

Competency Indicator Tool Level II Nursery Care Registered Nurse

Employee Name: ₋		_
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INTRODUCTION

This Competency Indicator Tool was designed by the Southwestern Ontario Maternal Newborn Child and Youth Network in collaboration with representation from nursing leaders from level II hospitals throughout the region. It is recognized that RNs caring for either preterm or sick term infants requiring level II nursery care must possess the competencies to recognize, communicate and intervene in commonly occurring urgent and emergent situations and to provide emergency care in the absence of the most responsible practitioner (MRP). Therefore, this tool has been designed to assist nurse orientees to build the knowledge and confidence necessary in these areas. It also offers preceptors and nurse managers a means by which to provide educational support, and constructive feedback while evaluating and monitoring the nurse's progress in skill development.

While the tool is most applicable for nurses orienting to practice in the level II nursery, it may also be of benefit to more experienced nurses who wish to review skills that are infrequently performed. According to the College of Nurses of Ontario, competency is defined as "the nurse's ability to use his/her knowledge, skill, judgment, attitudes, values and beliefs to perform in a given role, situation and practice setting. (College of Nurses of Ontario, 2002, p. 5). Each nurse has the responsibility to ensure on an ongoing basis that his /her competencies are relevant and current.

These core competencies and Clinical Practice Guidelines (CPGs) will provide guidance to the RN for the care of the neonate in the level II nursery within the framework of:

- assessment
- organization, coordination & provision of care
- communication & documentation
- management of urgent and emergent newborn conditions (BC, P. H. 2011, May, p. 1)

This tool requires that both the learner and the preceptor make an assessment of the learner's skill based on Benner's Model of Skill Acquisition in Nursing (1984) which describes the characteristics of performance at five different levels of proficiency. The following is a description of these levels of skill:

- **Stage 1 Novice:** This level is characterized by rule-governed behaviour, as the novice has no experience of the situation upon which to draw.
- **Stage 2 Advanced Beginner:** The advanced beginner is one who has had sufficient prior experience of a situation to deliver marginally acceptable performance. Advanced beginners need adequate support from mentors, supervisors and colleagues in the practice setting.
- **Stage 3 Competent:** This stage is characterized by conscious, deliberate planning based upon analysis and careful deliberation of situations. The competent practitioner is able to identify priorities and manage their own work and benefit from learning activities that centre on decision making, planning and coordinating patient care.
- **Stage 4 Proficient:** The proficient practitioner is able to perceive situations holistically and can therefore hone in directly on the most relevant aspects of a problem. Proficiency is normally found in practitioners who have worked in a specific area of practice for several years. Inductive teaching strategies such as case studies are most useful at this stage.
- **Stage 5 Expert:** This stage is characterized by a deep understanding and intuitive grasp of the total situation; the expert develops a feel for situations and a vision of the possibilities in a given situation. Critical incident technique is a useful way of attempting to evaluate expert practice, but Benner considers that not all practitioners are capable of becoming experts. (The Resource Group for Healthcare Professionals, 2012)

How to Use this Tool:

Nurse Orientee: Educational opportunities for the nurse orientee will be initiated at the nurse's hospital of employment but may be enhanced by clinical opportunities arranged in partnership with other institutions as needed. Prior to clinical placement at a partner hospital, it is expected that the nurse orientee has initiated her skill review using the Competency Indicator Tool at her home hospital. Nurses are encouraged to be self –directed by taking the opportunity for learning new skills whenever possible. The nurse will indicate her level of competence for each skill under the 'Self- Assessment' columns as she completes them. The key for Benner's Stages of Skill Acquisition is listed on the bottom of each page. Nursing leadership will indicate skills that will not be applicable for her learning (N/A) in accordance with the level of care provided at the hospital where she is employed. The nurse should indicate the method she has used to review information / technique for a specific skill. This learning tool is also intended to be completed by the nurse on clinical placement at the partner institution if this has been arranged as part of the orientation process.

Preceptor: Prior to mentoring the nurse orientee, preceptors are encouraged to visit the **Preceptor Education Program for Health Professionals and Students** (Bossers. A. et al, 2012) and complete the learning modules. The preceptor must also complete the nurse's copy of the Competency Indicator Tool by assessing the orientee using Benner's Stages of Skill Acquisition under the section entitled 'Assessment by Preceptor'. An attempt should be made to provide learning opportunities for each required skill that has not yet been completed successfully. The preceptor can also indicate the method of review and the method of evaluation used for each skill. The preceptor will date and sign off each skill that has been completed. The bottom of each page also requires the preceptor's printed name and signature. It is recommended that the preceptor keep a copy of the Competency Indicator Tool for her own reference.

