Nurse Professionals
Home Care & Staffing, L.L.C.
Phone : 443-644-6915

INTERMEDIATE CARE AND TELEMETRY SKILLS CHECKLIST

This profile is for use by Intermediate nurses with more than one-year experience in their discipline and specialty. It will be a determining factor for the Nurse Professional Home Care & Staffing, L.L.C. program. This document must be completed in its entirety; each page initialed, the last page signed, and then returned to Nurse Professional Home Care & Staffing, L.L.C. by any of the following methods:

Email: Save, then email completed document to nurseprof@comcast.net
Fax: Print and fax completed document to 443-664-6879

Please enter your full legal name as it appears on your Social Security Card.

First Name: _____ Last Name: _____

Social Security Number: _____ Date: _____ Email: _____

Please indicate your level of experience by checking 1 box in each of the category below (1-less experience → 4-more experience):

1. Theory, or only prior observation
2. Less than one-year current experience or any previous experience
3. One - Two years current experience or need minimal assistance
4. Two plus years experience or functions independently

A. CARDIOVASCULAR

	1	2	3	4
1. Assessment				
a. Auscultation (rate, rhythm)	☐	☐	☐	☐
b. Heart sounds/murmurs	☐	☐	☐	☐
c. Pulses/circulation checks	☐	☐	☐	☐
2. Interpretation of lab results	1	2	3	4
a. Cardiac enzymes/isoenzymes	☐	☐	☐	☐
b. Coagulation studies	☐	☐	☐	☐
3. Equipment & procedures				
a. Monitoring/telemetry	1	2	3	4
Arrhythmia interpretation	☐	☐	☐	☐
Basic 12 lead interpretation	☐	☐	☐	☐
Lead placement: 5 electrode tele	☐	☐	☐	☐
Lead placement: I, III, V-leads	☐	☐	☐	☐
Lead placement: Lead II and MCL	☐	☐	☐	☐
b. Pacemaker				
Permanent	☐	☐	☐	☐
Temporary epicardial wires	☐	☐	☐	☐
Temporary external pacing	☐	☐	☐	☐
Temporary transvenous	☐	☐	☐	☐
c. Assist with:				
Arterial line insertion	☐	☐	☐	☐
Central line insertion	☐	☐	☐	☐
d. Hemodynamic monitoring				
A-line (radial)	☐	☐	☐	☐
CVP monitoring	☐	☐	☐	☐
Femoral artery sheath removal	☐	☐	☐	☐
Swan-Ganz	☐	☐	☐	☐
e. Perform				
Controlled cardioversion	☐	☐	☐	☐
Emergency	☐	☐	☐	☐

A. CARDIOVASCULAR (cont...)

	1	2	3	4
4. Care of patient with:				
a. Abdominal aortic bypass	☐	☐	☐	☐
b. Aneurysm	☐	☐	☐	☐
c. Angina	☐	☐	☐	☐
d. Cardiac arrest	☐	☐	☐	☐
e. Cardiomyopathy	☐	☐	☐	☐
f. Carotid endarterectomy	☐	☐	☐	☐
g. Congestive heart failure (CHF)	☐	☐	☐	☐
h. Femoral-popliteal bypass	☐	☐	☐	☐
i. Post acute MI (24-48 hours)	☐	☐	☐	☐
j. Post angioplasty	☐	☐	☐	☐
k. Post arthrecotomy (DCA)	☐	☐	☐	☐
l. Post CABG (24 hours)	☐	☐	☐	☐
m. Post cardiac cath	☐	☐	☐	☐
n. Post stent placement	☐	☐	☐	☐
5. Medications	1	2	3	4
a. Atropine	☐	☐	☐	☐
b. Bretylium (Bretylol)	☐	☐	☐	☐
c. Cardizem (Diltiazem hydrochloride)	☐	☐	☐	☐
d. Digoxin (Lanoxin)	☐	☐	☐	☐
e. Dobutamine (Dobutrex)	☐	☐	☐	☐
f. Dopamine (Intropin)	☐	☐	☐	☐
g. Epinephrine (Adrenalin)	☐	☐	☐	☐
h. Heparin	☐	☐	☐	☐
i. Lidocaine (Xylocaine)	☐	☐	☐	☐
j. Nipride (Nitroprusside)	☐	☐	☐	☐
k. Nitroglycerine (Tridil)	☐	☐	☐	☐
l. Oral anticoagulants	☐	☐	☐	☐
m. Oral & IVP antihypertensives	☐	☐	☐	☐
n. Oral & topical nitrates	☐	☐	☐	☐
o. Verapamil (Calan, Isoptin, Verelan)	☐	☐	☐	☐

INTERMEDIATE CARE AND TELEMETRY SKILLS CHECKLIST

B. PULMONARY

	1	2	3	4
1. Assessment				
a. Breath sounds	☐	☐	☐	☐
b. Breathing patterns	☐	☐	☐	☐
2. Interpretation of lab results				
a. Arterial blood gases	☐	☐	☐	☐
b. Blood chemistry	☐	☐	☐	☐
3. Equipment & procedures				
a. Assist with intubation	☐	☐	☐	☐
b. Assist with thoracentesis	☐	☐	☐	☐
c. Care of airway management devices/ suctioning				
Endotrachial tube/suctioning	☐	☐	☐	☐
Nasal airway/suctioning	☐	☐	☐	☐
Oropharyngeal/suctioning	☐	☐	☐	☐
Oximetry	☐	☐	☐	☐
Sputum specimen collection	☐	☐	☐	☐
Tracheostomy/suctioning	☐	☐	☐	☐
d. Care of patient on a ventilator				
Extubation	☐	☐	☐	☐
Weaning modes	☐	☐	☐	☐
e. Care of patient with a chest tube				
Assist with set-up and insertion	☐	☐	☐	☐
Mediastinal tube removal	☐	☐	☐	☐
Pleural tube removal	☐	☐	☐	☐
Use of Pleurevac or Thoraclex	☐	☐	☐	☐
Use of water seal drainage system	☐	☐	☐	☐
f. Chest physiotherapy	☐	☐	☐	☐
g. Establishing an airway	☐	☐	☐	☐
h. Incentive spirometry	☐	☐	☐	☐
i. O2 therapy & medication delivery systems				
Ambu bag or mask	☐	☐	☐	☐
ET tube	☐	☐	☐	☐
External CPAP	☐	☐	☐	☐
Face masks	☐	☐	☐	☐
Inhalers	☐	☐	☐	☐
Nasal cannula	☐	☐	☐	☐
Portable O2 tank	☐	☐	☐	☐
Tracheostomy	☐	☐	☐	☐
Transtracheal cannulation	☐	☐	☐	☐
j. Oral airway insertion	☐	☐	☐	☐
4. Medications	1	2	3	4
a. Alupent (Metaproterenol sulfate)	☐	☐	☐	☐
b. Aminophylline (Theophylline)	☐	☐	☐	☐
c. Bronkosol (Isoetharine hydrochloride)	☐	☐	☐	☐
d. Corticosteroids	☐	☐	☐	☐
e. Ventolin (Albuterol)	☐	☐	☐	☐

B. PULMONARY (cont...)

	1	2	3	4
5. Care of patient with:				
a. ARDS	☐	☐	☐	☐
b. Bronchoscopy	☐	☐	☐	☐
c. COPD	☐	☐	☐	☐
d. Fresh tracheostomy	☐	☐	☐	☐
e. Lobectomy	☐	☐	☐	☐
f. Pneumonectomy	☐	☐	☐	☐
g. Pneumonia	☐	☐	☐	☐
h. Pulmonary edema	☐	☐	☐	☐
i. Pulmonary embolism	☐	☐	☐	☐
j. Status asthmaticus	☐	☐	☐	☐
k. Thoracotomy	☐	☐	☐	☐
l. Tuberculosis				

C. NEUROLOGICAL

	1	2	3	4
1. Assessment				
a. Cerebellar function	☐	☐	☐	☐
b. Cranial nerves	☐	☐	☐	☐
c. Glasgow xoma scale	☐	☐	☐	☐
d. Level of consciousness	☐	☐	☐	☐
e. Pathologic reflexes	☐	☐	☐	☐
2. Equipment & procedures	1	2	3	4
a. Assist with lumbar puncture	☐	☐	☐	☐
b. Halo traction	☐	☐	☐	☐
c. Nerve stimulator	☐	☐	☐	☐
d. Rotation bed	☐	☐	☐	☐
e. Seizure precautions	☐	☐	☐	☐
f. Use of hyper/hypothermia blanket	☐	☐	☐	☐
3. Care of patient with:	1	2	3	4
a. Aneurysm precautions	☐	☐	☐	☐
b. Basal skull fracture	☐	☐	☐	☐
c. Closed head injury	☐	☐	☐	☐
d. Coma	☐	☐	☐	☐
e. CVA	☐	☐	☐	☐
f. DTs	☐	☐	☐	☐
g. Encephalitis	☐	☐	☐	☐
h. Externalized VP shunts	☐	☐	☐	☐
i. Meningitis	☐	☐	☐	☐
j. Multiple sclerosis	☐	☐	☐	☐
k. Neuromuscular disease	☐	☐	☐	☐
l. Post craniotomy	☐	☐	☐	☐
m. Seizures	☐	☐	☐	☐
n. Spinal cord injury	☐	☐	☐	☐
4. Medications	1	2	3	4
a. Carbamazepine (Tegretol)	☐	☐	☐	☐
b. Carbidopa-Levodopa (Sinemet)	☐	☐	☐	☐
c. Clonazepam (Klonopin)	☐	☐	☐	☐
d. Decadron (Dexamethasone)	☐	☐	☐	☐
e. Dilantin (Phenytoin)	☐	☐	☐	☐

Initials: _____

INTERMEDIATE CARE AND TELEMETRY SKILLS CHECKLIST

C. NEUROLOGICAL (cont...)

	1	2	3	4
4. Medications (cont...)				
f. Lorazepam (Ativan)	☐	☐	☐	☐
g. Methylprednisone (Solu-Medrol)	☐	☐	☐	☐
h. Phenobarbital	☐	☐	☐	☐
i. Valium (Diazepam)	☐	☐	☐	☐

D. GASTROINTESTINAL

	1	2	3	4
1. Assessment				
a. Abdominal/bowel sounds	☐	☐	☐	☐
b. Fluid balance	☐	☐	☐	☐
c. Nutritional	☐	☐	☐	☐
2. Interpretation of blood chemistry	☐	☐	☐	☐
3. Equipment & procedures				
a. Administration of tube feeding	1	2	3	4
Feeding pump	☐	☐	☐	☐
Gravity feeding	☐	☐	☐	☐
b. Flexible feeding tube	1	2	3	4
(i.e., Corpak, Dobhoff)	☐	☐	☐	☐
c. Placement of nasogastric tube	☐	☐	☐	☐
d. Salem sump to suction	☐	☐	☐	☐
e. Saline lavage	☐	☐	☐	☐
4. Management of	1	2	3	4:
a. Gastrostomy tube	☐	☐	☐	☐
b. Jejunostomy tube	☐	☐	☐	☐
c. PPN (peripheral parenteral nutrition)	☐	☐	☐	☐
d. TPN and lipids administration	☐	☐	☐	☐
e. T-tube	☐	☐	☐	☐
5. Care of patient with:	1	2	3	4
a. Bowel obstruction	☐	☐	☐	☐
b. Colostomy	☐	☐	☐	☐
c. ERCP	☐	☐	☐	☐
d. Esophageal bleeding	☐	☐	☐	☐
e. GI bleeding	☐	☐	☐	☐
f. GI surgery	☐	☐	☐	☐
g. Hepatitis	☐	☐	☐	☐
h. Ileostomy	☐	☐	☐	☐
i. Inflammatory bowel disease	☐	☐	☐	☐
j. Liver failure	☐	☐	☐	☐
k. Liver transplant	☐	☐	☐	☐
l. Pancreatitis	☐	☐	☐	☐
m. Paralytic ileus	☐	☐	☐	☐
n. Whipple procedure	☐	☐	☐	☐

