



## PSYCHIATRIC NURSING SKILLS CHECKLIST

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

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

### INSTRUCTIONS

Please provide accurate answers so we can correctly match your abilities to our client job requirements. Please check the level of experience and expertise you have in each skill category, using the following scale:

**#1 = Familiar with procedure but will usually or almost always require some assistance.**

**#2 = Competent and familiar with procedure:** I can perform this procedure with excellence, usually without assistance.

**#3 = Very competent:** I have at least 12 months experience and can perform this procedure with excellence and without assistance.

**NOTE:** Leave blank any procedures which you have **no experience, training or low competence.**

SKILLS:	1	2	3
<b>A. Psychiatric</b>			
<b>1. Assessment</b>			
<b>Admission:</b>			
Initial nursing assessment & care plan			
Initial treatment plan			
Neurological vital signs			
Nursing diagnoses			
Nursing reassessment & care planning update			
Suicide risk assessment			
<b>2. Equipment &amp; 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/goal oriented			
Discharge planning			
Electroconvulsive therapy			
Group therapy leader			
<b>Insertion and care of straight and Foley catheter:</b>			
(1) Female			
(2) Male			
Management of drug/alcohol detox symptoms			
Management of assaultive behavior			
Multi-disciplinary treatment team participation			
O <sub>2</sub> therapy & medication delivery systems			

SKILLS:	1	2	3
(1) Bag and mask			
(2) External CPAP			
(3) Face masks			
(4) Inhalers			
(5) Nasal cannula			
(6) Portable O <sub>2</sub> tank			
(7) Trach collar			
Oro-naso-pharynx suctioning			
Participation in milieu therapy			
Patient teaching			
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			

<b>SKILLS:</b>	<b>1</b>	<b>2</b>	<b>3</b>
Tracheostomy			
<b>4. Medications:</b>			
Administration of oral psychotropic medications			
Heparin			
Intramuscular			
Management of extrapyramidal symptoms (EPS)			
Oral			
Rectal			
Sub - q			
Unit dose			
Z-technique			
<b>B. Phlebotomy/IV Therapy</b>			
<b>Equipment &amp; 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/ hyperalimantation			
Management of patient with IV			
<b>Starting IVs:</b>			
(1) Angiocath			
(2) Butterfly			
(3) Heparin lock			

<b>SKILLS:</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>1. Age Specific Practice Criteria</b>			
Newborn/Neonate (birth - 30 days)			
Infant (30 days - 1 yr)			
Toddler (1 - 3 yrs)			
Preschooler (3 - 5 yrs)			
School age children (5 - 12 yrs)			
Adolescents (12 -18 yrs)			
Young Adults (18-39 yrs)			
Middle Adults (39 - 64 yrs)			
Older Adults (64+ yrs)			
<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 (e.g., 05/31/2003).

<b>Certification</b>	<b>Expiration Date/ or Date of:</b>
<input type="checkbox"/> BCLS	
<input type="checkbox"/> MAB	
<input type="checkbox"/> Other (type):	
<input type="checkbox"/> Computerized charting system:	
<input type="checkbox"/> Medication administration system:	

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

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

Signature: \_\_\_\_\_  
Retyped name acts as signature, if submitting form by email

Reviewed by \_\_\_\_\_: Date: \_\_\_\_\_