Covenant School of Nursing

Professional Nursing Skills Critical Elements and Nursing Intervention Instructions

Covenant School of Nursing

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Covenant School of Nursing

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Professional Nursing Skills

Critical Elements and Nursing Intervention Instructions

The following is a collection of critical elements, competencies, and nursing intervention instructions compiled by the faculty of Covenant School of Nursing (CSON). The content is generally modeled after the work of Dr. Carrie Lenburg and is designed to be used in education that is based on the COPA Model.

Universal Competencies

Universal Competencies are to be applied throughout procedures with manikins and patients

Safety & Security

A. **Physical Safety and Security**: Any action or inaction on the part of the student that threatens the patient's well-being or violates the patient's physical security
B. **Emotional Security**: Any action or inaction on the part of the student that threatens the emotional well-being or emotional security of the patient

Critical Elements

1. Verify nursing interventions against healthcare provider orders, standing protocols, and evidence-based nursing practice
2. Identify the patient with 2 identifiers and verify allergies (check armband for name, date of birth, and allergy indicator)
3. Protect the patient from physical harm at all times. Examples include:
    1) Fall bundle
        a) Side rails are raised as indicated
        b) Bed is in low position prior to leaving the room
        c) Non-skid socks on
        d) No clutter on the floor
    2) Mobility level is assessed before patient position is altered
    3) If restraints are present, they are secure and safely applied
    4) Medication administration (patient, drug, dose, time, route, reason, documentation)
    5) Pre-procedure time out
4. Protect the patient and others from psychological harm. Examples include:
    a) Acknowledge, Introduce, Duration, Explanation, and Thank you (AIDET) – Pronounce patient name correctly
    b) Hourly rounding with 4 Ps ("Pain, Potty, Position, and Possessions," and tubes, drains, and dressings)
    c) Communicate verbally and non-verbally in a manner that promotes trust and respect
    d) Insure privacy during physical care and discussion of sensitive information
    e) Provide accurate information to the patient and/or authorized recipients
    f) Keep all patient-related information confidential
5. Protect the patient and others from both psychological and emotional harm by providing clear, accurate, and relevant teaching

Based on the work C. Lenburg in the COPA model

Standard Precautions

Prevent the introduction or transfer of microbial organisms

Critical Elements

1) Wash or cleanse hands before initiating direct contact with the patient and whenever hands are contaminated by body secretions or substances. **During the examination, cleanse hands in the presence of the CE before beginning care**
2) Wear gloves whenever contact with human secretions is possible and when preparing/administering medications
3) Protect self, patient, and others from microbial contamination, e.g. clean stethoscope, pulse oximeter, and other equipment before and after use, scrub the hub before intravenous medication administration
4) Employ principles of **asepsis** (medical/surgical) for procedures and medication preparation and administration
5) Confine and/or dispose of contaminated materials according to agency protocol
6) Implement special precautions as required by agency protocols

Based on the work C. Lenburg in the COPA model

Communication

Verbal and non-verbal interactions between the caregiver, the patient and/or significant other that are focused on patient-related or professional concerns

Critical Elements

1) Establish verbal communication with the patient at the beginning of the interaction by:
   a) Introducing self
   b) Explaining actions to be taken, purpose of the interaction, and relevant outcomes
2) Interact with the patient by using one of the following methods:
   a) Ask questions to determine response to nursing actions or/and patient's level of comfort
   b) Direct focus of communication toward patient-oriented interests
   c) Communicate verbal and non-verbal messages consistent with the patient's needs or status (e.g. infant, non-verbal person, non-English speaking person, etc.)
3) Modify language and communication style to be consistent with patient's needs and individual and cultural values
4) Teach patient regarding medication safety, procedures, labs
5) Utilize resources to enable communication consistent with agency protocols

Based on the work C. Lenburg in the COPA model

Critical Thinking

Deliberate and rational thinking that focuses on clinical decision-making

Critical Elements

1) Make decisions based on:
   a) Legal, ethical, professional, and institutional standards
   b) Evidence-based practice
   c) Logical analysis of pertinent objective and subjective assessment data
   d) Evaluation of healthcare provider orders, treatment plans, nursing care plan
   e) Revise the plan of care when outcomes are not met
2) Prioritize nursing interventions within the context of evidenced-based practice and agency protocols
3) Include members of the healthcare team in decision-making to facilitate patient outcomes through the use of SBAR communication

Based on the work C. Lenburg in the COPA model

Documentation

The recording of data required by, or pertinent to, the designated situation

Critical Elements

1) Document according to legal, ethical, professional, and institutional standards. Examples include:
    a) Standardized forms
    b) Electronic Medical Record
    c) Use language, terms, and abbreviations that are consistent with professional standards and agency protocols
2) Record data so that entries are:
    a) Accurate
    b) Clear
    c) Relevant

Based on the work C. Lenburg in the COPA model

Human Caring and Relationship

The use of professional behaviors, attitudes, and interactions with patients and others that incorporate discernible valuing, respect, and advocacy for their circumstances, preferences, and overall well-being

Critical Elements

1) Relate to patients and significant others in a manner that illustrates caring for their well-being
2) Engage in activities that demonstrate caring for the patient such as listening to patient needs and spending time with the patient. Include the patient in their plan of care
3) Within the confines of the law and agency protocols, implement behaviors that show respect for the patient's uniqueness using interventions that are specific to:
    a) Age
    b) Gender
    c) Ethnicity
    d) Religious beliefs
    e) Cultural differences
    f) Personal preferences
4) Use non-discriminatory principles to guide nursing care of individuals (physiological, spiritual, and cultural needs)

Based on the work C. Lenburg in the COPA model

Professional Role Performance

Demonstration of behaviors that are consistent with Covenant School of Nursing and agency protocols, based on guidelines established by governing bodies and professional nursing organizations

Critical Elements

1) Implement the student role with responsibility and accountability. Examples include:
    a) Comply with policies in Covenant School of Nursing Student Policy Handbook
    b) Prepare for clinical and lab sessions by completing assignments as designated
    c) Use constructive criticism and suggestions for continued self-development
    d) Implement professional roles with responsibility and accountability by using legal, ethical, and professional standards
2) Manage equipment, supplies, and human resources efficiently and economically
3) Interact professionally with peers, faculty, and members of the health care team
4) Maintain a clean working environment

Competencies for Specific Professional Nursing Skills

The following competencies and intervention instructions have been compiled as a concise and current reference for performance of professional nursing skills at Covenant School of Nursing.

Anti-Embolism Stockings **Nursing Intervention Instruction**		
Steps	**Key Points**	**Rationale**
1) Verify orders or protocol	Verify orders and length of use	The procedure is non-invasive and must have an order
2) Gather supplies	Single user AE stockings - fit to patient, thigh high or knee high	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Apply stockings	Measure Knee high: Largest circumference on calf and length from back of knee to heel Thigh high: Thigh circumference, calf circumference, and distance from heel to gluteal furrow Reach inside hose and grab heel, pull inside out Place over toes and pull over heel, then pull remainder of stocking up the leg Smooth out wrinkles in the stockings once applied Remove each shift to assess Check toes regularly to relieve pressure from stockings	 Sizes are S, M, L, and XL Correct fit provides firm, smooth support that prevents venous stasis Extremities should be clean prior to application Avoid skin breakdown and injury Assess color, warmth, and sensation of legs and feet Stockings creep up the leg and can compress the toes
5) Complete procedure	Perform hand hygiene Record results and report if indicated	
Created by IM2 Faculty, Covenant School of Nursing, Nov 2015 *Reviewed: Mar 2021* *Revised: IM2 Faculty, Mar 2016, July 2016, Feb 2018* *CHS Policy: PC48, Anti-embolism stockings, 2015* *Potter and Perry 9th ed., 2017*		

Cardiovascular Comprehensive Assessment: Adult

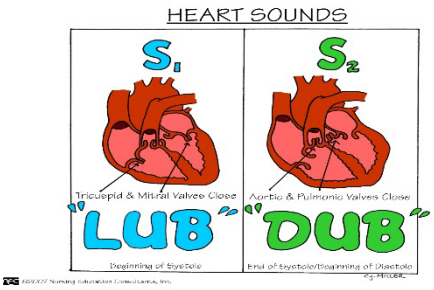
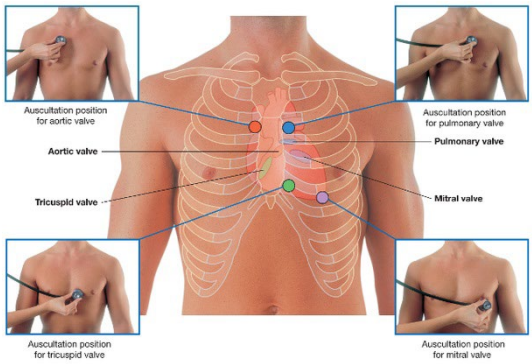
Focused assessment of the status of the heart and vascular system

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Auscultate heart sounds at 4 correct landmarks
5) Count apical heart rate
6) Palpate carotid, radial, and pedal pulses bilaterally at correct landmarks
7) Palpate nail beds on BLU and BLL extremities for capillary refill

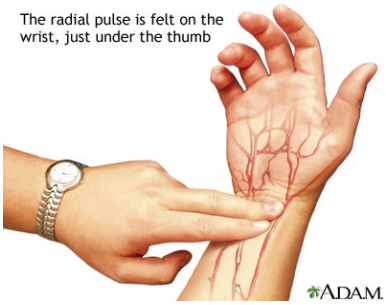
Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Inspect and auscultate	Inspect Chest Place a clean stethoscope diaphragm and bell (if available) on the chest Listen in 4 locations for at least 2 complete cycles at each location to assess the heart valves Place the stethoscope over the apex of the heart and count each set of "lub-dub" as one heartbeat. Count for one (1) full minute  http://www.slideshare.net/TeleClinEdcardiac-assessmentbmh-tele	Look for scars, bruising, or abnormalities, such as pacemaker implants, wires, etc. Patient Safety, Infection Control 2nd intercostal on **Rt** (aortic valve) 2nd intercostal on **Lt** (pulmonic valve) 5th intercostal on **Lt** (tricuspid valve) 5th intercostal mid clavicle on the **Lt** (mitral valve), also known as the apex, the apical site, and PMI (point of maximum impulse)  https://web.duke.edu/anatomy/Lab03/Lab4_preLab.html If an irregular rate or rhythm is assessed during vital signs, an apical rate is always indicated. Extra pulsations and slow or rapid rates are not normal. An apical rate is more accurate than a radial rate

Cardiovascular Comprehensive Assessment: Adult

Focused assessment of the status of the heart and vascular system

3) Palpate peripheral pulses (carotid, radial, pedal)	Place index and middle fingers on the neck Feel pulse in 2 locations for at least 2 complete cycles at each location  https://mclaren.org/flint/health-information/1525.aspx?iid=2_9800	Right and left carotid pulses should **NOT** be assessed at the same time. This is to ensure adequate blood flow to the brain. Check one side first, then the other for rhythm and quality (0 to +4)
	Place index and middle fingers on the wrist Feel radial pulses in 2 locations for at least 2 complete cycles at each location	Radial pulses should be assessed at the same time bilaterally for rhythm, quality (0 to +4), and symmetry
	Assess nail beds for capillary refill bilaterally  https://medlineplus.gov/ency/imagepages/19395.htm	Capillary refill should occur over 2-3 seconds
	Place index and middle fingers on the foot Feel pedal pulses in 2 locations for at least 2 complete cycles at each location  https://www.memorangapp.com/flashcards/66892/BLUE+BOXES+BLOCK+2/	Pedal pulses should be assessed at the same time bilaterally for rhythm, quality (0 to +4), and symmetry
	Assess toe nail beds for capillary refill bilaterally	Capillary refill should occur over 2-3 seconds
4) Inspect and palpate for edema	Inspect extremities for swelling	Dependent edema versus pitting edema Assess location, severity (0 to +4) if pitting, presence of weeping, discoloration

Cardiovascular Comprehensive Assessment: Adult Focused assessment of the status of the heart and vascular system		
5) Inspect and palpate skin	Inspect skin color	Pink, pale, cyanotic (lips, fingers, toes) Note areas of focused discoloration like lower extremities (possible indication of venous or arterial insufficiency)
6) Interview	Interview patient about activity tolerance	Ability to walk, take stairs, experience any shortness of breath, lightheadedness, dizziness Use of any supportive devices due to fatigue
7) Complete Procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed: April 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing Apical Pulse, 2019
HESI Clinical Skills Module, Assessing Apical-Radial Pulse, 2019
HESI Clinical Skills Module, Assessing the Heart and Neck Vessels, 2019
HESI Clinical Skills Module, Assessing the Peripheral Vascular System, 2019

Neurologic Comprehensive Assessment: Adult

Focused assessment of the status of the neurologic status in the adult

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Assess level of consciousness
5) Assess cranial nerves
6) Assess motor function
7) Assess sensation

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Assess level of consciousness (LOC)	Eye opening • Alert – Follows commands in a timely fashion • Lethargic – Appears drowsy, easily drifts off to sleep • Obtunded – Requires gentle shaking or repetitive verbal stimulus, responds with one-word answers • Stuporous – Requires vigorous or noxious stimulation before responding • Comatose – Does not respond to verbal or painful stimuli Verbal Response (Normal, slurred, incomprehensible, aphasic, with or without prompting) Orientation • What is your name and date of birth? • Where are you right now? • Why are you here? • What year is it? • Who is the president? • What does 2+2 equal?	To assess for presence of brain injury
3) Assess cranial nerves	Pupil Response Assessment: PERRL (CN 2,3) Cardinal gaze (CN 3,4,6) Raise eyebrows or wrinkle forehead (CN 7) Smile and show teeth (CN 7) Say "ah" (CN 10) Cough (CN 10) Protrude tongue, touch the roof of mouth, move side to side (CN 12) Hands on shoulders and ask to shrug (CN 11)	To assess for presence of brain injury
4) Assess motor function	Hand grasp, toe wiggle (HGTW), flexion and extension with resistance – **bilaterally** Romberg test for balance and gait disturbances (ataxia)	To assess for presence of brain/spinal injury

Neurologic Comprehensive Assessment: Adult Focused assessment of the status of the neurologic status in the adult		
5) Assess Sensation	Touch and pressure (on face and in all four extremities	To assess for presence of brain/spinal injury
6) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed 2021
Revised Mar, 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing the Neurologic System: Motor and Sensory Function, 2019
HESI Clinical Skills Module, Assessing the Neurologic System: Mental Status and Cranial Nerves, 2019

