DEDER GENERAL HOSPITAL

NURSING CARE PROTOCOL AND PROCEDURES FOR PRIORITIZED HEALTH CONDITIONS

Prepared By: ***Abdi T (BSc, MPH)-Quality Director***

July, 2024

Deder, Oromia

Table of Contents

Introduction

Nursing care is fundamental to achieving safe, effective, and compassionate healthcare delivery. At Deder General Hospital, the nursing department plays a pivotal role in managing high-burden and life-threatening conditions through prompt assessment, evidence-based interventions, and continuous patient monitoring.

To strengthen the quality and consistency of care, this Nursing Care Protocol and Procedure Manual has been developed with a focus on prioritized health conditions based on their prevalence, severity, and impact on patient outcomes at the hospital. These conditions were identified through clinical performance reviews, morbidity and mortality reports, and consultation with frontline healthcare providers.

The prioritized health conditions addressed in this manual include:

1. Diabetes Mellitus
2. Heart Failure
3. Hypertensive Disorders
4. Asthma
5. Liver Diseases
6. Renal Diseases
7. Meningitis
8. Neonatal Sepsis
9. Perinatal Asphyxia (PNA)
10. Antepartum Hemorrhage (APH)
11. Premature Rupture of Membranes (PROM)
12. Eclampsia
13. Puerperal Sepsis

These conditions were prioritized because they represent a significant portion of admissions, complications, and adverse outcomes in the hospital. Addressing them with standardized nursing protocols ensures a more targeted and effective approach to patient care.

Additionally, the manual includes 20 key nursing procedures and tools for monitoring protocol adherence, designed to support nurses in delivering high-quality, protocol-driven care across all units of the hospital.

Through the implementation of this manual, Deder General Hospital commits to promoting accountable, consistent, and patient-centered nursing services that align with national treatment guidelines and global best practices.

Purpose

The primary purpose of this protocol and procedure manual is to:

- Standardize nursing care practices across departments to ensure safe, high-quality, and patient-centered care.
- Provide clear and actionable guidance to nursing staff on how to assess, diagnose, and manage patients with prioritized health conditions.
- Promote the consistent application of evidence-based interventions and procedures.

- Improve nursing care outcomes by reducing variability in practice and supporting clinical accountability.
- Serve as a training and reference tool for both new and existing nursing staff.

Scope

This document applies to all nursing professionals working at Deder General Hospital, including those in inpatient wards, emergency units, outpatient departments, maternity units, neonatal care, and specialty services.

The scope of this manual includes:

- Nursing care protocols for 13 prioritized medical and obstetric conditions commonly encountered in the hospital setting.
- Step-by-step procedures for 20 essential nursing interventions and clinical techniques.
- Tools for monitoring the adherence to nursing protocols and assessing care quality.
- Practical checklists and formats to ensure ongoing supervision, evaluation, and improvement in nursing care delivery.

By adopting this manual, Deder General Hospital aims to foster a culture of clinical excellence, professional integrity, and patient safety, thereby aligning its nursing services with national and global healthcare standards.

1. Diabetes Mellitus

Assessment

- Blood glucose levels (fasting and postprandial).
- Symptoms of hyperglycemia (e.g., polyuria, polydipsia, fatigue) or hypoglycemia (e.g., sweating, tremors, confusion).
- Nutritional intake and dietary habits.
- Foot examination for ulcers or infections.
- Family history of diabetes.

Nursing Diagnoses

- Risk for unstable blood glucose levels.
- Deficient knowledge regarding diabetes management.
- Risk for impaired skin integrity.
- Risk for infection.

Goals and Outcomes

- Maintain blood glucose within target range (e.g., 80–130 mg/dL fasting).

- Prevent complications (e.g., neuropathy, retinopathy).
- Patient will demonstrate proper insulin administration and blood glucose monitoring.

Interventions

- Administer insulin or oral hypoglycemic agents as prescribed.
- Monitor blood glucose levels regularly.
- Provide diabetic diet education (e.g., carbohydrate counting, low glycemic index foods).
- Teach foot care and skin inspection techniques.
- Encourage regular physical activity.

Evaluation

- Blood glucose levels within target range.
- Absence of complications (e.g., no signs of infection or neuropathy).
- Patient demonstrates self-care skills.

1

Patient Education

- ☐ Teach signs and symptoms of hypo/hyperglycemia and emergency management.
- ☐ Educate on the importance of regular HbA1c testing.
- ☐ Provide resources for diabetic support groups.

2. Heart Failure

Assessment

- ☐ Vital signs (e.g., blood pressure, heart rate, oxygen saturation).
- ☐ Signs of fluid overload (e.g., edema, jugular vein distension, crackles in lungs).
- ☐ Daily weight monitoring.
- ☐ Activity tolerance and fatigue levels.

Nursing Diagnoses

- ☐ Decreased cardiac output.
- ☐ Excess fluid volume.
- ☐ Activity intolerance.
- ☐ Anxiety related to disease progression.

Goals and Outcomes

- ☐ Maintain stable fluid balance (e.g., no weight gain >2 kg/week).
- ☐ Improve activity tolerance.
- ☐ Patient will adhere to medication and dietary regimen.

Interventions

- ☐ Administer diuretics, ACE inhibitors, or beta-blockers as prescribed.
- ☐ Monitor daily weight and fluid intake/output.
- ☐ Encourage low-sodium diet (<2 g/day).
- ☐ Provide oxygen therapy if needed.
- ☐ Educate on energy conservation techniques.

Evaluation

- ☐ Stable weight and absence of edema.
- ☐ Improved activity tolerance.

- Patient reports reduced shortness of breath.

Patient Education

- Teach signs of worsening heart failure (e.g., weight gain, increased edema).
- Emphasize medication adherence and dietary restrictions.
- Encourage regular follow-up with healthcare provider.

3. Hypertensive Disorders

Assessment

- Blood pressure readings (e.g., systolic/diastolic).
- Symptoms of hypertension (e.g., headache, dizziness, blurred vision).
- Lifestyle factors (e.g., smoking, alcohol use, physical activity).
- Family history of hypertension.

Nursing Diagnoses

- Risk for decreased cardiac output.
- Nonadherence to therapeutic regimen.
- Deficient knowledge regarding hypertension management.

Goals and Outcomes

- Maintain blood pressure within target range (e.g., <140/90 mmHg).
- Patient will adopt lifestyle modifications (e.g., diet, exercise).

Interventions

- Administer antihypertensive medications as prescribed.
- Encourage DASH diet (low sodium, high potassium).
- Promote regular physical activity (e.g., 30 minutes/day).
- Monitor for side effects of medications (e.g., dizziness, electrolyte imbalances).

Evaluation

- Blood pressure within target range.
- Patient reports adherence to lifestyle changes.

Patient Education

- Teach importance of regular blood pressure monitoring.
- Educate on reducing sodium intake and avoiding processed foods.
- Encourage smoking cessation and stress management techniques.

4. Asthma

Assessment

- Respiratory rate, oxygen saturation, and breath sounds.
- Frequency and severity of asthma attacks.
- Triggers (e.g., allergens, exercise, stress).
- Medication use (e.g., inhalers, corticosteroids).

Nursing Diagnoses

- Ineffective airway clearance.
- Impaired gas exchange.
- Anxiety related to dyspnea.

Goals and Outcomes

- Maintain patent airway and normal breathing patterns.
- Reduce frequency of asthma attacks.
- Patient will demonstrate proper inhaler technique.

Interventions

- Administer bronchodilators and corticosteroids as prescribed.
- Monitor peak expiratory flow rate (PEFR).
- Provide oxygen therapy if needed.
- Teach breathing exercises (e.g., pursed-lip breathing).

Evaluation

- Improved respiratory status (e.g., normal breath sounds, oxygen saturation >95%).
- Reduced use of rescue inhalers.

Patient Education

- Teach avoidance of triggers (e.g., dust, smoke, pet dander).
- Educate on proper inhaler use and asthma action plan.
- Encourage regular follow-up with pulmonologist.

5. Liver Diseases

Assessment

- Signs of jaundice (e.g., yellowing of skin/eyes).
- Abdominal distension and ascites.
- Liver function tests (e.g., ALT, AST, bilirubin).
- Mental status (e.g., signs of hepatic encephalopathy).

Nursing Diagnoses

- Impaired liver function.
- Risk for bleeding.
- Imbalanced nutrition: less than body requirements.

Goals and Outcomes

- Prevent complications (e.g., bleeding, encephalopathy).
- Maintain nutritional status.

Interventions

- Administer lactulose or rifaximin for encephalopathy.
- Monitor for signs of bleeding (e.g., bruising, melena).
- Provide low-protein diet if encephalopathy is present.
- Encourage abstinence from alcohol.

Evaluation

- Stable liver function tests.
- Absence of complications (e.g., no bleeding or confusion).

Patient Education

- Teach signs of worsening liver disease (e.g., confusion, bleeding).
- Emphasize adherence to dietary restrictions.
- Provide resources for alcohol cessation programs.

6. Renal Diseases

Assessment

- Urine output and characteristics (e.g., color, proteinuria).
- Blood pressure and fluid balance.
- Lab results (e.g., creatinine, BUN, electrolytes).
- Symptoms of uremia (e.g., fatigue, nausea).

Nursing Diagnoses

- Excess fluid volume.
- Risk for electrolyte imbalance.
- Deficient knowledge regarding renal diet.

Goals and Outcomes

- Maintain fluid and electrolyte balance.
- Slow progression of kidney disease.

Interventions

- Administer medications (e.g., phosphate binders, antihypertensives).
- Monitor fluid intake/output.
- Provide low-sodium, low-potassium, and low-phosphorus diet.
- Prepare for dialysis if indicated.

Evaluation

- Stable lab values (e.g., creatinine, potassium).
- No signs of fluid overload.

Patient Education

- Teach importance of dietary restrictions.
- Educate on signs of fluid overload (e.g., swelling, shortness of breath).
- Encourage regular follow-up with nephrologist.

7. Meningitis

Assessment

- Neurological status (e.g., headache, neck stiffness, altered mental status).
- Vital signs (e.g., fever, tachycardia).
- Signs of infection (e.g., rash, photophobia).
- Lab results (e.g., CSF analysis, WBC count).

Nursing Diagnoses

- Risk for increased intracranial pressure.
- Acute pain.
- Risk for infection spread.

Goals and Outcomes

- Reduce intracranial pressure and pain.
- Prevent complications (e.g., seizures, hearing loss).

Interventions

- Administer antibiotics or antivirals as prescribed.
- Monitor neurological status frequently.
- Provide a quiet, dark environment to reduce photophobia.
- Administer analgesics and antipyretics as needed.

Evaluation

- Improved neurological status (e.g., no confusion or seizures).
- Reduced fever and pain.

Patient Education

- Teach signs of worsening condition (e.g., seizures, severe headache).
- Emphasize importance of completing antibiotic course.
- Provide information on vaccination (e.g., meningococcal vaccine).

8. Neonatal Sepsis

Assessment

- Vital signs (e.g., temperature instability, tachycardia).
- Signs of infection (e.g., poor feeding, lethargy, respiratory distress).
- Lab results (e.g., blood culture, CRP, WBC count).

Nursing Diagnoses

- Risk for infection spread.
- Impaired gas exchange.
- Ineffective thermoregulation.

Goals and Outcomes

- Stabilize vital signs.
- Eradicate infection.
- Prevent complications (e.g., septic shock).

Interventions

- Administer antibiotics as prescribed.
- Monitor vital signs and oxygen saturation.
- Maintain thermoregulation (e.g., use incubator or radiant warmer).
- Provide supportive care (e.g., IV fluids, oxygen therapy).

Evaluation

- Normal vital signs and lab values.
- Improved feeding and activity levels.

Patient Education

- Teach signs of worsening condition (e.g., increased lethargy, respiratory distress).
- Emphasize importance of completing antibiotic course.
- Provide emotional support to parents.

9. Perinatal Asphyxia (PNA)

Assessment

- Apgar score at 1 and 5 minutes.
- Signs of hypoxia (e.g., cyanosis, poor muscle tone).
- Neurological status (e.g., seizures, lethargy).
- Blood gas analysis.

Nursing Diagnoses

- Impaired gas exchange.
- Risk for seizures.
- Ineffective thermoregulation.

Goals and Outcomes

- Restore normal oxygenation.
- Prevent neurological damage.

Interventions

- Provide resuscitation (e.g., bag-mask ventilation, intubation).
- Monitor oxygen saturation and blood gases.
- Maintain thermoregulation (e.g., use radiant warmer).
- Administer anticonvulsants if seizures occur.

Evaluation

- Improved Apgar scores and oxygenation.
- No signs of seizures or neurological damage.

Patient Education

- Teach parents about potential long-term effects (e.g., developmental delays).
- Provide resources for follow-up care and early intervention programs.

10. Antepartum Hemorrhage (APH)

Assessment

- Amount and characteristics of bleeding.
- Vital signs (e.g., blood pressure, heart rate).
- Fetal heart rate and uterine activity.
- Risk factors (e.g., placenta previa, abruption).

Nursing Diagnoses

- Risk for maternal and fetal injury.
- Deficient fluid volume.
- Anxiety related to pregnancy outcome.

Goals and Outcomes

- Stabilize maternal and fetal condition.
- Prevent complications (e.g., shock, preterm labor).

Interventions

- Monitor bleeding and vital signs closely.
- Administer IV fluids or blood products as needed.
- Prepare for emergency delivery if indicated.
- Provide emotional support to the mother.

Evaluation

- Stable vital signs and reduced bleeding.
- Fetal heart rate within normal range.

Patient Education

- Teach signs of worsening condition (e.g., increased bleeding, abdominal pain).
- Emphasize importance of immediate medical attention.

11. Premature Rupture of Membranes (PROM)

Assessment

- Characteristics of amniotic fluid (e.g., color, odor).
- Vital signs and signs of infection (e.g., fever, tachycardia).
- Fetal heart rate and uterine activity.

