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End-of-Life Care

Performance Checklist

UNIT ONE The Grief Process

UNIT ASSESSMENT

- ☐ Observed for presence of psychological symptoms.
- ☐ Observed for somatic symptoms.
- ☐ Determined client's complaints.
- ☐ Observed stage of grief response client is experiencing.
- ☐ Observed for morbid reaction to grief.

UNDERSTANDING GRIEF

Procedure

	Performed yes	Performed no	Mastered
1. Understood importance of person lost as source of support.			
2. Observed degree of dependency of relationship.			
3. Identified degree of ambivalence felt toward deceased.			
4. Checked on number and nature of other relationships mourner had to depend on.			
5. Checked on number and nature of previous grief experiences.			
6. Determined degree of preparation for loss.			
7. Determined capacity to cope with loss.			

ASSISTING WITH GRIEF

Procedure

	Performed yes	Performed no	Mastered
1. Became familiar with grief process, stages of grief, and natural responses to grief so client would be provided with optimal support.			
2. Denial stage			

	Performed yes	Performed no	Mastered
3. Anger stage			
4. Bargaining stage			
5. Reactive depression stage			
6. Preparatory depression			
7. Resolution–acceptance stage			
8. Showed respect for cultural, religious, and social customs throughout stages of mourning.			
9. Offered support and reassurance to family.			

UNIT TWO The Dying Client

UNIT ASSESSMENT

☐ Observed client's physical symptoms.
   a. Evidence of circulatory collapse
   b. Variations in blood pressure and pulse
   c. Disequilibrium of body mechanisms
   d. Deterioration of physical and mental capabilities
   e. Absence of corneal reflex

☐ Observed client's ability to fulfill basic needs without complete assistance.

☐ Assessed nature and degree of pain client is experiencing.

☐ Observed for impending crisis or emergency situation.

☐ Observed for psychosocial condition.

☐ Determined anxiety level, which may be expressed in physical or emotional behavior.

☐ Determined depression level that client may be experiencing.

☐ Assessed family members' needs during the loss.

SUPPORTING THE CLIENT NEAR THE END OF LIFE

	Performed yes	Performed no	Mastered
Preparation			
1. Determined if client had a Do Not Resuscitate (DNR) signed form in chart or as part of informed consent.			
2. Determined if client had requested Limited Support or Comfort Support rather than CPR. Ensured physician has documented in client's chart.			
3. If client was unable to sign form, ensured legally recognized surrogate healthcare decision maker had signed request.			
Procedure			
1. Introduced self to client and family members.			
2. Determined if client had specific needs for comfort. Provided daily grooming, skin and mouth car, and exercise as tolerated.			
3. Determined if and how family members could assist client during this stage and assisted family members to provide care as requested.			
4. Moved client's bed near window so he/she could see outside vegetation, flowers, sky, etc.			
5. Reduced extraneous noise and odors (perfume, cigarette smoke). Moved client's room, if necessary. Did not place bed near nurses' station.			
6. Displayed cards, photos, "art work" from children, favorite objects that had special meaning for client in area where it was easier to see.			
7. Provided muted and soft room lighting, not overhead lighting.			

	Performed yes	Performed no	Mastered
8. Encouraged client to maintain independence by providing remote controls for TV, lights, and fans. Kept ice and water at the bedside in easy reach by client.			
9. Eliminated odors: a. Opened windows when possible. b. Turned on fans. c. Used air fresheners. d. Used aromatherapy (oils or lotion) for massage.			
10. Provided soft music according to client's preference for music.			
11. Limited visitors to no more than two at a time. Assessed if client needed rest by observing for signs of anxiety, restlessness, and voice trembling. When this occurred asked the visitors to please leave.			
12. Provided touch, like Peiki or other therapeutic touch techniques, especially over area of pain.			
13. Incorporated use of relaxation techniques in daily nursing care of client.			
14. Provided massage with aromatherapy products, if client agreed.			
15. Served only small portions of food that client requested.			
16. Kept lemon drops or mint fresheners at bedside and in easy reach for client.			
17. Used visualization and guided imagery through audiotapes if client desired.			
18. Ensured client had current Advance Directive on file in hospital and physician's office.			
19. Assisted with open communication with clients, family, and healthcare providers, regarding any cultural, spiritual or religious issues they wished to discuss relative to end of life.			

PROVIDING PAIN MANAGEMENT AT THE END OF LIFE

Procedure

	Performed yes	Performed no	Mastered
1. Assessed client for factors that play an important role in the management of pain. a. Completed detailed history of the client's condition. b. Determined effects of pain relief measures and medications currently taking. c. Had client explain characteristics of pain and use pain scale to determine severity of pain. d. Asked client if there were any cultural issues related to pain that should be known by the healthcare providers. e. Assessed client's psychosocial needs.			
2. Completed physical assessment of client.			
3. Assessed client for nonverbal clues indicating pain: restlessness, grimacing, moaning, irritability, and furrowed brow, crying, particularly if the client was sedated.			
4. Assessed client for physiological signs of pain, elevated blood pressure and pulse.			
5. After determining appropriate drug, dose, and route, administered drug and observed for effects of medication on pain relief and for potential side effects.			
6. Assessed client frequently for effects of pain management.			

7. Maintained around-the-clock sustained-release medications for continuous pain.
8. Treated breakthrough pain with immediate-release medications.

ASSISTING THE DYING CLIENT

Procedure

Performed yes	Performed no	Mastered

1. Minimized client's discomfort as much as possible.
2. Recognized symptoms of urgency or emergency conditions and sought immediate assistance.
3. Notified charge nurse if there was an impending crisis and performed emergency actions until help arrived.
4. Encouraged dying clients to do as much as they could for themselves so that they did not just give up—a state that only reinforces low self-esteem.
5. Provided emotional nursing care for client.
6. Provided level of care that encouraged client to retain confidence in health care team.
7. Assisted client through experience of dying in whatever way was appropriate.
8. Supported family of dying client.
9. Was aware of own personal orientation toward dying process.

SUPPORTING THE FAMILY OR CAREGIVER

Procedure

Performed yes	Performed no	Mastered

1. Introduced self to family or caregiver and explained your role in caring for client.
2. Provided honest answers to questions.
3. Reinforced client's wishes for end-of-life care related to DNR orders, living wills, and advance directive.
4. Explained each procedure/intervention you were providing for client.
5. Asked family members or caregiver how he/she wanted to participate in client care.
6. Encouraged family or caregiver to take time alone to regroup.
7. Provided or obtained psychosocial support and bereavement counseling for family.
8. Encouraged family members to build a support group of friends or other family members.
9. Reminded family or caregiver to eat properly and maintain an exercise schedule.
10. Referred family members to support groups as needed.
11. Referred family members to social services for help with issues such as insurance, living wills, funeral arrangements, and other financial constraints.
12. Prepared family for client's death.

UNIT THREE Postmortem Care

UNIT ASSESSMENT

- ☐ Verified that client had been pronounced dead by physician.
- ☐ Completed own observations that client had no observable responses to stimuli.
- ☐ Identified client by name and client's belongings for labeling.

PROVIDING POSTMORTEM CARE

Procedure

	Performed yes	Performed no	Mastered
1. If there were other clients or visitors in room, carefully explained situation and asked them to temporarily leave the room, if possible. Provided privacy.			
2. Collected necessary equipment.			
3. Followed hospital procedure regarding notification of various departments and personnel.			
4. Maintained proper alignment of body. Raised head of bed 30 degrees.			
5. Donned gloves.			
6. Did not replace dentures.			
7. Removed any external objects causing pressure or injury to skin.			
8. Converted all IV lines to hep locks or intermittent device.			
9. Cleansed body as needed. A partial bath may have been required to remove secretions, wound drainage, stains.			
10. Closed eyes. If necessary, used paper tape or gauze pads. This was done after family had visited the deceased.			
11. Placed protective incontinent pad under buttocks and between legs diaper fashion.			
12. If family was to visit deceased, provided clean linen and gown for client.			
13. Removed equipment used for cleansing client.			
14. If previously determined or requested by client or family, notified appropriate clergy or religious support person.			
15. After family and clergy had visited, labeled the body, attaching ID tags to big toe, wrist, and morgue bag or as determined by standard procedure.			
16. Placed arms and hands loosely at side or on abdomen.			
17. Placed body in shroud or in morgue bag.			
18. Labeled all personal belongings, and placed them in a bag.			
19. Removed gloves and washed hands.			
20. Closed doors to client's room, and cleared hallways in preparation to transfer body to morgue.			
21. Transferred body to morgue on gurney or special morgue cart. Kept client's head elevated.			
22. Placed client's personal belongings in appropriate place determined by hospital policy.			
23. Supported family members as needed.			

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Advanced Nursing Skills

Performance Checklist

UNIT ONE Pulmonary Artery Pressure (Hemodynamic) Monitoring

UNIT ASSESSMENT

- ☐ Evaluated client's understanding of procedure.
- ☐ Assessed for preexisting cardiovascular disease.
- ☐ Determined client's level of anxiety regarding procedure.
- ☐ Obtained baseline vital signs and ECG.
- ☐ Assessed insertion site for inflammation or infection.
- ☐ Assessed patency of all lines.
- ☐ Determined pressure on flush bag.
- ☐ Leveled and zeroed the monitoring system.
- ☐ Monitored PA systolic, PA diastolic, PA mean, and PAWP.
- ☐ Assessed cardiac output using thermodilution technique.

LEVELING AND ZEROING THE MONITOR SYSTEM

	Performed		Mastered
	yes	no	
Procedure			
1. Washed hands.			
2. Reassured client and explained procedure.			
3. Calibrated system.			
a. Using carpenter's level, adjusted height of transducer to level of client's atrium phlebotic access.			
b. To zero monitor, removed port cap, opened stopcock above transducer to air, closing it to client and flush system.			
c. Pushed "zero" monitor button and checked if monitor reading was zero.			
4. Checked that oscilloscope showed flat wave at zero line.			
5. Closed stopcock to reestablish flush system.			

ASSISTING PHYSICIAN WITH CATHETER INSERTION

Preparation

	Performed yes	Performed no	Mastered
1. Identified client's room, client's identaband, and had client state name.			
2. Explained rationale for procedure to client.			
3. Verbally reassured client.			
4. Washed hands.			
5. Connected rigid IV tubing to flush fluid bag.			
6. Placed prepared flush solution in pressure bag, and inflated to 300 mm Hg pressure.			
7. Prepared and assembled pressurized monitoring system (transducer, system flush device, and stopcocks) following manufacturer's instructions.			
8. Attached distal port stopcock to connecting tubing and heparinized flush solution, then attached to pressure-monitoring unit, making sure all connection were tight.			
9. Placed client in Trendelenburg's position and turned client's head to opposite side.			
10. Leveled and zeroed system according to manufacturer's instructions. Transducer was at level of client's atrium or phlebostatic axis (fourth intercostal space at the midchest line).			
11. Shaved and scrubbed skin with antiseptic solution.			
12. Opened sterile gloves for physician.			
13. Opened drape for physician.			
14. Cleansed lidocaine vial with alcohol wipe.			
15. Continuously monitored client's ECG throughout insertion of catheter.			

Procedure

	Performed yes	Performed no	Mastered
1. Donned gloves to assist physician as necessary.			
2. Observed for higher and more pronounced pressure waveform, indicating catheter's presence in right ventricle.			
3. Recorded right ventricular pressure (systolic and diastolic reading), and observed for dysrhythmias: premature ventricular contractions (PVCs) or ventricular tachycardia.			
4. Observed monitor for higher diastolic pressure and pulmonary arterial waveform.			
5. Removed syringe to allow balloon to deflate passively.			
6. Recorded pulmonary artery systolic (PAS), diastolic (PAD), and mean pressures. *Note: Measured all pulmonary artery pressures at end of expiration.*			
7. Inflated balloon fully or until a change was seen in waveform (pulmonary artery to wedge pressure).			
8. Recorded PAWP (pulmonary artery wedge pressure).			
9. Deflated balloon by releasing pressure syringe plunger or removed syringe to allow passive deflation.			
10. Determined balloon deflation by observing return of pulmonary artery waveform.			
11. Repeated steps and measurements to verify return of balloon function.			
12. Left balloon lumen port open at all times except during wedge placement.			
13. Cleared catheter using fast flush device.			
14. Applied occlusive dressing to site after physician secured catheter with sutures.			

