SKILLS LAB MANUAL

ASSOCIATE NURSING PROGRAM
SENIOR FOUR, FIVE AND SIX

First Edition

FOREWORD

The Rwanda Basic Education Board is pleased to introduce this skills laboratory manual of the Associate Nursing Program. This resource is crafted to support competence-based teaching and learning and ensure consistency in delivering the Clinical attachment subject. The Rwandan educational philosophy aims to help associate nurse students achieve their full potential, preparing them to address community health needs and pursue career opportunities.

To enhance education quality, the government of Rwanda emphasizes the alignment of teaching materials with the syllabus. Effective teaching relies on the relevance of content, pedagogical approaches, assessment strategies, and instructional materials. The skills laboratory manual focuses on activities that promote learning, allowing students to develop hands on skills and make discoveries.

In a competence-based curriculum, learning is an active process where knowledge, skills, and attitude and values are developed through practical activities and real-life scenarios.

I extend my gratitude to everyone involved in developing this guide, including the Ministry of Health, University of Rwanda, and other institutions. Special thanks go to faculty members, Nurses, Midwives, Teachers, Illustrators, Designers, Health Workforce development staff/MoH, and REB staff for their dedicated work.

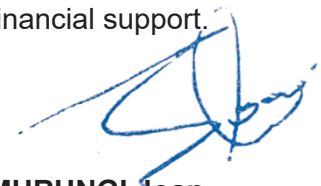
Dr. MBARUSHIMANA Nelson

Director General, REB

ACKNOWLEDGEMENT

I would like to express my deep gratitude to everyone who contributed to the development of this skills laboratory manual. The project would not have succeeded without the support of numerous stakeholders.

I extend special thanks to the Ministry of Health for leading the development process. My appreciation also goes to the Health Workforce development staff/ MoH, REB staff, University of Rwanda, College of Medicine and Health Sciences, Staff from Health Private training institutions, Teaching hospitals, Level II Teaching hospitals, District hospitals, National Council of Nurses and Midwives (NCNM), Rwanda Nurses and Midwives Union (RNMU) and Secondary schools having Associate Nursing program. Additional thanks are due to the Ministry of Health, the Ministry of Education, and the Clinton Health Access Initiative (CHAI) for their financial support.



MURUNGI Joan

Head of Curriculum, Teaching, and Learning Resources Department / REB

Contents

Definition of Terms

1. **Incident** An occurrence or event that interrupts normal procedure or precipitates an injury Incident report . A form that is filled out in order to record details of an unusual event that occurs at the facility
2. **Instructional resources Equipment:** or materials used during laboratory demonstration and return demonstration. These include CD and DVD, multimedia projector, and smart board.
3. **Laboratory technician**:He is the person in charge of the laboratory.
4. **Laboratory equipment and supplies:** All the equipment and materials used in the nursing procedures. These are, but not limited to the different types of mannequins, anatomic models, beds, wheelchairs, bedside tables, stretchers, infusion pumps and supplies.
5. **Laboratory Instructor:** He is the responsible person that provides professional support, supervision, guidance to the nursing learners during their clinical experience in the skills laboratory.
6. **Laboratory users:** All students, laboratory instructors and demonstrators using the laboratory.
7. **Nursing Laboratory:** A place where students acquire basic skills as part of their preparation in the actual clinical exposure.
8. **Nursing Clinical Learning:** This is a practical integration and application of knowledge, skills and attitudes learned from the skills laboratory and applied it in the actual clinical set-up.This process is facilitated with the provision of professional support, supervision, guidance, feedback and evaluation by a preceptor assigned in the hospital and clinical Instructor. It is on the aspect of clinical education that provides students with context-based learning that is gained through first-hand client and professional interactions and through opportunity to experience “the doing” in the clinical practice setting.
9. **Practical:** This is an actual application of knowledge gained from the theoretical aspect of nursing. The nursing student has a chance to practice all the skills required to meet the competency in caring patients in the skills laboratory or in the actual hospital clinical set-up.
10. **Skills Laboratory:** This is an area in the college in which lecture and demonstration is carrying-out by the laboratory instructor as well as the return demonstration of the nursing students are being performed.

UNIT 1 GENERAL INTRODUCTION

Skills lab based education practice in healthcare has been defined as any educational activity that utilizes simulative aides to replicate clinical scenarios.

In skills lab setting students use variety equipment such as manikins, medical equipment, consumables and checklists of procedures, but also, they can watch videos on healthcare professional education. The acquisition of hands-on clinical skills in a long education way is a key to protect patient safety.

1.1.Goal of skills laboratory

The goal for clinical skills laboratory is to create an artificial replication of the real world situation in which students can gain knowledge and psychomotor skills and be able to critically think through complex scenarios in a safe and non-threatening environment. This approach to experiential learning is a 'learner centric' educational method, which integrates the cognitive, psychomotor, and affective domains in a non-threatening and safe environment thus ensuring accuracy and competency of skills before the student enters the clinical environment.

1.2.Purpose of Skills lab

Maintain state-of-the-art laboratories that are equipped with human patient simulators, digitalized video, and electronic supply and static mannequins. These laboratories were designed to reproduce realistic practice settings, including the basic hospital unit, critical care, surgical/operating suite, pediatrics neonatal nursery, maternity, home care, health assessment and diagnostic laboratory. All laboratory spaces are also outfitted with tables and chairs for reflective thinking exercises that allow the students time to review their decisions and actions with the instructor and their classmates.

The Clinical Skill Laboratories exist primarily to serve the students, faculty and staff of Nursing department

The clinical skill laboratories provide a clinical learning environment utilizing task trainers and human patient simulation technology, as specified by the curriculum and on recommendation by the faculty, and facilitate optimum and efficient utilization of those resources.

1.3.Purpose of this teacher's guide

To facilitate the teacher in teaching activities, the content of this teacher`s guide is self-explanatory so that you can easily use it.

The purpose of skills laboratory manual is to guide teachers, students and other health care professionals to use the available facilities for the development of clinical competencies required in a skills lab environment before translating them to the real clinical settings for the provision of safe and quality health care services to clients.

1.4. Structure of the guide

The guide has two main parts

1.4.1.Part I: General guidelines

This part provides general guidance on:

- Rules and regulation for skills lab
- Methodological principles to be used in skills lab
- Guidance on assessment

1.4.2.Part II: Development of Checklist

This is the most important part of the guide. It includes Checklist of fundamental of Nursing for senior 4, 5 and 6, and Checklist of Maternal and Child health for Senior 4, 5 and 6.

Each checklist is developed in the following structure:

- **Checklist title:**This title is taken from course units;it contain the theory that need to be translated into practices
- **Aims of technique:**each checklist is divided into different procedures;technique and all staps compsed each checklist
- Procedure (Procedure).

1.5.Objectives of the Nursing Skills Laboratory

The objective of the Nursing Skills Laboratory is to provide realistic and quality clinical learning experience to associate nursing students through various clinical learning opportunities in the Nursing Skills Laboratory and serve as a provision for the students to become associate nurses. It specifically aims to:

1. Build the students' basic skills by providing definite connections between the theoretical and clinical learning of the students through definite and adept clinical learning experiences in the laboratory.
2. Develop the students' associate nurse in providing nursing care in accordance with the norms and values.
3. Foster the students' ability to utilize the nursing process in performing nursing procedures.

1.6. Duties and Student Nurse responsibilities in skills laboratory

Students are expected to come to skills laboratory prepared by having reviewed the skill(s) to be practiced and/or demonstrated as well as having read the assigned topics/chapters (if any) by his/her instructor prior to laboratory demonstration. They are advised to take advantage of every opportunity to enhance their nursing skills.

1. Log in on arrival to the attendance sheet provided by the laboratory instructor and log out before leaving.
2. Inform the laboratory instructor of any particular learning needs.
3. Gather and return the equipment used for skill performance.
4. Approach situations and scenarios as if they are actual client interactions.
5. Follow safety measures at all time.
6. Maintain cleanliness of the laboratory area.
7. Dispose of sharps appropriately.
8. Demonstrate respect and consideration for self and others. All students should display professional, courteous conduct.
9. Alert the laboratory instructor of allergies and injuries including latex allergy.
10. Any damage or malfunction of mannequins or equipment should be reported to the laboratory instructor immediately.
11. Students should at all times observe the safety precautions and appropriate techniques while learning and practicing skills in the lab. If not sure where to locate equipment, supplies or resources, ask.

12. Students should be knowledgeable of the care, handling, and proper use of equipment prior to using it in the laboratory.
13. The Identification card or ID should always be surrendered when borrowing equipment

1.7.Skills lab Technician responsibilities

1. Conduct monthly inventory of the existing laboratory equipment and supplies and submit semestral report to the program coordinator. It should include utilization, losses, and breakages/damages on all laboratory rooms, laboratory equipment and supplies.
2. Catalog and maintain security for audio visual and other media resources.
3. Check that the number of borrowed materials is complete and in good condition when returned.
4. Prepare laboratory equipment and supplies for each skills laboratory class based from the laboratory instructor or demonstrator's requests.
5. Oversee maintenance of laboratory equipment and supplies, and computer technology equipment for simulation; responsible in monitoring all equipment for optimum performance and also for the certification.
6. Initiate processes on ensuring repairs of damaged laboratory equipment.
7. Coordinate with the laboratory coordinator in the procurement/requisition of equipment and supplies.
8. Directly responsible on the documentation of usage of laboratory, laboratory equipment and supplies.
9. Ensure that the laboratory rooms are clean, safe, and organized.
10. Accomplishes the Daily Nursing Skills Lab Follow-Up Sheet.
11. Promote safe laboratory practices.
12. Ensure the completeness of the first aid kit everyday. He/she will replace supplies as needed.
13. Responsible for the Nursing skills laboratory lock/key.

1.8. Physical safety guidelines

1. Students should perform proper body mechanics during practice and return demonstration especially when they are studying skills related to moving, liftinginand transferring patients using simulators or mannequins.
2. Equipment used for body mechanics practice (bed, wheelchairs, stretcher, etc.) should be used only if in good working condition. Any malfunction in the equipment should be reported immediately to the laboratory technician using the incident/injury form.
3. The wheels of all equipment (wheelchairs, stretchers, and beds) should be

locked during practice and return demonstration.

1.9. Managing hazardous waste:

1. Batteries which are not functioning should be disposed properly.
2. Contaminated supplies used during laboratory activities are collected, singed as hazardous waste material and stored in designated area of the skills laboratory.
3. All biohazard wastes will be taken by a designated transporter.

1.10. RULES AND REGULATION FOR SKILLS LAB

1.10.1.Users of skills lab

Skills lab can be used by:

- Individual student,
- Individual instructor for his/her preparation before practice session,
- Group of students accompanied by a teacher,
- Group of students for peer tutoring,
- Group of instructors for continuous professional development,
- People from outside the institution upon request

1.10.2.Main consideration during a skills lab

1. In accordance with humanistic education, all manikins and models are to be treated with respect as though they are real clients. Models and manikins are to be handled gently and carefully, draped appropriately when used, and covered when not in use.
2. All skills lab users shall dress for skills lab as if attending the real clinical setting among others name badges and uniform (or clinical coat), tied up hair, close-toe shoes wear.
3. Tutors are responsible for supervising all students brought to the lab for tutor-led sessions. He/she must prepare and rehearsal the practical sessions before they start.
4. The tutor should not exceed a group of 8 students for session demonstration and the student should not have more than 3 practical sessions for one day.
5. English as a medium language of instruction is recommended in all teaching sessions including demonstration of procedures in skills lab.
6. Anybody who wants to practice in skills lab must make a booking for practical rooms and equipment.

7. Students/ tutors/. other users should checkout equipment from the simulation lab. All procedures for signing out and returning equipment should be followed.Failure to responsibly adhere to the policy may mean loss of check - out privileges.
8. Attendance and logbook for students should be signed after each simulation teaching/learning session.
9. If the material(s)/equipment(s) are lost or damaged the person responsible, signs the form of accepting the act and submit to the skills lab Technician within 24 hours of the incidence in working days, then the procedure of replacing it/them starts.
10. Clean-Up of the Area after Sessions: Upon completion of practice session, it is the responsibility of the users to ensure that they tidy up the room (furniture, trolleys,…) and leave the lab as they found it.
11. Coats, backpacks, and other personal belongings are not allowed in skills lab rooms.
12. Food and drinks are prohibited in the skills lab rooms.
13. Universal precautions are to be followed at all times as are all safety guidelines used in the clinical setting. Sharps and syringes are to be disposed in appropriate containers.
14. Incident report: In case of any incidence during session, the responsible person should report it in writing to the skills lab Technician within 24 hours of the incidence in working days.

1.10.3.Attendance and evaluation in skills lab

1. The signed attendance sheet is used in skill lab sessions as proof.
2. The module leader communicates the date of evaluation (OSCE) to be done in skills lab to the students and any change is communicated at least two weeks before.
3. OSCE should be prepared and rehearsed one day before by teachers.
4. Student must practice individually at least three times each procedure taught, before the OSCE.
5. The student who hasn't regularly attended the skills lab as indicated is not allowed to sit for OSCE.
6. The average pass mark of OSCE is 60% and the results should be communicated to the students within 48 hours of working days.
7. Debriefing is mandatory for all students within 2 working days after OSCE and HoD should be informed of the process.
8. The evaluator should turn off his/her phone during OSCE, and follow each

step of the procedure done by student.

9. The student who missed the OSCE without sound justification is awarded a zero mark. The justification has to be notified to the head of department at the latest within 48 hours after the OSCE.
10. No teacher shall accept a justification which is not countersigned by the head of the department.

1.10.4.Methodological principles to be used in skills lab

1.10.4.1.Techniques to be used in skills lab

Skills lab is an opportunity for a student to apply practically what he/she learned theoretically. Even if there are different techniques to be used, one of the recommendable techniques is Scaffolding.

Scaffolding is supporting new learning by building new concepts on previously learnt concepts. There are various ways teachers can do this. One way is by reminding the learners about concepts they have previously learned. Another is to display previously learned concepts so that learners can focus on the new learning. This gradual release of responsibility is sometimes called “I do, We do, You do”. This model proposes a plan of instruction that includes demonstration, prompt, and practice.

At the beginning of a procedure or when new material is being introduced, the teacher has a prominent role in the delivery of the content. This is the “I do” phase. But as the student acquires the new information and skills, the responsibility of learning shifts from teacher-directed instruction to student processing activities. In the “We do” phase of learning, the teacher continues to model, question, prompt and cue students, but as student move into the “You do” phases, they rely more on themselves and less on the teacher to complete the learning task.

The roles and responsibilities of teacher and student at every phase.

The table below shows the roles and responsibilities of teacher and student at every phase.

Teacher		**Student**
I do it Direct Instruction	• Provides direct instruction • Establishes goals and purpose • Models • Think aloud	• Actively listens, observation • Takes notes • Asks for clarification

We do it Guided instruction	• Interactive instruction • Works with students • Checks, prompts, clues • Provides additional modeling • Meets with needs-based groups	• Asks and responds to questions • Works with teacher and classmates • Completes process alongside others
You do it together Collaborative learning	• Moves among groups • Clarifies confusion • Provides support	• Works with classmates, shares outcomes • Collaborates on authentic task • Consolidates learning • Completes process in small group • Looks to peer for clarification
You do it independently Independent Practice	• Provides feedback • Evaluates • Determines level of understanding	• Works alone • Relies on notes, activities, classroom learning to complete assignment • Takes full responsibility for outcome

Adapted from the model developed by Ellen Levy 2007

1.10.4.2 Attention to special educational needs specific to skills lab practice

Teachers need to:

- Pair a student who has a disability with a friend. Let them do things together and learn from each other. Make sure the friend is not over protective and does not do everything for the student. Both students will benefit from this strategy.

Below are strategies related to each main category of disabilities and how to deal with every situation that may arise. However, the list is not exhaustive because each student is unique with different needs that should be handled differently.

1.10.4.3.Strategies to help student with physical disabilities:

- Be patient! If you find that the student takes longer than others to learn or to do an activity, allow more time.
- Do activities together with the student.
- Gradually give the student less help.
- Let the student do the activity with other students and encourage them to help each other.
- Divide the activity into small achievable steps.
- Remember to praise and say 'Well done' when the student learns something new or makes a strong effort.

1.10.5.Guidance on assessment

The various assessment will be undertaken to assess students in skills laboratory :

OSCE:

The objective structured clinical examination (OSCE), is designed to assess the student ability to competently apply the professional nursing or midwifery skills and knowledge into real practice. It is set at the level expected of nurses and midwives as they enter the profession. This means that you must show that you are capable of applying knowledge to the care of patients.

The examination is testing the student ability to apply knowledge to the care of patients rather than how well you can remember and recite facts. All of the scenarios and any questions relate to current best practice and you should answer them in relation to published evidence and not according to local arrangements.

Time for OSCE: The OSCE will be scheduled at the end of each unit theory, organized to assess the students' competencies using different stations according to the course units.

Equipment : All equipment needed to complete the station successfully,according to the station requirements.

2.1.Procedure: Hands Hygiene And Gloving

2.1.1.Technique: Simple Hand Washing

Aims of SIMPLE HAND WASHING

- To reduce the risk of infection by maintaining a clean environment
- To prevent infections
- To remove germs from hands
- To cleanse the hands of pathogens (bacteria, viruses, or other microorganisms that can cause disease).

Learning outcome

- Perform correctly hand washing technique using appropriate steps.

ASSOCIATE NURSE STUDENT/ PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back and put bonnet
- Assemble equipment and arrange on bedside chair in the order the items will be used
- Remove watch, jewels, and Rings
- Wear closed shoes

EQUIPMENT

- Water
- Plain (non-antimicrobial) soap
- Disposable towel

Simple hand washing's steps

IMPLEMENTATION	Done	Partially done	Not done	comments
Wet your hands with plenty of clean water.				
Cover all the surfaces of your hands in soap.				
Rub the palms together to form a lather.				
Rub the palm of one hand over the back of the other hand, making sure to clean in between your fingers. Repeat with the other hand.				
Rub the palms together again, and also clean in between the fingers again.				
Rub the backs of the fingers against the opposite palm, interlocking the fingers as you do this.				
Grasp the thumb of one hand with the other hand, and rotate the closed hand around the thumb to clean it. Repeat with the other thumb and hand.				
Rub the tips of the fingers of one hand on the palm of the other hand. Repeat with the other hand.				
If a clean nail brush is available, scrub gently under the nails.				
Rinse the hands under clean, running water.				
Dry them thoroughly, ideally, with a disposable towel. Alternatively, allow them to air dry.				
Use the towel (if you have one) to turn off the tap and then dispose it in non-infectious waste.				
COMPLETION				
Put material in order				

2.1.2.Technique Non-Sterile And Sterile Gloving

AIMS

- To protect Associate nurses' hands when handling substances
- To reduce likelihood of transmitting micro-organisms from nurses to the patient and vice-versa;
- To reduce likelihood of transmitting micro-organisms from one patient to the other.

ASSOCIATE NURSE PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Ensure nails are cut short
- Hand washing

EQUIPMENT

- Clean gloves(for non sterile gloving)
- Sterile Gloves(for sterile Gloving)

Steps of non-Sterile And Sterile Gloving

Implementation	Done	Partially Done	Not done	Comments
NON STERILE GLOVING				
Apply first glove in dominant hand: Insert your hand through the gloves opening and ensure fingers fit into fingers appropriately				
Apply the second glove: repeat the procedure with the second hand				
Adjust gloves to cover wrist or gown as required.				

Apply the glove of your dominant hand first by touching only the inside of the glove (the folded-over cuff) with your non-dominant hand. Apply the second glove by touching only the outer part of the glove with your already- gloved hand; keep your sterile thumb well away from your bare skin.				
FINISHING To check if there is no visible rips, tears or other issues, if yes remove gloves, wash hands and put on a new pair of gloves				

2.1.3.Technique: Removing Non-Sterile And Sterile Gloves

AIMS:

- To reduce likelihood of transmitting micro-organisms from associate nurse student to the patient and vice-versa;
- To reduce likelihood of transmitting micro-organisms from one patient to the other.

ASSOCIATE NURSE PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Ensure nails are cut short
- Hand washing

EQUIPMENTS

- Dustbin

Steps of removing Non-Sterile And Sterile Gloves

IMPLEMENTATION	Done	Partially done	Not done	Comments
Grasp glove on its palmar surface (taking care to touch glove to glove),				
Pull the first glove completely off by inverting or rolling the glove inside out				
Continue to hold the removed glove by the fingers of the remaining gloved hand.				
Place the two fingers of the bare hand inside the cuff of the second glove				
Pull the second glove off to the fingers by turning it inside out.				
Using bare hand, continue to remove the gloves, which are now inside out				
Dispose them in the appropriate waste container(Dustbin)				
FINISHING				
Perform hand hygiene.				

2.2. Procedure: Bedmaking

2.2.1.Technique: Unoccupied Bed, With Changing Bed-Sheets: One Nurse

AIMS

- To provide clean and comfortable position of the patient,
- To reduce risk of infection
- To Prevent bed sores

ASSOCIATE NURSE PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Ensure nails are cut short
- Hand washing

EQUIPMENTS

- Pillow case
- Protective gloves
- Blanket
- Waterproof protective pad
- Linen hamper or bag
- Trolley or and a Chair

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on a bedside chair in the order in which items will be used.				
Perform hand hygiene.and put on gloves				
Adjust the bed to a comfortable working height, usually elbow height of the caregive				
shift mattress up to head of bed. If mattress is soiled, clean and dry according to facility policy before applying new sheets.				
Place the bottom sheet in the center of the bed,open the sheet and make the superior corner,then the inferior and tuck it in.				
Place the rubber and drow sheet,tuck them in.				
Place the top sheet.unfold it,make the lower corners and tuck in.				
Place the blancket and bed-cover separately,unfold and make lower corners,don't tuck in.				
Fold the superior part of the bed linen over the blanket and bedcover forming an edge.				
Place the pillow at the head of the bed				
Fold the bed-cover, blanket and the main top bedsheet in an accordion or triangle at the foot of the bed.				
Help the patient to return to bed				
FINISHING				
Open the windows to ventilate the room				

Material				
Put material in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided				

2.2.2.Technique: Unoccupied Bed, With Changing Bed-Sheets : Two Associate Nurses.

