

Infection Control

Performance Checklist

UNIT ONE Basic Medical Asepsis

UNIT ASSESSMENT

- Assessed method of handwashing most appropriate for task.
- Identified clients at risk for infection.
- Assessed availability of equipment for frequent handwashing.
- Evaluated health status of nurse.
- Checked agency policy for handwashing protocol.
- Assessed need for use of clean gloves.
- Assessed nurses and clients for latex allergies.
- Assessed need for latex-free equipment.

HANDWASHING (MEDICAL ASEPSIS)

Procedure

1. Stood in front of but away from sink.
2. Ensured paper towel was hanging down from dispenser.
3. Turned on water faucet so that flow was adequate, but not splashing.
4. Adjusted temperature to warm.
5. Wet hands under running water.
6. Placed a small amount, one to two teaspoons, of liquid soap on hands. Thoroughly distributed over hands. Soap came from a dispenser, not bar soap.
7. Rubbed vigorously, using a firm, circular motion, while keeping fingers pointed down, lower than wrists. Started with each finger, then between fingers, then palm and back of hand.

Performed Mastered
yes no

Performed yes	Mastered no

MANAGING LATEX ALLERGIES

Procedure

1. Assessed clients and staff with allergies to avocados, bananas, kiwifruit, or chestnuts.
2. Recognized symptoms of latex allergy.
 - a. Contact dermatitis.
 - b. Type IV.
 - c. Type I.
3. Replaced latex-containing products (especially gloves) with nonlatex alternatives.
4. Obtained latex-free cart when a client is identified as having a latex allergy.
 - a. Placed cart inside client's room.
 - b. Checked that cart is supplied with appropriate equipment.
5. Ensured anaphylaxis medication is available for both clients and staff if latex allergy is suspected.

	Performed		Mastered
	yes	no	

DONNING PROTECTIVE GEAR UTILIZING STANDARD PRECAUTIONS

Procedure

1. Washed hands using nonanti-microbial soap and dried.
2. Put on gown by placing one arm at a time through sleeves. Wrapped gown around body to cover clothing completely.
3. Tied waist ties in front.
4. Tied gown at neck or attached Velcro strap to gown.
5. Donned mask.
6. Donned protective eyewear.
7. Donned disposable gloves.

	Performed		Mastered
	yes	no	

EXITING A CLIENT'S ROOM UTILIZING STANDARD PRECAUTIONS

Procedure

1. Untied string of gown at waist.
2. Removed glove first by turning it inside out, placed rolled-up glove in second hand, removed second glove by slipping one finger under glove edge and pulled it off. Disposed of them in garbage.
3. Untied gown at neck.
4. Took off gown by pulling down from shoulders, turned gown inside out, and then pulled arms out of gown.
5. Disposed of gown in linen hamper or, if disposable, in garbage.
6. Removed protective eyewear.

UNIT TWO Standard Precautions

UNIT ASSESSMENT

- Assessed skin integrity.
- Assessed for presence of drainage from lesion or body cavity.
- Assessed for ability to deal with oral secretions.
- Assessed for compliance to hygiene measures.
- Assessed ability to carry out ADLs.
- Assessed extent of barrier techniques needed.
- Assessed need for special equipment.

7. Removed mask and placed in garbage bag.
8. Washed hands in room.
9. Washed hands after exiting room.
10. Disposed of all double-bagged equipment.

Performed		Mastered
yes	no	

UNIT THREE Isolation

UNIT ASSESSMENT

- Identified appropriate times for handwashing.
- Identified type of protective clothing required for barrier nursing.
- Identified epidemiology of disease to determine how to prevent infection from spreading.
- Identified equipment needed to prevent spread of organisms.
- Assessed method of terminal cleaning and disposing of equipment.

PREPARING FOR ISOLATION

Procedure

1. Checked physician's order for isolation.
2. Obtained isolation cart from central supply if needed.
3. Checked that all necessary equipment to carry out isolation order was available.
4. Placed isolation card on client's door.
5. Ensured that linen hamper and trash cans were available if needed.
6. Explained purpose of isolation to client and family.

Performed		Mastered
yes	no	

7. Instructed family in procedures required.
8. Washed hands with antimicrobial soap before and after entering isolation room.

Performed		Mastered
yes	no	

DONNING AND REMOVING ISOLATION ATTIRE

Procedure

1. Washed and dried hands.
2. Took gown from isolation cart or cupboard. Put on new gown each time I entered an isolation room.
3. Held gown so that opening was in back when wearing gown.
4. Put gown on by placing one arm at a time through sleeves. Pulled gown up and over shoulders.
5. Wrapped gown around back, tying strings at neck.
6. Wrapped gown around waist, making sure back was completely covered. Tied strings around waist.
7. Donned eye shield and/or mask, if indicated.
8. Donned gloves and pulled over wristlets.

for Removing Attire

1. Untied gown waist strings.
2. Removed gloves and disposed of them in garbage bag.
3. Untied neck strings, bringing them around shoulders so that gown was partially off shoulders.

4. Using dominant hand and grasping clean part of wristlet, pulled sleeve wristlet over nondominant hand. Used nondominant hand to pull sleeve wristlet over dominant hand.
5. Grasped outside of gown through the sleeves at shoulders. Pulled gown down over arms.
6. Held both gown shoulders in one hand. Carefully drew other hand out of gown, turning arm of gown inside out. Repeated this procedure with other arm.
7. Held gown away from body. Folded gown up inside out.
8. Discarded gown in appropriate place.
9. Removed eyeshield and/or mask and placed in receptacle.
10. Washed hands.

USING A MASK

Procedure

1. Obtained mask from box.
2. Positioned mask to cover nose and mouth.
3. Bent nose bar so that it conformed over bridge of nose.
4. If using mask with string ties, tied top strings on top of head to prevent slipping. If using cone-shaped mask, tied top strings over ears.
5. Tied bottom strings around neck to secure mask over mouth with no gaps between mask and face.
6. Washed hands before removing mask.

Performed Mastered
yes no

Performed yes	Mastered no

7. Changed mask every 30 minutes or sooner if it became damp.
8. To remove mask, untied lowered strings first without touching mask.
9. Discarded mask in a trash container.
10. Washed hands.

ASSESSING VITAL SIGNS

Procedure

1. Washed hands.
2. Donned isolation clothing as required by type of isolation.
3. Proceeded to take vital signs as for any client.
4. Placed equipment in appropriate area if it was to be left in room.
5. Removed isolation clothing according to protocol.
6. Washed hands.
7. Wiped watch if accidentally contaminated. Used appropriate solution.

REMOVING ITEMS FROM ISOLATION ROOM

Procedure

1. Placed laboratory specimen in plastic bag and attached biohazard label.
2. Disposed of all sharps in red plastic container in room.

Performed Mastered
yes no

Performed yes	Mastered no

Performed Mastered
yes no

3. Placed all linen in linen bag.
4. Placed reusable equipment in plastic bags.
5. Disposed of all garbage in plastic bags.
6. Double-bagged all material from isolation room.
7. Replaced all bags (linen, garbage, etc.) in appropriate container in room.
8. Cleaned client's room using germicidal solution according to facility protocol.
9. Left client's room appropriately.

UTILIZING DOUBLE-BAGGING FOR ISOLATION

Procedure

1. Followed dress protocol for entering isolation room.
2. Closed isolation bag in the room when one-half to three-fourths full.
3. Double-bagged any bag in the room if could be easily penetrated, if contaminated material inside bag was heavy, or outside of bag was contaminated.
4. Set up new bag for continued use inside room.
5. Placed bag from inside room into a second bag held open by healthcare worker outside room. Healthcare worker stationed outside room made a cuff with the top of the bag and placed hands under cuff.

Performed yes	Mastered no

Performed Mastered
yes no

6. Placed bag into second bag without contaminating outside of bag. Secured top of bag by tying knot in top of bag.
7. Took bag to designated area where biohazard material is collected.
8. Removed gloves and washed hands.

REMOVING A SPECIMEN FROM ISOLATION ROOM

Procedure

1. Followed dress protocol for entering isolation room.
2. Marked specimen container with client's name, type of specimen, and the word "isolation" before entering isolation room.
3. Collected specimen, and placed container in clean plastic biohazard bag outside the room. Used clear bags so that laboratory personnel could see specimen easily.
4. Washed hands.
5. Sent specimen to laboratory with appropriate laboratory request form.

TRANSPORTING ISOLATION CLIENT OUTSIDE THE ROOM

Procedure

1. Explained procedure to client.
2. If client was being transported from a respiratory isolation room, instructed him or her to wear a mask for entire time out of isolation.

Performed yes	Mastered no

3. Covered transport vehicle with bath blanket if there was chance of soiling when transporting client with a draining wound or diarrhea.
4. Helped client into transport vehicle. Covered client with bath blanket.
5. Told receiving department what type of isolation client needed and what precautions hospital personnel should follow.
6. Removed bath blanket, and handled as contaminated linen when client returned to room.
7. Instructed all hospital personnel to wash their hands before they left area.
8. Wiped down transportation vehicle with germicidal/virucidal solution if soiled.
9. Washed hands.

Performed Mastered
yes no

	Performed yes	Mastered no

REMOVING SOILED LARGE EQUIPMENT FROM ISOLATION ROOM

Procedure

1. Donned isolation garb as recommended.
2. Washed equipment with an antimicrobial agent.
3. Covered equipment with plastic bag.
4. Removed garb, and washed hands outside room. Took equipment to decontamination area of central supply room.

Performed Mastered
yes no

	Performed yes	Mastered no

Bioterrorism—Disaster Nursing

Performance Checklist

UNIT ONE Bioterrorism Agents, Antidotes, and Vaccinations

UNIT ASSESSMENT

- Identified epidemiologic features
- Identified mode of dissemination and incubation period.
- Assessed the appropriate therapy/antidotes necessary to treat victims of a bioterrorist attack.
- Determined clients who could be in a high-risk group for smallpox vaccination.
- Assessed need for smallpox vaccination.
- Observed post-vaccination reactions and compared with adverse reactions.
- Assessed client's understanding of post-vaccination evaluation.
- Assessed need for collecting a clinical specimen to identify a specific bioterrorism agent.
- Identified acute radiation syndrome.
- Assessed radiation dose exposure of client.

IDENTIFYING AGENTS OF BIOLOGICAL TERRORISM

ANTHRAX

Procedure

1. Recognized clinical features.
 - a. Inhalation or pulmonary form.
 - b. Cutaneous form.
 - c. Gastrointestinal form (from contaminated meat).
2. Knew mode of dissemination and incubation period.
 - a. Inhalation of spores.
 - b. Cutaneous.
 - c. Gastrointestinal ingestion of contaminated food.
3. Managed decontamination.
 - a. Removed contaminated clothing.

Performed		Mastered
yes	no	

- b. Instructed clients to shower thoroughly with soap and water.
- c. Instructed personnel to use Standard Precautions.
- d. Decontaminated environment.
- 4. Instituted isolation precautions.
- 5. Assigned client placement.
- 6. Implemented therapy for anthrax infection.

Performed Mastered
yes no

Performed yes	Mastered no

PLAGUE

Procedure

- 1. Recognized clinical features.
 - a. Bubonic form.
 - b. Pneumonic form.
- 2. Knew mode of dissemination and incubation period.
- 3. Managed decontamination.
- 4. Instituted isolation precautions.
 - a. Bubonic form.
 - b. Pneumonic form.
- 5. Assigned client placement.
- 6. Implemented therapy.

BOTULISM

Procedure

- 1. Recognized clinical features.
 - a. Foodborne botulism.
 - b. Inhalational botulism.

- 2. Knew mode of dissemination and incubation period.
- 3. Managed decontamination.
- 4. Instituted isolation precautions.
- 5. Assigned client placement.
- 6. Implemented therapy.

Performed Mastered
yes no

Performed yes	Mastered no

TYPHOIDAL TULAREMIA

Procedure

- 1. Recognized clinical features.
 - a. Early symptoms: headache, cough, fever, and chills, malaise.
 - b. Delayed symptoms: pharyngeal ulcers, pleuritic chest pain, pneumonia, pericarditis—may progress to respiratory failure.
- 2. Knew mode of dissemination and incubation period.
- 3. Managed decontamination.
- 4. Instituted isolation precautions.
- 5. Assigned client placement.
- 6. Implemented therapy.

VIRAL HEMORRHAGIC FEVER (VHF)

Procedure

- 1. Recognized clinical features.
 - a. Characterized by abrupt onset of fever, myalgia, headache, prostration.

- b. Other signs and symptoms are nausea and vomiting, diarrhea, pain in abdomen and chest, cough, and pharyngitis.
 - c. Bleeding manifestations may occur as the disease progresses.
2. Knew mode of dissemination and incubation period.
 3. Managed decontamination.
 4. Instituted isolation procedures.
 5. Assigned client placement.
 6. Implemented therapy.

Performed Mastered
yes no

Q FEVER

Procedure

1. Recognized clinical features.
 - a. Early signs and symptoms: headache, fever, chills, malaise, diaphoresis, anorexia; insidious onset with nonspecific flu-like symptoms.
 - b. Delayed signs and symptoms: double vision, sore throat, cough, chest pain, nuchal rigidity, encephalitis, hallucinations, weight loss.
2. Knew mode of dissemination and incubation period.
3. Managed decontamination.
4. Instituted isolation precautions.
5. Assigned client placement.
6. Implemented therapy.

SMALLPOX

Procedure

1. Recognized clinical features.
 - a. Initially, fever, myalgia, headache, and backache.
 - b. Rash appears, progressing from macules to papules (in 1 week) to vesicles.
2. Knew mode of dissemination and incubation period.
3. Managed decontamination.
4. Instituted strict isolation precautions *immediately*.
5. Assigned client placement.
6. Implemented therapy.
 - a. Post-exposure immunization (*vaccinia virus*).
 - b. Prophylactic care with precautions.

Performed Mastered
yes no

RICIN TOXIN

Procedure

1. Recognized clinical features.
 - a. Signs and symptoms depend on route of exposure. ELISA test of blood will identify Ricin.
 - b. Ingestion and aerosol.
2. Knew mode of dissemination and incubation period.
3. Managed decontamination.
4. Instituted isolation precautions.
5. Assigned client placement.
6. Implemented therapy.

PRIORITIZING HIGH-RISK GROUPS FOR SMALLPOX VACCINATION

Procedure

1. Identified clients exposed to the smallpox virus.
2. Identified healthcare workers.
3. Determined contraindications for vaccination of noncontacts.

RECONSTITUTING VACCINIA VACCINE FOR SMALLPOX

Procedure

1. Removed vaccine vial from refrigerated storage and allowed vial to come to room temperature.
2. Washed hands and donned clean gloves.
3. Lifted tab of aluminum seal of vaccine vial.
4. Wiped off vial stopper with an alcohol swab and allowed it to dry.
5. Placed vaccine vial upright on a hard, flat surface.
6. Removed cap from prefilled syringe of diluent.
7. Held a 1.0 mL syringe (e.g., tuberculin syringe) and withdrew 0.25 mL from opening in prefilled diluent syringe.
8. Injected 0.25 mL of diluent in 1.0 mL syringe into vaccine vial.
9. Withdrew needle and syringe and discarded in appropriate biohazard sharps container.
10. Allowed vaccine vial to stand undisturbed for 3–5 minutes. Then, if necessary, swirled vial gently.

Performed Mastered
yes no

Performed yes	no	Mastered

11. Recorded date and time diluent was added for the purpose of vaccine reconstitution.
12. Disposed of vaccine vial and all other equipment.

ADMINISTERING RECONSTITUTED SMALLPOX VACCINE

Procedure

1. Washed hands and donned gloves.
2. Removed aluminum seal from vaccine vial by pulling down “tear off” tab.
3. Removed rubber stopper from vaccine vial and placed in sterile container.
4. Chose site of vaccination.
5. Cleaned vaccination site only if grossly contaminated. Dried thoroughly. Did not apply alcohol to cleanse site.
6. Dipped point of a sterile bifurcated needle into vial of reconstituted vaccine and withdrew needle perpendicular to the floor.
7. Held skin of upper arm taut and placed wrist firmly on the arm.
8. Held needle at a 90° angle (perpendicular) to skin and applied appropriate number of up-and-down (perpendicular) strokes rapidly within a 5mm diameter area.
9. Examined for a trace of blood at vaccination site.
10. Covered vaccination site with gauze bandage and tape.

Performed Mastered
yes no

Performed yes	no	Mastered

11. Disposed of bifurcated needle in a puncture-resistant medical waste sharps container.
12. Instructed client to keep site dry.
13. Recapped vial with sterile rubber stopper and stored capped vial at 2 to 8°C.
14. Removed gloves, discarded in appropriate receptacle, and washed hands.

UNDERSTANDING POST-VACCINATION REACTIONS

Procedure

1. Identified persons who should be revaccinated.
2. Confirmed successful vaccination.
3. Recognized adverse reactions.
4. Documented results on vaccination record in client's chart.

INSTRUCTING CLIENT IN POST-VACCINATION EVALUATION

Procedure

1. Instructed client that successful vaccination is normally associated with tenderness, redness, swelling, and a lesion at the vaccination site.
2. Instructed client vaccination may also be associated with fever for a few days, malaise, and enlarged, tender lymph nodes in the axilla of the vaccinated arm.

Performed Mastered
yes no

Performed yes	Mastered no

3. Checked for inoculation site becoming reddened and pruritic 3–4 days after vaccination.
4. Told client by the end of the 3rd week, scab falls off.
5. Instructed person who has been previously vaccinated (a partially immune person) that an attenuated primary vaccine site reaction will occur.

IDENTIFYING INDICATIONS FOR VACCINIA IMMUNE GLOBULIN (VIG) ADMINISTRATION

Procedure

1. Identified post-vaccination complications for which VIG may be indicated.
2. Checked physician's orders for VIG treatment of complications due to *vaccinia* vaccination.
3. Administered VIG intramuscularly (IM) as early as possible after onset of symptoms.
4. Gave VIG in divided doses over a 24 to 36 hour period.
5. Instructed staff VIG is not indicated for treatment of post-vaccination encephalitis and is contraindicated for vaccinia keratitis.

Performed Mastered
yes no

Performed yes	Mastered no

COLLECTING AND TRANSPORTING SPECIMENS

Procedure

1. Acquired and followed specific recommendations for diagnostic sampling of the specific agent.
2. Wore protective gear when entering environment where potential for exposure exists.
3. Chose gown with sleeve cuffs that could be covered by stretching gloves up and over cuff.
4. Collected specimen and placed in appropriate container (zip-closure plastic bag, sealed).
5. Removed original gloves handling specimen, and placed in biohazard container.
6. Donned new pair of gloves.
7. Placed specimen bag in second zip-closure bag and sealed, or if specimen was large, in trash bag.
8. Removed protective gear and placed in bio-hazard bag.
9. Labeled specimen with appropriate label outside of bag: date, person collecting specimen, location, and contact person.
10. Washed hands.
11. Documented specimen collection in duplicate, filled out worksheet, "Possible Biological Agent Exposure Contact."
12. Gave to person designated for this location.
13. Collected an acute phase serum sample, as well as a later convalescent serum sample.
14. Transported specimens by coordinating with local, state health departments and the FBI.

