PSYCHIATRIC SKILLS CHECKLIST FOR LICENSED NURSES

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

Name: ______________________________
Date: ______________________________

	1	2	3
STANDARD I: ASSESSMENT (The Nurse Collects Patient Health Data)			
I. Performs a mental status assessment on admission, and at least every shift, and as condition warrants			
A. Criteria:			
1. Assess patient's appearance			
2. Assess patient's behavior			
3. Assess patient's speech			
4. Assess patient's attitude			
5. Assess patient's affect and mood			
6. Assess patient's thought content			
7. Assess patient's insight			
8. Assess patient's judgement			
9. Assess patient's orientation			
10. Assess patient's recent and remote memory			
11. Assess patient's intellect			
12. Documents all pertinent information			
II. Obtains a psychological assessment on admission, and as patient's condition warrant			
A. Criteria:			
1. Documents patient's statement regarding reasons for hospitalization			
2. Documents prior health history			
3. Elicits patient's expectation of hospitalization			
4. Records substances used related to alcohol, drugs and tobacco			
5. Elicits information related to legal issues and courts dates			
6. Identifies ethnic, cultural, and/or religious beliefs, and documents these needs in Plan care			
III. Performs a neurological assessment on admission, and as patient's condition warrants			
A. Criteria:			
1. Assess patient's orientation			
2. Assess verbal responses			
3. Assess strength of upper and lower extremities			
4. Assess pupillary response to light			
5. Identify and describe seizure activity			
6. Document all pertinent information			
IV. Performs a respiratory assessment on admission, and as patient condition warrants			
A. Criteria:			
1. Assess the presence of cough and sputum production			
2. Assess shortness of breath			
3. Assess for flu or respiratory infection within the last two (2) weeks			
4. Documents all pertinent information			
V. Performs a cardiovascular assessment on admission, and as patient's condition warrants			
A. Criteria:			
1. Assess pulse			
2. Evaluates blood pressure, normal vs. abnormal			
3. Assess for peripheral edema			
4. Documents all pertinent information			
VI. Performs a gastrointestinal assessment on admission, and as patient's condition warrants			
A. Criteria:			
1. Assess bowel and bladder status			
2. Documents all pertinent information			
VII. Evaluates nutritional status on admission, and as patient's condition warrants			
A. Criteria:			
1. Assess change in appetite			
2. Assess for recent weight changes			
3. Assess skin rurgor			
4. Identifies dietary needs			
5. Document all pertinent information			

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VIII. Performs a genitourinary assessment on admission, and as patient's condition warrants			
A. Criteria:			
1. Assess for signs and symptoms of infection (e. g., frequency, urgency, pain and/or burning)			
IX. Performs a musculoskeletal assessment on admission & as patient's condition warrants			
A. Criteria			
1. Evaluates musculoskeletal weakness			
2. Establishes safety interventions			
3. Documents all pertinent information			
X. Performs a sensory assessment on admission and as patient's condition warrants			
A. Criteria			
1. Assess hearing deficit			
2. Assess visual deficit			
3. Documents all pertinent information			
XI. Performs a skin assessment on admission, and as patient's condition warrants			
A. Criteria			
1. Assess for skin integrity			
2. Initiates interventions for skin integrity deficits			
3. Document all pertinent information			
STANDARD II: DIAGNOSIS (The Nurse Analyzes the Assessment Data in Determining Diagnosis)			
I. Interprets and selects pertinent assessment data and sets priorities with patient and family			
A. Criteria			
1. Incorporates, with clinical pathway when appropriate, and obtains signature of patient			
2. Documents appropriate diagnosis in Plan of Care			
II. Identifies nursing diagnosis pertinent to assessment date			
A. Criteria			
1. Incorporates Plan of Care into Progress Note			
2. Document all pertinent information			

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STANDARD III: OUTCOME IDENTIFICATIONS (The Nurse Identifies Expected Outcomes Individualized to the Patient)			
I. Documents expected outcomes pertinent to plan of care on each shift			
A. Criteria			
1. Documents in the Progress Notes the patient outcomes or diagnosis relating o the Plan of Care			
II. Provides selected educational information related to disease process, and can provide patient instruct-ions for home care needs to and family before discharge			
A. Criteria			
1. Uses available educational material when appropriate			
III. Provides appropriate referrals, which includes one of the following, when appropriate			
A. Criteria			
1. Dietary			
2. Social Services			
3. Case Management			
4. Physical Therapy			
5. Occupational Therapy			
6. Home Health			
IV. Maintains a safe environment, and institutes safety measures for potential or recognized **physical limitations**			
1. Assess for orientation and comprehensive ability			
2. Apply restraints properly			
STANDARD IV: PLANNING The Nurse Develops a Plan of Care that Prescribes Interventions to Attain Expected Outcomes			
I. Establishes as initial plan of care on admission			
A. Criteria			
1. Participation in updating care plan every seven (7) days after the initial 72 hours after admission			
II. Initiates discharge planning on admission			
A. Criteria			
1. Documents discharge planning			
2. Documents discharge planning information on admission assessment			

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III. Delegates and supervises nursing care activities to healthcare team based on qualifications and patient needs			
A. Criteria			
1. Makes patient assignment			
2. Provides verbal instructions for daily patient care with the first hour after report			
3. Incorporate team activities into verbal report			
4. Documents collaboration with support services			
5. Documents all pertinent information			
STANDARD V: IMPLEMENTATION (The Nurse Implements the Interventions Identified In the Plan of Care)			
I. Provides safe medication administration			
A. CRITERIA			
1. Transcribes doctors medication orders on MAR(Medication Administration Record)			
2. Obtains order clarification for questionable medication orders			
3. Documents medication refused or held, and reasons why.			
4. Obtains and documents apical pulse when administering Digoxin			
5. Observes administration of medica-tion According to the five (5) rights:			
a. Right dose			
b. Right medication			
c. Right patient			
d. Right time			
e. Right route			
6. Obtains and documents BP when administering anti -hypertensive medication			
7. Notifies physician when BP is higher or lower than established parameters			
8. Evaluates and documents the patient's response to analgesic medication within one (1) hour			
9. Lock Medication Room after each use and carries key on person at all times			
10. Dates, times, and initials multidose vial upon opening			

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11. Obtains order when change in form of medication (e.g., crushing tablets)			
12. Transcribes, documents and administers medication according to approved medication schedule			
13. Acquires a second signature for the following medications:			
a. Insulin			
b. Drug Waste (Narcotic controlled Substance)			
c. Heparin			
14. Counts narcotics at the end of the shift			
15. Completes narcotics audit on medication controlled substance record			
16. Ensures appropriate signatures have been obtained from the patient, prior to administering psychiatric medication			
II. Provides safe intravenous administration			
A. CRITERIA			
1. Starts three (3) venipunctures using aseptic technique using the ff. ;			
a. Heparin lock			
b. Flowing I.V.			
2. Change tubing within 72 hours			
3. Change I.V. sites in 72 hours or documents exception			
4. Labels intravenous with the ff.:			
a. Patient's name			
b. Date			
c. Type of solution			
d. Time			
e. Route of infusion			
f. Tubing change sticker			
5. Change I.V. solution in 24 hours			
6. Changes transparent dressing in 24 hours			

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III. Provides safe administration of blood products			
A. CRITERIA			
1. Selects the correct I.V. catheter for blood administration			
2. Selects the correct I.V. fluid to prime the blood tubing			
3. Starts blood within 15 minutes from the time obtained from Lab			
4. Before administration verifies blood unit with two (2) licensed personnel			
5. Vital signs are recorded:			
a. In 15 minutes after beginning administration			
b. Hourly after the first 15 minutes			
STANDARD VI (The Nurse Evaluates the Patient's Progress Toward Attainment of Outcomes)			
I. Provides accurate documentation in a patient medical record			
A. CRITERIA			
1. Admission assessment			
2. Plan of Care			
3. Medication record routine/PRN			
4. Legal documents/consents			
5. Kardex			
6. Patient Progress Record			
7. Discharge instructions and checklist			
II. Participates in the unit-specific performance improvement plan			
A. CRITERIA			
1. Reviews and completes a minimum of four (4) years chart audits per month			

I believe the above represent my current skills.

Signature Date

I believe the above represents competency validation for the above clinical criteria.

Manager/Director Signature Date

Authentication by Facility:

Signature Date