SKILL CHECKLISTS FOR MIDTERM EXAM 1

1. Performing Hand Hygiene Using Soap And Water (Handwashing)
2. Using Personal Protective Equipment
3. Putting On Sterile Gloves And Removing Soiled Gloves
4. Assessing Body Temperature
5. Assessing a Peripheral Pulse by Palpation
6. Assessing Respirations
7. Assessing Blood Pressure
8. Assessing Height and Weight

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____

FORMULATING NURSING CARE PLAN

Assessment	
Subjective	
Objective	
Nursing Diagnosis	
Planning	
Implementation	**1.**
	2.
	3.
	4.
	5.
	6.
	7.
Evaluation	

Skill 2.1 PERFORMING HAND HYGIENE USING SOAP AND WATER

(HANDWASHING)

Handwashing, as opposed to Hand Hygiene with an Alcohol based rub is required when:

- When hands are visibly dirty
- When hands are visibly soiled with (or in contact with) blood or other body fluids
- Before eating or after using the restroom
- If exposure to certain microorganisms, such as those causing Anthrax or Clostridium deficile

Equipment:

- Antimicrobial soap
- Paper towels
- Oil free lotion (optional)

Goal: The hands will be free of visible soiling and transient microorganisms will be eliminated

PROCEDURE	Rationale
1. Gather the necessary supplies	
2. Stand in front of the sink. Do not allow your clothing to touch the sink during the washing procedure.	The sink is considered contaminated. Clothing may carry organisms from place to place
3. Remove jewelry, if possible, and secure in a safe place. A plain wedding band may remain in place.	Removal of jewelry facilitates cleansing. Microorganisms may accumulate in settings of jewelries
4. Turn on water and adjust force. Regulate the temperature until the water is warm.	Water splashed from the contaminated sink will contaminate clothing. Warm water is more comfortable and is less likely to open pores and remove oils from the skin
5. Wet the hands and wrist area. Keep hands lower than elbows to allow water to flow toward fingertips.	Water should flow from the cleaner area toward the more contaminated area. Hands are more contaminated than forearms.
6. Use about 1 teaspoon liquid soap from dispenser or rinse bar of soap and lather thoroughly.. Cover all areas of hands with the soap product.	Rinsing of soap before and after use removes the lather, which may contain microorganisms.
7. With firm rubbing and circular motions, wash the palms and backs of the hands, each finger, the areas between the fingers, and the knuckles, wrists, and forearms.	Friction helps to loosen dirt and microorganisms that can lodge between the fingers , in skin crevices between the knuckles, on the palms and back of the hands, and on the wrists and forearms
8. Wash at least 1 inch above area of contamination. If hands are not visibly soiled, wash to 1 inch above the wrists.	To prevent the spread of microorganisms from the hands to the forearms and wrists
9. Continue this friction motion for at least 15 seconds.	
10. Use fingernails of the opposite hand or a clean orangewood stick to clean under fingernails.	Area under the nails has high microorganism count, and organisms may remain under the nails

11. Rinse thoroughly with water flowing toward fingertips.	Running water rinses microorganisms and dirt into the sink
12. Pat hands dry with a paper towel, beginning with the fingers and moving upward toward forearms, and discard it immediately.	To prevent chapping. Dry hands first because they are considered the cleanest and least contaminated area
13. Use another clean towel to turn off the faucet..	Protects the clean hands from contact with the soiled surface.
14. Discard towel immediately without touching other clean hand	To prevent contamination
15. Use oil-free lotion on hands if desired.	Oil free lotion helps keep the skin soft and prevents chapping

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score ____ /10 marks

Skill 2.1 PERFORMING HAND HYGIENE USING SOAP AND WATER (HANDWASHING)

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The hands will be free of visible soiling and transient microorganisms will be eliminated.

Equipment:

- Antimicrobial soap
- Paper towels
- Oil free lotion (optional)

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Gather the necessary supplies	
			2. Stand in front of the sink. Do not allow your clothing to touch the sink during the washing procedure.	
			3. Remove jewelry, if possible, and secure in a safe place. A plain wedding band may remain in place.	
			4. Turn on water and adjust force. Regulate the temperature until the water is warm.	
			5. Wet the hands and wrist area. Keep hands lower than elbows to allow water to flow toward fingertips.	
			6. Use about 1 teaspoon liquid soap from dispenser or rinse bar of soap and lather thoroughly..	
			7. Cover all areas of hands with the soap product.	
			8. With firm rubbing and circular motions, wash the palms and backs of the hands, each finger, the areas between the fingers, and the knuckles, wrists, and forearms.	
			9. Wash at least 1 inch above area of contamination. If hands are not visibly soiled, wash to 1 inch above the wrists.	
			10. Continue this friction motion for at least 15 seconds.	
			11. Use fingernails of the opposite hand or a clean orangewood stick to clean under fingernails.	
			12. Rinse thoroughly with water flowing toward fingertips.	

			13. Pat hands dry with a paper towel, beginning with the fingers and moving upward toward forearms, and discard it immediately.	
			14. Use another clean towel to turn off the faucet..	
			15. Discard towel immediately without touching other clean hand	
			16. Use oil-free lotion on hands if desired.	

Scoring and Evaluation

Range	**Interpretation**
24.25 – 32	Excellent
16.50 – 24.24	Satisfactory
8.75 – 16.49	Fair
1.00 -8.74	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

Skill 2.2 Using Personal Protective Equipment

Equipment:

- Gloves
- Mask
- Gown (disposable)
- Protective eyewear

Goal: The transmission of microorganisms is prevented.

PROCEDURE	Rationale
1. Check medical record and nursing plan of care for type of precautions and review precautions in infection control manual.	Mode of transmission of organism determines type of precautions required
2. Plan nursing activities before entering patient's room.	Organization facilitates performance of task and adherence to precautions
3. Perform hand hygiene.	Hand hygiene prevents the spread of microorganism
4. Provide instruction about precautions to patient, family members, and visitors.	Explanation encourages cooperation of patient and family and reduces apprehensions about precaution procedures
5. Put on gown, gloves, mask, and protective eyewear, based on the type of exposure anticipated and category of isolation precautions.	Use of PPE interrupts chain of infection and protects patient and nurse.
a. Put on the gown, with the opening in the back. Tie gown securely at neck and waist.	Gown should protect entire uniform. Gown should fully cover the torso from the neck to the knees, arms to the end of wrists and wrap around the back
b. Put on the mask or respirator over your nose, mouth, and chin. Secure ties or elastic bands at the middle of the head and neck	Masks protect nurse or patient from droplet nuclei and large particle aerosols. A mask must fit securely to provide protection
c. Put on goggles. Place over eyes and adjust to fit. Alternately, a face shield could be used to take the place of the mask and goggles.	Eye wear protects mucous membranes in the eyes from splashes. Must fit securely to provide protection
d. Put on clean disposable gloves. Extend gloves to cover the cuffs of the gown.	Gloves protect hands and wrists from microorganisms
6. Identify the patient. Explain the procedure to the patient. Continue with patient care as appropriate.	Patient identification validates the correct patient and the correct procedure. Discussion and explanation helps allay anxiety and prepare the patient for what to expect.
Removing PPE	
7. Remove PPE: Except for respirator, remove PPE at the doorway or in an anteroom. Remove respirator after leaving the patient room and closing door.	Proper removal prevents contact with and spread of microorganism Prevents contact with airborne microorganism

a. If impervious gown has been tied in front of the body at the waistline, untie waist strings before removing gloves.	Outside front of equipment is considered contaminated. The inside, outside back, ties on the head and back are considered clean which are areas of PPE which are unlikely to have been in contact with infectious organism . Front of gown, including waist strings are contaminated. If tied in front of the body, the ties must be untied before removing the gloves
b. Grasp the outside of one glove with the opposite gloved hand and peel off, turning the glove inside out as you pull it off. Hold the removed glove in the remaining gloved hand.	
c. Slide fingers of ungloved hand under the remaining glove at the wrist, taking care not to touch the outer surface of the glove	Ungloved hand is clean and should not touch the contaminated areas
d. Peel off the glove over the first glove, containing the one glove inside the other. Discard in appropriate container.	Proper disposal prevents transmission of microorganisms
e. To remove the goggles or face shield: Handle by the headband or ear pieces. Lift away from the face. Place in designated receptacle for reprocessing or in an appropriate waste container	Outside of goggles or face shield is considered contaminated . **Do not touch.** Handling by headband or earpieces and lifting away from face prevents transmission of microorganism
f. To remove gown: Unfasten ties, if at the neck and back. • Allow the gown to fall away from shoulders. • **Touching only the inside of the gown**, pull away from the torso. Keeping hands on the inner surface of the gown, pull from arms. • Turn gown inside out. • Fold or roll into a bundle and discard.	Gown front and sleeves are contaminated. Touching only the inside of the gown and pulling it away from the torso prevents transmission of microorganism. Proper disposal prevents transmission of microorganism.
g. To remove mask or respirator: Grasp the neck ties or elastic, then top ties or elastic and remove. • **Take care to avoid touching front of mask or respirator**. • Discard in waste container.	Front of mask or respirator is contaminated. **Do not touch** prevents transmission of microorganism.
8. Perform hand hygiene immediately after removing all PPE.	Hand hygiene prevents spread of microorganisms.

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score ____ /10 marks

Skill 2.2 Using Personal Protective Equipment

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The transmission of microorganisms is prevented.

Equipment:

- Gloves
- Mask
- Gown (disposable)
- Protective eyewear

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Check medical record and nursing plan of care for type of precautions and review precautions in infection control manual.	
			2. Plan nursing activities before entering patient's room.	
			3. Perform hand hygiene.	
			4. Provide instruction about precautions to patient, family members, and visitors.	
			5. Put on gown, gloves, mask, and protective eyewear, based on the type of exposure anticipated and category of isolation precautions.	
			a. Put on the gown, with the opening in the back. Tie gown securely at neck and waist.	
			b. Put on the mask or respirator over your nose, mouth, and chin. Secure ties or elastic bands at the middle of the head and neck	
			c. Put on goggles. Place over eyes and adjust to fit. Alternately, a face shield could be used to take the place of the mask and goggles.	
			d. Put on clean disposable gloves. Extend gloves to cover the cuffs of the gown.	
			6. Identify the patient. Explain the procedure to the patient. Continue with patient care as appropriate.	
			Removing PPE	

			7. Remove PPE: Except for respirator, remove PPE at the doorway or in an anteroom. Remove respirator after leaving the patient room and closing door.	
			a. If impervious gown has been tied in front of the body at the waistline, untie waist strings before removing gloves.	
			b. Grasp the outside of one glove with the opposite gloved hand and peel off, turning the glove inside out as you pull it off. Hold the removed glove in the remaining gloved hand.	
			c. Slide fingers of ungloved hand under the remaining glove at the wrist, taking care not to touch the outer surface of the glove	
			d. Peel off the glove over the first glove, containing the one glove inside the other. Discard in appropriate container.	
			e. To remove the goggles or face shield: Handle by the headband or ear pieces. Lift away from the face. Place in designated receptacle for reprocessing or in an appropriate waste container	
			f. To remove gown: Unfasten ties, if at the neck and back.	
			• Allow the gown to fall away from shoulders.	
			• Touching only the inside of the gown, pull away from the torso. Keeping hands on the inner surface of the gown, pull from arms.	
			• Turn gown inside out.	
			• Fold or roll into a bundle and discard.	
			g. To remove mask or respirator: Grasp the neck ties or elastic, then top ties or elastic and remove.	
			• **Take care to avoid touching front of mask or respirator**.	
			• Discard in waste container.	
			8. Perform hand hygiene immediately after removing all PPE.	

Scoring and Evaluation

Range	**Interpretation**
37.75 - 50	Excellent
25.5 – 37.74	Satisfactory
13.25 – 25.49	Fair
1.00 -13.24	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

Skill 2.3 PUTTING ON STERILE GLOVES AND REMOVING SOILED GLOVES

Equipment:

- Sterile Gloves
- PPE

Goal: The gloves are applied and removed without contamination.

PROCEDURE	Rationale
1. Perform hand hygiene and put on PPE, if indicated.	
2. Identify the patient. Explain the procedure to the patient.	
3. Check that the sterile glove package is dry and unopened.	Moisture contaminates a sterile package.
4. Also note expiration date, making sure that the date is still valid.	Expiration date indicates the period that the package remains sterile
5. Place sterile glove package on clean, dry surface at or above your waist.	Moisture could contaminate a sterile gloves. Any sterile object held below the waist is considered contaminated.
6. Open the outside wrapper by carefully peeling the top layer back.	This maintains sterility of the gloves in inner packet
7. Remove inner package, handling only the outside of it.	Allows for ease of glove application
8. Place the inner package on the work surface with the side labeled 'cuff end' closest to the body.	
9. Carefully open the inner package. Fold open the top flap, then the bottom and sides.	
10. Take care not to touch the inner surface of the package or the gloves.	The inner surface of the package is considered sterile. The outer 1 inch border of the inner package is considered contaminated. The sterile gloves are exposed with the cuff end closest to the nurse
11. With the thumb and forefinger of the nondominant hand, grasp the folded cuff of the glove for the dominant hand, touching only the exposed inside of the glove.	Unsterile hand touches only inside of gloves. Outside remains sterile
12. Keeping the hands above the waistline, lift and hold the glove up and off the inner package with fingers down.	
13. ***Be careful it does not touch any unsterile object.***	Glove is contaminated if it touches any unsterile items
14. Carefully insert dominant hand palm up into glove and pull glove on. Leave the cuff folded until the opposite hand is gloved.	Attempting to turn upward with unsterile hand may result in contamination of sterile gloves
15. Hold the thumb of the gloved hand outward. Lift it from the wrapper, taking care not to touch anything with the gloves or hands.	Thumb is less likely to become contaminated if held outward. Sterile surface touching sterile surface prevents contamination.

16. Carefully insert nondominant hand into glove.	
17. Pull the glove on, taking care that the skin does not touch any of the outer surfaces of the gloves.	Sterile surface touching sterile surface prevents contamination.
18. Slide the fingers of one hand under the cuff of the other and fully extend the cuff down the arm, touching only the sterile outside of the glove.	Sterile surface touching sterile surface prevents contamination.
19. Repeat for the remaining hand.	
20. Adjust gloves on both hands if necessary, touching only sterile areas with other sterile areas.	Sterile surface touching sterile surface prevents contamination.
21. Continue with procedure as indicated.	
Removing Soiled Gloves	
22. Use dominant hand to grasp the opposite glove near cuff end on the outside exposed area.	Contaminated area does not come in contact with hands or wrists
23. Remove it by pulling it off, inverting it as it is pulled, keeping the contaminated area on the inside. Hold the removed glove in the remaining gloved hand.	
24. Slide fingers of ungloved hand between the remaining glove and the wrist. ***Take care to avoid touching the outside surface of the glove***	Contaminated area does not come in contact with hands or wrists
25. Remove it by pulling it off, inverting it as it is pulled, keeping the contaminated area on the inside, and securing the first glove inside the second.	
26. Discard gloves in appropriate container. Remove additional PPE, if used.	Proper disposal and removal of PPE reduces the risk for infection transmission and contamination of other items. Hand hygiene prevents the spread of microorganism
27. Perform hand hygiene.	

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score ____ /10 marks

Skill 2.3 PUTTING ON STERILE GLOVES AND REMOVING SOILED GLOVES

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The gloves are applied and removed without contamination.

Equipment:

- Sterile Gloves
- PPE

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Perform hand hygiene and put on PPE, if indicated.	
			2. Identify the patient. Explain the procedure to the patient.	
			3. Check that the sterile glove package is dry and unopened.	
			4. Also note expiration date, making sure that the date is still valid.	
			5. Place sterile glove package on clean, dry surface at or above your waist.	
			6. Open the outside wrapper by carefully peeling the top layer back.	
			7. Remove inner package, handling only the outside of it.	
			8. Place the inner package on the work surface with the side labeled 'cuff end' closest to the body.	
			9. Carefully open the inner package. Fold open the top flap, then the bottom and sides.	
			10. Take care not to touch the inner surface of the package or the gloves.	
			11. With the thumb and forefinger of the nondominant hand, grasp the folded cuff of the glove for the dominant hand, touching only the exposed inside of the glove.	
			12. Keeping the hands above the waistline, lift and hold the glove up and off the inner package with fingers down.	
			13. ***Be careful it does not touch any unsterile object.***	

			14. Carefully insert dominant hand palm up into glove and pull glove on. Leave the cuff folded until the opposite hand is gloved.	
			15. Hold the thumb of the gloved hand outward.	
			16. Lift it from the wrapper, taking care not to touch anything with the gloves or hands.	
			17. Carefully insert nondominant hand into glove.	
			18. Pull the glove on, taking care that the skin does not touch any of the outer surfaces of the gloves.	
			19. Slide the fingers of one hand under the cuff of the other and fully extend the cuff down the arm, touching only the sterile outside of the glove.	
			20. Repeat for the remaining hand.	
			21. Adjust gloves on both hands if necessary, touching only sterile areas with other sterile areas.	
			22. Continue with procedure as indicated.	
			Removing Soiled Gloves	
			23. Use dominant hand to grasp the opposite glove near cuff end on the outside exposed area.	
			24. Remove it by pulling it off, inverting it as it is pulled, keeping the contaminated area on the inside.	
			25. Hold the removed glove in the remaining gloved hand.	
			26. Slide fingers of ungloved hand between the remaining glove and the wrist. ***Take care to avoid touching the outside surface of the glove***	
			27. Remove it by pulling it off, inverting it as it is pulled, keeping the contaminated area on the inside, and securing the first glove inside the second.	
			28. Discard gloves in appropriate container. Remove additional PPE, if used.	
			29. Perform hand hygiene.	

Scoring and Evaluation

Range	**Interpretation**
43.75 - 58	Excellent
29.5 – 37.74	Satisfactory
15.25 – 25.49	Fair
1.00 -15.24	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

Skill 3.1 Assessing Body Temperature

Equipment:

- Digital, glass or electronic thermometer
- Disposable probe covers
- Non sterile gloves
- PPE
- Toilet tissue
- Pencil or pen, paper or flow sheet
- Alcohol swab

Goal: The patient's temperature is assessed accurately without injury and the patient experiences only minimal discomfort.

PROCEDURE	Rationale
1. Check medical order or nursing care plan for frequency of measurement and route. More frequent temperature measurement may be appropriate based on nursing judgment.	Assessment and measurement of vital signs at appropriate intervals provide important data about the patient's health status
2. Perform hand hygiene and put on PPE, if indicated.	Hand hygiene and PPE prevent the spread of microorganisms. PPE is required based on transmission precaution
3. Identify the patient.	Ensures that the patient receives the intervention and helps prevent errors
4. Close curtains around bed and close the door to the room, if possible.	This ensures the patient's privacy . Explanation relieves anxiety and facilitates cooperation.
5. Discuss the procedure with patient and assess the patient's ability to assist with the procedure.	Dialogue encourages patient participation
6. Assemble equipment to the bedside stand or overbed table within reach	Organization facilitates performance of task
7. Ensure the electronic or digital thermometer is in working condition.	Improperly functioning thermometer may not give an accurate reading
8. Put on gloves, if appropriate or indicated.	Gloves prevent contact with blood and body fluids. Gloves usually are not required for an oral , axillary or tympanic temperature measurement unless contact with blood or body fluids is anticipated. Gloves should be worn for rectal temperature measurement.
9. Select the appropriate site based on previous assessment data.	This ensures safety and accuracy of measurement
10. Follow the steps as outlined below for the appropriate type of thermometer.	
11. When measurement is completed, remove gloves, if worn. Remove additional PPE, if used.	Reduces the risk of infection transmission and contamination of other items.
12. Perform hand hygiene.	Prevents the spread of microorganisms

Measuring Oral Temperature	
1. Remove the electronic unit from the charging unit, and remove the probe from within the recording unit.	Electronic unit must be taken into the patient's room to assess the patient's temperature. On some models, by removing the probe, the machine is already turned on.
2. Cover thermometer probe with disposable probe cover and slide it on until it snaps into place.	Using a cover prevents contamination of the Probe
3. Place the probe beneath the patient's tongue in the posterior sublingual pocket. Ask the patient to close his or her lips around the probe.	When the probe rests deep in the posterior sublingual pocket, it is in contact with the blood vessels lying close to the surface
4. Continue to hold the probe until you hear a beep. Note the temperature reading.	If left unsupported, the weight of the probe tends to pull it away from the correct location . The signal indicates that the measurement is completed. \the electronic thermometer provides a digital display of the measured temperature.
5. Remove the probe from the patient's mouth. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the probe release button.	Disposing of the probe ensures that it will not be reused accidentally on another patient.
6. Return the thermometer probe to the storage place within the unit. Return the electronic unit to the charging unit, if appropriate.	The thermometer needs to be recharged for future use. If necessary, the thermometer should stay on the charger so that it is ready to use at all times.
Measuring a Tympanic Membrane Temperature	
1. If necessary, push the "on" button and wait for the "ready" signal on the unit.	For proper function. The thermometer must be turned on and warmed up
2. Slide disposable cover onto the tympanic probe.	
3. Insert the probe snugly into the external ear using gentle but firm pressure, angling the thermometer toward the patient's jaw line. Pull pinna up and back to straighten the ear canal in an adult.	If the probe is not inserted correctly, the patient's temperature may be noted as lower than normal
4. Activate the unit by pushing the trigger button. The reading is immediate (usually within 2 seconds). Note the reading.	
5. Discard the probe cover in an appropriate receptacle by pushing the probe-release button or use rim of cover to remove from probe	Disposing of the probe ensures that it will not be reused accidentally on another patient.
6. Replace the thermometer in its charger, if necessary.	The thermometer needs to be recharged for future use. If necessary, the thermometer should stay on the charger so that it is ready to use at all times.

