

Dialysis RN Skills Checklist

Name: Date: Experience Since:

| | Comfortable With | Done Occasionally | No Experience |
|--|--------------------------|--------------------------|--------------------------|
| A. RENAL/ GENITOURINARY | | | |
| 1. Assessment of Renal/GU System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Insertion of Foley | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Care of the Patient with: | | | |
| a. Nephrostomy Tube | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. AV Fistula/AV Graft | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tunneled/Non-Tunneled Catheter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ileal Conduit | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Supra-Pubic Catheter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Chronic Renal Failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Acute Renal Failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Nephrectomy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. TURP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Peritoneal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Hemodialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. HEMODIALYSIS SKILLS AND PROCEDURES | | | |
| 1. Experience | | | |
| a. Acute/Inpatient Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Chronic/Outpatient Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dialysis Home Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pediatric Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Predialysis Nursing Assessment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Teaching the Dialysis Patient and Family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Set Up/Initiate Dialysis Treatment | | | |
| a. Bicarbonate Dialysate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Conductivity Testing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Priming Dialyzer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Checks for Machine/Alarm Settings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Prep Vascular Access | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fistula Gortex/Bovine Graft | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Collect Blood Samples | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Anticoagulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Assess Patient and Equipment during dialysis | | | |
| a. System Assessment of Patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Volume Status | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Vascular Access Function | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Arterial and Venous Pressures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Blood Flow Rate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Subjective Response to Treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Management of Anticoagulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Conductivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name: Date:

| | Comfortable With | Done Occasionally | No Experience |
|--|--------------------------|--------------------------|--------------------------|
| i. Ultrafiltration Calculation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Operation of Myron L. Meter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Administration of Blood and Blood Products | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Administration of Mannitol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Sequential Ultrafiltration/PUF | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Documentation of dialysis treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Management of a Patient with | | | |
| a. Fluid Overload | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hypotension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Disequilibrium Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hyperkalemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Muscle Cramps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Clotted Access/Poor Blood Flow Rate from Catheter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Pyrogenic Reaction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Hemolysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Air Embolus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Neuropathy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Pericarditis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Filter Blood Leak | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Cardiopulmonary Arrest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Machine Alarm Troubleshooting Procedures | | | |
| a. Blood leak alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arterial Pressure Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Venous Pressure Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Conductivity Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Ultrafiltration Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. High Temperature Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Air/Foam Detector Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Power Failure Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Blood Pump Alarm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Discontinue Dialysis | | | |
| a. Dialysis Catheter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Fistula/Vein Graft | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Return of Blood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Post Treatment Access Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Equipment Clean Up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sterilization Procedures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Signature: _____

Date: _____

Agency Representative Signature: _____

Date: _____