FRONTIER HEALTH CARE SERVICES

Dialysis RN Skills Checklist

*** Denotes required field**

This profile is used for by Dialysis RNs 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. RENAL/GENITOURINARY

1. Assessment of Renal / GU System	1 ❑ 2 ❑ 3 ❑ 4 ❑
2. Insertion of foley	1 ❑ 2 ❑ 3 ❑ 4 ❑
3. Care of the patient with:	
a. Nephrostomy tube	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. AV Fistula/ AV Graft	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Tunneled/ Non-Tunneled Catheter	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Ileal Conduit	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Supra-Pubic Catheter	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Chronic Renal Failure	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Acute Renal Failure	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Nephrectomy	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Turp	1 ❑ 2 ❑ 3 ❑ 4 ❑
j. Pertioneal Dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
k. Hemodialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑

B. HEMODIALYSIS SKILLS/PROCEDURES

1. Experience	
a. Acute/Inpatient Dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Chronic/Outpatient Dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Diaysis Home Care	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Pediatric Diaylsis	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Predialysis Nursing Assessment	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Teaching the Dialysis Patient and Family	1 ❑ 2 ❑ 3 ❑ 4 ❑
2. Set Up/Initiate Dialysis Treatment	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Bicarbonate Dialysate	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Conductivity Testing	1 ❑ 2 ❑ 3 ❑ 4 ❑

c. Priming Dialyzer	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Checks for Machine/Alarm Settings	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Prep Vascualr Access	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Fistula Gortex/Bovine Graft	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Collect Blood Specimens	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Anticoagulation	1 ❑ 2 ❑ 3 ❑ 4 ❑
3. Assess Patient and equipment during dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Systems Assessment of patient	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Volume status	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Vascualar Access Function	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Arterial and Venous Pressures	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Blood flow rate	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Subjective Response to Treatment	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Management of Anticogulation	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Conductivity	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Ultrafiltration Calculation	1 ❑ 2 ❑ 3 ❑ 4 ❑
j. Operation of Myron L. Meter	1 ❑ 2 ❑ 3 ❑ 4 ❑
k. Administration of Blood and Blood products	1 ❑ 2 ❑ 3 ❑ 4 ❑
l. Administration of Mannitol	1 ❑ 2 ❑ 3 ❑ 4 ❑
m. Sequential Ultrafiltration/PUF	1 ❑ 2 ❑ 3 ❑ 4 ❑
n. Documentation of Dialysis Treatment	1 ❑ 2 ❑ 3 ❑ 4 ❑
4. Management of the patient with:	
a. Fluid Overload	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Hypertension	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Hypotension	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Disequilibrium syndrome	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Hyperkalemia	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Seizures	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Muscule Cramps	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Clotted Access/Poor Blood Flow Rate From Catheter	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Pyrogenic Reaction	1 ❑ 2 ❑ 3 ❑ 4 ❑
j. Hemolysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
k. Air Embolus	1 ❑ 2 ❑ 3 ❑ 4 ❑
l. Chest Pain	1 ❑ 2 ❑ 3 ❑ 4 ❑
m. Anemia	1 ❑ 2 ❑ 3 ❑ 4 ❑
n. Neuropathy	1 ❑ 2 ❑ 3 ❑ 4 ❑
o. Pericarditis	1 ❑ 2 ❑ 3 ❑ 4 ❑
p. Filter Blood Leak	1 ❑ 2 ❑ 3 ❑ 4 ❑
q. Cardiopulmonary Arrest	1 ❑ 2 ❑ 3 ❑ 4 ❑
5. Machine Alarm Troubleshooting Procedures	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Blood leak Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
b. Arterial Pressure Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Venous Pressure Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Conductivity Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Ultrafiltration Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
f. High temperature Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
g. Air/Foam Detector Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
h. Power Failure Alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
i. Blood pressure alarm	1 ❑ 2 ❑ 3 ❑ 4 ❑
6. Discontinued Dialysis	1 ❑ 2 ❑ 3 ❑ 4 ❑
a. Diaylsis Catheter	1 ❑ 2 ❑ 3 ❑ 4 ❑

b. fistula/ Vein Graft 1 ❑ 2 ❑ 3 ❑ 4 ❑
c. Return of Blood 1 ❑ 2 ❑ 3 ❑ 4 ❑
d. Post treatment Access care 1 ❑ 2 ❑ 3 ❑ 4 ❑
e. Equipment clean up 1 ❑ 2 ❑ 3 ❑ 4 ❑
f. Sterilization procedures 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)

❑ Medical _____ year(s)
❑ Surgical _____ year(s)
❑ Trauma _____ year(s)
❑ Cardiothoracic _____year(s)
❑ Coronary care _____year(s)
❑ Neuro _____ year(s)
❑ Burn _____ year(s)
❑ PACU _____ year(s)
❑ Other (specify) _____ _____ 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)

❑ Arrhythmia course date: _____(mm/dd/yyyy)
❑ Critical Care course date: _____mm/dd/yyyy)
❑ Computerized charting system: _____mm/dd/yyyy)
❑ Medication Administration system: _____(mm/dd/yyyy)
❑ ACLS Exp. date: _____(mm/dd/yyyy)
❑ BCLS Exp. date: _____(mm/dd/yyyy)

- ❑ **BTLS Exp. date: _____(mm/dd/yyyy)**
- ❑ **CCRN Exp. date: _____(mm/dd/yyyy)**
- ❑ **CNRN Exp. date: _____(mm/dd/yyyy)**
- ❑ **TNCC Exp. date: _____(mm/dd/yyyy)**
- ❑ **Other (type): _____(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 Dialysis RN Checklist to the Client Facilities in relation to consideration of employment as a Traveler with those facilities.**

Submit