HealthCap
RISK MANAGEMENT SERVICES

**LICENSED NURSE COMPETENCY CHECKLIST**

Administering Medications Via Enteral Feeding Tube

Applying a Sling

Applying & Caring for a TENS Unit

Caring for a Hemovac Drain

Caring for a Jackson Pratt Drain

Cast Care

Catheterizing a Male Resident

Changing an Ostomy Appliance

Clean Dressing Change

Closed Chest Tube Drainage System

Cold therapy Application

Continuous Bladder Irrigation

Female Urinary Catheterization

Hemodialysis Access Device

Pulse Oximetry

Small Volume Disposable Enema

Staple Removal

Suctioning the Oropharyngeal & Nasopharyngeal Airway

Suture Removal

Tracheostomy Tube Care

Wound Culture

Wound Irrigation

Clear All Forms

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**LICENSED NURSE COMPETENCY CHECKLIST**
**Administering Medications Via Enteral Feeding Tube**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Perform hand hygiene | ☐ | ☐ | |
| Prepare medication(s). Read the eMar/MAR and select the proper medication for the medication supply system. | ☐ | ☐ | |
| Compare the label with the eMar/MAR. | ☐ | ☐ | |
| Prior to pouring medications, determine if enteral feeding must be discontinued for a period of time prior to or post medication administration. | ☐ | ☐ | |
| Pills-*verify the ability to crush tablets or open capsules.* Using a pill crusher, crush one pill at a time. Dissolve the powder in water in a liquid medication cup, keeping each medication separate. | ☐ | ☐ | |
| Liquids-When pouring liquid medication from a multidose bottle, hold the bottle with the label against the palm. Use the appropriate measuring device when pouring liquids, and read the amount of medication at the bottom of the meniscus at eye level. (Use a syringe for measuring as needed for accurate dosing) | ☐ | ☐ | |
| Clean edge of bottle and replace multi dose containers in the medication supply system. | ☐ | ☐ | |
| Lock the medication supply system. | ☐ | ☐ | |
| Transport medications to the resident bedside, keeping in sight at all times. | ☐ | ☐ | |
| Perform hand hygiene. | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Check the necessary assessments before administering medications. | ☐ | ☐ | |
| Assist resident to high-Fowler's position unless contraindicated. | ☐ | ☐ | |
| Put on gloves. | ☐ | ☐ | |
| **Check placement of tube depending on the type of tube and facility policy.** | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Administering Medications Via Enteral Feeding Tube**

| | | | |
|---|---|---|---|
| If the resident is receiving a feeding, pause the feeding, clamp the G-tube and place a cap on the end of the feeding set. | ☐ | ☐ | |
| Remove the plunger of a 60 mL syringe; insert the syringe into the feeding tube. Pour the ordered amount of water into the syringe (30 mL is standard). Unclamp the tube and allow water to flow via gravity. | ☐ | ☐ | |
| Administer the first dose of medication by pouring into syringe. Follow each medication administration with the amount of water flush ordered by the physician (5-10 mL is standard). *Allow medications to flow by gravity* | ☐ | ☐ | |
| When all medications have been administered follow the last does with the amount of water ordered by the physician (30-60 mL of water is the standard). | ☐ | ☐ | |
| Clamp the tube. | ☐ | ☐ | |
| If resident is receiving a tube feeding, reconnect the feeding set (unless contraindicated by medication administration orders), unclamp the tube and set the feeding per the physician's orders. | ☐ | ☐ | |
| Discard all equipment per facility policy, or label reusable equipment per facility policy. | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the administration of the medications on the eMAR/MAR. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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# LICENSED NURSE COMPETENCY CHECKLIST
## Applying a Sling

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Perform a pain assessment, and if the resident reports pain, initiate pain management interventions per physician order. | ☐ | ☐ | |
| If pain medication is administered, allow sufficient time for the medication to take effect prior to initiating treatment. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Assist the resident to a sitting position if possible. | ☐ | ☐ | |
| Place the resident's forearm across the chest with the elbow flexed and the palm of the hand against the chest. | ☐ | ☐ | |
| Enclose the arm in the sling, making sure the elbow fits into the corner of the fabric. | ☐ | ☐ | |
| Run the strap up the resident's back and across the shoulder opposite the injury, then down the chest to the fastener on the end of the sling. | ☐ | ☐ | |
| Place and ABD pad under the strap, between the strap and the resident's neck. Ensure that the sling and forearm are slightly elevated and at a right angle to the body. | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Applying and Caring for a TENS Unit**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Assess the resident's pain using the facility approved pain scale and document | ☐ | ☐ | |
| Inspect the area where the electrodes are to be placed. Clean the resident's skin using disposable cleaning wipes or skin cleaner. Dry area thoroughly. | ☐ | ☐ | |
| Remove the adhesive backing for self-adhering electrodes and apply to the specified location. | ☐ | ☐ | |
| Leave at least a 2 inch space between electrodes. | ☐ | ☐ | |
| ***Check the controls on the TEN Unit to make sure they are off.*** | ☐ | ☐ | |
| Attach the wires (if not already attached) to the electrodes and plug them into the unit. | ☐ | ☐ | |
| Turn on the unit and adjust the intensity setting to the lowest intensity and determine if the resident can feel a tingling, burning or buzzing sensation. | ☐ | ☐ | |
| Adjust the intensity to the prescribed amount. Secure the unit to the resident. ***If the resident cannot tolerate the prescribed amount shut off the unit and notify the provider.*** | ☐ | ☐ | |
| Set the pulse width (duration of each pulsation) as prescribed. | ☐ | ☐ | |
| If intermittent use is ordered, turn the unit off after the specified duration of treatment, remove the electrodes and clean the resident's skin at the electrode sites. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Applying and Caring for a TENS Unit**

