



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**LICENSED VOCATIONAL NURSE SKILLS CHECKLIST**

- 1 = No Experience
- 2 = Perform infrequently (would require some supervision)
- 3 = Able to perform without any supervision

	1	2	3
<b>1. EMERGENCY PROCEDURES</b>			
A. CPR			
B. Ambu Bag			
<b>2. MEDICATION ADMINISTRATION</b>			
a. Unit Dose			
b. Oral			
c. Intramuscular			
d. Z Track			
e. Intradermal			
f. Charting Medications Given			
g. Charting Outcomes of Medications			
<b>3. DIRECT PATIENT CARE</b>			
a. Bed Making			
b. Bed Bath			
c. Oral Hygiene			
d. Vital Signs			
e. Bed Scale			
f. Range of Motion			
g. Turning			
h. Intake & Output			
i. Feeding Patient			
j. Decubitus Care			
k. Use of One-Touch Glucometer			
<b>4. ASEPTIC TECHNIQUE</b>			
A. Urinary Catheters			
1. Insertion – Female			
2. Insertion – Male			
3. Supra-Pubic			
4. Irrigation			

	1	2	3
B. Dressings			
1. Sterile			
2. Unsterile			
C. Infection Control Procedures			
<b>5. TUBES, INSERTION OF &amp; DRAINAGE</b>			
A. Nasogastric			
B. Feeding Tubes			
C. Chest Tubes (drainage only)			
D. Penrose Drain			
E. Pleur-Evac			
F. T-Tube			
G. Hemovac			
H. Technique & equipment to suction Emerson, Gomco, Wall-suction			
I. Rectal Tube			
<b>6. ENEMAS, TAP H2O, S.S., FLEETS</b>			
<b>7. NEUROLOGICAL SIGNS</b>			
a. Glasgow Coma Scale			
<b>8. RESPIRATORY</b>			
a. O2, Mask & Prongs			
b. Nebulizers			
c. IPPB			
d. Respirators – MA-1 Bird			
e. Percussion, Drainage			
F. Suction – Nasotracheal & Endotracheal			
G. Trach Care			
<b>9. INFUSIONS – TYPE &amp; METHOD</b>			
a. Care of IV site			
b. IV insertion			
c. Discontinuing IV site			

**LICENSED VOCATIONAL NURSE SKILLS CHECKLIST**

	1	2	3
d. "Adding on" IV fluid with medication			
e. Use of Butterfly Needle			
f. Pump/Controller			
g. Regulating IV drip rate			
<b>10. TELEMETRY AREAS ONLY</b>			
A. Perform 12 Lead EKG			
B. Telemetry Lead Placement			
<b>11. DOCUMENTATION</b>			
A. Focus Charting			
B. Meditech Computer System			
C. 24-Hour Patient Care Record			
D. Nursing Care Plans			
E. Flow Sheets			

Have had one year experience in this area within the last three years:

Yes \_\_\_\_\_ No \_\_\_\_\_

**CERTIFICATIONS:**

CPR \_\_\_\_\_ EXP DATE: \_\_\_\_\_

ACLS \_\_\_\_\_ EXP DATE: \_\_\_\_\_

OTHERS \_\_\_\_\_ EXP DATE: \_\_\_\_\_

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Premier Nursing Service to release this list to its client health care facilities.

\_\_\_\_\_  
Signature Date

Authentication By Agency:

\_\_\_\_\_  
DON Signature Date