

Advance Nursing

NURSERY / NICU

R.N. PROFICIENCY RECORD/SKILLS CHECKLIST

NAME: _____

SSN: _____

Date: _____

LEVELS OF PROFICIENCY:	
0 –	<i>No Experience:</i> Never performed this task/skill.
1 –	<i>Limited Experience:</i> Performed this task/skill infrequently, needing practice and/or supervision.
2 –	<i>Experienced & Competent:</i> Performed this task/skill frequently and proficiently.
3 –	<i>Experienced & Able to Teach:</i> Proficient at performing this task/skill; able to teach and supervise.

SKILLS	3	2	1	0	SKILLS	3	2	1	0
PATIENT ASSESSMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL				
NURSERY TECHNIQUE					Identification of Neurologically Suspect Infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handwashing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NUTRITION				
Gowning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Basic Requirement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	METHODS OF FEEDING:				
NURSERY PROCEDURES					Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VITAL SIGNS:					Bottle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gavage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apical Pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY				
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SUCTIONING WITH:				
Dextrostix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bulb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cord Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suction Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADMINISTRATION OF:					Identification of Respiratory Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Silver Nitrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	USE OF OXYGEN WITH:				
Vitamin K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mask & Bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICATION ADMINISTRATION:					Hood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculation of Neonatal Doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of Routine Neonatal Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continuous Positive Airway Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of Emergency Neonatal Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen Analyzer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intramuscular Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD GASES:				
IV Push	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Arterial Venipuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Piggyback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arterialized Capillary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTRAVENOUS THERAPY:					Endotracheal Intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Venipuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reinsertion of Tracheostomy Tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needle & Syringe Aspiration of Pleural Cavity R/O Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total Parental Nutrition Including Intralipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHEST TUBES:				
Blood & Blood Component Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Assist with Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKILLS	3	2	1	0	SKILLS	3	2	1	0
ASSESSMENT					GENTOURINARY				
Physical Assessment of the Neonate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urethral Catheterization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
APGAR Scoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EVALUATION OF				
Gestational Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN					Respiratory Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identification of Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laboratory Values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Bili Lite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THERMOREGULATION					Assessment of Parent-Infant Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gordon – Armstrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isolette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Umbilical Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiant Warmer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ECMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Servocontrol Mechanisms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care of Ventilated Neonate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LICENSURE	STATE	NUMBER	EXP. (MM/YYYY)

CERTIFICATIONS	EXP. (MM/YYYY)	CERTIFICATIONS	EXP. (MM/YYYY)
BCLS		Other ()	
ACLS		Other ()	
CCRN		Other ()	
PALS		Other ()	

INDICATE ANY UNIT IN WHICH YOU HAVE EXPERIENCE (EXP), CHARGE EXPERIENCE (CH) OR H.N./SUPERVISOR EXPERIENCE (HN).

UNIT	EXP	CH	HN	UNIT	EXP	CH	HN
Burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pediatrics ICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Partum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Risk OB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L&D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stepdown Nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neonatal ICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuro Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

The information I have given is true and accurate to the best of my knowledge. By checking this box, I hereby authorize Advance Nursing to release this Nursery NICU Skills Checklist to Client facilities of Advance Nursing in relation to consideration of my employment with those facilities.