Professional Psychiatric Nursing Service

Name: ___________________________ Date: ___________________________

Years of Experience: ___________________________

Directions for completing skills checklist:

The following is a list of equipment and/or procedures performed in rendering care to patients. Please indicate your level of experience/proficiency with each area and, where applicable, the types of equipment and/or systems you are familiar with. Use the following key as a guideline:

A) Theory Only/No Experience--Didactic instruction only, no hands on experience
B) Limited Experience--Knows procedure/has used equipment, but has done so infrequently or not within the last six months
C) Moderate Experience--Able to demonstrate equipment/procedure, performs the task/skill independently with only resource assistance needed.
D) Proficient/Competent--Able to demonstrate/perform the task/skill proficiently without any assistance and can instruct/teach.

A. PSYCHIATRIC

1. Clinical Assessment/Assessment Tools
   a. General Admission Procedures
   b. Initial Nursing Assessment and Care Plan
   c. Initial Treatment Plan
   d. Neurological Vital Signs
   e. Nursing Diagnoses
   f. Nursing Reassessment/Care Plan Updating
   g. Suicide Risk Assessment
   h. Intelligence Assessment
      (1) Wechsler Intelligence Scale (WAIS)
      (2) Wechsler Intelligence Scale for Children
   i. Personality Assessment
      (1) Minnesota Multiphasic Personality Inventory (MMPI)
      (2) Rorschach Test
      (3) Thematic Apperception Test (TAT)
      (4) Child's Apperception Test (CAT)
   j. Informal Cognitive Status Assessment
   k. Mental Status Assessment
   l. Gestalt Test
   m Stanford-Binet Test

2. Equipment and Procedures
   a. Participation in Multi-Disciplinary Staffing
   b. Charge Nurse Experience
   c. Charting
      (1) Behavioristic

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

---

---
(2) Treatment/Goal Oriented

d. Discharge Planning
e. Patient Teaching/Education
f. Psychiatric Emergency Response Team
g. Psychiatric Home Health
h. Rapid Tranquilization
I. Cardiopulmonary Resuscitation
j. Insertion/Care of Foley Catheter
k. Oxygen Therapy and medication Delivery Systems
   (1) Bag and Mask
   (2) External CPAP
   (3) Face Masks
   (4) Inhalers
   (5) Nasal Cannula
   (6) Portable Oxygen Tanks
   (7) Trach Collar
l. Restraints, Application and Assessment of:
   (1) Ambulatory Cuffs
   (2) Full Restraints
   (3) Wrist Restraints
m Group Therapy Leader
n. Participation in Milieu Therapy
o. Psychotherapy
p. Behavior Therapy
q. Relationship/Family Therapy
r. Electroconvulsive Therapy
s. Crisis Counseling
t. Telephonic Crisis Intervention
u. Suicide Precautions

3. Communication Skills
   a. Active Listening
   b. Questioning
   c. Restatement/Reflection
   d. Clarification
   e. Focusing
   f. Confrontation
   g. Summarizing
   h. Boundaries
   I. Positive Reinforcement
   j. Orientation Assessment
   k. De-escalation
   l. Empathizing
   m Reframing Skills

4. Care of the Patient with:
   a. Depressive Disorders
   b. Anxiety Disorders
   c. Schizophrenia-Spectrum Disorders
d. Personality Disorders
e. Eating Disorders
f. Congenital/Developmental Disorders
   (1) Mental Retardation
   (2) Down’s Syndrome
<table>
<thead>
<tr>
<th>Condition</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina Bifida</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asperger's Syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rett's Syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degenerative Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alzheimer's Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Huntington's Chorea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape Victimization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault/Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation Anxiety Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorders (ADD/ADHD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elimination Disorders (Encopresis/Enuresis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B. MEDICATIONS/METHODS OF DELIVERY**

1. Medications
   a. Antipsychotics                           |   |   |   |   |   |
   b. Analgesics/Narcotics                     |   |   |   |   |   |
   c. Antidepressants                          |   |   |   |   |   |
   d. Antianxiety                              |   |   |   |   |   |
   e. Anticonvulsants                          |   |   |   |   |   |
   f. Anti-Parkinson                           |   |   |   |   |   |

2. Methods of Delivery
   a. Intramuscular                            |   |   |   |   |   |
   b. Oral                                     |   |   |   |   |   |
   c. Rectal                                   |   |   |   |   |   |
   d. Subcutaneous                             |   |   |   |   |   |
   e. Unit Dose                                |   |   |   |   |   |

3. Phlebotomy/IV Therapy
   a. Administration of Blood and Blood Products |   |   |   |   |   |
   b. Drawing Blood from Central Line          |   |   |   |   |   |
   c. Drawing Venous Blood                     |   |   |   |   |   |
   d. Management of Patient with Hyperalimentation |   |   |   |   |   |
   e. Management of Patient with IV            |   |   |   |   |   |
   f. Starting IVs                             |   |   |   |   |   |
      (1) Angiocath                              |   |   |   |   |   |
      (2) Butterfly                             |   |   |   |   |   |
      (3) Heparin Lock                          |   |   |   |   |   |

**C. LEGAL/ETHICAL**

1. Legal Rights of the Mentaly Ill            |   |   |   |   |   |
2. Informed Consent                           |   |   |   |   |   |
3. Right to Refuse Treatment                  |   |   |   |   |   |
4. Involuntary Commitment                     |   |   |   |   |   |
5. Use of Restraints                          |   |   |   |   |   |
6. Use of Seclusion                           |   |   |   |   |   |
D. MISCELLANEOUS

1. AMA procedures  yes ○ no ○

AGE SPECIFIC PRACTICE

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

EXPERIENCE WITH AGE GROUPS

Able to adapt care to incorporate normal growth and development.

Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.

Can ensure a safe environment reflecting specific needs of various age groups.

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Professional Nursing Service to release Emergency Room Skills Checklist to client facilities of PNS in relations to consideration of employment as a Traveler with those facilities.

Signature ___________________________________________________________________________ Date __________

Signature ___________________________________________________________________________ Date __________