

VINTAGE HEALTHCARE SERVICES, INC

LPN Skills Checklist

Date: _____

Name: _____
First Middle Initial Last

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

The information I have given is true & accurate to the best of my knowledge.

Signature: _____ Date: _____

Evaluator's Signature: _____

PLEASE MARK YOUR LEVEL OF EXPERIENCE

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

	Mark One			
	1	2	3	4
A. Medication Administration				
1. Pouring from Stock Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Narcotic Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. IV Push Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. IV Drip Medications:				
a. Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mark One			
	1	2	3	4
B. Phlebotomy/IV Therapy				
1. Draw Blood:				
a. Venous Stick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Central Line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Inserting IVs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mixing IVs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Regulating IVs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Discontinuing Peripheral IVs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. IV Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CVP Lines-Measurement of CVP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mark One			
	1	2	3	4
8. Central Line Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood/Blood Product Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Administration of:				
a. Total Parenteral Nutrition (TPN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Peripheral Parenteral Nutrition (PPN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Multi-Lumen Central Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Port-A-Caths (Infusa-Ports)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Continuous Subcutaneous Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Patient Controlled Analgesia (PCA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mark One			
	1	2	3	4
C. Patients with Cardiovascular Problems				
1. Cardiac Monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Taking EKGs - 12 Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Performing Basic Rhythm Strip Measurements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Recognizing Basic & Life-Threatening Dysrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cardiopulmonary Resuscitation (CPR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Defibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Cardioversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Name _____

Mark One

1 2 3 4

8. Care of the Patient with:

a. Temporary Pacemaker

b. Permanent Pacemaker

9. Pulse Checks

10. Use of Doppler

11. Use of Automatic BP Cuff (i.e., Dinamap)

12. Administration of Nitrates (Oral, Topical)

13. Administration of Antiarrhythmics (Oral)

14. Administration of Antihypertensives (Oral)

Mark One

D. Respiratory

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

b. COPD

c. Asthma Exacerbation

d. Pneumonia

e. Pre/Post Thoracic Surgery

f. Chest Tubes

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Mark One

E. Patients with Neurological Problems

1 2 3 4

1. Assessing Levels of Consciousness

2. Pupil Checks

3. Seizure Precautions

4. Aneurysm Precautions

5. Assisting with Lumbar Puncture

6. Administration of Anticonvulsant Meds

7. Administration of IV Drip Steroids

8. Use of Hyper/Hypothermia Blanket

9. Care of Patient with:

a. Spinal Cord Injury — Fresh

b. Spinal Cord Injury — Long Term

c. CVA (Stroke)

d. Neuromuscular Disease

e. Alzheimer's Disease

Mark One

F. Patients with Wound/Skin Problems

1 2 3 4

1. Dressing Changes

2. Care of Patient with:

a. Pressure Sores

b. Leg Ulcers

c. Burns

3. Use of Special Pressure Relief Devices:

a. Air Fluidized, Low Airloss Beds

b. Pressure Relief Mattress/Seat Cushion

Mark One

G. Patients with Endocrine Problems

1 2 3 4

1. Insulin Administration:

a. Single Type

b. Mixed Insulins

c. Insulin Infusion

2. Blood Glucose Monitoring:

a. Performing Fingersticks

b. Use of Blood Glucose Meter Device

c. Use of Visual Blood Glucose Strips

Applicant's Name _____

H. Patients with Renal/GU Problems

	Mark One			
	1	2	3	4
1. Insertion of Catheter-Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Insertion of Catheter-Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 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"/>
4. Peritoneal Dialysis:				
a. Manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Automatic Cycler Machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Collection of Urine Specimens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Care of Patient on Hemodialysis:				
a. A-V Fistula/Shunt Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pre- and Post-Dialysis Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Care of Patient with Urinary Diversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Care of Patient with Supra-Pubic Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Care of Patient with Nephrostomy Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I. Patients with Gastrointestinal Problems

	Mark One			
	1	2	3	4
1. Nasogastric Tubes (i.e., Salem Sump, Levine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nasointestinal Tubes (i.e., Cantor, Miller-Abbot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Jejunostomy, Gastrostomy, Cecostomy Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Inserting Nasogastric Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Administration of Tube Feedings Via Flexible Tubes:				
a. By Gravity Infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. By Feeding Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Collection of Stool Specimens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Bowel Preparation and Cleansing Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Care of Patient with:				
a. Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J. Patients with Orthopedic Problems

	Mark One			
	1	2	3	4
1. Cast Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Circulation Checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Traction-Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Traction-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Range of Motion Exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Mark One			
	1	2	3	4
6. Use of Assistive Devices (i.e., Canes, Walkers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Care of Patient with Total Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Care of Patient with Rheumatic/Arthritic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Care of Patient with an Amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Application of Splints to Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Continuous Passive Motion Machine (CPM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K. Additional Medical-Surgical Skills

	Mark One			
	1	2	3	4
I. Care of Patients with:				
a. Hemovac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Jackson-Pratt Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Penrose Drains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. T-Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Surgical Wound Irrigations and Dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Universal Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

L. Age of Patients Cared For

	Mark One			
	1	2	3	4
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"/>