UCLA Health **DEPARTMENT OF NURSING (DON) INITIAL COMPETENCY VALIDATION CHECKLIST (CACP)-Excludes NICU**

New Hire Name: ____ Unit: _____________ Position: Clinical Administrative Care Partner (CACP)

Instructions: To complete this form, the new hire CACP must independently demonstrate each skill. The Preceptor(s) will validate this by initially and dating. The Preceptor(s) and new hire CACP must print and sign full names at the end of the form, before giving it to Unit Director/Manager.

Note: The unit/department may have a unit specific checklist to complete in addition to this form.

Age Group(s) Served (Check all that apply)	
□ Neonates (< 30 Days) □ Infants (>= 30 Days & < 1 Year) □ Pediatrics (>=1 Year & < 13 Years)	□ Adolescents (>= 13 Years & < 18 Years) □ Adults (>= 18 Years & < 65 Years) □ Geriatrics (>= 65 Years)

QSEN Competency Assessment Criteria	**Validation of Competency**	
Example on how to complete this form:	**Preceptor Initials**	**Date**
1. Read the directions above before starting this form	jp	1/31/20
A. Patient/Family Centered Care	**Preceptor Initials**	**Date**
Admit a patient: 1. Get report from the RN 2. Connect patient to Phillips monitor/telemetry box and central monitor, if ordered 3. Take vital signs, height, and weight 4. Orient patient/family to room, call light, mealtimes, visiting hours, and phone 5. Give patient a My Care Folder 6. Activate Bedside Tablet 7. Document in CareConnect		
Check patient belongings during Admission/Transfer/Discharge: 1. Review all belongings with the patient/family during Admission/Transfer/Discharge 2. Document all belongings in CareConnect 3. Secure all belongings per unit process 4. Tell RN about medications/equipment brought from home 5. Tell RN about unsafe items found (ex: weapons, sharps)		
Perform hourly rounding, using the 6Ps: 1. Report pain to the RN 2. Meet personal needs (offer assisted proactive toileting, hydration, nutrition)		

