Application of Foundation Nursing Skills NURS, 213

Observation Checklist

Prepared By

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List of Content

Module (1)

Infection Control

Medical hand wash

Personal protective equipment:

- Wearing sterile gloves

- Wearing a mask

- Wearing sterile gown

1- Medical Hand Wash Observation Checklist

Student Name:	**Academic Number:**
Day/ date:	

No	Steps of procedure	Mark	Done	Not Done	Comment
1	Prepare antiseptic soap and paper towel.	1.0			
2	Stand in front of sink don't allow for clothes to touch it.	0 .5			
3	Remove jewelry.	0.5			
4	Wet the hands and wrist, keep hands point down ward through hand washing	1.0			
5	Apply soap in hands and create leather	0 .5			
6	With firm rubbing and friction clean: palms, back of hands, each finger and thumb, between fingers, knuckles and wrist	3.0			
7	Continues rubbing for at least 40-60 seconds.	1.0			
8	Use nails of finger to clean under nails of other hands or by using organ stick	1.5			
9	Rinse thoroughly while maintaining hands point downs ward	1.5			
10	Dry hands and fingers From fingers toward wrist	1.5			
11	Use new tissues for each hands	1.0			
12	Clean faucet off by clean paper towel	1.0			
13	Apply lotions	1.0			
Total Score		15			

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Step-1

Rub palms together

Step-2

Rub the back of both hands

Step-3

Interface fingers and rub the hands together.

Step-4

Interlock fingers and rub the back of fingers of both hands

Step-5

Rub thumb in a rotating manner followed by the area between index finger & thumb.

Step-6

Rub fingertips on palm for both hands

Step-7

Rub both wrists in a rotating manner rinse and dry thoroughly.

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2- Donning Sterile Gloves Observation Checklist

Student Name: **Academic Number:**

Day/Date:

No	Steps of procedure	Mark	Done	Not Done	Comments
1	Fold your sleeves	0.5			
2	Wash your hands	1.0			
3	Select gloves package with appropriate size	1.0			
4	Place package on dry flat surface and flat surface - Open outer wrapper	1.0			
	- Open inner wrapper correctly by touching only the folded edge	1.0			
	- Unfold top edge first then lower edge.	1.0			
5	Grasp folded vertical to completely open inner wrapper	1.0			
6	Put on the first pair of sterile gloves - Grasping only the folded cuff with index and thumb	1.5			
7	Pick up away from wrapper	1.0			
8	Slide your hand into glove with maintaining grasping the folded	1.0			
9	Do not touch any other parts of gloves	1.5			
10	Put on the second gloves on other hand - Pick up the 2nd glove by inserting gloved finger of 1st hand under cuff of 2nd glove.	2.0			
11	Hyper extend thumb of gloved hand or fold it tightly across palm	1.0			
12	Insert hand into glove without allow to gloved finger touch skin of 2nd hand	1.5			
15	Adjust fingers in both gloves	1.0			
16	Straighten the cuff edged of gloves	1.0			
17	Keep gloves in sight , above waist level all the time	2.0			
Total Score		**20**			

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3- Using Personal Protective Equipment Observation Checklist

Student Name: **Academic Number:**

Day/Date:

NO	Steps of procedure	Mark	Done	Not Done	Comments
1	Collect all equipment before entering patient's room: -Mask - -Gown --Gloves -Yellow bag	1.0			
2	Wash hands	1.0			
3	Put on the personal equipment - Put on gown and tie strips of neck and waist	1.0			
4	Put on mask (filter surface should extend from nose to chin , while coloring surface expose to outside securely tied and fitted to face .	2.0			
5	Put on clean gloves and draw its cuff above gown sleeves.	1.0			
6	When care is completed: -Untie waist string of gown first	1.0			
7	Put off gloves by grasping outside of glove with other gloved hand then turn it out side	1.0			
8	While holding on removed gloves, slid your finger of ungloved hand under cuff of 2nd gloved hand then turn it outside to be removed.	2.0			
9	Drape it in correct container	1.0			
10	Remove used mask by open lower string first then upper one	1.0			
11	Hold used mask from its strings for discard	0.5			
12	Remove gown untie neck string	0.5			
13	Remove gown without touch outside of gown as the following: - Placing one hand under gown cuff this hand pulls out the opposite sleeve out.	2.0			
14	- Use hand and arm (un-gowned side)to grasp gown from its inside to turn off remaining gown	2.0			
15	- Turn outside gown in side	1.0			
16	Drop it incorrect container	1.0			
17	Wash hands	1.0			
	Total Score	**20**			

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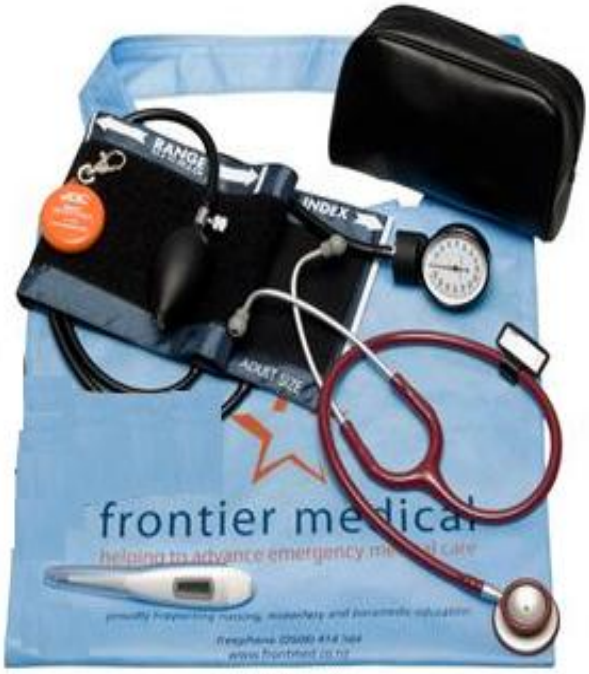
Module (2)

Vital Signs



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Prepare for Assessing Vital Signs Observation Checklist

Student Name: **Academic Number:**

Day/Date:

NO	Follow the common Procedure steps:	Mark	Done	Not Done	Comments
1.	Identify the patient	0.5			
2.	Explain procedure	0.5			
3.	Be sure that the patient does not have hot or cold fluids 30 min before oral temperature .	0.5			
4.	Ask the patient about drinking coffee, tea or smoke 1 hour ago.	0.5			
5.	Wash hands.	0.5			
6.	Collect the equipments : • Thermometer • Disposable probe cover • Watch • Alcohol swab • Vital signs record sheet.	1.0			
7.	Provide privacy.	0.5			
8.	Elevate bed to working level.	0.5			
9.	Stand at right side of patient.	0.5			
Total Score		**5.0**			

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1- Measuring Temperature Observation Checklist

Student Name: **Academic Number:**

Day/Date:

No	1- Measuring Temperature	Mark	Done	Not Done	Comments
1	Wash thermometer with cold water , rinse , dry and disinfect from tip to tail	2			
2	• Check reading on thermometer , it should be under 35 • Shake thermometer before use	1			
3	Apply protective disposable cover without contaminate the cover	2			
4	Place thermometer in correct site (according to age & level of consciousness) • If in oral cavity keep it for 3 min • Rectal site , keep it 1-2 min • If in axillary's site 3-5 min • If tampanic , keep it 2-5 sec • If digital, light or sound sign will be noticed .	2			
	Note; a) Be sure the client's axilla is dry. If it is moist, pat it dry gently before inserting the thermometer. b) Keep the arm flexed across the chest, close to the side of the body.	1 1			
5	While thermometer in place , count pulse rate for one full min.	1			
Total score		**10**			

