

Grenada Hospital Services

Nursing Department



Procedure Manual

TABLE OF CONTENTS

1. Administering of Medication

- 1.1 Administration of Oral Medication
- 1.2 Administration of Injections
- 1.3 Removal of Medicines from Vial
- 1.4 Removal of Medicines from Ampoule
- 1.5 Administration of Subcutaneous Injections
- 1.6 Administration of Intramuscular Injections
- 1.7 Administration of Intravenous Injections
- 1.8 Administration by Z Tract Technique
- 1.9 Administration of Intra-dermal
- 1.10 Administration of Topical Medication
- 1.11 Administration of inhalation Medication (Nebulization)
- 1.2 Administration of Medication via NG Tube or
Gastrostomy
- 1.13 Administration/Insertion of Rectal Suppository
- 1.14 Administration/instillation of Vaginal Medication
- 1.15 Calculation of Drug Dosage

2. Administration of Infant Phototherapy

3. Admission

4. Application of Heat and Cold

5. Application of Pressure Bandage

6. Application of Restraints

- 7. Assisting with Abdominal Paracentesis**
- 8. Assisting with Lumbar Puncture**
- 9. Barrier Nursing**
- 10. Bed Making**
 - 10.1** Post Operative Bed
 - 10.2** Occupied Bed
- 11. Blood Transfusion**
- 12. Breast Examination**
- 13. Cardio Pulmonary Resuscitation**
- 14. Care of Colostomy & Change of Bag**
- 15. Catheterization**
 - 15.1** Catheter Care
 - 15.2** Condom Catheter Application

- 16. Clinical Skills Assessment Tools**
 - 16.1** Monitoring vital signs
 - 16.2** Pain Assessment
 - 16.3** Health Assessment
 - 16.4** Head to Toe Assessment
 - 16.5** Auscultation of heart, lungs, and bowels
 - 16.6** Neurological Assessment
 - 16.7** Physical Assessment of the Newborn

17. Collection of Blood Samples

17.1 Vacutainer Method Used -----105
17.2 Collection of Blood Pediatrics-----106
17.3 Syringe Method-----107

18. Collection of Specimens ----- 109

18.1 Collection of Urine Specimen
18.2 24 Hour Urine Specimen
18.3 Stool Specimen
18.4 Nose and Throat Swab
18.5 Nose Culture
18.6 Wound Swab

19. Cough and Deep Breathing Exercises

20. Dressings & Suture Removal

20.1 Sterile Dressing Technique
20.2 Wet/Dry Dressing
20.3 Wound Inspection
20.4 Interrupted Suture Removal
20.5 Continuous Suture Removal

20.6 Staple Removal

21. Donning of Sterile Gowns & Gloves

22. Feeding Patients

22.1 Preparation for Feeding

22.2 Mouth care

22.3 Aspiration of Stomach Content via Nasogastric Tube

22.4 Oral feeding

22.5 Nasogastric Tube Feeding

22.6 Gastrostomy (Enteral nutrition)

23. Foot Care

24. Incidence Reporting

25. Installation of IV

25.1 Assisting with IV Installation

26. Nasogastric Tube Insertion

27. Peritoneal Dialysis

28. Post Mortem Care

29. Post Op. Nursing Care

30. Postural Drainage, Percussion and Vibration

31. Recording

32. Removal of Faecal Impaction (Manual Removal)

33. Reporting

34. Routine Hand Hygiene

35. Routine Urine Testing

- 36. Sitz Bath**
- 37. Steam Inhalation**
- 38. Suctioning**
- 39. Surgical Asepsis**
- 40. Tepid Sponging**
- 41. Tracheostomy Care**

1. ADMINISTRATION OF MEDICATION

Medication administration is a basic nursing function and an important nursing responsibility.

It involves skillful technique and consideration of the patient's development and safety.

The basic requirements for accurate drug administration are called the six (6) rights:

1. Right patient
2. Right drug
3. Right dosage
4. Right route
5. Right time
6. Right documentation

1.1 ADMINISTRATION OF ORAL MEDICATION

INTRODUCTION:

Medication is most commonly administered orally. It is the most simple and economical way. They are absorbed chiefly in the small intestine, although they can be absorbed in the mouth and stomach as well.

OBJECTIVES:

1. To correctly and safely prepare oral medication for patients
2. To correctly and safely administer oral medication to patient
3. To correctly and safely give the right drug to the right patient at the right time as prescribed by the physician

EQUIPMENT/SUPPLIES

- ✓ Physician order
- ✓ Medication chart
- ✓ Medication cups
- ✓ Stock medication
- ✓ Jug with water
- ✓ Glass
- ✓ Receptacle for used medicine cups
- ✓ Straw/ dropper/syringe for medicine containing iron

PROCEDURE

- 1 Wash hands
- 2 Explain procedure to patient obtain consent
- 3 Gather equipment/supplies
- 4 Ensure privacy
- 5 Obtain patient medication chart
- 6 Check physician's orders
- 7 Wash your hands
- 8 Read name of medication from record
- 9 Check label and take medication from cupboard or shelf
- 10 Check label for a second time

1.1 ADMINISTRATION OF ORAL MEDICATION CONT'D

- A. When all medication for one patient have been prepared recheck a third time with medication order before taking them to the patient NB: transport medication to patient's bedside and keep the medications in sight at all times- **MEDICATION TROLLEY SHOULD NEVER BE LEFT UNATTENDED**
- B. Take medication to patient's bedside and positively identify the patient, call patient by name, check identification tag, and verify the patient with another staff member who knows the patient.
- C. Explain to patient as appropriate
- D. For tablets or capsules, pour into bottle cap and transfer to medicine cup unless pre-packaged.
- E. For liquid, hold cap in crook of little finger and or place cap upside down on counter, hold bottle with the label against the palm and pour medication at eye level into the medicine cup.
- F. Wipe the lip of the bottle with a paper tissue.
- G. Give medication to patient along with juice or water and assist as necessary and appropriate.
- H. Watch to be sure that patient has swallowed medications
- I. Leave patient in comfortable position

1.1 ADMINISTRATION OF ORAL MEDICATION CONT'D

- J. Place used medicine cup in receptacle
- K. Wash your hands
- L. Chart whether medication was taken (write initials legibly in patient medication chart)
- M. Go to next patient or return to medication area
- N. Replenish supplies and tidy area
- O. Return to patient approximately 20 – 30 minutes to check for effects of medication.

1.2 ADMINISTRATION OF INJECTIONS

OBJECTIVES:

1. To safely prepare and administer medications by injection to patients (Subcutaneous, Intramuscular, Intravenous).
2. To administer irritating medication by the z-tract technique

EQUIPMENT/SUPPLIES

- ✓ Sterile receptacle (injection tray)
- ✓ Sterile syringes
- ✓ Sterile needles
- ✓ 95% alcohol
- ✓ Cotton swabs
- ✓ Band aids or gauze squares and adhesive tape
- ✓ Receptacle for dirty items

PROCEDURE

1. Wash your hands
2. Explain procedure to patient obtain consent
3. Ensure privacy
4. Wash hands
5. Gather equipment/supplies

1.3 REMOVING MEDICINES FROM VIAL:

- a. Remove the metal or plastic cap
- b. Clean top with alcohol/antimicrobial swab
- c. Remove cap from needle
- d. Draw back an amount of air into the syringe that is equal to specific dose of medication that is to be withdrawn
- e. Pierce the rubber stopper in the center with the needle tip and inject the measured air into the space above the solution
- f. The vial must be positioned upright on a flat surface or inverted
- g. Invert the vial and withdraw the needle tip slightly so that it is below the fluid level
- h. Draw up the prescribed amount of medication while holding the syringe at eye level and vertically. NB: Be careful to touch the plunger at knob only

1.4 REMOVING MEDICATION FROM AN AMPOULE:

- a. Tap the top of the ampoule lightly and quickly until the fluid move from the neck of the ampoule
- b. Place a small gauze pad around the neck of the ampoule
- c. Use a snapping motion along the pre-scored line at its neck and break - always break away from the body
- d. Inspect the solution for small particles of glass
- e. Discard the solution if particles of glass is present
- f. Place a first needle such as a filter needle on the syringe
- g. Insert needle into fluid and withdraw the appropriate amount of medication
- h. Finally, discard and replace the first needle with a second needle for administration. NB: By changing needles the nurse prevents irritation that may result from medication that remains on the outside of the first needle
- i. Medication is now ready for administration
- j. Administer promptly.

1.5 ADMINISTRATION OF SUBCUTANEOUS INJECTIONS

Definition – Involves depositing medication into the loose connective tissue underlying the dermis.

Objective:

To safely administer drugs that are isotonic, non irritating, non viscous, and water soluble eg. Insulin, heparin, tetanus toxoid, allergy medications and vitamin B 12.

NB: Only small doses 0.5 – 1 ml are given.

Some test doses of antibiotics are also given subcutaneously

EQUIPMENT/SUPPLIES

- ✓ Sterile syringes
- ✓ Sterile needles
- ✓ Methylated spirits
- ✓ Cotton balls
- ✓ Band-aids or gauze squares and adhesive tape

PROCEDURE:

1. Check orders
2. Wash hands
3. Calculate volume of medication needed
4. Select appropriate equipment
5. Remove medication from vial or ampoule
6. Check medication 3 times to ensure correctness
7. Carry to patient bedside:
8. Medication card/chart by bedside along with medication tray containing syringe and needle
9. Container with alcohol swab
10. Container for dirty swabs
11. Container for sharps (small sharp container)

1.5 SUBCUTANEOUS INJECTIONS CONT'D

12. Identify patient
13. Explain procedure to patient
14. Provide privacy and adequate lighting
15. Choose the injection site and expose the area
16. Clean site with spirits using circular motion
17. Allow the site to dry
18. Place swabs between fingers on non-dominant hand
19. Remove the needle guard/cover
20. Pinch or spread tissue as indicated
21. Insert needle at appropriate angle
22. Transfer non-dominant hand to barrel of syringe, and dominant hand to plunger
23. Pull back on plunger (aspirate) if blood appears discard injection and start
over. DO NOT aspirate when administering anticoagulant e.g Heparin/Clexane Anticoagulant may cause bruising if aspirated.
24. If no blood appears inject medication slowly
25. Steady tissue while removing needle at same angle that it was inserted
26. Massage area gently with alcohol swab unless contraindicated e.g. anticoagulant (Heparin) and insulin.
27. Do not recap used needles
28. Discard syringe and needle in appropriate receptacle
29. Assist patient to a comfortable position
30. Remove glove if worn and dispose of appropriately
31. Remove equipment
32. Wash hands
33. Record in patient notes and report to nurse-in-charge

SPECIAL POINT

Evaluate the patient's response to the medication within an appropriate time frame such as 15 – 30 minutes after injection is given.

1.6 ADMINISTRATION OF INTRAMUSCULAR INJECTION

Follow steps 1- 16 of procedure for subcutaneous injection

17. Locate site – upper outer quadrant of buttocks (dorso-gluteal), or upper arm (deltoid), or thigh (vastuslateralis).
18. Spread or pinch tissue as indicated
19. Insert appropriate needle at appropriate angle usually (90 degree)
20. Follow 20 to 33 of procedure for subcutaneous injection

1.7 ADMINISTRATION OF INTRAVENOUS INJECTION

Objectives:

To facilitate rapid action of the medication

Equipment:

- ✓ Syringes
- ✓ Needles
- ✓ Controlled volume administration sets
- ✓ Tourniquet
- ✓ Alcohol swabs
- ✓ Band-aids
- ✓ Medication
- ✓ Medication order
- ✓ Watch with second hand
- ✓ Sharp container

Procedure Medication (I.V. Push When IV is not in place):

1. Check physician's orders
2. Wash hands
3. Prepare medication
4. Identify patient
5. Examine arm for good injection site
6. Apply rubber tourniquet above identified injection site
7. Cleanse site well with alcohol swabs
8. Stabilize vein by holding above injection site with non dominant hand
9. With dominant hand insert needle quickly into vein, go in only a short distance so as not to go through vein
10. Hold syringe in non dominant hand and pull plunger back a short distance to check for blood return (if blood returns, release tourniquet)
11. With dominant hand, slowly inject medication

1.7 INTRAVENOUS INJECTION (I.V. Push When IV is not in place) CONT'D

12. Observe patient closely for reaction (if adverse reaction occurs stop injecting medication).
13. Remove needle and place in sharp container (DO NOT RECAP).
14. Place alcohol swab over site keeping steady pressure for 5 minutes to control bleeding and prevent haematoma formation.
15. Firmly place band-aid over site
16. Make patient comfortable
17. Follow instructions 29 – 33 of subcutaneous injections

Procedure Medication (I.V. Push when infusion is already in place):

Follow steps 1 – 4 above

1. Check that IV is functioning properly
2. Select injection port: use closest to patient
3. Clean port with alcohol swab
4. Insert needle through rubber port
5. Pinch off tubing between port and fluid container

10. Inject medication at appropriate speed

11. Observe patient

12. When all is injected, release tubing

13. Withdraw needle

14. Dispose of equipment

15. Wash hands

16. Chart

1.8 ADMINISTRATION BY Z TRACK TECHNIQUE

Follow steps 1-16 for subcutaneous injection

17. Pull skin laterally until taut
18. Insert needle at 90 degree angle
19. Aspirate
20. Inject slowly and wait several seconds (approx. 10 secs.)
21. Remove needle and immediately release skin
22. Do not massage injection site nor allow patient to wear tight fitting clothing over the area immediately after the injection. Either action can force the medication into the subcutaneous tissue and cause irritation.
23. To increase absorption rate encourage physical activity for example- walking
24. Follow steps 24 to 27 of procedure for subcutaneous injection

1.9 ADMINISTRATION of INTRA-DERMAL INJECTION

Follow steps 1 – 16 for subcutaneous injection

17. Stretch skin taut at appropriate site

18. Hold syringe at 10 – 15 degree angle, with bevel of the needle up

19. Insert needle until the bevel is no longer visible

20. Turn the needle slightly and administer

21. Follow steps 22 – 32 for subcutaneous injection

1.10 ADMINISTRATION OF TOPICAL MEDICATION

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Provide adequate lighting
6. Protect linen by using macIntosh/incontinent pads
7. Position patient appropriately
8. Obtain assistance to hold body parts if necessary
9. Wash affected area to be treated removing all debris, crustations or previous medication
10. Pat skin dry / allow to air dry
11. Apply medication appropriately. Using clean hands/gloves/tongue blades
12. Use light dressings if ordered
13. Remove equipment
14. Wash hands
15. Record in patient's record

1.11 ADMINISTRATION OF INHALATION MEDICATION - NEBULIZATION

DEFINITION:

Nebulization is a method by which a nonvolatile drug is inhaled into the respiratory tract

OBJECTIVES:

1. To administer medication to relieve bronchial congestion
2. To mobilize secretion and aid in expectoration

EQUIPMENT/SUPPLIES:

- ✓ Medication as ordered by the physician
- ✓ Nebulizer machine
- ✓ Face mask/mouth piece

PROCEDURE:

1. Wash hands
2. Explain procedure to patient
3. Ensure that consent is given by patient
4. Provide privacy
5. Prepare nebulization equipment
6. Follow Doctors orders
7. Make client comfortable
8. Chose equipment depending on ; severity of clients condition, and age (use of mouth piece, face mask and attachment of oxygen to nebulization cup)

1.12 ADMINISTRATION OF MEDICATION VIA NASO-GASTRIC OR GASTROSTOMY TUBE

INTRODUCTION:

An alternative route for administering medications for patients who has a nasogastric or gastrostomy tube.

NB: If medication do not come in liquid form check pharmacist to see if medication can be crushed (*enteric-coated, sustained action, buccal, and sublingual medication should never be crushed*).

OBJECTIVE:

To administer medications to patients who cannot take anything by mouth (NPO)

EQUIPMENT/SUPPLIES

- ✓ Large catheter tip syringes (20 to 60 mls)
- ✓ Stethoscope to auscultate/check for placement of tubes
- ✓ Warm water
- ✓ Medication chart
- ✓ Medication
- ✓ Towel
- ✓ Disposable towel to protect patient clothing Adhesive tape
- ✓ Spigot
- ✓

1.12 ADMINISTRATION OF MEDICATION VIA NASO-GASTRIC OR GASTROSTOMY TUBE CONT'D

PROCEDURE:

1. Explain procedure and obtain consent
2. Ensure privacy
3. Wash hands
4. Gather equipment and supplies
5. Position patient in semi or high fowler's position
6. Review Physician orders
7. Wash hands
8. Assess tube for patency and placement (aspirating gastric contents or by auscultation for air)
9. Dissolve tablet in water if required
10. If liquid dilute with 20 to 30 mls. of water
11. Flush tube with at least 15 to 30 mls water for adults and for the child 5 to 10 mls before administering medication.
12. If you are giving several medications administer each one separately and flush with at least 5 mls water (adults) and 3 mls water) for the child, between each medication
13. After medication administration flush with 30 to 50 mls of water to clear the tube. **NB: Never mix medication with feeding formulas**
14. Remove equipment
15. Wash hands
16. Record in patient chart and report to nurse-in-charge

1.13 ADMINISTRATION /INSERTION OF RECTAL SUPPOSITORY

OBJECTIVES:

1. To provide a local medication effect or a laxative suppository to soften feces and stimulate defecation
2. To provide a systemic medicinal effect e.g. aminophylline suppository to dilate the patient bronchi and enhance breathing, panadol suppository to reduce fever & pain

EQUIPMENT:

- ✓ The prescribed suppository
- ✓ The correct equipment
- ✓ Disposable gloves
- ✓ Paper towel
- ✓ Lubricant
- ✓ Protective covering for bed

PROCEDURE:

Explain procedure to patient

1. Obtain consent
2. Ensure Privacy
3. Wash hands
4. Gather equipment
5. Assist the patient to a lateral position with upper leg acutely flexed
6. Fold back the top bed clothes to expose only the buttocks
7. Unwrap the suppository and leave it on the opened wrapper or gauze
8. Don gloves or finger cot on the hand to be used to insert suppository
9. Lubricate the smooth rounded end of the suppository
10. Lubricate the gloved index finger

1.13 ADMINISTRATION/INSERTION OF RECTAL SUPPOSITORY CONT'D

11. Ask the patient to breathe through the mouth
12. Insert the suppository gently into the anus and along the walls of the rectum (in the direction of the umbilicus) with the gloved index finger, for an adult insert the suppository 10cm (4"), and for a child or infant insert it 5 cm (2") or less
13. Withdraw the finger, remove the glove by turning it inside out and placing it on the paper towel
14. Press the patient buttocks or asked him to squeeze for a few seconds
15. Leave the patient in a comfortable position
16. Leave the bed in a low position
17. If a laxative suppository have been given ask the patient to try to retain it as long as possible e.g. 15-20 minutes
18. Place the call signal within easy reach so that patient summon assistance to use bedpan or toilet
19. Dispose of the wrapper, paper towel, glove, or finger cot
20. Wash hands to avoid transmitting microorganisms to others
21. Record the type of suppository given, the time given, the time it was retained and the results or effects on the patient record and report to nurse-in-charge

1.14 ADMINISTRATION/INSTILLATION VAGINAL MEDICATION

INTRODUCTION:

Vaginal medication or instillation are inserted as cream, jellies, foams, or suppositories

OBJECTIVES:

1. To treat or prevent infection
2. To reduce inflammation
3. To relieve vaginal discomfort

N.B: Medical aseptic technique is used.

