



# Hudson Staffing

\* Denotes required field

This profile is for use by Psychiatric nurses with more than one year experience in their discipline and specialty. It will not be a determining factor in your acceptance for the program.

Please enter your full legal name as it appears on your **Social Security Card**.

**First name\***

**Last name\***

Email

**Please indicate your level of experience**

A. Theory, no practice

C. One - two years experience

B. Intermittent experience

D. Two plus years experience

## A. PSYCHIATRIC

### 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
- (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. Psychiatric emergency response team A  B  C  D
- s. Psychiatric 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 outpatient 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
- f. Rectal
- g. Sub-q
- h. Unit dose
- i. Z-technique

- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D

**B. PHLEBOTOMY/IV THERAPY**

- 1. Equipment & procedures
  - a. Administration of blood/blood products
    - (1) Packed red blood cells
    - (2) Whole blood
  - b. Drawing blood from central line
  - c. Drawing venous blood
  - d. Management of patient with hyperalimantation
  - e. Management of patient with IV
  - f. Starting IVs
    - (1) Angiocath
    - (2) Butterfly
    - (3) Heparin lock

- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- A  B  C  D
- 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:**

	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can ensure a safe environment reflecting specific needs of various age groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 date for each certificate that you have. If you do not know the exact date, please use the last date of the specific month (e.g., 08/31/2003).

- BCLS Exp. date: \_\_\_\_\_ (mm/dd/yyyy)
- MAB Exp. date: \_\_\_\_\_ (mm/dd/yyyy)
- Other (type): \_\_\_\_\_ Exp. date: \_\_\_\_\_ (mm/dd/yyyy)
- Computerized charting system: \_\_\_\_\_ date: \_\_\_\_\_ (mm/dd/yyyy)
- Medication administration system: \_\_\_\_\_ 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 Psychiatric Checklist to the Client facilities in relation to consideration of employment as a Traveler with those facilities.