**Electrocardiography (ECG )**

* one of the most valuable and frequently used diagnostic tools
* measures the heart’s electrical activity through the electric currents created by the impulses moving through the heart’s conduction system
* Electrodes attached to the skin can detect electric currents and transmit them to an instrument that produces a record of electrical activity called ELECTROCARDIOGRAM
* The data are graphed in wave forms

Standard 12 lead ECG –

* uses a series of electrodes placed on the extremities and the chest wall to assess the heart from 12 different viewpoints (leads) by attaching **ten (10) cables** with electrodes to the patients limbs and chest: **Four limb electrodes and six chest electrodes**
* These electrodes provide views of the heart from the frontal plane as well as the horizontal plane



* **PURPOSE:** to identify Myocardial Ischemia and Infarction , rhythm and conduction disturbances, chamber enlargement , electrolyte imbalances and drug toxicity
* NURSING RESPONSIBILITIES
* It is essential that connection or placement of ECG Electrodes / leads is accurate to prevent misdiagnosis
* Reassure client that leads just sense and record and do not transmit any electricity
* Instruct the patient to lie still and refrain from speaking to prevent body movement from creating artifact in the ECG

Equipment:

* ECG Machine
* ECG Paper
* ECG leads
* Alcohol swab

Name of Student Date

**Student No. Name of Teacher**

**Goal:** A cardiac electrical tracing is obtained without any complications.

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Verify the order for an ECG on the patient’s medical record. |  |  |
| 2. Gather all equipment and bring to bedside. |  |  |
| 3. Perform hand hygiene and put on PPE, if indicated. |  |  |
| 4. Identify the patient. |  |  |
| 5. Close curtains around bed and close the door to the room, if possible. |  |  |
| 6. As you set up the machine to record a 12-lead ECG, explain theprocedure to the patient. |  |  |
| 7. Tell the patient that the test records the heart’s electrical activity, and it may be repeated at certain intervals. |  |  |
| 8. Emphasize that no electrical current will enter his or her body.. |  |  |
| 9. Tell the patient the test typically takes about 5 minutes |  |  |
| 10. Ask the patient about allergies to adhesive, as appropriate. |  |  |
| 11. Place the ECG machine close to the patient’s bed, and plug the power cord into the wall outlet. |  |  |
| 12. If the bed is adjustable, raise it to a comfortable working height, usually elbow height of the caregiver (VISN 8 Patient Safety Center, 2009). |  |  |
| 13. Have the patient lie supine in the center of the bed with the arms atthe sides.. |  |  |
| 14. Raise the head of the bed if necessary to promote comfort |  |  |
| 15. Expose the patient’s arms and legs, and drape appropriately. |  |  |
| 16. Encourage the patient to relax the arms and legs |  |  |
| 17. If the bed is too narrow, place the patient’s hands under the buttocks to prevent muscle tension. Also use this technique if the patient is shivering or trembling.. |  |  |
| 18. Make sure the feet do not touch the bed’s footboard |  |  |
| 19. Select flat, fleshy areas on which to place the electrodes. Avoid muscular and bony areas. If the patient has an amputated limb, choose a site on the stump. |  |  |
| 20. If an area is excessively hairy, clip the hair. Do not shave hair. Clean excess oil or other substances from the skin with soap and water anddry it completely. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 21. Apply the limb lead electrodes. The tip of each lead wire is lettered and color coded for easy identification. |  |  |
| *The white or RA lead goes to the right arm* |  |  |
| *The green or RL lead to the right leg* |  |  |
| *The red or LL lead to the left leg* |  |  |
| *The black or LA lead to the left arm.* |  |  |
| 22. Peel the contact paper off the selfsticking disposable electrode and apply directly to the prepared site, as recommended by the manufacturer. |  |  |
| 23. Position disposable electrodes on the legs with the lead connectionpointing superiorly. |  |  |
| 24. Connect the limb lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright. |  |  |
| 25. Expose the patient’s chest. |  |  |
| 26. Apply the precordial lead electrodes. The tip of each lead wire is lettered and color coded for easy identification. The brown or V1 to V6 leads are applied to the chest |  |  |
| 27. Peel the contact paper off the self sticking, disposable electrode and apply directly to the prepared site, as recommended by themanufacturer. |  |  |
| 28. Position chest electrodes as follows |  |  |
| * *V1: Fourth intercostal space at right sternal border*
 |  |  |
| * *V2: Fourth intercostal space at left sternal border*
 |  |  |
| * *V3: Halfway between V2 and V4*
 |  |  |
| * *V4: Fifth intercostal space at the left midclavicular line*
 |  |  |
| * *V5: Fifth intercostal space at anterior axillary line (halfway between V4 and V6)*
 |  |  |
| *•V6: Fifth intercostal space at midaxillary line, level with V4* |  |  |
| 29. Connect the precordial lead wires to the electrodes. Make sure the metal parts of the electrodes are clean and bright. |  |  |
| 30. After the application of all the leads, make sure the paper speed selector is set to the standard 25 m/second and that the machine is set to full voltage. |  |  |
| 31. If necessary, enter the appropriate patient identification data into themachine. |  |  |
| 32. Ask the patient to relax and breathe normally. Instruct the patient to lie still and not to talk while you record the ECG. |  |  |
| 33. Press the AUTO button. Observe the tracing quality. The machine will record all 12 leads automatically, recording 3 consecutive leads simultaneously. Some machines have a display screen so you canpreview waveforms before the machine records them on paper |  |  |
| 34. Adjust waveform, if necessary. If any part of the waveform extends beyond the paper when you record the ECG, adjust the normal standardization to half-standardization and repeat. Note this adjustment on the ECG strip, because this will need to be consideredin interpreting the results. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 35. When the machine finishes recording the 12-lead ECG, remove the electrodes and clean the patient’s skin, if necessary, with adhesive remover for sticky residue. |  |  |
| 36. After disconnecting the lead wires from the electrodes, dispose of the electrodes. Return the patient to a comfortable position. Lower bed height and adjust the head of bed to a comfortable position. |  |  |
| 37. Clean ECG machine per facility policy. If not done electronically from data entered into the machine, label the ECG with the patient’s name, date of birth, location, date and time of recording, and other relevant information, such as symptoms that occurred during the recording(Jevon, 2007b). |  |  |
| 38. Remove additional PPE, if used. Perform hand hygiene. |  |  |
| TOTAL SCORE : 48 X 2 = 96 pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach, 4th* edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 77 - 96 | Excellent Performance | 5 |
| 58 – 76 | Very Good | 4 |
| 39 – 57 | Good | 3 |
| 20 – 38 | Fair | 2 |
| 1 - 19 | Poor | 1 |

