



## PSYCHIATRIC NURSING SKILLS CHECKLIST

|            |                   |           |
|------------|-------------------|-----------|
| First Name | MI                | Last Name |
| E-mail     | Last 4 digits SS# | date      |

**Instructions:** Please check the appropriate column that best describes your experience level for each knowledge competency and skill. Please use the rating scale below to evaluate yourself based on experiences within the last two years.

### Self-Assessed Experience Rating Scale

1 = No Experience    2 = Minimal Experience    3 = Performs well/competent    4 = Supervise and Teach

| Skills:   | 1        | 2        | 3        | 4        |
|---|----------|----------|----------|----------|
| <b>A. Psychiatric</b>   |          |          |          |          |
| <b>1. Assessment</b>  |          |          |          |          |
| <b>Admission:</b>   |          |          |          |          |
| Initial Nursing Assessment and Care Plan                        |          |          |          |          |
| Initial Treatment and Plan                                      |          |          |          |          |
| Neurological Vital Signs  |          |          |          |          |
| Nursing Diagnosis   |          |          |          |          |
| Nursing Reassessment and Care Planning Update                   |          |          |          |          |
| Suicide Risk Assessment   |          |          |          |          |
| <b>2. Equipment and Procedures</b>                              |          |          |          |          |
| Active Participation in Multi-disciplinary Staffing             |          |          |          |          |
| Assist Physician in Administration of Electroconvulsive Therapy |          |          |          |          |
| Assist with Lumbar Puncture                                     |          |          |          |          |
| Cardiopulmonary Resuscitation                                   |          |          |          |          |
| Charge Nurse Experience   |          |          |          |          |
| <b>Charting:</b>  |          |          |          |          |
| (1) Behavioristic   |          |          |          |          |
| (2) Treatment Oriented  |          |          |          |          |
| Discharge Planning  |          |          |          |          |
| Electroconvulsive Therapy                                       |          |          |          |          |
| Group Therapy Leader  |          |          |          |          |
| <b>Skills continued:</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |

| Insertion and Care of Straight and Foley Catheter: | 1 | 2 | 3 | 4 |
|--|---|---|---|---|
| (1) Female   |   |   |   |   |
| (2) Male   |   |   |   |   |
| Management of Drug/Alcohol Detox Symptoms          |   |   |   |   |
| Management of Assaultive Behavior                  |   |   |   |   |
| Multi-disciplinary Treatment Team Participation    |   |   |   |   |
| 02 Therapy & Medication Delivery Systems           |   |   |   |   |
| (1) Bag and Mask                                   |   |   |   |   |
| (2) External CPAP                                  |   |   |   |   |
| (3) Face Masks                                     |   |   |   |   |
| (4) Inhalers                                       |   |   |   |   |
| (5) Nasal Cannula                                  |   |   |   |   |
| (6) Portable 02 Tank                               |   |   |   |   |
| (7) Trach Collar                                   |   |   |   |   |
| Oro-naso-pharynx Suctioning                        |   |   |   |   |
| Participation in milieu Therapy                    |   |   |   |   |
| Patient Teaching                                   |   |   |   |   |
|  |   |   |   |   |
|  |   |   |   |   |
|  |   |   |   |   |

Ambulatory Nursing  
Skills Checklist (page 2)

| <b>Skills Continued:</b>                               | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|--|----------|----------|----------|----------|
| Psychiatric Emergency Response Team                    |          |          |          |          |
| Psychiatric Home Health                                |          |          |          |          |
| Rapid Tranquilization                                  |          |          |          |          |
| <b>Restraints, Application &amp; Assessment of:</b>    |          |          |          |          |
| (1) Ambulatory Cuffs                                   |          |          |          |          |
| (2) Full Restraints                                    |          |          |          |          |
| (3) Wrist Restraints                                   |          |          |          |          |
| Telephonic Crisis Intervention                         |          |          |          |          |
| Therapeutic Communication Skills                       |          |          |          |          |
| Tube Feeding   |          |          |          |          |
| <b>3. Care of the Patient with:</b>                    |          |          |          |          |
| Alcohol Dependency                                     |          |          |          |          |
| Drug Dependency  |          |          |          |          |
| Electroconvulsive Therapy                              |          |          |          |          |
| Hallucinations   |          |          |          |          |
| Manic Behavior   |          |          |          |          |
| Med-psych Patient                                      |          |          |          |          |
| Organic Disorder                                       |          |          |          |          |
| Partial Hospital/ Intensive Outpatient Program Patient |          |          |          |          |
| Seclusion and Restraints                               |          |          |          |          |
| Seizure Disorder                                       |          |          |          |          |
| Suicidal Behavior                                      |          |          |          |          |
| Tracheostomy   |          |          |          |          |

| <b>Skills Continued:</b>                        | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|---|----------|----------|----------|----------|
| <b>4. Medications:</b>                          |          |          |          |          |
| Administration of Oral Psychotropic Medications |          |          |          |          |
| Heparin   |          |          |          |          |
| Intramuscular                                   |          |          |          |          |
| Management of Extrapyrarnidal Symptoms (EPS)    |          |          |          |          |
| Oral  |          |          |          |          |
| Rectal  |          |          |          |          |
| Sub-q   |          |          |          |          |
| Unit Dose                                       |          |          |          |          |
| Z-technique                                     |          |          |          |          |
| <b>B. Phlebotomy/IV Therapy</b>                 |          |          |          |          |
| <b>Equipment and Procedures:</b>                |          |          |          |          |
| <b>Administration of Blood/Blood Products:</b>  |          |          |          |          |
| (1) Packed Red Blood Cells                      |          |          |          |          |
| (2) Whole Blood                                 |          |          |          |          |
| Drawing Blood from Central Line                 |          |          |          |          |
| Drawing Venous Blood                            |          |          |          |          |
| Management of patient w/ Hyperalimntation       |          |          |          |          |
| Management of Patient with IV                   |          |          |          |          |
| <b>Starting IVs:</b>                            |          |          |          |          |
| (1) Angiocath                                   |          |          |          |          |
| (2) Butterfly                                   |          |          |          |          |
| (3) Heparin Lock                                |          |          |          |          |

| <b>1. Age Specific Practice Criteria</b>  | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> |
|---|----------|----------|----------|----------|
| Newborn/Neonate (birth – 30 days)   |          |          |          |          |
| Infant (30 days – 1 year)   |          |          |          |          |
| Toddler (1 – 3 years)   |          |          |          |          |
| Preschooler (3 – 5 yrs)   |          |          |          |          |
| School age children (5 – 12 years)  |          |          |          |          |
| Adolescents (12 – 18 years)   |          |          |          |          |
| Young Adults (18 – 39 years)  |          |          |          |          |
| Middle Adults (39 – 64 years)   |          |          |          |          |
| Older Adults (64+ years)  |          |          |          |          |
| <b>2. Care of Patient with:</b>   |          |          |          |          |
| 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 groups.                                   |          |          |          |          |
|   |          |          |          |          |

**Certification:**

Please check the boxes below and indicate the expiration date for each certificate that you hold. If you do not know the exact date, please use the last date of the specific month (i.e. 1/31/2007).

| <b>Certification:</b>            | <b>Expiration Date:</b> |
|----------------------------------|-------------------------|
| BCLS                             |                         |
| MAB                              |                         |
| Computerized charting system     |                         |
| Medication administration system |                         |
| Other:                           |                         |
|                                  |                         |

I hereby certify all statements and claims as true and that any misrepresentation of the facts on this checklist is sufficient cause for dismissal at any time without prior notice even if I have been already employed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name (Print)