

COVID 19: Service Specific Checklist

(Day → Residential Training)

Staff Name:	
Residential program name:	
Date of training:	
Names of individuals living in the home and part of this training:	

It is understood that the staff received service specific training by their day program. Thus, this checklist MUST be completed prior to any staff working in the residential program as an unsupervised residential staff.

Your initials beside each task indicate that you have completed that task and any/all questions answered. Do not initial any area that you do not understand completely.

POLICY AND PROCEDURES

STAFF INITIAL

TRAINER INITIAL

*Review of Medisked to ensure access has been granted
(Review of daily notes and monthly note expectations)

Review of documentation requirements

(Review of AED logs, Daily Assignment Sheets, etc.)

FACILITY AND SAFETY

STAFF INITIAL

TRAINER INITIAL

Review and tour of the home including any intricacies

Identification of fire exits (walk-through)

Review of Evacuation Plan and Fire Procedures

Identify location of Fire Extinguisher, AED, FA Supplies, ER Contact, MSDS

Review of Site POP

Emergency contact information

*Wheelchair tie-down & lift hands-on training

*Hoyer lift hands-on training

*Vehicle overview

Review of environmental safety needs

COVID-19 Visitor and staff standards

COVID-19 Cleaning procedures

INDIVIDUAL NEEDS

STAFF INITIAL

TRAINER INITIAL

Review Staff Action Plans for all individuals

Review Behavior Plans for all individuals

(Including behavior charting, restrictions, etc.)

Review of approved restrictions for home and individuals

Review of person specific wheelchair use/safety/positioning needs

Review of special diets and feeding techniques for all individuals

Review Nursing care plans for all individuals

(Including positioning chart, BM charts, etc.)

Med pass for the specific home (Will require a separate AMAP cert form)

(Including MAR charts, Med sheets, controlled substance, Med process at this home, etc.)

ON-THE-JOB TRAINING (ONLY APPLICABLE FOR

Shift #1

Date: _____

Name of staff: _____

Shift #2

Date: _____

Name of staff: _____

- Status change submitted to allow the staff access to work in the associated cost center
- Confirm that all required trainings are current with CPR, First Aid, SCIP

The signature of the DSP staff below indicates completion and understanding of areas indicated above:

Staff Name (Signature)

Staff Name (Print)

Date

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The signature of the Residential Management staff below indicates completion of the COVID-19 Service Specific Checklist for staff transitioning from Day to Residential services on a temporary basis: Note: * items could be N/A as per mgmt. discretion

Mgmt Name (Signature)

Mgmt Name (Print)

Date