

## Nursery Skills Checklist

Level of Proficiency:

- 1. Can function independently**
- 2. Experienced but may need review**
- 3. Limited or no experience**

By accurately filling out this checklist, you will help us match your skills and interest with available assignments. Please select the button in the column that best describes your experience level with each skill.

Assesment Skills	1	2	3	<b>RESPIRATORY THERAPY (cont.)</b>	1	2	3
Gestational Age/Dubowitz Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CRAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apgar scoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Special Procedures</b>			
Physical Dimensions/landmarks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assisting parents bond w /baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infant security protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ABG certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast/Bottle/Nipple feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	of Premature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Managing Equipment</b>			
Tone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infant Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiant Warmers/probes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip Click	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac-apnea monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IV Therapy**

				OHD Infant warmer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Umbilical Artery/Vein lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isolettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Set-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BiliLights /Bili Blankets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulse Oximeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drawing ABG's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mechanical Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Wound Care**

Cord Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Assisting Physician**

Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tube insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insertion of UA/UV Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exchange transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intubation / Extubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Tube Care**

Gavage/Lavage Feedings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Test Tubes / Insertions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Test Tubes/maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Respiratory Care**

Suction / Bulb syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suction / DeLee/Mucaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Respiratory Therapy**

Bagging and sighing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Toilet/CPT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Maintaining Oxyhood

Name \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_