COMPETENCY ASSESSMENT SKILLS CHECKLIST
OCCUPATIONAL THERAPIST

Name:_____ **Date of Employment:**_____

_____ **Initial** _____ **Annual**

Key for Evaluation Method:

Verbal Test = V; Written Test = W; Observation = O; Demonstration = D; Special Training = ST

Self-Assessment				Competency for the Occupational Therapist	Evaluation Method (To be completed by Supervisor)
Do you have experience with this skill?		Are you competent performing the following?			
Yes	No	Yes	No		
Demonstrates ability to process paperwork and associated functions necessary to facilitate:					
Knowledge of Assessment Process:					
				Health history and physical exam	
				Development of problem list	
				Development and revision of care plan	
				Assesses response to treatment	
				Establishes and revises goals	
				Discharge planning	
				Conducts complete initial evaluation	
Documentation Skills: (accurate, timely, complete, and legible)					
				485, 486, 487	
				Progress notes, flow sheets	
				Summary reports	
				Incident reporting	
Adheres to Plan of Care (POC):					
				Reviews POC prior to care	
				Performs services as ordered	
				Documents according to POC	
				Communicates/coordinates as appropriate	
				Management and evaluation of the patients care plan	
Knowledge of Medicare/State Guidelines:					
				Criteria for participation	
				Skilled reimbursable visit	
				Reports and documents key information to Physician, Discharge Planner, Other Clinicians, Pharmacist, Supervisor	
				Participates as team member	
				Submits written summary reports as indicated	
				Attends/participates in case conferences as required	
Supervision of Ancillary Personnel:					
				OTA	
				HHA	
				Supply/HME requisition and management	

Self-Assessment				Competency for the Occupational Therapist	Evaluation Method (To be completed by Supervisor)
Do you have experience with this skill?		Are you competent performing the following?			
Yes	No	Yes	No		
Infection Control Practices:					
				Hand washing	
				Personal protective equipment	
				Exposure control plan	
				Equipment care, as appropriate	
Patient Education:					
				Determines learning needs	
				Sets objectives	
				Develops/implements teaching plan	
				Evaluates effectiveness of teaching	
				Revises teaching plan	
				Documents patient response	
Assessment and Evaluation:					
				Mental Status/Cognition (judgment, memory judgment, orientation, sequencing, following directions, problem solving)	
				Upper Extremity (ROM, Strength, Coordination)	
				Balance/Trunk Control	
				Ambulation/Endurance	
				Pain/edema, synergy	
				Visual/sensory/perceptual performance	
				Functional Findings: Eating/ Feeding	
				Functional Findings: Dressing	
				Functional Findings: Hygiene	
				Functional Findings: Toileting	
				Functional Findings: Cooking/ Laundry/ Cleaning/ Home Skills	
				Functional Findings: Writing/Phone Use	
				Functional Findings: Leisure interest	
				Functional Findings: Time use and structuring	
				Functional Findings: Medication Management	
Skilled Treatments/Interventions:					
				Teaches ADL/ IADL Program	
				Work simplification and energy	
				Teaches muscle re-education program	
				Perceptual motor training	
				Fine Motor Training/ Dexterity training/ Gross motor training	
				Neuro-developmental Training	
				Sensory enhancement (tactile, ocular, gustatory, olfactory, proprioceptive, auditory, vestibular, kinesthesia)	
				Arranges Orthotics/splinting	
				Arranges adaptive equipment	

Self-Assessment				Competency for the Occupational Therapist	Evaluation Method (To be completed by Supervisor)
Do you have experience with this skill?		Are you competent performing the following?			
Yes	No	Yes	No		
				Teaches caregiver exercises/activities	
				Safety evaluation/ environment adaption recommendations	
				Work capacity evaluation	
Other Categories:					
				Patient home safety	
				Clinical Skills – General Vital Signs	
				Environmental eval/Architectural barriers	
				Transfer Activities	

I have been instructed and have knowledge and ability in the occupational therapy areas indicated on this form.

Employee Signature _____ Date _____

Preceptor/ Supervisor Signature _____ Date _____