BlueCare Tennessee is an Independent Licensee of the BlueCross BlueShield Association.

Member: ______________________________ DOB: _________ Date: _________

MCO Name	Phone Number	Fax Number
BlueCare Tennessee	1-888-423-0131	(423) 535-5254
UnitedHealthcare	1-800-690-1606	1-855-544-0251
Amerigroup	1-800-454-3730	1-877-297-5003/1-866-920-6003

Initial Member/Caregiver Training Checklist

Include this completed and signed form within 60 days after an **initial** admission. Submit this completed form as additional clinical information if the completion of this form occurs prior to the recertification date. If the family requires additional time for training, please notify the appropriate MCO. When sending in a request for continuation or additional PDN and/or home health services, complete the Recertification Member/Caregiver Training Checklist Form. Complete the recertification training checklist form at each recertification, with any new training of the primary caregiver or new/additional backup caregivers, and annually once all training has been successfully completed.

The training checklist below is used to document the training provided by agency staff to the member/member's primary caregiver and the primary caregiver's designated backup plan caregivers. If there is not a backup plan for the caregiver, notify the appropriate MCO to discuss.

The purpose of this training is to provide support to the primary caregiver and backup caregivers to foster independence and confidence in caring for the member and/or support member self-care.

The initial and recertification training checklists can be used to monitor progress toward identified short-term and long-term goals and to identify any barriers that require intervention.

Checklist for Initial Caregiver Evaluation and Training

Agency staff is to date and initial the applicable care task(s) and mark an X in the appropriate column indicating the following codes to monitor progress toward successful demonstration by the member/caregiver:

- Member/Caregiver observes caregiving task(s): O
- Member/Caregiver discusses and explains caregiving task(s): E
- Member/Caregiver successfully provides (demonstrates) caregiving task(s): D
- If a skill is not applicable, indicate by N/A

VITAL SIGNS

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Temperature							
Axillary							
Oral							
Rectal							
Tympanic							
Pulse rate							
Radial							
Pedal							
Blood pressure							
Manual							
Electronic device							
Respiration rate							
Pulse oximetry							

Member: ______________________ DOB: __________ Date: __________

Hygiene

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Bed bath							
Complete							
Partial							
Assisted							
Tub with assist							
Shower with assist							
Perineal care							
Male							
Female							
Catheter care/ cleaning							
Indwelling							
Condom							

Oral Hygiene

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Oral Care							
Routine oral care							
Dentures							

BED MAKING

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Occupied							

TRANSFERS

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Stand/Pivot							
Bed to floor using assistive device							
Bed to chair							
Chair to bed							
Lift							
Hoyer							
Ceiling							
Other							
Slide/Transfer Board							
Bed to chair							
Chair to bed							
Chair to toilet/tub							

Member: ______________________ DOB: __________ Date: __________

ELIMINATION

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Bedpan							
Urinal							
Rectal tube							
Adult brief/diaper							
Bedside commode							
Bowel							
Cleansing enema							
Fleets enema							
Fecal incontinence pouch							
Ostomy Appliance							
Stoma site care							
Emptying							
Applying/changing							
Irrigating a colostomy							
Urinary							
Straight catheter (intermittent)							
Male							
Female							
Indwelling catheter							
Male							
Female							
Removal of catheter							
Ileal conduit							
Site care							
Emptying							
Applying/changing							
Suprapubic catheter care							

AMBULATION

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Gait belt							
Cane							
Walker							
Crutches							
Stander							
Wheelchair							
Stand by assist							

Member: ______________________ DOB: __________ Date: __________

ROM Exercises

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Passive							
Active							

POSITIONING

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Lateral							
Prone							
Supine							
Fowlers							
Dorsal recumbent							
Logrolling							

SAFETY MEASURES

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Risk factors							
Causes of falls							
Fall prevention measures *(Example: grab bars, lighting, stair railings, removing clutter)*							

INFECTION CONTROL

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Hand washing							
Gloves							
Biohazard waste							
Sharps safety							

