Active Staffing Resource Inc.

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

POSTPARTUM 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**

MEDS / IV THERAPY	1	2	3	4
Administer PO Medications				
Administer IM & SQ Medictions				
Peripheral IV Insertion				
Administer IV Medications				
Mix IV Infusion w/ Additives				
Use of Heparin / Saline Locks				
Needle-less System				
Administer / Monitor IV Infusions	1	2	3	4
- Oxytoxin Induction Augmentation				
- Magnesium Sulfate Therapy - Labor Suppressants - Ritordine				
- Antibiotics				
- Heparin				
Discontinue Peripheral IV's				
Patient Controlled Anesthesia (PCA)				
Administer Blood				
Administer Blood Products Draw Blood for Lab Studies				
Vital Sign Monitoring				
Pulse Oximetry:				
Setup				
Monitoring				
ANTE / INTRAPARTUM	1	2	3	4
Care for Patient With:				
Pregnancy - Induced HTN				
Pre-eclampsia				
Eclampsia				
Multiple Gestation				
Placenta Previa				
Abruptio Placenta				
Malpresentations				
Premature Labor				
Diabetes Mellitus				
Asthma				
Infectious Disease				
Hemorrhage				
Cystitis				
Sickle Cell Disease				
Rh Icompatibilities				
INTRAPARTUM PHASE	1	2	3	4
Contraction Characteristic				
Determine Fetal Position				

	1	2	3	4
Status of Membranes				
Fetoscope				
Doppler Ultrasound				
External Monitor:				
- Tocotransducer				
- Untrasound				
- Phono				
- Abdominal ECG Transducer				
Internal Monitor				
Variability / Reactivity				
Decelerations - Early, Late, Variables				
Assessment for Deep Reflexes				
Assessment for Clonus				
Intake and Output				
Assessment for Edema				
Insert Straight / Foley Catheter				
Bedside Clinical Testing:				
Urine Dipstik				
Blood Glucose Monitoring				
PARENT / INFANT BOND	1	2	3	4
Postpartum Assesstment				
Fundus Consistency / Location				
Initiate Fundal Massage PRN				
Lochia				
Bladder Distention				
Insert Straight / Foley Catheter				
Provide / Instruct Perineal Care				
Episiotomy Care				
Apply Ice to Perineum				
C-section Incision Care				
Assess Homa's Sign				
Manage Postpartum Pain				
Rhogam Administration	1	2	3	4
Rubella Vaccine				
Initiate Post-Anesthesia Care:				
Spiral				
Epidural				
General				
PARENT / INFANT BOND	1	2	3	4
Postpartum Assesstment				
Fundus Consistency / Location				
Initiate Fundal Massage PRN				
Lochia				

Initials: ________________

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

ACTIVE STAFFING RESOURCE INC.

JOB DESCRIPTION

JOB TITLE: **REGISTERED NURSE – POSTPARTUM**

REPORTS TO: **Director of Nursing**

STATEMENT OF PURPOSE:

Responsible for overall delivery of care utilizing the nursing process. Provides direction to LVNs, CNAs and Unit Ward Clerks.

PRINCIPAL DUTIES AND RESPONSIBILITES:

1. Head-to-toe assessments - knowledge of normal vs. abnormal findings and reporting of abnormal findings to Charge Nurse, M.D., if warranted.
2. Critical thinking to intervene with appropriate intervention for urgent/emergent care. Care of the acute and chronically ill patients.
3. Knowledge of hemodynamics.
4. Knowledge of care for an at risk newborn or mother anti and postpartum.
5. Basic IV and central line skills.
6. Phlebotomy skills.
7. Documents obvious, subtle and potential patient and family problems requiring intervention including teaching needs and discharge planning.
8. Develops, contributes and communicates a plan of care based on existing and potential patient problems.
9. Implement safe, therapeutic, and efficient patient care.
10. Demonstrates organizational skills, delivers safe, basic physical care and teaches other nursing personnel.
11. Uses experience and knowledge to anticipate problems, implements preventive actions.
12. Able to set priorities for own assignment. Recognizes unit needs reports appropriately and implements appropriate action.
13. Educates patient and family regarding care and treatment plans. Seeks out appropriate resources. Individualizes patient teaching materials as needed.

