

NURSING ASSISTANT COMPETENCY LIST ICU/PCU

Name: _____ Orientation Date: _____

NURSING ASSISTANT CLINICAL SKILL	Self-Assessment- prior to orientation	Demonstrated with supervision Date/Initialed	Demonstrated Independently Date/Initialed	Comments Date/Initialed
	Competent to Perform Skill			
1. Admission of patient				
a. Orients patient to room				
b. Inventories patient's belongings and places in closet or sends home with family. Documents in electronic health record(EHR)				
c. Shows patient how to use bed controls, lights and TV				
d. Performs initial V.S. and takes BP in both upper extremities upon admission				
e. Applies telemetry				
2. Operates bed safely				
a. Raises and lowers bed				
b. Raises head of bed				
c. Able to set bed alarms				
d. Able to raise and lower side rails				
e. Able to put bed in trendelenberg				
3. Communication				
a. Answers telephone by stating name, unit and title				
b. Transfers calls correctly				
c. Able to answer patient call bell system				
d. Opens GroupWise email, sends email, replies to email				
4. Makes occupied beds according to procedure				
5. Vital Signs				
a. Accurately obtains and reports changes				
Temperature				
1) Oral				
2) Rectal				
Pulse				
Respirations				
Blood Pressure				
1) Automated				
2) Manual				
b. Able to use pulse oximeter correctly				
c. States abnormal vital signs				
d. Documents vitals signs in EHR accurately				
6. Infection Control				
a. Uses transmission- based precautions per infection control manual				
b. Hand Hygiene before and after patient contact				

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c. Demonstrates use of waterless hand cleaner				
d. Verbalizes appropriate hand hygiene for patients with c. diff.				
7. Patient Care				
a. Provides bath in a safe manner providing privacy for patient				
b. Provides back care to bedridden patients				
c. Performs ROM exercises per procedure				
d. Provides oral care per procedure including safe mouth care to patients with artificial airways.				
e. Verbalizes and demonstrates appropriate use for bed-in-a-bath products				
f. Provides indwelling catheter care according to procedure				
g. Aware of HRMC Urinary Device Protocol				
h. Measure intake and output accurately and documents measurements in EHR.				
i. Applies cold compresses per procedure				
j. Feeds patient as directed				
k. Uses proper body mechanics				
l. Able to complete patient care assignment within allotted time frame				
m. Communicates changes in patient's condition to RNs and LPNs				
n. Documents patient care ADLs				
8. Transfers patient safely				
a. Bed to chair				
b. Bed to stretcher				
c. Chair to wheelchair				
d. Transfer using SLIPP				
e. Demonstrates use of Vanderlift				
9. Specimen collection per procedure				
a. From indwelling Urinary catheter				
b. Mid stream, clean catch				
c. Stool				
14. Restraints				
a. Applies and releases restraints according to Procedure				
b. Able to state duties as a sitter when providing 1:1 observation				
15. Accurately and safely weighs patients using				
a. Floor scale				
c. Bed scale				
16. Assembles suction canister per procedure				
Changes suction canisters & sets up new NGT supplies daily				

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17. Able to state personal role in hospital emergencies				
a. Code Red				
b. Code Blue				
c. Code White				
d. Code Pink				
e. Code Amber				
f. Code Yellow				
g. Code Gray				
h. Code Silver				
i. Code Orange				
j. Code Triage				
k. Code Clear				
l. Code Help				
m. Rapid Response Team				
n. OB Emergency				
o. Active Shooter Announcement				
18. Patient Safety				
a. Verbalizes two identifiers				
b. Identifies when to use two identifiers				
c. Verbalizes HRMC Fall Prevention protocol				
d. Demonstrates use of TABS bed alarm and chair alarm.				
e. Tests bedside nurse call button and bathroom call button when patient is admitted to room.				
f. Keeps patient supplies within their reach i.e. urinal, tissues, nurse call bell.				
g. Keeps path to bathroom unobstructed				
h. Informs nurse of alarms on patient equipment.				
i. Repositions patient safety taking into consideration medical condition and equipment that is in place.				
j. Test code buttons weekly				
k. Discusses examples of hand-off communication				
l. Documents skin protocol from task list				
m. Documents fall monitoring from task list				
19. Age Specific > 16 years				
a. Involves patient in care				
b. Involves the patient in planning and providing care				
c. Allows patient to maintain control and involves in decision making when possible				

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20. Geriatric a. Above (see # 21) and b. Recognizes potential for loss of hearing and/or sight c. slows pace of care to allow for slower mobility of elderly d. Adjusts for transportation & mobilization needs e. Monitors for breakdown of skin & need for increased protection f. Assists with meals				
Department Specific Policies a. Access online policies b. Locates department resources ➤ Reference books and materials				
c. Reviews department performance improvement activities, staff meeting schedule, unit change of command.				
d. Verbalizes understanding of department routine for 24 hrs.				
e. Demonstrates access to Learning Suite and obtaining assignments				
f. Prints education transcripts				
g. Able to locate supplies on unit, completes seek and find				
h. Verbalizes understanding of cell phone policy				
24. Patient Equipment				
a. Accurately and appropriately removes patient care items from Par-Ex system				
b. Checks defibrillator according to procedure and documentation log.				
c. Applies SCDs and checks proper function; assists nurse in measuring for appropriate size				
c. Verbalizes procedure for equipment that is not working				
d. Obtains V.S. using ICU bedside monitoring system.				
e. Obtains V.S. using portable DASH monitor				

Supervisor: Your signature indicates you have reviewed orientation checklist items with employee. Please have employee sign and send completed checklist to Nursing Education.

Supervisor/Designee Signature

Date

Employee Signature

Date