

**SOUTHERN SKILLS**  
**Made Incredibly Easy**  
with Dana Krause as your Skills Coordinator



**Hello, how may I help you?**

**Hi, I'm student nurse \_\_\_\_\_**

**Skills review videos-[saddleback.edu/alfa](http://saddleback.edu/alfa)**

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**Southern Adventist University**  
**School of Nursing**  
**Southern Skills**

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Skills Lab

Welcome to “Southern Skills.” Skills lab is here to prepare you to be wise and efficient in the hospital. The purpose is to increase your competency in the work field and also to decrease your anxiety. You will learn many skills ranging from simple procedures such as proper hand washing technique, crutch walking, and putting on sterile gloves, to the more complex, such as inserting an NG tube, phlebotomy, and starting an IV.

Listed below are some guidelines which are required for this class:

1. You will have a skills packet containing many of the skills procedures. This is required for lab and also for your hospital clinicals. There is room on the pages and in the packet for additional note-taking. You will be responsible for materials presented in class in addition to the packet.
2. There is a skills check-off sheet in each packet. You are responsible to Check-off the procedures as they are completed in lab. Your clinical instructor may ask to see your packets and go over them with you in lab before you perform a procedure in the hospital.
3. **Promptness to skills lab is a must.** This lab is considered to have the same value as clinical time in the hospital, since it is to prepare you. Attendance is not an option, it is a requirement. You will be in skills lab 2 hours a week as scheduled. **Two tardies from skills lab will constitute one extra make-up lab.** **A tardy is considered arriving anytime after the class is scheduled to start.**
4. Absence: If you are sick or have an extreme emergency situation, you should notify your skills instructor **ahead of time** to consider it an excused absence. This lab will still need to be made up within the week. If this is not done, it will be considered unexcused. Failure to make proper arrangements will result in an unexcused lab. Each make-up lab is **20\$ per hour; i.e., 40\$ for the whole lab.** This will be paid **before** make-up session. Excused labs also need to be made up. It is up to the student to call the teacher and make arrangements, not the teacher to find the student. Remember your schedule and stick to it.

5. There will be quizzes, worksheets and a final test. These grades are averaged into your class grade. If the skills final is not passed, you cannot proceed to the next level.
6. Once you have been exposed to a skill in lab, it is up to you to maintain and remember that skill. If that requires extra practice outside of class, then you are responsible to set up a time with the instructor for review. If you are sent back from clinical lab at the hospital for a deficiency in a skill that you have already learned and need to make up time, this is viewed as unexcused. It requires the student to set up a make-up time with the skills instructor and a payment of **20\$ per hour**.
7. Cell phones should be turned off in skills lab and clinicals. Please do not text message or play games on phone or answer it or go out in the hall to make calls. This is class time.
- 8, Keep your Skills packets. You will need them each semester for review and in the clinicals.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Instructors Signature \_\_\_\_\_ Date \_\_\_\_\_

# Professional Wear

1. Hair should be clean and groomed. Extreme hair designs and colors are considered unprofessional. In the hospital, hair should be pulled back, off the neck and shoulders to keep it out of the way.
2. Clothing in the skills lab should be modest and neat. No shirts with suggestive logos. Spaghetti straps and mid-drifts should not be worn.

In the hospital: The student uniform should be worn with the jacket and school patch. Clean, white uniform shoes should be worn. Patterned or colored underwear should not be worn under white uniform. Uniform should be clean and neat. Failure to do so can result in dismissal from lab (unexcused).

3. Nails - should be short and clean.
4. Supplies - Skills packets should be brought to skills lab and clinicals each week. Instructors should sign off skills at appropriate times.

Hospital supplies - should have stethoscope, penlight, pen, bandage scissors, and watch with a second hand for counting pulse.

5. Accessories - extra accessories should not be worn to class or lab to assure professional standards. Wedding bands only are acceptable, and are not recommended in some clinical settings. Plastic armbands, hair ties and hemp or other bracelets are considered also, items that pick up germs. Leave these at home.

Request for absence of accessories is not a moral issue, but a professional standard requested by the School of Nursing and the University. This is not intended to be a power struggle between the student and the instructor. Please honor this request. Instructors do not enjoy unnecessary discipline.

6. These guidelines are set to provide an atmosphere of high standards in quality of care and a professional appearance. We thank you for your hard work and dedication to excellence.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Instructor Signature \_\_\_\_\_ Date \_\_\_\_\_

## Professional Courtesy

1. When you go into a patient's room, introduce yourself and tell them who you are and how long you will be there. Tell them also when you leave. Find out from them a little about their background.
2. Take a minute to clean the patient's room up when you come on your shift. Remove old trash, linen, and clear off bedside table if possible.
3. Explain what you are doing to the patient as you do it. This will decrease their anxiety and let them know approximately how long it will take.
4. Tell the patient their vital signs and what they mean. Tell them to remember so they can know their average.
5. If there are visitors in the room, talk with them. Offer to sit with patient while they get up and take a break.
6. Introduce yourself to other staff and be available to help with procedures.
7. Don't congregate together in the hospital, unless you are with your teacher. Staff will not usually approach a group to get them involved.
8. When you are at the nurses' desk and a visitor comes up, make eye contact with them, even if you are not their nurse, and help them out.
9. If you are on the phone at the nurses' desk and a visitor comes up, make eye contact and acknowledge them, so they will know that you will help them in a moment.
10. When you give report to another nurse, or consulting over the phone, have all of your facts in front of you. Know what you are going to say.
11. If a visitor asks directions, stand up and help them if possible. Don't just point down the hall.
12. Check off with your instructor and nurse before administering medications.
13. If you see someone struggling with a wheelchair or stretcher or something else, help them. Don't wait to see if they are going to make it.
14. Don't shift bash.

15. Don't engage in hospital gossip about staff or patients.
16. Your response to a difficult encounter can either inflame the situation or calm it.
17. Don't talk about patient care or private issues in an elevator.  
Acknowledge others who are standing around.
18. Don't discuss the patient's situation over them as if they weren't there.  
Explain what you are doing, even if they don't respond.
19. The best way to cope with an anxious family is to keep them informed.
20. Don't have a negative confrontation with another nurse or physician in public. If something needs to be discussed, take it to a private area.

## Medical Hand Washing

1. Nails should be short and groomed. Accessories should be removed and clothing pushed above wrist level. Push lever to obtain paper towel when ready to avoid touching lever when hands are wet.
2. Turn water on, avoid splashing, adjust temperature to “warm.”
3. Wet hands and wrists, keeping hands and forearms below elbows.
4. Apply soap, and lather hands. Apply friction around each finger, interlace fingers, and rub palms and back surface of hand in a circular motion.
5. Should take about **10-15 seconds each hand**.
6. Cleanse fingernails.
7. Rinse thoroughly, keeping hands below elbows. **Rinse from wrists down**.
8. Dry hands thoroughly wiping from fingers up to wrists.
9. Turn off water at sink with paper towel.
10. Discard paper towel appropriately.

Performed\_\_\_\_\_ Skills Instructor\_\_\_\_\_

Performed\_\_\_\_\_ Clinical Lab Instructor\_\_\_\_\_

## Crutch Walking

Crutches should be placed approximately **4 inches to outside of each foot**. **When placed forward, they should be placed about 6 inches**. Crutches should be adjusted to appropriate height of patient, with their weight resting on the palm of their hands and not under the arms. The distance between the underarm and the top of the crutch should be approximately **2-3 inches**.

Instructions for falling - Push crutches out of the way so you do not land on them. Break fall with bent arms, to avoid fracture.

1. **Swing Gait** - Put both crutches forward at the same time. Swing both feet up to crutches. Repeat.  
This gait may be used by someone who has some paralysis.
2. **2-point Gait** - Put forward opposite foot and opposite crutch at the same time. Then bring forward other foot and crutch at the same time. (remember - crutch and foot should be on opposite sides of each other, to widen the base of the patient. This will help them to be more stable.)  
This gait is used for someone who need extra help and is unstable in their walk.
3. **3-point Gait** - Put both crutches forward and then follow through with unaffected foot on the ground and the other held up.  
This gait may be used for someone with a broken ankle.
4. **4-point Gait** - Put one crutch forward. Follow by putting the opposite foot forward, then put next crutch forward, followed by the opposite foot. (This is 4 distinct steps.)  
This gait may be used for someone who is re-learning to walk

Performance\_\_\_\_\_ Skills Lab Instructor\_\_\_\_\_

Performance\_\_\_\_\_ Clinical Lab Instructor\_\_\_\_\_

## Sterile Gloving

1. Hands should be clean.
2. Remove outer glove wrapper.
3. Open inner package keeping gloves on inner wrappers surface. Lay package on surface at waist level.
4. Identify right and left glove.
5. With non-dominant hand grasp inside edge of cuff of glove for dominant hand.
6. Carefully pull glove over dominant hand with thumb and fingers in proper spaces. Do not un-cuff at this point.
7. With gloved dominant hand, slip fingers under cuff of second glove.
8. Pull glove over non-dominant hand without contaminating gloved dominant hand.
9. Now, you may un-cuff dominant hand with gloved un-dominant hand.
10. Interlock fingers of gloved hands to ensure proper fit. Keep hands in front and at waist level or higher to reduce risk of contamination.

Performed \_\_\_\_\_ Skills Instructor \_\_\_\_\_

Performed \_\_\_\_\_ Clinical Lab Instructor \_\_\_\_\_

# Pulses

Make sure your hands are clean (and warm if possible.)

1. Radial - Place fingertips of first 2 or 3 fingers over the radial pulse. ( Do not circle wrists with hands, This is not a professional way of touching the patient.)  
Lightly compress against radius, determine strength of pulse, and begin to count rate.  
30 seconds x 2\_\_\_\_\_
  2. Apical - Expose patient's sternum and left side of chest for auscultation. Locate apex of heart at point of maximal impulse. Warm diaphragm of stethoscope between hands. Place over point of maximal impulse (PMI) and auscultate for S1 and S2 heart sounds.  
Make sure stethoscope earpieces are clean before and after you use it.  
60 seconds\_\_\_\_\_
  3. Brachial - 15 sec. x 4 \_\_\_\_\_
  4. Femoral - 15 sec. x 4 \_\_\_\_\_
  5. Temporal - 15 sec. x 4\_\_\_\_\_
  6. Pedal - 15 sec. x 4 \_\_\_\_\_
  7. Carotid - 15 sec. x 4 \_\_\_\_\_
  8. Palpatory B/P (Feel radial pulse. Pump B/P cuff up until pulse is obliterated. Slowly let cuff down with dial. At the point of pulse return, this is the palpatory pulse. (No stethoscope needed for this.) Palpatory pulse is equivalent to systolic B/P.) \_\_\_\_\_
  9. B/P with patient lying down\_\_\_\_\_
  10. B/P with patient sitting up\_\_\_\_\_
  11. B/P with patient standing up \_\_\_\_\_
  12. Respirations 15 x 4 \_\_\_\_\_
  13. Lung Sounds \_\_\_\_\_
  14. Bowel Sounds \_\_\_\_\_
- Performance\_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

## Central Venous Catheter CVC Dressing Change

1. Place patient in **Semi-Fowlers** position.
2. Have pt. **turn head away** from dressing site. **Put on mask**. This will help to prevent spread of infection.
3. **Apply clean gloves**.
4. Take transparent film dressing (Tegaderm) off by peeling edges from **outer to inner**. Hold down catheter to keep it from sliding out.
5. Put old dressing into gloves and **fold gloves over** it as you take gloves off.
6. Put on **sterile gloves**.
7. Use alcohol swabs or chloraprep cleanser to clean site from **inner to outer** to avoid pulling germs into CVC site. (Alcohol package comes with 3 swabs. Use them all. Open alcohol pad to cleanse underneath the port site.
8. Let dry, and **apply new Tegaderm**.