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2- Measuring Pulse Observation Checklist

Student Name: **Academic Number:**

Day/Date:

NO	Steps : Palpate radial pulse	Mark	Done	Not Done	Comments
6	• Place patient's forearm across chest with palm facing down for sitting position or arm alongside body with arm facing down if patient in supine position	2			
7	• Place the tips of your first, index, and third finger over the client's radial artery on the inside of the wrist on the thumb side (close to wrist at thumb side)	2			
8	• Apply only enough pressure to radial pulse.	1			
9	• Using watch, count the pulse beats for a full minute.	1			
Total Score		**6.0**			

Evaluator's Name:

Signature:

3- Measuring Respiration Observation Checklist

Student Name: **Academic Number:**
Day/date

	C- Respiration	Mark	Done	Not Done	Comments
10	- In same position count breath rate ***without inform patient*** you are counting breath rate by observe chest movement for full one min.	1			
12	- Give correct reading for following: a) Temperature , but you need to remove protective cover before read the thermometer.	2			
13	b) Pulse , if reading (+5) beats different between students and evaluator is accepted .	2			
14	c) Respiration , (+5) breath different between students and evaluator is accepted .	2			
15	Give comments about : I. Temperature normal range	2			
	II. Pulse, rate rhythm &volume	2			
16	III. Respiration , rhythm , rate , depth & effort	2			
17	**Follow common steps:** • Reassure the patient • Collect unnecessary equipments • Hand wash • Documentation in vital signs sheet	1 1			
	Total Score	**35**			

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4-Measuring Blood Pressure Observation Checklist

Student Name: **Academic Number:**
Day/Date:

No	Measuring Blood Pressure	Mark	Done	Not Done	Comments
1.	**Collect equipment :** -sphygmomanometer ---stethoscope ---alcohol swab	1.0			
2.	**Follow common steps :** greeting & identify the patient, introduce self	0.5			
	explain the procedure to the patient	0.5			
	perform hand hygiene	0.5			
	provide privacy	0.5			
	Have the client rest at least 5 minutes before measurement.	0.5			
3.	-expose upper arm.	1.0			
4.	-palpate brachial pulsation at anticubital fossa.	1.0			
5.	- Apply cuff of sphygmomanometer Correctly above 2.5 cm of elbow.	2.0			
6.	For first time measure blood pressure for patient palpate radial systolic pressure: -palpate radial pulse while tight valve of pump and inflate cuff	2.0			
	- Note reading of disappear feeling of pulsation.	1.0			
	-deflate cuff.	1.0			
7.	-Wear stethoscope correctly and place the diaphragm over pulsated area of brachial artery .	1.5			
8.	-Tight valve of pump with thumb and index finger one of one hand.	1.0			
9.	-inflate cuff to 30 mmHg reading above palpated systolic radial .pressure.	2.0			
10.	-Deflate cuff slowly 2 to 3 mmHg per beat but use only one hand to open the valve of pump .	2.0			
11.	-Note reading systolic sound which is first sound you heard	2.5			
12.	-Note of diastolic sound which no more sound you can heard.	2.5			
13.	- Document and record correctly on graph sheet.	2.0			
	Total Score	**25**			

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Module (3)

Positioning Patients

Range of Motion Excercises

1- Positioning the patient Observation Checklist

Student Name:	Academic Number:
Day/Date:	

NO	Steps of Procedure	Mark	Done	Not Done	Comments
1.	**Follow common steps:** • Greeting & identify the patient, introduce self • Explain the procedure to the patient. • Perform hand hygiene, provide privacy.	 1.5 0.5 1.0			
2.	**<u>Supine Position:(flat position)</u>** A. Center the patient face-up on a flat mattress. B. Make sure the arms and legs are straight . C. Place a pillow beneath the patient's head and neck. D. Place pillows or towel rolls on either side of the patient's hips to prevent rotating or twisting. E. Place a pillow or towel roll under the patient's knee.	 0.5 0.5 0.5 0.5 0.5			
3.	**<u>Fowler's Position</u>** A. Place the patient on a mattress in the supine position. B. Place a pillow behind the patient's head and neck. C. Raise the head of the bed between 45° and 90°. D. Fold the patient's arms across the abdomen, and place pillows beneath the patient's elbows to elevate the shoulders. E. Place pillows or rolled towels on either side of the patient's hips to prevent rotating or twisting. F. Place a pillow or towel roll under the patient's knees	 0.5 0.5 0.5 0.5 0.5 0.5			

NO	Steps of Procedure	Mark	Done	Not Done	Comments
4.	**Semi-Fowler Position:**				
	A. Place the patient on a mattress in the supine position.	0.5			
	B. Place a pillow behind the patient's head and neck.	0.5			
	C. Raise the head of the bed between 15° and 30°.	0.5			
	D. Fold the patient's arms across the abdomen, and	0.5			
	E. place pillows beneath the patient's elbows to elevate the shoulders.	0.5			
	F. Place pillows or rolled towels on either side of the patient's hips to prevent rotating or twisting	0.5			
	G. Place a pillow or towel roll under the patient's knees.				
5.	**Lateral Position:**				
	A. Assist the patient to the side of the bed that is opposite the side he or she will be facing when turned**.**	0.5			
	B. Turn the patient onto the side, facing the correct direction. Keep both arms in front of the patient.	0.5			
	C. Place a pillow beneath the patient's head and neck and the back.				
	D. Position the arms according to the patient's preference.	0.5			
	E. Place a pillow in front of the chest to support the upper arm.	0.5			
	F. Bend the upper leg so that it is slightly bent in front of the lower leg. Place a pillow beneath the leg for support.	0.5			
	Lateral position the very important part 2nurses and used the pillow or towels to support the back ,arm &between legs(thigh) .	1.0			
	• Cover the patient with a sheet or blanket from neck to feet .	0.5			
	• Check that the patient is comfortable and safe.	0.5			
	• Place the call bell within the patient's reach.	0.5			
	• Reporting All action taken &any observation during change position.	0.5			
	• Washing your hand .	0.5			
6.	**Assess the patient after change position**	0.5			
	Document the procedure	1.0			
	Total Score	**20**			

Evaluator's Name:

Signature:

2- Range of Motion Exercises Observation Checklist

Student name: **Academic Number:**

Day/Date:

