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Rajiv Gandhi University of Health Sciences, Karnataka

4th 'T' Block, Jayanagar, Bangalore 560041. www.rghus.ac.in

PART - I BASIC NURSING

FACULTY OF NURSING
STANDARD OPERATING PROCEDURES

BASIC NURSING

ART-I

FACULTY OF NURSING

STANDARD OPERATING PROCEDURES

FOR

BASIC NURSING

PART - I

Rajiv Gandhi University of Health Sciences
Bengaluru - 560041, Karnataka, India

VAJUBHAI VALA
Governor of Karnataka

No. GS 48 MSG 2020

14th December, 2020

MESSAGE

I am delighted to pen down few lines to congratulate the efforts of RGUHS toward quality nursing education to cater to the health care needs of today's society. There is a greater need to prepare skillful nurses with uniform standards of education, training and practice.

I am happy to learn that the Prestigioius University RGUHS has taken efforts towards reaching this goal by bringing out the Standard Operating Procedure manual, which will serve as a ready reference for all institutions under its umbrella.

I wish to appreciate the hardwork, meticulous planning, excellent and intelligent execution towards bringing out such an excellent document which will serve as a road map to quality education and training. I wish to place on record my appreciation to the faculty of RGUHS for supporting this venture and wish that this university shall turn out to be a role model to many other universities in the country.

Once again I wish the SOP implementation to be a grand success.

(VAJUBHAI VALA)

Raj Bhavan, Bengaluru - 560 001. (Karnataka)

B.S. YEDIYURAPPA
CHIEF MINISTER
No: CM/MS/365/2020

VIDHANA SOUDHA
BENGALURU - 560 001

Date : 17/12/2020

MESSAGE

It is a pleasure to know that the **Rajiv Gandhi University of Health Sciences** has developed a Manual on Standard Operating Procedures for Basic and Advanced Nursing Practice.

It is heartening to note that the Rajiv Gandhi University of Health Sciences is always at the forefront of innovation and educational reforms and has undertaken the mammoth task of developing this comprehensive procedure manual that is consistent with WHO guidelines.

I hope that this manual will facilitate uniform standards of teaching nursing skills and will also serve as a guide for nursing students who would soon be embarking on their nursing careers. Nurses play a vital role in the health care system, and I envisage that a document such as this would ultimately ensure enhanced quality in patient care and thus, contribute to the health of the nation at large.

I compliment the Vice Chancellor, other functionaries of the University and the experts in the nursing field for their efforts and extend my best wishes for the release of this manual.

I wish this SOP implementation to be a grand success.

ಬಿ.ಎಸ್.ಯಡಿಯೂರಪ್ಪ

(B.S.YEDIYURAPPA)

Dr.S.Sacchidanand
Vice Chancellor
Rajiv Gandhi University of Health Sciences
4th T block, Jayanagar
Bengaluru-560041.

ಡಾ॥ ಕೆ. ಸುಧಾಕರ್
Dr. K. SUDHAKAR

ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಹಾಗೂ
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ಕರ್ನಾಟಕ ಸರ್ಕಾರ
Minister for Health & Family Welfare,
Medical Education
and Chikkaballapur District In-Charge
Government of Karnataka

MESSAGE

Nurses play a vital role in the health care industry. There is a great need for them to upgrade their skill based knowledge to provide safe care to their patients.

Rajiv Gandhi University of Health Sciences is well known for its innovative educational strategies to provide quality health care professionals. It has taken the initiative to bring out this Standard Operating Procedures for Basic and Advanced Nursing Practices to improve nursing skills and to provide quality care for the patients.

This manual will help to lower the risk of procedural errors and safeguard the rights of the patients, and also enhance the credibility of the health care agencies. It helps to produce competent nurses to practice in the clinical area at all levels of health care, who will provide need based care to the satisfaction of the patients.

I congratulate and appreciate the efforts taken by Rajiv Gandhi University of Health Sciences which is always striving to bring about innovative educational strategies to impart quality health education and training and contribution for the health of the nation.

(Dr.K.Sudhakar)

Dr.S.Sacchidanand.
Vice Chancellor,
Rajiv Gandhi University of Health Sciences,
Karnataka.

Room No. 339, 339A, 3rd Floor, Vidhana Soudha Bengaluru - 560 001.
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Dr. B.R. Ambedkar Veedhi
Bengaluru - 560 001

MESSAGE

It gives me immense pleasure to know that the Nursing Professionals in whom we had reposed our trust for preparing a manual of Standard Operative Procedures have prepared an exceptionally commendable document.

The manual will serve as the standard bench mark of professional skills in both basic and advanced nursing procedures. As we all are aware, nursing professionals form the backbone of health care as they provide first and immediate care to the patients. Enabling the untiring professionals will ensure quality healthcare and patient safety.

I am sure that this manual will fulfil the long pending necessity of quality bench marks and quality care.

I hope the Nursing Profession will make complete use of this manual.

(T.K. Anil Kumar)

भारतीय उपचर्या परिषद्
आठवाँ तल, एनबीसीसी सेन्टर, प्लॉट नं. 2, कम्यूनिटी
सेन्टर, ओखला फेज - 1, नई दिल्ली - 110020

INDIAN NURSING COUNCIL
8th Floor, NBCC Centre, Plot No. 2, Community Centre
Okhla Phase - I, New Delhi - 110020

स्वास्थ्य एवं परिवार कल्याण मंत्रालय के तहत सांविधिक निकाय
Statutory Body under the Ministry of Health & Family Welfare

MESSAGE

I am happy to note that Rajiv Gandhi University of Health Sciences is publishing standard operative procedure manual. The said publication by the University during the International Year of Nurse and Midwife 2020 is significant. I would like to congratulate University and the Faculty for bringing out the book which will be useful to the students and to the faculty to improve the quality of nursing education.

Changes in the Epidemiological profile of population and illness served by nurses, technological advancements, knowledge proliferation and rapid changes in the health systems around the globe necessitate that the nursing education system respond to change in a timely and effective manner to enable graduates to function as a safe and competent nursing professionals in meeting the health needs of the patients.

The unique expertise of nursing is to identify the issues to be addressed during each encounter and explore them with the patient through their therapeutic relationship. This is the added value, the nurse brings to the procedure and what distinguishes nursing practice and medical practice. This is the true person-centred care and if practiced well, then nursing becomes in itself therapy that includes management of illness, education for wellness and support for physical, mental and emotional resilience.

I wish Faculty and students utilize the said manual as a guide in their day to day teaching and learning environment.

Thank You,

(Dr.T. Dileep Kumar)
PRESIDENT
Indian Nursing Council

ರಾಜೀವ್ ಗಾಂಧಿ ಆರೋಗ್ಯ ವಿಜ್ಞಾನಗಳ ವಿಶ್ವವಿದ್ಯಾಲಯ, ಕರ್ನಾಟಕ
Rajiv Gandhi University of Health Sciences, Karnataka

Dr. S. Sacchidanand MD, DVD, DHA, FRCP (Glasgow)
Vice-Chancellor

29.12.2020

MESSAGE

It is a huge sense of contentment that I feel on the occasion of releasing this compilation of Standard Operating Procedures (SOPs) for nursing practices. This is a culmination of a long journey characterised by committed teamwork driven by the passion to instil safety and quality into a range of critical nursing procedures. It is all the more satisfying that this project is an in-house effort by the teachers of our University affiliated colleges.

The need for standardisation is a relic of the industrial revolution that required a consistency of performance. This got a shot in the arm in post the world wars, which required the military to have a zero-risk performance on and off the battlefield. These ideas spread to other professional fields also with healthcare and education adapting the compulsions of standardisation to stay relevant in the increasingly competitive and adversarial environment.

In healthcare industry, quality management was accepted as essential to nursing practices for the improvement of healthcare delivery and patient satisfaction. The best way to ensure standardisation was therefore to understand flow of process and creating a systematic representation. This ensued into the development of SOPs, which describes each critical and sequential step one has to perform in a task in order to assure its expected result.

As the need to improve health care delivery and sustain a better living for the people has become the new normal, the role of nurses has transformed into multi-dimensional competencies. Not only are they required to perform their typical duties in hospitals such as caring for patients and managing essential tasks, they are also playing a role in promoting health care awareness among different segments of the society.

To meet such a need and to ensure that the practices are compliant for our local needs and compulsions, a compilation of SOPs for nursing procedures and practices was felt necessary to provide a comprehensive set of rigid criteria that outline the nursing care for each and every professional function in nursing care. It is in this background that we have the satisfaction of having not only compiled the SOPs, but also that we have made it relevant for our local needs.

I am sure that the nursing profession across the country will find this useful for their practice decisions, and also that the nursing students would find this compilation a standard guide to plan their learning and the teachers would find it useful for teaching and assessment.

I congratulate the entire team that undertook such an onerous task and has come up with such a wonderful practice guide.

Dr. S. Sacchidanand
Vice Chancellor

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PREFACE

Nursing is a core part in health service delivery system in which health promotion, disease prevention; curative and rehabilitative health strategies are applied. The clinical skills for the nurses are of paramount importance not only to provide comprehensive care but also enhance clinical competence. Over the years, evidence-based practice came into use more frequently and the scope of practice of nurses broadened, and so too did the invasive and non invasive procedures done on the patients. The ability to think critically and provide evidence-based care is the pivotal role of the skilled nurse. Students and Nurse Practitioner need to know the "facts" of the procedures done on the patients and not necessarily the whole world of knowledge surrounding that one fact or procedure. Student or Nurse- Practitioner need to identify and address common problems that would allow timely, evidence-based interventions to reduce long-term sequelae.

The principle of going from simple to complex concepts in nursing education is well established, and yet many textbooks provide voluminous rather theoretical knowledge to the students with "nice to know" concepts rather than "need to know" ones. Several textbooks on the theoretical aspects of the patient care procedures are available. However to get the most of the practical knowledge on the procedures, one might have to refer many textbooks.

This "Standard Operating Procedures - Manual" is intended to act as a reference for nurses working at public health facilities, hospitals, Institutions and home care settings. It can be used as a guide to refer to know how of the Basic and Advanced procedures outlined in this manual.

Lineaments of this Manual:
Development of this manual made the distribution of the Basic and Advanced procedures on a wider, yet on a systematic platform. With our students, Nurse Practitioners, faculty readers in mind, we have developed this manual as simple as possible, which we hope, will cater to the needs of all the health care professionals.

This manual is culminate product of efforts by 30 nursing experts, who were well known in their specialties and are from various organisations (Central Government, state Government and Private Institutions affiliated to the Rajiv Gandhi University of Health Sciences) and due care has been given to align the contents of this manual with that of the curriculum of the Nursing courses.

In this manual, each procedure is explained in an orderly way i.e Meaning, Purposes/ Indications, Article required, Pre procedural steps, Procedure and Post Procedures, which will help the readers to improve the understanding of the procedures and it also provides a ready reference to the students and nurse practitioners while doing or observing a procedure. However we encourage our readers to follow the steps of the procedures as indicated in the manual.

This "Standard Operating Procedures - Manual" has explained 115 Basic Procedures and 71 advanced patient care procedures. This has been a possible task for the Standard Operating Procedures - Manual - Committee members by referring more than 100 available text books, manuals, articles etc.

When we first started writing this manual, we aimed to include everything that fascinated us about bringing out a procedural manual on nursing courses, however what more

fascinated us is to include the procedures in alignment with the curriculum of the Nursing courses. There have been some exciting recent developments in the field of nursing like emergency medicine etc, but to sustain the interest of students, Nurse practitioners, health care professionals, we have simply outlined the commonly performed and advanced procedures in a ready reference semblance.

With the approval of the Rajiv Gandhi University of Health Sciences, Bangalore, this "Standard Operating Procedures - Manual" can be used or incorporated in the Log book of the nursing students, or can be utilised to conduct an exit examination for the Nursing students and as well can form the base for certification course. However the key focus is to understand the practical knowledge of the patient care procedures.

The committee acknowledges and is thankful to Dr.V.Manjula, IAS who initiated development of this manual, through Hon'ble Vice Chancellor, RGUHS and also acknowledges the efforts of all people who were involved in bringing about this manual.

We hope to improve this manual with more feedback and hope this will be helpful to students and faculty.

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Chairman SOP Committee &
Principal, Alva's College of Nursing
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Index

COVID-19

COVID-19 is an acronym that stands for **Corona VIrus Disease** of 2019. The name was given by the World Health Organization (WHO) on February 11, 2020 for the disease caused by the novel corona virus SARS-CoV-2.

COVID-19 is an acute respiratory illness characterized by:

- Fever
- Dry cough
- Shortness of breath

Some patients may also have aches and pains, nasal congestion, runny nose, sore throat or diarrhea.

The incubation period (time between infection and appearance of first sign/symptom) of COVID-19 is up to 14 days.

The incubation period is up to 14 days.

The disease ranges from mild to severe and has been classified according to severity as syndromes associated with COVID-19.

Syndromes associated with COVID-19

- Uncomplicated illness
- Mild pneumonia
- Severe pneumonia
- Acute Respiratory Distress Syndrome (ARDS)
- Sepsis
- Septic shock

COVID-19 is a new disease which has never existed before. Thus humans do not have any natural immunity against the virus. COVID-19 affects people of all age groups- BUT the following population sub groups are at greater risk of developing severe disease with complications

- Elderly
- People having other co-morbidities (CVD, hypertension, diabetes, respiratory illnesses)
- People who are immunocompromised (on immunosuppressant drugs/people with HIV)

Transmission of COVID-19

Transmission depends on several factors like infectiousness of agent, susceptibility of population and exposure of susceptible population.

How to reduce Transmission:

- Reducing the spread of agent from infected host (eg. Isolation, quarantine)
- Reducing exposure of susceptible host (eg. Social distancing, use of PPE)
- Reducing environmental survival of agent [eg. Disinfection of frequently touched surfaces, such as floors, and other commonly used areas (toilets, wash basins etc.) and objects (doorknobs, handles, keys etc.)]
- Increase resistance of susceptible hosts (eg. Vaccination).

COVID-19 spreads by the viral load present in respiratory droplets of infected persons released into the air when they cough or sneeze

These droplets can spread the infection in two ways:

- Direct spread: by droplets that land on the face (mouth, eyes) or hands of another person. Spread by direct contact has been seen to occur within a distance of 3 feet or 1 meter
- Indirect spread: by contact with a surface contaminated by respiratory droplets. The droplets settle on surfaces (floor, furniture, clothes, keyboards, mobiles etc.). The virus can survive on contaminated surfaces for up to 2-3 days

On 11 th March 2020 WHO declared COVID as Pandemic

Preventing Transmission

1. Control the source of infection

Source of infection: Confirmed COVID-19 cases (both symptomatic and pre-symptomatic)

Methods to control source of infection: Testing of suspected symptomatic and close contacts (includes pre-symptomatic cases) and isolation of positive cases. Since there is no proved treatment of the disease, isolation of cases remains the mainstay for controlling the source of infection.

2. Break the chain of transmission

Chain of transmission: Direct and indirect spread

Methods to break the chain of transmission: Reducing direct contact with respiratory droplets from infected persons (hand hygiene, respiratory hygiene, use of masks, social distancing, quarantine of contacts) and reducing indirect contact with surfaces infected with respiratory droplets (infection prevention and control protocols)

3. Reduce susceptibility to infection

Vaccination against COVID-19 is vital to reduce the susceptibility to infection. However till the Vaccination is accessible to all the members of the population, it is vital that we maintain the focus to break the chain of transmission and flatten the curve of disease.

4. Physical (Social) Distancing and methods

The virus can be prevented from spreading by maintaining safe distance (at least one meter).

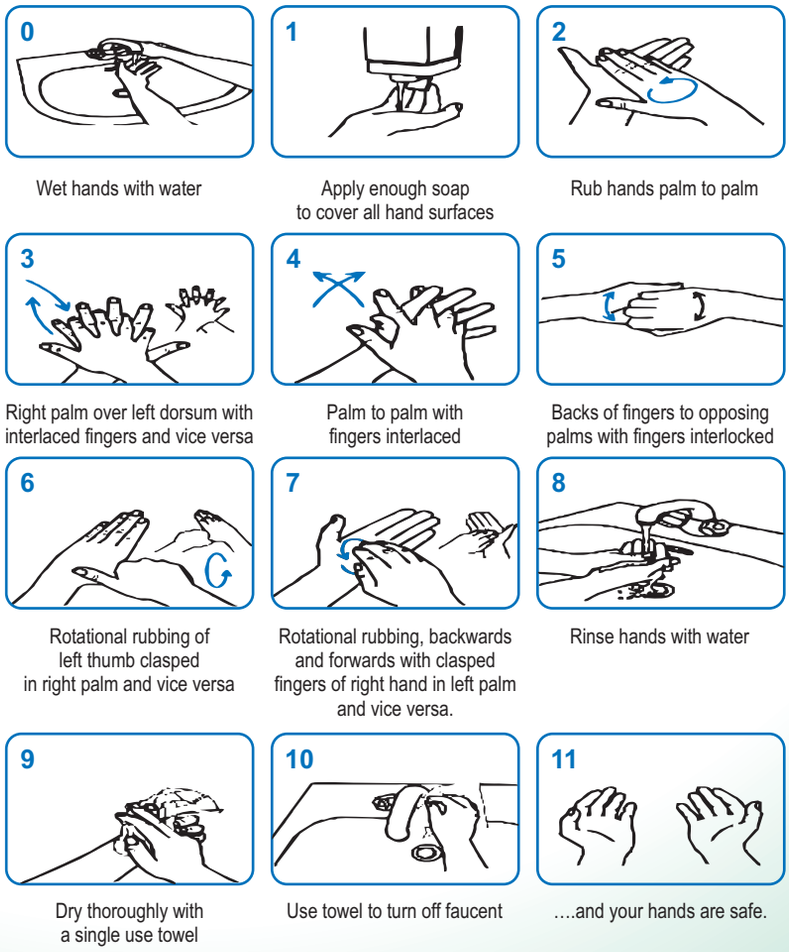
Since an infected person can spread the virus even before he/she develops symptoms of COVID-19, it is important to practice distancing from people whether they are sick or healthy. Physical distancing methods effectively reduce Transmission.

Method	Description	Rationale
Isolation of cases	Confirmed or suspected cases of COVID-19 are isolated in designated health facility or home (subject to fulfilling stipulated conditions)	Separating the sick from the healthy to avoid transmission of infection.
Home Quarantine of contacts	Healthy person(s) who have had contact with a suspected COVID-19 case are kept in quarantine for 14 days at home or in a facility quarantine. If they develop symptoms, they would be promptly tested.	Separation of potentially infected from others to avoid transmission if disease develops, even during pre-symptomatic* phase of the disease.
Physical distancing	All people are asked to stay at home. Closure of schools & other establishments Ban on gatherings Restricting non-essential travel Physical distancing maintained at markets and during travel	Recommendations for physical distancing of persons, particularly the high-risk groups, in order to reduce transmission, avoid increased morbidity, and thereby decrease the pressure to the health system.

- Wash hands with soap and clean water for at least 40 seconds
- Clean hands with alcohol based hand rub for at least 20 seconds

Make sure to wash your hands :

- After coming home from outside or meeting other people especially if they are ill.
- After having touch with the face, & coughing or sneezing.
- Before preparing food, eating or feeding children.
- Before and after using toilet, cleaning etc.



5. Use of masks

- Wash hands after removing and before wearing fresh masks.
- Masks are effective only when used properly in combination with frequent hand washing with soap and water or hand cleaning with alcohol-based hand rub and other physical distancing measures to be followed.

Triple layer surgical mask should be used by

- Persons with respiratory symptoms
- Persons in quarantine
- Healthcare workers in low risk settings (not in direct contact with COVID-19 patients).
- N-95 respirator mask should be used by healthcare workers at high risk settings (e.g. during clinical examination of patients, conducting aerosol generating procedures, etc.)

6. Measures to reduce indirect transmission.

Don't touch surfaces

- The virus survives on surfaces of inanimate objects for a few days.
- Therefore, avoid touching doors, handles, table tops, key boards, mobiles etc. of other people in public places.
- Also wash hands thoroughly after any contact with these.
- Clean and disinfect frequently touched surfaces at least once daily with household disinfectants and 1% sodium hypochlorite. This includes table tops, doorknobs, light switches, countertops, handles, desks, toilets, and sinks.
- Phones, computers, remote controls etc. should be disinfected with alcohol based (70% or more) disinfectant.
- Clothes should be washed with common detergent. If handkerchief is used to cough or sneeze, or as a face mask, it should be washed daily before reusing.
- All tissues and non-reusable masks should be disposed safely by burning or deep burial after disinfection with 1% sodium hypochlorite solution.

Management of cases

Case definitions

A Suspect Case is one who is likely to have been infected and should be tested for the disease immediately at designated testing centers.

Definition of suspect case:

A patient with acute respiratory illness {fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness of breath)}, AND a history of travel to or residence in a country/area or territory reporting local transmission of COVID19 disease during the 14 days prior to symptom onset;

OR

A patient/Health care worker with any acute respiratory illness and having been in contact with a confirmed COVID-19 case in the last 14 days prior to onset of symptoms;

OR

A patient with severe acute respiratory infection {fever and at least one sign/symptom of respiratory disease (e.g., cough, shortness breath)} AND requiring hospitalization AND with no other etiology that fully explains the clinical presentation;

OR

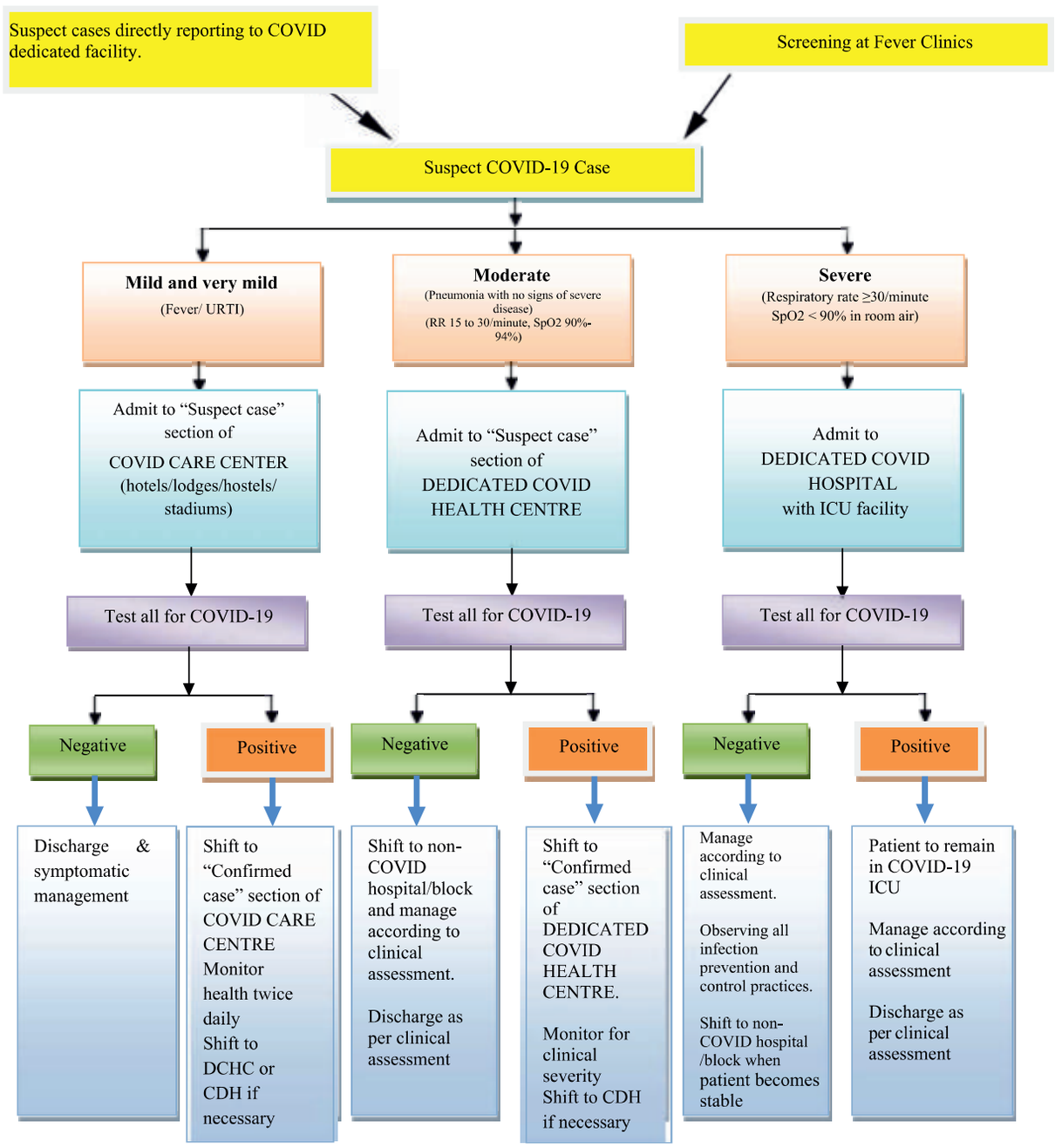
A case for whom testing for COVID-19 is inconclusive.

Laboratory Confirmed Case:
A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Testing Strategy for Covid 19 (ICMR guidelines)

- All symptomatic individuals who have undertaken international travel in the last 14 days
- All symptomatic contacts of laboratory confirmed cases
- All symptomatic healthcare workers
- All hospitalized patients with Severe Acute Respiratory Illness (fever AND cough and/or shortness of breath)
- Asymptomatic direct and high-risk contacts of a confirmed case should be tested once between day 5 and day 14 of coming in his/her contact
- In hotspots / cluster (as per MOHFW) and in large migration gatherings/evacuee centres:
- All symptomatic ILI (fever, cough, sore throat, runny nose) should get tested.

MOHFW's treatment strategy for COVID-19



https://www.mohfw.gov.in/pdf/FinalGuidanceonMangaementofCovidcasesversion2.pdf

Isolation and home quarantine

Isolation in a health facility is for:

- All confirmed positive cases of COVID-19 in order to prevent transmission of infection
- Isolation is for the period of disease (ie, till the person tests negative for the disease)
- Home quarantine is for:
- All asymptomatic individuals who have undertaken international travel from any COVID-19 infected countries or interstate travel from any COVID-19 infected state in the last 28 days.
- Home quarantine is for a period of 14 days* since the day of travel
- All those who fit the definition of 'contact' should be- home quarantined and monitored for symptoms of covid 19
- A contact in the context of COVID-19 is one who:
    - Provided direct care to a COVID-19 positive person without personal protective equipment (PPE)
    - Stayed in the same close environment of a COVID-19 patient (including workplace, classroom, household, gatherings).
    - Traveled in close proximity (1 m) with a symptomatic person who later tested positive for COVID-19.

Home isolation of very mild/pre-symptomatic case

However, recent guidelines have been issued by MOHFW for home isolation of very mild/pre-symptomatic

COVID-19 cases, provided the patient has requisite facility at his/her residence for self-isolation.

Eligibility criteria for home isolation:

- Should be clinically assigned as a very mild case/ pre-symptomatic case by the treating doctor.
- Should have the requisite facility at their residence for self-isolation and also for quarantining the family contacts.
- A care giver should be available to provide care on 24 x7 basis.
- A communication link between the caregiver and hospital is a prerequisite for the entire duration of home isolation.
- The care giver and all close contacts of such cases should take Hydroxychloroquine prophylaxis as per protocol and as prescribed by the treating medical officer.

Guidelines for home quarantine

Instructions for contacts being home quarantined
The home quarantined person should

- Stay in a well-ventilated single-room preferably with an attached/separate toilet.

- If another family member needs to stay in the same room, it's advisable to maintain a distance of at least one and a half meter between the two.
- Needs to stay away from elderly people, pregnant women, children and persons with co-morbidities within the household.
- Restrict his/her movement within the house.
- Under no circumstances attend any social/religious gathering e.g. wedding, condolences, etc.
- Instructions for the family members of persons being home quarantined
- Only an assigned family member should be tasked with taking care of the such person
- Avoid shaking the soiled linen or direct contact with skin
- Use disposable gloves when cleaning the surfaces or handling soiled linen
- Wash hands after removing gloves
- Visitors should not be allowed
- In case the person being quarantined becomes symptomatic, all his close contacts will be home quarantined (for 14 days) and followed up for an additional 14 days or till the report of such case turns out negative on lab testing

Vulnerable populations

Stay at home with physical distancing and other preventive measures:

- All people who do not have history of high risk contact but have high risk conditions such as immunocompromised status, heart or lung disease etc.
- All people above age of 60 years
- All these people must be monitored for symptoms of COVID-19 since they are at high risk of getting severe disease if they get infection.

PERFORMING MEDICAL HAND WASHING

1.0 Meaning:

1.1 Hand washing is a vigorous, brief rubbing together of all surfaces of hands lathered in soap followed by rinsing under a stream of water.

2.0 Purpose/Indication:

2.1 To remove dirt and transient organisms from the hands and reduce total microbial counts.
2.2 To protect nursing personnel from pathogenic organisms.
2.3 Before touching the patient
2.4 Before clean/aseptic procedure
2.5 After body fluid exposure
2.6 After touching the patient
2.7 After touching the patient surroundings
2.8 When hands are visibly dirty or contaminated.

3.0 Articles:

3.1 Warm/plain running water.
3.2 Antimicrobial or regular soap.
3.3 Paper towels or hand drier.

4.0 Pre Procedure:

4.1 Inspect the surface of hands for break in the continuity of skin.
4.2 Inspect and cut short the nails.
4.3 Roll up the sleeves above the elbow.
4.4 Remove articles such as ring, bangle, watch etc.

5.0 Procedure:

5.1 Wet hands from forearm to fingertips
5.2 Keep hands and forearms below the elbow while washing.
5.3 Wet at least one inch above the area of contamination. If hands are not visibly soiled, wet one inch above wrists.
5.4 Apply soap and lather well with firm circular motion
5.5 Rub the palms and back of the hands, each finger, the area between the fingers the knuckles, wrists and forearms.
5.6 Rub fingertips and nails against opposite palm.
5.7 Rub between thumb and forefinger.
5.8 Rub the hollow of the palm.
5.9 Total scrub-time may take 30 seconds - 2 minutes depending on the degree of contamination
5.10 Rinse thoroughly under running water from finger tips to forearm
5.11 Dry hands with clean towel or hand drier.

6.0 Post Procedure:

6.2 Replace the towel in dirty laundry bag.

ALWAYS REMEMBER

Palm to Palm

Right palm over back of left hand.
Left palm over back of right hand

Palm to palm fingers interlaced

Backs of fingers to opposing palms
with fingers interlaced

Rotational rubbing of right thumb clasped
over left palm and left palm over right palm

Rotational rubbing backwards and forwards with
clasped fingers of right hand in palm of left and vice versa

Image Retrieved from DAILYMAIL.COM, STACY LIBERATORE ©NHS

GOWN TECHNIQUE

1.0 Meaning:

1.1 Wearing of clean/disposable gowns during procedure using aseptic technique is known as gowning. Sterile gowns may be indicated when the nurse changes the dressings of a client with extensive wounds, burns etc.

2.0 Purpose/Indication:

2.1 To prevent soiling of clothes during contact with the patient
2.2 To protect health care personnel from coming in contact with infected material.
2.3 Before entering Operation theatre
2.4 Before doing invasive procedures like lumbar puncture, central line insertion, peritoneal dialysis etc
2.5 While handling infectious patients with air borne or droplet infections, MRSA, HIV/AIDS etc.

3.0 Equipments required:

3.1 Hand washing articles
3.2 Sterile Gown
3.3 Laundry bag

4.0 Pre Procedure:

4.1 Ensure sterility of the gown package
4.2 Perform hand washing
4.3 Collect all the articles and keep it in a sterile field.

5.0 Procedure:

5.1 Pick up the sterile gown
5.2 Allow it to unfold keeping inside of the gown towards the body without allowing the outside of the gown to touch any area
5.3 With hands at shoulder level, slip both arms into armholes simultaneously.
5.4 Ask the circulating nurse to bring the gown over the shoulders without touching the outer sterile surface of the gown.
5.5 Instruct the circulating nurse to fastens the ties at the neck & back.
5.6 Overlap the gown at the back as much as possible and fasten the waist, ties or belt
5.7 Prevent the gown from becoming wet

6.0 Post procedure:

6.1 For Removing the Gown: Untie the waist band and neck ties.
6.2 While removing avoid touching soiled parts on the outside of the gown.
6.3 Roll up the gown with the soiled part inside and discard in the appropriate container.

WEARING A STERILE GOWN

1. Dry Hands

2. Pick Up Gown

3. Let Gown Unfold

4. Open to Locate Sleeves

5. Slip arm into the sleeves,
hold arms out and slightly up

6. Circulatory Nurse pulls gown on

GLOVE TECHNIQUE

1.0 Meaning:

1.1 It means to wear gloves in an aseptic manner to protect hands when the nurse is likely to handle any body substances, eg: blood, urine, faeces, sputum, mucous membranes and non-intact skin.

2.0 Purpose/Indication:

2.1 To protect the nurse from pathogenic microorganisms
2.2 To handle sterile articles without contaminating
2.3 Before coming in contact with any infectious patient
2.4 Before any aseptic procedure
2.5 Before any invasive procedures.

3.0 Articles:

3.1 Soap/Antiseptic Solution
3.2 Nail brush
3.3 Pair of sterile surgical gloves
3.4 Running water
3.5 Sterile Towel

4.0 Pre Procedure:

4.1 Wash hands thoroughly
4.2 Ensure that the glove packet is not torn
4.3 Check the expiry date and the size of glove

5.0 Procedure:

5.1 Open a sterile glove packet of proper size on a flat surface above waist level.
5.2 Identify right and left hand.
5.3 Glove dominant hand first. With the thumb and first two fingers of the non-dominant hand, grasp on edge of the gloves cuff.
5.4 Pull the gloves carefully over the dominant hand. Ensure the thumb and the fingers are in proper spaces.
5.5 With gloved dominant hand, slip fingers underneath the second glove's cuff.
5.6 Carefully pull the second glove over the non-dominant hand. Don't allow fingers of the thumb of the gloved dominant hand to touch any part of the exposed non-dominant hand
5.7 After the second glove is on, interlock hands together.

6.0 Post Procedure:

6.1 Remove the first gloves by grasping it on the palmar surface just below the cuff, taking care to touch only glove to glove.
6.2 Pull the first glove completely off by inverting or rolling the glove inside out.
6.3 Place the first two fingers of the bare hand inside the glove and remove the second contaminated glove
6.4 Dispose them into the appropriate container

WEARING MASK

1.0 Meaning:

1.1 Masks are worn to reduce the risk for transmission of organisms by the droplet contact, air borne routes, and splatters of body substances.

2.0 Purpose/Indication:

2.1 Used by personnel who work close to the client if the infection is transmitted by large particle aerosol.
2.2 Used by all personnel entering room if the infection is transmitted by small particle aerosols (droplet nuclei) eg: pulmonary tuberculosis.
2.3 Used to prevent dispersal of droplets from wearer to environment and patient.
2.4 Before doing invasive procedures like lumbar puncture, central line insertion, peritoneal dialysis etc
2.5 While handling infectious patients with air borne or droplet infections, MRSA, HIV/AIDS etc.
2.6 Protecting self from splatters of body substances during procedures like mouth care, bed bath, catheterization, etc.

3.0 Articles:

3.1 Appropriate size mask

4.0 Pre Procedure:

4.1 Wash hands thoroughly
4.2 Ensure the mask is not torn and has four ties.
4.3 Select the appropriate type of mask of to be worn. (eg. N95/ simple face mask)

5.0 Procedure:

5.1 Hold mask by top two strings, keeping top edge above the bridge of the nose.
5.2 Tie two top ties at back of the head above ears.
5.3 Tie two lower tie snugly around the neck with the mask well under the chin
5.4 Gently pinch the upper portion of mask around the bridge of the nose.
5.5 Ensure that the mask covers the nose and mouth adequately
5.6 If the glasses are worn fit the upper edge of the mask under the glasses
5.7 Avoid unnecessary talking and if possible, sneezing or coughing

6.0 Post Procedure:

6.1 For removing the mask: First untie the lower string of the mask. Then untie the top strings and pull mask away from face.
6.2 Hold the mask by strings and Discard the disposable mask into the appropriate waste container.
6.3 Wash hands thoroughly.

WEARING AN N95 MASK

WHO A / H1N1 FAQ and mask (Mask) for installation stages

ADMISSION OF PATIENT TO THE HOSPITAL

1.0 Meaning:

1.1 Admission is a term which generally means the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the hospital or facility where patients generally reside.

2.0 Purpose/Indication:

2.1 To provide immediate care to the patient.
2.2 To provide comfort and safety to the patient.
2.3 To provide round the clock nursing care.
2.4 To receive medications and undergo tests and/or surgery that can only be performed in the hospital setting.
2.5 To obtain information about the patient that may serve as a basis of care.
2.6 To establish a therapeutic nurse-patient relationship.

3.0 Articles required:

3.1 Thermometer tray
3.2 B.P apparatus
3.3 Stethoscope
3.4 Weighing machine
3.5 Hospital gown
3.6 Articles for physical examination
3.7 Patient bed
3.8 Linen, sheets
3.9 Patient chart
3.10 Adequate light and ventilation
3.11 Wheel chair or stretcher

4.0 Pre Procedure:

4.1 The bed and the unit is kept ready prior to the patient's arrival.
4.2 The bed is positioned as per the need of the client depending on the ambulatory status of the client.
4.3 Assemble all the necessary equipment and supplies near to the bed such as hospital gown, vital signs tray, patient's file etc.
4.4 Ensure proper functioning and assemble of any special equipment that may be needed by the client such as oxygen cylinder, suction apparatus, cardiac monitor etc.
4.5 Provide adequate lighting and ensure proper ventilation as per clients need.

5.0 Procedure:

5.1 Greet the client and his/her relatives.
5.2 Check the client's identification by asking the client his/her full name; if the client is unable to identify himself, confirm the identity of the client through a guardian.
5.3 Introduce yourself to the client and relative.
5.4 Explain the procedure of admission to the client and regarding the arrival of the duty doctor to the patient.
5.5 Assess the vital signs, gather complete history and perform physical examination as needed and observe for any signs and symptoms.
5.6 Explain regarding the unit and bed to the patient such as the electrical switches, bed remote, locker facility etc.
5.7 Explain the use of other equipments in the room or ward and orient the patient to the nurses' station, bathroom facility etc.
5.8 Instruct the patient and relatives regarding visiting hours, visitors pass, hospital rules and protocols.
5.9 Ask the preference of the client regarding meals and inform the dietician or pantry, also inform the client about the meal timings and restricted food in the hospital campus.
5.10 Answer any queries of clients and relatives calmly.
5.11 Place the call bell within the reach of the client.
5.12 Provide hospital clothes for changing and give admission bath if needed.
5.13 Ask the client to remove any jewellery or threads tied on the body and hand it over to relatives after documenting in the nurses note.
5.14 Label and collect any specimens required for laboratory test, secure an IV line as needed.
5.15 Finish all the work and provide privacy to the patient to rest.

6.0 Post Procedure

6.1 Inform all the concern departments about the patient's arrival.
6.2 Inform the Doctor- In-Charge and the resident doctor on duty and make any necessary arrangements as required.
6.3 Complete any necessary records according to agency policy.
6.4 Record the date and time of admission.
6.5 Document the admission details in the hospital admission register, nurses record and any other necessary documents as per hospital policy.

DISCHARGE FROM THE HOSPITAL

1.0 Meaning:

1.1 Discharge from the hospital is the point at which the patient leaves the hospital and either returns home or is transferred to another facility.

2.0 Purpose/ Indication:

2.1 To ensure the client is provided with correct information on his/her condition, follow up visits and referral to other hospitals.
2.2 To safely return to the client all the patient's medications, medical files and other records of the patient.
2.3 To prevent any misunderstanding or difficulties for the patient in relation to the patient's release, medicines, billing etc.
2.4 To help make safest and fastest arrangements possible for the patient at the time of discharge.
2.5 To assist the patient to manage successfully the change from the hospital environment to home environment.

3.0 Articles required:

3.1 Wheel chair or trolley
3.2 Discharge summary card

4.0 Pre Procedure:

4.1 Primary admitting doctor should give indications of tentative date of discharge of patient at least 24 hours prior to the staff nurse.
4.2 The time when primary consultant advice for discharge is marked as "Intent to discharge time" by the nurse and to be noted down in Nurses' record.
4.3 The patient's relative / attendant are informed about the same. The other process should be started by informing the concerned departments regarding updating of billing, draft discharge summary/typed and pharmacy indent and returns etc.
4.4 The nurse should coordinate for the retrieval of imaging study reports and lab reports, billing, payment, canteen dues etc.

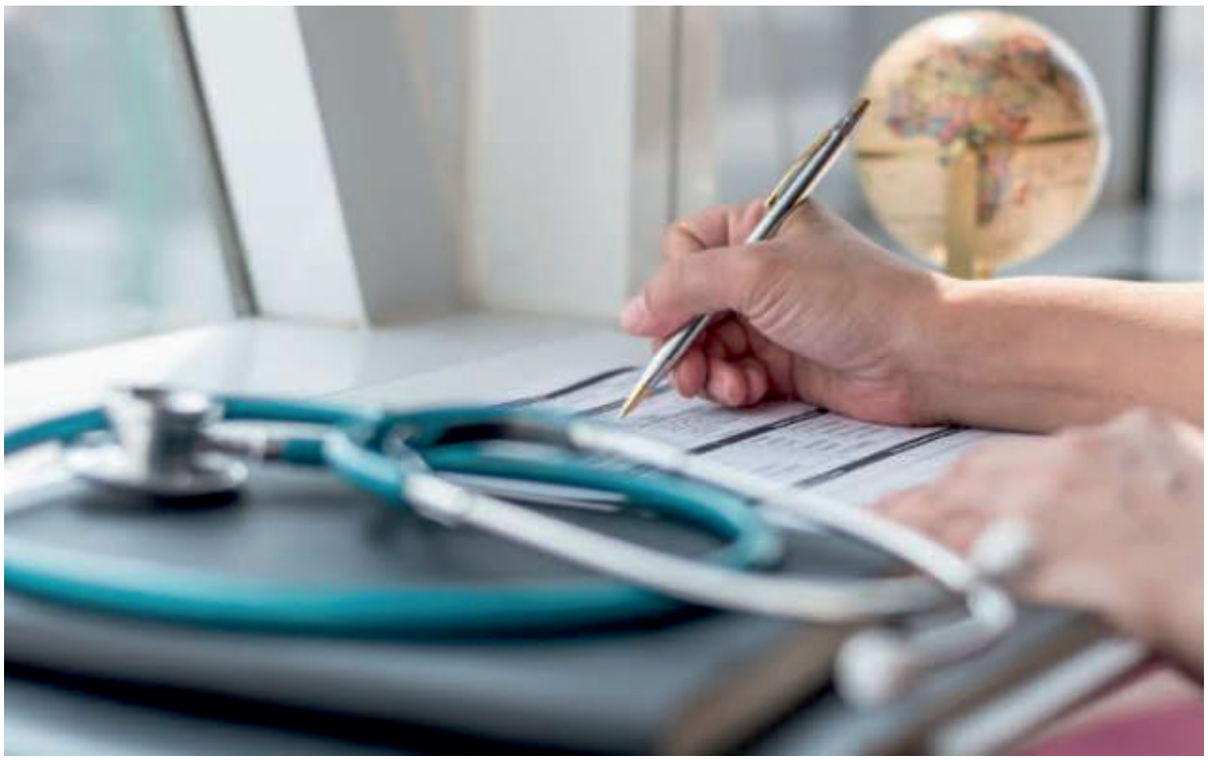
5.0 Procedure:

5.1 Ensure there is a written instruction for discharge and follow up prescription.
5.2 Make certain that the family and the patient understands the instructions for care.
5.3 If the client decides to leave the hospital against medical advice, get the clients and relatives signatures on LAMA/DAMA forms and other records as per protocol.
5.4 Provide the client with all the necessary documents and photocopies.
5.5 Assist the patient to change into his/her dress if needed and help in checking and packing of belongings.
5.6 Instruct the client regarding the discharge summary, prescriptions and follow up advices. Remind the client and relatives of any special instructions to be followed.

5.7 Check all the records of the client before final billing.
5.8 Provide any medication if pending to the client and then safely remove the IV cannula and secure it tightly.
5.9 Ensure all the bills are paid then remove the patients tag or ID band.
5.10 Answer any queries of the client and relatives.
5.11 Assist the patient and his belongings to be transported safely.

6.0 Post Procedure:

6.1 Collect the patient records and complete it and enter it into dispatch book.
6.2 After the discharge of patient, fumigate the room.
6.3 The bed and unit has to be kept ready for next admission.



CARE OF PATIENT UNIT

1.0 Meaning:

1.1 Patient Care Unit: It is the space where the patient is accommodated in hospital and consists of the bed, an over bed table, a bedside table, and possibly a chair.

1.2 Care of Patient Unit: Nursing staffs are not responsible for actual cleaning of dust and other dirty materials from hospital. However, it is the staff nurses duty to supervise the cleaner who perform this job.

1.3 Bed-making: It is the act of arranging the bed sheets and other bedding on a bed, to prepare it for use to make a patient/client comfortable in his/her suitable position for a particular condition.

2.0 Purpose/Indication:

2.1 To promote clients comfort.
2.2 To provide a clean environment for the clients.
2.3 To provide a smooth, wrinkle- free bed foundation, thus minimizing sources of skin irritation.
2.4 To conserve the clients energy and maintain current healthy status.
2.5 To prevent or avoid microorganisms to come in contact with the patient which could cause tribulations.

3.0 Articles:

3.1 Mattress 1
3.2 Bed sheets 2: Bottom sheet 1 Top sheet 1
3.3 Pillow 1
3.4 Pillow cover 1
3.5 Mackintosh 1
3.6 Drawsheet 1
3.7 Blanket 1
3.8 Savlon water or Dettol water in basin
3.9 Sponge cloth 4 : to wipe with solution 2 to dry 2
3.10 Kidney tray or paper bag 1
3.11 Laundry bag or Bucket 1
3.12 Trolley 1
3.13 Disposable gloves

4.0 Pre Procedure:

4.1 Perform hand hygiene and assemble all required equipments and bring the articles to the bedside.
4.2 Clean Bed-side locker: Wipe with wet and dry mittens.
4.3 Check bed linens for the patients belongings and disconnect the bell or any tubing's.
4.4 Loosen all the linen as you move around the bed.

4.5 Snugly roll all the soiled linen inside of the bottom sheet and place directly into the laundry hamper.
4.6 Do not place them on the floor or on furniture or hold the soiled linen away from your uniform

5.0 Procedure

5.1 Cleaning the mattress:

5.1.1 Stand at the right side.
5.1.2 Start wet wiping from top to center and from center to bottom in right side of mattress.
5.1.3 Gather the dust and debris to the bottom.
5.1.4 Collect them into kidney tray.
5.1.5 Give dry wiping.

5.2 Bottom sheet:

5.2.1 Place and slide the bottom sheet upward over the top of the bed leaving the bottom edge of the sheet.
5.2.2 Open it lengthwise with the center fold along the bed center.
5.2.3 Fold back the upper layer of the sheet toward the opposite side of the bed.
5.2.4 Tuck the bottom sheet securely under the head of the mattress

5.3 Make a mitered corner.

5.3.1 Pick up the selvage edge with your hand nearest the hand of the bed.
5.3.2 Lay a triangle over the side of the bed.
5.3.3 Tuck the hanging part of the sheet under the mattress.
5.3.4 Drop the triangle over the side of the bed.
5.3.5 Tuck the sheet under the entire side of bed.
5.3.6 Repeat the same procedure at the end of the corner of the bed.
5.3.7 Tuck the remainder in along the side.

5.4 Mackintosh and draw sheet:

5.4.1 Place a mackintosh with draw sheet at the middle of the bed.
5.4.2 Spread it forward and Tuck the mackintosh under the mattress on the right side.

5.5 Top sheet and blanket:

5.5.1 Place the top sheet evenly on the bed, centering it in the below 20-30cm from the top of the mattress.
5.5.2 Spread it downward.
5.5.3 Cover the top sheet with blanket in the below 1feet from the top of the mattress and spread downward.
5.5.4 Make a cuff at the head end of the bed sheet.
5.5.5 Tuck all these together under the bottom of mattress & make miter corner.
5.5.6 Tuck the remainder in along the side

5.6 Pillow and pillow cover:

5.6.1 Put a clean pillow cover on the pillow.
5.6.2 Place a pillow at the top of the bed in the center with the open end away from the door.

6.0 Post Procedure

6.1 Replace all equipments in proper place.
6.2 Discard linen appropriately.
6.3 Perform hand hygiene

HISTORY COLLECTION

1.0 Meaning

1.1 History collection involves the data collected about a patient's level of wellness, changes in life patterns, sociocultural role, and mental and emotional reactions to illness

2.0 Purpose

2.1 To establish a data base (all the information about the client)
2.2 To determine the client's overall level of functioning in order to make a professional clinical judgment
2.3 To supplement, confirm, or question data obtained in the nursing history
2.4 To obtain data that will help the nurse establish nursing diagnosis and plan patient care

3.0 Articles:

3.1 History collection format (APPENDIX 1)
3.2 Patient file
3.3 Previous records of the patient
3.4 Stationery items like pen, pencil and paper

4.0 Pre procedure

4.1 Make the patient comfortable
4.2 Arrange a suitable environment for history collection
4.3 Introduce about yourself (nurse) to the patient
4.4 Ask the client how they wish to be addressed
4.5 Maintain privacy
4.6 Establish a professional and therapeutic mode of communication
4.7 Lay out a foundation of trust and non-judgemental relationship

5.0 Procedure

5.1 Gather information regarding the demographic data(Name, Age, Gender, Religion, Education, Occupation, Address and Contact person, Date of admission)

5.2 Gather information about the following areas :
- 5.2.1 Chief complaints
- 5.2.2 Present complaints
- 5.2.3 Ask the patient about the complaints on the day of assessment
- 5.2.4 Diagnosis and any surgery been performed
- 5.2.5 Present medical and surgical history
- 5.2.6 Pain assessment including Location, quality, severity, exaggerating factors, relieving factors, associated symptoms

5.2.7 Past health history

5.2.7.1 Collect history regarding past experiences of any diseases (TB, DM, HTN etc), previous hospitalization, medication or treatment taken, childhood illness, any surgery undergone, any allergy towards food, medication or any environmental aspects and immunization status

5.2.8 Family history & Family tree

5.2.8.1 Gather information about the history of any hereditary diseases, communicable diseases, psychiatric illness and genetic diseases. Collect information about the family members and their details

5.2.9 Personal history

5.2.9.1 Gather data regarding sleeping and resting pattern, dietary habits, bowel and bladder pattern, smoking habit, alcoholism, drug abuse, social relation and relationship with family

6.0 Post procedure care

6.1 Make sure that the patient is comfortable
6.2 Assure the patient about the confidentiality of the data which was provided

PHYSICAL EXAMINATION

1.0 Definition

1.1 Physical examination is a complete assessment of a patient's physical and mental status. It is an important tool in assessing the client's health status. It is performed to collect objective data and to correlate it with subjective data.