Performance\_\_\_\_\_ Skill Lab Instructor\_\_\_\_\_

Performance\_\_\_\_\_ Clinical Lab Instructor\_\_\_\_\_

## Enema

1. Place patient in **Lt. lateral Sims** position. Enema flows better with the position of the colon, draining to gravity.
2. Clamp tubing before filling bag. Fill bag to **1000-1500ml.**
3. Water should be approximately **105** degrees.
4. Soap should be added to the bag **after the water to prevent bubbling** up in the bag.
5. **Prime** the tubing to allow the **water to replace the air** in the tubing.
6. Put pad under pt. and administer.
7. Insert **2-3 inches past the sphincter** so that enema will not spray back when unclamped.
8. If a patient is frail or diseased, potential problems with inserting the tube too far would be:
  - A. **Perforating the colon.**
  - B. **Stimulating the vagus nerve causing decreased heart rate which may result in bradycardia.**
9. Hold **12-18 inches above patient.** Enema works with gravity. If held too low, will go in very slowly; if held too high, pt. may not be able to hold much or cramping may occur.
10. If a patient states that they cannot hold any more, and enema has just been inserted, **reassure pt., have pt. take some deep breaths, slowly raise bag.** (Sometimes just stimulating the sphincter will cause a client to feel out of control.)
11. When patient has had as much as they can tolerate, **clamp and take out.** Patient may need to get up several times to evacuate enema.
12. Soap suds enema may be used in **L/D for childbirth, or for surgical procedures.**
13. Oil retention enema may be used for **fecal impaction** (hardened stool).
14. **Harris flush-used for patient with gas. Raise enema, then lower.**  
Fecal material will come into bag with gas rising to top of bag. Lower & repeat several times.

Performance \_\_\_\_\_ Skills Instructor \_\_\_\_\_ Clinical Instr. \_\_\_\_\_

# Ostomy

1. The intestine type protrusion that is showing is called a **stoma**.
2. The square adhesive that holds the ostomy bag in place is a **wafer**.
3. A **template** is used to measure around the stoma for the correct fitting of the wafer.
4. There should be about **1/4 to 1/8 inch** of skin showing around the stoma for correct fitting of the wafer.
5. The template is then held to the wafer and the correct size is drawn to the wafer and cut for appropriate sizing.
6. Connect the bag to the wafer and apply to the patient, hanging the bag **down and out** (away from the groin).
7. If the ostomy bag becomes full of air (gas), **burp it**, making sure the seal closes securely afterwards.
8. Do not use alcohol to cleanse the stoma. It is too harsh and can cause **vasodilation of the capillaries of the stoma, causing bleeding**.  
Cleanse with warm water and soap.
9. An irrigation of the stoma can be performed if needed. Remove the ostomy bag, place the irrigation bag on the wafer, and let water run in. (Set up of the irrigation is similar to the enema, see enema)
10. Let the patient sit on the toilet if possible to drain irrigation contents directly into toilet. Do not let patient sit on toilet longer than **15 minutes**.  
**This may increase risk of hemorrhoids or stimulate vagus nerve causing decreased heart rate resulting in bradycardia.**
11. The irrigation sleeve may be left on an additional **45 minutes** after taking the patient off the toilet to ensure total drainage. This makes it a total of **1 hr.** (!5 minutes on toilet + 45 minutes = 1 hr.)
12. Remove bag and attach new ostomy bag. Change pouch every **3-5 days** unless leaking.

Performance \_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical Lab instructor \_\_\_\_\_

## Injection Sites

**Deltoid** - (arm) Find the **acromion process** and follow it down to the **acromion notch**. Go down on the arm about **3-4 finger** breadths. This muscle cannot tolerate frequent injections or larger doses of medication (**not more than 1 ml** in the average sized adult). Limit injections into this muscle to adults and teenagers with well-developed muscle mass. **Make sure the elbow is flexed and supported** so the muscle can be relaxed.

The 3 **IM** injection sites below the hip are the **Dorsal Gluteal, Ventral Gluteal & the Vastus Lateralis**.

**Dorsal Gluteal**- is the site located on the back side of the buttocks. (Think of the dorsal or back fin of a shark) Bend the leg and find the **common landmark** to all 3 injection sites which is the **greater trochanter**. Follow up the **iliac crest**, and to the **posterior superior iliac spine (PSIS)**(the notch located at the top of the buttocks that starts about **1/4** inch from the spine). Draw a **straight line** between the greater trochanter and the PSIS. **Go halfway up the line, then 1/2 inch above line**. Inject.

This site should be used with extreme caution to avoid injury to the **sciatic nerve and the gluteal artery**. Do not use this site for children under **2** who have not been walking long enough to develop adequate musculature. **May also be contraindicated for the older adult or immobile client whose gluteal muscles are deteriorated**.

**Ventral Gluteal**- Find the common landmark which is the **greater trochanter**. Place your palm **over it** with your **thumb pointed toward the groin** and your **index finger pointed directly to the anterior superior iliac spine (ASIS)** (hip). Make a V with your index and middle fingers. Give injection in the lower part of the V, **after you remove your hand**, to prevent sticking it.

This site is free of major blood vessels, has a dense muscle and minimal fat. Good absorption rate.

**Vastus Lateralis**- Located on the side of the leg. Find the common landmark, the **greater trochanter**. Place palm **below** greater trochanter. Lower hand should be placed **above** the patella. Fingers are pointed **towards the groin**, and the **thumbs pointed towards each other on the "imaginary jean line"**. Go to middle and up from thumbs **1 1/2 inch**.

This site is also free of major nerves and blood vessels, and it is usually well developed in both adults and children.

Performance \_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical Lab Instructor \_\_\_\_\_

## Injections

**IM injection**-find appropriate landmark.

Wear gloves.

Swab with alcohol from inner to outer.

Put alcohol prep in non dominant hand that is holding skin.

Splay skin down to reach IM level.

