Sabbatical Leave Report

by
Betty Ruth Farris

Vocational Nursing Department
Mount San Antonio College
1979-1980

Acknowledgement

My appreciation to the Board of Trustees, the Board of Administration, and taxpayers of the Mount San Antonio College district.

Statement: Effectiveness of Sabbatical Leave in rendering service to Mount San Antonio College District.

1. Enabled me to become more realistic in my expectation of student performance.

2. Enabled me to update my professional knowledge by work experience, classroom instruction, and working on a procedure manual.

3. Enabled me to learn of new developments and changes taking place in the Allied Health Field.

4. Enabled me, through my work experience, to reaffirm my convictions that despite the new developments and changes in nursing, the patient is still a individual and is entitled to the best nursing care that can be provided.

5. Enabled me to develop a procedure manual, which should enable the student to become proficient in performing procedures.

6. Enhanced my love for nursing and the desire to see my students become caring and competent nurses, ready for the job market.

Work Experience

The most valuable part of my sabbatical was my work experience. I worked at Inter-Community Hospital in Covina a total of 39 days. I worked all three shifts (7 - 3), (3 - 11), and (11 - 7). I worked in most areas with the exception of obstetrics and critical care areas. I did team leading and patient care.

Because of this recent work experience, I have a better understanding of what will be expected of the Licensed Vocational Nurse in the job market. This has influenced my teaching. I will be putting more emphasis on organization and valuable use of time in order to complete work assignments and still maintain principles. Stress and the work load is great for the Vocational Nurse and I do not believe they are prepared for the tremendous responsibility they are expected to assume.

Hospital work experience is also an opportunity to update new techniques and equipment. I am sure it it true for all vocational instructors that recent on the job experience is invaluable.

Education Classes

INTER-COMMUNITY HOSPITAL

DUANE A. CARLBERG
EXECUTIVE VICE PRESIDENT/DIRECTOR

303 N. THIRD AVENUE
COVINA, CALIFORNIA 91723
(213) 331-7331

September 4, 1980

To Whom It May Concern,

This is to inform you that Betty Farris did attend a class on Basic Life Support in Cardiopulmonary Resuscitation, June 11, 1980.

Philomena Kumpis, R.N.
Coordinator, Nursing Education

INTER-COMMUNITY HOSPITAL
Covina, California
DEPARTMENT OF NURSING EDUCATION

This certifies that Betty R. Farris

License No. F 124973

has completed 2 contact hrs. in DECUBITUS CARE AND DOCUMENTATION

on September 16th, 1980.

This course has been approved by the California Board of Registered Nursing

B.R.N. Provider No. 00489.

* * This certificate must be retained by the licensee for a period of four (4) years after the course concludes.

Gail Bloom, RN, B.S.N.
Director of Education

Jeanette Brown RN, E.T.
Instructor or Coordinator

Nursing Education Associates

This is to certify that

BETTY R. FARRIS

has successfully completed the Continuing Education offering

BASIC MEDICAL EMERGENCIES

License No. F-124973

Course No. 009-129-94

BRN Provider No. 00926

Contact Hours 6

Dates 09-04-1980

Marilynn L Van Slambrook

MARILYNN L. VAN SLAMBROOK, Director

1139A West San Bernardino Road

Covina, California 91722

Nursing Education Associates

This is to certify that

BETTY FARRIS

has successfully completed the Continuing Education offering

MYOCARDIAL INFARCTION: NEW METHODS OF CARE

License No. F124973 Course No. 003-129-109

BRN Provider No. 00926 Contact Hours 6

Dates 03-05 & 03-12, 1980

Marilynn L Van Slambrook

MARILYNN L. VAN SLAMBROOK, Director

Box 5532 Hacienda Heights California

DUANE A. CARLBERG
EXECUTIVE VICE PRESIDENT/DIRECTOR

INTER-COMMUNITY HOSPITAL

303 N. THIRD AVENUE
COVINA, CALIFORNIA 91723
(213) 331-7331

September 4, 1980

To Whom It May Concern,

This is to inform you that Betty Farris did attend a class in Body Mechanics at Inter-Community Hospital on June 4, 1980.

Philomena Kumpis, R.N.
Coordinator, Nursing Education

INTER-COMMUNITY HOSPITAL
Covina, California
DEPARTMENT OF NURSING EDUCATION

This certifies that Betty R. Farris

License No. F174973

has completed 2 contact hrs. in Chemotherapy

on December ~~5th~~ 13th, 1979.

This course has been approved by the California Board of Registered Nursing

B.R.N. Provider No. 00489 .

* * This certificate must be retained by the licensee for a period of four (4) years after the course concludes.

Sandra A. Fordham RN BSN
Nursing Education

Gail Olson
Instructor or Coordinator

INTER-COMMUNITY HOSPITAL
Covina, California
DEPARTMENT OF NURSING EDUCATION

This certifies that Betty Farris

License No. F 124973

has completed 2 contact hrs. in Management of I.V. Therapy

on October 18, , 1979.

This course has been approved by the California Board of Registered Nursing

B.R.N. Provider No. 00489.

* * This certificate must be retained by the licensee for a period of four (4) years after the course concludes.

Sandra A. Fordham RN, BSN
Nursing Education

Cheryl Cox R.N., BS
Instructor or Coordinator

Manual of Nursing Procedures
and
Standard Method of Evaluation

Betty R. Farris

September, 1980

PURPOSE

The purpose of this procedure manual is to provide the student with an easy to understand and easy to follow procedure. This will provide needed references, the degree of expected proficiency, and method of measurement. The student will have a record of his/her level of achievement.

On an individual basis, the student will be able to repaet the procedure until the expected degree of proficiency is reached.

The student will practice these procedures after classroom demonstration until he/she is confident that they are able to perform them in the clinical situation. The needed assistance will be provided by the instructor.

In the clinical situation, the instructor will assist and supervise the student. When the instructor is confident the student can perform the procedure, applying principle and safety to the patient, he/she will proceed without supervision.

Section I

Personal Care

Hand Washing
Making the Unoccupied Bed
Making the Occupied Bed
Bed Bath
Oral Hygiene
Back Rub
Shaving the Male Patient

Section II

Vital Signs

Taking Oral Temperature
Taking Temperature by Rectum
Taking Pulse
Taking Respiration
Taking Blood Pressure

Section III

Body Mechanics

Moving and Lifting Patients
Moving a Patient up in Bed
Range of Motion Exercises

Section IV

Treatments

Enema - Cleansing and Commercial
Harris Flush
Sitz Bath
Changing a Surgical Dressing
Wound Irrigation
Naso-gastric Tube Irrigation
Colostomy Irrigation
Clinitest and Acetest
Ear Irrigation
Eye Irrigation
Urinary Catheterization - Female
Male Urinary Catheterization
Insertion of Retention Catheter
Urinary Bladder Irrigation

Vocabulary List

acetone
ampule
antiseptic
apothecary
aspirate
blood pressure
canthus
colon
colostomy
diastolic
exudate
intradermal
intramuscular
lacrimal duct
meatus
metric
microorganisms
miter
pathogens
perineal
pulse
respiration
sterile
subcutaneous
supine
systolic
vial

Hand Washing

Purpose: Prevent reinfection of patient and guard against a different type of infection (nosocomial). Protect yourself and other employees against infection.

Equipment:

1. running water
2. soap - liquid or bar
3. paper towels
4. disposable orangewood sticks - optional
5. brush - optional
6. lotion - optional

Comment: Hand washing is required before performing any procedure, after performing any procedure, before eating, after eating, and after using the bathroom.

