



DOCUMENTATION OF COMPETENCY FOR CERTIFIED NURSING ASSISTANTS & HOMEMAKERS

Wyoming Department of Health, Aging Division, Community Living Section
IHS-100

| | | | |
|-----------|------------|---|----------|
| (1) NAME: | (2) TITLE: | (3) EVALUATION 1 st 2 nd | (4) DATE |
|-----------|------------|---|----------|

QUALIFIED IHS SERVICE PROVIDER

The Documentation of Competency must be completed or updated a minimum of every **180 days**.

| | (5) SKILLS | (6) COMPETENT | | (7) How Determined Skill | | |
|-----------------------------|--|------------------|----|-----------------------------|--------|---------|
| | | YES | NO | Observed | Verbal | Written |
| Certified Nursing Assistant | Proper hand washing methods | | | | | |
| | Bathing techniques | | | | | |
| | Hair care techniques | | | | | |
| | Oral Hygiene techniques | | | | | |
| | Dress/undress client | | | | | |
| | Toileting | | | | | |
| | Caring for incontinence | | | | | |
| | Feed or assist with eating | | | | | |
| | Care of fingernails | | | | | |
| | Skin care | | | | | |
| | Other: Please list below | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| ENDORSEMENTS | | | | | | |
| | Blood pressures | | | | | |
| | Temp, Pulse, Respirations | | | | | |
| | Pulse oximetry | | | | | |
| | Other: Please list below | | | | | |
| | Blood glucose monitor | | | | | |
| | | | | | | |
| | | | | | | |
| Homemaker/Chore | Routine housekeeping | | | | | |
| | Basic meal preparation | | | | | |
| | Bed making | | | | | |
| | Laundry techniques | | | | | |
| | Maintain a safe and sanitary environment | | | | | |
| | Other: Please list below | | | | | |
| | | | | | | |

I certify that the above named individual is competent in the identified skills, including those for endorsement(s), if checked YES. Further, I certify that I have met the professional degree or certification required.

| | | |
|-----------------|-------------|--------|
| Signature: | Credential: | Date: |
| Position/Title: | Agency: | Phone: |

FOR PERSON VERIFYING COMPETENCY: SEE INSTRUCTIONS ON BACK

INSTRUCTIONS

INSTRUCTIONS FOR PERSON CERTIFYING INDIVIDUAL REQUESTING QUALIFIED SERVICE PROVIDER STATUS:

The person signing the Documentation of Competency (IHS-100) must be one of the following professionals for the certified nursing assistant section: physician, physician's assistant, nurse practitioner, registered nurse, or licensed practical nurse.

The person signing the Documentation of Competency (IHS-100) must be one of the following professionals or paraprofessionals for the homemaker/chore section: nurse practitioner, registered nurse, licensed practical nurse, or a state certified access care coordinator.

A new Documentation of Competency form (IHS-100) **must** be filled out every 180 days.

- Column (1): Name of the Certified Nursing Assistant or Homemaker
- Column (2): Title: CNA or Homemaker
- Column (3): Circle whether this is the first half or second half of the annual evaluation period
- Column (4): Indicate the date of evaluation
- Column (5) **SKILLS** – Listed is a brief explanation of each task
- Column (6) **COMPETENT** – Place an X in the YES box if the individual is found competent in this skill or mark NO if the individual did not meet the requirement for competency
- Column (7) **HOW DETERMINED SKILLS** – Place an X in the column that identifies the means by which the competency was verified:
OBSERVED – Observed the procedure
VERBAL – A **detailed** verbal explanation of the procedure was provided
WRITTEN – A **detailed** written explanation of the procedure was reviewed

This form needs to be completed every 180 days.
Place form in Employee File.