



SUB-ACUTE LTACH-LTC RN SKILLS COMPETENCY CHECKLIST

Name: _____ Date: _____

Total years of RN experience: _____

Please rate *your* Skill Level by checking the appropriate box using the key below:

- | | |
|---|---|
| 0 – No experience. | 2 – Experienced (Performs independently) |
| 1 – Limited competency; requires supervision | 3 – Proficient/Expert/Highly skilled |

| SKILLS | 0 | 1 | 2 | 3 | SKILLS | 0 | 1 | 2 | 3 |
|--|---|---|---|---|---|---|---|---|---|
| Documentation/Notes | | | | | Repositioning/Transferring | | | | |
| Vital Signs – BP, TPR, Height, Weight | | | | | Use of Walker/Canes | | | | |
| Intake & Output monitoring | | | | | Use of Hoyer Lift | | | | |
| Activities of Daily Living (ADLs) | | | | | Crutch walking | | | | |
| Admission of Client | | | | | Use of manual wheelchair | | | | |
| Medications: Oral, IM, SQ, PR, Topical | | | | | Use of electric wheelchair | | | | |
| Body Systems Review (Head to Toe Assessment) | | | | | Special Diet Restrictions (Diabetic, Low Salt, Fluid Restriction, etc.) | | | | |
| Bathing assistance | | | | | Making occupied bed | | | | |
| Oral Hygiene; Denture Care | | | | | Basic Medical Asepsis | | | | |
| Nail and Skin Care | | | | | Oxygen (cannula, mask, etc) | | | | |
| Backrubs/back care | | | | | Pulse Oximetry | | | | |
| Use of Bedpan/Urinal | | | | | Range of Motion Exercises | | | | |
| Bowel Regimen | | | | | Assist with Ambulation | | | | |
| Client Care Plans (Revise & Update) | | | | | Dressing changes | | | | |
| Client Safety Standards/Precautions | | | | | Advance Directives | | | | |
| Infection Control Precautions | | | | | Postmortem Care | | | | |
| Handwashing | | | | | Cast Care | | | | |
| Compresses: warm/cold | | | | | GT/NG tubes | | | | |
| CPR | | | | | Ostomy Care | | | | |
| Applying/Removing TEDS stockings | | | | | Catheterization – straight/foley | | | | |
| Prosthetic/Assistive Devices | | | | | Incentive Spirometry | | | | |
| Restraints – Apply/Monitor | | | | | Specimen Collection | | | | |
| Reporting changes in client’s condition | | | | | Phlebotomy | | | | |
| Intravenous therapy | | | | | Urine Dipstick | | | | |
| Colostomy Care & Irrigation | | | | | Fingerstick Blood Glucose Monitoring | | | | |
| Wound Care | | | | | Suctioning | | | | |
| Discharge of Client | | | | | Tracheostomy Care | | | | |
| Pain Assessment | | | | | Transfer/Transport Clients | | | | |
| Traction | | | | | Care of Client with: | | | | |
| Supervision of LNA, PCSP | | | | | Alzheimer’s/Dementia | | | | |
| Reporting concerns to team/supervisor | | | | | Stroke | | | | |



| | | | | | | | | | |
|--|--|--|--|--|---------------------------------|--|--|--|--|
| Assessing Educational Needs | | | | | Asthma/COPD/Respiratory Illness | | | | |
| Teaching Client, Staff, Family, Caregivers | | | | | Head Injuries | | | | |
| Coordinating Care with Team | | | | | Amputation | | | | |
| Communicating with Physician/Provider | | | | | Diabetes | | | | |
| Documenting Orders Appropriately | | | | | Pacemaker | | | | |
| Drug Calculations | | | | | Spinal Cord Injury | | | | |
| Handling Emergent Situations | | | | | Wounds/Drains | | | | |
| | | | | | Tracheostomy | | | | |
| Age-Appropriate Care of: | | | | | CHF/Cardiac Disease | | | | |
| Newborn (birth – 30 days) | | | | | Renal Disease | | | | |
| Infant (31 days – 1 year) | | | | | Hip/Knee Replacements | | | | |
| Toddler (1 – 3 years) | | | | | AIDS/Immunosuppression | | | | |
| Preschooler (3 – 5 years) | | | | | Cancer | | | | |
| School Age (5 – 12 years) | | | | | Burns | | | | |
| Adolescents (12 – 18 years) | | | | | Recent Surgery | | | | |
| Young Adults (18-39 years) | | | | | Mental Illness | | | | |
| Middle Adults (39 – 64 years) | | | | | Multiple Trauma | | | | |
| Older Adults (64+ years) | | | | | Terminal Illness | | | | |

Do you speak any other language(s) besides English? Yes/No If YES, please list other language(s):

Do you have any other skills not listed here that are pertinent to the position?

I hereby certify that all information I have provided on this skills checklist is true and accurate. I understand and acknowledge that any misrepresentation or omission may result in disqualification from employment and/or immediate dismissal.

Employee (LPN/RN)

Signature: _____ Date: _____

Representative Reviewer

Signature: _____ Date: _____