

Pensacola Christian College
Department of Nursing

**Procedure
Manual**



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Procedure Manual

Blood Glucose Monitoring

Pensacola Christian College Department of Nursing	January 19, 2007 Approved: 2/23/2007 Revised: 10/14/13
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Supplies Needed:

Blood glucose monitoring machine
Test strips
Lancet
Cotton balls
Alcohol swabs
Clean gloves
For an infant: heel warmer and bandage

Procedure:

1. Gather your equipment and wash your hands.
2. Identify the patient according to facility policy. Explain the procedure to the patient.
3. On an infant, apply heel warmer 5 minutes prior to procedure.
4. Steps for operating machine:
 - a) Turn machine on.
 - b) Enter or scan your operator ID.
 - c) Progress to the next screen.
 - d) Select patient test.
 - e) Scan the patient ID (medical record number) or choose from the patient list.
 - f) Progress to the next screen.
 - g) Scan the test strip container.
 - h) Take a test strip from the vial and insert metal end into the meter. Immediately recap the vial of test strips.
 - i) An icon of a flashing drop should appear on the screen. This means that the meter is ready for a drop of blood.

Exposing the test strips to light for > 2 minutes may lead to inaccurate results

5. Apply clean gloves.
6. Clean the puncture site with an alcohol swab and allow to air dry.

Alcohol can dilute the blood and cause false elevations of blood glucose levels.

7. Hold the lancet perpendicular to the site and press the lancet firmly against the skin prior to pressing the release button. (Inject the side of the finger on an adult and the side of the heel on an infant. Alternate **adult** sites include the earlobe and toes.)
8. Gently squeeze the site until you have a hanging drop of blood.

9. Touch the blood to the edge of the test strip until the collection area is full.
10. Hold a clean cotton ball to the puncture site until the bleeding has stopped. Apply a bandage to the heel of an infant.
11. An hourglass should appear on the screen of the machine while it is calculating the glucose level. Wait for the reading.
12. Take any immediate action necessary based on the glucose level.
13. Discard the supplies that were used. Lancets must be discarded in a sharps container.
14. Remove gloves and wash hands.
15. Return the machine and test strips back to the appropriate place.
16. Document the glucose level and actions taken.

Sources Used:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*. Springhouse, PA: Lippincott Williams & Wilkins.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.

Perry, Anne, Patricia Potter, and Wendy Ostendorf. 2014. Clinical Nursing Skills and Techniques. 8th ed. St. Louis: Elsevier.

Sacred Heart Health System. 2003. "Accu-Check Blood Glucose Monitor." Policies and Procedure. Policy no. PA10 (January). Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. 2006. "Accudata Glucose Test Station: Accucheck Inform for Glucose Monitoring." Policies and Procedures. Book 1, Section 1, #4B (February). West Florida Hospital, Pensacola, FL.

Procedure Manual

Blood Transfusions

Pensacola Christian College Department of Nursing	January 19, 2007 Approved: 2/23/2007 Revised: 10/21/13
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Supplies Needed:

Saline Flushes
Blood component
Blood tubing set
250-500 mL bag of NS
Alcohol swabs
Clean gloves
Biohazard bag
IV pump
VS equipment

Procedure:

1. Verify healthcare provider's order for blood type, amount to be infused, date and time of infusion, and flow rate.
2. Verify that blood consent form is in chart and is signed (obtain from patient or family if not in chart).
3. Verify patient has a patent 18 or 20 gauge IV catheter by flushing the line with NS.
4. Verify that a blood bank ID bracelet is on patient's arm.
5. Before picking up the blood from the blood bank, obtain patient's vital signs. Call healthcare provider if temperature is elevated per facility protocol.
6. Obtain blood/blood product from the blood bank. The blood may be picked up by any designated facility employee or volunteer with the appropriate paperwork.
7. The color and appearance of the blood should be examined. If it has a brown color, contains clots, or is separated, it should be returned to the blood bank.
8. At the patient's bedside:
 - a) Have the patient state his full name and DOB.
 - b) Two licensed personnel must verify and document that the following information on the patient's ID bracelet, the blood bank ID bracelet, transfusion report form, and the blood component bag matches:
 - i) Patient's name
 - ii) Patient's medical record number
 - iii) Donor number
 - iv) Blood type and Rh
 - v) Blood bank number (number and letter code)
 - vi) Expiration date/time
 - c) Teach the patient or family signs and symptoms of transfusion reaction.

9. Obtain and document vital signs per the facility protocol:
 - a) Pre-transfusion (no longer than 30 min. prior to infusion)
 - b) 15 minutes after starting
 - c) Every hour during transfusion
 - d) End of transfusion
10. Follow specific instructions provided with each filter for connecting the filter set to the blood. **Only 0.9% NaCL can be infused with blood or blood component.**
 - a) Apply clean gloves
 - b) Spike NS bag and prime tubing
 - c) Clamp Y-tubing to NS bag
 - d) Spike blood product
 - e) Squeeze drip chamber
 - f) Clean IV hub with alcohol
 - g) Flush IV with NS
 - h) Connect tubing to patient
 - i) Blood should never be warmed with anything other than an official blood warmer
11. Initiate the transfusion at a slow rate, observing the patient closely for any reaction. If no reaction is observed in the first 15 minutes, the rate of transfusion can be increased to the ordered rate.
 - If blood transfusion is not started within 30 minutes of obtaining the blood from the blood bank, the blood cannot be administered to the patient and should be returned to the blood bank. Blood or blood components should never be placed in a refrigerator that is not designated for blood storage.
 - A unit of blood should take no longer than 4 hours to infuse.
 - If the transfusion is not completed within 4 hours, the healthcare provider and the blood bank should be notified.
12. Flush the IV line with saline once the blood bag is empty.
13. Once the transfusion is complete and the patient has had no reaction to the blood, the empty bags and tubing should be discarded in a biohazardous waste bag.
14. Document the blood transfusion on both the patient's chart and on any transfusion slips.
 - **A 1.8° increase** in Fahrenheit temperature during the blood transfusion is significant and the transfusion should be stopped and the reaction reported.
 - **Transfusion Reactions:** If a patient displays any of the following reactions during a blood transfusion, the transfusion should be stopped immediately:
 - Chills, fever, flushing, urticaria, hives/rash, hemoglobinuria, flank and back pain, tightness or pain in chest, dyspnea, hypotension
 - **Delayed Transfusion Reactions:** Continue to monitor the patient for 24 hours after a transfusion for a delayed transfusion reaction. Signs of a delayed reaction may include jaundice or dark urine.

Sources Used:

Baptist Hospital. Policies and Procedures. Baptist Hospital, Pensacola, FL.

Sacred Heart Health System. Policies and Procedure. Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	January 19, 2007 Approved: 01/13/14 Revised: 04/24/15
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Supplies Needed:

3-4 10 mL NS flushes
10 mL syringe
Alcohol swabs
Clean gloves
Sterile IV tubing cap (if disconnecting an infusion)
Patient label
Blood transfer device (or needle)
Small biohazard specimen bag(s)
Blood specimen tubes:
a. Red/green/yellow for chemistries
b. Purple for blood counts (CBC) and hemograms
c. Blue for coagulation studies (PT/INR, PTT)
d. Blood culture bottles

Procedure:

1. Verify Healthcare Providers order and gather appropriate supplies.
2. Identify patient and explain procedure.
3. Wash hands and apply clean gloves. Raise patient's bed to waist level.
4. Stop all infusions to the central line. Choose a port with no IV connections or disconnect the IV tubing keeping the end of the tubing sterile with a cap.
5. Scrub the hub with alcohol for 15 seconds. Keep hub sterile during entire procedure.
6. Flush the port with 10-20 mL NS depending on facility policy. A 20 mL NS flush will be needed if TPN was infusing into the port.
7. With final flush syringe still attached, draw back 5-10 mL of blood as a waste and discard in the sharps container.

Trouble shooting PICC Lines that will not produce blood return:

- Have patient turn head to opposite side and cough.
- Have patient lift arm straight out to the side or above head.
- Call HCP for order for CathFlo (retavase) to declot PICC.

8. Attach sterile empty 10 mL syringe and slowly draw back enough blood to fill all desired specimen tubes.
9. Disconnect syringe from port and attach it to the sterile blood transfer device (or needle).

10. Insert end of blood transfer device (or needle) into each blood specimen tube, filling each tube at least halfway.
11. Flush port with at least 20 mL NS, ensuring all blood is completely cleared from the line. Cleanse blood off port with alcohol swab. If ordered, reattach IV tubing and resume infusion.
12. Discard all syringes and blood transfer devices in sharps container.
13. Attach patient label to each specimen tube and write date, time, and initials. Place all blood collection tubes in small biohazard specimen bag(s) per facility policy.
14. Discard gloves and other used supplies in the trash. Return patient's bed to lowest level. Wash hands.
15. Document blood collection, complete lab requisition, and send specimen tubes to the lab.

Sources Used:

West Florida Hospital. 2012. "Central Venous Catheters and vascular Access Devices: Insertion, Care, and Use." Policies and Procedures. (October). West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	January 19, 2007 Approved: 3/9/2007 Revised: 10/21/13
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Supplies Needed:

Biopatch
End Caps (one for each lumen)
NS Flushes
Stat-Lock (unless central line is sutured)
Skin Prep
Steri-Strips
Sterile transparent dressing (gauze dressing may also be used)
Chlorhexidine stick
Masks (two if you are planning to have the patient wear one)
Clean gloves
Sterile gloves
Tape
*Some of this material may be pre-packaged in a sterile dressing kit

Procedure:

1. Gather all needed materials.
2. Check allergies to ensure the patient is not allergic to any materials used.
3. Identify patient. Wash your hands.
4. Explain the procedure to the patient and have the patient turn his head away from the central line site (or you may have the patient wear a mask instead).
5. Apply mask and clean gloves.
6. Carefully remove the dressing by peeling it off toward the insertion site. Remove all tape and steri-strips from around the insertion site.
7. Unclip Stat-Lock. Remove Biopatch and Stat-Lock and discard in trash can. (Do not remove sutures.)
8. Assess the insertion site and skin noting any odor, redness, edema, ecchymosis, and drainage. Note the markings on the central line to ensure that the line has not migrated further in or out.
9. Remove and discard gloves.
10. Open sterile dressing package by the edges being careful not to contaminate contents. If not part of kit, open Biopatch, Stat-Lock, skin prep, and steri-strips and drop onto sterile field.
11. Apply sterile gloves.

The central line dressing change is the only dressing change where both hands will remain sterile during the procedure.

12. Pick up the chlorhexidine antiseptic and pinch the wings to allow the antiseptic to soak into the sponge.
13. Clean the central line insertion site by using a back and forth motion across the insertion site (this should take a minimum of 15 seconds). After the 15 seconds, move in a circular motion outward from the insertion site. Continue up the catheter approximately 3 inches.
14. Do not pat or blot dry. Allow the antiseptic to air dry before continuing with the procedure.
15. Starting no closer than 1" to insertion site, apply skin prep to the area the dressing will cover.
16. Apply a new Biopatch over the insertion site ensuring that the proper side is down.
17. Clip central line into Stat-Lock and apply Stat-Lock to patient.
18. Center and apply the transparent dressing over the insertion site.
19. Apply a single steri-strip to the area where the catheter comes out from under the dressing.
20. Flush and apply new end caps to each port.
21. Remove gloves and mask, and clean up the area.
22. Date, time, and initial the dressing.
23. Document the dressing change, site observations, and the patient's response to the procedure.

Avoid excessive manipulation of the central line to prevent advancement or retraction of the catheter.

Pediatric Considerations: Chlorhexidine is not recommended for children \leq 2 months. Use 3 betadine swab sticks and allow to dry. Follow with 3 alcohol swabs.

Sources Used:

Baptist Hospital. Policies and Procedures. Baptist Hospital, Pensacola, FL.

Sacred Heart Health System. 2008. "Central Line Tips." Policies and Procedure. (December).
Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 3/2/07 Revised: 10/21/13
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Supplies Needed:

10 mL NS flushes
Alcohol swabs
Clean gloves

Procedure:

1. Routine flush
 - a) Remove cap from syringe (keep cap sterile). Gently pull back on plunger of 10 mL NS flush to break suction. Expel all air from syringe and reapply cap.
 - b) Apply clean gloves.
 - c) Scrub the hub with alcohol swab for 15 seconds and allow to air dry.
 - d) Attach the syringe.
 - e) Unclamp the line you are flushing.
 - f) Flush the line with 2 mL NS. Pull back to check for blood return. Flush the line with the remaining 8 mL NS.
 - g) Holding positive pressure on the plunger of the syringe, re-clamp the line.
 - h) Disconnect syringe from the port.

- If you meet resistance, gently pull back on the plunger and try flushing again. If unable to flush or obtain blood return, notify appropriate personnel.
 - If no infusion is running, flushing should be completed at least every 12 hours to keep the line open. If the central line has multiple lumens, you must flush each port.
2. Flushing for medication administration
 - a) Follow the same procedure above with the following exception:
 - i) 10 mL of normal saline will be administered prior to administering the medication and
 - ii) 10 mL after administering the medication (flush saline at approximately the same rate as the medication for the first 2 mL).
 - b) Lines should be flushed between each medication.
3. Flushing after infusing blood products or after drawing blood from the central line
 - a) Follow the same procedure as number one with the following exception:
 - b) Flush the line with 20 mL of normal saline rather than 10 mL.
4. Flushing a central line after hyperalimentation or TPN has been administered
 - a) Follow the same procedure as number one with the following exception:
 - b) Flush the line with 20 mL of normal saline rather than 10 mL.

You must use a 10 mL syringe as anything smaller will create pressure that may damage the central line.

Sources Used:

Baptist Hospital. Policies and Procedures. Baptist Hospital, Pensacola, FL.

West Florida Hospital. Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	March 15, 2007 Approval: 4/13/07 Revised: 11/14/13
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Supplies Needed:

Clean gloves

Procedure:

1. General Assessment:
 - a) Assess whether chest tube (CT) is to suction, water seal, or clamped (chest tubes are only clamped per Healthcare Provider's (HCP) order).
 - b) Chest tube drainage devices must have water in the water seal chamber. Sterile water must be added to the 2 cm level when the chest tube drainage device is set up.
 - c) Drainage devices must be kept below the level of the chest at all times.
 - d) Place tubing between the mattress and the side rail, not over the top of the rail. Make sure chest tube device is not under the patient's bed. Avoid dependent loops.
2. Suction:
 - a) If the chest tube is to suction, the suction tubing will be connected to suction control. Chest tubes to suction must be connected to a drainage collection device (Atrium, Pleuravac, Aqualseal, or Sahara) and then to wall suction. **The CT should never be connected directly to wall suction as an NG tube would be.**
 - b) If the chest tube is connected to suction, observe the **suction control chamber** for slow, continuous bubbling. This bubbling indicates that the suction is present.
 - c) Check suction amount by temporarily turning off the valve on the suction tubing.
 - i) If the water in the suction control chamber is not at ordered level, sterile water should be added to the correct level.
 - ii) Suction is documented in negative centimeters of water (i.e. -20 cmH₂O).
 - d) With the dry system (i.e. Sahara), the amount of suction should be dialed to the ordered level and orange/red float will be present in the window.

The amount of suction applied is directly related to the setting on the chest tube, not the amount of suction from the wall.

3. Patency:
 - a) Assess for tidalizing in the **water seal chamber**. Tidalizing is indicated by a rise and fall of the water level in the water seal chamber with inspiration and expiration.
 - b) Tidalizing may also be assessed by observing for a back and forth motion of fluid in the chest tube drainage tubing.
4. Air leak check:
 - a) Assess for an air leak by observing for bubbling in the **water seal chamber** with normal inspiration and expiration. If none is present, ask the patient to take deep breaths and then cough while observing for bubbling in the water seal chamber.
 - b) Document whether an air leak is present or not.

- Continuous bubbling indicates an air leak in the system or around the CT insertion site. Report this to the HCP, and check for possible air entry sites.
- Bubbling will not be seen with mediastinal CT because they are not in the pleural space.

5. Drainage:

- Assess **collection chamber** for amount of drainage at the beginning of each shift and hourly.
- Assess the color and clarity of the drainage in the **tubing**.
- Measure drainage output at the end of every shift by marking the collection chamber with the date, time, and amount of drainage.
 - Drainage should not exceed more than 100 mL/hr in adults.
 - Drainage should not exceed more than 5 mL/kg/hr or 3 mL/kg/hr for 3 consecutive hours in children.
 - If drainage is excessive, the HCP should be notified immediately.

Never empty a chest tube collection system. The amount in the collection chamber should be a running total for the entire time the chest tube is in place. If the collection chamber becomes completely full, the entire system must be changed out.

6. Chest tube site and dressing:

- Apply clean gloves.
- Palpate area around chest tube site to determine if subcutaneous air (called crepitus or subcutaneous emphysema) is present. This will feel like bubbles in the subcutaneous tissue.
- Determine anatomical placement of chest tube. Document if tube is placed mid-axillary, mid-clavicular, or other location. Also determine the intercostal space (ICS) in which the tube is placed. This may require palpation of the chest tube dressing or looking at documentation of the insertion procedure.
- Chest tube dressings should be an occlusive dressing. A petroleum gauze is used only after the initial insertion.
- Have the patient turn, cough and deep breath every four hours and PRN.

7. A mnemonic to help you to remember what to assess and document: **DR PD PADS**

- | | |
|------------------------------------|-------------------------------------------------|
| a) Device (type/brand name) | f) Air leak (none, intermittent, or continuous) |
| b) Respiratory status | g) Dressing |
| c) Patency (tidaling) | h) Suction |
| d) Drainage (color, amount) | |
| e) Placement (anatomical location) | |

Emergency Procedures:

- The following emergency equipment must always be kept at the bedside and transported with the patient (rubber-tipped Kelly clamps, petroleum gauze, and bottle NS).
- If CT is dislodged, cover the insertion site with petroleum gauze.
- If the CT becomes disconnected from the drainage device, temporarily clamp the CT with the CT clamp or rubber-tipped Kelly clamps. Place the end of the CT into bottle of NS, unclamp the tubing, and notify HCP.
- Never clamp a CT without an order.

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Supplies Needed:

Clean gloves
Sterile gloves
Petroleum gauze
Sterile 4x4 gauze
Sterile ABD pad
Drain sponge
Tape
Normal saline
Chlorahexadine swabs

Procedure:

1. Verify healthcare provider order.
2. Gather supplies.
3. ID patient and explain procedure.
4. Provide a **clean** working area on the over bed table: Raise the table to waist level. Place the trash can where supplies can easily be disposed.
5. Wash hands.
6. Arrange sterile packages on table in the order in which they will be used.
7. Raise the bed, lower the side rails.
8. Lift up gown to visualize chest tube dressing, minimally exposing the patient; allow yourself room to work.
9. Open sterile packages just before use without reaching over open packages, or contaminating gauze. Remember the outer edge of sterile packages (where the glue was) is considered contaminated.
10. Apply clean gloves; and carefully remove old dressing.
11. Observe site for odor, redness, edema, ecchymosis, drainage, and approximation of wound edges (OREEDA), and drainage for color, consistency, odor, amount, and location of drainage (CCOAL).
12. Remove old gloves and apply sterile gloves.

13. Using sterile gauze and normal saline, or Chlorahexidine swabs (per facility protocol), clean insertion site in a circular motion moving from the insertion site outward and two inches down tubing. Carefully lift the tube with your nonsterile hand to ensure the entire wound gets cleansed.
14. If ordered, apply petroleum gauze securely around chest tube insertion site.
15. Place drain sponge around chest tube at insertion site and then cover with an ABD pad or 4x4 gauze.
16. Remove gloves and apply an occlusive dressing with tape being sure to secure the chest tube as well.
17. Write your initials, date, and time on a separate piece of tape, and attach this to the dressing.
18. Dispose of supplies, and wash hands.
19. Document procedure and patient's toleration.

Pensacola Christian College Department of Nursing	January 18, 2007 Approval: 4/27/07 Revised: 05/17/2016
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General Guidelines

1. Students are to write a daily narrative note for the patient(s) they had that day. The note is to be turned in at clinical.
2. Every note begins with the actual date and time the assessment or procedure was completed and ends with a signature.
3. The order of the note is in a general head-to-toe fashion, noting that peripheral extremity assessments of circulation (edema, pulses, and capillary refill) are included with the cardiovascular section.
4. Findings for all specific assessments are to be documented in the narrative note.
5. Items below in brackets are other word choices that may be used to describe a specific finding.
6. When abnormal assessments are identified, the nursing intervention must be documented along with the findings, and reassessments. (i.e. Rhonchi heard in upper anterior lobes; had patient cough, deep breath and use incentive spirometer. Reauscultation reveals clear upper lobes.)

Narrative Notes

1. Normal Head-to-Toe Assessment Note
 - a) The head-to-toe assessment note must include the following categories

• Neurological	• Gastrointestinal
• Neurovascular	• Genitourinary
• Respiratory	• Skin/Dressings
• Cardiac	• Equipment/Safety
 - b) Sample note with normal findings

4/20/14 0735 A and O x 3. Follows commands, PERRLA, brisk, 4mm. (neurological)
 MAEW. (neurovascular) Upper and lower BBS clear to auscultation anterior and posterior, O₂ Sat 96% on room air, respirations even & unlabored at 18. (respiratory) AP, strong & regular, Tel #45 showing normal sinus rhythm; No edema in extremities, DP, PT, and radial pulses strong bilaterally, capillary refill less than 2 seconds x 4 extremities. (cardiac) Abdomen soft, nontender, nondistended; bowel sounds active. Stated normal BM this am. (gastrointestinal) Voiding adequate amount clear, yellow urine without difficulty. (genitourinary) No skin breakdown noted. Lt hip gauze dressing clean, dry and intact. (skin/dressings) IV reseal intact to LFA without redness, edema, drainage, or tenderness at site, dressing clean, dry and intact. Denies pain. SR ↑ x 2, bed level ↓, HOB 30 degrees, call light in reach. Contact isolation ongoing. (equipment/safety) _____

N. Nurse, SN, PCC

2. Psychiatric Mental Health Assessment Note

a) The note must include the following categories

- General description
- Emotions
- Thought processes
- Perceptual disturbances
- Cognition
- Thoughts of self-harm
- Safety
- Physical condition(s)

b) Sample note

9/13/14 0745 Pt awake and in dayroom reading newspaper. Appears stated age of 35. Has not attended to ADL's or hygiene as evidenced by hair uncombed and unwashed, clothes stained and wrinkled, and teeth not brushed. Poor eye contact. Exhibits psychomotor retardation as evidenced by slowed movements and gait. Delayed responses to questions noted. Appears apathetic as evidenced by slumped posture and minimal verbal interaction.^(general description) States mood is "happy". Incongruent affect as evidenced by down cast eyes and blunted affect.^(emotions) Persecutory delusions as evidenced by stating other patients and staff want to harm her.^(thought processes) Denies hearing voices at this time. No evidence of response to internal stimuli.^(perceptual disturbances) Alert and oriented x 3. Recent memory intact as evidenced by ability to state the three words "book, dog, and rainbow" as given at beginning of conversation. Remote memory poor as evidenced by inability to recall names of last 3 Presidents. States "Bush, Carter, Nixon." Displays poor insight. States "I'm only in here because my husband has been lying about me." Judgment intact as evidenced by states, "If I got locked out of my house, I would ask my neighbor for the spare key." Poor abstract thought as evidenced by inability to state what "It's raining cats and dogs" means. States she has "no idea." Concentration poor as evidenced by inability to count backwards from 100 by 7's. States "There is no way I can do that!"^(cognition) Admits to thoughts of self-harm, but denies a plan at this time. RN Connie notified.^(thoughts of self-harm) Environment free from harmful objects. Will monitor every 15 minutes and PRN.^(safety) No signs and symptoms of asthma exacerbation noted. Dressing clean, dry, and intact to bilateral wrists, denies complaints of pain.^{(physical condition(s))}

N. Nurse, SN PCC

The narrative note for the psychiatric mental health patient must also address specific assessments for the patient's current physical condition(s). Current physical conditions include diseases/conditions that are in the patient's treatment plan or the nursing shift report and all diagnoses with active signs and symptoms or for which the patient is receiving medication.

3. Critical Care Assessment Note:

a) The note must include the physical assessment findings as well as documentation of critical care related findings/equipment.

- Ventilator settings
- IABP (settings/site)
- BIS monitoring (sedation amt.)
- ICP monitoring
- Hemodynamic monitoring
- CO₂ monitoring

b) Sample note

11/13/2013 0810 Opens eyes spontaneously [or to painful stimuli or to verbal stimuli or does not open eyes], intubated, unable to speak; nods head appropriately to yes and no questions [or confused conversation or inappropriate words or incomprehensible sounds or no verbal response. - Note: document A&O X 3 ONLY if the patient can talk]. PERRL briskly [or sluggishly or non-reactive], 3 mm bilaterally; follows commands [or localizes to pain or withdraws to pain or decorticate posturing or decerebrate posturing or no motor response]. Basic motor-neuro assessment completed, moves all extremities

equally strong against resistance. Denies HA, blurred vision, dizziness, light-headedness, recent falls or altered balance, and N/V. No slurred speech or facial droop noted. Oral ETT #7.5 secured with holder at 22 cm lip line. On SIMV at 750-35%-6, PEEP 7.5, PS 10 [*see vent note below*]. RR 18, even and unlabored. [or *not assisting vent*]. O₂ sats 92-95%. BBS clear and equal A&P except for crackles in RLL posteriorly and rhonchi in upper anterior lobes bilaterally. Suctioned for small amount light yellow, thick sputum. AP 86, irregular; monitor showing A-fib, alarms on. Denies [or *no signs or symptoms noted*] chest pain, pressure, or N/V. No carotid bruit noted. Capillary refill less than 2 seconds in fingers and toes bilaterally. Radial pulses strong and equal bilaterally. DP and PT pulses weak and equal bilaterally. No edema noted. Abdomen soft, non-tender with hypoactive BS x 4 quads. Salem sump [*or feeding tube*] intact in right nare to low intermittent suction draining small amt thick green drainage; placement verified with air bolus. Urinary catheter intact draining approximately 60 mL/hour clear, yellow urine [*if the pt doesn't have a urometer—just put “draining adequate, small, moderate, or large amount clear yellow urine*]. Skin warm, dry, and intact with no breakdown or reddened areas noted. Lower abdominal gauze dressing C,D&I; Right radial A-line intact, dressing dry, reading 110/70-correlates with cuff pressure; good waveform; drsg clean, dry and intact. Pulmonary artery catheter [*or TLC or Howes catheter*] intact in right subclavian [*for PA catheter put “at __ cm”*], tegaderm dry and intact; site without redness, edema, or drainage. PAS 30, PAD 12, PCWP 10, CVP 6. Good waveforms. Both lines zeroed and calibrated, flushes well. Dopamine 400 mg in 250 mL D₅W infusing at 15 mL/hr [8 mcg/kg/hr] into blue port of TLC; NS at 100 mL/hr infusing into blue port of TLC; Heparin 20,000 units in 500 mL NS at 32 mL/hr [1280 units/hour] infusing into RV [*or purple*] port. All IVs are on pumps. Bilateral wrist restraints in place. Turned to Lt side. HOB 30 degrees, bed low, side rails up X4. Call bell in reach. [*if pt is a DNR: “Code Status: DNR”*] [*if on isolation, write “contact isolation ongoing.”*] N. Nurse, SNPCC

Ventilator settings Chart settings in this order: Mode-TV-FiO₂-Vent rate-PEEP-PS and add the patient's RR. (*For example:* On SIMV at 700 - 40% - 10 - 5 PEEP - 10 PS; RR 16.)

If ETCO₂ is monitored include it after PEEP.

With AC mode, there is no PS.

With CPAP, there is no TV or rate.

4. Postpartum Assessment Note

- a) The following represents an example of a head-to-toe narrative note with postpartum-specific details. You will need to adapt the note to make it specific and accurate to your patient's physical assessment findings.
- b) Sample note

11/11/13 0900 A & O x 3. Follows commands, PERRLA brisk, 3 mm. MAEW. Upper and lower BBS clear to auscultation anterior and posterior; respirations 18, even and unlabored. Breasts soft & redness or tenderness. Bra on [*or bra off. Instructed on importance of good support bra.*] Nipples & cracks, or blisters. AP 86, strong & regular. No edema in extremities, DP, PT, & radial pulses strong bilaterally, capillary refill less than 3 seconds x 4 extremities. Abdomen soft, nontender, rounded post delivery; BS active. Fundus firm and midline at u/1. Stated normal BM this am. Voiding adequate amount clear, yellow urine & difficulty. Moderate lochia rubra & clots or foul odor. Episiotomy approximated & edema, ecchymosis, or drainage. One small hemorrhoid present—denies discomfort. No skin breakdown noted. IV reseal intact to LFA without redness, edema, drainage, or tenderness at site; dressing clean, dry, and intact. Patient

states that her perineal pain is well-controlled with topical medications and sitz baths. Bonding progressing well. Pt calm and cooperative with care. SR ↑ x 2, bed level ↓, HOB 30 degrees, call light in reach. _____ *N. Nurse, SN PCC*

- If fundus is above u/u or not midline, chart about voiding, bladder, and bleeding (i.e. Fundus firm at 1/u and slightly displaced to the right. Voiding q.s. s/c o burning. Pt. encouraged to void. Bladder nondistended. Lochia rubra remains small s/c clots or foul odor.) Then, follow-up by re-checking the pt. in 1-2 hrs. and document findings. (*Remember – always report abnormal findings to instructor.)
- **For C/S:** Chart re: Urinary catheter; I.V.; If pt. got up for the first time – how well she did; and abdominal dressing, or incision if no dressing is present [i.e. Low Transverse (LTV) incision well-approximated c staples intact. No redness, swelling, or drainage noted.] Also include: Deep breathing or use of incentive spirometer. Pain control would also be particularly important.

5. Newborn Assessment Note

- a) The note must include all of the categories mentioned in the normal head-to-toe assessment note.

b) Sample note

11/12/13 0900 Male baby sleeping supine c all extremities flexed. PERRL brisk, 2 mm; Red reflex observed bilaterally. MAEW. Anterior and posterior fontanels soft and flat. Pink, moist mucous membranes. Upper and lower BBS clear to auscultation anterior and posterior. Resp. 46, even and unlabored. No nasal flaring, grunting, or retractions noted. AP 142, regular s murmur. Bilateral brachial and femoral pulses palpable, strong, and equal. Capillary refill < 3 seconds x 4 extremities. Active BS, Abd. soft and nondistended s masses. Testes ↓↓. Voiding [*female: labia majora covering labia minora*]. No jaundice noted. Moro, suck, grasp, babinski reflexes WNL. No pain symptoms observed using NPASS scale. Infant remains in nursery at this time, swaddled in bassinet, with security band (# _____) attached to ankle. Bulb syringe in bassinett. _____ *S. Student, SN PCC*

- Closing Note: Date/time: Infant out to mom @ 0930. ID bands matched per R.N. Tolerated 1 ½ ounces of EWI s spit-up. Bonding progressing well. Teaching done re: (list items taught). See infant care teaching sheet. Infant in mom's arms at this time. _____ *S. Student, SN PCC*
- Admission Note: Date/time: Female infant admitted to NB nursery. Placed under radiant warmer c ISC probe on 37°C. Resp. even & unlabored. BBS clear x 5 lobes. Diffuse, soft-tissue swelling of approx. 1-inch diameter noted @ Lt. parietal area. Brown, flat birth mark noted on Rt. scapula. Refer to transition sheet for complete initial assessment. _____ *S. Student, SN PCC*
- Circumcision Check Note: 9/2/13 0915, 0930, 1030 Circ checks completed per protocol. Gauze intact. No excessive bleeding noted. _____ *S. Student, SN PCC*

6. Running Narrative Note

- a) Running narrative notes are completed throughout the day to document what was done after the initial narrative note. Each entry must be dated, timed, and signed.
- b) Running notes should include the following:
 - Focused reassessment (specify what system was assessed and any changes)
 - Changes in the patient's condition (include interventions)
 - Teaching (include what was taught as well as the patient's response)

- Procedures such as dressing changes; blood glucose monitoring with coverage; insertion/removal of urinary catheters, feeding/suction tubes, IVs, or drains; and ambulating the patient
 - Anytime the patient leaves the floor and/or returns (must include how the patient was transported, where they went, who accompanied the patient, and how they were returned)
 - PRN medication administration (must include pain reassessment within one hour)
 - Closing note (how you left the patient at the end of the day, pain assessment, call bell within reach, SR↑x2, bed in low and locked position)
- c) Running notes should **not** include:
- Normal medication administration – this is charted on the MAR
 - Normal intake and output
 - NOTE: You may chart that you checked on the patient in order to fill in longer than a 3 hour time lapse where nothing happened. ("Patient resting comfortably in bed watching TV, wife at bedside. No complaints at this time, call bell within reach, will continue to monitor.")
- d) Sample running notes
- 1/20/14 0900: Transported to radiology for CXR via bed. _____ *J. Nurse, SN, PCC*
 - 1/20/14 0925: Returned from radiology. Tolerated procedure well. Assisted into bed. Bed low, HOB 45 degrees. No complaints of pain. Call bell in reach. *Nurse, SN, PCC*
 - 1/20/14 1030: Complained of aching pain to left shoulder, a 7 on a 1-10 scale. PRN Flexeril 10 mg PO administered. Will continue to monitor. _____ *J. Nurse, SN, PCC*
 - 1/20/14 1115: Reassessed pain. States pain is a 2 on a 1-10 scale. Pt denies need for further pain interventions. Resting comfortably in bed. _____ *J. Nurse, SN, PCC*
 - 1/20/14 1130: Blood glucose 173. Administered Humalog 2 units subcutaneous per medium range sliding scale. _____ *J. Nurse, SN, PCC*
 - 1/20/14 1300: PM assessment completed of cardiac and genitourinary systems. No changes noted from AM assessment except urine output 20 mL for past hour. Encouraged PO fluids. _____ *J. Nurse, SN, PCC*
 - 1/20/14 1345: MD in, aware of decreased urine output, orders written. STAT order of Lasix 40 mg PO administered. Educated regarding indication for and side effects of Lasix. Indicated understanding. _____ *J. Nurse, SN, PCC*
 - 1/20/14 1500 Pt resting calmly in bed with spouse at bedside. Urine output now 100 ml/hr. Denies pain. Bed in low and locked position with SR↑x2 and call bell within reach. Contact isolation ongoing. _____ *J. Nurse, SN, PCC*

Sample Abnormals

1. Neurological

- A and O x 2, reoriented to time.
- CN II-XII grossly intact. (Specify CNs not checked).
- NIH stroke scale completed, see flow sheet.
- Basic motor neurological assessment completed. Moves all extremities equally strong against resistance. Denies headache, blurred vision, dizziness, light-headedness, recent falls, altered balance or numbness and tingling. No slurred speech or facial droop noted.

- Left hand grip trace (weak, moderate, strong), LUE and LLE weak against resistance, RUE and RLE strong against resistance. Lt facial droop noted. Speech slurred. See Neurological checklist.
- PERRLA sluggish 3mm [*fixed at 2mm*]
- LUE flaccid; withdraws to painful stimulus with RUE. BLE withdraw equally to painful stimulus.
- Does not follow commands; spontaneously moves all extremities.
- Lethargic, responds to voice. A&OX3 when aroused.
- Obtunded, responds only to vigorous vocal and physical stimuli. A&OX1 when aroused. Reoriented to time and place.
- For spinal cord injury: sensation intact from head to 4 cm above nipple line.
- Camino bolt intact in right cranium, dressing D&I; ICP 11 at rest; increases to 19 when painful stimulus applied. CPP 78.
- Ventriculostomy intact in right cranium, dressing clean, dry and intact. Stopcock presently turned to monitor ICP only (if HCP wants ventriculostomy to drain, you would chart "*drip chamber set at 15 cmH₂O per order*" [or mmHg, depends on the order]) ICP 14, good waveform; transducer leveled and recalibrated. CPP 68.
- Restless with decerebrate posturing; CPP 58; ICP 25, drained 12 mL light pink fluid and ICP decreased to 12; stopcock reset to monitor only, good waveform. Resting quietly, no posturing noted.
- Anterior fontanel soft [*tense*] and flat [*bulging*] [pediatrics]

2. Neurovascular

- Denies pain, numbness, or tingling in _____ (list specific extremity), sensation intact, able to move fingers/toes/hands/feet/legs (specify), skin pink and warm.
- Also document the patient's position (hips abducted with wedge pillow in use [*pillow between legs*]; _____ extremity straight and in alignment).
- Contracture to LUE.
- Fiberglass cast intact to LLE mid-thigh to foot. Elevate entire cast on pillows, toes warm [*cool*] and pink [*pale, blue*] with sensation and movement intact, capillary refill less than 2 seconds [# if greater than 2 seconds]. Denies numbness or tingling.

3. Respiratory

- Denies cough or shortness of breath.
- Crackles [*rhonchi, wheezes*] in bilateral posterior bases. Other lobes clear to auscultation.
- Do not use "coarse" to describe adventitious lung sounds.
- Productive cough of scant [*moderate, large, copious*] amount of thick white sputum.
- On 5 cm CPAP; 28% O₂; RR 24
- On BiPAP at 40% FiO₂ 8/12.
- #6 Shiley trach intact, midline, cuff inflated; on 40% TM [or document vent settings here]. O₂ sats 96%. RR 18, unlabored and even. Trach site without redness, edema or drainage. Coughed up [or suctioned for] moderate amount thick green sputum
- Continuous pulse ox monitor in place, SaO₂ 96% on O₂ 2L/NC, alarm limit set at 88%, settings verified per HCP orders. [*peds.*]
- Chest tube to right midaxillary (MCL) 3rd ICS intact to -20 cm suction [*clamped, to water seal*], draining moderate amount serosanguineous fluid, no air leak, to Aquaseal

(or name of appropriate chest tube device) with tidalizing, dressing C, D and I. Crepitus palpated 8 cm around site.

4. Cardiac

- Heart sounds normal.
- Denies chest pain and pressure; denies SOB, nausea, or vomiting; skin pink, warm, and dry.
- AP 64, irreg., Tel #45 showing atrial fibrillation.
- Faint murmur auscultated over right 2nd ICS sternal border.
- Clicking, snapping, or rubbing auscultated over left 5th ICS MCL.
- Mild (moderate, severe) non-pitting (pitting) edema to ankles, left greater than right.
- DP pulse weak (moderate, strong, bounding) and PT pulse found only with doppler in LLE. DP and PT pulses strong in RLE. Radial pulses strong bilaterally.
- Capillary refill 5 seconds to LLE, less than 2 seconds x 3 extremities.
- **For cardiac cath patients:** No evidence of bruising, bleeding or hematoma at right groin site; dressing C, D, and I; DP and PT pulses strong and equal bilaterally; lower extremity warm, dry, and pink; capillary refill less than 2 seconds; denies chest pain or numbness or tingling in extremities; reminded patient not to bend right leg; pt indicated understanding.
- **IABP:** Document timing of balloon: 1:1, 1:2 or 1:3 (i.e. 1:2 indicates the balloon is inflating every other beat). Good IABP waveform. Document denies chest pain, HOB level..., distal pulses (indicate if dopplerized) and left radial pulse, restraint on _____ ankle to keep leg straight, reminded patient not to raise HOB level or flex leg, location of catheter and site/dressing condition, no hematoma noted or palpated.

5. Gastrointestinal

- Abdomen large, rounded, mildly distended with hypoactive bowel sounds noted in RLQ, absent in all other quadrants.
- Passing flatus.
- Denies passing flatus. No BM for last 4 days, given 4 oz prune juice.
- NG (Salem sump) to right nare. Placement verified with air bolus. NG to low intermittent suction (low continuous; clamped) draining moderate amount dark green fluid.
- Feeding tube to left nare. Placement verified with air bolus, 10 mL residual obtained. Flushed with 15 mL H₂O. Nipro infusing at 30 mL/hour via pump.
- Jevity 1.5 cal. infusing to LUQ PEG tube at 45 mL/hour. Residual 5 mL green liquid, flushed with 30 mL H₂O, dressing C, D and I.
- *MIC-KEY intact, Site without redness, edema, or drainage. No residual. Flushed with 5 mL H₂O. [peds.]*
- Incontinent of large, light brown, soft BM; cleansed and new brief applied.
- RUQ ileostomy stoma red, moist, budded, peristomal skin intact, no redness; small amount brown liquid in pouch. Old pouch removed; wafer cut to fit stoma and ostomy pouch applied.
- LLQ colostomy appliance intact without leakage. Stoma red, moist, budded, active for moderate amount liquid brown stool.
- Rectal tube (type) intact without leakage, draining small amount light brown liquid stool. Flushed with 45 mL water. Cuff deflated and inflated.

6. Genitourinary

- Urinary catheter intact, draining adequate (more than 30 mL/hour) amount clear, yellow urine. If the patient has a urometer, document the specific mL/hour.
- Has not voided this am, patient denies problems with voiding, unable to assess urine at this time.
- Anuric, receiving hemodialysis MWF.
- Right upper arm AV fistula with palpable thrill and audible bruit (NOTE: for patients with fistulas, shunts, or mastectomies always chart: “No BP or VP in right arm” sign above bed).

7. Skin/Dressings

- 4 cm x 1 cm red area on sacrum with first layer skin loss. Small amount yellow purulent drainage noted at 8 o'clock position, cleansed with NS. Turned to left side.
- 2 cm x 1 cm red, intact, blanching area on left elbow.
- Midline abdominal incision. Open to air, well approximated with sutures; no redness, edema, ecchymosis or drainage.
- Left hip gauze dressing C, D and I.
- Mid-sternal chest incision with staples open to air. Incision well approximated without drainage noted. Small amount redness noted to staple insertion sites.

8. Equipment/Safety

- D₅/0.45 with 20 mEq KCl/L intact and infusing at 100 mL/hour to white port of dual lumen PICC (triple lumen central line, Groshong, Mediport) to right AC (IJ, SC) site. IV site without redness, edema, or drainage, dressing C, D and I.
- Heparin 25,000 units/500mL D₅W infusing at 20mL/hour (1000 units/hour) via pump.
- Dopamine 400 mg in 250 mg NS infusing at 20mL/hour (____ mcg/kg/min) via pump.
- CPMM in use with ____ degree of extension and ____ degree of flexion.
- SCDs (plexi pulses, Flotrons, ALPs) on bilaterally.
- Traction: ____ # weights hanging freely. (Include type of traction.)
- Pins: document location and skin condition.
- PCA of Morphine 1mg/1mL - basal 1mL/hr; dose 1mg/1mL; lockout 10 minutes; 1 hour limit 7mg. Settings verified with HCP order.
- Bilateral soft wrist restraints. Skin warm, capillary refill less than 2 seconds.
- C/O sharp pain in RUQ , a 7 on 1-10 scale. Offered pain medication denies need at this time.
- Wound Vac intact over midline abdominal wound with moderate amount serosanguineous fluid to 125 mmHg continuous suction.

All **critical** abnormal findings are to be reported to the appropriate personnel immediately.

Procedure Manual

Dopplerling Pulses

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 3/2/07 Revised: 11/12/13
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Supplies Needed:

Doppler
Transmission gel
Alcohol swabs
Paper towels

Procedure:

1. When a pulse is not palpable, a doppler should be used to determine the sufficiency of blood flow to the area.
2. Explain the procedure to the patient.
3. Apply a moderate amount of transmission gel on patient at desired site. (Gel is used to conduct sound.)
4. Place the probe over the desired artery at a 45-90 degree angle. (Place probe in glove for groin sites.)
5. Turn the doppler on and set the volume initially to the lowest detectable level making adjustments as necessary throughout the procedure.

If using a doppler with a stethoscope, cleanse the earpieces with alcohol swab and place earpieces in ears before turning on the device.

6. Move the probe around slowly in a circular motion while maintaining contact with the skin until a pulse is heard (whooshing sound).
7. Assess the presence and rhythm of the pulse for a few seconds.

If no pulse is heard after approximately 1 minute, notify appropriate personnel immediately.

8. When all necessary pulses have been assessed, wipe the gel off the patient's skin. Clean the probe.
9. Document procedure and results.

Sources Used:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*. Springhouse, PA: Lippincott Williams & Wilkins.

Procedure Manual

Drain Removal

Pensacola Christian College Department of Nursing	January 15, 2007 Approval: 4/13/07 Revised: 11/12/13
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Supplies Needed:

Clean gloves
4x4 sterile gauze
Tape (foam or occlusive)
Suture removal kit (if needed)
Biohazard bag

Procedure:

1. Verify healthcare provider's order. The patient may need to be pre-medicated with pain medication, prior to the procedure.
2. ID patient and explain procedure.
3. Wash hands.
4. Apply clean gloves.
5. If drain is a Jackson-Pratt or a Hemovac, empty and measure contents. Leave drain unclamped.
6. Remove old dressing.
7. Use suture kit to remove sutures, if present.
8. Have patient inhale then gently, but continuously pull drain out.
9. Apply gauze dressing to patient's skin and tape securely.
10. Dispose of all supplies. Place drain and saturated gauze into biohazard bag. Place suture kit scissors in sharp's container.
11. Document time of procedure, patient toleration, color, type, odor, and amount of drainage.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 4/27/07 Revised 11/11/13
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Supplies Needed:

Clean gloves
Sterile gloves (2 packages)
Sterile 4x4 gauze (3-4 packages)
Sterile 8x10 or 5x7 inch ABD pad
Cleansing solution
Tape
Biohazard bag

Procedure: Sterile Dressing Change

1. Offer the patient pain medication 45-60 minutes prior to dressing change.
2. Obtain preliminary information, including: size and location of wound to be dressed, frequency of dressing changes, healthcare provider's order to change or reinforce dressing, cleansing solution to be used, and special supplies, supplies already in patient's room, presence of drains, specifics regarding wound (i.e. to be packed, etc.). Also check for allergies to wound cleansing solutions or tape. If there is no order for a dressing change to be done, check with facility policy and consult staff.
3. Assemble supplies. Check the packages for expiration date, discoloration, holes/tears, wet areas, or stains to indicate previous wetness.
4. Identify patient. Assess comfort again at this time, including a need to use the bathroom, a urinal/bedpan or the bedside commode. Provide appropriate explanation for the patient regarding the procedure and allow for questions. Provide privacy by pulling the curtain.
5. Provide a **clean** working area on the over bed table: Raise the table to waist level. Place the trash can where supplies can easily be disposed.
6. Wash hands.
7. Arrange sterile packages on table in the order in which they will be used.
8. Raise the bed, lower the side rails.
9. Expose site of wound, minimally exposing the patient; allow yourself room to work.
10. Open sterile packages just before use without reaching over open packages, or contaminating gauze. Remember the outer edge of sterile packages (where the glue was) is considered contaminated.

11. Apply clean gloves; loosen tape from old dressing (pull toward wound, pressing firmly against the skin to lessen patient discomfort). Lift edge of outer dressing toward you so that the inside is away from the patient; handle the dressing only by the edges.
12. Remove both inner and outer dressing together unless the inner dressing sticks to the wound. While holding the dressing away from wound, note color, consistency, odor, amount and location (C-COAL) of drainage. Do not hold the dressing over the incision. Both the inner and the outer dressing are removed with clean gloves unless the inner dressing is a packed wound, or is stuck to the incision, staples, or sutures.
13. If the incision is a packed wound or the dressing is stuck to the incision, apply sterile gloves to remove inner dressing. Pouring saline over the wound may assist with loosening of the gauze.
14. Dispose of the dressings (in biohazard bag if saturated). Remove clean gloves.
15. Examine wound for odor, redness, edema, ecchymosis (bruising), drainage/bleeding, and approximation of wound of edges (O-REEDA): note the presence of staples, sutures or steri strips. Also note whether there is redness at the staple insertion sites (normal).
16. Check solution for expiration date and write date and time on the bottle if opening for the first time. Remove cap from cleaning solution (antiseptic/normal saline) and place cap inverted on the table.
17. Apply sterile glove on dominant hand. A one-handed sterile glove technique will be used.
18. Pick up nearest gauze with gloved hand, making a swab by pulling all 4 corners to center, while maintaining sterility of gauze sponges and your gloved hand. Anchor flap of package with ungloved hand so that the package does not move. Immediately dispose of empty packages without turning your back on the sterile field or reaching below the waist.
19. Pick up cleaning solution with the ungloved hand, holding the bottle with label toward palm. Hold the container 2-4 inches over swab and a pour small amount onto the end of the swab, being careful not to let the solution drip or pour down the side of the bottle.
20. Use long, continuous strokes applying light pressure to cleanse the incision; wipe the incision first from clean to dirty and continue to clean while working out from the center of the incision. Use a different gauze swab for each stroke, discarding it after use. Use as many swabs as appropriate for cleaning. The top of the incision is least contaminated, the bottom is more contaminated. Cleanse at least 2" beyond the incision.
21. If more than one incision, treat each incision separately. If there is an incision and a drain that are separate, treat each separately. If there is both a drain and an incision within the same incision, cleanse the incision area first since it is considered to be the least contaminated. To clean the drain, use a circular motion starting from the wound and working outward.
22. After the wound is adequately cleansed, use your sterile gloved hand to gently place 4x4 sterile gauze evenly over the wound (lift the gauze by the corner only) in one or two layers.

Do not move 4x4 gauzes once they have been placed on the wound. Cover as closely to the wound as possible.

23. Apply a 5x7 or 8x10 absorbent pad as the outer layer, lifting it by the edges only. Remove the glove at this time.
24. Secure the outer dressing with tape; measure tape before applying. Use the windowpane taping method for most dressings. Dressings over joints should be taped across the joint in order to allow movement.
25. Write your initials, date, and time on a separate piece of tape, and attach this to the dressing. Teach the patient how to care for the incision site as needed.
26. Raise side rail and lower bed level; leave call light within reach.
27. Make patient comfortable. Replace items on over bed table.
28. Wash hands.
29. Leave unopened disposable supplies in the patient's room and return re-usable supplies to the supply cart as indicated. Dispose of biohazard materials in appropriate area.
30. Document the details of the dressing change and any observations in the patient's chart.

Clean dressing changes are performed as above with the exception of using clean gloves rather than sterile gloves. An example of a clean dressing change would be PEG tubes. Incisions that are open to air are cleansed using clean technique.

Sources Used:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*.
Springhouse, PA: Lippincott Williams & Wilkins.

Pensacola Christian College Department of Nursing	January 5, 2007 Approval: 3/9/07 Revised: 11/11/13
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Supplies Needed:

Enema Kit (tubing is typically 22 to 30 French for an adult)

Enema Solution (typically 5 mL of castile or other mild soap in 1000 mL tap water)

Water soluble lubricant (especially if tubing not pre-lubricated)

Waterproof pad, towels, and washcloths

Bedpan (or bedside commode) and toilet tissue

Clean gloves

Procedure:

1. Verify healthcare provider's order (Note date and time enema is to be given, and any specifics regarding amount of solution or type of solution to be used.)
2. Gather preliminary information:
 - a) Determine activity tolerance or order (i.e. ambulatory, bedrest)
 - b) Assess for relative contraindications or areas of caution:
 - i) onset of severe abdominal pain (notify healthcare provider)
 - ii) rectal pathology or surgery
 - iii) recent vital sign ranges (obtain prior to procedure if necessary)
 - iv) age (note that the young child and the elderly are at increased risk for water intoxication when using hypotonic tap water)
3. Gather necessary equipment.
4. Wash hands.
5. Identify patient using proper procedure and explain the enema procedure allowing the opportunity for questions.
6. Prepare the enema solution and bring to bedside.
 - a) Unless otherwise ordered, add 5 mL of soap to 1000 mL of warm water (105-110° F).
 - b) Rotate bag gently to mix contents without creating numerous bubbles.
 - c) Open clamp and run solution to the tip of tubing to eliminate air in the entire length of the tube (cap on pre-lubricated tip may need to be loosened).
7. Provide for privacy.
8. After applying gloves, bring bedpan or bedside commode to bedside; elevate bed, & lower side-rail.
9. Assist patient into a left side-lying (Sims') position with upper leg flexed and drape appropriately (use bath blanket if necessary).

10. Place waterproof pad and any necessary towels (based on the patient's external sphincter control) under patient's buttocks/hip, and prepare toilet tissue.
11. Remove pre-lubricated cap from end of tubing if present, and apply additional water soluble lubricant as necessary. (If not pre-lubricated, lubricate to 2 inches of the catheter tip.)
12. Visualize the rectal sphincter by lifting the upper buttock and ask the patient to take a deep breath. Insert the end of the tubing into the rectum up to 3-4" while aiming toward the umbilicus. (Be gentle when entering rectal sphincter, especially if hemorrhoids are present.) Hold the tubing in place at all times as the sensation of pressure in the rectum may cause the patient to bear down and expel the tube.

When inserting the tube, never force it against resistance.
13. Open the clamp while the bag is held at the level of the patient's rectum then elevate the bag above the patient 12-18".
14. Administer the solution slowly over 10 minutes. Instruct the patient to pant if cramping occurs. Slow (lower bag) or stop the instillation until the cramping passes. Continue instillation until as much of solution as possible is administered. Inform the patient that a feeling of distention is normal.
15. Prior to removing the rectal tube, close the clamp, lower bag, and apply toilet tissue around the tube. Slowly withdraw the tube while asking the patient to tighten buttocks around it. Once the tube is removed, apply pressure against the rectum with the toilet tissue for a few seconds and gently wipe area clean. Remove soiled gloves.
16. Encourage the patient to attempt to hold the solution for 10-15 minutes. Assist patient into a position of comfort (replace any wet pads or towels with a dry pad).
17. Lower bed level and hand call light to the patient. Side rail may be left down if the patient is alert and able to ambulate to the bathroom without assistance.
18. Leave area clean and dispose of equipment appropriately. Wash hands prior to leaving room.
19. Return to place patient on bedpan or assist to bathroom after 10 minutes or when called by the patient. If patient is self-ambulatory, remind them not to flush the toilet. Check on the patient frequently during this time. Once results of the enema are evident, assist the patient with washing the perineum with soap/water and obtaining clean gown or linens.
20. Document the procedure and include the following details:
 - a) Cleansing enema: date, time, type, French size, and amount of solution instilled
 - b) Results: color, consistency, unusual odor, amount, and patient response
 - c) Assessment of patient during or after procedure: discomfort, respiratory distress, bleeding, hemorrhoids, or any obstruction to the passage of tubing.

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Supplies Needed:

Clean gloves
Tissue
Washcloth
Medication
MAR

Procedure:

1. Look up information about the eye drops and fill out medication administration checklist just as you would with any other medication.
2. Perform two medication checks. While performing the medication checks, observe the label on the bottle (not on the box) for the name and strength of the solution. Note how many drops and in which eye the drops are to be given. Make sure the label states the drops are for “ophthalmic use”. If the container is transparent, observe for precipitate. If seen, notify instructor who will help you obtain a new bottle.
3. Wash hands and gather supplies and take to the patient’s bedside.
4. Identify the patient, comparing the ID band to the MAR and ask patient to state name and date of birth.
5. If there is drainage present, apply clean gloves and cleanse the eye with a warm washcloth, wiping from the inner to outer canthus. Remove gloves.
6. Perform the final medication check on the eye drops at the patient’s bedside. If the eye drops are a suspension, roll bottle between hands to mix prior to instilling.
7. Apply clean gloves.
8. Remove lid of dropper bottle and place the lid on its side to prevent contamination. Remember, the inside of the lid and the tip of the dropper are to remain sterile at all times.
9. Explain the procedure to the patient. Instruct the patient to sit back in a chair or lie in a supine position with the head slightly tilted back and toward the affected side (do not hyperextend the neck of a patient with a head or cervical spine injury). Also instruct the patient to close the eye gently after instilling and to use a tissue to blot under the eye (not on top of the eye, as this will draw the medication out). Provide the patient with a tissue.

Pediatrics: Young children are often unable to comply with these specific instructions. Assistance may be necessary to restrain the child’s head in a slightly extended supine position. The child’s arms can often be simultaneously controlled by extending them upward on either side of the head and effectively “sandwiching” the child’s head between their

extended arms. Always use the minimum amount of restraint necessary to safely perform the procedure. A young child often squeezes his eyelids tightly together during the instillation of eye drops. Gentle traction may need to be applied both upward on the upper eyelid with index finger and simultaneously downward on the lower eyelid with thumb to achieve separation of the eyelids and expose the lower conjunctival sac. Avoid direct pressure on the eyeball itself. Instilling the eye drops when the young child is asleep may facilitate their administration.

10. Using a tissue, place the index finger or thumb on the patient's cheekbone below the eye and pull downward, exposing the conjunctival sac.
11. With the medication dropper in the dominant hand, rest the heel of the hand on the patient's forehead. Move to the other side of the bed as needed.
12. Hold the dropper approximately 1 inch from the eye above the conjunctival sac. Make sure the tip does not touch the eye or eyelashes.
13. Squeeze the ordered number of drops into the outer 1/3 of the conjunctival sac.

When administering 2 or more different eye drop medications at one time, check your drug information for the amount of time to wait between each medication.

14. Release eyelid and remind the patient to close the eye gently.
15. If the medication is known to cause systemic effects, press firmly on the patient's nasolacrimal duct with a tissue for 1-2 minutes. Patient can do this if able.

Eye drops that have systemic effects include Beta blockers such as Timolol; Cholinergics such as Corbachol and Pilocarpine; Sympathomimetics; and Sympatholytics.
16. Repeat the procedure if the drop does not go into the eye or lands on the margin of the lid.
17. Remind the patient to wipe under the eye with a tissue.
18. Remove gloves.
19. Assess the patient's response to the drops.
20. Raise the side rail, lower the bed level, and place the call light within reach.
21. Wash hands.
22. Record administration of the drops appropriately on the MAR.
23. Document anything unusual in the hospital chart (i.e. redness, drainage, itching, etc.)
24. Reassess the patient's response to the eye drops in 15-30 minutes.

Sources Used:

- Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.
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Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 4/27/07 Revised: 11/18/13
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Supplies Needed:

Towel
Small cup of water with straw
Emesis basin
1" Tape
Clean gloves
Water-soluble lubricant gel
Gastric/enteric tube
Penlight
60 mL cath tip syringe
Stethoscope
Skin prep
Suction equipment
Biohazard bag

Procedure:

1. Nasogastric Tube Insertion
 - a) Verify the healthcare provider's orders.
 - b) Gather equipment and wash hands.
 - c) Identify the patient by checking the identification band and asking him to state his name and date of birth.
 - d) Explain the procedure to the patient, showing him the tube, and giving him the rationale for the nasogastric (NG) tube to help alleviate fear and gain cooperation.
 - e) Provide privacy.
 - f) Raise bed level and lower side rail. Position patient in upright/high fowler's position.
 - g) Assess which of the patient's nasal passages is larger. Ask the patient if he has ever had a history of a deviated septum, any kind of facial/nasal trauma, or surgery. (Patients who have facial fractures, basal skull fracture, a history of facial/nasal injuries, surgeries, or trauma, a deviated nasal septum, head injuries, or tracheostomies may need to have NG tube insertion performed by the healthcare provider since the risk for NG tube misplacement is high.)
 - h) Place towel across patient's chest and have emesis basin, cup of water, and a straw nearby.
 - i) Tear two 4 inch-pieces of tape. Take one of the pieces and split it down the middle halfway.
Place both pieces of tape nearby.
 - j) Apply clean gloves.
 - k) Open tubing package and inspect tube for any physical defects.
 - l) Take the distal end of the gastric/enteric tube and measure from the tip of the patient's nose to his earlobe. Continue to hold and measure from the patient's earlobe down to his xiphoid process.
 - i) For adult, use the acronym N-E-X (Nose-Ear-Xiphoid).
 - ii) For pediatrics, use acronym N-E-U (Nose-Ear-Umbilicus).
 - iii) For an oral tube, use acronym M-E-X (Mouth-Ear-Xiphoid)
 - m) Mark determined distance on the tube with pen.

- n) Clean the top of the nose and apply small amount of skin prep.
- o) Coil the tubing over your fingers to help soften the tubing.
- p) Lubricate first 3-4 inches of tube with water-soluble lubricant. (If the tube is self-lubricating, activate the lubricant by dipping in water.)
- q) With the patient's head slightly extended, carefully insert tube through the nostril to the back of the throat. Aim the tube toward the ear and downward toward the nasopharynx.
- r) Once pharynx is reached, position patient's neck and chin down to his chest. This is done to close the trachea off and prevent the tube from migrating into the lungs.
- s) Instruct the patient to sip and swallow water while advancing the tube. If the patient is NPO, encourage him to dry swallow to facilitate tube insertion.
- t) Continue advancing the tube, in a downward and backward direction towards the esophagus, until mark is reached. (If inserting an enteric tube, remove guide wire.)

- If the patient coughs or gags, the tube may be going into the trachea. Stop advancing and use a penlight to check tube placement in the back of the patient's throat.
- Do not advance if resistance is met. Pull back slightly and continue to attempt to insert the tube.
- If the patient gasps, coughs, becomes cyanotic, and is unable to speak or hum, stop advancing the tube and pull the tube out at once.

- u) Determine tube placement with 30 mL air bolus (see checking placement). Aspirate gastric contents with a 60 mL catheter tip syringe to check color and pH; if the facility requires pH to be checked, it should be 5 or less.
- v) Secure tubing with tape.
- w) Per the HCP's order, clamp the NG tube, place it to gravity drainage, attach to wall suction or tube feeding (placement must be verified with a chest x-ray before starting tube feeding).
- x) Reposition the patient, lower the bed level and raise the side rails.
- y) Remove gloves and wash hands.
- z) Document procedure according to facility protocol.

Special Considerations for Patients with Enteric/Gastric Tubes

- Provide the patient with oral care every 2 hours and PRN. Use swabs to moisten patient's mouth or gently brush patient's teeth, tongue, and gums with mouthwash or normal saline. Provide patient with lip balm to prevent dryness and cracking of lips.
- If the patient has an NG tube, assess skin around nasal area for any type of breakdown or redness. Re-tape tubing every day and PRN, switching between the inner and outer sides of the nose to prevent constant irritation of skin. Provide patient with moisturizers daily and PRN that he can apply to his nose to soften dried skin and cotton swabs to remove dried nasal secretions
- If the patient is on tube feeding, keep HOB at least at a 30 degree angle at all times.

2. Checking placement

- a) Placement needs to be checked in the following situations: (Remember to place on hold and disconnect tube feeding or suction when checking placement.)
 - i) after tube insertion,
 - ii) the initial assessment of every shift,
 - iii) before giving medications,
 - iv) before administering bolus tube feedings, and
 - v) every four hours.

- NEVER check placement of a “Sacred NG”. A sacred NG is an NG/Salem Sump tube inserted during surgery. It may have been sutured into place. Patients that commonly have a sacred NG tube are those that have had bariatric surgery (gastric bypass, Roux-N-Y), a “Whipple”, esophageal types of surgery, or other upper gastrointestinal surgeries.
- Percutaneous endoscopic gastrostomy (PEG) tubes have been surgically placed directly into the stomach, therefore placement is not verified by the nurse. (Some LTC facilities verify placement of PEG tubes due to decreased elasticity in the elderly patient, making it possible for the PEG tube to migrate into the peritoneal cavity.)

- Take 60 mL catheter tip syringe and fill it with 15-30 mL of air for an adult or 5 mL of air for a child.
- While crimping the tubing below the connection site, disconnect the suction or feeding at the connection site.
- Attach the 60 mL catheter tip syringe to the connector site of the gastric/enteric tube. This will be the clear port of the NG tube or the larger port of the feeding tube.

- NEVER use the blue port to check placement, residual, or administer medications. Also never use anything to occlude the blue port except for an anti-reflux valve.

- Lift the patient’s gown and place stethoscope on epigastric region, 3 inches below sternum and slightly to the left (left upper quadrant of abdomen).
- Inject air from the syringe quickly into the tube and listen for a “whoosh” sound. If the tube is in the stomach, a whooshing sound should be heard. If the tube is still in the esophagus, resistance will be felt or the patient may burp.
- While the syringe is still in place from checking placement, withdraw the plunger to check gastric contents or feeding residual.

3. Checking residual

- Residual should be checked in the following situations: (Remember to place on hold and disconnect tube feeding or suction when checking residual.)
 - at the initial assessment of every shift,
 - before administering bolus tube feedings, and
 - every four hours.
- Wash hands.
- Identify the patient according to facility policy.
- Explain the procedure to patient. Raise the bed level and lower the side rail.
- Lay a disposable towel/pad on the patient’s chest.
- Apply clean gloves.
- If patient is receiving tube feeding, place tube feeding on hold and crimp the tubing near connection, disconnect, and cap the tube feeding.
- Attach a 60 mL catheter tip syringe to the end of the enteric/gastric tube (this will already be attached if you have just completed verifying placement).
- Pull back on the plunger of the 60 mL catheter tip syringe to withdraw residual gastric contents taking note of the amount, color, and consistency.
- If contents are in excess of 60 mL, temporarily clamp tube with non-dominant hand, disconnect syringe, and place aspirated contents into a cup. Reconnect syringe to the tube and continue aspirating gastric contents.

- i) If the residual is > 100 mL or if residual is greater than twice the amount of tube feeding infusing per hour, check with facility policy regarding appropriate action.
- ii) Residual should then be rechecked according to facility policy (this is often after one hour).
- k) Make sure connection is secure, and gently push syringe plunger to return residual contents to stomach. DO NOT push contents quickly or apply excessive pressure if encountering resistance or gastric contents will splatter. If resistance is met, have patient turn to his left side or remember to hold syringe more upright.
- l) Remember, if aspirated contents are excessive, return only the amount indicated in the facility policy manual, and discard the rest of the residual. Return all residual in pediatric patients.
- m) Flush the enteric/gastric tube to clear residual contents from the tubing (see flushing).
- n) While crimping the enteric/gastric tubing below the connection site, disconnect the 60 mL catheter tip syringe and clamp or reconnect the gastric tube to suction or feeding.
- o) Lower bed and raise side rail.
- p) Rinse any equipment to be reused and keep in patient's room. (Syringe and container should be changed every 24 hours.)
- q) Remove gloves and wash hands.
- r) Document color, consistency, amount of residual withdrawn, and any interventions performed or disciplines alerted.

4. Flushing

- a) Check HCP orders for type of flush to be used. Tepid tap water is usually used for flushing an NG. However, if a patient has a low sodium level, HCP may order normal saline flush.
- b) Flushing the enteric/gastric tube must be done in the following situations: (remember to place on hold and disconnect tube feeding or suction when flushing).
 - i) every 4 hours,
 - ii) before and after medications are administered through the tube,
 - iii) before and after bolus tube feedings, and
 - iv) after checking residual.
- c) Gather equipment.
- d) Wash hands.
- e) Identify the patient according to facility policy.
- f) Explain procedure to patient.
- g) Apply clean gloves.
- h) Raise the bed level and lower side rails. Lay disposable towel/pad under the tube's connection site.
- i) If the tube is to suction, crimp the tubing near the connection site and disconnect tubing from the suction device. If patient is receiving tube feeding, stop tube feeding and crimp the tubing near connection, disconnect, and cap the tube feeding.
- j) Placement must always be checked prior to flushing an enteric/gastric tube.
- k) Use a 60 mL catheter tip syringe to draw up 30 mL of fluid.
- l) Connect syringe to end of the enteric/gastric tubing.
- m) Holding the syringe upright, gently flush the tubing by pushing on the syringe plunger with your dominant hand.
- n) If resistance is met, reposition patient, usually on the left side and continue to flush.
- o) Reposition patient, lower the bed level, and raise the side rail.
- p) Rinse equipment that will be reused and set aside in patient's room. Dispose of equipment that will not be reused.

- q) Remove gloves and wash hands.
- r) Document type and amount of flush used and patient's tolerance of the procedure.
Remember, the amount of flush used needs to be added to the patient's intake.

Medication Administration via Gastric/Enteric Tube:

- Complete proper medication checks with MAR (ordered route must be per tube, not PO).
- All medications need to be in liquid form or crushed prior to entering the patient's room. Mix medications with warm water and allow time to dissolve. (Never crush medications that are extended release. Call pharmacy about opening capsules. Gel capsules may be punctured at the top with an 18G needle and squeezed into the medication cup.)
- Properly ID pt.
- Wearing clean gloves, follow procedure to check placement and flush tube.
- Pull up medications into 60 mL catheter tip syringe. Connect syringe to end of gastric/enteric tube. Holding syringe upright, gently push on plunger to administer medications.
- Flush the tube again and then reconnect tube feeding. If the patient's gastric tube is connected to suction, the suction should remain off for 30 minutes following medication administration.
- Complete documentation on MAR.

5. Gastric/enteric tube removal
 - a) Check HCP orders.
 - b) Wash hands and gather equipment.
 - c) Identify the patient according to facility policy.
 - d) Explain procedure to patient.
 - e) Apply clean gloves.
 - f) Raise the bed level and lower the side rails. Place towel on patient's chest.
 - g) Turn suction device or tube feeding off. If the tube is to suction, crimp the tubing near the connection site and disconnect tubing from the suction device. If patient is receiving tube feeding, stop tube feeding (for enteric/gastric, hold the tubing upright for a few seconds to allow any feeding remaining in the tubing to flow into the stomach via gravity) and crimp the tubing near connection, disconnect, and cap the tube feeding. Lay the tube on a disposable towel/pad and cover the connection site of the gastric tube with a clamp.
 - h) Remove the tape securing NG tube to the patient's nose.
 - i) Instruct patient to take a deep breath and hold it.
 - j) Double the tubing on itself and gently, but in one steady, continuous motion, pull out the tubing.
 - k) Provide patient with oral care or tissues and help patient into a comfortable position. Lower bed level and raise side rail.
 - l) Dispose of enteric/gastric tube and all other equipment (i.e. suction container) in biohazard bag.
 - m) Remove gloves and wash hands.
 - n) Document gastric/enteric tube removal and patient's tolerance of procedure.

Sources Used:

Baptist Hospital. "Nasogastric Tubes: Insertion, Care of Feeding, Irrigation, and Removal." Policies and Procedures. Baptist Hospital, Pensacola, FL.

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Sacred Heart Health System. "Nasoenteral Feeding Tubes." Policies and Procedure. Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. "Nasogastric Insertion: Maintenance and Removal of Small Bore Feeding Tubes." Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College
Department of Nursing

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Supplies Needed:

Sink with warm running water

Liquid hand soap

Plenty of paper towels

Trash can

*For alcohol based handwashing all that is needed is the alcohol based gel

Procedure:

1. Remove all jewelry on hands with the exception of a plain wedding band. When wearing a wedding band and washing your hands, it is important to move the ring up and down your finger to clean underneath it.
2. Nails should be short with no fingernail polish.
3. Assess your hands for any signs of dryness, cracking, or cuts in the skin, as well as for any hangnails.
4. Assess your hands to ascertain how soiled your hands are. Extremely soiled hands require a longer hand wash.
5. Check for all needed supplies.
6. Stand facing the sink with your hands and uniform away from the sink surface.
7. Adjust the water so that it is running warm water, not hot water, as this will remove protective oils in your skin. Turn on the water and wet hands. Dispense approximately a quarter size amount of soap on the palm of your hand and start lathering the soap by vigorously rubbing your palms together for about 15 seconds until lather is formed.
8. Rub hands together covering all surfaces of the hands, wrists, and between the fingers.
 - a) When cleaning the knuckle creases, flex them as you scrub the back of your hand.
 - b) To clean between your fingers, interlace them and then rub them back and forth several times.
 - c) Do not forget to clean the lateral portion of your hand and your smallest finger.
 - d) Clean the sides of your thumbs and index finger by grasping the opposite hand and thumb and rubbing vigorously.
 - e) Do not forget to clean the anterior and posterior portions of each wrist.
 - f) Clean underneath the fingernails by using a nail from the other hand to clean under each nail then clean the nails of the other hand using the same technique.
9. Rinse after all surfaces of the hands, fingers, and wrists have been washed. You may use friction to remove the soap suds. Be careful to not touch the sink; if you touch the sink, you should repeat the hand wash.

10. Thoroughly dry hands.
11. Use a separate unused paper towel to turn off the faucet (using the same wet paper towel you used to dry your hands will contaminate your hands because the microorganisms from the handle will be attracted to the water on the towel and then transfer to your hands).

Remember a good hand wash includes friction, covering all surfaces, not re-contaminating, and taking sufficient time to wash your hands.

Cleansing with alcohol based gel can be done anytime that the hands are not visibly soiled.

1. Put about a nickel to quarter size amount of gel on the palm of your hand.
2. Rub hands together covering all surfaces of the hands and wrists and between the fingers using friction.
3. Rub hands until hands are dry.

Alcohol based gel may NOT be used in the following situations:

- when hands are visibly soiled
- after leaving a C. Diff. isolation room
- before eating
- after using the restroom

Sources Used:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*.
Springhouse, PA: Lippincott Williams & Wilkins.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*.
Philadelphia: Lippincott Williams & Wilkins.

Procedure Manual

Hygiene

Pensacola Christian College
Department of Nursing

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Supplies Needed:

Bath basin
Emesis basin
5-6 washcloths
3 towels
Clean gown
Toiletries: soap, deodorant, lotion, powder, comb, toothbrush, toothpaste, and razor
Clean gloves

Procedure:

1. Gather all supplies.
2. Wash hands.
3. Apply clean gloves.
4. Assist the patient with bowel and bladder elimination before starting the bed bath. If you provided assistance with bowel and bladder elimination, remove gloves, wash hands, and apply clean gloves.
5. Oral care should be done on all patients. You can assist by providing supplies. Patients who are NPO or who have NG tubes should receive oral care every 2 hours.
6. Provide privacy. Raise bed level and lower side rail.
7. Using wet washcloth, wash eyes (from inner canthus outward). Ask if patient prefers soap for face and neck. Otherwise, use plain water to wash face, ears, behind ears, and neck. Rinse and dry.
8. If needed, wash patient's hair.

Never put a soapy or used washcloth back in the water. Use a clean washcloth.

9. Remove soiled gown, but keep patient covered during bath—this can be done with towels or a bath blanket.
10. Put clean washcloth in basin of water then apply soap.
11. Lather washcloth well and wash chest, abdomen, and upper extremities. Rinse and dry with a separate washcloth.
12. Wash patient's legs then feet using a clean washcloth. Rinse and pat dry.

13. Perform perineal care using clean washcloths. Gloves are essential for perineal care.
 - a) Female perineal care
 - i. Lather washcloth well with soap.
 - ii. Spread Labia Minora and Labia Majora and cleanse from urethral to vaginal orifice (always cleansing from cleanest to dirtiest); use a separate portion of the cloth for each side.
 - iii. Rinse in the above sequence.
 - iv. Cleanse pubic area and perineum from Mons Pubis downward and outward to inner thigh, stopping at the level of the vaginal orifice.
 - v. Rinse and pat dry with clean towel starting at beginning point (urethral orifice) and following through in sequence given above.
 - b) Male perineal care
 - i. If the patient has not been circumcised, the prepuce (foreskin) must be retracted before starting perineal care.
 - ii. Carefully hold the shaft of the penis in one hand, and the washcloth in the other hand.
 - iii. Start cleansing at the tip of the penis (urethral orifice). Using a circular motion, clean from the center to the periphery.
 - iv. Precede washing down the shaft toward the body.
 - v. Thoroughly rinse the penis in the above sequence.
 - vi. Return the prepuce to the original position.
 - vii. Wash the scrotum and perineum. Hold the scrotum so all surfaces of the sac can be cleansed. Be careful not to apply too much pressure while holding the scrotum, as this can be painful to the patient.
 - viii. Pat dry the penis, scrotum, and perineum in the same sequence as the cleansing.
14. Wash the patient's back followed by the buttocks. Rinse and pat dry.
15. Wash anal area. In the female wash from front to back, using a separate portion of the washcloth for each area; do not wash up to the vaginal area unless contaminated with feces.
16. Remove gloves and wash hands.
17. Apply deodorant and lotion. Comb the patient's hair. Shave the male patient unless contraindicated. Some female patients may need assistance shaving their underarms or legs.
18. Ensure patient comfort and lower bed level.
19. Tidy up the room after the bath and dispose of dirty linens (all soiled towels and linens must be placed in a laundry bag before leaving patient's room. Wash hands.

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Supplies Needed:

Ordered medication

Sterile syringe and needle (1- mL syringe, 26-28 gauge, 0.5 inch needle)

Alcohol swabs

Clean gloves

Medication Administration Record

Procedure:

1. Check healthcare provider's order and gather equipment.
2. Identify patient according to facility policy.
3. Explain procedure to patient.
4. Wash hands and apply gloves.
5. Select an area on the inner aspect of the forearm that is not heavily pigmented or covered with hair. For TB testing, typically the left forearm is used.
6. Cleanse the area with alcohol swab while wiping with a firm, circular motion and moving outward from the injection site. Allow the skin to dry.
7. Using two-handed technique, remove the needle cap.
8. Use the non-dominant hand to spread the skin taut over the injection site.
9. Place the needle at a 15 degree angle (almost flat) against the patient's skin, bevel side up, and insert the needle into the skin so that the point of the needle can be seen through the skin. Insert the needle only about 1/8" with entire bevel under the skin.
10. Carefully release skin.
11. Hold syringe in place with dominant hand. Non-dominant hand should push the plunger to inject medication.
12. Slowly inject the medication over 3 to 5 seconds while watching for a small bleb or blister to appear.
13. Once the medication has been injected, withdraw the needle quickly at the same angle that it was inserted.

14. Do not massage or bandage area after removing the needle. Tell patient not to rub or scratch site.
15. Do not recap the used needle. Activate safety device over needle if present. Discard the needle and syringe in the sharp's container.
16. Assist patient into a comfortable position.
17. Remove gloves and dispose of them properly. Perform hand wash.
18. Chart the administration of the medication as well as the site of administration.
19. For TB testing, in 48-72 hours, observe the area and document the size of induration if present.

Sources Used:

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 4/6/07 Revised 11/25/13
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Supplies Needed:

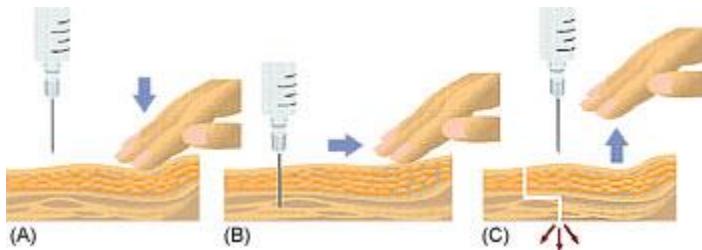
Ordered medication
Alcohol swabs
Sterile syringe and needle (2-to 3-mL syringe with 18-to-22 gauge, 1 to 1 1/2-inch needle)
Clean gloves
Medication Administration Record
Bandage

Procedure:

1. Check healthcare provider's order and assemble equipment.
2. Identify patient according to facility policy.
3. Explain procedure to patient.
4. Wash hands and apply clean gloves.
5. Provide privacy. Select appropriate injection site by inspecting muscle size and integrity, and locating anatomic landmarks.
6. Clean the area around the injection site with an alcohol pad. Use a firm circular motion while moving outward from the injection site. Allow area to dry.
7. Using two-handed technique, remove the needle cap.
8. As you tilt the needle downward for the injection, make sure the air lock rises to the plunger end of the syringe.
9. Hold the syringe between the thumb and the forefinger of dominant hand. Spread the skin at the site with non-dominant hand. If administering a medication that requires the Z-track technique, displace the skin by gently pulling the skin to one side using the non-dominant hand.
10. Stabilizing your wrist on the patient, insert needle quickly (using dart technique) at a 90 degree angle into the patient's skin and slowly inject medication.
 - a) Two-handed technique: Release the skin and use non-dominant hand to push down on the plunger.
 - b) One-handed technique: While continuing to stretch the skin with the non-dominant hand, reach up to plunger with the thumb or forefinger of the dominant hand and push the plunger.

The one-handed technique must be used when administering a medication that requires the

Z-track technique.



Z-Track Technique: An intramuscular injection that is designed to deposit medications deep into muscle tissue to prevent tissue irritation.

11. Do not recap used needle. Activate the safety device and dispose of needle and syringe in sharps container.
12. Massage over site with alcohol swab and apply bandage.
13. Assist patient into a comfortable position.
14. Remove gloves and wash hands.
15. Document the administration of the medication, including the site of administration.

Sources Used:

Advisory Committee on Immunization Practices. 2011. "General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." Morbidity and Mortality Weekly Report 60, no. RR02 (January 28): 1-60.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Crawford, Cecelia, and Joyce A. Johnson. 2009. "To Aspirate or Not to Aspirate: That is the Question: An Integrative Review of Evidence." Lecture, STTI International Nursing Research Congress, Vancouver, July 13-17.

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Supplies needed:

Ordered medication
Alcohol swabs
Sterile syringe and needle (1-to 3-mL syringe with 25-to-29 gauge, 5/8-to-1 inch needle)
Clean gloves
Medication Administration Record
Bandage

Procedure:

1. Check healthcare provider's order and assemble equipment.
2. Prepare medication according to facility policy.
3. Identify patient according to facility policy.
4. Explain the procedure to patient.
5. Wash hands.
6. Provide privacy and apply gloves.
7. Have patient assume a position appropriate for the site to be used.
8. Locate site. Ensure that the site is free from tenderness, swelling, scarring and inflammation.
9. Clean the area around the injection site with an alcohol swab. Use a firm, circular motion while moving outward from the injection site. Allow area to dry.
10. Using two-handed technique, remove the needle cap. (Due to the tight fit of a Lovenox cap, forcibly pull off the cap.)
11. Pinch up a large pad of skin tissue surrounding the injection site.
12. Hold the syringe in the dominant hand between the thumb and forefinger. Insert the needle quickly at a 45 degree angle.
 - Needle should be injected at a 90-degree angle if administering Insulin and anticoagulants.
 - With all pre-filled syringes, check to make sure air bubble is at the plunger end of syringe.
 - Heparin should be drawn-up in a 1 mL syringe and be given in the abdomen.

13. After the needle is in place, inject the medication with slow, even pressure on the plunger.
 - a) Two-handed technique: Release the tissue and immediately move your non-dominant hand to the plunger.
 - b) One-handed technique: With dominant hand reach with thumb or forefinger to plunger.
After injection, keep skin pinched, remove needle, and then release skin.
14. Withdraw the needle quickly at the same angle at which it was inserted while stabilizing the skin.
15. If necessary, apply a bandage (do not massage).
16. Do not recap used needle. Activate the safety device and discard the needle and syringe in sharp's container.
17. Assist patient to a comfortable position.
18. Remove gloves and wash hands.
19. Document the administration of the medication, including the site of administration.

Sources Used:

Advisory Committee on Immunization Practices. 2011. "General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." Morbidity and Mortality Weekly Report 60, no. RR02 (January 28): 1-60.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Crawford, Cecelia, and Joyce A. Johnson. 2009. "To Aspirate or Not to Aspirate: That is the Question: An Integrative Review of Evidence." Lecture, STTI International Nursing Research Congress, Vancouver, July 13-17.

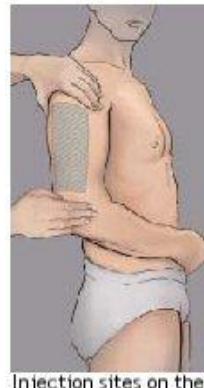
Pensacola Christian College Department of Nursing	March 28, 2007 Approval: 4/6/07 Revised: 11/25/13
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Subcutaneous Injection Sites



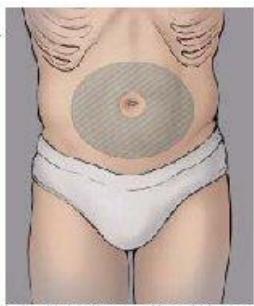
Injection sites on the arm backs

To locate injection sites on the arms, fold one arm across the chest. Place your hand on the shoulder and draw an imaginary line below your hand. Place another hand on the elbow. Draw an imaginary line down the outer side of the arm and down the center front of the arm, starting at the shoulder. The area inside these imaginary lines is where injections are given.

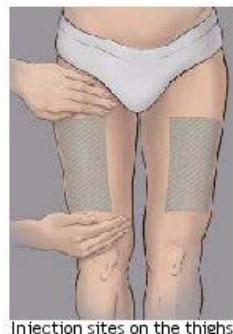


Injection sites on the side of the arm

2. To locate injection sites on the thighs, sit down, place your hand above the knee, and draw an imaginary line above it. Place your hand at the uppermost part of the thigh and draw an imaginary line below your hand. Draw an imaginary line down the outer side of the leg and down the center front of the leg. The area within these imaginary lines is where injections may be given.



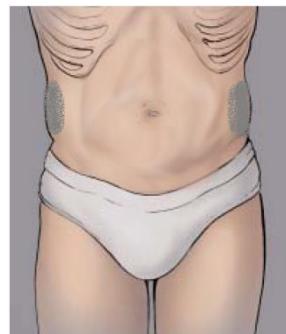
Injection sites on the abdomen



Injection sites on the thighs

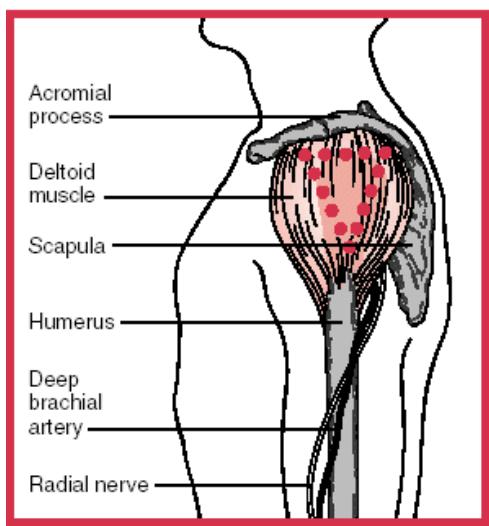
3. To locate injection sites on the abdomen, place your hands on the lower ribs and draw an imaginary line below them. Use this area below your hands for injections, as far around as you can pinch up fatty tissue. Do not use a 2-inch circumferential area around the umbilicus.

Lovenox Subcutaneous Injection Technique: Lovenox Injections are administered by deep subcutaneous injection using one-handed technique. To avoid the loss of drug when using the 30 and 40 mg prefilled syringes, do not expel the air bubble from the syringe before the injection. Administration should be alternated between the left and right anterolateral and left and right posterolateral abdominal wall (love handles). The whole length of the needle should be introduced into a skin fold held between the thumb and forefinger; the skin fold should be held throughout the injection. To minimize bruising, do not massage.



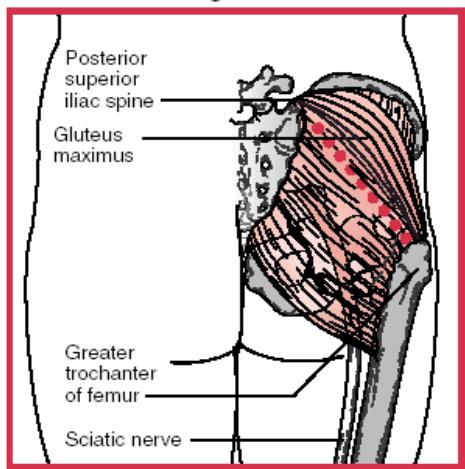
IM Injection Sites

Deltoid site



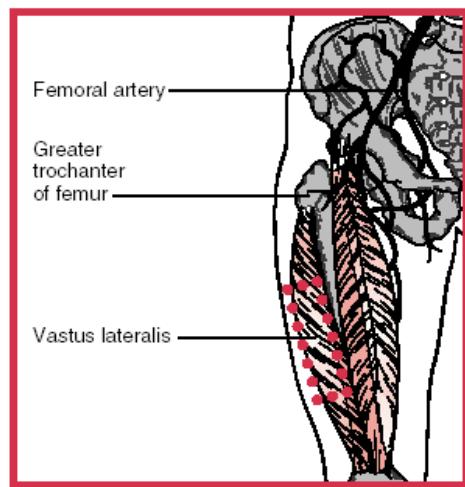
Find the lower edge of the acromial process and the point on the lateral arm in line with the axilla. Insert the needle 1-2 inches below the acromial process, usually two or three fingerbreadths, at a 90-degree angle or angled slightly toward the process.