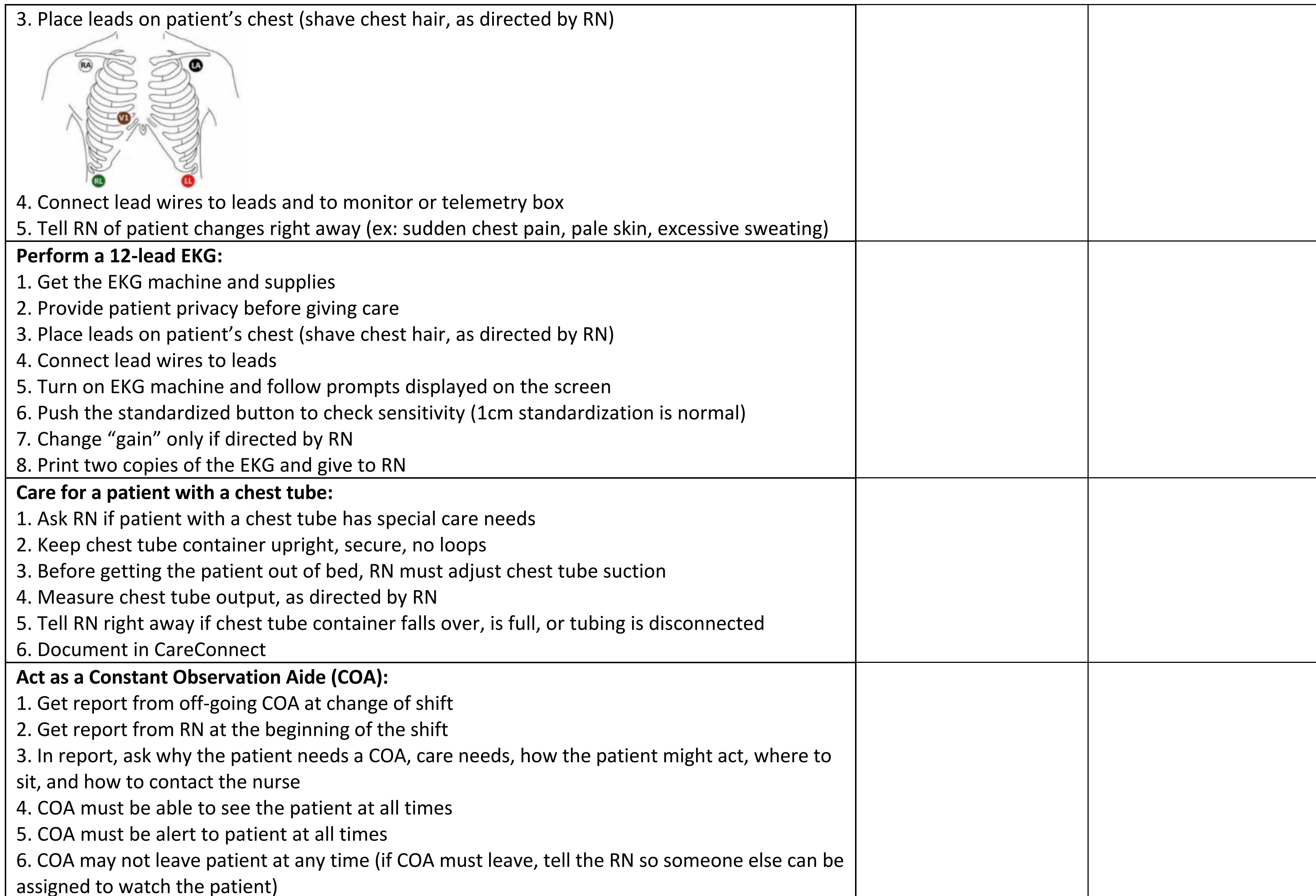
3. Ex: say to your patient, “it’s been 4 hours since your last time you went to the bathroom, I’m going to assist you now” 4. Position the patient or turn total care patients to prevent skin breakdown 5. Place the call light, phone, personal items within reach 6. Prevent falls by asking patient/family to use call light 7. Report pump alarms or empty IV bags to RN 8. Document in CareConnect		
Perform comfort interventions, as directed by the RN: 1. Provide warm blankets, pillows, repositioning 2. Provide distraction, emotional support 3. Set up a comfortable room based on patient need (turn lights down, open shade, adjust temperature, play music) 4. Offer resources for meditation, aromatherapy 5. Document in CareConnect		
Perform care using the Wellness Bundle: 1. Provide comfort interventions (ex: pillows, blankets, room temperature, etc.) 2. Provide hygiene for mouth, body, skin, and any catheters 3. Assist patient with mobility needs based on RN report (ex: sitting in chair, walking) 4. Assist patient with nutrition needs (ex: meal tray, positioning, feeding) 5. Assist patient with sleep (ex: turn lights down, close shade, adjust temperature, keep room and hallways quiet) 6. Document in CareConnect		
Transfer a patient: 1. Get report from RN that patient is ready for transfer 2. Take transfer vital signs 3. Make sure patient has all personal belongings 4. Call patient transport 5. Assist the patient to the wheelchair or gurney 6. Discharge the patient in Bedside Tablet 7. Transfer the patient in CareConnect 8. Take current monitor with the patient 9. Bring replacement monitor from receiving unit 10. Clean monitor/telemetry box with disinfectant wipes and store on unit 11. Document in CareConnect		