	Performed yes	Performed no	Mastered
15. Reassured client and positioned for comfort.			
16. Auscultated chest for presence of breath sounds.			
17. Validated catheter placement by chest x-ray.			

OBTAINING PRESSURE READINGS

Preparation

	Performed yes	Performed no	Mastered
1. Leveled transducer, and zeroed (calibrated) monitor at the beginning of every shift.			
2. Checked catheter, tubing, and connection points to ensure patency and security.			
3. Marked client's midchest level at 4th ICS for consistent readings.			
4. Placed client flat supine or up to 60° elevation.			
5. Reassured client.			
6. Washed hands.			

Procedure

	Performed yes	Performed no	Mastered
1. Checked that air reference port (stopcock) of pressure transducer was at level of client's atrium (phlebostatic axis).			
2. Exposed distal port to transducer.			
3. Opened balloon inflation port-locking device.			
4. Attached syringe filled with proper amount of air, and aligned stopcock to open position.			
5. Slowly injected 0.8 or 1.5 mL air into balloon. Inflated sufficient volume only to support float and change in waveform.			
6. Observed waveform change from pulmonary artery to pulmonary artery wedge pressure on monitor.			
7. Balloon inflated only long enough to observe PAWP waveform.			
8. Allowed balloon to deflate passively.			
9. Ensured readings always taken at end of expiration whether or not client was on ventilator (documented if client was on ventilator).			
10. Used analog strip chart recording to obtain most valid pressure measurements.			
11. Maintained empty syringe on balloon port.			
12. Flushed line with fast flush device system.			
13. Recorded readings; verified and reported unusual findings to physician, if they persisted.			
14. Placed client in comfortable position.			
15. Changed dressings per agency procedure, and observed for complications at catheter insertion site.			

MEASURING CARDIAC OUTPUT

Preparation

	Performed yes	Performed no	Mastered
1. Checked physician's orders.			
2. Identified client's room, checked identaband, and asked client to state name.			
3. Washed hands.			
4. Spiked injectate solution bag with tubing/stopcock.			
5. Unclamped injectate tubing, primed tubing and stopcock, then reclamped tubing.			
6. Connected primed system to client's PA catheter proximal port.			

Performed yes	Performed no	Mastered

7. Stopped any medication being infused through proximal port.
8. Noted pulmonary artery waveform on monitor.
9. Connected computer cable to thermistor port of pulmonary artery catheter (according to manufacturer's instructions).
10. Obtained client's height and weight measures.

Procedure

1. Placed client in position used with previous hemodynamic readings: supine, may be elevated up to 60°.
2. Slowly flushed proximal injectate lumen, if any medications were being infused.
3. Selected *cardiac output* on bedside monitor menu.
4. Checked and set computation constant to reflect size of catheter, volume (5 or 10 mL) of injectate, client's height and weight. *(See PA catheter manufacturer's instructions.)*
5. Unclamped injectate solution tubing.
6. Attached syringe to stopcock and opened stopcock to withdraw 5 or 10 mL of injectate into syringe.
7. Ensured that client was quiet.
8. Opened stopcock to client and injected rapidly (2–4 seconds).
9. Noted and recorded monitor display of client's cardiac output measure.
10. Repeated procedure two more times.
11. Recorded averaged measure.

Performed yes	Performed no	Mastered

12. Clamped injectate tubing.
13. Opened stopcock to continue previous infusion to client.
14. Preserved closed cardiac output system by leaving tubing, stopcock, and syringe connections intact.
15. Determined derived values using client's cardiac output measure (stroke volume, systemic vascular resistance, pulmonary vascular resistance).

UNIT TWO Arterial Blood Pressure Monitoring

UNIT ASSESSMENT

- ☐ Determined need for intraarterial blood pressure monitoring.
- ☐ Determined client's level of anxiety about procedure.
- ☐ Assessed collateral perfusion of the hand using Allen test.
- ☐ Measured intraarterial (direct) systolic and diastolic pressure readings on monitor.
- ☐ Observed mean arterial pressure on monitor and validated using analog strip measurement.
- ☐ Observed for trends in arterial pressure readings.
- ☐ Evaluated patency of arterial catheter.
- ☐ Validated pressure on infusion system. (Pressure should be 300 mm Hg.)
- ☐ Assessed catheter insertion site for signs of infection or bleeding.
- ☐ Assessed circulation, motion, and sensation of extremity distal to catheter insertion site.

PERFORMING THE ALLEN TEST

Procedure

1. Performed Allen test to determine distal peripheral perfusion.
2. Compressed both arteries at client's wrist for about 1 minute.
3. Instructed client to clench and unclench fist several times.
4. With client's hand in open, relaxed position, released pressure on ulnar artery.
5. Observed how quickly palm color flushed.
6. Repeated procedure with release of radial artery.
7. Reported to physician if collateral blood flow was insufficient.

ASSISTING WITH ARTERIAL LINE INSERTION

Preparation

1. Explained rationale for procedure to client.
2. Verbally reassured client.
3. Gathered equipment.
4. Washed hands.
5. Added heparin to D_5W or NS solution, and labeled bag with additive and date (commonly 2 U heparin/mL fluid).
6. Connected IV tubing to solution bag.
7. Removed all air from flush solution bag.
8. Inserted flush infusion bag into pressure bag, and hung bag on IV pole.

Performed yes	Performed no	Mastered

9. Prepared and assembled pressurized monitoring system (transducer, continuous flush device, and stopcocks) following manufacturer's instructions.
10. Leveled stopcock above transducer to level of client's phlebostatic axis. (See previous skill.)
11. Shaved or prepared site as needed.
12. Inflated pressure infusion bag to 300 mm Hg, using hand pump on bag.

Procedure

1. Donned gloves, and prepared to assist physician as needed.
2. Observed for pulsating bright-red blood spurting retrograde into catheter.
3. Attached catheter to pressure-monitoring system tubing—made sure all connections secure.
4. Pressed on flush valve to clear system.
5. Observed oscilloscope for arterial waveform.
6. Applied sterile antiseptic ointment, sterile dressings, and tape to site.
7. Set monitor alarms for both HIGH and LOW parameters.

MONITORING ARTERIAL BLOOD PRESSURE

Procedure

1. Leveling and zeroing the system.
   a. Calibrated system at beginning of each shift.
   b. Positioned client with HOB flat or up to 60° elevation.

Performed yes	Performed no	Mastered

	Performed yes	Performed no	Mastered
c. Using carpenter's level, aligned stopcock above transducer level with client's left atrium (phlebostatic axis) and marked client for future readings.			
d. To zero ("calibrate") the system, turned stopcock near transducer OFF to client. Removed cap from stopcock, opening it to air.			
e. Depressed monitor "zero" button, released button, and noted that monitor reading was zero.			
f. Turned stopcock so transducer was OPEN to client.			
2. Observed arterial waveform at eye level for sharp systolic upstroke, peak, dicrotic notch, and end diastole.			
3. Compared direct and indirect blood pressure measurements at least every 4 hours.			
4. Fast flushed line with valve device to keep system air free.			
5. Ensured pressure infusion bag was maintained at 300 mm Hg.			
6. Left cannulated extremity uncovered for easy observation.			
7. Assessed circulation, motion, and sensation of extremity distal to cannulation site every 2 hours initially, then every 8 hours.			
8. Immobilized extremity if necessary.			
9. Changed flush solution and tubing every 24–72 hours.			
10. Changed dressing every 24–48 hours or if wet.			
a. Donned gloves.			
b. Removed dressing and discarded in biohazard container.			
c. Covered with 2 × 2 sterile gauze pad.			
d. Taped securely.			
11. Removed gloves and washed hands.			

WITHDRAWING ARTERIAL BLOOD SAMPLES

Preparation

	Performed yes	Performed no	Mastered
1. Gathered appropriate equipment.			
2. Explained procedure to client.			
3. Washed hands and donned gloves.			
4. Attached label to specimen syringe with client's name, hospital number, room number, time, and date.			
5. Filled paper cup or emesis basin with ice.			

Procedure

	Performed yes	Performed no	Mastered
1. Removed protective cap from open port on three-way stopcock closest to arterial line insertion site.			
2. Attached nonheparinized 5-mL sterile syringe without needle to open port of three-way stopcock.			
3. Turned stopcock off to transducer.			
4. Aspirated 4 mL blood for waste.			
5. Turned stopcock midway between open port and tubing.			
6. Discarded blood-filled syringe.			
7. Removed needle from ABG specimen syringe.			
8. Attached ABG specimen syringe to stopcock.			
9. Turned stopcock to open port to syringe.			

	Performed yes	Performed no	Mastered
10. Withdrew 3 mL for arterial blood gas specimen.			
11. Turned stopcock off to open port.			
12. Removed syringe and, holding syringe upright, attached air filter device and activated to expel all air.			
13. Placed arterial blood gas specimen syringe in container filled with ice.			
14. Fast flushed remaining blood onto gauze pad.			
15. Reattached protective cap on open port.			
16. Validated good arterial waveform on monitor.			
17. Place syringe/specimen into biohazard bag with ice.			
18. Wrote client's current temperature and fractional inspired oxygen FIO_2 on laboratory slip.			
19. Sent specimen to laboratory immediately.			
20. Removed gloves and washed hands.			

REMOVING ARTERIAL CATHETER

Procedure

	Performed yes	Performed no	Mastered
1. Removed tape from site.			
2. Donned gloves.			
3. Removed dressing, and placed in appropriate container.			
4. Placed folded 4 × 4 gauze pad over cannula site with nondominant hand, and applied gentle pressure.			
5. Pulled arterial cannula straight out of artery with quick, even pressure.			
6. Applied firm pressure over cannula site for at least 5–10 minutes.			
7. Placed folded 4 × 4 gauze pad over puncture site, and taped tightly.			
8. Completed laboratory slip, and sent cannula to laboratory for culture and sensitivity, if ordered.			
9. Checked cannulation site frequently.			
10. Checked distal extremity for circulation, motion, and sensation intermittently for several hours, then routinely after catheter removal.			

UNIT THREE Cardiac Emergencies

UNIT ASSESSMENT

- ☐ Assessed client's responsiveness, heart rate, and rhythm.
- ☐ Identified ventricular or atrial dysrhythmias on ECG recording.
- ☐ Assessed need to call for emergency supportive measures and to use "crashcart."
- ☐ Identified appropriate drugs needed for an emergency situation.

MAINTAINING THE EMERGENCY CART

Procedure

	Performed yes	Performed no	Mastered
1. Identified equipment and medications commonly used in emergency situations.			
2. Gathered equipment.			

	Performed yes	Performed no	Mastered
3. Maintained equipment in drawers according to priority used in the most commonly occurring emergency situations.			
4. Locked drawers when cart was not in use.			
5. Placed emergency cart checklist on outside of cart in visible area.			
6. Placed cart in designated, easily accessible, and visible area of nursing unit.			
7. Familiarized all personnel with location and contents of cart, function of equipment, and emergency procedures.			
8. Practiced retrieving and setting up equipment through mock situations.			
9. Checked cart daily, and restocked immediately after use.			

PERFORMING DEFIBRILLATION

Preparation

	Performed yes	Performed no	Mastered
1. Validated client nonresponsiveness and pulselessness.			
2. Called a "code."			
3. Verified ECG reading of ventricular fibrillation (or ventricular tachycardia), if client on monitor.			