E. RENAL/GENITOURINARY

	1	2	3	4
1. Assessment				
a. A-V fistula/shunt	☐	☐	☐	☐
b. Fluid & electrolyte balance	☐	☐	☐	☐
2. Interpretation of BUN & creatinine	☐	☐	☐	☐

E. RENAL/GENITOURINARY (cont...)

	1	2	3	4
3. Equipment & procedures				
a. Insertion & care of straight and Foley catheter				
Female	☐	☐	☐	☐
Male	☐	☐	☐	☐
b. Supra-pubic	☐	☐	☐	☐
c. Bladder irrigations				
Continuous	☐	☐	☐	☐
Intermittent	☐	☐	☐	☐
d. Specimen collection				
Routine	☐	☐	☐	☐
24 hour	☐	☐	☐	☐
e. Nephrostomy tube care	☐	☐	☐	☐
f. Manual CAPD administration	☐	☐	☐	☐
g. Peritoneal dialysis via Automatic cycler	☐	☐	☐	☐
4. Care of patient with:	1	2	3	4
a. Hemodialysis	☐	☐	☐	☐
b. Nephrectomy	☐	☐	☐	☐
c. Peritoneal dialysis	☐	☐	☐	☐
d. Renal failure	☐	☐	☐	☐
e. Renal transplant	☐	☐	☐	☐
f. TURP	☐	☐	☐	☐

F. METABOLIC

	1	2	3	4
1. Assessment				
a. S/S diabetic ketoacidosis	☐	☐	☐	☐
b. S/S insulin shock	☐	☐	☐	☐
2. Interpretation of lab results	1	2	3	4
a. Blood glucose	☐	☐	☐	☐
b. Thyroid levels	☐	☐	☐	☐
3. Equipment & procedures	1	2	3	4
a. Blood glucose monitoring	☐	☐	☐	☐
Blood glucose measuring device: Type _____				
Insulin administration IV drip	☐	☐	☐	☐
Visual blood glucose strips	☐	☐	☐	☐
4. Care of patient with:	1	2	3	4
a. Cushing's syndrome	☐	☐	☐	☐
b. Diabetes insipidus	☐	☐	☐	☐
c. Diabetes mellitus	☐	☐	☐	☐
d. Diabetes ketoacidosis	☐	☐	☐	☐
e. Disorders of adrenal gland (Addison's disease)	☐	☐	☐	☐
f. Drug overdose	☐	☐	☐	☐
g. Hyperthyroidism (Grave's disease)	☐	☐	☐	☐
h. Hypothyroidism	☐	☐	☐	☐
i. Pheochromocytoma	☐	☐	☐	☐
j. Post adrenalectomy	☐	☐	☐	☐
k. Post hypophysectomy	☐	☐	☐	☐
l. Post thyroidectomy	☐	☐	☐	☐

Initials: _____

F. METABOLIC (cont...)

	1	2	3	4
5. Medications				
a. Hydrocortisone	☐	☐	☐	☐
b. IM vasopressin (Pitressin)	☐	☐	☐	☐
c. Insulin	☐	☐	☐	☐
d. Prednisone	☐	☐	☐	☐
e. Radioactive iodine	☐	☐	☐	☐

G. WOUNDMANAGEMENT

	1	2	3	4
1. Assessment				
a. Skin for impending breakdown	☐	☐	☐	☐
b. Stasis ulcers	☐	☐	☐	☐
c. Surgical wound healing	☐	☐	☐	☐
2. Equipment & procedures	1	2	3	4
a. Air fluidized, low airloss beds	☐	☐	☐	☐
b. Sterile dressing changes	☐	☐	☐	☐
c. Wound care/irrigations	☐	☐	☐	☐
3. Care of the patient with:	1	2	3	4
a. Burns	☐	☐	☐	☐
b. Pressure sores	☐	☐	☐	☐
c. Staged decubitus ulcers	☐	☐	☐	☐
d. Surgical wounds with drain(s)	☐	☐	☐	☐
e. Traumatic wounds	☐	☐	☐	☐

H. PHLEBOTOMY / IV THERAPY

	1	2	3	4
1. Equipment & procedures				
a. Drawing blood from central line	☐	☐	☐	☐
b. Drawing venous blood	☐	☐	☐	☐
c. Starting IVs				
Angiocath	☐	☐	☐	☐
Butterfly	☐	☐	☐	☐
Heparin lock	☐	☐	☐	☐
d. Administration of blood/blood products				
Albumin/plasma	☐	☐	☐	☐
Cryoprecipitate	☐	☐	☐	☐
Packed red blood cells	☐	☐	☐	☐
Whole blood	☐	☐	☐	☐
2. Care of the patient with:	1	2	3	4
a. Peripheral line/dressing	☐	☐	☐	☐
b. Central line/catheter/dressing				
Broviac	☐	☐	☐	☐
Groshong	☐	☐	☐	☐
Hickman	☐	☐	☐	☐
Portacath	☐	☐	☐	☐
Quinton	☐	☐	☐	☐

I. PAIN MANAGEMENT

	1	2	3	4
1. Assessment of pain level/tolerance	☐	☐	☐	☐
2. Care of the patient with:	1	2	3	4
a. Epidural anesthesia/analgesia	☐	☐	☐	☐
b. IV conscious sedation	☐	☐	☐	☐
c. Narcotic analgesia	☐	☐	☐	☐
d. Patient controlled analgesia (PCA pump)	☐	☐	☐	☐

AGE SPECIFIC PRACTICE CRITERIA

Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

A. Newborn/Neonate (birth – 30 days)
B. Infant (30 days – 1 year)
C. Toddler (1 – 3 years)
D. Preschooler (3 - 5 years)
E. School age children (5 – 12 years)
F. Adolescents (12 – 18 years)
G. Young adults (18 – 39 years)
H. Middle adults (39 - 64 years)
I. Older adults (64+ years)

Experience with Age Groups:

	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Can ensure a safe environment reflecting specific needs of various age groups.	☐	☐	☐	☐	☐	☐	☐	☐	☐

Initials: _____

Nurse Professionals
Home Care & Staffing, L.L.C.

INTERMEDIATE CARE AND TELEMETRY SKILLS CHECKLIST

MY EXPERIENCE IS PRIMARILY IN (Please indicate number of years)

- ☐ Cardiac _____ year(s)
- ☐ Trauma _____ year(s)
- ☐ Cardiac surgical _____ year(s)
- ☐ Neuro _____ year(s)
- ☐ Telemetry _____ year(s)

☐ Other (specify) _____ _____ year(s)

☐ Other (specify) _____ _____ year(s)

CERTIFICATION

Please check the boxes below and indicate the expiration date for each certificate that you have. If you do not know the exact date, please use the last date of the specific month (e.g., 05/31/2004).

- ☐ ACLS Exp. Date: _____ (mm/dd/yyyy)
- ☐ BCLS Exp. Date: _____ (mm/dd/yyyy)

- ☐ Arrhythmia course date: _____ (mm/dd/yyyy)
- ☐ Critical care course date: _____ (mm/dd/yyyy)
- ☐ Computerized charting system: _____ Date: _____ (mm/dd/yyyy)
- ☐ Medication administration system: _____ Date: _____ (mm/dd/yyyy)

☐ Other (specify) _____ _____ year(s)

☐ Other (specify) _____ _____ year(s)

The information I have given is true and accurate to the best of my knowledge. I am the individual completing this form. I hereby authorize Nurse Professional Home Care & Staffing, L.L.C. to release this checklist to client facilities in relation to consideration of my employment with those facilities.

_____ _____
Print Name Date

_____
Signature

DON'T FORGET TO SIGN ABOVE, INITIAL ALL OTHER PAGES, AND SEND THE FORM BACK TO YOUR POINT OF CONTACT!

Email to nurseprof@comcast.net , or Fax to 443-664-6879

Initials: _____