CHESAPEAKE HOME HEALTHCARE

Providing Service to a Community that Deserves Attention.

NAME: _____ DATE: _____

BASIC NURSING SKILLS ASSESSMENT

Directions: Please place an **(x)** in the space provided below, indicating your clinical experience regarding procedures, treatments, mechanical procedures, and mechanical operation of equipment.
Please check the appropriate space as follows: **Key: C – COMPETENT NP – NEEDS PRACTICE N – NEVER**

PROCEDURE OR TREATMENT	C	NP	N	PROCEDURE OR TREATMENT	C	NP	N
NURSING ASSESSMENT (SOC/ROC)	( )	( )	( )	OXYGEN THERAPY			
				Nasal Cannula	( )	( )	( )
S.O.A.P. CHARTING	( )	( )	( )	Vent/Face Mask	( )	( )	( )
				Trach Collar	( )	( )	( )
ADMISSION/DISCHARGE	( )	( )	( )	Tracheostomy Tube	( )	( )	( )
PREVENTIVE SKIN CARE	( )	( )	( )	SUCTION SET UP			
				Suctioning	( )	( )	( )
ROM EXERCISES	( )	( )	( )	Use of Yaunker	( )	( )	( )
APPLICATION OF RESTRAINTS				CODE			
Soft Limb Restraints	( )	( )	( )	Respiratory Arrest	( )	( )	( )
				Cardiac Arrest	( )	( )	( )
RECORDING INTAKE AND OUTPUT	( )	( )	( )	Ambu Bag	( )	( )	( )
ENEMAS				BLADDER CATHETERIZATION			
Cleansing	( )	( )	( )	Female Foley	( )	( )	( )
				Male Foley	( )	( )	( )
SPECIMEN COLLECTION				Condom Catheter	( )	( )	( )
Clean Catch	( )	( )	( )	Irrigations	( )	( )	( )
Foley Specimen	( )	( )	( )	Suprapubic/Care	( )	( )	( )
24 Hour Urine	( )	( )	( )				
Stool Specimen	( )	( )	( )	NGT INTUBATION			
Sputum Specimen				Insertion of NG Tube	( )	( )	( )
Expectorating	( )	( )	( )	Placement Verification	( )	( )	( )
Via Lukens's Tube	( )	( )	( )	Irrigation	( )	( )	( )
Wound Swab	( )	( )	( )	Bolus Feedings	( )	( )	( )
				Continuous Feedings	( )	( )	( )
ISOLATION TECHNIQUE							
Donning of mask and gown	( )	( )	( )	GASTROSTOMY TUBE			
Linen and Trash Disposal	( )	( )	( )	Feedings	( )	( )	( )
				Care	( )	( )	( )
DRESSINGS				MEDICATION ADMINISTRATION			

CHESAPEAKE HOME HEALTHCARE

Providing Service to a Community that Deserves Attention.

PROCEDURE OR TREATMENT	C	NP	N	PROCEDURE OR TREATMENT	C	NP	N
Dry Sterile Dressings	( )	( )	( )	P.O.	( )	( )	( )
Wet to Dry Dressings	( )	( )	( )	S.Q.	( )	( )	( )
IV Dressings	( )	( )	( )	Via NG/G Tube	( )	( )	( )
Central Line Dressings	( )	( )	( )	I.M.	( )	( )	( )
				Z-Track	( )	( )	( )
WOUND CARE				IV Minibag	( )	( )	( )
Dermal Ulcer (decubitus)	( )	( )	( )	IV Push	( )	( )	( )
Surgical Wound Care	( )	( )	( )	Instillation of Eye Drops	( )	( )	( )
Wound Irrigations	( )	( )	( )	Instillation of Ear Drops	( )	( )	( )
				Insulin Administration	( )	( )	( )
COLOSTOMY CARE							
Appliance Changes	( )	( )	( )	VASCULAR ACCESS DEVICES			
Irrigation	( )	( )	( )	Groshong	( )	( )	( )
				Mediport	( )	( )	( )
NEUROCHECKS/REFLEXES	( )	( )	( )	Hickman	( )	( )	( )
				Port-A-Cath	( )	( )	( )
DIABETIC CARE				Patient Care Analgesic Pump	( )	( )	( )
Fingerstick Blood Sugars	( )	( )	( )	IV Hook Up	( )	( )	( )
Glucometer	( )	( )	( )	Cap Changes and Flushing	( )	( )	( )
Flow Sheet Documentation	( )	( )	( )	Dressing Changes	( )	( )	( )
				Accessing	( )	( )	( )
PERITONEAL DIALYSIS	( )	( )	( )				
HEIMLICH MANEUVER	( )	( )	( )				
FOOT CARE	( )	( )	( )				
IV THERAPY							
IV Insertion	( )	( )	( )				
Equipment Set Up	( )	( )	( )				
Calculation of Drips	( )	( )	( )				
Daily Care	( )	( )	( )				
IV Infusion Pump	( )	( )	( )				
Heparin Locks	( )	( )	( )				
Conversion of IV to Hep Lock	( )	( )	( )				
Conversion of Hep Lock to IV	( )	( )	( )				
Heparin Lock Flush	( )	( )	( )				
Tubing Change	( )	( )	( )				

I have had _____ years of experience in medical/surgical nursing, and I declare that all the above information is complete and correct to the best of my knowledge.

Nurse's Signature _____

Date _____

RN Witness

_____

Date _____