

**HELP AT HOME HOMECARE
HOME HEALTH AIDE (HHA & CNA) COMPETENCY**

Employee Name: _____ Date _____

CNA/HHA Self Rating
 A = I can perform well
 B = I need to review
 C = I have no experience

Competency Assessment Method
 D = Direct Observation/Demonstration
 O = Oral Question/Answer

Touch or Mouse Click A, B or C Below for Each

	Self Rating	Supervisor Assessment Method	Supervisor Evaluation		
			Competency	Met	Not Met
I. VITAL SIGNS					
A. Temperature ____oral ____auxiliary	A B C	D O	Met	Not Met	
B. Pulse ____radial ____apical ____other	A B C	D O	Met	Not Met	
C. Respirations	A B C	D O	Met	Not Met	
D. Blood Pressure	A B C	D O	Met	Not Met	
II. ACTIVITIES OF DAILY LIVING					
A. Bath / Bed Bath	A B C	D O	Met	Not Met	
B. Sponge bath	A B C	D O	Met	Not Met	
C. Shower	A B C	D O	Met	Not Met	
D. Shampoo	A B C	D O	Met	Not Met	
E. Skin Care	A B C	D O	Met	Not Met	
F. Nail Care (clean & file only)	A B C	D O	Met	Not Met	
G. Foot soak	A B C	D O	Met	Not Met	
H. Oral hygiene	A B C	D O	Met	Not Met	
I. Denture care	A B C	D O	Met	Not Met	
J. Dressing patient	A B C	D O	Met	Not Met	
K. Apply Compression Stockings	A B C	D O	Met	Not Met	
L. Making occupied bed	A B C	D O	Met	Not Met	
III. TOILETING AND ELIMINATION					
A. Recording of Intake and Output	A B C	D O	Met	Not Met	
B. Use of bedpan and urinal	A B C	D O	Met	Not Met	

**HELP AT HOME HOMECARE
HOME HEALTH AIDE (HHA & CNA) COMPETENCY**

C. Care of internal/ external catheter	A B C	D O	Met	Not Met	
D. Care of Routine Foley	A B C	D O	Met	Not Met	
E. Care of Condom Catheter	A B C	D O	Met	Not Met	
F. Care of urinary drainage bag	A B C	D O	Met	Not Met	
G. Perineal care	A B C	D O	Met	Not Met	
H. Protective Undergarments	A B C	D O	Met	Not Met	
IV. SAFE TRANSFER TECHNIQUES & AMBULATION	Self Rating	Supervisor Assessment Method	Supervisor Evaluation		
			Competency		Supervisor Initials & Date
A. Pivot transfer	A B C	D O	Met	Not Met	
B. Total lift transfer	A B C	D O	Met	Not Met	
C. Safe ambulation	A B C	D O	Met	Not Met	
D. Range of Motion and Positioning	A B C	D O	Met	Not Met	
E. Use of Special Equipment (list type) _____ _____ _____ _____	A B C	D O	Met	Not Met	

Employee Signature : _____ Date: _____

Supervisor's Signature: _____ Date: _____

Employee Name: _____ Date _____