EQUIPMENT/SUPPLIES

- ✓ Drape
- ✓ Medication
- ✓ Medication chart
- ✓ Applicator
- ✓ Disposable gloves
- ✓ Lubricant for suppository
- ✓ Disposable towel
- ✓ Perineal pad
- ✓ Light source
- ✓ Disinfectant Solution for cleaning
- ✓ Sterile cotton
- ✓ Receptacle for soiled swabs
- ✓ Receptacle for soiled instruments

1.14 ADMINISTRATION/INSTILLATION OF VAGINAL MEDICATION

CONT'D

PROCEDURE

1. Wash hands
2. Explain procedure & obtain consent
3. Gather equipment & supplies
4. Ensure privacy
5. Review physician orders
6. Ask patient to void (empty bladder) and wash vulva area
7. Position in either dorsal or (sims position) NB: if patient is willing to do procedure herself give appropriate instructions and assist to go into lithotomy position
8. Prepare patient (explain procedure again and reassure patient clean perineal area)
9. Drape patient appropriately so that only the perineal area is exposed
10. Unwrap the suppository and place on open wrapper or fill the applicator with prescribed cream, jelly or foam
11. Assess and clean the perineal area
12. Don gloves
13. Inspect vaginal orifice and note any odour of discharge from the vagina and ask about any vaginal discomfort e.g. itching
14. Provide perineal care to remove microorganisms
15. Administer the vaginal suppository, cream, foam or jelly
16. Lubricate the rounded (smooth) end of the suppository, which is inserted first.
17. Lubricate your gloved index finger expose the vaginal orifice by separating the labia with your non-dominant hand
18. Insert the suppository about 8-10 cm (3-4inches) along the posterior wall of the vagina

1.14 ADMINISTRATION/INSTILLATION OF VAGINAL MEDICATION

CONT'D

19. Withdraw the finger and wipe excess lubricant around orifice and labia remove the glove, turning glove inside out and discard gloves appropriately (*Turning the gloves inside out prevents the spread of microorganisms*)
20. Ask the patient to remain lying in a supine position for 5 to 10 minutes. The hips may also be elevated on a pillow. (*This position allows the medication to flow into the posterior fornix after it has melted*)

1.14 VAGINAL MEDICATION (INSTILLATION) CONT'D
VAGINAL APPLICATION OF CREAM, JELLY OR FOAM

PROCEDURE

1. Gently insert the applicator about 5cm (2 inches)
2. Slowly push the plunger until the applicator is empty
3. Remove the applicator and place it on the disposable towel wrap and discard
4. Remove the glove turning inside out and discard appropriately
5. Ask patient to remain lying in supine position for 5 to 10 minutes
6. Ensure patient comfort- dry perineum with tissue
7. Apply clean perineal pad
8. Wash hands
9. Record relevant information in patient chart
10. Assess for patient response

1.15 CALCULATION OF DRUG DOSAGE

OBJECTIVES:

1. To understand and use all drug systems: metric, apothecary and household
2. To correctly calculate safe drug dosages for patients

Calculation of drug dosages:

- 1) There are many formulas for solving drug problems. Two common methods for adults are:

$$\text{a) } \frac{\text{Strength desired}}{\text{Hand}} = \frac{x}{V}$$

- b) The amount in which the known dose is contained = The desired Dose

D= desired dose (dose ordered)

H= on-hand or available dose (dose on the drug label; often in mg per tablet, capsule, or milliliter)

X= unknown (number of tablets, in this example)

V= unit (one tablet in this example)

For example: Give 25mg. of cortisone, your stock medication is 12.5 mg/tablets

$$\text{a. } \frac{25}{12.5} = \frac{x}{1}$$

$$\text{b. } \frac{12.5}{1} = \frac{25\text{mg}}{x}$$

1.15 CALCULATION OF DRUG DOSAGE CONT'D

- 2) All drug problems require all parts of the problem to be in the same system or units of measurement.

CALCULATIONS OF FLUID RATES:

1. Three (3) things must be known to calculate fluid rates
 - a. The total amount of fluid to be given
 - b. The time in which the infusion is to be administered
 - c. The drip factor you are going to use

2. This can be calculated by the formula

a. Amount per hour x drip factor = gtt/minute

60 (time in minute)

For example: Give 100 cc of Normal Saline (Nacl) over 1 hr. If your drip factor is 15:

a. $100 \times 15 = 25 \text{ gtts/minute}$

60 inutes

1.15 CALCULATING SAFE DRUG DOSAGE FOR PAEDIATRIC PATIENTS:

All aspects of pediatric drug therapy must be guided by the child's age, weight, and level of growth and development

1. It is not the nurse's responsibility to determine drug dosages for Paediatric patients. However, the nurse should be responsible for making sure that the prescribed dosage is within safe limits.
2. There are a number of formulas or rules which can be utilized to determine safe drug dosage.

- a. Clarke's rule (based on child's weight) and stated as follows:

Weight of child in pounds

----- x adult dose = child'

150

EXAMPLE: Using Clark's rule estimate the dose for a child weighing 30 lb if the adult dose is 2 g.

30 = 30 = x 3¹ x 2 = 2 or 0.4 g or 400 mg

---- ---- ----
150 150 15⁵ 5

- b. Young's rule (child's age - - over age two)

Age of child in years + 12

2. ADMINISTRATION OF INFANT PHOTOTHERAPY

Policy:

An order for phototherapy will be on the patient's medical record. Phototherapy is done on babies with serum bilirubin 90-160 mmols/greater than 12milligrams or rising at a rate of 5mg/dl per hour. All premature babies should be prophylactically treated.

NB: the physician will determine the length of time the infant is to be under the light based on serum bilirubin levels and clinical condition of the infant

OBJECTIVES:

1. To decrease levels of serum bilirubin in infants suffering from hyperbilirubinemia
2. To prevent or treat jaundice in the new born
3. To provide guidelines for safe and effective phototherapy treatment

EQUIPMENT/SUPPLIES

- ✓ Appropriate phototherapy source - Bilirubin light or sunlight
- ✓ Bilimeter (if bililight is used)
- ✓ Protective eye cover (eye pad)
- ✓ Diaper or other light coverings

PROCEDURE:

1. Identify baby to ascertain correct baby
2. Wash and dry hands to prevent cross infection
3. Explain the procedure to mother to aid cooperation and to reassure her
4. Remove clothes to expose entire skin surface to light
5. Cover scrotum in male neonates
6. Cover eye with protective shades to prevent eye damage from contact exposure to high intensity light which may cause retinal injury.
7. Do not apply pressure when the eyes are covered and the eye lid closed.

2.0 ADMINISTRATION OF INFANT PHOTOTHERAPY CONT'D

8. Change protective covers routinely and check conjunctiva; make sure nose is not occluded.
9. Develop a systematic schedule of turning infant to ensure all surfaces are exposed (every 2 hours).
10. Avoid hyperthermia. Monitor temperature every 2-4 hours.
11. Adequate fluid intake should be provided either orally or intravenously

The infant should be shielded (by plexiglass) from direct exposure of the lights to filter out and protect him from the ultraviolet radiation of daylight and cool white fluorescent lights. This shield will also protect infant from injury should the light break

A. SUNLIGHT

Expose front and then back of infant in the sunlight for 3-5 minutes (from cot or held by mother) to treat jaundice.

B. PHOTOTHERAPY LAMP

Place baby in cot and nurse naked or with nappy only, to expose wider area of skin.

Cover eyes with protective shades to prevent damage to eyes.

Perform phototherapy at right angle to the skin surface at a distance of 70degrees- 100 centimeters to prevent burning of baby's skin.

Ensure that serum bilirubin levels are obtained as prescribed.

- a. Light should be turned off when blood is being collected to eliminate false bilirubin levels.
- b. When phototherapy has been discontinued check serum bilirubin levels within 4 hours to determine rebound

Monitor side effects of phototherapy:

1. Lethargy
2. Loose green stools
3. Dark urine
4. Temperature elevation

2. ADMINISTRATION OF INFANT PHOTOTHERAPY CONT'D

Side effects of phototherapy Cont'd

5. Skin changes- greenish colour; rash due to capillary dilation.
6. Priapism- turn infant on abdomen for short period of time and this will cease.
7. Dehydration from increased skin evaporation.
8. If possible remove infant from under the lights, remove eye covers and hold infant for feedings.
9. Note sleeping and eating patterns.
10. The nurse should wear sunglasses and hair cover when caring for an infant under blue lights for her own protection.
11. Switch on lights and leave baby in cot for 4 days if full term, treat premature babies for 6-8 days until bilirubin level is reduced.
12. Remove baby from cot only for high volume feeds.
13. Add 10% of daily required fluid requirement to maintain fluid balance.
14. Record condition of baby before and after therapy to promote continuity and implementation of plan of care.
15. Obtain bilirubin test after 24 hours, discontinuation of treatment to confirm continuing decrease of serum bilirubin.
16. Record time the phototherapy commenced and the light used so that 1000 hours of lamp life would be accounted for.
17. Document, include the following:
 - Date and time phototherapy initiated
 - Time eyes assessed, eye care given and patches changed
 - Bilimeter reading every shift
 - Time out of phototherapy
 - Time phototherapy discontinued
 - Report to nurse in charge observation and action

3. ADMISSION OF PATIENT

OBJECTIVES

1. To facilitate examination, treatment and procedures
2. To facilitate diagnostic studies
3. For close observation of patient

EQUIPMENT

- ✓ Pen
- ✓ Admission/discharge summary/record (e.g. census)
- ✓ Admission assessment form
- ✓ Admission register
- ✓ Nurses notes
- ✓ Physician Orders
- ✓ Clinical progress notes
- ✓ History and physical examination forms
- ✓ Medication charts
- ✓ Stethoscope/sphygmomanometer
- ✓ Thermometer
- ✓ Pulse Oximeter
- ✓ Penlight
- ✓ Exemption forms
- ✓ Guarantee forms
- ✓ Urine testing tray/kit
- ✓ Wash basin
- ✓ Soap
- ✓ Toilet tissue
- ✓ ECG Machine
- ✓ Infant warmers
- ✓ Emesis basin
- ✓ Bedpan
- ✓ Urinals
- ✓ Identification band
- ✓ Water pitcher with glass

3. ADMISSION OF PATIENT

EQUIPMENT CONT'D

- ✓ Blood pressure charts
- ✓ Diabetic charts
- ✓ Pre-op check list
- ✓ Intake/output charts
- ✓ Vital signs chart
- ✓ Ante-natal charts
- ✓ Laboratory forms
- ✓ X-Ray forms
- ✓ Mental Status Examination Form (if applicable)
- ✓ Head Injury Chart

IMPLEMENTATION

Patients referred from Consultants private office are sent directly to Ward/Unit; unless otherwise indicated

4. APPLICATION OF HEAT AND COLD

INTRODUCTION:

Application of heat and cold are used as therapeutic measures and are carried out under the direction of the physician. Heat is applied to the body in both dry and moist form, cold is generally applied locally dry or moist (e.g. ice pack, ice bag, ice glove and ice collar) Moist cold includes cooling compress and cold sponge bath.

OBJECTIVES:

1. To appropriately and safely apply heat for any of the following purposes:
 - a. Increase blood circulation
 - b. Relieve pain
 - c. Reduce swelling
 - d. Relax muscles
 - e. Promote healing
2. To appropriately and safely apply cold for any of the following purposes:
 - a. Slow circulation
 - b. Reduce haemorrhage
 - c. Decrease pain
 - d. Reduce inflammation
 - e. Prevent the formation of oedema

NB: In local application of heat the nurse must determine the patient ability to tolerate the hot therapy, must explain the procedure to patient and assess skin area where heat is to be applied.

4. APPLICATION OF HEAT AND COLD CONT'D

EQUIPMENT/SUPPLIES:

- ✓ Dry heating device- e.g. heating pad , hot packs, infrared rays, ultra violet rays, ultra sound, (a means of applying deep penetrating heat to muscles and tissues), hot water bottle, heat lamp, heat cradle, aquathermia pad, compresses hot or cold, wet dressing, ice bag, cold pack, cold compress
- ✓ Mackintosh/water-proof pad
- ✓ Large basin or tub
- ✓ Device for holding ice- e.g. ice cap, glove, collar or cold pack
- ✓ Towels and dry linen
- ✓ Bed cradle for ice cap
- ✓ Bath blanket
- ✓ Bath thermometer
- ✓ Sterile gauze dressing
- ✓ Sterile container for solution
- ✓ Sterile gloves, disposable gloves
- ✓ Commercially prepared packs
- ✓ Petroleum jelly (if desired)
- ✓ Gauze bandage or tape

GENERAL PROCEDURE FOR APPLYING DRY HEAT:

1. Secure appropriate heating device
2. Wash hands
3. Explain procedure to patient
4. Provide for patient's privacy and warmth
5. Fan fold top covers to foot of bed
6. Expose only areas to be treated
7. Cover heating device, if necessary
8. Place and mold heating device over area to be treated, and secure
9. Return to check patient every 15-20 minutes after starting the heat
10. Observe the local skin area for possible redness, heat must be stopped if problem occurs

11. Remove device at end of specified time
12. Examine treated area
13. Leave the patient dry and comfortable
14. Wash hands
15. Record in patient's notes observation and action report to nurse in charge

APPLYING OF WARM MOIST HEAT (WARM MOIST COMPRESS)

1. Wash hands
2. Obtain materials to be used for compress
3. Obtain heating device to maintain heat of compress if necessary
4. Explain procedure to patient
5. Provide patient privacy and warmth
6. Expose only areas to be treated
7. Moisten, ring out, and apply compress, covering with plastic and towel
8. Place heating device over affected area to maintain heat
9. Secure in place with ties/tape as needed
10. Return to check patient at frequent intervals (10-15 minutes)
11. Remove compress
12. Examine treated area
13. Leave patient comfortable, warm, and dry
14. Wash hands
15. Document and report to nurse-in-charge

PROCEDURE FOR APPLYING WARM SOAKS:

1. Obtain basin
2. Wash hands
3. Explain procedure to patient
4. Provide for patient's privacy
5. Fill basin half full with water (100 degree F)

4. APPLICATION OF HEAT AND COLD CONT'D

PROCEDURE FOR APPLYING WARM SOAKS

6. Assist patient in immersing area of body to be treated in basin, checking for body alignment and pressure
7. Cover patient with blanket or towel
8. Maintain temperature constant throughout the soak 15-20 minutes
9. Check patient at least once during procedure
10. On completion remove and dry treated area
11. Examine and reapply dressing as needed.
12. Reposition patient in bed or chair and leave warm and dry
13. Remove basin
14. Wash hands
15. Document in patient's notes and report to nurse –in - charge

COLD COMPRESS:

The temperature should be between 59 – 90 degree Farenheit, the material used for the application is immersed in a clean basin appropriate for the size of the compress that contains pieces of ice with a small amount of water. The compress should be rung thoroughly before it is applied to avoid dripping, which is uncomfortable for the patient and may also wet the bed or clothing. The compresses should be changed frequently. The application should be continued for 20 minutes and repeated every 2-3 hours. Ice bags or commercial devices for keeping the compresses cold decreases the frequency to which the compresses must be changed.

5. APPLICATION OF PRESSURE BANDAGE

OBJECTIVE

To temporarily control excessive bleeding

EQUIPMENT

- ✓ Sterile gauze abdominal pressure dressing (if available)
- ✓ Adhesive tape
- ✓ Safety pins
- ✓ Sterile Gloves
- ✓ Cotton
- ✓ Crepe Bandage

PROCEDURE/IMPLEMENTATION

- 1 Wash hands
- 2 Explain procedure
- 3 Collect equipment
- 4 Ensure privacy
- 5 Don sterile gloves
- 6 1st person presses on site of bleeding
- 7 2nd person unwrap roller bandage and place within easy access
- 8 Quickly cut 3-5 lengths of adhesive tape and place within easy reach
- 9 1st person – firmly apply thick layer of gauze to bleeding area

5. APPLICATION OF PRESSURE BANDAGE CONT'D

PROCEDURE/IMPLEMENTATION CONT'D

11. Place adhesive strips of tape beyond width of dressing with even pressure on both sides of dressing
12. Gloved fingers should be placed as closely as possible to bleeding source
13. Secure tape on distal end, pulling across dressing and maintaining firm pressure ensuring tape is secure at proximate end
14. Continue re-enforcing area with tape, each successive strip is overlapping on alternating sides
15. When applying pressure dressing to extremities, apply roller gauze tautly in two circular motion; compressing bleeding site. Secure end with adhesive tape
16. Remove gloves
17. Wash hands
18. Report and document (time bleeding was discovered, estimated blood loss, nursing intervention, pulse, blood pressure, sensory levels, signs of restlessness, present status of bleeding control)
19. Record and implement Doctor's Order in response to reporting
20. Document in Nurses Notes and communicate findings during handing over of every shift.

6. APPLICATION OF RESTRAINTS

INTRODUCTION

Restraints are used to protect a confused disoriented and or restless patient and should be applied only for the patient health and safety and should be authorized by the attending physician.

OBJECTIVES:

1. To apply restraints in a manner which will maximize patient comfort
2. To apply in such a way as to ensure patient safety and protect from injury
3. To facilitate examination e.g. A restless alcoholic patient

EQUIPMENT/SUPPLIES

- ✓ Appropriate type of restraints:
- ✓ Wrist or ankle restraint
- ✓ Body restraints
- ✓ Vest restraints
- ✓ Elbow or knee restraints
- ✓ Mitts restraints
- ✓ Mummy restraints (blanket or sheet can be used to do this)
- ✓ Belt restraints

PROCEDURE:

1. Assess patient's need to be restrained
2. Have or obtain physician's order
3. Wash your hands
4. Select appropriate restraints
5. Explain to patient what you are going to do and why, explain even if the patient appears incapable of understanding
6. Apply restraint firmly, but not tight enough to obstruct; NB: ensure 2 fingers fit between the patient's skin and the restraint.

6. APPLICATION OF RESTRAINTS -PROCEDURE CONT'D:

7. Assess for areas which might be abraded by pulling or twisting; add extra padding if necessary NB: avoid using cotton
8. Reassure patient that you will check on him/her frequently (at least every half to one hour assess adequacy of restraint, colour of extremity, palpate pulse below the extremity)
9. Completely remove restraints at least every 2 hours for 30 minutes and do range of motion exercise and skin care; NB: during the release the patient should not be left alone.
10. Reassess the continued need for restraints every 8 hours
11. Record in nurses notes the nursing assessment before and after restraints are used, each time checked focusing on patient' safety and level of orientation, time, type and location of restraint.
12. Report to nurse to nurse in charge pertinent findings/information

7. ASSISTING WITH ABDOMINAL PARACENTHESIS (ABDOMINAL TAPPING)

Definition: A sterile procedure performed to obtain peritoneal fluid for observation, laboratory analysis or therapeutic purposes such as reducing intra abdominal pressure. There are two types: peritoneal and abdominal aspiration. The two most common medical diagnosis requiring paracentesis are: **1.** Blunt abdominal trauma with possible intra abdominal bleeding; **2.** Ascites or excess peritoneal fluid

OBJECTIVES:

1. To relieve abdominal distension (removal of fluid from the abdominal cavity)
2. To promote comfort (release of pressure on the diaphragm and the stomach)
3. To obtain specimen of fluid for diagnostic evaluation.
4. To introduce medication into the abdominal cavity.

EQUIPMENT/SUPPLIES:

- ✓ Sterile tray containing:
- ✓ Hypodermic syringe (two 3 mls.) or intracath size 14 (or as doctors request)
- ✓ Needle 19 – 21 gauge
- ✓ Dissecting forceps (tooth & non tooth)
- ✓ Small scalpel
- ✓ Sterile rubber tubing and clamp
- ✓ Suture needle and catgut
- ✓ Needle holder
- ✓ Sterile gloves
- ✓ Local anaesthetic e.g. lidocaine 1% or procaine hydrochloride 1%
- ✓ Sterile swabs
- ✓ Sterile towels
- ✓ Methylated spirit or ether or ethyl chloride
- ✓ Iodine scrub (for hand washing)
- ✓ Iodine solution (for prepping of site)
- ✓ Abdominal binder or firm dressing e.g. elastoplast or adhesive tape

7. ASSISTING WITH ABDOMINAL PARACENTHESIS (ABDOMINAL TAPPING) CONT'D

EQUIPMENT/SUPPLIES CONT'D

- ✓ Mackintosh and draw sheet or incontinent pad
- ✓ Specimen bottles
- ✓ Pail / large bowl
- ✓ Receptacle for soiled swabs
- ✓ Laboratory request forms

PROCEDURE:

1. Wash hands
2. Explain procedure to patient
3. Get written consent from patient
4. Ensure privacy
5. Collect and assemble equipment
6. Check patient vital signs
7. Have patient void before procedure begins
8. Position patient in the fowlers position
9. Expose patient abdomen
10. Assist the doctor where necessary during the procedure
11. Assess patient pulse, respiration during the procedure
12. Observe patient for pallor, cyanosis, and syncope
13. On completion of procedure:
14. Apply sterile dressing to punctured site.
15. Apply abdominal binder if indicated
16. Tidy and make patient comfortable.
17. Recheck and record vital signs
18. Measure amount of fluid drained
19. Give medication as ordered
20. Label specimen and send to laboratory with appropriate form
21. Remove equipment
22. Wash hands

7. ASSISTING WITH ABDOMINAL PARACENTHESIS (ABDOMINAL TAPPING)

PROCEDURE CONT'D

23. Record observation and action and report to nurse in charge

NB: Note the following:

- A. Baseline vital sign must be recorded
- B. Patient should be weighed and abdominal girth measured before and after the procedure

8. ASSISTING WITH LUMBAR PUNCTURE (SPINAL PUNCTURE OR SPINAL TAP)

Definition:

Lumbar puncture is the introduction of a needle into the lumbar subarachnoid space of the spinal column and the withdrawal of cerebrospinal fluid for diagnostic and therapeutic purposes.

NB: This procedure is contra-indicated if there is evidence of greatly increase intracranial pressure because sudden release of pressure may cause hernia of the brain structures through the foramen magnum.

It is a sterile procedure performed by a doctor, assisted by the nurse, and established institutional protocol should be followed.