AIMS

- To provide clean, safe and comfortable bed for the patient
- To promote rest and sleep
- To reduce the risk of infection by maintaining a clean environment
- To prevent bed sores
- To observe patient and to prevent complications
- To provide physical and psychological comfort and security to the patient.
- Demonstrate the ability to make an unoccupied bed

ASSOCIATE NURSE STUDENT/ PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

EQUIPMENTS

- Pillow case
- Protective gloves
- Blanket
- cleaning materials
- Linen hamper or bag
- 2 Bed sheet (bottom sheet and top sheet)
- Draw sheet
- Mackintosh (if contaminated or needed to change
- Chair

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on a bedside chair in the order in which items will be used				
Perform hand hygiene. Put on gloves				
Adjust the bed to a comfortable working height, usually elbow height of the caregiver				
NB: Never put linen on the floor.				

NB: Never put linen on the floor.				
Position the patient comfortably on a chair so as to observe him carefully.				
Loosen all linen as you move around the bed, from the head of the bed on the far side to the head of the bed on the near side.				
Fold reusable linens, such as sheets, blankets, or spread, in place on the bed in fourths and hang them over a clean chair				
roll all the soiled linen inside the bottom sheet and place directly into the laundry hamper. Do not place on floor or furniture. Do not hold soiled linens against your uniform.				
The second nurse arrives				
shift mattress up to head of bed. If mattress is soiled, clean and dry according to facility policy before applying new sheets.				
Place the bottom sheet with its center fold in the center of the bed. Open the sheet and fan-fold to the center				
Adjust the mattress and its protection				
Place the bottom bedsheet, make the superior corners, then the inferior and tuck it in.				

Place the rubber and the cloth draw sheet, tuck them in.				
Place the top sheet, unfold it, make the lower corners and tuck in.				
Place blanket and bed-cover separately, unfold, and make lower corners, don't tuck in.				
Fold the superior part of the bed linen over the blanket and bedcover forming an edge.				
Place the pillow at the head of the bed.				
Fold the bed-cover, blanket and the				
Material				
Put material in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided				

2.2.3.Technique: Unoccupied Bed Making Without Changing Bed Sheets

AIMS

- To be ready for the next occupant
- To prepare the bed for the client return
- To provide a clean environment
- To provide a good appearance
- To minimize sources of infections
- To provide physical and psychological comfort and security to the patient.
- Demonstrate the ability to make an unoccupied bed

ASSOCIATE NURSE / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

EQUIPMENTS

- Two large cotton sheets
- One water proof draw mackintosh (if necessary)
- One draw sheet (if necessary)
- One or two pillows
- Pillow slips/covers
- One blanket optional
- One bed cover or counterpane
- Chair

Steps of unoccupied Bed Making Without Changing Bed Sheets

IMPLEMENTATION	Done	Partially done	Not done	Comments
The above articles should be collected and put over two chairs placed back to back at the bottom of the bed. It is helpful to palace the linen in order which it is required.				
Place long mackintosh on mattress if necessary.				
Place bottom sheet evenly on the bed.				
Tuck the sheets under the mattress using enveloped corners, starting from the top.				
Pull sheet tight so that there are no creases				

Place a draw mackintosh (if necessary) across the bed with the upper corner under the edge of the pillow.				
Cover mackintosh with draw sheets and tuck it in				
Place the pillows on the bed so that the open ends of the slip are away from the door.				
Place top sheet on with the wrong side uppermost.				
Fold over about twenty inches of the sheet at the top.				
The sheet is loosely tucked in at the bottom to prevent restriction of feet.				
Place bottom sheet evenly on the bed.				
Place the bed cover or counterpane loosely over the sheet.				
Tuck in at the bottom end under the mattress using envelop carners.				
Fold top sheet over the counterpane with all the sides tucked under the mattress				
After bed making the nurse must make sure that all the locker (bedside) and the two chairs used have been replaced in their proper positions				
Remove trolleys.				
FINISHING				
Materials				
Put material in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided and sign.				

2.2.4.Technique: occupied bed, with changing bed-sheets: Two nurses patient can turn

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Check chart for limitations on patient's physical activity.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Pillow case
- Protective gloves
- Blanket
- cleaning materials ,
- Basin
- Linen hamper or bag
- 2 Bed sheet (bottom sheet and top sheet)
- Draw sheet
- Mackintosh (if contaminated or needed to change)
- Chair

Steps of 0ccupied Bed, With Changing Bed-Sheets:

Two Nurses Patient Can Turn

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on bedside chair in the order the items will be used				
Perform hand hygiene				
Close curtains around bed and close the door to the room, if possible				
Adjust the bed to a comfortable working height, usually elbow height of the caregive				
Tuck in at the bottom end under the mattress using envelop carners.				
Put on gloves. Check bed linens for patient's personal items. Disconnect the call bell or any tubes/drains from bed linens				
Place a bath blanket over patient. Have patient hold on to bath blanket while you reach under it and remove top linens. Leave top sheet in place if a bath blanket is not used.				
Fold linen that is to be reused over the back of a chair. Discard soiled linen in laundry bag or hamper. Do not place on floor or furniture. Do not hold soiled linens against your uniform				
The second nurse, grasp mattress securely and shift it up to head of bed.				
Assist patient to turn toward opposite side of the bed, and re-position pillow under patient's head.				
Loosen all bottom linens from head, foot, and side of bed				
Fan-fold soiled linens as close to patient as possible				

Use clean linen and make the near side of the bed. Place the bottom sheet with its center fold in the center of the bed. Open the sheet and fan-fold to the center, positioning it under the old linens. Pull the bottom sheet over the corners at the head and foot of the mattress				
If using, place the draw sheet with its center fold in the center of the bed and positioned so it will be located under the patient's midsection. Open the draw sheet and fan-fold to the center of the mattress. Tuck the draw sheet securely under the mattress. If a protective pad is used, place it over the draw sheet in the proper area and open to the center fold				
Loosen and remove all bottom linen. Discard soiled linen in laundry bag or hamper. Do not place on floor or furniture. Do not hold soiled linens against your uniform				
Ease clean linen from under the patient. Pull the bottom sheet taut and secure at the corners at the head and foot of the mattress. Pull the draw sheet tight and smooth. Tuck the draw sheet securely under the mattress pillow under the patient's head				
Apply top linen, sheet and blanket, if desired, so that it is centered. Fold the top linens over at the patient's shoulders to make a cuff. Have patient hold on to top linen and remove the bath blanket from underneath				
Secure top linens under foot of mattress and miter corners				

Return patient to a position of comfort. Remove your gloves. Raise side rail and lower bed. Reattach call bell				
Dispose of soiled linens according to hospital policy				
Perform hand hygiene				
FINISHING				
Patient				
Arrange personal effects and objects of the patient and to put them within his range				
Position the patient comfortably and appropriately				
Open the windows to ventilate the room				
Material				
Put material in order.				
Nurse				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provide				

2.2.5.Technique: Occupied bed making, patient can sit

AIMS

- To promote the clients comfort
- To provide a clean environment for the client
- To minimize source of skin irritation
- Provide safety
- These are appliances used in bed making

- Provide comfort of the patient
- For the protection of bed linen
- Prevention of pressure sores
- To facilitate putting the patient into bed without delay etc.
- To provide physical and psychological comfort and security to the patient.
- Demonstrate the ability to make an occupied bed

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of BP check up
- Position the patient in a comfortable position
- Instruct the patient to have a rest for at least 10 minutes.

EQUIPMENTS

- Gloves
- Mattress Pad
- Bottom draw Sheet
- Cotton draw sheet
- A plastic draw sheet
- Pillow and pillow cover
- Top sheet
- Blanket
- Bed Spread
- Linen Hamper or bag
- Bed side
- Trolley or and a chair

Steps of occupied bed making, patient can sit

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and supplies				
Explain to the client what you are going to do				
Wash hands				
Provide for clients' privacy				
Loosen all the top linen at the foot of the bed and remove the spread and the blanket				
Leave the top sheet over the client				
Change the bottom sheet and draw sheet				
Assist the client to turn on the side facing, Raise the side rail nearest the client				

Loosen the foundation of the linen on the side of the bed near the linen supply				
Fanfold the bottom sheet and the draw sheet at the center of the bed				
Place the new bottom sheet and draw sheet on the bed, and vertically fanfold the half to be used on the far side of the bed Tuck the sheet under the near half of the bed and miter the corner				
Assist the client to roll over toward you onto the clean side and Move the side rail before leaving the side of the bed.				
Remove the used linen and place it in the portable hamper				
Unfold the fan folded bottom sheet and the draw sheet from the center of the bed				
Use both hands to pull the bottom and draw sheet then tuck the excess under the side of the mattress				
Reposition the client in the center of the bed				
Reposition the pillows at the center of the bed				
Spread the top sheet and the blanket over the client				
Complete the top of the bed, And Raise the side rails				
Return the bed to previous position and wash your hands				
FINISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				

Thank the patient for his collaboration.				
Material				
Put material in order.				
Nurse				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign.				

2..2.6. Technique: Occupied Bed Making, Patient Cannot Sit Or Turn

AIMS

- To change the linen with the least possible disturbance to the patient
- To draw or fix the sheets under the patients very firmly so that it would not wrinkle
- To remove crumbs from the bed.
- To make patient feel comfortable.
- To provide physical and psychological comfort and security to the patient.
- Demonstrate the ability to make an occupied bed

ASSOCIATE NURSE / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position
- Make sure that the patient was at least 5-10 min before assessing respiration

EQUIPMENTS

- Necessary linen.
- Tray for stripping and airing.
- Laundry bag or hamper
- Gloves
- Mattress Pad
- Bottom draw Sheet
- Cotton draw sheet
- A plastic draw sheet
- Pillow case/pillow cover
- Top bed sheet
- Blanket
- Bed Spread
- Linen Hamper or bag
- Bed side
- Chair

Steps of occupied bed making, patient cannot sit or turn

IMPLEMENTATION	Done	Partially done	Not done	Comments
Do the medical hand washing				
Gather equipment s at bed side and arrange according to use. Explain procedure to patient and screen.				
Loosen the linens starting at the foot part, then to the sides and around. Remove pillows unless contraindicated				
Place clean top sheet over dirty top sheet wider hem, wrong side out at the head part of bed. Spread, then remove the dirty linen without exposing the patient.				
Turn patient towards one side of the bed.				
Place bottom sheet following the principles, tuck head part miter corner tuck. Roll used rubber sheet towards you. Replace with a new one.				
Place draw sheep over rubber sheet. Tuck together.				
Turn patient towards made bed.				
Work on the other side. Remove dirty linens.				
Spread clean linens, tuck head part of the bottom sheet, miter at side, tuck all together. Do the same with rubber sheet and draw sheet.				
Turn patient to the center of the bed.				
Arrange top sheet, fold head part up to the patient's chest.				
Make a toe pleat.				

Tuck foot part, miter corner.				
Time limit, check features of a good bed and proper body mechanics.				
FINISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Material				
Put material in order.				
Nurse				
Education/ Care-related guidance				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.2.7. Technique: Post-Operative Bed Making

AIMS

- To provide clean, safe and comfortable bed for the patient
- To promote rest and sleep
- To reduce the risk of infection by maintaining a clean environment
- To prevent bed sores
- To economize time and energy
- To observe patient and to prevent complications
- To provide physical and psychological comfort and security to the patient.
- Demonstrate the ability to make a postoperative bed

ASSOCIATE NURSE / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

EQUIPMENTS

- Pillow and pillow case
- Protective gloves
- Bed sheets: Bottom sheet (1)
- Top sheet (1)
- Draw sheet (1-2)
- Mackintosh
- Draw sheet
- Mackintosh (if contaminated or needed to change). According to the type of operation, the number required of mackintosh and draw sheet is different.
- Blanket (1) Hot water bag with hot water if needed
- Materials for vital signs
- Iv stand
- Chair

Steps of post-Operative bed making

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene				
Close curtains around bed and close the door to the room, if possible				
Adjust the bed to a comfortable working height, usually elbow height of the caregive				
Lower side rail nearest you, leaving the opposite side rail up. Place bed in flat position unless contraindicated				
Strip bed. Make foundation bed as usual with a large mackintosh, and cotton draw sheet.				
Put on gloves.				
Place top bedding as for closed bed but do not tuck at foot				
Fold back top bedding at the foot of bed.				
Tuck the top bedding on one side only.				
Bring head and foot corners of it at the center of bed and form right angles				
Fold back suspending portion in 1/3 and repeat folding top bedding twice to opposite side of bed				
Remove the pillow. Place a kidney-tray on bed-side. Place IV stand near the bed. Check locked wheel of the bed				
Transfer the client: Help lifting the client into the bed, Cover the client by the top sheet and blanket immediately				

Tuck top bedding and miter a corner in the end of the bed.				
Perform hand hygiene				
FINISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient and to put them within his range				
Open the windows to ventilate the room				
Thank the patient for his collaboration.				
Material				
Put material in order				
Associate Nurse student				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided				

2.3. Procedure: Bedbath

2.3.1. Technique: Complete bed bath patient can not sit

AIMS

- To promote hygiene
- To prevent bacteria spreading on the skin
- To stimulate circulation
- To promote patient comfort and induce sleep
- To prevent bed sores
- To observe the client for any complications

- To perform correctly the technic of bed bath
- Apply environmental safety

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Check chart for limitations on patient's physical activity.

EQUIPMENTS

- 2 Basins (1 with soap and 1 without soap)
- 2 Bucket: (1 for hot clean water, 1 for waste)
- 1 jug
- 1 Soap with soap dish
- 2 Sponge cloth (1 for wash another for rinse)
- Face towel
- 2 bath towels (1 for covering over mackintosh another for covering client body)

- 1 Mackintosh
- 1 trolley
- Chair
- Thermometer
- Paper bag
- Personal hygiene supplies (deodorant, lotion, powder, combs, etc)
- Folded screens.
- Bag for dirty linen.
- Clean Clothing or hospital gown.

Steps of complete bed bath patient can not sit

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene and put on gloves and or other PPE				
Close curtains around bed and close the door to the room, if possible. Adjust the room temperature, if necessary				
Offer patient bedpan or urinal				
Adjust the bed to a comfortable working height;usualy elbow height of the caregiver.''				
Put on gloves.				
Lower side rail nearer to you and assist patient to side of bed where you will work. Have patient lie on his or her back				

Remove patient's gown and keep bath blanket in place. If patient has an IV line and is not wearing a gown with snap sleeves, remove gown from other arm first. Lower the IV container and pass gown over the tubing and the container. Rehang the container and check the drip rate				
Raise side rails. Fill basin with a sufficient amount of comfortably warm water (110F to 115F). Add the skin cleanser, if appropriate, according to manufacturer's directions. Change as necessary throughout the bath. Lower side rail closer to you when you return to the bedside to begin the bath				
Put on gloves, if necessary. Fold the washcloth like a mitt on your hand so that there are no loose ends.				
Lay a towel across patient's chest and on top of bath blanket.				
With no cleanser on the washcloth, wipe one eye from the inner part of the eye, near the nose, to the outer part. Rinse or turn the cloth before washing the other eye.				
Bathe patient's face, neck, and ears.				
Expose patient's far arm and place towel lengthwise under it. Using firm strokes, wash hand, arm, and axilla, lifting the arm as necessary to access axillary region. Rinse, if necessary, and dry				
Place a folded towel on the bed next to the patient's hand and put basin on it. Soak the patient's hand in basin. Wash, rinse if necessary, and dry hand				
Repeat 2 previous steps for the arm nearer you. An option for the shorter nurse or one susceptible to back strain might be to bathe one side of the patient and move to the other side of the bed to complete the bath				

Return bath blanket to original position and expose far leg. Place towel under far leg. Using firm strokes, wash, rinse, if necessary, and dry leg from ankle to knee and knee to groin				
Wash, rinse if necessary, and dry the foot. Pay particular attention to the areas between toes				
Make sure patient is covered with bath blanket. Change water and washcloth at this point or earlier, if necessary				
Assist patient to prone or side-lying position. Put on gloves, if not applied earlier. Position bath blanket and towel to expose only the back and buttocks				
Wash, rinse, if necessary, and dry back and buttocks area. Pay particular attention to cleansing between gluteal folds, and observe for any redness or skin breakdown in the sacral area				
If not contraindicated, give patient a backrub. Back massage may be given also after perineal care.				
Raise the side rail. Refill basin with clean water. Discard washcloth and towel. Remove gloves and put on clean gloves				
Clean perineal area or set patient up so that he or she can complete perineal self-care. If the patient is unable, lower the side rail and complete perineal care, following guidelines in the accompanying Skill Variation. Apply skin barrier, as indicated. Raise side rail, remove gloves, and perform hand hygiene				

Apply appropriate lotion from head to toes				
Help patient put on a clean gown and assist with the use of other personal toiletries, such as deodorant or cosmetics				
Protect pillow with towel and groom patient's hair				
When finished, make sure the patient is comfortable, with the side rails up and the bed in the lowest position				
Change bed linens. (refer to bed making skills)				
Remove gloves and any other PPE				
FINISHING				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient and to put them within his range				
Open the windows to ventilate the room				
Thank the patient for his collaboration.				
Material				
Put material in order.				
Nurse				
Education/ Care-related guidance				
Wash hands				
Make a verbal or written report of Care provided				

2.3.2. Technque: Complete Bed Bath, Patient Cannot Sit Or Turn

AIMS

- To keep the skin healthy
- To prevent infections

EQUIPMENTS

- Soap
- Wash cloths
- 1 Bath towel
- 2 Wash basins
- Clean gown
- Bath blanket
- Lotion for back rub

ASSOCIATE NURSE / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing
- PATIENT PREPARATION
- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of pulse check up
- Position the patient in a comfortable position
- Make sure that the patient was at least 5-10 min before assessing respiration

Steps of complete bed bath, patient cannot sit or turn

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash your hands.				
Explain procedure to care recipient. Provide for privacy by pulling curtain and closing any window treatments				
Cover resident with bath blanket and fold top covers down.				
Ask water temperature preference. (105 degrees) Fill basin 2/3 full of water. Let the resident test the water.				
Make a mitten with washcloth.				
Do NOT use soap on the face. Wash eyes from resident's nose to outside of face (inner corner to outer corner.) Use separate corner of mitten with each eye. Wash rest of face, including ears				
Fold bath blanket down to abdomen. Wash, rinse, and pat dry chest and abdomen. Cover resident with bath blanket.				
Place towel across chest and fold blanket down to pubic area. Wash, rinse, and pat dry the abdomen. Pull blanket back up across the chest and remove towel.				
If water is dirty, soapy, or cool, empty basin and refill with clean water				
Place towel under leg farthest from you. Wash, rinse, and pat dry. Wash between each toe. Rinse and pat dry.				
Repeat the same for leg nearest you				

Lift blanket above groin area and cover legs with bedspread for privacy and comfort. Provide peri-care to the front part only. Return bedspread to foot of bed and cover resident with bath blanket.				
Turn resident onto side. Fold blanket up so back is uncovered. (Keep rest of body covered.)				
Place towel behind back on the bed. Wash, rinse, and pat dry neck, back, and buttocks first. Complete peri-care to rectal area from the back				
Give care recipient a back rub				
Assist resident to put on a clean gown. Take bath blanket off and pull bedspread back over resident. Place linens in laundry basket.				
Wash hands. Return equipment to proper place.				
Leave resident in a position of comfort and call light in place.				
Identify that you have washed your hands				
FINISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands				
Make a verbal or written report of Care provided				

2.3.3. Technique: Partial bed bath, perineal care

AIMS

- To Clean the skin
- To stimulate blood circulation
- To improved self-image
- To reduce body odors
- To promote range of motion exercises

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of pulse check up
- Position the patient in a comfortable position
- Make sure that the patient has been at rest for at least 10 minutes.

EQUIPMENTS

- Clean gloves (1 pair)
- washcloth (1)
- Basin with warm water (1)
- Bath Towels (1)
- Mackintosh (1)
- Soap with soap dish (1)
- Toilet paper
- Bed pan (1): as required

Steps of partial bed bath, perineal care

IMPLEMENTATION	Done	Partially done	Not done	Comments
Explain the procedure to the client				
Perform hand hygiene and wear on gloves				
Close the door to the room and place the screen.				
Ask the client to empty his or her bladder if necessary				
Raise the bed to a comfortable height if possible.				
Uncover the client's perineal area.				
Place a mackintosh and bath towel under the client's hips				
Cleanse the thighs and groin				
Make a mitt with the washcloth.				
Cleanse the client's upper thighs and groin area with soap and water.				
Rinse and dry.				
Wash the genital area next.				
FINISHING				

Patient

Position the patient comfortably and appropriately

Arrange personal effects and objects of the patient within his range

Thank the patient for his collaboration.

Material

Put material in order.

Associate Nurse Student

Education/ Care-related guidance.

Wash hands.

Make a verbal or written report of Care provided and sign

2.4.Procedure: Moving and positioning patients in bed

2.4.1. Technique: Turning client to the lateral or prone position In bed

Aims of the procedure

- To provide comfort
- To prevent the occurrence of bed sores
- To promote lung and cardiac function
- Identify the predilection sites a patient in the: lateral and/or prone position
- Correctly communicate with the patient during positioning
- Put the patient into the basic position as precautionary positioning of the body

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing
- PATIENT PREPARATION
- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of the procedure
- Position the client appropriately before moving the client

EQUIPMENTS

- Folded screen
- Protective gloves
- Pillows for positioning
- Possibly a draw-sheet.