Nursing Diagnoses

- Risk for infection.
- Anxiety related to preterm delivery.
- Deficient knowledge regarding PROM management.

Goals and Outcomes

- Prevent infection and preterm labor.
- Ensure safe delivery.

Interventions

- Monitor for signs of infection (e.g., chorioamnionitis).
- Administer antibiotics and corticosteroids as prescribed.
- Prepare for delivery if indicated.

Evaluation

- No signs of infection or preterm labor.
- Safe delivery of the baby.

Patient Education

- Teach signs of infection (e.g., fever, foul-smelling discharge).
- Provide information on preterm birth and neonatal care.

12. Eclampsia

Assessment

- Blood pressure and signs of preeclampsia (e.g., proteinuria, edema).
- Neurological status (e.g., seizures, headache).
- Fetal heart rate and uterine activity.

Nursing Diagnoses

- Risk for seizures.
- Impaired tissue perfusion.
- Anxiety related to maternal and fetal health.

Goals and Outcomes

- Prevent seizures and stabilize blood pressure.
- Ensure safe delivery of the baby.

Interventions

- Administer magnesium sulfate to prevent seizures.
- Monitor blood pressure and fetal heart rate.
- Prepare for emergency delivery if indicated.

Evaluation

- Stable blood pressure and no seizures.
- Safe delivery of the baby.

Patient Education

- Teach signs of worsening condition (e.g., severe headache, visual disturbances).
- Emphasize importance of regular prenatal care.

13. Puerperal Sepsis

Assessment

- Vital signs (e.g., fever, tachycardia).
- Signs of infection (e.g., foul-smelling lochia, uterine tenderness).
- Lab results (e.g., WBC count, blood culture).

Nursing Diagnoses

- Risk for infection spread.
- Impaired tissue integrity.
- Deficient knowledge regarding postpartum care.

Goals and Outcomes

- Eradicate infection and prevent complications.
- Promote healing and recovery.

Interventions

- Administer antibiotics as prescribed.
- Monitor vital signs and wound healing.
- Provide perineal care and encourage hygiene.

Evaluation

- Normal vital signs and lab values.
- No signs of infection or complications.

Patient Education

- Teach signs of infection (e.g., fever, foul-smelling discharge).
- Emphasize importance of completing antibiotic course.
- Provide resources for postpartum support.

Protocol for 20 key nursing procedures

1. Hand Hygiene

Purpose

To prevent the transmission of infections.

Equipment

- Soap and water or alcohol-based hand sanitizer.
- Clean towel or air dryer.

Steps

1. Wet hands with clean, running water.
2. Apply soap and lather thoroughly, covering all surfaces (palms, back of hands, between fingers, under nails).
3. Scrub for at least **20 seconds**.
4. Rinse hands under running water.
5. Dry hands with a clean towel or air dryer.
6. Use a towel to turn off the faucet.

Key Points

- Perform hand hygiene:
  - ✓ Before and after patient contact.
  - ✓ After removing gloves.
  - ✓ After touching contaminated surfaces.
  - ✓ Use alcohol-based sanitizer if hands are not visibly soiled.

2. Vital Signs Measurement

Purpose

To monitor the patient's physiological status.

Equipment

- Thermometer.
- Stethoscope.
- Blood pressure cuff.
- Pulse oximeter.

- Watch or timer.

Steps

1. **Temperature:**
   - ✓ Use oral, axillary, tympanic, or rectal method.
   - ✓ Record the reading.
2. **Pulse:**
   - ✓ Palpate the radial artery.
   - ✓ Count beats for 30 seconds and multiply by 2.
3. **Respirations:**
   - ✓ Observe chest rise and fall for 30 seconds.
   - ✓ Multiply by 2 to get breaths per minute.
4. **Blood Pressure:**
   - ✓ Place the cuff on the upper arm.
   - ✓ Inflate the cuff and slowly deflate while listening for Korotkoff sounds.
5. **Oxygen Saturation:**
   - ✓ Place the pulse oximeter on the finger.
   - ✓ Record the Spo2 reading.

Key Points

- ✓ Ensure the patient is at rest before measuring.
- ✓ Use the correct cuff size for accurate blood pressure readings.

3. Intravenous (IV) Cannulation

Purpose

To administer fluids, medications, or blood products.

Equipment

- ✓ IV cannula.
- ✓ Tourniquet.
- ✓ Antiseptic solution.
- ✓ Sterile gloves.
- ✓ IV tubing and fluids.
- ✓ Transparent dressing

Steps

1. Select an appropriate vein (e.g., forearm, dorsum of hand).
2. Apply a tourniquet proximal to the site.
3. Clean the site with antiseptic solution in a circular motion.
4. Insert the cannula at a **15–30° angle**.
5. Advance the cannula and release the tourniquet.
6. Secure the cannula with a transparent dressing.
7. Connect IV tubing and start the infusion.

Key Points

- Monitor for signs of infiltration (e.g., swelling, pain).
- Change the dressing and tubing as per protocol.

4. Medication Administration

Purpose

To deliver medications safely and effectively.

Equipment

- ✓ Medication.
- ✓ Medication administration record (MAR).
- ✓ Gloves.
- ✓ Appropriate administration tools (e.g., syringe, cup).

Steps

1. Verify the **5 Rights**: Right patient, drug, dose, route, and time.
2. Check for allergies and contraindications.
3. Prepare the medication using aseptic technique.
4. Administer via the prescribed route (e.g., oral, IV, IM).
5. Document administration and monitor for side effects.

Key Points

- Double-check calculations and labels.
- Educate the patient about the medication.

5. Wound Care

Purpose

To promote healing and prevent infection.

Equipment

- Sterile gloves.
- Antiseptic solution.
- Sterile gauze.
- Wound dressing.
- Adhesive tape.

Steps

1. Clean the wound with sterile saline or antiseptic.
2. Apply the appropriate dressing (e.g., hydrocolloid, alginate).
3. Secure the dressing with adhesive tape.
4. Document wound characteristics (e.g., size, drainage).

Key Points

- Use aseptic technique.
- Monitor for signs of infection (e.g., redness, swelling).

6. Catheterization (Urinary)

Purpose

To drain urine from the bladder.

Equipment

- Sterile catheter kit.
- Antiseptic solution.
- Sterile gloves.
- Lubricant.
- Urine collection bag.

Steps

1. Clean the urethral meatus with antiseptic solution.
2. Insert the catheter using sterile technique.
3. Inflate the balloon with sterile water.
4. Secure the catheter and connect the collection bag.

Key Points

- Maintain a closed drainage system.
- Monitor for signs of UTI (e.g., fever, cloudy urine).

7. Nasogastric (NG) Tube Insertion

Purpose

To administer feedings or medications, or decompress the stomach.

Equipment

- NG tube.
- Lubricant.
- Stethoscope.
- Syringe.
- Tape.

Steps

1. Measure the tube from the nose to the xiphoid process.
2. Lubricate the tube and insert through the nostril.
3. Advance the tube while the patient swallows.
4. Confirm placement (e.g., X-ray, pH testing).
5. Secure the tube with tape.

Key Points

- Monitor for complications (e.g., aspiration, tube displacement).

8. Blood Transfusion

Purpose

To replace lost blood or blood components.

Equipment

- Blood product.
- IV tubing with filter.
- Normal saline.
- Gloves.

Steps

1. Verify the blood product and patient identity.
2. Administer through a filtered IV line.
3. Start slowly and monitor for transfusion reactions.
4. Document the transfusion.

Key Points

- Monitor for signs of reaction (e.g., fever, rash).

9. Oxygen Therapy

Purpose

To maintain adequate oxygenation.

Equipment

- Oxygen delivery device (e.g., nasal cannula, mask).
- Oxygen source.
- Pulse oximeter.

Steps

1. Select the appropriate delivery method.
2. Adjust the flow rate as prescribed.
3. Monitor oxygen saturation and respiratory status.

Key Points

- Ensure proper humidification for high-flow oxygen.

10. Chest Tube Management

Purpose

To drain air or fluid from the pleural space.

Equipment

- Chest drainage system.
- Sterile gloves.
- Dressing supplies.

Steps

1. Monitor the drainage system for air leaks or blockages.
2. Ensure the system remains below chest level.
3. Document drainage amount and characteristics.

Key Points

- Never clamp the tube without an order.

11. Tracheostomy Care

Purpose

To maintain airway patency and prevent infection.

Equipment

- Sterile gloves.
- Sterile saline.
- Tracheostomy dressing.
- Suction catheter.

Steps

1. Clean the stoma and inner cannula with sterile saline.
2. Replace the tracheostomy ties and dressing.
3. Suction secretions as needed.

Key Points

- Use sterile technique.

12. Central Line Care

Purpose

To prevent infection and maintain line patency.

Equipment

- Antiseptic solution.
- Sterile dressing.
- Saline or heparin flush.

Steps

1. Clean the insertion site with antiseptic solution.
2. Change the dressing and tubing as per protocol.
3. Flush the line with saline or heparin.

Key Points

- Monitor for signs of infection or thrombosis.

13. Suctioning (Oral/Tracheal)

Purpose

To clear airway secretions.

Equipment

- Suction catheter.
- Sterile gloves.
- Suction machine.

Steps

1. Use sterile technique for tracheal suctioning.
2. Insert the catheter without applying suction.
3. Apply suction while withdrawing the catheter.

Key Points

- Limit suction time to 10–15 seconds.

14. Enteral Feeding

Purpose

To provide nutrition via a feeding tube.

Equipment

- Feeding formula.
- Syringe or feeding pump.
- Water for flushing.

Steps

1. Verify tube placement.
2. Administer the prescribed formula at the prescribed rate.
3. Flush the tube with water before and after feeding.

Key Points

- Monitor for aspiration or intolerance.

15. Lumbar Puncture Assistance

Purpose

To collect cerebrospinal fluid (CSF) for analysis.

Equipment

- Sterile gloves.
- Antiseptic solution.
- Lumbar puncture kit.

Steps

1. Position the patient in a lateral recumbent or sitting position.
2. Assist the physician with sterile technique.
3. Monitor for complications (e.g., headache, infection).

Key Points

- Ensure patient comfort and cooperation.

16. CPR (Cardiopulmonary Resuscitation)

Purpose

To restore circulation and breathing in cardiac arrest.

Equipment

- AED (if available).
- Barrier device for rescue breaths.

Steps

1. Perform chest compressions at a rate of 100–120/min.
2. Deliver rescue breaths at a ratio of 30:2.
3. Use an AED if available.

Key Points

- Continue until advanced life support is available.

17. Pain Management

Purpose

To alleviate pain and improve comfort.

Equipment

- Pain scale.
- Analgesics.
- Non-pharmacological tools (e.g., heat pack).

Steps

1. Assess pain using a validated scale (e.g., 0–10).
2. Administer analgesics as prescribed.
3. Use non-pharmacological methods (e.g., positioning, relaxation).

Key Points

- Reassess pain after interventions.

18. Isolation Precautions

Purpose

To prevent infection transmission.

Equipment

- PPE (e.g., gloves, gown, mask).
- Waste disposal bags.

Steps

1. Use appropriate PPE.
2. Follow specific precautions (e.g., contact, droplet, airborne).
3. Dispose of contaminated materials properly.

Key Points

- Educate visitors and staff on precautions.

19. Post-Mortem Care

Purpose

To provide dignified care after death.

Equipment

- Clean linens.
- Antiseptic solution.
- Identification tags.

Steps

1. Clean and prepare the body.
2. Remove tubes and lines as per policy.
3. Document the time of death and notify the family.

Key Points

- Respect cultural and religious practices.

20. Patient Transfer (Bed to Chair)

Purpose

To ensure safe mobility.

Equipment

- Gait belt.
- Non-slip footwear.
- Assistive devices (e.g., walker).

Steps

1. Assess patient's strength and balance.
2. Use a gait belt and assistive devices.
3. Guide the patient to a standing position and pivot to the chair.

Key Points

- Ensure the environment is safe and free of obstacles.

Monitoring nursing care for selected health conditions

	1. Diabetes Mellitus															
S/N	Criteria	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Blood glucose levels monitored (fasting and postprandial)?	Yes/No/NA														
2.	Symptoms of hyperglycemia/hypoglycemia assessed?	Yes/No/NA														
3.	Foot examination performed for ulcers/infections?	Yes/No/NA														
4.	Patient educated on insulin administration and blood glucose monitoring?	Yes/No/NA														
5.	Diabetic diet education provided?	Yes/No/NA														
6.	Blood glucose levels within target range (80–130 mg/dL fasting)?	Yes/No/NA														
7.	Absence of complications (e.g., neuropathy, infection)?	Yes/No/NA														
	Total performance															

	2. Heart Failure	

S/N	Criteria	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Vital signs monitored (BP, HR, Spo2 saturation)?	Yes/No/NA														
2.	Signs of fluid overload assessed (edema, crackles)?	Yes/No/NA														
3.	Daily weight recorded?	Yes/No/NA														
4.	Low-sodium diet encouraged (<2 g/day)?	Yes/No/NA														
5.	Diuretics, ACE inhibitors, CCB or Beta-Blockers administered as prescribed?	Yes/No/NA														
6.	Patient educated on signs of worsening heart failure?	Yes/No/NA														
7.	Stable weight and absence of edema?	Yes/No/NA														
	Total performance															
	3. Hypertensive Disorders															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Blood pressure monitored regularly?	Yes/No/NA														
2.	Symptoms of hypertension assessed (headache, dizziness)?	Yes/No/NA														
3.	Antihypertensive medications administered as prescribed?	Yes/No/NA														
4.	DASH diet encouraged (low sodium, high potassium)?	Yes/No/NA														
5.	Patient educated on lifestyle modifications (diet, exercise)?	Yes/No/NA														
6.	Blood pressure within target range (<140/90 mmHg)?	Yes/No/NA														
7.	Patient reports adherence to lifestyle changes?	Yes/No/NA														
	Total performance															

	4. Asthma	

S/N	Criteria	Compliant (Yes/No/NA)	MRN													Total	
																YES	NO
1.	Respiratory rate, oxygen saturation, and breath sounds monitored?	Yes/No/NA															
2.	Peak expiratory flow rate (PEFR) measured?	Yes/No/NA															
3.	Bronchodilators and corticosteroids administered as prescribed?	Yes/No/NA															
4.	Patient educated on proper inhaler use and asthma action plan?	Yes/No/NA															
5.	Oxygen therapy provided if needed?	Yes/No/NA															
6.	Patient demonstrates proper inhaler technique?	Yes/No/NA															
7.	Reduced use of rescue inhalers?	Yes/No/NA															
	Total performance																

	5. Liver Diseases																
S/N	Criteria	Compliant (Yes/No/NA)	MRN													Total	
																YES	NO
1.	Signs of jaundice, abdominal distension, and ascites assessed?	Yes/No/NA															
2.	Liver function tests (ALT, AST, bilirubin) monitored?	Yes/No/NA															
3.	Lactulose or rifaximin administered for encephalopathy (if applicable)?	Yes/No/NA															
4.	Low-protein diet provided if encephalopathy is present?	Yes/No/NA															
5.	Patient educated on signs of worsening liver disease (e.g., confusion, bleeding)?	Yes/No/NA															
6.	Abstinence from alcohol encouraged?	Yes/No/NA															
7.	Stable liver function tests and absence of complications?	Yes/No/NA															
	Total performance																

	6. Renal Diseases															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Urine output and characteristics monitored?	Yes/No/NA														
2.	Blood pressure and fluid balance assessed?	Yes/No/NA														
3.	Lab results (creatinine, BUN, electrolytes) monitored?	Yes/No/NA														
4.	Low-sodium, low-potassium, and low-phosphorus diet provided?	Yes/No/NA														
5.	Patient educated on dietary restrictions and signs of fluid overload?	Yes/No/NA														
6.	Medications (e.g., phosphate binders, antihypertensives) administered as prescribed?	Yes/No/NA														
7.	Stable lab values and no signs of fluid overload?	Yes/No/NA														
	Total performance															

	7. Meningitis																
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN													Total	
																YES	NO
1.	Neurological status monitored (headache, neck stiffness, altered mental status)?	Yes/No/NA															
2.	Antibiotics or antivirals administered as prescribed?	Yes/No/NA															
3.	Quiet, dark environment provided to reduce photophobia?	Yes/No/NA															
4.	Patient educated on signs of worsening condition (e.g., seizures, severe headache)?	Yes/No/NA															
5.	Analgesics and antipyretics administered as needed?	Yes/No/NA															
6.	Fever and pain reduced?	Yes/No/NA															
7.	No signs of complications (e.g., seizures, hearing loss)?	Yes/No/NA															
	Total performance																

	8. Neonatal Sepsis																
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN													Total	
																YES	NO
1.	Vital signs monitored (temperature, heart rate, oxygen saturation)?	Yes/No/NA															
2.	Antibiotics administered as prescribed?	Yes/No/NA															
3.	Thermoregulation maintained (e.g., incubator or radiant warmer)?	Yes/No/NA															
4.	Parents educated on signs of worsening condition (e.g., increased lethargy, respiratory distress)?	Yes/No/NA															
	Total performance																

	9. Premature Rupture of Membranes (PROM)															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Signs of infection (e.g., fever, foul-smelling discharge) monitored?	Yes/No/NA														
2.	Antibiotics and corticosteroids administered as prescribed?	Yes/No/NA														
3.	Patient educated on signs of infection and preterm birth?	Yes/No/NA														
	Total performance															

	10. Neonatal Sepsis															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Vital signs monitored (temperature, heart rate, oxygen saturation)?	Yes/No/NA														
2.	Antibiotics administered as prescribed?	Yes/No/NA														
3.	Thermoregulation maintained (e.g., incubator or radiant warmer)?	Yes/No/NA														
4.	Parents educated on signs of worsening condition (e.g., increased lethargy, respiratory distress)?	Yes/No/NA														
	Total performance															

	11. Perinatal Asphyxia (PNA)															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Apgar score recorded at 1 and 5 minutes?	Yes/No/NA														
2.	Resuscitation provided if needed (e.g., bag-mask ventilation)?	Yes/No/NA														
3.	Oxygen saturation and blood gases monitored?	Yes/No/NA														
4.	Parents educated on potential long-term effects (e.g., developmental delays)?	Yes/No/NA														
	Total performance															

	12. Eclampsia															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Blood pressure and signs of preeclampsia monitored?	Yes/No/NA														
2.	Magnesium sulfate administered to prevent seizures?	Yes/No/NA														
3.	Patient educated on signs of worsening condition (e.g., severe headache, visual disturbances)?	Yes/No/NA														
	Total performance															

