DEPARTMENT OF NURSING
OASIS COLLEGE OF NURSING SCIENCES

KUCHIYAKO DISTRICT II

KUJE, ABUJA

NURSING PROCEDURE MANUAL

PREFACE

The absence of any form of procedural guide in the hospital at the inception of the school created a dire need for such to be put in place. This is sequel to the fact that students and their proctors and instructors need to be guided in their practice of nursing with uniformity of standard. To achieve this therefore, as the coordinator of the programme of activities which will see to the take-off of the college, I was compelled to make wide consultations with other Schools of Nursing and Midwifery and also search literature to effect the production of this temporary Procedure Manual for the college.

It is pertinent to note that the instructions given to the students in the classroom as regards to the basic care of patients are required to be put into practice in the clinical settings, therefore, the need for those instructions to be in print and made available in all the wards.

The Procedure Manual serves as a reference point when in doubt as to what is required in the practice of nursing in any area. It is equally to be consulted by both the qualified nurses and the students to ensure that the right things are done at all times. Nurse Examiners also use the manual in assessing students' performance during practical examinations.

As time goes on, this temporal manual will be diligently reviewed by the Procedure committee in line with current advances in the field of nursing in particular and health system technology in general, so as to produce a more permanent one, though still subject to further reviews at intervals.

It is my candid belief that working with this document will provide job satisfaction to the nurse practitioners, impart the requisite knowledge and skills to the student nurses and ensure that the patients receive effective and quality nursing care for their rapid recovery and ultimate satisfaction.

June, 2023

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INFORMATION ABOUT THE INSTITUTION

BRIEF HISTORY OF THE COLLEGE

Timely access to high quality nursing care is the cornerstone of successful healthcare services. The historic global crisis in health care is traced to inadequacy in nurses' numbers and skill sets; Oasis College of Nursing Sciences is part of a global collective intervention established to enhance health care to all through excellent nursing education and services

PHILOSOPHY OF THE COLLEGE

The philosophy of the Oasis College of Nursing Sciences located at plot 1538 Kuchiyako District, Kuje, Abuja, Nigeria is derived from the philosophy of the Nursing and Midwifery Council of Nigeria which takes cognizance of the importance of preservation of human dignity, integrity and individualizing such services in the philosophy above are based on the following:

1. Man is a biological, spiritual, social and psychological individual unit whose needs are an inherent part of his nature and therefore is affected by factors within his environment.
2. Health is a changing bio-psycho-social and spiritual level of wellness, which the client / patient is assisted to maintain through the utilization of the Nursing process.
3. Health care with emphasis on primary healthcare is fundamentally related to the availability, accessibility and affordability of both health and socio-economic resources.
4. The client is capable of reasoning and possesses basic ideas, beliefs and values which guide his/her actions. He / she is an active partner in the Nursing care process and participates in decision-making regarding his /her care and environment.
5. The Nurse as a human being exists and shares the same nature and basic human needs as the client/patient.
6. Nursing is primarily concerned with human life, the quality of health of individual, family and community.
7. The Nurse practitioner requires Nursing knowledge, skills, attitudes and ethics in providing safe and effective health care.
8. The family is the basic unit of human existence thus nursing practice must be family-centered.
9. Nursing education is a systematic direction and guidance of the students in the school with the approval of the Nursing and Midwifery council of Nigeria.
10. Continuing education as a continuous process of educational development aimed at enhancing professional growth, competency and efficiency in achieving effective healthcare at all levels. Knowledge should be updated through self-directed learning

and regular participation in continuing education programmes.

11. General Nursing education provides a systematic direction and guidance for the student in an institution approved by the Nursing and Midwifery Council of Nigeria.

OBJECTIVES

1. To provide a tool that can be used by all Nursing personnel for continuous improvement in the total Nursing care of patient's who are receiving treatment in Anambra State and Nigeria in general.
2. To encourage the individual in attaining maximum competence in carrying out nursing procedures.
3. To promote effectiveness in functioning on a nursing care team.
4. To acquire alertness to the factors which contribute to safe, considerate and skillful Nursing care of an individual client.
5. To assist in improving the quality of performance through greater uniformity of methods.
6. To aid in developing a feeling of responsibility for personal contribution to client's welfare.
7. To increase job satisfaction and provide greater security through better understanding of Nursing care procedures.

COMPETENCES OF THE GRADUANDS

The competencies of a nurse who is a graduate of this General Nursing Education programme include the ability to:

1. Optimize the nursing process format in the care of the individual, family and community through history taking, physical assessment, review of relevant records and listing of appropriate actual and potential nursing diagnosis.
2. Plan for individual nursing diagnoses/problems and family health needs for the attainment and maintenance of healthy state.
3. Assess community through data gathering and identifying health needs to arrive at Community diagnosis.
4. Systematically implement necessary nursing actions to alleviate individual problems through holistic and client/family centered approach in homes, community and health care institutions.
5. Evaluate care through stated objectives to ascertain effectiveness of nursing actions and health activities rendered in all settings.
6. Develop strategies for meeting the Health Education needs of client/patient and families in homes, communities and health care institutions, geared towards optimal functioning.
7. Diagnose and treat simple medical and surgical conditions.
8. Utilize available resources within the home, community and hospital settings to achieve maximum provision of health care.
9. Participate in formulating health plans for the community.
10. Developing proficiency in instructing and supervising the use of Natural Family Planning methods and in follow up of clients.
11. Provide rehabilitative services to individuals and families to enable the client/patient adapt to changing conditions and optimize ability.
12. Demonstrate competence in the management of health care for clients/patients in the homes, community and health care institutions.
13. Manage clients in all developmental stages for healthy functioning.
14. Initiate care in emergency situations to save life.
15. Anticipate/recognize risk factors, take prompt action and refer as is
16. Initiate and participate in the development of recording and reporting systems, maintaining, analysis and utilizing the collected data.
17. Efficiently manage essential drugs by evolving an effective monitoring and cost recovery Systems in the rural settings.
18. Establish and maintain a two-way referral system.

HISTORY OF NURSING

'Nursing' means caring for or tending another person. It has always been necessary to care for sick people, so nursing is as old as humanity Nursing comes quite naturally to most women as the maternal instinct 5 natural to every woman, making it easy and natural for her to look after other people who need her help. Men can also make good nurses, but nursing is predominantly a profession of women.

Nursing was, of course, practiced in Nigeria throughout the centuries because wherever there are sick people they must be cared for, but this nursing was carried out in the home by the relatives of the patients, and there was no official training of nurses.
Formal training of nurses in hospitals had only developed in Nigeria since the 1940's, but it has made rapid progress, and can now compare favourably with the training given to nurses in any country in the world.

Nursing in the Pre-Christian Era
In ancient times, i.e., thousands of years ago, skilled nursing was given to the sick or wounded especially by the more cultured races e.g. the Egyptians, Greeks and Romans. However, there was no formal training given for nurse as there is today. Most sick people were nursed in their own homes and the knowledge of medicine and methods of caring for the sick was handed on, and added to, from generation to generation. People knew of the value of plants for the cure of certain diseases even in Ancient times, and many drugs in use today are derived from those plants. There were, however, some hospitals, especially in ancient Greek.
In those days physical illness was frequently attributed to spiritual powers e.g. illness was thought to be due to the displeasure of the gods. Sacrifice would consequently be offered in order to appease them. We know now that there is no truth in those superstitions, but that illness occurs as a result of physical causes. It attacks the good and the bad, and if accepted in the right spirit can be a means of bringing one closer to God and improving one's character in many ways.

The Christian Era
With the coming of Christ, the outlook on sickness began to change. Christ showed great kindness to the sick throughout His life and following his example, the Christians considered it a privilege as well as a duty to look after the sick. But Christians were persecuted in the first three centuries, so it was not until the Emperor Constantine proclaimed the Edict of Milan in 313A.D giving Christians freedom to practice their religion openly, that nursing could develop properly.

Some women dedicated their lives to serving others for God's sake. They took care of the sick in their homes and in hospitals. These women were called "Deaconesses" and later on some of them took a vow of chastity, thus commencing the long tradition of religious sisters looking after there 4th to the 18th century (300-1,700 A.D) hospitals were built and maintained by public contributions. In some of them, like the Hotel Dieu of Lyons and Paris, a form of training was given for one to be recognized as a nurse.

The Islamic Arabs made great strides in medicine, and were greatly in of the Europeans in their knowledge of medical science up to the century. They introduced inhalation anaesthesia, were skilled at and very sympathetic towards ail forms of insanity, which was not the attitude in the Christian Western World. They had many great is in which women nursed the sick. Between the 15th-16th centuries many queens and influential women were interested in nursing and supported it financially and in practice.
Military nursing orders were founded at the time of the Crusaders to care for the men wounded in battle. The greatest of these orders is still with us known as the "Knights of Malta".

After the fall of the Roman Empire, the advanced civilization of the in and Greeks began to decline, standard of living, healing and fell, and dirt and disease became rampart. This state of things rom the 9th to the 14th Century, and during the period it was only n the monasteries that effective nursing practice was carried out. Reformation took place in the 16th Century followed by suppression Catholic institutions in many countries. As most of the nursing care had carried out in these very institutions, they had disastrous results on the care of the sick, especially In England. There was no longer skilled available for the sick, no longer system of training nurses, and the n of the hospitals and care given to the sick fell to appalling During this period, hospitals were generally filthy places where sick were cared for by the lowest class of women - dirty, uneducated frequently of low moral standards.

Things were not quite so bad on the continent of Europe. St. Vincent de Paul founded the order of Sisters of Charity in France and these Sisters cared for the sick both in their own homes and hospitals. These are the same daughters of Charity of St. Vincent de Paul which we know today. These Sisters subsequently took over the management of some of the neglected hospitals and raised their standards greatly. Among these was the hotel Dieu of Paris, a famous hospital still in existence today.

During the 18th Century many hospitals were built in Britain but the quality of nursing, efficiency and cleanliness in them was very poor. In the beginning of the 19th century (1836) a clergyman called Theodor Fliedner was so upset by the condition of the hospitals that he

started a special hospital in Kaiserswerth, in Germany, specifically for the training of nurses. It was in this hospital that Florence Nightingale who was subsequently to reform nursing education went for her training. Pastor Flieder and Nightingale were responsible for the beginning of modern nursing in Britain education as we know it today.
It was at this period also that Joseph Lister and Louis Pasteur made a very important contribution to medicine in the discovery of micro- organism as the cause of many diseases. Anaesthetic agents were also discovered and all these knowledge together with the improved standard of nursing contributed to the first improvement in hospital conditions apparent since that time.

Florence Nightingale:
Florence Nightingale was an English girl of noble birth and high education, born in England in 1820. She wanted to look after the sick. At that period, nursing was performed only by girls of the lowest social class, and there was no formal training for nurses, so her parents were very opposed to her becoming a nurse. Florence however insisted, and went to Kaiserswerth in Paris, France to study methods of nursing there. In 1853 the Crimean war broke out with England and France. Fighting against Russia. Florence Nightingale and 38 other women went to care for the British soldiers wounded in battle. They worked in the barrack hospital in Scutari where she instituted various hygienic measures that revolutionized the care and recovery of the sick and the wounded.

On her return to England, the British people asked Florence to reorganize and renew the Nursing training system, and a sum of money was collected for this purposes. She did this in conjunction with Mrs. Wordroper who was Matron in St. Thomas' Hospital in London at that time. A group of intelligent girls were given a thorough training and were then scattered throughout other hospitals in the country to introduce the new system of training to them. Nursing education gradually developed until it reached the height it has today.

The Nursing Council of Ireland, England, Scotland and Wales was founded in 1919, and State examinations and State Registration of Nurses (S.R.N.) were introduced. This greatly enhanced the status of nursing as a profession.

HISTORY OF NURSING IN NIGERIA

Nursing was always carried out in Nigeria as was the case wherever people were sick, but it was carried out by the patient's own relatives, and they had no formal training for it.
The beginning of hospitals and hospital nursing dated back to 1846 when the C.M.S. Missionaries founded hospitals at Lagos, Ibadan and Abeokuta, but although girls and boys worked in those hospitals as nurses, they had no formal training as we have today.

Other Missionaries soon started hospitals, the Church of Scotland in Calabar in 1847 and Mary Slessor in Itu in 1876. The Catholic Mission opened a hospital in Lagos in 1868. Mission hospitals spread throughout the country, in Iyi-Enu, Zaria, Etinam etc. The first Government hospitals were later started in most of the principal towns. All these hospitals later formed the nucleus of the nursing training schools. Nursing sisters were first supplied to the hospitals from overseas, as there were as yet no qualified Nigerian Nurses.

At first, it was difficult to convince patients to come to the hospitals when they were sick, as this was alien to the tradition of the people, but gradually they came to recognize and appreciate the superior type of medicine and treatment given to them in the hospitals.

Nurses working in these hospitals were given some form of training by those in charge, and the law of Lagos legislated for the registration of these nurses. But it was not until 1946 that the Nursing Council laid down requirements for the education, examination and registration of nurses. The requirements for recognition as training school then was that the hospital should have a minimum of 60 beds, one Doctor and one Nursing Sister in-charge.

The Standard of education of girls admitted to training was necessarily low, standard VI was the usual attainment as the education of girls was not yet widely practiced. On completion of training, they were registered as N.R.N (Nigeria Registered Nurse) or N.R.M (Nigeria Registered Midwife) as the case maybe. This qualification did not have recognition from other nursing councils overseas as the standard of education of the girls and the standard of training in the hospitals, did not meet the requirements of the international Council of Nurses.

In order to remedy this, and in order that Nigerian Nurses would have equal status and reciprocity with their colleagues in other countries, the Nursing Council of Nigeria decreed that as from 1970 all hospitals not meeting the new standards of Nursing education formulated by them, would lose their status as training hospitals. On the other hand, those hospitals able to meet the standards and following the new syllabus, would have international recognition. The qualification of the nurse completion of training would be

"Registered Nurse (Nigerian) i.e. R.N. T new standard of Nursing Education was difficult to meet as a result ma » very good hospitals lost their recognition as training school as a result.

The new requirements stipulated that all candidates must have presented themselves for W.A.E.C. and hold at least a pass in English Language They must also pass the Nursing Council National Entrance test by the West African Examination Council. Minimum age for entry was 17 years. The hospital must have a minimum of 150 beds, water, electricity, physicians, surgeons, anesthetists, gynecologists, pediatricians, and one other specialist in E.N.T, Eye, or Psychiatry. The hospital must have or be affiliated to a maternity hospital where the students are seconded for 5 months obstetric experience. It must have a modern nurses' hostel adequate classroom facilities, and a full tutorial staff.

University Nursing Education

A University course in Nursing was organized by the Department of Nursing, University of Ibadan in the year 1965 leading to the degree of B.Sc (Nursing).The course was designed for the preparation of nurse educators and administrators to serve the needs of hospitals, Schools of Nursing, Public Health organizations and similar institutions. Admission requirements were RN or its equivalent, 5 credits in W.A.S.C, and at least one year post registration experience. The course lasted 3 years.

The students specialized either in teaching or administration in the last year of their training.

INTERNATIONAL COUNCIL OF NURSES (ICN) CODE OF ETHICS FOR NURSES, GENEVA 2006.

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal.

Inherent in nursing is respect for human rights, including cultural rights, life, choice and dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, culture, disability or illness, gender, orientation, nationality, politics, race or social status.

Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

THE CODE OF ETHICS

The ICN Code of Ethics for nurses has four principal elements that outline standards of ethical conduct.

The science of morality, what is right and what is wrong. It is on the Natural law, i.e. on God's law as arranged by God for the man, and so is not confined to any particular religion, but it is binding on all men. Different religion may interpret the law differently, and even individuals within a certain religion may interpret the law differently, and in each case, they are bound to follow their conscience.

If a nurse is uncertain as to the morality of a certain procedure she should consult with a spiritual person who is competent to advise her: a Catholic nurse should seek advice from a Catholic Priest, and a Protestant from a minister of her religion. She should not seek advice from her fellow nurses who are not more competent than herself to decide on such a matter.

Even pagan societies follow the Natural Law. They know what is right and what is wrong without having to be told. They know that stealing is wrong, direct abortion is wrong, and murder is wrong. Nurses are to respect all matters of Natural Law which are binding on all men.

ELEMENTS OF THE CODE:

Nurses and people:

1. The nurse's primary professional responsibility is to people requiring nursing care.

   In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.
2. The Nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

3. The nurse holds in confidence personal information and uses judgment in sharing this information.
4. The nurse shares with society the responsibility for initiating and supporting actions to meet the health and social needs of the public, in particular those of the vulnerable population.
5. The nursealso shares responsibility to sustain and protect the national environment from depletion, pollution, degradation and destruction.

Nurses and Practice:

1. The nurse carries personal responsibility to sustain accountability for nursing practice, and for maintaining competence for continual learning.
2. The nurse maintains a standard of personal health such that the ability to provide care is not compromised.
3. The nurse uses judgment regarding individual competence when accepting and delegating responsibility.
4. The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence
5. The nurse in providing care ensures that use of technology and scientific advances are comparable with the safety, dignity and rights of people.

Nurses and Profession:

1. The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.
2. The nurse is active in developing a core of research-based professional knowledge.
3. The nurse acting through the professional organization participates in creating and maintaining safe, equitable social and economic working conditions in nursing.

Nurses and Co-workers:

1. The nurse sustains a co-operative relationship with co-workers in nursing and other fields.
2. The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

NURSING AND MIDWIFERY COUNCIL OF NIGERIA

The Nursing Council of Nigeria is responsible for the maintenance of adequate nursing standards throughout the country, for the inspection of the training of student nurses, and the discipline of all members of the Nursing profession. Its headquarters was in Lagos but is now at Abuja. It holds the Register for nurses, and is the organization which puts a nurse's name into that register, and also has the power to cross it off again if it sees fit. The council works through its various committees. These committees include:

The Education Committee: Is responsible for all branches of nursing education, examinations etc.

The Registration Committee: Is responsible for the registration of duly qualified nurses.

The Disciplinary Committee: Is responsible for the discipline of nurses.

The Accreditation Committee: Supervises all the Schools, Colleges and Universities offering nursing programmes.

Branches of Nursing Studies:

Some aspects of Nursing have become specialized, and a special course of training can be taken in them. Some of these branches are Midwifery, Paediatrics, Orthopedics, Psychiatry, T. B. Nursing, etc.

THE RED CROSS SOCIETY

In the year 1859, the International Red Cross Society was founded by Joan Henry Dunant in Australia. The Red Cross is a voluntary organization of persons proposed to give assistance at times of emergency, e.g. accidents and wars. The emblem of the organization is a red cross, and this Red Cross should be a guarantee of safety to person carrying national emergency work in time of war. It has been internationally agreed that persons working under the Red Cross will be safe from enemy attack while carrying out their first aid or nursing out they must give emergency first aid to all injured persons, less of nationality or political inclination.

Ambulances and Military hospitals under the Red Cross must be neutral, i.e. they must be ready to render assistance to all injured persons respective of the side for which they may be fighting.

WORLD HEALTH ORGANIZATION (W.H.O.)

In 1946, the United Nations created the World Health Organization (WHO). The purpose of this organization is to try to eradicate diseases *and their* sources from all countries in the world. It has done a tremendous amount of good work in the development of prophylactic medicine and in the treatment of very wide-spread diseases.

U.N.I.CE.F. (United Nations International Children's Education Fund)

It is a branch of W.H.O. It is UNICEF that is responsible for campaign which has practically

eradicated T.B and Leprosy from Nigeria UNICEF helps to take care of the health and education of children all over the world.

THE NURSE AND THE PATIENT

The Nurse's Behaviour towards the Patient

The patient is the most important person in the hospital. It is for patients that the hospital exists, and it is in order to be able to look after him properly that doctors and nurses are trained, so whatever is of benefit the patient must be done no matter how much inconvenience it may cause the nurse or doctor.

Unfailing kindness and patience must be shown to the patient at all times, even if he is difficult and troublesome, or even rude to the nursing staff. It is very easy to get into a habit of impatience, and the nurse must guar: against it at all costs. She should try to see Christ in all her patients; who said "so long as you did it to these, the least of my brethren, you did it to me'. So remember, if you have been rude or unkind to your patient, you have been rude and unkind to Christ.

Most adult patients are responsible people, often the mother or father of a family. The fact that they become patients does not entitle the nurse to treat them like children or mental deranged. Very often they are much more experienced in life than the nurse, equally intelligent, may be more educated.

Special consideration should be given to elderly patients, as elder. people find it very difficult to adjust to any change in their way of life, and find the routine and discipline of a hospital ward very difficult to accept. They may react to this change in their life by becoming demanding, stubborn, or even childish, but the nurse must be very understanding towards them, show great kindness, and not be unfriendly in enforcing the regulations of the ward on them.

No barrier may be made because of colour, race, creed, neither should preferential treatment be given to any patient. Particularly, a nurse should preferential treatment to her own relatives or friends who may be sick in the ward, while ignoring others. However, the patient's social background may, and should be taken into account. Thus, if a patient cannot relax unless he has the privacy and comfort of a private room, then be provided for him.

Spiritual Welfare of the patient

It is not only to the patient's physical needs that the nurse administers but his whole self,

body, mind and soul. So it is not physical care alone that she gives, but also psychological and spiritual care. No matter to what religion the patient belongs, the nurse must attend to his spiritual needs, whether he is a Pagan, Muslim, Catholic or Protestant. It is wrong to think that you should only concern yourself with those of your own religion. All patients who are seriously ill and especially those who need spiritual consolation must be helped. The request of a patient who wants to see a minister or a priest should be granted. It is an excellent thing for a nurse to pray for with a very ill patient herself.

The Relatives of the Patient

Nurse should be kind and courteous to the relatives as well as the Relatives are ordinarily always worried and concerned about sick ones. Explain things to them simply and courteously. If a visitor on visiting the ward at the wrong time, it should be explained to him that this cannot be and if he insists the nurse should refer the matter to the ward head. But she should not get angry with the relative. She should listen to what he has to say, and if there is a genuine reason why the ordinary hospital rules should be waived in his favour, then this should be done. It may be for example that the patient is critically ill or dying or it may be that the relative has made a long journey and must leave again before the regular visiting hours.

If the relative complains that the patient is being neglected or not receiving proper treatment, listen to him, and investigate the matter, he may be right. If not it is understandable that he is over-anxious and the nature of the matter should be explained to him with courtesy.

ESSENTIAL QUALITIES OF A GOOD NURSE

Nursing is a vocation, and it is only the boy or girl who becomes a nurse because he/she feels compassion for the sick and likes looking after them who makes a real good nurse. Unless a girl enjoys her work of caring for the sick, the hardship and drudgery involved in nursing wears heir out, and she enable to give the patient the helping hand, love, and cheerful care which he needs. Some people do nursing for the sake of a job or the salary and not because they like it, and this is the reason they fail to make good dedicated nurses.

The essence of nursing is caring for the sick. It is not proficiency in carrying out procedures, although this is also involved, but what makes nursing a unique profession in its own right is the caring for the sick, doing this well, i.e. kindness.

Kindness

Kindness is the most beautiful gift which a nurse can bring to her patient. It is kindness which will make the patient's stay in the hospital pleasant or otherwise. It is on the kindness shown him that he will judge “the atmosphere” within the hospital; and it is for the kindness, or lack of it shown him that he will remember the hospital afterwards.

Other qualities that are important in a nurse include; empathy, conscientiousness, efficiency

etc., but kindness is the most human quality no machine or apparatus can ever compensate for or replace.

Some people are kinder than others by nature. Let them allow this kindness to develop to its fullness in them, and never try to repress it and those who are not so gifted, to whom kindness does not come so naturally, let them try to develop it, behave towards the patient with respect and sympathy, concern, and never to be unkind to him. It is through kindness, more than in any other way, that we show the patient the love of Christ, and nurses who are unkind cannot be approached by patients. Other qualities necessary to being a good nurse are generosity, observation, truthfulness, initiative, resourcefulness, and control of her emotions.

Generosity
She must be generous in giving herself to help others, whether patient or colleague. The generous person does not wait to be asked before offering to help, but she is alert to where help is needed, and quick to offer it. For example, she is always at the disposal of her fellow nurses who needs assistance in her work.

Conscientiousness
The nurse must be conscientious in carrying out her duties at all times. She may not relax while anyone needs her attention, either by day or by night. It is sometimes difficult to stay awake while on night-duty, but she has a serious obligation to do so. If she finds herself becoming sleepy, she should walk around, or wash her face, or drink tea or engage herself in some work to keep awake. And where two nurses are on night-duty together, they must help each other to keep awake. All treatments must be conscientiously carried out medicines given at the right times, incontinent patients changed as soon as they are wet; temperature and pulse taken and recorded accurately; feeble patients turned regularly etc.
It is a part of nurse's duty to attend to the patient whenever and for as long as he needs her. Therefore, even if it is time to go off duty but the work is not yet finished, she must stay on uncomplainingly for as long as she is needed. Nurses all over the world do this, and the Nigerian nurse must be generous and conscientious as any other nurse in the world in f she is on duty, or if called to help in any emergency, she must come willingly, anyone who is not willing to be inconvenienced for the sake of her patients should not be a nurse.

Truthfulness
A nurse must be a reliable person on whom people can depend, and this be so unless she is truthful. Truthfulness sometimes take courage. Everyone make mistakes, but we must have the courage to them. This is especially so where the mistake is a serious one endangering the life of a patient. Perhaps the nurse gave the wrong medicine, or the wrong dose, or to the

wrong patient, she may be afraid to tell those in authority but she must do so no matter what it costs her, the life of the patient may be at stake.

In order to develop the habit of truthfulness and have the courage to admit mistake in big things, she must start by being truthful always even in little things. So she should admit straight away if she has broken or spoiled equipment, e.g, a thermometer or syringe, and replace it without delay. He who is faithful in that which is lesser, is faithful in that which is greater, and unless she is faithful in little things now, she will not have the courage to admit to bigger things when they come.

Observation

A nurse should try to develop the habit of observation in herself to notice immediately if patient is looking well or ill, comfortable or uncomfortable, pale, cyanosed, distressed, etc. She should then take the necessary step concerning what she sees. It is not enough that the nurse should see, but she must be able to interpret what she sees and assess its significance. This is why a nurse must study, so that she will be able to look after her patients competently and intelligently.

Some nurses think that the purpose of study is to pass an examination, but this is not so. The purpose of study is for the nurse to be able to look after her patient properly, and the purpose of examination is simply to assess whether the nurse is in fact able to do this. Students who write perfect answers in an examination, but who fail to put this knowledge into practice in the wards should not be nurses at all.

Initiative and Resourcefulness

Initiative means that a person thinks of something to be done and does it without having to be told and guided by someone else all the time. The person who never sees what is to be done unless he is told to, or sees but does not do it unless told to do so by another, has no initiative. Obviously, a nurse must have initiative as each one will be in a position of authority some day, and will not have someone else to tell them what to do. Resourcefulness is the ability to manage with available materials in the absence of the ideal situation. It involves "using one's head" and a large share of common sense.

Preservation of Life

Life is a gift of God and man has a duty to preserve it both in himself and in others. Since God is the giver of life, only God can determine when that life is to be taken away. Every life is of equal importance in God's sight, the life of the poor man is as important as that of the rich man, and that of a mental defective as that of an intelligent person.

One might think that it would be better for a person to die because of extreme physical or mental suffering, but that is for God to decide. We will never really understand fully the

notions of the Almighty, but we must trust Him that He knows the best.

Collaboration in Unethical Procedures

A nurse should not collaborate in carrying out any unethical procedure, and she must refuse to do so, e.g. in such procedures as euthanasia and criminal abortion.

Euthanasia

Euthanasia is the practice of terminating life in a painless way when it is considered 'kinder' to the patient to kill him. It is just a nice word for 'murder' and a nurse must never be involved in it. For example, if a patient is suffering very severe pain from cancer which is incurable, someone might suggest giving him an overdose of a narcotic and letting him die painlessly now, rather than letting him live in agony.

Only God can give life, and only God has the right to take it away. The nurse's duty is to preserve life not to terminate it. More over the grace of God may be working in that person in his agony bringing him closer to God through prayer and suffering. So the nurse should not terminate that life, nor collaborate with such a procedure in any way.

Needless to say, the practice of killing deformed or mentally retarded infants is equally wrong. Euthanasia was officially condemned by the World Medical Association in 1950.

WARD ORGANIZATION

BEDS: Beds should be off the wall and at least one meter from each other. There must be a chair by the side. Nothing should be under the patient's bed. The wheels of the bed should be tight, secured and straight.

ARRANGEMENT OF THE LOCKERS: The locker must be at the patient's right side. Only a bottle of drinking water, flask and flower vase are to be allowed on top of the lockers.

NURSES TABLE: This should always be neatly arranged with Admission, Report, Treatment and Loan books, container for pins and keys etc as well as a flower vase. Nurses should not sit around the table except when taking reports, writing anything concerning the patient or reading case notes.

MEDICINE TROLLEY: This should always be near the nurses' table and neatly arranged at all times. It must always be locked and the key kept by the most Senior Nurse.

EMERGENCY BOX: This should always be close to the nurses table. It is marked 'Emergency Box'. It should be locked and the key kept at a central place. The senior nurse on duty should check it every morning. Any drug or other resuscitative material used must be replaced immediately.

THE RESUSCITATING COUCH: Must always be made up. Oxygen and suction machine should be very close to it.

WARD ANNEXES:

Kitchenette: Should always be left tidy. The fridge and filter should be cleaned daily. Special milk feeds should be labeled with patient's name. Leaking water or gas pipes should be reported. Fire extinguisher and/or sand should be handy.

Sluices: Sluices and lavatories should always be ready for use in spotless condition. Soiled linens are sluiced and washed by the ward orderlies and then sent to the laundry. Dirty linens are kept in 'dirty utility room' pending their being sent to laundry.

Bath and sinks: Should be cleaned after use.

Bed pans and urinals: Should be rinsed with cold water after use and clean with a special mop kept in disinfectant. Nurses should soak the bedpans in hot water and disinfectant every day or boil in bedpan sterilizer. All bedpans should always be hung on the rack. Where sterilizers are available they should be emptied, cleaned and rinsed before work resumes each day.

EQUIPMENTS IN THE SLUICE ROOM

Sputum mug, Bed pads
Urinals, Vomit bowl with its cover
Brush in its container with disinfectant

LINEN ROOM

Mattresses, Mackintoshes, Draw sheets, Pillows and their slips, Blankets, Bed elevators Skin tractors, Splints, Bed cradles, Sandbags, Bedsheets, Counterpane, Air-rings, Backrest, Fracture boards, Hot water-bottles.
All should be neatly arranged according to the labels on the rack shelves.

STAFF TOILET

This should be flushed after each use. People should provide water before using the toilet. It should be washed daily.

CLEAN UTILITY

Equipments there include: Sterilizer(s),
Equipments needed for nursing procedures: Trolleys, Drip stand, Racks for sterilized packs.
These racks should be observed as clean area. Nothing dirty or us should be taken there.

DIRTY UTILITY

Equipment there include: Urine testing equipments, Linen hamper

WARD ROUTINE

7.30am
1 .Morning staff report on duty
2 .Prayers
3 .The senior night nurse reads the report to the morning staff at the nurses' station.
4 .The night nurse takes the morning staff on an inspection tour of the ward to see the patients and check the following:
- Temperature, pulse and respiratory charts
- Blood pressure/heart apex beats charts
- Fluid balance charts
- Beds of incontinent or bed ridden patients
- The sluice etc
- The routine ward inventory
- Controlled drug cupboard

5. Night nurses report off duty
6. Bed making

7. Allocation of duty by the nurse in charge
8. Cleaning of patients' environment

8am-9am Breakfast
9am-10am Special treatment/routine care
10am Medication and 4 hourly vital signs
10am -12noon Breakfast for nurses (30 minutes each)
- Doctors Ward round
- Giving of 6hrly drugs

12.30pm -1. 30pm –Toilet round
- Lunch

1pm -2pm – A senior nurse prepares and writes the report
2.00pm - Medication, general completion of duties/fluid charts
-Afternoon nurses report on duty.
- The senior morning nurse hands over
3.00pm - Morning nurses report off duty
3.30pm - Rest
3.30pm – 4pm - Personal adjustment
- Games
4-6pm -Visiting time
5.30-6.30pm -Medication and vital signs
6.30-7pm -Dinner
7-8pm -The senior nurse prepares and writes the Report.
- Pressure areas, oral care and general completion of duties
8.30pm -Night nurses repot on duty
- Afternoon nurse-hands over as usual and reports off duty
9.30pm -Tidy ward
- Identify patients that need special care
10pm -Medication and vital signs
10.30pm -Settle the patients
- Shade lights, prayers, and lights out
- Drain the sterilizer, wash, refill and switch on to boil
10.30-12mn -Nurses prepare record books
-Drums are packed
- Bed Statistics
12mid night -Add up fluid balance charts (intake and output chart)
- Give 6 hourly injections
12am – 1.00am -Night nurses' break (1st set)
1.00am – 2am -Night nurses' break (2nd set)

2am-3am -Nurses round, and 4 hourly observations for ill patients
5am -6am -Lights on. morning routine care
6.00am -Injection, 8 hourly and 6 hourly drugs
6am-7am -The senior nurse writes the night report
- Prepares for report and hand-over.

