Dear Applicant,

Please provide a copy of the following credentials or information being requested.

We will need a copy of...

- A valid CA Driver License
- Social Security Card
- Clear Background Check
- Valid Auto Insurance verification
- Professional License
- Professional Resume
- Professional Liability Insurance if applicable
- Valid CPR Card
- Physical Exam Results (within the last 6 months)
- TB Test Results
- Additional documentation may be required

If you have any questions please DO NOT HESITATE to contact Beneficial Home Health Services, Inc. (714) 256-0756.

770 S. Brea Blvd. Suite 217 Brea, CA 92821
Tel. No. (714) 256-5312 * Fax No. (714) 256-0754

Beneficial Home Health Services, Inc.

Application for Employment
An equal opportunity Employer

Beneficial Home Health Services, Inc. is an Equal Opportunity Company and considers all applications for Employment equally regardless of race, color, and creed, national origin, sex, age, religion, veteran status or any disability that is not job related.

Applicant's Name (Last, First, Middle)			Today's Date
Address		Nursing License Number	Expiration Date
City State Zip Code		Certification Number	Effective Date
Social Security Number – –	CPR ☐ YES ☐ NO		Expiration Date
Home Phone Number (area code)	Cell Phone Number	Page Number	

WORK HISTORY – STARTING WITH YOUR MOST RECENT WORK EXPERIENCE, LIST LAST THREE (3) POSITIONS

Company's Name (Present or most present)	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Company's Name	Date Started	Date Ended	Phone Number
Address (Street, City, Zip Code)			
Supervisor's Name and Title/Department		Title of Your Position	
Describe Work Performed			
Reason for Leaving			
Have you ever been fired or asked to resign from a job for any reason? (if yes, please explain)			

Beneficial Home Health Services, Inc.

EDUCATION			
High School Name	Location	Diploma	
College Name	Location	Major Course	Degree
Graduate School	Location	Major Course	Degree

ARE THERE ANY REASONS YOU WOULD BE UNABLE OR UNWILLING TO PERFORM ANY OF THE TASK REQUIRED BY THE JOB YOU ARE APPLYING FOR? (IF YES, PLEASE EXPLAIN)

____

____

LIST THREE (3) PERSON WHO ARE FAMILIAR WITH YOUR WORK OR SCHOOL BACKGROUND (DO NOT LIST RELATIVES)

Name	Occupation	Address	Telephone No.	Relationship

HAVE YOU BEEN CONVICTED OF A FELONY WITHIN THE LAST SEVEN (7) YEARS?
(Conviction will not necessarily disqualify an applicant from employment) ☐ Yes ☐ No

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY ____________________
ADDRESS ____________________ TEL NO. ____________________

AFFIDAVIT

I certify that my answers to the foregoing questions are true and correct and that I have not left out any significant information of any kind whatsoever. I understand that if I am employed, any false, incomplete, misleading or otherwise, incorrect statements made on this application form, any other company document, or during any interviews, may be grounds for my immediate discharge, regardless of when discovered.

I hereby, undertand and acknowledge that unless otherwise defined by applicable law, any employment relationship with other organization is of an "at the nature", which means that I may resign at any time and that the company may discharge me any time, with or without cause, and with or without prior notice. Further, I understand that this "at will" employment relationship may not be changed by any written document, or by conduct, unless such change is specifically acknowledged in writing by the authorized division/subsidiary Administrator/Director of Nursing of this organization, and the writing condition of this affidavit.

I hereby authorize the Company to contact any entity or individuals it deems appropriate to investigate my employment history, character, and justifications, and give my full and complete consent to the companies and individuals revealing any and all information as a part of the investigation. In addition, I hereby waive my right to bring any cause of action against these companies or individuals for defamation, invasion of privacy, or any other reason because of their release of information. Applicant authorizes the use of a photocopy of this affidavit as authorization. I agree that If I am employed, I will abide by all the rules, regulations, and safety programs of the Company, as well as instructions I receive from my supervisor(s).

This application will be used by the Company to decide if you are to be hired, but its receipt does not imply that you will be employed. If I am employed, I further understand and agree that when my employment is terminated by retirement or otherwise, I must return all Beneficial Home Health Services, Inc., property in my custody, including beeper, forms, nursing bag, and disposable patient supplies. Otherwise, the cost of any property not returned will be withheld from the amount due upon separation until the property is returned.

THANK YOU FOR YOUR TIME, EFFORT AND INTEREST IN JOINING OUR COMPANY

SIGNATURE OF APPLICANT ____________________ DATE ____________________

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-__-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

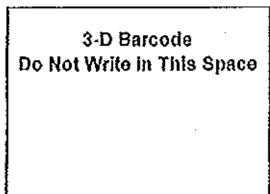
- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States *(See instructions)*
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ________________
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) __________ . Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: ________________

OR

2. Form I-94 Admission Number: ________________



If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ________________

Country of Issuance: ________________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. *If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).*

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . . **A** ____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ____

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** ____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ____

F Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ____

(**Note.** Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** ____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single** and have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- Separate here and give Form W-4 to your employer. Keep the top part for your records. ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	2 Your social security number

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ____

6 Additional amount, if any, you want withheld from each paycheck . . . . . . **6** $ ____

7 I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . . ▶ **7** ____

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Physical Examination and Health History

Name ________________________________ SSN ________________

Position ________________________________ Sex ________________

Date of Employment ____________________ DOB ________________

HEALTH HISTORY (TO BE COMPLETED BY EMPLOYEE)

Have you had or do you have any of the following conditions (check Yes or No)

	YES	NO		YES	NO
Back Pain			Hepatitis		
Chest Pain			Visual Problems		
Chronic Cough			High Blood Pressure		
Diabetes			Low Blood Pressure		
Epilepsy			Seizures		
Fainting or Dizziness			Shortness of Breath		
Hearing Disability			Tuberculosis		
Frequent Headaches			Varicose Veins		
Heart Trouble			Other:		

Physical Exam: (to be completed by Physician)

Height____________ Weight____________ BP___________ Pulse___________

PPD Test: Negative__________ Positive__________

Erythema ___________ mm. Induration___________ mm.

