

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

HOMEMAKER-HOME HEALTH AIDE
COMPETENCY EVALUATION

AGENCY NAME: _____

HOMEMAKER-HOME HEALTH AIDE _____

COMPETENCY SHALL BE DETERMINED THROUGH
OBSERVATION OF THE AIDE'S PERFORMANCE OF TASKS

ACTIVITY	OBSERVED / DATE	COMPETENT / DATE	COMMENTS / INITIALS
1. Reading & Recording			
A. Temperature			
* Oral			
* Axillary			
B. Pulse			
* Radial			
C. * Respirations			
2. Appropriate & Safe Techniques in Personal Care:			
A. Bathing			
* bed bath			
* sponge bath			
* tub bath			
* showers			
B. Shampoo			
* sink			
* tub			
* bed			
C. * Skin Care			
D.* Nail Care			
E.* Foot Care			
F.* Oral Hygiene			
G.*Toileting/ Elimination			
Reading/ recording output			
Bladder/ bowel training			

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ACTIVITY	OBSERVED / DATE	COMPETENT / DATE	COMMENTS / INITIALS
3. Safe Techniques For:			
* A. Ambulation			
* B. Transfers			
C. Use of Assistive Devices			
* cane			
* crutches			
* walker			
* wheelchair			
4. Proper Body Mechanics			
self			
patient			
5. Positioning			
* bed			
* chair			
6. Normal Range of Motion			
* Upper Extremities			
* Lower Extremities			
7. Patient Status and Care or Services Furnished			
A. Observation			
B. Reporting			
C. Documentation			

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EXAMINATION OR OBSERVATION OF A HOMEMAKER-HOME HEALTH AIDE

ACTIVITY	KNOWLEDGE OF / DATE	COMPETENT / DATE	COMMENTS / INITIALS
8. Communication Skills			
A. Patient / Family			
B. Staff			
9. Infection Control Procedures			
A. Universal Precautions			
B. Handwashing			
10. Emergency Procedures			
A. Recognizing			
B. Reporting			
C. Incident Reports			
D. Specific Procedures			
Heimlich Maneuver			
11. Physical, Emotional and Developmental Needs			
A. Recognition			
B. Approaches to Work w/ Clients			
ethnic considerations			

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ACTIVITY	KNOWLEDGE OF / DATE	COMPETENT / DATE	COMMENTS / INITIALS
C. Complaint Procedure			
D. Respecting Patients' Rights, Property, Privacy			
12. Basic Elements of Body Function and Changes in Body Functions that <u>must</u> be Reported to Aide's Supervisor			
A. Hemorrhage			
B. Chest Pain			
C. Urination			
D. Shortness of Breath			
13. Maintain Clean, Safe and Healthful Environment			
A. Homemaking			
B. Bedmaking			
occupied			
unoccupied			
C. Safety Hazards			
D. Cleaning Bathroom			

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ACTIVITY	KNOWLEDGE OF / DATE	COMPETENT / DATE	COMMENTS / INITIALS
E. Laundry			
14. Nutrition and Fluids Intake			
meals			
diet			
recording intake			
planning / shopping			
Other Approved Tasks			

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AGENCY NAME: _____

HOMEMAKER-HOME HEALTH AIDE _____

This trainee has successfully completed the minimum competency evaluation program requirements, and therefore, qualifies to furnish homemaker-home health aide services on behalf of a Home Health Care Agency and/or a Homemaker-Home Health Aide Agency.

Instructor's Signature / Initials

Instructor's Signature / Initials

Instructor's Signature / Initials

Date: _____

Primary Nursing Instructor

If training has occurred at another agency / institution indicate:

Name: _____

Address: _____

Telephone Number: _____

NOTE: The Homemaker-Home Health Aide Competency Evaluation Program must be performed by or under the general supervision of a registered nurse who possesses a minimum of two (2) years of nursing experience, one (1) year of which must be in the provision of home health care per Sec. 19-13-D69 (d) (2) (I) (i) and Sec. 19-13-D83 (b) (6).

* indicates task which must be observed