Put needle in at 90 degree angle.

Aspirate then give injection if not in vein.

Pull out then quickly, apply counter pressure.

Discard needle in sharps.

No more than **3 cc's** should be given IM in one site. The medicine will leak to surrounding areas. No more than **1 cc.** should be given in the deltoid muscle of the arm.

**Sub-q. injection**- find landmark

Wear gloves.

Swab with alcohol from inner to outer.

Put alcohol prep or cotton ball in non dominant hand.

Pinch up skin to stay in sub-q area.

Put needle in at a 45-90 degree angle. (depending on the needle length. If needle is short, it goes straight in at 90 degrees to stay in the sub-q area. If needle is longer, insert at 45 degree angle.

Many sub-q injections do not need to be aspirated. Check to see.

Pull out quickly, apply counter pressure.

Discard

No more than **1 ½ cc.** should be given in the sub-q site. No more than **1 cc.** should be given in the arm.

**ID injection**-. An example of this is a tb skin test. Find landmark. Should not be over veins, bruised or affected areas.

Wear gloves.

Cleanse from inner to outer.

Hold skin tight from underneath arm with non-dominant hand.

Inject at a 5-15 degree angle. Very superficial.

You should see a bleb (bubble) under the surface of the skin. Minimal bleeding.

The maximum medication dose for this is **.2 ccs**

**1 cc=1 ml. 30 cc=1 oz.**

## Needles

1. Three characteristics of an insulin syringe:
  - a. Insulin is measured in units instead of cc or ml.
  - b. Insulin has a bright orange top.
  - c. Insulin has a non-detachable needle
2. An IM injection is given at what angle? 90 degree angle.  
A sub-q injection is given at what angle? 45-90 degree, depending on the length of the needle.  
An intra-dermal injection is given at what angle? 15 degree. Avoid veins or scarred areas.
3. The maximum medication dosage that should be given IM is 3 cc.  
The maximum medication dosage that should be given Sub-q is 1½ cc.  
The maximum medication dosage that should be given ID is 0.2 cc.  
Do you aspirate on an ID injection? \_\_\_\_\_
4. The average length of the IM injection needle is 1-1½ inch. The shorter needle is used on a smaller person, the longer used on a larger person.
5. If you give 3 ml (or cc) of Demerol to a 200 lb. person, what size needle should you use? 1½ inch or 2 inch.  
What size syringe should you use? 5 cc, to allow room in the barrel to aspirate
6. How is the injection site cleansed before needle insertion? Use alcohol prep, and swab from inner to outer. Remember, alcohol cleans with friction. Let dry before inserting the needle.
7. After inserting an injection into the skin, what would be the first thing to do before giving the medication? Aspirate, to make sure that you are not in a vein. If you aren't, you will get an air bubble return. If you are in a vein, there will be a blood return. Take out needle, without re-inserting blood into patient. Start over with a clean needle and syringe and a different site.
8. When starting an IV, which way would the bevel (opening) of the needle be placed. Up, to make sure the needle penetrates the skin easily.
9. What is the hub of the needle? The plastic part at the end that connects to the syringe.
10. What is the barrel of the needle? The part that holds the medication.
11. What is a Z-track method? \_\_\_\_\_

# Body Mechanics Lab

James Igani- Instructor

Lifting patients

Moving patients up in bed, with & without assistance

Transferring patients from bed to chair and back

Log rolling patients

Proper bed height

Using draw sheet

Using gait belt

Proper body mechanics for self and patient.

Proper nutrition and self care as a health care worker.

Pressure points and their proper treatment

Transferring a patient to the wheel chair.

Class completed \_\_\_\_\_ Date \_\_\_\_\_

## Bedbath lab

- \_\_\_\_\_ Make unoccupied bed. Pull sides tight and tuck under mattress.
- \_\_\_\_\_ On top sheet and bedspread, the corners should be mitered.
- \_\_\_\_\_ Top sheet and bedspread should be folded down as instructed for the patient to get into bed with ease.
- \_\_\_\_\_ Pillow case should be tightened around the pillow with the open end facing away from the entry of the room.
- \_\_\_\_\_ Length of the sheet and bedspread should be equal on both sides.
- \_\_\_\_\_ Lower the bed so the patient can get into it.
  
- \_\_\_\_\_ Obtain bathing equipment
- \_\_\_\_\_ Elevate patients head
- \_\_\_\_\_ Offer bedpan before bath
- \_\_\_\_\_ Make sure bed is high enough to work comfortably.
- \_\_\_\_\_ Raise bed rail on opposite side that you are working from.
  
- \_\_\_\_\_ Obtain vital signs    Radial pulse 30 x 2 \_\_\_\_\_  
  Respirations 15 x 4 \_\_\_\_\_  
  Blood Pressure \_\_\_\_\_  
  Lung sounds \_\_\_\_\_
  
- \_\_\_\_\_ Give bed bath. Face (don't use soap on face)  
  Chest  
  Arms & hands (let patient wash own hands, if possible)  
  Legs & feet (soak feet in basin if needed)  
  Flatten bed. Turn patient to side. Wash back.  
  Perineal care is last (not required in lab).
  
- \_\_\_\_\_ While patient is on side, take out old sheets from under them. Roll sheets in toward patient. Have patient roll back over facing you. Pull side rails up. Go to other side. Lower side rail. Finish pulling out old sheets. Roll in new sheets. Remember to keep the patient covered.
  
- \_\_\_\_\_ Have patient hold new top sheet while pulling out old one. When sheet is tucked in, allow room for the toes. Put old linen in pillow case.
  
- \_\_\_\_\_ Keep dirty linen off the floor. Stash in pillow case in chair before you take it to the dirty linen room.
  
- \_\_\_\_\_ Transfer your patient from bed to chair and back.
  
- \_\_\_\_\_ Now trade places.

