NAME OF

PATIENT CARE SERVICES

ORIENTATION/COMPETENCY INVENTORY (OCI)

Registered Nurse, Nursery (1-37)

During orientation, you will be required to validate with your preceptor, administrative supervisor and/or department director established competencies for the above referenced position through either return demonstration or verbalizing the procedure, skill or criteria. Your preceptor, administrative supervisor and/or department director will date and initial each competency as they are satisfactorily completed. **THIS OCI MUST BE COMPLETED BEFORE YOU CAN BE RELEASED FROM ORIENTATION AND WORK WITHOUT A PRECEPTOR. (**Based on individual circumstances an employee may be released prior to completion of the OCI due to lack of opportunity for return demonstration. However, that procedure, skill or criteria may not be performed independently by the employee until s/he has been evaluated by the appropriate individual). At the conclusion of your orientation this OCI should be fully completed and will be reviewed by yourself, your preceptor and department director. This OCI will become a part of your Human Resources file.

Name of Employee: _____ Date of Hire: _____

Unit(s) Assignment: _____ Orientation Dates: _____ to _____

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

Department Director Signature: _____ Date: _____

KEY:

Self-Assessment:

0 = No knowledge and/or experience. (No competence).

1 = Limited knowledge and/or experience. (Some competence).

2 = Knowledgeable and feels confident. (Complete competency).

Validation:

RD = Return demonstration.

V = Verbalizes.

NA = Not applicable to area or no experience required.

Developed by: Name of Developer
Approved by: Name of Approver

SELF-ASSESSMENT (Orientee Initials)			COMPETENCIES The orientee will be able to:	VALIDATION (Preceptor, Administrative Supervisor, Department Director, Date and Initials)		
0	1	2		RD	V	NA
			1. Hospital Safety Procedures: a. Internal Disaster (Fire [including RACE] & Electrical Safety, Bomb Threat).			
			b. External Disaster (Emergency Preparedness).			
			c. Infection Control: Bloodborne Pathogens and Tuberculosis Exposure Control Plans.			
			d. Body Mechanics.			
			e. Domestic Violence/Reporting of Suspected Abuse.			
			f. Risk management (including Hazardous Materials, MSDS).			
			g. Radiation Safety.			
			h. Patient call system.			
			i. Code Blue Management.			
			j. Current BLS-Healthcare Provider.			
			k. Current NRP-Healthcare Provider.			
			2. Departmental Overview: a. Tour of department(s)/unit(s): 1) Patient room/bed numbers.			
			2) Location of waiting rooms.			
			3) Location of conference rooms.			
			4) Medication carts.			
			5) Linen closets.			
			6) Utility rooms: Clean and soiled.			
			7) Examining rooms.			
			8) Supply room: Charging, ordering, obtaining.			
			9) Location of emergency equipment.			
			10) Charting areas.			
			b. Mechanism for tracking time and attendance (Kronos).			
			c. Telephone system; etiquette.			
			d. Page operators; beepers.			
			e. Departmental staff meetings.			
			f. Standard of professional attire.			
			h. Role of the resource nurse.			
			i. Ethics committee role and access.			

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0	1	2		RD	V	NA
			3. Management of Information: a. Maintenance of infant records.			
			b. Confidentiality; facsimile of information.			
			c. Nursery History and Assessment.			
			d. Doctor's Order Sheets.			
			e. Flow Sheet.			
			f. Nursing Progress Notes.			
			g. Footprint Sheets.			
			h. Laboratory Slips (bloodbank, hematology, chemistry, microbiology, blood gas).			
			i. PKU Slips.			
			j. Crib Cards.			
			k. Day Book.			
			l. Birth Record Book.			
			m. Transfer Form. (nursing)			
			n. Hospital/departmental manuals:			
			1) Administrative.			
			2) Patient Care Standards.			
			3) Human Resources.			
			4) Infection Control.			
			o. Shift change Reporting system.			
			p Methods of assignments..			
			q. Use of SMS/MEDITECH computer system.			

