



LABOR AND DELIVERY SKILLS CHECKLIST

NAME: _____ DATE: _____

YEARS OF EXPERIENCE: _____

PLEASE INDICATE YOUR LEVEL OF EXPERIENCE

1. THEORY, NO PRACTICE - DIDACTIC INSTRUCTION ONLY, NO HANDS ON EXPERIENCE
2. LIMITED EXPERIENCE - KNOWS PROCEDURE/HAS USED EQUIPMENT, BUT HAS DONE SO INFREQUENTLY OR NOT WITHIN THE LAST SIX MONTHS.
3. MODERATE EXPERIENCE. - ABLE TO DEMONSTRATE EQUIPMENT/PROCEDURE, PERFORMS THE TASK/SKILL INDEPENDENTLY WITH ONLY RESOURCE ASSISTANCE NEEDED
4. PROFICIENT/COMPETENT - ABLE TO DEMONSTRATE/PERFORM THE TASK/SKILL PROFICIENTLY WITHOUT ANY ASSISTANCE AND CAN INSTRUCT/TEACH

A. ANTEPARTUM

- | | | | | |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT: | 1 | 2 | 3 | 4 |
| A. ASSESS FOR COMFORT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BREATHING/RELAXATION TECHNIQUES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. COACHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. POSITIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. EQUIPMENT & PROCEDURES: | | | | |
| A. CATHETER INSERTION | | | | |
| 1) FOLEY CATHETER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) STRAIGHT CATHETER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DELIVERY TABLE SET-UP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. ULTRA SOUND: | | | | |
| 1) AMNIOTIC FLUID INDEX | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) ASSIST WITH ULTRA SOUND | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) BIOPHYSICAL PROFILE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PERFORM SONOGRAM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

B. LABOR ASSESSMENT

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. FETAL ASSESSMENT: | | | | |
| A. AUSCULTATE FETAL HEART RATE | | | | |
| 1) DOPPLER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FETOSCOPE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. LEPOLD MANEUVERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DOCUMENT FHR PATTERNS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. IDENTIFY NORMAL & TREAT ABNORMAL FHR PATTERNS | | | | |
| 1) BASELINE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) EARLY DECELERATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) LATE DECELERATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) PROLONGED DECELERATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) VARIABILITY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) VARIABLE DECELERATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. MATERNAL ASSESSMENT: | | | | |
| A. DEEP TENDON REFLEXES (DTRs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. EDEMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. NORMS FOR PERINATAL VITAL SIGNS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. PERFORM ADMISSION RISK ASSESSMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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|---|--------------------------|--------------------------|--------------------------|--------------------------|
| E. PRESENCE OF CLONUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. PROGRESSION OF LABOR: | | | | |
| 1) CONTRACTION CHARACTERISTICS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) DILATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) EFFACEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) FETAL PRESENTATION/ POSITION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) STATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) STATUS OF MEMBRANES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) STERILE SPECULUM EXAM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) VAGINAL EXAM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. RUPTURE OF MEMBRANES | | | | |
| 1) FERN TEST | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) NITRAZINE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. EQUIPMENT & PROCEDURES: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A. AMNIOINFUSION (ASSIST OR PERFORM): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) FOR MECONIUM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FOR VARIABLE DECELERATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. ARTIFICIAL RUPTURE OF MEMBRANES (ASSIST): | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) PROLAPSED CORD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) RECOGNIZE POTENTIAL COMPLICATIONS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) VASA PREVIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. COLLECT BLOOD/ URINE SPECIMENS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. COLLECT VAGINAL CULTURES: | | | | |
| 1) CHLAMYDIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FLUID | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) GROUP B STREP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) HERPES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. DOCUMENT LABOR STATUS /ASSESSMENT & INTERVENTIONS: | | | | |
| 1) ANTICONVULSANTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) LABOR SUPPRESSANTS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. EXTERNAL FETAL MONITOR APPLICATION: | | | | |
| 1) DOPPLER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

- 2) TOCOTRANSDUCER, ULTRASOUND
- G. INTERNAL MONITORING (ASSIST OR PERFORM INSERTION):
 - 1) INTRAUTERINE PRESSURE CATHETER:
 - A) FLUID FILLED
 - B) B) TRANSDUCER TIPPED
 - 2) SPIRAL ELECTRODE
- 4. MEDICATIONS:
 - A. ADMINISTER IM/SC
 - B. ADMINISTER IV MEDS/MONITOR IV DRIPS:
 - 1) ANTIBIOTICS
 - 2) ANTIHYPERTENSIVES
 - 3) MAGNESIUM SULFATE
 - 4) NARCOTICS
 - 5) OXYTOCIN
 - C. ASSIST WITH PROSTIN GEL
 - D. CERVIDIL INSERTION
 - E. USE OF CYTOTEC
 - F. USE OF PROSTIN SUPPOSITORIES
- C. COMPLICATIONS OF PREGNANCY
 - 1. ASSESSMENT:
 - A. IDENTIFY COMMON ARRHYTHMIAS
 - B. NORMAL CARDIAC RHYTHMS
 - C. PATIENT EDUCATION FETAL MOVEMENT COUNTS
 - 2. EQUIPMENT & PROCEDURES:
 - A. ASSIST WITH EXTERNAL VERSION
 - B. ASSIST WITH FETAL SCALP SAMPLING
 - C. ASSIST WITH PERCUTANEOUS UMBILICAL SAMPLING
 - D. ASSIST WITH UMBILICAL BLOOD SAMPLING
 - E. CIRCULATE FOR CESAREAN DELIVERY
 - F. CIRCULATE, SCRUB FOR BILATERAL TUBAL LIGATION
 - G. CONDUCT CONTRACTION STRESS TEST:
 - 1) BREAST STIMULATION
 - 2) OXYTOCIN CHALLENGE
 - H. CONDUCT NON-STRESS TEST
 - I. GLUCOSE REFLECTOMETER
 - J. LINES/MONITORING:
 - 1) CENTRAL VENOUS LINES
 - 2) INVASIVE HEMODYNAMIC MONITORING
 - 3) PICC LINES
 - 4) PULMONARY ARTERY CATHETERS
 - K. SCRUB FOR CESAREAN DELIVERY
 - L. SET UP CESAREAN DELIVERY
 - 3. CARE OF THE PATIENT WITH:
 - A. ABRUPTIO PLACENTA
 - B. ASTHMA

- C. CARDIAC DISEASE
- D. CHORIOAMNIONITIS
- E. CHRONIC HYPERTENSION
- F. COLLAGEN VASCULAR DISEASE
- G. DIABETES
- H. ECLAMPSIA
- I. HBV
- J. HELLP SYNDROME
- K. HEMOLYTIC ANEMIAS
- L. HEMORRHAGE
- M. HIV POSITIVE
- N. HYPERTENSION
- O. MALPRESENTATIONS
- P. MULTIPLE GESTATION
- Q. OTHER INFECTIONS
- R. PLACENTA PREVIA
- S. PREECLAMPSIA
- T. PREMATURE LABOR
- U. PYELONEPHRITIS
- V. RH DISEASE
- W. SICKLE CELL DISEASE
- 4. MEDICATIONS:
 - A. INDOMETHACIN
 - B. INSULIN
 - C. MAGNESIUM SULFATE
 - D. PROCARDIA
 - E. RITODRINE
 - F. TERBUTALINE:
 - 1) IV
 - 2) PO
 - 3) PUMP
 - 4) SC
- D. INTERVENTIONS DURING PREGNANCY
 - 1. CESAREAN SECTION
 - 2. FORCEPS VAGINAL DELIVERY
 - 3. MONITOR PATIENTS WITH ANESTHESIA:
 - A. GENERAL ANESTHESIA
 - B. REGIONAL ANESTHESIA:
 - 1) EPIDURAL
 - 2) LOCAL INFILTRATION
 - 3) SPINAL
 - 4. SPONTANEOUS VAGINAL DELIVERY
 - 5. VACUUM EXTRACTION DELIVERY
- E. INFANT INTERVENTIONS POST DELIVERY
 - 1. ASSESSMENT:
 - A. APGAR SCORING
 - B. INITIAL VITAL SIGNS
 - C. INTERVENTION/RISK FACTORS FOR:
 - 1) IDM
 - 2) LGA, SGA, IUGR
 - D. NEWBORN PHYSICAL ASSESSMENT:

NAME: _____

- 1) BALLARD
- 2) DUBOWITZ
- 3) FINNEGAN SCORING
- 2. EQUIPMENT & PROCEDURES:
 - A. ASSIST WITH INITIAL BREAST FEEDING
 - B. ASSIST WITH INTERVENTIONS FOR MECONIUM STAINING
 - C. BATH-PERFORM AND TEACH
 - D. CARDIAC-RESPIRATORY MONITOR PLACEMENT
 - E. CIRCUMCISION CARE
 - F. CORD CARE
 - G. DISCHARGE TEACHING
 - H. HEELSTICK GLUCOSE DETERMINATION
 - I. INFANT IDENTIFICATION
 - J. NEONATAL RESUSCITATION
 - K. OBTAIN HEMATOCRIT
 - L. OBTAIN NEONATAL TOXICOLOGY SCREEN
 - M. PHOTOTHERAPY
 - N. PROMOTE BONDING BEHAVIORS
 - O. SUCTIONING
 - 1) BULB
 - 2) DELEE
 - 3) WALL
- 3. MEDICATIONS:
 - A. EYE PROPHYLAXIS
 - B. VITAMIN K
- F. POST PARTUM INTERVENTIONS
 - 1. ASSESSMENT:
 - A. BLADDER DISTENTION
 - B. BREAST FEEDING:
 - 1) LATCH-ON
 - 2) POSITIONING
 - C. DVT (DEEP VEIN THROMBOSIS)
 - D. EPISIOTOMY
 - E. FLUID BALANCE
 - F. FUNDAL HEIGHT
 - G. FUNDAL MASSAGE
 - H. LOCHIA AMOUNT
 - I. I. MATERNAL VITAL SIGNS