Member: ______________________ DOB: __________ Date: __________

WOUND CARE

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Cleaning							
Dry sterile dressing							
Irrigating							
Wet to dry							
Hydrocolloid							
Montgomery straps							
Abdominal binder							
Negative pressure							
Other (describe)							
Drains							
Penrose							
Jackson Pratt							
Hemovac							
T-tube							
Other							

PRESSURE ULCER

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Assess for risk factors							
Prevention measures (Turn and positioning; fluid intake monitoring, nutrition assessment)							

OXYGEN THERAPY

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Nasal cannula							
Mask							
Regular							
Non-rebreather							
Venti-Mask							
Incentive spirometer							
Chest physiotherapy							

Member: ______________________ DOB: __________ Date: __________

OXYGEN THERAPY continued

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Handheld resuscitation (ambu bag)							
Tracheostomy care							
Disposable inner cannula							
Non-disposable inner cannula (document single or double lumen instruction)							
Tracheotomy care							
Tying methods							
Two tie							
Posey							
Ventilator care							
Settings							
Alarm management							

SUCTIONING

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Oropharyngeal							
Nasopharyngeal							
Tracheostomy							
Open system							
Closed system							
Endotracheal tube							
Open system							
Closed system							

Member: ____________________ DOB: __________ Date: __________

ENTERAL TUBES

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Irrigating an NGT							
NG Feeding							
Continuous							
Intermittent (syringe & bag)							
NG site care/dressing							
GT Feeding (Peg/JT)							
Continuous							
Bolus/intermittent							
Jejunostomy tube care							
PEG care							

DIABETES MONITORING

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Capillary blood sugar test							
Sliding scale insulin							
Hypoglycemic							
Signs/symptoms							
Interventions							
Hyperglycemic							
Signs/symptoms							
Interventions							

MEDICATION PREPARATION AND ADMINISTRATION

Skill	Date	Code				Comments	Initials
		O	E	D	N/A		
Reading medication orders							
Medication reconciliation							
Documenting medication administration							
Preparing unit-dose packaged medications							
Splitting a tablet							
Preparing liquid medicine							

Member: ________________ DOB: ________ Date: ________

MEDICATION PREPARATION AND ADMINISTRATION continued							
Skill	**Date**	**Code**				**Comments**	**Initials**
		O	**E**	**D**	**N/A**		
Administering oral medications							
Applying a transdermal patch							
Administering eye drops							
Administering ear drops							
Administering a rectal suppository							
Administering dry powder inhaler							
Injectable medications							
Preparing medications from							
Ampule							
Vial							
Insulin							
Mixing two insulins in one syringe							
Administering insulin							
Intradermal injections							
Subcutaneous injections							
Intramuscular injection							
Intravenous							
IV medication by gravity							
IV medication by pump							
Changing IV solution container							
Changing IV administration set							
Monitoring an IV site							
Capping an IV line for intermittent use							
Central Venous Access Device							
Types of CVAD							
Changing a CVAD dressing							

Member: ______________________ DOB: __________ Date: __________

MEDICATION PREPARATION AND ADMINISTRATION continued							
Skill	**Date**	**Code**				**Comments**	**Initials**
		O	**E**	**D**	**N/A**		
CVAD care							
Flushing guidelines							

OTHER

Skill	**Date**	**Code**				**Comments**	**Initials**
		O	**E**	**D**	**N/A**		

Member: ______________________________ DOB: __________ Date: __________

Member/Caregiver/Agency Signature Page

☐ Yes ☐ No – I need additional training.
If yes, please list specific training needed:

Member/Primary Caregiver Signature: ______________________________ Date: __________

☐ Yes ☐ No – I need additional training.
If yes, please list specific training needed:

Backup Caregiver Signature: ______________________________ Date: __________

☐ Yes ☐ No – I need additional training.
If yes, please list specific training needed:

Backup Caregiver Signature: ______________________________ Date: __________

☐ Yes ☐ No – Additional training scheduled – Date: ______________________________

Agency Staff Signature & Degree: ______________________________ Date: __________