

**SPRING 2009****NUR-183, Basic Concepts and Skills of Nursing****COURSE DESCRIPTION**

NU-183 Basic Concepts and Skills of Nursing is a first level course in the nursing sequence. Concepts and Skills developed throughout the program are introduced. Orem's nursing model is presented as the organizing framework of the curriculum. The nursing process is introduced as a problem solving technique. Students will be required to pass performance tests and are expected to practice these skills to perfect techniques. Students will plan and implement nursing care in a variety of health care settings.

2 lec., 12 lab., 6 credits

PREREQUISITE: Admission to the Department

CO-REQUISITES: NUR-181, NUR-182, BIO-109, PSY-101

Students who require accommodations in accordance with the Americans with Disabilities Act (ADA) can request these services from the Office of Specialized Services. To learn more about how to apply for services, please visit them at: <http://www.bergen.edu/oss>.

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**COURSE LEARNING OUTCOMES**

1. Applies Orem's Self Care Model in relation to assessment of normal variations of USCRs for individuals.
2. Approaches individuals according to the identified norms for their growth and developmental capabilities.
3. Uses appropriate interview techniques to obtain basic information from individuals and expresses in written and oral forms an accurate physical assessment.
4. Modifies care according to biological, psychological, sociological, cultural, spiritual and economic factors that influence the health of individuals.
5. Develops assessment skills in the college and clinical laboratory.
6. Complies with ethical and legal practice in the classroom and clinical laboratory.
7. Uses the computer and laboratory technological resources pertinent to learning assessment theory and skills.
8. Performs systematic assessments and compares findings with textbook norms.
9. Uses normal numerical measurements when assessing individuals.
10. Assesses individuals for their teaching and learning needs.

**TEACHING AND LEARNING ACTIVITIES**

Lecture	Assigned Readings
Group Discussion	Audio Visual Aids
Computer Assisted Instruction	Nursing Skills
Clinical Practice: Acute, Long Term and/or Community Facilities	

**COURSE REQUIREMENTS**

1. Nursing Care Plan Satisfactory completion of two nursing care plans
2. Process Recording Satisfactory completion of one process recording
3. Assessments Satisfactory completion of weekly assessment sheets
4. CAI View Multicultural RN
5. Community Health Participation in one community health agency visit or project
6. Skills Validation of specific skills listed in course outline
7. Attendance Students are expected to attend all classes, clinical experiences, and skills labs. A skill or validation lab absence is considered a clinical absence. Students who are unprepared for clinical lab validation will be considered absent
8. NCLEX Preparation Student will answer 100 NCLEX questions throughout the semester.

**COURSE EVALUATION**

1. Theory Grade
 

Three tests totaling 80% of letter grade.  
 Final cumulative exam totaling 20% of letter grade.  
 A minimum grade of 75% in theory content is required for passing.

  - A = 89.5% and above
  - B+ = 84.5 to 89.4%
  - B = 79.5% to 84.4%
  - C+ = 74.5% to 79.4%
  - F = 74.4% and below
2. Clinical Grade
  - In order to pass clinical, the final grade must reflect an average of **3.0 (75%)** or greater on all areas of the clinical evaluation. A student who receives a cumulative grade of less than **3.0 (75%)** on all areas will not pass the clinical component and will receive a final grade of "F" in the clinical nursing course regardless of the theory grade.\*\* Attendance is a part of the scoring of the clinical grade. In the category regarding professional behaviors, the following rules apply: \*\*Includes Clinical

Conference

1. No absences = rating of 4
2. One absence = rating of 3
3. Two absences = rating of 2 and a make-up

assignment

4. Three absences = rating of 1 and failure of course

Exceptional circumstances for clinical absences may be reviewed by the clinical instructor, team and Program Director at the request of the student.

- Satisfactory completion of two nursing care plans.
- Satisfactory completion of one process recording.
- Participation in a community health activity.
- Satisfactory validation of specific skills listed in course outline.

**A grade below 75% in theory, or an "F" in clinical experience will result in an "F" for the entire course.**

#### **REQUIRED SUPPLIES**

1. Nursing Supply Kit
2. Stethoscope
3. Bandage scissors
4. Penlight

#### **REQUIRED TEXTS**

#### **NUR 183 - Concepts**

#### **NUR 183 – Concepts**

Potter and Perry. Fundamentals of Nursing. Elsevier. 7<sup>th</sup> edition.

ISBN: 978-0-323-06784-3

Davis' Drug Guide for Nurses. FA Davis Company, 11<sup>th</sup> edition, ISBN: 13:978-0-8036-1912-8

or

Mosby's 2009/2010 Nursing Drug Reference

ISBN: 9780323066518

Mosby's Dictionary of Medicine: Nursing and Health Professions 8<sup>th</sup> edition. 2009

ISBN: 978-0-323-04937-5

OR

Taber's Cyclopedic Medical Dictionary. 21<sup>st</sup> edition. ISBN-13: 978-0-8036-1559-5

#### Optional

Nugent and Vitale. Test Success. F.A. Davis Company,

Nugent and Vitale. Fundamental Success. F.A. Davis Co.,

#### **Nursing Care Plan Books - Recommended (one nursing care plan book)**

Ackley. Nursing Diagnosis Handbook: A Guide to Planning Care. Elsevier

Carpenito-Moyet, Lynda. Nursing Care Plans and Documentation.

Doenges, Moorhouse, Murr. Nursing Care Plans: Guidelines for Individualizing

Patient Care. F.A. Davis Co. , 5<sup>th</sup> edition, 2008. ISBN: 978-0-8036-1909-8  
Gulanick and Myers, Nursing Care Plans, Mosby, 6th edition, 2007.  
ISBN-13: 978-0-323-03954-3

**NUR 183 – Basic Concepts  
Computer Assisted Instruction Programs**

**Instructions:**

1. Click on Start ( bottom left of screen)
2. Click on All Programs
3. Click on Nursing
4. Click on Level One
5. Click on General or NUR183

**General**

F.A. Davis Drug Guide  
Tabers (dictionary)

**Test Taking – Beginning** – All students should review this program.

**NUR 183 – Basic Concepts**

Basic Concepts - (Fundamentally Fun Graphics)  
Documentation  
Fundamentals - (Finalizing Fundamentals)  
Legal  
Multicultural – RN  
Nursing Judgment (Assessment & Practice- Student Nurse Version)  
Protecting Patient and Resident Rights  
Beginning NCLEX  
Clinical Nursing Concepts  
    Perioperative Care  
    Inflammation, Infection and Wound healing.  
    Dave Mason – Wound Infection

**NUR 183 – Basic Concepts  
Videos**

**\*\*\*ALL VIDEOS CAN BE FOUND IN THE MEDIA CENTER (LIBRARY)**

Instructions for accessing videos from WebCt (at home or on campus)

1. Access WebCt from the college homepage.
2. In the upper box, enter your last name followed by the first 2 letters of your first name (no spaces).
3. In the lower box, enter your last name and the last four digits of your social security number (no spaces).
4. Go to BCC and scroll to nursing skills videos.
5. **The only videos available from WebCt are the videos that were produced on campus by the nursing faculty.**

**The following videos were produced on campus by the nursing faculty: (can be found on WebCt or in the Media Center - Library)**

- |  |                 |
|--|-----------------|
| 1. Hygiene                                 | RT 73.5 B46 V.1 |
| 2. Movement of patient                     | RT 73.5 B46 V.2 |
| 3. NG-tube irrigation: G-tube feeding      | RT 73.5 B46 V.4 |
| 4. Med Administration (SQ, PO, IM)         | RT 73.5 B46 V.8 |
| 5. Isolation Techinque (Gown, Glove, Mask) | RT 73.5 B46 V.7 |
| 6. IV Therapy                              | RT 73.5 B46 V.5 |
| 7. Wet-to-Dry Dressing Change              | RT 73.5 B46 V.6 |
| 8. Central Line Dressing Change            | RT 73.5 B46 V.3 |

**The following videos can be found in the Media Center (Library): (obtained Jan. 2002)**

- |  |                             |
|--|-----------------------------|
| Professor Nightengale's Test Taking Strategies | RT 73.N688 2004             |
| Portraits of Excellence, Florence Nightingale  | RT 37.N5 P67 1990 pts. 1& 2 |
| Basic Principles                               | RT 73.5 M67 B2 2001 pt. 5   |
| Bathing  | RT 73.5 M67 B2 2001 pt. 2   |
| Bedmaking                                      | RT 73.5 M67 B2 2001 pt. 1   |
| Nutrition and Fluids                           | RT 73.5 M67 B2 2001 pt. 9   |
| Measurements                                   | RT 73.5 M67 B2 2001 pt. 10  |
| Personal Hygiene and Grooming                  | RT 73.5 M67 B2 2001 pt. 6   |
| Normal Elimination                             | RT 73.5 M67 B2 2001 pt. 7   |
| Preventing and Treating Pressure Ulcers        | RT 73.5 M67 B2 2001 pt. 8   |
| Body Mechanics and Exercise                    | RT 73.5 M67 B2 2001 pt. 4   |
| Safety and Restraints                          | RT 73.5 M67 B2 2001 pt. 3   |

**The following intermediate videos can be found in the Media Center (Library):  
(All videos can be found under the same call number RC 541 MSB**

Ostomy Care	RT 41 M860 2002 pt. 4
Wound Care	RT 41 M860 2002 pt. 10
Specimen Collection	RT 41 M860 2002 pt. 7
Preoperative Nursing Care	RT 41 M860 2002 pt. 6
Postoperative Nursing Care	RT 41 M860 2002 pt. 5
Maintaining Intravenous Fluid Therapy	RT 41 M860 2002 pt. 3

**BASIC CONCEPTS COURSE OUTLINE AND READING ASSIGNMENT****\*\*\*Refer to Course Calendar for Weekly Topics\*\*\***

Theoretical Content	Teaching/Learning Activities
<p>THE NURSING PROFESSION</p> <p>A. Historical perspective of nursing</p> <ol style="list-style-type: none"> <li>1. Factors influencing the development of nursing</li> <li>2. Nightingale's theory as a model for nursing practice</li> <li>3. Orem's theory of nursing</li> </ol> <p>B. Educational preparation of the nurse</p> <ol style="list-style-type: none"> <li>1. Registered nurse programs               <ol style="list-style-type: none"> <li>a) Associate degree</li> <li>b) Diploma</li> <li>c) Baccalaureate</li> </ol> </li> <li>2. Graduate education</li> <li>3. Continuing education</li> <li>4. LPN programs</li> <li>5. Accreditation</li> <li>6. Licensure (NCLEX-RN)</li> </ol> <p>C. The practice of nursing</p> <ol style="list-style-type: none"> <li>1. Standards of nursing practice</li> <li>2. Nurse practice acts</li> <li>3. Practice settings</li> <li>4. Delegation</li> <li>5. Priority</li> </ol> <p>D. Characteristics of the nursing profession</p> <p>E. Ethics in nursing practice</p> <ol style="list-style-type: none"> <li>1. Nurses' code of ethics – Health Insurance Portability and Privacy Act (<b>HIPPA</b>)</li> <li>2. Accountability</li> <li>3. Responsibility</li> <li>4. Patients Bill of Rights</li> <li>5. Advanced directives</li> </ol>	<p>Read: Fundamentals of Nursing            Chapters 1, 4, 21, 22 and 23  <b>EDGT tutorial: Test Taking skills</b></p>

Theoretical Content	Teaching/Learning Activities
Theoretical Content	Teaching/Learning Activities
<p>OREM</p> <ul style="list-style-type: none"> <li>A. Orem's theory                             <ul style="list-style-type: none"> <li>1. Self-care</li> <li>2. Self-care deficits</li> <li>3. Nursing systems</li> </ul> </li> <li>B. Self-care requisites</li> <li>C. Basic Conditioning Factors</li> </ul>	<p>Read: fundamentals of Nursing Chapters 4,11,12,13,14</p> <p>Read: Orem handout, pp. 12-14 course outline Growth and Development (young, middle, older adult)</p>
<p>HEALTH AND ILLNESS</p> <ul style="list-style-type: none"> <li>A. Definition of health                             <ul style="list-style-type: none"> <li>1. Selected models of health and illness:</li> <li>2. Orem's definition of health</li> </ul> </li> <li>B. External variables influencing health beliefs                             <ul style="list-style-type: none"> <li>1. Family practices</li> <li>2. Socioeconomic factors</li> <li>3. Culture</li> </ul> </li> <li>C. Nurse's role in health promotion and disease prevention                             <ul style="list-style-type: none"> <li>1. Levels of preventative care                                     <ul style="list-style-type: none"> <li>a) Primary prevention</li> <li>b) Secondary prevention</li> <li>c) Tertiary prevention</li> </ul> </li> <li>2. risk factors</li> </ul> </li> <li>D. Illness and illness behavior</li> <li>E. Stress                             <ul style="list-style-type: none"> <li>1. Stress concepts</li> <li>2. Response to stress                                     <ul style="list-style-type: none"> <li>a) Physiological</li> <li>b) Psychological</li> </ul> </li> <li>3. Assessment of stress</li> <li>4. Interventions to reduce stress</li> </ul> </li> </ul>	<p>Read: Fundamentals of Nursing Chapters 6, 8, 9,</p> <p>Read: Fundamentals of Nursing Chapter 6,</p> <p>CAI: Multicultural RN</p> <p>Read: Fundamentals of Nursing Chapters 6,12,13,14</p> <p>Read: Fundamentals of Nursing Chapter 6,</p> <p>Read: Fundamentals of Nursing Chapters 27,31,</p> <p>CAI: Legal Aspect of Nursing Protecting the Patient's/Resident's Rights Nursing and the Law</p>

**Theoretical Content****HEALTH CARE DELIVERY  
SYSTEMS/HEALTH PROMOTION**

- A. Health care reform issues/issues in health care delivery
- B. Levels of health care
  - 1. Primary
  - 2. Secondary (acute)
  - 3. Tertiary
  - 4. Restorative
  - 5. Continuing care
- C. Health care services, agencies
- D. Financing health care in the United States

**PREVENTION OF HAZARDS -  
BACTERIOLOGICAL SAFETY**

- A. USCR - bacteriological principles
  - 1. Environmental conditions favoring growth of microorganisms
  - 2. Modes of transmission
  - 3. Stages of infectious process
- B. Precaution/infection control
  - 1. Asepsis
  - 2. Sterilization
  - 3. Disinfection
  - 4. Hygiene
- C. Non specific defenses
  - 1. Body defenses
  - 2. Inflammation
  - 3. Immunity
- D. Fire prevention
- E. Safety
- F. Radiation
- G. Poisoning

**Teaching/Learning Activities**

Read: Fundamentals of Nursing Chapters 1,2,

Read: Fundamentals of Nursing Chapter 34,38

**Theoretical Content**

- H. Electrical
- I. Disaster
- J. Seizure precautions

**ACTIVITY AND REST: MOBILITY**

- A. Body Mechanics
  - 1. Body alignment
  - 2. Body balance
  - 3. Coordinated body movement
- B. Principles of body mechanics
- C. Pathological influences on body alignment and mobility
  - 1. Postural abnormalities
  - 2. Impaired muscle development
  - 3. CNS damage
  - 4. Trauma

**COMMUNICATION**

- A. Levels of communication
  - 1. Intrapersonal
  - 2. interpersonal
  - 3. Public
- B. Components of the communication process
- C. Modes of communication
  - 1. Verbal
  - 2. Nonverbal
- D. Therapeutic and non-therapeutic communication
- E. Documentation and reporting
  - 1. Documentation
  - 2. Reporting

**Teaching/Learning Activities**

Read: Fundamentals of Nursing Chapter 33,37,47

Video: Body Mechanics & Exercise  
RT 73.5 M67 B2 2001 pt. 4

Read: Fundamentals of Nursing Chapter 24,26

CAI: Therapeutic Communication 1 & 2  
Therapeutic Client Communication

CAI: Chart Smart  
Documentation – Basic principles

**Theoretical Content****THE NURSING PROCESS**

- A. Assessment
  - 1. data collection
    - a) Types
    - b) Sources
    - c) Methods
  - 2. USCR
  - 3. Determinants
  - 4. Self-care agency
  - 5. Self-care deficits
  - 6. using judgments about data
  
- B. Nursing diagnosis
  - 1. The diagnostic process
    - a) Analysis and interpretation of assessment data
    - b) Identification of problems
      - 1) Actual
      - 2) At risk
  - 2. Nursing diagnosis two-part format
    - a) Diagnostic label
    - b) Related factors
    - c) Qualifiers
  - 3. NANDA list
  
- C. Planning
  - 1. Setting priorities
  - 2. Identifying goals
  - 3. Writing the care plan
  
- D. Implementation
  - 1. Selecting method of assistance
    - a) Doing for
    - b) Guiding
    - c) Supporting
    - d) Teaching
    - e) Providing developmental Environment
  - 2. Identifying nursing system
    - a) Partly compensatory
    - b) Wholly compensatory
    - c) Supportive-educative
  
- E. Evaluation
  - 1. Process of evaluation
  - 2. Evaluation of goal achievement
  - 3. Revising care

**Teaching/Learning Activities**

Read: Fundamentals of Nursing Chapter 16,17,18,19, 20, and 21  
 EDGT Tutorial: The Nursing Process

**Theoretical Content****SUPPORTIVE-EDUCATIVE NURSING SYSTEM**

- A. Standards and purposes of patient education
- B. Role of the nurse in teaching and learning
- C. Learning domains
  - 1. Cognitive
  - 2. Affective
  - 3. Psychomotor
- D. Principles of learning
- E. Teaching learning process
  - 1. Assessment
    - a) Learning needs
    - b) Motivation
    - c) Ability to learn
    - d) Teaching environment
    - e) Resources for learning
  - 2. Nursing diagnoses
  - 3. Planning
    - a) Developing objectives
    - b) Writing teaching plans
  - 4. Implementation
    - a) Teaching approaches
    - b) Methods
  - 5. Evaluation
    - a) Direct observation
    - b) Written reports
  - 6. Documentation

**CRITICAL THINKING**

- A. Critical thinking model
  - 1. Knowledge base
  - 2. Levels
- B. Attitudes for critical thinking

**Teaching/Learning Activities**

Read: Fundamentals of Nursing Chapter 25

EDGT Tutorial: Improve your study habits and test taking skills

Read: Fundamentals of Nursing Chapter 15,  
Review Chapters 16,17,18,19,20,21

### Theoretical Content

#### PREVENTION OF HAZARDS - PERIOPERATIVE NURSING

- A. Perioperative Care
  - 1. Assessment of basic conditioning factors
  - 2. Physical examination
  - 3. Risk factors
  - 4. Diagnostic screening
    - a) SMAC
    - b) CBC
    - c) PT, PTT
    - d) Chest X-Ray
    - e) EKG
  
- B. Nursing diagnoses
  
- C. Planning
  
- D. Implementation
  - 1. Informed consent
  - 2. Preoperative teaching
    - a) Turning
    - b) Leg exercises
    - c) Coughing, deep breathing
    - d) Pain relief measures
    - e) Emotional considerations
  - 3. Preoperative preparations
    - a) Medical records
    - b) Vital signs
    - c) Valuables
    - d) Preoperative medications
  
- D. Intraoperative phase
  - 1. Anesthesia
  - 2. Positioning
  - 3. Nurse's role
  
- E. Postoperative care
  - 1. Assessments and interventions
    - a) Air
    - b) Water
    - c) Food
    - d) Elimination
    - e) Activity and Rest
    - f) Solitude and Social Interaction
    - g) Prevention of Hazards
    - h) Normal Functions
  - 2. Wound care

### Teaching/Learning Activities

Read: Fundamentals of Nursing Chapter 50,  
Review Chapters 33,34,44 and 48

CAI: Perioperative Care: A Surgical Patient

Video: Pre-Operative Care (Media Center)  
RT 41.M860 2002

Read: Fundamentals of Nursing Chapters  
40,41,48,50,

CAI: Inflammation, Infection, Wound Care

Video: Post-Operative Nursing Care (Media Center)  
RT 41.M860 2002

|

**Theoretical Content**

3. Pain management - 5th vital sign
  - a) Physiology of pain
  - b) Acute & chronic pain
  - c) Factors influencing pain
  - d) Assessment
  - e) Interventions
  - f) Evaluation

**ACTIVITY AND REST: MOBILITY**

- A. Hazards of immobility
  1. Air
  2. Water
    - a) Pressure sores
  3. Food
  4. Elimination
  5. Activity and Rest
  6. Prevention of Hazards
  7. Normalcy (promotion of human functioning)
  8. Solitude/Social Interaction
- B. Assessment of hazards of immobility
- C. Nursing diagnoses/planning for immobility
- D. Interventions to reduce the hazards of immobility

**ACTIVITY AND REST- SLEEP**

- A. Sleep – physiology of sleep
  1. Stages of sleep
  2. Sleep cycle/function
  3. Developmental variations of sleep
  4. Sleep disorders
  5. Nursing interventions to promote rest and sleep
  6. Nursing assessment diagnose/ planning for sleep
- F. Sensory Disturbances

**SOLITUDE AND SOCIAL INTERACTION  
Death, Dying and Loss**

- A. Types of Loss
- B. Grief, mourning and bereavement

**Teaching/Learning Activities**

Read: Fundamentals of Nursing Chapters 36,43

Read: Fundamentals of Nursing Chapters 47,48

CAI: Pressure Sores

Video: Preventing & Treating Pressure Ulcers -  
Media Center (Library)  
RT 73.5.M67 B2 2001 pt. 8

Read: Fundamentals of Nursing Chapters 31,42

Read: Fundamentals of Nursing Chapters 29,30,31

- C. Stages of dying (Kubler-Ross)  
**Theoretical Content**
  
- D. Assessment of grief
  - 1. Conditioning factors
  - 2. Relationship of loss
  - 3. Nature of the loss
  - 4. Support systems
  - 5. Cultural/spiritual beliefs
  - 6. Hope
  - 7. Phases of grief
  
- E. Nursing diagnoses/planning
  
- F. Interventions
  - 1. Comfort/support measures
  - 2. Hospice

**Teaching/Learning Activities**

**OREM: CONCEPTS WITHIN HER THEORY**

- HEALTH:**
- State that is characterized by soundness of bodily and mental functioning and well-being (not just the absence of illness)
  - Responsibility of society and all its members
- PERSON:**
- The person (individual) is self-reliant and responsible for self-care and the well being of dependents (i.e. take care of yourself and those dependent upon you)
  - A biologically, symbolically (uses ideas and words), socially integrated whole
- ENVIRONMENT:**
- Any factors in the external surroundings that have an impact on the health needs of the patient.
- NURSING:**
- Field of knowledge and a practice discipline
  - Helps individuals when they can no longer care for themselves to recover from illness or injury, to achieve and maintain health or attain a peaceful death
- NURSING REQUIRES:**
- Practitioners
  - Educators
  - Researchers
- NURSING PROVIDES:**
- Human services: personal, family, community

**OREM'S SELF-CARE DEFICIT THEORY OF NURSING**

- SELF-CARE:**
- An adult's ongoing contribution to their health and well being
  - Is learned through family, culture, society
  - Is goal oriented
  - Is a right and a responsibility
  - Is deliberate - patient choose actions necessary for the continuance of life and health
- DEPENDENT-CARE:**
- Care to the unborn, infants, children and socially dependent adults
- SELF-CARE REQUISITE:**
- The activities performed to maintain life and health are needed to meet

**UNIVERSAL SELF-CARE REQUISITES (USCR):** (needs common to all)

- Air
- Water
- Food
- Elimination
- Activity and Rest
- Prevention of Hazards
- Normalcy (promotion of human functioning)
- Solitude/Social Interaction

**SELF-CARE REQUISITE** - Continued

**BASIC CONDITIONING FACTORS (BCF):** The USCR's need to be adjusted (individualizes the plan of care) according to:

- Age
- Gender
- Developmental state
- Health state
- Sociocultural orientation
- Health care system factors: (medical, diagnostic, and treatment modalities).
- Family system factor
- Patterns of daily living
- Environmental factors
- Resource availability and adequacy

**SELF-CARE AGENCY:** • Ability to practice self-care (taking care of yourself)

**SELF-CARE DEFICITS:** • What exists when the patient is unable to perform self-care or lacks self-care agency

**NURSE AGENCY:** • The nurse's abilities to help  
Methods of helping:

1. Acting for another
2. Guiding another
3. Providing physical support
4. Providing a developmental environment
5. Teaching

**NURSING SYSTEMS:** How nurses help or perform their role:

Wholly compensatory (WCNS) - nurse compensates for total inability of the patient (#1)

Partially compensatory (PCNS) - when both nurse and patient perform  
Supportive-Educative (SENS) - patient can do but doesn't know how (#2-5)

When an imbalance exists between the individual's self-care agency and the required self-care actions, the patient needs a nurse.

**BASIC CONDITIONING FACTORS**

- \*1. Age
- 2. Gender
- \*3. Developmental state
  - a. Physical
  - b. Functional
  - c. Cognitive
  - d. Psychosocial
- \*4. Health state
  - a. Current
  - b. Health history
  - c. Allergies
  - d. Medical history (personal and family)
  - e. General health state (from review of systems)
  - f. Current problem and complaint
  - g. Diagnostic and treatment data
  - h. Patient's perception of health
  - i. Meaning and impact of health state on life style
- 5. Health care system
  - a. Measures instituted by what institution
  - b. Roles and actions of the health team
- 6-7 Sociocultural-spiritual orientation/ family system
  - a. Living context
  - b. Language
  - c. Education
  - d. Occupation
  - e. Life experiences
  - f. Ethnic-cultural background and practices
  - g. Health beliefs
  - h. Religion and practices related to spirituality
  - i. Place in family constellation
  - j. Roles/relationships of family members
  - k. Impact of health state on family as unit, family members and economics of the family
  - l. Cultural prescriptions and acceptability
- 8. Patterns of living
  - a. What self-care actions are performed daily or at other regular intervals
  - b. Amounts of time devoted to self-care
  - c. Person's priority rating of self-care actions
  - d. Individual's perceptions of adjustment/changes in self-care actions caused by health state, health care system
- 9. Environment
  - a. Usual place of residence
  - b. Home environment (space, location, crowding)
- 10. Available resources
  - a. Available resources within and without living environment which are currently needed and used
  - b. Economic, personal and organizational resources
  - c. Patient's perception of resource adequacy

\* most critical to assess

Adapted from Dennis, CM, Self-Care Deficit Theory of Nursing. St. Louis: Mosby, 1997: 26-27.  
EFA 5/28/95

### CLINICAL SCAVENGER HUNT

**DIRECTIONS:** Locate and be prepared to discuss what you observe on your nursing unit in the hospital, relative to each of the Prevention of Hazards listed below.

#### HAZARDS

##### MECHANICAL

Condition and/or location of the following:

- Room Numbers
- Beds Manual/Electric
- Side rails
- Bedside stand
- Chairs
- Stretchers
- Wheelchairs
- I.V. poles
- Lights
- Electrical outlets
- Electric cords
- Call bell
- Television/Telephone
- Closets
- Window/Screens
- Oxygen from wall outlet
- Sphygmomanometer and
- Stethoscope
- Scale
- Hoyer lift
- Supportive devices
- Drinking fountain
- Extra papers for charts
- Nurses station
- Patient charts
- Kardex

- Blank laboratory slips
- Nurses' patient assignment
- Student patient assignment
- List of phone numbers
  - Central Supply
  - Maintenance
  - Transportation

##### CHEMICAL

- Medication preparation area
- Individual doses of medication
- Floor stock
- Narcotics and controlled drugs
- Books for counting controlled drugs
- Keys to locked medicine cabinet
- Medication information:
  - PDR
  - Hospital Formulary
  - Nurses Handbook
  - Equivalent forms
  - Insulin injection sites
  - Drug compatibility charts
  - Record of patient medications
  - Replenishing of pt. medications
  - Emergency drug cart and equipment
  - Syringes
  - Pharmacy phone number
  - Pharmacy location

## Scavenger Hunt - Continued

BACTERIOLOGICAL

Handwashing  
Clean utility room  
Contents of clean utility room  
Contents of dirty utility room  
Housekeeping:  
    Floors  
    Bathrooms  
    Garbage disposal  
    Patient rooms  
Bathrooms:  
    Patient  
    Visitors  
    Nurses  
Linen  
Isolation precautions  
Intravenous Pump  
Disposal of syringes  
Collected specimens  
Infection Control Department  
    phone number  
Extra patient soap

THERMAL

Temperature of room  
Temperature of hall  
Blankets and bath blankets  
Fire alarms  
Fire extinguishers  
Stairwells  
Emergency bell warning system  
Designated areas for cigarette smoking  
Refrigerator  
Stove  
Microwave  
Ice / Ice chips  
Equipment for heat/cold applications  
Thermometers:  
Ventilation

RADIOLOGICAL

Radiology Department  
Precautions for patient with implant  
    on the floor

## **CLINICAL CONFERENCE SKILLS GUIDE**

### STANDARD PROTOCOLS FOR ALL NURSING INTERVENTIONS

- \*1. Check Physician's order.
- \*2. Wash hands.
- \*3. Identify the patient.
- \*4. Introduce yourself.
- \*5. Explain the procedure to the patient.
- \*6. Gather equipment.
- \*7. Provide for privacy.
8. Assess the patient before the procedure.
9. Promote patient involvement if possible.
10. Assess the patient during the procedure.
11. Provide for patient safety following the procedure.
12. Remove and dispose of equipment.
13. Wash hands.
14. Document procedure.

**SKILLS FOR NURSING PRACTICE**

**Theoretical Content**

**Teaching/Learning Activities**

**PREVENTION OF HAZARDS**

Safety

- Standard Precautions
- \* Medical handwashing
- Disposable clean gloving
- Safety equipment
  - Call light
  - Side rails
  - \* Restraints (jacket, wrist)
  - Position of bed
  - Fire prevention

Read Fundamentals of Nursing:

Chapters 34,38

Video: Media Center (Library)

- 
- Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Asepsis: Performing Hand Hygiene (2 K)
- Watch and Learn: CNA (From Lippincott's Video Series for Nursing Assistants): The Chain of Infection (2 K)

Practice and Learn (From Taylor's Interactive Nursing Skills): Donning and Removing Sterile Gloves (3 K)

Hygiene

- Occupied bed making
- Bed bath (Include back rub)
- Oral hygiene
- Hair care
- Shaving a patient
- Foot and nail care
- Bedpan
- Urinal
- Incontinence (diapers and condom catheter)
- \* Routine catheter care (bed bath)

Read: Fundamentals of Nursing:

Chapters 39,46,47

- Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Hygiene: Giving a Bed Bath and Changing an Occupied Bed (2 K)
- Practice and Learn (From Taylor's Interactive Nursing Skills): Providing Oral Care for the Dependent Patient (3 K)
- Procedures Checklist: 31-1 Application of Restraints (42 K)

Video: Media Center (Library)

Hygiene and Personal Care

Bathing

Bed making

Normal Elimination

Personal Hygiene Grooming

RT 73.5 M67 B2 2001

BCC Video:

Bed Bath

Moving Patient in and out of Bed

Restraints

RT 73.5 B46 v. 2

Applications of heat and cold

Aqua - K pad  
Clean cold compress  
Ice bag  
Ice Collar  
Clean warm compress  
Sitz bath

Isolation

\* Donning and removing gown, mask  
gloves

Read: Fundamentals of Nursing: Chapter 48,

Read: Fundamentals of Nursing: Chapter 34

**Theoretical Content**

Specimen collection  
 C&S  
     Urine (Foley, midstream)  
     Nose  
     Throat  
     Vaginal  
     Gastric  
     Wound  
 24 hr. urine specimen  
 Stool specimen  
 Occult blood card  
 Monitoring glucose (includes finger stick)  
 Specific gravity

**ACTIVITY AND REST**

Body mechanics

- \* Log rolling a patient
- \* Moving a patient up in bed (draw sheet, assist of one nurse)
- Semi-Fowler's position
- Hi-Fowler's position
- Supine position
- Sim's position
- Right and left lateral positions
- Range of motion exercises

**Teaching/Learning Activities**

Read: Fundamentals of Nursing: Chapters 45,46  
 Review Chapter 34

Video: Media Center (Library)  
 RT 41.M860 2001 pt. 1 Specimen Collection  
 RT 73.5 M67 B2 2001 pt. 10 Measurements

○ Practice and Learn (From Taylor's Interactive Nursing Skills): Administering a Cleansing Enema (3 K)

○ Procedures Checklist: 42-1 Assessing Stool for Occult Blood (36 K)

Read: Fundamentals of Nursing: Chapter 47

- 
- Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Activity: Providing Range of Motion Exercises (2 K)
- Watch and Learn: CNA (From Lippincott's Video Series for Nursing Assistants): Body Mechanics (2 K)
- Practice and Learn (From Taylor's Interactive Nursing Skills): Assisting a Patient with Turning in Bed (3 K)
- 
- Procedures Checklist: 34-1 Using Body Mechanics to Move Clients (41 K)
- Procedures Checklist: 34-2 Positioning a Client in Bed (57 K)
- Procedures Checklist: 34-3 Providing Range-of-Motion Exercises (68 K)
- Procedures Checklist: 34-4 Assisting With Ambulation (48 K)
- Procedures Checklist: 34-5 Helping Clients With Crutchwalking (51 K)

Assistive devices

- Draw sheet
- Elbow and heel pads
- Trochanter roll
- Trapeze
- Hand roll
- Sheepskin
- Abduction pillow
- Air mattress

Transfers

- Minimizing orthostatic hypotension
- \* Bed to wheelchair
- Hoyer lift
- Bed to stretcher
  - draw sheet

- o Procedures Checklist: 34-6  
Transferring a Client to a Stretcher  
(38 K)
- o Procedures Checklist: 34-7  
Transferring a Client to a  
Wheelchair (43 K)
- o Procedures Checklist: 34-8  
Procedure for Transferring a Client  
From Bed to a Chair Using a  
Hydraulic Lift (34 K)

Read: Fundamentals of Nursing: Chapter 37

o Watch and Learn: Fundamentals  
(From Lippincott's Video Series: Nursing Procedures  
Student Set on CD-ROM): Hygiene: Giving a Bed Bath  
and Changing an Occupied Bed (2 K)

Read: Fundamentals of Nursing: Chapters 47

**Theoretical Content**

**Teaching/Learning Activities**

Ambulation

- Assist with weak side
- Falling patient
- Crutch walking
  - 4 point gait
  - 3 point gait
  - 2 point gait
  - Swing through gait
  - Climbing & descending stairs

Read: Fundamentals of Nursing: Chapter 37

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Activity: Providing Range of Motion Exercises (2 K)

Applying bandages

- Circular
- Spiral
- Spiral reverse
- Figure eight
- Recurrent (wrist, ankle, leg)

Read: Fundamentals of Nursing: Chapter 48

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Skin Integrity and Wound Care: Irrigating a Wound Using Sterile Technique (2 K)

Practice and Learn (From Taylor's Interactive Nursing Skills): Cleaning a Wound and Applying Sterile Dressing (3 K)

Applying binder

- Abdominal velcro

Read Fundamentals of Nursing: Chapter 48

\* Vital Signs

- Temperature
- Pulse
- Resp.
- B/P
- Pulse oximeter
- Heat production/heat loss
- Circadian rhythm

Read: Fundamentals of Nursing: Chapter 32  
Review Chapter 48

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Vital Signs: Measuring Oral Temperature, Radial Pulse, Respiratory Rate, and Blood Pressure (2 K)

Media Center

- Temperature – RC 74.V572 2002 v.1
- Pulse – RC 74.V572 2002 v.2
- Respiration – RC 74.V572 2002 v.3
- Blood Pressure – RC 74.V572 2002 v.4

Read: Fundamentals of Nursing: Chapter 35

Medications

- 5 Rights of administration
- \* Oral
  - P.O.
  - S.L.
  - Buccal
- Topical
- Instillations (eye, ear, nose, vagina, rectum)
- Irrigations (eye, ear, vagina)
- Inhalants
- Parenteral

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Medications: Administering an Intramuscular Injection (2 K)

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Medications: Administering IV Medications by Piggyback Infusion (2 K)

Practice and Learn (From Taylor's

- I.D.
- \* S.Q.
- \* I.M. (Z-Track)
- \* Vial, ampule, tubex
- \* Mixing meds (2 vials, 1 vial and 1 ampule - 1 tubex & 1 vial)
- \* Intermittent I.V.P.B.
- \* SAS

**Theoretical Content**

**AIR**

- Oxygen tanks
- Nasal cannula
- Flow meter
- Pulse Oximeter

Preparation Post-Op

- Turning, deep breathing & coughing
- Incentive spirometer
- Three leg exercises
- Anti-emboli hose
- Sequential compression devices
- Drainage devices
  - Hemovac
  - Jackson Pratt
  - Penrose drain
- \* Sterile techniques
  - Preparation of sterile field
  - Adding sterile items
  - Pouring sterile fluids
  - Removing & disposing of old Dressings
  - Donning sterile gloves
  - Cleansing wound
    - horizontal
    - vertical
    - circular
  - Applying sterile dressing
- \* Central line dressing

Interactive Nursing Skills): Administering a Subcutaneous Injection (3

**Teaching/Learning Activities**

Read: Fundamentals of Nursing: Chapter 40  
Review Chapter 32

o Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Oxygenation: Nasopharyngeal Suctioning (2 K)

o Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Oxygenation: Tracheostomy Care (2 K)

o Practice and Learn (From Taylor's Interactive Nursing Skills): Teaching Coughing and Splinting (3 K)

o Practice and Learn (From Taylor's Interactive Nursing Skills): Administering Oxygen via Nasal Cannula (3 K)

Read: Fundamentals of Nursing: Chapters 34,48,50

Video: Media Center (Library)  
Pre-op Skills RT 73.5 M67 B2  
Post-op Skills RT 73.5 M67 B2

o Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Bowel Elimination: Changing an Ostomy Appliance (2 K)

o Practice and Learn (From Taylor's Interactive Nursing Skills): Administering a Cleansing Enema (3 K)

o Procedures Checklist: 42-1 Assessing Stool for Occult Blood (36 K)

o Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Perioperative Nursing: Preoperative Care on the Day of Surgery (2 K)

FOOD AND WATER

- Nasogastric tube
- \* Placement
- \* Irrigating
- Removing
- Bolus feeding
- Gravity instillation
- Infusion pump
- Intravenous therapy
- \* Priming IV tubing
- Time tape
- \* Regulating flow rate
- \* Changing I.V. solutions
- \* Changing a gown
- Removing a peripheral line
- Saline lock
- Monitoring pump machines
- Peripheral I.V. dressing
- Secondary IV

- o Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM):

Video: Media Center (Library)  
 Wound Care and Applying Dressings  
 Sterile Dressing Change RT 73.5 B46 v. 6

Video: - Media Center  
 Central Line Dressing Change RT 73.5 B46 v. 3  
 BCC

Read: Fundamentals of Nursing:  
 Chapter 35,41,46  
 Review Chapters 37 and 38

Video: Media Center (Library)  
 Nutrition RT 73.5 M67 B2 1993 pt. 4

BCC Video: Media Center (Library)  
 NG Tube Irrigation and Maintenance of  
 G-Tube Feeding RT 73.5 B46 v. 4

Watch and Learn: Fundamentals (From Lippincott's Video Series: Nursing Procedures Student Set on CD-ROM): Nutrition: Administering a Continuous Tube Feeding Using a Feeding Pump and a Prefilled, Closed Tube Feeding Set-Up (2 K)

Video – Media Center  
 Managing Intravenous Fluid Therapy  
 RT 41.M860 2002 pt. 3

**Theoretical Content**

**Teaching/Learning Activities**

ELIMINATION

Bowel Elimination

Fecal impaction

SSE

Fleets enema

Rectal tube

Changing colostomy bag

Urine Elimination

foley care

Read: Fundamentals of Nursing:  
Chapters 41,45,46

Normal Elimination

RT 73.5 M67 B2 2001 pt. 7

Video: Media Center (Library)

Catheterization and Urinary Care

RT 73.5 M67 B2 1993 pt. 5

\* = validation required

**COLLEGE LABORATORY GUIDE**

### COLLEGE LABORATORY GUIDE

It is expected that all students be prepared for College Laboratory before the day of the scheduled lab. Preparation consists of reviewing films available, doing assigned readings, and being familiar with college lab guides. Participation in college lab is required.

SELF-CARE REQUISITE: Balance between Activity and Rest

FOCUS: Body Mechanics, R.O.M., Positioning, Transfers, Restraints

OBJECTIVES:

Practices skills required for maintenance of mechanical safety.  
Demonstrates basic technical skills necessary to promote and maintain Mechanical safety.

PREPARATION:

AV: RT 116 MC	Lifting & Moving the Patient	Media Center (Library)
Binders and Bandages	Media Center (Library)	
RT 73.5 M67 B2 2001 pt. 4	Body Mechanics, Exercise	Media Center (Library)
Apply Restraints	Media Center (Library)	
RT 73.5 M67 B2 2001 pt. 3	Safety and Restraints	Media Center (Library)
RT 73.5 B46 v. 2	<b>Movement of Patient</b>	

READING:

See Reading Assignment.

ACTIVITIES:

1. Body positions
  - Fowler's: high Fowler's, low Fowler's
  - Lateral or Side-Lying
  - Sims
  - Supine (dorsal recumbent)
  - Prone
  - Trendelenburg - Reverse Trendelenburg
2. Applying Restraints
3. Support Devices
  - Trochanter Roll
  - Hand Roll
  - Foot Board
  - Bed Cradle
  - Heel Pads
  - TED's
  - Binders
4. Bandages

5. Crutch Walk

TRANSFERS:

Moving pt. in bed. Procedure one and two person assist.  
Assisting on to bedpan  
Bed to Chair  
Bed to Stretcher - demonstration  
Assist with Walking  
Range of Motion Procedure  
Using a Walker

SELF-CARE REQUISITE: Prevention of Bacteriological Hazards to Human Life

FOCUS: Handwashing  
 Hygienic Care  
 Bedmaking

OBJECTIVES:

- Demonstrate correct handwashing techniques.
- Practice techniques of hygienic care.
- Demonstrate how to provide personal hygienic care satisfactorily.
- Demonstrate making an occupied bed with correct handling of linen.

PREPARATION:

AV: RT 87.H36.H37 1990	Handwashing, Sterile Technique and Changing Dressing	Media Center (Library)
RT 73.5 M67 B1 1993 PT.1	Bedmaking	Media Center (Library)
	PT.2 Bathing	Media Center (Library)
	PT.6 Hygiene and Grooming	Media Center (Library)
RT 73.5 B46 v. 1	Hygiene	Media Center (Library)
RT 73.5 B46 v. 2	Moving a Patient In and Out of Be	Media Center (Library)

READINGS:

See Reading Assignment.

ACTIVITY (Practice):

- Handwashing
- Bed Bath
- Mouth Care conscious & unconscious patient and denture handling
- Back rub
- Bedmaking Occupied
- Linen Handling
- Hair Care
- Perineal Care

SELF-CARE REQUISITE: Prevention of Bacteriological Hazards to Human Life

FOCUS: Universal and Isolation Precaution Techniques

OBJECTIVES:

1. Comprehend basic principles of medical asepsis
2. Differentiate between the various types of isolation (Example: Disease specific, CDC, etc.)
3. Identify precaution taken with each type of isolation.
4. Demonstrate how to don and remove gloves, gown, and mask appropriately.
5. Discuss procedure for transporting patients who are in isolation.
6. Describe the psychosocial reactions that often accompany the patient experiencing isolation.
7. Initiate measures to prevent social isolation and sensory deprivation.

PREPARATION:

READINGS:

See Reading Assignment.

ACTIVITIES:

1. Handwashing procedures (review)
2. Donning & Removing gowns
3. Donning & Removing face masks
4. Donning & Removing gloves
5. Handling refuse disposal

SELF-CARE REQUISITE: Air & Water

FOCUS: Vital Signs

OBJECTIVES:

1. Take an oral temperature on a fellow student.
2. Explain procedure for taking a rectal temperature.
3. Takes a radial pulse on a fellow student.
4. Counts his/her partners respirations
5. Takes his/her partner's blood pressure.
6. Demonstrates use of pulse oximeter.

PREPARATION:

AV:	Vital Signs		Media Center (Library)
	Temperature	RC 74.V572 2002 v.1	Media Center (Library)
	Pulse	RC 74.V572 2002 v.2	Media Center (Library)
	Respiration	RC 74.V572 2002 v.3	Media Center (Library)
	Blood Pressure	RC 74.V572 2002 v.4	Media Center (Library)

Readings:

See Reading Assignment

ACTIVITY/PERFORMANCE

1. Practice taking oral temperature.
2. Practice taking radial pulses.
3. Practice taking blood pressure.
4. Practice counting respirations.
5. Practice use of pulse oximeter

SELF-CARE REQUISITE: Prevention of Bacteriological Hazards

FOCUS: Sterile Dressing Techniques

OBJECTIVES:

1. Uses principles of asepsis when changing a dressing, gloving, and setting up a sterile field.
2. Observes wound drainage equipment (Jackson Pratt, Hemovac)

PREPARATION:

Video: Wound Care RT 41.M860 2002 pt.10 Media Center (Library)

READINGS:

See Reading Assignment

ACTIVITIES:

1. Set up a sterile field using principles of asepsis.
2. Don gloves using principles of asepsis.
3. Observe wound drainage equipment.
4. Opening sterile wrapped packages.
5. Wet to dry dressing.

SELF-CARE REQUISITE: Prevention of Chemical Hazards

FOCUS: Administration of medications

OBJECTIVES: Demonstrates skills in pouring and administering all types of medications, ie:

1. Read simulated doctor's order.
2. Check doctor's order with MAR.
3. Identifies calibration of measuring devices for oral meds, installations, and injectable medications.
4. Draw up desired amount of fluid into syringes from vials and ampules.
5. Pour correct doses of oral medications.
6. Manipulate syringes without contamination of needle, syringe or drug.
7. Identify sites for IM or SC injections.
8. Give IM and SC injection to mannequin.
9. Manipulate Tubex and Carpuject cartridge carriers.

PREPARATION:

Computer Lab: (B-306 )

Elimination of Med Errors - Nursing I - CHEM 3

Medical/Surgical Menu:

Medication Administration Pt. 1 & Pt. 2 - CHEM 1 & 2

Basic Principles of Pharmacology - GEN

READINGS:

See Reading Assignment

ACTIVITIES (PRACTICE):

1. See skills checklist for administration of medication.
2. Compare sizes and calibrations in a variety of syringes and needles.
3. Practice opening ampules.
4. Practice drawing specified amounts into syringes.
5. Assemble a tubex and carpuject cartridge carrier.
6. Follow procedure for subcutaneous injection
7. Explore various injection sites on yourself and other students as well as on mannequins.
8. Discuss insertion of suppositories.

SELF-CARE REQUISITE: Prevention of Chemical Hazards

FOCUS: Administration of intramuscular injections

OBJECTIVES:

1. Prepare medication using multiple vials/ampules and mixes drugs in one syringe whenever possible.
2. Prepare the correct dose of each medication.
3. Identify the correct site, depending on the given client.
4. Demonstrate giving an intramuscular injection into the simulated buttocks.
5. Demonstrate the ability to use a cartridge system.
6. Follow principles of asepsis throughout the preparation and administration of drugs.

PREPARATION:

Practice intramuscular injection technique following procedure given.  
Review rules for calculating drug dosages.

READINGS:

See Reading Assignment

ACTIVITIES (PRACTICE):

1. Will handle a variety of syringes and needles, ampules and vials.

SELF-CARE REQUISITE: Prevention of Chemical Hazards

FOCUS: Glucose Monitoring Systems  
Administration of Insulin

OBJECTIVES:

1. Demonstrate how to test blood sample for sugar using monitoring systems
2. Identify sites used to administer insulin and SQ.
3. Demonstrate steps in mixing medications from two vials.

PREPARATION:

RM 12-108 Medications: Subcutaneous Injection Media Center (Library)

READINGS:

See Reading Assignment

ACTIVITIES (PRACTICE):

1. Name the anatomical locations that can be used for insulin injections.
2. Practice preparations of two types of insulin using same syringe.

SELF-CARE REQUISITE: Prevention of Chemical Hazards

FOCUS: Intravenous Therapy, Administration of IVPB, Saline lock

OBJECTIVES:

1. Demonstrate basic technical skills in setting up an Intravenous and maintaining therapy.

PREPARATION:

READINGS:

See Reading Assignment

ACTIVITIES:

In the college laboratory the student will learn and practice:

1. Changing a patient's gown that has an I.V. infusing.
2. Priming IV tubing.
3. Changing an I.V. bottle.
4. Calculating and regulating the rate of flow of an I.V.
5. Administration of a medication via secondary set (IVPB)
6. Administer IV medications via saline lock
7. Record intake and output

SELF-CARE REQUISITE: Prevention of Thermal Hazards

FOCUS: Application of Heat and Cold

OBJECTIVES: Properly administers applications of heat and cold

PREPARATION:

RT 48.5.B35 1995 pt. 3  
Application of Heat and Cold Media Center (Library)  
RB 52 863 Hot & Cold

READINGS:

See Reading Assignment

ACTIVITIES (PRACTICE):

Sitz Bath  
Aqua K Pad  
Hot Water Bottle  
Warm/Cold Compress  
Ice Bag  
Sponge Bath (Tepid)  
Disposable Hot Packs  
Disposable Cold Packs

SELF-CARE REQUISITE: Maintenance of Sufficient Intake of Food  
Provision of Care Associated with Elimination Process and Excrements

FOCUS:

1. Gastrointestinal Intubation & Intestinal Decompression.
2. Enteral Feeding via Nasoenteric Tube
3. Gastrostomy Feeding
4. Gastrostomy Tube Irrigation.

OBJECTIVES:

1. Identify types of GI tubes
2. State purpose of each tube.
3. Identify nursing responsibilities related to care of patients with G.I. tubes.
4. Describe process of tube insertion.
5. Demonstrate ability to irrigate G.I. tubes.
6. Demonstrate gastrostomy feeding methods & equipment.
7. Identify safety principles of feeding methods.
8. Demonstrate ability to administer feeding via each method.

PREPARATION:

Review procedures for Nasoenteric Enteral Feeding, Gastrostomy Feeding and Irrigation of Nasogastric Tube.

Video: NG Tube Feeding – G Tube Feeding RT 73.5.B46 v.4      Media Center (Library)  
Watch and Learn Videos Chapter 38

READINGS:

See Reading Assignment

ACTIVITY/PERFORMANCE:

1.
  - a. Handle GI tubes.
  - b. Differentiate GI tubes by name & purpose.
  - c. Cite nursing responsibilities related to care of patients with G.I. tubes in place.
  - d. Perform irrigation of N.G. tube using guide.
2.
  - a. Cite nursing actions related to principles of feeding methods.
  - b. Perform nasoenteric enteral feeding using guide.

SELF-CARE REQUISITE: Provision of Care Associated with Elimination Processes and Excrements

FOCUS: Enemas, Intake & Output, Collection of Specimens,

OBJECTIVES:

1. Describe urinary and fecal output and record on appropriate recording sheets.
2. Demonstrate
  - a. Cleansing - Fleets, Tap H<sub>2</sub>O
  - b. Retention - Tap H<sub>2</sub>O, oil
3. Describe methods of collecting specimens.
4. Demonstrate collection of urine from:
  - a. Closed system (sterile)
5. List the characteristics of urine and/or feces

PREPARATION:

AV: RT 87.C54 1988	Cleansing Enema	Media Center (Library)
RT 73.5.M67 B2	Promoting Bowel Elimination	Media Center (Library)
RT 73.5.M67 B2	Specimen Collection	Media Center (Library)
RT 73.5.M67 B2	Normal Elimination	Media Center (Library)

READINGS:

See Reading Assignment

ACTIVITY/PERFORMANCE (PRACTICE):

1. Describe the following types of enemas
  - Fleets: Cleansing, oil retention
  - Tap Water Enema - cleansing or retention
2. Collect specimens
  - stool - parasites or occult blood
  - urine - voided (U/A and C & S)
  - urine - closed Foley
  - cultures

SELF-CARE REQUISITE: Provision of Care Associated with Elimination Processes and Excrements

FOCUS: Ostomy Care

OBJECTIVES:

1. Identify nursing responsibilities related to care of patients with an ostomy.
2. Demonstrate ability to remove colostomy appliance & replace colostomy appliance.

PREPARATION:

Video: Ms. B. - Ostomy Care RT 41.M860 2002 pt. 4 Media Center (Library)  
Watch and Learn Videos Chapters 41 and 42

READINGS:

See Reading Assignment

ACTIVITY/PERFORMANCE:

1. Handle equipment associated with ostomy care.
2. Practice removal and replacement of colostomy appliance

**SKILLS FOR NURSING PRACTICE**

**SKILLS REQUIRING VALIDATION**

1. Patient Care
  - a. Handwashing
  - b. Moving patient up in bed: one person assist
  - c. Moving patient up in bed: two or three person assist
  - d. Turning a patient: positioning on side
  - e. Transferring from bed to wheelchair
  - f. Mouth care
  - g. Assisting the client to use a bedpan
  - h. Posey Restraints
  
2. Vital Signs
  - a. Temperature - oral
  - b. Radial pulse
  - c. Respiratory rate
  - d. Blood pressure
  
3. Medication Administration
  - a. Administration of oral medications
  - b. Administration of SQ injections (Insulin)
  - c. Administration of IM injection (mixing two meds using tubex)
  
4. Intravenous Therapy
  - a. Setting up an IV
  - b. Changing a gown for a patient with an IV
  - c. Administration of a medication via secondary set
  
5. Sterility
  - a. Donning sterile gloves
  - b. Opening sterile wrapped package
  - c. Preparing a sterile field
  - d. Applying wet-to-dry dressing
  - e. Central venous line dressing change
  
6. Irrigation
  - a. Maintenance of gastrostomy tube
  - b. Irrigation of nasogastric tube
  
7. Protective Isolation techniques

**GENERAL GUIDELINES PRIOR TO STARTING ANY PROCEDURE**

- \* 1. Check physician/health care provider orders/
- \* 2. Wash your hands.
- 3. Organize your equipment.
- \* 4. Identify patient.
- \* 5. Introduce yourself
- \* 6. Explain procedure to patient.
- \* 7. Provide for privacy.
- 8. Raise the bed to a working level.
- 9. Position patient as needed.
- 10. Maintain safety.
- 11. Perform procedure.
- 12. Observe patient's response.
- 13. Wash your hands.
- 14. Document accordingly.

\* **Must be stated prior to starting validation procedure**

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>HANDWASHING</b>			
1. Stand away from sink approximately 6 inches.			
2. Remove jewelry except plain wedding band and push watch above wrist about 4 inches.			
3. Turn on water. Adjust to warm temperature.			
4. Wet hands and wrists.			
5. Apply soap.			
6. Wash palms and back of hands using friction.			
7. Wash fingers and spaces between them.			
8. Wash wrists and 3-4 inches above wrists.			
9. Wash for at least 10-15 seconds.			
10. Rinse with running water. Keep hands and forearms lower than elbows.			
11. Turn off faucet with paper towel, discard.			
12. Dry thoroughly from fingers to wrist.			
13. Assess your skin for rashes, chapping, and open areas.			
14. Use lotions to protect your skin.			

