

Recovery Room – PACU Skills Checklist

Level of Proficiency

- A:** Theory, no practice
B: Intermittent experience
C: One-two years experience
D: Two plus years experience

Name: _____

Date: _____

| SKILL | A | B | C | D | | SKILL | A | B | C | D | |
|-----------------------------------|---|---|---|---|--|-------------------------------------|---|---|---|---|--|
| RESPIRATORY: | | | | | | RESPIRATORY (CONT): | | | | | |
| Airway Management: | | | | | | Ventilator | | | | | |
| Chin Lift | | | | | | Assist with Arterial Line Insertion | | | | | |
| Jaw Thrust | | | | | | Arterial Line D/C | | | | | |
| Insertion of Oral Airways | | | | | | Draw Blood from Arterial Line | | | | | |
| Insertion of Nasal Airways | | | | | | Draw ABGs via Arterial Stick | | | | | |
| Removal of Oral/nasal Airways | | | | | | Interperate ABGs | | | | | |
| Oxygen Administration via: | | | | | | CARDIOVASCULAR: | | | | | |
| Nasal Cannula | | | | | | Abnormal Heart Sounds | | | | | |
| Face Tent | | | | | | Basic Arrythmias | | | | | |
| Mask | | | | | | Use of Cardiac Monitors | | | | | |
| Vent | | | | | | Controlled Cardioversion | | | | | |
| Non-Rebreather | | | | | | Set up CVP Line | | | | | |
| Aerosol | | | | | | Care of CVP Line | | | | | |
| Continuous Suction Set-up | | | | | | Obtain CVP Readings | | | | | |
| Intermittent Suction Set-up | | | | | | D/C Central Line | | | | | |
| Use of pulse oximeter | | | | | | Use of Doppler | | | | | |
| Extubation | | | | | | Care of Patient with: | | | | | |
| Assist with intubation | | | | | | Post-Op AAA Repair | | | | | |
| Assessment of breath sounds | | | | | | Hypovolemia | | | | | |
| Respiratory Obstruction | | | | | | Pacemaker | | | | | |
| Hypoventilation | | | | | | Management of Shock | | | | | |
| Laryngospasm/Bronchospasm | | | | | | Management of Hypertensive Crisis | | | | | |
| Aspiration | | | | | | Management of Hypotensive Crisis | | | | | |
| Atelectasis | | | | | | Assessment of Peripheral Pulses | | | | | |
| Use of Ambu Bag | | | | | | Vasoactive Drug Administration | | | | | |
| Tracheostomy | | | | | | | | | | | |
| Chest Tube | | | | | | | | | | | |

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| SKILL | A | B | C | D | | SKILL | A | B | C | D | |
|--|---|---|---|---|--|--|---|---|---|---|--|
| NEUROLOGICAL: | | | | | | MISCELLANEOUS: | | | | | |
| Level of Consciousness | | | | | | Care of patient with: | | | | | |
| Seizure Precautions | | | | | | Malignant Hyperthermia | | | | | |
| Intracranial Pressure Monitoring | | | | | | Latex Allergy | | | | | |
| Administration of Steroids | | | | | | HIV / AIDS | | | | | |
| Care of Post-Op Craniotomy | | | | | | Hypothermia | | | | | |
| GASTROINTESTINAL: | | | | | | Infectious Disease | | | | | |
| Nasogastric Tube Insertion | | | | | | Anaphylactic Shock | | | | | |
| Enterostomal Care | | | | | | Patient Stimulation and Stir-up Regimen | | | | | |
| Operation of Gomco/Emerson Suction | | | | | | Dressing Change | | | | | |
| GENITOURINARY: | | | | | | Isolation Techniques | | | | | |
| Insertion of Straight Catheter | | | | | | Use of Reversal Drugs | | | | | |
| Insertion of Foley Catheter | | | | | | Use of Warming Blankets | | | | | |
| Management of three-way Foley Catheter w/ Bladder Irrigation | | | | | | Use of Computers | | | | | |
| Care of Nephrostomy/Suprapubic Tubes | | | | | | Use of Anti-Emetic Drugs | | | | | |
| Management of Post-Op Renal Transplant | | | | | | <div style="border-bottom: 1px solid black; display: inline-block; width: 100px; margin-bottom: 5px;"></div> Years of Experience in PACU | | | | | |
| ORTHOPEDIC: | | | | | | | | | | | |
| Cast Care | | | | | | | | | | | |
| Management of Skeletal Traction | | | | | | | | | | | |
| Use of Continuous Passive Motion Machine (CPM) | | | | | | | | | | | |
| Management of Post-Op Total Joint Replacement | | | | | | | | | | | |
| PAIN MANAGEMENT: | | | | | | | | | | | |
| Administration of Morphine | | | | | | | | | | | |
| Administration of Meperidine | | | | | | | | | | | |
| Administration of Fentanyl | | | | | | | | | | | |
| Fracture tables | | | | | | | | | | | |
| Laser | | | | | | | | | | | |
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The information I have given is true and accurate to the best of my knowledge. I hereby authorize PACE Medical Staffing, Inc. to release this list to client health care facilities of PACE Medical Staffing, Inc.

Name

Signature (required):