Evaluator’s Name:

**Signature:**

**CARING FOR A PATIENT RECEIVING PATIENT CONTROLLED ANALGESIA**

**Name of Student Student No.**

**Date Name of Teacher**

**Equipment :**

* PCA system
* Syringe filled with medication
* PCA system tubing
* Alcohol Swabs

**Goal:** The patient reports increased comfort and decreased pain; and shows no signs of adverse effects, oversedation, or respiratory depression.

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Gather equipment . Check the medication order against the original physician’s order according to agency policy. Clarify any inconsistencies. Check the patient’s chart for allergies |  |  |
| 2. Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for thispatient. |  |  |
| 3. Prepare the medication syringe or other container, based on facility policy, for administration |  |  |
| 4. Perform hand hygiene and put on PPE, if indicated |  |  |
| 5. Identify the patient |  |  |
| 6. Show the patient the device, and explain its function and the reason for use. Explain the purpose and action of the medication to the patient |  |  |
| 7. . Plug the PCA device into the electrical outlet, if necessary. Check status of battery power, if appropriate |  |  |
| 8. Close the door to the room or pull the bedside curtain |  |  |
| 9. Complete necessary assessments before administering medication.Check allergy bracelet or ask patient about allergies. Assess the patient’s pain, using an appropriate assessment tool and measurement scale. |  |  |
| 10. Check the label on the preﬁlled drug syringe with the medication record and patient identiﬁcation. Obtain veriﬁcation of information from a second nurse, according to facility policy. If using a barcode administration system, scan the barcode on the medication label, if required |  |  |
| 11. . If using a barcode administration system, scan the patient’sbarcode on the identiﬁcation band, if required |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 12. Connect tubing to preﬁlled syringe and place the syringe into the PCA device. Prime the tubing.. |  |  |
| 13. Set the PCA device to administer the loading dose, if ordered, and then program the device based on the medical order for medication dosage, dose interval, and lockout interval. Obtain veriﬁcation of information from a second nurse, according to facility policy |  |  |
| 14. Put on gloves. Using antimicrobial swab, clean connection port on IV infusion line or other site access, based on route of administration. Connect the PCA tubing to the patient’s IV infusion line or appropriate access site, based on the speciﬁc site used. Secure the site per facility policy and procedure. Remove gloves. Initiate the therapy by activating the appropriate button on the pump. Lock the PCA device, per facilitypolicy |  |  |
| 15. Remind the patient to press the button each time he or she needs relief from pain |  |  |
| 16. Assess the patient’s pain at least every 4 hours or more often, as needed. Monitor vital signs, especially respiratory status, including oxygen saturation at least every 4 hours or more often as needed |  |  |
| 17. Assess the patient’s sedation score and end-tidal carbon dioxidelevel (capnography) at least every 4 hours or more often as needed |  |  |
| 18. Assess the infusion site periodically, according to facility policy and nursing judgment. Assess the patient’s use of the medication, noting number of attempts and number of doses delivered. Replace the drug syringe when it is empty. |  |  |
| 19. Make sure the patient control (dosing button) is within thepatient’s reach |  |  |
| 20. Remove gloves and additional PPE, if used. Perform hand hygiene. |  |  |
| TOTAL SCORE : 20 X 2 = 40 pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 32.4 – 40 | Excellent | 5 |
| 24.4 – 32.1 | Very Good | 4 |
| 16.6 – 24.3 | Good | 3 |
| 8.8 – 16.5 | Fair | 2 |
| 1.0 - 8.7 | Poor | 1 |

**Evaluator’s Name: Signature:**

**PROVIDING PREOPERATIVE PATIENT CARE: HOSPITALIZED PATIENT**

**Name of Student Date**

**Student No. Name of Teacher**

**Equipment:**

* BP Apparatus
* Stethoscope
* Thermometer
* Pulse Oximeter sensors
* IV pump, IV Solution
* Graduated compression stockings
* Tubes, drains
* Vascular access tubings
* Incentive spirometer
* Small pillow
* PPE