OBJECTIVES:

1. To obtain Cerebro Spinal Fluid (CSF) for laboratory examination
2. To measure and relieve CSF pressure
3. To determine the presence or absence of blood in the spinal fluid
4. To detect spinal subarachnoid block
5. To administer anaesthetic, diagnostic or therapeutic agents

NB: Lumbar puncture is useful in the diagnosis of meningitis, encephalitis, brain or spinal cord tumors, and cerebral haemorrhage

EQUIPMENT/SUPPLIES:

- ✓ Sterile lumbar puncture set
- ✓ Sterile gloves
- ✓ Anaesthetic agent e.g. lidocaine 1% or 2%
- ✓ Antiseptic solution (preferably povidone iodine)
- ✓ Alcohol swab
- ✓ Sterile gauze swabs (4x4- at least 10)
- ✓ Sterile towel
- ✓ Circum towel

8.0 ASSISTING WITH LUMBAR PUNCTURE (SPINAL PUNCTURE OR SPINAL TAP) CONT'D

EQUIPMENT/SUPPLIES: CONT'D

- ✓ Spinal needles x3 various sizes
- ✓ Syringes (3-5mls)
- ✓ Needles – 25G, 21G
- ✓ Face masks
- ✓ Protective goggles
- ✓ Band aid or small gauze dressing
- ✓ Antiseptic ointment
- ✓ 3-way stop- cork
- ✓ rolled bath towel
- ✓ Test tubes x 4
- ✓ Straight chair for physician

PROCEDURE:

1. Wash hands
2. Explain procedure to patient and ascertain consent(a consent form must be signed by patient or responsible family member)
3. Ensure privacy
4. Gather equipment
5. Have patient empty bladder and bowel before the procedure starts.
6. LYING POSITION: Position the patient on the side with a pillow under his head and a pillow between legs. The surface patient is lying on should be firm.
7. Instruct patient to arch the lumbar segment of his back and draw knees up to his abdomen, clasping knees with both hands
8. Assist the patient in maintaining this position by supporting him/her behind the knees and neck. Be sure to assist the patient to maintain the position throughout the procedure.
9. SITTING POSITION: Have the patient straddle a straight back chair (facing the back) and rest head on the back of the chair

8. ASSISTING WITH LUMBAR PUNCTURE (SPINAL PUNCTURE OR SPINAL TAP) CONT'D

NURSES RESPONSIBILITY:

10. Explain that patient must lie in the flexed position for entire procedure. And ensure the surface is firm.
11. Instruct the patient to breathe normally (not to hold breath or strain) and not to talk.
12. It is important that the patient remains motionless during the procedure

DOCTOR'S RESPONSIBILITY:

13. Prep skin with antiseptic solution
14. Infiltrate skin with local anaesthetic
15. Introduce spinal puncture needle with inner obturator at L3 – S1 interspace
16. After the needle enters the subarachnoid space, the obturator is removed, help the patient to straighten legs
17. The initial pressure reading is obtained by reading the level of the fluid column after it come to rest
18. Attach the 3-way stopcock and turn to allow CSF fluid approx 2-3 mls. to drip into test tubes for observation, comparison and analysis.
19. Remove spinal needle and place direct pressure on the insertion site
20. Apply sterile dressing on site
21. Assist patient to a comfortable position(recumbent or dorsal position preferably with pillow
22. Ask patient to maintain that position for 4 – 12 hours
23. Fluid is usually offered if patient complains of headache post procedure (this may be due to tear in the dura mater made by the needle)
24. Observe patient reaction (vital signs). NB: any signs of twitching, vomiting, slow pulse rate are to be reported to the physician promptly.
25. Remove Equipment
26. Remove gloves and wash hands

8. ASSISTING WITH LUMBAR PUNCTURE (SPINAL PUNCTURE OR SPINAL TAP) CONT'D

27. Record in patient notes pertinent information e.g. (procedure time, appearance of spinal fluid, whether specimen were sent to the laboratory, condition and reaction of patient etc.) and report to nurse in charge.

9. BARRIER NURSING/ISOLATION TECHNIQUE

INTRODUCTION:

Barrier nursing/techniques are mechanical barriers established to confine organisms within a given area. The importance of explanations and support is paramount for these patients; the nurse needs to understand both her own attitude and the practices that contribute to her own safety and that of the patient. Two infection precautions employed are barrier technique and reverse barrier technique.

OBJECTIVES:

1. To protect staff, visitors and other patients from those with infectious and communicable diseases.
2. To protect patients with altered immune status from coming into contact with pathogens from staff, visitors and other patients

EQUIPMENT/SUPPLIES

- ✓ Isolation laundry bag or colour coded bags to collect linen
- ✓ Caps,
- ✓ Masks
- ✓ Gloves
- ✓ Foot wear
- ✓ Paper towels
- ✓ Other items specific to patient care
- ✓ Laundry hamper for inside the isolation area
- ✓ Wastebasket lined with plastic
- ✓ Thermometer, blood pressure equipment which must be left in area
- ✓ Special containers as needed for used needles, syringes, and instruments, and paper towels
- ✓ Diversional therapy e.g. radio, Television, books, toys etc.

9. BARRIER NURSING/ISOLATION TECHNIQUE CONT'D

PROCEDURE:

Entering the area:

1. Remove rings , and watch, wash hands
2. Don gown, making sure that all parts of your uniform is covered
3. Don mask, tying both sets of the ties securely.
4. Don gloves, tucking in cuffs of sleeves securely.

Leaving the area:

1. Remove gloves, touching bare hands to inside surface only
2. Wash your hands in area
3. Untie mask ties and discard mask carefully, touching ties only
4. Wash your hands
5. Untie gown and remove it touching inside only
6. Carefully fold gown with all outside surfaces towards center and place in laundry hamper.
7. If in private room, open door, using paper towel as barrier
8. Wash hands outside of area

Double bagging

1. Inside Nurse:
 - a) Place linen bag and/or biohazard bag (red) being held by outside nurse. Be careful to touch only inside surfaces of outer bag.
2. Outside Nurse:
 - a) Hold laundry or large biohazard bag, protecting hands with cuff formed at top edges.
 - b) Carefully fold and secure top of bag.

9. BARRIER NURSING/ISOLATION TECHNIQUE CONT'D

SPECIAL INFECTION CONTROL CONSIDERATIONS:

- A private room is preferred for the patient in isolation. However the patient maybe isolated by placing him/her in a position removed from other patients and with the judicious use of screens.
- A sign indicating that the patient is on isolation, and extra stand outside the area to hold supplies.
- Placing patients with patient suffering from the same disease. NEVER place infections near someone whose immune status is compromised.
- Patient and family teaching – nature of disease, isolation techniques and their purpose, measures to prevent transmission of the disease.
- Visitors/family members should talk to a nurse before entering the room or unit of a patient on isolation precautions and visitors should be kept to a minimum.
- Children under 12 years should not be allowed to enter an isolation room
- Keeping patients record from contact with potentially infectious material or contaminated objects.
- Destruction of personal effects that are visibly soiled with infective material
- Daily routine cleaning of rooms, cubicles, cots. Wiping cloths and mop heads should be washed and thoroughly dried. Cleaning cloths and mop heads that become contaminated with infectious material or blood should be disinfected and laundered
- Terminal cleaning should be done when isolation precautions have been discontinued. Terminal cleaning includes – disposing disposable items, cleaning all furniture, mattress, covers and pillow covers with disinfectant; mop all floors with a disinfectant detergent; washing walls.
- Clean and disinfect urinals and bedpans.

10. BED MAKING

OBJECTIVE:

1. To promote the comfort and safety of patients.
2. To make beds appropriate to patients circumstances
3. To provide a clean, neat environment for the patient
4. To provide a smooth wrinkle free bed foundation thus minimizing skin irritation.

EQUIPMENT:

- ✓ Linen bag/linen hamper
- ✓ Sheets – fitted, flat, two large sheets,
- ✓ Macintosh, draw sheet
- ✓ Pillow cases
- ✓ Bedside chair
- ✓ Disposable gloves

PROCEDURE:

1. Wash hands
2. Assemble or gather equipment and proceed to bed
3. Place clean linen on patient's chair or table at foot of bed
4. Assess and assist patient out of bed when necessary
5. Loosen all bedding systematically
6. Check bed linen for any items belonging to the patient
7. Strip Bed:
 - Starting at the head of the bed and then go around to the other side of the bed
 - Remove pillow cases and place in linen bag, place pillows on bedside chair (chair foot of bed)
 - Fold reusable linen into fourths
 - First- Fold linen in half by bringing the top edge even with the bottom edge, and then grasp at the corner of the middle fold and bottom edges.
 - Remove mackintosh and discard if soiled.
 - Roll all soiled linen inside the bottom sheet. Hold it away from your uniform and place directly into linen hamper.

8. Apply Bottom Sheet

9. Place the folded bottom sheet with the center fold on the center of the bed, ensure the sheet is hem side down for a smooth foundation.
10. Spread the sheet out over the mattress allowing sufficient amount of sheet at the top to tuck under the mattress.
11. Place the sheet along the edge of the mattress at the foot of the bed and do not tuck it (unless it is a contour (fitted) sheet).
12. Mitre the sheet at the top corner on the near side and tuck the sheet under the mattress.
13. Working from the head of the bed to the foot of the bed, mitre corners

MCINTOSH

- Place McIntosh over the bottom sheet so that the center fold is at the center line of the bed and the top and bottom edges will extend from the middle of the patient's back to the mid-thigh or knee.
- Fan folds the uppermost half of the folded draw sheet and the center of far edge of the bed and tuck in the near edge.
- Lay the cloth draw sheet over the Mackintosh in same manner as above

TOP SHEET

- Place the top sheet hem side up on the bed so that the center fold is at the center of the bed and the top edge is even with the top edge of the mattress
- Unfold the sheet over the bed
- Make a vertical or horizontal toe pleat in the sheet to provide additional room for the patient's feet
- Tuck in the sheet at the foot of the bed and mitre the corner using all three layers of linen
- Fold the top of the sheet down, providing a cuff move to the other side of the bed and secure the top bed linen in same manner as above. If necessary fan fold covers down to center of bed as required

Pillow cases

- Grasp the closed end of the pillow case at the center with one hand
- Gather up the side of the pillow case and place them over the hand grasping the case, then grasp the center of one short side of the pillow through the pillow case.
- With the free hand pull the pillow case over the pillow,
- Adjust the pillow case so that the pillow fit into the corner of the case and the seams are straight.
- Place the pillows appropriately at the head of the bed
- NB: the open of pillow case away from the door
- Ensure patients comfort and safety
- Put away equipment
- Wash hands document and report to nurse in charge

10.1 POST OPERATIVE BED

Using all the steps for an unoccupied bed continue from 4-7 (fanfold)

10.2 OCCUPIED BED

OBJECTIVES:

1. To promote the comfort and safety of patients.
2. To make beds appropriate to patients circumstances
3. To provide a clean, neat environment for the patient
4. To conserve patient's energy and maintain current health status

EQUIPMENT:

Same as for unoccupied bed

PROCEDURE:

1. 1 Wash hands
2. Assemble or gather equipment and proceed to bed
3. Place clean linen on patient's chair or table at foot of bed
4. Assess and assist patient out of bed when necessary
5. Don disposable gloves (for soiled linen)
6. Assemble equipment and arrange on trolley
7. Adjust bed to comfortable working position
8. Lower side rails to one side of the bed
9. Remove any equipment attached to bed linen
10. Loosen all top linen
11. Remove sheet and discard in linen bag
12. Assist patient to turn on far side of bed facing away
13. Raise the side rails nearest patient
14. Adjust pillow under head
 - a. Loosen bottom linen moving from head of bed to foot
15. Fan fold bottom sheet and draw sheet towards patient, first the draw sheet, then the bottom sheet
16. Tuck edges of linen just under buttocks, back, and shoulders
17. Wipe off any moisture on exposed mattress with towel and appropriate disinfectant
18. Apply linen to exposed half of the bed
19. Place new bottom sheet on the bed, vertically fanfold the half to be used on the far side of the close to the patient as possible
20. Tuck the sheet under the near half of the bed and MITRE corner if a fitted not used
21. Place the clean draw sheet on the bed with the center fold at the center of the bed
22. Fan fold the uppermost half vertically at the center of the bed and tuck the near side edge under the side of the mattress
23. Assist the patient to roll over towards you onto the clean side of the bed

24. Move pillows to clean side of bed for patient's use
25. Raise the side rails before leaving the bed
26. Move to the other side of the bed and lower side rails
27. Remove soiled linen and place into hamper or linen bag
28. Unfold the fanfold bottom sheet from the center of the bed
29. Facing the side of the bed use both hands to pull the bottom sheet, so that it is smooth and tuck the excess under the side of the mattress
30. Unfold the draw sheet fan folded at the center of the bed and pull it tightly with both hands
31. Tuck the excess draw sheet under the side of the mattress
32. Reposition the patient in the center of the bed
33. Reposition the pillows at the center of the bed
34. Assist the patient to the center of the bed

APPLY BED SHEET

- Spread the top sheet over the patient and either ask patient to hold the top edge of the sheet or tuck it under the shoulders
- Make a one foot fold/cuff from the shoulder to over the chest area
- Make a vertical toe pleat with upper sheet by raising the sheet 5 cm to 2 inches parallel to the foot of the bed
- Tuck in sheet at foot of bed and MITRE the corners
- Raise side rails of bed
- Place bed in low position

11. BLOOD TRANSFUSION/BLOOD PRODUCTS

DEFINITION:

Blood transfusion is the infusing of whole blood or blood components into the blood stream of a patient.

OBJECTIVES:

1. To restore/increase circulating blood volume before/after surgery, and or following trauma or haemorrhage
2. To stop bleeding due to coagulation deficiencies e.g. haemophilia
3. To improve the oxygen –carrying capacity of the blood
4. To combat infection due to decrease white cell
5. To maintain the number of red blood cells to maintain haemoglobin levels in patient's with severe chronic anaemia
6. To maintain or increase serum granulocyte and immunoglobulin level and to replace plasma protein especially albumin

EQUIPMENT/SUPPLIES:

- ✓ Blood product as prescribed
- ✓ Blood transfusion set
- ✓ Needle or IV catheter – 22, 20 or 18 G
- ✓ IV pole
- ✓ Normal saline solution
- ✓ Tourniquet
- ✓ Adhesive tape
- ✓ Cotton Swab
- ✓ Antiseptic swab
- ✓ Iodine (if available)

11. BLOOD TRANSFUSION/BLOOD PRODUCTS CONT'D

PREPARATORY PHASE:

1. Make sure that the blood has been typed and cross matched ABO group and RH type on the label of the blood container are checked to be certain of compatibility record
2. Give blood immediately after taking it from the blood bank
3. Return to blood bank if any of these (in 1&2) occur
4. Educate patient of allergic reactions e.g. itching rash, headache, dyspnoea, fever etc.
5. Nil by mouth during the transfusion period

PERFORMANCE PHASE:

1. Check the labels identifying the donor and recipient blood (number and type) and confirm the identity himself by his full name, check chart to make sure of his blood type.
2. Take the patient vital signs (TPR and B/P)
3. Prepare the normal saline solution and clear administration set of air
4. Select a suitable vein, cleanse skin thoroughly (Alcohol and iodine) allow to dry
5. Perform the venipuncture using the appropriate gauge catheter
6. Allow the blood to run through the blood transfusion set
7. Allow 50 mls. to run into patient's vein
8. Hang the unit of blood about a meter about (3-4ft) above the level of the patient heart
9. Discontinue the saline and start the blood transfusion
10. **DO NOT GIVE MEDICATION IN THE BLOOD, DO NOT GIVE 5% DEXTROSE IN WATER OR RINGERS LACTATE IN BLOOD, ONLY NORMAL SALINE IS COMPATIBLE WITH BLOOD.** Just the rate of blood flow to 2 - 5mls a minute during the first 15-30 minutes after the start of the transfusion. If there are no signs or circulatory overloading, the infusion rate should be increased.
11. Give the blood at a slower rate if the patient is elderly or has heart disease
12. Monitor vital signs every 5 minutes for the first 15 minutes then every 15 minutes for the next hour.
13. Observe the patient carefully. Monitor the vital signs hourly or more frequently as indicated

14. Change the transfusion set if another unit is to be administered. If another IV is to be given change the infusion set
15. Record time started and completed and whether any adverse reactions occurred

NB: Do not transfuse for more than three (3) hours or as indicated by physician

If any reactions stop blood transfusion immediately and inform physician

12. BREAST EXAMINATION BY NURSE

Objectives:

- 1) To determine abnormalities in the breast.
- 2) To teach a person how to perform breast self examination.

Equipment:

- ✓ Bed /couch.
- ✓ Room with lighting facilities (Lamp).

Implementation

1. Prepare room
2. Explain procedure to patient.
3. Ensure privacy.
4. Wash hands.
5. Have patient undress to waist.
6. Position patient in a comfortable sitting position facing the examiner.
7. Observe breast for shape, size and abnormalities.
8. Palpate supra circular area
9. Hold patient forearm in your left palm and palpate auxiliary nodes with your right finger tips. Repeat on other side.
10. Allow patient to lie down on couch or bed.
11. Place patient right hand under his or her head
12. Position small pillow under right shoulder.
13. Gently palpate breast tissue starting at the upper outer quadrant using the flattened surface of two or three fingers. Palpate around the breast in a sequential pattern (clock wise).
14. Palpate the first quadrant of the breast twice.
15. Repeat procedure for the other breast.
16. Check the areola area for crust.
17. Check for discharge from nipple, signs of infection.
18. Instruct patient in performing breast examination.
19. Record findings and report abnormalities.

13.0 CARDIO PULMONARY RESUSCITATION (CPR)

OBJECTIVE

- 1 Establish effective circulation by adhering to the principles of CPR thereby preventing irreversible cerebral anoxic damage
- 2 Establish effective circulation and respiration promptly for a victim needing cardio pulmonary resuscitation
- 3 To restore cardiac function when it has stopped or severely decreased

NB: All Registered Nurses should be certified Basic Life Support Providers (BLS) with a recognized training centre.

EQUIPMENT

Resuscitation cart

Chest compression board (if available)

Face mask/ shield (adult/Peds) CPR pocket mask (if available)

Ambu Bag (adult/Peds)

Oral airway

Oxygen source with tubing's

Gloves

Flashlight

Adult and Pediatric manikin (for training purposes)

PROCEDURE

1. Check the Client for responsiveness and no breathing (tap them on the shoulders ask

“are you okay?” Position victim on flat, firm surface (e.g. floor, ground or back board)

2. Call for help and get the AED (Accelerated External Defibrillator)

3. Check for pulse (adult-Carotid, Peds-Brachial)

4. If no pulse, start chest compressions-give 30 compressions (assume correct and comfortable Position)

5. Open airway – give two breaths

6. Resume compressions

Please note the following changes to the CPR algorithm;

Compressions should be started within 10 seconds of assessing that the victim is in arrest

Compressions should be at a rate of at least 100 per minute, each set of 30 compressions should take 18 seconds or less

Compressions depth:- Adults and children at least 2 inches(5 cm) , Infants approximately 1 ½ inches (4 cm)

Cricoid pressure is no longer practiced

The steps of looking listening and feeling is no longer practiced, after the first (30) thirty compressions give 2 breaths

RESCUE BREATHING

TO INSERT ORAL AIRWAY

If victim does not resume breathing administer artificial respiration.

MOUTH TO MOUTH

Pinch victims nose with thumbs and index finger
Occlude mouth with CPR pocket mask

13. CARDIO PULMONARY RESUSCITATION (CPR) CONT'D

(Adult) Maintain head tilt chin lift, blow two (2) slow full breaths – two (2) breaths for every thirty (30) chest compression

(Child) Place mouth over child's mouth or use CPR pocket mask, use one (1) hand over sternum. Administer two (2) slow breaths lasting 1-1 ½ seconds with a pause between. Continue giving twenty (20) breaths per minute.

(Infant) Place mouth over infant's nose and mouth. Two (2) breaths with thirty (30) compressions ,for two (2) minutes until rise and fall of chest.

MOUTH TO NOSE

Keep victims head tilted with one (1) hand on forehead, use other had to lift jaw and close mouth. Seal lips with mask and blow; allow passive exhalation.

AMBU BAG

(Adult and child) use proper sized face masks, applied under chin, up and over victims mouth and nose. With each respiration, observe rise and fall of chest. Listen for escaping air during exhalation. Suction secretion if necessary or turn head to side. Check for presence of pulse before restoring breathing; if absent initiate chest compression. Record Report and inform.

- 1 Check carotid pulse
 - If pulse is present continue to perform rescue breathing, giving the victim one breath every five seconds until help arrives
 - Rescuer must check pressure of pulse every 60 seconds.
 - If pulse is absent, rescuer must circulate as well as breathe for the victim. Rescuer must perform external heart compressions

NB: Rescuer fingers should be kept off victim's ribs

- 2 Perform closed chest cardiac compression.

