**Registered Nurse Competency Checklist**

**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****F636, F641, F642, F726** | **Needs Additional Training** |
| **D** | **O** | **W** | **V** |
| **Basic Steps:****Neurological** **Physical Assessment** | Evaluation areas to include:* Neurological
* Respiratory
* Cardiac
* Abdominal.GI
* Head and Neck
* Upper Extremities
* Lower Extremities
* Skin
* General Appearance
* Level of Orientation: person, place, and time
* Level of consciousness
* Pupils
* Hand Grips
* Leg Strength
* Inspect gait (stability, stride, arm swing, and posture)
* Test Deep Tendon Reflexes Bilaterally (patella and plantar)
* Test for Sensory Responses Bilaterally with Sharp and Dull Stimuli (distal portion of hands and distal portion of feet)
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| **Basic steps: Respiratory, Chest and Lungs****Physical Assessment** | * Inspect Respiratory Pattern
* Auscultate breath sounds in anterior, posterior and lateral lung fields
* Inspect anterior, posterior, and lateral chest for symmetry and shape (no barrel chest)
* Inspect respiratory effort (effortless breathing)
* Palpate posterior chest bilaterally for lumps, masses, and tenderness
* Confirm symmetric expansion
* Auscultate each lobe of lungs bilaterally using systemic approach: anterior, posterior, lateral areas.
* Listen for one full respiratory cycle at each site
 |  |  |  |  |  |  |  |
| **Basic steps: Cardiac Physical Assessment**  | * Auscultate apical pulse site
* Rate and rhythm
* Palpate the carotid arteries for symmetry, regularity, and strength
* Inspect and palpate precordium for heave or thrills
* Palpate apical impulse and describe location
* Auscultate the precordium for S1 and S2 using diaphragm of the stethoscope for each area
* Auscultate the tricuspid and mitral areas with the bell of the stethoscope
* Auscultate the appeal heart rate with diaphragm
* Describes signs and symptoms of an acute MI
* Describes the difference in symptoms of an acute MI between men and women
 |  |  |  |  |  |  |  |
| **Basic Steps: Head, Face, and Neck Focused** **Physical Assessment** | * Inspect and palpate the skull for general size and contour, deformities, and tenderness: round, normocephalic, symmetric, smooth, proportional, no tenderness.
* Palpate temporal pulses: 2+, equal bilaterally
* Palpate temporomandibular joint: smooth movement, no limitations or tenderness
* Inspect the face for symmetry of movement, involuntary movements, edema, and lesions
* Inspect and palpate the neck for head position, lesions and tenderness
* Inspect, palpate, and identify anterior and posterior lymphatic chains in the neck area for size, delineation, mobility (movable), and tenderness. Lymph nodes to be included: occipital, post auricular, pre-auricular; submandibular, submittal; superficial cervical, deep cervical chain, posterior cervical chain; supraclavicular
 |  |  |  |  |  |  |  |
| **Basic Steps: Ears Focused Physical Assessment**  | * Inspect size and skin condition of external structures ears are symmetric
* Inspect ear canal for discharge, color, and cerumen
* Palpate and identify external structure of the ear for masses, lesions, or tenderness
* Test gross hearing by using whispered voice test: correctly repeated at least 3 out of 6 possible numbers/letters
 |  |  |  |  |  |  |  |
| **Basic Steps: Nose, Mouth, and Throat Focused Physical Assessment**  | * Inspect external nose for symmetry, deformity, and lesions
* Test potency of each nostril: each nostril is open, no obstructions
* Inspect nasal cavity for color, deviation, or exudate
* Inspect teeth for number, color, restoration, and alignment
* Palpate and identify the sinus areas for tenderness
* Inspect for presence or absence of lesions, masses, or inflammation of the buccal mucosa, gums, hard palate, soft palate, tonsils, uvula, and pharyngeal wall
* Inspect and palpate lips for color, intactness, and tenderness
* Inspect and palpate tongue for color, intactness, and tenderness
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| **Basic Steps: Abdomen Physical Assessment** | * Inspect abdomen for contour, symmetry, skin characteristics, pulsations and observe the resident’s demeanor-auscultate abdomen over 4 quadrants for bowel sounds- 3 areas per quadrant
