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ADMISSION OF A PATIENT (AMBULANT)

1. Welcomes patient and relatives to the nurses' station and makes them comfortable.
2. Introduces self (nurse) and any staff present
3. Collects necessary documents, admission notes and any other information from the accompanying nurse
4. Identifies and confirms patient's name, particulars and reassures him/her and relatives
5. Sends patient to bedside and introduces him/her to other patients near him/her
6. Checks vital signs and records
7. Informs charge nurse of any urgent prescribed medication
8. Assists patient to change into his/her night gown or pyjamas
9. Asks patient to declare valuables if any and informs charge nurse for safe keeping
10. Explains National Health Insurance System to patient and relative(s)
11. Orientates patient/relative(s) to ward
12. Informs relative(s) about visiting time as well as other ward activities and allow relative(s) to see patient and bid goodbye
13. Enters patient's name into admission, discharges book and daily ward state
14. Document on nurses' notes and plans care

ADMISSION OF A CHILD (AMBULANT)

1. Welcomes child, parent(s)/caregiver(s)into nurses' station, establishes rapport and makes them comfortable
2. Ask child's name and introduce self and other staff present to them and reassures them of your support during admission
3. Gets child records from accompanying nurse, confirms patient's name and diagnosis and applies identification band
4. Sends child to the prepared cot/bed with side rails and introduces other children near him/her
5. Administers urgent prescribed medication
6. Checks vital signs, weight, height and records and collects specimen if ordered
7. Assists child to change into pyjamas or hospital wear
8. Orientates child and parent(s)/caregivers(s) to the unit e.g. playroom, television room, bathroom and toilet room as well as snack room if available
9. Educates child on how to call the nurse and emphasize the willingness to meet his/her needs at all times
10. Explains the hospital ward policies e.g. visiting time, National Health Insurance policies etc. to parent(s)/caregiver(s)
11. Ensures parents/Legal guardian signs consent form for treatment where necessary
12. Informs parent(s)/caregiver(s) to bring learning/playing material
13. Enters child's name into admission and discharge book, Daily Ward State and document on nurses' notes

ADMISSION OF A SERIOUSLY ILL CHILD

1. Welcomes child and parent(s)/caregiver(s), establishes rapport and receives folder from accompanying nurse
2. Checks and confirms patient's name and diagnosis and immediate treatment
3. Puts child into cot/bed and directs parent(s)/caregiver(s) to sit in the day room while taking care of child
4. Administers immediate treatment or performs the necessary resuscitation
5. Checks vital signs, weight and records
6. Takes a brief history of child's condition from parent(s)/caregiver(s)
7. Allows parent(s)/caregiver(s) to see where child is lying and orientates them to the unit and its annexes
8. Explains ward and hospital policies, visiting time, National Health Insurance Scheme, meal time etc. to them
9. Encourages parent(s)/caregiver(s) to bring child's favourite toys etc. and find out child's likes and dislikes e.g. food
10. Guides parent(s)/caregiver(s) to sign consent form for treatment etc. if necessary
11. Enters child's name into admission and discharge book and Daily Ward State
12. Documents on nurses' notes

TAKING OVER A WARD

1. Greets staff on duty
2. Asks for oral information on major happenings on the ward from the outgoing nurse
3. Reads written ward reports
4. Enquires sensitive information about patients at the nurses' office
5. Takes over ward from bed to bed verifying the state of all patients; especially the seriously ill
6. Establishes rapport with patients during taking over and asks about general health
7. Conducts inspection of ward with the outgoing staff
8. Ensures resources needed for work are available and adequate and takes over controlled medication
9. Counter-signs written ward report
10. Notes important issues and document
11. Congratulates out-going staff

HANDING OVER THE WARD

1. Welcomes the in-coming staff
2. Gives ward reports on patients to in-coming nurse to read
3. Enquires from in-coming nurse if she needs further explanation on occurrences on the ward
4. Hands over sensitive information about patients at the nurses' office
5. Interacts with patients whiles handing over
6. Checks and confirms information about patients' charts and notes
7. Checks with incoming staff if gadgets on patients are functioning e.g. cardiac monitor, intravenous line, oxygen flow metre etc.
8. Checks and hands over controlled medication and other relevant consumables available
9. Hands over ward annexes for in-coming nurse to ensure they are clean
10. Reports on any defects on equipment and requests made for urgent repairs
11. Reports on departmental instructions and other important information

MAKING A SIMPLE UNOCCUPIED BED

1. Collects, arranges items on trolley and sends to bedside
2. Arranges items in order of use on chairs or heart table
3. Places bottom sheet evenly on the bed
4. Tucks the sheet evenly under the mattress at the top and bottom using enveloped corners
5. Pulls and tucks sheet at the sides with no creases
6. Places draw mackintosh across bed and covers with draw sheet
7. Slips the pillow case on the pillow with an assistant
8. Places pillows on bed with open ends away from the entrance
9. Places top sheet on bed with the wrong side uppermost
10. Folds over at the bottom and tucks in loosely
11. Places bed cover and counterpane loosely over the bed
12. Tucks bedcover and counterpane at the bottom end using envelop corners
13. Folds top sheet over the counterpane at the top end
14. Tucks in sides under mattress
15. Removes trolley and chair
16. Washes and dries hands or uses alcohol rub if applicable

MAKING AN ADMISSION BED

1. Collects, arranges items on trolley and sends to bedside
2. Arranges items in order of use on a chair or heart table
3. Places bottom sheet evenly on the bed
4. Tucks the sheet evenly under the mattress at the top and bottom using enveloped corners
5. Places draw mackintosh across bed and covers with draw sheet
6. Places long mackintosh on the bed
7. uses one bath blanket or sheet over and tucks in all around or folds under itself
8. Races second bath blanket over the bed
9. Puts in hot water bottles if necessary
10. Puts on top bed clothes
11. Races counterpane loosely over the top bed clothes
12. Tucks in the bed domes on the other side
13. Folds the clothes on the other side nearest to the door, leaving it open to facilitate quick admittance
14. Washes and dries hands or use alcohol rub it applicable

MAKING AN OPERATION BED

1. Collects, arranges items on trolley and sends to bedside
2. Arranges items in order of use on chairs or a heart table
3. Places bottom sheet evenly on bed and tucks the sheet under the mattress at the top using enveloped corners
4. Pulls sheet tight so that there are no creases and tucks the sheet under the mattress at the bottom using enveloped corners
5. Places draw mackintosh across bed and covers with draw sheet
6. Places protective dressing towel at top of the bed towards the sides
7. Leaves pillow on chair by the bed
8. Spreads blanket on bed
9. Places top sheet on with the wrong side uppermost and turns back the bottom end
10. Folds the top bed clothes at the open side in three parts over the bed for easy admission of patient
11. Places a post anaesthetic tray by bed side containing vomit bowl, dressing towel, kidney dish containing swab holding forceps, dissecting forceps, tongue holding forceps and padded spatula
12. Arranges other bed accessories by the bedside — e.g. drip stand/ bed rail, vital signs tray medication tray, suction machine, oxygen apparatus
13. Washes, dries hand or use alcohol rub if applicable

MAKING A CARDIAC BED

1. Collects, arranges items on trolley and sends to bedside
2. Arranges items in order of use on chairs or a heart table
3. Places bottom sheet evenly on the bed and tucks the sheet under the mattress at the top using enveloped corners
4. Pulls sheet tight so that there are no creases and tucks the sheet under the mattress at the bottom using enveloped corners.
5. Places draw mackintosh across bed and covers with draw sheet and tucks in
6. Places covered air rings in between the mackintosh and draw sheet
7. Places/elevates back rest at top end of bed and arranges pillows in an arm chair-like fashion
8. Places top sheet on bed with the wrong side upper most and folds sheets over at the bottom
9. Places foot rest in position
10. Places heart table with covered pillows in position
11. Places sputum mug and bell within reach of patient
12. Provides pen and paper if patient is literate
13. Clears chairs/heart table, trolley, washes, dries hand or use alcohol rub if applicable

CHANGING BOTTOM SHEET OF PATIENT FROM SIDE TO SIDE

1. Explains procedure to patient and ensures privacy
2. Collects and arranges items on trolley
3. Arranges sheets in order of use on chairs or a heart table
4. Removes any equipment attached to the bed e.g. drip stand, side rails etc.
5. Loosens sheets at the side of bed/ leaves patient with only one pillow and cover him/her with top sheet
6. Assists the patient to turn to the side away from the clean portion of the linen supported by another nurse
7. Rolls dirty bottom sheet under patient
8. Covers the bed with a clean rolled bottom sheet halfway in the middle of the bed
9. Puts on draw mackintosh and draw sheet across bed tucking in greater part nearest to the door
10. Removes dirty bottom sheet and places it in a receptacle
11. Pulls the bottom sheet tightly and tucks in
12. Covers patient with top sheet and counterpane, leaves him comfortable
13. Clears items and removes screen
14. Washes and dries hand
15. Document findings and report

CHANGING BOTTOM SHEET OF A PATIENT FROM TOP TO BOTTOM

1. Explains procedure to patient and provides privacy
2. Collects and arrange necessary items on a trolley
3. Arranges sheet in order of use on a chair or heart table
4. Loosens sheet at the sides and foot end of the bed
5. Removes counterpane by folding it into 3 and places it on chairs
6. Leaves patient covered with the top sheet
7. Holds top sheet over patient's shoulder with hand nearest to the head of bed
8. Moves patient to foot end of bed with help of an assistant and lets him/her lean/rest on a heart table with a pillow
9. Removes pillows on the head end of the bed and places on chair
10. Rolls the soiled sheets down from the top end of the bed to the patients' buttocks
11. Makes top half foundation bed with clean sheets and arranges pillows at top half of bed
12. Helps patient back to position keeping him/her covered
13. One nurse lifts the patient's legs while the other removes the soiled bottom sheets and places it in the dirty linen container
14. Pulls down the clean bottom sheet, mackintosh and draw sheets
15. Both nurses pull the bottom sheet tight and tucks in using enveloped corners
16. Finishes making bed using top sheet and makes patient comfortable
17. Clears items and removes screen
18. Washes and dries hands
19. Document findings

CHECKING VITAL SIGNS - TEMPERATURE, PULSE, RESPIRATION, BLOOD PRESSURE (USING THE INDIVIDUAL ELECTRONIC THERMOMETER AND ELECTRONIC SPHYGMOMANOMETER)

1. Explains procedure to patient
2. Presses knob to ensure thermometer and sphygmomanometer are functioning
3. Prepares and sends tray to patient's bedside
4. Makes patient comfortable by tying/sitting up in bed, washes and dries hands or use alcohol rub
5. Presses knob again to show reading on the screen, exposes axilla, dries with clean dry cotton wool and discards
6. Cleans the thermometer with a dry cotton wool swab from bulb to the stem
7. Inserts thermometer into the axilla between two skin folds
8. Checks and records pulse and respiration whiles thermometer is in axilla
9. Removes thermometer after beep, reads, records and cleans from stem to the bulb and inserts thermometer back into its container
10. Charts readings of temperature, pulse and respiration
11. Stretches patient's arm and places sphygmomanometer beside arm at the same level
12. Winds /wounds/wraps cuff around arm above elbow
13. Inflates cuff by pressing the start knob and wait for reading to appear on the screen
14. Removes cuff and reassemble apparatus
15. Thanks and makes patient comfortable
16. Washes and dries hands, records reading

CHECKING VITAL SIGNS - TEMPERATURE, PULSE, RESPIRATION, BLOOD PRESSURE (USING THE INDIVIDUAL NON-DIGITAL THERMOMETRE AND MERCURIAL OR ANEROID SPHYGMOMANOMETER)

1. Explains procedure to patient
2. Prepares and sends tray to patient's bed side
3. Makes patient comfortable by lying or sitting
4. Dip the bulb of the thermometer into a gallipot containing water
5. Cleans thermometer from bulb to stem using dry cotton wool swabs
6. Reads thermometer at eye level and ensure mercury is at $35^{o}C$
7. Wipes axilla with a dry cotton wool swab and discards
8. Inserts thermometer in to axilla between two skin folds
9. Leaves thermometer in axilla for three full minutes
10. Whiles the thermometer is in position check pulse and respiration rate
11. Records pulse and respiratory rates
12. Removes thermometer, cleans from stem to the bulb at eye-level
13. Reads thermometer at eye-level
14. Washes, dries hands or uses alcohol rub and records temperature
15. Stretches patient's arm and places sphygmomanometer at the shoulder level/if aneroid fix the manometer on the cuff
16. Winds/wounds/wraps cuff around arm above elbow
17. Palpates radial artery and inflates cuff until pulse disappears
18. Checks, wears and places stethoscope on brachial artery
19. Releases cuff pressure slowly and listens to sound with stethoscope

20. Removes cuff, folds and reassembles apparatus

21. Thanks and makes patient comfortable in bed

22. Washes and dries hands charts the readings vital signs chart

23. Records blood pressure readings on nurses' note and vital signs chart

MOUTH CARE FOR A SERIOUSLY ILL/UNCONSCIOUS PATIENT

1. Explains procedure to patient and provides privacy
2. Prepares a tray and takes it to the patient's bedside
3. Puts patient in a suitable position
4. Protects patient's gown and bed linen with mackintosh and towel
5. Pours lotion into gallipots, washes and dries hands
6. Cleans lips and outer part of teeth. Opens mouth with padded spatula. Inspects mouth for any abnormalities and removes dentures if any
7. Takes swab with forceps, dips into cleansing lotion and squeezes out excess
8. Cleans mouth thoroughly but gently i.e. from inside the cheeks, both sides of gums, tongue and palate changing swabs frequently
9. Controls movement of the tongue with spatula
10. Uses tooth pick to clean in between teeth
11. Cleans mouth with water or any mouth wash
12. Cleans lips and applies Vaseline
13. Makes patient comfortable in bed and removes screen
14. Discards tray, decontaminate, washes and sterilizes instruments
15. Washes, dries hands and documents procedure and findings

BED BATHING

1. Explains the procedure to the patient and provides privacy
2. Prepares and takes trolley to bedside
3. Offers bedpan or urinal if required
4. Loosens and removes top bed clothes and arranges on a chair/bed table
5. Removes patient's clothes and covers him/her with a bed linen
6. Protects bed and pillow with long mackintosh and a bath towel/blanket
7. Maintains individuality of patients by asking him/her if he/she would like soap on the face, temperature of water or if he/she will like to clean the genitalia himself/herself
8. Washes, rinses and dries patient's face beginning from the inner to the outer canthus of each eye
9. Washes, rinses and dries the rest of the face, ears and neck
10. Washes, rinses and dries patient's arm farther away from the nurse then washes, rinses and dries patient's arm near to the nurse
11. Washes, rinses and dries the chest and abdomen paying attention to the skin folds
12. Washes, rinses and dries the legs in the same way as the arms
13. Turns patient on his/her sides and washes, rinses and dries the back
14. Examines and treats pressure areas
15. Changes bottom linen and rolls patient on his/her back
16. Cleans patient's genitalia (performs vulva toileting if a female)
17. Grooms and dresses patient in clean clothes
18. Makes patient comfortable and thanks him/her
19. Discards trolley, washes and dries hands properly
20. Documents procedure and reports any abnormalities

RECORDING OF INTAKE AND OUTPUT

1. Explains the importance of keeping the fluid balance chart to patient to gain his/her co-operation
2. Explains the role patient has to play to him/her
3. Gets requirement e.g. measuring jugs for intake and output, fluid chart and pen
4. Washes and dries hands, dons gloves if applicable
5. Records in millilitres the amount of infusion/transfusion and other fluid intake at intake column
6. Records in millilitres any output such as urine, watery' stool, vomitus at output column
7. Totals intake and output for 24 hours depending on hospital's policy
8. Finds fluid balance by subtracting output from intake
9. Documents findings (Characteristic of the output)
10. Informs the nurse in charge/doctor immediately if amount of output is greater than the amount taken in or when there is abnormally low output

SPOON FEEDING OF AN ADULT ILL PATIENT

1. Explains procedure to patient, washes hands and prepares meal tray with food, spoon, a jug of drinking water, cup and napkins
2. Offers bedpan if required before feeding is started
3. Puts patient in a comfortable position, washes and dries hands
4. Gives patient a mouth wash
5. Brings food in a tray to patient's bedside and protects patient's clothing with the napkin
6. Ensures patient is in a comfortable position and asks if prayer is preferred
7. Takes food by spoon in small bits into patient's mouth
8. Allows patient time to chew and swallow
9. Continues feeding until patient is satisfied
10. Gives water intermittently as required by patient and after feeding
11. Cleans patient's lips and gives a mouth wash
12. Removes napkin and makes patient comfortable
13. Congratulates patient and discards tray
14. Washes hands and documents on nurses' notes

FEEDING A HELPLESS PATIENT

1. Explains procedure to patient and considers the likes and dislikes
2. Informs patient's about meal to be served to stimulate his/her appetite
3. Ensures clean atmosphere, clear all bed pans, urinals and vomit bowls and ensures brightness in the room
4. Puts patient in a comfortable position if patient's condition would allow it
5. Puts patient in a sitting up position and arrange pillows on the back rest to support him/her or in the lying position, elevate the head end of the bed
6. Places prepared tray on the bed table or patient's locker
7. Give patient a mouthwash
8. Washes patient's hands with soap and water and dry with a clean towel
9. Washes and dries hands before serving meals (the nurse)
10. Places napkin/serviette across the chest to protect patient's clothing
11. Sits on a chair at the bedside of the patient if convenient to make him/her feel relaxed
12. Cuts feed into bite sizes and feeds patient with levelled spoonful a little at a time
13. Allows patient enough time to chew and swallow
14. Observes the rate at which the patient eats
15. Co-ordinates the opening of the mouth and introduction of food into the mouth
16. Places the spoon or fork accurately into the mouth i.e. not too far back to produce gagging
17. Serves sips of water in between feeding with a spoon or flexible straw
18. Cleans or wipes patient's mouth and chin during and after the meal when necessary
19. Serves water; rinse mouth, removes used napkin/serviette and clear tray
20. Congratulates patient for efforts made in eating, washes and dries his or her hand with a towel

21. Encourages patient to comment on the food served
22. Makes patient comfortable
23. Washes and dries hands (nurse)
24. Documents procedure in the nurses' notes and/or fluid intake and output chart if applicable

FEEDING A PATIENT PER NASO-GASTRIC TUBE

1. Explains procedure to patient and provides privacy
2. Sends prepared feed in a tray to the patient's bedside
3. Assists patient into a fowler's position in bed or a sitting up position in a chair or a slightly elevated right side lying position
4. Makes patient comfortable and protects his/her clothes
5. Checks for proper placement of tube in the stomach by aspirating abdominal contents for a typical gastric fluid appearance (grassy-green, colourless with mucus shreds) OR inject 5 -- 20cc of air through the tube and auscultate epigastric region with a stethoscope and listens for the whooshing sound simultaneously indicating proper positioning
6. Washes and dries hands
7. Checks temperature of feed by dropping a little amount on the back of hand
8. Pinches tube and removes spigot of naso-gastric tube, pushes 10 15mls of water through the tube just before feed is introduced
9. Connects syringe with feed to tube, releases the pinch and allows the feed to run by gravity
10. Ensures tube is never allowed to empty completely to prevent air from entering patient's stomach
11. Continues feeding and observe patient for signs of discomfort till feeding is completed
12. Flushes the tube with 10 - 15 tills of water at the end of feeding
13. Pinches tube and removes syringe and replaces in spigot
14. Assists patient to remain in the sitting up position for at least 30 minutes after feed

15. Removes protective clothing, and makes patient comfortable, discards tray, washes and dries hands
16. Documents procedure on intake and output chart and nurses' notes

ADMINISTRATION OF TABLET

1. Identifies patient by mentioning the name and checks treatment sheet against doctor's order
2. Explains procedure to patient and sends tray to the bedside
3. Checks for the right patient, right medication, right time, right dose, ensures patient's right to know/consent and to refuse
4. Reads the label on the package and compares with patient's treatment sheet
5. Removes the package, checks the label of the packages and compares with patient's treatment sheet for the third time
6. Pours out water into a drinking glass or cup
7. Takes the tablet with a spoon
8. Gives the tablet to the patient and ensures that patient swallows it
9. Congratulates patient and makes him comfortable in bed
10. Discards tray, washes and dries hands
11. Documents procedure in the nurses' note and chart on treatment sheet

ADMINISTRATION OF MIXTURE

1. Identifies and checks for the right patient, right medication, right time, right dose ensures patient's right to know/consent and to refuse
2. Informs patient and sends tray to bedside
3. Identifies patient by mentioning the name and checks with treatment sheet
4. Reads and compares the label on the bottle with patient's treatment sheet
5. Shakes the bottle well
6. Removes the cork and holds it with the little or ring finger, compares label on the bottle a second time with patient's treatment sheet
7. Picks the medicine glass and with the thumb nail marks the level of the measure to be taken
8. Pours out the prescribed dose at eye level in the bright light, holding the bottle with the label upper most
9. Replaces the cork, reads the label a third time compares with patient's treatment sheet and dosage
10. Carries medicine to the patient on a tray or saucer, a teaspoon may be added for stirring if it is a suspension
11. Supervises patient to drink the medicine and serves water if necessary
12. Congratulates patient and makes him/her comfortable in bed
13. Discards tray, washes and dries hands
14. Documents procedure and signs treatment sheet

ADMINISTRATION OF RECTAL MEDICATION

1. Identifies patient by mentioning the name and checks treatment sheet against doctor's order
2. Establishes rapport and explains procedure to patient and encourage him/her to empty bowel
3. Observes the rights of medication administration
4. Sends tray to bedside and provides privacy
5. Assists patient to a left lateral or left Sim's position, with the upper leg flexed
6. Protects bed with dressing mackintosh and towel at the buttocks
7. Fold back the top bedclothes to expose the buttocks
8. Washes/dries hands dons gloves and cleans anal area with cotton wool swabs
9. Removes gloves, washes and dries hands
10. Removes medication, checks label and compares with patient's treatment sheet the third time
11. Wears gloves, unwraps the suppository encourages the patient to relax by breathing through the mouth
12. Inserts the suppository gently into the rectum using the gloved index finger and presses the patient's buttocks together for few minutes
13. Asks the patient to remain in the left lateral or supine position at least for (5) minutes or according to manufacturer's instruction
14. Congratulates patient and makes him/her comfortable in bed
15. Removes gloves, clears tray/ washes and dries hands
16. Documents procedure on treatment sheet and nurses' notes

ADMINISTRATION OF MEDICATION (AMPOULE RECONSTITUTED MEDICATION)

1. Establishes rapport and explains procedure to patient
2. Checks the Physician's order for the type of medication and the rights of medication administration
3. Checks medication label and be sure before reconstituting as per manufacturer's instructions especially expiry date
4. Washes, dries hands, reconstitutes, examines for cloudiness and sediments
5. Draws medication and expels air from the barrel of the syringe
6. Protects bed linen with a dressing mackintosh and towel and positions patient comfortably.
7. Washes, dries hands, wears gloves and cleans entry port of cannula with methylated spirit and cotton wool swab
8. Fixes syringe into the entry port of cannula and pushes medication slowly using the push-stop-push —stop technique till administration is completed whiles observing patient for any reaction
9. Continues observing patient even after injecting medication 5 to 10 minutes later
10. Encourages patient to inform the nurse for any adverse reaction
11. Thanks patient and makes him comfortable in bed
12. Removes dressing mackintosh, towel and discards used items
13. Washes, dries hands and record procedure on treatment chart and on the nurses' notes

PREPARING TRAY AND GIVING INTRAMUSCULAR INJECTION

1. Identifies and checks for the right patient/ right medication, right time, right dose ensures patient's right to know/consent and to refuse
2. Explains procedure to patient and provides privacy
3. Prepares and takes tray to patient's bedside
4. Chees details again with patient's treatment sheet
5. Washes and dries hands
6. Assembles syringe and needle using sterile technique
7. Files and breaks ampoule or removes metal cap of vial with a clean swab, draws medication and discards
8. Replaces needle with a new one and expels air
9. Assists patient into a required position and exposes site for injection
10. Cleans injection site with swab dipped in antiseptic lotion (i.e. upper outer quadrant for buttocks and outer aspect for thigh)
11. Inserts tie needle quickly and firmly deep into the muscle at right angle
12. Withdraws Piston a tittle to ensure needle is not in the blood vessel (if blood appears withdraws needle)
13. Pushes to release medication into the tissue
14. Withdraws the syringe and needle quickly and with a swab gently applies pressure to the site of injection
15. Discards syringe and needle into a safety box
16. Thanks patient and leaves him/her comfortable in bed
17. Washes and dries hands, documents any findings and signs treatment sheet

SETTING UP I.V. INFUSION

1. Explains procedure and its purpose to patient and reassures him/her
2. Checks the physician's order for the type of solution and checks the rights of medication administration
3. Ensures quality of the infusion (checks for cloudiness, sediments, other particles and expiry date)
4. Sends prepared trolley and other equipment to the patient's bedside
5. Encourages patient to use bedpan and checks vital signs and records
6. Selects and inspects sites and shaves if necessary
7. Places infusion stand at the side of the bed and prepares plaster strips/tape
8. Inserts the piercing needle of giving set into the rubber seal of the infusion bag/bottle
9. Hangs the bottle/bag on the drip stand
10. Removes the cap from the other end of the giving set and attaches needle to it
11. Protects the bed with dressing mackintosh and dressing towel
12. Fills the chamber half way and expels air from the giving set
13. Washes hands, dries and wears sterile gloves and cleans the site with antimicrobial solution (methylated spirit) with cotton swab
14. Asks assistant to apply tourniquet to locate the vein

DRESSING OF WOUND

1. Explains procedure to patient and ensures privacy
2. Put on mask, prepares and takes trolley to the patient's bedside
3. Positions patient comfortably and protects bed clothes
4. Exposes area of wound and removes plaster or bandage
5. Washes, dries hands, assemblies instruments and pours lotions into gallipots
6. Removes soiled dressing with dissecting forceps or gloved hand, discards, washes and dry hands
7. Dabs or cleans wound with sterile forceps/gloves using prescribed lotion or where necessary gently irrigates wound with syringe and saline from within outwards and deans the surrounding skin
8. Cleans or dabs wound with series of swabs until wound is clean
9. Applies sterile dressing using prescribed dressing lotion, add enough sterile dressing and secures into position or leaves exposed where necessary
10. Makes patient comfortable in bed, informs patient about the state of the wound and thanks him/her
11. Removes gloves, washes, dries hands, discards trolley, decontaminates instruments, removes screen
12. Washes, dries hands, documents and reports state of the wound

DRESSING OF WOUND (SIMPLE OR UNCOMPLICATED)

1. Establishes rapport and explains procedure to patient
2. Puts on mask, prepares and takes trolley to bedside and provides privacy
3. Puts patient into desired position, protect bed clothes and exposes the wound
4. Pours out lotions into galipots and remove plaster or bandage
5. Removes soiled dressings using dissecting forceps or disposable gloves and discards
6. Washes and dries hands and wears sterile gloves or uses sterile forceps
7. Cleans wound with swabs soaked in normal saline using sterile forceps or sterile gloves starting from the wound outward using one swab at a time
8. Cleans wound with series of swabs until clean
9. Applies sufficient sterile dressings and secures into position
10. Makes patient comfortable in bed, informs patient about the state of the wound and thanks him/her
11. Removes gloves, washes, dries hands discards trolley, decontaminates instruments, removes screen
12. Washes, dries hands, documents and reports state of the wound

DRESSING OF WOUND (WITH ASSISTANT)

1. Establishes rapport and explains procedure to patient
2. Puts on face mask, prepares and takes trolley to bedside and provides privacy
3. Asks assistant to:
    i. Put patient into desired position
    ii. Protect bed clothes and exposes wound

4. Asks assistant to:
    i. Pour out lotions into gallipots
    ii. Remove plaster or bandage
5. Removes soiled dressing using disserting forceps or disposable gloves and discards
6. Washes and dries hands and wear sterile gloves or uses sterile forceps
7. Cleans wounds with sterile swabs soaked in normal saline using sterile forceps or sterile gloves starting from the wound outward using one swab at a time
8. Cleans wound with series of swabs until clean
9. Applies sufficient sterile dressings and secures into position
10. Makes patient comfortable in bed, informs patient about the state of the wound and thanks him/her
11. Removes gloves, washes/ dries hands discards trolley, decontaminates Instruments, removes screen
12. Washes, dries hands, documents and reports state of the wound

EDUCATING PATIENT ON CONDITION

1. Explains the need for education to patient
2. Makes patient comfortable either sitting or lying down
3. Sits comfortably on a chair by patient's side
4. Ensures enabling and relaxed environment to maintain privacy and individuality of patient
5. Finds patient's level or awareness of condition
6. Builds on what the patient knows with scientific data of condition in language that patient understands
7. Explains to patient the rationale for treatment and possible outcome
8. Ensures patient understands the teaching and co-operates with health team
9. Allows patient to ask questions for clarification
10. Provides patient with clear simple pamphlets if available
11. Thanks patient and documents education

EDUCATING A PATIENT ON MEDICATION PRIOR TO DISCHARGE

1. Identifies patient's treatment chart and medication
2. Establishes rapport with patient
3. Uses language patient understands
4. Involves patient's and/or significant others
5. Speaks audibly to patient
6. Explains procedure to patient's and family
7. Assesses patient's previous knowledge on medication
8. Shows type of medication to patient and/or significant others
9. Informs patient and/or significant others about route(s) of administration
10. Instructs patient and/or significant others on dosage of medication to take at a time
11. Explains action of the medication to patient and/or significant others
12. Describes the side effect of the medication to patient and/or significant others
13. Instructs patient and/or significant others to report to hospital when serious side effects occur
14. Demonstrates to patient and/or significant others how to store drug at home safely
15. Allows patient and/or significant others to repeat instruction and asks question(s)
16. Responds to questions appropriately
17. Thanks patient and/or significant others for co-operating and documents procedure in the nurses' notes

PRE-OPERATIVE PREPARATION OF PATIENT FOR SURGERY

1. Explains procedure to patient and reassures him/her
2. Prepares a trolley with the following items: gauze, antiseptic lotion, plaster, bowl of water, soap and sponge, operating towel, theatre gown vital signs tray, mackintosh and dressing towel
3. Sends trolley to bedside and provides privacy
4. Places patient into desired position
5. Exposes the area to be prepared and protects the bed clothes
6. Wears gloves, washes the area with soap and water
7. Dries and cleans area with antiseptic lotion
8. Covers area with operating towel and secures it in position with adhesive strapping
9. Gowns patient with a clean theatre gown
10. Asks patient to empty bladder and remove dentures if any
11. Checks vital signs and records
12. Gives prescribed pre-medication when patient is ready for the theatre if necessary
13. Thanks patient, discards trolley, washes and dries hands
14. Document procedure

IMMEDIATE POST OPERATIVE CARE OF PATIENT FROM THEATRE

1. Ensures the following items are available and ready for use:
    a. Operation bed
    b. Post anaesthetic tray
    c. Oxygen cylinder
    d. Suction machine
    e. Vital signs tray
    f. Screen
    g. Infusion stand
    h. Bed rails
    i. Mouthcare tray
2. Receives patient gently into bed and reassures him/her if conscious
3. Places patient flat on bed with the head turned to one side or in the appropriate position according to the operation performed
4. Provides bed rails for safety If necessary
5. Reads through the patient's case notes for post-operative instructions
6. Observes for level of consciousness by the use of stimulus e.g. pointed object or by calling patient by name
7. Monitors vital signs for 15mjnutes for first one hour, 30 minutes for the next hour, 1 hour for the next 4 hours and 4 hourly intervals as condition stabilizes
8. Observes for bleeding from operational site and reports for possible reinforcement
9. Ensures canula is in situ, checks the flow rate of the intravenous fluid and regulates as ordered

10. Checks and ensures that all drainage tubes e.g. naso-gastric tube and catheter are in situ and are draining well
11. Records intake and output accurately
12. Assesses for pain and gives prescribed analgesics and records
13. Checks and administers all prescribed medication per the appropriate route
14. Maintains personal and oral hygiene
15. Observes any abnormality in the patient's condition and documents findings and nursing interventions
16. Puts patient in a comfortable position or as ordered by surgeon when he is fully conscious

CATHETER CARE FOR A MALE PATIENT

1. Establishes rapport and explains procedure to patient
2. Assembles necessary items
3. Ensures privacy
4. Washes, dries hands and puts patient in the supine position
5. Places mackintosh and towel under patient
6. Covers patient up so that only genital area is exposed
7. Removes anchor device to free catheter tubing, washes, dries hands and wears sterile gloves
8. Retracts foreskin if present to expose urethral meatus, cleans around catheter first, and then wipes in a circular motion around meatus and glans
9. Inspects urethral meatus for discharge
10. Uses sterile cotton swab soaked in antiseptic lotion, wipes in a circular motion along the length of catheter and anchors it back

11. Applies antibiotic ointment at urethral meatus and along 2.5cm of catheter if ordered by Physician/Surgeon
12. Removes gloves, washes, dries hands/ places patient in a safe and comfortable position and removes screen
13. Discards tray/trolley, washes, dries hands records and reports findings

CATHETER CARE FOR A FEMALE PATIENT

1. Establishes rapport and explains procedure to patient
2. Assembles necessary items
3. Ensures privacy
4. Washes hands and put patient in the supine position
5. Places mackintosh and towel under patient
6. Covers patient up so that only vulva area is exposed washes, dries hands and dons gloves
7. Removes anchor device to free catheter tubing, removes gloves, washes and dries hand
8. Dons sterile gloves, cleans vulva using cotton wool swab and antiseptic solution towards anus, cleans urethral meatus, moving down the catheter
9. Inspects urethral meatus for discharge
10. Uses cotton wool swab soaked in antiseptic lotion, wipes in a circular motion along the length of catheter and anchors back into position
11. Applies antibiotics ointment at urethral meatus and along 2.5cm of catheter If ordered by Physician/Surgeon
12. Removes gloves, washes, dries hands, places patient in a safe and comfortable position and removes screen
13. Discards tray/trolley, washes, dries hands records and reports findings

INSERTION OF AN INDWELLING CATHETER (FEMALE)

1. Explains procedure to patient, provides privacy
2. Washes, dries hands and assemblies the following:
    a. Sterile indwelling catheter (correct size)
    b. Syringe filled with 5 — 10mls of normal saline/sterile water
    c. Jug of warm water, soap and towel
    d. Sterile gloves
    e. Sterile drape, sterile fenestrated drape
    f. Sterile cotton wool
    g. Antiseptic cleansing agent
    h. Urine bag
    i. Lubricant e.g. xylocaïne Jelly
    j. Intake and output chart
    k. Urine specimen container and laboratory request form where applicable
    l. Sterile forceps
    m. Receiver
    n. Bedpan
3. Protects bed with mackintosh, towel and ensures adequate lighting
4. Washes, dries hand and dons gloves
5. Instructs assistant to place patient in the supine position with knees flexed and legs separated
6. Places bedpan under patient and washes perineum thoroughly with soap and water
7. Cleans patient, removes bedpan and drapes with a sterile towel
8. Removes the gloves, wears sterile gloves and cleans the vulva with an antiseptic cleaning agent

REMOVAL OF AN INDWELLING CATHETER

1. Explains the procedure to patient and provides privacy
2. Prepares and takes tray to bedside
3. Positions patient as for catheterization
4. Places mackintosh and dressing towel beneath the patient and around genital area
5. Washes and dries hands
6. Dons gloves and places a towel between legs of the female patient/on the thighs of the male patient
7. Inserts the syringe into the injection port of catheter and withdraws water from the balloon
8. Withdraws the catheter gently and places in the waste receptacle
9. Dabs the perineal area with a towel
10. Measures urine in the drainage bag and remove gloves
11. Thanks patient and discard used items
12. Washes hands and documents findings

PREPARATION AND CARE OF PATIENT DURING AND AFTER LUMBAR PUNCTURE

1. Explains the procedure to the patient and reassure him/her to gain co-operation
2. Ensures consent form has been signed
3. Provides privacy and instructs patient to void before the procedure
4. Washes and dries hands
5. Opens the equipment tray taking care not to contaminate
6. Provides adequate lightening at the puncture site
7. Assists patient into a required position i.e. lying or sitting and supports him/her

8. Continues to support, observes and reassures patient throughout the procedure
9. Wears sterile gloves and applies sterile dressing when needle is withdrawn and secures firmly with an adhesive tape
10. Allows patient to lie flat on the back and makes him/her comfortable
11. Observes patient for the next 24 hours for the following:
    a. Leakage from puncture site
    b. Headache
    c. Backache
12. Checks and record vital signs
13. Thanks patient, washes and dries hands
14. Documents procedure

PREPARING PATIENT AND A TROLLEY FOR LUMBAR PUNCTURE

1. Explains procedure to patient and ensures his/her co-operation and provide privacy
2. Washes dries, hands and prepares trolley with the following items:
3. Top shelve
    i. Sterile fenestrated drape, sterile gallipot with sterile cotton wool swabs
    ii. Sterile gallipot containing antiseptic cleaning agent
    iii. Sterile dressing pack
4. Bottom shelve
    i. Sterile gloves packs for the doctor and nurse
    ii. Pack of examination gloves
    iii. Face mask
5. i. Receiver for solid swabs
    ii. Receiver for used instruments
6. i. 2ml syringe for local anaesthetic agent
    ii. 18G or 20G 34 spinal needle with stylet
    iii. Three way stop cock
    iv. Manometer
    v. Adhesive strapping
7. i. 3 labelled specimen collection tubes with stoppers
    ii. Laboratory request forms
    iii. Light source (touch light)
    iv. Counter scissors

v. Vital signs tray

8. i. Brings trolley to bed side and provides privacy

   ii. Washes, dries hands and opens the top shelve

9. Assists patient to lie on his/her side at the edge of the bed and assumes the knee chest or foetal position
10. Places one hand behind his/her neck and other behind his/her knees and assists patient to maintain the assumed position

CHANGING OF COLOSTOMY BAG AND CARE OF STOMA

1. Explains procedure to patient and provides privacy
2. Prepares and sends trolley to bedside
3. Turns down top sheet to expose stoma
4. Protects site with mackintosh and dressing towel
5. Puts on disposable gloves and removes soiled bag gently and places in large receiver
6. Removes disposable gloves, washes and dries hands
7. Puts on sterile gloves, washes area around the stoma with soap/mild detergent and warm water
8. Dries area gently with sterile cotton wool balls and applies barrier cream/zinc oxide cream
9. Estimates stoma and fits correct size of stoma bag
10. Removes gloves/ washes and dries hands
11. Makes patient comfortable and thanks him/her
12. Discards soiled articles
13. Cleans, sterilize and stores used items
14. Documents procedure and reports any abnormalities

CARE OF THE PATIENT IN SKELETAL TRACTION

1. Explains procedure to patient and provides privacy
2. Sets trolley with sterile dressing set, sterile cotton balls, sterile gauze packs, normal saline and povidine iodine
3. Washes hands and observes infection prevention measures and inspects the traction apparatus
4. Ensures patient is in the appropriate position, and checks that the head, knee and foot of bed are properly elevated and trapeze well padded
5. Turn patient as a unit to prevent neck from twisting
6. In case of dislodgement of skull or Steinmann's pin, support the head, remove the weight, place sandbags or water bags on either side of the head or leg to maintain proper alignment
7. Assess neuro-vascular status of the affected extremity
8. Inspects carefully the pin site daily to detect infections early and provides pin site care using aseptic technique
9. Removes crusts from site and applies prescribed dressing agent and loosely applies gauze dressing around the pin site, obtain sample if purulent for laboratory investigation
10. Teaches patient deep breathing and coughing exercises, flexion and extension of affected limb's toes and range of motion exercises of the unaffected limb
11. Thanks patient for his co-operation
12. Washes, dries hands and document procedure noting abnormalities

CARE OF THE TRACHEOSTOMY TUBE

1. Explains procedure to patient/ engages his co-operation and provides privacy
2. Prepares trolley and sends to the bedside
3. Wears disposable gloves and suctions the tracheostomy tube
4. Removes the inner tube by turning the lock about 90 0 counter clockwise with the dominant hand and the non-dominant hand removes the inner cannula by gently pulling it out
5. Soaks the inner canula in hydrogen peroxide for five (5) minutes and suctions the outer canula
6. Removes gloves, washes hands and puts on sterile gloves
7. Removes the inner tube from hydrogen solution into the sterile bowl with saline solution and brushes the lumen and entire inner canula thoroughly
8. Rinses the inner tube in a cleans saline solution and dries the inner side of canula with gauze squares twisted together
9. Re-inserts inner canula into outer canula and turn 900 clock wise to lock
10. Cleans the stoma using square gauze on forceps or with sterile cotton buds with saline solution. If there are debris, cleans with hydrogen peroxide before saline solution
11. Applies a sterile dressing and changes the tie tapes, checks tightness of tracheostomy tie
12. Thanks patient, discards and decontaminates equipment
13. Washes and dries hands
14. Documents procedure and findings

CARE FOR A PATIENT WITH UNDER WATER-SEALED DRAINAGE

1. Explains procedure and reassures patient and puts him/her in the fowlers or semi fowlers position
2. Checks vital signs and records (baseline data)
3. Washes hands and dons gloves
4. Places the bottle below the chest level in a receptacle
5. Checks the rate and depth of respiration, chest movements and auscultates his lungs periodically
6. Observes dressing site for bleeding and dislodgement of tube and inspects air vent in the system periodically
7. Checks fluid level fluctuation and bubbling in the drainage system
8. Checks tube for kinking or perforations
9. Encourages patient to cough frequently and breathe deeply every two hours if indicated
10. Assesses patency of drainage system as evidenced by oscillations in the tubing and bubbling in the water
11. Tells patient to report any breathing difficulty immediately
12. Checks and changes the chest tube dressing when necessary and palpates the area surrounding the dressing for crepitus
13. Observes the volume, colour, consistency and odour of the drainage
14. Thanks patient for co-operation, washes and dries hands
15. Administers pain medication as needed for patient's comfort
16. Encourages chest expansion exercise (blowing of balloon)
17. Washes and dries hands again and documents procedure noting No. 13

DISCHARGING A PATIENT FROM THE HOSPITAL

1. Ensures that discharge papers are duly signed by discharging doctor
2. Informs patient about discharge
3. Ensures that patient's hospital bill is assessed and settled
4. Educates patient and relative(s) on need for continuing treatment and follow up care
5. Records all receipt numbers in admission and discharge book and hands over receipt to patient or relative
6. Collects medication for patient from hospital's pharmacy where applicable
7. Explains how medication should be taken and stored at home
8. Helps patient to pack his/her belongings
9. Hands over any valuables in the nurse's custody to the patient or relative(s) and records, witnessed and signed
10. Reminds patient and relative(s) of the review date and stresses on its importance
11. Thanks and bids them good-bye
12. Documents in the admission and discharge book, daily ward state and nurses'
13. Ensures linen are removed/ bed and lockers decontaminated