Measuring Rectal Temperature	
1. Adjust the bed to a comfortable working height, usually elbow height of the care giver (VISN 8 Patient Safety Center, 2009).	Prevents back and muscle strain
2. Put on nonsterile gloves.	
3. Assist the patient to a side-lying position. Pull back the covers sufficiently to expose only the buttocks.	Side-lying position allows the nurse to visualize the buttocks. Exposing only the buttocks keeps the patient warm and maintains his or her dignity
4. Remove the rectal probe from within the recording unit of the electronic thermometer. Cover the probe with a disposable probe cover and slide it into place until it snaps in place.	
5. Lubricate about 1 inch of the probe with a water-soluble lubricant.	Lubrication reduces friction and facilitates insertion minimizing the risk of irritation or injury to the rectal mucous membranes
6. Reassure the patient. Separate the buttocks until the anal sphincter is clearly visible.	If not placed directly into the anal opening , the thermometer probe may injure adjacent tissue or cause discomfort.
7. Insert the thermometer probe into the anus about 1.5 inches in an adult or 1 inch in a child.	Depth of insertion must be adjusted based on the patient's age. Rectal temperatures are not normally taken in an infant , but may be indicated.
8. Hold the probe in place until you hear a beep, then carefully remove the probe. Note the temperature reading on the display.	If left unsupported, movement in the probe of the rectum could cause injury or discomfort.
9. Dispose of the probe cover by holding the probe over an appropriate waste receptacle and pressing the release button	
10. Using toilet tissue, wipe the anus of any feces or excess lubricant. Dispose of the toilet tissue.	Wiping promotes cleanliness
11. Remove gloves and discard them.	
12. Cover the patient and help him or her to a position of comfort.	Ensures patient comfort
13. Place the bed in the lowest position; elevate rails as needed.	This action provides for patient's safety
14. Return the thermometer to the charging unit.	The thermometer needs to be recharged for future use
Assessing Axillary Temperature	
1. Move the patient's clothing to expose only the axilla.	Exposing only the axilla keeps the patient warm and maintains his or her dignity
2. Remove the probe from the recording unit of the electronic thermometer. Place a disposable probe cover on by sliding it on and snapping it securely.	

3. Place the end of the probe in the center of the axilla. Have the patient bring the arm down and close to the body.	The deepest area of the axilla provides the most accurate measurement surrounding the bulb with the skin surface provides a more reliable measurement
4. Hold the probe in place until you hear a beep, and then carefully remove the probe. Note the temperature reading.	
5. Cover the patient and help him or her to a position of comfort.	
6. Dispose of the probe cover by holding the probe over an appropriate waste receptacle and pushing the release button.	
7. Place the bed in the lowest position and elevate rails, as needed. Leave the patient clean and comfortable.	
8. Return the electronic thermometer to the charging unit.	

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score ____ /10 marks

Skill 3.1 Assessing Body Temperature

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The patient's temperature is assessed accurately without injury and the patient experiences only minimal discomfort.

Equipment:

- Digital, glass or electronic thermometer
- Disposable probe covers
- Non sterile gloves
- PPE
- Toilet tissue
- Pencil or pen, paper or flow sheet
- Alcohol swab

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Check medical order or nursing care plan for frequency of measurement and route. More frequent temperature measurement may be appropriate based on nursing judgment.	
			2. Bring necessary equipment to the bedside stand or overbed table.	
			3. Perform hand hygiene and put on PPE, if indicated.	
			4. Identify the patient.	
			5. Close curtains around bed and close the door to the room, if possible.	
			6. Discuss the procedure with patient and assess the patient's ability to assist with the procedure.	
			7. Ensure the electronic or digital thermometer is in working condition.	
			8. Put on gloves, if appropriate or indicated.	
			9. Select the appropriate site based on previous assessment data.	
			10. Follow the steps as outlined below for the appropriate type of thermometer.	
			11. When measurement is completed, remove gloves, if worn. Remove additional PPE, if used.	
			12. Perform hand hygiene.	

			Assessing Oral Temperature	
			13. Remove the electronic unit from the charging unit, and remove the probe from within the recording unit.	
			14. Cover thermometer probe with disposable probe cover and slide it on until it snaps into place.	
			15. Place the probe beneath the patient's tongue in the posterior sublingual pocket. Ask the patient to close his or her lips around the probe.	
			16. Continue to hold the probe until you hear a beep. Note the temperature reading.	
			17. Remove the probe from the patient's mouth. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the probe release button.	
			18. Return the thermometer probe to the storage place within the unit. Return the electronic unit to the charging unit, if appropriate.	
			Measuring a Tympanic Membrane Temperature	
			19. If necessary, push the "on" button and wait for the "ready" signal on the unit.	
			20. Slide disposable cover onto the tympanic probe.	
			21. Insert the probe snugly into the external ear using gentle but firm pressure, angling the thermometer toward the patient's jaw line. Pull pinna up and back to straighten the ear canal in an adult.	
			22. Activate the unit by pushing the trigger button. The reading is immediate (usually within 2 seconds). Note the reading.	
			23. Discard the probe cover in an appropriate receptacle by pushing the probe-release button or use rim of cover to remove from probe	
			24. Replace the thermometer in its charger, if necessary.	

Scoring and Evaluation

Range	Interpretation
36.25 - 48	Excellent
24.5 – 36.24	Satisfactory
12.75 – 24.49	Fair
1.00 -12.74	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

Skill 3.2 Assessing a Peripheral Pulse by Palpation

Equipment

- Watch with a second hand
- Pencil or pen, paper or flow sheet
- Non sterile gloves
- PPE
- Alcohol swab

Goal: The patient's pulse is assessed accurately without injury and the patient experiences only minimal discomfort.

PROCEDURE	Rationale
1. Check medical order or nursing care plan for frequency of pulse assessment. More frequent pulse measurement maybe appropriate based on nursing judgment.	Assessment and measurement of vital signs at appropriate intervals provide important data about the patient's health status
2. Perform hand hygiene and put on PPE, if indicated.	Hand hygiene and PPE prevent the spread of microorganisms. PPE is required based on transmission precaution
3. Identify the patient.	Ensures that the patient receives the intervention and helps prevent errors
4. Close curtains around bed and close the door to the room, if possible.	This ensures the patient's privacy .
5. Discuss the procedure with patient and assess the patient's ability to assist with the procedure.	Explanation relieves anxiety and facilitates cooperation.
6. Put on gloves, as appropriate.	Gloves usually are not usually worn to obtain a pulse measurement unless contact with blood or body fluids is anticipated.
7. Select the appropriate peripheral site based on assessment data.	This ensures safety and accuracy of measurement
8. Move the patient's clothing to expose only the site chosen.	
9. Place your first, second, and third fingers over the artery.	
10. Lightly compress the artery so pulsations can be felt and counted.	The sensitive fingertips can feel the pulsation of the artery
11. Using a watch with a second hand, count the number of pulsations felt for 30 seconds. • Multiply this number by 2 to calculate the rate for 1 minute. • ***If the rate, rhythm, or amplitude of the pulse is abnormal in any way, palpate and count the pulse for 1 minute.***	Ensures accuracy of measurement and assessment
12. Note the rhythm and amplitude of the pulse.	Provides additional assessment data regarding the patient's cardiovascular status

13. When measurement is completed, remove gloves, if worn.	
14. Cover the patient and help him or her to a position of comfort.	
15. Remove additional PPE, if used. Perform hand hygiene.	

