

PACU Skills Checklist

Name: Date: Experience Since:

	Comfortable With	Done Occasionally	No Experience
I. CHARTING			
a. Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. DARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. APIE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. SOAPIE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. FOCUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Discharge Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Utilization Review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Chart Review/Audit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. ADMISSION			
a. Initial Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Airway Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Proper Positioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Skin Color, Temperature, Turgor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Neurological Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. ASSESSMENT			
a. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor Recovery From:			
a. General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Regional Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Local Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. PULMONARY			
a. Auscultate Breath Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Recognize Abnormal Breath Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interventions For Abnormal Breath Sounds:			
1. Reposition Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pulmonary Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Bronchodilators, Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. O2, Suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Airway Insertion/Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognize Abnormal Breathing:			
1. Assess Respiratory Rate, Rhythm, Depth & Symmetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Labored, Dyspneic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Obstructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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4. Laryngospasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Insufficient Reversal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform Suctioning:			
1. Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nasal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Endotracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Tracheal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O2 Administration:			
1. Face-Trach Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nasal Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. T-Piece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ETT Mechanical Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Tube Care:			
1. Set Up Closed Drainage System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Recognize Air Leak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assess For Subcutaneous Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Measure Drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Troubleshoot Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. POST OPERATIVE CARE FOR:			
a. Thoracic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Vascular Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Orthopedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Neurosurgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Tonsillectomy/P.E. Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Major Abdominal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. ENT Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Genitourinary Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Gynecological Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Post-Angiogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Liver Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Cardiac Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Transplant Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI. TUBES & DRAINS			
Care of Patient With:			
1. Penrose Drain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Salem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Davol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Jejunostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Jackson Pratt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. T-Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Foley Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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a. Urethral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Suprapubic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cystotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. NG Tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VII. CARDIOVASCULAR			
Care of a Patient:			
1. On a Cardiac Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Permanent or Temporary Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Arrhythmia Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cardioversion and Defibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Assist With Insertion of a Temporary Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intravascular Hemodynamic Monitoring Equipment:			
a. Pulmonary Artery Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Arterial Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Swan-Ganz Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Central Venous Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Subclavian Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Epidural Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Equipment Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dressing Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Prevention of Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Leveling Waveform Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Cardiac Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. PA Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. PCWP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. CVP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. LAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Medications:			
a. Antiarrhythmics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Inotropes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Vasopressors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Vasodilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reversal Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Betablockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Calcium Channel Blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Inhalation Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Electrolyte Imbalances/ABG'S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VIII. EQUIPMENT			
a. Portable Suction Machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Transport Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Automatic BP Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Blanket Warmer/Bair Hugger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sequential Compression Device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Pulse Oximeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Pee Wee Weighing Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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h. Hyper/Hypothermia Blanket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Blood Warmer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. PACU Stretcher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. IV Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Invasive Pressure Monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Anesthesia Equipment:			
a. Blood Warmer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. BP Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dinamap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Omeda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. EKG Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. SAO2 Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Nitrogen Tanks/Wall Units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thermia Blankets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IX. DISCHARGE			
1. Implement Physician Orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. MD Notifications and Follow- Up Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment:			
a. Level of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pupillary Reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Motor and Sensory Functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Muscular Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Date

Agency Representative Signature

Date