



POST PARTUM/NURSERY 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. POST PARTUM INTERVENTIONS

- | | 1 | 2 | 3 | 4 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. ASSESSMENT: | | | | |
| A. BLADDER DISTENTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. BREAST ENGORGEMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DVT (DEEP VEIN THROMBOSIS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. EPISIOTOMY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. FLUID BALANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. FUNDAL HEIGHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. GI FUNCTION POST ANESTHESIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. LOCHIA AMOUNT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. MATERNAL VITAL SIGNS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. PARENTAL/
INFANTINTERACTION/
ATTACHMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. PERINEUM | | | | |
| 1) HEMATOMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) HEMORRHOIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. INTERPRETATION OF LAB RESULTS: | | | | |
| A. CHECK URINE FOR: | | | | |
| 1) GLUCOSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) KETONES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) PROTEIN | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) SPECIFIC GRAVITY | <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. ADULT CARDIOPULMONARY RESUSCITATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CONTRACEPTIVE COUNSELING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DISCHARGE TEACHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. FOSTER PARENTAL-INFANT INTERACTION/ ATTACHMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. INSERT CATHETER: | | | | |
| 1) FOLEY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) STRAIGHT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. POST ANESTHESIA CARE: | | | | |
| 1) EPIDURAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) GENERAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) LOCAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) SPINAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | 1 | 2 | 3 | 4 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| G. POST CESAREAN CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. TEACH AND ASSIST WITH: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1) BREASTFEEDING/ PARENT EDUCATION: | | | | |
| (A) LATCH-ON PROCEDURES | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (B) POSITIONING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (C) USE OF ELECTRIC BREAST PUMP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (D) USE OF MANUAL BREAST PUMP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) FORMULA PREPARATION AND FEEDING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) INFANT CARE RESTRAINT SYSTEMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) INFANT CARETAKING SKILLS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) PERINEAL CARE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) SITZ BATH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. CARE OF THE PATIENT WITH: | | | | |
| A. ASTHMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. CARDIAC DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. CESAREAN SECTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. DIABETES MELLITUS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. INFECTIOUS DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. KNOWN SUBSTANCE ABUSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. POST TUBAL LIGATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H. MULTIPLE BIRTHS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I. PREGNANCY INDUCED HYPERTENSION/ PREECLAMPSIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J. SPONTANEOUS VAGINAL DELIVERY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. MEDICATIONS | | | | |
| A. ANTIBIOTICS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DILUTED OXYTOCIN INFUSION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. IM ADMINISTRATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. RHOGAM ADMINISTRATION/ TEACHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NAME: _____

- E. SC MEDICATIONS, INCLUDING NARCOTICS** 1 2 3 4
- B. NORMAL NEONATAL CARE**
- 1. ASSESSMENT:**
- A. BALLARD SCALE
- B. CIRCUMFERENCE
- C. DUBOWITZ SCALE
- D. LENGTH
- E. NEONATAL JAUNDICE
- F. REFLEXES
- G. VITAL SIGNS
- H. WEIGHT
- I. LENGTH
- 2. EQUIPMENT & PROCEDURES:**
- A. ADMINISTER INJECTIONS TO NEONATE
- B. ASSIST WITH CIRCUMCISION
 1) ASSESS SITE POST OP
 2) TEACH CIRCUMCISION CARE TO PARENTS
- C. BATHE INFANT
- D. CULTURE SUSPECT INFECTIOUS NEONATE
- E. DISCHARGE PROCEDURE
- F. INCUBATOR/ISOLETTES
- G. INFANT IDENTIFICATION
- H. MONITOR BLADDER AND BOWEL PATTERNS:
 1) OBTAIN URINE SPECIMENS VIA SPECIMEN BAG
 2) TEST STOOL FOR BLOOD, REDUCING SUBSTANCES

- I. NEONATE CARDIOPULMONARY RESUSCITATION** 1 2 3 4
- J. PHOTOTHERAPY**
- K. THERMO-NEUTRAL ENVIRONMENT TO PREVENT COLD STRESS**
- C. PHLEBOTOMY/IV THERAPY**
- 1. EQUIPMENT & PROCEDURES:**
- A. ADMINISTRATION OF BLOOD/BLOOD PRODUCTS
 1) PACKED RED BLOOD CELLS
 2) PLASMA/ALBUMIN
 3) 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. ASSIS CENTRAL LINE / CATHETER/ DRESSING
- B. PERIPHERAL LINE/DRESSING
- D. PAIN MANAGEMENT**
- 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)

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"/> |

NAME: _____

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

COUPLET (MOTHER/BABY) _____YEAR(S)

NEWBORN NURSERY _____YEAR(S)

POST PARTUM _____YEAR(S)

CERTIFICATION:		EXP DATE:	CERTIFICATION:		EXP DATE:
<input type="checkbox"/>	BCLS		<input type="checkbox"/>	OTHER	
<input type="checkbox"/>	NRP		<input type="checkbox"/>	OTHER	
<input type="checkbox"/>	RNC		<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 POST PARTUM/NURSERY SKILLS CHECKLIST TO CLIENT FACILITIES OF AS NEEDED STAFFING IN RELATION TO CONSIDERATION OF MY EMPLOYMENT WITH THOSE FACILITIES.

SIGNATURE

DATE