

FRONTIER HEALTH CARE SERVICES

Post Partum/Nursery Skills Checklist

*** Denotes required field**

This profile is used for by Post Partum/Nursery nurses with more than one year experience in their discipline and specialty. It will not be a determining factor for the Frontier Health Care Services program.

Please enter your full legal name as it appears on your Social Security Card.

First name*

Last name*

Social Security Number

Date

Email

Please indicate your level of experience

- | | |
|----------------------------|----------------------------------|
| 1. Theory, no practice | 3. One – two years of experience |
| 2. Intermittent experience | 4. Two plus years of experience |

A. POST PARTUM INTEVENTIONS

1. Assessment

- | | |
|---|---|
| a. Bladder distension | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| b. Breast engorgement | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| c. DVT (deep vein thrombosis) | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| d. Episiotomy | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| e. Fluid balance | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| f. Fundal height | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| g. GI function post anesthesia | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| h. Lochia amount | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| i. Maternal vital signs | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| j. Parental/infant interaction/attachment | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| k. Perineum | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (1) Hematoma | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (2) Hemorrhoids | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |

2. Interpretation of lab results

- | | |
|----------------------|---|
| a. Check urine for | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (1) Glucose | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (2) Ketones | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (3) Protein | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| (4) Specific gravity | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |

3. Equipment & Procedures

- | | |
|--|---|
| a. Adult cardiopulmonary resuscitation | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| b. Contraceptive counseling | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| c. Discharge teaching | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| d. Foster parental-infant interaction-attachment | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |
| e. Insert catheter | 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> |

- | | | | | | | | | |
|--|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|
| (1) Foley | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (2) Straight | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| f. Post anesthesia care | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (1) Epidural | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (2) General | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (3) Local | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (4) Spinal | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| g. Post Cesarean care | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| h. Teach and assist with | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (1) Breastfeeding/parent education | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (a) Latch-on procedures | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (b) Positioning | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (c) Use of electric breast pump | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (d) Use of manual breast pump | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (2) Formula preparation and feeding | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (3) Infant care restraints systems | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (4) Infant caretaking skills | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (5) Perineal care | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (6) Sitz bath | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| 4. Care of patient with: | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| a. Asthma | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| b. Cardiac disease | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| c. Cesarean section | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| d. Diabetes mellitus | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| e. Infectious disease | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| f. Known substance abuse | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| g. Multiple births | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| h. Post tubal ligation | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| i. Pregnancy induced hypertension/preeclampsia | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| j. Spontaneous vaginal delivery | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| 5. Medications | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| a. Antibiotics | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| b. Diluted oxytocin infusion | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| c. IM administration | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| d. Rhogam administration/teaching | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| e. SC medications, including narcotics | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |

B. NORMAL NEONATAL CARE

- | | | | | | | | | |
|--|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|
| 1. Assessment | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| a. Ballard scale | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| b. Circumference | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| c. Dubowitz scale | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| d. Length | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| e. Neonatal jaundice | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| f. Reflexes | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| g. Vital signs | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| h. Weight | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| 2. Equipment & Procedure | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| a. Administer injections to neonate | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| b. Assist with circumcision | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (1) Assess site post op | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| (2) Teach circumcision care to parents | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| c. Bathe infant | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| d. Culture suspect infectious neonate | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> | 4 | <input type="checkbox"/> |

- e. Discharge procedure 1 2 3 4
- f. Incubator/isolettes 1 2 3 4
- g. Infant identification 1 2 3 4
- h. Monitors bladder and bowel movements 1 2 3 4
- (1) Obtain urine specimens via specimen bag 1 2 3 4
- (2) Test stool for blood, reducing substances 1 2 3 4
- i. Neonate cardiopulmonary resuscitation 1 2 3 4
- j. Phototherapy 1 2 3 4
- k. Thermo-neutral environment to prevent cold stress 1 2 3 4

C. PLEBOTOMY/ IV THERAPY

1. Equipment & procedures 1 2 3 4
- a. Administration of blood/blood products 1 2 3 4
- (1) Packed red blood cells 1 2 3 4
- (2) Plasma/albumin 1 2 3 4
- (3) Whole blood 1 2 3 4
- b. Drawing blood from central line 1 2 3 4
- c. Drawing venous blood 1 2 3 4
- d. Starting IV's 1 2 3 4
- (1) Angiocath 1 2 3 4
- (2) Butterfly 1 2 3 4
- (3) Herparin lock 1 2 3 4
2. Care of the patient with:
- a. Central line/catheter/dressing 1 2 3 4
- b. Peripheral line/dressing 1 2 3 4

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) F. Adolescents (12 – 18 years)
- B. Infant (30 days – 1 year) G. Young Adults (18 – 39 years)
- C. Toddler 1 – 3 years) H. Middle adults (39 – 64 years)
- D. Preschooler (3 – 5 years) I. Older adults (64+)
- E. School age children (5 – 12 years)

EXPERIENCE WITH AGE GROUPS:

- Able to adapt care to incorporate normal growth and development. 1 2 3 4 5
- Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level. 1 2 3 4 5
- Can ensure a safe environment reflecting needs of various age groups. 1 2 3 4 5

My experience is primarily in: (Please indicate number of years)

Total years or nursing _____ year(s)

Couplet (mother/baby) _____ year(s)

Newborn nursery _____ year(s)

Post partum _____ year(s)

Certification:

Please check the boxes and indicate the expiration date for each certificate that you have. If you know the exact date, please use the last date of the specific month(e.g., 08/31/2003)

BCLS: Exp Date: _____(mm/dd/yyyy)

NRP Exp Date: _____(mm/dd/yyyy)

RNC Exp Date: _____(mm/dd/yyyy)

Other (Type) Exp Date: _____(mm/dd/yyyy)

Computerized charting system: Exp Date: _____(mm/dd/yyyy)

Medication Administration system: Exp Date: _____(mm/dd/yyyy)

Please read and agree to the statements below by marking the checkbox.

* I attest that the information I have given is true and accurate to the best of my knowledge and I am the individual completing this form. I hereby authorize the Company to release this Post partum Checklist to the Client Facilities in relation to consideration of employment as a Traveler with those facilities.

Submit