

PSYCHIATRIC SKILLS CHECKLIST

Name _____ Date _____

Levels of Experience

- A = Perform Well (at least 1 year experience) C = Perform Infrequently (less than 3 months)
 B = Limited Experience (6 months to 1 year) D = No Experience

PERFORMANCE OF: A B C D

- Management of assaultive behavior ...
- Crisis Intervention.....
- Behavioristic charting.....
- Treatment / goal oriented charting...
- Suicide risk assessment.....
- Therapeutic counseling.....
- Active listening.....
- Role playing.....
- Supportive therapy.....
- Problem solving.....
- Stress management.....
- Non judgmental behavior.....
- Encouraging independence.....
- Reality testing.....
- Validation.....
- Relaxation methods.....
- Impulse control techniques.....
- Positive feedback.....
- Medication administration.....
- Neurological vital signs.....

INTERVENTIONS WITH: A B C D

- Personality disorder patients.....
- Manic patients.....
- Psychotic patients.....
- Aggressive patients.....
- Suicidal patients.....
- Voluntary hospital admission.....
- Involuntary hospital admission.....
- Restraints.....
- Telephonic crisis intervention.....
- Therapeutic communication skills.....
- Psychiatric emergency response team
- Mgmt. Of drug/alcohol
detox symptoms.....

PHLEBOTOMY/IV THERAPY A B C D

- Administration packed red
- blood cells.....
- Whole blood.....
- Drawing Venous blood.....
- Drawing blood from central line.....
- Mgmt. Of pt. w/hyperalimentation ...
- Starting IV's.....

EQUIPMENT / PROCEDURES A B C D

- Electroconvulsive
- Insertion and care of straight
and foley catheter
- Oxygen therapy & medication
delivery.....
- Oro-naso-pharynx suctioning.....
- Tube feeding.....
- Administration of psychotropic
medications.....
- Mgmt. Of extrapyramidal symptoms.

EXPERIENCE / CERTIFICATION

Indicate any specialty in which you have at least one year experience or certification within the past 3 years.

YEARS MONTHS

ICU: _____
CCU: _____
OPEN HEART CRITICAL CARE: _____
SICU: _____
EMERGENCY ROOM: _____
GERIATRICS: _____
BURN: _____
GYNECOLOGY: _____
GU: _____
LABOR / DELIVERY: _____
POST – PARTUM: _____
NURSERY: _____
NICU (INDICATE LEVEL): _____
PEDIATRICS: _____
MEDICAL: _____
SURGICAL: _____
TELEMETRY: _____
CARDIAC STEPDOWN: _____
NEURO: _____
ORTHO: _____
REHABILITATION: _____
DIALYSIS: _____
DIABETIC: _____
PSYCH: _____
OPERATING ROOM: _____
RECOVERY ROOM: _____
HOME HEALTH: _____
NURSING MANAGEMENT: _____
OTHER (INDICATE): _____

Please include copies of any certifications with this form.

I understand that I am legally accountable in the areas I have stated performance ability on the attached Clinical Skills Checklist. I realize that it is my personal responsibility to seek further instruction in areas of deficiency and I will make them known to Quality Medical Staffing.

Signature

Date