Procedure	Principle
1. Always keep hands lower than elbows.	Water should run from the area of least contamination (elbows).
2. Turn on water. Adjust to warm.	Water should be comfortable - hot water opens pores and irritates skin.
3. Wet hands	
4. Apply soap, getting under nails and between all fingers.	Destroy as much bacteria as possible.
5. If necessary, use brush and orangewood sticks.	
6. Using rotating and frictional motion. (Note: 20 seconds is recommended for this phase)	Loosen bacteria

Medical-Surgical Nursing

Procedure - Hand Washing

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Define a. microorganisms b. medical asepsis 2. Wash hands according to procedure as demonstrated and the procedure sheet. 3. List the required situations for hand washing.	Level A Level C	Demonstration working in clinical situation Written tests	1. Classroom demonstration 2. Procedure sheet 3. Culver, "Modern Bedside Nursing" 4. Filmstrip "Medical and Surgical Asepsis" 5. Slides "Growth of Micro-organisms"					

Instructor Comments

Making The Unoccupied Bed

Purpose: Make a bed quickly so that it will be comfortable for the patient and remain intact.

Equipment:

1. two bed sheets
2. draw sheet
3. pillow case
4. bedspread or blanket

Comment: Draw sheet and blanket will depend on specific hospital preference. Pillow cases for number of pillows being used by patient.

Procedure	Principle
1. Wash hands	
2. Collect all linen in the order that they will be used.	Save time
3. Place linen on clean surface near the bed.	Rule: Clean to clean
4. Elevate bed to a convenient height.	Protect nurse's back
5. Remove soiled linen and place in laundry bag, protecting nurse's clothes from contact with soiled linen.	Prevent spread of bacteria
6. Place sheet on bed so that one hem is even with foot of mattress and center fold is in center of bed. (Do not shake linen)	

15. Move to opposite side of bed, pull bottom sheet tight, miter corner, and tuck sheet under mattress, pulling tight.	Completing one side of bed before moving to other side saves time and energy. Keeps bed intact longer.
16. Pull draw sheet tight and tuck under mattress.	
17. Tuck top covers under foot of mattress and miter corner. Top covers hang loose at side.	
18. Fold hem of top sheet over blanket or spread.	
19. Fan fold top covers to bottom of bed if bed to be occupied.	
20. Put pillow case on pillow: a. grasp pillow with hand and while holding pillow case at closed end (to be demonstrated).	Pillow does not come in contact with nurse's clothes.
21. Place pillow on bed with open end away from door.	

Medical-Surgical Nursing

Procedure - Making the Unoccupied Bed

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Make a neat wrinkle-free bed. 2. Use proper body mechanics. 3. Use method as demonstrated to save time and energy. 4. Utilize linen as directed by individual hospital. 5. Provide and maintain comfort and protection for the patient.	Level C Level C	Written quiz Return demonstration	1. Classroom demonstration 2. Culver, "Modern Bedside Nursing" 3. Procedure sheet 4. Film cartridge "Bed Making - Mitered Corner"	Instructor Comments				

Making the Occupied Bed

Purpose: Make a bed occupied by a patient, so the bed will be comfortable and remain intact.

Equipment:

1. two bed sheets
2. draw sheet
3. pillow case
4. bed spread or blanket

Comment: Draw sheet and blanket will depend on specific hospital preference. Pillow cases for number of pillows being used by patient.

Procedure	Principle
1. Wash hands	
2. Collect all linen in the order to be used.	Save time
3. Place linen on a clean surface near the bed.	Rule: Clean to clean
4. Elevate bed to a comfortable height.	Protect nurse's back.
5. Remove top cover.	
6. Place bath blanket over patient and remove top sheet. Place dirty linen in laundry bag.	Patient will not be exposed.
7. Remove pillow (if patient is comfortable, leave it under patient's head.	

17. Have patient turn to back and place pillow, with a clean pillow case, under patient's head.

18. Place clean sheet over patient. Center sheet, then remove bath blanket from under sheet.

19. Place blanket or spread over sheet and center it.

20. Tuck both sheet and blanket under bottom of mattress, mitering both corners. Covers are to hang loose at sides of bed.

21. Fold top hem over sheet over edge of blanket.

22. Loosen top covers over toes by lifting.

23. Both side rails to be up. Lower bed and elevate head of bed if desired.

Medical-Surgical Nursing

Procedure - Making the Occupied Bed

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written test	1. Classroom demonstration					
1. Make a neat wrinkle-free occupied bed.	Level A	Demonstration	2. Culver, "Modern Bedside Nursing"					
2. Use proper body mechanics.			3. Procedure sheet					
3. Provide for safety of patient.			4. Film cartridge "Bed Making: Mitered Corner"					
4. Use method as demonstrated to save time and energy.				Instructor Comments				
5. Utilize linen as directed by individual hospital.								

Bed Bath

Purpose: Provide for cleansing of skin, refreshing of patient, provide exercise and examine condition of patient's skin.

Equipment:

1. bath towel
2. face towel
3. wash cloth
4. bath blanket
5. linen to change bed
6. basin with water at 105° - 115° F
7. soap in soap dish
8. lotion
9. powder
10. other toilet articles as desired by patient
11. laundry bag (for dirty linen)
12. gown or patient's own bed clothes
13. bed pan or urinal if needed

Procedure	Principle
1. Explain to patient what you are going to do.	Cooperation of patient.
2. Provide for privacy.	
3. Offer bed pan or urinal.	Saves time by preventing interruptions during bath.
4. Wash hands	
5. Raise bed to high position.	Nurse's comfort
6. Lower head of bed and remove pillow unless contraindicated.	Difficulty breathing or doctor's orders.

16. Place towel over chest. Pull blanket to waist, wash, rinse, and dry chest being careful not to expose patient, but examine skin. Leave towel over chest, pull blanket to pubis and wash, rinse, and dry abdomen.
    Note: If male patient wash chest and abdomen at the same time.

17. Uncover far leg, place towel under leg, wash, rinse, and dry.

18. Place towel under patient's foot, put basin of water on towel, and have patient bend knee and put foot in water. Wash and remove from water. Dry well, especially between toes.

    Easier to wash foot and feels good to patient.

19. Repeat for other leg and foot.

20. Change water.
    Note: Water is to be changed at any-time it is soapy or dirty.

21. Assist patient to turn on side. Wash, rinse, and dry back and buttocks. Give back rub. See procedure)

Medical-Surgical Nursing

Procedure - Bed Bath

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement A	B	C	D
The student will:	Level C	Written test	1. Culver, "Modern Bedside Nursing"				
1. Know the four purposes of a bed bath.	Level C	Classroom demonstration	2. Instructional demonstration				
2. Give a complete bed bath or partial bed bath as necessary for the patient who must remain in bed.	Level B	Clinical performance	3. Procedure sheet for bed bath				
3. Provide for safety of patient while giving a bed bath.	Level A Level A	a) safety of patient b) body mechanics	4. Procedure sheet for back rub				
4. Use proper body mechanics while giving a bed bath.			5. Filmstrips "Skin Care and Bathing, Part 1" "Skin Care and Bathing, Part 2"				

Instructor Comments

Oral Hygiene

Purpose: Provide clean teeth and mouth to prevent tooth decay and bad breath and maintain a healthy condition of the mouth.

Equipment:

1. tooth brush or denture brush
2. tooth paste or denture cleaner
3. emesis basin or denture cup
4. water and glass
5. face towel
6. mouth wash - optional
7. tongue depressors
8. cotton-tipped applicators
9. lubricant - water soluble (lemon juice and glycerin swabs)

Procedure	Principle
Self care or partial care	
1. Provide for privacy	
2. Elevate head of bed for the bed patient.	
3. Place hand towel under chin.	Protect bed linen.
4. Move over bed table to a convenient position across bed close to patient.	
5. Aid patient by arranging materials within easy reach.	
6. Prepare tooth brush.	

Dentures

1. Have patient remove dentures if able. Nurse may remove dentures by using a piece of gauze to remove lower plate, then the upper plate.

2. Place in basin or denture cup.

3. Use tepid water in basin to cleanse dentures. Do not clean in very hot or very cold water.

4. Brush well with denture cleaner and rinse well with tepid water.

5. Cover with tepid water and return to patient.

6. Have patient rinse mouth or cleanse mouth with cotton-tipped applicators.

7. Replace dentures in mouth or leave in water in covered denture cup.

Comment: Handle dentures carefully. They are expensive and it takes time to replace them.
Salt or sodium bicarbonate can be used to clean dentures if denture cleaner is not available.

Medical-Surgical Nursing

Procedure - Oral Hygiene

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	
The student will: 1. Provide for clean teeth and mouth. 2. Determine when patient needs oral hygiene. 3. Provide oral hygiene as a part of the morning bath.	Level C Level A	Written test Clinical performance (based on condition of patient's mouth)	1. Culver, "Modern Bedside Nursing" 2. Classroom discussion 3. Procedure sheet					
				Instructor Comments				

Back Rub

Purpose: Relax and relieve tension and stimulate the circulation. Prevent decubitus.

Equipment:
1. bath towel
2. lotion or powder

Procedure	Principle
1. Explain procedure	
2. Wash hands	
3. Provide privacy	
4. Assist patient to prone or side position.	
5. Fold covers down to expose back and buttocks.	
6. Place lotion in warm water.	
7. Place towel lengthwise on bed along side the back..	
8. Bathe back if necessary.	Back rub may be given at anytime.
9. Pour lotion in one hand and spread on both hands.	

Medical-Surgical Nursing

Procedure - Back Rub

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Know the purposes of a back rub.	Level C	Written test (included in bed bath)	1. Culver, "Modern Bedside Nursing" 2. Procedure sheet					
2. Know when a back rub is given.	Level B	Classroom demonstration						
3. Give a back rub.	Level A	Clinical demonstration						
				Instructor Comments				

Shaving the Male Patient

Purpose: Provide for clean shaven face and comfort for the male patient who cannot do this for himself.

Equipment:

1. razor (safety or electric)
2. basin with warm water
3. shaving cream or soap
4. wash cloth
5. hand towel
6. powder or after shave lotion

Procedure:

1. Place hand towel under patient's chin, over top part of chest.
2. Wet and lather patient's face.
3. Procede to shave patient, rinsing hair from razor frequently.
4. Change water.
5. Rinse face well and dry.
6. Apply lotion or powder.
7. Clean and replace equipment.

Comment: If using electric razor, place hand towel under chin. Plug in razor and procede to shave patient. Apply lotion according to patient's request.

Important: Patients on anticoagulant are never to be shaven with a safety razor.

Medical-Surgical Nursing

Procedure - Shaving the Male Patient

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	
The student will: 1. Determine the need for a patient to be shaved. 2. Make decision if patient can be shaved. 3. Shave patient with comfort to patient, according to procedure.	Level C	Clinical performance	1. Procedure sheet 2. Classroom discussion					
				Instructor Comments				

Oral Temperature

Purpose:

1. Moniter function of the body.
2. Determine body temperature.

Equipment:

1. oral thermometer of electronic thermometer.
2. soft tissue if using glass thermometer.
3. pen or pencil
4. paper or work sheet

Procedure	Principle
1. Wash hands	Prevent spread of infection
2. Explain procedure to patient	Patient cooperation
3. Wipe thermometer with soft tissue.	
4. If using electronic thermometer, assemble the kit with a disposable probe cover. Place cover on the probe.	
5. Glass thermometer: check level of mercury. Shake down mercury by holding it by distal end between thumb and forefinger. Sharply flick the wrist downward until mercury is below 35° C. (95° F).	
6. Ask patient to open mouth and place thermometer under the tongue.	

Taking Temperature by Axilla

Purpose: To determine body temperature.
To take temperature when an oral or rectal temperature cannot be taken.

Equipment:
Same material as used for an oral temperature.

Procedure:
Procedure is the same as for oral temperature, except the thermometer is placed in the axilla. Dry the axilla before putting thermometer in the axilla. After thermometer is in place, assist patient to place arm across the chest.

Medical-Surgical Nursing

Procedure - Taking Oral Temperature

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Classroom demonstration					
1. Define body temperature.	Level C	Return demonstration in classroom	2. Culver, "Modern Bedside Nursing"					
2. Know factors that affect body temperature.	Level A	Take temperature of hospital patient	3. Overhead transparencies "Body Temperature"					
3. Take an oral temperature.			4. Filmstrip "Temperature, Pulse, Respiration"	Instructor Comments				
4. Record or graph temperature								

Rectal Temperature

Purpose:

1. Determine body temperature
2. Take temperature when an oral temperature cannot be taken.
3. Monitor body temperature

Equipment:

1. rectal thermometer or rectal probe cover.
2. tissue
3. lubricant
4. pen or pencil
5. paper or work sheet

Procedure	Principle
1. Wash hands	
2. Explain procedure to patient.	
3. Wipe thermometer and shake down as described in procedure for oral temperature.	
4. Provide privacy.	
5. Assist patient to turn to side and expose buttocks.	
6. Put lubricant on tissue and lubricate thermometer. Electronic thermometer - put on rectal probe cover.	

Procedure - Taking Temperature by Rectum

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Same as 1 and 2 for oral temperature. 2. Take a rectal temperature. 3. Record or graph temperature	Same as for oral temperature	Same as for oral temperature	Same as for oral temperature					
				Instructor Comments				

Taking Pulse

Purpose:

1. Assess the rate, rhythm, and volume of pulse which may reflect a problem.
2. Assess the adequacy of the blood flow to an area (example: taking the dorsalis pedis pulse to assess blood flow to foot).

Equipment:

1. watch with second hand
2. paper and pencil

Procedure	Principle
1. Patient is to be comfortable, either sitting or reclining with part well supported	Comfort of Patient
2. Turn palm of hand down.	Easier access for nurse.
3. With tips of three fingers find radial pulse and press gently against radius.	Pulse can be felt with slight pressure against radius (Too much pressure will stop pulsation).
4. Count the number of pulsations (beats) for one minute.	One minute is necessary for patients who have circulatory problems in order to detect irregularities. (Some pulses can be taken for $\frac{1}{2}$ minute and multiply by 2.)
5. Record rate and observations (rhythm and quality).	

Medical-Surgical Nursing

Procedure - Taking Pulse

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Determine pulse rate. 2. Estimate character of pulse a. rhythm b. quality 3. Make observations as related to pulse. 4. Know why taking an accurate pulse is necessary.	Level A Level C	Return demonstration Written test	1. Culver, "Modern Bedside Nursing" 2. Demonstration 3. Prerequisite anatomy and physiology 4. Procedure sheet					
				Instructor Comments				

Taking Respiration

Purpose: To determine depth, rate, rhythm, and character.

Equipment:

1. watch with second hand
2. pen or pencil
3. paper or work sheet

Procedure:

1. Wash hands
2. Place hand against patient's chest or just observe chest movements. Inhalation and exhalation is counted as one respiration.
3. Count respiratory rate for 30 seconds if they are regular. Count for a full minute if irregular.
4. Observe for depth, rhythm, and character.

Comment: Count respiration while fingers are on the pulse, since people tend to control respiration.

Medical-Surgical Nursing

Procedure - Taking Respiration

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	
The student will:	Level C	Written test	1. Classroom lecture and demonstration					
1. Define respiration rhythm, depth, and character.	Level A	Return demonstration in classroom situation.	2. Culver, "Modern Bedside Nursing"					
2. Count respiration accurately.	Level A	Take accurate respiration on a patient	3. Procedure sheet					
				Instructor Comments				

Measuring Blood Pressure

Purpose:

1. To monitor functions of the body.
2. As a basis for assessing patient's condition or changing condition.

Equipment:

1. stethoscope
2. blood pressure cuff with sphygmomanometer (may be aneroid or mercury manometer)

Procedure	Principle
1. Wash hands	Remove microorganisms which should not be transmitted to patient.
2. Identify patient and explain procedure. Adjust explanation to patient's need and understanding.	Reassure patient
3. Assist patient to a comfortable position and expose upper arm.	Discomfort can elevate blood pressure.
4. Wrap cuff smoothly and evenly around upper arm.	Bladder of the cuff must be directly over the brachial artery to obtain an accurate reading.
5. Palpate brachial with fingertips.	Pulsation should be felt in the middle of antecubital area.
6. Put ear pieces to the stethoscope in ears. Ears pieces should be directed slightly forward (look at ear pieces before putting them in place).	This will follow the direction of the ear canal to make hearing easier.

16. Record blood pressure in designated place on chart (for example 120/72)

Comment: Do not keep cuff pumped up for a long period of time as it causes discomfort to the patient. Work rapidly in listening to blood pressure.

Medical-Surgical Nursing

Procedure - Measuring Blood Pressure

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Define - a. blood pressure b. systolic c. diastolic d. pulse pressure 2. Know factors that control blood pressure. 3. Know factors that affect blood pressure. 4. Take blood pressure accurately. 5. Chart blood pressure.	Level C Level A	Written test Return demonstration in classroom	1. Culver, "Modern Bedside Nursing" 2. Overhead transparencies - "Blood Pressure" 3. Classroom demonstration 4. Procedure sheet					

Instructor Comments

Body Mechanics

Moving and Lifting Patients

Purpose:

1. Move patient safely
2. Prevent back and other related injuries to nurse.

Equipment:

1. Wheelchair
2. gurney
3. lift sheet
4. "extra help"

Procedure	Principle
1. Inform patient what you plan to do, how you are going to do it and how he can help	Cooperation of patient. Even if unable to help, he won't resist
2. Size up job and <u>get help</u> if you need it.	Safety for patient and nurse
3. Feet should be apart	Broad base of support and better balance
4. Move close to patient to be moved	Hold load close to your center of gravity
5. Bend hips and knees. Keep back straight. "Squat"	Don't use back muscles to lift.
6. Use thigh muscles to lift	Prevent injury to back muscles
7. Synchronize moves (count 1, 2, 3, and move together)	Smooth for the patient and easy for the people lifting.

Medical-Surgical Nursing

Procedure - Body Mechanics - Moving and Lifting Patients

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Classroom lecture and demonstration					
1. List the safety factors involved in moving and lifting patients.	Level C	Return demonstration	2. Filmstrip "Lifting and Moving Patients"					
2. Demonstrate the transfer of patients to and from a gurney and to and from a wheelchair.	Level A	Clinical performance	3. Transfer activities and ambulation					
3. Demonstrate lifting and transferring a load.			4. Film cartridge "The Body Mechanics of Stooping, Lifting, and Carrying"	Instructor Comments				
			5. Culver, "Modern Bedside Nursing"					
			6. Procedure sheet					

Moving a Patient up in Bed

Purpose: To assist the patient who cannot move themselves or to give assistance to the patient who can help themselves to some degree.

Procedure	Principle
1. Explain to patient what you plan to do and how you are going to proceed.	Gain patient's assistance and cooperation.
2. Get help if necessary.	Prevent injury to patient and yourself.
3. Wash hands	
4. Lower the head of the bed to the lowest degree the patient can tolerate.	Avoid unnecessary lifting.
5. Remove pillow and place at head of bed.	Provide padding for head and move obstacle out of the way.
6. Stand at side of bed facing head of bed with a broad stance and feet pointed toward head of bed.	Avoid twisting and provide a wide base of support.
7. Knees and hips are flexed. Forearms are at the same level of the bed.	Work close to the load to be moved and use major muscles.
8. Flex the patient's knees so feet are flat on bed if possible without injuring the patient. Even with the uncooperative patient this can be of help.	Prevent nurse from moving entire weight of patient.

Medical-Surgical Nursing

Procedure - Moving a Patient up in Bed

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Assess the situation and determine the degree of assistance needed by the patient. 2. List the safety factors in moving and lifting patients. 3. Demonstrate moving a patient up in bed using one nurse and using two nurses.	Level A (safety factors)	Return demonstration	1. Lecture and demonstration 2. Film cartridge "Moving a Patient to the Head of the Bed" 3. Procedure sheet					
				Instructor Comments				

Vocabulary List for Range of Motion Exercises

flexion

extension

hyperextension

abduction

adduction

rotation

circumduction

eversion

inversion

pronation

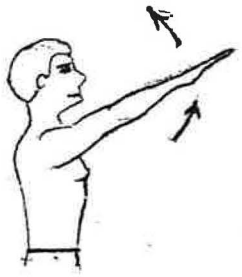
supination

protraction

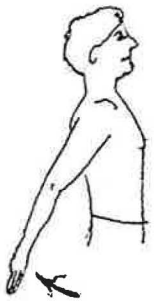
retraction

Shoulder

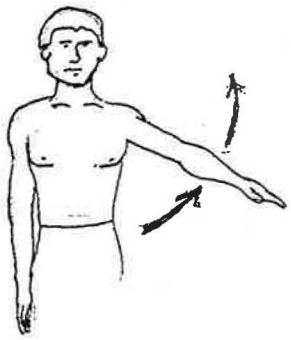
1. With palm down, raise arm forward above head to extend shoulder



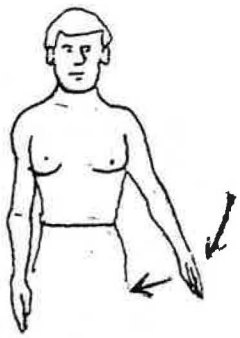
2. Hyperextend shoulder by moving arm behind the body



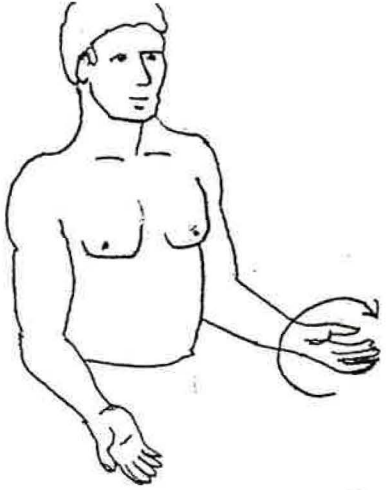
3. Abduct the shoulder by raising the arm to the side



4. Adduct the shoulder by bringing the arm in to the body

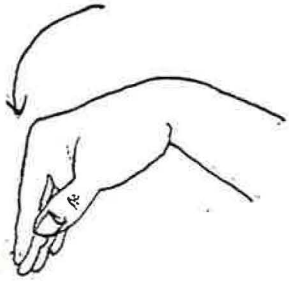


4. For supination, rotate the elbow by turning the hand so palm is facing upward

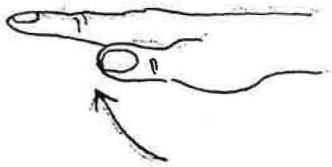


Wrist

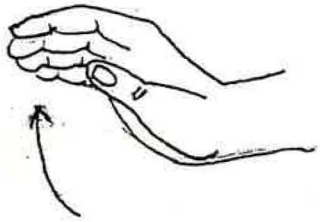
1. To flex the wrist bend the hand toward the inner aspect of the forearm



2. Extend the wrist by straightening the hand



3. To hyperextend the wrist bend the hand back as far as possible



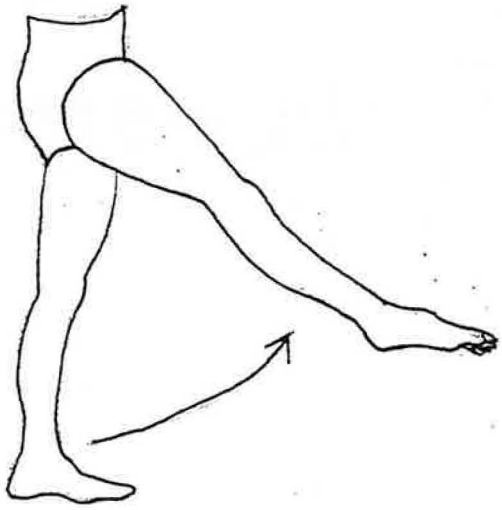
5. Adduct by bringing them together

6. Touch each finger with the thumb

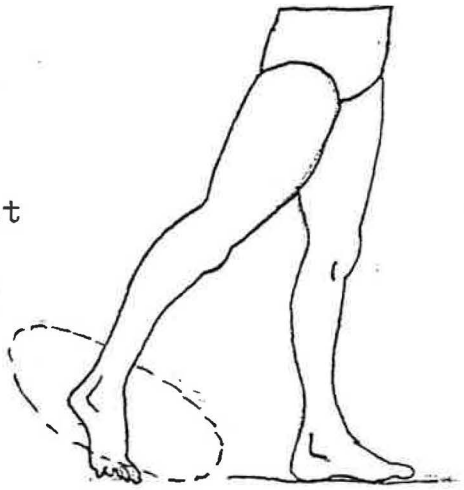
7. Move thumb in circle to rotate

Hip

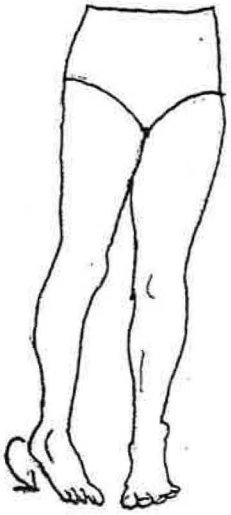
1. Move leg forward and up to flex



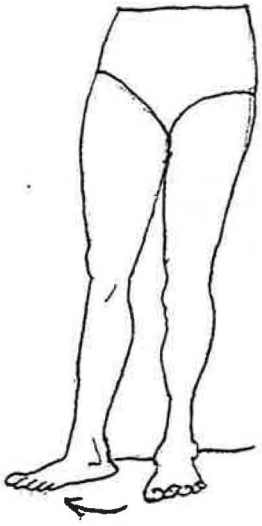
6. Move the leg in a circle to circumduct the hip



7. Rotate hip inward by turning leg and toes inward

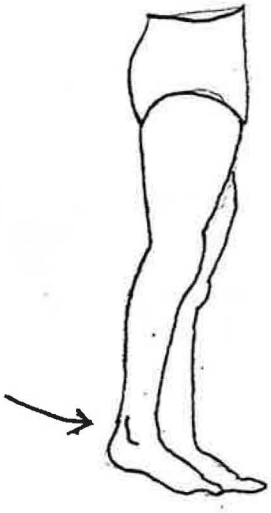


8. Rotate hip outward by turning leg and toes outward or laterally

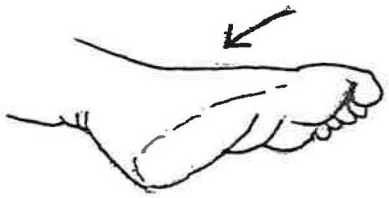


Knee

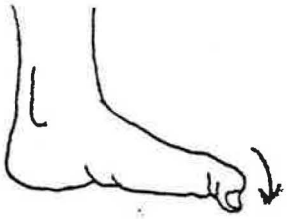
1. Straighten the knee to extend



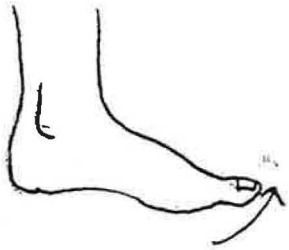
2. Turn the foot inward for inversion of the foot



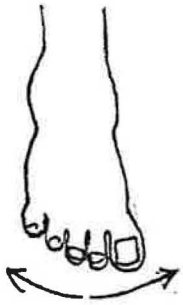
3. Bend toes down to flex



4. Straighten toes to extend



5. Spread toes to abduct



6. Bring toes together to adduct

Medical-Surgical Nursing

Procedure - Range of Motion Exercises

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	
The student will:	Level C	Written quiz	1. Lecture and classroom demonstration					
1. Define words on Vocabulary List of Range of Motion Exercises.	Level B	Demonstration	2. Procedure sheet					
2. Demonstrate all the ronge of motion exercises.			3. Culver, "Modern Bedside Nursing" a. Skeleton System b. Muscular System					
3. Have a previous knowledge of the skeleton, muscles, and joints.			4. Ciuca, Randy et. al. A handbook - "Range of Motion Exercises, Active and Passive"	Instructor Comments				

Enemas

Cleansing (soap suds, tap water) and Commercial

Purpose:

1. Remove feces
2. Remove feces and cleanse rectum for examination
3. Remove feces prior to surgery or delivery.

Equipment:

1. disposable gloves - optional
2. container for solution
3. solution as ordered
4. bath thermometer (perfered - not always available)
5. bed pan, toilet, or bedside commode
6. tubing with clamp (may be part of kit)
7. rectal tube - if not part of enema kit.
8. protective cover for bed
9. lubricant
10. tissue

#Note: Commercial enemas contain instructions.

Procedure	Principle
1. Wash hands	Protect patient from micro-organisms which might be on nurse's hands.
2. Identify patient	Insure right patient receives enema.
3. Explain procedure	Reassure patient and patient will be cooperative.
4. Provide privacy	Prevent embarrassment to patient.
5. Drape patient with bath blanket and fold top covers to bottom of bed.	Protect bed linen.

14. Clamp and remove tube when all solution has been given or if patient cannot tolerate more.	Prevent dripping over bed.
15. Encourage patient to retain solution. Length of time to hold depends of type and amount given.	Retention of solution softens feces and usually provides for better results.
16. Assist patient on bed pan or to the bathroom. Should be in sitting position.	Patient is usually uncomfortable and needs help. Aids in defecation.
17. Clean and replace or dispose of equipment.	
18. Straighten bed and assist patient to a comfortable position.	This is a tiring procedure and patient will probably want to rest.
19. Wash hands	
20. Chart the enema, type given, amount given, and how patient tolerated the procedure. Chart the color, amount, and consistency of the return.	

Comment: For the patient who, for any reason, cannot retain the solution, the enema may be given with the patient on the bed pan. The nurse will wear a glove on the hand that holds the rectal tube in place.

Medical-Surgical Nursing

Procedure - Enema - Cleansing and Commercial

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement A	B	C	D
The student will: 1. List purposes of giving an enema. 2. Identify the types of enemas. 3. List amount of solution used and temperature of solution. 4. Prepare an enema and a patient in classroom situation. 5. Administer an enema to a hospitalized patient.	Level C Level B	Written test Return demonstration	1. Culver, "Modern Bedside Nursing" 2. Filmstrip "Cleansing Enema" 3. Classroom lecture and demonstration 4. Procedure sheet				

Instructor Comments

Harris Flush

Purpose:

1. Stimulate peristalsis
2. Aid patient to eliminate flatus

Equipment:

Same as those listed for an enema.

Procedure	Principle
1. Follow steps 1 through 10 as listed for cleansing enema. Note: only 500cc of tap water is used.	
2. Raise container and allow approximately 200 - 250cc of solution to flow into intestine.	Too much solution can cause extreme discomfort when flatus is present.
3. Lower container approximately 18 inches below level of buttocks.	This allows solution and flatus to flow back into can.
4. Continue to raise and lower container, allowing solution to flow in and out until no flatus returns or 15 to 20 min.	Allowing solution to flow into intestine stimulates peristalsis and move flatus to lower portion of colon where it will be removed by lowering the can. 15 to 20 minutes is sometimes necessary to allow time for the flatus to move into lower colon.
5. Change and remove tubing.	
6. Patient may need to use bedpan or commode at this time.	Peristalsis may have been stimulated enough for the patient to feel the need to evacuate the bowels.

Medical-Surgical Nursing

Procedure - Harris Flush

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Instructor's lecture					
1. List purposes for giving a Harris flush.	Level B	Return demonstration	2. Classroom demonstration.					
2. Know amount and temperature of solution to be prepared.	Level A	Give a Harris flush to patient under supervision.	3. Procedure sheet					
3. Prepare and give a Harris flush under supervision.				Instructor Comments				
4. Chart Harris flush and results.								

Sitz Bath

Purpose:

1. cleanse anal and perineal area.
2. promote healing
3. provide relief from pain

Equipment:

1. bath tub, portable sitz, or upright sitz bath.
2. inflated plastic or rubber ring (if bath tub is used).
3. bath blanket
4. clean gown
5. 1 or 2 bath towels
6. bath thermometer, if available.

Procedure	Principle
1. Prepare sitz bath before patient is brought to area.	Patient doesn't have to stand while procedure is being prepared.
2. Put enough water, at 110° to 115°, to completely cover perineal and anal area - a. bath tub - water to umbilicus. b. in portable sitz - directions are included. c. in upright sitz - enough water to cover anal and perineal area.	Enough heated water must come in contact with involved area to cleanse and promote healing.
3. Assist patient into sitz and make comfortable.	
4. Drape so as not to expose patient.	
5. Cover with bath blanket to prevent chilling.	

Medical-Surgical Nursing

Procedure - Sitz Bath

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Know the purpose of sitz bath. 2. Have a knowledge of the types of equipment and how to use it. 3. Assist a patient in taking a sitz bath, following procedure as taught.	Level C Level C	Written quiz Give a sitz bath under supervision	1. Instructor's lecture 2. Culver, "Modern Bedside Nursing" 3. Hospital demonstration of equipment 4. Procedure sheet					
				Instructor Comments				

Changing a Surgical Dressing

Purpose:

1. Prevent infection
2. Prevent further tissue damage
3. Encourage measures that promote healing
4. Cleanse the wound
5. Provide a means of absorbing exudate
6. Prevent skin excoriation

Equipment:

1. sterile drape
2. cotton balls
3. basin
4. hemostat
5. forceps
6. scissors
7. water-proof bag
8. sterile gauze dressings to fit wound
9. cleansing solution if ordered
10. tape
11. sterile gloves - optional

#Note: All of materials may not be needed or additional materials may be needed.

Procedure	Principle
1. Wash hands	Remove microorganisms from hands.
2. Assemble materials	
3. Explain to patient what you plan to do.	Reassure patient
4. Provide privacy for patient and expose area of dressing.	
5. Place bag for old dressings nearby.	Placed so nurse does not have to reach over sterile field.

16. Wash hands. — Prevent spread of micro-organisms.

17. Chart dressing change and observations.

Comment: Type of wound, amount of drainage, and physician's order determines method and equipment used.

Medical-Surgical Nursing

Procedure - Changing a Surgical Dressing

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Classroom lecture and demonstration					
1. Know the purposes of dressing change.	Level A	Practical demonstration	2. Filmstrip "Sterile Technique and Dressing Change"					
2. List equipment necessary for a dressing change.			3. Procedure sheet					
3. Demonstrate a dressing change using equipment as necessary.				Instructor Comments				
4. Determine kinds of dressings necessary for various kinds of wounds.								

Wound Irrigation

Purpose:

1. To cleanse area
2. To apply heat
3. To apply a medication

Equipment:

1. sterile irrigation tray containing
   a. irrigating syringe
   b. water-proof drape
   c. sterile container for irrigating solution
2. dressing tray
3. sterile straight catheter
4. sterile gloves
5. sterile basin
6. plastic bag - for soiled dressings

Procedure	Principle
1. Explain to patient what you are going to do. Explanation should be so patient can understand.	To reassure patient To identify patient
2. Adjust patient to a comfortable position, so that solution will flow into basin below the wound.	Solution should flow from upper part of wound to lower part.
3. Adjust bed linen to expose wound and drape patient as necessary.	Provide privacy and not overexpose patient.
4. Wash hands and put on sterile gloves.	Prevent spread of micro-organisms.
5. Remove dressing and discard in plastic bag.	To avoid odor, dressings should be disposed of properly and prevent the spread of infection.

Medical-Surgical Nursing

Procedure - Wound Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Procedure sheet					
1. List purposes of a wound irrigation.	Level C	Answer oral questions and perform a wound irrigation.	2. Film strip "Sterile Technique and Dressing Change"					
2. Set up and prepare for a wound irrigation in the laboratory.			3. Classroom lecture and discussion					
3. Do a wound irrigation using appropriate technique to protect the patient and self.				Instructor Comments				

Naso-gastric Tube Irrigation

Purpose: Provide proper drainage of gastric contents when the naso-gastric tube is in place.

Equipment:

Tray containing:

1. irrigation syringe (usually 50 cc syringe)
2. container for solution
3. sterile solution - (usually normal saline, unless otherwise ordered)
4. collecting basin
5. protective drape
6. clamp or catheter plug
7. alcohol swabs

Procedure	Principle
1. Wash hands	Prevent spread of micro-organisms
2. Assemble equipment	
3. Explain procedure to patient	Obtain cooperation of patient
4. Place protective drape over patient and bed linen (under tubing)	Protect bed and patient from any drainage
5. Gastric suction may be turned off or left on	If turned off, be sure it is turned on after procedure
6. Disconnect naso-gastric tube from drainage tubing	
7. Check postion of tube by inserting end of naso-gastric tube in a glass of water.	Bubbles will appear in the water if tube is in the lung.

Medical-Surgical Nursing

Procedure _ Naso-gastric Tube Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement A	B	C	D	F
The student will:	Level C	Written quiz	1. Lecture and discussion					
1. List the safety precautions to be used when irrigating a naso-gastric tube.	Level C	Return demonstration	2. Classroom demonstration					
2. Assemble equipment	Level A	Clinical performance	3. Filmstrip "Instruction and Care of Gastric Tube"					
3. Irrigate the naso-gastric tube with the proper amount and type of solution.			4. Film cartridge "Irrigation - Levine Tube"	Instructor Comments				
			5. Procedure sheet					

Colostomy Irrigation

Purpose:

1. To empty the colon of feces, gas, and mucus.
2. Establish a regular pattern of evacuation (stimulate peristalsis).
3. Prevent intestinal obstruction

Equipment:

1. irrigating can
2. irrigating fluid - as ordered or tap water, amount as ordered or hospital policy.
3. tubing with clamp
4. rectal tube
5. irrigating bag with belt or self-adhesive
6. bag for soiled dressings or materials
7. lubricant
8. tissue
9. drape to protect bed, bedside commode, or commode in bathroom

Comment: Patients are usually given a complete kit with all necessary equipment and instructions. Kits may vary, but all contain necessary equipment. i.e. Hollister

Procedure	Principle
1. Check doctor's orders	
2. Check or order equipment	Become familiar with equipment
3. Select a time suitable to patient's life style	Irrigating at same time establishes regularity
4. Wash hands	
5. If first irrigation, explain procedure to patient.	
6. Provide privacy for patient	

16. Allow fecal material to flow through sheath into toilet or bed pan.	Allow sufficient time in privacy - 15 to 20 minutes is usually required.
17. Remove sheath	
18. Wash and dry area around stoma	Fecal material is very irritating to the skin.
19. Apply sealable type bag to allow patient to move about.	Prevent leakage
20. Clean equipment with soap and water. Dry well and replace.	Control odor and prolong life of equipment.
21. Record treatment, amount of solution, return and how tolerated.	

Medical-Surgical Nursing

Procedure - Colostomy Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Know purpose for irrigating a colostomy. 2. Be familiar with colostomy equipment. 3. Be familiar with anatomy of the intestine. 4. Instruct the patient in irrigating the colostomy while performing the procedure.	Level C Level B	Written quiz Set-up and performance in clinical situation	1. Trainex filmstrip "Colostomy Irrigation" 2. Culver, "Modern Bedside Nursing" 3. Handout sheets "Colostomy Care" 4. Diagrams of colostomy 5. Model with colostomy 6. Procedure sheet	Instructor Comments				

Clinitest and Acetest

Purpose: To determine sugar and acetone in the urine.

Equipment:

1. clinitest tablets
2. acetone tablets
3. test tube
4. medicine dropper
5. container for urine
6. paper towel

Procedure	Principle
1. Have patient void and discard. Use second voided specimen.	Second specimen reflects a more accurate status of glucose spillover into the urine.
2. Place five drops of urine in the test tube.	
3. Rinse dropper and add ten drops of water in the test tube.	
4. Add one clinitest tablet (being careful not to touch tablet with fingers)	Substances on fingers may cause a chemical reaction and give an inaccurate reading.
5. Watch while reaction takes place. Do not shake test tube.	
6. Wait 15 seconds after boiling inside tube has stopped.	