A positive PPD must be followed by a 35.56 cm x 43.18 cm (14" x 17") chest X-ray unless contraindicated by the Physician.

Chest X-ray results ____

Any treatment recommended for Positive Chest X-ray ________________________

Comments ____

I certify that the applicant is physically and medically qualified to perform the duties assigned and has no health condition that would create a hazard to patients.

MD Signature ________________________________ Date ________________

Applicant Signature ____________________________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-5054

AUTHORIZATION FOR BACKGROUND CHECK

I hereby authorize BENEFICIAL HOME HEALTH SERVICES, INC. to conduct a criminal background check, using the information provided below.

I acknowledge that in order to be employed at BENEFICIAL HOME HEALTH SERVICES, INC. this criminal background check must be conducted.

I understand that the information obtained during the criminal background check will be solely for the purpose of employment and will remain confidential.

I understand that if I am subject to a state criminal offense, I am deemed unsuitable for and may not be employed according to BENEFICIAL HOME HEALTH SERVICES, INC. policy.

However, before such determination is made, I will have the opportunity to review and challenge the factual accuracy of the criminal background result.

____ ____________________

Applicant Signature Date

First Name: ________________________________ MI: ________

Last Name: ________________________________

Date of Birth: ______________________________

City: ________________________ State: __________

County: _______________________ Zip Code: __________

- If residency at above address is less than one year, please list pervious address:

City: ________________________ State: ____________

County: _______________________ Zip Code: ___________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel. (714) 256-0756 Fax (714) 256-0754

To: ______________________________

____

____

Date: ______________________________

VERIFICATION AND REFERENCE CHECK

The undersigned, having applied for a position with Beneficial Home Health Services, Inc. does hereby authorize you to provide BHHS with the information requested herein, I specifically consent to disclose in accordance with the provisions of all applicable and state laws.

Name: ______________________________ SSN: ____________ Position: ____________

Dates: From__________To______________Signature______________________________

Is the above information correct? Yes ☐ No ☐

Eligible for Rehire Yes ☐ No ☐

	Above Average	Average	Below Average
Dependability			
Punctuality			
Quality of Work			
Job Knowledge			
Attitude			

Comment:____

____

Overall Performance: Excellent______ Good_______ Fair______ Poor_______

REASON FOR LEAVING (if applicable): ______________________________________

Printed Name:________________________Title:______________Date:______________

Signature:____

Beneficial Home Health Services, Inc.

Verification of State License & Confirmation

RN / LVN / CHHA / PT / ST / OT / MSW
(Please circle one)

Name: ______________________________

Position: ______________________________

License No.: ______________________________

Expiration Date: ______________________________

RN	(800) 838-6828	(WWW.RN.CA.GOV)
LVN	(916) 263-7800	(WWW.BVNPT.CA.GOV)
PT	(916) 263-2550	
OT	(916) 263-2550	
ST	(916) 263-2382	
MSW	(916) 445-4933	
CHHA	(916) 327-2445	

Findings (circle one) Active, Inactive, Suspended, No Record, Pending Case

Confirmation No.: ____________________ Date Verified: ______________

Verified by: ______________________________
Print Name & Sign

Beneficial Home Health Services, Inc.

Confidentiality Statement

I have been formally instructed in maintaining the confidentiality of the medical records and I understand that the medical information regarding the patient may not be discussed with anyone, either inside or outside the agency, (except as needed to conduct the business of the day). I understand that no medical records are to be removed from the home health agency, unless a "release for information" form has been completed and signed by the patient. It is my understanding that such discussion or release of information is cause for dismissal. I have been formally instructed in the policies and procedures of Beneficial Home Health Services, Inc. I have attended a formal orientation and have read and signed a job description for my specific classification.

____________________________________ ____________________

Employee's Signature Date

Beneficial Home Health Services, Inc.

Disclosure Authorization and Release

I, ____, hereby authorize ______________________________ (Company) and its employee representative to provide any pertinent information they deem appropriate, including any information regarding my employment, job performance, and related matters, to **BENEFICIAL HOME HEALTH SERVICES** and any of its employee representatives, and agents. This information may be provided either verbally or in writing. In addition to authorizing the disclosure and release of any information regarding my employment and/or acquaintance, I hereby fully waive any rights or claims I have or may have against any person or persons who provide the information to **BENEFICIAL HOME HEALTH SERVICES** and its agents, employees, and representatives, and release the above company and its agents, employees, and representatives from any and all liability, claims, and damages that may directly or indirectly result from the use, disclosure, or release of any information by any person or party, whether such information is favorable or unfavorable to me.

I acknowledge that I have read this authorization and release, fully understand it, and voluntarily agree to its provisions.

______________________________________ ______________________

Employee/Applicant Signature **Date**

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

PAY RATE AGREEMENT

Name:	Date of Hire:
Position:	Department:

Pay Rate:

- ☐ Rate per Visit
  - Evaluation = $ ________
  - Follow-up Visit = $ ________
  - Recertification = $ ________
  - Discharges = $ ________
- ☐ Rate Per Hour = $ ________
- ☐ Rate Per Month = $ ________

I agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedures regarding Clinical Documentation and Timely Submission of Clinical notes/documents as per Management of Information Policy and Clinical Documentation. I further agree to abide by BENEFICIAL HOME HEALTH SERVICES, INC. Policy and Procedure regarding Initial and Comprehensive Assessment and Update of the Comprehensive Assessment.

Signature:	Date:
Acknowledged/Approved By:	Date:

FOR PAYROLL DEPARTMENT USE ONLY

Posted By:	Date:

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

EMPLOYEE CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AGREEMENT is made and entered into by and between:

Employee: ____ ("Employee")

Home Health Agency: ____Beneficial Home Health Services, Inc.________ ("Agency")

Effective Date of these Terms and Conditions: ____________________________________

WHEREAS, the services of Agency performs for its patients are confidential; and

WHEREAS, by reason of employment with the Agency, Employee will have access to , will be provided with, and will, in some cases, prepare confidential and proprietary business information, such as patient services and diagnoses, employee information, financial data, and operations information, which must remain confidential for the protection of the Agency, its patients and its employees; and

WHEREAS, Employee acknowledges that he or she has received training by the Agency on all privacy policies and procedures applicable to the Employee's job function; and

WHEREAS, Employee understands that, by virtue of this Confidentiality Agreement ("Agreement"), it is hereafter a condition of employment with the Agency that all confidential information be maintained as confidential in compliance with the Agency's privacy policies and procedures as well as all applicable state and federal laws and regulations.

NOW, THEREFORE, in consideration of compensation paid in conjunction with the execution of this agreement; and intending to be legally bound hereby, the Agency and Employee agree as follows:

1. Contract Consideration. The following provision that is initialed and dated by both parties is hereby incorporated into this Agreement (initial and date only one provision, and only the initialed and dated provision is made part of theses Terms and Conditions):

   In consideration of employment, Employee agrees to the Terms and Conditions as provided herein.

_______________	_______________
Employee Initials/Date	Agency's Initials/Date

2. Confidentiality. Employee shall not, at any time during or following employment with the Agency, disclose or use, except as required in the course of employment, any confidential or proprietary information of the Agency whether such information is in memory or embodied in writing or other physical form. Confidential or proprietary information (i) is information that is not generally available to the general public, or competitors, or ascertainable through

common sense or general business knowledge; and (ii) includes, but is not limited to corporate information and patient information.

3. Property. All records, files, or other objects maintained by or under the control, custody, or possession of the Agency, including, without limitation, medical records, shall be and remain property of the Agency. Upon termination of employment, Employee shall return all such property received in connection with Employee's employment.

4. Breach. Disclosure or use of confidential or proprietary information, except as permitted under this Agreement, shall constitute a breach of this Agreement and a breach of a condition of employment with the Agency.

5. **REMEDIES. ANY BREACH OF THIS AGREEMENT MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING IMMEDIATE DISMISSAL. IN THE EVENT OF A BREACH OF THIS AGREEMENT, MONEY DAMAGES ALONE MAY NOT BE ADEQUATE TO COMPENSATE THE AGENCY FOR ITS LOSSES, AND, THEREFORE, EMPLOYEE AGREES THAT THE AGENCY SHALL BE ENTITLED TO INJUCTIVE RELIEF, IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW OR IN EQUITY.**

6. Further Information. If at any time during or after employment, Employee believes he or she needs further information regarding the Agency's confidentiality policies and procedures or how confidentiality relates to the Agency's business. Employee shall request information form a supervisor or other appropriate representative of the Agency.

7. Amendment. This Agreement may not be changed, modified, or terminated except in writing signed by both Employee and authorized Agency representative.

8. Law. This agreement shall be governed by and constructed in accordance with the laws of the State where the principal Agency office in which the Employee works is located.

IN WITNESS WHEROF, the parties have caused this Agreement to be executed by their duly authorized representatives on the date first above written.

EMPLOYEE

By: ______________________________
Name (Print): ______________________________
Title: ______________________________

BENEFICIAL HOME HEALTH SERVICES, INC.
By: ______________________________
Name (Print): ______________________________
Title: ______________________________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

DOCUMENTATION TIMELINE

Field staff of Beneficial Home Health Services, Inc. agree to abide by the documentation timelines of the company concerning all patient related paperwork. Please read and review this timeline, as it is imperative that we follow it in order to remain in compliance with our company Policies and Procedures and the Medicare Conditions of Participation.

Start of Care Evaluation (SOC) / Re-Certification Evaluation (Re-Cert) / Resumption of Care Evaluation (ROC) / Discharge Evaluation

____________ (initial) Verbal Report to be given immediately to the Case Manager, not to exceed 24 hours from the Evaluation date.

____________ (initial) All paperwork to be submitted to BHHS within 48 hours of the Evaluation.

Follow-up Notes and Additional Paperwork

____________ (initial) To be submitted weekly by 5 PM on the Monday after the visit occurred.

Chart Completion for End of Certification or Discharge

____________ (initial) All notes for the patient's chart must be submitted by the Monday after the patient's End of Certification of Discharge Date. The Discussed Discharge or Re-Certification with the Case Manager shall be considered the verbal request for all paperwork necessary to complete the chart or previous certification.

____________ (initial) 2 weeks after the patient's End of Certification or Discharge Date, BHHS will send a written request to the appropriate employee(s) if the patient's chart has not been satisfactorily completed.

____________ (initial) 3 weeks after the patient's End of Certification or Discharge Date, BBHS will send a 2nd written warning and request to the appropriate employee(s).

____________ (initial) 4 weeks after the patient's End of Certification or Discharge Date, if it has been decided that attempt to complete the necessary paperwork has not been sufficient, a 3rd letter will be sent to the appropriate employee(s), stating that lacking notes will no longer be accepted and will not be paid.

TIMELINESS OF DOCUMENTATION & SUBMISSION

RATIONALE

Home Health agencies are obligated to meet very strict guidelines as specified by California Title 22 and Medicare Conditions of Participation when it comes to documentation of services rendered to its home health recipients. Agencies found out of compliance may be subject to disciplinary actions by regulatory Agencies, including revocation of privileges to provide the Medicare Home Health Benefit. The burden of the responsibility to submit medical records in a timely manner must be shared by the staff/ contractor involved.

PURPOSE

To define the timeframe that documents are expected to be completed and be included in the clinical record.

To define the actions available to the Agency in the event of non-compliance to the State and Federal regulations as well as Agency policy.

POLICY

Clinical documentation from home visits by employees and/or contract staff will be ***completed the day of the visit*** and submitted to the home health office in a timely manner meeting the requirements as specified by Title 22 and Medicare Conditions of Participation.

PROCEDURE

1. **All clinical documentation must be completed *the same day* the visit is made.** _____
2. The Contractor shall personally prepare, complete and submit the initial evaluation to the agency within 72 hours from the time of initial visit.
3. The Contractor shall personally prepare, complete and submit all pertinent documents including clinical notes and progress notes to the agency within 7 days of visit from 9:00AM to 5:30PM.

   _____
4. OASIS documentation, Clinical notes and route sheets may be faxed to the Agency within that timeframe, with the original to be submitted to the Agency by the end of the following week.

   _____
5. The contractor understands that home health visits are not complete until 1) the visit is made and 2) a BILLABLE note is submitted. Therefore, no visit will be paid unless both criteria are met. The contractor understands it is his/ her responsibility to clarify deficient notes. _____
6. It is the responsibility of the visiting staff/ contractor to confirm receipt of the clinical documentation by the Agency. _____
7. It is the responsibility of the visiting staff/ contractor to maintain a copy of both the clinical records and the route sheet in the event that submitted records are "misplaced". _____

Printed Name ____________________ Signature ____________________ Date ______________

8. Failure to submit documentation 1 week from the day of the visit could result in a verbal warning. _____

9. Failure to submit documentation 2 weeks from the day of the visit could result in the visiting professional being relieved of his/ her duties and a written warning which will be placed in the employee's personnel record. _____

10. Failure to submit documentation 3 weeks from the day of the visit could result in a written grievance form being sent to the appropriate Board (See Complaint Process Attachments 5-023.B and 5.023.C) _____

11. Documentation submitted greater than 3 weeks from the date of the visit will be accepted for processing. However, payment will be reduced to a rate **equal to** an hour of the State minimum wage as set by California Labor Code (currently set at $8). _____

BY SIGNING BELOW, I AFFIRM THAT I HAVE THOROUGHLY READ THROUGH AND AGREE TO ABIDE BY THE AGENCY'S POLICY REGARDING TIMELINESS AND SUBMISSION OF DOCUMENTATION.

Printed Name _____________________ Signature _____________________ Date ____________

Beneficial Home Health Services, Inc.
770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714)256-0754

FIELD PERSONNEL STANDARDS AND PROCEDURES

Beneficial Home Health Services, Inc. requires adherence to the following standards and procedures:

1. All personnel are expected to dress in a manner appropriate to the health care environment, or as directed by the client/patient's family. This includes personal hygiene, jewelry, hair and make-up.
2. Smoking in the presence of the client/patient is prohibited.
3. Licensed personnel must always wear the company's badge, and carry their current professional license and CPR card while on assignment.
4. All personnel are expected to arrive on time to all accepted assignment. However, in the case of emergency or any other situation that should cause absence or at least a five minute delay on the assignment, Beneficial Home Health Services must be notified immediately.
5. If you have any problems, incident, or accidents on the job, do not discuss it with the client/patient, call Beneficial immediately.
6. If you are relieved by someone else, do not leave until your relief person has arrived.
7. Any deviation from the scheduled duration of assignment must be authorized by Beneficial Home Health Service, Inc.
8. Paraprofessional personnel (i.e. aides) hereby acknowledge that they WILL NOT UNDER ANY CIRCUMSTANCE, DISPENSE OR ADMINISTER ANY MEDICATION.
9. Under no circumstance is the client/patient's personal property to be asked, accepted or taken home.
10. Any involvement with the client/patient's financial affairs (i.e. check writing) is strongly prohibited.
11. All personnel are expected to honor the confidentiality of any client/patient information which is obtained in the regular course of employment.
12. No services of any kind, that require the "touching" of any person or running errands for others, will be performed on non-Beneficial Home Health Services patients.
13. All services must be provided by qualified assigned Beneficial staff.
14. No form of compensation will be accepted/made to or by Beneficial Home Health staff for services to be provided by Beneficial Home Health staff.

INITIAL HERE: ___________

Beneficial Home Health Services, Inc.

Hepatitis Vaccine Requirement

I ____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

__________ request that I receive the Hepatitis vaccine.

__________ refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

__________ provide written proof of immunity (attach)

__________ provide written proof of previous vaccination (attach)

__________ provide written proof of medical contraindication (attach)

Signature: ____________________________________ Date: ______________

Supervisor or witness: ____________________________ Date: ______________

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TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: ____

Do you currently have any of the following symptoms?	YES	NO
1. Any exposure to TB?	____	____
2. Unusual fatigue	____	____
3. Weight loss (unexplained)	____	____
4. Anorexia (loss of appetite)	____	____
5. Persistent cough (more than 3 weeks duration)	____	____
6. Hemoptysis (blood streaked sputum)	____	____
7. Fever associated with cough of more than 1 week	____	____
8. Night sweats	____	____

Signature: ______________________________ Date: ______________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217, Brea, CA 92821 Tel: (714)256-0756 Fax: (714)256-0754

Reporting of Child, Elder, Dependent Adult Abuse and Domestic Violence

California law requires the reporting of incidents of child, elder, dependent adult abuse and/or domestic violence that comes to your attention in your professional capacity. Please read the statements below and sign in the space provided to acknowledge that you will comply with the reporting requirements. If you have any questions, or need assistance with this requirement, please notify your Supervisor.

Chapter 1396, Status of 1987 mandates the reporting of any suspected Dependent Adult/Elder physical abuse. Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse either to the long-term coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report (SOC 341) thereof within two (2) working days.

Any person knowingly failing to report, when required, an instance of elder or dependent adult abuse is guilty of a misdemeanor punishable by imprisonment in the county jail for a maximum of six (6) months or fine $100 or both imprisonment and fine.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non medical practitioner, or employee of a child in his or her professional capacity or within the scope of his or her employment who he or she know or reasonably suspects on an instance of child abuse, to report to the child protective agency immediately or as soon as practically possible by telephone and/or prepare and send a written report thereof within 36 hours of reviewing the information concerning the incident.

Section 11160 of the Penal Code requires health care workers to report known or suspected cases of a wound or injury resulting from domestic violence or spousal abuse. Such cases must be reported immediately by telephone (or as soon as practically possible) to the local law enforcement agency, followed by a written report to the local law enforcement agency within two (2) working days.

____________________________ Signature

____________________ Date

Beneficial Home Health Services, Inc.

770 S. Brea Blvd., Suite 217 Brea, CA 92821 Tel. (714) 256-0756 Fax (714) 256-0754

VACCINATION DECLINATION FORM

***Please print clearly ***

Employee Name:

____

Last **First** **MI**

Discipline:__________________**SS#**_______- _______- _______

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me. However, I decline this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature/Title: ______________________________

Date:________________

Agency Representative Signature/Title:______________________

Date:________________

Beneficial Home Health Services, Inc.

770 S. Brea Blvd. Suite 217, Brea CA 92821 Tel: (714) 256-0756 Fax: (714) 256-0754

COMPETENCY EVALUATION

LVN / RN

INTERMITTENT

Date: ______________

Name: ________________________ Skills verified by: ______________________

	Skill Demonstrated	Date Observed	Comments
Blood Glucose Monitoring			
☐ Ability to do control test	☐ Yes ☐ No		
☐ Ability to use blood glucose monitoring equip.	☐ Yes ☐ No		
Wound Care			
☐ Wet to dry dsg.	☐ Yes ☐ No		
☐ Sterile dsg. change	☐ Yes ☐ No		
Foley Catheter Care	☐ Yes ☐ No		
Infection Control			
☐ Hand washing	☐ Yes ☐ No		
☐ Disposal of infectious materials in the home	☐ Yes ☐ No		
Physical Assessment			
☐ Lung sounds	☐ Yes ☐ No		
☐ Cardiac Assessment	☐ Yes ☐ No		

Comments:

____

____

____

____

______________________ ______________________

Signature of Evaluator Date

Beneficial Home Health Services, Inc.
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ADA REQUIREMENTS

Position: ____

The information below is intended to describe the general context/requirements for performance of this job. During the workday, this position requires the activities listed. *It is not to be considered an exhaustive statement of duties responsibilities, or requirements and does not limit the assignment of additional duties.* The frequency of each activity is identified by the following columns:

Physical activities required in this position	**Rarely Less than .5 hr/day**	**Occasionally .5 to .25 hr/day**	**Frequently 2.5-5.5 hr/day**	**Continually 5.5-8.0 hrs/day**	**NA**
Sitting					
Stationary standing					
Walking on a variety of surfaces (inside/outside)					
Ability to be mobile					
Crouching (bending at knees)					
Kneeling/Crawling					
Stooping (bending at waist)					
Twisting (knees/waist/neck)					
Turning/Pivoting					
Climbing					
Balancing					
Reaching Overhead					
Reaching Extension					
Grasping					
Pinching					
Position requires individual to:					
• **Push/Pull**					
- Less than 20 pounds					
- Typical Weight: 20 to 50 pounds					
- Maximum Weight: 75-100 pounds					
• **Lift/Carry**					
- Less than 20 pounds					
- Typical Weight 20-50 lbs					

Physical activities required in this position	Rarely Less than .5 hr/day	Occasionally .5 to .25 hr/day	Frequently 2.5-5.5 hr/day	Continually 5.5-8.0 hrs/day	NA
- Maximum Weight 75-100 pounds					
Other (specify):					
Sensory Activities					
Talking in person					
Talking on the telephone					
Hearing in person					
Hearing on telephone					
Vision for close work					
Other (specify):					
Environmental Considerations					
Driving a car in all weather conditions					
Providing services in variety of environment					
Potential for exposure to infections disease					
Ability to manage clinical equipment/machines					

I have read and understand the job description of ______________________________
as described on these pages.

Signed: ____________________________________ Date: _____ / _____ / _____

Job Title/Position: *Registered Nurse*

Reports To: *Clinical Supervisor*

JOB DESCRIPTION SUMMARY

The registered nurse plans, organizes and directs Home Health care and is experienced in nursing, with emphasis on community health education/experience. The professional nurse builds from the resources of the community to plan and direct services to meet the needs of individual and families within their homes and communities.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Patient Care

1. Completes an initial assessment of patient and family to determine Home Health needs. Provides a complete physical assessment and history of current and previous illness(es).
2. Provides professional nursing care by utilizing all elements of nursing process.
3. Assesses and evaluates patient's status by:
   A. Writing and initiating plan of care
   B. Regularly re-evaluating patient and family/caregiver needs
   C. Revising the plan of care as necessary
4. Initiates the plan of care and makes necessary revisions as patient status and needs change.
5. Uses health assessment data to determine nursing diagnosis.
6. Develops a care plan that establishes goals, based on nursing diagnosis and incorporates palliative nursing actions. Includes the patient and the family in the planning process.
7. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician in the physician's plan of care.
8. Counsels the patient and family in meeting nursing and related needs.
9. Provides health care instructions to the patient as appropriate per assessment and plan.
10. Assists the patient with the activities of daily living and facilitates the patient's efforts toward self-sufficiency and optional comfort care.
11. Acts as Case Manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload.

Job Title/Position: *Registered Nurse*

Communication

1. Completes, maintains and submits accurate and relevant clinical notes regarding patient's condition and care given. Records pain/symptom management changes/outcomes as appropriate.

2. Communicates with the physician regarding the patient's needs and reports changes in the patient's condition; obtains/receives physicians' orders as required.

3. Communicates with community health related persons to coordinate the care plan.

4. Teaches the patient and family/caregiver self-care techniques as appropriate. Provides medication, diet and other instructions as ordered by the physician and recognizes and utilizes opportunities for health counseling with patients and families/caregivers. Works in concert with the other Home Health interdisciplinary group members.

5. Provides and maintains a safe environment for the patient.

6. Assists the patient and family/caregiver and other team members in providing continuity of care.

7. Works in cooperation with the family/caregiver and Home Health Interdisciplinary Team Members to meet the emotional needs of the patient and family/caregiver.

8. Attends interdisciplinary group meetings.

Additional Duties

1. Participates in on-call duties as defined by the on-call policy.

2. Ensures that arrangements for equipment and other necessary items and services are available.

3. Supervises ancillary personnel and delegates responsibilities when required.

4. Assumes responsibility for personal growth and development and maintains and upgrades professional knowledge and practice skills through attendance and participation in continuing education and inservice classes.

5. Fulfills the obligation of requested and/or accepted case assignments.

6. Actively participates in quality management program.

Job Title/Position: *Registered Nurse*

POSITION QUALIFICATIONS

1. Registered nurse with current licensure to practice professional nursing in the state.
2. Graduate of National League for Nursing accredited school of nursing.
3. Maintains a current CPR certification.
4. Current valid driver's license.
5. Minimum of two years experience, at lease one of which is in the area of public health, home care, or Home Health nursing is preferred.
6. Self directed and able to work with minimal supervision.
7. Management experience not required. Responsible for supervising Home Health aides.
8. Demonstrates excellent observation, problem solving, verbal and written communications; nursing skills per competency checklist.
9. Shows ability to organize and priotize workload independently.
10. Prolonged or considerable walking or standing. Able to lift, position, and/or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling, and/or crouching. Visual acuity and hearing to perform required nursing skills.

PERFORMANCE EVALUATION

Job Title/Position: *Registered Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 1**

Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance

A. Patient Care Responsibilities

	Rating
Patient Care	
1. Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es).	1 2 3 4
2. Regularly re-evaluates patient nursing needs.	1 2 3 4
3. Initiates the plan of care and makes necessary revisions as patient status and needs change.	1 2 3 4
4. Uses health assessment data to determine nursing diagnosis.	1 2 3 4
5. Develops a care plan that establishes goals, based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions. Includes the patient and the family in the planning process.	1 2 3 4
6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician.	1 2 3 4
7. Counsels the patient and family in meeting nursing and related needs.	1 2 3 4
8. Provides health care instructions to the patient as appropriate per assessment and plan.	1 2 3 4
9. Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient.	1 2 3 4
Communication	
1. Prepares clinical notes and updates the primary physician when necessary and at least every other week.	1 2 3 4
2. Communicates with the physician regarding the patient's needs and reports and changes in the patient's condition; obtains/receives physician's orders as required.	1 2 3 4
3. Communicates with community health related persons to coordinate the care plan.	1 2 3 4
Additional Duties	
1. Participates in on-call duties as defined by the on-call policy.	1 2 3 4
2. Ensures that arrangements for equipment and other necessary items and services are available.	1 2 3 4
3. Instructs, supervises and evaluates Home Health aide care provided every fourteen days.	1 2 3 4
	1 2 3 4
	1 2 3 4

Targeted Goals For Next Review Cycle: ____________________

____

Comments: ____________________

____

Reviewer: ____________________ Date: __________

Name of Personnel: ____________________ Date: __________

INITIAL COMPETENCY ASSESSMENT SKILLS CHECKLIST—REGISTERED NURSE

Name: ______________________________

Date of Employment: ____________________ Date Completed: ________________

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				A. Demonstrates ability to process paperwork and associated functions necessary to facilitate:	*		
				1. Admission to organization			
				a. Initiates assessment form	*		
				b. Initiates care plan based on assessment	*		
				c. Knowledge of nursing process	*		
				d. Health history/physical exam	*		
				e. Development of problem list and care planning	*		
				f. Conducts complete initial evaluation	*		
				2. Knowledge of the Medicare Home Health Benefit	*		
				a. Patient rights	*		
				b. Services available	*		
				c. Participation requirements	*		
				d. Other	*		
				3. Concepts of death and dying	*		
				a. Normal vs. abnormal	*		
				b. Cultural attitudes toward death	*		
				c. Values of patient/family	*		
				d. Denial and coping mechanisms			
				e. Grief and family, children and others	*		
				f. Anticipatory grief	*		

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				g. Other			
				4. Home Health concept and philosophy of care	*		
				a. Treating the family and the patient as the unit of care	*		
				b. Palliative care	*		
				c. Participation in the interdisciplinary group	*		
				d. Demonstrating continuity of care at inpatient settings; alternate settings	*		
				e. Philosophy of comfort, dignity, autonomy, quality of life, and empowerment	*		
				f. Other			
				5. Documentation			
				a. Medicare guidelines for documentation	*		
				b. Corrections to the medical record	*		
				c. Accident/incident reports	*		
				d. Clinical notes, flow charts	*		
				6. Other			
				a. Supervision of ancillary staff			
				b. Supply requisition and management			
				B. Review of Systems: Demonstrates ability to obtain and document appropriate age specific history/ assessment for patients in the following categories:			
				1. Symptom assessment/management			
				a. Nausea/vomiting			
				b. Anorexia			
				c. Fluid/electrolyte imbalance			
				d. Weight loss/nutritional deficiency			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				e. Diarrhea			
				f. Constipation			
				g. Mucous membrane lesions			
				h. Skin breakdown/lesions			
				i. Weakness/fatigue			
				j. Fever			
				k. Dysphagia			
				l. Edema			
				m. Hypotension			
				n. Dyspnea			
				o. Cognitive impairment			
				p. Depression			
				q. Urinary incompetence/retention			
				r. Other			
				2. Pulmonary System			
				a. Pulmonary Assessment			
				b. Tracheostomy care			
				c. Oxygen administration			
				d. Pharyngeal suction			
				e. Use of oral/nasal inhalers			
				f. Oxymeter			
				g. CPAP			
				h. Oxygen mask, nasal cannula, concentrator, portable oxygen			
				i. Airway insertion			
				j. SVN/Nebulizer treatment			
				k. Home ventilator management			
				l. Foreign body airway obstruction			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				m. Breathing exercises/incentive spirometry			
				n. Other			
				3. Cardiovascular System			
				a. Cardiovascular assessment			
				b. Pulses (apical, radical, femoral, pedal)			
				c. Edema assessment and management			
				d. Supine and orthostatic blood pressure			
				e. NTG use, inhaler use			
				f. CPR			
				g. Energy conservation techniques			
				h. Other			
				4. Neurologic System			
				a. Neurologic assessment			
				b. Aphasia care			
				c. Mental status exam			
				d. Seizure precautions			
				e. Spinal cord injuries care			
				f. Head injury care			
				g. Other			
				5. Gastrointestinal System			
				a. Gastrointestinal assessment			
				b. Nutritional assessment			
				c. NG tube insertion/care			
				d. Jejunostomy tube care			
				e. Gastrostomy tube care			
				f. Enteral feedings			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				g. Suction machine(s)			
				h. Ostomy care			
				i. Dysphagia precautions			
				j. Impaction removal			
				k. Enema			
				l. Bowel training			
				m. Other			
				6. Genitourinary System			
				a. GU assessment			
				b. Urinary catheterization insertion and care (male and female)			
				c. Irrigation of catheters			
				d. Obtaining specimens			
				e. Removal of urinary catheter			
				f. Care of supra-pubic catheter			
				g. Care of urostomy			
				h. Bladder training			
				i. Nephrostomy tubes			
				j. Knowledge of types of catheters and indications for use (straight, indwelling, condom)			
				k. Ileostomy care			
				l. Incontinence care			
				m. GU post op care			
				n. Other			
				7. Integumentary/Wounds/Dressings			
				a. Assessment of skin/wound			
				b. Measurement of wounds			
				c. Wound irrigation			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				d. Wet to dry dressing(s)			
				e. Decubitis care:			
				1. Assessment and staging			
				2. Prevention			
				3. Various treatments (hydrocollid, calcium alginate, transparent films)			
				4. Documentation/pictures			
				f. Ace wrap, cast care, compresses			
				g. Hemovac			
				h. Sterile dressing change			
				i. Suture/staple removal			
				8. Musculoskeletal System			
				a. Assessment			
				b. Range of motion (ROM)			
				c. TED hose			
				d. Total knee care			
				e. Total hip care			
				f. Cast assessment and care			
				g. Devices:			
				1. Walker			
				2. Wheelchair			
				3. Transfer board			
				4. Hoyer lift			
				h. Pain assessment			
				i. Transfers			
				j. Other			
				9. Pain assessment and management			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				a. Conducts pain evaluation which includes location, onset, intensity, duration, alleviating factors		*	
				b. Utilizes a pain rating scale to collect data		*	
				c. Knowledgeable about types of pain (neuropathic, viseral, bone, smooth muscle, psychologic)		*	
				d. Knowledgeable about drug therapies indication and dosing		*	
				1. NSAIDS		*	
				2. Steroids		*	
				3. Benzodiazipines		*	
				4. Tricylic antidepressants		*	
				5. Anticonvulsants		*	
				6. Narcotics		*	
				7. Other			
				e. Non-pharmacologic methods:			
				1. Relaxation (guided imagery, meditation, massage)		*	
				2. Psychologic (biofeedback, therapy)		*	
				3. Neurologic (TENS)		*	
				4. Ice/heat		*	
				f. Patient/family teaching			
				1. Drug use, side effects		*	
				2. Management of constipation		*	
				3. Addiction vs. tolerance		*	
				4. Other			
				10. Metabolic			
				a. Assessment			
				b. Diabetic assessment and teaching			

Self Assessment				Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
Do you have experience with this skill?		Are you competent performing the following:					
YES	NO	YES	NO				
				1. Insulin types and teaching			
				2. Use, care and teaching of glucose monitoring system			
				3. Diet, exercise and sick day teaching			
				4. Signs and symptoms of Hypo-Hyperglycemic reactions			
				5. Foot and skin care			
				c. Coumadin therapy			
				d. Other			
				11. Behavioral Assessments			
				a. Psychosocial Status			
				b. Suicide precautions			
				c. Psychotropic drugs			
				d. Care of the demented patient			
				e. Spiritual			
				f. Grief			
				g. Other			
				12. Miscellaneous Skills			
				a. Vital signs			
				b. Intake and output			
				c. Caring for immunocompromised patients			
				d. Eye/ear irrigation			
				e. Post mortem care			
				f. Collection, labeling and delivering laboratory specimens (blood, urine, sputum, wound, stool)			
				C. Medication Administration: Demonstrates ability to administer, monitor and document medications for patients.			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				1. Medication Administration Techniques			
				a. Oral			
				b. Intra muscular			
				c. Intravenous-bolus/push			
				d. Subcutaneous			
				e. Total Parenteral Nutrition			
				f. Suppositories			
				g. Ear, eye, nose drops			
				h. Heparin administration			
				i. Insulin administration, site rotation			
				j. Assessment for side effects, adverse reactions, therapeutic response			
				2. Intravenous Therapy			
				a. Technique and care of:			
				1. Venipuncture			
				2. Butterfly			
				3. Over the needle catheter			
				4. Regulation of IV flow rate, use of infusion pumps			
				b. Other			
				3. Central Venous Access Devices			
				a. Drawing blood from			
				b. Site care			
				c. Flushing			
				d. Cap change			
				e. Needleless system			
				f. Other			
				D. **Infection Control**			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				1. Handwashing technique	*		
				2. Aseptic technique	*		
				3. Proper bag technique	*		
				4. Safe needle technique	*		
				5. Personal protective equipment	*		
				6. Exposure control plan	*		
				7. TB exposure control plan	*		
				8. Reporting of infections for patient and staff	*		
				9. Standard precautions	*		
				E. Equipment			
				1. Displays knowledge of the following:			
				a. Electric bed			
				b. Special beds			
				c. Alternating pressure mattress			
				d. Infusion pumps			
				e. Ambulatory infusion devices			
				2. Home Glucose Monitoring:			
				a. Verbalizes purpose of test	*		
				b. Specimen collection	*		
				c. Instrument calibration	*		
				d. Quality control process	*		
				e. Test correctly performed and interpreted	*		
				3. Other			
				F. Safety			
				1. Restraints, indications and policy			
				2. Fire extinguishers			
				3. Emergency preparedness			

Self Assessment: Do you have experience with this skill? YES	NO	Are you competent performing the following: YES	NO	Competency for the Registered Nurse	Proficiency Required	Evaluation Method	Competency Validation Indicated by Preceptors Initials and Date
				4. Hazardous materials			
				5. Assessment of patient safety risks and home safety			
				G. Patient Education			
				1. Determine patient and family learning needs	*		
				2. Sets measurable objectives	*		
				3. Develops/implements teaching plan	*		
				4. Evaluates effectiveness of teaching	*		
				5. Revises teaching plan based on patient needs	*		
				6. Documents response to teaching	*		
				7. Provides instruction in the following:			
				a. Emergency care	*		
				b. Diet and nutrition	*		
				c. Medications	*		
				1. Route, dosage, frequency, side effects, adverse reactions, safe storage, labeling, indications, drug/food interactions, home monitoring program, therapeutic blood levels	*		
				8. Provides instruction about advance directives and patient rights			
				9. Disease process			
				10. Death and dying			
				11. Grief process			
				12. Other			

Comments:

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Employee Signature ____________________ Date ____________

Supervisor Signature ____________________ Date ____________

Preceptor(s) ____________________ Date ____________

Preceptor(s) ____________________ Date ____________

Preceptor(s) ____________________ Date ____________