

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

#### A. PSYCHIATRIC

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

- 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<sub>2</sub> 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<sub>2</sub> 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 1  2  3  4
- 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 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b. Drawing blood from central line              | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. Drawing venous blood                         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d. Management of patient with hyperalimantation | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| e. Management of patient with IV                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| f. Starting IV's                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (1) Angiocath                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (2) Butterfly                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (3) Heparin lock                                | 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)

- 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**