INITIAL COMPETENCY CHECKLIST

RN/LPN

NAME_____RN_____ LPN ____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS
	YES	NO	
1. Urinary catheters:			
a. Foley insertion–male/female			
b. Suprapubic insertion/removal			
2. Central Cath Lines			
3. Enteral Feedings:			
a. Bolus			
b. Continuous			
c. Removal/insertion PEG tubes			
4. Equipment:			
a. IV pumps			
b. Enteral pumps			
c. Oxygen concentrator			
d. Oxygen tank			
e. Nebulizer			
5. IV therapy:			
a. Peripheral/INT			
b. Adm fluids/meds			
c. Dressing change			
6. Irrigations:			
a. Bladder			
b. Colostomy			

SKILLS	COMPETENT		COMMENTS
	YES	NO	
7. Suctioning:			
a. Nasal			
b. Oral			
c. Tracheal			
8. Tracheostomy Care			
9. TPN:			
a. Administration			
b. Labs			
c. Starting/stopping			
d. Additives			
10. Venipunctures			
11. Transporting lab specimens			
12. Wound care:			
a. Aseptic technique			
b. Sterile technique			
13. Standard Precautions:			
a. Gloves			
b. Gowns			
c. Masks/goggles			
d. Shoe covers			
e. CPR resusci masks			

DATE OF INITIAL COMPLETION: _____

Goals:_____

Achievement to previously established goals:_____

_____

_____ _____

Employee Signature/Title *Observer Signature/Title*