Both the nurse and the preceptor are encouraged to write comments about the learning experience on the last page of the tool.

KEY ASSUMPTIONS

1. Definition of Level II Nursery Care

The core competencies included in this document reflect the care of infants in Level II A, B and C centres as outlined in the "Standardized Maternal and Newborn Levels of Care Definitions" developed by the Provincial Council for Maternal and Child Health (PCMCH). (Provincial Council for Maternal and Child Health, 2011) For the purpose of this document, managing level II nursery care includes providing care, advice and support to the infant and their family guided by current standards and evidence for optimum care. It includes collaborating with other care providers, as appropriate, to each regulated health care professional's scope of practice, and is carried out in the context of informed consent, respecting the family's values and their role in decision making.

Managing an infant in the level II nursery means taking professional responsibility and accountability for:

- the comprehensive and ongoing physical assessment of the infant
- the assessment of growth and development
- clinical decisions and clinical actions based on the above assessments

2. Developmental Care

• will be valued and demonstrated in all the care that we provide

3. Practice Setting

• The core competencies apply to all RNs caring for infants in the Level II nursery.

4. Family Centered Care

- Parent(s) are integral and equal parts of the health care team
- Parent(s) are promoted as the decision makers and build mutually beneficial parent/professional relationships
- Core concepts of Family Centered Care are:
 - o dignity and respect
 - o information sharing
 - $\circ \quad \text{participation} \\$
 - collaboration

5. Evidenced Based Practice

- The provision of care, advice and support will be guided by current standards and evidence to optimize care and outcomes.
- Acute Care of at-Risk Newborns (ACoRN), American Academy of Pediatrics (AAP), Canadian Pediatric Society (CPS) and National Association of Neonatal Nurses (NANN) will be used as primary resources on which to base current standards and practice.

6. Certifications

- All regulated health care professionals who provide care to infants are expected to keep current in their Neonatal Resuscitation Program (NRP) certification.
- All regulated health care professional are expected to keep current in Basic Life Support (BLS).
- All regulated health care professionals who provide Level II nursery care will successfully complete an orientation program during which the RN is required to demonstrate the knowledge, skills, judgment and attitudes delineated in this guideline prior to practising independently.
- Annual demonstration of competencies utilizing Benner's framework of Novice to Expert

CORE NURSING PRACTICE COMPETENCIES

	Organization, Coording	nation & Provision of Care	
KNOWLEDGE of:	SKILL in:	JUDGEMENT / REASONING in:	ATTITUDE by:
 Methods used to promote growth, comfort and development Physical and psychological needs during admission and discharge Non-pharmacologic comfort techniques and pharmacologic pain relief options Neonatal levels of care and transport 	 Assessing family's knowledge, expectations of care Using clinical reasoning and judgment in decision making Providing a safe physical and therapeutic environment in expected and unplanned situations Supporting the family using therapeutic support measures and providing evidenced based care / advice Implementing appropriate comfort measures Monitoring the neonate's response to pain relief options Administering appropriate medications / treatment Collecting specimens and interpreting laboratory results Initiating intravenous access Facilitating breastfeeding Performing neonatal resuscitation 	 Advocating for developmentally supportive care Ensuring parent(s) are involved in directing and providing care Recognizing indications for and the effects of non-pharmacological pain relief options Selecting appropriate interventions to neonatal well being Interpreting laboratory test and imaging results and taking appropriate action 	 Promoting developmentally supportive care Involving parent(s) in care decisions Promoting skin-to-skin contact Demonstrating self-awareness of own attitudes and beliefs

Communication & Documentation											
KNOWLEDGE of:	SKILL in:	JUDGMENT / REASONING in:	ATTITUDE by:								
 Effective and systematic communication Documentation and reporting requirements 	 Communicating the neonate's assessment and care plans with the MRP in a thorough and timely manner Utilize a systematic method of communication Using provincial, regional and institutional documentation records 	 Appropriate consultations to MRP, other health care providers, community services Guiding the family through an informed decision-making process Providing evidenced based information to the family and their support person(s) 	 Demonstrating respect to others Celebrating birth Respecting the family's choices Discussing with the family their wishes, concerns and questions regarding level II nursery admission and discharge 								