Discharge a patient: 1. Get report from RN that patient is ready for discharge 2. Take discharge vital signs 3. Make sure patient has all personal belongings 4. Help set up transportation and discharge location 5. Call patient transport 6. Assist the patient to the wheelchair or gurney 7. Discharge the patient in Bedside Tablet, CareConnect, and monitor 8. Clean monitor/telemetry box with disinfectant wipes and store on unit 9. Document in CareConnect		
Perform end of life care, as directed by the RN: 1. Place patient in a comfortable position 2. Provide support to family 3. Report any symptoms of discomfort to the RN 4. Provide care for an expired patient (ex: cleansing body, wrapping body, linen change) 5. Document in CareConnect		
B. Teamwork and Collaboration	**Preceptor Initials**	**Date**
Communicate with healthcare team: 1. Get report from RNs you share patients with on your shift 2. Speak with RNs during your shift about patient changes/updates 3. Ask RN if you have any questions about patient care 4. Ask other CACPs for help, as needed 5. Provide help to other CACPs, as needed		
Communicate with patient and family: 1. Use CICARE (connect, introduce, communicate, ask, respond, exit) each time you enter/exit a patient room 2. Use CICARE during every patient/family interaction and procedure 3. Use CICARE at the greeter stations and while doing administrative duties 4. Update the whiteboard in each patient room per unit process 5. Use interpreter services as needed		
Use chain of command: 1. Tell RN of patient changes right away 2. Tell charge RN if patient needs are not being met by the team 3. Tell unit leadership (Unit Director, Supervisor) if charge RN cannot resolve issue		

Order and restock supplies: 1. Order supplies per unit process 2. Restock supplies per unit process		
C. Evidence-Based Practice	**Preceptor Initials**	**Date**
Perform job duties within the CACP scope and job description: 1. Review UCLA Health Policy/Guideline and Lippincott Procedures, as needed 2. Complete mandatory education 3. Ask RN if you have questions about patient care		
D. Quality Improvement	**Preceptor Initials**	**Date**
Provide daily hygiene: 1. Provide patient privacy before giving care 2. Be careful giving a bath if patient is connected to IV and other tubes (ex: chest tube) 3. Assist patient with daily bath (ex: provide towels, run water, provide bath wipes) per unit process 4. Give total care patient a bed bath 5. Provide daily CHG treatment (tell RN if patient/family refuses) 6. Provide peri-care every shift and after each bowel movement 7. Remove urine/stool with chux/plain disposable washcloths and water (no soap) 8. Cleanse peri-area with CHG cloths (once daily) 9. Provide oral care (ex: brushing teeth, mouthwash, denture care) 10. Only shave a patient if approved by RN 11. Tell RN if any dressings are wet or falling off 12. Document in CareConnect		
Provide daily CHG Treatment: (Exclude Perinatal) 1. Ask RN if patient should get daily CHG treatment 2. Tell RN if patient/family refuses CHG treatment 3. Get a CHG pack from the warmer (a light on the warmer shows which CHG cloths are ready for use) 4. Provide patient privacy before giving care 5. Use one pack per patient (6 cloths total) 6. Use one cloth per “skin area”, in the order listed below 7. Wipe neck, shoulders, and then chest 8. Wipe arms and hands 9. Wipe abdomen, groin, then perineum		