## Catheter

- \_\_\_\_\_ Introduce yourself to patient and explain procedure.
- \_\_\_\_\_ Take kit out of bag and set bag to the side. Bag can be used as trash.
- \_\_\_\_\_ Open sterile drape away from you so you don't contaminate sterile field.
- \_\_\_\_\_ Pick up first barrier drape by the corners. The corners that you touch, go under the patient. Put the shiny side down. (It repels water)
- \_\_\_\_\_ Put on sterile gloves.
- \_\_\_\_\_ Use the next drape as a barrier between your non-dominant hand and the pt.
- \_\_\_\_\_ Open cleaning solution and pour over cotton balls. Discard empty package.
- \_\_\_\_\_ Check balloon on catheter by instilling the water from the syringe. Deflate and leave the syringe attached.
- \_\_\_\_\_ Designate a non-sterile hand (your non-dominant one). Use it to hold open the labial area and find the urethra.
- \_\_\_\_\_ Cleanse with cotton balls from top to bottom after locating the urethra. 2 cotton balls on far side, 2 cotton balls on near side, 2 down the middle. Discard by going around the sterile field towards self.
- \_\_\_\_\_ Insert catheter with dominant hand. After urine flashback, advance another 2-3 inches on a female. (7-9 total on a male)
- \_\_\_\_\_ Continue to hold catheter with dominant hand while using non-dominant hand to insert water into the balloon. Give a little tug with sterile hand before letting go of catheter to make sure it stays in place. Remove sterile hand to assist taking off the syringe.
- \_\_\_\_\_ Tape to inner thigh and hang to gravity. Sterile specimen port found on tube.

## Nasogastric tube (NG)

1. There are several purposes for an NG tube. For example:  
Post-op to prevent vomiting    feeding or medication

The main purpose for the surgical (or post-op) patient would be:  
Suction of stomach secretions.

2. What is the equipment that you need to gather for NG insertion?  
60 cc Syringe with catheter tip  
Tape  
Stethoscope  
Lubricant  
Clean gloves  
Correct NG tube  
Water or ice chips to swallow for easier insertion  
Basin
3. How is the patient measured for NG insertion?  
From the tip of the nose----to tip of ear-----to xyphoid process-----and then taped on tube to mark the distance.
4. Which nostril is the NG tube place in?  
The largest or most patent.
5. What is the position of the patient for insertion?  
High Fowlers
6. How is an NG tube inserted?  
Lots of lubrication on the end, may tip head back initially to insert through nose, then have patient drop their chin to chest while they swallow.  
Insertion is continued past the gag reflex and down to marked area.
7. What are three ways to check for proper placement?
  1. Put air in syringe and push in 30 cc, use stethoscope to listen (not very accurate).
  2. Aspirate gastric secretions.
  3. X-ray (most accurate)
8. What are the 2 lumina (openings) on the NG tube used for?  
The main one is used for suction, feeding or medications.  
The smaller connector tube is just an air vent and nothing should be placed in it or removed from it. It is usually blue or purple and is called a "pigtail".

9. Define Gavage - giving (such as nourishment or medication),  
Lavage - leaving (such as suctioning out).
10. How does a long-term tube differ from a short-term tube?  
A long-term tube is used for feeding. It is thinner, more flexible, more durable, less irritating, more comfortable, usually has a stylette (guide wire) for easier insertion that will be removed after insertion, and an x-ray detectable black tip on the end.
11. If a patient has a p.o. medication order and they are on continuous suction, what would be an appropriate nursing action?  
Turn suction off until the medication is absorbed. (Check PDR for absorption time.)

A better method would be to give medication an alternate route. (this might include IV, IM, sub-q, patch, suppository) The form of the medication changes with the route. For example, a pill cannot be given rectally, it needs to be in suppository form.

Performance \_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical Instructor \_\_\_\_\_

## Trach Cleaning

Obtain clean gloves  
Peroxide  
Sterile Normal Saline  
Trach cleaning kit  
Clean gloves

Position patient sitting upright. Put on clean gloves and remove old dressing. Discard dressing inside gloves.  
Open peroxide & water. Turn lids facing up on the table. Pour from both over the labeled side into the trashcan.

Put one sterile glove on and remove supplies. Shiny side goes down on the large white sheet that you set your items on.

Pour peroxide & saline into sectioned areas. Pour with ungloved hand. Do not set the cleaning kit on the sterile sheet.

Put on other glove.

Take inner cannula out, touching only the flange.

Use the scrub brush to clean inside the cannula entering the tube from the top, after soaking it in peroxide.

Rinse with water. Tap off the excess water. Dry the inner part out with a pipe cleaner.

Can use extra 4 x 4 to dry off outside.

Reinsert holding only the flange.

Clean the outside with swabs, pulling germs from inner to outer. Discard.

Clean with 4 x 4's using a different edge to prevent cross contamination.

Use peroxide first, then rinse with saline.

If the trach ties need to be replaced, only untie one side at a time.

Hyper-oxygenate if needed.

Clean cannula and stoma every 8 hrs. or more if needed.

## Tracheostomy Suctioning

1. Get trach suction kit and sterile water.
2. Open water before opening kit. Lids up, pour over labeled side into trash to cleanse spout.
3. Open sterile kit. It should have in it, sterile gloves, small suction tube and paper cup to hold water.
4. Put sterile glove on **dominant hand, and pick up paper cup with that hand**. Pour water in cup held by dominant gloved hand with ungloved non-dominant hand. Set down water, and continue with sterile gloving to both hands.
5. Pull tubing out of clear plastic wrap. Roll it up in dominant sterile hand leaving the end out that connects to suction. Connect to suction with non-dominant hand (dirty hand) Then, straighten tube out keeping it taut (tight).
6. The non-dominant hand is established as the dirty hand. Turn on suction.
7. Check water with tubing attached to suction to make sure it works.
8. Insert suction tube down through trach, keeping it straight and not contaminating gloves. Do not suction on the way down.
9. Put down until you meet resistance, then put thumb over suction and twist as you take out, keeping tubing straight. Intermittent suction.
10. Irrigate in water.
11. Repeat a couple more times, irrigating in between. No more than 3 or 4 times total. Do not compromise the patient's oxygen. Look at the O2 saturation.
12. May need to **hyperoxygenate** patient before and after procedure.

Performance \_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical Lab Instructor \_\_\_\_\_

## **Ace Wrap**

1. Wrap from distal to proximal to promote blood return to the heart.
2. Circular wrap to hold, then come up arm with a reverse spiral. \_\_\_\_\_
3. Wrap a stump. Circular wrap to hold (only time you wrap proximally), then bring wrap down over stump. Looks kind of like a reverse spiral. \_\_\_\_\_
4. Figure 8 on hand. \_\_\_\_\_
5. Figure 8 on foot. \_\_\_\_\_
6. Check extremity for coolness. Do not cut off circulation with a tight bandage. \_\_\_\_\_

## **TED Hose Application**

1. Know how to measure. \_\_\_\_\_
2. Know how to apply. \_\_\_\_\_
3. Know how to take off. \_\_\_\_\_

## **Restraint**

1. Know how to tie. \_\_\_\_\_
2. Know how to release. \_\_\_\_\_

## Wet to Dry Dressing

Gloves, sterile gloves

Tape

Abd. Dressing

Toppers

Gauze

Sterile water

To remove old dressing.

Apply clean gloves and pull tape from each side toward the middle of the dressing. Remove Abd. and toppers.

Discard old dressing in clean gloves and put on sterile gloves.

Gently remove gauze from inside wound. Debris will be sticking to it, but this is the way to remove old infection and stimulate new healing.

After removal of old gauze, gently cleanse wound with sterile water on gauze. Make sure not to pull germs down inside of wound. The length, width, depth, and condition of the wound should be noted and charted. Use sterile ruler.

To dress wound.

Unfold gauze so it will pack better. Will need several, depending on the size. Gauze should be moistened in sterile water, but not dripping.

Toppers are applied on top of the gauze and wound.

Abd. dressing is applied.

Secure with tape pressing evenly towards each side. One side should not be tighter than the other.

This is one type of sterile dressing.

Performance \_\_\_\_\_ Skills instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical instructor \_\_\_\_\_

## **Drawing up Medications**

Obtain needle and vial.

Alcohol prep

If vial has not been opened, snap off the lid.

If vial has been opened, swab with alcohol prep from inner to outer.

If you are giving 1 cc. of medication, pull up 1 cc. of air to inject into vial first.

Turn vial over, label should be away from you. And pull up same amount of medication.

With the air replacing the fluid loss in the vial, the pressure inside the vial stays the same. This eliminates the vacuum affect or the suction affect when medication is drawn up.

# Venipuncture

Name \_\_\_\_\_

1. What is an INT? \_\_\_\_\_
2. What should be the angle of the needle upon insertion? \_\_\_\_\_
3. What direction should the bevel be upon insertion? \_\_\_\_\_
4. What is infiltration and the signs that accompany infiltration? \_\_\_\_\_  
\_\_\_\_\_
5. What are the nursing actions for infiltration? \_\_\_\_\_  
\_\_\_\_\_
6. What is phlebitis, and the signs that accompany it? \_\_\_\_\_  
\_\_\_\_\_
7. What are the nursing actions for phlebitis? \_\_\_\_\_  
\_\_\_\_\_
8. What are the most common reasons for starting an IV? \_\_\_\_\_  
\_\_\_\_\_
9. If the vein is cordlike, it is probably \_\_\_\_\_
10. If the vein is flat, it \_\_\_\_\_
11. When starting an IV, what types of areas should you avoid? \_\_\_\_\_  
\_\_\_\_\_
12. If the patient is getting blood or having surgery, what gauge would be used? \_\_\_\_\_
13. The nurses notes should include \_\_\_\_\_  
\_\_\_\_\_

## **IV's Let's Do IV's!!!!**

Remember - organization is the key.

1. Spike your IV (hook it up to the tubing)
2. Check the cap on the tubing to loosen it.
3. Prime the tubing.

Now, check your patient.

4. May need to get towel to place under pts. arm.
5. Tear tape strips. (3 fairly long)
6. Open bandaid.
7. Prepare tegaderm.
8. Get tourniquet.
9. Open betadine packet.
10. Open alcohol preps (about 3)
11. Check both arms before deciding where you will stick.
12. Have your body at the same level as the patient to spot the vein better, and to avoid blood rushing to your head!

After you receive blood flow, loosen tourniquet.

13. When you are hooking catheter to tubing, occlude blood flow with one or two fingers. (Use 3<sup>rd</sup> or 4<sup>th</sup> finger,)
14. After you hook the patient up, stop occluding blood flow!
15. Don't bend the catheter. It should be threaded all the way up to the hub. (Remember to insert it with the bevel of the needle up.)
16. Open up fluids. Keep your eye on the infusion site to make sure that it is not infiltrating.
17. Put on tegaderm.
18. Take off gloves.
19. Apply tape, but not over the insertion site.

## Medication Administration

1. Know 7 rights. 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
6. \_\_\_\_\_  
7. \_\_\_\_\_
2. Correct handling of a p. o. medication. \_\_\_\_\_
3. Know form of medication to put down NG tube.  
\_\_\_\_\_
4. Mixing powders and drawing up meds in syringe. \_\_\_\_\_
5. Opening ampules. \_\_\_\_\_
6. Drawing up medication from vials. \_\_\_\_\_
7. Mixing insulin and drawing it up. (Clear to cloudy) \_\_\_\_\_
8. Giving injection correctly. \_\_\_\_\_

Performance \_\_\_\_\_ Skills Lab Instructor \_\_\_\_\_

Performance \_\_\_\_\_ Clinical Instructor \_\_\_\_\_

# Postmortem Care

## General Consideration

1. Begin postmortem care after physician has finished examination, family has visited, and any religious rites have been performed.
2. If relatives are unable to come to the hospital within 30 minutes after death, patient may be viewed in the morgue. This procedure should be discouraged other than in cases where the body needs to be identified.
3. A living patient and a patient who has deceased should not left in the same room.