Respiratory Comprehensive Assessment: Adult

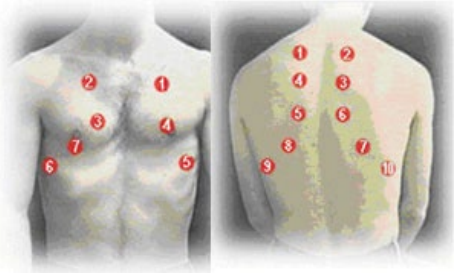
Focused assessment of the status of the lungs

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Obtain respiratory rate and oxygen saturation (O_2 or SaO_2)
5) Observe depth, rhythm, and symmetry of chest movement, and nailbeds for clubbing
6) Auscultate anterior and posterior lung fields, moving systematically from side to side and top to bottom
7) Identify presence or absence of adventitious respiratory sounds
8) Assess for the presence of respiratory distress

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Obtain respiratory rate and O_2 Sat	Perform during assessment based on priority need	Helps detect deterioration of physiological function
3) Inspect upper airway	Assess for pursed-lipped breathing; circumoral pallor; cyanosis of lips, oral mucosa Assess position of trachea Assess for cough	Cyanosis indicates hypoxia Deviated trachea can indicate a mediastinal shift
4) Inspect chest and nails	Visually inspect size, shape, symmetry, scars, wounds, dressings, and drains Observe for intercostal retractions Visually inspect nails for color and signs of clubbing	Visualize before auscultation or palpation Clubbing indicates chronic hypoxia
5) Auscultate chest 	Place a clean stethoscope diaphragm on the chest Listen for 1 full breath in each location, 7 anterior locations and 10 posterior locations Listen anteriorly, laterally, and posteriorly Move in a side to side, top to bottom pattern, comparing left and right sides to one another	Clean stethoscope to minimize risk of infective agent transfer from person to person Adventitious sounds such as wheezing, crackles, stridor, rubs are not normal Absent or distant sounds are also abnormal
6) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing Respiration: Rate, Rhythm, and Effort, 2019
HESI Clinical Skills Module, Assessing the Thorax and Lungs, 2019

Gastrointestinal Comprehensive Assessment: Adult

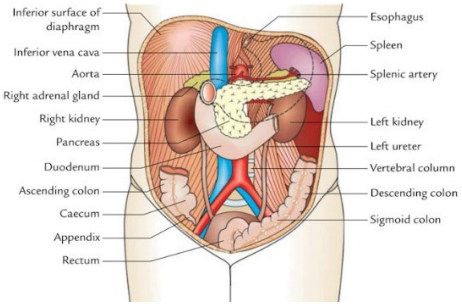
Focused assessment of the abdomen and its structures

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Inspect the abdomen for size, shape, discoloration, surgical scars, wounds, and lesions
5) Auscultate for the presence or absence of bowel and vascular sounds in epigastric region and all four quadrants of the abdomen
6) Perform light palpation over the epigastric region and all four quadrants of the abdomen to assess for presence of tenderness, guarding, distention, or masses
7) Interview patient about bowel habits

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Inspect abdomen	Visually inspect size, shape, symmetry, scars, wounds, dressings, and drains	Visualization is the least invasive assessment and helps identify areas that might require caution with auscultation and palpation
3) Auscultate abdomen  	Place a clean stethoscope diaphragm over the right lower quadrant (RLQ) above the cecum region Listen for 5-20 seconds in 4 quadrants and below the xyphoid process Absent sounds are defined by no sound in 3-5 minutes Move clockwise around the abdomen	Clean stethoscope to minimize risk of infective agent transfer from person to person If sounds are heard immediately, continue around the abdomen Swishing sounds with pulsation (bruits) are not normal in the abdomen
4) Palpate abdomen	Begin in RLQ and move clockwise around abdomen Palpate for tenderness, pain, masses, distention, and guarding	Use gentle pressing motion with ends of fingers Never palpate a pulsating abdominal mass
5) Interview patient about bowel habits	Ask about: Normal pattern Appearance Changes History How often Elimination aides	History of bowel habits or changes to regular bowel routine can indicate poor gastrointestinal function

Gastrointestinal Comprehensive Assessment: Adult

Focused assessment of the abdomen and its structures

6) Complete procedure	Perform hand hygiene	

Gastrointestinal Comprehensive Assessment: Adult Focused assessment of the abdomen and its structures		
	Record results and report if indicated	
		Created by IM1 Faculty, Covenant School of Nursing, Jan 2019 *Reviewed 2021* *Fundamentals of Nursing (9th ed.), Potter & Perry, 2017* *HESI Skills Module, Head to Toe Examination of the Adult, 2019* *HESI Clinical Skills Module, Assessing the Abdomen, 2019*

Genitourinary Comprehensive Assessment: Adult

Focused assessment of the structures of the urinary system

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Perform light palpation above the pubis synthesis for presence of bladder distention
5) Inspect perineal area
6) Interview patient regarding urinary habits

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Palpate for bladder distention	Use light palpation to assess the area directly above the pubis symphysis Palpate for tenderness, pain, masses, distention, and guarding	Palpation of bladder indicates a distended bladder An empty bladder will not be felt during examination
3) Inspect perineal areas	Inspect urethral meatus and perineal area	Look for redness, swelling, abnormalities, presence of urinary catheter, presence of urine or stool
4) Interview patient about urinary habits	Ask about: Normal pattern How often Nocturia Hematuria Leakage Hesitancy Appearance/Odor Changes Fluid intake	History of urinary habits or changes to regular urinary routine can indicate poor genitourinary function Painless hematuria can indicate bladder cancer
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed: April 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing the Female Genitalia and Rectum, 2019
HESI Clinical Skills Module, Assessing the Male Genitourinary, Rectum, and Prostate, 2019

Musculoskeletal Comprehensive Assessment: Adult

Focused assessment of the musculoskeletal system in the adult

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Assess posture and spinal alignment
5) Assess joints and muscles
6) Test strength through hand grasp and toe wiggle
7) Assess range of motion (active or passive)
8) Assess gait

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Assess posture and spinal alignment	Inspect back and position for scoliosis, kyphosis, or Lordosis	Abnormal spinal alignment and/or posture can affect comfort, pain, gait
3) Assess joints and muscles	Inspect joints for color, contour, temperature, or pain Inspect muscles in bilateral upper extremities (BUE) and bilateral lower extremities (BLE) for mass symmetry and firmness or bogginess	Joint pain or discomfort can indicate conditions like arthritis Decreased muscle mass or boggy muscles can reflect poor nutrition or degenerative muscle disease process
4) Hand grasp and toe wiggle (HGTW)	Provide index and middle finger for hand grasps bilaterally Assess toe wiggle bilaterally	Tests strength in extremities
5) Active or passive range of motion	Neck motion up and down, make a head circle Arms out straight, up in "touchdown", wrist circles Legs straight, bent at knees, ankle circles	Active indicates ability to move all extremities without assistance Passive indicates help is required to move one or more areas
6) Assess gait	Assess gait by asking patient to take a couple of steps (if able) Note whether gait is normal, antalgic, propulsive, scissor, spastic, steppage, or waddling	Abnormal gait or balance can indicate pain or other health concern
7) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed: April 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing the Musculoskeletal System, 2019

Integument Comprehensive Assessment: Adult

Focused assessment of the skin

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Assess all skin

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Assess skin	Assess skin turgor with light skin pinch by clavicle Assess skin all over body for color, temperature, texture, rashes/bruising/lesions, edema, moles, scars, tattoos Examine bony prominences for redness or skin breakdown Examine nails for shape, contour, and cleanliness	Skin tenting is an indication of dehydration Bony prominences are the most likely areas to experience skin breakdown and pressure injuries
3) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed: April 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing the Skin, Hair, and Nails, 2019

Basic Head to Toe Assessment: Adult

General Assessment of the adult

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Assess orientation
5) Assess head, neck, and shoulders
6) Auscultate heart sounds, anterior lung sounds, abdominal sounds
7) Posterior lung sounds and skin assessment
8) Assessment of bilateral upper extremities
9) Assessment of bilateral lower extremities
10) Assessment of perineal area

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Assess alertness and orientation	Ask name, date of birth, current date, current location	To assess level of consciousness, and orientation to person, place, and time
3) Assess head, neck, and shoulders	Inspect hair and scalp for dryness, hygiene, color, presence of parasites Use penlight to assess: • eyes for PERRL and cardinal gaze • ears for color, drainage, symmetry • nose for drainage, color and moisture of mucous membranes • mouth and throat for color and moisture of mucous membrane, presence and condition of teeth Inspect facial nerves with smile, tongue movement out and side to side, eyebrow raise Inspect and palpate neck for swelling/edema, pain, tenderness Carotid pulse palpation (ONE at a time) bilaterally Assess neck range of motion with movement side to side, chin to chest, neck extension Assess strength or weakness with shoulder shrug against resistance Assess skin turgor at clavicle	Lack of symmetry indicates neurologic deficit
4) Auscultate heart sounds, anterior lung sounds, abdominal sounds	Place a clean stethoscope diaphragm on chest Listen in 4 locations to assess the heart valves (aortic, pulmonic, tricuspid, mitral or PMI) for at least 2 complete cycles at each location Place stethoscope diaphragm on chest	Clean stethoscope to minimize risk of infective agent transfer from person to person Swishing, rubs, clicks, and/or irregular heart sounds are not normal in the chest

Basic Head to Toe Assessment: Adult

General Assessment of the adult

	Listen for 1 full breath in 7 locations Listen anteriorly and laterally Move in a side to side, top to bottom pattern, comparing left and right sides to one another Inspect abdomen for rashes, lesions, distention Place stethoscope diaphragm over the right lower quadrant (RLQ) above the cecum region Listen for 5-20 seconds in 4 quadrants Absent sounds are defined by no sound in 3-5 minutes Move clockwise around the abdomen Palpate abdomen for pain, tenderness Ask patient about bowel and urinary output habits	Adventitious sounds such as wheezing, crackles, stridor, and/or rubs are not normal Absent or distant sounds are abnormal If sounds are heard immediately, continue around abdomen Swishing sounds (bruits) with visual pulsations are not normal in the abdomen and may indicate abdominal aortic aneurysm
5) Assess posterior lung sounds and skin	Place stethoscope diaphragm on back Listen for 1 full breath in 10 locations Listen posteriorly and laterally Move in side to side, top to bottom pattern, comparing left and right sides to one another Inspect skin on back, buttocks, and posterior bony prominences for redness, breakdown	Adventitious sounds such as wheezing, crackles, stridor, and/or rubs are not normal Absent or distant sounds are also abnormal Bony prominences are the most likely areas to experience skin breakdown and pressure injuries
6) Assessment of bilateral upper extremities	Inspect skin of bilateral upper extremities (BUE) for edema, color, temperature, symmetry Perform range of motion (ROM) – out to side, circles, “touchdown” Wrist ROM – circles, flexion and extension Bilateral hand grasps, resistance pulling and pushing hands Palpate radial pulses at the same time bilaterally Assess fingers/nail bed for capillary refill, nail shape bilaterally	Bilateral assessment to check equality
7) Assessment of bilateral lower extremities	Inspect skin of bilateral lower extremities (BLE) for edema, color, temperature, symmetry with attention to heels Perform ROM – lift, knee bend, hip flexion Ankle ROM – circles, flexion and extension Bilateral toe wiggle, resistance pulling and pushing feet Palpate pedal pulses at the same time bilaterally Assess toes/nail beds for capillary refill, nail shape bilaterally	Bilateral assessment to check equality
8) Assessment of perineal area	Inspect urethral meatus and perineal area	Look for redness, swelling, abnormalities, presence of urinary catheter, presence of urine or stool

Basic Head to Toe Assessment: Adult General Assessment of the adult		
9) Complete procedure	Perform hand hygiene Record results and report if indicated	
		Created by IM1 Faculty, Covenant School of Nursing, Jan 2019 *Revised: Jan 2022* *Reviewed: 2021* *Fundamentals of Nursing (9th ed.), Potter & Perry, 2017* *HESI Skills Module, Head to Toe Examination of the Adult, 2019*

Assessments

Abdominal Focused Assessment: Adult

Focused assessment of the abdomen and its structures

Critical Elements

1) This procedure is NOT delegated to unlicensed assistive personnel (UAP)
2) Follow Universal Competencies
3) Inspect the abdomen for size, shape, discolorations, surgical scars, wounds, and lesions
4) Auscultate for the presence or absence of bowel and vascular sounds in epigastric region and all four quadrants of the abdomen
5) Perform light palpation over the epigastric region and all four quadrants of the abdomen to assess for presence of tenderness, guarding, distention, or masses

Based on C. Lenburg COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Inspect abdomen	Visually inspect size, shape, symmetry, scars, wounds, dressings, and drains	Visualization is the least invasive assessment and helps identify areas that might require caution with auscultation and palpation
3) Auscultate abdomen	Place a clean stethoscope diaphragm over the right lower quadrant (RLQ) above the cecum region Listen for 5-20 seconds in 4 quadrants and below the xyphoid process Absent sounds are defined by no sound in 3-5 minutes Move clockwise around the abdomen	Clean stethoscope to minimize risk of infective agent transfer from person to person If sounds are heard immediately, continue around the abdomen Swishing sounds (bruits) with visual pulsations are not normal in the abdomen as they may indicate abdominal aortic aneurysm
4) Palpate abdomen	Begin in RLQ and move clockwise around abdomen Palpate for tenderness, pain, masses, distention, and guarding	Use gentle pressing motion with ends of fingers Never palpate a pulsating abdominal mass
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing Nov, 2015
Revised: IM2 Faculty, Mar 2016, July 2016, Feb 2018, Mar 2019
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Cardiac Focused Assessment: Adult

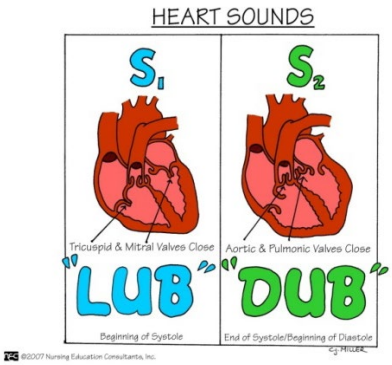
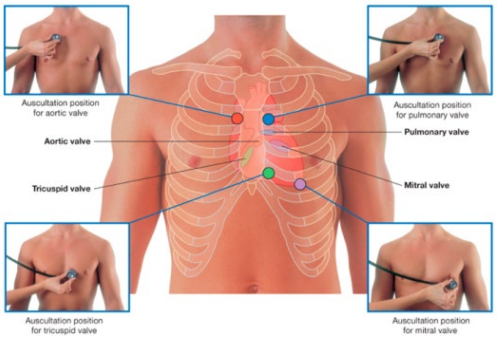
Focused assessment of the status of the heart