| | | | |
|---|---|---|---|
| If continuous therapy is ordered, periodically remove the electrodes from the skin (after turning the unit off) to inspect the area and clean the skin. Change electrodes according to manufacturer's directions and facility protocol. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Caring for a Hemovac Drain**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. Utilize PPE as indicated. | ☐ | ☐ | |
| Place a waterproof pad under the drain outlet. | ☐ | ☐ | |
| Using sterile technique, open gauze pad, making a sterile field with the outer wrapper. | ☐ | ☐ | |
| Place the graduated collection container under the drain outlet; without contaminating the outlet, pull of the cap. | ☐ | ☐ | |
| The chamber will expand completely as it draws in air. | ☐ | ☐ | |
| Empty the contents completley into the container and use the gauze pad to wipe the outlet. | ☐ | ☐ | |
| Fully compress the chamber by pushing the top and bottom together with your hands. Keep the device tightly compressed while you apply the cap. | ☐ | ☐ | |
| The device should remain compressed and be free of twists and kinks. | ☐ | ☐ | |
| Secure the Hemovac drain making sure that there is no tension on the tubing. | ☐ | ☐ | |
| Carefully measure and record the character color, amount of the drainage and discard according to facility policy. | ☐ | ☐ | |
| Remove gloves and wash hands. | ☐ | ☐ | |
| Put on clean gloves. If the drain site has a dressing, remove dressing, assess and clean the site and replace with clean dressing per the physicians orders. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Caring for a Hemovac Drain**

| | | | |
|---|---|---|---|
| If the drain site is open to air, observe the sutures that secure the drain to the skin. Gently clean the sutures with the gauze pad moistened with normal saline. Dry with a new gauze pad. | ☐ | ☐ | |
| Remove additional PPE equipment if used. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Caring for a Jackson Pratt Drain**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. Utilize PPE as indicated. | ☐ | ☐ | |
| Place a waterproof pad under the drain site. | ☐ | ☐ | |
| Using sterile technique, open gauze pad, making a sterile field with the outer wrapper. | ☐ | ☐ | |
| Place the graduated collection container under the drain outlet. Without contaminating the outlet, pull of the cap. | ☐ | ☐ | |
| The chamber will expand completely as it draws in air. | ☐ | ☐ | |
| Empty the contents completely into the container and use a sterile gauze pad to wipe the outlet. | ☐ | ☐ | |
| Fully compress the bulb with one hand and replace the cap with your the other gloved hand. | ☐ | ☐ | |
| The bulb should remain compressed and the tubing should be free from twists and kinks. | ☐ | ☐ | |
| Secure the JP drain making sure that there is no tension on the tubing. | ☐ | ☐ | |
| Carefully measure and record the character color, amount and discard drainage per facility policy. | ☐ | ☐ | |
| Remove gloves and wash hands. | ☐ | ☐ | |
| Put on clean gloves | ☐ | ☐ | |
| If the drain site has a dressing, remove dressing, assess and clean the site | ☐ | ☐ | |
| Include cleaning of the sutures with a sterile gauze pad moistened with normal saline, dry with a new gauze pad. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Caring for a Jackson Pratt Drain**

| | | | |
|---|---|---|---|
| Redress the site with a clean dressing per the physician's orders. | ☐ | ☐ | |
| If the drain site is open to air, observe the sutures that secure the drain to the skin. | ☐ | ☐ | |
| Gently clean the sutures with a sterile gauze pad moistened with normal saline and dry with a new sterile gauze pad. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove PPE equipment if used. | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Cast Care**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves as indicated. | ☐ | ☐ | |
| Assess the condition of the cast, be alert for cracks, dents, or the presence of drainage. | ☐ | ☐ | |
| Perform a skin assessment particularly around the edges of the cast and a neurovascular assessment. *Check for pain, edema, inability to move body parts distal to the cast, pallor, pulses and abnormal sensations.* | ☐ | ☐ | |
| If the cast is on an extremity, compare the extremity with the non-casted extremity. | ☐ | ☐ | |
| If breakthrough bleeding or drainage is noted on the cast, mark the area on the cast, according to facility policy. Indicate the date and time next to the area. Follow provider orders for the amount of drainage that needs to be reported to the provider. | ☐ | ☐ | |
| Assess for signs and symptoms of infection; *foul odor, increased pain, extreme warmth over an area of the cast.* | ☐ | ☐ | |
| Instruct resident to report any pain, odor, drainage, changes in sensation, or the inability to move fingers or toes of the affected extremity. | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |







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# LICENSED NURSE COMPETENCY CHECKLIST
## Cast Care

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# LICENSED NURSE COMPETENCY CHECKLIST
## Catheterizing a Male Resident

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Place the resident on his back with thighs slightly apart. | ☐ | ☐ | |
| Place a waterproof pad under the resident and drape the resident so that only the area around the penis is exposed. | ☐ | ☐ | |
| Clean around the genital area with washcloth, skin cleanser or warm water. Clean the tip of the penis first, moving the washcloth in a circular motion from the meatus outward. | ☐ | ☐ | |
| Wash the shaft of the penis using downward strokes. Rinse and dry. | ☐ | ☐ | |
| Remove gloves and perform hand hygiene. | ☐ | ☐ | |
| Prepare urinary drainage system and ensure it is clamped. | ☐ | ☐ | |
| Open sterile catheterization tray on clean overbed table, using sterile technique. | ☐ | ☐ | |
| Apply sterile gloves. Place the sterile drape with a window over the thighs, exposing the penis. | ☐ | ☐ | |
| Open all supplies. Remove cap from the prefilled sterile saline syringe and attach to the balloon inflation portion the catheter. | ☐ | ☐ | |
| Lubricate 1 to 2 inches of the catheter tip. | ☐ | ☐ | |
| Lift the penis with nondominant hand. Retract the foreskin in an uncircumcised resident. *Be prepared to keep this hand in this position until the catheter is inserted and urine is flowing.* | ☐ | ☐ | |





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**Catheterizing a Male Resident**

| | | | |
|---|---|---|---|
| Use dominant hand to pick up antiseptic swab or use forceps to pick up cotton balls. | ☐ | ☐ | |
| Using a circular motion, clean the penis, moving from the meatus down. Repeat this cleansing motion two or three more times, using a new cotton ball/swab each time. Discard each cotton ball/swab after one use. | ☐ | ☐ | |
| Hold the penis with slight tension and perpendicular to the resident's body. Use dominant hand to pick up the lubricant syringe. | ☐ | ☐ | |
| Gently insert the tip of the syringe with a lubricant into the urethra and instill 10 ml of lubricant. | ☐ | ☐ | |
| Use the dominant hand to pick up the catheter and hold it an inch or two from the tip. Insert the catheter into the meatus. Have resident take deep breaths. | ☐ | ☐ | |
| Advance the catheter to the "Y" level of the ports. ***Do not use force to introduce the catheter.*** If the catheter resists entry, ask the resident to breathe deeply and rotate the catheter slightly. If there are still problems with insertion stop the procedure and notify the practitioner. | ☐ | ☐ | |
| Hold the catheter securely at the meatus with your nondominant hand. Use your non-dominant hand to inflate the catheter balloon. | ☐ | ☐ | |
| Inject the entire volume of sterile water supplied in the prefilled syringe. Once the balloon is inflated, the catheter may be gently pulled back into place. ***Replace foreskin, if previously retracted.*** | ☐ | ☐ | |
| Attach the catheter to drainage system. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Secure catheter tubing to the resident's inner thigh with catheter securing device, leaving some slack in the tubing for leg movement. | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Catheterizing a Male Resident**

| | | | |
|---|---|---|---|
| Secure the drainage bag below the level of the bladder, check to ensure that there are no kinks in the tubing. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Changing An Ostomy Appliance**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Place a disposable pad on the work surface. Open the premoistened disposable washcloths or set up the washbasin with warm water and the rest of the supplies. | ☐ | ☐ | |
| Put on clean gloves. Place waterproof pad under the resident at the stoma site. Empty the appliance and document amount and character of contents. | ☐ | ☐ | |
| Remove gloves, perform hand hygiene and apply clean gloves. | ☐ | ☐ | |
| Start at the top of the appliance keeping abdominal skin taut, gently remove pouch faceplate from the skin by pushing the skin from the appliance. | ☐ | ☐ | |
| Dispose of the appliance. | ☐ | ☐ | |
| Cleanse the stoma site, cover the stoma with a gauze pad. | ☐ | ☐ | |
| Clean the skin around the stoma with skin cleanser and water or other cleaning agent. | ☐ | ☐ | |
| Remove all old adhesive from the skin. Do not apply lotion to the area. | ☐ | ☐ | |
| Gently pat area dry. Assess the stoma and the condition of the skin. | ☐ | ☐ | |
| Apply skin protectant to a 2 inch radius around the stoma, allow to dry completely. | ☐ | ☐ | |
| Lift gauze squares for a moment and measure the stoma opening, using measurement guide. Replace gauze. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Changing An Ostomy Appliance**

| | | | |
|---|---|---|---|
| Trace the same size opening on the back center of the appliance, cutting the opening 1/8 inch larger than the stoma size. | ☐ | ☐ | |
| Remove the paper from the appliance faceplate. Quickly remove gauze squares and place the appliance over the stoma. Gently press onto skin while smoothing over the surface. Apply gentle even pressure for approx. 30 seconds. | ☐ | ☐ | |
| Close the bottom of the appliance or pouch by folding the end upward and using the clamp or clip. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Clean Dressing Change**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Assess the resident for pain medication prior to initiating wound care dressing changes. Administer prescribed pain interventions/medications and allow enough time to achieve effectiveness. | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Loosen tape or adhesive edge of old dressing by using the push-pull method; lift a corner of the dressing away from the skin, then gently push the skin away from the dressing/adhesive. Continue moving fingers of opposite hand to support the skin as the product is removed. | ☐ | ☐ | |
| After removing the dressing, note the presence, amount, type, color of any drainage on the dressing. | ☐ | ☐ | |
| Place soiled dressing in appropriate waste receptacle. | ☐ | ☐ | |
| Remove gloves, discard and perform hand hygiene. | ☐ | ☐ | |
| Inspect the wound site for size, appearance, and drainage. Access if any pain is present. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Cleanse wound per physician orders. *Cleanse from top to bottom and/or from the center to the outside.* Use new gauze for each wipe. | ☐ | ☐ | |
| Once the wound is cleansed, dry area with a gauze in a similar manner. | ☐ | ☐ | |
| Remove gloves and place in waste receptacle. Perform hand hygiene and apply clean gloves. | ☐ | ☐ | |