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score _____/ 10 marks

Skill 3.2 Assessing a Peripheral Pulse by Palpation

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The patient's pulse is assessed accurately without injury and the patient experiences only minimal discomfort.

Equipment

- Watch with a second hand
- Pencil or pen, paper or flow sheet
- Non sterile gloves
- PPE
- Alcohol swab

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Check medical order or nursing care plan for frequency of pulse assessment. More frequent pulse measurement maybe appropriate based on nursing judgment.	
			2. Perform hand hygiene and put on PPE, if indicated.	
			3. Identify the patient.	
			4. Close curtains around bed and close the door to the room, if possible.	
			5. Discuss the procedure with patient and assess the patient's ability to assist with the procedure.	
			6. Put on gloves, as appropriate.	
			7. Select the appropriate peripheral site based on assessment data.	
			8. Move the patient's clothing to expose only the site chosen.	
			9. Place your first, second, and third fingers over the artery.	
			10. Lightly compress the artery so pulsations can be felt and counted.	
			11. Using a watch with a second hand, count the number of pulsations felt for 30 seconds. • Multiply this number by 2 to calculate the rate for 1 minute. • ***If the rate, rhythm, or amplitude of the pulse is abnormal in any way, palpate and count the pulse for 1 minute.***	

			12. Note the rhythm and amplitude of the pulse.	
			13. When measurement is completed, remove gloves, if worn.	
			14. Cover the patient and help him or her to a position of comfort.	
			15. Remove additional PPE, if used. Perform hand hygiene.	

Scoring and Evaluation

Range	**Interpretation**
22.75 – 30 .00	Excellent
15.5 – 22.74	Satisfactory
8.25 – 15.49	Fair
1.00 -8.24	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

Skill 3.3 Assessing Respiration

Equipment:

- Watch with a second hand
- Pencil or pen, paper or flow sheet
- PPE

Goal: The patient's respirations are assessed accurately without injury and the patient experiences only minimal discomfort.

PROCEDURE	Rationale
1. ***While your fingers are still in place for the pulse measurement, after counting the pulse rate, observe the patient's respirations.***	The patient may alter the rate of respiration if he or she is aware they are being counted.
2. Note the rise and fall of the patient's chest.	A complete cycle of inspiration and an expiration composes one respiration
3. Using a watch with a second hand, count the number of respirations for 30 seconds. Multiply this number by 2 to calculate the respiratory rate per minute.	Sufficient time is necessary to observe the rate, depth, and other characteristics
4. ***If respirations are abnormal in any way, count the respirations for at least 1 full minute.***	Increased time allows the detection of unequal timing between respirations
5. Note the depth and rhythm of the respirations.	Provides additional assessment data regarding the patient's respiratory status
6. When measurement is completed, remove gloves, if worn.	
7. Cover the patient and help him or her to a position of comfort.	
8. Remove additional PPE, if used. Perform hand hygiene.	

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score _____/ 10 marks

Skill 3.3 Assessing Respiration

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The patient's respirations are assessed accurately without injury and the patient experiences only minimal discomfort.

Equipment:

- Watch with a second hand
- Pencil or pen, paper or flow sheet
- PPE

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. While your fingers are still in place for the pulse measurement, after counting the pulse rate, observe the patient's respirations.	
			2. Note the rise and fall of the patient's chest.	
			3. Using a watch with a second hand, count the number of respirations for 30 seconds. Multiply this number by 2 to calculate the respiratory rate per minute.	
			4. If respirations are abnormal in any way, count the respirations for at least 1 full minute.	
			5. Note the depth and rhythm of the respirations.	
			6. When measurement is completed, remove gloves, if worn.	
			7. Cover the patient and help him or her to a position of comfort.	
			8. Remove additional PPE, if used. Perform hand hygiene.	

Scoring and Evaluation

Range	**Interpretation**
12.25 – 16 .00	Excellent
8.5 – 12.24	Satisfactory
4.75 – 8.49	Fair
1.00 -4.74	Poor

For Major Examination:

$$\frac{\text{Actual Score}}{\text{Perfect Score}} \times 10 \text{ marks}$$

Skill 3.4 Assessing Brachial Artery Blood Pressure

Equipment

- Stethoscope
- Sphygmomanometer
- Blood Pressure cuff of appropriate size
- Pencil or pen, paper or flow sheet
- PPE
- Alcohol swab

Goal: The patient's blood pressure is measured accurately with minimal discomfort to the patient.