## Official Notification of Death

1. Notify physician and administrative supervisor.
2. Physician examines patient and pronounces death.
3. Record time of death and discharge of patient on progress notes.
4. Make out hospital death report for release of body.
5. Transfer patient to morgue.

## Death Occurring in Operating Room or Recovery Room

1. When a patient dies in the OR or Recovery room, personnel in these units are responsible for completion of postmortem care.
2. Upon completion of postmortem care, the nursing supervisor is notified. Arrangements will be made for transfer to the morgue and disposition of the patient's property.
3. In the situation in which OR personnel are not able to complete care, the nursing supervisor is to be notified.

## Procedure

1. Remove all valuables from patient whenever possible. Do not remove ID band from wrist. If it is impossible to remove a ring, tie it on; do not tape ring to finger. Give valuables to family.
2. Remove pillows and place patient in dorsal recumbent position. Raise head slightly. Straighten limbs. Close eyelids gently.
3. Bathe patient if necessary. Wear gloves.
4. Apply dry sterile dressing to wounds and drain sites as necessary. Remove tubes and drains, including IV and arterial lines. Wear gloves when coming in contact with body fluids.
5. Place pads under rectum.
6. ID tag. Be sure tags are filled out. Record whether patient was receiving radiation therapy or had radium implanted at time of death. If patient was on precautions, specify type on precautions.
7. Tie tag around big toe. Do not tie wrists together.
8. Obtain stretcher and cover patient with sheet; do not use a blanket.
9. Transport patient and belongings to morgue. If family is not available for belongings, all packages or items should be individually labeled with patient's name, unit, and hospital number.

## Care of Personal Possessions

1. When rings are left on hand, note this on valuables slip.
2. If patient's hair has been shaved off, the hair should be sent with the patient.
3. Deposit valuables in cashier's office if family is not available.
4. If patient's family asks to assume responsibility for taking clothes, they may do so by signing the valuables slip. Carefully list all items before getting this signature.

## Patient Assessment

1. General overview:
2. Neurological:
3. Musculoskeletal:
4. Cardiovascular/ peripheral vascular:
5. Respiratory:
6. Gastrointestinal:
7. Genitourinary:
8. Integumentary:
9. Psychological:
10. Spiritual:
11. Patient's developmental level of functioning (may use Erickson, Havihurst, etc.) (Identify level of patient and describe how patient displays level of development chos)

## Patient History & Assessment

1. General Overview: general statement \_\_\_\_\_  
\_\_\_\_\_  
Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_  
Race \_\_\_\_\_ Apparent state of health \_\_\_\_\_  
Diagnosis \_\_\_\_\_ V/S : T \_\_\_\_\_ P \_\_\_\_\_  
R \_\_\_\_\_ B/P \_\_\_\_\_  
Grooming & hygiene \_\_\_\_\_  
Nourishment \_\_\_\_\_ Dressings & tubes \_\_\_\_\_  
Stature & weight (obese vs. emaciated) \_\_\_\_\_
2. Neurological: LOC alert & oriented x 3 (person, place, time) \_\_\_\_\_  
Senses intact \_\_\_\_\_ Speech communication \_\_\_\_\_  
Movement \_\_\_\_\_ PEARLA \_\_\_\_\_  
Vision correction \_\_\_\_\_
3. Musculoskeletal: Posture \_\_\_\_\_ Gait \_\_\_\_\_  
ROM with/without limitations \_\_\_\_\_ Leg strength \_\_\_\_\_  
Motor coordination \_\_\_\_\_ Muscle tone \_\_\_\_\_  
Grip strong & equal bilaterally \_\_\_\_\_
4. Cardiovascular/Peripheral Vascular: Pulse & rhythm \_\_\_\_\_  
S1S2 strong & regular \_\_\_\_\_ Cyanosis \_\_\_\_\_  
Edema \_\_\_\_\_ Extremities (warmth & color) \_\_\_\_\_  
Strong/weak pedal pulses: Lt. \_\_\_\_\_ Rt. \_\_\_\_\_ O2 Sat. \_\_\_\_\_  
Capillary refill less than 2 seconds \_\_\_\_\_ Bed position \_\_\_\_\_

5. Respiratory: respirations deep/shallow? \_\_\_\_\_ regular? \_\_\_\_\_  
Bilateral breath sounds \_\_\_\_\_ Advantageous sounds \_\_\_\_\_  
O2 at \_\_\_\_\_ SOB \_\_\_\_\_ Cough \_\_\_\_\_ Sputum \_\_\_\_\_  
Activity tolerance \_\_\_\_\_
6. GI: Diet \_\_\_\_\_ Appetite \_\_\_\_\_ N/V \_\_\_\_\_ Last BM \_\_\_\_\_  
ABD (soft, firm, flat, non-distended) \_\_\_\_\_ Suppositories used \_\_\_\_\_  
Foley \_\_\_\_\_ Size \_\_\_\_\_ Infection/redness \_\_\_\_\_  
Condition of gums & teeth \_\_\_\_\_
7. GU: Urine output \_\_\_\_\_ Odor \_\_\_\_\_ Color \_\_\_\_\_  
Itching/burning \_\_\_\_\_ Bladder distention \_\_\_\_\_  
Sexual problems \_\_\_\_\_ Menses \_\_\_\_\_ PMS \_\_\_\_\_
8. Integumentary: (skin, hair, scalp) \_\_\_\_\_  
Warm & dry \_\_\_\_\_ Pale \_\_\_\_\_ Turgor \_\_\_\_\_ Lesions \_\_\_\_\_  
Nails/hair \_\_\_\_\_ Texture \_\_\_\_\_ Temperature \_\_\_\_\_  
Decubiti \_\_\_\_\_ Moisture \_\_\_\_\_ Color \_\_\_\_\_
9. Psychosocial / Spiritual: Source of strength \_\_\_\_\_  
Support system \_\_\_\_\_ Acceptance of illness \_\_\_\_\_  
Changes or expression of concern \_\_\_\_\_
10. Other pertinent findings eg. lab values or x-ray reports: \_\_\_\_\_  
\_\_\_\_\_

# History & Physical Exam

Subjective- \_\_\_\_\_

Objective- \_\_\_\_\_

1. ID- \_\_\_\_\_

2. CC- \_\_\_\_\_

3. HPI- \_\_\_\_\_

Includes:

1. O/C  
\_\_\_\_\_

2. N/D  
\_\_\_\_\_

3. L/R  
\_\_\_\_\_

4. Q/Q  
\_\_\_\_\_

5. A/R  
\_\_\_\_\_

6. Associated symptoms  
\_\_\_\_\_  
\_\_\_\_\_

4. PMH- \_\_\_\_\_

5. FH- \_\_\_\_\_

6. SH- \_\_\_\_\_

7. ROS- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. PE- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. PE- extra \_\_\_\_\_

## Continuous Bladder Irrigation (CBI)

### Equipment:

- Irrigating solution and container
- Tubing
- IV pole
- Alcohol swab
- Clean gloves

### Purpose of continuous irrigation:

- Rinse bladder of clots and debris following prostatic surgery
- Provide hemostasis
- Instill medication

### Procedure:

Maintain CBI by using a triple lumen catheter for procedure.

Explain procedure and get equipment ready.

Remove protective covering from spike and insert it into port of solution container.

Place irrigating solution container on IV pole and prime tubing. Pole is usually 24-36 inches above bladder.

Fill drip chamber by pinching fluid chamber until half full.

After priming, connect tubing to third lumen.

Adjust drip rate by adjusting clamp on the tubing to deliver hourly rate of irrigant.

With clear drainage, drip rate should be about 40-60 drops per minute.

When drainage is bright red or contains blood clots, increase drip rate.

**Rationale:** Increased drip rate will clear the drainage and flush out clots.

Tubing should be changed at a minimum of every 24 hrs.

### Clinical problems:

Irrigation flow is not infusing at prescribed rate. May need to raise or lower IV to regulate flow. Move flow adjuster clamp to a new site on the tubing. Tubing may collapse due to constant pressure from clamp. If infusion rate slows, may indicate clots are blocking flow. Irrigate catheter.

Irrigation solution is not returned because of an obstruction in the system. Aspirate the solution from the catheter using a moderate pull-back method. If nothing happens, palpate patient's bladder & instill 30-50 ml of irrigating solution to agitate and clear clots. If irrigant doesn't return, reconnect urinary system and observe for 30 minutes. Bladder spasms can block the flow of urine through the system.

**The output from the irrigation solution is not considered urinary output.**

The amount that goes in should be subtracted from the total output to get an accurate urine output.

## **Eardrops**

1. Gather solution and check labels to ensure correct dosage and time.
2. Remove and discard any ear packing.
3. Irrigate the ear if the tympanic membrane is intact.
4. Place the bottle of eardrops (with the top on tightly) in a bowl of warm water for 5 minutes.
5. Tilt the patient's head in the opposite direction of the affected ear and place the drops in the ear.
6. With the head tilted, gently move the head back and forth five times.
7. Insert a cotton ball into the opening of the ear canal to act as a packing.

## **Eyedrops**

1. Administer drugs at frequent, precise intervals. The timing of administration is critical. Patient's with eye problems are often given several broad spectrum antibiotics. If each drug is administered every hour, create separate dosage schedules. For example, give antibiotic A at 7:00, 8:00, 9:00 & 10:00. Then give antibiotic B at 7:30, 8:30, 9:30 & 10:30.
2. If two medications must be administered at the same time, separate the instillation by 5 minutes.
3. If the same medication is required for both eyes and one eye is infected, use separate bottles of medication.
4. Clearly label each bottle for the appropriate eye.
5. Wear gloves especially when ocular drainage is present.
6. Wash hands before & after administration.





SOUTHERN ADVENTIST UNIVERSITY  
SCHOOL OF NURSING

### Desired Skills

Name \_\_\_\_\_

ID# \_\_\_\_\_  
 \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 \_\_\_\_\_

L = Skills Lab

H = Hospital

Skill	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Handwashing - Medical															
Handwashing - Surgical															
Sterile Gloving															
Vital Signs BP P,R,T															
Crutch walking Swing Gait 2-Point 3-Point 4-Point															
Cane															
IM Injection Sites Deltoid Dorsal Gluteal Ventral Gluteal Vastus Lateralis															
Body Mechanics Class															
Moving patient up in bed, turning, etc.															
Transfer from bed to chair & back															

Skill	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Pillow pressure points															
Restraints in bed & wheelchair															
Making unoccupied bed															
Mitered corners															
Making occupied bed															
Bed bath															
Log rolling patient															
Enema															
Ostomy sizing & pouch changing															
Female catheterization															
Male catheterization															
NG insertion suction feeding															
Trach care cleaning suctioning															
CVC dressing change															
SimMan heart sounds bowel sounds lung sounds vital signs															
Ace bandage wraps															
TED hose application															
Pulse oximeter															

Skill	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Sterile dressings															
0 <sub>2</sub> equipment face mask nasal cannula															
Postmortem care															
Spiritual assessment															
Physical assessment															
Code															
Oral medication handling															
ProCalc															
PDR															
Mixing powders															
Opening ampules															
I & O															
Syringe sizes, types, needles, gauges															
Insulin syringes vs. intradermal															
Injection technique practice or giving injections															
IV setup & demonstration															
Start IV															
Vacupac & CBI															
Ear irrigations															
Eye drops															

Skill	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Fitness lab															
Health screening mammogram PAP smears prostate exams															
Phlebotomy															
Quizzes															

Notes:

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Skills Instructor's Signature \_\_\_\_\_

Hospital Clinical Instructor's Signature \_\_\_\_\_

Dana Krause, Skills Instructor  
 Lab Phone # 236-2969  
 Office Phone # 236-2964