OUT-PATIENT DEPARTMENT ROUTINE
7.30am -Morning staff reports on duty
- Prayers
- The nurse in charge re-deploys staff to various sections
- Couch/bed making and cleaning of patients' Environment

CARE AND MAINTENANCE OF WARD EQUIPMENTS

Electric Lights: Dust daily if within reach, centre lights are wash periodically (while switched off).

Metals: Clean with metal polish

Wood Work: Scrub with soap and water, rinse, dry then polish. Furniture cream should be applied once a week.

Glass: Wash with soap and water, rinse and polish with dry duster newspaper.

Trolley and screen wheels: Scrape and oil periodically.

Ward kitchen: Use gas and electricity with care. Turn off when not in use. Food spilt must be wiped off immediately and used utensils neatly stacked. Scrape left over and discard.

Refrigerators: Wash daily, replace articles on correct shelves.

General repairs: E.g. dripping taps should be reported to the ward head.

Ward bathroom, lavatory and sluice: Must be cleaned daily with cleaning power(vim). Washing bowls, sputum mugs and vomit bowls should be emptied, washed with soapy water, rinsed and boiled for 20minutes after each use and hung in the rack.

Sterilizers: Empty, clean and rinse before use each morning (carried by the night nurse).

Dirty dressing bins: They should be emptied by the porter into the incinerator. It should be mopped with disinfectant e.g. Izal 1:40, rinsed and turned upside down to drain. It may be lined with a waxed paper bag before use.

Bed pan washer, sluices and lavatory pans: Sprinkle with harpic or suitable disinfectant. Leave for at least half an hour, then, scrub with special brush and flush Brush should be kept in enamel holder containing disinfectant 1:40. Wash and dry seats of lavatory pans, and both sides.

Bed pans, urinals: Flush with cold water after use, mop with hot water and rinse. Boil for 5 minutes after each round.

Sputum mugs: Empty and flush with cold water (contents should be measured first if necessary). Wash in hot soapy water using mop and boil
in a special sterilizer or pan.

USE, STORAGE AND CARE OF WARD EQUIPMENTS, INCLUDING LINEN AND BED APPLIANCES.

Removal of stains from linens

Blood: Soak in cold water. If stain dries into material, hydrogen peroxide may be used, rinse afterwards.

Ink: Soak article at once in cold water or milk. Prolonged soaking may be necessary, e.g. twenty-four (24) hours.

Tea, coffee, coccoa: Wash in cold water, then pour boiling water on stain. Bleaching agent may be used, then rinse well.

Fruit stains: Rub with salt then treat as above.
Rust Marks: Difficulty to remove, but may be possible with salt and lemon sure to sunlight.
Removal of vomit or excreta from floor:
Cover with sand or sawdust.
Remove with dust pan and brush which can be washed. Mop floor with disinfectant or clean up with newspaper which can be burnt.
NB: Torn linens should be reported to the ward head.

WARD EQUIPMENTS

Hospital bed, couch, bed cradle, canvas and bag, bed elevator, Dressing bin, foot pedal bin, linen hamper, splint. Those not in constant use are stored. They are taken care of properly and stored after use.

Care of Ward Equipments
Purpose: -To prolong life of articles
-To prevent spread of infection
The care to be given to equipment depends on the material with which they are made, e.g. metals.
Metals: Clean with metal polish
Stainless steel: Wash with cold soapy water, rinse and dry with clean duster. Cold water is used if the stain is protein in origin e.g. blood stain, pus stain. It can be scrubbed if it is sticky.
Stainless steel forceps, bowls, gallipots, receiver etc.: Wash with soap and water, allow to dry. Return to the proper places. If needed for a sterile procedure, put into an already boiling sterilizer to boil for 5 minutes.
Enamel ware: Should be treated like stainless steel. When there are a lot of stains, vim is used.
Glass ware: Should be washed and boiled e.g. Pyrex.
Glass syringe, medicine droppers, connecting tips, funnels: Clean immediately in cold water after use Wash with soapy water, rinse, dry an: pack ready for sterilization or return to proper places in cupboard. If glass syringe, separate piston and the barrel, wrap separately with gauze an: put in the sterilizer to boil for 5 minutes Remove from the sterilizer and pi/ in a sterile receiver ready for use.
Glass jars: Can be boiled but could be put first in cold water to prevent the glass from cracking due to the unevenness of expansion of glass.
Rubber ware: It is spread out and washed if soiled, disinfect with mop an: hung out to dry. When dried, powder it to prevent sticking and then store for use.

RUBBER GOODS

-Remove traces of the blood or other body discharge with cold water
-Spread on a flat surface, wash with soap and water, rinse well and dry away from direct heat.
- When dry, dust lightly with powder. Roll or hang over a rod to avoid creases from folding

RUBBER GLOVES

-Wash in cold water turning it inside out so that both sides are washes
-Wash with soap and water
-Rinse well
-Hang to dry with cuffs down
-If used for infectious patient, soak in Lysol 1:50 or carbolic lotion or Izanfpr30minuttes
-Pack dry powered gloves in drums for autoclaving

SOFT RUBBER CATHETERS AND TUBES

-Flush thoroughly with cold water
-Wash with soap and water
-Rinse and dry outside of bag
-Hang with neck-end down to dry inside
-Inflate with air to avoid sticking together
-Keep washers in screw tops
-Hang up in proper place

HOT WATER BOTTLES, ICE BAGS, AIR CUSHIONS E.T.C.

-Remove trace of blood or body discharge with cold water
-Wash with soap and water
-Rinse and dry outside of bag
-Hang with air to avoid sticking together
-Keep washers in screw tops
-Hang up in proper place

STITCH AND SURGICAL SCISSORS

- Wash with soap and water using brush under running tap.
- Immerse in inhabitant-in spirit or methylated spirit, Ethicon fluid in a receiver lined with gauze with blades open
- Change solution weekly

OXYGEN APPARATUS

- Dust cylinder daily
- Check t*he* gauge and flow meter daily to ensure that they are functioning
- Change water in humidifier weekly
- Ensure that the key is available all the time
- Ensure always that cylinder is not empty

SUCTION MACHINE

- Dust daily
- Wash glass bottles daily and change lotion
- Make sure that the washers around bottle are intact
- If manually operated, oil the hinges on the pedal weekly

DRAINAGE BOTTLES

- Empty content
- Wash with soapy water and rinse
- Send for autoclaving

STERILIZERS: All sterilizers should be washed daily by the night nurse to get it ready for the day.

CUPBOARDS: Clean cupboard weekly and re-arranged. Re-label where necessary.
URINE TESTING ROOM: Tidy up the room daily. Replenish the regents as necessary. Discard specimens not needed again and wash test tubes use.

Special points to note:

- Avoid sticking pins into rubber
- Oil, grease and acid destroy rubber, so prevent contact with these.
- Hot destroys rubber so keep away from direct contact
- Rubber deteriorates when not used. Occasionally soak to prevent cracking.

-Rub talcum powder into rubber goods before storage to keep them soft 5 -: Tom sticking together.

-**Stor**e rubber goods in dark, cool and dry atmosphere

CARE OF PATIENT'S ENVIRONMENT

Purpose: To provide and maintain cleanliness as a precaution against the spread of infection.

Rules of general cleaning

1. Collect all articles required before commencing work.
2. Brooms, dusters, polishers and water must be clean.
3. Sweep first, except for high dusting, with a proper brush, of walls ledges and blinds.
4. Dusting should be done with a damp duster, polish surface and dry afterwards with a soft dry duster. Dust from top to bottom of article using firm even strokes.
5. All rubbish must be removed from tables and locks (with patients permission) when dusting. Scrub and tidy insides of lockers weekly for long-term patients.
6. Furniture (including locker tops and bed-tables) should be polished once every week using furniture scream sparingly.
7. Paintwork should be washed with soapy water, clearing powder used only to remove marks.
8. Use all cleaning materials with care and economy.

Requirements: **A trolley**

Top Shelf

- Cleaning cloths or 2 duster dry and wet
- Bowl of warm water with detergent
- Cleaning powder or vim; a bottle of disinfectant

Bottom Shelf;

- Destructor bowl or bucket for used items.

Procedure:

- Assemble all requirements on a trolley or portable table.
- Check and inspect ward equipment so that defects may be reported for immediate repair.
- Open windows to ensure proper ventilation at all times
- Keep window blinds and windows sills from all articles
- Remove all articles from tabletops
- With wet cloth soaked in soapy water, dust table tops, side lockers and bed frames daily.
- With cleaning powder pop vim weekly wash table and side locker inside and outside
- Obtain patient's permission before discarding newspaper, magazines -Arrange articles needed by patient neatly and within easy reach for the patient
- Heads of beds are well arranged, in even line.
- Always ensure that bedside locker are at the right hand side of the patient
- Clean and return equipment used for cleaning to proper place.

Principles:

- Daily routine cleaning is done each morning after the beds are made. As each bed is finished it is pulled away from the wall together with the bed table, chairs or stools.
- Put enough clean water into a bowl and add disinfectant. Dust with a cloth wrung out in water containing disinfectant. Every edge and corner should receive special attention so that no germ laden dust remains to carry infection.
- Do not apply too much polish on wooden lockers and tables as it leaves the surface dull and sticky and a trap for germ.
- Glass trolleys and shelves are washed first with soapy water then polished with a little diluted methylated spirit
- Clean all trolleys daily before commencing work in the morning.
- Dust metal frames of screens before commencing work. Weekly remove dirt from wheel of screens and trolleys
- Oil wheels weekly to prevent stiffness.

Note: General ward cleaning is usually done by ward orderlies but the nurse must know how it is done so that she could supervise the cleaning.

CARBOLIZATION OF BED AFTER DISCHARGE

Requirements: A trolley
Top shelf
- Bowl of disinfectant e.g. Dettol 1:80
- Mop stick

Bottom shelf
- Bucket for soiled-linen
- Dairy linen bin on the floor

Procedure
- Collect all articles
- Strip bed place dirty linen in bin and soiled linen in bucket
- Dip mops stick in disinfectant
- Fold mattress cover into half to mop bedstead and spring. Do same to other half
- Wheel bedstead and mattress outside to sun

TERMINAL DISINFECTION
Requirements:
Top shelf
A large bowl of disinfectant solution with detergent (Izal, 1:60, Dettol 1: 80 Savlon 1:400)
- A receiver with 2 dusters (one for washing and one for drying)

Bottom shelf
- A large bowl for collection rubbish
-Linen hampers.

Procedure:
-Strip the linen and mackintosh into the hamper leaving the pillows and blanket on the mattress.
-Hang the blanket outside to sun
-Take the pillows and mattress outside and place on 2 chairs to sun
-Remove anything on the locker and around the bed to the bottom shelf of the trolley
-Clear bed table and bed stead carefully reaching all corners.
-Wheel the bed outside to air
-Remove the linen bag o the sluice room
-Remove and clear the trolley

-Take the locker outside and wash
-Wash thermometer ad change lotion
-Clean thermometer and change lotion
-Carbonize the bed including the floor

CONCURRENT CARBOLIZATION

-This is done where a patient has stayed too long in the ward
-The patient is given a seat while carbolization is carried out -After the procedure the patient is taken back to his corner/bed.

DAMP DUSTING (CLEANING OF PATIENTS' ENVIRONMENT)

Purpose:

-To make the ward clean and tidy
-To reduced spread of infection

Requirements: Trolley setting
Top shelf
-A bowl of warn soapy water
-A bowl of water containing disinfectant (Izal or Lysol) 1:160 Bottom shelf
-Receiver containing 4 dusters
-A bottle of disinfectant (Izal or lysol)
-Receiver for used dusters
-Detergent soap (powder or liquid)
-Polish/vim

N/B:

1. The bed must have been made and the ward swept about thirty (30) minutes before commencement of the procedure.
2. Dusting starts from the topmost surface to the down ones because the down ones are dustier.
3. Patients lockers are cleaned and also arranged
4. If the surfaces are of enamel ware, vim should be used with the rag.
5. Polished surface should be polished and shined.

Procedures:

1. Wet one of the dusters in the soapy water, squeeze out excess water and use it to clean.
2. Rinse same duster in the disinfectant solution and use it to wipe

3. Use the dry duster to dry the area cleaned.
4. Clean all the surfaces in the ward in this manner until the whole ward has been completely cleaned.
5. As soon as on as the dry duster becomes wet drop it in the receiver at the bottom shelf and pick another.
6. Change water as soon as it becomes dirty.
7. At the completion of the procedure, wash all used equipment and put them in appropriate places
8. Dry the duster under the sun and keep them for use next time.

THE PATIENTS CHART

Well- kept patient records are essential parts of good patient care. The patient's record serves the following purposes:

1. It is a means of communicating exact information to other professionals.
2. It records the services of hospitals rendered to the patient.
3. It aids in teaching and research.
4. It is a source of satisfactory information.
5. It is an important source of evidence in medico-legal cases. A patient record is confidential and should be available only to the health team.

PROCEDURE:

1. Fill in completely all headings. Add new sheet when you observe that a page is completed. Both side of each sheet should be used.
2. Chart T.P.R on the graph sheets and nurse's notes
3. If weight measurement is ordered this should be recorded on the graph sheet
4. Drugs are charted on the back of the graph sheet
5. The nurse's note should furnish an accurate observation of the patient condition and record of his care for the use of all professional personnel. Quality of observation and not quantity is important. Charting on the nurse's note should be as follows.

a. Admission: Note the condition of the patient, how he was admitted to the ward and any other observation made.

b. Chart all specimens which are sent to the laboratory.

c. Chart baths, treatment and medication (as they might be giving specific needs such as pain)

d. Chart pre-operations(shaving, enemas, etc)

e. Chart any changes in patient condition.

f. Chart all observation made on patient.

g. Chart time of discharge.

h. If patient dies, chart time and name of the Doctor, that was notified.

When the patient is discharged the chart should be organized in the proper order and heading of each page checked to see that they have been filled in properly. This record is then sent to the record office. No chart should remain on the ward after the patient has gone.

The chart is filed by the medical record office as a permanent record of the patient's treatment in the hospital.

ADMISSION OF PATIENT TO THE HOSPITAL

PURPOSE:

To admit a patient to the hospital for diagnosis and treatment.

METHOD:

1. Greet the patient and his relatives cheerfully.
2. Offer them seats and proceed to care for the patient.
3. If it is an emergency admission, place the patient on bed straightway and proceed with the orders.
4. Obtain the following information and make sure the folder is completed:
   a. Full name of the patient
   b. Address of the patient
   c. Age
   d. Sex
   c. Marital status
   f. Occupational status
   g. Religion
   h. Nationality
   i. If the patient is below 18 years, the consent form must be signed by the parent or Guardian, if surgery involves certain gynecological procedures, the husband and wife must both sign
   j. Address of the next of kin
   k. Telephone number, if any.
   i. Name and address of a religious leader.
   m. Doctor's Name.
5. Obtain nursing. medical,, obstetric (if female), surgical and mental history.
6. Use opportunity for health teaching and allow patient to ask questions.
7. Monitor and record the temperature, pulse and respiration report any abnormality to the nurse in charge.
8. Monitor the blood pressure. Report any abnormality to the charge nurse.
9. Orient the patient to the ward and ward routine.
10. Introduce him to patient around him and to the staff.

11. Bath the patient in bath room. If the condition is poor, it is done in bed and provide hospital gown. If he is able this can be done by the patient in the bathroom.
12. Observe patient's physical and emotional status during the procedure and after.
    a. Signs of Anxiety, Agitation, Restlessness, Irritability, Timidity, Withdrawal. Depression, Euphoria, etc.
    b. General body cleanliness.
    c. Signs of vomitus.
    d. Physiological status, Dyspnoea, Height, weight, Vision, Nutrition, Motor function, speech impairment, Constipation, Diarrhoea, Menstruation (female 14-45years). Condition of the hair and scalp, Eye, Nose, Mouth, Lips, Teeth, and all parts of the body.
13. Obtain a urine specimen and check for specific gravity, general characteristics, reaction, sugar, albumen and acetone. Report any abnormalities to the nurse in charge.
14. Check the patient clothe and other valuables. Label them and place them in the ward store or give them to the nearest relative who must sign for them.
15. Instruct the relatives and patient on any special diet or special orders.
16. Begin treatment as ordered.
17. Reassure the patient and do everything possible to make his hospital stay as comfortable as possible.

DISCHARGE OR TRANSFER OF PATIENT

Definition: It is incorporation of series of activities which occur when a patient is leaving the hospital after admission.

PURPOSE:

1. To give individual care and consideration to a patient who is leaving the hospital
2. To provide facility for maximum comfort of the patient.
3. To emphasize necessary health instruction(s) to the patient before he returns to his home or place of transfer.

METHOD:

1. Confirm the patient discharge by checking bed head ticket.
2. Inform the patient's family and assist in getting him transferred.
3. Ensure that the patient collects all his belongings.
4. If he has deposited any belongings with the charge nurse or money in the hospital safe, assist in getting this for him/her.
5. Ensure that the patient and his family understand treatment and medication that should be taken at home.
6. Inform him/her when he is to return for follow-up visit.
7. Assist the patient to his transport. If he is too weak provide' wheelchair for him. If he has no means of transport contact the Senior Matron.
8. Remove the bed linens from the bed and send them to laundry.
9. Prepare the unit for the next patient.
10. Record discharge proceedings on bed head ticket and take the bed head ticket to the medical record office.

NOTE: If the patient is being transferred to another institution the same procedure is followed. A letter from the attending Doctors should accompany the patient who is usually transferred by ambulance.

USE OF THE TELEPHONE

1. Use the telephone for necessity only.
2. When the phone rings answer it at once. The most senior person nearby should answer. Paper and pen should be kept -near the phone.
3. Answer the phone by giving the name of the ward and then your rank. If it is a direct line you may give your number.
4. When it is necessary to phone a Doctor, the compound nurse or a senior nurse should do it. While you are calling state your rank, the patient's name and bed number tell the Doctor exactly why you are calling. If the Doctor gives you an order write it down and re-read it to him to be sure it is correct. Narcotics and antibiotics should not be ordered by phone.

ORAL REPORT PROCEDURE PURPOSE:

To give a concise and brief report of every patient to those who are assuming responsibility of patient care for the next shift.

PROCEDURE:

1. The Nurse in charge of the ward is to give an oral report to the incoming Nurse, students and ward aides.
2. It should be given from the report book.
3. To keep everyone alert to patient needs, the report should include everything mentioned about Patient, Name, Diagnosis and Bed Number.
4. Special attention should be brought to any change in the patient's condition, new orders, unusual incident and work that is to be done on that shift,
5. The report should also include administrative and nursing problems e.g. Patient on continues suction IV Infusion, intake and out put. Insufficient equipment, repair need, etc

WRITING THE WARD REPORT

Definition: It is a non verbal communication regarding the patient's condition between the medical staff and the nursing staff, regarding morning, evening and night shift.

PURPOSE:

1. To give an up-to-date picture of the ward or department
2. To give some guidelines to the nurse taking over the ward or department as regards to orders to be carried out.
3. To provide an accurate record of patient care and treatment.
4. To provide a means of communication to assist in giving comprehensive nursing care.

METHOD:

Report should be written on the following patients

a. Newly admitted patient:

Report should be written on every new patient giving such details as the History, Diagnosis, Investigation, Vitals signs and Order to be carried out. Finally general observation of the patient conditions both on admission and while compiling the report should be stated.

b. Seriously ill patient:

Report should be written on such patient stating their vital signs at report time as well as their general condition throughout the shift. New treatment should be mentioned and any fresh order or instructions given by the Doctors

c. Discharges and abscondment report:

Report should be written on every discharge patient *or* absconded ones giving such detail as the final diagnosis, result date and time of discharge or approximate time of abscondment.

d. Dead patient:

Report should be written on every patient who died giving such detail as the condition of the patient when shift started, the time the patient condition deteriorated to the time the compound nurse was informed, and his order or the name of the doctor informed, the time he was informed and his order. Method through which each contact with the compound nurse or the doctor was made should be stated as well as the method by which order were received e.g. through telephone or written text.

e. Transfer:

Report should be written on any patient transferred in or out of the ward. The name of the Hospital or ward from which or to which the patient has been transferred should be stated. Diagnosis, Treatment, Investigation and any Order to be carried out should be stated both transferred in or out. In the case of transferred out, especially to another Hospital method by which the patient is to be conveyed to the Hospital and the time the patient is to be conveyed to the other Hospital and the time of departure should be stated.

f. Pre-operative patient:

Report should be written on all those to go for surgery. It should include the preparation that is to be done or that has been done. Information about the pre-operative medication should be noted e.g. time it is to be given or when it was given. Instruction should also be included about food and drinks for the patient and when he is to have nothing personal.

g. Post-operative patient:

Report should be written about every post-operative patient stating the time he was sent to the theatre and when he came back from the theatre. His general condition at the time of report whether regaining consciousness or not, whether he passed urine or stool and the latest vital signs should be stated. Any post operative treatment or medication given and the time it was given or when it is to be given should be stated. Condition of the operated site should also be noted.

h. **Recovering patient:**

Having Specific treatment or problem, e.g. patient having a POP, report should be written on such patient whenever something has been done for them e.g. any new prescription, x-rays, readjustment of traction or re-application of POP. Report should also be written on the following:

a. Drugs:

All new prescriptions should be stated in the report with such detail as the name and dosage of the drugs, the time it was administered last and when it is to be administered next . A drugs order should be written with the dose clearly stated.

b. Haemorrhage:

In case of haemorrhage or any heavy-bleeding should be indicated in the report and

all pads saved during the shift should also be stated.

c. Any observation made :

Anything observed on the patient should be written in the reports as it may also aid in diagnosis e.g. in the case of the patient with gastro-entritis the number of stools passed or vomitus should be stated.

d. Diet:

Any special instruction regarding diet should be clearly written in the report e.g. salt free diet, high protein etc. also where a patient fails to take his meal this should be stated and reason for such failure should be stated, similarly patient intake and output after the shift or after 24 hours should be mention in the report.

e. Nursing procedures:

Every nursing procedure carried out should be indicated in the report, e.g. Bed bath, Oral toilet, Treatment of pressure area etc. and it should be stated as how often such procedure is to be repeated.

Report: should be written after each shift and such report should he compiled by the nurse just before she hands over to the reliever. Reports should be neatly written and legible otherwise they will serve no purpose. Report is to be countersigned by the nurse- in charge or the compound nurse on duty.

NB any abnormality or sub normality detected, should b documented in red ink

BED MAKING

I. MAKING AN UNOCCUPIED BED

Definition: This is a bed made without a patient in it.

PURPOSE:

1. For general tidiness of the ward.
2. To make a bed which is comfortable and safe for the patient and which gives a neat finishing appearance.
3 To provide convenience for adequacy of nursing care.

EQUIPMENT REQUIREMENT

1. Cover if possible
2. Bed Sheet
3. Draw sheet
4. Draw mackintosh
5. Top sheet
6. Blanket (if weather indicates)
7. Counterpane (if available)
8. Pillow and pillow case
9. Long mackintosh

METHOD:

Note: Bed making is a two persons procedure.

1. Turn the mattress and proceed with bed making. Place mackintosh over the mattress.
2. Place bottom sheet over the mattress so that it hangs with an equal amount at the side of the bed (head and foot).
3. Tuck in the sheet at the head of the bed. Making an envelope corner at each side.
4. Move to the foot of the bed.
5. Pull sheet tightly and tuck in at the foot of the bed and make envelope corner at each side.

6. Tuck in sheet tightly along each side.
7. Place draw mackintosh and draw sheet over bottom sheet and tuck in tightly.
8. Place the top sheet on the bed with top edge equal with the head of the mattress.
9. Tuck in the sheet at front of the bed and make envelope corner without pulling the sheet too tightly.
10. Place the blanket on top of the sheet with its top edge from head of the bed.
11. Fold sheet down over top edge of blanket.
12. Tuck in the blanket at foot of the bed and make an envelope corner each side.
13. Tuck in the edge along side of the bed.
14. Place the counterpane on the bed and tuck in as blanket and make an envelope corner.
15. Place the pillows in pillows case and lay at the head.
16. Leave the unit neat and tidy.

2. MAKING AN OCCUPIED BED

Definition: It is the bed which is occupied by a patient who cannot get out of bed due to the nature of his illness/treatment.

PURPOSE:

1. For general tidiness of the ward.
2. To make a bed which is comfortable and safe for the patient and which gives a neat appearance.
3. To provide convenience for adequacy of nursing care.
4. To make a bed neat and clean with minimum discomfort to the patient while he is still on bed.

EQUIPMENT/REQUIREMENT:

As for unoccupied bed except counterpane and dirty linen bin.
Two chairs backing each other.

METHOD A: FROM SIDE TO SIDE

1. Explain to the patient what you are going to do.
2. Bring necessary clean linen and the soiled linen bin to the bed side.
3 loosen the bed linens.
4. Screen the bed if not already done.
5 Remove all top linen except the top bed sheet if not done previously.
6. Assist the patient to roll to one side of the bed. One nurse should support the patient if necessary.
7. Roll separately the draw sheet, draw mackintosh and bottom sheet as near to the patient as possible
8. if a clean sheet is to be use place it on the bed and tuck it in at the top, bottom and sides, making envelop corner
9. Roll excess sheet near the patient.
10. Unroll the draw mackintosh straight and tuck in.
11. Place clean draw sheet over the mackintosh and tuck in.
12. Roll the remaining sheet near the patient and turn patient unto the new linen.
13. Support the patient comfortably.
14. The other nurse remove soiled linen and make the other side of the bed pulling the linen as tight as possible.
15. Position the patient comfortably.
16. Make the top part of the bed.
17. Remove screen and dirty linen leaving the unit tidy.

METHOD B: FOR THE PATIENT WHO CANNOT LIE DOWN FLAT

1. Explain to the patient what you are going to do.
2. Take necessary clean linen and soiled linen bin to the bedside.
3. Screen the patient if not already done, to provide privacy.
4. Remove top linens.
5. Loosen all the bed linens.
6. Lift the patient near the foot of the bed the other Nurse support him comfortably.
7. While one nurse support the patient the second nurse then makes the top side of the

pillow or backrest.

8. Arrange the pillows or backrest.
9. Lift the patient back in position properly supported.
10. Complete the foundation of the bed, making it as tight as possible.
11. Lift the patient's feet and remove the dirty linen and roll down the clean linen.
12. Place clean top cover on bed.
13. Remove screen and dirty linen leaving the unit tidy. Leave patient comfortable.

3. MAKING CARDIAC BED

PURPOSE:

1. To make a bed for a patient with dyspnoea or orthopnoea so that he can be nursed in a sitting up or upright position.
2. To provide maximum comfort, support and ease in breathing.

EQUIPMENT/REQUIREMENT:

1. As for an unoccupied bed
2. Backrest
3. Three or four extra pillows
4. Bed table (cardiac table) and sputum mug
5. Air ring and cover
6. Foot board or sandbags
7. Chest blanket

METHOD:

1. Make the foundation bed as usual.
2. Fix the blanket at the head of the bed and arrange pillows against backrest.
3. Place foot board or sandbag at the foot of the bed to support the patient feet.
4. Place inflated covered air ring on the draw sheet for patient to sit on.
5. Position the patient comfortably.
6. Cover the patient chest and shoulder with blanket (if the weather indicates).
7. Place sputum mug on bed table within easy reach of the patient.
8. Use bed cradle to protect the extremities of the patient.
9. Place top sheet and blanket over the patient and pull top covers enough to cover his shoulder. Tuck in at the foot of the bed.
10. Place the bedside locker within easy reach of the patient.

4. MAKING A DIVIDED BED

PURPOSE:

1. For the patient with amputation above the knee.
2. For abdominal drainage or inspection of the abdomen.

EQUIPMENT/ REQUIREMENT:

Same as for occupied bed with the following additional equipment

1. One extra top sheet
2. One blanket
3. A bed cradle
4. A thin blanket to cover the patient

METHOD:

1. Make bed up to foundation level.
2. Using top sheet tuck in the bottom and fold the sheet up to lower half of bed.
3. With the blanket tuck in the bottom and fold inward the lower half of the blanket.
4. Spread the extra sheet and blanket on bed, fold in one third of the blanket and sheet from the bottom and fold in blanket and sheet! from the top.
5. Insert the bed cradle and put in position.
6. Cover the patient with the blanket if necessary.
7. Make the patient comfortable.

***5.* MAKING AN EMERGENCY ADMISSION BED**

PURPOSE:

To make a bed for reception of a patient from the emergency unit or casualty department

EQUIPMENT/REQUIREMENT:

1. Same as for an unoccupied bed
2. Long mackintosh
3. Two well used sheets
4. Two hot water bottles and cover (if weather indicates)

5. Gown for the patient
6. Bed elevator or bed blocks
7. Curved basin and cover (for vomitus)
8. Oxygen cylinder and mask (if available)
9. I.V drip stand
10. TRP tray
11. Suction machine
12. Post-operative tray

METHOD

1. Make a foundation, bed.
2. Place long mackintosh over the foundation bed.
3. Place one well-used sheet over the mackintosh in preparation for bathing the patient.
4. Fold top bed linen, patient gown, into a pack, place the second well used sheet at center of the bed.
5. Place the filled covered hot water bottle in the pack.
6. Place pillow on the chair.
7. Place additional equipment in a place ready for use

6. MAKING A PLASTER BED (WET)

PURPOSE:

a. To provide a firm level bed.
b. To provide support for the cast in such a way as to provide circulation of air to aid in the drying of the cast.

EQUIPMENT/ REQUIREMENT:

As for an occupied bed with the addition of:

1. Fracture board
2. Extra draw mackintosh and sheet [1]
3. Protective pillow if necessary
4. Bed cradle

PROCEDURE:

1. Place fracture board under the mattress to prevent sagging and possible cracking of plaster.
2. Make extra draw mackintosh and sheet under the cast.
3. Place pillow underneath the patient to support him and to allow for circulation of air around the cast.
4. The number of pillows used depends on the position and extent of the plaster and size of the patient.
5. Place cradle over the patient and make up bed in the usual way.

PRECAUTIONS:

1. Always use the palm of the hand in lifting the patient in a plaster cast that is not thoroughly dry.
2. Always give adequate support to the part in the cast in order to assure proper alignment.
3. Observe the patient for any swelling, discoloration or lack of movement of the exposed part. Discoloration may indicate lack of adequate circulation and pressure on a nerve.
4. Observe for evidence of bleeding on the cast and if it occurs, encircle the area and record time to ascertain the degree of bleeding.
5. Note if the patient has pain underneath the cast.
6. Any of the symptoms mentioned in 3, 4 or 5 should be reported immediately to the nurse charge.
7. Remove plaster off fingers or toes.

7. MAKING AN OPERATION BED ,

PURPOSE:

To make a bed to received a patient from the theater who has had anaesthesia

EQUIPMENT/REQUIREMENT:

1. Equipment for an unoccupied bed

2. Dressing mackintosh and towel
3. Two hot water bottles with cover (if weather indicate)
4. Bed elevator
5. Post anaesthetic tray ready for use
6. Oxygen cylinder for use

a. Bowl containing gauze swabs
b. Bowl containing normal saline
c. Vomit bowl with cover
d. Receiver for soiled swabs
e. Large receiver containing a mouth gag. a pair of tongue forceps, a tongued depressor and sponge holding forceps
f. Vital signs tray and observation chart
g. Special equipment may be needed, depending of the type operation done.

METHOD:

1. Make the bed up to foundation level.
2. Fold the top bed linen into a pack and leave it on the bed.
3. Place filled hot water bottle on the bed to warm up the bed (if weather indicate).
4. Place dressing mackintosh and towel at the head of the bed to protect the linen in case of vomiting.
5. Keep bed elevator and oxygen cylinder at the bedside until needs arise for their use.
6. Place post-anaesthetic tray on locker near the bed and use its content as necessary.
7. Keep vital signs tray near the bed. Check and record vital sign every 15 minute until stable or every half hour (½) or 1-2 hours until stable and 4 hourly until discharge.
8. Unconscious patient or post-operative patient should NEVER be left alone until he regains consciousness.

NOTE: There are two other methods of making an operation bed i.e. side packing, on the bed and making out of the bed.

AMPUTATION BED (ABOVE KNEE OR DIVIDED BED)

Requirements: As for simple hospital bed plus:

1 set of extra top bed clothes	Dressing mackintosh and towel
2 covered sand bags	Roller towel or dressing towel
2 bed elevators	1 tourniquet

Procedure:

1. Make foundation bed as usual.
2. Place dressing mackintosh and towel under the stump.
3. Arrange roller bandage over stump and support sides with two sand bags.
4. Place a small bed cradle over stump.
5. Top bed clothes are made into two packs, the top pack must overlap the lower pack by about 20cm.
6. The lower pack is tucked in at the foot of the bed.
7. The two sets of top clothes are tucked in at the sides of the unaffected leg while they are drawn open on the affected side.
8. Secure the tourniquet at the bottom bedstead, and place bed elevators near the bed.

AMPUTATION BED (POST OPERATIVE)

Requirements: As for amputation bed (above knee).

1. Make up the bed as for simple admission bed up to the draw sheet.
2. Place the treatment mackintosh and towel at the site of the stump.
3. Place the dressing mackintosh and towel in position at the top end of the bed.
4. Using the extra sheet and blanket fold as for amputation bed make into a pack
5. Make the top bedclothes into the normal post-operative pack.
6. Place the top end under the lower end of the top pack.
7. Leave both packs as for post-operative bed.
8. Tidy patient's environment.

FRACTURE BED

This is a bed of special firmness. The objective of making this bed is to provide a firm base to prevent sagging of the mattress and ensure level support of a fractured spine, pelvis, lower limbs and slipped disc.

Requirements: Same as for simple occupied bed with the following addition:

- Fracture board (preferably orthopaedic bed)
- 1 mackintosh covered pillow in case of drying of P. O. P
- 1 bed cradle

- 1 flannelette sheet in case of drying of P. O. P

1 .Sand bags as indicated for immobilization.

Note: i. Special orthopaedic bed and appliances may be used according to doctor's instructions, availability and patient's condition,

ii. If a lower limb is fractured, it must be immobilized with splints, sand bags, POP or by surgical means.

Procedure:

3 .Place fracture board (s) under mattress and make bed as for simple bed up to the draw sheet.

Place bed cradle over affected leg. Place the flannelette sheet in bed sheet over unaffected leg if needed for warmth.

4 .Place top beddings in the usual manner.

5 .Make patient comfortable, clear and put away used items.

POSITIONS USED IN NURSING

1. **Dorsal recumbent:** place the patient flat on his back with a pillow under his head. If this is desired, place small pillow or rolled towel under knees to flex knees slightly. This position is commonly used for patient to encourage early breathing post-operatively and to prevent hypostatic pneumonia.

2. **Semi-recumbent:** position patient on his back with two or three pillows or a backrest under his head and shoulders.

3. **Prone recumbent:** position patient on anterior surface of his body with head turned to one side. Place hands by the sides of the head. Place a pillow under the ankles to keep toes from pressing on the mattress. If desired, place a small pillow or pad under the abdomen at the waist especially in a woman with large breasts.

4. **Fowler's position:** place the patient in a sitting up position using a backrest with several pillows. Use a cardiac table and foot rest to prevent the slipping down in bed.

5. **Lateral position:** place patient on his side with his kneels flexed, the upper one more sharply than the lower. Place a pillow under the head, behind the back, between the legs, in front of the body under the patient, if the patient is being positioned for a period of time. This position is use for enema, rectal examination and suppositories application.

6. **Sims:** place the patient so that chest and upper extremities are in prone position and lower part of the body is in a left lateral position. If desired, place a pillow under the chest especially in a post operative tonsillectomy patient.

7. **Litothomy:** patient lie in dorsal recumbent position with the legs up knees flexed and ankles suspended on stirrup. It is use in Perineal surgery and vaginal

examination.

GUIDELINES FOR LIFTING AND MOVING PATIENT

1. Tell the patient what you are going to do and what help he can render.
2. Remove" watches and rings before handling and lifting the patient.
3. Make a plan of action so that both nurses know what each is to do. Always count three before lifting i.e. count to three and lift on three
4. Make sure you have adequate help i.e., two nurses for a light patient or more for a heavy patient
5. Use good body mechanics

A. Bend from the hips and knees not form the back

B. Use strong thin muscle for lifting

C. Stand with feet wide apart enough to give a good base for working.

LIFTING A PATIENT FROM STRETCHER TO BED AND VICE VERSA

(usually three people are needed)

I. Place the patient's head near the foot of the bed so that the stretcher is at right angles to the bed side.

2. If the patient is conscious tell him what you are going to do.
3. All three nurse stand on the side of the stretcher near the bed.
4. The tallest nurse place hand under the head and thorax of the patient. The next carries the lower back and buttocks and the third nurse lift the thighs and legs.
5. After all hands are in position count to three and lift the patient upward together, tightening him slightly toward the nurse chest bearing the weight with the muscle of t h e upper arm and chest.
6. Take one step backward and then walk to the bed with the patient. Lay him gently and safely in bed.

MOVING A PATIENT IN BED - ROLLING TO THE SIDE

1. Explain to the patient what you are going to do.
2. Both nurse stand on one side of the bed place hands under the head, shoulder, pelvis and knees.

3. Lift the patient to the edge of bed near the nurse.
4. Roll him onto his side and position him comfortably in the lateral position.

(if there is only one nurse, lift the legs of the patient partially by crossing one over the other. Place hand under pelvis and shoulder and turn the patient).

LIFTING A PATIENT IN BED

1. **Lying; down to a position higher in bed:** instruct him to pull, if able when you move him by lifting at the head and shoulders.
2. **Lying down to a sitting up position:** place one hand under the axilla and the other behind the shoulder. Assist him into a sitting position and position comfortably.
3. **Lifting a patient who is sitting up:** Use to move a patient from chair to bed or from bed to chair. Two nurses stand facing each other on each side of the patient. Place patient's hands on the shoulders of the nurses join hands behind at the hip joint and below the thighs and lift patient on the count of three.

HYGIENE PROCEDURES

GIVING SPECIAL MOUTH CARE (ORAL HYGIENE)

PURPOSE:

1. To cleanse the mouth and thus prevent the formation of dental carries.
2. To moisten the mouth and encourage the flow of saliva.
3. To observe the condition of the mouth.
4. To teach the patient good principles of mouth care.

EQUIPMENT /REQUIREMENT:

1. Mackintosh cape and towel
2. Bowl of swabs
3. Three galipot containing:
   Sodium bicarbonate solution (2%), Glycothymoline mouth wash, Hydrogen peroxide or water. Glycerin borax or liquid paraffin or Vaseline.
4. Container or small tray containing, dissecting forceps, artery forceps and tongue spatula.
5. Mouth gag (if the patient is unconscious or semi conscious).
6. Receiver for soiled swabs.
7. Receiver for soiled instruments.
8. Feeding cup and receiver, if the patient is able to use the mouth wash himself.

NOTE: The tray maybe placed on a small trolley or chair by the bed side

METHOD:

1. Place mackintosh cape around the patient's neck and place towel under the chin, depending on position of the patient.
2. Place the patient in a position which is comfortable for the procedure.
3. Grip the swabs firmly with an artery forceps in such a way that ends of the forceps are well padded to avoid injuring the patient mouth.
4. Dip the swabs in the sodium bicarbonate solution and press excess solution from swabs by holding against edge of the galipot.

5. Clean all part of the mouth
    a. Inside the cheek
    b. Teeth and inner gums and outer surface
    c. Roof of the mouth
    d. Upper and lower surfaces of the tongue
    e. Lips
6. Use each swabs only once. Discard it by using dissecting forceps to remove it from the artery forceps.
7. Swabs the mouth with mouthwash following the same procedure! If the patient is able to rinse his mouth, give him some mouth waste and allow him to spit in into the receiver.
8. Swab the mouth with liquid paraffin or glycerin borax being sure no cover all parts of the mouth.
9. Apply Vaseline to the lips if they are dry.
10. Remove the mackintosh cape and towel.
11. Clean the equipments. Sterilize forceps and set tray to be ready for the next use.
12. Leave the patient in a comfortable position and remove screen.

CARE OF PRESSURE AREAS

PURPOSE:

To prevent the development of pressure sores by encouraging circulation and reducing friction on the sites where pressure sores are prone to develop.

EQUIPMENT/REQUIREMENT:

1. Bowl of warm water-temp (39"$_c$-40"c)
2. Towel
3. Flannel
4. Soap in a dish
5. Dusting powder
6. Vaseline ointment or any barrier ointment

METHOD:

1. Explain the procedure to the patient if conscious.
2. Provide privacy.
3. Remove the top linen leaving the patient covered with one sheet.
4. Turn the patient into lateral position with the back toward the nurse.
5. Fold sheet to expose the back and spread the bath towel under the back.
6. Wash the back thoroughly rubbing vigorously.
7. Lather the palm of the hand with soap and rub this into the skin for few minute using circular movements.
8. Apply powder or zinc oxide, Vaseline ointment or a silicone barrier cream may be applied in the patient who is incontinent.
9. Treat other pressure areas in the same way.
10. Rinse off the skin and dry body thoroughly.
11. Straighten the foundation bed.
12. Change the patient position from the previous one.
13. Change linens as necessary.
14. Clean equipment and return them for next use.

BATH IN BATHROOM

PURPOSE:

a. To make the patient clean and comfortable for the day.
b. To teach hygienic habits.
c. For minor exercise

EQUIPMENT /REQUIREMENT:

a. Soap
b. Washing cloth and towel
c. clean bed clothes for the patient
d. Clean linen for bed
e. Tooth brush or chewing stick

PROCEDURE:

1. Accompany the patient to the bathroom after permission for self bathing has been granted.
2. Assist the patient by undressing if necessary.
3. Instruct the patient on how to regulate the shower or place a basin of warm water within reach.
4. Supervise or assist with showering and drying if necessary, or be available to offer assistance if self bathing is permitted.
5 When the bath is finished give the patient any assistance he needs in dressing.
6. Accompany or direct the patient back to his /her bed.
7. Make unoccupied bed before patient return from bath room.
8. Leave the unit clean and in order.

CHART

a. Time
b. Procedure
c. Any important observations

GIVING BED BATH

PURPOSE:

1. To maintain personal cleanliness by cleaning the body of dried secretions, perspiration and micro-organism.
2. To refresh the person and to relieve discomfort.
3. To encourage blood circulation.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

TOP SHELF

1. Washing bowl
2. Bath thermometer
3. Soap in a dish
4. Jug of hot water
5. Jug of cold water
6. Soft sponge for the face and washing flannels
7. Nail brush and scissors in a receiver
8. Powder and Vaseline
9. Hair brush and comb
10. Receiver and cup of mouth wash or water

BOTTOM SHELF

1. Two bath towels
2. Lightweight bath blanket (if weather indicates)
3. Clean gown and necessary linen for bed
4. Basin for dirty linen

METHOD:

1. Explain to the patient what will be done.
2. Close windows (if local condition warrants) and screen the patient.
3. Offer bed pan or urinal before the bath is stated.

4. Bring trolley to the bedside.
5. Remove extra pillow and top cover leaving the patient covered with only top sheet. If it is cold a light bath blanket may be used.
6. Remove patient clothes and move the patient near the side where the nurse is working.
7. Prepare water at proper temperature *(3* 9°$_{C}$-42^{U},) by the use of a bath thermometer or as is comfortable to the patient.
8. Wrap face flannel around hand, apply soap and wash face, neck and ears.
9. Rinse the flannel and gently wash patient eyes without using soap.
10. Rinse the flannel well and remove soap from the area washed dry the skin well.
11. Place the bath towel under one arm (away from your face) and fold sheet back to expose the arm wash the axilla well to remove all perspiration. Rinse and dry well, do other arm in the same manner.
12. Fold the top sheet to the level of the abdomen and wash, rinse and dry the chest, using circular movement. Apply powder to the breast of a woman with large breast.
13. Cover chest with towel and fold top sheet to the level of pubis wash, rinse and dry the abdomen well, special care to the umbilicus.
14. Place the bath towel under one leg and expose the leg. Wash, rinse and dry the leg well. The feet may be placed in the basin of water. Apply soap to hands and massage the ankles and heels well. Apply powder to dry the skin and prevent friction.
15. Turn the patient onto his back wash, rinse and dry the genital area well. If the patient is able, he may prefer to do this himself.
16. Dress the patient with clean gown and trousers.
17. Rinse the mouth.
18. Trim the fingernail and toenails if necessary.
19. Brush and comb the hair if necessary.
20. Make the bed and leave the patient comfortable.
21. Remove equipment, clean them and put in the proper place.
22. Remove screen and leave the unit tidy.

NOTE: When two nurses make a bed. One nurse will be the leader; she will give direction and do the washing of the patient, the second nurse will be the assistant he will dry the part after washing and assist in positioning and turning the patient.

BATHING BABY WITH OR WITHOUT CORD

1. To maintain personal hygiene.
2. To care for the cord if the cord is still on.
3. To teach mother how to bath a baby.

TOP SHELF

1. Small bowl of water at 39", on the table stand for the bath.
2. Two gallipots containing sterile swabs, water in a receiver and covered by another receiver.
3. Mild soap in a dish
4. Baby powder
5. A jug of cold water
6. . A jug of hot water
7. Bath thermometer
8. Baby's brush/comb and nappy
9. Nail scissors in a small receiver if needed
10. Normal saline in a gallipots

BOTTOM SHELF

1. A plastic apron for the nurse
2. Clean gown and nappy
3. Bucket for soiled linen
4. Bath towel. Soft flannel or washing cloth

METHOD:

1. Explain to the mother what you are going to do. Wash your hands.
2. Gather all equipment and arrange them within easy reach.
3. Close windows to prevent draught, wash your hands again.
4. Get water ready by pouring cold water first, followed with hot water to a temperature of $37°_{c}$ $38°_{c}$ if no thermometer, use elbow to test the water (just warm).

5. Moisten swabs with sterile water clean the eyes, swabbing from the nasal side (canthus) outward: use each swab only once and discard it using a different hand for each eye.
6. Clean the face and ears with swabs using cotton buds to clean the nostrils if necessary, do not use soap on the face.
7. Hold baby wrapped in the towel with his feet tucked under the nurses left arm and his head resting over the edge of the bath. The baby's hair is then washed with soap and water, rinse carefully and dried with the towel.
8. Put baby back on the table and unwrap the nappy. Using both hands soap the body, arms, legs and back soaping the buttocks last (if the buttocks are dirty, clean before you continue). Pay special attention to greasy area, e.g. groin, armpit etc.
9. After soaping the baby all over lift baby into the bath. To do this the nurse slips her left hands under the baby's shoulder and grasps his left upper arm. The baby's head will rest on her forearm. The nurse them passes her right hand under the feet and grabs both feet.
10. Lift the baby into the bath maintain the grip on the left upper arm rinse the body with the right hands, sits the baby and hold its left upper with the right hands and rinse the back special attention is given to axilla and groin areas.
11. Lift from the bath in the same way as above unto the towel and the table gently dry the baby thoroughly.
12. Powder or cream the body. If the buttocks are red (nappy rash) apply barrier cream e.g. Vaseline.
13. Apply nappy, wash hand and attend to the cord by cleaning it, dress the baby.
14. Brush hair, cut nail and leave the baby comfortable in a clean cot.
15. Wash and return equipment to proper place.

NOTE:

1. Report any sign of infection on the eye, ear noise, skin and cord.
2. The bath can be placed on the floor in the absence of a table.
3. Take baby's temperature before you bath. If temperature is lower then 36"$_c$ do not bath.

CARE OF THE HEAD AND HAIR

GENERAL CARE:

The hair should be brushed and combed twice a day in order to keep it free from dust and tangles and to promote good blood supply to the scalp. The hair and the scalp of female patient should be washed every week. On admission to the hospital, the patient's hair should be inspected.

INSPECTION OF THE HEAD

PURPOSE:

To inspect the hair for lice and nits.

EQUIPMENT/REQUIREMENT:

1. Bowl of carbolic acid. 1:20 solution/
2. Jaconet cape
3. Receiver containing fine comb and brush and a wide-toothed comb.
4. Waterproof pillow case or a draw mackintosh to protect the pillow if the patient is on bed.
5. Two gowns and a head tie.
6. Hand gloves

METHOD:

1. Explain the procedure to the patient.
2. Screen the patient.
3. Wear hand gloves.
4. Wear gown and head tie.
5. Put on the second jaconet cape around the patient shoulder and the draw sheet or waterproof pillowcase over the pillows, if the patient is in bed.
6. Hold the swabs with the other hand underneath the comb to prevent any lice from failing off and wipe the comb on the swab.
7. Repeat this process all over the head inspecting carefully especially the nape and behind the ears.

8. Drop the used swabs in the receiver containing carbolic acid 1:20 solution.
9. Brush and comb the hair if not infected.
10. Clear away the tray and the screen,
11. Disinfect the comb by leaving it in carbolic acid 1:20 for two hours.
12. Report the condition of the head to the nurse in charge.

TREATING A VERMINOUS HEAD

A verminous head must be treated immediately in order to kill the nits and the lice. The nurse should protect her uniform by wearing a gown and covering his/her hair.

The following three methods are often used in the hospital for the treatment of a verminous head.

1. Sulks D.D.T emulsion: This kills the nits and the lice. The hair should be carefully parted. The emulsion is applied to the scalp with the cotton wool swabs and massaged with the finger tips. The hair should be washed daily sulk D.D.T emulsion remains active for 14 days.

2. Benzyl benzoate cream: This kills the nits and the lice. The oil is applied in the same way by massaging it well into the scalp. The hair should be combed daily in order to remove dead lice and nits do not wash the hair for ten days.

3. Lethane oil: Like the two chemical substances above this also kills the nits and the lice. The oil is applied in the same way by massaging it well into the scalp. The hair should be combed daily :n order to remove dead lice and nits. Do not wash the hair for :en days.

WASHING A PATIENTS HAIR IN BED

PURPOSE:

To wash the hair of a patient confined to bed in order to:

1. Keep the hair free from dirt and tangles.
2. Promote good blood supply to the scalp.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

1. Bowl of warm water-termp 38^{0c}

2. Large jug of cold water
3. large jug of hot water
4. small jug for pouring water
5. small container for shampoo or Soap solution
6. clean brush and comb
7. hand gloves

BOTTOM SHELF

1. Long mackintosh
2. Floor mackintosh
3. Two bath towels
4. One jaconet cape
5. apron

BY THE SIDE OF THE TROLLEY

Two buckets, one for dirty water and the other for wet cape and
Mackintosh.

POSSIBLE POSITIONS OF WASHING THE HAIR IN BED

1. Place the patient in a-dorsal position, Turn the top part of the mattress underneath', thereby making room for the washing bowl on bed spring. .
2. Place the patent in a-setting-up position. Put the bowl on a bed table and have the patient lean forward over it.

METHOD: (Carried Out By Two Nurses)

1. Explain the procedure to the patient;
2. Screen the patient. '
3. Close the nearby windows (if the weather is cold):
4. Strip the top beddings, leaving the patients covered WITH ONLY A sheet.
5. Apply the long mackintosh and spread out the floor

mackintosh.

6. Turn down the top part of the patient's gown and place the bath towel around the patient shoulder-and cover it with a long mackintosh cape
7. Turn the top of the mattress underneath, side it downward with a long mackintosh
8. Remove the pillows and protect the springs with a long mackintosh.
9. Wear hand gloves and apron.
10. Place the bowl of warm water on the bed springs and support the patient's head over the bowl.
11. Using a small jug of warm water over the hair to make it wet.
12. Apply shampoo and massage well with the fingers. Rinse well and change the water.
13. Repeat the procedure until the hair is clean.
14. Squeeze the hair gently and wrap the head in a towel.
15. If the head is verminous apply the chemical substance for the destruction of lice and nits.
16. Remove the bowls, mackintosh and cape.
17. Replace the mattress and pillows, protect the top pillow with a plastic jaconet.
18. Dry the hair with towel, brush and comb the hair.
19. Remove the equipment and leave the patient comfortable.
20. Clean the trolley, remove the screen, do not open the windows (if closed) until the hair is dry.

SITZ BATH

PURPOSE:

a. To relieve congestion of the pelvic organs.
b. As a post - operative treatment for circumcision, haemorrhoidectomy, or fistulectomy.
c. To relieve discomfort after cystoscopy.
d. To relieve tenesmus.
e. To relieve painful haemorrhoids.

EQUIPMENT/REQUIREMENT:

1. Tub, sits or bath.
2. 2 bath towels.
3. Bath thermometer.
4. Bed sheet.

NOTE: if needed or desired a rubber ring may be used.

PROCEDURE:

a. Preparing for a sitz bath

1. Fill tub with 6-8 inches of water.
2. With bath thermometer, check to see that the temperature is 106-! 20F or as ordered.
3. Inflate rubber ring and place in tub if desired.

b. Giving a sitz bath

1 . Have patient to void.
2. Assist patient to undress.
3. Remove dressing, as indicated.
4. Assist patient into the tub.
5. Place folded bath towel behind the back.
6. Cover shoulder, legs and thighs with sheet.
7. Have patient remain in tub for 10-30 minute or as ordered.
8. Remain with patient or within call.

c. After care of the patient

1. Assist patient out of tub. Use other towel to dry patient
2. Observe condition of lesion and surrounding area.
3. Re-apply dressing as needed.
4. Assist patient to dress

d. Chart:

1. Treatment
2. Length of time
3. Reaction of patient

NOTE: sometimes a soapy sitz bath is ordered. Use ordinary bath soap and make surds,

GIVING BEDPAN AND URINAL

PURPOSE:

1. To provide the patient with facilities for defecation and urination.
2. Collect specimen to send to the laboratory.

EQUIPMENT/REQUIREMENT:

1. Bedpan and cover or urinal and cover
2. Tissue paper

PROCEDURE:

a. Take the covered bedpan or urinal to the bedside and screen the bed.
b. Place the bedpan cover between the mattress and springs and prepare tissue paper.,
c. Assist the patient by directing her to draw her knees up and press her heels against the bed, slip your left hand under the pelvis, raise the hips, place the bedpan in proper position and gently lower her on it. Remain with helpless, weak patients.
d. To remove the bedpan raise her hips in the same manner be careful not to scrape her hips when removing the pan.
e. Turn helpless patient on the side to cleanse with tissue paper.
f. Cover the bedpan or urinal and place on a bench; they should never be placed on the floors.
g. If the patient has soiled her hands wash them and make her comfortable.
h. Remove the screen, take bedpan or urinal to the utility room for cleaning, if the patient is on bed rest, it is advisable to leave the bedpan and urinal in his locker.
i. Examine the contents of the bedpan before emptying it.
j. Clean and disinfect the bedpan or urinal before re-using it.

CHART:

1. Time.
2. Amount.

3. Any abnormality in the appearance of urine or stool.
4. Any pain or discomfort on passing stool or urine.
5. If specimen is sent to the laboratory.

MONITORING OF VITAL SIGNS
MONITORING ORAL TEMPERATURE

PURPOSE:

1. To detect a rise or fall in the body temperature
2. To assess the physical conditions of the patient

EQUIPMENT/REQUIREMENT ON A LARGE TRAY:

1. Thermometer in a container of disinfectant
2. Container for dry swabs
3. Receiver for soiled swabs
4. Receiver with lint and a disinfectant
5. Watch with second hand or pulsometer
6. TPR chart
7. Writing pen

METHOD:

1. Take the prepared tray to the bedside.
2. Explain to the patient what you are going to do.
3. Take thermometer from the solution and wipe it with dry swabs moving downwards.
4. Check reading and be sure it is below $35^{\circ c}$ (94F) hold it firmly and shake with a quick movement of the wrist.
5. Place the bulb of the thermometer under the patient's tongue.
6. Instruct the patient to keep his lips closed.
7. Have patient rest his arm on bed with palm downward.
8. Place fingers along radial artery applying only pressure so that the pulsating artery can be felt.
9. Count the pulsations for one minute by using a watch with a second hand,
10. Observe rhythm, volume and condition of the artery wall.
11. Before removing fingers from arm. observe and count "the respiration for one minute, observe the depth, regularity and character of the breathing.

12. Record the pulse and respiration.
13. After three minute remove the thermometer from the patient's mouth.
14. Wipe it with dry swabs away from the bulb.
15. Read the thermometer and record temperature accurately.
16. Report any abnormality/sub normality.

MONITORING AXILLARY TEMPERATURE

PURPOSE:

To monitor the temperature by axilla.

EQUIPMENT/REQUIREMENT ON A TRAY:

1. Thermometer in disinfectant
2. Two galipot containing dry swabs and disinfectant
3. Receiver for used swabs
4. Watch with second hand or pulsometer
5. TPR chart and a pen

METHOD:

1. Explain the procedure to the patient.
2. Bring the tray to the bed side.
3. Expose axillary area.
4. Dry the axillary area.
5. Wipe the thermometer and check mercury to be sure it is below 35^{0c} (94F).
6. Place in the axilla, pointing upward the chest.
7. Place the patient's arm near the body, with the forearm over the chest.
8. Count pulse and respiration
9. Remove the thermometer after the time indicated.
10. Wipe the thermometer with dry swabs.
11. Read and record showing that the temperature was taken auxiliary by making an "a" above the temperature recording.
12. Wash equipment and return them to their proper place.

MONITORING RECTAL TEMPERATURE

PURPOSE:

To take the temperature of a patient who cannot have his temperature taken by other routes.

EQUIPMENT/REQUIREMENT ON A TRAY:

1. Rectal thermometer in a container (a thermometer with a coloured blue bulb should be used for this purpose).
2. Lubricant, e.g. Vaseline, liquid paraffin etc.
3. Swabs in a galipot.
4. Receiver for use swabs and thermometer.
5. Watch with second hand.
6. TPR chart or bed head ticket and pen.
7. Hand gloves

METHOD

1. Gather the equipment and take to the bedside.
2. Explain the procedure and screen the bed.
3. Wear hand gloves
4. Torn the patient to the left lateral position.
5. Fold bed linens to expose the buttocks.
6. Wipe thermometer with dry swabs and make sure mercury is below 55"^{C}(94F).
7. Lubricate thermometer to reduce friction and prevent irritation.
8. Separate buttocks, wipe anal region and insert thermometer in anal opening for about *2-3cm*..
9. Leave thermometer in situ for 3 minute, remove, then wipe with dry swabs and read.
10. Place the used thermometer in a receiver.
11. Record the reading accurately, showing that the temperature was taken rectally by making "r" above the temperature reading.

MONITORING THE BLOOD PRESSURE

PURPOSE:

To measure the arterial Blood pressure of a patient

EQUIPMENT/REQUIREMENT:

1. Stethoscope (for method a only).
2. Sphygmonanometer.

METHOD A: AUDITORY OR AUSCULTATORY METHOD

1. Explain the procedure to the patient.
2. Reassure the patient and handle the equipment carefully, place the sphygmomanometer in a position level with the patient's chest.
3. Neatly wrap the cuff to the upper arm of the patient above the elbow joint.
4. Palpate the brachial artery below the cuff and place the bell of the stethoscope over the brachial artery.
5. Inflate the cuff and allow the mercury to rise until no beat is hard.
6. Deflate the cuff slowly, until the first beat is heard. Note the point where the first beat is heard. This is the systolic pressure.
7. Continue to deflate the cuff until the beat is no more heard. Note the point. This is the diastolic pressure.
8. Remove the cuff gently, fold and place it neatly inside the container.
9. Record the result on the bed head ticket. If the reading is abnormal/subnormal it should be in red and reported to the nurse in charge.
10. Reassure the patient again.
11. Place the patient in a comfortable position.
12. Wash hands and take pulse and respiration as per oral temperature.
13. Wash thermometer with soapy water, rinse and return it to. the disinfectant solution.

METHOD B: PALPATORY METHOD

1. Explain the procedure to the patient.
2. Reassure the patient.
3. Place the sphygmomanometer in a position level with the patient's chest.
4. Neatly wrap the cuff to the upper arm of the patient above the elbow joint.
5. Palpate the brachial artery and inflate the cuff until you can no longer feel the radial pulse.
6. Deflate the cuff slowly, until you are able to feel the pulse.
7. Note the point where the first pulse is felt. This is the systolic pressure (only the systolic blood pressure can be obtained using this method).
8. Remove the cuff gently, fold and place it neatly inside the container.
9. Record the result on the bed head ticket. If the reading is abnormal/subnormal it should be in red ink and reported to the nurse in charge.
10. Reassure the patient.
11. Return the equipment in its proper place.

MONITORING THE APEX BEAT

PURPOSE:

1. To measure the apex heartbeat.
2. To compare the apex beat with pulse rate.

EQUIPMENT/REQUIREMENT:

1. Stethoscope.
2. Watch with a second hand or pulsometcr.

METHOD:

1. Explain the procedure to the patient.
2. Reassure the patient.
3. place the bell of the stethoscope between fifth and sixty ribs of left Side of the chest at about nine cm to the left of exist form process of the sternum or about three cm.

below the left nipple in males.

4. Listen to the sound made by the left ventricle on the chest wall as it pushes blood into the aorta.
5. Count the beats.
6. Record the result.
7. Reassure the patient.

Note: If a comparison of the apex beat is to made with radial pulse, two nurses should be used taking the two rates simultaneously using the same watch.

TEPID SPONGING

PURPOSE:

1. To lower elevated body temperature.
2. To comfort the patient.
3. To avoid mental confusion

EQUIPMENT/REQUIREMENT:

TOP SHELF

1. A large basin for the water
2. Seven (7) Sponges, flannels or soft washing cloth in a bowl
3. Two bowls, one for cold water and other for hot water (25-27^{OC})
4. Bath thermometer
5. Small towel for the patient's face
6. Bowl with two compresses for forehead, iced water

BOTTOM SHELF

1. Clinical thermometer and cotton wool swabs in a receiver.
2. Extra linen for the bed.
3. Cold drink.
4. Clean patient's gown.
5. Receptacle for soiled equipment.
6. Bucket for used water.
7. Water proof protection for bed or bath towel.

METHOD:

1. Explain the procedure to the patient.
2. Bring the trolley to the patient's bed side.
3. Provide privacy by screening the patient's bed.
4. Monitor the patient's body temperature.
5. Remove the top linen and leave the patient covered with one sheet or thin blanket.

6. Remove the patient gown and place towel beneath him.
7. Sponge the face and dry it.
8. Place one sponge in each axilla and one on the forehead.
9. Place one sponge in each ground. Use one sponge to sponge the body and leave the other in the cold water until the first one becomes warm. Then place the warm one in the cold water and change as necessary.
10. Sponge the upper extremities first. Use long strokes from the shoulder to the fingertips changing sponges as necessary.
11. As sponging is done, some of the water should be left on the skin to give a cooling effect upon evaporation.
12. Allow the patient to dip his hands into the bowl of water after sponging the arm.
13. Change the sponges in the axilla and on the forehead at frequent intervals.
14. Sponge chest and abdomen with circular movements.
15. Sponge the lower extremities using long stroke.
16. Place the patient's feet in the water, then change the water.
17. Turn the patient and sponge the back with long strokes.
18. Give care to the pressure area on the back.
19. Remove the towel from under the patient and replace his gown.
20. Replace the top linen and make the patient comfortable.
21. Give the patient cold drinks if possible.
22. Clean the equipment and place them in their proper place.
23. Monitor the patient's temperature after ten minute and chart the result. A fall of 1^{0c} is considered normal.

WOUND DRESSING PROCEDURES

SURGICAL DRESSING

PURPOSE:

1. To protect the wound from injury.
2. To prevent contamination of the wound.
3. To keep the edges of the wound together.
4. To provide local application of drugs.
5. To apply pressure to the area.
6. To absorb materials being discharged from the wound.

EQUIPMENT/REQUIREMENT: (For single wound dressing):

TOPSHELF

1. A large tray with lid containing

i. Receiver for used swabs,

ii. 2 Dissecting forceps,

iii. 2 Dressing forceps.

iv. 1 Probe or sinus forceps if needed.

v. I Suture scissors or clip remover if needed.

vi. 1 Dressing scissors.

vii. 2 Galipots for lotion.

2. A bowl with gauze, lint, cotton swabs and dressing towel.

BOTTOM SHELF

1. Bottle of' lotion for cleaning the skin and for application to the wound.
2. Tray containing bandages, adhesive plaster, scissor, a jar of mask and non sterile mackintosh if needed.
3. Receiver for soiled dressing
4. Receiver for soiled instruments.
5. By the side of the trolley, a bowl of warm water on a bowl stand or chair, soap and towel for washing and drying hands.

METHOD

One nurse should carry out the dressing procedure. The dresser could call for assistance only when necessary.

1. Explain the procedure to the patient and screen the bed.
2. All equipment must be sterile.
3. Wash hands, put on mask, disinfect the trolley and set the trolley.
4. Take the trolley to the bed side, pour required lotion, turn back bed linen and remove outer dressing using your hands.
5. Wash hands thoroughly and dry and put on surgical gloves.
6. Using your hand, take a pair of dressing forceps to remove the dressing.
7. Discard the dressing in the receiver on the bottom shelf and discard the forceps in the receiver for used instrument on the bottom shelf.
8. Using your hands take two pair of forceps and use those to place a dressing towel around the wound.
9. Clean the wound, using as many swabs as necessary.
10. Cover the wound with a suitable dressing.
11. If suture are to be remove, the same technique is used.
12. Discard soiled instruments in the receiver for used instrument on the bottom shelf.
13. Finish the bandaging, or strapping the dressing with hands.
14. Make the patient comfortable and leave the unit tidy.
15. Remove the trolley and empty the dirty dressing.
16. Remove the screen.
17. Clean the instrument and re-sterilize them.
18. Wash and dry your hands.

ADMINISTRATION OF DRUGS

GENERAL RULES FOR CARE AND ADMINISTRATION OF DRUGS

Storage of Drugs: Drugs and lotion are stored in three different cupboards.
1. A cupboard for drugs for internal use only
2. A cupboard for C.D. A drugs
3. A cupboard for external lotions and applications. State laws regulate the supply, storage and administration of drugs in order to safeguard the public and prevent abuse.

THE CONTROL DRUGS ACT (C.D.A)

The aim of this act is to control the sale and use of narcotic drugs of addiction.
These drugs, include opium, monopod, morphine, pethidine, doorman amidone (physeptone), phenadoxone (heptagin), heroine and India hemp (cannabis).

These C.D. A drugs may be obtain or administered only on a doctor's prescription. They must be kept in a special locked cupboard and the key kept on the care of the ward head or her deputy. All C.D.A drugs administered must be entered in a special register and written up under its special headings. This must be kept for at least 2 years following the last entry date.

A.C.D.A. drug must always be checked by a second person who must be a registered nurse, pharmacist, or doctor, unless the administrator is a registered nurse. If so, student may check it for her.

Note: If in case of emergency a doctor orders a C.D.A drug over the telephone, it must be confirmed on the patient's chart within 24 hours, i.e. before 24hours elapse, the doctor must have come to the ward to write it on the patient's chart.

Nurses' Responsibilities

There is an element of danger in the administration of all drugs and as such the greatest possible care should be taken with their administration

1. Read the prescription carefully and make sure it refers to the patient about to receive the drug.
2. Check and read the label on the drug container to make sure it is the correct drug and take note of the following:
   - The strength (stock strength)
   - The expiring date if any
   - Any special instruction about its administration or dilution
3. Measure out the correct dose as prescribed.

4. Recheck the label against the prescription before giving it to the patient.
5. Examine the drug to exclude any evidence of deterioration,
6. Before giving the drugs to the patient call him by his name to be he is the right patient. Also make sure that there has been no change in his condition.
7. Give the drug at the right time.
8. Offer water to patient. To ensure the drug has been swallowed encourage patient to talk.
9. Record the time the drug was given. This is very important be with some potent modern drugs variation in time of administration may lead to serious consequences.
10. Write your name and signature after administration.

The seven 'Right' of drug administration

1. The right drug
2. The right dose
3. The right route
4. The right time
5. The right name
6. The patient's right to know
7. The patient's right to refuse medication

Calculation of drug dosage

$$\frac{\text{What you want (Required Strength)}}{\text{What you have (Stock Strength)}} \times \frac{\text{Volume (Stock Volume)}}{1}$$

Examples:

An ampoule of drug contains 200mg in 2ml. The does prescribed is 100mg. What amount will you take from the stock?

$$\frac{\text{Reg. strength}}{\text{Stock strength}} \times \frac{\text{Stock volume}}{1} = \frac{100}{200} \times \frac{2}{1} = \frac{4}{5} = 0.8\text{ml}$$

Time for Medication

DAILY	=	10am			
BD	=	10am		6pm	
TDS	=	10am	2pm	6pm	
QDS	=	10am	2pm	6pm	10pm
6HOURLY	=	6am	12noon	6pm	12mn

8HOURLY	=	6am	2pm	10pm

Units of measurement

Two systems of weighing and measuring are in use throughout the world. These are: The Imperial and the Metric systems. The metric system is the better of the two, and has now been officially adopted by Nigeria instead of the Imperial system hitherto used.

In any system of measuring there are units of length, units of weight, and units of volume. In the Metric system the unit of length is the meter, the unit of weight is the gramme and the unit of volume is the litre.

The Measures	**Metric System**	**Imperial System**
Mass (weight)	Microgram (mcg)	ounce (oz)
	Milligrams (mg)	
Volume	Gramme (gm)	
	Kilograms (kg)	
Length	Millimeter (mm)	fluid ounce (fl. oz)
	Litre (l)	
	Millimeter (mm)	inch (es)
	Centimeter (cm)	foot (feet)
	Meter (m)	yards
Capacity	Cubic centimeter (cm^3 or cc)	

Conversion of Scales: Imperial to Metric and Vice Versa

1 fl.oz	=	30ml. approx.. (28.4ml accurate).
1 pint	=	600ml. approx.. (568.2ml. accurate).

Note: 1 ml. of water weights 1gm.

1 mega unit (m. u)	=	1,000,000 units
1 ml.	=	15 drops.

DILUTION OF LOTIONS

If 1 gramme of a substance is dissolved in 1 ml. of diluent (usually water or spirit), the resulting solution is considered as pure and undiluted and its strength is reckoned as 1 (one).

If more diluents is then added, its strength is less than 1 and is reckoned according to its percentage strength, e.g. if 1ml of the above pure solution is taken and water is added up to a total of 100ml (i.e. 99ml is added), the strength now is 1-100 or 1% that is 1/100 of the

strength of the pure undiluted solution. 5% solution (5 in 100, or 1 in 20) means that each 100ml. contains 5ml of the pure undiluted solution or 5g. of the undissolved ingredient.

Formula

In order to dilute a stronger solution to a stocked one, the following formula is used.

$$\frac{\text{Required strength}}{\text{Stock strength}} \times \frac{\text{Amount required}}{1}$$

= the amount of concentrated solution to be placed in the measure and the diluent to be added to the required amount.

Question: Prepare 1 litre of Savlon 1-200 from pure Savlon.

Answer: Stock strength = 1. Required strength = 1-200. Amount required 1 litre (1000ml).

Therefore using the formula, $\frac{\text{Required Strength}}{\text{Stock strength}} \times \frac{\text{Amount Required}}{1}$

$$= \frac{1}{200} \times \frac{1}{1} \times \frac{1000}{1} = 5\text{ml}$$

Therefore, put 5ml of concentrated Savlon into a measure and add water until a total of 1 litre (1000ml) is reached (i.e. 995ml. of water is added).

Another example:

Prepare 500ml of Hibitane 1-200 in spirit from Hibitane concentrate 5% solution.

Hibitane concentration is 5% = 5 – 100 = 1 - 20

Stock strength is 1 – 20; Required Strength is 1 – 200; Amount Required is 500ml

$$= \frac{\text{Req. Str}}{\text{Stock Str}} \times \frac{\text{Amt. Req}}{1} = \frac{1-200}{1-20} \times \frac{500}{1}$$

$$= \frac{1}{200} \times \frac{20}{1} \times \frac{500}{1} = 50\text{ml}$$

Therefore pour 50ml of Hibitane concentrate in a measure and add Spirit up to the 500ml level i.e. 450ml of Spirit is added.

Requirements: A tray containing:

- Lotion to be diluted
- Measure
- Jug of water
- Pencil / pen and paper
- Container for diluted lotion

Procedure:

1. Prepare the tray.
2. Calculate amount of lotion and water required using the formula:

$$\frac{\text{Strength required}}{\text{Stock strength}} \times \frac{\text{Volume required}}{1}$$

3. Measure correct amount of lotion and pour into the container
4. Measure correct amount of water and add to lotion.
5. Discard tray.

A. Care of the Medicine Cupboard

1. Always keep it locked.
2. Ward Head or most senior nurse carries the key.
3. Inspect medicine cupboard for drugs which may have signs of deterioration such as sediments (unless labeled "shake well") and check for crumbling, or change in colour. Do not give such drugs. They should be returned to the pharmacy department.
4. Inspect labels on all bottles, boxes and ampoules.
5. Drugs which should be refrigerated include some antibiotics, oils, animal gland, extracts, anti-toxins and vaccines should be kept in the refrigerator.
6. External drugs should be kept separately in specified areas.

B. Medicines

1. Always shake medicine bottle before pouring
2. Liquid iron medicines are to be given through straws and patient given a drink of water after, if straw is not available, use chewing stick or brush the teeth immediately and rinse mouth.
3. Powders should be placed on back of tongue and swallowed with drink of water.
4. Cough medicines should be undiluted
5. Avoid mixing medicines unless specifically ordered
6. Attempt to administer medicines in palatable form. May dilute with orange juice.

C. Pouring Medicines

1. Full attention is required when pouring medicines. Never speak when pouring medicines.
2. Administer all medicines on time and give exactly what is ordered.
3. Read all three times, checking with prescription card as follows:
    a. Before removing bottle from shell
    b. Before pouring medication
    c. After pouring
4. Remove medicine from container by
    a. Open by holding stopper or lid with the 3rd and 4th fingers of the right hand.
    b. Hold bottle with label toward palm of hand

c .With one hand, take medicine glass, place thumb nail on required dosage mark and raise medicine glass to eye level.
d .Pour medicine into glass
e .Wipe mouths of liquid medicine bottles before replacing lids.
5. Pills or capsules should not be handled with the fingers. The desired number should be shaken into lid of the bottle and from there into a spoon on a saucer. The nurse serving medicines is responsible for charting.
6 .Nurse is to remain with a patient until medication has been swallowed.
7 .Observe patient.
8 .A drug should never be poured from one bottle to another.
9 .A drug must never be poured back into a bottle from which it was originally taken.
10. Amount poured in excess should be discarded.

D. Prescription

1 . All orders for medicines must be written and signed by the doctor.
2 . Prescription sheet must contain the following informations:
   a. Patient's name
   b. Room or bed number
   c. Indications
   d. Frequency and time
   e. Date and time of initial dose
   f. Date and time medication should stop

Transfer from doctor's order sheet to the medicine book

1 .It is the responsibility of the nurse in-charge of the ward to transfer orders from doctor's sheet to medicine book.
2 .Verify with the doctor if there is difficulty in reading an order.

Note: If labels on bottles are soiled or illegible, the bottle should be sent to the pharmacy for re-labeling.
Nurses should not label bottles the contents of which are not their responsibility.

ADMINISTRATION OF INTRAMUSCULAR INJECTION

PURPOSE:

To give a drug by injecting the muscle in the following situation:

a. When the substances is irritating to the subcutaneous tissue.

b. When a more rapid absorption is desired than is possible through the subcutaneous route.

c. When there is a large quantity of fluid than the subcutaneous tissue-cannot absorb easily.

EQUIPMENT/REQUIREMENT:

1. Sterile receiver containing the following:
   5 or 10ml syringe.
   2ml needles (size 1, 1-2).
   1 large needle for drawing the drug.
2. galipot of sterile spirit swabs (or any antiseptic solution).
3. Receiver for used swabs.
4. galipot containing file and ampoule or bottle of medication.
5 Prescription list and bed head ticket.

METHOD:

1. Explain the procedure to the patient and take the tray to bedside.
2. Provide privacy/check prescription.
3. Select the proper site, which is most commonly the gluteus, inner outer thigh muscle. Position the patient in a prone or lateral position and choose a place in the upper outer quadrant of the buttocks.
4. Withdraw the quantity of drug required.
5. Clean the area well.
6. Expel air from the syringe by holding it upright.
7. Stretch skin with thumb and forefinger and with quick movement insert the needle into the muscle at an angle of 90 degrees. If the patient is emaciated, special care must be taken.
8. Withdraw the back of the plunger to ensure that the needle is not in a blood vessel and than inject the drugs into the tissue. If there is blood in the syringe. Withdraw the syringe, and needle is change another site.
9. Withdraw the needle quickly and press the area with antiseptic swab for a moment.

10. Remove the equipment wash and put it a way.
11. Make the patient comfortable.
I2. Record the injection on the patient's file.

NOTE: Hand gloves should be worn.

ADMINISTRATION OF INTRAVENOUS INJECTION

Definition: It is the introduction of drugs into the general circulation through the vein by the use of syringe and needle.

PURPOSE:

To give a drug by injection directly into blood stream in the following Situations.

a. When a very fast action is desired
b. When a drug is given which irritate the tissues '
c. When large amount (more than 10ml) are to be given

EQUIPMENT/REQUIREMENT: ON A TRAY:

Sterile receiver containing.
5 or 10ml syringe.
2 needle (size 1 or2).
1 large needle for withdrawing drug.
2. Sterile galipot containing sterile antiseptic swabs
3. Tourniquet or piece of rubber tubing or syghmomanometer.
4. Dressing mackintosh and a towel.
5. Receiver for used swabs.
6. Galipot containing file and medicine to be given.

METHOD:

1. Take the tray to the bedside and explain the procedure to the patient.
2. Provide privacy.
3. Place mackintosh and towel under the patient arm to protect the bed linen.

4. Withdraw drug into the syringe and place the syringe in a sterile receiver.
5. Tie the tourniquet around the patients upper arm.
6. Choose the side and clean the area with antiseptic swabs.
7. Expel air from the syringe and inset the needle into the vein. withdraw the plunger of the syringe to be sure that the needle is in the vein.
8. Inject the drug slowly; being carefully that the needle docs not puncture the vein wall.
9. Withdraw the needle and using, an antiseptic swabs, apply pressure over the area to stop any bleeding.
10. Make the patient comfortable and record the injection on the patient's chart.
11. Remove the equipment and wash immediately.

ORAL ADMINISTRAT1ON OF DRUG

For this method the drug may be in the form of mixture or suspension, pills or capsules, powder or table and sachet.

PURPOSE:

To give medication by mouth this is absorbed into the blood stream from the gastrointestinal tract for the purpose of treatment of disease and preservation of health.

EQUIPMENT/REQUIREMENT:

I. Mixture, tablets, capsules, oil etc.
2. Medicine glass.
3. Drinking straw.
4. Stirring medicine rod.
5. Drinking glass.
6. Bowl of water for washing glasses.
7. Cloth for drying glass.
8. Tea or dessert spoon.
9. Medicine chart or patient list.
10. Container for used cups.

METHOD:

1. Take trolley to bedside and explain procedure to the patient, Position the patient comfortably.
2. Identify the patient and check medicine list for the right drug.
3. Read drug label carefully if is a mixture, shake the bottle properly.
4. Hold bottle upper most and remove cork supporting with little finger of left hand.
5. Keep bottle at eye level and read mixture for accurate dose, check the drug again.
6 Do not pour excess medicine back into the bottle. Put capsule into the spoon and pour the proper amount of mixture into the medicine cup.
8. Offer water with medicine and use drinking straw for patient on drugs that may stain the teeth.
9. Bitter medicine may be mixed with orange.
10. Record amount of water ,fluid, especially for patient intake and output chart.
11. Record medication on patient chart; observe any abnormal reaction and report.
12. Clean medicine glass and make patient comfortable.

NOTE: For digitalis and its derivatives the pulse should be checked before administration of the drug.

ADMINISTRATION OF SUBCUTANEOUS (HYPODERMIC) INJECTION

PURPOSE:

To give a drug by injecting into the subcutaneous tissue in the foI lowing situation.

a. When the drugs is absorbed more effective from the subcutaneous tissue.
b. When the action of the drug is destroyed by secretion of the gastrointestinal track or it is irritating to the tract.
c. When the patient is vomiting or having gastric suction.

REQUIREMENTS ON A TRAY (FOR A SINGLE INJECTION)

1. Sterile receiver with cover containing:

a. 2ml syringe.

b. 2 hypodermic needle (size 17,12).
c. Large needle for drawing drug.
2. Sterile receiver containing dissecting forceps.
3. Galipot of sterile spirit swabs (or any antiseptic solution).
4. Receiver for use swabs.
5. Galipot containing file and ampoule or bottle medication.
6. Prescription sheet.

NOTE: If a number of injections are to be given, a trolley should be used, set up as follows:

TOPSHELF

I. Sterile receiver with cover containing.
a. 2ml and 5ml syringes.
b. Hypodermic and intramuscular needles.
c. Large needle for drawing medication.
2. Sterile receiver containing dissecting forceps.
3. Galipot containing file and ampoule or bottles of medication.

BOTTOM SHELF

1. Receiver for use swabs.
2. Receiver containing water for used syringes and needle.
3. Bowel of H_2^0, soap and towel for washing hands.

METHOD:

1. Check the bed head ticket and select the correct medicine.
2. If the drug is in a bottle with a rubber cap:
a. Swab the rubber carefully with an antiseptic swab.
b. Assemble a sterile syringe using dissecting forceps.
c. Attach large needle to the syringe taking care to keep the needle and the plunger (piston) sterile.
d. Invert the bottle and withdraw the exact amount desired,

e. Turn the bottle upright and withdraw needle taking care not to lose any drug.

f. Loosen the large needle, with hand attached to the other needle using dissecting forceps.

g. Expel air until a drop of fluid is seen at the tip of the needle.

3. If the drug is in an ampoule:

a. Flick the ampoule lightly with the finger to be sure all fluid is in the lower part of the ampoule.

b. Cleanse the neck of the ampoule with an antiseptic swab.

c. Using a file and holding the ampoule against the counter, make several strokes across the neck of the ampoule. Sharp off the top round of the ampoule.

d. If the ampoule has a line around or a dot on its neck, it can be broken off without using the file

e. Insert the needle into the ampoule and withdraw the required amount of drug,

f. Remove the large needle and attach the needle of correct size using dissecting forceps.

4. Re-check drug carefully with the bed head ticket.

5. Place syringe in a sterile receiver with an antiseptic swabs.

6. Check the patients name by greeting him and calling his name so that he responds.

7. Explain to the patient what you are going to do.

8. Choose the area to be used and cleanse with an antiseptic swabs.

9. Take a fold of flesh between the thumb and forefinger and insert the needle at an angle of 45" to the skin surface.

10. pull back on the plunger of syringe to ensure that the needle is not in a blood vessel and then inject drug into the tissue.

11. Remove needle quickly and press area with antiseptic swab for a few minutes to prevent escape of fluid.

12. Record the injection on patient chart.

NOTE: If several injections are given, the same procedure is followed up through step 11. After giving the injection, the following steps should be followed: discard used syringe and needle into safety sharp box.

Record patient's injection.

Proceed to the next patient.

After all injections arc given, wash equipment and return to its proper place.

All drugs served to patient should be checked/ witness by a second nurse and charted.

INTRAVENOUS INFUSION

Definition. It is the introduction of solution into the blood stream through the vein.

PURPOSE:

To supply the body with fluid by a way that it is painless and can be done rapidly by introduction through the vein.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

TOPSHELF

All equipment on the tray should be sterile:

1. Bowl containing a sterile towel.
2. Bowl containing cotton wool swabs and gauze swabs.
3. Receiver containing one dressing forceps one dissecting forceps.
4. Sterile galipot for antiseptic solution.
5. Sterile gloves

BOTTOM SHELF:

1. Tray containing lotions.
2. Dressing mackintosh.
3. Splint and bandages.
4. Tourniquet (rubber tubing).
5. Bottle of solution for the infusion.
6. Disposable giving set for intravenous infusion.
7. Counter scissors.

8. Adhesive strapping.
9. 5ml disposable syringe and needles.
10. Fluid balance chart.

BY THE SIDE:

Drip stand

METHOD:

1. Explain procedure to the patient and screen the bed.
2. Gather the equipment and take to the bedside.
3. Fix the giving set into the infusion bottle and run the fluid through the giving set. Expel air then fill the chamber halfway and clamp the tubing.
4. Place the mackintosh and towel under the arm to be used for the' infusion and clean the skin with antiseptic swabs using a dissecting forceps. :
5. Wear sterile gloves
6. by using tourniquet, insert cannula into the vein.
7. When you are sure that the cannula is in the vein, release tourniquet, loosen the trochar and attach to tubing.
8. Start the fluid running.
9. Fasten the needle with strapping being sure that the fluid continues to run into the vein.
10. Allow the fluid to run 30 drops a minute or as indicated by the doctor.
11. Remove the equipment, clean and store away in proper place and make the patient comfortable.

NOTE: Observe the infusion frequently to be sure that it is dripping at the proper rate. If medication is ordered, introduce into fluid bag before hanging it on the drip stand, label the bottle, stating the drug and amount In children and older patient the infusion should run slowly because of the danger of cardiac and pulmonary oedema. A student nurse may set up and assist with the procedure but is not responsible for starting the infusion.

PREPARATION FOR BLOOD TRANSFUSION

Definition: it is the introduction of compatible blood component into the body circulation.

PURPOSE:

To introduce a large quantity of compatible blood group into another person in order to:

a. Replace blood plasma loss.
b. Improve blood volume and quantity before operation.
c. Treat anaemia.
d. Before surgical intervention

EQUIPMENT/REQUIREMENT ON A TROLLEY :

(All articles are to be covered and sterile).

TOP SHELF

1. Bowl containing a sterile dressing towel.
2. Bowl containing cotton wool swabs and gauze swabs.
3. Tray containing:
    a. 5ml syringe an three needles, cannula.
    b. 2 pair of dressing forceps.
    c. 2 pair of dissecting forceps.
4. Cheatle forceps in disinfectant solution.
5. Sterile galipot for antiseptic solution.
6. Sterile gloves

BOTTOM SHELF

1. Tray containing lotions.
2. Dressing mackintosh.
3. Receiver containing disinfectant for used instrument.
4. Splint and bandage.
5. Bottle of blood ,properly grouped and cross-matched and marked with the patient's name.
6. Sphygmomanometer.

7. Disposable giving set for blood.
8. Counter scissor.
9. Adhesive strapping.

BY THE TROLLEY

1. Covered container for soiled dressing towel and mackintosh.
2. Covered container for soiled swabs.
3. Intravenous drip stand.
4. Good light or and lepoise lamp.

METHOD:

1. Explain the procedure to the patient.
2. Screen the patient,
3. Check and record vital sign.
4. Reassure the patient
5. Check blood brought from the laboratory to be sure that is the blood for the patient prepared and the type that is to receive. Allow it to warm to room temperature.
6. Position the patient comfortably.'
7. Place the mackintosh and towel underarm to be used.
8. Place sphygmomanometer in position proximal to the area to be used for the transfusion.
9. Attach the giving set to the bottle of blood and expel the air from the tubing, clamp tubing fill the chambers.
10. Inflate the sphygmomanometer.
11. Clean the site where the needle is to be inserted.
12. Wear gloves
13. Attach the needles/cannula to the syringe and insert it into the vein.
14. Remove the syringe and attach tubing from the giving set to the needle.
15. Release the sphygmomanometer cuff.
16. Cover needle/cannula, with sterile gauze and tape in place.

17. Immobilize the arm with bandage fastened to bed.
18. Observe the patient very closely for twenty minutes.
19. Remove the equipment and clean immediately, replace in storage place.
20. Care to be giving during blood transfusion:

a. Pulse should be monitored every half an hour.
b. Fluid balance chart should be started.
c. Check whether the needle is still in vein.
d. Check whether the blood is running properly.
e. Observed the patient for any reaction such as urticaria, jaundice, collapse and pain.

21. When transfusion is finished remove the needle and make the patient comfortable.
22. Remove the equipment and clean them properly
23. Remove gloves and wash hand and dry.

NOTE: A student nurse may set up and assist with this procedure but does actually do it. . A specimen of blood from the bottle should be kept in case the patient reacts to the trans fusion.

FEEDING OF PATIENT
SERVICE MEALS

PURPOSE:

1. To provide adequate food both in quality and quantity to a patient.
2. To stimulate appetite by the attractiveness of the food, tray.
3. To determine the eating habits of each patient.

EQUIPMENT/REQUIREMENT:

1. Clean tray cloth
2. Salt and pepper pot
3. One knife (optional)
4. One fork (optional).
5. One desert spoon (optional).
6. Food in a covered plate.
7. Glass of water.
8. Clean napkin.
9. Extra plate for serving

METHOD:

1. Prepare the tray in the pantry (ward kitchen).
2. Make the patient comfortable and tell him the food on offer.
3. Take the tray to the bedside.
4. Dish out enough food neatly on the plate and serve it to him.
5. Allow enough time for eating and assist him where necessary.
6. Report the amount consumed by each patient to the ward sister.
7. Remove the utensils, clean them and replace to their proper place.

NOTE: For serving of meal to many patients the following additional utensils are required.

1. Food trolley.
2. Food bowl with cover.
3. Serving spoon.

4. A drinking jug.
5. Clean napkin.

A bed pan should be offered if the patient so desire before serving the meal.

FEEDING OF HELPLESS PATIENTS

To give food by mouth when the patient is unable to feed himself.

EQUIPMENT/REQUIREMENT:

a. Diet as ordered.
b. Bowl and or plate.
c. Spoon or fork as needed,
d. Drinking cup or a feeding cup.
e. Towel.
f. Washcloth.
g. Tray.
h. Napkin, if appropriate.
i. Small bowl with water for washing cloth.

PROCEDURE:

1. Explain the procedure to the patient.
2. Prepare the food on the tray in an attractive way and take it to the bed side.
3. Wash the patient's face and hands and make him as comfortable as possible.
4. Place the food within the patient line of vision.
5. Place the towel under the chin and over the chest.
6. Encourage the patient to eat by offering him small amounts.
7. Offer small amount of liquid between swallowed foods.
8. After the meal is finished, remove the towel, wash the patient's face and hand and leave him to be comfortable.
9. Remove the tray to the utility room.

AFTER CARE OF EQUIPMENT:

a) Wash the dishes and make them ready for the attendants to take a way.

b) Clean and return other utensils to their proper place.

POINTS TO REMEMBER:

A. Be slow. Do not hurry the patient.

B. Offer the food in small amount and slowly enough for the patient to empty his mouth each time.

C. Make sure the food is what has been ordered.

D. Make the patient feel that you are interested in what you are doing for him.

E. If the patient is not hungry or does not want to eat, remember that it is she nurse's responsibility to encourage him to do so. The patient's diet is an important part of his treatment.

F. Never force patients to take food against his will.

G. If the patient has to remain lying flat, liquids should be giving with a straw or feeding cup.

H. Whenever possible, use the utensils that the patient normally use.

I. If the patient can help by handling part of food, let him do so.

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NASOGASTRIC FEEDING:

PURPOSE:

To provide nutrition and medication for a patient who cannot swallow, for example, an unconscious patient, a patient with a fractured jaw or a patient who has had operation of the mouth, throat or lips.

EQUIPMENT/REQUIREMENT ON A LARGE TRAY:

1. Cape and towel.
2. Feed in a container in and another container of warm water.
3. A glass measure to hold the prepared liquid food.
4. Litmus paper.

5. 5- 10 ml syringe for aspiration of gastric juice.
6. 50 ml. syringe for the feed.
7. A scissor, strapping, spigot.
8. A glass of water.

METHOD:

1. Carry the equipment to the bedside.
2. Explain the procedure to the patient and screen the bed.
3. Put the patient in a sitting up position if his condition permits.
4. Apply cape and towel.
5. Wash hand and dry thoroughly.
6. Remove spigot and using 5- 10mls syringe, aspirate a small amount of the gastric content and test with a litmus paper.
7. If the gastric content is acidic, it is certain that tube is in the stomach, give the feed very slowly, using 50 ml syringe.
8. When the feeds are finished, syringe a little water down the tube. Put the spigot back and apply the strapping.
9. Remove the cape and towel and assist the patient into a comfortable position.
10. Give mouth care.
11. Chart the procedure, including the characteristic of the gastric contents also chart any other treatment.

NOTE:

a) Mouth care should be given frequently for a patient on tube feeding.
b) A nasal tube with funnel and clip can be used for feeding.
c) Feeds can be giving by continues drip.

SURGICAL DRESSING USING A PACK:

PURPOSE:

1. To protect the wound from injury.
2. To prevent contamination of the wound.
3. To keep the edges of the wound together by immobilizing the area.
4. To provide local application of drugs.
5. To absorb materials being discharging from the wound.
6. To apply pressure.

EQUIPMENT/REQUIREMENT:

Dressing pack on a trolley which contains:

1. Two large towels for packing. .
2. One small dressing towel.
3. One receiver.
4. Two gallipots.
5. Two dressing forceps.
6. Two dissecting forceps.

BUTTON SHELF

1. Lotion as needed.
2. Small tray containing bandages.
3. Adhesive strapping, safety pains or plaster.
4. Scissor
5. Receiver for soiled instruments.
6. Receiver for soiled dressing.

METHOD:

1. Explain the procedure to the patient and provide privacy.
2. Wash the trolley and prepare the equipment.
3. Wash your hand and put on mask.

4. Put your dressing pack on the trolley.
5. Move the trolley to the bedside.
6. Open dressing pack and arrange the equipment as needed.
7. Pour lotion as required.
8. Remove strapping and outer dressing, discard in the receiver on bottom shelf and wash hands.
9. Place sterile towel below the wound.
10. Remove the inner dressing with forceps, soak the dressing with Lotion First if it is sticking to the wound.
11. Wear sterile gloves.
12. Using the dressing forceps and swabs, use swabs for each stroke.
13. Apply the sterile dressing using the dressing forceps.
14. Fasten the dressing with strapping or bandage.
15. Make the patient comfortable.
16. Carry the trolley with content of the pack to the treatment area.
17. Decontaminate, wash the equipment in soapy water, rinse, dry and return them to their proper place.
18. Take another sterile dressing pack if you are to proceed to the next patient.
19. When all dressing is *over* clean all the equipment and return to their proper place.

PACKING OF WOUNDS

PURPOSE:

a. To clean the area.
b. To promote healing from the inside to outside.
c. To absorb discharge from the wound
d. To provide local application of drug.
e. Packing is used to stop haemorrhage from an orifice.

EQUIPMENT/ REQUIREMENT:

a. Same requirements as for dressing plus one extra galipot or receiver.

b. Packing material.

c. Probe or one extra dressing forceps as needed.

d. Scissors in a receiver if needed to cut packing materials.

PROCEDURE:

A. Clean the wound with savlon swabs.

b. Place packing materials in galipot to wet with saline/drug, grasp each end of the packing gauze with dressing forceps and squeeze out excess saline, drug.

c. Use one forceps to pack wound and use other forceps TO HOLD the other end of the gauze.

d. Place outer dressing.

REMOVAL OF PACKING

PURPOSE: To assess wound healing

EQUIPMENT/REQUIREMENT:

TOP SHELF

1. Drum containing the following sterile equipment.
    a. 1 forceps.
    b. Cotton balls.
    c. Galipots.
    d. Receiver.
    e. Cheatle forceps

BOTTOM SHELF

1. Macintosh and towel
2. Bottle of normal saline solution
3. Receiver for waste

NB: If a new pack is to be inserted, another forceps and a new pack are needed. If the pack is only to be partially removed, a pair of sterile scissor is needed.

PROCEDURE:

1. Wash hands and assemble the equipment.
2. Take the equipment to the bedside and explain the procedure to the patient.
3. Screen the bed.
4. Remove galipot, cotton balls, receiver, and forceps from sterile drum using cheatle forceps
5. Place the patient in a convenient position.
6. Place the mackintosh and towel in it proper place.
7. Pour a small amount of normal saline solution over the cotton balls.
8. Place the receiver underneath the orifice.
9. Wear your sterile gloves.
10. Using the forceps wet the exposed part of the pack with saturated cotton balls.
11. Using the forceps, remove the pack by slowly and gently pulling on the packing.
12. Observe for bleeding should it begin, report to the doctor at once.
13. Use other cotton balls to clean around the area if necessary.

ORIFICES THAT MAY BE PACKED:

I. VAGINA
II. Uterus
III. Nostrils
IV. Rectum

PACKING THAT MAY BE USED

Plain gauze
Vaseline gauze

PREPARATION FOR CUT DOWN

Definition: It is a simple surgical procedure that exposes the vein, when peripheral vein have collapsed.

PURPOSE:

1. To enter a vein when the vein is too deeply embedded for accessible through the skin.
2. To give fluids continuously over a long period of time.

EQUIPMENT/REQUIREMENT:

A. sterile tray from CSSR containing the following:

1. 3pair of mosquito artery forceps and 1 pair of dressing forceps.
2. 1 pair of tooth dissecting forceps.
3. I pair of dissecting scissors and 1 pair of suture scissors.
4. 2 small curved suturing needles and 1 needle holder.
5. Fine cotton suture.
6. 1 knife handle (No3).
7. 1 No. 1 5 knife blade for skin and No 11 knife blade for vein.
8. 2ml syringe and suitable cannula.
9. 4 gauze square and 2 towels.
10. 1 galipot with cotton balls.

B. Sterile gloves.

C. Tray containing different sizes of sterile polythene tubing with attached needles.

D. Ordered solution or blood and IV or blood transfusion set.

E. Bottle of local anaesthetic agent.

F. Bottle of normal saline solution.

G. Receiver containing adhesive strapping, scissors and bandage.

H. Receiver for waste materials".

I. Mackintosh and cover.

PROCEDURE:

A. Identify the patient and explain the procedure to him / her.

B. Assemble the equipment and take to the bed side or take patient to treatment room.

D. Check the solution to be given with the 'doctor's order.

E. Assists the doctor in the following ways.

1. Place the I.V stand in position.

2. Expose the area and place mackintosh and cover
3. Wash the area thoroughly with soap and water if necessary.
4. Turn the light and adjust it properly.
5. Open the tray when they are ready to use it.
6. Assemble the infusion set and the solution to be used or the blood and recipient set.
7. Expel all air from the tubing.
8. Cut piece of adhesive strapping to the size needed.
9. Help the doctor in any other ways necessary.
10. Splint or restrain the part if doctor does not do so.

F. Remove the screen and make patient comfortable.

G. Adjust rate of flow. Attach fluid label.

H. Clean the equipment and return tray to CSSR.

CAUTION:

A. Never discontinue a cut down without a doctor's order.

B. Do not pull on tubing. Tape the tubing so that the patient should not pull it down out of the vein.

CHART:

i. Time and by whom the procedure was performed.

ii. Amount and type of solution given and rate of flow.

iii. Unusual symptom and reaction of the patient.

iv. Signature.

INCISION AND DRAINAGE

PURPOSE:

1. To determinate suppuration of a localized infection.
2. To hasten the healing process.

EQUIPMENT/REQUIREMENT:

TOP SHELF

a. I pair of artery forceps.
b. 1 pair of suture scissors.
c. 1 knife handle (No.3).
d. 1 knife blade (No.l1). . -
e. Needles, cutting edge needle.
   23 gauge x1 $^{1/2}$
   20 gauge x 1x ½
f. Galipot
g. *2 S*terile towels.
h. 1 rubber drain,
i. Gauze squares 4" x 4".
j. Galipot containing sterile application for culture and sensitivity test if desired.
k. Sutures;
l. package of sterile gloves.
m. Good light source
n. 5mls syringe.
o. Sterile gloves

BOTTOM

1. Bottle of sterile l% Novocain.
2. Receiver for soiled articles.
3. Receiver containing adhesive strapping, bandage and scissors.
4. Mackintosh.

PROCEDURE:

a. Wash hands and assemble the equipment.
b. Explain the procedure to the patient.

c. Take light to the bed side.
d. Screen the bed and adjust the light.
e. Wear sterile gloves.
f. Cut the strapping to the correct length.
g. Assist the doctor, in any other way he may desire.
h. After the doctor has finished, make the patient comfortable. remove the screen and equipment.
i. Wash and dry all articles. Return the tray to CSSR.
j. Return all others equipment to its proper place.
k. Discard all wasted material.
l. Wash hands and dry.

CHART

a. Time.
b. By whom it was performed.
c. Treatment.
d. Reaction.
e. Nurse's signature.

REMOVAL OF SUTURES

PURPOSE:

To remove the skin sutures after the wounds is healed.

EQUIPMENT/REQUIREMENT:

a. Suture removal tray from CSSR or CSSD consisting of:
   Receiver containing:
   Suture scissor.
   Dissecting forceps.
   Gauze square.
b. Mackintosh and towel.

c. Bottle of methylated spirit.
d. Dressing equipment if dressing is to be required.
e. Gloves

PROCEDURE:

a. Open the tray and pour spirit over cotton balls.
b. Wear gloves
c. Clean the wound with spirit sponge/gauze.
d. Using dissecting forceps and scissor, remove the suture. The way in which they are removed depends on type of the suture that has been made. Cut the suture at the side where it enters the skin with the dissecting forceps pull the suture from the opposite side.
e. When all sutures have been removed, inspect the wound to make sure it has healed well, swabs with spirit. Leave off dressing unless there is some reason it should be reapplied.
f. Clean the equipment and return them to the CSSR or CSSD.
g. Remove gloves and wash hands and dry.

PRECAUTIONS:

a. Carry out aseptic technique.
b. Never pull exposed suture underneath the skin

N.B: If wound is open or draining, savlon should be substituted for spirit.

PREPARATION FOR INTRAVENOUS INJECTION

Definition: It is the introduction of drugs 'into the general circulation through the vein by the use of syringe and needle.

PURPOSE:

To give a drug by injection directly into blood stream in the following situations:

a. When a very fast action is desired
b. When a drug is given which irritate the tissue.

c. When large amount (more than 10ml) are to be given

EQUIPMENT/REQUIREMENT ONA TRAY:

1. Sterile receiver containing.
   5 or 10ml syringe.
   2 needle (size 1 or2).
   1 large needle for withdrawing drug.
2. Sterile galipot containing sterile antiseptic swabs.
3. Tourniquet or piece of rubber tubing or sygmomanometer.
4. Dressing mackintosh and towel.
5. Receiver for used swabs.
6. Galipot containing file and medicine to be given.

METHOD:

1. Take the tray to the bedside and explain the procedure to the patient.
2. Provide privacy.
3. Place mackintosh and towel under the patient arm to protect the bed line.
4. Withdraw drug into the syringe and place the syringe in a sterile receiver.
5. Tie the tourniquet around the patient upper arm.
6. Choose the side and clean the area with antiseptic swabs.
7. Expel air from the syringe and insert the needle into the vein, withdraw the plunger of the syringe to be sure that the needle is in the vein.
8. Inject the drug slowly; being carefully that the needle does not puncture the vein wall.
9. Withdraw the needle and using, an antiseptic swabs, apply pressure over the area to stop any bleeding.
10. Make the patient comfortable and record the injection on the patient's chart.
11. Remove the equipment and wash immediately.

NOTE: Intravenous injection should be given by a physician.

PRE- AND POST OPERATIVE PROCEDURES

PRE OPERATIVE CARE

PURPOSE:

1. To prepare the patient mentally, spiritually and physically for surgery.
2. To assist the patient to make a successful and prompt recovery.
3. To prevent post-operative complications.

PRELIMINARY PREPARATION:

1. Explain the procedure and purpose of pre-operation care.
2. Answer all questions which the patient may ask and reassure him.
3. Have consent form properly signed by the patient. If he is under 18 years of age, unconscious or irrational the parent or next of kin should sign the permission.
4. Test urine and have haemoglobin determination done and get reports / result to the surgeon and anaesthetist.
5. Encourage proper diet through dinner the previous evening before surgery or as indicated by the surgeon.
6. Encourage deep breathing exercise and instruct as to post operative procedure with coughing and breathing exercise.
7. Withhold food after evening meal before surgery and withhold fluid after midnight of the day of surgery unless otherwise indicated.
8. Ensure the patient is clean.
9. Provide sedation on the evening before surgery if necessary.
10. Give cleansing enema if ordered.
11. Prepare the skin of the operation area.

AREAS TO PREPARE:

1. Chest surgery-chest and abdomen.
2. Abdominal surgery-chest and abdomen including pubic region.
3. Perinea and rectal surgery-perineum, pubic region and thighs.
4. Eye surgery-cut eye lashes with scissors, smear with Vaseline.

5. Back surgery-back including the sides.
6. Extremities-whole length of the extremities.

EQUIPMENT/REQUIREMENT:

Large tray containing:

a) Soap dish with soap.
b) Receiver for waste.
c) Razor blade with handle in receiver.
d) Bowl of water.
e) Bowl with swabs.
f) Mackintosh.

SHAVING PREPARATIONS:

1. Explain the procedure to the patient.
2. Provide privacy.
3. Prepare the equipment and take to the bedside.
4. Wash hands thoroughly.
5. Place the mackintosh near area to be shaved.
6. Place receiver for waste within easy reach.
7. Place other equipment on the mackintosh or near at hand.
8. Apply soap and water to the area using cotton swabs.
9. Shave the area completely and then dry it.
10. If the patient condition allow him to bath in the bathroom.
11. Clear a way the soiled equipment.
12. Make patient comfortable.
'13. Clean the equipment and replace in their proper place.
14. Remove gloves and wash hands properly.

IMMEDIATE PRE- OPERATIVE-CARE (morning of surgery)

1. Give mouth care and bath, if the patient is unable to do so.
2. Place the. patient's gown on him after properly identifying him as the one for the

surgery.

3. Instruct or assist the patient to empty his bladder or pass catheter . Check and record the patient's vital signs.
4. Remove jewelry and pins from the hair also remove dentures and artificial finger nail polish.
5. Give any valuables to the nearest relative of the patient or put them in an envelope and place them in the safe.
6. Check to be sure that the consent form is properly signed.
7. Give pre-operative medication promptly and chart the time it was given on the bed head ticket.
8. Provide rest and quiet.
9. Accompany patient to the theatre, carrying the patient's folder including the results of all investigations done

POST-OPERATIVE CARE

PURPOSE:

To care for the patient during the immediate post-operative period so that he will have successful and prompt recovery, free from post-operative complications.

PROCEDURE:

1. As soon as the patient has been taken to the theatre, make an operation bed with the post-operative tray at the bedside.
2. Receive the patient with his folder from the theater, and transport him carefully to the ward. Observe his pulse and respiration and check the operation site for bleeding; transfer him carefully to his bed.
3. Place the patient in a dorsal recumbent position with no pillow and the head turned to one side unless contra- indicated.
4. Check that the airway is patent.
5. Attach any necessary tubing or catheters as required.
6. Monitor vital signs every fifteen minute while the patient is unconscious or more frequent if the patient's condition indicates. Report any abnormality.
7. Check for immediate post-operative orders.

8. Do not leave the patient alone during the unconscious period and while he is recovering.
9. Inspect the operated site frequently for bleeding or oedema.
10. Note the following:

a. Condition of skin- cold, clammy, moist.
b. Cyanosis.
c. Vomitus- character and amount.
d. Restlessness.

11 After the patient regains consciousness monitor the vital signs every half hour until stable. Then take vital signs every two hours for 24 hours.
12 Give fluid and food as ordered and tolerated.
13 Give drugs as ordered.
14 Assess the patient frequently during first 48hrs.
15 Check that the patient has passed sufficient quantity of urine within the first eight hours, if he has not .check for distension and catheterize.
16 Encourage deer wreathing every *2* hours; for several days.
17 Give personal, hygiene to meet the patient's needs.

NOTE: Specific type of surgery may require special nursing care. e.g. the patient with eye surgery.

TEST AND INVESTIGATIONS

OBTAINING A BLOOD SPECIMEN

PURPOSE:

1. To obtain a specimen of blood for microscopic examination or for cross matching before transfusion.
2. To determine the level of haemoglobin.

EQUIPMENT/REQUIREMENT: (On a Tray)

1. Antiseptic swab in a galipot.
2. Clean dressing towel and mackintosh.
3. Sterile syringe and needle (5 or l0mls) in a receiver,
4. Sterile specimen bottle.

5. Tourniquet to compress the vein.

METHOD:

1. Explain the procedure to the patient.
2. Place the towel and mackintosh under the arm to be used.
3. Cleanse the area with an antiseptic swab.
4. Compress the vein with tourniquet.
5. Insert the needle into the vein and withdraw about 5ml of blood and put it into specimen bottle.
6. Release the tourniquet immediately.
7. Label the bottle and send immediately to the laboratory with a completed and signed request form.
8. Clean the equipment.
9. Make the patient comfortable.

NOTE: This procedure should not be done by student nurses.

OBTAINING A URINE SPECIMEN

PURPOSE:

To collect a urine specimen that is to be examined for the presence of protein. Sugar, blood, urea, pus, phosphate, bacteria or to detect an early pregnancy.

EQUIPMENT/REQUIREMENT:

1. Bedpan or urinal.
2. Specimen bottle with label.
3. Laboratory form.

METHOD:

1. Explain the procedure to the patient

2. Screen the patient.
3. Give a clean urinal or bedpan to the patient to pass urine.
4. Place about 120ml of urine into a specimen glass or bottle.
5. Attach a label to the specimen container.
6. Send the specimen immediately to the laboratory with a lab. Form duly signed.

Clean the urinal or bedpan and return it to its proper place. Make the patient comfortable.

NOTE: Special urine specimen need special preparations e.g. glucose tolerance test specimen for renal function test, etc.

COLLECTION OF MIDSTREAM CLEAN CATCH URINE SPECIMEN

PURPOSE:

To obtain urine specimen free of external contamination.

EQUIPMENT/REQUIREMENT ON A TRAY:

a) Plastic gloves.
b) Galipot with savlon sponges.
c) Urine specimen container or culture bottle.
d) Bedpan and cover.
e) Receiver for soiled savlon sponges.
f) Tissue paper.

PROCEDURE:

a) Explain the procedure to her
b) Cover bedpan. Take it and other equipment to the bedside.
c) Place the patient on the bedpan.
d) Put on gloves.
e) If a female cleansed the labia majora with savlon sponges. Use one sponge for each stroke and use downward strikes.
f) With the left hand use thumb and index finger to separate labia cleanse labia minora and meatus with savlon sponges. Place soiled sponge in a receiver. Continue to hold labia open until the patient can void.

g) Let a small amount of urine pass into the bedpan .Collect midstream directly into the container. Try to remove the container before stream is finished.

h. Have the patient dry herself with tissue paper or water.

I. Clean equipment.

j. Label specimen and send to the lab.

k. Chart procedure.

ROUTINE TESTS OF URINE MADE BY THE NURSE

A NEW patient should have the following observation and test made on a fresh specimen of urine:

a. Colour:

This is normally pale yellow to amber yellow, depending on the amount of fluid taken.

i. Dark brown with green tinge is due to the presence of bile Pigment.

ii. Smoky is clue to presence of small amount of blood.

iii. Red is much blood present. May also appear red if the patient is Taken certain drugs e.g. phenindione (Dindevan).

iv. Green is clue to presence of certain properties e.g. drugs, pseudoniasis.

Deposits: urine is normally clear. If cloudy, this may be due to disease or the presence of certain salts.

Specific Gravity: This is the density of urine compared, to that of water which is taken as 10:00. Normal urine has a specific gravity of between 10:10 - 10:30, measure with a Urinometer which most float in the vessel containing the urine.

Reaction: This is tested with universal indicator paper and is normally acidic, the PI 1 being 5.3 to 6.8.

Odour: Normal urine has a characteristic odour of aromatic smell, 'fishy'odour, may denote infection.

TESTING OF URINE IN THE WARD

PURPOSE:

To observe and lest urine for abnormal constituents.

To observe reaction of the urine.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

All equipment should be kept ready for use in an area specially set aside for urine testing with a sink available.

1. Urine testing set, test tubes, in test tube rack, tube holder, dropper or pi-pette.
2. Spirit lamp/candle.
3. Matches.
4. Fresh urine specimen in a conical glass.
5. Litmus paper both red and blue.
6. Urinometer.
7. 5ml syringe in the absence of graduated measuring cylinder.
8. Test tube with clean water.
9. Benedict's solution.
10. Sulphosalicylic acid.
11. Acetic acid.
12. Various Ames regent, tablet and various strip tests.
13. Colour chart for reading result.
14. Receiver for waste.
15. Glass stirring rod.
16. Hand gloves.
17. Apron.

METHOD:

1. Collect urine specimen in a clean conical glass.
2. Observe the urine for any visible signs of blood or other abnormal constituents. Wash your hand dry, wear an apron and gloves.
3. Check the odour
4. Check the colour
5. Check specific gravity by using the Urinometer.

6. Check the acidity of the urine by the use of litmus paper.
7. Proceed with specified tests which are desired. Be sure that all equipments arc clean and dry.

TEST FOR GLUCOSE

1. BENEDICT'S SOLUTION TEST

a. Place 5ml of Benedict solution in a test tube.
b. Add 8 drops of urine using a dropper or pipette.
c. Boil for five minutes and allow to cool down, after cooling. shake the test tube.
d. Observe the colour change, if no sugar is present the colour will be BLUE, if there is a slight amount present the colour will be GREEN, if there is large amount of sugar, the colour will be YELLOW OR DARK RED.

2. CLINITEST

a) Place 5 drops of urine into a dry test tube.
b) Add 10 drops of water.
c) Add one clinitest tablet using dry hand.
d) Wait for fifteen seconds, after the reaction has stopped.
c) Shake test tube and compare color with the color chart result, varies between negative (BLUE) to a very deep YELLOW.

3. CLINISTIX

a) Place a clinistix (a special medicated paper) into the urine specimen.
b) Tap the edge of the strip against the side of the urine container to remove excess.
c) Compare the end stick with the corresponding colour chart and make the reading quickly.

TEST FOR ACETONE

ACETEST TABLET

i. Place one acetest tablet on a white sheet of paper.

ii. Drop one or two drops of urine on the tablet using a pipette.

iii. Wait for thirty seconds and compare with the colour chart.

If the tablet remain white or yellowish the result is negative, if the tablet remain pink or purple acetone is present, the darker the colour the more the amount of acetone.

TEST FOR ALBUMEN

COLD TEST

a. Place 5mls of urine in a test tube.

b. Add 2-3 drops of sulphosalicylic acid, wait for 2-3 minutes.

c. 1f white colour results, albumen is present.

BOILING TEST;

a. Fill a test tube 2/3 quarter full with urine and add a few drop of acetic acid.

b. Boil upper part of the tube.

c. Cloudiness may appear during the boiling. If it appears upon cooling add a few drop of acetic acid, if the cloudiness disappear it is due to phosphate, if the cloudiness remain album is present.

USES OF VARIOUS AMES REAGENTS FOR TESTING URINE AND BLOOD

EXAMPLE OF VARIOUS STRIP TEST:

1. Multistix: Reagent strip test for PM, Protein, glucose, ketones. bilirubin and blood in urine (also urobilligen).

2. Bili-labstix: Reagent strip test for PH. protein, glucose, ketones bilrubin and blood in urine.

3. Labstix: Reagent strip test for PH. protein, glucose, ketones, blood in urine.

4. Urobilistix: Reagent strip test for urinary urobilinogcn.

5. Dextrostix: Reagent strip test for urinary urobi Imogen.

6. Ketostix: Reagent strip test for urine ketones.

7. Hacmastix: Arc used for blood test.

DIRECTIONS FOR THE USE OF AMES REAGENTS

1. Collect a fresh specimen in a clean container.
2. Stir specimen to be sure that it is well mix.
3. Do not acidify, centrifuge or filter specimen before testing.
4. Dip the strip to be used into the specimen quickly and remove immediately.
5. Tap the edge of the strip against the side of the urine container to remove excess urine.
6. Compare the strip with colour chart at the designated time. Hold the strip close to the block and match quickly.
7. Recap bottle of reagent tightly after removing a test strip, store the bottle in a cool dry place, keep away from excessive heat, moisture and direct sunlight. Do not refrigerate.

COLLECTION OF SPECIMENS FOR INVESTIGATING STOOL

PURPOSE:

To send stool to the laboratory for investigation in order to detect parasite, occult blood, metabolic disorders, presence of pus. gall stone or foreign bodies.

EQUIPMENT/REQUIREMENT:

1. Bed pan with cover.
2. Wide mouth bottle.
3. Small scoop or wooden spatula.

METHOD:

1. Explain the procedure to the patient.
2. Provide privacy to the patient.
3. Wear gloves
4. Give bed pan to the patient.
5. After taking the bed pan to sluice room, transfer small amount of stool into the

specimen container by using the small scoop or wooden spatula.

6. Make patient comfortable.
7. Clean the bed pan and put bed pan away.
8. Place the specimen bottle in a small tray and take it to the laboratory together with completed laboratory form signed.
9. Attach a label to the specimen container bearing the following information:
   a. Name of the patient
   b. Ward and number of bed
   c. Nature of specimen
   d. Type of test required.
   e. Name and address of doctor if necessary.
   f. Time the specimen was collected.

SPUTUM COLLECTION

PURPOSE:

To obtain a specimen of sputum for diagnostic purpose e.g. in pulmonary tuberculosis.

EQUIPMENT/REQUIREMENT:

I. Sputum mug.
2. Tissue or gauze for wiping the mouth.
3. Laboratory form signed by a doctor.
4. Specimen bottle from the laboratory.

METHOD:

1. An early specimen is usually required before the patient has anything to drink and before cleaning his teeth.
2. Explain to the patient that it must be coughed from the lungs and expectorated into specimen container provided.
3. Labeled and 'sent to the laboratory with the requisition form signed.
4. Gastric washing is sometimes used if the patient cannot expectorate (obtain

specimen). This -is commonly used in young children who cannot be made to understand what is required.

OBSERVATIONS TO BE MADE:

1. Sputum may be frothy due to the effort in expectoration or pulmonary oedema.
2. It may be yellow or greenish due to infection or may contain blood.
3. Blood-stained sputum may indicate a recent pulmonary embolus.

NOTE: Gastric washing, same method as gastric aspiration

INSERTION OF SUPPOSITORY OR MEDICATED PESSARY

Definition: It is the introduction of tablet into the vagina/anus.

PURPOSE:

A. SUPPOSITORY:

1. To provide local anaesthesia, pain relief or soothing action on rectal mucosa.
2. To provide a systemic relief, such as relief of fever, promotion of sleep or relict of nausea and vomiting.
3. To promote defecation.
4. To control bleeding.

B. MEDICATED PESSARY

1. To provide local effect such as astringent, antiseptic effect or relief of itching in the vagina.
2. To treat vaginal infection.

EQUIPMENT/REQUIREMENT:

a. Medicated pessary or suppository. -
b. Lubricant.
c. Disposable glove.
d. Receiver.
e. Chart.

PROCEDURE:

a. Identify the patient, explain the procedure and screen the bed.
b. Assemble the equipment and carry to the bedside.
c. Place the patient in sim's position for the suppository or dorsal recumbent for the medicated pessary.
d. Put on gloves and lubricate the pessary 'suppository.
e. For suppository, separate the buttocks with the left hand, insert into rectum for about

5-7cm, apply pressure over anus until desire to expel suppository has passed.

f. For pessary, gently insert it far into the vagina, using the introducer

g. Return lubricant and receiver to the treatment room, discard the soiled glove, and after charting, return card to medication box.

CHART

A: On medication sheet.

1. Time.
2. Medication.
3. Signature.

B: On nurse's note.

Any significant reaction of pain or observation e.g. discharge.

NOTE: Medication per vagina may be in the form of jelly or cream. A special applicator is used for instillation and each patient has her own applicator. The applicator is washed after use if dropped on the floor it may be soaked in disinfectant solution.

FILLING AND APPLYING HOT WATER BOTTLE

PURPOSE:

a. To relief pain, inflammation and congestion.

b. To provide comfort.

c. To supply warmth to the patient.

EQUIPMENT/REQUIREMENT:

a. Hot water bottle and cover.

b. Bath thermometer.

c. Jug of water 120-135"f (48-57°c)-(according to the patient, the area which it is applied and the thickness of the cover).

PROCEDURE:

a. Test the temperature of the water.
b. Fill the bottle 2/3.
c. Expel air by grasping the neck of the bottle and placing on the bottom
d. Dry the bottle with a towel and test for leakage by turning and pressing the side of the hot water bottle.
e. Put the cover on the bottle and take it to the patient.
f. Keep the bottle hot by changing the water frequently.

CARE OF THE EQUIPMENT/REQUIREMENT:

A. Dry the pitcher and bath thermometer and return them to their proper place.
b. Remove the cover and discard it in the laundry.
c. Empty the bottle, wash it with soap and water and dry it.
d. Inflate the bottle slightly and hang it in the proper place to dry.

CHART:

a. Time.
b. Temperature
c. Area to which applied.
d. Time removed.
c. Result- obtained.

CAUTION:

a. Do not place the bottle to the skin surface. Under the back or on the Limbs
b. Watch for redness of the skin especially if the patient is an infant. old. paralytic, diabetic, omphritic patient.
c. Never apply a hot water bottle to a patient's body without an order.

COLD APPLICATION

PURPOSE:

1. To control headache
2. To control haemorrhage

TYPE:

a. Ice bag
b. Cold compress
c. Cold pack

GENERAL PURPOSE:

1. To relieve pain.
2. To reduce temperature.
3. To control haemorrhage.
4. To reduce swelling

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a) ICE BAG EQUIPMENT/REQUIREMENT: (On a tray)

1. Ice bag and cover.
2. Bowl for chipped ice.
3. Salt.
4. Ice cubes.
5. Spoon ice pack.

METHOD:

1. Prepare the equipment and inform patient.
2. Fill the bowl with ice cubes and sprinkle salt on the cover.
3. Suspend the bag over the affected area, resting on the skin.
4. Place the chipped ice on a blanket and break in piece, sprinkle salt and put into the bag then suspend over the affected area and rest over the skin.

5. The duration of procedure could be for about an hour.
6. The procedure can be repeated as required.
7. Keep the patient comfortable: clean equipment and put them in their proper place.

b) COLD PACK EQUIPMENT/REQUIREMENT:

1. Large basin.
2. Six small towels.
3. Large mackintosh.
4. TPR tray.
5. Stimulant tray containing drugs, e.g. hydrocortisonc, adrenaline, hot drinks e.g. coffee etc.

METHOD:

1. Assemble the equipment and inform the patient.
2. Check the temperature and record.
3. Put ice water in basin. Soak the towels and place in the axilla and groin.
4. Change the towel when necessary until temperature reduces.
5. Monitor the temperature again and record it.
6. The temperature should not be reduce by more than 1^{Oc} at once.
7. Make the patient comfortable and leave the unit tidy.
8. Clean the equipment and place them back to their proper place

c) COLD COMPRESS

PURPOSE:

1. To relieve pain.
2. To reduce temperature.
3. To control haemorrhage.
4. To reduce swelling.

EQUIPMENT/REQUIREMENT:

1. Receiver containing two pieces of square lint.
2. Bowl of ice or clod water.
3. Mackintosh and cover.

METHOD:

1. Prepare the equipment and inform the patient.
2. Take the equipment to the bed side and screen the bed.
3. Expose the area and place the mackintosh and cover under the affected area.
4. Place one square lint in the ice water and rinse lightly, then place on the affected area.
5. Keep the second one in readiness for changing frequently, so as to keep them cold and moist over the prescribed length of time.
6. Clean and dry the area, leave the patient comfortable.

AFTER CARE OF EQUIPMENT:

a. Discard the water.
b. Wash the utensils with soap and water and return them to their proper place.
c. Clean mackintosh as directed in the procedure of cleaning rubber goods.

MEDICAL FERMENTATIONS (HOT APPLICATION)

PURPOSE:

a. To dilate the superficial blood vessels thus increasing blood supply to a part.
b. To increase the number and activity of leucocytes, thus favouring suppression and removal of micro-organism.
c. To relax muscles.
d. To relieve pain and congestion.

EQUIPMENT/REQUIREMENT:

a. TOP SHELF

1. Fermentation bowl.
2. Receiver containing cotton wool, bandage (or binder) and safety pins.
3. Receiver containing wringer and piece of old flannel or wash cloth.

b. BOTTOM SHELF

1. Mackintosh and towel.
2. Hot water bottle (at 120°F).
3. Kettle of hot water.
4. Receiver for soiled articles.

PROCEDURE:

a. Prepare to apply fomentation (to be done in treatment room).
1. Prepare the hot water bottle if necessary.
2. Heat water fermentation.
b. Explain the procedure to the patient.
c. Assemble the equipment.
d. Take the equipment to the bed side immediately.
e. Assist the patient to a comfortable and convenient position.
f. Expose the area to be treated.
g. Protect bedding with mackintosh and cover.
h. Place the flannel or wash cloth inside the wringer and put into fermentation bowl.
i. Pour very hot water over flannel or wash cloth in wringer
j. Wring the cloth dry.
k. Remove cloth from wringer and shake to let stream escape.
1. Raise and lower edges of fermentation on designed area until heat is been tolerated
m. Change fermentation every 2 minute for 15 minute period, if the fermentation is intermittent. If continues, change every 1- 2 hours depend on the order.
n. Cover fermentation with plastic or heavy cloth. After remove off the fermentation,

dry the area.

AFTER CARE OF EQUIPMENT:

a. Discard all waste.
b. Place soiled linen in soiled linen bag.
c. Wash and dry thoroughly all soiled utensils and instrument and return to proper place.

PRECAUTION:

a. Use caution to avoid burning the patient, especially those whose"circulation or temperature sensitivity is impaired.
b. The skin should be carefully inspected when replacing an old fomentation with a new one. Confine fomentation to designated area to avoid increasing congestion.

CHART:

a. Time.
h. Treatment.
c. Area on which applied.
d. Result.
e. Signature.

HOT APPLICATION (kaolin poultice)

PURPOSE:

To dilate the superficial blood vessels, thus increasing the blood supply.

EQUIPMENT/REQUIREMENT : (On a tray)

1. Tin of kaolin and small saucepan.
2. Poultice spatula in a jug of boiling water.
3. Poultice board.
4 Lint or old lint cut to required size (the cover should be trimmed, to avoid over lapping when the edges are twined).
5. Gauze to face the poultice.

6. Cotton wool one inch length all around.
7. Bandage or strapping.
8. Two metal poultice plate or two receivers.

PROCEDURE:

1. Place the tin of kaolin poultice in the pan of boiling water, loosen the cover and allow it to warm for 20 minutes.
2. Stir the content with spatula to mix thoroughly.
3. Prepare the lint according to the required size.
4. Place the lint and spread the poultice evenly a quarter of an inch thick.
5. Cover the lint with single layer of gauze then twist the edges of the lint.
6. Put the prepared kaolin poultice in a warm receiver.

METHOD OF APPLICATION:

1. Inform the patient, screen the bed and close the nearby window
2. Bring the tray to the bed side.
3. Test the poultice. The poultice is tested using the inner side of the nurse's arm to ensure the desired temperature (not too hot).
4. Apply the poultice to the affected area and cover with warm cotton wool and bandage.
5. Make the patient comfortable.
6. Wash and replace the equipment.

ADDED REQUIREMENTS:

1. A bottle of olive-oil in a bowl of warm water.
2. Galipot with cotton wool.
3. Galipot for olive oil.
4. A receiver for used swabs (clean the skin before applying the poultice).

INHALATIONAL THERAPY PROCEDURES

PURPOSE:

1. To introduce drugs through the respiratory passage in other to soothe irritated, inflamed, and congested membrane of the respiratory tract.
2. To loosen secretion in the respiratory tract, thus making breathing easier.

STEAM INHALATION

PURPOSE:

To relieve congestion of the upper respiratory tract by the inhalation of medical substance, such as tincture of benzoin 4mis -500mls of water, eucalyptus 4mls-500mls of water combined with steaming hot water.

EQUIPMENT/REQUIREMENT: (On a cardiac Table)

1. Nelson inhaler with glass mouth piece covered with gauze.
2. A bowl (medium size) to hold the inhaler.
3. Bottle of medicine e.g. T. B.C. and a measure.
4. Crystal mentol, eucalyptus 4ml - 500m! of water also T.B.C.
5. Towel.
6. Jug of hot water.
7. One litter of measuring jug
8. Sputum mug.
9. Small blanket or bath towel.

METHOD:

1. Explain the procedure to the patient and set up the necessary equipment.
2. Pour 300-450mls of water and add lotion.
3. Wrap the mouth piece with gauze and secure it in place.
4. Place the month piece in the inhaler, pointing in the opposite direction of the air inlet. .
5. Place the inhaler in its cover and place it in a bowl. Line the bowl with part of the bath

towel and place the inhaler in the bowl and wrap with the remaining part of the bath towel.

6 Carry the equipment to the bed side of the patient.

7. Screen the patient and support him in a sitting position with his shoulders covered with a blanket or bath towel if whether indicate.

8. Close windows and place the inhaler in front of the patient on a cardiac table.

9. Direct the spout of the inhaler away form the patient.

10. Instruct the patient to place his lips around the mouth piece of the inhaler and to breathe through his mouth and out through the nose.

11. Continue the treatment as long as the steams remain.

12. Use a small towel to wipe the patient's face during the treatment if he is perspiring.

13. Make the patient comfortable following treatment, keeping him warm for a period of time.

14. Empty the inhaler in to the drain (not the skin) and clean the inside of the inhaler with sprit.

NOTE: Do not leave the patient alone during the treatment.

ADMINISTRATION OF OXYGEN

Definition. It is the administration of Oxygen to patient whose respiratory capacity is diminished.

PURPOSE:

To give oxygen to a patient who has anoxia or hypoxia.

METHOD OF GIVING OXYGEN:

1. Nasal catheter.
2. Nasal tubes attached to Tudor Edward speckle frames.
3. B.L.B masks (Boothby, Loudace or Bulbulan).
4. Disposable plastic mask.
5. Oxygen tent.

TOP SHELF: Equipment attached to the cylinder

1. Oxygen key/spanner.
2. Length of tubing.
3. Small tray containing B.L.I? mask and disposable mask.
4. Small tray containing 2 nasal catheters and Tudor spectacle frames with nasal tubes and Y-conuector.
5. Small tray for cleaning nostrils if the nasal method is used containing sodium-bicarbonate, artery and dissecting forceps. strapping and scissors.

BOTTOM SHELF:

Receiver for used swabs.

BY THE SIDE OF THE TROLLEY:

Oxygen cylinder on stand.

Humidifier, flow meter, pressure gauge, attached to oxygen cylinder, oxygen

transporter.

Rate of flow of oxygen:

1. Nasal method-4-5 liters per minute.
2. B.L.B. mask - 7 liters per minute.
3. Disposable mask -7 liters per minute.
4. Oxygen tent flouted at first and then 10-12 litter per minute.

METHOD BY NASAL CATHERTERS:

1. Explain the procedure to the patient.
2. Attach the nasal catheter to the connecting tube (cannula).
3. Turn on the oxygen and test by putting the catheter into a glass, of water which will bubble when oxygen is flowing.
4. Cleans the nostrils with sodium bicarbonate swabs.
5. Lubricate the catheter and insert it in the nostril in a back ward direction for I -5inches (nasal-pharynx).
6. Tape the catheter to the patient chic and make him as comfortable as possible.
7. Regulate rate to 5 litre per minute.

EQUIPMENT/REQUIREMENT:

1. One and two catheter in a receiver.
2. Y- Connector and rubber tubing.
3. A lubricant not petroleum jelly.
4. Receiver for soiled swabs.
5. Wooden application (arrange sticks).
6. Oxygen cylinder, flow meter, humidifier, pressure gauge. Galipot and swabs.

METHOD BY TUDORS EDWARD'S SPECTACLES FRAME:

Set up the same requirements as for nasal Catheter except that two rubber tubes are attached to the spectacle frames for insertion into each nostril.

METHOD BY B.L.B MASK

1. Connect the tubing from the oxygen supply to B. L.B mask (rubber mask with bag).
2. Clean mask after used and replace it in the proper place.