Procedure

	Performed yes	Performed no	Mastered
1. Plugged defibrillator into electric outlet.			
2. Turned defibrillator power ON, and allowed to warm up.			
3. Placed cardiac board under client's torso if not already present from CPR, or converted bed to cardiac position.			
4. Dried client's chest if necessary.			
5. Placed conductive pads on client's chest, or spread thin coat of defibrillation electrode gel to surface of paddles. One pad placed below right clavicle near sternum and second pad placed to left of cardiac apex (below and to the left of left nipple) in anterior axillary line. Did not place over broken skin. Pressed firmly for adhesion.			
6. Alternatively, applied "hands free" defibrillation pads.			
7. Inserted electrode connector into cable and pushed firmly for proper connection.			
8. Made certain defibrillator was NOT in synchronized mode.			
9. Dialed defibrillator to charge at 200 watt-seconds.			
10. Instructed all persons to move away from bed area and any equipment connected to client.			
11. Stood away from bed area.			
12. Applied paddles with firm pressure (25 lbs).			
13. Depressed discharge buttons on defibrillator simultaneously to ensure appropriate discharge.			
14. Delivered 3 stacked shocks if necessary in close sequence (200 J, 200–300 J, 360 J).			
15. When using "hands free" electrodes, activated system by three-step process: a. Turned on machine. b. Charged. c. Pushed to defibrillator.			

	Performed yes	Performed no	Mastered
16. Analyzed ECG pattern to determine effects of defibrillation. Reinstituted CPR for one minute and administered appropriate medications if indicated.			
17. Prepared defibrillator equipment for second attempt at increased shock energy if lethal arrhythmia continues.			
18. Repeated defibrillation procedure.			
19. Monitored client every 15 minutes after defibrillation until stable: a. Monitored heart rhythm b. Vital signs c. Level of consciousness and neurologic signs			
20. Continued oxygen administration.			
21. Continued IV medication administration in ACLS protocol.			

ADMINISTERING ADVANCED LIFE-SUPPORT MEDICATIONS

Preparation

	Performed yes	Performed no	Mastered
1. Familiarized self with most commonly used medications, their action, usual dose, route and rate of administration, and side effects.			
2. Reviewed skill for *Administration of Intravenous Medications* (Chapter 28).			
3. Client was intubated and airway placement confirmed (See *Respiratory Care,* Chapter 26).			
4. Established IV access if not already present (intraosseous [IO] access may be necessary in emergency situations).			
5. Continued client cardiac monitoring.			

Procedure

	Performed yes	Performed no	Mastered
1. Prepared cartridge/syringe unit by removing caps from cartridge vial and injector.			
2. Inserted vial into injector, rotating clockwise until medication entered injector needle.			
3. Removed protected needle or male luer lock cover and gently pressed vial to initiate medication flow.			
4. Swabbed needleless IV port with antimicrobial swab and inserted system for medication injection.			
5. Administered emergency response algorithm as ordered. a. If ventricular fibrillation or pulseless ventricular tachycardia persisted following the first 3 shocks, administered *adrenergic* agents as ordered. b. Within 30–60 seconds of *first dose* of the medication, three stacked defibrillation shocks of 360 J (or equivalent biphasic) were delivered, each three shocks followed by 1 mg epinephrine, as ordered. c. If defibrillation was ineffective, rhythm-appropriate *antiarrhythmic* agents may be attempted, as ordered.			

ASSISTING WITH ELECTIVE SYNCHRONIZED CARDIOVERSION

Preparation

	Performed yes	Performed no	Mastered
1. Reviewed cardioversion orders, and checked that equipment was functioning properly.			
2. Reviewed precardioversion laboratory values or drug levels, particularly potassium level.			
3. Brought equipment to client's room.			

	Performed yes	Performed no	Mastered
4. Checked that digitalis was discontinued 24 hours or more before cardioversion, or as ordered by physician.			
5. Checked that client had been receiving anticoagulation therapy for atrial fibrillation.			
6. Withheld food and fluids for 6–12 hours before elective cardioversion.			
7. Obtained baseline 12-lead ECG, and labeled it "precardioversion."			
8. Obtained baseline vital signs and ECG rhythms.			
9. Notified anesthesiologist and physician of readiness.			
10. Placed emergency cart in room.			

Procedure

1. Established IV line, and administered fluids at "keep open" rate.			
2. Administered oxygen as ordered pre-cardioversion.			
3. Plugged in defibrillator and turned power switch ON.			
4. Turned *synchronizer* switch ON.			
5. Tested synchronization by pushing manual synchronization button.			
6. Disconnected all electric equipment from client except ECG monitor and cardioverter.			
7. Administered sedative as ordered by physician. (Anesthesiologist may do this.)			
8. Charged machine to level specified by physician, usually 25–50 J to start (1 joule = 1 watt-second). Noted that designated charge was reached.			
9. Placed client in supine position			
10. Made sure client's chest was dry and transdermal patch removed.			
11. Applied conductive gel to surface of paddles, or used "hands-free" defibrillator pads on chest. a. Anterolateral paddles placed as in defibrillation, one over second intercostal space to right of sternum and other over fifth intercostal space in left midclavicular line. b. Anteroposterior paddles placed with flat paddle posteriorly between scapulae and anterior, handheld paddle over fifth intercostal space in left midclavicular line.			
12. Observed ECG rhythm on monitor.			
13. Discontinued oxygen.			
14. Ensured that synchronization indicator superimposed on R wave of ECG.			
15. Gave command to "stand clear," and stood clear.			
16. The *physician* depressed discharge buttons on paddles and kept them depressed until countershock was delivered. The shock may not have occurred instantly because machine waits until the next R wave in the ECG to discharge.			
17. Observed postcardioversion rhythm.			
18. Provided postcardioversion care. a. Supported airway and ventilation, and oxygenated as needed. b. Obtained 12-lead ECG, and labeled it "postcardioversion." c. Monitored heart rhythm continuously.			

Performed yes	Performed no	Mastered

d. Evaluated vital signs, ECG, level of consciousness, peripheral pulses, and neurologic status every 15 minutes until stable, then routinely.
e. Kept client under observation for 12–24 hours.

UNIT FOUR Mechanical Ventilation

UNIT ASSESSMENT

☐ Assessed client for presence of risk factors for acute respiratory distress syndrome.

☐ Auscultated heart and lung sounds for baseline data.

☐ Assessed vital signs and measured arterial blood gases and hemodynamic pressures if CVP and Swan–Ganz catheter were in place.

☐ Identified if need for mechanical ventilation was present. Assessed criteria for non-COPD clients.

☐ Observed for trend of respiratory values. (Trend is more important than isolated measurements.)

☐ Assessed client for indications for PEEP.

☐ Checked physician's orders for ventilator mode.

☐ Assessed client's readiness for ventilator weaning.

☐ Assessed client's response to ventilator weaning.

CARING FOR CLIENTS ON VENTILATORS

Preparation

Performed yes	Performed no	Mastered

1. Double-checked ventilator settings against those ordered by physician.
2. Plugged machine in, and turned ON.
3. Familiarized self with location of alarm systems on ventilator, and turned on all alarm systems.
4. Validated that tube cuff inflation appropriate with minimal occlusive volume or minimal leak (squeak heard at end inspiration) while austicultating over suprasternal notch.
5. Connected ventilator tubing to client's ET or tracheostomy tube.

Procedure

Performed yes	Performed no	Mastered

1. Monitored client's heart rate and blood pressure until stable.
2. Obtained arterial blood gases 15 minutes after ventilation established.
3. Monitored ventilator settings and delivered values: tidal volume, inspiratory pressure, peak pressure, rate, FIO_2, inspiratory–expiratory (I:E) ratio, ventilatory modes.
4. Ensured adequate heat and humidification of inspired gases.
5. Checked humidifier fluid level every 8 hours, and refilled as necessary, if applicable.
6. Recorded intake, output, and daily weights.
7. Suspended ventilator tubing from an IV hook or supported it on pillow.
8. Changed ventilator tubing if necessary, minimizing frequency of circuit opening.
9. Checked vital signs every hour, and auscultated lungs.
10. Observed and listened for possible cuff leaks around tracheostomy or endotracheal tubes.

	Performed yes	Performed no	Mastered
11. If necessary, discarded accumulated water in ventilator tubing via inline closed circuit drain.			
12. Provided client with call bell and method of communication, such as a "magic slate."			
13. If ordered, tested the nasogastric fluid pH and administered medication (antacids) as ordered.			
14. Tested nasogastric fluid and stool for occult blood if ordered.			
15. Assessed lung compliance frequently.			
16. Implemented methods for stress reduction, such as careful explanation of procedures, pain management, etc.			
17. Checked that appropriate ventilator alarm parameters were set.			
18. Maintained appropriate "sigh" delivery.			
19. Monitored client frequently to detect changes in status.			

WEANING THE MECHANICALLY VENTILATED CLIENT

Preparation

1. Validated order for weaning trial and assessed client's readiness.
   a. Spontaneous tidal volume ≥ 7 mL/kg/ideal body weight (IBW).
   b. Respiratory rate between 12 and 20 breaths/min.
   c. Minute ventilation (respiratory rate X TV) ≤ 10 L/min.
   d. Vital signs stable (SBP > 90 and < 180, HR > 50 and < 120).
   e. Vital capacity ≥ 10 mL/kg IBW.
   f. Negative inspiratory force is –20 cm H_2O or better.
   g. ABGs: pH 7.35–7.5, PO_2 ≥ 60 mm Hg or FIO_2 ≤ 40%.
   h. Able to protect airway and responsive on minimal sedation.
   i. PEEP < 5 cm H_2O.
2. Noted client's work of breathing and use of accessory muscles.
3. Noted current ECG pattern for baseline.
4. Explained weaning process to client. Reassured client that transition would be based on client's responses.
5. Suctioned client. Hyperinflated client's lungs with 100% oxygen before and after suctioning.
6. Maintained endotracheal or tracheostomy cuff at minimal occlusive pressure while mechanically ventilated.
7. Established continuous pulse oximetry.

Procedure

1. Elevated head of bed to facilitate client's diaphragmatic excursion.
2. If physician ordered ET tube cuff deflated during weaning, suctioned secretions that accumulated above cuff as follows:
   a. Provided positive pressure to end of tube with handheld resuscitation bag and 100% oxygen.
   b. Placed tip of suction catheter in posterior pharynx.
   c. Deflated cuff, and applied suction to catheter.
   d. Hyperinflated lungs with 100% oxygen for three to five breaths.

Performed yes	Performed no	Mastered

	Performed yes	Performed no	Mastered
3. If ordered, connected T-piece to wide-bore oxygen tubing leading to gas source.			
4. Set oxygen concentration as ordered by physician (usually 10% *higher* than ventilator FIO_2 client had been receiving).			
5. If appropriate, removed ventilator tubing from airway, and connected T-piece to client's airway.			
6. Covered end of ventilator tubing with sterile gauze.			
7. Observed for vital sign changes, apprehension, diaphoresis, and dysrhythmias. (A mild increase in blood pressure, pulse, and respiratory rate is normal. Mild-to-moderate anxiety is also normal.)			
8. Measured arterial blood gases 1 hour after initiating weaning, if client tolerates.			
9. Proceeded with weaning procedure as ordered (e.g., time off ventilator).			
10. If client tolerated no ventilator support (other than PSV), extubated client. (See Chapter 26).			
11. Following weaning, measured vital signs, vital capacity, inspiratory pressure, blood gases, and subjective response.			

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Community Based Nursing

Performance Checklist

UNIT ONE Admission to Home Care

UNIT ASSESSMENT

- ☐ Assessed client's financial eligibility for home care service.
- ☐ Assessed client's care requirements.
- ☐ Observed client's physical, emotional, and intellectual status.
- ☐ Observed client's ability to adapt to the home setting.
- ☐ Assessed client's level of comfort or discomfort.
- ☐ Determined client's understanding of the disease and its limitations.
- ☐ Assessed home condition prior to client returning home.
- ☐ Assessed safety factors in the home.
- ☐ Observed equipment for safety features.
- ☐ Assessed nurses' safety for making home visit.
- ☐ Determined client's safety in home.
- ☐ Determined caretaker's ability to provide client care and safety.

