



CERTIFIED NURSING ASSISTANT SKILLS CHECKLIST

Name:-----

Date:-----

- 1 = No Experience
 2 = Perform infrequently (would require some supervision)
 3 = Able to perform without any supervision

	1	2	3
1. TAKING & RECORDING VITAL SIGNS			
a. Temperature			
b. Blood Pressure			
c. Pulse			
d. Respirations			
2. PROVIDE AM/PM CARE: Back care, skin care, oral care, hair care, nail care, peri-care, range of motion exercises			
3. BED MAKING: Unoccupied, occupied, post-op			
4. FEEDING			
a. Recording % food consumed			
b. Recording cc's fluid consumed			
5. FEEDING TUBES: Observe tubes are taped securely			
6. INTAKE AND OUTPUT:			
a. Accurately measure/records I/O			
b. Fluid restrictions			
c. Pushing fluids			
7. AMBULATION:			
a. Ambulates according to orders			
b. Reports patients tolerance to ambulation			
c. Use of good body mechanics			
d. Maintains safety of patients while ambulating			
8. UTILIZES MECHANICAL AIDS IF APPROPRIATE			
9. POSITIONING			
a. Maintains proper body alignment			

	1	2	3
b. Care of the bedridden patient			
c. Knowledge of positions: Fowler's, supine, lateral, semi-Fowler's, Trendelenburg			
d. Care of the bedridden patient			
10. TRANSPORTING			
a. Via Stretcher			
b. Moving from bed to stretcher			
c. Moving from bed to chair			
d. Secures tubes/equipment for transport			
11. INCONTINENT CARE			
12. COLLECTION OF SPECIMENS			
13. WEIGHING PATIENTS: bed scale, standing scale, chair scale			
14. COLOSTOMY CARE			
a. Empty and remove drainage bag			
b. Observe skin around stoma			
c. Care to skin around stoma			
15. RESTRAINTS: hard, soft, vest			
16. INFECTION CONTROL/ ISOLATION			
17. ADMITTING A PATIENT			
18. DISCHARGING A PATIENT			
19. TRANSFERRING A PATIENT			
20. USE OF EQUIPMENT/SUPPLIES			
a. One-Touch Glucometer			
b. Ted Hose			

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	1	2	3
c. Hypo/hyperthermia blankets			
d. Icebag/moist pack			
e. Sitz bath (where applicable)			
f. Oral suctioning			
g. Straining urine			
h. Seizure precautions			
i. K-pad			
j. Sharps containers			
k. Electric thermometer			
l. BP equipment and Dinamap			
m. Electric beds			
n. Wheel chairs			
o. Suction canisters			
p. Oxygen-flow meter, cannula, mask			
q. Feeding pumps			
r. Use of Ace bandages			
s. Basic use of computer			
t. Gurneys			
21. RECOGNIZES NORMALS FOR THE FOLLOWING AND REPORTS ANY CHANGES TO RN IMMEDIATELY			
a. LOC (level of consciousness)			
b. Orientation			
c. Speech changes, swallowing difficulty			
d. Color, temp of skin			
e. Vital signs			
f. Adequate respiratory status			
g. Imbalance in intake/output			

Have had one year of experience in this area within the last three years:

Yes _____ No _____

CERTIFICATIONS:

CPR _____ EXP DATE: _____

OTHERS _____ EXP DATE: _____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Premier Nursing Service to release this list to its client health care facilities.

Signature Date

Authentication By Agency:

DON Signature Date