Initial ______________

14. Develops and implements individualized patient care plans in accordance with standards of nursing practice through the implementation of the nursing process and nursing diagnosis.
15. Provide individual psychological support to achieve optimal health. Utilizes other health care professionals in dealing with psychological problems as appropriate.
16. Implement preparation prior to procedure for patient and family.
17. Understands coping processes and allows time for interaction. Takes steps to decrease stress and/or increase effectiveness of coping mechanisms of patient/family having difficulty dealing with illness and hospitalization.
18. Safety performs and documents nursing procedure consistent with scientific principals and nursing department and hospital policies and including:
    A. Administering medications and treatments
    B. Anticipating, recognizing, and participating in emergency situations
19. Ability to use equipment if Postpartum unit and troubleshoot problems and follow through appropriate.
20. Knows the normal routine lab values and their significance.
21. Initiates appropriate type of isolation. Discontinues isolation as appropriate.
22. Evaluates the effectiveness of intervention/actions and gives rationale for nursing interventions based on patient outcome. Documents the patient' response to care and revises patient plan of care as appropriate.
23. Sets realistic, measurable goals for performance with the assistance of Nursing Leadership. Some goals to demonstrate professional growth.
24. Plans for own growth based on evaluation and feedback.
25. Participates in educational opportunities appropriate to professional growth and communicates learning to fellow staff instructed and informal methods.
26. Starts work at time scheduled. Completes work on time. Complies with nursing and hospital policy.
27. Complied with Active Staffing Resource Inc policies.
28. Communicates to unit leadership own needs and identified learning own need of personnel. Coordinates resources available to meet learner's needs.
29. Utilizes and facilitates effective communication strategies with individual patients, family and staff.

Initial ______________

30. Gives feedback to other staff regarding behavior that is detrimental to achievement of patient care and unit objectives. Incorporates options suggested by nursing leadership for achieving change in behavior when needed.
31. Attends and participates in Active Staffing Resources Inc organization meetings. Initiates discussion regarding unit issues. When not present, obtains information presented in staff meetings and is responsible for information.
32. Demonstrates as understanding of the abuse reporting requirements of the various age groups.
33. Understands and adheres to the hospital's restraint procedure.
34. Able to identify and manage life-sustaining physiologic functions in unstable patients.
35. Other duties, as assigned.

EXPERIENCE/SKILLS REQUIRED:

Has a minimum of two (2) years hospital experience with at least one (1) year postpartum experience. BLS, ACLS, NRP certification preferred. Demonstrates knowledge and skill necessary to provide care appropriate to the age of the patients served.

EDUCATOINAL REQUIREMENTS:

Graduate from an accredited school of nursing. Currently licensed as a Registered Nurse in the State of California.

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 ____________

ACTIVE STAFFING RESOURCE INC.

POSTPARTUM EXAMINATION

Name: ______________________________ Date: ___________________ Score ______________

I. Choose the correct answer:

1. The delivery nurse is reporting to the postpartum nurse about the client who just delivered her first baby, a term newborn. Which number should the delivery nurse report for the client's parity?
   ________________ Parity (Record your answer as a whole number)

2. Immediately after delivery of the client's placenta, the nurse palpates the client's uterine fundus. The fundus is firm and located halfway between the umbilicus and symphysis pubis. Which action should the nurse take based on the assessment findings?
   A. Immediately begin to massage the uterus
   B. Document the findings of the fundus
   C. Assess the client for bladder distention
   D. Monitor for increased vaginal bleeding

3. The client, who delivered a 4200-g baby 4 hours ago, continues to have bright red, heavy vaginal bleeding. The nurse assesses the client's fundus and finds it to be firm and midway between the symphysis pubis and umbilicus. What should the nurse do **next**?
   A. Continue to monitor the client's bleeding and weigh the peripads.
   B. Call the client's HCP and request an additional visual examination.
   C. Prepare to give oxytocin to stimulate uterine muscle contraction.
   D. Document the findings as normal with no intervention needed at that time.