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**LICENSED NURSE COMPETENCY CHECKLIST**
**Clean Dressing Change**

| | | | |
|---|---|---|---|
| Apply any topical medications, gels, gauze, or products as prescribed. | ☐ | ☐ | |
| Cover with prescribed dressing and apply tape. Self-adhesive products wound not require tape, follow manufacturers directions. | ☐ | ☐ | |
| Remove and discard gloves. | ☐ | ☐ | |
| Label dressing with the date and time and your initials. | ☐ | ☐ | |
| Perform hand hygiene. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Closed Chest Tube Drainage System**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies and place on the overbed table or other surface within reach. | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves as indicated. | ☐ | ☐ | |
| Move the resident's clothing to expose the chest and observe the dressing at the chest tube insertion site, confirming that it is dry, intact and occlusive. | ☐ | ☐ | |
| Check that all connections are securely taped. Gently palpate around the insertion site, feeling for crepitus, a result of air or gas collecting under the skin. (This may feel crunchy or spongy, or liked "popping" under your fingers). | ☐ | ☐ | |
| Check drainage tubing to ensure that there are no dependent loops or kinks. | ☐ | ☐ | |
| Ensure the drainage collection system is below the tube insertion site. | ☐ | ☐ | |
| Assess the amount and type of fluid drainage. Measure drainage output at the ned of each shift by marking the level on the container or placing a small piece of tape at the drainage level to indicate date and time. (The amount should be a running total because the drainage system is never emptied. If it is full it is replaced). | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the physician. | ☐ | ☐ | |





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# LICENSED NURSE COMPETENCY CHECKLIST
## Closed Chest Tube Drainage System

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Cold Therapy Application**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Assess the condition of the skin where treatment is to be applied. | ☐ | ☐ | |
| Prepare the device, fill the bag, collar, etc. about ¾ full with ice, remove excess air and securely fasten the end of the device. Prepare commercially prepared ice pack, according to manufacturer's directions. | ☐ | ☐ | |
| Cover the device with a towel or washcloth, (commercially prepared devices may come with a protective cover). | ☐ | ☐ | |
| Position the ice bag on the affected area and lightly secure in place., as needed. | ☐ | ☐ | |
| After 30 seconds, remove the ice, assess the site for redness and ask the resident about the presence of burning sensations. | ☐ | ☐ | |
| If there are no identified concerns, replace the device snugly against the site and secure in place with gauze, ties, tapes if necessary. | ☐ | ☐ | |
| Remove the device after the prescribed amount of time (the standard is <30 minutes) DO NOT exceed the prescribed amount of time. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Cold Therapy Application**

| | | | |
|---|---|---|---|
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____







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# LICENSED NURSE COMPETENCY CHECKLIST
## Continuous Bladder Irrigation

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Empty the catheter drainage bag, measure amount of urine and document. | ☐ | ☐ | |
| Expose the irrigation port on the catheter setup. | ☐ | ☐ | |
| Place a waterproof pad under the catheter and irrigation port. | ☐ | ☐ | |
| Prepare sterile irrigation bag for use as directed by manufacturer. | ☐ | ☐ | |
| Clearly label the solution as Bladder Irrigant, include the date and time on the label. Hang the bag on an IV pole 2 ½-3 feet above the residents bladder. | ☐ | ☐ | |
| Close tubing clamp | ☐ | ☐ | |
| Insert sterile tubing with drip chamber into the container using sterile technique. | ☐ | ☐ | |
| Release clamp, and remove protective cover on end of tubing without contaminating it. Allow solution to flush tubing and remove air. | ☐ | ☐ | |
| Clamp tubing and replace end cover. | ☐ | ☐ | |
| Apply gloves and cleanse the irrigation port on the catheter with an alcohol swab. Using aseptic technique, attach irrigation tubing to irrigation port of the three-way indwelling catheter. | ☐ | ☐ | |
| Check drainage tubing to ensure the clamp is open | ☐ | ☐ | |
| Release clamp on irrigation tubing and regulate flow according to physician order. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Continuous Bladder Irrigation**

