

Maternal Child Skills Checklist

Name: _____

Date: _____

Indicate your level of experience rating with one of the following:

A – No Experience.

B – Minimal Experience - need review and supervision, have performed at least once.

C – Competent - able to perform independently.

D – Expert - able to act as resource to others.

A. ANTEPARTUM

1. Assessment

- | | |
|------------------------------------|---|
| a. Assess for comfort | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| b. Breathing/relaxation techniques | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| c. Coaching | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| d. Positioning | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |

2. Equipment & procedures

- | | |
|--------------------------|---|
| a. Catheter insertion | |
| (1) Foley catheter | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (2) Straight catheter | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| b. Delivery table set-up | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| c. Sonogram | |
| (1) Amniotic fluid index | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (2) Assist with sonogram | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (3) Biophysical profile | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (4) Perform sonogram | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |

B. LABOR ASSESSMENT

1. Fetal assessment

- | | |
|--|---|
| a. Auscultate fetal heart rate | |
| (1) Doppler | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (2) Fetoscope | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| b. Determine fetal position | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| c. Document FHR patterns | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| d. Identify normal & treat abnormal FHR patterns | |
| (1) Baseline | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (2) Early decelerations | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (3) Late decelerations | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (4) Prolonged decelerations | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (5) Variability | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |
| (6) Variable decelerations | A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> |

Initials _____

2. Maternal assessment

- a. Deep tendon reflexes (DTRs) A B C D
- b. Edema A B C D
- c. Norms for perinatal vital signs A B C D
- d. Perform admission risk assessment A B C D
- e. Presence of clonus A B C D
- f. Progression of labor
 - (1) Contraction characteristics A B C D
 - (2) Dilation A B C D
 - (3) Effacement A B C D
 - (4) Fetal presentation/position A B C D
 - (5) Station A B C D
 - (6) Status of membranes A B C D
 - (7) Sterile speculum exam A B C D
 - (8) Vaginal exam A B C D
- g. Rupture of membranes
 - (1) Fern test A B C D
 - (2) Nitrazine A B C D

3. Equipment & procedures

- a. Amnioinfusion (assist or perform)
 - (1) For meconium A B C D
 - (2) For variable decelerations A B C D
- b. Artificial rupture of membranes (assist)
 - (1) Prolapsed cord A B C D
 - (2) Recognize potential complications A B C D
 - (3) Vasa previa A B C D
- c. Collect blood/urine specimens A B C D
- d. Collect vaginal cultures
 - (1) Chlamydia A B C D
 - (2) Fluid A B C D
 - (3) Group B strep A B C D
 - (4) Herpes A B C D
- e. Document labor status/assessment & interventions
 - (1) Anticonvulsants A B C D
 - (2) Labor suppressants A B C D
- f. External fetal monitor application
 - (1) Doppler A B C D
 - (2) Phono or abdominal, ECG transducer A B C D
 - (3) Tocotransducer, ultrasound A B C D
- g. Internal monitoring (assist or perform insertion)
 - (1) Intrauterine pressure catheter A B C D
 - (a) Fluid filled A B C D
 - (b) Transducer tipped A B C D
 - (2) Spiral electrode A B C D
- h. Perform Leopold's maneuvers A B C D
- i. Toxicology studies A B C D

4. Medications

- a. Administer IM/SC A B C D
- b. Administer IV meds/monitor IV drips
 - (1) Antibiotics A B C D
 - (2) Antihypertensives A B C D
 - (3) Heparin A B C D
 - (4) Magnesium sulfate A B C D
 - (5) Narcotics A B C D
 - (6) Oxytocin A B C D
- c. Assist with prostin gel A B C D
- d. Cervidil insertion A B C D
- e. Use of Cytotec A B C D
- f. Use of prostin suppositories A B C D

C. COMPLICATIONS OF PREGNANCY

1. Assessment

- a. Identify common arrhythmias A B C D
- b. Normal cardiac rhythms A B C D
- c. Patient education – fetal movement counts A B C D