PROCEDURE	Rationale
1. Check physician's order or nursing care plan for frequency of blood pressure measurement. More frequent measurement may be appropriate based on nursing judgment.	Provides for patient safety
2. Perform hand hygiene and put on PPE, if indicated.	
3. Identify the patient.	
4. Close curtains around bed and close the door to the room, if possible.	
5. Discuss procedure with patient and assess patient's ability to assist with the procedure. Validate that the patient has relaxed for several minutes.	
6. Put on gloves, if appropriate or indicated.	
7. Select the appropriate arm for application of the cuff.	Measurement of Blood pressure may temporarily impede circulation to the extremity
8. Have the patient assume a comfortable lying or sitting position with the forearm supported at the level of the heart and the palm of the hand upward. • Support the arm yourself or by using the bedside table. • Have the patient sit back in the chair so that the chair supports his or her back. • Make sure the patient keeps the legs uncrossed	➢ This position places the brachial artery on the inner aspect of the elbow so that bell or diaphragm of the stethoscope can rest on it easily. ➢ Sitting position ensures accuracy ➢ The position of the arm can have a major influence when the blood pressure is measured; • if the upper arm is below the level of the atrium , the readings will be too high. • If the arm is above the level of the atrium , the readings will be too low. • If the back is not supported , the diastolic pressure maybe elevated falsely • If the legs are crossed, the systolic pressure maybe elevated falsely.
9. If the measurement is taken in the supine position, support the arm with a pillow.	

10. Expose the brachial artery by removing garments, or move a sleeve, if it is not too tight, above the area where the cuff will be placed.	Clothing over the artery interferes with the ability to hear sounds and can cause inaccurate blood pressure readings. A tight sleeve would cause congestion of blood and possibly inaccurate readings.
11. Palpate the location of the brachial artery.	
12. ***Center the bladder of the cuff over the brachial artery, about midway on the arm, so that the lower edge of the cuff is about 2.5 to 5 cm (1 to 2 inches) above the inner aspect of the elbow.***	Pressure in the cuff applied directly on the artery provides the most accurate readings . If the cuff gets in the way of the stethoscope , readings are likely to be inaccurate .
13. Line the artery marking on the cuff up with the patient's brachial artery. The tubing should extend from the edge of the cuff nearer the patient's elbow.	A cuff placed upside down with the tubing toward the patient's head may give a false reading .
14. Wrap the cuff around the arm smoothly and snugly, and fasten it. Do not allow any clothing to interfere with the proper placement of the cuff.	A smooth cuff and snug wrapping produce equal pressure and helps promote an accurate measurement . A cuff wrapped too loosely results in an inaccurate reading.
15. Check that the needle on the aneroid gauge is within the zero mark. If using a mercury manometer, check to see that the manometer is in the vertical position and that the mercury is within the zero level with the gauge at eye level.	If the needle is not in the zero area, the BP reading may not be accurate. Tilting a mercury manometer , inaccurate calibration, or improper height for reading the gauge can lead to errors in determining the pressure measurements.
Estimating Systolic Pressure	
16. Palpate the pulse at the brachial or radial artery by pressing gently with the fingertips.	Palpation allows for measurement of the approximate systolic readings.
17. Tighten the screw valve on the air pump.	The bladder within the cuff will not inflate with the valve open.
18. Inflate the cuff while continuing to palpate the artery. Note the point on the gauge where the pulse disappears.	The point where the pulse disappears provides an estimate of the systolic pressure. To identify the first Korotkoff sound accurately, the cuff must be inflated to a pressure above the point at which the pulse can no longer be felt.
19. Deflate the cuff and wait 1 minute.	Allowing a brief cause before continuing permits the blood to refill and circulate through the arm
Obtaining Blood Pressure Measurement	
20. Assume a position that is no more than 3 feet away from the gauge.	A distance of more than 3 feet can interfere with accurate reading of the numbers on the gauge
21. Place the stethoscope earpieces in your ears. Direct the earpieces forward into the canal and not against the ear itself.	Proper placement blocks extraneous noise and allows sound to travel more clearly
22. Place the bell or diaphragm of the stethoscope firmly but with as little pressure as possible over the brachial artery.	Allows more accurate reading. Heavy pressure on the brachial artery distorts the shape of the artery and the sound. .
23. Do not allow the stethoscope to touch clothing or the cuff.	Placing the bell or the diaphragm away from the clothing and the cuff prevents the noise , which

	would distract from the sounds made by blood flowing through the artery
24. Pump the pressure 30 mm Hg above the point at which the systolic pressure was palpated and estimated.	Increasing the pressure above the point where the pulse disappeared ensures the period before hearing the first sound that corresponds with the systolic pressure.
25. Open the valve on the manometer and allow air to escape slowly (allowing the gauge to drop 2 to 3 mm per second).	It prevents misinterpreting phase II sound as phase I sound
26. Note the point on the gauge at which the first faint, but clear, sound appears that slowly increases in intensity. Note this number as the systolic pressure. Read the pressure to the closest 2 mm Hg.	Systolic pressure is the point at which the blood in the artery is first able to force its way through the vessel at a similar pressure exerted by the air bladder in the cuff. The first sound is phase I of Korotkoff sounds.
27. Do not reinflate the cuff once the air is being released to recheck the systolic pressure reading.	Reinflating the cuff while obtaing the BP is uncomfortable for the patient and can cause an inaccurate reading . Reinflatiing the cuff causes congestion of blood in the lower arm , which lessens the loudness of Korotkoff sounds .
28. Note the point at which the sound completely disappears.	The point at which the sound disappears corresponds to the beginning of phase V Korotkoff sounds and is generally considered the diastolic pressure reading.
29. Allow the remaining air to escape quickly. Repeat any suspicious reading, but wait at least 1 minute. Deflate the cuff completely between attempts to check the blood pressure.	False readings are likely to occur if there is congestion of blood in the limb while obtaining repeated readings
30. When measurement is completed, remove the cuff. Remove gloves, if worn. Cover the patient and help him or her to a position of comfort	
31. Clean the diaphragm of the stethoscope with the alcohol wipe. Clean and store the sphygmomanometer, according to facility policy.	
32. Remove additional PPE, if used. Perform hand hygiene.	

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score _____ / 10 marks

Skill 3.4 Assessing Brachial Artery Blood Pressure

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The patient's blood pressure is measured accurately with minimal discomfort to the patient.