| | | | |
|---|---|---|---|
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Female Urinary Catheterization**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies and obtain assistance of another staff member, if necessary. | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on overbed table or other surface. | ☐ | ☐ | |
| Assist the resident to a dorsal recumbent position with knees flexed, feet about 2 feet apart, with legs abducted. Drape the resident. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Clean the perineal area washing front to back. Use a different area of the washcloth or wipe with each stroke. | ☐ | ☐ | |
| Prepare urine drainage setup if a urine collection system will be used. | ☐ | ☐ | |
| Open the sterile catheterization tray on a clean overbed table using sterile technique. | ☐ | ☐ | |
| Put on sterile gloves. Grasp upper corners of drape and unfold without touching non sterile areas. Ask resident to lift buttock and slide sterile drape under the resident. | ☐ | ☐ | |
| Place the sterile drape with a window over the the perineal area, exposing the labia. | ☐ | ☐ | |
| Open all supplies. Remove cap from the prefilled sterile saline syringe and attach to the balloon inflation portion the catheter. | ☐ | ☐ | |
| Open all other packages in the kit. | ☐ | ☐ | |
| Lubricate 1 to 2 inches of the catheter tip. | ☐ | ☐ | |
| With the thumb and one finger of the non dominant hand, spread labia and identify the meatus. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Female Urinary Catheterization**

| | | | |
|---|---|---|---|
| Use the dominant hand to pick up antiseptic pads, cotton balls or swabs. | ☐ | ☐ | |
| Cleanse one labial fold top to bottom, then discard the item. Using a new pad, cotton ball or swab for each stroke continue to clean the other labial fold, then directly over the meatus. | ☐ | ☐ | |
| With your noncontaminated, dominate hand, place the drainage end of the catheter in a receptacle. If the catheter is preattached to sterile tubing and drainage container (closed drainage system), position the catheter and setup within easy reach of sterile field. Ensure the clamp on the drainage bag is closed. | ☐ | ☐ | |
| Using your dominant hand, hold the catheter 2 to 3 inches from the tip and insert slowly into urethra. Advance the catheter until there is a return of urine. Once urine drains, advance the catheter another 2 to 3 inches. Do Not Force. | ☐ | ☐ | |
| Hold the catheter securely at the meatus with your nondominanat hand. Use your dominant hand to inflate the catheter balloon. Inject the entire volume of sterile water supplied in the prefilled syringe. Remove syringe from the port | ☐ | ☐ | |
| Pull gently on the catheter after the balloon is inflated until you feel resistance. | ☐ | ☐ | |
| Attach the catheter to the drainage system if not already pre-attached. If clamped, unclamp the the drainage bag. | ☐ | ☐ | |
| Remove equipment and items and dispose of according to facility policy. | ☐ | ☐ | |
| Remove gloves, wash and dry hands thoroughly. | ☐ | ☐ | |
| Secure the catheter tubing to the resident's inner thigh with a catheter securing device. | ☐ | ☐ | |
| Secure the drainage bag below the level of the bladder, check to ensure that there are no kinks in the tubing. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Female Urinary Catheterization**

| | | | |
|---|---|---|---|
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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# LICENSED NURSE COMPETENCY CHECKLIST
## Hemodialysis Access Device
## (Arteriovenous Fistula or Graft)

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves if applicable. | ☐ | ☐ | |
| Inspect area over the access site for continuity of skin color. Inspect for redness, warmth, tenderness, edema, rash, blemishes, bleeding, tremors, and twitches. | ☐ | ☐ | |
| Inspect the muscle strength, and the resident's ability to perform ROM in the extremity with the access device. | ☐ | ☐ | |
| Palpate over the access site, feel for thrill or vibration. | ☐ | ☐ | |
| Palpate pulses above and below the site. | ☐ | ☐ | |
| Palpate continuity of the skin temperature along and around the extremity. | ☐ | ☐ | |
| Check capillary refill in fingers or toes of extremity with fistula or graft. | ☐ | ☐ | |
| Auscultate over the access site with bell of stethoscope, listening for a bruit or "swishing" sound. | ☐ | ☐ | |
| Discard all items and equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any negative findings to the provider. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |







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# LICENSED NURSE COMPETENCY CHECKLIST
## Hemodialysis Access Device
## (Arteriovenous Fistula or Graft)

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Pulse Oximetry**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves as indicated. | ☐ | ☐ | |
| Turn the pulse oximeter on by pressing the power button. | ☐ | ☐ | |
| Attach the sensor (the part that opens and closes like a clothespin) on the finger (middle, index or ring finger) do not use the thumb. | ☐ | ☐ | |
| *Nail polish may affect an accurate reading especially dark colors; consider removing nail polish* | ☐ | ☐ | |
| The percentage of oxygen saturation is typically indicated by the symbol “SpO2”. | ☐ | ☐ | |
| Once the SpO2 registers on the unit, remove the sensor from the residents finger. | ☐ | ☐ | |
| Note the reading on the unit and shut the power unit off. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Small Volume Disposable Enema**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol. | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Have a bedpan, commode or nearby bathroom ready for use. | ☐ | ☐ | |
| Position resident on the left side (Sims position), with upper thigh pulled toward abdomen, if possible, or the knee chest position, as dictated by resident comfort and condition. | ☐ | ☐ | |
| Fold top linen back just enough to allow access to resident's rectal area, place a waterproof pad under resident's hip. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves | ☐ | ☐ | |
| Remove cap and gently insert the enema tip into the rectum pointing the tip toward the naval. DO NOT FORCE THE TUBE. | ☐ | ☐ | |
| Squeeze the bottle until the recommended amount of the drug is inside the rectum. | ☐ | ☐ | |
| Remove the tip from the rectum and encourage the resident to hold the solution until they feel a strong urge to have a bowel movement. | ☐ | ☐ | |
| Remove gloves and return the resident to a comfortable position. | ☐ | ☐ | |
| Wash hands | ☐ | ☐ | |
| Dispose of equipment per facility policy | ☐ | ☐ | |
| When the resident has a strong urge to have a bowel movement, wash and dry hands and apply gloves. | ☐ | ☐ | |
| Place resident on bedpan or assist to commode or bathroom. | ☐ | ☐ | |
| Stay with the resident or have call bell within reach based on resident care plan | ☐ | ☐ | |







