Maternal Health Nursing Competency/Skills Checklists

Employee Name: ____

Position Title: ____ Enhanced Role Nurse: Yes ___ No ____

Checklists Contained (as individual tabs/worksheets within this workbook)

√ General Maternal Health Program Knowledge and Skills
√ Patient Interview, Counseling/Education, & Documentation
√ Fetal Assessment
√ Specimen Collection

Assessment Method Key:

O = Observation
RD = Return Demonstration
V = Verbal Review
RA = Record Audit

Assessment Rating Key:

S = Satisfactory
I = Needs Improvement
NA = Not Applicable (Use this rating when the skill is not performed by the RN)

Instructions: This tool is a template and should be modified by each health department to reflect the agency's policies and practices. It is intended to assist LHDs in assessing the competency/clinical skills of nurses and enhanced role nurses (ERRNs) working in Maternal Health Clinics through the use of standardized checklists. This or a similar tool should be completed periodically for each nurse/ERRN to assess and ensure the quality of patient services. A specific checklist for patient physical assessment by the ERRN is not included. It is recommended that agencies use the tools previously provided through the MH ERRN Training Program for this portion of the ERRN's competency assessment.

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Maternal Health Nurse Competency Skills Checklist for General Maternal Health Knowledge and Skills				
Skills Assessed ↓	**Assessment Date**	**Assessment Method**	**Assessment Rating**	**Name of Person Completing Assessment**
Demonstrates the essential knowledge and skills required to perform competently in the Maternal Health (Title V) Program setting				
1. Verbalizes understanding of and demonstrates compliance with Maternal Health Agreement Addenda (HMHC and High-Risk if applicable) and program requirements	Comments:			
2. Verbalizes understanding of priority populations for MH program services				
3. Demonstrates knowledge of the role (scope and limitations) of nursing staff in the MH clinic				
4. Demonstrates knowledge of agency and MH program policies, procedures, and standing orders				
5. Demonstrates knowledge of requirements for consent for services, fee for services, schedule of discounts, and services not denied due to inability to pay				
6. Verbalizes understanding of and demonstrates compliance with confidentiality and privacy requirements				
7. Demonstrates knowledge/skill in accurately collecting and documenting the patient history and visit/encounter details				
8. Demonstrates ability to educate/counsel patients on topics as required on the MH Monitoring Tool				
9. Demonstrates accurate distributing and/or dispensing and documentation of prescribed medications.				
10. Demonstrates knowledge of pharmacy related requirements, including the agency's system for ordering/dispensing of medication/supplies				

11. Verbalizes understanding of other HD programs/services available to patients (including WIC, Lamaze/childbirth education, parenting classes, FP, STD, Immunizations, Pregnancy Care Management, Care Coordination for Children, and Postpartum Maternal/Newborn Home Visiting) and demonstrates how to refer patients to them	
12. Verbalizes understanding of available community resources/services (including DSS, food and housing assistance, primary care, urgent care, specialty care) and demonstrates how to refer patients to them	
13. Demonstrates how to access language translation and interpreter services	
14. Verbalizes understanding and location of agency's written emergency plan, staff roles in handling emergencies, and location/contents of emergency cart	

Maternal Health Nurse Competency Skills Checklist for Patient Interview, Counseling/Education, & Documentation				
Skills Assessed ↓	**Assessment Date**	**Assessment Method**	**Assessment Rating**	**Name of Person Completing Assessment**
Conducts Patient Interview (Pre & Post), Provides Counseling/Education, & Prepares Documentation				
1. Establishes rapport with patient and personalizes the discussion with the patient based on her needs	Comments:			
2. Serves patient in a manner which shows respect, maintains patient's dignity, protects patient's privacy/confidentiality, and is culturally sensitive				
3. Systematically collects, provides, and records data that is comprehensive and accurate				
4. Demonstrates familiarity with the patient record and chart composition				
5. Accurately documents patient's **Last Normal Menses** in the chart and is able to then demonstrate how to correctly calculate an EDD by using the computer calculator in the agencies EMR and by use of a gestational wheel.				
6. Accurately documents information (history, education and counseling, labs, etc.) in the record in a timely manner, using agency approved abbreviations and according to agency policy				
7. Provides education and counseling specific to patient's knowledge/needs and verifies patient's understanding via "teach back", signed consent, or agency approved method				
8. Invites patient to ask questions, and responds to patient's questions appropriately, maintaining a sensitive and non-judgmental attitude				
9. Counsels/educates patient per program requirements				
10. Reports critical information (current complaint, previous reaction to treatment, etc.) obtained during the pre/post interview or at anytime during the visit directly to provider				

11. Collaborates with patient and other MH staff to develop a plan of care for the patient which is tailored to the patient's preferences and needs	
12. Appropriately makes referrals to internal and external programs/services as indicated	

Maternal Health Nurse Competency Skills Checklist for Fetal Assessment				
Skills Assessed ↓	**Assessment Date**	**Assessment Method**	**Assessment Rating**	**Name of Person Completing Assessment**
Performs Nonstress Testing (Done after 26-28 Weeks Gestation) *				
1. Reviews provider or standing order	Comments:			
2. Explains procedure				
3. Allows patient to empty her bladder				
4. Washes hands				
5. Assists patient in a semi-Fowler or lateral-tilt position (typically on the left side) with a pillow under one hip				
6. Exposes abdomen and applies conductive gel and elastic belts/transducers to transmit & record FHR/fetal movement				
7. Instructs patient to depress the monitor's mark/test button when she feels the fetus move. If fetus does not move spontaneously within 20 minutes, reposition the patient and have her consume a snack to stimulate fetal movement				
8. If patient is 32+ weeks gestation, concludes test if the monitor records 2 FHR accelerations that exceed baseline by at least 15 bpm for longer than 15 seconds . If patient is 28 to 31 weeks 6 days gestation, concludes test if the monitor records 2 FHR accelerations that exceed baseline by at least 10 bpm for longer than 10 seconds.				
9. If reassuring results aren't obtained in 20 minutes, monitors the fetus for an additional 40 minutes. If reassuring NST results are still not obtained, notifies the provider who may order a more definitive test for assessment of fetus				
10. Removes the belts/transducers and gives patient tissues to wipe conductive gel from abdomen				
11. Has the provider review the test results and documents results in the patient's record				
12. Demonstrates knowledge of criteria for notifying provider of concerns/findings before, during, or after assessment (per clinical policies)				

***Should only be done by agency trained RNs**

Maternal Health Nurse Competency Skills Checklist for Specimen Collection				
Skills Assessed ↓	**Assessment Date**	**Assessment Method**	**Assessment Rating**	**Name of Person Completing Assessment**
Clean Catch Urine for Urinalysis & Urine Culture				
1. Reviews provider or standing order	Comments:			
2. Accurately completes lab requisition form				
3. Accurately labels sterile collection cup in patient's presence				
4. Gives patient the specimen cup and 2 disposable towelettes				
5. Instructs patient to wash hands, unscrew cap from cup and place cap on counter with the top of the lid on the counter (preferably on a clean paper towel) and open the towelettes				
6. Instructs patient as follows: a. Separate the labia and use one towelette to wipe inner labial folds front to back in a single motion. Using a new towelette, wipe down through the center of the labial folds b. Keep labia separated and urinate a small amount into toilet c. Place cup into stream of urine and collect specimen d. Replace cap on cup and place specimen in designated area				
7. Submits specimen and requisition form to the lab				
8. Demonstrates knowledge of criteria for notifying provider of concerns/findings before, during, or after specimen collection (per clinical policies)				
9. Demonstrates knowledge of normal/abnormal findings per agency's lab value reference ranges or clinical policies				

Urine Pregnancy Testing				
1. Reviews provider or standing order	Comments:			
2. Accurately completes lab requisition form				
3. Accurately labels specimen collection cup				
4. Gives patient collection cup and instructs patient as follows: a. Void into the cup (it is not necessary for specimen to be clean-catch unless urinalysis will be performed on specimen) b. After collecting the specimen, remove the cup and continue voiding into the toilet c. If cup has a lid, replace lid and return it to designated area				
5. Submits the specimen and requisition form to the lab				
6. Demonstrates knowledge of criteria for notifying provider of concerns/findings before, during, or after specimen collection (per clinical policies)				

Self Collection of Vaginal Group B Strep Screening				
1. Reviews provider or standing order	Comments:			
2. Accurately completes lab requisition form				
3. Accurately labels specimen collection tube				
4. Gives patient the collection kit (collection tube and swab)				
5. Assures patient is ready for specimen collection and has washed hands.				
6. Instruct patient as follows: a. Partially peel open swab pack without touching soft tip or laying swab down. Use new specimen kit if the soft tip is touched or the swab is laid down b. Remove swab with gloved hand, holding swab in middle of shaft with the thumb and forefinger c. Insert swab into vagina about 2 centimeters past the introitus and gently rotate for several seconds, making sure swab touches walls of the vagina and absorbs moisture d. Remove swab from vagina and insert same swab about 1 centimeter into the anus e. Withdraw swab without touching skin, unscrew cap from tube, and place swab into tube with tip visible below label f. If swab is scored, break it at score line and discard top portion of swab shaft. Tightly screw cap onto the tube g. If fluid contents of tube spill at any time, notify nurse so a new collection kit can be given				
7. Receive specimen from the patient and transports specimen and requisition form to lab				
8. Explains to patient how she will be notified of results				
9. Demonstrates knowledge of criteria for notifying provider of findings before/during collection (per clinical policies)				

Self-Collection of Vaginal Swabs for Gonorrhea and Chlamydia NAAT Testing				
1. Reviews provider or standing order	Comments:			
2. Accurately completes lab requisition form				
3. Accurately labels specimen collection tube				
4. Gives patient the collection kit (collection tube and swab)				
5. Instructs patient as follows: a. Wash hands thoroughly and undress from the waist down b. Open the kit package and set the unopened tube to the side c. Partially peel open swab pack, exposing stick end of swab d. Remove the swab from the package but do not lay it down e. Hold swab in middle of the stick with thumb and forefinger f. Insert soft tip end of swab 2 inches into the vagina g. Gently rotate the swab 10-30 seconds, making sure the swab touches the walls of the vagina to absorb moisture h. Withdraw the swab without touching your skin i. While holding the swab, unscrew the cap from the tube of liquid and do not spill the contents of the tube j. Immediately place the swab into the tube so that the soft tip of the swab is visible below the tube label k. Carefully break the swab shaft at the score line and throw away stick end of swab. Leave the soft end in the tube l. If the contents of the tube are spilled or the tip of the swab touches anything, ask for a new test kit m. Return the tube as instructed by the nurse/staff				
6. Submits the specimen and requisition form to the lab				
7. Explains to patient how she will be notified of results				
8. Demonstrates knowledge of criteria for notifying provider of findings before/during collection (per clinical policies)				

Oral Glucose Tolerance Testing				
1. Reviews provider or standing order for test: 50 gram 1-hour challenge test, 100 gram 3-hour OGTT, or 75 gram 2-hour OGTT	Comments:			
2. Accurately completes lab requisition form				
3. For 2-hr or 3-hr OGTT, confirms patient has been fasting for 8 hours prior to test and advises patient to remain fasting during entire test period. Sends patient to lab to have fasting blood sugar drawn and submits requisition form to lab				
4. Gives patient the glucose drink and instructs her to drink it within 5 minutes. Notes the time the patient finishes the drink and notifies the lab of the time				
5. Instructs patient to stay in waiting room where she will be called by the lab at the necessary times (according to test being done) to have additional blood draws				
6. Once all labs are completed, obtains results and reviews them with the provider				
7. Instructs patient regarding results, plan of care, and any follow-up labs to be done per provider or clinical policies				
8. Demonstrates knowledge of abnormal lab values for each test type per agency policy.				

Miscellaneous Lab Specimens				
1. Identifies other available Maternal Health lab tests, including but not limited to: a. Syphilis Screening b. Hepatitis B Screening c. HIV Screening d. Hgb/Hct e. Hgb Electrophoresis f. Genetic Serum Screening g. Serum hCG h. Blood Group, Rh Determination, and Antibody Screening i. Rubella/Varicella Immunity	Comments:			
2. Demonstrates accurate knowledge of these lab tests, including but not limited to: a. Indications for testing b. Procedures for specimen collection including patient instructions for preparation c. Basic interpretation of results -normal/abnormal findings- and agency's policies related to interpretation of results d. Implications of results, required treatment/plan of care and potential consequences for patient if treatment not received/plan of care not followed				
3. Accurately identifies lab tests indicated for individual patient based on patient history/symptoms, exam findings, MH program guidelines, or clinical policies				
4. Obtains informed patient consent for lab tests when indicated per MH guidelines or agency policies				
5. Accurately completes lab requisition form(s) for each specified lab test and correctly labels and handles specimens				
6. Promptly submits requisitions forms and specimens (when appropriate) to the lab				
7. Explains to patient how she will be notified of results				

8. Promptly retrieves lab results once available and notifies provider. Reviews with patient the results and provider's plan of care/treatment	
9. Demonstrates knowledge of criteria for notifying provider of concerns/findings before, during, or after specimen collection (specifically for each lab test per clinical policies)	