



## EMERGENCY ROOM SKILLS CHECKLIST

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

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

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

	1	2	3
<b>1. EMERGENCY PROCEDURES</b>			
A. CPR			
B. ACLS			
C. Defibrillation			
<b>2. CARDIAC</b>			
A. EKG – 12 Lead			
B. Familiarity with Marquette Monitors			
C. Lead Placement			
D. Dysrhythmia Recognition – Basic & External			
E. Use of Pacemakers– Transvenous & Advanced			
F. Assist with Cardioversion			
G. Auscultation of Heart Sounds			
H. Intra-aortic Balloon Pump Management			
I. AICD			
<b>3. ARTERIAL LINES</b>			
A. Assembly			
B. Calibration Monitor			
C. Wave Forms			
D. Arterial Blood Gas – Collection from Arterial Line			
E. Interpretation of ABG Results			
<b>4. RESPIRATORY</b>			
A. Assess Breath Sounds			
B. Endotracheal Tubes			
1. Care			
2. Suction			
3. Assist with Insertion			
4. Familiarity with Weaning Protocols			
5. Assist with Removal			
C. Care of Patient on Respirator			
1. MA-1			
2. Bear-1, Bear-2			

	1	2	3
3. Bennett 7200			
4. PEEP			
5. IMV			
6. Servo			
D. Post-Thoracentesis Care			
E. Chest Tube Management			
1. Suction, Pleur-Evac			
2. Autotransfusion Using Cell-Saver			
<b>5. RENAL</b>			
A. Peritoneal Dialysis			
1. Automatic			
2. Manual			
3. Record Exchanges			
B. Hemodialysis			
1. Care of A-V Access, Patency, Dressing			
2. Assist with Insertion & Care of Quinton Catheter			
C. Genito-Urinary Assessment Skills			
D. Glasgow Coma Scale			
<b>6. NEUROLOGY</b>			
A. Neurologic patient Assessment Skills Including Neuro Checks			
B. Glasgow Coma Scale			
C. Crutch field Tongs			
D. Increased Intracranial Pressure – Monitoring & Management			
<b>7. INFUSIONS – TYPE &amp; METHOD</b>			
A. Blood			
B. Blood Products			
C. Hyper alimentation			
D. IV Push - Bolus			
E. IV Piggyback - Additives			
F. Heparin Locks			
G. Use of Intra-caths, Medicuts			

## EMERGENCY ROOM SKILLS CHECK LIST

	1	2	3
H. Butterfly			
I. Assist with Central Line Insertion			
J. Venous Blood Drawing			
K. Intravenous Infusion Pumps/Controllers			
L. P.C.A. Pumps			
<b>8. PULMONARY ARTERY LINE MANAGEMENT</b>			
A. Assembly			
B. Patency			
C. Calibration			
D. Assist with Insertion of P.A. Catheter			
E. Pressure Reading			
F. Calculation of :			
1. Cardiac Index			
2. Cardiac Output			
3. SVR			
<b>9. CVP</b>			
A. Assembly			
B. Readings			
<b>10. IV DRUG INFUSION</b>			
A. Lidocaine			
B. Pronestyl			
C. Bretylium			
D. T.P.A.			
E. Osmolal			
F. Cardizem			
G. Adenonine			
H. Epinephrine			
I. Levophed			
J. Dopamine			
K. Dobutamine			
L. Isuprel			
M. Nitride			
N. Heparin			

	1	2	3
O. Neosynehrine			
P. Urokinase			
Q. Streptokinase			
R. Fentanyl			
<b>11. MISCELLANEOUS</b>			
A. Access Bowel Sounds			
B. Insertion of Folly Catheters			
C. Use of Hemovac			
D. Post-paracentesis Care			
E. Specific Gravity			
F. Use of One-Touch Glucometer			
<b>12. DOCUMENTATION</b>			
A. Use of Critical Care Flow Sheet			
B. Nursing Care Plans			
C. Focus Charting			
D. Meditech Computer Training			
E. Post Anesthesia Recovery Record			
<b>EMERGENCY ROOM</b>			
<b>1. EMERGENCY MANAGEMENT OF PATIENT WITH:</b>			
a. Head Trauma			
b. Seizure Disorder			
c. Cardiogenic Shock			
d. Aneurysm			
e. Near Drowning			
f. Smoke Inhalation			
g. Chemical Exposure			
h. Septic Shock			
i. Anaphylactic Shock			
j. Hypovolemic Shock			
k. Neurgenic Shock			
l. ETOH Intoxication			

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C. Acute Psychotic Events (Attempt Suicide, Depression, etc.)			
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	1	2	3
n. Pediatric Emergency			
o. Multiple Trauma			
<b>p. Orthopaedic Injury Including application of Splints, Immobilizers, etc.</b>			
<b>q. MAST Suit – Application &amp; Removal</b>			
r. Burns			
<b>2. ASSISTANCE WITH PROCEDURES INCLUDING REQUIRED LEGAL DOCUMENTATION OF:</b>			
a. Sexual Assault			
b. Psychiatric Legal Holds (5150, 5250)			
c. Patients in Police Custody			
d. Child Abuse			
e. Elder Abuse			
f. Blood Drawing for Police Purposes			

**NUMBER OF YEARS EXPERIENCE:**

ICU \_\_\_\_\_ CCU \_\_\_\_\_ Recovery Room \_\_\_\_\_

**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:

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DON Signature Date