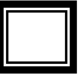


Physical Assessment—Pass Off

Student: ______________________________ Instructor: ____________________________

☐	=completed
◯	= not completed
■	= skipped back to complete

General Observations: Vital Signs☐ Mental Status☐ Measurements ☐ (done in advance)

Vision: Snellen or Rosenbaum☐ (done in advance and reported to lab instructor @ pass-off) **2 points**

Skin: (done throughout exam) inspect lesion/nevi/scars☐ temperature☐ turgor☐

Head: scalp☐ hair☐ nodules☐

Face: facial movements/ CN VII ☐ facial sensations/CN V☐ palpate muscles/CN V☐ temporal arteries☐

Eyes: eyebrows/eyelashes/eye lids☐ conjunctiva☐
corneal light reflex☐ pupils equal response direct/consensual to light & accommodation☐ EOMs ☐

Ears: external inspect/palpate☐ otoscope☐ **hearing**: whisper☐ Weber & Rinne☐

Nose: patency (& CN I) ☐ internal mucosa & nasal septum☐ tenderness☐ palpate or percuss sinuses☐

Mouth: lips☐ oral mucosa☐ teeth & gums☐ tongue m/l ☐ tongue movement/CNXII☐
"ah"/soft palate/uvula /CN X☐ tonsils/palatine arches☐ gag reflex/CN X☐

Neck: lymph nodes☐ trachea m/l☐ ROM☐ strength against resistance/CNXI ☐
shrug shoulders/CNXI ☐ carotid arteries☐

Thorax/posterior: inspection☐ symmetry☐ chest expansion☐ percuss☐ percuss CVA tenderness☐ auscultate☐
RML: auscultate ☐ **Anterior**: auscultate☐ (examiner requests deep breaths in & out through mouth before auscultating ☐)

Cardiovascular: pulsations/heaves/lifts☐ PMI☐ auscultate: sitting, diaphragm & bell☐ supine, diaphragm & bell☐)

Abdomen: inspect☐ auscultate BS/bruits☐ percuss (4 quads, liver) ☐ light palpate (tenderness) ☐
deep palpation (masses, liver, spleen)☐ (examiner requests knees flexed before palpation ☐)

Upper Ext: Inspect: arms/hands/fingers ☐ nail plate angle/curvature ☐ Palpate: capillary refill ☐ handgrip ☐ **Pulses**: radial ☐ brachial

Lower Ext:: Inspect: legs/feet/toes/nails☐ Palpate: capillary refill☐ edema☐ **Pedal Pulses:** dorsalis pedis☐ posterior tibial☐

Muscle strength: upper extremities ☐ lower extremities ☐

Sensory: light touch ☐ location/vibration ☐ sharp/dull ☐ proprioception ☐

Coordination: rapid alternating movements☐ heel to shin☐

Reflexes: biceps & triceps ☐ knee jerk & achilles ☐ plantar ☐

ROM: upper extremities (shoulders, elbow, wrist, hands, fingers) ☐ lower extremities (hips, knees, ankles, feet, toes) ☐ spine ☐

Ambulation/Gait/Balance: gait☐ Romberg☐

Spine: inspection☐ palpation☐ (points from Skin-Spine = 1 point/square, total 85 points) sub-**total** _____**/87**

Professional dress yes☐ no☐ **hand hygiene**: yes☐ **no☐ Equipment** yes☐ **no☐ & Pass-off form**: yes☐ **no☐ (1/2 point for each)**

Explains procedures to client: always☐ usually (2 points)☐ **sometimes ☐** (1 point)

Organized & follows general order: always☐ usually (skips back x1-2) ☐ (2 points) **sometimes (skips back 3) ☐** (1 point) >3 ☐ **(0 points)**

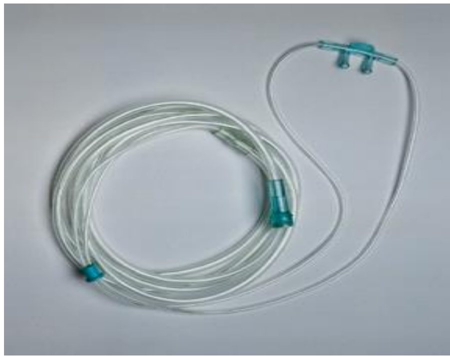
Refers to 3X5 card: end of exam only ☐ rarely (once during exam & once @ end) ☐ (2 points) **occasionally (2-3 during exam) ☐** (minus 1)
often (>3 during exam)☐ (minus 2 points)

Performs skills/techniques correctly: always☐ usually (1 incorrect) ☐ (3 points) **sometimes (2 techniques incorrect) ☐** (1 point)
≥ 3 techniques incorrect☐ (0 points)

Complete in ≤ 40 minutes (2 points) Required excessive time >40 minutes (0 points) ☐