10. Wipe right leg and foot 11. Wipe left leg and foot 12. Wipe back of neck, back, and then buttocks 13. Do not use CHG cloths on face 14. Do not wipe off, allow skin to air dry (skin may feel sticky for a few minutes until dry)		
Provide skin care: 1. Report any skin breakdown to RN (ex: redness, peeling, rashes) 2. Make the bed to limit layers and wrinkles 3. Change bed when wet/soiled 4. Use sheets, pillows, and wedges to position, prevent injury, and promote comfort 5. Turn patient every 2 hours 6. Perform incontinence care, as directed by RN 7. Remove urine/stool with chux/plain disposable washcloths and water (no soap) 8. Cleanse with CHG cloths (once daily) 9. Apply CHG-compatible barrier cream 10. Use products to clean and protect skin, as directed by RN (ex: barrier cream, dressings) 11. Do not diaper bedbound patients, unless directed by RN 12. Document in CareConnect		
Provide Foley catheter care: 1. Provide patient privacy before giving care 2. Perform catheter care after bath is completed 3. Perform every shift using CHG (once daily)/comfort bath wipes 4. Get an extra pack of CHG (2-CHG cloths)/comfort bath wipes 5. Clean 6 inches of Foley catheter with CHG cloths/comfort bath wipes, cleaning down tubing away from body 6. Perform catheter care after each bowel movement with comfort bath wipes 7. Empty the urinary catheter bag (prevent overfill) 8. Check for and prevent catheter loops/kinks by keeping bag off the floor and below patient's waist (do not place on the bed) 9. Report changes in urine or peri-area to RN (ex: urine color, clear/cloudy, amount, redness, swelling around catheter) 10. Document in CareConnect		
Place a condom catheter on a male patient: 1. Gather supplies, including urinary device, skin protectant, and Foley bag		

2. Provide patient privacy before giving care 3. Clean penis with CHG wipes (once daily)/comfort bath wipes, do not pat dry 4. If patient is not circumcised, gently pull back the foreskin and clean, allow to air dry, and replace foreskin to normal position 5. Apply skin protectant at the base of penis and let dry completely 6. Apply urinary device on penis 7. Connect device to drainage bag tubing and position bag below the patient's waist 8. To remove: apply warm, wet washcloth for 30 seconds, gently roll the device off the penis, and discard 9. Document in CareConnect		
Place a PrimaFit device on a female patient: 1. Gather equipment, including suction source, tubing, and canister 2. Provide patient privacy before giving care 3. Place protective pad under patient and assist patient to lie on their back 4. Place device on patient's perineum 5. Connect device to suction canister tubing (make sure canister lid is closed) 6. ONLY the RN will connect and turn on/off wall suction 7. Check that tubing is connected at all times and is not underneath the patient 8. Write urine output on canister, per unit process 9. Change device every 12 hours or if soiled with stool or body fluids (other than urine) 10. Change canister and tubing every 24 hours or when canister is 2/3 full 11. To remove: apply warm, wet washcloth for 30 seconds, gently remove device, and discard 12. Document in CareConnect		
Collect and handle lab specimens: 1. Collect lab specimens (ex: sputum, stool, urine), as directed by RN 2. Gather supplies 3. Make sure you are collecting a specimen from the correct patient 4. Use two patient identifiers (name and date of birth) 5. Use bar code scanner and label each lab specimen at bedside 6. Transport lab specimens based on lab test requirements (ex: on ice)		
E. Safety	**Preceptor Initials**	**Date**
Apply cardiac leads (5-lead): 1. Gather supplies 2. Provide patient privacy before giving care		

3. Place leads on patient's chest (shave chest hair, as directed by RN)  4. Connect lead wires to leads and to monitor or telemetry box 5. Tell RN of patient changes right away (ex: sudden chest pain, pale skin, excessive sweating)		
Perform a 12-lead EKG: 1. Get the EKG machine and supplies 2. Provide patient privacy before giving care 3. Place leads on patient's chest (shave chest hair, as directed by RN) 4. Connect lead wires to leads 5. Turn on EKG machine and follow prompts displayed on the screen 6. Push the standardized button to check sensitivity (1cm standardization is normal) 7. Change "gain" only if directed by RN 8. Print two copies of the EKG and give to RN		
Care for a patient with a chest tube: 1. Ask RN if patient with a chest tube has special care needs 2. Keep chest tube container upright, secure, no loops 3. Before getting the patient out of bed, RN must adjust chest tube suction 4. Measure chest tube output, as directed by RN 5. Tell RN right away if chest tube container falls over, is full, or tubing is disconnected 6. Document in CareConnect		
Act as a Constant Observation Aide (COA): 1. Get report from off-going COA at change of shift 2. Get report from RN at the beginning of the shift 3. In report, ask why the patient needs a COA, care needs, how the patient might act, where to sit, and how to contact the nurse 4. COA must be able to see the patient at all times 5. COA must be alert to patient at all times 6. COA may not leave patient at any time (if COA must leave, tell the RN so someone else can be assigned to watch the patient)		

7. COA to observe and monitor the patient for safety, comfort, or signs of distress 8. If the patient is in restraints, monitor for changes in condition (ex: restraints are too tight) 9. If patient needs to use the restroom, keep the door open and remain within arms distance 10. COA must have magnetic bathroom key at all times (give the key to oncoming COA) 11. Call for help, as needed (ex: RN, Charge RN, Security, Code Gray) 12. At the end of shift, give report to the oncoming COA (in the room) 13. Document in CareConnect		
Care for a suicidal patient: 1. Make sure the suicidal patient was searched by security 2. Do not give patient any of their belongings 3. Complete Suicide Safety Rounds once per shift with RN 4. Act as a COA, as directed by RN 5. Document in CareConnect		
Provide assistance in Emergency Response (Code Blue, Code Stroke, Rapid Response): 1. Press Staff Assist/Code Blue button (patient has no pulse) 2. Dial #36 on nearest phone 3. Bring Crash cart to bedside 4. Begin chest compressions (CPR), as directed by RN		
Demonstrate how to prevent a fall: 1. Put bed in low position and keep 2-3 side rails up 2. Make sure patient wears non-skid socks or footwear when out of bed 3. Place the call light, phone, and personal items within reach 4. Offer toileting hourly 5. Help patient to bathroom, as needed 6. Keep room and hallways well-lit and free from clutter 7. Keep floors dry and wipe up any spills immediately 8. Use the bed alarm and chair alarm, as directed by RN 9. Document in CareConnect		
Care for a patient after a fall: 1. Follow fall prevention measures with patient and family (see above) 2. Take frequent vital signs, as directed by RN (ex: every 30 minutes x 2 hours, then every 2 hours x 24 hours, then every 4 hours) 3. Tell RN of patient changes right away (ex: confusion, pain, dizziness) 4. Participate in the post-fall huddle		

5. Document in CareConnect		
Measure intake and output: 1. Measure intake and output, including oral intake, urine output, bowel movements (ostomy/ colostomy), and emesis 2. Measure output from drains and tubes as directed by RN 3. Report intake and output to RN, including volume, color, and consistency 4. Document in CareConnect		
Feed a patient: 1. Check that patient has a menu and help patient order food 2. Make sure patient is sitting up straight during meals to prevent aspiration, choking 3. Put meal tray and utensils within patient's reach 4. Help patient with denture care (if applicable) 5. Feed patient, as needed (slowly to allow patient to chew/swallow) 6. Tell RN right away if patient has trouble chewing/swallowing or coughs while eating 7. Document in CareConnect		
Put on and remove Personal Protective Equipment (PPE): 1. Perform hand hygiene (soap and water or alcohol-based hand sanitizer) each time you enter/exit room and before all patient contact (Standard Precautions) 2. For Contact/Spore Precautions (ex: C-Diff), perform hand hygiene with soap and water only (do not use hand sanitizer) 3. Place isolation signs on patient door, as directed by RN (ex: Contact, Contact/Spore, Droplet, Airborne precautions) 4. Use required PPE as shown on the isolation precaution signs 5. Put on PPE in this order: gown, mask/respirator, goggles/face shield, gloves 6. Take off PPE in this order: gloves, goggles/face shield, gown, mask/respirator		
Care for a patient on oxygen: 1. Oxygen settings are maintained by RN 2. Check that oxygen device (nasal cannula/facemask) is on the patient and connected to oxygen source 3. Check patient saturation level (Pulse Ox, SPO2), as directed by RN 4. Tell RN if there is redness, discoloration, or discomfort around the oxygen device 5. Check with RN before walking with a patient on oxygen 6. Report patient/family use of candles, smoking, and lighters to RN right away (this is unsafe around oxygen use)		