**Goal:** The patient proceeds to surgery physically and psychologically prepared.

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Check the patient’s chart for the type of surgery and review the medical orders. Review the nursing database, history, and physical examination. Check that the baseline data are recorded; report those that are abnormal. |  |  |
| 2. Check that diagnostic testing has been completed and results are available;identify and report abnormal results |  |  |
| 3. Gather the necessary supplies and bring to the bedside stand or overbed table. |  |  |
| 4. Perform hand hygiene and put on PPE, if indicated. |  |  |
| 5. Identify the patient |  |  |
| 6. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient. |  |  |
| 1. Explore the psychological needs of the patient related to the surgery as well as the family.
	1. Establish the therapeutic relationship, encouraging the patient to verbalize concerns or fears.
	2. Use active learning skills, answering questions and clarifying any misinformation.
 |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Use touch, as appropriate, to convey genuine empathy
2. Offer to contact spiritual counselor (priest, minister, rabbi) to meet

spiritual needs. |  |  |
| 8. Identify learning needs of patient and family. Ensure that the informed consent of the patient for the surgery has been signed, witnessed, and dated. |  |  |
| 9. Inquire if the patient has any questions regarding the surgical procedure. |  |  |
| 10. Check the patient’s record to determine if an advance directive has been completed. If an advance directive has not been completed, discuss with the patient the possibility of completing it, as appropriate. If patient has had surgery before, ask about this experience |  |  |
| 11. . Provide teaching about deep breathing exercises |  |  |
| 12. Provide teaching regarding coughing and splinting (providing support to the incision |  |  |
| 13. Provide teaching regarding incentive spirometer |  |  |
| 14. Provide teaching regarding leg exercises, as appropriate. |  |  |
| 15. Assist the patient in putting on antiembolism stockings and demonstrate how the pneumatic compression device operates |  |  |
| 1. Provide teaching regarding turning in the bed.
	1. Instruct the patient to use a pillow or bath blanket to splint where the incision will be. Ask the patient to raise his or her left knee and reach across to grasp the right side rail of the bed when turning toward his or her right side. If patient is turning to his or her left side, he or she will bend the right knee and grasp the left side rail.
 |  |  |
| b. When turning the patient onto his or her right side, ask the patient to push with bent left leg and pull on the right side rail. Explain to patient that you will place a pillow behind his/her back to provide support, andthat the call bell will be placed within easy reach. |  |  |
| c. Explain to the patient that position change is recommended every 2 hours. |  |  |
| 1. Provide teaching about pain management.
	1. Discuss past experiences with pain and interventions that the patient has used to reduce pain.
	2. Discuss the availability of analgesic medication postoperatively.
	3. Discuss the use of patient controlled analgesia (PCA), as appropriate
	4. Explore the use of other alternative and nonpharmacologic methods to reduce pain, such as position change, massage, relaxation/diversion, guided imagery, and meditation.
 |  |  |
| 18. Review equipment that may be used. a. Show the patient various equipment, such as IV pumps, electronic blood pressure cuff, tubes, and surgical drains |  |  |
| 19. Provide skin preparation. a. Ask the patient to bathe or shower with theantiseptic solution. Remind the patient to clean the surgical site |  |  |
| 20. Provide teaching about and follow dietary/ﬂuid restrictions. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| a. Explain to the patient that both food and ﬂuid will be restricted before surgery to ensure that the stomach contains a minimal amount of gastricsecretions. This restriction is important to reduce the risk of aspiration. |  |  |
| 21. Emphasize to the patient the importance of avoiding food and ﬂuids during the prescribed time period, because failure to adhere may necessitate cancellation of the surgery |  |  |
| 1. Provide intestinal preparation, as appropriate. In certain situations, the bowel will need to be prepared by administering enemas or laxatives to evacuate the bowel and to reduce the intestinal bacteria.
	1. As needed, provide explanation of the purpose of enemas or laxatives before surgery. If patient will be administering an enema, clarify the

steps as needed. |  |  |
| 23. Check administration of regularly scheduled medications. |  |  |
| 24. Review with the patient routine medications, over-the counter medications, and herbal supplements that are taken regularly. |  |  |
| 25. Check the physician’s orders and review with the patient whichmedications he or she will be permitted to take the day of surgery. |  |  |
| 26. Remove PPE, if used. Perform hand hygiene. |  |  |
| TOTAL SCORE : 28X 2 = 56pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 45 – 56 | Excellent | 5 |
| 34. – 44.9 | Very Good | 4 |
| 23 – 33.9 | Good | 3 |
| 1.1 22.9 | Fair | 2 |
| 1.00 – 11.9 | Poor | 1 |

**Evaluator’s Name:**

**Signature:**

**PROVIDING PREOPERATIVE PATIENT CARE: HOSPITALIZED PATIENT (DAY OF SURGERY)**

**Name of Student Date**

**Student No. Name of Teacher**

**Legend**

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

**Equipment:**

* BP Apparatus
* Stethoscope
* Thermometer
* Pulse Oximeter sensors
* IV pump, IV Solution
* Graduated compression stockings
* Tubes, drains
* Vascular access tubings
* Incentive spirometer
* Small pillow
* PPE