start time___________ completion time______________

Comments/suggestions: Final Score _____**/100**



Nasal Cannula

- 1-6 LPM
- 25-45% oxygen
- Does not deliver humidified air

Simple Mask

- 6-12 LPM
- 35-60% oxygen

Non-rebreather Mask

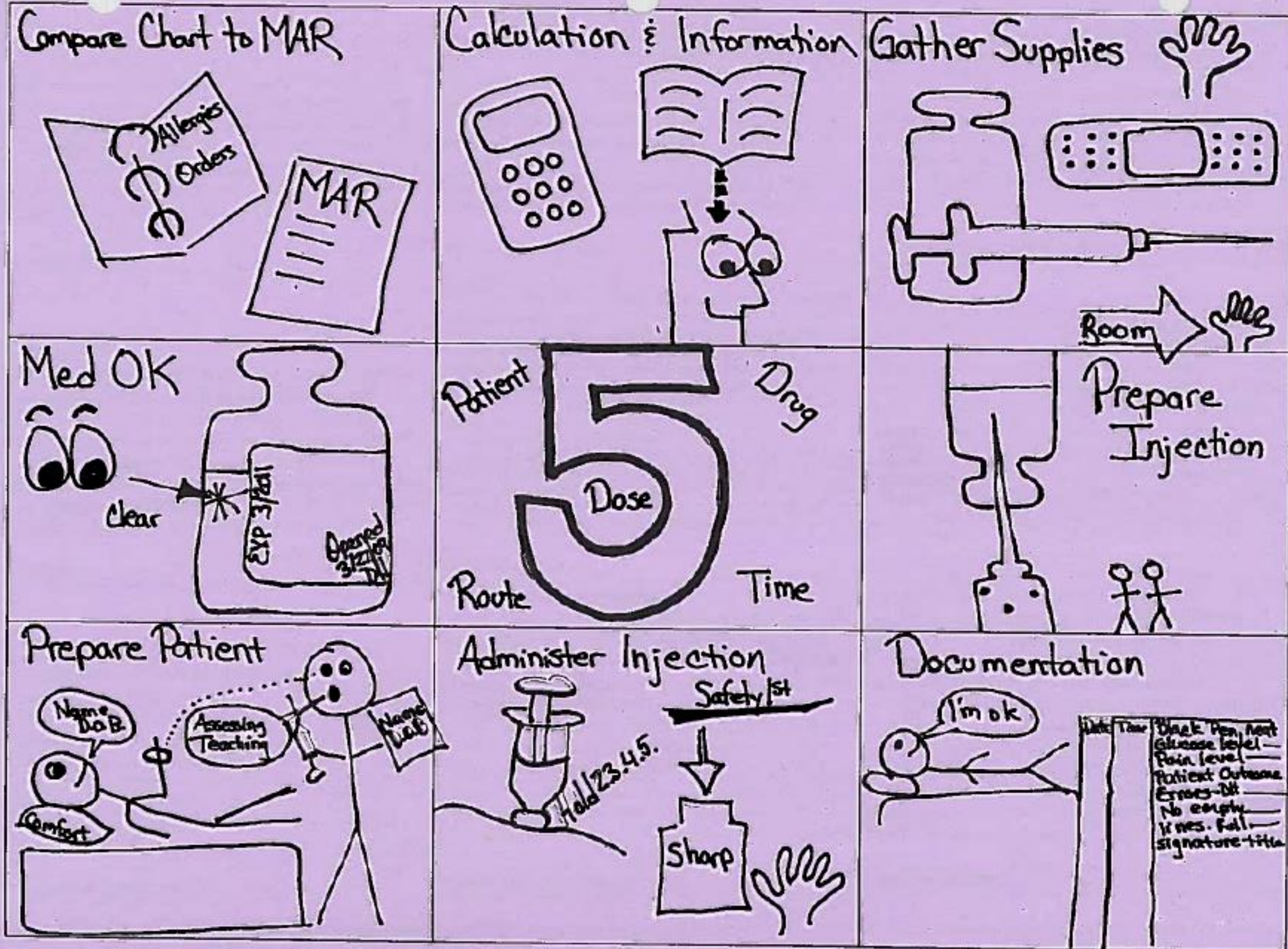
- 10-15 LPM
- Up to 90% oxygen

Venturi Mask

- Blue : 2 LPM, 24% oxygen
- Yellow: 4 LPM, 28% oxygen
- White: 6 LPM, 31% oxygen
- Green: 8 LPM, 35% oxygen
- Pink: 10 LPM, 40% oxygen
- Orange: 12 LPM, 50% oxygen

(colors may vary by manufacturer – read the attachment)

N295 Skills Lab: 9 Steps of Medication Administration



N 295 Skills Lab: 9 Steps of Medication Administration

Compare Chart to MAR

Usually at the start of the shift the RN will sit down with the chart to look at the actual orders and the patient's allergies and be sure that these match the MAR. The order is the highest level of data and the most accurate, sometimes errors in transcription occur when someone types up the MAR. If there is a discrepancy that cannot be resolved by looking back to the original order then the provider must be called to clarify. In our lab we won't do this step because of time constraints.

Calculation & Information

Nurses should have a working knowledge of all the drugs they administer. Often a quick check in the drug guide is needed. It is important to know if the ordered dose falls within the usual dose parameters, the side effects of the drug, and any special things that need to be assessed before administering the drug. The drug guide has a special section on administration that lets nurses know if a pill can be crushed, if one medication can be mixed with another, if the medication can be taken with meals etc. Nurses need to be especially careful when doing calculations. It is never a bad idea to have another nurse double check the calculation.

Gather Supplies

Thinking ahead about what supplies you will need saves a lot of time and steps. Before gathering your supplies perform hand hygiene. Be sure you have everything you need and then as always, perform hand hygiene on the way into the room. Medications are often prepared in the patient room and that is how we will practice. Some facilities are set up so that nurses prepare medications at a nurses station and then bring them to the room. Studies on medication errors have found that any time there is an extra transport of medication there is a chance for error. It is preferred to keep medications locked in the patient room when possible.

Med OK

A quick inspection to be sure the medication is suitable for injection involves three things. First, a general look at the solution. Be sure it is the appropriate color and there are no precipitates. Next, be sure the medication is not expired. Expiration dates often include just the year and month. Finally, a multi dose vial must be dated, timed, and initialed as it is opened. In our lab you are only allowed to inject from a vial that was opened on the same day

5 of the Rights

Even though you have already read the medication name and even though you have already calculated the dose there comes a time when you have to "do the rights" and double check everything from the MAR to the medication. The MAR must have all of this information, so if you start with the patient name and then go to the line of the med you want to give and just read everything, you won't miss a thing. It is important when looking at the drug to go to the highest level of information possible. For example, if the drug is in a bag, don't count as correct the information on the bag if that information is also on the drug label. Or, when giving an inhaler, actually take out the canister and look at the name of the drug on the inside, not just the name printed on the label. Stock OTC medications will not have all of the same information as the Rx meds. For example, a bottle of vitamin C used by the whole floor won't have your patient's name on it. In these cases you do the rights you can.

Prepare Injection

If you swab the vial before you do the rights then it should be dry by now. Don't forget to roll the vial to mix NPH insulin. Draw up the dose and get the air bubbles out. Don't forget to check the dose with another RN if needed. Different facilities have different policies. Many acute care settings require a double check with insulin and lovenox. If you need to waste any narcotic it must be wasted in front of another nurse and co-signed with the other nurse. Be sure you re-cap by scooping the lid with only one hand to take the syringe over to the bedside.