Medical-Surgical Nursing

Procedure - Clinitest and Acetest

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Instructions issued with testing kits					
1. List the various diabetic urine tests.	Level A	Classroom demonstration	2. Procedure sheet					
2. Know why sugar and acetone appear in the urine.	Level A	Clinical performance						
3. Check urine for sugar and acetone using clinitest and acetest.								
4. Read results accurately				Instructor Comments				

Ear Irrigation

Purpose:

1. Cleansing
2. Application of antiseptic solution
3. Removal of ear wax

Equipment:

1. sterile container for irrigating solution
2. sterile irrigating syringe
3. basin
4. water-proof drape
5. cotton-tipped applicators
6. cotton balls

Procedure	Principle
1. Explain procedure to patient	
2. Assist patient to a comfortable position, with head turned to the affected side.	Solution will flow from the ear canal.
3. Wash hands	
4. Place water-proof drape over the shoulder under the patient's ear.	Protect patient from solution.
5. Place basin under ear to be irrigated.	
6. Clean around the opening to the ear canal with cotton-tipped applicator.	Eliminate possibility of washing any discharge into the ear canal.

Medical-Surgical Nursing

Procedure - Ear Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written quiz	1. Procedure sheet					
1. List purposes for an ear irrigation	Level C	Oral quiz	2. Lecture and discussion					
2. Know the anatomy of the ear.	Level C	Return demonstration	3. Demonstration					
3. Prepare patient for an ear irrigation								
				Instructor Comments				

Eye Irrigation

Purpose:

1. Treat an infection
2. Apply antiseptic soltuion
3. Remove a foreign object
4. Remove an irritating chemical

Equipment:

1. sterile container for irrigating solution
2. solution as ordered at 100° F.
3. sterile eye syringe
4. sterile cotton balls
5. water-proof drape
6. sterile basin

Procedure	Principle
1. Explain procedure to patient	Reassure patient
2. Assist the patient to a comfortable position either sitting or lying. The head must be tilted toward the effected side.	Solution must run away from the other eye.
3. Wash hands	
4. Place drape over patient and bed	Keep linen dry
5. Place basin under the eye and against the patient's cheek	
6. Wipe eyelid and lashes with cotton ball wet with irrigating solution.	Avoid washing exudate into the eye.
7. Wipe from the inner canthus to the outer canthus.	Wipe away from lacrimal duct

Medical-Surgical Nursing

Procedure - Eye Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. List the purposes of an eye irrigation. 2. List safety precautions necessary when doing an eye irrigation.	Level C	Written quiz	1. Procedure sheet 2. Lecture and discussion 3. Classroom demonstration 4. Filmstrip "Care of Patient with Eye Disorders"	Instructor Comments				

Urinary Catheterization (Female)

Purpose:

1. Obtain a sterile specimen
2. Measure residual urine
3. Empty bladder prior to surgery
4. Prevent bladder distention post operatively
5. Manage incontinency

Equipment:

Tray with following equipment:

1. sterile gloves
2. drape
3. fenestrated drape (optional)
4. antiseptic
5. cotton balls
6. forceps
7. lubricant
8. catheter (use one on tray unless a specific size has been ordered)
9. basin or tray containing equipment to be used as a collecting container
10. receptacle for used materials
11. specimen container if needed

Comment: Equipment varies from hospital to hospital. Prepared trays may contain many or all the equipment needed. Equipment will be listed on wrapper.

Procedure	Principle
1. Check order	
2. Assemble equipment	
3. Explain procedure to patient	Patient should understand and will cooperate.
4. Screen patient	Provide privacy

the urinary meatus with one downward stroke. (Discard each cotton ball after use, being sure not to allow it to contaminate the sterile equipment)	
15. Pick up the catheter with the sterile gloved hand and hold it approximately 2 inches from the tip. The opposite end is in the collection receptacle.	The female urinary meatus is approximately 2 inches long. The urine will run into collection receptacle.
16. Insert the catheter into the meatus. If resistance is met, do not force. Ask patient to take a deep breath. If resistance is not relieved discontinue and report.	Deep breathing may aid in relaxation and make insertion easier.
17. While urine flows, hand holding the labia may be transferred to the catheter.	Portion of catheter outside the urinary meatus does not remain sterile.
18. Collect a urine specimen if required after the urine has flowed for a few seconds. Pinch the catheter and transfer to sterile specimen container. (Do not contaminate)	
19. Remove catheter when urine has stopped flowing or 1000ml has been removed.	Urine should be removed slowly. Removing large amounts of urine too quickly can cause engorgement of pelvis, blood vessels and cause shock.

Medical-Surgical Nursing

Procedure - Urinary Catheterization - Female

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written test	1. Trainex Filmstrip "Female Catheterization"					
1. List the purpose for doing a catheterization.	Level A	Return demonstration	2. Film on male catheterization					
2. List equipment used in the procedure.	Level A	Clinical performance	3. Culver, "Modern Bedside Nursing"					
3. Properly prepare patient for procedure.	Level A	Sterility	4. Procedure sheet	Instructor Comments				
4. Return demonstration of catheterization without contaminating.			5. Classroom demonstration					
5. Make appropriate observations while doing catheterization.								
6. Correctly chart catheterization and observation.								

Male Urinary Catheterization

Purpose: Same as for female urinary catheterization.

Equipment:
Same as for female urinary catheterization.

Procedure	Principle
1. Follow steps 1 through 6 as described in female catheterization.	
7. Flex knees and slightly abduct legs.	
8. Follow steps 9 through 11 in female catheterization.	
12. Place a sterile drape under the penis and the fenestrated drape over the penis.	Provide a sterile field.
13. To cleanse the meatus, grasp the penis behind the glans and the urinary meatus, spread between the thumb and forefinger. For the uncircumcised males, the foreskin is retracted. Cleanse the tissues around the meatus, holding cotton balls with forceps, in circular motion and the meatus last. Discard cotton ball after only one wipe.	Use firm pressure, rather than light pressure to avoid an erection.

Procedure - Male Urinary Catheterization

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
Same as for female catheterization	Same as for female catheterization	Same as for female catheterization	Same as for female catheterization 1. Filmstrip "Male Regular Catheterization, Bladder Instillation, and the Clean Voided or Midstream Catch"					
				Instructor Comments				

Insertion of Retention Catheter

Purpose: See purposes listed for female catheterization.

Equipment:

Equipment is same for straight catheterization except for catheter. A Foley catheter is used. (This is a double lumen tube with an inflatable ballon on the tip).

Procedure:

Same as for straight catheterization. The only variation is the ballon must be inflated in order to hold Foley catheter in the bladder. The method of inflation depends on the Foley catheterization tray. With some catheters a 5cc syringe with 5cc of sterile water will be necessary to fill the ballon. Other catheters will have the water in the distal end of the catheter with a clamp. The clamp is to be removed after insertion and the water forced into the ballon.

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Procedure - Insertion of Retention (Foley) Catheter

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
Same as female catheterization	Same as female catheteriza-tion	Same as female catheteriza-tion	Same as female catheterization					
				Instructor Comments				

Urinary Bladder Irrigation

Purpose:

1. Wash out the bladder
2. Place a drug or antiseptic solution into the bladder.

Equipment:

1. sterile irrigation tray containing:
   a. piston syringe (50cc)
   b. sterile drape
   c. container for sterile solution
   d. tray or container, which holds sterile equipment, for collecting irrigant.
2. Catheterization tray containing:
   a. Foley catheter, if Foley catheter is not already in place.
3. bath blanket
4. sterile solution as ordered at room temperature

Procedure	Principle
1. Explain procedure to patient	Relieve patient's anxiety
2. Wash hands and assemble equipment	
3. Drape patient	
4. If catheter is not in place, insert a catheter according to procedure.	
5. If catheter is in place, disconnect from drainage tube and place ends in a sterile basin, except in instances when a three-way catheter has been used.	Keep ends free of pathogens

15. Measure solution

16. Discard equipment or return to central supply.

Since this is a sterile procedure, equipment cannot be used a second time unless it has been sterilized.

17. Record procedure and describe return.

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Procedure - Urinary Bladder Irrigation

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written test	1. Culver, "Modern Bedside Nursing"					
1. List purposes of bladder irrigation	Level A	Return demonstration - sterile technique	2. Trainex filmstrip					
2. Define sterile			3. Classroom demonstration					
3. Return demonstration using sterile technique.	Level A	Performance in clinical situation	4. Procedure sheet					
4. Chart the procedure				Instructor Comments				

Administration of Medications

Purpose: Safetly administer medications to patients as ordered by physician.

