

Geriatrics & Long Term Care Skills Checklist

Level of Proficiency:

- 1. Can function independently**
- 2. Experienced but may need review**
- 3. Limited or no experience**

By accurately filling out this checklist, you will help us match your skills and interest with available assignments. Please select the button in the column that best describes your experience level with each skill.

IV THERAPY	1	2	3	RESIDENTS WITH GASTROINTESTINAL PROBLEMS (cont.)	1	2	3
Inserting IV•fS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Administration of Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mixing IV•fS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeding Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heparin Locks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gravity Infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasogastric Tubes:			
Discontinuing Peripheral IV•fS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Levin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulating IV•fS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salem Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICATION ADMINISTRATION				Other GI Tubes:			
Medications:				Cecostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Topical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jejunostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PATIENTS WITH			
Vaginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR PROBLEMS			
Ophthalmic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognize Basic & Life-Threatening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV Additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dysrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary Resuscitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syringe Count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assessment of Peripheral Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Controlled Substance Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Patient with Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Controlled Substance Count & Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heimlich Maneuver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pouring From Stock Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker Check Telecommunication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unit Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Administration of Antiarrhythmics:			
INFECTION CONTROL				Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intramuscular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enteric Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Administration of Antihypertensives:			
Hazardous Waste/Sharps Disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Universal Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aseptic Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Administration of Nitrates:			
PATIENTS WITH RESPIRATORY PROBLEMS				Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of Sputum Specimens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Topical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of the Patients with:				PATIENTS WITH DERMOTOLOGICAL PROBLEMS			
Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insert an Oral Airway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Oxygen Delivery Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irrigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suctioning:				Use of Special Pressure Relief Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Air Fluidized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasotracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Airloss Beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oropharyngeal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pressure Relief Mattress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seat Cushion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incentive Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prevention and Treatment of:			
Administer Intermittent Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dermal Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pressure Breathing Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Internal Causes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PATIENTS WITH NEUROLOGICAL PROBLEMS				External Causes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Identifying Common Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administration of Anticonvulsants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recognizing Normal Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Suicide Precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PATIENTS WITH MUSCULOSKELETAL PROBLEMS			
Care of Patients with Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cast Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patients with Behaviors of:							
Wandering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Range of Motion Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Assisstive Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer Techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gait Retraining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Combativeness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Application of Prosthetic Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reality Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Application of Othotic Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessing Levels of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Patients with:			
OBRA GUIDELINES				Neuromuscular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interdisciplinary Care Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritic/Rheumatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Antipsychotic Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PATIENTS WITH ENDOCRINE PROBLEMS			
Patients Rights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Single Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertion of:				Mixed Insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catheter – Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of Blood Glucose Meter Device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catheter – Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Performing Fingersticks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catheter – Suprapubic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PATIENTS WITH GENITOURINARY PROBLEMS			
Bladder Irrigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Removal of a Pessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collection of Vaginal Cultures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermittent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Collection of Urine Specimens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patients with:				Bladder Retraining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESIDENTS WITH SENSORY PROBLEMS			
A-V Shunt/Fistula Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Denture Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Urinary diversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Application of Hearing Aid Devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrostomy Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Patient with Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESIDENTS WITH GASTROINTESTINAL PROBLEMS				Prosthetic Eye Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitz Bath Treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of Stool Specimens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Resident with:			
Care of Patients with Ostomies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Disimpaction & Cleansing Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Retraining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syringe Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Inserting:							
Nasogastric Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Gastrostomy Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Name _____

Address _____

Date _____

Signature _____