4. When looking in the mirror at her abdomen, the postpartum client says to the nurse, "My stomach still looks like I'm pregnant!" The nurse explains that the abdominal muscles, which separate during pregnancy, will undergo which change?
   A. Regain tone within the first week after birth
   B. Regain pregnancy tone with exercise
   C. Remain separated, giving the abdomen a slight bulge
   D. Regain tone as the weight gained during pregnancy is lost

5. The clinic nurse reviews the laboratory results illustrated from the postpartum client who is 3 days post-delivery. What should the nurse do in response to these results?

Laboratory Value	Result
Hct	35%
Hgb	11 g/dL
WBCs	20,000/mm^3

   A. Document the laboratory report findings
   B. Assess the client for increased lochia
   C. Assess the client's temperature orally
   D. Notify the health care provider immediately

Initial ___________

6. The Caucasian postpartum client asks the nurse if the stretch marks (striae gravidarum) on her abdomen will ever go away. Which response by the nurse is **most** accurate?
   A. "Your stretch marks should totally disappear over the next month."
   B. "Your stretch marks will always appear raised and reddened."
   C. "Your stretch marks will lighten in color with good skin hydration."
   D. "Your stretch marks will fade to pale white over the next 3 to 6 months."

7. Twenty-four hours post-vaginal delivery, the postpartum client tells the nurse that she is concerned because she has not had a bowel movement (BM) since before delivery. Which action should be taken by the nurse?
   A. Document the data in the client's health care records
   B. Notify the health care provider immediately
   C. Administer a laxative that has been prescribed prn
   D. Assess the client's abdomen and bowel sounds

8. The RN and the student nurse are caring for the postpartum client who has 16 hours post-delivery. The RN evaluates that the student needs more education about uterine assessment when the student is observed doing which activity?
   A. Elevating the client's head 30 degrees before doing the assessment
   B. Supporting the lower uterine segment during the assessment
   C. Gently palpating the uterine fundus for firmness and location
   D. Observing the abdomen before beginning palpation

9. The nurse is assessing the postpartum client, who is 5 hours post-delivery. Initially, the nurse is unable to palpate the client's uterine fundus. Prioritize the nurse's actions to locate the client's fundus by placing each step in the correct sequence.
   A. Place the side of one hand just above the client's symphysis pubis.
   B. Press deeply into the abdomen.
   C. Place the other hand at the level of the umbilicus.
   D. Massage the abdomen in a circular motion.
   E. Position the client in the supine position.
   F. If the fundus is not felt, move the upper hand lower on the abdomen and repeat the massage.

   Answer: ______________________________________

10. The client delivered a healthy newborn 4 hours ago after being induced with oxytocin. While being assisted to the bathroom to void for the first time after delivery, the client tells the nurse that she doesn't feel a need to urinate. Which explanation should the nurse provide when the client expresses surprise after voiding 900 mL of urine?
    A. "A decreased sensation of bladder filling is normal after childbirth."
    B. "The oxytocin you received in labor makes it difficult to feel voiding."
    C. "You probably didn't empty completely. I will need to scan your bladder."
    D. "Your bladder capacity is large; you likely won't void again for 6-8 hours."

11. When up to the bathroom for the first time after a vaginal delivery, the client states, "A friend told me that I'm going to have trouble with urinary incontinence now that I have had a baby." Which is the **best** response by the nurse?
    A. "That' not true. You won't need to worry about this until menopause."
    B. "I will teach you how to do Kegel exercises strengthen your muscles."
    C. "Wearing a pad similar to a sanitary pad will help contain the incontinence."
    D. "If this occurs, notify your HCP to have surgery to correct urinary incontinence."

