FRONTIER HEALTH CARE SERVICES

Psychiatric Nurses Skills Checklist

*** Denotes required field**

This profile is used for by Psychiatric nurses with more than one year experience in their discipline and specialty. It will not be a determining factor for the Frontier Health Care Services program.

Please enter your full legal name as it appears on your Social Security Card.

First name*

Last name*

Social Security Number

Date

Email

Please indicate your level of experience

1. Theory, no practice
2. Intermittent experience
3. One – two years of experience
4. Two plus years of experience

A. PSYCHIATRIC

1. Assessment	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Admission	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Initial nursing assessment and care plan	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Initial treatment plan	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Neurological vital signs	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Nursing diagnosis	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Nursing reassessment and care planning update	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Suicide risk assessment	1 ❑ 2 ❑ 3 ❑ 4 ❑
2. Equipment & Procedures	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Active participation in multi-disciplinary staffing	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Assist physician in administration of electroconvulsive therapy	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Assist with lumbar puncture	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Cardiopulmonary Resuscitation	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Charge nurse experience	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Charting	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Behavioristic	1 ❑ 2 ❑ 3 ❑ 4 ❑
(2) Treatmeant/goal oriented	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Discharge planning	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Electroconvulsive therapy	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Group therapy leader	1 ❑ 2 ❑ 3 ❑ 4 ❑
j. Insertion & care of straight and foley catheter	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Female	1 ❑ 2 ❑ 3 ❑ 4 ❑
(2) Male	1 ❑ 2 ❑ 3 ❑ 4 ❑

k. Management of drug/alcohol detox symptoms	1 ❑ 2 ❑ 3 ❑ 4 ❑
l. Management of assaultive behavior	1 ❑ 2 ❑ 3 ❑ 4 ❑
m. Multi-disciplinary treatment team participation	1 ❑ 2 ❑ 3 ❑ 4 ❑
n. O_2 therapy & medication delivery system	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Bag and mask	1 ❑ 2 ❑ 3 ❑ 4 ❑
(2) External CPAP	1 ❑ 2 ❑ 3 ❑ 4 ❑
(3) Face masks	1 ❑ 2 ❑ 3 ❑ 4 ❑
(4) Inhalers	1 ❑ 2 ❑ 3 ❑ 4 ❑
(5) Nasal cannula	1 ❑ 2 ❑ 3 ❑ 4 ❑
(6) Portable O_2 tank	1 ❑ 2 ❑ 3 ❑ 4 ❑
(7) Trach collar	1 ❑ 2 ❑ 3 ❑ 4 ❑
o. Oro-naso-pharynx suctioning	1 ❑ 2 ❑ 3 ❑ 4 ❑
p. Participation in milieu therapy	1 ❑ 2 ❑ 3 ❑ 4 ❑
q. Patient teaching	1 ❑ 2 ❑ 3 ❑ 4 ❑
r. Psychiatric emergency response team	1 ❑ 2 ❑ 3 ❑ 4 ❑
s. Psychiatric home health	1 ❑ 2 ❑ 3 ❑ 4 ❑
t. Rapid tranquilization	1 ❑ 2 ❑ 3 ❑ 4 ❑
u. Restraints, application and assessment of	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Ambulatory cuffs	1 ❑ 2 ❑ 3 ❑ 4 ❑
(2) Full restraints	1 ❑ 2 ❑ 3 ❑ 4 ❑
(3) Wrist restraints	1 ❑ 2 ❑ 3 ❑ 4 ❑
v. Telephonic crisis intervention	1 ❑ 2 ❑ 3 ❑ 4 ❑
w. Therapeutic communication skills	1 ❑ 2 ❑ 3 ❑ 4 ❑
x. Tube feeding	1 ❑ 2 ❑ 3 ❑ 4 ❑
3. Care of the patient with:	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Alcohol dependency	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Drug dependency	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Electroconvulsive therapy	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Hallucinations	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Manic behavior	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Med-psych patient	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Organic disorder	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Partial hospital/intensive outpatient	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Seclusion and restraints	1 ❑ 2 ❑ 3 ❑ 4 ❑
j. Seizure disorder	1 ❑ 2 ❑ 3 ❑ 4 ❑
k. Suicidal disorder	1 ❑ 2 ❑ 3 ❑ 4 ❑
l. Tracheostomy	1 ❑ 2 ❑ 3 ❑ 4 ❑
4. Medications	
a. Administration of oral psychotropic medications	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Heparin	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Intramuscular	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Management of extrapyramidal symptoms (EPS)	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Oral	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Rectal	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Sub-q	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Unit dose	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Z-technique	1 ❑ 2 ❑ 3 ❑ 4 ❑

B. PHLEBOTOMY/IV THERAPY

1. Equipment & procedures	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Administration of blood/blood products	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Packed red blood cells	1 ❑ 2 ❑ 3 ❑ 4 ❑

(2) Whole blood	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Drawing blood from central line	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Drawing venous blood	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Management of patient with hyperalimentation	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Management of patient with IV	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Starting IV's	1 ❑ 2 ❑ 3 ❑ 4 ❑
(1) Angiocath	1 ❑ 2 ❑ 3 ❑ 4 ❑
(2) Butterfly	1 ❑ 2 ❑ 3 ❑ 4 ❑
(3) Heparin lock	1 ❑ 2 ❑ 3 ❑ 4 ❑

AGE SPECIFIC PRACTICE CRITERIA

Please check the boxes below for e ach age group for which you have expertise in providing age-appropriate nursing care.

A. Newborn/Neonate (birth – 30 days)
B. Infant (30 days – 1 year)
C. Toddler 1 – 3 years)
D. Preschooler (3 – 5 years)
E. School age children (5 – 12 years)
F. Adolescents (12 – 18 years)
G. Young Adults (18 – 39 years)
H. Middle adults (39 – 64 years)
I. Older adults (64+)

EXPERIENCE WITH AGE GROUPS:

Able to adapt care to incorporate normal growth and development. 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑

Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level. 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑

Can ensure a safe environment reflecting needs of various age groups. 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑

My experience is primarily in: (Please indicate number of years)

❑ Adolescent _____year(s)

❑ Adult _____year(s)

❑ Chemical dependency/detox _____year(s)

Certification:

Please check the boxes and indicate the expiration date for each certificate that you have. If you know the exact date, please use the last date of the specific month(e.g., 08/31/2003)

❑ BCLS: Exp Date: _____(mm/dd/yyyy)

❑ MAB Exp Date: _____(mm/dd/yyyy)

❑ Other (Type) Exp Date: _____(mm/dd/yyyy)

❑ Computerized charting system: Exp Date: _____(mm/dd/yyyy)

❑ **Medication Administration system:** **Exp Date: _____(mm/dd/yyyy)**

Please read and agree to the statements below by marking the checkbox.

❑ * **I attest that the information I have given is true and accurate to the best of my knowledge and I am the individual completing this form. I hereby authorize the Company to release this Psychiatric Checklist to the Client Facilities in relation to consideration of employment as a Traveler with those facilities.**

Submit