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing history that prompts focused assessment
4) Auscultate heart sounds at 4 correct landmarks
5) Count apical heart rate

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Inspect and auscultate	Inspect chest Place a clean stethoscope diaphragm and bell (if available) on the chest Listen in 4 locations for at least 2 complete cycles at each location to assess the heart valves  http://www.slideshare.net/TeleClinEdcardiac-assessment-bmh-tele	Look for scars, bruising, or abnormalities, such as pacemaker implants, wires, etc. Patient Safety, Infection Control 2nd intercostal on **Rt** (aortic valve) 2nd intercostal on **Lt** (pulmonic valve) 4th or 5th intercostal on **Lt** (tricuspid valve) 5th intercostal mid clavicle on the **Lt** (mitral valve), also known as the apex, the apical site, and the PMI (point of maximal impulse)  https://web.duke.edu/anatomy/Lab03/Lab4_preLab.html Swishing, rubs, clicks, and or irregular heart sounds are not normal in the chest
3) Auscultate apical pulse	Place the stethoscope over the apex of the heart and count each set of "lub-dub" as one heartbeat. Count for one (1) full minute	If an irregular rate or rhythm is assessed during vital signs, an apical rate is always indicated. Extra pulsations and slow or rapid rates are not normal. An apical rate is more accurate than a radial rate
4) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Apr 2017, Feb 2018
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Neurological Focused Assessment: Adult

A focused examination of the neurologic status in the adult

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Assess level of consciousness
4) Assess motor function
5) Assess sensation

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Assess level of consciousness (LOC)	Eye opening (PERRL) Verbal Response (Normal, slurred, incomprehensible, aphasic, with or without prompting) Orientation (Person, place, and time)	To assess for presence of brain injury
3) Assess motor function	Hand grasp, toe wiggle (HGTW), flexion and extension - bilaterally	To assess for presence of brain/spinal cord injury
4) Assess sensation	Pain, temperature, touch, pressure	To assess for presence of brain/spinal cord injury
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

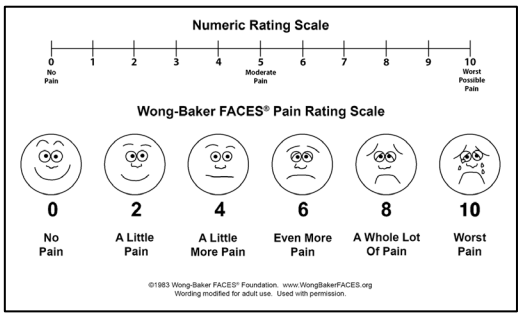
Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Feb 2018, Mar 2021
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Pain Focused Assessment: Adult - Focused assessment of the comfort level of patients

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform pain assessment

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Assess patient for pain	Have patient rate pain on Numeric Rating Scale (0-10) or Wong-Baker FACES Pain Rating Scale  Ask patient to describe the following: Intensity Characteristics Location Quality Patterns of radiation Onset Duration Alleviating, aggravating and contributing factors Current pain management regimen and effectiveness	Assess every 4 hours and PRN Open-ended questions lead patient to describe in more detail Consider using the pneumonic PQRST **P**rovoke – what causes, what improves, what makes worse **Q**uality – patient's own descriptive word; dull, sharp, crushing… **R**adiate – does the pain travel or stay in one place **S**everity – use the pain scale 0-10 **T**ime – of onset, duration, frequency http://www.crozerkeystone.org/healthcare-professionals/nursing/pqrst-pain-assessment-method/
3) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, July 2016, Apr 2017, Feb 2018, Mar 2019
Reviewed: Feb 2021
CHS Policy: Management of Pain, 2015
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

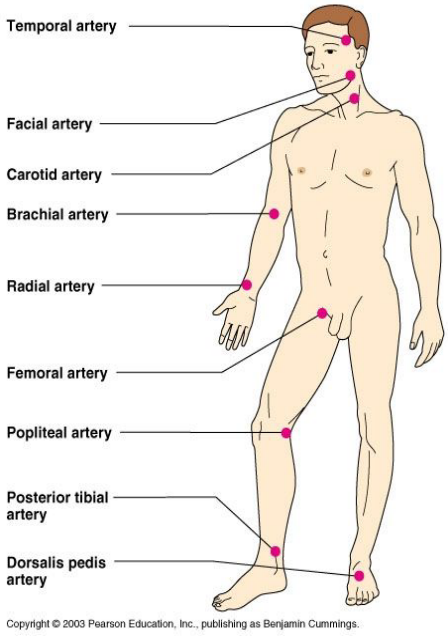
Peripheral Neurovascular Focused Assessment: Adult - An examination and comparison of the status of the circulation and innervation to the extremities bilaterally

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing history that prompts focused assessment
4) Assess six "Ps" (pain, pallor, pulselessness, paresthesia, paralysis, poikilothermia) bilaterally

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Assess the six "Ps"	Assess for **pain** in the extremity Assess for **pallor** (paleness) of the extremity and check capillary refill Assess peripheral **pulse** for strength and equality Assess for **paresthesia** (numbness or tingling) Assess for **paralysis** (loss of movement) Assess for **poikilothermia** (coolness) in the extremity	Patient safety Assessment abnormalities can indicate insufficient or absent arterial circulation and innervation to the extremity 
3) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Reviewed: IM2 Faculty, Feb 2021
CHS Policy: X-E-1, Application, Care and Removal of Casts, 2012
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

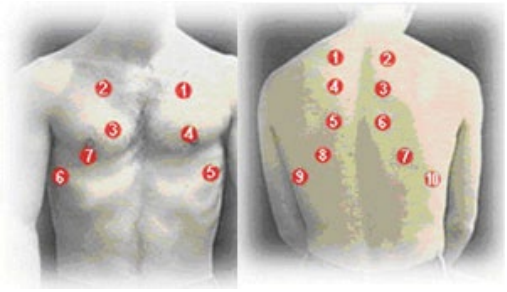
Respiratory Focused Assessment: Adult - An examination of the status of the lungs

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Assess oxygen saturation (O_2 Sat or SaO_2)
4) Obtain respiratory rate
5) Observe depth, rhythm, and symmetry of chest movement
6) Auscultate anterior and posterior lung fields, moving systematically from side to side and top to bottom
7) Identify presence or absence of adventitious respiratory sounds
8) Assess for the presence of respiratory distress

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Identify patient Teach patient	
2) Obtain respiratory rate and O_2 Sat	Perform during assessment based on priority need	Helps detect deterioration of physiological function
3) Inspect upper airway	Assess for purse-lipped breathing, circumoral pallor, cyanosis of lips, oral mucosa, or fingertips Assess position of trachea Assess for cough	Cyanosis indicates hypoxia Deviated trachea can indicate a mediastinal shift
4) Inspect chest	Visually inspect size, shape, symmetry, scars, wounds, dressings, IV sites, and drains Observe for intercostal retractions	Visualize before auscultation or palpation
5) Auscultate chest 	Place a clean stethoscope diaphragm on the chest Listen for 1 full breath in each location Listen anteriorly, laterally and posteriorly Move in a side to side, top to bottom pattern, comparing left and right sides to one another	Clean stethoscope to minimize risk of infective agent transfer from person to person Adventitious sounds such as wheezing, crackles, stridor, rubs are not normal Absent or distant sounds are also abnormal
6) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty Mar 2016, July 2016, Apr 2017, Feb 2018, Mar 2019
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Blood Draws

Blood Draw from a Subclavian, Jugular, or PICC Central Venous Access Device (CVAD)
The aspiration of blood into a collection device from an intravenous device located in a central vein to obtain a specimen for testing

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Aseptically collect a blood sample

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders or protocol	Requires an order or agency protocol	Patient Safety
2) Gather supplies and prepare workspace	**Follow CDC guideline for one syringe, one access, one time** Collection device depending on method Luer-Lok vacutainer sleeve (Safe-T Holder) OR 10 mL syringes Blood specimen tubes 3 prefilled sodium chloride 10 mL syringes Antiseptic cap Needleless connector if needed Alcohol swabs Patient labels for vacutainer tubes 2 biohazard bags for blood tube transport	**Never use anything smaller than a 10 mL syringe to flush (assess) patency of the line** Smaller barrel syringes can increase pressure in the lumen causing dislodgement of a thrombus (if present) and/or rupture the lumen
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Draw blood	*Stop any intravenous infusion for 2 minutes before blood is drawn* Perform hand hygiene and don clean gloves Remove antiseptic cap and allow access port to dry Clean needleless connector with alcohol pad for 15 seconds using friction and twisting motion, allow to dry before connecting sterile syringe Do not reuse alcohol pads Purge air from prefilled 10 mL sodium chloride flush syringe, attach to needleless connector and aspirate for blood return then flush with the 3 - 5 mL sodium chloride. Without disengaging flush syringe, aspirate 3 - 5 mL of blood and discard Aseptically attach new empty 10 mL syringe or Luer-Lok safety holder and obtain blood specimen	Prevents erroneous results Bactericidal effect is achieved with drying Follow CDC guidelines: **One needle, one stick, one time** **One access, one syringe, one time** **One alcohol pad, one time** Aspirating establishes presence in vessel **Failure to purge air from any syringe for intravenous use can result in an air embolus** To help prevent hemolysis: Use distal port; allow blood to wash down the side of the blood tube; aspirate sample slowly when using a syringe Scrub access port between every syringe attachment

Blood Draw from a Subclavian, Jugular, or PICC Central Venous Access Device (CVAD)

The aspiration of blood into a collection device from an intravenous device located in a central vein to obtain a specimen for testing

	Follow order of draw	Use blunt fill needle on syringes to transfer blood to specimen tubes
5) Complete the job	Flush catheter with 19 mL sodium chloride flush using a pulsing technique Remove flush syringe then clamp lumen Apply antiseptic cap Label blood specimen tubes in presence of patient Place specimen samples in biohazard bag for transport Dispose of used supplies Perform hand hygiene and document	Use 2 10 mL sodium chloride flush syringes - use full 10 from first syringe, scrub hub with alcohol pad, allow to dry, then use 9 mL from second syringe

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Sep 2016, Apr 2017, Feb 2018, Mar 2019, Apr 2020, ***Feb 2021***
CDC: "Central Line-associated bloodstream infections: Resources for Patients and Healthcare Providers", Mar 2016
pp. 1122-1124, Clinical Nursing Skills: Basic to Advanced, Smith, et. Al., 9th ed., 2017
CHS Policy: Use, Care, Maintenance, Removal of All Central Venous Catheters, 2016
CHS Policy: Blood Draws, 2015
CDC: One and Only Campaign, Safe injection practices: what they are and why follow them, 2016
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Blood Draw from a Peripheral Vein

The insertion of a needle into a peripheral vein and aspiration of blood into a collection device to obtain a specimen for testing

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Aseptically collect a blood sample

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders or protocol	Requires an order or agency protocol	Patient Safety
2) Gather supplies and prepare workspace	Needle with safety device Collection device depending on method Syringe Butterfly Vacu-holder™ Blood specimen tubes Alcohol pad/chlorhexidine Tourniquet Elastic self-adhering wrap Cotton balls Patient labels for blood tubes Biohazard bags  Vacu-holder™	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Draw blood	Don clean gloves Apply tourniquet Select the vein Clean skin with alcohol swab and allow to dry Anchor the vein Pierce the skin with bevel up, holding device at a 15-30-degree angle Obtain blood specimen adhering to order of draw Release the tourniquet	2-4 inches above chosen site Median or middle area of antecubital site is normally used Bactericidal effect is achieved with drying Prevents erroneous results
5) Complete the job	Place cotton ball over puncture site Apply gentle pressure to the surface of the skin, remove needle, obtain hemostasis, instruct patient not to bend elbow Leave cotton ball in place and wrap with an elastic self-adhering wrap Tilt tubes with additives so that blood washes down the side of tube Label blood specimen tubes in presence of patient	If using Vacu-holder™, remove vacutainer prior to removing needle from puncture site Bending elbow may cause bleeding or hematoma Helps mix specimen with additives in tubes to prevent hemolysis and clotting Patient Safety

Blood Draw from a Peripheral Vein

The insertion of a needle into a peripheral vein and aspiration of blood into a collection device to obtain a specimen for testing

	Place in biohazard bag for transport Dispose of used sharps and syringes in sharps container Dispose of other contaminated supplies Perform hand hygiene and record	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, July 2016, Feb 2018, Mar 2019, Apr 2020
Reviewed: Feb 2021
pp. 695-697, Clinical Nursing Skills: Basic to Advanced, Smith, et. Al., Pearson Publishing, 9th ed., 2017
CHS Policy: Blood Draws, 2015
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Blood Glucose Monitoring

Collection and analysis of a finger-stick blood sample to determine blood sugar level

Critical Elements

1) This procedure CAN be delegated to certified UAP
2) Gather supplies and prepare workspace and clean equipment as required
3) Follow Universal Competencies
4) Perform finger stick on lateral aspect of finger pad
5) Obtain blood glucose reading

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Check Sliding Scale orders	The procedure is invasive and must have an order
2) Gather supplies	Blood Glucose Monitor Approved Cleaning Agent Clean Gloves Lancets Test strips Alcohol pads	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Prepare Glucose Monitoring device	Prepare workspace and clean equipment as required Power On Scan staff ID Select “Patient Test” on device Scan patient ID band Scan bar code on test strip container Insert strip into device	Infection Control Verify user Patient Safety Quality Control
5) Perform finger-stick	Perform hand hygiene and don gloves Clean lateral side of finger pad with alcohol swab or soap and water Allow to air dry completely Apply pressure to knuckle below finger pad and hold securely Pierce with lancet Allow blood to collect at puncture site Wipe away the first drop of blood and obtain a healthy sample Fill test strip window Apply pressure and place Band-Aid® if needed	Ensure accurate reading, avoid finger pad nerve endings Alcohol can cause blood hemolysis rendering an inaccurate reading Helps ensure large enough sample Wiping away first drop of blood can be advantageous because it ensures the cleansing agent is dry, stimulates blood flow, and clears interstitial fluid from the sample Ensure hemostasis
6) Complete procedure	Obtain reading Dispose of lancet in sharps container Dispose of other used supplies Lancet in sharps container Perform hand hygiene Record results and report if indicated	

Blood Glucose Monitoring Collection and analysis of a finger-stick blood sample to determine blood sugar level		
	Clean equipment and return to docking station for download of data	
Revised: IM2 Faculty, Covenant School of Nursing, Nov 2015, Mar 2016, Feb 2018 *Reviewed: Feb 2021* *CHS Policy X-G-4: "Operation of Accu-check Glucose Test Station" – Revised June 2013* *Potter and Perry 9th ed., 2017* *https://www.mayoclinic.org/diseases-conditions/diabetes/expert-answers/blood-glucose-monitors/faq-20057902, Revised March 2019*		