Initial ___________

12. The client, who had preeclampsia and delivered vaginally 4 hours ago, is still receiving magnesium sulfate IV. When assessing the client's deep tendon reflexes (DTRs), the nurse finds that they are both weak, at 1+, whereas previously they were 2+ and 3+. Which actions should the nurse plan? **Select all that apply**.
    A. Notify the client's HCP about the reduced DTRs.
    B. Prepare to increase the magnesium sulfate dose.
    C. Prepare to administer calcium gluconate IV.
    D. Assess the level of consciousness and vital signs.
    E. Ask the HCP about the drawing serum calcium level.

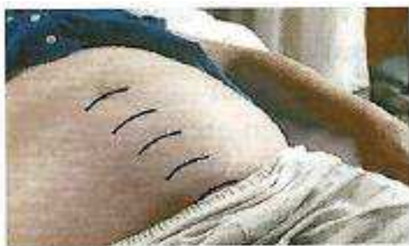
13. The postpartum client delivered a full-term infant 2 days previously. The client states to the nurse, "My breasts seem to be growing, and my bra no longer fits." Which statement should be the basis for the nurse's response to the client's concern?
    A. Rapid enlargement of breasts usually is a symptom of infection.
    B. Increasing breast tissue may be a sign of postpartum fluid retention.
    C. Thrombi may form in veins of the breast and cause increased breast size.
    D. Breast tissue increases in the early postpartum period as milk forms.

14. While assessing the postpartum client who is 10 hours post-vaginal delivery, the nurse notes a perineal pad that is totally saturated. To determine the significance of this finding, which question should the nurse ask the client **first**?
    A. "How often are you experiencing uterine cramping?"
    B. "When was the last time you changed your peri-pad?"
    C. "Are you having any bladder urgency or frequency?"
    D. "Did you pass clots that required changing your peri-pad?"

15. Two hours after the client's vaginal delivery, she reports feeling "several large, warm gushes of fluid" from her vagina. The nurse assesses the client's perineum and finds a large pool of blood on the client's bed. Which nursing action is **priority**?
    A. Encourage the client to ambulate to the bathroom in order to empty her bladder.
    B. Place two hands on the uterine fundus and prepare to vigorously massage the uterus.
    C. Reassure the client that heavy bleeding is expected in the first few hours postpartum.
    D. Support the lower uterine segment with one hand and assess the fundus with the other.

16. The oncoming shift nurse assesses the fundus of the postpartum client 6 hours after a vaginal birth and finds that it is firm. When the nurse then assists the client out of bed for the first time, blood begins to run down the client's leg. Which action by the nurse in response to the client's bleeding is correct?
    A. Explain that extra bleeding can occur with initial standing
    B. Immediately assist the client back into bed
    C. Push the emergency call light in the room
    D. Call the HCP to report this increased bleeding

17. An LPN asks an RN to assist in locating the fundus of the client who is 8 hours post-vaginal delivery. Place an X at the location on the client's abdomen where the RN should direct the LPN to begin to palpate the fundus.



Initial ___________

18. The nurse is caring for the client who just give birth. Which observation of the client should lead the nurse to be concerned about the client's attachment to her male infant?
    A. Asking the care giver about how to change his diaper
    B. Comparing her newborn's nose to her brother's nose
    C. Calling the baby "Kelly", which was the name of selected
    D. Repeatedly telling her husband that she wanted a girl

19. The nurse is caring for the postpartum family. The nurse determines that paternal engrossment is occurring when which observation is made of the newborn's father?
    A. Talks to his newborn from across the room
    B. Shows similarities between his and the baby's ears
    C. Expresses feeling frustrated when the infant cries
    D. Seems to be hesitant to touch his newborn

20. The nurse is caring for the postpartum primiparous client who is 13 hours post-vaginal delivery. The nurse observes that the client is passive and hesitant about making decisions about her own and her newborn's care. In response to this observation, which interventions should be implemented by the nurse? **Select all that apply**.
    A. Question her closely about the presence of pain.
    B. Ask if she would like to talk about her birth experience.
    C. Encourage her to nap when her infant is napping.
    D. Encourage attendance in teaching sessions about infant care.
    E. Suggest that she begin to write her birth announcements.

Initial ___________