IDENTIFYING ELIGIBILITY FOR MEDICARE REIMBURSEMENT

Procedure

	Performed yes	Performed no	Mastered
1. Completed OASIS forms.			
2. Checked required criteria for Medicare coverage eligibility.			
3. Identified client as homebound.			
4. Checked that home service was considered skilled.			
5. Provided supplemental services from home health aide, social worker, or occupational therapist.			
6. Provided care that was part time and intermittent.			
7. Checked that plan of treatment was authorized by physician and recertified every 60 days.			
8. Assessed that care was medically reasonable and necessary.			

COMPLETING ADMISSION DOCUMENTATION

Procedure

	Performed yes	Performed no	Mastered
1. Completed all sections of the OASIS document. a. Demographic data: address, referring physician, payment source, etc. b. Present History. c. Present Illness. d. Living Arrangements. e. Supportive Assistance. f. Physical Assessment/Review of Systems. g. ADLs. h. Medications. i. Equipment Management. j. Homebound Status. k. Therapy Modalities Required. l. Unmet Needs. m. Lack of Knowledge section. n. Treatment/Procedures Performed. o. Response to Teaching/Training Performed. p. Patient Rights and Responsibilities. q. Coordination of Patient Services. r. Discharge Planning.			
2. Obtained signed consent forms. a. IV therapy. b. Consent for treatment. c. Consent for service.			
3. Obtained signed Advance Directive document.			
4. Obtained signed Patient's Bill of Rights document.			
5. Established Billing Data Base.			
6. Established Discipline Specific Evaluation if therapy was instituted.			
7. Instituted Plan of Care.			
8. Included H485 worksheet.			
9. Included Aide Assignment and Duties, if appropriate.			
10. Initialed Physician Plan of Care.			
11. Initialed Home Health Plan of Care.			
12. Initialed Nurses' Notes as necessary.			
13. Identified if Prehospital "Do Not Resuscitate Form" had been signed.			

MAINTAINING NURSE'S SAFETY

Procedure

	Performed yes	Performed no	Mastered
1. Evaluated safety of nurse prior to visit. a. Called client before visit to determine convenient time. b. Confirmed directions to home. c. Determined if household pets are present; if so, asked that they be secured during visit. d. Checked neighborhood to determine need for assistance from police to make home visit.			
2. Wore identifying name badge. Wore lab coat according to agency policy.			
3. Wore flat shoes to allow myself to walk quickly or to run if necessary.			
4. Maintained personal safety while traveling in car. a. Kept car in good working order and stocked with necessary equipment. b. Kept gas tank at least half full at all times. c. Obtained automobile club membership for emergency use.			

	Performed yes	Performed no	Mastered
d. Kept a windshield cover with CALL POLICE sign available.			
e. Had car phone available and charged at all times.			
f. Kept blanket in car.			
g. Kept thermos of water in car at all times.			
h. Kept doors locked and windows up at all times.			
i. Parked in full view of neighbors, preferably directly in front of home.			
j. Locked all personal items in trunk of car before leaving home or office.			
k. Kept all equipment in trunk of car. Restocked nurses' bag before visits for the day.			
l. Kept nurses' bag on front seat.			
m. Kept change in car for phone calls if necessary.			
n. Placed all valuable objects out of direct sight in car, (e.g., laptop computers, phone).			
5. Maintained personal safety while walking on street.			
a. Kept one arm and hand free when walking from car to house.			
b. Walked directly to client's residence.			
c. Crossed street or walkway, if appropriate, when approaching a group of strangers.			
d. Kept keys in my hand with pointed end of key facing outward when leaving a residence.			
e. Carried a chemical spray and whistle in easy reach.			
6. Maintained personal safety when making home visit.			
a. Used common walkways or hallways. Did not park behind a building or in a dark area.			
b. Knocked on door and waited for permission to enter.			
c. Kept a clear pathway to door if situation was potentially unsafe.			
d. Observed home environment for safety hazards.			
e. Made a joint visit with another agency staff member or asked for an escort if there was a potentially unsafe situation.			
f. Called for police support if visit was essential and situation unsafe.			
g. Made visit in morning when good visual support exists if neighborhood unsafe.			
h. Closed case if nurse felt situation was unsafe and there were no alternative actions that could guarantee nurses' safety.			

ASSESSING HOME FOR SAFE ENVIRONMENT

Procedure

	Performed yes	Performed no	Mastered
1. Identified type of dwelling.			
2. Identified water source.			
3. Identified sewer source.			
4. Identified type of plumbing available.			
5. Determined if any pollutants were present in the environment.			
6. Assessed exterior of home for			
a. Condition of sidewalks and steps.			
b. Presence of railings on steps.			
c. Barriers that prevent easy access to home.			
d. Adequacy of lighting.			
7. Assessed interior of home for			
a. Presence of scatter rugs or worn carpeting.			
b. Uncluttered pathways throughout house.			
c. Adequacy of lighting.			
d. Doorways wide enough to permit assistive devices.			

	Performed yes	Performed no	Mastered
e. Cleanliness of house.			
f. Presence of insects, rodents, or infective agents.			
g. Presence of functioning smoke detectors.			
h. Adequacy of heating and cooling systems.			
i. Presence of running water.			
j. Presence of insects or rodents.			
8. Determined if hazardous material was safely stored.			
9. Assessed for presence of lead-based paint.			
10. Determined if medications could be adequately stored out of reach of children and impaired individuals.			
11. Assessed stairway and halls for			
a. Adequacy of light.			
b. Handrails that are securely fastened to wall.			
c. Flooring in good repair.			
d. Rugs or carpeting in good repair.			
e. Light switches in easy reach and accessible at both ends of stairs or hallway.			
12. Assessed kitchen for			
a. Properly functioning stove.			
b. Adequacy of light surrounding stove and sink.			
c. Condition of small appliances.			
d. Accessibility of appliances to clients in wheelchairs.			
e. Adequacy of sewage disposal.			
13. Assessed bathroom for			
a. Skidproof strips or mat in tub or shower.			
b. Handrails around toilet and tub or shower.			
c. Accessibility of medicine cabinet.			
d. Adequate space if wheelchairs or walkers are used.			
e. Temperature of hot water from faucets in sink, tub, or shower.			
14. Assessed bedroom for			
a. Accessibility of closets and cabinets.			
b. Ease in getting into and out of bed.			
c. Adequate space if commode or wheelchair was required.			
d. Night-light availability.			
e. Accessibility of medications, water on nightstand.			
f. Calling system to alert health care provider.			
g. Flooring in good repair and nonslippery surface.			

EVALUATING CLIENT'S SAFETY

Procedure

	Performed yes	Performed no	Mastered
1. Evaluated client's cognitive abilities: level of consciousness, orientation, ability to make appropriate judgments, ability to follow commands and directions.			
a. Knowledge of how to operate appliances (e.g., stoves and heaters).			
b. History of alcohol or drug abuse.			
c. Knowledge of medication times and doses to be taken.			
d. Knowledge of how to call for help: physician, nurse, fire, police.			
2. Evaluated client's sensory and motor function.			
a. Hearing and vision acuity.			
b. Ability to ambulate with assistance.			
c. Need for assistive devices or support in ambulation.			
3. Assessed if client needed alternatives to physical restraints.			
a. Determined if environment needed to be modified by removing unsafe objects or barriers.			

	Performed yes	Performed no	Mastered
b. Removed wheels from chairs or bed.			
c. Installed bed check system or alarm device.			
d. Decreased auditory and visual stimuli.			
e. Placed supplies close to bed or chair (e.g., tissues or water).			
4. Evaluated most effective type of restraint, if absolutely necessary.			
a. Determined that less restrictive methods had been attempted.			
b. Assessed purpose of restraint to determine most appropriate type.			
c. Obtained physician's order for restraint. Ensured order included reason, type, and time of restraints.			
d. Obtained informed consent from client or guardian before applying.			
e. Explained purpose of restraints to client and family members.			
f. Ensured caregiver was instructed on use of restraints.			
g. Evaluated effectiveness and continued need for restraints.			
5. Determined client's ability to manage self-care.			
a. Bathing, grooming, and dressing.			
b. Preparing food and feeding.			
c. Toileting.			
d. Housekeeping, shopping, transportation to physician and pharmacy.			
6. Determined client's financial support.			
a. Determined healthcare insurance plan, worker's compensation, Medicare, Medicaid.			
b. Determined need for social service intervention.			

ASSESSING CAREGIVER'S SAFETY

Procedure

	Performed yes	Performed no	Mastered
1. Determined caregiver's cognitive function.			
a. Ability to understand and carry out interventions.			
b. Ability to make safe decisions and judgments.			
c. Willingness to care for client.			
2. Determined caregiver's sensory and motor function.			
a. Ability to hear client's needs.			
b. Visual acuity to read directions and medication labels.			
c. Ability to feel temperature changes (e.g., water for bathing).			
3. Determined caregiver's motor function and strength.			
a. Ability to assist client in transfer, moving, turning, and ADLs.			
b. Ability to provide treatments and care for client.			
c. Ability to prepare food and do housekeeping chores.			
d. Ability to do shopping and provide transportation for physician visits.			

ASSESSING FOR ELDER ABUSE

Procedure

	Performed yes	Performed no	Mastered
1. Assessed client for indications of neglect. Checked body for signs of cleanliness. Determined if emotional abuse was present. Asked about threats, intimidation, or isolation.			
2. Identified if financial abuse had occurred, such as misuse of finances or property.			
3. Assessed for signs of physical abuse.			

	Performed yes	Performed no	Mastered
4. Assessed for signs of malnourishment or dehydration.			
5. Checked skin for pressure ulcers.			
6. Assessed for signs of sprains or dislocations from pulling or pushing client.			
7. Asked about visits to the hospital ER. Asked why client sought medical care, how long between injury and visit to ER.			
8. Assessed for signs of emotional abuse. Observed if client was fearful of strangers, became quiet when caregiver entered room, craved attention and socialization.			

UNIT TWO Infection Control

UNIT ASSESSMENT

- ☐ Assessed need for handwashing.
- ☐ Identified clients at risk for infection.
- ☐ Assessed need for cleaning equipment and decontaminating equipment.
- ☐ Identified type of waste material requiring special disposal.
- ☐ Assessed equipment needed to deliver care in the home.
- ☐ Assessed need for teaching preventive measures in the home of HIV or AIDS clients.

PREPARING FOR CLIENT CARE

Procedure

	Performed yes	Performed no	Mastered
1. Arranged equipment in bag prior to making home visit so that handwashing equipment was accessible. Brought only supplies needed.			
2. Placed bag on flat, dry surface to establish a clean work area during visit.			
3. Washed hands. a. Used liquid soap and paper towels from bag and client's water supply; *or* b. Used client's soap and towels if I felt comfortable with this and client approves; *or* c. Used germicide as alternative for handwashing when soap and water were not available. Sprayed or squeezed small amount of germicide onto palm of hand and rubbed for 30 seconds along all surfaces of hands, fingers, and nails.			
4. Donned disposable gloves when appropriate for infection control, especially when handling blood and body fluids.			
5. Took other equipment that would be needed during visit out of bag and placed on clean work surface.			
6. Kept bag closed when not in use to promote cleanliness, safety, and security. Did not reenter bag wearing soiled gloves.			
7. Wore disposable apron or gown, goggles, or masks if necessary.			
8. Cleansed thoroughly any equipment that left clean area and was to be returned to bag on completing care. a. Rinsed equipment (such as bandage scissors, forceps) under *cold* water, washed with soap and water, placed in plastic bag, and took back to agency to sterilize. b. Replaced stethoscope and blood pressure cuff in nursing bag.			
9. Ensured nursing bag was monitored regularly for safety. a. Kept bag out of reach of children.			

b. Kept bag in trunk of car or kept in home overnight.
c. Cleaned bag monthly and PRN.

DISPOSING OF WASTE MATERIAL IN THE HOME SETTING

Procedure

1. Disposed of wastes contaminated with blood or body fluids.
   a. Placed waste products in impenetrable, heavy-duty plastic bag.
   b. Removed gloves by rolling inside out (so contaminated side was on inside) and dropped into plastic bag.
   c. Sealed plastic bag with tie.
   d. Discarded in client's trash.
   e. Washed hands with soap and water or germicide.
2. Disposed of body wastes, such as urine, feces, respiratory secretions, vomitus, and blood, by flushing them down toilet.
3. Disposed of needles and sharp objects.
   a. Did *not* remove needle from syringe or bend, break, clip, or recap after use.
   b. Dropped entire disposable syringe and needle intact into rigid, puncture-proof receptacle provided by agency.
   c. Washed hands.
4. Discarded other trash.
   a. Placed in plastic bag.
   b. Discarded in client's trash.

Performed yes	Performed no	Mastered

CLEANSING THERMOMETER

Procedure

1. Prepared clean work area.
2. Tore one alcohol wipe in half, and applied soap to each half.
3. Cleansed thermometer with alcohol swab from distal end toward tip using circular movements.
4. Repeated above using second swab.
5. Opened remaining alcohol wipe, and wrapped it around thermometer, letting it "soak" at least 10 minutes.
6. Discarded swabs, and replaced thermometer in case.
7. Wiped case with alcohol before replacing in nursing bag.

CARING FOR AN AIDS OR HIV CLIENT IN THE HOME

Procedure

1. Washed hands before and after client care and after disposing of soiled materials.
2. Donned disposable gloves for any procedure.
   a. Donned double gloves if tearing was likely during procedure.
   b. If staff member had any type of open wounds or weeping dermatitis, she or he did not administer care (even with gloves) until condition resolved.
3. Donned disposable gown or apron to protect clothing from soilage.

Performed yes	Performed no	Mastered

4. Put on mask and protective eyewear if splattering was anticipated during procedure (e.g., suctioning, wound irrigations).
5. Collected specimens in appropriate containers labeled "Blood and Body Fluid Precautions."
6. Used extraordinary care to avoid puncture wounds with needles and other sharp objects.
   a. If puncture occurred, bled wound, washed with soap and water.
   b. Notified supervisor immediately, and filled out unusual occurrence report.
7. Cleaned spills of blood and body fluids with 10% bleach solution (one part liquid chlorine bleach to nine parts water). Made solution fresh each time.
8. Washed eating utensils (dishes and silverware) in hot, soapy water. Water was hot enough to need gloves to tolerate the temperature. No other special precautions were required. Used dishwasher, if available.
9. Stored linens and laundry soiled with body fluids in a plastic bag and then washed separately with very hot water. Used detergent and 10% bleach solution.
10. Disposed of gown or apron in plastic bag after completing care.
11. Took off gloves by peeling them down and turning them inside out so that contaminated side was on inside. Placed in plastic bag.
12. Washed hands.
13. Took off mask and goggles.
14. Washed hands.

Performed yes	Performed no	Mastered

CLEANSING EQUIPMENT IN THE HOME SETTING

Procedure

1. Donned gloves when working with equipment contaminated with any body fluid or blood.
2. Rinsed article with cold running water.
3. Washed with hot, soapy water using friction.
4. Rinsed well with clear water.
5. Dried thoroughly.
6. Disinfected equipment or article as indicated: one part chlorine bleach (Clorox) to nine parts water.
7. Dried thoroughly.
8. Removed disposable gloves.
9. Disposed of gloves (inside out) into plastic bag.
10. Washed hands.

TEACHING PREVENTIVE MEASURES IN THE HOME

Procedure

1. Discussed inadvisability of allowing any person who is ill or who has depressed immune function to come in contact with client.
2. Taught client these appropriate hygiene principles:
   a. Wash hands after use of toilet or contact with any body fluids.
   b. Do not share thermometers, razors, razor blades, toothbrushes, douche, or enema equipment.

Performed yes	Performed no	Mastered

	Performed yes	Performed no	Mastered
c. Do not cough without covering mouth. d. Be careful to dispose of nasal secretions in tissue, then in plastic bags. 3. Taught guidelines for sharing kitchens and bathrooms. 4. Taught principles of food preparation. 5. Taught how to care for linens and laundry. 6. Informed client and family of measures for disposing of trash. 7. Discussed procedures for caring for pets. 8. Taught general principles of preventing cross-infection. 9. Taught to keep supplies in clean, dry location and if refrigeration required, to place medication in sealed, plastic storage bag.			

TEACHING SAFER PRACTICES TO IV DRUG USERS

Procedure

	Performed yes	Performed no	Mastered
1. Informed persons of risk behaviors and factors associated with IV drug use. a. Direct transmission with shared needles and syringes. b. Transmission to sexual partners. c. Transmission to fetus during pregnancy. d. Suppression of immune system caused by alcohol or drug use. e. Impaired judgment while under influence of drugs. 2. Taught IV drug users how to reduce risk. a. Do not share needles or syringes with others. b. Clean needles and other equipment vigorously. Wash twice with full-strength bleach or alcohol; rinse twice with water. c. Boil needles and other equipment for 15 minutes. d. Do not borrow or use needles or equipment from others, even if they appear healthy or say that they do not have AIDS. 3. Taught basic health maintenance measures. a. Decrease use of all immunosuppressive drugs (marijuana, speed, cocaine, alcohol). b. Maintain an adequate, nutritionally sound diet. c. Reduce stress on self through stress-reduction practices, or removing self from a stressful situation (e.g.,living with others who routinely use drugs). d. Obtain regular medical and dental care. e. Follow lifestyle that provides adequate rest and exercise. f. Obtain counseling to assist in living life without dependence on drugs.			

UNIT THREE Body Mechanics

UNIT ASSESSMENT

☐ Assessed family's knowledge of principles of body mechanics.

☐ Assessed home care provider's knowledge of how to use correct muscle groups for specific activities.

☐ Assessed knowledge of how to improvise for a nonhospital bed.

☐ Assessed knowledge and corrected any misinformation about body alignment and ability to move client up in bed without assistance.

POSITIONING NONHOSPITAL BED FOR CLIENT CARE

Procedure

Performed yes	Performed no	Mastered

1. Positioned foam wedges to simulate change in position when head of bed did not move. High-Fowler's/90°; Fowler's/60°; semi-Fowler's/30°.
2. Used correct body mechanics to adjust height.
   a. Flexed body at knees and kept back straight if bed was only slightly low.
   b. Knelt on pillow by bed or sat in chair alongside bed if bed was extremely low.
3. Locked each wheel or leg of bed in position by securing with bricks or blocks of wood.
4. Made footboard of lumber, or item such as a TV tray; positioned legs of tray under mattress so that tray became footboard.

MOVING A HELPLESS CLIENT UP IN BED WITHOUT ASSISTANCE

Procedure

Performed yes	Performed no	Mastered

1. Lowered head of bed, and placed pillow at head of bed.
2. Stood at side of client's bed.
   a. Faced far corner at foot of bed.
   b. Placed one foot behind the other, assumed a broad stance, and flexed knees.
3. Flexed arms so forearms were level with bed. Placed one arm under client's head and one under small of back.
4. Rocked and shifted weight from forward to rear foot; hips moved downward.
5. Guided client as he or she slid diagonally across bed toward head.
6. Repeated for trunk and leg sections.
7. Moved to other side of bed and repeated steps 2 through 5.
8. Repeated until client was satisfactorily positioned in bed.

UNIT FOUR Hygienic Care

UNIT ASSESSMENT

- ☐ Assessed for signs of skin breakdown or stage of pressure ulcer.
- ☐ Assessed color of skin.
- ☐ Checked for alterations in skin turgor.
- ☐ Assessed ability to assist with transfer to tub or shower.
- ☐ Checked general hygienic state.
- ☐ Assessed for presence of lice.

BATHING CLIENT IN THE HOME

Procedure

Performed yes	Performed no	Mastered

1. Kept all personal care items (soap, deodorant, lotion, powder, cosmetics, cologne, hair products, oral hygiene supplies, and other personal items) on a tray or in handy carry tote.
2. Used beach towel for bath blanket.
3. Placed plastic under towel to protect mattress prior to beginning bath.

4. Ensured that nonskid strips or mats were on floor of tub or shower.
   a. Asked family to purchase strips.
   b. Placed wet terrycloth towel on floor of tub or shower if strips or mat not available.
5. Provided tub or shower stool or chair.
   a. Ordered from supply company if family desired and could afford.
   b. Improvised shower chair by using straight-backed chair and attaching suction cups to legs to prevent sliding.
6. Simulated client call bell by placing dinner bell or battery-powered smoke detector that emits a loud alarm within easy reach of client.

TRANSFERRING CLIENT TO TUB OR SHOWER

Procedure

1. Gathered equipment.
2. Placed wet bath towel on floor of tub or shower if safety grips or mats were not available.
3. Positioned chair or shower stool securely in tub or shower. Placed second chair or wheelchair outside tub.
4. Assisted client to bathroom.
5. Transferred client to tub or shower chair before putting water in tub.
   a. Stood in front of client.
   b. Lowered client into chair, bending knees and keeping back straight.
   c. Flexed knees, moved to kneeling position, and kept back straight while assisting client to swing legs over side of tub.

Performed yes	Performed no	Mastered

ADAPTING BEDMAKING TO THE HOME

Procedure

1. Followed directions for making an occupied or unoccupied bed. (See Chapter 8.)
2. Turned pillowcase inside out and used as laundry bag, or used plastic trash bag.
3. Placed one knee on bed if bed could not be moved away from wall, (especially useful when making water beds).
4. Made incontinent pads with cotton flannel if commercial pads were not available.
5. Made bed protectors by cutting piece of plastic shower curtain or heavy trash bag. Covered with draw sheet or cotton flannel.

PROVIDING PRESSURE ULCER CARE

Procedure

1. Washed hands.
2. Donned clean gloves.
3. Removed dressings. Discarded in plastic bag.
4. Cleansed with normal saline solution. Irrigated the wound if excessive drainage was present.
5. Allowed to dry or applied medicated ointment as ordered.
6. Applied dressing as ordered.
7. Disposed of waste according to protocol.
8. Removed gloves and washed hands.
9. Followed specific directions for pressure ulcer care. (See Chapter 25.)

Performed yes	Performed no	Mastered

PREPARING NORMAL SALINE

Procedure

1. Sterilized jar for storage.
   a. Placed cover and jar in large pan of cold water, completely immersing jar and lid in water.
   b. Brought to a boil.
   c. Boiled 20 minutes.
   d. Poured off water.
   e. Handled only outside of jar and lid.
2. Added 1 teaspoon salt to 500 mL (1 pint) water.
3. Boiled salted water for 20 minutes in covered pan to sterilize.
4. Allowed solution to cool in covered pan.
5. Poured water into sterilized jar for storage.

REMOVING LICE

Procedure

1. Obtained order for treatment and notified family members and health caregiver.
2. Removed and bagged client's clothing and linens, and placed in plastic bag. Laundered these articles separately. Used hot water at 125°F and detergent.
3. Items that could not be washed were dry-cleaned. Placed in plastic bag, sealed, and brought to dry cleaner.
4. Began treatment as ordered by physician. (Common treatment is gamma benzene hexachloride applied as a cream, lotion, or shampoo.)

Performed yes	Performed no	Mastered

5. Shook lotion well, applied thin film of lotion over entire body, excluding face and urethral meatus. Rubbed in, allowed to dry and cool. Left in place 8–12 hours.
6. Applied shampoo, and left in place 4 minutes.
7. Rinsed thoroughly.
8. Combed through hair with fine-toothed comb.
9. Disinfected comb and brushed with Kwell shampoo.
10. Washed hands.
11. Instructed client to vacuum rugs, upholstery, and furniture. Then, sprayed with commercial spray. Emptied vacuum cleaner bag into trash bag, and sealed.
12. Discussed with client and family the cause, treatment, and preventive measures regarding lice infestation.
13. Instructed client or family to repeat treatment in 7–10 days only if living lice are present.

Performed yes	Performed no	Mastered

UNIT FIVE Medications

UNIT ASSESSMENT

☐ Assessed that client and family understood time and dosage for medication administration.

☐ Assessed most appropriate methods for aiding client to remember to take medications.

☐ Assessed client's and family's knowledge and skill in sterilizing medication equipment.

☐ Determined client's physical ability to take medication as ordered.

ADMINISTERING MEDICATIONS

Performed yes	Performed no	Mastered

Procedure

1. Examined all medications taken by client during admission visit and subsequent visits. Included all over-the-counter (OTC), as well as prescription drugs.
2. Discussed lifestyle with client and family as it relates to medication schedule and their beliefs about medications.
3. Established medication regimen based on physician's orders or prescribed drugs and client's schedule.
4. Taught client and family the medication regimen.
5. Taught client and family how to monitor for effects and side effects of drugs.
6. Designed medication aids, such as calendar of drugs or daily/weekly pill reminder boxes, to help client and family remember to take medications.
   a. Investigated and shared with client and family those aids commercially available.
   b. Improvised using household items, such as egg cartons, tiny paper cups attached together or stacked, or empty match boxes glued together to make a row of pill containers that could be labeled with time and day.
7. Designed creative methods to assist client and family to administer medication.
8. Discarded uncapped needles and syringes in sharps container.
9. Documented all teaching and learning outcomes, administration of medication, and client response to medications.

STERILIZING NONDISPOSABLE MEDICATION EQUIPMENT

Performed yes	Performed no	Mastered

Preparation

1. Gathered appropriate equipment.
2. Washed hands.

Procedure

1. Placed jar, lid, tongs, and equipment in large clean pan.
2. Filled pan with cold water until all equipment was covered.
3. Placed pan on stove.
4. Boiled water for 20 minutes.
5. Poured off water.
6. Lifted equipment out of pan, using tongs. Removed jar from pan by touching only the outside.
7. Positioned jar so sterile equipment could easily be inserted without touching edges of jar.
8. Placed lid on jar by grasping outside edge and twisting tightly.

UNIT SIX Total Nutrient Admixture

UNIT ASSESSMENT

☐ Observed for correct additives in each hyperalimentation bag.

☐ Checked label on solution bag.

☐ Checked rate of infusion on volumetric pump.

☐ Assessed ability of client to understand instructions during procedure.

☐ Ensured patency of central venous line.

☐ Observed catheter insertion site for signs of infection, thrombophlebitis, or possible infiltration.

☐ Inspected dressing over central line to ensure a dry, noncontaminated dressing.

☐ Identified client and family's ability to provide TNA in the home.

ADMINISTERING TOTAL NUTRIENT ADMIXTURE (TNA) IN THE HOME

Procedure

	Performed yes	Performed no	Mastered
1. Removed TNA solution from refrigerator at least 1 hour before using.			
2. Gathered equipment.			
3. Washed hands and donned gloves.			
4. Inspected TNA solution for cloudiness, clarity, and intact bag.			
5. Prepared to administer TNA solution by spiking bag with tubing and adding filter, then flushed tubing of all air.			
6. Prepared catheter when solution was ready for infusion by clamping catheter with padded Kelly forceps and removing injection cap.			
7. Cleansed end of catheter with povidone–iodine swab or other antimicrobial swab.			
8. Removed protective cap from IV tubing and inserted tubing into catheter.			
9. Taped connection site.			
10. Removed gloves.			
11. Threaded IV tubing through electronic ambulating infusion pump according to manufacturer's directions, and set machine to deliver appropriate rate.			
12. Monitored infusion rate, and assessed IV site throughout procedure.			
13. Monitored blood glucose daily using Accu-chek or autolet and chemstrips. Reported 31 or 41 or positive urine acetone findings to physician.			
14. Instructed client to follow physician's directions for lab work.			
15. Maintained accurate intake and output and TNA sheet.			
16. Instructed client to monitor weight and temperature frequently throughout therapy.			

MONITORING CLIENT ON TNA

Procedure

	Performed yes	Performed no	Mastered
1. Instructed client or caregiver to document assessment data in log book, to bring book to physician during office visit, and share with home health nurse during visits.			
2. Instructed client to weigh daily at same time and with same clothing, shoes off.			
3. Checked glucose when first initiating TNA according to following guidelines: a. Before starting TNA. b. Several hours after starting cyclic TNA. c. One hour after discontinuing TNA.			
4. Checked glucose every 8–12 hours with continuous TNA.			

	Performed yes	Performed no	Mastered
5. Maintained serum glucose under 200 mg/dL for continuous TNA clients and 240 mg/dL for cyclic TNA clients.			
6. Measured intake and output daily and recorded in log book.			
7. Instructed client or caregiver on signs of fluid volume deficit (poor skin turgor, dry mucous membranes, etc.).			
8. Explained signs and symptoms associated with electrolyte imbalance (increased fatigue and muscle weakness).			
9. Took temperature daily at same time and recorded in log book.			
10. Monitored any drainage for amount, color, consistency, or any changes from usual.			
11. Ensured client had routine blood drawn as scheduled.			
12. Instructed client to observe for signs of edema and to report these immediately.			
13. Instructed client or caregiver to monitor central venous catheter site for signs of infection, to immediately report to home health nurse, and not infuse TNA until nurse observes site.			

DISCONTINUING TNA INFUSION

Procedure

	Performed yes	Performed no	Mastered
1. Gathered equipment.			
2. Washed hands and donned clean gloves.			
3. Withdrew 2 mL normal saline into syringe.			
4. Turned IV solution off by closing roller clamp and turning off controller or pump.			
5. Clamped catheter with padded Kelly forceps.			
6. Disconnected IV tubing from catheter.			
7. Cleansed catheter site with povidone-iodine swab or antimicrobial swab.			
8. Placed sterile injection cap on catheter.			
9. Wiped injection cap with alcohol swab.			
10. Injected 2 mL of normal saline solution through cap.			
11. Withdrew needle.			
12. Coiled catheter and placed 4 × 4 gauze pad over catheter and taped catheter to chest or abdomen. Site care was performed every 48 hours using same sterile technique. (See Chapter 29.)			
13. Discarded used equipment.			
14. Removed gloves and washed hands.			

UNIT SEVEN Elimination

UNIT ASSESSMENT

- ☐ Assessed client's bladder for distention.
- ☐ Assessed client's physical ability to cooperate with positioning.
- ☐ Assessed urinary meatus and catheter for exudate, edema, inflammation, and general cleanliness.
- ☐ Assessed need for perineal care before catheterization procedure.
- ☐ Assessed condition of skin surrounding catheter or ostomy opening.
- ☐ Assessed dialysate solution for clarity.
- ☐ Assessed dialysis returns for cloudiness.

☐ Assessed family's ability to use gloving technique and maintain asepsis.

☐ Assessed need for catheterization procedure.

☐ Assessed for proper function of dialysis machine.

☐ Assessed client's ability to perform colostomy irrigation.

USING CLEAN TECHNIQUE FOR INTERMITTENT SELF-CATHETERIZATION

Procedure

Performed		Mastered
yes	no	

for Female Client

1. Attempted to urinate. If unable to do so, continued to follow these steps.
2. Washed hands, and gathered equipment. (Kept equipment in one large container.)
3. Assumed sitting position on bed or commode. (Placed plastic under towel if bed is used.)
4. Separated labia with one hand while cleaning with soap and water front to back with other hand.
5. Positioned mirror to visualize urinary meatus.
6. Removed catheter from container (plastic bag or aluminum foil).
7. Lubricated end of catheter with water-soluble lubricant and placed other end in container to catch urine.
8. While holding labia apart with one hand, inserted catheter about 3 inches or until urine flows.
9. Pressed down with abdominal muscles to promote bladder's emptying.
10. Pinched off catheter after all urine had drained and withdrew catheter gently, holding tip of catheter upright.
11. Washed and dried perineal area.
12. Washed catheter in warm, soapy water.
13. Rinsed with clear water and dried outside with paper towel.
14. Placed in plastic bag for storage.
15. Used catheters for 2–4 weeks and then discarded.
16. Washed hands.

for Male Client

Performed		Mastered
yes	no	

1. Attempted to urinate. If unable to do so, continued to follow these steps.
2. Washed hands, and gathered equipment. (Kept equipment in one large container.)
3. Assumed sitting position on bed or commode. (Placed plastic under towel if bed was used.)
4. Retracted foreskin, if present, and washed tip of penis with soap and water.
5. Removed catheter from container (plastic bag or aluminum foil).
6. Lubricated first 7–10 inches of catheter with water-soluble lubricant. Placed other end in container to catch urine.
7. Held penis at right angle to body, keeping foreskin retracted. Inserted catheter 7–10 inches into penis or until urine began to flow. Then inserted catheter 1 inch further.
8. Pressed down with abdominal muscles to promote bladder's emptying.

	Performed yes	Performed no	Mastered
9. Pinched off catheter after all urine had drained and gently withdrew, holding tip of catheter upright.			
10. Washed and dried area.			
11. Washed catheter in warm, soapy water.			
12. Rinsed with clear water and dried outside with paper towel.			
13. Placed in plastic bag for storage.			
14. Used catheters for 2–4 weeks and then discarded.			
15. Washed hands.			

SUPRAPUBIC CATHETER CARE

Procedure

	Performed yes	Performed no	Mastered
1. Instructed client to gather equipment for specific skill to be done.			
2. Washed hands and donned gloves.			
3. Cleaned around catheter site with normal saline solution or mild soap and water. Used applicator sticks to remove material from around catheter opening.			
4. Ensured catheter was not pulling on exit site. Taped catheter to skin so a gentle curve was present to prevent tugging on catheter.			
5. Emptied catheter bag (regular catheter drainage bag or leg bag). Emptied into container and then disposed of contents in toilet or, if removing bag, emptied directly into toilet.			
6. Cleaned drainage bags with warm water and soap every day or two. Placed one teaspoon of vinegar in rinse water to reduce odor.			
7. Instructed client in bladder testing. a. Washed hands and catheter connections with soap and water. b. Clamped the SP tube so it did not drain. Used catheter plug or clamp. c. Had client attempt to void when client felt urge to urinate. Measured amount of urine. d. Unclamped SP immediately after voiding; emptied urine into container and measured residual urine amount. e. Instructed client to keep a log of each voiding and residual amount. f. Called physician with findings when residual amount was less than 20% voided amount.			
8. Instructed client to monitor carefully for signs of urinary infection and notify physician immediately. Checked for bladder pain, bleeding, temperature over 100°F, chills, cloudy urine, drainage, or edema around SP tube.			

ADMINISTERING CHRONIC AMBULATORY PERITONEAL DIALYSIS (CAPD)

Procedure

for Draining Fluid

	Performed yes	Performed no	Mastered
1. Donned clean gloves.			
2. Donned mask.			
3. Unclamped catheter, maintaining aseptic technique.			
4. Attached sterile bag and transferred set to catheter for drainage dialysate. Placed pouch on low stool or table below level of client's abdomen.			

