



TELEMETRY SKILLS CHECKLIST

Date: _____

Applicant's Name: _____ FIRST MIDDLE INITIAL LAST

To Assignment America's Healthcare Professionals:

The purpose of the following checklist is to assist in matching your skills and interests with available assignments, thus meeting your needs and the needs of our clients as much as possible. Your employment is not dependent upon responses given in this checklist.

**Please make sure this Skills Checklist is signed and dated.

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize Assignment America, to release this Skills Checklist to client institutions of Assignment America, in relation to my employment with that institution.

Signature _____ Date _____

To Assignment America's Client Institution:

Assignment America has developed unique skills checklists for each nursing specialty. This checklist is not necessarily a valid indicator of clinical skills and should not be utilized as the sole measure of the ability of an individual to perform the duties of a registered nurse or therapist in your facility. It is intended to be used only as a guide in your screening procedures and in orientation to procedures within your institution.

PLEASE MARK YOUR LEVEL OF EXPERIENCE [X]

- 1 No Experience: Observed Only
2 Limited Experience: Performs < 6 Times Per Year; Needs Review
3 Moderate Experience: Performs 1-2 Times/Month; May Need Minimal Resource
4 Highly Experienced: Performs on Daily or Weekly Basis; Proficient

Table A: Medication Administration. Mark One. 1. Pouring from Stock Medications, 2. Narcotic Administration, 3. Use of Pyxis, 4. IV Push Medications, 5. IV Medications: a. Antibiotics, b. Narcotics, c. Chemotherapy.

Table B: Phlebotomy/IV Therapy. Mark One. 1. Draw Blood: a. Arterial Stick, b. Central Line, c. Venous Line, 2. Obtain IV Access, 3. Discontinue Peripheral IV, 4. Mix IV Medications, 5. Regulating IV's, 6. Use of IV Infusion Pumps.

Table C: Cardiovascular. Mark One. 7. PCA Pumps (Patient Controlled Analgesia), 8. Continuous Subcutaneous Infusion Pumps, 9. Central Line Dressing Changes, 10. Multi-Lumen Central Catheters, 11. Port-A-Caths (Infusa-Ports), 12. CVP Lines - Measurement of CVP, 13. Blood/Blood Product Administration, 14. Administration of: a. TPN - Total Parenteral Nutrition, b. PPN - Peripheral Parenteral Nutrition.

Table D: Cardiovascular. Mark One. 1. Put Patient on Cardiac Monitor, 2. Rhythm Strip Measurements, 3. Recognize and Interpret Dysrhythmias, 4. Obtain 12 Lead EKG, 5. CPR, 6. Defibrillation, 7. Cardioversion.

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- | | |
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Applicant's Name _____

Mark One

1 2 3 4

8. Use of Automatic BP Cuff

9. Use of Doppler

10. Pulse Checks

11. Care of the Patient with:

a. Temporary Pacemaker

b. Permanent Pacemaker

12. Administration of:

a. Nitrates (Oral/IV)

b. Antiarrhythmics (Oral/IV)

c. Antihypertensives (Oral/IV)

13. Care of the PTCA Patient (Pre/Post)

14. Care of the Cardiac Cath Patient (Pre/Post)

15. Pre-Op Checklist

16. Care of the Patient with:

a. Angina

b. Hypertension

D. Respiratory

Mark One

1 2 3 4

1. O₂ Cannulas/Masks

2. Nebulizer Set-up/Use

3. Incentive Spirometry

4. Chest PT

5. Pulse Oximetry

6. Suctioning:

a. Oral

b. Tracheostomy Tube

7. Care of the Ventilator Patient:

a. Mouth Care

b. Suctioning - Endotracheal Tube

c. Ambu

d. Weaning the Patient Off the Ventilator

8. Bronchodilator Administration:

a. Oral

b. IV

c. Inhalers

9. Care of the Patient with:

a. Tracheostomy

Mark One

1 2 3 4

b. COPD

c. Asthma Exacerbation

d. Pneumonia

e. Pre/Post Thoracic Surgery

f. Chest Tubes

Mark One

1 2 3 4

E. Neurological

1. Neuro Assessment

2. Glasgow Coma Scale

3. Seizure Precautions

4. Aneurysm Precautions

5. Assist with Lumbar Puncture

6. Use of Hyper/Hypothermia Blanket

7. Use and Administration of:

a. Decadron

b. Dilantin

c. Phenobarbitol

d. Valium

8. Care of the Patient with:

a. Spinal Cord Injury

b. CVA (Stroke)

c. Neuromuscular Disease

Mark One

1 2 3 4

F. Gastrointestinal

1. Nasogastric Tube Care and Maintenance

2. Use of Feeding Tube

3. Stool Specimen Collection

4. Bowel Preparation

5. Care of the Patient with:

a. Tube Feedings

b. Ileostomy

c. Colostomy

d. Gastrostomy/Jejunostomy Tube

6. Enterostomal Care

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Applicant's Name _____

G. Genitourinary/Renal

Mark One

- 1 2 3 4

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Urinary Catheter Insertion (Male/Female) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Bladder Irrigations: | | | | |
| a. Continuous | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Intermittent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Electrolyte Imbalance/Replacement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Peritoneal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Urine Specimen Collection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Care of the Patient with: | | | | |
| a. Hemodialysis (Pre/Post) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A-V Fistula/Shunt Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. T.U.R.P. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nephrostomy Tube | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Supra-Pubic Catheter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

H. Orthopedics

Mark One

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- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Cast Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Traction: | | | | |
| a. Skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skeletal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ROM Exercises | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Use of Assistive Devices (Canes, Walkers) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Application of Splints to Extremities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Continuous Passive Motion Machine (CPM) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Circulation Checks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Care of the Patient with: | | | | |
| a. Total Joint Replacement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Amputation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Rheumatic/Arthritic Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I. Wound Care

Mark One

- 1 2 3 4

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|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Dressing Changes (Sterile/Non-Sterile) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Care of the Patient with: | | | | |
| a. Pressure Sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Leg Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Burns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

- 1 2 3 4

- | | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. Use of Air Fluidized Beds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Wound Irrigations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

- 1 2 3 4

J. Endocrine

- | | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Insulin Administration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Finger Sticks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Diabetic Patient Teaching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

- 1 2 3 4

K. Miscellaneous

- | | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Normal Serum Lab Values | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Universal Precautions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Isolation Techniques | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Discharge Planning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Care of the Patient with: | | | | |
| a. Sickle Cell Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Alzheimer's Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Suicide Precautions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

- 1 2 3 4

L. Age of Patients Cared For

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Infants and Toddlers (ages 0-3 years) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Young Children (ages 4-6 years) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Older Children (ages 7-12 years) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Adolescents (ages 13-20 years) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Young Adults (ages 21-39 years) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Middle Adults (ages 40-64) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Older Adults (ages 65-79) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Adults (ages >80) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |