


Exhibit C		
Solicitation No.:	BPM006652	
Description:	Nursing and Habilitation Services for Individuals with Intellectual Disabilities at Intermediate Care Facilities and State Owned Group Homes	

Exhibit C - State Operated Residential Services Nursing Skills Checklist

Name: _____

Date: _____

Years of Experience: _____

Directions for completing skills checklist:

The following is a list of procedures performed in rendering care to patients. Please indicate the level of experience/proficiency. Use the following key as a guideline:

- A.) Theory Only/No Experience-** Received Education, has not performed skill.
- B.) Limited Experience-** Knows procedure/has used equipment but has done so infrequently or not within the last six months.
- C.) Moderate Experience-** Able to demonstrate equipment/procedure, perform the task/skill independently with only resource assistance needed.
- D.) Proficient/Competent-** Able to demonstrate/perform the task/skill proficiently without any assistance and can instruct/teach

A.) CARDIAC

- | | | | | |
|-------------------------------|---|---|---|---|
| 1. Assessment of heart sounds | A | B | C | D |
| 2. Use of cardiac monitors | A | B | C | D |
| 3. Cardiac Arrest | A | B | C | D |
| 4. CPR | A | B | C | D |
| 5. Use of AED | A | B | C | D |
| 6. Care of patients with CHF | A | B | C | D |

B.) GENITOURINARY


- | | | | | |
|------------------------|---|---|---|---|
| 1. Fluid Balance | A | B | C | D |
| 2. Foley Catheter | A | B | C | D |
| 3. Straight Catheter | A | B | C | D |
| 4. Suprapubic Catheter | A | B | C | D |
| 5. Ileostomy | A | B | C | D |
| 6. GU Irrigations | A | B | C | D |
| 7. Nephrostomy Tube | A | B | C | D |

C.) ENDOCRINE

- | | | | | |
|------------------------------------|---|---|---|---|
| 1. Blood Glucose Check | A | B | C | D |
| 2. Insulin Administration | A | B | C | D |
| 3. Care of residents with Diabetes | A | B | C | D |

D.) GASTROINTESTINAL

- | | | | | |
|---|---|---|---|---|
| 1. NG tube care, insertion and feeding | A | B | C | D |
| 2. Gastrostomy tube care, insertion and feeding | A | B | C | D |
| 3. Jejunostomy tube care and feeding | A | B | C | D |

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|-------------------------------|---|---|---|---|
| 4. Colostomy Care | A | B | C | D |
| 5. Assessment of Bowel Sounds | A | B | C | D |

E.) MEDICATIONS

- | | | | | |
|--------------------------------------|---|---|---|---|
| 1. Medication Calculation | A | B | C | D |
| 2. Reconstitution | A | B | C | D |
| 3. Oral Administration | A | B | C | D |
| 4. Eye/Ear Administration | A | B | C | D |
| 5. IM Administration | A | B | C | D |
| 6. SQ Administration | A | B | C | D |
| 7. Rectal Administration | A | B | C | D |
| 8. Enteral tube Administration | A | B | C | D |
| 9. Nebulizer/ Inhaler Administration | A | B | C | D |

F.) NEUROLOGY

- | | | | | |
|--|---|---|---|---|
| 1. Assessment of Neurological Status | A | B | C | D |
| 2. Seizure Precautions/management | A | B | C | D |
| 3. Care of patient with a CVA | A | B | C | D |
| 4. Care of patient with Alzheimer's | A | B | C | D |
| 5. Care of patient with Spinal Cord Injury | A | B | C | D |
| 6. Use of Vagal Nerve Stimulator | A | B | C | D |

G.) ORTHO/SKIN


- | | | | | |
|---|---|---|---|---|
| 1. Assessment of skin | A | B | C | D |
| 2. Wound Care and Treatments | A | B | C | D |
| 3. Use of special pressure relief devices | A | B | C | D |
| 4. Care of patients with a total hip replacement | A | B | C | D |
| 5. Care of patients with a total knee replacement | A | B | C | D |
| 6. Assistive Devices (walkers, wheelchairs, gauntlets, AFO's) | A | B | C | D |

H.) RESPIRATORY

- | | | | | |
|--|---|---|---|---|
| 1. Assessment of lung sounds | A | B | C | D |
| 2. Pulse Oximetry | A | B | C | D |
| 3. Oxygen Administration via nasal cannula | A | B | C | D |
| 4. Oxygen Administration via face mask | A | B | C | D |
| 5. Principles of chest percussions | A | B | C | D |
| 6. Care of patients with COPD | A | B | C | D |
| 7. Care of patients with a Tracheotomy | A | B | C | D |
| 8. Use of coughalator | A | B | C | D |
| 9. Nasal/Oral deep suctioning | A | B | C | D |

I.) LEADERSHIP/PATIENT CARE

- | | | | | |
|-------------------------|---|---|---|---|
| 1. Taking Charge | A | B | C | D |
| 2. Admission Procedures | A | B | C | D |
| 3. Discharge Procedures | A | B | C | D |

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|---|---|---|---|---|
| 4. Patient/Staff Education | A | B | C | D |
| 5. Nursing Care Plans | A | B | C | D |
| 6. Documenting clear, concise narrative about the resident’s status | A | B | C | D |
| 7. Maintain Doctors orders | A | B | C | D |

The information I have given is true and accurate to the best of my knowledge.

_____	_____
Signature	Date
Signature of person reviewing _____ Date _____	