

## Home Health Aide Skills Checklist

Home Health Aide: \_\_\_\_\_

**CNAHHA Self-Rating**

**Competency Assessment Method**

A = I can perform well	D = Direct Observation and/or Demonstration
B = I need to review	O = Oral Question and Answer
C = I have no experience	(Circle the appropriate method below)

Skills	Self Rating	Supervisor Assessment Method	Supervisor Evaluation	
			Competency	Supervisor Initials & Date
Communication	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Observation, reporting and documentation of patient status and the care of services provided	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Basic elements of body functions and changes in condition that must be reported	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Maintaining a clean, safe and health environment	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Ability to recognize emergency situations	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Ability to recognize physical and emotional needs and work with the client and respect the pt's privacy and property	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Appropriate and safe techniques in personal hygiene and grooming:</b>				
Toileting and elimination	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Bed Bath	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Tub Bath	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Shower	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Sponge Bath	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Shampoo (sink, tub or bed)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Skin Care	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Oral Hygiene	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Assistance with dressing a patient	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Transfer Assistance</b>				
Safe transfer techniques	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Bed to chair;	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Chair to bed	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Safe Ambulation</b>				

Use of Equipment (Wheelchair, lift, walker, cane)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Normal positioning with proper body alignment	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Assistance with Feeding</b> (Aspiration Precautions)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Ability to recognize adequate nutrition and intake	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Medication reminders</b> (NOTE: this skill increases supervisory RN visit frequency from every 4 to every 3 months)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Infection Control</b> (Handwashing, use of gloves, use of hand sanitizers)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
<b>Proper and Complete Patient Care Documentation</b>	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Reportable events to RN	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Equipment Use/Maintenance/Cleaning (Describe: _____)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	
Other (Describe: _____)	A, B, or C	D or O	<input type="checkbox"/> Met <input type="checkbox"/> Not Met	

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CNA/HHA Signature

\_\_\_\_\_  
/Date

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RN Evaluator Name/Signature

\_\_\_\_\_  
Initials//Date