**Licensed Nurse Competency Checklist – Change of Condition**

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**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hire Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Skill Area** | | **Evaluation**  **(Check One)** | | **Method of Evaluation**  **(Check One)**  D = Skills Demonstration  O = Performance Observation  W = Written Test  V = Verbal Test | | | | **Verification**  **(Initials/Date)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Competency**  **Demonstrated/**  **Meets**  **Standards** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Licensed Nurse** | Demonstrate blood pressure measurement. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual resident and facility recommended parameters for systolic and diastolic blood pressure readings. |  |  |  |  |  |  |  |
| Demonstrate peripheral pulse measurement. |  |  |  |  |  |  |  |
| Demonstrate apical heart rate measurement. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual resident and facility recommended parameters for resting pulse rates and irregular rhythms. |  |  |  |  |  |  |  |
| Demonstrate respiratory rate measurement. |  |  |  |  |  |  |  |
|  | Demonstrate understanding of individual resident and facility recommended parameters for tachypnea or bradypnea. |  |  |  |  |  |  |  |
| Demonstrate oral, rectal, axillary, and tympanic temperature measurement. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual resident and facility recommended parameters for fever and hypothermia. |  |  |  |  |  |  |  |
| Demonstrate weight measurement using standing, wheelchair, lift, and bed scales. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual resident and facility recommended parameters for physician notification of weight loss. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual resident and facility recommended parameters for weight gain associated with heart failure, chronic kidney failure, or other volume overload state. |  |  |  |  |  |  |  |
| Demonstrate pulse oximetry measurement on room air and on oxygen. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual and facility recommended parameters for hypoxia. |  |  |  |  |  |  |  |
|  | Demonstrate blood glucose measurement. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual and facility recommended parameters for hyperglycemia and hypoglycemia. |  |  |  |  |  |  |  |
| Demonstrate Pain Evaluation; including presence of new or worsening pain, location, description, pain intensity using numerical and verbal scales. |  |  |  |  |  |  |  |
| Demonstrate Pain Evaluation for a non-verbal resident with dementia. |  |  |  |  |  |  |  |
| Demonstrate understanding of individual and facility recommended parameters for pain management. |  |  |  |  |  |  |  |
| Demonstrate Mental Status Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline mental status. |  |  |  |  |  |  |  |
| Demonstrate Functional Status Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline functional status. |  |  |  |  |  |  |  |
| Demonstrate Behavioral Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline behaviors. |  |  |  |  |  |  |  |
| Demonstrate Respiratory Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline respiratory status. |  |  |  |  |  |  |  |
|  | Demonstrate Cardiovascular Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline cardiovascular status. |  |  |  |  |  |  |  |
| Demonstrate Abdominal/GI Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline abdominal/GI status. |  |  |  |  |  |  |  |
| Demonstrate GU/Urine Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline GU/urine status. |  |  |  |  |  |  |  |
| Demonstrate Skin Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline skin condition. |  |  |  |  |  |  |  |
| Demonstrate Neurological Evaluation. |  |  |  |  |  |  |  |
| Demonstrate understanding of deviations from resident’s baseline neurological status. |  |  |  |  |  |  |  |
| Demonstrate facility procedure for physician or physician extender notification regarding change of condition by telephone, fax. |  |  |  |  |  |  |  |
|  | Demonstrate facility documentation standards for change of condition identification, evaluation, communication, and intervention. |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**References**

Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

LTC Survey Pathways (Download) CMS-20062 “Sufficient and Competent Nurse Staffing Review”

<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes.html>

**\*I certify that I have received orientation in the above-mentioned areas.**

**\*Employee:**

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**Initials**  **Signature**  **Date**

**Evaluator/Trainer:**

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**Initials Signature Date**

***(PLACE IN EMPLOYMENT FILE)***