NO	Steps of Procedure	Mark	Done	Not Done	Comments
1.	**Follow common steps:** • Greeting & identify the patient, introduce self • Explain the procedure to the patient. • Perform hand wash. • Provide privacy.	 1.0 0.5 0.5 0.5			
2.	**Types of ROM will use : Select the suitable type according patient condition** • **Active ROM** : movements performed by the patient . • **Passive ROM : movements performed** by the health care members . • **Active Assistive ROM:** the patient dose the exercises with some assistance from another person**.**	 2.0			
3.	**Exercise** : A. **Abduction** : moving a body part away from the midline. B. **Adduction**: moving a body part toward the midline C. **Flexion** : bending a body part. D. **Extension** : straightening a body part. E. **Hyperextension** : excessive straightening of a body part. F. **Rotation**: moving in a circle at a joint. G. **Dorsiflexion** : bending backward. H. **Plantar Flexion** : bending forward.	 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5			
4.	**Preparation for ROM:** • Check that the bed is securely locked and lock the wheels if necessary. • Raise bed to its working height if possible. • Put patient in comfortable position (bed, chair).	 0.5 0.5 0.5			
5.	**Upper Range of Motion: (shoulder, elbow ,wrist)** **A. Shoulder exercise:** a. Support the patient's arm by placing one hand at the elbow and the other at the wrist. b. Flex the shoulder by raising the arm in front of the body, and then above the head. c. Extend the shoulder by bringing the arm back down to the side. d. Abduct the shoulder by moving the arm straight out to the side. e. Adduct the shoulder by moving the arm back to the body.	 0.5 0.5 0.5 0.5 0.5			

NO	Steps of Procedure	Mark	Done	Not Done	Comments
	Repeat the exercise 3-5 times for each part RT,LF.				
	B. Elbow exercise :				
	a. Support the patient's arm by placing one hand at the elbow and the other at wrist.	0.5			
	b. Flex the elbow by bending the forearm and hand up to the shoulder.	0.5			
	c. Extend the elbow by moving the forearm and hand down to the side.	0.5			
	d. Pronate by turning the palm of the hand down.	0.5			
	e. Supinate by turning the forearm and hand so the palm is up.	0.5			
	C. Wrist exercise :				
	a. Support the patient's wrist by placing one hand above it and the other hand below it.	0.5			
	b. Flex the wrist by bending the hand down toward the forearm.	0.5			
	c. Extend the wrist by straightening the hand.	0.5			
	d. Hyperextend the wrist by bending the top of the hand back toward the forearm.	0.5			
	e. Move the hand at the wrist toward the thumb side (radial deviation).	0.5			
	f. Move the hand at the wrist toward the little finger side (ulnar deviation).	0.5			
6.	**Lower Range of motion:(hip ,knee ,ankle)**				
	A. Hip exercise:				
	a. Support the patient's leg by placing one hand under the knee and the other hand under the ankle.	0.5			
	b. Abduct the hip by moving the entire leg out to the side.	0.5			
	c. Adduct the hip by moving the leg back toward the body.	0.5			
	d. Flex the hip by bending the knee and moving the leg toward the abdomen.	0.5			
	e. Extend the hip by straightening the knee and moving the leg back to the bed.	0.5			
	f. Medially rotate the hip by turning the leg toward the midline.	0.5			
	g. Laterally rotate the hip by turning the leg toward the side.	0.5			

NO	Steps of Procedure	Mark	Done	Not Done	Comments
	B. Knee exercise: a. Support the patient's leg by placing one hand under the knee and the other hand under the ankle. b. Flex the knee by moving the lower leg back toward the thigh. c. Extend the knee by straightening the leg.	0.5 0.5 0.5			
	C. Ankle exercise: a. Support the patient's foot by placing one hand under the foot and the other hand behind the ankle. b. Dorsiflexion the ankle by moving the toes and foot up toward the knee. c. Plantar flex the ankle by moving the toes and foot down away from the knee. d. Rotate the ankle clockwise and then rotate the ankle counterclockwise.	0.5 0.5 0.5 0.5			
7.	**Repeating :** • The exercise from 3 to 5 times for each side . • Allow for patient to rest between doing the exercise 5-10 min.	1.0 1.0			
8.	***Covering the patients after ROM exercise and encourage them to do it as much as they can.***	1.0			
9.	**Documentation** The time ,type of exercise, patient assessment and response.	2.0			
	Total Score	**28**			

Evaluator's Name:
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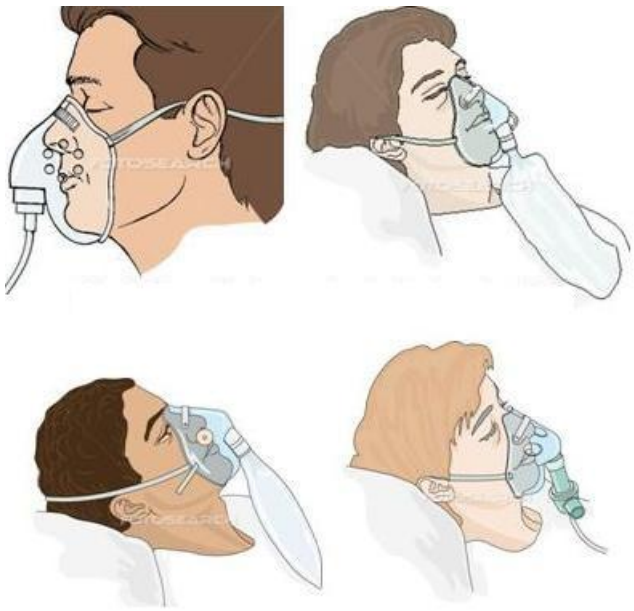
Module (4)

Administration of Oxygen Therapy



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Administration of Oxygen Therapy Observation Checklist

Student name:	Academic Number:
Day/Date:	

NO	Steps of procedure	Mark	Done	Not Done	Comments
1.	**Collect equipments:** • Oxygen source • Simple face mask, nasal cannula, according to order • Humidifier • Sterile or tape water to fill humidifier • Oxygen tubing • Tape	2			
2.	**Follow common steps :** • Identifying and greeting patient • Explain the procedure • Perform hand hygiene • Provide patient privacy	2			
3.	**Check the physician order**	2			
4.	**Set up the oxygen equipment and the humidifier:** • Attach the flow meter to the wall outlet or tank, the flow meter should be in off position • If needed fill the humidifier bottle. • Attach the humidifier bottle to the base of the flow meter. • Attach the prescribed oxygen tubing and delivery device to the humidifier.	1.0 1.0 1.0 1.0			
5.	**Turn on the oxygen at the prescribed rate and ensure proper functioning :** • Check that the oxygen is flowing freely , no kinks in the tubing , and the connection should be airtight • There should be bubbles in the humidifier as the oxygen flow through • You should feel the oxygen at the outlet of the cannula, mask or tent • Set the oxygen at the flow rate ordered	2.0 1.0 1.0 2.0			

NO	Steps of procedure	Mark	Done	Not Done	Comments
6.	**Apply the appropriate oxygen delivery device :** **A. Cannula** : • Put the cannula over the client's face with the outlet prongs fitting into the nares and elastic band around the head. • If the cannula will not stay in place, tape it at the side of the face. • Pad the tubing and band over the ears and cheekbones as needed **B. Face mask :** • Guide the mask toward the client's face and apply it from the nose downward. • Fit the mask to the contours of the client's face. • Secure the elastic band around the client's head so that the mask is comfortable but snug	1.0 1.0 1.0 1.0 1.0 1.0			
7.	**Assess the client's regularly:** • Asses the client's vital signs , level of anxiety, color and ease of respiration • Asses the client for clinical signs of hypoxia, tachycardia, confusion, dyspnea, restlessness and cyanosis. • Asses the client's nares for irritation , • Apply water-soluble lubricant • Asses the top of the client's ear for any signs of irritation	3.0 3.0 1.0 1.0 1.0			
8.	**Inspect the equipment on a regular on a regular basis**	1.0			
9.	**Follow after care**	1.0			
10.	**Documentation**	2.0			
Total Score		**35**			

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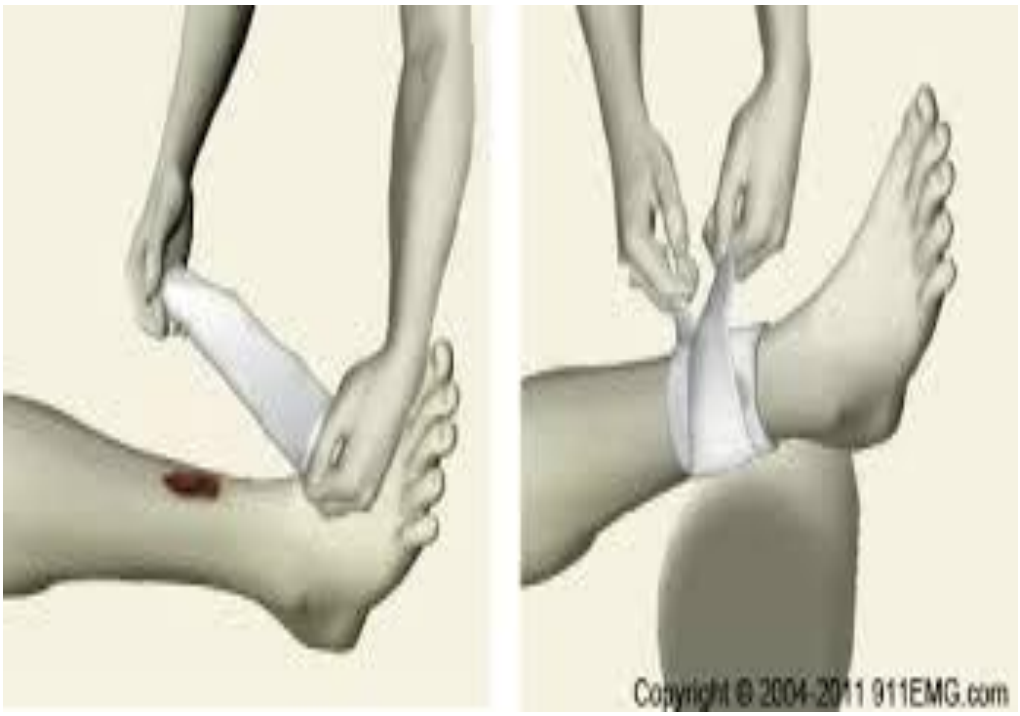
Module (5)

Wound Dressing



Wound Dressing Observation Checklist

Student name: **Academic Number:**

Day/Date:

No	Steps	Mark	Done	Not Done	Comments
1.	**Collect equipment :** -moisture –proof bag -mask(optional) - Antiseptic solution & saline. - Clean gloves. - Sterile gloves. -sterile dressing set. -additional supplies if required - tape , tie and binder	1.0			
2.	**Follow common steps :** - greeting & identify the patient, introduce self - explain the procedure to the patient - perform hand hygiene - provide privacy	1.0			
3.	**Remove binder or tape :** -remove the tape by holding down the skin and pulling the tape gently but firmly toward the wound. -use solvent to loose tape if required.	**1.5**			
4.	**Remove and dispose of solid dressing appropriately :** -put on clean gloves. -lift the outer dressing. -Place the soiled dressing in the moisture –proof bag . -remove the under dressing, not to dislodge any drain. -assess the wound (location, color, odor of wound drainage.) -discard the soiled dressing in the bag. -remove gloves , wash hands	3.0			
5.	**Set up the sterile supplies :** -open the sterile set. -place the sterile drape beside the wound. -open the sterile cleaning solution &pour it over the gauze. -put on sterile gloves.	3.0			

NO	Steps of procedure	Mark	Done	Not Done	Comments
6.	**Cleaning the wound :** -clean the wound using the gloved hands or forceps and gauze swabs moistened with cleaning solution. -using the cleaning direction methods appropriately. -use a separate swab for each stroke. **if a drain is present :** -clean it next - clean the skin around the drain site . -support and hold the drain erect while cleaning it . -dry the surrounding skin by dry gauze	4.0 2.5			
7.	**Apply dressing on the drain and incision site:** -apply the bulk of the dressing over the drain area. -apply the final surgical pad -remove gloves and dispose it. -secure the dressing with tape or ties. -collect unnecessary equipment - cover the patient , put him in comfortable position . -hand wash.	3.0			
8.	**Document the procedure and all nursing assessment**	**1**			
Total Score		**20**			

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Module (6)

Medication Preparation and Administration

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1- Administering Oral Medications Observation Checklist

Student name: **Academic Number:**

Day/Date:

No	Steps	Mark	Done	Not Done	Comments
1.	Check physician's most recent medication orders for any discrepancy on medication record sheet	0.5			
2.	Wash hands.	0.5			
3.	Prepare the medication in the medication room **Collect equipment :** • Medication (tablet, capsule or liquid) • Liquid (water, juice, or milk, if not contraindicated by drug absorption) for washing down medication • Medication Administration Record (MAR)	2.0			
4.	Pour liquid by setting medicine cup on a firm surface. At eye level, read fluid level at the lowest point of the meniscus.	1.0			
5.	• Wipe bottle lip before replacing cap. • Check medication label again. • Remember, check the label three times: When taking the medication from the drawer Before placing medicine in the medicine cup Before returning medicine to storage place	0.5 0.5 1.0			
6.	Take medication tray/cart to client's room	0.5			
7.	• Greet & identify the patient, introduce self • Check room and bed number against medication record. • Check client's identification band and ask client to state name.	0.5 0.5 1.0			
8.	Determine client's physical ability to take the medication as ordered a. Swallow reflex is present b. State of consciousness c. Signs of nausea and vomiting	2.0			
9.	Explain to the patient what medication you are going to give , and explain the actions this medication will produce	1.0			
10.	Place client in sitting /semi sitting position, if not contraindicated by his condition	0.5			

No	Steps	Mark	Done	Not Done	Comments
11.	Determine if bedside assessment is indicated before administering medication.(e.g. vital signs) and assess client	2.0			
12.	Hand medication cup to client if assessment findings do not contraindicate administration	1.0			
13	**Offer glass of water or other liquid** a. Tablets and capsules are given with water to prevent antagonism of chemical properties of the drug b. Cough syrups and antacids are not followed by water c. Crushed pills or liquids may be mixed with a small quantity of food, if not contraindicated by the client's diet	0.5 0.5 0.5			
14.	Make sure client swallows the medication.	0.5			
15.	Discard used medicine cup.	0.5			
16.	Position client for comfort	0.5			
17.	Document in the medication record including assessment findings, if it is indicated.-time, dosage , route, site and nursing assessment should be recorded .	1.0			
18.	Assess client for therapeutic drug action and possible side effects.	0.5			
19.	Report to physician if any adverse reaction noticed and document in the client's file	0.5			
Total Score		**20**			

Evaluator's Name:

Signature:

2- Intradermal Injection Observation Checklist

Student name:	**Academic Number:**
Day/Date:	

No	Steps of Procedure	Mark	Done	Not Done	Comments
1.	**Collect equipment :** • Vial or ampoule of the correct medication. • Sterile 1-ml syringe • Alcohol swabs	1.0			
2.	**Follow common steps :** • Greet & identify the patient, introduce self • Explain the procedure to the patient • Perform hand hygiene • Provide privacy	0.5 1.0 0.5 0.5			
3.	**Check the medication administration record:** • Check the label on the medication carefully against the MAR. • Following the three check.	1.0 1.0			
4.	**Select and clean the site:** • Select a site. • Avoid using inflamed, tender or swollen sites. • Clean the skin at the site using the circular motion starting at the center and widening the circular outward. • Allow the area to dry thoroughly.	1.0 0.5 2.0 0.5			
5.	**Prepare the syringe for the injection :** • Remove the needle cap • Expel any air pebbles from the syringe. • Grasp the needle correctly.	1.0 1.0 1.0			

No	Steps of Procedure	Mark	Done	Not Done	Comments
6.	**Inject the fluid :** • Pull the skin at the site. • Insert the tip of the needle far enough to place the bevel through the epidermis into the dermis. • Stabilize the syringe and needles. • Inject the medication carefully and slowly so that it produces small wheal on the skin. • Withdraw the needle quickly at the same angle at which it was inserted. • Do not massage the area. • Dispose of the syringe and needle into sharp box. • Do not recap the needle. • Circle the injection site with ink to observe for redness, indurations (hardening). • Collect unnecessary equipment. • Hand wash.	0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5			
7.	**Document all relevant information :** • Record the testing material given. • Time, dosage, route site and nursing assessment should be recorded.	2.0			
Total Score		**20**			

Evaluator's Name:

Signature:

3- Subcutaneous Injection Observation Checklist

Student name: **Academic Number:**

Day/Date:

No	Steps of Procedure	Mark	Done	Not Done	Comments
1.	**Collect equipment:** • Client's MAR. • Vial or ampoule of correct medication • Syringe and needle (3-ml) • Antiseptic swabs. • Dry sterile gauze for opening ampoule.	2.0			
2.	**Follow common steps :** • Greet & identify the patient, introduce self • Explain the procedure to the patient • Perform hand hygiene • Provide privacy	2.0			
3.	**Check the medication administration record:** • Check the label on the medication carefully against the MAR. • Follow the three check.	2.0			6.0
4.	**Select and clean the site:** • Select a site. • Avoid using inflamed, tender or swollen sites. • Clean the skin at the site using the circular motion starting at the center and widening the circular outward. • Allow the area to dry thoroughly. **Prepare the syringe for the injection :** • Remove the needle cap • Expel any air pebbles from the syringe. • Grasp the needle correctly.	1.0 0.5 2.0 0.5 0.5 0.5 0.5			5.5
5.	**Inject the medication** • Grasp the needle in the dominant hand. • Pinch or spread the skin at the site and insert the needle by 45-degree angle.	0.5 2.0			2.5

No	Steps of Procedure	Mark	Done	Not Done	Comments
6.	**Remove the needle :** • Remove the needle smoothly while depressing the skin with non dominant hand • If bleeding occurs, apply pressure to the site with dry sterile gauze.	1.0 1.0			
7.	**Dispose of supplies appropriately:** • Discard the uncapped needle in the sharp box . • Collect the unnecessary equipment and discard it . • Performing hand wash.	1.0 1.0 1.0			
8.	**Document all relevant information :** • Document the medication, dosage , time and route	0.5			
9.	**Document the medication reaction**	0.5			
Total Score		**20**			

Evaluator's Name:

Signature:

4- Intramuscular Injection Observation Checklist

Student name:	**Academic Number:**
Day/Date:	

No	Steps of procedure	Mark	Done	Not Done	Comments
1.	**Collect equipment:** • Client's MAR. • Vial or ampoule of correct medication • Syringe and needle with appropriate size • Antiseptic swabs. • Dry sterile gauze for opening ampoule.	1.0			
2.	**Follow common steps :** • Greet & identify the patient, introduce self • Explain the procedure to the patient • Perform hand hygiene • Provide privacy	0.5 0.5 0.5 0.5			
3.	**Check the medication administration record:** • Check the label on the medication carefully against the MAR. • Following the three check.	1.0 1.0			
4.	**Position the patient :** • Assist the patient in supine , lateral prone or setting position	1.0			
5.	**Select , locate and clean the site:** • Site free of lesions tenderness, swelling • Clean the skin at the site using the circular motion starting at the center and widening the circular outward.	1.0 2.0			10.5
6.	**Prepare the syringe for injection :** • Remove needle cap without causing stick needle injury.	1.5			

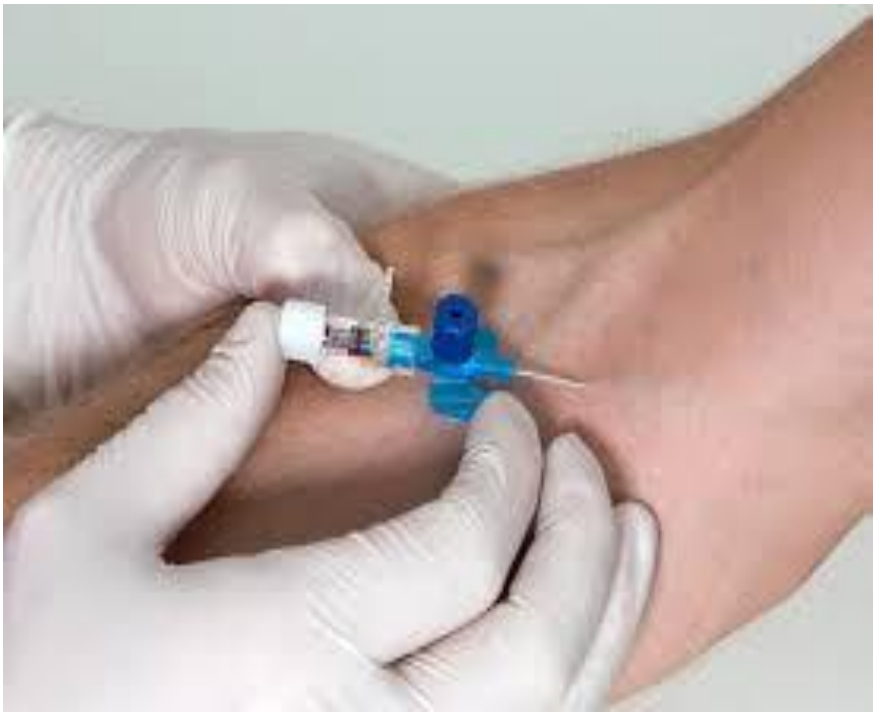
No	Steps of procedure	Mark	Done	Not Done	Comments
7.	**Inject the medication :**				3.5
	• With non dominant hand pull skin 2.5 cm laterally to spread skin and hold skin taut.	0.5			
	• Hold syringe like dart with dominant hand with needle bevel upward.	0.5			
	• Inject needle at 90 –degree angle.	0.5			
	• Hold syringe steady into the site with non dominant hand.	0.5			
	• Aspirate to be sure needle is not into blood vessels.	0.5			
	• Inject the medication slowly .	0.5			
	• After injection wait for 10 seconds	0.5			
8.	**Withdraw the needle :**				
	• Withdraw the needle smoothly with the same angle of insertion.	1.5			
	• Apply gentle pressure	1.5			
9.	**Discarding the needle in sharp box:**				6
	• Collect unnecessary equipments.	1.0			
	• Perform hand wash.	1.0			
10.	**Documentation**	1.0			
Total Score		**20**			