Performed Mastered
yes no

IDENTIFYING CHEMICAL AGENT EXPOSURE

Procedure

1. Identified **pulmonary agents**: such as chlorine, chloropicrin, or phosgene, when inhaled produce pulmonary edema with little damage to other pulmonary tissues (with resulting hypoxemia) and hypovolemia.
2. Identified **cyanide agents**: may be gases or solids, such as hydrogen cyanide or cyanogens chloride; with high concentrations death occurs in 6 to 8 minutes.
3. Identified **vesicant agents**: cause vesicles or blisters. Common agents are sulfur mustard and lewisite. More lethal than pulmonary agents and cyanide.
4. Identified **nerve agents**: liquids or vapors that are the most toxic of all chemical agents. Common agents are Sarin, tabon, Soman, GF, and VX.

Performed Mastered
yes no

TRIAGING FOR CHEMICAL AGENT EXPOSURE

Procedure

1. Triaged for **pulmonary agents**.
2. Triaged for **cyanide agents**.
3. Triaged for **vesicant agents**.
4. Triaged for **nerve agents**.

MANAGING CARE AFTER CHEMICAL AGENT EXPOSURE

Procedure

1. Managed care of client exposed to **pulmonary agents**: Client with pulmonary edema placed on immediate bedrest with no exertion and received oxygen.
2. Managed care of client exposed to **cyanide agents**: Administered antidotes.
3. Managed care of client exposed to **vesicant agents**.
 - a. Mustard.
 - b. Lewisite.
4. Managed care of client exposed to **nerve agents**.
 - a. Donned personal protection equipment.
 - b. Gave appropriate antidotes.

IDENTIFYING ACUTE RADIATION SYNDROME

Procedure

1. Assessed for an acute illness characterized by manifestations of cellular deficiencies.
2. Determined the radiation dose, if possible.
3. Attempted to identify dose exposure of client.
4. Identified if radiation dose includes radioactive iodine.
5. Administered potassium iodide before exposure, if possible, or as soon as available (within 4 hours).

	Performed yes	no	Mastered

UNIT TWO Personal Protection Equipment and Decontamination

UNIT ASSESSMENT

- Identified clients who present risk to healthcare professionals.
- Assessed need for special equipment (biohazard bags, specimen bags, etc.).
- Determined type of protection equipment required according to biohazard that is identified (biological, chemical, or radiological).
- Assessed need for decontaminating victims prior to triage.
- Assessed strategy for decontamination at site of incident.
- Assessed need for mass casualty decontamination.

IMPLEMENTING HOSPITAL INFECTION CONTROL PROTOCOL

Procedure

1. Utilized Standard Precautions for all clients admitted to or arriving at the hospital.
2. Followed routine client placement for normal number of admissions.
 - a. Isolated suspicious cases.
 - b. Grouped similar cases.
3. Utilized alternative placement for large numbers of clients.
4. Controlled entry to client designated areas.
5. Transported bioterrorism clients as little as possible—limited to essential movement.
6. Cleaned, disinfected, and sterilized equipment according to principles of Standard Precautions.

	Performed yes	no	Mastered

DECONTAMINATING VIA TRIAGE

Procedure

1. Decontaminated at scene of incident (hot zone).
2. Familiarized emergency personnel with stages of decontamination.
 - a. Gross decontamination.
 - b. Secondary decontamination.
 - c. Definitive decontamination.
3. Checked to determine if initial decontamination was accomplished by the fire department with hoses spraying water at reduced pressure.
4. Decontaminated salvageable clients first.
5. Reduced extent of contamination in facility by decontaminating clients prior to receiving in healthcare facility.
6. Implemented procedure for decontaminating client.

Performed Mastered
yes no

CHOOSING PROTECTIVE EQUIPMENT FOR BIOLOGICAL EXPOSURE

Procedure

1. Planned for protection from biological hazards.
 - a. Understood that first responders to a biological hazard could be exposed to bacteria, viruses, or toxins via inhalation (through respiratory tract) or ingestion (contact with mucous membranes of eyes, nasal tissues, or open cuts).
 - b. Knew that biological weapons are particles and will not penetrate proper protective equipment.

Performed Mastered
yes no

- c. Selected type of respirator according to hazard identified and its airborne concentration.
 - (1) High level of protection: Self-contained breathing apparatus (SCBA) with full facepiece. Provides highest level of protection against airborne hazards when used correctly.
 - (2) Minimal level of protection: Half-mask or full facepiece air-purifying respirator with particulate filters like N95 (used for TB) or P100 (used for hantavirus).
 - d. Selected protective clothing that includes gloves and shoe covers—necessary for full protection.
2. Identified *anthrax* precautions.
 3. Identified *plague* precautions.
 4. Identified *botulism* precautions.
 5. Identified *smallpox (variola)* precautions.
 6. Identified *brucellosis* precautions.
 7. Identified *typhoidal tularemia* precautions.
 8. Identified *viral encephalitides* precautions.

CHOOSING PROTECTIVE EQUIPMENT FOR CHEMICAL EXPOSURE

Procedure

1. Identified victims who were exposed to chemical substance.
2. Covered all skin surfaces with protective clothing impervious to chemicals.

3. Donned masks with filtered respirator. (HEPA filter respirator—N100 with full facepiece—and fit-tested N95 meet CDC performance criteria for chemical exposure.)
4. Wore boots or boot covers.
5. Initiated decontamination procedures with trained personnel.
6. Used chemical detection devices, if available.

CHOOSING PROTECTIVE EQUIPMENT FOR A RADIOLOGICAL ATTACK

Procedure

1. Identified victims contaminated by radiation.
2. Donned protective clothing: basic gear will stop alpha and some beta particles, not gamma rays.
3. Transported victim to facility.
4. Instituted decontamination procedures.
5. Rechecked radiation levels at each stage of treatment until reduced to background levels.
6. Disposed of used protective gear appropriately.

DECONTAMINATING VICTIMS FOLLOWING A BIOLOGICAL TERRORIST EVENT

Procedure

1. Donned protective clothing and adhered strictly to Standard Precautions for emergency personnel.

Performed Mastered
yes no

Performed yes	Mastered no

2. Identified dermal exposure, if possible.
3. Removed victim's clothing as soon as possible and placed in biohazard bags.
4. Cleansed exposed areas using soap and tepid water (large amounts) or diluted sodium hypochlorite (0.5%).
5. Adhered strictly to Standard Precautions for emergency personnel.
6. Sent victims home, if possible, to continue decontamination procedure by washing thoroughly with soap and water.

DECONTAMINATING VICTIMS FOLLOWING A CHEMICAL TERRORIST EVENT

Procedure

1. Knew general principles to guide actions following a chemical agent incident.
2. Practiced triage guidelines for mass casualty decontamination.
3. Decontaminated victims as early as possible.
4. Treated eyes and mucous membranes with special protocol.
5. Monitored victim for remains of agent or contaminant using chemical agent monitor (CAM) or M-8 paper for chemical agents.

Performed Mastered
yes no

Performed yes	Mastered no

DECONTAMINATING VICTIMS FOLLOWING RADIATION EXPOSURE

Procedure

1. Determined cause of incident to identify radiation exposure or contamination.
2. Understood difference between exposure and contamination.
3. Used appropriate personnel protection equipment (PPE).
4. Triaged client's medical condition first, regardless of radiation exposure.
5. Completed decontamination of victims.
6. Implemented isolation techniques for contaminated victims.
7. Determined source of radiation, type of radioactive material, length of time of exposure, if possible.

CONTROLLING RADIATION CONTAMINATION

Procedure

1. Decontaminated all victims, removed all clothing, and completed a full body wash.
2. Instituted isolation techniques.
3. Decontaminated equipment touched by client.
4. Decontaminated care providers who touched or moved client.
5. Examined surrounding area (walls, floor that client may have touched).
6. Controlled entry and exit of victims.

Performed Mastered
yes no

Performed yes	Mastered no

Performed Mastered
yes no

Performed yes	Mastered no

7. Covered floor areas with rolls of heavy, wide paper and taped securely to floor.
8. Controlled waste by using large plastic-lined containers for contaminated articles.
9. Monitored radiation by using meter.

UNIT THREE Triage and a Communication Matrix

UNIT ASSESSMENT

- Assessed the need to establish triage treatment areas.
- Validated that public health parameters are established.
- Observed that the steps of triage are followed.
- Assessed that victim is not in immediate danger, or conversely, required immediate intervention.
- Assessed vital signs of victims.
- Assessed the treatment steps necessary to treat life-threatening conditions
- Assessed victims post-triage and observed for any signs or symptoms that indicated major injury.
- Identified victims having a severe psychological reaction to bioterrorism event.
- Assessed possibility of post-traumatic stress syndrome developing.
- Assessed that lines of communication are established and activated.
- Assessed that Federal Response Plan is activated.
- Assessed that external, internal, and collaborative communication networks were in place.

ESTABLISHING TRIAGE TREATMENT AREAS

Procedure

1. Assigned roles to personnel in treatment areas.
2. Selected a site as soon as possible—advance planning is essential.
3. Protected treatment area and delineated area using tarps, covers, etc.
4. Set up signs to identify subdivisions of area.
 - a. I = Immediate care.
 - b. D = Delayed care.
 - c. Dead = Dead for morgue.
5. Established I and D areas close together.
6. Positioned victims in head-to-toe configuration, with 2 to 3 feet between victims.
7. Established morgue site secure and away (and not visible) from medical treatment areas.

