

Introduction to Nursing Basic Care - Day 2

Skills Checklist Instructions

Practicing these skills will ensure you can safely assist your patients with basic care and ADLs during clinical experiences!

- Print checklists from Edvance, review ATI lessons & skills videos
- Attend class, take notes
- Complete rationale for each step of the 5 checklists - **Due Wed @ 0830**
- Practice skills in the sim lab
- Obtain 2 peer review signatures for each skill
- Bring completed checklists to school on Friday for Skills Check-Off

Skills Check-off (Friday 8/27): Each student will demonstrate the following skills on a manikin while working with a partner

- 1. Positioning and Removing a Bedpan**
- 2. Providing Perineal Care - Male**
- 3. Providing Perineal Care - Female**
- 4. Bathing an Adult Client**
- 5. Replacing Linens on an Occupied Bed**

Bedpan

- Non-ambulatory or bedrest patients
- Offered prior to meals, bath and prn
- Protect the bed/sheets with absorbent pad
- Ask client to raise hips or assist to roll onto side
- Check positioning, then raise HOB
- Provide toile paper/wipes and call bell
- Check on client every 2-5 minutes
- Assist to clean (front to back)
- Assess contents, measure output if ordered
- If contents are unusual, save and report to RN
- Rinse and dry bedpan after use, store in bathroom
- Types of bedpans: regular, bariatric, fracture

Perineal Care

- ▶ After elimination, during bath, & PRN
- ▶ Expect patient may be uncomfortable or embarrassed
- ▶ Be professional and straightforward
- ▶ Ask for assistance/chaperone as needed
- ▶ Wipe front to back! (clean to dirty)
- ▶ Use new perineal wipe, or clean section of wipe, for each pass
- ▶ Dry thoroughly
- ▶ Males: clean urinary meatus in circular motion. If present, retract foreskin first to clean, then replace when dry. Clean shaft of penis, scrotum, & between buttocks.
- ▶ Females: separate labia, wash both sides then middle of perineum, then between buttocks.

Bathing

- ▶ Use 8-pack Sage bath wipes for most patients
- ▶ Encourage independence, assist as needed
- ▶ Completion of daily bath is staff responsibility
- ▶ #1 purpose: reduce bacteria/contaminants on skin
- ▶ Other benefits: _____
- ▶ Always bathe “clean to dirty”
- ▶ Use washcloth for face and towels to dry
- ▶ Use bath blanket, keep covered
- ▶ Offer lotion / moisturize skin after bathing
- ▶ No powders unless ordered (antifungals)
- ▶ Bath caps available for hair – no rinse
- ▶ Soap/shampoo available if needed
- ▶ Bar soap/basins are single use only
- ▶ Do not cut nails!! May clean under nails
- ▶ Shaving- electric razor only
- ▶ Partial Bed Bath: dirty/odorous areas
- ▶ Surgical bath/ICU: _____

Changing Bed Linens

- ▶ Change after bath, daily, and as needed when wet/soiled
- ▶ Only bring needed linen into room, do not store extra
- ▶ Do not use linen from another patient's room
- ▶ When transporting linen, _____
- ▶ May reuse blanket if clean – DO NOT SHAKE LINEN
- ▶ Do not reuse linen that has touched floor
- ▶ Wear gloves when making beds
- ▶ Roll dirty linens inward, place in cart before leaving room
- ▶ Avoid carrying dirty linen (and wearing gloves) in hallway!
- ▶ Raise bed to comfortable height to make bed
- ▶ Maximum _____ layers of linen between mattress and client

Unoccupied Bed = easy!

Occupied Bed

- ▶ Client on bedrest, critically ill, unable to get OOB
- ▶ Monitor tolerance while moving in bed
- ▶ Lower HOB flat, assist client to turn, ensure siderail is raised
- ▶ Roll & tuck dirty linens toward client's back
- ▶ Place & tuck clean linens under dirty ones
- ▶ Keep client in good body alignment while moving
- ▶ Consider IV lines, tubes, drains, cables, etc.
- ▶ Use draw sheet to slide patient up in bed when finished (with help)

Urinary Catheters

- Indwelling or Foley catheters inserted to drain bladder
- Bladder is sterile environment, catheter is closed/sterile system
- Catheter tubing & collection bag are also sterile
- Introduction of microbes can cause _____
- Catheter insertion must be _____
- Everyone is responsible for preventing infection in clients with a urinary catheter!

CAUTIs = Catheter-Associated Urinary Tract Infections

CAUTI Prevention:

Limit use of catheters!