Provide respiratory hygiene: 1. Suction mouth, as directed by RN 2. Provide patient with an Incentive Spirometer and assist, as directed by RN 3. Assist patient in coughing, deep breathing, and position changes, as directed by RN		
Care for a patient in non-violent restraints: 1. Apply soft restraints, mesh vests, mittens-restrained, poesy stay safe bed, elbow immobilizer, no-no's, as directed by RN 2. Use 4 bed side rails only if directed by RN 3. Tell RN right away if restraints are too tight or there are signs of injury 4. Tell RN right away if patient is pulling on lines/tubes, getting out of bed, yelling, crying, kicking 5. Help RN with repositioning and range of motion every two hours 6. Offer toileting, hydration, nutrition to patient every hour, as directed by RN 7. Document patient care in CareConnect, RN will document restraints		
Care for a patient in violent restraints: 1. Apply violent restraints (tuff cuffs), as directed by RN 2. Check that patient has a Constant Observation Aide (COA) 3. Tell RN right away if restraints are too tight or there are signs of injury 4. Tell RN right away if there is immediate danger to patient, family, or staff 5. Tell RN right away if patient is pulling on lines/tubes, getting out of bed, yelling, crying, kicking 6. Help RN with repositioning and range of motion every two hours 7. Offer toileting, hydration, nutrition to patient every hour, as directed by RN 8. Document COA duties in CareConnect, RN will document restraints		
Perform Safe Patient Handling (SPH): 1. Get report from the RN, including Bedside Mobility Assessment Tool (B.M.A.T) level, activity level, and SPH equipment needed 2. Place SPH equipment near patient 3. Make sure patient wears slip resistant footwear 4. Use hearing aids, glasses, cane, walker, wheelchair, splint, as needed 5. Use a transfer/gait belt, as needed 6. Assist patient in position changes, dangling, and walking, as directed by RN 7. Assist patient in and out of bed, as directed by RN 8. Tell RN right away if patient complains of pain or feels dizzy/lightheaded 9. Tell RN right away if patient falls 10. Clean equipment used after each use with disinfectant wipes		

11. Document in CareConnect		
Care for a patient on seizure precautions: 1. Get seizure pads 2. Keep bed in low position and place seizure pads over side rails 3. Tell RN right away if patient is having a seizure 4. Monitor vital signs after seizure, as directed by RN 5. Document in CareConnect		
Take vital signs, height, and weight: 1. Take vital signs per unit process, including temperature, blood pressure, heart rate, respiration rate, and oxygen saturation (Pulse Ox, SPO2) 2. Take orthostatic blood pressure, as directed by RN 3. Take height and weight, per unit process 4. Tell RN right away if there is a change in patient's vital signs or weight 5. Document in CareConnect		
Care for a patient on ETCO2 Monitoring: 1. Connect orange end of the cannula to ETC02 monitor 2. Check that patient wears ETCO2 device at all times 3. Ask RN if patient can remove ETCO2 device for eating, drinking, and walking 4. Tell RN right away if ETCO2 decreases or increases by 10mm Hg 5. Change nasal cannula ETCO2 tubing every 72 hours 6. Clean monitor with disinfectant wipes after ETCO2 monitoring is discontinued 7. RN will document ETCO2		
Place TED hose on a patient: 1. Place TED hose on a patient, as directed by RN 2. Measure patient leg to choose TED hose length/size 3. Provide patient privacy before giving care 4. Apply TED hose one leg at a time 5. Tell RN if patient/family refuses TED hose 6. Remove and replace TED hose every shift, as directed by RN 7. Tell RN right away if patient has swelling, redness, bruising, pain, or skin breakdown 8. Document in CareConnect		
Place Sequential Compression Device (SCD) on a patient: 1. Get SCD machine and compression sleeves 2. Provide patient privacy before giving care		