ESTABLISHING PUBLIC HEALTH PARAMETERS

Procedure

1. Assigned personnel to monitor public health concerns where disaster victims were sheltered.
2. Made available search and rescue safety equipment.
3. Maintained proper hygiene by washing hands and using gloves.
4. Wore a mask and goggles.
5. Avoided direct contact with body fluids.

Performed Mastered
yes no

6. Maintained sanitation.
7. Purified water for drinking, cooking, medical use, if potable water was not available.

DEVELOPING A COMMUNICATION NETWORK

Procedure

1. Understood lines of communication.
2. Understood the network of communication that would be activated in response to a suspected or actual bioterrorism event.
3. Activated Federal Response Plan.

ESTABLISHING VIABLE COMMUNICATION

Procedure

1. Set up **external communication** system designated spokesperson.
2. Reported to appointed community-wide regional spokesperson or small group designated as being in command throughout the incident.
3. Set up a single community site for family and friends to obtain victim-locator information.
4. Established **internal communication**.
5. Established a **collaborative communication system**.
6. Developed clear communication systems that had access to telecommunications as well as a person-to-person communication system.

Performed Mastered
yes no

TREATING LIFE-THREATENING CONDITIONS

Procedure

1. Implemented Simple Triage and Rapid Treatment (START).
2. **Checked breathing immediately.**
 - a. Opened airway.
 - b. Checked if tongue is obstructing airway.
3. Used head-tilt/chin-lift method if victim was not breathing and airway not obstructed.
 - a. Touched victim and shouted “CAN YOU HEAR ME?”
 - b. If victim did not respond, placed one hand on forehead, 2 fingers of other hand under chin, and tilted jaw upward and head back.
 - c. Looked for chest to rise, listened for air exchange, and felt for abdominal movement.
 - d. If no response (victim did not start breathing) repeated procedure. (If AED available, applied to victim.)
 - e. If victim did not respond after 2nd attempt, moved on to next victim.
 - f. If the victim began breathing—maintained airway.
4. **Controlled bleeding.**
5. Identified type of bleeding.
6. Chose appropriate method to control bleeding.
7. Used tourniquet if bleeding could not be controlled by other methods.
8. **Recognized and treated shock.**
9. Observed for signs/symptoms of shock.
10. Administered treatment for shock.

Performed Mastered
yes no

	Performed yes	Mastered no

ASSESSING VICTIMS POST-TRIAGE

Procedure

1. Performed head-to-toe assessment, always in the same order.
2. Completed assessment before beginning any treatment.
3. Observed for any sign/symptom that indicated major injury.
4. Provided immediate treatment. During treatment, reclassified victim, if necessary.
5. Assessed that victim was not in immediate danger. If available staff, continued to assess for signs of head, neck, and spinal injury.
6. Immobilized head, neck or spine by keeping spine in straight line, putting cervical collar on neck, or placing victim on board—if equipment was available.
7. Documented who person was and relevant medical information.

Performed Mastered
yes no

	Performed yes	Mastered no

CARING FOR THOSE WHO DIED

Procedure

1. Tagged victims pronounced DOA (dead on arrival).
2. Placed bodies in cordoned off area for field triage.
3. Notified those performing post-mortem care of victim’s diagnosis.
4. Completed a record for all bodies including identification, name of person who was declared dead, diagnosis, if known, name of agency removing body, etc.

CARING FOR CLIENTS WITH PSYCHOLOGICAL REACTIONS

Procedure

1. Expected major psychological reactions of fear, panic, anger, horror, paranoia, etc., following a bioterrorism event.
2. Planned prior to such an event for professional and educated volunteers to be on site.
3. Minimized fear and panic in staff.
4. Coped with psychological reactions of fear and anxiety.
5. Treated major anxiety reactions in unexposed persons with factual information, reassurance, and medication, if indicated.
6. Prevented post-terrorism trauma.

Performed Mastered
yes no

	Performed yes	Mastered no

IDENTIFYING POST-TRAUMATIC STRESS DISORDER

Procedure

1. Recognized possibility of existing traumatic event condition.
2. Assessed signs and symptoms of anxiety and depression.
3. Assessed aggressive or acting-out behavior; may be explosive or impulsive behavior.
4. Assisted client through recovery process.

Performed Mastered
yes no

	Performed yes	Mastered no

Pain Management

Performance Checklist

UNIT ONE Pain Relief

UNIT ASSESSMENT

- Assessed type of pain.
- Chose a pain intensity scale and identified the degree of pain client experienced.
- Assessed nonverbal indications of pain.
- Assessed client's behavioral responses to pain.
- Assessed location, quality, intensity, onset, duration, pattern, aggravating factors, associated factors, and alleviating factors.

ALLEVIATING PAIN THROUGH TOUCH (MASSAGE)

Procedure

1. Determined whether client achieved more relief from pain with massage over painful area, near painful area, or from foot rub, back rub, or hand rub.
2. Warmed hands by rubbing them together or rinsing in warm water.
3. Warmed lotion to be used by holding closed bottle under warm running water.
4. Massaged area of client's choice with slow and steady motion.
5. Used deep pressure or light stroking motion, whichever was more comfortable for the client.

Performed Mastered
yes no

Performed yes	Mastered no

USING RELAXATION TECHNIQUES

Performed Mastered
yes no

Procedure

1. Helped client assume comfortable position.
2. Instructed client to inhale deeply, hold breath for a moment, then exhale deeply. Repeated several times.
3. Gave the appropriate instructions to client, using a slow, soothing voice.
4. Continued with these instructions until client had time to relax all points of tension.
5. To end process, instructed client to open eyes slowly and say, "I feel relaxed and awake."

Performed yes	no	Mastered

UNIT TWO Pharmacology Pain Management

UNIT ASSESSMENT

- Assessed client's type, description, rating (use a pain intensity scale), and level of pain.
- Assessed vital signs for baseline comparison.
- Assessed allergy to pain medications—morphine.
- Assessed patency of IV lines.
- Assessed sedation level of client on epidural analgesia.
- Assessed insertion site for drainage, inflammation, etc.
- Assessed potential use of PCA as method of pain control.
- Assessed reliability of candidate—ability to self-administer PCA.
- Assessed client throughout PCA therapy.

ADMINISTERING PAIN MEDICATIONS

Performed Mastered
yes no

Procedure

1. Assessed pain intensity by selecting a pain tool based on client's preference.
 - a. Verbal description scale.
 - b. Numeric rating scale.
 - c. FACES pain scale.
2. Checked physician's orders for changes in pain medication.
3. Administered pain medication or requested change in dosing schedule of infusion, PCA, etc.
4. Recorded results and set schedule for follow-up reassessment.

Performed yes	no	Mastered

ADMINISTERING EPIDURAL NARCOTIC ANALGESIA*

Preparation

1. Checked physician's orders for epidural narcotic indicating minimum and maximum dosage.
2. Checked that safety sign was over bed "Epidural Protocol Client."
3. Checked that catheter was labeled "epidural catheter."
4. Checked that a naloxone (Narcan) ampule and 3-mL syringe were at bedside.
5. Checked that there was IV access for administration of Narcan.
6. Checked that Ambu bag was available on unit.
7. Checked if an apnea monitor or pulse oximeter was ordered.

* Many hospitals require specific certification before the RN can administer narcotics via an indwelling epidural catheter. A student nurse *should not* administer solutions via epidural catheter.

8. Assembled equipment.
9. Washed hands and maintained strict aseptic technique.
10. Checked client's identaband.

Procedure

for Bolus Injection

1. Put on sterile gloves and maintained sterile technique.
2. Wiped narcotic vial with antiseptic swab.
3. Drew up ordered dose of prediluted preservative-free narcotic in 12-mL syringe with filter needle.
4. Changed filter needle to 20-gauge needle.
5. Expelled air from syringe.
6. Verified narcotic with a second nurse before administering.
7. Disinfected catheter injection port (Luer-Lok port or the injection cap) with nonalcohol antimicrobial wipe.
8. Dried injection cap or port with sterile 2 × 2 gauze.
9. Inserted cannula into injection cap or port, and attempted to aspirate for 30 seconds.
10. Injected medication slowly.
11. Removed cannula from injection cap or port.
12. Disposed of cannula in appropriate safety container.
13. Checked that a sterile, occlusive dressing was over insertion site. Dressing was changed every 72 hours (certified RN or MD to change dressing).

Performed Mastered
yes no

Performed yes	Mastered no

14. Taped all injection ports on epidural line if no continuous infusion.
15. Closely monitored respirations every 1 hour for 24 hours or used apnea monitor or pulse oximeter.
16. Monitored vital signs: BP and pulse every 30 minutes for 1 hour after initial epidural dose, then every 8 hours.
17. Monitored for possible side effects of narcotic administration: respiratory depression, urinary retention, nausea and vomiting, and pruritus.
18. Documented dose and client status.

for Continuous Infusion

1. Checked physician's orders for epidural narcotic.
2. Checked that safety signs were near bed and label was on catheter.
3. Washed hands and donned gloves.
4. Attached container of narcotic to infusion pump tubing.
5. Primed tubing according to specific protocol.
6. Attached proximal end of tubing to pump and distal end to epidural catheter.
7. Taped all connections securely.
8. Set infusion pump to ordered calibration.
9. Observed for side effects of narcotic or client response and pain level.
10. Disposed of gloves and washed hands.
11. Charted pump reading every hour for 12–24 hours or as dictated by institutional policy.
12. Recorded narcotic on appropriate sign-out sheet.

Performed Mastered
yes no

Performed yes	Mastered no

QUALIFYING CLIENT FOR PCA

Procedure

1. Determined whether physician wished to use PCA for pain control.
2. Determined if client was candidate for PCA.
3. Determined which type—electronic or mechanical—PCA unit was appropriate.
4. Assessed any allergy to prescribed pain medication.
5. Performed basic physical assessment before initiating PCA.

