



# NEONATAL INTENSIVE CARE SKILLS CHECKLIST

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

### To Assignment America's Healthcare Professionals:

The purpose of the following checklist is to assist in matching your skills and interests with available assignments, thus meeting your needs and the needs of our clients as much as possible. Your employment is not dependent upon responses given in this checklist.

**\*\*Please make sure this Skills Checklist is signed and dated.**

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize Assignment America, to release this Skills Checklist to client institutions of Assignment America, in relation to my employment with that institution.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### To Assignment America's Client Institution:

Assignment America has developed unique skills checklists for each nursing specialty. This checklist is not necessarily a valid indicator of clinical skills and should not be utilized as the sole measure of the ability of an individual to perform the duties of a registered nurse or therapist in your facility. It is intended to be used only as a guide in your screening procedures and in orientation to procedures within your institution.

## PLEASE MARK YOUR LEVEL OF EXPERIENCE ☒

- 1 No Experience: Observed Only
- 2 Limited Experience: Performs < 6 Times Per Year; Needs Review
- 3 Moderate Experience: Performs 1-2 Times/Month; May Need Minimal Resource
- 4 Highly Experienced: Performs on Daily or Weekly Basis; Proficient

**A. Medication Administration**

Mark One

	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
1. Unit Dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. IV Push Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. IV Drip Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Calculation of Neonatal Doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Administration of Eye Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**B. IV Therapy**

Mark One

	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
1. Starting IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Mixing IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Regulating IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. IV Infusion Pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CVP Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Umbilical Artery Line (Maintenance and D/C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Umbilical Venous Line (Maintenance and D/C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Percutaneous Arterial Line (Maintenance and D/C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood/Blood Products Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Exchange Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mark One

	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>II. IV Hydration/Intralipid:</b>				
a. Central	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Peripheral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Broviac (Implanted) Lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Double Lumen Catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C. Evaluation and Management of Infant Post Delivery**

Mark One

	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
1. Apgar Scoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Thermoregulation:				
a. Temperature (Axillary, Rectal, Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Use of Isolette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Use of Radiant Warmer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use of Warming Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Gestational Age Assessment Tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Transport of Neonate to Nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Initial Neonatal Physical Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE MARK YOUR LEVEL OF EXPERIENCE**

- |   |  |
|---|--|
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Applicant's Name \_\_\_\_\_ Mark One

**D. Infants with Cardiovascular Problems** 1 2 3 4

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Cardiac/Apnea Monitor                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Taking EKG Rhythm Strip                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Taking EKG - 12 lead                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Neonatal Cardiopulmonary Resuscitation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Preparation of Emergency Drugs         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Defibrillation                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Care of Infant with:                   |                          |                          |                          |                          |
| a. PDA Ligation                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cyanotic Heart Disease                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Acyanotic Heart Disease                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Assessment of:                         |                          |                          |                          |                          |
| a. Pulses                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Perfusion                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heart Sounds                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Blood Pressure:                        |                          |                          |                          |                          |
| a. Doppler                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Palpation                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Non-Invasive Machine (Dinamap)         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Administration of Cardiac Drugs:      |                          |                          |                          |                          |
| a. Oral                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. IV                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. IM                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Intracardiac Line                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Care of Infant in Shock:              |                          |                          |                          |                          |
| a. Cardiogenic                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Septic                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hypovolemic                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Care of the Infant:                   |                          |                          |                          |                          |
| a. Pre/Post-Op Cardiac Surgery            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Measurement of Arterial Pressure      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Measurement of CVP                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Parent/Child Teaching                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**E. Infants with Respiratory Problems** 1 2 3 4

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Assessment of Breath Sounds         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Silverman Anderson Retraction Score | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Assisting with Intubation           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

**4. Obtaining Blood Gases/Lab Tests:** 1 2 3 4

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Heelstick (Capillary)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Umbilical Artery Line  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Peripheral (Percutaneous) Line                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Peripheral Arterial Stick                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Interpretation of Blood Gases                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Care of Infant on Ventilator                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chest Physiotherapy/Suction                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Care of Infant with:   |                          |                          |                          |                          |
| a. Respiratory Distress Syndrome (RDS)                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Persistent Fetal Circulation (PFC)                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Diaphragmatic Hernia   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Broncho-Pulmonary Dysplasia (BPD)                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Massive Aspiration Syndrome                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Persistent Pulmonary Hypertension                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Chest Tube (Pleurovacs):                                       |                          |                          |                          |                          |
| a. Assisting with Insertion and Setup                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Maintenance Care   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Oximeters/Transcutaneous Oxygen Monitor (to PO <sub>2</sub> ) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ventilation with Anesthesia Bag                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Assessment of Pneumothorax by Transillumination               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Use of Respiratory Assistance Equipment                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. ECMO (Extracorporeal Membrane Oxygenation)                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Jet Ventilators or Oscillators                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Use of Artificial Surfactant                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Mark One

**F. Infants with Neurological Problems** 1 2 3 4

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Assessment of LOC                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Assessment of Fontanels                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Assessment of Pupil Size and Response       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Care of Infant with:                        |                          |                          |                          |                          |
| a. Seizures                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Disorders of Head, Spine and Nervous/System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Drug Addiction/Drug Exposure                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Assisting with Lumbar Puncture              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant's Name \_\_\_\_\_

Mark One

1  2  3  4

**6. Administration of:**

a. Anticonvulsive Medications

b. Steroids

c. Anticoagulants

7. Maintaining a Neutral Thermal Environment

8. Parent Teaching

Mark One

**G. Infants with Gastrointestinal Problems**  1  2  3  4

**1. Assessment of GI Status:**

a. Measurement of Abdominal Girth

b. Assessment of Bowel Sounds

c. Feeding Tolerance

2. Stool Tests

3. Nasogastric Tube, Sump Tube, Intermittent & Continuous Suctioning

4. Gastrostomy Tube

**5. Gavage Feeding:**

a. Nasogastric

b. Nasojejunal

6. Colostomy/Ileostomy Care

7. Phototherapy Treatment

**8. Care of an Infant with:**

a. Tracheoesophageal Fistula (TEF)

b. Omphalocele

c. Gastroschisis

d. Inguinal Hernia

e. Necrotizing Enterocolitis

f. Cleft Palate/Lip

9. Parent Teaching

Mark One

**H. Infants with Renal/GU Problems**  1  2  3  4

1. Peritoneal Dialysis

2. Insertion of Urinary Catheter

3. Collection of Urine Specimen

**4. Care of Infant with:**

a. Disorders of External Organs (Bladder Atresia)

b. Malformation of GU Tract, Kidney

5. Test and Interpret Urine Abnormalities

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Mark One

**I. Infants with Orthopedic Problems**  1  2  3  4

1. Assistance with Devices (i.e., Splints, Casts, Traction)

2. Range of Motion Exercises

Mark One

**J. Infants with Electrolyte and Endocrine System Disorders**  1  2  3  4

1. Normal Electrolyte/Mineral Values

2. Blood Glucose Levels via Dextrostix/Glucometer

3. Care of an Infant of a Diabetic Mother (IDM)

Mark One

**K. Infants with Wound or Skin Problems**  1  2  3  4

1. Assessment of Wound Healing

2. Prevention of Impaired Skin Integrity

**3. Assessment of Color Change of Skin:**

a. Jaundice

b. Cyanosis

c. Mottling

d. Petechiae

4. Care of Infant with Neonatal Sepsis

5. Collection of Culture Specimens

Mark One

**L. Other**  1  2  3  4

1. Pain Management—Post-Op and Post Procedure

2. Developmental Interventions and Assessment

3. Care of Extremely Low Birth Weight Infant

4. Bereavement Support

5. Universal Precautions

6. Isolation Techniques and Procedures

7. Blood Glucose Monitor Type: \_\_\_\_\_

8. OSHA TB Fit Test Mask Type: \_\_\_\_\_

9. Computer Charting Type: \_\_\_\_\_

Applicant's Name \_\_\_\_\_

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M. Age of Patients Cared For:	Mark One			
	1	2	3	4
1. Infants and Toddlers (ages 0-3 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Young Children (ages 4-6 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Older Children (ages 7-12 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adolescents (ages 13-20 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Young Adults (ages 21-39 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Middle Adults (ages 40-64)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Older Adults (ages 65-79)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Adults (ages >80)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>