2.0 Purpose

2.1 To collect objective data from the client
2.2 To use the information to identify deviations in health patterns of the patient
2.3 To detect the abnormalities
2.4 To identify normal and deviations from normal
2.5 To determine the status of present health in health check-up and refer the client for consultation
2.6 It offers an opportunity for health teaching

3.0 Articles

3.1 Tray 1
3.2 Watch with a seconds hand 1
3.3 Height scale 1
3.4 Weight scale 1
3.5 Thermometer 1
3.6 Stethoscope 1
3.7 Sphygmomanometer 1
3.8 Measuring tape 1
3.9 Scale 1
3.10 Tourch light or penlight 1
3.11 Spatula 1
3.12 Reflex hammer 1
3. 13 Otoscope if available 1 set
3.14 Disposable gloves 1 pair
3.15 Cotton swabs and cotton gauze pad
3. 16 Examination table
3.17 Record form
3.18 Ballpoint pen, pencils
3.19 Drape sheets

4.0 Pre Procedure

4.1 Physical preparation
- 4.1.1 Maintain privacy
- 4.1.2 Empty bladder and bowel

4.1.3 Loose draping
4.1.4 Good lighting
4.1.5 Provide comfortable environment
4.1.6 Provide appropriate position according to area to be assessed

4.2 Psychological preparation
4.2.1 Explain the procedure and general instructions to the patient
4.2.2 Maintain a comfortable environment throughout the procedure

5.0 Procedure

5.1 Assess the overall body appearance and mental status
5.2 Observe the client's level of consciousness
5.3 Observe the client's ability to think, remember, process information, and communicate.
5.4 Observe the client's ability to see, hear, smell and distinguish tactile sensations
5.5 Observe general appearance: posture, gait, and movement
5.6 Measure the height with measuring scale.
5.7 Check weight.
5.8 Check vital signs.

5.9 Skin assessment.
5.9.1 Inspect the skin for color, lesion(Note the appearance, size, location, presence and appearance of drainage.)
5.9.2 Palpate the skin on the back and palms of the client's hands for moisture, texture, temperature, turgor, presence of edema

5.10 Nail
5.10.1 Inspect and palpate the fingernails and toenails. Note color, shape and any lesions.
5.10.2 Check capillary refill by pressing the nail edge to blanch and then release pressure quickly, noting the return of color.

5.11 Hair and scalp
5.11.1 Inspect the hair for color, texture, growth and distribution
5.11.2 Inspect the scaly, lumps, nevi, or other lesions

5.12 Head and Neck Assessment
5.12.1 Skull - Observe for the size, shape, and symmetry. Palpate and note any deformities, depressions, lumps, or tenderness
5.12.2 Face - Inspect the client's facial expression, asymmetry, involuntary movements, edema, and masses
5.12.3 Eyes - Check the position and alignment
5.12.4 Inspect the eyebrows (noting their quantity and distribution and any scaliness)
5.12.5 Inspect the position, presence of edema, lesions, condition and direction of the eyelashes
5.12.6 Conjunctiva and sclera - Inspect the color of palpebral conjunctiva, vascular pattern against the white scleral background and any nodules or swelling

5.12.7 With oblique lighting, inspect the cornea of each eye for opacities and note any opacity in the lens.

5.12.8 Inspect the size, shape and compare symmetry

5.12.9 Pupillary response to light -Ask the client to look into the distance and light a torch from the side of the eye. Remove it on the other side to and observe how pupil reacts .Repeat other side with same procedure

5.12.10 Coordination of eye movements - Hold as object at a distance from the client. Ask him/her to keep his/her head still and follow the object with the eyes only. Move the object towards his/her right and left eye, then towards the ceiling and floor. Repeat it on the other side

5.12.11 Check visual acuity by using Snellen eye chart

5.12.12 Ears - Inspect and palpate the external ears. Inspect location, shape and measure the size. Inspect the external auditory canal by touch or otoscope

5.12.13 Nose - Inspect the anterior and inferior surface of the nose. Palpate for sinus tenderness

5.12.14 Mouth - Observe the color, moisture, any lumps, ulcers, cracking or scaliness. Inspect the color, presence of ulcers, swelling, white patches and nodules in mucosa and gums. Tongue and floor of the mouth - inspect the tongue for color, texture of dorsum, papillae symmetry

5.12.15 Pharynx - Inspect soft palate anterior and posterior pillars, uvula, tonsils, and pharynx

5.12.16 Neck - Inspect the neck for any masses or scars, enlargement of the parotid or submandibular glands, and condition of any visible lymph nodes

5.12.17 Trachea - Inspect the trachea to detect any deviation from its usual midline position. Palpate for any trachea shift. Place your index finger on the trachea in the sternal notch and slip it off to each side

5.12.18 Thyroid gland- Inspect thyroid gland: Ask the client to sip some water, to extend the neck, and swallow. Observe for upward movement of the thyroid gland, noting its contour and symmetry.

5.13 Chest and Lungs

5.13.1 Observe the color, shape and movement of the anterior and posterior chest. Palpate the anterior and posterior wall over lung areas

5.13.2 Assess chest expansion on the posterior chest - Place your hands in the posteriolateral chest wall with thumbs at the level of T9 or T10.Slide your hands medially to pinch up a small fold of skin between your thumbs. Ask the client to take a deep breath. Watch your thumbs' move apart symmetrically and note smooth chest expansion with your finger

5.13.3 Assess tactile(vocal) fremitus - Begin palpating by using the ball or ulnar surface of your hand from the lung apices .Touch the client's chest while he/she repeats the words "ninety-nine" or " blue moon" .Compare vibration from one side to the other

5.13.4 Percussion of Lung Fields - Percuss the posterior chest comparing both sides

5.13.5 Auscultation - Listen to the breath posteriorly when the patient breathe through mouth and more deeply than the normal

5.14 Heart

5.14.1 Inspect the anterior chest for pulsation. Localize the apical impulse by using one finger pad. Note location, size, amplitude, and duration. Search for any other pulsations in the the apex, the left sternal border, and the base of heart.

5.14.2 Auscultate at Second right intercostal space, Second left intercostal space, Left lower sternal border, Fifth intercostal space at around left midclavicular line. Note the rate and rhythm

5.14.3 Percuss from third to fifth intercostal space to find cardiac dullness

5.15 Breasts andAxillae

5.15.1 Note symmetry of size, shape, color, texture, bulging, dimpling, any skin lesions or edema

5.15.2 Nipple -Inspect symmetry, shape, any dry scaling, any fissure or ulceration, and bleeding or other discharge.

5.15.3 Inspect and palpate the axillae

5.15.4 Palpate the breasts in a wheel pattern, Concentric-circles and move in a clockwise direction

5.15.5 The male breast - Inspect the chest wall, noting the skin surface and any lumps or swelling. Palpate the nipple area for any lump or tissue enlargement.

5.16 Abdomen

5.16.1 Inspect the abdomen for skin color, rashes, contour, symmetry, localized bulging, and visible mass or asymmetric shape while the client takes a deep breath

5.16.2 Auscultate bowel sounds - Place the diaphragm of your stethoscope gently in the abdomen. Listen for the sounds, and noting the character and frequency of bowel sounds

5.16.3 Percuss the abdomen lightly in all four quadrants

5.16.4 Perform palpation to judge the size, location, tenderness, muscle tone, consistency of certain organs, and mobility of any palpable organs

5.16.5 For light palpation, Depress the abdominal surface about 1 cm. Lift the fingers and move clockwise to the next location around the abdomen

5.16.6 Perform deep palpation using the same technique described earlier, but push down 5 to 8 cm (2 to 3 inches)

5.16.7 Liver - Stand on the client's right side. Place your left hand under the client's back parallel to the 11th and 12th ribs. Lift up to support the abdominal contents. Place your right hand on the RUQ, with fingers parallel to the midline. Push deeply down and under the right costal margin. Ask the client to take a deep breath. Feel for liver sliding over the fingers as the client inspires. Note any enlargement or tenderness. Also palpate spleen and kidneys.

5.16.8 Percuss the kidney to assess the tenderness in the kidney.

5.17 Musculoskeletal system -

5.17.1 Inspect his/her neck, shoulder, arms, hands, hips, knees, legs, ankle and feet.

5.17.2 Note the size and contour of the joint, skin and tissues over the joints for color, swelling, and any masses or deformities.

5.17.3 Palpate each joint, including its skin for tenderness, its muscles, bony articulations, and area of joint capsule. Note any heat, tenderness, swelling or masses.

5.17.4 Assess deep tendon reflexes:

Biceps- Flex the client's arm at elbow with the palms facing up. Place your thumb in antecubital fossa at the base of biceps tendon. Strike the thumb with a reflex hammer. Normal reflex is flexion of arm at elbow.

Triceps- Flex the client's elbow, holding arm across the chest, or hold the upper arm horizontally and allow the lower arm to go limp. Strike the triceps tendon just above the elbow. Observe for extension at the elbow.

Patellar- Make the client sit with legs hanging freely over the side of the bed and support knee in a flexed position. Briskly tap patellar tendon just below patellar

Achilles- Make the client to assume same position as patellar reflex. Slightly dorsiflex the client's ankle by grasping toes in the palm of your hand. Strike Achilles tendon just above the heel.

Plantar- Have the client lie in supine position with legs straight and feet relaxed. Take handle end of the reflex hammer and stroke lateral aspect of the sole from the heel to the ball of the foot, curving across the ball of the foot toward the big toe.

5.17.5 Assess cutaneous reflex:

Gluteal - Have the client assume side-lying position, spread buttocks apart and lightly stimulate the perineal area with a cotton applicator.

Abdominal - Have the client stand or lie in supine position. Stroke abdominal skin with the base of a cotton applicator over the lateral border of rectus abdominus muscles towards midline. Repeat test in each abdominal quadrant.

5.18 Nervous system - test for all the 12 cranial nerves.

Cranial nerve I- Olfactory- ask the client to identify different nonirritant aromas (coffee or vanilla).

Cranial nerve II- Optic- Use Snellen chart or read any printed material

Cranial nerve III- Oculomotor- assess directions of gaze. measure pupillary reaction to light reflex and accommodation.

Cranial nerve IV- Trochlear- assess directions of gaze

Cranial nerve V- Trigeminal- lightly touch cornea with wisp of cotton. Assess corneal reflex
Cranial nerve VI - Abducens- assess directions of gaze
Cranial nerve VII - Facial-as client smiles, puffs out cheeks and raises and lowers eyebrows, look for symmetry
Cranial nerve VIII - Auditory- assess ability to hear spoken word (Rinne's and Weber's test)
Cranial nerve IX - Glossopharyngeal- ask the client to identify sour or sweet taste on front of tongue
Cranial nerve X-Vagus- ask the client to say "ah".observe movement of palate and pharynx
Cranial nerve XI-Spinal accessory- ask client to shrug shoulders and turn head against passive resistance
Cranial nerve XII- Hypoglossal- ask client to stick out tongue to midline and move it from side to side.

5.19 Anus - Inspect the perineal area for any irritation, cracks, fissure or enlarged vessels
5.20 Male Genitalia- Inspect and palpate the penis
5.21 Female genitals- Note skin color, hair distribution, labia majora, any lesions, clitoris, labia minora, urethral opening, vaginal opening, perineum, and anus
5.21.1 Look for any discharge or bleeding, prolapse from the vagina

6.0 Post procedure

6.1 Replace all the articles
6.2 Assess for patient comfort
6.3 Record the data after examination

RANGE OF MOTION EXERCISES

1.0 Meaning:

1.1 Range of motion is a group of exercises performed to preserve movement of a joint.

2.0 Purpose/ Indication:

2.1 Prevent joints from becoming stiff and from developing contractures.
2.2 Helps joints to move more freely and as a result, the clients remain more independent.
2.3 Prevents the loss of minerals from bones (osteoporosis) and improve circulation.
2.4 Prevents muscles from losing strength and shrinking.

3.0 Contraindication:

3.1 Immediately after food.
3.2 Pain and inflammation at site.
3.3 Patients with cardio-pulmonary diseases.

4.0 Articles:

4.1 No special articles required. Extra pillows may be used as per comfort of the patient

5.0 Pre Procedure:

5.1 Wash your hands.
5.2 Explain what you are going to do.
5.3 Provide privacy. Make sure client is wearing adequate clothing.
5.4 Raise bed to a comfortable working height if possible.
5.5 Assist client into supine position.

6.0 Procedure:

6.1 Shoulder

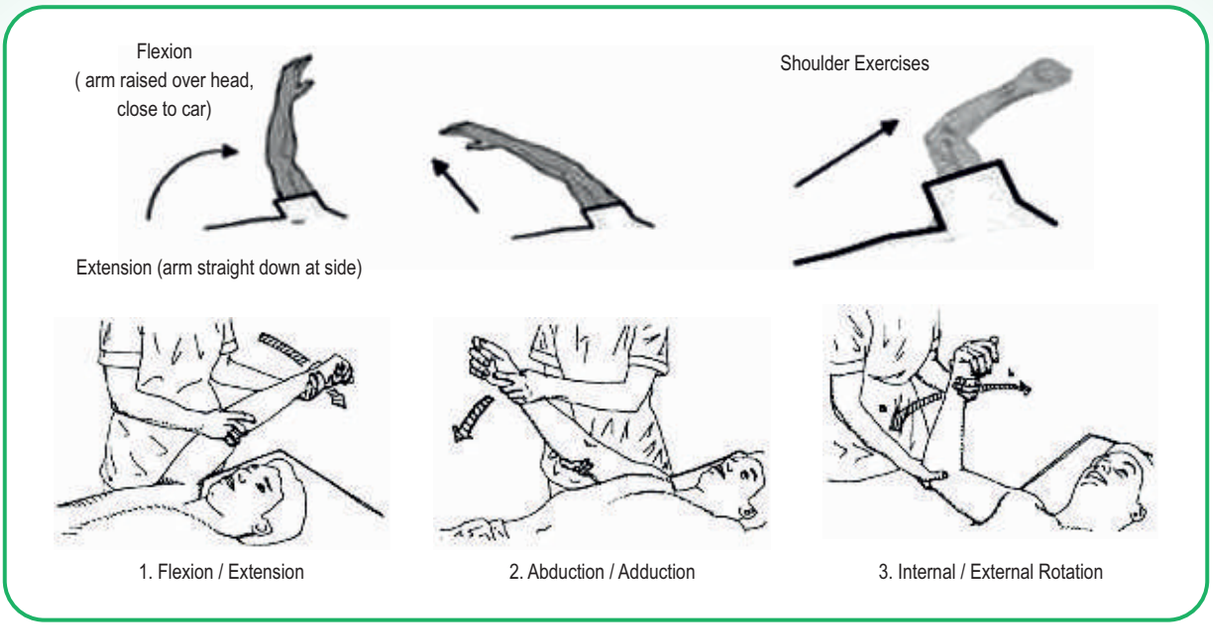
6.1.1 Flexion/extension.
- 6.1.1.1 Support the arm at the wrist and elbow and lift the arm toward the ceiling. Continue lifting the arm over the client's head until you feel resistance.
- 6.1.1.2 Slowly lower the arm to the client's side.

6.1.2 Abduction/adduction.
- 6.1.2.1 Support the arm at the elbow and shoulder and move the arm out to the side. Continue moving toward client's head.
- 6.1.2.2 Slowly move the arm back toward the center of body.

6.1.3 Internal/external rotation.

6.1.3.1 Move the arm away from the body to shoulder level.

6.1.3.2 Bring the hand forward to touch the bed and then backward to touch the bed.



6.2 Elbow

6.2.1 Flexion/extension.

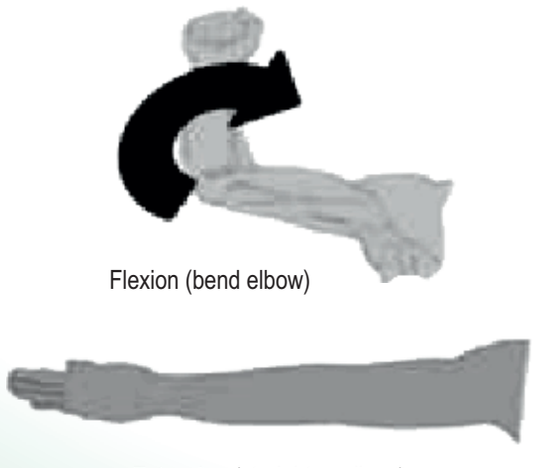
6.2.1.1 Bend the arm at the elbow, touch the shoulder, and then straighten the arm.

6.2.1.2 Bend the arm at the elbow and touch the chin, and then straighten the arm.

6.2.2 Supination/Pronation.

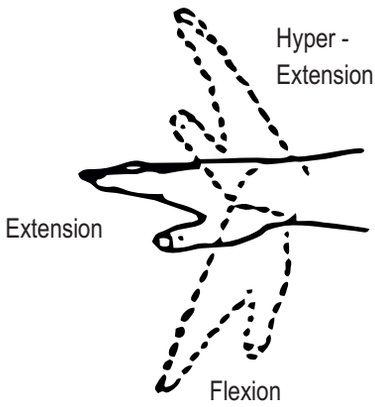
6.2.2.1 Hold the client's hand in a handshake position; support the arm at the elbow joint.

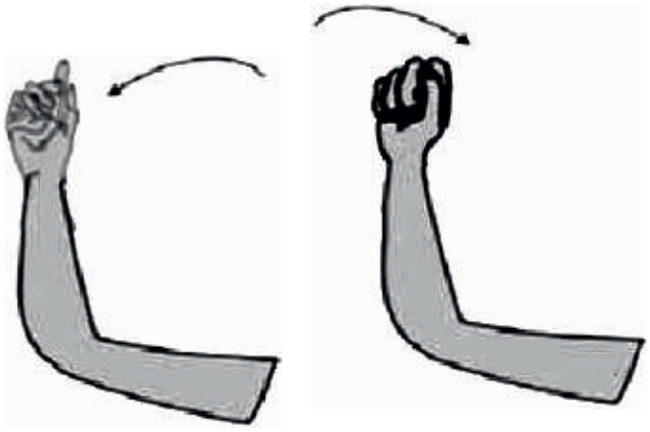
6.2.2.2 Turn palm of the hand toward the floor and then toward the ceiling.



6.3. Wrist:

6.3.1 Flexion/extension/hyperextension
6.3.1.1 Support arm and hand; bend the wrist forward, straighten it, and then bend it backward.
6.3.2 Abduction/adduction
6.4.2.6 Move the hand from side to side at the wrist.

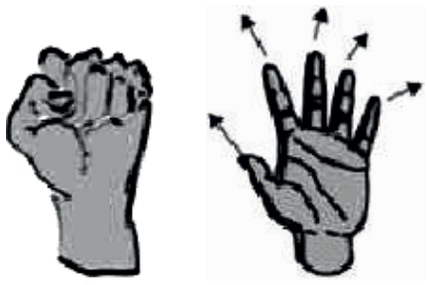




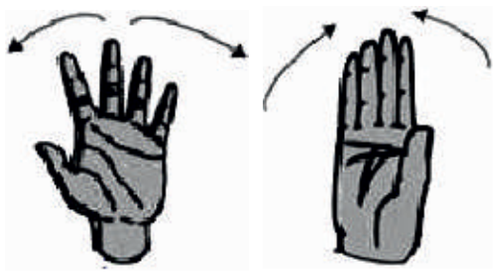
2. Abduction / Adduction

6.4 Fingers:

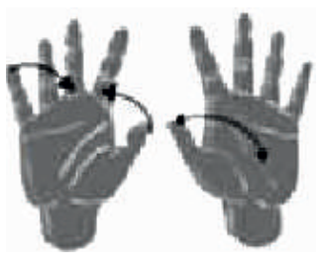
6.4.1 Flexion/extension
6.4.1.1 Support the hand at the wrist. Instruct client to make a clenched fist and then relax it. Make sure that the thumb is on top of the hand fully.
6.4.2 Abduction/adduction
6.4.2.1 Move each finger away from the nearest finger and then return it.
6.4.3 Thumb opposition
6.4.3.1 Bend the little finger toward inner hand and stretch the thumb toward the little finger and move it to the base of the little finger and back. Repeat with each finger.
6.4.4 Thumb rotation
6.4.4.1 Move the thumb in a circle one direction and then the other direction.



1. Flexion / Extension



2. Abduction / Adduction



3. Thumb Opposition

4. Thumb Rotation

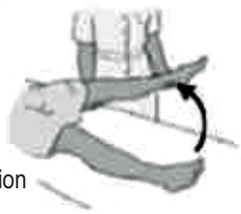
6.5 Hip and knee:

6.5.1 Flexion/Extension
- 6.5.1.1 Support the leg at the knee and ankle joints and keep the knee straight. Raise and lower the leg.
- 6.5.1.2 Bend the knee and move toward the chest; slowly straighten the knee.

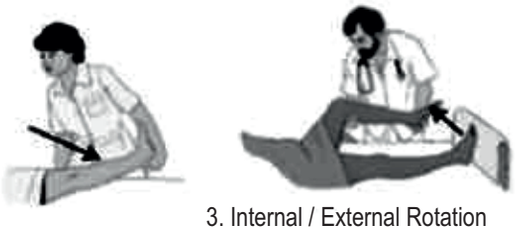
6.5.2 Abduction/adduction
- 6.5.2.1 Move the leg straight out to the side of the body until you feel resistance.
- 6.5.2.2 Slowly move the leg back toward the center of the body.

6.5.3 Internal/external rotation
- 6.5.3.1 Support knee and ankle joints; move the ankle in toward the opposite leg and then outward.

1. Flexion / Extension



2. Abduction / Adduction



3. Internal / External Rotation

6.6 Ankle:

6.6.1 Inversion/Eversion
- 6.6.1.1 Support the foot at the ankle joint and turn the foot toward the opposite foot and then way from the opposite foot.

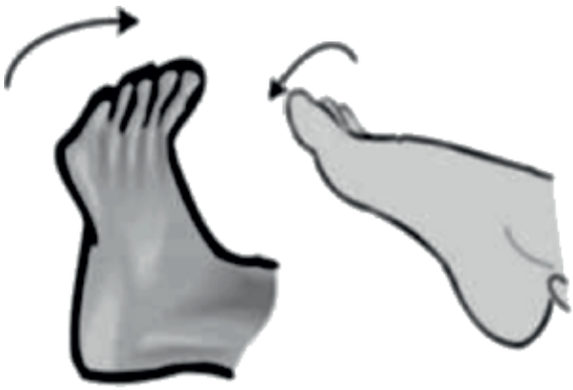
6.6.2 Dorsiflexion / Plantar flexion
- 6.6.2.1 Bend the foot up toward the knee then down toward the floor.

1. Inversion / Eversion

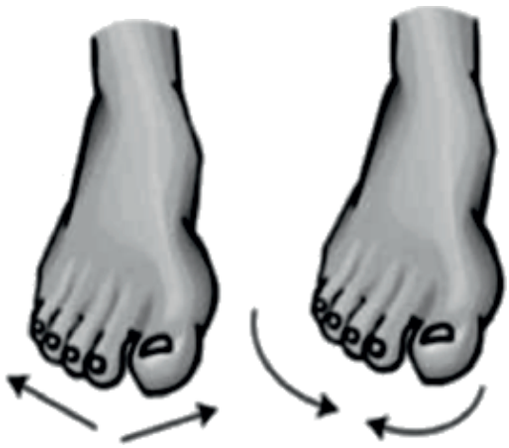
2. Dorsiflexion / Plantar flexion

6.7 Toes

6.7.1 Flexion/extension
6.7.1.1 Bend and then straighten the toes.
6.7.2 Abduction/adduction
6.7.2.1 Move each toe toward the next toe and then away from the next toe.



1. Flexion / Extension



2. Abduction / Adduction

7.0 Post Procedure:

7.1 Lower bed to a position of safety and raise side rails
7.2 Make the client comfortable; place call signal within reach.
7.3 Wash your hands then Record and report.

MONITORING OF VITAL SIGNS

1.0 Meaning:

1.1 Vital signs are measurements of the body's most basic functions. The four main vital signs routinely monitored by medical professionals and health care providers include the following:

1.1.1 Body temperature
1.1.2 Pulse rate
1.1.3 Respiration rate (rate of breathing)
1.1.4 Blood pressure (Blood pressure is not considered a vital sign, but is often measured along with the vital signs.)

2.0 Purposes /Indications:

2.1 To reveal any deviation from the normal body function
2.2 To identify any change in the condition of the client
2.3 To obtain specific information which will aid in the diagnosis of disease, the result of treatment, medications and nursing care.

3.0 Articles:

3.1 Thermometer (digital thermometer, thermal thermometer)
3.2 Small bowl - 1 (with dry cotton balls)
3.3 Kidney tray/container for soiled swabs
3.4 Á watch with a seconds hand
3.5 TPR chart, scale, blue and red pen
3.6 Antiseptic Solution

4.0 Pre Procedure:

4.1 Identify the client and note the diagnosis
4.2 Assess the ability of client to retain the thermometer in the axilla
4.3 Provide a well-lighted area
4.4 Wash hands

5.0 Procedure:

5.1 Explain the procedure
5.2 Provide proper position to the patient.
5.3 Wipe the thermometer with antiseptic solution dipped cotton swab using firm rotary motion from the bulb to the end of the stem. Do not discard the swab.
5.4 Grasp the thermometer firmly with the thumb and forefinger, shake the thermometer with strong movements of the wrist till the mercury line reaches below 95^0F (35^0C).
5.5 Wipe the axilla with the client's towel.
5.6 Place the bulb of the thermometer in the axilla with stem directed outwards.

5.7 Place the client's forearm over the chest with the wrist extended and the palm downward to hold the thermometer in place.
5.8 Leave the thermometer in place for a minimum of 3 minutes.
5.9 Feel for the radial pulse and count the pulse with the index, middle and ring finger for one complete minute.
5.10 Note the pulse for any abnormalities related to rhythm, volume and tension.
5.11 Retain the hand of the client over his/her chest and count the respiratory rate for one minute.
5.12 Note for any abnormalities in the respiration.
5.13 Remove the thermometer from the client's axilla.
5.14 Wipe the thermometer with the same spirit cotton from stem to bulb using rotatory motion.
5.15 Hold the thermometer at eye level and read the mercury level.
5.16 Discard the swab in the kidney tray.
5.17 Shake the thermometer and bring down the level of mercury to below 95^0F.
5.18 Replace the thermometer in the bottle containing Antiseptic

6.0 Post Procedure:

6.1 Make the client comfortable
6.2 Clean, dry and replace equipment in its proper place.
6.3 Wash hands.
6.4 Document the axillary temperature, pulps respiration and mark it as it is. Report and record any abnormalities if noted.

BLOOD PRESSURE MONITORING

1.0 Meaning:

1.1 Blood pressure is the force of the blood exerted against the artery walls during contraction and relaxation of the heart.

2.0 Purpose/Indication:

2.1 To reveal any deviation from the normal body function
2.2 To identify any change in the condition of the client
2.3 To obtain specific information which will aid in the diagnosis of disease, the result of treatment, medications and nursing care.
2.4 To note the emotional status of the client

3.0 Contraindications:

3.1 A limb on which an I.V. infusion is present
3.2 A limb which is injured e.g., fracture, burns, open wound
3.3 A limb on which a shunt or a fistula is present
3.4 The side on which a breast or axillary surgery is done

4.0 Articles:

4.1 Sphygmomanometer / android gauge BP operator / Digital BP operator
4.2 Stethoscope
4.3 Client's chart
4.4 Pen, Paper bag and spirit swabs

5.0 Pre Procedure:

5.1 Identify the client and check the diagnosis
5.2 Assess the general condition of the client
5.3 Ensure that the client is resting for 10 - 15 minutes prior to the procedure
5.4 Assess the extremity of any contraindication
5.5 Wash Hands
5.6 Instruct the patient not to talk during the procedure

6.0 Procedure:

6.1 Explain the procedure
6.2 Position the client preferably in supine position or sitting position if not contraindicated.
6.3 Place the sphygmomanometer at the level of the heart with palm facing upwards.
6.4 The level of mercury should be read at eye level and not more than 3 feet away.
6.5 Place the cuff so that:
    6.5.1 The inflatable area of the cuff is centred over the brachial artery

6.5.2 The lower edge of the cuff is about 2.5cm to 5cm above the antecubital fossa

6.5.3 The edge of the cuff where the tubing leaves should face towards the antecubital fossa.

6.6 Apply the cuff evenly over the arm. Make sure it is not too tight or too loose. Do not allow any clothing to interfere with the proper placement of the cuff.

6.7 Check the mercury level in the manometer. It should be within the zero.

6.8 Close the valve on the pump. Palpate the radial artery gently with the non dominant hand and inflate the cuff. Note the point where the pulsations disappear (palpation method).

6.9 Palpate the brachial artery with the fingertips. Place the earpiece of the stethoscope in the ear and keep the diaphragm over the brachial artery. Do not allow the stethoscope to touch the clothing or the cuff.

6.10 Inflate the cuff until the mercury rises 30 mm of Hg above the point at which the pulse disappeared.

6.11 Loosen the valve and deflate the cuff at a rate of 2 - 3 mm of Hg/ second. If deflation is too fast it gives false low reading. If it is too slow, it causes false high reading and discomfort to the client.

6.12 Note the point at which the sound became clear and louder. Read the pressure to the closest even number.

6.13 Continue deflating the cuff. Observe the point at which the sound completely disappears.

6.14 Do not exhibit alarm on the face when a considerably low or high reading is obtained.

6.15 To double check the reading, deflate the cuff fully and repeat the steps 9 to 14 after 30 - 60 seconds.

6.16 Allow the remaining air to escape quickly. Remove the cuff and fold and keep it in place.

7.0 Post Procedure:

7.1 Make the client comfortable

7.2 Instruct the client resting at least for some time

7.3 Clean the ear piece and the diaphragm of the stethoscope using spirit cotton swab

7.4 Compare the previous reading and report any deviation

7.5 Clean and replace the equipment in its proper place

7.6 Wash hands

7.7 Document the findings and report any deviation noted

COMFORT DEVICES

1.0 Definition:

Comfort devices are the mechanical device to promote comfort to the patient by relieving the discomfort and helping to maintain correct posture

2.0 Pillows:

Pillows are used to give comfortable position to the patient. These are mostly used to support various body parts

2.1 Purpose:
- 2.1.1 To maintain proper body alignment.
- 2.1.2 To support body parts in good alignment
- 2.1.3 Helps to reduce pressure
- 2.1.4 Helps to relieve pain

2.2 Indications:
- 2.2.1 Used to support incision area in abdominal and thoracic surgeries.
- 2.2.2 Used post-operatively, during activity or cough and deep breathing.

3.0 Backrest:

It is a mechanical device which provides a suitable support and rest for the back of the patient in sitting position.

3.1 Purpose:
- 3.1.1 Used to relieve dyspnea as in asthmatic patients by providing Fowlers or High Fowlers Position.
- 3.1.2 Used in positioning cardiac patient to reduce workload on heart.

3.2 Indications:
- 3.2.1 It is used in non-adjustable beds to make the patients to be in comfortable sitting position.

4.0 Hand rolls:

Hand Rolls are made of cloth that rolled into a cylinder about 4-5 inches long and 2-3 inches in diameter and stiffed firmly.

4.1 Purpose:
- 4.1.1 Used to maintain thumb in slightly adducted position and in apposition to fingers.
- 4.1.2 Used to maintain fingers in slightly flexed position.

4.2 Indications:
- 4.2.1 Helps in maintaining the hand, thumb and fingers in functional position.

5.0 Footrest/ Footboard:

These are the mechanical devices used to give rest to feet.

5.1 Purpose:
- 5.1.1 To maintain the patient's in a dorsiflexed position
- 5.1.2 To promote comfort
- 5.1.3 To prevent foot drop

5.2 Indications:
- 5.2.1 Post surgery or Post Trauma Patients
- 5.2.2 Unconscious patients.
- 5.2.3 Older Adults
- 5.2.4 Weak Muscles

6.0 Sandbags:

These are canvas, rubber or plastic bags filled with sand. These are used to immobilize a part. They are available in various sizes

6.1 Purpose:
- 6.1.1 To relieve discomfort.
- 6.1.2 Used to immobilize the body part
- 6.1.3 To prevent foot drop or wrist drop
- 6.1.4 Used to support body part
- 6.1.5 Used to support in fractured bones.

6.2 Indications:
- 6.2.1 Post surgery or Post Trauma Patients
- 6.2.2 Unconscious patients.
- 6.2.3 Older Adults
- 6.2 4 Weak Muscles
- 6.2 5 Fracture patients

7.0 Air/Water Mattress:

Special type of mattresses filled with water or air which moves from one part of the mattress to the other, thus reducing pressure to the same area.

7.1 Purpose:
- 7.1.1 To improve circulation
- 7.1.2 To provide comfort
- 7.1.3 To prevent pressure sores

7.2 Indications:
- 7.2.1 Obese or thin patients
- 7.2.2 Chronic bed-ridden patients

8.0 Air Cushion/ Rings:

Air cushion or air rings are made of rubber. The ring is inflated about half full, tested for leakage, covered and then placed under the patient's hips in such a way that the valve is on one side and not in contact with body.

Cotton rings are wrapped with bandage then placed under bony prominences and fastened in place if necessary.

8.1 Purpose:
- 8.1.1 To lift the hip from bed to prevent bed sore
- 8.1.2 To prevent direct pressure on bony prominences
- 8.1.3 To improve circulation

8.2 Indications:
- 8.2.1 Obese or thin patients
- 8.2.2 Chronic bed-ridden patients

9.0 Bed cradles:

They are semicircular in shape, made of wood, metal and electronic.

9.1 Purpose:
- 9.1.1 To prevent the contact of top cloth with the patients especially burns, amputated patient
- 9.1.2 To apply heat in case of drying plaster cast
- 9.1.3 For protection and comfort of the patient

9.2 Indications:
- 9.2.1 Burns patient
- 9.2.2 Amputated patient

10.0 Bed blocks:

It is made up of wood or metal. It is used to raise the head end or foot end of the bed.

10.1 Purpose:
- 10.1.1 To prevent shock
- 10.1.2 To retain enema
- 10.1.3 To position postural drainage
- 10.1.4 To provide traction
- 10.1.5 To give trendelenburg position

10.2 Indications:
- 10.2.1 After spinal anesthesia
- 10.2.2 In patients with bleeding, to arrest hemorrhage.
- 10.2 3 Patients with fracture

11.0 Cardiac Table:

It is a device designed as an over-bed table and is placed in front of the patient while they are in fowler's position.

11.1 Purpose:
- 11.1.1 Used by patients who can lean forward with pillow.
- 11.1.2 For serving food and other self-care activities.
- 11.1.3 For positioning the patients.

11.2 Indications:
- 11.2.1 Cardiac patients
- 11.2 2 Patients with respiratory diseases
- 11.2.3 Diagnostic procedure like thoracentesis

12.0 Trochanter Rolls:

Devices used to prevent the external rotation of the legs when the client is in supine position.

It is made of a cylindrical prop such as a rolled up towel, foam roll, cylindrical cushion/pillow or rolled up blanket/linen that is positioned around the lateral hip/thigh area of an individual to provide added support to the hip/leg regions and prevent the legs from rolling outwards.

12.1 Purpose:
- 12.1.1 To keep patients hips/legs properly aligned when the body is unable to support itself without causing further injury.

12.2 Indications:
- 12.1.1 A patient who is undergoing surgery or becomes immobilized due to an injury.
- 12.1.2 Patients with muscle weakness, hip dislocation or paralysis.

13 .0 Knee Rest:

The Knee Rest Wedge Pillow helps provide proper knee alignment for increased comfort.

13.1 Purpose:
- 13.1.1 To prevent bedsore
- 13.1.2 It gives relaxation by relieving pain on abdominal muscles and on tendons beneath the knees.

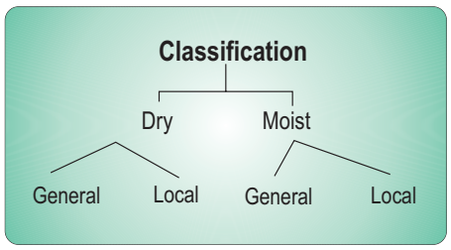
13.2 Indications:
- 13.2.1 Patients with varicose veins, swollen ankles and phlebitis.

HOT APPLICATIONS

1.0 Meaning:

1.1 The Nursing Interventions Classification (NIC) defined hot application as stimulation of the skin and underlying tissues with hot application for the purpose of decreasing pain, muscle spasms, or inflammation.

2.0 Purpose/Indication:



2.1 To relieve the pain and congestion
2.2 To relieve inflammation
2.3 To promote suppuration
2.4 To relieve retention of urine
2.5 To relieve muscular spasm
2.6 To rise the body temperature in case of Hypothermia

3.0 Articles:

3.1 Hot water bag with cotton cloth cover
3.2 Kettle with hot water
3.3 Bath thermometer
3.4 Pint measure

4.0 Pre Procedure:

4.1 Identify the client
4.2 Assess the general condition of the client
4.3 Provide privacy
4.4 Switch off fan
4.5 Wash Hands

5.0 Procedure:

5.1 Explain the procedure
5.2 Check the temperature with bath thermometer (105^0 F-115^0 F for children and 115^0 F to 125^0 F for adults)
5.3 Pour the hot water into the hot water bag by keeping the bag on a flat surface
5.4 Expel the air from the hot water bag and close the lid tight.
5.5 Check for any leak or damage in the bag
5.6 Cover the bag with a cotton cloth
5.7 Take the hot water bag to the client's side
5.8 Drape the client appropriately.
5.9 Apply on a specified area
5.10 Remain with the client and check periodically for tolerance of the heat
5.11 Assess the site of application every 10-15 minutes

5.12 In case of unconscious patient, hot application should be given under straight supper vision

6.0 Post Procedure:

6.1 Make the client comfortable
6.2 Clean, dry and replace the equipment in the proper place.
6.3 Hang the hot water bag upside down till the water drains out. Fill a little air and close the lid
6.4 Wash hands
6.5 Record the date and time, duration, observation made and the client's condition before and after the procedure

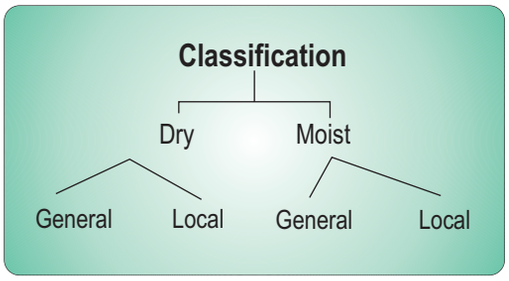
COLD APPLICATIONS

1.0 Meaning:

1.1 It is the application of moist cold, using pieces of gauze, linen to a specific area on the body

2.0 Purpose/Indication:

2.1 To normalize body temperature in case of fever
2.2 To stop epistaxis
2.3 To reduce inflammation and oedema
2.4 To relieve pain, burning sensation and irritation
2.5 To anesthetize for a short period
2.6 To control haemorrhage
2.7 To reduce metabolic rate of body
2.8 To relieve retention of urine



3.0 Articles:

3.1 Small mackintosh
3.2 Small towel
3.3 6 gauze pieces
3.4 Non-absorbent cotton balls
3.5 Cold water
3.6 Kidney tray
3.7 Thermometer tray

4.0 Pre Procedure:

4.1 Identify the client
4.2 Assess the general condition of the client
4.3 Check the diagnosis and indication for cold application
4.4 Provide privacy
4.5 Switch off the fan
4.6 Wash hands

5.0 Procedure:

5.1 Explain procedure to the client
5.2 Place mackintosh and bath towel under the client's head and cover pillow
5.3 Plug ears with non- absorbent cotton balls
5.4 Drape the client appropriately
5.5 Dip 3-4 gauze pieces in water and remove the excess water by gentle squeezing
5.6 Spread and place the wet gauze piece on the forehead

5.7 After few minutes change the compress
5.8 Squeeze the water to the kidney tray before dipping into the cold water
5.9 Continue for 15 to 20 minutes. Repeat every few hours with one hour gap in between, check the temperature to prevent hypothermia.
5.10 Replace equipment once procedure is over

6.0 Post Procedure:

6.1 Record the date and time, procedure, duration of application, client's reaction and change in patient condition

COLD APPLICATIONS : ICE CAP

1.0 Meaning:

1.1 Ice cap is a dry cold application. The ice cap used for the head, has a wide opening that allows it to be filled easily with ice chips, as does the ice collar, a narrow bag curved to fit the neck.

2.0 Purpose/Indication:

2.1 To relieve pain / discomfort in muscle and joints
2.2 To reduce inflammation and prevent suppuration
2.3 To lessen and prevent swelling
2.4 To reduce temperature

3.0 Articles:

3.1 Bath towel
3.2 Ice cap with ice cubes in a cotton cloth cover
3.3 Salt
3.4 Thermometer tray
3.5 Mackintosh

4.0 Pre Procedure:

4.1 Identify the client
4.2 Assess the general condition of the client
4.3 Check the diagnosis and indication for cold application
4.4 Provide privacy
4.5 Switch off the fan

5.0 Procedure:

5.1 Explain procedure to the client
5.2 Place mackintosh and bath towel under the client's head and cover pillow
5.3 Plug ears with non- absorbent cotton balls
5.4 Drape the client appropriately
5.5 Open the ice cap and fill it with ice pieces
5.6 Add 2 pinches of salt into the ice cap
5.7 Place the ice cap in a flat surface and expel the air
5.8 Close the lid tightly
5.9 Wipe the outside of the cap
5.10 Place it in a cotton cloth cover
5.11 Apply on the specified area
5.12 Assess the site of application every 10 - 15 minutes

6.0 Post Procedure:

6.1 Make the client comfortable. Record the date and time, procedure, duration of application, client's reaction and change in client's condition
6.2 After emptying the ice cap, place its mouth downward till all the water drains out and Dries. Fill in with little air to prevent sticking and close with the lid
6.3 Clean, dry and replace the equipment in its proper place

PERFORMING ORAL CARE

1.0 Meaning:

1.1 Oral hygiene is the practice of keeping the mouth clean and healthy by brushing & flossing for a critically ill patents.

2.0 Purpose/Indication:

2.1 To maintain healthy state of mouth, teeth, gums and lips.
2.2 To keep the mucosa clean, soft, moist and intact
2.3 To prevent oral infections and inflammation.
2.4 To massage gums.
2.5 To remove food debris as well as dental plaque without damaging the gum
2.6 To relieve discomfort resulting from unpleasant odours and tastes.
2.7 To alleviate pain and enhance oral intake with appetite
2.8 Paralyzed patients or seriously ill, who have physical restrictions to upper extremities, unconsciousness or depressed

3.0 Contraindication:

3.1 No significant contraindication. However patient with risk for bleeding eg. Chemotherapy patients, diabetes patient all tissues should be handled with care.

4.0 Articles:

4.1 Gloves - 1 pair
4.2 Small mackintosh with a face towel - 1
4.3 Mouthwash solution (Potassium permanganate 1:5000, Hydrogen peroxide 1:8 and Chlorhexidine 1:1)
4.4 Bowl with plain water - 1
4.5 Tray with forceps-1
4.6 Gauze pieces in a container - 1
4.7 Mouth gag-1
4.8 Tongue depressor-1
4.9 Kidney tray - 1
4.10 Lubricants: Vaseline/Glycerin/soft white paraffin gel/lip cream
4.11 Suction catheter with suction apparatus 1

5.0 Pre procedure:

5.1 Assess the condition of the oral cavity and general condition of the patient.
5.2 Verify doctors instructions for specific precautions regarding the movement and positioning of the patient

5.3 Explain procedure to the patient if conscious, to gain his cooperation and confidence
5.4 Maintain a safe and comfortable position for the mouth care sitting or in fowler's positions with a cardiac table in front, whichever is comfortable.
5.5 Provide privacy- screen point
5.6 Wash hands before procedure.

6.0 Procedure:

6.1 Prepare antiseptic solution for mouth wash
6.2 Place the mackintosh and towel on the neck to chest
6.3 Place the kidney tray over the towel and mackintosh under the chin
6.4 Inspect the oral cavity:
Inspect oral cavity, such as teeth, gums, mucosa and tongue with the aid of gauze padded tongue depressor and torch.
6.5 Place a gag well protected in the mouth: and wrap a gauze piece around forceps covering the tips completely.
6.6 Moist the gauze and dip it in a cleaning agent, swab each tooth gently; take care to clean sides of the teeth
6.7 To clean the inner and chewing surfaces of the teeth use a mouth gag
6.8 With mouth gag in position clean the tongue using gauze covered artery forceps. Wet the gauze only with a small amount of solution
6.9 Clean tongue from inner to outer aspect.
6.10 Rinse oral cavity:
- 6.10.1 Provide tap water to gargle mouth and position kidney tray.
- 6.10.2 If the client cannot gargle by him/herself. Rinse the areas using moistened cotton ball
- 6.10.3 Insert of rubber tip of irrigating syringe into the client's mouth and rinse gently with a small amount of water.
- 6.10.4 Instruct to spit the contents into kidney tray. If the client cannot spit up, especially in the case of unconscious client, perform suction.

6.11 Confirm the condition of client's teeth, gums, mucosa and tongue.
6.12 Wipe mouth and around it. Apply emollients by using foam swab or gauze piece with artery forceps.

7.0 Post Procedure

7.1 Make the client comfortable
7.2 Clean, dry and replace the equipment in its proper place.
Wash hands then document and record the time and date when procedure was done, observation made and client's condition during and after the procedure.

PERFORMING BED BATH

1.0 Meaning:

1.1 Bed bath refers to the procedure of giving bath to a patient who is confined to bed and is not physically or mentally capable of self- care.

2.0 Purpose/ Indication:

2.1 To prevent bacteria spreading on skin.
2.2 To clean the client's body.
2.3 To stimulate the circulation.
2.4 To improve general muscular tone and joint mobility.
2.5 To make client comfort and help to induce sleep.
2.6 To relieve fatigue.
2.7 To provide active and passive exercise.
2.8 Bedridden patients.
2.9 Patients with plaster cast and traction
2.10 Paralyzed patients.
2.11 Unconscious patients.
2.12 Post operative patients

3.0 Articles:

3.1 Basin 2
3.2 Bucket 2
3.3 Jug 1
3.4 Soap with soap dish 1
3.5 Sponge cloth 2
3.6 Face towel 1
3.7 Bath towel 2
3.8 Gauze piece 2-3
3.9 Mackintosh 1
3.10 Trolley 1
3.11 Bath or lotion Thermometer 1
3.12 Paper bag 2
3.13 Nail cutter
3.14 Comb and oil
3.15 Set of patients clothes
3.16 Screen/ curtain
3.17 A laundry bag

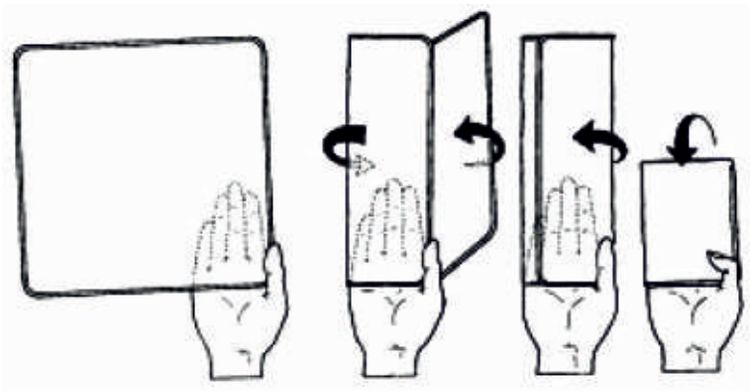
4.0 Pre procedure:

4.1 Assess the patients need for bathing and his ability for self care.
4.2 Arrange the articles required in the patient's unit.
4.3 Explain the patient regarding the sequence of the procedure.

4.4 Provide privacy by means of screen/ curtains.
4.5 Remove extra pillows and the backrest; keep one pillow under the patient's head, if condition permits.
4.6 Bring the patient to the edge of the bed nearer to the nurse.
4.7 Offer a bed pan urinal if necessary.
4.8 Remove the top linen, patient's clothes.
4.9 Replace the top linen with bath blanket/sheet.

5.0 Procedure:

5.1 Check client identification and condition.
5.2 Wash hands and wear gloves
5.3 Mix hot and cold water in the basin and check the temperature for tolerance (preferably to be checked with bath thermometer)
5.4 Assist the client to move toward the side of the bed where you will be working. Usually you will do most work with your dominant hand.
5.5 Face, neck, ears:
- 5.5.1 Put mackintosh and big towel under the Client's body from the head to shoulders. Place face towel under the chin which is also covered the top sheet.
- 5.5.2 Make a mitt with the sponge towel and moisten with plain water.



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- 5.5.3 Wash the client's eyes. Cleanse from inner to outer corner. Use a different section of the mitt to wash each eye.
- 5.5.4 Wash the client's face, neck, and ears.
- 5.5.5 Use soap on these areas only if the client prefers. Rinse and dry carefully.

5.6 Upper extremity:
- 5.6.1 Move the mackintosh and big towel to under the client's far arm.
- 5.6.2 Uncover the far arm.
- 5.6.3 Fold the sponge cloth and moisten.
- 5.6.4 Wash the far arm with soap and rinse. Use long strokes: wrist to elbow, elbow to shoulder, axilla, hand
- 5.6.5 Dry by face towel
- 5.6.6 Rinse and dry the hands thoroughly. Giving special attention to the skin between fingers and nails.

5.6.7 Move the mackintosh and big towel to under the near arm and uncover it.
5.6.8 Wash, rinse, and dry the near arm as same as procedure.

5.7 Chest and abdomen:
5.7.1 Move the mackintosh and bath towel under the upper trunk
5.7.2 Put another bath towel to cover the chest
5.7.3 Fold the sponge towel and moisten with one hand, lift the edge of the towel away from the chest. With mitten hand clean the chest using long firm strokes. Give special attention to the skin folds under the breast in a female patient, keep the chest covered between wash and rinse periods. Dry by the big towel covering.
5.7.4 Move the bath towel covering the chest to abdomen.
5.7.5 Fold the sponge cloth and moisten.
5.7.6 Wash abdomen with soap, rinse and dry
5.7.7 Keep the abdomen covered between washing and rinsing.
5.7.8 Cover the trunk with top sheet and remove the bath towel from the abdomen.

5.8 Exchange the warm water.

5.9 Turn the patient to the prone position or lying position place a towel length- wise along the clients side. Keep the patient draped by sliding a bath blanket over shoulder and thighs.

5.10 Back and buttocks:
Wash, rinse and dry back from the neck to buttocks, using long firm stokes. After drying the back give a thorough back rub with oil or powder longitudinally in circular movements. Pay special attention to all pressure points.

5.11 Return the client to the supine position.
5.12 Lower extremities:
- 5.12.1 Move the mackintosh and bath towel. Under the far leg. Put pillow or cushion under the bending knee. Cover the near leg with bath towel.
- 5.12.2 Place the basin on the towel and keep foot in the basin.
- 5.12.3 Fold the sponge cloth and moisten.
- 5.12.4 Wash with soap, rinse and dry using long firm strokes.
- 5.12.5 Direction to wash: from foot joint to knee from knee to hip joint
- 5.12.6 Repeat the same procedure on the near side.
- 5.12.7 At the end clean the foot under water, paying particular attention to the toes and nails.
- 5.12.8 Cover the lower extremities with top sheet Remove the cushion, mackintosh and big towel.

5.13 Perineal care: By exposing only genitalia, clean the perineum thoroughly and dry. Give special attention to skin folds. The patient can do it himself if he is able to do so.
5.14 Assist the client to wear clean cloth.

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6.0 Post procedure:

6.1 Make the bed tidy and keep the client in comfortable position.
6.2 Check the IV flow and maintain it with the speed prescribed if the client is given IV.
6.3 Document on the chart with your signature and report any findings to senior staff.
6.4 Take all the articles to the utility room, clean them with soap and water. Dry them and replace at their respective places
6.5 Disinfect the linen and other articles in case the patient is suffering from any communicable disease
6.6 Cut short finger and toe nails
6.7 Apply oil and comb the hair

PERFORMING BACK CARE

1.0 Meaning:

1.1 Back care means cleaning and massaging an individual's back as a therapeutic and comfort measure.

2.0 Purpose/Indication:

2.1 To prevent bed sore
2.2 To improve circulation to the back
2.3 To detect early signs of pressure sore
2.4 To refresh the mood and feeling of the patient
2.5 To relieve from fatigue, pain and stress
2.6 To care for bedridden clients

3.0 Contraindication:

3.1 Patients with pulmonary embolism
3.2 Any open wounds on the back
3.3 Burns patients.
3.4 Patients with fracture of the ribs or vertebral column.

4.0 Articles:

4.1 Screen
4.2 Mackintosh with cover
4.3 Fresh bed linen and the patient's cloth
4.4 A small basin - 1
4.5 Sponge cloth - 2
4.6 Soap dish with soap
4.7 Oil / Body lotion
4.8 Powder
4.9 A towel
4.10 Warm water
4.11 Bucket - 1
4.12 Gauze pieces - 2

5.0 Pre Procedure

5.1 Explain the procedure to the client.
5.2 Provide privacy by placing the screen.

6.0 Procedure:

6.1 Place the patient in a lateral or prone position
6.2 Expose the patent's back, shoulders, upper arm and buttocks. Cover the remainder of the body with a bath blanket. Spread mackintosh and towel alongside the patient's back.
6.3 Perform hand hygiene in warm water
6.4 Lather soap by sponge towel. Wipe with soap and rinse with plain warm water from cervical spine to coccyx.
6.5 Apply some lotion or oil into your palm. Apply the oil or the lotion in circular motion. Massage the clients back using following steps

6.5.1 Effleurage - firm and light stroke with palmer surface of hand without dragging the skin
6.5.2 Petrissage - kneading with the finger tips applied slowly and rhythmically
6.5.3 Friction - apply deep direct pressure to one particular site using palmer surface
6.5.4 Tapotment-cupping fast and stimulating movement of massage

6.6 Apply talcum powder on the back
6.7 Remove the mackintosh and towel, put the patient's clothes and make him comfortable.

7.0 Post Procedure

7.1 Replace all equipments in proper place. Remove the screen, take the articles to the utility room, wash and replace.
7.2 Perform hand hygiene.
7.3 Document on the chart with your signature, including date, time and the skin condition. Report any findings to senior staff.

SHAMPOOING (HEAD BATH)

1.0 Meaning:

1.1 The action of cleaning a patient's hair and scalp in the bed provided to a client who cannot clean the hair.

2.0 Purpose / Indication:

2.1 To keep the hair clean and healthy.
2.2 To have a sense of well- being.
2.3 To prevent hair loss and promote growth.
2.4 To prevent accumulation of dust, dandruff and oil.
2.5 To prevent itching and infection.
2.6 Patients who are unconscious.
2.7 Bed ridden patients.
2.8 Pre operatively or before any procedures like EEG.

3.0 Contraindications:

3.1 For clients with increased Intracranial pressure and cerebro spinal fluid leak.
3.2 Clients having open lesions or incisions of face, head or neck
3.3 Cervical neck injury.
3.4 Presence of tracheostomy.
3.5 Severe facial edema.
3.6 Respiratory distress.

4.0 Articles:

4.1 Gloves
4.2 Bath towels-2
4.3 Wash cloth or face towel
4.4 Bath blanket-1
4.5 Mackintosh-1
4.6 Kelly's pad
4.7 Cotton balls and gauze pieces in a bowl
4.8 Oil
4.9 Shampoo or liquid soap
4.10 Hair comb
4.11 A kidney tray and the paper bag
4.12 Basin-1, mug-1
4.13 Bucket-1
4.14 Jugs-2
4.15 Hair dryer (optional)
4.16 Hair conditioner (optional)

5.0 Pre procedure:

5.1 Explain the procedure to the client.
5.2 Collect and arrange articles conveniently at bed side.
5.3 Provide privacy.
5.4 Close windows and put off the fan
5.5 Remove the top linen after covering the patient with the bath blanket.
5.6 Keep the patient diagonally and place a pillow under the shoulder to tilt the head.
5.7 Cover the pillow with mackintosh and towel.
5.8 Make an improvised trough with mackintosh and paper and place it under the head of the patient, to facilitate drainage of water into bucket.
5.9 Plug ears with cotton balls and cover the eyes with the sponge cloth.

6.0 Procedure:

6.1 Perform hand hygiene
6.2 Put another pillow or a cushion under the bending knee.
6.3 Brush and comb hair
6.4 Maintain water at about 43^0 C to 44^0 C or 110^0 to 115^0 F.
6.5 Wet the hair by warm water and wash it roughly.
6.6 Apply soap or shampoo and massage the scalp well while washing the hair using fingernails
6.7 Work upward with both hands. Start at hairline and work towards the back of the neck. Lift head with one hand slightly and wash the back side of the head.

6.8 Rinse the hair and reapply shampoo for a second washing, if indicated and rinse the hair.

6.9 Wrapping the hair:
- 6.9.1 Remove the cotton balls from the ears; discard into the paper bag and mackintosh with the towel from the client's neck.
- 6.9.2 Wrap the hairs in the big towel which are used to cover the client's neck.

6.10 Drying the hair:
- 6.10.1 Wipe the face and neck and dry the hair as quick as possible.
- 6.10.2 Massage the scalp with oil as required
- 6.10.3 Comb the hair and arrange the hair according to the client's preference
- 6.10.4 Make the client tidy and provide comfortable position

7.0 Post procedure

7.1 Clean the equipments and replace them to proper place.
7.2 Perform hand hygiene
7.3 Document the condition of the scalp, hair and any abnormalities on the chart. Report any abnormalities to senior staff or doctors.

CARE OF EYES

1.0 Meaning:

1.1 It is the act of cleaning the eye using aseptic technique.

2.0 Purpose/ Indication:

2.1 To clean the eye
2.2 To remove the irritating discharges from the eye
2.3 To prepare the eyes for any treatment
2.4 To prevent infection
2.5 Unconscious clients needs frequent eye care.

3.0 Contraindications:

3.1 Corneal abrasions
3.2 Recent eye trauma/surgery

4.0 Articles:

4.1 Clean wash cloth - 1
4.2 Sterile bowl with sterile cotton swab - 1
4.3 Normal saline
4.4 Sterile glove - 1
4.5 Gauze piece
4.6 Eye patch - 1
4.7 Eye medication or lubricant according to physicians order

5.0 Pre procedure:

5.1 Check the physician's order
5.2 Identify the patient
5.3 Prepare the articles required
5.4 Ensure privacy
5.5 Ensure adequate light source taking care not to dazzle the patient

6.0 Procedure:

6.1 Explain the procedure to the patient.
6.2 Position the patient comfortably, preferably supine position
6.3 Place the mackintosh and towel under the head
6.4 Wash and dry the hands
6.5 Wet cotton swabs with sterile normal saline
6.6 Gently swab the inner canthus of the eye to the outer canthus

6.7 In case of one eye infection, clean the unaffected eye first and then the infected.
6.8 One stroke with each swab until all the discharge has been removed
6.9 Gently dry the patient's eyelids
6.10 Repeat the same for the other eye
6.11 Lubricating eye drops maybe given according to the physicians order.
6.12 Ensure that the patient is comfortable

7.0 Post procedure:

7.1 Wash hands and dry
7.2 Replace the articles safely
7.3 Document the procedure appropriately and report any abnormal findings

EYE IRRIGATION

1.0 Meaning:

1.1 Eye irrigation is rinsing the eyes with large amount of saline solution.

2.0 Purpose/Indication:

2.1 To clean and remove secretions
2.2 To relieve inflammation, congestion and pain
2.3 To remove foreign bodies
2.4 To apply medication
2.5 To wash eyes when exposure to acidic or alkaline chemicals

3.0 Contraindications:

3.1 Ruptured globe

4.0 Articles:

4.1 Eye dropper - 1
4.2 Syringe or plastic bottle with the prescribed solution and an IV set with attached tubing -1
4.3 Bowl with solution -1
4.4 Sterile wet swabs in bowl - 1
4.5 Sterile cotton balls
4.6 Small towel
4.7 Mackintosh - 1
4.8 Kidney tray and paper bag
4.9 I.V stand - 1

5.0 Pre Procedure:

5.1 Explain the procedure to the patient
5.2 Prepare the articles and keep near the patient's bed side
5.3 Provide supine position or sitting position

6.0 Procedure:

6.1 Place the mackintosh and towel under the head
6.2 Place kidney tray on the affected side of the face with convex side near the eye to receive the outflow
6.3 Wash hands
6.4 Clean eyelids and eyelashes from the inner canthus to the outer canthus using sterile wet swabs(one for each stroke)
6.5 Irrigate the eye using irrigator

6.6 Test the temperature of the irrigation solution by pouring some fluid on the back of your hand and ask the client to close the eye and pour a little solution on eyelids
6.8 Pull down the lower eyelid with the index finger.
6.9 Instruct the client to look up, avoid touching the eye with nozzle held 2cm above the eye.
6.10 Allow irrigating fluid to flow from the inner canthus to the outer canthus
6.11 Irrigate the eye till the desired effect is achieved and repeat the procedure on other side

7.0 Post procedure:

7.1 Pat the eye and dry the face with a sterile small towel
7.2 Record the type and amount of fluid used as well as the effectiveness.
7.3 Discard the swabs.
7.4 Replace all the articles in proper place after proper washing.

EAR IRRIGATION

1. 0 Meaning:

1.1 Ear irrigation is a routine procedure used to remove ear wax and foreign materials from the ear.

2.0 Purpose/Indications:

2.1 To clean the auditory canal
2.2 To remove any foreign object
2.3 To relieve pain
2.4 Cerumen impaction

3.0 Contraindication

3.1 When the auditory canal is obstructed by a vegetable foreign body such as pea, grains, or corn kernel. These vegetable absorb moisture, causing them to swell.
3.2 Patient has a cold, fever, ear infection or unknown injury or rupture of the tympanic membrane.

4.0 Articles:

4.1 Irrigating syringe with prescribed solution
4.2 Swab stick
4.3 Gauze pad
4.4 Towel
4.5 Kidney tray
4.6 Mackintosh with towel
4.7 Otoscope speculum(if needed)
4.8 Torch

5.0 Pre Procedure:

5.1 Perform hand wash and gather the equipment and solutions required for the ear irrigation
5.2 Warm and test the solution by allowing a small amount of the fluid to run on the inner aspect of the wrist

6.0 Procedure:

6.1 Assist the patient to assume the sitting position with the patient's head tilted toward the opposite shoulder of ear to be irrigated.
6.2 Insert the otoscope speculum into the external ear canal.
6.3 Use a cloth swab stick to remove any discharges externally.
6.4 Straighten the external ear canal by gently pulling the auricle upward and backward for adults, and downward and backward for a child.

6.5 Observe and document the external ear canal for redness, swelling, drainage, or foreign bodies and the tympanic membrane for bulging, perforation, and color change.
6.6 Drape the patient's shoulder with absorbent pads under the affected ear; cover the shoulder and the upper arm area.
6.7 Cleanse the external ear and meatus at the entrance of the ear canal. Place one gauze pad in irrigation solution, wring out excess solution, and clean any debris from the external ear and the meatus of the auditory canal.
6.8 Fill the irrigating syringe and test the flow of solution from the syringe by expel a small quantity of solution back into the container.
6.9 Position the emesis basin and irrigate the patient's ear by directing a slow, steady stream of irrigating solution against the roof of the ear canal.
6.10 Use no more than 500cc of irrigating solution unless ordered.
6.11 Repeat steps until the irrigating solution returns free of wax or debris, and until the prescribed amount of solution has been used.
6.12 Dry the pinna of ear by using a small towel and make the patient comfortable.

7.0 Post Procedure:

7.1 Remove the emesis basin.
7.2 Instruct the Patient to tilt his head toward the affected side for a few minutes to allow any remaining solution to drain out of the ear and to dry the external ear.
7.3 Record the time of irrigation, the kind and amount of solution used, nature of the return flow, effect of the treatment and condition of the patient.

NASAL IRRIGATION

1. 0 Meaning:

1.1 It is the washing out of the nasal cavity by a sterile solution.

2.0 Purpose/ Indication:

2.1 To cleanse the nose
2.2 To apply heat
2.3 To relieve the congestion, swelling and pain.
2.4 Patients with acute or chronic nasal conditions, including post nasal surgeries.

3.0 Contra Indication:

3.1 Advanced destruction of the sinuses,
3.2 Frequent nosebleeds,
3.3 Foreign bodies in the nasal passages

4.0 Articles:

4.1 Bulb syringe or an irrigating device
4.2 Rigid or flexible disposable irrigation tips or an irrigating can with rubber tubing and clamp
4.3 Hypertonic saline solution
4.4 Mackintosh with towels

5.0 Pre Procedure:

5.1 Explain the patient how to breathe during the procedure.
5.2 Collect all the articles and bring it near the bedside.
5.3 Wash hands

6.0 Procedure:

6.1 Position the patient on a chair or a bed as comfortable.
6.2 Place a mackintosh with towel around the neck.
6.3 Irrigate the nose by maintaining steady and continuous stream of solution in one nostril and allow the fluid to return.
6.4 Irrigate till the desired effect is achieved.
6.5 Dry the nose and face using a small towel and make the patient comfortable.

7.0 Post Procedure:

7.1 Wash and Replace all the articles carefully.
7.2 Wash hands thoroughly.
7.3 Record the time, amount and the type of solution used, effectiveness of treatment.

CARE OF NAILS

1.0 Meaning:

1.1 Nail care is a nursing intervention defined as promotion of clean, neat, attractive nails and prevention of skin lesions related to improper care of nails.

2.0 Purpose/ Indication:

2.1 To maintain nail hygiene
2.2 To prevent inflammatory lesions, thick horny nails, ingrowing nails.
2.3 Unconscious/ Dependent Patient
2.4 To prevent infections and injury to tissues.
2.5 Patients who are not able to perform activities of daily living.

3.0 Contraindication:

3.1 In clients with peripheral vascular diseases, diabetes and neuropathy.
3.2 Individuals with impaired circulation.
3.3 Individuals with active leg ulcers.

4.0 Articles:

4.1 Nail cutter /nail clippers / with file
4.2 Soap in a dish
4.3 Mackintosh
4.4 Towel
4.5 Kidney tray
4.6 Cotton swab in a bowl
4.7 Wet swab in a bowl
4.8 Nail polish remover if required
4.9 Gloves
4.10 Basin with warm water

5.0 Pre Procedure:

5.1 Assess the condition of the nails
5.2 Assess for any signs of pain, tenderness, swelling, presence of ingrown nails.
5.3 Provide adequate light.
5.4 Wash hands

6.0 Procedure:

6.1 Explain the procedure
6.2 Assist client to bed side chair if possible

6.3 Place a mackintosh and towel on the bed
6.4 Place the basin with water on the bedside locker if the client is able to sit up and place hands in the water.
6.5 Instruct client to soak hands for 10 minutes
6.6 Remove hands from the water and dry thoroughly
6.7 Wipe the hands gently with the towel
6.8 Clip or trim the nails with cutter while protecting the surrounding tissues with cotton.
6.9 File or trim the nails with cutter.
6.10 Repeat the same for the other hand
6.11 Change the water
6.12 Place the mackintosh and towel under the feet
6.13 Place the basin with water on the mackintosh. Immerse the first foot in water for 15 minutes.
6.14 If the client can sit up on a stool place the basin of water on the floor or foot stool and instruct the client to immerse feet in water for 15 minutes.
6.15 Remove the basin and dry the feet.
6.16 Place the feet on the mackintosh
6.17 Trim the nail straight.
6.18 File the toe nails
6.19 Repeat the same for the other foot
6.20 Remove the basin and the mackintosh and make the client comfortable

7.0 Post Procedure:

7.1 Clean, dry and replace the equipment in its proper place
7.2 Clean and disinfect the nail cutter.
7.3 Record the date and time when procedure was done, observation made and client's condition during and after the procedure.

POSITIONING PATIENTS IN BED

1.0 Meaning:

1.1 Positioning is moving a patient into a specific posture.

2.0 Purpose/Indication:

2.1 To provide comfort to the patient
2.2 For maintaining alignment
2.3 For preventing bed sores, foot drop and contractures
2.4 Bedridden patients
2.5 Patients with decreased mobility related to a medical condition or treatment.

3.0 Articles:

3.1 Bedsheet to cover the patient
3.2 Pillows as needed
3.3 Back rest
3.4 Towel rolls
3.5 Blanket
3.6 Cardiac table
3.7 Bed cradle
3.8 Foot rest

4.0 Pre Procedure:

4.1 Explain the procedure to the patient.
4.2 Wash hands thoroughly.
4.3 Gather the supplies for the procedure.
4.4 Address the patient by name and introduce yourself.
4.5 Identify the patient
4.6 Explain the procedure to the patient.
4.7 Provide the patient with privacy.

5.0 Procedure:

5.1 Supine Position

- Center the patient face-up on a flat mattress.
- Make sure the arms and legs are straight and pointing toward the foot of the bed.
- Place a pillow beneath the patient's head and neck, keeping the head as level as possible.
- Place pillows or towel rolls on either side of the patient's hips to prevent rotating or twisting.
- Place a pillow or towel roll under the patient's knees.

5.2 Fowler's Position

5.2.1 Center the patient on a mattress in the supine position.

5.2.2 Make sure the hips are placed directly above the joint in the bed frame.

5.2.3 Raise the head of the bed between 30° and 90°.

5.2.4 Place a pillow behind the patient's head and neck.

5.2.5 Fold the patient's arms across the abdomen, and place pillows beneath the patient's elbows to elevate the shoulders.

5.2.6 Place pillows or rolled towels on either side of the patient's hips to prevent rotating or twisting.

5.2.7 Place a pillow or towel roll under the patient's knees.

5.3 Prone Position

5.3.1 Center the patient face-down on a flat mattress. Make sure the legs are straight and pointing toward the foot of the bed.

5.3.2 Gently turn the head to one side.

5.3.3 Place a pillow beneath the patient's head and neck, keeping the head as level as possible.

5.3.4 Ask the patient which position would be more comfortable: arms at the side or upward around the head. Then position the arms accordingly.
5.3.5 Place pillows or towel rolls on either side of the patient's hips to prevent rotating or twisting.
5.3.6 Place a pillow beneath the lower legs of the patient.

5.4 Sim's Position

5.4.1 Center the patient face-down on a flat mattress.
5.4.2 Gently turn the head to one side.
5.4.3 Place a pillow beneath the patient's head and neck, keeping them as level as possible.
5.4.4 Place the back arm down by the patient's side.
5.4.5 Bend the front arm up by the patient's head. Support the arm with a pillow.

5.4.6 Position the back leg so that it points toward the foot of the bed.
5.4.7 Bend the front leg so that it is sharply flexed in front of the patient. Support the leg with a pillow

5.5 Lateral Position

5.5.1 Assist the patient to the side of the bed that is opposite the side he or she will be facing when turned.

5.5.2 Raise the bed rail on the side the patient will be facing when turned.

5.5.3 Turn the patient onto the side, facing the correct direction. Keep both arms in front of the patient.

5.5.4 Place a pillow beneath the patient's head and neck, keeping them as level as possible.

5.5.5 Place pillow lengthwise behind the patient's back, and tuck it firmly behind the patient.

5.5.6 Position the patient's lower shoulder either slightly in front of the body or slightly behind the body, depending upon the patient's preference

5.5.7 Position the arms according to the patient's preference. Place a pillow in front of the chest to support the upper arm.

5.5.8 Position the lower leg so that it points toward the foot of the bed.

5.5.9 Bend the upper leg so that it is slightly bent in front of the lower leg.Place a pillow beneath the leg for support.

5.6 Trendelenburg position

5.6.1 Place the head of the bed lower than the feet using bed blocks or remote operated bed.

5.6.2 This position is used in situations such as hypotension and medical emergencies. It helps promote venous return to major organs such as the head and heart.

6.0 Post Procedure:

6.1 Cover the patient with a sheet or blanket as needed.

6.2 Make patient comfortable and safe and place the call signal within the patient's reach.

6.3 Wash hands.

6.4 Report all actions taken and any observations.

TRANSFERRING A PATIENT

1.0 Meaning:

1.1 It involves moving a patient from bed to any other facility.

2.0 Purpose/ Indication:

2.1 Dependant patients

3.0 Pre Procedure:

3.1 Perform hand hygiene.
3.2 Check room for additional precautions.
3.3 Introduce yourself to patient.
3.4 Confirm patient ID using two patient identifiers.
3.5 Listen and attend to patient cues.
3.6 Ensure patient's privacy and dignity.
3.7 Assess ABC's/suction/oxygen/safety.
3.8 Ensure tubes and attachments are properly placed prior to the procedure to prevent accidental removal.
3.9 Ensure patient has a draw sheet or a friction-reducing sheet on the bed prior to repositioning.

Use of Body mechanics while transferring patients.

4.0 Procedure:

4.1 Moving a Patient

- 4.1.2 Raise the bed and lock the wheels.
- 4.1.3 Stand on either side of the bed with feet shoulder width apart, knees bent, and back in a neutral position.
- 4.1.4 Keep your knees bent, with equal weight placed on both feet. Tighten the stomach and back muscles to maintain a correct support position.
- 4.1.5 To support the patient use muscles of arms and use your leg muscles as you lift the person
- 4.1.6 Roll the sides of the draw sheet up to the person's body.
- 4.1.7 Hold on to the draw sheet with your palms facing up.
- 4.1.8 Count"1-2-3"before shifting your body weight from the back to the front leg. Keep arms and back in a locked position. Slide the person smoothly up the bed.
- 4.1.9 Place pillows under the patients head.
- 4.1.10 Ensure the patient is in a comfortable position.
- 4.1.11 When turning, pivot body by turning on one foot. Do not twist the body.
- 4.1.12 Breathe deeply and keep shoulders relaxed but not hunched.

4.2 Lifting of the Patient:

- 4.2.1 Never lift more than you can comfortably handle.
- 4.2.2 Create a base of support first. Stand with your feet at shoulder width apart and place one foot a half-step ahead of the other.
- 4.2.3 Do not use your back to do the heavy lifting. The back muscles are not your strongest muscles. Use your legs.
- 4.2.4 If the bed is low, place one foot on a footstool. This will relieve the pressure on your lower back.



4.2.5 Whenever possible, mechanical safe patient handling devices should be used to lift patients.
4.2.6 Manual lifting should not be performed unless use of a mechanical lift is medically contraindicated, there is immediate danger to the patient, or there is no feasible alternative.
4.2.7 Use upright, neutral working postures and proper body mechanics.
4.2.8 Move obstructions out of the way before lifting.
4.2.9 When lifting or moving patient, always face the patient.
4.2.10 Never twist the back when lifting.
4.2.11 Try to keep the person, equipment, or supplies you are lifting close to your body
4.2.12 Keep handholds between waist and shoulders.
4.2.13 Move the person towards you, not away from you.
4.2.14 Use slides and lateral transfers instead of manual lifting.
4.2.15 Use a wide, balanced stance with one foot slightly ahead of the other.
4.2.16 Lower the patient slowly by bending legs. Return to an erect position as soon as possible.
4.2.17 Use smooth movements and do not jerk.
4.2.18 When lifting with others, coordinate lifts by counting down and synchronizing the lift.

4.3 Transferring a patient:
4.3.1 Transferring a patient in and out of bed is an important caregiver activity.
4.3.2 Place the wheelchair at a 45° angle to the bed
4.3.3 Lock the wheels of the chair and the bed.
4.3.4 Explain the procedure to the patient.
4.3.5 Assist the patient to be seated in a fowler's position while his legs are over the edge of the bed.
4.3.6 Let the patient rest a while if the patient feels dizzy.
4.3.7 Use a transfer belt or take help from another caregiver if the person needs a lot of support.
4.3.8 Help the patient stand with support.
4.3.9 Get the patient to reach for the arms of the chair and pivot body slowly.
4.3.10 Support him with arms and knees as needed.
4.3.11 Adjust the patient comfortably in the chair.

RESTRAINTS

1.0 Meaning:

1.1 Restraint is defined as 'the intentional restriction of a person's voluntary movement or behavior'. They are physical, chemical or environmental measures used to control the physical or behavioral activity of a person or a portion of his/her body.

2.0 Purpose/Indication:

2.1 To prevent client's from falling.
2.2 To prevent interruption of therapy
2.3 To reduce the risk of injury to others.
2.4 When patient is a danger to self or others.
2.5 When patient requires to be immobilized temporarily to perform a procedure.

3.0 Articles:

3.1 Restraints as indicated
3.2 Comfort devices as needed

4.0 Pre Procedure:

4.1 Explain type of restraint and reason for its use.
4.2 Follow Hospital Policy for using restraints.
4.3 Obtain Informed consent from patient or family as needed.

5.0 Procedure:

5.1 Obtain properly sized restraint.
5.2 Pad bony prominences before applying restraint.
5.3 Tie knots so that restraints can be released quickly in an emergency.
5.4 Do not tie restraints to a side rail; ties to bed frame or chair frame.
5.5 Adjusts restraint to maintain good body alignment, comfort, and safety.
5.6 Assess that restraints are snug enough to prevent them from slipping off, but not tight enough to impair blood circulation.
5.7 Change the restraint when it becomes soiled or damp
5.8 At least every 2 hours, release restraints and provide skin care, passive and active range of motion, ambulation, and toileting.
5.9 Check restraints every 30 minutes.
5.10 At least every 2 hours, assess circulation, skin integrity, and need for continuing restraint.

6.0 Post Procedure:

6.1 Document and fill restraint form with the following details:
- 6.1.1 Date and time restraint is initiated.
- 6.1.2 Date of assessment
- 6.1.3 Reason for restraint
- 6.1.4 Alternative methods attempted prior to restraint and attempts to discontinue restraint
- 6.1.5 Date and time restraint is discontinued

OXYGEN ADMINISTRATION

1.0 Meaning:

1.1 Oxygen administration is a method by which oxygen is supplemented at higher percentages than what is available in atmospheric pressure.

2.0 Purpose/ Indication

2.1 Any case of documented hypoxia/ hypoxemia as determined by SpO2 levels and PaO2 levels.
2.2 During Perioperative period

3.0 Contraindications:

3.1 In adults:
- 3.1.1 Carbondioxide narcosis.
- 3.1.2 Oxygen toxicity.

3.2 In children:
- 3.2.1 Retrolental fibroplasias
- 3.2.2 Carbondioxide narcosis.
- 3.2.3 Atelectasis

4.0 Articles:

4.1 Client's chart
4.2 Oxygen supply with regulator, flow meter, humidifier and connecting tube (central supply/ oxygen cylinder) A tray containing:
4.3 Oxygen administration devices(simple facemask, cannula or venturi masks)
4.4 Swab sticks
4.5 Normal saline/ distilled water
4.6 Bowl of water
4.7 Kidney tray

5.0 Pre Procedure

5.1 Wash hands.
5.2 Explain the procedure.
5.3 Fill the humidifier with sterile / distilled water.
5.4 Position the client in semi fowler's position if not contraindicated.

6.0 Procedure

6.1 Clean the nostrils.
6.2 Select appropriate oxygen delivering device.
6.3 Connect the tubing to the source of oxygen.

6.4 Open the regulator.
6.5 Connect the oxygen tubing to the oxygen administration device.
6.6 Open the regulator and allow the oxygen to flow at the prescribed rate.
6.7 Secure the oxygen administration device.

7.0 Post Procedure

7.1 Make the client comfortable.
7.2 Monitor the vital signs.
7.3 Clean, dry and replace the equipment in its proper place.
7.4 Wash hands.
7.5 Record the date and time when the procedure was done, observation made and client's condition during and after the procedure.
7.6 Record the method of oxygen administration, if continuous/ intermittent and the flow rate.

STEAM INHALATION

1.0 Meaning:

1.1 It is the act of drawing in moist air into the lungs in the form of water vapour.

2.0 Purpose/ Indication:

2.1 To soften thick, tenacious mucus and help it's expulsion from the respiratory tract.
2.2 To provide heat and moisture.
2.3 To prevent dryness of the mucus membranes of the lungs and upper respiratory passage.
2.4 To relieve spastic condition of the larynx and bronchi.

3.0 Articles:

3.1 Steam inhaler with steaming water (electric/ plastic)
3.2 Cotton sheet
3.3 Bath towel
3.4 Sputum mug with disinfectant solution
3.5 Stethoscope

4.0 Pre Procedure:

4.1 Identify the client and check the diagnosis.
4.2 Assess the general condition of the client.
4.3 Assess the level of consciousness of the client.
4.4 Ensure that the client has voided prior to the procedure.
4.5 Wash hands.
4.6 Explain the procedure.
4.7 Fill the inhaler with water below the spout.

5.0 Procedure:

5.1 Make the client to sit on a chair or on the bed, if not contraindicated
5.2 Place the electric steam inhaler in the foot end of the bed on the floor or on a low table according to the design, with the source of steam as close as permissible.
5.3 Plug the electric steam inhaler to the source of electricity. Switch off the fan.
5.4 Spread a sheet across and over the client and on the spout of the steam inhaler. Instruct the client to take deep breath, hold his breath briefly and then exhale.
5.5 Remain with the client and observe carefully.
5.6 Encourage the client to remain inside the sheet for about 15-20 minutes, depending on the source and amount of steam.
5.7 Unplug the inhaler once the procedure is completed.
5.8 Wipe the client thoroughly and keep him/her warm.

6.0 Post Procedure:

6.1 Make the client comfortable.
6.2 Provide chest physiotherapy and encourage client to cough out secretions.
6.3 Auscultate client's chest for abnormal breath sounds. Report the findings.
6.4 Clean, dry and replace the equipment in its proper place.
6.5 Wash hands.

GASTRIC GAVAGE

1.0 Meaning:

1.1 Gastric gavage is an artificial method of giving fluids and nutrients through a tube that has been passed into the oesophagus and stomach through the nose, mouth or through an opening made on the abdominal wall.

1.2 Types of gastric gavage:
- 1.2.1 Nasogastric tube feeding
- 1.2.2 Oro- gastric feeding
- 1.2.3 Gastrostomy tube feeding

2.0 Purposes / Indications:

2.1 To introduce liquid food into the stomach in order to meet nutritional needs of patients who are unable to meet their nutritional needs.

3.0 Contraindication:

3.1 Gastric surgery
3.2 Trachea esophageal fistula.
3.3 Paralytic ileus
3.4 Acute abdomen.
3.5 NPO status

4.0 Articles:

4.1 Ryle's tube
4.2 Large syringe.
4.3 Water in a container.
4.4 Stethoscope.
4.5 Kidney tray.
4.6 Towel
4.7 Clean gloves.
4.8 Measuring cup.

5.0 Pre Procedure:

5.1 Provide privacy.
5.2 Explain the procedure and reassure him to win his confidence and co-operation.
5.3 Remove the dentures.
5.4 All equipment used for feeding should be clean.
5.5 The feed has to be prepared, under hygienic conditions.
5.6 Every time before giving the feed, make sure that the tube is in the stomach.
5.7 Warm the feed to room temperature before administration.
5.8 Assemble all equipments.

6.0 Procedure (Orogastric Feeding/ Nasogastric Feeding):

6.1 Position the client with the head of the bed elevated at least 30 - 45^0 angle
6.2 Spread towel and mackintosh over clients chest
6.3 Determine placement of feeding tube
6.4 Before giving the feed connect funnel a syringe, pour some water through it and lower the funnel slowly so as to expel air
6.5 Hold the funnel or syringe 8 inches above the bed
6.6 Slowly introduce feed into the funnel or syringe barrel, keep it full until total amount had been introduced
6.7 When the required quantity of food is administered then introduce small amount of water to flush the tube
6.8 Disconnect the funnel or syringe barrel and clamp the tube to prevent the leakage of the fluid
6.9 Tube may be removed or left in place
6.10 Remove the mackintosh and towel. Keep the head of the bed elevated for 30-60 minutes after feeding.

7.0 Post Procedure

7.1 Clean & replace the articles
7.2 Wash hands
7.3 Document the procedure
7.4 Provide frequent mouth care

WOUND DRESSING

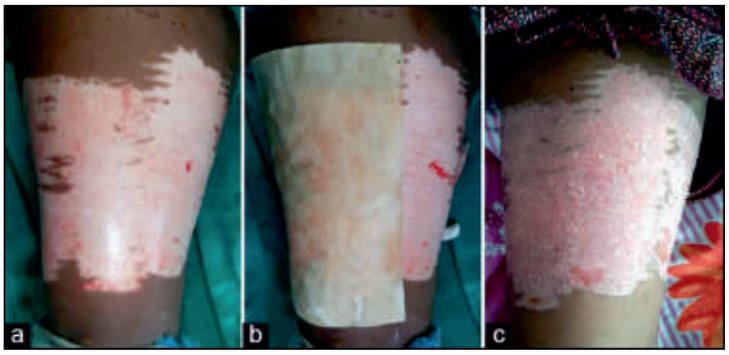
1.0 Meaning:

1.1 Wound dressing refers is cleansing a wound or incision and application of sterile protective covering using aseptic technique. .

2.0 Purposes/Indication:

2.1 To prevent infection
2.2 To prevent further tissue damage
2.3 To promote healing
2.4 To absorb inflammatory exudates and to promote drainage
2.5 To prevent hemorrhage
2.6 To prevent skin excoriation
2.7 To apply medications in place

3.0 Articles:



3.1 Dressing set
3.2 Dressing bin
3.3 Sterile towels
3.4 Gloves
3.5 Cheatle forceps
3.6 Mask
3.7 Sterile scissors
3.8 Cleaning solutions
3.9 Medications as per order
3.10 Culture tube
3.11 Mackintosh
3.12 Adhesive tape & scissors
3.13 Bandages
3.14 Sterilium
3.15 Kidney tray / waste disposal containers

4.0 Pre Procedure:

4.1 Identify the client and explain the procedure.
4.2 Assess the general condition of the client, the site, type and condition of the wound.
4.3 Determine the type of dressing to be applied
4.4 Administer an analgesic as prescribed.
4.5 Provide privacy
4.6 Provide a well-lighted area
4.7 Maintain a sterile field.
4.8 Wash hands & wear clean gloves.

5.0 Procedure:

5.1 Place the mackintosh under the client at the site of the wound
5.2 Position the client as required
5.3 Drape the client appropriately
5.4 Removal of old dressing

5.5 5.5.1 Open the dressing tray
5.5.2 Pour the cleaning solution and place adequate dressing material in the dressing tray by using cheatle forceps.
5.5.3 Wash hands wear sterile gloves.

5.6 Obtain swab or tissue for culture and sensitivity, if required.

5.7 Dip a gauze piece into the cleaning solution & squeeze off excess solution

5.8 Wound care:
5.8.1 Clean wound: clean the wound from inside or from the center towards outside with each stroke.
5.8.2 Infected wound: clean the wound from outside towards inside with each stroke.
5.8.3 Transverse or horizontal incision: clean the wound from the center towards outside on either side with each stroke.
5.8.4 Vertical incision: clean the wound from top to downwards with one stroke & towards outside on either side in the same vertical direction.

5.9 Remove drains or sutures / clips, if required.
5.10 If the wound has got copious drainage, the wound should be squeezed from both sides by using sterile gauze pieces.
5.11 Use a fresh swab for each stroke.
5.12 Dry the wound with dry swabs in the same manner.
5.13 Apply medications on the wound, if required.
5.14 Ensure the drain is in position.
5.15 Apply dry sterile dressing.
5.16 If the client is ambulatory and has excessive drainage, additional dressing can be placed at the lowest portion of the wound.
5.17 Remove gloves and mask
5.18 Secure the dressing with adhesive tape or with bandage.
5.19 Discard the waste in the appropriate container.

6.0 Post Procedure:

6.1 Make the client comfortable
6.2 Assess the client's response to the wound dressing
6.3 Replace the articles
6.4 Send the specimen to the lab with appropriate client identification
6.5 Wash hands.
6.6 Document the procedure.

BANDAGES

1.0 Meaning:

1.1 Bandages are strips of material used to bind up injuries.

2.0 Purpose:

2.1 To support and immobilize the injured parts.
2.2 To prevent infection and contamination of wound.
2.3 To control hemorrhage

3.0 Articles:

3.1 Appropriate size bandages
3.2 Safety pins or metal pins to secure the bandage

4.0 Pre Procedure

4.1 Identify and explain the procedure.
4.2 Make the patient comfortable.
4.3 Keep the injured part supported.

5.0 Procedure:

5.1 Simple Spiral:
Spiral bandages are used to bandage upper & lower limbs of the body.
- 5.1.1 Make two circular turns to anchor the bandage.
- 5.1.2 Continuous spiral turns at about a 30 degree angle, each turn, overlapping the preceding one by two third the width of the bandage.
- 5.1.3 End the bandage with two circular turns and secure with tape, metal clips or safety pin over an uninjured area.

5.2 Spiral reverse turns:
Spiral reverse turns are used to bandage the cylindrical part of the body.
- 5.2.1 Make two circular turns to anchor the bandage and bring the bandage upward at about 30 degree angle.
- 5.2.2 Place the thumb of the free hand on the upper edge of the bandage.
- 5.2.3 Unroll the bandage around about 15 cm (6 inches) then turn the hand so that the bandage falls over itself.
- 5.2.4 Continue the bandage around the limb, overlapping each previous turns by two- thirds the width of the bandage.
- 5.2.5 End the bandage with two circular turns and secure with tape, metal clips or safety pin over an uninjured area.

5.3 Circular:
Used chiefly to anchor bandages or to bandage certain areas, such as the proximal aspect of a finger or a wrist.

5.3.1 Apply the end of bandage to the part of the body to be bandaged.
5.3.2 Encircle the body part a few times or as close as needed, each turn directly covering the previous turn.
5.3.3 Secure the end of the bandage with tape, metal clips or safety pin over an uninjured area.

5.4 Spica:
Spica is a form of figure of eight in which one turn is very much larger than the other. It is used for joints at right angles to the body.
5.4.1 Lay the outer side of the bandage on the inner side of the joint and take two straight turns carrying the bandage over the joint tip and around the joint.
5.4.2 Make a second turn.
5.4.3 Ensure the first turn is covered 1/3rd of the width of the bandage below and above.
5.4.4 Continue bandaging, covering 2/3rd of the previous turn until the entire dressing is secured.
5.4.5 Complete bandaging by taking two circular turns above and secure it with safety pins or tape.

6.0 Post Procedure:

After applying bandages:
6.1 Check the circulation in a bandaged limb every 10 minutes.
6.2 Ensure the blood flow is not impeded.
6.3 Check for capillary refill.
6.4 Wash hands.
6.5 Document the procedure.

COLLECTING BLOOD, SPECIMEN FOR CULTURE & SENSITIVITY

1.0 Meaning

1.1 Collecting of blood specimen for culture is a sterile procedure to obtain blood specimen.

2.0 Purpose

2.1 To identify disease-causing organisms
2.2 To detect the right antibiotics to kill the particular microorganisms

3.0 Articles

3.1 Sterilized syringes with needles (10 mL): 2-3
3.2 Tourniquet 1
3.3 Blood culture bottles
3.4 Spirit swabs
3.5 Dry gauze
3.6 Disposable gloves
3.7 Adhesive tape or bandages
3.8 Sharps Disposal Container 1

4.0 Pre - Procedure

4.1 Identify the client & explain the procedure.
4.2 Assemble the necessary equipment appropriate to the client's physical characteristics.
4.3 Label all tubes or specimen bottles with client name, age, sex, inpatient no. date and time.

5.0 Procedure

5.1 Perform hand hygiene and put on gloves.
5.2 Protect the bed with a pad under the client's arm
5.3 Place the arm with proper position and clean around the cannulation site to draw the blood.
5.4 Place the specimen into the container with strict sterile technique & close the container tightly.
5.5 Close the container promptly and tightly.

6.0 Post Procedure

6.1 Place a sterile gauze pad & secure with a tape.
6.2 Send the sample to lab & document the procedure.
6.3 Replace the articles.

COLLECTING URINE SPECIMEN

1.0 Meaning

1.1 Collection of urine to obtain a specimen for diagnostic purposes.

2.0 Purpose

2.1 To diagnose illness
2.2 To monitor the disease process
2.3 To evaluate the efficacy of treatment

3.0 Articles

3.1 Sterile container with lid or cover 1: wide-mouthed container is recommended
3.2 Bedpan or urinal 1: as required
3.3 Disposable gloves 1: if available
3.4 Toilet paper

4.0 Pre Procedure

4.1 Label specimen containers or bottles before the client voids.
4.2 Note on the specimen label if the female client is menstruating at that time.

5.0 Procedure

5.1 Explain the procedure & provide labelled container to the client
5.2 Instruct the client to collect midstream urine in the container.

6.0 Post Procedure

6.1 Send the specimen bottle or container to the laboratory immediately with the specimen form.
6.2 Document the procedure in the designated place and mark it off on the Kardex.

COLLECTING STOOL SPECIMEN

1.0 Meaning

1.1 Collection of faecal matter to obtain a specimen for diagnostic purpose.

2.0 Purpose

2.1 To identify specific pathogens
2.2 To determine presence of ova and parasites
2.3 To determine presence of blood and fat
2.4 To examine for stool characteristics such as color, consistency and odor

3.0 Articles

3.1 Closed specimen container with label
3.2 Spatula

4.0 Pre Procedure

4.1 Explain the procedure and provide the labelled container.

5.0 Procedure

5.1 Instruct not to contaminate specimen with urine
5.2 Instruct the patient to use spatula to transfer the stool to container
5.3 Cover the container

6.0 Post procedure

6.1 Send the specimen bottle or container to the laboratory immediately with the specimen form.
6.2 Document the procedure.

COLLECTING A SPUTUM SPECIMEN

1.0 Meaning

1.1 Collecting a sputum specimen is defined as a sample of material expelled from the respiratory passage which is collected to determine the presence of pathogen.

2.0 Purpose

2.1 To diagnose respiratory infection
2.2 To assess the efficacy of treatment to diseases

3.0 Articles

3.1 Sterile covered & labelled sputum container 1
3.2 Paper tissues as required

4.0 Pre Procedure

4.1 Identify & explain the procedure to the client and ask the client to rinse the mouth with plain water.

5.0 Procedure

5.1 Instruct the client to cough up secretions from deep in the respiratory passage.
5.2 Have the client expectorate directly into the sterile container.
5.3 Instruct the client to wipe around mouth if needed. Discard it properly
5.4 Close the specimen immediately

6.0 Post procedure

6.1 Send the specimen bottle or container to the laboratory immediately with the specimen form.
6.2 Document the procedure.

INSTILLATION OF MEDICINE INTO THE EYE

1.0 Meaning

1.1 It is the dispensation of medicine into the eye.

2.0 Purpose/ Indications

2.1 To contract or dilate the pupil.
2.2 To relieve pain and discomfort
2.3 To combat infection and inflammation.
2.4 For moistening the eye.
2.5 Eye infections like conjunctivitis.
2.6 Pre and post surgery e.g. cataract
2.7 Glaucoma
2.8 Dry eye

3.0 Articles

3.1 Dressing tray with sterile cotton swab, sterile eye pad & eye shield
3.2 Normal saline
3.3 Prescribed medicine (drops or ointment)
3.4 Gloves
3.5 Kidney tray
3.6 Medication card
3.7 Client's chart

4.0 Pre Procedure

4.1 Identify the client & explain the procedure.
4.2 Use separate eye dropper for different medicines.
4.3 Take only the required amount of medicine in the dropper.
4.4 Wash hands
4.5 Perform the procedure in a well lighted area.

5.0 Procedure

5.1 Position the client in supine position with a pillow below the shoulders.
5.2 Wash hands & wear gloves.
5.3 Take a wet saline swab and clean the eye from inner canthus to outer canthus.
5.4 Discard the swab.
5.5 Open the medicine bottle (dropper) & hold it 2cm above the eye.
5.6 Gently pull the lower eyelid down and instruct the client to look up.
5.7 Instill prescribed drops into the center of the eyelid.
5.8 Instruct the client to close the eyelids and roll eyeballs from side to side.
5.9 Hold a cotton ball over the inner angle of the eye.

5.10 Wipe off the overflow of the medicine.
5.11 Cover the eye with sterile eye pad and shield if required.
5.12 Remove gloves.

6.0 Post Procedure

6.1 Make the client comfortable
6.2 Instruct the client not to touch the eye/ eye dressing
6.3 Instruct to inform if any adverse reaction occurs.
6.4 Clean, dry and replace the equipment in its proper place.
6.5 Wash hands.
6.6 Document the procedure.

INSTILLATION OF MEDICINE INTO THE EAR

1.0 Meaning

1.1 Instillation of medicine into the auditory canal.

2.0 Purpose/ Indication

2.1 To soften the ear wax.
2.2 To reduce inflammation and infection.
2.3 To create an anaesthetic effect.
2.4 Patients with conditions like otitis media

3.0 Contraindication

3.1 Perforated tympanic membrane

4.0 Articles

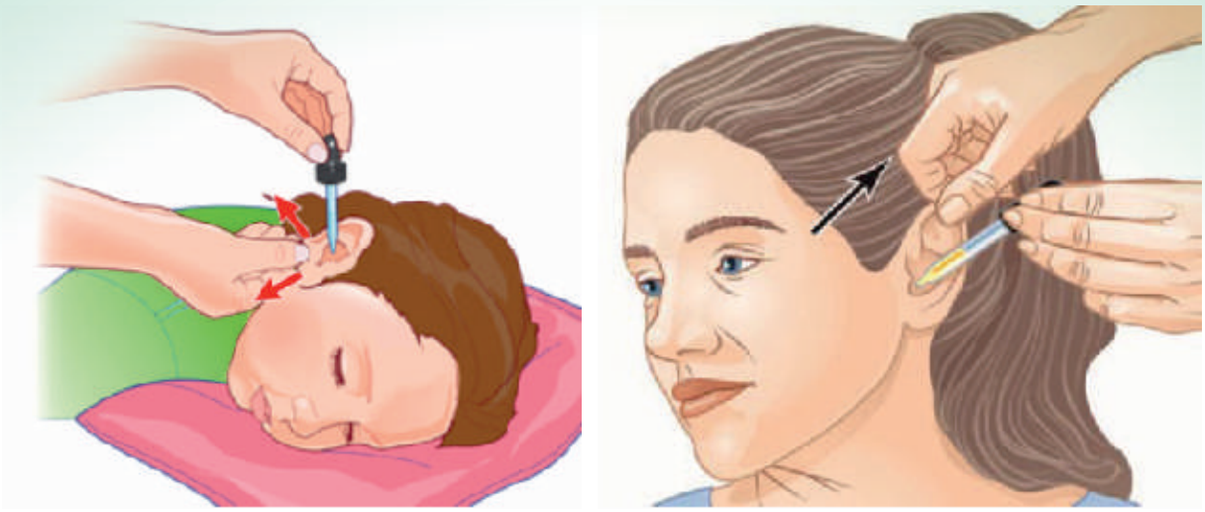
4.1 Medication bottle with dropper
4.2 Cotton tipped applicator
4.3 Clean swabs
4.4 Gloves
4.5 Kidney tray
4.6 Medication card
4.7 Client's chart.

5.0 Pre Procedure

5.1 Identify the client & explain procedure.
5.2 Assess the general condition of the client
5.3 Provide a well lighted area.
5.4 Provide a pillow
5.5 Wash hands

6.0 Procedure

6.1 Place the client in side lying position with the ear to be treated facing up
6.2 If cerumen or drainage occludes the outer most portion of ear canal wipe out gently with cotton tipped applicator
6.3 Do not force the tipped applicator inwards to block or occlude the canal.
6.4 Straighten ear canal by pulling auricle down and back for children and upward and outward for adults.
6.5 Instill prescribed drops holding the dropper 1 cm above the ear canal.
6.6 Instruct the client to remain in side lying position for 5 minutes.
6.7 Place a cotton ball in the outer most part of the canal if necessary.



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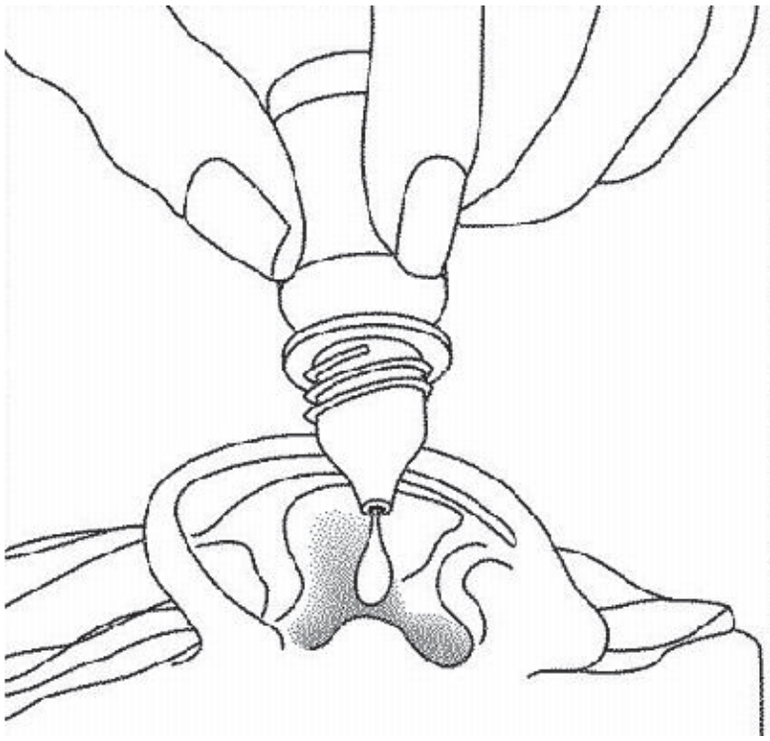
7.0 Post Procedure

7.1 Make the client comfortable
7.2 Instruct to inform if any adverse reaction occurs.
7.3 Clean, dry and replace the equipment in its proper place.
7.4 Wash hands.
7.5 Document the procedure.



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INSTILLATION OF MEDICINE INTO THE NOSE

1.0 Meaning

1.1 A nasal instillation is defined as a process by which liquid medicines are introduced into the nasal cavity drop by drop.

2.0 Purpose/ Indication

2.1 To shrink swollen mucous membranes of nasal cavity(astringent effect)
2.2 To loosen secretions and facilitate drainage
2.3 To treat infections of the nasal cavity or sinuses.
2.4 To give local anaesthesia.
2.5 Pre and post operative surgery of nasal cavity.

3.0 Articles:

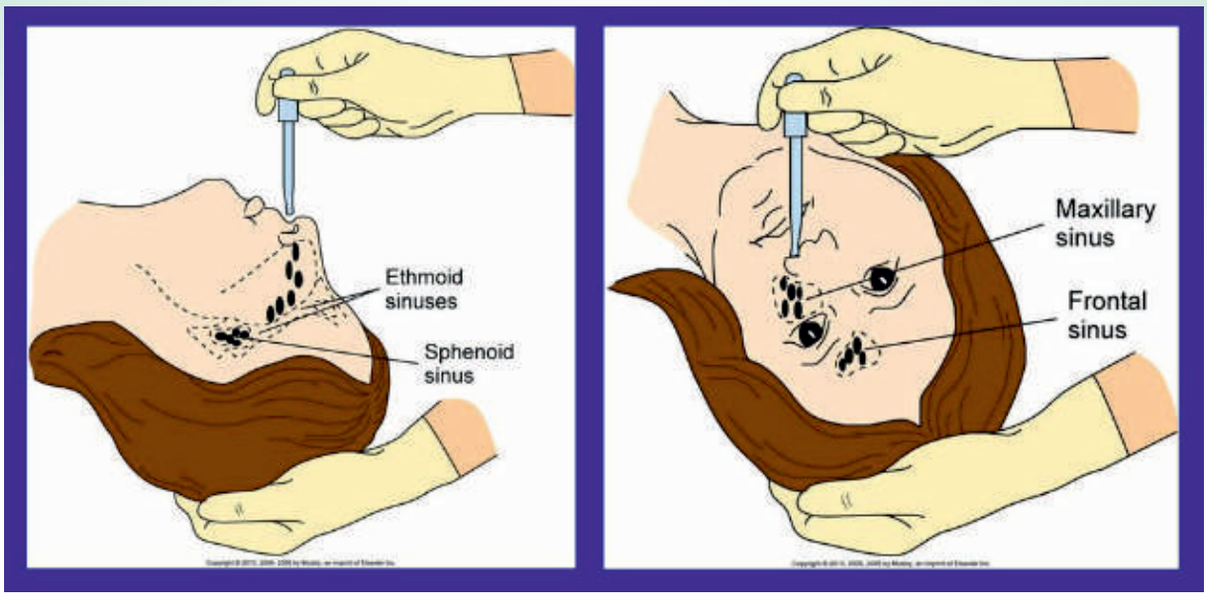
3.1 Medication with dropper
3.2 Cotton swabs
3.3 Kidney tray
3.6 Client's chart

4.0 Pre procedure

4.1 Identify the client & explain the procedure.
4.2 Assess the general condition of the client
4.3 Provide a well-lighted area.
4.4 Wash hands
4.5 Instruct the client to blow nose if not contraindicated.

5.0 Procedure

5.1 Place the client in supine position, for instillation of medicine.
5.2 Tilt the head by placing a small pillow under the patient's shoulder.
5.3 Instruct client to breathe through mouth.
5.4 Administer the nasal drops holding the dropper 1 cm above the nares and without touching the nares.
5.5 Instill prescribed drops towards the midline of the ethmoid bone.
5.6 Instruct the client to remain in position for 5 minutes.
5.7 Provide a tissue to clean the nose.



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6.0 Post Procedure

6.1 Make the client comfortable.
6.2 Instruct the client not to blow his/ her nose for 10 - 15 minutes.
6.3 Instruct to inform if any adverse reaction occurs.
6.4 Clean, dry and replace the equipment in its proper place.
6.5 Wash hands.
6.6 Document the procedure.

ADMINISTERING ORAL MEDICATIONS

1.0 Meaning:

1.1 Oral medication is defined as the administration of medication by mouth.

2.0 Purposes/ indications

2.1 To prevent the disease and take supplement in order to maintain health
2.2 To cure the disease
2.3 To promote the health
2.4 To give palliative treatment
2.5 To give as a symptomatic treatment

3.0 Contraindications

3.1 Unconscious patient
3.2 Oral surgery

4.0 Articles:

4.1 Steel tray
4.2 Drinking water in jug
4.3 Doctor prescription
4.4 Medicine card
4.5 Medicine cup
4.6 Mortar & pestle if needed
4.7 Kidney tray/ paper bag

5.0 Pre Procedure

5.1 Perform hand hygiene.
5.2 Collect prescription and ensure that the client is available and understandable to take the medication.
5.3 Check the 5 Rights of drug administration: Right drug, Right dose, Right route, Right time, Right client and Right documentation.
5.4 Identify the client before giving the medication: By asking the client his/her name, by asking family or staff member to identify the client or by checking the name on the identification bracelet if available.
5.5 Prepare one client's medication at a time. Proceed from top to bottom of the medicine card when preparing medications
5.6 Complete necessary assessments(vital signs assessment) before giving medications

6.0 Procedure

6.1 Assist the client to a comfortable position to take medications

6.2 Select the correct medication from the shelf or drawer and compare the label to the medication order on the medicine card
6.3 From the multidose bottle: Pour a pill from the multi-dose bottle into the container lid and transfer the correct amount to a medicine cup.
6.4 In the case of unit packing: Leave unit dose medication in wrappers and place them in a medication cup
6.5 Liquid medications: Measure liquid medications by holding the medicine cup at eye level and reading the level at the bottom of the meniscus. Pour from the bottle with the label uppermost and wipe the neck if necessary
6.6 Recheck each medication with the medicine card
6.7 When you have prepared all medications on a tray, compare each one again to the medication order.
6.8 Crush pills if the client is unable to swallow them.
6.9 Mix powder medications with fluids at the bedside if needed
6.10 Open unit dose medication package and put the medication to the medicine cup
6.11 Bring medication to the client you have prepared
6.12 Administer the medication.
6.13 Offer water or fluids with the medication as directed
6.14 Review the medication's name and purpose
6.15 Discard any medication that falls on the floor
6.16 Remain with the client until he/she has taken all medication. Confirm the client's mouth if needed.

7.0 Post Procedure

7.1 Perform hand hygiene
7.2 Record medication administration on the appropriate form. Record fluid intake on the balance sheet
7.3 If a client refused the medication, record according to your hospital/agency policy on the record.
7.4 Document vital signs or particular assessments according to your hospital's form
7.5 Sign in the narcotic record for controlled substances when you remove them from the locked area(e.g., drawer or shelf).
Check the client within 30 minutes after giving medication.

For Paediatric Clients:

Pre-Procedure:
1. Determine the age of the child, weight & developmental status.
2. Select measuring dropper, calibrated spoon syringe or medicine cup to measure dose.

Procedure:

5.1 Liquid Medications

5.1.1. Select a measuring spoon, dropper, calibrated spoon, syringe or medicine cup to measure dose.

5.1.2. Uncap medication bottle and place cap topside down.
5.1.3. Hold measuring container at eye level to locate.
5.1.4. Pour the medication opposite to the label placed in the bottle.
5.1.5. Fill container with medication to the correct amount. Discard any excess medication, never returning it to the bottle.
5.1.6. Clean bottle lip & container with damp paper towel.
5.1.7. Place dropper or syringe in mouth along the buccal area.
5.1.8. Slowly squeeze a small amount of medication (about 0.5ml) into the mouth or allow the child to suck medication from the syringe or dropper.
5.1.9. Another method with infants is to use a bottle nipple filled with the medication. Allow child to suck medication from nipple.
5.1.10. Have child sip medication from cup or straw cut in half.

5.2 Tablets / Capsule

5.2.1. Pour medication from bottle into the bottle's lid. Transfer the medication from the lid to medication cup.
5.2.2. Never return unwanted tablets or capsules to the stock bottle from the medication cup.
5.2.3. Break the tablet using manufacture's score. Do not try to divide a medication that is not scored.
5.2.4. If necessary, crush the tablets using a mortar and pestle check that medication can be crushed and mixed with food or beverages.
5.2.5. Place medication in mouth of the child.
5.2.6. If necessary, assist child to swallow medication. By offer drink have child hold nose while medicine is placed in mouth with child's head slightly tilted back, massage anterior neck down ward.
5.2.7. Offer child liquid of preference after medication is taken.
5.2.8. Confirm that medications have been swallowed before leaving child.
5.2.9. Reinforce expected therapeutic benefit and need to notify nurse immediately should an unexpected reactions occur. Provide necessary teaching about medication.
5.2.10. Rinse or wipe the teeth and gums with plain water after sweetened liquid or chewable medications.
5.2.11. Return to check child to evaluate response to medication, note and adverse effects if present.

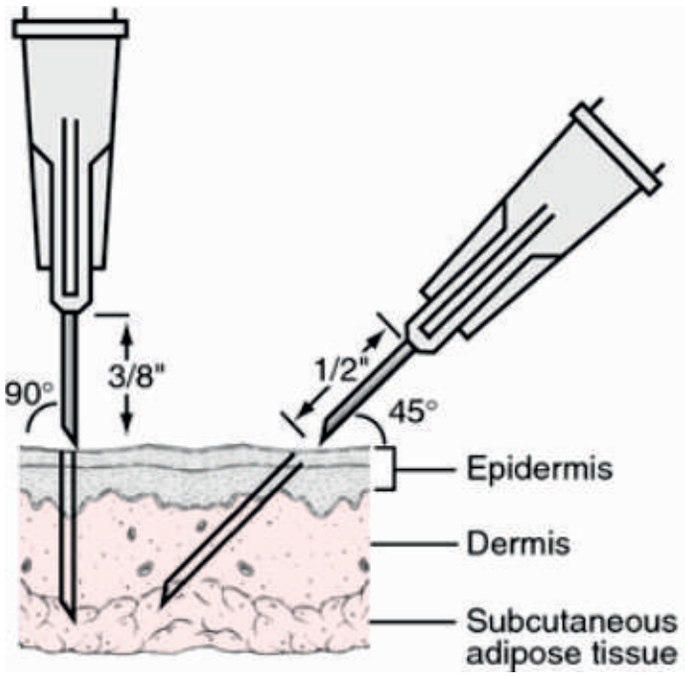
SUBCUTANEOUS INJECTION

1.0 Meaning

1.1 Injecting fluid into subcutaneous tissue. The usual sites are umbilical, lateral or posterior aspect of lower part of upper arm, anterior aspect of thighs. A maximum of 1ml can be injected subcutaneously.

2.0 Purpose/ Indications

2.1 To cure disease condition
2.2 To provide immunization
2.3 Diabetes mellitus
2.4 Vaccination



3.0 Contraindication:

3.1 Muscle dystrophy

4.0 Articles:

4.1 Syringes and needle
4.2 Medicine
4.3 Medicine card
4.4 Gloves
4.5 Alcohol and Cotton swab

5.0 Pre- Procedure

5.1 Wash hands and wear gloves.
5.2 Explain the procedure to the patient.
5.3 Place the client in an appropriate and relaxed position
5.4 Provide privacy if required
5.5 Drape appropriately exposing only the site selected

6.0 Procedure

6.1 Locate the site heeding to clients preference like outer aspect of the upper arms, anterior aspect of the thigh, loose abdominal tissue or tissue over the scapula.
6.2 Wear gloves
6.3 Clean the site thoroughly using circular motion with a alcohol swab
6.4 Grasp the area surrounding the site of injection and hold it in a cushion fashion.
6.5 Insert the needle 26 gauge at 90 degree angle and 23gauge at 45 degree angle.
6.6 After inserting the needle, release the grasp on the tissue.
6.7 Aspirate slightly to determine whether the needle is in blood vessel.
6.8 If blood is not aspirated, inject the medicine slowly.

6.9 Remove the needle quickly at the same angle as when inserted, wipe with a dry cotton swab.

7.0 Post Procedure

7.1 Discard the needle in to the puncture proof container.
7.2 Remove gloves
7.3 Wash hands

For Paediatric Clients:

3.0 Pre-Procedure

3.2 Infants and young children should be seated comfortably.
3.3 If using the anterolateral site encourage the parent to cuddle the child close to them with the child's nearest arm around their back.
3.4 If using the deltoid site encourage the parent to hold the child's arm that is to be injected close to the child's body and to tuck the child's arm behind their own back. The child's legs are tucked between the parents legs or the parent holds them firmly.

Procedure:

4.4.1 Upper arm - Center third of the lateral aspect of the upper arm in a line from the point of the shoulder to the bony protuberance of the elbow.
4.4.2 Abdomen - Rectangular area formed by the horixontal line between the right and left anterior superior iliac spines and between the 10th ribs, excluding the belt line & the area immediately surrounding the umbilicus.
4.4.3 Anterior thigh - Center third of anterior thigh.

4.6 Engage child in conversation and encourage distraction by humming a song, counting etc., throughout the procedure.

INTRADERMAL INJECTION

1.0 Meaning

1.1 Intradermal injection is the injection of a medicine or drug into the dermis, just below the epidermis.

2.0 Purposes/ Indications

2.1 To assess for any allergy in the client
2.2 To give a test dose.
2.3 To diagnose disease
2.4 To give local anesthesia
2.5 Mantoux test in Tuberculosis
2.6 Multiple allergies
2.7 Local anesthesia before surgery

3.0 Contraindication:

3.1 Allergy or hypersensitivity to the medicine
3.2 Infection near the site of injection

4.0 Articles:

4.1 Syringes and needle
4.2 Medicine
4.3 Medicine card
4.4 Gloves
4.5 Spirit swab

5.0 Pre- Procedure

5.1 Wash hands and wear gloves.
5.2 Explain the procedure to the patient.
5.3 Place the client in an appropriate and relaxed position
5.4 Provide privacy if required
5.5 Drape appropriately exposing only the site selected

6.0 Procedure

6.1 Place the client in a comfortable and relaxed position
6.2 Clean the skin on the medial aspect of the forearm four fingers away from the anti cubital fossa, using circular motion with a spirit swab
6.3 Insert the needle (26 gauge) with the bevel side up at 10 to 15 degree angle until just the tip is under the outer layer of the skin
6.4 Aspirate slightly to ensure the needle is not in a blood vessel
6.5 Inject the required amount of medicine slowly till a wheal is formed.

6.6 Withdraw the needle
6.7 Gently mop the area, if medicine is spilled
6.8 Remove gloves
6.9 Draw a circle around the injection site with a black or blue ball pen and note the time (If it is a test dose).

7.0 Post Procedure

7.1 Make the client comfortable
7.2 Discard each item in the appropriate container
7.3 Record the injection given and enter your signature, dose, site of injection.

INTRA-MUSCULAR INJECTION

1.0 Meaning:

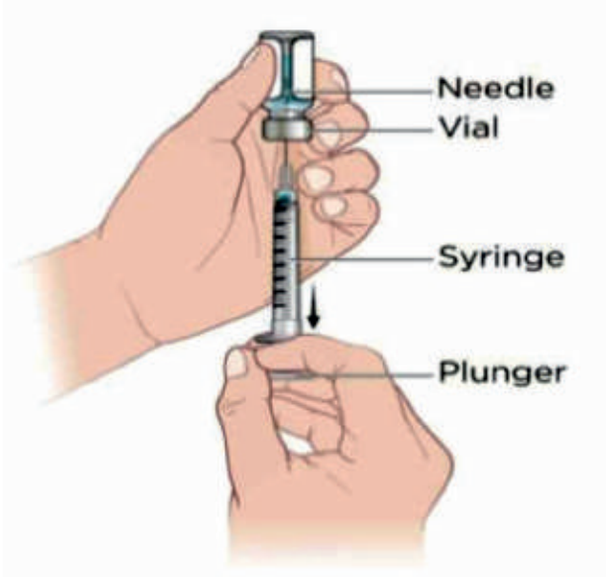
1.1 Intra-muscular injection is the injection of medicine into muscle tissue. Intramuscular injections are often given in the deltoid, vastus lateralis, ventrogluteal and dorsogluteal muscles.

2.0 Purpose/ Indications

2.1 To relieve symptoms of illness
2.2 To promote and prevent from disease
2.3 To treat the disease accordingly

3.0 Contraindication

3.1 Impaired coagulation mechanisms
3.2 Occlusive peripheral vascular disease
3.3 Edema
3.4 Shock
3.5 After thrombolytic therapy

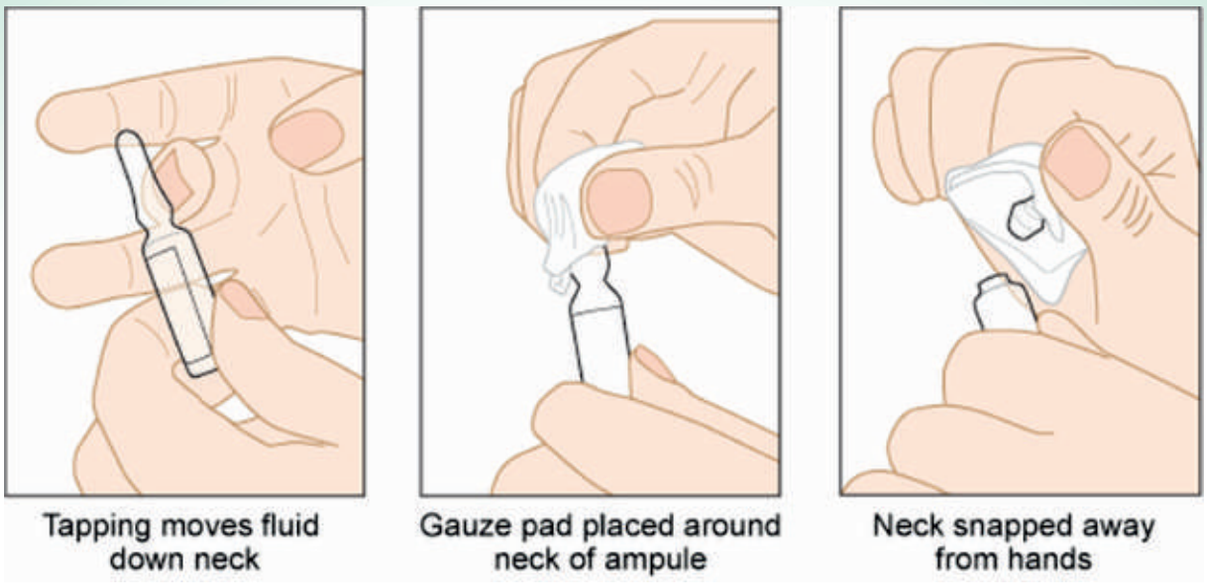


4.0 Articles:

4.1 Client's chart and medication card
4.2 Prescribed medication
4.3 Sterile syringe
4.4 Sterile needle in appropriate size
4.5 Spirit swabs
4.6 Kidney tray
4.7 Disposable container
4.8 Ampoule cutter if available

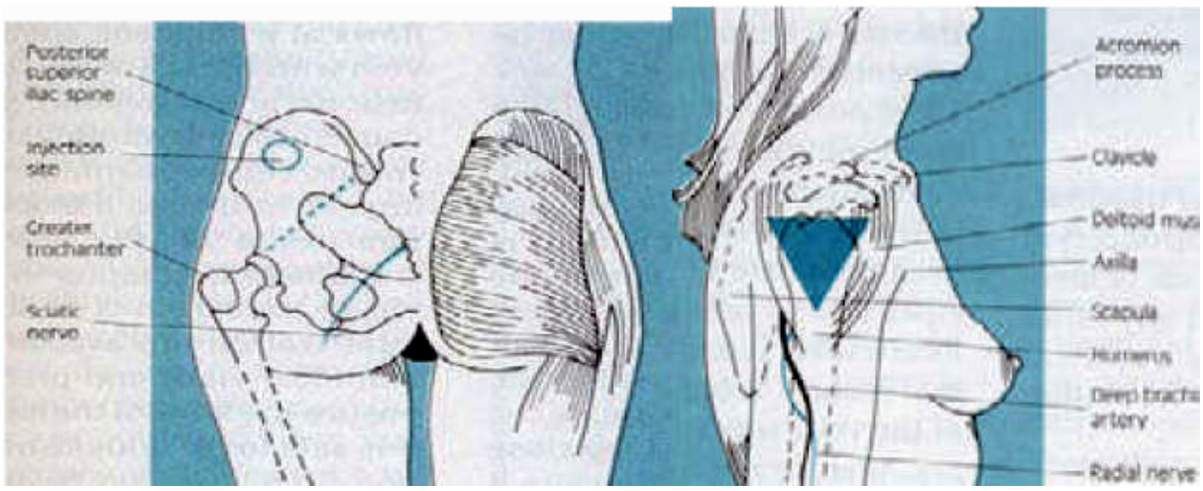
5.0 Pre Procedure:

5.1 Assemble equipments and check the medication order
5.2 Explain the procedure to the client
5.3 Close the door and put a screen.
5.4 Perform hand hygiene and put on gloves
5.5 Withdraw medications from an ampoule or a vial and take the medications to the client bedside.
5.6 Assess medical history of allergies



6.0 Procedure:

6.1 Identify the client carefully.
6.2 Assist the client to a comfortable position.
6.3 Select the appropriate injection site using anatomic landmarks
6.4 Locate the site of choice. Ensure that the area is not tender and is free of lumps or nodules



6.5 Cleanse the skin with a spirit swab: Start from the injection site and move outward in a circular motion to a circumference of about 2" (5cm) from the injection site. Allow the area to dry
6.6 Place a small, dry gauze or spirit swab on a clean, nearby surface or hold it between the fingers of your non-dominant hand.
6.7 Remove the needle cap by pulling it straight off
6.8 Spread the skin at the injection site using your non-dominant hand
6.9 Hold the syringe in your dominant hand like a pencil or dart.
6.10 Insert the needle quickly into the tissue at a 90 degree angle
6.11 Release the skin and move your non-dominant hand to steady the syringe's lower end

6.12 Aspiration blood:
- 6.12.1 Aspirate gently for blood return by pulling back on the plunger with your dominant hand
- 6.12.2 If blood enters the syringe on aspiration, withdraw the needle and prepare a new injection with a new sterile set-up.

6.13 If no blood appears, inject the medication at a slow and steady rate(10 seconds/ml of medication)

6.14 Remove the needle quickly at the same angle you inserted it

6.15 Massage the site gently with a small, dry gauze or spirit swab, unless contraindicated for specific Medication. If there are contraindications to massage, apply gentle pressure at the site with small, dry gauze.

7.0 Post Procedure

7.1 Discard the needle

7.2 Remove your gloves and perform hand hygiene

7.3 Record the medication administered, dose, date, time, route of administration, and IM site on the appropriate form.

7.4 Check the client's response to the medication within an appropriate time. Assess the site within 2 to 4 hours after administration

For Paediatric Clients:

- Locate the IM site preferable lateral ‘aspect of high’ (vastus lateralis)

INTRAVENOUS INJECTIONS AND INFUSIONS

1.0 Meaning:

1.1 The administration of a substance into a vein for the purpose of instilling a single dose of medication or injecting a contrast medium is known as Intravenous injection, when it allows the administration of large amount of fluid into the body through veins, it is called as intravenous infusions.

2.0 Purpose/ Indications

2.1 To restore the fluid volume in case of haemorrhage, dehydration etc.
2.2 To meet the patient's basic requirement
2.3 To prevent and treat shock and collapse
2.4 To supply the body with an adequate fluid and electrolytes
2.5 Unconscious patients
2.6 Imbalance in fluid electrolytes

3.0 Contraindications

3.1 Venous thrombosis
3.2 Allergic to medication

4.0 Articles:

4.1 Cotton swabs
4.2 Spirit solution
4.3 Small sterile injection tray with lid
4.4 File/opener
4.5 Water for injection/ dilutents if required
4.6 Prescribed injection
4.7 Solution for infusion
4.8 IV cannula
4.9 IV set with Three way and extension if needed
4.10 IV stand
4.11 Disposable syringe and needle
4.12 Gloves
4.13 Normal saline or heparinized saline
4.14 Tourniquet
4.15 Kidney tray/ waste disposal container
4.16 Small mackintosh
4.17 Client's chart

5.0 Pre Procedure

5.1 Wash hands
5.2 Verbally confirm the identity of patient by asking their full name. If patient is unable to tell check identity with family member or caregiver.

5.3 Introduce yourself as a staff member and any colleagues involved.
5.4 Explain the procedure and the need for injection
5.5 Refer injection book and counter check with the doctors order
5.6 Take the appropriate medicine from the bedside locker/ container and compare the label with the clients chart. Read the entire label including the expiry date.
5.7 Prepare the medicine from the appropriate vial or ampoule:
5.8 Choose the appropriate disposable syringe and disposable needles
5.9 Check whether it is functioning well

6.0 Procedure

6.1 Intravenous Injection
- 6.1.1 Place the client in a comfortable position
- 6.1.2 Select an appropriate site by looking and palpating.
- 6.1.3 Apply the tourniquet 5-7 cm above the site of entry
- 6.1.4 Make the client open and close his/her fist several times if the injection site is selected in the arm
- 6.1.5 After selecting the entry site, place the mackintosh beneath the site.
- 6.1.6 Clean the skin thoroughly using circular motion with a spirit swab.
- 6.1.7 After clean hold swab between third and fourth singer of non dominant hand because swab remains readily accessible when needle is withdrawn.
- 6.1.8 Allow the antiseptic to dry and do not touch the skin after it have been cleaned.
- 6.1.9 Use your thumb to retract the skin, the soft tissue and vein about two inches below the intended site of entry.
- 6.1.10 Enter the skin gently, along the side of the vein with the IV cannula held level side up at about 30-45 degree angle.
- 6.1.11 Once the IV cannula enters the skin, lower it nearly parallel to the skin.
- 6.1.12 Advance the IV cannula into the vein by following the course of the vein.
- 6.1.13 Observe for return flow of the blood and remove the stylet.
- 6.1.14 Release the tourniquet and flush the cannula with normal saline.
- 6.1.15 Inject the medicine very slowly.
- 6.1.16 Observe for any swelling in the entry site, while injecting. If so, do not inject further. Counter check the placement of the needle.
- 6.1.17 After administering the medicine, remove the syringe and flush with normal saline.
- 6.1.18 Close the IV line.

6.2 Intravenous solution
- 6.2.1 Read the doctor's order and compare it with the solution available for infusion.
- 6.2.2 Check the solution for any precipitation, change of colour and the expiry date.
- 6.2.3 Remove the protective cover from the inlet of the IV bag / bottle.
- 6.2.4 Wipe it with a spirit swab.
- 6.2.5 Open the IV infusion set.
- 6.2.6 Remove the protective cap from the insertion tip of the IV set without touching it and insert it into the inlet of the IV bag/ bottle.

6.2.7 Turn the tip of the IV set in clockwise direction as you insert it into the IV bag/ IV bottle. Place the roller clamp 2- 4 cms below the drip chamber and clamp it.
6.2.8 Invert the solution container and hang from IV stand.
6.2.9 Compress and release the drip chamber, till it is 1/3rd to ½ full.
6.2.10 Remove the cap from the end of the IV tubing and connect the 3-way connection to it.
6.2.11 Clamp the roller clamp, close the tip of the IV line or the three - way connection and hang it on the IV stand
6.2.12 Make sure the IV tubing is clear of air.
6.2.13 Connect the tip of the IV line or the 3 way connection to the hub of the needle.
6.2.14 Release the roller clamp gently to allow the solution to flow.

7.0 Post Procedure

7.1 Remove the mackintosh and gloves.
7.2 Make the client comfortable.
7.3 Discard each item in the appropriate container.
7.4 Wash hands.
7.5 Reassess the client for any expected or unexpected reactions and report the findings.
7.6 Document the date and time when the procedure was done, observation made and client's condition during and after the procedure.

For Paediatric Clients:

Pre-Procedure:
- 4.2.3 to be followed from Pg 230

Procedure:
- 5.5 to be followed from Pg 230
- Immobilise the hand of the child by using appropriate restraints 5.7 & 5.8 from Pg 230

BOWEL WASH

1.0 Meaning

1.1 It is also called as colonic irrigation or enteroclysis which means washing out the colon with large quantity of solution in order to clear the colon of faeces

2.0 Purpose

2.1 To clean the bowel
2.2 To empty the bowel

3.0 Contraindications

3.1 Appendicitis
3.2 Bowel obstruction
3.3 Perforation of bowel

4.0 Articles

4.1 Bowel wash tube with rectal catheter and tubing with enema can, clamps with connector or funnel with tubing.
4.2 Vaseline
4.3 Gauze pieces in a bowl
4.4 Plastic apron
4.5 Mask and sterile glove
4.6 Mug
4.7 Bucket with lukewarm water
4.8 Mackintosh and draw sheet
4.9 Bucket (to collect the return fluid)
4.10 Bed pan(for pediatric client)
4.11 Clean linen

5.0 Pre procedure

5.1 Identify the client and explain the procedure
5.2 Assess the general condition of the client
5.3 Ensure that the client has voided prior to the procedure
5.4 Provide privacy
5.5 Provide a well lighted area and wash hands
5.6 Check the tube and funnel for any leakage after filling the funnel with solution and expelling the air from the tube.
5.7 Wear the mask, plastic apron and gloves

6.0 Procedure

6.1 Cover the client with the top sheet
6.2 Remove extra comfort devices and loosen the pyjama
6.3 Place the mackintosh and draw sheet under the patient's buttocks close to the edge of the bed and right knee flexed (sims position)
6.4 Drape the client appropriately
6.5 Lubricate the catheter
6.6 Separate the client's buttock with a gauze piece to visualize the anus clearly
6.7 Instruct the client to take deep breath
6.8 Insert the rectal catheter in rotating motion up to 3-4 inches directing it slightly upwards
6.9 If any resistance occurs while inserting it, withdraw the catheter slightly, then continue to insert. Do not force the catheter against resistance
6.10 Lower the funnel below the level of the rectum to aid the escape of flatus
6.11 Pour about 500 ml of the solution and raise the funnel to a height of 10-18inches above the level of the client's rectum
6.12 Note that the funnel is not emptied at any time. Pinch the tube before the funnel is completely empty
6.13 Siphon out the solution by lowering the funnel to 10-18 inches below the level of the rectum and directing it into the bucket
6.14 When the return flow ceases, keep the funnel at the same level below the rectum, pour solution into the funnel and gradually raise the funnel

6.15 If the return flow is not adequate
- 6.15.1 Rotate the rectal catheter gently within the rectum
- 6.15.2 Introduce the rectal catheter 2-3 inches further into the rectum and withdraw slightly
- 6.15.3 If (6.17.1) and (6.17.2) fails remove the rectal catheter, clean and re-insert

6.16 Repeat the procedure till the return flow is clear
6.17 Observe the client for signs of exhaustion such as cold and clammy skin and fainting
6.18 Pinch the rectal catheter and gently remove it
6.19 Place the funnel with tubing in the kidney tray

7.0 Post procedure

7.1 Make the client comfortable
7.2 Clean, dry and replace the equipment in its proper place
7.3 Document the procedure

ENEMA

1.0 Meaning

1.1 Introduction of liquid through the Anus into the large intestine.

2.0 Purposes

2.1 To cleanse the bowel
2.2 To stimulate defecation
2.3 To administer medication
2.4 To relieve gaseous distension
2.5 To induce peristalsis
2.6 To induce anesthesia
2.7 To reduce temperature
2.8 To revive a client in shock
2.9 To administer fluid and nutrients
2.10 To evacuate intestinal parasites

3.0 Contraindications

3.1 Diarrhea
3.2 Soon after abdominal and pelvic surgery

4.0 Articles

4.1 Enema can with tubing
4.2 Artery clamp
4.3 Pint measure
4.4 Vaseline
4.5 Gauze pieces in a bowl
4.6 Solution
4.7 Gloves
4.8 Mask
4.9 Mackintosh & drawsheet
4.10 Kidney tray
4.11 Waste disposal containers
4.12 IV stand

5.0 Pre procedure

5.1 Identify the client and explain procedure
5.2 Assess the client's ability to retain the fluid
5.3 Provide privacy
5.4 Provide a well-lighted and ventilated area
5.5 Wash hands

6.0 Procedure

6.1 Cover the client with the top sheet
6.2 Place the mackintosh and drawsheet under the patient's buttocks close to the edge of the bed and right knee flexed (left lateral)
6.3 Drape the client appropriately
6.4 Adjust the height of the IV stand to hold the enema can at the required height
6.5 Connect the enema can, tubing and the rectal catheter
6.6 Attach the clamp to the tubing
6.7 Wear gloves
6.8 Allow a small amount of the solution to run into the kidney tray by loosening the clamp
6.9 Clamp the tubing
6.10 Apply lubricant to the tubing
6.11 Instruct the client to take deep breath
6.12 Insert the rectal catheter
6.13 Release the clamp and allow the solution to run in
6.14 Assess the level of solution and make sure that it is flowing
6.15 After sufficient amount of solution is administered, clamp the tubing
6.16 Gently remove the rectal catheter
6.17 Discard the gauze pieces in the kidney tray
6.18 Separate the rectal catheter from the can and place it in the kidney tray
6.19 Instruct the client to retain the solution for 5-10 minutes until there is a strong urge to defecate

7.0 Post procedure

7.1 Make the patient comfortable and explain the need to evacuate the bowel several times in the next few hours
7.2 Clean ,dry and replace the equipment in its proper place
7.3 Wash hands
7.4 Document the procedure

INSERTION OF SUPPOSITORIES

1.0 Meaning

1.1 It is the insertion of a cone or oval-shaped mass of mixture of drugs into the lining of the rectum for local and then systemic effect after being absorbed.

2.0 Purposes

2.1 To stimulate secretion of mucosa by local irrigation
2.2 To stimulate peristalsis
2.3 To stimulate evacuation of bowel
2.4 To relieve pain in haemorrhoids, migraine
2.5 To sedate the patient

3.0 Contraindications

3.1 Fluid and electrolyte imbalances
3.2 Chronic constipation
3.3 Diarrhoea
3.4 Intestinal obstruction

4.0 Articles

4.1 Screen
4.2 Tray containing
- 4.2.1 Kidney tray
- 4.2.2 Mackintosh and towel
- 4.2.3 Bowl with cotton swabs
- 4.2.4 Suppository in a bowl
- 4.2.5 Gloves

5.0 Pre procedure

5.1 Explain the procedure to the patient
5.2 Provide privacy using a screen
5.3 Arrange all articles near bedside and wash hands
5.4 Instruct the patient to take a deep breath during insertion of suppository

6.0 Procedure

6.1 Provide a left lateral position to the patient with buttocks close to the edge of the bed
6.2 Wear gloves and hold the suppository in the right hand between two fingers
6.3 Separate the buttocks with the left hand and insert the suppository into the anus

6.4 Once it has passed the external sphincter, advance beyond the internal sphincter by pushing it with the index finger
6.5 Make sure that the suppository is positioned.
6.6 Instruct the patient to retain the suppository as long as possible(20-30min)
6.7 Encourage slow breathing with an open mouth for relaxation

7.0 Post procedure care

7.1 Replace all articles
7.2 Document the procedure

INSERTION OF FLATUS TUBE

1.0 Meaning

1.1 It is introduction of a tube into the rectum for expulsion of gas.

2.0 Purpose

2.1 To remove flatulence from the lower bowel
2.2 To relieve abdominal distension

3.0 Articles

3.1 Screen
3.2 Clean tray with extra tubing in a kidney tray with water
3.3 Vaseline in a container
3.4 Wet cotton swabs in a container
3.5 Mackintosh
3.6 Kidney tray with water

4.0 Pre procedure

4.1 Assess the client's abdomen for hardness and distension

5.0 Procedure

5.1 Identify & explain the procedure to the patient
5.2 Arrange articles near bedside and ensure privacy
5.3 Arrange draw sheet and mackintosh on the bed
5.4 Position the patient- left lateral with right knee flexed
5.5 Expose the rectum and clean the anal area
5.6 Lubricate the flatus tube and insert about 12cm
5.7 Connect the free end of flatus tube to extra tubing and keep it under water in kidney tray(placed between the thighs)
5.8 Watch the expulsion of gas and remove it after 20 minutes
5.9 Clean area with wet cotton balls

6.0 Post procedure:

6.1 Clean and replace all articles
6.2 Document the procedure

CATHETERIZATION OF URINARY BLADDER

1.0 Meaning

1.1 It is the introduction of a catheter through the urethra into the urinary bladder to remove urine.

2.0 Purpose

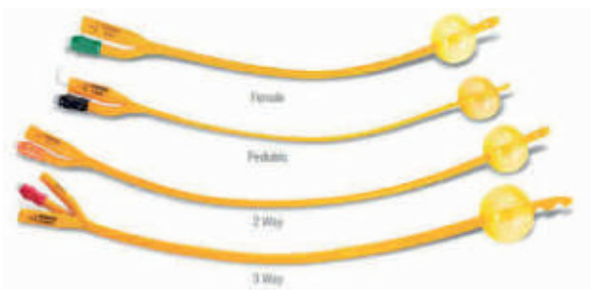
2.1 Diagnostic
- 2.1.1 To obtain a sterile urine specimen

2.2 Therapeutic
- 2.2.1 To relieve acute or chronic urinary retention
- 2.2.2 To provide for intermittent or continuous bladder drainage and irrigation
- 2.2.3 To prevent bed wetting, when the patient is incontinent
- 2.2.4 To empty the bladder before surgeries

3.0 Contraindication

3.1 Urethral trauma

4.0 Articles



4.1 Screen - 1
4.2 Mackintosh and towel - 1
4.3 Bed pan, perineal care tray - 1
4.4 Kidney tray and paper bag - 1
4.5 Gloves - 2 pair
4.6 Drainage bag with tubing - 1
4.7 Sterile catheterization tray- 1
4.8 Cotton balls
4.9 Sponge holding forceps, rubber catheter - 1
4.10 Syringe filled with 5-8ml of normal saline - 1

5.0 Pre procedure

5.1 Ascertain the patient's fluid intake and urine output in the previous 24 hrs.
5.2 Palpate bladder to assess the level of distension
5.3 Identify the purpose of catheterization
5.4 Assess the level of consciousness and ability to follow instructions
5.5 Explain the procedure to the patient and provide privacy
5.6 Arrange articles at bedside

6.0 Procedure

6.1 Wash hands and put on the gloves
6.2 Place a mackintosh under the patient's buttocks
6.3 Position the patient : Male-supine position with thighs abducted. Female-supine position with knees flexed
6.4 Expose genital area by covering the both legs
6.5 Provide perineal care
6.6 Remove gloves and wash hands
6.7 Using sterile technique open catheterization tray and pick sterile catheter with 3-4 inches away from catheter tip
6.8 Hold one end of the catheter loosely coiled in the palm of the same hand
6.9 Lubricate the tip of the catheter with a sterile lubricant
6.10 For female, separate the labia majora and minora then gently insert appropriate size of the catheter 2-4inches
6.11 For male, lift penis from the shaft just below the glans, perpendicular to the client's body and apply light traction upwards. Retract the fore skin and introduce 7-9 inches
6.12 Do not use force to insert the catheter and assess for flow of urine through the catheter
6.13 Collect urine specimen, if needed by placing the open end catheter into specimen container
6.14 If indwelling catheter, inflate balloon with adequate amount of normal saline.
6.15 Pull gently to feel resistance and secure the catheter.
Female- To inner thigh with a strip of non-allergic tape.
Male- On top of the thigh or lower abdomen with penis directed towards the chest

7.0 Post procedure

7.1 Wash perineum if required and dry
7.2 Wash hands and remove gloves
7.3 Remove drape sheet and replace the bed linen
7.4 Position the patient in correct body alignment
7.5 Measure and observe the characteristics of urine and record
7.6 Wash the articles, dismantle and replace in the utility room
7.7 Send the specimen to laboratory tests
7.8 Record the procedure on nurse's record(time, purpose, amount and characteristics of urine drained)
7.9 Maintain an intake and output chart

For Paediatric Clients:

- Size of the catheter to be selected as per age of the child.

CONDOM DRAINAGE

1.0 Meaning

1.1 It is a method for men experiencing urinary incontinence to collect and drain urine.

2.0 Purpose

2.1 To prevent bed-wetting, when the patient is incontinent

3.0 Articles

3.1 Condom - 1
3.2 Collection bag - 1
3.3 Clean gloves - 1

4.0 Pre procedure

4.1 Assess the condition of the penis and scrotum
4.2 Assess urinary elimination pattern
4.3 Explain the procedure to the patient
4.4 Wash hands

5.0 Procedure

5.1 Using sheet, drape client so only genitals are exposed
5.2 Prepare condom catheter and drainage system
5.3 Holding penis in non-dominant hand, apply condom by rolling smoothly onto penis.
5.4 Secure condom drainage:

6.0 Post procedure

6.1 Observe urinary drainage, drainage tube patency, condition of penis, and tape placement
6.2 Wash hands
6.3 Document the procedure

ASSISTING IN THE USE OF BED PAN AND URINAL

1.0 Meaning

1.1 Procedure used to assist patient in elimination of bladder & bowel

2.0 Purpose

2.1 To assist Bedridden patient for elimination

3.0 Contraindication

3.1 Back surgeries
3.2 Fracture / hip dislocation

4.0 Articles

4.1 Clean / disposable gloves
4.2 Clean bed pan with cover / clean urinal
4.3 Mackintosh
4.4 A set of clean bed linen
4.5 Screen to provide privacy

5.0 Pre procedure

5.1 Identify the client & explain the procedure
5.2 Provide privacy.
5.3 Wash hands

6.0 Procedure

6.1 Wear clean gloves
6.2 Adjust the bed to appropriate height to prevent back strain
6.3 Elevate the side rail on the opposite side
6.4 Place mackintosh under the buttocks of the client
6.5 Ask the client to assist in lifting his buttocks
6.6 Ensure that the urethra / anus is just above the open space of the bed pan.
6.7 Drape the client adequately to maintain privacy
6.8 Ask the client to defecate / urinate
6.9 Place call bell within reach of the client and leave the client alone for some time.
6.10 To remove the bed pan
6.11 Remove the mackintosh and make the client comfortable

7.0 Post procedure

7.1 Empty the bed pan, wash & replace
7.2 Document the procedure

BASIC LIFE SUPPORT

1.0 Meaning

1.1 Basic Life Support (BLS) is a level of medical care which is used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital. It can be provided by trained medical personnel, including emergency medical technicians, paramedics, and by qualified bystanders.

2.0 Purpose

2.1 BLS provided in the field increases the time available for higher medical responders to arrive and provide ACLS (Advanced cardiac life support) care.

2.2 It promotes adequate blood circulation in addition to breathing through a clear airway:

3.0 Articles

3.1 Gloves
3.2 Face towel
3.3 Airway
3.4 AMBU

4.0 Pre Procedure

4.1 Assess the patient.
4.2 Bring the crash cart to the patient's bedside.
4.3 Call for the help
4.4 Ensure privacy and clear the area.

5.0 Procedure

5.1 Check for the carotid pulse and respiration. Feel for the pulse for at-least 5 seconds, but not more than 10 seconds

5.2 If no pulse, start with 30 chest compressions on the lower half of the breastbone.

5.3 Lock the hands and position the heel of dominant hand over 2/3 of the sternum (2 fingers above xiphoid sternum).

5.4 The elbow should be straight and the shoulder of nurse should be perpendicular to the patient body and the spine should be straight.

5.5 The sternum should be depressed 2 inches in adults and cardiac compression should be hard and fast, and should be sustained at a rate of 100-120/ min with loud counting.

5.6 Allow the chest to recoil completely after each compression.

5.7 Open the airway and give 2 breaths using a pocket mask or bag valve mask after 30 compressions

5.8 Provide head tilt and chin lift manoeuvre while giving rescue breaths.

5.9 Maintain cardiac compression and ventilation ratio 30:2 for adults and 15:2 for children, 1 person 5:1 2 person. This must be continued until the cardiac output return or until code blue team arrives.

5.10 After 5 cycles of CPR, the BLS protocol should be repeated from the beginning, assessing the patient's airway, checking for spontaneous breathing, and checking for a spontaneous pulse as per new protocol sequence C-A-B.

5.11 BLS protocols should be continued until:

- 5.11.1 The patient regains a pulse
- 5.11.2 The rescuer is relieved by another rescuer of equivalent or higher training
- 5.11.3 The rescuer is too physically tired to continue CPR
- 5.11.4 The patient is pronounced dead by a medical doctor or other approved healthcare provider.

6.0 Post procedure

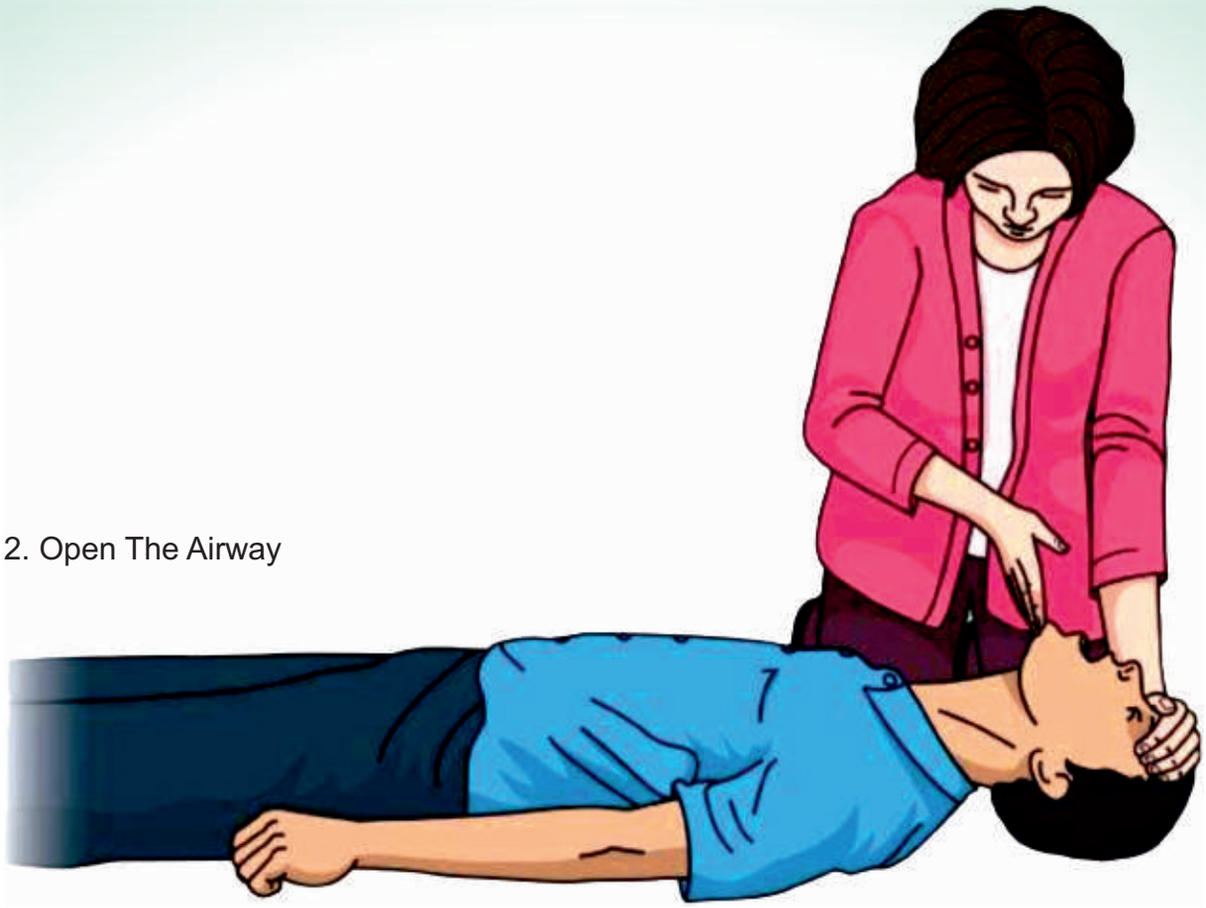
6.1 The patient should be placed in the recovery position and monitored

6.2 Document the procedure immediately.

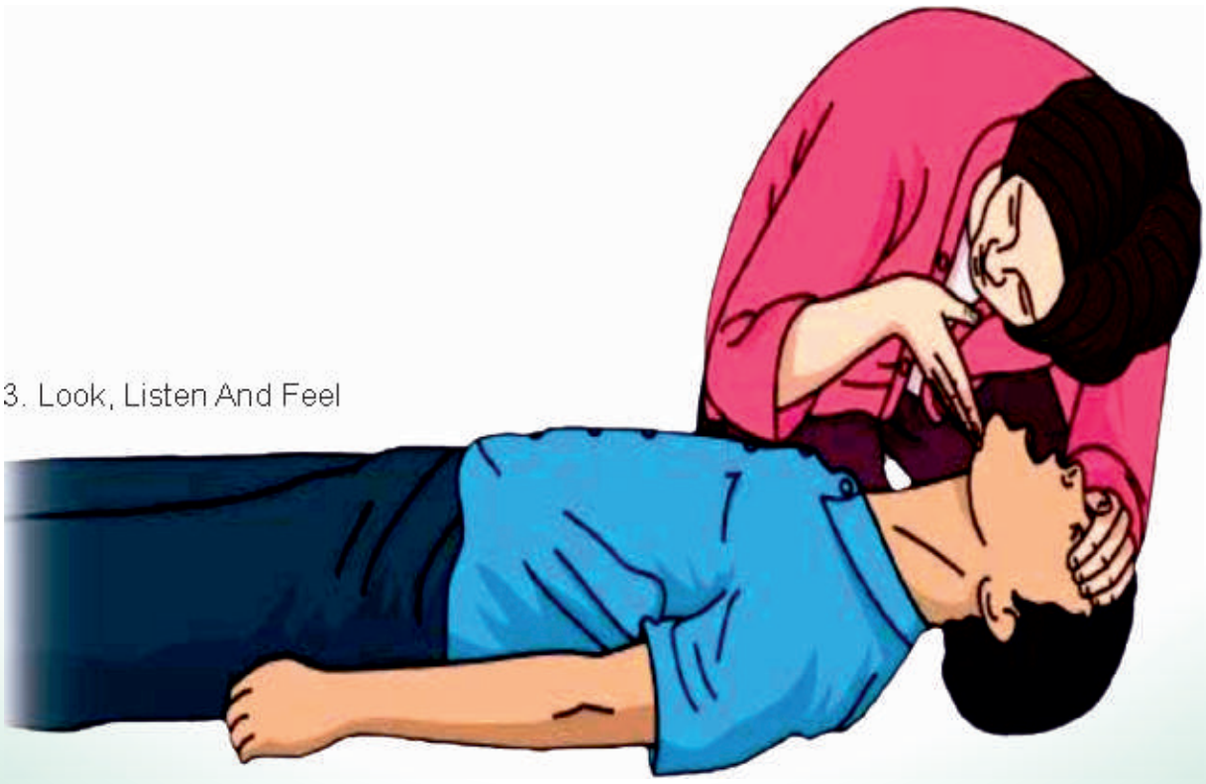
STEPS OF BLS

1. Check For Response

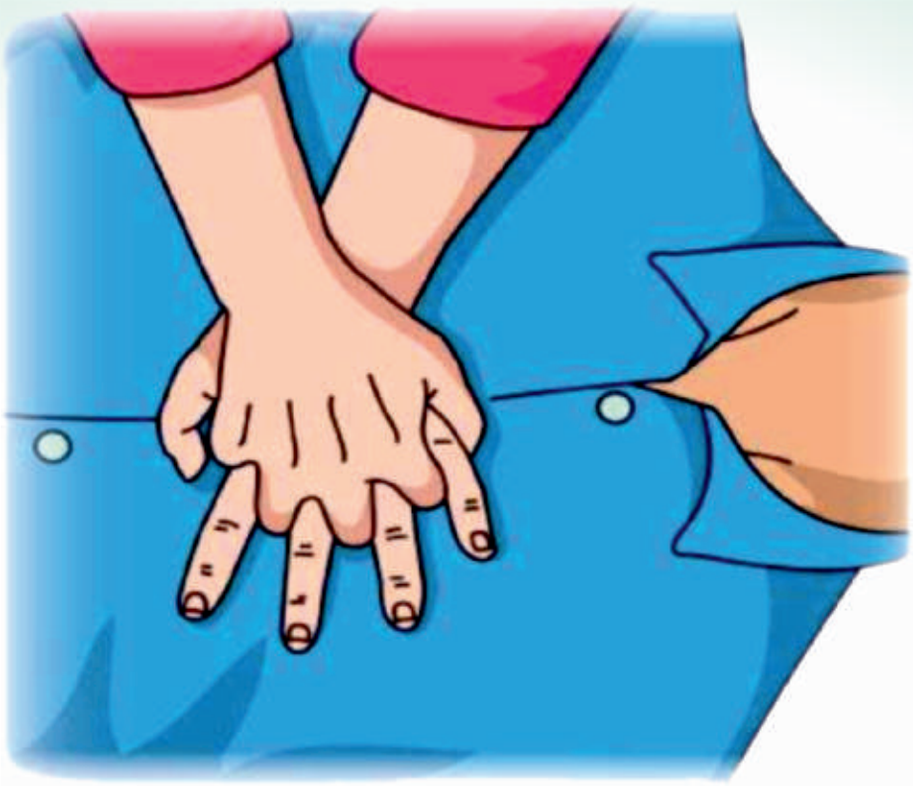
https://tgraph.io/Learn-To-Save-Life-in-a-Minute--You-Should-Know-Basic-Life-Support---Learning-Medical-05-29



2. Open The Airway



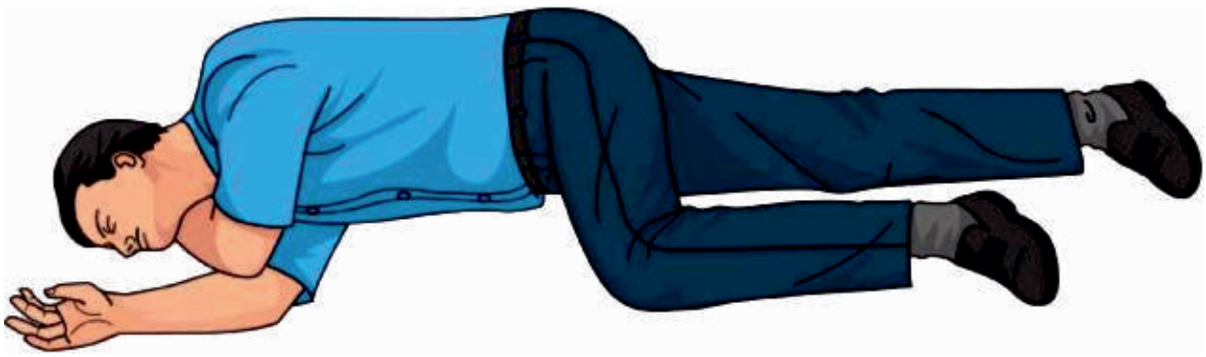
3. Look, Listen And Feel



4.Place Heel of Hands on The Sternum

5. Start the Compressions

6. Mouth to Mouth Respiration



7. Place the patient in recovery position

CARE OF THE BODY AFTER DEATH

1.0 Meaning:

1.1 It means to care for the client's body with dignity and sensitivity and in a manner consistent with client's religious or cultural beliefs.

2.0 Purpose/Indication:

2.1 To take care of the body and give special care such as cleaning the body.

3.0 Articles:

3.1 Screen
3.2 Mortuary sheet (white sheet)
3.3 Tag/Label
3.4 Cotton swabs
3.5 Long forceps
3.6 Wash Cloths
3.7 Bath Towels
3.8 Soap
3.9 Water
3.10 Comb
3.11 Basin
3.12 Bandages
3.13 Scissors
3.14 Adhesive tape
3.15 Plastic apron
3.16 Mask
3.17 Gloves
3.18 Documentation Forms

4.0 Pre Procedure:

4.1 Wash hands
4.2 Check orders for any specimens or special orders needed by the physician.
4.3 Ask for any special request of relatives while preparing the body for viewing (eg. Shaving, special gown, Holy Books in hand, preference of facial hairs)

5.0 Procedure:

5.1 In order to keep the body in normal positions, the body should be cared for immediately after death and before the rigor mortis develops
5.2 Remove all the appliances, lines, tubes and dirty linen used for the care of the patient. Thorough suctioning to be done before removing Ryle's tube.
5.3 To arrest the bleeding use the right adhesives after manually applying pressure and ensuring the bleeding does not persist.

5.4 The patient's body should be sponged thoroughly and cleaned of adhesive stains. Identification marks has to be informed to the doctor and documented if required.

5.5 Brush and comb client's hair. Apply any personal hairpiece or tie it up with a gauze piece if needed.

5.6 All the orifices are to be plugged with cotton to prevent escape of body fluids.

5.7 Position the client according to protocol:

- 5.7.1 The eyes are closed immediately as in sleep by gently holding them down a few minutes.
- 5.7.2 Any dentures that have been removed are replaced and the mouth is closed.
- 5.7.3 Tie the jaw bandages appropriately, packing should not be visible during viewing.
- 5.7.4 The body is straightened with the arms and legs.
- 5.7.5 The hands are brought together on the chest and the thumbs are tied together.
- 5.7.6 The right and left big toes are tied together
- 5.7.7 Cover the patient with a clean white sheet up to the chin and wrap the body thoroughly.

5.8 Before shifting the patient's body enters the details like Name, Age, Sex, Hospital number, IP number, Ward, bed number, Consultant's name, date of admission, time of death along with patient's body.

5.9 There needs to be three labels prepared with the above details, one label has to be put on the inner side and two labels on the outer side of the patient's body. This is to ensure correct identification of the patient.

5.10 The relative have to identify the patient (the patient's face has to be disclosed) and then the same would be documented and the body would be handed over safely in the presence of the security officer.

5.11 In handling MLC cases follow MLC protocol of the organization. The patient's body hand over and the documentation process should be completed with utmost care as these serve as legal documents for reference at any given situation. Appropriate acknowledgments have to be obtained from the person receiving the patient's documents.

6.0 Post Procedure:

6.1 Clarify and handover personal belongings to relatives and document it with date, time and signature of the relatives.

6.2 There should be appropriate & complete documentation of all the incidents throughout the care process.

6.3 Record the procedure.

BIOMEDICAL WASTE MANAGEMENT

1.0 Meaning:

1.1 Bio-medical waste:

1.1.1 It means any waste, which is generated during the diagnosis, treatment or immunization of human beings or animals or in research activities pertaining thereto or in the production or testing of biological or in health camps and including categories mentioned in Schedule I of the BMW rules.

1.2 Bio-medical waste management:

1.2.1 It includes all steps required to ensure that bio- medical waste is managed in such a manner as to protect health and environment against any adverse effects due to handling of such waste.

2.0 Purpose/ Indication:

2.1 To ensure that biomedical waste is handled and disposed in a safe manner

2.2 To prevent injuries from sharps leading to infection to all categories of hospital personnel and waste handler.

2.3 To prevent nosocomial infections in patients from poor infection control practices and poor waste management.

2.4 To prevent risk of infection outside hospital for waste handlers and scavengers and at time general public living in the vicinity of hospitals.

2.5 To prevent risk associated with hazardous chemicals, drugs to persons handling wastes at all levels.

2.6 To prevent "Disposable" being repacked and sold by unscrupulous elements without even being washed.

2.7 To prevent drugs which have been disposed of, being repacked and sold off to unsuspecting buyers.

2.8 To prevent risk of air, water and soil pollution directly due to waste, or due to defective incineration emissions and ash.

3.0 Articles:

3.1 Personal Protective Equipments such as Gloves, Mask, Plastic aprons

3.2 Chemical disinfection such as 1 % hypochlorite solution

3.3 Color coded garbage bags:

3.3.1 Yellow container with yellow liner

3.3.2 Red container with red liner

3.3.3 Double Blue liner with cardboard boxes

3.3.4 Black container with black liner

3.3.5 Green container with green liner

3.3.6 White translucent puncture proof container

3.3.7 White container with white liner

3.3.8 Container with leakproof sac

4.0 Pre Procedure:

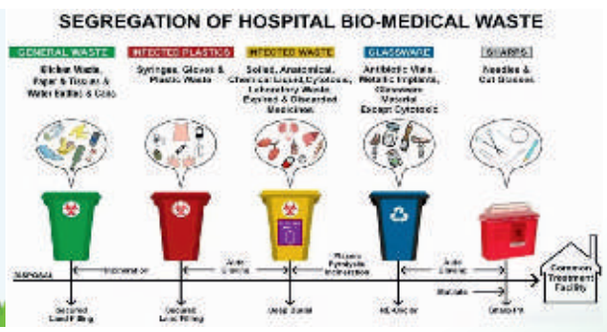
4.1 Assemble required containers and check for biohazard label on the container (if contagious wastes are present).
4.2 Wash hands.
4.3 Wear Personal Protective Equipments.

5.0 Procedure:

5.1 Segregate the hospital wastes according to the categories.
5.2 Dispose it in the appropriate containers.
5.3 The various types of biomedical wastes should be segregated from each other.
5.4 Fluid waste should be contained from solid waste.
5.4 Containers for biomedical waste must be appropriate for its contents.
5.5 Biomedical waste must not be mixed with other non-infectious wastes. If by mistake this has occurred, then non-infectious wastes are treated as biomedical waste.
5.6 Biomedical waste shall be segregated into containers at the point of generation.
5.7 The containers will be labeled with biohazard symbol which will be non-washable and prominently visible.
5.8 Chemical treatment to be done by using 1% sodium hypochlorite for 20 minutes for chemical liquid wastes.
5.9 Double bag if necessary to prevent perforations.
5.10 Add absorbent material if the possibility of large volumes of liquid exists
5.11 Ensure the bags are well sealed
5.12 Secondary containment should also be labeled with the biohazard symbol.
5.13 Treatable waste should not be allowed to accumulate.
5.14 Waste that is to be disposed off-site should be stored in designated areas that are secure and access is limited to delegated individuals.
5.15 The Biomedical waste authority will contact the Consolidated Waste Services to arrange for a waste pick-up from the storage area.

6.0 Post Procedure:

6.1 Wash hands.
6.2 Document and maintain the records regarding the nature of the waste generated.



BIOMEDICAL WASTE CATEGORY

SL NO	TYPE OF WASTE	COLOR OF CONTAINER
	INFECTIOUS WASTE	
1.	**HUMAN ANATOMICAL WASTE:** Human tissue, organs, body parts and animal anatomical waste	YELLOW CONTAINER WITH YELLOW LINER
2.	**SOLID WASTE:** Dressings, POP, cotton swabs, mask, head cap, shoe cover, sand bed and disposable apron(cloth)	
3.	**DISCARDED LINEN:** Patient cloths, mattress, cover, mat(cloth)	
4.	**MICROBIOLOGY, BIOCHEMISTRY & OTHER CLINICAL LABORATORY WASTE:** Laboratory cultures, soda lime, formalin tablet	
5.	Blood bags with blood, blood bags without blood, to be autoclaved	
II	**EXPIRED, UNUSED OR DISCARDED MEDICINES:** Separate yellow liner, aluminium foil with drugs, vaccines	
III	**CYTOTOXIC DRUGS NO SHARPS** Cytotoxic waste except sharps	(Yellow container with yellow liner (biohazard and cytotoxic label)
IV	**CONTAMINATED PLASTIC WASTE** Suction tubing's, IV tubes, catheter, urine bags, syringes without needle, IV plastic bottles, vaccutainer, gloves and glove wrappers, disposable plastic apron, medicine blister packets without drugs, needle caps, plastic packaging materials, plastic containers/dispensers (povidone container, hand rub and other containers) cautery plate, plastic mat, Rexene, mackintosh.	RED CONTAINER WITH RED LINER (BIOHAZARD LABEL)
1.	**GLASS WARE:** Broken or discarded medicine vials, culture glass bottles, slides and ampoules.Laboratory glass waste should autoclave/disinfect then put it in blue liner	Double blue liner with cardboard boxes with blue marks (biohazard label)
2.	**METALLIC BODY IMPLANTS:** Separate thick cardboard box with label	
V	**WASTE SHARPS INCLUDING METALS:** Needles, syringes with fixed needles, scalpels, blades, sharp object.	WHITE TRANSLUCENT PUNCTURE PROOF CONTAINER
VI	**CHEMICAL LIQUID WASTE:** CHEMICALS/DISINFECTANTS, formalin, infected secretions, aspirated body fluids, liquid from laboratories, floor washing	Decontaminated with 1% hypochlorite solution before discard into sluice

BIOMEDICAL WASTE CATEGORY

SL NO	TYPE OF WASTE	COLOR OF CONTAINER
	NON INFECTIOUS WASTE	
I	**CLEAN WASTE:**	
1.	**WHITE LINER** Syrup box, glove box, individual packaging of injection/vial box aluminium foil without drugs, paper CSSD wrappers, syringe cover, gloves wrappers	WHITE CONTAINER WITH WHITE LINER
2.	**LEAK PROOF SACK WITH CONTAINER** Administrative papers, news papers, unused request forms, carbon papers, patient sticker	CONTAINER WITH LEAK PROOF SACK
II	**FOOD WASTE:**	
1.	**WET FOOD WASTE:** Leftover foods, vegetables, fruits, egg shell and non vegetarian food waste etc	GREEN CONTAINER WITH GREEN LINER
2.	**FOOD PACKAGING MATERIALS:** Badam/juice glass bottle, tetra packs, milk/curd packets, coffee cups, drinking bottles, aluminium foil food parcels, parcel paper/plastics etc	BLACK CONTAINER WITH BLACK LINER

FUMIGATION OF INFECTED WARD

1.0 Meaning

1.1 Fumigation is a process of gaseous sterilization, used for killing the micro-organisms and prevention of microbial growth in air, surface of wall or floor.

2.0 Purpose

2.1 To disinfect operating room / theatre.

3.0 Articles

3.1 Personal protective equipment (PPE-cap, mask,foot wear,spectacle, etc.)
3.2 Formalin solution
3.3 Distilled/tap water
3.4 Potassium Permanganate
3.5 Vapouriser
3.6 Steel buckets (3-4)

4.0 Pre Procedure

4.1 Dust and remove all the visible contamination, and wash floor of the O.T. with soap solution
4.2 Clean all the doors ,walls, windows, operation table with soap and water.
4.3 Seal the room- airtight to avoid the leak of gas
4.4 Determine the size of the O.T.(L x B x H) and calculate the adequate amount of formalin.
4.5 Wear all the PPE
4.6 Warning notice mentioning that the "O.T. under FUMIGATION" should be displayed on the entrance of room.

5.0 Procedure

5.1 Electric Boiler Fumigation Method

5.1.1 In an electric boiler, mix 500ml of formaldehyde(40%) to 1000ml of distilled water(or tap water for a size of 1000 cubic feet.

5.1.2 Seal the room after turning on the boiler and leave the O.T. vacant for approximately 45 minutes that may vary depending upon the boiler or its heating efficiency.

5.1.3 Turn off the main switch of the boiler from outside without entering in to the O.T.

5.2 Potassium Permanganate Method

5.2.1 In a heat resistant container such as steel bucket, put 500ml of formaldehyde (40%) to 1000ml of distilled water (or tap water). Add 450ml potassium permanganate for area of 1000 cubic feet.

5.2.2 Leave the room immediately once the formaldehyde vapors are visible and seal it for at least 12-24 hours.

6.0 Post procedure

6.1 Take out the boiler/bucket from the O.T.
6.2 Counteract the adverse effects of formaldehyde vapor with ammonia solution.
6.3 For this, wet a cotton piece with 300ml of 10% ammonia (for each 500ml of formaldehyde used) and leave it on the fumigated floor for at least 4 hours before using the area. This is also known as sterility test.
6.4 Ammonia reacts with the formaldehyde gas and produce hexamine which is a harmless substance.
6.5 Document date and time of fumigation, neutralization, personnel involved and result of the sterility test in the record book so as to ensure that the procedure is done.

NEBULIZATION

1.0 Meaning:

1.1 The process of delivering a therapeutic dose of desired drug using a respiratory device called nebulizer which turns an aqueous solution of a drug into a mist of fine particles for inhalation

2.0 Indications/ purposes:

2.1 To reduce bronchospasm.
2.2 To liquify the respiratory tract mucus and sputum.
2.3 To relieve edema of the bronchial walls.

3.0 Contraindications:

3.1 No significant contraindications.

4.0 Articles required:

4.1 Client's chart
4.2 A tray containing:
- 4.2.1 Nebulizer
- 4.2.2 Connection tubing and mouth piece/ nebulization mask
- 4.2.3 Medication and saline solution
- 4.2.4 Disposable syringe 5cc
- 4.2.5 Sputum mug with disinfectant solution.
- 4.2.6 Tissue paper

5.0 Pre-procedure:

5.1 Identify the client and check for doctor's orders.
5.2 Assess the general condition of the client.
5.3 Assess the client's breathing pattern, breath sounds and heart rate.

6.0 Procedure:

6.1 Wash hands.
6.2 Explain the procedure.
6.3 Auscultate for breath sounds before and after the procedure.
6.4 Position the client in a comfortable sitting or semi fowler's position.
6.5 Follow the rights of administration of medication.
6.6 Keep the oxygen flow rate at 4 lts/ minute. (If prescribed)
6.6 Add the prescribed amount of medication to normal saline in the nebulizer.
6.8 A fine mist from the device must be visible.
6.9 Instruct the client to take deep breath from the mouth piece, hold his breath briefly and then exhale.

6.10 Observe the expansion of the client's chest to ascertain that he is taking deep breaths.
6.11 Instruct the client to breath slowly and deeply until all the medication is nebulized. (15-20 minutes)
6.12 Stop the regulator once the vapor stops.

7.0 Post procedure

7.1 Make the client comfortable.
7.2 Help patient to rinse his mouth with warm water.
7.3 On completion of the treatment, encourage the client to cough out secretions.
7.4 Assess the response to the procedure.
7.5 Observe for any adverse reaction.
7.6 Clean, dry and replace the equipment in its proper place.
7.7 Record the date and time, observation made and client's condition.
7.8 Record the details about the medication used for nebulization - name and dosage.

BARIUM ENEMA

1.0 Meaning:

1.1 It is a fluoroscopic X ray examination visualizing the entire large intestine by giving an enema of Barium sulfate.

2.0 Indications/ purposes:

2.1 For visualization of the lower GI system
2.2 For diagnosis of any abnormalities

3.0. Contraindications:

3.1 Hypersensitivity to contrast barium

4.0 Pre-Procedure:

4.1 Identify the client and check the doctor's order
4.2 Explain the procedure
4.3 Fix an appointment for the procedure
4.4 Patients are given a Coloprep Solution previous day
4.5 Obtain an informed consent

5.0 Procedure:

Instruct the client to:
5.1 Withhold medication containing bismuth for three days prior to the procedure
5.2 Take a low residue diet on previous day of the procedure
5.3 Have a light meal on the previous evening and then fast for 6-8 hours
5.4 Clear his/ her bowel. If constipated give an enema
5.5 Walk for a while before the procedure
5.6 Instruct the client he/ she will be given a barium solute enema and X-rays will be taken at various intervals
5.7 Shift the client to radiology department

6.0 Post procedure :

6.1 Observe for any adverse reaction
6.2 Instruct the client to take adequate amount of fluid, if not contraindicated
6.3 Administer laxatives as prescribed
6.4 Ascertain that the client has defecated
6.5 Documentation: Record the date and time when procedure was done, observation made and client's condition before and after procedure.

BARIUM SWALLOW

1.0 Meaning:

1.1 It is an oral administration of Barium Sulfate Suspension for radiographic investigation of hypopharynx and esophagus

2.0 Indications / Purposes:

2.1 For visualization of the upper GI system
2.2 For diagnosis of any abnormalities

3.0 Contraindications:

3.1 Hypersensitivity to contrast barium

4.0 Procedure:

4.1 Identify the client and check the doctor's order
4.2 Explain the procedure
4.3 Fix an appointment for the procedure
4.4 Obtain an informed consent
4.5 Instruct the client to fast 6-8 hours prior to the procedure
4.6 Withhold any medication that may interfere with peristalsis (anticholinergic)
4.7 Instruct the client that he/she will have to drink barium which is a white, thick, chalky tasting solution at various intervals during the procedure
4.8 Shift the client to radiology department
4.9 Post procedure Observe for any adverse reaction
4.10 Instruct the client to take adequate amount of fluid, if not contraindicated
4.11 Administer laxatives as prescribed
4.12 Ascertain that the client has defecated
4.13 Record the date and time when procedure was done, observation made and client's condition before and after procedure.

CARE OF THE SURGICAL DRAIN

1.0 Meaning

1.1 Surgical drains are the tubes placed near the surgical incisions in the postoperative patient, to remove pus, blood or other fluid, preventing them from accumulating in the body.

2.0 Purposes

2.1 To prevent infection.
2.2 To promote healing.
2.3 To evacuate existing accumulation of fluid or gas.
2.4 To remove pus, blood, serous exudates, chyle or bile.
2.5 To prevent the potential accumulation of fluid or gas.

3.0 Articles A clean tray containing:

3.1 Mackintosh with draw sheet.
3.2 Screen
3.3 Sterile gloves-1 pair
3.4 Clean gloves-1 pair
3.5 Cotton swabs
3.6 Sterile gauze pads
3.7 Dressing pack
3.8 Measuring Cup
3.9 Normal Saline
3.10 Hydrogen Peroxide
3.11 Sterile bowl
3.12 Kidney Tray
3.13 Adhesive Tape
3.14 Waste receptacle
3.15 Medication as ordered

4.0 Pre Procedure

4.1 Identify the patient
4.2 Explain the purpose of the procedure
4.3 Assemble all the articles on the clean trolley, place it next to the bedside
4.4 Check the surgeon's order for any specific instructions.
4.5 Provide privacy to the patient
4.6 Assist patient to the comfortable position that provides easy access to the drain site
4.7 Place the protective mackintosh with draw sheet beneath the area of the drain site
4.8 Wear the clean gloves
4.9 With at most, care open the outlet knob of the drain bag, without spilling the contents on the bed

4.10 Squeezing the drainage container, empty the contents of drainage bag in the measuring cup.
4.11 Press the drainage bag flat
4.12 Release the clamp on the drain tubing to allow the drain to flow.
4.13 Measure the drainage amount in the cup and record the color, odour(if any)
4.14 Discard the contents as ordered
4.15 Remove the old dressing.
4.16 Assess the drain insertion area for signs of leakage, redness and sloughing and also assess for the suture used to position the drain in situ.
4.17 Remove and discard gloves and wash hands.
4.18 Clamp the drain tube before opening the outlet knob to drain the content.

5.0 Procedure

5.1 Open the sterile dressing pack and arrange the supplies on the work area
5.2 Pour normal saline in to the bowl
5.3 Wear the sterile gloves
5.4 Clean the drainage area by using cotton swabs soaked in normal solution, moving from inside out in a circular motion.
5.5 Use separate cotton swabs for each stroke
5.6 Use medication as ordered on a sterile gauze
5.7 Place the medicated gauze on the drainage area
5.8 Cover the area with dressing pad
5.9 Remove the gloves
5.10 Secure the dressing with adhesive tape

6.0 Post procedure

6.1 Dispose of all the waste according the waste management protocol.
6.2 Make the patient comfortably.
6.3 Remove the screen and replace all the articles
6.4 Wash and repack all the articles to be sent for sterilization.
6.5 Wash hands.
6.6 Document the procedure specifying the appearance of the drainage site ,color and odour, amount of drainage output and patency of the drainage tube.
6.7 Ensure the tractions are appropriate positioned.

PIN SITE CARE IN SKULL TRACTION / EXTERNAL FIXATOR APPLICATORS / SKELETAL TRACTIONS

1.0 Meaning

1.1 Skin care provided to the pin insertion site, for patients who are on various types of pin applications/tractions.

2.0 Purposes

2.1 To prevent Infection.
2.2 To maintain healthy skin around the pin site.

3.0 Articles

3.1 Sterile dressing tray.
3.2 Sterile gloves & clean gloves.
3.3 Normal saline solution.
3.4 Hydrogen peroxide.
3.5 Povidine solution.
3.6 Sterile cotton swabs.
3.7 Guaze pieces.
3.8 Bowl for solutions.
3.9 Kidney trays.
3.10 Mackintosh with drawsheet.

4.0 Pre Procedure

4.1 Assemble all the articles on the dressing trolley & place it near the patient's bedside
4.2 Explain the procedure to the patient and attendants.

5.0 Procedure

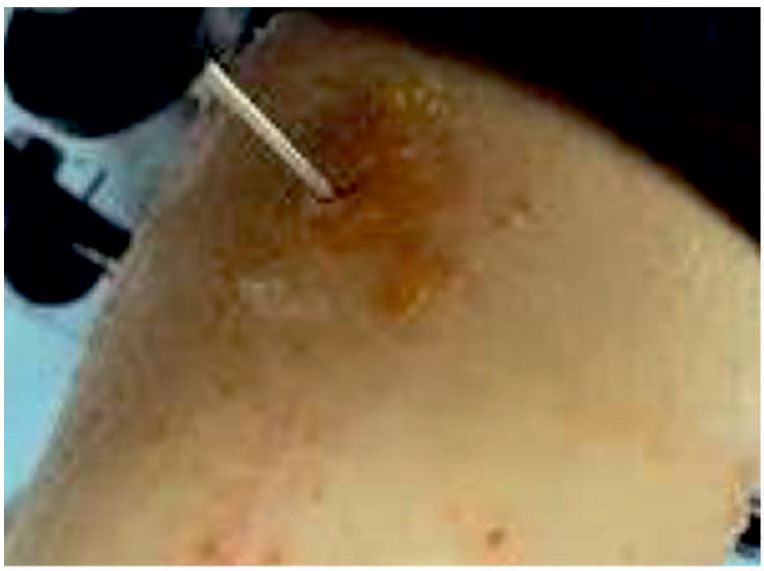
5.1 Position the patient.
5.2 Place mackintosh and drawsheet under pin site.
5.3 Open the dressing tray.
5.4 Wash hand and wear clean gloves.
5.5 Pour normal saline solution and hydrogen peroxide solution in 1:1 dilution in a bowl.
5.6 Pour povidine solution in another bowl.
5.7 Soak the old dressing around the pin site with plain normal saline swabs
5.8 Remove old dressing from the pin site and discard.
5.9 Take a sample for culture and sensitivity from pin site (if necessary).
5.10 Wear the sterile gloves after removing the clean gloves
5.11 Gently clean the pin sites one by one thoroughly, first with hydrogen peroxide soaked swabs, followed by saline swabs.
5.11 Soak sterile gauze in povidine solution squeeze, and warp it around the each pin site

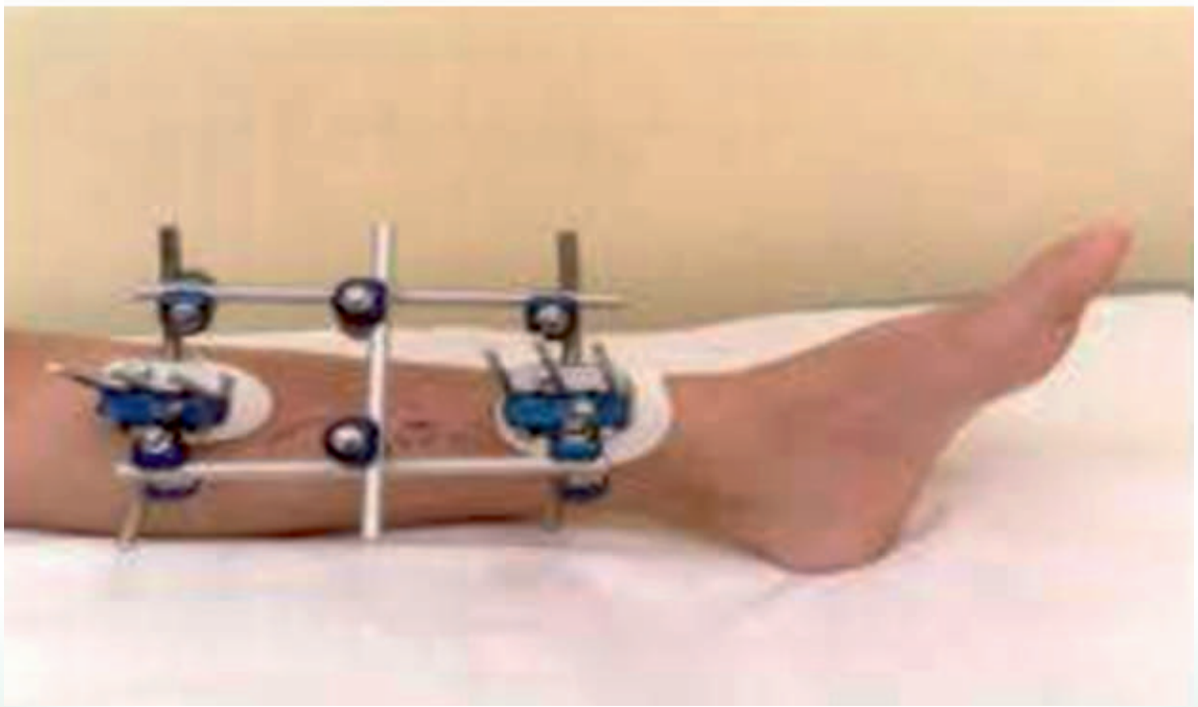
5.12 Ensure that all the pin sites are covered
5.13 Ease the patient to the comfortable position

6.0 Post procedure

6.1 Dispose of all the waste and clean the patient's unit.
6.2 Replace the articles after cleaning
6.3 Remove gloves and Wash hands
6.4 Record the condition of the pin site, any discharges, bleeding (in any), induration
6.5 Record all the solutions and medications used for pin site care.

IMAGES OF PIN INSERTION SITE





PROCEDURE OF CAST APPLICATION & CARE

1.0 Meaning

1.1 A plaster cast is a rigid immobilizing device that is molded to contours of body to encase an injured part.

2.0 Purpose:

2.1 To immobilize a body part in a specific position.
2.2 To correct or prevent deformity.
2.3 To provide support/stability for weakened joints.
2.4 To immobilize a reduced fracture.

3.0 Articles - Trolley containing,

3.1 Plaster bandages.
3.2 Stockinet.
3.3 Scissors.
3.4 Dressing materials.
3.5 Protective sheet.
3.6 Rubber sheet.
3.7 Plastic apron.
3.8 Gloves
3.9 Bowl/bucket of warm water.
3.10 Shaving set.
3.11 Short trimming knife.

4.0 Pre Procedure

4.1 Assemble all the articles next to the patient
4.2 Assess patient's health status including conditions of wound healing
4.3 Explain the purpose and procedure to the patient
4.4 Asses the condition of skin in the planned area of cast application, including the circulation to the extremities
4.5 Assess the patient's pain level
4.6 Advice the patient to use appropriate and loose clothing
4.7 Protect patient's cloths with protective sheet

5.0 Procedure

5.1 Position the patient according to the body area to be casted
5.2 Wash hands and put on the gloves
5.3 Prepare the skin for cast if necessary (changing dressing, shaving and trimming of long hair. Take care to maintain skin integrity)
5.4 Place the stockinette over the skin where cast need to be applied
5.5 Wrap the site with cast padding

5.5.1 Depending on the cast material being applied, do as following
5.5.2 Hold plaster roll under water in a casting bucket/basin of water until bubbles stop, then squeeze a slightly and handover to person applying the cast
5.5.3 Submerge synthetic cast roll in the lukewarm water for 10-15 seconds, and squeeze to remove the excess water
5.5.4 Hold body or body parts to be put on cast in position as planned for applying cast

5.6 Continue to apply dampened rolls of plaster to hold body parts as necessary as possible until cast is finished (sufficient thickness to be maintained togive strength to the cast
5.7 Assist with finishing the cast by folding stockinette or other padding down the outer edge of cast to provide smooth edge to cast. Damp plaster is then rolled over padding to hold outside cast firmly
5.8 Trim the plaster roll around the thumb, fingers' ,or toes as necessary

5.9 Depending on body parts casted , do one of the following
5.9.1 Place damp cast on cloth covered pillows to prevent deformation or pressure points as it sets
5.9.2 Handle the damp plaster cast with only the palm of the hand and not with the fingers.

6.0 Post procedure

6.1 Transfer the patient to stretcher or wheel chair ,shift the patient to ward.
6.2 Clean the cast applying unit, and replace the articles in their usual place
6.3 Explain the purpose of exposure of the cast applied area for facilitate drying of the cast as it prevents breaking of the cast
6.4 Observe patient for sign of pain and anxiety.
6.5 Assess neurovascular status by performing neurovascular checks
6.6 Observe color of tissues distal to the cast
6.7 Observe for edema distal to the cast
6.8 Assess temperature of tissues above and below the cast
6.9 Palpate the distal pulses of casted extremity. Note presence and strength of the pulse.
6.10 Ask patient to move parts distal to cast in ROM if possible. If patient cannot do active ROM, perform passive ROM on these joints noting responses or complaints of increased pain
6.11 Ask patient to describe sensations or feelings of the tissue in cast listen for descriptions such as pins and needles
6.12 Record cast application and condition of skin and circulation status
6.13 Record patient's ability or inability to perform Activities of daily living and specific need for care
6.14 Educate parient to aviod prevent any foreign body inside the cast

PRE - OPERATIVE CARE

1.0 Meaning

1.1 The preoperative care begins with the decision that surgical intervention is necessary and ends when the patient is transferred to the operating room.

2.0 Purposes

2.1 To prepare the client physically and psychologically for the surgery
2.2 To assess the client's financial status
2.3 To verify completion of client's pre-operative preparation

3.0 Articles

3.1 Shaving kit
3.2 Skin preparation
3.3 Enema can
3.4 Bowel wash articles
3.5 Urinary catheter
3.6 Nasogastric tube
3.7 Micro shield
3.8 IV cannula
3.9 3 times bath will be given with microshield (previous day morning & evening and morning day to surgery)
3.10 Clean hospital uniform (ensure inner garments are removed)
3.11 Head cap
3.12 Materials, medications and equipment to be sent to OT along with the client as per orders
3.13 Stretcher with clean linen with blanket, O2 cylinder if required & plastic bowel or kidney tray
3.14 Preop Medication, preop check list

4.0 Pre Procedure

4.1 Explain the procedure regarding the pre, intra and post-operative care
4.2 Assist for pre-anesthetic checkup (PAC) and carry out the orders
4.3 Teach re-breathing exercise (incentive spirometer)
4.4 Prepare the client as per the pre-operative checklist, informed consent for surgery
4.5 Ensure availability of blood for transfusion, if required
4.6 Enquire about advance payment towards surgery. If financial support is needed direct to medical work department
4.7 Explain and reassure the client and attendants
4.8 Ensure the client is comfortable with adequate sleep and rest. If required medication can be administered

5.0 Procedure

5.1 Prepare the client as per the pre-operative checklist
5.2 Administration of pre medication as per the order
5.3 Ensure that informed consent is obtained
5.4 Collect and report the results of the specific investigations to the anesthetist on duty
5.5 Check on NPO status and vitals
5.6 Confirm availability of blood for transfusion, if required
5.7 Confirm advance payment towards surgery
5.8 Explain and reassure the client and attendants
5.9 Follow up for all reports and escalate to surgeons any abnormal values
5.10 Collect and document the contact number of patient relative who has to be timely updated of the progress of OT
5.11 Shift the patient as per doctors order in clean stretcher with blanket

POST - OPERATIVE CARE

1.0 Meaning

1.1 The post operative phase lasts from the patient's admission to the recovery room through the complete recovery from surgery.

2.0 Purposes

2.1 For close observation & monitoring of the client
2.2 To prevent potential post-operative complications

3.0 Articles

3.1 Stretcher with linen, blanket.
3.2 Plastic basin (medium).
3.3 Portable IV stand.
3.4 Oxygen cylinder with mask & ambubag (if required).
3.5 Portable ventilator if needed to shift to ICU.
3.6 BP apparatus
3.7 TPR tray
3.8 Kidney tray
3.9 Oxygen connection
3.10 Suction connection
3.11 Pulse Oxymeter
3.12 Ventilator connections
3.13 Emergency trolley with resuscitation equipment
3.14 Medications & IV fluids as prescribed

4.0 Pre Procedure

4.1 Identify the client & check doctor's orders
4.2 Assess the general condition & level of consciousness of the client while receiving the patient.

5.0 Procedure

5.1 Shift the client gently to the stretcher (check for skin status)
5.2 Observe & monitor the level of consciousness, IV fluids, drainage tubes & surgical wound dressing
5.3 Receive client's chart along with reports of investigations (ECG, Echo, X-ray, CT scan, MRI & biopsy sample with form)
5.4 Take over the remaining medications, materials and equipment (implants, infusion pumps etc)
5.5 Drape the client with a blanket
5.6 Carefully wheel out the client from the receiving area of OT to the respective unit

5.7 Explain the client's condition to the attendants (immediate post-operative care)
5.8 During transportation of the client, observe continuously and provide appropriate care
5.9 Shift the client gently from the stretcher to the postoperative bed
5.10 Position the client comfortably (depending on the type of surgery and anesthesia)
5.11 Keep the client warm with adequate linen
5.12 Assess the client as per the immediate postoperative checklist

5.13 Explain specific instructions to the client and attendants regarding
- 5.13.1 Maintaining of position in the bed and mobilization
- 5.13.2 Meeting the nutritional requirement (NPO duration)
- 5.13.3 Meeting the elimination need
- 5.13.4 Providing adequate rest and sleep
- 5.13.5 Importance of restriction of visitors

5.14 Continue observing, monitoring and reassessing of the client until the vital parameters are stable
5.15 Check the vitals of the patient, surgical wound site for any bleeding
5.16 Confirm from the surgical and anaesthesia team if patient is for a shift out to respective unit
5.17 Inform the respective unit to be prepared with essential equipments and accessories to receive the patient
5.18 Check the pain score and order for pain management
5.19 Check for post op orders
5.20 Surgical update and expectations in the post op to be briefed to the patient attendant by respective surgical team

6.0 Post procedure

6.1 Make the client comfortable
6.2 Reassure the client and attendants
6.3 Clean, dry and replace equipment in its proper place
6.4 Wash hands
6.5 Record the date and time when patient was received from O.T.
6.6 Record all the observation's made, client's condition and items received from OT along with the client (chart, reports x-ray (number of films), ECG, materials, medications and equipment).
6.7 Document the specimen taken and if sent to lab

PREOPERATIVE CHECKLIST

Case file No. …….. Date …… Patient's Name: …….
Age & Gender …… Ward ……. Height …….. Weight…..……..
Diagnosis ……. Proposed Operation ……. Vital Signs: Pulse ….....……
Respiration ……Temp ……..B.P……..
Consent signed ……Yes/No
Pre-Anesthesia Check up done ……..Yes/No
Pre -Medication Given ……Yes/No
At……by ……Specify
……

Investigation Reports of

Blood: Hb% ……, Blood group ……. Blood arranged……..Units……
Other lab reports ……
X-ray : yes/no
ECG : yes/no
USG : yes/no
Previous surgical history…….....……
…….……..
Fasting from ……..
Dentures removed……Yes/No
Glasses/lenses……..Yes/No
Hearing aid .....Yes/No
Jewellery removed……Yes/No
Make-up/Nail polish removed……..Yes/No
Hairpins removed……Yes/No
Nasogastric tube in place……..Yes/No
Bladder emptied……Yes/No
Catheter present……Yes/No
I.V. Infusion……..Yes/No
O.T gown/cap worn……..Yes/No
Skin preparation done, specify area as per the instructions…….
…….

Patient blood group.....
GRBS.....
Patient is clear of all personal clothings Yes/No
contact number of patient attendant.....

Other accessories handed over to the relative and sign taken……..
Patient's case file handed over to the theater nurse along with all the investigation reports……..Yes/No

Signature of the relative

Hand over by
Ward Nurse Name & Sign Date & Time
Received by
Operation theatre Nurse Name Date & Time

Post operative checklist

Date: ..... Time: ..... Case file No: .....

Date: ..... Patient's Name: .....

Age & Gender: ..... Surgery Performed: .....

Surgeon: ..... Anesthesiologist: .....

Anesthesia: General ..... Spinal ..... Block ..... Local .....

Intra -operative History

Type and Amount of I.V. fluid administered: .....

Blood Transfusion ..... Yes/No (If any) Number of units: .....

Urine Output ..... ml, Color ..... Catheter Present

Nasogastric tube is present -Yes/No (If any) content in ml & color .....

Urinary output at the time of shifting to PACU(Recovery Room)

Dressing and further instructions .....

Initial Assessment at Recovering Room:

Vitals:

Pulse ..... Resp ..... B.P ..... Tem .....

Level of Consciousness: .....

Oriented /Disoriented /Unconscious, Others Specify .....

Position to be maintained after the surgery .....

Saturation.....

Pain score ..... pain medication.....

GRBS.....

IV fluid on flow.....

Post operative Instructions

By the Anesthesiologist: .....

By the Surgeon ..... Medications to be continued in the post-operative phase

.....

Patient's case file along with all the investigation reports Handed over by the O.T. staff nurse

Name of the staff ..... Signature ..... Date & Time .....

Patient's case file along with all the investigation reports Taken over by the Ward staff nurse

Name of the staff ..... Signature ..... Date & Time .....

ASSESSMENT AND MANAGEMENT OF PRESSURE SORES

1.0 Meaning

1.1 Bedsores are also called pressure ulcers or decubitus ulcers and are injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Bedsores, most often develop on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone.

2.0 Purposes

2.1 To protect the wound from contamination.
2.2 To promote healing of the wound.
2.3 To promote physical, psychological and aesthetic comfort to the patient.
2.4 To support the site of the wound.
2.5 To promote thermal insulation to the wound surface.

3.0 Articles

3.1 Artery forceps-2
3.2 Thumb Forceps-1
3.3 Cotton swabs
3.4 Gallicup-2 No. for Normal solution and povidine solution
3.5 Surgical Pads
3.6 Kidney Tray
3.7 Sterile scissors
3.8 Gauze pieces
3.9 Sterile gloves
3.10 Water proof pad or mackintosh
3.11 Culture tube (optional)
3.12 Adhesive plaster
3.13 Receptacle for waste
3.14 Medication as ordered

4.0 Bedsore Dressing-Guidelines for bedsore dressing are

Condition	Cover dressing
None to moderate exudates	Gauze with tape or composite
Moderate to heavy exudates	Foam Dressing with tape or composite
Frequent soiling	Hydrocolloid dressing, film, or composite
Fragile skin	Stretch gauze or stretch net

5.0 Pre Procedure

Assemble all the equipment and take to the bedside of the patient.

5.1 Explain the procedure to the patient/care giver
5.2 Position the patient. It depends on the area of the body involved
5.3 Place mackintosh and small cotton sheet under the patient

6.0 Procedure

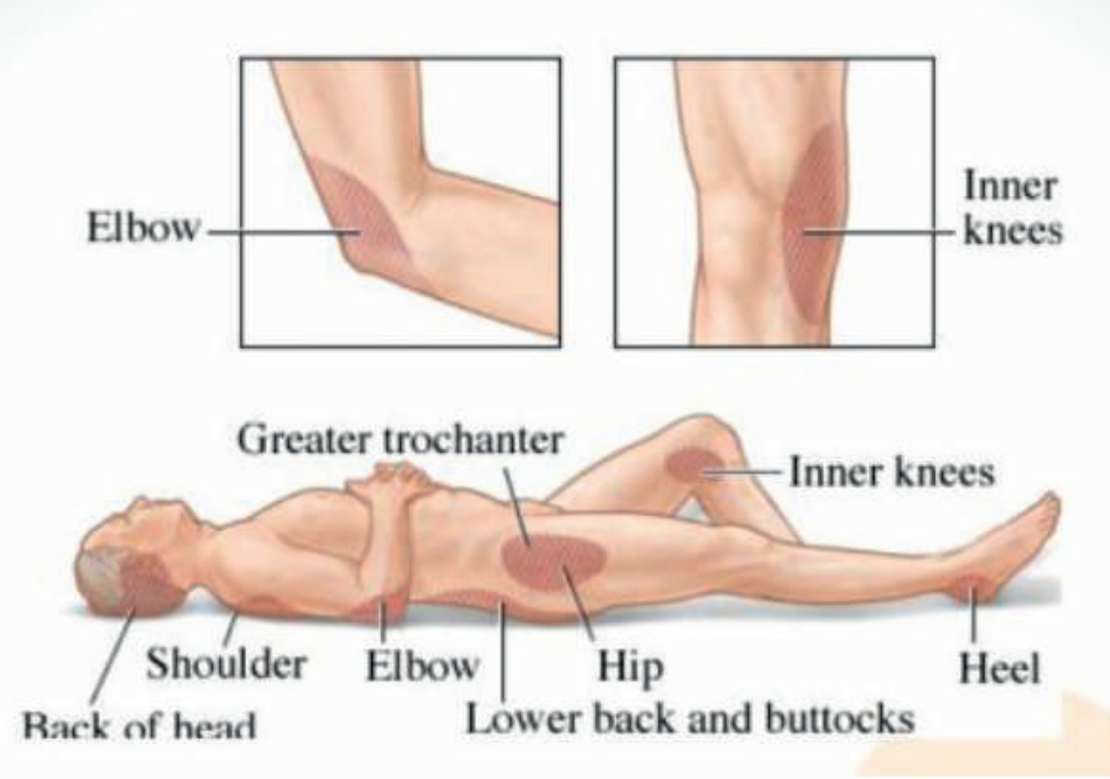
6.1 Wash hands thoroughly with soap and water and dry with the clean towel
6.2 Remove and dispose off the previous dressing.
6.3 Assess the condition of the wound and amount, color and odour of drainage
6.4 Again wash your hands thoroughly
6.5 Pour normal saline in the bowl and soak 2-4 cotton swabs
6.6 Put on sterile gloves
6.7 Clean the wound from inside out circular motion using the wet normal saline swabs
6.8 Dry the wound by using a gauze pieces in the same motion
6.9 Apply a thin layer of prescribed medication on the wound and cover it with sterile gauze piece
6.10 Supplement the primary dressing with the help of secondary dressing according to the size of the wound
6.11 Remove gloves
6.12 Secure the dressing with a adhesive tape or bandage
6.13 Re-position the patient
6.14 Make the patient comfortable
6.15 Use of wound assessment scale staging and grading of pressure ulcer
6.16 Advanced dressing technique vac, comfil dressing

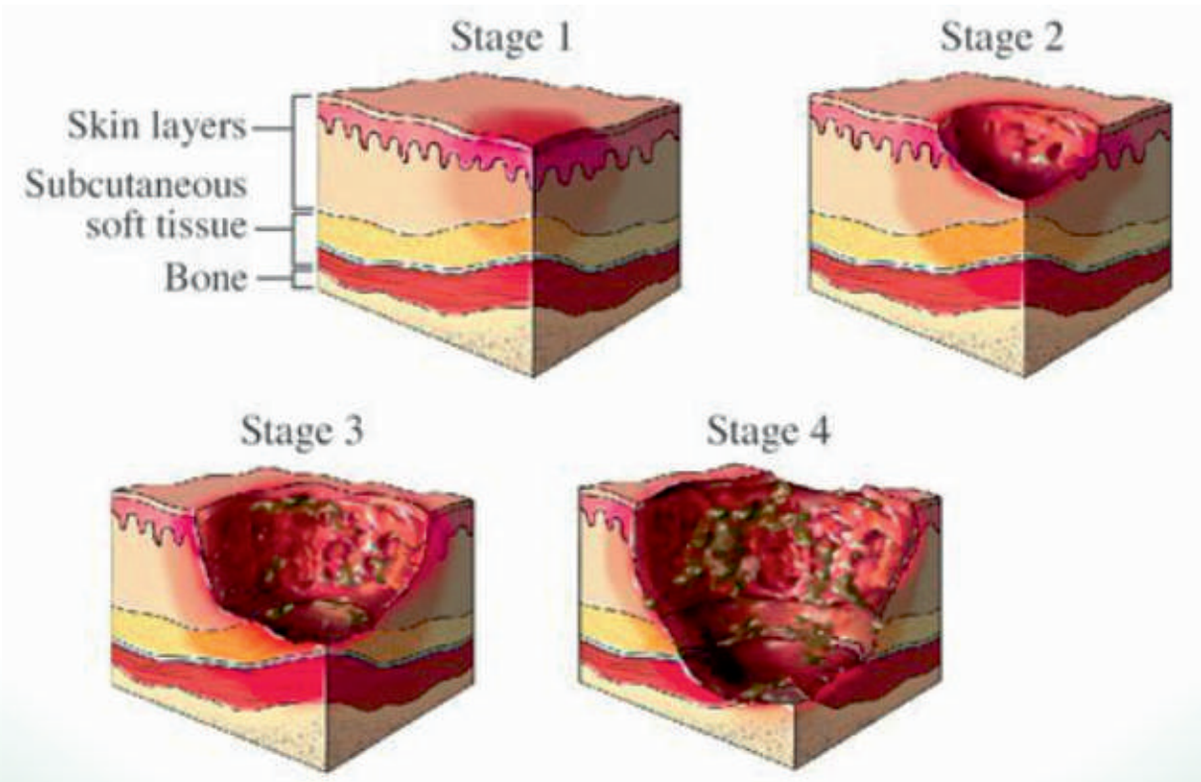
7.0 Post procedure

7.1 Wash the contaminated articles under running water, dry them and replace them in their regular space.
7.2 Wash the hands thoroughly with soap and water
7.3 Document the appearance of the wound odour, color and amount of drainage (if any)

Diagrams of Pressure sores and Areas Where Bed Sores Develop




Elbow
Inner knees
Greater trochanter
Inner knees
Shoulder
Elbow
Hip
Heel
Back of head
Lower back and buttocks


Stage 1
Stage 2
Skin layers
Subcutaneous soft tissue
Bone
Stage 3
Stage 4

SKIN PREPARATION FOR SURGERY

1.0 Meaning

1.1 Skin preparation is a preoperative procedure performed to decontaminate and reduce the number of micro organisms on skin to eliminate the transference of such organisms into the incision site.

2.0 Purposes

2.1 To remove hair from the marked skin area around the surgical site.
2.2 To prevent wound infection postoperatively.

3.0 Techniques of Hair Removal

3.1 Clipping
3.2 Wet Shaving
3.3 Use of depilatory cream

4.0 Articles

4.1 Razor Set
4.2 Tissue paper
4.3 Sponge pieces
4.4 Kidney Tray
4.5 Basin with water
4.6 Mackintosh/ waterproof pad
4.7 Antiseptic Soap
4.8 Bath towel
4.9 Clean gloves Scissors
4.10 Depilatory cream (optional)
4.11 Clippers
4.12 Bath Blanket

5.0 Pre Procedure

5.1 Inspect general condition of skin
5.2 Review the agency protocol for any specific instructions
5.3 Follow the Surgeons order for specific skin area to be shaved
5.4 Explain the procedure to the patient to gain his confidence and co-operation during the procedure.

6.0 Procedure

6.1 Wash hands.
6.2 Provide privacy.
6.3 Position patient comfortably so as to access the surgical site easily.
6.4 Put on the clean gloves
6.5 Remove Hair

6.5.1 Wet Shave

6.5.1.1 Place towel or waterproof pad under body part to be shaved

6.5.1.2 Drape patient with bath blanket, exposing only the area to be shaved

6.5.1.3 Cut long hair with scissors, lather the skin with sponge pieces soaked in antiseptic soap solution

6.5.1.4 Shave small area at a time. With non dominant hand hold gauze sponge to stabilize the skin. Hold razor at 45% angle in dominant hand and shave in the direction of hair growth.

6.5.1.5 Rinse the razor blade in between the strokes of shaving.

6.5.1.6 Use wash cloth and warm water to rinse away remaining hair and soap from the skin.

6.5.1.7 If the shaven area is over the body cervices, like axilla ,groin, umbilicus, cleanse with cotton clipped applicator's dipped in antiseptic solution.

6.5.1.8 Dry the shaven area with towel

6.5.1.9 Discard all soil sponges, gauze pieces

6.5.1.10 Observe skin for any nicks and cuts, if any

6.5.1.11 Record the procedure in the case record.

6.5.2 Hair Clipping

6.5.2.1 Drape the area to be clipped.

6.5.2.2 Slightly dry the area to be clipped with towel

6.5.2.3 Hold clippers in dominant hand, above 1cm above skin, and cut hair in direction it grows, clip small area at a time

6.5.2.4 Brush off the cut hair with the help of the towel

6.5.2.5 When clipping the hairy area over the body cervices clean cervices with cotton tipped applicators or cotton balls dipped in antiseptic solution, then dry

6.5.3 Depilatory Hair Removal

6.5.3.1 First do the sensitivity test of the cream, by applying a small amount of cream on the inner aspect of the forearm skin

6.5.3.2 Check for any sensitivity reaction like redness, rashes ,or itching of skin after 15-20 minutes

6.5.3.3 Drape the area to be cleaned and depilated

6.5.3.4 Apply the required amount of cream evenly on the area to be depilated wait for the required number of minutes and wipe off the cream with gauze pieces or tissue paper

6.5.3.5 Wash skin and rinse thoroughly

7.0 Post Procedure

7.1 Inform the patient that the procedure is completed

7.2 Clean and dispose the articles according to the agency policy.

7.3 Wash hands

7.4 Record the procedure, area clipped or shaved and condition of the skin before and after in the nurse's notes

7.5 Place the patient in the comfortable position. Change the dress of the patient if needed

7.6 Report any skin alterations or nicks and cuts in skin to the surgeon.

8.0 Skin preparation depends on the type of surgery to be performed:

8.1 Head & Neck: The site extends from above the eyebrows over the top of the head and includes the ears and both anterior and posterior area of the neck and face In females face is not shaved unless advised by the operating surgeon.

8.2 Lateral Neck: Clean the external auditory canal with a cotton swab. Anteriorly, prepare the side of the face from above the ear to the upper thorax to just below the clavicle. Posteriorly prepare from the neck to the spine including the area above the scapula.