METHOD OF GIVING OXYGEN IN A TENT:

NOTE: The tent is a transparent plastic material that surrounds the bed.

1. Tuck the edges of the tent around the mattress so that the tent forms an enclosure around the patient.
2. Start the oxygen flow and floot the tent by opening the flow to full capacity.
3. Make sure that thermometer inside the tent maintain a temperature of I7-21^{oc}.
4. Regulate the oxygen flow at 10-12 liters per minute.
5. Observe the patient carefully to be sure that he is receiving the benefit of oxygen.

PRECAUTION TO BE TAKING WHEN USING OXYGEN:

1. Matches, cigarettes or anything' which may spark is forbidden in the room.
2. There should be no electrical or battery operated equipment on or near the bed.
3. No sprit should be applied to the patient's skin.
4. The gas cylinder must be handled carefully.
5. Oil or grease should never be applied to any part of the oxygen equipment.
6. Always check the cylinder and turn it off when it is not in use. Place "No smoking' and "No noise" notice in the vicinity where the oxygen is administered.

NOTE; The rate of flow in infant differs between 1-2 litres per minute. If the cylinder is finished it should be marked "EMPTY" the temperature for incubators is about 32$^{oc.}$

URINE RETENTION RELIVING PROCEDURES:

CATHETERIZATION

Definition. It is the introduction of a catheter into the urinary bladder via the urethra.

PURPOSE:

1. To relieve retention of urine.
2. To empty the bladder before operation.
3. To washout the bladder.
4. To obtain a sterile specimen of urine.

FEMALE CATHETERIZATION

EQUIPMENT/REQUIREMENT ON A TROLLEY:

TOPSHELF

All equipment must be sterile.

1. Bowl containing cotton wool and gauze swabs.
2. Bowl or small galipot containing savlon or disinfectant for cleansing the vulva.
3. Five dressing towels in a bowl.
4. A receiver containing two pairs of forceps.
5. Small tray containing 2 catheters of suitable sizes.
6. Receiver to collect urine.
7. A galipot containing sterile lubricant.

BOTTOM SHELF

1. Angle poise lamp.
2. Mask
3. Receiver for used instrument.
4. Bowl for used swabs.
5. Receiver for soiled swabs.
6. Measuring jug.
7. A pier of suitable (sterile) size-D gloves.

8. Bottle of savlon or other lotion.
9. Hand gloves
10. A small tray containing a tube of lubricant, a ward specimen bottle and a laboratory form, if needed.

BY THE BED SIDE

Bowl of water and soap on a stand.

METHOD:

1. Explain the procedure to the patient and screen the bed.
2. Prepare the trolley and take it to the bedside.
3. Provide privacy.
4. Place the patient in dorsal recumbent position and fold the gown and bed clothing to the level of the umbilicus.
5. Flex her legs and abduct the knees. Adjust light so that it is focused on the perineal area.
6. Wash and dry your hands with one of the sterile towel from the bowl and wear hand gloves.
7. Place a sterile towel under each thigh and a towel across the abdomen and under the buttocks.
8. Put the sterile receiver between the patient thighs.
9. Swabs the vulva, using forceps in the right hand and separating labia, using swabs in the fingers of the left hand.
10. Use each swab only once and swab downwards. Discard the soiled forceps.
11. Pick up the eyelet of the catheter and lubricate the end for about 2-3cm. place the other end of the catheter into the sterile receiver. Insert the eyelet end of the catheter into the urethral orifice for 2- cm or until urine is obtained.
12. If a specimen is to be collected then a second nurse should hold the specimen bottle at the end of the catheter to be inserted or the bottle can be sterilized and placed in the receiver on the towel.

NOTE: if the catheter touches any part of the external genitalia or the thigh, it must be discarded and fresh one use.

13. When all the urine is withdrawn gently remove the catheter and swabs and dry the vulva with gauze swabs.
14. Remove the receiver and towel.
15. Make the patient comfortable.
16. Clear away the trolley and screen.
17. Measure and record the amount of urine.
18. Label the specimen for laboratory investigation.
19. Wash all the soiled equipment and sterilize them.

MALE CATHETERIZATION

Equipment is the same as the female catheterization.

METHOD:

1. Explain the procedure to the patient and screen the bed.
2. Prepare the trolley and take it to the bedside.
3. Turn back the bed clothes to the level of the umbilicus and cove the patient with a small blanket or sheet.
4. Place the patient in a dorsal recumbent position with knees and legs abducted. Adjust the light as necessary.
5. Wash and dry your hands, and wear hand gloves.
6. Place a sterile towel over the upper thighs and place the penis on top of the sterile towel. A piece of gauze may be used to hold the penis out of the way while dropping it done
7. Place the sterile forceps receiver between the patient thighs.
8. Using sterile forceps, cleanse the end of the penis well. The penis may then rest on the sterile towel.
9. Using the second pair of forceps, pick up the eyelet end of the catheter and lubricate well for about 5cm to the eyelet end.

10. With the left hand, extend the penis and with the forceps in the right hand, introduce the catheter for about 20-25cm until urine is obtained.
11. When the urine cases to flow pinch the catheter and gently withdraw it then swabs the penis.
12. Remove the receiver, towel and mackintosh.
13. Make the patient comfortable.
14. Clear away the trolley and screen.
15. Measure and record the amount of urine.
16. Prepare specimen for laboratory investigations.
17. Remove gloves and wash hand.

CONTINUOUS URETHRAL DRAINAGE

A trolley is set for catheterization with, the addition of the following:

1. A length of sterile rubber tubing.
2. Sterile glass connector.
3. A clip.
4. A bottle for closed drainage.
5. If a urine bag is used, then omit items 1,2 and 4.

NOTE: if an indwelling catheter is used, a spigot (5-10cm) should be use, or as indicated on the catheter. A syringe and some sterile water are needed to inflate the balloon.

CATHETER IRRIGATION (BLADDER IRRIGATION)

Definition: It is a continuous or intermittent process of rinsing the urinary bladder by continuous or intermittent flow of solution through the bladder.

PURPOSE:

1. To cleanse the bladder of mucus, pus, decomposed urine or blood clots.
2. To instill medication.
3. To restore the patency of an indwelling catheter.

EQUIPMENT/REQUIREMENT ON A TRAY:

1. A tray containing a covered, sterile receiver containing a sterile

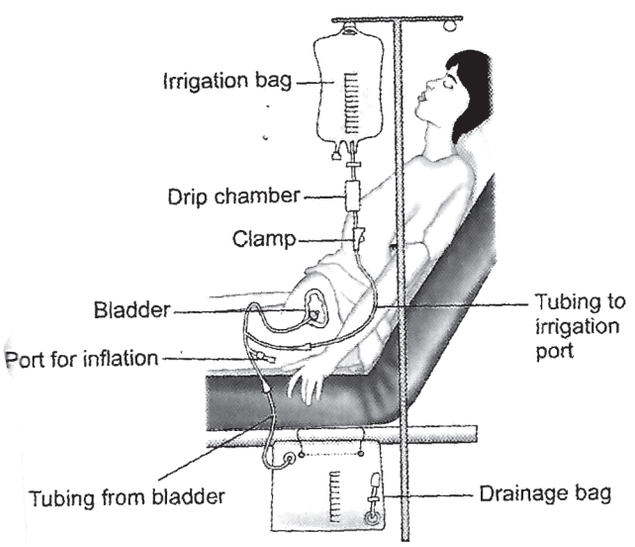
bladder syringe or a 20ml disposable syringe.

2. A sterile container for the desired lotion for the washout.
3. Receiver holding a sterile dressing towel (the receiver later to be used for the return).
4. Dressing mackintosh,
5. Sterile bowel containing sterile drainage tubing and a sterile glass connector.
6. Lotion to be used.
7. Lotion thermometer.
8. Hand gloves.

CONTINUOS CLOSE BLADDER IRRIGATION

Procedure:

1. Close clip on the tube leading to the drainage bay.
2. Open clip on the tube from the drip set and 160-200mls of fluid is allowed to run into the bladder, then the clip is again closed.
3. Open the clip on the drainage tube, thus allowing the irrigation fluid and any debris to be washed out of the bladder.
4. Continue the process until the returned fluid is clear.



INTERMITTENT OPEN BLADDER IRRIGATION

1. Withdraw irrigation fluid into bladder syringe.
2. Use the three-way catheter, if a 2-way Foley's catheter is used, disconnect urine bag and introduce fluid through the opening.
3. Allow irrigation fluid to run out into the urine bag or into the receiver already placed on the bed.
4. Continue irrigation until returned fluid is clear.
5. If a 3-way catheter is used, the free end is used to introduce the irrigation, after clipping the tube from the drainage bag.

CONTINUOUS BLADDER IRRIGATION

LOTION TO BE USED: Normal saline, sterile water, boric lotion 1-2%-Temperature 37^{oc} warm.

RELIEVING THE RETENTION OF URINE PURPOSE:

a) To stimulate the patient to pass urine, who is Uncomfortable because of his inability to void.

b) To prevent the possibility of catheterization with its Inherent problems.

EQUIPMENT/REQUIREMENT:

1. Bedpan or urinal.
2. Other equipments are determined by method use. e.g. Pitcher of warm water, hot water bottle etc.

PROCEDURE:

a) Observe for and recognize symptoms of retention:

1. Failure to void.
2. Feeling of fullness and discomfort, sometimes amounting to severe pain.
3. A distended bladder.

b) Try to relieve any mental distress present.

c) Remove any physical pain or discomfort, if possible.

d) See that patient is put, as nearly as possible, into the position in which he normally urinates, if he is allowed to get into this position.

e) Many persons find it difficult to void in another person's presence. If he is not too ill, leave him alone on bedpan, urinal or toilet for a short time.

f) Do not hurry the patient when he is trying to void.

g) Use the power of suggestion by:

1) Letting the patient hear water running.

2) Letting the patient hear poured water from one pitcher to another.

3) Pour warm water over the vulva or penis.

h) Apply hot water bottle or hot towel over lower abdomen or have patient take sitz bath.

i) Gently message the lower abdomen, if this is permitted.

BARRIER NURSING

PURPOSE:

To give comprehensive nursing care to a patient with an infectious disease in order to prevent the spread of infection to other patients or personnel.

REQUIREMENTS:

A single room or a corner bed near the sluice should be used if at all possible and screen are use to form the barrier.

INSIDE THE BARRIER

Two or three gowns clearly market on the front and hanging just at the entrance, bowl of water, nailbrush, Soap and towel for hand washing for the nurse at the entry.

Toilet requirement such as washing bowl, face and body flannels, towel, pressure area tray.

Mouth care tray

Tray for monitoring vital signs.

food utensils and bowl washing and drying them.

Two bedpans, a urinal, a sputum mug, a vomit bowl with cover for each,

cleaning equipment: brush, duster, bucket for cleaning the inside of the barrier for soiled dressing if necessary.

Large bin for soiled linen containing Izal 11:100 for soaking linens.

OUTSIDE THE BARRIER:

Label on the screens:

INFECTIOUS PATIENT DO NOT ENTER

Label containing supply of clean masks

Bed head tickets

POINTS TO REMEMBER

1. Gather all equipment for barrier nursing as outlined above.
2. When attending to the patient the nurse or the doctor must protect his/her clothes by the use of a gown. The outside fastening of the gown are considered "contaminated"

or dirty while the inside that comes into contact with uniform is "clean" strict technique must be maintained in putting on and taking off gown. Gown must be change every 24 hours.

METHOD OF PUTTING ON GOWNS:

1. If a mask is used, put it on first before entry into barrier area
   wristwatch should be removed before putting on the gown.
2. With the palms of the hands together reach into the inner part of the gown and remove it from the hook or hanger.
3. Open the gown, touching only the inner surface and place over the shoulders. Care must be taken that only the inner surface of the gown touches the nurse's uniform
4. Put arms into the sleeves of the gown.
5. Grasp the edges of the gown opening, at the back bring the left side under the right. Holding these in place with right hand, release the waist ties in front (using the left hand) and bringing the left one to the back. Hold firmly with the left hand while the right tie is brought around to the front and tie.

METHOD OF REMOVING THE GOWN:

1. Untie the left belt, bring the strings to front and then tie in a loose loop.
2. Wash hands and expose arms well.
3. Untie neck strings letting them fall loosely down the back.
4. Place the right hand under the sleeve cuff of the left side (Inside) and pull left the sleeve over the head. Do not touch the outer part of the gown.
5. Grasp right lower sleeve with covered left hand and work it down over the head.
6. Remove gown and hang it on a hanger or a hook with outer part of the gown exposed.
7. Wash your hands well.

INSTRUCTIONS REGARDING THE WEARING AND CARE OF MASKS

1. A supply of clean masks should be kept outside the barrier and one is put on before entering the room of a patient with an infectious disease.
2. The nurse must not touch the mask again until it is removed

3. The hands are washed before untying the mask.
4. The mask is not touched after removal but is dropped into a container for used mask with disinfectant 1:00 and takes to the laundry for washing.
5. Under no circumstances should the mask be pulled down from the face and allowed to hang around the neck.
6. The mask should be changed after caring for patient or finishing a nursing procedure. Do not wear one mask longer than 45 minute. If a mask is still needed, take a clean one. If the mask becomes moist before the 45 minute has passed take a clean one. A wet mask offers no protection.

GASTRO-INTESTINAL PROCEDURES

INSERTION OF NASO-GASRIC TUBE

Definition: It is the introduction of a tube through the nose into the stomach.

PURPOSE:

a. To provide a means of feeding an unconscious or one who Cannot swallow
b. To provide a means of continual suction of the stomach.
c. To relieve acute distension of the stomach.
d. To obtain specimen for gastric analysis.

EQUIPMENT/REQUIREMENT ON A LARGE TRAY:

a) Nasogastric tube.
b) Strapping and scissors.
c) Receiver.
d) Small cup or glass of water.
e) Syringe.
f) Mackintosh and cover (tissue paper for infant),
g) Wash cloth for adult.
h) Any other equipment necessary for specific purpose,
i) Spigot and swabs in a galipot.
j) Sterile gloves

PROCEDURE:

a. Give sufficient explanation to the patient to allay apprehension and secure co-operation.
b. Carry the equipment to the bed side and screen the bed.
c. Assist the patient to a sitting or semi recumbent position.
d. Arrange the mackintosh and for infant tissue paper can be used to protect the bedding. Clean the nostril with swabs.
e. Explain to adult patient how breathing and swallowing can lessen discomfort as the

tube is passed. Give him a wash cloth and a receiver for use if necessary.

f. Determine the length of the tubing to be inserted by measuring from the ear to the nose and to the tip of the Sternum / xiphoid process mark with a strapping / indelible marker.

- Test the content aspirated with litmus paper. The content should turn blue litmus paper red.
- Visualize the aspirated contents checking for colour and consistency.
- Obtain radiograph (x-ray) of placement of the tube.

g. Lubricate the tube and gently insert it through the nose. As you continue to pass the tube downward, remind the patient to breathe deeply and continue to swallow until mark on tube is reached or gastric content begins to flow, offer sips of water to adult patient assist him in swallowing.

h. Using the syringe, aspirate the tubing to a ascertain its presence in the stomach, If gastric content arc not aspirated, place free end of tubing in water. Rhythmic bubbling will occur if it is in the trachea, if this happen it should be remove at once.

i. When you are certain that the tube is in the stomach, tape it to the face.

j. Remove the mackintosh and cover and assist the patient to a comfortable position

k. Chart the procedure, nature of gastric content and any other treatment that is given.

PRECAUTION:

a) Do not use force to introduce the tube.

b) Withdraw the tube if there is any obstruction to its passage or if there is chocking or coughing.

c) In infant, if there is no aspiration of the gastric content and the tube is not in the trachea insert a few millimetre of air via the syringe while you listen with stethoscope over the stomach.

GASTRIC ANALYSIS

PURPOSE:

1. To determine the degree of acidity of the stomach at different times.

2. To determine the presence of problem such as slow emptying time or distension of the stomach.

EQUIPMENT/REQUIREMENT::

a) Receiver containing square linen with lubricant and 10mls syringe.
b) Receiver containing strapping and scissors.
c) Nasogastric tube in a bowl.
d) Glass of water.
e) Towel.
f) Jar labeled 'Resting juice'.
g) Jar labeled 'Residue'.
h) 8-10 specimen tubes numbered 1 through 10.
i) Cup.
j) Gruel in a container in a bowl of water or other test meal.
k) A clamp.
1) Hand glove.

PROCEDURE:

1. The patient is given a light supper the evening before-meal of carbohydrate nature, (sometimes charcoal is given 2-3 hours afterwards;
2. The patient should have NPO for night.
3. At 8-9am the following morning, the Nasogastric tube is passed as per procedure.
4. The content of the fasting stomach is withdrawn. This is the RESTINGJUICE. The quantity is noted and is put in a labeled flask (60-120mls is consider normal).
5. The patient is given one of the following test meals:

a. Gruel: **2oz** meal into 1qt. Boil until it is reduced to 1 pint strain. It may be flavored with sugar but not salt.
b. Ewald test meal: 2 slices of dry toast without crust and 400mls of tea without sugar or milk or 400mls water. Give patient to take.

c. After test meal, specimen of 10mls are collected every 15 minutes from 2-2.5 hours until 8-10 specimens are obtained. These are placed in numbered tubes.

6. After specimens have been collected, collect the remaining stomach contents and put in to container labeled 'Residue'.

7. Remove the tube if no further-test has been ordered.

CHART:

1. Procedure.
2. Specimens send to the lab. Any unusual observation.

GASTRIC LAVAGE

PURPOSE:

1. To wash, out the stomach in other to remove poisons and irritating materials.
2. To relieve nausea and vomiting.
3. To cleanse the stomach pre-operatively in preparation for surgery.
4. For diagnostic purpose.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

TOP SHELF:

1. Large bowl containing the funnel and stomach tube.
2. Two large jugs of prepared solution.
3. Calibrated jugs for filling the funnel.
4. Small bowl containing gauze swabs.
5. Lotion thermometer.
6. A galipot for sterile lubricant.
7. A length of rubber tubing, clip and glass connector.
8. Wash cloth for patient.
9. Strapping and scissors.
10. Mouth gag and tongue depressor if required.
11. Specimen bottle and laboratory form.
12. Litmus paper.

BOTTOM SHEET

1. Vomit bowl, mouth wash in a bowl.
2. Receiver for soiled swabs.
3. Mackintosh cape and towel.
4. Floor mackintosh.
5. Bucket for return flow.

METHOD:

1. Prepare the equipment in the treatment room.
2. Check the temperature-of the solution.
3. Explain the procedure to the patient.
4. Carry the equipment to the bed side and screen the bed.
5. Position the patient in a sitting up or semi-recumbent position.
6. Insert the Nasogastric tube according to the procedure.
7. Pour the solution slowly through the syringe, then draw out content again (funnel and tubing may by used in place of a syringe).
8. Continue irrigating until all the fluid has been given and the desired result obtained.

ASSISTING WITH LUMBAR PUNCTURE

Definition. It is the insertion of a needle and trocar into the sub-arachnoid space of the lumbar spine.

PURPOSE:

a. To secure a sample of Cerebro-spinal fluid for the study and diagnosis of the patient's condition.
b. To ascertain the pressure of the spinal fluid.
c. To remove the Cerebro-spinal fluid in other to relieve intracranial pressure.
d. To introduce drugs into the spinal canal (intrathecally).

EQUIPMENT/REQUIREMENT:

A. For an adult patient, a tray from CSSR/CSSD with following

a. Spinal needles,
b. Sterile gauze.

c. 2ml syringe.
d. Galipot containing l% Novocain.
e. Specimen containers.
f. Towel or drape.
g. Bowl with cotton balls and tincture of savlon.
h. Prop forceps.
i. Strapping.

B. For a child, paediatric lumbar puncture tray from CSD which consist of a sterile receiver containing: one galipot with cotton balls, two specimen tubes, one towel, and a spinal needle.

C. Sterile gloves.
D. Savlon.
E. Receiver for soiled articles.
F. Adhesive strapping and scissors.
G. Light.
H. IF pressure is to be measured, a water manometer and 3-way stopcock is needed.
I. Sterile gloves

PROCEDURE:

a. Explain the procedure to the patient and screen the bed.
b. Assemble the equipment and take them to the bedside.
c. Turn the patient on his side and bring his back even with the edge of the mattress.
d. Direct the patient to draw up the knees, keeping his shoulders and hips even with the edge of the mattress. The back should be attached and the head flexed. An alternate position is to have patient sit up and flex his head. In cither position, he needs to be supported.
e. Expose the patient's entire back from his neck to his coccyx.
f. Uncover the tray for the physician and open the packages of the sterile gloves. Add savlon if not on tray.
g. The physician, after putting on sterile gloves, prepares the skin, drapes the

patient. He then injects the anaesthetic and makes the puncture. The pressure within the canal may be measure at this time.

h. The physician may request the nurse to hold the test tubes for collecting the specimen,

I) When the fluid has been withdrawn, the physician removes the needle, apply a sterile dressing and secure the dressing with adhesive strapping,

j) Label the specimen with the patient's name, ward, bed number, type of fluid. Fill out the lab. Request according to doctor order and send it to the laboratory.

k) Make the patient comfortable and leave the cubicle in other.

AFTER CARE OF EQUIPMENT:

a) Discard all waste.

b) Clean the equipment and return tray to the CSSD.

c) On paediatrics make out charge slip to return with tray to CSSD.

CHART:

a) .Hour and treatment.

b) By whom it was performed.

c) Amount of fluid withdrawn, colour and consistency.

d) Patient's reaction.

e) Specimen sent to lab.

f) Signature.

RECTAL EXAMINATION

PURPOSE:

This is carried out for the following reasons:

1. Any suspected disease of the rectum e.g. new growth, hemorrhoids, fistula.
2. Pelvic and reproductive diseases.
3. Prostates enlargement in males.

EQUIPMENT/REQUIREMENT:'

1. A receiver containing a pair of gloves.
2. A receiver containing prostoscope.
3. Lubricant jelly or Vaseline.
4. Receiver for used article.
5. Dressing towel and dressing mackintosh.
6. Good lighting.
7. Specimen container when necessary.
8. Galipot containing gauze swabs.

NOTE:

1. The procedure should be perform by a doctor.
2. Special preparation such as plain water enema, evening before the examination may be required.
3. The examination may include siginoid colon.
4. The patient may be placed in the left lateral or knee chest position.

PASSING FLATUS TUBE

PURPOSE:

To relieve abdominal distension.

EQUIPMENT /REQUIREMENT:

1. Mackintosh and towel.
2. Bowl of water or drainage bottle half filled with water.
3. Bowl containing rectal tube connector, rubber tubing and small funnel.
4. Vaseline for lubrication.
5. Swabs in a container.
6. Receiver for soiled swabs.
7. Hand Gloves.

METHOD:

1. Explain the procedure to the patient and screen the bed.
2. Assemble the equipment and place the funnel underwater in a bowl or insert the tube in to the drainage bottle.
3. Place the patient in left lateral position with mackintosh and towel under the buttocks and wear hand glove.
4. Lubricate the rectal tube and insert in to the rectum for about 4-5 niches.
5. Observe the water in the bowl drainage bottle, if flatus is expelled, bubbles will be seen in water.
6. Leave the tube in position for about ten minute or longer if results are obtained.
7. Remove the rectal tube and mackintosh and towel.
8. Make the patient comfortable.
9. Cleanse the equipment and make them ready for future use.
10. Record procedure done: chart time, treatment and signature of the nurse.

COLOSTOMY IRRIGATION

PURPOSE:

1. To cleanse the colon through a colostomy opening.
2. To assist in establishing regularity of the colosomy, this promotes control of the colostomy drainage.

EQUIPMENT/REQUIREMENT:

TOP SHELF:

1. Irrigating can, tubing glass connector and clip.
2. Rectal tube.
3. Two colostomy towels.
4. One flannel.
5. Mackintosh and towel.
6. Wash out solution (500-1000mls e.g. Norma saline, sodium bicarbonate 37.8).

7. Measuring jug.
8. Lubricant in galipot.
9. Hand glove.

BOTTOM SHELF:

1. Floor mackintosh.
2. Lotion thermometer.
3. Bedpan with water.
4. Bucket with lid.
5. Apron

METHOD:

1. Check doctor's order for the irrigation.
2. Explain the procedure to the patient and encourage him to watch the procedure closely and assist if possible.
3. Screen patient to provide privacy.
4. Gather the equipment and take them to the bedside of the patient.
5. Wash hands, wear apron and glove
6. Place the patient in low flower position and expose abdomen.
7. Remove the dressing from the colostomv and place in a bucket.
8. Place a towel over the edge of the bedpan and place the patient's side to catch return flow.
9. Expel air from the rectal tube and lubricate the tip of the tube.
10. Insert the tube gently into the colostomy opening. If the opening is not seen, consult the Nurse in Charge.
11. Insert the tube about 4-5cm and start fluid to flow, gently ease the tube in (about 15cm). Do not force the tube.
12. Hold the irrigator Can about 50cm above the level of the colostomy opening.
13. Allow the fluid to run in. If there is any cramping, stop the flow temporarily and then

resume later.

14. Remove the rectal tube.
15. Allow approximately 30minutes for evacuation.
16. Cleanse the area around the colostomy with mild soap and water and replace dressing or bag if used.
17. Make the patient comfortable.
18. Remove the equipment. Wash thoroughly and return to their place, record procedure.

CARE OF COLOSTOMY

PURPOSE:

1. To teach the patient to give herself a colostomy care.
2. To remove faecal drainage from the colostomy area.
3. To prevent excoriation of the patient skin.
4. To promote comfort for the patient.

EQUIPMENT/REQUIREMENT:

TOP SHELF:

1. Basin with warm water.
2. Clean flannel and towel.
3 Receiver to place at patient side.
4. Mackintosh.
5. Lint in a bowl.
6. Receiver with a drainage forceps.
7. Hand gloves and face mask.

BOTTOM SHELF:

1. Strapping.
2. Scissors.
3. Bucket for soiled dressing.

NOTE: Maintenance of a pleasant professional altitude and complete abstinence from showing signs of distaste to the patient are essential.

METHOD:

1. Explain the procedure to the patient and gather the equipment.
2. Screen the patient to provide privacy.
3. Place protective material (mackintosh and draw sheet) under patient side.
4. Arrange the equipment. Place curved basin at patient side.
5. Wear hand gloves and face mask.
6. Remove soiled dressing (or bag) with hands, cleansing as much faecal drainage from the skin as possible. Do not wipe roughly as this may cause bleeding, place the dressing in a bucket.
7. Place the flannel in water and rinse out slightly.
8. Hold the flannel above the stoma of the colostomy and Squeeze out excess water. Allow drainage to (low into the curve basin.
9. Wash the area around colostomy gently with soap and water.
10. If ointment or Vaseline is to be use, apply gently.
11. Use gauze. To form a cup-like dressing over the stoma and cover with larger pieces of lint.
12. Make the patient comfortable.
13. Remove the equipment and wash carefully. Return to their proper place.
14. Record the treatment.

ASSISTING IN ABDOMINAL PARACENTESIS

Definition: It is the draining of unwanted fluid from the abdominal cavity

PURPOSE:

To relieve ascitis.

EQUIPMENT/REQUIREMENT:

TOP SHELF:

1. Tray from the CSSD containing the following sterile articles:
2. Syringe (2ml and 5ml).
3. Needle-25gaugex 1 ½ .
4. Trocar and cannula with rubber tubing and clamp.
5. 4 gauze square, 1 Ox 10 cm.
6. Abdominal pad, as indicated.
7. Towel or drapes.
8. Needle holder, cutting needle and skin suture.
9. Galipot containing local anaesthetic (1% Xylocainc). (Anaesthetic may come separate in bottle to be withdrawn).
10. Culture tube/ specimen bottle
11. Sterile bowl containing cotton balls with savlon.
12. Suture scissors and dissecting forces.
13. A pack of sterile gloves.

BOTTOM SHELF:

1. A large container.
2. Mackintosh and cover.
3. A clean specimen container in case test for specific gravity is ordered.
4. Receiver for soiled articles.
5. Scissors and strapping Equipment for shaving (if necessary). .

PROCEDURE:

1. Explain procedure to the patient; check his pulse rate and record as baseline.
2. Shave the line of incision if necessary. Have the patient void just before the procedure is preformed.
3. Assemble the equipment in the treatment room and take them to the bed side.
4. Place the patient in position. The following position may he used.

a. Sitting in a chair or on the bed with feet and back well supported.

b. Fowler's position close to the edge of the bed.

5. Use top sheet to drape the patient.
6. Roll the patient's gown up to expose his abdomen and fasten it to the back. Place mackintosh and cover it over the patient's lap.
7. Place the basin for return flow in front of the patient.
8. Hold the specimen bottle under the end of the cannula as the trocar is removed, if a specimen is desired.
9. The doctor will attach the rubber tubing to the end of the eannula and direct the tubing into the basin for the return flow.
10. Watch the patient for changes in colour and pulse rate.
11. When the treatment is over, the cannula is removed and "a sterile dressing applied.
12. Make the patient comfortable in bed and leave the unit in order.
13. Measure the fluid and send the specimen to the lab.
14. Clear the equipment and return to CSSD.

CHART:

1. Treatment.
2. Amount.
3. By whom the procedure was performed.
4. Patient reaction.
5. Signature.

NOTE: Occasionally, instead of a tray, the doctor will simply insert a large gauge needle and allow fluid to drip out slowly.

ENEMAS

Definition. It is an introduction of fluid into the lower bowels, through the anus.

PURPOSE:

a. To remove faeces from the colon and rectum.

b. To relieve abdominal distension.

c. To apply local treatment.

d. To introduce fluid or drugs into the body.

TYPES OF ENEMAS

A. Cleansing enema:

1. Given to relieve constipation and remove faeces from the rectum.
   Solutions commonly used.

a. Tap water 1-2 liters for adult: approximately 45mls per year of age for children.

b. Soap solution-Use soft soap (pieces about the size for palm mil in one liter of water) (Amounts of water the same).

c. Temperature of solution should be 38-40^{o}c

B. Oil Retention enema:

1. Given to soften faeces so that it may *be* expelled.
   Solution commonly used

a) Minerals oil, cod liver oil, olive oil 120mls

b) Glycerine 4-8mIs for adult: in children dilute glycerine with equal amount of water to prevent diarrhea.

c) Temperature of solutions should be approximately 38-40^{oc}.

d) All solutions be retained for at least 30 minutes.

C. Carminative enema:

1. Given to aid expulsion of flatus.
   Solutions to be use.

a. Turpentine 60-120mls in mixture of 60-120mls of olive oil and 50mls of soap solution.
b. Oxbite 8-16mls in 250mls solution.

D. Emollient enema:

1. Given to soothe irritated mucous membrane.
2. Mix 1 teaspoon of powder starch with cold water to make paste.
3. Add sufficient boiling water to make fluid that is enough to run through enema tube. Let it cool to 38-40°c.

b. 180ml of solution is given to be retained.

Stimulant:

1. Given to supply stimulant in drug over dosage.
2. Black coffee solution of 2 teaspoonful of pure coffee in 300mls of boiling water, let it for 5 minute and filter.
3. Give 150ml at a temperature of 30°c retained.

Nutritive enema:

1. To supply food when it cannot be taken by mouth.
2. Solution commonly used for are normal saline, 5% glucose, milk, formula, buttermilk or yoghurt.

EQUIPMENT/REQUIREMENT:

FOR CLEANSING ENEMA

TOP SHELF:

a. Lotion thermometer
b. Solution to be used
c. Enema
d. Rubber rubbing with mental stopcock

3. Glass connecting tube.
4. Receiver containing lubricant and tissue paper.
5. Hand Glove.
6. Receiver containing rectal tube.

BOTTOM SHELF:

1. Mackintosh and cover.
2. Bedpan with cover.
3. Tissue paper.
4. Receiver for waste.

PROCEDURE:

a. I n treatment room.

2. Assemble the equipment. Be sure that stopcock is closed.
3. Prepare the solution and check for proper temperature of 38-40°c
4. Pour the solution into enema can.
5. Lubricate the rectal tube.
6. Open stopcock and allow a small amount of solution to run through the tube in order to expel air. Then close stopcock again.
7. Explain the procedure to the patient.
8. Take the equipment to the patient bed side screen the bed.
9. Loosen the top sheet and use it to drape the patient.
10. Wear hand gloves.
11. Turn the patient into left lateral position and expose the buttocks place mackintosh and cover under the buttocks.
12. Separate the bullocks and gently insert the tube into the rectum about 8-10cm.
13. Hold irrigating Can about I meter above the hip.
14. Open stopcock and allow the solution to flow in slowly.
15. Instruct the patient to notify the nurse of any discomfort. When this occurs stop the

flow of water temporary and have the patient take a few deep breaths.

16. When the solution is almost finished or when the patient cannot take any more, close the stopcock.
17. Withdraw the rectal tube gently, cover the end with tissue paper and place the rectal tube in the receiver.
18. Place the patient on the bedpan and raise head of bed or support the patient with pillows. Put tissue paper within reach. Make sure that the patient is comfortable before leaving the bed side. Do not leave if the patient is weaker
19. Remove the trolley to the treatment room and clean the equipment with soap and water. Run water through the tubing. Boil the rectal tube for 5 minutes.
20. When the patient is ready remove the bedpan and allow the patient to wash his hand.
21. Remove the mackintosh and cover.
22. Leave the patient clean and comfortable.
23. Observe the enema return. If necessary, save for inspection otherwise dispose it in the toilet.

CHART

1. Time.
2. Treatment result obtained (include consistency, colour, amount of faeces and presence of abnormal constituents, return flow, amount of flatus passed, etc).
3. Patient's reaction if any.
4. Signature.

NOTE:

1. Never give an enema without a doctor's order.
2. For rectal or intestinal surgery or examinations of lower gastrointestinal tract, "enemas until clean" may be ordered. This means that a series of cleansing enemas is given until the rectum is clear. The patient should not become exhausted, (rectal lavage)

CHEST PROCEDURES

CARE OF PATIENT W1TH TRACHEOSTOMY

Definition: Tracheotomy is an artificial opening made into the trachea.

PURPOSE:

1. To prevent or relieve hypoxia due to accumulation of secretion in the trachco-brachial tree in patient suffering from wide variety of disorders.
2. To maintain an adequate airway through which the patient can breathe easily and comfortably.

The purpose is achieved by applying the following principles

Moisture's: To prevent the formation of encrustation of trachea.

Cleanliness: To limit the introduction of infection.

Deep suction: To remove secretion from the respiratory Passage.

EQUIPMENT/REQUIREMENT:

a) Suction machine.
b) Bottle of plain water for suctioning through tube.
c) Y-tube.
d) Two sterile suction catheters: one for nose and mouth: the other for trachcostomy.
e) A plastic catheter container to be filled with Hibitane solution and attached to the side of the suction machine.
f) Tray from the CSSD containing:
1. Two covered basins.
2. Towel.
3. Linen.
4. Brush or pipe stems cleaners.
5. One clamp catheter.
g) Receiver for soiled articles.
h) A humidifier, if ordered.
i) A bell for patient to ring for the nurse.
j) Hydrogen peroxide.

k) Normal Saline Solution.

l) Hibitane solution.

m) Hand glove

PREPARATION FOR A PATIENT TO RETURN FROM THE OPERATION ROOM.

a. Obtain the suction machine. Y tube and plastic catheter holder from the central supply.
b. Move the patient's bed to place close to the nurse's desk. Test suction to see if the plug and suction are working proper.
c. Obtain the other solutions and place on the bedside table.
d. Order for two catheters from the CSSD (one for nose and mouth: the other for trachcostomy). The size depends on the size of the patient's tracheal tube.
e. Order tracheotomy care tray from the CSSD.
f. Attach a plastic catheter container to the suction. Fill with Hibitane solution and label clearly which is to be use FOR tracheotomy and which is to be use for nose and mouth. Never substitute one for another.

CARE OF PATIENT WITH TRACHEOSTOMY

Each morning the nurse should return tracheostomy care tray and obtain a new one from CSSD. The plastic catheter Container should be washed and new Hibitane solution added. IF the patient requires frequent suction of the mouth and nose, this catheter should also be changed daily.

PROCEDURE:

A. Suctioning the cannula

1. Wash your hands.
2. Wear gloves
3. Give sufficient explanation to the patient to help allay his fear.
4. Readjust the patient position as indicated.

5. Attach the catheter and turn on the suction, Dip the catheter into the bottle of water to rinse off Hibitance and to test suction.
6. Insert the catheter into the cannula leaving the y- tube valve open.
7. Direct the tube into right or left bronchus by having the patient turn the head to the opposite side.
8. Start suctioning putting your finger over y-tube valve.
9. If any sign that the mucous membrane has been suctioned into the tube remove the finger immediately from y- tube valve.
10. Rotate the tube slowly as it is withdrawn and do not pinch the tube valve while suctioning.
11. Suction should not exceed 15 seconds, the patient should be allowed to rest after *3* minutes unless secretion area is so great that there is no choice.
12. Suction some water through tubing to clear it after suctioning.
13. 1f ordered or if the mucous secretion seem very dry 2ml of sterile normal saline should be injected into the trachea tube and immediately suctioned.

B. Cleaning the inner cannula

1. Suction the inner cannula before removing as in above.
2. Remove the inner cannula and place it in hydrogen peroxide solution.
3. Aspirate outer cannula.
4. Use pipe stem cleaners (or brush) to clean around the outside of the tube as indicated.
5. Use the stem cleaners (or brush) to clean inside of inner cannula.
6. Rinse the inner cannula in normal saline.
7. Aspirate the outer cannula again before reinserting the inner cannula.
8. Inspect, replace and fasten the inner cannula.
9. Check the tapes to be sure they are tightly secured.

NOTE: Points to remember in this phase of the procedure.

a) Use every opportunity to condition the patient to self care as early as possible.
b) Inspect the pipe stem cleaner or brush, before use.

c) Take care not to bend or dent the cannula thereby making reinsertion difficult.

C. Changing the gauze square:

1. Make one slit in the soft sterile gauze square.
2. Gently remove the soiled gauze square.
3. Place the fresh piece of cut gauze from below upward.

D. Changing moist gauze square (to Be done if Dr. Orders):

1. Damp sterile gauze square with sterile water or normal saline.
2. Fasten in place by a piece of tape and suspend over the open end of the tube.
3. Change when dry or soiled.

E. Changing soiled tape:

Insert fresh tapes when soiled. Prepare tapes before removing soiled ones. Have an assistant hold tracheostomy tube in place while inserting new tapes.

F. changing the complete tracheostomy tube:

This is ALWAYS DONE BY THE DOCTOR. Assist the doctor as necessary.

POINTS TO REMEMBER:

a) Constant attention is required until the patient is convalescent.

b) The inner tube is removed and cleaned as often as indicated; this may be every few minutes or every hour, depending on the condition of the patient. It should always be cleaned every 8 hour.

c) Avoid manipulation about the wound during suctioning or when inserting the inner tube, or applying clean gauze square, because this can cause violent coughing which could damage the tube. Such attacks always make it difficult to breath.

d) Any secretion from the mouth of the tube is wiped away quickly to prevent its aspiration in to the cannula.

e) Never remove the outer cannula.

f) Never use cotton applicators or linty materials in the patient's tube.

g) Never leave the tapes untied. The patient may cough it out.

h) Urge the patient not to cough forcefully but to indicate the need for suction.

i) When the patient is convalescent and has been taught to care for the tube, be sure his

signal bell is nearby. ANY SIGNAL FROM A TRACHEOSTOMY PATIENT SHOULD BE CONSIDERED A POTENTIAL EMERGENCY.

j) Gurgling or noisy respiration are indications for the need of suctioning and should be attended to immediately.

k) Obturator should be taped to the patient's chest or to the bed. It is the nurse's responsibility to ensure that the Obturator is not lost.

ASSISTING WITH THORACENTESIS

Definition: It is the withdrawal of fluid from the pleural cavity.

PURPOSE:

1. To remove fluid from the chest in order to relieve pressure.
2. To obtain specimen of the pleural fluid from the pleural cavity.

EQUIPMENT/REQUIREMENT:

TOP SHELF

1. A tray with two sterile towels, needles(21-23),dissecting forceps.
   Container , containing the Following articles:
   a) A bottle or ampoule of local anaesthetic (e.g. Xylocaine 1-2 %).
   b) Syringes (5 ml and 50 ml).
   c) 3 way stopcock.
   d) Rubber tubing with adaptor.
   e) Specimen container.
   f) 4 gauge sponges 4x4.
   g) Towels or drapes if required.
   h) one bowl with 4 cotton balls in savlon solution.
   i) One hemostat.
2. A package containing sterile gloves.

BOTTOM SHELF

1. Mackintosh and cover.

2. Receiver for soiled articles.
3. Scissors and plaster in a receiver.
4. *Jug to* catch aspirated fluid, if large amount.
5. Equipment for shaving if required.

PROCEDURE:

a. Explain the procedure to the patient.
b. Check and record vital signs.
c. Shave the area if necessary.
d. Wash your hands.
e. Obtain a tray from CSSD and assemble the other equipment.
f. Assist the patient into a sitting up position, with the back towards the physician.
g. Assist with the collection of specimen.
h. Adjust the patient's position as needed, for aspiration of fluid, support the patient as much as possible to minimize fatigue.
i. Observe and record any changes in TPR or skin colour.
j. When the procedure is finished, remove the drape and assist the parent into a comfortable position.
k. label the specimen.
I. Make the patient comfortable and leave the unit in good order.

AFTER CARE OF EQUIPMENT

1. Measure the fluid withdrawn and then dispose it.
2. Disinfect the articles that have been in contact with the fluid.
3. Wrap sponges and cotton balls and dispose them in a dustbin.
4. Wash and dry all equipment on the tray and return them to CSSD
5. Send specimen to the lab. if required.
6. Remove gloves and wash your hand.

PRECAUTION:

i. Carry out strict aseptic technique.

ii. After the procedure, observe the patient for syncope, pain. cough, or symptoms of shock.

iii. Always exercise caution in handling material which may be highly infectious.

iv. Watch the sputum for the presence of blood, which max suggest injury to the lung tissue.

CHART:

a. Time.

b. Treatment and who order

c. Amount, colour and type of fluid withdrawn.

d. Reaction of the patient (e.g. fainting. coughing, etc),

e. Collection of specimen and when it was sent to the laboratory.

LARYNGOSCOPE

This is the visualization of the larynx. Indirect method is by means of a mirror held in the pharynx while a light is directed unto the mirror. Direct method is when a hollow instrument is passed into the larynx after the throat has been anaesthetized.

CARE OF PATIENT WITH CHEST-TUBE (UNDER WATER SEAL DRAINAGE)

PURPOSE:

a. To maintain a closed drainage system to drain the pleural cavity.

b. To prevent pressure and possible collapse of the lungs.

EQUIPMENT / REQUIREMENT:

TOP SHELF

i. Drainage bottle, tubing and connector.

ii. Sterile mackintosh and towel.

iii. Measuring jug.

iv. Needle holder.

v. Trocar and cannular.

BOTTOM SHELF

i. Sterile water.

ii. Syringe and needles.

iii. Local anaesthetic.

iv. Sterile glove and strapping.

PROCEDURE:

1. While patient is in the theatre, get a bath bin and a draw sheet or towels to maintain the stability of the drainage bottle. Obtain a clamp large enough to clamp the chest tube
2. Prevent air from entering the thoracic cavity by checking the following:

- End of the tubing is kept under water at all the time.
- Sheet or towel is wrapped around the base of the bottle in the bath basin.
- All connection of tubing's are carefully taped so they will not come unconnected.
- A clamp for each tube is taped to head of the bed at all times. Instruct all personal and the patient that if any break in the system occurs the chest tube should be clamped close to chest.

3. Observe the patient and the potency of the drainage system frequently. Observe the vital signs, noting especially the rate and character of the respiration. Observe to see that the tube is draining. If tube is blocked, draining will not occur. If tubing appears blocked, milk the drainage tube from the patient toward the draining bottle. If drainage docs not resume, notify the doctor. Observe the colour and amount of the chest drainage. In order to know the amount strapping should be place lengthwise on the bottle. A line should be drawn designating the amount of sterile water which was added to the bottle. Every 24 hours a line should be drawn and the date and hour written on the strapping.
4. Encourage turning, coughing and deep breathing every hour. 1 f the patient does not

effectively cough, notify the doctor. Patient should turn on the back and unaffected side.

5. If the patient has to be transported to X ray or moved out of the bed for any reason, the chest tube should be handled carefully and always below the level of the patient.

6. If doctor orders the drainage bottle to be changed:

- Double clamp the tube close to the chest
- Obtain sterile bottle and sterile normal saline
- Assemble equipment maintaining sterile technique
- Measure the content of the old drainage bottle and subtract the amount of sterile water which was originally in the bottle from the total drainage. Record this amount as chest drainage in the chart.

i. Pillow and pillow ease.

PROCEDURE:

A. Obtain the equipment from the CSSD with change clip (bilateral traction, state on slip and also state how much weigh is needed).
B. Assemble the equipment.
C. Put the bed board under the mattress and put a bed block under the foot of the bed.
D. Shave from knee down on leg(s) to receive the traction.
E. Apply tincture of benzoic to lower leg
F. Take extension plaster and begin applying on medial aspect of the lower leg, just below the knee. Continue with the plaster to about 2 inches below the foot. Wrap the plaster around the distal end, making sure that the spreader is parallel to the foot. Continue to apply the plaster on the lateral side of the leg.
G. Take Elastoplasts and wrap it into circular motion around the leg. Be careful to apply plaster without wrinkles to avoid skin breakdown.
H. Put the rope through a hole in the spreader and tie a secure knot between the foot and the spreader.
I. Apply pulley to the end of the bed in a straight line with the affected leg. Put a rope over the pulley.

J. Tie a bowline knot and hang a weight pan.
K. Apply prescribed weight.
L. Put a pillow under the affected leg, with the heel touching the bed or pillow unless the purpose of the traction is to straighten the knee.
M. Return unused equipment to the CSSD immediately.
N. When the traction is discontinued, return weight, rope pulley, spreader, and weight pan to the CSSD.

NOTE: The above procedure is the application of Buck's extension skin traction. In order to apply Bryant's skin traction, the basic procedure for applying the plaster is the same, except that, it is always applied to both legs. There are pulleys over the head and extending over the bed. But tocks should be one inches from the bed.

APPLICATION OF SKELETAL TRACTION

EQUIPMENT/REQUIREMENT:

A. Bed frame (two end bars, one over-bed bar).

B. Trapeze.

c. Short bar to be attached to the frame at the end of the bed.

D. Three pulleys.

E. Thomas splint with pearon and dorsiflexion attachments.

F. Three rope lengths. Approximately eight feet and four feet long.

G. Two weight pans.

H. Prescribed weights.

1. Bandages.

J. Strapping and scissors.

K. Bed board.

L. Bed blocks. -

M. Hand gloves.

NOTE: The above equipment is needed for the application of traction to one pin in the lower extremity., Additional equipment would be needed for additional pins.

PROCEDURE:

A. Put the bed board on the bed and attach it over the bed frame.

B. Assemble and prepare the equipment. Prepare the Thomas splint and attachment in the following way:

C. Wear hand gloves.

1. The Thomas splint may be used for either leg. To determine proper positioning of the splint place the Long side of the splint on the lateral side of the leg.

2. Attach the person's attachment to the underneath portion of the
Thomas splint at a place about ;two inches above the knee joint.

3. Wrap the upper position of the Thomas splint loosely, with a bandage to form splint for the thigh.

4. .Wrap the pearon's, attachment loosely, with a. bandage to make a sling for the lower leg.
5. Wrap the dorsiflexion attachment tightly with bandage, to support the foot.
6. Assist with the actual application of the traction.
7. When the traction is discountinued, all equipment should be returned to the CSSD.

APPLICATION OF PLASTER OF PARIS (P.O.P)

PURPOSE: To immobilize the affected part.

EQUIPMENT/REQUIREMENT:

i. POP of difference Sizes (3,5,4,6,5 and 8,5)
ii. Sheet wadding and stockinette
iii. Deep bucket full of tap water.
iv Plaster knife or a blade parker with blade.
v. Plaster shears and scissors if window is to be cut immediately.
vi. Dressing scissors.
vii Application such as walking heel if needed. . .
viii Something to protect the floor or bed if the procedure is not done in the east room.

PROCEDURE:

A. Assemble the equipment for the doctor to apply cast.
B. Assist where necessary while the cast is being applied.
C. The following point should be remembered in assisting with the cast.
D. Place the patient in the most convenient position for applying the east.

2. When the plaster is being applied, unroll the bandage about six inches. Hold the ends with the palms of the hands against each side of the plaster roll and, without squeezing the roll, place it in a basin of water. Leave it until the bubbles cease to rise. Lift it carefully with both hands and compress it very gently.
3. Place next bandage in water and repeat the procedure as in number 2; continue until no more are needed. Do not place a bandage under water unless you are sure it is going to be used.

4. The person supporting the part while the cast is being applied must always hold it with the palms of both hands to avoid indentations in the wet plaster.
5. The person holding the part must be careful to hold the part in the exact position required.
6. When bandages are sufficiently thick and the plaster is set lightly, it is trimmed with a sharp knife and if necessary, a window is cut.

AFTER-CARE OF EQUIPMENT:

A. Discard waste and clean all equipment used.
B. Never throw the basin of water in which the plaster and bandages were moistened down the sink or toilet, since the plaster will harden and block the pipes. You most pour it out in an inconspicuous place outside.

POINTS TO REMEMBER:

A. In moving the patient, lift the wet plaster cast on pillows with the palms of the hands. Never allow the finger to touch it. Always give adequate support to the part to maintain proper alignment.
B. Carefully turn the patient 4 hourly to allow all sides of the plaster to dry.
C. Allow 24 hours for a large plaster before weight is applied to it.
D. Watch carefully for the following symptoms, which may indicate interference with blood or nerve supply. If observed, the doctor should be notified immediately:

1. Blueness or pallor of the extremities
2. Tingling or numbness of the extremities
3. Coldness or pain of the extremities
4. Lack of movement of fingers' or toes
5. Swelling at the extremities of the cast
6. Observe for evidence of bleeding on the cast, and if it occurs, encircle the area and record the time to ascertain the degree of bleeding,

F. Out patient who have had plaster applied should be given written instructions to return to the hospital at once if any of the symptoms mentioned above, appear.
G. Watch the plaster at the patient's fingers or toes.

INSTILLATION OF EAR DROP

Definition. It is the introduction of drug into the ear.

PURPOSE:

1 To soften hardened Carmen.
2. To relieve inflammation.
3. To anaesthetize the tympanic membrane.

EQUIPMENT/REQUIREMENT:

1. Medication as ordered.
2. Sterile medicine dropper in a sterile galipot with pipette.
3. Galipot of sterile swabs and another for soiled swabs.

DRUGS AND SOLUTIONS:

1. Soda bicarbonate and glycerin.
2. Sterile water.
3. Boric acid 5%.
4. Specific ear medication.

METHOD:

1. Explain the procedure to the patient.
2. Prepare the equipment.
3. Warm the medication by placing in bowl of warm water.
4. Position the patient's head so that the ear to be treated is on the upper side.
5. Remove external drainages or discharge with a cotton swabs.
6. Draw the solution or drug into the medicine dropper.
7. Instil the ordered number of drop into the external meatus. .
8. Straighten the ear canal by holding the pinna upward and back ward in an adult or a child pull downward and forward.
9. If treatment is given for hardened carmen drops may be ordered at specific intervals before the syringe is done.

10. Have the patient lie down during the period, syringing is to be done soon after the ear drops are instilled.
11. If both ears are to be treated, permit some minute before instilling drops into the second ear.
12. Wipe excess medication from the external ear with cotton swabs.
13. Make patient comfortable.
14. Keep medication and dropper in designated place.
15. Chart treatment. - .

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EAR SYRINGING

PURPOSE:

1. To apply heat to relieve pain.
2. To soften and remove impacted carman.
3. To promote drainage by cleaning external medullary canal of purulent material.
4. To remove foreign bodies from the external canal.

EQUIPMENT/REQUIREMENT:

1. Measuring jug.
2. Receiver for return flow.
3. Aural syringe (bulb syringe).
4. Galipot for cotton swabs.
5. Mackintosh cape and towel.
6. Receiver for used swabs.
7. *Ear* stressing forceps.
8. Auroscope or head mirror.
9. Lotion thermometer.
10. Angle poise lamp (good lighting).
11. Aural speculum.

SOLUTIONS TO BE USED (250ml FOR EACH EAR)

1. Boric acid 2% in normal saline or water.
2. Soda bicarbonate 2% in normal saline or water.

METHOD:

1. Explain the procedure to the patient.
2. Prepare the equipment.
3. Place the patient in a recumbent position. If the patient is a child, an assistant may be needed to immobilize the patient.
4. Place mackintosh cape and towel under the effected ear.
5. Fill the syringe, expel air and test temperature of solution by allowing a small amount to drop on the wrist.
6. Assist the nurse to hold the receiver for return flow of solution.
7. Expel a small amount of the solution over the external ear to acquaint the patient with the temperature of the solution.
8. Hold the pinna upward and backward to straighten the external canal in an adult. In a child, put it downward and forward.
9. Insert the tip of the syringe in the upper portion of meatus allowing space for return flow.
10. Keep the stream of solution continuous and keep it directed towards the anterior or posterior wall.
11. Repeat injections of the drainage after each insertion.
12. Dry the outer ear with cotton swabs and place the swabs in receiver.
13. Make the patient comfortable.
14. Remove the equipment from the room. Clean it properly and return it to its place.
15. Chart the procedure and results.

NOTE: This is a potentially dangerous procedure which should only be performed by an experience nurse.

1. Gentle Force should not be used in injecting the solution into the canal.

2. Foreign bodies of vegetable nature (e.g. beans) are removed with an instrument by a doctor, fluids cause them to swell up and make their removal difficult.
3. Be sure the patient does not have vertigo before he gets up to walk.
4. If the patient shows sign of fainting, the procedure should immediately be discontinued.

INSTILLATION OF NOSE DROPS

PURPOSE:

To shrink swollen mucous membrane of the nose and allow adequate Passage of air.

EQUIPMENT/REQUIREMENT:

a. Nose drops and dropper.
b. Medicine to be instilled.
c. Tissue paper.

PROCEDURE:

a. Explain the procedure to the patient
b. Position the patient.
i) The adult should lie on his back with his head extending over the edge of the bed.
ii) The child should have a pillow under his shoulder to position the head downward, or may be held on the nurse's lap with head downward.
c. The head should be turned slightly to the side into which the drop; are to be placed.
d. Drop the number of drops ordered into one or both nostril. After instillation ask the patient to sniff.
e. Have the patient maintain the position for several minutes.

NOTE: If nasal spray is used the patient sits in an upright position with the head tiled slightly backward. The patient inserts the nebuler into one nostril and close the opposite nostril by applying pressure with finger. The patient sniffs as he squeezed the nebulizer.

EYE PROCEDURES

INSTILLATION OF EYE DROPS

PURPOSE:

To instil drops in the eye in ordered to:

1. Dilate the pupil (mediate).
2. Contract the pupil (meiotic).
3. Produce local anaesthetic.
4. Relieve an inflammation.

EQUIPMENT/REQUIREMENT:

1. Medication as ordered.
2. Sterile medicine dropper in a sterile galipot, if necessary.
3. Galipot of cotton swabs.
4. Receiver for use swabs.

METHOD:

I. Explain the procedure to the patient.
2. Gather the equipment and take them to the bedside.
3. Position the patient in a dorsal recumbent position or in a sitting up position with the neck hyper-extended.
4. Read label on the medication carefully and draw the amount in medicine dropper.
5 Stand behind the patient or at the head of the bed and instruct him to look upward.
6. Use the right hand holding the dropper on the forehead and use the left hand to apply slight pressure on the lower lid. Do Not apply pressure on the eye ball.
7. Allow one drop to fall into the conjunctiva sac.
8. Instruct the patient to close eyelid slowly, allowing the medication to squeeze his eye tightly shut.
9. Wipe eyelashes with cotton swabs and apply gently pressure over the inner cantus area to prevent absorption by nasal mucous membrane of the medications given.
10. If an ointment is used, allow a thin of ointment to fall into the lower fornix,

instruction the patient to close the eyeball, instruct him not to squeeze his eye tightly shut.

11. Make the patient comfortable.
12. Return the equipment to their proper place.
13. Chart procedure.

IRRIGATION OF THE EYE

Definition. It is the introduction of sterile solutions into the eye by using undine.

PURPOSE:

To wash the eye with warm lotion in order to clean the eye and conjunctiva sac of:

1. Any foreign body.
2. Infection.
3. Any irritation.

EQUIPMENT/REQUIREMENT:

1. Receiver with undine irrigator.
2. Measuring jug with lotion at 3 7^{0c}
3. Receiver with 2 galipots.
   One for cotton swabs.
   One for eye pad if order.
4. Receiver for soiled swab.
5. Receiver for washing.
6. Dropper bottle of ordered medication.
7. Mackintosh, towel and lotion thermometer.

METHOD:

1. Explain the procedure to the patient.
2. Gather the equipment and take them to the bedside.
3. Place the patient in dorsal recumbent position with the towel and mackintosh placed

on the effected side.

4. Turn the patient's head slightly to the side of the effected eye and place receiver in position to receive the return flow.
5. Wipe the lids with a cotton swabs, using each swabs only once and wiping in a direction from the inner cantus towards the lateral side.
6. Open the patient's eye by applying gentle pressure and holding the lids open.
7. Pour lotion from undine irrigator into inner aspect of the eye.
8. Instruct the patient to move his eye up and down so that all area is irrigated.
9. Dry eye lids and face with cotton swabs and discard.
10. Make the patient comfortable.
11. Clean the equipment properly and return them to their proper place.
12. Chart procedure and results.

HEAT APPLICATION TO THE EYE

PURPOSE:

1. To apply moist heat and thereby relieve pain and congestion in the eye.
2. To increase blood supply to the eye.
3. To hasten the absorption of drugs.

EQUIPMENT / REQUIREMENT:

1. Bowl with hot water.
2. Galipot with swabs.
3. Padded wooden spoon.
4. Receiver for soiled swabs.
5. Mackintosh cape and towel.

METHOD:

1. Explain the procedure to the patient.
2. Prepare equipment and take the tray to the bedside.

3. Place cape and towel around the neck.
4. Place the patient in a sitting position if possible.
5. Place bowl of water and padded spoon in front of him on a cardiac table.
6. Squeeze excess water from the pad by pressing against the side of the bowl and them hold the padded spoon near his closed eye and allow the steam to circulate over the eye.
7. Dip spoon in water and repeat at frequent intervals.
8. Swabs the eye by wiping from inner cantus outward using each swab only once.
9. Dry by using a cotton swab.
10. Make the patient comfortable.
11. Clean equipment properly and return to their proper place.
12. Chart the procedure.

NOTE: This procedure can be done by able patient with the nurse's supervision

VAGINAL PROCEDURES

VAGINAL DOUCHE

PURPOSE:

I. To cleanse the vaginal canal and combat infection.

2. To overcome irritation, and bleeding.

EQUIPMENT/REQUIREMENT:

TOP SHELF: All equipments are sterile but the clean technique is used.

- A large bowl containing douche can and tubing, douche nozzle, glass connector and clip.
- Bowl of dettol 1:80 for swabbing.
- Bowl of wool swabs, vulva pad and towel.
- A measure jug with a solution at 40^{0c}.
- A receiver with 2 pairs of sponge holding forceps.
- Hand Glove.

BOTTOM SHELF:

- A small tray with dettol measure. T-bandage.
- Bed pan with cover.
- Receiver for soiled swab.
- Treatment mackintosh and towel.
- Receiver for soiled instrument.

BESIDE THE TROLLEY:

Bucket for soiled pad, mackintosh and towel.

METHOD:

1. Explain the procedure to the patient screen her to provide Privacy.
2. Fold the top linens back to the thighs.
3. Place mackintosh towel and bed pan under the buttocks.
4. Ask the patient to flex her legs and abduct thighs.

5. Wash your hand and put on glove. Pour the lotion into the douche can. Allow a small amount of lotion to run through the tubing and clamp the tube.
6. Swaps the vulva as outlined under vulva swabbing.
7. Separate labias with the finger of the left hand.
8. Check the vaginal glass nozzle tip, for any crack and insert into the vagina for about 7-8 cm in an upward and backward position.
9. Open the clip and hold the can about 30 cm above the vagina, allow the fluid to run into the vagina rotate the nozzle very gently 2-3 times so that all part of the cavity and the external surface of the cervix will be reached by the solution.
10. Remove the nozzle clip from the vagina when the fluid is finish.
11. Place the patient is a sitting up position on the bedpan and ask her to cough so as to allow all the fluids to drain out.
12. Dry the vulva area and remove the bedpan.
13. Turn the patient to her side and dry the perineal area.
14. Place a pad over vulva area and remove the towel and mackintosh.
15. Make the patient comfortable.
16. Wash the equipment and return to their place.
17. Record the treatment.

VULVA SWABBING

PURPOSE:

1. To cleans the vulva of secretion and organism without contamination
2. For patient with indwelling catheter
3. As post operative, post-partum treatment or care for every ill patients.
4. Before catheterization and vaginal douching
5. For patient with profuse vaginal discharge.
6. Before vaginal examination
7. To provide comfort

EQUIPMENT/REQUIREMENT

TOP SHELF

Pack from CSSD containing:

1 . A large bowl containing wool swab and pad if necessary.

2. Kidney dish with 3 pairs of sponge holding forceps.

3. A small bowl for cleansing lotion e.g. (savlon 1:200. temperature 38^{OC})

4. Lotion thermometer in antiseptic.

5. Sanitary pad if necessary.

BOTTOM SHELF

1. Covered destructor bowl

2. Covered kidney dish for used instruments

3. Bedpan

4. Gloves

PROCEDURE:

I. Explain the procedure to the patient

2. Wash hand, wear mask, clean and set trolley.

3. Take the trolley to the bed side.

4. Provide privacy

5. Open pack flap

6. Put patient in a dorsal position with one or two pillows under the head. Turn down the bed clothes to the thighs leaving patient's chest covered with a flannel blanket. Set patient on the bed pan.

7. Wash and dry hands wear gloves; open out pack and position bowls, put three swabs into a small bowl using pair of forceps.

8. Rest forceps in the bowl and pour a little hibitane over the bowl swabs.

9. Test the temperature (37^{oc}) and remove the jug from the bowl of water.

10. Pour a little amount of savlon on the patient thigh over the bed pan to test the temperature again.

11. With a pair of forceps, discard the pad (if any) discard forceps.
12. With another pair of sponge holding forceps and using one swabs once swab down the vestibule, labia minora (using one swab for each labium also), discard the forceps.
13. Pour the remaining savlon from the jug over the vulva.
14 Use another pair of forceps dry the vulva, groin and perineum and rest forceps
15. Remove bed pad
16. Turn the patient to the left side and dry the buttocks.
I7. Apply pad (if necessary)
I8. Change pad PRN
19. Make patient comfortable
20. Remove the screen, and return the equipment to their proper place.
21. Remove golves.
22. Wash hands and record treatment and any abnormality.

INSERTION OF RUBBER RING (PESSERINES)

PURPOSE:

To give temporary support to a prolapsed or connect a displace uterus.

EQUIPMENT/REQUIREMENT:

1. Bowl of 2 sterile towel or perineal sheet.
2. Bowl of swabs.
3. Receiver containing different pesserines.
4. Vaginal speculum.
5. A pair of sterile gloves.
6. A galipot with sterile lubricant.

METHOD:

As for vaginal swabbing.

RESUSCITATION OF THE NEWBORN

PURPOSE:

1. To help baby establish respiration
2. To bring newborn baby back to life
3. To clear baby's airways of any secretions
4. To establish circulation of blood to vital organs
5. To treat hypoxia

EQUIPMENT/REQUIREMENT:

Sterile procedure

on a trolley by the bedside

1. Neonatal bag, face mask of various sizes
2. Emergency drug tray

10% dextrose, normal saline 0.9%

Sodium bicarbonate 4.2%

Naloxone hydrochloride 1ml ampoules

Adrenaline injection 1:10,000 and 1:1000

Injection hydrocortisone l00mg

Endotracheal tubes sizes 2.0,2.5,3.0 and 3.5mm and connectors

Baby laryngoscope and its blade

Stethoscope, cord clamp

Warm dry towels

Soluset or pediatric administration set ,

Injection Vitamin K

Assorted syringes- 2mls, 5mls, 10mls & 20mls

Hypodermic needles

Adhesive plaster Scissors

Suction machine, catheters sizes 6,8, and 10 FG

Oxygen cylinder or concentrator

PROCEDURE:

Step I

- Call for help
- start the clock
- dry the baby, wrap in a fresh warm towel
- asses initially by listening with a stethoscope at the apex.

A. Airway:

- place the head in a neutral position to open the airway
- if the baby is floppy use the jaw thrust to bring the tongue forward and open the airway
- gently suction the oropharynx or nostrils only using a soft suction catheter

B. Breathing: if the baby does not respond to opening the airway do the following,

- place the mask (attached to the bag) firmly over the newborn's mouth, chin and nose to form seal between the mask and the newborn's face
- using bag and mask, give five inflation breath each lasting 2-3 seconds
- check the rise of the chest. The chest may not move during the first 1-3 inflation breath, which are needed to displaced fluid from the lungs.
- Check the seal and that the chest rises and falls with inflation breath after that.
- Re-asses the heart rate after the first five breath, and increasing heart rate or a heart rate maintained at more than l00beat/ minute is a sign of adequate ventilation. If the heart rate has not responded check for chest movement and for patent airway when attempting to deliver ventilation.
- Ventilation should be continued at 30-40 breaths/minute

C. Circulation: if there is no heart beat or the heart beat is less than 60 beat/minute even when the chest is being ventilated, give chest compressions

- Encircle the baby's chest with two hands so that the thumbs meet on the sternum below the line between the nipples
- Compress chest by one third of its depth-three time for each inflation breath
- Once the heart rate is above 60beat /minute and rising, chest compression should be discontinued.

