**Nursing Assistant Competency Checklist-Airway Trach**

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**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 Nursing Assistant Competency Checklist: Airway Trach** | Monitors the resident for any complaints, or exhibits any signs or symptoms of shortness of breath |  |  |  |  |  |  |  |
| Communicates to nurseif there is a report from the resident, family, or other staff that the resident is experiencing shortness of breath  |  |  |  |  |  |  |  |
| Participates/shares information for revisions to the care plan if the interventions did not work e.g., adding humidified air for dry nares |  |  |  |  |  |  |  |
| Monitors for kinks in oxygen tubing |  |  |  |  |  |  |  |
| Nursing assistant follows interventions of the care plan e.g., coughing and deep breathing and communication needs |  |  |  |  |  |  |  |
| Demonstrates / verbalizesunderstanding of resident preference. |  |  |  |  |  |  |  |
| Nursing Assistant demonstrates documentation responsibilities related to:* Care Plan Interventions
* Etc.
 |  |  |  |  |  |  |  |
| Reports to nurse any signs and symptoms of respiratory difficulty to include shortness of breath:* nasal flaring,
* shortness of breath
* use of accessory muscles
* pursed-lip breathing
 |  |  |  |  |  |  |  |
| Demonstrates the following skills:* Temperature

 • BP, pulse • Respirations • Oxygen saturation  |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**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) Respiratory Care Critical Element Pathway, Form CMS 20080 (7/2018): <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:**

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

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

**Evaluator/Trainer:**

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

**Initials Signature Date**

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