*** Proper placement of hands on chest is vitally important. For the sake of clarity we will assume that the rescuer is on victim's right side.**

- 1 With the middle and index finger of right hand, the rescuer locates the lower motion of rib café on victim's right side
 - 2 The fingers are then moved along the rib café to the notch where the ribs meet the sternum in the centre of the lower chest.
 - 3 With the middle finger on the notch the index finger is placed on the lower end of sternum, above the middle finger
 - 4 The heel of the left hand (which had been used on forehead to maintain head position) is placed on lower back of sternum just next to the index finger of the right hand
 - 5 The right hand is then removed from the notch, and placed on top of the left hand, the finger of both hands should e pointed away from the rescuer
 - 6 The finger should be interlaced – this keeps them off the chest and diminished the chance of rib fracture
 - 7 The elbows are straightened and locked, and the rescuer positions his shoulders directly over his hand so that the thrust for compression us straight down (the shoulders of the rescuer should be directly near the breast bone of the victim)
 - 8 Depress the sternum one and a half inches with each compression, you want to squeeze the heart and pump blood through the body. Then you must release the pressure to allow the heart to refill. You must compress in this manner at rate of 100 times per minute in 1 rescuer CPR,that is 30 compressions to every two breaths.
 - 9 If you use the weight of your upper body during compressions you do not depend on the strength of your shoulders and arms as much. Instead of having to push from your shoulders, you left the natural weight of your body falling forward provide the force to depress the victims, sternum. Keep the arms straight.
 - 10 Do not lift your hands off the chest or change the position in airway because correct hand position may be lost.
- There should be 30 compression alternating with 2 ventilations

One - Rescuer CPR

- 1 Perform 15 cardiac compressions at a rate of 80 per minute. Count one and two, three and etc, through 15
 - 2 Have up to the victims head, lean over quietly, open the airway again. Take a deep breath, seal the victim's nose and deliver 2 quick full breaths.
 - 3 Move back to victims chest locate proper hand position and begin 15 compressions at a rate of 80 per minute again
 - 4 Repeat cycle four (4) times
 - 5 Check the return of pulse or breathing after first minute
 - a. After delivering the two (2) quick full breaths of last cycle look, listen and feel to determine whether spontaneous breathing has resumed
 - 6 Resume CPR if breathing and pulse are still absent
 - 7 Check for return of spontaneous breathing and pulse every 4-5 minutes
- **Never interrupt CPR for more than 5 seconds**

Two - Rescuer CPR

- 1 When a second rescuer become available, he/she ideally takes over ventilation. The second rescuer should interpose a breath during the upstroke of any compression as soon as he/she arrives
- 2 The first rescuer changes from a rate of 80-60 compressions per minute and changes to a slower rhythm, counting aloud, 1-1000. 2-1000, etc up to 5-1000
- 3 The rescuer breathing is then interposed on the upstroke of each 5th chest compression. The chest compression should not pause for the other rescuer to ventilate the patient
- 4 The ventilator should feel for carotid pulse frequently during chest compressions to assess the effectiveness of compression
- 5 Every 4-5 minutes ventilation and compression should be interrupted to check for return of spontaneous breathing and pulse

14.0 CARE OF COLOSTOMY & CHANGING OF BAG

Definition: Colostomy is an artificial opening to the abdomen to divert faeces from the intestinal tract. It could be temporary or permanent. The changing of the bag is a clean procedure rather than a sterile one.

OBJECTIVES:

1. To maintain comfort and hygiene of the patient
2. To affix clean bag as necessary
3. To assess and care for the peristomal skin

EQUIPMENT:

- ✓ Disposable gloves
- ✓ Tissue to wipe away stool
- ✓ Warm water & mild soap
- ✓ Wash cloth and bath towel
- ✓ Ostomy bag or pouch of the appropriate size
- ✓ Measuring tape to measure stoma
- ✓ A seal or special adhesive or non allergic tape to attach the bag to abdomen
- ✓ A receptacle for soiled items
- ✓ A skin barrier or protective spray for the skin
- ✓ Solvent for removing the bag from the ostomy
- ✓ Cotton tip applicator for applying adhesive to bag if needed

PROCEDURE

1. Explain procedure to patient
2. Obtain consent
- 3.
4. Ensure privacy
5. Wash hands
6. Gather equipment
7. Don clean gloves
8. Unfasten belt if one is worn
9. Empty the colostomy bag, measure and record contents (amount & characteristics)

10. Check the type of adhesive on the bag
11. Apply solvent with an applicator if needed
12. Peel the bag off slowly while holding the patient's skin taut so as not to pull or abrade it
13. Dispose of old bag (appropriately)
14. Using warm water and mild soap, clean the peristomal skin and the stoma
15. Remove dirty gloves and don clean gloves
16. Dry the area thoroughly by patting with a towel
17. Place a piece of gauze/tissue on the stoma to absorb any seepage
18. Measure the size of the stoma using the measuring tape or measuring guide
19. Check the size of the stoma
20. Prepare the peristomal seal
21. Apply the skin barrier around the stoma
22. Remove the tissue from stoma
23. For a urostomy apply an antifungal agent to the peristomal skin if there is any indication of a fungus infection
24. Put the ostomy bag over the stoma
25. Press the bag into place
26. Remove the air from the bag and then close the bottom if applicable
27. Apply the belt if one is to be used
28. Assist the patient to a comfortable position
29. Assess the patient's response to the procedure
30. Measure liquid faeces
31. If the bag is to be reused wash it with warm water and soap, rinse and dry
32. Dispose of used supplies

4.0 CARE OF COLOSTOMY & CHANGING OF BAG CONT'D

PROCEDURE CONT'D

33. Wash hands
34. Report any increase in stomal size to charge nurse

35. Record on Patient chart pertinent information - (any swelling, appearance of skin, amount and type of the drainage, fatigue, and significant behavior about ostomy)

15.0 CATHETERIZATION

INSERTION OF STRAIGHT OR INDWELLING CATHETER

OBJECTIVES

- (1) To obtain sterile urine specimen for diagnostic purposes
- (2) To relieve bladder distension
- (3) To measure the amount of residual urine when the bladder is incompletely emptied
- (4) To manage long term patient with spinal injury/neuromuscular degeneration and incompetent bladder

EQUIPMENT

- ✓ Sterile gloves
- ✓ Sterile drapes
- ✓ Water soluble lubricant
- ✓ Antiseptic cleaning solution
- ✓ Incontinent pad
- ✓ Cotton balls or gauze swabs
- ✓ Forceps
- ✓ Sterile water
- ✓ Syringe (e.g. 5-20 m/s)
- ✓ Alcohol swabs
- ✓ Needles gauge 18-20
- ✓ Catheters - Adult female sizes 14-16
 - Younger female size 12
 - Male size 16-18
 - Children sizes 8-10
- ✓ Goose neck lamp or flashlight
- ✓ Bath blanket/bath towel
- ✓ Trash receptacle
- ✓ Sterile disposable drainage bags with tubing
- ✓ Basins with warm water
- ✓ Soap
- ✓ Face cloth
- ✓ Tape
- ✓ Safety pin and Sterile specimen container

IMPLEMENTATION / PROCEDURE

- (1) Follow steps 1-4
- (2) Raise bed to appropriate height. Facing patient, stand on left side of bed if right handed – opposite for left handed
- (3) Raise side rail on opposite side of bed
- (4) Place incontinent pad
- (5) Position patient – female
- (6) Dorsal recumbent position is used nurse must take extra precaution to cover rectal area with drape
- (7) Drape with towel, placing in a diamond fashion over patient

15.1 CATHETER CARE

OBJECTIVE

- (i) To prevent infection
- (ii) Maintaining constant flow of urine
- (iii) To ensure that drainage is maintained as a closed sterile system

PROCEDURE

1. Wash hands and don gloves
2. Do not disconnect tubing or irrigate catheter unless specifically ordered
3. If patient is ambulant ensure bag goes along with him/her
4. Secure catheter externally to prevent pressure and trauma to urethral meatus
5. Cleanse urethral meatus and the first four inches of the catheter twice a day or as ordered.
6. Cleanse perineal area with mild soap and water or other perineal cleanser
7. Apply antimicrobial ointment to meatus area as ordered by physician.
8. Empty urine bag eight (8) hourly (Rational – minimize risk of urinary tract infection)
9. Position tubing over patients leg not under
10. Ensure tubing falls straight down from bed to drainage bag and attach collection bag to frame of bed.
11. Always keep level of bag to below level of bladder
12. Do not open bag except to empty from bottom
13. Measure and record output on fluid balance chart.

14. Observe colour quality characteristics of urine in tube and drainage bag (report significant findings)
15. Note patient's body temperature
16. Dispose of gloves
17. Document accurately

15.2 COMDOM CATHETER APPLICATION

EQUIPMENT

- ✓ Solution for cleaning
- ✓ Gauze 4x4
- ✓ Condom drain
- ✓ Appropriate size of condom
- ✓ Urine drainage bag
- ✓ Basin with warm water
- ✓ Soap
- ✓ Wash cloth/Towel
- ✓ Non sterile gloves
- ✓ Incontinent pad
- ✓ Razor/shaving stick

PROCEDURE

1. Follow steps 1-4
2. Ensure bed is at appropriate height
3. Lower side rails that work will be done
4. Position patient – supine or according to patient’s condition
5. Cover patient with bed sheet; Expose only genitalia
6. Prepare equipment
7. Don gloves
8. Clean perineal area thoroughly, then dry
9. Shave base of penis (with consent), cleaning shaft of penis
10. Use non dominant hand to grasp penis along shaft
11. With dominant hand hold condom
12. Smoothly roll sheath onto penis
13. Apply tape in spiral pattern and connect condom drain.
Allow about 2.5 cms or 1” of space from opening of the urethra to the end of the catheter

14. Apply urine bag and secure to bed frame
15. Tidy surroundings
16. Document
17. Monitor for 1st hour, then four (4) hour
18. Rationale – e.g. poor circulation
19. Change every 24 hours
20. Inspecting and cleaning before applying a new condom
drain

16.0 CLINICAL SKILLS ASSESSMENT TOOLS

16.1 Monitoring Of Vital Signs

Objectives:

1. To monitor the vital functions of the body's –temperature regulation, cardiac and respiratory functions and pain
2. To gather data on which major nursing and therapeutic decisions are based

Skills: Temperature, Pulse, Respiration, Blood Pressure, Adult Pain score and Pediatric Pain score.

Equipment:

- ✓ Thermometer
- ✓ Clinical (Oral/rectal)
- ✓ Digital (Electronic)
- ✓ Tympanic (for pediatrics)
- ✓ Methylated spirit swabs
- ✓ Dry cotton swab
- ✓ Cotton swab in disinfectant
- ✓ Water soluble lubricant (for rectal temperature)
- ✓ Watch with second hand
- ✓ Stethoscope
- ✓ Blood pressure cuff (Sphygmomanometer)
- ✓ Pain chart
- ✓ Pulse oximeter
- ✓ Graphic chart

Wong –Baker faces pain skills recommended for children three to seven (3-7) years

Face – Non verbal pain scale used for two months to seven years (2mths -7 yrs)

PROCEDURE:

Temperature:

1. Wash hands
2. Obtain consent
3. Prepare equipment
4. Explain procedure to patient
5. Check to see that thermometer reading is 96 degree F or 36 degree centigrade or lower
6. Clean thermometer with soaked disinfectant swab, then spirit cotton swab and wipe with dry swab.

Oral temperature:

1. Place clean thermometer under patient's posterior sublingual pocket
2. Ask patient to hold thermometer with lips closed
3. Leave thermometer in place for seven to ten minutes, remove thermometer, wipe and read.
4. Read thermometer while holding it at eye level
5. Inform patient of temperature reading
6. Clean thermometer with disinfectant according to agency policy
7. Return thermometer to container
8. Record and report temperature

Axillary Temperature:

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Position patient sitting or lying
6. Remove clothing from area (e.g. shoulders and arms)
7. Place thermometer in center of axilla and place arm across chest. (Ensure contact of skin)
8. Leave thermometer in place for ten (10) minutes in adults and five (5) minutes for pediatrics
9. Read thermometer while holding it at eye level
10. Clean thermometer with disinfectant swab
11. Return thermometer to container
12. Record and report temperature

Tympanic (Digital)**Procedure:**

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Cover thermometer with tympanic probe
6. Apply gentle, but firm pressure to external ear(pull up and backwards for adults)
7. For children six (6) years and under pull ear down and backwards
8. Insert probe slowly into patient ear with a back and forth motion until it seals the ear canal
9. when in position, press button to activate, leave for twenty-five seconds (25 sec)

PROTOCOL: Discard probe after use

Rectal temperatures:

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Wash hands and follow steps 1 -4
6. Provide privacy
7. Position patient in left Sims positions (left side) with upper leg flexed
8. Don gloves
9. Expose only anal area
10. Squeeze lubricant on clean swab, then dip blunt end of thermometer into lubricant up to 1 ½ inches for adults and ½ - 1 ½ inches for pediatrics.
11. with non dominant hand separate patient buttocks to expose anus
12. Ask patient to breathe slowly and relax
13. Gently insert lubricated end of thermometer in anus (1/2inch for pediatrics and 1 ½ inches for adults)
14. Hold thermometer in place for three (3) minutes then remove and wipe
15. Wipe anal area to remove lubricant
16. Read thermometer while holding at eye level
17. Clean thermometer with warm soapy water
18. Return thermometer to container
19. Record and report findings

Apical Pulses:

Procedure

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Place patient in supine or sitting position
6. Expose sternum and left side of chest
7. Palpate Louis's Angle just below the supra sternal notch
8. Place index finger at the right sternum and palpate second intercostal space
9. Place next finger in third (3rd) intercostal space and proceed downward to the fifth (5th) intercostal space
10. Move index finger horizontally along fifth intercostal space to left mid-clavicular line
11. Palpate point of maximal impulse (PMI)

Apical Pulses:

12. Place diaphragm (warm diaphragm of stethoscope and place over
oscillate

for normal S₁ and S₂ heart sounds (Lub-Dub)

13. Use watch with second hand count for one full minute

14. Note regularity and presence of sounds

Radial pulse

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Position patient forearm across lower chest with wrist extended straight and palm down
6. Place tips of first (1st), two (2) or middle fingers of dominant hand over groove along radial or thumb side/inner wrist.
7. Lightly compress radial artery against the radius, press gently so that pulse becomes easily palpable
8. Look at watch with second hand and begin to count for thirty seconds (30) and multiply by two.
9. If irregular count for one minute
10. Assess regularity and frequency
11. Determine strength of pulse (full, bounding, weak or thready)
12. Record findings (Report any abnormal findings)

Respiration:

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Ensure chest is visible. If necessary remove bed linen or gown.
6. Place patient hand across the abdomen or lower chest or the nurses hand directly over the patient upper abdomen
7. Observe complete respiratory cycle
8. Look at watch second hand and count rate thirty seconds (30sec) multiply by two (x2) while keeping finger tip on patient's pulse.
9. If the rhythm in adults is irregular count for one full minute.
10. If infant or child count for one full minute
11. Note depth of respiration, rhythm of ventilatory cycle and use of accessory muscles)
12. Replace patient gown and cover with bed linen
13. Wash hands
14. Discuss with patient the findings
15. Record findings and report abnormal findings to nurse in charge

BLOOD PRESSURE

Equipment

- ✓ Sphygmomanometer
- ✓ Bladder and cuff
- ✓ Stethoscope

Measurement

Average measurement with width of bladder

ADULT: 12-13 cm - 4.8-5.2ins

OBESE: 15-16cm - 6.2-6.4ins

INFANT: 6.8cm - 2.4-3.2ins

Length of bladder

ADULT: 22-23cm -8.5-9ins

OBESE: 30cm 12ins

INFANT: 12-13cm 4.8-5.4ins

Pen

Graphic Chart

Alcohol swab

Procedure:

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Support patient forearm with palm turn up
6. Expose patient forearm fully by removing constricting clothing
7. Palpate brachial artery
8. Position cuff one inch above the site of brachial pulsation (Anti-cubital space)
9. Center bladder cuff above artery. Wrap fully deflated cuff evenly and snugly around upper arm
10. Position manometer vertically above eye level
11. Palpate radial or brachial artery with finger tips of one hand
12. Close the screw clamp on the bulb and inflate the cuff to pressure 20mmhg
above the point at which the pulse disappears; while checking the pulse
with the other hand
13. Deflate cuff fully and wait for 30sec
14. Place stethoscope earpiece in ear
15. Relocate brachial artery and place bell or diaphragm/chest piece over it
(Do not allow chest piece to touch chest or clothing)

16. Close valve or pressure bulb clockwise until tight.
17. Inflate cuff to 30mmhg above palpated systolic pressure
18. Slowly release valve and note point on manometer when first clear sound is heard, continue deflating gradually noting point at which muffled or dampened sound appears
19. Deflate cuff rapidly and completely
20. Remove from patient arm
21. Record and Report findings, report abnormal findings to Nurse in charge.

PULSE OXIMETER:

Objectives:

1. Assess clinical status of patients at risk for unstable oxygen status and prevent complications
2. To measure the arterial blood saturation SaO₂

Equipment

- ✓ Pulse oximeter module
- ✓ Cutaneous sensor probe
- ✓ Acetone continuous print out

Implementation

1. Wash hands
2. Explain procedure to patient
3. Obtain consent from patient
4. Ensure privacy
5. Position patient comfortably
6. If finger is chosen support lower arm
7. Instruct patient to breathe normally
8. Remove fingernail polish
9. Attach sensor probe to finger
10. Watch pulse bar for pulse sensing
11. Determine patient radial pulse
10. Correlate with pulse on oximeter
11. Read saturation level. (Normal SaO₂ 95%-100%)
12. Sensor probe must be cleaned after each use and changed every 48-72hrs
13. Record findings. (Report abnormal findings)

NB: Cover sensor with a sheet or towel to block light from external sources.
E.g. Bili light

16.2 PAIN ASSESSMENT:

OBJECTIVES

1. Differentiate between the different types of pain
2. Measure difference of pain using pain scale 0-10. Pain distress scale

McGill Melzack pain questionnaire (Adult)

Wong Baker faces pain scale 3-7 yrs FLACC non-verbal pain scale, 2 months – 7 yrs persons who cannot speak (several, intellectually impaired patients)

WASH HANDS

Follow steps 1-4

Equipment

- ✓ Disposable gloves
- ✓ Proper lighting
- ✓ Using coldspa memory guide gather data about pain

Implementation (procedure)

Ensure privacy

Assist patient to comfortable position fully expose area of discomfort. (Clothing, bed linen etc)

Apply splinting

- (a) explain purpose of splinting to patient
- (b) Assist patient to place hand firmly over area of discomfort
- (c) Assist patient to splint during coughing , deep breathing and turning

Assist to comfortable positions

- (a) Use pullouts to support body
- (b) Remove disposable gloves
- (c) Record and Report.
- (d) Take appropriate action
- (e) Document all results

16.3 HEALTH ASSESSMENT

- (1) Identify the rationale for performing health assessment
- (2) Differentiate between subjective and objective data
- (3) Utilize four (4) sources of data collection

EQUIPMENT

- ✓ Stethoscope
- ✓ Sphygmomanometer and cuff
- ✓ Standard scale
- ✓ Watch with 2nd hand
- ✓ Tape measure
- ✓ Pinad stethoscope/sonicade (optional)
- ✓ Pulse oximeter
- ✓ Gown
- ✓ Penlight
- ✓ Autoscope
- ✓ Tongue depressor
- ✓ Patella hammer
- ✓ Swelling chart
- ✓ Urine container/specimen bottle
- ✓ Disposable gloves
- ✓ Thermometer
- ✓ Forms (e.g. pain charts, etc)
- ✓ Speculum

PROCEDURE

Wash hands – follow steps 1-4

Identify yourself to patients

Gather equipment

Ensure privacy

16.3 HEALTH ASSESSMENT CON'T

Prepare patient

- (a) Empty bladder (collect urine specimen)
- (b) Undress patient and put on gown
- (c) Expose only parts to be examined
- (d) Assume appropriate position, drape accordingly

TECHNIQUES

(I) INSPECTION: expose body part; keep rest of patient properly clothed.

(A) Always look before touching

(B) Use good light

(C) Ensure room is warm

(D) Observe for colour, size, location, texture, symmetry, odors and sounds

(II) PALPATION: touch and feel body parts with hands to detect the following

(A) Texture (roughness/smoothness)

(B) Temperature (warm, hot, cold)

(C) Moisture (dry, wet or moist)

(D) Motion (stillness/vibration)

(E) Consistency of structure (solid/fluid)

(F) Finger nails must be short

(G) Use most sensitive part of hand

(H) Conduct light palpation then deep palpation

(I) Palpate tender areas last.

