

## Medical/Surgical Skills Checklist

Name:  Date:  Experience Since:

	Comfortable With	Done Occasionally	No Experience
Admission Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti Embolism Hose (TEDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care Plan Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient with chest tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinitron Electronic Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge of Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Notification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postmortem Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transcribe Physician's Orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer Patient to Another Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intake and Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHARTING</b>			
Flow Sheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOAP Charting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CRT Computer</b>			
a. Entering Data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Ordering Supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Charting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>DRESSING CHANGE:</b>			
a. Dry Sterile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wet to Dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wound Packing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ADMINISTRATION OF:</b>			
<b>a. Enemas:</b>			
1. Fleets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Medicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Soapsuds/Tapwater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Douche (Vaginal Irrigation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EMERGENCIES</b>			
a. Cardiac Arrest (Code)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Patient Call Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FOLEY CATHETER</b>			
a. Daily Catheter Care/Perineal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Insertion-Straight/Foley-Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Insertion-Straight/Foley-Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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e. Continuous Bladder Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hygiene</b>			
Daily Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Foot Care/Observations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INFECTION PRECAUTIONS:</b>			
a. Universal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Enteric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Protective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Wound and Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MEDICATION ADMINISTRATION</b>			
a. Direct IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Double Check (Heparin, Insulin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Intramuscular Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Heparin Lock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Mixing Meds in a syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. PCA (Pain Control Apparatus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Piggy Back (Mini Bags)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Preoperative Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Subcutaneous Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTRAVENOUS</b>			
<b>a. IV Therapy:</b>			
1. Bottle / Bag Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Dressing Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Discontinuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Flow Rate Regulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. IV initiation</b>			
1. Butterfly (Scalpvein)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Plastic Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. IV site care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. IV Infusion Monitoring Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. IV Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. IV Rate Controller	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NASOGASTRIC TUBES:</b>			
a. Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Nutrition (Regular and Special)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OSTOMY CARE</b>			
a. Appliance Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Patient Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Oxygen Therapy</b>			
a. Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PREOPERATIVE CARE:</b>			
a. Checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Patient Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Shave operative area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Signing Patient Off Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>POSTOPERATIVE CARE:</b>			
a. Receiving Patient From Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Postoperative Observations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Managing Postop Orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WOUND MANAGEMENT</b>			
a. Irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Montgomery Straps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Report (Change of Shift):</b>			
a. Giving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Receiving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SPECIMEN COLLECTION:</b>			
<b>a. Urine</b>			
1. Clean Catch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sterile from Foley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sugar and Acetone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 24 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. plain urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Culture and sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Glucometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Stool for ova & parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Stool guaic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESTRAINTS</b>			
a. Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Patient Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SUCTION</b>			
a. Endotracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hemovac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Jacson-Pratt (Grenade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nasogastric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Nasotracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TRACTION</b>			
a. Buck's (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cervical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pelvic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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e. Site (Pin) Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TRANSFER OF A PATIENT WITH:</b>			
a. Assisted device (cane, walker)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Stretcher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Wheelchair/Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WEIGHT:</b>			
a. Bed Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Standard Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MISC:</b>			
a. Heat/Cold Applications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Turn, Cough, and Deep Breathe (TCDB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Valuable (jewelry, medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Signature

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Date

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Agency Representative Signature

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Date