Dorsogluteal site



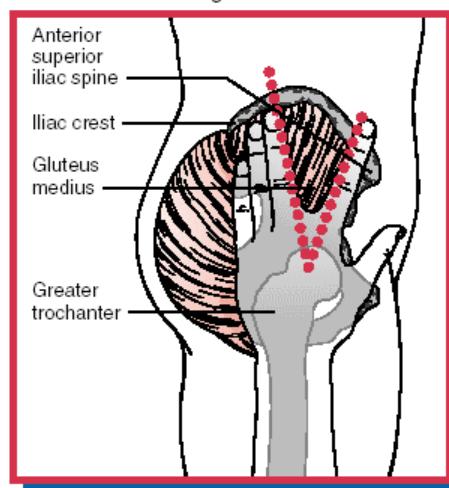
Inject above and outside a line drawn from the posterior superior iliac spine to the greater trochanter of the femur. Or, divide the buttocks into quadrants and inject in the upper outer quadrant, about 2-3 inches below the iliac crest. Insert the needle at a 90-degree angle. (Rest curve of your hand on the iliac crest and swing thumb downward at a 45-degree angle.)

Vastus lateralis site



Use the lateral muscle of the quadriceps group, from a handbreadth below the greater trochanter to a handbreadth above the knee. Insert the needle at a 90-degree angle into the middle third of the muscle parallel to the surface on which the patient is lying. For infants, you may have to bunch the muscle before insertion, not just the skin.

Ventrogluteal site



Locate the trochanter of the femur with the heel of your hand. Then spread your index and middle fingers from the anterior superior iliac spine to as far along the iliac crest as you can reach. Insert the needle between the two fingers at a 90-degree angle to the muscle. (Remove your fingers before inserting the needle.)

Pensacola Christian College Department of Nursing	December 14, 2015 Approved: 02/15/2016
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Supplies Needed:

Medication vial (powdered)
Sterile diluent (NS, water, or specified diluent), which may be in an ampule
Sterile syringe
Sterile needles
Blunt-tipped (vial) needle and filtered (ampule) needle, if required
Alcohol swabs
Label for syringe

Procedure:

1. Complete the Medication Administration procedure from the beginning up through #6 under Completing Routine Medication Checks.
2. Perform any calculations needed to know the amount of diluent to use, the concentration, and amount of medication to withdraw from the reconstituted vial. Discuss any concerns with your instructor.
3. Gather your equipment and wash your hands.
4. Clean the tops of the medication and diluent vials with an alcohol swab. Discard swab.
5. Open the wrapper of the appropriate syringe and carefully remove the needle, if present, while maintaining the sterility of the syringe hub.

If the diluent is contained in an ampule, clean around the neck of the ampule with an alcohol swab then break the ampule carefully while maintaining sterility of the ampule. Use a filtered needle to remove the diluent from the ampule. Remove the filtered needle and continue the procedure. Dispose of the ampule in the sharp's container.

6. Add a blunt-tipped needle to the syringe. If a blunt-tipped needle is unavailable, use a standard needle.
7. Add an amount of air to the syringe equivalent to desired amount of diluent.
8. Inject the air into the diluent vial and remove the correct amount of diluent.
9. Inject the diluent into the medication vial, allowing the medication to mix. Swirl the vial gently. Do not shake the medication vigorously.

If the medication is taking a lot of time to mix properly, you may remove the needle from the vial. Place it lightly into the protective cap that came with the syringe. Swirl the vial or roll between the palms of your hands to mix the solution. Clean the top of the vial again as you may have contaminated it during the mixing process. Using the sterile syringe again, reinser the needle in the medication vial.

10. Remove the desired amount of reconstituted medication.
11. Remove the needle from the vial and activate the safety guard on the needle, if available.
12. Remove the used needle from the syringe and discard in the sharps container. If there is no safety guard, safely recap the needle or use hemostats to remove the uncovered needle and discard the needle in the sharps container.
13. Attach a standard needle with the correct length and gauge to the syringe, if needed for IM/subcutaneous injection. If used for intravenous administration, either retain the used blunt-tipped needle or apply a cap to the syringe hub.
14. Add an air lock, if appropriate.
15. If this medication preparation takes place outside of the patient's room, attach a durable label with the following information.
 - Patient Name
 - Room Number
 - Name, Dose, and Concentration of Medication
 - Name of Diluent
 - Route
 - Date and Time of Preparation
 - Date and Time of Expiration
 - Initials
16. Clean up your workspace and discard waste. Glass vials and needles are to be placed in the sharps container. Vials may need to be retained until medication administration is completed.
17. Resume the Medication Administration procedure at #7 under Completing Routine Medication Checks. You may also need to refer to the appropriate Injection procedure for the site you will be using.

Sources Used:

Smith, Sandra F., Donna J. Duell, and Barbara C. Martin. 2012. Clinical Nursing Skills: Basic to Advanced Skills. Upper Saddle River, NJ: Pearson.

Pensacola Christian College
Department of Nursing

January 16, 2009
Approval: 5/18/09
Revised: 3/12/15

Supplies Needed:

Insulin pen
Single-use needle
Alcohol swabs
Clean gloves

Procedure:

1. Remove the cap and check insulin pen against MAR. The pen will be for a specific patient.
2. If the insulin is a suspension, turn the pen end-to-end at least 10 times.
3. Clean the rubber stopper at the end of the pen with an alcohol swab.
4. Remove the protective tab from the needle and screw it onto the pen.
5. Turn the dose dial to 2 units. Remove the needle cap, and with the needle still pointing up, press the push button as far as it will go. This is done to prime the needle, the selector dial should return to zero. A drop of insulin should appear at the needle tip. If not, repeat this procedure until a drop of insulin appears.

The first time you use the insulin cartridge, you will need to hold the pen with the needle point up and tap the reservoir gently with your fingers a few times. This will cause any air in the cartridge to rise to the top so that it can be expelled when priming the needle.

6. With the dose selector at zero, dial the number of units prescribed.
7. Complete the final medication check.

Insulin type and dose must be verified by two RN's prior to administration.

8. Apply clean gloves.
9. Choose your injection site and inject according to the subcutaneous injection procedure, pushing the button all the way in. With the push button fully depressed, keep the needle in the skin and count to five to ensure the full dose has been delivered. Keep the button fully depressed until the needle is withdrawn from the skin.
10. Using one hand, carefully replace the needle cap. Remove the contaminated needle and place in a sharps container. Place the cap on the insulin pen for storage.
11. Remove gloves and wash hands.
12. Sign the MAR per the medication administration guidelines.

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Supplies Needed:

Intravenous catheter (20-22 gauge for adults/18-20 gauge for blood products or large volumes)

Tourniquet

Chlorahexidine swabs

Clean gloves

Gauze

Tape

Tegaderm

IV hub or J-loop

Normal saline flush

Chux or towel

IV Insertion Procedure:

1. Verify healthcare provider's order.
2. Gather supplies and wash hands.
3. Identify patient and explain the procedure.
4. Set-up the supplies at the bedside. (Prime the IV hub or J-loop with the normal saline flush to remove air, and keep the syringe attached.)
5. Locate IV site: for adults, use veins in the hands or arms; for children, one may use superficial veins in the hands, feet, or scalp (try to avoid the feet if the child ambulates).
 - Do not use an arm with a dialysis shunt or fistula, or the involved arm of a radical mastectomy or stroke.
 - If you have difficulty locating a vein, you can place a warm towel on the extremity or have the patient hang his arm down to increase blood flow to the area.
6. Place the chux or towel under the extremity to be used for the IV insertion.
7. Apply tourniquet 3-6 inches above site—it should not stop arterial blood flow—and palpate the vein to be used. Do not use a vein that has valves (feels like knots) or make sure you insert the catheter above a valve.
8. Cleanse site with chlorahexidine swab for 30 seconds and let it dry.
9. Apply clean gloves and observe standard precautions.
10. Apply traction to skin and with the bevel up place the IV needle 0.1 to 0.2 cm below where you want to pierce the vein.

11. Insert the tip of the needle, lower the angle, and advance until a flashback of blood is obtained. If no flashback is obtained, then by using your non-dominant hand palpate above the site to feel where the vein is and advance the catheter in that direction.

Do not make more than two attempts to insert an IV. Obtain help if more than two attempts are necessary.

12. Advance the catheter to the hub, release the tourniquet, withdraw the needle and activate the safety device. Apply venous pressure as the needle is disconnected.

Never reinsert the needle into the catheter after it has been withdrawn.

13. Connect the IV hub or J-loop to the catheter hub.

14. Flush the reseal with normal saline while observing for any signs of infiltration. If the patient complains of pain, check for blood return.

15. Place tegaderm over the catheter hub and insertion site; place tape across the reseal hub to secure it.

16. Remove gloves and wash hands.

17. Label the dressing with the date, time, catheter gauge, and your initials.

18. Document the date, time, catheter gauge, and patient's tolerance of the procedure.

IV Site Maintenance Procedure:

1. IV sites are changed every three to four days. If IV was started outside of the hospital, it should be changed within the first 24 hours. Refer to facility policies for specifics.
2. The IV site must be assessed for patency, redness, edema, drainage, and tenderness at the beginning of every shift and every hour if IV fluids are infusing.
3. IV reseals must be flushed with normal saline every shift as well as before and after medication infusion.
4. Always document IV maintenance and intake & output in the patient's chart and/or MAR.

Always wear gloves when removing an IV or IV reseal. After removing the catheter, inspect the catheter to be sure it is intact.

Sources Used:

Sacred Heart Health System. Policies and Procedure. Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College
Department of Nursing

January 19, 2007
oval: 5/4/07
Revised: 12/02/13

Supplies Needed:

Alcohol swabs
Syringe
Normal saline flushes
Needle or Needleless adaptors (if necessary)
Clean gloves
MAR
Primary or secondary IV tubing

Drawing medication from a vial:

1. Wash hands, obtain MAR and ordered medications. Always verify new or handwritten orders with the healthcare provider's (HCP) orders.
2. Perform necessary medication checks.
3. Perform any necessary calculations (including rate of administration). Medications must be precisely prepared. If label reads 20mg / 2mL, then exactly 2 mL must be obtained, not the entire contents of the vial or ampule. The above example is not considered a unit dose.
4. Remove plastic cover from vial and cleanse top of vial with alcohol swab.
5. Attach a needle or needleless device to the syringe.
6. Draw air into the syringe equal to the amount of solution being withdrawn.
7. Inject air into the vial and withdraw the appropriate amount of medication.
8. Remove needle and recap needle using the one-handed technique.
9. Label syringe with name of medication and concentration prepared. (It is helpful to also include the rate of administration.)
10. Dilute medication if necessary (refer to IV medication book).

Calculate the amount of medication to be given every 15 seconds over the recommended total safe rate of administration. Push the calculated amount and then wait 15 seconds before pushing the correct amount again.

Administration of IV push medications

1. Wash hands. Obtain 2 mL normal saline (NS) flush for peripheral IV sites or 10 mL for central lines, including PICC lines. The IV site will need flushed prior to and after medication administration. (You do not need to flush an infusing IV line if the medication is compatible with the infusing fluids.)

2. Identify the patient by comparing the identification band with the patient's MAR and asking the patient to state his name and DOB.
3. Apply clean gloves prior to accessing a central line.
4. Scrub the hub or Y-site closest to the patient, for 15 seconds and attach syringe.
5. If using resealed IV, flush port with appropriate amount of normal saline to verify patency.
6. Administer medication over the appropriate time and remove the syringe.

- Determine the rate of administration for all IV medications and check the compatibility of the medication with the IV solution if administering medication through infusing IV fluids.
- For central lines, a 10 mL syringe is the smallest size syringe with which to flush or to administer medications.
- STOP administering the medication IMMEDIATELY if the patient develops a reaction or change in hemodynamic status.

7. Flush the resealed IV port with the appropriate amount of normal saline. (For central lines, flush at the same rate as the medication administration.)
8. Document medication administration on the MAR.

Administering Intravenous piggyback (IVPB) medications:

1. Verify healthcare provider's order with the MAR.
2. Wash hands, obtain MAR and ordered medications. Always verify new or handwritten orders with the HCP's orders.
3. Perform necessary medication checks.

Compatibility of medications MUST be determined PRIOR to mixing two or more medications in the same line.

4. Obtain secondary IV medication administration tubing if the patient does not have one or it is expired.
5. Perform any necessary medication calculations (including rate of administration). IVPB that are prepared by pharmacy will come with pharmacy recommendation for administration time. *Pharmacy's recommendation should be compared to IV drug book recommendation.*
6. Identify the patient by comparing the identification band with the patient's MAR and asking the patient to state his name and DOB.
7. Clamp the secondary tubing and spike the IV piggyback medication bag.
8. Fill the drip chamber halfway.

9. Prime and label the tubing (some infusion pumps have the option of “backpriming” fluids into the secondary tubing as a way to prime the tubing).
10. Scrub the hub for 15 seconds.
11. Connect the secondary tubing to the port on the primary tubing above the level of the pump if using the same pump for primary and secondary medications OR attach the tubing to the cassette port on the PLUM pump tubing. If using separate pump for secondary medications, use primary tubing and connect it to the port closest to the patient or a resealed port.
12. Set infusion pump for the correct rate and volume to be infused, unclamp the tubing and visually ensure that fluid is running. (If an infusion pump is not available, adjust the roller clamp to the appropriate drip rate.)
13. When the IVPB is completed, disconnect the tubing and if a resealed port was used, flush the IV port with normal saline (2 mL for peripheral sites and 10 mL for central lines).

Cover the end of the tubing with a sterile cap when it is disconnected from the port so the tubing can be reused.

Pensacola Christian College Department of Nursing	May 12, 2009 Approval: 02/02/14
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Supplies Needed:

Clean gloves
Isolation gown
Particulate Respirator mask (N95 Respirator)
Surgical mask (may also need connected face shield)
Hair cap

Procedure: Isolation Procedure

1. Isolation should be indicated on the patient's door. In long-term facilities it may simply say to report to the nurse's station.
2. Before caring for an isolation patient, read the sign on the door. This sign will give information on how the facility complies with the CDC recommendations for preventing nosocomial infections.
3. Vital sign equipment including a stethoscope may be dedicated to the patient and kept in the room. Equipment not in the room must be cleansed with disinfectant cloth (i.e. PDI sani-cloth) at the patient's doorway before exiting the room.
4. When entering the room to give medications, hold the MAR in one hand and then set the medication down in the room in a safe place. ID the patient. If this requires you to touch the ID band, do so with your hand opposite the one holding the MAR. After identifying the patient, be careful not to touch the MAR with the hand that touched the patient. Take the MAR and place it upside down outside of the room on the isolation cart. With e-mar, sign out with your clean hand and then push the e-mar cart outside of the patient's room. Clean the cart with a disinfectant cloth if it has been contaminated. (No other personal papers should be brought into the room.)

Contact precautions are needed with each of the following diseases: Clostridium Difficile (C. diff.), Scabies, Shingles (Varicella Zoster), Lice, MRSA, VRE, RSV, Rotavirus.

1. Gloves should be applied prior to entering the room of a person on contact isolation. It is assumed that every surface in the room is contaminated, not just the patient and the bed. Prior to any direct contact, a gown must be worn (some facilities require a gown anytime you enter the room).
2. Mask should be worn when suctioning, or in close contact with a patient that is coughing that has MRSA in the sputum.
3. When caring for a patient that has lice, hair caps are also worn.
4. Before exiting the room, remove the gloves then gown touching only the inside of the gown. (This prevents contamination of your hands from the gown.) Wash hands with soap and water before leaving the room.

Airborne precautions are needed with active TB, SARS, Varicella Zoster, Measles (Rubeola).

1. Gown, gloves, and a properly fitted mask (N95 respirator) required.
2. A negative air pressure private room is required.

Droplet precautions are needed with Bacterial Meningitis, H. Influenzae, German Measles (rubella); Mumps, Pertussis (whooping cough), and Diphtheria.

1. Gloves and surgical mask required.

Protective precautions (reverse isolation) are needed with immunodeficient patients (neutropenic) or those with new organ transplants.

1. Gown, gloves, and surgical mask may be required. If not, hands should be washed in front of the patient.
2. No fresh fruits, vegetables, flowers, or raw meat are permitted.

Chemotherapy precautions are needed when patients are receiving chemotherapy.

1. Gown, mask with face shield, and double gloves may be needed while administering IV chemotherapy (RN must be chemo certified).
2. Double gloves may be needed while administering IM, PO, or subcutaneous chemotherapy (RN does not need to be chemo certified).
3. All materials used to prepare and administer chemotherapy agents (pill packages, IV bags, and IV tubing) must be disposed of in the yellow chemotherapy waste containers. The computer MAR will remind the nurse in which color bin to dispose materials.
4. When dealing with patient's body fluids (blood, emesis, stool, sweat, urine), double glove and double flush commode for 48 hours after administration of chemotherapeutic agent.
5. Wash hands with soap and running water after handling chemotherapy agents or body fluids.

If a patient that is on airborne, droplet, or protective isolation is transferred outside of his room, he must wear a surgical mask.

Sources Used:

Baptist Hospital. 2014. "Chemotherapy and Hazardous Drug Safety." Policies and Procedures. PH-2069 (February). Baptist Hospital, Pensacola, FL.

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*. Springhouse, PA: Lippincott Williams & Wilkins.

Healthcare Infection Control Practices Advisory Committee (HICPAC). 2013. "2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings." Centers for Disease Control and Prevention. Last modified December 9, 2010. Accessed October 2013.
<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>.

West Florida Hospital 2012. “Administering and Disposing of Parenteral Chemotherapy Agents.” Policies and Procedures. (November) West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 5/4/07 Revised: 11/25/13
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General Guidelines

1. Students are never to take a verbal or telephone order from a healthcare provider (HCP), except during preceptorship when directly supervised and witnessed by their preceptor.
2. Student nurses are never to give IV medications unless directly supervised by the instructor.

First Thing in the Morning

1. Read all pages of the MAR to determine your patient's medication needs for the day.
(Especially note times for routine medications and all PRN medications ordered.)
2. IV fluids must be checked against the MAR to verify correct solution and rate in mL/hr. (If fluid is to gravity, calculate and verify drops/min.)
 - a) Any medication that is added must be looked up.
 - b) Critical drip dosage must be calculated to verify safe dose.

Prior to Looking Up Medications

1. Check for any new HCP orders. Chart must be checked:
 - a) before or after report,
 - b) after lunch, and
 - c) any time a HCP has been in to see the patient.
2. Verify any handwritten MAR orders with the chart.

Looking Up Medications

1. Using the MAR write down all medications and dosages on your medication administration checklist (MAC). Start at the top of your MAR and work down. (Use a separate MAC for each medication administration time, clearly labeling the top with the time.)
2. Using previous knowledge or your drug book, complete all sections of the MAC:
 - a) Safe dose: to determine if your patient is getting a safe dose you need to look at the amount of medication the patient is getting for the entire day. (Use a pediatric-specific drug guide with children and fast facts book in critical care.)
 - b) Indication(s): indication must be relevant to your patient's diagnosis/history.
 - c) Critical information: to determine if the medication is safe for your patient complete the following steps and record all the information on the MAC:
 - i) Determine drug classification/action.
 - ii) If this classification is listed at the bottom of the MAC determine critical information needed.
 - iii) Determine critical side effects.
 - d) Safe to give: based upon the critical findings, is it safe to give your patient this medication?
 - e) Priority follow-up/teaching: determine if you need to follow up with repeat vital signs or reassess for critical side effects. Also list pertinent teaching needed.

When administering combination medications, you must have knowledge of all components of

the medications.

Completing Routine Medication Checks

1. Obtain all needed supplies (i.e. syringes, IV tubing, medication cup, alcohol wipes, etc.)
2. First medication check
 - a) Obtain all medications for the designated time by starting at the top of the MAR and finding the first medication.
 - b) Compare the name and dose with the MAR.
 - c) Repeat with the second and all remaining medications.
 - d) You should only obtain medications you have determined are safe to give.

Isolation patients may have some of their medications at the bedside (i.e. insulin, topical medication, eye drops, inhalers, etc.). You cannot take these medications out of the room to bring to your instructor; therefore, after verifying that they are indeed in the room and completing two medication checks put a note on the MAR indicating what medications are in the room.

3. Calculate all IV push and piggyback rates and determine compatibility.
4. Second medication check
 - a) Starting at the top of the MAR, verify the following:
 - i) Right patient
 - ii) Right medication
 - iii) Right dose
 - (1) if the dose is greater than or less than one, write the information on the medication package (write on post-it note if multi-dose packaging)
 - (2) if the dose needs to be poured or drawn up, be prepared to indicate to the instructor how this will be done
 - iv) Right route
 - v) Right time
 - vi) Expiration date
 - vii) Allergies
 - b) Repeat with the second and all remaining medications
 5. Bring medications, MAR, MAC, and all supplies to your instructor.

You are fully responsible for all medications brought or not brought to your instructor. (It is just like you are handing the medications to the patient to take.)

Any questions should be resolved prior to beginning your medication checks.

Bring the medications unopened with the MAR to the instructor after you have completed your second medication check.

Medication checks should be fully completed on one patient at a time. (You can only have ONE patient's medications at a time.)

For PRN medication checks, time and dose of last administration must be verified.

6. Third and final medication check (with **E-MAR system**)
 - a) Log in to your patient's chart.
 - b) Scan the patient's ID band.
 - c) Ask patient to state name and date of birth and verify with MAR.

- d) Starting at the top of the MAR, scan and verify the name, dose, time, and route of the first medication.
 - e) Open the package and pour medication into the medication cup, or draw up into the syringe (syringes must be labeled and at your instructor's discretion may be prepared outside of the patient's room).
 - f) Verify that the correct dose was prepared.
 - g) Repeat with the second and all remaining medications
 - h) After administering all medications, click and save information in the E-MAR system.
(Some systems require you to scan the patient's ID band a second time prior to saving.)
 - i) If a medication is not given, this must be documented.
7. Third and final medication check (with **paper MAR**)
- a) Verify that name and medical record number on patient's ID band and MAR match.
 - b) Ask patient to state name and date of birth and verify with MAR.
 - c) Starting at the top of the MAR, verify the name, dose, time, and route of the first medication.
 - d) Open the package and pour medication into the medication cup, or draw up into the syringe (syringes must be labeled).
 - e) Verify that the correct dose was prepared.
 - f) Repeat with the second and all remaining medications.
 - g) After administering medications, initial each medication given on the MAR and sign the back.
 - h) If a medication is not given, this must be documented.

All medications must be given on time (within one half hour before or after scheduled time).

PRN pain medications must be administered within 15-20 minutes.

If your patient questions a medication, STOP and investigate the patient's concerns.

When administering insulin the dose drawn up must be verified by your patient's RN after being checked with your instructor.

Occasionally some forms of Heparin must be verified by two RN's

Narcotics must be wasted by two RN's.

The Five Rights to Medication Administration

The right patient The right dose The right time
The right medication The right route

Three Additional Rights

The right documentation The right to refuse The right to be educated

Pensacola Christian College Department of Nursing	January 3, 2007 Approval: 3/23/07 Revised: 12/16/13
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Supplies Needed:

Medication administration record (MAR) or EMAR
Medication canister
Inhaler mouthpiece
Spacer device (optional)

Procedure:

1. Check the medication order for type of medication, dose, and route.
2. Review the patient's medical and medication history, noting any allergies.
3. Assess the patient's respiratory system noting breathing pattern, respiratory rate, use of accessory muscles, and breath sounds.
4. Assemble medication canister, inhalation mouthpiece, and spacer device if needed. Insert the metal medication canister into the long end of the mouthpiece. Shake the canister several times to mix the medication.
5. Assist the patient to a sitting or standing position to ensure full expansion of the lungs.
6. Have the patient take a deep breath and completely exhale.
7. Have the patient seal lips around mouth piece. Have the patient inhale slowly through the mouth, pressing down on the canister to release a dose of the medication as the patient begins to breathe in.
8. If the patient is able, have him hold his breath for 10 seconds after inhaling the medication.
9. If a spacer is used for the administration of the medication, attach the spacer to the mouthpiece and instruct the patient to exhale and then to place the mouthpiece of the spacer in his mouth. After pressing down on the canister to release the medication, instruct the patient to take and hold a deep breath. If the patient is unable to do this, encourage him to take 2 or 3 short breaths to inhale the medication from the spacer.
10. Separate subsequent doses of the inhaler or other inhaled medications by 1 minute.

Bronchodilators given via MDI should be given before other inhaled medications.

11. Have the patient rinse his mouth if **steroid** medication was inhaled.
12. Clean the mouthpiece and spacer and wash your hands.

13. Document administration of medication, the patient's status before and after administration of the MDI medication, and the effectiveness of the inhaled medication.

Sources Used:

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 3/30/07 Revised: 12/16/13
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Supplies Needed:

Draw sheet or incontinence pad

Stretcher

Chair

Procedure:**Turning a Patient in Bed from One Side to the Other:**

1. Remove pillows from behind patient's back and between legs.
2. Check to make sure that the pad is positioned centered where it can be used to turn the patient in bed.
3. Raise the bed to waist level. Put the head of the bed flat.
4. Roll the pad close to the patient's body and grasp it tightly.
5. While keeping your trunk erect and bending at the knees, slide the patient across the bed on the pad so that hips are positioned next to the side rails. (This allows room so that when the patient is turned he will be positioned in the center of the bed.)
6. Using the pad, turn the patient facing the opposite direction. Straighten the pad under the patient. Tuck pillow behind the patients back. Place pillows between legs and float heels appropriately.
7. Put head of the bed to comfortable level. Return bed level to lowest position. Place call bell within reach.

Flex top leg toward the side on which patient is turning allowing the patient's weight to help gravity with rolling.

Moving a Patient Up in Bed:

1. Check that pad is positioned in the center of the bed where it can be used to move the patient up in bed.

Never move a patient up in bed by grasping the patient's arms, since this could cause injury. The patient should never be pulled up by placing arms under patient's hips. The nurse could be injured and this would also violate universal precautions.

2. Raise the bed to hip level and place the head of the bed flat. Remove pillow from behind patient's head.
3. Roll the pad close to the patient's body and grasp it tightly.
4. Tell the patient to lift head if possible and cross arms across the chest.
5. Patient may also bend at the knees and push with feet if able.
6. Position yourself as close to the patient's bed as possible. Assume a broad stance with knees slightly bent. Count to three and shift weight forward while sliding the patient up in the bed.
7. Straighten pad under patient. Put the head of the bed back up. Place the pillow back under the patient's head. Return bed to the lowest position. Place the call bell where it can be reached easily.

Transfer – Bed to Chair: Pivot transfer

1. Place chair at the side of the bed with the back toward the foot of the bed. If the patient can only bear weight on one leg, the chair should be placed by that leg.
2. Assist the patient to a sitting position on the side of the bed. Bed should be in lowest position to prevent fall. Dangle patient for a short period of time before beginning transfer.
3. Assume a broad stance in front of your patient and be prepared to pivot transfer your patient to the chair.
4. With hips and knees flexed, place the patient's hands on your shoulders, with your hands in a position where you could lift patient to chair if necessary. A gait belt is preferable if available.
5. Assist the patient to an erect standing position if possible and brace your knee against the patient's knee to steady the patient.
6. With the leg that is supported against the patient, step backward as the patient steps forward. Guide the patient forward until he is in front of the chair. If the patient is unable to take steps, instruct the patient to pivot on the balls of his feet as you turn him so that his back is toward the chair.

If patient is unable to stand, place the patient back down on the side of the bed and using the call bell, ask another person to assist with the transfer.

7. Flex your knees and hips and assist the patient to a sitting position.
8. Align the patient properly in the chair and make sure he is comfortable. Place the call bell where it can be easily reached.

Transfer – Bed to Stretcher:

1. Make sure draw sheet or incontinence pad is centered under the patient to support the shoulders, back, and buttocks.
2. A minimum of two people are needed for this transfer, at least one on each side of the bed.
3. The bed and the stretcher should be placed side by side at hip level to allow for smooth transfer. Both bed and stretcher wheels must be locked.
4. Position the patient supine with his arms and hands across his chest.
5. Position yourself as close to the patient as possible and grasp the draw sheet close to the patient's body. Assume a broad stance with knees slightly bent.
6. At the count of three, the transfer team should use the draw sheet to lift and slide the patient from the bed onto the stretcher. If pulling, weight should be shifted from the front foot to the back. If pushing, weight should be shifted from the back foot to the front.
7. Be sure the patient is aligned and covered properly, and provide a pillow under the patient's head.
8. Raise the side rails of stretcher.