Prepare Patient

Explain to your patient what you are going to do. If you are giving insulin, tell them what the blood sugar was and how many units will be given. If you are giving a pain medication verify the pain level. Assist the client to a comfortable position. Look at the arm band and note the allergies. Have the patient state their name and date of birth and be sure this matches BOTH the arm band that you are reading as well as the MAR

Administer Injection

Wear gloves if needed. Find your site and inject as appropriate according to the injection method. Be sure to dart in quickly to decrease pain and avoid movement while the syringe is in the skin. Be sure to hold the syringe in place for 5-10 seconds before withdrawing it (immunizations are the exception). As soon as you withdraw the needle think "safety first" and deploy the safety, if a sharps container is immediately available then drop it in; if not you can set the syringe aside. If you need a bandaid use it. Help your patient to a comfortable position and ask how they did. Remove gloves and do hand hygiene.

Documentation (the 6th right)

Chart what you did. Remember some principles of charting include: begin each entry with date and time, use black pen, write neatly, if you don't go to the end of a line you started then draw a line through to the end so more can't be added later, if you make a mistake draw a line through it and initial it, always end with your full signature and title (SN-BYU), be sure the patients name is on every page you chart on, always document patient outcomes (e.g. "patient tolerated with minimal discomfort" or "tolerated well" or "verbalizes understanding of need to ask for prn pain med as pain increases."

Injections: Finding Your Site & Equipment

Site	Finding the right site	Needle Gauge	Needle Length	Insertion Angle	Max Fluid	Notes
ID **Intradermal**	Inner forearm, hairless site with light pigment and free of vessels or lesions. About 3 fingers down from inner crease of elbow is a good place.	TB syringe 25 to 27	TB syringe ¼ to 5/8	5-15 degrees	Very small 0.1 mL	**Don't put air in vial before drawing up.** Stretch skin, administer **bevel up**. Should see needle tip through skin. Inject very slowly. **No aspirating** Should feel resistance and see bleb appear. If bleb doesn't appear must do again. (this is not like a double dose) **Read TB test at 48 – 72 hours** Only count as positive areas of induration (thick or raised), not redness. Positive if > 15 mm for pts. with no risk; if. 10 mm for High Risk (recent immigrants, inj drug users, lab personnel, children <4, or children exposed to high risk adults), or if > 5mm for immunosuppressed (HIV, Organ transplants) or have evidence of previous TB infection on X-ray)
IM **Intramuscular Deltoid**	Lateral upper arm. Place 4 fingers across the deltoid muscle with first finger on the acromion process. This will give you a top border of about 2 inches below the acromion process. The lower border is the top of the axillae.	23 or 25	1 to 1.5 inch (may go down to ½ or 5/8 inch for very thin)	90 degrees	No more than 1 mL	Find site. Swab. Pull skin laterally approx 2.5 to 3.5 cm with ulnar side of hand to z-track. Dart needle in quickly up to hub. Continue holding skin pulled aside. **Aspirate**, if no blood inject slowly. **Wait 5-10 seconds**. Withdraw needle & deploy safety with one hand. Release z-track. Band-Aid, dispose of sharp. **For immunizations** (**no** aspiration, **no** z-track, **no** wait before withdrawal)
IM **Intramuscular ventrogluteal**	Pt. lies on side or back, flexing the knee and hip. If upper knee bends down towards the bed it is easier to find the Trochanter. Place heel of hand over greater Trochanter using right hand for left hip. Wrist should be perpendicular to the femur. Point thumb toward groin, Middle finger extends back along the iliac crest towards the buttock. The index finger points towards the anterior superior iliac spine. The index finger, the middle finger and the iliac crest form a V-shaped triangle. Feel for a thick muscle area in the middle. The injection site is in the center of the triangle	21 or 22	1.5 inch if obese 3 inch	90 degrees	2-3 mL Children & older adults no more than 2 mL infants no more than 0.5 mL	Same as above: Note z-track is used especially for medications that are very irritating to the tissue or may stain the tissue. Some people advocate z-tracking all medications. The only medication that should not be z-tracked is immunizations. Immunizations are to be given quickly. The CDC has determined that if some small amount of immunizations went IV vs. IM it would not be a problem, so no need to aspirate either. Immunizations are often given to wiggly children.
IM **Intramuscular Vastus Lateralis**	Pt. sit or lay on back. Use middle third of the muscle. Inject between the midline of the anterior leg and the midline of the lateral leg. Palpate the muscle mass	21 or 22	1 to 1.5inch	90 degrees	2-3 mL	Same as above
SQ **Subcutaneous Posterior Upper Arm**	Pt. can sit or lay down. Back of arm in the middle, grasp the fleshy part.	27 to 25 Ga (insulin is #26-31 gauge)	½ to 5/8 inch Can select by pinching tissue at site and select needle that is half the width of the skin fold	45 to 90 degrees	0.5 to 1 mL	**Pinch or spread** skin at site. Inject needle quickly and firmly at **45 to 90-degree angle**. Then release skin before injecting if pinched. General rule: if you can grasp 2 inches of tissue, insert the angle at 90 degrees, if you can grasp one inch insert at 45 degrees. You can be sure muscle is not in your pinch by asking pt. to flex and extend the elbow. If muscle is in your pinch you will feel it and need to try again**. Do NOT need to aspirate.** Inject and **wait 5-10 seconds** before withdrawing needle.
SQ **Subcutaneous Abdomen**	At least 2 inches away from umbilicus. Not into any vessels or lesions.	27 to 25 Ga		90 degrees	0.5 to 1 mL	Same as above: It is preferred that Lovenox be injected in abdomen only. If using pre-filled syringe for Lovenox **do not expel air bubble** before administering and **hold the pinch**.