Assess daily for removal

Maintain sterility during insertion

Urinary catheter care: how often? _____

Keep catheter bag lower than bladder

Keep bag/tubing from touching floor

Wash hands, wear gloves while handling catheter

Urinary Catheter Care

- ▶ SureStep system = 5 wipes
- ▶ When? _____
- ▶ Essential for client safety, infection prevention
- ▶ Instructions for male/female on package
- ▶ Refer to skill video, practice in lab

Emptying Catheter & Measuring Urine

- ▶ Empty catheter bag every shift & PRN
- ▶ Apply gloves, drain tubing contents into collection bag
- ▶ Use graduate for accurate urine measurement
- ▶ Use paper towel to keep graduate from touching floor
- ▶ Clean drainage tip with alcohol wipe before & after emptying
- ▶ Ensure tip of drainage tube does not touch inside of graduate
- ▶ Hold graduate at eye level to correctly visualize total volume
- ▶ Calculate total urine output at end of shift, or as ordered
- ▶ Rinse & dry graduate, store in bathroom (single patient use)
- ▶ Report abnormal urine (color/clarity/odor/volume)
- ▶ What is normal urine? _____
- ▶ Normal volume = _____

Urinals

Clients on bedrest, unable to ambulate, convenience at night

Provide instructions

Assist if needed:

Instruct client to spread legs apart

Place urinal between client's legs with handle up
Male: place penis inside urinal
Hold urinal while client urinates
Measure, empty, rinse, & store at bedside within reach

Female External Catheters

PureWick system
Provide education & consent
Assist with perineal care before application
Separate legs, labia, & buttocks
Align soft gauze between gluteal cleft and pubic bone
Connect to tubing, wall suction @ _____
Place legs together to maintain placement
Check skin/placement q2h and with position changes
Change catheter when? _____
Monitor canister and record output
Never insert catheter into body!

Male External Catheters

Texas or condom catheters
Liberty or ReliaFit system
Provide education, obtain consent
All require adhesion to areas of penis
Assess for skin breakdown – do not use if present
Provide perineal care first / dry thoroughly
Apply protective barrier – “skin prep” pads
Connect to collection tubing & bag

Elimination for Ambulatory Patients

Hat: Place hat in toilet to collect urine or stool
Instruct client not to put toilet paper into hat
Pour urine into graduate and hold at eye level for accurate measurement, then rinse and replace hat in toilet
Bedside commode: difficulty ambulating, often preferred over bedpan
Can use hat or line commode for easy cleaning
Ensure commode is proper height & size
Measure contents, empty & clean for future use

Client Positioning

Turn or reposition every 2 hours

Prevent skin breakdown

↑ comfort, ↓ stress on musculoskeletal system

Follow Lifting guidelines = need at least _____ people to lift

Always use a draw sheet / lift sheet in bed

Turn and Position (TAP) System assists in positioning

Use foam wedges or pillows for support

Float elbows & heels

Place behind back/buttocks after turning client on side

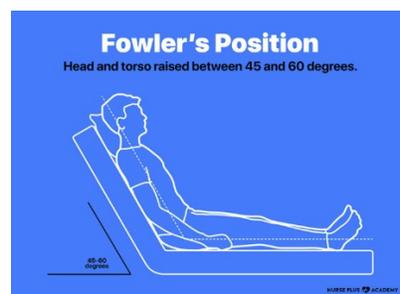
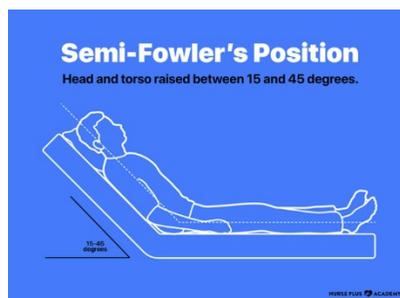
Friction: when 2 surfaces rub together (skin against sheet)

Shear: pressure on skin combined with surface friction (force exerted parallel to skin surface)

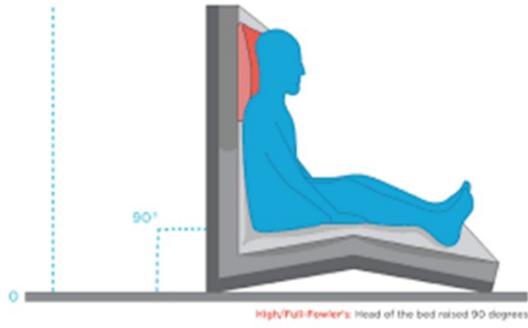
How to Avoid Friction: _____

How to Avoid Shear: _____

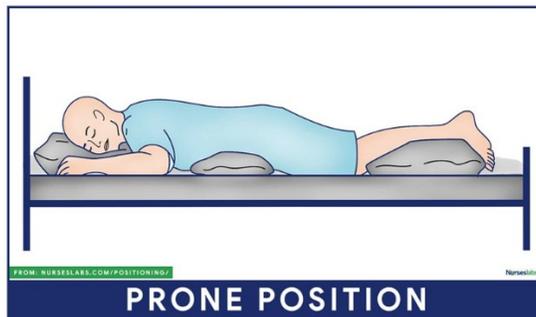
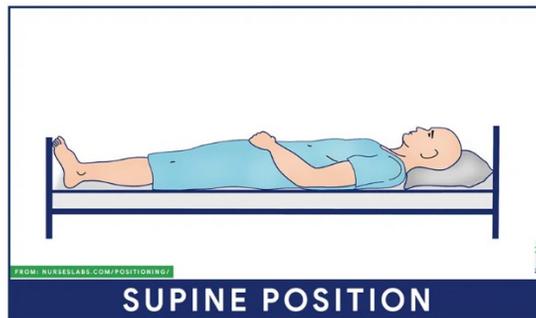
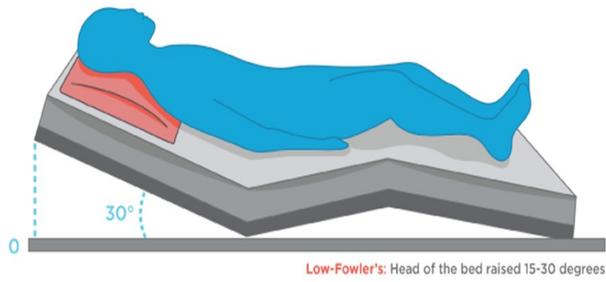
Bed Positions:

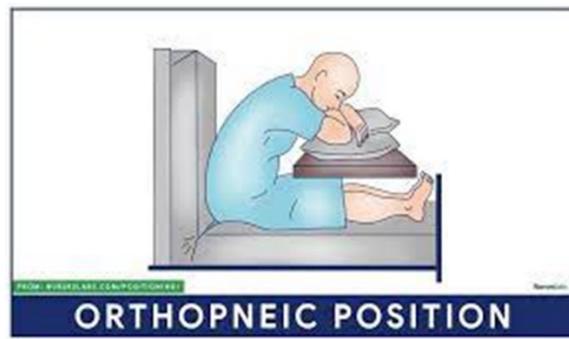
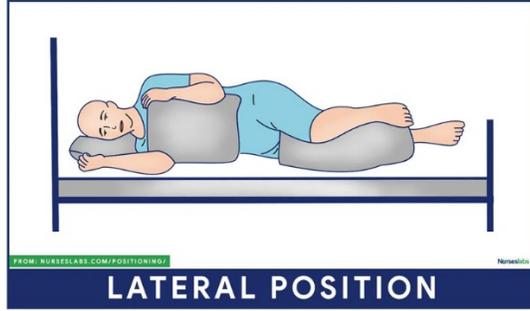


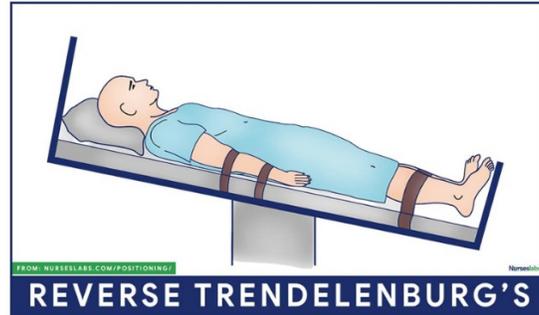
High Fowler's



Low Fowler's







Pressure Injuries

- Localized damage to skin and underlying tissues as a result of prolonged pressure, or a combination of pressure and shear
- Usually over bony prominences
- Can also occur due to medical devices
- Nurses responsible for preventing skin breakdown
- Thorough assessment & documentation is essential
- Braden scale: Assessment tool to identify risk for impaired skin integrity

Bony Prominences

“Pressure points”

Areas where bones are close to surface of skin

Increased pressure, risk for breakdown

Require extra monitoring & protection

Pressure Injury Prevention

Turn & reposition Q2h

Encourage OOB to chair/ambulate if able

Float heels/elbows on pillows

Apply Aquacel foam dressing to sacrum

Avoid moisture, clean & change sheets ASAP if incontinent

Keep sheets clean, avoid wrinkles, no more than 3 layers

Use skin protectant cream for incontinent clients

Maintain proper body alignment

Use lift sheet – avoid friction & shear

Waffle boots, chair cushions, special mattresses if needed

Report changes in skin color or new areas of open skin!

Risk Factors for Skin Breakdown

-
-
-
-
-
-
-

Hospital Beds

Beebe uses Hill-Rom beds

Newer: Centrella Smart+ beds

Older: VersaCare beds

Bariatric beds

Envella air fluidized therapy bed – ordered for skin breakdown

Hospital Bed Safety

Ensure working call bell is in reach

Ensure client can use call bell

Bed in lowest position

Bed locked when not in motion

Bed alarms on

Side rails up as needed

Avoid using all 4 rails – why? _____

Exception: all rails up for transport

Padded rails for seizure precautions

Side Rail Alternatives

Bed in lowest position

Floor mats

Bed alarms

Room close to RN station

Patient Safety Attendants (1:1 sitters)

Tele-sitters: video monitors

Hill-Rom Centrella Smart+ Beds (or VersaCare)

Responsible for Knowing:

- Bed Features
 - o Foot pedals
 - o Brakes
 - o Side rails
 - o Headboard & footboard
- Bed Positioning
 - o Move entire bed, HOB, & knees up/down
 - o Adjustable bed length
 - o Surface features – max inflate, turn assist
 - o Lock/unlock controls
- Bed alarms
 - o Bed exit alarm (3 modes)
 - o Bed exit alarm silence
 - o Brake alarm
- Other Features
 - o Zero the scale (new patient)
 - o Weigh patient