(III) PERCUSSION:

(A) Direct; directly tap body parts with one (1) or two (2) finger tips

(B) Indirect – press middle finger of non-dominant hand firmly on body part while keeping other fingers away from body part. Strike finger on body part with the middle finger of dominant hand and listen to sound

(IV) AUSCULTATION: use stethoscope diaphragm and bell

16.4 HEAD TO TOE ASSESSMENT

1. INSPECT INTEGUMENTARY STRUCTURES (e.g.. hair, nail, skin)
2. HEAD AND NECK - Perform Central neurologic function - vision, hearing, and mouth structures
3. OBSERVE PATIENT LEVEL OF CONSCIOUSNESS – assess ability to respond
4. MUSCULO – SKELETAL– assess muscles, joints, body movements and neuromuscular – function
5. CHEST – Observe respiratory and cardio- vascular structures and functions
6. BREASTS – Check for shape, size and symmetry. Nipples for discharges
7. ABDOMINAL: - check gastro intestinal structures and function, and kidney structure
8. GENITALS: - assess male and female genitalia.
9. ANUS: - assess anus
10. OBJECTIVE DATA: - things directly seen and measured
11. SUBJECTIVE DATA: - patients feelings and expressions, verbal or non verbal
 - Patient significant other Medical Records and other

16.5 AUSCULTATION (listening for sound within the body) OF HEART, LUNGS AND BOWELS

OBJECTIVE

- 1 To accurately ascertain pulse rate when peripheral pulse cannot or should not be used
- 2 To detect abnormalities in heart sounds
- 3 To assess for normal and abnormal breath sounds
- 4 To assess for the presence or absence of bowel sounds

EQUIPMENT

- ✓ Stethoscope

PROCEDURE

- 1 Explain procedure to patient
- 2 Control environmental noise
- 3 Screen patients
- 4 Pause patient's gown or pajama top to shoulders
- 5 Wash hands
- 6 Heart
 - a place patient in supine position
 - b Fan-Fold bed linen to patient's waist
 - c Warm diaphragm of stethoscope
 - d Position diaphragm
 - e Locate apical pulse and count rate
 - f evaluate rhythm
 - g listen for 1st and 2nd heart sounds correlating carotid pulse with 1st heart sound
- 7 Lungs
 - a Assist patient to sitting position, or roll from side to side
 - b Ask patient to mouth breath
 - c Ascultate anterior chest

- d If Rhymes or rhonchi are present, have patient cough and listen again
- e Ascultate posterior chest

8 Bowels

- a A fan fold bed linen to patients symphysis pubis
- b systematically listen to all four quadrants of abdomen, beginning with right lower quadrant

9 Replace patients gowns

10 Assist patient to position of comfort

11 Readjust environment

12 Wash Hands

13 Chart

16.6 NEUROLOGICAL ASSESSMENT

Objectives:

- 1) To assess patient neurological status as regards to pupillary response, strength, motor activity and level of consciousness.
- 2) To determine whether patient have taken any analgesic, sedative, hypnotic, anti- psychotic, anti-depressant or any nervous system stimulant/depressant.
- 3) To screen patient for headache, dizziness/vertigo, seizures, weakness/numbness or tingling of body parts, visual weakness, pain or change in speech.
- 4) To assess patient for history of change in vision, hearing, smell, touch or taste.
- 5) To assess for increase irritability, mood swings or memory loss.

Equipment:

- ✓ Pen light
- ✓ Tuning fork.
- ✓ Patella hammer.
- ✓ Tongue blade.
- ✓ Safety pin.
- ✓ Reading material
- ✓ Cotton applicator/cotton ball.
- ✓ Two glasses water (Hot or cold).
- ✓ Salt and sugar, coffee or vanilla extract
- ✓ Snellen chart.
- ✓ Diagnostic set
- ✓ Receptacle for soiled items

IMPLEMENTATION:

PUPILLARY RESPONSE

- 1) In a semi darkened environment shine light in patient's eye, moving from lateral to medial cantus. Check for
 - a. Direct reaction to light.
 - b. Consensual reaction to light.
- 2) Evaluate size and symmetry of pupil, strength and motor activity.
 - a. Assess patient response to verbal command.

- b. Assess patient response to pain by firm squeeze on gastrocnemius muscle.
- c. Ask patient to grasp your hand and squeeze.
- d. Evaluate strength as follows:
 - i. + 4 - Normal- grasps hands firmly.
 - ii. + 3 - Moderate – Grasp hands with guarded strength.
 - iii. + 2 – Fair – Grasp hand with decrease power
 - iv. + 1 – Weak – Grasp hand slightly.
 - v. + 0 – No movements.

LEVEL OF CONSCIOUSNESS:

Assess verbal response to question.

- a. Oriented – Patient should know who he is, where he is, why he is there and the month and year.
- b. Confused – attention can be held and the patient responds in a conversation, but the responses show some disorientation and confusion.
- c. Incoherent – infrequent, intelligible articulation but speech is used in an exclamatory or random way; no sustained conversational exchange.
- d. Incomprehensible – Moaning and groaning but, without any recognizable words.

16.7 PHYSICAL ASSESSMENT OF THE NEWBORN

Objectives:

- 1) To collect data for the assessment of the newborn by observation (same must be done by pediatrician in first twenty-four (24) hours.
- 2) To determine abnormalities/injuries.
- 3) To commence prompt management.

Equipment:

- ✓ Gloves
- ✓ Stethoscope.
- ✓ Bulb syringe.

17.0 COLLECTION OF BLOOD SAMPLES (ADULTS)

EQUIPMENT

- Sterile needles - 20-21 gauge - adults
- (1) Vacutainer tube with needle holder 20-21 same gauge for syringe
 - (2) Appropriate blood tube
 - (3) Completed laboratory forms and label
 - (4) Plastic bags for delivery specimen
 - (5) Completed label forms
 - (6) Plastic bags for specimen

SYRINGE METHOD

- (1) Attached syringe to needle securely
- (2) Clean vein puncture site with alcohol sponge
- (3) Remove needle cover and inform patient that sticking last for a few seconds
- (4) Place thumb or forefinger of non dominant hand 1 inch or 2.5 cm above or below site and pull skin taut or firmly
- (5) Hold syringe and needle at 15-30 degrees angle with bevel up
- (6) Slowly insert needle into vein
- (7) Hold syringe securely and pull back gentle on plunger
- (8) Look for blood return
- (9) Obtain desired amount of blood keeping the needle stabilize
- (10) Release tourniquet
- (11) Apply two by two gauze pad or dry swab over puncture site without pressure quickly removing needle from vein

17.1 VACUTAINER METHOD USED WHEN APPLICABLE

- (1) Attached double ended needle to vacutainer tube
- (2) Wave proper blood specimen tube resting inside container but do not puncture rubber tubing
- (3) Cleanse vein puncture site with alcohol swab
- (4) Remove needle cover and inform patient that sticking last for a few seconds
- (5) Repeat steps four to eleven of syringe method. Using vacutainer instead
- (6) For blood obtain by syringe transfer blood to tube
- (7) Using one hand technique insert needle through stopper of blood tube and vacuum to fill tube
- (8) Take blood tube containing additives and gentle rotate back and forth eight to ten times
- (9) Inspect puncture site for bleeding and apply adhesive tape with gauze or band aid
- (10) Remove disposable gloves assist patient to comfortable position
- (11) Label blood samples appropriately
- (12) Dispose needles syringes and soiled equipment in appropriate containers
- (13) **DO NOT RECAP NEEDLES**
- (14) Wash hands after procedure and sent to laboratory immediately
- (15) Document date and time of vein puncture
- (16) Test samples obtained in nurse's notes
- (17) Send blood sample immediately to laboratory

17.2 COLLECTION OF BLOOD (PEDIATRICS)

OBJECTIVE

To obtain blood samples for diagnostic purposes in the care and evaluation of patients.

EQUIPMENT

- ✓ Alcohol swabs
- ✓ Disposable gloves
- ✓ Sterile gauze pads 2"x2"
- ✓ Rubber tourniquet
- ✓ Disposable syringe of appropriate sizes 2 ml – 10 ml, (gauge 20-21)
- ✓ Band aid/adhesive
- ✓ Pediatric (needles) gauge 23
- ✓ Vacutainer tubes with needle holder, same gauge as for syringe method
- ✓ Pediatric – scalp view needles/butterfly
- ✓ Completed laboratory forms/labels
- ✓ Plastic bags for delivery of specimen

IMPLEMENTATION / PROCEDURE

- (1) Wash hands; follow steps 2 – 4
- (2) Check physicians orders
- (3) Explain procedure to patient
- (4) Assist patient to supine/semi fowler's position with arms extended
- (5) Ask staff members to assist (rationale) to prevent sudden movement of arm
- (6) Don disposable gloves
- (7) Apply tourniquet 5-5cm 2"-6" above venipuncture site selected (most often used site is antecubital fossa site)
- (8) Palpate distal pulse e.g. radial, below tourniquet, if pulse is not palpable reapply tourniquet
- (9) Keep tourniquet no longer than 1-2 minutes

- (10) If vein is prominent, do not ask patient to make fist
- (11) Palpate selected vein with index finger

17.3 SYRINGE METHOD

- (1) Attach syringe to needle securely
- (2) Clean venipuncture site with alcohol swabs
- (3) Remove needle cover and inform patient that sticking is for only a few seconds
- (4) Place thumb or fore finger of non-dominant hand 1" (2.5cm) above or below site and pull skin firmly
- (5) Hold syringe and needle at a 15^o -30^o angle from patients arm with bevel up
- (6) Slowly insert needle into vein, hold syringe securely and pull back gently on plunger
- (7) Look for blood return
- (8) Obtain desired amount of blood keeping needle stabilized
- (9) Release tourniquet
- (10) Apply 2x2 gauze pad/dry swab over puncture site without pressure
- (11) Quickly withdraw needle from vein

18.0 COLLECTION OF SPECIMENS

18.1 COLLECTION OF URINE SPECIMEN

OBJECTIVE

- To determine the presence of micro organisms, the type of organism (s), and the antibiotics to which the organisms are sensitive.
- To determine kidney, liver, metabolic and hormonal function.

EQUIPMENT

- ✓ Sterile specimen container
- ✓ Specimen identification label
- ✓ Clean bed pan or urinal
- ✓ Disposable or sterile gloves
- ✓ Antiseptic solution (hibitane) or antiseptic towelettes based on hospital policy
- ✓ Sterile cotton balls or 2x2 gauze pads
- ✓ Bio Hazard bag to transport sample
- ✓ Basin of warm water, soap, wash cloth and towel for non-ambulatory patient.

PROCEDURE

- Follow steps 1 – 4
- Label specimen container include patients name, date, ward/Unit and Physician name

The Ambulatory Patient

- (1) Direct or assist patient to bathroom
- (2) Instruct patient to wash and dry genital and perineal area with soap and water or antiseptic towelettes.
- (3) Instruct uncircumcised male to retract foreskin to expose urinary meatus, clean meatus and distal portion of penis using circular motion
- (4) Instruct patients to start voiding into specimen container or appropriate receptacle, taking care not to touch the container to the perineum or penis.

- (5) (Nurse) Place specimen container into the stream of urine and collect the specimen, taking care not to touch the container to the perineum or penis.
- (6) Collect 30 – 60 ml of urine in the container
- (7) Cap the container tightly, touching only the outside of the container and the cap
- (8) If necessary, clean the outside of the specimen container with disinfectant
- (9) Refer to beginning of procedure
- (10) Place in bio-hazard bag and arrange for transporting to laboratory
- (11) Wash hands
- (12) Document pertinent data; record collection of specimen, colour, odor, or consistency of urine and any difficulty in voiding that the patient experienced
- (13) Report pertinent findings

Non Ambulatory Patient

- (1) Wash the perineal area with soap and water; rinse and dry.
- (2) Assist the patient onto a clean commode or bed pan. If using a bed pan or urinal, position the patient as upright as allowed or tolerated.
- (3) Open the clean catch kit, taking care not to contaminate the inside of the specimen container or lid.
- (4) Don clean gloves
- (5) Clean urinary meatus and perineal area as described in step 3.
- (6) Instruct the patient to start voiding; follow step 5 – 13.

18.2 24 HOUR URINE COLLECTION

OBJECTIVE

- To determine kidney function status

EQUIPMENT

- ✓ litre collection bottle with lid
- ✓ Label for container
- ✓ Container of ice or refrigerator for storage
- ✓ Towel
- ✓ Bed pan
- ✓ Urinal
- ✓ Kidney dish or a specimen hat
- ✓ Gloves
- ✓ Bio-hazard bag
- ✓ Measuring graduate (measurement drug)

PROCEDURE

- (1) Follow steps 1 – 4
- (2) Label the collecting bottle with patients name, age, ward/unit, physician, date, time of commencement
- (3) Place a sign on patient bed indicating that 24 hour urine test is being done. Also emphasize that no urine is to be discarded without informing the nurse
- (4) Give the bed pan, urinal or Kidney Dish to the patient and instruct patient to void
- (5) Discard this urine and record the time on patients' chart and the collection bottle
- (6) Measure each specimen of urine voided and pour into collecting bottle, record each amount
- (7) If the patient has an indwelling catheter, the urine collection bag should be placed in a cooler with ice
- (8) Keep collecting bottle closed

- (9) Continue collection for 24 hours from the time the first urine was discarded
- (10) Ask patient to void during the last fifteen minutes of the urine collection period and pour this amount into the bottle
- (11) Record collection of specimen in patients chart. Time started and ended and total amount collected.
- (12) Send specimen bottle immediately to laboratory

18.3 OBTAINING STOOL SPECIMEN

OBJECTIVE

- To obtain stool specimen to determine pathological conditions e.g. tumors, hemorrhage, infection and mal absorption problems in patients

EQUIPMENT

- ✓ Specimen containers with or without liquid
- ✓ e.g. With liquid - OCP
 - Without liquid - Stool culture, occult blood
- ✓ Sterile test tube with swab (or culturette) (use in liquid stool)
- ✓ Clean bed pan / commode (adult); potty chair (Paeds)
- ✓ tongue blades (wooden) sterile
- ✓ Disposable gloves
- ✓ Disposable paper towels
- ✓ Required forms
- ✓ Save stool signs
- ✓ Antibacterial Soap and water
- ✓ Air freshener

IMPLEMENTATION / PROCEDURE

Follow steps 1-4

- (1) Instruct patient to pass urine into toilet/bed pan. (if in bed pan discard urine before collecting stool) (rationale) feces should not be mixed with urine or tissue as urine inhibits fecal bacteria growth
- (2) Provide patients with clean dry bed pan to defecate
- (3) Position patient on bed pan in good body alignment
- (4) After defecating, remove bedpan and cover
- (5) Clean patient as required
- (6) Offer soap and water to wash hands
- (7) Assist patient to comfortable position
- (8) Take covered bed pan to sluice/bathroom with specimen containers

(9) Using tongue blades transfer stool specimen into container, taking care not to contaminate outside of container.

(10) Wrap used tongue blades in paper towel prior to disposing in waste paper Basket

(11) Empty and clean bed pan and return to its place

(12) Remove gloves & wash hands

(13) Ensure that specimen label and laboratory forms have correct information on them and securely attached

(14) Provide air freshener for odor

(15) Document collection of specimen on patients charts

18.4 NOSE AND THROAT SPECIMEN FOR CULTURE

OBJECTIVE

- To obtain specimen from Nose and throat for diagnostic purposes
- To determine treatment for patient

EQUIPMENT

- ✓ sterile swabs/cultures
- ✓ Disposable gloves
- ✓ Emesis basin
- ✓ Nasal spatula
- ✓ Tongue blades/depressor
- ✓ Penlight
- ✓ Facial tissues/paper towel
- ✓ Required forms

PROCEDURE/ IMPLEMENTATION

- (1) Follow steps 1-4
- (2) Ask patient to sit erect in bed or chair facing nurse. Acutely ill or young child - lie back with head of bed at 45° angle
- (3) Have swabs in tube ready for use
- (4) Collect throat culture:- instruct patient to tilt head backward. For patient in bed, place a pillow behind shoulders. Ask patient to open mouth and say “ah”
- (5) If pharynx is not visible depress tongue with tongue blade or depressor and note inflamed areas of pharynx on tonsils
- (6) Use penlight as needed
- (7) Insert swabs without touching lips, tongue or cheek
- (8) Gently but quickly swab tonsillar area from side to side making contact with inflamed or purulent sites
- (9) Carefully withdraw swab without striking oral structure. Immediately place swab in culture tube and crush ampoule at bottom of tube

(10) Push tip of swab into liquid medium, place top on culture tube securely

(11) Discard tongue depressor into trash

(12) Remove and dispose gloves

18.5 NOSE CULTURE

- (1) Follow protocol as for throat
- (2) Encourage patient to blow nose and check nostrils for patency with penlight
- (3) Gently insert nasal speculum in one nostril
- (4) Carefully remove nasal speculum and insert swabs into culture tube
- (5) Crush ampoule at bottom of tube and push tip of swab into liquid medium
- (6) Place top on culture tube securely
- (7) Remove gloves and discard
- (8) Wash hands
- (9) Label specimen and fill form
- (10) Send to the laboratory immediately

18.6 VAGINAL DISCHARGE SPECIMEN

OBJECTIVE

- To obtain specimen from vagina/urethra for diagnostic purposes and treatment

EQUIPMENT

- ✓ Vaginal speculum (sterile)
- ✓ Sterile gloves
- ✓ Vaginal cream (Hibitane)
- ✓ Spot light /goose light
- ✓ Culturettes
- ✓ Sterile drape/towels
- ✓ Vulval toilet tray
- ✓ Receivers for soiled swabs/equipment

PROCEDURE / IMPLEMENTATION

- (1) Follow steps 1 – 4
- (2) Prepare tray with culturette
- (3) Position patient (female) lithotomy, position light
- (4) Don sterile gloves
- (5) Clean and drape patient
- (6) Insert speculum using cream on Speculum (rotate speculum exposing collection/pocket of discharge)
- (7) Using culturette, obtain specimen and insert culturette into tube
- (8) Follow protocol as previously established for removal of swab
- (9) Remove speculum carefully
- (10) Tidy patient and reposition
- (11) Label specimen, fill form and send to laboratory immediately
- (12) Document in nurses notes all pertinent information and inform/report appropriately

18.7 WOUND SWAB FOR CULTURE

OBJECTIVES:

1. To identify the microorganisms potentially causing an infection and the antibiotics to which they are sensitive
2. To evaluate the effectiveness of the antibiotic therapy

EQUIPMENT/SUPPLIES:

- ✓ Disposable gloves
- ✓ Sterile gloves
- ✓ Biohazard bag/moisture resistant bag
- ✓ Sterile dressing tray
- ✓ Normal saline or sterile water & irrigating syringe
- ✓ Culturette (culture swab with culture medium)
- ✓ Completed requisition form to accompany swab

PROCEDURE:

1. Explain procedure to patient and obtain consent
2. Wash hands
3. Gather equipment and supplies
4. Ensure privacy
5. Don unsterile gloves
6. Remove any dressings covering wound
7. Observe any drainage in dressing
8. Discard dressing in bio-hazard bag
9. Remove glove and discard
10. Wash hand thoroughly
11. Open sterile dressing tray using sterile technique
12. Don sterile glove
13. Assess appearance of tissue in and around wound and the drainage
14. Irrigate the wound with normal saline until all visible exudates has been washed away???
15. After irrigating apply sterile gauze pad to the wound
16. Remove sterile gloves
17. Obtain curette, rotate swab back and forth over clean areas of granulation tissue from the sides of base of wound. NB: Do not use pus or pooled exudates to culture???
18. Avoid touching the swab to intact skin at wound edges

19. Position the applicator swab in the wound at the site of the most drainage.
20. Collect as much of the drainage as possible *NB: Do not collect a surface specimen, this can affect the accuracy of the laboratory analysis.*
21. Return swab to culture tube taking care not to touch the top or outside of the tube
22. Crush the inner ampoule containing the medium for organism growth at the bottom of the tube
23. Twist the cap to secure it
24. Dress wound
25. Wash hands
26. Label carefully the specimen and send immediately to laboratory with appropriate form.
27. Document relevant information in patient's chart (name, date & time, investigation requested, appearance of wound, colour, consistency, amount and odour of any drainage, any discomfort experienced by the patient)
28. *Never refrigerate the specimen*

COUGH AND DEEP BREATHING

Objective

- 1 to avoid pulmonary complications post operatively
- 2 to maximize oxygen intake and decrease potential for hypoxemia
- 3 to promote the removal of chest secretions

EQUIPMENT

- ✓ Tissues
- ✓ Pillow
- ✓ Stethoscope
- ✓ Equipment for oral hygiene

Implementation

DEEP BREATHING -

- 1 Instruct patient in deep breathing techniques, demonstrating as needed
- 2 Position patient for comfort and maximum effectiveness- fowlers or semi fowlers if possible. Avoid constriction of chest area.
- 3 Relieve pain if possible
- 4 Assist patient to splint area using interlaced fingers or pillow
- 5 Have patient inspire while counting slowly to 2
- 6 Have patient expire while counting slowly to 4
- 7 Observe patient for chest and abdominal expansion
- 8 Correct patient's technique as necessary
- 9 Repeat, for a total of 10 deep breaths
- 10 Observe effect on patient
- 11 Chart appropriately

COUGHING

- 1 Instruct patient
- 2 Position patient in sitting position if possible. Other position may be used depending on the needs of patient
- 3 Relieve pain if possible
- 4 Assist patient to splint area using interlaced fingers or pillow
- 5 Have patient take deep breaths
- 6 After third deep breath, have patient inspire and hold air
- 7 Have patient perform valsalva maneuver (i.e expire forcefully against closed glottis) and then release air abruptly while flexing forward.
- 8 Repeat for 3 deep coughs or until mucus is cleared
- 9 Auscultate lungs
- 10 Offer oral hygiene
- 11 Chart appropriately noting the effects on patient

20.0 DRESSING & SUTURE REMOVAL

20.1 STERILE DRESSING TECHNIQUE

OBJECTIVE:

- (1) To protect wound from trauma and external contamination
- (2) To provide opportunity to assess the wound

EQUIPMENT

- ✓ Dressing trolley
- ✓ Sterile dressing set (pre packed)
- ✓ Dressing materials
- ✓ Cotton swabs
- ✓ Gauze
- ✓ Face mask
- ✓ Antiseptic or ordered solution for wound cleaning
- ✓ Medication for wound
- ✓ Sterile gallipots for antiseptic
- ✓ Sterile instruments
- ✓ Receptacle for soiled dressings
- ✓ Adhesive tape (Ether or acetone for removal or gum from adhesive tape)
- ✓ Marked Red Bio-Hazard bags
- ✓ Abdominal pads
- ✓ Sterile dressings
- ✓ Tongue blade applicator
- ✓ Sterile saline or water according to hospital policy
- ✓ Water proof pads (incontinent pads)\bath blanket

IMPLEMENTATION / PROCEDURE

- 1 Follow steps 1-4 as established by protocol
- 2 Check physicians orders for type of dressing
- 3 Fold cuff of biohazard bag and place in receptacle positioning on working area
- 4 Don disposable gloves
- 5 Gently loosen tape on dressings and remove

- 6 If dressings appears adherent, apply sterile saline or water to moisten dressing
- 7 Remove gloves and place in biohazard bag
- 8 Wash Hands
- 9 Prepare sterile field
- 10 Ensure availability of sterile dressings
- 11 Pour dressing solution into sterile receptacle
- 12 Wash hands. Don sterile gloves
- 13 Moisten sterile dressings or swabs and cleanse wound from inside out (depending on location of wound cleanse from top to bottom)
- 14 Use a new swab for each cleaning motion (ensure outside of wound is cleaned)
- 15 Use gauze/swab to dry wound using same motion as cleaning. Inspect wound
- 16 Apply dressing as prescribed by Physician
- 17 Apply layer of dry sterile dressings (if abdominal wound apply abdominal pad)
- 18 Apply adhesive/ bandage
- 19 Remove trolley/soiled dressings/instruments
- 20 Wash hands
- 21 Reposition patient
- 22 Document procedure and observation
- 23 Report findings

20.2 WET/DRY DRESSINGS

EQUIPMENT

- ✓ Sterile/Disposable gloves
- ✓ Sterile dressings
- ✓ Sterile drapes
- ✓ Sterile solution (normal saline)
- ✓ Incontinent pads
- ✓ Sterile solution as ordered by doctor
- ✓ Adhesive tape/adhesive tape remover (optional)
- ✓ Cotton bandages
- ✓ Face mask
- ✓ Biohazard bag

IMPLEMENTATION

1. Ensure privacy
2. Explain procedure
3. Make cuff of biohazard bag and place within easy reach
4. Wash hands thoroughly
5. Don mask
6. Put on water proof gown (if available) or apron
7. Don gloves
8. Remove tape and bandages
9. With gloved hand remove soiled dressing (if adhesive remove gently)
10. Observe character of drainage on dressing and inspect wound
11. Dispose soiled dressings into biohazard bag
12. Remove glove by putting them inside out and dispose
13. Wash hands
14. Prepare sterile dressing supplies
15. Pour prescribed solution onto gauze

16. Don sterile gloves
17. Clean wound with prescribed solution
18. Clean from least to most contaminated area (from inside out)
19. Apply moist gauze directly to wound in a single layer ensuring all surfaces are covered
20. Apply dry gauze over wet gauze, using sofratulle gauze when needed
21. Apply tape over dressings
22. Roll gauze for circumferential dressings
23. Remove and dispose of gloves, cover gown or apron and mask
24. Assist patient to comfortable position
25. Wash hands
26. Document and report

20.3 WOUND INSPECTION

1. To determine if enough healing has occurred
2. Use sterile scissors to cut sutures, if the side opposite the knot is pulled, the knot will pull through the incision possible causing it to tear incision and increase patients discomfort
3. With sterile forceps remove suture by pulling it on the same side of the knot

20.4 INTERRUPTED SUTURE REMOVAL

1. Place gauze from suture line
2. Use dominant hand to hold scissors and non-dominant hand to hold forceps
3. Cut suture close to skin surface and end distal to knot
4. Gently lift end of suture from skin
5. Grasp knotted end with forceps and remove with a continuous action
6. Place sutures removed on gauze and continue repeating procedure.

20.5 CONTINUOUS SUTURE REMOVAL

1. Follow steps 1 and 2 in intermittent sutures
2. Cut 2nd suture on same side and repeat procedure as previously indicated
3. Clean wound after suture removal
4. Apply light dressing
5. Discard gloves and used equipment
6. Document and report observation

20.6 STAPLE REMOVAL

This is done according to manufactures recommendation and specific protocol of institution

1. Slip staple remover under staple, press down centre piece between two ends, bend staple down in middle. Force sides of staples up, prongs of staples will be straightened. Staples are easily pulled out without injuring patient.
2. Apply narrow sterile adhesive skin closures to wound after staples or skin suture has been removed.
3. Apply adhesive (tincture of Benzoin) to skin around incision where steristrip will be placed. Strips are applied from one side of incision to the other with a slight pulling as strip is pulled.

NB: Tub bath is not advised

SUTURE / STAPLE REMOVAL

OBJECTIVES

1. To prevent suture adhesion
2. To promote comfort
3. Ensure adequate wound healing progression

EQUIPMENT/SUPPLIES

Sterile suture set pre packed (Suture Scissors, Tooth and non tooth dissecting forceps)

Sterile drapes/ circum towel

Sterile gloves

Receiver for soiled dressings

Steri-strip

Bio- Hazard bags

Staple Remover

Alcohol Swabs/ Gallipot

Incontinent Pad

NB:

1. Staples are usually removed seven to ten (7 – 10) days after surgery
2. Sutures are usually removed nine (9) days

PROCEDURE / IMPLEMENTATION SUTURE/STAPLE REMOVAL

1. Provide privacy
2. Explain procedure to patient
3. Position patient
4. Place cuffed disposal bag within easy reach
5. Prepare sterile field
6. Don gloves (disposable) to remove dressing and discard same after
7. Wash hands
8. Don sterile gloves
9. Clean suture/staple area with antiseptic swab

21.0 DONNING OF STERILE GOWN AND GLOVES

EQUIPMENT

Package of proper sized sterile gloves

Package of sterile proper sized gowns

PROCEDURE/IMPLEMENTATION

- 1 Have circulating nurse prepare/opening package of sterile gown and gloves
- 2 Pick up sterile gown grasping the inside surface of gown at the arm/neck.
- 3 Lift folded gown directly upwards and step back away from table
- 4 Holding folded gown locate neck bands with both hands, grasp inside front of gown just below neck band
- 5 Hold gown at arms length away from your body allowing gown to unfold
- 6 Keep inside of gown towards body, with hands at shoulder level and slip both arms into arm holes simultaneously
- 7 Ask circulating nurse to bring gown over shoulder by reaching inside of arm seam
- 8 Gown is pulled over and tied at the back not touching sterile gown
- 9 Ensure gown's sleeves are covering hands

DONNING OF STERILE GLOVES

PROCEDURE /IMPLEMENTATION

- 1 With hands covered by gown sleeves, open inner sterile package
- 2 With none dominant hand, inside of gown cuff, pick up gloves for the dominant hand by grasping folded glove cuff
- 3 Extend dominant forearm with palm up and place palm of glove against palm of dominant hand

- 4 With fingers pointing towards elbow grasp back of glove cuff with dominant hand and turn glove cuff over end of dominant hand and gown cuff
- 5 Grasp top of glove and under lining glove sleeve with over non-dominant hand carefully extend fingers into gloves
- 6 Ensuring that glove cuff covers gown cuff
- 7 Glove non-dominant hand in same manner reversing hands
- 8 Ensure fingers are fully extended into gloves
- 9 For wrapped around sterile gown take gloved hands and release fastener/ties in front of gown.

22.0 FEEDING PATIENTS

OBJECTIVES:

1. To ensure the adequate intake of nutrients to patients who are unable to feed themselves

EQUIPMENT

Napkin/towel

Meal tray

Prescribed meal

Utensils - Cup or feeding cup, dishes, spoon (appropriate size for patient)

Glass /Jug with water

PROCEDURE:

Inform the patient of intent to feed

Position the patient comfortably

Minimize unpleasant sight and odours

Wash hands

Prepare tray and take to patient's bedside

Nurse/attendant sits or stands beside patient

Position napkin or towel under chin

LIQUID FEED-

Check temperature of liquid

Slightly elevate patient's head

Offer feed slowly from appropriate cup, straw, spoon

SOLIDS:

Offer small amounts on a spoon or fork

Serve food at acceptable temperature

Allow patient to chew and swallow food before more is given

Allow patient to breathe between mouthfuls

Offer fluids at the completion of solids

Perform oral hygiene/offer mouth wash

Remove tray and utensils

Make patient comfortable

Record type and amount of food taken and report to nurse in charge

22.2 MOUTH CARE (ORAL HYGIENE)

Definition: Mouth care is the care given to the patient to maintain oral hygiene

OBJECTIVES:

1. To reduce bacterial count
2. Prevent dental caries
3. To facilitate proper nutrition
4. To promote the patient's comfort and nutritional intake
5. To enhance the patient's feeling of well-being/
attractiveness

EQUIPMENT/SUPPLIES:

Tray containing:

Emesis basin

1 artery forcep

1 dissecting forcep

1 gallipot for antiseptic solution

Denture cup (if patient wears dentures)

Receiver for soiled swabs

Normal saline or fluoride mouth wash or toothpaste

Towel

Gauze squares

Lubricant / Orange sticks

Cotton swabs

Tongue spatula

Mouth gag (for unconscious patients)

PROCEDURE

1. Wash hands
2. Clean trolley

3. Assemble all equipment/supplies
4. Explain procedure to patient and obtain consent
5. Ensure privacy
6. Wash hands
7. Don gloves
8. Position patient
9. Place towel and incontinent pad to protect bed linen
10. Remove dentures (if present)
11. Position swabs firmly in artery forcep (lock forcep)
12. Moisten swab thoroughly in appropriate solution
13. Clean teeth with an up and down movement
14. Clean gums, mucous membrane of cheek, tongue and roof of mouth
15. Use tooth brush to remove particles from between teeth
16. Use each swab once
17. Moisten lips with lubricant
18. Make patient comfortable Clear equipment
19. Wash hands
20. Record observation and action, report to nurse in-charge

NB: Dentures to be brushed under running water

The use of toothbrush and mouth washes should be encouraged as appropriate

CARE OF DENTURES

EQUIPMENT/SUPPLIES

Gloves

Disposable tissue or gauze square

Labelled denture container & lid

Wash cloth

Tooth brush

Denture cleaner

Tap water

Mouth wash

Emesis basin

Towel

PROCEDURE

1. Wash hands
2. Explain procedure to patient obtain consent
3. Gather equipment and supplies
4. Ensure privacy
5. Position patient in upright or lateral position
6. Don gloves
7. Assist patient with removal of dentures or when possible encourage patient to remove own dentures; if patient is unable, use a gauze square to grasp the upper plate with your thumb and index finger, gently move the denture up and down, try to grasp the gum and not the individual teeth, place in labeled container
8. Remove the lower plate from the mouth by turning it to a slight angle, place it in the labeled container
9. Carry the denture container carefully to the sink or emesis basin
10. Place a wash cloth in the bottom of the sink or emesis basin
11. Fill the sink or emesis basin with water
12. Pick up the dentures, one plate at a time
13. Brush all surfaces of dentures with denture cleaner
14. Rinse the denture with cool to lukewarm water
15. If dentures are stained, soak in commercial cleaner or substitute (bleach or vinegar), NB: to prevent corrosion, dentures with metal parts should not be soaked overnight
16. Observe dentures for any rough sharp or worn areas that could irritate the tongue or mucous membranes of mouth, lips and gums
17. Inspect mucosa of mouth for redness and irritation
18. Assist the patient to rinse his/her mouth with mouth wash
19. Apply denture adhesive if the patient request
20. Encourage patient to replace dentures, if unable insert dentures one plate at a time, holding at a slight angle while inserting
21. Press gently to seat the plate in the adhesive
22. Wipe patient's mouth and chin
NB if patient choose not to wear or is unable to wear dentures store in a labeled covered container with water
23. Remove and discard gloves
24. Clear equipment
25. Wash hands
26. Document in patient notes and report to nurse in charge

SPECIAL MOUTH CARE THE DEPENDENT PATIENT

OBJECTIVES:

1. To maintain the integrity of the lips, tongue and mucous membrane of the mouth
2. To prevent oral infections
3. To clean and moisten the membranes of the mouth and lips

EQUIPMENT/SUPPLIES

Towel

Water proof pad

Emesis basin

Gloves

Tongue blade/spatula

Artery forcep

Water

Normal saline

Mouth wash

Hydrogen peroxide (according to institutional policy)

Water soluble lubricant (e.g. glycerin or petroleum jelly)

Suction catheter & suction apparatus (optional)

Rubber tipped bulb syringe

PROCEDURE

1. Wash hands
2. Explain procedure to patient and obtain consent
3. Ensure privacy
4. Gather equipment/supplies
5. Position the unconscious patient in lateral position with head lowered
6. Place towel under the patient's chin

7. Place curved basin against the chin and chest to receive fluid from mouth
8. Don gloves
9. If natural teeth, clean teeth and rinse mouth
10. If dentures remove and put in labeled receptacle
11. Open the patient's mouth, insert the padded tongue blade between the patient's back molar; NB: Never insert finger into the patient's mouth
12. Dip a padded tongue blade or soft tooth brush in water or mouth wash, move the padded blade or tooth brush back and forth across all the tooth surfaces and chewing areas
13. Cleanse roof of the mouth and inner cheek area
14. Cleanse gum and tongue
15. Rinse the mouth using a locked padded artery forcep moistened in water using an irrigating syringe instill a small amount of water into the mouth
16. Suction the mouth if all fluid does not drain out
17. Wipe the patient's mouth
18. Observe mouth closely for inflammation and dryness
19. Apply water lubricant e.g. glycerin to lips
20. Re-position comfortably in bed
21. Discard gloves
22. Remove equipment
23. Wash hands
24. Record in patient notes and report to nurse-in-charge

22.5 NASO-GASTRIC TUBE FEEDING

OBJECTIVES:

1. To Maintain nutritional, fluid and electrolyte balance of patients who are unable to ingest adequate nutrients orally.
2. To control gastro-intestinal disturbances

EQUIPMENT

Naso-gastric tube in situ

Syringe (connector if necessary)

Feeding bag

Glass/container with water

Thermometer to test temperature of the feed

The Prepared liquid standing in a bowl of warm water or place (hot/cold)water as required in pouch of feeding bag

Towel and mackintosh/face towel to protect patients clothing

Gauze swabs

Adhesive tape

PROCEDURE:

1. Wash hands
2. Collect and assemble equipment
3. Inform patient
4. Ensure privacy
5. Position patient with head elevated (unless contraindicated by the doctor)
6. Attach syringe to end of feeding tube
7. Aspirate for gastric contents
8. Return all gastric aspirate unless otherwise ordered
9. Disconnect syringe from naso gastric tube (NGT)

10. If feeding with syringe remove plunger from barrel of syringe or attach feeding bag to NGT
11. Reconnect barrel of syringe to naso gastric tube
12. Pour warm feed into syringe or bag allowing no air to enter
13. Hold syringe between 6' – 12' above the nose
14. Allow the ordered volume of feed to (run) flow in slowly by gravity
15. Instill approximately 100mls of water into tube after tube feeding
16. Clamp/spigot nasogastric tube
17. Remove syringe or bag from the tube
18. Wash with warm water
19. Keep patient's head elevated for at least 30 minutes after feeding
(unless contra-indicated by doctor)
20. Make patient comfortable
21. Clear equipment
22. Wash hands
23. Record observation and action and report to charge nurse

23.0 FOOT CARE

OBJECTIVES:

1. To maintain the skin integrity of the feet
2. To prevent foot infections
3. To prevent foot odours
4. To assess or monitor foot problems

EQUIPMENT/SUPPLIES

Large basin

Warm water (approx. 35 – 37 degree centigrade/95 – 100 degree fahrenheit)

Towels

Plastic or protective covering for bed

Soap

Wash cloth

Lotion or foot powder

Toe-nail cleaning and trimming equipment

Gloves

Commercially prepared salts such as Epsom salts or other solution as ordered

Foot brush

Bath thermometer

PROCEDURE

1. Explain procedure to patient and obtain consent
2. Wash hands
3. Gather equipment and supplies
4. Ensure privacy
5. Position patient to a comfortable upright position with feet uncovered or if too weak allow to recline in bed with head of bed elevated
6. Place protective pad on bed or floor
7. Mix required solution of warm water in the basin and place on the protected bed or floor

8. Place both feet in basin allow to soak for 10-20 minutes
9. Gently brush under foot to remove dead skin (if present)
10. Dry feet thoroughly with a blotting or patting motion
11. Dry between each toe
12. If the bath is non-medicinal, apply lotion and gently massage each foot
13. Apply foot powder if patient prefers
14. If agency policy allows it – trim patient nails
15. Carefully observe skin integrity while drying (e.g. for corns, calluses or other abnormal conditions
16. Remove equipment
17. Remove gloves
18. Wash hands
19. Document and report to nurse-in-charge

24.0 INCIDENCE REPORTING

OBJECTIVE

1. To inform relevant authorities of incidents occurring within the department/unit
2. To assist nursing staff in identifying risk
3. To develop and implement strategies to prevent repeated incidence

EQUIPMENT

Incident Report Form

IMPLEMENTATION

- 1 Assess extent of injury to patient or others and inform physician immediately
- 2 Be observant, note sequence of events
- 3 Document time, type and nature of incident
- 4 Indicate contributing factors if incident involves an injury take steps to restore individuals safety
- 5 If staff member or visitor sustain injury refer to emergency department immediately
- 6 Complete incident report form
- 7 Document events in patients' chart
- 8 Implement ordered treatment if patient is injured

Incidence Report should not be stored in patients' notes (patients charts are legally recoverable and can be used in a court of law)

25.0 INSTALLATION OF INTRAVENOUS THERAPY

OBJECTIVES:

1. To facilitate an adequate intake of fluid and electrolyte in situations where oral or nasogastric intubation are hazardous or ineffective
2. To provide supplement for patients with large electrolyte losses e.g. burns
3. To enable the digestive tract to rest
4. To facilitate the administration of medication

INSTRUMENTS & SUPPLIES:

Sterile intracath of appropriate size

Sterile administration set

Bottle/bag of solution (prescribed)

Heplock

Drip stand (if required)

Rubber tourniquet

Gauze squares

Alcohol swabs

Adhesive tape

Disposable Gloves

Arm board/splint

Bandage

Mackintosh and towel

Receiver for soiled swabs

Receiver for sharps

IV Flush (if required)

PROCEDURE

To be performed by a person qualified to do the procedure

Wash hands

Explain procedure to patient

Ensure privacy

Position patient

Provide adequate lighting

Don gloves

Identify suitable site

Apply tourniquet

Swab area

Remove intracath from package

Insert catheter into selected vein with bevel upwards

Observe for back flow of blood

Remove stylet (inner cannula) gradually while advancing catheter

Loosen tourniquet

Anchor catheter with adhesive

Attach IV line or heplock

Secure line or heplock

Regulate rate of flow

Confirm that solution is infusing at ordered rate

Make the patient comfortable

Remove equipment

Wash hands

Record volume and type of solution on intake and output chart

Record observation and action and report to nurse in charge (if necessary)

25.1 ASSISTING WITH INSTALLATION OF INTRAVENOUS THERAPY

OBJECTIVES:

5. To facilitate an adequate intake of fluid and electrolyte in situations where oral or nasogastric intubation are hazardous or ineffective
6. To provide supplement for patients with large electrolyte losses e.g. burns
7. To enable the digestive tract to rest
8. To facilitate the administration of medication

PROCEDURE:

The nurse assisting –

Wash hands

Ensure privacy

Position patient

Provide adequate lighting

After venipuncture:-

Secure intracaths in place

Assist to regulate rate of flow

Confirm that solution is infusing at ordered rate

Make the patient comfortable

Remove equipment

Wash hands

Record volume and type of solution on intake and output chart

Record observation and action and report to nurse in charge (if necessary)

26.0 NASOGASTRIC TUBE INSERTION

OBJECTIVES

1. To remove fluid and gas from stomach
2. To determine the amount of pressure and motor activity in the stomach (Diagnostic studies)
3. To treat patients with mechanical obstruction and bleeding within the upper alimentary tract
4. To administer medications and feeding (gavage) directly into stomach
5. To obtain a specimen of gastric contents for laboratory studies
6. To lavage (wash) the stomach in case of poisoning or overdose of medication
7. To establish a means for suctioning stomach contents to prevent gastric distention, nausea and vomiting.