**Goal:** The patient will be prepared physically and psychologically to proceed to surgery.

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Check the patient’s chart for the type of surgery and review the medical orders. Review the nursing database, history, and physical examination. Check that the baseline data are recorded; report those that are abnormal |  |  |
| 2. Gather the necessary supplies and bring to the bedside stand oroverbed table |  |  |
| 3. Perform hand hygiene and put on PPE, if indicated. 4. Identify the patient |  |  |
| 4. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to thepatient |  |  |
| 5. Check that preoperative consent forms are signed, witnessed, and correct; that advance directives are in the medical record (as applicable); and that the patient’s chart is in order. |  |  |
| 6. Check vital signs. Notify primary care provider and surgeon of any pertinent changes (e.g., rise or drop in blood pressure, elevated temperature, cough, symptoms of infection). |  |  |
| 7. Provide hygiene and oral care. Assess for loose teeth and caps. Remindpatient of food and ﬂuid restrictions before surgery. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 8. Instruct the patient to remove all personal clothing, including underwear, and put on a hospital gown |  |  |
| 9. Ask patient to remove cosmetics, jewelry including body piercing, nail polish, and prostheses (e.g., contact lenses, false eyelashes, dentures, and so forth). Some facilities allow a wedding band to be left in place depending on the type of surgery, provided it is secured to the ﬁnger with tape |  |  |
| 10. If possible, give valuables to family member or place valuables in appropriate area, such as the hospital safe, if this is not possible.They should not be placed in narcotics drawer. |  |  |
| 11. Have patient empty bladder and bowel before surgery. |  |  |
| 12. Attend to any special preoperative orders, such as starting an IV line. |  |  |
| 13. . Complete preoperative checklist and record of patient’s preoperative preparation |  |  |
| 14. Question patient regarding the location of the operative site. Document the location in the medical record according to facility policy. The actual site will be marked on the patient when the patient arrives in the preoperative holding area by the licensed independentpractitioner who will be directly involved in the procedure |  |  |
| 15. . Administer preoperative medication as prescribed by physician/anesthesia provider |  |  |
| 16. Raise side rails of bed; place bed in lowest position. Instruct patient to remain in bed or on stretcher. If necessary, use a safety belt. |  |  |
| 17. Help move the patient from the bed to the transport stretcher, if necessary. Reconﬁrm patient identiﬁcation and ensure that allpreoperative events and measures are documented. |  |  |
| 18. Tell the patient’s family where the patient will be taken after surgery and the location of the waiting area where the surgeon will come to explain the outcome of the surgery. If possible, take the family to thewaiting area. |  |  |
| 19. After the patient leaves for the operating room, prepare the room and make a postoperative bed for the patient. Anticipate any necessary equipment based on the type of surgery and the patient’s history. |  |  |
| 20. Remove PPE, if used. Perform hand hygiene. |  |  |
| TOTAL SCORE : 20 X 2 = 40 pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 32.4 – 40 | Excellent | 5 |
| 24.4 – 32.1 | Very Good | 4 |
| 16.6 – 24.3 | Good | 3 |
| 8.8 – 16.5 | Fair | 2 |
| 1.0 – 8.7 | Poor | 1 |

**Evaluator’s Name: Signature:**

**PROVIDING POSTOPERATIVE PATIENT CARE WHEN PATIENT RETURNS TO ROOM**

**Name of Student Date**

**Student No. Name of Teacher**

**Legend**

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

**Equipment:**

* BP Apparatus
* Stethoscope
* Thermometer
* Pulse Oximeter sensors
* IV pump, IV Solution
* Graduated compression stockings
* Tubes, drains
* Vascular access tubings
* Incentive spirometer
* Small pillow
* PPE
* Blankets

**Goal:** The patient will recover from the surgery with postoperative risks minimized by frequent assessments.

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| **Immediate Care** |  |  |
| 1. When patient returns from the PACU, obtain a report from the PACU nurse and review the operating room and PACU data |  |  |
| 2. Perform hand hygiene and put on PPE, if indicated |  |  |
| 3. Identify the patient. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient |  |  |
| 4. Place patient in safe position (semi- or high Fowler’s or side-lying).Note level of consciousness |  |  |
| 5. Obtain vital signs. Monitor and record vital signs frequently. Assessment order may vary, but usual frequency includes taking vitalsigns every 15 minutes the ﬁrst hour, every 30 minutes the next 2 hours, every hour for 4 hours, and ﬁnally every 4 hours. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 6. Assess the patient’s respiratory status |  |  |
| 7. Measure the patient’s oxygen saturation level. 8. Assess the patient’s cardiovascular status |  |  |
| 8. Assess the patient’s neurovascular status, based on the type ofsurgery performed. |  |  |
| 9. Provide for warmth, using heated or extra blankets, as necessary. Assess skin color and condition. |  |  |
| 10. Check dressings for color, odor, presence of drains, and amount of drainage. Mark the drainage on the dressing by circling theamount, and include the time. |  |  |
| 11. Turn the patient to assess visually under the patient for bleeding from the surgical site. |  |  |
| 12. Verify that all tubes and drains are patent and equipment isoperative; note amount of drainage in collection device. If an indwelling urinary (Foley) catheter is in place, note urinary output |  |  |
| 13. Verify and maintain IV infusion at correct rate |  |  |
| 14. Assess for pain and relieve it by administering medications ordered by the physician. If the patient has been instructed in use of PCA for pain management, review its use. Check record to verify ifanalgesic medication was administered in the PACU. |  |  |
| 15. . Provide for a safe environment. Keep bed in low position with side rails up, based on facility policy. Have call bell within patient’s reach |  |  |
| 16. Remove PPE, if used. Perform hand hygiene. |  |  |
| **Ongoing Care** |  |  |
| 1. Promote optimal respiratory function.
	1. Assess respiratory rate, depth, quality, color, and capillary reﬁll. Ask if the patient is experiencing any difﬁculty breathing.
	2. Assist with coughing and deep breathing exercises
	3. Assist with incentive spirometry
	4. Assist with early ambulation.
	5. Provide frequent position change.
	6. Administer oxygen as ordered.
	7. Monitor pulse oximetry
 |  |  |
| 1. Promote optimal cardiovascular function:
	1. Assess apical rate, rhythm, and quality and compare with peripheral pulses, color, and blood pressure. Ask if the patient has any chest pains or shortness of breath.
	2. Provide frequent position changes.
	3. Assist with early ambulation.
	4. Apply antiembolism stockings or pneumatic compression devices, if ordered and not in place. If in place, assess for integrity.
	5. Provide leg and range-of-motion exercises if not contraindicated
 |  |  |
| 1. Promote optimal neurologic function:
	1. Assess level of consciousness, motor, and sensation.
	2. Determine the level of orientation to person, place, and time.
 |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Test motor ability by asking the patient to move each extremity.
2. Evaluate sensation by asking the patient if he or she can feel

your touch on an extremity. |  |  |
| 1. Promote optimal renal and urinary function and ﬂuid and electrolyte status. Assess intake and output, evaluate for urinary retention and monitor serum electrolyte levels.
	1. Promote voiding by offering bedpan at regular intervals, noting the frequency, amount, and if any burning or urgency symptoms.
	2. Monitor urinary catheter drainage if present.
	3. Measure intake and output.
 |  |  |
| 1. Promote optimal gastrointestinal function and meet nutritional needs:
	1. Assess abdomen for distention and ﬁrmness. Ask if patient feels nauseated, any vomiting, and if passing ﬂatus.
	2. Auscultate for bowel sounds.
	3. Assist with diet progression; encourage ﬂuid intake; monitor intake. D. Medicate for nausea and vomiting, as ordered by physician
 |  |  |
| 1. Promote optimal wound healing.
	1. Assess condition of wound for presence of drains and any drainage. B. Use surgical asepsis for dressing changes.

