

Certified Nursing Assistant Skills

Name: _____

Please check the appropriate Level of proficiency for each skill.

1. Highly Experienced: Performs on Daily or Weekly Basis; Proficient
2. Moderate Experience: performs 1-2 times/month; may need minimal resource
3. Limited Experience or No Experience

	1	2	3		1	2	3
Bathing				Nutrition and Safety			
1. Sitting bath				1. Diabetic diet exchange system			
2. Tub bath				2. Low sale and other restricted diets			
3. Shower with stool				3. Safe feeding of patient			
4. Bed bath							
5. Hair shampoo				Physical Therapy Activities			
				1. Ambulation with walker or cane			
Decubitus				2. Transfer activities			
1. Positioning				A. Bed to chair			
2. Body alignment				B. Chair to bed			
3. Following simple instructions for decubitus care				C. Into tub or shower			
				3. Range of motion exercises			
Foley Care				A. Active			
1. Meatus care for male				B. Passive			
2. Meatus care for female				4. Knowledge of proper body mechanics			
3. Proper positioning of tubing and drainage bags				5. Use of Hoyer lift			
4. Technique to change drainage bags							
5. Intake and output				Care of the Diabetic			
6. Observation of urine (color, consistency, odor)				1. Skin and foot care			
				2. Checking urine for S&A and recording			
Checking Vital Signs							
1. Temperature - Oral				Care of the Cardiac Patient			
2. Temperature - Axillary				1. Ability to detect swelling of ankles			
3. Temperature - Rectal				2. Position of legs when in a sitting position, if edema is present			
4. Radial pulse							
5. Respirations				Care of Environment			
6. Pain Score				1. Aware of signs and symptoms to be reported			
				Management of incidents in the patient			
				Emergency and first aid procedures			
				Understanding differences in families and interpersonal relationships			
				Care of Geriatric patient			
				Care of CVA / Rehab patient change of command			

Affidavit statement by the practitioner:

I, _____ here by acknowledge that the following information attached herein is true and correct to the best of my knowledge. In addition, I hereby authorize Advanced Medical Placement, to release the skills checklist to any client institutions of Advanced Medical Placement, in relation to my employment.

Therefore, I authorize release of this checklist on this date of ____/____/____

Signature _____ Date _____