



# Medical / Surgical Unit

## Clinical Skills Evaluation / Self-Assessment

Employee Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the column that best describes your level of proficiency and experience in providing each skill in care of patients.

- 0 – Never done
- 1 – Skill performed infrequently
- 2 – Skill performed several times, but resource person is required
- 3 – Skill performed frequently and independently
- N/A – Not Applicable

SKILLS	0	1	2	3	N/A	SKILLS	0	1	2	3	N/A
AIDS						<b>CARDIOVASCULAR: (CONTINUED)</b>					
ARDS						Muscoskeletal					
Aneurysms						Neurological					
Burns						Nutritional status					
Carotid endarterectomy						Pain					
Craniotomy						Pacemaker					
Colostomy						Pulses / circulation checks					
CVA						Respiratory					
DT's						Vital signs					
Femoral-popliteal bypass						Wound care					
GI bleeding						<b>ENDOCRINE:</b>					
Ileostomy						Addison's disease					
Isolation						Blood testing					
Near Drowning						Exercise/activity/rest					
Overdose						Foot and skin care					
PCA						Grave's disease					
Spinal cord injury						Hypo/hyperglycemia (signs & symptoms)					
Thoracic surgery						Hypothyroidism					
						Injection site rotation					
<b>CARDIOVASCULAR:</b>						Insulin administration/prep					
12-Lead EKG						Pituitary gland disorders					
Basic arrhythmia interpretation						Sick day routine					
Blood Pressure interpretation						Thyroidectomy					
Cardiovascular						Urine testing					
Doppler						<b>PULMONARY:</b>					
Drug / food interactions						Airway management					
Drug / drug interactions						Apnea monitor					
Effects/side effects of medication						Breathing exercises					
GI						Chest tube patient care					
GU						Chest physiotherapy					
Heart sounds / murmurs						Endotracheal intubation (assist)					
Integumentary						Incentive Spirometry					
Lab values						Inhaler use					
Lead placement						Nasotracheal suction					
Mental status											
<b>CONTINUE NEXT COLUMN</b>											

Employee Name \_\_\_\_\_

Date \_\_\_\_\_

Please check the column that best describes your level of proficiency and experience in providing each skill in care of patients.

- 0 – Never done
- 1 – Skill performed infrequently
- 2 – Skill performed several times, but resource person is required
- 3 – Skill performed frequently and independently
- N/A – Not Applicable

SKILLS	0	1	2	3	N/A	SKILLS	0	1	2	3	N/A
<b>PULMONARY: (CONTINUED)</b>						<b>NEUROLOGICAL:</b>					
Oralpharyngeal suction						Aneurysm precautions					
Oxygen therapy						Basal skull fracture					
Oximetry						Closed head injury					
Postural drainage and percussion						Coma					
Pulmonaide use						CVA					
Sputum specimen collection						DT's					
Tracheostomy care						Encephalitis					
Tracheostomy suctioning						Externalized VP shunts					
Ventilator patient care						Hyper/hypothermia blanket use					
<b>GI:</b>						Lumbar puncture (assist)					
Digital rectal exam						Meningitis					
Gastrostomy						Neuro checks					
Hemovac						Pain control measures					
Irrigation						Post Craniotomy					
Jackson Pratt						TENS					
Jejunostomy						<b>WOUND CARE:</b>					
Manual disimpaction						Burns					
Nasogastric suction						Debridement					
NG insertion / removal						Irrigation					
Ostomy care						Occlusive dressing					
Salem sump to suction						Packing					
T-tube						Pressure sores					
Tube feeding administration						Staging decubitus ulcers					
<b>RENAL/GU:</b>						Sterile dressing changes					
3-Way foley catheter						Surgical wounds with drain(s)					
3-Way foley catheter removal						Wet to dry dressing					
Bladder training						<b>INFECTIOUS DISEASES:</b>					
Condom catheter						AIDS patient care					
Foley catheter insertion						Blood borne pathogens					
Foley catheter removal						Blood count interpretation					
Foley catheter irrigation						Fever management					
Nephrostomy tube irrigation						Hazardous waste disposal					
Peritoneal dialysis						Hepatitis patient care					
Renal transplant						Isolation					
Specimen collection						Particulate Respirators					
Suprapubic tube insertion						Universal precautions					
Suprapubic catheter irrigation						<b>IV THERAPY:</b>					
Suprapubic tube removal						Blood administration					
TURP						Cryoprecipstate					
Urinary diversion / ileal conduit nephrostomy						Drawing blood - central line					
<b>CONTINUE NEXT COLUMN</b>						Drawing blood - venous					
						IV insertion					

CONTINUE ON PAGE 3

Employee Name \_\_\_\_\_

Date \_\_\_\_\_

Please check the column that best describes your level of proficiency and experience in providing each skill in care of patients.

- 0 – Never done
- 1 – Skill performed infrequently
- 2 – Skill performed several times, but resource person is required
- 3 – Skill performed frequently and independently
- N/A – Not Applicable

SKILLS	0	1	2	3	N/A	SPECIALTY EXPERIENCE																							
<b>IV THERAPY: (CONTINUED)</b>						Please check the appropriate specialty and the number of years experience. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="width: 70%;">SPECIALITY</th> <th style="width: 30%;">YEARS</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> AIDS / HIV</td><td></td></tr> <tr><td><input type="checkbox"/> Medical</td><td></td></tr> <tr><td><input type="checkbox"/> Neurology</td><td></td></tr> <tr><td><input type="checkbox"/> OB / GYN</td><td></td></tr> <tr><td><input type="checkbox"/> Oncology</td><td></td></tr> <tr><td><input type="checkbox"/> Orthopedics</td><td></td></tr> <tr><td><input type="checkbox"/> Other (please specify)</td><td></td></tr> <tr><td><input type="checkbox"/> Rehabilitation</td><td></td></tr> <tr><td><input type="checkbox"/> Telemetry</td><td></td></tr> <tr><td><input type="checkbox"/> Transplant</td><td></td></tr> </tbody> </table>		SPECIALITY	YEARS	<input type="checkbox"/> AIDS / HIV		<input type="checkbox"/> Medical		<input type="checkbox"/> Neurology		<input type="checkbox"/> OB / GYN		<input type="checkbox"/> Oncology		<input type="checkbox"/> Orthopedics		<input type="checkbox"/> Other (please specify)		<input type="checkbox"/> Rehabilitation		<input type="checkbox"/> Telemetry		<input type="checkbox"/> Transplant	
SPECIALITY	YEARS																												
<input type="checkbox"/> AIDS / HIV																													
<input type="checkbox"/> Medical																													
<input type="checkbox"/> Neurology																													
<input type="checkbox"/> OB / GYN																													
<input type="checkbox"/> Oncology																													
<input type="checkbox"/> Orthopedics																													
<input type="checkbox"/> Other (please specify)																													
<input type="checkbox"/> Rehabilitation																													
<input type="checkbox"/> Telemetry																													
<input type="checkbox"/> Transplant																													
Central line dressing																													
Brovic																													
Groshong																													
Hickman																													
Portacath																													
Quinton																													
Heparin lock																													
<b>ONCOLOGY:</b>																													
Bone marrow transplant																													
Inpatient chemotherapy																													
Inpatient hospice																													
Leukemia																													
Nutritional status																													
Pain control																													
Reverse isolation																													
<b>PAIN MANAGEMENT:</b>																													
Epidural anesthesia patient care																													
Family teaching																													
IV conscious sedation																													
Narcotic analgesia																													
Patient controlled analgesia																													
Patient teaching																													
						<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th colspan="2">ADDITIONAL EXPERIENCE:</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Computerized charting system(s)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Medication administration system(s)</td> <td></td> </tr> </tbody> </table>		ADDITIONAL EXPERIENCE:		<input type="checkbox"/> Computerized charting system(s)		<input type="checkbox"/> Medication administration system(s)																	
ADDITIONAL EXPERIENCE:																													
<input type="checkbox"/> Computerized charting system(s)																													
<input type="checkbox"/> Medication administration system(s)																													

Signature (required): \_\_\_\_\_