Equipment

- Stethoscope
- Sphygmomanometer
- Blood Pressure cuff of appropriate size
- Pencil or pen, paper or flow sheet
- PPE
- Alcohol swab

Performed Correctly	Performed with assistance	Not Performed	PROCEDURE	Comments
			1. Check physician's order or nursing care plan for frequency of blood pressure measurement. More frequent measurement may be appropriate based on nursing judgment.	
			2. Perform hand hygiene and put on PPE, if indicated.	
			3. Identify the patient.	
			4. Close curtains around bed and close the door to the room, if possible.	
			5. Discuss procedure with patient and assess patient's ability to assist with the procedure. Validate that the patient has relaxed for several minutes.	
			6. Put on gloves, if appropriate or indicated.	
			7. Select the appropriate arm for application of the cuff.	
			8. Have the patient assume a comfortable lying or sitting position with the forearm supported at the level of the heart and the palm of the hand upward. • Support the arm yourself or by using the bedside table.	

			• Have the patient sit back in the chair so that the chair supports his or her back. • Make sure the patient keeps the legs uncrossed	
			9. If the measurement is taken in the supine position, support the arm with a pillow.	
			10. Expose the brachial artery by removing garments, or move a sleeve, if it is not too tight, above the area where the cuff will be placed.	
			11. Palpate the location of the brachial artery.	
			12. ***Center the bladder of the cuff over the brachial artery, about midway on the arm, so that the lower edge of the cuff is about 2.5 to 5 cm (1 to 2 inches) above the inner aspect of the elbow.***	
			13. Line the artery marking on the cuff up with the patient's brachial artery. The tubing should extend from the edge of the cuff nearer the patient's elbow.	
			14. Wrap the cuff around the arm smoothly and snugly, and fasten it. Do not allow any clothing to interfere with the proper placement of the cuff.	
			15. Check that the needle on the aneroid gauge is within the zero mark. If using a mercury manometer, check to see that the manometer is in the vertical position and that the mercury is within the zero level with the gauge at eye level.	
			Estimating Systolic Pressure	
			16. Palpate the pulse at the brachial or radial artery by pressing gently with the fingertips.	
			17. Tighten the screw valve on the air pump.	
			18. Inflate the cuff while continuing to palpate the artery. Note the point on the gauge where the pulse disappears.	
			19. Deflate the cuff and wait 1 minute	
			Obtaining Blood Pressure Measurement	
			20. Assume a position that is no more than 3 feet away from the gauge.	
			21. Place the stethoscope earpieces in your ears. Direct the earpieces forward into the canal and not against the ear itself.	
			22. Place the bell or diaphragm of the stethoscope firmly but with as little pressure as possible over the brachial artery.	
			23. Do not allow the stethoscope to touch clothing or the cuff.	
			24. Pump the pressure 30 mm Hg above the point at which the systolic pressure was palpated and estimated.	
			25. Open the valve on the manometer and allow air to escape slowly (allowing the gauge to drop 2 to 3 mm per second).	

			26. Note the point on the gauge at which the first faint, but clear, sound appears that slowly increases in intensity. Note this number as the systolic pressure. Read the pressure to the closest 2 mm Hg.	
			27. Do not reinflate the cuff once the air is being released to recheck the systolic pressure reading.	
			28. Note the point at which the sound completely disappears.	
			29. Allow the remaining air to escape quickly. Repeat any suspicious reading, but wait at least 1 minute. Deflate the cuff completely between attempts to check the blood pressure.	
			30. When measurement is completed, remove the cuff. Remove gloves, if worn. Cover the patient and help him or her to a position of comfort	
			31. Clean the diaphragm of the stethoscope with the alcohol wipe. Clean and store the sphygmomanometer, according to facility policy.	
			32. Remove additional PPE, if used. Perform hand hygiene.	

Scoring and Evaluation

Range	**Interpretation**
48..25 – 64 .00	Excellent
32.5 – 48.24	Satisfactory
16.75 – 32.49	Fair
1.00 -16.74	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score

King Saud university		NURS 215
College of Nursing		FUNDAMENTALS OF NURSING
Medical Surgical Department		1st Semester AY 1439-1440

Name _____ Date _____

Instructor/Evaluator: _____ Score _____/ 10 marks

Skill 3.5 Assessing Height And Weight

Legend:

2 Performed Correctly
1 - Performed with Assistance
0 - Not performed

Goal: The assessment is completed without the patient experiencing anxiety or discomfort,

Performed C...	Performed ...	Not Performed	PROCEDURE	Comments
			1. Perform hand hygiene and put on PPE, if indicated.	
			2. Identify the patient.	
			3. Close curtains around bed and the door to the room, if possible.	
			4. Explain the purpose of the health examination and what you are going to do. Answer any questions	
			5. Have the patient remove shoes and heavy outer clothing.	
			6. Weigh the patient using a scale	
			7. Compare the measurement with previous weight measurements and recommended range for height.	
			8. With shoes off, and standing erect, measure the patient's height using a wall-mounted measuring device or measuring pole.	
			9. Compare height and weight with recommended average weights on a standardized chart.	
			10. Using the tape measure, measure the patient's waist circumference. Place the tape measure snugly around the patient's waist at the level of the umbilicus	
			11. Measure the patient's temperature, pulse, respirations, blood pressure, and oxygen saturation.	
			12. Remove PPE, if used.	
			13. Perform hand hygiene. Continue with assessments of specific body systems as appropriate or indicated.	
			14. Initiate appropriate referral to other healthcare practitioners for further evaluation as indicated	

.

Scoring and Evaluation

Range	**Interpretation**
21.25 – 28 .00	Excellent
14.5 – 21.24	Satisfactory
7.75 – 14.49	Fair
1.00 -7.74	Poor

For Major Examination:

Actual Score X 10 marks
Perfect Score