Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hire Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CRITICAL ELEMENTS** | **VALIDATOR’S ASSESSMENT** | | **Key** | | | | | | COMMENTS  (Elaboration on “Needs Improvement”) |
| Independent | Needs  Improvement | DO | D | DR | WT | VR | O |
| **ABOUT AHC** | | | | | | | | | |
| AJRS Objective/Mission/  Philosophy |  |  |  |  |  |  |  |  |  |
| Principles of Person-  Centeredness |  |  |  |  |  |  |  |  |  |
| Mandated Reporter  responsibilities |  |  |  |  |  |  |  |  |  |
| Serious Incident reporting |  |  |  |  |  |  |  |  |  |
| Behavior Intervention |  |  |  |  |  |  |  |  |  |
| Individuals rights/  human rights  policies and practices |  |  |  |  |  |  |  |  |  |
| CPR/First Aid |  |  |  |  |  |  |  |  |  |

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| Staff Responsibilities | |  |  |  |  |  |  |  |  |  |
| Emergency Preparedness | |  |  |  |  |  |  |  |  |  |
| Transportation procedures | |  |  |  |  |  |  |  |  |  |
|  | **INDIVIDUAL RECORD** | | | | | | | | | |
| HIPAA/Confidentiality | |  |  |  |  |  |  |  |  |  |
| Access, Duplication, and Dissemination of Individual’s Record | |  |  |  |  |  |  |  |  |  |
| HCBS Compliance Training | |  |  |  |  |  |  |  |  |  |
| Policy on Coercion, Restraint,  Seclusion and Time out. | |  |  |  |  |  |  |  |  |  |

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| Health Needs |  |  |  |  |  |  |  |  |  |
| Nutritional Requirements |  |  |  |  |  |  |  |  |  |
| Adaptive Devices |  |  |  |  |  |  |  |  |  |
| Infection Control Practices | | | | | | | | | |
| Hand washing techniques |  |  |  |  |  |  |  |  |  |
| Use of protective gloves |  |  |  |  |  |  |  |  |  |
| Disposal of contaminated  materials |  |  |  |  |  |  |  |  |  |
| Disinfecting reusable  equipment |  |  |  |  |  |  |  |  |  |
| Disinfecting surfaces |  |  |  |  |  |  |  |  |  |
| Flu Epidemic |  |  |  |  |  |  |  |  |  |
| Toileting techniques |  |  |  |  |  |  |  |  |  |
| Food preparation, service,  sanitation and storage |  |  |  |  |  |  |  |  |  |
| Community Inclusion Training |  |  |  |  |  |  |  |  |  |
| Recognizing signs of  mental/physical status change |  |  |  |  |  |  |  |  |  |
| Medication Administration |  |  |  |  |  |  |  |  |  |
| I understand the content and have completed the above staff training. I believe that I am competent to provide services because of training, experience and/or competency verification. I am aware that additional training and resources will be available and provided if assistance is required. I also understand that this form will be kept in my file and available upon request.  Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Validator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |