**Aide Skills Inventory**



Date: Caregiver Name: CNA HHA

Please mark an X in the appropriate box next to each entry based on your experiences in patient care.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Skill | Experienced | Needs Review | Not Capable | Skill | Experienced | Needs Review | Not Capable |
| **SPECIALTY CARE** |  |  |  | **PERSONAL CARE** |  |  |  |
| Infant 0-2 yr |  |  |  | Tub Bath/Shower |  |  |  |
| Pediatric 2-13 yr |  |  |  | Bed Bath/Sponge Bath |  |  |  |
| Adolescent 13-18 yr |  |  |  | Hair Care |  |  |  |
| Adult |  |  |  | Oral/Mouth Care |  |  |  |
| Geriatric |  |  |  | Denture Care |  |  |  |
| Alzheimer’s/Dementia |  |  |  | Hearing Aids |  |  |  |
| Parkinson’s Disease |  |  |  | Skin Care/Grooming |  |  |  |
| Hospice Care |  |  |  | Shaving |  |  |  |
| Spinal Cord Injury |  |  |  | Nail Care |  |  |  |
| Brain/Head Injury |  |  |  | Foot Care |  |  |  |
| Stroke |  |  |  | Pressure Sore Precautions |  |  |  |
| Amputee |  |  |  | **NUTRITION** |  |  |  |
| Diabetes |  |  |  | Prepare/Serve Meals |  |  |  |
| Cardiac/Heart |  |  |  | Fluid Restrictions |  |  |  |
| Pulmonary/Respiratory |  |  |  | Assist with Feeding |  |  |  |
| **HOMEMAKING** |  |  |  | Intake/Output Readings |  |  |  |
| Laundry/Washer/Dryer |  |  |  | PEG Site Care |  |  |  |
| Dishes/Dishwasher |  |  |  | Swallow Precautions |  |  |  |
| Linens/Making Beds |  |  |  | **UNIVERSAL PRECAUTIONS** |  |  |  |
| Vacuum/Mop |  |  |  | Use of Protective Equipment |  |  |  |
| Garbage Disposal |  |  |  | Masks |  |  |  |
| Blender |  |  |  | Gloves |  |  |  |
| **TRANSFERRING** |  |  |  | Gowns/Aprons |  |  |  |
| Wheelchair |  |  |  | CPR Shields |  |  |  |
| Pivot |  |  |  | **VITAL SIGNS** |  |  |  |
| Repositioning |  |  |  | Temperature |  |  |  |
| Hoyer |  |  |  | Pulse |  |  |  |
| Slide Board |  |  |  | Respirations |  |  |  |
| **DRESSING** |  |  |  | Blood Pressure |  |  |  |
| Upper Body |  |  |  | **TOILETING** |  |  |  |
| Lower Body |  |  |  | Toilet Transfers |  |  |  |
| Sock Aids |  |  |  | Use of Bedside Commode |  |  |  |
| Shoe Horn |  |  |  | Use of Bedpan/Urinal |  |  |  |
| Immobilizers |  |  |  | Foley Cath Care |  |  |  |
| TEDHose/Elastic Stockings |  |  |  | Empty Ostomy |  |  |  |
| Orthopedic Devices |  |  |  | Use of Diapers/Depends |  |  |  |
| Prosthesis |  |  |  | **AMBULATION** |  |  |  |
| **OTHER** |  |  |  | Use of Gait Belt |  |  |  |
| Medication Reminders |  |  |  | Range of Motion |  |  |  |
| Weight/Scale |  |  |  | Weight-bearing Restrictions |  |  |  |
| Languages Spoken |  | | | Ambulation with Devices  *(Cane, Walker, Crutches)* |  |  |  |
| Languages Read/Write |  | | |