ADMINISTERING PCA

Preparation

1. Checked that physician's orders, including medication orders for PCA, were complete.
2. Checked client's identaband.
3. Assembled IV administration set.
 - a. Washed hands and donned gloves.
 - b. Started IV line.
4. Assembled PCA vial injector following manufacturer's instructions.
 - a. Snapped caps from injector (plunger) and vial.
 - b. Connected plunger to vial by twisting them together.
 - c. Primed unit by pushing down on injector to release air.
 - d. Connected PCA tubing to injector.
5. Primed PCA tubing only to the "Y," then clamped tubing.
6. Attached maintenance IV to unprimed portion of Y.

Performed Mastered
yes no

Performed yes	Mastered no

7. Taped maintenance IV securely to Y of PCA tubing.
8. Primed lower tubing of PCA set with IV solution from gravity administration set.
9. Closed slide clamp on PCA tubing.
10. Opened flow control clamp on IV.
11. Explained ongoing procedure to client.
12. Left PCA booklet with client for referral during pain control time.

Procedure

1. Unlocked by turning key, and opened door of infuser.
2. Activated drive release mechanism by pinching spring-loaded lever, and moved drive assembly to uppermost position.
3. Loaded vial injector into vial injector holder by moving drive assembly downward.
4. Clamped securely, and listened for "click" sound.
5. Rotated vial injector in holder, and inspected for leakage or cracks.
6. Validated drug dose as PCA was activated.
7. Set PCA parameters for infusion.
 - a. Pressed on-off button to turn on infuser.
 - b. Used dose volume control to set DOSE VOLUME.
 - c. Set LOCKOUT INTERVAL
 - d. Checked that slide clamps on infuser were open.
8. Calculated number of milliliters needed for loading dose.
 - a. Pressed and released LOADING DOSE.
 - b. Checked that display screen showed volume delivered.

Performed Mastered
yes no

Performed yes	Mastered no

- c. Monitored respirations every 15 minutes after loading dose until client stabilized.
- 9. Set 4-HOUR LIMIT by calculating maximum dose client may receive in a 4-hour period.
- 10. Closed and locked security door to initiate client control. Removed key and placed with narcotic keys or followed hospital protocol.
- 11. Handed control button to client.
- 12. Reviewed client instructions.
- 13. Monitored client status every 2 hours for 24 hours, and revised parameters with physician if necessary.

TERMINATING A PCA INFUSION

Procedure

- 1. Closed manual slide clamp proximal to Luer-Lok connector on vial injector.
- 2. Unlocked and opened security door.
- 3. Removed vial injector from PCA infuser, and disconnected from set.
- 4. Pressed OFF button to turn off PCA infuser.
- 5. Continued or discontinued IV as required.
- 6. Recorded and disposed of PCA narcotic vial injector per hospital policy for disposal of narcotic drugs.
- 7. Disposed of narcotic that remained in vial injector per protocol.

Performed Mastered
yes no

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TEACHING PCA TO A CLIENT

Preparation

- 1. Determined if client was candidate for PCA.
- 2. Allowed client to directly handle equipment.

Procedure

- 1. Demonstrated how PCA device works.
- 2. Had client explain and demonstrate PCA use before initiating therapy.
- 3. Clarified with client how he or she administered medication dose when pain was felt.
- 4. Programmed PCA infuser for continuous infusion plus bolus dose.
- 5. Reassured client that PCA would control, but not totally abolish, pain.
- 6. Taught client how to evaluate pain level on five-point scale. If client's pain was not sufficiently relieved, medication dose was increased.
- 7. Evaluated client's response to medication schedule.
- 8. Reassessed client's ability to control pain level and effectiveness of medication dosage to control pain.
- 9. Instructed client to notify staff if machine malfunctioned, pain was not controlled or changed in severity, or if he or she had any questions.

Performed Mastered
yes no

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Alternative Therapies and Stress Management

Performance Checklist

UNIT ONE Stress and Adaptation

UNIT ASSESSMENT

- Identified client who demonstrated stressed behavior.
- Evaluated with the client, past and present stressors that client had experienced.
- Evaluated the stressors' effect on client's body and signs of distress in the body.
- Assessed client's level of energy and degree to which it was depleted.
- Evaluated client's awareness of thoughts, attitudes, values, and beliefs that influence stress response and adaptation.
- Assessed present level of distress in client's body.
- Assessed possible causes of stress affecting client.
- Assessed factors that influenced how client responded to stress.

DETERMINING THE EFFECT OF STRESS

Procedure

1. Identified client's stress tolerance level.
2. Discussed the concept of stress to elicit understanding of the effect on client's body.
3. Encouraged client to feel free to discuss life patterns that relate to stress.
4. Discussed effect of stress.
5. Assisted client in formulating a plan to reduce or eliminate at least some sources of stress.

DETERMINING RESPONSE PATTERNS

Procedure

1. Evaluated adaptation factors that influence stress management.
2. Assessed effects of stress on the client.

Performed Mastered
yes no

Performed yes	no	Mastered

MANAGING STRESS

Procedure

1. Discussed client's body response to stress.
2. Taught client to be aware of stress sensations in his or her body.
3. Suggested that client frequently monitor thought patterns to identify those thoughts that cause automatic tensing responses.
4. Assisted client to decide whether these thoughts are essential to survival or if they could be changed, eliminated, or replaced.
5. Assisted client in planning to set aside periods each day for self-stress evaluation.
6. Provided problem-solving assistance so client could examine new, more appropriate response patterns.
7. Referred client to resources that will assist in developing new responses.

Performed Mastered
yes no

MANIPULATING THE ENVIRONMENT TO REDUCE STRESS

Procedure

1. Modified client's external environment so that adaptation responses were within his or her capacity.
2. Supported efforts of client to adapt or to respond.
3. Provided client with materials required to maintain constancy of his or her environment.

Performed Mastered
yes no

4. Understood body's mechanisms for accommodating stress.
5. Prevented additional stress.
6. Reduced external stimuli and input through senses.
7. Reduced or increased physical activity depending on cause of and response to stress.

TEACHING COPING STRATEGIES

Procedure

1. Analyzed client's stress status.
2. Discussed various options for reducing stress—which alternatives fit with client.
3. Suggested client use diversion methods of coping.
4. Planned with client how to use rest as a way to cope with stress.
5. Taught client how to use concentration, body relaxation, breathing, or meditation techniques to relieve mind stress.
6. Reminded client that laughter is a great tranquilizer and healer as well as a stress reducer, and assisted client to plan how to use this method.

MANAGING STRESS USING A HOLISTIC MODEL

Procedure

1. [Taught client to] manage stress through exercise.
2. [Taught client to] manage stress through diet.
3. [Taught client to] manage stress by altering lifestyle patterns.

ALLEVIATING STRESS USING CONTROLLED BREATHING

Procedure

1. Instructed client to sit so that his or her back is well supported, with spine straight but not rigid.
2. Had client place feet flat on floor and place hands on legs.
3. If client was lying down, had him or her place hands at side.
4. Suggested client find a comfortable position, close eyes, and take a deep, slow breath through nostrils.
5. Continued giving client instructions on how to reduce stress through controlled breathing.
6. Stopped process by having client open his or her eyes.

Performed Mastered
yes no

	Performed yes	Mastered no

ALLEVIATING STRESS USING BODY RELAXATION

Procedure

1. Placed client in a comfortable position.
2. Instructed client to concentrate on each key muscle of the body, tensing and relaxing each muscle until it was totally relaxed.
3. Asked client to tense and release the muscles in left toes, left foot, left calf, left thigh, and left leg.
4. Had client continue process on right leg, trunk, upper torso, arms, shoulders, neck, and face. Then had client check to see that every muscle was relaxed.
5. Asked client to check for tight areas, any tension, any uncomfortable areas or sensations, and then to let it all go. Asked client if he or she was willing to let all of the tension go.
6. Asked client to practice being totally relaxed.

ALLEVIATING STRESS USING MEDITATION

Procedure

1. Instructed client in meditation techniques—suggested books or tapes that focus on meditation.
2. Encouraged client to begin meditation—suggested positive outcomes.

Performed Mastered
yes no

	Performed yes	Mastered no

Medication Administration

Performance Checklist

UNIT ONE Medication Administration

UNIT ASSESSMENT

- Validated medication to be given with physician’s order and client’s MAR.
- Knew desired therapeutic action of the drug, side effects, and adverse reactions.
- Assessed for potential drug interaction with client’s other medications or contraindications to administration (allergy, lab data, vital signs, usage, dose).
- Identified route for drug administration.
- Recognized need to calculate drug dosage and seek verification of calculation by another nurse.
- Validated drug and amount of certain critical drugs with another nurse.

PREPARING MEDICATIONS

Procedure

Preclinical Preparation

1. Checked physician’s orders and client’s MAR for medications client is to receive (drug, dosage, route of administration, time intervals).
2. Identified unfamiliar drugs.
3. Researched unfamiliar drugs using appropriate reference.
4. Reviewed client’s record for allergies, lab data, any factor (e.g., NPO status, planned procedures) that contraindicated administration of ordered medications.
5. Checked client’s MAR with physician’s orders every 24 hours for any adjustments to drug, dosage, route, and time to be given.

	Performed yes	Mastered no

6. Checked client's vital signs if indicated before administering medication.
7. Washed hands and donned gloves if indicated.
8. Administered medication according to route procedure and adhering to the "Five or Six Rights" of medication administration.
9. Disposed of equipment appropriately; then removed gloves, if used, and washed hands.
10. Recorded administered medications in client's record: the time, medication given, dosage, route (including site of injection), and any relevant assessment findings.