D. Drugs: sodium bicarbonate 4.2%, Naloxone hydrochloride 1ml ampoules, Adrenaline

injection 1:10,000 and 1:1000,10% dextrose, normal saline 0.9%

Note: if the baby's breathing is normal 30-60 breaths/minute and there is no in drawing of the chest and no grunting:

- put in skin to skin contact with mother
- observe breathing at frequent intervals
- measure the temperature and re-warm if less than 36°c
- encourage mother to begin breast feeding keep baby under observation until stable for at least six hours
- if there is no gasping or breathing at all after 20minutes of ventilation, or gasping but no breathing after 30minutes of ventilation, stop ventilating:

DON'TS:

Slap, blow on, or pour cold water on the baby

Hold the baby upside down

Routinely suction the mouth of a well baby

Use heavy suctioning of the back of the throat of any baby

Give injection of respiratory stimulant or routine sodium bicarbonate injection

SELF BREAST EXAMINATION

PURPOSE:

The breast is examined to assess the following

i. Their suitability for breast feeding

ii. To exclude abnormalities e.g. breast abscess, mastitis, crack nipples and breast lumps.

iii. The size and shape

SITTING/STANDING OR LYING DOWN

Standing mirror with client sitting or standing up with breast exposed and arms by sides

PROCEDURE:

Wash and dry hands. Inspect the breast noting the following;

1. The size, shape, symmetry, scars, thickening of the skin, discharge, visible lumps, "peau d" orange" (skin looking like orange peel with little dimples).
2. Engorgement, redness, colour of nipples, the size and shape, the dimples of nipples and ulceration.
3. Dimpling and drawing in of the nipples by;

i. Lifting both arms over the head and check if both breasts rise equally

ii. Lean forward letting the breast hang loosely from the chest.

iii. Place hands on hips and press.

4. Position arm over the head and make imaginary line, divining the breast into four quadrant and go through the steps.

Step I

- Stand before the mirror
- Check both breasts for anything unusual
- Look for discharge from the nipples, puckering, dimpling or scaling of the skin.

Step II

- Watch in closely in the mirror as you clap your hand behind your head and press your hand forward.
- Note any change in the contour of your breast

Step III

- Next, press your hands firmly on your hips and bow slightly towards the mirror as you pull your shoulders and elbow forward. Some women will do the next part of the examination in the shower. Your fingers will glide easily over soapy skin. Concentrate on feeling for changes in the breast.

Step IV

- Raise your left arm
- Use the pad of three or four fingers of your right hand to feel your left breast firmly, carefully and thoroughly
- Beginning at the upper outer quadrant, press the pad part of your fingers in small circles, moving the circles clockwise slowly around the breast.
- Gradually work toward the nipple
- Be sure to cover the whole breast
- Pay special attention to the area between the breast and under arm, including the armpit itself
- Feel for any unusual lump or mass under the skin.

5. Gently squeeze the nipple and look for discharge
6. Repeat with the other breast
7. If lump is present, ask client if she is aware of it.
8. Ask her if the lump is increasing in size, and whether it hurts.
9. Teach the client to examine the breast every month 2-3 days after menstrual period and for menopausal, once in a month in a chosen day and to maintain that day for every check.
10. Report any abnormality.
11. Repeat step iv and v while lying down, and repeat procedure for the other breast.

GENERAL INFORMATION

Information on immunization:

A. The following will be considered standing order on admission and maybe given without written doctors orders.

1. BCG:

Every patient is given if under 5 years of age, before it is given, the mother should be asked if the child has had BCG. the clinic card should also be checked to see if he has had BCG, this may be administered at the same time with DPT but is not administered if the child has open sores.

2. **DPT AND TETANUS TOXIOD:**

Every patient to be given either DPT or Tetanus Toxoid. DPT is given to older children and adult. They should be given the 2"^{d} and 3^{ld} injection at one month intervals, while in the hospital or be given clinic appointment. Do not give DPT to children weighing less than 6-12 pounds or 3kg. DPT may be given at one or two month intervals.

3. **POLIO:**

Polio vaccine is to be given in a series of three doses one to two month apart. Polio vaccine is usually not given at the same time with measles vaccine as both of these are live viruses and can counteract each other they should be given at least one mouth apart. However in situations where child will not be available again it is permitted.

4. MEASLES:

Measles vaccine is to be given to children between the age of 6 mouth and 4 years. Do not give the vaccine if there is a definite history of the child having measles.

5 TETANUS FOR MOTHER OF BABIES ADMITTED WITH TETANUS:

Mother of babies admitted with tetanus should be issued a card and be given immunization as a part of the baby's admission. They should be given a clinic slip to come for 2nd and 3rd injections.

A. ADDITIONAL NOTE:

1. Stress to patient and families the important of getting all the series of immunization for the full protection.
2. Be sure to record the immunization given on clinic card as well as on medication record. Charge slips will be taken to the Paediatrics or OPD by whoever supplies the drugs.
3. An immunizations card is to be given to all newborn baby as well as small children who are beginning the immunization series. It is better to make sure that the mothers understand which immunizations have been given.
4. If a child is very ill, wait until the child is recovering but be sure his immunization are given before discharge.

SPECIFIC PROCEDURES:

TETANUS ANTITOXIN: (passive immunity to tetanus)

1. Before tetanus antitoxin is given a skin test must be done except in newborn infants. To do the skin test.

.a. Draw up 0. 1ml, tetanus antitoxin into a syringe.

b. Add sterile water to make 1ml, when mixed this become a 1:10 solution.

c. Give O.lml of this 1:10 solution intradermally.

d. Wait 20 -30 minute. If there is no local reaction such as enlarged raised wheal redness, or hest, give the order amount of tetanus antitoxin intramuscularly.

2. Dosage: Not usually less than 1500 IU for prophylactics. Not less than 5.000 IU IV or IM for treatment.

3. Adrenaline 0. 5 ml should be available to be given in case of anaphylactic shock. Given subcutaneously.

4. Another method for testing for sensitivity is to drop 1:1 0ml solution into the lower conjunctival sac. Strong conjunctival reddening would indicate allergy to the horse serum.

6 Tetanus antitoxin is stored in the refrigerator

BCG VACCINE :(Active Immunity To Tuberculosis)

a) Add water to the content of the ampoule and allow to standing for few minute. Do not shake it

b) Give the 0.05mls of vaccine intradermally. In a child it is given high on the left shoulder, it may cause an ulcer or bed scar for a long time. The forearm may also be used.

c) Tuberculin testing is usually done before administration of BCG Except in newborns. A positive tuberculin test will be contraindicated to be given BCG.

d) BCG is kept in the refrigerator. If it is not used within 24 hours after mixing it must be thrown away. The vaccine must be protected against Light

TRIPLE VACCINE OR DPT

(Active immunity to diphtheria, pertusis and tetanus)

a. 0.5ml is given intramuscularly
b. Site for injection are anterior and lateral thigh buttocks or upper arm
c. DPT must be stored in the refrigerator
d. inform the mother that the child may have slight fever for 1 -2days

- **TEATANUS TOXOID**

(Active immunity to tetanus)

a. 0.5ml is given IM
b. Tetanus toxoid is stored in the refrigerator
c. Inform the mother that there may be slight fever

- **POLIO OR SABINE ORAL VACCINE**

(Active immunity to poliomyelitis)

a. Place 3 drop of the liquid vaccine in to the person's mouth and make sure that he swallows it may be given on a sugar cube.
b. Polio vaccine is stored in a refrigerator.
c. Polio vaccine is contraindicated in a very ill person especially those with diarrhoea or vomiting.

d. Inform the mother that there may be slight fever for 1 -2days

- **MEASLES VACCANE:** (Active immunity of measles)

a) Add cold diluents to the vaccine to mix. Do not mix with warm water solution

b) Clean the skin and allow to dry before injecting the vaccine

c) Inject 0.5ml intramuscularly

d) Measles vaccine should be kept frozen until used and protected from light .After being mixed it must be used within 4 hours or discarded

e) Inform the mother that child may have fever and possibly a slight rash during the next 1 -2 weeks

- **SMALLPOX:** (Active immunity to small Pox).

a) Clean the skin with soap and water Allow to dry

b) Place a drop of vaccine unto the skin, usually the rights shoulder.

c) Use a sterile needle and place it flat on the skin the tip should be in the vaccine drop. Lift the needle up and down rapidly 30 -40 times so that the tip stays in the area of the vaccine and just makes the skin but does not draw blood

d) Do not apply dressing

e) Instruct the patient's mother to let the site dry not to wash the arm until the following day and to keep the children from scratching it. Explain to the mother that there may be slight fever for i -2days

f) vaccination is contraindicated in the presence of severe malnutrition or skin disorders such as eczema, scabies or boils

CHOLERA: (active immunity to Cholera)

a) Cholera vaccine is given in 2 dose 1 month apart dosage varies with age:

b) under 5 years - 0.1ml and 0.3ml

c) 5-10 years 0.3ml and then 0.5ml

d) over 10 years 0.5ml and then 1 ml

Cholera vaccine is only effective for 6 month so boosters are necessary every 6months. Booster dosages are the same as the first dosage in the series. The vaccine should be kept in the refrigerator

APPENDIX ONE
THE NURSING PROCESS

This is the systematic, scientific, and individual process that professional nurse adopt for caring for patient: It is systematic because it follows certain logical and overlapping steps it is scientific because nurse have to rely heavily on their knowledge of the life science such as physiology and pharmacology to account for their nursing action and it is individual because it is based on the premise that every patient has to be treated as a unique individual taking into consideration his or her specific physical, social, psychological and spiritual problems.

Another unique feature of the nursing process is its flexibility. This means that it is dynamic enough to be muffled to suit any patient (and patient relative) involvement in the plan of his own care thus it ensure consistent and continues quality nursing care it also provide the basis for professional accountability. The nursing process is made up of six steps namely:

Assessment
Nursing Diagnosis
Patient out come
Planning
Implementation
Evaluation

ASSESSMENT

Assessment means collection, organization, validating and documenting data about patient health status. Assessment is carried out in a systematic way it focuses on the patient response to illness rather than to the pathology of the illness itself. There are four type of assessment namely;-

- Initial Assessment is the comprehensive assessment of the patient when he or she is. first admitted.
- Problem focused Assessment: is the assessment done with a view to discovering specific problems.
- Emergency Assessment is carried out when an unexpected or acute problem occurs while the patient is on scheduled nursing care.

- Time lapsed Assessment is a schedules assessment carried out after a specified time interval.

Assessment deals with data. Data is any information collected from or about the patient. There are two types of data; subjective data;

- subjective data is any information that the patient or his family provide.
- objective data is any information that is obtained by observation or physical examination. Sources of data include the patient (primary sources). Significant others: friends, relatives, family, etc. Records (medical, laboratory), previous professional magazines, journals and textbooks (secondary sources)

Methods of data collecting are observation (gathering data by using all the senses), interview (a structure question and answer communication or conversation with a view to finding out the patient's health problems), and examination (a systematic method of assessment that relies on sight, body from, hearing, smell, and touch.) it utilizes inspection of the body (examining the patient's body from head to toe), palpitation (digital inspection of body cavities, especially the abdominal cavity),percussion (tapping with the fingers on the thoracic or abdominal cavity),and auscultation (the used of stethoscope to hear sound pattern in the interpretation. It is this raw data that is later analyzed to arrive at the patient's nursing diagnoses.

NURSING DIAGNOSIS

Nursing diagnosis is defined by NANDA as the statement of the patient potential or actual health problem that the nurse. Licensed to treat, it implies the discovery of the patient health problems after assessment. In other words it is the interpretation of the nurse assessment of the patient. Nursing diagnosis differs from medical diagnosis for example where as nursing diagnosis is response-oriented medical diagnosis disease oriented is. Secondary medical diagnosis revolves around pathology, but nursing diagnosis revolves around the individual, thirdly nursing diagnosis is dynamic but medical diagnosis is static. Again medical diagnosis guides medical management, but nursing diagnosis guides nursing activities There are three types of nursing diagnosis. Actual, risk and wellness nursing diagnosis ,

Actual nursing diagnosis means real health problem the patient is suffering from now. Risk nursing diagnosis refer to the health problem the patient is likely to suffer in the near future, while wellness make patient to remain healthy.

Nursing diagnosis has components:

1. The problem, or the basic diagnosis
2. The etiologic or the cause of the problem (the related to factor)
3.The defining characteristics, or the evidence that supports the diagnosis choice (as evidenced by.)

In making a diagnosis the nurse has to follow certain guidelines. For example the nurse must use NANDA (North America Nurse Diagnosis Association) term or name for the diagnosis. In addition, she must make sure that the diagnosis and the related to or aetiology did not say the same things. For instance, it is wrong to say: altered sleeping pattern related to insomnia[1] because here, insomnia is supposed to be the altered sleeping pattern for the same reason, it will be wrong to say; alteration in the body comfort related to pain, thirdly, medical diagnosis should not be used in place of aetiology, Thus its wrong to say; hyperthermia related to malaria, because malaria is a medical diagnosis, fourthly, avoid wordiness be concise, fifthly, prioritize attend to must basic diagnosis first, and attend to the order next.

PATIENT OUTCOME

A patient outcome statement provides a description of the specific, measurable behaviour (outcome critical) that the patient will be able to perform rather than what the nurse will do. The nurse predict the condition of the patient following nursing interventions. This prediction is expressed in a statement which may be referred to as patient outcome. A patient statement about the purpose for which an effort is directed. For example, the nurse might want to "prevent constipation or promote activity" and thus carrying out activities to accomplish these goals. However, this type of goal statement does not describe the desired behaviours that a patient is expected to demonstrate following nursing intervention. A goal statement indicating what the nurse should do is considered in correct. Patient-centred goals or desired patient outcomes are written as follows:

- Patient temperature will reduce by 1oc.
- Patient will ambulate 100 feet by the second day following surgery.
  A well written patient outcome does the following:
- Uses the ward patient/client as the subject of the statement
- Uses a measurable verb
- Is specific for the patient and the patient's problem" is realistic for the patient and patient's problem
- Includes a time frame for patient re-evaluation
- A time frame is written into the patient-centred goal/desired patient outcome to provide a decline for evaluation of the patient's progress.

PLANNING

This is series of steps taken by the nurse and the patients set priorities and goals to eliminate or diminish the identify problems. The goals (or objective) are stated as specific expected out come. In planning the nurse and patient collaborate and choose the most appropriate intervention for each nursing diagnosis. Planning is a continuous process and it result in the actual nursing care plan tailored for individual patient. When planning, the nurse has to consider such factors as the patient socioeconomic status, his physiological and spiritual state and of course his physical status.

Additionally, time and the resources are important consideration in setting behavioural objective or goals. These goals may therefore be short term or long term, depending on the nature of the problem. They must be very specific patient-centered, realistic and measurable, in setting a goals, you have to mentioned the subject (the named of the patient you are planning for) you also have to make a statement for the expected out come by using an action verb that denoted for what the patient will do, learn or experience and then state the time frame within which the goal should be achieved.

IMPLEMENTATION

This refers to the action the nurse takes to achieve stated goals. Implementation must be safe

and appropriate for the patient. It must also be realistic, achievable, and congruent with the patient values and beliefs. Similarity, it must be based on the nursing knowledge and within the established standard of care. Implementation is classified as dependant, independent and collaborative.

Independent actions initiated by the nurse, based on her professional knowledge. Dependent actions are initiated by the physician who order or prescribe specific actions such as administration of drugs. Collaborative actions are carried out by the nurse, in collaborative actions with order health care providers. In writing implementation, the nurse must use action verbs. The action to be performed must be specific and the frequency of their performance specified, they should also be tailored to meet patient needs and preferences.

EVALUATION

This is way of finding out whether the intervention carried out by the nurse has been successful in solving the patient's problem or not. In other words, are the objectives set by the nurse been achieved? If they have not been achieved, then the nurse has to reassess the patient and start the process all over. Evaluation is done by examining the goal and expected outcome, collecting data concerning client achievement, comparing the outcome and client data and drawing conclusion on whether the goals have been met or unmet.

NANDA Nursing Diagnosis List for 2015-2017

Nanda Nursing Diagnosis list - Domain 1: health Promotion

Class 1. Health awareness

- Deficient diversional activity
- Sedentary lifestyle

Class 2. Health management

- Frail elderly syndrome
- Risk for frail elderly syndrome
- Deficient community
- Risk-prone health behavior
- Ineffective health maintenance
- Ineffective health management
- Readiness for enhanced health management
- Ineffective family health management
- Noncompliance
- Ineffective protection

Nanda Nursing Diagnosis list - Domain 2: nutrition

Class 1. Ingestion

- Insufficient breast milk
- Ineffective breastfeeding
- Interrupted breastfeeding
- Readiness for enhanced breastfeeding
- Ineffective infant feeding pattern
- Imbalanced nutrition: less than body requirements
- Readiness for enhanced nutrition
- Obesity
- Overweight
- Risk for overweight

- Impaired swallowing

Class 2. Digestion

None at present time

Class 3. Absorption

None at present time

Class 4. Metabolism

- Risk for unstable blood glucose level
- Neonatal jaundice
- Risk for neonatal jaundice
- Risk for impaired liver function

Class 5. Hydration

- Risk for electrolyte imbalance
- Readiness for enhanced fluid balance
- Deficient fluid volume
- Risk for deficient fluid volume
- Excess fluid volume
- Risk for imbalanced fluid volume

Nanda Nursing Diagnosis list - Domain 3: elimination and exchange

Class 1. Urinary function

- Impaired urinary elimination
- Readiness for enhanced urinary elimination
- Functional urinary incontinence
- Overflow urinary incontinence
- Reflex urinary incontinence
- Stress urinary incontinence
- Urge urinary incontinence
- Risk for urge urinary incontinence
- Urinary retention

Class 2. Gastrointestinal function

- Constipation
- Risk for constipation
- Chronic functional constipation
- Risk for chronic functional constipation
- Perceived constipation
- Diarrhea

- Dysfunctional gastrointestinal motility
- Risk for dysfunctional gastrointestinal motility
- Bowel incontinence

Class 3. Integumentary function

None at this time

Class 4. Respiratory function

- Impaired gas exchange

Nanda Nursing Diagnosis list - Domain 4: activity/rest
Class 1. Sleep/rest

- Insomnia
- Sleep deprivation
- Readiness for enhanced sleep
- Disturbed sleep pattern

Class 2. Activity/exercise

- Risk for disuse syndrome
- Impaired bed mobility
- Impaired physical mobility
- Impaired wheelchair mobility
- Impaired sitting
- Impaired standing
- Impaired transfer ability
- Impaired walking

Class 3. Energy balance

- Fatigue
- Wandering

Class 4. Cardiovascular/pulmonary responses

- Activity intolerance
- Risk for activity intolerance
- Ineffective breathing pattern
- Decreased cardiac output
- Risk for decreased cardiac output
- Risk for impaired cardiovascular function
- Risk for ineffective gastrointestinal perfusion
- Risk for ineffective renal perfusion

- Impaired spontaneous ventilation
- Risk for decreased cardiac tissue perfusion
- Risk for ineffective cerebral tissue perfusion
- Ineffective peripheral tissue perfusion
- Risk for ineffective peripheral tissue perfusion .
- Dysfunctional ventilatory weaning response

Class 5. Self-care

- Impaired home maintenance
- Bathing self-care deficit
- Dressing self-care deficit
- Feeding self-care deficit
- Toileting self-care deficit
- Readiness for enhanced self-care
- Self-neglect

Nanda Nursing Diagnosis list - Domain 5: Perception/Cognition
Class 1. Attention

- Unilateral neglect

Class 2. Orientation

None at this time

Class 3. Sensation/perception

None at this time

Class 4. Cognition

- Acute confusion
- Risk for acute confusion
- Chronic confusion
- Labile emotional control
- Ineffective impulse control
- Deficient knowledge
- Readiness for enhanced knowledge
- Impaired memory

Class 5. Communication

- Readiness for enhanced communication
- Impaired verbal communication

Nanda Nursing Diagnosis List-Domain 6: self-Perception

Class 1. Self-concept

- Readiness for enhanced hope
- Hopelessness
- Risk for compromised human dignity
- Disturbed personal identity
- Risk for disturbed personal identity
- Readiness for enhanced self-concept

Class 2. Self-esteem

- Chronic low self-esteem
- Risk for chronic low self-esteem
- Situational low self-esteem
- Risk for situational lo\V self-esteem

Class 3. Body image

- Disturbed body image

Nanda Nursing Diagnosis list - Domain 7: role relationships

Class 1. Care giving roles

- Care giver role strain
- Risk for care giver role strain
- Impaired parenting
- Readiness for enhanced parenting
- Risk for impaired parenting

Class 2. Family relationships

- Risk for impaired attachment
- Dysfunctional family processes
- Interrupted family processes
- Readiness for enhanced family processes

Class 3. Role performance

- Ineffective relationship
- Readiness for enhanced relationship

- Risk for ineffective relationship
- Parental role conflict
- Ineffective role performance
- Impaired social interaction

Nanda Nursing Diagnosis list - Domain 8: sexuality

Class 1. Sexual identity

None at present time

Class 2. Sexual function

- Sexual dysfunction
- Ineffective sexuality pattern

Class 3. Reproduction

- Ineffective childbearing process
- Readiness for enhanced childbearing process
- Risk for ineffective childbearing process
- Risk for disturbed maternal-fetal dyad

Nanda Nursing Diagnosis list - Domain 9: Coping/stress tolerance

Class 1. Post-trauma responses Post-trauma syndrome

- Risk for post-trauma syndrome
- Rape-trauma syndrome
- Relocation stress syndrome
- Risk for relocation stress syndrome

Class 2. Coping responses

- Ineffective activity planning
- Risk for ineffective activity planning
- Anxiety (Read more: Nursing Care Plan For Anxiety)
- Defensive coping
- Ineffective coping

- Readiness for enhanced coping
- Ineffective community coping
- Readiness for enhanced community coping
- Compromised family coping
- Disabled family coping
- Readiness for enhanced family coping
- Death anxiety
- Ineffective denial
- Fear
- Grieving
- Complicated grieving
- Risk for complicated grieving
- Impaired mood regulation
- Readiness for enhanced power
- Powerlessness
- Risk for powerlessness
- Impaired resilience
- Readiness for enhanced resilience
- Risk for impaired resilience
- Chronic sorrow
- Stress overload

Class 3. Neurobehavioral stress

- Decreased intracranial adaptive capacity
- Autonomic dysreflexia
- Risk for autonomic dysreflexia
- Disorganized infant behavior
- Readiness for enhanced organized infant behavior
- Risk for disorganized infant behavior

Nanda Nursing Diagnosis list - Domain 10: life Principles

Class 1. Values

None at this time

Class 2. Beliefs

- Readiness for enhanced spiritual well-being

Class 3. Value/belief/action congruence

- Readiness for enhanced decision-making

- Decisional conflict
- Impaired emancipated decision-making
- Readiness for enhanced emancipated
- Decision-making
- Risk for impaired emancipated decision-making
- Moral distress
- Impaired religiosity
- Readiness for enhanced religiosity
- Risk for impaired religiosity
- Spiritual distress
- Risk for spiritual distress

Nanda Nursing Diagnosis list-Domain 11: safety/Protection

Class 1. Infection

Risk for infection

Class 2. Physical injury

- Ineffective airway clearance Risk for aspiration
- Risk for bleeding (Read more: Nursing Care plan for Risk for Bleeding)
- Risk for dry eye
- Risk for falls Risk for injury
- Risk for corneal injury
- Risk for preoperative positioning injury
- Risk for thermal injury
- Risk for urinary tract injury
- Impaired detrition
- Impaired oral mucous membrane
- Risk for impaired oral mucous membrane
- Risk for peripheral neurovascular dysfunction
- Risk for pressure ulcer
- Risk for shock
- Impaired skin integrity
- Risk for impaired skin integrity
- Risk for sudden infant death syndrome
- Risk for suffocation Delayed surgical recovery
- Risk for delayed surgical recovery
- Impaired tissue integrity
- Risk for impaired tissue integrity

- Risk for trauma
- Risk for vascular trauma

Class 3. Violence
- Risk for other-directed violence
- Risk for self-directed violence
- Self-mutilation
- Risk for self-mutilation
- Risk for suicide

Class 4. Environmental hazards
- Contamination
- Risk for contamination
- Risk for poisoning

5. Defensive processes
- Risk for adverse reaction to iodinated contrast media
- Risk for allergy response
- Latex allergy response•
- Risk for latex allergy response

Class 6. Thermoregulation

- Risk for imbalanced body temperature
- Hyperthermia
- Hypothermia
- Risk for hypothermia
- Risk for preoperative hypothermia
- Ineffective thermoregulation

Nanda Nursing Diagnosis list- Domain 12: Comfort
Class 1. Physical comfort

- Impaired comfort
- Readiness for enhanced comfort
- Nausea
- Acute pain
- Chronic pain
- Labor pain
- Chronic pain syndrome

Class 2. Environmental comfort

- Impaired comfort
- Readiness for enhanced comfort

Class 3. Social comfort

- Impaired comfort
- Readiness for enhanced comfort
- Risk for loneliness
- Social isolation

Nanda Nursing Diagnosis list - Domain 13: growth/Development

Class 1. Growth

- Risk for disproportionate growth

Class 2. Development

- Risk for delayed development

APPENDIX TWO

It is important to use correct spellings and acceptable abbreviation in charting or recording. The use of abbreviations depends on the regulations of the hospital or agency.

THE FOLLOWING ARE SOME OF THE ABBREVIATION IN USE

The student is advised to refer to the nurse's dictionary for further information on these abbreviations

abd	-	Abdomen
AM	-	Morning
amb	-	Ambulatory, Walking
amt	-	Amount
approx	-	Approximately
ax	-	Axillary (Armpit)
BM	-	Bowel Movement
BP	-	Blood Pressure
C.	-	Celsius (centigrade)
c.	-	With
Ca	-	Cancer
CC	-	Cubic Centimeters
CD	-	Communicable Diseases
CCF	-	Congestive Cardiac Failure
CHF	-	Congestive Heart Failure
c/o	-	Complaining or complaints
CVA	-	Cerebro Vascular Accident
Dist	-	Distilled
ECG	-	Electrocardiogram
Exam	-	Examination
CSD	-	Central Sterilization Department
NPO	-	Nil per os
F	-	Fahrenheit
Gutt	-	Drops
NSS	-	Normal saline solution

APPENDIX THREE
NURSING ETHICS

Ethics is derived from the Greek word "ethics" which means customs or practice. Ethics is the science that deals with customs, habits and general value of people. Therefore, nursing ethics is the science that deals with nursing conducts and their relationship with the wider society.

ETHICAL CONCEPT: APPLIED TO NURSING

The fundamental responsibilities of the nurse are fourfold:

1. To promote health
2. To prevent illness
3. To restore health
4. To alleviated suffering

The need for nursing is universal. Inherent in nursing is respect for life, dignity and the rights of man. It is unrestricted by consideration of nationality, race, creed, colour, age, sex or social status. Nurses render health service to individuals, the family and community to co-ordinate their service with those of related groups.

QUALITIES OF A GOOD PROFESSIONAL NURSE

A good professional nurse must posses certain. Qualities she must be:

1. Reliable
2. Intelligent
3. Sympathetic
4. Sensible
5. Tolerant
6. Obedient
7. Morally Good
8 Economical
9. Adaptable
10. Smart

11. Faithful
12. Punctual
13. Truthful
14. Observant
15. Evaluation or Assessor
16. Guidian and Counsellor

CONDUCT:

Nurses should know the acceptable professional conducts in nursing so that they can adhere to them.

Be courteous in all aspect of your duty. Show respect to your senior. Respond to patient, relatives and co-worker politely. Be courteous in attending to visitors; give respect and consideration to them as if they were your personal guest. Provide information about patient only when it is absolutely necessary to do so. Do not leave your department for any reason without permission from your Charge Nurse. Report before and after duty.

UNIFORM:

Respect the uniform, for it carries qualities that identify the wearer. Similarly in wearing the uniform, the following rules should be observed.

Neatness and cleanliness from head to toe, finger nails shall be cut short. No nail varnish. Full Uniform must be worn on duty. Nurse on duty should never chew gun. Hair should be neatly done. No long hair hanging over the shoulder or face.

Hair style should be the type that head tie will be well fixed. Shoes should be brown and properly cared. No smoking on duty.

APPENDIX FOUR

The Ward Team

THE NURSING TEAM

1. Chief nursing Officer ((CNO) the over-all head of the nursing team in the hospital
2. Assistant Chief Nursing office (ACNO) acts in the absence of the CNO.
3. Matron/Sister Charge Nurse: Is the leader of the ward team, responsible for the nursing care of each patient and for enabling all the members of the nursing team to carry out their work proficiently He/She is essentially a good administrator, teacher and an adviser as we as skilled nurse: the doctor depends highly on the charge nurse.
4. The Staff Nurse: works hand in hand with the charge nurse she is an assistant if sister is absent her deputy taking the responsibilities of the above
5. The Clinical Teacher/Instructor: works in conjunction with the, hospital and school. In the Hospital, he/she works closely with the Charge Nurse in training the Students at the beside of the patient. Group discussions and practical demonstrations are held whenever time permits. They are concerned with all matter involving student's experiences in the clinical area.
6. The students: are important member of the word team and are to care for patient under staff supervision the students are in the ward to lean. This is achieved by the effort and support given by members of the trainer staff. Students should aim at the highest possible degree of nursing skill acquisition and they should be given increasing responsibility according to their level of training.
7. The Tutors: Teething in the school by their priority. They also visit the word to help in practical teaching this helps to get the feedback from the classroom.

THE WARD

The ward is a department in the hospital where patient are admitted and cared for as in-patients. There are surgical, medical, paediatric, orthopaedic, and maternity ward. The ward is also a classroom for students.

THE CHARGE NURSE: MATRON/SISTER

The Charge Nurse is responsible for nursing care-of all patients and for enabling all the

members of the nursing team to carry out their work proficiently. The charge nurse should:

1 Set a good example and be compassionate
2 Be appreciable and cheerful
3 Competent and knowledgeable
4 Available at time of need
5 Know her staff and her patient and their problems
6 Be consistent in character.
7 Be a good leader and teacher,

Plan her work, supporting supervisors, co-ordinate and delegates.

ABBREVIATION OF MEDICAL TERMS AS USED IN PRESCRIPTIONS

TERM	LATIN	ENGLISH
aa	Ana	Of each
ac	aute cibum	before meal
ad lib	ad libtum	to the desire amount
bal.	balneum	Bath
bdorbid	bis in die	twice a day
cat.	cateplasma	a poultice
c.m	eras mane	tomorrow morning
c.n	eras nocte	tomorrow night
amp	emplastrum	a plaster
axt.	extractum	Extract
gutt.	gutter	drop or drops
h.n	hac nocte	tonight
hor. decub	hora decubitus	at bed time
m.	mi see	mix
Mist.	mistura	mixture
Mit	mitten	send
o.m	omni mane	every morning
o.n	omni nocie	every night
p.c	post cibun	after food
p.r.n	pro re nata	whenever necessary
Pulv	pulvis	powder
q.d. orq.i.d	quarter in die	four times a day
q.h	quantis horis	four hourly
q.s	quantum sufficit	as much as it necessary
r	recipe	take
rep.	repeater	let it be repeated
s.o.s	si opus sit	if necessary (but once only)
ss or fs	Semi	half
sig.	signatur	let it be labeled
stat.	statim	at once
svr.	syrupus	syrup
t.d.s	ter die sumendum	three times a day
t.i.d.	term die	three times a day
ung.	unguentum	ointment
P.O.	per os	By mouth

LAST OFFICE

PURPOSE:

1. To care for the human body after death in a respectful way. And to prepare the body for burial.
2. To show sympathy to the bereaved relatives and friends.

EQUIPMENT/REQUIREMENT ON A TROLLEY:

TOP SHELF:

1. Flannel and towel.
2. Soap in a dish.
3. Hair brush and a comb
4. Tray containing the following.
    a. Cotton wool.
    b. Scissors.
    c. Bandage.
    d. Strapping.
5. Dressing forceps.
6. Hand gloves
7. Label with patient's full name. ward, hospital number, sex. time. date, religion, and address of the dead.

BOTTOM SHELF:

1. Sheet and burial cloth.
2. Apron
3. Receiver for soiled swabs.
4. Bucket for soiled lines in a decontamination solution e.g. Jik.

METHOD:

1. Screen the bed.
2. Give consideration and thought to the relatives.

3. Put on apron and gloves.
4. Remove all bed covers and pillow except one thin blanket on sheet. Do not over-expose the body.
5. Close the eyes and mouth. If necessary, place a gauze swabs (wet) over the eye.
6. Straight out the limbs as well as the whole body.
7. Remove all tubing's that may be present.
8. If dressings are present, change them if necessary.
9. Wash and dry the body well.
10. Place a cotton wool in the nostril and vaginal opening in females to prevent any discharges.
11. Brush the hair and arrange it neatly.
    Place the shroud or burial cloth. over the patient body and label identification information.
12. Carry the body to the mortuary or release it to the relatives.
13. Release any personal effect to the nearest relative.

NOTE:

1. Preparation should conform to the norms and culture of the relative.
2. Personal effect should be released by two nurses.