INITIAL COMPETENCY CHECKLIST
RN/LPN/LVN

NAME _____ RN _____ LPN _____

Date and signature indicate that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

Initial Competency Checklist RN/LPN/LVN (continued)

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resuscitate masks				

DATE OF INITIAL COMPLETION: _____

_____ _____

Employee Signature/Title *Observer Signature/Title*