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**LICENSED NURSE COMPETENCY CHECKLIST**
**Small Volume Disposable Enema**

| | | | |
|---|---|---|---|
| Once resident has had a bowel movement, assist with peri care as needed. | ☐ | ☐ | |
| Remove gloves, wash and dry hands thoroughly. | ☐ | ☐ | |
| Assist resident to a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the resident's response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Staple Removal**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol. | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves | ☐ | ☐ | |
| Carefully remove any dressing that may be in place | ☐ | ☐ | |
| Clean the incision, according to prescribed wound care or facility policy and procedure | ☐ | ☐ | |
| Assess the wound | ☐ | ☐ | |
| Remove gloves, and wash hands | ☐ | ☐ | |
| Open the staple removal kit and put on clean gloves | ☐ | ☐ | |
| Position the staple remover under the staple to be removed. Firmly close the staple remover. *The staple will bend in the middle and the edges will pull up out of the skin.* | ☐ | ☐ | |
| Remove every other staple to be sure the wound edges are healed. If the wound edges remain approximated, remove the remaining staples, as ordered. *If the wound edges are not approximated do not remove any additional staples, notify the provider.* | ☐ | ☐ | |
| If wound closure strips are to be used, apply skin protectant to skin around incision and apply adhesive closure strips. | ☐ | ☐ | |
| Based on the providers order, reapply a dressing or leave open to air. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Staple Removal**

| | | | |
|---|---|---|---|
| Document the procedure, assessment and resident response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

**EVALUATOR**_____**DATE**_____





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Suctioning the Oropharyngeal and Nasopharyngeal Airway**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves as indicated. | ☐ | ☐ | |
| If the resident is conscious, place the resident in a semi-Fowler's position | ☐ | ☐ | |
| If the resident is unconscious, place the resident in a side lying, lateral position facing you | ☐ | ☐ | |
| Place a towel or waterproof pad across the resident's chest | ☐ | ☐ | |
| Adjust suction machine to appropriate pressure depending on physician order and manufacturer's instruction (<150 mm Hg for adults) | ☐ | ☐ | |
| Open sterile suction package using aseptic technique. (The open wrapper or container becomes a sterile field to hold other supplies). | ☐ | ☐ | |
| Carefully remove the sterile container touching only the outside surface. Place on the sterile work surface and fill with sterile saline. | ☐ | ☐ | |
| Place a small amount of water-soluble lubricant on the sterile field. | ☐ | ☐ | |
| Increase the resident's supplemental oxygen level or apply supplemental oxygen per facility policy or provider order. | ☐ | ☐ | |
| Put on PPE as appropriate. | ☐ | ☐ | |
| Put on sterile gloves. | ☐ | ☐ | |
| The dominant hand will manipulate the catheter and must remain sterile. | ☐ | ☐ | |
| The non-dominant hand is considered clean (not sterile) and will be used to manipulate the suction valve (Y-port) on the catheter. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Suctioning the Oropharyngeal and Nasopharyngeal Airway**

| | | | |
|---|---|---|---|
| With the dominant, sterile gloved hand pick up the sterile catheter. | ☐ | ☐ | |
| Pick up the connecting tubing with the non-dominant hand and connect the tubing to the suction catheter. | ☐ | ☐ | |
| Moisten catheter by dipping it into the container of sterile saline and occlude Y-tube to check suction. | ☐ | ☐ | |
| IF the resident is conscious, encourage them to take several deep breaths. | ☐ | ☐ | |
| Apply lubricant to the first 2-3 inches of the catheter. | ☐ | ☐ | |
| Remove oxygen delivery system if appropriate. | ☐ | ☐ | |
| **Do not apply** suction as catheter is inserted. | ☐ | ☐ | |
| ***Nasopharyngeal suctioning***-gently insert the catheter through the nares and along the floor of the nostril toward the trachea. Roll catheter between your fingers to help advance it. Advance the catheter approximately 5-6 inches to reach the pharynx. | ☐ | ☐ | |
| ***Oral pharyngeal suctioning***-insert catheter along the side of the mouth toward the trachea. Advance the catheter 3-4 inches in to reach the pharynx. | ☐ | ☐ | |
| Apply suction by intermittently occluding the Y-port on the catheter with the thumb of the non-dominant hand and gently rotate the catheter as it is being withdrawn. ***Do not suction for more than 10-15 seconds at a time.*** | ☐ | ☐ | |
| Replace the oxygen delivery device with your non-dominant hand, if appropriate, and if the resident is conscious, have them take several deep breaths. | ☐ | ☐ | |
| Flush the catheter with saline. Assess the effectiveness of suctioning and repeat, as needed, and based on the resident's tolerance. | ☐ | ☐ | |
| ***Allow at least a 30-seconds to 1-minute interval if additional suctioning is needed. No more than 3*** | ☐ | ☐ | |







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**LICENSED NURSE COMPETENCY CHECKLIST**
**Suctioning the Oropharyngeal and Nasopharyngeal Airway**

| | | | |
|---|---|---|---|
| ***suction passes should be made per suctioning episode.*** | | | |
| When suctioning is complete, remove gloves from the dominant hand over the coiled catheter, pulling them off inside out. | ☐ | ☐ | |
| Remove the glove from the non-dominant hand and dispose of gloves, catheter, and container with solution in appropriate receptacle. | ☐ | ☐ | |
| Shut off suction. Remove supplemental oxygen placed for suctioning, if appropriate. | ☐ | ☐ | |
| Wash hands and apply non-sterile gloves | ☐ | ☐ | |
| Perform oral hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Reassess the resident's respiratory status, including rate, effort, oxygen saturation and lung sounds. | ☐ | ☐ | |
| Remove additional PPE, if used, perform hand hygiene. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |



**NAME**_____**DATE**_____

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**LICENSED NURSE COMPETENCY CHECKLIST**
**Suture Removal**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review physician order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves | ☐ | ☐ | |
| Carefully and gently remove any dressing that may be in place | ☐ | ☐ | |
| Clean the incision, according to prescribed wound care or facility policy and procedure | ☐ | ☐ | |
| Assess the wound | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Open the suture removal kit and put on clean gloves | ☐ | ☐ | |
| Using forceps, grasp the knot of the first suture and gently lift the knot up off the skin | ☐ | ☐ | |
| Using scissors, cut one side of the suture below the knot, close to the skin. | ☐ | ☐ | |
| Grasp the knot and pull the cut suture through the skin. | ☐ | ☐ | |
| Remove every other suture to be sure the wound edges are healed. If the wound edges remain approximated, remove the remaining sutures, as ordered. *If the wound edges are not approximated do not remove any additional sutures, notify the physician.* | ☐ | ☐ | |
| If wound closure strips are to be used, apply skin protectant to skin around incision and apply adhesive closure strips. | ☐ | ☐ | |
| Based on the physician order, reapply the dressing or leave open to air. | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Suture Removal**

| | | | |
|---|---|---|---|
| Document the procedure, description of incision site and the residents response. | ☐ | ☐ | |

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**LICENSED NURSE COMPETENCY CHECKLIST**
**Tracheostomy Tube Care**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves and PPE, if indicated. | ☐ | ☐ | |
| If the resident is conscious, place in a semi-Fowler's position | ☐ | ☐ | |
| If the resident is unconscious, place the resident in a side lying, lateral position facing you | ☐ | ☐ | |
| **Cleaning the Tracheostomy**: Disposable Inner Cannula -Carefully open the new disposable inner cannula, taking care not to contaminate the cannula or the inside of the package. | ☐ | ☐ | |
| Carefully open the package with the sterile cotton-tipped applicators, taking care not to contaminate them. | ☐ | ☐ | |
| Open the sterile cup or basin and fill 0.5 inches deep with sterile saline. | ☐ | ☐ | |
| Remove oxygen source if one is present. | ☐ | ☐ | |
| Stabilize the outer cannula and face plate of the tracheostomy with your non-dominant hand. | ☐ | ☐ | |
| Grasp the locking mechanism of the inner cannula with your dominant hand; press the tabs and release the lock. | ☐ | ☐ | |
| Gently remove the inner cannula, dispose of per facility policy and remove site dressing and dispose. | ☐ | ☐ | |
| Working quickly, discard gloves, wash hands and put on sterile gloves. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Tracheostomy Tube Care**

| | | | |
|---|---|---|---|
| Pick up new inner cannula with your dominant hand; stabilize the faceplate with your non-dominant hand and gently insert the new inner cannula into the outer cannula. | ☐ | ☐ | |
| Press the tabs to allow the lock to grab the outer cannula and reapply the oxygen source if needed. | ☐ | ☐ | |
| **Apply Clean Dressing** | ☐ | ☐ | |
| Remove oxygen source, if necessary. Dip cotton-tipped applicator in cup or basin with sterile saline and clean stoma under faceplate. Use each applicator only once, moving from stoma site outward. | ☐ | ☐ | |
| Pat skin dry with sterile 4x4 gauze sponge. | ☐ | ☐ | |
| Slide commercially prepared tracheostomy dressing or pre-folded non-cotton-filled, sterile 4x4 dressing under the faceplate. | ☐ | ☐ | |
| Reapply oxygen source if needed. | ☐ | ☐ | |
| **Change the tracheostomy holder:** Obtain the assistance of a second nurse to hold the tracheostomy tube in place while the used collar is removed and a new collar is placed. | ☐ | ☐ | |
| Open the package of the new tracheostomy collar. | ☐ | ☐ | |
| Both nurses should put on clean gloves. | ☐ | ☐ | |
| One nurse holds the faceplate while the other gently removes the collar. | ☐ | ☐ | |
| The first nurse continues to hold the tracheostomy faceplate. | ☐ | ☐ | |
| The second nurse places the new collar around the resident's neck and inserts one tab, then the other into the opening of the faceplate and secures the Velcro tabs on the tracheostomy holder. | ☐ | ☐ | |
| Check the fit of the tracheostomy collar. You should be able to fit one finger between the neck and collar. Check to make sure the resident can flex the neck comfortably. | ☐ | ☐ | |
| Replace oxygen source, if necessary. | ☐ | ☐ | |
| Discard all equipment per facility policy. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Tracheostomy Tube Care**

| | | | |
|---|---|---|---|
| Remove and discard gloves, and PPE equipment if applicable and perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

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**LICENSED NURSE COMPETENCY CHECKLIST**
**Wound Culture**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the Resident per facility protocol | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| If there is a dressing in place, remove dressing. | ☐ | ☐ | |
| Note the presence, amount, type, color, and odor of any drainage on the dressing. | ☐ | ☐ | |
| Dispose of the soiled dressing per facility protocol. | ☐ | ☐ | |
| Remove gloves and perform hand hygiene, apply clean gloves. | ☐ | ☐ | |
| Assess and clean the wound per the provider order. Dry the the surrounding skin with gauze. | ☐ | ☐ | |
| Twist the cap to loosen the swab on the Culturette tube, or open the separate swab(s) and remove the cap from the suture tube. *Keep the swab and inside of the culture tube sterile.* | ☐ | ☐ | |
| Identify a 1 cm area of the wound that has a clean wound bed, free from necrotic tissue. | ☐ | ☐ | |
| Press the swab to apply sufficient pressure to express fluid from the wound tissue and rotate the swab several times. | ☐ | ☐ | |
| Place the swab back in the culture tube. *Do not touch the outside of the tube with the swab.* Secure the cap. | ☐ | ☐ | |
| If the swab container has an ampule of medium at the bottom of the tube, crush the ampule to activate or per manufacturer's instructions. | ☐ | ☐ | |
| Remove gloves and discard, perform hand hygiene, apply clean gloves | ☐ | ☐ | |
| Apply dressing according to facility protocol. | ☐ | ☐ | |



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**LICENSED NURSE COMPETENCY CHECKLIST**
**Wound Culture**

| | | | |
|---|---|---|---|
| Label the specimen according to facility guidelines. | ☐ | ☐ | |
| Place specimen in biohazard bag and store per facility policy until the specimen is transported to the laboratory. | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

**NAME**_____**DATE**_____

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**LICENSED NURSE COMPETENCY CHECKLIST**
**Wound Irrigation - Clean Technique**

| AREA OBSERVED | MET | NOT MET | COMMENTS |
|---|---|---|---|
| Review provider order | ☐ | ☐ | |
| Gather necessary supplies | ☐ | ☐ | |
| Identify the resident per facility protocol | ☐ | ☐ | |
| Determine if the resident is experiencing pain, document character of pain and initiate pain management interventions as appropriate | ☐ | ☐ | |
| Explain the procedure to the resident prior to beginning | ☐ | ☐ | |
| Provide privacy | ☐ | ☐ | |
| Assemble equipment on a clean overbed table or other surface. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Loosen tape or adhesive edge of old dressing by using the push-pull method; lift a corner of the dressing away from the skin, then gently push the skin away from the dressing/adhesive. Continue moving fingers of opposite hand to support the skin as the product is removed. | ☐ | ☐ | |
| After removing the dressing, note the presence, amount, type, color of any drainage on the dressing. | ☐ | ☐ | |
| Place soiled dressing in appropriate waste receptacle. | ☐ | ☐ | |
| Remove gloves, discard and perform hand hygiene. | ☐ | ☐ | |
| Inspect the wound site for size, appearance, and drainage. | ☐ | ☐ | |
| Wash hands and dry thoroughly, apply clean gloves. | ☐ | ☐ | |
| Pour irrigating solution into a container. | ☐ | ☐ | |
| Place a waterproof pad under wound. | ☐ | ☐ | |
| Fill the irrigating syringe with solution, | ☐ | ☐ | |
| Position a basin under the wound if possible. | ☐ | ☐ | |
| Direct the stream of solution into the wound. Keep the tip of the syringe at least 1 inch above the upper edge of the wound. Flush all wound areas. | ☐ | ☐ | |





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**LICENSED NURSE COMPETENCY CHECKLIST**
**Wound Irrigation - Clean Technique**

| | | | |
|---|---|---|---|
| When the solution from the wound flows out clear, discontinue irrigation. | ☐ | ☐ | |
| Once the wound is cleaned, dry surrounding skin using a gauze sponge. | ☐ | ☐ | |
| Remove gloves and discard. Perform Hand hygiene. | ☐ | ☐ | |
| Apply clean gloves and provide treatment to the wound per the provider orders. (refer to clean dressing change protocol) | ☐ | ☐ | |
| Discard all equipment per facility policy | ☐ | ☐ | |
| Remove and discard gloves, perform hand hygiene | ☐ | ☐ | |
| Place the resident in a comfortable position, ensure call bell is within reach. | ☐ | ☐ | |
| Document the procedure, assessment and the residents response. | ☐ | ☐ | |
| Report any abnormal findings to the provider. | ☐ | ☐ | |

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