

Active Staffing Resource Inc.

17315 Studebaker Road, Suite 110, Cerritos CA 90703 • Tel. no. 562-865-3222 Fax no. 562-865-5142

NEONATAL ICU SKILLS CHECKLIST

This evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Active Staffing Resource Inc.

1 = Limited or no experience **2 = Somewhat experience but may need review**
3 = Can function independently **4 = Competent to supervise**

ADMISSION / ASSESSMENT	1	2	3	4
Maternal History				
Gestational Age				
Apgar Scoring				
Attend High Risk Delivery				
Collect Cord Blood Samples				
Dextrostix				
Urine Output				
Weight - Scale / Bed Scale				
Identifying Infant				
Preparation for Transport				
Interfacility Emergency Transport				
Initial Physical Assessment				
Anomalies				
Resp Status / Breath Sounds				
Suction				
Assist with Intubation				
Apical Pulse				
Blood Pressure				
Skin Care / Cord Care				
Thermoregulation:				
Use of Isolette (Incubator)				
Use of Radiant Warmer				
Temperature				

MEDS / IV THERAPY	1	2	3	4
Eye Prophylaxis				
Vitamin K				
Immunizations				
Calculation of Neonatal Doses				
Knowledge of Routine Neonatal Drugs				
Knowledge of Emergency Neonatal Drugs				
Administer IM Meds				
Peripheral IV Insertion				
Scalp IV Insertion				
PICC Line Insertion				
Use of Heparin / Saline Locks				
Needle-less Systems				
Administer IV Medications				
Mix IV Infusion with Additives				
Discontinue Peripheral IV's				
Administer Blood				
Administer Blood Products				
Exchange Transfusion				
Central Hyperalimentation				
Peripheral Hyperalimentation				
Administer / Monitor IV Infusions:				
IV Pump				
Syringe Pump				

GENITOURINARY	1	2	3	4
Insertion of Foley Catheter				
Collect Urine Specimen Bag / Cath				
Urine Bedside Testing (pH, Sp, Gr., Glu)				
Care of Neonate with:				
Peritoneal Dialysis				
Circumcision				
Urostomy				
Disorders of External Organs				
Malformation of GU Tract / Kidney				
Acute Renal Failure				
Congenital Hip Dysplasia				

NUTRITION	1	2	3	4
Calculate Basic Requirement				
Assessment of Suck / Swallow				
Assist / Instruct Breastfeeding				
Collection / Storage of Breast Milk				
Assist / Instruct Bottlefeeding				
Gavage Feedings				

MEDS / IV THERAPY	1	2	3	4
Draw Venous Blood				
Access / Care:				
PICC Line				
Midline				
Central Line				
Portacath				
Percutaneous Arterial Line				
Umbilical Artery / Venous Line				

METABOLIC / INFECTIONS	1	2	3	4
Interpretations of Lab Results				
Isolation Technique				
Care of the Neonate with:				
Heptitis Surface Antigen				
HIV Positive Mother				
DIC (Disseminated Intravascular Coagulation)				
IDM (Infants of Diabetic Mother)				
Hypo/ Hperglycemia				
Phototherapy for Jaundice				

Initial _____

GASTROINTESTINAL	1	2	3	4
Assess Bowel Sounds				
Assess Abdominal Girth				
Stool Test				
Nasogastric Tube Insertion & Care				
Gastrostomy Tube				
Reflux Precautions				
Care of Neonate with:				
Cleft Lip / Cleft Palate				
Colostomy / Ileostomy				
Gastroschisis / Omphalocele				
GI Bleeding				
Bowel Obstruction				
Necrotizing Enterocolitis				
Inguinal Hernia				
Post-abdominal Surgery				
Tracheoesophageal Fistula (TEF)				
Feeding Dysfunction				
Small for Gestational Age				
Large for Gestational Age				

PULMONARY	1	2	3	4
Resp Status / Breath Sounds				
Pulse Oximetry				
Respiratory / Apnea Monitor				
Assist with Intubation / Extubation				
Obtain ABGs (Heelstick / Arterial Line)				
Interpretation of ABGs				
Evaluation of Xray Reports				
Suctioning (Nasal, Oral, Trach)				
Chest Physiotherapy				
Assist Chest Tube Insertion / Removal				
Use of Oxygen with:				
Mask and Bag				
Hood				
Isolette				
CPAP to Cannula				
Oxygen Anylizer				
Transcutaneous Monitoring				
Care of the Neonate with:				
Apnea				
Ventilator (CPAP / PEEP / IMV / Jet Vent)				
Tracheostomy				
Meconium Aspiration				
Bronchopulmonary Dysplasia (BPD)				
Respiratory Distress Syndrome (RDS)				
Chest Tubes				
ECMO-Extracorporeal Membrane Oxygenation				
Persistent Pulmonary Hypertension				
Diaphragmatic Hernia				