Can be delegated to LPN and UAP (p. 656)

LPN = Licensed Practical Nurse  
 UAP = Unlicensed Assistive Personnel

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>.MOVING A PATIENT WHO CAN ASSIST UP IN BED: ONE PERSON ASSIST*</i></b>			
1. Raise bed to height of nurse's center of gravity.			
2. Adjust head of bed to flat position or as low as patient can tolerate.			
3. Lower side rail on working side.			
4. Remove pillows, place one against head of bed			
5. Have patient bend knees and place soles firmly on bed.			
6. Have patient grasp headboard or place palms on bed to assist with move. If an overhead trapeze is available have patient use it to assist with move.			
7. Face direction of movement and assume broad stance. Stand with foot nearest bed behind other foot. Place weight on forward foot.			
8. Flex your hips, knees and ankles.			
9. Instruct patient to move with you on your count, pulling with arms and pushing with feet.			
10. Return bed to low position.			

\*If patient cannot assist or is very heavy get help with moving him/her.  
Can be delegated to LPN and UAP (p. 1252, 1253)

<b><i>MOVING A DABILITAED PATIENT UP IN BED: TWO OR THREE PERSON ASSIST</i></b>			
1. Move patient close to one side of bed.			
2. Follow steps 1 - 8 for one person assist.			
3. Assistant 1 slides arms under patient's head and shoulders.			
4. Assistant 2 slides arms under patient's hips.			
5. Assistant 2 counts and both move patient.			
6. Raise side rails and return bed to lowest position.			
7. Alternate approach: Each assistant places one arm under client's shoulders and one arm under client's thighs.			
8. Alternate approach: Use a draw or turning sheet to facilitate movement.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>TURNING A PATIENT: LOG ROLLING</b>			
1. Raise bed to height of nurse's center of gravity. Bed should be in flat position			
2. Lower side rail on side you will move patient toward. Two or more persons assume a broad stance, with one foot in front of the other, will move patient to the side of bed opposite to side patient will be rolled toward.			
3. Follow steps 3 - 5 for Two Person Assist above.			
4. With help, move patient to side of bed in one unit. Raise side rail.			
3. All assistants move to other side of bed.			
4. Lower side rail and place a pillow to support patient's head.			
5. Place a pillow between patient's legs to support upper leg.			
6. Assistants reach across and grasp patient's body.			
7. At count, all turn patient in one unit. Leave patient in comfortable and properly aligned position.			
8. Raise side rail and return bed to low position. Place patient's call bell and possessions within easy reach.			
9. Variation: use a draw or turning sheet to facilitate log rolling patient.			

Can be delegated with specific training  
Nurse should supervise UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>TRANSFERRING FROM BED TO WHEELCHAIR*</i></b>			
1. Check patient's activity order.			
2. Assess patient's leg strength by checking leg lifts and foot pushes.			
3.. Lower bed to lowest position.			
4. Lock wheels of bed.			
5. Place wheelchair parallel to bed as close to bed as possible on patient's stronger side. Lock wheels of wheelchair.			
6.. Assist patient to edge of bed.			
7. Raise head of bed slowly.			
8. Place one hand behind patient's back with the other under/over the knees and assist him to swing into a sitting position on side of bed.			
9. Allow patient to dangle for several minutes and assess for dizziness and weakness. (If weakness or dizziness occurs check vital signs. If weakness or dizziness persists or vital signs indicate problem do not get patient out of bed and notify doctor.)			
10. Assist patient with putting on bathrobe and nonskid slippers or shoes.			
11. Place patient's feet slightly apart, and position patient's hands on bed surface.			
12. Assume broad stance, placing one foot forward in between patient's legs and other foot back.			
13. Encircle patient's waist with arms.			
14. Support patient in rising and standing up for a few moments.			
15. Together pivot or take a few steps toward wheelchair.			
16. When patient's back is at wheelchair, instruct patient to place hands on armrests when he feels his legs against the seat.			
17. Lower patient onto seat.			
18. Be sure patient's buttocks are positioned in back of seat.			

**\* If using a chair, place chair against wall to prevent movement when patient sits.**

Can be delegated to LPN and UAP If first time, should be supervised by RN

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>MOUTH CARE FOR UNCONSCIOUS OR DYSPHASIC PATIENT</i></b>			
1. Obtain oral hygiene solution, water soluble jelly, oral swabs, basin, towel, or tongue blade and 4x4's.			
2. Close curtain or room door for privacy.			
3. Wash hands and apply disposable gloves.			
4. Position patient on side with head turned toward mattress to prevent aspiration.			
5. Place towel under patient's face and position emesis basin under patient's chin.			
6. Clean teeth and mucosa using swab or padded tongue blade moistened in oral cleansing solution; thoroughly swab areas of accumulated crusts or secretions.			
7. Apply water-soluble jelly to lips.			
8. Dispose of equipment and soiled linen properly.			
9. Remove gloves and dispose in proper receptacle.			
10. Reposition patient safely and comfortably after procedure.			
11. Wash hands.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>ASSISTING THE PATIENT TO USE A BEDPAN</b>			
1. Provide privacy			
2. Put opposite side rail up			
3. Position bed at appropriate working height.			
4. Position bed flat or level.			
5. Wash hands and apply gloves			
6. Turn patient onto side and place a clean protective pad under buttocks.			
7. Place bedpan under patient's buttocks.			
8. Hold bedpan firmly in place while turning patient onto the bedpan.			
9. Raise patient's head 30 ° or more (unless contraindicated).			
10. Ensure patient's comfort.			
11. Lower height of bed to lowest position.			
12. Allow patient to be alone, but monitor status. Place call bed in reach.			
13. Remove gloves and wash hands.			
14. Respond to patient's call bell immediately.			
15. Don clean gloves.			
16. Position patient's bedside chair near working side of bed for placement of bedpan.			
17. Collect basin of warm water.			
18. Position bed at appropriate working height. Lower side rail.			
19. Remove upper linens.			
20. Lower head of bed until flat or level.			
21. Turn patient onto side while firmly holding bedpan in level position.			
22. Remove bedpan from underneath patient.			
23. Cleanse and dry perineal area from front to back.			
24. Raise side rail and return patient to comfortable position.			

PROCEDURE	SATIS- FACTORY	UNSATIS- FACTORY	COMMENTS
<b><i>ASSISTING THE PATIENT TO USE A BEDPAN (Continued)</i></b>			
25. Lower bed to lowest position and return patient's environment to former status.			
26. Wearing gloves, empty contents of bedpan and rinse it. Obtain stool specimen if indicated.			
27. Replace all used equipment.			
28. Dispose of soiled linens.			
29. Remove gloves and wash hands.			
30. Bring wash cloth, soap and water to patient for hand washing. Record and describe output appropriately.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>BATHING A PATIENT</i></b>			
1. In privacy, offer patient bedpan or urinal before bath.			
2. Wash hands and apply gloves.			
3. Assist patient in assuming a comfortable position, raise bed to comfortable working level and lower side rail on working side..			
4. Use bath blanket properly while removing top linens of bed.			
5. Dispose of soiled linen correctly.			
6. Remove patient's gown correctly.			
7. Raise side rail. Fill washbasin two-thirds full. Check bath water temperature to ensure patient's comfort and tolerance.			
8. Fold washcloth into mitt.			
9. Wash and dry patient's eyes (without using soap) from inner canthus to outer canthus. Use different sections of cloth for each eye.			
10. Wash, rinse, and dry patient's forehead, cheeks, nose, neck, and ears, using or avoiding soap as appropriate.			
11. Remove bath blanket from patient's far arm and place bath towel under arm.			
12. Bathe patient's far arm, axilla and hand. Always hold limbs at joints.			
13. Rinse and dry arm, axilla and hand thoroughly; provide deodorant (or talcum powder if used by patient). Soak hands if necessary and use orange stick to clean nails – do not cut nails.			
14. Assess skin during bath for redness and break down. Apply lotion to bony prominences, dry areas, hands and feet.			
15. Repeat Steps 12-14 for other arm.			
16. Check temperature of bathwater and change water if necessary.			
17. Fold bath blanket down to waist. Cover chest and abdomen with towel. Remove towel over chest. Wash, rinse, and dry chest. Replace towel on chest.			
18. Raise bottom of towel up over chest exposing abdomen.			

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>BATHING A PATIENT (Continued)</i></b>			
19. Wash, rinse and dry abdomen.			
20. Follow procedure for placing towel under patient's far leg.			
21. Wash leg from ankle to knee; from knee to thigh. Dry well.			
22. Repeat steps for other leg. Wash, rinse and dry feet. Soak feet if necessary.			
23. Cover patient with bath blanket and change bathwater.			
24. Place patient on side for bathing back and buttocks.			
25. Place towel lengthwise on bed, as close to back as possible.			
26. Wash, rinse, and dry patient's back from neck to buttocks.			
27. Give back rub using lotion.			
28. Change bathwater and washcloth.			
29. Position and drape patient for washing perineum.			
30. Cleanse perineum front to back, pat dry thoroughly.*			
31. For patients with an indwelling catheter, using a clean washcloth, cleanse catheter from meatus down the length of tubing. Perform general perineal care as well.			
32. Apply lotion to bony prominences, dry areas, hands and feet.			
33. Apply and secure gown, comb client's hair.			
34. Make patient's bed.			
35. Dispose of soiled linen properly; clean and replace bathing equipment; replace call light and personal possessions.			
36. Wash hands. Document findings.			

**\* Alternative: For highly soiled perineal areas, place patient on clean bedpan and pour warm water over area, top - down, to flush perineum. Remove bedpan and wash as usual and pat dry.**

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>POSEY VEST RESTRAINT</i></b>			
1. Check for physician's order written within past 24 hours.			
2. Explain to patient and family need for restraint and document in chart.			
3. Obtain correct size vest.			
4. Place vest on patient as per manufactures instruction. (If non-zippered vest, place opening of vest in front, bring ties through loops.) Leave 2 fingers width space between restraint and patient to prevent constriction.			
5. Secure ties to bed frame ( <b>never to side rail</b> ) using quick release tie.			
6. Make sure patient is in proper alignment and comfortable.			
7. Place call bell within patient's reach.			
8. Monitor and document restraints as per institution's policy.			

Can be delegated to LPN and UAP (p. 834)

PROCEDURE	SATIS- FACTORY	UNSATIS- FACTORY	COMMENTS
<b><i>MAKING AN OCCUPIED BED</i></b>			
1. Assemble equipment with linen stacked in order of use (top to bottom). Remove unnecessary equipment from bedside area.			
2. Close curtain or room door for patient's privacy.			
3. Reposition mattress toward head of bed if assistance is available.			
4. Wash hands and don clean gloves.			
5. Adjust bed to comfortable working height. Lower side rail on working side and remove call light.			
6. Loosen top linen sheet at foot of bed taking care not to dislodge tubes, IV, etc..			
7. Remove blanket, fold and discard into linen bag. Do not allow soiled linen to come in contact with uniform. Do not flutter sheets to prevent debris and bacteria from being dispersed in air.			
8. Cover patient with bath blanket and remove top sheet without exposing body parts. If bath blanket not available top sheet may be left in place to cover patient during bath.			
9. Ensure that side rail on opposite side of bed is elevated and assist patient to side-lying position.			
10. Loosen bottom linen from head to foot of bed.			
11. Fanfold soiled bottom sheet and draw-sheet and tuck them under patient's shoulders, back, and buttocks.			
12. Fanfold clean bottom linen onto uncovered side of mattress.			
13. Make mitered corner at top corner of bottom sheet.			
14. Tuck bottom sheet tightly under mattress.			
15. Fanfold draw-sheet under patient and tuck under mattress.			
16. Fanfold waterproof pad under patient's buttocks.			
17. Raise side rail on working side and move to other side of bed.			

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>MAKING AN OCCUPIED BED (Continued)</i></b>			
18. Lower side rail and assist patient in rolling over folds of linen to clean side. Loosen edges of soiled linen from underneath mattress.			
19. Remove and dispose of soiled linen.			
20. Spread clean, fan-folded linen smoothly over edge of mattress from head to foot of bed.			
21. Place patient in supine position on clean bottom linen.			
22. Miter top corner of bottom sheet.			
23. Tuck all bottom linen under mattress.			
24. Place top sheet over patient and unfold from head to foot.			
25. Remove bath blanket and discard it appropriately.			
26. Place clean blanket correctly on bed.			
27. Make cuff out of top edge of sheet and blanket.			
28. Tuck top sheet and blanket under mattress leaving room for patient's toes.			
29. Make modified mitered corner with top sheet and blanket.			
30. Raise side rail and head of bed to patient's comfort level.			
31. Remove and discard soiled pillow case. Correctly apply clean pillow case over pillow.			
32. Reposition pillow under patient's head.			
33. Place call light within patient's reach and lower height of bed to lowest level.			
34. Discard linen properly. Remove gloves and wash hands.			
35. Open room curtains. Ensure that surfaces of furniture are clean and arrange patient's personal items within easy reach.			

Can be delegated to LPN and UAP (p. 900)

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>PROTECTIVE ISOLATION - DONNING</b>			
1. Wash hands.			
2. Apply long-sleeved isolation gown, securing ties at neck and waist behind back. (Gown ties may be tied in front of gown only after gloves have been applied.)			
3. Apply mask over nose and mouth.			
4. Don clean gloves with glove edges covering gown cuffs.			

<b>PROTECTIVE ISOLATION - REMOVING</b>			
1. If gown is tied in front, untie while gloves remain on hands. If gown is tied in back, remove gloves before untying ties. (see number 7)			
2. Grasp glove of dominant hand on palmar surface below cuff.			
3. Pull glove off completely by inverting or rolling glove inside out.			
4. Hold removed glove with fingers of gloved hand.			
5. Place first two fingers of bare hand inside cuff of second glove and pull glove off fingers by turning inside out.			
6. Dispose of gloves appropriately.			
7. Untie waist ties if knotted in back.			
8. Untie neck ties and bring them forward until gown is partially off shoulders.			
9. Work from inside of gown and slide gown down arms and over hands.			
10. Roll gown up inside out and discard in appropriate container.			
11. Untie lower strings of mask.			
12. Untie top strings of mask.			
13. Fold mask in half with moist inner surfaces together.			
14. Dispose of mask appropriately.			
15. Wash hands.			

Can be delegated to LPN and UAP (p. 664)

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>TEMPERATURE - ORAL</b>			
1. Wash hands. Apply clean gloves.			
2. Explain procedure to patient.			
3. Rinse thermometer in cool water and wipe dry with tissue from stem to bulb end.			
4. Grasp thermometer with thumb and forefinger and shake down mercury to below 96° F.			
5. Apply plastic sheath.			
6. Insert thermometer into patient's posterior sublingual pocket and under tongue and ask patient to keep lips closed.			
7. Leave in place 3 to 4 minutes.			
8. Remove thermometer from patient's mouth. Remove and discard plastic sheath.			
9. Read temperature at eye level to nearest tenth of a degree.			
10. Shake thermometer down, rinse in cool water and replace in patient's bedside container.			
11. Remove gloves. Wash hands.			
12. Record temperature according to agency procedure.			

Can be delegated to LPN and UAP (p. 510)

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>RADIAL PULSE</i></b>			
1. Wash hands. Explain procedure to patient.			
2. Position patient - either sitting in chair or in bed.			
3. Support patient's arm when taking the pulse.			
4. Palpate radial artery by using pads of the middle three fingers of your hand.			
5. Count for 30 seconds and multiply by 2.			
6. Note and record pulse rate, quality, and regularity.			

Can be delegated to LPN and UAP (p. 522)

<b><i>RESPIRATORY RATE</i></b>			
1. Wash hands.			
2. Position patient so chest is easily observed..			
3. Observe chest rise and fall, count respirations for 30 seconds and multiply by 2.			
4. Note and record respiratory rate, rhythm, and any abnormal sounds associated with breathing.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>BLOOD PRESSURE</b>			
1. Wash hands. Explain procedure.			
2. Obtain appropriate size cuff and stethoscope.			
3. Place patient in relaxed reclining or sitting position with arm supported.			
4. Select appropriate arm for application of cuff.			
5. Expose upper arm and position it with palm upward, arm slightly flexed.			
6. Locate brachial artery with fingertips.			
7. Position fully deflated cuff snugly and smoothly 1 - 2 inches above the antecubital space and with the center of cuff bladder over brachial artery.			
8. Close valve on sphygmomanometer cuff.			
9. (If you do not know client's baseline blood pressure) a. Inflate cuff until pulse becomes obliterated and note systolic reading on sphygmomanometer. b. Deflate cuff. c. Wait 30 seconds.			
10. Place diaphragm of stethoscope on brachial artery.			
11. Inflate the cuff 30 mm Hg. above the estimated systolic reading noted above.			
12. Open the valve and slowly (about 2 mm Hg/second) release and note the first clear sound heard (systolic reading).			
13. Note when the sound completely disappears (diastolic reading).			
14. Deflate cuff completely and remove from arm.			
15. Note and record the B/P according to agency procedure.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>ADMINISTRATION OF ORAL MEDICATION</b>			
1. Adhere to the 6 rights* of medication administration.			
2. Compare medication record with original physician's order.			
3. Check for allergies.			
4. Describe actions, nursing considerations and side effects of medication to be administered.			
5. Wash hands.			
6. Obtain medication.			
7. Read drug label at time of contact with drug bottle or unit dose and compare with medication record.			
8. Place unopened medication unit dose package in a disposable cup.			
9. For liquid medications, place cap upside down on counter, hold bottle with label against palm, pour and read the amount at the bottom of the meniscus at eye level.			
10. Compare name and number on medication record with patient's identification band.			
11. Before opening medication compare with MAR.			
12. Administer the medication and stay with patient until medication is taken.			
13. Record on medication administration record (MAR).			
14. Evaluate patient's response to medication administered.			

\*Right Drug, Right Dose, Right Route, Right Time, Right Patient and Right Reason. Right Documentation

Can be delegated to LPN

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>ADMINISTRATION OF LONG-ACTING AND SHORT-ACTING INSULINS BY SQ INJECTION</b>			
1. Check chart for medication order and current blood sugar.			
2. Wash hands.			
3. Gather equipment: Long-acting and Short-acting (Regular) Insulin vials, U-100 insulin syringe with needle, alcohol sponges, medicine tray.			
4. Compare medication order with the labels on the vials.			
5. Rotate vial. (Necessary for all types of insulin except Regular insulin).			
6. Clean each vial of insulin using aseptic technique.			
7. Remove the needle guard.			
8. Pick up syringe and obtain measured amount of air equal to the dose of long-acting insulin <b>which is to be drawn up second.</b>			
9. Insert needle and inject the air into the vial containing long-acting insulin <b>checking label carefully.</b>			
10. Obtain measured amount of air equal to the dose for short-acting (Regular) insulin and inject into the vial containing short-acting (Regular) insulin <b>checking label carefully..</b>			
11. Withdraw correct amount of short-acting (Regular) insulin from vial.			
12. Expel air bubbles.			
13. Insert needle into second vial and withdraw correct amount of long-acting insulin <b>checking label carefully.</b>			
14. Attach needle guard. Return medication vials to storage place.			
15. Assemble all items on a medicine tray.			
16. Identify patient appropriately.			
17. Select correct site.			
18. Open sponge.			
19. Pick up syringe and remove needle guard.			
20. Prepare skin site with alcohol wipe..			
21. Gently pinch up skin prior to administration.			
22. Insert needle at 90° angle (45° for emaciated patients).			

PROCEDURE	SATIS- FACTORY	UNSATIS- FACTORY	COMMENTS
<b>ADMINISTRATION MIXED INSULINS BY SQ INJECTION – Continued</b>			
23. Inject medication without aspirating while skin is gently pinched up.			
24. Release skin. Remove needle. Do not recap.			
25. Wipe skin with antiseptic sponge. Do not rub.			
26. Leave patient comfortable.			
27. Dispose of equipment in proper manner. Wash hands.			
28. Record on patient's medication record and diabetic record the following: date, time, site, dose of each insulin, and blood sugar level.			

Can be delegated to LPN

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>I.M. INJECTION (Mixing 2 medications using tubex)</i></b>			
1. Compare medication record with physician's order.			
2. Check for allergies.			
3. Obtain medications and read label 3 times – 1 when selecting each medication (cartridge and vial or ampoule); 2 when loading cartridge into Tubex and drawing up second medication from vial or ampoule; 3 just prior to administering drugs to patient.			
4. Calculate correct dosage to be administered.			
5. Insert cartridge into Tubex..			
6. Expel air from cartridge.			
7. Draw up correct dose of second drug from a vial or ampoule.			
8. Don clean gloves.			
9. Identify patient appropriately..			
10. Have patient assume correct position for the site selected.			
11. Identify chosen IM site by landmarks.			
12. Prepare site with alcohol swab.			
13. With non-dominant hand, using thumb and fore finger, spread skin taut.			
14. Using a quick darting action, insert needle at 90° angle.			
15. With non-dominant hand, grasp hub of needle with fore finger and thumb.			
16. With dominant hand, aspirate for blood return. Withdraw needle if blood return occurs and restart procedure.			
17. If no blood is aspirated inject medication slowly at a rate of 10 seconds per ml of medication.			
18. Wait 10 seconds and then remove needle quickly.			
19. Apply gentle pressure at the site.			
20. <b>Do not recap needle. Disengage cartridge from Tubex and discard cartridge in sharps container.</b> Remove gloves and discard. Wash hands.			
21. Record on medication administration record (MAR) indicating site used.			
22. Evaluate patient's response to medication administration.			