	Performed yes	Mastered no

UNIT TWO Oral Administration

UNIT ASSESSMENT

- Checked that medication was to be given by oral route.
- Determined that client was not NPO.
- Determined that client was able to take medications orally.
- Determined that medication could be safely altered if necessary for administration.

PREPARING ORAL MEDICATIONS

Procedure

for Liquid Medications

1. Removed bottle lid and placed topside down to avoid contamination.

	Performed yes	Mastered no

2. Held bottle with label facing up to avoid dripping medication onto label.
3. Set medication cup on firm surface and poured liquid medication; read fluid dispensed at eye level; *read at lowest point of meniscus*.
4. Wiped bottle lip before replacing cap. Checked medication label again.
5. Returned multidose bottle to storage area. Signed out for any narcotic dispensed on narcotic sheet with date, client's name room number, physician's name, dosage, your signature, and any wasted narcotic (co-signed by another nurse).
6. Remembered to check the label three times:
 - a. When taking the medication container from storage place.
 - b. When placing medication into medicine cup.
 - c. When returning medication container to storage place.

for Crushing or Altering Medications

1. Left pill in unit dose packaging and placed on firm surface.
2. Pounded pill with pestle or other tool to crush, pulverizing thoroughly or placed pill between two soufflé cups before crushing.
3. Removed any uncrushed pill coating if medication is to be given per feeding tube.
4. Checked orders for partial dose medication. Placed tablet in pill cutter if not scored.
5. If giving orally, mixed pulverized medication (or powder from opened capsule) carefully in small amount of soft food (pudding, jelly, applesauce).

	Performed yes	Mastered no

6. Opened capsule and sprinkled “beads” over soft food to administer. Warned client not to chew the “beads.”
7. Ensured client has received all of medication.
8. Offered liquid or food to cleanse palate.

ADMINISTERING ORAL MEDICATIONS TO ADULTS

Procedure

1. Took medication tray or cart to client’s room; checked room and bed number against medication record.
2. Checked client’s identaband, and asked client to state name.
3. Placed client in sitting position.
4. Explained to client what type of medication you were giving and its purpose.
5. Determined if bedside assessment was indicated before administering medication and assessed client.
6. Removed medication from packet and placed in medication cup.
7. Handed medication cup to client.
8. Offered fresh glass of water or other liquid.
9. Made sure client swallowed medication.
10. Discarded used medicine cup.
11. Recorded medication on appropriate forms.
12. Assessed client for drug action and side effects.

Performed Mastered
yes no

Performed yes	no	Mastered

ADMINISTERING MEDICATIONS PER NG OR ENTERAL TUBE

Procedure

1. Stopped any continuous tube feeding for 30 minutes if medication was to be given on empty stomach.
2. Diluted crushed tablet or powder from capsule in 30 mL warm water.
3. Donned gloves.
4. Disconnected NG tube from feeding system.
5. Inserted 50 mL syringe into NG tube and aspirated to check.
6. Administered each medication separately, allowing to flow through tube by gravity.
7. Flushed tube with 15-30 mL water after each medication, monitoring amount of flush to record on I&O sheet.
8. Restarted tube feeding at appropriate time.

ADMINISTERING ORAL MEDICATIONS TO CHILDREN

Procedure

1. Checked child’s identaband and had child state name.
2. Told child it was time to take medicine and explained rationale for medication to family.
3. Assessed any indicated assessment findings before medication administration.
4. Allowed child to select which medication to take first.

Performed Mastered
yes no

Performed yes	no	Mastered

5. Told child, if indicated, that medication was mixed with food/liquid and would not taste like the food or liquid without medication.
6. Asked family about best way to administer medication.
7. Administered medication (or medication/food mixture) considering child's developmental level.
8. Followed with fluids of child's choice.
9. Confirmed that medication has been swallowed.
10. Offered praise to child for taking medication.

	Performed yes	Mastered no

for Liquid Medication

1. Placed dropper or syringe in buccal area of child's mouth, aiming toward cheek.
2. Allowed child to suck, or squeezed medication slowly into mouth—or allowed infant to suck medication from nipple.

UNIT THREE Topical Administration

UNIT ASSESSMENT

- Assessed for proper route of medication administration.
- Observed skin for open lesions, rash, or redness.
- Determined drug manufacturer's recommended site for transdermal application.
- Assessed that area for transdermal application was dry, hairless, intact.
- Assessed for allergies as reported by client or noted in client's chart.
- Assessed condition of ear or eye and surrounding area.

- Determined purpose for eye or ear irrigation.
- Assessed client's ability to cooperate with eye/ear medication administration or irrigation.

APPLYING DERMAL MEDICATIONS

Procedure

1. Took medication container and dressing supplies to client's room.
2. Checked room and bed number against client's record and checked client's identification band, asking client to state name.
3. Provided privacy.
4. Explained procedure and purpose to client.
5. Washed hands and donned clean gloves.
6. Cleansed skin site with soap and water and dried thoroughly.
7. Squeezed medication from tube or used tongue blade to take cream/ointment from medication container.
8. Spread a small quantity of medication smoothly and evenly with gloved hand over client's skin following direction of hair follicles.
9. Applied dressing if indicated.
10. Labeled dressing with date, time, and your initials.
11. Removed gloves and washed hands.
12. Checked that client was comfortable.
13. Returned medication container to storage area.

	Performed yes	Mastered no

APPLYING CREAMS TO BURNS OR LESIONS

Procedure

1. Took medication to client's room; checked room and bed number against medication record.
2. Checked client's identaband and asked client to state name.
3. Provided privacy.
4. Washed hands and donned mask and clean gloves.
5. Removed previous dressing if present.
6. Noted characteristics of site and cleansed area as ordered. Removed and discarded gloves.
7. Opened medication container.
8. Donned sterile gloves.
9. If no dressing was ordered: used gloved hand to apply medication directly to burn or lesion; applied medication sparingly to 1/16th inch thickness.
10. If dressing was ordered: applied thin layer of medication to sterile gauze, then applied dressing to burn/lesion area.
11. Secured dressings with Kerlix wrap or body net if large area was involved.
12. Labeled dressing with date, time, and your initials.
13. Checked to assure that client was comfortable following procedure.
14. Removed gloves and washed hands.
15. Returned medication container to appropriate storage area.

Performed Mastered
yes no

APPLYING TRANSDERMAL MEDICATIONS

Procedure

1. Took medication to client's room; checked room and bed number against medication record.
2. Checked client's identaband, and asked client to state name.
3. Provided privacy.
4. Washed hands.
5. Donned gloves.
6. Alternated areas with each dose of medication to prevent skin irritation. Removed and discarded previous medicated paper/patch and cleansed area prior to applying new dose. Observed for any skin reaction.
7. Placed prescribed medication directly on paper.
8. Applied medicated paper to clean, dry, hairless intact skin.
9. Used paper to spread medication paste over a 2 inch area. Secured paper with tape or covered medicated area with plastic wrap and tape.
10. For patch, removed protective covering and immediately applied patch to clean, dry, hairless intact skin.
11. Removed gloves and washed hands.
12. Labeled patch or paper with date, time, and your initials.
13. Checked to assure that client was comfortable following procedure.
14. Returned medication to appropriate storage area.

Performed Mastered
yes no

12. Cautioned client that ointment would cause vision to be temporarily blurred.
13. Recapped and replaced medication.
14. Removed gloves and washed hands.

IRRIGATING THE EYE

Preparation

1. Checked physician's orders for irrigation.
2. Washed hands.
3. Gathered equipment.
4. Warmed irrigation solution to body temperature (about 105°F) by placing container in dry heating pad.

Procedure

1. Took equipment to client's room, checked room and bed number against medication record.
2. Checked client's identaband and asked client to state name.
3. Provided privacy.
4. Explained procedure and purpose to client.
5. Placed client in semi-Fowler's position, turned to side of client's affected eye.
6. Had client hold curved basin on cheek under affected eye.
7. Donned gloves.
8. Opened client's eye and used your thumb and forefinger to expose lower conjunctival sac by pulling the sac down toward cheek.

Performed Mastered
yes no

Performed yes	Mastered no

9. Placed eye irrigation bottle spout tip $\frac{3}{4}$ inch above client's inner canthus, pointing downward toward the outer canthus.
10. Squeezed bottle, allowing irrigation solution to flow into client's conjunctival sac to remove debris.
11. Continued irrigating for ten minutes or until eye was cleansed completely.
12. Noted results of debris returned with irrigation.
13. Wiped client's eyelid with gauze, wiping from inner to outer canthus.
14. disposed of equipment in appropriate area.
15. Removed gloves and washed hands.
16. Assisted client to comfortable position.
17. Documented irrigation and results.

for Bilateral Irrigation

1. Spiked saline bag with IV tubing and hung bag on pole.
2. Affixed end of IV tubing to nasal cannula, then fitted cannula around client's head (or around ears as for oxygen administration) securing prongs at bridge of client's nose with tape.
3. Started flow of saline solution from IV bag and allowed to flush client's eyes to neutralize a chemical exposure.
4. Increased flow rate, then continued wide open irrigation until 500 mL had been used over a 10 minute period.
5. Followed steps 12–17 above.

Performed Mastered
yes no

Performed yes	Mastered no

ADMINISTERING OTIC MEDICATIONS

Performed Mastered
yes no

Preparation

1. Checked medication record with most recent physician's orders.
2. Gathered equipment.
3. Removed medication from cart.
4. Compared label on medication bottle to medication record.
5. Warmed medication bottle to body temperature.

