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University of Tabuk

Ministry of Higher Education
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University of Tabuk
Faculty of Applied Medical Science
Department of Nursing

Adult Health Nursing Skills Procedure Manual

ADULT HEALTH NURSING 1 SKILLS LABORATORY

2nd Edition, 2018

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P R E F A C E

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 as 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.

The clinical nursing skills for the nurses are of paramount importance not only to provide comprehensive care but also to enhance clinical competence. The purpose of preparing this Nursing Skills Procedure Manual is to prepare University of Tabuk Nursing students and ultimately be fit for registered practice as well as to ensure that every UT student nurse could become proficient in all the necessary skills. Doing skills before having actual clinical experience gives UT nursing students the opportunity to practice clinical procedures in a safe environment and make mistakes without endangering patients. This also will provide an ideal opportunity for lecturers to assess the students and ensure that they had achieved the appropriate level of clinical competence or proficiency and to evaluate their performance in a 'controlled' learning environment.

The Adult Health Nursing Skills Procedure Manual, revised edition, is composed of skills checklists designed to meet learning outcomes of the courses, Adult Health Nursing 1 and 2 - Practical. Specifically, it encompasses the skills in meeting the needs of clients with alterations/disorders in fluids and electrolytes, gas exchange and respiratory function, cardiovascular, circulatory and hematologic function, digestive and gastrointestinal function, metabolic and endocrine function, urinary tract and renal function, immunologic function, neurologic function, and musculoskeletal function. It also includes skills in providing perioperative nursing care.

Adult Health Nursing-Practical Lecturers
Department of Nursing
Faculty of Applied Medical Science
University of Tabuk

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Revised Edition, 2019

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الرؤية

Vision

التميز في تعليم التمريض والبحث العلمي و خدمة المجتمع.

Excellence in nursing education, research, and community services.

الرسالة

Mission

تخريج ممرضين أكفاء قادرين على تعزيز الرعاية الصحية من خلال معايير تعليمية عالية الجودة وأبحاث مبتكرة تلبي الاحتياجات الصحية للمجتمع.

To graduate competent nurses who are able to enhance healthcare services through high quality educational standards and innovative research that addresses the health needs of the community.

الأهداف

Goals

1. To achieve excellence in nursing education through an advanced educational environment that promotes creativity and innovation.
2. To enhance faculty members capacity and professional development.
3. To achieve national and international accreditation.
4. To establish partnership with national and international institutions to enhance nursing education.
5. To conduct research relevant to the health care.
6. To provide educational activities that increases awareness towards health promotion and prevention of illnesses and its complications.

1. تحقيق التميز في تعليم التمريض من خلال بيئة تعليمية متقدمة تعزز الإبداع والابتكار.
2. تعزيز القدرات والتطور المهني لأعضاء هيئة التدريس.
3. تحقيق الاعتماد الوطني والدولي.
4. إقامة شراكة مع المؤسسات الوطنية والدولية لتعزيز تعليم التمريض.
5. إجراء البحوث المتعلقة بالرعاية الصحية.
6. توفير الأنشطة التعليمية التوعوية من أجل تعزيز الصحة والوقاية من الامراض ومضاعفاتها

القيم

Values

1. Quality and Distinction
2. Creativity and Innovation
3. Leadership and Team work
4. Loyalty and Commitment
5. Transparency and Accountability
6. Fairness and Honesty
7. Confidentiality and Respect

1. الجودة والتميز
2. الإبداع والابتكار
3. القيادة والعمل الجماعي
4. الولاء والانتماء
5. الشفافية والمساءلة
6. النزاهة والامانة
7. السرية والاحترام

Table of Contents

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

SURGICAL SCRUBBING, APPLYING STERILE GOWN and GLOVES

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for scrubbing, gowning and gloving. 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: Completes surgical scrub, applies sterile gown and gloves via closed method.*	*3*	*2*	*1*	*0*	*Remarks*
Surgical Scrub Procedure						
1	Use a deep sink with side or foot pedal. Have two surgical scrub brushes and nail file. Remove rings, watches, and bracelets. (Note: Sterile field has been created by Instructor already)					
2	Apply surgical shoe covers and cap to cover hair and ears completely and mask.					
3	Stand in front of sink, being careful that uniform does not touch sink during washing procedure.					
4	Turn on warm water; wet hands under flowing water, beginning at tips of fingers, to forearms—keeping hands at level above elbows. Prewash hands and forearms to 2 inches above the elbow.					
5	Apply a liberal amount of soap onto hands, and rub hands and arms to 2 inches above elbows.					
6	Using nail file under running water, clean under each nail of both hands, and drop file into sink when finished.					
7	Open prepackaged scrub brush if available. If not, wet and apply soap to scrub brush. With brush in dominant hand, in circular motion, scrub nails and all skin areas of nondominant hand and arm-- 10 strokes to nails; palm of hand, and anterior side of fingers.					
8	Rinse brush thoroughly, and reapply soap.					
9	Continue to scrub of nondominant arm with a circular motion for 10 strokes each to the lower, middle, and upper arm; drop brush into the sink.					
10	Maintain hands and arms above elbow level, place fingertips under running water, and thoroughly rinse fingers, hands, and arms (allow water to run off elbows into the sink); take care not to get uniform wet.					
11	Take the second scrub brush and repeat Actions 7-10 on dominant hand and arm.					
12	Keep arms flexed and proceed to operating or procedure room with sterile items.					
13	Secure sterile towel by grasping it on one edge, opening the towel, full length, making sure it does not touch uniform.					
14	Dry each hand and arm separately; extend one side of the towel around fingers and hand, and dry in a rotating motion up to the elbow.					
15	Reverse the towel and repeat the same action on the other hand and arm, thoroughly drying the skin.					
16	Discard the towel into a linen hamper.					
	Total Score:					
Applying Sterile Gown and Gloves						
1	Open the package of sterile gloves. Remove the outer wrap from the sterile gloves and leave the gloves in their inner sterile wrap on the sterile field. (The sterile gown is folded inside out.)					
2	Grasp the gown inside the neckline, step back, and allow the gown to open in front of you; keep the inside of the gown toward you; do not allow it to touch anything.					
3	Put your hands inside the shoulders of the gown without touching the outside of the gown.					
4	With hands at shoulder level, slip both arms into the gown; keep your hands inside the sleeves of the gown.					

5	With hands still inside the gown sleeves, open the inner wrapper of the gloves on the sterile gown field.					
6	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.					
7	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.					
8	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.					
9	With the gloved dominant hand, repeat Actions 7 and 8.					
10	Interlock gloved fingers; secure fit.					
	Total Score:					

Surgical Scrubbing:

Total Score/Total Points (48): _____ x ____ marks = _____

Applying Sterile Gown and Gloves

Total Score/Total Points (30): _____ x ____ marks = _____

Comments:

_____

_____

Student's signature over printed name: _____ Date/ Time: _____

Clinical Instructor's signature over printed name: _____ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

INITIATING & DISCONTINUING INTRAVENOUS INFUSION

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in **initiating and discontinuing 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

Goal: Access device is inserted using sterile technique on the first attempt.	**3**	**2**	**1**	**0**	**REMARKS**
INITIATING					
1. Verify prescription for IV therapy, check solution label, and identify patient. Check for allergies (i.e., latex, iodine).					
2. Explain the procedure to patient.					
3. Prepare IVF bag and tubing: a. Check solution for discoloration or particulate matter.					
b. Label the IV solution container with the patient's name, date, and own initials.					
c. Place a time tape on the solution container with the prescribed infusion rate, time the infusion began, and the time of completion.					
d. Take the administration set from the package, labels the tubing with the date and time, and then closes the roller clamp.					
e. Remove the protective cover from the IV solution container port.					
f. Remove the protective cover from the spike on the IV administration set, making sure the spike remains sterile. Place the spike into the port of the solution container.					
g. Make certain the tubing is clamped; hang the IV solution container on an IV pole.					
h. Lightly compress the drip chamber and allow it to fill up halfway. If using extension tubing, attach it to the end of the administration set.					
i. Prime the tubing by opening the roller clamp and allow the fluid to slowly fill the tubing.					
j. Inspect the tubing for air. If air bubbles remain in the tubing, flick the tubing with a fingernail to mobilize the bubbles. Recap end of tubing firmly.					
4. Locate a vein for inserting the IV catheter. Select the most distal vein on the hand or arm. Avoid using an arm or hand that contains a dialysis graft or fistula or the affected arm of a mastectomy patient.					
5. Place a linen-saver pad under the patient's arm. Places the patient's arm in a dependent position and applies a tourniquet 4 to 6 inches above the selected site.					
6. Palpates the radial pulse; if no pulse is present, loosens the tourniquet and reapplies it with less tension.					

7. Palpates the vein and presses it downward, making sure that it rebounds quickly. If the vein is not adequately dilated, has the patient open and close his fist, applies heat (e.g., a warm towel), lightly taps the vein site, or strokes the extremity from distal to proximal below the selected venipuncture site.					
8. After selecting the vein, gently releases the tourniquet.					
9. Apply procedure gloves.					
10. Choose an appropriate IV catheter based on the size of the vein and the solution to be infused.					
11. Using aseptic technique, open the catheter package.					
12. Gently reapply the tourniquet and cleanse the site, using an antiseptic swab that contains 2% tincture of iodine, alcohol, or chlorhexidine. (Avoid using chlorhexidine in infants under age 2 months.)					
13. Cleanse the area using a circular motion starting at the site and work outward several inches.					
14. Allow the antiseptic to dry on the skin.					
15. Using the nondominant hand, stabilize the vein by stretching the skin over the vein, making sure not to contaminate the insertion site.					
16. Inform the patient that he is about to insert the catheter and that it may be uncomfortable.					
17. Pick up the catheter. Grasp the catheter by the hub, using the thumb and forefinger of the dominant hand—bevel up.					
18. Holding the catheter at a 20- to 30-degree angle, pierce the skin.					
19. Lower the catheter so that it is parallel to the skin and advance the catheter into the vein. Watch for a flashback of blood into the chamber of the catheter or the tubing of the winged catheter.					
20. Advance the catheter to half its length. Withdraw the needle while advancing the catheter fully into the vein.					
21. While holding the catheter in place with one hand, release the tourniquet with the other hand.					
22. Quickly connect the administration set adapter to IV catheter, using aseptic technique.					
23. Still stabilizing the catheter, slowly open the roller clamp and allow the IV fluid to flush the catheter. Adjust the flow rate according to the physician's order.					
24. Cover the insertion site with a sterile semipermeable transparent dressing. If the site isn't clean and dry, clean the site with an antiseptic swab and allow it to dry before applying the dressing.					
a. Open the package containing the dressing. Using aseptic technique, remove the protective backing from the dressing making sure not to touch the sterile surface.					
b. Cover the insertion site and the hub or winged portion of the catheter with the dressing. Does not cover the tubing of the administration set.					
c. Gently pinch the transparent dressing around the catheter hub to secure the hub.					
d. Smooth the remainder of the dressing so that it adheres to the skin.					
25. Loop the administration tubing and place a piece of tape over the catheter tubing connection, and looped section of tubing.					

26. Label the dressing with the date and time of insertion, catheter size, and own initials.					
27. If the insertion site is located near a joint, place an arm board under the joint and secures it with tape.					
DISCONTINUING					
1. Assist the client to a comfortable position.					
2. Place a linen-saver pad under the extremity that contains the IV catheter.					
3. Apply procedure gloves.					
4. Close the roller clamp on the administration set.					
5. Carefully remove the IV dressing and tape that is securing the tubing.					
6. Apply a sterile 2×2 gauze pad above the IV insertion site and gently remove the catheter, directing it straight along the vein. Do not press down on the gauze pad while removing the catheter.					
7. Immediately apply firm pressure with the gauze pad over the insertion site. Hold pressure for 2 to 3 minutes; longer if bleeding persists.					
8. Check the IV catheter if complete.					
9. Remove the soiled 2×2 gauze pad and replaces it with a sterile 2×2 gauze pad. Secures it with a piece of 1-inch tape.					
10. Dispose of the IV catheter in the appropriate sharps container.					
11. Discard the IV tubing, linen-saver pad, IV solution container, and gloves in the appropriate trash container, according to agency policy.					
TOTAL SCORE					

Initiating:

Total Score/Total Points (81): _____ x ___ marks = _____

Discontinuing:

Total Score/Total Points (33): _____ x ___marks = _____

Comments:

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

ADMINISTERING OXYGEN

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps follow for 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

Goal: The patient will exhibit an oxygen saturation level within acceptable parameters.	***3***	***2***	***1***	***0***	***Remarks***
1. Verify the prescribing practitioner's order.					
2. Perform hand hygiene, put on PPE (if indicated).					
3. Identify the patient.					
4. Gather equipment on overbed table. • Oxygen source • Oxygen delivery device (i.e. nasal cannula, face mask) • Oxygen flow meter • Oxygen humidifier • Distilled water or normal saline • Pulse oxymeter					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain what you are going to do and the reason for doing it to the patient. Review safety precautions necessary when oxygen is in use.					
7. Connect the appropriate oxygen delivery device to oxygen setup with humidification. Set-up humidification as needed.					
A. Administer oxygen **by nasal cannula:**					
8. Adjust flow rate as ordered. Check that oxygen is flowing out of prongs. Place prongs in patient's nostrils. Keep flange against upper lip.					
9. Place tubing over and behind each ear with adjuster comfortably under chin. Place gauze pads at ear beneath the tubing, as necessary.					
10. Adjust the fit of the cannula, as necessary. Tubing should be snug but not tight against the skin.					
11. Encourage patients to breathe through the nose, with the mouth closed.					
B. Administer oxygen **by oxygen mask:**					
8. 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.					
9. Position face mask over the patient's nose and mouth.					
10. Adjust the elastic strap so that the mask fits snugly but comfortably on the face.					
11. If patient reports irritation, or you note redness, use gauze pads under the elastic strap at pressure points.					
12. Reassess patient's respiratory status (respiratory rate, effort, and lung sounds); any signs of respiratory distress (tachypnea, nasal flaring, use of accessory muscles, or dyspnea).					
13. Remove PPE, if used. Perform hand hygiene.					
14. (nasal cannula): Put on clean gloves. Remove and clean the cannula an assess nares at least every 8 hrs. Check nares for evidence of irritation or bleeding. (mask): Remove the mask and dry the skin every 2-3 hrs if oxygen is running continuously. Do not use powder around mask.					
TOTAL SCORE:					

Total Score/Total Points (**42 points**):_____ x ____ marks = _____

Comments:

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_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

SKILLS IN PROVIDING CARE OF A CHEST TUBE DRAINAGE SYSTEM

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps to follow for Care of a Patient with Chest Tube Drainage System. 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

Goal: The patient does not experience any complications related to the chest drainage system or respiratory distress.	***3***	***2***	***1***	***0***	***Remarks***
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Assemble equipment on overbed table.					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain what you are going to do and the reason for doing it to the patient.					
7. Assess the patient's level of pain. Administer prescribed medication, as needed.					
8. Put on clean gloves.					
Assessing the Drainage System					
9. 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.					
10. 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.					
11. Check drainage tubing to ensure that there are no dependent loops or kinks. Position the drainage collection device below the tube insertion site.					
12. 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.					
13. 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.					
14. 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.					
15. Remove gloves. Assist patient to a comfortable position. Raise the bed rail and place the bed in the lowest position, as necessary.					
16. Remove additional PPE, if used. Perform hand hygiene.					

Changing the Drainage System					
1. 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.					
2. Put on clean gloves and additional PPE, as indicated.					
3. Engage the clamp on drainage tubing. Alternately apply Kelly clamps 1.5 to 2.5 inches from insertion site and 1 inch apart, going in opposite directions.					
4. 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.					
5. 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.					
6. Assess the patient and the drainage system as outlined in Steps 9–16 "Assessing the Drainage System".					
7. Remove additional PPE, if used. Perform hand hygiene.					
Total Score					

Assessing the Drainage System

Total Score/Total Points (**48 points**): _____ x ____ marks = _____

Changing the Drainage System

Total Score/Total Points (**21 points**): _____ x ____ marks = _____

Comments:

_____

_____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

SKILLS IN ASSISTING WITH REMOVAL OF CHEST TUBE

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in steps to follow for removal of chest tube. 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

Goal: The chest tube is removed with minimal discomfort to the patient and the patient remains free of respiratory distress.	***3***	***2***	***1***	***0***	***Remarks***
1. Gather equipment.					
2. Perform hand hygiene and put on PPE, if indicated.					
3. Identify the patient.					
4. Assemble equipment on overbed table.					
5. Administer pain medication, as prescribed. Premedicate patient before the chest tube removal, at a sufficient interval to allow for the medication to take effect, based on the medication prescribed.					
6. Close curtains around bed and close the door to the room, if possible.					
7. Explain what you are going to do and the reason for doing it to the patient. Explain any nonpharmacologic pain interventions the patient may use to decrease discomfort during tube removal.					
8. Explain that patient will be required to take and hold a deep breath or exhale during removal. Instruct on taking deep breaths and holding them. Alternately, patient may be asked to take a deep breath and hum during removal.					
9. Put on clean gloves.					
10. Provide reassurance to the patient while the physician removes the dressing and then the tube.					
11. After physician has removed chest tube and secured the occlusive dressing, assess patient's lung sounds, vital signs, oxygen saturation, and pain level.					
12. Anticipate an order for a chest x-ray.					
13. Dispose of equipment appropriately.					
14. Remove gloves and additional PPE, if used. Perform hand Hygiene.					
15. Continue to monitor the patient's cardiopulmonary status and comfort level. Monitor the site and dressing.					
Total Score:					

Total Score/Total Points (**45 points**): _____ x ____ marks = _____

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

OBTAINING AN ELECTROCARDIOGRAM (ECG)

DIRECTIONS: Below is a list of criteria to evaluate the student's skills 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

Goal: ECG is obtained without any complications and the patient demonstrates an understanding of the need for and about the ECG.	***3***	***2***	***1***	***0***	***Remarks***
1. Verify order for an ECG in patient's health record.					
2. Gather all equipment.					
3. Perform hand hygiene, put on PPE if indicated.					
4. Identify patient.					
5. Close curtains around bed and close the door to the room, if possible.					
6. Explain the procedure to the patient; that the test 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*; and that the test takes about 5 minutes. Ask about allergies to adhesive.					
7. Place ECG machine close to the patient's bed, and plug the power cord into the wall outlet.					
8. If the bed is adjustable, raise it to a comfortable working height, usually elbow height of the caregiver.					
9. Position patient supine in the center of the bed with arms at the sides. *Raise the head of the bed to semi-Fowler's position if necessary.* Expose the patient's arms and legs, and drape appropriately. Encourage the patient to relax the arms and legs. Make sure wrists do not touch the waist; and the feet do not touch the bed's footboard.					
10. Prepare skin for electrode placement. 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.					
11. Apply RA lead electrode.					
12. Apply LA lead electrode.					
13. Apply RL lead electrode.					
14. Apply LL lead electrode					
15. Connect the limb lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright.					
16. Expose the patient's chest.					
17. Apply the precordial lead electrode V1					
18. Apply the precordial lead electrode V2					
19. Apply the precordial lead electrode V3					
20. Apply the precordial lead electrode V4					
21. Apply the precordial lead electrode V5					
22. 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, if necessary, with adhesive remover for sticky residue.					
27. Return the patient to a comfortable position. Lower bed height and adjust the head of bed to a comfortable position.					
28. Clean ECG machine per facility policy. 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.					
TOTAL:					

Total Score/Total Points (**87 points**): _____ x ____ marks = _____

Comments:

_____

Student's Signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

Name of Student: _____ Section: _____

Student ID: _____ Date: _____ Score:_____

SKILLS IN PROVIDING COLOSTOMY CARE

DIRECTIONS: Below is a list of criteria to evaluate the student's skill in providing colostomy 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

Goal: The stoma appliance is applied correctly to the skin to allow stool to drain freely.	***3***	***2***	***1***	***0***	***Remarks***
1. Gather equipment.					
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. 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.					
EMPTYING AN OSTOMY APPLIANCE					
6. Assist patient to a comfortable sitting or lying position in bed (or a standing or sitting position in the bathroom). Place waterproof pad under patient at stoma site.					
7. Put on gloves. Remove clamp and fold end of pouch upward like a cuff.					
8. Empty contents into bedpan, toilet, or measuring device.					
9. Wipe the lower 2 inches of the appliance or pouch with toilet tissue					
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 patient to a comfortable position.					
CHANGING AN OSTOMY APPLIANCE					
11. Place disposable pad on work surface. Set up washbasin with warm water and the supplies. Place a trash bag within reach.					
12. Put on clean gloves. Place waterproof pad under the patient at the stoma site. Empty appliance.					
13. Put on gloves. Start at top of appliance and keep abdominal skin taut. Gently remove pouch from skin by pushing skin from appliance.					
14. Place appliance in trash bag. Use toilet tissue to remove any excess stool from stoma. Cover stoma with gauze pad. Clean skin around stoma with skin cleanser and water. Remove all old adhesive from skin.					
15. Gently pat area dry. Make sure skin around stoma is thoroughly dry. Assess stoma and condition of surrounding skin.					
16. Apply skin protectant to a 2-inch (5 cm) radius around the stoma, and allow it to dry completely, which takes about 30 seconds.					

17. Lift the gauze squares for a moment and measure the stoma opening, using the measurement guide. Replace the gauze.					
18. Trace the same-size opening on the back center of the appliance. Cut the opening 1/8 inch larger than the stoma size. Using a finger, gently smooth the wafer edges after cutting.					
19. Remove the backing from the appliance. Quickly remove the gauze squares and ease the appliance over the stoma. Gently press onto the skin while smoothing over the surface. Apply gentle pressure to appliance for 30 seconds.					
20. Close bottom of appliance or pouch by folding the end upward and using the clamp or clip that comes with the product, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient's body.					
21. Remove gloves. Assist the patient to a comfortable position. Cover the patient with bed linens. Place the bed in the lowest position.					
22. Put on clean gloves. Remove or discard equipment and assess patient's response to procedure.					
TOTAL SCORE:					

Total Score/Total Points (**66 points**):_____ x ____ marks = _____

Comments: _____

Student's signature over printed name/ Date/ Time: _____

Clinical Instructor's signature over printed name/ Date/ Time: _____

References

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Lynn, P. (2019). *Skills Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach* (5th ed.). Wolters Kluwer.

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