Chest Tube Maintenance (Basic)

Safely maintaining a chest tube which has been placed to evacuate the chest or re-expand the lung

Critical Elements

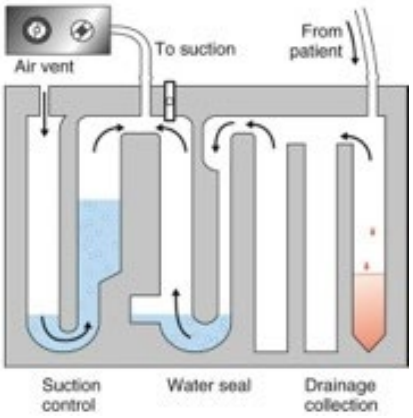
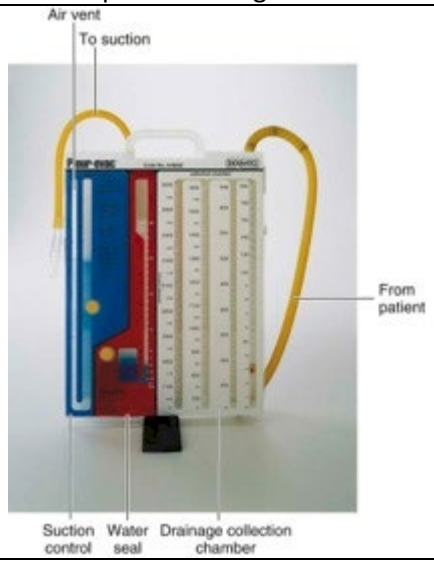
1) This procedure is limited in terms of what a UAP may perform
2) Gather supplies and prepare workspace and clean equipment as required
3) Follow Universal Competencies – including focused respiratory assessment
4) Assess chest tube
5) Assess collection device
6) Position tube to avoid kinks and facilitate drainage
7) Keep tube and reservoir positioned safely

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify protocol	Verify frequency required for monitoring device	
2) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
3) Assess patient	Position of comfort Respiratory assessment Intact dressing Correct placement with intact sutures, if visible	HOB is usually elevated to promote drainage and facilitate removal of air, blood, and other fluids from chest cavity To monitor effectiveness of treatment and status of lungs If sutures are dislodged, the tube can migrate
4) Assess chest tube	Amount, color, character of drainage, and presence of “tidaling” Connections intact, taped and labeled, no system air leak Tubing free of kinks and dependent loops	Characteristics and motion of drainage are indicators of lung status Secure connections insure seal Kinks can cause pneumothorax
5) Assess collection device and chambers	Below level of heart Upright position Clear of bed frame Suction vs gravity drainage Water seal is intact and free of bubbling Drainage in collection device	Ensures proper function of system Bubbling in water seal that fluctuates with respirations indicates an air leak in the chest. Continuous bubbling indicates there may be a leak in the drainage system

Chest Tube Maintenance (Basic)

Safely maintaining a chest tube which has been placed to evacuate the chest or re-expand the lung

		
6) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Feb 2018
Reviewed: Feb 2021
CHS Policy: Chest Tube Insertion, Care, Emptying/ Leveling, Transport and Removal 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Central Venous Access Device Dressing Change

The aseptic cleaning of a central venous catheter

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Clean site
5) Allow to completely dry
6) Apply antimicrobial disc
7) Apply occlusive dressing

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify protocol	Agency Policy is to change every 7 days or as needed based on assessment	The procedure requires aseptic technique
2) Gather supplies	Central Line Dressing kit	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Prepare for care	Clean work surface with antiseptic and allow to dry Open Cleaning pack and apply mask Mask application to patient Perform hand hygiene and don sterile gloves Inspect site for redness or drainage and palpate for tenderness	Infection Control Nurse dons mask first, performs hand hygiene, then ensures patient mask placement **Applying the mask after gloving will contaminate the gloves and the patient**
5) Remove old dressing	Loosen edges of dressing and remove **TOWARD** the insertion site (toward neck/axilla). Avoid touching insertion site during removal Grasp used dressing in glove and pull gloves over dressing Visually re-inspect site for drainage, odor, and condition of sutures	Removing toward the insertion site will help prevent dislodging the catheter
6) Perform dressing change	Open sterile pack and create sterile field Perform hand hygiene Don sterile gloves Activate chlorhexidine sponge Scrub the insertion site using friction for 30 seconds Allow to dry completely (May take as long as 3 minutes)	 Use alcohol pads if patient is allergic to chlorhexidine May use alcohol pads to pre-clean if excessively soiled Back and forth friction scrub works the solution into the skin. A 30 second scrub is evidence-based from the manufacturer Must dry completely for antisepsis
7) Apply dressing	Cover insertion site with antimicrobial product (disk, gel, etc.) and transparent	**Do not use if patient is allergic antimicrobial agent**

Central Venous Access Device Dressing Change

The aseptic cleaning of a central venous catheter

	dressing; press from site outward and seal edges Label dressing with initials, date, and time	Antimicrobial dressings are used to prevent microbial growth and must come in contact with the skin Transparent dressing acts as a barrier to microbes, allows skin to "breathe" and allows visualization of site
8) Assess need to change needleless ports and antiseptic caps	Refer to facility policy. Covenant policy: Change needleless ports every 7 days, for precipitate in connector, cracks, leaks, defects, contamination, or removal of needleless port	Safety and maintenance guidelines vary widely, refer to specific protocols
9) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated Teach patient to keep site dry and avoid touching site and tubing as much as possible Teach patient to report changes to healthcare workers, such as: loose dressing, wetness, soreness, redness, and onset of fever or chills	Moisture at site encourages bacterial growth. Touching tubing and site will contaminate with bacteria from hands. Early intervention with impaired integrity of dressing will help prevent bacterial invasion. Early intervention with signs of infection will help prevent sepsis

Created by IM2 Faculty, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Sep 2016, Apr 2017, July 2017, Feb 2018, Mar 2019, Apr 2020, Feb 2021
CDC: "Central Line-associated bloodstream infections: Resources for Patients and Healthcare Providers", Mar 2016
pp. 1119-1120, Clinical Nursing Skills: Basic to Advanced, Smith, et. Al., Pearson Publishing, 9th ed., 2017
CHS Policy VIII-E-5, Revised April 2015
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Central Venous Access Device Removal: Subclavian, Jugular, and PICC lines

The aseptic removal of a central venous catheter

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Position patient supine
5) Clean site
6) Remove line and apply petroleum-based gauze or ointment
7) Apply occlusive dressing and hold pressure

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify order and protocol	Intravenous catheters are usually discontinued before discharge. An order must be written to keep it. Some lines can only be removed by specialists	The procedure requires aseptic technique
2) Gather supplies	Central Line Dressing kit Suture Removal Set with 2x2 gauze Petroleum-based gauze or ointment	Sterile cup if catheter culture ordered
3) Follow Universal Competencies	Introduce self and identify patient Perform hand hygiene Teach patient: when to hold breath and positioning following procedure	
4) Remove old dressing and prepare site	Follow CVAD Dressing Change NII steps	
5) Remove line	Position patient supine Remove sutures or securement device Place folded 4x4 gauze over site Have patient hold breath Remove line and verify that it is intact (must measure length for PICC lines) Hold pressure 5 min (10 min for anticoagulated patients and PICC lines) Apply petroleum-based gauze or ointment to insertion site Apply transparent dressing **(must add 4x4 folded gauze over transparent dressing and secure with elastic self-adhering wrap for PICC lines)** Have patient remain supine for 30 min after removal Teach patient about home care	Prevent air embolus Helps prevent air embolism Notify healthcare provider if not intact May need more than 10 min pressure for anticoagulated patient Transparent dressing and petroleum-based gauze or ointment act as barriers to air entry, microbes, and allow skin to “breathe” Supine position is precautionary to prevent potential embolism migration to head Dressing should remain in place for 24 hours **(48 hours for PICC lines)**, Don’t get dressing wet

Central Venous Access Device Removal: Subclavian, Jugular, and PICC lines The aseptic removal of a central venous catheter		
6) Culture of tip, if required	As catheter is removed, avoid contamination and drop onto sterile field Using sterile scissors cut off at least 2 inches from tip end of catheter, allowing tip to drop into sterile specimen container Seal container Apply identification label to container and place in Bio-hazardous specimen bag	
7) Complete procedure	Dispose of used supplies Perform hand hygiene and record	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Feb 2018, Mar 2019
Reviewed: Feb 2021
Central venous catheter removal: procedure and rationale., BJN, Vol. 9, (22), 2000
CHS Policy VIII-E-5, Revised April 2015, System-wide update monthly education, Apr 2016
ATI Skills Modules: Central Venous Access Devices, 2016
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Enema Administration in Adults: Tap Water or Prepared Solution

The administration of a solution into the bowel via the rectum to promote defecation or instill a medication

Critical Elements

1) This procedure CAN be delegated to UAP with restrictions
2) Gather supplies, verify orders, and prepare workspace
3) Follow Universal Competencies
4) Administer enema

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify order and protocol	Order written by healthcare provider or mandated by agency protocol	
2) Gather supplies	Enema kit or pre-packaged solution (Ex. Fleet's) Lubricant Bedpan, bedside commode, or toilet access Water absorbent pads IV pole Linen savers, washcloths, soap and water Clean gloves	
3) Follow Universal Competencies	Introduce self and identify patient Perform hand hygiene Assess allergies if solution is medicated Teach patient	
4) Assess patient	Date of last bowel movement Assess abdomen	Establishes baseline for effectiveness of enema
5) Administer the enema	Position patient left Sims Prepare warmed solution for administration Lubricate tip of rectal tube if needed Insert end of tubing 3-4 inches in the <u>adult</u> rectum Hold container approximately at 12 inches above anus (in adults) Administer solution slowly Remove the tubing after solution instills Encourage patient to retain solution for ten to fifteen minutes, or as long as tolerated Provide for evacuation based on assessment of patient	Unless contraindicated (i.e. hip fracture) Hot solutions can injure; cold solutions can cause cramping This distance prevents perforation from over insertion Height will change rate of instillation Enema administration can stimulate the vagal nerve and cause cardiac disturbances Retention of the enema facilitates evacuation of the bowel May be bedpan, bedside commode, or bathroom
6) Complete procedure	Dispose of used supplies Perform hand hygiene & record	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Feb 2018
Reviewed: Feb 2021
CHS Policy: X-C-2, Enemas
Potter and Perry 9th ed., 2017
pp. 1040-1041, Treas et al. 2nd ed., 2018
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Enteral Feeding: Adult

The intermittent or continuous feeding of a patient via an enteral tube by a pump or syringe

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies, verify orders, and prepare workspace
3) Follow Universal Competencies
4) Position patient for procedure (Head of bed elevated 30 degrees or higher)
5) Assess bowel sounds
6) Administer feeding at correct rate

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders and check relevant lab work	Order written by healthcare provider	7 Rights (Right patient, feeding, dose, route, time, reason, documentation) Patient Safety, Legal, Ethical Practice
2) Gather supplies	Irrigation tray kit (60 mL syringe with catheter tip and graduated container – date and time replace every 24 hours) Feeding pump and tubing, if required Sterile water (date and time container opened, replace every 24 hours) Clean gloves Adapter valve (Lopez valve) Take supplies to room	Pump supplies aren't needed for gravity feedings via syringe Sterile water prevents introduction of microbes that may be in tap water Discard after 24 hours
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient, Assess allergies Teach patient	
4) Prepare feeding for administration by pump	Prepare feeding per facility protocol Load Kangaroo (enteral feeding) pump Prime tubing	
5) Administer Feeding	Auscultate for bowel sounds Follow tube from insertion site to connection and ensure tube is labeled at the connection Verify type of tube and that it has been approved for use with feeding Assess patient before use: • Measure length of external portion of nasogastric tube and document • If signs and symptoms of intolerance are present (i.e. nauseated, vomiting, abdominal distention, pain, etc.), measure residual and return residual	Absence of bowel sounds may mean obstruction Checking location of tubes prevents incorrect connections that could be fatal **Do not aspirate** jejunostomy and Dobhoff tubes. Lumens are too small and collapse. Large residual volume may indicate bowel is not digesting Criteria for holding feedings based on residual will vary with healthcare providers and institutional policies

Enteral Feeding: Adult

The intermittent or continuous feeding of a patient via an enteral tube by a pump or syringe

	(If residual is 500 mL or greater after 2 consecutive assessments at least 4 hours apart, contact healthcare provider/dietitian.) **By gravity:** Elevate head of bed 30 degrees or higher Administer feeding gradually via gravity flow Flush with 30 mL of sterile water when feeding is completed **By pump - Continuous** Connect pump tubing to feeding tube or adapter Open clamp Ensure feeding is infusing before leaving room Always leave HOB elevated at least 30 degrees while feeding is running Monitor gastric residual every 4 hours during feeding for the first 48 hours **By pump – Intermittent** Connect pump tubing to feeding tube or adapter Open clamp Ensure feeding is infusing before leaving room Always leave HOB elevated at least 30 degrees while feeding is running After feeding completed, flush with 30 mL sterile water Provide oral care daily while on feeding	Returned residual gives back valuable electrolytes to patient Rapid flow may cause vomiting, diarrhea, or abdominal discomfort Elevation of head helps prevent aspiration of feeding into lungs Clearing tubing of formula helps prevent clogging Place feeding on hold any time head of bed is flat (i.e. repositioning patient, changing linens) Keep HOB elevated at 30 degrees at least 1 hour after feeding has been discontinued – includes gravity and intermittent feedings
6) Complete procedure	Clean used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Nov 2015
Revised: Apr 2016, Apr 2017, Feb 2018, Mar 2019, Apr 2020
Reviewed: Feb 2021

ASPEN Safe Practices for Enteral Nutrition Therapy, 2017
Part 1 Enteral Feeding Barriers: Pesky Bowel Sounds & Gastric Residual Volumes by Parrish and McCray, Jan 2019

CHS Policy: Administration of Enteral Feedings, 2019
CHS Policy: Enteral Feeding Pump, 2019
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Incentive Spirometry Teaching

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Gather supplies	Incentive Spirometer - some assembly required	
2) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient	
3) Perform teaching	Position patient upright Teach patient process before performing Have patient completely cover mouthpiece with lips Instruct patient to inhale slowly and steadily to raise and maintain the flow rate indicator to the "best" range. Continue inhaling until recommended maximum inspiration is reached Hold breath for 3-5 seconds, then exhale slowly Record maximum inspiratory capacity in mL inspired Have patient perform at least 10 times in an hour while awake, resting between each of the 10 breaths	Upright position facilitates expansion of lungs A good seal ensures adequate inhalation This process improves ventilation and oxygenation Package insert contains parameters – can mark goal on device Prevents hyperventilation and fatigue One way to help patient remember is to use commercial breaks as reminder to perform exercise 2-3 times per break
4) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, Feb 2018
Reviewed: Feb 2021
CHS Policy: XIII-A-10, Oxygen Therapy, 2013
Potter and Perry 9th ed., 2017
p. 1053, Fundamentals of Nursing: Theory, Concepts, and Applications, Vol. 1, 3rd ed., 2016

