

LVAD Clinic RPM Skills Competency Checklist

LVAD Clinic Name:

Location:

Participant Name:

Role:

Training Objective	Method Of Assessment*	Competency Observed			Date	Reassessment	
		Yes	No	N/A		If No, List Reassessed Date	Method Of Review
Demonstrates Ability To Access And Login To WCR Advantage Landing Page	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Reviews And Utilizes Clinician Dashboard <input type="checkbox"/> RPM List <input type="checkbox"/> Alerts <input type="checkbox"/> Use Notifications <input type="checkbox"/> Column Adjustments/Table Of Contents <input type="checkbox"/> Selects Individual/Group Batch Alarms	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Accesses, Reviews, And Edits Patient Profile	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Reviews Check-In Process For Patient Measurements <input type="checkbox"/> Origin Of Measurements <input type="checkbox"/> Enter Notes <input type="checkbox"/> Add Review <input type="checkbox"/> Quick Reply (Add/Delete/Edit)	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Sends/Receives Messages With Patients Via RPM <input type="checkbox"/> Understands Facility EHR Procedure	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Initiates A Telehealth Virtual Call With Patient	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Registers A Patient <input type="checkbox"/> Add Patient Button <input type="checkbox"/> Male/Female Toggle <input type="checkbox"/> Add Provider <input type="checkbox"/> Add RPM Program <input type="checkbox"/> Add Location <input type="checkbox"/> Training Mode <input type="checkbox"/> Device Ordering <input type="checkbox"/> Adding/Editing Patient Goals <input type="checkbox"/> Customizing Alarm Settings	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>

* DO (Direct Observation), V (Verbalization), RD (Return Demonstration)

Training Objective	Method Of Assessment*	Competency Observed			Date	Reassessment	
		Yes	No	N/A		If No, List Reassessed Date	Method Of Review
Runs Summary Report(s)	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>
Adds A User (Super User Function Only - Requires NPI/Admin Access)	DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			DO <input type="checkbox"/> V <input type="checkbox"/> RD <input type="checkbox"/>

* DO (Direct Observation), V (Verbalization), RD (Return Demonstration)

Initial Competency

Participant Signature:

Trainer Name:

Date:

Trainer Signature:

Date:

Reassessment Competency

Participant Signature:

Trainer Signature:

Date:

Date:

If "NO" is checked in any category above, please document action plan for the participant to meet competency in the table below.

Action Plan	
Competency Requiring Review	
Education Plan For Competency	
Target Date For Review	
Trainer Name	