STAFFING ON THE GO

SKILLS ASSESSMENT FOR CNA/GNA

Name: _____ Position: _____

Date: _____ Supervisor/Observer's Name (print clearly) _____

Personal Care Skill	Observed		Signature of (DON) RN	DATE	COMPLETED	
	Yes	No			Yes	No
TEMPERATURE						
a) Oral						
b) Axillary						
c) Rectal						
PULSE						
a) Radial						
b) Apical						
RESPIRATION						
GENERAL SURVEY						
a) Alertness						
b) Orientation						
PAIN MANAGEMENT						
a) Turning and Repositioning						
b) Backrub						
PERSONAL HYGIENE						
a) Sponge Bath						
b) Shower						
c) Tub Bath						
d) Applying Lotion						
SHAMPOOING						
a) Dry						
b) Wet						
NAIL CARE						
a) Clip and Clean						
b) Diabetic Referral						
ORAL HYGIENE						
RANGE OF MOTION TO ALL EXTREMITIES						
BOWEL/BLADDER MANAGEMENT						
a) Use of Bed Pan						
b) Urinal						
c) Applying Briefs						
AMBULATION						
a) Cane						

b) Crutches						
c) Walker						
TRANSFER TECHNIQUES						
FEEDING						
a) Breakfast						
b) Lunch						
c) Dinner						
BED MAKING						
a) Occupied						
b) Unoccupied						
COMFORT MANAGEMENT						
a) Showing Empathy						
b) Listening to Patient						
CARING						

Staff Signature: _____

Supervisor/Observer's Name (print clearly):

License Number:	Signature:

Director of Nursing:
Date of Observation: