CHECKLISTS FOR MIDTERM 2

1. Common Steps for Preparing Medications
2. Administering an Intradermal Injection
3. Administering a Subcutaneous Injection
4. Administering an Intramuscular Injection
5. Administering Intravenous Medication using IV Push
6. Wound Care
7. Administering Oxygen by Nasal Cannula and face mask
8. Teaching Moving, Leg Exercise, Deep Breathing and Coughing Exercises

**Skill : Common steps for preparing medications**

**Procedure**

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| 1. Check the MAR: Check the label on the medication carefully against the MAR | To make sure that the correct medication is being prepared |
| 2. Follow the three checks for administering medications.  **Read the label on the medication :**  (a) when it is taken from the medication cart,  (b) before withdrawing the medication, and  (c ) after withdrawing the medication. |  |
| 3. Organize the equipment |  |
| 4. Perform hand hygiene and observe other appropriate infection prevention procedures. |  |
| 5. Prepare the medication from the vial or ampule for drug withdrawal |  |
| 6. Prepare the client: Prior to performing the procedure, introduce self and verify the client’s identity using agency protocol. | This ensures that the right client receives the medication. |
| 7. Provide for client privacy. |  |
| 8. Explain the purpose of the medication and how it will help, Using language that the client can understand. Include relevant information about effects of the medication. | Information can facilitate acceptance of and compliance with the therapy. |

**Skill : Common Steps For Preparing Medications**

**Procedure**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No. \_\_\_\_\_\_ Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1- Performed incorrectly

0- Not performed

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
|  |  |  | 1. Check the MAR: Check the label on the medication carefully against the MAR |  |
|  |  |  | 1. Follow the three checks for administering medications |  |
|  |  |  | 3. Read the label on the medication :  (a) when it is taken from the medication cart, |  |
|  |  |  | (b) before withdrawing the medication |  |
|  |  |  | (c ) after withdrawing the medication. |  |
|  |  |  | 1. Organize the equipment |  |
|  |  |  | 1. Perform hand hygiene and observe other appropriate infection prevention procedures. |  |
|  |  |  | 1. Prepare the medication from the vial or ampule for drug withdrawal |  |
|  |  |  | 1. Prepare the client: Introduce self and verify the client’s identity |  |
|  |  |  | 1. Provide for client privacy. |  |
|  |  |  | 1. Explain the purpose of the medication and how it will help, Using language that the client can understand. Include relevant information about effects of the medication. |  |
|  | | | TOTAL SCORE = 11 X 2 = 22  Score \_\_\_\_\_ x 10 = \_\_\_\_\_\_ marks  22 |  |

ADMINISTERING AN INTRADERMAL INJECTION

**PURPOSE**

• To provide a medication that the client requires for allergy testing and TB screening

Equipment

|  |
| --- |
|  |
| * Client’s MAR or computer printout. |
| * Vial or ampule of the correct medication. |
| * Sterile 1 ml syringe. |
| * Alcohol swabs. |
| * 2×2 sterile gauze square (optional). |
| * Clean gloves (according to agency protocol). |
| * Bandage (optional). |
| * Sharp container . |

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale:** |
| 1. Explain to the client that the medication will produce a small wheal, sometimes called a bleb. | Information can facilitate acceptance of and compliance with the therapy. |
| 1. **Select and clean the site:**    1. Select a site (e.g., the forearm about a hand’s width above the wrist and three).   **b-** Avoid using sites that are tender, inflamed, or swollen and those that have lesions. |  |
| 3- Apply gloves as indicated by agency policy. |  |
| 1. Cleanse the skin at the site using a firm circular motion starting at the center and widening the circle outward. Allow the area to dry thoroughly. |  |
| 1. Prepare the syringe for the injection:    1. Remove the needle cap while waiting for the antiseptic to dry.    2. Expel any air bubbles from the syringe. Small bubbles that adhere to the plunger are of no consequence.    3. Grasp the syringe in your dominant hand, close to the hub, holding it between thumb and forefinger. Hold the needle almost parallel to the skin surface, with the bevel of the needle up. | A small amount of air will not harm the tissues.  The possibility of the medication entering the subcutaneous tissue increases when using an angle greater than 15 |
| **Inject the fluid:**   1. With the nondominant hand, pull the skin at the site until it is taut. | Taut skin allows for easier entry of the needle and less discomfort for the client. |
| 1. Insert the tip of the needle far enough to place the bevel through the epidermis into the dermis. The outline of the bevel should be visible under the skin surface. |  |
| 1. Stabilize the syringe and needle. Inject the medication carefully and slowly so that it produces a small wheal on the skin. | This verifies that the medication entered the dermis. |
| 1. Withdraw the needle quickly at the same angle at which it was inserted. |  |
| 10- Do not massage the area. | Massage can disperse the medication into the tissue or out through the needle insertion site. |
| 1. Dispose of the syringe and needle into the sharps container. | Do not recap the needle in order to prevent needlestick injuries. |
| 1. Remove and discard gloves. |  |
| 1. Perform hand hygiene. |  |
| 1. Circle the injection site with ink to observe for redness or indurations (hardening), per agency policy. |  |
| 1. **Document all relevant information :**   Record the testing material given, the time, dosage, route, site, and nursing assessments. |  |
| 1. **EVALUATION :**    1. Evaluate the client’s response to the testing substance.    2. Evaluate the condition of the site in 24 or 48 hours, depending on the test. Measure the area of redness and induration in millimeters at the largest diameter and document findings. | Some medications used in testing may cause allergic reactions. Epinephrine may need to be used. |

ADMINISTERING AN INTRADERMAL INJECTION

**Procedural Checklist**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Studen No. \_\_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1. Performed incorrectly
2. Not performed

|  |  |  |
| --- | --- | --- |
| Equipment: | Prepared | Not Prepared |
| Client’s MAR or computer printout. |  |  |
| Vial or ampule of the correct medication. |  |  |
| Sterile 1 ml syringe. |  |  |
| Alcohol swabs. |  |  |
| 2×2 sterile gauze square (optional). |  |  |
| Clean gloves (according to agency protocol). |  |  |
| Bandage (optional). |  |  |
| Sharp container . |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
|  |  |  | 1. Explain to the client that the medication will produce a small wheal, sometimes called a bleb. |  |
|  |  |  | * 1. **Select and clean the site.** Select a site (e.g., the forearm about a hand’s width above the wrist and three). |  |
|  |  |  | 3- Apply gloves as indicated by agency policy. |  |
|  |  |  | 1. Cleanse the skin at the site using a firm circular motion starting at the center and widening the circle outward. Allow the area to dry thoroughly. |  |
|  |  |  | 1. Prepare the syringe for the injection: |  |
|  |  |  | * 1. Remove the needle cap while waiting for the antiseptic to dry. |  |
|  |  |  | * 1. Expel any air bubbles from the syringe. |  |
|  |  |  | * 1. Grasp the syringe in your dominant hand, close to the hub, holding it between thumb and forefinger. |  |
|  |  |  | * 1. Hold the needle almost parallel to the skin surface, with the bevel of the needle up |  |
|  |  |  | 1. **Inject the fluid:** With the nondominant hand, pull the skin at the site until it is taut. |  |
|  |  |  | 1. Insert the tip of the needle far enough to place the bevel through the epidermis into the dermis. The outline of the bevel should be visible under the skin surface. |  |
|  |  |  | 1. Stabilize the syringe and needle. Inject the medication carefully and slowly so that it produces a small wheal on the skin. |  |
|  |  |  | 1. Withdraw the needle quickly at the same angle at which it was inserted. |  |
|  |  |  | 10- Do not massage the area. |  |
|  |  |  | * + 1. Dispose of the syringe and needle into the sharps container. |  |
|  |  |  | * + 1. Remove and discard gloves. |  |
|  |  |  | * + 1. Perform hand hygiene. |  |
|  |  |  | * + 1. Circle the injection site with ink to observe for redness or indurations (hardening), per agency policy. |  |
|  |  |  | * + 1. **Document all relevant information :**   Record the testing material given, the time, dosage, route, site, and nursing assessments. |  |
|  |  |  | Total score : 19 X 2 = 38  Score \_\_\_\_\_\_ x 10 marks = \_\_\_\_\_\_ marks  38 |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ADMINISTERING A SUBCUTANEOUS INJECTION

**PURPOSE**

• To provide a medication the client requires

Equipment

|  |
| --- |
| * Client’s MAR or computer printout |
| * Vial or ampule of the correct sterile medication |
| * Syringe and needle (e.g., 3-mL syringe, #25-gauge needle or smaller, 3/8 or 5/8 in. long) |
| * Antiseptic swabs |
| * Dry sterile gauze for opening an ampule (optional) |
| * Clean gloves |

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| 1. Prepare the equipment |  |
| 1. Assist the client to a position in which the arm, leg, or abdomen can be relaxed, depending on the site to be used. | A relaxed position of the site minimizes discomfort |
| 1. Obtain assistance in holding an uncooperative client. | This prevents injury due to sudden movement after needle insertion |
| 1. Select and clean the site. • Select a site free of tenderness, hardness, swelling, scarring, itching, burning, or localized inflammation. Select a site that has not been used frequently | These conditions could hinder the absorption of the medication and may also increase the likelihood of injury and discomfort at the injection site. |
| 1. Apply clean gloves |  |
| 1. As agency protocol indicates, clean the site with an antiseptic swab. Start at the center of the site and clean in a widening circle to about 5 cm (2 in.). Allow the area to dry thoroughly | The mechanical action of swabbing removes skin secretions, which contain microorganisms |
| 1. Place and hold the swab between the third and fourth fingers of the nondominant hand, or position the swab on the client’s skin above the intended site | Using this technique keeps the swab readily accessible when the needle is withdrawn. 7. Prepare the syringe for injection |
| 1. Remove the needle cap while waiting for the antiseptic to dry. Pull the cap straight off to avoid contaminating the needle by the outside edge of the cap | The needle will become contaminated if it touches anything but the inside of the cap, which is sterile. |
| 1. Dispose of the needle cap. |  |
| 1. Inject the medication.    * Grasp the syringe in your dominant hand by holding it between your thumb and fingers.    * With palm facing to the side or upward for a 45° angle insertion, or with the palm downward for a 90° angle insertion, prepare to inject. |  |
| 1. Using the nondominant hand, pinch or spread the skin at the site, and insert the needle using the dominant hand and a firm steady push. Recommendations vary about whether to pinch or spread the skin and at what angle to administer subcutaneous injections.  * The most important consideration is the depth of the subcutaneous tissue in the area to be injected. If the client has more than 1/2 inch of adipose tissue in the injection site, it would be safe to administer the injection at a 90° angle with the skin spread. |  |
| 1. If the client is thin or lean and lacks adipose tissue, the subcutaneous injection should be given with the skin pinched and at a 45° to 60° angle.  * One way to check that the pinch of skin is subcutaneous tissue is to ask the client to flex and extend the elbow. * If any muscle is being held in the pinch, you will feel it contract and relax. If so, release the pinch and try again |  |
| 1. When the needle is inserted, move your nondominant hand to the end of the plunger. Some nurses find it easier to move the nondominant hand to the barrel of the syringe and the dominant hand to the end of the plunger |  |
| 1. Inject the medication by holding the syringe steady and depressing the plunger with a slow, even pressure | Holding the syringe steady and injecting the medication at an even pressure minimizes discomfort for the client. |
| 1. It is recommended that with many subcutaneous injections, especially insulin, the needle should be embedded within the skin for 5 seconds after complete depression of the plunger to ensure complete delivery of the dose. |  |
| 1. Remove the needle. • Remove the needle smoothly, pulling along the line of insertion while depressing the skin with your nondominant hand | Depressing the skin places countertraction on it and minimizes the client’s discomfort when the needle is withdrawn |
| 1. If bleeding occurs, apply pressure to the site with dry sterile gauze until it stops. Bleeding rarely occurs after subcutaneous injection. |  |
| 1. Dispose of supplies appropriately. |  |
| 1. Activate the needle safety device or discard the uncapped needle and attached syringe into designated receptacles.  * The CDC recommends not capping the needle before disposal to reduce the risk of needlestick injuries. | Proper disposal protects the nurse and others from injury and contamination. |
| 1. Remove and discard gloves |  |
| 1. Perform hand hygiene |  |
| 1. Document all relevant information. • Document the medication given, dosage, time, route, and any assessments ... • Many agencies prefer that medication administration be recorded on the medication record. The nurse’s notes are used when prn medications are given or when there is a special problem. |  |
| 1. Assess the effectiveness of the medication at the time it is expected to act and document it. |  |
| EVALUATION |  |
| 1. Conduct appropriate follow-up such as desired effect (e.g., relief of pain, sedation, lowered blood sugar, a prothrombin time within preestablished limits), any adverse effects (e.g., nausea, vomiting, skin rash), and clinical signs of side effects. |  |
| 1. • Relate to previous findings if available. • Report deviations from normal to the primary care provider |  |

ADMINISTERING A SUBCUTANEOUS INJECTION

**Procedural Checklist**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Studen No. \_\_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1. Performed incorrectly
2. Not performed

|  |  |  |
| --- | --- | --- |
| Equipment: | Prepared | Not Prepared |
| Client’s MAR or computer printout. |  |  |
| Vial or ampule of the correct medication. |  |  |
| Sterile 1 ml syringe. |  |  |
| Alcohol swabs. |  |  |
| 2×2 sterile gauze square (optional). |  |  |
| Clean gloves (according to agency protocol). |  |  |
| Bandage (optional). |  |  |
| Sharp container . |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
|  |  |  | 1. Prepare the equipment |  |
|  |  |  | 1. Assist the client to a position in which the arm, leg, or abdomen can be relaxed, depending on the site to be used. |  |
|  |  |  | 1. Obtain assistance in holding an uncooperative client. |  |
|  |  |  | 1. Select and clean the site. |  |
|  |  |  | 1. Apply clean gloves |  |
|  |  |  | 1. Clean the site with an antiseptic swab. Start at the center of the site and clean in a widening circle to about 5 cm (2 in.). Allow the area to dry thoroughly |  |
|  |  |  | 1. Place and hold the swab between the third and fourth fingers of the nondominant hand, or position the swab on the client’s skin above the intended site |  |
|  |  |  | 1. Remove the needle cap while waiting for the antiseptic to dry. Pull the cap straight off to avoid contaminating the needle by the outside edge of the cap |  |
|  |  |  | 1. Dispose of the needle cap. |  |
|  |  |  | 1. Inject the medication.    * Grasp the syringe in your dominant hand by holding it between your thumb and fingers.    * With palm facing to the side or upward for a 45° angle insertion, or with the palm downward for a 90° angle insertion, prepare to inject. |  |
|  |  |  | 1. Using the nondominant hand, pinch or spread the skin at the site, and insert the needle using the dominant hand and a firm steady push. |  |
|  |  |  | 1. When the needle is inserted, move your nondominant hand to the end of the plunger. |  |
|  |  |  | 1. Inject the medication by holding the syringe steady and depressing the plunger with a slow, even pressure |  |
|  |  |  | 1. Remove the needle. • Remove the needle smoothly, pulling along the line of insertion while depressing the skin with your nondominant hand |  |
|  |  |  | 1. If bleeding occurs, apply pressure to the site with dry sterile gauze until it stops. |  |
|  |  |  | 1. Dispose of supplies appropriately. |  |
|  |  |  | 1. Activate the needle safety device or discard the uncapped needle and attached syringe into designated receptacles. |  |
|  |  |  | 1. Remove and discard gloves |  |
|  |  |  | 1. Perform hand hygiene |  |
|  |  |  | 1. Document all relevant information.. |  |
|  |  |  | Total score : 20 X 2 = 40  Score \_\_\_\_\_\_ x 10 marks = \_\_\_\_\_\_ marks  40 |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADMINISTERING AN INTRAMUSCULAR INJECTION**

## Equipment:

-Client’s MAR or computer printout

- Sterile medication (usually provided in an ampule or vial or prefilled syringe)

- Syringe and needle of a size appropriate for the amount and type of solution to be administered

- Antiseptic swabs

- Clean gloves

PURPOSES

• To provide a medication the client requires (see specific drug action)

PREPARATION:

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| **Preparation** |  |
| 1. -Check the MAR. |  |
| 1. Check the label on the medication carefully against the MAR to make sure that the correct medication is being prepared. |  |
| 1. Follow the three checks for administering the medication and dose.    1. Read the label on the medication    2. when it is taken from the medication cart, before withdrawing the medication,    3. After withdrawing the medication. |  |
| 1. Confirm that the dose is correct. | This comparison helps to identify errors that may have occurred when orders were transcribed. The primary care provider’s order is the legal record of medication orders for each facility |
| 1. Organize the equipment. |  |
| **Performance** |  |
| 1. Perform hand hygiene and observe other appropriate infection prevention procedures. | Prevents the spread of microorganism  Because the outside of a new needle is free of medication, it does not irritate subcutaneous tissues as it passes into the muscle. • |
| 1. Prepare the medication from the ampule or vial for drug withdrawal. Whenever feasible, change the needle on the syringe before the injection. |  |
| 1. Invert the syringe needle uppermost and expel all excess air |  |
| 1. Provide for client privacy.. |  |
| **Prepare the client.**   1. Introduce self and verify the client’s identity using agency protocol. |  |
| 1. Assist the client to a supine, lateral, prone, or sitting position, depending on the chosen site.   If the target muscle is the gluteus medius (ventrogluteal site), have the client in the supine position flex the knee(s); in the lateral position, flex the upper leg; and in the prone position, toe in. | This ensures that the right client receives the medication.  Appropriate positioning promotes relaxation of the target muscle. |
| 1. Obtain assistance in holding an uncooperative client. | This prevents injury due to sudden movement after needle insertion. |
| 1. Explain the purpose of the medicate on and how it will help, using language that the client can understand. Include relevant information about effects of the medication. | Information can facilitate acceptance of and compliance with the therapy. |
| 1. Select, locate, and clean the site.    * + Select a site free of skin lesions, tenderness, swelling, hardness, or localized inflammation and one that has not been used frequently.      + If injections are to be frequent, alternate sites.      + Avoid using the same site twice in a row. discuss with the prescribing primary care provider an alternative method of providing the medication. |  |
| 1. Locate the exact site for the injection. |  |
| 1. Apply clean gloves |  |
| 1. Clean the site with an antiseptic swab. Using a circular motion, start at the center and move outward about 5 cm (2 in.). |  |
| 1. Transfer and hold the swab between the third and fourth fingers of your nondominant hand in readiness for needle withdrawal, or position the swab on the client’s skin above the intended site. |  |
| 1. Allow skin to dry prior to injecting medication. | This will help reduce the discomfort of the injection. |
| 1. Prepare the syringe for injection.    * + Remove the needle cover and discard without contaminating the needle.      + If using a prefilled unit-dose medication, take caution to avoid dripping medication on the needle prior to injection. If this does occur, wipe the medication off the needle with a sterile gauze.      + Some sources recommend changing the needle if possible. | Medication left on the needle can cause pain when it is tracked through the subcutaneous tissue |
| 1. Inject the medication using the Z-track technique.   Use the ulnar side of the nondominant hand to pull the skin approximately 2.5 cm (1 in.) to the side. Under some circumstances, such as for an emaciated client or an infant, the muscle may be pinched. | Pulling the skin and subcutaneous tissue or pinching the muscle makes it firmer and facilitates needle insertion. |
| 1. Holding the syringe between the thumb and forefinger (as if holding a pen), pierce the skin quickly and smoothly at a 90° angle and insert the needle into the muscle. | Using a quick motion lessens the client’s discomfort. |
| 1. Hold the barrel of the syringe steady with your nondominant hand and aspirate by pulling back on the plunger with your dominant hand. |  |
| 1. Aspirate for 5 to 10 seconds. If blood appears in the syringe, withdraw the needle, discard the syringe, and prepare a new injection. | If the needle is in a small blood vessel, it takes time for the blood to appear.  This step determines whether the needle has been inserted into a blood vessel.  Note, however, that as stated previously, the practice of aspiration immediately before the administration of an IM vaccine injection is not necessary. Aspiration should be used with the dorsogluteal site (last resort) because needle insertion is close to the gluteal artery. Currently there is no clear evidence with other sites. Thus, it is recommended that nursing students consult the policy manual at the institution where they are practicing to determine the recommended guidelines for IM injection technique. |
| 1. If blood does not appear, inject the medication steadily and slowly (approximately 10 seconds per milliliter) while holding the syringe steady if using the ventrogluteal site. | Injecting medication slowly promotes comfort and allows time for tissue to expand and begin absorption of the medication  Holding the syringe steady minimizes discomfort |
| 1. After injection, wait 10 seconds if using the ventrogluteal site. | Waiting permits the medication to disperse into the muscle tissue, thus decreasing the client’s discomfort. |
| 1. Withdraw the needle smoothly at the same angle of insertion. | This minimizes tissue injury. Release the skin. |
| 1. Apply gentle pressure at the site with a dry sponge . It is not necessary to massage the area at the site of injection. If bleeding occurs, apply pressure with dry sterile gauze until it stops. | Use of an alcohol swab may cause pain or a burning sensation.  Massaging the site may cause the Leakage of medication from the site and result in irritation. |
| 1. Activate the needle safety device or discard the uncapped needle and attached syringe into the proper receptacle***.*** |  |

**ADMINISTERING AN INTRAMUSCULAR INJECTION**

Procedural Checklist

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student No. \_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1- Performed incorrectly

0- Not performed

|  |  |  |
| --- | --- | --- |
| Equipment: | **Prepared** | **Not Prepared** |
| -Client’s MAR or computer printout |  |  |
| - Sterile medication (usually provided in an ampule or vial or prefilled syringe) |  |  |
| - Syringe and needle of a size appropriate for the amount and type of solution to be administered |  |  |
| - Antiseptic swabs |  |  |
| - Clean gloves |  |  |
|  |  |  |

PURPOSES

• To provide a medication the client requires (see specific drug action)

PREPARATION:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Remarks** |
|  |  |  | **Preparation** |  |
|  |  |  | 1. Check the MAR. |  |
|  |  |  | 1. Check the label on the medication carefully against the MAR to make sure that the correct medication is being prepared. |  |
|  |  |  | 1. Follow the three checks for administering the medication and dose. |  |
|  |  |  | 1. Confirm that the dose is correct. |  |
|  |  |  | 1. Organize the equipment. |  |
|  |  |  | **Performance** |  |
|  |  |  | 1. Perform hand hygiene and observe other appropriate infection prevention procedures. |  |
|  |  |  | 1. Prepare the medication from the ampule or vial for drug withdrawal. Whenever feasible, change the needle on the syringe before the injection. |  |
|  |  |  | 1. Invert the syringe needle uppermost and expel all excess air |  |
|  |  |  | 1. Provide for client privacy.. |  |
|  |  |  | **Prepare the client.**   1. Introduce self and verify the client’s identity |  |
|  |  |  | 1. Assist the client to a supine, lateral, prone, or sitting position, depending on the chosen site. |  |
|  |  |  | 1. Obtain assistance in holding an uncooperative client. |  |
|  |  |  | 1. Explain the purpose of the medication, how it will help and effects of the medication. |  |
|  |  |  | 1. Select, locate, and clean the site |  |
|  |  |  | 1. Locate the exact site for the injection. |  |
|  |  |  | 1. Apply clean gloves |  |
|  |  |  | 1. Clean the site with an antiseptic swab. Using a circular motion, start at the center and move outward about 5 cm (2 in.). |  |
|  |  |  | 1. Transfer and hold the swab between the third and fourth fingers of your nondominant hand in readiness for needle withdrawal, or position the swab on the client’s skin above the intended site. |  |
|  |  |  | 1. Allow skin to dry prior to injecting medication. |  |
|  |  |  | 1. Prepare the syringe for injection.    * + Remove the needle cover and discard without contaminating the needle.. |  |
|  |  |  | 1. Inject the medication using the Z-track technique.   Use the ulnar side of the nondominant hand to pull the skin approximately 2.5 cm (1 in.) to the side |  |
|  |  |  | 1. Holding the syringe between the thumb and forefinger (as if holding a pen), pierce the skin quickly and smoothly at a 90° angle and insert the needle into the muscle. |  |
|  |  |  | 1. Hold the barrel of the syringe steady with your nondominant hand and aspirate by pulling back on the plunger with your dominant hand. |  |
|  |  |  | 1. Aspirate for 5 to 10 seconds. |  |
|  |  |  | 1. After injection, wait 10 seconds if using the ventrogluteal site. |  |
|  |  |  | 1. Withdraw the needle smoothly at the same angle of insertion. |  |
|  |  |  | 1. Apply gentle pressure at the site with a dry sponge . |  |
|  |  |  | 1. Activate the needle safety device or discard the uncapped needle and attached syringe into the proper receptacle***.*** |  |
|  |  |  | Total score \_\_\_\_\_\_ x 10 marks = \_\_\_\_\_\_ marks  56 |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ADMINISTERING INTRAVENOUS MEDICATIONS USING IV PUSH

**PURPOSE**

• To achieve immediate and maximum effects of a medication

Equipment

|  |
| --- |
| * Client’s MAR or computer printout |
| * Vial or ampule of the correct sterile medication |
| * Syringe and needle (e.g., 3-mL syringe, #25-gauge needle or smaller, 3/8 or 5/8 in. long) |
| * Antiseptic swabs |
| * Dry sterile gauze for opening an ampule (optional) |
| * Clean gloves |
| * Vial of normal saline to flush the IV catheter or vial of heparin flush solution or both depending on agency practice |
| * Watch with a digital readout or second hand |

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| 1. Prepare the medication according to the manufacturer’s direction. | Rationale: It is important to have the correct dose and the correct dilution. |
| 1. Put a small-gauge needle on the syringe if using a needle system |  |
| 1. Administer the medication by IV push. |  |
| **Existing Line** |  |
| 1. Identify the injection port closest to the client. Some ports have a circle indicating the site for the needle insertion... | Rationale: An injection port must be used because it is selfsealing. Any puncture to the plastic tubing will leak |
| 1. Clean the port with an antiseptic swab. |  |
| 1. Stop the IV flow by closing the clamp or pinching the tubing above the injection port |  |
| 1. Connect the syringe to the IV system |  |
| **a. Needle system:**   * + Hold the port steady.• Insert the needle of the syringe that contains the medication through the center of the port. * After injecting the medication, withdraw the needle and activate the needle safety device | Rationale: This prevents damage to the IV line and to the diaphragm of the port |
| **b. Needleless system:**   * + Remove the cap from the needleless injection port.   + Connect the tip of the syringe directly to the port. |  |
| * + Inject the medication at the ordered rate. Use the watch or digital readout to time the medication administration. | Rationale: This ensures safe drug administration because a too rapid injection could be dangerous. |
| 1. Release the clamp or tubing |  |
| 1. For a needleless system, detach the syringe and attach a new sterile cap to the port. |  |
| 1. Dispose of equipment according to agency practice. | Rationale: This reduces needlestick injuries and spread of microorganisms |
| 1. Remove and discard gloves. |  |
| 1. Perform hand hygiene |  |
| 1. Observe the client closely for adverse reactions. |  |
| 1. Determine agency practice about recommended times for changing the IV lock. Some agencies advocate a change every 48 to 72 hours for peripheral IV devices. |  |
| 1. Document all relevant information. • Record the date, time, drug, dose, and route; client response; and assessments of infusion or heparin lock site if appropriate. |  |
| **Administering IV Push medication by IV Lock** |  |
| 1. **Flushing with saline:** 2. Prepare two syringes, each with 1 mL of sterile normal saline |  |
| 1. **Flushing with heparin (if indicated by agency policy) and saline:** 2. Prepare one syringe with 1 mL of heparin flush solution (if indicated by agency policy) |  |
| 1. Prepare two syringes with 1 mL each of sterile, normal saline. |  |
| 1. Draw up the medication into a syringe |  |
| 1. Put a small-gauge needle on the syringe if using a needle system |  |
| 1. Administer the medication by IV push. |  |
| **IV Lock with Needle**   1. Clean the injection port with the antiseptic swab. | This prevents microorganisms from entering the circulatory system during the needle insertion |
| 1. Insert the needle of the syringe containing normal saline through the injection port of an IV lock and aspirate for blood.. | The presence of blood confirms that the catheter or needle is in the vein. In some situations, blood will not return even though the lock is patent |
| 1. Flush the lock by injecting 1 mL of saline slowly.. | This removes blood and heparin (if present) from the needle and the lock |
| 1. Observe the area above the IV catheter for puffiness or swelling. This indicates infiltration into tissue, which would require removal of the IV catheter. |  |
| 1. Remove the needle and syringe. Activate the needle safety device |  |
| 1. Clean the lock’s diaphragm with an antiseptic swab. | This prevents the transfer of microorganisms. |
| 1. Insert the needle of the syringe containing the prepared medication through the center of the injection port |  |
| 1. Inject the medication slowly at the recommended rate of infusion. Use a watch or digital readout to time the injection | Injecting the drug too rapidly can have a serious untoward reaction |
| 1. Observe the client closely for adverse reactions. Remove the needle and syringe when all medication is administered |  |
| 1. Activate the needle safety device |  |
| 1. Clean the injection port of the lock.   • Attach the second saline syringe, and inject 1 mL of saline.  . If heparin is to be used, insert the heparin syringe and inject the heparin slowly into the lock. | The saline injection flushes the medication through the catheter and prepares the lock for heparin if this medication is used. Heparin is incompatible with many medications |
| **IV Lock with Needleless System** |  |
| 1. • Clean the injection port of the lock |  |
| 1. • Insert syringe containing normal saline into the injection port |  |
| 1. • Flush the lock with 1 mL of sterile saline. Remove the syringe. | This clears the lock of blood. • |
| 1. Insert the syringe containing the medication into the port. |  |
| 1. Inject the medication following the precautions described previously |  |
| 1. Withdraw the syringe. • |  |
| 1. Repeat injection of 1 mL of saline. |  |
| 1. Dispose of equipment according to agency practice. | This reduces needlestick injuries and spread of microorganisms |
| 1. Remove and discard gloves. • Perform hand hygiene. |  |
| 1. Observe the client closely for adverse reactions. |  |
| 1. Determine agency practice about recommended times for changing the IV lock. Some agencies advocate a change every 48 to 72 hours for peripheral IV devices. |  |
| 1. Document all relevant information. • Record the date, time, drug, dose, and route; client response; and assessments of infusion or heparin lock site if appropriate. |  |

ADMINISTERING INTRAVENOUS MEDICATIONS USING IV PUSH

**Procedural Checklist**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Studen No. \_\_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1. Performed incorrectly
2. Not performed

|  |  |  |
| --- | --- | --- |
| Equipment: | Prepared | Not Prepared |
| * Client’s MAR or computer printout |  |  |
| * Vial or ampule of the correct sterile medication |  |  |
| * Syringe and needle (e.g., 3-mL syringe, #25-gauge needle or smaller, 3/8 or 5/8 in. long) |  |  |
| * Antiseptic swabs |  |  |
| * Dry sterile gauze for opening an ampule (optional) |  |  |
| * Clean gloves |  |  |
| * Vial of normal saline to flush the IV catheter or vial of heparin flush solution or both depending on agency practice |  |  |
| * Watch with a digital readout or second hand |  |  |
| * Client’s MAR or computer printout |  |  |
| * Vial or ampule of the correct sterile medication |  |  |
| * Syringe and needle (e.g., 3-mL syringe, #25-gauge needle or smaller, 3/8 or 5/8 in. long) |  |  |
| * Antiseptic swabs |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 2 | 1 | 0 | **PROCEDURE** | **Comments** |
|  |  |  | 1. Prepare the medication.   **Existing Line •** Prepare the medication according to the manufacturer’s direction. |  |
|  |  |  | 1. Put a small-gauge needle on the syringe if using a needle system |  |
|  |  |  | 1. Administer the medication by IV push. |  |
|  |  |  | **Existing Line** |  |
|  |  |  | * Identify the injection port closest to the client. |  |
|  |  |  | * Clean the port with an antiseptic swab. |  |
|  |  |  | * Stop the IV flow by closing the clamp or pinching the tubing above the injection port |  |
|  |  |  | * Connect the syringe to the IV system |  |
|  |  |  | **a. Needle system:**  • Hold the port steady. Insert the needle of the syringe that contains the medication through the center of the port. |  |
|  |  |  | **b.Needleless system:**  • Remove the cap from the needleless injection port. Connect the tip of the syringe directly to the port. |  |
|  |  |  | • Inject the medication at the ordered rate. Use the watch or digital readout to time the medication administration. |  |
|  |  |  | * + Release the clamp or tubing |  |
|  |  |  | * + After injecting the medication, withdraw the needle and activate the needle safety device. For a needleless system, detach the syringe and attach a new sterile cap to the port. |  |
|  |  |  | 1. Dispose of equipment according to agency practice. |  |
|  |  |  | 1. Remove and discard gloves. |  |
|  |  |  | 1. Perform hand hygiene |  |
|  |  |  | 1. Observe the client closely for adverse reactions. |  |
|  |  |  | 1. Document all relevant information. Record the date, time, drug, dose, and route; client response; and assessments of infusion or heparin lock site if appropriate. |  |
|  |  |  | Total Score : 17 X 2 = 34  Score \_\_\_\_\_\_ X 10 = \_\_\_\_\_ marks  34 |  |
|  |  |  | **Administering IV Push medication by IV Lock** |  |
|  |  |  | 1. **Flushing with saline:** 2. Prepare two syringes, each with 1 mL of sterile normal saline |  |
|  |  |  | 1. **Flushing with heparin (if indicated by agency policy) and saline:** 2. Prepare one syringe with 1 mL of heparin flush solution (if indicated by agency policy) |  |
|  |  |  | 1. Prepare two syringes with 1 mL each of sterile, normal saline. |  |
|  |  |  | 1. Draw up the medication into a syringe |  |
|  |  |  | 1. Put a small-gauge needle on the syringe if using a needle system |  |
|  |  |  | 1. Administer the medication by IV push. |  |
|  |  |  | **IV Lock with Needle**   * Clean the injection port with the antiseptic swab. |  |
|  |  |  | * Insert the needle of the syringe containing normal saline through the injection port of an IV lock and aspirate for blood.. |  |
|  |  |  | * Flush the lock by injecting 1 mL of saline slowly.. |  |
|  |  |  | * Observe the area above the IV catheter for puffiness or swelling. This indicates infiltration into tissue, which would require removal of the IV catheter. |  |
|  |  |  | * Remove the needle and syringe. Activate the needle safety device |  |
|  |  |  | * Clean the lock’s diaphragm with an antiseptic swab. |  |
|  |  |  | * Insert the needle of the syringe containing the prepared medication through the center of the injection port |  |
|  |  |  | * Inject the medication slowly at the recommended rate of infusion. Use a watch or digital readout to time the injection |  |
|  |  |  | * Observe the client closely for adverse reactions. Remove the needle and syringe when all medication is administered |  |
|  |  |  | * Activate the needle safety device |  |
|  |  |  | * Clean the injection port of the lock.   • Attach the second saline syringe, and inject 1 mL of saline. If heparin is to be used, insert the heparin syringe and inject the heparin slowly into the lock. |  |
|  |  |  | **IV Lock with Needleless System** |  |
|  |  |  | * Clean the injection port of the lock |  |
|  |  |  | * • Insert syringe containing normal saline into the injection port |  |
|  |  |  | * • Flush the lock with 1 mL of sterile saline. Remove the syringe. |  |
|  |  |  | * Insert the syringe containing the medication into the port. |  |
|  |  |  | * Inject the medication following the precautions described previously |  |
|  |  |  | * Withdraw the syringe. • |  |
|  |  |  | * Repeat injection of 1 mL of saline. |  |
|  |  |  | 1. Dispose of equipment according to agency practice. |  |
|  |  |  | 1. Remove and discard gloves. Perform hand hygiene. |  |
|  |  |  | 1. Observe the client closely for adverse reactions. |  |
|  |  |  | 1. Document all relevant information. • Record the date, time, drug, dose, and route; client response; and assessments of infusion or heparin lock site if appropriate. |  |
|  |  |  | Total Score : 28 X 2 = 56  Score \_\_\_\_\_\_ X 10 = \_\_\_\_\_ marks  56 |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Wound Care**

Procedure

**PURPOSES**

* To promote wound healing by primary intention
* To prevent infection
* To assess the healing process
* To protect the wound from mechanical trauma

**EQUIPMENT**

• Bath blanket (if necessary)

Moisture-proof bag

• Mask (optional)

• Acetone or another solution (if necessary to loosen adhesive)

• Clean gloves

• Sterile gloves

• Sterile dressing set; if none is available, gather the following Sterile items:

• Drape or towel

• Gauze squares

• Container for cleaning solution

• Cleaning solution (e.g., normal saline)

• Two pairs of forceps

• Gauze dressings and surgipads

• Applicators or tongue blades to apply ointments

• Additional supplies required for the particular dressing (e.g., extra gauze dressings and ointment, if ordered)

Tape, tie tapes, or binder

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| **PREPARATION** |  |
| 1. Prepare the client and assemble the equipment. |  |
| * Obtain assistance for changing a dressing on a restless or Confused adult. | The person might move and contaminate the sterile field or the wound |
| * Assist the client to a comfortable position in which the wound can be readily exposed. Expose only the wound area, using a bath blanket to cover the client, if necessary. | Undue exposure is physically and psychologically distressing to most people. |
| * Make a cuff on the moisture-proof bag for disposal of the soiled dressings, and place the bag within reach. | Making a cuff helps keep the outside of the bag free from contamination by the soiled dressings and prevents subsequent contamination of the nurse’s hands or of sterile instrument tips when discarding dressing or sponges.  Placement of the bag within reach prevents the nurse from reaching across the sterile field and the wound and potentially contaminating these areas |
| * Apply a face mask, if required. | Some agencies require that a mask be worn for surgical dressing changes to prevent contamination of the wound by droplet spray from the nurse’s respiratory tract. |
| **PERFORMANCE** |  |
| 1. Prior to performing the procedure, introduce self and verify the client’s identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss how the results will be used in planning further care or treatments. |  |
| 1. Perform hand hygiene and observe other appropriate   Prevention control procedures |  |
| 1. Provide for client privacy. |  |
| 1. Remove binders and tape.   Remove binders, if used, and place them aside. Untie tie tapes, if used. Montgomery straps (tie tapes) are commonly used for wounds requiring frequent dressing changes. | These straps prevent skin irritation and  discomfort caused by removing the adhesive each time the dressing is changed. |
| If adhesive tape was used, remove it by holding down the skin and pulling the tape gently but firmly toward the wound. | Pressing down on the skin provides countertraction against the pulling motion. Tape is pulled toward the incision to prevent strain on the sutures or wound. |
| 1. Remove and dispose of soiled dressings appropriately.  * Apply clean gloves and remove the outer abdominal dressing or surgipad. |  |
| * Lift the outer dressing so that the underside is away from the client’s face. | The appearance and odor of the drainage may be upsetting to the client |
| * Place the soiled dressing in the moisture-proof bag without touching the outside of the bag. | Contamination of the outside of the bag is avoided to prevent the spread of microorganisms to the nurse and subsequently to others. |
| * Remove the underdressings, taking care not to dislodge any drains. If the gauze sticks to the drain, support the drain with one hand and remove the gauze with the other |  |
| * Assess the location, type (color, consistency), and odor of wound drainage, and the number of gauzes saturated or the diameter of drainage collected on the dressings. |  |
| * Discard the soiled dressings in the bag as before |  |
| * Remove and discard gloves in the moisture-proof bag |  |
| * Perform hand hygiene |  |
| 1. Set up the sterile supplies. |  |
| * Open the sterile dressing set, using surgical aseptic   technique.   * Place the sterile drape beside the wound. * Open the sterile cleaning solution and pour it over the gauze sponges in the plastic container. * Apply sterile gloves. |  |
| 1. Clean the wound, if indicated.  * Clean the wound, using your gloved hands or forceps and gauze swabs moistened with cleaning solution. |  |
| * If using forceps, keep the forceps tips lower than the   handles at all times. | This prevents their Contamination by fluid traveling up to the handle and nurse’s wrist and back to the tips. |
| * Use a separate swab for each stroke and discard each swab after use. | This prevents the introduction of microorganisms to other wound areas. |
| * If a drain is present, clean it next, taking care to avoid reaching across the cleaned incision. Clean the skin around the drain site by swabbing in half or full circles from around the drain site outward, using separate swabs for each wipe |  |
| * Support and hold the drain erect while cleaning around it. Clean as many times as necessary to remove the drainage. |  |
| * Dry the surrounding skin with dry gauze swabs as required |  |
| * Do not dry the incision or wound itself. | Moisture facilitates wound healing |
| 1. Apply dressings to the drain site  * Place a precut 4×4 gauze snugly around the drain, or open a 4×4 gauze to 4×8 in., fold it lengthwise to 2×8 in., and place it around the drain so that the ends overlap | This dressing absorbs the drainage and helps  prevent it from excoriating the skin. Using precut gauze or folding it as described, instead of cutting the gauze, prevents any threads from coming loose and getting into the wound, where they could cause inflammation and provide a site for infection. |
| * Apply the sterile dressings one at a time over the drain and the incision. Place the bulk of the dressings over the drain area and below the drain, depending on the client’s usual position. | Layers of dressings are placed for best  absorption of drainage, which flows by gravity. |
| * Apply the final surgipad. Remove and discard gloves.Secure the dressing with tape or ties. |  |
| * Perform hand hygiene. |  |
| 1. Document the procedure and all nursing assessments. |  |

**Wound Care**

Procedural Checklist

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student No. \_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1- Performed incorrectly

1. Not performed

|  |  |  |
| --- | --- | --- |
| **EQUIPMENT** | Prepared | Not Prepared |
| • Bath blanket (if necessary) |  |  |
| Moisture-proof bag |  |  |
| • Mask (optional) |  |  |
| • Acetone or another solution (if necessary to loosen adhesive) |  |  |
| • Clean gloves |  |  |
| • Sterile gloves |  |  |
| • Sterile dressing set; if none is available, gather the following Sterile items: |  |  |
| • Drape or towel |  |  |
| • Gauze squares |  |  |
| • Container for cleaning solution |  |  |
| • Cleaning solution (e.g., normal saline) |  |  |
| • Two pairs of forceps |  |  |
| • Gauze dressings and surgipads |  |  |
| • Applicators or tongue blades to apply ointments |  |  |
| • Additional supplies required for the particular dressing (e.g., extra gauze dressings and ointment, if ordered) |  |  |
| * Tape, tie tapes, or binder |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
|  |  |  | **PREPARATION** |  |
|  |  |  | 1. Prepare the client and assemble the equipment. |  |
|  |  |  | * Obtain assistance for changing a dressing on a restless or Confused adult. |  |
|  |  |  | * Assist the client to a comfortable position in which the wound can be readily exposed. Expose only the wound area, using a bath blanket to cover the client, if necessary. |  |
|  |  |  | * Make a cuff on the moisture-proof bag for disposal of the soiled dressings, and place the bag within reach. |  |
|  |  |  | * Apply a face mask, if required. |  |
|  |  |  | **PERFORMANCE** |  |
|  |  |  | 1. Prior to performing the procedure, introduce self and verify the client’s identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss how the results will be used in planning further care or treatments. |  |
|  |  |  | 1. Perform hand hygiene and observe other appropriate   Prevention control procedures |  |
|  |  |  | 1. Provide for client privacy. |  |
|  |  |  | 1. Remove binders and tape.   Remove binders, if used, and place them aside. Untie tie tapes, if used. Montgomery straps (tie tapes) are commonly used for wounds requiring frequent dressing changes. |  |
|  |  |  | If adhesive tape was used, remove it by holding down the skin and pulling the tape gently but firmly toward the wound. |  |
|  |  |  | 1. Remove and dispose of soiled dressings appropriately.  * Apply clean gloves and remove the outer abdominal dressing or surgipad. |  |
|  |  |  | * Lift the outer dressing so that the underside is away from the client’s face. |  |
|  |  |  | * Place the soiled dressing in the moisture-proof bag without touching the outside of the bag. |  |
|  |  |  | * Remove the underdressings, taking care not to dislodge any drains. If the gauze sticks to the drain, support the drain with one hand and remove the gauze with the other |  |
|  |  |  | * Assess the location, type (color, consistency), and odor of wound drainage, and the number of gauzes saturated or the diameter of drainage collected on the dressings. |  |
|  |  |  | * Discard the soiled dressings in the bag as before |  |
|  |  |  | * Remove and discard gloves in the moisture-proof bag |  |
|  |  |  | * Perform hand hygiene |  |
|  |  |  | 1. Set up the sterile supplies. |  |
|  |  |  | * Open the sterile dressing set, using surgical aseptic technique. |  |
|  |  |  | * Place the sterile drape beside the wound. |  |
|  |  |  | * Open the sterile cleaning solution and pour it over the gauze sponges in the plastic container. |  |
|  |  |  | * Apply sterile gloves. |  |
|  |  |  | 1. Clean the wound, if indicated.  * Clean the wound, using your gloved hands or forceps and gauze swabs moistened with cleaning solution. |  |
|  |  |  | * If using forceps, keep the forceps tips lower than the handles at all times. |  |
|  |  |  | * Use a separate swab for each stroke and discard each swab after use. |  |
|  |  |  | * If a drain is present, clean it next, taking care to avoid reaching across the cleaned incision. Clean the skin around the drain site by swabbing in half or full circles from around the drain site outward, using separate swabs for each wipe |  |
|  |  |  | * Support and hold the drain erect while cleaning around it. Clean as many times as necessary to remove the drainage. |  |
|  |  |  | * Dry the surrounding skin with dry gauze swabs as required |  |
|  |  |  | * Do not dry the incision or wound itself. |  |
|  |  |  | 1. Apply dressings to the drain site  * Place a precut 4×4 gauze snugly around the drain, or open a 4×4 gauze to 4×8 in., fold it lengthwise to 2×8 in., and place it around the drain so that the ends overlap |  |
|  |  |  | * Apply the sterile dressings one at a time over the drain and the incision. Place the bulk of the dressings over the drain area and below the drain, depending on the client’s usual position. |  |
|  |  |  | * Apply the final surgipad. Remove and discard gloves.   Secure the dressing with tape or ties. |  |
|  |  |  | * Perform hand hygiene. |  |
|  |  |  | 1. Document the procedure and all nursing assessments. |  |
|  |  |  | TOTAL |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADMINISTERING OXYGEN BY NASAL CANNULA OR BY MASK**

**Procedure**

Purposes:

Cannula

1. To deliver a relatively low concentration of oxygen when only minimal O2 support is required
2. To allow uninterrupted delivery of oxygen while the client ingests food or fluids

Face Mask

1. To provide moderate O2 support and a higher concentration of oxygen and/or humidity than is provided by cannula
2. To provide a high flow of O2 when attached to a Venturi system

Equipment:

* Oxygen supply with a flow meter and adapter
* Humidifier with distilled water or tap water according to agency protocol
* Nasal cannula and tubing / Prescribed face mask of the appropriate size
* Tape (optional
* Padding for the elastic band

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| **Preparation** |  |
| 1. Determine the need for oxygen therapy, and verify the medical order for the therapy. |  |
| 1. Prepare the client and support people  * Assist the client to a semi-Fowler’s position if possible | This position permits easier chest expansion and hence easier breathing. |
| * Explain that oxygen is not dangerous when safety precautions are observed. Inform the client and support people about the safety precautions connected with oxygen use. |  |
| **Performance** |  |
| 1. Introduce self and verify the client’s identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. |  |
| 1. Discuss how the effects of the oxygen therapy will be used in planning further care or treatments |  |
| 1. . Perform hand hygiene and observe other appropriate infection prevention procedures |  |
| 1. Provide for client privacy, if appropriate |  |
| 1. Set up the oxygen equipment and the humidifier |  |
| * Attach the flow meter to the wall outlet or tank. The flow meter should be in the off position. |  |
| * If needed, fill the humidifier bottle. (This can be done before coming to the bedside.). |  |
| * Attach the humidifier bottle to the base of the flow meter. |  |
| * Attach the prescribed oxygen tubing and delivery device to the humidifier |  |
| 1. Turn on the oxygen at the prescribed rate and ensure proper functioning. |  |
| * Check that the oxygen is flowing freely through the tubing. There should be no kinks in the tubing, and the connections should be airtight |  |
| * There should be bubbles in the humidifier   as the oxygen flows through. You should feel the oxygen at the outlets of the cannula or mask |  |
| * + Set the oxygen at the flow rate ordered. |  |
| 1. Apply the appropriate oxygen delivery device. |  |
| **Cannula**   * + Put the cannula over the client’s face, with the outlet prongs fitting into the nares and the tubing hooked around the ears |  |
| * If the cannula will not stay in place, tape it at the sides of the face |  |
| * Pad the tubing and band over the ears and cheekbones as needed. |  |
| **Face Mask**   * + Guide the mask toward the client’s face, and apply it from the nose downward |  |
| * Fit the mask to the contours of the client’s face | *The mask should mold to the*  *face so that very little oxygen escapes into the eyes or*  *around the cheeks and chin.* |
| * + Secure the elastic band around the client’s head so that the mask is comfortable but snug. |  |
| * Pad the band behind the ears and over bony prominences. | *Padding will prevent irritation from the mask.* |
| 1. Assess the client regularly. |  |
| * Assess the client’s vital signs, level of anxiety, color, and ease of respirations, and provide support while the client adjusts to the device. |  |
| * Assess the client in 15 to 30 minutes, depending on the   client’s condition, and regularly thereafter for any signs of hypoxia, tachycardia, dyspnea, restlessness and cyanosis. |  |
| 10. **For nasal cannula**   * Apply a water-soluble lubricant as required to soothe the   Nasal mucous membranes.   |  | | --- | | * Place gauze pads at ear beneath the tubing, as necessary. | |  |
| **For face mask**   * Inspect the facial skin frequently for dampness or chafing, and dry and treat it as needed. |  |
| 11. **Inspect the equipment on a regular basis.**   * Check the liter flow and the level of water in the humidifier in 30 minutes and whenever providing care to the client. * Make sure that safety precautions are being followed. |  |
| 12. Remove PPE, if used. Perform hand hygiene |  |
| 13. Document findings in the client’s record. |  |

**ADMINISTERING OXYGEN BY NASAL CANNULA OR BY MASK**

**Procedure**

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1- Performed incorrectly

1. Not performed

|  |  |  |
| --- | --- | --- |
| Equipment | Prepared | Not Prepared |
| * Oxygen supply with a flow meter and adapter |  |  |
| * Humidifier with distilled water or tap water according to agency protocol |  |  |
| * Nasal cannula and tubing / Prescribed face mask of the appropriate size |  |  |
| * Tape (optional |  |  |
| * Padding for the elastic band |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
|  |  |  | **Preparation** |  |
|  |  |  | 1. Determine the need for oxygen therapy, and verify the medical order for the therapy. |  |
|  |  |  | 1. Prepare the client and support people  * Assist the client to a semi-Fowler’s position if possible |  |
|  |  |  | * Explain that oxygen is not dangerous when safety precautions are observed. Inform the client and support people about the safety precautions connected with oxygen use. |  |
|  |  |  | **Performance** |  |
|  |  |  | 1. Introduce self and verify the client’s identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. |  |
|  |  |  | 1. Discuss how the effects of the oxygen therapy will be used in planning further care or treatments |  |
|  |  |  | 1. . Perform hand hygiene and observe other appropriate infection prevention procedures |  |
|  |  |  | 1. Provide for client privacy, if appropriate |  |
|  |  |  | 1. Set up the oxygen equipment and the humidifier |  |
|  |  |  | * Attach the flow meter to the wall outlet or tank. The flow meter should be in the off position. |  |
|  |  |  | * If needed, fill the humidifier bottle. (This can be done before coming to the bedside.). |  |
|  |  |  | * Attach the humidifier bottle to the base of the flow meter. |  |
|  |  |  | * Attach the prescribed oxygen tubing and delivery device to the humidifier |  |
|  |  |  | 1. Turn on the oxygen at the prescribed rate and ensure proper functioning. |  |
|  |  |  | * Check that the oxygen is flowing freely through the tubing. There should be no kinks in the tubing, and the connections should be airtight |  |
|  |  |  | * There should be bubbles in the humidifier   as the oxygen flows through. You should feel the oxygen at the outlets of the cannula or mask |  |
|  |  |  | * + Set the oxygen at the flow rate ordered. |  |
|  |  |  | 1. Apply the appropriate oxygen delivery device. |  |
|  |  |  | **Cannula**   * + Put the cannula over the client’s face, with the outlet prongs fitting into the nares and the tubing hooked around the ears |  |
|  |  |  | * If the cannula will not stay in place, tape it at the sides of the face |  |
|  |  |  | * Pad the tubing and band over the ears and cheekbones as needed. |  |
|  |  |  | **Face Mask**   * + Guide the mask toward the client’s face, and apply it from the nose downward |  |
|  |  |  | * Fit the mask to the contours of the client’s face |  |
|  |  |  | * + Secure the elastic band around the client’s head so that the mask is comfortable but snug. |  |
|  |  |  | * Pad the band behind the ears and over bony prominences. |  |
|  |  |  | 12. Remove PPE, if used. Perform hand hygiene |  |
|  |  |  | 13. Document findings in the client’s record. |  |
|  |  |  | Total Score : 25 X 2 = 50  **Score \_\_\_\_ X 10 marks = \_\_\_\_\_\_\_ marks**  **50** |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Teaching Moving, Leg Exercises, Deep Breathing, and Coughing**