	Urgent and Emergen	t Neonatal Conditions	
 Neonatal urgent and emergent conditions Guidelines for neonatal urgent and emergent conditions 	 Initiating appropriate treatment for urgent and emergent conditions Communicating effectively and in a timely manner with MRP Facilitating transfer to another facility Keeping mother and support person(s) informed of condition Participating in post event debriefing Participating in emergency drills 	Recognizing the onset of urgent and emergent complications	Demonstrating Family Centered Care principles

Modified from the document entitled "Guidelines for Registered Nurses - Core Competencies: Management of Infants Requiring Care in the Special Care Nursery". St. Thomas Elgin General Hospital, St. Thomas, Ontario

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http://www.perinatalservicesbc.ca/NR/rdonlyres/9F63F0E5-9AF0-422A-B6AD-FA0B9FE137FF/0/CoreCompMngmentofLabourCompetenciesOnly.pdf

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Method of Review Key:	Method of Evaluation Key:	Self-Assessment by Employee				Method of		As	sessm	Date	Initials				
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	4	3	2	1	NA	(Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	

I. SAFETY /	INFECTION PREVENTION & CONTROL													
Follows unit	protocol for Safety & Security of Newborns:													
	strates how to apply the infant security system is how it operates	m and												
2. Provide	s family education regarding safety & securit	у												
3. Verifies	family ID before giving telephone information	n												
4. States	actions to be taking in the event of a Code Pi	nk												
Identifies ar Nursery	d locates personal protective equipment in the	ne Level II												
Demonstrat policies & p	es knowledge of Level II Nursery infection co rotocols for basic procedures eg.	ntrol												
1. Uses a	opropriate skin preparation prior to procedure	es												
2. Implem adminis	ents 'scrub the hub' protocol prior to IV medic tration	cation												
Demonstrat	es correct hand hygiene through:													
1. Hand w	ashing or hand rub between infants													
2. Remov	al of jewelry and watches													
3. Adhere	nce to fingernail policy													
Instructs pa	rents/visitors about the importance of hand h	ygiene												
Cleans com	mon equipment appropriately between infant	s												
	e: Not a skill that I have learned or developed : Solid experience, recognize deviations, has	•		_					•				e, support i	required;
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Performs surveillance of visitors	/siblings for illness														
II. TECHNOLOGY															
Utilizes standard unit specific te as appropriate for (check appro	chnology and advanced technology priate boxes)														
□Incubator															
□Infant Warmer															
□Cardiorespiratory Mo	onitor														
□Portable SpO₂ Monit	or														
□СРАР															
□SiPAP															
□Mechanical Ventilato	r														
□T-piece Resuscitator															
□Bag/ Mask Ventilatio	n														
☐ IV infusion pump															
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□syringe pump															
□Phototherapy Lights															
□Bili Blanket															
□Bili Mattress / Bed															
□Transcutaneous Bilim	neter														
□Chest Tube Drainage	Equipment														
□Transport Isolette															

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Demonstrates a working knowle	day of amarganay aguinment and														
documents:	dge of emergency equipment and														
1. Is familiar with location & ful	nction of emergency supplies														
2. Is able to set up intubation 6	· ·														
Checks emergency equipment	ent and documents appropriately														
III. DOCUMENTATION / COM	IMUNICATION														
Documents in a thorough and tir on: (check appropriate boxes)	nely manner as per unit protocol														
□Admission / Discharg	e Record														
□Transfer Record															
□Progress Notes															
□Unit Flow Sheet															
□Neonatal Resuscitation	on Record														
☐ Medication Administr	ration Record														
Initiates & documents ongoing fa	amily teaching.														
3-Proficient: Solid experience, re	ave learned or developed; 1 – Advar ecognize deviations, has an ability t	o resp	ond i	ndepe	enden	tly; 4-E	xpert: vast	experi	ence	; intui	tive k		lge	, support	required;