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0	1	2		RD	V	NA
			4. Physiologic Assessment: a. General: Recognize initial transition phases related to adaptation to extrauterine life. Accurately obtain weight, length, head and chest circumference, abdominal girth to establish baseline.			
			b. Skin: Recognize normal/abnormal turgor, texture, color, temperature, presence of rashes, acrocyanosis, mottling, birthmarks, presence of vernix or lanugo, desquamation, milia, Mongolian spots, jaundice. Able to obtain temperature (rectal, axillary) correctly.			
			c. Respiratory: Assesses rate, rhythm, breath sounds, depth and symmetry.			
			d. Cardiovascular: Assess cardiac rhythm and rate. Assess pulses, capillary refill, and general color.			
			e. Abdomen: Assess size, symmetry, umbilical stump (vessels), tone, presence of bowel sounds. Able to obtain and assess gastric aspirate.			
			f. Buttocks/Anus: Assess symmetry, patency, notes passage of meconium.			
			g. Genitourinary: Assess genitalia , and voiding.			
			h. Neurosensory: Assess tone, posture, and reflexes.			
			i. Head: Assess symmetry, presence of molding, cephalohematoma, caput, and fontanels.			
			j. Eyes: Assess general appearance, symmetry, color of sclera and conjunctiva.			
			k. Ears: Assess symmetry, presence of tags, sinuses or clefts.			
			l. Nose: Assess shape, size, symmetry, patency of nares. Able to pass feeding tube nasally.			
			m. Mouth: Assess symmetry of lips, color, placement , size, and palate.			

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0	1	2		RD	V	NA
			n. Neck: Assess free movement of the head, skin folds present with no webbing.			
			o. Chest: Assess shoulder symmetry, movement, and breast tissue.			
			p. Spine: Assess symmetry, presence of dimples/sinus tracks.			
			q. Extremities: Assess digits, symmetry, tone, creases, and pulses.			
			r. Health History: Review prenatal record and delivery record.			
			5. Care of the Infant - Admission: a. Assemble appropriate equipment and assures functioning prior to use.			
			b. Complete accurate physical assessment in accordance with policy and procedure.			
			c. Infant's assignment to nursery is based on admission criteria.			
			d. Appropriately notify the physician of infant's arrival.			
			e. Recognize signs of maladaption to extrauterine life and reports to the physician in a timely manner.			
			f. Delivers prophylactic medication in accordance with policy.			
			g. Confirm a plan of care based on comprehensive review of admission assessment.			
			h. Formulate a plan of care based on comprehensive review of initial infant assessment.			
			i. Review/transcribe physician orders.			
			j. Document information accurately.			
			6. Reassessment/Routine Infant Care: a. Review delivery history, initial infant assessment and physician orders.			
			b. Initiate parental contact as soon as possible to determine routine care issues related to feeding, rooming in , circumcision.			

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0	1	2		RD	V	NA
			c. Provide parent(s) with report on infant's condition. Furnishes parent(s) with rationale of procedures/events to occur.			
			d. Accurately determine weight in accordance to policy.			
			e. Assess sucking reflex with every feeding noting deviations from expected outcomes.			
			f. Continue with the development/ implementation of plan of care based on infant's condition, assessment of parental needs related to continued care while in hospital and following discharge. Accurately complete parental interview.			
			g. Accurately completes physical assessments according to policy.			
			h. Assess factors that promote/ interfere with appropriate parent infant bonding.			
			i. Assess and appropriately intervene to avert complications.			
			j. Follow through with appropriate referrals as indicated.			
			k. Appropriately alter/complete goals with parent(s).			
			7. <u>Heelstick Blood Sampling</u>: a. Verify physician order/protocol.			
			b. Prepare supplies needed to complete procedure; utilize appropriate aseptic technique related to universal precautions.			
			c. Select/cleanse appropriate site on lateral or medial plantar surface.			
			d. Grasp foot gently to control leg movement.			
			e. Puncture skin with quick stabbing action.			
			f. Compress/release foot to facilitate flow of blood.			
			g. Complete collection, apply pressure to site until bleeding stops, apply sterile dressing.			
			h. Correctly label specimen and slips.			
			8. <u>Security/Infant Abduction Prevention</u>: a. Verbalize understanding of need for prevention of infant abduction.			

