



Psychiatric 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
GENERAL:					
Active listening					
Assaultive behavior management					
Behavioristic charting					
Crisis intervention					
Encouraging independence					
Impulse control techniques					
Medication administration					
Neurological vital signs					
Non-judgmental behavior					
Positive feedback					
Problem solving					
Reality testing					
Relaxation methods					
Role playing					
Stress management					
Suicide risk assessment					
Supportive therapy					
Therapeutic counseling					
Treatment / goal oriented charting					
Validation					
INTERVENTIONS WITH:					
Aggressive patients					
Drug / alcohol detox symptom mgmt					
Involuntary hospital admission					
Manic patients					
Personality disorder patients					
Psychotic patients					
Psych emergency response team					
Restraints					
Suicidal patients					
CONTINUE NEXT COLUMN					

SKILLS	0	1	2	3	N/A
INTERVENTIONS WITH: (CONTINUED)					
Telephonic crisis intervention					
Therapeutic communication skills					
Voluntary hospital admission					
EQUIPMENT AND PROCEDURES:					
Catheter insertion & care, Foley					
Catheter insertion & care, straight					
Electroconvulsive					
Extrapyramidal symptoms mgmt.					
Oro-naso-pharynx suctioning					
Oxygen therapy & meds delivery					
Psychotropic meds - admin					
Tube feeding					
PHLEBOTOMY / IV THERAPY					
Drawing blood - central line					
Drawing blood - venous					
Hyperalimantation patient care					
IV insertion					
Packed red blood cells					
Whole blood					
SPECIALTY EXPERIENCE					
Please check the appropriate specialty and the number of years experience.					
SPECIALTY		YEARS			
<input type="checkbox"/> Juvenile / Child					
<input type="checkbox"/> Adolescent					
<input type="checkbox"/> Adult					
<input type="checkbox"/> Chemical Dependency / Detoxification					

Signature (required): _____