Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

Skill Checklists Manual for Nursing Students


Academic Year 2023-2024

Introduction

Nurses are very important members of the healthcare world. In addition to their education requirements and training, clinical skills lie at the heart of nurses' professional practice. It is considered an incalculable part of the students' whole clinical learning experience. It is vital that student nurses are well-rounded individuals with the highest level of proficiency in skills to give the quality and safe care to patients entrusted to them.

Clinical competency is an important challenge for each nursing students to facilitate the mastery of nursing skills, this manual will provide skill checklists for each skill included in fundamentals, medical surgical, pediatric, maternal, critical care nursing, and Emergency care Nursing. Students can use the Skill Checklists Manual to facilitate self -evaluation, and faculty will find them useful in measuring and recording students' performance. These checklists can easily reproduce and brought to simulation laboratory or clinical area.

The Clinical Training Committee

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Prepared by:

CLINICAL TRAINING COMMITTEE

January 2024

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
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FUNDAMENTAL I

NURSING

SKILL

CHECKLISTS

PERFORMING HAND HYGIENE (HANDWASHING)

Name of Student: _____ **Section: _____**
Student ID: _____ **Date: _____**

Purpose: The hands will be free of visible soiling and transient microorganisms will be eliminated

Indications: The World Health Organization (**WHO)** has identified the "My 5 Moments for Hand Hygiene" approach to define the key moments when health care workers should perform hand hygiene. These include:

- Before touching a patient
- Before a clean or aseptic procedure
- After body fluid exposure risk
- After touching a patient
- After touching patient surroundings

Equipment:

- Handwashing Sink
- Antimicrobial or no antimicrobial soap (if in bar form, soap must be placed on a soap rack)
- Paper towels
- Oil-free lotion (optional)

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for handwashing**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory ***satisfactory*** demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The hands will be free of visible soiling and transient microorganisms will be eliminated.	*3*	*2*	*1*	*0*	*Remarks*
1	Gather necessary supplies. Stand in front of the sink. Do not allow your clothing to touch the sink during the washing procedure.					
2	Roll up sleeves; remove jewelry and watch.					
3	Turn on water and adjust the force. Regulate the temperature until water is warm.					
4	Wet hands and wrist area. Keep hands lower than elbows to allow water to flow toward fingertips.					
5	Use 3-5 ml liquid soap and lather thoroughly. Cover all areas of your hands with lather. If using bar soap, rinse soap bar again and return to soap rack without touching the rack.					
6	With firm rubbing and circular motions, wash palms and backs of hands, each finger, the areas between the fingers, and the knuckles, wrists, and forearms.					
7	Continue this friction motion for at least 20 seconds.					
8	Use fingernails of opposite hand or a clean orangewood stick to clean under fingernails.					
9	Rinse thoroughly with water flowing toward fingertips.					

10	Pat hands dry with paper towel, beginning with fingers and moving upward toward forearms, and discard it immediately. Use another clean towel to turn off the faucet. Discard towel immediately without touching other clean hand.					
11	Use oil-free lotion on hands, if desired.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

DONNING AND DOFFING (REMOVAL) OF PERSONAL PROTECTIVE EQUIPMENT (PPE's)

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: The transmission of microorganism is prevented

Indications: Reducing the spread of microorganism (disease), minimizing complications, and reducing adverse outcomes for their patients. Indications for the following:

- Protecting the health workers to ensure continuous health services
- Must be worn in dealing a patient with contact precautions either direct or indirect contact
- Handling of any human-related specimens like blood, urine, stool, and saliva

Equipment:
Gown Goggles/Face shield
Gloves Mask/Respirator

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in *Donning and Doffing of PPE*. Indicate your evaluation by
Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	STANDARD PRECAUTIONS	***3***	***2***	***1***	***0***	***Remarks***
1.	Wash hands between client contacts; after contact with blood, body fluids, secretions or excretions, non-intact skin, or mucous membranes; after contact with equipment or contaminated articles; and immediately after removing gloves.					
2.	Wear gloves when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items; remove gloves and wash hands between client care contacts.					
3.	Wear masks, eye protection, or face shields if client care activities may generate splashes or sprays of blood or body fluid.					
4.	Wear gowns if soiling of clothing is likely from blood or body fluid; wash hands after removing a gown.					
5.	Clean and reprocess client care equipment properly and discard single-use items.					
6.	Place contaminated linen in leak-proof bags and handle to prevent skin and mucous membrane exposure.					

7.	Use needleless devices or special needle safety devices whenever possible to reduce the risk of needle sticks and sharps injuries to health care workers.					
8.	Discard all sharp instruments and needles in a puncture -resistant container; dispose of needles uncapped or use a mechanical device for recapping the needle, if necessary and available.					
9.	Clean spills of blood or body fluids with a solution of bleach and water (diluted 1:10) or agency-approved disinfectant.					
	Donning of Personal Protective Equipment (PPE's)					
10.	Review patient's file and identify the appropriate type of infection control precaution.					
11.	Gather needed PPEs. Select appropriate type and size of: Gloves, Gown, Face Mask, Face shield or eye goggles					
12.	Do hand hygiene.					
13.	Pick up gown by shoulders; allow to fall open without touching any contaminated surface.					
14.	Slip arms into the sleeves; fasten/tie at the neck and then waist properly.					
15.	Pick up mask with the top ties or ear loops.					
16.	Identifies the filter and the top edge of the mask by locating the thin metal strip.					
17.	Place metal strip over bridge of nose and ties upper ties or slips loops around ears.					
18.	Place lower edges of mask below chin and ties lower ties.					
19.	Press metal strip so it conforms to the bridge of the nose.					
20.	Don face shield by placing shield over eyes, adjusting metal strip over bridge of nose, and tucking the lower edge below the chin. Secures straps behind head.					
21.	Don safety glasses or goggles by setting them over the top edge of the face mask.					
22.	Don on gloves.					
23.	Make sure that the gloves cuff extends over the cuff of the gown.					
24	Grasp the outside of the glove at the wrist with the other hand and pull to remove it.					
25	Ball the glove up in the fist of the gloved hand.					
26	Grasp the remaining glove inside the wrist, and slowly pull it downwards to remove					
27	Dispose of the gloves in a proper receptacle.					
28	Remove the goggles and place them in an area to be decontaminated					
29	Untie the gown from the waist then neck					
30	Remove the gown by pulling it off from the neckline, so that the sleeves end up turned inside out.					
31	Ball the gown and place it into an appropriate receptacle					
32	Remove the face mask and place it into the correct trash container.					

33	Carefully wash your hands including wrists					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: _____

Student Signature: _____ Clinical Instructor Signature: _____

COMPLETE BED BATH

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: the patient will be clean and fresh

Indications: For patients who require total or partial assistance with bathing in bed due to physical limitations such as fatigue or limited range of motion.

Equipment:

- Wash basin and warm water
- Towels (2)
- Washcloths (2)
- Bath blanket
- Gown, pajamas, or appropriate clothing
- Bedpan or urinal
- Laundry bag
- Personal hygiene supplies (deodorant, lotion, and others)
- Skin-cleaning agent
- Emollient and skin barrier
- Nonsterile gloves; other PP

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for a complete bed bath**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The patient will be clean and fresh.	*3*	*2*	*1*	*0*	*Remarks*
1	Review the patient's health record for any limitations in physical activity.					
2	Perform hand hygiene, put on gloves and/or PPE, if indicated.					
3	Identify the patient. Discuss the procedure and assess patient's ability to assist in the process, and personal hygiene preferences.					
4	Gather equipment on overbed table.					
5	Close curtains, door if possible. Adjust room temperature, if necessary.					
6	Adjust bed to comfortable working height; usually elbow height of caregiver.					
7	Put on gloves. Offer bedpan or urinal.					

8	Remove gloves, perform hand hygiene.					
9	Put on clean pair of gloves. Lower the side rail nearest you and assist patient to side of bed where you will work. Have patient lie on his /her back.					
10	Loosen top covers and remove all except top sheet. Place bath blanket over patient and remove top sheet while patient holds bath blanket in place.					
11	Remove patient's gown and keep bath blanket in place.					
12	Raise side rails. Fill basin with enough amount of warm water. Add skin cleanser. Change, as necessary, throughout the bath. Lower side rail nearest you when you return to the bedside to begin the bath.					
13	Put on gloves. Lay a towel across patient's chest and on top of bath blanket.					
14	With washcloth (no cleanser added), wipe one eye from inner part of eye, near the nose, to outer part. Rinse or turn the cloth before washing the other eye.					
15	Bathe patient's face, neck and ears. Apply emollient.					
16	Expose patient's far arm and place towel lengthwise under it. Using firm strokes, wash hand, arm, and axilla. Rinse and dry. Apply emollient. Cover the area with bath blanket.					
17	Repeat Action 16 for the arm nearest you.					
18	Spread towel across patient's chest. Lower bath blanket to patient's umbilical area. Wash, rinse, and dry chest. Keep chest covered with towel between wash and rinse. Pay special attention to folds of sin under breasts. Apply emollient.					
19	Lower bath blanket to perineal area. Place towel over patient's chest.					
20	Wash, rinse, and dry abdomen. Clean umbilical area, abdominal folds or creases. Apply emollient.					
21	Return bath blanket to original position and expose far leg. Place towel under far leg. Using firm strokes, wash, rinse, and dry leg from ankle to knee and knee to groin. Apply emollient.					
22	Wash, rinse, and dry the foot and areas between toes. Apply emollient.					
23	Repeat actions 21 and 22 for the other leg and foot.					
24	Make sure patient is covered with bath blanket. Change water and washcloth at this point.					
25	Assist patient to a prone or side-lying position. Put on gloves (if not applied earlier). Position bath blanket and towel to expose back and buttocks.					
26	Wash, rinse, and dry back and buttocks area and between gluteal folds. Observe for any redness or skin breakdown in sacral area.					
27	If not contraindicated, give patient a backrub. Back massage may be given after perineal care. Apply emollient.					
28	Raise side rail. Refill basin with clean water. Discard washcloth and towel. Remove gloves. Put on clean gloves.					
29	Clean perineal area. Apply skin barrier, as indicated. Raise side rail, remove gloves, perform hand hygiene.					
30	Help patient put on clean gown. Assist with use of personal toiletries.					

31	Protect pillow with towel, groom patient's hair.					
32	Position patient comfortably, side rails up, bed in lowest position.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: _____
Student Signature: _____Clinical Instructor Signature: _____

BED MAKING: OPEN / UNOCCUPIED BED

Name of Student: _____ **Section: _____**
Student ID: _____ **Date: _____**

Purpose: the bed linens are changed without injury to the patient or nurse

Indications: bed linens are changed after the bath or when it is soiled

Equipment:

- One large flat sheet
- One fitted sheet
- Drawsheet (optional)
- Blankets
- Bedspread
- Pillowcases (2)
- Linen hamper or bag
- Bedside chair
- Waterproof protective pad (optional)
- Disposable gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for making an unoccupied bed. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The bed linens are changed without injury to the patient or nurse.	*3*	*2*	*1*	*0*	*Remarks*
1	Perform hand hygiene, put on PPE, as indicated.					
2	Explain to patient the procedure and rationale, if patient is present in the room.					
3	Assemble necessary equipment on overbed table.					
4	Adjust bed to comfortable working height, elbow height of caregiver.					
5	Disconnect call bell or any tubes from bed linens.					
6	Put on gloves. Loosen all linen as you move around the bed, from the head of bed on far side to the head of bed on near side.					
7	Fold reusable linens—sheets, blankets, or spread, in place on the bed in fourths and hang them over a clean chair.					
8	Snugly roll all soiled linens in bottom sheet. Hold linen away from your body and place directly into hamper.					
9	Shift mattress up to head of bed.					

10	Remove your gloves. Place bottom sheet on mattress, secure bottom sheet over corners at head and foot of mattress.					
11	Push the sheet open to center of mattress, pulling the sheet taut from secured corners.					
12	Place drawsheet with its centerfold in center of bed and position so it will be located under patient's midsection. Open drawsheet and fan-fold to center of mattress. If protective pad is used, place it over drawsheet and open to centerfold. Tuck drawsheet securely under mattress.					
13	Move to other side of bed to secure bottom linen. Pull bottom sheet tightly and secure over corners at head and foot of mattress. Pull drawsheet tightly and tuck it securely under mattress.					
14	Place top sheet on bed with its centerfold in center of bed and with hem even with the head of mattress. Unfold top sheet. Follow same procedure with top blanket/spread, placing upper edge about 6 inches below the top of sheet.					
15	Tuck the top sheet and blanket under foot of bed on near side. Miter the corners.					
16	Fold the upper 6 inches of the top sheet down over the spread and make a cuff.					
17	Move to other side of bed and follow the same procedure for securing top sheets under foot of bed and making a cuff.					
18	Place pillows on bed. Open each pillowcase in same manner as you opened other linens. Gather pillowcase over one hand toward closed end. Grasp pillow with the hand inside the pillowcase. Keep a firm hold on the top of the pillow and pull the cover onto the pillow. Place pillow at head of the bed.					
19	Fan-fold or pre-fold the top linens.					
20	Secure the signal device on bed.					
21	Raise side rail and lower the bed.					
22	Dispose soiled linen.					
23	Remove PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

BED MAKING: CLOSED / OCCUPIED BED

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: The bed linens are changed without injury to the patient or nurse
Indications: Bed linens are changed after the bath or when it is soiled
Equipment:

- One large flat sheet
- One fitted sheet
- Drawsheet (optional)
- Blankets
- Bedspread
- Pillow cases (2)
- Linen hamper or bag
- Bedside chair
- Waterproof protective pad (optional)
- Disposable gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for making an occupied bed**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The bed linens are applied without injury to the patient or nurse.	*3*	*2*	*1*	*0*	*Remarks*
1	Check health care record for limitations on the patient's physical activity.					
2	Perform hand hygiene. Put on PPE, as indicated.					
3	Identify the patient. Explain what you are going to do.					
4	Assemble equipment on overbed table.					
5	Close the curtains around the bed, close the door to the room.					
6	Adjust bed to a comfortable working height, elbow height of caregiver.					
7	Lower the side rail nearest you, leave opposite side rail up. Place bed in flat position unless contraindicated.					
8	Put on gloves. Check bed linens for patient's personal items. Disconnect the call bell or any tubes from bed linens.					

9	Place bath blanket over the patient. Have patient hold on to bath blanket while you reach under it and remove topo linens. Leave top sheet in place if bath blanket is not used. Fold linen that is to be reused over the back of chair. Discard soiled linen in hamper.					
10	Grasp mattress securely and shift it up to head of bed (done with another person if possible).					
11	Assist patient to turn toward opposite side of bed, reposition pillow under patient's head.					
12	Loosen all bottom linen from head, foot, and side of bed.					
13	Fan-fold or roll soiled linens as close to the patient as possible.					
14	Use clean linen and make the near side of bed. Place bottom sheet in center of bed. Open sheet and pull bottom sheet over the corners at head and foot of mattress. Push sheet toward center of bed, pull it taut and position it under old linens.					
15	If using, place the drawsheet with its centerfold in center of bed and position under patient's midsection. Open drawsheet and fan-fold to center of mattress. Tuck drawsheet securely under mattress. If protective pad is used, place over drawsheet in proper area and open to centerfold.					
16	Raise the side rail. Assist patient to roll over the folded linen in middle of bed toward you. Reposition pillow and bath blanket or top sheet. Move to other side of bed and lower side rail.					
17	Loosen and remove all bottom linen. Discard soiled linen in hamper.					
18	Ease clean linen from under the patient. Pull bottom sheet taut and secure at corners at head and foot of mattress. Pull drawsheet tight and smooth. Tuck drawsheet securely under mattress.					
19	Assist patient to turn back to center of bed. Remove pillow and change pillowcase. Open each pillowcase in same manner as you opened other linens. Gather pillowcase over one hand toward closed end. Grasp pillow with hand inside the pillowcase. Keep a firm hold on top of pillow and pull cover onto the pillow. Place pillow under patient's head.					
20	Apply top linen, sheet and blanket, if desired, so that it is centered. Fold top linens of patient's shoulders, to make a cuff. Have patient hold on to top linen and remove bath blanket from underneath.					
21	Secure top linens under foot of mattress and miter corners. Loosen top linens over patient's feet by grasping them in the area of the feet and pulling gently toward the foot of bed.					
22	Return patient to comfortable position. Remove gloves. Raise side rail, lower bed. Reattach call bell.					
23	Dispose soiled linens.					
24	Remove PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

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TRANSFERRING PATIENT FROM BED TO A CHAIR

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: the transfer is accomplished without injury to patient or nurse

Indications: - Change patient's position to prevent complications related to immobility
-Help patient to begin engaging in physical activities

Equipment:

- Chair or wheelchair
- Gait belt
- Stand-assist aid, if available
- Additional staff person to assist.
- Blanket to cover the patient in the chair.
- Nonsterile gloves and/or other PPE, as indicated.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps followed for transferring a patient from the bed to a chair**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The patient is transferred without injury to patient or nurse.	*3*	*2*	*1*	*0*	*Remarks*
1	Review medical record and NCP for conditions that may influence patient's ability to move. Assess tubes, IV lines, incisions, or equipment that may alter positioning procedure. Identify and movement limitation.					
2	Perform hand hygiene, put on PPE, as indicated.					
3	Identify patient. Explain the procedure to the patient.					
4	Close curtains, close door for privacy.					
5	Place bed n lowest position. Raise head of bed to sitting position, or as high as patient can tolerate.					
6	Make sure bed brakes are locked. Put chair next to the bed.					
7	Encourage patient to make use of stand-assist aid, and move to side of bed and to a side-lying position, facing the side of bed on which patient will sit.					
8	Lower the side rail, stand near patient's hips. Stand with your legs shoulder width apart with one foot near head of bed, slightly in front of the other foot.					
9	Encourage patient to make use of stand-assist device. Assist patient to sit up on side of bed; ask patient to swing his legs over side of bed. At the same time, pivot on					

	your back leg to lift patient's trunk and shoulders. Keep your back straight; avoid twisting.					
10	Stand in front of patient. Assess for any balance problems and complaints of dizziness. Allow patient's leg to dangle a few minutes before continuing.					
11	Assist patient to put on robe and nonskid footwear.					
12	Wrap gait belt around patient's waist.					
13	Stand facing the patient. Spread your feet about shoulder width apart and flex hips and knees.					
14	Ask patient to slide his buttocks to edge of bed until feet touch the floor. Position yourself as close as possible to patient, with your foot position on the outside of patient's foot. If a second person is assisting, have him assume similar position. Grasp the gait belt.					
15	Encourage patient to make use of stand-assist device. If needed, have second person grasp the gait belt on opposite side. Rock back and forth while counting to three. On three, using the gait belt and your legs, assist patient to a standing position. Brace your front knee against patient's weak extremity as he stands. Assess patient's balance and leg strength.					
16	Pivot on your back foot and assist patient to turn until patient feels the chair against his legs.					
17	Ask patient to use his arm to steady himself on the arm of chair while slowly lowering to a sitting position. Continue to brace patient's knees with your knees and hold gait belt. Flex your hips and knees when helping the patient sit in the chair.					
18	Assess patient's alignment in the chair. Remove gait belt. Cover with blanket. Make sure call bell is within easy reach.					
19	Clean transfer aids. Remove gloves and other PPE. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

TRANSFERRING PATIENT FROM BED TO A STRETCHER

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: The transfer is transferred without injury to patient or nurse

Indications: - Change patient's position to prevent complications related to immobility
-Help patient to begin engaging in physical activities

Equipment:

- Transport stretcher
- Friction-reducing sheet
- Lateral-assist device, such as a transfer board, roller board, or mechanical lateral-assist device, if available
- Bath blanket
- Regular blanket
- At least two assistants, depending on the patient's condition
- Nonsterile gloves and/or other PPE, as indicate

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for transferring a patient from the bed to a stretcher**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The transfer is accomplished without injury to patient or nurse.	*3*	*2*	*1*	*0*	*Remarks*
1	Review medical record and NCP for conditions that may influence patient's ability to move. Assess tubes, IV lines, incisions, or equipment that may alter positioning procedure. Identify and movement limitation.					
2	Perform hand hygiene, put on PPE, as indicated.					
3	Identify patient. Explain the procedure to the patient.					
4	Close curtains, close door for privacy. Adjust head of bed to flat position. Raise bed to height that is even with the transport stretcher. Lower side rails.					
5	Place bath blanket over patient and remove top covers from underneath.					
6	Place friction-reducing transfer sheet under patient's midsection. Have patient fold arms against chest and move chin to chest. Use friction-reducing sheet to move patient to side of bed where stretcher will be placed. Alternately, place a lateral-assist device under the patient.					

7	Position the stretcher next (and parallel) to the bed. Lock the wheels on the stretcher and bed.					
8	Two nurses should stand on stretcher side of bed. A third nurse should stand on side of bed without the stretcher.					
9	Use friction-reducing sheet to roll the patient away from the stretcher. Place transfer board across the space between stretcher and bed. Poll patient onto his back, so patient is partially on transfer board.					
10	The nurse on the side of bed without the stretcher should grasp the friction-reducing sheet at head and chest areas of patient. The nurse on stretcher side of bed should grasp friction-reducing sheet at head and chest, and the other nurse on that side should grasp the friction-reducing sheet at chest and leg areas of patient.					
11	At a signal given by one of the nurses, have the nurses standing on the stretcher side of bed pull the friction-reducing sheet. At the same time, the nurse/s on the other side push, transferring the patient's weight toward the transfer board, and pushing the patient from bed to stretcher.					
12	Once patient is transferred to stretcher, remove transfer board, secure patient. Raise side rails. Cover patient with blanket and remove bath blanket from underneath. Leave the friction-reducing sheet in place for the return transfer. Make sure call bell is within easy reach.					
13	Clean transfer aids. Remove gloves, other PPE. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ASSESSING VITAL SIGNS
USING A PULSE OXIMETER

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose: Pulse oximetry is a test used to measure the oxygen level (oxygen saturation) of the blood. It is an easy, painless measure of how well oxygen is being sent to parts of your body furthest from your heart, such as the arms and legs**.**

Indications:
•Endotracheal intubation.
•Cardiac arrest.
•Procedural sedation.
•Asthma/chronic obstructive pulmonary disease (COPD)
•Respiratory complaints.
•Acute respiratory distress syndrome (ARDS)
•Sleep disorders/sleep apnea.
•Shunts in cyanotic heart diseases.

Equipment:
•Pulse oximeter
•Alcohol wipe

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for transferring a patient from the bed to a stretcher**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

USING A PULSE OXIMETER **Goal:** The patient exhibits arterial blood oxygen saturationwithin acceptable parameters, or greater than 95%.	***3***	***2***	***1***	***0***	***Remarks***
1. Review health record for any health problems that wouldaffect the patient's oxygenation status. Gather Equipment					
2. Perform hand hygiene and put on PPE, if indicated					
3.Identify the patient.					
4.Assemble equipment to the bedside stand or overbed tableor other surface within reach					
5.Close the curtains around the bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient					
6. Select an appropriate site for application of the sensor. Use the patient's index,					

middle, or ring finger. a. Check the proximal pulse and capillary refill closest tothe site. b. If circulation to the site is inadequate, consider usingthe earlobe, forehead, or bridge of the nose. Use the appropriate oximetry sensor for the chosen site. c. Use a toe only if lower extremity circulation is notcompromised.					
7.Select proper equipment: a. If one finger is too large for the probe, use a smallerfinger. b. Use probes appropriate for the patient's age and size. c. Use a pediatric probe for a small adult, if necessary. d. Check if the patient is allergic to adhesive. A non-adhesive finger clip or reflectance sensor is available					
8.Prepare the monitoring site. Cleanse the selected area					
9.with the alcohol wipe or disposable cleansing cloth, as necessary. Allow the area to dry. If necessary, remove the nail polish and artificial nails after checking pulse oximeter's manufacturer's instructions.					
10.Attach the probe securely to the skin. Make sure that the light-emitting sensor and the light-receiving sensor are aligned opposite each other (not necessary to check if placed on the forehead or bridge of the nose).					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Temperature, Peripheral Pulse, Respiratory Rate, Blood Pressure

Name of Student: _____ Section: _____

Student ID: _____ Date: _____

Purpose: to objectively measure the physiologic health status of an individual which is reflected by the body temperature, pulse rate, respiration rate and blood pressure.

Indications: they signal early signs of an infection, prevent misdiagnosis, detect symptom-less medical problems, and encourage us to make better choices.

Equipment:

Measuring Body Temperature

- Digital or electronic thermometer, appropriate for site to be used
- Electronic record, or a pen, paper or flow sheet
- Water-soluble lubricant (for rectal temperature measurement)
- Disposable probe covers
- Nonsterile gloves, if appropriate
- Additional personal protective equipment (PPE), as indicated
- Toilet tissue, if needed

Assessing Peripheral Pulse by Palpation

(Peripheral Pulse)

- Watch with second hand or digital readout
- Electronic record, or a pen, paper or flow sheet
- Nonsterile gloves, if appropriate; additional PPE, as indicated

(Apical Pulse)

- Stethoscope
- Alcohol swab

Assessing Respiration

- Watch with second hand or digital readout
- Electronic record, or a pen, paper or flow sheet
- PPE, as indicated

Assessing Blood Pressure by Auscultation

- Stethoscope
- Sphygmomanometer
- Blood pressure cuff of appropriate size
  Electronic record, or a pen, paper or flow sheet
- Alcohol swab
  PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for assessing vital signs**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The patient's vital signs are assessed accurately without injury and the patient experiences minimal discomfort.	*3*	*2*	*1*	*0*	*Remarks*
Measuring a Tympanic Membrane Temperature						
1	Check medical order or NCP for frequency of measurement and route.					
2	Perform hand hygiene, put on PPE, if indicated.					
3	Identify the patient.					
4	Close the curtains, close the door. Discuss procedure with patient, assess patient's ability to assist with the procedure.					
5	Assemble equipment on overbed table within reach.					
6	Ensure electronic/digital thermometer is in working condition.					
7	Put on gloves, if indicated.					
8	Select appropriate site based on assessment data.					
9	Push the "ON" button and wait for the "ready" signal on the unit.					
10	Attach the disposable cover onto the tympanic probe.					
11	Insert probe snugly into external ear using gentle but firm pressure angling the thermometer toward patient's jaw line. Pull pinna up and back to straighten ear canal in adult.					
12	Activate unit by pushing trigger button. Not the reading after 2 seconds.					
13	Discard the probe cover in an appropriate receptacle by pushing the probe-release button. Replace thermometer in its charger, if necessary.					
Assessing Peripheral Pulse by Palpation						
14	Select appropriate peripheral site based on assessment data.					
15	Move patient's clothing to expose only the site chosen.					
16	Place your first, second, and third fingers over the artery. Ends of your fingers are flat against patient's skin when palpating peripheral pulses. Lightly compress the artery so pulsations can be felt and counted.					
17	Using a watch with a second hand, count the number of pulsations felt for 30 seconds, multiply by 2 to calculate rate per minute.					
18	Note rhythm, and amplitude of pulse. If abnormal, palpate and count for 1 full minute.					
Assessing Respiration						
19	While your fingers are still in place for the pulse measurement, after counting the pulse rate, observe patient's respirations.					
20	Note the rise and fall of the patient's chest.					
21	Using a watch with a second hand, count the number of respirations for 30 seconds, multiply by 2 to calculate rate per minute.					

22	Note the depth and rhythm of the respirations. If abnormal, count respirations for 1 full minute.					
23	When measurement is completed, cover patient and assist him to a comfortable position.					
Assessing Blood Pressure by Auscultation						
24	Select the appropriate arm for application of cuff.					
25	Have patient assume a comfortable lysing/sitting position with forearm supported at level of heart and palm of hand upward.					
26	Expose brachial artery by removing garments or move a sleeve if it is not too tight, above area where the cuff will be placed.					
27	Locate the brachial artery. Center the bladder of cuff over brachial artery, about midway on arm, so lower edge of cuff is 2.5 – 5 cm above inner aspect of elbow. Line up artery marking on cuff with patient's brachial artery. Tubing should extend from edge of cuff nearer the patient's elbow.					
28	Wrap cuff around arm smoothly and snugly and fasten it.					
29	Check that the needle on aneroid gauge is within zero mark. If using mercury manometer, check to see that the manometer is in vertical position and that mercury is within zero level with gauge at eye level.					
Estimating Systolic Pressure						
30	Palpate pulse at brachial/radial artery by pressing gently with fingertips.					
31	Tighten screw valve on air pump.					
32	Inflate cuff while continuing to palpate the artery. Note the point on gauge where pulse disappears.					
33	Deflate cuff and wait 1 minute.					
Obtaining Blood Pressure Measurement						
34	Place stethoscope earpieces in your ears.					
35	Place the bell of stethoscope firmly but with as little pressure as possible over brachial artery.					
36	Pump pressure 30 mmHg above the point at which systolic pressure was palpated and estimated. Open the valve on manometer and allow air to escape slowly (2-3 mm/sec)					
37	Note the point on the gauge at which the first faint, but clear, sound appears that slowly increases in intensity. Note this number as systolic pressure. Read the pressure to the closest 2 mmHg.					
38	Note the point at which sound completely disappears. Note this number as diastolic pressure. Read the pressure to the closest 2 mmHg.					
39	Allow remaining air to escape quickly. Deflate cuff completely.					
40	When measurement is completed, remove cuff. Remove gloves. Cover patient and position comfortably.					

41	Clean the bell of stethoscope with alcohol wipe and store sphygmomanometer.					
42	Remove PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING A SMALL-VOLUME CLEANSING ENEMA

Name of Student: _____ **Section: _____**

Student ID: _____ **Date: _____**

Purpose:

- ✓ Relieve constipation or fecal impaction.
- ✓ Prevent involuntary escape of fecal material during surgical procedures.
- ✓ Promote visualization of the intestinal tract by radiographic or instrument examination.
- ✓ Help to establish regular bowel function during a bowel training program.

Indications:

- ✓ For Constipation or fecal impaction.
- ✓ Before surgical procedures.

Equipment:

- commercially prepared enema with rectal tip
- water-soluble lubricant
- waterproof pad
- bath blanket
- bedpan and toilet tissue
- disposable gloves
- additional PPE, as indicated.
- paper towel
- washcloth, skin cleanser, and towel
-

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for assessing vital signs**.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No	*Goal: The patient expels feces and reports a decrease in pain and discomfort.*	*3*	*2*	*1*	*0*	*Remarks*
1	Verify the order for the enema. Gather equipment.					
2	Perform hand hygiene and put on PPE, if indicated.					
3	Identify the patient.					
4	Explain the procedure to the patient and provide the rationale why the tube is needed. Discuss the associated discomforts that may be experienced and possible interventionsthat may allay this discomfort. Answer any questions, as needed.					

5	Assemble equipment on overbed table within reach. Warm the enema solution to bodytemperature by placing the container in a bowl of warm water.					
6	Provide privacy. Discuss where the patient will defecate. Have a bedpan, commode, ornearby bathroom ready for use.					
7	Adjust the bed to a comfortable working height, usually elbow height of the caregiver.Position the patient on the left side (Sim's position), as dictated by patient comfort andcondition. Fold top linen back just enough to allow access to the patient's rectal area. Drape the patient with the bath blanket., as necessary, to maintain privacy and provide warmth. Place a waterproof pad under the patient's hip.					
8	Put on gloves.					
9	Remove the cap and generously lubricate end of rectal tube 2 to 3 inches (5 to 7 cm).					
10	Lift buttock to expose anus. Ask the patient to take several deep breaths. Slowly and gently insert the rectal tube 3 to 4 inches (7 to 10 cm) for an adult. Direct it at an anglepointing toward the umbilicus, not bladder. Do not force entry of the tube.					
11	Compress the container with your hands. Roll the end up on itself, toward the rectal tip. Administer all the solution in the container. Assess for dizziness, light headedness, nausea, diaphoresis, and clammy skin during administration. If the patient experiences any of these symptoms, stop the procedure immediately, monitor the patient's heart rateand blood pressure, and notify the primary care provider.					
12	After the solution has been given, remove the tube, keeping the container compressed.Have paper towel ready to receive the tube as it is withdrawn. Encourage the patient to hold the solution until the urge to defecate is strong, usually in about 5 to 15 minutes.					
13	Remove gloves. Return the patient to a comfortable position. Make sure the linens underthe patient are dry. Ensure that the patient is covered.					
14	Raise the side rail. Lower bed height and adjust head of bed to a comfortable position.					
15	Remove additional PPE, if used. Perform hand hygiene.					
16	When patient has a strong urge to defecate, place him/her in a sitting position on a bedpanor assist to commode or bathroom. Stay with patient or have call bell readily accessible.					
17	Remind the patient not to flush the toilet or empty the commode before you inspect theresults of the enema.					
18	Put on gloves and assist patient, if necessary, with cleaning the anal area. Offerwashcloth, skin cleanser, and water for handwashing. Remove gloves.					
19	Leave the patient clean and comfortable. Care for equipment properly.					
20	Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

ASSISTING A PATIENT WITH AMBULATION USING WALKER

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: Walking exercises most of the body's muscle and increases joint flexibility. It improves respiratory and gastrointestin functions. It also reduces the risks for complications of immobility.

Indications:

- Post-trauma patient
- Elderly patients
- Post-operative patients

Equipment

Gait belt
Non-skid shoes
Non-sterile gloves or PPE if indicated
Stand-assist device as necessary, if available
Additional staff for assistance if needed
Walker

Directions: Below is a list of criteria to evaluate the student's skill in ***assisting a patient with ambulation using walker.*** Indica your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in - ASSISTING A PATIENT WITH AMBULATION USING WALKER	***3***	***2***	***1***	***0***	***Remar***
1	Review the medical record and nursing care plan for conditions that may influence the patient's ability to move and ambulate, and for specific instruction for ambulation, such as distance. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation. Assess patient knowledge and previous experience regarding the use of a walker. Identify any movement limitations.					
2	Perform hand hygiene. Put on PPE, if indicated.					
3	Identify the patient. Explain the procedure to the patient. Tell the patient to report any feelings of dizziness, weakness, or shortness of breath while walking. Decide how far to walk.					
4	Place the bed in the lowest position, if the patient is in bed.					
5	Encourage the patient to make use of a stand-assist aid, either free-standing or attached to the side of the bed, if available, to move to the side of the bed.					

6	Assist the patient to the side of the bed, if necessary. Have the patient sit on the side of the bed. Assess for dizziness or light-headedness. Have the patient stay seated until he or she feels secure.					
7	Assist the patient to put on footwear and a robe, if desired.					
8	Wrap the gait belt around the patient's waist, based on assessed need and facility policy.					
9	Place the walker directly in front of the patient. Ask the patient to push him- or herself off the bed or chair; make use of the stand-assist device, or assist the patient to stand. Once the patient is standing, have him or her hold the walker's hand grips firmly and equally. Stand slightly behind the patient, on one side.					
10	Have the patient move the walker forward 6 to 8 inches and set it down, making sure all four feet of the walker stay on the floor. Then, tell the patient to step forward with either foot into the walker, supporting him- or herself on his or her arms. Follow through with the other leg.					
11	Move the walker forward again, and continue the same pattern. Continue with ambulation for the planned distance and time. Return the patient to the bed or chair based on the patient's tolerance and condition, ensuring that the patient is comfortable. Make sure call bell and other necessary items are within easy reach.					
12	Ensure the patient is comfortable, with the side rails up and the bed in the lowest position, as necessary. Place call bell and other essential items within reach.					
13	Clean transfer aids per facility policy, if not indicated for single patient use. Remove gloves and any other PPE. Perform hand hygiene.					
14	Document activity, any other pertinent observations, the patient's ability to use the walker, the patient tolerance of the procedure, and the distance walked. Document the use of transfer aids and the number of staff required for transfer.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ASSISTING A PATIENT WITH AMBULATION USING AXILLARY CRUTCHES

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: Walking exercises most of the body's muscle and increases joint flexibility. It improves respiratory and gastrointestin functions. It also reduces the risks for complications of immobility.

Indications:

- Post-trauma patient
- Elderly patients
- Post-operative patients

Equipment

Gait belt
Non-skid shoes
Non-sterile gloves or PPE if indicated.
Stand-assist device as necessary, if available
Additional staff for assistance if needed.
Crutches

Directions: Below is a list of criteria to evaluate the student's skill in assisting a patient with ambulation using axillary crutches. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in - assisting a patient with ambulation using - axillary crutches	***3***	***2***	***1***	***0***	***Rema***
1	Review the medical record and nursing plan of care for conditions that may influence the patient's ability to move and ambulate. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation. Assess the patient's knowledge and previous experience regarding the use of crutches. Determine that the appropriate size crutch has been obtained.					
2	Perform hand hygiene. Put on PPE, if indicated.					
3	Identify the patient. Explain the procedure to the patient. Tell the patient to report any feelings of dizziness, weakness, or shortness of breath while walking. Decide how far to walk.					
4	Encourage the patient to make use of the stand-assist device, if available. Assist the patient to stand erect, face forward in the tripod position. This means the patient holds the crutches 12 inches in front of and 12 inches to the side of each foot.					

5	Using Crutches: Four-Point Gait A. Have the patient move the right crutch forward 12 inches B. then move the left foot forward to the level of the right crutch. C. Then have the patient move the left crutch forward 12 inches D. Then move the right foot forward to the level of the left crutch.					
6	Using Crutches: Three-Point Gait a. Have the patient move the affected leg and both crutches forward about 12 inches. b. Have the patient move the stronger leg forward to the level of the crutches.					
7	Using Crutches: Two-Point Gait Demonstrate the crutch-foot sequence to the client. A. Advance the right foot and left crutch simultaneously B. Advance the left foot and right crutch simultaneously					
8	Using Crutches: Swing-to-Gait and Swing through Gait A. Have the patient move both crutches forward about 12 inches. B. Have the patient lift the legs and swing them to the crutches, supporting his or her body weight on the crutches.					
9	Continue with ambulation for the planned distance and time. Return the patient to the bed or chair based on the patient's tolerance and condition, ensuring that the patient is comfortable. Make sure call bell and other necessary items are within easy reach.					
10.	Remove PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ASSISTING A PATIENT WITH AMBULATION USING A CANE

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: Walking exercises most of the body's muscle and increases joint flexibility.
It improves respiratory and gastrointestinal functions. It also reduces the risks for complications of immobility

Indications:
- Post-trauma patient
- Elderly patients
- Post-operative patients

Equipment
Gait belt
Non-skid shoes
Non-sterile gloves or PPE if indicated.
Stand-assist device as necessary, if available
Additional staff for assistance if needed.

Directions: Below is a list of criteria to evaluate the student's skill in ***assisting patients with ambulation cane***. Indicate yo evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.
Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in assisting a patient with ambulation cane.	***3***	***2***	***1***	***0***	***Remarks***
1	Review the medical record and nursing plan of care for conditions that may influence the patient's ability to move and ambulate. Assess for tubes, IV lines, incisions, or equipment that may alter the procedure for ambulation.					
2	Perform hand hygiene. Put on PPE, as indicated.					
3	Identify the patient. Explain the procedure to the patient. Tell the patient to report any feelings of dizziness, weakness, or shortness of breath while walking. Decide how far to walk.					
4	Encourage the patient to make use of a stand-assist aid, either free-standing or attached to the side of the bed, if available, to move to and sit on the side of the bed.					
5	Wrap the gait belt around the patient's waist, based on assessed need and facility policy.					

6	Encourage the patient to make use of the stand-assist device to stand with weight evenly distributed between the feet and the cane.					
7	Have the patient hold the cane on his or her stronger side, close to the body, while the nurse stands to the side and slightly behind the patient.					
8	Tell the patient to advance the cane 4 to 12 inches (10 to 30 cm) and then, while supporting his or her weight on the stronger leg and the cane, advance the weaker foot forward, parallel with the cane.					
9	While supporting his or her weight on the weaker leg and the cane, have the patient advance the stronger leg forward ahead of the cane (heel slightly beyond the tip of the cane).					
10	Tell the patient to move the weaker leg forward until it is even with the stronger leg, and then advance the cane again.					
11	Continue with ambulation for the planned distance and time. Return the patient to the bed or chair based on the patient's tolerance and condition, ensuring the patient's comfort. Make sure call bell and other necessary items are within easy reach.					
12	Clean transfer aids per facility policy, if not indicated for single patient use.					
13	Standing: Teach patient to do the following: A. Hold cane in hand opposite weak side. B. Move hips forward in chair. C. Grasp arms of chair. D. Push to standing position. E. Gain balance.					
14	Sitting: Teach patient to do the following: A. Turn around and back to chair. B. Grasp arm of chair. C. Lower self into chair.					
15	Gait pattern: Teach patient to do the following: A. Hold cane ahead 4-6 inches. B. Move weak leg ahead, opposite cane. C. Put weight on weak leg and cane. D. Move strong leg ahead. E. Repeat sequence.					
	Nurse stands to side of and behind patient.					
16	Remove PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

FUNDAMENTAL II

NURSING

SKILL

CHECKLISTS

ADMINISTERING ORAL MEDICATION

Student name _____ Section: _____
Student ID _____ Date _____

PURPOSE: Medication is administered orally to produce local effect on the alimentary canal or systemic effect after absorption into
the blood streams.

INDICATION: Administration of medicines

EQUIPMENT:

- Medication in disposable cup or oral syringe
- Liquid (e.g. water, juice) with straw, if not contraindicated
- Medication cart or tray
- Computer-generated Medication Administration Record CMAR) or Medication Administration Record (MAR)
- Personal Protective Equipment (PPE), as indicated

Directions: Below is a list of criteria to evaluate the student's skill in ***assisting patients with ambulation cane***. Indicate you evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Goal: the medication is successfully administered via the oral route; the patient does not aspirate: the patient experiences decreased anxiety; and the patient does not experienceadverse effects.	***3***	***2***	***1***	***0***	***Remarks***
1	Gather equipment. Check each medication order against the original order in the medication record. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administrationin the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					
6	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.					
7	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if needed.					
8	Prepare the required medications: a. **Unit dose packages:** Place medication in a disposable cup.					
	b. **Multidose containers:** Remove tablets/capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the					

	tablets/capsules in a medicationcup. Break only scored tablets, if necessary, to obtain the proper dosage. Do not touch tablets or capsules with hands.					
	c. **Liquid medication in multidose bottle:** Pour liquid medications out of a multi-dose bottle, hold the bottle so the label is against the palm. Use the appropriate measuringdevice when pouring liquids and read the amount of medication at the bottom of the meniscus at eye level. Wipe the lip of the bottle with a paper towel.					
9	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.					
10	Replace any multi-dose containers in the patient's drawer or unit stock. Lock themedication cart before leaving it.					
11	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.					
12	Perform hand hygiene and put on PPE, if indicated.					
13	Identify the patient using at least two methods: ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.					
14	Check about allergies. Explain the purpose and action of each medication to the patient.					
15	Recheck the labels with the Medication Record before administering the medications to thepatient.					
16	Assist the patient to an upright/lateral (side-lying) position.					
17	Administer medications: ➢ Offer water or other permitted fluids with pills, capsules, tablets, and some liquidmedications. ➢ Ask whether the patient prefers to take the medications by hand or in a cup.					
18	Remain with the patient until each medication is swallowed.Never leave medication at the patient's bedside.					
19	Assist the patient to a comfortable position.					
20	Document the administration of the medication immediately after administration.					
21	Evaluate the patient's response to the medication within the appropriate time frame.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING INTRADERMAL (ID) INJECTION

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: The intradermal route has the longest absorption time of all parenteral routes for this reason are used for sensitivity tests, such as tuberculin and allergy tests and local anesthesia.
INDICATION: are used for sensitivity tests, such as tuberculin and allergy tests and local anesthesia.
EQUIPMENT:

- Prescribed Medication
- Sterile syringe, usually a tuberculin syringe calibrated in tenths and hundredths, and needle, ¼ to ½ inch, 25 or 27 gauge
- antimicrobial swab
- disposable gloves
- small gauze square
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)
- PPE, as indicated

Directions: Below is a list of criteria to evaluate the student's skill in steps follow for ***administering intradermal (id) Injection.*** Indicate your evaluation by placing a corresponding score on the raw Score column using the following descriptive
Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	*Goal: The medication is injected, and a wheal appears at the site of injection.*	*3*	*2*	*1*	*0*	*Remarks*
1	Gather equipment. Check each medication order against the original order in the medication record. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administration in the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					
7	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.					
8	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if needed.					
9	**Withdraw the medication from an ampule or vial.**					

	10	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.						
	11	Lock the medication cart before leaving it.						
	12	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.						
	13	Perform hand hygiene and put on PPE, if indicated.						
	14	Identify the patient using at least two methods. ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.						
	15	Provide privacy. (Close the door to the room and pull the bedside curtain.)						
	16	Check about allergies. Explain the purpose and action of each medication to the patient.						
	17	Recheck the labels with the Medication Record before administering the medications tothe patient.						
	18	Put on clean gloves.						
	19	Select the appropriate administration site. Assist the patient to the appropriate position forthe site chosen. Drape, as needed, to expose only site area to be used.						
	20	Cleanse the site with an antimicrobial swab while wiping with a firm, circular motion andmoving outward from the injection site. Allow the skin to dry.						
	21	Remove the needle cap with the non-dominant hand, pulling it straight off.						
	22	Use the non-dominant hand to spread the skin taut over the injection site.						
	23	Hold the syringe in the dominant hand, between the thumb and forefinger with the bevel ofthe needle up.						
	24	Hold the syringe at a 5-15 degrees angle from the site. Place the needle almost flat againstthe patient's skin, bevel side up, and insert the needle into the skin. Insert the needle only about 1/8 inch with entire bevel under the skin.						
	25	Once the needle is in place, steady the lower end of the syringe. Slide your dominant hand to the end of the plunger.						
	26	Slowly inject the agent while watching for a small wheal or blister to appear.						
	27	Withdraw the needle quickly at the same angle that it was inserted. Do not recap the usedneedle. Engage the safety shield or needle guard.						
	28	**DO NOT MASSAGE** the area after removing the needle. Tell the patient not to rub orscratch the site. If necessary, gently blot the site with a dry gauze square. Do not applypressure or rub the site.						
	29	Assist the patient to a comfortable position.						
	30	Discard the needle and syringe in the appropriate receptacle.						
	31	Remove gloves and additional PPE, if used. Perform hand hygiene.						
	32	Document the administration of the medication immediately after administration.						
	33	Evaluate the patient's response to the medication within an appropriate time frame.						

	34	Observe the area for signs of a reaction at determined intervals after administration.Inform the patient of the need for inspection.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING SUBCUTANEOUS (SC) INJECTION

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: Provide a medication the client requires.
-Allow slower absorption of a medication compared with either the intramuscular and intravenous route.
INDICATION: Medication administered subcutaneously are

- ✓ vaccines
- ✓ insulin
- ✓ heparin

EQUIPMENT:

- prescribed medication
- sterile syringe and needle
- antimicrobial swab
- non-latex disposable gloves
- small gauze square
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)
- PPE, as indicated

Directions: Below is a list of criteria to evaluate the student's skill in steps follow for ***administering*** subcutaneous ***Injection.*** Indicate your evaluation by placing a corresponding score on the raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	***Goal: The patient receives medication via the subcutaneous route and experiences the intended effect of the medication.***	***3***	***2***	***1***	***0***	***Remarks***
1	Gather equipment. Check each medication order against the original order in the medication record. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administrationin the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					

	6	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.						
	7	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if needed.						
	8	**Withdraw the medication from an ampule or vial.**						
	9	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.						
	10	Lock the medication cart before leaving it.						
	11	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.						
	12	Perform hand hygiene and put on PPE, if indicated.						
	13	Identify the patient using at least two methods: ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.						
	14	Provide privacy.						
	15	Check about allergies. Explain the purpose and action of each medication to the patient.						
	16	Recheck the labels with the Medication Record before administering the medications tothe patient.						
	17	Put on clean gloves.						
	18	Select the appropriate administration site. Assist the patient to the appropriate position forthe site chosen. Drape as needed, expose only site area to be used.						
	19	Identify the appropriate landmarks for the site chosen.						
	20	Cleanse the site with an antimicrobial swab while wiping with a firm, circular motion andmoving outward from the injection site. Allow the skin to dry.						
	21	Remove the needle cap with the non-dominant hand, pulling it straight off.						
	22	Grasp and bunch the area surrounding the injection site or spread the skin taut at the site.						
	23	Hold the syringe in the dominant hand between the thumb and forefinger.Inject the needle quickly at a 45-90 degrees angle.						
	24	After the needle is in place, release the tissue. If a large skin fold is pinched up, ensure thatthe needle stays in place as the skin is released. Immediately move non-dominant hand to steady the lower end of the syringe. Slide dominant hand to the end of the plunger. Avoid moving the syringe.						
	25	Inject the medication slowly (at a rate of 10 sec/ml).						
	26	Withdraw the needle quickly at the same angle at which it was inserted, while supporting the surrounding tissue with your non-dominant hand.						
	27	Using a gauze square, apply gentle pressure to the site after the needle is withdrawn. DO NOT MASSAGE THE SITE.						
	28	Do not recap the used needle. Engage the safety shield or needle guard. Discard the needle and syringe in the appropriate receptacle.						

	29	Assist the patient to a position of comfort.						
	30	Remove gloves and additional PPE, if used. Perform hand hygiene.						
	31	Document the administration of the medication immediately after administration.						
	32	Evaluate the patient's response to the medication within an appropriate time frame.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING IM INJECTION

Student name _____ Section: _____
Student ID _____ Date _____

PURPOSE: Chosen when a reasonably rapid systemic uptake of the drug is needed by the body and when a relatively prolonged action is required.

INDICATION:

- ✓ Administering medication, Antibiotics- penicillin G benzathine.
- ✓ Vaccines.
- ✓ Hormonal agents- testosterone.

EQUIPMENT:

- Gloves
- Additional PPE, as indicated.
- Medication
- Sterile syringe and needle of appropriate size and gauge:
  - Adult: 19-25G, 1 - 1.5 inches
  - Infant: 25-27G, 7/8 - 1 inch
  - Child >18mos: 22-25G, 7/8 - 1 1/4 inches
- Microbial swab
- Small gauze square
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for **administering intramuscular (im) injection.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	*Goal: The patient receives the medication via the intramuscular route and experiencesthe intended effect of the medication.*	*3*	*2*	*1*	*0*	*Remarks*
1	Gather equipment. Check each medication order against the original order in the medicalrecord. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administrationin the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					
6	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.					

	7	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if needed.					
	8	**Withdraw the medication from an ampule or vial.**					
	9	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.					
	10	Lock the medication cart before leaving it.					
	11	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.					
	12	Perform hand hygiene and put on PPE, if indicated.					
	13	Identify the patient using at least two methods: ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.					
	14	Provide privacy.					
	15	Check about allergies. Explain the purpose and action of each medication to the patient.					
	16	Recheck the labels with the Medication Record before administering the medications tothe patient.					
	17	Put on clean gloves.					
	18	Select the appropriate administration site. Assist the patient to the appropriate position forthe site chosen. Drape as needed, expose only the site area being used.					
	19	Identify the appropriate landmarks for the site chosen.					
	20	Cleanse the site with an antimicrobial swab while wiping with a firm, circular motion andmoving outward from the injection site. Allow the skin to dry.					
	21	Remove the needle cap by pulling it straight off. Hold the syringe in dominant hand between the thumb and forefinger.					
	22	Displace the skin in a Z-track manner. Pull the skin down or to one side about 1 inch (2.5cm) with non-dominant hand and hold the skin and tissue in this position.					
	23	Quickly dart the needle into the tissue, needle is perpendicular to the patient's body, anangle between 72 and 90 degrees.					
	24	As soon as the needle is in place, use the thumb and forefinger of non-dominant hand to hold the lower end of the syringe. Slide the dominant hand to the end of the plunger. Inject solution slowly (10 seconds/ml of medication).					
	25	Once the medication has been instilled, wait 10 seconds before withdrawing the needle.					
	26	Withdraw the needle smoothly and steadily at the same angle at which it was inserted,supporting tissue around the injection site with non-dominant hand.					
	27	Apply gentle pressure at the site with a dry gauze. DO NOT MASSAGE THE SITE.					
	28	Do not recap the used needle. Engage the safety shield or needle guard, if present. Discardthe needle and syringe in the appropriate receptacle.					
	29	Assist the patient to a comfortable position.					
	30	Remove gloves and additional PPE, if used. Perform hand hygiene.					

	31	Document the administration of the medication immediately after administration.						
	32	Evaluate the patient's response to the medication within an appropriate time frame.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature:_____

ADMINISTERING MEDICATIONS BY INTRAVENOUS BOLUS/PUSH THROUGH AN INTRAVENOUS INFUSION

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: Achieve immediate and maximum effects of a medication.
INDICATION: -It is used when a medication cannot be diluted
-In an emergency.

EQUIPMENT:

- Antimicrobial swab
- Watch with a second hand or stopwatch.
- Disposable gloves
- Additional PPE, as indicated.
- Prescribed medication
- Syringe with a needleless device or 23-to-25-gauge needle; 1 inch needle (follow facility policy)
- Syringe pump if necessary
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)

Directions: Below is a list of criteria to evaluate the student's skill in steps follow for administering intravenous bolus through an IV infusion. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	***Goal: The medication is given safely via the IV route and the patient experiences theintended effect of the medication.***	***3***	***2***	***1***	***0***	***Remarks***
1	Gather equipment. Check each medication order against the original order in the medical record. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare foradministration in the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					
6	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.					
7	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if necessary. Scan the bar code on package, if required.					
8	**Withdraw the medication from an ampule or vial.**					

9	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.					
10	Lock the medication cart before leaving it.					
11	Transport medications to the patient's bedside carefully and keep the medications in sight at all times. Ensure that the patient receives the medications at the correct time.					
12	Perform hand hygiene and put on PPE, if indicated.					
13	Identify the patient using at least two methods: ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.					
14	Provide privacy.					
15	Check about allergies. Explain the purpose and action of each medication to the patient.					
16	Recheck the labels with the Medication Record before administering the medications tothe patient.					
17	Assess IV site for presence of inflammation or infiltration.					
18	If IV infusion is being administered via an infusion pump, pause the pump.					
19	Put on clean gloves.					
20	Select injection port on tubing that is closest to venipuncture site. Clean port withantimicrobial swab.					
21	Uncap syringe. Steady port with non-dominant hand while inserting syringe into centerof port.					
22	Move non-dominant hand to the section of the IV tubing just above the injection port.Fold the tubing between fingers.					
23	Pull back slightly on plunger just until blood appears in tubing.					
24	Inject the medication at the recommended rate.					
25	Release the tubing. Remove the syringe. Do not recap the used needle, if used. Engage the safety shield or needle guard, if present. Release the tubing and allow the IV fluid toflow. Discard the needle and syringe in the appropriate receptacle.					
26	Check IV fluid infusion rate. Restart infusion pump, if appropriate					
27	Remove gloves and additional PPE, if used. Perform hand hygiene					
28	Document the administration of the medication immediately after administration					
29	Evaluate the patient's response to the medication within an appropriate time frame					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

INSERTING A NASOGASTRIC TUBE

Student name _____ Section: _____
Student ID _____ Date _____

PURPOSE: -It permits the patient to receive nutrition through a tube feeding using the stomach as a reservoir for food.
Used to decompress or to drain unwanted fluid or air from the stomach.
Monitor bleeding in the gastrointestinal tract.
Remove undesirable substances (lavage) such as poisons.
Help treat an intestinal obstruction.

INDICATION: esophageal atresia, stricture, and cancer.
dysphagia due to neuromuscular disorders or after.

EQUIPMENT:

- ✓ nasogastric tube of appropriate size (8-18 Fr.)
- ✓ stethoscope
- ✓ water-soluble lubricant
- ✓ normal saline solution or sterile water, for
- ✓ irrigation, depending on facility policy
- ✓ tongue blade / tongue depressor
- ✓ flashlight
- ✓ non-allergenic tape (1- inch wide)
- ✓ tissues
- ✓ glass of water with straw

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for inserting a nasogastric tube. Indicateyour evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Satisfactory demonstration for required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No	*Goal: The tube is passed into the patient's stomach without any complications.*	*3*	*2*	*1*	*0*	*Remarks*
1	Verify the medical order for NGT insertion. Gather equipment, select appropriate NGT.					
2	Perform hand hygiene and perform PPE, if indicated.					
3	Identify the patient.					
4	Explain the procedure to the patient, including the rationale why the tube is needed. Discuss the associated discomforts that may be experienced and possible interventions that may allay this discomfort. Answer any questions, as needed.					
5	Assemble equipment on over bed table within your reach.					
6	Provide privacy. Raise bed to a comfortable working position. Assist the patient to high Fowler's position or elevate the head of the bed 45 degrees if the patient is unable to maintain an upright position. Drape chest with bath towel or disposable pad. Have emesisbasin and tissues handy.					

	7	Measure the distance to insert the tube by placing the tube tip at the patient's nostril and extending it to tip of earlobe and then to tip of xiphoid process. Mark tube with indelible mark					
	8	Put on gloves. Lubricate tip of tube (at least 2-4 inches) with water soluble lubricant.Apply topical anesthetic to nostril and oropharynx, as appropriate.					
	9	After selecting the appropriate nostril, ask the patient to flex head slightly back against thepillow. Gently insert the tube into the nostril while directing the tube upward and backward along the floor of the nose. Provide tissues for tearing or watering of eyes. Offer comfort and reassurance to the patient.					
	10	When pharynx is reached, instruct the patient to touch chin to chest. Encourage the patientto sip water through a straw or swallow. Advance the tube in downward and backward direction when patient swallows. Stop when patient breathes. If gagging and coughing persist, stop advancing the tube and check placement of tube with tongue blade and flashlight. If tube is curled, straighten the tube and attempt to advance again. Keep advancing the tube until pen marking is reached. Do not use force. Rotate the tube if it meets resistance.					
	11	Discontinue the procedure and remove the tube if there are signs of distress, such asgasping, coughing, cyanosis, and inability to speak or hum.					
	12	Secure the tube loosely to the nose or cheek until it is determined that the tube is in thepatient's stomach.					
		Confirm placement of NG tube in patient's stomach **using at least 2 methods**, based onthe type of tube in place, a) Put on gloves. Attach syringe to the end of tube and aspirate a small amount of stomach contents. If unable to obtain a specimen, reposition the patient and flush the tubewith 30 ml of air in a large syringe. Slowly apply negative pressure to withdraw fluid. b) Measure the pH of aspirated fluid using pH paper or a meter. Place a drop of gastric secretions onto pH paper or place small amount in a plastic cup and dip the pH paper intoit. Within 30 seconds, compare the color on the paper with the chart supplied by the manufacturer. Mark the tube with an indelible marker.					
	13	After confirmation of the tube placement, secure the tube.Remove gloves and secure tube to patient's nose.					
	14	Put on gloves. Clamp the tube and remove the syringe. Cap the tube or attach tube tosuction according to the medical orders.					
	15	Measure length of exposed tube. Reinforce marking on tube at nostril with indelible ink.Ask the patient to turn his or her head to the side opposite the nostril in which the tube isinserted. Secure tube to patient's gown by using rubber band or tape and safety pin. If a double lumen tube (e.g. Salem sump) is used, secure vent above stomach level. Attachvent at shoulder level.					
	16	Put on gloves. Assist with or provide oral hygiene, at 2-4 hour interval. Lubricate the lipsgenerously and clean nares and lubricate, as needed. Offer analgesic, throat lozenges or anesthetic spray for throat irritation, if needed.					

	17	Remove equipment and return patient to a comfortable position. Remove gloves. Raiseside rail and lower bed.						
	18	Remove additional PPE, if used. Perform hand hygiene.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING TUBE FEEDING

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: Restore or maintain nutritional status**.** Administer medications
INDICATION: Esophageal atresia, stricture, and cancer.
Dysphagia due to neuromuscular disorders or after trauma.
EQUIPMENT:

• Prescribed tube feeding formula at room • temperature • Feeding bag or prefilled tube feeding set • Enteral feeding pump • Stethoscope • Nonsterile gloves • Alcohol preps • Disposable pad or towel	• Asepto or Toomey syringe • Rubber band • Clamp (Hoffman or butterfly) • IV pole • Water for irrigation and hydration, as needed • pH paper • Tape measure, or other measuring device

Directions: Below is a list of criteria to evaluate the student's skill in steps follow for administering tube feeding. Indicate yo evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.
Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No	***Goal: The patient receives the tube feeding without complaints of nausea, episodes of vomiting, gastric distention, or diarrhea.***	***3***	***2***	***1***	***0***	***Remarks***
1	Gather equipment. Check amount, concentration, type and frequency of tube feeding inthe patient's medical record. Check formula expiration date.					
2	Perform hand hygiene.					
3	Identify the patient.					
4	Explain the procedure to the patient. Answer any questions as needed.					
5	Assemble equipment on overbed table within your reach.					
6	Provide privacy. Raise the bed to a comfortable working position. Perform key abdominalassessments.					
7	Position the patient with head of bed (HOB) elevated at least 30 to 45 degrees or as nearnormal position for eating as possible.					
8	Put on gloves. Unsecure the tube from the patient's gown. Verify the position of the marking on the tube at the nostril. Measure length of exposed tube and compare with the documented length.					
9	Attach syringe to the end of tube and aspirate a small amount of stomach contents.					
10	Check the pH.					
11	Visualize aspirated contents, check color and consistency.					

12	(If not possible to aspirate contents; assessment to check placement are inconclusive; the exposed tube length has changed; or there are any other indications that the tube is not inplace), check placement by x-ray.							
13	After multiple steps in ensuring correct placement, aspirate all gastric contents with thesyringe and measure to check for gastric residual. Return the residual based on facility policy. Proceed with feeding if amount of residual does not exceed agency policy or thelimit indicated in the medical record.							
14	Flush tube with 30 ml of water for irrigation. Disconnect syringe from tubing and cap endof tubing while preparing the formula feeding equipment. Remove gloves.							
15	Put on gloves before preparing, assembling, and handling any part of the feeding system.							
16.1	Administer feeding. **A. WHEN USING A FEEDING BAG (OPEN SYSTEM)** a. Label bag and/or tubing with date and time. Hang bag on IV pole and adjust to about 12 inches above the stomach. Clamp tubing.							
	b. Check the expiration date of the formula. Cleanse top of feeding container with a disinfectant before opening it. Pour formula into feeding bag and allow solution to run through tubing. Close clamp.							
	c. Attach feeding setup to feeding tube, open clamp, and regulate drip according to the medical order, or allow feeding to run in over 30 minutes.							
	d. Add 30 to 60 ml (1 to 2 oz.) of water for irrigation to feeding bag when feeding is almost completed and allow it to run through the tube.							
	e. Clamp tubing immediately after water has been instilled. Disconnect feeding setup from feeding tube. Clamp tube and cover end with cap.							
16.2	**B. WHEN USING A LARGE SYRINGE (OPEN SYSTEM)** a. Remove plunger from 30 or 60 ml syringe.							
	b. Attach syringe to feeding tube, pour premeasured amount of tube feeding formula into							
	syringe, open clamp, and allow food to enter tube. Regulate rate, fast or slow, by height of the syringe. Do not push formula with syringe plunger.							
	c. Add 30 to 60 ml (1 to 2 oz) of water for irrigation to syringe when feeding is almost completed, and allow it to run through the tube.							
	d. When syringe has emptied, hold syringe high and disconnect from tube. Clamp tube and cover end with cap.							
16.3	**C. WHEN USING AN ENTERAL FEEDING PUMP** a. Close flow-regulator clamp on tubing and fill feeding bag with prescribed formula. Amount used depends on agency policy. Place label on container with patient's name, date and time the feeding was hung.							
	b. Hang feeding container on IV pole. Allow solution to flow through tubing.							
	c. Connect to feeding pump following manufacturer's directions. Set rate. Maintain the patient in an upright position throughout the feeding. If the patient needs to lie flat temporarily, pause the feeding. Resume the feeding after the patient's position has been changed back to at least 30 to 45 degrees.							
	d. Check placement of tube and gastric residual every 4 to 6 hours.							

17	Observe the patient's response during and after tube feeding and assess the abdomen at least once a shift.						
18	Have patient remain in upright position for at least 1 hour after feeding.						
19	Remove equipment and return patient to a position of comfort. Remove gloves. Raise side rail and lower bed.						
20	Put on gloves. Wash and clean equipment or replace according to agency policy. Remove gloves.						
21	Remove additional PPE, if used. Perform hand hygiene.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

REMOVING A NASOGASTRIC TUBE

Student name _____ Section: _____
Student ID _____ Date _____

PURPOSE: The NG tube is no longer necessary for treatment.
INDICATION: The NG tube is no longer necessary for treatment.
EQUIPMENT:

✓ Tissues	✓ Bath towel or disposable pad
✓ 50 ml syringe	✓ Emesis basin
✓ Non-sterile gloves	✓ Normal saline solution for irrigation (optional)
✓ Stethoscope	
✓ Disposable plastic bag	✓ Additional PPE, as indicated

Directions: Below is a list of criteria to evaluate the student's skill in steps follow for removing a nasogastric tube.. Indica your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No	***Goal: The tube is removed with minimal discomfort to the patient; the patient does notaspirate; and the patient maintains adequate nutritional intake.***	*3*	*2*	*1*	*0*	*Remarks*
1	Check medical record for the order for removal of NG tube.					
2	Perform hand hygiene and put on PPE, if indicated.					
	Identify the patient.					
4	Explain the procedure and rationale of procedure to the patient. Describe that it will entaila quick few moment of discomfort. Perform key abdominal assessments.					
5	Pull the patient's bedside curtain. Raise the bed to a comfortable working position. Assistthe patient into a 30 to 45 degrees' position. Place towel or disposable pad across the patient's chest. Give tissues and emesis basin to patient.					
6	Put on gloves. Discontinue suction and separate tube from suction. Unpin tube frompatient's gown and carefully remove adhesive tape from patient's nose.					
7	Check placement and attach syringe and flush with 10 ml of water or normal salinesolution (optional) or clear with 30 to 50 ml of air.					
8	Clamp tube with fingers by doubling tube on itself. Instruct the patient to take a deep breath and hold it. Quickly and carefully remove tube while patient holds breath. Coil thetube in the disposable pad as you remove it from the patient.					
9	Dispose of tube per facility policy. Remove gloves. Perform hand hygiene.					
10	Offer mouth care to the patient and facial tissue to blow nose. Lower the bed and assistthe patient to a position of comfort, as needed.					
11	Remove equipment and raise side rail and lower bed.					
12	Put on gloves and measure the amount of nasogastric drainage in the collection device and record on output flow record, subtracting irrigate fluids if necessary. Add solidifyingagent to nasogastric drainage and dispose of drainage according to facility policy.					
13	Remove additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

CATHETERIZING THE FEMALE URINARY BLADDER

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: Relieve discomfort due to bladder distention or to provide gradual decompression of a distended bladder.
Assess the amount of residual urine if bladder empties incompletely.
Obtain sterile urine specimen
To empty the bladder completely prior to surgery.
Facilitate accurate measurement of urinary output for critically ill clients whose output needs to be monitored hourly.

INDICATION: Urinary retention (can't urinate on your own)
Urinary incontinence (leakage)
Pelvic organs prolapse.
Spinal injuries or trauma.
Lower body paralysis.
Multiple sclerosis (MS)
Parkinson's disease.
Benign prostatic hyperplasia (BPH)

EQUIPMENT:

• Sterile catheter kit that contains: • Sterile gloves • Sterile drapes (one is fenestrated) • Sterile catheter (use the smallest appropriate size catheter, usually a 14F to 16F catheter with 5 to 10 ml balloon (Newman, 2008). Antiseptic cleansing solution and cotton balls or gauze squares; antiseptic swabs • Flashlight or lamp • Waterproof, disposable pad • Sterile, disposable urine collection bag and • drainage tubing (may be connected to • catheter in catheter kit)	• Lubricant • Forceps • Prefilled syringe with sterile water (sufficient to inflate indwelling catheter balloon) • Sterile basin (usually base of kit serves as this) • Sterile specimen container (if specimen is required) • Velcro leg strap, catheter securing device, or tape • Disposable gloves • Additional PPE, as indicated • Washcloth, skin cleanser, and warm water to perform perineal hygiene before and after catheterization

Directions: Below is a list of criteria to evaluate the student's skill student's skill in steps to follow **for the female urinary bladder**. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Catheterizing the Female Urinary Bladder	3	2	1	0	Remarks
	Goal: The patient's urinary elimination is maintained, with a urine output of at least 30 mL/hour, and the patient's bladder is not distended					
	1. Review the patient's chart for any limitations in physical activity. Confirm the medical order for indwelling catheter insertion.					
	2. Gather equipment. Obtain assistance from another staff member, if necessary.					
	3. Perform hand hygiene and put on PPE, if indicated.					
	4. Identify the patient.					
	5. Close the curtains around the bed and close the door to the room, if possible. Discuss the procedure with the patient and assess the patient's ability to assist with the procedure. Ask the patient if she has any allergies, especially to latex or iodine.					
	6. Provide good lighting. Artificial light is recommended (use of a flashlight requires an assistant to hold and position it). Place a trash receptacle within easy reach.					
	7. Assemble equipment on overbed table or other surface within reach.					
	8. Adjust the bed to a comfortable working height, usually elbow height of the caregiver (VHACEOSH, 2016). Stand on the patient's right side if you are right-handed, patient's left side if you are left-handed.					
	9. Assist the patient to a dorsal recumbent position with knees flexed, feet about 2 ft apart, with her legs abducted. Drape the patient. Alternately, the Sims', or lateral, position can be used. Place the patient's buttocks near the edge of the bed with her shoulders at the opposite edge and her knees drawn toward her chest. Allow the patient to lie on either side, depending on which position is easiest for the nurse and best for the patient's comfort. Slide waterproof pad under the patient.					
	10. Put on clean gloves. Clean the perineal area with washcloth, skin cleanser, and warm water, using a different corner of the washcloth with each stroke. Wipe from above orifice downward toward sacrum (front to back). Rinse and dry. Remove gloves. Perform hand hygiene again.					
	11. Prepare urine drainage setup if a separate urine collection system is to be used. Secure to bed frame, according to the manufacturer's directions.					
	12. Open sterile catheterization tray on a clean overbed table using sterile technique.					
	13. Put on sterile gloves. Grasp upper corners of drape and unfold drape without touching nonsterile areas. Fold back a corner on each side to make a cuff over gloved hands. Ask the patient to lift her buttocks and slide sterile drape under her with gloves protected by cuff.					

	14. Based on facility policy, position the fenestrated sterile drape. Place a fenestrated sterile drape over the perineal area, exposing the labia.						
	15. Place sterile tray on drape between the patient's thighs.						
	16. Open all the supplies. Remove cap from the prefilled sterile saline syringe and attach to the balloon inflation port on the catheter. Open the package of antiseptic swabs. Alternately, fluff cotton balls in a tray before pouring antiseptic solution over them. Open specimen container if specimen is to be obtained.						
	17. Lubricate 1 to 2 in of catheter tip.						
	18. With thumb and one finger of nondominant hand, spread labia and identify meatus. ***Be prepared to maintain separation of labia with one hand until catheter is inserted and urine is flowing well and continuously.*** If the patient is in the side-lying position, lift the upper buttock and labia to expose the urinary meatus.						
	19. Use the dominant hand to pick up an antiseptic swab or use forceps to pick up a cotton ball. ***Clean one labial fold, top to bottom (from above the meatus down toward the rectum), then discard the cotton ball. Using a new cotton ball/swab for each stroke, continue to clean the other labial fold, then directly over the meatus.***						
	20. With your noncontaminated, dominant hand, place the drainage end of the catheter in a receptacle. If the catheter is preattached to sterile tubing and drainage container (closed drainage system), position the catheter and setup within easy reach on sterile field. Ensure that the clamp on the drainage bag is closed.						
	21. ***Using your dominant hand, hold the catheter 2 to 3 in from the tip and insert slowly into the urethra. Advance the catheter until there is a return of urine (approximately 2 to 3 in [4.8 to 7.2 cm]). Once urine drains, advance the catheter another 2 to 3 in (4.8 to 7.2 cm). Do not force the catheter through the urethra into the bladder.*** Ask the patient to breathe deeply, and rotate catheter gently if slight resistance is met as the catheter reaches the external sphincter.						
	22. Hold the catheter securely at the meatus with your nondominant hand. Use your dominant hand to inflate the catheter balloon. Inject the entire volume of sterile water supplied in a prefilled syringe. Remove the syringe from the port.						
	23. Pull gently on the catheter after the balloon is inflated to feel resistance.						
	24. Attach the catheter to the drainage system if not already preattached.						
	25. Remove equipment and dispose of it according to facility policy. Discard syringe in sharps container. Wash and dry the perineal area, as needed.						

	26. Remove gloves. ***Secure catheter tubing to the patient's inner thigh with a catheter-securing device.*** Leave some slack in catheter for leg movement.					
	27. Assist the patient to a comfortable position. Cover the patient with bed linens. Place the bed in the lowest position.					
	28. Secure the drainage bag below the level of the bladder. Check that drainage tubing is not kinked, and that movement of side rails does not interfere with the catheter or drainage bag.					
	29. Put on clean gloves. Obtain urine specimen immediately, if needed, from the drainage bag. Label specimen. Send urine specimen to the laboratory promptly or refrigerate it.					
	30. Remove gloves and additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

CATHETERIZING THE MALE URINARY BLADDER

Student name _____ **Section:** _____
Student ID _____ **Date** _____

PURPOSE: Relieve discomfort due to bladder distention or to provide gradual decompression of a distended bladder.
Assess the amount of residual urine if bladder empties incompletely.
Obtain sterile urine specimen
To empty the bladder completely prior to surgery.
Facilitate accurate measurement of urinary output for critically ill clients whose output needs to be monitored hourly.

INDICATION: Urinary retention (can't urinate on your own)
Urinary incontinence (leakage)
Pelvic organs prolapse.
Spinal injuries or trauma.
Lower body paralysis.
Multiple sclerosis (MS)
Parkinson's disease.
Benign prostatic hyperplasia (BPH)

EQUIPMENT:

• Sterile gloves • Sterile drapes (one is fenestrated) • Sterile catheter (use the smallest appropriate size catheter, usually a 14F to 16F catheter with 5 to 10 ml balloon (Newman, 2008). • Antiseptic cleansing solution and cotton balls or gauze squares; antiseptic swabs • Lubricant • Forceps • Velcro leg strap, catheter securing device, or tape • Disposable gloves • Additional PPE, as indicated	• Prefilled syringe with sterile water (sufficient to inflate indwelling catheter balloon) • Sterile basin (usually base of kit serves as this) • Sterile specimen container • Flashlight or lamp • Waterproof, disposable pad • Sterile, disposable urine collection bag and • drainage tubing (may be connected to • catheter in catheter kit) • Washcloth, skin cleanser, and warm water to perform perineal hygiene before and after catheterization

Directions: Below is a list of criteria to evaluate the student's skill student's skill in steps to follow **for the Male urinary bladder**. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Catheterizing the Male Urinary Bladder	3	2	1	0	Remarks
Goal: The patient's urinary elimination is maintained, with a urine output of at least 30 mL/hour, and the patient's bladder is not distended.					
1. Review chart for any limitations in physical activity. Confirm the medical order for indwelling catheter insertion.					
2. Gather equipment. Obtain assistance from another staff member, if necessary.					
3. Perform hand hygiene and put on PPE, if indicated.					
4. Identify the patient.					
5. Close the curtains around the bed and close the door to the room, if possible. Discuss the procedure with the patient and assess the patient's ability to assist with the procedure. Ask the patient if he has any allergies, especially to latex or iodine.					
6. Provide good lighting. Artificial light is recommended (use of a flashlight requires an assistant to hold and position it). Place a trash receptacle within easy reach.					
7. Assemble equipment on overbed table or other surface within reach.					
8. Adjust the bed to a comfortable working height, usually elbow height of the caregiver (VHACEOSH, 2016). Stand on the patient's right side if you are right-handed, patient's left side if you are left-handed.					
9. Position the patient on his back with thighs slightly apart. Drape the patient so that only the area around the penis is exposed. Slide waterproof pad under the patient.					
10. Put on clean gloves. Clean the genital area with washcloth, skin cleanser, and warm water. Clean the tip of the penis first, moving the washcloth in a circular motion from the meatus outward. Wash the shaft of the penis using downward strokes toward the pubic area. Rinse and dry. Remove gloves. Perform hand hygiene again.					
11. Prepare urine drainage setup if a separate urine collection system is to be used. Secure to bed frame according to the manufacturer's directions.					
12. Open sterile catheterization tray on a clean overbed table or other flat surface, using sterile technique.					
13. Put on sterile gloves. Open sterile drape and place on patient's thighs. Place fenestrated drape with opening over the penis.					
14. Place the catheter setup on or next to the patient's legs on sterile drape.					
15. Open all the supplies. Remove cap from the prefilled sterile saline syringe and attach to the balloon inflation port on the catheter. Open package of antiseptic swabs. Alternately, fluff cotton balls in a tray before pouring antiseptic solution over them. Open specimen container if specimen is to be obtained. Remove cap from syringe prefilled with lubricant.					
16. Place the drainage end of the catheter in a receptacle. If the catheter is preattached to sterile tubing and drainage container (closed drainage system), position catheter and setup within easy reach on sterile field. Ensure that the clamp on drainage bag is closed. Lubricate 1 to 2 in of catheter tip.					

17. Lift the penis with the nondominant hand. Retract the foreskin in an uncircumcised patient. ***Be prepared to keep this hand in this position until the catheter is inserted and urine is flowing well and continuously. Use the dominant hand to pick up an antiseptic swab or use forceps to pick up a cotton ball. Using a circular motion, clean the penis, moving from the meatus down the glans of the penis. Repeat this cleansing motion two more times, using a new cotton ball/swab each time. Discard each cotton ball/swab after one use.***					
18. Hold the penis with slight upward tension and perpendicular to the patient's body. Use the dominant hand to pick up the lubricant syringe. ***Gently insert the tip of the syringe with a lubricant into the urethra and instill the 10 mL of lubricant.***					
19. Use the dominant hand to pick up the catheter and hold it an inch or two from the tip. Ask the patient to bear down as if voiding. ***Insert the catheter tip into the meatus. Ask the patient to take deep breaths. Advance the catheter to the bifurcation or "Y" level of the ports. Do not use force to introduce the catheter.*** If the catheter resists entry, ask the patient to breathe deeply and rotate the catheter slightly.					
20. Hold the catheter securely at the meatus with your nondominant hand. Use your dominant hand to inflate the catheter balloon. ***Inject the entire volume of sterile water supplied in a prefilled syringe. Once the balloon is inflated, the catheter may be gently pulled back into place. Replace foreskin, if present, over the catheter.*** Lower the penis.					
21. Pull gently on the catheter after the balloon is inflated to feel resistance.					
22. Attach the catheter to drainage system, if necessary.					
23. Remove equipment and dispose of it according to facility policy. Discard syringe in sharps container. Wash and dry the perineal area, as needed.					
24. Remove gloves. Secure catheter tubing to the patient's inner thigh or lower abdomen (with the penis directed toward the patient's chest) with a catheter-securing device or tape. Leave some slack in the catheter for leg movement.					
25. Assist the patient to a comfortable position. Cover the patient with bed linens. Place the bed in the lowest position.					
26. Secure drainage bag below the level of the bladder. Check that drainage tubing is not kinked and that movement of side rails does not interfere with the catheter or drainage bag.					
27. Put on clean gloves. Obtain urine specimen immediately, if needed, from drainage bag. Label specimen. Send urine specimen to the laboratory promptly or refrigerate it.					
28. Remove gloves and additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

REMOVING AN INDWELLING URINARY CATHETER

Student name _____ Section: _____
Student ID _____ Date _____

EQUIPMENT:

- syringe sufficiently large to accommodate the volume of solution used to inflate the balloon.
- (Balloon size/inflation volume is printed on the balloon inflation valve on the catheter at the bifurcation)
- waterproof disposable pad
- disposable gloves
- additional PPE, as indicated.
- washcloth, skin cleanser, and warm water to perform perineal hygiene after catheter removal.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow **Removing indwelling urinary catheter.** Indicateyour evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

- *Raw Score (R) based on the student's performance:*
- **3 - Satisfactory** Satisfactory demonstration for required level in a consistent and efficient manner
- **2 - Borderline** Performs with minimal error or omission (1-2 mistakes)
- **1 - Unsatisfactory** Performs with numerous errors or omissions (3 and more mistakes)
- **0 - Poor** Procedure is not done

No	*Goal: The catheter is removed without difficulty and with minimal patient discomfort.*	*3*	*2*	*1*	*0*	*Remarks*
1	Confirm the order for catheter removal in the medical record. Gather equipment.					
2	Perform hand hygiene and put on PPE, if indicated.					
3	Identify the patient.					
4	Close the curtains around the bed and close the door to the room, if possible. Discuss withthe patient and assess the patient's ability to assist with the procedure.					
5	Adjust the bed to a comfortable working height, usually elbow height of the caregiver. Stand on the patient's right side if you are right-handed, patient's left side if you are left-handed.					
6	Position the patient as for catheter insertion. Drape the patient so that only the area around the catheter is exposed. Slide waterproof pad between the female's legs or over the male patient's thigh.					
7	Remove the leg strap, tape or other device used to secure the catheter to the patient's thighor abdomen.					
8	Insert the syringe into the balloon inflation port. Allow water to come back by gravity. Alternately, aspirate the entire amount of sterile water used to inflate the balloon. Refer tomanufacturer's instructions for deflation. DO NOT CUT THE INFLATION PORT.					
9	Ask the patient to take several slow deep breaths. Slowly and gently remove the catheter.Place it on the waterproof pad and wrap it in the pad.					
10	Wash and dry the perineal area, as needed.					
11	Remove gloves. Assist the patient to a comfortable position. Cover the patient with bedlinens. Place the bed in the lowest position.					
12	Put on clean gloves. Remove equipment and dispose of it according to facility policy.Note characteristics and amount of urine in drainage bag.					

13	Remove gloves and additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

SPECIMEN COLLECTION

Students name: ---------- **Section:** ----------
Student ID: ---------- *Date:* ----------

Purpose:

1. To determine the cause of an acute onset of illness.
2. To aid in diagnosis and treatment.
3. To determine the progress of a patient's condition.

Indication*:*

- It's used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease anddiabetes
- To make a presumptive or definitive diagnosis so that therapy can begin

Equipment:

- Toilet soap, water and towel.
- Adhesive tape.
- Specimen bottle.
- Completed lab form.
- Kidney basin or paper bag.
- Cotton ball.
- Bag specimen (plastic disposable urine collector).
- Stool specimen container
- Tongue blade

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **Obtaining a Specimen for Analysis.** Indicate yourevaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 – Poor Procedure is not done

Obtaining a Specimen for Urine Analysis	*3*	*2*	*1*	*0*	*Remarks*
1. Gather Equipment or supplies on the patients' bedside stand.					
2. Introduce yourself to the patient.					
3. Perform hand hygiene. Put the gloves and mask as necessary					
4. Verify the patient identity by using two patient identifiers (e.g., name and date of birth).					

5.	Explain the procedure to the patient					
6.	Ensure the patient's privacy and dignity.					
7.	If the patient allowed going to the bathroom, ask him /her to collect specimen there, by voiding directly into the specimen container. a. <u>For the Male patient:</u> After urinating for a few seconds, move the specimen container into the urinary stream and collect 120-150 cc. Fill the specimen container ¾ full and replace the cover. <u>b. For the female patient:</u> Cleanse the perineum with water before starting to urinate. After voiding a few seconds, move specimen container into the urinary stream and collect 120 to 150 cc. Fill the specimen container ¾ full and replace the cover.					
8.	If the patient is confined to bed, a. For male patient, give him a clean urinal for collecting specimen and have him notify you when it is ready. b. For female patient, cleanse the perineum with wash cloth, assist her to a clean bed pan from collecting specimen and have her notify you when it is ready					
9.	Label all specimens clearly and attach the proper laboratory slip, collected specimens should be transported inplastic bag (check institution policy)Use a sterile container or apply a urine collectiondevice					
10.	Clean and return used equipment and materials.					
11.	Preform hand hygiene.					
12.	Document procedure the procedure and unusual findings.					
Obtaining a stool specimen						
1.	Prepare the equipment's & instruments					
2.	Explain the procedure to the patient					
3.	Wash hands well & wear gloves to obtain specimen					
4.	Obtain stool specimen directly from the patient by ask him to put it in **Stool specimen container** (it should be not contaminated by urine), or use the tongue blade to receive the specimen from the collection device .					
5.	The specimen is labeled properly, and the laboratory slipis attached					
6.	Some specimens must be sent to the laboratory while theyare warm					
7.	Document procedure a. Charts the time, color, amount, and consistency ofthe stool. The purpose for which it was collected (e.g., blood, ova, parasites,					

	bacteria) & any relatedinformation					
	Obtaining throat culture					
	1. Prepare the equipment's • Throat swab • Tongue depressor • Media culture					
	2.Explain the procedure to the woman & describing thesensation to expect					
	3.Gather equipment					
	4.Wash hand, wears gloves					
	5.Have the patient stick out tongue and say "ah"					
	6.Depress anterior half of tongue with tongue depressor ifnecessary					
	7.Swab area with exudates or redness, one time only perswab (Avoid teeth, tongue, cheeks, lips & palate					
	8.Label, obtain requisition					
	9.Transport to laboratory					
	10. Document procedure, including description ofpharyngeal area if you can see it					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

HEALTH ASSESSMENT

NURSING

SKILL

CHECKLISTS

PERFORMING GENERAL SURVEY

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:

Performing General Survey

- Adequate lighting
- Tape measure
- A scale with height attachment; chair scale; or bed scale
- PPE, as indicated.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Performing General Survey*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety or discomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Performing General Survey						
1	Perform hand hygiene, put on PPE, if indicated.					
2	Identify the patient.					
3	Close the curtains, close the door. Discuss procedure with patient, assess patient'sability to assist with the procedure.					
4	Assess patient's overall appearance. A. Age B. Sex C. Level of Consciousness D. Skin Color E. Facial Features F. No signs of acute distress are present					
5	Assess patient's body structure. A. Stature B. Nutritional Status C. Symmetry D. Posture E. Position F. Physical Deformities					
6	Assess the patient's mobility. A. Gait B. Range of Motion C. Involuntary Movement					

7	Assess the patient's behavior. A. Facial Expression B. Mood and Affect						
8	Assess for pain.						
9	Weigh the patient using a scale.						
10	Measure patient's height.						
11	Calculate the patient's BMI Weight in kilograms = Height in meters^2						
12	Measure patient's waist circumference.						
13	Take Vital Signs						

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(39)**
Comments: _____

Student Signature: _____ Evaluator's Signature: _____

INTEGUMENTARY SYSTEM ASSESSMENT

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.

Ensure that you are maintaining a healthy diet and exercise routine

Equipment:

Assessing the Hair, Scalp and Nails •Bath blanket or other drape •Adequate light source •Gloves •Additional PPE, as indicated	Assessing the Head, Face, Neck and Throat •Stethoscope •Bath blanket or other drape •Lighting, including a penlight •Gloves •Additional PPE, as indicated •Tongue blades/depressor

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Integumentary System Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	*Goal: The assessment is completed without the patient experiencing anxiety or discomfort and the findings are documented.*	*3*	*2*	*1*	*0*	*Remarks*
Assessing the Hair, Skin, Scalp and Nails						
1	Ask patient to remove all clothing and put on an examination gown. Let patient remain in sitting position, but let patient stand or lie on the side when posterior part of body is examined. Expose only the body part being examined.					
2	Use bath blanket/drape to cover and expose area other than the one being assessed.Inspect overall skin coloration.					
3	Inspect skin for vascularity, bleeding, or ecchymosis.					
4	Inspect skin for lesions. Note size, shape, color, exudates, and distribution/pattern, and presence of drainage or odor. Assess location and condition of body piercings,tattoos.					
5	Palpate skin using backs of your hands to assess temperature. Wear gloves when palpating any open area of skin.					
6	Palpate for texture and moisture.					
7	Assess skin turgor by gently pinching the skin under the clavicle.					
8	Palpate for edema.					
9	Put on gloves. Palpate lesions if present.					

10	Inspect nail condition: shape, texture, and color; nail angle; clubbing					
11	Palpate nails for texture, capillary refill.					
12	Inspect hair and scalp: color, texture, and distribution. Wear gloves for palpation iflesions is suspected or if hygiene is poor.					
Assessing the Head, Face, Neck and Throat						
13	Inspect head for size and shape. Inspect face for color, symmetry, lesions, facial hairdistribution. Note facial expression. Palpate skull.					
14	Inspect external eye structures. Note color, edema, symmetry, and alignment.					
15	Examine pupils for equality of size and shape. Examine pupillary reaction to light.					
16	Test for pupillary accommodation.					
17	Assess extraoccular movements.					
18	Test convergence.					
19	Test patient's visual acuity with Snellen chart.					
20	Inspect both external ears for shape, size and lesions. Palpate ear and mastoid process.Inspect ear canal. Note cerumen, edema, discharge, foreign bodies.					
21	Use whispered voice to test hearing.					
22	Put on gloves. Inspect and palpate external nose.					
23	Palpate over frontal and maxillary sinuses.					
27	Occlude one nostril externally with a finger while patient breathes through the other;repeat for the other side.					
25	Inspect each anterior nares and turbinate. Examine mucous membranes for color andpresence of lesions, exudates, or growths.					
26	Inspect lips, oral mucosa, hard and soft palates, gingivae, teeth, and salivary gland openings. Ask patient to open mouth wide and use tongue blade and penlight to seestructures.					
27	Inspect tongue and uvula. Palpate tongue for muscle tone and tenderness. Removegloves.					
28	Inspect and palpate lymph nodes.					
29	Inspect and palpate left and then right carotid arteries.					
30	Inspect and palpate trachea.					
31	Assess thyroid gland. Observe lower portion of neck. Assess for symmetry andvisible masses. Ask patient to swallow and observe.					
32	Inspect ability of patient to move the neck.					
33	Assess gag reflex					
34	Inspect tonsils					
35	Inspect and palpate tongue					
36	Assess tongue strength					
37	Check taste sensation					
38	Remove gloves, perform hand hygiene					
39	Document					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(39)**

Comments: _____

Student Signature: _____ Evaluator's Signature: _____

RESPIRATORY ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:
Assessing the thorax and Lungs

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated
- Stethoscope

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Respiratory System Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Performing Assessment of Thorax and Lungs						
1	Perform hand hygiene, put on PPE, if indicated.					
2	Identify the patient.					
3	Close the curtains, close the door. Discuss procedure with patient, assess patient'sability to assist with the procedure.					
4	Use bath blanket/drape to cover and expose area other than the one being assessed.					
5	Inspect posterior thorax. Examine skin, bones, muscles of spine, shoulder blades, andback, symmetry of expansion and accessory muscle use during respiration.					
6	Assess antero-posterior (AP) and lateral diameters of thorax.					
7	Palpate over sine and posterior thorax. Palpate for temperature using dorsal surface ofhand. Palpate for tenderness, muscle development, and masses using palmar surface of hand.					
8	Assess thoracic expansion.					
9	Auscultate lungs across and down posterior thorax to bases of lungs in a sequentialpattern, comparing sides.					

10	Inspect anterior thorax. Inspect skin, bones, and muscles, as well as symmetry of lungexpansion and accessory muscle use.					
11	Palpate anterior thorax. Palpate for temperature, tenderness, muscle development, andmasses using palmar surface of hand.					
12	Auscultate lungs across and down anterior thorax to bases of lungs in a sequentialpattern, comparing sides.					
13	Wash hands. Document					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(39)**
Comments: _____

Student Signature: _____ Evaluator's Signature: _____

CARDIOVASCULAR ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine

Equipment:

- Assessing the Cardiovascular System
- Bath blanket or other drape
- Adequate light source
- Additional PPE, as indicated
- Examination gown
- Gloves
- Stethoscope

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Cardiovascular Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Performing Assessment of Cardiovascular System						
1	Perform hand hygiene, put on PPE, if indicated.					
2	Identify the patient.					
3	Close the curtains, close the door. Discuss procedure with patient, assess patient'sability to assist with the procedure.					
4	Use bath blanket/drape to cover and expose area other than the one being assessed.					
	Assessing the Cardiovascular System					
5	Inspect and palpate left and then right carotid arteries. Note strength of pulse and grade it as with peripheral pulses.					
6	Inspect neck for distention of jugular veins.					
7	Inspect precordium for contour, pulsations and heaves. Observe for apical impulse at 4th -5th ICS at left midclavicular line (MCL).					
8	Using palmar surface and four fingers held together, gently palpate precordium for pulsations.					

9	Assess the aortic, pulmonic, tricuspid, and mitral areas and Erb's point. Palpate apical impulse in mitral area. Note size, duration, force, and location in relation to MCL.					
10	Auscultate heart sounds. Focus in rate and rhythm of heart and normal heart sounds. Begin at aortic area, to pulmonic area, to Erb's point, to tricuspid area, and mitral area					
11	Wash hands Document					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(33)**
Comments: _____

Student Signature: _____ Evaluator's Signature: _____

BREAST and AXILLA ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:
Assessing the Breast and Axilla

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Breast and Axilla Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Assessing Breast and Axilla						
1	Check the patient's health record or nursing care plan for monitoring schedule.					
2	Gather equipment.					
3	Perform hand hygiene and put on PPE, if indicated.					
4	Identify the patient.					
5	Close the curtains around the bed and close the door to the room. Explain the purpose of the assessment and what you are going to do. Answer any questions.					
6	Inspect both breasts for size, shape, symmetry, color, texture, skin lesions. Inspect areola and nipples for size and shape and the nipples for discharge, crusting and inversion.					
7	Inspect for retractions and dimpling nipples: 1. Ask the client to raise her arms overhead; 3. Press her hands against her hips; 2. Ask her to press her hands together 4. Ask the client to					

	lean forward from the waist					
8	Palpate breast tissue and axilla					
9	Palpate axillae with patient's arms resting against side of body. If any nodes are palpable, assess location, size, shape, consistency, tenderness, and mobility.					
10	Assist patient into supine position with hand on patient's side being examined underthe head.					
11	Wear gloves if with nipple discharge or lesion. Palpate each quadrant of breast in a systematic method. Palpate nipple and areola, gently compress nipple between thumb and forefinger to assess for discharge.					
12	Teach patient self- breast examination					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(36)**
Comments: _____

Student Signature: _____ Evaluator's Signature: _____

GASTROINTESTINAL ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:

Assessing the Gastrointestinal System

- Bath blanket or other drape
- Adequate light source
- Additional PPE, as indicated
- Examination gown
- Gloves
- Stethoscope

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Gastrointestinal Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Assessing Abdomen						
1	Check the patient's health record or nursing care plan for monitoring schedule.					
2	Gather equipment.					
3	Perform hand hygiene and put on PPE, if indicated.					
4	Identify the patient.					
5	Close the curtains around the bed and close the door to the room. Explain the purpose of the assessment and what you are going to do. Answer any questions.					
6	Inspect abdomen for skin color, contour, pulsations, umbilicus, and other surfacecharacteristics (rashes, lesions, masses, etc.)					
7	Auscultate all four quadrants of the abdomen for bowel sounds. Listen for bowelsounds, their frequency and character.					
8	Auscultate abdomen for vascular sounds over abdominal aorta, femoral arteries, and iliac arteries for bruits.					
9	Palpate abdomen lightly in all four quadrants. Watch patient's face for nonverbal signs of pain during palpation. Palpate each quadrant in a systematic manner, noting muscular resistance, tenderness, enlargement of					

	organs, or masses.					
10	Palpate and then auscultate femoral pulses in groin. Not the strength of pulse andgrade it as with peripheral pulses.					
11	Assist patient to a comfortable position.					
12	Wash Hands Document					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(36)**
Comments: _____
Student Signature:_____ Evaluator's Signature: _____

FEMALE GENITALIA ASSESSMENT

Student name _____ **Section:** _____
Student ID _____ **Date** _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:

Assessing the Female Genitalia

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Female Genitalia Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	3	2	1	0	Remarks
Assessing Female Genitalia						
1	Check the patient's health record or nursing care plan for monitoring schedule.					
2	Gather equipment.					
3	Perform hand hygiene and put on PPE, if indicated.					
4	Identify the patient.					
5	Close the curtains around the bed and close the door to the room. Explain the purpose of the assessment and what you are going to do. Answer any questions.					
7	Inspect external genitalia for color, size of labia majora, vaginal opening, lesions and discharge.					
8	Palpate labia for masses.					
9	Assist patient to a comfortable position.					
10	Wash hands.Document					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(30)**

Comments: _____

Student Signature:_____ Evaluator's Signature: _____

MALE GENITAL ASSESSMENT

Student name _____ **Section:** _____
Student ID _____ **Date** _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:

Assessing the Male Genital

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Female Genitalia Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety ordiscomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
Assessing Male Genitalia						
1	Perform hand hygiene, put on PPE, if indicated.					
2	Identify the patient.					
3	Close the curtains, close the door. Discuss procedure with patient, assess patient'sability to assist with the procedure.					
4	Inspect external genitalia for size, placement, contour, appearance of skin, redness, edema and discharge.					
5	If patient is uncircumcised, retract foreskin for inspection of glans penis.					
6	Assess location of urinary meatus.					
7	Inspect scrotum for symmetry.					
8	Palpate scrotum for consistency, nodules, masses, and tenderness.					
9	Inspect inguinal area. Ask patient to bear down and note for bulging of area.					
10	Assist patient to a comfortable position.					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(30)**

Comments: _____

Student Signature:_____ Evaluator's Signature: __

MUSCULOSKELETAL ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:

Assessing Bones, Joints and Muscles

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Musculoskeletal Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

No.	Goal: The assessment is completed without the patient experiencing anxiety or discomfort and the findings are documented.	*3*	*2*	*1*	*0*	*Remarks*
1	Perform hand hygiene, put on PPE, if indicated.					
2	Identify the patient.					
3	Close the curtains, close the door. Discuss procedure with patient, assess patient'sability to assist with the procedure.					
Assessing Joints & Muscles						
4	Inspect size, shape, color, and symmetry. Note any masses, deformities, or muscle atrophy. Compare bilateral joint findings.					
5	Palpate for edema, heat, tenderness, pain, nodules, or crepitus. Compare bilateral joint findings.					
6	Test each joint's range of motion (ROM). Demonstrate how to move each joint through its normal ROM, then ask the client to actively move the joint through the same motions. Compare bilateral joint findings					

7	Test muscle strength by asking the client to move each extremity through its full ROM against resistance. Do this by applying some resistance against the part being moved.					
8	Observe the client's gait as the client enters and walks around the room.					
9	**Inspect and palpate the TMJ**. Have the client sit; put your index and middle fingers just anterior to the external ear opening					
10	Ask the client to open the mouth as widely as possible.					
11	Move the jaw from side to side. Protrude & retract jaw.					
12	**Cervical, Thoracic & Lumbar Spine** Observe the cervical, thoracic, and lumbar curves from the side, then from behind. Have the client standing erect with the gown positioned to allow an adequate view of the spine.					
13	Palpate the spinous processes and the paravertebral muscles on both sides of the spine for tenderness or pain.					
14	*Test ROM of the cervical spine* by asking the client to touch the chin to the chest (flexion) and to look up at the ceiling (hyperextension).					
15	*Test lateral bending*. Ask the client to touch each ear to the shoulder on that side					
16	*Evaluate rotation*. Ask the client to turn the head to the right and left. Ask the client to repeat the cervical ROM movements against resistance					
17	*Test ROM of the thoracic and lumbar spine*. Ask the client to bend forward and touch the toes. Observe for symmetry of the shoulders, scapula, and hips.					
18	Sit down behind the client, stabilize the client's pelvis with your hands, and ask the client to bend sideways (lateral bending), bend backward toward you (hyperextension), and twist the shoulders one way then the other (rotation)					
19	**Inspect and palpate shoulders and arms**. With the client standing or sitting, inspect anteriorly and posteriorly for symmetry, color, swelling, and masses. Palpate for tenderness, swelling, or heat.					
20	*Test ROM*. Ask client to stand with both arms straight down at the sides. Next, ask the client to move the arms forward (flexion), then backward with elbows straight					
21	Have the client bring both hands together overhead, elbows straight, followed by moving both hands in front of the body past the midline with elbows straight					
22	Have the client bring the hands together behind the head with elbows flexed and behind the back. Repeat these maneuvers against resistance.					
23	**Inspect for size, shape, deformities, redness, or swelling. Inspect elbows** in both flexed and extended positions					
24	With the elbow relaxed and flexed about 70 degrees, use your thumb and middle fingers to palpate the olecranon process and epicondyles.					
25	*Test ROM*. Ask the client to perform the following movements to test ROM, flexion, extension, pronation, and supination					
26	Flex the elbow and bring the hand to the forehead. Straighten the elbow. Then the hold arm out, turn the palm down, then turn the palm up. Repeat with resistance					

27	**Inspect wrist** size, shape, symmetry, color, and swelling. Then palpate for tenderness and nodules					
28	Palpate the anatomic snuffbox (the hollow area on the back of the wrist at the base of the fully extended thumb					
29	*Test ROM*. Ask the client to bend the wrist down and back. Have the client hold the wrist straight and move the hand outward and inward. Repeat these maneuvers against resistance.					
30	**Inspect size, shape, symmetry, swelling, and color**. Palpate the **fingers** from the distal end proximally, noting tenderness, swelling, bony prominences, nodules, or crepitus of each interphalangeal joint					
31	Assess the metacarpophalangeal joints by squeezing the hand from each side between your thumb and fingers. Palpate each metacarpal of the hand, noting tenderness and swelling.					
32	*Test ROM* Ask the client to: (A) spread the fingers apart (abduction), (B) make a fist (adduction), (C) bend the fingers down (flexion) and then up (hyperextension), (D) move the thumb away from other fingers, and then (E) touch the thumb to the base of the small finger. Repeat these maneuvers against resistance					
33	**Hips assessment.** With the client standing, inspect symmetry and shape of the hips. Observe for convex thoracic curve and concave lumbar curve. Palpate for stability, tenderness, and crepitus					
34	With the client supine, ask the client to: 1. Raise extended leg 2. Flex knee up to chest while keeping other leg extended 3. Move extended leg away from midline of body as far as possible and then toward midline of body as far as possible. 4. Bend knee and turn leg inward (rotation) and then outward (rotation). 5. Ask the client to lie prone and lift extended leg off table. 6. Alternatively, ask the client to stand and swing extended leg backward. Repeat these maneuvers against resistance.					
35	**Knee Assessment** With the client supine then sitting with **knees** dangling, inspect for size, shape, symmetry, swelling, deformities, and alignment. Observe for quadriceps muscle atrophy					
37	Palpate for tenderness, warmth, consistency, and nodules. Begin palpation 10 cm above the patella, using your fingers and thumb to move downward toward the knee					
38	*Test ROM* Ask the client to: 1. Bend each knee up (flexion) toward buttocks or back. 2. Straighten the knee (extension/hyperextension). 3. Walk normally. Repeat these maneuvers against resistance.					
39	**Ankle and Feet Assessment.** With the client sitting, standing, and walking, inspect position, alignment, shape, and skin					

40	Palpate ankles and feet for tenderness, heat, swelling, or nodules. Palpate the toes from the distal end proximally, noting tenderness, swelling, bony prominences, nodules, or crepitus of each interphalangeal joint					
41	Assess the metatarsophalangeal joints by squeezing the foot from each side with your thumb and fingers					
	Test ROM Ask the client to: 1. Point toes upward and then downward 2. Turn soles outward and then inward 3. Rotate foot outward and then inward 4. Turn toes under foot and then upward Repeat these maneuvers against resistance.					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(123)**

Comments: _____

Student Signature:_____ Evaluator's Signature: _____

Reference: Lynn, Pamela (2019). Taylor's Clinical Nursing Skills, A Nursing Process Approach. Wolters Kluwer, USA.

NEUROLOGICAL ASSESSMENT

Student name _____ Section: _____
Student ID _____ Date _____

Purpose: The assessment is completed without the patient experiencing anxiety or discomfort, an overall impression of the patientis formulated, the findings are documented, and the appropriate referral is made to other professionals, as needed for further evaluation

Indications: - Check for possible diseases so they can be treated early.
- Identify any issues that may become medical concerns in the future.
- Ensure that you are maintaining a healthy diet and exercise routine.

Equipment:
Assessing Cranial Nerves

- Bath blanket or other drape
- Examination gown
- Adequate light source
- Gloves
- Additional PPE, as indicated
- CN 1 – Odorous materials such as coffee, chocolate, alcohol, etc
- CN 2, 3 and 4 – Penlight, Snellen chart, Pupil size assessment chart
- CN 5 - Cotton balls/ cotton tip applicators
- CN 8 – Tuning fork
- CN 9 and 10 – Tongue depressor

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Cranial Nerve Assessment*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in Neurologic Examination (Cranial Nerve Assessment)	***3***	***2***	***1***	***0***	***Remarks***
1	Check the patient's health record or nursing care plan formonitoring schedule.					
2	Gather equipment.					
3	Perform hand hygiene and put on PPE, if indicated.					
4	Identify the patient.					

	5	Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the CN examination and whatyou are going to do. Answer any questions.					
	6	Help the patient undress, if needed, and provide a patient gown.Assist the patient to a supine position, if possible. Use the bath blanket to cover any exposed area other than the one being assessed.					
		Assess Cranial Nerves.					
	7	**CN I – Olfactory** • Ask the patient to close eyes, occlude one nostril, and then identify the smell of different substance, such as coffee, chocolate, or alcohol. Repeat with other nostril.					
	8	**CN II – Optic** • Test patient's visual acuity using the Snellen's Chart					
		• Position patient 20 ft (6 meters) from the chart					
		• Test one eye at a time. (Ask patient to close one eye while reading)					
	9	**CN III – Oculomotor; CN IV – Trochlear; CN VI – Abducens** • Extra ocular movements (EOM)/ six cardinal directions of gaze/wagon wheel method					
		• The client must keep the head still while following a pen that you will move in several directions to form a star in front of the client's eyes.					
		• Always return the pen to the center before changing direction.					
		• An object or pencil held about 10 cm from the client's nose, observe the convergence of the eyes and pupillary reaction.					
		• Check for pupillary light reflex, PERRLA					
	10	**CN V- Trigeminal** • Palpate jaw muscles					
		• Ask client to close his eyes and test forehead, each cheek, and jaw on each side for sharp or dull (use a cotton swab) sensation.					
		• With the individual's eyes open and looking upward, take a strand of cotton, approaches the cornea from the side, and touches it with the cotton.					
	11	**CN VII – Facial** • Ask the client to close both eyes and keep them closed. Try to open them by retracting the upper and lower lids simultaneously and bilaterally.					
		• Ask patient to raise eyebrows, show teeth, grimace, smile, puff both cheeks					
	12	**CN VIII – Acoustic** • **Weber Test-** A vibrating tuning fork is placed on the patient's forehead or the top of the head. Ask if the tone is louder in the left ear, the right ear or equally loud in both ears.					

		• **Rinne's Test.** Using a vibrating tuning fork, place the base of the tuning fork on the client's mastoid process. Ask patient to tell you when the sound is no longer heard.					
		• Immediately move the fork in front of the external auditory meatus (1-2 cm). Ask the patient to tell you when the sound is no longer heard.					
		• **Romberg's Test**. Patient should stand with feet together on level ground, arms at their sides, and eyes open.					
		• Stand facing the patient with their arms out, without touching them, to catch the patient if they fall					
		• Ask the patient to close both eyes for 30 seconds. Note the patient's ability to maintain an upright posture					
	13	**CN IX- Glossopharyngeal; CN X – Vagus** • Put on gloves					
		• Ask the client to open the mouth, depress the client's tongue with the tongue blade, ask the client to say "ah", observe upward movement of the soft palate.					
		• Test the gag reflex by touching the posterior pharynx with the tongue depressor. Explain to patient that this may be uncomfortable. Ask the patient to swallow.					
		• Remove the gloves					
	14	**CN XI – Spinal Accessory** • Have the client shrug the shoulders while you resist with your hands					
		• Ask the client to try to touch the right ear to the right shoulder without raising the shoulder. Repeat with the left shoulder					
	15	**CN XII – Hypoglossal** • Ask patient to protrude tongue and move it side to side. Assess for symmetry, atrophy					
	16	Remove PPE, if used. Perform hand hygiene					

Total Points: Actual Score X Marks = ___ X Mark (__) = Final Mark_____
Possible Score **(30)**

Comments: _____

Student Signature:_____ Evaluator's Signature: _____

ADULT

HEALTH

NURSING 1

SKILL

CHECKLIST

APPLYING STERILE GOWN AND GLOVES VIA CLOSED METHOD

Students name: ---------- **Section** ----------
Student ID: ---------- **Date** ----------

Purpose: -To understand the importance and principle of surgical hand antisepsis
- To understand the principle of surgical gown and glove techniques
-To reinforce techniques of donning sterile and gloves gowns and gloves

Indications: To standardize the procedure for surgical hand antisepsis, gowning and gloving.
To reduce and inhibit growth of bacteria under the surgical gloved hand for the duration of the procedure.

Equipment:

- Deep sink with foot or knee controls for dispensing water and soap
- Antimicrobial agent approved by agency
- Surgical scrub brush with plastic nail file
- Package of proper sterile gloves
- Sterile pack containing sterile gown
- Clean, flat dry surface (table or Mayo Stand) on which to open gown and gloves
- Proper face mask, cap or surgical shoe covers
- Proactive eyewear

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for applying sterile gown and gloves via closed method. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following
descriptive scale of 0-3.
Raw Score (R) based on the student's performance:
*3 - **Satisfactory** Demonstrates required level in a consistent and efficient manner*
*2 - **Borderline** Performs with minimal error or omission (1-2 mistakes)*
*1 - **Unsatisfactory** Performs with numerous errors or omissions (3 and more mistakes)*
*0 - **Poor** Procedure is not done*

APPLYING STERILE GOWN and GLOVES VIA CLOSED METHOD	*3*	*2*	*1*	*0*	*Remar*
1. The sterile gown is folded inside out.					
2. With one hand, pick up the entire folded gown from the wrapper by grasping the gown through all layers, being careful to touch only the inside top layer which is exposed.					
3. Grasp the gown inside the neckline, step back, and allow the gown to open in front of you;					
4. Keep the inside of the gown toward you. Make sure the gown does not touch any surrounding unsterile objects					
5. Grasp the inside shoulder seams and open the gown with the armholes facing you.					
6. Carefully insert your arms part way into the gown one at a time, keeping hands at shoulder level away from the body.					

7. Slide the arms further into the gown sleeves and when the fingertips are level with the proximal edge of the cuff, grasp the inside seam at the cuff hem using thumb and index finger. Be careful that no part of the hand protrudes from the sleeve cuff.						
8. A theatre assistant will fasten the gown behind you, positioning it over the shoulders by grasping the inside surface of the gown at the shoulder seam. The theatre assistant's hands should only ever be in contact with the inside surface of the gown.						
9. With hands still inside the gown sleeves, open the inner wrapper of the gloves on the sterile gown field.						
10. With nondominant sleeved hand, grasp the cuff of the glove for the dominant hand and lay it on the extended dominant forearm; with palm up, place the palm of the glove against the sleeved palm, with fingers of the glove pointing toward elbow.						
11. Manipulate the glove so the sleeved thumb of dominant hand is grasping the cuff; with nondominant hand, turn the cuff over the end of dominant hand and gown's cuff.						
12. With sleeved nondominant hand, grasp the cuff of the glove and the gown's sleeve of the dominant hand; slowly extend the fingers into the glove, making sure the cuff of the glove remains above the cuff of the gown's sleeve						
13. With the gloved dominant hand, repeat Actions 8 and 9.						
14. Interlock gloved fingers; secure fit.						
Total Score						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

INITIATING A PERIPHERAL VENOUS ACCESS IV INFUSION

Student name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose: IV infusion are primarily used for therapeutic purposes such as administration of medications, fluids and/or blood products as well as blood sampling.

Indications

- Provide fluid and electrolyte maintenance, restoration, and replacement
- Administer medication and nutritional feedings
- Administer blood and blood products
- Administer chemotherapy to cancer patients
- Administer patient-controlled analgesics
- Keep a vein open for quick access

Equipment:

- IV Strat Kit (if available)- contains sterile tourniquet sterile tape, sterile drape, antiseptic preps
- a tourniquet to help the healthcare professional identify a suitable vein
- local anesthetic to numb the injection site
- a needle for the initial injection
- a catheter tube to keep the vein open
- an access cap that the healthcare professional can open when administering medications and close when not in use
- a syringe for administering the medication into the catheter
- IV bags and lines for delivering infusions
- gauze, bandage, and medical tape to help protect the injection site

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Initiating an IV Infusion**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Initiating a Peripheral Venous Access IV Infusion	*3*	*2*	*1*	*0*	*Remarks*
Goal: The access device is inserted on the first attempt, using sterile technique.					
1. Verify the IV solution order on the eMAR/MAR with the medical order. Consider the appropriateness of the prescribed therapy in relation to the patient. Clarify any inconsistencies. Check the patient's chart for allergies. Check solution for color, leaking, and expiration date. Know techniques for IV insertion, precautions, and purpose of the IV solution administration, if ordered. Gather necessary supplies.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					

4.	Assemble equipment to the bedside stand or overbed table or other surface within reach.					
5.	Close the curtains around the bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient. Ask the patient about allergies to medications, tape, or skin antiseptics, as appropriate. If considering using a local anesthetic, inquire about allergies for these substances as well.					
6.	If using a local anesthetic, explain the rationale and procedure to the patient. Apply the anesthetic to a few potential insertion sites. Allow sufficient time for the anesthetic to take effect.					
7.	Compare the IV container label with the eMAR/MAR. Remove IV bag from outer wrapper, if indicated. Check expiration dates. Scan bar code on container, if necessary. Compare patient identification band with the eMAR/MAR. Alternately, label the solution container with the patient's name, solution type, additives, date, and time. Complete a time strip for the infusion and apply to IV container.					
8.	Maintain aseptic technique when opening sterile packages and IV solution. Remove administration set from the package. Apply label to the tubing reflecting the day/date for next set change, per facility guidelines.					
9.	Close the roller clamp or slide the clamp on the IV administration set. Invert the IV solution container and remove the cap on the entry site, taking care not to touch the exposed entry site. Remove the cap from the spike on the administration set. Using a twisting and pushing motion, insert the administration set spike into the entry site of the IV container. Alternately, follow the manufacturer's directions for insertion.					
10.	Hang the IV container on the IV pole. Squeeze the drip chamber and fill at least halfway.					
11.	Open the IV tubing clamp and allow fluid to move through the tubing. Follow the additional manufacturer's instructions for specific electronic infusion pump, as indicated. Allow fluid to flow until all air bubbles have disappeared and the entire length of the tubing is primed (filled) with IV solution. Close the clamp. Alternately, some brands of tubing may require removal of the cap at the end of the IV tubing to allow fluid to flow. Maintain its sterility. After fluid has filled the tubing, recap the end of the tubing.					
12.	If an electronic device is to be used, follow the manufacturer's instructions for inserting the tubing into the device.					
13.	Place the patient in low-Fowler's position in bed. Place a protective towel or pad under the patient's arm.					
14.	Provide emotional support, as needed.					

15. Open the short extension tubing package. Attach the needleless connector or end cap, if not in place. Clean the needleless connector or end cap with alcohol wipe. Insert a syringe with normal saline into the extension tubing. Fill the extension tubing with normal saline and place the extension tubing and syringe back on the package, within easy reach.					
16.Select and palpate for an appropriate vein. Refer to the guidelines in the previous Assessment section. If the intended insertion site is visibly soiled, clean the area with soap and water.					
17. If the site is hairy and facility policy permits, clip a 2-in area around the intended entry site.					
18. Put on gloves.					
19. Apply a tourniquet 3 to 4 in above the venipuncture site to obstruct venous blood flow and distend the vein. Direct the ends of the tourniquet away from the entry site. Make sure the radial pulse is still present					
20. Instruct the patient to hold the arm lower than the heart.					
21. Ask the patient to open and close the fist. Observe and palpate for a suitable vein. Try the following techniques if a vein cannot be felt:					
a. Lightly stroke the vein downward.					
b. Remove tourniquet and place warm, dry compresses over intended vein for 10 to 15 minutes.					
22. ***Cleanse the site with >5% chlorhexidine, or according to facility policy. Press the applicator against the skin and apply chlorhexidine using a gentle back and forth motion. Do not wipe or blot. Allow to dry completely for at least 30 seconds (INS, 2016a).***					
23. Using the nondominant hand placed about 1 or 2 in below the entry site, hold the skin taut against the vein. ***Avoid touching the prepared site.*** Ask the patient to remain still while performing the venipuncture.					
24. Align the IV catheter on top of the vein; enter the skin gently, holding the catheter by the hub in your dominant hand, bevel side up, at a 10- to 15-degree angle. Insert the catheter from directly over the vein or from the side of the vein. While following the course of the vein, advance the needle or catheter into the vein. A sensation of "give" can be felt when the needle enters the vein.					
25. Continue to hold the skin taut. When blood returns through the catheter and/or the flashback chamber of the catheter, use the push-off tab to separate the catheter from the needle stylet and advance the catheter into the vein until the hub is at the venipuncture site. The exact technique depends on the type of device used.					

26. Release the tourniquet. Activate the safety mechanism on the needle stylet. Compress the skin well above the catheter tip to stop the flow of blood. Quickly remove the protective cap from the extension tubing and attach it to the catheter hub and tighten the Luer lock. Stabilize the catheter or needle with your nondominant hand.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Administrating Oxygen Therapy

Students name: ---------- **Section:** ----------
Students ID: ---------- **Date:** ----------

Purpose: to the administration of supplemental oxygen as part of managing breathing disorders**.**

Indications

- chronic obstructive pulmonary disease (COPD)
- pneumonia
- asthma
- heart failure
- cystic fibrosis
- sleep apnea
- lung disease
- trauma to the respiratory system.

Equipment:

- Pulse oximeter to obtain a patient's oxygen saturation level
- Oxygen Flow Meter. ...
- Oxygen source
- Delivery device ordered by physician
- Sterile water for humidifier

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Applying oxygen therapy.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Administering Oxygen by Mask **Goal:** The patient exhibits an oxygen saturation level withinacceptable parameters	**3**	**2**	**1**	**0**	**Remarks**
1	Review the medical order to verify the use of the mask, flow rate/concentration, and administration parameters. Gather equipment.					
2	Perform hand hygiene and put on PPE, if indicated.					
3	Identify the patient.					
4	Assemble equipment on the overbed table or other surfacewithin reach.					

5	Close the curtains around the bed and close the door tothe room, if possible.					
6	Explain what you are going to do and the reason for doingit to the patient. Review safety precautions necessary when oxygen is in use.					
7	Attach the face mask to the oxygen source (with humidification, if appropriate, for the specific mask). Start the flow of oxygen at the specified rate. For a mask with a reservoir, be sure to allow oxygen to fill the bag before proceeding to the next step.					
8	Position face mask over the patient's nose and mouth. ***Adjust the elastic strap so that the mask fts snugly butcomfortably on the face.*** Adjust to the prescribed flow rate.					
9	If the patient reports irritation or you note redness, use gauze pads under the elastic strap at pressure points to reduce irritation to ears and scalp.					
10	Reassess the patient's respiratory status, including respiratory rate, effort, and lung sounds. Note any signsof respiratory distress, such as tachypnea, nasal flaring, use of accessory muscles, or dyspnea.					
11	Remove PPE, if used. Perform hand hygiene.					
12	***Remove the mask and dry the skin every 2 to 3 hours ifthe oxygen is running continuously. Do not use powderaround the mask.***					
Administering Oxygen by Nasal Cannula						
Goal: The patient exhibits an oxygen saturation level withinacceptable parameters.						
1	Review the medical order to verify the use of the nasal cannula, flow rate, and administration parameters. Gather equipment					
2	Perform hand hygiene and put on PPE, if indicated					
3	Identify the patient					
4	Assemble equipment on the overbed table or other surfacewithin reach.					
5	Close the curtains around the bed and close the door tothe room, if possible.					
6	Explain what you are going to do and the reason for doingit to the patient. Review safety precautions necessary when oxygen is in use.					
7	Connect the nasal cannula to the oxygen source, with humidification, if appropriate. Adjust the flow rate as ordered. Check that oxygen is flowing out of prongs					
8	Place prongs in the patient's nostrils. Place tubing over and behind each ear with adjuster comfortably under chin. Alternatively, the tubing may be placed around the patient'shead, with the adjuster at the back or base of the head. Place gauze pads at ear beneath the tubing or commercially available ear pads, as necessary.					
9	Adjust the fit of the cannula, as necessary. Tubing shouldbe snug but not tight against the skin.					
10	***Encourage patients to breathe through the nose, with themouth closed.***					
11	Reassess the patient's respiratory status, including the respiratory rate, effort, and lung sounds. Note any signsof respiratory distress, such as tachypnea,					

	nasal flaring, use of accessory muscles, or dyspnea.					
12	Remove PPE, if used. Perform hand hygiene.					
13	Put on clean gloves. Remove and clean the cannula and assess nares at least every 8 hours, or according to facilityrecommendations. Check nares for evidence of irritation or bleeding.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

OBTAINING AN ELECTROCARDIOGRAM (ECG)

Students name: ---------- **Section:** ----------
Students ID: ---------- **Date:** ----------

Purpose: to detect various heart problems in a patient. The procedure helps the doctor to diagnose the heart related problems at an early stage.

Indication:

- Chest pain
- Shortness of breath
- Dizziness
- Fatigue
- Very fast heartbeat

Equipment:

1. ECG machine
2. Electrode paste (gel)
3. ECG leads or electrodes
4. Alcohol wipes
5. Razor

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **obtaining an ECG.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS	3	2	1	0	Remarks
1. Review the patient's medical record about the patient's need for ECG. Verify the order for an ECG on the patient's medical record.					
2. Ask the patient about allergies to adhesive.					
3. Keep patient away from objects that might cause electrical interference (equipment, fixtures, power cords).					
4. Inspect the patient's chest for areas of irritation, breakdown, or excessive hair that might interfere with electrode placement.					

5. Gather all equipment and bring to bedside. ☐ ECG machine ☐ Recording paper/tracing paper, ☐ Disposable pre-jelled electrodes, ☐ Adhesive remover swabs, ☐ 4x4 gauze pads ☐ Gloves ☐ personal protective equipment as necessary					
6. Perform hand hygiene and put on PPE, if indicated.					
7. Identify the patient.					
8. Close curtains around bed and close the door to the room.					
9. Explain the procedure to the patient. ☐ It records the heart's electrical activity, and it may be repeated at certain intervals. ☐ *Emphasize that no electrical current will enter his or her body*. ☐ Tell the patient the test typically takes about 5 minutes.					
10. Place the ECG machine close to the patient's bed and plug the power cord into the wall outlet.					
11. Raise the bed to a comfortable working height, usually elbow height of the caregiver.					
12. Have the patient lie supine in the center of the bed with the arms at the sides.					
13. *Raise the head of the bed if necessary to promote comfort.* Expose the patient's arms and legs, and drape appropriately.					
14. Encourage the patient to relax the arms and legs. Make sure the feet do not touch the bed's footboard.					
15. Select flat, fleshy areas on which to place the electrodes. Avoid muscular and bony areas. If the patient has an amputated limb, choose a site on the stump.					
16. If an area is excessively hairy, clip the hair. **Do not shave hair.** Clean excess oil or other substances from the skin with soap and water and dry it completely.					
17. Apply the limb lead electrode- RA lead. *					
18. Apply the limb lead electrode- LA lead. *					
19. Apply the limb lead electrode- RL lead. *					
20. Apply the limb lead electrode- LL lead. *					
21. Connect the limb lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright.					
22. Expose the patient's chest. *					
a) Apply the precordial lead electrode –V1*					
b) Apply the precordial lead electrode–V2*					
c) Apply the precordial lead electrode–V3*					
d) Apply the precordial lead electrode–V4*					

e) Apply the precordial lead electrode–V5*					
f) Apply the precordial lead electrode–V6*					
23. Connect the precordial lead wires to the electrodes.					
24. Ask the patient to relax and breathe normally. Instruct the patient to lie still and not to talk while you record the ECG.					
25. Press the AUTO button. Observe the tracing quality.					
26. Remove the electrodes and clean the patient's skin.					
27. Return the patient to a comfortable position. Lower bed height and adjust the head of bed to a comfortable position.					
28. Label the ECG with the patient's name, date of birth, location, date and time of recording, and other relevant information, such as symptoms that occurred during the recording.					
29. Remove additional PPE, if used. Perform hand hygiene.					
30. Document the date and time that the ECG was obtained, and the patient's response to the procedure.					
31. Refer significant assessment findings.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

INTAKE AND OUTPUT MONITORING

Students name: ---------- **Section:** ----------
Students ID: ---------- **Date:** ----------

Purposes & Indication

- Ensures accurate record keeping of intake and output.
- Prevents circulatory overload and or dehydration.
- Contributes to accurate assessment record.
- Helps to determine kidney function as to adequate urine output.
- Helps in analyzing fluid status that would affect fluid and electrolytes balance.

Equipment

- Clean gloves
- Bedpan
- Urinal
- Calibrated Measuring Container
- Pen and paper

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **intake and output monitoring.**
Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	STEPS	3	2	1	0	Remarks
1	Check patient chart: (I and O Monitoring Sheet).					
2	Explain the procedure and purposes to the patient.					
3	Wash hands and wear clean gloves.					
4	a. Using the measuring container, measure accurately the volume of voided urine collected in the catheter bag, urinal, bedpan; and include liquid stool, vomitus and other body discharges. b. Using diaper, weigh diaper in the weighing scale. 1 gm is to 1 ml.					
5	Record the data immediately, using pen and paper.					
6	Discard body fluids per hospital protocol. Wash the equipment used and return to its proper place.					

7	Remove soiled gloves and dispose of them in the proper garbage container. Wash hands.					
8	Check the volume remaining in the current infusing IV fluids. And subtract the amount of fluid consumed.					
9	Record the total amount of all fluid intake and output volumes on the I/O monitoring sheet.					
10	Compare the data to determine **Positive** or **Negative** balance.					
11	Report significant findings to the attending physician.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____ Marks

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

EMPTYING AND CHANGING AN OSTOMY APPLIANCE

Students name: ---------- **Section:** ----------
Students ID: ---------- **Date:** ----------

Purpose: -It allows for drainage or evacuation of colon contents to the outside of the body.
Indication:

- Tumors of the colon.
- Trauma to perforation of the colon.
- Inflammatory diseases of the colon as ulcerative colitis.
- Congenital anomalies of G.I.T such as, Hirsh sprung, necrotizing enter colitis imperforate anus.

Equipment's:

- Pouch.
- Clamp or pouch valve.
- Clean gloves.
- Gauze pads or washcloth.
- Towel or disposable waterproof barrier.
- Basin with warm tap water.
- Scissors.
- Skin barrier such as sealant wipes or wafer.
- Stethoscope.
- Measuring an ostomy

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Emptying and Changing an Ostomy Appliance.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps	3	2	1	0	Remarks
Goal: The stoma appliance is applied correctly to the skin to allow stool to drain freely.					
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Close the curtains around the bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient. Encourage the patient to observe or participate, if possible.					
5. Assemble equipment on overbed table or other surface within reach.					
6. Assist the patient to a comfortable sitting or lying position in bed or a standing or sitting position in the bathroom. If the patient is in bed, adjust					

the bed to a comfortable working height, usually elbow height of the caregiver (VHACEOSH, 2016). Place waterproof pad under the patient at the stoma site.					
Emptying an Appliance					
7. Put on gloves. Remove clamp and fold end of appliance or pouch upward like a cuff.					
8. Empty contents into bedpan, toilet, or measuring device.					
9. Wipe the lower 2 in of the appliance or pouch with toilet tissue or paper towel.					
10. Uncuff edge of appliance or pouch and apply clip or clamp, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body. Remove gloves. Assist the patient to a comfortable position.					
11. If appliance is not to be changed, place bed in lowest position. Remove additional PPE, if used. Perform hand hygiene.					
Changing an Appliance					
12. Place a disposable pad on the work surface. Open the premoistened disposable washcloths or set up the washbasin with warm water and the rest of the supplies. Place a trash bag within reach.					
13. Put on clean gloves. Place waterproof pad under the patient at the stoma site. Empty the appliance as described in Steps 7–10.					
14. Put on gloves. Start at the top of the appliance and keep the abdominal skin taut. Gently remove pouch faceplate from skin by pushing skin from the appliance rather than pulling the appliance from skin. Apply a silicone-based adhesive remover by spraying or wiping with the remover wipe.					
15. Place the appliance in the trash bag, if disposable. If reusable, set aside to wash in lukewarm soap and water and allow to air dry after the new appliance is in place.					
16. Use toilet tissue to remove any excess stool from the stoma. Cover the stoma with gauze pad. Clean the skin around the stoma with skin cleanser and water or a cleansing agent and a washcloth. Remove all old adhesive from the skin; use an adhesive remover, as necessary. Do not apply lotion to the peristomal area.					
17. Gently pat area dry. ***Make sure the skin around the stoma is thoroughly dry.*** Assess the stoma and the condition of the surrounding skin.					
18. Apply skin protectant to a 2-in (5 cm) radius around the stoma, and allow it to dry completely, which takes about 30 seconds.					
19. Lift the gauze squares for a moment and measure the stoma opening, using the measurement guide. Replace the gauze. Trace the same size opening on the back center of the appliance. Cut the opening 1/8 in larger than the stoma size. Using a finger, gently smooth the wafer edges after cutting.					

20. Remove the paper backing from the appliance faceplate. Quickly remove the gauze squares and ease the appliance over the stoma. Gently press onto the skin while smoothing over the surface. Apply gentle, even pressure to the appliance for approximately 30 seconds.					
21. Close the bottom of the appliance or pouch by folding the end upward and using the clamp or clip that comes with the product or secure the Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body.					
22. Remove gloves. Assist the patient to a comfortable position. Cover the patient with bed linens. Place the bed in the lowest position.					
23. Put on clean gloves. Remove or discard equipment and assess the patient's response to the procedure.					
24. Remove gloves and additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

ADULT HEALTH II

NURSING

SKILL

CHECKLISTS

OBTAINING A CAPILLARY BLOOD SPECIMEN AND MEASURING BLOOD GLUCOSE

Name of Student: _____ Section: _____
Student ID _____ Date: _____

Purpose:
Blood glucose monitoring is performed by patients with diabetes mellitus daily to monitor their glucose levels. It is performe routinely on diabetic patients in hospital and also in all unconscious/collapsed patients that are brought into A&E to ensure th patient is not having a hypo or hyperglycemic episode.

Indications: Controlling blood glucose levels is an important part of care for patients with the following conditions:

- Diabetes
- Alcohol and drug intoxication
- Stroke
- Seizure
- Patients who taking corticosteroids
- Sepsis
- Liver disease
- Enteral and parenteral feeding
- Head injury
- Pancreatitis

Equipment's:

Glucometer
Lancing Device
Gloves
Alcohol wipes
Glucose monitoring test strips
Cotton wool

Directions: Below is a list of criteria to evaluate the student's skill in *Obtaining a Capillary Blood Specimen and Measurin Blood Glucose.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the followin descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps in **obtaining a capillary blood specimen and measuring blood glucose**	**3**	**2**	**1**	**0**	**Remarks**
Goal: Patient blood glucose levels are accurately monitored.					
1. Check the patient's health record or nursing care plan for monitoring schedule. You may decide that additional testing is indicated based on nursing judgment and the patient's condition.					
2. Gather equipment. Check expiration date on blood test strips.					

3. Perform hand hygiene and put on PPE, if indicated.					
4. Identify the patient. Explain the procedure to the patient and instruct the patient about the need for monitoring blood glucose.					
5. Close curtains around the bed and close the door to the room, if possible.					
6. Turn on the monitor.					
7. Enter the patient's identification number or scan his or her identification bracelet, if required, according to facility policy.					
8. Put on nonsterile gloves.					
9. Prepare lancet using aseptic technique.					
10. Remove test strip from the vial. ***Recap containter immediately.*** Test strips also come individually wrapped. ***Check that the code number for the strip matches the code number on the monitor screen.***					
11. Insert the strip into the meter according to directions for that specific device. Alternately, strip may be placed in meter after collection of sample on test strip, depending on meter in use.					
12. ***Have the patient wash hands with skin cleanser and warm water and dry thoroughly. Alternately, cleanse the skin with an alcohol swab. Allow skin to dry completely.***					
13. Choose a skin site that is intact, warm, and free of calluses and edema (Van Leeuwen & Bladh, 2017).					
14. Hold lancet perpendicular to skin and pierce skin with lancet.					
15. Encourage bleeding by lowering the hand, making use of gravity. Lightly stroke the finger, if necessary, until a sufficient amount of blood has formed to cover the sample area on the strip, based on monitor requirements (check instructions for monitor). Take care not to squeeze the finger, not to squeeze at puncture site, or not to touch puncture site or blood.					
16. Gently touch a drop of blood to the test strip without smearing it. Depending on meter in use, insert strip into meter after collection of sample on test strip.					
17. Apply pressure to puncture site with a cotton ball or dry gauze. ***Do not use alcohol wipe.***					
18. Read blood glucose results and document the results in EHR or other designated location, based on facility policy. Inform patient of test result.					
19. Turn off meter, remove test strip, and dispose of supplies appropriately. Place lancet in sharps container.					
20. Remove gloves and any other PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

MIXING OF TWO MEDICATIONS AND INSULIN ADMINISTRATION

Student name _____ **Section:** _____
Student ID _____ **Date** _____

Purpose: The accurate withdrawal of the medication into a syringe in a sterile manner; the medication is free from contaminatio and the proper dose is prepared

Indications: Insulin is used to control blood sugar in people who have type 1 diabetes (condition in which the body does no make insulin and therefore cannot control the amount of sugar in the blood) or in people who have type 2 diabetes (condition which the blood sugar is too high because the body does not produce or use insulin normally) that cannot be controlled with or medications alone.

Equipment

Two vials of medication (intermediate and short acting insulin)
Sterile insulin syringe
Electronic Medication Administration Record (EMAR)
Gloves
antimicrobial swabs (Alcohol wipe)
Tissue or cotton balls

DIRECTIONS:
Below is a list of criteria to evaluate the student's skill in *Mixing of two medications and insulin administration.* Indicate you evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in Mixing of Two Medications and Insulin Administration	3	2	1	0	Remarks
1	Gather equipment. Check medication order against the original order in the medical record, according to facility policy. 1. Insulin syringe 2. Medication-Insulin 3. Gloves 4. Alcohol wipe 5. Tissue or cotton ball 6. Sharps container or disposal plan					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered Consider the appropriateness of the medication for this patient.					
3	Perform hand hygiene					

4	Move the medication supply system to the outside of the patient's room or prepare for administration at the medication supply system in the medication area. Alternatively, access the medication administration supply system at room inside the patients.					
5	Unlock the medication supply system or drawer. Enter passcode and scan employee identification, if required.					
6	Prepare medication for one patient at a time.					
7	Read the cMAR/MAR and select the proper medications from the medication supply system or the patient's medication drawer.					
8	Compare the labels with the cMAR/MAR, check expiration dates and perform dosage calculations, if necessary, Scan the bar code on the package, if required.					
9	If necessary, remove the cap that protects the self-sealing stopper on each vial.					
10	If medication is a suspension (e.g. modified insulin, such as NPH insulin), roll and agitate the vial to mix well.					
11	Scrub the self-sealing stopper top with the antimicrobial swab and allow to dry.					
12	Remove cap from needle by pulling it straight off. Touch the plunger only at the knob. Draw back an amount of air into the syringe that is equal to the dose of modified insulin to be withdrawn.					
13	Hold the modified vial on a flat surface. Pierce the self-sealing stopper in the center with the needle tip and inject the measured air into the space above the solution. Do not inject air into the solution. Withdraw the needle.					
14	Draw back an amount of air into the syringe that is equal to the dose of unmodified insulin to be withdrawn.					
15	Hold the unmodified vial on a flat surface. Pierce the self-sealing stopper in the center with the needle tip and inject measured air into the space above the solution. Do not inject air onto the solution. Keep the needle in the vial.					
16	Invert the vial of unmodified insulin. Hold the vial in on hand and use the other hand to withdraw the medication. Touch the plunger only at the knob. Draw up the prescribed amount of medication while holding the syringe at eye level and vertically. Turn the vial and then remove the needle from the vial.					
17	Check that there are no air bubbles in the syringe.					
18	Check the amount of medication in the syringe with the medication dose and discard any surplus.					
19.	Recheck the vial label with the cMAR/MAR.					
20	Calculate the endpoint on the syringe for the combined insulin amount by adding the number of units for each dose together.					
21	Insert the needle into the modified vial and invert it, taking care not to push the plunger and inject medication from the syringe into the vial.					

	▪ Invert vial of modified insulin. ▪ Hold the vial in one hand and use the other to withdraw the medication. ▪ Touch the plunger only at the knob. ▪ Draw up the prescribed amount of medication while holding the syringe at eye level and vertically. ▪ Take care to withdraw only the prescribed amount. ▪ Turn the vial over and then remove the needle from the vial. ▪ Carefully recap the needle. ▪ Carefully replace the cap over the needle.					
22	Check the amount of medication in the syringe with the medication dose.					
23	Depending on facility policy, the third check of the label may occur at this point. If so, recheck the label with the MAR before taking the medications to the patient. However, many facilities require the third check to occur at the bedside, after identifying the patient.					
24	Label the vials with the date and time opened and beyond-use date, and store the vials containing the remaining medication, according to facility policy.					
25	Lock the medication supply system before leaving it.					
26.	Perform hand hygiene.					
27	Proceed with administration, based on prescribed route.					
28	Assemble equipment and supplies: ✓ 1. Insulin syringe ✓ 2. Medication-Insulin ✓ 3. Gloves ✓ 4. Alcohol wipe ✓ 5. Tissue or cotton ball ✓ 6. Sharps container or disposal plan					
29	Introduce yourself and verify the client's identity. Explain to the client what you are going to do, why it is necessary, and how the client can cooperate.					
30	Perform hand hygiene and observe other appropriate infection control procedures.					
31	Provide for client privacy					
32	Gather the equipment.					
33	Check 6 Rights of medication administration Right Patient - Right time - Right medication Right dose - Right route - Right documentation					
34	Selecting site-rotate (change) sites.					
35	If using alcohol pad, clean selected site and allow drying.					
36	Pinch a large area of skin and push the needle straight into the skin all the way, at a 45 or 90 degree angle.					
37	Push the plunger all the way down to injects insulin.					

38	Release pinched skin, and count to 5 slowly, and pull the needle straight out.					
39	Safely dispose of used needle and syringe in sharps container.					
40	Remove gloves and wash hands					
41	Inspect area for blood spills and follow district/ program protocols for cleaning. Put insulin and supplies away.					
42	Document procedure-including date, time, site of injection and amount of insulin administered. Sign/initial documentation.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

NEUROLOGIC EXAMINATION (CRANIAL NERVE ASSESSMENT FOCUS)

Name of Student: _____ **Section: _____**
Student ID: _____ **Date: _____**

Purpose: For early identification of neurovascular impairment and time investigation.
It includes assessing for the changes in circulation, motor function and sensation.

Indications:
Musculoskeletal trauma (crush injuries, trauma, orthopedic surgery, external pressures from cast or tight-fitting bandage ca cause damage to blood vessels and nerves

Equipment
PPE, if necessary, Blanket / drape
Examination gown Gloves
CN 1 – Odorours materials such as coffee, chocolate, alcohol, etc
CN 2, 3 and 4 – Penlight, Snellen chart, Pupil size assessment chart
CN 5 - Cotton balls/ cotton tip applicators
CN 8 – Tuning fork
CN 9 and 10 – Tongue depressor

Directions: Below is a list of criteria to evaluate the student's skill in *Neurologic Examination- Cranial Nerves.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

	Steps in Mixing of Two Medications and Insulin Administration	3	2	1	0	Remarks
1	Check the patient's health record or nursing care plan for monitoring schedule.					
2	Gather equipment.					
3	Perform hand hygiene and put on PPE, if indicated.					
4	Identify the patient.					
5	Close the curtains around the bed and close the door to the room, if possible. Explain the purpose of the CN examination and what you are going to do. Answer any questions.					
6	Help the patient undress, if needed, and provide a patient gown. Assist the patient to a supine position, if possible. Use the bath blanket to cover any exposed area other than the one being assessed.					

7	Begin with a survey of the patient's overall hygiene and physical appearance.					
8	Assess the patient's mental status. Evaluate LOC, patient's orientation, memory and ability to understand spoken and written words. Identify if it is alert, lethargic, obtunded, stupor or comatose.					
9	Assess pupil for size, shape, reaction to light and accommodation.					
10	Assess for neuro vital signs.					
11	Assess for motor function. Assess the muscle size, Muscle tone, muscle strength involuntary movements, posture and gait.					
12	Check reflexes					
	Assess Cranial Nerves.					
13	**CN1 Olfactory** a. Ask the patient to close eyes, occlude one nostril, and then identify the smell of different substance, such as coffee, chocolate, or alcohol. Repeat with other nostril.					
14	CNII Optic and CN III Oculomotor b. Test visual acuity and pupillary constriction.					
15	CN III. Oculomotor, lV. Trochlear, Vl. Abducens c. Move the patient's eyes through the six cardinal positions of gaze.					
16	V. Trigeminal f. Palpate the jaw muscles. Ask the patient to open and clench jaws. Stroke the patient's face with a cotton ball.					
17	CN VII Facial d. Ask the patient to smile, frown, and wrinkle the forehead and puff out cheeks.					
18	CN XII Hypoglossal e. Ask the patient to protrude tongue and push against the cheek with the tongue.					
19	Vlll. Acousticg. Test hearing with the whispered voice test. Refer to previous discussion in the assessment of the head and neck.					
20	lX. Glossopharyngeal and X. Vagus h. Put on gloves. Ask patient to open mouth. While observing soft palate, ask patient to say "ah"; observe upward movement of the soft palate. Test the gag reflex by touching the posterior pharynx with the tongue depressor. Explain to patient that this may be uncomfortable. Ask the patient to swallow. Remove gloves					
21	CN Xl. Spinal Accessory i. Place your hands on patient's shoulders while he or she shrugs against resistance. Then place your hand on the patient's left cheek, then the right cheek, and have the patient push against it.					

	ASSESS NEUROVASCULAR – THE 6PS (COMPARE BETWEEN AFFECTED AND UNAFFECTED LIMB).					
22	A. Check for pain. Extreme pain, especially on passive motion, is a significant sign of probable neurovascular impairment in an extremity. Subjective and objective assessment should be included. Opioid analgesia is unlikely to relieve the pain.					
23	B. Check for pallor. Check for the color and temperature of the extremity. Pale skin, decreased tone, or white color may indicate poor arterial perfusion. Cyanosis may indicate venous stasis. Coolness or decreased temperature may indicate decreased arterial supply. Compare distal to proximal temperature variation in affected limb. Assess capillary refill. Using your thumb and forefinger, squeeze the patient's fingernail or toenail until it appears white. Release the pressure and observe the time it takes for normal color to return. Normally, color returns immediately, in less than 2 to 3 seconds					
24	C. Check for peripheral pulses. Assess the consistency of arterial blood flow (pulse presence, rate, and quality) up to and past the affected area. Assess capillary refill, especially in patients whose pulses cannot be palpated due to casts or bandages and in nonverbal patients.					
25	D. Check for paresthesia (sensation). Compare sensation to touch between affected and unaffected limb. Numbness, tingling, or pins and needles sensations may be reported. Evaluate the areas above and below the affected area.					
26	E. Check for paralysis (movement). The ability of the patient to move the extremity distal to the injury. Paralysis of an extremity may be the result of prolonged nerve compression or irreversible muscle damage.					
27	F. Check for pressure. Affected area may become taut and firm to the touch, with surrounding skin appearing shiny. The feeling of tightness or pressure may be present.					
28	Discuss findings with the patient.					
29	Remove PPE, if used. Perform hand hygiene. Continue with assessments of specific body systems, as appropriate, or indicated. Initiate appropriate referral to other health care providers for further evaluation, as indicated.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PROVIDING CARE OF A CHEST TUBE DRAINAGE SYSTEM

Name of Student: _____ **Section: _____**
Student ID: _____ **Date: _____**

Purpose:

A chest tube drainage system is a sterile, disposable system that consists of a compartment system that has a one-way valve, with one or multiple chambers, to remove air or fluid and prevent return of the air or fluid back into the patient.

Indications

- Pleural effusions
- Pneumothorax
- Post cardiac surgery
- Haemothorax

Equipment: for dressing

- Dressing pack
- Chlorhexidine solution (Yellow or blue)
- Gloves
- Two small occlusive tegaderm dressings
- Split gauze

Directions: Below is a list of criteria to evaluate the student's skill in **providing care of a chest tube drainage system.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps	*3*	*2*	*1*	*0*	*Remarks*
Goal: The patient does not experience any complications related to the chest drainage system or respiratory distress.					
1. Bring necessary equipment to the bedside stand or overbed table.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Close curtains around bed and close the door to the room, if possible.					
5. Explain what you are going to do and the reason for doing it to the patient.					
6. Assess the patient's level of pain. Administer prescribed medication, as needed.					
7. Put on clean gloves					
Assessing the Drainage System					

8. Move the patient's gown to expose the chest tube insertion site. Keep the patient covered as much as possible, using a bath blanket to drape the patient, if necessary. Observe the dressing around the chest tube insertion site and ensure that it is dry, intact, and occlusive.						
9. Check that all connections are securely taped. Gently palpate around the insertion site, feeling for subcutaneous emphysema, a collection of air or gas under the skin. This may feel crunchy or spongy, or like "popping" under your fingers.						
10. Check drainage tubing to ensure that there are no dependent loops or kinks. Position the drainage collection device below the tube insertion site.						
11. If the chest tube is ordered to be suctioned, note the fluid level in the suction chamber and check it with the amount of ordered suction. Look for bubbling in the suction chamber. Temporarily disconnect the suction to check the level of water in the chamber. Add sterile water or saline, if necessary, to maintain correct amount of suction.						
12. Observe the water-seal chamber for fluctuations of the water level with the patient's inspiration and expiration (tidaling). If suction is used, temporarily disconnect the suction to observe for fluctuation. Assess for the presence of bubbling in the water-seal chamber. Add water, if necessary, to maintain the level at the 2-cm mark, or the mark recommended by the manufacturer.						
13. Assess the amount and type of fluid drainage. Measure drainage output at the end of each shift by marking the level on the container or placing a small piece of tape at the drainage level to indicate date and time. The amount should be a running total, because the drainage system is never emptied. If the drainage system fills, it is removed and replaced.						
14. Remove gloves. Assist patient to a comfortable position. Raise the bed rail and place the bed in the lowest position, as necessary.						
15. Remove additional PPE, if used. Perform hand hygiene.						
Changing the Drainage System						
16. Obtain two padded Kelly clamps, a new drainage system, and a bottle of sterile water. Add water to the water-seal chamber in the new system until it reaches the 2-cm mark or the mark recommended by the manufacturer. Follow manufacturer's directions to add water to suction system if suction is ordered.						
17. Put on clean gloves and additional PPE, as indicated.						
18. Apply Kelly clamps 1.5 to 2.5 inches from insertion site and 1 inch apart, going in opposite directions.						
19. Remove the suction from the current drainage system. Unroll or use scissors to carefully cut away any foam tape on the connection of the chest tube and drainage system. Using a slight twisting motion, remove the drainage						

system. Do not pull on the chest tube.					
20. Keeping the end of the chest tube sterile, insert the end of the new drainage system into the chest tube. Remove Kelly clamps. Reconnect suction, if ordered. Apply plastic bands or foam tape to chest tube/drainage system connection site.					
21. Assess the patient and the drainage system as outlined (Steps 5–15).					
22. Remove additional PPE, if used. Perform hand hygiene.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

CLEANING A WOUND AND APPLYING A DRESSING (GENERAL GUIDELINES)

Name of Student: _____ Section: _____
Student ID: _____ Date: _____

Purpose: provide a temporary protective physical barrier, absorb wound drainage, and provide the moisture necessary to optimize re-epithelialization.

Indications:

- Reduce pain.
- Apply compression for hemorrhage or venous stasis.
- Immobilize an injured body part.
- Protect the wound and surrounding tissue.
- Promote moist wound healing.

Equipment:

- PPE
- Dressing Kit
- nonsterile gloves
- sterile gloves
- wound cleansing solution or sterile saline
- sterile 2″x 2″ gauze for wound cleansing
- 4″ x 4″ sterile gauze for wound dressing,
- scissors, and tape (if needed).
- Antiseptic solution (Iodine)
- waste receptacle or bag
- a waterproof pad
- dressing adhesive or tape

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in Cleaning a Wound and Applying a Dressing. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Cleaning a Wound and Applying a Dressing (General Guidelines)	*3*	*2*	*1*	*0*	*Remarks*
Goal: The wound is cleaned and is applied without contaminating the wound area, causing trauma to the wound, or causing the patient to experience pain or discomfort.					
1. Review the patient's health record for prescribed wound care or the nursing care plan related to wound care. Gather necessary supplies.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Assemble equipment on the overbed table or other surface within reach.					
5. Close the curtains around the bed and close the door to the room, if possible. Explain to the patient what you are going to do and why you are going to do it.					
6. Assess the patient for the possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care dressing change. Administer appropriate prescribed analgesic. Allow enough time for the analgesic to achieve its effectiveness.					
7. Place a waste receptacle or bag at a convenient location for use during the procedure.					
8. Adjust the bed to a comfortable working height, usually elbow height of the caregiver (VHA Center for Engineering & Occupational Safety and Health [CEOSH], 2016).					
9. Assist the patient to a comfortable position that provides easy access to the wound area. Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.					
10. Check the position of drains, tubes, or other adjuncts before removing the dressing. Put on clean, disposable gloves and loosen the tape or adhesive edge on the old dressings by removing in the direction of hair growth and the use of a push–pull method. Push–pull method: lift a corner of the dressing away from the skin, and then gently push the skin away from the dressing/adhesive. Continue moving fingers of the opposite hand to support the skin as the product is removed (McNichol, Lund, Rose, & Gray, 2013). Carefully lift the adhesive barrier from the surrounding skin to prevent medical adhesive–related skin injury (MARSI). Remove the sides/edges first, then the center. If there is resistance, use an adhesive remover (McNichol et al., 2013).					

11. Carefully remove the soiled dressings. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove it.						
12. After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle. Remove your gloves and dispose of them in an appropriate waste receptacle.						
13. Perform hand hygiene.						
14. Inspect the wound site for size, appearance, and drainage. Assess if any pain is present. Check the status of sutures, adhesive closure strips, staples, and drains or tubes, if present. Note any problems to include in your documentation.						
15. ***Using sterile technique, prepare a sterile work area and open the needed supplies.***						
16.Open the sterile cleaning solution. Depending on the amount of cleaning needed, the solution might be poured directly over gauze sponges over a container for small cleaning jobs, or into a basin for more complex or larger cleaning.						
17.Put on sterile gloves. Alternatively, clean gloves (clean technique) may be used when cleaning a chronic wound or pressure injury.						
18. Clean the wound. ***Clean from top to bottom and/or from the center to the outside.*** Use new gauze for each wipe, placing the used gauze in the waste receptacle. Alternatively, spray the wound from top to bottom with a commercially prepared wound cleanser; wound irrigation is often used to clean open wounds and may also be used for other types of wounds. Refer to Skill 8-3.						
19. Once the wound is cleaned, dry the area using a gauze sponge in the same manner.						
20. If a drain is in use at the wound location, clean around the drain. Refer to Skills 8-6, 8-7, 8-8, and 8-9.						
21. Remove gloves and place them in the waste receptacle. Perform hand hygiene.						
22. Put on sterile gloves. Alternately, clean gloves (clean technique) may be used when cleaning a chronic wound or pressure injury. Apply a skin protectant or barrier to the healthy skin around the wound where the dressing adhesive or tape will be placed and where wound drainage may come in contact with the skin.						

23. Apply any topical medications, foams, gels, and/or gauze to the wound as prescribed; ensure products stay confined to the wound and do not impact on intact surrounding tissue/skin.						
24. Gently place a layer of dry, sterile dressing, or other prescribed cover dressing at the wound center and extend it at least 1 in beyond the wound in all directions. Alternately, follow the manufacturer's directions for application. Forceps may be used to apply the dressing.						
25. As necessary, apply a surgical or abdominal pad (ABD) over the gauze at the site of the outermost layer of the dressing, with the side of the dressing with the blue line facing away from the patient. Alternately, note the side of the dressing that contains the moisture barrier and place away from the patient, based on the dressing material in use.						
Note: May not be necessary or appropriate, based on the cover dressing used in step 22.						
26.Apply tape, Montgomery straps, or roller gauze to secure the dressings. Alternately, many commercials wound products are self-adhesive and do not require additional tape. Remove and discard gloves.						
27.After securing the dressing, label it with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up as indicated and bed in the lowest position						
28.Remove PPE, if used. Perform hand hygiene.						
29.Check all wound dressings at least every shift. More frequent checks may be needed if the wound is more complex, or dressings become saturated quickly.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING IRRIGATION OF A WOUND

Name of Student: _____ **Section:** _____
Student ID: _____ **Date:** _____

Purpose: to remove foreign material, decrease bacterial contamination of the wound, and to remove cellular debris or exudate from the surface of the wound.

Indications: in the management of both acute and chronic wounds, and especially those that will be undergoing suturing, surgical repair, or debridement.

Equipment:

- PPE
- Waste receptacle or bag
- sterile basin
- irrigation syringe
- irrigation solution (sterile water /Normal saline 0.9%)
- Sterile gauze
- sterile gloves
- dressing adhesive or tape
- Dressing kit.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing irrigation of a wound. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory **Demonstrates required level in a consistent and efficient manner**
2 - Borderline **Performs with minimal error or omission (1-2 mistakes)**
1 - Unsatisfactory **Performs with numerous errors or omissions (3 and more mistakes)**
0 - Poor **Procedure is not done**

Performing Irrigation of a Wound	*3*	*2*	*1*	*0*	*Remarks*
Goal: The wound is cleaned without contamination or trauma, and without causing the patient to experience pain or discomfort.					
1. Review the patient's health record for prescribed wound care or the nursing care plan related to wound care. Gather necessary supplies.					
2. Perform hand hygiene and put on PPE, if indicated.					

3.	Identify the patient.					
4.	Assemble equipment on the overbed table or other surface within reach.					
5.	Close the curtains around the bed and close the door to the room if possible. Explain what you are going to do and why you are going to do it to the patient.					
6.	Assess the patient for possible need for nonpharmacologic pain-reducing interventions or analgesic medication before wound care and/or dressing change. Administer appropriate prescribed analgesic. Allow enough time for the analgesic to achieve its effectiveness before beginning the procedure.					
7.	Place a waste receptacle or bag at a convenient location for use during the procedure.					
8.	Adjust the bed to a comfortable working height, usually elbow height of the caregiver (VHACEOSH, 2016).					
9.	Assist the patient to a comfortable position that provides easy access to the wound area. Position the patient so the irrigation solution will flow from the clean end of the wound toward the dirtier end or top to bottom. Use the bath blanket to cover any exposed area other than the wound. Place a waterproof pad under the wound site.					
10.	Put on a gown, mask, and eye protection or face shield.					
11.	Check the position of drains, tubes, or other adjuncts before removing the dressing. Put on clean, disposable gloves and loosen the tape on the old dressings by removing in the direction of hair growth and the use of a push–pull method. Push–pull method: lift a corner of the dressing away from the skin, then gently push the skin away from the dressing/adhesive. Continue moving fingers of the opposite hand to support the skin as the product is removed (McNichol et al., 2013). Carefully lift the adhesive barrier from the surrounding skin to prevent medical adhesive–related skin injury (MARSI). Remove the sides/edges first, then the center. If there is resistance, use an adhesive remover (McNichol et al., 2013).					
12.	Carefully remove the soiled dressings. If any part of the dressing sticks to the underlying skin, use small amounts of sterile saline to help loosen and remove it.					
13.	After removing the dressing, note the presence, amount, type, color, and odor of any drainage on the dressings. Place soiled dressings in the appropriate waste receptacle.					
14.	Assess the wound for appearance, stage, presence of eschar, granulation tissue, ***epithelialization***, undermining, tunneling, necrosis, ***sinus tract***, and drainage. Assess the appearance of the surrounding tissue. Measure the wound.					
15.	Remove your gloves and put them in the receptacle. Perform hand hygiene.					

16.	Set up a sterile field, if indicated, and wound cleaning and irrigation supplies. Pour warmed sterile irrigating solution into the sterile container. Put on the sterile gloves. Alternately, clean gloves (clean technique) may be used when cleaning a chronic wound or pressure injury.					
17.	Position the sterile basin below the wound to collect the irrigation fluid.					
18..	Fill the irrigation syringe with solution. ***Alternately, irrigation solution may be packaged in individual, single-use syringe; remove cap on syringe. Using your nondominant hand,*** gently apply pressure to the basin against the skin below the wound to form a seal with the skin.					
19.	***Direct a stream of solution into the wound. Keep the tip of the syringe at least 1 in above the upper edge of the wound. Flush all wound areas.***					
20.	Watch for the solution to flow smoothly and evenly. When the solution from the wound flows out clear, discontinue irrigation.					
21.	Once the wound is cleaned, dry the surrounding skin using a gauze sponge.					
22.	If a drain is in use at the wound location, clean around the drain. Refer to Skills 8-6, 8-7, 8-8, and 8-9.					
23.	Remove gloves and place in a waste receptacle. Perform hand hygiene.					
24.	Put on sterile gloves. Alternately, clean gloves (clean technique) may be used when cleaning a chronic wound or pressure injury. Apply a skin protectant or barrier to the healthy skin around the wound where the dressing adhesive or tape will be placed and where wound drainage may come in contact with skin.					
25.	Apply any topical medications, foams, gels, and/or gauze to the wound as prescribed; ensure products stay confined to the wound and do not impact on intact surrounding tissue/skin.					
26.	Gently place a layer of dry, sterile dressing or other prescribed cover dressing at the wound center and extend it at least 1 in beyond the wound in all directions. Alternately, follow the manufacturer's directions for application. Forceps may be used to apply the dressing.					
27.	Apply tape, Montgomery straps, or roller gauze to secure the dressings, if needed. Alternately, many commercials wound products are self-adhesive and do not require additional tape. Remove and discard gloves.					
28.	After securing the dressing, label it with date and time. Remove all remaining equipment; place the patient in a comfortable position, with side rails up as indicated and bed in the lowest position.					

29. Remove PPE, if used. Perform hand hygiene.					
30. Check all wound dressings at least every shift. More frequent checks may be needed if the wound is more complex, or dressings become saturated quickly.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

CHILD HEALTH

NURSING

SKILL

CHECKLISTS

BATHING AN INFANT OR SMALL CHILD

Student name _____ **Section:** _____
Student ID _____ **Date** _____

Purpose: The aim of the first bath is to remove undesired fluids as blood and meconium on the newborn's body and to provide hydration to the stratum corneum of the newborn's skin in order to maintain skin integrity, barrier function property and body temperature

Indication:

1. To promote infant comfort and cleanliness.
2. To prevent the spread of infection.
3. To improve circulation.
4. To give an opportunity for the nurse to observe.
5. To give a child a chance to exercise without clothing.

Equipment

A wash basin with warm water (38-40 ºc).
Two soft wash cloths for sponging.
Two to three towels (place under baby and dry), cotton balls, a cup, alcohol wipes.
Baby shampoo.
Mild soup
Dry clean clothing
Bath towel to make an absorbent cushion for the baby to lie on.
A bag to dispose of cotton balls.
A baby combs.
Mild lotion or baby oil.
Diaper, non-sterile gloves
Alcohol swab

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Bathing an Infant or Small Child**
Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps	3	2	1	0	Remarks
1.Explain the procedure to the patient and family.					
2.Assemble the Equipment at the bedside.					
3.Wash hands					
4.Assess the child					
5.Take & record temperature, pulse, and respiration					

6.Wash the child from head to feet. Dry washed areas with a towel, giving added emphasis to skin folds						
7.Moisten a cotton ball with water and wipe eyes from inner canthus to outer canthus. repeat with a clean cotton ball on the other eye						
8.Wet washcloth & wring. Gently wash one side of the face from forehead to chin, going around the nose and mouth. Repeat on other side of the face. Do not use soap on the face						
9. Dry infant's face with towel						
10.To clean the baby's scalp, pick up baby securely by sliding hand under the baby until the head is well supported in the palm of the hand. Cover ears with thumb and middle finger. Hold baby's head over the basin. Soap and rinse head and dry with towel						
11.Continue washing ears and neck, giving particular attention to the skin folds of the neck, behind the ears, and the external part of the ears. Wipe washed areas repeatedly to rinse off soap						
12.Remove infant's shirt. Wash trunk and arms. Wash between fingers. Turn infant one on side to wash back						
13.Cover infant with a blanket. Rinse and wring washcloth, then wipe away soap. Repeat to ensure removal of soap						
14.Dry area with towel. Cover trunk after drying						
15.Wash and rinse the infant’s chest and abdomen						
16.Use an alcohol wipe to clean gently around the edge of the umbilical cord. Dry the baby, and keep her body covered with a towel.						
17.Remove diaper, exposing lower half of body. Keep upper half of body covered with blanket						
18.Work down each leg to the foot, using long stroking motions. Wash between toes. give special attention to the area between the toes						
19.Wash genitalia with cotton balls. Spread apart the female's labia and clean between folds, using a front to back motion. use each cotton ball for one stroke only						
20.The male genitalia should be washed with cotton balls from penis to anus. Do not retract the foreskin of the penis						
21. Next wash the anus and between the gluteal fold and buttocks						
22.Dry lower half of body. Apply mild baby oil or lotion to skin. don’t apply powder to prevent dermatitis and protect skin from inflammation.						
23.Rediaper. Redress and position the infant in the isolate or bassinet						
24.Clean the finger nail& toe nail cut, if necessary, Brush and comb hair						
25.Document any abnormalities in the skin surface in the medical record						
28. Document the infant's tolerance of the bath process						
29. Replace equipment's						
30.Wash hands						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

Care of the Incubator after Baby Discharge

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:
Main purpose of keeping and caring a neonate in incubator are: -

1. Maintenance of the normal temperature
2. Provision of desired humidity and oxygenation
3. Observation of very sick neonates
4. Isolation newborn babies from infections

Indication:

1. All premature babies
2. Babies with low birth weight (<1000g)
3. Hypothermic child (<32˚c)
4. Sick children.
5. Frequently incubator is used to transport babies from one place to another

Equipment:
Soup or disinfectant solution
Water
Basin
Towel
Gloves
Brush to clean the plastic bottoms

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Care of the Incubator after Baby Discharge.** Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps in Care of the Incubator after Baby Discharge	*3*	*2*	*1*	*0*		*Remarks*
1. Wash hands.						
2.Put on disposable gloves.						
3.Switch the electricity off from the incubator and the wall socket.						
4.Remove all detachable parts and soaks it in a soapy solution and warm water for 1 hour.						
5.Inspect the mattress cover for tears.						
6.Wash mattress with soap and water, dry it well.						

7.Wash the inside walls, the floor, and the outside walls of the incubator with soapy solution and warm water then dry it well.							
8.Wipe the inside and outside wall, floor, mattress of the incubator with Chloride solution 0.5% diluted 10ml/L and let it to dry well.							
9.Wipe the incubator with distilled water, dry it well.							
10.After the incubator dry completely, reassembles all the removed parts.							
11.Remove gloves and discard it.							
12.Wash hands.							
13.Document the date and the time of incubator care.							

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

CLEANING AND STERILIZATION OF THE INCUBATOR

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose: Main purpose of keeping and caring a neonate in incubator are: -
1.Maintenance of the normal temperature
2.Provision of desired humidity and oxygenation
3.Observation of very sick neonates
4.Isolation newborn babies from infections

Indication:

- All premature babies
- 2.Babies with low birth weight (<1000g)
- Hypothermic child (<32˚c)
- Sick children.
- Frequently incubator is used to transport babies from one place to another

Equipment:
Soup or disinfectant solution
Water
Basin
Towel
Gloves
Brush to clean the plastic bottoms

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **Cleaning and Sterilization of the Incubator.** Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Cleaning and sterilization of the incubator	*3*	*2*	*1*	*0*		*Remarks*
1.Wash hands.						
2.Move the incubator to a suitable area of the nursery.						
3.Remove all movable parts.						
4.Soak all the parts in a detergent solution for 1 hour.						

5.Wipe both the inside and the outside walls of the hood and the base of the incubator with a detergent solution. Make sure that all dirt is removed.							
6.Allow the incubator to dry completely before re-assembling it.							
7.Document the date and time of incubator care.							

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

DAILY CARE OF THE INCUBATOR

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose: Main purpose of keeping and caring a neonate in incubator are: -
1. Maintenance of the normal temperature
2.Provision of desired humidity and oxygenation
3.Observation of very sick neonates
4.Isolation newborn babies from infections

Indication:
- All premature babies
- Babies with low birth weight (<1000g)
- Hypothermic child (<32˚c)
- Sick children.
- Frequently incubator is used to transport babies from one place to another

Equipment:
Soup or disinfectant solution
Water
Basin
Towel
Gloves
Brush to clean the plastic bottoms

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **Daily Care of the Incubator**. Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Daily Care of the Incubator		*3*	*2*	*1*	*0*		*Remarks*
1.Wash hands.							
2.Put on disposable gloves.							
3.Clean the mattresses with warm water using a clean towel or paper tissues then dry it.							
4.Clean the inside walls of the incubator with a warm water then dry it.							
5.Cover the mattress with a sheet and tuck it under the sides.							
6.Fill the humidity reservoir with distilled water.							

7.Clean the outside walls of the incubator with a warm water or using disinfectant solution (Chlorine 0.5% diluted in 10ml/l).								
8.Check that temperature is between 28-35°C.								
9.Check that humidity is between 55-65%.								
10.Monitor oxygen flow rate and concentration as prescribed.								
11.Monitor oxygen flow rate and concentration as prescribed.								
12.Remove gloves and discard it.								
13. Wash hands.								

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PREPARING THE INCUBATOR FOR A NEW BABY

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:
Main purpose of keeping and caring a neonate in incubator are: -
1.Maintenance of the normal temperature
2.Provision of desired humidity and oxygenation
3.Observation of very sick neonates
4.Isolation newborn babies from infections

Indication:
- All premature babies
- Babies with low birth weight (<1000g)
- Hypothermic child (<32˚c)
- Sick children.
- Frequently incubator is used to transport babies from one place to another

Equipment:
- Soup or disinfectant solution
- Water
- Basin
- Towel
- Gloves
- Brush to clean the plastic bottoms
-

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in Preparing the Incubator for a new baby.**Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

PREPARING THE INCUBATOR FOR A NEW BABY	*3*	*2*	*1*	*0*		*Remarks*
1. Wash hands.						
2. Warm and oxygenate the incubator.						
3. Check the physician's order as regarding adjustment.						

4. Cover the mattress with a sheet and tuck it under the sides.						
5. Explain the needs of incubator care to the parents of neonate.						
6. Adjust the incubation parameters and maintain, follow the chart.						
7. Remove the cloths of the neonate and place inside the incubator.						
8. Provide meticulous care as long neonate remains inside.						
9. Continue care through port hole.						
10. Report to the doctor if baby is not maintaining the normal temperature.						
11. Do not bring the neonate out without justifiable cause.						
12. Document time and condition of the neonate.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

SPECIMEN COLLECTION

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:

1. To determine the cause of an acute onset of illness.
2. To aid in diagnosis and treatment.
3. To determine the progress of a patient's condition.

Indication:

- It's used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes
- To make a presumptive or definitive diagnosis so that therapy can begin

Equipment:

- Toilet soap, water and towel.
- Adhesive tape.
- Specimen bottle.
- Completed lab form.
- Kidney basin or paper bag.
- Cotton ball.
- Bag specimen (plastic disposable urine collector).
- Stool specimen container
- Tongue blade

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **Obtaining a Specimen for Analysis.**Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

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Obtaining a Specimen for Urine Analysis	***3***	***2***	***1***	***0***		***Remarks***
1.Explain the procedure a. Apply newborn and pediatric urine collection ✓ The skin must be clean and perfectly dry						

✓ Avoid oils, baby powder & lotion soap ✓ Application must begin on the tiny area of skin between the anus and genitals ✓ The narrow bridge on the adhesive patch keeps feces from contaminating the specimen and help position the collector correctly b. Put the child on his back, spread the legs and wash each skin fold in genital area c. Do not use a scrub soap solution d. Wash the anus last, allow a few moments for air drying e. Remove protective paper from the bottom half of the adhesive patch g. For girl, stretch the perineum to separate the skin folds and expose the vagina h. For boys, begin between the anus and the base of scrotum i. Press adhesive firmly against the skin and avoid wrinkles, remove paper from the upper portion of adhesive patch						
2.Explain the procedure a. Apply newborn and pediatric urine collection ✓ The skin must be clean and perfectly dry ✓ Avoid oils, baby powder & lotion soap ✓ Application must begin on the tiny area of skin between the anus and genitals ✓ The narrow bridge on the adhesive patch keeps feces from contaminating the specimen and help position the collector correctly b. Put the child on his back, spread the legs and wash each skin fold in genital area c. Do not use a scrub soap solution d. Wash the anus last, allow a few moments for air drying e. Remove protective paper from the bottom half of the adhesive patch g. For girl, stretch the perineum to separate the skin folds and expose the vagina h. For boys, begin between the anus and the base of scrotum i. Press adhesive firmly against the skin and avoid wrinkles, remove paper from the upper portion of adhesive patch						
3. Use a sterile container or apply a urine collection device						
4. If a bag is used, Secure the diaper over the bag						
5. Check bag every 20 to 30 minutes						
6. Label all specimens clearly and attach the proper laboratory slip, collected specimens should be transported in plastic bag (check institution policy)						
7.Document procedure						

Obtaining a stool specimen						
1.Prepare the equipment's & instruments						
2.Explain the procedure to the child or parent						
3.Wash hands well & wear gloves to obtain specimen						
4.Obtain stool specimen directly from the diaper (If it has not been contaminated by urine) With the tongue blade ,or use the tongue blade to receive the specimen from the collection device						
5.The specimen is labeled properly, and the laboratory slip is attached						
6.Some specimens must be sent to the laboratory while they are warm						
7.Document procedure a. Charts the time, color, amount, and consistency of the stool. The purpose for which it was collected (e.g., blood, ova, parasites, bacteria) & any related information						
Obtaining throat culture						
1. Prepare the equipment's • Throat swab • Tongue depressor • Media culture						
2.Explain the procedure to the woman & describing the sensation to expect						
3.Gather equipment						
4.Wash hand, wears gloves						
5.Have child stick out tongue and say "ah"						
6.Depress anterior half of tongue with tongue depressor if necessary						
7.Swab area with exudates or redness, one time only per swab (Avoid teeth, tongue, cheeks, lips & palate						
8.Be sure parents or nurse comfort child						
9.Label, obtain requisition						
10.Transport to laboratory						
11. Document procedure, including description of pharyngeal area if you can see it						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTRATING OXYGEN THERAPY

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:

1. To manage the condition of hypoxia
2. To increase the oxy hemoglobin in red blood cells
3. To maintain the ability of cells to carry out the normal metabolic function
4. To reduce the risk of complications

Indication:

1- Cyanosis
2- Breathlessness or labored breathing
3- Anemia
4- Diseases such as - pulmonary edema, pneumonia, chest trauma
5- Environment with low oxygen content
6- Poisoning with chemicals that alter the tissues' ability to utilize oxygen
7- Hemorrhage

Equipment:

1. Oxygen source - 02 cylinder
2. Oxygen instrument according to methods like – oxygen mask, oxygen hood, nasal prongs, nasal catheter, oxygen tent
3. Flow meter
4. Humidifier
5. Gauze pieces
6. Adhesive tape
7. 'No smoking' signs
8. Spinner to open the main valve of oxygen cylinder

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in Oxygen Therapy .**Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Steps in Administrating oxygen therapy	***3***	***2***	***1***	***0***		***Remarks***
1.Prepare the equipment's						

2.Explain the procedure to the child and allow him or her to feel the equipment and the oxygen flowing through the tube, mask							
3.Maintain a clear airway by suctioning, if necessary							
4.Measure oxygen concentration every 1-2hours when a child is receiving oxygen through incubator hood or tent ✓ Measure when the oxygen environment is closed ✓ Measure the concentration close to the child's airway ✓ Record oxygen concentrations and simultaneous measurements of pulse & respiration							
5.Observe the child response to oxygen							
6.Organize nursing care so that interruption of therapy is minimal							
7.Periodically check all equipment during each tour of duty							
8.Clean equipment daily and change it at least once each week							
9.Keep combustible materials & potential sources of fire away from oxygen therapy Pt teaching: • Avoid using oil or grease around oxygen connections • Do not use alcohol or oils on a child in an oxygen tent • Do not permit any electrical devices in or near an oxygen tent • Avoid the use of wool blankets and those made from some synthetic fiber because of the hazards resulting from static electricity • Prohibit smoking in areas where oxygen is being used • Have a fire extinguisher available							
10. **Terminate oxygen therapy gradually** a. Slow reduce liter flow b. Open air events in incubators Continually monitor the child's response during weaning. a. Observe for restlessness b. Increase pulse rate c. Observe respiratory distress, cyanosis							
Oxygen by mask 1.Choose an appropriate size mask that cover the mouth and nose but no the eye 2. Use a mask that can deliver the desired oxygen concentration 3.Place the mask over the child, s mouth and nose so that it fits securely. Secure the mask with an elastic head grip 4.Remove the oxygen mask at hourly intervals, wash the face & dry 5.Do not use masks for comatose infant or children							

Face tent 1.Face tent are available in the adult size only 2.A flow of 8-10 L should be to flush the system and provide a stable oxygen concentration						
Incubator oxygen therapy 1.The incubator is used to provide a controlled environment for the neonate 2.Adjust the oxygen flow to achieve the desired oxygen concentration 3.An oxygen limiter prevents the oxygen concentration inside the incubator from exceeding 40% 4.Higher concentrations (up to 85%) may be obtained by placing the red reminder flag in the vertical position 5.Secure a nebulizer to the inside wall of incubator if mist therapy is desired 6.Keep sleeves of incubator closed to prevent loss of oxygen 7.Periodically analyze the incubator atmosphere						
Oxygen hood 1.*Warmed, humidified oxygen is supplied through a plastic container that fits over the child's head 2.*Continuously monitor the oxygen concentration, temperature & humidity inside the hood 3.Open the hood or remove the baby from its infrequently as possible 4. Several different designs are available for use. The manufacture's direction should be carefully followed						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PROMOTING POSTURAL DRAINAGE IN PEDIATRIC PATIENT

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:

1. Keep child airway clearance.
2. Comfort the child.
3. Promote child respiratory condition.

Indication:

It is indicated for patients in whom cough is insufficient to clear thick, tenacious, or localized secretions.

Equipment:

- Stethoscope
- Pillows
- tissue
- an emesis basin
- suction tube different sizes
- suction machine (wall or portable)

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in promoting postural drainage in pediatric patient.**Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Promoting postural drainage in pediatric patient	***3***	***2***	***1***	***0***		***Remarks***
Preparatory phase 1.Assess the child's respiratory status 2.Obtain a baseline respiratory rate 3.Observe for respiratory distress retraction, nasal flaring, and so forth						
4. Identify the involved portions of the lung by auscultation, percussion, or review of the x ray report						
5. Explain the procedure to the child or the parent						
6. Make the child comfortable a. Remove constricting clothes b. Flex the child's knee and hips						

c. Have tissue and an emesis basin available d. Have several pillows available						
7.Provide bronchodilator or nebulization therapy prior to the procedure if indicated						
Performance phase **8**.Place the child in asides of appropriate position a. Thereat to be drained should be elevated b. The spine should be as straight as possible to permit optimal expansion of the rib cage						
9.Unless contraindicated, cup the chest wall for 1-2 minutes						
10. Have the child inhale deeply, then, as he exhales, vibrate the chest wall during three to five exhalations						
11. Encourage the child to cough						
12.Allow the child to rest for a minute, then repeat cupping vibration and coughing until no more mucus is produced or the child, s condition indicates that the procedure should be stopped						
Promoting postural drainage in pediatric patient						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

BABY RESTRAINT

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:

1. Restraints are protective devices used to limit the physical activity of the child's body or part of the body also can be used to control or prevent harmful behavior and to prevent movement or falling during surgery
2. To prevent infant or small children from flexing their elbows and hands
3. Scratching surgical incision, skin lesion
4. Removing I.V line from the scalp
5. Prevent active young children from climbing out of Crib.

Indication:
They are applied to safeguard the child against injury, such as falling or movements that would disrupt therapy to a limb, which is connected to tubes or appliance.

Equipment:
1. Jacket restraints
2. Mitt or hand restraints
3. Large dressing
4. Gauze bandage
5. Adhesive tape
6. Stockinette if available.
7. Elbow restraints
8. Safety pins
9. Glove hitch restraints
10. Bandage 5-8 cm wide and 90-120 cm long.
11. Cotton.
12. Mummy restraints
13. Blanket or sheet
14. Crib net restraints
15. A stretch net with long strap

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in Baby Restraint**
Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Baby Restraint	*3*	*2*	*1*	*0*		*Remarks*
Jacket Restraint 1.Check physician's order and agency policy regarding use of restraints.						
2. Gather equipment.						

3. Wash hands						
4. Explain purpose of restraints to child and parents. Reassure child that restraint is not a punishment						
5. Place the jacket on the patient gown and tie it from back						
6. Ensure that patient's gown and jacket are not wrinkled						
7.Secure each tie to unmovable portion of the bed, using half bowknot which is easily removed						
8.Secure shoulder straps to head of the bed						
9.Secure abdomen straps on either sides						
Mitt or hand restraint 1.Place a large, folded dressing in patient's palm • Separate the fingers with a piece of large dressing • Put a padded dressing around the wrist • Place two large dressings over the hand, one is first placed from the back of the hand over the fingers to the palm and the other is then wrapped from side to side around the hand • Cover these dressing by placing stockinette dressings over the hand or elastic bandage, using the recurrent pattern • Secure the stockinette or elastic bandage with adhesive tape						
2. Apply commercially made restraints • If mitts are worn for several days remove them at least every twelve hours, wash, exercise the hand and reapply again						
Elbow restraint 1. Check the restraints to make sure that the tongue depressors are intact and in place						
2. Apply elbow restraint over gown sleeves						
3. Make sure the end of the tongue depressors are covered by padded material						
4. Place elbow in the center of restraint						
5. Warp the restraint smoothly around the arm						
6. Secure the restraint, using safety pins, ties or strings						
7. Ensure that it is not too tight so not to occlude blood						
Clove hitch restraint 1. prepare the equipment • Bandage 5-8 cm wide and 90 –120 cm long • Cotton • Commercially made restraint						
2. Apply 2-3 layers of cotton around ankle or wrist						
3. Make 2 loop forming finger of 8						
4. Pick up the two loops						
5. Make sure that the loops are small to fit patient hands						

6. Using half – bow knot attach the end of restraint to the end of the bed spring						
7. Check every two hours and readjust accordingly						
Mummy restraint 1. Prepare the equipment • Blanket or sheet • Safety pins or adhesive tape						
2. Lay the blanket or sheet on flat dry surface						
3. Fold down one corner of the blanket and place the baby on it the supine position, make sure that the infant shoulder touches the upper border of the blanket						
4. Fold the right side of the blanket over the infant's body and tuck it under his back leaving the left arm free						
Crip net restraint 1. prepare the equipment * A stretch net with long strap						
2. Place the net over sides and ends of the Crip						
3. Secure the tie to bed frame						
4. Tie the strap in half –bow knot						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Anthropometric measurements of newborn

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose:

1. Measurement of physical growth in children is a key element in evaluating their health status.
2. They also provide a means of recording objective measurements of present developmental functioning for future reference.

Indication:

Screening procedures are designed to identify quickly and reliable those children whose developmental level is below normal for their age who therefore require further investigation.

Equipment:

1. Scale
2. Gloves
3. Cover sheets
4. Paper tape measure
5. Alcohol swab
6. Gauze
7. Baby chart

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in weighting & measuring the newborn .** Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

WEIGHTING & MEASURING THE NEWBORN	***3***	***2***	***1***	***0***	***Remarks***
Prepare the equipment's & instruments					
1. Scale					
2. Cover sheets					
3. Paper tape measure					
Weighting					
1. Place cover sheet on scale					
2. Wear gloves if newborn has not been bathed					
3. Adjust the scale balances to 0, or push the appropriate pads on the digital scales, using a protective barrier on your hand					
4. Record weight on baby's chart. Weight baby at the same time					

Measuring the length						
1. To measure length, place the newborn in supine position on the crib mattress, with the hand against the top of crib						
2. Place the paper tape measure beside the infant, with the 0 end of the tape against the top of the crib						
3. Wear gloves if the newborn has not been bathed						
4. Hold the newborn's head straight with one hand, and extended one leg, with the other hand						
5. Watch that the tape measures remain straight						
6. Note the length and record it in the infant's chart						
7. Compare your finding with the normal range, most infants are 48 to 53 cm in length						
Measuring the head circumferences						
1. Place the paper tape under the newborn's head to measure head Circumferences. Compare your finding with the normal range, most infants are 32-37 cm.						
2. Wrap the tape around the newborn's head, measuring just above the eyebrows so that the largest area of the occiput is included						
3. Record your finding in the infant's chart						
To measure chest circumference						
1.Place the paper tape under the newborn's chest, at nipple level						
2. Wrap the tape around the chest, at the nipple line						
3. Note the circumference and record it in the infant's chart. Chest circumference is measured at the nipple line, average chest circumference is 30.5 to 33 cm						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

MEASURING BODY TEMPERATURE

Students name: ---------- **Section:** ----------
Student ID: ---------- **Date:** ----------

Purpose: Vital signs are useful in detecting or monitoring medical problems.
Indication

- Vital signs are an important component of monitoring the adult or child patient's progress during hospitalization
- Help Assessing Patient Wellbeing
- Prevent Misdiagnosis
- Detect Underlying Health Problems
- Motivate Lifestyle Changes

Equipment:

1. Tray
2. Thermometer
3. Stethoscope
4. Sphygmomanometer
5. Appropriate size cuff
6. Gauze
7. Alcohol swab
8. Watch

DIRECTIONS: Below is a list of criteria to evaluate the student's skill **in Measuring body Temperature.** Indicate your evaluation by Placing a corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

Measuring the body Temperature	***3***	***2***	***1***	***0***		***Remarks***
1.Prepare the equipment's & instruments *Thermometer 1. Oral bulb 2. Rectal or stubby bulb 3 Electronic (Interchangeable oral and rectal probes) 4. Tympanic probe 5. Gloves						
2.Explain the procedure to the patient and family y. **assemble the Equipment at the bedside**.						
3.Oral determination a. Wash hand						

b. Select an instrument (oral, stubby or electric) c. If the thermometer has been stored in chemical solution, rinse it with water and wipe it dry with a soft tissue d. Shake a glass thermometer until the mercury is below the 35.5 c mark. Firmly hold the non-bulb end of the thermometer and briskly snap the hand at the wrist. If using an electronic thermometer, remove from charger and slide cover over probe e. Place the bulb under the right side of the child tongue. Have the child close mouth around the thermometer (If the child is over the age of 6 years) f. Leave the thermometer under the tongue for							
3-5 minutes. Stay with the child while thermometer is in place g. *If an electronic thermometer is used, use the oral probe with a disposable plastic probe cover. The thermometer will signal when the peak temperature has been reached h. Remove the thermometer from the mouth and read the temperature 4. After use, wipe thermometer with soft tissue, rinse in cold water, and store according to policy							
Rectal determination a. Wash hand b. Select an instrument (Rectal /stubby or electric) and provide privacy for the child c. Rinse, wipe and shake the rectal thermometer as in oral temperature. If an electronic thermometer is used, remove from charger and slide cover over probe d. Lubricate the bulb with a water-soluble gel **Infant** 1.place infant prone, spread the buttocks with one hand and insert the thermometer slowly and gently with other hand 2.Insert the bulb into the rectum about 1/4 -1/2. 3.If resistance is felt, remove thermometer, and choose another route							
Older child 1.Position child on side, separate buttocks to expose the anal opening 2.Gently insert the thermometer into the rectum about 1- 11/2 3.Hold thermometer in place for 3-4 minutes or until electronic thermometer signal is heard 4.Never leave child alone with a rectal thermometer in place 5.Remove the thermometer in a straight line 6.Wipe it off with a soft tissue. If an using an electronic thermometer 7.Insert probe into base and store in charger							

8.Read the temperature 9.Reposition child in a comfortable position and clean thermometer according to the policy						
Axillary determination 1.Wash hand 2.Select instrument – follow institution policy concerning whether to use a rectal or oral thermometer 3.Rinse, wipe and shake the thermometer as suggested in the procedure for obtaining an oral temperature. If an electronic thermometer is used, remove from charger and place cover on probe 4.Place the bulb under the arm, well up into the armpit. Bring the child's arm down close to the body and hold in place 5.Leave in place 10 minutes or until electronic thermometer signal is heard						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

MATERNAL

HEALTH

NURSING

SKILL

CHECKLISTS

PROVIDING PRENATAL CARE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose:
To enhance the knowledge, attitude, and practice of nurses on focused antenatal care

Specific Objectives

- To demonstrate how to make an immediate general assessment of the pregnant woman
- To apply the process flow of providing antenatal care.
- To discuss the importance of a birth and emergency plan
- To detect diseases which may complicate pregnancy
- Educate women on danger and emergency signs & symptoms
- Prepare the woman and her family for childbirth

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ VS machine,
- ✓ stethoscope,
- ✓ tape measure,
- ✓ CTG machine,
- ✓ Examination bed
- ✓ ultrasound gel,
- ✓ blanket,
- ✓ paper tissue
- ✓ calendar (Hijjri, Gregorian)
- ✓ Maternity record book
- ✓ Drape
- ✓ Bed roll under pad
- ✓ Pelvic model

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in providing prenatal care. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PROVIDING PRENATAL CARE	3	2	1	0	Remarks
1. Identify patient.					
2. Immediate assessment for emergency signs. Ask about warning symptoms.					
3. Wash hands and wear appropriate PPE as indicated. Assemble all materials and equipment needed (stethoscope, tape measure, CTG machine, ultrasound gel, blanket, paper tissue)					
4. Make the woman comfortable.					
5. Register the client and issue antenatal record form/book. *Check appointment schedule as indicated.*					
6. Assess the following and determine risk factors.					
7. Take history on *(GPTPAL, Length of previous gestations, Weight of infants at birth , Labor experiences, Types of anesthesia if any, Maternal complications, Infant complications and Special concerns).*					
8. Identify the LNMP					
9. Compute for the AOG and EDD					
10. Assess any previous gynecologic problems and contraceptive history					
11. Ask for medical and surgical history *(Age, race, and ethnic background, Childhood diseases and immunizations, Chronic illnesses such as asthma, heart disease, hypertension, diabetes, renal disease, lupus, Previous illnesses, surgical procedures, and injuries, Previous infections such as hepatitis, STDs, tuberculosis, History of and treatment for anemia, Bladder and bowel function, Amount of caffeine and alcohol, Tobacco use, Prescription, Appetite, general nutrition, Contact with pets, Allergies and drug sensitivities, Occupation and related risk factors)*					
12. Ask for family history					
13. Ask for partner's health history					
14. Perform Physical Examination a) Get Vital Signs (*T-P-R-BP, Oxygen saturation*)					
b) Perform Review of Systems 1. Cardiovascular System -*venous congestion, edema*)					
2. Musculoskeletal System -*Posture and gait, height and weight, abdomen-contour, size, and muscle tone. Palpate fundus and check FHR.*					
3. Neurovascular System (*Deep tendon reflex, carpal tunnel syndrome*- pain, burning, numbness, or tingling of the hand and wrist)					
4. Integumentary system-*pallor, jaundice, lesions, bruising, rashes, hyperpigmentation such as melisma, linea nigra and striae*. Check nail beds					
5. Endocrine system- *check thyroid for enlargement*					
6. Gastrointestinal system- *mouth, gums, lips, teeth, bowel sounds*					

	7. Urinary System-*any difficulty or painful urination, check U/A for protein, glucose, ketones and bacteria*						
	8. Reproductive System-breast (*Breast size and symmetry, condition of the nipples, lumps, dimpling of the skin, or asymmetry of the nipples),* external reproductive system-perineum, vulva, and anus						
15.	Assist in getting laboratory exams ordered*(CBC, VDRL, Rubella titer, Hepa B screening, Pap's Smear, UA, Glucose Challenge Test)*						
16.	Identify risk for complications and determines the need for specialized care *(age, low socio economic status, parity, obesity, height, smoking, use of alcohol and unprescribed drugs, existing medical conditions such as DM, thyroid, cardiac, renal and concurrent infections.*						
17.	Assist patient to examination table.						
18.	Measure fundal height and compare findings to Bartholomew's rule.						
19.	Do Leopold's maneuver.						
20.	Assist in ultrasonography. (Position patient on examining table/bed in dorsal recumbent position. Place folded towel under right hip to prevent hypotension. Drape client for privacy with her abdomen exposed. Protect client's clothing with paper tissue as needed. Assist the doctor while performing the procedure. Provide ultrasound gel as needed). (*Instruct to full bladder during second semester). Wipe when done and make patient comfortable.*						
21.	Determine results of ultrasound: ✓ Presence of intrauterine pregnancy; location ✓ Size appropriate to AOG ✓ Number of embryos/fetus ✓ Cardiac activity; FHR ✓ Fetal position, presentation ✓ Fetal biparietal diameter (BPD) and femur length (FL) ✓ Amniotic fluid index ✓ Location of placenta ✓ Uterine abnormality						
22.	Wipe the ultrasound gel gently with paper tissue/towel at the end of the procedure.						
23.	Assist patient in getting up and sitting/comfortable position. Discard materials appropriately. Perform hand hygiene.						
24.	Ask patient for any discomforts/concerns *(Nausea and Vomiting, Heartburn, Backache, Round Ligament, Pain, Urinary Frequency and Loss of Urine, Varicosities, Constipation, Hemorrhoids, Leg Cramps)*						
25.	Provide health education regarding *(Bathing, Hot Tubs and Saunas, Douching, Breast Care, Clothing, Exercise, Sleep and Rest, Sexual Activity, Nutrition, Employment, Medications such as folic acid, ferrous*						

	sulfate, management of discomforts, signs of possible complications and providing resources)					
26.	Encourage the woman to come for return visits.					
27.	Document all procedures done and findings.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

OBTAINING OBSTETRIC SCORE, CALCULATING EXPECTED DATE OF CONFINEMENT (EDC) AND AGE OF GESTATION (AOG)

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses on obtaining obstetric score.

Specific Objectives

- To demonstrate how to calculate for the Expected date of delivery
- To demonstrate how to calculate age of gestation

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Calendar (Hijjri, Gregorian)
- ✓ Maternity record book
- ✓ calculator

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in in obtaining obstetric score, calculating Expected Date of Confinement (EDC) and Age of Gestation (AOG). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:

3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN OBTAINING OBSTETRIC SCORE, CALCULATING EXPECTED DATE OF CONFINEMENT (EDC) AND AGE OF GESTATION (AOG)	***3***	***2***	***1***	***0***	***Remarks***
1. Identify the patient.					
2. Gather needed materials and equipment.					
3. Explain the procedure to the patient.					
4. Identify the first day of last menstrual period (LMP).					
5. Obtain the obstetric score of the client by determining the:					
a. Gravida					
b. Para					
c. Term					
d. Preterm					
e. Abortion					
f. Living					
g. Multiple pregnancy					

9. Calculate EDC: a. Take note LMP in month, day and year.							
b. Add 7 days (Gregorian) or 14 days (Hijiri) to first day of LMP.							

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING LEOPOLD'S MANEUVER, FUNDIC HEIGHT MEASUREMENT AND AUSCULTATING FETAL HEART RATE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude and practice of nurses on performing Leopold's maneuver, fundic height measurement and auscultating fetal heart tone/rate.

Specific Objectives

- To determine fetal position, presentation, attitude and engagement.
- To demonstrate Leopold's maneuver
- To measure fundic height and determine normal from abnormal measurement.
- To determine position of fetal back
- To compare normal from abnormal FHR

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Disposable pad,
- ✓ Tape measure,
- ✓ Blanket,
- ✓ Stethoscope

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Leopold's maneuver. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING LEOPOLD'S MANEUVER, FUNDIC HEIGHT MEASUREMENT AND AUSCULTATING FETAL HEART RATE	***3***	***2***	***1***	***0***	***Remarks***
1. Identify the patient.					
2. Gather needed materials and equipment (Disposable pad, Tape measure, Blanket, Stethoscope					
3. Explain the procedure to the woman and the rationale for each step as it					

is performed. Tell her what is found at each step. Gives information, teaches the woman, and reassures her when the assessment findings are normal.						
4. Ask the woman to empty her bladder if she has not done so recently. Have her lie on her back with her knees flexed slightly. Place a small pillow or folded towel under one hip. Decreases discomfort of a full bladder during palpation and improves ability to feel fetal parts in the suprapubic area. Knee flexion helps the woman relax her abdominal muscles to enhance palpation. Uterine displacement prevents aortocaval compression, which could reduce blood flow to the placenta						
5. Wash your hands with warm water. Wear gloves if contact with secretions is likely. Prevents transmission of microorganisms. Warm hands are more comfortable during palpation and prevent tensing of abdominal muscles.						
6. Stand beside the woman, facing her head, with your dominant hand nearest her. The first three maneuvers are most easily performed in this position						
7. Palpate the uterine fundus. The breech (buttocks) is softer and more irregular in shape than the head. Moving the breech also moves the fetal trunk. The head is harder and has a round, uniform shape. The head can be moved without moving the entire fetal trunk. Distinguishes between a cephalic and breech presentation. If the fetus is in a cephalic presentation, the breech is felt in the fundus. If the presentation is breech, the head is felt in the fundus.						
Maneuver 1 8. Hold the left hand steady on one side of the uterus while palpating the opposite side of the uterus with the right hand. Then hold the right hand steady while palpating the opposite side of the uterus with the left hand. The fetal back is a smooth, convex surface. The fetal arms and legs feel nodular, and the fetus often moves them during palpation. Determines on which side of the uterus is the back and on which side are the fetal arms and legs ("small parts").						
Maneuver 2 9. Palpate the suprapubic area. If a breech was palpated in the fundus, expect a hard, rounded head in this area. Attempt to grasp the presenting part gently between the thumb and fingers. ✓ *If the presenting part is not engaged, the grasping movement of the fingers moves it upward in the uterus.* ✓ *Confirms the presentation determined in the first maneuver.* ✓ *Determines whether the presenting part is engaged (widest diameter at or below a zero station) in the maternal pelvis.*						
10. Omit the fourth maneuver if the fetus is in a breech presentation. Is performed only in cephalic presentations to determine whether the fetal head is flexed						

Maneuver 3 11. Turn so that you face the woman's feet. Is most easily performed in this position.						
12. Place your hands on each side of the uterus with fingers pointed toward the pelvic inlet. Slide hands downward on each side of the uterus. ✓ *On one side, your fingers easily slide to the upper edge of the symphysis.* ✓ *On the other side, your fingers meet an obstruction, the cephalic prominence.* ✓ *Determines whether the head is flexed (vertex) or extended (face). The vertex presentation is normal.* ✓ *If the head is flexed, the cephalic prominence (the forehead in this case) is felt on the opposite side from the fetal back. If the head is extended, the cephalic prominence (the occiput in this case) is felt on the same side as the fetal back.*						
Maneuver 4						
13. Measure fundic height in cm by stretching the tape measure from the level of symphysis pubis to the point marking the top of fundus.						
14. Palpate for presence of uterine contractions						
15. Auscultate for fetal heart rate (at the end of uterine contraction). Count FHT for 1 minute and determine location (in abdominal quadrant).						
16. Assist patient in getting up and sitting as needed.						
17. Discard materials to appropriate container. Do aftercare.						
18. Evaluate patient's response to the procedure.						
19. Document findings.						
20. Perform hand hygiene.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING INTERNAL EXAMINATION (IE)

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses on performing Internal Examination.

Specific Objectives

- To determine true labor.
- To assess the cervical dilation and effacement
- To assess the fetal presentation, position, station, integrity of bag of water and cord prolapse.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Sterile examination gloves (clean gloves may be used if the membranes are intact)
- ✓ Sterile lubricant
- ✓ Antiseptic solution and light source (if required)
- ✓ Disposable wipes

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Internal Examination (IE). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING INTERNAL EXAMINATION (IE)	3	2	1	0	Remarks
1. Wash and dry your hands. Explain the procedure and purpose of the examination to the patient.					
2. Assess for latex allergies					
3. Ensure privacy					
4. Assemble necessary equipment including clean gloves (if the membranes are intact) or sterile examination gloves (if the membranes are ruptured), sterile lubricant, and antiseptic solution (if required).					
5. Position the patient in a supine position with a small pillow or towel under her hip to prevent supine hypotension.					

6. Instruct the patient to relax and position herself with her thighs flexed and abducted.					
7. Don sterile gloves (clean gloves may be used if the membranes are intact).					
8. Inspect the perineum for any redness, irritation, or vesicles					
9. Using the nondominant hand spread the labia majora and continue assessment of the genitalia. Note the presence of any discharge including blood or amniotic fluid					
10. Gently insert the lubricated gloved index and third fingers into the vagina in the direction of the posterior wall until they touch the cervix.					
11. Placing the nondominant hand on the woman's abdomen to stabilize the uterus					
12. Assess the cervix for **effacement** and the amount of **dilation**					
13. Assess fetal descent and **station** by identifying the **position** of the posterior fontanel.					
14. Assess for **presentation**					
15. Assess for intact **membranes**; if fluid is expressed, test for amniotic fluid					
16. Assess for **prolapsed umbilical cord**					
17. Withdraw the fingers. Assist the patient in wiping her perineum from front to back to remove lubricant or secretions.					
18. Help her to resume a comfortable position					
19. Inform the patient of the findings from the examination					
20. Wash hands					
21. Document findings					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PREPARING OB INSTRUMENTS FOR NORMAL SPONTANEOUS VAGINAL DELIVERY (NSVD)

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses in preparing OB instruments for NSVD.
Specific Objectives

- To identify labor and delivery instruments accurately.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Mayo table
- ✓ Rubber suction bulb
- ✓ Kelly clamp (curve)
- ✓ Kelly clamp (straight)
- ✓ Mayo scissors
- ✓ Metzenbaum
- ✓ Needle holder
- ✓ Tissue forceps
- ✓ Suture
- ✓ Suction Machine
- ✓ Gauze
- ✓ Syringe with lidocaine
- ✓ Lubricating Gel
- ✓ Basin with antiseptic solution

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in preparing OB Instruments for NSVD. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PREPARING OB INSTRUMENTS FOR NORMAL SPONTANEOUS VAGINAL DELIVERY (NSVD)	**3**	**2**	**1**	**0**	**Remarks**
1. Prepare the woman.					

2. Routinely check for crowing, cervical dilation and effacement (Done by Ob-Gyne through IE).						
3. When crowning, and cervical dilation and effacement complete put the mother in the birthing table.						
4. Position the mother in lithotomy						
5. Clean the perineum with warm antiseptic solution						
Identify the equipment correctly 6. Mayo table						
7. Rubber suction bulb						
8. Kelly clamp (curve)						
9. Kelly clamp (straight)						
10. Mayo scissors						
11. Metzenbaum						
12. Needle holder						
13. Tissue forceps						
14. Suture						
15. Suction Machine						
16. Gauze						
17. Syringe with lidocaine						
18. Lubricating Gel						
19 Basin with antiseptic solution						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

DELIVERY OF PLACENTA

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude and practice of nurses in the delivery of placenta.

Specific Objectives

- To demonstrate techniques in the delivery of placenta.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Ring forceps
- ✓ Watch
- ✓ Folded sterile towel Gauze
- ✓ Gloves

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **delivery of placenta**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN DELIVERY OF PLACENTA	3	2	1	0	Remarks
1. Note the time of the birth of baby					
2. Assemble equipment: Ring forceps, Watch, Folded sterile towel gauze, gloves					
3. Place the ring forceps on the portion of the umbilical cord that is just outside the introitus and let it hang down by its own weight					
4. Place your hand over the uterus through the abdominal wall (inside a folded sterile towel) to note for Calkins sign- uterus contracts into a hard globular ball which rises slightly under your hand.					
5. Ask the mother when she next has contractions or cramps					
6. Note for small gush of blood lengthening of the cord.					
7. Note for lengthening of the cord.					
8. After 3 signs of separation, or ten or more minutes have elapsed, ask the mother to bear down					
9. Provide some firm pressure against the fundus of the uterus with your cupped hand, and your thumb placed just above the pubic bone.					

10. Provide some steady cord traction to note whether there is a sense of "give" as the placenta moves into the vagina and the cord lengthens, or conversely, does not progress --- in which case you cease your maneuvers and wait.					
11. If you are uncertain whether the placenta has actually separated, you may also follow the cord with your hand in the vagina, up to the cervix, to determine if the placenta is trapped in the cervical os, or whether the cord disappears into the uterus.					
12. Document findings					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ASSESSMENT OF PLACENTA

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude and practice of nurses in the assessment of placenta.

Specific Objectives

- To demonstrate skills in the assessment of placenta.
- To differentiate two kinds of placenta
- To compare normal from abnormal placenta.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Gloves
- ✓ Basin large to accommodate the placenta

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in the assessment of Placenta. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN THE ASSESSMENT OF PLACENTA	3	2	1	0	Remarks
1. Start with the fetal surface					
2. Identify the placenta type if it is "shiny Schultz" or Duncan (dirty). Correctly					
3. Note the **placement** of the cord insertion on the placenta and note the umbilical vessel.					
4. It should contain 3 vessels inside. (2 arteries and one vein)					
5. Turn the placenta over to the maternal surface					
6. Pull the membranes up gently to identify the location of the hole which resulted from the rupture of the membranes					
7. A hole near the center of the membranes indicates a placenta attached in the upper portion of the uterus.					
8. A hole near an edge of a placenta indicates a low-lying placenta, e.g., one attached in the lower uterine segment closer to the cervical os.					

9. After noting whether there are any tears in the membranes or blood vessels passing through them, pull the membranes completely back to expose the maternal surface of the placenta					
10. Note the cotyledons which make up a normally thick, red surface and ensure that there is not a missing section.					
11. Look for infarctions (white, thickened areas), or a pale overall color. These signs may indicate an aging placenta, or one that has not had healthy maternal/fetal transfer unit lobes in the membranes.					
12. Run your finger around the edge of the placenta to determine whether there are any vessels or succinturiate.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING POSTPARTUM ASSESSMENT

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses in performing Postpartum assessment.

Specific Objectives

- To Identify physiologic and abnormal changes during postpartum period.
- Perform postpartum assessment and appropriate nursing care.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ VS machine (Dynamap)
- ✓ Alcohol/hand sanitizer
- ✓ Patient's file
- ✓ Breast model
- ✓ Manikin (Female)
- ✓ Newborn manikin
- ✓ Maternity napkins
- ✓ Simulated blood
- ✓ gloves

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **performing postpartum assessment**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.
Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING POSTPARTUM ASSESSMENT	3	2	1	0	Remarks
1. Review patient's file and determine patient's postpartum day.					
2. Perform hand hygiene.					
3. Gather needed materials.					
4. Identify the patient.					
5. Explain the procedure to the patient.					
6. Ask when her last urination was or check if bladder is full. If bladder is full, let the patient urinate before the examination.					
7. Provide privacy to the patient.					

8. Don on clean gloves.						
9. Assess the patient's vital signs and identify abnormal findings. a. Temperature						
b. Pulse						
c. Blood pressure						
d. Respirations						
10. Review patient's file and determine patient's postpartum day.						
11. Perform hand hygiene.						
12. Gather needed materials.						
13. Identify the patient.						
14. Explain the procedure to the patient.						
15. Ask when her last urination was or check if bladder is full. If bladder is full, let the patient urinate before the examination.						
16. Provide privacy to the patient.						
17. Don on clean gloves.						
18. Assess the patient's vital signs and identify abnormal findings. e. Temperature						
f. Pulse						
g. Blood pressure						
h. Respirations						
BREAST						
19. Assess patient's breasts, nipples, and presence of colostrum/milk. Take note of engorgement.						
20. Assess patient while giving breastfeeding and observe the following: a. Is baby positioned well?						
b. Is baby able to attach to the nipples well?						
c. Is baby sucking effectively?						
UTERUS-FUNDUS						
21. Position patient to supine or flat position. Support uterus with one hand under and palpate with other hand. Assess the relation of fundus to umbilicus, if it is in the midline or displaces and palpate for uterine firmness.						
22. For C-section delivery, also check the surgical incision presence of inflammation, discharge.						
23. Describe the expected anatomic position of the fundus of the uterus.						
BOWEL						
24. Ask patient for bowel movement (passed out flatus and/or stool).						
25. Determine characteristics of stool and bowel pattern						
BLADDER						
26. Ask patient if she has voided.						
27. Determine characteristics of urine voided.						
28. Palpate for distension of urinary bladder and presence of boggy or displaced uterus.						
LOCHIA						

29. Assess for presence and type of lochia: color, amount, odor, presence of clots and foul odor.					
30. Weigh perineal pad before and after use and identify the amount of time between pad changes.					
LEGS					
31. Press down gently on the patient's knee (legs extended flat on bed) and ask her to flex her foot (dorsiflex). Assess for presence of Homan's sign, edema on legs, and redness, warmth and tenderness on the patient's calf.					
EPISIOTOMY/PERINEUM					
32. Have woman lay on her side, lift her leg and bring it forward. Assess the perineum for "REEDA" Redness Ecchymosis Erythema Drainage/Odor Suture approximation;					
33. And also assess for presence of hemorrhoids and evaluate effectiveness of comfort measures.					
EMOTIONS					
34. Assess patient's attitude, feelings of competence, support systems, fatigue level and ability to accomplish task. Determine patient's current emotion according to Rubin's stages of maternal psychological adaptation.					
EARLY ATTACHMENT-BONDING					
35. Assess for the presence of early attachment: presence of engrossment to newborn, eye contact to newborn, nurturing behavior of the mother, consistency, sensitivity and enjoyment.					
PAIN					
36. Assess for presence of pain. Determine the location, level, duration of pain.					
37. Remove gloves and discard appropriately. Perform hand hygiene.					
38. Teach patient about danger signs/reportable signs and symptoms.					
39. Ask the patient for concerns/issues.					
40. Explain the findings to the patient. Refer abnormal findings.					
41. Document findings, care provided and responses of the patient.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING FUNDAL MASSAGE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude and practice of nurses in performing fundal massage.

Specific Objectives

- Identify the indications of fundal massage.
- Perform fundal massage.

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Peripad,
- ✓ disposable pad,
- ✓ paper tissue/wet wipes,
- ✓ clean gloves

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing fundal massage. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING FUNDAL MASSAGE	3	2	1	0	Remarks
1. Review patient's file and determine indication for fundal massage.					
2. Perform hand hygiene.					
3. Gather needed materials: Peripad, disposable pad, paper tissue/wet wipes, clean gloves					
4. Identify the patient.					
5. Explain the procedure to the patient.					
6. Ask when her last urination was or check if bladder is full. If bladder is full, let the patient urinate.					
7. Provide privacy to the patient.					
8. Assist patient to supine position with knees flexed and feet placed together.					
9. Don on clean gloves.					
10. Remove the peripad and inspect the perineum. Determine the character and amount of discharge on the pad. Apply a clean peripad.					
11. Place non-dominant hand on the abdomen just above the symphysis pubis.					

12. Place dominant hand around the top of the fundus.					
13. With the lower hand maintained in a stable position, rotate the upper hand and massage the uterus until it is firm. Avoid over massaging the uterus.					
14. Once the uterus has become firm, gently press the fundus between the hands. Apply a slight downward pressure against the lower hand.					
15. Observe the perineum for the passage of clots and the amount of bleeding.					
16. Once the uterus remains firm, cleanse the perineum and apply a clean peripad. Dispose of soiled gloves and pads according to institutional policy.					
17. Ask the patient for concerns/issues.					
18. Remove gloves and discard appropriately. Perform hand hygiene.					
19. Teach patient about danger signs/reportable signs and symptoms.					
20. Refer abnormal findings.					
21. Document findings, care provided and responses of the patient.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING IMMEDIATE NEWBORN CARE (Part 1)
Thermoregulation, Airway and APGAR Scoring

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses in performing immediate newborn care.

Specific Objectives

- Identify materials, equipment, instruments needed for immediate newborn care.
- Use critical thinking in assessing and evaluating newborn condition.
- Perform immediate newborn care

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

- ✓ Radiant warmer
- ✓ Sterile gloves
- ✓ Towel to dry newborn
- ✓ Suction machine
- ✓ Bulb syringe
- ✓ Stethoscope
- ✓ Watch with 2nd hand
- ✓ Newborn file paper

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing newborn care. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING IMMEDIATE NEWBORN CARE (Part 1) Thermoregulation, Airway and APGAR Scoring	**3**	**2**	**1**	**0**	**Remarks**
1. Prepare needed equipment.					
2. Turn on radiant warmer.					
3. Wear sterile gloves.					
4. Bring newborn under radiant warmer immediately after delivery. Thoroughly dry newborn immediately, wipe face including eyes and stimulate crying by rubbing.					
5. Assess breathing and establish Airway. Assess for secretions					

6. Position the newborn's head to the side and downward if vomiting or gagging						
7. Suction the mouth first then the nares with bulb syringe or suction machine						
8. Assess APGAR score. Start first with ***Activity (Muscle Tone)*** 9. Observe the posture and muscle tone of the newborn (some flexion of extremities and body)						
10. Gently pull the babies leg and am and note if there is some resistance felt.						
11. Put the baby in prone position in the arm or hand.						
12. Score the baby and be guided by the interpretation						
Second, Pulse (Heart rate when not crying) 13. Get the heart rate when baby is not crying						
14. Warm the bell/diaphragm of the stethoscope with the palm of the hand prior to placing in the chest						
15. Place the stethoscope on the left side of the chest or where the heartbeat is loud.						
16. Score the baby and be guided by the interpretation						
Third, Grimace (Reflex irritability) 17. While baby is being suctioned observe the reflex irritability.						
18. Score the baby and be guided by the interpretation						
Fourth, Appearance (Color) 19. Observe for the babies skin color (pink, acrocyanosis, or cyanosis)						
20. Score the baby and be guided by the interpretation						
Fifth, Respiratory effort/rate 21. Observe the respiratory effort of the baby by listening to the cry. It is shrill and vigorous.						
22. Observe the rise and fall of the chest and abdomen. Count for 1 full minute.						
23. Perform tangential foot slap with the nurse's finger the sole of the foot to stimulate if not crying.						
24. Score the baby and be guided by the interpretation						
25. Record the total APGAR score and interpret findings.						
26. Note the characteristic of cry. Monitor for nasal flaring, grunting, retractions and abnormal respirations, such as seesaw respiratory pattern. Refer to physician as needed.						
27. Report to the doctor if the score is 6 and below and initiate appropriate nursing interventions.						
28. Document procedure and findings.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING IMMEDIATE NEWBORN CARE (Part 2)- BATHING to BONDING

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Purpose: To enhance the knowledge, attitude, and practice of nurses in performing immediate newborn care.

Specific Objectives

- Identify materials, equipment, instruments needed for immediate newborn care.
- Use critical thinking in assessing and evaluating newborn condition.
- Perform immediate newborn care

Indication: Use for providing Antenatal Care among 3rd year Nursing students enrolled in Maternal Health Nursing course

Equipment/Materials:

✓ Basin	✓ Antiseptic solution/saline solution
✓ soap	✓ Weighing scale
✓ Baby oil	✓ Tape measure
✓ Cotton balls	✓ Streptomycin
✓ Hair soft brush	✓ Vitamin K
✓ Towels (3- body, face)	✓ 1 cc syringe
✓ Baby dress with head cover	✓ Rectal thermometer
✓ Blood tubes	✓ Name tag
✓ Cord clamp	✓ Stamps for foot printing
✓ Blade	✓ Swaddling towel

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **performing immediate newborn care**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN PERFORMING IMMEDIATE NEWBORN CARE (Part 2)- BATHING to BONDING	**3**	**2**	**1**	**0**	**Remarks**
1. Prepare needed equipment					
2. Bring the newborn near the sink and bathe: a. Fill the basin with warm water and add mild liquid soap.					
b. Put oil all over the body with cotton balls. And gently remove some of the vernix caseosa of the baby but do not remove entirely. Do this in a quick					

manner. Wrap the baby with towel.						
c. Bathe keeping the baby's head above the water level.						
3. Discard wet cloth, cover newborn with dry cloth and bring back to the radiant warmer.						
4. Off the cord a. Get blood sample directly from the cord and submit to laboratory.						
b. Clamp 0.5-1 inch above umbilical stump.						
c. Cut the cord with sterile blade using aseptic technique.						
d. Cleanse the cord with betadine or antiseptic solution, according to agency policy.						
e. Leave the umbilical stump uncovered.						
5. Get the anthropometric measurements: a. Weight						
b. Head circumference						
c. Chest circumference						
d. Length						
e. Record and interpret findings.						
6. Cover the head with hat and dress the newborn appropriately.						
7. Do Crede's prophylaxis. Place the newborn on a firm surface. Open eyelids and put ointment from inner to outer canthus at the lower conjunctiva.						
8. Prepare and administer 0.2 ml of Vitamin K in vastus lateralis at 90 degree angle.						
9. Check for anal patency.						
10. Place matching identification band (name tag) on newborn and mother. Indicate the mother's name, gender, date and time of delivery and type of delivery.						
11. Footprint the newborn and fingerprint the mother on the identification sheet per agency policies and procedures.						
12. Swaddle the baby and place under radiant warmer and check every 30 minutes.						
13. Position the newborn on the side with a rolled blanket at the back to facilitate drainage of mucus.						
14. Keep the newborn with the mother to facilitate bonding.						
15. Document procedure and findings.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

CRITICAL CARE NURSING SKILL CHECKLISTS

GLASGOW COMA SCALE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

GLASGOW COMA SCALE

The GCS is based on the three criteria of eye opening, verbal responses, and motor responses to verbal commands or painful stimuli. It does not take the place of an in- depth neurologic assessment. Each response is scored (the greater the number, the better the functioning), and the sum of these scores gives an indication of the severity of coma and a pre- diction of possible outcome. The lowest score is 3 (least responsive); the highest is 15 (most responsive). A GCS between 3 and 8 is generally accepted as indicating a severe head injury. The GCS is used in conjunction with other neurologic assessments, including pupillary reaction and vital sign measurement, to evaluate a patient's status.

Indication:

1. It is particularly useful for monitoring changes during the acute phase, the first few days after a head injury.
2. It tests in three major areas: Eye response, Motor response, Verbal response.
3. It is used to assess LOC at regular intervals, because changes in the LOC precede all other changes in vital and neurologic signs

Equipment (Depending on Components of Examination)

- Percussion hammer
- Wisps of cotton to assess light-touch sensation
- Sterile safety pin for tactile discrimination
- Penlight

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **GLASGOW COMA SCALE**. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS IN GLASGOW COMA SCALE	3	2	1	0	Remarks
1. Identify the patient and explain the procedure.					
2. Wash hands					
3. Use appropriate PPE.					
4. Provide privacy.					
5. Check level of consciousness					

• **Full Consciousness-** Check for patient's alertness, attentiveness and ability to follow command. If asleep, she responds promptly to external stimulation and once awake remains atten					
• Lethargy- Check if patient is drowsy. She will answer questions & follow commands, but will do so slowly & inattentively					
• **Obtundatio**n- Check patient if she/he is difficult to arouse and needs constant stimulation in order to follow a simple command. Patient may respond verbally with one or two wor but will drift back to sleep between stimulation					
• **Stupor-** Elicit pain (nail bed pressure, supraorbital notch pressure), patient aro to vigorous & continuous stimulation, patient may moan briefly but does not follo commands, Patient may attempt to withdraw from or remove the painful stimulus.					
• **Coma**- Patient does not respond to continuous or painful stimuli, does not mo except, possibly, reflexively & does not make any verbal sounds					
6. <u>Eye Opening</u> • E4 – (Spontaneous) Observe the patient's eyes. Patient opens eyes spontaneously, give score of 4.					
• E3 – (Opens To speech) ask the patient loudly and clearly to open eyes. If patient responds by opening eyes, give score of 3.					
• E2 – (To pain). Apply nail bed pressure, patient opens eyes after pressure, give score of 2.					
• E1 - (No response) Apply nail bed pressure, if patient has no response give 1.					
• Record **C** if eyes closed by swelling					
7. <u>Verbal Response</u> • V5 – Oriented to TIME, PLACE, and PERSON. Ask the patient to answer "What day is today? "Where are you at this moment?" If patient answers correctly, give 5.					
• V4 - (Confused). Ask the patient to answer "What day is today? "Where are you at this moment?", if the patient appears slightly confused or disoriented during conversation, give 4.					
• V3 – (Inappropriate words). If patient has random or muddled speech without exchange of info during conversation, give 3.					
• V2 – (Incomprehensible words). If patient is making sounds but is unable to formulate words, give 2.					
• V1 – (No response). IF patient is unable to produce sounds, give1. Don't confused this with aphasia due to laryngeal injury or airway obstruction.					
Record **E** if endotracheal tube is in place, **T** if tracheostomy tube is in place					

8. Motor Response • M6 – (Obeys command). Shake the patient's hand upon arrival. A patient responds and does what you ask, give 6.						
• M5 – (Localized pain) elicit a pain (Supraorbital notch, or nailbed pressure), if patient purposefully attempts to remove the stimulus or pushes away your hand away from pain, give 5.						
• M4 – (Flex to withdraw from pain). Elicit a pain (Supraorbital notch, or nailbed pressure), if patient pulls away from stimulus, give 4.						
• M3 – (Abnormal flexion). Elicit a pain (Supraorbital notch, or nailbed pressure), if patient's arms moves toward their chest, their fingers and wrist flex on their chest and they point their toes, and assumes decorticate position, give 3.						
• M2 – (Abnormal extension). Elicit a pain (Supraorbital notch, or nail bed pressure), if patient's arms and legs extend, wrist rotate away from their body and they point their toes, and assumes decerebrate position, give 2.						
• M1 – (No response). Patient does not have motor response, give 1.						
9. Give the total GCS Eye - ___/4 + Verbal= /5 + Motor= /6 = ____ ____/15						
10. Interpret the results of total GCS GCS 15: NORMAL GCS 13-14: minor depression of consciousness GCS 9-12: moderate depression of consciousness GCS 3-8: COMA						
11. Pupillary Assessment • P-upils- Let the patient sit in a dimly lit room. Assess pupils if they are at the center of the iris, which is the colored part of the eyes. Pupils dilates and constricts when light enters the eyes.						
• E-qually- Check for the same size of the pupils.						
• R-ound- Check for the perfect round shape of the pupils.						
• R-eactive to Light. - Move a penlight to the patient's eyes back and forth every two distance and ask patient to look at a distance, check both pupils react to light at the same time.						
• and Accommodation. Tell the patient to focus on a pen or index finger. Move it towards and away from patient, and side to side, check if pupils can properly focus. The pupils constrict when watching an object that's shifting perspectives.						
12. Interpret Pupil Assessment. Pupils are PERRLA. Pupils are equally round, and reactive to light and accommodation.						
13. Document findings						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING TRACHEOSTOMY CARE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Tracheostomy: is a surgical procedure in which an opening is made into the trachea. The indwelling tube inserted into the trachea is called a tracheostomy tube. A tracheostomy may be either temporary or permanent.

Indication:

- To maintain airway patency
- To maintain cleanliness and prevent infection at the tracheostomy site
- To facilitate healing and prevent skin excoriation around the tracheostomy incision
- To promote comfort

Equipment

- Sterile disposable tracheostomy cleaning kit or supplies including sterile containers, sterile nylon brush and/or pipe cleaners, sterile applicators, gauze squares
- Disposable inner cannula if applicable
- Towel or drape to protect bed linens
- Sterile suction catheter kit (suction catheter and sterile container for solution)
- Sterile normal saline (Some agencies may use a mixture of hydrogen peroxide and sterile normal saline. Check agency protocol for soaking solution.)
- Sterile gloves (two pairs—one pair is for suctioning if needed.)
- Clean gloves
- Moisture-proof bag
- Commercially prepared sterile tracheostomy dressing or sterile 4×4 gauze dressing
- Cotton twill ties or Velcro collar
- Clean scissors

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Tracheostomy care. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

PERFORMING TRACHEOSTOMY CARE	3	2	1	0	Remarks
1. Identify patient					

2. Identify equipment needed: Sterile gloves, Hydrogen peroxide, Normal saline solution or sterile water, Cotton-tipped applicators-Q tips, Dressing, Twill tape, Type of tube prescribed, if the tube is to be changed						
3. A cuffed tube air is injected into cuff) is required during mechanical ventilation. A low- pressure cuff is most commonly used. Patients requiring long term use of a tracheostomy tube and who can breathe spontaneously commonly on uncuffed, metal tube.						
4. Inspect the tracheostomy dressing for moisture or drainage.						
5. Perform hand hygiene.						
6. Explain procedure to patient and family as appropriate.						
7. Places the patient in semi-Fowler's position. Places a towel or linen-saver pad over the patient's chest.						
8. Put on clean gloves, remove & discard the soiled dressing in a biohazard container.						
9. Prepare sterile supplies. Pours hydrogen peroxide into one of the sterile solution containers and pours normal saline solution into the other one.						
10. Opens three 4×4 gauze packages; wets the gauze in one package with hydrogen peroxide; wets the gauze in another package with normal saline; keeps the third package dry.						
11. Opens 2 cotton-tipped applicator packages. Wets the applicators in one package with normal saline solution and wets the applicators in the other package with hydrogen peroxide.						
12. Opens the package containing a new disposable inner cannula, if available.						
13. Opens the package of Velcro tracheostomy ties or cuts a length of twill tape long enough to go around the patient's neck two times. Makes sure to cut end of the tape on an angle.						
14. Dons sterile gloves (or sterile on dominant and clean on non-dominant hand); keeps the glove on the dominant hand sterile. Handles the sterile supplies with the dominant hand only.						
15. With the non-dominant hand removes the oxygen source, if the patient has been receiving supplemental oxygen.						
16. Unlocks and removes the inner cannula with the non-dominant hand and cares for it accordingly: a. Disposable Inner Cannula: Disposes of the inner cannula in the biohazard receptacle according to agency policy.						
b. Reusable Inner Cannula: Places the inner cannula into the basin filled with hydrogen peroxide.						
17. Attaches the oxygen source to the outer cannula, if possible.						
18. Removes the oxygen source, using non-dominant hand, (if the patient requires supplemental oxygen) and reinserts the inner cannula into the patient's tracheostomy in the direction of the curvature.						
19. Reattaches the oxygen source, if indicated.						

20. Cleans the stoma under the faceplate with the cotton-tipped applicators saturated with hydrogen peroxide, using a circular motion from the stoma site outward.						
21. Uses each applicator only once and then discards it.						
22. Clean the top surface of the faceplate and the skin around it with the gauze pads saturated with hydrogen peroxide. Uses each gauze pad only once, and then discards it.						
23. Repeats steps 20, 21, and 22, using the cotton-tipped applicators and gauze pads saturated with normal saline.						
24. Dries the skin and outer cannula surfaces by patting them lightly with the remaining dry gauze pads.						
25. Removes soiled tracheostomy stabilizers: a. Variation: Velcro Tracheostomy Holder: With an assistant stabilizing the tracheostomy tube, disengages the Velcro on both sides of the soiled holder and removes it gently from the eyes of the faceplate. Discards the Velcro holder in the nearest biohazard receptacle.						
b. Variation: Twill Tape Tracheostomy Ties: With the assistant stabilizing the tracheostomy tube, cuts the soiled tracheostomy ties using bandage scissors. Avoids cutting the tube of the tracheostomy balloon. Removes the ties gently from the eyes of the faceplate and discards them in the nearest biohazard receptacle.						
26. Has the patient flex his neck and applies new tracheostomy stabilizers.						
a. Using Twill Tape: 1) Threads one end of the twill tape into one of the eyelets on the tracheostomy faceplate; continues to thread the twill tape through the eyelet, bringing both ends of the tape together.						
2) Brings both ends of the twill tape around the back of the patient's neck.						
3) Threads the end of the twill tape that is closest to the patient's neck through the back of the eyelet on the faceplate.						
4) Has the assistant place one finger under the tape while tying the two ends together in a square knot.						
27. Inserts a precut, sterile tracheostomy dressing under the faceplate and new tracheostomy stabilizers.						
28. Disposes of used equipment/supplies in the appropriate biohazard receptacle, according to agency policy.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

PERFORMING TRACHEAL SUCTIONING

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Suctioning the Tracheal Tube (Tracheostomy or Endotracheal Tube)
Tracheal suctioning is performed when adventitious breath sounds are detected or whenever secretions are obviously present. Unnecessary suctioning can initiate bronchospasm and cause mechanical trauma to the tracheal mucosa. When a tracheostomy or endotracheal tube is in place, it is usually necessary to suction the patient's secretions because of the decreased effectiveness of the cough mechanism.

Indication:
- To remove secretions that obstruct the airway
- To facilitate ventilation
- To obtain secretions for diagnostic purposes
- To prevent infection that may result from accumulated secretions

Equipment:
• Suction catheters
• Gloves (sterile and non-sterile), gown, mask, and goggles for eye protection
• Basin for sterile normal saline solution for irrigation
• Manual resuscitation bag with supplemental oxygen
• Suction source

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Tracheal Suctioning. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

PERFORMING TRACHEAL SUCTIONING	3	2	1	0	Remarks
1. Picks up the suction catheter with the dominant hand and attaches it to the connection tubing.					
2. Puts the tip of the suction catheter into the sterile container of normal saline solution and suctions a small amount of normal saline solution through the catheter. Applies suction by placing a finger over the suction control port of the suction catheter.					
3. Hyper-oxygenates the patient according to agency policy:					

a. Patient Requiring Mechanical Ventilation: Presses the 100% O_2 button on the ventilator or attaches the resuscitation bag to the endotracheal tube or tracheostomy tube and manually hyper-oxygenates the patient by compressing the resuscitation bag 3 to 5 times as the patient inhales. Removes the resuscitation bag and places it next to the patient when finished. b. Patient Not Requiring Mechanical Ventilation: Attaches the resuscitation bag to the tracheostomy or endotracheal tube and hyper-oxygenates the patient by compressing the resuscitation bag 3 to 5 times. Removes the resuscitation bag and places it next to the patient when finished.					
4. Lubricates the suction catheter tip with normal saline.					
5. Using the dominant hand, gently but quickly inserts the suction catheter into the endotracheal tube or tracheostomy tube.					
6. Advances the suction catheter, with suction off, gently aiming downward and being careful not to force the catheter.					
7. Applies suction while withdrawing the catheter.					
8. Does not apply suction for longer than 10 seconds.					
9. Repeats suctioning as needed, allowing at least 30-second intervals between suctioning.					
10. Hyper-oxygenates patient between each pass.					
11. Replaces the oxygen source, if the patient was removed from the source during suctioning.					
12. Coils the suction catheter in the dominant hand (alternatively, wraps it around the dominant hand). Pulls the sterile glove off over the coiled catheter.					
13. Discards the glove and catheter in a water resistant receptacle designated by the agency.					
14. Using the non-dominant hand, clears the connecting tubing of secretions by placing the tip into the container of sterile saline.					
15. Provides mouth care.					
16. Positions the patient in semi-Fowler's position, unless contraindicated.					
17. Places a linen-saver pad or towel on the patient's chest.					
18. Puts on a face shield or goggles.					
19. Turns on the wall suction or portable suction machine and adjusts the pressure regulator according to agency policy (typically 100 to 120 mm Hg for adults, 95 to 110 mm Hg for children, and 50 to 95 mm Hg for infants).					
20. Tests the suction equipment by occluding the connection tubing.					
21. Opens the suction catheter kit or the gathered equipment if a kit is not available.					
22. Dons sterile gloves. Considers the dominant hand sterile and the non-dominant hand non-sterile					
23. Pours sterile saline into the sterile container, using the non-dominant hand.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

INTERPRETING AN ELECTROCARDIOGRAPH

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

Analyzing the Electrocardiogram Rhythm Strip

The ECG must be analyzed in a systematic manner to determine the patient's cardiac rhythm and to detect dysrhythmias and conduction disorders, as well as evidence of myocardial ischemia, injury, and infarction.

1. To help identify
   - ❖ primary conduction abnormalities,
   - ❖ cardiac arrhythmias,
   - ❖ cardiac hypertrophy,
   - ❖ pericarditis,
   - ❖ electrolyte imbalances,
   - ❖ myocardial ischemia, and
   - ❖ the site and extent of myocardial infarction.

2. To monitor recovery from a Myocardial Infarction (MI)

3.To evaluate the effectiveness of cardiac medication

4.To assess pacemaker performance

5. To determine effectiveness of thrombolytic therapy

Equipment
- ECG machine with complete electrodes
- ECG strips
- Lubricating gel
- Gloves
- Paper towel

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in interpreting an ECG. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

STEPS in Assessing & Interpreting ECG	3	2	1	0	Remarks
1. Check the ECG rhythm if it is regular or irregular.					
a. Check sinus rhythm showing standard waves, segments and intervals.					
b. Identify the R waves using a six second strip, measure the R to R intervals between QRS complex and determine if the rhythm is regular or irregular					
c. Interpret the rhythm. Tell if it is regular or irregular.					
2. Calculate the Heart Rate					
a. Use the 1500 method-for regular rhythm- Count the number of small boxes within an R-R interval and divide 1500 by that number					
b. R-R method for irregular rhythm- count the number of RR intervals in 6 seconds and multiply it by 10 (if it is a 6 seconds ECG paper), multiply 10 seconds by 6 (if it is a 10 seconds ECG paper)					
c. Use the formula: 300(1 big box between R-R, 150(2 big boxes), 75(3 big boxes), 60 (4 big boxes, and 50(5 big boxes)					
d. Tell the heart rate value. Interpret if it is normal, bradycardia or tachycardia.					
3. Find the P waves					
a. Check for the presence of P waves					
b. Check if the P waves is upright					
c. Check if it followed by a QRS complex					
d. Describe the P wave (missing, barrowed, waveform, fibrillatory wave, etc.)					
4. Measure the PR interval					
a. Check if it is 0.12-0.20 seconds or 3-5 small boxes on the ECG graph					
b. Tell the duration. Interpret if it is normal, shortened or prolonged.					
5. Measure the QRS complex/segment					
a. Check for the 3 graphical deflections, the negative wave (Q wave); the positive wave above the isoelectric line (R wave) and the negative wave after the positive wave (S wave)					
c. Check time duration is 0.06-0.10 seconds. Write the QRS time.					
d. Describe QRS. Tell if it is normal, wide narrow or fibrillatory in form.					
6. Interpret the overall condition- Normal Sinus rhythm or what type of dysrhythmia					
7. Document findings					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

EMERGENCY

NURSING CARE

SKILL CHECKLISTS

PRIMARY AND SECONDARY SURVEY

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: The primary survey is the initial assessment and management of a trauma patient. It is conducted to detect and treat actual or imminent life threats and prevent complications from these injuries.
The purpose of the secondary survey is to obtain pertinent historical data about the patient and his or her injury, as well as to evaluate and treat all significant injuries not found during the primary survey by performing a systematic, complete examination.

INDICATIONS: Life threatening situations, medical or trauma.

MATERIALS NEEDED:

- PPEs (gloves, masks)
- Airway adjuncts (nasopharyngel, oropharyngeal)
- Penlight
- Extra Linen for patient's privacy

DIRECTIONS:
Below is a list of criteria to evaluate the student's skill in *Primary and Secondary Survey*. Indicate your evaluation by placing corresponding score on the Raw Score column using the following descriptive scale of 0 to 3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

PRIMARY SURVEY	3	2	1	0	REMARKS
A. Scene sizes up					
1. Verbalizes body substance isolation and wear PPE					
2. Scene safety • Safety of the Health Care Team *Safety of the patient • Safety of bystanders					
3. Identify the Mechanism of Injury or Nature of Illness					
B. Initial Assessment					
4. Check for Responsiveness • Is the patient **A**lert? • Respond to **V**erbal stimuli					

• Respond to **P**ain stimuli • Is the patient **U**nresponsive						
5. Airway • Assess and open the airway o Head tilt-chin lift for medical patient o Jaw thrust for trauma patient						
6. Insert airway adjuncts a. Oropharyngeal airway (without gag reflex) b. Nasopharyngeal airway (with gag reflex)						
7. Assess breathing • Look-chest rise and fall * Listen-breath sound • Feel-breathing/air						
8. Evaluate rate, rhythm and quality						
9. Check for symmetry of chest movement						
10. Observe any usage of accessory muscles						
11. Auscultate lungs for presence of bilateral breath sounds						
12. Circulation • Check for major bleeding						
13. Check for perfusion a. Capillary refill						
14. Skin color i. Normal pink ii. Abnormal-cyanotic, pale, jaundice, flushed skin Skin Temperature iii. Normal-warm * Abnormal-Hot and cold						
15. Evaluate Pulse a. Quality *Rhythm *Rate						
16. Disability Assess for Level of Consciousness using GCS						
17. Assess pupil size and reactivity (PERRLA)						
18. Expose • Expose patient to check for additional cues/injuries that are hidden (whenever necessary)						
SECONDARY SURVEY						
TRAUMA PATIENT						
19. SAMPLE HISTORY Accurate assessment of history/ mechanism of injury incorporating: • S – igns/ symptoms • A – allergies • M- medications • P - past medical & surgical history • L – last oral intake						

• E - events leading to illness or injury					
HEAD TO TOE ASSESSMENT					
20. HEAD • Inspects mouth, nose, and assesses facial area • Inspects and palpates scalp and ears					
21. NECK • Checks position of trachea • Checks jugular veins* Palpates cervical spine					
22. CHEST • Inspects, palpates, auscultate chest					
23. ABDOMEN/PELVIS • Inspects and palpates abdomen* Assesses pelvis • Verbalizes assessment of genitalia/perineum as needed					
24. UPPER EXTREMITIES • Inspects, palpates, and assesses motor, sensory, and distal circulatory functions					
25. LOWER EXTREMITIES • Inspects, palpates, and assesses motor, sensory, and distal circulatory functions					
26. POSTERIOR THORAX, LUMBAR AND BUTTOCKS • Inspects and palpates posterior thorax • Inspects and palpates lumbar and buttocks area					
MEDICAL PATIENT					
27. HISTORY OF PRESENT ILLNESS • Onset *Provocation *Quality* Radiation/region • Severity *Time					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

TRIAGE

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: To identify and prioritize those with the most urgent needs to use the emergency service first.

INDICATIONS: Performed during mass casualty incidences.

MATERIALS NEEDED:

- PPEs (masks, gloves, gown as indicated)
- Triage tags

DIRECTIONS: Below is a list of criteria to evaluate the student's performance in performing *Triage*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

PRIMARY SURVEY	3	2	1	0	REMARKS
Scene size up					
1. Verbalizes body substance isolation and wear PPE					
2. Scene safety • Safety of the Health Care Team • Safety of the patient • Safety of bystanders					
3. Call for assistance and start triaging					
4. Able to sort patients • Separate walking wounded and uninjured from others					
5. Identify patient/s with minor injury (green category)					
RESPIRATION					
6. Able to assess the respiration of the patient/s and identify life threats • Present o Under 30 cycles per minute o over 30 cycles per minute • Absent o Reposition the airway and Look Listen and Feel					
7. Categorize patient/s correctly based on the assessment of respiration					

(immediate, delayed or dead)					
PERFUSION					
8. Able to assess perfusion (radial pulse and/or capillary refill) of the patient/s and identify life threats • Radial pulse (present or absent) • Capillary refill (over 2 seconds or under 2 seconds)					
9. Categorize patient/s correctly based on the assessment findings (Immediate or delayed)					
MENTAL STATUS					
10. Able to assess mental status of the patient/s and identify life threats • Follow simple commands • Can't follow simple commands					
11. Categorize patient/s correctly based on the assessment findings (Immediate or delayed)					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADULT 1 RESCUER CPR

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: The goal of CPR is to keep oxygen flowing in and out of the lungs and to keep oxygenated blood flowing through the body. This will delay tissue death. During cardiac arrest, the heart cannot pump blood to the rest of the body, including the brain and lungs. Death can happen in minutes without treatment. CPR uses chest compressions to mimic how the heart pumps. These compressions help keep blood flowing throughout the body.

INDICATIONS: CPR should be performed immediately on any person who has become unconscious and is found to be pulseless. Assessment of cardiac electrical activity via rapid rhythm strip recording can provide a more detailed analysis of the type of cardiac arrest, as well as indicate additional treatment options

MATERIALS NEEDED:

- PPEs (gloves, mask)
- Adult Resusci Manikin

DIRECTIONS: Below is a list of criteria to evaluate the student's performance performing *Adult 1-Rescuer CPR*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

ADULT 1 RESCUER CPR	3	2	1	0	REMARKS
1. Body substance isolation/Wear Personal Protective Equipment					
2. Check scene safety					
3. Establish unresponsiveness					
4. Call for HELP and Activate medical assistance					
5. Locate and check carotid pulse near you (@least 5 secs but not more than 10 secs) at the same time check for breathing (rise and fall of the chest).					
Instructor must state that the patient has no pulse					
6. Start CPR • 2 hands placed on the lower half of the sternum (2nd hand on top of the first) • *30 compressions:2 breaths, depth 5-6 cm/ at least 2 inches at a rate of 100-120 compressions per minute*					
7. Open airway using head tilt chin lift maneuver and deliver 2 rescue breaths (deliver each breath over 1 sec) using the bag mask					

8. Continue CPR until 5cycles is finished.					
9. Recheck pulse *Note: patient still no pulse, repeat procedure 6-9*					
Instructor must state that the patient has pulse and good breathing					
10. Place patient in recovery position					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

AIRWAY OBSTRUCTION MANAGEMENT

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: To prevent and relieve airway obstruction. This ensures an open pathway for gas exchange between a patient's lungs and the atmosphere.

INDICATIONS: (1) Failure to oxygenate.
(2) Failure to ventilate.
(3) Failure to maintain a patent airway.
The modality of airway management primarily depends on the cause and severity of the patient condition but is also subject to factors such as environment and clinician skill.

MATERIALS NEEDED:

- PPEs (gloves, mask)
- Adult Resusci Manikin
- Infant Resusci Manikin

DIRECTIONS: Below is a list of criteria to evaluate the student's performance performing *Airway Obstruction Management*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

HEIMLICH MANEUVER: Conscious Choking ADULT	**3**	**2**	**1**	**0**	**REMARKS**
1. Ask person who appears to have choked but who is not coughing, "Are you choking?"					
2. Determine that victim cannot expel object on own and state that you will help.					
3. Stand behind victim.					
4. Wrap arms around victim's waist.					
5. Clench fist, keeping thumb straight.					
6. Place clenched fist, thumb side in, against abdomen between navel and tip of sternum.					

7.	Grasp clenched fist with opposite hand.					
8.	Push abdomen forcefully with upward thrusts until object is removed, victim starts to cough, or becomes unconscious.					
9.	Once patient start to cough and speak; stop the maneuver and ask patient to sit and rest.					
Conscious Choking INFANT						
1.	Look for choking signs, like bluish skin, lips or nose, high-pitched noise.					
2.	Tap baby's foot and check for responsiveness.					
3.	Pick up the infant and give 5 back blows between the shoulder blades, with the head supported and with the head lower than the infant's bottom.					
4.	Then flip the infant and provide 5 chest thrusts just below the nipple line, keeping the head lower that the infant's bottom.					
5.	Repeat until infants able to cry or becomes unconscious.					
6.	Carry the baby once start to cry and become conscious.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

BANDAGING

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: To hold dressings in place, apply pressure to a part, immobilize a part, obliterate cavities, support an injured area, and check hemorrhages. Allow for the effective provision of wound care for a variety of different injuries and facilitate the wound healing process.

INDICATIONS: Circular Bandage- used primarily for anchoring a bandage-where it is begun and where it is terminated.
Spiral Bandage- injuries in the wrist, the finger and the trunk, wrist, upper arm and upper leg.
Figure of Eight- around joints, such as the knee, the elbow, the ankle and the wrist.
Recurrent Bandage- used for fingers, hand and for the stump of an amputated limb.

MATERIALS NEEDED:

- PPEs (gloves)
- Elastic bandage/ Crepe bandage
- Micropore tape
- Pins

DIRECTIONS: Below is a list of criteria to evaluate the student's performance performing *Bandaging*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

BANDAGING	3	2	1	0	REMARKS
1. Assemble equipment					
2. Explain procedure and obtain permission. Wash hands, dry and don gloves. Provide privacy					
3. Assist victim to assume comfortable position & support the body part to be bandaged.					
4. Always stand in front of the part/ victim to be bandaged except when applying bandage to the head, eye & ear.					
5. Be sure the bandage is rolled firm. Expose part to be bandaged, making sure it is clean, dry & no skin breakdown.					

6. Observe circulation by noting pulse, surface temperature, skin color & sensation of the body part to be wrapped					
7. Hold bandage so that roll is up and loose end is on bottom.					
8. Apply bandage from the smallest part of extremity to be bandaged.					
9. Make two circular turns around extremity and proceed with the chosen type of bandaging.					
10. **Circular bandaging**: The bandage is wrapped around the part with complete overlapping of the previous bandage turn.					
11. **Spiral bandaging**: The bandage ascends in a spiral manner so that each turn overlaps the preceding one by one-half or two-thirds or 30-degree angle of the width of the bandage.					
12. **Figure-of-eight**: The figure-of-eight turn consists of making oblique overlapping turns that ascend and descend alternatively.					
13. **Recurrent bandaging**: the initial end of the bandage is placed in the center of the body part being bandaged, well back from the tip to be covered.					
14. Apply bandage smoothly with firm, even pressure.					
15. End the bandaging with two circular turns.					
16. Pin, tape, or clip end of bandage to hold in place Make sure pin or clip is not under body part.					
17. Check extremity for the following: • **P**ain *__P__ulselessness * **P**aresthesia • **P**allor *__P__oikilothermia					
18. Instruct patient to report feeling of pain, numbness or tingling sensations on the bandaged area. Remove the bandage if those symptoms are present & report immediately.					
19. Remove gloves and wash hands. Document.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

SPLINTING

Name of Student: _____ **Section: ----------**

Student ID: ---------- **Date: ----------**

PURPOSE: (1) Immobilize musculoskeletal injuries, support healing, and to prevent further damage.
(2) Provide pain relief of the fractured limb.
(3) Support bone ends of the fracture site.
(4) Helps prevent bone protruding through the skin, soft skin and tissue damage, as well as bleeding.

INDICATIONS: Temporary stabilization of acute fractures, sprains, or strains before further evaluation or definitive operative management.

MATERIALS NEEDED:
- PPEs (gloves)
- Triangular bandage

DIRECTIONS: Below is a list of criteria to evaluate the student's performance performing *Splinting*. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory Demonstrates required level in a consistent and efficient manner
2 - Borderline Performs with minimal error or omission (1-2 mistakes)
1 - Unsatisfactory Performs with numerous errors or omissions (3 and more mistakes)
0 - Poor Procedure is not done

SPLINTING -SLING and SWATHE	3	2	1	0	REMARKS
1. Assemble equipment: triangular bandages					
2. Explain procedure and obtain permission Wash hands, dry and don gloves Provide privacy					
3. Support the injured area above and below the site of the injury, including the joints.					
4. Don't try to realign bones or joints.					
5. Immobilize above and below the injury.					
6. For an injured arm: • A triangular bandage can be used as a **sling**, to support the arm in a bent position over the chest.					
7. A second cravat (folded as a long band) can be used around the torso as a **swathe**, to immobilize the arm against the chest.					

8. After splinting, check for proper circulation (warmth, feeling, and color). • Instruct patient to report feeling of pain, numbness and tingling sensation.						
9. Remove gloves and wash hands						
10. Document						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

COMMUNITY

HEALTH NURSING

SKILL CHECKLISTS

Evaluation Criteria for Family Health Care

Student name…… **Student number……**
Section……. **Date……**

PURPOSE: family care includes meeting the basic needs of its members for health, nutrition, shelter, physical and emotional care, and personal individual development, as well as the maintenance of family morale and the customs, values, and beliefs of the family's culture.
INDICATION: To help family to develop and strengthen its capacity to meet its health needs and solve health problems.

EQUIPMENT:
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR).
- Community health bag.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Evaluation Criteria for Family Health Care.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

1	Greeting the family	**3**	**2**	**1**	**0**	**REMARKS**
2	Introduce your self					
3	Explain the purpose of the family assessment or the visit					
4	Assessment of Family members (physical mental & social)					
5	Health needs identified					
6	Planning for family health nursing care (including short term & long-term plan)					
7	Implementation of home nursing care plan with scientific rationale					
8	Health education planning & implementation					
9	Planning for diet					
10	Drugs study & home care					
11	Evaluation: - Outcome of family health care - Self learning as a Nurse					
12	Future plan					
13	Conclusion & suggestion					
14	Use of table / graphs etc.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Evaluation Criteria for Elderly Health Care

Student name…… Student number……

Date…… Section…….

PURPOSE: Provide protection against Alzheimer's disease, disabilities, cardiovascular problems, and impairment, and lead to longer, happier live.

INDICATION: To provide a safe, welcoming, nurturing, environment where service users can develop and grow at their own pace to maximize their potential emotionally, physically, intellectually, socially, and spiritually

EQUIPMENT:

• Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR).

• Community health bag.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Evaluation Criteria for elderly Health Care.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:

3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*

2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*

1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*

0 - Poor *Procedure is not done*

No.	***Items***	**3**	**2**	**1**	**0**	**REMARKS**
1	Greeting the elderly patient					
2	Review medical history					
3	Perform hand hygiene, put on PPE, if indicated.					
4	Introduce your self					
5	Explain the purpose of the elderly assessment or the visit					
6	Close the curtains, close the door. Discuss procedure with patient, assess patients. ability to assist with the procedure.					
7	Assess patient's overall appearance and behavior.					
8	Assess the patient's mobility.					
9	Take Vital Signs and Oxygen Saturation					
10	Weigh the patient using a scale.					
11	Measure patient's height.					
12	Assessment of elderly (physical)					
13	Assessment of elderly (Mental)					
14	Assessment of elderly (Social)					
15	Health Problem identified					

16	Planning for elderly health nursing care (including short term & long-term plan)					
17	Implementation of home nursing care plan with scientific rationale					
18	Health education planning & implementation					
19	Planning for diet					
20	Evaluation: - Outcome of elderly health care - Self learning as a Nurse					
21	Future plan					
22	Conclusion & suggestion					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Home Visit

Student name…… Student number……

Date…… Section…….

PURPOSE: Home visiting is a prevention strategy used to support pregnant moms and new parents to promote infant and child health, foster educational development and school readiness, and help prevent child abuse and neglect.
INDICATION: reducing the frequency of hospitalization in the older adults and improving physical and psychosocial health.

EQUIPMENT:
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR).
- Community health bag.

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for *Evaluation Criteria for elderly Health Care.* Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

Getting Ready (Preparation for Visit)	**3**	**2**	**1**	**0**	**REMARKS**
1. Review of the family's chart.					
2. Prepare nursing care plan.					
3. Contact the family to set up appropriate time for home visit.					
4. Assessment of personal supplies & equipment (Inventory of **nurse's bag content).**					
Initiation Phase:					
1. Knock on the door & gain entrance into the residence.					
2. Introduce self and other colleague (if present) and the agency.					
3. Clearly states the expected purpose of the visit.					
4. Allow a few moments of socialization before beginning the visit.					
5. Ask the family if there is a pressing concern that they would like to deal with first, and if so, follows their lead.					
6. If this is the first visit, discuss expectations and management of future visits.					
7. Place the bag on a clean surface (not the floor).					
8. Wash hands before removing equipment from the bag.					

9. Places contents of bag on a clean surface.						
Implementation Phase						
If this is the first visit, assessment of:						
Client's environment.						
Thorough physical assessment.						
Psychosocial needs.						
Functional abilities.						
Medication.						
Nutrition.						
During Subsequent Visit:						
Takes vital signs.						
Perform a routine head- to- toe assessment**.**						
Explain any procedure (according to situation) before, during and after care.						
Clean, dispose contaminated materials. The client & caregivers should be taught proper management of contaminated wastes & rational behind such management.						
Wash hands before returning materials.						
Wash hands between family members.						
Maintain safe environment.						
Use proper communication technique.						
Appropriate referral.						
Teaching related to individual, use simple and understandable language.						
Teaching related to family.						
Use appropriate methods & materials in the instruction process.						
Termination Phase:						
Briefly summarizes the continuing plan of care with the family.						
Set up a time & the purpose for the next home visit.						
POST VISIT ACTIVITIES						
Document home visit in complete, concise, & accurate manner.						
Communicate finding to other health care provider.						
Review of the family's chart.						
Prepare nursing care plan.						
Contact the family to set up appropriate time for home visit.						
Assessment of personal supplies & equipment (Inventory of nurse's bag content)						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Administering Intradermal Injection

Student name…… Student number……

Date…… Section…….

PURPOSE: The intradermal route has the longest absorption time of all parenteral routes for this reason are used for sensitivity tests, such as tuberculin and allergy tests and local anesthesia.

INDICATION: are used for sensitivity tests, such as tuberculin and allergy tests and local anesthesia.

EQUIPMENT:

- Prescribed Medication
- Sterile syringe, usually a tuberculin syringe calibrated in tenths and hundredths, and needle, ¼ to ½ inch, 25 or 27 gauge
- antimicrobial swab
- disposable gloves
- small gauze square
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)
- PPE, as indicated

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for ***administering intradermal (id) Injection.*** Indicate your evaluation by placing a corresponding score on the raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:

3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

No.	*Goal: The medication is injected, and a wheal appears at the site of injection.*	*3*	*2*	*1*	*0*	*Remar*
1	Gather equipment. Check each medication order against the original order in the medication record. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administration in the medication area.					
5	Unlock the medication cart or drawer. Enter pass code into the computer and scan employee identification, if required.					
7	Read the Medication Record and select the proper medication from the unit stock or patient's medication drawer.					
8	Compare the medication label with the Medication Record. Check expiration dates and perform calculations, if needed.					

	9	**Withdraw the medication from an ampule or vial.**						
	10	When all medications for one patient have been prepared, recheck the labels with the Medication Record before taking the medications to the patient.						
	11	Lock the medication cart before leaving it.						
	12	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.						
	13	Perform hand hygiene and put on PPE, if indicated.						
	14	Identify the patient using at least two methods. ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.						
	15	Provide privacy. (Close the door to the room and pull the bedside curtain.)						
	16	Check about allergies. Explain the purpose and action of each medication to the patient.						
	17	Recheck the labels with the Medication Record before administering the medications to the patient.						
	18	Put on clean gloves.						
	19	Select the appropriate administration site. Assist the patient to the appropriate position for the site chosen. Drape, as needed, to expose only site area to be used.						
	20	Cleanse the site with an antimicrobial swab while wiping with a firm, circular motion and moving outward from the injection site. Allow the skin to dry.						
	21	Remove the needle cap with the non-dominant hand, pulling it straight off.						
	22	Use the non-dominant hand to spread the skin taut over the injection site.						
	23	Hold the syringe in the dominant hand, between the thumb and forefinger with the bevel of the needle up.						
	24	Hold the syringe at a 5-15 degrees angle from the site. Place the needle almost flat against the patient's skin, bevel side up, and insert the needle into the skin. Insert the needle only about 1/8 inch with entire bevel under the skin.						
	25	Once the needle is in place, steady the lower end of the syringe. Slide your dominant hand to the end of the plunger.						
	26	Slowly inject the agent while watching for a small wheal or blister to appear.						
	27	Withdraw the needle quickly at the same angle that it was inserted. Do not recap the used needle. Engage the safety shield or needle guard.						
	28	**DO NOT MASSAGE** the area after removing the needle. Tell the patient not to rub or scratch the site. If necessary, gently blot the site with a dry gauze square. Do not apply pressure or rub the site.						
	29	Assist the patient to a comfortable position.						
	30	Discard the needle and syringe in the appropriate receptacle.						
	31	Remove gloves and additional PPE, if used. Perform hand hygiene.						
	32	Document the administration of the medication immediately after administration.						
	33	Evaluate the patient's response to the medication within an appropriate time frame.						

34	Observe the area for signs of a reaction at determined intervals after administration. Inform the patient of the need for inspection.						

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

ADMINISTERING INTRAMUSCULAR (IM) INJECTION

Student name…… Student number……

Date…… Section…….

PURPOSE: Chosen when a reasonably rapid systemic uptake of the drug is needed by the body and when a relatively prolonged action is required.

INDICATION:

- ✓ Administering medication, Antibiotics- penicillin G benzathine.
- ✓ Vaccines.
- ✓ Hormonal agents- testosterone.

EQUIPMENT:

- Gloves
- Additional PPE, as indicated.
- Medication
- Sterile syringe and needle of appropriate size and gauge:
  - Adult: 19-25G, 1 - 1.5 inches
  - Infant: 25-27G, 7/8 - 1 inch
  - Child >18mos: 22-25G, 7/8 - 1 1/4 inches
- Microbial swab
- Small gauze square
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR)

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for **administering intramuscular (IM) injection.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

No.	*Goal: The patient receives the medication via the intramuscular route and experiencesthe intended effect of the medication.*	*3*	*2*	*1*	*0*	*Remarks*
1	Gather equipment. Check each medication order against the original order in the medicalrecord. Clarify any inconsistencies. Check the patient's chart for allergies.					
2	Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider theappropriateness of the medication for this patient.					
3	Perform hand hygiene.					
4	Move the medication cart to the outside of the patient's room or prepare for administrationin the medication area.					

	5	Unlock the medication cart or drawer. Enter pass code into the computer and scanemployee identification, if required.					
	6	Read the Medication Record and select the proper medication from the unit stock orpatient's medication drawer.					
	7	Compare the medication label with the Medication Record. Check expiration dates andperform calculations, if needed.					
	8	**Withdraw the medication from an ampule or vial.**					
	9	When all medications for one patient have been prepared, recheck the labels with theMedication Record before taking the medications to the patient.					
	10	Lock the medication cart before leaving it.					
	11	Transport medications to the patient's bedside carefully and keep the medications in sightat all times. Ensure that the patient receives the medications at the correct time.					
	12	Perform hand hygiene and put on PPE, if indicated.					
	13	Identify the patient using at least two methods: ➢ Check the name on the patient's identification band. ➢ Check the identification number on the patient's identification band. ➢ Check the birth date on the patient's identification band. ➢ Ask the patient to state his/her name and birth date, based on facility policy.					
	14	Provide privacy.					
	15	Check about allergies. Explain the purpose and action of each medication to the patient.					
	16	Recheck the labels with the Medication Record before administering the medications tothe patient.					
	17	Put on clean gloves.					
	18	Select the appropriate administration site. Assist the patient to the appropriate position forthe site chosen. Drape as needed, expose only the site area being used.					
	19	Identify the appropriate landmarks for the site chosen.					
	20	Cleanse the site with an antimicrobial swab while wiping with a firm, circular motion andmoving outward from the injection site. Allow the skin to dry.					
	21	Remove the needle cap by pulling it straight off. Hold the syringe in dominant hand between the thumb and forefinger.					
	22	Displace the skin in a Z-track manner. Pull the skin down or to one side about 1 inch (2.5cm) with non-dominant hand and hold the skin and tissue in this position.					
	23	Quickly dart the needle into the tissue, needle is perpendicular to the patient's body, anangle between 72 and 90 degrees.					
	24	As soon as the needle is in place, use the thumb and forefinger of non-dominant hand to hold the lower end of the syringe. Slide the dominant hand to the end of the plunger.Inject solution slowly (10 seconds/ml of medication).					
	25	Once the medication has been instilled, wait 10 seconds before withdrawing the needle.					

26	Withdraw the needle smoothly and steadily at the same angle at which it was inserted,supporting tissue around the injection site with non-dominant hand.					
27	Apply gentle pressure at the site with a dry gauze. DO NOT MASSAGE THE SITE.					
28	Do not recap the used needle. Engage the safety shield or needle guard, if present. Discardthe needle and syringe in the appropriate receptacle.					
29	Assist the patient to a comfortable position.					
30	Remove gloves and additional PPE, if used. Perform hand hygiene.					
31	Document the administration of the medication immediately after administration.					
32	Evaluate the patient's response to the medication within an appropriate time frame.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Ministry of Higher Education
Kingdom of Saudi Arabia
University of Tabuk
Faculty of Nursing
Medical Surgical Department

Mental

HEALTH NURSING

SKILL CHECKLISTS

NURSE PATIENT INTERACTION

Student name…… Student number……

Date…… Section…….

DIRECTIONS: Below are lists of criteria to evaluate the student's communication skills during **Nurse-Patient Interaction.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

CHECKLIST: NURSE PATIENT INTERACTION	3	2	1	0	Remarks
1. Address client by name; introduce self and role; used clear, specific communication.					
2. Assess client's need, coping strategies, defenses, and adaptation styles.					
3. Assess client's language, ability to speak, literacy level, ability to hear, ensure client hears and understand words.					
Orientation Phase					
4. Create a climate of warmth and acceptance, was aware of non-verbal cues, provided comfort and support.					
5. Use appropriate non-verbal behavior					
6. Observe client's non-verbal behaviors, sought clarification if necessary.					
7. Explain purpose of interaction when information was being shared.					
8. Use active listening					
9. Interview client about health status, lifestyle, support system, patterns of health and illness, and strengths and limitation.					
10. Encourage client to ask clarification at any time.					
Working Phase					
11. Use therapeutic communication techniques when interacting with client.					
12. Help client express needs and feeling.					
13. Use question carefully and appropriately, asked one					

question at a time' used direct question, used open-ended statements as much as possible					
14. Avoid communication barriers or non-therapeutic communication technique					
15. Observe client's verbal and non-verbal responses and willingness to share information and concerns.					
16. Note your response to client and client's response to you, reflected on effectiveness of technique.					
Termination Phase					
17. Use therapeutic communication skills to discuss discharge or termination issues, guided discussion to patient changes in thoughts and behavior.					
18. Summarize with client what was discussed during interaction and restated goals, reinforced patient strengths, outlined issues requiring work, develop an action plan.					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

MINI MENTAL STATUS EXAMINATION

Student name…… Student number……

Date…… Section…….

DIRECTIONS: Below are lists of criteria to evaluate the student's communication skill during **Mini Mental Status Examination.** Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

MINI MENTAL STATUS EXAMINATION CHECKLIST	3	2	1	0	*Remarks*
1. Explains the procedure briefly to the patient.					
2. Checks patient's orientation by asking: • 'What is the year, season, month, day, date?' • 'Where are we: country, province, city, hospital, room?'					
3. Checks patient's memory – registration. • Names three unrelated objects, taking 1 second to say each. • Then asks the patient to repeat all three. (Rehearses the answers if needed until the patient has learnt all three).					
4. Checks patient's attention and calculation. 2 methods acceptable here: • Asks patient to count backwards by 7s, starting with 100 (93, 86, 79, 72, 65). Stops patient after these 5. OR • Asks the patient to spell the word 'world' backwards.					
5. Checks patient's memory – recall. • Asks the patient to repeat the names of the three objects learned in question 3 above.					
6. Checks patient's language – naming. • Points to a pencil and a watch, asks the patient to name them as s/he points					
7. Checks patient's language – repetition. • Asks patient to repeat after her/ him (one trial lonely allowed): 'No ifs, ands or buts'.					

8. Checks patient's language – 3 stage command. • Tells the patient, once only: 'Take this paper in your right hand. Fold the paper in half. Put the paper on the floor.'					
9. Checks patient's language – reading. • Writes large on a piece of paper: 'Close your eyes'; asks patient to read and carry out. instruction.					
10. Checks patient's language – writing. • Asks patient to write a sentence of his/ her choice. Check if the sentence has a subject and a verb and make sense (spelling not important)					
11. Checks patient's ability to copy. Asks patient to copy a design provided (it is on the table). Check the point if all 5 sides are preserved and if the intersecting sides form a diamond shape					
12. Communicates the examination findings briefly to the patient					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

Hallucination Rating Scale

Student name…… Student number……

Date…… Section…….

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Mental State Examination (hallucination State). Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

HALLUCINATION RATING SCALE CHECKLIST	3	2	1	0	RATING
1. Explains the procedure briefly to the patient. I will ask him the following questions:					
2. How often do you experience voices?					
3. When you hear voices, how long do they last?					
4. When you hear your voices, where do they sound like they are coming from? Do you hear it inside your head or outside your head? If voices sound like they are outside your head, where do you think they are coming from?					
5. How loud are the voices? Are they louder than your voice, about the same loudness, quieter or just a whisper?					
6. What do you think are the causes of these voices? Are the voice caused by factors related to yourself, or solely due to other people, or other factors? If the individual expresses an external origin: How much do you believe that your voices are caused by_____ (add attribution) on a scale of 0-100 with 100 being that you are totally convinced, have no doubts, and 0 being that it is totally untrue?					
7. Do your voices say unpleasant or negative things? Are you able to give an example(s) of what the voices say? How much of the time do the voices say these type of unpleasant or negative things?					
8. Rate using criteria or scale, asking patient for more detail if necessary.					
9. Are your voices distressing? • How much of the time?					

10. When voices are distressing, how distressing are they? • Do they cause you minimal. Moderate, severe distress?					
11. How much disruption do the voices cause to your life? • Do the voices stop you from taking part in daytime activities? • Do they interfere with your relationship with other patients / friends / family? • Do they prevent you from looking after yourself?					
12. Do you have any control over the voices? • Can you call up the voices? • Can you make the voices stop / go away?					
TOTAL: 36/36					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____

Comments: ----------

Student Signature: _____ Clinical Instructor Signature: _____

DELUSION RATING SCALE

Student name…… Student number……

Date…… Section…….

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in performing Mini Mental State Examination. Indicate your evaluation by placing a corresponding score on the Raw Score column using the following descriptive scale of 0-3.

Raw Score (R) based on the student's performance:
3 - Satisfactory *Demonstrates required level in a consistent and efficient manner*
2 – Borderline *Performs with minimal error or omission (1-2 mistakes)*
1 - Unsatisfactory *Performs with numerous errors or omissions (3 and more mistakes)*
0 - Poor *Procedure is not done*

DELUSION RATING SCALE CHECKLIST	3	2	1	0	RATING
21. AMOUNT OF PREOCCUPATION WITH DELUSION • How much time do you spend thinking of your beliefs?					
22. DURATION OF PREOCCUPATION WITH DELUSIONS • When the beliefs come into your mind, how long do they persist? –few seconds / minutes / hours					
23. CONVICTION • At the present time how convinced are you that your beliefs are true? • Can you estimate this on a scale from 0-100, where 100 means that you are totally convinced by your beliefs and 0 being that you are not convinced at all.					
24. AMOUNT OF DISTRESS • Do you beliefs cause you distress? • How much of the time do they cause you distress?					
25. INTENSITY OF DISTRESS • When your beliefs distress you, how severe does this feel?					
26. DISRUPTION OF LIFE CAUSED BY BELIEFS • How much disruption do your beliefs cost you? • Do they prevent you from working or carrying out daytime activity? • Do they interfere with your relationships with family or friends? • Do they interfere with your ability to look after yourself e.g. washing, changing clothes.					
TOTAL: 18/18					

Total Raw Score/Total No. of Points X weigh in % = _____/_____ X ____% = _____
Comments: ----------
Student Signature: _____ Clinical Instructor Signature: _____

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3. Murray, S. S., & McKinney, E. S. (2019). *Foundations of maternal-newborn and women's health nursing* (7th ed.). Saunders.

4. Susan Scott Ricci (2017) Essentials of Maternity, Newborn, and Women's Health Nursing, Fifth Edition. Philadelphia, Wolters Kluwer".

5. Hockenberry, M. & Wilson, D. (2020). Wong's Nursing Care of Infants and Children. 11th edition. London: Mosby Company"