**Nursing Assistant Competency Checklist-Skin Integrity/Pressure Ulcer**

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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-Skin Integrity/Pressure Ulcer** | Identifies and verbalizes areas of boney prominence that are at risk for pressure ulcers |  |  |  |  |  |  |  |
| Verbalizes understanding of tissue tolerance |  |  |  |  |  |  |  |
| Demonstrates accurate use of tissue tolerance form (if applicable) |  |  |  |  |  |  |  |
| Demonstrates understanding of center policies and procedures for skin integrity/pressure ulcers |  |  |  |  |  |  |  |
| Participates/shares information for revisions to the care |  |  |  |  |  |  |  |
| Demonstrate /verbalizes what, when, and to whom do you report changes in skin condition |  |  |  |  |  |  |  |
| Demonstrates use of pressure reducing/relieving devices as well as other devices/interventions on resident as care planned (heels floated, boots, splints, etc.) |  |  |  |  |  |  |  |
| Demonstrates / verbalizesunderstanding of resident /resident representative preference, and when to notify the nurse |  |  |  |  |  |  |  |
| Nursing Assistant demonstrates documentation responsibilities:* Care Plan Interventions
* Specific facility form for skin/pressure ulcers if indicate
* Shower forms
* Etc.
 |  |  |  |  |  |  |  |
| Identifies signs and symptoms of infection |  |  |  |  |  |  |  |
|  Knows PU interventions are used for residents |  |  |  |  |  |  |  |
| **Other (Describe)**  |  |  |  |  |  |  |  |  |
| **Other (Describe)** |  |  |  |  |  |  |  |  |

**\*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)***

**References:**

* Centers for Medicare and Medicaid Services (CMS) State Operations Manual, Appendix PP. Guidance to Surveyors for Long Term Care Facilities: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>
* Centers for Medicare and Medicaid Services (CMS): <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html>
* CMS 20078: Pressure Ulcer/Injury Critical Element Pathway: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
* Nursing Skills Reference Manuals
* Manufacturer’s Recommendations on equipment, adaptive equipment, supplies, etc.