**Licensed Nurse Competency Checklist-Hospice**

*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 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 Competency Checklist-Hospice Services | Verbalizes understanding of facility hospice policy and procedure |  |  |  |  |  |  |  |
| Demonstrates and verbalizes understanding of change of condition reporting to Hospice |  |  |  |  |  |  |  |
| Demonstrates collaborative approach to care planning with Hospice |  |  |  |  |  |  |  |
| Licensed nurse demonstrates documentation responsibilities for Hospice resident:   * Assessment Process * RAI Process * Care Plan Development, Implementation and Revisions * Communication * Education * Etc. |  |  |  |  |  |  |  |
| Demonstrates and verbalizes  understanding of resident preference, individualized resident care plan, and follows advance directive interventions and goals. |  |  |  |  |  |  |  |
| Describes the responsibilities of the facility when a resident is on Hospice |  |  |  |  |  |  |  |
| Demonstrates the responsibilities of the hospice entity |  |  |  |  |  |  |  |
| Documents in designated areas for hospice |  |  |  |  |  |  |  |
| Demonstrates respect of the expertise of each hospice entity |  |  |  |  |  |  |  |
| Demonstrates the defined communication process between facility and hospice |  |  |  |  |  |  |  |
| Participates in hospice care plan meetings |  |  |  |  |  |  |  |
|  | Collaborates with hospice regarding care plan changes |  |  |  |  |  |  |  |
|  | Contacts hospice for order changes. |  |  |  |  |  |  |  |
|  | Verbalizes name of facility hospice representative |  |  |  |  |  |  |  |
|  | Verbalizes process for medical equipment with residents on Hospice |  |  |  |  |  |  |  |
|  | Verbalizes process for medication supply with residents on Hospice |  |  |  |  |  |  |  |
|  | Participates/verbalizes Hospice bereavement services for SNF. |  |  |  |  |  |  |  |
| **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, Hospice end of Life Critical Element Pathway. CMS 20073 (5/2017): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>