



Please Complete and Fax to: 800-807-1963

Or mail to:

Medical Staffers, LLC
910 Brooks St.
Missoula, MT 59801

Questions? 800-393-1559

Last Name _____ First Name _____ MI _____

DIALYSIS RN SKILLS CHECKLIST

The following checklist is used to assess your experience and skills and help us place you in the proper assignment. Please provide an accurate self-assessment of your skills using the following guidelines:

1. No experience
2. Limited Experience
3. Experienced
4. Highly Skilled
5. Able to teach and supervise

| RENAL / GENITOURINAR | 1 | 2 | 3 | 4 | 5 |
|--------------------------------|---|---|---|---|---|
| Assessment of Renal/GU System | | | | | |
| Insertion of Foley | | | | | |
| CARE OF PATIENT WITH | | | | | |
| Nephrostomy Tube | | | | | |
| AV Fistula/AV Graft | | | | | |
| Tunneled/Non-Tunneled Catheter | | | | | |
| Ileal Conduit | | | | | |
| Supra-Pubic Catheter | | | | | |
| Chronic Renal Failure | | | | | |
| Acute Renal Failure | | | | | |
| Nephrectomy | | | | | |
| Turp | | | | | |
| Peritoneal Dialysis | | | | | |
| Hemodialysis | | | | | |

| HEMODIALYSIS | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| EXPERIENCE | | | | | |
| Acute/Inpatient Dialysis | | | | | |
| Chronic/Outpatient Dialysis | | | | | |
| Pediatric Dialysis | | | | | |
| Predialysis Nursing Assessment | | | | | |
| Teaching the Dialysis Patient and Family | | | | | |
| SET UP / INITIATE DIALYSIS TREATMENT | | | | | |
| Bicarbonate Dialysate | | | | | |
| Conductivity Testing | | | | | |
| Priming Dialyzer | | | | | |
| Checks for Machine/Alarm Settings | | | | | |
| Prep Vascular Access | | | | | |
| Fistula Gortex/Bovine Graft | | | | | |
| Dialysis | | | | | |
| Collect Blood Specimens | | | | | |
| Anticoagulation | | | | | |
| ASSESS PATIENT AND EQUIPMENT DURING DIALYSIS | | | | | |
| Systems Assessment of Patient | | | | | |
| Volume Status | | | | | |
| Vascular Access Function | | | | | |
| Arterial and Venous Pressures | | | | | |
| Blood Flow Rate | | | | | |
| Subjective Response to Treatment | | | | | |
| Management of Anticoagulation | | | | | |
| Conductivity | | | | | |

| HEMODIALYSIS - CONTINUED | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| ASSESS PATIENT AND EQUIPMENT DURING DIALYSIS | | | | | |
| Ultrafiltration Calculation | | | | | |
| Operation of Myron L. Meter | | | | | |
| Administration of Mannitol | | | | | |
| Sequential Ultrafiltration/PUF | | | | | |
| Documentation of Dialysis Treatment | | | | | |
| MANAGEMENT OF THE PATIENT WITH | | | | | |
| Fluid Overload | | | | | |
| Hypertension | | | | | |
| Hypotension | | | | | |
| Disequilibrium Syndrome | | | | | |
| Hyperkalemia | | | | | |
| Seizures | | | | | |
| Muscle Cramps | | | | | |
| Clotted /Poor Blood Flow Rate from Catheter | | | | | |
| Pyrogenic Reaction | | | | | |
| Hemolysis | | | | | |
| Ar Embolus | | | | | |
| Chest Pain | | | | | |
| Anemia | | | | | |
| Neuropathy | | | | | |
| Pericarditis | | | | | |
| Filter Blood Leak | | | | | |
| Cardiopulmonary Arrest | | | | | |
| MACHINE ALARM TROUBLESHOOTING PROCEDURES | | | | | |
| Blood Leak Alarm | | | | | |
| Arterial Pressure Alarm | | | | | |
| Venous Pressure Alarm | | | | | |
| Conductivity Alarm | | | | | |
| Ultrafiltration Alarm | | | | | |
| High Temperature Alarm | | | | | |
| Air/Foam Detector Alarm | | | | | |
| Power Failure Alarm | | | | | |
| Blood Pump Failure | | | | | |
| DISCONTINUE DIALYSIS | | | | | |
| Dialysis Catheter | | | | | |
| Fistula/Vein Graft | | | | | |
| Return of Blood | | | | | |
| Post Treatment Access Care | | | | | |
| Equipment Clean up | | | | | |
| Sterilization Procedures | | | | | |

DIALYSIS RN SKILLS CHECKLIST

Age Appropriate Care: The ability to adapt care to incorporate normal growth and development, adapt method and terminology of client instructions as it relates to the age and comprehension level of the client, and to ensure a safe environment - reflecting specific needs of the client and various age groups.

| AGE | 1 | 2 | 3 | 4 | 5 |
|-----------------------------|---|---|---|---|---|
| Newborn (birth- 30 days) | | | | | |
| Infant (30 days-1 year) | | | | | |
| Toddler (1-3 years) | | | | | |
| Preschooler (3- 5 years) | | | | | |
| School Age (5 -12 years) | | | | | |
| Adolescents (12-18 years) | | | | | |
| Young Adults (18-39 years) | | | | | |
| Middle Adults (39-64 years) | | | | | |
| Older Adults (64+ years) | | | | | |

The information I have provided above is true and accurate to the best of my knowledge, and I hereby authorize Medical Staffers, LLC to release this checklist to any potential employer that is contracted with Medical Staffers, LLC.

Employee Signature _____

Name and Title (please print) _____

Date _____