**CNA and RA Competency Checklist for Restorative Nursing**

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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** |
| **CNA’s or RA’s** | Demonstrate understanding of the principles and purpose of restorative nursing |  |  |  |  |  |  |  |
| List the types of Restorative Programs* PROM
* AROM
* Splint/Brace
* Bed Mobility
* Transfer
* Walking
* Dressing
* Grooming
* Eating/Swallowing
* Amputation/ Prosthesis Care
* Communication
* Toileting
 |  |  |  |  |  |  |  |
| List restorative techniques including verbal cueing, physical cuing, repetition and task segmentation |  |  |  |  |  |  |  |
| Describe the types of assistive devices utilized in Restorative programs and how they are used |  |  |  |  |  |  |  |
| Describe obstacles to resident participation in restorative nursing programs |  |  |  |  |  |  |  |
| Describes communication essentials for the CNA* Change in condition or function
* Pain
* Endurance
* Refusal
* Etc.
 |  |  |  |  |  |  |  |
| Verbalizes process to follow care plan interventions for Restorative Nursing Program |  |  |  |  |  |  |  |
| Can verbalize resident assignment and demonstrate where to obtain current information on care delivery tasks |  |  |  |  |  |  |  |
| Reports to the nurse immediately if assignment sheet is not current or correct |  |  |  |  |  |  |  |
| Demonstrates proper documentation of Restorative Program implementation |  |  |  |  |  |  |  |
| Demonstrates proper ADL tracking (paper or electronic per facility system) |  |  |  |  |  |  |  |
| Demonstrates proper minutes tracking of Restorative Nursing Programs |  |  |  |  |  |  |  |
| Describes how to encourage resident participation in Restorative Nursing |  |  |  |  |  |  |  |
| Demonstrates explaining Restorative Program to resident prior to implementation |  |  |  |  |  |  |  |
| Demonstrates privacy for ADL and ROM Programs |  |  |  |  |  |  |  |
| Demonstrates hand hygiene procedures |  |  |  |  |  |  |  |
| Describe the difference between ADL general care and a formal Restorative Nursing Program |  |  |  |  |  |  |  |
| Range of Motion Demonstration (PROM, AROM and AAROM):* Technique
* Joint Support
* Smooth Motions
* Not past the point of resistant
* Resident considerations (Pain, skin integrity, refusals, etc.)
 |  |  |  |  |  |  |  |
| Application, removal and care of a resident with a splint or brace* Hand Splint
* Wrist Splint
* Cone
* AFO
* Etc.
 |  |  |  |  |  |  |  |
| Bed Mobility exercises |  |  |  |  |  |  |  |
| Demonstrate Transfer (1-Person, 2-Person) |  |  |  |  |  |  |  |
| Use of slide board for transfer if used in facility |  |  |  |  |  |  |  |
| Gait Belt Use Per Policy |  |  |  |  |  |  |  |
| Use of assistive devices for ambulation/transfer (Cane, walker, wheeled walker, etc.) |  |  |  |  |  |  |  |
| Walking a resident:* Assistance
* Devices
* Surfaces
* Footwear
* Gait belt
 |  |  |  |  |  |  |  |
| Restorative Dressing Program demonstration including assistive devices used in the facility |  |  |  |  |  |  |  |
| Restorative Grooming Program demonstrationIncluding assistive devices used in the facility |  |  |  |  |  |  |  |
| Care of a resident with an amputation and/or prosthesis* Prosthesis application and removal
* Use of a stump shrinker if ordered
* Observation of skin integrity
 |  |  |  |  |  |  |  |
| Communication program including communication board use and other program materials |  |  |  |  |  |  |  |
| Demonstrates completion of bowel and bladder diary to identify pattern |  |  |  |  |  |  |  |
| Demonstrates implementation of individualized toileting program |  |  |  |  |  |  |  |
| Demonstrates implementation of a swallowing program:* Thickened liquids
* Mechanically altered diet
* Resident positioning
* Table height
* Chin tuck
* Size of the bite
* Altering liquids and solids
* Supervision
* Etc.
 |  |  |  |  |  |  |  |
| Describes signs and symptoms of dysphasia and lists swallowing precautions |  |  |  |  |  |  |  |
| Demonstrates implementation of a functional eating program |  |  |  |  |  |  |  |
| Demonstrates use of adaptive dining equipment |  |  |  |  |  |  |  |
| Use of Mechanical Lift Competency (per facility policy and Manufacturer’s recommendations) |  |  |  |  |  |  |  |
| Sit-to-Stand Lift. Competency (per facility policy and Manufacturer’s recommendations) |  |  |  |  |  |  |  |
|  | Demonstrates Peri-Care per facility procedure |  |  |  |  |  |  |  |
|  | Demonstrates catheter care per facility procedure |  |  |  |  |  |  |  |
|  | Verbalizes requirements for Restorative Group Programs:* No more than 4 residents/care-giver
* Work with resident within the group
* Understanding of individualized need for the Restorative Program and interventions
 |  |  |  |  |  |  |  |
| **Paid Feeding Assistants****(Note: Follow State Requirements)** | Demonstrates:* Proper feeding techniques
* Assistance with feeding and hydration
* Follows resident individualized approaches on the care plan
 |  |  |  |  |  |  |  |
|  | Demonstrates appropriate communication skills with the residents |  |  |  |  |  |  |  |
|  | Verbalizes appropriate responses for resident behaviors |  |  |  |  |  |  |  |
|  | Verbalizes safety and emergency procedures |  |  |  |  |  |  |  |
|  | Demonstrates the Heimlich maneuver on a mannequin |  |  |  |  |  |  |  |
|  | Verbalizes and demonstrates appropriate infection control protocols including Hand Hygiene |  |  |  |  |  |  |  |
|  | Describes the facility policy on Resident Rights |  |  |  |  |  |  |  |
|  | Verbalizes the process for identification and reporting of a resident change in condition |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |
| **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) Specialized Rehabilitative or Restorative Services Critical Element Pathway, Form CMS 20080 (5/2017): <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:**

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

**Evaluator/Trainer:**

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**Initials Signature Date**

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