Steps of turning client to the lateral or prone position In bed

IMPLEMENTATION	Done	Partially done	Not done	Comments
Lateral positioning: lying down, pulled, assisted, 1 nurse				
Ensure client's privacy				

Neutralize the inactive arm				
Let client place the active hand under the small of his back				
Bend the active leg and place against the inactive leg				
Move the pillow back, ask the client to move his head in the direction of the slide.				
Tell the client: “Press with the head, the hand and the foot (in order to lift your body up).”				
Tell the client: “Come here,1,2,3, go!				
Pull, at the same time and towards oneself, in “rappelling” position.				
Re-center the head and put on a pillow case				
Lateral positioning: lying down, pulled, controlled; with draw-sheet and 2 nurses				
Move the pillow in the direction of the slide.				
Untuck the draw sheet on each side of the bed.				
Two nurses gather draw-sheet in pronation, above the shoulder and below the hip.				
Change, at the same time, in supination to obtain two bars under the client.				
Be in a rappelling position, arms extended.				
Ask the client to move the head towards in the direction of the slide.				
Tell the client: “Press with the head 1,2 ,3 go!”				
One nurse leans a little back in order to move the client towards him.				

Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.4.2. Technique: Logrolling a client

Aims of the procedure

- To turn the client whose body must at all times be kept in a straight alignment
- To provide comfort
- Identify the predilection sites a patient in Logrolling
- Correctly communicate with the patient during Logrolling
- Put the patient into the basic position as precautionary positioning of the body

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of the procedure
- Position the client appropriately before moving the client

EQUIPMENTS

- Folded screen
- Protective gloves
- Pillows for positioning
- Possibly a draw-sheet.

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Position yourself and the client appropriately before moving the client				
Place the client's arms across the chest				
Pull the client to the side of the bed:				
Use a turn sheet to facilitate logrolling. First, stand with another nurse on the same side of the bed.				
Assume a broad stance with one foot forward, and grasp half of the fan folded or rolled edge of the turn sheet or friction-reducing device.				
On a signal, pull the client toward both of you.				
One nurse counts: "One, two, three, go."				
Then, at the same time, all staff members pull the client to the side of the bed by shifting their weight to the back foot				
Move to the other side of the bed, and place supportive devices for the client when turned				
Place a pillow where it will support the client's head after the turn				
Place one or two pillows between the client's legs to support the upper leg when the client is turned				
Roll and position the client in proper alignment: Go to the other side farthest from the client, grasp the far edges of the turn sheet and roll the client towards you				

One nurse count “one, two three, go.”				
Then, at the same time, all nurses roll the client to a lateral position				
The nurse behind the client helps turn the client and provides pillow supports				
Completion				
Client				
Position the client comfortably and appropriatel				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance				
Make a verbal or written report of Care provided and sign				

2.4.3. Technique: Moving patient In bed (Two nurses using turn sheet)

Aims of the procedure

- To assist clients who have slid down in bed from the Fowler’s position to move up in bed
- Correctly communicate with the patient during moving the patient
- Move the patient correctly

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of the procedure
- Position the client appropriately before moving the client

EQUIPMENTS

- Folded screen
- Protective gloves
- Pillows for positioning
- Draw-sheet or full sheet

Steps of moving patient In bed (Two nurses using turn sheet)

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wear protective gloves				
Place a draw sheet or a full sheet folded in half under the client, extending from the shoulders to the thighs.				

Each person rolls up or fanfolds the turn sheet close to the client's body on either side.				
Both individuals grasp the sheet close to the shoulders and buttocks of the client.				
Assist the client to flex the hips and knees and place the client's arms across the chest.				
Ask the client to flex the neck during the move and keep the head off the bed surface				
Position yourself and the client appropriately before moving the client				
Face the direction of the movement, and then assume a broad stance with the foot nearest the bed behind the forward foot and weight on the forward foot.				
Lean your trunk forward from the hips.				
Flex the hips, knees, and ankles				
Tighten your gluteal, abdominal, leg, and arm muscles and rock from the back leg to the front leg and back again.				
Then, shift your weight to the front leg as the client pushes with the heels so that the client moves toward the head of the bed				
Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				

Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.4.4. Technique: Moving The Patient From Bed To Chair Or Wheel Chair (One Nurse And Two Nurses)

Aims of the procedure

- Changing position
- Ambulation
- Transfer to operating room
- Implement position changes correctly
- Use the appropriate means to facilitate the movement of the patient.

ASSOCIATE NURSE / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess Client body size, Activity tolerance, Muscle strength, joint mobility presence of paralysis, degree of comfort, orthostatic hypotension and the ability of the client

- , Explain to the patient/ family the rationale of the procedure
- Position the client appropriately before moving the client

EQUIPMENTS

- Protective gloves
- Appropriate clothing
- Slippers or other appropriate open shoes
- Chair or wheelchair (depending the purpose)

Steps moving the patient from bed to chair or wheel chair (One Nurse And Two Nurses)

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wear protective gloves				
Position the equipment appropriately				
Lower the bed to its lowest position so that the client's feet will rest flat on the floor				
Lock the wheels of the bed.				
Place the wheelchair parallel to the bed and as close to the bed as possible				
Put the wheelchair on the side of the bed that allows the client to move toward his or her stronger side				
Lock the wheels of the wheelchair and raise the footplate.				
Assist the client to a sitting position on the side of the bed				
Assess the client for orthostatic hypotension before moving the client from the bed				
Assist the client in putting on a bathrobe and slippers or shoes				

Ask the client to Move forward and sit on the edge of the bed (or surface on which the client is sitting) with feet placed flat on the floor				
Ask the client to Lean forward slightly from the hips				
Ask the client to Place the foot of the stronger leg beneath the edge of the bed (or sitting surface) and put the other foot forward				
Ask the client to Place the client's hands on the bed surface (or available stable area) so that the client can push while standing				
Position yourself correctly: stand in front of the client on her weaker side, hold him in the waist.				
Ensure you are stable by leaning your trunk forward, flexing your hips, knees, and ankles.				
Assist the client to stand, and then move together toward the wheelchair or sitting area to which you wish to transfer the client.				
Ensure wheelchair brakes are on.				
Assist the client to sit by: Assist the client to have back up to the wheel chair (or the desired sitting area) and place legs against the seat				

Assist the client to sit by: Assist the client reach back and hold the arms of wheel chair				
While standing in front of the client with one foot forward, another back and tightening your muscles help the client to sit down bending your knees and hips and lowering the client onto the wheel chair.				
To Ensure client safety: Ask the client to push back into the wheelchair seat				
Variation: Transferring with Two Nurses:				
If two nurses: Position yourselves on both sides of the client, facing the same direction as the client.				
Flex your hips, knees, and ankles.				
Grasp the client's waist or transfer belt (if any) with the hand closest to the client				
With the other hands support the client's elbow.				
Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.4.5. Technique: Moving the client from bed to stretcher

Aims of the procedure

- To transfer the client in supine position from one location to another.
- Implement position changes correctly
- Use the appropriate means to facilitate the movement of the patient.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess client body size, Activity tolerance, Muscle strength, joint mobility, presence of paralysis, degree of comfort, orthostatic hypotension and the ability of the client
- Explain to the patient/ family the rationale of the procedure
- Position the client appropriately before moving the client

EQUIPMENTS

- Protective gloves
- Appropriate clothing
- Stretcher
- Assistive devices as required or bedsheet

Steps of moving the client from bed to stretcher

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wear protective gloves				
Adjust the client's bed in preparation for the transfer.				
Lower the head of the bed until it is flat or as low as the client can tolerate.				
Place the friction-reducing device (if not available, use a bedsheet) under the client.				
Raise the bed so that it is slightly higher than the surface of the stretche				
Locked the wheels of the bed				
Place the stretcher parallel to the bed				
Lock the brakes				
Transfer the client to the stretcher				

If client can transfer independently, encourage him or her to do so and stand by safety				
If the client is partially able or not able to transfer: one caregiver (nurse), stands on the bed's side between client's shoulder and hip, the second and the third on the side of the stretcher (one between shoulder and hip and other between hips and lower leg) and all should stand in a walking stance				
Ask the client to flex the neck during the move, if possible, and place the arms across the chest				
At a signal given by one of the nurses, have the nurses standing on the stretcher side of the bed pull the friction reducing sheet				
At the same time, the nurse (or nurses) on the other side push, transferring the patient's weight toward the transfer board, and pushing the patient from the bed to the stretcher				
Once the patient is transferred to the stretcher, remove the transfer board, and secure the patient until the side rails are raised.				
Raise the side rails.				
To ensure the patient's comfort, cover the patient with blanket and remove the bath blanket from underneath.				

Leave the friction-reducing sheet in place for the return transfer				
Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.5.Procedure: Application of local heat and cold

2.5.1. Technique: application dry and moist heat.

AIMS

- To treat sprains muscle pulls
- To provide relief of pain

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check chart for limitations on patient's physical activity.
- Cleanliness or condition of the bed and surrounding environmen

EQUIPMENTS

- Tray,
- Folded screen
- Non sterile Gloves

Dry heat

- Hot water bag
- Kettle with cover/ or any other material that can kook the water.

EQUIPMENTS

- Water container.
- Hot water bag cover / small towel to cover.
- Vaseline or oil for applying on the skin in case there is redness

Moist Heat

- Basin or tub.
- Small towel.
- Bath towel
- Ties, tape, or rolled gauze.
- Mackintosh

Steps of application dry and moist heat

IMPLEMENTATION	Done	Partially done	Not done	Comments
Dry Heat				
Close the door and/ or put folded screen				
Keep water boiling in a kettle with cover/ or another material that cook water				
Pull some hot water in a bottle and empty it				
Pull water to fill the ½ to 2/3 of the capacity of hot water bottle.				
Expel the air by placing the bag over a flat surface. Cork it tightly.				
Dry the outside of the bottle and hold the bottle upside down for checking leakage.				
Apply folded screen				
Wear Gloves				
Cover the hot water bottle with towel and apply the hot water bottle to the affected area.				

Keep the bottle in place for about 20 – 30 minutes; change its position as necessary				
Inspect the area occasionally for redness, pain and swelling.				
Apply Vaseline or oil on the skin in case there is redness				
Moist Heat				
Wear gloves				
Place the plastic sheet under the body part.				
Fill the basin one-half to two - thirds full with hot water.				
Check the water is not too hot				
Place the compress in the water				
Squeeze out the compress				
Apply the compress quickly till it is warm				
INISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.5.2. Technique: application dry and moist cold.

AIMS

- To treat sprains muscle pulls
- To provide relief of pain

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Clean and short nails
- Remove watch, jewels, and Rings
- Wear closed shoes

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check chart for limitations on patient's physical activity.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Tray,
- Folded screen
- Non sterile Gloves
- Dry heat
- Hot water bag
- Kettle with cover/ or any other material that can kook the water.
- Water container.
- Hot water bag cover / small towel to cover.
- Vaseline or oil for applying on the skin in case there is redness
- Moist cold
- Large basin Contains of ice.
- Small basin Contain with cold water.
- Gauze squares, wash cloth, or small towels.
- Waterproof pad/ Plastic sheet.
- A towel
- Mackintosh

Steps of technique: application dry and moist cold.

IMPLEMENTATION	Done	Partially done	Not done	Comments
Dry cold application				
Closed the door and/ or put folded screen				
Fill the ice bag with water. Put in the stopper, turn the bag upside down to check for leaks				

Remove excess air, bend, twist, or squeeze the bag, or press it against a flat area.				
Dry the bag with paper towels.				
Apply the ice bag to the surface area				
Check the skin after every 10 minute				
Check for redness and complaints of pain, discomfort, or numbness. Remove the bag if any occur.				
Moist cold application				
Closed the door and/ or put folded screen				
Place the small basin with cold water into the large basin with ice.				
Place the compress/cloth/gauze into the cold water.				
Place the bed protector under the affected body surface and expose the area				
Squeeze out a compress so water is not dripping.				
Apply the compress to the surface and note the time				
Check for redness and complaints of pain, discomfort, or numbness. Remove the compress				
Change the compress when it warms. Usually, compress is changed every 5 minutes				
Remove the compress after 20 minutes				
Pat dry the area with towel.				
Remove the gloves				
FINISHING				
Patient				
Position the patient comfortably and appropriately				

Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands				
Make a verbal or written report of Care provided and sign				

2.6.Procedure: Assisting the patient to eliminate

2.6.1. Technique: Use of urinal

Aims of the procedure

- To assist in urination when the client is unable to get out of bed
- To take urine sample
- Assist in urination when the client is unable to get out of bed
- Take urine sample correctly

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Clean and short nails
- Remove watch, jewels, and Rings
- Wear closed shoes

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Urinal
- Protective Clean gloves
- Toilet paper
- Material for personal hygiene if necessary
- Receptacle for waste disposal
- Bed Chair
- Screen
- Linens such as privacy blankets
- Water proof protector/Macintosh

Steps of use of urinal

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put Gloves				
Assist the patient to an appropriate position, as necessary				
If the patient remains in the bed, fold the linens just enough to allow for proper placement of the urinal				
Put the individual sheet/cover or water proof protector				
If the patient is not standing, have him spread his legs slightly.				
Hold the urinal close to the penis and position the penis completely within the urinal.				
Keep the bottom of the urinal lower than the penis.				
If necessary, assist the patient to hold the urinal in place				
Cover the patient with the bed linens				
Place toilet tissue within easy reach				
Have a receptacle, such as plastic trash bag, handy for discarding tissue.				
Leave patient if it is safe to do so.				
Use side rails appropriately				
Pull back the patient's bed linens just enough to remove the urinal				
Remove the urinal.				
Cover the open end of the urinal.				
Place on the bedside chair.				

If patient needs assistance with hygiene, wrap tissue around the hand several times, and wipe patient clean or use water and wash cloth depending on patient.				
Place tissue in receptacle				
Remove your gloves				
Offer patient supplies to wash and dry his hands, assisting as necessary				
Put on clean gloves.				
Observe the characteristics of urine, measuring urine in graduated container as necessary				
Empty and clean the urinal, and return it to patient for future use				
Discard trash receptacle with used toilet paper per facility policy				
Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.6.2. Technique: Use of bed pan

Aims of the procedure

- To assist in voiding when the client is unable to get out of bed
- To take stool sample
- Assist in voiding when the client is unable to get out of bed
- Take stool sample correctly

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Bed pan
- Protective Clean gloves
- Toilet paper
- Material for personal hygiene if necessary
- Receptacle for waste disposal
- Screen
- Linens such as privacy blankets
- Water proof protector/Macintosh

Steps of use of bed pan

IMPLEMENTATION	Done	Partially done	Not done	Comments
Place the screen.				
Close the door to the room and				
Put the individual sheet/cover or water proof protector				
Fill the bedpan with just enough water to cover the bottomor piece of toilet paper(if no specimen is required				
Position the patient in the correct position				
Assist the patient to remove the cloths				
Cover the patient and leave him alone if his condition allows it.				
Instruct the patient to call you if he finish.				
Avail a toilet paper if the patient is able to use it independently.				

Removing the bedpan				
Return to patient as soon as he/she call you				
If the patient didn't call within 5 to 10 minutes check on their progress and continue checking every few minutes				
If the patient can lift their hips				
Ask the patient to bend their knees.				
Instruct the patient to raise their lower half.				
Place your hand beneath the lower back to offer gentle support				
Slide the bedpan from its current position and allow the patient to rest				
Clean the patient				
If the patient cannot lift their hip				
Hold the bedpan flat on the bed so that it does not spill.				
Simultaneously roll the patient to the side facing away from you.				
Slide the bedpan from its current position and allow the patient to rest				
Cover the bedpan with a towel and set it aside for the time being.				
If patient needs assistance with hygiene, wrap tissue around the hand several times, and wipe patient clean, using one stroke from the pubic area toward the anal area.				
Discard tissue, and use more until patient is clean. Place patient on his or her side and spread buttocks to clean anal area.				

Remove your gloves				
Cover the patient				
Completion				
Client				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration.				
Material				
Put material in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.6.3. Technique: Administering enema (Evacuating Enema/ Return Flow Enema)

Aims of the procedure

- To relieve constipation
- To clean bowel before endoscopic examination or procedure
- To clean bowel before surgical operation
- To reduce inflammation of intestine
- Perform enema
- Prepare the patient for enema administration
- Prepare the aids for enema administration

ASSOCIATE NURSE STUDENT / PREPARATION

Should appear professional (in full and clean uniform) with student ID Card

- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Ensure client privacy
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Folding screens.
- Tray, Trolley.
- Bracket
- Impermeable protection and cotton cloth.
- Appropriate rectal tube.
- Kidney dish.
- Lubricant.
- Protective gloves.

- Clean compress and toilet paper.
- Enema cannula with connection tube.
- Grip for clamping or tap.
- Water or other solution at the temperature prescribed.
- Bed pan
- Material for personal hygiene, if necessary.

Steps of Administering enema (Evacuating Enema/Return Flow Enema)

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on protective gloves				
Place the clean equipment on the bedside stand and arrange the supplies so they can be easily reached.				
Close curtains around the bed to ensure privacy				
Close the clamp on the enema tubing				
Prepare warm solution in amount ordered,				
Check temperature with a bath thermometer, if available or use your inner wrist to feel the temperature.				

Pour the water into the enema container				
Open the clamp on the enema container.				
Let a small amount of the solution run through the tubing to eliminate any air in the tubing.				
Reclamp on the enema container				
Adjust the patient's clothing to expose the buttocks.				
Cover the patient with a bath blanket/sheet				
Place the bed protector under the patient's buttocks and assist his/her to turn on the left side.				
Bend the right knee toward his/her chest unless contraindicated by the patient's medical condition.				
Place the bedpan at the foot of the bed				
Elevate solution to 12 to 18 inches (30-45 cm) above level of anus.				
Hang the container on an IV pole/ stand or hold it at the proper height				
Lubricate the tip of the tubing about 3 to 4 inches				
Check the opening of the tube to be sure that it is not plugged.				

Expose the buttocks by grasping the bath blanket or other protective covering at the anal area.				
Lift bath blanket up and fold over the buttock				
Separate the buttocks so that you can see the anal area.				
Slowly and gently insert the enema tube 3 to 4 inches (7 to 10 cm) for an adult. Direct it at an angle pointing toward the umbilicus, not bladder.				
Ask patient to take several deep breaths during insertion				
If resistance is met while inserting tube, permit a small amount of solution to enter, withdraw tube slightly, and then continue to insert it.				
Do not force entry of the tube. Ask patient to take several deep breaths				
Clamp tubing or lower container if patient has desire to defecate or cramping occurs.				
Instruct the patient to pant(to take small, fast breaths).				
After solution has been given, clamp tubing and remove tube.				
Have paper towel ready to receive tube as it is withdrawn				
Return the patient to a comfortable position.				

Encourage the patient to hold the solution until the urge to defecate is strong, usually in about 5 to 15 minutes.				
Remove your gloves				
Wear other gloves and				
Cover the patient				
When patient has a strong urge to defecate, place him or her in a sitting position on a bedpan or assist to commode or bathroom.				
Offer toilet tissues, if not in patient's reach. Stay with patient or have call bell readily accessible.				
Assist patient, if necessary, with cleaning of anal area.				
Offer washcloths, soap, and water for hand washing.				
Remove gloves				
Completion				
Client				
Position the client comfortably and appropriately				

2.6.4. Technique: Assisting patients In using diapers

Aims of the procedure

- To promote cleanliness to the client
- To prevent infection and bed sores

ASSOCIATE NURSE STUDENT / PREPARATION

Should appear professional (in full and clean uniform) with student ID Card

- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Ensure client privacy
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Tray or trolley
- Proper Gloves
- A clean diaper (consider the size of the patient)
- Dust bin or bucket to receive soiled diaper
- Bucket with a lid and filled with water for non-disposable diapers.
- Skin protection barrier cream
- Bed linens, if necessary.

Steps of assisting patients In using diapers

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on protective gloves				
Place the clean equipment on the bedside stand and arrange the supplies so they can be easily reached.				
Remove the diaper, fold it in such a way that the soiled part is turned inward, and discard it.				
Remove gloves, rub hands and put on clean gloves				
Fold the diaper length-ways so that the back sheet is facing outwards. Don't touch the inside of thebrief				
Pass the folded brief from front to back				
Pull out the brief horizontally at front, shape it to create pants with legs				
Pull out the back of brief horizontally. Make sure it fit snuggly into the groin area, back sheet turned outwards.				
Fix bottom tapes on both sides. It may be helpful to angle the tapes slightly upwards to improve the fit around the legs				
Form a pleat in the band of the brief. Fix top tapes angles downwards over the pleat.				
Make sure the edges of the brief easy into the groin area, back sheet turned away from the skin				

Completion				
Position the client comfortably and appropriately				
Arrange personal effects and objects of the client within his range				
Thank the client for his collaboration				
Material				
Put material in order				
Associate Nurse Student				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign				

2.6.5.Technique: Manual removal of fecaloma

AIMS

- To remove impacted feces

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Clean and short nails
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check chart for limitations on patient's physical activity.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- The trolley.
- Serving forceps in its container.
- Disinfectant solution (for hands).
- Bed pan with cover.
- Impermeable protection and cotton protection.

- Lubricant.
- Toilet paper.
- Kidney dish for wastes.
- Individual blanket or towel.
- Protective gloves.
- Plastic apron if available

Steps of manual removal of fecaloma

IMPLEMENTATION	Done	Partially done	Not done	Comments
Provide patient privacy				
Position the patient laterally, knees bent towards the chest.				
Place impermeable protection on the bed				
Respect the patient privacy by covering him/her and expose only the buttocks.				
-Place bed pan for collection of feces				
Get behind the patient				
Put on clean gloves.				
Assess perineum and anus status.				