Procedure

1. Took warmed medication to client's room and checked room number against medication card or sheet.
2. Checked client's identaband and asked client to state name.
3. Explained procedure and purpose to client.
4. Washed hands.
5. Donned gloves.
6. Positioned client on side, with ear to be treated in the uppermost position.
7. Filled medication dropper with prescribed amount of medication.
8. Prepared client for instillation of ear medication.
 - a. *Infant.* Drew pinna gently downward and backward.
 - b. *Adult.* Lifted pinna upward and backward.
9. Instilled medication drops, holding dropper slightly above ear.
10. Instructed client to remain on side for 5–10 minutes following instillation.
11. Disposed of gloves and washed hands.

IRRIGATING THE EAR CANAL

Performed Mastered
yes no

Procedure

1. Took equipment and warmed solution to client's room; checked room and bed number against medication record.
2. Checked client's identaband and asked client to state name.
3. Provided privacy.
4. Explained procedure and purpose to client.
5. Donned clean gloves.
6. Placed client in Fowler's position and placed absorbent towel over client's chest and shoulders.
7. Poured irrigating solution into round basin.
8. Placed curved basin under ear to catch irrigating solution.
9. Filled syringe with irrigating solution.
10. Opened and straightened client's ear canal by pulling the pinna up and backward for adult or down for an infant or child.
11. Held irrigating syringe at entrance to ear canal without occluding meatus.
12. Pushed plunger, directing flow of solution toward the top of the canal.
13. Noted return flow throughout procedure.
14. After solution has ceased to flow, removed syringe from ear.
15. Returned client to comfortable position and dried ear canal with hair dryer on "Low."
16. Returned used equipment to appropriate area.
17. Removed gloves and washed hands.
18. Documented irrigation and results.

UNIT FOUR Mucous Membrane Administration

UNIT ASSESSMENT

- Assessed that drug could be administered sublingually.
- Assessed client's ability to understand and follow directions.
- Assessed vital signs, SpO₂, relevant to medication action.
- Assessed for dyspnea, labored breathing, wheezing.
- Determined possible undesired systemic effects of inhaled agents (tremor, nausea, tachycardia).
- Assessed client's bowel elimination pattern.
- Reviewed physician's orders for medication and diluent administration, and frequency of treatment.
- Assessed client's breath sounds before and after each treatment.
- Observed amount and character of expectorated sputum.
- Determined need for other respiratory techniques.

ADMINISTERING SUBLINGUAL MEDICATIONS

Preparation

1. See *Preparing Medications, Unit 1*.
2. Assessed vital signs if administering sublingual nitroglycerin. (*Systolic BP should not be lower than 90 mm Hg.*)
3. Placed client in sitting position.

Procedure

1. Followed steps for preparing and administering oral medications, *except*:
 - a. Explained that client must not swallow drug or eat, smoke, or drink until medication was completely absorbed.

Performed Mastered
yes no

Performed yes	Mastered no

- b. Asked client to place tablet under tongue or to hold tongue up so that tablet could be placed under tongue.

or Alternate:

- c. held nitrolingual canister vertically with spray opening as close to mouth as possible. Delivered 1 or 2 metered sprays onto or under tongue, then had client close mouth immediately. Told client not to inhale medication.
2. Evaluated client for drug action and possible side effects (e.g., headache).
3. Documented actions of drug or client's response in nurses' notes to monitor effects.

INSTILLING NOSE DROPS

Procedure

1. Took equipment to client's room; checked room and bed number against medication record.
2. Checked client's identaband and asked client to state name.
3. Placed client in sitting position with head tilted back or in supine position with head tilted back over pillow.
4. Filled dropper with prescribed amount of medication.
5. Placed dropper just inside the naris and instilled correct number of drops. Repeated procedure in other naris.
6. Wiped away any excess medication with tissue.

Performed Mastered
yes no

Performed yes	Mastered no

7. Instructed client not to sneeze or blow nose and to keep head tilted back for 5 minutes to prevent medication from escaping.
8. Checked to see that client was comfortable before leaving room.
9. Returned medication to appropriate storage area.
10. Washed hands.

ADMINISTERING METERED-DOSE INHALED MEDICATIONS (MDI)

Procedure

1. Took medication canister and MDI dispenser to client's room.
2. Checked client's identaband and asked client to state name.
3. Provided privacy.
4. Explained procedure and purpose to client.
5. Assisted client to standing or sitting position.
6. Inserted canister (stem down) into longer part of metered-dose dispenser.
7. Shook MDI with canister to mix medication and propellant. (*Shook canister before each MDI puff.*)
8. Instructed client to removed mouthpiece and hold inhaler 2 inches away from mouth (following manufacturer's instructions).
9. Instructed client to exhale through pursed lips.

	Performed yes	Mastered no

10. Instructed client to depress inhalation device, releasing a puff of medication while inhaling slowly and deeply (3–5 seconds).
11. Told client to hold breath for 10 seconds, then remove unit and slowly exhale through pursed lips.
12. Assessed client's breathing and reaction to medication.
13. Provided tissues.
14. Instructed client to wait 1 or 2 minutes between inhalations and to shake canister before each puff.
15. Had client replace mouthpiece cap.
16. Cautioned client not to increase dose without physician's order.
17. Had client rinse mouth after using MDI that contains steroids.
18. Taught client to remove canister and to clean mouthpiece *daily*, washing with soap and water and allowing to air dry.
19. Reviewed medication side effects with client.
20. Washed hands.
21. Documented procedure and results.

USING MDI WITH SPACER

Procedure

1. Assembled medication canister in MDI.
2. Inserted MDI mouthpiece into spacer.
3. Removed mouthpiece cover from spacer.

	Performed yes	Mastered no

4. Holding upright, shook MDI with spacer to mix medication and propellant.
5. Instructed client to exhale slowly through pursed lips.
6. Instructed client to close lips around spacer mouthpiece.
7. Activated MDI canister, pressing down with fingers, pushing it further into plastic adapter.
8. After activation, instructed client to inhale slowly and deeply through mouth and hold breath 10 seconds.
9. Instructed client to exhale and relax.
10. Provided water mouth rinse following corticosteroids.
11. Removed drug canister and cleaned mouthpiece and spacer daily, washing with soap and water.

ADMINISTERING MEDICATION BY NONPRESSURIZED (NEBULIZED) AEROSOL (NPA)

Preparation

1. Washed hands.
2. Diluted medication as ordered and placed in nebulizer chamber.
3. Attached one end of tubing to compressed air source.
4. Attached other end of tubing to nozzle at side or bottom of nebulizer.

Performed Mastered
yes no

Performed yes	Mastered no

5. Kept nebulizer chamber vertical and connected top of nebulizer chamber to mask or T-piece sidearm.
6. Held mouthpiece in its protective cover and attached mouthpiece to one end of T-piece.
7. Attached corrugated tubing to other end of T-piece.

Procedure

1. Turned on air or oxygen (8 L/min) source, and observed for mist flow.
 - a. If client was receiving 3 L/min or less of oxygen therapy, delivered aerosolized medications with compressed air (yellow wall outlet).
 - b. If the client was receiving 4 L/min or more of oxygen therapy, delivered the aerosol medication with the oxygen flowmeter (green wall outlet) set at 8 L/min.
2. Had client place mouthpiece in mouth and closed lips.
3. Instructed client to breathe normally in and out of mouthpiece or mask.
4. Had client take deep breath and hold for several seconds, then exhale slowly every 3–5 breaths.
5. Turned power (air or O₂ flow) off, and unplugged compressor (if used), or reset prescribed O₂ flow rate.
6. Cleaned mouthpiece and placed equipment in plastic bag at bedside. (Disposed of and replaced components according to agency policy.)

Performed Mastered
yes no

Performed yes	Mastered no

5. Removed needle guard and any air bubbles.
6. Determined if dosage in cartridge was greater than required amount. If so, inverted Tubex and gently expelled excess medication, being careful to maintain sterility of needle.
7. Replaced needle guard.

ADMINISTERING INTRADERMAL INJECTIONS

Procedure

1. Took prepared injection to client's room; checked room and bed number against client's medication record.
2. Checked client's identaband and asked client to state name.
3. Explained procedure and purpose to client.
4. Washed hands and donned gloves.
5. Selected lesion-free injection site on undersurface, upper third of forearm for skin testing.
6. Cleansed area with antimicrobial wipe, using circular motion outward from site and allowed to dry.
7. Removed needle guard.
8. Grasped client's dorsal forearm to gently pull skin taut on ventral forearm.
9. Held syringe almost parallel to skin, inserted needle at 10°–15° angle with bevel facing up, about 1/8 inch. Needle point should be visible under skin. **DID NOT ASPIRATE.**

Performed Mastered
yes no

Performed yes	Mastered no

10. Injected medication slowly, observing for a wheal (blister) formation and blanching at the site.
11. Withdrew needle at same angle as inserted. Patted area gently with a dry gauze pad but **DID NOT MASSAGE.**
12. Activated needle safety feature and discarded syringe unit in puncture-proof container.
13. Marked injection site with pen for future assessment.
14. Returned client to comfortable position.
15. disposed of gloves and washed hands.
16. Recorded site and antigen in client's record.

ADMINISTERING SUBCUTANEOUS (SUB Q) INJECTIONS

Procedure

1. Took prepared injection to client's room; checked room and bed number against client's medication record.
2. Checked client's identaband and asked client to state name.
3. Explained procedure and purpose to client.
4. Washed hands and donned gloves.
5. Selected fatty site for injection (e.g., abdomen, avoiding 2 inch radius around umbilicus), alternating sites for each injection.
6. Cleansed area with antimicrobial wipe, using circular motion from inside outward.