	Performed yes	Performed no	Mastered
5. Unclamped tubing.			
6. Allowed fluid to drain into bag from abdomen until flow ceased, approximately 10–20 minutes.			
7. Reclamped tubing.			
8. Examined drainage for discoloration or cloudiness.			
9. Disconnected tubing from drainage bag while maintaining strict aseptic technique. Unscrewed catheter from tubing and attached Mini Cap, according to clinic's instructions.			
10. Weighed drainage bag on scale. Effluent should weigh at least $4\frac{1}{2}$ pounds, equal to 2 liters of fluid.			
11. Disposed of effluent into toilet.			
12. Double bagged tubing and drainage bag. Placed biohazardous label on bag. Discarded by placing in biohazardous container. Disposed of tubing following exchange.			
13. Removed and discarded gloves and mask.			
14. Washed hands.			
15. Checked blood pressure and pulse.			
for Infusing Dialysate			
1. Warmed dialysate by encasing it in a heating pad for one hour. DID NOT PLACE IN MICROWAVE.			
2. Washed hands for 3 minutes with antibacterial soap.			
3. Gathered equipment. Donned gloves and mask.			
4. Opened plastic wrap on dialysate solution and inspected solution bag for expiration date, color, and consistency of dialysate, and assessed bag for possible leaks.			
5. Added medications as ordered. Maintained sterile technique.			
6. Connected tubing to dialysate bag by removing protective cover from port and spiking into dialysate bag. Maintained sterility throughout. Followed manufacturer's directions.			
7. Hung new dialysate bag on hook, which was positioned above client at shoulder length.			
8. Opened clamp and adjusted height to ensure inflow of solution by gravity over a 10- to 20-minute period.			
9. Clamped tubing.			
10. Discarded empty dialysate bag or placed in carrying–holding pouch at client's waist, according to type of transfer set being used.			
11. Allowed fluid to remain in peritoneal cavity approximately 4 hours.			
12. Removed mask and gloves.			
13. Washed hands.			
14. Repeated procedure four times daily, the last time at bedtime, allowed fluid to remain in peritoneal cavity overnight.			
15. Ensured that client and caregiver were knowledgeable in strict aseptic technique.			
16. Instructed client to notify physician if there was evidence of infection.			
17. Documented findings and brought to physician at each visit.			

CHANGING DRESSING FOR CAPD CLIENT

Procedure

Performed yes	Performed no	Mastered

1. Washed hands.
2. Donned gloves.
3. Removed old dressing with sterile gloves.
4. Inspected site for infection (erythema, edema, warmth, exudate).
5. Removed any dried blood or drainage with normal saline solution.
6. Rinsed area with normal saline.
7. Dried area thoroughly.
8. Changed gloves.
9. Cleansed area surrounding catheter with antimicrobial swab.
10. Applied dressing according to facility policy.
11. Removed gloves and washed hands.

INSTRUCTING CLIENT IN COLOSTOMY IRRIGATION

Procedure

Performed yes	Performed no	Mastered

1. Instructed client in benefits of relaxing and taking periodic deep breaths.
2. Donned clean gloves.
3. Removed and disposed of used pouch in plastic bag.
4. Cleaned stoma and skin with warm water and soft cloth. Assessed skin for signs of irritation or breakdown.
5. Applied irrigation sleeve to peristomal skin, and placed belt around waist.
6. Filled container with 1000 mL lukewarm water (500 mL for first irrigation).
7. Suspended container on bathroom hook at level of client's shoulders, no higher than 18 inches above stoma.
8. Opened roller clamp and allowed solution to run through tubing; closed clamp.
9. Assisted client to sit on toilet or on chair in front of toilet.
10. Placed sleeve between client's thighs and direct end into toilet.
11. Lubricated cone tip with water-soluble lubricant.
12. Positioned cone in sleeve by placing through top opening. If cone could not be inserted easily, did not force it.
13. Held cone snugly against stoma.
14. Opened roller clamp on tubing and allowed water to run through cone while inserting cone into stoma.
15. Instilled solution (750–1000 mL) over 5–10 minutes.
16. Clamped tubing for a few minutes if cramping occurs. Instructed client to take a deep breath when solution was instilled.
17. Removed cone, and closed off or folded over top of sleeve after solution was instilled.
18. Allowed client to remain seated while the majority of stool and solution returned, usually 10–15 minutes.

	Performed yes	Performed no	Mastered
19. Removed gloves, and discarded.			
20. Instructed client to rinse sleeve with water. Dried bottom of sleeve and closed end of sleeve.			
21. Asked client to wear sleeve in this manner for 30–60 minutes. Allowed client to sit in chair, walk, return to bed, or proceed to other activities.			
22. Instructed client to remove sleeve, clean, and store in designated area of bathroom.			
23. Instructed client to clean skin and stoma with warm water, and dry thoroughly.			
24. Instructed client on how to apply skin barriers and clean pouch.			
25. Instructed client to reorder supplies as needed.			
26. Placed discarded supplies in client's trash.			

PERFORMING IRRIGATION IN BED

Procedure

	Performed yes	Performed no	Mastered
1. Identified client and explained procedure to client.			
2. Positioned client comfortably in bed, using side-lying position.			
3. Placed bed protector on bed.			
4. Donned clean gloves.			
5. Closed off the bottom of irrigation sleeve and allowed it to rest in bedpan at client's side.			
6. Removed and disposed of used pouch in plastic bag.			
7. Cleaned stoma and skin with warm water and soft cloth.			
8. Applied irrigation sleeve to peristomal area.			
9. Filled container with 500–1000 mL lukewarm water.			
10. Suspended container on IV pole, 18 inches above stoma.			
11. Opened clamp and allowed solution to run through tubing.			
12. Clamped tubing			
13. Placed bedpan on chair by bedside. Placed bed protector under bedpan to prevent soiling chair.			
14. Placed sleeve in bedpan.			
15. Lubricated cone tip with water-soluble lubricant.			
16. Followed steps 13–18 for *Instructing a Client in Colostomy Irrigation*.			
17. Removed gloves, and discarded.			
18. Waited 55–60 minutes to allow most of irrigation fluid to return.			
19. Donned clean gloves.			
20. Opened bottom of sleeve into bedpan.			
21. Removed sleeve, cleaned, and returned to storage place.			
22. Cleaned client's skin and stoma with warm water, and dried thoroughly.			
23. Applied appropriate pouch and skin barriers.			
24. Removed and discarded gloves.			
25. Washed hands.			
26. Placed client in comfortable position.			
27. Put away all supplies, and reordered as necessary.			

UNIT EIGHT Respiratory Care

UNIT ASSESSMENT

- ☐ Checked if client had patent airway.
- ☐ Assessed need for oxygen therapy.
- ☐ Assessed family's ability to suction using aseptic technique.
- ☐ Observed for cleanliness of equipment (tubing or reservoir).
- ☐ Assessed family's knowledge about safety factors when oxygen is in use.
- ☐ Assessed family's knowledge base related to setup and monitoring of ventilator.
- ☐ Determined if client had contraindications to using transtracheal oxygenation.
- ☐ Determined client's willingness to comply with daily routine.

CARING FOR OXYGEN EQUIPMENT

Procedure

	Performed yes	Performed no	Mastered
1. Obtained order for oxygen therapy.			
2. Determined type of oxygen system to be used.			
3. Contacted inhalation therapy company and ensured company offers 24-hour emergency service.			
4. Rinsed cannula or mask clean with water and dried with paper towel daily.			
5. Washed tubing daily. Hung in bathroom to dry. Stored in clean plastic bag when not in use.			
6. Washed long tubing weekly. Replaced monthly.			
7. Cleaned compressor filter daily with water or according to company instructions.			
8. Used distilled water in humidifier. (Stored distilled water in refrigerator.) Washed humidifier with soap and water every few days.			

TEACHING SAFETY MEASURES FOR OXYGEN USE

Procedure

	Performed yes	Performed no	Mastered
1. Posted "No Smoking" signs.			
2. Kept room temperature at 65–70°F.			
3. Kept an alternative supply of oxygen (e.g., tank), which was not dependent on electrical system.			
4. Posted emergency number of oxygen company by the phone.			
5. Avoided clothing with nylon or wool, which produces static electricity and sparks.			
6. Stored oxygen away from heat, open flames, or flammable materials.			
7. Did not use electric equipment, (e.g., hair dryers, shavers) when oxygen was in use.			
8. Kept environment dust-free. Damp dusted three or four times per week with cotton cloth. Used oxygen equipment in noncarpeted room if possible.			

MANAGING VENTILATOR EQUIPMENT

Preparation

	Performed yes	Performed no	Mastered
1. Evaluated home for best room in which to place client and equipment.			

	Performed yes	Performed no	Mastered
2. Ordered necessary equipment from vendor, based on type of ventilator being used (positive pressure or negative pressure ventilator).			
3. Evaluated client and family's understanding of principles of ventilator care before client began treatment.			
4. Ensured that fire department, electrical company, and telephone company were aware that ventilator-dependent client was in the home. Had electrical company place home on high-risk list.			
5. Checked home environment for cleanliness and safety prevention, such as condition of floors.			

Procedure

1. Read manufacturer's directions for setting up ventilator.			
2. Attached ventilator to oxygen or compressed air source.			
3. Filled humidifier with distilled water.			
4. Set ventilator parameters for tidal volume and rate.			
5. Set alarm parameters.			
6. Analyzed oxygen concentration at least every 8 hours or as ordered.			
7. Measured tidal volume at least every 8 hours or as ordered.			
8. Suctioned airway as needed.			
9. Provided a communication method with client if tracheostomy tube was in place.			
10. Provided oral hygiene for clients with tracheostomy tubes.			
11. Forced fluids if tolerated.			
12. Observed for signs and symptoms of respiratory infection.			
13. Drained condensation from tubing by draining fluid into bucket or large bowl.			
14. Changed ventilator tubing, compressor filter, and humidifier every 24 hours.			
15. Cleaned tubing and humidifier reservoir using weak bleach solution (nine parts water to one part bleach).			
16. Rinsed thoroughly and allowed tubing to hang dry.			
17. Stored clean equipment in plastic bag.			

PROVIDING CATHETER CARE FOR TRANSTRACHEAL CATHETER

Preparation

1. Cleansed catheter site with cotton swab and tap water twice a day. Used mild bar soap if secretions were thick.			
2. Rinsed well following use of soap.			

Procedure

for Heimlich Micro-Trach

1. Applied nasal cannula oxygen during cleaning procedure.			
2. Disconnected oxygen tubing from catheter and connected to nasal catheter.			
3. Observed for edema, erythema, or excess drainage around catheter site.			

	Performed yes	Performed no	Mastered
4. Instilled 0.5–1.0 mL sterile normal saline into catheter. Repeated instillation two to three times each day.			
5. Reconnected oxygen tubing to catheter.			
6. Reestablished oxygen flow at ordered amount, usually 1–2 L/min.			
7. Replaced catheter if dislodged during coughing. Swabbed catheter with alcohol, and reinserted.			
for SCOOP Catheter Cleaning In Place			
1. Gathered equipment.			
2. Washed hands.			
3. Applied nasal cannula oxygen during cleaning procedure.			
4. Disconnected SCOOP oxygen tubing from catheter, and connected to nasal catheter. Adjusted flow rate to prescribed nasal cannula rate.			
5. Observed for edema, erythema, or excess drainage.			
6. Donned clean gloves.			
7. Cleaned around trach opening using cotton-tipped applicator and mild soap.			
8. Dried area.			
9. Washed cleaning rod with antibacterial soap. Rinsed under running water.			
10. Instilled 1.5 mL sterile saline into catheter.			
11. Inserted cleaning rod into catheter. Pulled back and forth three times.			
12. Instilled additional 1.5 mL normal saline into catheter.			
13. Reconnected SCOOP oxygen tubing to both catheter and oxygen tubing.			
14. Returned oxygen flow rate to SCOOP resting flow rate.			
15. Allowed catheter to remain in place for 6–8 weeks. Did not remove or insert catheter until matured.			
16. Replaced SCOOP catheter every 90 days.			
17. Cleaned SCOOP rod with antibacterial soap and stored in clean, dry place.			
for SCOOP Catheter Cleaning After Removal			
1. Gathered equipment.			
2. Washed hands.			
3. Applied nasal cannula oxygen during cleaning procedure.			
4. Disconnected SCOOP oxygen tubing from catheter and connected to nasal cannula to oxygen supply. Adjusted oxygen flow rate to prescribed nasal cannula rate.			
5. Cleaned mucus crusts from around trach opening using cotton-tipped applicator and mild soap. Blotted area dry. Did not use ointments or creams around trach opening.			
6. Donned clean gloves.			
7. Applied small amount of water-soluble lubricant to tip of clean second SCOOP catheter.			
8. Disconnected bead chain necklace and removed catheter.			
9. Inserted second clean catheter. Placed tip into trach opening and gently pushed catheter straight back. Catheter directed itself into trach. If resistance was felt, twisted catheter as it was inserted. (Properly inserted, SCOOP label was visible in upright position.)			