Evaluator's Name:

Signature

Module (7)

Insertion of Intravenous Cannula



Insertion of Intravenous Cannula Observation Checklist

Student name:	**Academic Number:**
Day/Date:	

NO	Steps of procedure	Mark	Done	Not Done	Comments
1.	**Collect equipment** : • Alcohol gel, clean glove. • Antiseptic swabs, a tourniquet. • Dry sterile gauze, an IV cannula. • A suitable plaster, a syringe 5ml • Saline, sharp container.	1.5			
2.	**Follow common steps:** • Greet & identify the patient, introduce self • Explain the procedure to the patient. • Perform hand hygiene. • Provide privacy.	1			
3.	**Apply the tourniquet :** • Palpate the vein and apply it Above the site we selected.	1.5			
4.	**Select and clean the site :** • Select a Site • Avoid Using Inflamed, Tender Or Swollen Sites. • Clean The Skin at the site using the circular motion starting at the center and widening the circular outward • Allow The Area to dry thoroughly.	1.5 0.5 2.0 0.5			
5.	**Positions patient properly and preferred site is selected:** • Grasp the patient's hand with the non – dominant hand. • Use the thumb of the non – dominant hand to stretch the skin taut and the forefinger to stabilize the vein.	0.5 1.0			

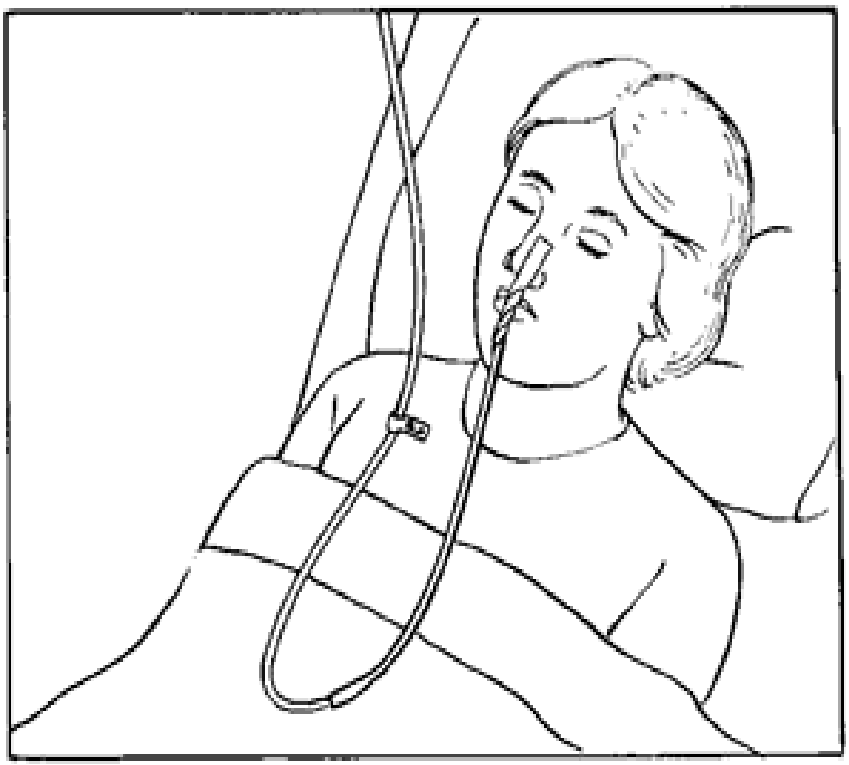
No	Steps of the procedures	Mark	Done	Not done	Comments
6.	**Insertion the needle :** • At a 30 degree angle through the skin & Hold cannula with the bevel up. • Observe hub of cannula for flashback of blood, and then drop the cannula down to the horizontal and advance along the line of the vein another few millimeters. • Slowly aspirates blood into the syringe.	1.0 1.0 1.0			
7.	**Release the tourniquet**: • Apply pressure to the vein at the tip of the cannula and remove the needle fully. • Remove the cap from the needle and put this on the end of the cannula. • Fill the syringe with saline and flush it through the cannula to check for patency. • **If there is any resistance,** causes any pain, or you notice any localized tissue swelling, immediately stop flushing, remove the cannula and start again	0.5 0.5 0.5 0.5			
8.	**Secure the cannula :** • With op-site or steri-strips and Apply the plaster to the cannula to fix it in place	2			
9.	**Dispose of supplies appropriately** • Collect the unnecessary equipment and discard it • Performing hand wash .	1.0 1.0			
10.	**Documentation :** The size of gauge, data, time and location of it.	1.0			
Total Score		**20**			

Evaluator's Name:

Signature:

Module (8)

Nasogastric Tube Insertion and Feeding



1- Nasogastric Tube Insertion Observation Checklist

Student name:	Academic Number:
Day/Date:	

NO	Steps of Procedure	Mark	Done	Not Done	Comments
1	Wash hands	0.5			
2	Prepare the Equipment: Tray containing: • NG tube (size) (12 Fr. or less in adults for long term feeding) / (type) • Stethoscope • 50 ml syringe / 20ml syringe • Cap and clamp for tubing • Kidney tray • Measured volume of water • Blue litmus paper • Protective material - White towel, tissue • Clean gloves • Tape measure • Pre cut tape • Lubricant, ky-Jelly	2			
3	Greet and Identify the Client Provide Privacy	0.5			
4	Assess the client's nares : a) Ask the client to hyperextend the head, and using a flash-light , observe the intactness of the tissues including any irritation or abrasion. b) Examine the nares for any obstruction or deformity by asking the client to breathe through one nostril while occluding the other. c) Select the nostril that has the greater airflow.	0.5 0.5 0.5			

NO	Steps of Procedure	Mark	Done	Not Done	Comments
5	**Determine how far to insert the tube** a) Use the tube to mark off the distance from the tip of the client's nose to the tip of earlobe and then from the tip of the earlobe to the xiphoid. b) Mark this length with adhesive tape if the tube doesn't have marking.	0.5 0.5			
6	**Insert the tube :** a) Put on gloves. b) Prepare the tube. Ensure that stylet is secured in position c) lubricate the tip of the tube well with water-soluble lubricant or water to ease the insertion d) Insert the tube with its natural curve toward the client. e) Ask the client to hyperextend the neck and select the nostril then gently insert the tube. f) Slight pressure and twisting motion are sometimes required to pass the tube into the nasopharynx . g) If the tube meets resistance, withdraw it relubricate it, and insert it in the other nostril. h) Once the tube reaches the throat will feel the tube in the throat and may be gag . Ask the patient to tilt the head forward and encourage client to drink and swallow. i) If the client gag, stop passing the tube momentary, has the client rest, take a few breaths and take sips of water to calm the gag reflex. j) In cooperation with patient pass the tube 5-10cm with each swallow, until the indicated length is inserted. k) If the client continuous to gag and the tube doesn't advance with each swallow , withdraw it slightly , and inspect the throat for by looking through the mouth	0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5 0.5			

NO	Steps of Procedure	Mark	Done	Not Done	Comments
7	**Ascertain correct placement of the tube :** a) Aspirate stomach contents and check the PH. b) Place a stethoscope over the client's epigastrium and inject 10-30 ml air into the tube while listening a whooshing sound. c) If the sign indicate placement in the lung , remove the tube and try again d) If the sign do not indicate placement in the lungs or stomach, advance the tube 5cm and repeat the test.	0.5 0.5 0.5 0.5			
8	**Secure the tube by taping it to the bridge of the client's nose :** e) If the client has oily skin, wipe with the nose first with alcohol to defat the skin. f) Cut 7.5cm of tape, and split it lengthwise at one end, leaving a 2.5 cm tab at the end. g) Place the tape over the bridge of the client's nose, and bring the split ends either under and around the tubing or under the tubing and back up over the nose.	0.5 0.5 0.5			
9	Once correct position has been ensured, attach the tube to a suction source or feeding apparatus as ordered or clamp the end of the tubing.	0.5			2.