EQUIPMENT

Gloves
Nasogastric tube
Water soluble substance (K-Y Jelly)
Protective towel for patients
Emesis basin
Litmus paper
Clamp or spigot for tubing (optional)
Non-allergic tape/adhesive tape
Rubber band aid/ safety pins
Sterile swabs/alcohol swabs
Tissues/paper towel
Flashlight
Stethoscope
Glass of water
20-60 ml catheter tip syringe
Suction apparatus
Tube feeding equipment
Specimen container

NB: Two persons may be needed for insertion. One person to assist patient with positioning, holding the glass of water (if allowed) and giving encouragement

PROCEDURE / IMPLEMENTATION

1. Check Physician Orders to determine the type ,size and purpose of tube
2. Identify patient
3. Set up tube feeding/suction equipment and test to ensure proper functioning
4. Explain procedure to patient
5. Wash hands, don gloves, position patient in high fowlers
6. Place clean towel over patient chest
7. Measure length of tube that will be needed to reach the stomach
8. Measure from tip of patient's nose to ear lobe and to the tip of the sternum
9. Wipe patient's nose and face with damp wash cloth (NB: It may be necessary to wipe the outside of the nose with alcohol wipes) and cover eyes with small dry towel (to prevent spills from entering the eye)
10. Select nostril that have greater air flow
11. Apply water soluble lubricant to 4-8 inches of tube
12. Insert tube with natural curve towards patient into the selected nostril
13. Ask patient to flex head forward
14. Tilt tip of nose upwards and insert tube gently into nose to as far as the back of the throat, guide tube straight back. When tube reaches nasopharynx stop briefly and have patient lower head slightly
15. Have assistant hold glass of water
16. Ask patient to swallow as the tube is advanced 2-4 inches or 5-10 cms until indicted length is inserted
17. Encourage patient to breathe through their mouth
18. If coughing, persistent gagging , dyspnoea occurs remove tube immediately
19. If obstruction, remove tube and try next nostril (repeat # 12-17)
20. Place a temporary piece of tape across nose and tube for anchorage
21. Check back of patient's throat to ensure tube is not coiled at the back of the throat
22. Check tube for correct placement by using any of the following:
 - (a) Aspirate stomach content
 - (b) Check PH of aspirated content
 - (c) Insert 30 mls of air into stomach and listen with stethoscope for "rush" of air into stomach
 - (d) Place end of tube into glass of water and watch for the appearance of air bubbles.
23. Once stomach placement has been confirmed; secure tube with tape

24. Document time of tube insertion, means used to determine correct placement and patient's response.

26.1 INSERTION OF NASOGASTRIC TUBE IN INFANT

1. For infant and young children restrain
2. Place infant in an infant seat or roll sheet/towel/pillow under head and shoulder
3. Obstruct one (1) nare with one finger and feel for air passage in other nare (to determine greater air flow)

MEASUREMENT

Measure tubing from tip of nose to tip of earlobe and then to the point midway between umbilicus and xiphoid

Do not hyperextend or hyper flex neck of an infant (as same would occlude airway)

Tape tube between end of nose and upper lip as well as the cheek

PROCEDURE

Refer to procedure as for the adults

26.2 CARE OF NASOGASTRIC TUBE

1. Inspect patient's nostrils daily for discharge and irritation
2. Clean nostril with moistened cotton tip applicator/cotton swab
3. If nostril appears dry/crusted apply water-soluble lubricant to nostril and change adhesive tape as required
4. Maintain oral hygiene frequently

26.3 IRRIGATION OF NASOGASTRIC TUBE

EQUIPMENT

Irrigation set/tray

Disposable gloves

Room temperature tap water or normal saline (NACL)

Stethoscope

Disposable incontinent pads/bath towel

Clamps

PROCEDURE

1. Wash hands
2. Don gloves (sterile technique is not applicable)
3. Pour ordered solution into irrigation bottle (30-60 mls)
4. Disconnect N.G. tube from suction and check to ensure its in the stomach
5. Use stethoscope to listen to gurgling sound when 10-15 mls of air are injected rapidly
6. Slowly introduce solution using specified irrigation syringe
7. Do not use excessive force

8. Reconnect tube to low or intermediate continuous or intermittent suction as ordered
9. Tube should remain patent without putting undue stress due to suction on the gastric mucosa
10. Note the amount, colour and consistency of drainage
11. Note amount of fluid instilled or aspirated on intake and output chart

27.0 PERITONEAL DIALYSIS

OBEJECTIVES:

1. Aid in the removal of toxic substances and metabolic waste
2. Establish electrolyte balance
3. Remove excessive body fluid
4. Assist in regulating the fluid balance of the body
5. Control blood pressure
6. Control severe, intractable heart failure where diuretics no longer promote elimination of water and sodium

EQUIPMENT/SUPPLIES

- ✓ Dialysis administration set
- ✓ Disposable system- closed
- ✓ Peritoneal dialysis solution as requested
- ✓ Peritoneal catheter
- ✓ Supplemental drugs as requested
- ✓ Local anaesthetic (if required)
- ✓ 3ml Syringe with 25G needle
- ✓ Central venous pressure monitoring equipment
- ✓ ECG Machine
- ✓ Suture set
- ✓ Sterile gloves
- ✓ Skin antiseptic povidone iodine solution
- ✓ Alcohol swabs
- ✓ Scalpel
- ✓ Gauze sponge
- ✓ Sterile drape
- ✓ Trocar
- ✓ Non –allergic tape
- ✓ Sterile cap gown and mask
- ✓ Peritoneal dialysis flow sheet
- ✓ IV pole/stand
- ✓ The following is a brief summary of the method of insertion of a temporary peritoneal catheter which is done with strict aseptic technique.

PROCEDURE:

Performed by the Doctor

1. The abdomen is prepared surgically, and skin and subcutaneous tissue are infiltrated with local anaesthetic
2. A small midline stab wound is made below the umbilicus
3. The trocar is inserted through the incision with stylet in place, or a thin stylet cannula may be inserted percutaneously
4. The patient is requested to raise his head from **km??** the pillow after the trocar is introduced
5. When the peritoneum is punctured, the trocar is directed to the left side of the pelvis, the stylet is removed, the catheter is inserted through the trocar and maneuvered into position
6. After the trocar is removed, skin maybe closed with a purse string suture, a sterile dressing is placed around the catheter or a clear transparent occlusive dressing
7. Attach the catheter connector to the administration set
8. Drugs are added in advance
9. Allow the dialysis solution to flow unrestricted into the peritoneal cavity (takes 5-10 minutes for completion) if the patient experiences pain slow down the drip
10. Allow the fluid to remain in the peritoneal cavity for 15 minutes to four hours. Prepare the next exchange while the fluid is in the peritoneal cavity.

NURSING ACTION:

11. Unclamp the outflow tube. Drainage should take approximately 10 – 20 minutes although the time varies with each patient
12. If the fluid is not draining properly, move the patient from side to side to facilitate the removal of peritoneal drainage. The head of the bed may also be elevated. Ascertain if the catheter is patent, Check for closed clamp, kinked tubing or air lock, never push the catheter in.
13. When the out flow drainage cease to run, clamp off the drainage tube and infuse the exchange using strict aseptic technique.
14. Check B/P and pulse every 15 minutes during the first exchange and every 4 hours thereafter. Monitor the heart rate for signs of arrhythmia
15. Take the temperature every (4) four hours.
16. The procedure is repeated until the blood chemistry level is improved. The usual duration for short term dialysis is 36 – 48 hours. Depending on the patient condition he will receive 24- 48 exchanges

17. Keep an exact record of the patient's fluid balance during the treatment
 - a. Know the status of the patient loss or gain of fluid at the end of each exchange. Check dressing for leakage and weigh in grams if significant
 - b. The fluid should be about even or should show slight fluid loss or gain, depending on the patient fluid status.
18. Promote patient comfort during dialysis
 - a. Provide frequent back care and massage pressure areas
 - b. Have the patient turn from side to side
 - c. Elevate head of bed at intervals
 - d. Allow the patient to sit in chair for brief periods if condition permits.
19. Observe for the following:
 - a. respiratory difficulty
 1. Slow the in-flow rate
 2. Make sure the tubing is not kinked
 3. Prevent air from entering the peritoneal by keeping drip chamber of tubing $\frac{3}{4}$ (3 fourths) full of fluid
 4. Elevate head of bed, encourage coughing and breathing exercises
 5. Turn patient from side to side
 - b. Abdominal pain:
 1. Encourage the patient to move about
 - c. Leakage:
 1. Change the dressings frequently being careful not to dislodge the catheter
 2. Use sterile plastic/waterproof drapes to prevent contamination
20. Keep accurate records:
 - a. Exact time of beginning and end of each exchange; starting and finishing time of each drainage
 - b. Amount of solution infused and recovered
 - c. Fluid Balance Charting
 - d. No. of exchanges
 - e. Medication added to dialyzing solution
 - f. Pre and post dialysis weight plus daily weight
 - g. Level of responsiveness at beginning, throughout and end of treatment
 - h. Assessment of vital signs (body temperature) denotes the presence or absence of infection
 - i. Measure the abdominal girth an increase abdominal girth indicates fluid retention

- j. Assess patient's condition
- 21. Prepare the patient emotionally and physically for the procedure
- 22. See that the consent form has been signed
- 23. Weigh the patient before dialysis and every 24 hours thereafter preferably on a bed scale
- 24. Take TPR and B/P before dialysis
- 25. Have the patient empty bladder. if patient is producing urine and does not have a foleys in place, catheterize with a straight catheter, (this reduces the risk of bladder puncture)
- 26. An enema can be given to clear the colon this reduces the bowel perforation
- 27. Wash hands
- 28. Ensure privacy
- 29. Arrange equipment by bedside
- 30. Administer analgesics and anti-anxiety medication if required as ordered by the physician
- 31. Assist with insertion of CVP catheter, ECG monitoring may also be required
- 32. Flush the tubing with dialysis fluid
- 33. Make the patient comfortable in a supine position
- 34. Clear bedding from umbilical region
- 35. The physician and nurse complete sterile scrubs and don sterile caps mask and gowns
- 36. Physician follows procedure insert catheter into peritoneal cavity
- 37. Have the patient and health care personnel wear mask
- 38. Vital signs should be monitored every 15 minutes during the procedure
- 39. When complete clear equipment
- 40. Wash hands and dispose of contaminated supplies according to hospital policy
- 41. Document in patient notes (colour of drainage, temperature and status of catheter site and dressing)

NB: This can be a medical procedure or be designated to nurse in specialized units.

28.0 POST-MORTEM CARE (LAST OFFICES)

OBJECTIVES

To maintain the anatomical features of the patient's body until transferred to the mortuary/undertaker

EQUIPMENT

Water
Disposable gloves
Soap
Gowns and other protective clothing
Wash cloth/wash rags
Towel/small pillow
Comb/hair brush
Nail scissors
Moist swabs to cleanse orifices
Cotton wool to plug orifices
Artery forceps
Dissecting forceps
Shroud kit
Label for identification
Notification of death forms
Adhesive tape

PROCEDURE

- 1 Secure identification label on wrist/abdomen
- 2 Wrap body in mortuary sheet and pin identification label on sheet
- 3 Cover body with sheet
- 4 Clear equipment
- 5 Complete records
- 6 Check records and secure personal belongings
- 7 Submit notification of death forms to appropriate personnel
- 8 Transfer body on trolley to mortuary
- 9 Clean bed and other equipment

28.1 MORTUARY SHEETS

EQUIPMENT

Dressings and strapping if required
Container for soiled instruments
Bin for soiled dressings
Razor to shave males
Safety pins
Plastic bags for hazardous waste disposal
Absorbent pads
Paper bag/plastic bag/other suitable receptacle for patient's clothes/belongings and other items to return to family
Valuables envelopes

IMPLEMENTATION

- 1 Wash hands
- 2 Don gloves/gown
- 3 Screen bed
- 4 Notify supervisor
- 5 Inform doctor
- 6 Inform relatives as appropriate
- 7 Position body in correct anatomical position: - supine position
Arms alongside body
Palms down
Head on one pillow
- 8 Insert dentures and eye prosthesis of appropriate then close eye lids
- 9 Close mouth lip
- 10 Remove all valuable
- 11 Allow one (1) hour to elapse after death before performing last offices
- 12 Bathe body
- 13 Dress wound if appropriate
- 14 Remove drains and tubes
- 15 Pack orifices e.g. Rectum, vagina, nostril (avoid altering shape)
- 16 Shave the face of males if appropriate
- 17 Cut and clean toe and finger nail
- 18 Dress in shroud/mortuary gowns
- 19 Comb hair
- 20 Position body straight, arms alongside, eyes and mouth closed

29.0 POST OPERATIVE NURSING CARE

OBJECTIVE:

- 1) To ensure patient safety and comfort during the immediate post-operative period and the remainder of their hospital stay.
- 2) To prevent post-operative discomfort and complications as much as possible.

RECOVERY ROOM

EQUIPMENT:

1. Pulse Oximeter/Monitor.
2. Stethoscope.
3. Thermometer.
4. Sphygmomanometer.
5. I.V Drip stand.
6. Oxygen equipment. Example: Mask/cannular, tubing and oxygen regulator.
7. Suction equipment.
8. Dressing supplies.
9. Incontinent pads.
10. Equipment for oral hygiene (toothpaste, toothbrush, dental floss, normal saline or fluoride mouth wash and glass with water).
11. Gloves (surgical / disposable)
12. Other required items (emesis bowls, kidney dishes, spatulas etc.)
13. Equipment for physical assessment.

WARD

14. Stethoscope.
15. Pulse Oximeter.
16. Thermometer.
17. Sphygmomanometer.
18. I.V Drip stand.
19. Oxygen equipment. Example - mask/cannula, tubing and oxygen regulator.
20. Suction equipment.
21. Dressing supplies.
22. Emesis basin.
23. Wash cloth and towel.
24. Incontinent pads.
25. Equipment for oral hygiene (toothpaste, toothbrush, dental floss, normal saline or fluoride mouth wash and glass with water).
26. Gloves (surgical / disposable).
27. Pillow
28. Facial tissue
29. Intermittent suction to connect nasogastric or wound drainage tubes
30. Orthopaedic appliances (if required)

Implementation:

IMMEDIATE RECOVERY PERIOD

All equipment should be checked and prepared prior to receiving patients

1. Wash hands.
2. Attach monitors
3. Attach oxygen tubing to regulator.
4. Hang IV fluid and check IV flow rate.
5. Conduct complete assessment (vital signs, physical assessment)
6. Assessment should be done every fifteen minutes or more frequently until patient is stabilized.
7. Dorn gloves
8. Connect any drainage tube if present/required.
9. Position patient: Place small folded towel under patient head or elevate head slightly and turn to side if in supine position.
10. Document findings accurately
11. Suction artificial airway and oral cavity as required.
12. Once gag reflexes returns remove patient's airway.
13. Encourage patient to cough and deep breath on awaking.
14. Use moderate tone of voice to call patient by name, if patient does not respond arouse patient by gently touching or moving a body part.

NB: 1:1 nursing care may be required depending on the nature of clients' surgery, preexisting medical conditions, and the onset of complications.

30.0 Postural Drainage, Percussion and Vibration

Objectives:

- 1) To utilize the force of gravity to assist in the removal of bronchial secretion from the affected bronchioles and trachea by means of expectoration.
- 2) To dislodge mucus adhering to the bronchioles and bronchi.
- 3) To help mobilize secretion and to prevent respiratory complications.
- 4) To obtain a specimen of sputum for laboratory investigation.

Equipment:

Pillow or other positioning aid.

Sputum cup.

Stethoscope.

Equipment for oral hygiene

Specimen container (if required)

Tissues

Implementation:

30.1 Postural drainage

- 1 Explain procedure to patient
- 2 Gather needed equipment
- 3 Position patient as described below
- 4 Identify specific segments of lung to be drained
- 5 Drain upper lobes -
 - a Have patient sit upright if possible
 - b Have patient lean (45° angle) to right for five (5) minutes
 - c Have patient lean left (45° angle) for five (5) minutes
 - d Have patient lean forward (45° angle) for five (5) minutes
 - e Have patient lean back (30° – 40° angle) for five (5) minutes
 - f Have patient lie on abdomen, back and side, while horizontal.
- 6 Drain lower lobes
 - a place patient in bed
 - b use pillows or bed controls to elevate hips higher than (head should be about 30°-40° below horizontal angle)
 - c have patient lie in each position for five (5) minutes breathing deeply
 - d on left side with shoulders perpendicular to bed
 - e on left side with shoulders slanted backward to 40° angle from bed
 - f on right side with shoulders slanted backwards at a 45° angle from bed
 - g on right side with shoulders perpendicular to bed
 - h on abdomen with head turned to side
 - i while still on abdomen have patient cough to raise secretions
 - j return patient to comfortable position
 - k observe effect of procedure on patient
- 7 offer oral hygiene
- 8 allow patient to rest
- 9 chart appropriately

30.2 **PERCUSSION**

- 1 Place patient in appropriate position for postural drainage
- 2 Use cupped hands
- 3 Clap rapidly over area being drained
- 4 Return patient to comfortable position
- 5 Observe effect to procedure on patient
- 6 Offer oral hygiene
- 7 Allow patient to rest
- 8 Chart appropriately

30.3 VIBRATION

- 1 Place patient in appropriate positions for postural drainage
- 2 Use flat hands placed firmly against chest wall
- 3 Vibrate hands against chest while patient exhales

Proceed as above (steps 6 – 9)

31.0 RECORDING (CHARTING)

A record is a written, formal, legal documentation of a patient's progress.

Recording or charting is the process of making an entry on a patient record.

OBJECTIVES

1. To provide a comprehensive account of health status, needs and care given to patient.
2. To facilitate communication, educational assessment, research, auditing, financial billing and legal documentation.
3. To monitor patient's response to therapy

EQUIPMENT:

1. Admission/Discharge Summary Form
2. Flow sheets
 - a) Medical History/ Physical Examination form
 - b) Physician Orders
 - c) Progress Notes
 - d) Nurses Notes
 - e) Graphic chart
 - f) Medication Chart
 - g) Diabetic Chart
 - h) Blood Pressure Chart
 - i) Pre Operative Checklist
 - j) ICU Chart (for use in ICU)
 - k) Mental Status Assessment Chart (for use in Psychiatry)
 - l) Intake Output Chart
 - m) Head Injury Chart (ICU, Pediatrics Male and female surgical Units if required)
 - n) Feed chart (if required)
 - o) Diagnostic Reports
 - p) Patient's discharge report and discharge summary
 - q) Referrals consultation records/report
 - r) Any other Chart as required
 - s) Pen
 - t) Computer

GUIDELINES FOR CHARTING:

1. Document observation accurately and in sequence with a dark colored ink pen.
2. Be specific.
3. Use direct quotes.
4. Documentation must be complete, clear, concise, consistent and legible.
5. Record all relevant information in a timely manner.
6. Respect confidentiality.
7. Do not leave vacant line in the health records: if one is left between entries, draw a line and affix signature at the end to close entry.
8. Use standard terminology (Abbreviation and terms).
9. Affix signature at all entries (Include name and designation).
10. Reporting unusual findings to nurse in charge.

Do not use correction fluids on patient health records because it is illegal. If an error is made in documenting, cross out incorrect statement with a single line and write error and initial.

32.0 REMOVAL OF FAECAL IMPACTION (MANUAL REMOVAL OF IMPACTED FAECES)

Definition: Fecal impaction is a mass or collection of hardened putty-like faeces in the folds of the rectum that maybe too large or too hard to be expelled by the patient. Suppositories and enemas may be ordered to promote evacuation of the stool. However, if the enemas fail, the nurse must use her fingers to break up and remove the fecal mass

OBJECTIVES:

1. To relieve pain and discomfort caused by blockage and impacted faeces
2. To establish the normal defaecation pattern.

EQUIPMENT

Disposable gloves

Wash basin

Toilet tissue

Bed pan with cover

Water soluble lubricant

Incontinent pad or mackintosh and draw sheet

Bath towel

Wash cloth

Soap

PROCEDURE

1. Explain procedure to patient
2. Obtain consent
3. Ensure Privacy
4. Wash hands
5. Gather equipment
6. Obtain assistance to help change patient position if necessary
7. Position in left lateral with knee flexed
8. Raise bed to comfortable working height
9. Put side rails up on opposite side of the bed

10. Drape patient's trunk and lower extremities with bath blanket/sheet
11. Place water proof pad under patient's buttocks
12. Place bedpan in close proximity next to patient
13. Lubricate gloved index finger with lubricating jelly
14. Insert index finger into rectum and advance finger slowly along rectal wall towards umbilicus
15. Gentle loosen faecal mass by massaging around it and work fingers into hardened mass
16. Work stool down wards to the end of the rectum and remove small section of the faeces
17. Assess heart rate and look for signs of fatigue
18. Stop procedure if patient's heart rate drops or the rhythm changes
19. Continue to clear rectum of faeces and allow patient to rest at intervals
20. After removal of impaction assist patient to clean anal area with toilet tissue and then wash thoroughly with soap and water
21. Dry with bath towel
22. Remove bedpan and dispose of faeces
23. Remove gloves by turning inside out and discard
24. NB: Assist patient to toilet or offer bed pan as required
25. Wash hands
26. Repositioned patient in bed and make comfortable
27. Leave bed in a low position
28. Allow patient to rest
29. Provide a deodorizer/airfreshener if necessary
30. Remove equipment
31. Wash hands
32. Record all relevant information and report to nurse in charge (patient's tolerance to procedure, amount and consistency of stool removed and any adverse effects)

SPECIAL POINT TO NOTE:

Excessive rectal manipulation may cause irritation to the mucosa, bleeding, and stimulation of the vagus nerve, which can cause a reflex slowing of the heart.