- G. PHLEBOTOMY/IV THERAPY
 - 1. EQUIPMENT & PROCEDURES:
 - A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS:
 - 1) CRYOPRECIPITATE
 - 2) PACKED RED BLOOD CELLS
 - 3) PLASMA/ALBUMIN
 - 4) WHOLE BLOOD
 - B. DRAWING BLOOD FROM CENTRAL LINE
 - C. DRAWING VENOUS BLOOD
 - D. STARTING IVS:
 - 1) ANGIOCATH
 - 2) BUTTERFLY
 - 3) HEPARIN LOCK
 - 2. CARE OF THE PATIENT WITH:
 - A. CENTRAL LINE/CATHETER/DRESSING
 - B. PERIPHERAL LINE/DRESSING
- H. PAIN MANAGEMENT & ANESTHESIA
 - 1. ASSESSMENT OF PAIN LEVEL/TOLERANCE
 - 2. CARE OF THE PATIENT WITH:
 - A. EPIDURAL ANESTHESIA/ANALGESIA
 - B. IV CONSCIOUS SEDATION
 - C. PATIENT CONTROLLED ANALGESIA (PCA PUMP)
 - 3. ASSIST WITH DELIVERY OF ANESTHESIA:
 - A. ANESTHESIA TOXICITY
 - B. COACHING PATIENT
 - C. EPIDURAL BLOCK
 - D. FLUID CHALLENGE
 - E. HYPOTENSION
 - F. INTRATHECAL NARCOTICS
 - G. INTRAVASCULAR INJECTION
 - H. POSITIONING PATIENT
 - I. SIGNS/SYMPTOMS OF DURAL PUNCTURE
 - J. SPINAL ANESTHESIA
 - 4. DOCUMENTATION OF ANESTHESIA:
 - A. COMPUTER
 - B. FLOWCHART

NAME: _____

AGE SPECIFIC PRACTICE CRITERIA:

PLEASE CHECK THE BOXES BELOW FOR EACH AGE GROUP FOR WHICH YOU HAVE EXPERTISE IN PROVIDING AGE-APPROPRIATE NURSING CARE.

A. NEWBORN/NEONATE (BIRTH - 30 DAYS)	D. PRESCHOOLER (3 - 5 YEARS)	G. YOUNG ADULTS (18 - 39 YEARS)
B. INFANT (30 DAYS - 1 YEAR)	E. SCHOOL AGE CHILDREN (5 - 12 YEARS)	H. MIDDLE ADULTS (39 - 64 YEARS)
C. TODDLER (1 - 3 YEARS)	F. ADOLESCENTS (12 - 18 YEARS)	I. OLDER ADULTS (64+)

	A	B	C	D	E	F	G	H	I
ABLE TO ADAPT CARE TO INCORPORATE NORMAL GROWTH AND DEVELOPMENT.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABLE TO ADAPT METHOD AND TERMINOLOGY OF PATIENT INSTRUCTIONS TO THEIR AGE, COMPREHENSION AND MATURITY LEVEL.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAN ENSURE A SAFE ENVIRONMENT REFLECTING SPECIFIC NEEDS OF VARIOUS AGE GROUPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MY EXPERIENCE IS PRIMARILY IN:
(PLEASE INDICATE NUMBER OF YEARS.)**

LABOR & DELIVERY YEAR(S)

LDR _____ YEAR(S)

LDRP _____ YEAR(S)

COMMUNITY HOSPITAL _____ YEAR(S)

RURAL HOSPITAL _____ YEAR(S)

TEACHING HOSPITAL _____ YEAR(S)

NUMBER OF BIRTHS PER MONTH _____

CERTIFICATION:	EXP DATE:	CERTIFICATION:	EXP DATE:
<input type="checkbox"/> BCLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> ACLS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> PALS		<input type="checkbox"/> OTHER	
<input type="checkbox"/> OTHER		<input type="checkbox"/> OTHER	

THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE AS NEEDED STAFFING TO RELEASE THIS LABOR AND DELIVERY SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

SIGNATURE

DATE