c. Inspect all skin surfaces for beginning signs of pressure ulcer development and use pressure-relieving supports to minimizepotential skin breakdown |  |  |
| 1. Promote optimal comfort and relief from pain.
	1. Assess for pain (location and intensity using scale).
	2. Provide for rest and comfort; provide extra blankets, as needed, for warmth.
	3. Administer pain medications, as needed, or other nonpharmacologic methods
 |  |  |
| 1. Promote optimal meeting of psychosocial needs:
	1. Provide emotional support to patient and family, as needed.
	2. Explain procedures and offer explanations regarding postoperative recovery, as needed, to both patient and family

members. |  |  |
| TOTAL SCORE : 24X 2 = 48pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor’s Clinical Nursing Skills: A Nursing Process Approach,* 4rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2015.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 38.6 – 48 | Excellent | 5 |
| 29.2 – 38.5 | Very Good | 4 |
| 19.8 – 29.1 | Good | 3 |
| 10.4– 19.7 | Fair | 2 |
| 1.0 – 10.3 | Poor | 1 |

**Evaluator’s Name: Signature:**

**ADMINISTERING MEDICATION VIA METERED DOSE INHALER (MDI)**

**Name of Student Date**

**Student No. Name of Teacher**

**Legend**

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

**Equipment:**

* Incentive Spirometer
* Stethoscope
* Folded Blanket Or Pillow For Splinting Of Chest Or Abdominal Incision
* PPE
* Medication in an MDI
* Spacer or holding chamber
* Medication administration record

**Goal:** The patient receives the medication via an inhaler using the correct technique

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Gather equipment. Check each medication order against the originalorder in the medical record, according to facility policy. Clarify any inconsistencies. Check the patient’s chart for allergies. |  |  |
| 2. . Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for thispatient |  |  |
| 3. Perform hand hygiene |  |  |
| 4. Move the medication cart to the outside of the patient’s room orprepare for administration in the medication area |  |  |
| 5. Unlock the medication cart or drawer. Enter pass code and scan employee identiﬁcation, if required |  |  |
| 6. . Prepare medications for one patient at a time. |  |  |
| 7. Read the CMAR/MAR and select the proper medication from the patient’s medication drawer or unit stock. |  |  |
| 8. Compare the label with the CMAR/MAR. Check expiration dates and perform calculations, if necessary. Scan the bar code on the package, if required |  |  |
| 9. When all medications for one patient have been prepared, recheck thelabel with the MAR before taking them to the patient. |  |  |
| 10. Lock the medication cart before leaving it. |  |  |
| 11. Transport medications to the patient’s bedside carefully, and keep the medications in sight at all times |  |  |
| 12. Ensure that the patient receives the medications at the correct time. |  |  |
| 13. Perform hand hygiene and put on PPE, if indicated. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Identify the patient. Usually, the patient should be identiﬁed using two methods. Compare information with the CMAR/ MAR.
	1. Check the name and identiﬁcation number on the patient’s identiﬁcation band.
 |  |  |
| 1. Ask the patient to state his or her name and birth date, based on facility policy.
2. If the patient cannot identify him- or herself, verify the patient’s identiﬁcation with a staff member who knows the patient for

the second source |  |  |
| 15. Complete necessary assessments before administering medications. Check the patient’s allergy bracelet or ask the patient about allergies. |  |  |
| 16. Explain what you are going to do and the reason to the patient |  |  |
| 17. Scan the patient’s bar code on the identiﬁcation band, if required |  |  |
| 18. Remove the mouthpiece cover from the MDI and the spacer. Attach the MDI to the spacer. |  |  |
| 19. Shake the inhaler and spacer well. |  |  |
| 20. Have patient place the spacer’s mouthpiece into mouth, grasping securely with teeth and lips. Have patient breathe normally throughthe spacer |  |  |
| 21. Patient should depress the canister, releasing one puff into the spacer, then inhale slowly and deeply through the mouth |  |  |
| 22. . Instruct patient to hold his or her breath for 5 to 10 seconds, or aslong as possible, and then to exhale slowly through pursed lips. |  |  |
| 23. Wait 1 to 5 minutes, as prescribed, before administering the next puff. |  |  |
| 24. . After the prescribed amount of puffs has been administered, have patient remove the MDI from the spacer and replace the caps on both. |  |  |
| 25. Have the patient gargle and rinse with tap water after using an MDI,as necessary. Clean the MDI according to the manufacturer’s directions |  |  |
| 26. Remove gloves and additional PPE, if used. Perform hand hygiene |  |  |
| 27. Document the administration of the medication immediately after administration. |  |  |
| 28. Evaluate the patient’s response to medication within appropriate time frame. Reassess lung sounds, oxygenation saturation if ordered, and respirations |  |  |
| TOTAL SCORE : 28 X 2 = 56 pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 45 - 56 | Excellent | 5 |
| 34 – 44 | Very Good | 4 |
| 23 – 33 | Good | 3 |
| 12 – 22 | Fair | 2 |
| 1- 11 | Poor | 1 |

**Evaluator’s Name: Signature:**

**BLOOD GLUCOSE MONITORING**

* + Provides information about how the body is controlling glucose metabolism
	+ Point of care testing (testing done at the bedside, where samples re not sent to the lab) provides convenient, rapid, and accurate measurement of blood Glucose
	+ Blood samples are commonly obtained from the edges of the fingers for adults, but samples can be obtained from the palm of the hand, forearm, upper arm, calf and anterior thigh, depending on the time of testing and monitor used.
	+ Avoid fingertips because they are more sensitive
	+ Rotate site to prevent skin damage.
	+ It is important to be familiar with and follow the manufacturer’s guidelines and facility policy and procedure to ensure accurate results.
	+ Normal fasting glucose for Adults is less than 110 mg/ dl
	+ **Equipment:** Blood glucose meter, Sterile lancet, cotton balls or gauze squares, testing strips for meter, non sterile gloves, additional PPE as indicated, Skin cleanser and water or alcohol swab
	+ **Assessment:** Assess the patient’s history for indications necessitating the monitoring of blood glucose levels such as high carbohydrate feedings, history of DM, or corticosteroid therapy, signs and symptoms of hypoglycemia, hyperglycemia, patient’s knowledge about monitoring blood glucose . Inspect the area of the skin to be used for testing. Avoid bruised and open area.
	+ **Nursing diagnoses:** Risk for unstable blood glucose level, Deficient knowledge , Anxiety

General Considerations:

* + If the selected site feels cold or appears pale, warm compresses can be applied for 3-5minutes to dilate the capillaries
	+ Blood in the fingertips shows changes in glucose levels more quickly than blood in other parts of the body
	+ Caution patients to use a fingertip sample if it is less than 2 hours after eating, less than 2 hours after injecting rapid acting insulin, during exercise or within 2 hours of exercise, when sick or under stress, when having symptoms of hypoglycemia
	+ Inadequate sampling can cause errors in the results.
	+ Heel sticks using the outer aspect of the heel may be used for infants. Warming the heel before the sample is taken dilates the blood vessels in the area and aids in sampling.

Equipment: Blood Glucose Meter, Sterile Lancet, Cotton balls or gauze squares, Testing strips, Non sterile gloves, Additional PPE, Skin Cleanser and water or alcohol swab

Name of Student Date

**Student No. Name of Teacher**

**Goal:** The Blood Glucose level is measured accurately without adverse effect

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Check the patient’s medical record or nursing plan of care for monitoring schedule. You may decide that additional testing is indicated based on nursing judgment and the patient’s condition. |  |  |
| 2. Gather equipment. |  |  |
| 3. Perform hand hygiene and put on PPE, if indicated. |  |  |
| 4. Identify the patient. Explain the procedure to the patient and instruct the patient about the need for monitoring blood glucose |  |  |
| 5. Close curtains around bed and close the door to the room, if possible. |  |  |
| 6. Turn on the monitor. |  |  |
| 7. Enter the patient’s identification number, if required, according to facility policy |  |  |
| 8. Put on nonsterile gloves. |  |  |
| 9. Prepare lancet using aseptic technique |  |  |
| 10. Remove test strip from the vial. Recap container immediately. Test strips also come individually wrapped. |  |  |
| 11. Check that the code number for the strip matches code number on themonitor screen. |  |  |
| 12. Insert the strip into the meter according to directions for that specific device. |  |  |
| 13. For adult, massage side of finger toward puncture site. |  |  |
| 14. Have the patient wash hands with soap and warm water and dry thoroughly. |  |  |
| 15. Alternately, cleanse the skin with an alcohol swab. |  |  |
| 16. Allow skin to dry completely. |  |  |
| 17. Hold lancet perpendicular to skin and pierce site with lancet. |  |  |
| 18. Wipe away first drop of blood with gauze square or cotton ball if recommended by manufacturer of monitor |  |  |
| 19. Encourage bleeding by lowering the hand, making use of gravity. |  |  |
| 20. Lightly stroke the finger, if necessary, until sufficient amount of blood has formed to cover the sample area on the strip, based on monitor requirements (check instructions for monitor). Take care not to squeeze the finger, not to squeeze at puncture site, or not to touchpuncture site or blood. |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 21. Gently touch a drop of blood to pad to the test strip without smearing it. |  |  |
| 22. Press time button if directed by manufacturer. |  |  |
| 23. Apply pressure to puncture site with a cotton ball or dry gauze. Do not use alcohol wipe. |  |  |
| 24. Read blood glucose results and document appropriately at bedside. |  |  |
| 25. Inform patient of test result. |  |  |
| 26. Turn off meter, remove test strip, and dispose of supplies appropriately. Place lancet in sharps container. |  |  |
| 27. Remove gloves and any other PPE, if used. |  |  |
| 28. Perform hand hygiene. |  |  |
| TOTAL SCORE : 28 X 2 = 56 pts |  |  |

Reference: Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 49.8 - 56 | Excellent | 5 |
| 43.7 – 49.7 |  | 4.5 |
| 37.6 – 43.6 | Very Good | 4.0 |
| 31.5 - 37.5 |  | 3.5 |
| 25.4 – 31.4 | Good | 3.0 |
| 19.3 – 25.3 - |  | 2.5 |
| 13.2 – 19.2 | Fair | 2.0 |
| 7.1 – 13.1 |  | 1.5 |
| 1.0 – 7.0 | Poor | 1 |

**Evaluator’s Name:**

**Signature:**

**CHANGING AND EMPTYING AN OSTOMY APPLIANCE**

**Ostomy** - A term for surgically formed opening from the inside of an organ to the outside

**Stoma –** the part of Ostomy that is attached to the skin. The intestinal mucosa is brought out to the abdominal wall

**Ileostomy –** allows liquid fecal content from the ileum of the small intestines to be eliminated through the stoma

**Colostomy –** permits formed feces in the colon from which they originate

**Ostomy appliance or pouches** are applied to the opening to collect the stool . **;** Available in one piece ( barrier backing already attached to the pouch) or two piece ( separate pouch that fastens to the barrier backing) system.

Equipment:

* + Basin with warm water, skin cleanser, towel , wash cloth, toilet tissue or paper towel, silicone based adhesive remover, gauze squares, washcloth , skin protectant such as skin prep, one piece ostomy appliance, closure clamp, if required for appliance, stoma measuring guide, graduated container, toilet or bed pan, ostomy belt, disposable gloves, additional PPE as indicated, small plastic trash bag, water proof disposable pad

Assessment

* + Assess current ostomy appliance , looking at product style, condition of appliance, and stoma (if bag is clear) Note length of time the appliance has been in place. Determine the patient’s knowledge of Ostomy Care . After removing the appliance , assess the stoma and the skin surrounding the stoma. Assess any abdominal scars if surgery is recent. Assess the amount, color, consistency and odor of stool from the ostomy.

Nursing Diagnoses:

* + Risk for impaired skin integrity
	+ Deficient knowledge
	+ Disturbed body Image

Special Consideration

* + Keep the patient as free of odors as possible.
	+ They should be emptied promptly, usually when they are one third to one half full. If they are allowed to fill up , they may leak or become detached from the skin
	+ Appliances are usually changed every 3-7 days , although they could be changed more often. Proper application minimizes the risk for skin breakdown around the stoma. Non drainable pouches require removal and changing when they are half full.
	+ Drain or empty the pouch when it is one third full .
	+ Inspect the patient’s stoma regularly. Notify physician if bleeding persists or is excessive or if color changes around the stoma
	+ Keep the skin around the stoma (peristome) clean and dry to prevent irritation
	+ Record intake and output every 4 hours for the first three days after surgery
	+ Patient teaching is one of the most important aspect of Colostomy care. Include the family as well
	+ Encourage patient to participate in care and to look at the ostomy. Help the patient cope with emotional depression by listening , explaining, and being available and supportive

|  |  |  |
| --- | --- | --- |
| Character of Stoma | Normal | Abnormal |
| a. Color | * dark pink to red, and moist
 | * pale stoma may indicate Anemia,
* dark or purple blue stoma may reflect compromised

circulation or ischemia |
| b. size of the stoma (usually stabilizes within 6 – 8 weeks .) | * Most Stomas protrude 0.5 to 1 inch from the abdominal surface
 | * Increase in normal size
 |
| c. Bleeding | * minimal
 | * excessive
 |
| d. edema | * may initially appear swollen and edematous
* subsides after 6 weeks
 | * edema persists longer
* erosion of skin around the stoma
 |

**CHANGING AND EMPTYING AN OSTOMY APPLIANCE**

Name of Student Date

**Student No. Name of Teacher**

Goal: The stoma appliance is applied correctly to the skin to allow stool to drain freely.

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Bring necessary equipment to the bedside stand or overbed table. |  |  |
| 2. Perform hand hygiene and put on PPE, if indicated. |  |  |
| 3. Identify the patient. |  |  |
| 4. Close curtains around bed and close the door to the room, if possible. |  |  |
| 5. Explain what you are going to do and why you are going to do it to the patient. Encourage the patient to observe or participate, if possible. |  |  |
| 6. Assist patient to a comfortable sitting or lying position in bed or astanding or sitting position in the bathroom. |  |  |
| **Emptying an Appliance** |  |  |
| 7. Put on disposable gloves. |  |  |
| 8. Remove clamp and fold end of pouch upward like a cuff |  |  |
| 9. Empty contents into bedpan, toilet, or measuring device |  |  |
| 10. Wipe the lower 2 inches of the appliance or pouch with toilet tissue. |  |  |
| 11. Uncuff edge of appliance or pouch and apply clip or clamp, or secure Velcro closure. Ensure the curve of the clamp follows the curve of the patient’s body. |  |  |
| 12. Remove gloves. |  |  |
| 13. Assist patient to a comfortable position |  |  |
| 14. . If appliance is not to be changed, remove additional PPE, if used. |  |  |
| 15. Perform hand hygiene |  |  |
| **Changing an Appliance** |  |  |
| 16. Place a disposable pad on the work surface. |  |  |
| 17. Set up the wash basin with warm water and the rest of the supplies. |  |  |
| 18. Place a trash bag within reach. |  |  |
| 19. . Put on clean gloves |  |  |
| 20. Place waterproof pad under the patient at the stoma site. |  |  |
| 21. Empty the appliance as described previously |  |  |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 22. Gently remove pouch faceplate from skin by pushing skin from appliance rather than pulling appliance from skin. |  |  |
| 23. Start at the top of the appliance, while keeping the abdominal skin taut |  |  |
| 24. Apply a silicone-based adhesive remover by spraying or wiping withthe remover wipe. |  |  |
| 25. Place the appliance in the trash bag, if disposable. |  |  |
| 26. If reusable, set aside to wash in lukewarm soap and water and allow to air dry after the new appliance is in place. |  |  |
| 27. Use toilet tissue to remove any excess stool from stoma. |  |  |
| 28. Cover stoma with gauze pad |  |  |
| 29. Clean skin around stoma with mild soap and water or a cleansing agent and a washcloth. |  |  |
| 30. . Remove all old adhesive from skin; use an adhesive remover, asnecessary. Do not apply lotion to peristomal area |  |  |
| 31. Gently pat area dry. Make sure skin around stoma is thoroughly dry. |  |  |
| 32. Assess stoma and condition of surrounding skin |  |  |
| 33. Apply skin protectant to a 2-inch (5 cm) radius around the stoma, and allow it to dry completely, which takes about 30 seconds. |  |  |
| 34. Lift the gauze squares for a moment and measure the stoma opening, using the measurement guide. |  |  |
| 35. Replace the gauze. Trace the same-size opening on the back centerof the appliance. Cut the opening 1/8 inch larger than the stoma size |  |  |
| 36. Remove the backing from the appliance. |  |  |
| 37. Quickly remove the gauze squares and ease the appliance over the stoma. |  |  |
| 38. Gently press onto the skin while smoothing over the surface. |  |  |
| 39. Apply gentle pressure to appliance for ***approximately 30 seconds*** |  |  |
| 40. Close bottom of appliance or pouch by folding the end upward and using the clamp or clip that comes with the product, or secure Velcro closure. Ensure the curve of the clamp follows the curve of thepatient’s body |  |  |
| 41. Remove gloves.. |  |  |
| 42. Assist the patient to a comfortable position. |  |  |
| 43. Cover the patient with bed linens. |  |  |
| 44. Place the bed in the lowest position |  |  |
| 45. Put on clean gloves.. |  |  |
| 46. Remove or discard equipment and assess patient’s response to procedure |  |  |
| 47. Remove gloves and additional PPE, if used. |  |  |
| 48. Perform hand hygiene. |  |  |
| TOTAL SCORE : 48 X 2 = 96 pts |  |  |