33.0 REPORTING

OBJECTIVES

- 1 To communicate specific information to a person or group (it can be oral or written)
- 2 To provide continuity of care for patient

EQUIPMENT

Assignment sheets
Ward reports
Nursing care plan
Tape recorder
Black ink pen with stationary

There are various types of reporting:

- (a) Change of shift report
- (b) Telephone Reports
- (c) Conferencing Report
- (d) Nursing Conference Report

IMPLEMENTATION

2. Provide a detailed description of the patient's progress during the shift using the Nursing process.
 - a. Personal information (e.g. name, age, etc)
 - b. Assessment Data (Provided objective, observation and measurements made by nurse during the shift)
 - c. Nursing diagnosis
 - d. Interventions/evaluation
 - e. Family information (report on family involvement and visitation, explain if family member were included in the care procedures or instruction)
 - f. Discharge plan
 - g. Current priorities (explain clearly the priorities to which oncoming nurses must attend)
3. Ask staff from the oncoming shift if they have any questions regarding information reported

SPECIAL CONSIDERATIONS

1. Report on the immediate treatment planned for a newly admitted patient

2. Explain the status of specific preparatory activities for patients who are going for diagnostic treatment procedures
3. Describe current physical status of patients returning from operative procedures
4. Discuss status of educational progress, communication with referral agencies, preparation of family members for patients who are being discharged
5. A more in depth report may be needed if a nurse is new to the unit or an inexperienced nurse who will be working the next shift

34.0 ROUTINE HAND HYGIENE

OBJECTIVES:

- 1) To prevent and control transmission of pathogen from persons to Persons.
- 2) Reducing the chances of disease transmission.

EQUIPMENT:

1. Sink with warm running water.
2. Antimicrobial liquid soap or regular soap.
3. Nail brush (Optional).
4. Paper towel.
5. Hand lotion as provided by the institution.

PROCEDURE/ IMPLEMENTATION

1. Remove hand jewellery (wedding band optional).
2. Inspect hand for breaks, cut in skin and cuticle.
3. Keep hands and uniform away from sink surfaces.
4. Turn on tap.
5. With arms lowered, wet hand thoroughly under running water
6. Keep hands and forearm lower than elbows.
7. Apply three milliliters (3mls) of antiseptic liquid soap to hands and lather thoroughly, washing for ten to fifteen seconds (10-15 sec).
8. Rub with fingers interlace, massaging between fingers with right palm over back of left hand, then left palm over back of right hand.
9. Scrub with fingers locked including finger tips.
10. Rub rotationally with thumbs locked.
11. Rinse thoroughly from fingers to lower fore arm keeping hands down when rinsing.
12. Dry palms and back of hands using paper towel, working towel between fingers.
13. Dry around and under finger nails.
14. Turn off tap using clean dry paper towel and discard.

35.0 ROUTINE URINE TESTING

Purpose: This provides information about the status of kidney function, nutrition, metabolic function and certain systemic diseases

OBJECTIVES

1. To evaluate the function of the kidney
2. To determine concentration of hydrogen ions in urine
3. To ascertain the degree of acidity or alkalinity of the specimen
4. To detect alterations in the chemical properties of the patient's urine e.g. glucose, protein, ketones, blood

EQUIPMENT

Fresh specimen of voided urine

Disposable Gloves

Paper towels

Clean urine container

Bed pan or urinal

Reagent strips e.g. total urine screen strips

Receptacle for dirty items

PROCEDURE

1. Explain procedure to patient and obtain consent
2. Wash hands
3. Gather equipment and supplies
4. Ensure privacy
5. Read instructions on reagent strip including expiry date
6. Dip correct end of reagent strip into fresh urine
7. Wait for 30 seconds, compare results with colour chart
8. Discard waste
9. Wash container with soap and water
10. Wash hands
11. Record findings and report to nurse- in- charge

36.0 SITZ BATH

OBJECTIVES:

1. To administer a warm soak to the perineal area for hygienic or therapeutic purposes.
2. To relieve discomfort and promote healing of perineum/anal area
3. To minimize infection
4. To educate patient on self-care and hygiene

EQUIPMENT/SUPPLIES

Solution e.g. potassium permanganate (pot permag.), normal saline or common salt

Warm water

Sitz bath tub or basin

Bath towel

Cleanser

Perineal pad (if required)

PROCEDURE

1. Explain procedure to patient
2. Obtain consent
3. Ensure privacy
4. Wash hands
5. Gather equipment
6. Assist patient to location for sitz bath
7. Fill receptacle (tub/basin) with enough water (40 – 43 degree centigrade or 105 – 115 fahrenheit , or as patient can tolerate) to cover perineal and anal area
8. Assist patient to sit into tub
9. Check patient at least once during treatment
10. Provide patient with some means to call for assistance in your absence

11. Allow patient to sit for at least 15 – 25 minutes
12. Assess pulse rate
13. Check vital signs and colour for any change in patient's condition
14. Assist patient out of tub or basin
15. Assist patient to dry
15. Examined treated area and reapply dressing if indicated
16. Assist patient to dress
17. Assist patient back to bed
18. Leave patient comfortable and dry
19. Remove equipment
20. Wash hands
21. Record in patient's chart and report to nurse in charge

NB: Encourage patient to report any oedema of vulva/perineum and any offensive smelling vaginal discharge.

37.0 STEAM INHALATION

OBJECTIVES:

1. To add humidity to the patient environment for therapeutic purposes
2. To loose and mobilize pulmonary secretions
3. To ease respiratory effort
4. To deliver some types of inhalant medication

EQUIPMENT/SUPPLIES

Hot or cool steam vapourizer

Tissues

Fresh linen

PROCEDURE:

1. Explain the procedure to the patient and advise to breathe water vapor deeply
2. Take safety precautions to protect the patient from burns if hot steam inhalation is used
3. Wash hands
4. Prepare vaporizer according to doctor's orders
5. Arrange the humidifier so that the water vapour surrounds the patient's head
6. Change linen as it becomes damp
7. Encourage the patient to expectorate mucus during the inhalation and provide them with a container for the mucus
8. Chart procedure and results.
9. Report to Nurse In Charge

38.0 SUCTIONING

Introduction: ORO-PHARYNGEAL AND NASO –PHARYNGEAL suctioning is aspirating secretions through a catheter connected to a suction machine or wall suction outlet. It is performed for patients who have difficulty handling their secretions or have an airway in place and suctioning is necessary to clear air passage.

OBJECTIVES:

1. To maintain a patent airway
2. To prevent infection that may result from accumulating secretion
3. To obtain secretion for diagnostic purposes

EQUIPMENT/SUPPLIES

Sterile and non-sterile gloves

Portable or wall suction machine with tubing and collection receptacle

Sterile normal saline or water

Sterile disposable container for fluids

Sterile suction catheter of appropriate sizes (Could be either open tipped or whistle-tipped)

Catheter sizes

- Adult size 12 – 18
- Children 8-10
- Infant 5-8

Yaunkauer catheter

Sterile basin

Drape or towel

Sterile gauze

Water soluble lubricant (for naso-pharyngeal suctioning)

Nasal or oral airway (if indicated)

Moisture resistant disposable bag

Sputum container (if sputum to be collected)

NB: For oropharyngeal suctioning pull tongue forward if necessary using gauze. Do not apply suction (that is leave your finger off the port) during insertion as applying suction during insertion causes trauma to the mucus membranes. Advance the catheter about 10-15 cms (4-6 inches) along one side of the mouth into the oropharynx. This prevents gagging. Moisten catheter tip with sterile water or saline.

For nasopharyngeal suction, without applying suction, insert the catheter the premeasured or recommended distance into either nares and advance it along the floor of the nasal cavity. This avoids the nasal turbinates. Moisten catheter tip with water, saline, or water soluble lubricant.

PERFORM SUCTION:

Apply finger to suction control port

To start suction gentle rotate the catheter (gentle rotation ensure all surfaces are reached and prevent trauma to respiratory mucosa)

Apply suction 5 to 10 seconds slowly withdrawing catheter while rotating back and forth between dominant thumb and forefinger

Encourage patient to cough (replace oxygen device if applicable)

NB: Suctioning over 15 seconds may cause compromise

It may be necessary during oro-pharyngeal suctioning to apply suction to secretions that collect in the vestibule of the mouth and beneath the tongue

Clean catheter and connecting tubing with normal saline/sterile water until clear

Repeat suctioning until air passage is clear

39.0 SURGICAL ASEPSIS

OBJECTIVE

- 1 To prevent spread of Infection
- 2 To prevent introduction of all micro-organisms

DONNING OF CAPS

EQUIPMENT

Paper or cloth caps
Paper hood (male must cover all facial hair)
Hairpins, rubber bands (or both)

PROCEDURE

- 1 If hair is long fold hair at back and put up to top of head.
- 2 Secure hair with pins
- 3 Apply cap on head as you will apply hair net (for male with facial hair apply hood over head as you would apply ski-mask)
- 4 Remove cap and dispose
- 5 Grasp outer surface of cap and lift from head

DONNING OF MASK

EQUIPMENT

Masks
Different sizes are available for different skin sensitivity

PROCEDURE/IMPLEMENTATION

- 1 Find top edge of mask (thin edge metal stripe along edge)
- 2 Hold mask on top of two (2) top strings keeping top edge above bridge of nose

- 3 Tie the top strings to back and top of head with strings above ear. Tie the two (2) lower strings around neck ensuring masks is covering nose, mouth and chin; gently pinch metal band around bridge of nose.

REMOVE MASK AND DISPOSE

Untie top strings of masks first. Untie bottom string and remove mask from face holding ties securely, discard, wash hands.

39.1 SURGICAL HAND WASHING/HAND HYGIENE

OBJECTIVE

To reduce the risk of transmitting disease

EQUIPMENT

Antiseptic solution (Betadine; some institutions use Hibiscrub septisol))

Deep sink with foot, knee or elbow control

Surgical scrub brushes

Sterile hand towels

PROCEDURE/IMPLEMENTATION

- 1 Wet hands and arms with lukewarm water
- 2 Apply antiseptic solution and lather from fingers to two (2) inches above elbows
- 3 Wet brushes and apply antiseptic solution
- 4 Scrub nails of one (1) hand with fifteen (15) strokes (total times applied for procedure, 5 minutes)
- 5 Scrub palm inside up to the thumbs each side of thumbs and fingers and the postern side of hands with ten (10) strokes each.
- 6 Mentally divide arms in thirds and scrub each part ten (10) times
- 7 Discard brush, rinse hands and arms thoroughly from tip of fingers to elbows not touching tap or anything else
- 8 Turn off tap with elbow and back into room entrance with hands elevated in front and away from body
- 9 Use sterile towel to dry one hand thoroughly moving from fingers to elbows in a rotated motion and repeat drying method with the other hand using a different area of sterile towel

40.0 TEPID SPONGE

Introduction: It is a method used to reduce the patient's fever by promoting heat loss through conduction and vaporization using cool water. Tepid sponge is performed when the body temperature reaches 100 – 105 degree fahrenheit and above. The frequency of repeating the procedure depends on the patient's condition. It may not be repeated more often than every hour.

OBJECTIVES:

1. To reduce an elevated body temperature
2. To minimize patient's discomfort during the cool sponge application.

EQUIPMENT/SUPPLIES:

Trolley

Basin

Bowl with sponges or wash cloth

Jug with water approx. 37 degree celcius or 98.6 degree fahrenheit

Bath thermometer

Clinical thermometer and cotton swabs

Cotton wool swabs/bath towels

Bowl with tap water and compress for forehead

Bath towel and face towel

Clean bed linen

Clean night dresses/pajamas

Receptacle for soiled linen and bucket for used water

PROCEDURE

1. Explain procedure to patient/parent/guardian and get consent
2. Wash hands
3. Assemble equipment/supplies
4. Ensure privacy
5. Record temperature, pulse and respirations
6. Pour tepid/tap water in basin

7. Remove top bed linen and cover patient with bath blanket or sheet
8. Undress patient
9. Immerse wash cloth or sponges in water
10. Using 2 sponges alternately, sponge face first, followed by hands and then body
11. Place extra wash cloth under each axilla and over groin
12. Use circular motion when sponging chest
13. Use vertical motions for other parts of body
14. Place cold compress on forehead
15. Complete the entire body
16. Observe patient's reaction
17. Dress patient in clean gown/pajamas
18. Remove bath blanket/sheet
19. Replace top bed linen
20. Make patient comfortable
21. Take temperature, pulse and respirations 30 minutes following tepid sponge bath
22. Clear equipment
23. Wash hands
24. Record in nurses notes observation and patient's condition and report to nurse in charge

41.0 TRACHEOSTOMY CARE

DEFINITION: is a surgical incision in the trachea just below the larynx to create an artificial opening in the throat when there is serious obstruction in the upper airway (nose, mouth or throat). It could be temporary or permanent.

OBJECTIVES:

6. To maintain a patent airway
7. To promote cleanliness and prevent infection at the tracheostomy site
8. To facilitate healing and prevent skin excoriation (skin break down) around the tracheostomy incision
9. To promote comfort

EQUIPMENT/SUPPLIES

Sterile tracheostomy set/kit containing:

- Sterile containers
- Sterile nylon brush/pipe cleaners
- Sterile applicators & dilators
- Gauze squares

Sterile Suction catheter kit (suction catheter, container for solution)

Tracheostomy tubes

Suction machine

Sterile gloves (2 pairs)

Normal saline or sterile water

Hydrogen peroxide

Cotton twill ties

Face mask

PROCEDURE:

- Explain procedure to patient and obtain consent (provide a means of communication e.g. eye blinking, to indicate pain or distress)
- Wash hands
- Collect equipment and supplies

- Ensure privacy
- Position patient into semi-fowlers or fowlers
- Wash hands
- Don face mask
- Don sterile gloves
- Suction to the full length of the tracheostomy tube to remove secretions and ensure a patent airway
- Rinse suction catheter and discard into the glove of one hand
- To clean inner cannula:
- Unlock the inner cannula
- Remove it gently by pulling it out toward you in line with its curvature
- Place the inner cannula in hydrogen peroxide solution
- Remove the soiled tracheostomy dressing and discard glove and dressing
- Wash hands
- Don sterile gloves
- Clean incision and tube flange:
- Using sterile applicators or gauze dressings, moisten with normal saline, clean the incision site
- Use each applicator or gauze dressing only once and discard
- NB: Hydrogen peroxide maybe used (half strength solution mixed with sterile normal saline) it is used to remove encrustations; thoroughly rinse the cleaned area using gauze squares, moisten with sterile normal saline.
- Clean the flange of the tube in the same manner.
- Thoroughly dry the patient skin and tube flanges with dry gauze squares

Clean the inner cannula:

- Remove the inner cannula from soaking solution
- Clean the lumen and entire inner cannula thoroughly, using the brush or pipe cleaners moistened with sterile normal saline, inspect the cannula for cleanliness by holding it at eye level and looking through it into the light
- Rinse the inner cannula thoroughly in sterile normal saline
- After rinsing gently tap the cannula against the inside edge of the sterile saline container, use a pipe cleaner folded in half to dry only the inside of the cannula
- Using sterile technique, suction the outer cannula

Replace the inner cannula, securing it in place:

- Insert the inner cannula by grasping the outer flange and inserting the inner cannula in the direction of its curvature
- Lock the cannula in place by turning the lock into position to secure the flange from the inner cannula to the outer cannula

Applying a sterile dressing:

- Use a commercially prepared tracheostomy dressing of non-ravelling material, or open and refold a four by four gauze dressing into a V-shape
- Place the dressing under the flange of the tracheostomy tube
- While applying the dressing ensure that the tracheostomy tube is securely supported

Changing the tracheostomy ties:

- Cut a length of tape (twill tape) long enough to go around client's neck two times. Cut ends diagonally
- Insert one end of tie through face plate eyelet and pull ends evenly
- Slide both ends of tie behind the head and around the neck to other eyelet and insert one tie through second eyelet.
- Pull snugly
- Tie ends securely in double square knot, allowing space for only one finger in tie
- Insert fresh tracheostomy dressing under clean ties and face plate
- Position client comfortably and establish respiratory status
- Remove gloves and face shield and discard in appropriate receptacle.
- Remove equipment
- Wash hands
- Document all relevant information:
- Record suctioning, tracheostomy care, and dressing change, noting your assessment, report to nurse-in-charge

42.0 ELECTRO CARDIOGRAM

OBJECTIVES

- 1 To record the electrical activity of the heart
- 2 To assist in diagnosing
 - (a) Myocardial infarction and arteriosclerotic heart disease
 - (b) Cardiac arrhythmias
 - (c) Cardiac enlargement
 - (d) Electrolyte imbalances (especially potassium)
 - (e) Pericarditis
 - (f) Pericardial effusion

EQUIPMENT

Electrocardiograph machine with limb and chest leads
Electrode paste
Alcohol sponges
Extra roll of electrocardiograph paper
Razor

PROCEDURE

- 1 Wash hands
- 2 Explain procedure to patient and encourage patient to lie still if possible
- 3 Obtain consent
- 4 Provide privacy
- 5 Place patient in comfortable supine position
- 6 Attach limb leads – they are marked as to which extremity they should be on and should be placed on a flat surface just above the wrist and ankles; to ensure good contact, electrode paste or an alcohol sponge is placed under each electrode. The limb strap is adjusted firmly to hold each electrode in place. They should not be so tight as to pinch or decrease circulation distal to the strap
- 7 Turn machine on then put in “run” mode. Depress standard button 2-3 times to mark paper with sensitivity indicator. Turn lead selector to lead I and record 5-6 cardiac complexes, repeat this procedure for leads II, III, AVR, AVL, AVF, in that order.

- 8 Apply electrode paste to the chest lead and place it in the VI position.
Turn the lead selector to "V" and record 5-6 cardiac complex. Repeat this procedure for the remaining precordial positions.

The positions are:

- 1 Fourth intercostal space at the right side of the sternum
- 2 Fourth intercostal space at the left side of the sternum
- 3 Midway between positions 2 and 4
- 1 Fifth intercostal space midclavicular line
- 2 Same level as 4 in the anterior axillary line
- 3 Same as 4 and 5 in the midaxillary line
- 4 Record the following information on the ECG strip
 - (a) Patient name and identification number
 - (b) Location, date and time of recording
 - (c) Patient age, sex and cardiac medications
- 5 The following information should accompany the strip
 - (a) Weight and height, blood pressure, tentative clinical diagnosis, clinical status and non cardiac medications
 - (b) Any unusual position of the position of the patient during the procedure or the presence of thoracic deformities, chest dressing, amputation, respiratory distress or muscle tremor.
- 6 Clean paste off patient and make comfortable
- 7 Clean and dispose of equipment properly
- 8 Wash hands
- 9 Chart
- 10 Put away equipment
- 11 Remove clothing from wrist up, clean skin and wipe site with alcohol.
- 12 Disconnect leads wipe excess electrode paste from chest

43.0 EYE IRRIGATION

Definition: is a lavage of the eye/s with fluids which may or may not be medicated.

OBJECTIVES:

1. To safely and correctly irrigate one or both eyes of the patient for hygienic or therapeutic purposes
2. To irrigate chemicals or foreign bodies from the eye
3. To remove secretions from the conjunctival sac
4. To treat infections using prescribed solution
5. To relieve itching and discomfort

EQUIPMENT/SUPPLIES

Bulb syringe

Solution (Balanced Salt Solution or Normal Saline or water)

Kidney dish or receptacle for solution

Sterile cotton balls

McIntosh or incontinent pad (to protect bed)

Towel

PROCEDURE:

1. Wash hands
2. Explain procedure to patient and obtain consent
3. Ensure privacy
4. Gather equipment supplies
5. Wash hands
6. Using sterile technique(do not touch irrigating syringe to eye)
7. Place McIntosh under head and shoulders of patient
8. Position patient dorsal/recumbent position with head turn towards the side of the eye to be irrigated
9. Place kidney dish beside and below eyes
10. Hold the eye open with the thumb and forefinger of the non-dominant hand (*resting your hand on the patient forehead may make this easier*)
11. Fill syringe with solution

12. Release fluid with gentle pressure from inner to outer canthus
13. Continue irrigation until eye is clear or until all solution is used
14. Dry eye from inner to outer aspect using cotton balls
15. Re-position patient
16. Remove equipment
17. Record all findings and report to nurse-in- charge
18. NB: If both eyes are done treat eye as a separate irrigation to prevent cross-contamination