COMPETENCY-BASED CHECK OFF

General Direction: Please rate the following questions according to the staff's performance with the following scale. Mark with (√) for the best response for each item:

(4) Strongly Agree: there is sense of certainty; no further questions; executes without any lapses
(3) Agree: there is sense of certainty but still leaves room for some questions; executes with some minor lapses
(2) Disagree: there is sense of uncertainty that leaves room for a lot of questions; executes but with major lapses
(1) Strongly Disagree: there is absolute uncertainty that leaves room for so many questions; executes but in a wrong manner or unable to perform at all.

TITLE: NEONATAL PHYSICAL ASSESSMENT

COMPETENCY STATEMENT: The nurse demonstrates competence in Neonatal Physical Assessment.
Standard: Access and Continuity of care
Patient assessment
Care of patients
Quality, safety and environment
Patient and Family Education

PERFORMANCE CRITERIA:	**4**	**3**	**2**	**1**
Communication and Interpersonal Skills				
1. Displays effective verbal and non-verbal communication: a. Acknowledge the patient (Privacy, Dignity, Culturally sensitive caring, aware on patients' Bill of Rights)				
b. Introduce her/himself to the patient				
c. Verbalize the reason for the procedure/intervention				
d. Explain the duration and outcome of the procedure				
e. Educates patient and family / caregiver (where appropriate)				
Psychomotor skills				
2. * Identify the newborn				
3. Demonstrate hand hygiene as per the 5 moments throughout the procedure				
4. *Review essential labor records				
5. *Position the neonate safely				

6. *Prepare the neonate and environment				
7. Observe the color and posture				
8. *Measure vital signs				
9. *Measure height, weight, head circumference				
Skin				
10. Assess hair distribution and skin turgor				
11. Assess nails for pitches, ridges and hypertrophy				
12. Inspect for common variations in newborn skin and common pigmented lesions				
13. Assess for skin lesions secondary to trauma				
14. Inspect for presence of edema				
Head and Neck				
15. Examine head and face for symmetry, paralysis, shape, swelling, movement.				
16. Inspects scalp and hair and recognize abnormal findings				
17. Assesse the shape of the infant's head and identifies effects of molding of the skull during delivery				
18. Inspect and palpate the infant's skull to identify bones, sutures and fontanels and recognize abnormalities				
19. Inspect the face and verbalize types of abnormalities				
20. Assess the eyes (sclera, pupils, eyelids, red reflex, strabismus)				
21. *Inspect the nose for patency, nasal flaring, nasal septum and discharge				
22. Examine ears for the formation, position in relation to the eye, cartilage, hearing				
23. Inspect inside baby's mouth and tongue when baby's mouth opens				
24. Palpate hard and soft palate with gloved finger to identify clefts				
25. Observe shape and symmetry of the neck by elevating the shoulders				

26. Allowing the neck to extend backwards while supported by one hand				
Thorax and Lungs				
27. Inspect the chest for abnormalities of shape and structure				
28. Assess respiratory effort				
29. Auscultate breath sounds and recognize abnormalities				
30. Inspect the breast, nipples and areola				
Cardiovascular System				
31. Auscultate heart sounds and states findings and interpretation				
32. Assess color, and assess pulses and heart rate				
33. Assess capillary fill time and state normal times				
Abdomen				
34. *Inspect abdomen for size, shape and symmetry				
35. Auscultate abdomen				
36. Palpate abdomen				
37. Inspect the umbilical cord				
Genitourinary System				
38. *Wear gloves				
39. Inspect genitalia for abnormalities				
40. *Assess urinary output				
41. Check for passing of meconium				
Musculoskeletal System				
42. Assess posture, position, and identify abnormalities				
43. Examine extremities for fractures, paralysis, number of fingers and toes				

44. Assess range of joint motion				
45. Assess muscle size, symmetry and strength				
46. Assess the spine for signs of neural tube defects				
47. Examine hips for dislocation				
48. Examine feet for structural and positional deformities				
16 Neurological System				
49. *Assess reflexes: blink, cough, sneeze, gag, rooting/sucking, moro, startle, tonic neck, stepping, and palmar/plantar grasp				
Critical Thinking				
50. Responds appropriately to scenario and questions presented				
51. Explains the concept of holistic care as related to the patient				
Documentation				
52. Documents appropriately and inform the physician of any abnormality				

RN Name:	**Signature:**	**Employee No.**
Evaluator's Signature:	**Date of Evaluation:**	**Employee No.**

Note:

During 'orientation' the Competency Based Check off is used as a reference only. When the competency is successfully completed the Assessor/Evaluator signs the Mandatory Competency Assessment Record (MCAR) and places it in the employee's file.

Should a learner be found not competent the learner will repeat the Competency Based Check Off and "Competency Not Met" forms are completed and placed in the employee's Portfolio