

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 3. One – two years of experience
2. Intermittent experience 4. Two plus years of experience

A. RENAL/GENITOURINARY

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

B. HEMODIALYSIS SKILLS/PROCEDURES

- | | |
|---|---|
| 1. Experience | |
| a. Acute/Inpatient Dialysis | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| b. Chronic/Outpatient Dialysis | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| c. Diaysis Home Care | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| d. Pediatric Diaylsis | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| e. Predialysis Nursing Assessment | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| f. Teaching the Dialysis Patient and Family | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| 2. Set Up/Initiate Dialysis Treatment | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| a. Bicarbonate Dialysate | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| b. Conductivity Testing | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |

- c. Priming Dialyzer 1 2 3 4
- d. Checks for Machine/Alarm Settings 1 2 3 4
- e. Prep Vascular 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. Vascular 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 Anticoagulation 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: 1 2 3 4
- 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. Muscle 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. Dialysis Catheter 1 2 3 4

- | | |
|-------------------------------|---|
| b. fistula/ Vein Graft | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| c. Return of Blood | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| d. Post treatment Access care | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| e. Equipment clean up | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| f. Sterilization procedures | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |

AGE SPECIFIC PRACTICE CRITERIA

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

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

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)

- | | | | |
|--|---------------|--|---------------|
| <input type="checkbox"/> Medical | _____ year(s) | <input type="checkbox"/> Coronary care | _____ year(s) |
| <input type="checkbox"/> Surgical | _____ year(s) | <input type="checkbox"/> Neuro | _____ year(s) |
| <input type="checkbox"/> Trauma | _____ year(s) | <input type="checkbox"/> Burn | _____ year(s) |
| <input type="checkbox"/> Cardiothoracic | _____ year(s) | <input type="checkbox"/> PACU | _____ year(s) |
| <input type="checkbox"/> 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)

- | | |
|--|--------------------|
| <input type="checkbox"/> Arrhythmia course date: | _____ (mm/dd/yyyy) |
| <input type="checkbox"/> Critical Care course date: | _____ mm/dd/yyyy) |
| <input type="checkbox"/> Computerized charting system: | _____ mm/dd/yyyy) |
| <input type="checkbox"/> Medication Administration system: | _____ (mm/dd/yyyy) |
| <input type="checkbox"/> ACLS Exp. date: | _____ (mm/dd/yyyy) |
| <input type="checkbox"/> 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