## Agency Name
## CHHA Self-Assessment of Skills

**Employee: _____ ID# _____ Date: ____/____/____**

| **Skill** | **Adult** | | | **Child** | | |
|---|---|---|---|---|---|---|
| | **Able to Do** | **Need to Review** | **Never Done** | **Able to Do** | **Need to Review** | **Never Done** |
| **Vital Signs:** | | | | | | |
| **Temperature** | | | | | | |
| **Pulse** | | | | | | |
| **Respiration** | | | | | | |
| **Basic Care:** | | | | | | |
| **Complete Bed Bath** | | | | | | |
| **Bath: Sponge, Tub or Shower** | | | | | | |
| **Foot Care** | | | | | | |
| **Mouth Care** | | | | | | |
| **Hair Care** | | | | | | |
| **Nail Care** | | | | | | |
| **General Skin Care** | | | | | | |
| **Decubiti Care (bed sore)** | | | | | | |
| **Shampoo: Sink, Tub, or Bed** | | | | | | |
| **Patient Positioning** | | | | | | |
| **Toileting and Elimination** | | | | | | |
| **Care of an Incontinent Client** | | | | | | |
| **Range of Motion** | | | | | | |
| **Make Bed** | | | | | | |

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| **Patient Safety:** | | | | | | |
| **Wheelchair** | | | | | | |
| **Cane** | | | | | | |
| **Walker** | | | | | | |
| **Assist Patient Walking** | | | | | | |
| **Transfer (bed to chair or wheelchair)** | | | | | | |
| **Body Mechanics** | | | | | | |
| **Patient Home Safety** | | | | | | |
| **Special Care:** | | | | | | |
| **Foley Catheter** | | | | | | |
| **Condom Catheter** | | | | | | |
| **Fractional Urines (S&A)** | | | | | | |
| **Assist with Colostomy Care** | | | | | | |
| **Knowledge of Low Salt Diet** | | | | | | |
| **Knowledge of Low Cholesterol (low fat) Diet** | | | | | | |
| **Knowledge of Diabetic Diet** | | | | | | |
| **Hoyer Lift** | | | | | | |
| **Reinforce Dressing** | | | | | | |
| **Change Simple Non-Sterile Dressing** | | | | | | |
| **Care of Paralyzed Patient** | | | | | | |

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| **Care of Handicapped Patient** | | | | | | |
| **Care of Developmentally Delayed Patient** | | | | | | |
| **Care of Psychiatric Patient** | | | | | | |
| **Care of Autistic Patient** | | | | | | |
| **Care of Elderly Patient** | | | | | | |
| **Care of Confused Patient** | | | | | | |
| **Infection control:** | | | | | | |
| **Gloves** | | | | | | |
| **Disposal of hazardous materials** | | | | | | |
| **Universal Precautions** | | | | | | |
| **Mask** | | | | | | |
| **Gown** | | | | | | |
| **Chart Maintenance:** | | | | | | |
| **Read and follow Aide Plan of Care** | | | | | | |
| **HHA Worksheet** | | | | | | |
| **Activities of Daily Living:** | | | | | | |
| **Dust & Vacuum** | | | | | | |
| **Wash Dishes** | | | | | | |
| **Clean:**<br>**Kitchen, bedroom, and bathroom** | | | | | | |

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| **Shop for Client** | | | | | | |
| **Wash and Iron Clothes** | | | | | | |
| **Prepare Meals** | | | | | | |
| **Communication with:** | | | | | | |
| **Client** | | | | | | |
| **Family/Caregiver** | | | | | | |
| **Health Care Team** | | | | | | |
| **Supervisor** | | | | | | |

Reviewed by RN:

Name (print): _____ Date: _____

Signature: _____ Title: _____

Date Implemented: ____/____/_____

Date Revised: ____/____/_____