2. Equipment & procedures

- a. Assist with external version A B C D
- b. Assist with fetal scalp sampling A B C D
- c. Assist with percutaneous umbilical sampling A B C D
- d. Assist with umbilical blood sampling A B C D
- e. Circulate for Cesarean delivery A B C D
- f. Circulate, scrub for bilateral tubal ligation A B C D
- g. Conduct contraction stress test
 - (1) Breast stimulation A B C D
 - (2) Oxytocin challenge A B C D
- h. Conduct non-stress test
 - (1) Stimulate fetus A B C D
 - (2) Vibroacoustic stimulation A B C D
- i. Draw umbilical blood samples A B C D
- j. Glucose reflectometer A B C D
- k. Lines/monitoring
 - (1) Central venous lines A B C D
 - (2) Invasive hemodynamic monitoring A B C D
 - (3) PICC lines A B C D
 - (4) Pulmonary artery catheters A B C D
- l. Scrub for Cesarean delivery A B C D
- m. Set up Cesarean delivery A B C D

3. Care of the patient with:

- a. Abruptio placenta A B C D
- b. Asthma A B C D
- c. Cardiac disease A B C D
- d. Chorioamnionitis A B C D

- 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

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4. Medications

- a. Indomethacin
- b. Insulin
- c. Magnesium sulfate
- d. Procardia
- e. Ritodrine
- f. Terbutaline
 - (1) IV
 - (2) PO
 - (3) Pump
 - (4) SC

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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

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E. INFANT INTERVENTIONS POST DELIVERY

1. Assessment

- a. Apgar scoring A B C D
- b. initial VITal signs A B C D

- c. Intervention/risk factors for
 - (1) IDM A B C D
 - (2) LGA, SGA, IUGR A B C D

- d. Newborn physical assessment
 - (1) Ballard A B C D
 - (2) Dubowitz A B C D
 - (3) Finnegan scoring A B C D

2. Equipment & procedures

- a. Assist with initial breast feeding A B C D
- b. Assist with interventions for meconium staining A B C D
- c. Bath-perform and teach A B C D
- d. Cardiac-respiratory monitor placement A B C D
- e. Circumcision care A B C D
- f. Cord care A B C D
- g. Discharge teaching A B C D
- h. Heelstick glucose determination A B C D
- i. Infant identification A B C D
- j. Neonatal resuscitation A B C D
- k. Obtain hematocrit A B C D
- l. Obtain neonatal toxicology screen A B C D
- m. Phototherapy A B C D
- n. Promote bonding behaviors A B C D
- o. Suctioning
 - (1) Bulb A B C D
 - (2) DeLee A B C D
 - (3) Wall A B C D

3. Medications

- a. Eye prophylaxis A B C D
- b. Vitamin K A B C D

F. POST PARTUM INTERVENTIONS

1. Assessment

- a. Bladder distention A B C D
- b. Breast feeding A B C D
 - (1) Latch-on A B C D
 - (2) Positioning A B C D
- c. DVT (Deep vein thrombosis) A B C D
- d. Episiotomy A B C D
- e. Fluid balance A B C D
- f. Fundal height A B C D
- g. Fundal massage A B C D

- h. Lochia amount A B C D
- i. Maternal vital signs A B C D

G. PHLEBOTOMY / IV THERAPY

- 1. Equipment & procedures
 - a. Administration of blood/blood products
 - (1) Cryoprecipitate A B C D
 - (2) Packed red blood cells A B C D
 - (3) Plasma/albumin A B C D
 - (4) Whole blood A B C D
 - b. Drawing blood from central line A B C D
 - c. Drawing venous blood A B C D
 - d. Staring IVs
 - (1) Angiocath A B C D
 - (2) Butterfly A B C D
 - (3) Heparin lock A B C D
- 2. Care of the patient with:
 - a. Central line/catheter/dressing A B C D
 - b. Peripheral line/dressing A B C D

H. PAIN MANAGEMENT & ANESTHESIA

- 1. Assessment of pain level/tolerance A B C D
- 2. Care of the patient with:
 - a. Epidural anesthesia/analgesia A B C D
 - b. IV conscious sedation A B C D
 - c. Patient controlled analgesia (PCA pump) A B C D
- 3. Assist with delivery of anesthesia
 - a. Anesthesia toxicity A B C D
 - b. Coaching patient A B C D
 - c. Epidural block A B C D
 - d. Fluid challenge A B C D
 - e. Hypotension A B C D
 - f. Intrathecal narcotics A B C D
 - g. Intravascular injection A B C D
 - h. Positioning patient A B C D
 - i. Signs/symptoms of dural puncture A B C D
 - j. Spinal anesthesia A B C D
- 4. Documentation of anesthesia
 - a. Computer A B C D
 - b. Flowchart A B C D

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

Experience with Age Groups

Able to adapt care to incorporate normal growth and development.

Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.

Can ensure a safe environment reflecting specific needs of various age groups.

	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.)

- Maternal Child _____ year(s)
- LDR _____ year(s)
- LDRP _____ year(s)
- Community hospital _____ year(s)
- Rural hospital _____ year(s)
- Teaching hospital _____ year(s)
- _____ # of births/month

Certification:

Please check the boxes below and indicate the expiration day for each certificate that you have. If you do not know the exact day, please use the last date of the specific month (e.g., 8/31/2003).

- BCLS Exp. Date: _____ (mm/dd/yyyy)
- RNC Exp. Date: _____ (mm/dd/yyyy)
- NRP 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)

Initials _____

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 that I am the individual completing this form. I hereby authorize the Company to release this Maternal Child Skills Checklist to the Client facilities in relation to consideration of employment as a Registered Nurse with those facilities.

Signature

Date



Registered Professional Nurse Job Description Maternal Child

Job Summary:

The Maternal Child RN is responsible for managing the care of the adolescent, adult or elderly patient experiencing general medical conditions or general surgical procedures, which require general assessments related to specific conditions, and general therapies and interventions. The Maternal Child RN is responsible to the Clinical Manager assigned to the Maternal Child Unit.

Qualifications

- Current licensure in good standing in the state of practice
- Evidence of 1 year of Maternal Child nursing experience within the past two years
- Evidence of current BLS credential mandatory

Responsibilities

- Conducts an individualized patient assessment and reassessment, prioritizing the data collection based on the adolescent, adult or elderly patient's immediate condition or needs within timeframe specified by client facility's policies, procedures or protocols.
- Develops individualized plan of care reflecting collaboration with other members of the healthcare team.
- Collaborates with physician and other team members to implement orders and plan of care in an accurate and timely manner.
- Provides individualize patient/family education customized to the adolescent, adult or elderly patient and his/her family.
- Documents patient assessment findings, physical/psychosocial responses to nursing intervention and progress toward problem resolution and communicates these responses to team members as appropriate.
- Responds to emergencies according to facility policy and procedure.
- Maintains confidentiality in matters related to patient, family and client facility staff.
- Provides care in a non-judgmental, non-discriminatory manner that is sensitive to the adolescent, adult or elderly patient's and family's diversity, preserving their autonomy, dignity and rights.
- Reports relative indicators of patient condition to appropriate personnel during and at the end of each shift.
- Maintains current competency in Maternal Child nursing.

RN Name: _____

RN Signature: _____

Date: _____

Initials _____

Joint Commission
**2006 Critical Access Hospital and Hospital
National Patient Safety Goals**

Note: New Goals and Requirements are indicated in **bold**.

- Goal 1 Improve the accuracy of patient identification.
- 1A Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.
- 1B Not applicable.
- Goal 2 Improve the effectiveness of communication among caregivers.
- 2A For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- 2B Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- 2C Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- 2D Not applicable.
- 2E Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.**
- Goal 3 Improve the safety of using medications.
- 3A Retired in 2006.
- 3B Standardize and limit the number of drug concentrations available in the organization.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- 3D Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.**
- Goal 4 Not applicable.
- Goal 5 Retired in 2006
- Goal 6 Not applicable.
- Goal 7 Reduce the risk of health care-associated infections.

- 7A Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
- 8A Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- 8B A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program and evaluate the effectiveness of the program.
Note: Replacement for 9A.
- Goal 10 Not applicable.
- Goal 11 Not applicable.
- Goal 12 Not applicable.
- Goal 13 Not applicable.
- Goal 14 Not applicable.