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0	1	2		RD	V	NA
			b. Appropriately display employee identifying information and wears attire according to departmental policy.			
			c. Ensure infant transportation in bassinets only.			
			d. Ensure infant identification bands are present/ secure.			
			e. Verbalize/demonstrate appropriate release of infant to mother once bands re-checked for accuracy.			
			f. Provide rationale/literature to mother/ significant other related to enhancing the security of the infant.			
			g. Demonstrate proper use of locked doors to unit and fire exits.			
			h. Verbalize procedures related to potential or actual infant abduction.			
			i. Demonstrate application of security sensor with proper documentation in accordance with hospital policy.			
			9. Medication Administration: a. Identify types of medications approved for administration by the nurse in the nursery.			
			b. Verbalize classification of specific drugs including side effects, dosage, and nursing implications.			
			c. Accurately calculate dosage/delivery rates.			
			d. Prepare, label and administers medications per physician orders/policy .			
			e. Correctly program infusion pump to prescribed rate.			
			f. Provide rationale to parent regarding use of medications.			
			g. Assess/monitor/document infant's response to therapy.			
			h. Report effectiveness/ineffectiveness and untoward effects to the physician.			
			i. Surfactant: Verbalize and demonstrate guidelines related to administration.			

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0	1	2		RD	V	NA
			10. Thermal Stabilization: a. Verbalize understanding of elements that contribute to establishing and maintaining a neutral thermal environment for the neonate.			
			b. Prepare equipment prior to use and maintains safe operation of same.			
			c. Place infant under servo-controlled radiant warmer or in isolette; appropriately attaches temperature lead.			
			d. Obtain baseline temperature reading.			
			e. Adjust controls as needed; set alarms.			
			f. Appropriately reassess/document temperature of infant and environment per policy.			
			g. Observe/recognize symptoms/laboratory values that may indicate temperature instability.			
			h. Initiate/document actions to restore neutral thermal environments.			
			i. Provide rationale to parent(s) regarding thermo-control interventions used.			
			j. Instruct parent(s) regarding maintaining thermal stability in hospital and at home.			
			k. Demonstrate appropriate interventions related to weaning from warmer/isolette to open crib.			
			l. Assess infant's response to procedure/ documents outcomes.			
			11. Cardiac/Respiratory Monitoring: a. Appropriately recognize need to institute use of mechanical monitoring based on accurate assessment, reporting to the physician and physician orders.			
			b. Appropriately place leads.			
			c. Appropriately set high/low alarms.			
			d. Identify normal rates/rhythm and documents based status of infant and physician orders.			
			e. Recognize deviations from normal rates/ rhythms and nursing interventions are appropriate.			
			f. Document infant's response to interventions.			

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0	1	2		RD	V	NA
			g. Document lab values; reports abnormalities.			
			h. Provide rationale to parent(s) regarding need for equipment usage.			
			12. Nasogastric Feedings: a. Verify physician order.			
			b. Prepare supplies needed to complete procedure, utilize appropriate aseptic technique related to universal precautions.			
			c. Determine size and maximum safe length of catheter for insertion.			
			d. Properly position infant.			
			e. Insert tube into nostril/mouth to predetermined placement mark (indwelling tube may be present).			
			f. Ensure proper tube placement.			
			g. Aspirate air/residual formula, noting character, reports/documents same.			
			h. Accurately measure abdominal girth and assess tone prior to feeding.			
			i. Ensure proper temperature of formula/breast milk.			
			j. Appropriately deliver feeding per physician order via gravity/syringe pump.			
			k. Assess infant for tolerance of feeding, possibility of reflux or aspiration resultant from feeding, discontinues if necessary, reports and documents same.			
			l. Provide rationale to parent(s) regarding need for feeding procedures.			
			13. Phototherapy: a. Assess infant's color/physical status/lab values related to the need for intervention. Notify physician/transcribe orders, verify presence of consent.			
			b. Prepare supplies needed to complete procedure, utilizes appropriate aseptic technique related to universal precautions.			
			c. Provide rationale to parent(s) regarding need for intervention.			
			d. Maintain a neutral thermal environment.			

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0	1	2		RD	V	NA
			f. Position infant to allow maximum skin exposure to optimize therapy.			
			g. Initiate/discontinue phototherapy per physicians order.			
			h. Maintain accurate intake/output.			
			i. Assess infant's response to therapy, collect/monitor results of bilirubin levels and documents the same.			
			j. Recognize potential side effects of therapy and initiate interventions as needed.			
			k. Include parent(s) in daily routines to maximize bonding despite therapy.			
			l. Measure/adjust/record illumination.			
			m. Provide eye care every 3-4 hours.			
			n. Provide infant feedings per physician order.			
			14. Stabilization of Infant in Labor & Delivery: a. Prepare/demonstrate necessary stabilization equipment: 1) Infant radiant warmer.			
			2) Use of ISC probe and thermoregulation principles.			
			3) Oxygen setup with correct size face mask, Mapleson resuscitator, and manometer. Verbalizes correct pressure needed.			
			4) Suction setup with appropriate sized catheter. Verbalizes correct suction pressures.			
			5) Laryngoscope blades, stylets and endo-tracheal tubes appropriately sized.			
			6) Meconium aspirator setup. Verbalizes and demonstrates correct procedure.			
			7) Emergency medication and location.			
			b. Demonstrate correct technique of implementing resuscitative or stabilization measures.			
			c. Demonstrate/verbalize correct calculation of emergency medications as per NRP guidelines.			

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0	1	2		RD	V	NA
			d. Demonstrates ability to bag/mask infant until further measures are initiated.			
			e. Demonstrate ability to assist the physician with intubation and stabilization of tube placement.			
			f. Demonstrates bag-valve mask/ET tube ventilation of infant.			
			g. Demonstrate/verbalize use of the transport isolette.			
			15. Stabilization of Infant in Nursery: a. Initial Stabilization: 1. Check equipment prior to infant arrival, including code cart, and emergency medications.			
			2. Weigh infant, place under radiant warmer, attaches ISC probe.			
			3. Prepare and demonstrate use of pulse oximeter and cardiac monitor; sets alarm limits.			
			4. Initiate infant assessment, flow sheets and plan of care.			
			5. Verbalize/demonstrate administration and correct dosage of routine admission medications; Vitamin K, Erythromycin, Hepatitis B Vaccine when indicated.			
			6. Perform capillary blood glucose testing using proper technique.			
			b. If peripheral I.V. is needed: 1) Understand/verbalize rationale for use.			
			2) Assemble necessary equipment and supplies.			
			3) Display correct technique for inserting I.V. catheter in accordance with hospital policy.			
			4) Prepare I.V. fluids or bolus as per physician order and demonstrates correct technique for primary tubing and cassette.			
			5) Document solutions or bolus and insertion site correctly.			
			6) Maintain I.V. certification.			

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0	1	2		RD	V	NA
			c. If umbilical catheter is to be placed: 1) Ensure that consent or administrative guidance is obtained and verifies physician order is in the medical record.			
			2) Assemble necessary equipment and supplies.			
			3) Position infant appropriately for procedure, checks that cardiac monitor and pulse oximeter are functioning.			
			4) Assist medical staff with procedure. Verbalize/demonstrate proper steps.			
			5) Correctly notify radiology to ascertain line placement.			
			6) Interpret radiology orders and is able to maintain infant prior to line placement verification.			
			7) Prepare umbilical vein and artery solutions as ordered.			
			8) Assist the physician with securing lines.			
			9) Demonstrate attachment of transducer, line calibration and zero adjust on cardiac monitor.			
			10) Document procedure tolerance and solutions appropriately.			
			11) Verbalize/demonstrate correct blood sampling from UA or UV line if indicated and ordered.			
			12) Demonstrate/verbalize location and preparation of items for UA insertion.			
			d. If oxygen therapy is needed: 1) Properly notify respiratory care department.			
			2) Demonstrate/verbalize understanding use of: a) Manometer and correct pressures. b) Use of suction equipment, correct setup, catheter size and pressure. c) Bag-valve mask ventilation. d) Bag/endotracheal tube ventilation. e) Oxyhood setup with analyzer.			

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0	1	2		RD	V	NA
			f) Ventilator mechanics. g) Taping and stabilizing ET tube. h) Indications and setup of nasal CPAP and cannula. i) Procedure for obtaining ABG/CBC.			
			16. Transfer of Infant to a NICU/IICN: a. Ensure that physician has obtained consent for transfer .			
			b. Obtain physician order for transport.			
			c. Complete all necessary and urgent procedures, treatments, and charting prior to transport.			
			d. Notify administrative supervisor.			
			e. Obtain copy of infant's records.			
			f. Affix one infant identification bracelet to glossy identification footprint form. Document transfer of infant on form.			
			g. Complete nursing transfer summary.			
			h. Demonstrate ability to verbally report to receiving facility.			
			i. Present transport team with a concise report and assist if indicated.			
			j. Demonstrate ability to jointly identify the infant with the transport nurse and documents appropriately.			
			k. Document appropriate information in patient transfer log.			
			17. Infant of Drug Addicted Mothers: a. Obtain results of maternal drug screen,			
			b. If positive, demonstrate/verbalize protocol steps including: 1) Social service consult.			
			2) Signs and symptoms of withdrawal.			
			3) Indications to initiate neonatal addiction score (NAS).			
			4) Notification to the physician.			

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0	1	2		RD	V	NA
			c. If no maternal drug screen was sent on mother with a positive history: 1) Demonstrate method of obtaining infant urine drug screen.			
			2) Social service consult.			
			3) Notification to the physician.			
			4) Treatment of infant as indicated.			
			18. Infant with Suspected Sepsis: a. Locate protocol and can verbalize necessary necessary indications for treatment.			
			b. Locate and verbalize pertinent maternal history obtained from labor & delivery summary, along with antibiotic intervention.			
			c. Perform heelstick correctly to obtain CBC and blood culture.			
			d. Correctly complete lab requisition, label and places call to patient escort.			
			e. Document when specimens are obtained, results and physician notification.			
			f. Verbalize what to look for during 48 hour observation period and interventions, if appropriate.			
			g. Assist physician/designee in obtaining central blood specimens or further tests.			
			h. Correctly initiate peripheral access and document procedure.			
			19. Infant Feeding/Nutrition: a. Identify correct patient and review patient orders.			
			b. Identify feeding status (NPO, nipple, breastfeeding).			
			c. Review medical record for information on tolerance of previous feedings.			
			d. Identify correct feeding time(s).			
			e. Measure abdominal girth.			
			f. Assess bowel sounds.			
			g. Obtain blood glucose, as appropriate.			
			h. Identify correct type and amount of feed.			

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0	**1**	**2**		**RD**	**V**	**NA**
			i. Prepare appropriate feeding using clean technique.			
			j. Assess suck and swallow during nipple feed.			
			k. Assess infant for distress during feed.			
			l. Assess infant for spitting after feeding.			
			m. Appropriately document infant's condition prior to feed, feeding type amount, and tolerance.			
			n. Demonstrate/verbalize appropriate breastfeeding techniques.			