NO	Steps of Procedure	Mark	Done	Not Done	Comments
	NGT feeding:				
10	Document relevant information : the insertion of the tube ,means by which correct placement was determined and client's response	1			
11	**Establish a plan for providing daily NGT care :** a) Inspect the nostril for discharge , irritation b) Clean the nostril and tube with moistened, cotton. c) Apply water soluble lubricant to the nostril if it is appearing dry. d) Change the adhesive tape if required. e) Give frequent mouth care.	 0.5 0.5 0.5 0.5 0.5			
12	**If suction is applied,** a) Ensure that the patency of both the nasogastric and suction tube is maintained. B) Irrigation of the tube may be required at regular intervals. C) Keep accurate record of the client's fluid intake and output, and record the amount and characters of the drainage.	 0.5 0.5 0.5			
14	Document the type of the tube inserted, date and time of tube insertion, type of suction used, color and amount of gastric contents, and the client's tolerance of the procedure.	1			
	Total Score	**25**			

Evaluator's Name:

Signature:

2- Nasogastric Tube Feeding Observation Checklist

Student name:	**Student Number:**
Day/Date:	

No	Steps	Mark	Done	Not Done	Comments
1	Wash hands	0.5			
2	Prepare the Equipment: Tray containing: • NG tube (size) / (type) • Stethoscope • Prescribed Feeding solution at room temperature ▪ (Ensure/ Glucerna) • 50ml syringe / 20ml syringe • Cap and clamp for tubing • Kidney tray • Measured volume of water • Blue litmus paper • Protective material - White towel, tissue • Clean gloves	1.0			
3	Greet and Identify the Patient Explain the procedure to the Patient	0.5			
4	Place the patient in semi to high fowler's position or a lateral if patient cannot be propped up.	1.0			
5	Check for proper NG placement: a. Connect syringe to NG tubing after removing cap/plug b. Place stethoscope over mid-left abdomen and gently pushes in 5-10 cc of air with syringe c. Listen with stethoscope and identifies sounds heard with proper placement	2.0			
6	Aspirate stomach contents by pulling plunger back. Observe the nature of aspirate for color, volume and presence of blood.	1.0			

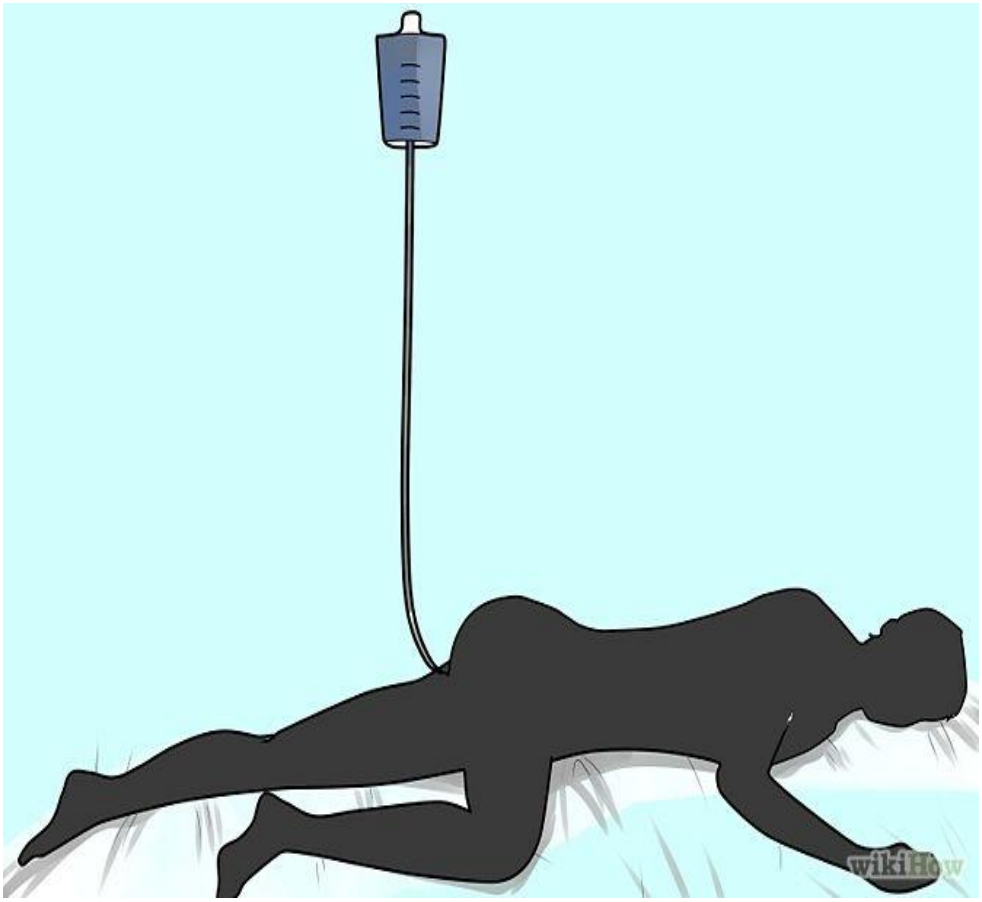
No	Steps	Mark	Done	Not Done	Comments
7	Measure stomach contents and return to stomach If volume is over 50 cc, verify if feeding is to be done	1.5			
8	Clamp/pinch NG tubing	0.5			
9	Attach syringe without plunger to NG tube. Pour 30-40 cc feeding into syringe	0.5			
10	Open clamp on NG tubing, allow feeding to run in slowly (the higher the syringe is held, the faster the feeding will flow) Height of feeding is 12 inches above the tube's point of insertion into the client. Do not allow the funnel to become empty.	2			
11	Add more formula when liquid is at 5cc mark. Continue to add until feeding is completed over prescribed time (lower syringe if flow is too fast).	1			
12	Observe the patient during feed.	1			
13	Conclude feed by Flushing NG tube with 30 ml of water To keep the lumen of tube feeding.	1.5			
14	Pinch or clamp NG tubing. Disconnects syringe. Clamp and/or cap NG tube. Makes sure NG tube is secured To prevent backflow and leakage.	1.5			
15	Keep the client in feeding position for at least 30 minutes after completing feeding	1			
16	Clean and store syringe	0.5			
17	Record the type and amount of feed and water given.	1			
Total Score		**15**			

Evaluator's Name:

Signature:

Module (9)

Administring Enema



Administring Enema Observation Checklist

Student name:	**Academic Number:**
Day/Date:	

