UAP Skills Checklist for Nurse Delegation

Agency Name_____ UAP_____Date_____

Nurse_____ Phone #_____

Delegation Skill Review

- ☐ Evaluation of new UAP
- ☐ Renewal evaluation for UAP

The unlicensed assistive personnel must, without prompting or error, demonstrate all skills delegated in accordance with published guidelines with 100% accuracy to the Nurse Delegator. (Refer to published guidelines and policies/procedures for assisted living community)

Basic Medication Information and Medical Terminology	**Date**	**Nurse**
A. States common medical abbreviations and meanings	_____	_____
B. Describes common dosage forms of medication and routes of delivery for medication.	_____	_____
C. States the 6 rights of assisting with medication	_____	_____
D. Describes what constitutes a medication error	_____	_____
E. Describes consumer rights related to refusal, privacy and respect	_____	_____
F. Defines a medication allergy and signs of a possible allergic reaction	_____	_____
G. State the name and location of medication references available in Facility	_____	_____

Demonstrated appropriate technique to obtain and record the following:

A. Blood Pressure	_____	_____
B. Temperature	_____	_____
C. Pulse	_____	_____
D. Respiration	_____	_____
E. Weight	_____	_____
F. Finger stick blood glucose	_____	_____

Assistance with Medications (Refer to published guidelines and checklists)

Assistance with medications. Check the type(s) of medications for which demonstrated competency is validated.

☐ Oral-pills/tablets/capsules	_____	_____
☐ Oral-liquid	_____	_____
☐ Oral-buccal/sublingual	_____	_____
☐ Eye-Drops	_____	_____

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	Date	Nurse
☐ Eye-Ointment	_____	_____
☐ Eye-Patches	_____	_____
☐ Ear-Drops	_____	_____
☐ Ear-Topical (creams/lotions)	_____	_____
☐ Nose-Drops	_____	_____
☐ Nose-Spray	_____	_____
☐ Nose-Inhalers	_____	_____
☐ Topical-Creams/ointment/paste	_____	_____
☐ Topical-Lotions	_____	_____
☐ Topical-Sprays/powders	_____	_____
☐ Topical-Patches	_____	_____
☐ Topical-Medicated Shampoo	_____	_____
☐ Respiratory Inhalers	_____	_____
☐ Rectal Medication-Suppositories/Enemas	_____	_____
☐ Vaginal Medication-Suppositories/Cream	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____

Other Nursing Tasks Validated

☐ Glucometer	_____	_____
☐ Nebulizer	_____	_____
☐ CPAP	_____	_____
☐ Oxygen Concentrator/Cannula/Mask	_____	_____
☐ Filling Companion Oxygen Tank	_____	_____
☐ Epipen	_____	_____
☐ Hospital Bed Operation	_____	_____
☐ Mechanical Lift	_____	_____
☐ Use of Weight Scales	_____	_____
☐ **Other_____**	_____	_____
☐ **Other_____**	_____	_____
☐ **Other_____**	_____	_____

Appropriate Documentation Validated

☐ Medication Administration Record (MAR)	_____	_____
☐ Refusal of Medications	_____	_____
☐ Missed Dose	_____	_____
☐ Medication Error	_____	_____

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	Date	Nurse
☐ PRN Medications/Reasons/Follow Up	_____	_____
☐ Self Administration	_____	_____
☐ Narcotic Count Sheet	_____	_____
☐ Incident Report Form	_____	_____
☐ RN Notification Documentation	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____

Other Skills Validated

☐ Handwashing	_____	_____
☐ First Aid/Emergency Management	_____	_____
☐ Medication Security	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____
☐ Other_____	_____	_____

UAP_____ Date_____

Nurse_____ Date_____