NEUROLOGICAL	1	2	3	4
Assess Neurological Status				
Assess Hearing of Neonate				
Assess Eyes of Neonate				
Assess Pain				
Assist with Lumbar Puncture				
Care of Neonate with:				
Sedation				
Seizures				
Chemical Addiction / Withdrawal				
Hydrocephalus				
Spina Bifida				
Meningitis				
Increased Intracranial Pressure				
Intracranial Pressure Monitor				
Internalized VP Shunt / Reservoir				
Brain Death / Organ Procurement				
Intracranial Hemorrhage				

CARDIOVASCULAR	1	2	3	4
Cardiac / Respiratory Monitor				
Assessment of Pulses				
Assessment of Perfusion				
Assessment of Heart Sounds / Murmurs				
Blood Pressure - Doppler				
Blood Pressure - Arterial Line				
EKG Interpretation				
Defibrillation / Cardioversion				
Invasive Hemodynamic Monitoring				
Care of Neonate with:				
Congenital Heart Disease / Defects				
Cardiomyopathy				
Post Cardiac Surgery				
Cardiac Transplant				
Cardiac Arrest				
Shock - Cardiogenic				
Shock - Hypovolemic				
Shock - Septic				

MISCELLANEOUS	1	2	3	4
Foster Parent / Infant Bonding				
Consents - Procedural / Treatment				
Consents - Immunization				
Preoperative Care				
Postoperative Care				
Discharge Teaching				
Bereavement / Postmortem Care				

Initial _____

Age-Appropriate Care: Ability to adapt care to incorporate normal growth and development, adapt method and terminology of client instructions as it relates to the age and comprehension level of the client, and to ensure a safe environment - reflecting specific needs of the client and various age groups.

AGE	1	2	3	4
Newborn (birth - 30 days)				
Infant (30 days - 1 year)				
Toddler (1 - 3 years)				
Preschooler (3 - 5 years)				
School Age (5 - 12 years)				

AGE	1	2	3	4
Adolescents (12 - 18 years)				
Young Adults (18 - 39 years)				
Middle Adults (39 - 64 years)				
Older Adults (64+ years)				

The information I have given is true and accurate to the best of my knowledge and I hereby authorize Active Staffing Resource Inc., to release this Skills Checklist to staffing clients of Active Staffing Resource Inc. Submit this skills self evaluation with your initial application
To be updated annually.

Applicant Name & Signature

Date

ASRI Representative

Date



JOB DESCRIPTION

JOB TITLE: REGISTERED NURSE – NICU

REPORTS TO: Director of Nursing

REQUIREMENTS:

- At least 1 year of acute care – hospital based – NICU Nurse experience.
- Certifications: BLS, NRP required
- The NICU Nurse reports directly to the Director of Nursing and Hospital
- NICU staff nurse responsibilities and include but not limited to:
 - Work closely with the physicians and other members of the NICU support team.
 - Operate and monitor equipment (ventilator, oxygen, fluids and warming table, etc.) that balance the baby's body processes and condition
 - Monitoring respiration, heart, temp and oxygen levels of the newborn
 - Additional duties may be asked based on scope of practice.

PHYSICAL REQUIREMENTS:

See attached “Essential Functions” Form.

The above statements reflect the general duties considered necessary to describe the principal functions of the job as identified and shall not be considered as a detailed description of all the requirements that may be inherent in the position.