**Procedure**

**PURPOSES**

**Moving**

• To promote venous return

• To enhance lung expansion and mobilize secretions

• To stimulate gastrointestinal motility

• To facilitate early ambulation

Equipment

• Pillow

• Teaching materials (e.g., audiovisual, written materials) if Available at the agency

|  |  |
| --- | --- |
| **PROCEDURE** | **Rationale** |
| **Preparation**   1. Ensure that potential distracters (e.g., pain, TV, visitors) to teaching are not present. 2. Family and/or significant others should be included in the teaching plan, if appropriate. |  |
| **Performance** |  |
| 1. introduce self and verify the client’s identity using agency protocol. |  |
| 1. Explain to the client what you are going to teach and the importance of the client’s participation in the exercises he or she is going to be taught. |  |
| 1. Perform hand hygiene and observe other appropriate infection prevention procedures. |  |
| 1. Show the client ways to turn in bed and to get out of bed (**moving) .** |  |
| 1. Instruct a client who will have a right abdominal incision or a right-sided chest incision to turn to the left side of the bed and sit up as follows: |  |
| * Flex the knees. |  |
| * Splint the wound by holding the left arm and hand or a small pillow against the incision. |  |
| * Turn to the left while pushing with the right foot and grasping a partial side rail on the left side of the bed with the right hand. |  |
| * Come to a sitting position on the side of the bed by using the right arm and hand to push down against the mattress and swinging the feet over the edge of the bed |  |
| * Teach a client with a left abdominal or left-sided chest incision to perform the same procedure but splint with the right arm and turn to the right. |  |
| * For clients with orthopedic surgery (e.g., hip surgery), use special aids, such as a trapeze, to assist with movement |  |
| 1. Teach the client the following three leg exercises: |  |
| * Alternate dorsiflexion and plantar flexion of the feet. | This exercise is sometimes referred to as calf pumping, because it alternately contracts and relaxes the calf muscles, including the gastrocnemius muscles. |
| * Flex and extend the knees, and press the backs of the * knees into the bed while dorsiflexing the feet. |  |
| * Instruct clients who cannot raise their legs to do isometric exercises that contract and relax the muscles. |  |
| * Raise and lower the legs alternately from the surface of the bed. Flex the knee of the stable leg and extend the knee of the moving leg. | This exercise contracts and  relaxes the quadriceps muscles. |
| 1. Demonstrate deep-breathing (diaphragmatic) exercises as   follows: |  |
| * Place your hands palms down on the border of your rib * cage, and inhale slowly and evenly through the nose until * the greatest chest expansion is achieved |  |
| * Hold your breath for 2 to 3 seconds. |  |
| * Then exhale slowly through the mouth. |  |
| * Continue exhalation until maximum chest contraction has * been achieved. |  |
| 1. Help the client perform deep-breathing exercises. |  |
| * Ask the client to assume a sitting position. |  |
| * Place the palms of your hands on the border of the client’s rib cage to assess respiratory depth |  |
| * Ask the client to perform deep breathing, as described in   step 7. |  |
| 9-Instruct the client to cough voluntarily after five deep inhalations. |  |
| • Ask the client to inhale deeply, hold the breath for a few seconds, and then cough once or twice |  |
| • Ensure that the client coughs deeply and does not just clear the throat |  |
| 10-If the incision will be painful when the client coughs, demonstrate techniques to splint the abdomen. | Coughing uses the abdominal  and other accessory respiratory muscles. Splinting the incision may reduce pain while coughing if the incision is  near any of these muscles. |
| * Show the client how to support the incision by placing the palms of the hands on either side of the incision site or directly over the incision site, holding the palm of one hand over the other. |  |
| * Show the client how to splint the abdomen with clasped hands and a pillow firmly held against the client’s abdomen |  |
| 11-Inform the client about the expected frequency of these  exercises. |  |
| * Instruct the client to start the exercises as soon after surgery * as possible. |  |
| * Encourage clients to carry out deep breathing and coughing at least every 2 hours, taking a minimum of five breaths at   each session. Note, however, that the number of breaths and frequency of deep breathing vary with the client’s condition.   * People who are susceptible to pulmonary problems may need deep-breathing exercises every hour. People with chronic respiratory disease may need special breathing exercises (e.g., pursed-lip breathing, abdominal breathing, exercises using various kinds of incentive spirometers). |  |
| 12-Document the teaching and all assessments. Some agencies  may have a preoperative teaching flow sheet. Check agency  policy. |  |

**Teaching Moving, Leg Exercises, Deep Breathing, and Coughing**

Procedural Checklist

**Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student No. \_\_\_\_\_\_\_\_\_\_\_**

Legend:

2- Performed correctly

1- Performed incorrectly

1. Not performed

|  |  |  |
| --- | --- | --- |
| Equipment | Prepared | Not Prepared |
| Pillow |  |  |
| Teaching materials (e.g., audiovisual, written materials) if available |  |  |

| **2** | **1** | **0** | **PROCEDURE** | **Comments** |
| --- | --- | --- | --- | --- |
|  |  |  | **Preparation**   1. Ensure that potential distracters (e.g., pain, TV, visitors) to teaching are not present. |  |
|  |  |  | 1. Family and/or significant others should be included in the teaching plan, if appropriate. | |  | | --- | |  | |
|  |  |  | **Performance** |  |
|  |  |  | 1. Introduce self and verify the client’s identity using agency protocol. |  |
|  |  |  | 1. Explain to the client what you are going to teach and the importance of the client’s participation in the exercises he or she is going to be taught. |  |
|  |  |  | 1. Perform hand hygiene and observe other appropriate infection prevention procedures. |  |
|  |  |  | 1. Instruct a client who will have a right abdominal incision or a right-sided chest incision to turn to the left side of the bed and sit up as follows: |  |
|  |  |  | * Flex the knees. |  |
|  |  |  | * Splint the wound by holding the left arm and hand or a small pillow against the incision. |  |
|  |  |  | * Turn to the left while pushing with the right foot and grasping a partial side rail on the left side of the bed with the right hand. |  |
|  |  |  | * Come to a sitting position on the side of the bed by using the right arm and hand to push down against the mattress and swinging the feet over the edge of the bed |  |
|  |  |  | * Teach a client with a left abdominal or left-sided chest incision to perform the same procedure but splint with the right arm and turn to the right. |  |
|  |  |  | 1. Teach the client the following three leg exercises: |  |
|  |  |  | * Alternate dorsiflexion and plantar flexion of the feet. |  |
|  |  |  | * Flex and extend the knees, and press the backs of the * knees into the bed while dorsiflexing the feet. |  |
|  |  |  | * Instruct clients who cannot raise their legs to do isometric exercises that contract and relax the muscles. |  |
|  |  |  | * Raise and lower the legs alternately from the surface of the bed. |  |
|  |  |  | * Flex the knee of the stable leg and extend the knee of the moving leg. |  |
|  |  |  | 1. Demonstrate deep-breathing (diaphragmatic) exercises as   follows: |  |
|  |  |  | * Place your hands palms down on the border of your rib * cage, and inhale slowly and evenly through the nose until * the greatest chest expansion is achieved |  |
|  |  |  | * Hold your breath for 2 to 3 seconds. |  |
|  |  |  | * Then exhale slowly through the mouth. |  |
|  |  |  | * Continue exhalation until maximum chest contraction has * been achieved. |  |
|  |  |  | 1. Help the client perform deep-breathing exercises. |  |
|  |  |  | * Ask the client to assume a sitting position. |  |
|  |  |  | * Place the palms of your hands on the border of the client’s rib cage to assess respiratory depth |  |
|  |  |  | * Ask the client to perform deep breathing, as described in   step 6. |  |
|  |  |  | 8-Instruct the client to cough voluntarily after five deep inhalations. |  |
|  |  |  | • Ask the client to inhale deeply, hold the breath for a few seconds, and then cough once or twice |  |
|  |  |  | • Ensure that the client coughs deeply and does not just clear the throat |  |
|  |  |  | 9-If the incision will be painful when the client coughs, demonstrate techniques to splint the abdomen. |  |
|  |  |  | * Show the client how to support the incision by placing the palms of the hands on either side of the incision site or directly over the incision site, holding the palm of one hand over the other. |  |
|  |  |  | * Show the client how to splint the abdomen with clasped hands and a pillow firmly held against the client’s abdomen |  |
|  |  |  | 10-Inform the client about the expected frequency of these  exercises. |  |
|  |  |  | * Instruct the client to start the exercises as soon after surgery as possible. |  |
|  |  |  | * Encourage clients to carry out deep breathing and coughing at least every 2 hours, taking a minimum of five breaths at each session. |  |
|  |  |  | 11-Document the teaching and all assessments. |  |
|  |  |  | **Total Score :** 30 X 2 = 60  **Score \_\_\_\_ X 10 marks = \_\_\_\_\_\_\_ marks**  **60** |  |

**OVER ALL REMARKS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Signature of Evaluator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**