10. Reconnected bead chain necklace.
11. Reconnected SCOOP oxygen tubing to oxygen source and catheter. Adjusted flow rate to SCOOP resting flow rate.
12. Removed nasal cannula.
13. Rinsed mucus off soiled catheter under running water. Cleaned entire length of catheter, especially tip. Did not soak catheter in disinfectant solution.
14. Ran cleaning rod through inside of catheter until clean.
15. Washed catheter with antibacterial soap and running water. Rinsed thoroughly.
16. Wiped dry and stored in clean, dry place.
17. Instructed client to keep oxygen tubing under clothes.

TEACHING THE CLIENT CATHETER CARE

Preparation

1. Ensured client's readiness to learn catheter care.
2. Evaluated client's level of understanding.
3. Determined appropriate time and place for teaching.
4. Arranged for family members to attend teaching session.

Performed yes	Performed no	Mastered

Procedure

1. Reviewed verbally and in writing signs and symptoms of infection, bronchospasm, bleeding, respiratory failure, subcutaneous emphysema, and pneumothorax with client and family prior to discharge from hospital.
2. Instructed client to take oral temperature twice a day for 1 week and to report fever greater than 99.5°F.
3. Reviewed instructions for ordered medications.
4. Instructed client about follow-up hospital and physician visits. Clients with SCOOP catheters have at least two physician visits for catheter change.
5. Instructed in use of pulse oximeter as needed.
6. Instructed to return to physician for catheter change every 6 month for Micro-Trach or every 3 month for SCOOP catheter.

Performed yes	Performed no	Mastered

TEACHING TRACHEOSTOMY SUCTION

Procedure

1. Gathered equipment.
2. Filled basin with 1/2 cup water or normal saline.
3. Instructed client to wash hands thoroughly using soap and water. If high-risk for infection, used antimicrobial soap. Donned gloves.
4. Connected suction catheter to suction machine, turned on, and checked that it was functioning properly.
5. Removed oxygen or humidity source, if using.

	Performed yes	Performed no	Mastered
6. Inserted catheter 6–8 inches without applying suction.			
7. Placed thumb over catheter vent and applied intermittent suction, for no more than 10 seconds, as catheter was withdrawn. Rotated catheter as it was being withdrawn.			
8. Reapplied oxygen source.			
9. Repeated procedure if necessary. Cleaned catheter with normal saline before reinserting into tracheostomy.			
10. Suctioned nasal or oral pharynx, if needed.			
11. Rinsed catheter with water in basin until clean.			
12. Disconnected suction catheter and coiled around gloved hand; cleaned and disinfected or discarded catheter. If discarded, when removing glove, enclosed catheter in glove and discarded in trash.			

CLEANING SUCTION EQUIPMENT

Procedure

	Performed yes	Performed no	Mastered
1. Gathered equipment			
2. Washed hands and donned gloves when cleaning equipment.			
3. Placed suction catheter in bowl with mild soap and water. Allowed to soak in soapy water for 5 minutes. Used bulb syringe to force soapy water through catheter.			
4. Rinsed catheter with sterile water.			
5. Soaked catheter for 30 minutes in solution of 1/2 cup white vinegar and 1 quart water.			
6. Rinsed thoroughly with water.			
7. Dried outside with paper towel, placed on towel, and allowed inside of catheter to thoroughly dry.			
8. Stored in clean towel until ready to use.			
9. Emptied suction bottle, washed with soap and water, and rinsed at least once a day. Replaced disposable bottles once a week or sterilized nondisposable bottles weekly.			
10. Washed connecting tubing daily with soapy water. Discarded and replaced tubing weekly.			
11. Replaced solution containers daily.			
12. Cleaned bulb syringe with soapy water and rinsed after each use.			
13. Discarded secretions from suction bottle into toilet every day.			

TEACHING TRACHEOSTOMY CARE

Procedure

	Performed yes	Performed no	Mastered
1. Gathered equipment.			
2. Washed hands.			
3. Poured hydrogen peroxide or warm soapy water in one container and water or normal saline in second container.			
4. Donned clean gloves.			
5. Removed soiled dressing and placed in trash bag.			
6. Removed soiled gloves and replaced with new gloves.			
7. Washed skin around stoma and under trach ties and flanges with presoaked gauze sponges and damp applicators			
8. Dried area thoroughly.			

	Performed yes	Performed no	Mastered
9. Removed inner cannula and placed in hydrogen peroxide or soapy water basin.			
10. Cleaned inner cannula using brush or pipe cleaners.			
11. Rinsed cannula with water or normal saline for at least 15 seconds.			
12. Replaced inner cannula.			
13. Changed trach ties. Instructed family member to hold on to face plate of trach tube when removing old ties and applying new ones. Threaded ties through opening in trach flange. Tied knot along side of client's neck, leaving one fingerbreadth under tie.			
14. Placed clean gauze with slit under tracheostomy tube and slipped up under tube.			
15. Discarded disposable items. Cleaned and soaked basins and brush in warm soapy water, followed by 30-minute soak in equal parts of vinegar and water; or boiled equipment for 15 minutes, air dried, and placed in baggie.			
16. Removed gloves and discarded in trash.			
17. Washed hands.			
18. Stored reusable equipment in baggie.			

UNIT NINE Circulatory Care

UNIT ASSESSMENT

☐ Assessed client's ability to monitor pulse accurately.

☐ Identified client's and family's knowledge of pacemaker function and safety measures.

☐ Assessed pacemaker site for signs and symptoms of infection.

☐ Assessed for signs and symptoms related to pacemaker dysfunction, including dizziness, weakness, altered level of consciousness, irregular pulse, low blood pressure, decreased urine output, fatigue.

☐ Assessed client's ability and knowledge related to contacting pacemaker clinic.

MONITORING PACEMAKER AT HOME

Procedure

	Performed yes	Performed no	Mastered
1. Instructed client in care immediately following pacemaker insertion to: a. Keep site clean and dry for at least 2 weeks. b. Demonstrated daily dressing change using sterile gauze and paper tape. c. NOT use any ointments on incision site unless physician instructed to do so. d. Assess site daily for signs of erythema, edema, or drainage. Call physician if any of these symptoms occur. e. Leave seri-strips in place until physician removes them. f. Keep dressing dry when bathing. g. Limit activity for four weeks. h. NOT lift arm above shoulder level on side of pacemaker for 4 weeks. i. NOT hit or rub insertion site or manipulate pacemaker under skin. j. Avoid heavy lifting, running, or contact sports for at least 2 weeks.			
2. Established daily routine check. a. Sit on side of bed. b. Check pulse for 1 full minute before arising. c. Record on daily record.			
3. Contact physician if any of these symptoms occur: a. Sudden slowing or increasing in pulse rate. b. Irregular pulse. c. Pain or erythema over incision site.			

4. Check with pacemaker magnet if ordered by physician.
   a. Sit on side of bed.
   b. Place magnet over pacemaker generator.
   c. Take pulse for 1 full minute.
   d. Record.
5. Taught the following safety factors to client and family:
   a. Wear Medic-Alert identification band, and carry pacemaker identification card at all times.
   b. Avoid sources of electromagnetic interference (e.g., large engines, strong magnets, airport screening devices, alarm systems).
   c. Avoid leaning over open hood of running automobile.
   d. Use microwave ovens only if in good working order.
   e. Use cellular phone on different side from pacemaker.
6. If dizziness occurs, then check pulse. Pulse should return to normal within 5 minutes; otherwise, seek medical attention.

CHECKING WITH PACEMAKER CLINIC VIA TELEPHONE

Preparation

1. Arranged schedule of calls with nurse at pacemaker clinic.
2. Taught client to follow directions of monitoring service, as follows.
3. Place electrodes on the skin.
4. Turn on ECG transmitter.

Performed yes	Performed no	Mastered

5. Informed client that transmitter transmits single-lead ECG pattern to monitor in clinic.
6. Instructed client to contact physician if
   a. Pulse was 5 beats or more per minute less than before magnet use.
   b. ECG pattern was altered from baseline ECG on file in clinic.

INSTRUCTING CLIENT IN USE OF HOLTER MONITOR

Procedure

1. Explained that heart rate and rhythm is monitored during entire time monitor in place. The Holter monitor is used to obtain a continuous graphic tracing of a client's pulse while ADLs are performed.
2. Explained that Holter monitor would be in place 24–48 hours.
3. Placed electrodes at both negative and positive poles, as directed by laboratory staff (either 5 or 7 leads).
4. Assisted client in strapping monitor in place, on belt or over shoulder.
5. Connected electrodes to recorder.
6. Instructed client to record any unusual pain, abnormal sign, symptom, or activity, stating exact time.
7. Explained that while wearing Holter monitor, must
   a. Sleep on back, not abdomen.
   b. Take sponge bath only, avoid shower.
   c. Call for instructions if electrode falls off.
   d. Maintain normal activity level.

Performed yes	Performed no	Mastered

	Performed yes	Performed no	Mastered
8. Explained to client that he or she could call laboratory or clinic any time during period Holter monitor was in place if he or she had questions. Provided client with phone number of appropriate facility.			
9. Instructed client to take recorder, strap, and paper documentation to laboratory as directed.			

TEACHING CARE OF IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR

Procedure

	Performed yes	Performed no	Mastered
1. Instructed client in the following: a. Call physician immediately if three shocks in a row are felt, dyspnea develops, or feet or ankle edema occurs. b. Take a bath whenever, but don't take a shower until incision is dry and completely healed. c. Do not change any medications for treating arrhythmia unless specifically instructed by physician. d. Take all medications prescribed by physician. Carry information about medications at all times, including name and dose. e. Refrain from wearing tight clothing over defibrillator or lead wires if ICD is in abdomen. (Most ICDs are now implanted in chest, so clothing restriction is not as much an issue.) Women can wear bras. f. Do not participate in contact sports or activities that could damage defibrillator. g. Drink caffeinated beverages in moderation. h. Carry medical alert band and ICD number at all times. Know settings on ICD (cutoff points in heart rate that triggers pacing and defibrillation).			
2. Explained symptoms associated with infection and instructed client to phone physician if: a. Erythema, edema, or tenderness surrounding incision. b. Fluid accumulation around surgical site. c. Fever of 100°F or higher.			
3. Instructed client to not lift anything over 10–15 pounds or excessively push, pull, or twist anything the first month after surgery.			
4. Instructed client to not exercise arms or overuse them for at least 3 months following surgery.			
5. Instructed client not to resume the following activities until approved by physician: a. Returning to work. b. Doing household chores. c. Traveling. d. Resuming sexual activity. e. Walking, swimming, sports. f. Using large electrical appliances or electrical motors in the workplace until they have been tested to determine if there is any influence on defibrillator.			
6. Reminded client not to undergo an MRI test.			
7. Reminded client that wand metal detectors can affect ICD, and walking through security checkpoint will set off alarms; therefore, they need to be searched by hand and allowed to enter the search area without going through scanner.			
8. Explained that the following devices will not interfere with the defibrillator: a. Electric razor. b. Small kitchen appliances, including microwave ovens and small power tools. c. Analog cellular phones, but digital phones may be sensed as abnormal and affect ICD.			