NO	PROCEDURE STEPS	Mark	Done	Not Done	Comments
1	Check physician's order.	0.5			
2	Gather equipment. • Gloves and disposable apron. • Incontinence pads. • Lubricating solution. • Jug with thermometer. • Bedpan /commode. • Prepared solution.	1.0			
3	Wash hands.	0.5			
4	Explain procedure to the patient.	0.5			
5	Fill container with prescribed enema Solution, unless it is a prepackaged enema.	0.5			
6	Warm solution to body temperature or 37.7° C	0.5			
7	Provide privacy.	0.5			
8	Don on clean gloves.	0.5			
9	Advise the patient to empty her or his bladder before the procedure.	0.5			
10	Lower the bed. Position patient appropriately. Place the patient on left side lying with kneed flexed towards the abdomen	1.5			
11	Drape patient with bath blanket, leaving only the buttocks and rectum exposed.	0.5			
12	Place the bedpan flat on the bed directly beneath the rectum, up against the patient's buttocks; or place the bedside commode near the bed	0.5			
13	Place a waterproof pad under the patient's Buttocks/hips.	0.5			
14	Check the enema for expiry and intactness Warm the solution to desired temperature. Assess the area.	1.5			
15	Generously lubricate the tip of the enema tubing.	0.5			

NO	Procedure steps	Mark	Done	Not Done	Comments
16	If necessary, lift the superior buttock to expose the anus.	0.5			
17	Gently separate the buttocks, identifying the anus. Insert the lubricated nozzle into the rectum slowly to a depth of approximately 10cm (in adult).	0.5			
18	If tube does not pass with ease, do not force; allow a small amount of fluid to infuse and then try again.	0.5			
19	Remove the container from the IV pole and hold it at the level of the patient's hips. Begin instilling the solution.	0.5			
20	Slowly raise the level of the container and instill fluid slowly or squeeze prepackage enema. Don't elevate it more than 10 cm above rectum.	0.5			
21	Continue a slow, steady instillation of the enema solution.	0.5			
22	Continuously monitor the patient for pain or discomfort. If pain occurs or resistance is met at any time during procedure, stop and consult with primary care provider.	0.5			
23	Assess ability to retain the solution. If the patient has difficulty with retention, lower the level of the container, stops the flow for 15–30 seconds, and then resumes the procedure.	1.0			
24	When the correct amount of solution has been instilled, clamp the tubing and slowly removes the tubing from the rectum.	0.5			
25	If there is stool on the tubing, wrap the end of the tubing in a washcloth or toilet tissue until it can be rinsed or disposed of.	0.5			
26	Instruct patient to hold the enema solution for 5 to 10 minutes.	0.5			
27	Put drapes on the patient.	0.5			

NO	PROCEDURE STEPS	Mark	Done	Not Done	Comments
28	Depending on the patient's mobility status, assist patient to use bedpan, to the bedside commode, or to the toilet when she feels compelled to defecate. Remind the patient not to flush the toilet bowl.	1.5			
29	After the patient has defecated, inspect the stool for color, consistency, and quantity.	0.5			
30	Place call light within reach.	0.5			
31	Dispose of enema supplies or, if reusable, clean and store in an appropriate location in the patient's room.	1			
2	Remove gloves; wash hands.	0.5			
33	Document the procedure	0.5			
Total Score		**20**			

Evaluator's Name:

Signature:

Module (10)

Cathrterization

Catheterization Observation Checklist

Student name:	Academic Number:
Day/Date:	

No	Steps of procedure	Mark	Done	Not Done	Comments
1.	Prepare the necessary equipment: • Sterile catheter of appropriate site. • Catheterization kit. • Waterproof drape. • Antiseptic solution. • Cleansing ball • Forceps. • Water- soluble lubricant. • Uri- bag • Sterile specimen container. • Urine receptacle • Yringe prefilled with sterile water for indwelling • catheter. • Supplies for performing perineal cleansing	2.0			
2.	Assess status of client. • Ask the client time of last urination, check I &O flow sheet or palpate bladder. • Level of awareness • Mobility and physical limitations of client • Allergies	1.0			
3.	Review client's medical record, including physician's orders and nurses' notes.	1.0			
4.	• Introduce self to the patient. Identify the patient. • Explain the procedure and purpose to the client. • Perform hand hygiene. • Provide privacy (close curtain or door).	0.5 0.5 0.5 0.5			
5.	Raise bed to the appropriate working height.	1.0			
6.	Position client appropriately. • Put the female patient in supine position with knee flexed, feet about 2 feet apart. • Use a bath blanket to drape the client. • Ensure adequate lighting.	1.0			

No	Steps of procedure	Mark	Done	Not Done	Comments
7.	Place waterproof drape under the female patient's buttocks.	0.5			
8.	Wear disposable gloves, wash perineal area with soap and water as needed; dry. Remove and discard gloves; wash hands.	1.0			
9.	Open sterile kit according to directions, keeping bottom of container sterile.	0.5			
10	Put on sterile gloves.	0.5			
11.	• Organize supplies on sterile field. • Open inner sterile package containing catheter. • Pour sterile antiseptic solution into correct compartment containing sterile cotton balls. • Open packet containing lubricant. • Remove specimen container (lid should be placed loosely on top) and prefilled syringe from collection compartment of tray. • Place container with catheter and bag toward foot of the bed	0.5 0.5 0.5 0.5 0.5 0.5			
12.	• Attach the prefilled syringe to the indwelling catheter inflation hub to test the balloon . • Pull back on syringe to remove fluid	0.5 0.5			
13	• Lubricate the catheter 2.5 to 5 cm (1-2 in) for female.	0.5			
14	• Apply sterile drapes.	0.5			
15.	**<u>Cleans the meatus using the correct method and direction .</u>** • With nondominant hand, carefully retract labia to fully expose urethral meatus. • Maintain position of nondominant hand throughout the procedure. • Using forceps in sterile dominant hand, pick up cotton ball saturated with antiseptic solution and clean perineal area, wiping from front to back from clitoris toward anus. • Using a new cotton ball for each area, wipe along the far labial fold, near labial fold, and directly over the center of urethral meatus.	0.5 0.5 0.5 0.5			

No	Steps of procedure	Mark	Done	Not Done	Comments
16	• Pick up catheter with gloved dominant hand 7.5 to 10 cm (3 to 4 in) from catheter tip. • Hold end of catheter loosely coiled in palm of dominant hand.	0.5			
17	• Insert the catheter by grasping the catheter firmly 2-3 in from the tip. • Ask the patient to take deep breath and insert the catheter. Guide the catheter gently 1-2 inches beyond the point at which urine begins to flow	1.0			
18	• Release labia, and hold catheter securely with nondominant hand. • For an indwelling catheter, inflate the retention balloon with designated volume of saline .	0.5 0.5			
19	• Collect a urine specimen if needed . • Connect the catheter to the tubing.	0.5 0.5			
20	• Secure catheter tubing to inner thigh with strip of nonallergenic tape. • Attach drainage bag to bed frame (not side rails)	0.5 0.5			
21	• Wipe the perineal area of any remaining antiseptic solution or lubricant. • Assist client to a comfortable position with side rails up.	0.5 0.5			
22	• Remove gloves and dispose of equipments, drapes, and urine in proper receptacles. • Wash hands.	1.0			
23	• Observe character and amount of urine in drainage system. • Document all relevant information.	0.5 0.5			
Total Score		**25**			

Evaluator's Name:

Signature: