



**RESPIRATORY THERAPY (NICU)
SKILLS CHECKLIST**

NAME: _____ **DATE:** _____

Please check the appropriate letter of proficiency for the following types of clinical situations and equipment.

LEVEL OF PROFICIENCY

- A** = Able to teach & supervise
- B** = 1 year constant experience
- C** = Intermittent experience
- D** = No experience

	A	B	C	D
Ventilators : VIP Bird				
BP200				
Bear Cub				
Sechrist				
Healthdyne				
Infant Star / HFV / SIMV				
New Port Wave:				
Servo 300				
3100A Sensor Medics				
Troubleshooting ventilator				
Ventilator tubing change				
Assisting physician with intubation				
Intubation of patient				
Suctioning of endotracheal tube				
Postural drainage and percussion				
Oxygen hood				
Use of resuscitation bags				
Nasal CPAP				
Mask CPAP				
Bump Beds				
Resuscitation in delivery room				



RT Skills Checklist

	A	B	C	D
Transport of neonatal ventilator patient between hospitals				
Nasal Cannula				
Hand held nebulizer				
Medication Inline with ventilator				
Transcutaneous O2 monitors				
Nitric Oxide Delivery				
Surfactant Therapy				
Airway Maintenance				
Insertion oral airway				
Insertion nasal trumpet				
Orotracheal suction				
Nasotracheal suction				
Endotracheal tube suction				
Change of trach tube dressing				
Cleaning of trach tube				
Tracheal talking devices				
Trach button				
Measurement of cuff pressure				
Oral intubation of adult				
Nasal intubation of adult				
Assist physician in intubation				
Simple spirogram				
Flow volume loop				
Respiratory Care Experience				
Infant				
Preschool child				
Simple spirogram				
Flow volume loop				
Respiratory Care Experience				
Infant				
Preschool child				



RT Skills Checklist

	A	B	C	D
Adolescent Patient				
Adult Patient				
Geriatric Patient				
Ventilator Patient				
Arterial Blood Gases				
EKG				
Acute Care Experience				
MS				
ICU				
PEDS				
PICU				
NICU II				
NICU III				
Acute Care Experience				
Intubation				
Adults				
PEdS				
NEONATAL				
Other				
BCLS				
ACLS				
NRP				
PALS				
PFT				
EKG - What machines _____				
ABG's - What machines _____				

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Nurse Connection, Inc. to release checklist to client health care facilities of Nurse Connection, Inc. relating to my contract employment with that facility.

(Signature)

(Date)