Print Name

Date

Signature

Initial _____

NICU EXAMINATION

Name: _____ Date: _____ Score _____

I. Choose the correct answer:

1. The nurse and student nurse are caring for the postpartum client who delivered a term newborn 24 hours previously. The nurse recognizes that the student needs more information on newborn nutrition when making which statement?
 - A. About half of the baby's calorie needs are met by the fat in breast milk or formula.
 - B. Lactose is the primary source of carbohydrates in breast milk and formula.
 - C. Calcium supplements are not needed for the newborn regardless of the feeding method.
 - D. Supplemental water should be given to all infants daily, regardless of feeding method.
2. While preparing parents of a 2-day-old, bottle-feeding newborn for discharge, the nurse recognizes the parents' need for additional teaching about formula feeding. Which statement prompted the nurse's conclusion?
 - A. "We plan to clean our baby's bottles in the dishwasher."
 - B. "Placing the formula in a bowl of warm water will warm it."
 - C. "We will put the bottle of unfinished formula in the refrigerator."
 - D. "Using our city tap water to mix the powdered formula is safe."
3. A breastfeeding mother is being discharged with her 2-day-old, full-term newborn. The nurse recognizes that the mother understands how to determine if her newborn is getting enough breast milk when making which statement?
 - A. "He should have at least three wet diapers tomorrow."
 - B. "He should have one stool per day during the next week."
 - C. "At his 1-week checkup, he should weigh an additional 8 ounces."
 - D. "He should nurse for 5 minutes on each breast to get enough milk."
4. The nurse is caring for a 32-weeks' gestation infant is about to perform a heel stick to obtain blood for a prescribed test. Which intervention should the nurse utilize to maximize the amount of pain the neonate will experience?
 - A. Apply an ice pack
 - B. Apply a heel warmer
 - C. Give morphine sulfate
 - D. Give sucrose or Sweet-Ease
5. The nurse is assessing the infant who may have FAS. Which finding, if observed, should be the nurse associate with FAS? **Select all that apply.**
 - A. Broad nasal bridge and flat midface
 - B. Growth deficit in weight and length
 - C. Excessive irritability and hypotonia
 - D. Poor feeding and persistent vomiting
 - E. Large jaw and overdeveloped maxilla
6. The nurse is caring for the client who has just given birth to a baby boy. The mother is O negative. The nurse should assess for ABO incompatibility and hyperbilirubinemia if the infant's blood type is which type?
 - A. O positive
 - B. O negative
 - C. A negative

Initial _____

- D. Any type
7. Before beginning a newborn's physical assessment, the nurse reviews the newborn's medical record and sees this notation: "31 weeks' gestation." Considering this information, the nurse determines that a physical assessment of the infant should reveal which finding?
- A. Flexion of all four extremities
 - B. The ability to suck
 - C. The absence of lanugo
 - D. Vernix covering the infant
8. An infant had four wet diapers during the 8-hour shift. The weight of a dry diaper is 15 g. The four wet diapers weighed 30 g, 24 g, 21 g, and 25 g. What amount in milliliters should the nurse record for the total 8-hour urine?
_____ mL (Record your answer as a whole number.)
9. The nurse is caring for a preterm infant who must be fed via bolus gavage feeding. The infant has a 5 French feeding tube already secured in the left naris. The nurse has aspirated the infant's stomach contents, noting color, amount, and consistency, and has reinserted the residual amount because it was less than one-fourth the previous feeding. Prioritize the remaining steps that the nurse should take to complete this feeding.
- A. Separate the barrel of the syringe from the plunger and connect the syringe barrel to the feeding tube.
 - B. Remove the syringe and clear the tubing with 2 to 3 mL of air.
 - C. Elevate the syringe 6 to 8 inches over the infant's head.
 - D. Position the infant on the right side.
 - E. Uncrimp the tubing and allow the feeding to flow by gravity at a slow rate.
 - F. Crimp the feeding tube and pour the specified amount of formula or breast milk into the barrel.
 - G. Cap the lavage feeding tube.

Answer: _____

10. The nurse evaluates a preterm infant after a gavage feeding. The nurse determines that feeding intolerance has developed when which finding is noted during assessment?
- A. The infant immediately falls asleep after feeding.
 - B. The gastric residual is zero prior to the next feeding.
 - C. The infant's abdominal girth has increased in size.
 - D. The infant is having soft, loose stools.
11. The nurse completes teaching a new mother about swaddling her infant. Which illustration shows that the mother understood the teaching?





B.



C.