Intravenous Therapy

Intravenous (IV) Catheter Insertion

The insertion of a catheter into a vessel for the continuous or intermittent infusion of fluids or administration of medications

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Aseptically start an IV

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders or protocol	Requires an order or agency protocol	The procedure requires an order or a protocol
2) Gather supplies and prepare workspace	IV start kit Containing a tourniquet, chlorhexidine swab, occlusive dressing, 2x2 gauze, and tape IV catheter Needleless port Antiseptic caps Sodium chloride flush	 Size of catheter is dependent upon vein chosen or intent of use – 22 to 20 gauge is a good starting place, but if blood is going to be given, an 18 g is preferred
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Prepare for care	Apply tourniquet and select vein Release tourniquet Perform hand hygiene Prepare supplies for use Scrub insertion site with chlorhexidine prep pad and allow to dry Re-apply tourniquet Don clean gloves	 Bactericidal effect is achieved with drying Apply approx. 4-6 inches above insertion site
5) Insert catheter	Anchor the vein Prepare the device for use Pierce the skin with stylet bevel up, holding device at an angle of no greater than 5 degrees Observe for blood return Lower and advance the entire catheter and needle unit slightly Hold needle assembly stationary Advance catheter off needle Continue to advance catheter off the needle until the hub meets the skin Release the tourniquet Remove or retract stylet and ensure activation of safety mechanism	Prevents vein from rolling Confirmation of vessel entry Ensures catheter tip is in vessel Observation of blood return between the needle and catheter confirm catheter is in the vessel

Intravenous (IV) Catheter Insertion

The insertion of a catheter into a vessel for the continuous or intermittent infusion of fluids or administration of medications

6) Complete the job	Dispose of needle in sharps container Use prefilled sodium chloride syringe to flush lumen, then clamp Stabilize catheter and apply transparent dressing Label dressing with initials, date, and time Apply antiseptic cap to needleless connector Dispose of used supplies Perform hand hygiene	

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Apr 2016, Apr 2017, Feb 2018, April 2020
Reviewed: Feb 2021
CHS Policy: Peripheral IV Venipuncture- Starting and Maintaining, 2015
Potter and Perry 9th ed., 2017

Converting a Continuous Infusion to an INT
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders or protocol	Verify order Review any guidelines mandated by agency protocol	
2) Gather supplies	10 mL Sodium chloride flush Antiseptic caps	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
4) Convert line	Assess the site Stop infusion Disconnect primary tubing Flush extension with sodium chloride according to flush protocol Close clamp on INT extension Apply antiseptic cap	Verify healthy IV site Verify patency of IV site Safety and maintenance guidelines vary widely, refer to specific protocols
5) Complete procedure	Discard used supplies Perform hand hygiene Record results and report if indicated	

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Mar 2016, Apr 2017, Feb 2018
Reviewed: Feb 2021
CHS Policy: IVPB Medications by Gravity or Pump 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Pump Use with Primary Intravenous Infusions
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify primary crystalloid (solution)	Verify order Review any guidelines mandated by agency protocol Check relevant lab work	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies	IV Pole IV Pump IV solution Pump tubing Tubing label and IV solution label Antiseptic cap	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
4) Basic Setup	Assess IV site **Close roller clamp on tubing** Label bag with flow rate and tubing with date and time Remove tab from bag Remove cap from sterile spike Aseptically spike IV solution bag Hang solution Squeeze and release middle of drip chamber until it fills to 2/3 full Invert tubing portion covered with blue plastic sleeve and open roller clamp SLOWLY prime tubing to the end Close roller clamp Remove blue plastic sleeve from tubing Open module door Position white slide clamp into the cassette and listen for click Position upper fitment into top of the cassette Close module door and lock securely Select “System On” then Select “Yes” for new patient – “No,” if not Select “Channel Select” on module Select “Guardrails IV Fluids” or “Basic Infusion” Select “Maintenance IVF” Select “Yes” Select “Rate” and enter the number Select “VTBI” and enter the number	Inversion of sleeve-covered tubing and in-line filters during filling will help prevent accumulation of air bubbles in line Do NOT remove cover off connecting end of tubing to prime tubing

Pump Use with Primary Intravenous Infusions
Nursing Intervention Instruction

	Remove antiseptic cap or clean INT connection site Connect infusion to INT Open roller clamp Press “Start” Verify rate on module display is correct Verify Guardrails selection is correct Verify machine is delivering drops Check IV site after infusion starts Apply antiseptic cap to any unused access ports	
5) Discontinue IV fluid	Select “Channel Off” on module and hold for a few seconds Close roller clamp Disconnect from INT and flush Open module door Lift upper fitment from recess and remove cassette	
6) Complete procedure	Discard used supplies if required Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Feb 2018
Reviewed: Feb 2021
pp. 1071-1074, Clinical Nursing Skills: Basic to Advanced, Smith, et. Al., Pearson Publishing, 9th ed, 2017
CHS Policy: Carefusion (Alaris) Pump Delivery with Guardrails 2014
Alaris Carefusion® Quick Reference Guide, 2009

Medication Administration

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

Enteral Medication Administration in the Adult
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Order written by healthcare provider or mandated by agency protocol Check relevant lab work	Part of 7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies and prepare workspace and clean as required	Irrigation tray kit (60 mL syringe with catheter tip and graduated container – replace with new every 24 hours) Calibrated medication cup Sterile water (date and time opened – replace with new every 24 hours) Three-way adapter Pill crusher	Sterile water prevents introduction of microbes that may be in tap water. Sterile water should be discarded after 24 hours
3) Prepare medication for administration	Obtain medication Perform hand hygiene Crush medications in medication room, retain original label for each medication to scan at bedside Transport medications to room in labeled container or bag	Liquid forms are preferred Crush one medication at a time – label as you go If a medication is indicated for administering on empty stomach, stop feeding 30 minutes prior to administration and resume 30 minutes after
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient, Assess allergies Teach patient	
5) Administer Medication	Scan armband and verify on eMAR Scan medication label and verify on eMAR Auscultate for bowel sounds Follow tube connection to point of origin and ensure tube is labeled.	Absence of sounds may indicate obstruction or ileus

Enteral Medication Administration in the Adult
Nursing Intervention Instruction

Steps	Key Points	Rationale
	Mix crushed meds **separately** in 15 mL sterile water. Liquid meds that are very viscous should be diluted to a thin consistency	Check for fluid restrictions – may need to modify volumes Do NOT mix medications together, may clog tube or result in medication interactions or incompatibilities Viscous liquids may also clog the tube
	Raise HOB 30 degrees or higher unless contraindicated	Helps prevent aspiration of the drug
	Verify type of tube and that it has been approved for use with feeding	
	Assess patient before use: • Measure length of external portion of nasogastric tube and document • If signs and symptoms of intolerance are present (i.e. nauseated, vomiting, abdominal distention, pain, etc.), measure residual and return residual	
	Flush with 30 mL of sterile water	To check patency or clear the tube of feeding
	Remove plunger and attach syringe to feeding tube or adapter	Do not aspirate jejunostomy tubes or Dobhoff, they can split or crack from the negative pressure of aspiration
	Pour dissolved medication into syringe and allow to flow by gravity	Large residual volume indicates bowel is not digesting or moving
	Flush with 15 mL between each medication	Irrigation of tube before and after medication administration helps prevent obstruction of tube
	After final med, flush tube with 30 mL of water	
	Leave HOB elevated for 30 minutes	Facilitates flow of medication into bowel and helps prevent reflux into pharynx
6) Complete procedure	Clean used supplies Perform hand hygiene Record results and report if indicated Restart feedings when appropriate if applicable	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, July 2016, Apr 2017, Feb 2018, Mar 2019, Apr 2020
Reviewed: Feb 2021
ASPEN Safe Practices for Enteral Nutrition Therapy, 2017
CHS Policies: Administration of Enteral Feedings
CHS Policies: Medication Administration via Gastric Tube, 2015
Potter and Perry 9th ed., 2017
pp. 382-384, Berman and Snyder, Skills in Clinical Nursing, 8th ed,
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

Intradermal (ID) Injection Medication Administration

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify medication	Verify order in EMR Review any guidelines mandated by agency protocol	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies and prepare workspace and clean as required	Select needle and syringe appropriate for targeted tissue and body mass Needle Syringe Syringe label Alcohol swabs Band-Aid if needed	Needle: 25 g x 5/8" Syringe: 1 mL Tuberculin with needle or 1 mL syringe with attachable needle as specified above Site: Middle third, ventral aspect of the forearm
3) Prepare medication for administration	Obtain medication Perform hand hygiene Aseptically prepare syringe Aseptically draw up medication Label syringe Transport syringe and vial to room in labeled container	
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer Medication	Scan armband and verify patient on eMAR Scan medication vial and verify on eMAR Perform hand hygiene and don clean gloves Select site and prep with alcohol swab Stretch skin taut over site with forefinger and thumb Hold syringe parallel with skin with bevel up	Patient Safety

Intradermal (ID) Injection Medication Administration

Nursing Intervention Instruction

	Pierce skin and advance needle approx. 1/8 " into skin Slowly inject serum into skin, forming a bleb Withdraw needle at same angle Activate safety device Apply Band-Aid if needed	Degree is low, 5-15 degrees at most - depending on thickness of skin You should see outline of needle under the skin **Do not aspirate** A bleb or wheal with blanching indicates medication is in the dermis If no wheal, the medication was not administered correctly Prevents tissue trauma **Do not massage site** Prevent needle stick
6) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Mar 2016, Apr 2017, Feb 2018
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration Based on the work of C. Lenburg in the COPA Model

Intramuscular (IM) Medication Administration in the Adult
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify medication	Verify order in EMR Review any guidelines mandated by agency protocol Check relevant lab work	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies and prepare workspace and clean as required	Select needle and syringe appropriate for targeted muscle and viscosity of medication Syringe Needle Filtered or blunt fill needles, if required Alcohol swabs Syringe labels Band-Aid®	Filter needle for ampules Blunt fill (if available) for vials Needle gauge: Deltoid – 25 g to 20 g Ventro – 21 g to 18 g depending on viscosity Needle length: Deltoid – 1 in Vastus lateralis or Ventrogluteal – 1 to 1 ½ in depending on muscle mass Syringe size: 3 mL is typical Less than 1 mL solution - use 1 mL syringe for accuracy Maximum volume in well-developed adult: Vastus lateralis or Ventrogluteal: up to 3 mL Deltoid: up to 1 mL
3) Prepare medication for administration	**Follow CDC guideline for one needle, one stick, one time** Obtain medication Perform hand hygiene Aseptically attach needle to syringe Aseptically draw up medication Label syringe Transport syringe and vial to room in labeled container	

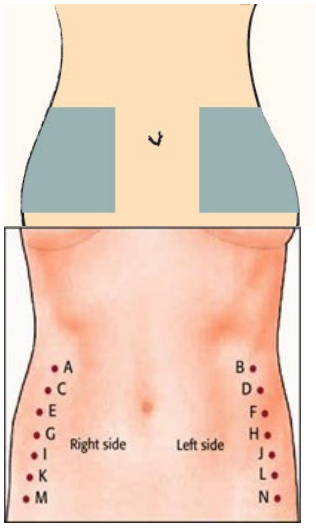
Intramuscular (IM) Medication Administration in the Adult
Nursing Intervention Instruction

Steps	Key Points	Rationale
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer Medication	Scan armband and verify patient on eMAR Scan medication vial and verify on eMAR Select site and prep with alcohol swab Displace the skin at site of injection (Apply Z-track) Holding the syringe with the index finger and thumb of the dominant hand, insert the needle at a 90-degree angle and stabilize the syringe with non-dominant thumb and index finger while continuing to displace skin Aspirate for at least 5 seconds- if blood returns, withdraw immediately and discard Inject medication slowly Leave needle in place for approximately 3-5 seconds before withdrawing at same angle Release Z-track Activate safety device Apply Band-Aid® if needed	Patient Safety Z-track is recommended because it minimizes pain and helps prevent irritation of subcutaneous tissue. Z-track is not required for immunizations Aspiration is NOT required for immunizations Prevents tissue trauma Prevent needle stick Aspiration of blood indicates the needle has penetrated a vein Leaves a zigzag track that traps the medication in the muscle Leave needle in muscle until all medicine has been administered to ensure all medication administered
6) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Apr 2017, Feb 2018, Apr 2020
Reviewed: Feb 2021
Potter and Perry Fundamentals of Nursing, 9th ed., 2017
Pink Book, CDC, cdc.gov, 2016
p.622, Clinical Nursing Skills: Basic to Advanced, Smith, et. Al., Pearson Publishing, 9th ed., 2017
p. 651, Fundamentals of Nursing: Theory, Concepts, and Applications, Vol. 1, 3rd ed., 2016

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

Subcutaneous (SubQ) Enoxaparin Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Order written by healthcare provider or mandated by agency protocol Check relevant lab work	Part of 7 Rights (Right patient, drug, dose, route, time, reason, documentation) CBC: Platelets below 100,000 warrants a hold for the medication
2) Gather supplies and prepare workspace and clean as required	Alcohol swabs Band-Aid® Medication	
3) Prepare medication	Calculate medication dose	Joint Commission Standard
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer Medication 	Scan armband and verify on eMAR Scan manufacturer's pre-filled medication and verify on eMAR Place patient in lying position Select site on either side of the **lateral abdomen** (love handles), avoiding the umbilicus by more than 4 inches Prepare solution in syringe so that nitrogen bubble is next to plunger Prep with alcohol swab Bunch a fold of tissue and administer the medication at a 90-degree angle maintaining the bunch for the duration of the injection (Follow facility policy) Withdraw needle at same angle Activate safety device **Do NOT aspirate or massage** – Teach patient not to rub site	Patient Safety Syringe with needle is pre-filled at factory Injection close to the umbilicus can result in intra-abdominal bleeding May use anterior or posterior lateral aspect of abdomen Nitrogen serves as "air lock" for solution- "air lock" is last to go into the tissue Prevents tissue trauma and injection behind the peritoneum Needle stick prevention Prevent bleeding or hematoma
6) Complete procedure	Dispose of used supplies	

Subcutaneous (SubQ) Enoxaparin Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
	Perform hand hygiene Record results and report if indicated	