8.3 Chest Surgery: The site extends from the neck to the umbilicus and to the lateral midline

8.4 Abdominal Surgery: The preparation site extends from axilla to the mid thighs extending bilaterally to the lateral midline. All visible pubic hair should be shaved

8.5 Perineal Surgery: Shave all the pubic hair and inner thighs to the mid thigh. The area starts above the pubic bone anteriorly and extends beyond the anus posteriorly.

8.6 Lumbar Spine Surgery: Shave entire back including shoulders and neck to hairline and down to knees including both axilla.

8.7 Rectal Surgery: Shave the buttocks from iliac crest down to the upper third of the thighs including the anal region. The area extends to the mid line on each side.

8.8 Flank Surgery: Extends anteriorly from the axilla down to the upper thigh including external genial area. Posteriorly the area extends from mid scapular to the mid gluteal regions.

8.9 Hand and Forearm Surgery: The area includes the full circumference of the affected hand from axilla to the fingers.

8.10 Lower Extremity Surgery: The area includes the area from the umbilicus anteriorly including the entire leg, toes and foot of the affected leg and posteriorly from top the buttocks to the heel.

8.11 Lower Leg Surgery: The area to be prepared includes the circumference of the entire leg from mid thigh to the toes of the affected leg.

Skin Preparation Before Surgery

ANTENATAL EXAMINATION

1.0 Meaning:

1.1 Systematic examination of a pregnant woman

2.0 Purposes /indications:

2.1 To diagnose the normal pregnancy.
2.2 To measure the abdominal girth and fundal height.
2.3 To determine the lie attitude, presentation and position of the foetus.
2.4 To promote the health of the mother and fetus.
2.5 To prevent from complications.

3.0 Articles:

A tray containing

3.1 Hand rub lotion
3.2 Measuring tape
3.3 Fetoscope/stethoscope
3.4 Top sheet(optional)
3.5 Thermometer tray
3.6 BP apparatus
3.7 Specimen bottle for urine
3.8 Urosticks for testing sugar and albumin
3.9 Articles for per vaginal examination if necessary
3.10 Other articles
- 3.10.1 Weighing machine
- 3.10.2 Height scale fixed on the wall

4.0 Pre Procedure

4.1 Explain the procedure to the patient and get her consent
4.2 Instruct the patient to pass urine and collect a small sample in the specimen bottle
4.3 Check the weight and height
4.4 Make her lie comfortably on the bed
4.5 Provide privacy
4.6 Take a detailed history on
- 4.6.1 The presenting complaints, duration, associated factors
- 4.6.2 Socio-economic history
- 4.6.3 Environmental conditions of the family
- 4.6.4 Dietary habits
- 4.6.5 Other habits like smoking, drinking alcohol, pan chewing etc
- 4.6.6 Family history
- 4.6.7 Menstrual history
- 4.6.8 Obstetric history
- 4.6.9 Present pregnancy

4.6.10 LMP, EDD
4.6.11 Weeks of gestation at first antenatal visit
4.6.12 Details of antenatal visits
4.6.13 Inj. TT 1st and 2nd doses
4.6.14 Any problems in 1st, 2nd and 3rd trimesters (most of these information will be obtained from Antenatal card if she has registered)
4.6.15 Bowel pattern - regular/ constipation
4.6.16 Bladder - reduced urine output/ frequency of urination

5.0 Procedure

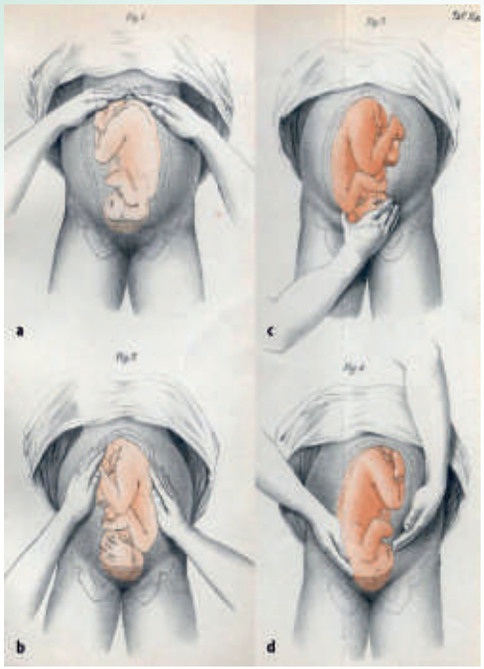
5.1 Perform a general physical examination (perform hand sanitization before touching the patient)
- 5.1.1 General health
- 5.1.2 Mental and emotional status
- 5.1.3 Attitude towards pregnancy
- 5.1.4 General head to foot assessment
- 5.1.5 Specially assess for anaemia, oedema - physiological or pathological, varicose vein
- 5.1.6 Other changes related to pregnancy like skin changes, nasal congestion, teeth and spongy gums etc.
- 5.1.7 Breast changes, enlarged lymph nodes, nipple - position
- 5.1.8 Any other observation

5.2 Abdominal examination
- 5.2.1 Inspection- expose the abdomen and observe for
  - 5.2.1.1 Size, shape, contour of the uterus
  - 5.2.1.2 Skin changes, bladder, fetal movements
  - 5.2.1.3 Operation scar, umbilicus

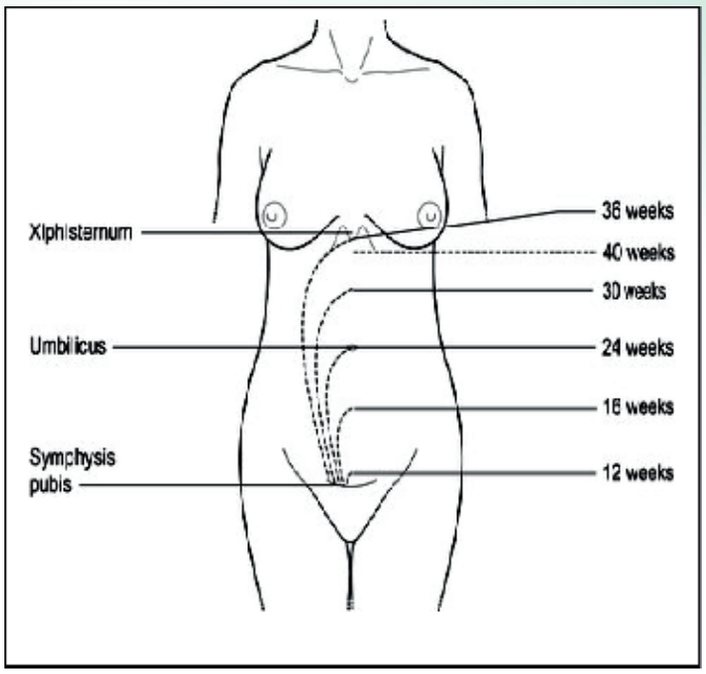
- 5.2.2 Palpation
  - 5.2.2.1 Warm up your hands and place on the fundus of the uterus for 10 minutes to note if there is any palpable uterine contractions. If uterus is relaxed, proceed with further steps.

  - 5.2.2.2 Measure the abdominal girth encircling the woman's abdomen with the measuring tape at the level of umbilicus

  - 5.2.2.3 Identify the fundus by placing the ulnar border of the left palm between the xiphoid process and the upper border of the fundus. Measure the fundal height in centimeters by placing the measuring tape from the upper border of the symphysis pubis to the upper border of the fundus. Place the fingers of the right palm between the upper border of the umbilicus to the upper border of the fundus. Each finger correspond to approximately one week of gestation till 36 weeks.



Steps of abdominal examination



Growth of the fundus

Palpation of fundus	Corresponding weeks
Upper border of the umbilicus	24 weeks
Midway between umbilicus and xiphisternum	32 weeks
At the level of xiphisternum	36 weeks
2 to 3 finger breadths below the xiphisternum(if the lightening takes place)	40 weeks

5.2.2.4 Fundal palpation: facing the woman place both palms on either side of the fundus, palpate with the examining fingers for shape, consistency and mobility of the fetal part in the fundus.

5.2.2.5 Lateral palpation: move both palms on either side of the midline of the abdomen. Using one hand to steady the uterus, with other hand palpate the fetal parts in the opposite side. The roles of the hands are then reversed.

5.2.2.6 Pelvic palpation: Ask the woman to flex her legs. face towards the woman's feet, place both hands on either side and gently move the fingers downward towards pubis and palpate to determine the fetal presentation, attitude and engament or non engagement of the presenting part. Press the palms against the symphysis pubis to see if the hands are converging or diverging.

5.2.2.7 Pawlik's grip; Facing the woman, place the left hand over the fundus to stabilize the fetus. Grips the lower pole of the fetus between the four fingers and the thumb of the right hand and assess the mobility of the presenting part.

5.2.3 Auscultation: place the fetoscope(stethoscope) over the abdomen where the fetal back is felt at the level of the umbilicus to hear the fetal heart sound (count the fetal heart for one full minute if the uterus is relaxed)

5.2.4 Perform Per vaginal examination if indicated

6.0 Post procedure

6.1 Cover the woman and make her comfortable

6.2 Remove the articles

6.3 Make her comfortable

6.4 Do the urine analysis for sugar and albumin

6.5 Record the findings of the procedure

6.6 Inform the concerned obstetrician if any abnormalities found

URINE ANALYSIS

1.0 Meaning

1.1 Urine analysis is an examination of urine to detect any abnormalities

2.0 Purposes

In obstetric nursing it is done specially

2.1. To detect the presence of albumin, sugar and ketone bodies

3.0 Articles required

3.1. Test tube stand with set of test tubes
3.2. Test tube holder
3.3. Spirit lamp
3.4. Match box
3.5. Kidney tray
3.6. Dropper - one for urine and second for reagents
3.7. Specimen container
3.8. One bowl of water to rinse the dropper after use
3.9. Reagents; benedicts solution and 2% acetic acid solution

4.0 Pre procedure

4.1. Identify the woman whose urine to be collected.
4.2. Explain the procedure and instruct her to collect a clean catch mid stream urine in the specimen bottle and provide the container
4.3. After collecting, instruct her to keep the specimen in the tray.
4.4. Assemble all the articles in the urine testing room
4.5. Wash hands and preferably wear clean gloves

5.0 Procedure

5.1. Test for albumin in the urine
- 5.1.1. Fix the test tube holder on the upper one third of the test tube and hold it.
- 5.1.2. Take the test tube and fill 3/4th of it with urine
- 5.1.3. Heat the upper third of the urine over the spirit lamp and allow it to boil
- 5.1.4. Keep the mouth of the test tube away from your face to avoid spillage of urine
- 5.1.5. Observe the top heated column of the urine for a cloudy appearance. Clear urine indicates absence of albumin
- 5.1.6. If cloudy, add five drops of 2% acetic acid into the test tube. If urine still remains cloudy, it indicates the presence of albumin. If it becomes clear, it indicates the presence of phosphates. (clear - nil, scanty cloudy - trace, as the cloudiness increase, reading increase as +, ++, thick cloud - +++)

5.2. Test for presence of sugar in the urine

5.2.1. Take another test tube and fix on the holder. Pour 5 ml of Benedict's solution into the test tube

5.2.2. Hold the bottom of the test tube over the spirit lampand heat the solution for 2 minutes

5.2.3. Add eight drops of urine through the sides of the test tube using the dropper and allow it to boil for another few seconds and let it cool.

5.2.4. Watch for the color change; blue - nil(no sugar),green liquid without deposit - +, green liquid with yellow deposit - ++, colorless liquid with orange deposit - +++, brick red color - ++++.

6.0 Post procedure

6.1. Discard the urine and rinse the test tubes

6.2. Discard the specimen bottle and the gloves into the appropriate waste bins

6.3. Wash hands and record the procedures with the results into the chart and inform the doctor if any abnormal findings for appropriate management

DAILY FETAL MOVEMENT CHART

1.0 Meaning

1.1 The daily fetal movement chart (DFMC) is a tool that is inexpensive, uncomplicated, non invasive and clinically effective means of screening for fetal well being after 20 weeks of pregnancy

2.0 Purposes

2.1 To assess the fetal well - being in pregnancy
2.2 To enhance the psychological and emotional bonding between the pregnant woman and the fetus
2.3 To detect any signs of fetal jeopardy at the earliest and to take the preventive measures

3.0 Articles

3.1 Note book/ paper to record fetal movement
3.2 Pencil to mark the fetal movement in the paper
3.3 Clock or watch
3.4 Food or beverage

4.0 Pre procedure

4.1 Ask the woman to drink or eat a carbohydrate containing food or move around that will stimulate the fetus to move
4.2 Ask her to empty the bladder and to assume a comfortable position preferably lying on her left side

5.0 Procedure

5.1 Educate her to mark the fetal movement on the paper whenever she feel the fetal movement for one hour
5.2 Instruct her to repeat the count for one hour after lunch and after the dinner
5.3 If she feel less than three fetal movements in one hour, she should chart for one more hour.

6.0 Post procedure

6.1 Reassure the woman
6.2 Encourage her to continue charting the fetal movement daily
6.3 If she feels less than three fetal movements in one hour for two consecutive hours, advise her to consult the Obstetrician

ADMISSION OF WOMAN IN LABOUR ROOM

1.0 Meaning

1.1 It refers to the procedure to be followed during the time of admission of an antenatal woman for safe confinement.

2.0 Indications

2.1 Woman in active phase or latent phase of labour
2.2 For induction of labour (IOL)
2.3 For emergency LSCS
2.4 Mothers with preterm contractions.

3.0 Articles

3.1 A clean bed
3.2 Clean hospital gown
3.3 Thermometer tray
3.4 BP apparatus and stethoscope
3.5 Measuring tape
3.6 Fetoscope/ hand Doppler
3.7 Weighing scale
3.8 Chart holder and admission sheets.
3.9 Perineal preparation tray
3.10 Enema and lubricating jelly
3.11 Clean gloves
3.12 IV cannulation tray, label , ID tag
3.13 Specimen collection containers

4.0 Pre procedure

4.1 Client
- 4.1.1 Determine the general condition of the woman
- 4.1.2 Assess the weeks of gestation.
- 4.1.3 Assess whether she is in active labour.
- 4.1.4 Assess whether she has any associated medical complications.
- 4.1.5 Private room admission - assess the financial status

5.0 Procedure

5.1 Receive the woman from the admitting department with all the documents.
5.2 Provide a neat and comfortable bed and ensure privacy.
5.3 Check the height and weight..
5.4 Assist her in changing into hospital gown and plait hair
5.5 Instruct her to remove ornaments and hand over to attendant.

5.6 If no attendant is available, remove the ornaments, verify the documents and obtain her signature. Hand over all ornaments to the ward in charge
5.7 Assist her in emptying the bladder and instruct her to collect a clean catch urine in the specimen bottle provided
5.8 Check vital signs and record.
5.9 Perform abdominal examination to know the condition of the uterus, lie, attitude, presentation, engagement of fetal head and FHR
5.10 If uterine contractions present, assess the frequency, duration and interval of uterine contractions,
5.11 Assess the perineum for any leaking or bleeding and visibility of presenting part.
5.12 Perform a vaginal examination to note the progress of labour
5.13 Collect medical and obstetric history; if the woman is in latent phase of labour, obtain a detailed history about the pregnancy and time of onset of labour pain, leaking per vagina etc.
5.14 Inform the duty doctor about the admission as well as her condition
5.15 Prepare the skin from the level of umbilicus to mid thigh.
5.16 Administer enema as per doctor's order.
5.17 Perform the urine sugar and albumin test
5.18 Assist the obstetrician in examining the woman.
5.19 Assess the need to start the IV injections or infusions as per order and perform the same as required after starting an IV line.
5.20 Collect the specimens indicated.
5.21 Inform the woman and attendant about the condition and progress of labour.
5.22 Orient them to the ward including the delivery charges.

6.0 Post procedure

6.1 Ensure comfort.
6.2 Send the specimen to the lab, with appropriate patient identification
6.3 Clean, dry and replace equipments in its proper place.
6.4 Record the time of admission of the patient, when the procedure was done, observation made and her condition during and after the procedure.

VAGINAL EXAMINATION IN LABOUR

1.0 Meaning

1.1 It is an internal examination performed on the vagina and the cervix in a woman during labour.

2.0 Purposes /Indications

2.1 To make a positive diagnosis of labour
2.2 To identify the presentation and position of the fetus
2.3 To determine whether the head is engaged in case of doubt
2.4 To ascertain whether the fore waters have ruptured or to rupture them artificially
2.5 To exclude cord prolapsed after rupture of fore waters, especially if there is an ill fitting presenting part
2.6 To assess undue delay in progress of labour
2.7 To confirm full dilatation of cervix

3.0 Contraindications

3.1 In case of frank bleeding until the location of placenta is confirmed

4.0 Articles required

4.1 A trolley containing mackintosh and towel to protect the bed
4.2 A fetoscope or stethoscope to assess the FHR after P V examination
4.3 A sterile bowl with cotton swab to clean the perineum
4.4 Antiseptic lotion
4.5 Antiseptic cream to smear on the examining fingers/ act as a lubricant
4.6 A pair of sterile gloves
4.7 Kidney tray - small to discard the used cotton
4.8 Articles for ARM if needed
- 4.8.1 Sterile curved Kocher's forceps (amniotomy forceps)
- 4.8.2 Sterile vaginal pad
- 4.8.3 Big kidney tray to receive amniotic fluid

4.9 Other articles
- 4.9.1 Screen
- 4.9.2 Mackintosh and towel to protect the bed
- 4.9.3 Clean bed sheets and patient gown

5.0 Pre procedure

5.1 Preliminary assessment
- 5.1.1 Identify the patient by calling by her name
- 5.1.2 Assess the general condition.
- 5.1.3 Assess the ability for self care and follow the instructions
- 5.1.4 Assess the uterine contractions - frequency, duration and intensity

5.1.5 Do an abdominal examination for presentation, position and decent of the fetal head (to be confirmed later with the findings of per vaginal examination)
5.1.6 Check the chart for any contra indications or any specific instructions

5.2 Preparation of the patient
5.2.1 Explain the procedure and get her cooperation
5.2.2 Make her to empty the bladder
5.2.3 Screen the bed and provide privacy
5.2.4 Position the patient - lying on her back with knees flexed and thighs separated
5.2.5 Expose only necessary area

6.0 Procedure

6.1 Assemble the articles near the bed side
6.2 Wash hands and wear the sterile gloves
6.3 Expose the perineal area
6.4 Observe the external genitalia for oedema, varicosities, vulval warts, sores or scars from previous tear or episiotomy or operation. Note any discharge or bleeding P V
6.5 Clean the vulva with gloved left hand or use a sterile artery forceps from top to bottom. Use only one swab for one stroke
6.6 Smear the index and middle finger of the right hand with antiseptic cream and gently insert downwards and backward into the vagina until the cervix is felt while the labia are held apart by the thumb and for finger of the left hand. The fingers may initially be directed with the palmar surface downward and backward and then rotated upwards.(Curl the last two fingers inwards)
6.7 Assess the condition of the vagina. Normal vagina should feel moist and warm. The walls are soft and distensible
6.8 Assess the cervix for consistency, position of the osuteri by gently sweeping the fingers side to side.
6.9 Assess for effacement and dilatation. The normal length of the uneffaced cervix is 2.5 to 3 cm. If the os is opened, the length can be assessed by inserting the fingers into the cervix up to the internal os and assess the proximity of the presenting part to the tip of the external os. If os is not opened, examine the outside of the cervix by sweeping the fingers side to side One finger is approximately equal to 1.5 to 2 cms
6.10 Assess the forewaters (status of the membranes), presentation, position, caput, moulding and level of presenting part(station of the head).. Presentation and postion are assessed by feeling the posterior fontanelle and the direction of the sagittal suture.
6.11 Assess the station. Station is assessed by assessing the level of the presenting part in relation to the maternal ischial spine Caput and moulding if present, should avoided while assessing the station. One station is approximately 1 cm(if the presenting part is 1cm above the maternal ischial spine then the station is -1,if it is 1 cm below the ischial spine then the station is +1)
6.12 Assess the pelvic capacity. Diagonal conjugate should be 12 to 13 cm, ischial spines blunt, wide sciatic notch, the curve of the sacrum is noted (well curved), side walls should be straight.
6.13 After obtaining the required information, withdraw the fingers from the vagina gently and observe for the type of discharge

7.0 Post procedure

7.1 Replace the perineal pad if any and cover the patient.
7.2 Remove gloves and wash hands
7.3 Assess the FHR
7.4 Assist the patient to assume a comfortable position
7.5 Inform the progress of the labour to the patient
7.6 Document the findings and compare the findings with the previous findings

Points to remember

- Vaginal examination must not be done if there is a frank bleeding
- Vaginal examination in labour is an aseptic procedure
- It should be limited as it can introduce infection and should be done only to confirm the findings of abdominal examination in case of doubt and the woman's bladder must be empty.
- Once the fingers are introduced into the vagina, it should not be withdrawn until the required information has been obtained
- While turning the finger upward in the vagina, the thumb must not be brought into contact with anus where it may be contaminated, not the clitoris where it may cause great discomfort.
- FHR must be assessed at the completion of examination

CONDUCTING NORMAL DELIVERY

1.0 Meaning

1.1 Conducing or managing a normal vaginal delivery involves the hand maneuvers to assist the baby's birth, immediate care of new born and the delivery of placenta and membranes.

2.0 Purposes

2.1. To have the child birth event take place in a prepared and safe environment
2.2. To conduct delivery with least trauma to mother and baby
2.3. To assist mother go through the process without undue stress, injury or complication
2.4. To promote smooth transition of newborn to the extra uterine life

3.0 Articles

3.1. Facilities to be provided in the delivery room
- 3.1.1. An adjustable delivery cot/ table with facility for providing lithotomy position which should be covered with protective sheet and Kelly pad to prevent soiling the mattress
- 3.1.2. Shadow less overhead light
- 3.1.3. Facility for surgical hand washing with elbow operated tap and plastic aprons
- 3.1.4. Wall suction and oxygen
- 3.1.5. Manual suction apparatus
- 3.1.6. Cardiac monitor and pulse oxy meter
- 3.1.7. Wall cupboards to store sterile delivery packs and instruments, IV fluids and other sterile items
- 3.1.8. Facilities for receiving and resuscitating the new born(refer neonatal resuscitation procedure)
- 3.1.9. Room heater
- 3.1.10. Facilities to examine and disposing the placenta
- 3.1.11. Infant weighing scale and length scale

3.2. A delivery trolley which should have two levels - upper sterile portion and lower clean portion
3.3. Prepare the sterile upper portion when the woman is in active phase of first stage with the following items to conduct the delivery
- 3.3.1. Delivery pack containing drapes, towels, surgical gown, a pair of leggings
- 3.3.2. Sterile loves
- 3.3.3. Basins - 2(one for placenta and another for cleaning the patient)
- 3.3.4. Instruments -

3.3.4.1.Sponge holding forceps - 1
3.3.4.2.Kocher's forceps - 2 to clamp the cord
3.3.4.3.Episiotomy scissors - 1(if required)
3.3.4.4.A pair of straight scissors/ cord cutting scissors to cut the cord

3.3.5. Large perineal pad to support the perineum during delivery of the head
3.3.6. Cotton balls to clean the perineum
3.3.7. Gauze pieces to wipe the blood from the episiotomy site

3.4. Clean lower portion of the trolley containing
3.4.1. Shoe cover- 2
3.4.2. Masks,
3.4.3. Syringes -10 cc,5cc, 2cc and needles with cover,
3.4.4. Inj. Xylocaine 1%,
3.4.5. Inj. Oxytocin,
3.4.6. Inj. Methergin
3.4.7. Antiseptic solution
3.4.8. Specimen tubes for collecting cord blood

3.5. Another trolley for episiotomy suturing (refer episiotomy and suturing procedure)

4.0 Pre procedure

4.1. Prepare the labour room and neonatal resuscitation area for conducting delivery
4.2. Recheck all the equipments for the working condition
4.3. Perform vaginal examination and ascertain that the patient is in second stage of labour and whether the membranes are ruptured
4.4. Clean the patient and shift her onto the labour table
4.5. Assess the uterine contractions and vital signs every 5 minutes
4.6. Reassure and encourage her to bear down with contractions if she feel like bearing down
4.7. Assess the bladder. If full and she is not able to pass urine, pass a red rubber catheter and empty the bladder
4.8. Open the delivery trolley, pour the antiseptic solution into the bowl
4.9. Never leave the patient unattended
4.10. Perform surgical hand washing and wear the plastic apron meanwhile the assistant position the patient in a semi sitting position with the buttocks to the lower edge of the table all the while assessing for the advance of the presenting part along with contractions
4.11. Wear head cap, mask, gown and gloves

5.0 Procedure

5.1. Clean the lower abdomen, thighs and complete perineal area in the following manner Use separate sponge for each stroke
5.1.1. First sponge is used to clean side to side from pubic bone to the lower abdomen then discard
5.1.2. Second and third sponge to clean the thighs in an up and down motion from labia majora to the midthigh
5.1.3. The fourth and fifth sponge are used to clean the labia major a on either side using long stroke downwards avoiding the rectum
5.1.4. The last cleaning sponge passes directly over the vagina and anus

5.2. Drape the patient. Cover the lower abdomen, both thighs and place a sterile towel under the buttocks

5.3. Assess for the decent of the fetal head while encouraging the mother to bear down with contractions
5.4. Assistant support the patient to maintain the position and bearing down efforts
5.5. When the scalp is visible about 5 cm in diameter, flexion of the head is maintained during contractions by pushing the occiput downwards and backwards by using thumb and index finger of the left hand while pressing the perineum by the right palm with a sterile vulval pad.
5.6. The process is repeated during the subsequent contractions until the suboccipu t is placed under the symphysis pubis. At this stage the biparital diameter of the head stretches the vulval outlet and crowning occurs.
5.7. Once the head is crowned, assess the need for an episiotomy, if required perform episiotomy.
5.8. Instruct the mother not to bear down at this stage to prevent sudden escape of the head instead to gently blowing or sighing out each breath and to press the fetal head firmly by the right palm with a sterile pad placed over the head
5.9. Deliver the head slowly between contractions by pushing the chin with fingers of the right hand placed over the ano coccygeal region while the left hand exerts pressure on the occiput. The fore head, nose, mouth and the chin are thus born successively over the stretched perineum by extension
5.10. Wipe the baby's eyes and face with a sterile cotton pad. Wipe the mouth with a sterile gauze piece.
5.11. Palpate the neck for any loop of cord around. If it is present and if loose enough, slip over the head. If it is tightly around the neck, clamp in two places about5 cm apart and cut in between
5.12. Once the head is delivered, wait for uterine contractions to come and for the movements of restitution and external rotation of the head.
5.13. During the next contraction, the head is grasped by both hands and gently drawn posteriorly until the anterior shoulder is released from under the pubic bone
5.14. Deliver the posterior shoulder by gently drawing the head in upward direction towards the mother's abdomen
5.15. After the delivery of the shoulders, the forefingers of each hand are inserted under the axilla and the trunk is delivered gently by lateral flexion and place the baby over the mother's abdomen.
5.16. Note the time of birth
5.17. If the cord is not cut, perform delayed cord clamping. Wait until the cord pulsation stop. Clamp the cord in two places at least 5 cm apart and cut in between the clamps
5.18. If the newborn has cried after birth and Apgar score is more than 7, maintain skin to skin contact for as much as possible to promote attachment
5.19. Continue to monitor the mother as she progress to the third stage of labour to detect any change in the mother's condition.
5.20. Place one hand over the fundus to feel the contraction of the uterus
5.21. Watch for the signs and symptoms of placenta separation; lengthening of cord, gush of bleeding, fundus becoming hard, round and mobile and fundal height rises above the umbilicus
5.22. Deliver the placenta by Brandt Andrews Maneuver. As soon as the placenta passes through the introitus, grasp it in cupped hands, twist the placenta round and round while applying gentle traction so that the membranes are stripped intact
5.23. Examine the placenta for its completeness

5.24. Examine the mother's vulva, vagina and perineum for any lacerations and and any retained bits of placenta or membranes
5.25. Massage the uterus to expel any retained blood clots and to promote contraction and retraction
5.26. Suture episiotomy in layers (refer episiotomy and suturing procedure)

6.0 Post procedure

6.1. Clean the mother, apply perineal pad, change the soiled linen, cover with a fresh sheet and position her comfortably
6.2. Clean and sent the articles for sterilization. Dispose the waste into the appropriate containers
6.3. Remove the gloves and wash hands
6.4. Assess the vital signs, the uterine consistency, amount of bleeding every 15 minutes until stable
6.5. Assess for urinary retention
6.6. Provide the mother some warm drinks.
6.7. Record the process of delivery in detail including the date and time of birth, condition, sex, weight and Apgar score of baby
6.8. When the condition of the mother and the baby are stable, shift the mother and baby to the postnatal room after the mother voids

Points to remember

1. Follow strict aseptic technique
2. Never encourage the mother to bear down before the cervix is fully dilated and the mother gets an urge to bear down
3. Always give episiotomy at the height of uterine contraction
4. Record the time of rupture of the membranes and the color of the amniotic fluid
5. Check the fetal heart rate immediately after a uterine contraction

To prevent perineal tear

1. Maintain flexion of the head till crowning
2. Spontaneous forcible delivery of the head to be avoided by assuring the patient not to bear down during uterine contractions
3. Deliver the head in between contractions
4. Perform timely episiotomy
5. Take care during delivery of shoulders

PLACENTAL EXAMINATION

1.0 Meaning

1.1 It is a systematic examination of placenta and membranes immediately after the expulsion from the uterine cavity

2.0 Purposes

2.1. To ascertain the placenta and membranes delivered completely
2.2. To detect any abnormality in the placenta, membranes or in the cord
2.3. Ta assess for retroplacental clots
2.4. To collect cord blood for investigation

3.0 Articles

3.1. A large kidney tray with placenta to be examined
3.2. Scale or measuring tape
3.3. Clean gloves, plastic apron or gown, face mask
3.4. Specimen tubes

4.0 Pre procedure

4.1. Wear the gown, mask and clean gloves
4.2. Examine the placenta before the mother is shifted out from the labour room
4.3. Take the placenta to a safe place where spillage from the placenta does not contaminate the area.

5.0 Procedure

5.1. Collect the blood from the cut end of the placenta as soon as delivered
5.2. Hold the placenta by the cord allowing the membranes to hang like an inverted umbrella
5.3. Identify the hole through which the baby was delivered. If the membranes are not torn into pieces, a single round hole can be identified completely
5.4. Lay the placenta on a flat surface with fetal surface up and identify the site of cord insertion, color and transparency of amnion, circumvalate placenta
5.5. Turn the maternal surface up and hold it in the palms of both hands and examine the cotyledons for approximation. Note for any anatomical variation of the placenta or cord
5.6. Examine the surface for calcium deposits, infarction, retro placental clots or any other abnormality

5.7. Assess the cord for any true or false knots, thickness number of arteries and vein
5.8. Measure the length of the cord by placing a measuring tape or scale along the side of the cord. The extra length of the cord which was cut off from the baby while clamping also should be added to the measurement
5.9. Place the placenta in an yellow plastic cover and weigh the placenta

6.0 Post procedure

6.1. Dispose the placenta into the yellow bucket
6.2. Remove gloves, wash hands, remove the mask and gown
6.3. Wash the kidney basin, measuring tape or scale and clean the area and replace the articles
6.4. Record the procedure and correlate the findings with the gestational age of the baby

POSTNATAL ASSESSMENT

1.0 Meaning

1.1 Assessment of a mother immediately after delivery and during the puerperal period

2.0 Indications

2.1 To know the normal physiological changes in the body in the postnatal period
2.2 To check for potential medical problems after delivery
2.3 To check for involution of the uterus
2.4 To assess any breast feeding problems
2.5 To assess the emotional status of the mother and attitude towards the baby
2.6 To provide an opportunity for the mother to clarify her doubts

3.0 Articles

3.1 Hand washing facility
3.2 A pair of clean gloves and mask(optional)
3.3 A draw sheet
3.4 Measuring tape
3.5 Vital signs tray - thermometer, BP apparatus and stethoscope, cotton balls,
3.6 Weighing machine
3.7 Screen to provide privacy

4.0 Pre procedure

4.1 Explain the procedure to the mother and get her verbal consent
4.2 Assemble articles at the right side of the mother
4.3 Wash the hands
4.4 Instruct the mother to empty the bladder , wash the perineal area with water from front to back
4.5 Make her to check the weight before asking her to lie on the bed and pull the screen to provide privacy
4.6 Position her in dorsal recumbent with legs slightly flexed

5.0 Procedure

5.1 Collect the history related to
- 5.1.1 The presenting complaints
- 5.1.2 History of labour and delivery, condition of the baby
- 5.1.3 Complications during the antenatal period

5.2 Perform a general physical examination
- 5.2.1 General appearance, hydration and nutritional status
- 5.2.2 Mental and emotional status and attitude towards baby
- 5.2.3 Check the vital signs

5.3 Head to foot assessment
- 5.3.1 Head, face, eyes, mouth, heart, lungs, G I system, spleen and bladder, lymphatic system and thyroid glands

5.4 Assess the breast
- 5.4.1 Inspect for the shape, color, contour or any bleeding from the nipple
- 5.4.2 Gently palpate the breast with the pad of the fingers in circular motion from nipple to the base including the axillary tail for tenderness, fullness, engorgementor any nodules (an engorged breast will feel tender, painful and heavy usually occurs on the third postnatal day)
- 5.4.3 Stretch the skin on either side of the nipple with the thumb and forefinger to see if the nipples are retracted

5.5 Abdominal examination
- 5.5.1 Expose the abdomen from below the breast to the symphysis pubis
- 5.5.2 Inspect for size, shape, skin changes(lineanigra and striaealbicanse)
- 5.5.3 Palpate the abdomen for consistency
- 5.5.4 Palpate the fundus of the uterus for consistency and mobility. A well contracted and retracted uterus feel hard and round beneath the flabby abdominal muscles
- 5.5.5 Identify the upper border of the fundus, measure the fundal height from the upper border of the symphysis pubis to the upper border of the fundus using a measuring tape.(fundal height will vary depending on the number of postnatal day)

5.6 Assess for full bladder

5.7 Bowel movement
- 5.7.1 Ask the patient about her bowel pattern. She may not have bowel movement for two day postpartum. Encourage her to drink plenty of fluids and include roughage in the diet

5.8 Assess the genital area for
- 5.8.1 Color, odor and amount of vaginal discharge (lochia)

5.9 Assess episiotomy site for REEDA (Redness, Edema, Echymosis, Discharge and Approximation)

5.10 Check the anal area for haemorrhoids

5.11 Expose the patient's legs and ask her to keep the legs straight

5.12 Assess for vericose veins, warmth, discoloration, tenderness on the calf muscles and edema

5.13 Instruct her to dorsiflex her foot . Pain in the calf muscles together with tenderness and edema indicate positive Homan's sign(sign of DVT)

6.0 Post procedure

6.1 Remove the articles, cover the patient and make her comfortable

6.2 Reassure the patient and share the findings with her.

6.3 Clarify her doubts if any

6.4 Wash and replace the articles

6.5 Wash hands and record the finding

EPISIOTOMY CARE WITH INFRARED LIGHT THERAPY

1.0 Meaning

1.1 It is the treatment given to the episiotomy wound for a postnatal woman during the postnatal period

2.0 Indications/purposes

2.1. Episiotomy and perineal tear
2.2. Perineal surgeries

3.0 Contraindications (For infrared light therapy)

3.1 Indwelling urinary catheters
3.2 Perineal area burns

4.0 Articles

A trolley containing:

4.1 Episiotomy dressing pack
4.2 Betadine solution
4.3 Normal saline
4.4 Sterile cotton and gauze pieces,
4.5 Cheatle forceps
4.6 Sterile gloves
4.7 Betadine ointment &sterile pad (patient's own)
4.8 Kidney tray
4.9 Infra Red lamp
4.10 Draw sheet

5.0 Pre procedure

5.1 Identify the client and check the doctor's orders.
5.2 Assess the indication and frequency of the therapy
5.3 Ensure that client has voided prior to the therapy.
5.4 Ask the client to clean the perineum, dry it with a clean towel and dispose the used pad.
5.5 Provide privacy
5.6 Provide a well-lighted area.
5.7 Switch off the fan

6.0 Procedure

6.1 Assemble all the articles near to the client.
6.2 Do medical hand washing

6.3 Make the client to lie down on the bed and bring thigh at the edge of the foot end of the bed.
6.4 Diamond' drape the client
6.5 Prepare the sterile tray
6.6 Place the sterile pack on to the tray, open it and transfer adequate cotton and 3 gauze pieces from sterile bin with cheatle forceps to the pack. Pour the betadine solution to bowl.
6.7 Open the outer cover of sterile gloves, drop the gloves with inner cover to the pack
6.8 Do surgical hand washing and wear gloves
6.9 Make adequate small cotton balls
6.10 Dip the cotton in betadine solution (Care to be taken not to drip the solution and squeeze the extra solution to the kidney tray if needed. Use separate swab for each stroke)
6.11 Clean the central part of the episiotomy wound on either sides using one stroke by separate swabs
6.12 Clean the clitoris including urethra and vaginal orifice with one stroke.
6.13 Clean Mons pubis, labia majora & minora from top to bottom on either side using same swab
6.14 Clean the inner part of the thigh if its soiled
6.15 Repeat the same steps with normal saline to wash off the betadine
6.16 Use last cotton swab to clean the anus

6.17 Application of infra red light therapy
6.17.1 Make sure that the perineum is dry.
6.17.2 Switch on the infra red light, expose the perineal area and focus the light at least 12-18 inches away from the area on to the episiotomy site for 15-20 minutes.

6.18 Clean the nozzle of betadine ointment with sterile gauze (not required for new ointment)
6.19 Take another sterile gauze, discharge the ointment to it and place it along the episiotomy site without touching the skin/wound

7.0 Post procedure

7.1 Place a clean perineal (vulval) pad over the perineum, secure it and ask the client to wear inner wear.
7.2 Remove the drape.
7.3 Assist the client to climb down from the cot and make her comfortable.
7.4 Switch off the infra-red lamp, clean and replace the dressing articles
7.5 Record the procedure, characteristics of lochia and condition of the episiotomy wound.

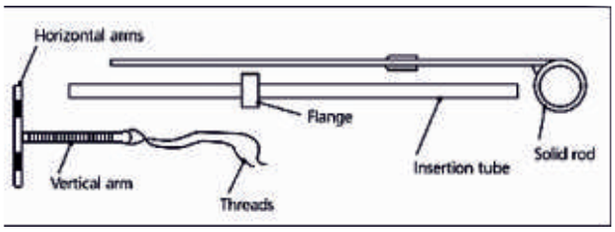
INSERTION OF INTRA UTERINE CONTRACEPTIVE DEVICE (IUCD)

1.0 Meaning

1.1 It is a small often T shaped birth control device that is inserted into the woman's uterus to prevent pregnancy. IUCDs are one form of long acting reversible birth control methods

2.0 Indications

2.1. To avoid unwanted pregnancies
2.2. To space pregnancies



IUDC and inserter (aabp.org)

3.0 Contraindications

3.1. During pregnancy
3.2. Structural abnormalities of the uterus
3.3. Myomas of the uterus
3.4. Hypoplastic uterus
3.5. Uterus auctus
3.6. Inflammations of the genital tract
3.7. Recurrent menstrual difficulties and dysmenorrhoea

4.0 Articles

4.1. A sterile pack containing
  4.1.1. Sterile tray with bivalve vaginal (cuscos) speculum- 1, Sim's vaginal speculum - 1,Vulsellum - 1, uteine sound - 1, multiple toothed vulsellum forceps, Sponge holding forceps - 2,bowl containing cotton swabs, sterile gloves, hole towel - 1,scissors, disinfectant(Betadine) solution, kidney tray
  4.1.2. Sterile intra uterine device with inserter (Cu T (copper releasing device) or Mirena (hormone releasing intra uterine device)

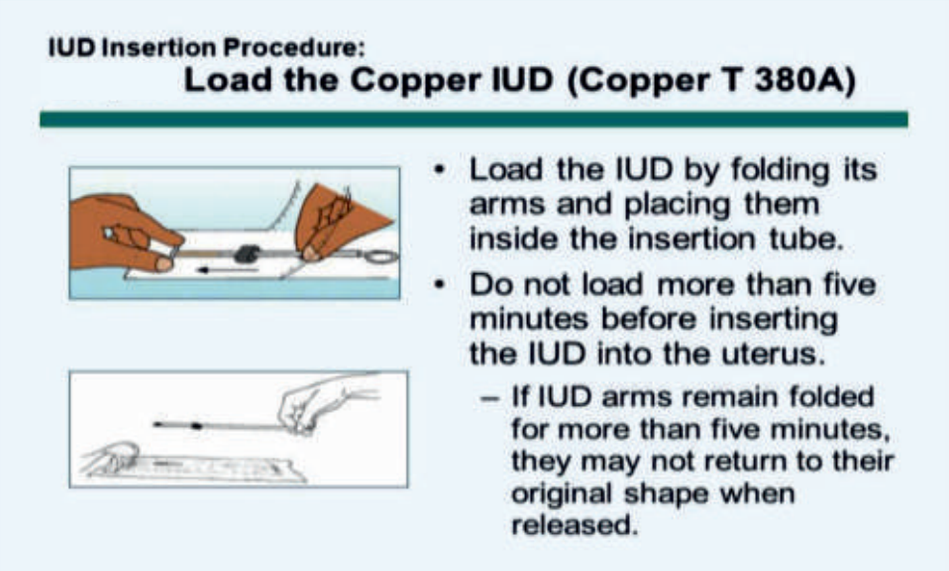
5.0 Pre procedure

5.1. Identify the woman by the name and OP number , the procedure is usually done in the OPD
5.2. Take history about - LMP, previous pregnancy, labour and delivery, age of the last child, (usually inserted 2 to 3 days post menstruation, 6 weeks after delivery or abortion or after an MTP) to exclude pregnancy
5.3. Explain the procedure including the advantages and side effects and take a written consent of the couple
5.4. Instruct the woman to empty the bladder and lie on the examination table
5.5. Provide privacy
5.6. Check the expiry date of copper T and inspect the devise for any damage. The Copper 'T' IUCD comes in a sterile package. Place the package on a clean table,

paper side down. This way you can see the IUCD through the plastic cover.

5.7. The arms of the IUD are to be folded and placed through the plastic cover into the insertion tube far enough to retain them. (no touch technique is adopted)

5.8. Wash hands, wear sterile gloves and arrange the articles on a sterile trolley



6.0 Procedure

Preparing for insertion (aabp.org)

6.1. Clean the perineum with Betadine solution using sponge holding forceps and drape the perineum with the hole towel

6.2. Do a per vaginal examination

6.3. Introduce posterior vaginal speculum into the vagina and clean the vagina, fornices and cervix by antiseptic solution using sponge holding forceps. Observe the discharge or bleeding

6.4. The anterior lip of the cervix is grasped by vulsellum forceps. Uterine sound is passed through the cervical canal to note the position of the uterus and the length of the uterine cavity

6.5. Measure the length of the device to be inserted into the uterine cavity. The depth of the gauge on the inserter tube is used to mark the depth of the uterus

6.6. Pull the loaded inserter tube gently until the distance between the top of the folded 'T' and the edge of the depth gauge closest to the 'T' is equal to the depth of the uterus as measured on uterine sound

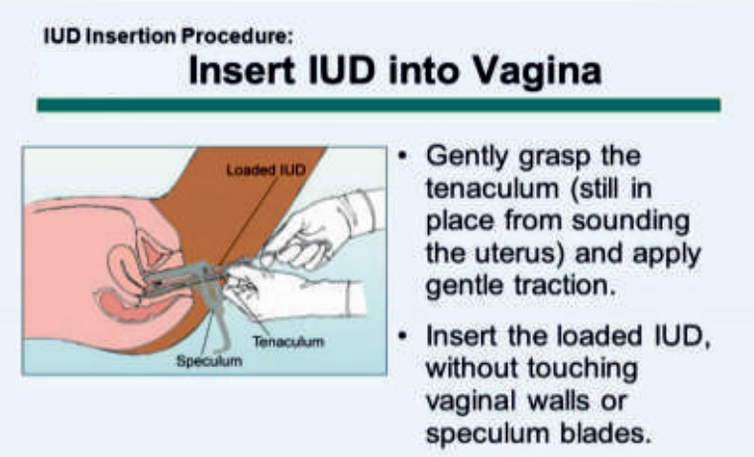
6.7. Carefully peel the clean plastic cover of the package away from the white packing. Lift the loaded inserter keeping it horizontal so that neither the 'T' nor the white rods fall out. Be careful not to push the white rode towards the 'T'

6.8. Grasp the vulsellum firmly downward and outward to align the uterine cavity and cervical canal with vaginal canal

6.9. Gently insert the loaded inserter assembly through the cervical canal keeping the depth gauge into a horizontal position

6.10. According to the position and direction of the uterine cavity, gently and carefully advance the loaded inserter assembly until the depth gauge comes in contact with cervix or resistance of the uterine fundus is felt

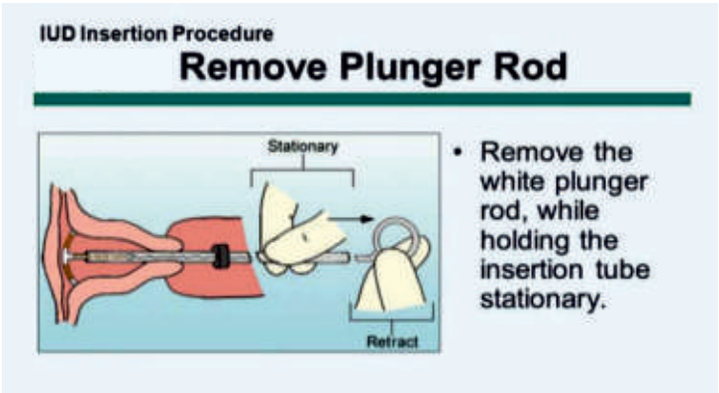
6.11. Hold the vulsellum and the white plunger rod in one hand



emedicine.medscape.com

6.12. Keep the plunger rod stationary, withdraw the insertion tube downwards with the other hand, till it touched the grip of the plunger tube(thus releasing the copper T in the uterus) - withdrawal technique - to prevent perforation

6.13. The insertion tube is kept stable and white plunger tube is removed to prevent the thread to be caught between the two and displacing TUCD



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6.14. Gently push the insertion tube up towards the fundus till resistance is felt to ensure high position of Copper T in uterus - to prevent expulsion. Remove the insertion tube

6.15. Check the strings protruding from the uterus. Cut the strings shorter so that they protrude only 2 - 3 cm outside the cervix (from external os)

6.16. Assist the woman to feel the threads floating in the vagina

6.17. Remove the vulsellum. If there is excessive bleeding from the vulsellum site, press a sterile gauze to the site using forceps until the bleeding stops

6.18. Remove the speculum and the drape

7.0 Post procedure

7.1. Clean the area and apply perineal pad and make the woman comfortable

7.2. Instruct the woman to stay in the bed for 15 - 20 minutes for observation

7.3. Remove the gloves and discard all the wastes in the appropriate container

7.4. Wash the instruments and send for sterilization

7.5. Record the procedure

REMOVAL OF INTRA UTERINE CONTRACEPTIVE DEVICE (IUCD)

1.0 Meaning :

1.1 Removal of intra uterine contraceptive device (IUCD)

2.0 Indications

2.1. At the expiration of date,
2.2. When the woman develops a contraindication,
2.3. Adverse effect which do not resolve
2.4. On patient's request

3.0 Articles

3.1. Sterile gloves
3.2. Sponge holding forceps - 2
3.3. Bowl containing cotton swabs
3.4. Disinfection solution
3.5. Kidney tray
3.6. Bivalve vaginal (Cuscus) speculum - 1
3.7. Vulsellum / Allies forceps - 1
3.8. Long straight artery forceps - 1

4.0 Pre procedure

4.1. Explain the procedure (as it was explained during the insertion of IUCD
4.2. Instruct her to empty the bladder
4.3. Position her in dorsal recumbent with thighs flexed and separated

5.0 Procedure

5.1. Clean the perineum with sterile antiseptic swabs and sponge holding forceps
5.2. Clean the vaginal canal and cervix with another sponge holding forceps using sterile cotton swabs and antiseptic solution
5.3. Drape the perineal area with sterile sheet
5.4. Insert vaginal speculum
5.5. Hold the anterior lip of the cervix with vulsellum
5.6. Grasp the string of the IUCD with long straight artery forceps
5.7. Pull the strings out using gentle traction. If resistance is felt, the removal should be abandoned until it is determined why IUD is not moving. A deeply embedded IUCD may have to be removed hysteroscopically

5.8. Show the woman the IUCD and discard or clean and hand over to woman as per her choice
5.9. Encourage the woman to express feeling, pain or discomfort

6.0 Post procedure

6.1. Remove gloves and discard
6.2. Wash hands and replace the articles
6.3. Allow the woman to go home if she express no discomfort and instruct her to report back if she feels any discomfort or bleeding

ESSENTIAL NEW BORN CARE

1.0 Meaning:

1.1 Essential New Born Care should be applied immediately after the baby is born and continued for at least the first 7 days after birth.

2.0 Purpose:

2.1 To Maintain normal thermal regulation
2.2 To initiate normal breathing
2.3 To establish open airway
2.4 To maintain circulation and spontaneous respiration
2.5 To maintain and establish homeostasis

3.0 Articles:

3.1 Clock with second hand
3.3 Bucket of water
3.4 Towels
3.5 Blanket
3.6 Cord ties and blade
3.7 2 small blankets or pieces of cloth
3.8 2 pairs of gloves
3.9 Cord clamps, cord cutting instruments, cord tying material, cotton swabs, gauze pieces
3.10 Oxygen cylinder, suction device, resuscitation equipments, laryngoscope, tape, scissors etc. must be checked well in advance , ready to use during emergency situations
3.11 Weighing scales, measuring tapes, identification tags, clinical thermometer

4.0 Care of The Newborn at Birth

4.1 Preparations before delivery
4.2 Immediate care at birth
4.3 Care after birth

5.0 Pre procedure

5.1 Preparation for institutional delivery
- 5.1.1 Well-lighted, well-ventilated and warm micro-environment without draughts
- 5.1.2 Care area meant for the baby in the delivery room should have
- 5.1.2.1 Warming device
- 5.1.2.2 Clean sterile linen
- 5.1.2.3 A tray of medication may include spirit, distilled water / normal saline for cleaning eyes, silver nitrate, tetracycline or erythromycin ointment, Vit. K and medication needed during resuscitation

6.0 Procedure

6.1 Call out the time of birth
6.2 Receive the baby onto a warm, clean and dry towel or cloth on a warm dry surface
6.3 The baby should be kept on the mother's chest or close to the mother.
6.4 Suction the baby's mouth
6.5 APGAR Rating at 1 minute and 5 minute is to be recorded
6.6 Clamp and cut the umbilical cord
6.7 The umbilical cord should be clamped by two khocher's forceps or disposable, sterile clamp(the near one is placed 5cm away from the umbilicus)
6.8 Cut using a sterile blade/scissor about 2.5 cm (1-inch) away from the skin and tie the cord with sterile thread using reef knot
6.9 Immediate care of the umbilical cord: Steps:
- 6.9.1 Put ties tightly around cord at 2 cm and 5 cm from the abdomen.
- 6.9.2 Cut between the ties with a sterile instrument
- 6.9.3 Observe for oozing blood. If blood oozes, place a second tie between the skin and first tie.
- 6.9.4 Do not apply any substance to the stump.
- 6.9.5 Do not bind or bandage stump.
- 6.9.6 Leave stump uncovered.

6.10 Ensure that hands are cleansed with a clinical disinfectant before proceeding to clean the eyes of the baby.
6.11 Take some normal clean water in a properly washed bowl and soak a cotton pad in it.
6.12 Carefully cleanse the eyes of the baby from the inside to the outside. But make sure that the eyes were closed at that time.

7.0 Post procedure:

7.1. Immediately dry the baby with a warm clean towel or piece of cloth; wipe the eyes.
7.2. The baby should be thoroughly dried to prevent from getting cold
7.3. Blood or meconium on the baby's skin should be wiped away
7.4. Remove wet linen .

ANTHROPOMETRIC ASSESSMENT

1.0 Meaning:

1.1 Anthropometric Assessment which are systematic measurements of the size, shape and composition of the human body.

2.0 Purposes

2.1. To evaluate the nutritional status of a child

3.0 Articles

3.1 Paper
3.2 Disinfectant
3.3 Pediatric weighing scale
3.4 Adult weighing scale whichever is appropriate
3.5 Stedeometer
3.6 Simple measuring tape
3.7 Infantometer

4.0 Pre -Procedure

4.1 Rule out presence of any physical anomalies as certain physical anomalies may interfere with accurate weight measurements.

4.2 Determine which growth measurements are to be obtained.

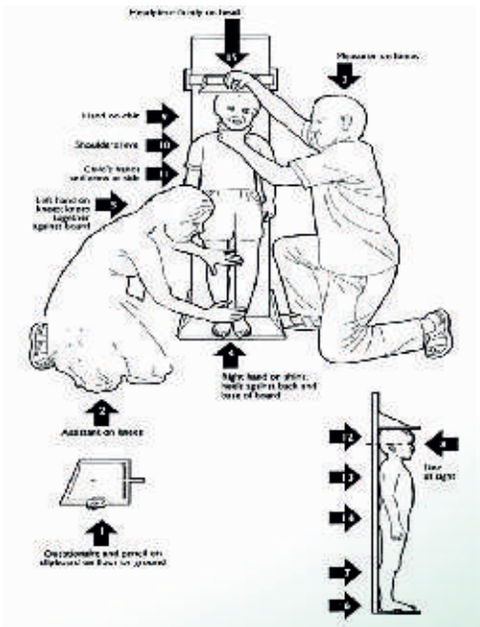
5.0 Procedure

5.1. Measurement of Weight

- 5.1.1 Wash hands
- 5.1.2 Know the age of the child
- 5.1.3 Note the previous weight of the child
- 5.1.4 Ensure the balance beam scale, depending on child's age. Before use, balance scale by placing weights at zero position and adjusting screws as necessary until beam is in zero balance.
- 5.1.5 Obtain weight measurement. Place undressed child in middle of weighing surface.
- 5.1.6 Keep the hands close
- 5.1.7 Record weight to nearest half ounce (1 gm) on pediatric scales

5.2 Measurement of Height

- 5.2.1 Set the measuring board vertically on a stable level surface.
- 5.2.2 Remove the child's shoes and any head-covering.
- 5.2.3 Place the child on the measuring board, standing upright in the middle of the board.
- 5.2.4 Record and announce the measurement to the nearest 0.1cm.
- 5.2.5 Record and repeat the measurement to the measurer to make sure it has been correctly heard.



5.3 Measurement of Length

5.3.1 This measurement is taken for children below two years of age and/or for those who are less than 85 cm.
5.3.2 Place the measuring board horizontally on a flat, level surface.
5.3.3 Remove the child's shoes and any head covering.
5.3.4 Place the child so he/she is lying down and face up in the middle of the board.
5.3.5 Hold the sides of the child's head and position the head until it is touching the head board.
5.3.6 Allow the measurer to place his/her hands on the child and firmly hold the child's knees together while pressing down. The soles of the feet should be flat on the foot piece, toes pointing up at right angles.
5.3.7 The measurer should immediately remove the child's feet from contact with the footboard with one hand while holding the footboard securely in place with the other.
5.3.8 Record the measurement.

5.4 Measurement of Child Head Circumference

5.4.1 Wash hands
5.4.2 explain the procedure to the parent.
5.4.3 If the child is below 5 years , measure them when they are seated.
5.4.4 Stand to the side of the child.
5.4.5 Make sure their arms are relaxed by their sides and their head is in the Frankfort Plane.
5.4.6 Position the tape so that the zero mark is on the side of the head.
5.4.7 Measured by placing the tape over the occipital protuberance at the back and just above the supraorbital ridge and the glabella.
5.4.8 Measure to the nearest 0.1cm (1mm)
5.4.9 Record the measurement.

5.5 Measurement of Child Chest Circumference

5.5.1 Wash hands
5.5.2 Explain the procedure to the child and parent.
5.5.3 Whilst the child is standing, feel for the xiphisternum where the ribs meet the sternum and mark with a short horizontal line.
5.5.4 Pass the tape around so that the mark is at the upper border of the tape.
5.5.5 Make sure the tape is at the right level. It should rest on the skin but not indenting it or not pulled too tight.
5.5.6 Take the reading at the end of expiration.
5.5.7 Measure to the nearest 0.1cm (1mm).
5.5.8 Make three measurements of chest circumference.
5.5.9 Record the measurement.

5.7 Measurement of Mid Upper Arm Circumference

5.7.1 Wash your hands and explain the procedure to the parent.
5.7.2 Make the measurement on the left arm.
5.7.3 Palpate for the acromion process and with the infant's arm flexed at 90°, palpate for the olecranon process.
5.7.4 Using a tape measure the distance between the mark at the acromion and the mark at the olecranon. Whilst still holding the tape in place, make a

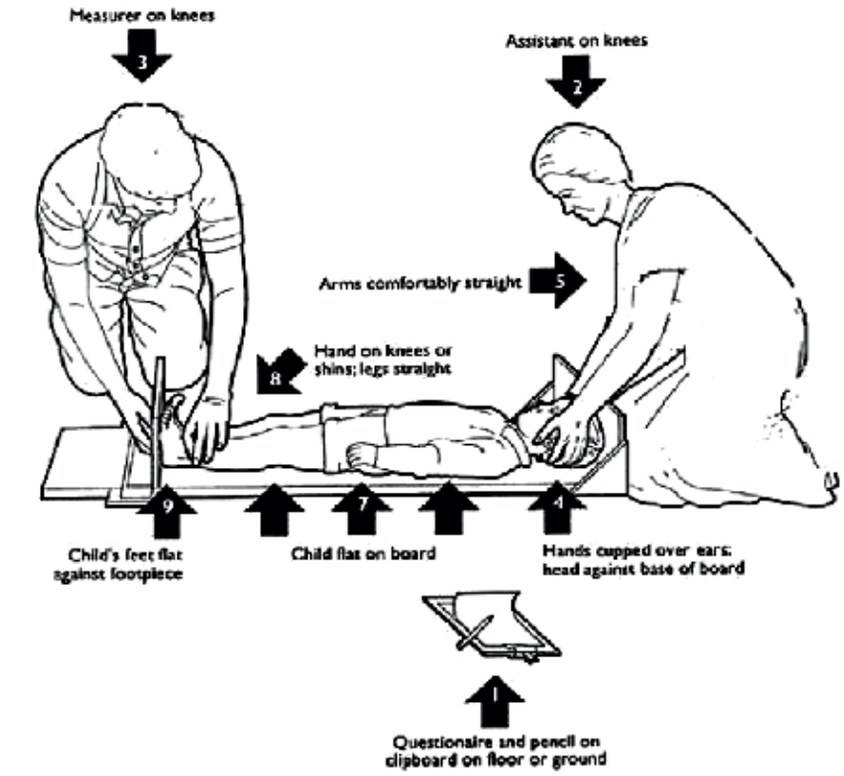
short horizontal line at the mid-point. This line marks the middle of the upper-arm.

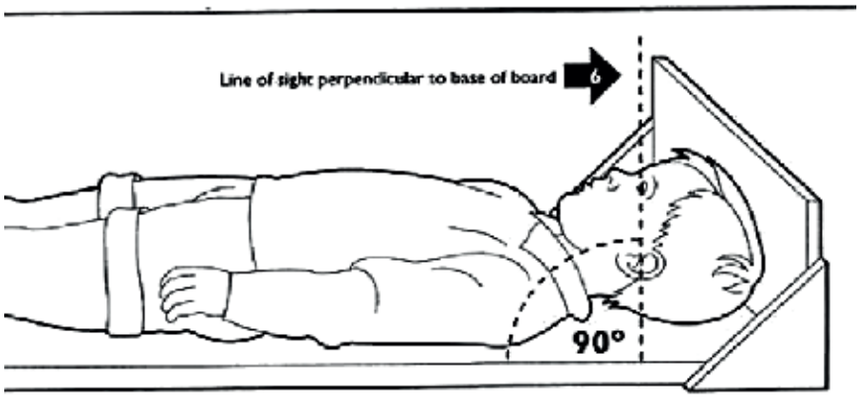
5.7.5 Ensure that the infant is as relaxed as possible with their arm hanging by their side.

5.7.6 Place the tape around the upper arm, with the upper border of the tape on the mark. Ensure that the tape is horizontal all round.

5.7.7 Make sure the tape is not pulled too tight. It should rest on the skin, but not indent it.

5.7.8 Record the measurement.





6.0 Post -Procedure

6.1 Date and actual numerical values of all measurements are recorded and plotted on appropriate growth charts.

6.2 Results of physical growth measurements should always be reviewed with family and child.

BABY BATH

1.0 Meaning:

The bathing the newborn is cleansing the skin of blood and amniotic fluid.

2.0 Purposes

2.1 To maintain daily hygiene.
2.2 To observe the newborn.
2.3 To teach the family about their newborn and bathing skills

3.0 Articles:

3.1 Clean towel
3.2 Baby soap
3.3 Cotton balls
3.4 Gauze

4.0 Pre-Procedure

4.1. Assess the body temperature. Bathe newborn after the temperature has stabilized at 37^0C.
4.2. Assess for signs and symptoms of respiratory distress.

5.0 Procedure

5.1 Position the newborn comfortably in one arm or lying in a radiant warmer or incubator.
5.2 Adjust the water temperature by checking with a water thermometer or on outer aspect of own forearm. Water temperature should not be above 100^0F.
5.3 Run water into a clean basin, infant bathtub, or sink to a shallow depth of 3 to 4 inches. Do not place a newborn in the water until cord detachment, which usually occurs in a few weeks. Use the water for sponge bathing and shampooing the hair.

5.4 At the beginning of the bath, wipe eyes from the inner to the outer canthus, using clean water and a different area of clean cloth for each wipe.
5.5 Gently wash face, using plain water.

5.6 Shampoo hair:
- 5.6.1. With newborn in the "football hold" gently wet the hair with water.
- 5.6.2. Shampoo the newborn's hair with a cloth and non-alkaline soap.
- 5.6.3. Rinse the hair completely and dry the scalp quickly and thoroughly.

5.7 Wash external ears: use a clean part of the cloth rolled to a point to clean the external ear. Repeat with a different part of the cloth for the other ear.

5.8 Wash body and extremities:
- 5.7.1 After removing the newborn's blanket, wash the neck, chest, arms, legs and back in the same manner.
- 5.7.2 Wash each body part with mild soap and water, gently rinse and dry the part before moving to the next body part.

5.9 Clean the genitalia:
- 5.9.1 Female: Gently separate labia and carefully wash in posterior direction(front to back)
- 5.9.2 Male: In the uncircumcised newborn, gently retract the foreskin only as far as it will easily go. Cleanse the tip of the glans in a circular motion with a moistened cotton ball or wash cloth.
- 5.9.3 Wash and thoroughly dry perianal area after rinsing.

5.10 Avoid using powders, oils, or lotion on newborn's skin.
5.11 Apply diaper, folding the front below the cord so that the cord is exposed.
5.12 Dress the newborn in clothes appropriate to environmental conditions

6.0 Post-Procedure

6.1. Record the time of the procedure, medications administered, dressings applied and newborn's reactions.
6.2. Note whether there were signs or symptoms of hypothermia or respiratory distress, Skin injury, Purulent drainage, foul odour, redness or swelling from the stump or circumcision line.

CARDIOPULMONARY RESUSCITATION

1.0 Meaning:

1.1 Cardiopulmonary resuscitation is an emergency procedure that combines chest compressions often with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a child who is in cardiac arrest.

2.0 Purpose

2.1 To restore and maintain breathing and circulation
2.2 To provide oxygen and blood flow to the heart , brain and other vital organs

3.0 Articles :

3.1 Resuscitation bag with manometer
3.2 Mask and Glove
3.3 Endotracheal tubes
3.4 Laryngoscope blades
3.5 Oral airway
3.6 Suction devices: catheters and tonsil tip
3.7 Intravascular catheters, spinal needle, or bone marrow needle.
3.8 Oro gastric tube.
3.9 Oxygen flow meter with flowing
3.10 Laryngoscope handles and blades
3.11 Batteries
3.12 Stilets
3.13 Scissors and tapes
3.14 Syringes with needle
3.15 Medications
3.16 Cardiac monitors and electrodes
3.17 Stethoscope

4.0 Pre-Procedure

4.1 Assess patency of airway.
4.2 Assess respiratory status.
  4.2.1 Respiratory rate / Breath sounds / Cyanosis

4.3 Assess cardiovascular status.
  4.3.1 Heart rate.
  4.3.2 Peripheral pulses.
    - Colour
    - Capillary refill.
  4.3.3 Level of consciousness.

4.4 Determine age of child.
4.5 In the neonates, review the maternal- foetal history for indicators of asphyxia.
4.9 Pre calculate emergency drug doses based on child's weight.

5.0 Procedure

5.1 Determine unresponsiveness, respiratory distress, apnea, or pulselessness
5.2 Call for help
5.3 Position infant or child on back on a flat, firm surface.
5.4 Open the airway by positioning the head in a slightly extended position using the head-tilt (or) chin- lift maneuver
5.5 In the neonate, suction the mouth, then nose with a bulb syringe, DeLee trap, suction catheter using pressures less than 100 mm/Hg
5.6 Observe for respiratory effort.
- 5.6.1 Place ear close to child's mouth and nose.
- 5.6.2 Watch for rise and fall of chest and abdomen.
- 5.6.3 Listen for exhaled air.
- 5.6.4 Feel for exhaled air.

5.7 If no spontaneous respirations are noted, initial positive pressure ventilations by mouth or with a resuscitation bag, watching for a rise and fall of the chest.
5.8 Resuscitation bag: using a bag and mask or bag and endotracheal tube, provide 90% to 100% oxygen by the following parameters.

- 5.8.1 Neonate: At a flow rate of 0.5 liters/minute(lpm) deliver 40 to 60 breaths per minute at the following pressures:
  - 5.8.8.1 First 2 to 3 breaths (in newly delivered): 30 to 40 cm H^2O.
  - 5.8.8.2 Normal lungs: 15 to 20 cm H_2O.
  - 5.8.8.3 Chronic lung disease: 20 to 40 cm H_2O.

- 5.8.2 Infant/child/adolescent: At a flow rate of 10 to 15 lpm, deliver two slow breaths (1 to 1.5 seconds per breath). Deliver subsequent breaths at a rate of:
  - 5.8.2.1 Infant: 20 breaths per minute.
  - 5.8.2.2 Child: 15 breaths per min
  - 5.8.2.3 Adolescent: 12 breaths per minute.

5.9 Mouth:
- 5.9.1 Infant:
  - 5.9.1.1 Form tight seal by placing mouth over infant's mouth and nose.
  - 5.9.1.2 Using just enough pressure to cause the chest to rise, give two slow (1 to 1.5 seconds per breath) ventilations, allowing the chest to deflate between breaths.
  - 5.9.1.3 Continue at a rate of 20 breaths per minute.

- 5.9.2 Child/adolescent:
  - 5.9.2.1 Form tight seal by placing mouth over child's mouth and pinching the nose.
  - 5.9.2.2 Using just enough pressure to cause the chest to rise, give two slow (1 to 1.5 seconds per breath) ventilations, allowing the chest to deflate between breaths.

5.9.3 Continue at the following rates:
5.9.3.1 Child -15 breaths per minute.
5.9.3.2 Adolescent- 12 breaths per minute.

5.10 If resistance to air flow is met, troubleshoot and make appropriate corrections. Insert an oral airway if resistance persists.

5.11 Evaluate heart rate and pulses.
5.11.1 Neonate: Auscultate apically for 6 seconds after 15 to 30 seconds of effective ventilations.
5.11.2 Infant: palpate brachial pulse for presence of pulsations by lightly placing index finger just above the antecubital space on the side closest to the body.
5.11.3 Child/adolescent: gently palpate carotid artery for pulsations.

5.12 Initiate chest compressions if the following criteria are noted:
5.12.1 Neonate: a heart rate below 60 bpm or between 60 to 80 bpm and not rising.
5.12.2 Infant/child/adolescent: absence of pulsations.

5.13 Use proper technique to provide chest compressions. Do not take digits or heel of hand off child's skin between compressions.
5.13.1 Neonate:
5.13.1.1 Place digits over sternum just below the nipple line.
5.13.1.2 Deliver at a rate of 120 bpm in a ratio of 3 compressions to 1 breath.
5.13.1.3 Depress to a depth of ½ to ¾ inch.

5.13.2 Infant:
5.13.2.1 Position fingers over sternum one finger width below nipple line.
5.13.2.2 Deliver at a rate of 100 bpm and a ratio of 5 compressions per breath.
5.13.2.3 Depress sternum ½ to 1 inch.

5.13.3 Child/adolescent: locate placement by sliding middle finger along lower edge of rib cage to notch where ribs and sternum meet.
5.13.3.1 Child:
5.13.3.1.1 Place heel of hand next to index finger on sternum.
5.13.3.1.2 Deliver at a rate 80-100bpm in a ratio of 5 compression per breath.

5.13.3.1.3 Depress sternum 1-1 ½ inches.
5.13.3.2 Adolescent:
5.13.3.2.1 Place heel of hand next to index finger on sternum. Place other hand on top, locking fingers to avoid touching the chest.
5.13.3.2.2 Delivery 80-100 compression per min in a ratio of 15 compressions to 2 breaths.
5.13.3.2.3 Depress sternum to a depth of ½- 2 inches.

5.14 Re-evaluate heart rate and pulses throughout resuscitative effort:
5.14.1 Neonate: auscultate apical rate every 30 secs.
5.14.2 Infant/ child: palpate pulses after 10cycle of compressions and breaths.
5.14.3 Adolescent: palpate pulses after 4 cycle of compression and breath.

5.15 Discontinue compression when the following criteria are met or resuscitative efforts are aborted.
5.15.1 Neonate: heart rate is 80 breath/ min or above.
5.15.2 Infant/child/adolescent: palpable pulses are present.

5.16 Continue positive pressure ventilations as described after ceasing chest compression until the following criteria are met or resuscitative efforts are aborted.
5.16.1 Neonate: ventilate 40 times per min until heart rate exceeds 100bpm and spontaneous respiration are present.
5.16.2 Infant: ventilate 20 times per min until spontaneous respiration are present.
5.16.3 Child: ventilate once every 4 seconds until spontaneous respiration are present.
5.16.4 Adolescent: ventilate once every 5 sec until spontaneous respiration are present.

5.17 Assist with the intubation if ventilation are ineffective, the child is unable to protect airway, prolonged artificial ventilation is required, or direct suctioning of the trachea is necessary.

6.0 Post - Procedure

6.1 Document the events preceding the arrest, and the time and type of arrest.
6.2 Note interventions performed, the personal involved and the child's response to interventions.
6.3 Record the time and child's status when resuscitation efforts completed.

ADMINISTERING AND MONITORING OXYGEN

1.0 Meaning:

1.1 Oxygen is frequently administered to infant and children to correct hypoxia, minimize the work of breathing, and decrease myocardial work.

2.0 Purpose:

2.1 To manage the condition of hypoxia
2.2 To maintain the oxygen tension in blood plasma
2.3 To increase the oxy-hemoglobin in red blood cells
2.4 To maintain the ability of cells to carry the normal metabolic functions
2.5 To reduce the risk of complications

3.0 Articles

3.1 Oxygen sources (one of the following)
- 3.1.1 50 psi wall outlet.
- 3.1.2 Compressed oxygen (cylinder/tank)
- 3.1.3 Liquid oxygen concentrator.

3.2. Flow meter
3.3 Humidification source (optional) and sterile water (one of following):
- 3.3.1 Pass-over humidifier
- 3.3.2 Diffusion-head humidifier (bubbler)
- 3.3.3 Nebulizer
- 3.3.4 Croupette

3.5 Heating device (optional) (one of following):
- 3.5.1 Wrap- around heater
- 3.5.2 Hot-plate device
- 3.5.3 Probe-type heating element

3.6 Device to regulate oxygen concentration (optional) (one of following):
- 3.6.1 Blender (mixer)
- 3.6.2 Venture system

3.7 Connective tubing
- 3.7.1 Large bore (22mm) for nebulizers and heated humidifiers
- 3.7.2 Small bore for other delivery systems.

3.8 Oxygen analyzer
3.9 Delivery system
- 3.9.1 Appropriate-sized nasal cannula
- 3.9.2 Oxygen mask:
- 3.9.3 Simple face mask
- 3.9.4 Partial rebreather mask

3.9.5 Non- rebreathing mask
3.9.6 Venturi mask
3.9.7 Aerosol mask with large-bore tubing
3.9.8 Face tent
3.9.9 Tracheostomy mask (collar)
3.9.10 Oxygen/croup tent
3.9.11 Appropriate-sized oxygen hood with baffle and thermometer.

4.0 Pre-Procedure

4.1 Assess child for manifestation of hypoxia, including:
Respiratory status, Neurological, Cardiovascular, Laboratory and Non-invasive monitoring values.
4.2 Assess size and developmental status of child.
4.3 Review medical history
4.4 Review physician order for:
Oxygen concentration and/ or flow rate, Method of delivery, Therapy duration and Decided SaO2.
4.5 Assess child/ family's understanding of oxygen therapy.

5.0 Procedure

5.1 Initiate delivery of oxygen by adjusting flow rate to required amount.
5.2 Initiate oxygen therapy to the child.
5.3 Nasal cannula
5.4 Assess nares for patency; clear nasal passage of mucus.
5.4.1 Following the natural curve, insert prong into nares after ensuring free flow of oxygen.
5.4.2 Place cannula tubing over ears and under neck or around back of head and adjust to fit.
5.4.3 If necessary, secure cannula to face with tape and a skin barrier.
5.4.4 Pad pressure area if needed by placing gauze or cotton beneath tubing.
5.4.5 The flow rate of oxygen should be 1-2 litres per minutes

5.5 Oxygen mask
5.5.1 Slip mask over child's head, placing over chin, mouth and nose. Adjust metal band to fit nasal bridge.
5.5.2 Place elastic band around child's head. Adjust for a snug but comfortable fit.
5.5.3 Pad pressure area if needed with gauze or cotton under elastic band.
5.5.4 The flow rate of oxygen should be 6-10 litres per minute

5.6 Oxygen/croup tent
5.6.1 Place child in tent. Provide a favourite toy or blanket or use fantasy such as pretend child is camping.
5.6.2 Tuck tent edge under mattress or fanfold with the bedding. A bath blanket or draw sheet may also be used to secure front edge over child's legs. Ensure that zippers are closed.
5.6.3 If applicable, secure drainage tube of ice chamber.
5.6.4 The flow rate of oxygen should be 2-4 litres per minute

5.7 Oxygen hood
- 5.7.1 Place hood over infant's head/upper body.
- 5.7.2 Close ports, lids. Pad base of hood if needed. Do not pad neck opening.

5.8 Assist child's emotional adaptation to delivery system

5.9 Assess child's response to oxygen therapy in 15-30 min after initiation and on a regular basis throughout therapy.

5.10 Monitor equipment function at least every 2-4 hours and adjust as needed.
- 5.10.1 Check flow liter rate.
- 5.10.2 Check water level in humidifier/nebulizers; ice in croup tent reservoir.
- 5.10.3 If using portable oxygen source, check amount of oxygen remaining.
- 5.10.4 Check connecting tubing for kinks or disconnection; check ports on mask for obstruction.
- 5.10.5 Check nasal prongs and nares for patency.
- 5.10.6 Check integrity of tent/hood. Ensure snug fit of mask or cannula.
- 5.10.7 Check oxygen concentration of tent or hood with analyser at child's face level at least every 2 hour. Recalibrate analyser every 8 hours.
- 5.10.8 Check child's temperature within tent/hood.
- 5.10.9 Dry the inside of mask as needed.

5.11 Organize nursing care to minimize disruption of oxygen therapy.

5.12 Change oxygen equipment daily.

5.13 Check pressure points, mouth and nose at least every 8 hours; cleanse and apply water soluble lubricant if needed.

5.14 Suction airway as needed.

5.15 Monitor fluid status.

5.16 When removing child from oxygen source for feeding, bathing, comforting, or procedure, provide alternate forms of oxygen especially changes in colour, increase respiratory effort, or restlessness.

5.17 Obtain fundoscopic eye exam for newborns before discharge or at 5 to 7 weeks of age if infant remains hospitalized.

6.0 Post-Procedure

6.1 Record assessment finding including laboratory and non invasive monitoring values.

6.2 Note time of oxygen therapy was initiated and ended.

6.3 Document type of oxygen delivery system:

6.4 Note changes in therapy and adverse reaction or side-effects from oxygen therapy and corrective measures taken.

6.5 Document child and family reactions

COLOSTOMY CARE

1.0 Meaning:

1.1 Colostomy is a surgical opening into the colon brought out onto the abdominal wall as a stoma. Colostomy care involves emptying the stoma bag and cleaning & observing the stoma site on a regular basis.

2.0 Purpose:

2.1 To maintain integrity of stoma and peristomal skin
2.2 To prevent lesions and ulcerations
2.3 To prevent from infections
2.4 To promote general comfort and positive self image
2.5 To provide clean ostomy pouch for fecal evacuation
2.6 To reduce odour from over use of old pouch

3.0 Articles

3.1 Pair of gloves, Mackintosh / towel
3.2 Basin of warm water
3.3 Gauze piece
3.4 Measuring guide & New pouch appliance
3.5 Scissors
3.6 Stoma plate
3.7 Kidney tray
3.8 Screen
3.9 Medications / Karaya powder, Dressings

4.0 Pre Procedure:

4.1 Gather equipment
4.2 Encourage clients to look at the stoma
4.3 Explain the procedure to the patient
4.4 Provide privacy
4.5 Perform hand hygiene & wear gloves.

5.0 Procedure:

5.1 Spread mackintosh & draw sheet.
5.2 Remove used pouch & skin barrier gently by pushing the skin away from the barrier.
5.3 Remove clamp and empty the content into bed pan. Rinse the pouch with tap water.
5.4 Discard the disposable pouch in paper bag.
5.5 Observe stoma for colour, swelling, trauma & healing.
5.6 Stoma should be moist & pink. Cover the stoma with a gauze piece.
5.7 Clean peristomal region gently with warm tap water using gauze pad. Don't scrub the skin, dry by patting the skin.

5.8 Remove gauze & clean stoma with gauze
5.9 Measure the stoma using measuring guide.
5.10 Put skin barrier (Ex: Karaya Powder) & pouch over the stoma
5.11 Use the pouch if it is drainable using a clamp or clip.

6.0 Post procedure

6.1 Remove gloves and wash hands.
6.2 Make the patient comfortable.
6.3 Clean the area and replace all articles.
6.4 Record the procedure with following details:
Date/Time, Amount, Colour, Consistency of faecal matter & Sign of any infection

USE OF RESTRAINTS IN CHILDREN

1.0 Meaning:

1.1 Restraints are the device which is of various kinds, types and with different materials used on the children for various reasons to immobilize them from their routine movements.

2.0 Purpose:

2.1 To temporarily immobilize a body part during a procedure.
2.3 To prevent children from rolling off a cart while being transported.

3.0 Articles

3.1 Adhesive tape
3.2 Board
3.3 Gauze
3.4 Restraints
3.5 Mummy board

4.0 Types

4.1 Chest or Jacket restraint
4.2 Mummy restraint
4.3 Extremity restraint
4.4 Clove-hitch restraint
4.5 Cloth restraint
4.6 Mitt restraint
4.7 Elbow restraint
4.8 Leather or plastic restraint
4.9 Abdominal restraint
4.10 Bubble top crib/ Net top crib/ Crib and dome

5.0 Pre- procedure

5.1 Determine the child's size and development level.
5.2. Review pertinent information such as medical history, medications given (or illicit drug use) and psychosocial behaviors. E.g. The presence of fear, anxiety or anger.
5.3. Determine the situation and or behaviors that necessitate the need for restraints.
5.4 Determine previous interventions to avoid restraints, initiate least restrictive interventions before using a restrains.
5.5 Assess the family's understanding of the need for the restraint.
5.6 Determine the type of restraint needed, the extremities to be restrained, and the approximate amount of time the restrain is likely to be used.
5.7 Assess the area dorsal, ventral proximal and distal to the restraint site for adequate circulation and absence of lesions or compromised skin integrity.

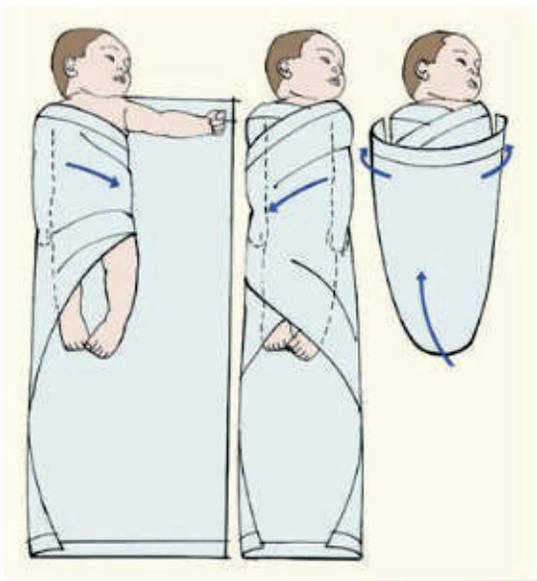
5.8 Obtain physicians order to follow facility protocol for restraint.
5.9 Gather needed materials according to the type of restraining needed.
5.10 Recruit an assistant to apply restraints, if needed.

6.0 Procedure

6.1 Approach the child/ family in a calm, confident manner to discuss planned use of restraint. Review the reasons restraint is needed. Explain the procedure.
6.2 Provide psychological support before and during application of the restraint as appropriate, e.g. Reassuring the child he or she will not be harmed, talking to the child, etc.
6.3 Invite the child's participation by showing how he or she may help.
6.4 Use other professionals to assist in holding the child during the application of restraints
6.5 Lower the side rails of bed or crib; if the child is in a hospital bed raise the bed.
6.6 If appropriate to the type of restraint, wrap soft gauze around the restraint site and tape securely.
6.7 Apply the restraint in a safe and efficient manner. Position the restraint to allow for the greatest safety while maintaining developmental needs, Eg., infant sucking thumb when restraint is prolonged
6.8 If the restraint needs to be tied to a secure object, tie it to the bed frame if lying; if sitting, tie to the back of the chair/wheelchair, using a slipknot.
6.9 Place one finger under the restrained area to ensure one finger's breadth space between the restraint and the skin.
6.10 After application of restraint, check the child's capillary refill, skin color,or peripheral pulses to assess peripheral circulation. Recheck in 15 minutes after initial application.
6.11 Continue to evaluate the need for restraints.
6.12 Encourage parental participation, especially if using restraint for an extended period of time.
6.13 Encourage interaction with the child.
6.14 Teach parents how to remove and apply restraints that can be periodically united.
6.15 Teach the parents how to monitor for signs of circulatory or musculoskeletal impairment, and appropriate actions to take.

7.0 Application of Types of restraints

7.1 Mummy Restraint: used to restrict baby's movements, maintains warmth, head and neck examination
- 7.1.1 Infant is placed on folded corner of blanket.
- 7.1.2 One corner of blanket brought across body and secured beneath body.
- 7.1.3 Second corner brought across and secured, and the lower corner folded and tucked or pinned in place



7.2 Chest or Jacket restraint: Used to restrict movements of thorax and abdomen. It restraint is a cloth, wraparound restraint with armholes. Although not frequently used in most settings, it can be used for children of all ages. The restraint prevents gross movement but permits some mobility.

7.2.1 Place closed side of the chest restraint over the front of the child. Put arms through arm holes.

7.2.2 Cross the ends of the restraint in the back.

7.2.3 Place one end of the restraint through the back slit of the other side.

7.2.4 Secure the chest restraint to the underneath side of the bed or back of chair or wheelchair by tying the ends together with a bow or slipknot. If the child gets out of the chest restraint easily, place two on- one backwards and one forward. Long ties on each side are to be secured to the bed Frame, if child is in bed.

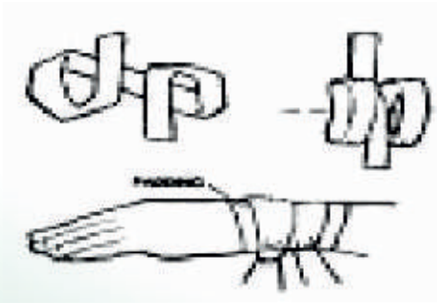
7.3. Clove hitch restraint

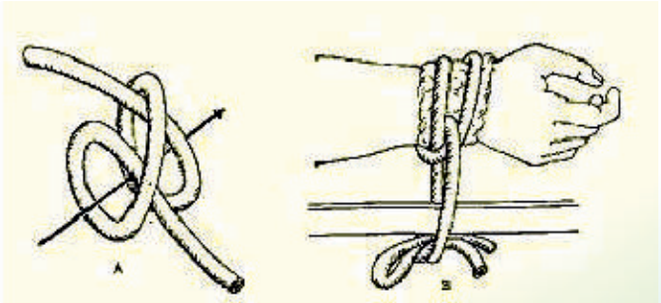
7.3.1 The clove hitch restraint, is normally used on the wrists, is a simple to make soft restraint.

7.3.2 Wrap an ACE bandage around the area to be restrained (use soft gauze for infant). Make a clove hitch with soft gauze.

7.3.3 Place the clove hitch over the wrapped area of the child's extremity and tighten to secure.

7.3.4 Tie the ends of the clove hitch to the bed frame, as with jacket restraint.





7.4 Cloth restraint

7.4.1 The cloth restraint is a commercially prepared soft restraint that can be used for the wrists of ankles.

7.4.2 Wrap padded area of the restraint around the wrist (or ankle).

7.4.3 Slip the strap through the slit in the restraint securely

7.4.4 Tie the ends of the restraint to the bed frame.

7.5 Mitt restraint

7.5.1 The mitt restraint is used with the younger child to prevent irritating an area with the hand.

7.5.2 Wrap gauze around the child's fingers, if necessary, to absorb moisture or protect the restrained area.

7.5.3 Place the mitt over the gauze and tighten. Tie the straps at the wrist of to the bed frame.

7.6 Elbow restraints

7.6.1 Place tongue blades in the pockets of the restraint.

7.6.2 Place elbow restraints over elbow of one or both arms and wrap around. If long sleeved clothing is to be worn, pull the sleeve, wrinkle free down to the child's wrist and wrap restraint around the sleeve.

7.6.3 Tie restraint ends.

7.7. Leather or plastic restraints

7.7.1 Wrap the restraint around the child's wrist (or ankle).

7.7.2 Slip the end of the restraint into the locking device until the end is secured. Close the lock keep the key accessible, E.g. Tape it to head of the child's bed.

7.7.3 Pull the leather of cloth tie down straps through the opening on the side of the restraint. Tie the straps to the bed frame.

7.8. Palm up method

7.8.1. Place arm palm up on an arm board (for full extremity restraint, use arm board that extends from beyond the fingertips to under the scapula. For distal extremity restraint, use arm board that extends from the fingertips to the elbow)

7.8.2. Place two adhesive strips across the hand in an X fashion, allowing the thumb full range of motion and fingers to move freely.

7.8.3. Make a double adhesive strip by using one long and one short piece of tape. Attach them to one another, adhesive sides together, with the short strip touching the child's arm, tape the arm to the arm board at the edge of the antecubital fossa. Tape does not need to be secured directly to the arm.

7.8.4. A final double adhesive strip may be placed midway between the hand and the antecubital fossa or above the antecubital fossa, depending on the greatest need for stabilization.

7.9 Palm down method

7.9.1 Place the arm palm down on the arm board. Place the first adhesive strip over the wrist. (Use 5-cm width adhesive for the child, 2cm width for the infant.)

7.9.2 Secure the second adhesive strip across the proximal end of the phalanges, leaving the thumb mobile.

7.9.3 Using a double adhesive strip, secure the arm just under the elbow.

7.9.4 The final piece of tape is placed obliquely over the thumb and for security, over the second strip.

7.9.5 Adhesive placement for the infant: it may be necessary to start with at least one strip on the fingers to prevent movement during the rest of the procedure.

7.10 Lower Extremity with Board Restraint

7.10.1 With the child in a supine position, leg in full external or internal rotation on the restraint board, place a 5 cm piece of adhesive diagonally across the foot. For a full leg restraint, choose restraint board that extends from beyond the end of the foot to the mid portion of the buttock.

7.10.2 The second piece of adhesive is placed securely over the heel and across the foot in an X formation.

7.10.3 Using a double strip of adhesive, tape the third strip above the knee.

7.11 Bubble top crib/Net top crib

7.11.1 Place the child in the crib and the rails all the way up.

7.11.2 Place the bubble top, and the crib and secure it to the ends of the crib frame with clamps.(when using net instead of bubble top, place straight on top, drawn tight and secured to the legs and frame).

8.0 Post -Procedure

8.1. Check restraints at least every hour; ensure proper positioning of child and restraints and assess circulation and sensation, also determine condition of the skin.
8.2. If appropriate offer the child a bathroom break and food every 2 to4 hours.
8.3. Place the call light in an accessible location to the child, if appropriate for child's age.
8.4. Check whether restraints are properly applied, securely applied and properly maintained.
8.5. Check for the child's safety
8.6. Check whether the child's skin integrity is maintained.
8.7. Documentation of the physician notification and approval, time of the application and removal of restraints, condition of the skin, maintenance and care recieved with emotional response of the restraint and play or stimulation activities provided.

RESTRAINTS

KANGAROO CARE OR KANGAROO MOTHER CARE (KMC)

1.0 Meaning

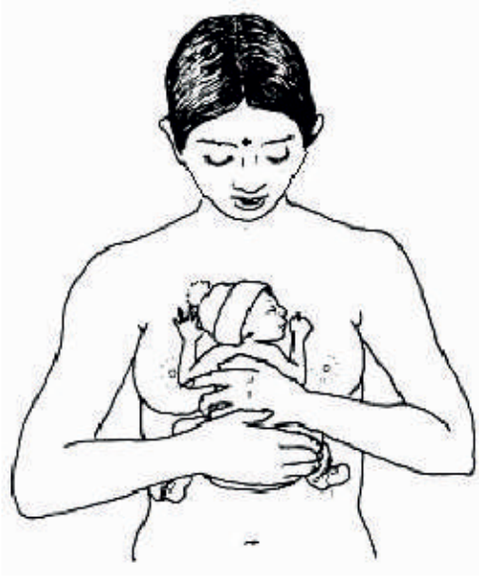
1.1 Kangaroo Mother Care is a special way of caring low birth weight babies. It fasters their health and will be by promoting effective thermal control, breast feeding, infection prevention and bonding.

2.0 Purpose

2.1 To decrease mortality and morbidity in preterm and low birthweight infants.
2.2 To protect from infection and to regulating temperature, breathing, and brain activity;
2.3 To encourage mother-baby bonding.

3.0 The KMC Pre procedure

The baby should be placed between the mother's breasts in an upright position.



3.1. The head should be turned to one side and in a slightly upturned position. This position helps in breathing of and allows eye-to-eye contact between the mother and her baby.
3.2. The legs and arms should be folded.
3.3. Baby's abdomen should be at the level of the mother's upper abdomen.
3.4. Support the baby bottom with a sling/binder.

4.0 Feeding

4.1 Holding the baby near the breast stimulates milk production.
4.2 Mother should express milk while the baby is still in KMC position.
4.3 The baby could be fed with paladai, cup, spoon or tube, depending on the condition of the baby.

5.0 Privacy

5.1. KMC requires some exposure on the part of the mother. This can make her nervous and could be de-motivating. So mother should be provided some privacy for practicing KMC.

6.0 Procedure :Duration for which KMC should be practiced

6.1. To begin with, it may not be possible for the mother to provide KMC for a prolonged period of time. But each session of KMC should last at least an hour. The aim should be to provide KMC as long as possible preferably 24 hours a day.

6.2. Using a comfortable chair or several pillows on an ordinary bed KMC can be provided during sleep and rest.

7.0 Post procedure:

7.1 KMC is continued for as long as possible, at the institutions and then at home. Often this is disrible untill the baby's gestation reches term or the weight is around 2,500 gm.

7.2 After discharge baby should be taken to the hospital as and when advised by doctor/nurse.

ALTERNATIVE METHODS OF FEEDING FOR SMALL OR SICK NEONATES

Alternative Methods of Feeding for Small or Sick Neonates

1.0 Meaning

1.1 Most newborn babies can breast feed without difficulty after birth. However, some infants may not be able to accept breast feeding in the initial few days of life. Insuch situations when breast feeding is temporarily or permanently not possible, alternative ways to feed the breast milk to the baby have to be found.

2.0 Indications:

2.1. When the baby is preterm
2.2. When the baby is ill or has a malformation such as cleft lip & palate
2.3. When baby is referred to another hospital / NICU / PICU
2.4. When the mother is ill or referred is other hospital
2.5 When mother has soar, breast Enhancement, cracked nipples, mastitis abscess
2.6. When mother is HIV positive and has decided not to breast feed the child

3.0 Articles

At least three alternative methods can be used to feed a baby if breastfeeding is not possible. These include:

3.1. Cup or Paladai
3.2. Spoon
3.3. Sterile feeding cup
3.4. Syringe or dropper
3.5. Napkin / Bib

Expression of breast milk

4.0 Pre procedure:

4.1. Expression of breast milk is indicated for women whose infants cannot breast feed effectively but are able to accept oral feeds by alternative feeding methods or Intra-gastric tube feeding.
4.2. Breast milk can be expressed by hand or by pump (manual or electric - operated). Hand expression is the most useful method because it can be done anywhere and at any time. More over, hand expressed breast milk has a lower risk of bacterial contamination when compared to mechanical or electric pumps.
4.3. A mother should express her own milk. The breasts can easily be hurt if expressed by another person. The steps of expression of milk (using hands) are given below:
a) Pre procedure
4.4. Wash her hands thoroughly with soap every time before she expresses*.
4.5. Make herself comfortable.

5.0 During procedure

5.1. Hold a wide necked container under her nipple and areola.
5.2. Ask her to gently massage the breast for 5-10 minutes before expressing the milk (using the pulp of two fingers or with knuckles of the fist in a circular motion towards the nipple as if kneading dough). Massage should not hurt her.
5.3. Place her thumb on top of the breast at least 4 cm from the tip of the nipple, and the first finger on the under side of the breast opposite the thumb.
5.4. Compress and release the breast tissue between her fingers and thumb a few times.
5.5. If the milk does not appear she should re-position her thumb and finger closer to the nipple and compress and release the breast as before#.
5.6. Compress and release all the way around the breast, keeping her fingers the same distance from the nipple.
5.7. Express one breast until the flow of milk slows and milk only drips out, and then express the other breast until the milk only drips.
5.8. Alternate between breasts 5 or 6 times, for at least 20 to 30 minutes.
5.9. Stop expressing when the milk no longer flows.
5.10 Advise mother to clean her breast & wash hands.

6.0 Post procedure

Storage of expressed breast milk

6.1 If EBM cannot be given to the infant soon after expression, it has to be stored and used when necessary. The expressed milk can be stored in one of the following ways:

6.2 At room temperature

6.3. EBM can be kept at room temperature for up to 6 hours without significant risk of bacterial growth. It should be kept in a covered container. Any milk not fed to the infant within 6 hours of expression should be discarded.

6.4. In a refrigerator EBM can be stored in a refrigerator at +3^{0}C to +4^{0}C for 24 hours. The container should be placed at the back of the top shelf where the temperature is constant.

6.5. It should not be put in the door because whenever the door is opened the temperature increases.

6.6. In a freezer EBM can be stored in the freezing compartment of a refrigerator (-4^{0}C) for 2 weeks, or in a separate freezer at -20^{0}C for 3 months.

6.7. The refrigerated or frozen EBM should be brought to room temperature before feeding it to the infant. This can be done by running warm water over the closed container, or by standing the closed container in a safe place in the room.

5.1 CUP FEEDING

5.0 Pre-procedure

An ideal cup should have the following features:

5.1 Holds about 50 to 90 ml of milk
5.2 Made of glass or plastic and easily washable and
5.3 Has smooth and rounded edges

6.0 During procedure Steps of cup feeding

6.1 Infant should be awake and held sitting semi-upright on caregiver's lap; keep a small cloth on his or her front to catch drips of milk
6.2 Pour a measured amount of milk in the cup
6.3 Touch the edge of the cup to the outer parts of the upper lip
6.6 Allow the infant to take the milk himself
6.7 Feed the infant slowly; some milk may spill from the infant's mouth
5.8 When the infant has had enough, he or she will close his or her mouth and will not take any more. Do not force-feed the infant.
6.9 It is essential to caution the mother about pouring the milk into the baby's mouth, as it may cause aspiration.
6.10 Mark on the outside of the cup to guide her how much milk is needed each time.

7.0 Post procedure:

Record on daily feed chart amount of feed taken by cup

5.2 PALADAI FEEDING

5.0 Pre procedure:

5.1 Paladai should be cleaned thoroughly & sterelized before use.
5.2 Infant should be awake and held sitting semi-upright on caregiver's lap; put a small cloth on his or her front to catch drips of milk

6.0 Procedure:

6.1 Keep a measured amount of milk in the paladai
6.2 Hold the paladai so that the pointed tip rests lightly on the infant's lower lip
6.3 Tilt the paladai to pour a small amount of milk into the infant's mouth
6.4 Feed the infant slowly
6.5 Make sure that the infant has swallowed the milk already taken before giving any more
6.6 When the infant has had enough, he or she will close his or her mouth and will not take any more. Do not force-feed the infant.

7.0 Post procedure:

Record on daily feed chart amount of feed taken by cup.

5.3 SPOON FEEDING

1.0 Meaning

Feeding by spoon is appropriate for an infant who is stable and is able to coordinate sucking, breathing and swallowing.

Spoon feeding is, however, very useful in the first few days of life when mothers secrete only a few drops of colostrum. This small amount can easily be given to the baby by using a spoon.

2.0 The advantage of this feeding method is that a measured quantity of milk can be given to the infant.

3.0 Ensuring adequacy of intake /Health education to the mother It is the duty of health personnel to assess the adequacy of feeding by alternate methods and then reassure the mothers about it. In general, feeding by alternate methods is considered adequate if the baby

3.1 Passes urine 6-8 times in 24 hours
3.2 Goes to sleep for 2-3 hrs after the feeds
3.3 Gains weight at10-15 gm/kg/ day
3.4 Crosses birth weight by two weeks
3.5 It is also important to counsel the mothers regarding breastfeeding so that once the baby attains sufficient maturity or the underlying condition (illness) improves, (s)he can be put directly on the breast.

BREAST FEEDING TECHNIQUE

1.0 Meaning:

1.1 Breastfeeding is the feeding of an infant or young child with breast milk directly from female human breast vya lactation rather than using infant formula from a baby bottle or container.

2.0 Purposes

2.1 To provide nutrition for the baby
2.2 To Protect against infection and deficiency status
2.3 To maintain Psychological bond

3.0 Contra Indications:

3.1 Mother on psychotropic medication.
3.2 Mother has sore / cracked nipples / abscess / mastitis / Breast engorgement inverted nipple
3.3 Severe Psychotic illness

4.0 Pre procedure

4.1 Mother should Find a comfortable position that works well for her and her baby. Make sure mother arms and back are well supported
4.2 Advise the mother to get close to baby by bundling
4.3 Advise to hold baby in one arm and support her breast with her other hand.
4.4 Placethe thumb on the upper part of breast well behind the areola, and fingers and the palm of hand underneath the breast away from the areola.
4.5 Her hand should gently support the breast and form a "C" shape around it.

5.0 Procedure

5.1 Techniques of Breast Feeding
- 5.1.1 The baby should be properly positioned to achieve effective latching
- 5.1.2. The mother should wear comfortable apparel, with the breast well exposed for the infant to be able to latch.
- 5.1.3. The infant is brought to the breast, with the nose touching or close to the breast.
- 5.1.4. The gum line should overlap the areola, and the nipple straight back into the mouth.
- 5.1.5. The tongue moves forward beyond the lower gum, cupped and forming a reservoir.

5.2 Attachment of the baby's mouth
- 5.2.1 The baby's mouth is wide open and the lips are turned outwards. The lower lip especially can be seen to be curled right back and the baby's chin is touching the mother's breast.
- 5.2.1 The nipple will be deep into the baby's mouth, with the tip touching the baby's palate

5.2. 2 The baby suckles by making two simultaneous movements: the lower jaw goes up and down and a muscular wave goes from the tip to the back of the tongue.

5.2.3. The baby suckles with short quick movements at first, but changes the rhythm to a more continuous deep suckling as the milk flows. The baby pauses throughout with the pauses getting longer as the feed continues.

5.2.4 The baby's cheeks will be rounded and not drawn in and sometimes the baby's ears will move as it suckles.

5.3. Positioning for Breast feeding

5.3.1 Cradle hold

5.3.1.1 This is commonly used method and very comfortable with breastfeeding. Support baby at breast level with a pillow in her lap.

5.3.1.2 Wrap mother arm around baby so baby head is just below the bend of arm, and the rest of arm and hand supports baby's lower body.

5.3.1.3 Baby is facing mother(tummy-to-mummy) and baby nose is across from her nipple.

5.3.1.4 Keep the baby's ear, shoulder and hip in a straight line.

5.3.1.5 Place baby's lower arm around her side.

5.3.1.6 Make sure her baby's head is tilted back slightly as she bring him onto the breast.

5.3.1.7 Bring her baby to the breast chin and jaw first.

5.3.1.8 Support her breast with her free hand using the "C" hold.

5.3.2. Cross-cradle hold

5.3.2.1 Many moms find this position comfortable when learning to breastfeed. It also works well with a smaller baby.
5.3.2.2 Support her baby at breast level with a pillow in her lap.
5.3.2.3 Using her right hand, place her thumb behind her baby's ear and her fingers behind baby's other ear. Baby's head, neck and shoulders will be supported by the palm of mother hand and baby's body will rest on her forearm.
5.3.2.4 Advise mother to Hold her baby so he is facing mother(tummy-to-mummy) his nose across from her left nipple.
5.3.2.5 Make sure her baby's head is tilted back slightly as she bring him onto the breast.
5.3.2.6 Bring her baby to the breast chin and jaw first.
5.3.2.7 Support her left breast with her left hand in the "C" hold.
5.3.2.8 She can also use this position to breastfeed her baby on her right breast. Advise her to hold baby in her left hand in the same way as above and support her right breast with her right hand.

5.3.3. Football hold

5.3.3.1 Advise her to Sit either in a bed or an armchair with a pillow behind her back, one under her arm, and one across her lap.
5.3.3.2 She should hold baby's shoulders with her right hand ,her fingers support the weight of her baby's head. Her baby's bottom rests on the pillow under her arm with his legs against the back of the chair or bed.
5.3.3.3 His nose should be in front of her right nipple, his body should be snuggled close to her side.
5.3.3.4 Support and offer her breast with her left hand using the "C" hold. Her baby will come onto the breast from below, chin and jaw first.

5.3.3.5 Advise her to Hold her baby in her left hand to breastfeed him from her left breast. Support and offer her breast with her right hand, using the "C" hold.

5.3.3.6 This technique can be conveniently used for feeding twin babies.

5.3.4 Side Lying Position

5.3.4.1 This is a good position if she have a painful episiotomy*, if she want to rest during the day or night feeding, or if she've had a Cesarean birth.

5.3.4.2. Advise mother to lie on her left side with her head supported by 1-2 pillows, a pillow behind her back and one between her bent knees.

5.3.4.3 Keep baby on her right side, with his nose at nipple level, and nose, chin, tummy and knees touching her

5.3.4.4 Keep baby ear, shoulder and hip in a straight line.

5.3.4.5 If needed, place a folded towel under her baby to bring him to nipple level, and a rolled towel behind her baby to keep him from rolling backwards.

6.0 Post procedure

6.1 Signs that the baby is getting enough breast milk

- 6.1.1 Baby is contented for 1-2 hours after a feed
- 6.1.2 Passes clear dilute urine 5-6 times a day
- 6.1.3 Passes bright yellow watery stools 6-8 times a day
- 6.1.4 Baby regains birth weight after 2weeks
- 6.1.5 After each feeding, ensure that baby is burped adequately.

RECORDING OF TEMPERATURE PULSE AND RESPIRATION USING COMMUNITY BAG

1.0 Meaning

1.1. Temperature: Temperature is defined as the degree of heat maintained by the body or it is balance between heat produced and lost in the body. The normal body temperature is 36.1^{0}C - 37.2^{0}C.

1.2 Pulse: It is an alternate expansion and recoil of an artery. Pulse can be felt by fingers on a point where an artery crosses a bone close to the surface of the skin. The normal pulse is 60-100 beats/min.

1.3 Respiration: Is an act of breathing. It constitutes of inspiration, expiration and a pause. The normal respiration is 18-20 breaths/ min.

2.0 Purposes

2.1 To assess the clients general condition

2.2 To evaluate patient's recovery from illness

3.0 Contraindications

3.1 Unconscious patients

3.2 Inability of small child or confused child

4.0 Articles

4.1 Oral thermometer

4.2 Watch with seconds hand

4.3 Dry swab

4.4 Kidney tray /paper bag

4.5 Bowl with spirit cotton

5.0 Pre procedure preparation

5.1 Select a proper place

5.2 Spread the news paper, place the bag on it

5.3 Unbutton the bag

5.4 Take out hand washing articles and wash the hands

5.5 Take out and arrange the articles from right to left according to use.

6.0 Procedure

6.1 Disinfect the thermometer by wiping

6.2 Wipe with dry swab

6.3 Keep the thermometer for at least two minutes in the axilla.

6.4 By the time, hold the hand of the person and check the pulse rate for one minute.

6.5 After counting the pulse without changing the patients position watch the rise and fall of chest, count chest movements for one minute
6.6 Remove the thermometer and check the reading, by keeping the thermometer at eye level

7.1 Post procedure care

7.1 Record the results in client's chart
7.2 Take out the thermometer and wipe it with a soapy swab first then with wet swab and dry swab at last
7.3 Wash , dry and put the articles on news paper for drying up
7.4 Wash your hands
7.5 Give health education
7.6 Wipe all articles with sprit swab before replacing them in the bag
7.7 Replace all the articles in to the bag
7.8 Close and pick up the bag
7.9 Fold the news paper with used side inside and place in the outer pocket

RECORDING BLOOD PRESSURE USING COMMUNITY BAG

1.0 Meaning

1.1 It is the force exerted by the blood against the walls of the blood vessels as it flows through them. The normal blood pressure is 120/80 mmHg.

2.0 Indications/ Purposes

2.1. To assess the clients general condition
2.2. To evaluate patient's recovery from illness.

3.0 Contraindications

3.1 Fistula on hand
3.2 Underwent surgery
3.3 Paralyses of arms
3.4 Underwent Mastectomy

4.0 Articles

4.1 Hand washing articles
4.2 Cotton balls with kidney tray
4.3 Bowl with spirit cotton
4.4 Sphygmomanometer
4.5 Stethoscope

5.0 Pre procedure preparation

5.1 Select a proper place
5.2 Spread the news paper, place the bag on it
5.3 Unbutton the bag
5.4 Take out hand washing articles and wash the hands
5.5 Take out and arrange the articles from right to left according to use.
5.6 Check for the working condition of BP Apparatus.
5.7 Provide comfortable sitting or lying down position to client

6.0 Procedure

6.1 Apply the deflated cuff evenly with rubber bladder over the brachial artery. The lower edge being 2 inches above the antecubital fosse. The tubes turned towards the palm.
6.2 Palpate the radial artery with 2 finger tips and inflate the cuff and check the BP by palpatory method. This will give only systolic BP.
6.3 Palpate the brachial artery. Place the bell of stethoscope on the brachial pulse. The stethoscope must hang freely from the ears.

6.4 Close the valve on the pump by turning the knob clockwise. Pump up air in the cuff above 20 mmHg above the point at which the radial pulsation disappears.
6.5 Open the valve slowly by turning the knob anti-clockwise. Permit the air to escape slowly. Note the number on the manometer where the sound first begins. This is systolic pressure.
6.6 Continue to release the pressure slowly. The sound become louder and clear. Note the point on the manometer where the sound ceases. This is diastolic pressure.
6.7 Allow the air to escape and the mercury to fall zero and remove the cuff.

7.0 Post procedure care

7.1 Record the results in client's chart
7.2 Wash, dry and put the articles on news paper for drying up
7.3 Wash your hands
7.4 Give health education
7.5 Wipe all articles with sprit swab before replacing them in the bag
7.6 Replace all the articles in to the bag
7.7 Close and pick up the bag
7.8 Fold the news paper with used side inside and place in the outer pocket

URINE ANALYSIS USING COMMUNITY BAG

1.0 Meaning

1.1 Urine analysis is the analysis of urine in order to find out the presence of sugar, albumin and microorganism.

2.0 Purposes

2.1 To evaluation general health of clients
2.2 To Diagnose the disease or disorders of the kidneys or urinary tract
2.3 To Diagnose the other systemic disease that affect kidney function
2.4 To Monitor the clients with diabetes
2.5 To test the evidence of sugar in the urine
2.6 To test the evidence of albumin in the urine
2.7 To test the reaction
2.8 To test the specific gravity

3.0 Articles

3.1 Container for specimen
3.2 Benedict's solution
3.3 Acetic acid
3.4 Test tubes and Test tube holder
3.5 Kidney tray
3.6 Paper bag
3.7 Spirit lamp / candle
3.8 News paper
3.9 Match box
3.10 Cotton balls in bowl
3.11 Litmus paper
3.12 Urinometer

4.0 Pre procedure

4.1 Select a proper place
4.2 Spread the news paper
4.3 Unbutton the bag
4.4 Take out the kidney tray and specimen bottle
4.5 Give the specimen bottle to the client for collecting urine
4.6 Take out hand washing articles and wash the hands
4.7 Take the articles required for the test

5.0 Procedure

5.1 Test for sugar: -
5.1.1. Pour 5ml of Benedict's solution in the test tube

5.1.2. Boil it to find out the color change, if no change that shows the purity of Benedict's solution
5.1.3. Add 8 drops of urine into the solution and reheat it, allow it to cool
5.1.4. Observe the color change which indicates the sugar level
Blue : 0%
Green: 1%
Yellow: 2%
Orange: 3%
Brick red: 4%

5.2 Urine for albumin: - (Hot test)
5.2.1 Take urine up to 2/3 of the test tube and heat the upper 1/3, rotate test tube constantly
5.2.2 Then add few drops of acetic acid along the sides of the test tube and observe for the precipitation
5.2.3 If the cloud disappears, it is due to phosphate if the cloud still remains it indicate the presence of albumin; it will not disappear with acetic acid
5.2.4 If urine is highly acidic or highly alkaline, the reading will be false

Precipitation	Albumin Level
No precipitate	Nil
Slightly cloudy	Trace
One finger breadth or translucent	1+
Two finger breadth or translucent	2+
Three finger breadth or opaque	3+
Thick Precipitate	4+

5.3 Test for the reaction
5.3.1. Dip one end of litmus in to the urine
5.3.2. If urine is acidic, blue litmus turn into red
5.3.3. If urine is alkaline, red litmus turn in to blue
5.3.4. No changes in litmus indicates neutral reaction Normal urine is acidic in nature
5.4. Test for specific gravity
5.4.1. Take conical glass fill 2.-30 ml of urine
5.4.2 Allow urinometer to float in the urine
5.4.3 Take reading just before spinning stops.
5.4.4 Read the specific gravity at the eye level
(Normal specific gravity is 1.003 to 1.030 .Urinometer scale is 1.000 to 1.060)

6.0 Post procedure care

6.1 After the procedure it is essential to terminate the articles in a proper manner
6.2 After the result, recording & reporting, dispose the urine sample, as well as the liquid from the test tube
6.3 Take the articles to the hand washing area
6.4 Wash each article clearly
6.5 Put the articles on newspaper for drying up
6.6 Wash your hands

6.7 Give health education
6.8 Wipe all articles with spirit swab before replacing them in the bag
6.9. Replace all articles in to the bag
6.10 Close and pickup the bag
6.11 Fold the news paper with used side inside and place in the outer pocket

TESTICULAR SELF EXAMINATION USING COMMUNITY BAG

1.0 Meaning

A testicular self examination (TSE) is an easy way for guys to check their own testicles to make sure there aren't any unusual lumps or bumps, which can be the first sign of testicular cancer.

2.0 Purposes

2.1 To detect testicular cancer (TC) at an early and very curable stage.
2. 2 To notice if anything changes in testis.
2.3 Testicular exam and testicular self-exam are two ways to find lumps or other problems in the testicles.

3.0 Indications

3.1 Swelling in the scrotum
3.2 Pain the scrotum
3.3 Lump in the scrotum

4.0 Contraindications

4.1 No Significant contraindication

5.0 Articles

5.1 Mirror
5.2 Cotton (If necessary)
5.3 Gloves (If necessary)
5.4 Torch (If necessary)

6.0 Pre procedure preparation

6.1 Select a proper place
6.2 Spread the news paper
6.3 Unbutton the bag
6.4 Take out the kidney tray
6.5 Take out hand washing articles and wash the hands
6.6 Take the articles required for the test
6.7 Self-examination for TSE is best performed after a warm bath or shower

7.0 Procedure

7.1 It should be done once a month.

7.2 It is best to do a TSE during or right after a hot shower or bath. The scrotum (skin that covers the testicles) is most relaxed then, which makes it easier to examine the testicles.

7.3 To do a self examination, stand and place your right foot on a chair or other surface about chair height.

7.4 Examine one testicle at a time. Use both hands to gently roll each testicle (with the slight pressure) between your thumb and fingers of both hands.

7.5 The gently feel your scrotum until you locate the right testicle.

7.6 Place your thumb over the top of your testicle, with the index and middle fingers of each hand behind the testicle, and then roll it between your fingers.

7.7 Check the surface carefully for lumps.

7.8 The skin over the testicle moves freely, so it is easy to feel the whole surface of the testicle.

7.9 Repeat the process on the other side. Lift your left leg and check your left testicle. Feel the whole surface of both testicles.

7.10 The person should be able to feel the epididymis which feel soft, rope like, and slightly tender to pressure, and is located at the top of the back part of each testicle. This is the normal lump.

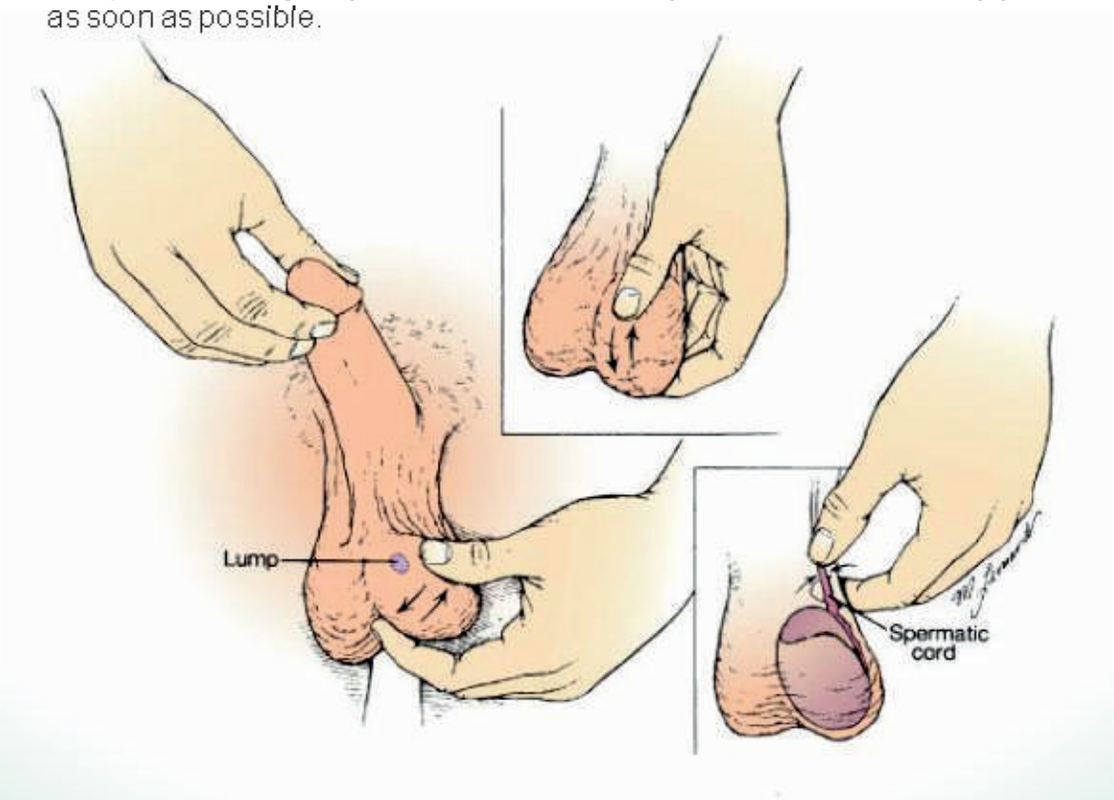
7.11 Remember that one testicle(usually the right one) is slightly larger than the other for most guys-this is also normal.

7.12 When examining each testicle feel for any lumps or bumps along the front or sides. Lumps may be as small as a piece of rice or a pea.

7.13 A self examination does not cause pain or discomfort unless a testicle is swollen or tender. A lump that it is cancer usually feels firm. But it probably will not be tender or painful when pressed.

7.14 If your notice any swelling, lumps or changes in the size or colour of a testicle, or if you have any pain or ache areas in your groin, let your doctor know right away.

7.15 Lumps or swelling may not be cancer, but they should be checked by your doctor as soon as possible.



7.16 Testicular cancer is almost always curable if it is caught and treated early.

8.0 Post procedure care

8.1 After the procedure it is essential to terminate the articles in a proper manner
8.2 After the procedure, recording & reporting the Pain or burning during urination, Blood in the urine or semen, Any enlargement of a testicle, A feeling of heaviness in the scrotum
8.3 Take the articles to the hand washing area
8.4 Wash each article clearly
8.5 Put the articles on newspaper for drying up
8.6 Wash your hands
8.7 Give health education
8.8 Wipe all articles with spirit swab before replacing them in the bag
8.9 Replace all articles in to the bag
8.10 Close and pickup the bag
8.11 Fold the news paper and place in the outer pocket

STOOL SPECIMEN COLLECTION USING A COMMUNITY BAG

1.0 Meaning

1.1 A sample of patient's feaces is collected in a special sterile container to identify causes in patients with a suspected infection of the digestive tract.

2.1 Indications

2.1 Inflammatory bowel disease
2.2 Ulcerative colitis
2.3 To find out intestinal parasites
2.4 Fecal Occult Blood Test (FOBT) colorectal cancer Or stomach cancer
2.5 Person has complaints of passing of abnormal stool
2.6 Gastro-enteritis
2.7 Melaena
2.8 Fecal fat test to diagnose steatorrhea

3.0 Contraindications

3.1 Use of antibiotics and antifungal drugs two weeks before sample collection
3.2 Use of oral castoroil, probiotics, laxatives,aspirin,three days before Collection
3.3 Use of supplements like enzymes, amino acids or liver cleansings 3 days before Collection.

4.0 Articles

4.1 Bed pan
4.2 Gloves 1 pair
4.3 Plastic apron
4.4 Sterile specimen container and spatula
4.5 Specimen bag

5.0 Pre procedure preparation

5.1 Select a proper place
5.2 Spread the news paper
5.3 Unbutton the bag
5.4 Take out hand washing articles and wash the hands
5.5 Take the articles required for the test
5.6 Explain procedure to the client
5.7 Maintain privacy.
5.8 Precautions should be taken to prevent cross infection
5.9 Prevent contamination of the specimen.

6.0 Procedure

6.1 Label the container with name, date and time of collection
6.2 Wash hands thoroughly and dry them
6.3 Wear gloves and apron
6.4 Ask patient to defecate in to a clinically clean bed pan,
6.5 Provide assistance if necessary
6.6 Use spoon or spatula that comes with the container to place the sample in clean screw top container, fill third of it, and screw the lid.
6.7 Place the sample in a plastic bag tie it up and place in the bag

7.0 Post procedure care

7.1 Terminate the procedure in proper manner
7.2 Attain to patient hygiene as required
7.3 Take the articles to the hand washing area
7.4 Wash each article clearly
7.5 Place the articles on newspaper for drying
7.6 Dispose of gloves, apron and waste
7.7 Wash hands
7.8 Give health education
7.9 Wipe all articles with spirit swab before replacing them in the bag
7.10 Complete the appropriate documentation
7.11 Replace all articles in to the bag
7.12 Close and pickup the bag
7.13 Fold the news paper with the used side inside and place in the outer pocket
7.14 Send the sample to the laboratory.

STOOL EXAMINATION FOR OVA & CYST USING COMMUNITY BAG

1.0 Meaning

1.1 Ova, cysts and parasites test is performed on a sample of stool to measure the level of parasites in the stool.

It is performed to confirm GI system infection and parasites infestation and also during the treatment and after treatment of GI system infection and parasite infestation.

2.0 Purposes

2.1 To find dysentry, (bacillary and amoebic)
2.2 To find any Parasitic infestation
2.3 To detect microorganisms
2.4 To find ova or parasites
2.5 To screen of colon cancer
2.6 To screen asymptomatic ulceration of GI tract
2.7 To rule out the presence of WBC'S and RBC'S

3.0 Articles

3.1 Specimen container with lid
3.2 Gloves
3.3 Two tongue blades - (wooden spatula)
3.4 Paper towel or paper bag
3.5 Bed pan or portable commode

4.0 Pre procedure preparation

4.1 Select a proper place
4.2 Spread the news paper
4.3 Unbutton the bag
4.4 Take out the kidney tray and specimen bottle
4.5 Universal precautions should be followed
4.6 Assess for the container to be dry, sterilized and of wide mouthed
4.7 Container should be labeled properly
4.8 Give stool collection instruction to the patient
4.9 Advice to avoid using laxatives, antibiotics.

5.0 Procedure

5.1 Hand washing with appropriate techniques to be done
5.2 Collect a small sample of your stool using latex gloves or plastic wrap
5.3 Avoid mixing stool sample with urine or toilet paper
5.4 In case of children stool sample may be collected from diapers as long as the sample isn't soiled with urine

5.5 A cotton swab is used to collect a sample of stool from their rectum
5.6 After collecting the sample of stool place it in a clean labeled container and scale it.
5.7 Discard the gloves and soiled, articles into appropriate biohazard bag
5.8 Hand washing with aseptic techniques to be done.

6.0 Post procedure care

6.1 After the procedure it is essential to terminate the procedure in a proper manner
6.2 Take the articles to the hand washing area
6.3 Wash each article clearly
6.4 Put the articles on newspaper for drying up
6.5 Wash your hands
6.6 Give health education
6.7 Wipe all articles with spirit swab before replacing them in the bag
6.8 Replace all articles in to the bag
6.9 Close and pickup the bag
6.10 Fold the news paper with used side inside and place in the outer pocket
6.11 Fill in the requests forms for investigations as per doctors order.
6.12 Then take the scaled sample container to the clinic or laboratory as instructed by the doctor
6.13 A technician will use dye and a microscope to look for parasites and eggs in the stool sample.
6.14 A normal test result means that no eggs or parasites are found in stool.
6.15 An abnormal tests results means that parasites eggs or both have been found in the stool sample.

SPUTUM COLLECTION USING COMMUNITY BAG

1.0 Meaning

1.1 A sample of patient's sputum is collected in a water proof sterile container to identify causes in patients with a suspected infection of the respiratory tract.

2.0 Indications

2.1 To diagnose respiratory infection.
2.2 To assess the efficacy of treatment to diseases such as TB.

3.0 Contraindications

3.1 Patients with haemoptysis

4.0 Articles

4.1 Laboratory form
4.2 Gloves 1 pair
4.3 Sterile covered sputum container
4.4 Sputum mug or cup with disinfectant
4.5 Kidney tray (1)
4.6 Label as required
4.7 Paper tissue as required
4.8 Ball point pen (1)

5.0 Pre procedure preparation

5.1 Select a proper place
5.2 Spread the news paper
5.3 Unbutton the bag
5.4 Take the articles required for the procedure
5.5 Explain procedure to the client
5.6 Maintain privacy.
5.7 Precautions should be taken to prevent cross infection
5.8 Care should be taken to Prevent contamination of the specimen.

6.0 Procedure

6.1 Label the container with name, date and time of collection
6.2 Wash hands thoroughly and dry them, put on gloves
6.3 Ask the patient to rinse the mouth with plain water. Don't use any antiseptic mouth washes
6.4 Instruct the client to breath deeply for two to three times and cough up secretions from deep in the respiratory passage
6.5 Have the client expectorate directly into the sterile container
6.6 Instruct the client to wipe around mouth if needed. Discard it properly

6.7 Provide assistance if necessary
6.8 Close the specimen container immediately
6.9 place the sample in a plastic bag tie it up and place in the bag

7.0 Post procedure care

7.1 Terminate the procedure in a proper manner
7.2 Attend to patient hygiene as required
7.3 Take the articles to the hand washing area
7.4 Wash each article
7.5 Place the articles on newspaper for drying
7.6 Dispose of gloves,
7.7 Wash hands
7.8 Give health education
7.9 Wipe all articles with spirit swab before replacing them in the bag
7.10 Complete the appropriate documentation
7.11 Replace all articles in to the bag
7.12 Close and pickup the bag
7.13 Fold the news paper with used side inside and place in the outer pocket
7.14 Send the sample to the laboratory.

SELF BREAST EXAMINATION

1.0 Meaning

1.1 It is a screening method used in an attempt to detect early breast cancer.
OR It is a method that involves the women herself looking at and feeling each breast for possible lumps, distortions or swelling.

2.0. Indications

2.1 Pain, lump or swelling in breast
2.2 Family history of cancer
2.3 Unusual Discharge from Nipple

3.0. Contraindications

3.1 Surgical incision

4.0 Articles

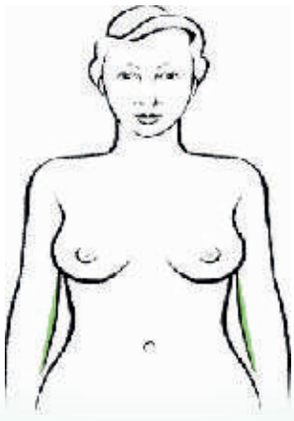
4.1 Mirror
4.2 Small pillow /rolled towel
4.3 Cotton to wipe discharge

5.0 Pre procedure preparation

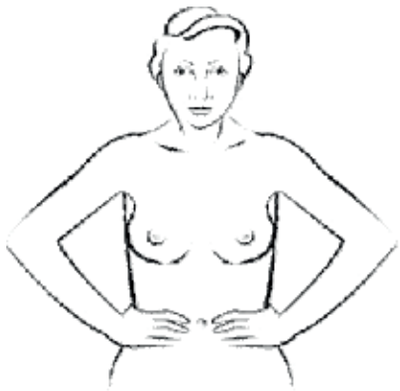
5.1 Identify and review personal and family health history
5.2 Explain the procedure to patient and ask her to wear a gown with front opening
5.3 Provide privacy to patient
5.4 Wash hands

6.0 Procedure

6.1 Stand before a mirror and look at both breasts. Check for anything unusual, such as nipple retraction, redness, puckering, dimpling, or scaling of the skin. Look for nipple discharge. Note the colour of the discharge, whether it came from both breasts and whether it came from one or more openings.



6.2 Next, press your hands firmly on your hips and lean slightly toward your mirror. Look for any change in the normal shape of your breasts.



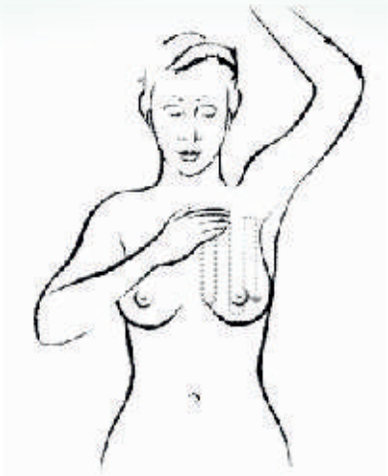
6.3 Looking in the mirror, raise your arms and rest your hands behind your head. This allows you to see the underside of your breasts.

6.4 Place your left hand on your waist, roll your shoulder forward and reach into your underarm area and check for enlarged lymph nodes. An enlarged node would feel like a corn kernel or a bean. Also check the area above and below the collar bone. Repeat on the right side.

6.5 Raise your left arm. Use the pads of three or four fingers of your right hand to examine your left breast. Use three levels of pressure (light, medium, and firm) while moving in a circular motion. Check your breast area using a set pattern. You can choose (a) lines, (b) circles or (c) wedges

6.5.1 LINES: Beginning at the outer edge of your breast move your fingers downwards until they are below the breast . Go up and down until you cover entire breast area

6.5.2 CIRCLES: Beginning at the outer edge of your breast use the flat part of your fingers, moving in circles slowly around the breast. Gradually make smaller and smaller circles toward the nipple. Be sure to cover the entire breast and check behind the nipple.



6.5.3 WEDGES: Starting at the outer edge of the breast, move your fingers toward the nipple and back to the edge. Check your entire breast, covering one wedge-shaped area at a time

6.6 Lie flat on your back, left arm over your head and a pillow or folded towel under your left shoulder. This position flattens the breast and makes it easier to examine. Use the same motion described above

7.0 Post procedure care

7.1 Allow patient to dress
7.2 Wash hands
7.3 Give the patient written materials to reinforce teaching
7.4 Record the findings with date and time

PREPARATION OF HYDERABAD MIX

1.0 Meaning

1.1 It refers to a supplementary feed made of a mixture of wheat (40gm), Bengal grams(16gm), groundnut (10gm) and Jaggery (20gm). A ball of Hyderabad mix weighing 86gms will be providing 330 kcal energy and 11.3gms protein which will be given for a period of 30days.

2.0 Indications/Purposes

2.1 Food supplements are required for those children, who show obvious clinical signs of malnutrition deficiency
2.2 Hyderabad mix is an energy supplement, used for malnourished children.
2.3 Domiciliary/home management of PEM
2.4 The incidence of malnutrition among pre-school children can be considerably reduced with such preparations which are much cheaper than proprietary and processed foods.

3.0 Contraindications

3.1 No significant contraindications

4.0 Articles

4.1 Wheat (40gm)
4.2 Bengal grams (16gm)
4.3 Groundnut (10gm)
4.4 Jaggery (20gm)

5.0 Pre procedure preparation

5.1 Hand wash
5.2 Explain the procedure to the parents.
5.3 Get ready with all the articles.

6.0 Procedure

6.1 Use palm jaggery(panai vellam) for more healthier ladoos.
6.2 Syrup consistency need not be string level. It should be little thick that's enough
6.3 While roasting the powder, do not burn it by over heating.
6.4 You can keep this laddu for one week without refrigerating.

7.0 Post procedure care

7.1 Tell the parents to give Hyderabad mix to the children in their daily diet.
7.2 Ask the parents to wash hands before making Hyderabad mix.

BAG TECHNIQUE

1.0 Meaning

1.1 It is a vehicle for carrying the tools needed during a home visit to the antenatal, postnatal, infant, preschool and school child as well as to the person suffering from diseases.

It is a tool which the nurse uses during his/her home visit to perform nursing procedures.

2.0 Purposes

2.1 Cleanliness: The bag and its contents are all designed for efficiency and cleanliness.
2.2 Protect and take care of bag: A well made bag that has been properly cared for should; last for 8-10 years.

3.0 Articles

3.1 Paper lining
3.2 Extra paper for making waste bag
3.3 Apron
3.4 Hand towel
3.5 Soap in a Soap dish
3.6 Thermometers
- 3.6.1. Oral Thermometer
- 3.6.2. Rectal Thermometer

3.7 Two pairs of Scissors
- 3.7.1. Surgical
- 3.7.2. Bandage

3.8 Two Pairs of Forceps
- 3.8.1. Curved
- 3.8.2. Straight

3.9 Disposable syringe with needles
- 3.9.1. G 23 and 25

3.10 Hypodermic needles
3.11 Sterile dressing
3.12 Cotton balls
- 3.12.1. Dry cotton
- 3.12.2. With alcohol

3.13 Cord clamp
3.14 Micropore plaster

3.15 Tape measures
3.16 One pairs of sterile gloves
3.17 Baby's scale
3.18 Alcohol lamp
3.19 Two test tubes
3.20 Test tube holders
3.21 Solutions
- 3.21.1. Betadine
- 3.21.2. Spirit of ammonia
- 3.21.3. Acetic acid
- 3.21.4. 10% Alcohol
- 3.21.5. Hydrogen peroxide
- 3.21.6. Ophthalmic ointment
- 3.21.7. Benedicts solution

3.22 Dropper
3.23 Kidney Tray

4.0 Pre procedure preparation

4.1 Maintain hand hygiene before the procedure
4.2 Explain the importance of the bag to the community people

5.0 Procedure

5.1 Hand washing
5.2 Place the bag on the table or any flat surface lined with paper lining.
5.3 Keep the bag on the corner of the paper sheet in a manner such as bag should face away from the door of the room
5.4 Unbutton the outer fold of bag
5.5 Take the plastic lining and spread over the work area, place waste paper bag outside of work area.
5.6 With the help of index finger open the unbuttoned outer fold of bag, fold the draw strings inside and tuck them at the side then open the wooden slab to remove the articles from sterile area put out things needed for the specific procedure, then take out the articles from clean chamber of the bag.
5.7 Close the bag
5.8 Proceed to the specific nursing care or treatment
5.9 After completing nursing care or treatment clean the things used
5.10 Do hand washing again
5.11 Open the bag and put back all articles in their proper places

6.0 Post procedure care

6.1 Open the bag and put back all articles in their proper places
6.2 Fold the linen or plastic lining, place it in the bag
6.3 Record the findings, make a post visit
6.4 Address on matters relevant to health care.

ADMINISTRATION OF TYPHOID VACCINE

1.0 Meaning

1.1 Typhoid vaccine is a vaccine containing a suspension of inactivated salmonella typhi, used to immunize against typhoid fever.

2.0 Indications

2.1 Immunization against typhoid fever
2.2 Adult, given at least 2 weeks before expected exposure: may Repeat every 2 years 0.5ml, IM once in deltoid.
2.3 Children, above 2years 0.5 ml in deltoid or vastus lateralis.

3.0 Contraindications

3.1 Vaccination should be postponed in patients with acute febrile illness or acute GI illness.
3.2 Not to be used in congenital or acquired immunodeficient state, including patients receiving immunosuppressive or antimitotic drugs
3.3 Typhoid vaccine is capsule contraindicated if the child is having vomiting and chronic diarrhoe and body temperature more than 101^{0} F.

3.0 Articles

3.1 Clean place or room
3.2 Trained health person
3.3 Clean table with sheet
3.4 Vaccine Ice pack carrier with vaccines
3.5 For hand wash soap and water and sterile hand gloves
3.6 The sterile tray containing paper bag, dry swabs, wet swabs.
3.7 Emergency drug trays.
3.8 For segregation of waste-dust bins
3.9 For registration -Record book.

4.0 Pre procedure preparation

4.1 Before giving vaccine to give information about typhoid vaccine, its indications and contra indications and to collect all information about patient illness.
4.2 To arrange clean and well ventilated room are place
4.3 To arrange required articles for vaccination
4.4 To keep hospital immunization record book and client record book.
4.5 To observe patient present condition and ask any allergies about previous vaccination.
4.6 To check client records and lab investigations.

5.0 Procedure

5.1 Interview patient : Determine whether the patient is pregnant
5.2 To determine what immunization are needed
5.3 Determine whether known allergies
  5.3.1 Have emergency tray available
  5.3.2 Hand wash

5.4 Perform patient care hand wash
5.5 Wear sterile gloves for hands
  5.5.1 Obtain immunizing agent: Vaccines are kept in a refrigerator or carrier
  5.5.2 Check label for expiry date
  5.5.3 Examine vial and contents
  5.5.4 Draw up required amount of immunizing agent

5.6 Select site and route for administration
5.7 Prepare the site by the use of suitable cleaning agent
5.8 Administer vaccine.

6.0 Post procedure care

6.1 Dispose of the needle and syringe in appropriate bin
6.2 Store unused vaccine in accordance with the manufacture's instruction and wash hand after procedure.
6.3 Observe for the client after administration of vaccine
6.4 Record and both hospital and client record
6.5 To check any allergies.

ADMINISTRATION OF ANTI RABIES VACCINE (ARV)

1.0 Meaning

1.1 Anti Rabies vaccine is an inactivated rabies virus. It is an active immunization against rabies. It can be given in two forms. Pre-exposure Immunization and Post-exposure Immunization

2.0 Indications/Purposes

2.1 Pre-exposure immunization :
2.2 Veterinary medicine students
2.3 Animal keepers
2.4 Hunters, Forestry workers
2.5 Animal handlers
2.6 Personnel in Rabies research laboratories
2.7 Post-Exposure Treatment
2.8 Treatment after contact with animals which are rabies or suspected to be rabies.

3.0 Contraindications

3.1 Immuno suppression
3.2 Pregnancy and Breast feeding
3.3 Allergies
3.4 Anti Malarial drugs
3.5 Treatment after exposure In view of fact that rabies is a fatal disease " there are no contra indications to immunization after suspected exposure"

4.0 Articles

4.1 Inj ARV with Reconstituent (solvent for solution)
4.2 0.5 ml D/S (AD Syringe)
4.3 Gloves one pair
4.4 Saline swabs
4.5 Paper bag or Kidney tray
4.6 Needle cutter
4.7 Waste disposable bins

5.0 Pre procedure preparation

5.1 Select a proper place
5.2 Spread the news paper
5.3 Unbutton the bag
5.4 Take out the kidney tray and specimen bottle
5.5 Take out hand washing articles and wash the hands
5.6 Explain the procedure to the patient
5.7 Arrange all articles

6.0 Procedure

6.1 Wash hands with soap and water
6.2 Wear gloves
6.3 Dilute the injection with solvent solution
6.4 Take required amount(1dose=0.5ml)
6.5 Administer injection by Intramuscularly into the deltoid muscle(upper-arm muscle) or into the anterolateral region of the thigh in small children(The vaccine must not be given by intragluteal)
6.6 Dispose of the waste to respected bins.

7.0 Post procedure care

7.1 Watch for any reactions
7.2 Inform the patient about due date for next dose
7.3 Record the procedure.

APPENDIX 1:
HEALTH HISTORY FORMAT

1. Identification data
   - Name
   - Age in years
   - Gender
   - Reg.no
   - Bed No.
   - Ward
   - Religion
   - Education
   - Occupation
   - Monthly Family Income
   - Marital status
   - Duration of marriage
   - Blood group
   - Contact person
   - Address
   - Doctor's Name
   - Diagnosis
   - Date of admission
   - Surgery
   - Date of surgery
   - Date of discharge

2. Chief Complaints: According to Priority indicating duration.
3. Present medical/surgical history: According to chronological order.
4. Present complaints: Complaints of the patient on the day of assessment.
5. Past Health History: Medical/Surgical history, Any medications used, History of any allergies, immunization status(in case of children)
6. Family History: History of hereditary diseases, communicable diseases, psychiatric illness etc. also include family tree

7. Personal History:
   - Sleep and Resting patterns
   - Dietary pattern
   - Bowel and Bladder habits
   - Personal habits/Substance abuse:
   - Relationship with Family members:
   - Socioeconomic status:
   - Psycho social status:
   - Menstrual history
   - Obstetric history

APPENDIX 2:
PHYSICAL EXAMINATION

General Survey

- Appearance - healthy/unhealthy
- Grooming - well groomed/ill groomed
- Posture - erect/slouched, bent posture, guarding
- Gait - coordinated movement/ uncoordinated
- Facial expression - relaxed/ tense; any signs of distress - grimacing
- Mood - appropriate/inappropriate
- Attitude - Co-operative/uncooperative
- Hygiene - clean/ unclean
- Body/ breath odour - no odour/ foul body odour, ammonia odour, acetone breath odour, halitosis
- Speech-
    - Amount & Pace - understandable, moderate pace/rapid or slow pace
    - Quality - loud, clear/low, slurred
    - Organization - exhibits thought association/lacks thought association
    - Sequence- Logical sequence, makes sense/ illogical, confusion
- Body build- thin/normal/obese

Anthropometric measurements

- Height-
- Weight-
- BMI -

Vital signs

- Temperature-
- Pulse-
- Respiration-
- Blood Pressure-

Integument

- **Skin**
    - Colour : Pallor/ Cyanosis/ Jaundice/ Erythema/ Vitiligo/ Hyperpigmentation
    - Lesions : maculae, papule, plaque, vesicle, bulla, pustule, nodule, wheal
    - Edema: pitting/ non-pitting; generalized/localized.
    - Moisture: excessive moisture/ dryness/ normal
    - Temperature: bilaterally uniform, within normal range/ hyperthermia/hypothermia
    - Turgor: good/poor

- **Nails**
    - Clubbing/ koilonychias/paronychia; smooth/rough; thin/thick; pink/blue/pale
    - Capillary refill.

Hair

- Evenly distributed/alopecia; thick/thin; silky, resilient/ brittle, oily or dry; flaking, lice, sores
- Body hair: variable/hirsuitism

Head

- Skull- normocephalic/hydrocephalus; round, symmetrical/unsymmetrical; smooth/nodules/depressions
- LOC, dizziness, seizures, headache, injury
- Face - puffy/ moon face/ acromegaly; symmetrical/unsymmetrical; facial movements- symmetrical/ unsymmetrical/ tics.

Eyes

- Eyebrows- thinning/ evenly distributed, dandruff
- Eyelids- drooping/ equally distributed/unequal; inversion , swelling, redness, closure- symmetrical/ unsymmetrical; sunken eyes
- Conjunctiva- pale/ red/ pink; shiny, smooth/ nodules; discharge
- Sclera- white/ jaundiced/ pale/ red; lesions
- Lacrimal gland- edema/ tenderness; excessive tearing/ dryness
- Cornea- transparent, smooth, shiny/ opaque, not smooth, arcus senilis; corneal reflex- present/ absent.
- Pupils- black/brown, equal size/ anisocoria; 3-7mm/ mydriasis/ miosis, cloudiness ; reaction- direct- illuminated pupil constricts, consensual- non-illuminated pupil- constricts. Accommodation- dilates when looking at far objects and constricts when looking at near objects, converges/ squint [PERRLA.]
- Peripheral vision- normal/ smaller field

Ears

- Auricles- colour- same as face/ bluish/ pallor/ redness; position- aligned with outer canthus of eye/ low set ears; mobile, firm, non-tender/ tender, recoils easily after folding
- External ear- cerumen normal/ excess & obstructing the ear canal; redness/ discharge
- Hearing -normal/ not audible; able to hear in both ears/ one ear

Nose & sinus

- Nose- symmetric/ asymmetric; straight, flaring; tender, uniform colour/ localized redness;, air movement - restricted/ moves freely.
- Nasal cavity- mucosa- redness/ pink/ pallor/ discharge/ polyp/nasal septum- midline/deviated.
- Sinus- tender/ non-tender

Mouth & Oropharynx

- Lips- dry/ moist; pink/ blue/ redness; soft/ swelling/fissures; white patches
- Teeth- missing teeth/ discoloration- brown/ black; caries/
- Gums- pink/ excessively red; moist, firm/ spongy; hypertrophy/ atrophy/ swelling
- Tongue- pink/ red; smooth/ slightly rough; moist/ dry, coated; central/ deviated ; movement- moves freely/ tongue tie;
- Uvula- midline/ deviated
- Palates- pink, smooth/ pallor,/ jaundice

- Tonsils- enlarged/ pink/ inflamed/ discharge
- Oropharynx- swelling/ throat pain/ swallowing difficulty
- Gag reflex- present/ absent

Neck

- Neck muscles- equal in size/ unilateral swelling
- Movement- flexion/ hyperextension/ lateral flexion/ lateral rotation
- Strength -equal/ unequal
- Lymph nodes- enlarged/ not enlarged
- Trachea- deviated / midline
- Thyroid gland- visible/ not; movable with swallowing; enlarged; smooth/ nodules

Thorax & Lungs

- Chest- symmetric/ asymmetric; barrel chest/ kyphosis;
- Posterior thorax-tenderness/ bulges/ depressions; temperature; skin -intact
- Respiratory excursion- full & symmetric chest expansion/ asymmetric & decreased
- Vocal fremitus- bilateral symmetry/ decreased/ absent fremitus
- Percussion- resonance, symmetry/ dullness or flatness, asymmetry
- Breath sounds- vesicular & bronchovesicular sounds/ rales, rhonchi, crepitus, wheeze/ absent; cough- dry/ productive, sputum- colour, consistency
- Respirations - dyspnoea, hyperventilation, hypoventilation/ quiet, rhythmic, effortless breathing

Heart & peripheral vascular system

- Heart- precordium- abnormal pulsations/ lifts, heaves; PMI- displaced laterally/lower; apical pulse- pulse deficit
- Heart sounds- S1, S2- increased/ decreased intensity
- Carotid arteries- symmetric/ asymmetric, rate- left, right; bruit
- Jugular veins- distention- > 3-4cm
- Peripheral pulses- temporal, brachial, radial, femoral, popliteal, posterior tibial, pedal- rate, volume, rhythm
- Peripheral veins- distended veins on posterolateral part of calf; phlebitis - tenderness, warmth & redness, swelling of leg, pain in calf muscles
- Peripheral perfusion- pink colour/ cyanotic/ pallor/ dusky red/ brown pigmentation; cool/ not very warm or cool; edema
- Breasts & axillae- round, symmetric/ swelling, asymmetric; retraction or dimpling; masses, discharge; cracks, tenderness

Abdomen

- Skin- rash/ striae/ scar/ tense, glistening skin/
- Shape & size- round, flat or scaphoid/ distended/ ascites/ hernia/ dilated veins
- Distension- abdominal girth-
- Palpation- soft/ hard, tenderness, masses, hepatomegaly
- Abdominal movements- any visible peristalsis/ limited movements
- Bowel sounds- audible/ absent/ hypoactive/ hyperactive
- Bladder - distended, palpable; urine output/ bladder catheterised/ no incontinence

Musculo- skeletal

- Muscle size & strength- equal on both sides/ less than 25%; contractures; atrophy/ hypertrophy
- Muscle tone- firm/ atonicity; flaccid/ spastic
- Bones- deformities, misaligned/ tenderness/ swelling
- Joints- swelling, ROM-limited/ smooth; tenderness
- Back -scoliosis/ bedsore

Neurologic

- Consciousness- conscious/ stupor
- Orientation- time, place, person
- Memory- immediate, recent, remote
- Attention & calculation
- Reflexes- no reflex, normal/ maximal

Genitalia - lesions, pubic lice, discharge, swelling, bleeding/incontinence/ retention

Rectum & anus - haemorrhoids, constipation, diarrhoea, incontinence

Impression/Final Findings:

APPENDIX 3:
PAIN ASSESSMENT TOOLS

1. FLACC - The acronym FLACC stands for Face, Legs, Activity, Cry and Consolability.

- Each category (Face, Legs etc) is scored on a 0-2 scale, which results in a total pain score between 0 and 10.
- The person assessing the child should observe them briefly and then score each category according to the description supplied.

	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaints	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or "talking to" Distractable	Difficult to console or comfort

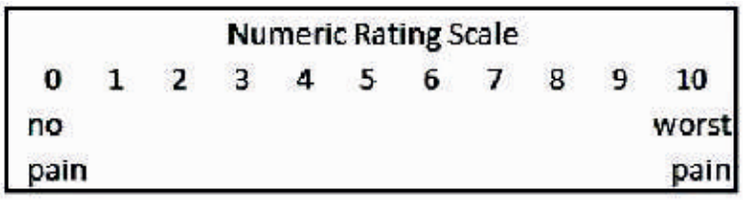
2. Wong-Baker faces pain scale

- Ask the person to choose the face that best describes how he is feeling.
- Explain to the patient that each face helps to understand how much pain they have.
- Face 0 is very happy because he doesn't hurt at all (I.e. has no pain).
- Face 2 hurts just a little bit.
- Face 4 hurts a little more.
- Face 6 hurts even more.
- Face 8 hurts a whole lot.
- Face 10 hurts as much as you can imagine.

Wong-Baker FACES Pain Rating Scale

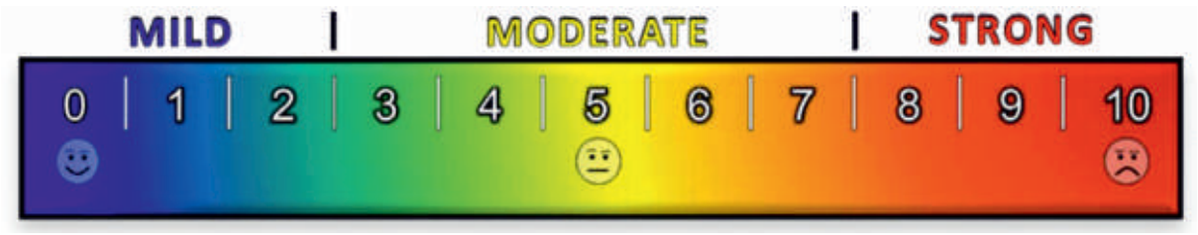
3. Visual Analogue scale

- Ask the patient to rate their experience of pain using numbers from 0 (being no pain) through to 10 (being the worst pain).



4. Color scale for pain

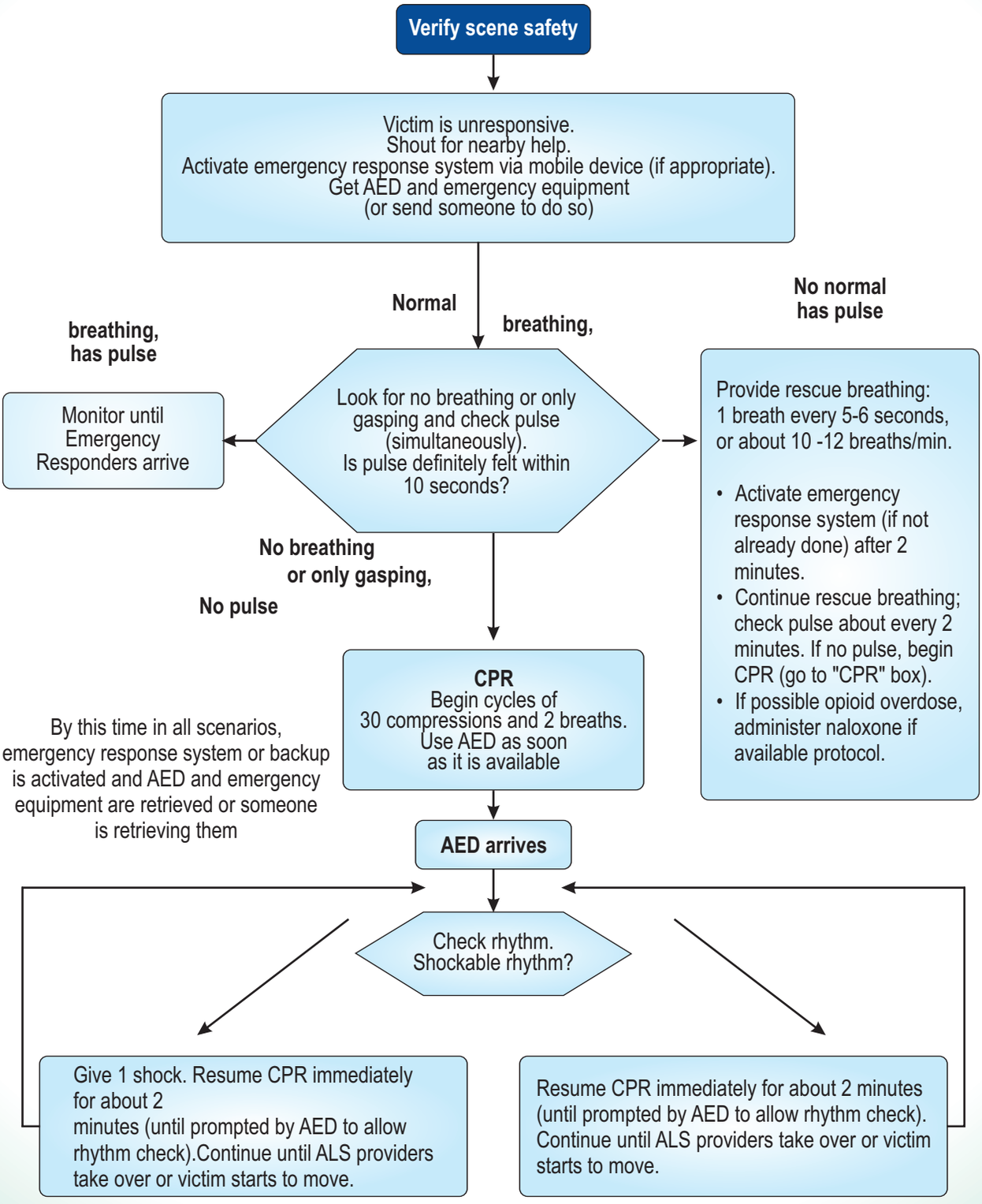
- Color pain scales are another way to help children judge their pain levels.
- But for many who are visually-inclined, colors may also represent a really powerful way to associate and understand your pain.
- For children, this scale is usually shaped like a thermometer, with darker red colors indicating more pain.



APPENDIX 4:
BIOMEDICAL WASTE CATEGORIES

Waste category no.	Waste category	Treatment and disposal
Category no.1	Human anatomical waste (human tissues, organs, body parts)	Incineration/deep burial
Category no.2	Animal waste (animal tissues, organs, body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals, colleges, discharge from hospitals, animal houses)	Incineration/deep burial
Category no.3	Microbiology & biotechnology wastes (wastes from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of cultures)	Local Autoclaving/ microwaving/incineration
Category no.4	Waste sharps (needles, syringes, scalpels, blades, glass etc. That may cause puncture and cuts. This includes both used and unused sharps)	Disinfection (chemical treatment/ autoclaving/microwaving and mutilation/shredding
Category no.5	Discarded medicines and cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines)	Incineration/destruction and drugs disposal in secured landfills
Category no.6	Waste (items contaminated with blood, and body fluids including cotton, dressings, soiled plaster casts, lines beddings, other material contaminated with blood)	Incineration autoclaving/microwaving
Category no.7	Solid waste (wastes generated from disposable items other than the waste [sharps] such as tubing's, catheters, intravenous sets etc.)	Disinfection by chemical treatment autoclaving/ microwaving and mutilation/shredding
Category no.8	Liquid waste (waste generated from laboratory and washing, cleaning, house-keeping and disinfecting activities)	Disinfection by chemical treatment and discharge into drains.
Category no.9	Incineration ash (ash from incineration of any bio-medical waste)	Disposal in municipal landfill
Category no.10	Chemical waste (chemical used in production of biological, chemicals used in disinfection, as insecticides etc.)	Chemical treatment and discharge into drains for liquids and secured landfill for solids

BLS Healthcare Provider Adult Cardiac Arrest Algorithm - 2015 Update



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RAJATA SAMVATSARA 2020-2021

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