Sources Used:

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Potter, Patricia A., and Anne Griffin Perry. 2001. *Fundamentals of Nursing*. 5th ed. St. Louis: Mosby.

Pensacola Christian College Department of Nursing	March 30, 2007 Approval: 3/30/07
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Purpose:

To outline the process to follow when an accidental contaminated needlestick and/or mucous membrane exposure occurs.

1. Parenteral: Needlestick or cut with a sharp instrument, contaminated with blood.
2. Mucous membrane: Blood splash to the eye or mouth.
3. Cutaneous: Skin exposure involving large amounts of blood or prolonged contact with blood, especially when the exposed skin is chapped or abraded.

Procedure:

1. Immediately cleanse the affected area.
 - a) In the event of a contaminated needlestick or sharps injury, immediately promote bleeding by applying pressure to the injured area to express a small amount of blood. Wash site immediately with antimicrobial soap and copious amounts of water for approximately 3-5 minutes, cover with a dressing if possible.
 - b) In the event of a contaminated mucous membrane exposure immediately flush eyes, nose, or mouth with copious amounts of water or normal saline.
2. Notify instructor and supervisor of health care facility.
3. Complete a Pensacola Christian College Department of Nursing incident report and any appropriate agency occurrence reports.
4. If the incident occurs in the PCC nursing lab, the student that sustained the needlestick as well as the source student should report to the Graf clinic within 2 hours for testing.

Drug prophylaxis following a high-risk exposure is time sensitive therefore you must immediately seek help from the appropriate hospital or college department. Treatment should occur within a 2-hour time frame from incident.

5. If the incident occurs at one of the local healthcare facilities, follow the agency's needlestick protocol. *Remember it is important to know the name and medical record number of the source patient, in order for rapid testing to be completed.*
 - a) **Baptist Hospital:** Report to the Emergency Room for initial testing. If follow-up treatment is needed the student will be referred to their private healthcare provider.
 - b) **Baptist Manor:** Report to the nursing supervisor on duty, they will arrange for patient testing, however they do not cover testing or treatment for the student. The student should report to the Graf Clinic, emergency room, or private healthcare provider within 2 hours for testing.
 - c) **Escambia County Health Department:** Notify the supervisor on duty. The incident will be handled through the Health Department worker's compensation and needlestick policy.
 - d) **Gulf Breeze Hospital:** Contact nurse manager, house supervisor, or employee health who will arrange for your initial testing to be completed.

- e) **Health Care Center of Pensacola:** Report to the nursing supervisor on duty, they will arrange for patient testing, however they do not cover testing or treatment for the student. The student should report to the Graf Clinic, emergency room, or private healthcare provider within 2 hours for testing.
- f) **Sacred Heart Hospital:** Call the hospital operator and ask for the needlestick hotline. You will be called back by employee health and given further instructions on how to obtain testing/treatment.
- g) **Santa Rosa Hospital:** Notify the house supervisor who will arrange for initial testing to be done through the emergency room. If follow-up treatment is needed, the student will be referred to their private healthcare provider.
- h) **West Florida Hospital:** Report to employee health (Monday-Friday, 0800-1630). All other hours, contact the house supervisor ASAP.
- i) **Other:** (i.e. Friary, healthcare provider's offices, community clinics, etc.) Report to the supervisor on duty and follow the agency's needlestick protocol. If the agency does not have a procedure for handling students, then you should report to the Graf Clinic, emergency room, or private healthcare provider within 2 hours for testing.

If you need follow-up treatment, you will need to sign a release form in order for the Graf Clinic or your private healthcare provider to obtain the results of your initial testing. It will be necessary for them to have this information so they can provide adequate treatment.

6. The student will be responsible for any costs incurred as a result of the exposure.

Sources Used:

Baptist Hospital. Policies and Procedures. Baptist Hospital, Pensacola, FL.

Sacred Heart Health System. Policies and Procedure. Sacred Heart Hospital, Pensacola, FL.

West Florida Hospital. Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 4/20/07 Revised: 12/16/13
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Supplies Needed:

Clean ostomy appliance/pouch
Gauze pad
Closure clamp (tail)
Biohazard bag
Clean gloves
Stoma measuring guide
Wafer
Water or any other special cleaning solution for cleaning pouch
Bedpan, toilet, or graduated cylinder
Scissors
Toilet tissue
Skin protective barrier wipes
Stomahesive powder
Warm water, soap, towel, washcloths
Disposable pad
Pouch deodorant (optional)
Marking pen

Procedure:

1. Gather equipment.
2. Wash hands.
3. Identify patient according to agency policy.
4. Explain procedure to patient.
5. Provide privacy. Move patient to a comfortable sitting or lying position if in the bed or in a sitting or standing position in the bathroom.
6. Apply clean gloves.
7. Empty pouch when 1/3-1/2 full
 - a) Remove tail clamp and uncuff end of appliance.
 - b) Empty contents into bedpan, toilet, or graduated cylinder.
 - c) Use toilet tissue or wet washcloth to wipe lower 2 inches of appliance.
 - d) Fold end of appliance/pouch upward and use tail clamp to close appliance off.
 - e) Document assessment of stoma, peristomal skin, color, amount, odor, and consistency of drainage, and patient's toleration of procedure.

Types of ostomies, location, and output

Ascending colostomy: in ascending colon, more towards outer side of RLQ. Output = liquid to semiliquid.

Transverse colostomy: in transverse colon, in LUQ. Output = liquid to semiformed.

Descending colostomy: in descending colon, more towards outer side of the LUQ. Output = semiformed to formed.

Sigmoid colostomy: in sigmoid colon, in LLQ. Output = normal, formed consistency.

Ileostomy: in ileum (small intestine), more towards inner RLQ. Output = watery and constant.

8. Ostomy appliances are changed every 3-7 days, but this must be done more often if there is leakage or problems with wafer/faceplate adherence to the skin.
 - a) Starting from the top, remove appliance/pouch by slowly pressing down and away from the skin and lifting up on the tape. Be careful not to strip the epidermis. Throw disposable appliance in biohazard bag, but save clamp.
 - b) Wipe off excess stool from stoma with toilet tissue. Clean stoma with disposable washcloths and water. Apply gauze pad to stoma, so that any secretions or drainage are absorbed by the gauze while the peristomal skin is being cleaned.
 - c) Clean peristomal skin with water (if needed, mild non-deodorized soap without lotion may be used). Pat skin dry with clean washcloth. Do not apply lotion to peristomal area as this will tamper with the creation of a tight seal.
 - d) Observe stoma, making sure it is moist and reddish pink. If stoma is pale or bluish-purple in color, this needs to be reported to appropriate personnel. (This could indicate anemia or circulation problems.) Observe peristomal skin for redness, irritation, or broken skin and report findings to appropriate personnel.
 - e) Use stoma measuring-guide template to pick a size for the stoma opening which is 1/4"- 1/8 " larger than the stoma. If the stoma is oval-shaped, trace a pattern on paper that is also 1/4"- 1/8 " larger than the stoma. The opening is cut slightly larger than the actual stoma size to prevent stomal irritation; however, the opening should not be large enough to allow for skin excoriation.
 - f) Trace size chosen onto wafer and cut out with scissors. Smooth out rough edges with fingers.
 - g) Use skin protective barrier wipes or apply appropriate stoma powder as necessary.
 - h) Prepare the wafer and appliance/pouch as one unit-system. (If a two-piece system is used, assemble face plate and wafer together and then apply to skin. Applying the appliance in this manner decreases discomfort.)
 - i) Remove backing behind wafer.
 - j) Remove gauze pad covering stoma and apply wafer and appliance/pouch onto the abdomen and over the stoma at the same time. Press wafer over the skin to smooth out any wrinkles and hold pressure for 2-3 minutes to make sure wafer and appliance are on securely.
Warmth from the patient's skin and applicator's hands helps create a secure, snug seal.
 - k) Fold end of appliance/pouch upward and use tail clamp to close appliance off.
 - l) Discard of any dirty equipment/supplies according to agency policy and/or rinse equipment to be reused and keep in patient's room.
 - m) Remove and discard gloves and wash hands.
 - n) Document assessment of stoma, peristomal skin, color, amount, odor, and consistency of drainage, and patient's tolerance of procedure.

Procedure Manual

Ostomy Care (Irrigating)

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 4/20/07 Revised: 12/16/13
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Supplies Needed:

Irrigation drainage sleeves
Irrigation kit
Clean gloves
Waterproof pad
Bedpan or toilet
IV pole
Lukewarm solution (usually tapwater)
Washcloth, soap, towels
Paper towel
Combination cone/tube stoma
Ostomy belt
Stoma lubricant
Drainable bag clamp

Procedure:

1. Check healthcare provider's (HCP) orders for type of solution to be used.
2. Gather equipment.
3. Wash hands.
4. Identify patient according to agency policy.
5. Explain irrigation procedure to patient and position patient sitting on the bed or sitting on the toilet or in a chair in front of the toilet.
6. Warm solution.
7. Fill irrigation bag with ordered amount of fluid. Usually regular irrigation amount is between 750-1000 mL and between 250-500 mL for first time irrigation. Make sure roller clamp is completely closed on the tubing.
8. Hang irrigation bag on IV pole, making sure the bag is no higher than the patient's shoulder when the patient is sitting.
9. Apply clean gloves.
10. Remove appliance/pouch from ostomy and attach the irrigation sleeve. Put end of irrigation sleeve into toilet bowl or bedpan so that irrigation fluid and any stool will go directly into the

toilet bowl or bedpan. Secure irrigation sleeve by clipping ostomy belt to either side of sleeve and wrapping soft side of belt around waist. Belt should be snug to prevent leakage of fluid or stool.

11. Take cone and lubricate. Set aside on a paper towel.
12. If dilation is ordered by HCP, place small amount of lubricant on gloved little finger and gently insert into stoma with a massaging action. Insert a lubricated gloved larger finger as stoma opening enlarges.
13. Prime irrigation tubing by slowly unclamping roller clamp and allowing fluid to flow through until all air bubbles are cleared. Clamp tubing once air bubbles are cleared.
14. Connect cone to irrigation tubing and insert cone into stoma about 1/2 - 3/4 inch. (Never force the cone into the stoma as this could cause perforation of the bowel. Tubing should never be used without the cone.)
15. Allow irrigation fluid to flow through slowly over 10-12 minutes. If cramping occurs, slow rate down or even stop irrigation for a few minutes. Hold tubing at all times (can be done by patient).
16. Once all irrigation fluid has flowed through, keep cone in place for an additional 10 seconds, then remove cone.
17. Allow colostomy to drain for 10-15 minutes. During this time, the patient should remain in the same position and allow the fluid to drain into the bedpan or toilet.
18. When most of the fluid has been drained, rinse irrigating sleeve with water, then clamp bottom of irrigating sleeve. Remove gloves and discard.
19. Allow patient to return to bed or ambulate for 15-30 minutes, which will help expel any remaining water, stool, and flatus.
20. Apply new gloves and remove irrigation sleeve. Cleanse skin around stoma with soap and water. Pat skin dry with a washcloth.
21. Attach a new appliance/pouch to the stoma (see previous guidelines for how to attach a new appliance/pouch).
22. Document the irrigation procedure, amount of irrigation fluid used, color, amount, and consistency of stool, stoma condition, patient's tolerance of procedure, and patient's participation in procedure.

Sources:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*. Springhouse, PA: Lippincott Williams & Wilkins.

- Black, Joyce M. and Jane Hokanson Hawks. 2005. *Medical-Surgical Nursing: Clinical Management for Positive Outcomes*. 7th ed. St. Louis: Elsevier Inc.
- Convatec. 2003. *Living with Confidence after Colostomy Surgery*. Princeton, NJ: E. R. Squibb & Sons L.L.C.
- Convatec. 2002. *Living with Confidence after Ileostomy Surgery*. Princeton, NJ: E. R. Squibb & Sons L.L.C.
- Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.
- West Florida Hospital. "Colostomy care/management procedure." Policies and Procedures. West Florida Hospital, Pensacola, FL.

Pensacola Christian College Department of Nursing	April 29, 2007 oval: 5/4/07 Revised: 12/16/13
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Supplies Needed:

Oxygen device
Oxygen source
Pulse oximeter

Procedure:

1. Verify healthcare provider's (HCP) order or the oxygen protocol if it is being used for the patient. Pediatric patients have exact orders for the oxygen and this should be verified with the HCP's orders.
2. Assess pulse oximeter with initial vital signs. Oxygen saturations below 92% or the level determined by the healthcare provider's order must be reported immediately to the appropriate personnel. When oxygen saturations are documented, the amount of oxygen the patient is on must be documented.
3. Assess the patient for signs and symptoms of hypoxia such as confusion, dyspnea, tachycardia, decreased level of consciousness, restlessness, and eventually cyanosis.
4. While adjustments are being made with the oxygen therapy, the patient's oxygen saturation should be monitored every 30 minutes. Typically, children are on continuous pulse oximeters.
5. The most common oxygen delivery device is the nasal cannula. The nasal cannula is documented in liters of flow per minute. To calculate the percentage of oxygen a patient receives with a nasal cannula, it is important to remember room air is 21% oxygen, 1 liter is 24% oxygen, and then you add 4% for each additional liter. (See example below.) Low flow nasal cannulas provide from between 24% and 44% of oxygen. Three liters or more should have humidity added to the oxygen to prevent mucosal drying. There is also a high flow nasal cannula device that can be increased to up to 15 liters per minute of flow.



Room air 21%
1 liter 24%
2 liter 28%
3 liter 32%
4 liter 36%
5 liter 40%
6 liter 44%

6. The ventimask is a precise way of delivering oxygen in mask form. This device delivers between 24%-50% oxygen. To determine the percentage of oxygen look at the tubing below the mask portion of the device. On this tubing is an area with varying percentages and liters of flow. The arrow should point to the desired percentage of oxygen and liter of flow should be exact. Document in percent of oxygen rather than liter of flow.
7. The partial rebreather and non-rebreather masks have a reservoir bag attached below the mask. These devices deliver between 60% and 100% oxygen. The percentage is based on liter of flow and number of flaps open or closed on the side of the mask. The amount of oxygen is not precise but rather an estimate. The flow meter amount is usually greater than 15 liters.
8. The simple face mask provides 40-60% of oxygen. The percentage of oxygen is an estimate based on liter of flow. A simple mask should never be used with less than 6 liters of flow.
 - 6 Liters = 40%
 - 7 Liters = 50%
 - 8 Liters = 60%
9. The aerosol trach mask is similar to the ventimask to determine percentage of oxygen except for the fact that the dial is located on the humidifier directly below the flow meter. Look at the dial for arrow and what percentage of oxygen it is turned. The flow meter amount is usually greater than 10 liters and not documented in liters, only in percentages.
10. CPAP and BiPAP devices provide continuous airway pressure to allow for oxygen exchange. The difference between CPAP and BiPAP is with BiPAP the pressures vary with inspiration and expiration, and with CPAP the pressure is the same for both inspiration and expiration. For CPAP, document percent of oxygen and pressure. For BiPAP, document percent of oxygen as well as inspiratory and expiratory pressures.
11. Oxygen may also be administered by face tent, ventilators, etc.

Patients that are considered to be carbon dioxide retainers must be carefully treated with the amount of oxygen they receive. There may be differing parameters for acceptable oxygen saturations with these patients.

Pensacola Christian College Department of Nursing	May 2, 2007 Approval: 5/4/07 Revised: 12/16/13
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Procedure:

1. Verify the healthcare provider's order.
2. Concentration of the syringe or bag must be assessed and compared with the PCA settings.
3. Gather the following information from the PCA pump by pressing the history button and using the arrows on the pump to scroll through the digital readout:
 - a) History (This information is what has occurred since the pump was last cleared.)
 - i) Total mL delivered
 - ii) Total injections/total attempts
 - iii) Bolus given
 - iv) Fluid volume remaining
 - b) Prescription details
 - i) Basal rate
 - ii) PCA dose
 - iii) Lockout time
 - iv) Hourly limit (This amount should be calculated to verify the pump is programmed correctly).

Calculation: Basal rate + (PCA dose x total injection allowed each hour) = hourly limit
Example: 1 mg basal + (0.7 mg dose x 6 injections allowed each hour) = 5.2 mg hourly limit

4. The history, patient's pain score, and vital signs are documented on the PCA flowsheet by the RN at the beginning of the shift and every four hours, as well as following any changes made to PCA pump programming.
5. The prescription details are compared with the healthcare provider's order and the PCA flowsheet.
6. The above information would be documented in a narrative note (i.e. PCA of Morphine 1 mg/mL-Basal 1 mg/hr; Dose 1 mg/1 mL; Lockout 10 min; 1 hr limit 7 mg.)

Be sure to monitor the patient for respiratory depression during the use of a PCA pump.
Patients and families should be taught about the importance of only the patient pushing the button.

The PCA pump is cleared at the end of each shift according to hospital protocol. Generally, this requires verification by two nurses, both the off-going and on-coming nurse.

If you need to use the PCA line to administer medications, you must check compatibility.

Procedure Manual

Physical Assessment (Routine Head-to-Toe with Specific Assessments)

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 5/4/07 Revised: 3/12/15
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Supplies Needed:

Alcohol swabs
Stethoscope
Penlight
Clean gloves

Procedure:

1. A physical assessment should be done on all patients at the beginning of each shift.
2. Before performing a physical assessment on your patient, you should obtain a report on the patient, review his chart noting the current problem, past medical history (H&P), healthcare provider's orders and code status, and obtain the patient's vital signs. (The patient's current problem and past medical history may necessitate a more detailed assessment.)
3. Wash hands. Gather and clean equipment.
4. Identify the patient according to facility policy.
5. Provide privacy by closing the door and pulling the curtain. Raise the bed to waist level and lower the side rails. Observe standard precautions throughout the assessment.
6. The physical assessment will be completed in a head-to-toe fashion. Begin by establishing the patient's level of consciousness by asking the patient to state his name, the day of the week, and his location. (If the patient stated his name when you identified him, there is no need to ask the patient to state his name again.)
7. Examine the pupils to determine if they are equal, round, and reactive to light and accommodation (PERRLA).
 - a) Inspect both pupils noting the shape of and size in millimeters. The pupils should be round and equal in size.
 - b) Inspect both pupils for reaction to light. Hold a penlight approximately 3 inches above and to the side of the patient's head. Slowly move the penlight in front of the patient's pupil area and then back to the side of the head. Observe the pupil for constriction and dilation. Repeat the procedure noting consensual light response, then repeat for the patient's other eye.
 - c) With the penlight turned off, inspect both pupils for accommodation by holding the penlight twelve to fifteen inches from the patient's nose and moving the penlight towards the patient's nose. Tell patient to keep eyes focused on the penlight. Do not touch the nose. Observe both eyes for constriction and convergence of the pupils.

8. Inspect the patient's ears, nose and throat.
 - a) Assess the ears for any abnormalities. If the patient is on oxygen via nasal cannula, it is very important to check behind the ears for irritation.
 - b) Observe the patient's nose for any abnormalities, noting any drainage or dryness.
 - c) Ask the patient to open his mouth and using the penlight examine for any abnormalities of the mucous membranes, tongue, and throat.
9. Auscultate the anterior breath sounds.
 - a) Adjust the patient's gown by untying the gown rather than unsnapping and drape chest from nipple level down with the gown. Be sure to keep the nipple area of the breast covered. Inspect skin and skin folds for any abnormalities.
 - b) Auscultate the upper chest from the clavicle to the upper levels of the breast. Place the stethoscope on the skin of the patient's upper chest and while listening, ask the patient to breathe deeply in and out of his mouth.
 - c) Move the stethoscope to a new auscultation site after each full inspiration and expiration. Progress from the upper lobes to the lower lobes, listening to the same lobe of both the right and left lung before proceeding downward bilaterally to the area above the breast.
 - d) Re-drape the patient's gown to expose the lower portion of the chest. Raise the gown from the bottom to the lower edge of the breast and adjust the blanket to the level of the abdomen. Provide privacy for the patient but have enough space to see the skin as you complete the auscultation of the lungs.
 - e) Auscultate the bilateral areas of the chest below the breast and mid-axillary spaces for any abnormal lung sounds.

Respiratory Specific Assessment

A respiratory assessment is performed if the patient has any current issues affecting the respiratory system or any new onset of respiratory distress. This includes pneumonia, bronchitis, emphysema, chronic obstructive pulmonary diseases (COPD), asthma, pulmonary embolism (PE), pulmonary effusion, congestive heart failure (CHF), lung cancer, or cystic fibrosis.

- Assess the patient's respiratory rate and oxygen saturation. Note if the patient is experiencing any SOB or dyspnea.
- If present, assess the type of oxygen delivery device in use as well as the amount of oxygen.
- Auscultate anterior and posterior bilateral breath sounds, noting any adventitious sounds.
- Ask if the patient has been experiencing a cough. If so, assess the frequency and aggravating factors.
- If the patient has a cough, ask, "Are you coughing anything up?"
- If the cough is productive, assess the color, consistency, and amount of sputum.

10. Auscultate the apical pulse (also known as the mitral valve) at the mid-clavicular line, left of the sternum, at the 5th ICS. Note the rate, rhythm, and any abnormalities (auscultate for one full minute if any abnormal heart rhythms or sounds are noted).

Cardiovascular Specific Assessment

If the patient has a history of or current cardiovascular problem such as: coronary artery disease (CAD), congestive heart failure (CHF), myocardial infarction (MI), angina, coronary artery bypass graft (CABG), stents, pacemaker, cardiac de-conditioning, atrial fibrillation, or any other arrhythmias heart sounds along with cardiovascular (CV) questions are needed.

Cardiovascular questions

Do you have any chest pain or any chest pressure? (*If pain or pressure is present, then radiation must be determined along with more specifics regarding the type and location of the pain or pressure.*)

Do you have any shortness of breath or nausea and vomiting?

Observe for any diaphoresis.

Heart sounds

Press lightly on each of the valve sites with the bell of the stethoscope. During auscultation, assess the rate, rhythm, and intensity. Note any murmurs.

Closure of the tricuspid and mitral valves create S1 (lub) and closure of the aortic and pulmonic valves create S2 (dub). Murmurs heard between S1 and S2 are systolic murmurs; murmurs heard after S2 are diastolic murmurs.

If heart sounds are indicated, then auscultate the upper heart sounds while upper portion of the chest is exposed.

Aortic—auscultate along the right sternal border at the 2nd intercostal space (ICS).

Pulmonic—auscultate along the left sternal border at the 2nd ICS.

The remaining heart sounds will be auscultated when the lower portion of the chest is exposed.

Erb's Point—auscultate along the left sternal border at the 3rd ICS.

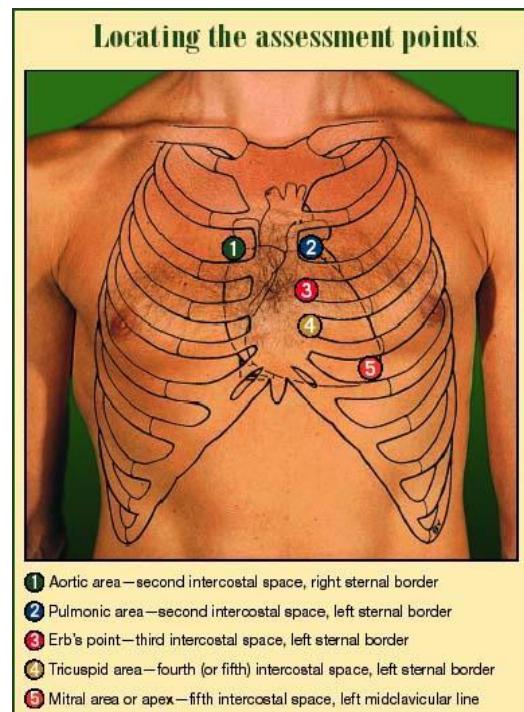
Tricuspid—auscultate along the left sternal border at the 4th ICS.

Mitral (Apical pulse)—auscultate at the mid-clavicular line, left of the sternum at the 5th ICS.

A mnemonic to help you to remember the heart sounds:

All People Eat Too Much

(Aortic, Pulmonic, Erb's point, Tricuspid, Mitral)



11. Examine and auscultate the abdomen.

- a) Adjust the patient's gown to expose the skin and contour of the abdomen.
- b) Inspect the skin and skin folds for any abnormalities.
- c) With the stethoscope auscultate for bowel sounds; if sounds are heard it is not necessary to auscultate all four quadrants.
- d) Ask the patient to tell you if there is any pain or tenderness when you press on the abdomen in all four quadrants. Allow the patient to respond before you ask further questions.
- e) Ask the patient, "When was your last bowel movement?" "Was it normal for you?"
- f) Palpate over the bladder for firmness, this will be done even if the patient has a urinary catheter inserted. Do not ask about pain or tenderness when palpating the bladder.
- g) If the patient has a catheter, inspect the tubing and the collection bag, noting the color and clarity of the urine in the tubing. Apply clean gloves before handling tubing.
- h) If the patient does not have a catheter ask the patient, "When did you last urinate?" "Did you notice if it was clear yellow?"

12. Reposition the patient's covers and gown to cover the patient.

13. Inspect the upper extremities bilaterally.

- a) Palpate radial pulses bilaterally, comparing pulse strength and quality.
- b) Inspect the capillary refill by lightly pressing the nail or pad of one finger from each hand, noting how long it takes for normal color to return. Return of color should take less than 2 seconds.
- c) Inspect the extremities for muscle wasting and strength. Inspect for skin turgor by gently pinching up the skin on the lower forearm, noting if tenting of the skin is present.
- d) Inspect the elbows for breakdown.
- e) Assess any IV sites for redness, edema, drainage, or tenderness. Also note if dressing covering the IV site is clean, dry, and intact.

Neurovascular Specific Assessment:

A neurovascular assessment is performed if the patient has any current issues affecting the peripheral nervous system. This includes fractures, joint injury or replacement, spinal surgeries, as well as arthritis.

- Pain: Ask the patient if he is experiencing any pain. Have the patient rate his pain on a scale of 0-10. Have patient describe characteristics.
- Pallor: Inspect the affected area for paleness.
- Pulses: Palpate pulses distal to the affected area.
- Paralysis: Ask the patient to move the extremity distal to the affected area. This could include wiggling toes or fingers.
- Paresthesia: Ask the patient if he is experiencing any numbness or tingling in the affected area. Touch the area and ask the patient if he can feel you touching him and if it is the same on both sides (unaffected and affected).
- Poikilothermia: Assess the skin for any coolness.

14. Examine the lower extremities.

- a) Make sure the patient is comfortable and go to the foot of the bed. Pull the covers to one side to expose the lower legs at least to the knees. Remove socks or SCD's. Inspect bilaterally for any obvious skin lesions, muscle wasting, or edema.
- b) Bilaterally palpate the posterior tibial (PT) and dorsalis pedis (DP) pulses in the feet.
- c) Inspect the capillary refill on one toe by pressing on the nail or pad slightly. Do not press so firmly to cause the patient pain.
- d) Assess for edema by pressing and holding for a few seconds on the top of the foot, the ankle area, and along the shin bone up to the knee.
- e) Assess the calf for any redness, pain, tenderness, warmth, or edema.
- f) Inspect the heels for breakdown.
- g) Reapply socks and SCD's. Return the covers to the proper position.

Neurological Specific Assessment

Note the patient's ability to move in the bed throughout the assessment. If the patient has a neurological problem or a history of neurological problems such as: cerebrovascular accident (CVA), transient ischemic attack (TIA), Guillain Barré syndrome, multiple sclerosis, altered mental status (AMS), syncope, or head injury then a basic motor neurological exam must be completed.

Patients at risk for a neurological problem should also have a neurological exam completed. Examples of patients at risk for a neurological problem would include all critical care patients, post CABG patients, a patient with atrial fibrillation, and a patient with critically low platelet levels.

Neurological questions

- Are you experiencing any numbness, tingling, or weakness?
- Are you experiencing any blurred vision?
- Have you been experiencing any altered balance or recent falls?
- Are you experiencing a sudden, severe headache with no known cause?
- Observe for slurred speech or a facial droop.

Basic neurological assessment

The basic neurological assessment includes five upper components and seven lower components:

Five upper components of the neurological assessment to be assessed bilaterally.

- Shoulder abduction: Ask the patient to abduct (move out) arms against resistance; the motion of "flapping wings".
- Hand grips: Ask patient to tightly grasp and squeeze your fingers with both hands.
- Bicep: Ask the patient to pull you towards him as you resist the effort.
- Tricep: Ask the patient to push you away from him as you resist the effort.
- Barré drift (Pronator drift): Ask patient to hold both arms, palms up, in front of him (as if holding a pizza) and close his eyes.

Seven lower components of the neurological assessment to be assessed bilaterally.

- Hip extension: Place your hand under patient's thigh with leg bent and ask him to lower the leg against resistance; repeat on opposite leg.
- Hip flexion: Place one hand under the patient's thigh (near the knee) and the other hand on top of the thigh and ask the patient to lift his thigh against resistance; Repeat on opposite leg.

- Knee extension: While patient's knee is bent, place one hand under the patient's knee and one on top of the shin and ask the patient to lift his leg up (as if to "kick a soccer ball") against resistance. Repeat on opposite leg.
- Knee flexion: While patient's knee is bent, support the leg under the knee with one hand and place the other hand under the patient's calf with his heel off the bed and ask him to lower the leg against resistance. Repeat on opposite leg.
- Dorsiflexion: Place your hands on top of the patient's feet and ask him to pull his toes back against resistance (as if "pointing toes towards head").
- Plantarflexion: Place your hands on the bottom of the patient's feet and ask him to push down against resistance (as if "stepping on a gas pedal").
- Babinski: Using a blunt object (such as a penlight) stroke the lateral aspect of the feet to the toes (making an upside-down "L") and note movement of toes. Plantar flexion or no movement is normal; dorsal flexion of great toe and fanning of other toes indicates upper motor neuron (UMN) problems.

If any abnormality is found with the basic motor neurological assessment, or any other obvious neurological deficits such as facial droop are noted, then the cranial nerves should be assessed. Cranial nerves I and IX are not routinely assessed at clinical.

Cranial Nerves

Mnemonic: On Old Olympus Towering Tops A Fin And German Viewed Some Hops.

For Sensory/Motor: Some Say Marry Money But My Brothers Say Bad Business Marry Money.

CN	CONTROLS	ASSESS
I-Olfactory	(S) smell	Identifying smells one nostril at a time
II-Optic	(S) vision	Read printed material; Identify number of fingers shown
III-Oculomotor	(M) pupillary constriction upper eyelid elevation	EOMs: inwards/upwards; down/outward eye movements
IV-Trochlear	(M) eye movement looking down towards nose	EOM: have pt to look at nose
V-Trigeminal	(B) (M) mastication, lateral jaw movement (S) sensation to corneas and facial skin	Pt clenches his teeth as examiner places hands on jaws Touch jaw line, cheeks, forehead
VI-Abducens	(M) lateral eye movement	EOM: look towards ear
VII-Facial	(B) (M) facial muscles (S) taste perception on anterior tongue and salivation of mouth and lacrimal duct.	Smile, frown, puff cheeks, raise eyebrows Not assessed
VIII-Acoustic	(S) auditory and equilibrium	Whisper; Weber & Rinne tests

		Romberg Test for balance
X-Glossopharyngeal	(B) (M) Swallowing, gag reflex	Tongue blade to back of throat: uvula and soft palate should lift symmetrically.
	(S) Sensation of throat taste for posterior tongue	Not assessed
X-Vagus	(B) Swallowing and voice production affects heart, stomach, bowel stimulation. slows heart (Valsalva maneuver) Stimulates HCL acid production in stomach	Swallow and talk
XI-Spinal Accessory	(M) Shoulder movement, neck, rotation & nodding of head	Have pt shrug/lift shoulders and turn head from side to side with resistance to examiner's hands on shoulders/face
XII-Hypoglossal	(M) Tongue movement	Ask patient to stick out tongue- it should be midline and not deviate to the side

15. Auscultate the posterior breath sounds.
- Ask the patient to either turn to one side or sit up. If the patient sits up in the bed for auscultation, it will be necessary to turn the patient to adequately assess the coccyx.
 - Separate the gown in the back or adjust clothes to expose the patient's back, while keeping the buttocks covered.
 - Inspect the skin for any abnormalities.
 - Auscultate the back bilaterally for breath sounds. Auscultate between the scapula and the spine until you reach the bottom of the scapula (do not listen over the scapula) and then listen to all the areas of the back for breath sounds, including the lateral aspects of the back. The right middle lobe of the lung is most easily auscultated in this position.
 - Return the gown or clothes to the proper position.
16. Apply clean gloves, inspect the sacrum, both hips, and ischial tuberosity areas. Assess reddened areas for blanching and tissue loss.
17. Reposition the patient in a comfortable position.
18. Remove gloves and discard.
19. Ask the patient if he is experiencing any pain. Have the patient rate his pain on a scale of 0-10. If the patient reports any pain, ask for further details (see mnemonic for "old carts" below):
- Onset
 - Location
 - Duration
 - Characteristics
 - Alleviating /aggravating factors

- f) Radiation
- g) Timing
- h) Severity

20. Complete any specific assessments and ask questions pertinent to the patient's diagnosis.

21. Assess all equipment.

22. Lower the bed level and raise the side rails. Wash hands.

All critical abnormal assessment findings should be reported to the appropriate personnel immediately.

A physical assessment should be completed in 10 minutes.

Pensacola Christian College Department of Nursing	January 8, 2014 Approval: 01/13/14
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Critical Care Nursing Note:

The note must include the typical physical assessment findings as well as documentation of critical care related findings and equipment as noted in the assessment below.

Procedure:

1. Neurological (Also see “Basic Neurological Assessment” in Procedure Manual). Some equipment you may document are:
 - a) Ventriculostomy and ICP monitoring
 - i) Assess the type of drain (Common type is Codman), as well as the location of the drain and the site condition.
 - ii) Is stopcock open to continuous drainage or to monitoring pressure only?
 - (1) May drain continuously (and still see pressure)
 - (2) May drain PRN when pressure rises above level set by the healthcare provider (HCP)
 - iii) Is the transducer level with tragus of the patient’s ear?
 - iv) Assess the mmHg or cmH₂O where drip chamber is placed which is usually around 10-15 mmHg.
 - v) Look at the monitor to obtain ICP value (normal: 0-10 with upper limit of 15).
 - vi) Calculate the CPP (cerebral perfusion pressure) which is obtain by subtracting the MAP from the ICP (CPP=MAP-ICP). The normal range is 60-100.
 - vii) A patient with an ICP monitor will have the HOB elevated (document level)
 - b) “Pressure only” ICP monitoring includes a subarachnoid screw (Camino Bolt) or an epidural catheter.
 - c) Bispectral Index (BIS) Monitoring – a type of “mini-EEG” that, via an electrode attached to the patient’s forehead, monitors the level of sedation on a scale of 0-100 (typically kept between 60-80).
 - i) 70-80 Moderate sedation
 - ii) 40-60 Deep sedation
 - iii) 10-20 Drug-induced coma (ex: barbituate coma)

Neurological Assessment for ICU

Observe the patient’s general condition. If the patient is not intubated or sedated, complete a normal neurological specific assessment.

If the patient is intubated, sedated, or otherwise impaired; you must still assess the patient’s level of consciousness, alertness, ability to follow commands, and movement in all 4 extremities.

If the patient is sedated, best practice is to complete a “sedation vacation.” To accomplish this, critical drips causing sedation are temporarily stopped so the neurological status can be assessed. Your instructor or the facility nurse must be present when you place your patient in a sedation vacation.

- . Assess level of consciousness and alertness— does the patient open his eyes spontaneously? To voice? To touch?
- . To assess ability to follow commands and movement in all 4 extremities, ask the patient to give you a thumbs up and to wiggle toes bilaterally.
 - a) If the patient does not follow commands, look for spontaneous movement in all extremities.
 - b) If the patient does not follow commands and is not moving, ascertain the reason. If the patient is on a neuromuscular blockade, has extensive trauma to the extremities, or is heavily sedated, you would not expect movement.
 - c) If there is no reason that the patient is not moving, use nail bed pressure to apply painful stimulus to all extremities. Observe the patient's response. Did the patient withdraw? Extend? Posture? Do nothing?

2. Cardiac

a) Pacemaker:

- i) For an internal pacer, the nurse will note the location and assess the site condition; settings (fixed or demand as well as rate) will be found in the patient's chart.
- ii) When assessing an external pacer, used most frequently after heart surgery, the nurse will note if the device is on or off and the location, as well as assess the site and settings {fixed or demand, rate, mA Output (nl: 2.5-5.0) and mV (nl: 0.5-20)}.

b) Telemetry Monitor:

- i) In analyzing a telemetry strip, the nurse will determine the rhythm, rate, and any abnormal findings (PVCs, BBB, etc.).
- ii) Verify that the monitor alarm(s) are on.
- iii) If artifacts (squiggly, fuzzy lines) are noted in the EKG, change the patient's electrodes as the electrode gel may be dried out.
- iv) ALWAYS watch the EKG rhythm on the monitor while you are auscultating heart sounds.

3. Hemodynamic

a) Pulmonary Artery (PA) Catheter (brand name: Swan-Ganz)

- i) The nurse will note the location and the placement of the PA catheter (documented in cm) at the site's entrance as well as the level of the transducer (should be at the phlebostatic axis (right atrium: 4th ICS/mid-axillary)).
- ii) The nurse will assess the site/dressing condition and obtain the pulmonary artery pressures (PAS, PAD, CVP, and Cardiac Output if done) from the monitor. One must note the condition of the PA waveform:
 - (1) Good
 - (2) Fair
 - (3) Dampened (poor). Possible reasons for this are:
 - (a) low body fluid volume
 - (b) pressure bag not tight or not enough fluid in bag
 - (c) loose connection
 - (d) may need irrigated

b) Arterial Line (A-line)

- i) An A-line is placed either in the radial or femoral artery by an anesthesiologist. If the radial artery is used he will determine if the patient has adequate collateral circulation to the distal portion of the arm by performing the Allen's test prior to inserting the line.
 - ii) The nurse will note the location and assess the site condition, dressing, neurovascular condition of the area distal to A-line, if the transducer is at phlebostatic axis (right atrium: 4th ICS/mid-axillary), the tightness of the pressure bag of NS to the line that ensures the line stays patent, correlation of A-line pressure reading with cuff pressure obtained (Intra-arterial pressures are usually at least 10 mmHg greater than cuff BP) and the pressure waveform:
 - (1) Good
 - (2) Fair
 - (3) Dampened (poor). Possible reasons for this are:
 - (a) low BP
 - (b) position of patient's wrist
 - (c) pressure bag not tight or not enough fluid in bag
 - (d) loose connection
 - (e) may need irrigated
 - iii) The student will only re-calibrate and zero the A-line with the patient's nurse (typically done at the beginning of the shift and every 4-8 hours)
 - iv) Remember to NEVER cover an A-line due to potential for bleeding
 - v) One must NEVER give medication through an A-line
- c) Intraaortic Balloon Pump (IAPB): An IABP is a counterpulsation device that assists during diastole (diastolic augmentation) to increase blood flow through coronary arteries and increases perfusion of myocardium and also decreases left ventricular workload (afterload). The balloon inflates during early diastole and deflates just prior to systole-timing is coordinated with the EKG. The nurse will assess:
- i) Site location (usually femoral artery) and condition (documentation same as for cardiac catheterization—no hematoma, etc.)
 - (1) HOB 15-20 degrees
 - (2) Affected leg must be kept straight
 - (3) Assess distal pulses and do neurovascular checks
 - (4) Assess for chest pain
 - ii) Timing of balloon augmentation (usually a ratio of 1:1, 1:2 or 1:3)
 - iii) Slippage of catheter resulting in occlusion of renal artery which will lead to a decrease in urinary output as well as flank pain
 - iv) Migration of catheter resulting in occlusion of left subclavian artery which leads to a diminished or absent left radial pulse and dizziness
 - v) Assess for additional complications of IABP which include: arterial embolism, rupture of aorta, perforation of iliac or femoral artery, infection and bleeding

4. Respiratory

- a) Ventilator (see explanation of ventilator information in NU 407 supplement on LR)
- i) Mode
 - (1) Synchronized Intermittent Mandatory Ventilation (SIMV)
 - (a) Not all breaths are assisted by ventilator.
 - (b) Preferred mode as patient uses his diaphragm more as he can breathe on his own and pull in his own TV in breaths that are not preset

- (c) Usually accompanied by Pressure Support (PS)
 - (2) Assist Control (AC)
 - (a) All breaths are assisted by ventilator but the patient can breathe more than rate entered but not any less than the rate entered into the ventilator.
 - (b) No Pressure Support (PS) entered separately as it is built in for this mode
 - (c) Preferred mode for sedated patients or critically-ill (ARDS)
 - (d) For both SIMV and AC: note settings (see below under “settings”)
 - (3) Pressure Regulated Volume Controlled (PRVC)
 - (a) A form of assist-control ventilation that delivers a fixed TV.
 - (i) Ventilator initiated (control breath)
 - (ii) Patient initiated (assist)
 - (b) A test breath is delivered.
 - (c) The pressure is then automatically adjusted (in response to lung compliance) to deliver the amount of pressure required for the patient to receive the set TV. *Pressure delivered is dependent on the tidal volume achieved with the last breath.
 - (d) Constant pressure is applied during inspiration (whether control or assist breath), resulting in improved oxygenation (inspiration times may also be adjusted by the ventilator).
 - (e) The ventilator monitors each breath, comparing delivered TV to set TV, and then adjusting the inspiratory pressure delivered on the next breath. The ventilator constantly monitors and adapts to the patient's needs.
 - (f) This setting is recommended for patients who need a consistent TV delivered with the minimum amount of pressure (ARDS patients).
 - (g) This setting is not recommended for patients with severe asthma or COPD (due to longer inspiratory times and higher risk of gas trapping).
 - (4) Continuous Positive Airway Pressure (CPAP)
 - (a) Assess FiO₂ and cm H₂O settings (patient breathes on his own--no rate or TV installed with this setting)
 - (b) Often the mode used for weaning the patient from the ventilator
- ii) Settings (Document in this order: TV-FiO₂-RR-PS-PEEP)
- (1) Tidal Volume (TV)
 - (2) Fraction of Inspired Oxygen (FiO₂)
 - (3) Respiratory Rate (as set by ventilator, not the patient's) (RR)
 - (4) Pressure Support (PS)
 - (5) Positive End Expiratory Pressure (PEEP)
- b) Endotracheal Tube (ETT) Assessment. An ETT can be placed either orally or nasally.
- i) The nurse will assess the size which is indicated on the end of the tube (typically an 8 for males and a 7 for females) and cm location mark on the tube (22-24 cm is common). The nurse must note if the ETT holder or bite block is secure, but not too tight or too loose around the patient's face.
 - ii) A Ballard suction device is typically used to suction a patient who has an ETT or even a trach. The device should be off when patient isn't being suctioned and the tubing must be kept above the patient's shoulder to prevent the patient from grabbing it and pulling out the ETT.
- c) BiPAP machine. The nurse needs to ensure the mask fits the patient properly (no air leakage) and document FiO₂, inspiratory and expiratory settings

- d) End tidal CO₂ monitoring (capnography). A capnography piece will be on the ETT. If the device is yellow, it indicates the presence of CO₂; if it is purple, it indicates low levels or no CO₂. Normal etCO₂ readings seen on the monitor will be 30-43 mmHg (2-4%).
- e) Tracheostomy. The nurse will note the size and type of trach (typical: #6 or #7 Shiley).
 - Assess the trach:
 - i) Site condition and type of drainage (if any)
 - ii) Amount, color and thickness of sputum (coughed up or suctioned)
 - iii) Cuff pressure (will have cuff if on ventilator). The cuff should feel slightly firm to pressure; normal pressure is 25-34 cmH₂O and it is checked once a shift by respiratory therapy
 - iv) Holder (secure and not too tight or too loose)
 - v) Is the trach to room air or attached to the ventilator or to a trach mask?
 - (1) Assess ventilator settings or oxygen setting of mask
 - (2) Assess oxygen saturation
- f) Chest Tube. Assess DR PD PADS
 - i) Device (type/brand name)
 - ii) Respiratory status: BBS, RR and O₂ saturation
 - iii) Patency: Look at the water seal chamber for tidaling
 - iv) Drainage collection chamber for amount, color and consistency; note where the level on the collection chamber was marked prior to your shift
 - v) Placement (anatomical location)
 - vi) Air leak: Look at the water seal chamber for bubbling (none, intermittent, or continuous); palpate for subcutaneous emphysema especially in trauma patients with chest injuries
 - vii) Dressing condition; the dressing needs to be occlusive
 - viii) Suction chamber for amount of suction (negative number)
- g) Cardiopat
 - i) The CardioPat system is a type of chest tube that allows for the collection and return transfusion of blood for patients who have excessive bleeding after surgery. It is normally used in patients after open heart surgery.
 - ii) Assess the site and tubing of a CardioPat chest tube exactly as you would assess a normal chest tube.
 - (1) The dressing around the insertion site should be an occlusive dressing.
 - (2) Observe the color and characteristics of the drainage in the tubing.
 - iii) The CardioPat includes an electronic screen that shows the following:
 - (1) The total amount of drainage
 - (2) Hourly drainage amounts
 - (3) The length of time the chest tube has been in place
 - (4) The amount of suction in cmH₂O

5. Critical Drips

- a) Go into patient's room after report and get critical drip information and calculate before performing head-to-toe assessment.
 - i) Medication, amount, solution, rate, concentration (calculate this) and where it is infusing
 - ii) Example: Dopamine 400 mg in 250 mL D₅W infusing at 15 mL/hr (8 mcg/kg/hr) into proximal injectable port (jagged) of triple lumen catheter (TLC)

- b) Calculate the safe dosage amount or range for each critical drip and compare to the drug book information. For example: Dopamine maximum safe dosage is 20 mcg.
6. Wound Vac. Assess the site and dressing condition, drainage information and suction amount (i.e. 125 mmHg). Note: If a whistling sound is heard, the dressing may not be sealed or intact and you may need to reinforce it. If you cannot identify the source of the leak, call the Wound Ostomy Certified Nurse at the facility.

Sources Used:

Tobias, J. 2010. "Conventional mechanical ventilation." *Saudi Journal of Anaesthesia* 4, no.2:86-98. Accessed January 2014. <http://dx.doi.org/10.410>.

Procedure Manual

Physical Assessment (Mental Health Assessment)

Pensacola Christian College
Department of Nursing

January 19, 2007
Approval: 01/06/14

Procedure:

1. General Description: Observe patient during assessment for the following general description:
 - a) Appearance: grooming, hygiene, posture, appears stated age
 - b) Motor Activity: tremors, tics, mannerisms, gestures, gait
 - c) Speech Patterns: rate (pressured), tone, volume, stuttering, aphasia
 - d) Eye Contact: appropriate, staring, none
 - e) Normal: "Patient awake and in dining room eating breakfast. Appears stated age of 50. Has attended to ADL's and hygiene aeb hair well-groomed and clothes clean and neat. Movements smooth and coordinated. Quick verbal responses to questions. Cooperative and interested in conversation. Maintains appropriate eye contact."
2. Emotions
 - a) Ask patient "What is your mood?"
 - i) Examples: angry, frustrated, happy, sad, depressed, excited, anxious
 - ii) Clarify mood if patient states: "good" "fair" "okay" "fine"
 - b) Observe patient's affect (facial expressions)
 - i) Is it congruent with patient's stated mood?
 - ii) If it is incongruent, describe the patient's affect.
 - iii) Examples:
 - (1) Blunt/Constricted (minimal emotion)
 - (2) Flat (expressionless)
 - (3) Inappropriate (does not match situation)
 - c) Normal: "States mood is 'happy.' Congruent affect."
3. Thought Processes: Observe patient's conversation
 - a) Form of Thought (the pattern of the patient's thinking)
 - i) Clang Associations
 - ii) Circumstantiality
 - iii) Flight of Ideas
 - iv) Tangentiality
 - b) Content of Thought (what the patient is thinking about)
 - i) Delusions: persecutory, jealous, erotomanic, somatic, grandiose
 - (1) Re-orient patient to reality
 - (2) Do not go into a delusion with the patient
 - ii) Obsessions: religiosity
 - iii) Paranoid
 - iv) Phobias
 - c) A comprehensive list of terms can be found in the psych handbook.
 - d) Normal: "Thoughts logical and connected aeb ability to carry on logical conversation and appropriate responses to questions."
4. Perceptual Disturbances: Only assess if patient has a history

- a) Can be any of the 5 senses (visual, auditory, tactile, gustatory, olfactory)
 - b) Categories
 - i) Hallucinations (experiencing something that is not really there)
 - ~ Are you hearing any voices?
 - ~ What are the voices saying?
 - (Only refer to auditory hallucinations as “the voices”)
 - ii) Illusions (misperception or a change to reality)
 - ~ I believe the vent looks like a spider to you; but in reality, it is a vent.
 - c) Observe patient for any signs of responding to internal stimuli:
 - i) Listening Pose: head tilted to one side
 - ii) Patient speaking/mumbling to self
 - d) Normal: “No history of perceptual disturbances.”
5. Cognition (You must know the answer to the questions you are asking.)
- a) Alertness and Orientation: Ask patient to state name, place, time (usually done at beginning of assessment when you properly identify patient)
 - b) Determine if the following cognitive areas are “intact” or “poor”:
 - i) Recent Memory: Ask patient about something that happened today
 - i.e. Recall the three words mentioned at the beginning of the conversation.
 - ii) Remote Memory: Ask patient about something that happened months/years in the past
 - i.e. List the last three Presidents; What national holiday is in February?
 - iii) Abstract Thought: Ask patient to interpret a proverb (Do not assess with children.)
 - i.e. What does this mean: You can’t judge a book by its cover.
 - iv) Judgment: Present an everyday problem and ask patient to solve it
 - i.e. What would you do if you walked out of the mall and couldn’t find your car?
 - v) Insight: Ask patient what led to admission to facility (see if patient accepts responsibility)
 - vi) Concentration: Ask patient to focus on a mental task
 - i.e. Count backwards from 100 by 7’s; State the months of the year backwards
 - c) Normal: “A&O x 3. Recent memory intact aeb ability to recall SN’s name ‘Emily’ as given at the beginning of the conversation. Remote memory intact aeb ability to recall that ‘Alaska’ is a cold state. Insight intact aeb states in hospital due to ‘wanting to harm myself.’ Judgment intact aeb states if having thoughts of self-harm in the future will ‘talk to a friend instead of hurting myself.’ Abstract thought intact aeb correct interpretation of proverb ‘Every cloud has a silver lining.’ States it means ‘you can find some good in every situation.’ Concentration intact aeb ability to count backward from 100 by 7’s.”
6. Thoughts of Self-Harm
- a) Ask: “Are you currently having thoughts of harm to yourself or others?”
 - i) If “yes” ask “Do you have a plan?”
 - ii) If “yes” to either of the above questions, report it to the instructor and facility RN.
 - iii) If the patient has a plan, do NOT leave them alone, send someone else to notify the RN.
 - b) Contract for Safety: “If you have thoughts of harming yourself or others, will you agree to tell the staff?” — If “no” report it to the instructor and facility RN.
 - c) Normal: “Denies thoughts of self harm at this time. Agrees to notify staff if having thoughts of harm to self or others.”

7. Safety
 - a) Notify RN if there are obstacles to patient's safety.
 - b) Keep environment free from harmful objects.
 - c) Monitor every 15 minutes and PRN.
 - d) Normal: "Environment free from harmful objects. Will monitor every 15 minutes and PRN."
8. Physical Condition(s)
 - a) Read through patient's treatment plan, nursing shift report, and MAR.
 - b) Determine what physical issues are currently relevant.
 - i) Complete the appropriate specific assessment and document on all active problems, such as:
 - (1) Cuts (skin/dressings)
 - (2) Withdrawal symptoms (drug/alcohol abuse)
 - (3) Active medical problem (e.g. UTI, asthma, seizures, COPD, etc.)
 - (4) Recent hospitalizations
 - ii) Assess and document on all recent issues addressed in the nursing shift report (e.g. pain).
 - iii) Document on all diseases/conditions for which the patient is being medicated. (e.g. If a patient has a history of asthma and is on an inhaler, you would need to address the respiratory system, even if the patient is not currently exhibiting signs and symptoms.)
 - (1) If the patient is not exhibiting signs and symptoms, simply document that.
 - (2) If the patient is exhibiting signs and symptoms, complete a specific assessment on the appropriate body system and document the findings.
 - c) Normal: See "Documentation Guidelines"

Include as many direct patient quotes as possible to increase validity of documentation.

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Supplies Needed:

Clean gloves
Stethoscope
Ophthalmoscope
Alcohol Swabs

Keep the infant warm and covered as much as possible during assessment. Wear gloves during entire assessment if infant has not had first bath.

Procedure:

1. Know infant's Birth History (C-Section, Narcotics, Trauma, etc.)
2. Safety:
 - a) Verify security band is intact to ankle and document number.
 - b) Ensure bulb syringe is in bassinette.
3. General Appearance:
 - a) Flexed, Extremities (offer resistance) vs. Hypotonic
 - b) Prominent abdomen and rounded chest
 - c) Large Head - MAEW – Alert – Tremors
 - d) Cry (High-Pitched)
4. Obtain Heart Rate (Apical for 1 minute) and Lung sounds while infant is quiet.
 - a) Apical Pulse (Murmur) = 120-160 (up to 180 if crying)
 - b) Respiratory rate = 30-60 (for 1 minute)
 - c) BP = 60-80/40-45 (at birth) and 100/50 (by 10th day)
5. Skin (The skin should be assessed as you examine the baby in the normal head-to-toe fashion.)
 - a) Ruddy
 - b) Jaundice (Icterus)
 - c) Mottling
 - d) Bruising/Petechiae
 - e) Turgor (abd.)
 - f) Acrocyanosis
 - g) Milia
 - h) Erythema toxicum (newborn rash)
 - i) Mongolian spots (fade by 1-2 yrs.)

- j) Nevi (Birth Marks):
 - i) Hemangiomas
 - (1) Flat
 - (a) Stork bites (Salmon patches) = telangiectatic nevi (usually fade as child grows)
 - (b) Port-Wine Stain = Nevus Flammeus (More Permanent)
 - (2) Raised
 - (a) Strawberry Mark = Nevus Vasculosus (Grows until 8 months then shrinks and is gone by 7 yrs.)
 - k) Café au lait spots (Neurofibromatosis)
 - l) Meconium staining
 - m) Vernix
 - n) Peeling
 - o) Lanugo
 - p) Harlequin sign

6. Head

- a) 1/4th size of body – Measure OFC (33-35 cm.) and plot on percentile graph
- b) Molding
- c) Fontanelles (should feel soft and flat):
 - i) Anterior
 - ii) Posterior
 - iii) Bulging or Sunken
- d) Cephalhematoma
- e) Caput Succedaneum

7. Face

- a) Symmetry (Facial or Cranial Nerve Palsy)
- b) Low set ears/flat
- c) Preauricular skin tags or fistulas
- d) Hearing
- e) Intact Palate (Hard & Soft) – wear clean gloves
- f) Thrush (Candida albicans)
- g) Patent Nostrils (choanal atresia) – (obligatory nose breathers)
- h) Precocious teeth
- i) Sucking reflex – wear clean gloves
- j) Rooting reflex
- k) Epstein pearls
- l) Eye Color (blue/gray in Caucasian up to 3 months and black/brown in dark-skinned)
- m) Reaction of pupils to light
- n) Red reflex (Cataracts if absent) – use ophthalmoscope
- o) Drainage
- p) Subconjunctival hemorrhages in sclera
- q) Strabismus (normal up to 3-6 months)
- r) Nystagmus (normal up to 3-6 months)
- s) Brushfield spots
- t) Sneezing reflex

- u) Dysmorphic (abnormal or asymmetrical) features
 - v) Rhinorrhea
8. Neck
- a) Short (webbed = Turner's Syndrome)
 - b) Rigid (Torticollis – Sternocleidomastoid muscle)
 - c) Head lag up to 45 degrees until head control at 3 months (cervical curve)
 - d) Check clavicles for crackling or lumps (fracture)
9. Hands and Feet
- a) MAEW (Brachial Palsy)
 - b) Syndactaly
 - c) Polydactaly
 - d) Palmar creases (Simian line)
 - e) Short fingers
 - f) Club foot (talipes)
 - g) Grasp reflex (palmar and plantar)
 - h) Babinski (normal up to 12-18 months)
10. Chest
- a) Respiratory distress
 - i) See-Saw Respirations
 - ii) Retractions (sub-xiphoid, sub-sternal, or intercostal)
 - iii) Nasal flaring
 - iv) Tachypnea
 - v) Central Cyanosis
 - vi) Grunting
 - b) Measure circumference (approximately 2 cm smaller than head) = 31-33 cm
 - c) Breast engorgement or discharge
 - d) Supernumerary nipples
 - e) Frequent suction with bulb syringe immediately after birth, especially C-section
11. Abdomen
- a) Slightly prominent (not distended or scaphoid)
 - b) Bowel sounds
 - c) Palpate for masses:
 - i) Wilms tumor
 - ii) Neuroblastoma
 - iii) Polycystic kidney
 - d) Umbilicus
 - i) # of vessels = 3
 - ii) Moist/Dry
 - iii) Bleeding
 - iv) Foul odor
 - v) Hernia
 - vi) Keep dry and use alcohol
 - vii) Do not immerse in water—Sponge bath until cord falls off
 - viii) Falls off by 7-10 days

- e) Groin
 - i) Inguinal hernia (mass—especially when crying)
 - ii) Femoral and brachial pulses (coarctation of aorta?)
- f) Omphalocele
- g) Gastrochisis
- h) Hepatosplenomegaly (HSM)

12. Genitalia – wear clean gloves

- a) Female
 - i) Smegma = Thick; cheesy
 - ii) Smooth, white, thin discharge = Pseudomenstruation (hormonal)
 - iii) Clean front to back
 - iv) Labia majora covering labia minora
 - v) Skin tags (Hymen)
- b) Male
 - i) Check Circumcision (leave gauze dressing intact)
 - (1) Red
 - (2) Drainage
 - (3) Bleeding
 - ii) Placement of urethral orifice
 - (1) Hypospadias
 - (2) Epispadias
 - iii) Phimosis
 - iv) Ambiguity
 - v) Hydrocele
 - vi) Undescended testes (Cryptorchidism)
- c) Diaper rash

13. Hips and Legs

- a) Check for hip click:
 - i) Barlow's maneuver
 - ii) Ortoloni's maneuver
 - iii) Abduct
- b) Check femur leg length—look for extra creases in skin folds of legs
- c) Legs look bowed

14. Back

- a) Pilonidal dimple or hair tuft (nevus pilosus) at base of spine?
- b) Trunk Incursion Reflex
 - i) Prone – stroking one side of spine causes pelvis to turn to stimulated side
- c) Spinal curve
- d) Normal anus (imperforate or fissures)

15. Other Reflexes

- a) Moro (up to 4-6 months; absent or prolonged or asymmetrical)
- b) Stepping (Disappears at 4-5 mo.)
- c) Tonic Neck/Fencing (up to 3-4 mo.)
- d) Doll's eyes (up to 10 days)

- e) Rooting
- f) Sucking
- g) Grasp
- h) Babinski

Newborn Admission Assessment

1. Get Report – Put on gloves – Check I.D. Bands
2. Place in warm overhead radiant warmer with hat on
3. Suction frequently
4. Observe for respiratory distress
5. Obtain V.S. (except BP can wait a while) – Try to get apical pulse and respirations while quiet (before temperature). A rectal temperature (rather than axillary) is frequently obtained for the first time (Check Hospital Policy) – Check for anal patency
6. Obtain Weight – Remove all clothing and diaper.
7. Measure Occipital Frontal Circumference (OFC) and Chest Circumference
8. Measure length
9. Give I.M. medications (Vitamin K; Hepatitis B) and eye medication (Ilyotycin ointment)
10. Do Dextrostix if indicated (LGA; SGA; peeling/postmature; Maternal Hx. of diabetes); abnormal is < 50
11. Do complete physical and gestational assessments
12. Place infant on side with ICS radiant warmer probe affixed (by adhesive decal) to abdomen radiant heater set at 37°C (or according to hospital policy).
13. Remove gloves and wash hands.
14. Assess and chart on infant admission sheet hourly (for 6 hours).

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Supplies Needed:

Clean gloves
Stethoscope
Alcohol Swabs
Penlight

Instruct patient to empty bladder prior to assessment.

Procedure:

1. Preliminary Assessment
 - a) Vital signs
 - b) Emotional status and pain assessment
 - c) Neurological status—alert and oriented/PERRLA
 - d) EENT
 - e) Breath sounds and apical pulse
 - f) I.V. and/or other equipment if present
2. Breasts (wear clean gloves if drainage is present)
 - a) Is patient wearing a bra? (If not, remind her of the importance.)
 - b) Complaints of pain or warmth?
 - c) Soft (supple); Firm (milk coming in); or Hard (engorgement)
 - d) Cracks or Fissures of Nipples; Blisters
 - e) Inverted or Flat nipples
 - f) Any localized areas of redness, hardness, or excessive warmth?
3. Uterus/Abdomen
 - a) Auscultate bowel sounds and gently palpate abdomen (including bladder area)
 - b) Palpate height and position of uterine fundus—Is it midline? Above or below umbilicus (# of cm)? Firm or boggy? (HOB must be low and bladder should be empty for an accurate assessment of the fundus.)
 - c) Diastasis Recti muscle—split?
 - d) Assess C-Section incision if present—OREEDA (odor, redness, edema, ecchymosis, drainage, approximation); staples, sutures, or steri-strips
4. Bowel and Bladder
 - a) Investigate last bowel movement and teach about constipation prevention
 - b) Assess frequency and amount of voiding—Any complaints of burning (dysuria) or foul smell?
 - c) Assess indwelling urinary catheter if present—characteristics of urine—cloudy or sediment.
 - d) Encourage increased fluid intake.

5. Legs
 - a) Edema—Pitting? How far up leg? Bilateral or unilateral? Thigh? Face? Hands?
 - b) Assess for redness, streaks, excess warmth, pain, or hard veins.
 - c) Signs of thrombophlebitis?—Do not massage legs.
 - d) Note presence of antiembolic stockings (TED) or Sequential Compression Devices (SCDs; also called Plexi-Pulses or ALPs)—remove these to assess extremities and then reapply them.
 - e) Pedal pulses

6. Lochia
 - a) Note: Have patient turn on side and assess: (Remember to wear clean gloves)—Color? (rubra; serosa; alba); Amount? (scant; small; moderate; large); Presence of clots or placental tissue? (size); Foul smell?
 - b) If bleeding is excessive, have patient turn onto back and reassess position and firmness of fundus. If the fundus is boggy, massage while observing lochia for expression of clots. Ask re: last voiding. May need to start doing a pad count if excessive bleeding noted. Check about need for PRN medication (i.e. Methergine).
 - c) Ask patient how often she has been changing her pads and inquire about the saturation amount of the last pad change.

Should listen to posterior BBS and check back skin integrity before assessing perineum.

7. Episiotomy (Perineum)
 - a) If patient had a C-Section, this assessment may be skipped unless patient complains of hemorrhoids.
 - b) Assess episiotomy or lacerations for REEDA. “Intact perineum” = No episiotomy or lacerations present.
 - c) Assess perineum for hematoma formation (bulging, bruising, pain, or complaints of rectal pressure).
 - d) Assess hemorrhoids: Number, Size, Discomfort (Teach re: Comfort measures and medications)

B = Breasts

U = Uterus

B = Bowel

B = Bladder

L = Lochia

E = Episiotomy

H = Hemorrhoids

A = Attachment (Bonding between mom/baby)

E = Emotional Status

Include teaching throughout the assessment, if mom is receptive (Examples: Wearing bra-Breast feeding-Engorgement-Deep Breathing-Constipation-Signs of infection or excessive bleeding-Kegel exercises-Relief of Perineal Pain-Nutrition-Return of Menstrual Cycle and Fertility-Signs of Thrombophlebitis-Need for Rest-P.P. “Baby Blues”).

Assess need for Rubella vaccine (if “Rubella non-immune”) or Rhogam injection (if Rh negative) and know your patient’s allergies. This information can be gathered from report or from the chart.

Check your patient’s lab results in chart (may only be in the computer chart).

Assessment of Complicated Pregnancies (Antepartum/Postpartum)

When caring for mothers with the following complications of pregnancy, include these additional assessments along with those routinely performed. If you are unfamiliar with the care of a mother with these problems, please ask the instructor about extra charting/paperwork that goes along with these assessments.

1. Pregnancy Induced Hypertension (PIH)
 - a) Deep tendon reflexes and clonus
 - b) Urine protein levels
 - c) Edema (especially of hands and face) and weight changes
 - d) Blood pressure (monitor closely)
 - e) Muscle twitching (onset of seizures)
 - f) Lung sounds for congestion (pulmonary edema)
 - g) Urine output (oliguria)
 - h) Level of consciousness and orientation with neuro assessment being very important
 - i) Complaints of the following symptoms: severe headache; epigastric pain; visual disturbances; nausea and vomiting; and bleeding.
2. Gestational Diabetes or Diabetes Mellitus
 - a) Blood glucose results (Accucheck)
 - b) Urine ketones
 - c) Polyuria; polydypsia; polyphagia
 - d) Dehydration
 - e) Yeast infections (Monilia)
 - f) Hyperglycemia—look up S&S
 - g) Hypoglycemia (if on insulin)—look up S&S
3. Pre-Term Labor
 - a) Contractions (repetitive pains in lower abdomen or back)
 - b) Leaking of vaginal fluid or blood
 - c) Fetal heart tones—via Doppler or external monitor
 - d) Fetal movement
 - e) Non stress test (NST) results
 - f) Thrombophlebitis
 - g) Signs or symptoms of UTI (dysuria, foul odor, suprapubic pain)
 - h) Signs or symptoms of PIH or Diabetes

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Supplies Needed:

Restraint (vest, limb, mitt, or belt)
Padding for bony prominences, if needed
Restraint flow sheet

Procedure:

1. Make sure less restrictive alternative measures have been attempted before applying restraints. Choose the restraint type that is least restrictive to the patient. Criteria for using restraints in the acute medical area include the following:
 - a) Patient is confused or disoriented or otherwise unable to follow instructions after alternative measures have been attempted, and one or more of the following:
 - b) Patient persists in efforts to disconnect medical equipment or essential medical devices.
 - c) Patient is thrashing his extremities about in a manner that could result in injury.
 - d) Patient is disturbing surgical/wound dressings in a manner that could compromise healing or promote infection.
 - e) Patient is climbing over side rails.
2. Verify healthcare provider's order has been written, based on assessment and documentation that other measures are ineffective to protect the patient and others. This order cannot be PRN or a standing order. The order must include the rationale for the restraint, the length of time and the type of restraint to be used and the extremity or body part(s) to be restrained. The nurse must obtain a verbal or written order with 12 hours of restraint application if the healthcare provider is not available to personally write the order.
3. Obtain adequate assistance to apply the restraint.
4. Explain the need for restraints for the patient, and inform him of the conditions necessary for his release from restraints. Assure him that they are being used to protect him from injury, not to punish him. Clarify how care will be provided while the restraints are in place.
5. Wash hands.
6. Assure that restraint chosen is correct size for the intended use.

Applying a vest restraint:

1. Assist the patient to a sitting position, if condition permits. Slip the vest over the patient's gown. Crisscross the flaps at the front, placing the V-shaped opening over the patient's chest.

Never crisscross the flaps in the back because this may cause the patient to choke if he tries to squirm out of the vest.

2. Pass the tab on one flap through the slot on the opposite flap. Then adjust the vest for the patient's comfort. You should be able to slip your fist between the vest and the patient. Wrapping the vest too tightly may restrict respiration.
3. Tie restraints securely to the frame of the bed, chair, or wheelchair and out of the patient's reach. Use a slip knot that can be released quickly and easily in an emergency. Never tie a regular knot to secure the straps. Leave 1" to 2" of slack in the straps to allow room for movement.
4. For a bed, be sure to tie the restraint to the bed frame, usually there are holes provided to thread the restraint through.

Never secure restraints to the lower portion of the frame of the bed or the side rail, since raising the bed or moving the side rails could inadvertently tug on the patient's body and cause trauma.

5. For a wheelchair, drop the restraints through the gap between the back and the bottom of the seat. Then tie the restraints to the posts at the base of the chair, near the wheel axles.
6. For a chair, put the restraint ties through the space between the back and bottom of the chair. Tie restraint to the back legs of the chair.
7. After applying the vest, check the patient's respiratory rate and breath sounds regularly. Be alert for signs of respiratory distress. Also, make sure the vest hasn't tightened with the patient's movement. Loosen the vest frequently, if possible, so the patient can stretch, turn, and breathe deeply.

Applying a limb restraint:

1. Assess the skin and circulation to the extremity that will have a restraint applied. Determine if extra padding is required due to the nearness (proximally) of an IV or previous skin injury.
2. Wrap patient's wrist or ankle with a padded restraint.
3. Pass the strap on the narrow end of the restraint through the slot in the broad end, and adjust for a snug fit, or fasten the buckle or hook-and-loop cuffs to fit the restraint. You should be able to slip one or two fingers between the restraint and the patient's skin. Avoid applying the restraint too tightly because it may impair circulation distal to the restraint.
4. Tie the restraint as described previously. Maintain the extremity in the slightly flexed, normal anatomic position. Affix arm restraints to the bed below the patient's waist level and ankle restraints to the bed below the patient's knee level.
5. After applying the limb restraints, be alert for signs of impaired circulation, movement, or sensation in the restrained extremity. If the skin appears blue or feels cold or if the patient complains of a tingling sensation or numbness, loosen the restraint. Perform range-of-motion exercises regularly to stimulate circulation and prevent contractures.

Applying a mitt restraint:

1. Place a rolled-up a washcloth or gauze pad in the patient's palm. Have him form a loose fist, if possible; then pull the mitt over the hand and secure the closure.
2. To restrict the patient's arm movement, attach the strap to the mitt and tie it securely (see #3 above), using a slip knot that can be released quickly and easily in an emergency.
3. When using mitts made of transparent mesh, check hand movement and skin color frequently to assess circulation.
4. Remove the mitts regularly to stimulate circulation, and perform passive ROM exercises to prevent contractures.

Applying a belt restraint:

1. Center the flannel pad of the belt on the bed. Then wrap the short strap of the belt around the side of the bed fasten it to the bed frame.
2. Position the patient on the pad. Then have him roll slightly to one side while you guide the long straps around his waist and through the slot in the pad.
3. Wrap the long strap around the side of the bed and fasten it to the bed frame.
4. After applying the belt, slip your hand between the patient and the belt to ensure a secure but comfortable fit. The belt is too loose if it can be raised to chest level; a belt that is too tight can cause abdominal discomfort.

Applying an elbow restraint (pediatrics):

1. Wrap the elbow restraints snugly around each elbow with an equal amount of the restraint material above and below the joint. (Some types may initially slide onto the arm prior to tightening.) The restraint should not rub against the child's axilla or wrist. Be sure that the restraint is padded and not applied too tightly.
2. Secure the restraint to the elbow area with the appropriate pins, tape, or ties to prevent its slipping down the extremity.
3. Provide the child with diversional activities.

After restraint application:

1. Assure call light is within easy reach. Return bed level and side rails to the safest positions.
2. Wash hands.
3. If the patient is in restraints for behavioral management, provide for continuous patient monitoring in which a designated person can directly observe the patient at all times.
4. Assess and assist the restrained patient at least every 2 hours (for medical/surgical restraints) or every 15 minutes (for behavioral management restraints) to assure safety. Monitor for injuries

caused by the restraint, as well as nutrition, hydration, circulation, ROM, physical, hygiene, and psychosocial needs. Assess the patient's readiness for restraint discontinuation.

5. Release the restraint and provide ROM of the affected area, elimination, hygiene and other needs at least every 2 hours.
6. Within 12 hours of placing a patient in acute medical/surgical restraints (1 hour of placing a patient in behavioral management restraints), the patient should be evaluated by a healthcare provider and an order written for restraints. If restraints are still necessary, obtain an order to renew restraints every 24 hours for acute medical/surgical restraints (4 hours for behavioral management restraints). If a patient requires the use of restraints for at least 2 separate episodes in a 24-hour period, the chief medical officer or chief executive officer must be notified.
7. If the patient has consented to have his family informed of his care, notify them of the use of restraints.

Documentation:

1. Document each episode of restraint use, including date and time initiated. Document the condition of the area prior to restraint application, i.e. circulation, skin intactness, etc.
2. Record the circumstances that required restraint use and include alternative interventions that were attempted first. Describe why the type of restraint chosen was used.
3. Chart the name of the healthcare provider who ordered the restraint. Include the conditions or behaviors necessary to discontinue the restraint and whether these conditions were communicated to the patient.
4. Document each in-person evaluation by the healthcare provider who ordered the restraints.
5. Record on the restraint flow sheet every assessment of the patient, including injuries caused by the restraint, nutrition, hydration, circulation, ROM, physical, psychosocial, and hygiene status and readiness to have restraints discontinued. Assessments must be done every 2 hours (for acute medical/surgical restraints) or every 15 minutes (for behavioral management restraints).
6. Record your interventions to help the patient meet the conditions for removing restraints. Note the frequency that the patient was monitored.
7. Document any injuries or complications, the time and name of the healthcare provider notified of your interventions, and your actions.

Special considerations:

1. If the patient is at risk for aspiration, restrain him on his side. Never secure all limb restraints to one side of the bed, because the patient may fall out of bed.
2. When loosening restraints, a coworker may be needed to manually restrain the patient.
3. Do not apply a limb restraint above an I.V. site because this restriction may occlude the infusion and cause infiltration into the tissues.

4. Never secure restraints to the side rail or the fixed, lower portion of the frame of the bed, since moving the side rails or raising the bed could inadvertently pull on the patient's body and cause trauma.
5. Use of restraints can affect circulation and skin condition, and may lead to pneumonia, urine retention, constipation, and sensory deprivation as a result of long term immobility. Reposition the patient, monitor circulation and bony prominences, and use restraints for as short a term as possible.
6. When restraints are used for behavioral management, they must be assessed and documentation completed at least every 15 minutes instead of every 2 hours.

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Pensacola Christian College
Department of Nursing

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Supplies Needed:

Clean gloves
Cleaning solution
4x4 gauze
Staple or suture removal kit

Procedure: Staple Removal

1. Verify the healthcare provider's orders, note whether every staple or every other staple is to be removed. Also check the order for cleaning solution preferred by the doctor and if steri-strips are to be applied.
2. Wash hands, and gather equipment.
3. Explain the procedure to the patient.
4. Apply clean gloves, provide privacy, raise the bed level and lower the side rails.
5. After exposing the incision site, insert the tip of the staple remover under the first staple. If all staples are to be removed, begin by removing every other staple, so that you are able to check for wound approximation. If the wound starts to separate, stop the procedure and notify the healthcare provider.
6. Once the staple remover has been stabilized under the center of the staple, slowly and completely close the ends of the staple remover. This squeezes the center of the staple and frees the staple from the skin.

Do not lift the staple remover up as you are squeezing, this may cause the skin to tear and cause pain.

7. Once all the ordered staples have been removed, open the 4x4 gauze. Pick the gauze up by the four corners to form a swab.
8. Holding the 4x4 gauze over the trash can, pour the preferred cleaning solution over the swab.
9. Using the moistened gauze, cleanse the incision from top to bottom. Discard the gauze in the trash can.

Small gaps in the staple line can be approximated with the use of steri-strips.

10. Lower the bed level and raise the side rails.

11. Discard the staple remover in the sharps container and all other supplies in the trash can.
12. Remove gloves and wash hands.
13. Document the procedure in the patient's chart. Include the location of the incision, the number of staples that were removed, and the condition of the incision site.
Example: Ten midline abdominal skin staples removed without difficulty. Incision dry and edges approximated without redness, edema, or pain. Incision cleansed with normal saline and left open to air.

Procedure: Suture Removal

1. Verify the healthcare provider's orders, note whether every suture or every other suture is to be removed. Also check the order for the cleaning solution preferred by the healthcare provider and if steri-strips are to be applied.
 2. Wash hands and gather equipment.
 3. Explain the procedure to the patient.
 4. Apply clean gloves, provide privacy, raise the bed level and lower the side rails.
 5. After exposing the incision site, use the forceps in the suture removal kit to grasp the suture at the knot.
 6. Place the curved tip of the suture removal scissors under the suture, as close to the skin as possible, and on either side of the knot, but not through the knot.
 7. Cut the suture as close to the skin as possible, and pull the suture out with the forceps. The visible part of the suture should never be pulled underneath the skin, as an infection could result.
 8. Inspect the removed suture to make sure that none has been left behind in the skin.
 9. If all sutures are to be removed, begin by removing every other suture, so that you are able to check for wound approximation. If the wound starts to separate, stop the procedure and notify the healthcare provider.
 10. Once all the ordered sutures have been removed, open the 4x4 gauze. Pick the gauze up by the four corners to form a swab.
 11. Holding the 4x4 gauze over the trash can, pour the preferred cleaning solution over the swab.
 12. Using the moistened gauze, cleanse the incision from top to bottom. Discard the gauze in the trash can.
- Small gaps in the incision line can be approximated with the use of steri-strips.
13. Lower the bed level and raise the side rails.

14. Discard the suture forceps and scissors in the sharps container and all other supplies in the trash can.
15. Remove gloves and wash hands.
16. Document the procedure in the patient's chart. Include the location of the incision, the number of sutures removed, and the condition of the incision site.

Example: Ten midline abdominal skin sutures removed without difficulty. Incision dry and edges approximated without redness, edema, or pain. Incision cleansed with normal saline and left open to air.

Sources Used:

Bartelmo, Joanne, ed. 2003. *Best Practices: A Guide to Excellence in Nursing Care*. Springhouse, PA: Lippincott Williams & Wilkins.

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Supplies Needed:

Suctioning unit (portable or wall)
Ambu bag Oxygen adapter
Yankauer suction catheter with Y-port-Size 12 French to 16 French for an adult
Suction tubing
X-Ray Opaque Rubber Suction Catheter (if Ballard suctioning device cannot be used)
Clean gloves
Sterile gloves
Sterile water or normal saline
Towel or waterproof pad
Pulse oximeter
Mask with plastic eye shield
Sterile specimen cup
*Some items may be included in a sterile kit.

Procedure:

1. Wash hands.
2. Gather all equipment before entering the patient's room. If this is a post-operative patient, you may need to administer pain medication 20-30 minutes before you plan to suction the patient.
3. Explain the procedure to the patient and establish a signal the patient can use to indicate he needs you to stop the procedure. Explain that some coughing and/or gagging is normal and may help to remove secretions.
4. Provide privacy for the patient.
5. Raise the bed level and lower the side rails. Assist the patient into a semi-Fowler's position.
6. Place a towel or waterproof pad across the patient's chest.
7. If not already being monitored, attach a pulse oximeter to the patient.
8. Place the ambu bag and suction tubing within easy reach. Verify that oxygen is flowing to the ambu bag at a high flow rate.
9. Turn on the suction to the correct pressure.

Wall Suction:

Adult: 80-120 mm Hg
Child: 95-110 mm Hg
Infant: 50-95 mm Hg

Portable Suction:

Adult: 10-15 mm Hg
Child: 5-10 mm Hg
Infant: 2-5 mm Hg

10. If the patient is infectious, has copious amounts of secretions, or has a trach, apply a mask with a protective plastic eye shield attached to it.
11. Open the suction catheter kit or individual supplies using sterile technique (open the catheter package so only the suction connection portion is exposed; do not open the package to the distal tip or sterility will be difficult to maintain).
12. Place sterile specimen cup on the bedside table. Fill it with 30 to 50 mL of sterile water or normal saline.
13. Apply sterile gloves.
14. Use your dominant hand (that will remain sterile) to grasp the suction catheter. If necessary, coil the catheter in your hand to keep it from becoming contaminated.
15. Use your non dominant hand (that now becomes your “clean/non-sterile” hand) to grasp the suction tubing and connect it to the connection portion of the suction catheter. Do not contaminate the suction catheter or sterile dominant hand that is holding the catheter as you make the connection.
16. Ensure that the suction is functioning correctly by first suctioning the normal saline in the sterile cup.
17. Using your non-sterile hand, disconnect the patient from oxygen/humidification source.
18. Using your sterile hand, insert the catheter into the airway device-**WITHOUT applying suction**- until you meet resistance then pull back the catheter slightly before applying suction. With children, insert the catheter to a previously determined depth where the catheter tip’s most distal holes just exit the end of the ETT or trach.
19. Apply suction by using your thumb to close the control valve. Rotate the catheter by rolling it between your fingers as you slowly withdraw it keeping the tubing steady; don’t allow it to be tossed around and become contaminated—this can be done by pulling the catheter out with your non-sterile hand while using the sterile hand and as a guide to prevent the catheter from flopping around and getting contaminated.

Do not suction an adult for more than 10 seconds or a child for more than 5 seconds. Hold your own breath while you are suctioning to help you maintain an appropriate time frame. Remember your patient cannot breathe while you are suctioning him!

20. If you determine the need for hyperventilation, ventilate the patient using the ambu bag. With your non-sterile hand, use the ambu bag to hyper-oxygenate the patient for 3 to 4 breaths. If

your patient is on PEEP, you may need a PEEP adapter for the ambu bag. Note: In critical care, you are able to hyper-oxygenate a patient by using the ventilator.

21. Rinse the catheter by inserting catheter into cup of normal saline and apply suction.
22. Repeat the suctioning procedure once or twice as needed.
23. Reconnect the trach/ETT to the patient's oxygen/humidification source. (If the patient is on a ventilator, be sure to check the alarms before you leave the room.)
24. Discard the suction catheter, connect a yankauer to the suction tubing and suction the patient's mouth to eliminate secretions.
25. Rinse the yankauer and suction tubing with the remaining normal saline in the cup and return the yankauer to the plastic cover and place it where the patient can reach it (keep it out of the patient's reach if he is confused).
26. Discard used supplies and remove gloves.
27. Ensure that your patient is properly positioned and is comfortable with the call light within reach.
28. Wash hands.
29. Document the procedure, including color, amount and consistency of the secretions, and the patient's tolerance of the procedure.

Suctioning Via an In-Line Suctioning Device (i.e. Ballard)

For a ventilated patient, suctioning is usually done via the in-line suction device.

Before suctioning a ventilated patient, you must:

- Change the patient's oxygen setting to 100%.
- Silence the ventilator alarms.
- Ensure that the in-line suction catheter is connected to the suction tubing.

To suction:

- Apply clean gloves.
- Turn the white suction knob on the in-line sunction catheter 180 degrees to activate suction.
- Stabilize the patient's ETT or trach with your non-dominant hand.
- With your dominant hand, gently insert the in-line suction catheter into the airway. When resistance is met or the patient starts to gag/cough, pull back the catheter slightly and press down on the white suction knob and pull the catheter out as you suction.
- You can repeat the suctioning process several times depending on the amount of secretions.
- When you are done suctioning, be sure the in-line suction catheter is completely out of the patient's airway by noting the presence of a "black mark" seen on the distal end of the suction catheter.

Turn the white suction knob 180 degrees to turn off the suction and place the catheter up around the patient's shoulder out of his reach.

After you are done suctioning the patient, verify that the oxygen ventilator settings have returned to the patient's ordered amount and the alarms are on (oxygen and alarms will automatically return to ordered settings after 120 seconds or 2 minutes).

Sources Used:

Baptist Hospital. 2002. "Tracheostomy Care." Policies and Procedures. (January). Baptist Hospital, Pensacola, FL.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.

Potter, Patricia A., and Anne Griffin Perry. 2001. *Fundamentals of Nursing*. 5th ed. St. Louis: Mosby.

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West Florida Hospital. 2006. "Tracheostomy Management Procedure." Policies and Procedures. Book 1, Section 1, #59 (February). West Florida Hospital, Pensacola, FL

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Supplies Needed:

Alcohol swabs
Clean gloves
Sterile gloves
Normal Saline
Sterile 4x4 gauze pads
Tape
Graduated cylinder
Sterile 4x4 drain sponge

Procedure for emptying a T-tube

1. Verify healthcare provider's order.
2. Gather supplies (clean gloves, alcohol swab, and graduated cylinder).
3. Explain procedure to patient.
4. Wash hands.
5. Apply clean gloves.
6. Place graduated cylinder below drainage bag, pull cap off drainage bag and empty contents into cylinder.
7. Wipe valve clean with alcohol swab and replace cap.
8. Measure and record the amount, color, and characteristics of drainage.
9. Dispose of drainage according to hospital policy.
10. Dispose of gloves and wash hands.

Procedure for cleaning T-tube insertion site

1. Verify healthcare provider's order.
2. Gather supplies (clean gloves, sterile gloves, normal saline, sterile 4x4 gauze pads, sterile 4x4 drain sponge, and tape).
3. Explain procedure to patient.
4. Wash hands.

5. Apply clean gloves.
6. Remove old dressing (note color, amount, odor, and type of drainage on old dressing).
7. Dispose of dressing and gloves.
8. Prepare sterile field.
9. Apply sterile gloves.
10. Cleanse skin at drain site with sterile gauze moistened with normal saline making a circular motion moving from the insertion site outward. Lift the tube to cleanse underneath. Use each gauze only once.
11. Place drain sponge around drain at insertion site.
12. Cover the site with sterile 4x4 gauze.
13. Tape dressing occlusively to patient's skin.
14. Dispose of used and open supplies.
15. Wash hands.
16. Document procedure, patient's toleration, and drainage information (color, type, odor, and amount of drainage).

Be sure to check dressing every shift or more often. The dressing may need to be changed more frequently depending on the amount of drainage from the insertion site.

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Supplies needed:

Tracheostomy Kit which includes:

- a. Sterile gloves
- b. Cotton tip applicators
- c. Dressing
- d. Split 4 x 4 gauze
- e. Brush
- f. Drape
- g. Soaking tray

Clean gloves

Velcro trach holder

Mask

Disposable inner cannula (same size as patient's trach)

Sterile normal saline

Sterile suction kit

Ambu bag

Hydrogen peroxide

If not at patient's bedside: Extra proper-sized trach (cuffed or uncuffed)

Procedure:**Disposable Inner Cannula**

1. Gather supplies (obtain the correct size disposable inner cannula for your patient). Please note that in small children, trachs often do not contain an inner cannula.
2. Identify the patient and explain procedure.
3. Wash hands.
4. Raise bed level and lower the side rails. Place the patient into a semi-to high Fowler's position and provide privacy.
5. Suction patient, if needed, prior to providing trach care (follow suctioning guidelines).
6. Open the new sterile inner cannula package and set aside (same size as the patient's trach).
7. Apply clean gloves.
8. Remove oxygen/humidification device from the trach.
9. Using your non-dominant hand, hold the flange (the outer neck plate of the trach); with your dominant hand, remove the inner cannula by firmly pinching the side clamps of the snap-lock connector and gently pulling it out. ***Never leave patient alone while inner cannula is out.***

10. After determining that the inner cannula is DISPOSABLE, discard it into the trash. ***Do not clean, re-sterilize, or re-use the disposable inner cannula.*** Remove old split 4x4 gauze from around trach site.
11. Remove gloves. Apply sterile gloves and remove the new sterile disposable inner cannula from the package by grasping the top portion with your dominant hand (not the tubing that is inserted into the patient).
12. Hold the flange with your non-dominant hand and insert the sterile inner cannula into the patient's trach and clamp it securely in place. Proceed with trach care.

If your patient is on the ventilator, you should insert a new inner cannula immediately. You may remove the sterile inner cannula by grasping the top portion with your gloved dominant hand, but you must not touch/contaminate the portion that is inserted into the patient's trach tube.

13. Using a new normal saline moistened cotton tip applicator for each area, cleanse the stoma site, around the trach tube, and the flanges. If the patient has copious secretions/drainage, you may need to cleanse the flanges and the surrounding neck area with normal saline moistened 4x4 gauze.
14. Observe the area around the stoma and trach ties for skin irritation.
15. Insert a sterile, dry, split 4x4 gauze under the flange and around the stoma site. If the trach is sutured into place, you may need to place the 4x4 on top of the flange and around the trach.
16. Place the patient's oxygen/humidification device over the trach.
17. Change trach holder if soiled (see *Changing tracheostomy ties or Velcro trach holder*).
18. Assist patient into a comfortable position and offer oral hygiene. Lower the bed level and raise the side rails. Make sure call bell is within reach.
19. Discard used supplies, remove gloves and wash hands.
20. Document the procedure, the patient's tolerance of the procedure, as well as the assessment of trach site.

Cleaning a Non-disposable Inner Cannula

Reusable Inner Cannula:

1. Gather supplies.
2. Identify the patient and explain procedure.
3. Wash hands.

4. Raise the bed level and lower the side rails. Place the patient into a semi-to high Fowler's position and provide privacy.
5. Suction patient, if needed, prior to providing trach care (follow suctioning guidelines).
6. Open sterile tracheostomy kit and remove supplies keeping the contents sterile.
7. Pour normal saline into one basin and hydrogen peroxide into another basin.
8. Open several sterile cotton-tipped applicators and a package of sterile split 4x4 guaze and place them on sterile field.
9. Apply clean gloves.
10. Remove oxygen/humidification device from trach.
11. Stabilize the trach and remove used tracheostomy dressing and discard it in the trash.
12. Apply sterile gloves.
13. With sterile non-dominant hand, unlock and remove inner cannula and hold it in hydrogen peroxide without allowing your fingers to touch the sterile water. ***Never leave patient alone while inner cannula is out.***
14. *Working quickly:* Using your sterile dominant hand, take the brush/pipe cleaners and scrub the inner and outer aspects of the inner cannula and then rinse it in normal saline as you hold the outer portion of the trach.
15. With your sterile hand, use sterile gauze to thoroughly dry the inner cannula.
16. Replace the inner cannula with your dominant hand into outer cannula and secure it in the locked position immediately after cleaning.
17. Using separate normal saline moistened cotton tip applicator, cleanse the patient's stoma and tube flanges. If the patient has copious secretions/drainage, you may need to cleanse the flanges and the surrounding neck area with normal saline moistened 4x4 gauze.
18. Observe the area around the stoma and trach ties for skin irritation.
19. Insert a sterile, dry, split 4x4 gauze under the flange and around the stoma site. If the trach is sutured into place, you may need to place the 4x4 on top of the flange and around the trach.
20. Place the patient's oxygen/humidification device over the trach.
21. Change trach holder if soiled (see *Changing tracheostomy ties or Velcro trach holder*).

22. Assist patient into a comfortable position and offer oral hygiene. Lower the bed level and raise the side rails.
23. Discard used supplies, remove gloves and wash hands.
24. Document the procedure, the patient's tolerance of the procedure, as well as the assessment of trach site.

Changing Velcro Tracheostomy Holder

1. Gather supplies and an assistant.
2. Identify patient. Explain the procedure to patient.
3. Wash hands.
4. Raise bed level, lower side rails and place the patient in a semi-Fowler's position.
5. Apply clean gloves; have your assistant apply gloves as well.
6. Have the assistant secure the trach as you undo the used Velcro ends and remove the holder. Assess neck for skin irritation and cleanse the area. Put on the new Velcro trach holder.
7. Assist patient into a comfortable position and offer oral hygiene. Lower the bed level and raise side rails.
8. Discard used supplies, remove gloves and wash hands.
9. Document procedure and assessment.

Sources used:

Baptist Hospital. 2000. "Tracheostomy Care." Policies and Procedures. Policy no. 36.146 (December). Baptist Hospital, Pensacola, FL.

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Procedure Manual

Urinary Catheterization

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 3/23/07 Revised: 09/02/16
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Supplies Needed:

Indwelling or Straight Catheter Kit (check orders)—use an appropriate gauge for your patient's age and size. If a kit is not available; obtain the following items:

- a) Catheter
- b) Water-soluble lubricant
- c) Betadine swabsticks or betadine solution/dry cotton balls
- d) Drainage collection bag (for indwelling catheters)
- e) Rectangular water-proof drape
- f) 10 mL sterile water-filled syringe
- g) Forceps
- h) Sterile gloves

Extra catheter kit or supplies listed above

Extra pair sterile gloves

Clean gloves

Trash can or small trash bag

Clean tabletop

Bath blanket

Foley stat-lock

If you are obtaining a urine specimen, you will also need the following supplies:

- a) Alcohol pad
- b) Sterile needle/syringe (10-20 mL)
- c) Urine specimen cup/culture tube
- d) Small biohazard specimen bag

Procedure:

1. Verify healthcare provider's order.
2. Assemble supplies; wash hands.
3. ID and explain procedure to patient; provide privacy.
4. Raise bed level (to waist level); lower side rail.
5. Position female patient in a supine position with knees flexed and hips abducted. Keep patient modestly covered (i.e. pull covers from bottom of bed over patient's hips; or place bath blanket over patient's abdomen and hips). Only expose patient when ready to begin procedure. The male patient will be positioned supine with legs extended.
6. Remove outer plastic package from catheter kit. Place kit on lower part of patient's bed or bedside table that has been positioned over the lower part of the bed.

7. Unwrap the kit, being sure to open flap furthest from yourself first, side flaps next, and front flap last (this order prevents contamination of items inside package).
8. Remove rectangular drape from the top of the catheter kit and place shiny-side-down, under the female patient's perineum, being careful to minimize contact with top surface. The drape should be placed across the male patient's upper thighs.
9. Remove the glove package by touching only the top corners of the package. Set package down on bed or clean tabletop. Do not turn your back on your sterile field. Put on gloves using sterile technique.
10. Open sterile betadine swab package and place swabs into plastic tray (some kits have betadine solution to pour over cotton balls).
11. Open water-based lubricant package and squeeze contents into another portion of the tray. (or package can just remain opened, instead of squeezed-out, for insertion of catheter tubing later).
12. Remove top portion of tray and set to one side of box (side closest to patient), being sure to keep it on the sterile field.
13. Pick up catheter tubing and remove sheath from tubing. Be cautious about keeping the tubing from moving around uncontrollably. (It is helpful to coil tubing around hand while unwrapping the plastic sheath from the tubing.)
14. Attach the syringe to balloon port on catheter tubing, keep syringe attached to the tubing and place the tubing in the lubricant portion of the tray or in the lubricant package. The catheter bag can remain in the box at this point.

Apply approximately 2 inches of lubricant to the tubing for the female patient, and approximately 6 inches of lubricant for the male patient.

15. If kit is set up on table, pick up box with sterile dominant hand and set on bed between patients legs prior to picking up tubing with dominant hand to insert catheter.
16. For the female patient, use non-dominant hand to spread the labia majora and minora. This hand will be considered contaminated from this point forward! Do not remove hand from this area.
17. With sterile dominant hand, pick up one betadine swab (if using cotton ball, forceps must be used because this hand must remain sterile) and follow cleansing procedure as follows:
 - a) Clean down inside of labia minora on side furthest from you first (top to bottom).
 - b) Dispose of swab.
 - c) Use a new swab to clean down other side of labia minora (top to bottom).
 - d) Dispose of swab.
 - e) Finally, use your last sterile swab to clean down the center of the vagina (from clitoris to perineum).

- f) Dispose of swab.
18. Pick up lubricated tubing with dominant, sterile hand and insert tubing into the urethral meatus. For the male patient, hold the penis in a vertical position while inserting the catheter.
- If you mistakenly place the catheter into the vaginal orifice instead of the urethral meatus, leave the tubing there as a marker, obtain a new catheter (follow sterile technique), and insert the new catheter into the urethra.
19. Continue to insert the tubing into the urethra (use finger-over-finger technique to insert tubing, being cautious to avoid touching patient). Insert until urine flow is noticed in the tubing and then approximately 2-4 inches further (to ensure proper placement in the bladder chamber). For the male, insert the catheter up to the "Y" portion of catheter. The catheter should never be forced if resistance is encountered.
20. Use fingers of non-dominant hand to hold the tubing in place. Use dominant hand to inflate the catheter balloon. Be careful to not let go of the syringe plunger until the syringe is removed from the balloon port as the fluid will automatically return to the syringe, causing the balloon to deflate.

In an uncircumcised male, return the foreskin to original position.

21. Obtain urine specimen if ordered.
22. Dispose of all remaining trash; remove soiled gloves and wash hands.
23. Clip indwelling catheter bag to bed frame. Clip tubing into foley stat-lock and apply to patient's leg.
24. Return patient to a comfortable position.
25. Lower bed level.
26. Document:
- Completion of procedure including type and size of catheter inserted.
 - Amount, color, and clarity of urine.
 - Patient's toleration of procedure.
 - Specific instructions provided to patient.

Source Used:

Potter, Patricia A., and Anne Griffin Perry. 2001. *Fundamentals of Nursing*. 5th ed. St. Louis: Mosby.

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Supplies Needed:

Clean gloves	Diaper (infant)
Sterile specimen container (be sure to check expiration date)	Adhesive collection bag (infant)
Patient label	Sterile scissors (infant)
Bedpan or urinal (bedridden patient)	Alcohol pads (catheter)
Antiseptic towelettes	10 mL-syringe (catheter)
Small biohazard specimen bag(s)	21G or 22G 1½" needle (catheter)
Lab requisition	Urine hat and ice basin (24-hr collection)

Procedure:

1. Verify healthcare provider's order for a urine analysis, Culture and Sensitivity (C&S), 24 hour collection, or Creatinine (CR) clearance specimen.
2. Wash hands and gather needed equipment.
3. Standard precautions will be followed, including proper hand washing before and after procedure and the use of gloves.
4. Identify patient according to facility policy.
5. Provide privacy for the patient.
6. Explain the purpose, procedure, including performing hand wash before and after specimen collection, and the need for the urine specimen to the patient.
7. Do not use first early a.m. specimen- it is the most concentrated and will reveal sediment abnormalities.
8. Apply clean gloves.
9. Obtain urine specimen.
 - a) Clean catch
 - i) Female patient
 - (1) Separate the labia and expose the urethral orifice using thumb and forefinger.
 - (2) Cleanse the meatus with antiseptic solution wipes moving from front to back with one stroke down the left side, the right side, and then down the middle using a clean towelette each time.
 - (3) While the labia are separated, instruct the female to void forcibly.
 - (4) Allow initial urinary flow to drain into bedpan (toilet) and then collect the "midstream" urine in the sterile container (10-20 mL is usually sufficient).
 - ii) Male patient

- (1) Expose the glans (retract foreskin if present) and cleanse the meatus with antiseptic wipes using a circular motion moving from center to outside.
 - (2) Allow initial urinary flow to escape.
 - (3) Collect the “midstream” urine specimen in a sterile container.
 - (4) Return foreskin if present.
 - (5) Avoid collecting the last drops of urine due to higher sediment levels.
- iii) Infant
- (1) Perform thorough perineal care with a clean towelette for each wipe.
 - (a) For girls, spread the labia and cleanse area.
 - (b) For boys, retract foreskin if present and cleanse glans.
 - (2) Pat skin dry with a clean towel.
 - (3) Remove paper backing from the adhesive facing on the collection bag.
 - (4) Place bag facing over labia or penis and scrotum (both should be in the bag).
 - (5) Gently push facing against skin forming a seal. Apply posterior of bag first to avoid covering anus.
 - (6) Take caution not to touch the inside of the bag as it is considered sterile.
 - (7) Apply a clean diaper over the bag and frequently check for urine in the bag. You may cut a hole in the diaper before placing it on the infant to provide for easier visualization.
 - (8) When there is enough urine in the collection bag, wash hands and apply gloves.
 - (9) Gently remove the bag taking care not to spill.
 - (10) Pull blue tab off bag and drain urine into a sterile lab container.
 - (11) Perform perineal care and reapply diaper.
- iv) Bedridden patient
- (1) Void into a clean unused bed pan or urinal. (Non sterile specimen)
 - (2) Transfer urine into sterile lab container.
- b) Sterile specimen
- i) Patient with indwelling urinary catheter
- (1) Cleanse rubber entry portal on drainage tubing with alcohol swab.
 - (2) Allow alcohol to dry.
 - (3) Connect syringe to port of catheter or insert needle into entry port at 45° angle.
 - (4) Aspirate urine from tubing (1-2 mLs for a culture and 10-12 mLs for routine urinalysis).
 - (5) If no urine is in the tubing, clamp tubing below the entry port until urine is visible.
Be careful not to keep tubing clamped for a long period.
 - (6) Never obtain urine from the drainage bag.
- c) 24-hour urine specimen
- i) Obtain a urine container and a basin.
 - ii) Fill the basin ¾ full of ice and place urine container in the ice.
 - iii) Have the patient void in the urine hat or urinal and discard this sample.
 - iv) Begin the collection time at that point and note this time. With each void, place urine **immediately** in the container that is being kept on ice.
 - v) Determine the start and end times of the 24 hour collection period and place a sign on the patient’s door with this information.
 - vi) When the 24-hr period is over, ask the patient to void and include this specimen. Take the urine container to the lab.
 - vii) If the patient has an indwelling catheter, place the urine collection bag in ice. After emptying the catheter bag, place urine into container on ice as stated above.

viii) If the patient leaves the unit, the department receiving the patient should be notified of the 24 hour urine collection in progress.

10. The nurse will transfer urine to a culture tube using sterile technique, if needed.
11. Label the specimen according to facility policy, usually including patient's name (chart label), date, time, and initials of health care worker collecting the specimen.
12. Place specimen container in small biohazard specimen bag(s) per facility policy.
13. Remove gloves and perform appropriate hand wash.
14. Send specimen to the lab within 15-20 minutes. If unable to transfer specimen immediately, the specimen must be placed in the specified refrigerator.
15. Document:
 - a) Time and date of when the specimen was sent
 - b) Urine characteristics (odor, color, and consistency)
 - c) Amount, if known
 - d) Pt's tolerance of procedure

Sources Used:

Baptist Health Care. 2001. "Urine Specimen Collection." Policies and Procedures. Reference 36, Policy 370 (October). Baptist Hospital, Pensacola, FL.

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Pensacola Christian College Department of Nursing	March 9, 2015 Approval: 03/12/15
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Supplies Needed:

Safety needle (22 gauge or less for adults; 21 gauge butterfly needle for pediatric patients or for difficult sticks)

Blood transfer device

Tourniquet

Chlorahexadine swabs (alcohol/betadine – per facility policy)

Clean gloves

Gauze

Tape

Blood specimen tubes:

- a. Red/green/yellow for chemistries
- b. Purple for blood counts (CBC) and hemograms
- c. Blue for coagulation studies (PT/INR, PTT)
- d. Blood culture bottles

Small biohazard specimen bag(s)

Procedure:

1. Verify healthcare provider's order.
2. Gather supplies and wash hands.
3. Identify patient and explain procedure.
4. Set-up supplies at the bedside. Raise patient's bed to waist level.
5. Locate venipuncture site: for adults, use veins in the hands or arms; for children, use superficial veins in the hands, feet, or scalp (try to avoid the feet if the child ambulates).
 - a) Do not use an arm with a dialysis shunt or fistula, or the involved arm of a radical mastectomy or stroke.
 - b) Avoid areas of hematoma, extensive scarring, burns, or tattoos.
 - c) If you have difficulty locating a vein, you can place a warm towel on the extremity or have the patient hang his arm down to increase blood flow to the area.

Stop currently infusing intravenous fluids until after the blood draw is complete.

6. Apply tourniquet 3-6 inches above site – it should not stop arterial blood flow – and palpate the vein to be used. Do not use a vein that has valves (feels like knots) or make sure you insert the needle above a valve. *Never leave the tourniquet on for over 1 minute.
7. Cleanse site with chlorahexadine swab for 30 seconds and let it dry.
8. Apply clean gloves and observe standard precautions.

9. Attach the safety needle to the hub of the blood transfer device twisting it tight.
10. Remove the plastic cap over the needle and hold bevel up.
11. Pull the skin taut with your thumb or index finger just below the puncture site.
12. Holding the needle in line with the vein, use a quick, small thrust to penetrate the skin and enter the vein in one smooth motion.
13. Holding the blood transfer device securely, insert the first blood collection tube (following proper order of draw) into the large end of the hub penetrating the stopper. Blood should flow into the evacuated tube.

***Special note when using butterfly collection device:** When coagulation tube (Light Blue top) will be the first tube collected, it is **mandatory** to collect a discard Light Blue top first to remove the air from the tubing. A second Light Blue top can then be collected appropriately. Failure to collect the discard tube may result in specimen being rejected due to inappropriate volumes.

14. After blood starts to flow, release the tourniquet. If patient made a fist, ask the patient to open his hand.
15. When blood flow stops, securely hold the blood transfer device while pulling out the collection tube. If multiple tubes are needed, the **proper order of draw** to avoid cross contamination and erroneous results is as follow:
 - a) Blood culture vials or bottles, sterile tubes
 - b) Light Blue top: Coagulation studies
 - c) Red, Gold, or Tiger top (with or without clot activator and gel separator): Chemistries
 - d) Green top (heparin additive): Chemistries
 - e) Lavender top (EDTA additive): Hematology
 - f) Gray top (glycolytic inhibitor additive): blood glucose, ETOH level, lactate, bicarbonate
16. Each Light Blue top should be gently inverted 4 times after being removed from the blood transfer device. Red, Gold, and Tiger tops should be inverted 5 times. All other tubes containing an additive should be gently inverted 8-10 times. DO NOT SHAKE OR MIX VIGOROUSLY.
17. Place a gauze pad over the puncture site and remove the needle. Immediately apply slight pressure. Ask the patient to apply pressure for at least 2 minutes. When bleeding stops, apply a fresh gauze and tape bandage.
18. Properly dispose of blood transfer device and attached needle into a sharps container.
19. After comparing patient identifiers with the label, attach patient label to each specimen tube and write initials, date, and time. Place all blood collection tubes in a small biohazard specimen bag(s) per facility policy.
20. Discard gloves and other used supplies in the trash. Return patient's bed to lowest level.
Wash hands.

21. Document blood collection, complete lab requisition, and send specimen tubes to the lab.

Sources Used:

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University of Arkansas for Medical Services. 2014. "Routine Venipuncture Guidelines." University of Arkansas for Medical Services. Last modified December 3, 2014. Accessed January 2015. <http://www.uams.edu/clinlab/venipuncture.htm>.

Procedure Manual

Vital Signs

Pensacola Christian College Department of Nursing	January 15, 2007 Approval: 4/27/07 Revised: 01/06/14
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Supplies Needed:

Clean gloves
Thermometer
Thermometer sheaths
Watch with second hand
Sphygmomanometer
Stethoscope
Alcohol swab
Pulse Oximeter
Vital signs graphic sheet or I&O sheet
Water soluble lubricant for rectal temperature

Procedure:

1. Collect preliminary information such as:
 - a) agency policy
 - b) order for patient
 - c) patient's age, diagnosis, and vital sign ranges
 - d) special considerations (i.e. mastectomy, A/V shunt, or PICC in one arm - do not take BP in affected arm)
 - e) special orders for orthostatic BP
2. Wash hands and gather necessary equipment. Clean diaphragm of stethoscope with alcohol swab.
3. Introduce self and identify the patient.

Oral temperatures are not routinely taken in children under five years of age. For children five and under an axillary, rectal or tympanic temperature may be obtained. The most common route would be axillary due to the risk of injury with rectal temperatures and the difficulty of performing a tympanic temperature in a manner that yields reliable results.

Oral Temperature: (blue probe)

1. An alternate method of temperature should be used if the patient has had anything to eat, drink, or smoke within the last fifteen minutes.
2. Cover the blue oral probe with a protective sheath and place under the patient's tongue. Ask the patient to seal his lips around the probe. Leave the probe in place until a reading is obtained.

- A glass thermometer should remain in place: 3 minutes for oral, 2 minutes for rectal and 9-11 minutes for axillary temperatures.
- An electronic thermometer should remain in place until it registers a reading, typically a beep.
- A tempadot is used in isolation rooms.

3. Remove the probe and discard the sheath into the trash.
4. Record temperature on your information sheet.

Rectal Temperature: (red probe)

1. Explain the procedure to the patient. Provide privacy, raise bed level and lower the side rail.
2. Apply clean gloves.
3. Assist patient in the lateral position with upper legs slightly flexed. Cover the red rectal probe with a protective sheath and lubricate the sheath with water soluble lubricant 1-1 ½ inches from the tip.
4. Lift the patient's upper buttock to expose the anus. If it remains difficult to see the anal opening, ask patient to bear down.
5. Ask the patient to take a deep breath and insert thermometer probe 2 inches (for an adult) or ½-1 inch (for an infant or child) into anal orifice in the direction of the umbilicus. Never force the probe against resistance when inserting. If the patient has hemorrhoids, avoid contact with the hemorrhoids as much as possible when inserting the probe.
6. Hold the thermometer in place until a reading is obtained.
7. Inform the patient you will be removing the thermometer probe and remove it at the same angle as inserted. Cleanse the anal area with tissue and discard the tissue and sheath into the trash.
8. Remove gloves. Reposition the patient and lower the bed level.
9. Wash hands and record temperature on your information sheet.

Differentiate between oral, rectal, and axillary temperatures by recording a rectal temperature as an R with a circle around it and axillary temperature as Ax with a circle around it.

Axillary Temperature: (blue probe)

1. When axillary temperatures are taken, the axillary area must be clean and dry.
2. Cover the blue oral probe with a protective sheath and place under the patient's arm into the axillary area. Be sure the tip of the probe is not sticking out the back of the arm. Hold the arm firmly against the oral probe until a reading is obtained. Remove the probe and discard the sheath into the trash.
3. Record temperature on your information sheet.

Tympanic Temperature:

1. When using a tympanic thermometer, apply a probe cover and pull the helix of the ear up and back (for adult), or the ear lobe down and back (for child less than 3 years of age). Insert the probe, assessing that a snug fit in the ear canal is obtained and hold in place until a reading is obtained.
2. Remove the probe and discard the sheath into the trash.
3. Record temperature on your information sheet.

Radial Pulse:

1. Place the soft pads of the first two or three fingers of your dominant hand over the patient's radial pulse point (the radial pulse point is located on the thumb side of the patient's distal forearm at the wrist joint). Slide your fingers around to the inside of the wrist just below the thumb. Using moderate pressure, press the soft tissue and artery up against the radial bone.
2. Using the watch's second hand, count a regular pulse for fifteen seconds and multiply the number obtained by four. Count an irregular pulse for sixty seconds. In addition to assessing the rate, note the intensity, and rhythm of the pulse. Continue with respirations.

If infant, obtain an apical pulse for 60 seconds.

Respirations:

1. While your hand is still in place as if taking the pulse, note the rise and fall of the patient's chest or abdomen as patient is breathing.
2. Count respirations for thirty seconds and multiply the number obtained by two if respirations are regular and unlabored. Count for sixty seconds in infants or if the respirations are irregular or labored.
3. Assess the rate, rhythm, depth, and character of the respirations.
4. Record the pulse and respirations on your information sheet.
5. If your patient requires a pulse oximetry reading:
 - a) Turn oximeter on and apply the pulse oximeter with the "indentation" finger of the probe on top of the patient's finger. (The infra-red light is on the top inside of the probe.)
 - b) In infants, an elastic probe is typically wrapped around the great toe.
 - c) Observe both the pulse rate and pulse oximeter reading. Pulse rate reading should correlate to actual pulse. (In infants, hold extremity still if necessary.)
 - d) Leave the clip/probe in place for several seconds and observe readings. If the oxygen saturation (O_2 Sat) is less than 92% or the specified level, encourage coughing and deep breathing and reassess the reading with pulse oximeter clip/probe left in place. (Suction the patient if appropriate.)

If the clip/probe is attached properly and no reading is received, warm the site and recheck. A different finger or site may also be assessed. (Some clips are made to fit a patient's ear lobe). If the patient is wearing fingernail polish, it may be difficult to obtain an accurate reading.

- e) Record the number on your information sheet.
- f) Document appropriately.

For continuous pulse oximeter monitoring, make sure appropriate alarm limits have been set and documented.

Blood Pressure:

1. Explain procedure to patient as needed. Raise the bed and lower side rail.
2. Measure the cuff size to determine if it is appropriate for patient's arm size. The bladder of the cuff should encircle the upper arm without overlapping itself.
3. Verify that the sphygmomanometer registers zero and find the midpoint on the bladder of the cuff. The midpoint of the cuff's bladder will be positioned above the brachial artery.
4. Apply the cuff 1-2 inches above the antecubital site, wrapping it evenly, smoothly and snugly around the upper arm, making sure that no clothing is underneath the cuff. Position the bladder tubing anteriorly.
5. With the patient's arm extended and relaxed, place the diaphragm of the stethoscope over the brachial pulse site, close the valve and pump up the cuff to a level 20-30 mmHg higher than the patient's highest reported BP.
6. Gently loosen the valve to release air slowly.
7. Note the manometer numbers at which you first hear faint, clear, tapping sounds (systolic pressure) and the final disappearance of sound (diastolic pressure).
8. Deflate the cuff to zero and remove stethoscope from pulse site. If you need to recheck the blood pressure, wait several minutes or use the other arm.
9. Remove the cuff.
10. Record both systolic and diastolic pressures on your information sheet. You will need to record your patient's vital signs on the graphic sheet and in the computer as soon as possible after leaving the patient's room.

Pain:

1. Assess the patient's level of pain by asking him to rate his pain on a scale of 0 to 10 with 0 being "no pain" and 10 being "the worst pain ever experienced". For infants or young children, use an appropriate alternative pain assessment scale (i.e. FLACC or Wong-Baker Faces scales).
2. If the patient complains of pain, check healthcare provider's orders and medication administration record (MAR) for pain medications ordered.
3. Reassess effectiveness of pain medication within 30-60 minutes and document.

Pediatric Vital Signs

T: Newborn: 97-100° ax To 5 yrs: 98-99.9° rectal >: 5 yrs: 97.5-99° oral	P: Newborn: 110-160 Infant to 2 yrs: 80-120 2-6 yrs: 70-110 6-10 yrs: 60-95 10-16 yrs: 60-85
R: Newborn: 30-60 1 yr: 25-40 3 yr: 20-30 6 yr: 16-22 10 yr: 16-20	BP: Age in years: SBP DBP 1-2 95-110 50-65 3-5 100-115 60-75 6-10 105-122 65-80 11-17 110-135 75-85

Adult Vital Signs

T: 96-100° F	P: 60-100 BPM
R: 12-20	BP: 90-120 Normal Systolic 121-139 High Normal Systolic 60-80 Normal Diastolic 81-89 High Normal Diastolic

Sources Used:

Hockenberry, Marilyn J. and David Wilson, ed. 2007. *Wong's Nursing Care of Infants and Children*. 8th ed. St. Louis: Mosby/Elsevier.

Procedure Manual

Wound Culture

Pensacola Christian College Department of Nursing	January 19, 2007 Approval: 3/9/07 Revised: 01/06/14
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Supplies Needed:

Sterile Culturette kit with swab

Clean gloves

Specimen biohazard bag

Patient label

Supplies to clean the wound and reapply a sterile dressing after obtaining the culture

Procedure:

1. Verify healthcare provider's order.
2. Gather necessary supplies.
3. Wash hands.
4. Identify the patient according to facility policy.
5. Apply clean gloves and remove dressing. Assess wound for OREEDA especially for the characteristics of any drainage.
6. Remove clean gloves. Apply sterile gloves.
7. Utilizing sterile technique, clean the wound with normal saline to remove exudates.

Drainage from the wound should not be cultured as drainage is contaminated medium. Cultures should be obtained from the wound bed itself to capture organisms living on the wound bed surface for accurate wound bed colonization.

8. Use sterile swab from culture tube. Insert swab into the superior aspect of the wound and using a zig-zag motion, swab downward covering all aspects of the wound.

9. Insert swab into culture tube. Do not touch outside of the tube with the swab.

If there are 2 swabs, swab with one swab from the superior to inferior aspect of wound and place in tube. Repeat with the second swab.

10. Place patient label on specimen tube and note date and time. Place specimen into a specimen biohazard bag.

11. Apply sterile dressing according to facility policy.

12. Wash hands.

13. Document all relevant information in the patient's chart.

Sources Used:

Craven, Ruth, and Constance J. Hirnle. 2006. *Fundamentals of Nursing: Human Health and Function*. 5th ed. Philadelphia: Lippincott Williams and Wilkins.

Evans-Smith, Pamela. 2005. *Taylor's Clinical Nursing Skills: A Nursing Process Approach*. Philadelphia: Lippincott Williams & Wilkins.