



## Psychiatric Skills Assessment Checklist

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

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

Please indicate your level of experience

A. Theory, no practice	C. One - two years experience
B. Intermittent experience	D. Two plus years experience

### 1. Psychiatric

#### a. Assessment

- |  |   |   |   |   |
|--|---|---|---|---|
| i. Admission                                 | A | B | C | D |
| ii. Initial nursing assessment and care plan | A | B | C | D |
| iii. Initial treatment plan                  | A | B | C | D |
| iv. Neurological vital signs                 | A | B | C | D |
| v. Nursing diagnoses                         | A | B | C | D |
| vi. Nursing care plan updates                | A | B | C | D |
| vii. Suicide risk assessment                 | A | B | C | D |

#### b. Equipment & procedures

- |   |   |   |   |   |
|---|---|---|---|---|
| i. Participation in multi-disciplinary staffing       | A | B | C | D |
| ii. Assist physician in administration of             |   |   |   |   |
| 1. electroconvulsive therapy                          | A | B | C | D |
| iii. Assist with lumbar puncture                      | A | B | C | D |
| iv. Cardiopulmonary resuscitation                     | A | B | C | D |
| v. Charge nurse experience                            | A | B | C | D |
| vi. Charting  |   |   |   |   |
| 1. Behavioristic                                      | A | B | C | D |
| 2. Treatment/goal oriented                            | A | B | C | D |
| 3. Discharge planning                                 | A | B | C | D |
| 4. Electroconvulsive therapy                          | A | B | C | D |
| vii. Group therapy leader                             | A | B | C | D |
| viii. Insertion & care of straight and Foley catheter |   |   |   |   |
| 1. Female   | A | B | C | D |
| 2. Male   | A | B | C | D |
| ix. Manage drug/alcohol detox symptoms                | A | B | C | D |
| x. Management of assaultive behavior                  | A | B | C | D |
| xi. Multi-disciplinary team participation             | A | B | C | D |
| xii. O2 therapy & medication delivery systems         |   |   |   |   |
| 1. Bag and mask                                       | A | B | C | D |



	2.	External CPAP	A	B	C	D
	3.	Face masks	A	B	C	D
	4.	Inhalers	A	B	C	D
	5.	Nasal cannula	A	B	C	D
	6.	Portable O2 tank	A	B	C	D
	7.	Trach collar	A	B	C	D
	xiii.	Oro-naso-pharynx suctioning	A	B	C	D
	xiv.	Participation in milieu therapy	A	B	C	D
	xv.	Patient teaching	A	B	C	D
	xvi.	Psychiatric emergency response team	A	B	C	D
	xvii.	Psychiatric home health	A	B	C	D
	xviii.	Rapid tranquilization	A	B	C	D
	xix.	Restraints, application and assessment of				
		1. Ambulatory cuffs	A	B	C	D
		2. Full restraints	A	B	C	D
		3. Wrist restraints	A	B	C	D
	xx.	Telephonic crisis intervention	A	B	C	D
	xxi.	Therapeutic communication skills	A	B	C	D
	xxii.	Tube feeding	A	B	C	D
c.		Care of the patient with:				
d.		Alcohol dependency	A	B	C	D
	i.	Drug dependency	A	B	C	D
	ii.	Electroconvulsive therapy	A	B	C	D
	iii.	Hallucinations	A	B	C	D
	iv.	Manic behavior	A	B	C	D
	v.	Med-psych patient	A	B	C	D
	vi.	Organic disorder	A	B	C	D
	vii.	Partial hospital/intensive outpatient patient	A	B	C	D
	viii.	Seclusion and restraints	A	B	C	D
	ix.	Seizure disorder	A	B	C	D
	x.	Suicidal behavior	A	B	C	D
	xi.	Tracheostomy	A	B	C	D
e.		Medications				
	i.	Administer oral psychotropic medications	A	B	C	D
	ii.	Heparin	A	B	C	D
	iii.	Intramuscular (IM)	A	B	C	D
	iv.	Manage of extrapyramidal symptoms (EPS)	A	B	C	D
	v.	Oral (PO)	A	B	C	D
	vi.	Rectal	A	B	C	D
	vii.	Subcutaneous (SQ)	A	B	C	D
	viii.	Unit dose	A	B	C	D



ix. Z-technique (IM) A B C D

**2. Phlebotomy / IV Therapy**

a. Equipment & procedures

i. Administration of blood/blood products

1. Packed red blood cells A B C D

2. Whole blood A B C D

ii. Drawing blood from central line A B C D

iii. Drawing venous blood A B C D

iv. Manage patient with hyperalimantation A B C D

v. Management of patient with IV A B C D

vi. Starting IVs

1. Angiocath A B C D

2. Butterfly A B C D

3. Heparin lock A B C D

**Certification:**

Please read and agree to the statements below by signing and dating the bottom of this form.

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize RN Exclusive to release this Skills Checklist to the Client facilities in relation to consideration of employment with those facilities.

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