Updated 3/4/13 Deborah Himes

Medication Administration Student Name ____________________________ Scenario: _________ Total Minutes: __________

Step By Step Appropriate Actions	General Steps	Pts	Pts off	Point Deductions & Notes
-Compare orders & allergies from the chart to MAR -Be sure med is not contraindicated due to allergies or other reasons -Know what the drug is, and why it is needed, look up if necessary	Order & Allergy Verification			(This is not done in lab as we don't have charts and time. But you will do this in practice)
-Calculate the Required Dose • Double check with another RN if needed -Take time here to look up the drugs in the drug guide for information.	**Calculation & Information**	4		-4 comes up with incorrect dose -2 needs hint on calculation
- Hand Hygiene -Gather Supplies - MAR, drug, needle & syringe, alcohol prep, gauze, band-aid, & PPE (if needed) • Will need to know volume to be injected to determine which IM site can be used • Will need to be sure the needle is the right gauge and length for the injection • Will need to choose a syringe that accurately measures the dose to be given	**Gathering Supplies**	2		-1selects incorrect needle length for injection -1 selects incorrect needle gauge for injection -1 selects syringe that cannot accurately measure dose to be given -0.5 leaves supplies behind, has to go back -other
During the pass off you do the calculation and gathering supplies before your TA comes to observe. At this point in the scenario you are at the bedside and all of the following will be observed by the TA, you will have 15 minutes to complete the next steps.				
-Hand Hygiene Check Expiration Date of Medication; printed on bottle -Note date vial was opened; the handwritten date (in lab we use only vials opened today) ○ If a new vial, date, time and initial the bottle -Look at Vial Solution (color/ Clarity) **(note, you can swab the vial top here before doing the "Rights" so that it has more time to dry-)**	**Be sure medication is suitable for injection**	2		-1 doesn't perform hand hygiene (must state all these things out loud for pass off) -1 does not note (out loud) expiration date on vial/ carpuject -1 does not note date vial opened (all injections in NLC to be from vials opened on date of administration) -1 does not note solution color & clarity (out loud)
-Compare data from MAR to the drug (YOU HAVE TO ACTUALLY READ BOTH) • Patient Name (not always on the vials – may have to look at bag) • Drug (read the pretend "med name" but also read "0.9% NaCl for injection") Must read this one from the actual drug you are going to give (not the baggie) • Dose (not always on the vials – may have to look at bag) • Route (not always on the vials, but be sure your med is ok for injection via the route you are planning on using) • Date & Time Due (not always on the vials – may have to look at bag)	**5 of the Rights**	3		Reads out loud each of the "rights" on the MAR AND THE DRUG and states out loud. -1 doesn't state patient name -1 doesn't state "drug" name and 0.9% NaCl for injection -1 doesn't state dose (example: "25 mg, so I'll need to draw up one mL" -1 doesn't state route -1 doesn't state date and time due
-Prepare the Injection • Swab top of vial ○ If NPH insulin roll vial to re-suspend • Wait until dry • Inject air • Pull back dose • Remove bubbles ○ If insulin check dose with another RN • One handed re-cap ○ Do not let needle touch unclean objects/ counter • If needed waste narcotic in the sink. Have another RN (the lab instructor) witness the waste. • Document use of narcotic in narcotic book and have another RN co-sign the waste.	**Preparing the Injection**	5		-2 doesn't swab vial (or needs reminding – about to stick needle in without swabbing) -2 doesn't roll NPH to re-suspend -1 doesn't wait until vial dry to inject air -1 doesn't inject air -3 pulls up incorrect dose -1 doesn't check insulin dose with another RN -3 doesn't notice a bent needle and get new syringe/ needle without prompting -2 re-caps with two hands -3 lets needle touch counter/ other objects -1 doesn't waste properly/ down sink (puts carpuject in sharps with narcotic in it, or throws in trash with narcotic in it). -1 doesn't document in narcotic book and have waste co-signed if needed at this point (don't wait until end of the scenario)
-Hand Hygiene -Provide patient privacy -Explain procedure to patient • Here you would tell a patient what their glucose level was and how much insulin they will get, for insulin based on CHO counting confirm what they plan to eat; ask about pain level for pain meds, and tell them what other medication they are getting and why. -Double Indentify patient:	**Prepare patient**	3		-0.5 leaves something behind, has to go back -0.5 doesn't provide patient privacy -1 doesn't perform hand hygiene -2 doesn't have client state name and birthday -2 doesn't compare the stated information with the MAR -0.5 doesn't make a verbal note of allergies -1 doesn't explain the procedure to patient

• Check arm band ○ Note allergies ○ Have client state name and birthday ○ Compare name and birthday to MAR -Assist patient to comfortable position				-1 patient not positioned well -0.5 doesn't check pain level with patient
-Put on gloves (if desired or policy) -Find injection site (state out loud how you are finding it for pass off) -Swab site -Administer injection • Use correct angle of insertion for injection type • Aspirate for IM (except immunization) • No aspiration for SQ • Release the pinch for SQ • Minimal movement of needle while in tissue • Don't let go of z-track while in the muscle (no z-track for immunization) • Hold before withdrawing needle (except for immunization) -Immediately deploy safety on needle • One handed is best; ok to use two as long as both stay behind the needle at all times; if administering with carpuject immediately empties into sharps container. -Apply pressure with gauze if needed (If you do not have gloves on, do not put your finger right over gauze to soak up blood. The blood goes through the gauze.) -Apply band-aid if needed -Help patient back to comfortable position/ assess how patient did (tolerate ok?) -Discard syringe in sharps container -Remove gloves (if on) -Hand hygiene	**Administer Injection**	15		-4 doesn't display correct site selection (notes out loud landmarks and distances – ok to need to be asked to state out loud) -2 doesn't pinch or spread skin for SQ injection -2 doesn't release pinched or spread skin after needle inserted on SQ -2 doesn't use correct angle of insertion -2 doesn't position bevel up (or needs reminding) on intradermal -2 doesn't prep site with alcohol prep (or needs reminding) -2 doesn't use a smooth quick darting action or go all the way to the hub -2 doesn't aspirate on IM injection (except immunization) -2 does aspirate on a SQ injection -2 doesn't hold z-track until needle removed if z-track is ordered -2 too much needle movement while in tissue -2 injects too rapidly or too slowly (about 1 mL/ 10 sec) -2 doesn't hold in place for 5-10 seconds after injection (except immunization) -2 doesn't immediately protect sharp -2 uses a risky 2 handed method to protect sharp -2 doesn't put sharp in sharp's container -2 doesn't perform hand hygiene after procedure -1 doesn't check on how the patient is doing
Your 15 minutes of time ends here. The next section "documentation" is done independently. The TA will go on to observe the next student at this point.				
Documentation (nurses notes) -Writing is in black pen, neat and legible - Notes: Date, Time, Pt Name, Drug name, dose (in mg or units NOT in mL), route, location of injection site. -Notes patient outcome (toleration/ understanding) -Student signature and title -No empty lines -No "do not use" items ("u" for units; trailing zeros (5.0); naked decimals (.25) -Notes glucose level for insulin & pain level/ location for pain meds. -Any errors that occur are corrected with a single line through the mistake and initial -Documents narcotic use in the narcotic book with countersigned waste if needed. (this is done at the time of preparing the injection, the score is down here though)	**Documentation** (the 6th right) On Nurses Notes On pass off his will be free text documentation on nurse's notes. This won't be simply putting initials in a box on the MAR…	3		-0.5 not in black pen -0.5 not neat and legible -0.5 empty part of lines that have been used -1 missing patient name -1 missing date -1 missing time -1 missing drug name -1 missing dose (in mg or units NOT in mL) -1 missing route (IM, subcutaneous, ID) -1 missing location of injection site -0.5 missing patient outcome (toleration or understanding) -1 missing student signature or title -0.5 corrections are scribbled out or not initialed with a single line -0.5 pain med does not have notation of pain level -0.5 insulin does not have notation of glucose level -0.5 a "do not use" item was used: ("u" for units; trailing zeros (5.0); naked decimals (.25) -1 doesn't document in narcotic book at all -1 documents in mL in narcotic book instead of mg -1 doesn't sign narcotic waste with second RN -1 doesn't fill out MAR completely/ correctly.
Completes Pass-off in 15 min (time of TA observation) - Start Time: __________ Finish Time: ____________ Total Time:	Timely Pass Off	3		-1 for every minute over 15 min (scenario is considered finished with injection) documentation does not count in time.)
Staple together the documentation/ critical thinking questions/ the narcotic sheet if there is one, the MAR and the scratch paper				**Total of 40 ______**

