**Licensed Nurses and Other Department Managers, Supervisors, Leaders**

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**Competency Checklist for Infection Control**

**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** |
| **Infection Control Program and Infrastructure** | Identify the facility’s part-time or full-time Infection Preventionist(s) |  |  |  |  |  |  |  |
| Locate written infection control policies and procedures. |  |  |  |  |  |  |  |
| State location of emergency preparedness plans for pandemic influenza or norovirus outbreak. |  |  |  |  |  |  |  |
| **Healthcare Personnel**  | Identify work exclusion policies concerning avoiding contact with residents when personnel have potentially transmissible conditions. |  |  |  |  |  |  |  |
| State facility policy regarding prompt reporting of signs/symptoms of a potentially transmissible illness. |  |  |  |  |  |  |  |
| State facility policy regarding baseline tuberculosis (TB) screening for new personnel and annual TB screening. |  |  |  |  |  |  |  |
| State Hepatitis B vaccination policy. |  |  |  |  |  |  |  |
| State facility personnel influenza vaccination policy. |  |  |  |  |  |  |  |
| State how a blood-borne pathogen exposure is managed. |  |  |  |  |  |  |  |
| **Resident Safety** | State facility policy regarding tuberculosis screening for residents. |  |  |  |  |  |  |  |
| State facility policy regarding annual influenza vaccination to residents. |  |  |  |  |  |  |  |
| State facility policy regarding pneumococcal vaccination to residents. |  |  |  |  |  |  |  |
| **Surveillance** | State facility policy of notification of nurse/infection preventionist of signs or symptoms of potentially infectious resident. |  |  |  |  |  |  |  |
| **Licensed Nurses:**State facility system for notification of Infection Preventionist when MDRO organisms or *C. difficile* are reported by clinical laboratory. |  |  |  |  |  |  |  |
| **Disease Reporting** | Identify location of local and state health department contacts and current list of reportable diseases. |  |  |  |  |  |  |  |
| **Hand Hygiene** | Demonstrate hand hygiene using alcohol-based hand rub (ABHR). |  |  |  |  |  |  |  |
| Demonstrate hand hygiene using soap and water. |  |  |  |  |  |  |  |
| **Standard Precautions** | **Licensed Nurses and Anyone at risk of contact with body fluids or non-intact skin:**Demonstrate donning and removal of * Gloves
* Gown
* Mask
* Face shield
 |  |  |  |  |  |  |  |
| **Personal Protective Equipment** | State how the facility identifies residents to be placed in transmission-based precautions (*i.e.,* contact, droplet, airborne) |  |  |  |  |  |  |  |
|  | Identify location and proper storage of Personal Protective Equipment when in use for a resident. |  |  |  |  |  |  |  |
| Identify location and proper storage of Personal Protective Equipment for back-up use or re-stocking. |  |  |  |  |  |  |  |
| **Respiratory Hygiene/Cough Etiquette** | Demonstrate cough etiquette |  |  |  |  |  |  |  |
| **Antibiotic Stewardship** | **Licensed Nurses:*** Identify the location of policies and procedures related to Antibiotic Stewardship.
 |  |  |  |  |  |  |  |
| * State the location of resources for criteria of infections in long-term care (McGeer, Loeb, AHRQ, care paths)
 |  |  |  |  |  |  |  |
| **Injection Safety** | **Licensed Nurses:**Demonstrate proper technique for injection safety – single-use or multi-use vial, disposal of needle and syringe. |  |  |  |  |  |  |  |
| **Point of Care Testing** | **Licensed Nurses:**Demonstrate blood glucose testing.* Use of fingerstick device or lancet
 |  |  |  |  |  |  |  |
| **Environmental Cleaning** | **Housekeeping Staff:**Demonstrate:* Routine cleaning and disinfection of resident room
 |  |  |  |  |  |  |  |
| * Terminal cleaning and disinfection of resident room
 |  |  |  |  |  |  |  |
| * Cleaning and disinfection of resident room on contact precautions (*e.g., C. difficile*)
 |  |  |  |  |  |  |  |
| Identify high-touch surfaces in common areas. |  |  |  |  |  |  |  |
| **Licensed Nurses:**Demonstrate cleaning/disinfection of:* Blood glucose meters
 |  |  |  |  |  |  |  |
| * Blood pressure cuffs
* Resident care equipment
 |  |  |  |  |  |  |  |
| **Indwelling Urinary Catheter (Foley catheter)** | **Licensed Nurses:*** State clinically appropriate reasons for use of indwelling urinary catheter.
 |  |  |  |  |  |  |  |
| * Perform appropriate infection control practices while:
* Emptying catheter bag
 |  |  |  |  |  |  |  |
| * Obtaining a urine specimen
 |  |  |  |  |  |  |  |
| **Central Venous Catheter or PICC Line Maintenance** | **Licensed Nurses:**Perform appropriate (aseptic technique) infection control practices when accessing line. |  |  |  |  |  |  |  |
| **Wound Dressing Change** | **Licensed Nurses:**Perform appropriate infection control practices during wound dressing change. |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**References**

* Centers for Medicare & Medicaid Services 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>
* Infection Prevention and Control Assessment Tool for Long-Term Care Facilities. <https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf>

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

**\*Employee:**

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

**Evaluator/Trainer:**

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

**Initials Signature Date**

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