



CNA SKILLS CHECKLIST

NAME: _____ DATE: _____

YEARS OF EXPERIENCE: _____

PLEASE INDICATE YOUR LEVEL OF EXPERIENCE

1. THEORY, NO PRACTICE - DIDACTIC INSTRUCTION ONLY, NO HANDS ON EXPERIENCE
2. LIMITED EXPERIENCE - KNOWS PROCEDURE/HAS USED EQUIPMENT, BUT HAS DONE SO INFREQUENTLY OR NOT WITHIN THE LAST SIX MONTHS.
3. MODERATE EXPERIENCE. - ABLE TO DEMONSTRATE EQUIPMENT/PROCEDURE, PERFORMS THE TASK/SKILL INDEPENDENTLY WITH ONLY RESOURCE ASSISTANCE NEEDED
4. PROFICIENT/COMPETENT - ABLE TO DEMONSTRATE/PERFORM THE TASK/SKILL PROFICIENTLY WITHOUT ANY ASSISTANCE AND CAN INSTRUCT/TEACH

- A. VITAL SIGNS (TAKE & RECORD)**
- | | 1 | 2 | 3 | 4 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. TEMPERATURE: AXILLARY, ORAL, AND RECTAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. PULSE: RADIAL, APICAL, AND BRACHIAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. RESPIRATION'S | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HEIGHT AND WEIGHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- B. COMMUNICATIONS**
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. VERBAL AND NON-VERBAL WITH COGNITIVELY IMPAIRED PATIENTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. MAINTAINING PATIENT CONFIDENTIALLY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. BILINGUAL <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LANGUAGE USED: | _____ | | |

- C. ENVIRONMENT**
- | | | | | |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. LINEN CHANGE: | | | | |
| A. UNOCCUPIED | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. OCCUPIED | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. LIGHT HOUSEKEEPING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. MEAL/SNACK PREPARATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- D. AMBULATING**
- | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. CANE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CRUTCHES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. WALKER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. STANDBY ASSISTANT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- E. TRANSFER TECHNIQUES**
- | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. GAIT BELT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. WEIGHT BEARING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. HOYER/EASYSTAND | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 2-PERSON TRANSFER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. PIVOT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. WHEELCHAIR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- F. POSITIONING/TURNING**
- | | | | | |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. SUPINE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|

- | | 1 | 2 | 3 | 4 |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. SIDE LYING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. USE OF DRAW SHEET | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. RANGE OF MOTION EXERCISES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. IN CHAIR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- G. PERSONAL CARE**
- | | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. BATH: | | | | |
| A. BED | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. TUB | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. SHOWER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. SKIN CARE | | | | |
| A. BACK RUB | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. APPLYING LOTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DECUBITUS CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. SHAMPOO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. NAIL CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. ORAL HYGIENE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DENTURE CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. SHAVING: SAFETY/ELECTRIC RAZOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. DRESSING: ASSIST/COMPLETE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. PERINEAL CARE | | | | |
| A. MALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. FEMALE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- H. NUTRITION/HYDRATION:**
- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ENCOURAGE FLUIDS PER PATIENT ORDERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. TYPES OF DIET | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ASSIST IN FEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. FEEDING TECHNIQUES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. MEASURE AND RECORD INPUT/OUTPUT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- I. INFECTION CONTROL**
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. HAND WASHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. UNIVERSAL PRECAUTIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

- J. ELIMINATION**
- | | 1 | 2 | 3 | 4 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. BED PAN/URINAL & FRACTURE PAN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. BEDSIDE COMMODE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. MEASURE & RECORD OUTPUT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. FOLEY CATHETER CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. EXTERNAL CATHETER CARE/
PLACEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ENEMAS: TAP H2O, FLEETS AND
SOAP SUDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- K. SPECIMEN COLLECTIONS**
- | | | | | |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. URINE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. STOOL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. SPUTUM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- L. SAFETY DEVICES**
- | | 1 | 2 | 3 | 4 |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. VEST RESTRAINT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. SOFT ANKLE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. WRIST RESTRAINTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- K. OXYGEN THERAPY**
- | | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. FLOW RATE (CHECK FOR
ACCURACY) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CANNULA/MASK PLACEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- L. OBSERVATIONS/REPORTING/
DOCUMENTATION**
- | | | | | |
|-----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. CHANGE IN BODY FUNCTIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. CHANGE IN BEHAVIOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CHANGE IN ROUTINES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CHANGE IN MENTATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES

SIGNATURE

DATE