Sterile Dressing Change: Student Name _______________________________ Start Time: __________ Finish Time:

Step By Step Appropriate Actions Dressing Change	Category	Pts	Point Deductions & Notes
-Compare orders & allergies to MAR -Be sure not allergic to any substances in the dressing change (irrigant, latex, tape etc.)	Review Orders & Allergies		
-Hand Hygiene at nurses station and gather supplies • Sterile Gloves 4x4 tub 4x4 • Sterile Saline Red Bag Sterile q-tips (2) • ABD dressing 30 mL syringe Angiocath • Tape black pen PPE (if needed)	**Gather Supplies & Bring to Room**	2	(-1) no hand hygiene before gathering supplies (-1) skips items and has to go back
Hand Hygiene upon room entry	**Hand Hygiene**	1	(-1) no hand hygiene upon room entry
Assesses readiness/ pain & explains to patient what is going to happen and what is needed from the patient.	**Assess & Explain to client**	1	(-.5) doesn't check on pain or for readiness (-.5) doesn't explain what is expected from patient
Have patient state name and DOB, compare to MAR or order	**Right Patient**	1	(-1) doesn't double identify patient or doesn't look at wrist band and order
Don PPE (needs gown & gloves, as well as mask & goggles (or face shield)	**Don PPE**	1	(-1) all PPE needed not put on, or put on in wrong order (gown, mask, goggles, gloves)
Pull curtain/ close door Position client with pillows (will need to be propped for direction of irrigation flow) Place Chux to protect linen from irrigation Position Bedside tray & trash can in good position for working with sterile field • Think about where on the tray things should be positioned (e.g. do you want your wet stuff dripping across the dry stuff on your way to packing the wound?) Position disposable red biohazard bag (cuff the edges)	**Set up for dressing change**	1	(-.5) misses any of the things to the left – up to max of 1 point off (-.5) Leaves trash can in a position where will not be able to drop things in freely without turning back on field or dropping hand below field)
Remove tape (pull parallel to skin) Remove Secondary dressing (taking note of what was removed and drainage present) Remove packing (taking note of how much packing was removed and drainage color, odor, amount) Put folded dressing in bag	**Remove old dressing & note drainage**	2	(-1) contaminates other areas with soiled dressings (-1) doesn't note drainage on the old dressing
Assess wound edges for blanching and thickness Use q-tip to check depth, width, length Assess for false base, tunneling or undermining State out loud what you are looking at (wound base, edges, surrounding skin) Remove gloves and perform hand hygiene	**Assess wound**	3	(-1) skips length, width or depth (out loud) (-1) doesn't probe for false base, tunneling or undermining (out loud) (-1) doesn't assess wound base, edges and surrounding skin (out loud) (-1) doesn't perform hand hygiene after removing old dressing
Getting ready to set up sterile field. Will need to prepare anything that cannot be touched with sterile gloves. Specific order setting these things up is not important. Be sure things such as bedside tray and trash can are in final position. Be sure there is a measuring tape out/ in place for wound assessment. • Lays out tape • Opens 4x4 tub • Pours in sterile solution ○ Checks solution type/ expiration (out loud) ○ Palms the label & Pours off a bit into trash (keeping above waist level) ○ Does not contaminate the lid Open sterile gloves and use the glove wrapper to create a sterile field. Drops onto the field: • Syringe & angiocath, Q-tips & 4x4s • ABD drsg. (may leave off field, since applying with clean hands later)	**Lays out supplies/ begin sterile field set up that is done with clean hands**	5	(-1) Bedside tray left in a position where will have to turn back to sterile field during dressing change. (-1) Doesn't note out loud the name of the sterile solution (-1) doesn't note out loud the expiration date and date opened on the solution. *(Any breeches of sterile field in this section to be addressed in "Sterile Technique" section below.)*
Confidently dons sterile gloves without touching outside and preserving glove wrapper as sterile field Place things where they will be convenient to use and safely away from edges.	**Don Sterile Gloves & Arrange sterile field**	1	(-1) awkward or slow with donning sterile gloves *(Any breeches in sterile technique marked below)*
Set up syringe with catheter and irrigate directly into wound/ not across skin first Should drain from least contaminated to most (inside of wound to out)	**Irrigate Wound**	2	(-1) Doesn't protect needle immediately after taking angiocath off (-1) Irrigant goes across skin before going into wound
Clean base of wound from center outward with wrung out gauze. Use new gauze to clean surrounding skin, from wound margins outward	**Clean Wound**	2	(-1) doesn't clean from base of wound out (-1) doesn't clean outward on skin
Pack wound with wrung out gauze (should be moist, not sopping; should not go over dry intact skin) Secondary dressing 4 x 4 s (2)	**Apply New Dressing**	3	(-1) any granulation tissue is still showing (won't be moist) (-1) wound is packed too tightly (tissue will be compressed) (-1) moist gauze over intact skin (will macerate the intact skin)

Your hands have just been in a wound. You don't want those organisms all over the outside of the dressing that will be in contact with gown and bedding? • Remove Gloves (can do hand hygiene here if sanitizer is right at bedside) • Apply abd pad (touch outside only) • Apply tape (so much easier without gloves – don't touch a roll of tape with unclean hands) • Initial, date, time written on the dressing with pen (don't touch that pen with unclean hands)	**Top off Dressing**	3	(-1) touches inside of ABD pad (-1) touches a whole roll of tape with unclean hands (-1) touches a pen with unclean hands (-1) forgets to date, time, initial the dressing
Clean up: anything with body fluids/ exudate in red bag (e.g. chux), paper stuff can go in regular trash. Help patient to comfortable/ safe position/ check patient response Hand hygiene again on way out of room.	**Clean up/ patient response/ patient safety**	3	(-1) leaves bed in high position or upper side rails down (-1) touches inside of red bag (-1) doesn't check on patient response (-1) doesn't clean up trash/ leave patient in comfortable position (-1) doesn't hand hygiene on way out of room
Sterile Technique –write in misses in boxes to right…			
Students can lose up to 20 points on sterile technique. May have three free "strikes" before they start to count at 1 point each. For a strike to be "free" the student has to catch it his or herself, and has to tell what he or she would do to correct the situation.	**Free Strikes:** #1 #2 #3		
• Forgets to do a "clean set-up" technique before applying sterile gloves • Tears a packet setting up field • Something rolls, or flips off the field or past the one inch margin • Sterile gloves become contaminated • Reaches across sterile field • Drops hands below waist • Turns back on sterile field • Contaminates field with water • Contaminates irrigant (lid face down/ doesn't pour off over lip before using)	**One Point off Strikes:**		
• Date, Time, Pt Name • Names event: "Sterile wet to moist dressing change of abdomen" • Dressings removed (type & amount) with exudates noted (quantity, color, odor, thickness) • Measurement of wound: Length, width, depth • Description of wound base (color or tissue type by percent, tunneling, undermining) • Irrigation performed (solution, amount, equipment) • Description of wound borders (measurements of color, thickness, temperature, blanching) • Description of cleaning wound base and surrounding skin with gauze • Materials used for packing/ dressing • Notes patient outcome (toleration of procedure / understanding of any teaching) • Writing is in black pen, neat and legible • No empty ends of lines that were started • Errors corrected with a single line and initial • Signed with student name and title (SN-BYU)	**Document**	6	Take 0.5 points for any single item missing to the left, **with a max of up to one point for any single bullet point.** **Sample Charting** 1/5/09 1400: Sterile wet to moist dressing change midline abdominal wound: states pain at "3" before procedure. Removed: abd pad (dry), 2 - 4x4 gauze pads (4 cm spot serosanguineous drainage – no odor) and packing (4 - 4x4s still moist, serosanguineous drainage throughout, no odor). Wound irrigated /c 30 mL NS using 20 ga angiocath. Approx 1 cm slough tissue removed. Wound 3 cm wide x 14 cm long x 3.5 cm deep. Uniform depth throughout, no tunneling or undermining. Base 100% red granulation tissue post irrigation. Wound edges: pink, blanchable, non-edematous, warmer than surrounding skin (to 1 cm out from wound), beyond that, skin is natural color and temperature, blanchable. Some pink areas where tape has been, but skin intact. Wound packed with 4 – 4x4 gauze moist with NS, covered with 2 – 4x4 and reinforced with abd pad. JP #1 serous fluid 20 mL; emptied and stripped. JP #2 with serosanguineous fluid 40 mL emptied and stripped. Pain "6" during irrigation, removal old packing. Otherwise states "it was ok" rating pain as "4" at end of procedure. States "anxious to get the drains pulled." Positioned R side. SR up x2, bed low position. D. Himes SN-BYU
Completes Pass-off in 15 min	**Timely Pass Off**	3	-1 for every minute over 15 min: Scenario starts after supplies are gathered and finished when abd dressing is set down, even though student still has to clean up. At this point TA does not need to watch sterile technique, brings next student in to begin gathering supplies.

Total of 40 ______

Foley Removal & Insertion: Student Name ______________________________ Total Time: __________

Step By Step Appropriate Actions Dressing Change	Category	Pts	Point Deductions & Notes
-Look at orders for order to insert catheter and FR -Compare to MAR -Check Allergies If allergic to latex, check for latex in products to be used. If allergic to betadine (mannequins can never have betadine, it stains them so they are "allergic")	**Review Orders**	1	(-.5) doesn't look at orders for insertion order (-.5) doesn't double check allergies
-Hand Hygiene at nurses station and gather supplies • Foley Insertion Kit • An extra pack of sterile gloves if needed • Syringe for removal • Washcloth or Towel for removal • Towel or bath blanket for draping patient legs • PPE (if needed) • **Identify patient (look @ wrist band, pt states name, DOB- compare to order or MAR)**	**Gather Supplies & Bring to Room**	1	(-.5) no hand hygiene before gathering supplies (-.5) skips items and has to go back (-.5) doesn't assure is the right patient
Hand Hygiene upon room entry	**Hand Hygiene**	1	(-1) no hand hygiene upon room entry
Assesses readiness & explains to patient what is going to happen and what is needed from the patient.	**Explain to client**	1	(-1) doesn't explain procedure to patient
Pull curtain/ close door Position Bedside tray, garbage can, bag for linen close by Don clean gloves Empty urine from foley bag if needed Raise Bed & Position/drape client (side rail down on working side, chux underneath, drape) Remove tape or leg band, place towel (if tape, can be good to remove the tape before donning gloves) Note on the port # of mL that should be in balloon (out loud), withdraw solution from catheter balloon with syringe Give warning about to remove the catheter Pull out smoothly and quickly, catch end of catheter with towel Discard bag & tubing in trash Remove Gloves Hand Hygiene	**Remove indwelling catheter**	8	(-1) does not ensure privacy (-1) does not position supplies within reach of where they will be needed (-1) does not measure and empty urine before removal (-1) does not apply clean gloves for removal (-1) does not raise bed to good working level (-1) does not position pt well (chux, drape, legs) **(-3)** attempts to pull out catheter without removing sterile water (-1) does not double check appropriate number of mL have been removed (-1) does not give patient warning that catheter is about to be pulled, eg:"ok this will sting a little, take a deep breath, 1,2,3" (-1) sets bag and tubing anywhere else other than trash (-1) touches things in room (self, linens, side rails) with contaminated gloves (-1) doesn't do hand hygiene after glove removal
Cuff outer bag of cath kit and place within reach of work area for disposal of used supplies Open cath kit, pulling first corner away from self Place sterile underpad Apply Sterile Gloves Organize supplies on the tray:, remove plastic from catheter, attach syringe to balloon port, moisten cotton balls with antiseptic solution, lubricate catheter tip (1-2 inches women, 5-7 inches men) Apply fenestrated drape if desired	**Set up Sterile Field for inserting new catheter**	8	(-1) bag for trash not placed well (greater chance of contaminating hands while discarding supplies) (-1) awkward or slow donning of sterile gloves. (-1) lays out supplies in a way that catheter is not secure and tends to flip out of the package (-1) does not adequately lubricate the catheter tip (-1) does not put antiseptic solution on cotton balls. (-1) forgets to attach syringe to balloon port tightly before beginning cleaning. (-1) holds catheter too far back so that tip flops around increasing risk of contamination ***(Any breeches of sterile field in this section to be addressed in "Sterile Technique" section below.)***
Clean Urethra • Men: meatus out / Women meatus out **and** front to back ○ Maintains position of non-dominant hand holding skin throughout procedure **Insert Catheter** • Hold catheter in sterile hand 3-4 inches from the tip (holding too far back allows the catheter to be floppy) • Control catheter tubing by coiling into dominant hand • Insert catheter into meatus watching for urine to come into the catheter tube. • Advance catheter 1-2 inches further after urine in tube	**Insert new catheter**	10	(-2) cleans meatus with gauze that has already gone across other skin. (-1) allows non-dominant hand to lose hold of skin while cleaning. (-1) does not secure catheter tubing in dominant hand so that it won't flop around while inserting. (-2) does not advance catheter 1-2 inches past first sign of urine in tube (-1) syringe pops off while inflating balloon (-1) does not hold catheter securely while filling balloon (-1) does not fill balloon to appropriate # of mL (-1) does not remove gloves before touching leg/ bag/ side rail (-1) does not do hand hygiene after removing gloves

○ Men usually 7-9 inches (up to hub)/ Women usually 2-3 inches total **Fill Balloon with Sterile water** • Hold catheter securely with non-dominant hand while inflating balloon. (catheter will start to slip out if not secured) • Correct number of mL listed on balloon port – puts in this much sterile water • Stop filling if pain voiced, deflate and insert further before attempting fill again • Once balloon is inflated to proper mL/ gently pull back until resistance is met • If male patient with foreskin, replace foreskin • Remove gloves & perform hand hygiene	**Insert new catheter (cont.)**		***(Any breeches of sterile field in this section to be addressed in "Sterile Technique" section below.)***
Attach tubing to leg with leg band or tape Place bag on bed frame below level of the bladder (never on side rail)Position patient for comfort Put patient in comfortable/ safe position Assess how patient did/ is doing Clean up	**Finish Up**	2	(-.5) leaves bed in high position (-.5) doesn't put pt back in comfortable position (-.5) leaves pt sitting in a wet chux (-.5) doesn't ask pt how they did (-.5) leaves supplies/ trash around (-1) places bag on side rail (vs. bed frame) (-.5) doesn't attach tubing to leg
Sterile Technique –write in misses in boxes to right…			
Students can lose up to 20 points on sterile technique. May have three free "strikes" before they start to count at 1 point each. For a strike to be "free" the student has to catch it his or herself, and has to tell what he or she would do to correct the situation.	**Free Strikes (student must catch the mistake themselves for it to be free):** #1 #2 #3		
• Forgets to do a "clean set-up" technique before applying sterile gloves • Tears a packet setting up field • Something rolls, or flips off the field or past the one inch margin • Sterile gloves become contaminated • Reaches across sterile field • Drops hands below waist • Turns back on sterile field • Contaminates field with water	**One Point off Strikes (anything student doesn't catch or beyond the three):**		
• Patient Name is on page • Each entry is marked with Date and Time • Each entry is signed with student name and title • Calls to provider list what nurse told provider (situation, background, assessment, recommendations) and orders/ instructions received. • Telephone Orders are signed: provider name & title/ nurse name & title • Names event: "Change indwelling urinary catheter," or, "removal of indwelling urinary catheter," or "insertion of indwelling urine catheter" • RC removal comments on volume, color and character of urine emptied (eg: 220 mL urine, pale, yellow, with sediment/ or/ 150 mL urine, pink with blood clots/ or/ 160 mL urine, dark amber, clear), volume of solution removed from balloon and patient toleration of procedure • RC insertion comments on FR of catheter, number of mL to fill balloon, sterile technique used, return of urine (amount/ color/ character) patient toleration. • Writing is in black pen, neat and legible • No empty ends of lines that were started (draw line to end) • Errors corrected with a single line and initial	**Document**	5	**Take 0.5 points for any single item missing to the left, with a max of up to one point for any single bullet point. Students should know how to chart both nurse's notes and prescriber orders.** **EXAMPLE CHARTING:** **NURSES NOTES:** *2/3/12 0100: removal of RC: Emptied 200 mL clear yellow urine in bag. Withdrew 5 mL solution from balloon. Removed RC without difficulty. Pt tolerated well with some mild stinging. John Whitaker SN BYU --* *2/3/12 0800: telephoned Dr. Saunders, notified patient has not voided since RC removed 6 hours ago, pt c/o full bladder sensation, bladder is full and tender to palpation, pt has tried voiding with running warm water over perineum, no results. Suspect urinary retention and requested order for new RC placement. Dr. Saunders ordered new 14 FR urinary catheter placed. Sally Stevens SN BYU--* *2/3/12 0830: Insertion 14 FR urinary catheter via sterile technique. Filled balloon with 10 mL sterile water. 250 mL of pink urine with small 2-3 mm clots out immediately. Pt reports bladder feels "much better." Bladder not distended or tender to palpation anymore. Tolerated with mild discomfort. Sally Stevens SN BYU --* **ORDERS:** *2/3/12 08:00 Insert foley catheter 14 fr. TO: Dr Saunders/ Sally Stevens SN-BYU--------------*
Completes Pass-off in 15 min	**Timely Pass Off**	3	(-1) for every minute over 15 min (timer starts when does hand hygiene at bedside, is considered finished when balloon is filled)

