient and caregiver knowledge deficits, reinforces education and documents patient/caregiver understanding 5. Communicates changes to the RN/MD appropriately				
Genitourinary						1. Assesses urine output for quality and quantity 2. Assesses for urinary continence 3. Foley Catheter <ul style="list-style-type: none"> a. Able to insert using proper procedure b. Routinely assess tube for placement and patency c. Properly performs irrigation d. Maintains catheter and insertion site 4. Supra pubic catheter care <ul style="list-style-type: none"> a. Assess tube for placement and patency b. Properly performs irrigation c. Maintains catheter and insertion site 5. Nephrostomy tube management and irrigation 6. Incontinence Management <ul style="list-style-type: none"> a. Understands brief fitting and educates Hospice Aide 7. Assesses urine for signs and symptoms of UTI 8. Understands and evaluates related clinical changes with UTI i.e. VS, behavior, intake 9. Identifies potential and actual problems and appropriate interventions and updates plan of care				

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Functional Status						1. Able to complete functional status assessment 2. Identifies 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. Identifies potential and actual problems and appropriate interventions including consulting PT and OT as appropriate 5. Positioning a. Able to properly align body b. Supports joints and limbs c. Floats pressure points 6. Identifies actual and potential problems and appropriate interventions 7. Documents assessment, interventions, and evaluation of effectiveness and updates plan of care				
Psycho-social						1. Able to accurately assess the patients and caregivers coping mechanism, adjustment and risk factors 2. Performs pre-bereavement assessment 3. Identifies potential and actual problems and appropriate interventions including use of volunteer services in collaboration with the Medical Social Worker 4. Meets psycho-social needs in collaboration with the MSW when patient refuses social worker visit				
Spiritual						1. Able to accurately assess patient spiritual/religious preferences and needs 2. Identifies potential and actual problems and appropriate interventions in collaboration with the Spiritual Care Coordinator 3. Meets spiritual needs in collaboration with the Spiritual Care Coordinator (SCC) when patient refuses SCC visit				

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Patient Safety						<ol style="list-style-type: none"> 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. Identifies potential and actual problems, appropriate interventions using the Patient Family Handbook and updates the plan of care 4. Assesses patient care giver knowledge deficit, ability to learn and how each learns 5. Provides education and documents patient caregiver understanding 6. Utilizes principles of proper body mechanics 				
Promotion of Communication With Patient/Caregiver						<ol style="list-style-type: none"> 1. Identifies best method of communication to meet the patient/caregiver needs i.e. verbal, written, demonstration 2. Connects with those patients with memory deficits using the "You Are A Member Of The Team" section of the Patient Family Handbook 3. Shares best method of connection with patient with IDG and documents in the medical record 4. Listens and speaks clearly and directly to the patient/caregiver 5. Identifies special needs i.e. language, vision, hearing and shares needs with IDG and updates plan of care 6. Accesses language line when appropriate 7. Identifies environment that promotes effective communication 8. Requests permission to speak about patient and care when others are present i.e. friends, roommates 9. Confirms each visit that the patient knows how and when to contact the hospice nurse using the Patient Family Handbook as a reference 10. Confirms the next scheduled visit at the end of each visit 				

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Symptom Management						<ol style="list-style-type: none"> 1. Assess the patient considering individual differences, cultural background, terminal diagnosis, comorbid conditions 2. Consistently evaluates and documents patient outcome measures 3. Identifies the patient's level of pain, dyspnea, anxiety and shortness of breath at each visit using the appropriate scale and documents accurately 3. Plans care based on the patient's assessed needs, symptom management protocols and physician collaboration 4. Evaluates and implements non pharmacological measures 5. Evaluates and documents effectiveness of symptom management and updates plan of care 6. Educates the patient and caregiver on symptom management and documents education and understanding in the medical record 				
Infection Control <ul style="list-style-type: none"> • Bag Technique • Hand Hygiene • Aseptic Technique • Sterile 						<ol style="list-style-type: none"> 1. Institutes Standard Precautions at all times 2. Performs proper bag technique 3. Performs hand washing per CDC guidelines 4. Uses Personal Protective Equipment (PPE) appropriately 5. Properly handles biohazardous materials 6. Demonstrates proper sharps disposal 7. Instructs patient/family on infection control policies and practices referencing the Patient Family Handbook related to the care of the patient 8. Documents patient/caregiver education and how the patient demonstrated understanding 9. Understands Exposure Control Plan and related responsibilities 10. Understands responsibility to report patient infections and communicable diseases <ol style="list-style-type: none"> a. Uses correct form 11. Knows procedure of obtaining, labeling, transporting specimen 12. Instructs patient on specimen collection when appropriate 13. Demonstrates location of Infection Control Policies 				

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Patient Family Education and Support						1. Assesses patient/care giver knowledge deficits at each visit and with changes in the plan of care 2. Individualizes instruction based on individuals ability and readiness to learn 3. Evaluates learning/understanding and documents in the medical record 4. Updates the plan of care 5. Refers to the Patient Family Handbook as appropriate and supplements written educational material when appropriate					
Discharge Planning						1. Identifies difference between discharge and revocation 2. Coordinates care across the continuum 3. Plans care to include any necessary family counseling, patient education, or other services before the patient is discharged because he/she is no longer terminally ill 4. Identifies three (3) reasons CMS allows a hospice to discharge a patient 5. Obtains order to discharge and accurately completes discharge					
Death of a Patient						1. In preparation for death, helps the family to understand what will happen at time of death i.e. what the patient will look like, how they will breathe 2. Assess imminently dying patient and intervenes appropriately 3. Follows policy and procedure on Post Mortem Care 4. Understands state Pronouncement laws and responsibilities to the coroner 5. Assures that all necessary paperwork is completed, signed and dated timely 6. Disposes of narcotics per policy; documents in medical record 7. Communicates effectively with family letting them know what to expect next, answer questions 8. Supports the grieving process 9. Coordinates care with the IDG 10. Ensures hospice and attending physician is notified 11. Ensures DME is picked up timely					

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Medication Management						1. Reconciles medications across the continuum of care at admission and live discharge 2. Identifies drug allergies 3. Observes and reports adverse drug reaction a. Assesses patient for adverse reaction b. Notifies physician and intervenes appropriately c. Reports using incident report 4. Knowledgeable of drug formulary 5. Uses approval process for off formulary medications 6. Patient/Caregiver teaching related to medications a. Explains reason for drug, action and side effects b. Explains precautions related to food-drug interactions c. Explains how to assess for effectiveness and when and how to communicate needs to the RNCM/on-call staff 7. Checks patient supply at each visit; manages delivery cost 8. Follows "Tuck- In" process to ensure				
Physician Orders						1. All telephone orders are read back and the read back is documented 2. All physician orders are noted and authenticated and carried out timely and accurately				

Initials	Print Name	Signature/Title	Date
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