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	☐Met ☐Not Met	
Observation, reporting and documentation of patient status and the care of services provided	A, B, or C	D or O	☐Met ☐Not Met	
Examining and recording temperature, pulse and respiration	A, B, or C	D or O	☐Met ☐Not Met	
Universal Precautions	A, B, or C	D or O	☐Met ☐Not Met	
Basic components of body functions and alterations in a condition that must be reported	A, B, or C	D or O	☐Met ☐Not Met	
Maintaining a clean,safe and healthy environment	A, B, or C	D or O	☐Met ☐Not Met	
Ability to recognize emergency	A, B, or C	D or O	☐Met ☐Not Met	
Capability to identify physical and emotional needs and work with the client and respect the pt's privacy and property	A, B, or C	D or O	☐Met ☐Not Met	
Proper and reliable methods in personal hygiene and grooming:				
Bed Bath	A, B, or C	D or O	☐Met ☐Not Met	
Tub Bath	A, B, or C	D or O	☐Met ☐Not Met	
Sponge Bath	A, B, or C	D or O	☐Met ☐Not Met	
Shampoo (sink, tub or bed)	A, B, or C	D or O	☐Met ☐Not Met	
Nail Care	A, B, or C	D or O	☐Met ☐Not Met	
Skin Care	A, B, or C	D or O	☐Met ☐Not Met	
Oral Hygiene	A, B, or C	D or O	☐Met ☐Not Met	
Toileting and elimination	A, B, or C	D or O	☐Met ☐Not Met	
Safe transfer techniques	A, B, or C	D or O	☐Met ☐Not Met	
Safe Ambulation	A, B, or C	D or O	☐Met ☐Not Met	
Use of Equipment (Wheelchair, lift, walker, cane)	A, B, or C	D or O	☐Met ☐Not Met	
Normal positioning with proper body alignment	A, B, or C	D or O	☐Met ☐Not Met	
Assistance with Feeding (Aspiration Precautions)	A, B, or C	D or O	☐Met ☐Not Met	
Capability to recognize adequate nutrition and intake	A, B, or C	D or O	☐Met ☐Not Met	
Medication Reminders	A, B, or C	D or O	☐Met ☐Not Met	
Infection Control (Handwashing, use of gloves, sanitizers)	A, B, or C	D or O	☐Met ☐Not Met	
Patient Care Documentation	A, B, or C	D or O	☐Met ☐Not Met	
Reportable events to RN	A, B, or C	D or O	☐Met ☐Not Met	
Other	A, B, or C	D or O	☐Met ☐Not Met	

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CNA/HHA Signature /Date

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Supervisor's Signature Initials//Date