Helping Hand
HEALTHCARE SERVICES

Aide Skills Inventory

HOME HEALTH CARE

Date: _____ Caregiver Name _____ RN _____ LPN _____

Please mark an X in the appropriate box next to each entry based on your experiences in patient care.

Skill	Experienced	Needs Review	Not Capable	Skill	Experienced	Needs Review	Not Capable
Specialty Care				**PERSONAL CARE**			
Infant 0-2 yr				Tub Bath / Shower			
Pediatric 2-13 yr				Bed Bath / Sponge Bath			
Adolescent 13-18 yr				Hair Care			
Adult				Oral/Mouth Care			
Geriatic				Denture Care			
Alzheimer's / Dementia				Hearing Aids			
Parkinson's Disease				Skin Care / Grooming			
Hospice Care				Shaving			
Spinal Cord Injury				Nail Care			
Brain / Head Injury				Foot Care			
Stroke				Pressure Sore Precautions			
Amputee				**NUTRITION**			
Diabetes				Prepare / Serve Meals			
Cardiac / Heart				Fluid Restrictions			
Pulmonary / Respiratory				Assist with Feeding			
HOMEMAKING				Intake / Output Readings			
Laundry/Washer/Dryer				PEG Site Care			
Dishes/Dishwasher				Swallow Precautions			
Linens/Making Beds				**UNIVERSAL PRECAUTIONS**			
Vacuum/Mop				Use of Protective Equipment			
Garbage Disposal				Masks			
Blender				Gloves			
TRANSFERRING				Gowns/Aprons			
Wheelchair				CPR Shields			
Pivot				**VITAL SIGNS**			
Repositioning				Temperature			
Hoyer				Pulse			
Slide Board				Respirations			
DRESSING				Blood Pressure			
Upper Body				**TOILETING**			
Lower Body				Toilet Transfers			
Sock Aids				Use of Bedside Commode			
Shoe Hom				Use of Bedpan / Urinal			
Immobilizers				Foley Cath Care			
TED Hose / Elastic Sockings				Empty Ostomy			
Orthopedic Devices				Use of Diapers / Depends			
Prosthesis				**AMBULATION**			
OTHER				Use of Gait Belt			
Medication Reminders				Range of Motion			
Weight / Scale				Weight -beating Restrictions			
Language Spoken				Ambulation with Devices			
Language Read / Write				(Come, Walker, Cutches)			