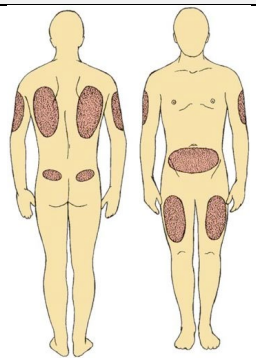
Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Apr 2017, Feb 2018, Mar 2019, Feb 2021
Reviewed: Feb 2021
https://druginserts.com/lib/rx/meds/lovenox-3/

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

Subcutaneous (SubQ) Insulin Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Order written by healthcare provider or mandated by agency protocol Check relevant lab work Monitor blood glucose prior to administration	Part of 7 Rights (Right patient, drug, dose, route, time, reason, documentation)
2) Gather supplies and prepare workspace and clean as required	Alcohol swabs Syringe label Band-Aid® Select insulin syringe to match insulin vial	Insulin syringe: **U-100 (u=units) for U-100 Insulin Vials**
3) Prepare medication for administration	Prepare medication per protocol	NPH insulin should be gently agitated before withdrawing the medication **DO NOT SHAKE THE VIAL** – can disturb protein bonds Methods for restoring suspension to normal cloudy state include gently rolling in palms of hands or inverting vial back and forth 10 or more times until solution appears uniform
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer Medication	Scan armband and verify on eMAR Scan medication barcode and verify dose on eMAR Select subcutaneous site and prep with alcohol swab	Patient Safety **Second nurse must verify and co-sign at bedside** Most consistent absorption is in the abdomen – may use other acceptable subcutaneous sites Rotate sites – no closer than 1 inch to last injected site

Subcutaneous (SubQ) Insulin Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
	Inject at 90 degrees and administer slowly Leave the needle in place for 3-5 seconds Withdraw needle at same angle Do not rub or massage Activate safety device Apply Band-Aid® if needed	 May need to bunch the skin in the lean adult or when administering to a child Prevents needle stick
6) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

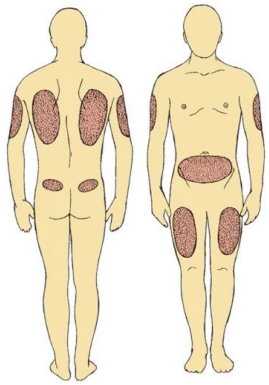
Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2017, Feb 2018
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017
p. 688, Pharmacology for Nursing Care, Lehne, 10th ed, p. 2019
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

Subcutaneous (SubQ) Injection for Other Medications
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Order written by healthcare provider or mandated by agency protocol Check relevant lab work	Part of 7 Rights (Right patient, drug, dose, route, time, reason, documentation)
2) Gather supplies and prepare workspace and clean as required	**Follow CDC guideline for one needle, one stick, one time** Select appropriate equipment for targeted subcutaneous tissue and medication viscosity Syringe Needle Filter Needle if required Alcohol swabs Syringe labels Band-Aid®	Filter needle for ampules Blunt fill needle for vials Needle gauge: 27 g to 25 g depending on viscosity Needle length: 3/8" – 5/8" depending on site Syringe size: 1-3 mL is typical Less than 1 mL solution - use 1 mL syringe for accuracy Maximum Volume: 1.5 mL
3) Prepare medication for administration	Obtain medication and take to patient room in labeled container or bag	
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer Medication	Scan armband and verify on eMAR Scan medication vial and verify on eMAR Select site and prep with alcohol swab Inject slowly at 45 to 90 degrees Withdraw needle at same angle Apply Band-Aid if needed	Patient Safety 90 degrees is acceptable if adipose is ample (bunching of adipose is 2 inches or greater), 45-degree angle for adipose bunching if less than 2 inches In obese patients, do not bunch, use 90-degree angle and needle length

Subcutaneous (SubQ) Injection for Other Medications
Nursing Intervention Instruction

Steps	Key Points	Rationale
		that is sufficient to reach subcutaneous tissue 
6) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Oct 20, 2015
Revised: Apr 2016, July 2016, Apr 2017, Feb 2018
Reviewed: Feb 2021
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

IV Push Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify medication	Verify order in EMR Review any guidelines mandated by agency protocol **Follow CDC guideline for one access, one syringe/needle, one time** Check relevant lab work	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies	Prescribed medication Syringe medication label Syringe 2 – 10 mL prefilled sodium chloride syringes Blunt fill needle Blue sterile cap Alcohol pad Antiseptic cap	**One flush syringe, one access, one time** Keeps tip of syringe sterile after admixture
3) Prepare medication	Prepare workspace and clean as required Verify dose, dilution, and rate of administration Prepare medication per manufacturer's recommendations; Use a dose appropriate syringe to administer a medication. Do not prepare medication in a prefilled sodium chloride flush syringe Label syringe Take supplies to room in a labeled container	Correct dilution is very important Commercially available prefilled syringes of sodium chloride are regulated by the US FDA as a medical device, not as a medication. They are approved for flushing vascular access devices, but NOT approved for reconstitution, dilution, and/or subsequent administration of IV push medications. (ISMP) Joint Commission Standard
4) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
5) Administer medication	Scan armband and verify patient on eMAR	Patient Safety

IV Push Medication Administration
Nursing Intervention Instruction

Steps	Key Points	Rationale
	Scan medication and verify on eMAR Assess IV site Remove antiseptic cap and scrub port with alcohol pad for 15 seconds. Allow to dry Assess patency of IV catheter: **Peripheral INT**: Use a pre-filled 10 mL sodium chloride syringe and flush with 9 mL **Central line**: Using pre-filled 10 mL sodium chloride syringe, aspirate for blood return, flush with 9 mL If continuous infusion, select closest port to patient Scrub needleless port for 15 seconds and allow to dry Aseptically attach medication syringe Push medication at recommended rate Flush with 9 mL sodium chloride, remove syringe, clamp lumen, apply antiseptic cap	Verify healthy IV site Aspiration not required to verify patency of peripheral site **Remember** – only use 10 mL syringes to verify patency with central venous access devices; once patency is established may use dose appropriate syringe for medication administration No flush required with compatible continuous infusions Safety and maintenance guidelines vary widely, refer to specific protocols – clean ports and allow to dry prior to each connection with a syringe Asepsis
6) Complete procedure	Discard used supplies if required. Any labels with patient name go in confidential bin Perform hand hygiene Record results and report if indicated	HIPAA

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: Apr 2016, July 2016, Sep 2016, Apr 2017, Feb 2018, Mar 2019, Apr 2020
Reviewed: Feb 2021
CHS Policy: IVPB Medications by Gravity or Pump 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

IVPB Medication Administration via Gravity to a Peripheral INT
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify medication	Verify order in EMR Review any guidelines mandated by agency protocol **Follow CDC guideline for one access, one syringe, one time** Check relevant lab work	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies	IVPB medication IV primary tubing for gravity infusion IV tubing label 2 10 mL Sodium chloride flush Alcohol swabs Antiseptic cap	Gravity infused medications can only be used with peripheral lines in adults – some medications mandate use of pumps Long tubing allows patient to move freely without hindrance Joint Commission Standard
3) Prepare tubing	Prepare workspace and clean as required Calculate rate, verify dose and dilution Perform hand hygiene Label tubing **Close roller clamp**	 **Prevents air in tubing and loss of medication**
4) Prepare medication for administration	Pull protective covering off access site on bag where spike will enter Remove cover off spike of IV tubing Aseptically spike medication bag Pinch chamber and fill to line Open roller clamp and prime tubing Close roller clamp Take supplies to room in a labeled container	 Prime to expel existing air from tubing Joint Commission Standard
5) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	

IVPB Medication Administration via Gravity to a Peripheral INT
Nursing Intervention Instruction

Steps	Key Points	Rationale
6) Administer medication	Scan armband and verify patient on eMAR Scan medication and verify on eMAR Assess IV site Clean port, allow to dry and flush INT with 9 mL sodium chloride Attach IV tubing Open clamp and regulate flow rate Monitor for approximately 1 minute to ensure infusion rate is correct	Patient Safety Site must be healthy Verify patency Avoid rapid infusion and adverse effects
7) Discontinue Infusion	Close tubing clamp Disconnect tubing, protect tip, and prepare tubing for next dose, if indicated. Clean port, allow to dry and flush INT with 9 mL sodium chloride, remove syringe, clamp lumen Apply antiseptic cap	 Asepsis: IV tubing for multiple doses of same medication can be used for 24 hours Clears medication and maintains patency Safety and maintenance guidelines vary widely, refer to specific protocols
8) Complete procedure	Discard used supplies if required (patient labels to confidential bin) Perform hand hygiene Record results and report if indicated	

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Apr 2016, July 2016, Feb 2018, Apr 2020
Reviewed: Feb 2021
CHS Policy: IVPB Medications by Gravity or Pump 2013
Potter and Perry 9th ed., 2017

Global Medication Administration Rights and Responsibilities: The administration of oral, parenteral, or topical medications to designated patients
Critical Elements
1) Follow Universal Competencies 2) Prior to administration, verify accuracy of drug and dose prescribed for the right patient 3) Identify patient and assess allergies at bedside 4) Administer right dose of medication using right route and right location 5) Administer medication at the right time to right patient within +/- 60 minutes of scheduled time 6) Comply with established protocols related to medication administration per Nursing Intervention Instruction 7) Assess patient response within 30 minutes after administration *Based on the work of C. Lenburg in the COPA Model*

IVPB Medication Administration via Infusion Pump
Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify medication	Verify order in EMR Check relevant lab work Review any guidelines mandated by agency protocol **Follow CDC guideline for one access, one syringe, one time**	7 Rights (Right patient, medication, dose, route, time, reason, documentation)
2) Gather supplies	IVPB medication – verify compatibility with primary infusion Secondary IV Set with hanger 24 hour IV tubing label Antiseptic cap if needed	
3) Prepare tubing	Prepare workspace and clean as required Verify pre-calculated rate of administration Perform hand hygiene Label tubing **Close roller clamp**	**Prevents air in tubing and loss of medication**
4) Prepare medication for administration	Pull protective cover off access site on bag where spike will enter Remove cover off spike of IV tubing Aseptically spike medication bag Pinch chamber and fill to line Open roller clamp and prime tubing Close roller clamp Take supplies to room in a labeled container	Asepsis Prevent entrance of air into line Prime to expel existing air from tubing Joint Commission Standard
5) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Assess allergies Teach patient	
6) Administer medication	Scan armband and verify patient on eMAR Scan medication and verify on eMAR Assess IV site	Patient Safety Verify healthy site and patency

IVPB Medication Administration via Infusion Pump
Nursing Intervention Instruction

Steps	Key Points	Rationale
	Place Primary infusion bag on hanger Hang IVPB Remove antiseptic cap from port above pump and connect IVPB tubing in port above the pump Press "Channel Select" on module Select "Secondary" Choose medication from alphabetical list Verify concentration and drug dose Select "Yes" if correct Select "Next" to confirm Verify rate and VTBI is correct Open secondary roller clamp and start infusion Verify infusion is running correctly from the secondary bag	Secondary bag must hang higher than primary for it to infuse When secondary infusion is complete, pump will automatically revert back to primary infusion parameters
7) Complete procedure	Clamp the roller on Secondary tubing and disconnect from the IV port **Immediately place sterile blue cap over end of tubing if intended for multiple doses** Discard used supplies if required (patient labels to confidential bin) Perform hand hygiene Record results and report if indicated	Tubing is replaced every 24 hours and can be used for multiple doses of the same medication during that 24 hours HIPAA

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Feb 2018
Reviewed: Feb 2021
CHS Policy: IVPB Medications by Gravity or Pump 2013
pp. 675-683, Potter and Perry 9th ed., 2017

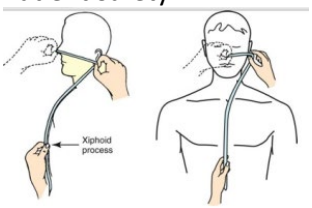
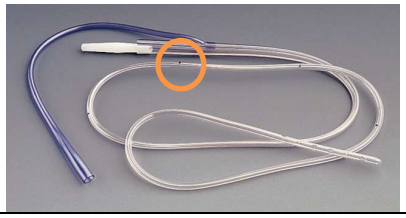
Nasogastric Tube Insertion and Removal

The insertion of a tube into the stomach via the nasal passage through the esophagus to empty the stomach, decompress the bowel, or to instill feedings or medications

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Position patient for procedure
5) Insert catheter into the stomach and verify return of gastric contents
6) Remove nasogastric tube

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Requires an order	Infection Control, Patient Safety
2) Gather supplies and prepare workspace	Nasogastric tube Disposable irrigation set Emesis bag or bath basin Water soluble lubricant Tube guard Suction set up Ice chips or water with straw	16 Fr is a common selection for an adult
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Prepare for care	Position patient in high Fowler's Perform hand hygiene and don clean gloves Assess nasal passage Place towel over chest Measure with tube from tip of nose, to earlobe, to xyphoid process Note measurement for insertion on tube Attach irrigation syringe to the tube	Patient Safety  
5) Insert the tube	Lubricate 3-4 inches on end of tube Insert tube into the nare, advance gently along floor of the nasal passage toward the nasopharynx Once nasal passage is cleared, with tube just above oropharynx, have the patient flex head forward and begin swallowing Advance tube 1-4 inches with swallowing Continue advancing until mark is reached	To minimize friction Tilting the head forward helps close the airway and facilitates placement of the tube in the esophagus Swallowing closes the epiglottis and helps prevent entry of the tube into the trachea May use ice chips or water to help swallow

Nasogastric Tube Insertion and Removal

The insertion of a tube into the stomach via the nasal passage through the esophagus to empty the stomach, decompress the bowel, or to instill feedings or medications

	Secure the tube to the nose temporarily with a piece of tape. Aspirate for gastric contents Once final tube location is set, secure with the nose guard, ensuring there is no tension from the tube on the nare Connect to suction if ordered Secure the tube to the gown Measure and document length of external portion of tube	If patient begins to choke or cough after tube is well advanced, then tube may be in trachea. Patient may even become cyanotic Tension from the tube on the nare can cause necrosis Change in length may indicate migration of the tube
6) Removal of the tube	Requires an order Position upright Disconnect suction and free tube Assess nasal passage for mucous plugging and clear if present Have patient hold breath Gently remove tube Provide nasal and oral hygiene Record results and report if indicated	 Helps prevent aspiration of gastric contents

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, Feb 2018
Reviewed: Apr 2021
CHS Policy: X-C-12, Nasogastric Tube Insertion, Irrigation and Removal, 2012
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Ostomy Care

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify protocol	Change according to protocol or assessed need	
2) Gather supplies	Ostomy appliance Ostomy measuring guide Skin Barrier Stoma Paste if needed Adhesive remover Clean cloths Waste receptacle Clean gloves	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Assess stoma	Remove used appliance Assess the stoma and surrounding skin Clean peristomal area with warm water Dry thoroughly with gentle patting motion Measure stoma with guide or pattern Cut an opening for the stoma into new appliance to fit – no larger spacing than 1/8 inch from edge of stoma	Stoma should be pink and moist, Skin should be intact – notify healthcare provider if stoma is blue, black, or brown Effluent (waste) is caustic to skin
5) Apply barrier and pouch	Apply skin barrier with pouch gently over the stoma and warm to secure to skin Close end of pouch Record results and report if indicated	Press hands or a warm washcloth against the barrier to facilitate adhesion to skin Some appliances will require adhesive or powder

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Feb 2018
Reviewed: Apr 2021
CHS Policy: X-C-10, Ostomy Care
Potter and Perry, 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Oxygen Administration

Nasal Cannula Oxygen Administration

Administering oxygen at 24-44% via the nasal passage to improve the oxygen status of a patient

Critical Elements

1) This procedure is NOT delegated to certified UAP, unless oxygen already in place
2) Gather supplies and prepare workspace, clean equipment as required
3) Follow Universal Competencies
4) Set flow rate
5) Apply cannula
6) Assess patient response

Based on the work of C. Lenburg in the COPA model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Verify type and amount of oxygen	The procedure is non-invasive and must have an order, oxygen is the equivalent of a medication
2) Gather supplies	Flow meter Nasal cannula Humidifying bottle for rate $\geq$ 3 L/min Notify Respiratory Therapy Department	 Humidification is required for $\geq$ 3 L/min for comfort to prevent irritation and drying of membranes
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient Avoid smoking Avoid petroleum-based lubricants Avoid use of combustible materials – especially oil-based	 Oxygen causes combustion of flammable materials
4) Apply oxygen	Assess respiratory status, skin color, and oxygen saturation Insert flow meter into wall outlet Connect tubing Set rate 1-5 L/min for average use CAUTION: rates in patients with COPD per order Place nasal cannula prongs into nares with curve of prongs arching downward Drape tubing over ears and adjust under chin until cannula fits snuggly and securely Assess patient response and monitor oxygen saturation a minimum of every 4 hours while on oxygen therapy Monitor pressure areas after application	 Oxygen can suppress hypoxic drive The floor of the nasal passage curves down toward the throat Oxygen may need adjustment Device can cause trauma, so monitor contact areas such as nares, ears, and cheeks
5) Complete procedure	Perform hand hygiene	

Nasal Cannula Oxygen Administration

Administering oxygen at 24-44% via the nasal passage to improve the oxygen status of a patient

	Record results and report if indicated	

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Apr 2017, Feb 2018, Apr 2020
Reviewed: Feb 2021
CHS Policy: XIII-A-10, Oxygen Therapy, 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Non-Rebreather Mask Oxygen Administration

Administering oxygen via the oral and nasal passage simultaneously via mask with dosing adapters to deliver oxygen in the range of (60-95%) to patients and improve oxygen status

Critical Elements

1) This procedure is NOT delegated to certified UAP, unless oxygen already in place
2) Gather supplies and prepare workspace and clean equipment as required
3) Follow Universal Competencies
4) Set rate
5) Place face mask
6) Ensure reservoir is inflated
7) Ensure vent flap on mask is in place
8) Assess patient response

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Verify type and amount of oxygen Notify Respiratory Therapy Department Do not use in patients with COPD	The procedure is non-invasive and must have an order, oxygen is the equivalent of a medication Can interfere with respiratory drive
2) Gather supplies	Flow meter Non-Rebreather mask set	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient Avoid smoking Avoid petroleum-based lubricants Avoid use of combustible materials – especially oil-based Keep mask on face with seal	Oxygen causes combustion of flammable materials
4) Apply oxygen	Assess respiratory status, skin color, and oxygen saturation Insert flow meter into wall outlet Connect tubing Set flow rate at 10-15 L/min to inflate reservoir Place mask on face Pinch nose piece to fit mask snugly Pull elastic straps until mask fits cheeks and chin snuggly Assess patient response and monitor oxygen saturation a minimum of every 4 hours while on oxygen therapy	Reservoir must remain inflated to deliver high concentrations of oxygen Flow rate may need adjustment  Device can cause trauma, so monitor contact areas such as nares, ears, and cheeks

Non-Rebreather Mask Oxygen Administration

Administering oxygen via the oral and nasal passage simultaneously via mask with dosing adapters to deliver oxygen in the range of (60-95%) to patients and improve oxygen status

	Monitor pressure areas after application	
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, Feb 2018
Reviewed: Feb 2021
CHS Policy: XIII-A-10, Oxygen Therapy, 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

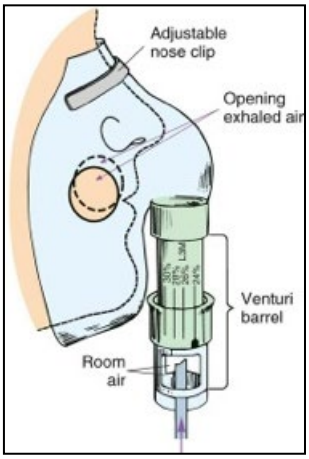
Venturi Mask Oxygen Administration

Administering oxygen via the oral and nasal passage simultaneously via mask with dosing adapters to accurately deliver specific percentage (24-60%) of oxygen to patients and improve oxygen status

Critical Elements

1) This procedure is NOT delegated to certified UAP, unless oxygen already in place
2) Gather supplies and prepare workspace and clean equipment as required
3) Follow Universal Competencies
4) Select correct dosing adapter
5) Set flow rate
6) Place face mask
7) Ensure dosing adapter is open to air
8) Assess patient response

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Verify type and amount of oxygen Notify Respiratory Therapy Department	The procedure is non-invasive and must have an order, oxygen is the equivalent of a medication
2) Gather supplies	Flow meter Venturi mask set	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient Avoid smoking Avoid petroleum-based lubricants Avoid use of combustible materials – especially oil-based Keep mask on face	Oxygen causes combustion of flammable materials
4) Apply oxygen	Assess respiratory status, skin color, and oxygen saturation Insert flow meter into wall outlet Connect tubing Select adapter to achieve ordered percentage and set rate as depicted on adapter (varies, 4-12 L/min) Place mask on face Pinch nose piece to fit mask snugly Pull elastic straps until mask fits cheeks and chin snuggly Assess patient response and monitor oxygen saturation a minimum of every 4 hours while on oxygen therapy Monitor pressure areas after application	Patient Safety, Oxygenation  Device can cause trauma, so monitor contact areas such as nares, ears, and cheeks

Venturi Mask Oxygen Administration Administering oxygen via the oral and nasal passage simultaneously via mask with dosing adapters to accurately deliver specific percentage (24-60%) of oxygen to patients and improve oxygen status		
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: Feb 2018
Reviewed: Feb 2021
CHS Policy: XIII-A-10, Oxygen Therapy, 2013
Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Safety for Tubes, Lines, and Drains

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify protocol	A label must be applied to **ALL** types of catheters, tubes, lines, and drains	Misconnections can result in failure of drains, feedings being introduced via veins and ultimately, patient harm
2) Gather supplies	Obtain label relevant for lines and drains Adhesive tape can be used, depending on type and location of line or drain	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Identify tubes	Perform hand hygiene and don clean gloves Prepare labels for all tubes with date, time, site, type, route, and initial Trace tubing to source	
5) Label tubes	Place labels near connection points Retrace tubes, lines, and drains during handoff report at bedside, at end of shift, when tubes become disconnected, and before any new connections are made into tubes For new connections, make sure appropriate equipment is used	Use tubes and related equipment only as intended. If tubes don't fit, don't force
6) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Reviewed: Feb 2021
Revised: IM2 Faculty, Apr 2016, Feb 2018
CHS Policy Safety Protocol for Tubes, Drains, and Lines

SBAR Report Protocol

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Identify protocol	SBAR format	Patient Safety – Communication Joint Commission stated industry best practice for standardized communication
2) S	Identify self, unit, patient, room number Clearly and briefly describe the situation	Patient Safety, Communication, Prioritization
3) B	Pertinent background information related to the situation: Admitting diagnosis Pertinent medical history Brief description of current treatment Recent VS Pertinent Lab results	Communication of relevant background information to frame situation
4) A	Nursing assessment of the problem or situation warranting notification to healthcare provider Signification changes in VS, lab values, medication regimen, operative site, family dynamics, etc.	Communication of your assessment of the problem
5) R	What is the nurse's recommendation? Briefly and concisely state what the nurse believes would benefit patient to resolve problem or situation Examples: order a lab test, healthcare provider needs to visually assess patient, a consult needs to be ordered, a new medication needs to be ordered, etc.	Proposition for action or resolution of problem

Created by IM2 Faculty, Covenant School of Nursing, Nov 2019
Revised: Mar 2019
Reviewed: Feb 2021
CHS Policy: Standardized Handoff Communication, 2014
Institute for Healthcare Improvement:
http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx

Sequential Compression Device (SCD) Use

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders or protocol	Verify orders and length of use	The procedure is non-invasive and must have an order
2) Gather supplies	SCD machine with hoses Single user compression sleeves - fit to patient, thigh high or knee high	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Apply sleeves	Arrange sleeve under leg Wrap sleeve securely around leg Attach hose to sleeve by snapping connectors together Turn on power Observe cycle of the unit for at least one full cycle on both legs Remove each shift to assess skin	Holes should be over back of knee and on top of knee for thigh high lengths Verify fit by placing two fingers under sleeve Ensure equipment is functioning correctly Compression device can cause skin breakdown
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Reviewed: IM2 Faculty, Apr 2021
Revised: Feb 2018
Potter and Perry 9th ed., 2017

Staple and Suture Removal

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify order or protocol	Staples and sutures are commonly discontinued after the incision has closed	The procedure requires clean technique
2) Gather supplies	Staple Removal kit or Suture Removal kit Steri strips as needed or as is applicable Tincture of Benzoin	
3) Follow Universal Competencies	Introduce self Identify patient Perform hand hygiene Teach patient	
4) Assess Wound	Assess for approximation and healing	If staples or sutures are removed from an incision that has not closed, the wound can dehisce
5) Staple Removal	Pre-clean incision per protocol or as indicated Hold staple remover parallel to skin Insert the lower tip of the remover under the staple Slowly close the end of the staple remover together and squeeze center of the staple with the tips to free it from the skin Remove every other staple to observe for gaping of incision Apply tincture of benzoin to each side of the incision Apply steri strips	 Lift staples vertically out of the incision Allow to dry to “tacky” consistency Secures incision until fully healed
6) Suture Removal	Pre-clean incision per protocol or as indicated Starting at either end of incision, grasp suture knot with forceps and lift up slightly Clip suture at skin level on opposite side of knot Remove every other suture with a gentle pull Observe for gaping of incision Apply tincture of benzoin to each side of the incision Apply steri strips	 Never pull the visible portion through the underlying skin – it will contaminate the incision
7) Complete procedure	Dispose of used supplies Perform hand hygiene and record Report results, if indicated	

Created: by IM2 Faculty, Covenant School of Nursing, Nov 2015
Reviewed: Apr 2021
Revised: Feb 2018
CHS Policy II-E-20, Suture and Staple Removal, Dec 2014
Potter and Perry, 2017

Sterile Gloving

The aseptic application of sterile gloves for use in a sterile procedure

Critical Elements

1) This procedure is NOT performed by UAP
2) Check for Latex allergies
3) Gather supplies and prepare workspace
4) If associated with an aseptic procedure, follow Universal Competencies
5) Don gloves without contamination

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify need for asepsis	Aseptic procedures use sterile gloves	
2) Prepare to don gloves Clean work surface	Check patient for latex allergy Select correctly sized gloves Keep glove packaging dry and **intact (no tears)** Perform hand hygiene Remove sterile glove package from outer wrapper	Patient Safety Moist packaging contaminates the gloves
3) Don sterile gloves	Working at waist level, grasp flaps of package without touching inner surface and pull open Grasp the edge of cuff on the glove with the dominant hand touching only the inside of the cuff Pick glove straight up from the package Carefully pull the glove over the hand and wrist by the fold of the cuff Use gloved hand to pick up remaining glove by inserting all fingers under the cuff of the remaining glove and extend the thumb of the gloved hand as you pull the remaining glove over the hand and wrist Fix fingers and palms – AVOID wrists and back of hand When gloves are on, interlock hands above waist level and away from body	Sterile technique: inner surface of wrapper is sterile Placing fingers in the cuff keeps sterile to sterile Hitchhiker technique: Keeping thumb extended while glove is being applied protects thumb from contamination Interlocking prevents accidental contamination of gloved

Revised by IM2 Faculty, Covenant School of Nursing, Nov 2015, Apr 2017
Reviewed: Feb 2021
Revised: Feb 2018
CHS Policy: Latex Allergy Management, revised Aug 2015
pp.467-476; 481-482 Potter and Perry, 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Sterile Moist Dressing Change

The aseptic cleaning of a wound and the peri-wound area, moist packing the wound, and then redressing the wound

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Remove old dressing and packing without contaminating wound
5) Perform wound care
6) Apply dressing

Based on the COPA Model by C. Lenburg

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Right patient, right dressing	
2) Gather supplies	Sterile gloves Sterile dressing Sterile sodium chloride Sterile 4x4 gauze 10 pack Sterile 4x4 gauze 2 pack Sterile cotton-tipped applicators Sterile suture removal set Tape Measuring device	 Paper tape for elderly or sensitive skin
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Remove old dressing	Pre-medicate for pain if indicated Clean work surface with antiseptic Perform hand hygiene and don clean gloves Loosen tape to release dressing Grasp dressing on outer surface and remove Remove any packing without contaminating wound, use forceps if needed Discard dressing and gloves Assess for odor, color, eschar, drainage Perform hand hygiene	Patient comfort May require adhesive remover May need to loosen packing in wound with sterile sodium chloride
5) Clean wound	Prepare sterile field and supplies Open 4x4 gauzes and moisten with sterile sodium chloride Open remaining sterile items Clean wound bed with sodium chloride moistened gauze in a smooth motion without lifting gauze, clean center of wound first, then work outwards (“clean” to “contaminated” concept), using new gauze as needed during process Measure depth, length, width of wound with sterile cotton-tipped applicator without contaminating wound	 If wound is round, start in the middle and work out. If wound is a long line, clean down the center of the wound in one stroke, then with new gauze clean inside border of wound, and then with second gauze, clean the other side of wound. Use new gauze to clean the peri-wound area