Lubricate the fingertips of the hand you use.				
Alert the patient and ask him/her to relax				
Gently insert the lubricated fingertips into the rectum.				
Direct the fingertips towards the direction of the umbilical point following the rectum and remove gently feces by massage and kneading fingers on hard mass of fece				
Fragment feces and push them towards the anus and remove the feces in small pieces and put them in bed pan while observing for signs of intolerance by the patient				
Remove the feces in small pieces and put them in bed pan.				
Communicate to him /her and explain what you are doing in rectum and remove gentlly feces by massage and kneading finger on hard mass of feces.”				
Give nutritional education and appropriate habits of defecation and examine the consistency of fecal matter				
Change gloves and perform perineal care and hygiene				
Remove gloves				
FINISHING				

Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration				
Materials				
Put materials in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.6. 6.Hygiene care of Ileostomy or colostomy

AIMS

- To prevent infection
- To prevent irritation of the skin

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Clean and short nails
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check chart for limitations on patient's physical activity.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Bed pan
- Protective Clean gloves
- Toilet paper
- Material for personal hygiene if necessary
- Receptacle for waste disposal
- Screen

- Linens such as privacy blankets
- Water proof protector/Macintosh
- Pieces of gauzes
- Physiologic 0.9% solution The trolley.

Steps of hygiene care of ileostomy or colostomy

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand rubbing				
Wear gloves Close the door to the room and place the screen.				
Put the individual sheet/cover or water proof protector				
Assist the person to a comfortable sitting or lying position in bed or preferably a sitting position				
If a drainage colostomy pouch is sed				
Remove the clamp and empty the contents of a drainable colostomy through the bottom opening into a bedpan. (Assess the consistency, color and amount of stool.)				
If the appliance uses a separate clamp, do not throw it away as it can be reused.				
Peel the skin barrier off slowly, beginning at the top and working downward, while holding the person's skin taut.				

Remove and discard the colostomy pouch.				
Use a toilet paper to remove excess stool Use warm water and washcloth to clean the peristomal skin.				
You may also use piece of gauze and physiologic solution 0.9% to clean peristomal skin				
Clean from inside to outside				
Dry the area thoroughly by patting with a dry gauze or washcloth.				
Assess the stoma and peristomal skin				
Inspect the stoma for color, size, shape and bleeding.				
Inspect the peristomal skin for any redness, ulceration or irritation				
Place a piece of gauze over the stoma and change it as needed				
Prepare and apply the skin barrier				
On the backing of skin barrier trace a circle the same size as the stomal opening				
Cut out the traced stoma pattern to make an opening in skin barrier.				
Remove the backing to expose the sticky adhesive side.				

Centre the new colostomy bag over the stoma and gently press it onto the person's skin for 30 seconds.				
FINISHING				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Materials				
Put materials in order				
Associate Nurse Student				
Education/ Care-related guidance				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.7. Vital signs and parameters

2.7.1.Technique: Body temperature mesurement

Aims of the procedure

- To assist in diagnosis
- To evaluate patient recovery from illness,
- To determine if immediate measure is needed to any abnormal body temperature

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of body temperature measurement
- Position the patient in a comfortable position

EQUIPMENTS

EQUIPMENTS (axillary body temperature)

- Appropriate and functional thermometer.
- Cleaned and disinfected tray.
- Swabs and disinfectant.
- Pen and vital sign flow sheet or electronic health record
- Functional watch on the second hand
- Kidney dish and bowl

EQUIPMENTS(tympanic body temperature)z

- Infrared (tympanic) thermometer, appropriate for site to be used
- Disposable probe covers
- Non sterile gloves, if appropriate
- Cleaned and disinfected tray.
- Swabs and disinfectant
- Kidney dish and bowl
- Additional Personal Protective Equipment (PPE),as indicated
- Toilet tissue, if needed
- Pencil or pen, paper or flow sheet, computerized record

EQUIPMENTS(temporal body temperature)

- Infrared temporal artery thermometer, appropriate for site to be used
- Disposable probe covers
- Non sterile gloves, if appropriate
- Cleaned and disinfected tray.
- Swabs and disinfectant
- Kidney dish and bowl
- Additional Personal Protective Equipment (PPE),as indicated
- Toilet tissue, if needed
- Pencil or pen, paper or flow sheet, computerized record

Steps of body temperature mesurement

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand washing				
Close curtains around bed and close the door to the room, or use fold medical screen to insure patient's privacy				
Ensure the electronic or digital thermometer is in working condition				
Put on gloves				
1. Axillary Temperature measurement				
Move the patient's clothing to expose only the axilla				
Wipe the zone for the taking of the temperature				
Remove the probe from the recording unit of the electronic thermometer. Place a disposable probe cover on by sliding it on and snapping it securely				
Place the end of the probe in the center of the axilla. Have the patient bring the arm down and close to the body				
Hold the probe in place until you hear a beep, and then carefully remove the probe.				
If using mercury thermometer, Leave the thermometer for the required time which is 5 to 10 min				
Withdraw the thermometer and read the value.				
Disinfect the thermometer, then shake it to lower the mercury.				
Cover the patient and help him or her to a comfortable position.				
Dispose the thermometer to the tray.				
Interpret and inform the result to the patient /family.				

Wash hands				
Write down the result on the patient's vital sign flow sheet				
2. Rectal Temperature measurement				
Adjust the bed to a comfortable working height				
Assist the patient to a side-lying position. Pull back the covers sufficiently to expose only the buttock				
Remove the rectal probe from within the recording unit of the electronic thermometer. Cover the probe with a disposable probe and slide it into place until it snaps in place				
Lubricate about 1 inch of the probe with a water-soluble lubricant				
Reassure the patient. Separate the buttocks until the anal sphincter is clearly visible				
Insert the thermometer probe into the anus about 1.5 inches in an adult or 1 inch in a child				
Hold the probe in place until you hear a beep, then carefully remove the probe. Note the temperature reading on the display				
Using toilet tissue, wipe the anus of any feces or excess lubricant. Dispose of the toilet tissue. Remove gloves and discard them.				
Interpret the result and inform the result to the patient /family.				
Wash hands				
Write down the result on the patient's vital sign flow sheet				
3. Oral Temperature measurement				
Remove the electronic unit from the charging unit, and remove the probe from within the recording unit.				

Cover thermometer probe with disposable probe cover and slide it on until it snaps into place.				
Place the probe beneath the patient's tongue in the posterior sublingual pocket. Ask the patient to close his or her lips around the probe				
Continue to hold the probe until you hear a beep. Note the temperature reading				
Remove the probe from the patient's mouth. Dispose of the probe cover by holding the probe over an appropriate receptacle and pressing the probe release button.				
Return the thermometer probe to the storage place within the unit. Return the electronic unit to the charging unit, if appropriate.				
Interpret the result and inform the result to the patient /family.				
Tympanic membrane body temperatre measurement.				
Apply clean gloves.				
Select the appropriatesite based on previous assessment data.				
Assist patient in assuming comfortable positionwith head turned toward side ,away from you .If patient has been lying on one side use upper ear .Obtain temperature from patient's right ear if you are right handed.Obtain temperature from patient's left ear if you are left-handed.				
Note if there is an obvious presence of cerumen (earwax) in patient's lleft ear canal.				

Slide disposable speculum cover over the otoscope-like lens tip until it locks in place. Be careful not to touch lens cover				
Insert speculum into ear canal following manufacturer instructions for tympanic probe positioning: (a) Pull ear pinna backward, up, and out for an adult, For children less than 3 years of age, pull pinna down and back, point covered probe toward midpoint between eyebrow and sideburns.				
Tympanic membrane thermometer with probe cover placed in patient's ear. (b)Move thermometer in a figure-eight pattern (c)Fit speculum tip snug in canal, pointing toward the nose				
Once positioned, press scan button on handheld unit. Leave speculum in place until audible signal indicates completion and patient's temperature appears on digital display				
Carefully remove speculum from auditory meatus. Push ejection button on hand held unit to discard speculum cover into appropriate receptacle.				
If temperature is abnormal or second reading is necessary, replace probe cover and wait 2 minutes before repeating in same ear or repeat measurement in other ear. Consider an alternative temperature site or instrument.				
Return handheld unit to thermometer base.				

Help patient assume a comfortable position.				
Perform hand hygiene.				
Inform patient of temperature reading and record measurement				
Record temperature and route on vital sign flow sheet, nurses' notes, or electronic health record (EHR)				
Report abnormal findings to nurse in charge or healthcare provider				
5. Temporal artery body temperature measurement				
Check medical order or nursing care plan for frequency of measurement and route. More frequent temperature measurement may be appropriate based on nursing judgment. Bring necessary equipment to the bedside stand or overbed table.				
Perform hand hygiene				
Identify the patient.				
Close curtains around bed and close the door to the room,				
Discuss the procedure with patient and assess the patient's ability to assist with the procedure				

Ensure the thermometer is in working condition.				
Apply clean gloves				
Select the appropriate site based on previous assessment data				
Press red scan button with your thumb. Slowly slide thermometer straight across forehead while keeping sensor flat and firmly on skin				
If patient is diaphoretic, keeping scan button depressed, lift sensor after sweeping forehead and touch sensor on neck just behind the earlobe. Peak temperature occurs when clicking sound during scanning stops. Release scan button.				
Gently clean sensor with alcohol swab				
Inform patient of temperature reading and record measurement				
Help patient assume a comfortable position.				
Perform hand hygiene.				
Record temperature and route on vital sign flow sheet, nurses' notes, or electronic health record (EHR)				
Report abnormal findings to nurse in charge or healthcare provider				

2.7.2.Technique: Pulse Measurement

AIMS

- To gather information about heart rhythm and pattern of beat
- To assess heart ability to deliver blood to distant areas
- To evaluate heart effect to cardiac medication, activity, blood volume and gas exchange

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of pulse check up
- Position the patient in a comfortable position
- Make sure that the patient has been at rest for at least 10 minutes.

EQUIPMENTS

- Watch with second hand.
- Stethoscope (for taking the apical pulse only).
- Non-sterile gloves
- Pen and vital sign flow sheet or electronic health record
- Swabs with disinfectant in kidney dish in the event of the apical pulse.

Steps of pulse measurement

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand washing				
Close curtains around bed and close the door to the room, to insure				
patient's privacy				
Put on gloves				
FOR PERIPHERAL PULSE				
Select the appropriate peripheral site based on assessment data				
Move the patient's clothing to expose only the site chosen				
Place your second, and third fingers over the artery				

Lightly compress the artery so pulsations can be felt and counted				
Using a watch with a second hand, count the number of pulsations felt for 60 seconds.				
Note the rhythm and amplitude of the pulse.				
When measurement is completed, remove gloves. Cover the patient and help him or her to a comfortable position				
Interpret and inform the result to the patient /family.				
Wash hands				
Write down the result on the patient's vital sign flow sheet				
FOR APICAL PULSE				
Put on gloves, as appropriate				
Use alcohol swab to clean the diaphragm of the stethoscope. Use another swab to clean the earpieces, if necessary				
Assist patient to a sitting or reclining position and expose chest area.				
Move the patient's clothing to expose only the apical site				
Hold the stethoscope diaphragm against the palm of your hand for a few seconds				

Palpate the space between the fifth and sixth ribs (fifth intercostal space), and move to the left midclavicular line				
Place the diaphragm over the apex of the heart.				
Listen for heart sounds (“lub-dub”). Each “lub-dub” counts as one beat				
Using a watch with a second hand, count the heartbeat for 1 minute.				
When measurement is completed, remove gloves. Cover the patient and help him or her to a position of comfort.				
COMPLETION				
Clean the diaphragm of the stethoscope with an alcohol swab				
Interpret and inform the result to the patient /family.				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order				
Education/ Care-related guidance.				
Make a verbal or written report of Care provided and sign.				

2.7.3. Technique: Blood pressure measurement

Aims of the procedure

- To obtain baseline data for diagnosis and treatment
- To compare and evaluate subsequent change occurred during care.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing
-

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation(Make sure that the skin is dry and injury-free. Do not take BP on an arm with perfusion, paralyzed, or on the side of a former mastectomy)
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of BP check up
- Position the patient in a comfortable position
- Instruct the patient to have a rest for at least 10 minutes.

EQUIPMENTS

- Hand washing
- Disinfected Tray/Trolley
- Disposable pressure cuff of appropriate size for patient
- Functional sphygmomanometer
- Non sterile Gloves
- Alcohol swabs(concentrated at 70%)
- Functional stethoscope.
- Kidney dish
- Pen and vital sign flow sheet or electronic health record

Steps of blood pressure measurement

IMPLEMENTATION	Done	Partially done	Not done	Comments
Close curtains around bed and close the door to the room or use screen to respect patient privacy				
Put on gloves				
Select the appropriate arm for application of the cuff and relax it.				

Have the patient assume a comfortable lying or sitting position with the forearm supported at the level of the heart and the palm of the hand upward. If the measurement is taken in the supine position, support the arm with a pillow. In the sitting position, support the arm yourself or by using the bedside table. If the patient is sitting, have the patient sit back in the chair so that the chair supports his or her back. In addition, make sure the patient keeps the legs uncrossed.				
Make sure that the bladder is fully depleted				
Apply cuff over upper arm, 2.5 cm above antecubital space with center of cuff over brachial artery.				
Check that the needle on the aneroid gauge is within the zero mark. If using a mercury manometer, check to see that the manometer is in the vertical position and that the mercury is within the zero level with the gauge at eye level.				
Palpate the pulse at the brachial or radial artery by pressing gently with the fingertips				
Place the ear-pieces of the stethoscope in the ears.				
Lock the decompression screw at the level of the inflating switch and Pump the pressure 30 mm Hg above the point at which the systolic pressure was palpated and estimated.				

Place the bell or diaphragm of the stethoscope firmly but with as little pressure as possible over the brachial artery. Do not allow the stethoscope to touch clothing or the cuff.				
Release gradually the decompression screw one cm at every second (5 to 10 mm of pressure per second).				
Identify the maximum level and minimum at which the first sounds appear and disappeared respectively as the screw is released.				
Do not reinflate the cuff once the air is being released to recheck the systolic pressure reading				
Allow the remaining air to escape quickly. Repeat any suspicious reading but wait at least 2 minute. Deflate the cuff completely between attempts to check the blood pressure				
Take the blood pressure in the two arms				
Remove the stethoscope ear-phones from ears and deflate the cuff.				
COMPLETION				
Interpret and inform the result to the patient or his family.				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				

Put material in order.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.7.4.Technique: Respiratory rate measurement

AIMS

- To gather information about rhythm and depth
- To determine number of respiration occurring per minutes
- Take correctly the Respiration rate
- Record the results and interpret them.
- Communicate results

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing
-

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation(Make sure that the skin is dry and injury-free. Do not take BP on an arm with perfusion, paralyzed, or on the side of a former mastectomy)
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of BP check up
- Position the patient in a comfortable position
- Instruct the patient to have a rest for at least 10 minutes.

EQUIPMENTS

- Functional watch
- Pen and vital sign flow sheet
- Nonsterile glove

Steps of respiratory rate measurement

IMPLEMENTATION	Done	Partially done	Not done	Comments
Make sure that the thorax of the patient is exposed. While pretending to take the radial pulse, observe the thorax motions.				
Or, place the arm of the client at rest on his abdomen or on the bottom of the thorax, and count the respiratory motions while pretending to take the radial pulse.				
Select the appropriate arm for application of the cuff and relax it.				
Using a watch with a second hand, count the number of respirations for 60 seconds				
Note the depth and rhythm of the respirations.				
When measurement is completed, remove gloves. Cover the patient and help him or her to a comfortable position				
Perform hand washing				
Interpret and inform the result to patient/family.				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.7.5. Technique: Pulse Oximetry Measurement (Oxygen Saturation)

AIMS

- To review basics of the hemodynamics of cardiovascular system
- To recognize various mechanisms for control of vascular disorders
- To incorporate hemodynamic concepts in treatment decision-making process, including when selecting pharmacologic agents for management of cardiovascular diseases.
- To assess the effectiveness of treatment
- To monitor the health of individuals with any type of condition that can affect blood oxygen levels

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing
-

PATIENT PREPARATION

- dentification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

I

EQUIPMENTS

- Pulse oximeter
- Pen
- Vital signs monitoring chart

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Turn the pulse oximeter on: it will go through internal calibration and checks.				
Select the appropriate probe with particular attention to correct sizing and where it will go (usually finger, toe or ear).				
If used on a finger or toe, make sure the area is clean. Remove any nail varnish				
Connect the probe to the pulse oximeter.				
Position the probe carefully; make sure it fits easily without being too loose or too tight.				
Allow the pulse oximeter to detect the pulse and calculate the oxygen saturation.				
Look for the most displayed pulse that the machine has detected				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.7.6. Technique: Height Measurement

AIMS

- To assess overall health

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Height gauge, lath fixed on the wall or tape measure and gloves
- Pen and height recording flow sheet

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on gloves				
Position the height gauge accurately.				
Help the patient to remove shoes.				
Position the patient under the height gauge and ask him to stand right, the head slightly elevated. If the patient cannot move, a meter-tape can be used: The patient is positioned in dorsal decubitus, legs together and straight, and feet at right angle.				
Gently adjust the movable part of the height gauge until reaching the cranium.				
Read the length in cm.				
Inform the result to the patient.				
Record result on the height recording flow sheet				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Education/ Care-related guidance.				
Remove gloves and Wash hands.				
Make a verbal or written report of Care provided				

2.7.7.Technique: Weight Measurement

AIMS

- To assess overall of health

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Position the patient in a comfortable position

EQUIPMENTS

- Appropriate and functional Balance
- Pen, weight recording flow sheet
- Gloves

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on gloves				
Calibrate the balance scale				
Make sure that the patient is wearing a minimum of clothing and is barefoot.				
Help the patient to get on the scale				
Ask the patient not to move.				
Wait until the needle is perfectly stable to read the weight.				
Read weight in kgs or pounds.				
Inform the result to the patient.				
Record result on the recording flow sheet				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Education/ Care-related guidance.				
Remove gloves and Wash hands.				
Make a verbal or written report of Care provided and sign				

2.8.Procedure: Drug Administration

2.8.1.Enteral Routes Of Drug Administration

2.8.1.1.Technique: oral drug administration.

AIMS

- To take supplement in order to maintain health,
- To administer medication indicated for oral route
- To administer specific medication for local action

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Review patient's note and prescription
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Tray
- kidney tray for waste
- Clean gloves
- Drinking water in a jug
- Medication administration record
- Medication cup
- Drug prescription
- Tablet cutter if needed

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene and put on gloves and or other PPE				
Verify the rights of drug administration				
Prepare the medications for one client at a time				
Assist the patient to a comfortable position to take medications				
Check again the Nursing Drug Record and the prepared drug.				
Open the drug package				

Offer a drink of water or other permitted fluid with pills, capsules, tablets to help the patient swallow the medicine if this is allowed and ensure they have swallowed it.				
When administering a liquid suspension, shaken the bottle before the appropriate dose is poured. When administering sprays, the container also needs to be shaken				
Discard any medication that falls on the floor and start over.				
Offer water or fluid with the medication				
Check if the patient swallowed the drug properly.				
FINISHING				
patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				
Check the patient within 30 minutes after giving medication				

2.8.1.2.Technique: Sublingual Drug Adminisatration

AIMS

- To ensure a consistent standardized practice for administering medications sublingually
- To provide the substances that diffuse into the blood through tissues under the tongue which is predominantly a mucous gland that produces a thick mucinous fluid and lubricates the oral cavity.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing
-

PATIENT PREPARATION

- Identification of the patient
- Review patient's note and prescription
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- The nurse should examine mucous membranes of the patient's mouth for irritation or sores.If there are sores in the mouth the physician should be contacted before any sublingual drug administration.
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Medication,

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Ensure that the patient qualifies for the appropriate medical directive, or contact a Base Hospital Physician (BHP) for further direction				
Communicate the need for the medication, and its effects, to the patient/family member whenever possible				
[1] Check medication for proper labelling and for an expiry date.				
Refer to the correct medical directive for correct dosages.				
Instruct the patient to open his or her mouth and raise the tongue				
The tablet should then be placed under the tongue.				
Explain to the patient that nothing should be eaten ,drank,swallowed,chewed, or smoked until the tablet has dissolved.				

Assess the patient closely for any change in condition following the medication administration.				
Discontinue the medication if adverse effects occur or as directed by a BHP.				
Document patient condition before and after the medication administration.				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient and to put them within his range				
Open the windows to ventilate the room				
Thank the patient for his collaboration				
Put material in order.				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided				

2.8.1.3.Technique: Rectal Suppository Drug Administration

AIMS

- To administer some inflammatory drugs,
- To administer some antipyretic,
- To soften stools in case of constipation
- To treat hemorrhoid

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing
-

PATIENT PREPARATION

- Identification of the patient
- Review patient's note and prescription
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Medication administration record,
- Nonsterile gloves
- swabs,
- Bed pan
- Prescribed rectal suppository,
- Water-soluble lubricant

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
IMPLEMENTATION				
Perform hand hygiene and put on gloves and or other PPE				
Close curtains around bed and close the door to the room or use fold medical screen.				
Verify the rights of drug administration				
Ask client if he or she needs to void.				
Assist the patient to his left side in a Sims position. Drape accordingly to expose only the buttocks				

Remove the suppository from its wrapper. Apply lubricant to the rounded end.				
Lubricate the index finger of your dominant hand.				
Separate the buttocks with your non-dominant hand and instruct the patient to breathe slowly and deeply through the mouth.				
Insert the suppository into the rectal canal beyond the internal sphincter about 4 inches (10 cm) for an adult and 2 inches (5 cm) for a child. Avoid inserting the suppository into feces.				
Withdraw the finger and wipe the anal area with tissue.				
Instruct the client to remain in bed for 15 minutes and to resist urge to defecate.				
Remove gloves, turning them inside out; dispose of gloves; wash hands.				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Observe for effect of suppository after administration				
Education/ Care-related guidance.				
Wash hands.				

2.9.Procedure: Topical Application

2.9.1. Technique: Topical Skin Application

AIMS

- To Apply medication through the skin.
- To produce local effects, some topical preparations have systemic effects, absorbed through the skin and mucous membrane
- To provide the continuous absorption of medication over several hours.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient and ask consent
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Tray
- Gauzes
- Clean gloves
- Topical medication

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Provide privacy if needed.				
Clean hands				
Put on clean gloves.				
After opening the container, place the lid with inside up to keep from contaminating the inside of the lid. Do not touch the inside of the container				
Use gauze or a cotton tipped applicator to apply cream or ointment				
If you get too much out of the container, do not put it back due to risk of contaminating the remaining medication.				
Use a new gauze or cotton tipped applicator each time medication is removed from the container to prevent contaminating the medication left in the container.				

When finished getting the required amount of medication, replace and tighten the cap on container.				
Apply a thin layer of medication to the client's affected skin				
Throw away supplies (such as gauze or cotton-tipped swabs) used in application				
Remove gloves and discard hands.				
Completion of The Procedure				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient and to put them within his range				
Open the windows to ventilate the room				
Thank the patient for his collaboration				
Put material in order.				
Education/ Care-related guidance.				
Wash hands.				

2.9.2. Technique: Eye Medication Administration

AIMS

- To administer medication indicated for eye route
- To test for medication allergy

ASSOCIATE NURSE STUDENT / PREPARATION

- The nurse introduces to the patient, explain the purpose of that medication and ask for consent
- Wash hands
- The student nurse prepares and assemble all the materials after disinfecting the tray/ trolley
- Assess the information related to the drug such as mode of action, purpose, route, time of onset and peak of action, side effects and nursing implications
- Apply privacy
- Assess the condition of external eye and note changes
- Assess for allergy, level of consciousness and ability to follow command
- Assess the ability for self-administration

PATIENT PREPARATION

- Identification of the patient and identify patient's names
- Self-presentation to the patient and ask for consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Check drug : name of the drug, name of the patient, dose, method and hour of administration, expiry date
- Explain the procedure and purpose to the patient
- Check for any drug allergies and ensure that there is no skin tenderness.
- Understand the therapeutic indications of the drug, mode of action and its side effects.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Eye medicine,
- Medication chart,
- Clean gloves,
- Swabs,
- Disinfectant,
- Tray or trolley.

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash hand and put on gloves				
In a supine position patient looks up, in sitting position on a chair he or she slightly hyperextend the head and look in the ceiling.				
Use the thumb of forefinger of non-dominant hand to open the lower eye lid by pulling it back against the orbit				
In a supine position patient looks up, in sitting position on a chair he or she slightly hyperextend the head and look in the ceiling.				
Eye drop:				
Ask the patient to look in the ceiling and hold the medication eye dropper at approximately 1 to 3 cm above the conjunctiva sac.				
Instill prescribed drops				
In the patient blinks or close eye so that the drops				
Went out of lids margin, dry it with a swab and repeat the procedure.				
Eye ointment:				
Ask the patient to close the eye, apply a gentle circular massage on the eye unless contraindicated				
Wipe the excess ointment from inner to outer canthus				

COMPLETION				
Thank the patient and arrange his environment				
Remove gloves				
Give related health education, train the patient for self-administration				
Document the procedure and other relevant findings				

2.9.3. Technique: Ear Drug Administration

AIMS

- To take supplement in order to maintain health,
- To administer medication indicated for nasal route
- To administer specific medication for local action

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Short cut nails

- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Review patient's note and prescription
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the patient the procedure regarding positioning and sensation to expect such us burning or straining of mucosa or shocking sensation as medication strikes into throat .
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Right Medication
- Gloves
- Medication administration record
- Tray
- Drug prescription
- Tissues

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Rub hands				
wear gloves				
Shake the bottle or canister				
Offer a position that exposing the affected ear				
Pull the pinna up and back for adults and children greater than 3 years, then down and back for younger children to straighten the ear canal				
If the cerumen prevents the entrance the ear canal, wipe it gently with a wooden cotton and avoid to introduce the cerumen into the inner canal				
Hold the dropper and instill the prescribed drop				
Keep the patient is the lying position for some minutes				
If ordered, insert a cotton ball to the entry of the ear canal				
Remove the cotton after 15 minutes and help the patient to resume preferred position				
Remove gloves				
FINISHING				
Patient				
Position the patient comfortably and appropriately				

Arrange personal effects and objects of the patient within his range				
Observe the patient for 15 to 30 minutes after administration				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.9.4. Technique: Nasal Drug Administration

AIMS

- To take supplement in order to maintain health,
- To administer medication indicated for nasal route
- To administer specific medication for local action

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Short cut nails
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Review patient's note and prescription
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the patient the procedure regarding positioning and sensation to expect such us burning or straining of mucosa or shocking sensation as medication strikes into throat .
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Right Medication
- Gloves
- Medication administration record
- Tray
- Drug prescription
- Tissues

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Rub hands				
Wear gloves				
Share the bottle or canister				
Wear non-sterile gloves.				
Position patient in sitting back or lying down with head tilted back over a pillow.				
Hold the dropper near the entry to the nostril and instruct the client to inhale as you drop the appropriate dose into the nostril.				
Instruct the patient to breathe through mouth				
Keep the client's head back for two to three minutes to allow the drops to roll to the back of the nostril.				
Repeat in the other nostril.				
Keep Tissues at hand to wipe residue away(if needed).				
Instruct the patients to cover the mouth and nose with tissues when sneezing				
FINISHING				
Patient				
Position the patient comfortably and appropriately				

Arrange personal effects and objects of the patient within his range				
Observe the patient for 15 to 30 minutes after administration				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.9.5 Technique: Vaginal Suppository Medical Administration

AIMS

- To treat certain conditions, such as yeast infections.
- To treat fungal infections and vaginal dryness.
- To administer some contraceptives method used as a form of birth control
- To provoke uterine muscle contraction

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Short cut nails
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient and ask for consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Check for any drug allergies
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Medication administration record,
- Nonsterile gloves,
- Gauzes
- Prescribed vaginal suppository,
- Water-soluble lubricant,
- Disposable applicator

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene and put on gloves and or other PPE				
Close curtains around bed and close the door to the room or fold medical screen.				
Verify the rights of drug administration				
Fill a vaginal applicator with the prescribed amount of cream, or have a suppository ready				
Lubricate the applicator with water, as necessary. A suppository may be lubricated with a water-soluble gel. If not using an applicator, apply a small amount of lubricant to gloved index finger.				
Position the client in a dorsal recumbent position with knees flexed and hips rotated laterally or in a Sims' position if the client cannot maintain the dorsal recumbent position.				
Spread the labia well with the fingers and clean the area at the vaginal orifice with a washcloth and warm water to remove discharge.				
Introduce the applicator gently in a rolling manner while directing it downward and backward to follow the normal contour of the vagina for its full length.				
Push the plunger to its full length, and then gently remove the applicator with the plunger depressed.				

Wipe the perineum with clean, dry tissue.				
Instruct the client to remain in bed for 15 minutes.				
Wash applicator under cool running water to clean and return to appropriate storage in the client's room.				
Remove gloves, turning them inside out; dispose of gloves; wash hands.				
Completion				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Observe for effect of suppository after administration				
Education/ Care-related guidance.				
Wash hands.				

2.10.Technique: Leopord's Manoeuver

AIMS

- To determine the fetal well being
- To confirm pregnancy
- To determine gestational age
- To determine presentation, lie, position and engagement of the presenting part

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Ask the client to empty her bladder and explain why
- Check chart for limitations on patient's physical activity.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Tray
- Table of examination
- Tape measure
- ANC card and Client records
- Gloves (examination gloves)
- Dust bin

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand rubbing				
Wear gloves Close the door to the room and place the screen.				
Ask the woman to lie on her back, feet posed on the bed and knees bending				
Assess fundal /uterine height:				
Use two hands to palpate the top of the uterus,				
Measure the uterine height from the upper border of the symphysis pubis to the highest point of the fundus of the uterus by using a tape measure				
First Maneuver:				

Feel the consistency and the mobility of the fetal part lying in the fundus of the uterus (If fundus is empty suspect transverse lie)				
Second Maneuver:				
Determine the lie (presentation) by moving the hands to half way down the uterus,				
Palpate the abdomen, apply gentle pressure.				
One hand palpates, the other hand supports the abdomen.				
Third Maneuver:				
Place one hand just above the symphysis.				
Determine which part of the fetus occupies the lower uterine pole:				
Verify if the presentation is engaged				
Fourth Maneuver:				
Place two hands to the lower uterine pole				
Slide hands on the sides of the uterus towards the pubis				
Identify a cephalic, a breech or another presentation.				
Determine the degree of the engagement of the presentation				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided and sign				

2.11.Technique: Auscultation of fetal heart rate

AIMS

- To listen and count fetal heart rate
- To differentiate Fetal heart rate rhythm from maternal pulse

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Ask the client to empty her bladder and explain why
- Check chart for limitations on patient's physical activity.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Tray
- Table of examination
- Pinard fetoscope
- ANC card and Client records
- Watch
- Gloves (examination gloves)
- Dust bin

Steps of auscultation of fetal heart rate

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand rubbing				
Wear gloves Close the door to the room and place the screen.				
Ask the woman to lie on her back, feet posed on the bed and knees bending				
Determine the position of the fetal back				
Put the abdominal end of the pinard's fetoscope on the side of the fetal back				
Put the aural end of pinard's fetoscope on the ear and hear fetal heart rate				
Take the pulse rate of the mother and compare with fetal heart rate				
Take the watch and count the fetal heart rate, assess the rythme				
COMPLETION				
Patient				
Position the patient comfortably and appropriately				
Adjust the environment of the patient as necessary.				

Education/ Care-related guidance.				
Thank the patient for his collaboration				
Materials				
Put materials in order.				
Associate Nurse Student				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

2.12.Technique: Vulval Disinfection

AIMS

- Reduces the risk of infection

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Ask the client to empty her bladder and explain why
- Check chart for limitations on patient's physical activity.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Table of examination
- Client records
- Set for disinfection (sterile packet containing a gall pot with minimum of 5 swabs and Kocher's forceps)
- Non-irritant solution for disinfection
- Examination gloves
- Kocher' s forceps
- Tray or trolley
- Mackintosh and sterile drape
- Folding screen if no curtains available,
- Bucket with solution of decontamination
- Dust bin

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Rub hands				
Assist the client into a suitable and comfortable position: usually on the back, thighs bent and in abduction				
Put on gloves				
Take Kocher' s forceps				

Disinfect the distal labia majora (1 swab, minimum)				
Disinfect the distal labia minora (1 swab, minimum)				
Disinfect proximal labia majora (1 swab, minimum)				
Disinfect proximal minora (1 swab, minimum)				
Separate the labia in the ventral direction with the index				
Disinfect the vulval vestibule from top to bottom (1 swab, minimum)				
COMPLETION				
Patient				
Position the patient comfortably and appropriately				
Adjust the environment of the patient as necessary.				
Education/ Care-related guidance				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Wash hands				
Make a verbal or written report of Care provided/findings and sign				

2.13.Technique: Digital Vaginal Examination

AIMS

- To assess the status of the cervix and membranes,
- To assess the position of head and degree of molding.
- To evaluate the bishop score(descent,effacement,dilation,consistence, position).
- To detect the cephalopelvic disproportion.
- To identify complications as cordprolapse, Vasa previa

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Ask the client to empty her bladder and explain why
- Check chart for limitations on patient's physical activity.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Table of examination
- Client records
- Set for disinfection (sterile packet containing a gall pot with minimum of 5 swabs and Kocher's forceps)
- Non-irritant solution for disinfection
- Examination gloves
- Kocher' s forceps
- Tray or trolley
- Mackintosh and sterile drape
- Folding screen if no curtains available,
- Bucket with solution of decontamination
- Dust bin

Steps of digital vaginal examination

IMPLEMENTATION	Done	Partially done	Not done	Comments
Rub hands				
Assist the client into a suitable and comfortable position: usually on the back, thighs bent and in abduction.				
Put on gloves				
Take Kocher' s forceps				
Disinfect the distal labia majora (1 swab)				
Disinfect the distal labia minora (1 swab)				
Disinfect proximal minora (1 swab)				
Separate the labia in the ventral direction with the index and disinfect from top to bottom				

Gently insert lubricated gloved index and third finger into the vagina in the direction of the posterior wall until they touch the cervix.The uterus may be stabilised by placing the nondominant hand on the woman's abdomen.				
Assess the cervix for effacement and the amount of dilatation.				
Assess for intact mebranes;if fluid is expressed test for amniotic fluid.				
Palpate the presenting part.				
Assess foetal descent and station by identifying the position of the posterior fontanel.				
Withdraw the finger.Assist teh patient in wiping her perneum from front to back to remove lubricant or secretion.				
COMPLETION				
Patient				
Position the patient comfortably and appropriately				
Adjust the environment of the patient as necessary.				
Education/ Care-related guidance.				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

2.14.Technique: Spontaneous Vaginal Delivery

AIMS

- To assist the mother in childbearing safely without the use of drugs, techniques or others special material.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Explain the procedure and purpose to the patient
- Ask the client to empty her bladder and explain why
- Check chart for limitations on patient's physical activity.
- Respect the client privacy.
- Check Cleanliness or condition of the bed and surrounding environment
- Position the patient in a comfortable position

EQUIPMENTS

- Table of examination
- Client records
- Set for disinfection (sterile packet containing a gall pot with minimum of 5 swabs and Kocher's forceps)
- Non-irritant solution for disinfection
- Examination gloves
- Kocher' s forceps (serving)
- Tray or trolley
- Mackintosh and sterile drape
- Folding screen if no curtains available,
- Bucket with solution of decontamination
- Dust bin
- Material of protection: plastic apron, boots, glasses, hat and mask.
- Folding screen if no curtains available
- Local anesthesia (lignocaine 2%)
- Syringe of 10ml and 2 needles
- Syringe of 2ml and 2 needles (1 for aspiration and 1 IM injection)
- 1 ampoule of 10 IU oxytocin.
- Gauzes
- Foetoscope, Doppler
- Check if the newborn resuscitation equipment is ready and in working
- Material for taking vital signs.
- Container for placenta, Dustbin

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Give her continuous emotional support and reassure her.				
Decide, together with the woman, the position for delivery (squatted position, knee position, lateral position, gynecological position with support of cushions/pillows).				
Allow the client in labor to push spontaneously once she is fully dilated with full effacement, and the baby is well engaged in the pelvis.				
Evaluate for episiotomy if necessary (see the checklist for the episiotomy procedure).				
Maintain a firm but delicate pressure on the head to maintain its flexion				
Ask the client to blow gently to avoid pushing in the absence of a contraction.				
Once the head is delivered, put the hand to receive the head.				
Wipe the mouth and nose of the baby with a sterile gauze and remove any mucosa.				
Verify that the cord is not around the baby's neck: if the cord does not tighten, make it slip over the head of the baby. If the cord tightens, apply two Kocher's forceps and the cord is cut between the two clamps.				
Allow the rotation of the head to occur spontaneously.				
Delivery of the shoulders				
Place a hand of each side of the baby's head over the ears.				

Practice gentle downward traction to allow the anterior shoulder to slip in under the syphilis pubis.				
When the axillary crease is seen, the head and the trunk are guided with an upward movement to allow the posterior shoulder to escape over the perineum.				
Hold the baby around the chest to assist the birth of the trunk and lift the baby on to the client's abdomen and cover the baby.				
Memorize the hour and the date of birth.				
Inform the client about the sex of the baby and congratulate her.				
Wait 2 to 3 minute before clamping the umbilical cord (assess umbilical pulse, before clamping)				
Apply a Kocher's forceps on the umbilical cord at 20 cm from the baby's abdomen, apply the second forceps at 25 cm from the baby.				
Cut the cord between the two Kocher's forceps by using the scissors reserved for the baby and a gauze to prevent that blood does not spurt.				
COMPLETION				
Patient				
Position the patient comfortably and appropriately				
Adjust the environment of the patient as necessary.				
Thank the patient for his collaboration.				
Materials				

Put materials in order.				
Associate Nurse Student				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

2.15.Technique: Immediate Care Of The New-Born Baby

AIMS

- To detect the newborn abnormalities and reassure the parents

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands

PATIENT PREPARATION

- Introduce to the mother
- Explain the procedure to the mother and obtain her consent
- Ask about newborn's information (Breastfeeding, elimination, sleeping, state of umbilical cord and skin color)

EQUIPMENTS

- Tape measure,
- Baby weighing scale,
- Radiant warmer (if needed),
- Flannel to cover baby,
- Examination gloves,
- Neonatal stethoscope,
- Watch,
- Thermometer,
- Tongue depressor,
- Vitamin K
- Pamper &baby's clothes if soiled,
- Hand disinfectant.

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on clean gloves				
Create an emotional relationship with the baby				
Dry the baby quickly with the sterile drape which is on the abdomen of the client. Remove the wet and cold drape/tissue				
Put the baby in skin to skin on the client's chest and cover them with the fourth sterile drape.				
Keep baby warm skin to skin if necessary move baby to heating table.				

Observe the baby's respiration all along the previous steps. If the new-born baby does not breathe, begin helping baby breath(see the checklist for the resuscitation of the newborn baby) If the new-born baby breathes normally continue with the observations.				
Leave the new-born baby in skin to skin contact on client's trunk.				
Evaluate the APGAR's score at the 5 and 10 minutes if not yet done.				
Check if the child presents abnormalities (congenital malformations, obstetrical injuries/ trauma, signs of respiratory distress).				
Clamp the cord 2 times with the umbilical clamps or strings 1 cm from the umbilicus of the baby.				
Cut the cord at 3 cm from the umbilicus of the baby.				
Check the umbilical cord for 1 vein and 2 arteries.				
Weigh the child.				
Take the measurements of the baby (size, head circumference).				
Put the cap and socks.				
Take the temperature of the child.				
Administer vitamin K 1mg (for the baby of 1500gr and above) and 0, 5 mg (for the baby less than 1500gr).				
Continue putting on the clothes.				
Apply the tetracycline ointment in the eyes.(one tube for each baby)				
Identify the baby (Name of the mother, sex, date and hour of birth).				
Assist the mother to breastfeed her baby				
Provide appropriate and relevant health education (immediate breastfeeding, check umbilical cord for bleeding, keep warm)				

COMPLETION				
Put the material used in the bucket of decontamination solution.				
Leave the area tidy.				
Wash and dry hands				
Provide appropriate and relevant health education(immediate breastfeeding, check umbilical cord for bleeding, keep warm, immunization, family planning, nutrition, hygiene, danger signs for baby).				
Document the findings				

2.16.Technique: Assessment Of The New Born

AIMS

- To assess the adaptations of a newborn after birth
- To detect early possible abnormalities
- To establishes a baseline for subsequent examinations
- To reassure the parents

ASSOCIATE NURSE STUDENT / PREPARATION

- Identification of the patient
- Self-presentation to the patient
- Ask for the consent from the parents
- Explain the procedure to the mother and relatives
- Give them opportunity to ask questions.
- If possible, let them participate during the care.

PATIENT PREPARATION

- Introduce to the mother
- Explain the procedure to the mother and obtain her consent
- Ask about newborn's information (Breastfeeding, elimination, sleeping, state of umbilical cord and skin color)

EQUIPMENTS

- Tape measure,
- Baby weighing scale,
- Radiant warmer (if needed),
- Flannel to cover baby,
- Examination gloves,
- Neonatal stethoscope,
- Watch,
- Thermometer,
- Tongue depressor,
- Pamper &baby's clothes if soiled,
- Hand disinfectant.

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Close the door and the windows to avoid coldness.				
Ask about the history of pregnancy and delivery				
Wash and dry hands.				
Put on the examination gloves.				
Create a relationship with the new born and explain to the mother what you are going to do step by step.				

Close the door and the windows to avoid coldness.				
Ask about the history of pregnancy and delivery				
Wash and dry hands.				
Put on the examination gloves.				
Create a relationship with the new born and explain to the mother what you are going to do step by step.				
Remove the baby under warm table				
Weigh the baby.				
Evaluation of the reflexes:				
Sucking: introduce his finger into his mouth or breastfeed him to see whether he is sucking.				
Swallowing: see whether the child swallows.				
Moro: hold the head of the child and leave it rock behind and see whether he draws aside the arms and bring them back on his chest				
Grasping or Gripping: give an object to the new-born baby and make it hold by his hand, in case of existence of this reflex he strongly tightens it.				
Walking and stepping: hold the baby and support him upright, if this reflex exists the child makes small steps.				
Examination of the skin:				
Color, skin peeling off, lanugo, traumatic cyanosis, urticaria neonatorum				
Birthmarks: Mongolian blue spots, vascular naevi				
Examination of the head:				
Look for birth trauma: superficial bruising, forceps marks, caput succedaneum, molding of the head, suction cap marks.				

Look for abnormalities (hydrocephaly, anencephaly, microcephaly, macrocephaly, fontanels, sutures….)				
Face: symmetry				
Eyes: hemorrhage, symmetry, iris, sticky and crusts, conjunctivae: anemia or jaundice				
Ears: shape, symmetry, absence of the cartilage and/or notch of the pinna				
To check for signs of Down syndrome (trisomy 21) ...				
Nose: shape, presence of the grains milium				
Mouth: symmetry, Ebstein pearls, tongue tie, macroglossia, teeth, harelip, palate cleft; edema				
Neck: length, stiffness of the nape of the neck, hypotonic				
Examination of the chest:				
Symmetry, shape.				
Heart:120-160,bradycardia, tachycardia, heart sounds(S1andS2)				
Check respiration rate (30 to 60 mvts/min).				
To observe the signs of respiratory distress.				
Breast: symmetry, number, swelling and discharge among girls and boys...				
Examination of the abdomen:				
Flexibility or distension, or any abnormalities of organs.				
Check the umbilicus, umbilical cord (2 arteries and 1 vein, bleeding, hernia)				

Genital organs:				
ambiguous genitalia				
Males: assess descent of testes, hypospadias, phimosis.				
Female: labia minora if not prominent, labia majora, perforation of hymen, discharge.				
Upper limbs:				
To assess Moro reflex, (fracture of the clavicle, humerus, paralysis of the plexus brachial).				
To assess the abnormalities: supernumerary fingers (polydactyl), fusion of 2 fingers (syndactyl).				
Lower limbs:				
To assess the abnormalities, club-foot				
To assess the abnormalities: supernumerary fingers (polydactyl), fusion of 2 fingers (syndactyl).				
To check the Ortolani's maneuver for hips dislocation				
Examination of the back:				
Spinal bifida and other vertebral deformities				
Anus: assess anal imperforation with thermometer.(apply lubricant)				
COMPLETION				
Dress the baby.				
Give the baby to her mother and encourage breastfeeding.				
Provide health education (Danger signs, immunization, hygiene, cold care :avoid rumors)				
Remove the gloves.				
Document the results in the file and inform the client.				
Provide health education to the client				

2.17.Technique: Helping Babies Breathe

AIMS

- To ensure the newborn breath within the Golden minute.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with Student's ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed shoes
- Clean and short nails
- Wear closed shoes
- Wash Hands and dry
- Close doors & windows to keep the environment warm
- Ensure good light

PATIENT PREPARATION

- Introduce to the mother
- Explain to the mother and the relatives about the procedure.
- Reassure her and give continuous emotional, physical support

EQUIPMENTS

- Examination gloves,
- Ambu bag,
- Clothes and head cap,
- Stethoscope,
- Penguin (suction)
- Ties,
- Scissors

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Identify 2 other nurses to assist				
Identify a pediatrician/ Neonatal nurse for the resuscitation of the newborn				
Wash hands				
Keep warm				
Recognize that the baby is not crying				
Clear airway if necessary				
Stimulate breathing				
Cut the umbilical cord				
Move to area for ventilation				
Call for help				
Ventilate				
Improve ventilation				
Monitor with mother if breathing well or Seek advanced care if not breathing weak				
COMPLETION				
Inform the mother about findings after delivery and thank her for collaboration				
Decontaminate used materials				
Decontaminate gloved hands in the solution of decontamination before removing them				
Rearrange material and remove gloves				
Provide health education to the client				
Wash and dry hands				

3.1. Procedure: Wound Dressing

3.1.1. Technique: Aseptic Dry Wound Dressing

Aims of aseptic wound dressing

- To keep the wound clean and maintain acceptic field
- To prevent the wound from injury and contamination
- To keep in position, the drugs applied locally
- To keep the edges of the wound together
- To apply pressure

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

Identification of the client

- Self-presentation to the client
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the client
- Location, area, state of the wound.
- Type of dressing to carry out.
- Type of product to use.
-

Materials

- Cleaned and disinfected trolley.
- On the upper shelf of the trolley.
- Sterile dressing set : for the sterile scissors and forceps(1 anatomic and 1 Kocher), Gauze dressings, Sterile drape, Sterile kidney dish
- Serving forceps
- Specific and Additional Material: in drums, boxes, individual packing.
- Sterile cleaning solution as ordered (commonly 0.9% normal saline solution)
- Tape or bandage
- Sanitizer for hand rub
- Kidney basin with a pair of scissors for cutting the adhesive plaster..
- On the lower shelf of the trolley.
- Kidney dish
- Protective gloves.
- Waterproof pad
- Container or Recipient for used material.
- Additional personal protective Equipment (PPE), as indicated
- Dust bin.

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assess the client for the possible need for non-pharmacologic pain-reducing or analgesic medication and check allergy status				
Wash hands with soap and water, and put on appropriate PPE.				
Close the door, curtain or put on fold screen				

Position the materials on the appropriate side of the client.				
Position the client in a suitable position.				
Place a waste receptacle or bag at a convenient location for use during the procedure.				
Place the trolley at a convenient location near patient's bedside				
Place the waterproof pad.				
Examine the wound site.				
Disinfect the hands.				
Open the outer cover of the sterile dressing pack (Open the sterile field using only the corners of the wrapper) and open other sterile supplies gently onto the center of the sterile field				
Take a serving forceps.				
Arrange the material.				
Clean hands with an alcohol-based sanitizer and put on glove				
Add sterile swabs if necessary.				

Add pads if necessary.				
Pour the disinfectant in the sterile cup				
Loosen the adhesive of any existing dressing, remove and check it.				
Observe the wound and its surrounding area or tissue.				
Place the dressing in the disposal bag. Remove the gloves and dispose of them in the disposal bag.				
Take some forceps for working.				
Place the sterile cloth on the waterproof pad				
Open the sterile cleaning solution. Depending on the amount of cleaning needed, the solution might be poured directly over gauze sponges over a container for small cleaning jobs, or into a basin for more complex or larger cleaning				
Clean the wound from top to bottom and from the center to the outside. Following this pattern, use new gauze for each wipe, placing the used gauze in the waste receptacle Alternately, spray the wound from top to bottom with indicated solution				
Clean the wound using many pads if necessary.				
Clean around the wound.				
Once the wound is cleaned, dry the area using a gauze sponge in the same manner. Apply ointment or perform other treatments, as ordered				

Apply a layer of dry, sterile dressing over the wound. Forceps may be used to apply the dressing.				
Place a second layer of gauze over the wound site, as necessary.				
Remove and discard gloves and apply tape/ straps, or roller gauze/bandage to secure the dressings.				
Completion of procedure				
Client				
Position the client comfortably and appropriately				
Lower patient's bed (if raised) and draw back the curtains (if applicable).				
Thank the client for his collaboration.				
Associate Nurse/Student				
Education/advisory guidance				
Wash hands				
Material				
Remove the gloves.				
Document the results in the file and inform the client.				
Provide health education to the client				
Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				
Clean instruments, disinfect them				
Remove gloves and wash hands.				
Make a verbal or written report of Care provided				

3.1.2. Technique: Wet dressing

AIMS

- To optimize timely and cosmetically appropriate healing
- Maintain a moist environment
- Control or absorb excess exudate, and aid debridement of necrotic or slough tissue
- To prevent or combat infection non adherent to the wound surface, not to shed fibres or cause trauma to the wound or surrounding tissue on removal

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional(in full and clean uniform) with student ID card.
- Hair tied back
- Remove watch , jewels and rings
- wear closed shoes
- Hand washing

Client preparation

- Identification of the client
- Self-presentation to the client
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the client
- Location, area, state of the wound.
- Type of dressing to carry out.
- Type of product to use.,

Materials

- Cleaned and disinfected trolley.

On the upper shelf of the trolley.

- Sterile dressing set : for the sterile scissors and forceps(1 anatomic and 1 Kocher), Gauze dressings, Sterile drape, Sterile kidney dish
- Serving forceps
- Specific and Additional Material: in drums, boxes, individual packing.
- Sterile cleaning solution as ordered (commonly 0.9% normal saline solution)
- Tape or bandage
- Sanitizer for hand rub
- Kidney basin with a pair of scissors for cutting the adhesive plaster…

On the lower shelf of the trolley.

- Kidney dish
- Protective gloves.
- Waterproof pad
- Container or Recipient for used material.
- Additional personal protective Equipment (PPE), as indicated
- Dust bin.

Steps of wet dressing

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assess the client for the possible need for non-pharmacologic pain-reducing or analgesic medication and check allergy status				
Wash hands with soap and water, and put on appropriate PPE.				

Close the door, curtain or put on fold screen				
Position the materials on the appropriate side of the client.				
Position the materials on the appropriate side of the client.				
Position the client in a suitable position.				
Place a waste receptacle or bag at a convenient location for use during the procedure.				
Place the trolley at a convenient location near patient's bedside				
Place the waterproof pad.				
Examine the wound site.				
Disinfect the hands.				
Open the outer cover of the sterile dressing pack (Open the sterile field using only the corners of the wrapper) and open other sterile supplies gently onto the center of the sterile field				
Take a serving forceps.				
Arrange the material.				
Clean hands with an alcohol-based sanitizer and put on glove				
Add sterile swabs if necessary.				
Add pads if necessary.				
Pour the disinfectant in the sterile cup				
Loosen the adhesive of any existing dressing, remove and check it.				
Observe the wound and its surrounding area or tissue.				

Place the dressing in the disposal bag. Remove the gloves and dispose of them in the disposal bag.				
Clean hands with an alcohol-based sanitizer and put on gloves				
Take some forceps for working.				
Place the sterile cloth on the waterproof pad Place the sterile cloth on the waterproof pad				
Open the sterile cleaning solution. Depending on the amount of cleaning needed, the solution might be poured directly over gauze sponges over a container for small cleaning jobs, or into a basin for more complex or larger cleaning				
Clean the wound using many pads if necessary.				
Clean around the wound.				
Once the wound is cleaned, dry the area using a gauze sponge in the same manner. Apply ointment or perform other treatments, as ordered				
By use of two forceps squeeze excess fluid from the gauze dressing. Unfold and apply the gauze dressing over the wound				
Place a second layer of gauze over the wound site, as necessary.				
Remove and discard gloves and apply tape/straps, or roller gauze/ bandage to secure the dressings.				

Completion of procedure				
Client				
Position the client comfortably and appropriately				
Lower patient's bed (if raised) and draw back the curtains (if applicable).				
Thank the client for his collaboration.				
Associate Nurse/Student				
Education/advisory guidance				
Wash hands				
Material				
Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				
Clean instruments, disinfect them				
Remove gloves and wash hands.				
Make a verbal or written report of Care provided				

3.2. Procedure: Bandaging

3.2.1. Technique: Spiral Bandage

Aims of spiral bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To immobilize the injured part of the body
- To Provide additional support to an injured structureof the wound together
- To apply pressure

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position.

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size.
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used).

Spiral bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
Continue wrapping overlapping turns by 1/3 width of bandage roll.				
End by two wraps				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				

Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thanks the client for his or her collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.2. Technique : Spica Bandage

Aims of spica bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To immobilize the injured part of the body
- To Provide additional support to an injured structure

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size.
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used).

Spica bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand				
Face the client				
Make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
Wrap progressively by crossing the bandage towards the top, in a figure 8 fashions				
Make sure that the crosses are well one above the other.				
Continue wrapping overlapping turns by 1/3 width of bandage roll.				
End by two wraps				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
COMPLETION				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				

Nurse				
Wash hands				
Make a verbal or written report of Care provided/findings and sign				

3.2.3. Technique: Earlobe Bandage

Aims of Earlobe bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing to the ear

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size.
- Gloves
- Adhesive plaster or safety pin
- Scissors (if adhesive plaster is used)

Earlobe bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
LEFT EAR: Start from the top of the head, at the right side to Make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
RIGHT EAR: Start under the ear to Make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
Make three oblique drops as for the eye, which means upward from the ear and downward on the parietal region of the opposite side				
Avoid covering the eye.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				

Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary				
Education/ Care-related guidance				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.4. Technique: Cranial Bandage

Aims of Cranial bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing to the skull

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used

Cranial bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Bandage A describes circles around the face and nape of the neck				

The bandage B describes the repeating ones on the right and the left side of the cranium while returning to the middle of the forehead and nape of the neck.				
A: Make 2 occipito-frontal circles.				
B: Place the lead of the bandage in the middle of the face				
A: secures B by semicircles.				
B: Direct the lead of the bandage to the nape of the neck.				
A: secures B by semicircles.				
B: Direct the lead of the bandage to the forehead.				
Avoid covering the eye.				
Carry out this technique several times as necessary				
Secure by 2 circles.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
COMPLETION				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.5. Technique: Monocular Bandage (Right Or Left)

Aims of monocular bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing to the eye

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used

Monocular bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Start on the forehead by a first circular, turned at an angle, at which it is fold back between first and the second circular without tightening too much.				
Oblique wraps are made, ascending while passing under the right/left earlobe.				
Go up to the interior angle of the right/left eye and at the left/right top of the head.				

Cover the first jet of the 2/3rd while moving away from the center, which means, crossing on the face then move away from the nose on the eye-level.				
It is necessary to systematically move up on the ear, and down on the top from the head.				
Make 3 wraps.				
End by a frontal circle.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
COMPLETION				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.6. Technique: Binocular Bandage

Aims of binocular bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing to the eyes

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used).

Binocular bandage's steps

Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Start on the forehead, make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
From the nape of the neck pass through the right top of the head, the interior angle of left eye and under the left earlobe.				
Go down in the nape of the neck, under the right earlobe, the interior angle of right eye and pass at the left top of the head.				
Make a frontal circle.				
Three times, repeat the movement while deviating, on the one hand from the top of the head, on the other hand from the nose: the wraps cross on the face above the nose.				
Do not tighten on the eyes.				
End by 2 wraps.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				

Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.7. Technique: Hand Gloved Bandage

Aims of hand gloved bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing to the fingers

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Adhesive plaster or safety pin.
- Scissors (if adhesive plaster is used).

Hand gloved bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				

Make 2 circles, the 1st slightly at an oblique angle, then fold up the formed point and maintain it by the 2nd circle.				
If hand is pronated: start with the small finger of the right hand or start with the thumb of the left hand If hand is supinated: start with the thumb of the right hand or start with the small finger of the left hand				
Form a spiral at each finger, starting with the distal part of each finger.				
Each time, make the bandage pass over the back of the hand before returning to the wrist.				
Make a circle at the wrist before to start wrapping next finger.				
End by 2 circles at the wrist.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.8. Technique: Triangular Bandage

Aims of triangular bandage procedure is to:

- To minimize swelling in the initial management of injury
- To support and immobilize fractured forearm
- To support and immobilize shoulder luxation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Safety pins.
- Scissors (if adhesive plaster is used).

Triangular bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Ask to the client to bend his arm to be placed in a sling bringing the forearm on the chest, so that the hand is placed higher than the elbow.				
Place the bandage under the client's arm on his chest (the center of the triangle base under the wrist, angle point at the level of the elbow, neck scarf at the level of the neck)				
Hold upward lower the sling of the arm, above the wrist.				
Fix a reef knot on the unaffected side (never fix it on the spinal column). Fold the excess cloth on the level of the elbow and fix it with safety pins				
Check the correct setting of the scarf (hand and forearm maintained above the elbow).				

Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.2.9. Technique: Stump Bandage

Aims of stump bandage procedure is to:

- To minimize swelling in the initial management of injury
- To stop bleeding
- To support a dressing
- To control posperative edema and to shape the stump

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

EQUIPMENTS

- A clean tray
- 2 or many bandages of appropriate size (Usually 1.5 to 2width).
- Gloves
- Safety pins.
- Scissors (if adhesive plaster is used).

Stump bandage's steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Set up material in front of the client and on the side of the dominant hand of the nurse.				
Put Protective gloves				
Take the bandage				
Hold the roll in the dominant hand, and the beginning of the bandage in the other hand.				
Face the client.				
Use a four-inch bandage and make two circular turns round the limb and place the end of the bandage in the center of the upper side of the limb.				
Carry the bandage over the center of the stump to the same level behind holding the turns back and front with the thumb and finger of the other hand.				
Repeat the recurrent turns over the end of the stump first on the left and then on the right side of the original turn, until the whole of the dressing is covered.				
Fix the loop with a straight turn round the stump and continue the bandage with figure of eight turns round the limb until the dressing is completely covered.				

Secure by 2 circles				
Secure bandages with adhesive plaster or a safety pin.				
If using adhesive plater, cut it and Secure bandage/(or secure with safety pin.)				
Completion				
Patient				
Position the client comfortably and appropriately				
Adjust the environment of the client as necessary.				
Education/ Care-related guidance.				
Thank the client for his collaboration.				
Materials				
Put materials in order.				
Associate Nurse Student				
Wash hands.				
Make a verbal or written report of Care provided/findings and sign				

3.3. Procedure: Basic Laboratory Tests

3.3.1. Technique: Rapid Test for Malaria

AIMS

- Diagnosis of malaria by detecting evidence of malaria parasites (antigens) in human blood.

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale of technique
- Position the client in a comfortable position

Materials preparation

- Gloves
- Rapid Diagnostic Test (RDT) kit
- Safety box
- Dustbin
- Timer

Steps of rapid test for malaria

IMPLEMENTATION	Done	Partially done	Not done	Comments
wash /rub hands				
Put on clean gloves				
Open the RDT package				
Select and disinfect the finger of the client				

Prick the edge of the finger with the lancet				
Discard the used lancet				
Using a plastic pipette withdraw drops of blood				
Put on drop of blood into sample strip well				
Discard the used pipette				
Add 3 drops of buffer into the sample well				
Read results within 15 to 20 minutes and interpret them				
Discard used materials in appropriate container				
Remove gloves				
Wash hands				
Completion				
Client				
Position the client comfortably and appropriately				
Lower patient's bed (if raised) and draw back the curtains (if applicable)				
Thank the client for his collaboration.				
Material				
Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				
Associate Nurse/Student				
Education/advisory guidance				
wash hands				
Make a verbal or written report of Care provided				

3.3.2. Technique: Performing urine test (albumin, glucose)

AIMS

- Introduce urinalysis testing procedures,
- Apply clinical correlation of the results with the diseases.

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

Materials preparation

- Dipstick bottle
- Strips
- Specimen container
- Gloves
- Timer

Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash hands and wear gloves				
Fill a sterile container with urine				
Dip the test strip into the urine				
Turn the strip sideways before reading				
Wait approximately 2 minutes for the results				
Compare the test squares to the color chart on the dipstick bottle				
Read the test square in chronological order				
Inform the result to the client				
Dispose the remaining urine sample in the toilet				
Remove gloves and wash hands				
Completion				
Client				
Position the client comfortably and appropriately				
Lower patient's bed (if raised) and draw back the curtains (if applicable). Thank the client for his collaboration.				
Material				

Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				
Associate Nurse/Student				
Education/advisory guidance				
Remove gloves				
Wash hands				
Make a verbal or written report of Care provided				

3.3.3. Technique: Performing glycemia test

AIMS

- Monitor the effect of diabetes medications on blood sugar levels
- Identify blood sugar levels that are high or low
- Track progress in reaching overall treatment goals
- Learn how diet and exercise affect blood sugar levels

Learning Outcomes

- Perform glycemia test by respecting steps, report findings according to laboratory protocol
- Recognize normal and abnormal glycemia test results and correlate with the diseases.

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands
-

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

Materials preparation

- Blood glucose monitor (Glucometer)
- Test strips (check that they are in date and have not been exposed to the air)
- Alcohol swab
- Single-use safety lancets or lancing device,
- Gloves,
- Cotton wool/gauze,
- Sharps box or safety box,

Steps of performing glycemia test

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash/rub the hands				
Put on gloves				
Choose the site for the blood sample: usually the side of a finger, but the arm or thigh may be used				
Use an alcohol swab to clean the site and let the alcohol dry				
Insert the test strip into the monitor/ Glucometer, following the instructions				
Prick the edge of the finger with the lancet				
Use a single-use lancet or a lancing device to draw blood and dispose of it in a sharps container.				
Apply the blood to the testing strip in the correct way				
Place the gauze over the site and hold it there, or let the client hold it there until the bleeding stops.				
Read and record the result and Report readings.				
Tell the client what the result is, explain it				
Completion				
Client				
Position the client comfortably and appropriately				
Lower patient's bed (if raised) and draw back the curtains (if applicable)				
Thank the client for his collaboration				
Material				
Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				

Associate Nurse/Student				
Education/advisory guidance				
Remove gloves				
Wash hands				
Make a verbal or written report of Care provided				

3.4. Parenteral Route Of Drugs Administration

3.4.1. Technique: Withdrawing Medication From An Ampoule

AIMS

- To prepare medication before administration.

Leaning outcome

- The student will be able to withdrow the drug from ampoule
- The student will be able to hold and manipulate the syringe

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

Materials

- Medication administration record,
- Sterile syringe and needle,
- Second needle,
- Alcohol swab,
- Sterile gauze,
- Ampoule of prescribed medication,
- Ampoule cutter if available,
- Kidney dish
- Container for discards,
- Nonsterile gloves,
- Safety box for sharp instrument

Steps of withdrawing medication from an ampoule

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene				
put on gloves and or other PPE				
Verify the rights of drug administration				
Hold the ampule quickly and lightly tap the top chamber until all fluid flows into the bottom chamber				
Place a sterile gauze or alcohol wipe around the neck of the ampule				
Wrap a small gauze pad around the neck of the ampule to protect fingers from breaking				
Use a snapping motion to break off the top of the ampule along the scored line at its neck.				
Always break away from your body. Place the ampule on a flat surface.				

Always break away from your body. Place the ampule on a flat surface.				
Attach filter needle to syringe.				
Remove the cap from the needle by pulling it straight off.				
Withdraw medication in the amount ordered plus a small amount more				
While inserting the needle into the ampule, be careful not to touch the rim				
Remove the filter needle and dispose it in the container of sharp objects, and replace with the ID needle				
If air bubbles are aspirated, remove the needle from the ampule				
Hold syringe with needle pointing up and tap sides of the syringe.				
Check the dosage of medication in the syringe				
Discard any unused portion of the medication, and dispose of the ampule top in a suitable container after comparing with the medical prescription				
Change needle and properly discard used needle.				
Secure needle to syringe by turning the barrel to right while holding the needle guard				
Remove gloves				
COMPLETION				
Materials				
Put materials in order.				
Nurse				
Wash hands.				
Proceed with administration, based on prescribed route.				

3.4.2. Technique : Withdrawing Medication From A Vial

AIMS

- To prepare medication before administration.

Leaning outcome

- The student will be able to withdrow the drug from a vial
- The student will be able to hold and manipulate the syringe

STUDENT / NURSE PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

Materials

- Medication administration record,
- Sterile syringe and needle,
- Second needle,
- Alcohol swab,
- Sterile gauze,
- A vial of prescribed medication,
- Kidney dish
- Container for discards,
- Nonsterile gloves,
- Safety box for sharp instrument.

Steps of withdrawing medication from a vial

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene				
Put on gloves and or other PPE				
Verify the rights of drug administration				
Prepare medications for one client at a time.				
Open the alcohol wipe. For new vial, remove metal or plastic cap and make				
sure sterility is maintained.				
For used vial, cleanse the rubber top of the vial before withdrawing medication.				
Choose a syringe of appropriate size to accommodate the volume of medication to be withdrawn.				
Draw back an amount of air into the syringe that is equal to the specific dose of medication to be withdrawn.				
Pierce the rubber stopper in the center with the needle tip and inject the measured air into the space above the solution. Do not inject air into the solution.				
Invert the vial while keep the tip of the needle or blunt cannula below the fluid level				

Hold the vial in one hand and use the other to withdraw the medication.				
If any air bubbles accumulate in the syringe, tap the barrel of the syringe sharply and move the needle past the fluid into the air space to re-inject the air bubble into the vial.				
Return the needle tip to the solution and continue withdrawal of the medication.				
After the correct dose is withdrawn, remove the needle from the vial and carefully replace the cap over the needle.				
COMPLETION OF PROCEDURE				
Equipment				
Put material in order.				
Associate Nurse Student				
Remove gloves and wash hands				
Proceed with administration, based on prescribed route.				

3.4.3. Technique: Intramuscular (IM) Injection

AIMS

- To Apply medication through the muscles
- To promote rapid drug absorption
- To provide an alternate route of parenteral drug administration

Leaning outcome

- To find suitable sites for administering intramuscular injections;
- To prepare materials for administering intramuscular injections in adults and paediatric patients;
- To apply the aseptic method during procedures;
- To explain the importance of intramuscular injections;
- To assess the risks of potential complications of intramuscular injections.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with ID Card
- Hair tied back
- Remove watch, jewels, and Rings
- Wear closed shoes
- Hand washing

PATIENT PREPARATION

- Identification of the patient and ask consent
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Sterile syringes and needles
- Alcohol-based antiseptic solution
- Drug,
- Protective Gloves
- Medication chart
- Dry cotton swab
- Safety box
- Disposable gloves
- Dustbin
- Trolley
- Trolley or tray (Plate).

Steps of intramuscular (IM) injection

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on a bedside in the order in which items will be used.				
Wear protective gloves				
Hold the syringe and needle in your dominant hand				
Draw-up the appropriate medication into the syringe using a drawing-up needle				
Remove the air bubbles from the syringe				
Remove the drawing-up needle and immediately dispose of it into a sharps bin, then attach the needle to be used for performing the injection				

Choose an appropriate site for the injection				
Position the patient to provide optimal access to your chosen site				
Clean the site				
Gently place traction on the skin with your non-dominant hand away from the injection site, continuing the traction until the needle has been removed from the skin.				
If the patient is elderly with reduced muscle mass or the patient is emaciated, do not apply traction, instead, bunch the muscle up to ensure adequate bulk before injecting.				
Warn the patient of a sharp scratch				
Holding the syringe like a projectile in your dominant hand, pierce the skin at a 90° angle				
Insert the needle quickly and firmly, leaving approximately one-third of the shaft exposed				
Aspirate to check if the needle is not in a blood vessels				
inject the contents of the syringe whilst holding the barrel firmly(If aspiration does not reveal blood)				
If the aspiration reveal blood into syringe (this is a sign of intravascular injection), do not inject medication, remove syringe and needle immediately, discard it with contained medication and start over with anew medication.				
Inject the medication slowly at a rate of approximately 1ml every 10 seconds				
Remove the needle and immediately dispose of it into a safety box				
Release the traction you were applying to the skin				

Apply gentle pressure over the injection site with a cotton swab or gauze. Do not rub the site.				
Discard the gauze				
Remove gloves, turning them inside out; dispose of gloves; wash hands.				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Observe for effect of intramuscular injection after administration				
Wash hands.				

3.4. 4. Technique: Subcutaneous Injection

AIMS

- To Apply medication under the skin
- To promote rapid drug absorption
- To provide an alternate route of parenteral drug administration

Leaning outcome

- To find suitable sites for administering subcutaneous injections;
- To prepare materials for administering subcutaneous injections
- To explain the importance of subcutaneous injections;
- To assess the risks of potential complications of subcutaneous injections.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient and ask consent
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Sterile syringes and needles
- Alcohol-based antiseptic solution
- Drug,
- Protective Gloves
- Medication chart
- Dry cotton swab
- Safety box
- Disposable gloves
- Dustbin
- Trolley
- Trolley or tray (Plate).

Steps of subcutaneous injection

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on a bedside in the order in which items will be used.				
Wear protective gloves				
Hold the syringe and needle in your dominant hand				
Draw-up the appropriate medication into the syringe using a drawing-up needle				
Remove the air bubbles from the syringe				
Remove the drawing-up needle and immediately dispose of it into a sharps bin, then attach the needle to be used for performing the injection				
Choose an appropriate site for the injection				
Position the patient to provide optimal access to your chosen site				
Clean the site				
Hold the syringe and needle in your dominant hand and pinch the skin together using the non-dominant hand to lift the tissue away from underlying muscle				
Insert the needle at the required angle 45 degree or 90 degrees for the obese patients to ensure that you inject medication in subcutaneous tissue				
Aspirate to check if the needle is not in a blood vessel				
inject the contents of the syringe whilst holding the barrel firmly(If aspiration does not reveal blood)				
If the aspiration reveal blood into syringe (this is a sign of intravascular injection), do not inject medication, remove syringe and needle immediately, discard it with contained medication and start over with a new medication.				

Inject the medication slowly at a rate of approximately 1ml every 10 seconds				
Remove the needle and immediately dispose of it into a safety box				
Release the lifted skinfold				
Apply gentle pressure over the injection site with a cotton swab or gauze. Do not rub the site.				
Discard the gauze				
Remove gloves and dispose them				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration				
Put material in order.				
Observe for effect of subcutaneous injection after administration				
Education/ Care-related guidance.				
Wash hands.				

3.4.5. Technique: Intradermal (ID) Injection

AIMS

- To Apply medication into the dermal layer of the skin just under the epidermis
- To promote rapid drug absorption
- To provide an alternate route of parenteral drug administration
- To test allergy before administering large amount of drug by other route or in case of tuberculosis vaccination and screening.

Leaning outcome

- To find suitable sites for administering subcutaneous injections;
- To prepare materials for administering subcutaneous injections
- To explain the importance of subcutaneous injections;
- To assess the risks of potential complications of subcutaneous injections.

ASSOCIATE NURSE STUDENT / PREPARATION

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear closed and short shoes
- Wash hand

PATIENT PREPARATION

- Identification of the patient and ask consent
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary.
- Cleanliness or condition of the bed and surrounding environment

EQUIPMENTS

- Sterile syringes and needles
- Alcohol-based antiseptic solution
- Drug,
- Protective Gloves
- Medication chart
- Dry cotton swab
- Safety box
- Disposable gloves
- Dustbin
- Trolley
- Trolley or tray (Plate).

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assemble equipment and arrange on a bedside in the order in which items will be used.				
Wear protective gloves				
Hold the syringe and needle in your dominant hand				
Draw-up the appropriate medication into the syringe				
Remove the air bubbles from the syringe				
Choose an appropriate site for the injection				

Position the patient to provide optimal access to your chosen site				
Clean the site				
Remove the needle cap with the non-dominant hand by pulling it straight off				
Use the non -dominant hand to spread skin taut over the injection site.				
Place the needle almost flat(an angle of 10 to 15 degrees) against the patient's skin.				
Insert 0.4cm bevel up so that needle can be seen through the skin.				
Slowly inject the drug (0.01ml-0.1ml do not exceed 0.5m				
Watching for a bleb to develop				
Withdraw the needle quickly at the same angle as it was inserted				
Remove the needle and immediately dispose of it into a safety box				
Release skin				
Discard the gauze				
Remove gloves and dispose them				
COMPLETION				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Put material in order.				
Observe for effect of intradermal drug injection.				
Education/ Care-related guidance				
Wash hands.				

AIMS

- Protect the burned person from further harm

Learning Outcomes

- Able to understand and describe how the technique of first aid in case of burn
- Maintain comfort and safety during the procedure
- Perform the procedure by respecting the steps

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

3.4.6.Technique : Venous puncture

AIMS

- To collect blood sample for analysis.
- To administer some drugs ,infusion, blood transfusion.

ASSOCIATE NURSE STUDENT / PREPARATION

- Clean uniform (dress or gown).
- Hair tied properly.
- Remove watch, jewelry, etc.
- Wash hands.
- .Clean uniform (dress or gown).

PATIENT PREPARATION

- Identification of the patient and ask consent
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Adjust the environment of the patient as necessary
- Cleanliness or condition of the bed and surrounding environment.

EQUIPMENTS

- Clean and disinfected trolley.
- Sterile cup/gallipot.
- . Gauze / sterile pads.
- Tubes for blood samples according to laboratory request
- IV needles or vacutainer system.

- Laboratory request forms completed and signed.
- Syringes corresponding to the blood volume to be taken /vacutainer.
- Kidney dish
- Protective gloves.
- Protection for the bed.
- Adhesive tape
- Scissors.
- Tourniquet
- Container for sharp objects.
- Disinfectant (alcohol).
- Labels.

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash hands.				
Check medical prescription.				
Determine, with the patient, the position of the arm (avoid the side where mammectomy has been done, if applicable).				
Position the patient in a decubitus dorsal position, or seated with back supported.				
Place protection under the limb to be punctured.				
Observe patient reactions throughout the procedure				
Inspect the patient's surface anatomy and venous system in the chosen venipuncture site before applying the tourniquet				
Apply protective gloves.				
Locate the vein, stimulating the circulation, if necessary.				
Place the tourniquet at approximately 10 cm above the puncture site.				

Massage along the vein in the direction of venous return				
Select the vein.				
For 1 minute widely disinfect the selected puncture site				
Take the catheter packing and open it.				
Visualize what you are going to do and begin by stretching the skin downward below the anticipated venipuncture site with the opposite hand to anchor the vein and limit vein movement.				
Penetrate in the vein, either from the top, or from the side.				
Insert the needle with the bevel up at about a 15- to 30-degree angle so that the needle penetrates halfway into the vessel.				
When the needle has entered the skin, lower the needle until it is almost parallel with the skin				
Keep securely the needle in the vein.				
Withdraw the blood gently or connect the vacutainer				
Loosen the tourniquet and remove it.				
Place a sterile compress at the insertion base of the needle and withdraw the needle quickly and maintain pressure at the site .				
Immediately put the needle in the sharp's container				
If syringe was used: put blood in different tubes using a new G18 needle.				
Make a small compressive bandage and fix it with an adhesive tape				

Ask the patient to press on that small bandage while holding the arm in a vertical position for a few minutes. NB: Very significant for patient using anticoagulants or antithrombocytic drugs.				
COMPLETION OF THE PROCEDURE				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects of the patient and put them within reach.				
Thank the patient for his or her collaboration.				
Material				
Eliminate waste, separating the sharp materials				
Clean and arrange material.				
Nurse/Student				
Education/ Care-related guidance.				
Remove gloves and Wash hands.				
Tick and sign the administration of drug, if applicable				
Submit written and oral report and sign.				
Take the samples and request forms to the laboratory.				
Monitor the results				

3..4.7.TECHNIQUE : ADMINISTRATION OF IV DRUGS; PATIENT HAS AN IV LINE.

AIMS

- To fasten action of medicine
- To administer medicines or fluid.
- To maximize the action of medicines
- To feed patient by parenteral route

ASSOCIATE NURSE STUDENT / PREPARATION

- Clean uniform (dress or gown).
- Hair tied properly
- Remove watch, jewelry, etc.
- Wash hands.

PATIENT PREPARATION

- Patient identification
- Physical and psychological condition of the patient.
- Respect patient privacy
- Inform and explain to the patient/family: objective, procedure, etc and care.
- Assess the IV line site for hygiene and any sign of inflammation

EQUIPMENTS

- Clean and disinfected Trolley/tray.
- Sterile cup/gallipot.
- Sterile gauze
- Drugs for injection (bottle or ampoule), according to medical prescription
- Solvent, according to medical prescription

- Check drug and solvent (aspect, expiry date, verify prescription).
- 1 drug drawing needle
- 1 needle for drawing normal saline
- Syringe with a capacity according to the volume of drug.
- 10ml Syringe for flushing
- 0.9% normal saline solution (5ml))
- Kidney dish.
- Protective gloves.
- Protection for bed.
- Container for sharp objects.
- Disinfectant (alcohol).
- Patient's file / chart
- Material for taking vital signs.

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash hands.				
Take vital signs.				
Prepare the drug and 10ml of 0.9% NS for flushing				
Position the patient in dorsal decubitus.				
Place protection under the limb with IV line for injection.				
Apply protective gloves.				
Slip sterile gauze under the catheter pavilion.				
Clean the external part of the catheter if necessary				

Verify the patency of the vein with 5ml of normal saline; aspirate to make sure that there is no clot into the catheter. If there is no clot, use it to flush the line.				
NB: If the patient has the running infusion, flushing is not necessary. Use injection port for giving the drug.				
Inject the drug very slowly, observing the patient's reaction and assuring it is entering the vein				
Flush the line again with 5ml of normal saline				
Lock the catheter and Monitor vital signs.				
COMPLETION OF THE PROCEDURE				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects of the patient and put them within reach.				
Thank the patient for his or her collaboration.				
Materials				
Eliminate waste, separating the sharp objects.				
Clean and arrange materials.				
Nurse/Student				
Education/ Care-related guidance.				
Submit a verbal or written report of Care provided and sign				
Remove gloves and Wash hands.				
Tick and sign for the administration of the drug.				

3.4.8.TECHNIQUE : IV INFUSION OR INTRAVENOUS PERFUSION

AIMS

- To restore fluid volume to normal in case of haemorrhage, extensive burns, diarrhoea and vomiting (hypovolemic shock)
- To dilute poisons or toxins
- To administer IV fluid
- Administration of antibiotics, chemotherapeutics, or other medically necessary treatments may require IV access

ASSOCIATE NURSE STUDENT / PREPARATION

- Clean uniform (dress or gown).
- Hair tied properly
- Remove watch, jewelry, etc.
- Wash hands.

PATIENT PREPARATION

- Patient identification
- Physical and psychological condition of the patient.
- Respect patient privacy
- Inform and explain to the patient/family: objective, procedure, of the care etc..
- Assess the puncture site for hygiene and integrity
- Make sure that clothing can be withdrawn easily.

EQUIPMENTS

- Clean and disinfected Trolley/tray.
- Sterile cup/gallipot.
- Sterile gauze
- Infusion solution
- Check the solution (aspect, expiry date)
- Calculate the drip rate

- Infusion kit
- Adapted catheter.
- Tourniquet
- Kidney dish.
- Protective gloves.
- Protection for the bed
- Adhesive tape
- Scissors.
- Bracket/IV stand/ drip stand.
- Container for sharp objects.
- Disinfectant (alcohol).
- Fastener for bottle, if necessary.
- Splint.
- Watch with second hand.
- Label.
- Material for taking vitals signs.

IMPLEMENTATION	Done	Partially done	Not done	Comments
Wash hands.				
Select the opposite limb of the dominant side (letf for right-handed and right for left-handed persons).				
Determine, with the patient, the position of the arm				
Place protection under the limb to be punctured.				
Take vital signs.				
Prepare the IV set for infusion:				
* Move the drip regulator approximately 5 cm from the dropper.				
* Close the drip regulator				
Disinfect the cap of the bottle / nozzle of the bag.				

Connect the infusion set to the bottle / bag				
Hang the bottle and tubing to the bracket.				
Fill the dropper halfway				
Open the “tube-tightener” and purge the case.				
Close again the “tube-tightener” and put back the cap on the nozzle of the case.				
Hang the infusion container on the bracket.				
Apply protective gloves.				
Locate the vein, stimulating the circulation, if necessary.				
Place the tourniquet at approximately 10 cm above the puncture site.				
Massage along the vein in the direction of venous return				
Select the vein.				
For 1 minute widely disinfect the selected puncture site				
Take the catheter packing and open it.				
Visualize the vein and begin by stretching the skin downward below the anticipated venipuncture site with the opposite hand to anchor the vein and limit vein movement.				
Penetrate in the vein, either from the top, or from the side.				
Puncture the vein using direct or indirect entry:				

Direct (one step, used for larger veins): Hold the over-the-needle assembly at 15 to 20 degrees above the site and enter the vein directly.				
Indirect (two steps, used for smaller veins): hold the assembly 15 to 20 degrees above the site and 20 degrees lateral to the vein, insert the catheter into the skin, and then advance into the vein.				
When the vein is punctured, blood should appear in the flash chamber: withdraw slightly the needle while slipping the catheter into the vein.				
Put a small compress below the end of the needle.				
Remove the needle by slightly pressing on the skin from the top of the catheter extremity.				
Maintain the catheter holder in place.				
Loosen the tourniquet and remove it.				
Quickly connect the case to the catheter.				
Open the drip regulator and adjust it to the prescribed rate of infusion				
Slip sterile gauze under the catheter pavilion.				
Fix the catheter with adhesive tape				
Adjust the flow according to the prescription.				
Place the label (name of the patient, n° of bed, dates, hour of beginning, hour of end, flow rate, drugs added, signature)				

Label the catheter inserted (date of insertion, time, date of removal/replacement)				
Monitor the patient reactions				
COMPLETION OF THE PROCEDURE				
Patient				
Position the patient comfortably and appropriately				
Arrange personal effects of the patient and put them within reach.				
Thank the patient for his or her collaboration.				
Materials				
Eliminate waste and separate the sharp objects				
Clean and arrange the materials.				
Nurse				
Education/ Care-related guidance.				
Submit a verbal or written report of Care provided and sign				
Remove gloves, wash and disinfect hands.				
Tick and sign the administration of drug, if applicable				
Monitor the infusion				

3.5.First Aid

3.5.1. Technique: Putting the victim into the recovery position

AIMS

- Prevent suffocation through obstruction of the airway

Learning Outcomes

- Able to understand and describe how the technique of putting the victim into the recovery position is done
- Maintain comfort and safety during the procedure
- Perform the procedure by respecting the steps

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands if applicable

Client preparation

- Identification of the patient
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

Materials preparation

- A clean tray if applicable
- Gloves if available

IMPLEMENTATION	Done	Partially done	Not done	Comments
Rub hands if applicable				
Put the person on the floor if he is not there already				
Remove the person's spectacles if necessary				
Kneel down by the side of the casualty				
Make sure both victim's legs are outstretched				
Place the nearest arm (the one on the side you are kneeling next to) at right angles to the victim's body				
Place the nearest arm (the one on the side you are kneeling next to) at right angles to the victim's body				
Bend the forearm upwards with palm facing up				

Lay the person's other arm across his chest.				
Hold the back of this hand against his cheek on the side at which you are kneeling				
Keeping that hand in that position, with your other free hand, grasp the leg on the other side of the victim's body under the knee.				
Raise that leg, but leave the person's foot on the ground				
Pull the raised leg towards you				
In the meantime, keep the back of the victim's hand held against his cheek. Roll the person towards you so he turns on his side.				
Position the victim's upper leg in such a way that his hip and knee are at right angles. This will allow the victim to maintain lateral position				
Tilt the head of the person backwards to keep the airway open.				
Make sure the mouth is angled towards the ground. This will prevent the risk of choking on blood or vomit.				
Adjust the hand under the cheek if necessary so that the head remains tilted backwards and the mouth remains at a downward angle				

3.5.2. Technique: First aid interventions in case of burn

AIMS

- Protect the burned person from further harm

Learning Outcomes

- Able to understand and describe how the technique of first aid in case of burn
- Maintain comfort and safety during the procedure
- Perform the procedure by respecting the steps

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

Materials

- A clean tray if applicable
- Gloves if applicable
- Tape water
- personal protective equipment if applicable
- Antibiotic / burn cream if available
- Bandages if available

First aid steps interventions in case of burn

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assess the situation quickly and calmly to get an understanding of what happened				
Calm and motivating the victim to collaborate				
Ensure that the source of the burn has been dealt with, and the scene is safe				
Wear personal protective equipment, and get the first aid kit if available.				
Gently remove any clothing and jewelry from the burned area. DO NOT try to remove any clothing that is sticking to it				
Rinse the burn in cool water for about 20 minutes. If the area cannot be immersed such as the face, a towel, sheets or wet clothes that have been soaked in water can be applied.				
Change/rewet these regularly as they will absorb heat from the burn.				
For small burn apply antibiotic / burn cream if available and the victim is not allergic to it				
Cover the burn with a clean, dry non-stick dressing and loosely bandage in place. If this is not available or the burn covers a large area use a dry, clean sheet or other tissue material				
Have the person follow up with a health care provider				
Do not apply ice to a burn.				
Completion of procedure				
Client				
Position the client comfortably and appropriately				

Lower patient's bed (if raised) and draw back the curtains (if applicable).				
Thank the client for his collaboration				
Material				
Dispose of waste in clinical waste receptacle or bag and sharps in a sharps bin				
Clean and arrange the material being used.				
Associate Nurse/Student				
Education/advisory guidance				
Wash hands				
Remove gloves and wash hands.				
Make a verbal or written report of Care provided				

3.5.3. Technique: First aid in case of Drowning

AIMS

- Treat the victim for hypothermia
- To help the victim to regain the normal breathing

Learning Outcomes

- Able to understand and describe how the technique of helping drowned person is done
- Maintain comfort and safety during the procedure
- Perform the procedure by respecting the steps

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

Steps of first aid in case of drowning

IMPLEMENTATION	Done	Partially done	Not done	Comments
Assist the victim to get out of the water by giving directions. If possible use an item that floats to assist get the victim to the dry land				
Turn the victime onto one side keeping the victim's head lower than the rest of the body to reduce the risk of inhaling water				
Open the airway and let any water or vomit drain out				
If no signs of life immediately start cardiorespiratory resuscitation (CPR)				
Treat the victim for hypothermia: by removing wet clothes and cover him/ her with dry warm blanket.				

If the person regains full consciousness, give him/her a warm drink				
Completion of procedure				
Client				
Position the client comfortably and appropriately				
Thank the client for his collaboration				
Material				
Dispose of waste in clinical waste receptacle				
Clean and arrange the material being used.				
Associate Nurse/Student				
Remove gloves				
Wash hands				
Make a verbal or written report of Care provided				

3.5.4. Technique: Choking relief in a responsive adult or child

AIMS

- To remove the foreign object lodged in the throat in order to clear airways
- To provide first aid as quickly as possible.

Learning Outcomes

- Able to perform abdominal thrusts (Heimlich maneuver)

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

Materials

- Gloves if available

First aid steps choking relief in a responsive adult or child

IMPLEMENTATION	Done	Partially done	Not done	Comments
Stand or kneel behind the victim and wrap your arms around the victim's waist				
Make a fist with one hand.				

Place the thumb side of your fist against the victim's abdomen, in the midline, slightly above the navel and well below the breastbone.				
Grasp your fist with your other hand and press your fist into the victim's abdomen with a quick, forceful upward thrust				
Repeat thrusts until the object is expelled from the airway or the victim becomes unresponsive.				
Give each new thrust with a separate, distinct movement to relieve the obstruction				
Completion				
Client				
Position the client comfortably and appropriately if applicable				
Thank the client for his collaboration if applicable .				
Associate Nurse/Student				
Education/advisory guidance if applicable				
Wash hands				

3.5.5. Technique: Choking relief in an unresponsive adult or child

AIMS

- To remove the foreign object lodged in the throat in order to clear airways
- To provide first aid as quickly as possible.

Learning Outcomes

- Able to perform abdominal thrusts (Heimlich maneuver).

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable
- Ensure client privacy if applicable
- Self-presentation to the patient if applicable
- Physical and psychological client preparation if applicable
- Assess levels of comprehension and collaboration of the patient if applicable
- Explain to the patient/ family the rational of technique if applicable
- Position the client in a comfortable position if applicable

Materials

- Gloves if available

First aid staps in chocking relief in an unresopnsive adult or child Steps

IMPLEMENTATION	Done	Partially done	Not done	Comments
Shout for help. If someone else is available, send that person to activate the emergency response system				
Gently lower the victim to the ground if you see that he is becoming unresponsive				
Begin CPR, starting with chest compressions. Do not check for a pulse.				

Each time you open the airway to give breaths, open the victim's mouth wide and look for the object.				
If you see an object that can be easily removed, remove it with your fingers.				
If you do not see an object, continue CPR.				
After about 5 cycles or 2 minutes of CPR, activate the emergency response system if someone has not already done so.				
If the victim is pregnant or obese, perform chest thrusts instead of abdominal thrusts.				
You can tell if you have successfully removed an airway obstruction in an unresponsive victim if you feel air movement and see the chest rise when you give breaths or see, remove a foreign body from the victim's mouth				
Completion of procedure				
Client				
Position the client comfortably and appropriately if applicable				
Thank the client for his collaboration if applicable				
Associate Nurse/Student				
Education/advisory guidance if applicable				
Wash hands if applicable				
Remove gloves if applicable				
Make a verbal or written report of Care provided if applicable				

3.5.6. Choking relief in infants (Back slaps and chest thrusts)

AIMS

- To remove the foreign object lodged in the throat in order to clear airways
- To provide first aid as quickly as possible.

Learning Outcomes

- Able to perform abdominal thrusts (Heimlich maneuver).

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable.
- Ensure client privacy if applicable.
- Self-presentation to the patient or family if applicable.
- Physical client preparation if applicable.
- Explain to the patient/ family the rational of technique if applicable.
- Position the client in a required position
-

Materials

- Gloves if available

First aid steps in chocking relief in infants (Back slaps and chest thrusts)

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on gloves if possible				
Kneel or sit with the infant in your lap				
If it is easy to do, remove clothing from the infant's chest				
Hold the infant facedown with the head slightly lower than the chest, resting on your forearm				
Support the infant's head and jaw with your hand.				
Take care to avoid compressing the soft tissues of the infant's throat.				
Rest your forearm on your lap or thigh to support the infant				
Deliver up to 5 back slaps forcefully between the infant's shoulder blades, using the heel of your hand.				
Deliver each slap with sufficient force to attempt to dislodge the foreign body.				
After delivering up to 5 back slaps, place your free hand on the infant's back				
Support the back of the infant's head with the palm of your hand				
The infant will be adequately cradled between your 2 forearms, with the palm of one hand supporting the face and jaw while the palm of the other hand supports the back of the infant's head.				
Turn the infant as a unit while carefully supporting the head and neck.				
Hold the infant face-up, with your forearm resting on your thigh				
Keep the infant's head lower than the trunk.				
Provide up to 5 quick downward chest thrusts in the middle of the chest, over the lower half of the breastbone				

Deliver chest thrusts at a rate of about 1 per second, each with the intention of creating enough force to dislodge the foreign body				
Repeat the sequence of up to 5 back slaps and up to 5 chest thrusts until the object is removed or the infant becomes unresponsive.				
Completion of procedure				
Client				
Position the client comfortably and appropriately if applicable				
Thank the client for his collaboration if applicable				
Associate Nurse/Student				
Education/advisory guidance if applicable				
Wash hands if applicable				
Remove gloves if applicable				
Make a verbal or written report of Care provided if applicable				

3.5.7. Choking Relief in an Unresponsive Infant

AIMS

- To remove the foreign object lodged in the throat in order to clear airways
- To provide first aid as quickly as possible.

Learning Outcomes

- Able to perform abdominal thrusts (Heimlich maneuver).

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable.
- Ensure client privacy if applicable.
- Self-presentation to the patient or family if applicable.
- Physical client preparation if applicable.
- Explain to the patient/ family the rational of technique if applicable.
- Position the client in a required position

First aid steps in Chocking relief in an Unresponsive Infant

IMPLEMENTATION	Done	Partially done	Not done	Comments
Shout for help. If someone responds, send that person to activate the emergency response system				
Place the infant on a firm, flat surface and begin CPR starting with compressions with 1 extra step: each time you open the airway, look for the object in the back of the throat.				
If you see an object and can easily remove it, remove i				
After about 2 minutes of CPR, if no one has done so, activate the emergency response system.				
Completion of procedure				

Client				
Position the client comfortably and appropriately if applicable				
Thank the client for his collaboration if applicable				
Associate Nurse/Student				
Education/advisory guidance if applicable				
Wash hands if applicable				
Remove gloves if applicable				
Make a verbal or written report of Care provided if applicable				

3.5.8.Technique: Cardiorespiratory Resuscitation: CPR

AIMS

- To restore partial flow of oxygenated blood to the brain and heart
- To delay tissue death including permanent brain damage.

Learning Outcomes

- The student will be able to provide CPR effectively.

Preparation

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient if applicable.
- Ensure client privacy if applicable.
- Self-presentation to the patient or family if applicable.
- Physical client preparation if applicable.
- Explain to the patient/ family the rational of technique if applicable.
- Position the client in a required position

Materials

- Gloves if available
- AED (Automated External Defibrilator or automatic Electronic Defibrillator) if available.

First aid Steps in CPR

IMPLEMENTATION	Done	Partially done	Not done	Comments
Put on gloves if available				
Place the victim on a hard surface, often on the ground				
Check for responsiveness-stimulate patient: tap the victim on the shoulder and ask if he or she is okay				
Look for the chest to rise and fall, listen for sounds of air movement at the mouth and nose, feel for the breath against your cheek				
Shout for nearby help				
Check for pulse and breathing: this should take no more than 10 seconds to assess for breathing and check for a pulse.				
If you do not definitely feel a carotid pulse in adults and brachial pulse in children within that time period, start chest compressions				

Open the airway				
If no breathing or only gasping and no pulse, begin cycles of 30 compressions and 2 breaths until AED is available				
Chest compressions:				
Kneel by the victim's side				
Place the heel of one hand in the centre of the victim's chest.				
Place the heel of your other hand on top of the first hand and ensure that pressure is not applied over the victim's ribs.				
With your arms straight, Push straight down on the sternum 5-6 cm at a rate of at least 100 per minute (nearly 2 compressions each second) but no more than 120 per minute				
After each compression, release all the pressure on the chest without losing contact between your hands and the sternum to allow chest recoil				
Minimize frequency and duration of interruptions in compressions				
Once chest compressions have been started, deliver breaths by bag-mask to provide oxygenation and ventilation at a ratio of 30 compressions: 2 breaths in adults and a rate of 15 compressions: 2 breaths if 2 or more rescuers involved (if 1 rescuer involved a rate of 30 compressions: 2 breaths)				
Managing the Airway:				
Use a head tilt–chin lift maneuver to open airway of a victim with no evidence of head or neck trauma				

Use cervical spine injury is suspect, open airway using a jaw thrust without neck extension.				
Give breaths using use a mask; however, mouth-to-mouth can also be performed				
Use ambubag-valve-mask attached to oxygen once available:				
Choose the right mask size to cover the mouth and nose				
Give breaths slowly (over one second)				
Watch for chest rise. Don't over-inflate, especially infants				
Reposition if no chest rise				
Check for pulse every 2 minutes				
Completion of procedure				
Client				
Position the client comfortably and appropriately if applicable				
Thank the client for his collaboration if applicable				
Associate Nurse/Student				
Education/advisory guidance if applicable				
Wash hands if applicable				
Remove gloves if applicable				
Make a verbal or written report of Care provided if applicable				

3.5.9. First aid care for broken bones

AIMS

- To rescue the patient's life,
- To protect the affected limb
- To transport it safely and quickly in a simple and effective way in order to get proper treatment

Learning Outcomes

- To Stop any bleeding.
- To Immobilize the injured area.
- To limit swelling and help relieve pain

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

Preparation

Materials

- Gloves
- Gauze
- Wood
- Splint material
- Tape
- Triangular arm sling

First aid steps in caring for brocken bones.

IMPLEMENTATION	Done	Partially done	Not done	Comments
Ensure the scene is safe and wear personal protective equipment				
Apply gauze to any open wounds				
Splint the bones in the position you find them in (Splints can be made by using magazines, wood, or rolled-up towels)				
Splint material are placed on either side of the injured extremity, supporting the joints above and below the injury				
Secure in place using tape or gauze ensuring they are not compromising blood circulation				
Use a triangular arm sling to secure arm and shoulder injuries				
Move the fractured body part as little as possible or handle gently to prevent making the fracture worse and to lessen the person's pain.				

Encourage further evaluation by a health care provider and avoid use of the injured part				
Completion of procedure				
Client				
Position the client comfortably and appropriately				
Thank the client for his collaboration.				
Associate Nurse/Student				
Education/advisory guidance				
Wash hands				
Remove gloves and wash hands.				
Material				
Dispose of waste in clinical waste bag				
Clean instruments, disinfect them				
Make a verbal or written report of Care provided				

3.5.10. First aid in case of Epileptic seizure

AIMS

- keeping the person safe until the seizure stops

Learning Outcomes

- To Stay calm,
- To Loosen anything around the person's neck,
- To Clear the area around
- To Stay with patient after the seizure stops

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back
- Remove watch, jewelries, and Rings
- Wear short and closed shoes
- Wash hands

Client preparation

- Identification of the patient
- Ensure client privacy
- Self-presentation to the patient
- Physical and psychological client preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rational of technique
- Position the client in a comfortable position

Materials

- Gloves

First aid Steps in case of epileptic seizure

IMPLEMENTATION	Done	Partially done	Not done	Comments
Stay calm and remain with the casualty				
Note the start time and length of the seizure				
Protect the head from impacts				

Remove nearby objects and/or bystanders to protect from harm as cuts, abrasion, suffocation, burns, and broken bones or teethes				
Loosen tight clothing				
Follow the casualty's seizure management plan (if there is one in place)				
When convulsions stop, or if vomiting starts, roll into recovery position and maintain airway				
Observe and monitor breathing				
Call for an ambulance				
Reassure and let the person rest until fully recovered				
Completion of procedure				
Client				
Position the client comfortably and appropriately				
Thank the client for his collaboration.				
Associate Nurse/Student				
Education/advisory guidance				
Wash hands				
Remove gloves and wash hands.				

3.6.Technique: Immediate Post Natal Care Of The mother

AIMS

- To have the general picture of the mother's well being
- To find out the level of consciousness
- To find out if the woman's condition gives rise to concern
- To find out the woman's urgent need of care

Learning Outcomes

- Monitor a mother during postnatal period

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back and put bonnet
- Assemble equipment and arrange on bedside chair in the order the items will be used
- Remove watch, jewels, and Rings
- Respect dignity and privacy of the client
- Wear closed and short shoes
- Hand washing

Client preparation

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale
- Position the patient in a comfortable position
- Ensure privacy

Equipment

- Vital signs materials
- Examination gloves
- Gauze
- Kit for vulva disinfection
- Dustbin, and
- Examination table and folding/curtain screen if necessary
- Sanitary pad

steps of immediate post natal care of the mother

IMPLEMENTATION	Done	Partially done	Not done	Comments
Place a folding screen or close the curtains				
Take vital signs (refer to checklist of taking vital signs				
Inspection: Observe the mother's overall health				
Observe the general appearance, skin colour, level of consciousness or mental status, and vaginal bleeding.				
Observe dyspnea-labored breathing, shortness of breath, and chest pain				
Inspect breast, for the redness and engorgement.				
Inspect abdomen for the presence of visible scars, distention and its movement during the respiration.				
Inspect the conjunctiva palor				
Palpation				
Palpate the Pulse rate				
Palpate the breast nipple for ensuring the presence of colostrum breast				
Palpate the Bladder fullness				
Palpate the Lower limbs for pitting oedema, warmth for negative Homan's sign.				
Palpate the uterus (for atony or retraction)				
Fundal height				
Measure the fundal height from the pubic bonne to the top of the uterus.				
Auscultation				
Auscultate the bowel sounds				
COMPLETION				

Patient				
Position the patient comfortably and appropriately				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Materials				
Put materials in order.				
Nurse				
Education/ Care-related guidance.				
Wash hands.				
Make a verbal or written report of Care provided				

3.7. Technique: Pre HIV Testing and Counselling For Pregnant Woman (PMTCT)

AIMS

- To ensure primary prevention of HIV among women of childbearing age
- To integrate PMTCT interventions into routine maternal and child's health services

Learning Outcomes

- To promote voluntary testing in the context of PMTCT when offering antenatal care.
- To provide appropriate regimens to prevent mother-to-child transmission
- To Provide psychosocial support to HIV positive pregnant women.
- Improving follow-up care for HIV positive women and their infants.

Associate Nurse/student preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back and put bonnet
- Assemble equipment and arrange on bedside chair in the order the items will be used
- Remove watch, jewels, and Rings
- Respect dignity and privacy of the client
- Wear closed and short shoes
- Hand washing

Patient preparation

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Assess levels of comprehension and collaboration of the patient
- Explain to the patient/ family the rationale
- Position the patient in a comfortable position
- Ensure privacy

steps of Pre HIV Testing and Counseling for Pregnant Woman

	Done	Partially done	Not done	Comments
Introduce yourself and give an overview of the counseling session				
Review HIV basics, transmission, and prevention				
Review HIV basics and answer questions				
Modes of HIV transmission, including from mother to baby				
Ways to prevent HIV transmission, including PMTCT				

Counsel on benefits of HIV testing				
You cannot tell from looking at a person if he or she has HIV				
Everyone should learn their HIV-status, especially pregnant women				
HIV testing is a part of routine antenatal care and is offered to all pregnant women				
If a pregnant woman has HIV, she can pass it to her baby				
Explain HIV testing process				
Confidentiality				
Client's right to refuse or get tested				
Method of HIV testing				
Meaning of test results				
Counsel on discordance and partner testing				
One partner can be living with HIV while the other is HIV-negative				
Encourage partner testing and couples counseling				
Counsel on HIV prevention and HIV/STI risk reduction				
High risk of MTCT if she becomes HIV-infected during pregnancy or breastfeeding				
Practice safer sex (e.g., mutual faithfulness, always using condoms, abstinence)				
Counsel on PMTCT and having a safe pregnancy				

Ways to reduce MTCT, including ARVs for mother and baby				
HIV testing and early treatment for herself, the baby, partner, and family members				
Attend all antenatal care appointments				
Deliver baby at a health facility				
Exclusive breastfeeding (or exclusive formula feeding) for 6 months or as long as possible up to 6 months. Then introducing complementary foods at 6 months.				
Bring the baby back to the clinic for appointments (immunization, weighing, checkups)				
Family planning to prevent or space future pregnancies				
Offer the client an HIV test				
If she gives consent (written or verbal, depending on your guidelines), perform HIV test				
If she refuses, encourage her to think about why and to come back if she has more questions or changes her mind; set up a return visit date				
Provide referrals for ongoing counseling or other support, as needed				
Ask if she has any questions or concerns				
Summarize the session and next steps				

Completion				
Arrange personal effects and objects of the patient within his range				
Thank the patient for his collaboration.				
Wash hands.				
Make a verbal or written report of Care provided and sign.				

4.1. Procedure: Nasogastric Tube (NGT) Feeding

Aims NGT feeding:

- NGT feeding is aimed to administer fluids, medications and liquid food complete with nutrients directly into the stomach.

Learning outcome

- Demonstrate knowledge and skills of NGT feeding
- Describe the procedures for NGT feeding
- Demonstrate competence of NGT feeding

Student/nurse preparation

- Should appear professional (in full and clean uniform) with student ID Card
- Hair tied back and put bonnet
- Assemble equipment and arrange on bedside chair in the order the items will be used
- Remove watch, jewels, and Rings
- Respect dignity and privacy of the client.
- Wear closed and short shoes
- Hand washing

Patient preparation

- Identification of the patient
- Self-presentation to the patient
- Physical and psychological patient preparation
- Explain the procedure to be performed and purpose
- Position the patient in a comfortable position
- Ensure privacy

Equipment

- Trolley or tray cleaned and desinfected.
- A container with liquid or semi liquid food at room temperature or a disposable feeding bag, tubing, or ready-to-hang system
- 50-60mL or larger “Janet” Syringe
- Clean gloves
- Protection for the patient
- A cup of clean water to rinse the catheter
- Clean gauze / tissue to wipe the patient’s mouth, if necessary
- Stethoscope
- Kidney dish
- Enteral infusion pump for continuous feedings if applicable
- pH indicator strip (scale 0.0 to 11.0)
- Document (file) for recording the frequency and administered quantity
- Prescribed enteral formula.

Steps of NGT feeding

IMPLEMENTATION	Done	Partially done	Not done	Comments
Perform hand hygiene.				
Check the room for transmission-based precautions.				
Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.				
Confirm patient ID using two patient identifiers (e.g., name and date of birth).				
Explain the process to the patient and ask if they have any questions.				
Be organized and systematic.				

Use appropriate listening and questioning skills.				
Listen and attend to patient cues.				
Ensure the patient's privacy and dignity.				
Assess ABCs.				
Perform hand hygiene.				
Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.				
Don the appropriate PPE as indicated.				
Perform abdominal and nasogastric tube assessment:				
Assess skin integrity on the nose and ensure the tube is securely attached.				
Use a flashlight to look in the nares to assess swelling, redness, or bleeding.				
Ask the patient to open their mouth and look for curling of the tube in the patient's mouth. The tube should go straight down into the esophagus.				
Lower the blankets and move the gown up to expose the abdomen				
Auscultate bowel sounds and then palpate the abdomen. If the patient is receiving NG suctioning, turn off the suction prior to auscultation.				
Check for tube placement:				
Verify tube measurement at insertion site based on documentation.				
If agency policy dictates, test the pH of the aspirate. The pH should be equal or less than 5.5				
If agency policy dictates, measure and document residual amount. Instill residual back into gastric tube if placement				

Draw up 30 mL of water in a 60-mL syringe. (If applicable, use sterile water according to agency policy.)				
Connect the syringe to the tubing port (not the blue pigtail).				
.Instill 30 mL water.				
Reconnect the plug tube or clamp tube.				
Remove the plunger from the syringe and attach the syringe to the NG tube				
Complete tube feeding administration:				
Verify the order for the type of formula, amount, method of administration, and rate.				
Check the expiration date on the formula.				
Verify if the tops of the containers need cleaning or if feeding needs mixing/shaking.				
Add the formula to the syringe until the ordered amount is administered. Hold the syringe above the insertion site and allow it to enter via gravity.				
Assess the patient for tolerance of the feeding. Slow infusion as necessary. Do not allow air to enter the tube when refilling the syringe.				
After formula is administered, flush the NG tube with 30 mL of water.				
If a patient is unable to tolerate the feeding, slow or stop the infusion. Document and report the intolerance.				
. Disconnect the syringe and plug the NG tube.				

Maintain the patient at or above a 30-degree angle for a minimum of one hour to prevent aspiration. Ask the patient if they have any questions and thank him/her for their time.				
Disconnect the syringe and plug the NG tube.				
COMPLETION				
10.Perform hand hygiene.				
11. Document assessment findings and report any concerns and include the following:				
Time performed				
Irrigation solution used				
Quantity instilled				
Residual amount, color, odor, and consistency				
Method for checking the placement (including pH of gastric contents, if performed)				
Related assessments				
Amount of tube feeding				
Patient tolerance for the procedure				
12.Discard and arrange materials used				