**Licensed Nurse Competency Checklist-Dialysis**

*State logo added here. If not, delete text box*

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

| **Skill Area** | **Evaluation****(Check One)** | **Method of Evaluation****(Check One)**D = Skills DemonstrationO = Performance ObservationW = Written TestV = Verbal Test | **Verification** **(Initials/Date)** |
| --- | --- | --- | --- |
| **Competency****Demonstrated/****Meets** **Standards** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Evaluator complete** **Licensed Nurse Competency Checklist-Dialysis** | Demonstrates /verbalizes understanding of hospital/dialysis facility agreement for dialysis |  |  |  |  |  |  |  |
| Demonstrates /verbalizes understanding of hospital transfer /change of condition |  |  |  |  |  |  |  |
| Demonstrates / verbalizesunderstanding of communication and collaboration required between dialysis facility and nursing home. |  |  |  |  |  |  |  |
| Demonstrate /verbalizes understanding of dialysis emergency policy and procedure e.g., bleeding/hemorrhage. |  |  |  |  |  |  |  |
| Demonstrates / verbalizesunderstanding of resident preference, individualized resident care plan, interventions and goals. |  |  |  |  |  |  |  |
| Demonstrates proper MDS 3.0 Coding for Sections (if applicable):* H
* K

Dialysis should not be coded Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis* O

Do not include IV medications of any kind that were administered during dialysis* O

O0100J, Dialysis* (other):
 |  |  |  |  |  |  |  |
| Verbalizes understanding of Federal Requirements of Participation as it relates to dialysis: * Dignity
* Right to be informed and make treatment decisions
* Right to refuse
* Advance Directives CA
* Notification of change
* Accommodation of needs, call system
* Be provided by qualified persons
* Pressure ulcer
* Nutrition
* Hydration
* Unnecessary Medications
* Infection Control
* Medical director
* Resident Records
 |  |  |  |  |  |  |  |
| Licensed nurse demonstrates documentation responsibilities for dialysis:* Assessment Process
* RAI Process
* Care Plan Development, Implementation and Revisions
* Communication
* Etc.
 |  |  |  |  |  |  |  |
| Demonstrates patient teaching:* diet,
* fluid restriction,
* no BP, Sleeping on or tight clothes on the arm with access point?
 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

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

**\*Employee:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

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

**Evaluator/Trainer:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Initials Signature Date**

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

**References:**

Centers for Medicare and Medicaid Services (CMS) 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>

Centers for Medicare and Medicaid Services (CMS) Dialysis Critical Element Pathway, Form CMS 20076 (5/2017): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>