

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
<input type="checkbox"/> Eye-Ointment	_____	_____
<input type="checkbox"/> Eye-Patches	_____	_____
<input type="checkbox"/> Ear-Drops	_____	_____
<input type="checkbox"/> Ear-Topical (creams/lotions)	_____	_____
<input type="checkbox"/> Nose-Drops	_____	_____
<input type="checkbox"/> Nose-Spray	_____	_____
<input type="checkbox"/> Nose-Inhalers	_____	_____
<input type="checkbox"/> Topical-Creams/ointment/paste	_____	_____
<input type="checkbox"/> Topical-Lotions	_____	_____
<input type="checkbox"/> Topical-Sprays/powders	_____	_____
<input type="checkbox"/> Topical-Patches	_____	_____
<input type="checkbox"/> Topical-Medicated Shampoo	_____	_____
<input type="checkbox"/> Respiratory Inhalers	_____	_____
<input type="checkbox"/> Rectal Medication-Suppositories/Enemas	_____	_____
<input type="checkbox"/> Vaginal Medication-Suppositories/Cream	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Other Nursing Tasks Validated

<input type="checkbox"/> Glucometer	_____	_____
<input type="checkbox"/> Nebulizer	_____	_____
<input type="checkbox"/> CPAP	_____	_____
<input type="checkbox"/> Oxygen Concentrator/Cannula/Mask	_____	_____
<input type="checkbox"/> Filling Companion Oxygen Tank	_____	_____
<input type="checkbox"/> Epipen	_____	_____
<input type="checkbox"/> Hospital Bed Operation	_____	_____
<input type="checkbox"/> Mechanical Lift	_____	_____
<input type="checkbox"/> Use of Weight Scales	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Appropriate Documentation Validated

<input type="checkbox"/> Medication Administration Record (MAR)	_____	_____
<input type="checkbox"/> Refusal of Medications	_____	_____
<input type="checkbox"/> Missed Dose	_____	_____
<input type="checkbox"/> Medication Error	_____	_____

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	Date	Nurse
<input type="checkbox"/> PRN Medications/Reasons/Follow Up	_____	_____
<input type="checkbox"/> Self Administration	_____	_____
<input type="checkbox"/> Narcotic Count Sheet	_____	_____
<input type="checkbox"/> Incident Report Form	_____	_____
<input type="checkbox"/> RN Notification Documentation	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Other Skills Validated

<input type="checkbox"/> Handwashing	_____	_____
<input type="checkbox"/> First Aid/Emergency Management	_____	_____
<input type="checkbox"/> Medication Security	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

UAP _____ Date _____

Nurse _____ Date _____