

Wise Medical Staffing, Inc.

Clinical Skills Checklist

Name _____

Date _____

Levels of Proficiency

A = Perform Well (Able to teach/Supervise)
 B = Comfortable Performing (at least one year Experience)

C = Perform Infrequently (less than three months experience in the last two years)
 D = No Experience (Theory only)

| PSYCH.: | A | B | C | D |
|-----------------------|----------|----------|----------|----------|
| Psych. pt. Assessment | | | | |
| Adminis. Psych. meds | | | | |
| Use of Restraints | | | | |
| Takedown | | | | |
| ECG | | | | |

| IV Therapy: | A | B | C | D |
|--------------------------|----------|----------|----------|----------|
| Insert peripheral line-- | | | | |
| Regulate/Maintain IV | | | | |
| D/C peripheral IV | | | | |
| Maintain Hickman | | | | |
| Insert PICC Line | | | | |
| Maintain PICC Line | | | | |
| Discontinue PICC Line | | | | |
| CVP tray set-up | | | | |
| Maintain CVP Line | | | | |
| Dressing Change CVP | | | | |
| Discontinue CVP | | | | |
| CVP Reading | | | | |
| Blood/Blood Products | | | | |
| Arterial Puncture | | | | |

| Medication Adminis: | A | B | C | D |
|----------------------------|----------|----------|----------|----------|
| PO | | | | |
| SL | | | | |
| Drops | | | | |
| IM | | | | |
| Sub Q | | | | |
| Site Selection | | | | |
| IV Push | | | | |
| IV Piggyback | | | | |
| Chemotherapy | | | | |
| Hyperalimantation | | | | |
| Other | | | | |
| | | | | |

| IV Infusion Pumps: | A | B | C | D |
|---------------------------|----------|----------|----------|----------|
| IVAC | | | | |
| IMED | | | | |
| PCA | | | | |
| Other | | | | |
| | | | | |

| GI/Endocrine: | A | B | C | D |
|------------------------|----------|----------|----------|----------|
| Acute Cholccystitis | | | | |
| Bowel Obstruction | | | | |
| GI Bleed | | | | |
| Diabetes | | | | |
| Hyper/Hypoglycemia | | | | |
| Pancreatitis | | | | |
| Abdominal Wounds | | | | |
| Crohn's Disease | | | | |
| NG tube insertion | | | | |
| G-Tubes | | | | |
| Insulin Administration | | | | |
| Glucose monitoring | | | | |
| Ostomy/Stoma care | | | | |
| Eating Disorders | | | | |

| GU: | A | B | C | D |
|-----------------------|----------|----------|----------|----------|
| Acute Renal Failure | | | | |
| Renal Transplant | | | | |
| Kidney Transplant | | | | |
| Pre/post Nephrectomy | | | | |
| Hemodialysis | | | | |
| Peritoneal Dialysis | | | | |
| AV shunt/fistula care | | | | |
| Foley Cath. Insertion | | | | |
| Foley Care | | | | |
| GU Irrigation | | | | |

| Neurological: | A | B | C | D |
|------------------------|----------|----------|----------|----------|
| Neuro. Assessment | | | | |
| Acute CVA/TIA | | | | |
| Closed Head Injury | | | | |
| Seizure Disorder | | | | |
| Spinal Cord Injury | | | | |
| Hyper/hypothermia | | | | |
| I.C.P. monitoring | | | | |
| Assist w/Lumbar Punct. | | | | |
| Cervical Traction | | | | |
| Crutchfield Tongs | | | | |
| Halo Traction | | | | |
| Glascow Scale | | | | |

| Emergency Meds: | A | B | C | D |
|------------------------|----------|----------|----------|----------|
| Atropine | | | | |
| Bicarbonate | | | | |
| Bretylium | | | | |
| Aminodarone | | | | |
| Dextrose | | | | |
| Digitalis | | | | |
| Dopamine | | | | |
| Epinephrine | | | | |
| Heparin | | | | |
| Isuprel | | | | |
| Lidocaine | | | | |
| Nipride | | | | |
| Nitroglycerin | | | | |
| Steptokinanse | | | | |
| Vasopressin | | | | |

| CV/Circulatory: | A | B | C | D |
|---------------------------|----------|----------|----------|----------|
| Acute Aneurysm | | | | |
| Acute MI, Agina, CHF | | | | |
| Pulmonary Edema | | | | |
| Shock | | | | |
| Cardiogenic | | | | |
| Hypervolemic | | | | |
| Septic | | | | |
| Pre/post Angioplasty | | | | |
| Post CABG | | | | |
| EKG Interpretation | | | | |
| Ext. Pacemaker Maint. | | | | |
| Cardioversion | | | | |
| Cardiopulmonary/Monitor | | | | |
| Arterial line/Swan Ganz | | | | |
| Arrhythmia Interpretation | | | | |
| Perform defibrillation | | | | |
| Use of Doppler | | | | |

Clinical Skills Checklist

| Respiratory: | A | B | C | D |
|----------------------|----------|----------|----------|----------|
| Acute Resp. Distress | | | | |
| COPD | | | | |
| Asthma | | | | |
| Emphysema | | | | |
| Pneumonia | | | | |
| Long CA | | | | |
| Administer oxygen | | | | |
| Assess lung sounds | | | | |
| Assist w/Chest tube | | | | |
| Maintain Chest tube | | | | |
| Obtain ABG's | | | | |
| Interpret ABG's | | | | |
| Pulse oximetry | | | | |
| Suctioning | | | | |
| Tracheostomy | | | | |
| Assist Thoracentesis | | | | |
| Nebulizer | | | | |
| Ventilators | | | | |
| | | | | |
| | | | | |

| Post/Surgical Care: | A | B | C | D |
|----------------------------|----------|----------|----------|----------|
| Arthroscopy | | | | |
| Total Hip/Knee | | | | |
| Bowel Resection | | | | |
| Carotid | | | | |
| Laparoscopy | | | | |
| Abdominal | | | | |
| ENT | | | | |
| T.U.R.P. | | | | |
| Thoracic | | | | |
| CABG | | | | |
| Spinal | | | | |
| Hysterectomy | | | | |
| | | | | |
| | | | | |

Detail any additional experience that makes you exceptionally qualified to practice as a traveling registered nurse.

Nurse's signature

Date

Age Specific Competency Criteria

Instructions: Please check the boxes below for age specific competency skills for which you can provide expertise-nursing care.

- | | | |
|------------------------|--------------------------------|---------------------------------|
| A. Infancy 0-1 Years | D. Adolescent 12-18 Years | F. Middle Adulthood 45-60 Years |
| B. Toddler 1-3 Years | E. Early Adulthood 19-45 Years | G. Older Adults (60+ Years) |
| C. Preschool 3-6 Years | | |

| Experience with Age Groups: | A | B | C | D | E | F | G |
|--|----------|----------|----------|----------|----------|----------|----------|
| Involve patient and / or family in planning decision-making and control of treatment and care. | | | | | | | |
| Demonstrates knowledge of the physical and psychosocial needs of the patient. | | | | | | | |
| Demonstrates understanding of equipment and procedure needs. | | | | | | | |
| Provides safe environment for specific needs for all age groups. | | | | | | | |

I certify that the information given in this checklist is true and accurate to the best of my knowledge.

Signature _____

Date _____