Sterile Moist Dressing Change

The aseptic cleaning of a wound and the peri-wound area, moist packing the wound, and then redressing the wound

6) Pack and dress wound	Remove excess moisture from a 4x4 gauze Fluff gauze lightly and place in non-dominant hand Grasp end of gauze and gently feed into the wound base using forceps or cotton-tipped applicator – avoid touching skin with packing Pack semi-loosely, covering all wound surfaces with moistened gauze Apply dry 4x4 gauze to cover wound Apply final surface dressing and secure Label dressing with date, time, and initials	Dragging gauze over the skin surface and then placing in wound will contaminate the wound Cover wound surface only, moist gauze on skin will macerate
7) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Reviewed: IM2 Faculty, Apr 2021
Revised: IM2 Faculty, Feb 2018
CHS Policy PX22, Sterile Dressing Change, Revised 2015
pp. 1228-1230, Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

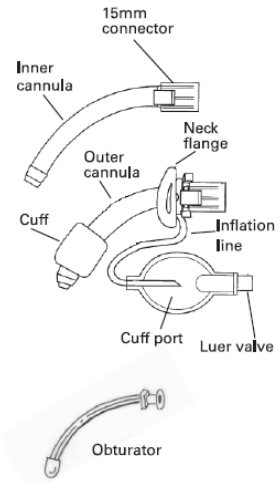
Tracheostomy Care with Suctioning

The aseptic suctioning of a tracheostomy followed by cleaning of the peristomal area and replacing the inner cannula

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Suction patient
5) Aseptically replace inner cannula
6) Perform peristomal care

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify protocol	Performed each shift and prn	Requires aseptic technique
2) Gather supplies	Sterile suction kit Sterile normal sodium chloride 4x4 gauzes Cotton-tipped applicator Trach ties Trach dressing, if present	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Suction trach 	Ensure suction is on Clean work surface with antiseptic Perform hand hygiene Open kit and don sterile gloves Connect catheter to suction line Lubricate catheter tip with sodium chloride Pass catheter tip into trachea and gently advance until patient starts coughing or resistance is met Withdraw catheter about ¼ to ½ inch and begin suctioning intermittently as catheter is withdrawn – not to exceed 10 seconds Apply supplemental oxygen, before, between, and following suctioning Assess lung sounds and repeat if needed	Do NOT force catheter against carina, can erode the tissue Patient can become hypoxic rapidly with suctioning Oxygen supplementation helps alleviate hypoxia
5) Change inner cannula	Oxygenate Open inner cannula package Support neck flange of tracheostomy with one hand, unlock and remove inner cannula with the other Use finger and thumb to pick up sterile inner cannula, grasping only on connector Aseptically insert sterile inner cannula Lock into position Replace oxygen source	
6) Clean and dress peristomal area	Remove old dressing, if present	Not all tracheostomies have a dressing

Tracheostomy Care with Suctioning

The aseptic suctioning of a tracheostomy followed by cleaning of the peristomal area and replacing the inner cannula

	Clean site with normal sodium chloride using gauze and swabs with clean technique Pat dry Repeat behind bottom of flange Dress with fenestrated dressing as required	Sodium chloride is gentle on skin Cannot move in a circle due to ties or sutures Drying helps prevent maceration
7) Replace trach ties	If patient is 3 days post-tracheotomy, replace ties Place new ties **BEFORE** removing old ties or have second person hold tracheostomy in place securely on neck while ties are replaced Secure new ties snugly, allowing clearance of 1 to 2 finger widths between neck and tie Provide oral care daily for the patient with a tracheostomy	Removing ties before stoma is well-established puts patient at risk for loss of airway Prevents risk of coughing out trach during procedure Prevents pressure or friction injury on neck from ties
8) Complete procedure	Dispose of used supplies Perform hand hygiene Record results and report if indicated **Ensure tracheostomy kit with obturator is readily available at bedside and is correct size**	

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: Apr 2016, Apr 2017, Feb 2018
Reviewed: Mar 2019, Apr 2021

pp. 1209-1211, Smith: Clinical Nursing Skills: Basic to Advanced Skills, 9th ed., 2017
pp. 736-741, Wilkinson: Fundamentals of Nursing, Vol. 2. 3rd ed., 2016
Dawson, Essential principles: tracheostomy care in the adult patient., BACCN, 2014
CHS Policy, CC22, Tracheostomy Care and Changing of Tracheostomy Tube, 2015
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020

Urinary Catheter Insertion – Indwelling and Straight

The insertion of a catheter into the bladder to either drain continuously or to obtain a sterile urine specimen

Critical Elements

1) This procedure is NOT delegated to UAP
2) Gather supplies and prepare workspace
3) Follow Universal Competencies
4) Position patient for procedure
5) Prepare and maintain sterile field
6) Aseptically insert catheter

Based on C. Lenburg COPA Model

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Requires an order	Requires aseptic technique
2) Gather supplies	Catheter insertion kit containing a sterile Indwelling Urinary Catheter with drainage bag Extra pair of sterile gloves (if needed) Clean gloves	Choose appropriate kit In the adult, 14-16 Fr. is a good starting place for size selection
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Prepare for care	Clean work surface with antiseptic Perform hand hygiene Don clean gloves Assess bladder Position patient (dorsal recumbent) and assess perineum and pre-clean if needed Open outer packaging of urinary catheter kit and remove tray Position catheter tray between patient's legs Arrow on tray should point toward patient Cleanse genitalia Remove soiled gloves	 Use soap and water if excessive soiling is present Placing tray between legs may not always be feasible Use soap wipes included in kit
5) Prepare for catheter insertion	Perform hand hygiene Open catheter tray to create sterile field Don sterile gloves Position under pad beneath the patient Position fenestrated drape over external genitalia Advance the tray toward the patient so that the outer wrap overlaps the under pad Prepare items in numerical order as listed on the tray 1. Open povidone-iodine 2. Pour solution onto the 3 foam swab sticks 3. Attach syringe filled with sterile water to inflation port	 **Place without crossing over sterile field**

Urinary Catheter Insertion – Indwelling and Straight

The insertion of a catheter into the bladder to either drain continuously or to obtain a sterile urine specimen

	4. Locate syringe with lubricant. Pour all of lubricant into tray 5. Remove Foley catheter from the blue wrap and place in lubricant Clean peri-meatus area with antiseptic solution:	
	Female: With non-dominant hand, expose meatus by spreading labia. Maintain position throughout procedure.	Fully exposing meatus prevents contamination
	Clean inner aspect of labia minora farthest from you with a downward stroke. Discard swab	Closure of the labia requires cleaning procedure be repeated
	Repeat on labia minora closest to you Repeat in middle area between both labia minora	
	Male: If not circumcised, retract foreskin with non-dominant hand. Clean beginning at meatus and work in a circular motion to the base of the glans. Repeat with remaining swabs	If foreskin is retracted, it MUST be returned to original position when procedure is completed to prevent necrosis of the penis
6) Insert catheter	Hold lubricated catheter approximately 2 inches from tip and insert catheter:	
	Female: Aim upward until meatus is entered, then insert catheter using gentle pressure downward as it is advanced	Aiming upward to enter female meatus helps prevent entry into the vagina
	Advance half the length of the catheter into the bladder	Advancing half the length of the catheter into the bladder ensures balloon is fully in bladder Urine should return before catheter is advanced to half-length
	Male: Hold penis at 90-degree angle and insert catheter in a downward direction and advance catheter to the Y-section	Holding catheter 2 inches from meatus will allow for additional advancement of sterile catheter if required
	Stabilize catheter with thumb and finger of non-sterile hand	
	Inflate balloon to volume directed on catheter	Monitor patient response to ensure inflation of balloon does not produce pain
	Pull back on catheter gently until resistance is met	
	Attach catheter to urinary catheter stabilization device before applying to extended leg	May use drapes to clean off lubricant from gloves
	Secure drainage bag on bed frame below level of bladder and off the floor	Minimizes possibility of dislodgment, reduces motion of catheter in urethral tract, reducing infection risk
	Measure urine and document	

Urinary Catheter Insertion – Indwelling and Straight

The insertion of a catheter into the bladder to either drain continuously or to obtain a sterile urine specimen

7) Removal of Catheter	Don clean gloves Empty drainage unit and measure output Insert 10 mL syringe into balloon port of catheter at Y-site Allow fluid to fill syringe passively. May aspirate to ensure balloon is fully deflated Remove catheter and clean genitalia Dispose of contaminated supplies Provide urinal (male) or specipan (female) for measuring voids after removal Record results and report if indicated	Fluid must be removed from balloon before removal to prevent urethral trauma Voiding should occur within 4 – 8 hours

Created by IM2 Faculty, Covenant School of Nursing, Nov 2015
Revised: IM2 Faculty, Apr 2016, July 2016, Apr 2017, Feb 2018
Reviewed: Feb 2021
CHS Policy: Indwelling and Straight Urinary Catheters: Revised Mar 2015
pp. 1119-1125; 1131-1142, Potter and Perry 9th ed., 2017
HESI: Clinical Skills for Nursing Collection/Essentials Collection, 2020
ud-surestep-in-service-bmd-tray-0717-0128: https://vimeo.cog1m/203967103
Bard Surestep Foley Catheter Utilization & Introduction video
Bard Surestep Foley Catheter Insertion, Male Catheterization
Bard Surestep Foley Catheter Insertion, Female Catheterization

Wrist Restraint Application for Non-Violent, Non-Destructive Behavior

Critical Elements

1) The skill of assessing a patient's behavior, orientation to environment, need for restraints, and appropriate use is NOT delegated to UAP. The application and routine checking of restraints CAN be delegated to certified UAP
2) Follow Universal Competencies
3) Assess patient's behavior
4) Apply restraints safely
5) Assess patient response and need for continuation of restraint

Nursing Intervention Instruction

Steps	Key Points	Rationale
1) Verify orders	Order must include purpose, type of restraint, location, and time or duration of restraint	The procedure is invasive and must have an order
2) Gather supplies	Review manufacturer's instructions for restraint application before entering patient's room. Determine most appropriate size restraint	
3) Follow Universal Competencies	Introduce self Perform hand hygiene Identify patient Teach patient	
4) Assess patient's behavior	Observe for confusion; disorientation; agitation; restlessness; combativeness; inability to follow directions or repeated removal of tubing, dressing, or other therapeutic devices. Determine if less restrictive measures are possible.	Patient Safety, Patient Right for least restrictive type of restraint
5) Apply restraints	Adjust bed to proper height and lower side rail on side of patient contact Place patient in lateral position or with head of bed elevated (unless contraindicated) rather in supine position Be sure patient is comfortable and in proper body alignment Inspect area where restraint will be placed. Note if there is any nearby tubing or device. Assess condition of skin, sensation, adequacy of circulation, and range of joint motion Pad skin and bony prominences, as necessary, under restraint Apply proper size wrist restraint made of soft, quilted material or sheepskin with foam padding. Wrap limb restraint around wrist with soft part toward skin and secure snugly (not tightly) in place with Velcro strap or quick	Patient Safety Patient with wrist restraints is at risk of aspiration if positioned supine. Restraints may compress or interfere with functioning of tubing or devices. Assessment provides baseline to monitor patient's response to restraint Reduces friction and pressure from restraint to skin and underlying tissue Tight application interferes with circulation and potentially causes neurovascular injury

Wrist Restraint Application for Non-Violent, Non-Destructive Behavior		
	release buckle. Insert two fingers under secured restraint Attach restraint buckle and straps to bedframe that moves when bed is raised or lowered. Do NOT attach to side rails. Be sure straps are secure Secure restraint with quick release buckle or tie straps in a quick-release method. Do NOT tie strap in a knot. Be sure the buckle is out of patient's reach Assess for proper placement of restraint, including skin integrity, pulses, skin temperature and color, and sensation of restrained body part. Double check and insert two fingers under secured restraint After application, evaluate patient every 15 minutes – 2 hours or continually as indicated by patient condition. Remove restraint at least every two hours and reposition patient, providing comfort and toileting measures. Reapply restraints based on assessment findings Secure call light within reach Place bed in lowest position	Properly positioned strap does not tighten and restrict circulation when bed is raised or lowered Allows for quick release in an emergency Provides baseline data if injury develops from restraint Frequency of monitoring patient depends upon patient condition, cognitive status, and risk associated with chosen intervention. Frequent evaluation prevents injury and ensures removal of restraint at earliest possible time. Provides for patient's basic needs and determines need for continuation
6) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM6 Faculty, Covenant School of Nursing, Aug 2016
Reviewed and revised by IM2 Faculty, Nov. 2016, Feb 2018, Mar 2019
Reviewed: Apr 2021
Presentation: What Hospitals Need to Know About Restraint and Seclusion, Sue Dill Calloway RN, Esq. CPHRM, CCMSCP, MSN, JD, 2016
CHS Policy: PC 07 Restraint & Seclusion, 2014
CHS Policy: V-E-1, Restraints Requirements & Documentation, 2014
pp. 391-403, Potter and Perry 9th ed., 2017

Genitourinary Comprehensive Assessment: Adult
Focused assessment of the structures of the urinary system

Critical Elements

1) This procedure is NOT delegated to UAP
2) Follow Universal Competencies
3) Perform nursing health history that prompts focused assessment
4) Perform light palpation above the pubis synthesis for presence of bladder distention
5) Inspect perineal area
6) Interview patient regarding urinary habits

Based on C. Lenburg's work in the COPA Model

Nursing Intervention Instruction

Steps	**Key Points**	**Rationale**
1) Follow Universal Competencies	Introduce self Perform hand hygiene Don gloves if indicated Teach patient	
2) Palpate for bladder distention	Use light palpation to assess the area directly above the pubis symphysis Palpate for tenderness, pain, masses, distention, and guarding	Palpation of bladder indicates a distended bladder An empty bladder will not be felt during examination
3) Inspect perineal areas	Inspect urethral meatus and perineal area	Look for redness, skin breakdown, swelling, abnormalities, presence of urinary catheter, presence of urine, stool, infection
4) Interview patient about urinary habits	Ask about: Normal pattern/History Frequency Incontinence Hesitancy Appearance/Odor Recent Changes Typical Fluid intake	History of urinary habits or changes to regular urinary routine can indicate poor genitourinary function Painless hematuria can indicate bladder cancer
5) Complete procedure	Perform hand hygiene Record results and report if indicated	

Created by IM1 Faculty, Covenant School of Nursing, Jan 2019
Reviewed: April 2021
Fundamentals of Nursing (9th ed.), Potter & Perry, 2017
HESI Skills Module, Head to Toe Examination of the Adult, 2019
HESI Clinical Skills Module, Assessing the Female Genitalia and Rectum, 2019
HESI Clinical Skills Module, Assessing the Male Genitourinary, Rectum, and Prostate, 2019

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