



MEDICAL/SURGICAL/TELEMETRY SKILLS CHECKLIST

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

Name: _____

Date: _____

| | 1 | 2 | 3 |
|--------------------------------------|---|---|---|
| 1. EMERGENCY PROCEDURES | | | |
| A. CPR | | | |
| B. Defibrillation | | | |
| C. Ambu Bag | | | |
| 2. MEDICATION ADMINISTRATION | | | |
| A. Unit Dose | | | |
| B. Oral | | | |
| C. Intramuscular | | | |
| D. Subcutaneous | | | |
| E. Z Tract | | | |
| F. Intravenous Push | | | |
| G. IV Piggyback - Additives | | | |
| H. Charting medications with results | | | |
| 3. DIRECT PATIENT CARE | | | |
| 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. One Touch Glucometer | | | |
| 4. ASEPTIC TECHNIQUE | | | |
| 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 | | | |
| D. Isolation Techniques | | | |
| 1. Skin & Wound | | | |
| 2. Strict | | | |
| 3. Respiratory | | | |
| 4. Enteric | | | |
| 5. Reverse | | | |
| 6. Universal Precautions | | | |
| 5. TUBES, INSERTION OF & DRAINAGE | | | |
| A. Nasogastric | | | |
| B. Feeding Tubes | | | |
| C. Chest Tubes | | | |
| D. Penrose Drain | | | |
| E. Pleur-Evac | | | |
| F. T-Tube | | | |
| G. Hemovac | | | |
| H. Technique & equipment to suction Emerson, Gomco, Wall-suction | | | |
| I. Rectal Tube | | | |
| 6. ENEMAS, TAP H2O, S.S., FLEETS | | | |
| 7. NEUROLOGICAL SIGNS | | | |
| 8. RESPIRATORY | | | |
| A. O2, MASK & PRONGS | | | |
| B. NEBULIZERS | | | |
| C. IPPB | | | |
| D. RESPIRATORS – MA-1 BIRD | | | |
| E.. PERCUSSION, DRAINAGE | | | |
| F. SUCTION – NASOTRACHEAL & ENDOTRACHEAL | | | |
| G. TRACH CARE | | | |

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| | 1 | 2 | 3 |
|---|---|---|---|
| 9. INFUSIONS – TYPE & METHOD | | | |
| A. Blood | | | |
| B. Blood Products | | | |
| C. Hyper alimentation | | | |
| D. Butterfly | | | |
| E. Intravenous Catheters | | | |
| F. Heparin Locks | | | |
| G. Pump/Controller | | | |
| H. Care of IV Site | | | |
| I. PCA Machines | | | |
| 10. TELEMETRY AREAS ONLY | | | |
| A. Perform 12 Lead EKG | | | |
| B. Telemetry Lead Placement | | | |
| C. Dysrhythmia Recognition | | | |
| D. Care of Patients on Lidocaine Bolus & Drip | | | |
| 11. DOCUMENTATION | | | |
| A. Focus Charting | | | |
| B. Meditech Computer System | | | |
| C. 24-Hour Patient Care Record | | | |
| D. Nursing Care Plans | | | |
| E. Flow Sheets | | | |

NUMBER OF YEARS EXPERIENCE:

MS _____ Tele _____

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