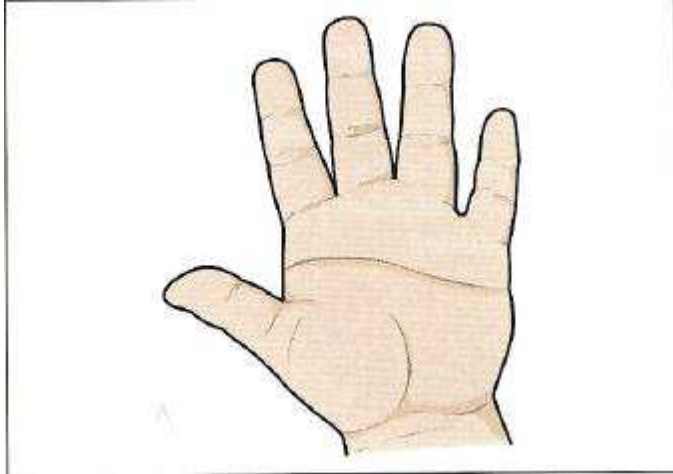
D.

12. The nurse is administering surfactant via ET tube to a 48-hour-old infant with respiratory distress syndrome (RDS). The father asks the nurse how this treatment will help his baby. The nurse should explain that the preterm infant is unable to produce adequate amounts of surfactant and that giving it to his baby will have what effect?
- A. Increase Paco₂ levels in the bloodstream
 - B. Prevent collapse of the alveoli
 - C. Decrease Paco₂ levels in the bloodstream
 - D. Prevent pleural effusion
13. The nurse is caring for a preterm infant with respiratory distress syndrome (RDS). Which intervention should the nurse implement to maximize the infant's respiratory system?
- A. Check blood glucose levels every 4 hours.
 - B. Cool and humidify all inspired gases.
 - C. Weigh the infant every other day.
 - D. Place the infant in a prone position.

Initial _____

14. The nurse is reviewing the following labor history of a postpartum mother: “Mother positive for group B streptococcal (GBS) infection at 37 weeks’ gestation. Membranes ruptured at home 14 hours before presentation to the hospital at 40 weeks’ gestation. Precipitous labor, no antibiotic given.” Considering this information, the nurse should observe her 15-hour-old newborn closely for which finding?
- A. Temperature instability
 - B. Pink stains in the diaper
 - C. Meconium stools
 - D. Presence of erythema toxicum
15. The nurse is caring for the infant in the neonatal ICU who has an umbilical artery catheter (UAC) in place. To monitor for and prevent complications with this catheter, which actions should be planned by the nurse? **Select all that apply.**
- A. Check the position marking on the catheter every shift.
 - B. Position the tubing close to the infant’s lower limbs.
 - C. Check for erythema or discoloration of the abdominal wall.
 - D. Palpate for femoral, pedal, and tibial pulses every 2 to 4 hours.
 - E. Reposition the catheter tubing every hour.
 - F. Monitor blood glucose levels.
16. While caring for the small-for-gestational-age newborn (SGA), the nurse notes slight tremors of the extremities, a high-pitched cry, and an exaggerated Moro reflex. In response to these assessment findings, what should be the nurse’s **first** action?
- A. Assess the infant’s blood sugar level.
 - B. Document the findings in the infant’s medical record
 - C. Immediately inform the pediatrician of the symptoms.
 - D. Assess the infant’s axillary temperature.
17. When assessing the infant undergoing phototherapy for hyperbilirubinemia, the nurse notes a maculopapular rash over the infant’s buttocks and back. What action should the nurse take **next**?
- A. Document the results in the newborn’s medical record.
 - B. Call the HCP immediately to report this finding.
 - C. Discontinue the phototherapy immediately.
 - D. Assess the infant’s axillary temperature.
18. The full-term newborn is placed under phototherapy lights to treat hyperbilirubinemia. The nurse should assess the newborn for dehydration due to which effect of phototherapy?
- A. Decreases sodium absorption
 - B. Increases absorption of bilirubin
 - C. Decreases urinary output
 - D. Increases insensible water loss
19. The mother of a healthy 15-hour-old term newborn asks the nurse if the PKU blood test could be completed now on her infant because she and her infant are being discharged to home. Which statement should be the basis for the nurse’s response?
- A. The PKU test must be completed when the infant is at least 1 month of age.
 - B. The parents must sign a consent form if the PKU test is completed before 24 hours of age.
 - C. The PKU test is best of completed after the infant is 24 hours old but before 7 days of age.
 - D. The PKU test is not needed if the infant is tolerating feedings without diarrhea or vomiting.

20. While assessing the full-term newborn, the nurse notes the abnormality illustrated in the infant's palm. The nurse should further assess the infant for signs and symptoms of which condition?



- A. Trisomy 13
- B. Turner's syndrome
- C. Trisomy 18
- D. Trisomy 21