LD/ LDRP RN Skills Checklist

First Name _____ Last Name _____

Social Security number _____ Date _____

Email _____

Please indicate your level of experience (0, 1, 2, or 3)
0 = Theory, no practice 1 = Limited 2 = Confident 3 = Very Confident

A. LABOR AND DELIVERY

Assist with vaginal delivery	0 ☐	1 ☐	2 ☐	3 ☐
Assist with forceps vaginal delivery	0 ☐	1 ☐	2 ☐	3 ☐
Emergency delivery	0 ☐	1 ☐	2 ☐	3 ☐
Assist with high risk delivery	0 ☐	1 ☐	2 ☐	3 ☐
Assist with vacuum delivery	0 ☐	1 ☐	2 ☐	3 ☐
Circulate for C-section	0 ☐	1 ☐	2 ☐	3 ☐
Abdominal shave/perineal prep/scrub prep	0 ☐	1 ☐	2 ☐	3 ☐
Internal monitor, lead connection and calibration	0 ☐	1 ☐	2 ☐	3 ☐
Assist with placement of intrauterine pressure cathter	0 ☐	1 ☐	2 ☐	3 ☐
Assist with fetal scalp blood sampling	0 ☐	1 ☐	2 ☐	3 ☐
Sterile vaginal exams	0 ☐	1 ☐	2 ☐	3 ☐
Fundal assessment/height	0 ☐	1 ☐	2 ☐	3 ☐
Use of Doppler/fetoscope	0 ☐	1 ☐	2 ☐	3 ☐
Interpretation of fetal monitoring	0 ☐	1 ☐	2 ☐	3 ☐
Identify FHR Patterns	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient in premature labor	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with pregnancy induced hypertension	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with preeclampsia	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with multiple gestation	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with placenta previa	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with abruption placenta	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with malpresentations	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with diabetes mellitus	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with drug addiction/withdrawal	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with HIV	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with RH incompatibilities	0 ☐	1 ☐	2 ☐	3 ☐
Administration of Pitocin	0 ☐	1 ☐	2 ☐	3 ☐
Administration of magnesium sulfate therapy	0 ☐	1 ☐	2 ☐	3 ☐
Administration of insulin drips	0 ☐	1 ☐	2 ☐	3 ☐
Administration of labetalol	0 ☐	1 ☐	2 ☐	3 ☐

B. IMMEDATE CARE OF BABY IN THE DELIVERY ROOM

Apgar scored	0 ☐	1 ☐	2 ☐	3 ☐
Suctioning	0 ☐	1 ☐	2 ☐	3 ☐
Eye prophylaxis	0 ☐	1 ☐	2 ☐	3 ☐
Collect cord samples	0 ☐	1 ☐	2 ☐	3 ☐

C. POSTPARTUM CARE

Fundus consistency	0 ☐	1 ☐	2 ☐	3 ☐
Lochia	0 ☐	1 ☐	2 ☐	3 ☐
Bladder distention	0 ☐	1 ☐	2 ☐	3 ☐
Episiotomy	0 ☐	1 ☐	2 ☐	3 ☐
Post-op C-Section	0 ☐	1 ☐	2 ☐	3 ☐
Postpartum assessment	0 ☐	1 ☐	2 ☐	3 ☐
Breastfeeding assistance	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with diabetes mellitus	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with sickle cell disease	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with infectious disease	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with cardiac disease	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with neurological disease	0 ☐	1 ☐	2 ☐	3 ☐
Care of Patient with tubal irrigation				

D. NEWBORN CARE IN DELIVERY ROOM

Transfer to newborn nursery	0 ☐	1 ☐	2 ☐	3 ☐
Obtain specimen for UAC and UVC	0 ☐	1 ☐	2 ☐	3 ☐
Radiant warmers	0 ☐	1 ☐	2 ☐	3 ☐
Apnea monitoring	0 ☐	1 ☐	2 ☐	3 ☐
Cord Care	0 ☐	1 ☐	2 ☐	3 ☐
Transfer to Neonatal ICU	0 ☐	1 ☐	2 ☐	3 ☐
Neonatal resuscitation	0 ☐	1 ☐	2 ☐	3 ☐

E. PAIN MANAGEMENT & ANESTHESIA

Assessment of pain level/tolerance	0 ☐	1 ☐	2 ☐	3 ☐
Care of the patient with Epidural anesthesia/analgesia	0 ☐	1 ☐	2 ☐	3 ☐
Care of the patient with IV conscious sedation	0 ☐	1 ☐	2 ☐	3 ☐
Care of the patient with Patient controlled analgesia (PCA pump)	0 ☐	1 ☐	2 ☐	3 ☐

F. Age specific practice criteria

Please check the box corresponding to each age group for which you have expertise in providing age-appropriate nursing care.

- ☐ Newborn/Neonate (birth - 30 days)
- ☐ Infant (30 days-1year)
- ☐ Toddler (1 - 3 years)
- ☐ Preschooler (3 - 5 years)
- ☐ School age children (5-12 years)
- ☐ Adolescents (12-18 years)
- ☐ Young adults (18-39 years)
- ☐ Middle adults (39-64 years)
- ☐ Older adults (64+)

G. EXPERIENCE WITH AGE GROUPS

1.Calculate body weight to verify correct dosing of medication	0 ☐	1 ☐	2 ☐	3 ☐
2.Assess immunization status for pediatric, and adolescent	0 ☐	1 ☐	2 ☐	3 ☐
3.Set age-appropriate short-term and long-term goals in care planning	0 ☐	1 ☐	2 ☐	3 ☐
4.Provide age-appropriate education, considering possible vision and hearing impairment for Older than 65years.	0 ☐	1 ☐	2 ☐	3 ☐

My experience is primarily in: (Please indicate number of years.)

☐ LDR _____ year(s)
☐ LDRP _____ year(s)

# of births/month _____

Certification: (mo/day/yr)

☐ BCLS Completion Date: ___/___/___
☐ RNC Completion Date: ___/___/___
☐ NRP Completion Date: ___/___/___
☐ Other (type): _____ Exp. Date: ___/___/___

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Professional Nursing, Inc. to release this LD/LDRP RN Skills Checklist to Client facilities of Professional Nursing, Inc. in consideration of my assignment to work at those facilities.

_____ _____
Signature Date