Can be delegated to LPN

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>SETTING UP AN I.V.</b>			
1. Check physician's order.			
2. Wash hands. Assess patient's IV site for redness, swelling and patency.			
3. Obtain correct I.V. solution and apply time tape label.			
4. Obtain appropriate IV tubing.			
5. Clamp I.V. tubing.			
6. Remove protective cover from entry site on I.V. bag.			
7. Remove cover from spike on the end of I.V. tubing.			
8. Insert spike into I.V. bag.			
9. Hang or hold bag upright and fill drip chamber half full.			
10. Remove cap at end of tubing and attach access device (needle).			
11. Remove cap at end of access device.			
12. Unroll roller clamp and allow solution to fill entire length of I.V. tubing slowly, maintaining sterility by keeping the end of tubing above waist and in plain sight.			
13. Close roller clamp. Re-cap access device.			
14. Identify patient. Prepare saline (heparin) lock port with alcohol wipe and attach access device (needle) to the port.			
15. Slowly open roller clamp and regulate IV rate of flow.			
16. Record on I&O sheet.			

Should not be delegated  
 LPN can change IV bottle if same IV

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>CHANGING A GOWN FOR A PATIENT WITH AN I.V.</i></b>			
1. Remove soiled gown from arm without I.V. and move it across patient's chest.			
2. Place clean gown on uncovered arm and move clean gown over patient's exposed chest.			
3. Remove soiled gown from arm with the I.V.			
4. Remove IV bag from pole and pull bag and tubing through sleeve of soiled gown from outside to inside freeing IV and tubing from gown.			
5. While removing gown hold IV upright to maintain gravity flow.			
6. Pull I.V. bag and tubing through the sleeve of clean gown from inside to outside.			
7. Slip patient's arms through sleeve of clean gown. Assess IV site.			
8. Hang IV bag on pole and secure patient's gown.			

Can be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>ADMINISTRATION OF A MEDICATION VIA SECONDARY SET (INTERMITTENT IVPB)</b>			
1. Compare medication record with physician's order and wash hands.			
2. Obtain correct IVPB medication and compare with MAR			
3. Assess patient's IV site.			
4. Assess patency and infusion rate of main IV.			
5. Calculate rate of flow in gtts/minute for IVPB.			
6. Obtain and clamp secondary piggyback tubing.			
7. Connect piggyback tubing to piggyback.			
8. Fill drip chamber halfway.			
9. Attach access device (needle) to end of tubing.			
10. Prime tubing while maintaining sterility by keeping the end of tubing above waist and in plain sight. .			
11. Place label on piggyback tubing with appropriate date and time.			
12. Swab upper port of primary IV tubing with alcohol wipe.			
13. Insert access device (needle) into upper port of the primary IV tubing.			
14. Lower primary IV bag with extension hook.			
15. Hang bag with IV medication higher than primary bag.			
16. Open piggyback roller clamp <b>completely.</b>			
17. Regulate flow with primary IV tubing clamp so that the medication infuses over the prescribed amount of time.			
18. Wash hands			
19. When medication infusion is complete, washed hands, clamp piggyback tubing and raise primary IV bag to original height.			
20. Restore flow rate of primary IV to original rate ordered by physician.			
21. Record on medication record and I&O sheet. Wash hands.			

Can be delegated to LPN providing it is not initial dose.  
Piggyback must be prepared by RN or pharmacist.

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>DONNING STERILE GLOVES</i></b>			
1. Select appropriate size gloves. Wash hands.			
2. Peel apart sides of outer package wrapper.			
3. Lay inner package on clean, flat surface just above waist level.			
4. Open package, keeping gloves on inside surface of wrapper.			
5. Identify right and left gloves.			
6. Grasp cuff of glove for dominant hand with thumb and fingers of non-dominant hand touching only inside surface.			
7. Carefully pull glove over dominant hand keeping hand in upward position.			
8. Pick up second glove by inserting the gloved fingers of the dominant hand under the cuff of second glove.			
9. Pull on second glove with gloved hand grasping under the cuff. Maintain hand in upward position. (Do not allow gloved hand to touch any part of exposed hand.)			
10. When both gloves are on, interlock fingers of both hands to secure gloves in position.			

Can be delegated if specially trained

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>OPENING STERILE WRAPPED PACKAGE</i></b>			
1. Wash hands.			
2. Check expiration date on package and place package on clean, dry, flat surface at waist level.			
3. Place package so the top flap of wrapper opens away from self.			
4. Reach around package and pinch uppermost flap between thumb and index finger and pull flap open laying it flat on surface.			
5. Open uppermost side flap first, using right hand for right flap and left hand for left flat. Pull each flap open separately laying each flat on surface.			
6. Pull last flap toward self by grasping corner that is turned down with thumb over and fingers under corner. Pull the flap open laying it on flat surface.			
7. Maintain asepsis throughout procedure by not reaching over open field and keeping field in sight.			

Can be delegated to LPN

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>PREPARING A STERILE FIELD</i></b>			
1. Select clean work surface at waist level.			
2. Assemble equipment and check expiration dates of supplies.			
3. Wash hands.			
4. Place package with sterile drapes on work surface and open it.			
5. Pick up top of drape with one hand within the one inch border. Let drape unfold. Discard outer cover.			
6. Hold drape up and away from the body with both hands.			
7. Position bottom half of drape over work surface.			
8. Allow top half to be placed over work surface last.			
9. Adding sterile items a. Open sterile item. b. Peel wrapper; do not allow it to touch sterile field. c. Place item onto field at an angle. Do not hold arm over field.			
10. Perform procedure using sterile technique.			

Can be delegated to LPN  
 Only if specifically trained – OR techs

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>APPLYING WET-TO-DRY DRESSING</b>			
1. Assess wound and patient's comfort level.			
2. Instruct patient not to touch wound area or sterile supplies.			
3. Position patient comfortably.			
4. Drape patient exposing only wound site.			
5. Make cuff at top of disposable moisture proof bag for waste and place nearby. Wash hands.			
6. Open sterile dressing tray or individually wrapped sterile supplies. Place on clean, dry bedside table.			
7. Pour solution into sterile basin or onto sterile dressings packed in plastic container.			
8. Apply clean gloves.			
9. Remove tape of previous dressing by gently pulling parallel to skin and toward dressing.			
10. With gloved hand, hold top of outer layer of dressing and remove entire dressing. Keep soiled surface away from patient.  If wet-to-dry dressing sticks, gently free dressing but do not touch inner dressing or wound with clean glove <b>unless</b> dressing is to be performed with clean rather than sterile technique.			
11. Observe character and amount of drainage on dressing.			
12. Properly dispose of dressings in moisture proof waste bag.			
13. Properly remove and dispose of gloves in disposable waste bag.			
14. Apply sterile or clean gloves, according to written hospital policy which designates this kind of dressing as a clean or sterile procedure.			
15. Cleanse wound with prescribed solution or normal saline from least to most contaminated area (from center of wound outward).			

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>APPLYING WET-TO-DRY DRESSING (continued)</i></b>			
16. Apply wet but not dripping fine-mesh gauze onto wound, ensuring that all surfaces are in contact with wet gauze.			
17. Apply dry sterile 4 X 4s over wet gauze.			
18. Cover with ABD pad.			
19. Properly apply tape, Kling roll or Montgomery ties over dressing.			
20. Properly remove and dispose of gloves.			
21. Dispose of all supplies.			
22. Wash hands.			
23. Reassess client.			
24. Record procedure, observations and patient's tolerance.			

Wound that require sterile technique can be delegated to LPN if not a new wound  
 If using clean technique for chronic wounds, may be delegated to LPN and UAP

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>CENTRAL VENOUS LINE DRESSING CHANGE</b>			
1. Assess wound and patient's comfort level.			
2. Explain procedure and instruct patient not to touch wound area or sterile supplies.			
3. Place patient in a supine position (or low fowlers) with bed at comfortable height for nurse.			
4. Wash hands.			
5. Drape patient exposing only the wound site.			
6. Tape waste bag by bedside.			
7. Open the central line kit.			
8. Don clean gloves.			
9. Obtain 2 masks from central line kit. Place 1 mask on self and other mask on patient. If a second mask is unavailable, instruct (or assist) patient to turn head away from the central line site.			
10. Remove the old dressings carefully and discard in waste bag. Inspect the skin for signs of irritation or infection.			
11. Remove gloves and discard following correct procedure.			
12. Don sterile gloves.			
13. Open all packages within the sterile kit.			
13. Use <b>chloraprep applicator</b> to clean the skin. <b>Provide friction, scrub area using vertical and horizontal strokes covering all the skin that is under the dressing.</b>			
15. Allow the skin to dry.			
16. Apply sterile transparent (see thru) dressing over the site. The dressing should be occlusive to prevent contamination.			
17. Remove gloves and mask from self and patient and discard.			
18. Label the dressing with the date, time and your initials.			
19. Discard waste bag. Wash hands.			
20. Leave patient in comfortable position with bed returned to lowest position.			
21. Document procedure and findings			

Cannot be delegated (p. 1019)

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b>MAITENANCE OF A CONTINUOUS PEG FEEDING</b>			
1. Check health care provider's order.			
2. Head of bed must be maintained at 45 degrees elevation.			
3. Assemble equipment.			
4. Turn off pump.			
5. Assess patient for nausea and abdominal distention. Assess bowel sounds.			
6. Wash hands. Put on clean gloves.			
7. Place clean protective pad on work area.			
8. Disconnect G-tube from continuous feeding. Kink G-tube to prevent backflow.			
9. Aspirate stomach contents with bulb or Toomey syringe.			
10. If stomach contents are greater than 100cc do not re-instill them, notify doctor and discontinue feeding. If stomach contents are less than 100cc. re-instill stomach contents noting color, consistency and amount.			
11. Flush tube with 30cc of tap water.			
12. Reconnect G-tube to feeding tube and turn on pump. Resume feeding at ordered rate of flow.			
13. Wash bulb or Toomey syringe, and irrigation set and store in clean area for next procedure.			
14. Remove gloves and wash hands.			
15. Add feeding to enteral bag if necessary. (ENTIRE SYSTEM NEEDS TO BE REPLACED EVERY 24 HOURS.)			
16. Record on I&O and nurses notes.			

Can be delegated to LPN after tube placement is verified

PROCEDURE	SATIS-FACTORY	UNSATIS-FACTORY	COMMENTS
<b><i>IRRIGATION OF A NASOGASTRIC TUBE</i></b>			
1. Check health care provider's order.			
2. Assemble equipment. Place patient in supine position with the head of bed up 30 degrees. Explain procedure. Raise bed to comfortable working height.			
3. Inspect nasal insertion area for condition of tape holding tube for signs which indicate possible dislodgement of tube.			
4. Wash hands and don clean gloves			
5. Check for correct placement of tube. a. Place stethoscope to the left of the tip of xiphoid process. Instill 10-20cc air into tube while listening for swish in stomach. b. Aspirate contents from NG tube and check pH of stomach contents with gastro occult test strip (pH should be less than 4) c. If placement is in doubt obtain an x-ray.			
6. Instill 20cc of N/S (or as ordered by physician) slowly and gently by squeezing bulb with syringe vertical to nasogastric tube.			
7. Lower syringe and allow bulb to re-inflate or gently aspirate with the Toomey syringe. Assess returns for color, odor, particles and amount..			
8. Leave patient in comfortable upright position with bed at lowest level.			
9. Reconnect NG tube to suction.			
10. Remove gloves and wash hands.			
11. Record on I&O and nurses notes.			

Cannot be delegated to LPN or UAP