* Auscultate abdomen over aorta for vascular sounds
* Percuss abdomen over all 4 quadrants- percuss in 3 areas per quadrant
* Palpate lightly and deeply over all 4 quadrants for tenderness and masses
 |  |  |  |  |  |  |  |
| **Basic Steps: Upper Extremities** **Physical Assessment** | * Assess radial pulses
* Assess skin condition of upper extremities
* Assess capillary refill
* Assess gross motor movement and strength with bilateral hand grasp
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| **Basic Steps: Lower Extremities** **Physical Assessment** | * Assess dorsalis pedis pulse
* Assess extremities for edema, temperature, and color
* Assess gross motor movement and strength with plantar flexion and extension
* Assess skin condition of lower extremities
* Inspect and palpate joints of upper and lower extremities bilaterally for symmetry, deformities, and tenderness: cervical joint, should joints, elbow joints, wrist joints, hand/finger joints, hip joints, knee joints, and ankle joints
* Perform range of motion of upper and lower extremities for limitations,
* Test muscle strength of upper and lower extremities
* Inspect and palpate spine for posture, symmetry, and curvature
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| **Basic Steps: Peripheral Vascular Focused** **Physical Assessment**  | * Inspect and palpate upper extremities for symmetry, texture, skin characteristics
* Assess capillary refill bilaterally
* Palpate upper extremity pulses: brachial and radial
* Inspect and palpate lower extremities for, texture, temperature of feet, and edema
* Palpate lower extremity pulses: femoral, popliteal, dorsalis pedis, and posterior tibial
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| **Basic steps eyes focused Physical Assessment**  | * Test visual fields
* Inspect parallel tracking of object with both eyes
* Inspect external eye structures: symmetry, eyebrows move symmetrically with no lesions, lashes touch completely when closed, skin intact with no redness, swelling, discharge, or lesions, conjunctivae, and sclera
* Inspect cornea, iris, and pupils for size, shape, and equality
* Test pupillary light reflex and accommodation; PEERLA is present
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| **Basic Steps: Skin, Hair, and Nails Focused** **Physical Assessment** | * Inspect the skin color for generalized pigmentation
* Palpate the skin for temperature, moisture, texture, and edema
* Assess turgor
* Inspect for skin breakdown or lesions
* Inspect and palpate the hair for texture, observe distribution, and lesions -inspect and palpate the nails for shape and contour and color
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| **Report Findings that are Not Within Baseline for the Individual Resident** | * Observe documented baseline to determine extent of changes
* Gather pertinent history and physical information
* Formulate report for provider (i.e. SBAR)
* Follow up prescribed orders
 |  |  |  |  |  |  |  |
| **Document Findings and Actions Taken in the Resident’s Record** | * Describe findings
* Describe impact on resident’s function, condition, comfort
* Record action taken and follow up to prescribed orders
 |  |  |  |  |  |  |  |
|  | * Demonstrates documentation on the care plan:
	+ Assessment information
	+ Resident preferences
	+ Change in Condition information
	+ PASARR information
	+ Discharge Care Planning
 |  |  |  |  |  |  |  |
| **Additional Assessments Recommended for Competency** | * Pain Assessment
* Behavioral Health Assessment
* Bowel and Bladder Assessment
* Skin/Wound Risk Assessment
* Sleep Assessment
* Psychotropic Medication Assessment
* Bedrail Assessment
* Restraint Assessment
* Mood/Depression Assessment
* Functional ADL Assessment
* Range of Motion Assessment
* Self-Administration of Medication Assessment
 |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**\*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)***

**Resources:**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17) Advance Copy 6/29/22: <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>
* Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
* LTC Survey Pathways (Download) CMS 20131 Resident Assessment Critical Element Pathway <https://www.cms.gov/files/zip/ce-pathways.zip>