



Nursing Learning Needs Assessment

Name _____ Date _____

Title _____

1) Do you have recent homecare experience? If so, please explain:

2) Considering your experience in the past one (1) year, rate the following skills/tasks according to the following scale at time of interview.

Scale:

- 1) Unable
- 2) Requires additional review/clinical experience
- 3) Competent

SKILL/TASK

RATING

COMMENTS

Unable
 Needs Review
 Competent

Wound Care

Assessing/Measuring	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Clean Technique	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Sterile Technique	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Calcium Alginate Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Chemical Debrider Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Collagen Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Hydrogel Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Foam Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Hydrocolloidal Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Transparent Film Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Irrigation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Wet-to-Dry Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

SKILL/TASK**RATING****COMMENTS**

Unable	Needs Review	Competent
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Suture Removal

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Staple Removal

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Unna boot Application

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Stump Care

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Pressure Relief Measure

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Wound Vac

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Patient Teaching

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Injection Technique

SC

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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IM

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Lovenox

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Intradermal (PPD)

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Mobility

ROM

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Slide Board Transfer

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Hoyer Lift

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Stand Pivot Transfer

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Cast Care

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Hip Precautions

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Halo Vest Care

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Ortho-teaching & ability

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Genitourinary CareIndwelling Foley Insertion-*male/female*

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Intermittent Straight Catherization

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Bladder Training

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Suprapubic Catheterization

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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Nephrostomy/Cystostomy Care

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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SKILL/TASK**RATING****COMMENTS**

Unable	Needs Review	Competent
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Genitourinary Care (con't)

Bladder Instillation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Foley Catheter Irrigation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Peritoneal Dialysis/Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Ileo Conduit Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Patient Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

Gastrointestinal Care

Bowel Training	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Fecal Disimpaction	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Fleets Enema	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
SS Enema	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Enemaeaze	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Colostomy Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Ileostomy Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
G-tube Change/Insertion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Enteral Feeding - Gravity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Enteral Feeding - Pump	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Biliary Tube Care/Flush/Dressing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Patient Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

Respiratory Care

Oral Pharyngeal Suctioning	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Tracheal Suctioning	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Tracheostomy Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Changing Tracheostomy Tube	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Nebulizer Treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

<u>SKILL/TASK</u>	<u>RATING</u>			<u>COMMENTS</u>
	Unable	Needs Review	Competent	
<u>Respiratory Care (con't)</u>				
Postural Drainage & Percussion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Ventilator Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Lung Auscultation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Chest Tube Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Pluerax Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Patient Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
<u>Cardiac Care</u>				
Pacemaker Care/Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Coronary Stent Care/Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
CHF Care/Teaching	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
CPR / ALS ? BLS / Instructor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Patient Teaching (MI, CABG, etc.)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
<u>Venipuncture</u>				
Peripheral Venipuncture	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Heel Sk (Newborn Only)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
<u>IV Therapy</u>				
Flushing Central Venous Line	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Blood Draw - Central Venous Line	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Central Venous Line Dress Change	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
TPN Care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
Peripheral Angio Insertion	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
CADD/Curlin	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
IV Push	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

SKILL/TASK

RATING

COMMENTS

Unable
Needs Review
Competent

IV Therapy (con't)

IV MB Infusion by Gravity	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Implantable Port Access/Care	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Chemotherapy Care	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____

Other Teaching

Nutrition	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Diabetic	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Medication	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____

Other Tasks

Hospice Care	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Palliative Care	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Supportive Counseling	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____

Computer/Office Skills

Personal Computer	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Laptop Computer	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Windows Operating Systems	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
MAC Operating Systems	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
SmartPhone / PDA	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Texting	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
Outlook/ Other E-mail	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____
GPS Systems	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	_____

SKILL/TASK

RATING

COMMENTS

Unable
Needs Review
Competent

Other Skills

Please list and rate additional skills:

_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____
_____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	_____

Certifications

☐ Hospice or ☐ Palliative Care

☐ Oasis

☐ IV

☐ VP

☐ WOCN – Wound Vac Certificate

Prospective Employee Signature _____ Date _____

Reviewed by VNS _____ Date _____