

## LPN Skills Checklist

Name:  Date:  Experience Since:

	Comfortable With	Done Occasionally	No Experience
<b>I. DEPARTMENTS</b>			
a. Burn Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Mother/Baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Cardiac Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Labor and Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Obstetrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Pediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Orthopedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Post Partum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Telemetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Doctor's Office/Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II. INFECTION CONTROL</b>			
a. Knowledge of universal precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Knowledge of waste disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Proper disposal of sharps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Management of patient in respiratory isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Care of the patient in reverse isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Cleaning of equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III. PROCEDURES</b>			
a. Set-up/ Instruct patient in Sitz Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Administer:</b>			
1. Tap/saline enema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Soap suds enema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Oil retention enema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fleets enema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Post mortem care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Douches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. Perform:</b>			
1. Wet to dry dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sterile dressing changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Bladder irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name:

Date:

	Comfortable With	Done Occasionally	No Experience
4. Ostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. NG tube feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Gastrostomy tube feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Personal hygiene/oral care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Wound irrigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Catheterization (male & female)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Nasal suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Oral suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d. Management of:</b>			
1. Levine tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nephrostomy catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Jejunostomy tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Chest tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV. MEDICATION ADMINISTRATION</b>			
a. Oral medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Subcutaneous injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Intramuscular injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Z - track injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Heparin lock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Intradermal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Vaginal suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Ophthalmic drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Nasal drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Ophthalmic ointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Inhalers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Rectal suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Emergency medications/crash cart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>V. INTRAVENOUS</b>			
a. Starting an IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Change IV tubing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Discontinuing an IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Piggyback administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. IV push drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Plasma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Packed RBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Regulate flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Maintain IV site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Hyperalimentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. CVP line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Medication addition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Whole blood administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Serum albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VI. SPECIMEN COLLECTION</b>			

Name: Date: 

	Comfortable With	Done Occasionally	No Experience
<b>a. Obtain:</b>			
1. Urine for specific gravity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Urine for culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Foley catheter specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Stool specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Stool hemocult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Stool ova/parasite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sputum specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Perform straight catheterization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Instruct patient/assist with clean catch midstream urine specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Collect 24 hour urine specimen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VII. ASSESSMENT</b>			
<b>a. Management of a patient with:</b>			
1. Drug/allergic reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiopulmonary arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Perform:</b>			
1. Neurological assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiovascular assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Gastrointestinal assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Musculoskeletal assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Genitourinary assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Respiratory assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VIII. EQUIPMENT</b>			
<b>a. Use of:</b>			
1. Hemovac/Davol suction pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Wall suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Corstovac suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pleurevac/Emerson suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Infusion devices (volumetric pump)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Venturi mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Hoyer lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Enteral pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ambu-bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Humidifiers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Heat lamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Blood glucose monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Bed scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Heating pad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Incentive spirometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Egg crate mattress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Alternate pressure mattress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. Management of:</b>			
1. Trach collar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Oxygen mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nasal cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Care of patient with PCS pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name:  Date:

	Comfortable With	Done Occasionally	No Experience
d. Application of TED hose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. ABG kits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Assist with set-up of water seal suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>g. Application of:</b>			
1. Soft limb restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Leather restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Posey restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Observation of patient in restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Documentation of restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Knowledgeable of safety guidelines of patient in restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date