

MSI HEALTH INTERNATIONAL.

RPN NURSING SKILLS CHECKLIST

The following checklist is used to assess your experience and skills. Please provide a self-assessment of your skills using the following guidelines: **(MARK WITH AN "X")**

1 - No experience

2 - Require training

3 - Have performed this task and able to perform without supervision

4 - Experienced and able to perform independently

I understand that the information provided in this application is true to the best of my knowledge. I authorize the release of the information in this document to Master Staffing, Inc. and the facilities where I may be employed.

Name -

Date -

CARDIAC				
	1	2	3	4
1. Obtaining 12 lead EKG				
2. Interpreting 12 lead EKG				
3. Arrhythmia Interpretation				
4. Assisting with Cardio version				
5. Defibrillation				
6. Arrest/Resuscitation Management				
7. Interpreting Heart sounds				
8. Care, maintenance and monitoring of Swan Ganz Catheters				
9. Care of Post Open Heart Surgery Patients				
10. Care and monitoring of Balloon Pump Patients				
11. Assist and care of Temporary Pacemaker Recipients				
12. Titration of Medications:				
Dopamine				
Dobutrex				
Levophed				
Isuprel				
Lidocaine				
Epinephrine				
Digitalis				
Bretyllium				
Nipride				
13. Setup and assist for Swan Ganz Catheter Insertion				
14. Setup and assist for Arterial Line Catheter Insertion				
15. Care of patient in shock				
16. Care of patient with Fresh or Extending MI				
RESPIRATORY				
1. Endotracheal intubation				
2. Endotracheal extubation				
3. Care/maintenance of Tracheal Tubes				
4. Care of Ventilator Patients				
5. Care of patients Weaning from Ventilator				
6. Care of patients with Pulmonary Edema				
7. Care of patients with Adult Respiratory Distress Syndrome (ARDS)				

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8. Suctioning of Tracheal and Endotracheal Tubes					
9. Chest Tube Insertions					
10. Care of patients with chest tubes					
11. Drawing ABG's					
12. Interpreting ABG's					
NEURO					
1. Neuro Vital Signs					
2. ICP Monitors					
3. Care and assessment of Fresh CVA Patients					
4. Care of patients with Closed Head Injuries					
5. Post Op care of patient with Craniotomy					
6. Care of patients with Seizures					
7. Care of patients with Spinal Trauma					
8. Care of patients with Halo Traction					
9. Care of patients with Cruthchfield Tongs					
GASTRO					
1. Care, maintenance and insertion of NG Tubes					
2. Care, maintenance and reinsertion of G Tubes					
3. Care of patients with Duodenal Tubes					
4. Care of patients with Blakemore Tube					
5. Care of patients with Miller Abbot Tube					
6. Care of patients with GI Bleeding					
RENAL					
1. Care of Hemodialysis patients					
2. Care of Peritonealdyalysis patients					
3. Care of CAVH patients					
4. Care of Supra Pubic Catheters					
5. Care of patients with Renal Failure					
6. Care of patients with Nephrectomy					
PHLEBOTOMY					
1. Starting IV's					
2. Using Heplock/Salinelock					
3. Using Infusion Pumps					
4. Administering Blood Products					
5. Administering Hyperal/TPN					
FIRST AID					
Identify and Respond to:					
Bleeding					
Burns					
Cardiac arrest					

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Respiratory arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic coma/insulin shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syncope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NUTRITION					
Basic principles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Special needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AGE SPECIFIC PRACTICE CRITERIA Please Check-OFF if you have experience with the following.					
Adapts care to incorporate normal growth/dev of:					
Newborn/Neonate(birth - 30 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant(30 days - 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toddler(1-3 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preschooler(3-5 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School age children(5-12 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents(12-18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young Adults(18-39 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adults(40-64 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Older Adults(65-80 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eldest Adults(80+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adapts method/terminology of pt. instr to comprehension level of:					

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Newborn/Neonate(birth - 30 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant(30 days - 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Older Adults(65-80 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eldest Adults(80+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensures a safe environment reflecting specific needs of:					
Newborn/Neonate(birth - 30 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant(30 days - 1 year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toddler(1-3 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Adolescents(12-18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young Adults(18-39 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Eldest Adults(80+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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- I certify that all of the above information is correct and that any misrepresentation or falsification of fact may be considered sufficient cause for Immediate dismissal from _____.
I have filled out this skills checklist to the best of my knowledge and agree that all of the information Provided is correct (please check box).

NAME (Please Print Clearly)

DATE

SIGNATURE
LICENSE NUMBER

When you have completed the application form, below.

To send this form please completed this form then go to save as type your title and first and last name save this into your documents or any file so wish.. You will be able to email this form back to richard@msinursing.com we hope this will save you time.