Equipment:

1. Physician's orders
2. cardex
3. medication container
4. medication
5. medication cups

Procedure	Principle
1. Check medication card or cardex with physician's orders. (Hospital policy varies as to necessity of checking cardex with physician's orders)	
Things to be checked:	"6 Rights"
a. patient's name	1. Right patient
b. name of medication	2. Right medication
3. dosage	3. Right dose
4. time of administration	4. Right time
5. route of administration	5. Right route
6. method of preparation	6. Right method
2. Know each medication to be given.	Observations must be made of patient's reaction to medications.
3. Assemble all necessary equipment.	Save time
4. If necessary, compute dosages and if in doubt have computation checked.	Errors in dosage places patient's safety in jeopardy.
5. Wash hands	Reduce spread of micro-organisms

11. Administer medication to patient using right route. Assist patient as necessary.	
12. Clean or dispose of all used equipment appropriately.	Reduces spread of micro-organisms. Know hospital policy for disposing of used equipment.
13. Leave medication cart or medicine room clean and in order.	Conserves time.
14. Record medication in appropriate place on chart. Record other necessary information.	Aid physician in treating patient.

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Procedure - Administration of Medications

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Know drugs administered a. classification b. usual dosage c. action d. toxic or side effects e. methods of administration 2. Figure dosage accurately when required. 3. Know equivalents of the metric and apothecary systems. 4. Know channels for administering drugs. 5. Know "6 Rights" in administering medications.	Level C Level A	Written test and return demonstration Administer medications in clinical situation	1. Classroom demonstration and discussion. 2. Culver, "Modern Bedside Nursing" 3. Filmstrip "Administration of Medication - General Consideration" 4. Filmstrip "Administration of Medications - Routes, Procedures and Techniques" 5. Squire, "Basic Pharmacology"	Instructor Comments				

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Procedure Administration of Medications

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
6. Know laws governing the responsibility of administering medications.			6. Procedure sheet					
				Instructor Comments				

Intradermal Injection

Purpose: Method of injecting medications between upper layers of skin. Usually used for diagnostic purposes.

Equipmant:

1. Physician's order on cardex or medicine card.
2. tray if used
3. medication in ampule or vial
4. sterile disposable syringe
5. sterile needle - 1 to 1½ inch, 24 - 26 gauge.
6. alcohol sponges - 2

Procedure	Principle
1. Check physician's orders. Procedure for checking is same as for administering any medication.	"6 Rights"
3. Know each medication	Observation of patient
4. Assemble all equipment	Save time
5. Compute dose if necessary	Safety of patient
6. Wash hands	Reduce spread of micro-organisms
7. Check medication three times	
8. If using ampule, clean with alcohol sponge and break off top keeping the alcohol sponge in place.	Prevent contamination and protect nurse's fingers from injury.

18. Remove equipment. Dispose of equipment properly.

19. Chart in appropriate place.

Chart how given and site given.

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Procedure - Intradermal Injection

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written and practical quiz	1. Classroom demonstration and discussion.					
1. Student performance goals same as for "Administration of Medications" numbers 1 through 6.	Level A	Prepare and administer an intradermal injection in a clinical situation using sterile technique.	2. Culver, "Modern Bedside Nursing"					
7. Know sites used for intradermal injections.			3. Squire, "Basic Pharmacology"					
8. Prepare an intradermal injection from a vial and an ampule using sterile technique.			4. Injection equipment available for practice.	Instructor Comments				
9. Administer an intradermal injection			5. Filmstrip "Intradermal Injection Technique"					
10. Chart accurate information			6. Procedure sheet					

Intramuscular Injection

Purpose: To give a medication when it cannot be given by mouth, subcutaneous injection, or a more rapid absorption is desired.

Equipment:
Same as required for intradermal injection. Needle size is 19 - 23 gauge and length is 1½ to 2 inch.

Procedure	Principle
1. Follow steps 1 through 13 for "Intradermal Injection"	
14. Select site to be used: a. dorsogluteal b. ventrogluteal c. vastus lateralis d. deltoid - (seldom used)	Avoid major blood vessels and nerves, especially the sciatic nerve.
15. Inject needle at a 90° angle.	Assure needle enters muscle - not subcutaneous tissue.
16. Aspirate before injecting medication.	Avoid injecting medication into blood stream.
17. Inject medication slowly	Allow time for medication to be absorbed.
18. Withdraw needle and massage.	
19. Remove and dispose of equipment properly.	
20. Chart in appropriate place	Chart time, how given, and site.

Medical-Surgical Nursing

Procedure - Intramuscular Injection

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written and practical quiz	1. Instructional material same as for "Intradermal Injection" numbers 1 through 4.					
1. Student performance goals same as for "Administration of Medications" numbers 1 through 6.	Level A	Prepare and administer an intramuscular injection in a clinical situation using sterile technique.	5. Filmstrip "Intramuscular Injection Technique"					
7. Know sites to be used for intramuscular injection.			6. Procedure sheet					
8. Prepare an intramuscular injection from an ampule and vial using sterile technique.				Instructor Comments				
9. Administer an intramuscular injection.								
10. Chart accurate information								

Subcutaneous Injection

Purpose: Method of giving a medication when it cannot be taken orally and when a more rapid and complete absorption is desired.

Equipment:
Same as required for intradermal injection.
to 1 inch needle is used.

Procedure	Principle
1. Follow steps 1 through 13 for "Intradermal Injection"	
14. Select site most commonly used - outer aspect of upper arm, anterior thigh, and abdomen.	Sites should be alternated.
15. Inject needle at a 45° angle.	
16. Aspirate before injecting medication.	Avoid injecting medication into blood stream.
17. Inject medication slowly.	Allow time for medication to be absorbed.
18. Withdraw needle and massage area.	
19. Remove and dispose of equipment properly.	
20. Chart in appropriate place.	Chart time, how given and site.

Medical-Surgical Nursing

Procedure - Subcutaneous Injection

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will:	Level C	Written and practical quiz	1. Instructional materials same as "Intradermal Injection" numbers 1 through 4.					
1. Student performance goals same as for "Administration of Medications" numbers 1 through 6.	Level A	Prepare and administer a subcutaneous injection in a clinical situation using sterile technique.	5. Filmstrip "Subcutaneous Injection Technique"					
7. Know sites to be used for subcutaneous injection.			6. Procedure sheet	Instructor Comments				
8. Prepare a subcutaneous injection from an ampule and a vial using sterile technique.								
9. Administer a subcutaneous injection.								
10. Chart accurate information								

Neurological Assessment

Purpose: To determine impending cerebral disaster usually due to increased intracranial pressure. A sudden increase may produce an emergency situation very rapidly which can result in death or the patient living a vegetable existance.

Equipment:

1. watch with second hand
2. stethoscope
3. sphygmomanometer
4. thermometer
5. flashlight

Procedure	Principle
1. Assemble equipment	Time saving
2. Inform patient what you intend to do. Inform patient even though he/she does not respond.	Patient cooperation Many times patients hear even though they are unable to respond.
3. Determine the level of consciousness by: a) how readily and correctly patient answers questions. b) how patient responds to simple command.	Increased intracranial pressure can cause damage to the motor and sensory nerve pathways, if symptoms go undetected.
4. Take vital signs: a) blood pressure b) temperature c) pulse d) respiration	Pressure on the cerebral blood vessels can interfere with vital functions by interferring with blood flow.

Medical-Surgical Nursing

Procedure - Neurological Assessment

Student Performance Goals	Expected Degree of Achievement	How Measured	References and Instructional Materials	Student Achievement				
				A	B	C	D	F
The student will: 1. Know the four areas to be assessed for the neurological assessment. 2. Know why these areas are assessed. 3. Chart the finding accurately.	Level C Level B	Written quiz Student demonstration	1. Keane, "Essentials of Medical - Surgical Nursing" 2. Lecture and demonstration 3. Procedure sheet 4. Film cartridge "Care of the Patient with Head Injury"	Instructor Comments				