Pamela Lynn and Marilee LeBon. *Skill Checklists for Taylor's Clinical Nursing Skills: A Nursing Process Approach,* 3rd edition, by Wolters Kluwer Health | Lippincott Williams & Wilkins. 2011.

SCORING OF PERFORMANCE

|  |  |  |
| --- | --- | --- |
| Score | Level of Performance | Marks |
| 77 - 96 | Excellent Performance | 5 |
| 58 – 76 | Very Good | 4 |
| 39 – 57 | Good | 3 |
| 20 – 38 | Fair | 2 |
| 1.0- 19 | Poor | 1 |

**Evaluator’s Name:**

**Signature**

**Nebulizer**

Name of Student Date

**Student No. Name of Teacher**

**\*Definition of nebulizer:**

 - Nebulization is the process of medication administration via inhalation. It utilizes a nebulizer which transports medications to the lungs by means of mist inhalation.

**\*Indications of nebulizer .**

 - Broncho-spasms
 - Chest tightness
 - Excessive and thick mucus secretions
 - Respiratory congestions
 - Pneumonia

**\*Contraindications of nebulizer:-**

 - Patients with unstable and increased blood pressure
 - Individuals with cardiac irritability (may result to dysrhythmias)
 - Persons with increased pulses
 - Unconscious patients (inhalation may be done via mask but the

 therapeutic effect may be significantly low).

**\*Complications of nebulizer:-**

 Possible effects and reactions after nebulization therapy are as follows:
 • Palpitations
 • Tremors
 • Tachycardia
 • Headache
 • Nausea
 • Broncho-spasms (too much ventilation may result

 or exacerbateBroncho-spasms)

\*Reference :-

-TARLAC STATE UNIVERSITY,COLLEGE OF NURSING Lucinda Campus, 2015, Brgy. Ungot, Tarlac City Philippines, website: www.tsu.edu.ph.

Legend

|  |  |
| --- | --- |
| 2 | Done Correctly |
| 1 | Done with Assistance |
| 0 | Not done |

|  |  |  |
| --- | --- | --- |
| Procedure | Score | Remarks |
| 1. Demonstrate knowledge of the procedure by identifying health needs of the patients
 |  |  |
| 1. Review medical orders and obtain information on drug/dosage/specific administration, responses to pervious treatment .
 |  |  |
| 1. Explain the purpose of the procedure to the patient.
 |  |  |
| 1. Prepare the equipment's needed.
* Prescribed drug/s
* Patient medical record/chart
* Air compressor or nebulizer
 |  |  |
| 1. Monitor heart rate before and after the treatment for patient using bronchodilator drugs.
 |  |  |
| 1. Explain the procedure to the patient.
 |  |  |
| 1. Place the patient in a comfort position (semi-fowler or sitting position.
 |  |  |
| 1. Add the prescribed amount of medication and saline to the nebulizer.
 |  |  |
| 1. Connect the tubing to the compressor and turn it on.
 |  |  |
| 1. Instruct the patient to exhale.
 |  |  |
| 1. Tell the patient to take in a deep breath from the mouthpiece and hold breath briefly then exhale.
 |  |  |
| 1. Observe expansion of the chest to ascertain that patient is taking deep breath.
 |  |  |
| 1. Instruct the patient to breathe slowly and deeply until all the medication is nebulized. All medication is given, usually 10-15 minutes.
 |  |  |
| 1. Observe for adverse effect during administration.
 |  |  |
| 1. On completion of the treatment, encourage the patient to cough after several deep breaths.
 |  |  |
| 1. Assess need for percussion, vibration. postural drainage and suctioning
 |  |  |
| 1. Record medication used and description of secretions.
 |  |  |
| 1. Disassemble and clean nebulizer after each use.
 |  |  |
| 1. Remove gloves and dispose of them.
 |  |  |
| 1. Wash hands then clean and replace equipment as specified.
 |  |  |
| 1. Document giving the medication including each of the 6rights ,pulse and respiration at the of the treatment any action taken
 |  |  |
| 1. Drugs and dosages administered , increase wheezing, increased work of breathing, more limited air entry, cyanosis, agitation, desaturation or other deterioration during or after treatment, topics discussed with the patient and his family.
 |  |  |
| 1. Documents accurately relevant data about the before, during and after the procedure.
 |  |  |
| TOTAL SCORE : 23 X 2 = 46 |  |  |

**Evaluator’s Name:**

**Signature**