

## Behavioral Health RN Skills Checklist

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Indicate your level of experience rating with one of the following:**

A – No Experience.

B – Minimal Experience - need review and supervision, have performed at least once.

C – Competent - able to perform independently.

D – Expert - able to act as resource to others.

### A. BEHAVIORAL HEALTH

1. Assessment
  - a. Admission A  B  C  D
  - b. Initial nursing assessment and care plan A  B  C  D
  - c. Initial treatment plan A  B  C  D
  - d. Neurological vital signs A  B  C  D
  - e. Nursing diagnoses A  B  C  D
  - f. Nursing reassessment and care planning update A  B  C  D
  - g. Suicide risk assessment A  B  C  D
  
2. Equipment & procedures
  - a. Active participation in multi-disciplinary staffing A  B  C  D
  - b. Assist physician in administration of electroconvulsive therapy A  B  C  D
  - c. Assist with lumbar puncture A  B  C  D
  - d. Cardiopulmonary resuscitation A  B  C  D
  - e. Charge nurse experience A  B  C  D
  - f. Charting
    - (1) Behavioristic A  B  C  D
    - (2) Treatment/goal oriented A  B  C  D
  - g. Discharge planning A  B  C  D
  - h. Electroconvulsive therapy A  B  C  D
  - i. Group therapy leader A  B  C  D
  - j. Insertion & care of straight and Foley catheter
    - (1) Female A  B  C  D
    - (2) Male A  B  C  D
  - k. Management of drug/alcohol detox symptoms A  B  C  D
  - l. Management of assaultive behavior A  B  C  D
  - m. Multi-disciplinary treatment team participation A  B  C  D
  - n. O<sub>2</sub> therapy & medication delivery systems
    - (1) Bag and mask A  B  C  D
    - (2) External CPAP A  B  C  D
    - (3) Face masks A  B  C  D
    - (4) Inhalers A  B  C  D

Initials \_\_\_\_\_

- (5) Nasal cannula A  B  C  D
- (6) Portable O<sub>2</sub> tank A  B  C  D
- (7) Trach collar A  B  C  D
- o. Oro-naso-pharynx suctioning A  B  C  D
- p. Participation in milieu therapy A  B  C  D
- q. Patient teaching A  B  C  D
- r. Behavioral Health emergency response team A  B  C  D
- s. Behavioral Health home health A  B  C  D
- t. Rapid tranquilization A  B  C  D
- u. Restraints, application and assessment of
  - (1) Ambulatory cuffs A  B  C  D
  - (2) Full restraints A  B  C  D
  - (3) Wrist restraints A  B  C  D
- v. Telephonic crisis intervention A  B  C  D
- w. Therapeutic communication skills A  B  C  D
- x. Tube feeding A  B  C  D
- 3. Care of the patient with:
  - a. Alcohol dependency A  B  C  D
  - b. Drug dependency A  B  C  D
  - c. Electroconvulsive therapy A  B  C  D
  - d. Hallucinations A  B  C  D
  - e. Manic behavior A  B  C  D
  - f. Med-psych patient A  B  C  D
  - g. Organic disorder A  B  C  D
  - h. Partial hospital/intensive output program patient A  B  C  D
  - i. Seclusion and restraints A  B  C  D
  - j. Seizure disorder A  B  C  D
  - k. Suicidal behavior A  B  C  D
  - l. Tracheostomy A  B  C  D
- 4. Medications
  - a. Administration of oral psychotropic medications A  B  C  D
  - b. Heparin A  B  C  D
  - c. Intramuscular A  B  C  D
  - d. Management of extrapyramidal symptoms (EPS) A  B  C  D
  - e. Oral A  B  C  D
  - f. Rectal A  B  C  D
  - g. Sub-q A  B  C  D
  - h. Unit dose A  B  C  D
  - i. Z-technique A  B  C  D

**B. PHLEBOTOMY/IV THERAPY**

- 1. Equipment & procedures
  - a. Administration of blood/blood products
    - (1) Packed red blood cells A  B  C  D
    - (2) Whole blood A  B  C  D
  - b. Drawing blood from central line A  B  C  D

- c. Drawing venous blood A  B  C  D
- d. Management of patient with hyperalimantation A  B  C  D
- e. Management of patient with IV A  B  C  D
- f. Starting IVs
  - (1) Angiocath A  B  C  D
  - (2) Butterfly A  B  C  D
  - (3) Heparin lock A  B  C  D

**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+)

**Experience with Age Groups**

Able to adapt care to incorporate normal growth and development.

**A B C D E F G H I**

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.

**My experience is primarily in: (Please indicate number of years.)**

- Adolescent \_\_\_\_\_ year(s)
- Adult \_\_\_\_\_ year(s)
- Chemical Dependency/Detox \_\_\_\_\_ year(s)

**Certification:**

Please check the boxes below and indicate the expiration day for each certificate that you have. If you do not know the exact day, please use the last date of the specific month (e.g., 8/31/2003).

- BCLS Exp. Date: \_\_\_\_\_ (mm/dd/yyyy)
- MAB Exp. Date: \_\_\_\_\_ (mm/dd/yyyy)
- Other (type): Exp. Date: \_\_\_\_\_ (mm/dd/yyyy)

**Please read and agree to the statements below by marking the checkbox.**

I attest that the information I have given is true and accurate to the best of my knowledge and that I am the individual completing this form. I hereby authorize the Company to release this Behavioral Health RN Skills Checklist to the Client facilities in relation to consideration of employment as a Registered Nurse with those facilities.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Registered Professional Nurse Job Description  
Behavioral Health**

**Job Summary:**

The Behavioral Health RN is responsible for managing the care of the adult or elderly patient experiencing general medical conditions or general surgical procedures, which require general assessments related to specific conditions, and general therapies and interventions. The Behavioral Health RN is responsible to the Clinical Manager assigned to the Behavioral Health Unit.

**Qualifications**

- Current licensure in good standing in the state of practice
- Evidence of 1 year of Behavioral Health nursing experience within the past two years
- Evidence of current BLS credential mandatory

**Responsibilities**

- Conducts an individualized patient assessment and reassessment, prioritizing the data collected based on the preschool, school age, adolescent, adult or elderly patient's immediate condition or needs within timeframe specified by client facility's policies, procedures or protocols.
- Develops individualized plan of care reflecting collaboration with other members of the healthcare team.
- Collaborates with physician and other team members to implement orders and plan of care in an accurate and timely manner.
- Provides individualize patient/family education customized to the preschool, school age, adolescent, adult or elderly patient and his/her family.
- Documents patient assessment findings, physical/psychosocial responses to nursing intervention and progress toward problem resolution and communicates these responses to team members as appropriate.
- Responds to emergencies according to facility policy and procedure.
- Maintains confidentiality in matters related to patient, family and client facility staff.
- Provides care in a non-judgmental, non-discriminatory manner that is sensitive to the preschool, school age, adolescent, adult or elderly patient's and family's diversity, preserving their autonomy, dignity and rights.
- Reports relative indicators of patient condition to appropriate personnel during and at the end of each shift.
- Maintains current competency in Behavioral Health nursing.

RN Name: \_\_\_\_\_

RN Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Joint Commission  
**2006 Behavioral Health Care  
National Patient Safety Goals**

**Note:** New Goals and Requirements are indicated in **bold**.

- Goal 1 Improve the accuracy of patient identification.
- 1A Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.
- 1B Not applicable.
- Goal 2 Improve the effectiveness of communication among caregivers.
- 2A For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- 2B Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- 2C Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- 2D Not applicable.
- 2E Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.**
- Goal 3 Improve the safety of using medications.
- 3A Retired in 2006.
- 3B Standardize and limit the number of drug concentrations available in the organization.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- 3D Not applicable
- Goal 4 Not applicable.
- Goal 5 Retired in 2006
- Goal 6 Not applicable.
- Goal 7 Reduce the risk of health care-associated infections.

- 7A Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines when providing services to a high-risk population, or administering physical care.
- 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
  - 8A Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
  - 8B A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.
- Goal 9 Not applicable.
- Goal 10 Not applicable.
- Goal 11 Not applicable.
- Goal 12 Not applicable.
- Goal 13 Not applicable.
- Goal 14 Not applicable.