Total of 40 ______

Applying a Condom Catheter

See Potter and Perry, Fundamentals of Nursing,

8th Edition, pages 1064-1065

Notes for GI Lab

Enemas that work by stretching the colon:	Enema that work by irritating the colon:	Enema that work by lubricating the colon:
Tap Water Enema • Hypotonic – water is pulled into interstitial space • Infused volume stretches bowel and stimulates defecation • DO NOT REPEAT d/t risk of water toxicity • Retain as long as able Normal Saline • Isotonic • The volume stimulates peristalsis • No risk of excess fluid absorption Hypertonic Solutions (e.g. Fleets) • Pull fluid from interstitial space • Colon fills with fluid – distention promotes defecation. • Usually only need 4-6 ounces	Soap Suds Enema • Only pure castile soap is safe • Harsh soaps/ detergents can cause serious bowel inflammation	Oil Retention Enema • Feces absorb the oil & become softer • Client should retain for several hours if possible

	Adult	Adolescent	Child
Enema Volume	750 to 1000 mL	500 to 750 mL	300 to 500 mL
Insert lubricated rectal tube	3-4 inches	3-4 inches	2-3 inches

Sim's Position
- Left side-lying with right knee flexed
- The preferred position for enema administration
- Rotate after administration

Enema's until clear
- Administer enemas until fluid comes out with no fecal material
- Don't do more than 3 without notifying provider
- Can deplete fluids and electrolytes

Digital Removal of Stool
- Breaking up and removing fecal mass with fingers
- Can stimulate the vagal nerve causing bradycardia
- Requires an order (rectal exam for fecal impaction does not require order

Raise height of enema container above rectum
- Low enema: 3 inches
- Regular enema: 12 inches
- High enema: 12-18 inches

Contraindications for enemas
- Increased intracranial pressure
- Glaucoma
- Recent rectal or prostate surgery

Unexpected Outcomes & Interventions:

Abdomen becomes rigid/ distended
- Stop the enema if going
- Get vitals
- Notify health care provider

Abdominal pain or cramping
- Slow rate of instillation (by lowering bag or slowing rate of squeeze)

Bleeding occurs
- Stop the enema
- Get vitals
- Notify health care provider

Failure to defecate after enema
- Assess patient
- Notify health care provider

Documentation
- Type & Volume of enema
- Characteristics of results
- Patient reaction

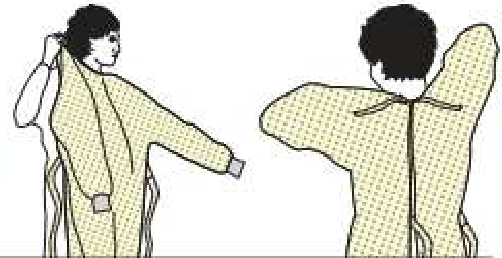
STOMA CARE
- Done before a meal
- Clean with tap water only/ no soap
- Opening should be cut to 1/6 inch larger than stoma

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

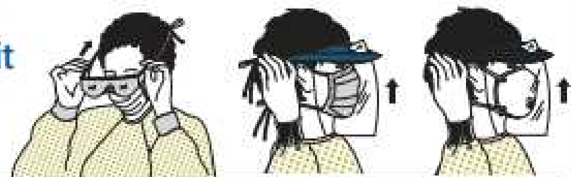


2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

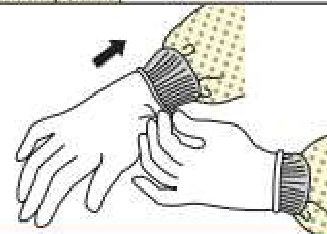
3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

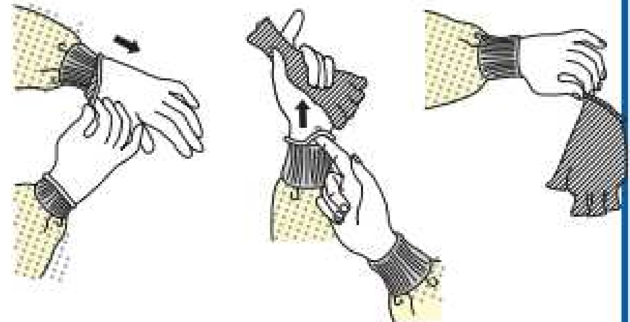
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES

- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glovet
- Discard gloves in waste container

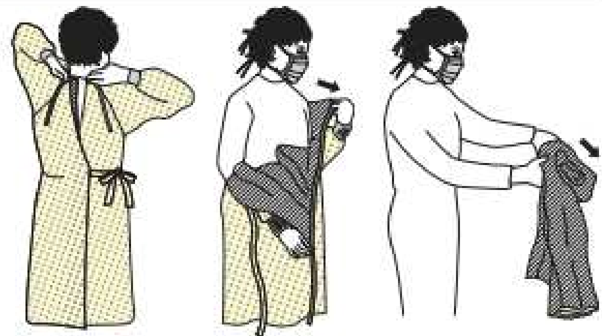


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

3. GOWN

- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard



4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CS250672-A