	13. Puerperal Sepsis															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Vital signs and signs of infection (e.g., fever, foul-smelling lochia) monitored?	Yes/No/NA														
2.	Antibiotics administered as prescribed?	Yes/No/NA														
3.	Patient educated on signs of infection and importance of completing antibiotic course?	Yes/No/NA														
	Total performance															

Selected Nursing Procedure Monitoring Tool

	1. IV Line Securing															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Appropriate vein selected for cannulation?	Yes/No/NA														
2.	Aseptic technique followed during insertion?	Yes/No/NA														
3.	Cannula secured with transparent dressing?	Yes/No/NA														
4.	IV site monitored for signs of infiltration (e.g., swelling, pain)?	Yes/No/NA														
5.	IV tubing and fluids connected properly?	Yes/No/NA														
6.	Patient educated on IV care and signs of complications?	Yes/No/NA														
7.	Documentation completed accurately?	Yes/No/NA														
	Total performance															

	2. Catheterization (Urinary)															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Sterile technique followed during catheter insertion?	Yes/No/NA														
2.	Urethral meatus cleaned with antiseptic solution?	Yes/No/NA														
3.	Catheter balloon inflated with sterile water?	Yes/No/NA														
4.	Catheter secured to prevent pulling or displacement?	Yes/No/NA														
5.	Closed drainage system maintained?	Yes/No/NA														
6.	Patient monitored for signs of UTI (e.g., fever, cloudy urine)?	Yes/No/NA														
7.	Documentation completed accurately?	Yes/No/NA														
	Total performance															

	3. Medication Administration															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	**5 Rights** of medication administration followed (right patient, drug, dose, route, time)?	Yes/No/NA														
2.	Patient allergies and contraindications checked?	Yes/No/NA														
3.	Medication prepared using aseptic technique?	Yes/No/NA														
4.	Medication administered via the correct route (e.g., oral, IV, IM)?	Yes/No/NA														
5.	Patient educated about the medication?	Yes/No/NA														
6.	Documentation completed accurately?	Yes/No/NA														
7.	Patient monitored for side effects?	Yes/No/NA														
	Total performance															

	4. Nasogastric (NG) Tube Insertion															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	NG tube measured and marked correctly before insertion?	Yes/No/NA														
2.	Lubricant applied to the tube before insertion?	Yes/No/NA														
3.	Tube inserted while patient swallows (if conscious)?	Yes/No/NA														
4.	Placement confirmed (e.g., X-ray, pH testing)?	Yes/No/NA														
5.	Tube secured with tape or device to prevent displacement?	Yes/No/NA														
6.	Patient monitored for complications (e.g., aspiration, discomfort)?	Yes/No/NA														
7.	Documentation completed accurately?	Yes/No/NA														
	Total performance															

	5. Wound Care															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Wound cleaned with sterile saline or antiseptic?	Yes/No/NA														
2.	Appropriate dressing applied (e.g., hydrocolloid, alginate)?	Yes/No/NA														
3.	Wound characteristics documented (e.g., size, drainage)?	Yes/No/NA														
4.	Signs of infection (e.g., redness, swelling) monitored?	Yes/No/NA														
5.	Patient educated on wound care and signs of infection?	Yes/No/NA														
6.	Documentation completed accurately?	Yes/No/NA														
7.	Wound healing progress monitored?	Yes/No/NA														
	Total performance															

	6. Blood Transfusion															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Blood product and patient identity verified?	Yes/No/NA														
2.	Transfusion started slowly and monitored for reactions?	Yes/No/NA														
3.	Signs of transfusion reaction (e.g., fever, rash) monitored?	Yes/No/NA														
4.	IV line with filter used for transfusion?	Yes/No/NA														
5.	Patient educated on signs of transfusion reaction?	Yes/No/NA														
6.	Documentation completed accurately?	Yes/No/NA														
7.	Transfusion completed without complications?	Yes/No/NA														
	Total performance															

	7. Oxygen Therapy															
S/N	**Criteria**	Compliant (Yes/No/NA)	MRN												Total	
															YES	NO
1.	Appropriate oxygen delivery device selected (e.g., nasal cannula, mask)?	Yes/No/NA														
2.	Oxygen flow rate adjusted as prescribed?	Yes/No/NA														
3.	Oxygen saturation monitored using a pulse oximeter?	Yes/No/NA														
4.	Patient educated on oxygen therapy and safety precautions?	Yes/No/NA														
5.	Humidification provided for high-flow oxygen?	Yes/No/NA														
6.	Documentation completed accurately?	Yes/No/NA														
7.	Patient's respiratory status improved?	Yes/No/NA														
	Total performance															