3. Place SCD on patient, as directed by RN 4. Attach compression sleeves to the SCD machine and turn it on 5. Make sure patient is not lying on tubing 6. Remove SCDs every shift, as directed by RN 7. Remove SCDs before patient gets out of bed 8. Tell RN if patient/family refuses SCDs 9. Tell RN right away if patient has swelling, redness, bruising, pain, or skin breakdown 10. Document in CareConnect		
Tell RN when patient condition is not normal (ex: adult sepsis): 1.Tell RN right away if vital signs change (as listed below) 2. Temperature is greater than 38.3C or less than 36C 3. Heart rate is greater than 90/minute 4. Respiratory rate is greater than 20/minute 5. Blood pressure change (top number is less than 90 or drops by 40 mm Hg, mean arterial pressure (MAP) is less than 65) 6. Tell RN right away if patient has urine output less than 30 mL/hour 7. Tell RN right away if patient is confused or not waking up 8. If RN does not respond, tell the charge RN 9. Document in CareConnect		
F. Informatics	**Preceptor Initials**	**Date**
Document in CareConnect: 1. Document vital signs, height, and weight 2. Document all care provided (ex: hygiene, CHG treatment, feeding, intake, and output)		
Use the Nurse Call System to respond to patient call lights: 1. Sign on shift, sign out for break/lunch, and sign off shift in Nurse Call System per unit process 2. View patient assignment (use display icon) 3. Use nursing station console to answer patient call light, assign RN/CACP to patient call, call into patient room/staff lounge 4. Keep special instructions (ex: patient unable to speak or hear) at console 5. Cancel the call light from the console, as needed		
Use the Responder 5 (Electronic Whiteboard): 1. Add caregivers (RN, LVN, CACP, CCP) to patient assignment (ex: Responder 5)		
Use the Pneumatic Tube System to send items: 1. Use correct canister (ex: red canister for blood)		

2. Make sure canister is closed completely and latched 3. Include paperwork, as needed 4. Check that system says "station ready" 5. Select destination from list 6. Check that system says "selection accepted" 7. Send broken canisters to Facilities		
Use the Pneumatic Tube System to receive items: 1. Check for broken/leaking items 2. Tell charge RN right away if items are broken/leaking 3. Clean canister/bin (ex: disinfectant wipes), as directed by charge RN 4. Tell RN right away when medications are received 5. Take extra canisters from bin 6. Select "0" to send extra canisters back		
Document patient transfer out of unit in CareConnect: 1. Update patient location, unit, and room number 2. Reset Bedside Tablet		
Document patient transfer to the unit in CareConnect: 1. Update room number, admission status, accommodation, and level of care 2. Admit patient at bedside and central monitor 3. Activate Bedside Tablet		
G. Department of Nursing Required Modules		
Age Specific Care		
Constant Observation Aide (COA) for the Suicidal Patient		
Crisis Intervention		
End-Tidal Carbon Dioxide (ETCO2) Monitoring		
Essential Elements of Patient Safety		
Medsled module		
Pain Management Guideline: The Role of the Care Partner in Patient Comfort		
Patient Education Bundle for In-Patient Nursing		

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New Hire Name: ____ Unit: _______________ Position: Clinical Administrative Care Partner (CACP)

Preceptor Printed Name	Preceptor Signature	Preceptor Initials	Preceptor Employee ID	Preceptor Unit	Date

In signing this Initial Competency Validation Checklist, the New Hire CACP has demonstrated the skills required to provide safe patient care appropriate to the age groups served.

New Hire Printed Name: ______________________ New Hire Signature: ______________________

New Hire Employee ID: ______________________ Date: ______________________

Unit Director/Manager Printed Name: ______________________ Unit Director/Manager Signature: ______________________

Unit Director/Manager Employee ID: ______________________ Date: ______________________

One Staff = “Init Comp”