Performed Mastered
yes no

Performed yes	Mastered no

USING Z-TRACK METHOD

Procedure

1. Gathered equipment.
2. Washed hands.
3. Added 0.3–0.5 mL of air to syringe.
4. Attached a new 2-inch sterile needle to syringe.
5. Took medication to client’s room; checked room number against MAR.
6. Checked client’s identaband and asked client to state name.
7. Provided privacy.
8. Explained procedure and purpose to client.
9. Donned gloves.
10. Placed client in prone position if possible.
11. Cleansed site with antimicrobial wipe.
12. Pulled skin 1 to 1½ inch laterally away from injection site.

Performed Mastered
yes no

Performed yes	Mastered no

13. Maintaining displacement, inserted needle at a 90° angle. Aspirated by pulling back on plunger to see if needle was in blood vessel. If so, discarded and prepared new injection.
14. Injected medication and air bubble slowly and waited 10 seconds, keeping skin taut.
15. Withdrew needle and released retracted skin.
16. Applied light pressure with antimicrobial swab. Did *not* massage.
17. Activated needle safety feature.
18. Returned client to a position of comfort and safety.
19. Discarded gloves and equipment in appropriate area.
20. Washed hands.
21. Documented administration of medications in medication record.

Performed Mastered
yes no

Performed yes	Mastered no

Nutritional Management

Performance Checklist

UNIT ONE Modified Therapeutic Diets

UNIT ASSESSMENT

- Assessed client's total health status—physical, emotional, and mental status.
- Determined appropriateness of prescribed therapeutic diet as related to altered state of health.
- Evaluated client's ability to tolerate diet.
- Assessed client's acceptance of diet regimen.
- Referred to general assessment steps in maintaining normal nutritional status.
- Assessed client's dietary preferences.

RESTRICTING DIETARY CARBOHYDRATES

1. Hypoglycemia diet: chose foods with moderate carbohydrate reduction; 5 or 6 meals per day.
2. Diabetic diet: chose foods to provide balance of protein, fat, and carbohydrates.

RESTRICTING DIETARY PROTEIN

1. Low-protein diet: decreased protein allowance to 0.6/kg/day; reduced intake of eggs, meat, milk, and milk products.
2. PKU diet: reduced protein intake; avoided milk and milk products.

Performed **Mastered**
yes **no**

Performed yes	no	Mastered

RESTRICTING DIETARY FAT

1. Restricted cholesterol diet: limited foods such as egg yolk, red meat, shellfish, organ meats, bacon, and pork.
2. Modified fat diet: avoided gravies, fatty meats and fish, cream, fried foods, rich pastries, whole-milk products, cream soups, oils, nuts, and chocolate.

RESTRICTING MINERAL NUTRIENTS

1. Restricted sodium diet: restricted intake of salt, and products containing sodium.
2. Low calcium diet: restricted whole grain breads and cereals, dried fruits and vegetables, fish, shellfish, cheese, chocolate, and nuts.

PROVIDING NUTRIENT ENHANCED DIETS

1. Increased potassium diet: included foods such as fruit juices, eggs, legumes, whole grains, milk, dried fruits, meat, and fish.
2. High iron diet: included foods such as organ meats, egg yolks, whole-wheat products, seafood, leafy vegetables, nuts, and dried fruit.
3. High calcium diet: encouraged intake of leafy green vegetables, and non-liquid dairy products (cheese, yogurt).

Performed Mastered
yes no

Performed yes	Mastered no

PROVIDING MODIFIED DIETS

for Dietary Fiber

1. High fiber diet: included beans, nuts, fruits, vegetables, grains, and cereals.
2. Low fiber diet: included foods such as ground meat, fish, broiled chicken without skin, creamed cheeses.

for Postoperative Diet Progression

1. Clear-liquid diet: included water, tea, broth, gelatin, and juices.
2. Full-liquid diet: included any food that is liquid at room temperature.
3. Surgical soft diet: included foods easy to chew, digest, and limited fiber.
4. General diet: included foods appropriate for client's health status.

PROVIDING CONSISTENCY DIETS

for Bland Diet

1. Eliminated food sources that are chemically and mechanically irritating.
2. Provided frequent, small feedings.

for Mechanical Soft Diet

1. Provided foods easily broken down.
2. Allowed client choice variations from soft diet.

for Pureed Diet

1. Provided foods blended to a smooth consistency.
2. Assisted client by describing foods and keeping them separate.

Performed Mastered
yes no

Performed yes	Mastered no

UNIT TWO Nutrition Maintenance

UNIT ASSESSMENT

- Checked appropriate dietary order.
- Assessed client's nutritional needs.
- Determined client's sociocultural orientation.
- Obtained client's diet history, and determined eating habits and food preferences.
- Assessed client's ability to comply with diet regimen.
- Assessed client's fluid intake needs.
- Checked recommended daily dietary allowances and essential body nutrients.
- Evaluated results of appropriate data.
- Assessed client's risk for aspiration.
- Checked for specific instructions for positioning and feeding techniques for dysphagic client.

SERVING A FOOD TRAY

Procedure

1. Washed hands and assisted client to wash hands.
2. Raised bed to HIGH position and lowered side rail.
3. Assisted client to sitting position if possible.
4. Placed protective covering over gown.
5. Placed tray on tray table. Positioned table so client could see food.
6. Assisted client as needed (e.g., cut meat, opened milk carton).

Performed Mastered
yes no

Performed yes	Mastered no

Performed Mastered
yes no

Performed yes	Mastered no

7. Checked on client during meal to determine if assistance was necessary.
8. Repositioned tray table at bedside when completed.
9. Provided hand cleaning and oral care.
10. Offered bedpan or assistance to commode or bathroom.
11. Raised side rail.
12. Positioned bed for comfort.
13. Noted amount of food eaten.
14. Removed food tray from room.
15. Washed hands.
16. Charted amount eaten. If necessary, recorded liquid intake.

ASSISTING THE VISUALLY IMPAIRED TO EAT

Procedure

1. Checked client care plan for current changes in diet.
2. Check room number, client's identaband and allergy band, and asked client to state name.
3. Washed hands.
4. Raised bed to HIGH, and lowered side rail.
5. Assisted client to wash hands and face if desired.
6. Placed client in sitting position if possible.
7. Placed protective covering over gown.

18. Helped with feeding only if client showed signs of weakness, fatigue.
19. Provided positive reinforcement for accomplishment.
20. Assisted with oral care and hand washing following meal.
21. Removed food tray and raised side rails as indicated.
22. Placed call bell in reach.
23. Recorded percentage of food eaten and amount of liquid intake, if indicated.
24. Maintained client's sitting position for 30 minutes after eating.
25. Carefully observed client with impaired communication for 30 minutes after the first few servings.

	Performed yes	no	Mastered

UNIT THREE Gastrointestinal Intubation

UNIT ASSESSMENT

- Assessed client status necessitating GI decompression.
- Assessed client's nutritional status.
- Evaluated oral intake and diet history.
- Assessed nutritional requirements.
- Assessed status of GI tract.
- Assessed capacity to chew and swallow and presence of gag reflex.
- Assessed patency of nares.
- Checked for vomiting, diarrhea, or abdominal distension.
- Assessed risk for aspiration.

INSERTING A LARGE BORE NASOGASTRIC TUBE

Preparation

1. Checked physician's orders and client care plan.
2. Determined appropriate size of catheter. Checked tube for defects and patency.
3. Checked client's identaband and asked client to state name.
4. Discussed procedure with client.
5. Provided privacy.
6. Gathered equipment.

Procedure

1. Washed hands and donned clean gloves.
2. Positioned client at 45° angle or higher with head elevated.
3. Examined nostrils, and selected the most patent nostril by having client breathe through each one.
4. Placed towel over client's chest and emesis basin within reach; established cueing signal for client.
5. Measured from tip of nose to earlobe to xiphoid (NEX) process of sternum to determine appropriate length for tube insertion.
6. Coiled end of tube over fingers.
7. Lubricated first 4 inches of tube with water-soluble lubricant.
8. Inserted tube through nostril to back of throat. Aimed the tube toward back of throat and down. Suggested client swallow to assist tube insertion.

	Performed yes	no	Mastered

PROVIDING CONTINUOUS FEEDING VIA NASOINTESTINAL/JEJUNOSTOMY TUBE

Preparation

1. Checked physician's order for feeding formula (type and volume to administer).
2. Checked x-ray report.
3. Washed hands.
4. Gathered equipment.
5. Marked date on formula, reservoir, administration tubing (to be changed daily).

Procedure

1. Filled with enough formula to limit hang time to 4 hours if using reservoir or bag for continuous intestinal feeding.
2. Connected administration tubing to formula reservoir (container or bag) and primed tubing per manufacturer's instructions.
3. Threaded tubing through pump per manufacturer's instructions.
4. Noted mark on client's feeding tube to determine if migration had occurred.

Performed Mastered
yes no

Performed yes	Mastered no

Performed Mastered
yes no

Performed yes	Mastered no

5. Connected primed formula tubing to client's small-bore nasointestinal tube. Initiated feeding with isotonic (300 mOsmol) or slightly hypotonic formula. *Alternate Method for Continuous Jejunostomy Feeding Tube: Connected formula tubing to client's surgically established jejunostomy feeding tube.*
6. Started feeding at slow constant infusion rate (25–50 mL/hr).
7. Increased rate in 8–24 hours (increase by 25–50 mL/hr) to prescribed rate, if client tolerated feeding.
8. Kept client's head of bed elevated at 30–45° angle at all times if infusion was continuous.
9. Flushed small-bore continuous feeding tube, using side-port, every 4–6 hours with 30 mL warm water.
10. Obtained a new sterile syringe each time closed system side port was used for flushing.
11. Rinsed open system reservoir thoroughly before adding additional formula.