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Documents assessments of par	rent / infant interactions.																
Communicates an understandir report child protection concerns																	
Demonstrates knowledge of wh consent must be obtained.	en, and by whom informed																
IV. PROFESSIONAL ACC	COUNTABILITY																
Understands and practises with II (A,B or C) Nursery (circle as a	in the scope of service for a Level appropriate)																
Communicates and documents MRP in a timely manner	changes in infant's condition to																
V. PROVISION OF CARE																	
2. Reviews operation of T- pie	supplies per NRP Guidelines ece resuscitator are aware of impending birth																
Takes, records and interprets v	ital signs																
Obtains length, head circumfere	ence – records in cm																

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E = Education Session RI S = Self Learning Package T	 Observation (in clinical setting) P = Return Demonstration Written Test Verbal Review 	4	3	2	1	NA	Review (Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	
Obtains weight –records in kg.															
Provides cardiorespiratory monitorin 1. Selects appropriate sites for lea 2. Sets alarm limits as per unit pol 3. Navigates monitor menus to tro	ad placement licy														
Performs non-invasive blood pressure. 1. Indirect measurement using available. 2. Four limb BP as appropriate. 3. Chooses correct cuff size. 4. Selects appropriate site. 5. Follows procedure for blood pressure. 6. Accurately records & interprets.	ailable device														
 Attends appropriately to infant therr Provides humidified environment Intervenes to prevent heat loss Differentiates indications for ser Assesses appropriateness of engestational age and clinical control of the cooling appropriately 	nt according to Protocol by 4 mechanisms rvo & non-servo control nvironment for weight, idition														

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Follows unit specific protocol fo provided via:	r use of supplemental oxygen														
1. Incubator															
2. Nasal Cannula															
3. Free Flow (Blow By) O2															
Adheres to protocol for nasopha collaboration with Respiratory T															
Prong size & placement															
2. Skin care & positioning															
3. System assessment & main	ntenance														
Adheres to protocol for the use with Respiratory Therapy:	of the ventilator in collaboration														
Relates ventilator changes condition	to blood gases and patient														
2. Correctly interprets blood g	as results														
3. Assists with intubation															
4. Ensures ETT is secure															
5. Assesses level of distress															
6. Responds appropriately to	alarms														
7. Responds appropriately to	infant condition														
8. Identifies actions to be take	en if vent malfunctions														

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	monstrates appropriate know nea / bradycardia:	ledge to care for infants with														
1.	Identifies infants at risk for a	apnea / bradycardia														
2.	Demonstrates appropriate r	management / documentation														
Fol	lows appropriate procedure f	or oral/ nasal/ ETT suctioning														
1.	Correctly sets up and maint safe suction pressures and	ains suction equipment to ensure effective function														
2.	Assesses the infant's need procedure and & effectivene	for suctioning, tolerance of the ess														
3.	Supports infant physiological	ally & developmentally														
Ass	sists with the management of	pneumothorax:														
1.	Identifies infants at risk for p	oneumothorax														
2.	Identifies the signs of pneur	nothorax														
3.	Locates & uses transillumin	ator / vein viewer														
4.	Assists with thoracentesis &	or chest tube insertion														
5.	Sets up and reviews chest	drainage system														
	a. Appropriately assesses	s the infant & documents findings														
	b. Appropriately assesses	s system function														
	c. Trouble shoots / manag	ges complications PRN														
6.	Ensures chest tube remains	s secure														

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Method of Review Key: Method of Evaluation Key: P = Protocol/Procedure Review O = Observation (in clinical setting)					Self-A	ssessi		by	Method of		As	sessm	ent b	y Prece	eptor	Date	Initials
P = Protocol/ E = Education S = Self Learn C = Clinical P D = Demonst	n Session ning Package ractice	O = Observation (in clinical RD = Return Demonstration T = Written Test V = Verbal Review	0,	4	3	2	1	NA	(Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/	
Follows the hypoglycem		ol for the management of ne	wborn														
1. Correct	ly identifies infants a	at risk for hypoglycemia.															
2. Describ	es the signs of hypo	oglycemia in the newborn.															
	es the appropriate tre unit protocol	eatment to the hypoglycemi	c infant														
Adheres to	protocols for breastf	eeding / pumping:															
1. Breast	milk verification prod	cedure															
2. Instruct	s mother on pump s	set up and procedure															
3. Provide	es recommendations	s to establish and maintain s	supply														
4. Instruct	s mother on correct	methods for storage															
5. Correct	ly adds Human Milk	Fortifier as ordered															
6. Suppor	ts transition from tub	pe/bottle feeding to breast															
7. Encour	ages Kangaroo Car	e / skin-to-skin															
8. Uses th	ne baby weigh scale	as a tool for feeding advan-	cement														
		es to support lactation															
		eding formula or providing so	oother														
		erapy as per unit protocol															
Prepares/la	bels/stores formula	according to unit policy															
Adheres to	unit specific protoco	I for bottle feeding															
NA – Novice	e: Not a skill that I h	ave learned or developed;	1 – Advan	iced E	Beginn	ner: Fa	milia	r but re	quire guida	nce; 2	2- Cor	npete	nt: ha	ve bas	ic experience	e, support	required;
		recognize deviations, has a			_							-			-		
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Cal	culates total fluid intake (TFI) correctly.														
Foll	ows unit specific protocol for	r NG / OG Feeding														
1.	Selects appropriate size tul	pe for weight														
2.	Correctly estimates insertion measurement technique	n depth using an approved														
3.	Safely places & secures tul	ре														
4.	Correctly assesses correct	tube placement														
5.	Correctly administers <i>interr</i> pump as ordered	mittent feed via gravity or syringe														
6.	Correctly administers continuordered	nuous feed via syringe pump as														
7.	Interacts with infants / prov	ides non-nutritive sucking														
8.	Identifies signs of feeding in	ntolerance														
9.	Positions syringe containing delivery	g breast milk to maximize nutrient														
10.	Changes feeding tubing at	required intervals														
11.	Facilitates gastric drainage	as per unit protocol														

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Adheres to unit specific protocols	s for IV therapy														
Appropriately initiates IV the	erapy.														
Assesses the IV site for sign per unit protocol Takes corre	ns of extravasation regularly as ective action PRN.														
3. Operates infusion &/or syrin	ge pump correctly.														
4. Documents hourly intake															
5. Initiates/maintains saline loc	cks														
Initiates, assesses and mair products as per hospital pro	ntains infusion of blood and blood tocol														
Demonstrates ability to appropria	ately manage central lines:														
Sets up tray & assists with in	nsertion														
2. Maintains asepsis during all	aspects of line care														
3. Demonstrates ability to draw	v blood work														
4. Ensures that lines are secur	red														
5. Assesses for catheter comp	lications														
Demonstrates ability to initiate, is solutions as per unit protocol	maintain and safely change TPN														

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Adheres to unit specific protocols	s for Medication Administration														
Administers medications foll	owing CNO Standards														
2. Determines appropriateness	s of dose for weight														
3. Confirms doses, calculations	s, drug and rates														
4. Labels all medication syringe	es														
5. Safely administers enteral m	nedications (PO & NG)														
6. IV administration															
a. Demonstrates asep system	otic establishment of closed IV														
b. Follows procedure medication adminis															
c. Ensures that IV me fluids prior to admir	dications are compatible with IV nistration														
7. Reconstitutes drips for contin	nuous infusion														
8. Initializes the drug library on	the infusion pump.														
9. Safely administers IM medic	eations														
10. Assists with the administration	on of:														
a. Surfactant															
b. Prostaglandin E															
c. Vasopressors															

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Method of Review Key:	Method of Evaluation Key:	:	Self-A E	ssess		by	Method of		Ass	essm	ent b	y Prece	eptor	Date	Initials
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review	4	3	2	1	NA	(Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	
11. Appropriately transcribes at administration on MAR12. Performs 24hr chart checks															
Provides appropriate skin care:	sessment and care as per unit per unit protocol gly to minimize absorption esives														
 6. Minimizes baths & exposure Adheres to protocol for circumci 1. Attends to pain management 2. Monitors for complications particular 3. Enters orders and document 	sion: nt before, during and after														
Assesses, documents and mana Adheres to unit protocol for urina 1. Demonstrates correct inser 2. Assesses urinary drainage	ary catheterization: tion technique and maintenance														

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	Method of Review Key:	Method of Evaluation Key:	:	Self-A E	ssessi mploy		by	Method of		As	sessm	ent b	y Prece	eptor	Date	Initials
E = S = C =	Protocol/Procedure Review Education Session Self Learning Package Clinical Practice Demonstration	 O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review 	4	3	2	1	NA	(Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	
	llows unit specific guidelines ecimens.	for the collection of all lab														
1.	Uses appropriate procedure (including NBS)	e for capillary blood draws														
2.	Follows unit accepted proto venous blood draws	ocol for IV starts for the purpose of														
3.	Assists with arterial blood d	lraws														
4.	Identifies how to correctly of aspirate for culture	btain an endotracheal tube(ETT)														
5.	Assists with lumbar punctur	re														
6.	Obtains surface cultures															
7.	Labels lab specimens appre	opriately														
8.	Interprets lab results and co	ommunicates results														
9.	Demonstrates the appropria	ate procedure for obtaining a urine urine collection system														
As	sists with infant x-ray as requ	ired														
1.	Correctly assists with positi	oning the infant														
2.	Dons the lead apron															
3.	Correctly applies the throat cover the infant's reproduct	protector and the lead protector to ive organ														

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Method of Review Key:	Method of Evaluation Key:	!		ssessi mploy	ment l	by	Method of		Ass	sessm	ent b	y Prece	eptor	Date	Initials
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	 O = Observation (in clinical setting) RD = Return Demonstration T = Written Test V = Verbal Review 	4	3	2	1	NA	Review (Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	
Appropriately cares for infants st Abstinence Syndrome (NAS): 1. Identifies infants at risk of NAS 2. Identifies the signs of NAS 3. Documents using the Finne Tool 4. Modifies environment accord 5. Educates and supports pare	gan Neonatal Abstinence Score														
Follows unit protocol for hyperbilians. 1. Identifies infants at risk for how the signs and adversary. 2. Identifies the signs and adversary. 3. Uses phototherapy sources. 4. Correctly applies eye shields. 5. Maximizes skin exposure for how the signs and supports pare. 7. Educates and supports pare.	yperbilirubinemia erse effects of hyperbilrubinemia appropriately s most effective treatment ograms														

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Method of Review Key:	Method of Evaluation Key:			ssess mplo	ment yee	by	Method of		Ass	sessm	ent b	y Prece	eptor	Date	Initials
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Adheres to unit procedure for im	munizations:														
Ensures informed consent is	s documented														
2. Employs pain management	technique														
3. Documents administration in	ncluding lot number														
4. Initiates Vaccine Record and	d gives to family														
5. Follows procedure for enroll	ment in RSV program														
a. Has MRP sign number	paperwork and fax to appropriate														
Demonstrates an understanding developmentally supportive care	of the principles and practices of														
Provides appropriate parental su	upport:														
Supports parent's relationsl care	hip with infant and participation in														
2. Educates families about ava	ailable supports/resources														
3. Encourages mothers to use	Parent Room when appropriate														

Initials	Print / Signature	Initials	Print / Signature	Initials	Print / Signature

Method of Review Key:	Method of Evaluation R	Key:	Self-Assessment by Employee			Method of	Assessment by Preceptor			eptor	Date	Initials				
P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration	O = Observation (in clinical se RD = Return Demonstration T = Written Test V = Verbal Review	etting)	4	3	2	1	NA	Review (Use Key on Left)	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/ yyyy)	
Provides relevant family teaching	g regarding:															
1. Family education of the hos	pitalized infant															
2. Breastfeeding / use of breas	st milk															
3. Medication administration																
4. Discharge home with oxyge	n															
5. Gastric Reflux																
6. Nasogastric tube feeding																
7. Formula preparation	7. Formula preparation															
8. SIDS	8. SIDS															
9. Safe sleep environment																
Shaken Baby Syndrome (using Period of Purple Crying® educational information)		R														
Adheres to protocol for discharge	e planning:															
Implements Car Seat Challe	enge															
Ensures that Hearing Screen (including ABAER as indicated) is completed		cated)														
Collaborates with relevant community service providers																
Assesses family learning needs																
NA – Novice: Not a skill that I have learned or developed; 1 – Advanced Beginner: Familiar but require guidance; 2- Competent: have basic experience, support required; 3-Proficient: Solid experience, recognize deviations, has an ability to respond independently; 4-Expert: vast experience; intuitive knowledge																
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Method of Review Key:	Method of Evaluation Key:			ssessi		by	Method of	Assessment by Preceptor						Date	Initials
 P = Protocol/Procedure Review E = Education Session S = Self Learning Package C = Clinical Practice D = Demonstration 	n RD = Return Demonstration	4	3	2	1	NA	(Use Key on Left) 4	4	3	2	1	NA	Method of Evaluation (Use Key on Left)	(dd/mm/	
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V.	EMPLOYEE COMMENTS:
VI.	PRECEPTOR COMMENTS: