

## **Preface**

***It is privilege to participate in this project. I began to ask myself about inspiration to write this procedure file. This procedure record is for multipurpose health worker (Female) at 10+2 level students. The main objective of writing this practical manual is to develop skill, under scientific principles in giving care to the patient to render basic Nursing Care.***

***This procedure manual presents the basic Nursing core and specific Nursing core step by step in performing the activities Nursing responsibilities while doing the procedures.***

***It is my mission and hope that this procedure manual will help the students to better performance of nursing procedures.***

***I extend my thanks to our faculty, who helped in brining up this procedure manual to this shape. This procedure manual dedicated to the all Nursing Students.***

**Smt. D. SAROJINI.,  
B. Sc Nursing P.G.D.H.A.  
PRINCIPAL  
SCHOOL OF NURSING,  
GANDHI HOSPITAL, SECUNDERABAD.**

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## STANDARD ABBREVIATIONS AND SYMBOLS

| ABBREVIATION | DERIVATION      | MEANING                  |
|--------------|-----------------|--------------------------|
| aa           | ana             | of each                  |
| a.c.         | ante cibum      | before meals             |
| ad           | ad              | to up, to                |
| ad lib.      | ad libitum      | freely as desired        |
| aq.          | aqua            | water                    |
| aq. dest.    | aqua destillata | distilled water          |
| b.i.d.       | bis in die      | two times a day          |
| b.i.n.       | bis in noctis   | two times a night        |
| c.           | cum             | with                     |
| caps         | capsula         | capsule                  |
| comp.        | compositus      | compound                 |
| dil.         | dilutus         | dilute                   |
| elix.        | elixir          | elixir                   |
| ext.         | extractum       | extract                  |
| fid.         | fluidus         | fluid                    |
| Ft.          | fiat            | make                     |
| Gm.          | Gramme          | gram                     |
| gr.          | granum          | grain                    |
| gtt.         | gutta           | a drop                   |
| h.           | hora            | hour                     |
| h.s.         | hora somni      | hour of sleep (bed time) |
| M.C.         | misce           | mix                      |
| m.           | minimum         | a minim                  |
| mist.        | mistura         | mixture                  |
| non rep.     | non repetatur   | not to be repeated       |
| noct.        | nocte           | in the night             |
| O.           | octarius        | pint                     |
| ol.          | oleum           | oil                      |
| o.d.         | omni die        | every day                |
| o.h.         | omni hora       | every hour               |
| o.m.         | omni mana       | every morning            |
| o.n.         | omni nocte      | every night              |
| os           | os              | mouth                    |
| oz.          | uncial          | ounce                    |
| p.c.         | post cibum      | after meals              |
| per          | per             | through or by            |
| pil.         | pilula          | pill                     |
| p.r.n.       | pro re nata     | when required            |

|              |                  |                        |
|--------------|------------------|------------------------|
| q.h.         | quaque hora      | every hour             |
| q.2h.        |                  | every two hours        |
| q.3h         |                  | every three hours      |
| q.4h         |                  | every four hours       |
| q.i.d.       | quater in die    | four times a day       |
| q.s.         | quantum sufficit | as much as is required |
| Rx           | recipe           | take thou              |
| S.           | sine             | without                |
| Sig. or S.   | signa            | without                |
| S.O.S.       | siopus sit       | if necessary           |
| sp.          | spiritus         | spirits                |
| ss.          | semis            | a half                 |
| stat.        | statim           | immediately            |
| syr.         | syrupus          | syrup                  |
| t.i.d.       | ter in nocte     | three times a night    |
| tr.or tinct. | tinctura         | tincture               |
| ung.         | unguentum        | ointment               |
| vin.         | vini             | wine                   |

**FUNDAMENTALS**

**OF**

**NURSING**

**MINIMUM STANDARDS OF PERFORMANCE**  
**IN NURSING ARTS LABORATORY**

- I. For the first laboratory practice after class-room demonstration, the student should have.
  1. Knowledge of equipment needed.
  2. Knowledge of procedure-principles, sequence of performance of procedure and standards of performance expected.
  3. Knowledge of underlying principles and application of the same.
  4. Appreciation for neatness of work areas and completed work.
  
- II. After the first laboratory practice under supervision, the student is expected to practice individually in the free time in the laboratory until she has developed skill in performing and handling the equipment she should be able to perform the procedure within a period specified by the instructor and at the designated standard.
  
- III. For the designated procedures, by the date specified by instructor, student must be ready to give a satisfactory return demonstration before they may be allowed to perform the procedure on the ward.
  
- IV. Satisfactory performance indicates:
  1. Knowledge and application of underlying scientific principles
  2. Knowledge of equipment needed.
  3. Knowledge of sequence of performance.
  4. Ability to adopt procedure to the needs of individual patients.
  5. Gentle and considerate attention to handling the patient.
  6. Economical in time, effort and materials.
  7. Implementation of good body mechanics for the patient and the Nurse.
  8. Neatness in work area and completed work.
  9. Accurate concise, clear, complete recording and reporting.

## **Hand Washing Technique** **(Medical Asepsis)**

### **PURPOSE:**

To cleanse the hands to minimize the cross infection to an each patient self and in the environment for aesthetic sense.

### **REQUIREMENTS:**

1. Soap in a dish
2. A sink equipped with a tap
3. Towel
4. A nail brush and hand brush
5. A nail file
6. A container with disinfectant
7. A timer.

### **HAND WASHING TECHNIQUE:**

1. Stand well away from the sink, turn on the tap and adjust its flow.
2. Wet hands, for arms and, elbow thoroughly. Holding them down ward over the sink to allow the water to run toward the finger tips.
3. Apply enough soap on hands and fore arms to make a good lather.
4. Rinse soap cake and replace to the soap dish.
5. Scrub each hand with the other creating friction by interlacing the fingers and moving the hands back and forth. Continue scrubbing for 1-2 minutes starting from the areas around the finger nails in

## N.B.

1. Washing of the hands should be done for 2 to 3 minutes with a brush if the hands are grossly contaminated.
2. A nail file is used to clean the sub ungula area, if the nails are dirty.
3. Use paper pieces if sink is used with and controlled tap to open or to close the tap, depending up on the areas whether it is clean or contaminated.
4. Scrubbing the hands with a brush is not re-commended for medical asepsis because brushing may force some bacteria into the skin crevices while others are being brushed out.
5. Always use running water as it removes the bacteria and dirt along with soap mechanically.
6. If a tap is not available an assistant is needed to pour the water for hand washing.

**GENERAL RULES OF CLEANING**

1. Warm water dissolves grease easily and dirt, so it is more effective in cleaning than the cold water.
2. Cold water dissolves aluminous water therefore articles soiled with body wastes, blood and so forth should be rinsed in cold water before being washed in hot soapy water.
3. Soap lowers the surface tension of water and therefore should be used in sufficient amount to remove dirt.
4. hold the cleaning cloth in such a manner so as allow a large area of cleaning as far as possible at one time.
5. Friction will speed the removal of dirt, Friction is accomplished by the movement of the cleaning equipment over the surface. Cleaning cloth spread over the palm of the hand will facilitate this. Mild abrasives can be used to further increase the friction.
6. Start to clean area closer to you and work away from yourself start clean are a near t far.
7. Proceed from the higher are to floor.
8. All surfaces of the articles should be cleaned. This includes creases and crevices etc.
9. The movement of cleaning should be so organized as to avoid cleaning the same surface more than once.
10. Maintaining articles adequately dry will discourage the growth of the micro-organisms replaced.
11. Keeping the living place clean and free from waste food will help to keep the vermin animal, pets, away. Food should

be stored and kept in reserved containers. The chief danger from pets is its spread of communicable disease.

12. Sun light and ultra violet rays help to control the bacteria in the air and thereby on the articles which are exposed to Sun light for 6-8 hours.

## **BED UN-OCCUPIED MAKING OF**

### **PURPOSE:**

To make bed which is comfortable and safe for the patient neat, economical in time and effort.

### **EQUIPMENT**

Basin with water and a duster  
2 (two) sheet  
Draw Mackintosh  
Draw sheet if required  
Blanket if necessary  
Counter pane and  
Pillow case

### **PROCEDURE**

1. Collect the cleaning equipment and clean line. Bring to the bedside and place in the stool or chair in the order of use.
2. Dust the bed and mattress.
3. Place the sheet on the mattress so that the centre fold is in the centre of the bed. Unfold the sheet, keeping the right side of the upper most.
4. tuck top of the sheet 6 (six) inches under the top of the mattress. Make mitered corner at the top edge of the mattress on the side nearest to the nurse.
5. Pull the sheet to the feet end of the bed. If long enough, tuck under the mattress. Make mitered corner on the side of the mattress. Tuck the sheet at the sides of the mattress.
6. Centre the mackintosh on the mattress with the upper edge about 16 (sixteen) inches from the top of the mattress.

Centre the draw sheet over the mackintosh and tuck in at the sides of the mattress.

7. Centre the top sheet on the foundation with the wrong side of the upper most and place the top sheet hem at the edge of the mattress. Pull the sheet to the foot end of the bed and make the mitered corner at the lower edge of the mattress on the side nearest to the nurse.
8. Centre the blanket on the top sheet. Place the upper edge of the blanket 6 to 8 inches below the top of the bed. Fold the top sheet over the blanket. Tuck in the lower edge of the blanket under the mattress. Make the mitered corner.
9. Centre the counter pane on the bed. Place the upper edge of the counter pane even with the top edge of the mattress. Pull the counter pane at the feet end of the bed. Tuck in and make the mitered corner. Leaving the sides of the counter pane hanging free.
10. Go to opposite side of the bed. Fan fold each piece of linen at the centre of the bed in order. Repeat the steps from 4 to 8.
11. Return the opposite side of the bed. Cover the pillow with the pillow case. Adjust the pillow case to the size of the pillow. Place one pillow on the bed with open end facing away from the ward entrance.
12. A line the cot with other cots in the ward.

**Note :-**

1. At Govt. General Hospital, Kurnool, proceed through step no. 7. Then if needed centre the blanket fold in quarters horizontally at the feet end of the bed with the folded edge about 4 inches above from the edge of the mattress. Tuck the upper quarter of the blanket under the mattress make mitred corner at the edge of the mattress and tuck the blanket under the mattress at the side edge of the bed. Repeat this step on the opposite side of the bed. No counter pane is used on the bed.
2. For remaking the bed :
  - a) Place stool chair at 45 angel of the bed.
  - b) Unstuck the bed linen from all sides and place pillow on the school or chair.
  - c) Fold the linen from the head end to the foot end.
  - d) Fold the counter pane, Blanket and top sheet in quarters and place them on the stool or chair one by one with the open ends away from the ward entrance.
  - e) Dust the draw sheet and draw mackintosh, fold and remove the remaining bed linen one by one and put them on the stool or chair.
3. For admission bed:
  - a) Fan folds the top linen at the foot end of the bed.
  - b) Use long bed mackintosh and two sheets.
4. Fracture bed: Use fracture bed or wooden boards and firm mattress.
5. When it is not desired to put the top linen on the patient directly eg burn cases or the patient is unable to bear the weight of the top linen then place the top linen over the bed cradle.
6. To keep the patient warm enough use extra flannel blankets.

## **SPECIAL MOUTH CARE**

### **PURPOSE:**

1. To keep the mouth clean and moist
2. To refresh the patient (to prevent sores and mouth odours)

### **INDICATED:**

Every 2 to 4 hours for the patients who have fever, injuries, surgery, inflammation or nothing by mouth, who are un-conscious of seriously ill.

### **EQUIPMENT:**

A tray containing:  
Cotton swabs 8-10  
Potassium permanganate solution 1 in 6000.  
Salt and soda-bi-carb in a packet.  
Bore Glycerine  
Feeding cup  
Artery forceps  
Kidney tray-deep and large  
Treatment mackintosh and towel  
Wrapped tongue deposer.  
Small bowl  
A glass of water. Paper bag.

### **PROCEDURE:**

1. Turn the patient to the side.
2. Place treatment mackintosh and towel under the chin and over the bedding.
3. If the patient has his own brush and paste then use it for the help less patient or patients who have mouth injuries. Surgery unconscious or inflammation use the artery forceps, cotton swabs and salt for cleaning the teeth with circular movements.

4. Hold the kidney tray under the patients mouth while patient cleanse his teeth. If the patient is unable to help him self, then perform all the steps. Use wrapped tongue depressor for cleaning the tongue and holding the mouth open.
5. Remove the tooth brush rinse and place on the locker.
6. Have the patient rinse its mouth with potassium permanganate solution followed by clean water.
7. Remove kidney tray.
8. Dry the lips and chin with towel.
9. Apply boro-glycerine to the lips and gums if needed.
10. Leave the patient comfortable – remove the equipment to the utility room-dirty of the mouth.

Example:

| Date & Time          | Diet | Medication     | Nursing Note                             |
|----------------------|------|----------------|--|
| 29-6-05<br>8-00 a.m. |      |                | Special mouth care lips dry.<br>To lips. |
|                      |      | Boro Glycerine | Satish                                   |

#### **CARE OF THE EQUIPMENT:-**

1. Rinse tooth brush under cold running water. Return to the patients locker.
2. Wash equipment –Artery forceps, feeding cup and bowl with soap and water boil for 10 minutes, dry and replace.

**Note:-**

1. For the patient who are un-conscious or seriously ill and who have mouth injures surgery or inflammation use the artery forceps, for cleaning the teeth.
2. If a patient can do the procedure himself arrange the articles at a convenient position. Let the patient help himself and encourage him to do so.

**MORNING & EVENING CARE (A.M. AND P.M. Care)****PURPOSE:**

1. To refresh and prepare patient for break fast.
2. To relax and prepare patient for the night.

A.M. care is indicated for all the bed patients upon awakening and before break-fast. P.M. care indicated for all the bed patients and newly convalescent patients.

**EQUIPMENT:**

1. Half full basin of warm water.
2. Patient tooth brush, tooth paste or salt.
3. A tray containing.  
Soap in soap dish  
Feeding cup with water  
Kidney tray  
Mackintosh  
Towel and wash cloth.  
Comb  
Spirit and powder

**PROCEDURE:**

1. Offer bed pan or urinal
2. Give oral hygiene
3. Wash face, hands and back
4. Comb hair
5. Straighten bed linen
6. Leave the bedside unit clean and neat.

**NOTE**

1. Morning care is given by the night duty nurse.  
Evening care is given by the evening duty nurse

## **BED BATH**

### **PURPOSE:**

1. To remove accumulated waste products and dirt from the skin
2. To stimulate the functions of the skin
3. To stimulate circulation.
4. To smooth and refresh the body.
5. To observe and to detect abnormalities.

### **REQUIREMENTS:**

1. A. tray containing: Salt, spirit or skin lotion, powder, comb oil, Kidney tray, Hand brush, pair of scissors and nail file or nail cutter, soap in soap dish.
2. Basin.
3. Jug (2)
4. Bucket
5. Patients clothes and linen for bed making as required.
6. Big News paper.

### **PROCEDURE OF ACTION:**

1. Collect articles, take to bed-side, screen the patient (and provide privacy), Explain the procedure to the patient.
2. Place the patient in a comfortable position.
3. Give mouth care if needed.

4. Remove the blanket and counter pane, fold and place over the foot end of the bed, if weather permits.
5. undress the patient.
6. Take water half full in a basin
7. Bath towel, sponge bag (2).

**NOTE:-** Water is to be changed whenever necessary ring bath when it is dirty or cold.

8. Place towel over the chest. Wash rinse and dry the face, ears and neck.
9. Place towel under the fore arm, wash rinse and dry fore arm and upper arm place basin on towel. Dip the hand in water wash, rinse and dry . Repeat for the arm nearest to the nurse.
10. Fold the top sheet up to the waist. Covering the chest with towel. Wash, rinse and dry the chest.
11. Fold the top sheet up to pubis. Wash rinse and dry abdomen. Replace the sheet.
12. Place the towel under the far leg. Wash rinse and dry the thigh and the leg repeat for the leg nearest to the nurse.
13. Place basin on the towel. Flex the far knee and place the foot in the basin wash with the brush, rinse and dry, Repeat for the foot nearest to the nurse.
14. Turn the patient to the side facing away from the nurse, if the assistance is available, otherwise turn the patient to the side facing towards the nurse, place the towel on the bed along the side line of the back. Wash, rinse and dry back and rub with spirit or skin lotion or powder or oil depending upon the condition of the skin and policy of the institution.
15. Make half of the bed.

16. Let the patient wash, rinse and dry the pubic area.

**NOTE:** If patient is unable to care for herself the nurse will cleanse the pubic are.

17. Help the patient to put on clothes.
18. Complete the bed.
19. Assist with the care of hair and nails as needed.
20. Remove screen.
21. Take equipment for cleaning to the dirty area. Wash dry and replace, boil and wash the sponge bags. Dry and replace them.
22. Records observations and reactions of the patient.

**NOTE:**

1. For incontinent patient –clean the patient first. Wear gloves for cleaning the patient Discard the sponge-bag and gloves wash hands, clean the basin. Then proceed for the bath.
2. For admission bath:
  - Use a long bed mackintosh and two sheets.
  - Fan fold the top bed clothes at the foot-end of the bed.
  - Spread the long bed mackintosh and a sheet over foundation of the bed.
  - Cover the patient with the other sheet.
  - After the bed bath remove the long bed mackintosh and both the sheets.
  - Put the patient on the clean bed.

## **PEDICULOSIS TREATMENT**

### **PURPOSE:**

To destroy pediculi and nits in the hair.

### **EQUIPMENT:**

- screen
- A Tray containing
- Comb
- Treatment mackintosh
- Triangular Mackintosh
- Triangular bandage and safety pin
- Kidney tray with 5% Dettol solution
- Few cottons swabs in container & artery forceps if available
- A bowl with medicine 68% Benzyl Benzoate or 10% Dettol solution or kerosene oil with sweet, oil or 10% acetic acid or hot vinegar.
- Paper bag – Vaseline and card board spatula.

### **PROCEDURE:**

1. Explain treatment to patient.
2. Screen the patient
3. Place treatment mackintosh under head and cover with triangular bandage with the medicine at convenient place.
4. Apply Vaseline around the hair line.
5. part the hairs in two groups directing them from fore- head to neck line part the hairs at the interval of ½ inch, apply medication to the scalp using cotton swabs.

6. Return the comb back to the kidney tray.
7. Cover hairs completely with triangular bandage and secure with safety pin.
8. Roll mackintosh and place on the tray.
9. Inspect the bed linen and uniform for pedicel. If found, discard them into the disinfectant.
10. Remove the tray to the utility room.
11. Put the paper bag into waste container – wash the comb with soap and water – place the comb in the kidney tray and immerse it into 5% Dettol solution for 30 minutes.
12. Inspect the tray and other articles for pediculi wash with soap and water then dry and replace.
13. Wash hands.
14. Records the treatment.

| Date & Time | Diet       | Medication           | Nursing Note           | Sign. |
|-------------|------------|----------------------|------------------------|-------|
| 24-4-72     | 11.00 a.m. | 68% Benzyl Benzoate  | To the scalp           |       |
| 27.4.72     | 11.00 a.m. | Shampoo in the scalp | Few nits still present |       |

**NOTE:-**

1. After 24 hours shampoo the hairs and put the triangular bandage for laundry.
2. To prevent the nits hatching, dress the hairs with a fine comb for eight days regularly since nits take eight days to hatch.
3. Repeat the whole treatment if necessary.
4. If Benzyl Benzoate is used treatment should not be repeated within a week.
5. Use artery forceps or brush to apply medication if they are available.
6. To remove then its, soak the hair in the hot vinegar to the capacity of endurance of the patient and let the hairs remain reached for two hours, then give shampoo.

## **MUSTARD PLASTER**

**PURPOSE:** To relieve chest congestion and pain by the application of counter irritant

**EQUIPMENT:**

Tray

Dry mustard

Flour

Small container cotton balls moistened in oil.

Bowl

Spoon

Spatula

Fennel size of the plaster (or cotton pad)

Plastic piece size of the plaster

Piece of lint and gauze (the size according to area of application)

Binder and safety pins

Hot water bottle- uncovered- temp not to exceed 150<sup>0</sup>.F

Pitcher or tepid water.

Kidney tray.

**PROCEDURE:**

Take to the bedside, tray containing, binder safety pin flannel or cotton pad, plastic piece lubricant and kidney tray.

Screen the patient and explain procedure

Apply binder but do not pin

Prepare poultice

One parts dry mustard                      Note: for sensitive skin.  
Four parts flour                              Mixture 1:5  
Tepid water to make a paste for children mixture 1: 6-10  
Spread into rough surface of piece of lint resting on hot water bottle  
cover with gauze and fold edges to prevent any leakage.  
Cover with plastic and flannel and take to bedside  
Apply plaster to dry skin  
Cover with plastic and flannel  
Secure in place with binder and pin  
Lift the corner of the plaster every 3 or 4 minutes to  
Minutes to inspect skin and plastic piece.  
When skin shows a pink flush remove the plaster (usual duration of  
the application is 10-20 minutes)  
Apply oil to the skin  
Cover flannel and reapply binder  
Clean and replace equipment  
Record treatment, time during and condition of skin and other  
response to treatment.  
Kept well covered to prevent chilling.

## **SHAMPOO (HAIR WASH) FOR A BED PATIENT**

### **PURPOSE**

1. To provide cleanliness and comfort
2. To help in eliminating pediculi and comfort
3. To prepare for operating unless it is contra indicated.
4. To prepare for certain diagnostic procedure e.g. E.E.G.

### **EQUIPMENT :**

|  |        |
|--|--------|
| Draw mackintosh  | 1 No.s |
| Kelly pad  | 1 No.s |
| Bath towel   | 1 No.s |
| Small jug  | 1 No.s |
| Soap   |        |
| Cotton swabs for ear plugs   |        |
| Wash cloth   | 1 No.s |
| Buckets  | 2 No.s |
| (One with warm water comfortable for the head application 100F to 115F or 44.44 C to 48.1C |        |
| Stool  |        |
| Paper bad and News paper   |        |
| Screen   |        |

### **PROCEDURE :**

1. Explain procedure to the patient
2. Collect equipment, bring to the bed side and arrange at a convenient place.
3. Screen the patient
4. Fan fold blanket half way to the foot end of the bed.
5. Remove all the pillows except one.
6. Place the draw mackintosh and bath towel over the pillow.

7. Place the rolled end of the trough over the pillow and the other end in the empty bucket.
8. Bring the patient's head and shoulders to the edge of the bed.
9. Slip the pillow under –neath the shoulders so that the rolled and fixes under the hollow of the neck of the patient.
10. Plug the ears.
11. Give patient folded moistened wash cloth for covering eyes if desired.
12. Cover the stool with the news paper and put it near the head end of the bed. Place a bucket of water on the stool.
13. Loosen the hair.
14. Wet the hairs thoroughly.
15. Apply soap to the scalp and the hair.
16. Massage well with the finger tips and rinse.
17. Repeat sequence until the scalp and the hair.
18. Rinse thoroughly with water.
19. Squeeze out the water form the hair
20. Remove the e ad and ear plugs.
21. Drop the Kelly pad into the bucket if trough is used open the string-knot, remove the inside towel or paper and drop trough into the bucket.
22. Place patient's head on towel and wrap the head with towel. Put the patient in a comfortable position.
23. Wipe the hair gently with towel.
24. Examine the bed to see whether it is wet, change it if necessary.

25. Clean and replace the equipment.
26. When the hair is dry comb the hair.
27. Record the procedure and reaction of the patient.

**EXAMPLE:**

| Date & Time       | Diet      | Medicines | Nursing Notes   |
|-------------------|-----------|-----------|---|
| 29-4-1971<br>9-30 |           |           | Shampoo in bed,<br>scalp & hair clean no<br>lice found patient<br>felt slightly cold. |
| 10-15a.m.         | Tea 180ml |           | Comfortable in bet,<br>states felling alright<br>shamala.                             |

## After care of equipment

- Wash and dry mackintosh and place over the rod in the bathroom
- Discard the news paper.
- Wash jugs and buckets and replace in the cup board.
- Wash the comb with soap and water, immerse the com in 5% dettol solution for 30 minutes.

**NOTE:-**

Place hot water bottle under the hair in cold weather.

## **ARM SOAK / FOOT SOAK**

### **PURPOSE :**

1. To reduce inflammation
2. To hasten suppuration
3. To relieve pain and congestion
4. To hasten healing.

### **EQUIPMENT :**

If there is a wound usually equipment for sterile dressing plus:

One sterile towel

Tub or basin of suitable size to immerse the part with the prescribed solution draw mackintosh.

Sheet-1

Jug with prescribed solution at 150 or 65.55 c

Extra pillow with rubber cover for the arm-soak. pad to remove the parts from the pressure over the tub or basin rim.

Sterile lotion thermometer.

### **PROCEDURE:**

1. Boil required amount of water in a basin. let it cool 100 F or 44054 C and prepare the solution.
2. Screen the patient and explain the treatment .
3. Position the patient.
4. Place rubber covered pillow, over that place the mackintosh and towel for support of the part.
5. Place tub or basin over the towel.
6. Assist the patient to lower the part in to the based thereby completely immersing the affected area.
7. Place the pad on the edge of the basin to avoid pressure.
8. As solution cools during the treatment, lift the part from the basin

and add hot solution to maintain the temperature at 110 c or 44.44 c.

10. continue the treatment for 30 minutes(or as ordered)
11. remove the basin.
12. dry the part with the towel.
13. leave the patient in a comfortable position.
14. clean and replace the equipment.
15. record.

**Time treatment.**

In nursing notes .nature and temperature of the solution, duration, condition of the affected part,if wound is there amount and kind of discharge observed in the water and response of the patient to the treatment.

**SOLUTION COMMONLY USED:**

1. soda bicarb 10 to 25 gms/gallons of water.
2. normal saline.
3. potassium permengate-1 :10000.
4. magnesium Sulphate 2-5%.

**NOTE:**

1. if there is a wound ,remove the dressing and cleanse the would before immersing the part in the solution.
2. after the treatment. Apply the sterile dressing.
3. pour hot solution into the tub or basin if required away from the eternity to avoid burns.
4. Place the tub on level surface to avoid spilling of water.
5. watch the color of skin carefully for signs of burns.

## **TURPENTINE STUPE**

**PURPOSE:** to stimulate peristalsis and to relieve tympanites, commonly used in pneumonia. and in peritonitis.  
 Contra indications: menstruation. pregnancy, typhoid fever kidney pathology.

### **EQUIPMENT:**

Enamel tray

Medicine glass:                   oil.....4 parts  
   Turpentine....1 part  
   (for sensitive skin for children 5:1  
   not stronger than....6:1)

Kidney basin

Artery forceps and cotton swab

2 stupes (heavy flannel or woolen pieces size to cover abdomen)

1 flannel piece (same size)

1 piece plastic (or any waterproof material) same size

abdominal binder and pins (or scultetus)

bath towel

mackintosh(size-to go around patient)

stupe wringer and poles

treatment basin and rubber

bath basin with boiling water

rectal tube and lubricant

urinal and cover

sheet

### **PROCEDURE:**

Assemble equipment

Place one stupe in wringer and immerse in boiling water

Take to the bedside. a tray containing:

Binder and pins

Bath-towel and mackintosh folded together

Flannel piece and plastic piece. artery forceps and cotton

swab Medicine glass with turpentine-oil mixture

Kidney basin, rectal tube lubricant, urinal and cover

Fanfold upper bedding to public area, replacing with sheet place binder rubber, bath towel under patient.

(binder next to bed)

Apply oil-turpentine mixture

Insert rectal tube, place free end in urinal

Cover patient with the sheet and return to utility room

Wring stupe out of boiling water and remove poles

Carry stupe to bedside in basin covered with rubber

Expose area

Apply stupe as formentation, cover with plastic and flannel.

Bring bath towel and mackintosh up around abdomen and secure with the binder.

Cover the patient

Continue the treatment for 20-30 minutes.

Changing stupes as for fermentations and painting the skin every third application.

## **TEMPERATURE-ORAL, PULSE AND RESPIRATION GROUP TECHNIQUE**

### **PURPOSE:**

- 1.To determine the patients temperature, pulse and respiration.
- 2.To aid in diagnosis and to prevent complications.

### **EQUIPMENT OR REQUIREMENT:**

1.a tray containing:

- 3 jars or glasses containing dettol(1 in 20)
- Covered container or a glass with fresh lint or gauze for clean thermometers.
- 12 thermometers
- Covered container of the cotton swabs.
- Covered container of the cotton soap swabs.
- Kidney tray
- Paper bag
- Chart

### **PROCEDURE:**

1. Keep the tray at a convenient place in the ward.
2. Remove the two thermometers. check that the mercury level reads below 95 F or 35 c
3. remove the two
4. Place the thermometer beneath the tongue of two patients at a time.
5. Count the respiration and pulse for one minute for each patient.
6. Remove the thermometer, wipe with the cotton swab from top of the stem to the bulb of the thermometer, using firm circular movement, read record T.P.R.

7. Remove the thermometer from the second patient's mouth clean read. Count the respiration and pulse record T.P.R.
8. Discards swabs into paper bag, shake the mercury level below 95 For 35 C.
9. Remove the soapy swabs and cleanse thermometers.
10. Discard the swabs into the paper bag.
11. Place used thermometers in the container one. Keep only four thermometers in each container.
12. Repeat the procedure for the rest of the patients. Putting the next four thermometers in the second container and the last four thermometers in the container.
13. When the twelve thermometers are used remove thermometers from the first container wash them under the cold water with the bulb of the thermometer pointing downwards.
14. Place them in the clean container.
15. When all the thermometers have been in the disinfectant solution for 15 minutes, rinse under cold water and place in the covered container, empty the kidney tray, wash rinse and replace on the tray. Refill the containers with swabs and solutions.

**NOTE:**

1. Keep a thermometer in the mouth for 3 minutes. When more accurate temperature is desired keep the thermometer for 5-7 minutes.
2. Used thermometers must be kept in the disinfectant solution for not less than 15 minutes.

3. Not more than two students should use the thermometer tray at a time.
4. The disinfected solution must be changed every 12 hrs wash the container with soap and water, rinse and fresh solution to the containers.
5. Rectal temperature is recorded by writing a circular (O) and oral temperature by a (.)Axially temperature is indicated by writing a letter 'A' near the dot (.A).
6. Dotted line temperature graph sheet indicates variations in temperature with the rigor and the cold sponge, other variations to be recorded in the nurse's notes.
7. Use boiled colled water to prepare 5% dettol solution.

## **COAT TECHNIQUE**

**PURPOSE:** To protect self infection

**REQUIREMENTS:** a clean coat

**COAT TECHNIQUE:**

### **BEFORE ENTERING THE PATIENTS UNIT**

1. Wash hands.
2. Put on coat.
3. Remove watch and fix in the first button hole of the coat.
4. Button the coat from top towards bottom.

### **BEFORE LEAVING HOSPITAL PREMISES**

1. Wash the hands
2. Unbutton the coat from top towards bottom.
3. Wash hands and dry.
4. Remove watch from the button hole of the coat and fix on the wrist.
5. Slip off the coat up to the elbow level by touching the inside of the coat.
6. Remove one hand and hold the coat at the sleeves of the shoulders so as to prevent the loose end of the coat from

touching the floor. remove the second hand. so that the interior of the coat is out.

7. Hold the coat in front with open flaps facing, away from the uniform.
8. Adjust the coat by holding the inside and the fold it vertically into one half away from you.
9. Hold it on left fore-arm.

### **REUSE OF THE COAT**

1. Hold the coat at the sleeves of the shoulders without touching the contaminated side.
2. Unhold the coat by keeping it away from the uniform.
3. wear the coat as per above steps mentioned

## **SURGICAL DRESSING**

### **PURPOSE:**

1. To promote healing of the wound.
  - a) To cleanse the wound.
  - b) To apply pressure to promote haemostatic.
  - c) To prevent further injury and infection and to absorb secretions.
  
2. To provide cosmetic effect.
3. To prevent deformities and loss of function.

### **EQUIPMENT:**

#### **GENERAL TROLLEY CONTAINING**

|  |             |
|--|-------------|
| Sterile dressing sets                  | ....6       |
| Each set consists swabs                | ...6        |
| - dressing gauze                       | ...1        |
| - gauze pad                            | ....1       |
| - dissecting forceps                   | ...3 pair   |
| - bowl                                 | .....1      |
| Sterile cotton balls                   | .....1 pack |
| Sterile suture removal scissor         | ...1 pair   |
| Sterile surgical scissors packs        | ...2        |
| Vaseline, gauze.                       |             |
| Instruments tray containing:           |             |
| Probe                                  | .....1      |
| Director                               | .1          |
| Sinus forceps                          | ....1 pair  |
| Spatula S.S.                           | ...1        |
| Paper bags                             | ...1        |
| - bandages 4"                          | ....6       |
| - bandages 6"                          | ..12        |
| Bottles containing antiseptic solution | ...4        |

|                                      |              |
|--------------------------------------|--------------|
| Antiseptic cream                     | .....1       |
| Bottles containing antibiotic powder | .....1       |
| Bottles with cleansing agent         | .....1       |
| Kidney tray.....6 large              |              |
| Treatment mackintosh and towel       | .....6 large |
| Bandages scissors                    | .....1 pair  |
| Adhesive tape                        | .....1 roll  |
| Normal saline bottle                 | .....1       |
| Large bowls                          | .....6       |
| Safety pins                          | .....6       |

**INDIVIDUAL TROLLEY:**

|                              |             |
|------------------------------|-------------|
| A tray containing            | .....1      |
| Sterile dressing set         | .....1      |
| Sterile spatula              | .....1      |
| Normal saline bottle         | .....1      |
| Bottle with spirit           | .....1      |
| Required medication          |             |
| Bandage                      | .....1      |
| Bandage scissors             | .....1 pair |
| Adhesive tape                | .....1 roll |
| Treatment mackintosh + towel | .....1 set  |
| Paper bag                    | .....1      |
| A bowl with disinfectant     | .....1      |
| Kidney tray                  | ..... 1     |

**ONE NURSE TECHNIQUE****PURPOSE:**

1. Explain procedure to the patient
2. Screen the patient
3. Bring the individual trolley to bed side
4. Expose only the site to be dressed
5. Protect bed linen with mackintosh and towel
6. Place kidney basin with paper bag with in the reach
7. Remove outer dressing with hand and discard it in the paper bag
8. Wash hands and dry.
9. Open the dressing set
10. Arrange the equipment conveniently
11. Moisten the swabs with saline.
12. Remove inner dressing withy one forceps and discard dressing into the paper bag and forceps in to disinfectant.
13. Squeeze out the solution from swab using 2<sup>nd</sup> and 3<sup>rd</sup> forceps.
14. Cleanse the wound thoroughly starting from the center towards periphery, use one swab for each stroke.
15. Cleans the skin around the wound with saline, wipe with dry swabs and clean with spirit.
16. Take the required medication with sterile spatula and spread it in a thin layer over a guaze piece and cover the wound.
17. Apply sterile dressing.
18. Discard used instruments into the disinfectant.
19. Secure the dressing.
20. Remove mackintosh and towel place it on the lower shelf of the trolley.

21. Discard soiled dressing and swabs in to the wash receptacle.
22. Wash hands.
23. Straighten bedclothes, make the patient comfortable.
24. RECORD.

---

| <b>Time</b> | <b>diet</b> | <b>meditation &amp; treatment</b> | <b>Nursing Note</b> | <b>Sign</b> |
|-------------|-------------|-----------------------------------|---------------------|-------------|
| 10am        |             | furacin<br>Ointment<br>Dressing   | wound<br>healing    |             |
|             |             |                                   |                     | D.Reuben    |

---

25. Take the trolley to the work room replace clean articles in general trolley.
26. Discard towel in soil linen box.
27. Wash instruments bowl, kidney tray mackintosh with soap and water, dry and replace.

N.B:-

1. Soiled dressing should never be handled with bare fingers but use forceps or glove in extensive wounds.
2. Disinfect mackintosh and kidney tray if grossly contaminated.
3. Keep sterile safety pins if required.
4. Keep a cheadle forceps in a bottle with disinfectant, if packs are not available.

## **RETENTION ENEMA**

### **PURPOSE:**

1. To obtain the hardened feces and gently stimulate peristalsis.
2. To supply food and fluid 120 ml to 180 ml.
3. to administer medication:
  - a) Stimulating enemata - coffee
  - b) Sedative enemata - starch and opium enema
  - c) Anesthetic enemata -paraldehyde avertin.
4. To aid in diagnosis
5. To produce local emollient effect.

### **EQUIPMENT :**

Screen

A tray containing:

-draw mackintosh and draw sheet

Funnel with 12" length or rubber tubing with glass connection and screw clamp

Rectal catheter No.12

Jug or a bowl for solution

Vaseline

Paper square

Kidney basin

Measure for making solution

Bed blocks Two

Lotion thermometer

### **PROCEDURE:**

1. Screen the patients and explain the procedure.
2. Prepare the required amount of solution at 100 F or 37.66 C Oil enemata and nutritive enemata, other enemata at 105 F or 40.6 C.
3. Carry the tray to the bedside.
4. Turn the patient in left lateral position and place on pillow under the hips. Raise the foot end of the bed by using the bed blocks.

5. Place the mackintosh and draw sheet under the patient. Drape the patient with the top sheet.
6. Take the funnel and tubing in one hand, lubricate the rectal catheter 3"-4".
7. Fill the funnel with solution, open the screw clamp and allow the solution to flow in the tube.
8. Pinch the catheter and insert 4"-6".
9. Release the tubing and elevate the funnel not higher than 8" allowing the solution to enter in the rectum slowly.
10. Keep the funnel full with solution for 15-20 minutes until the entire solution has entered into the rectum.
11. Pinch the rectal catheter and withdraw slowly.
12. Wrap the soiled part of the rectal catheter with paper, disconnect it from the glass connector and place it in the kidney basin. Place the funnel and tubing in the tray.
13. Encourage the patient to take deep breathing and apply the pressure over the anus by holding the two buttocks together to help the patient to retain the solution according to the purpose of the enema.
14. Straighten the bedding. Leave the comfortable.
15. Take the tray to the clean up area. Wash the funnel and tubing with soap and warm water, rinse. Boil for 5 minutes.
16. Replace the equipment.
17. Remove screen and pillow from the patients hip.
18. Record: treatment, solution used amount and retention results.
19. Keep the foot end of the bed raised for 30 minutes.

## **BED PAN-GIVING AND REMOVING**

### **PURPOSE:**

1. To facilitate elimination for a patient confined to bed.
2. to provide test

### **EQUIPMENT OR REQUIREMENT:**

Screen  
Bed pan cover if available  
Bed pan towel  
Basin and towel  
A tray containing:  
Soap in soap dish  
Jug with water  
2 – 3 dry cottons swabs  
paper bag duster

N.B. if you have to swab the patient who is unable to do it herself / himself , bowl with 6-8 wet swabs, kidney tray and forceps.

### **PROCEDURE OR ACTION:**

1. Screen the patient.
2. Obtain clean dry bed pan with cover if available carry to the bedside and place it on the stool.
3. Remove blanket and counterpane.
4. Fan fold draw sheet to the opposite side.
5. Remove bed pan cover and tuck under the mattress.
6. Remove the lid and place it up side down on stool.
7. Lift the top sheet. Ask the patient to flex the knees and pull patient's skirt or dhoti up to the waist.
8. Place left hand under the back and help the patient to lift the hips

while passing the bed pan with the right and be sure the patient is properly centered on the bed pan.

9. Leave the patient alone if not very ill. Instruct the patient that you will return.
10. Collect the articles for cleaning the patient and carry to the bedside.
11. Fold back the top sheet.
12. Pour warm water over the genitalia.
13. Patient will clean the genital area with her hand and wipe with the dry cotton swabs and discard them into paper bag.
14. Remove the bed pan with the right hand and place it on stool. Cover it with the lid and bed pan cover.
15. Turn the patient to the side and dry the back well.
16. Let the patient wash her hands with soap and water then dry them.
17. Remove the tray and bed pan to the clean up area.
18. Observe the contents.
19. Wash hands record observations and report if it is necessary.

**NOTE:**

1. When patient is unable to care for herself turn down the top sheet to the groin and put them down. At the midpoint to form a drape pour the warm water over the genitalia pick up the wet cotton swabs with the forceps and the area down to the anus making one down ward stroke with each cotton swab and discard in paper bag.
2. In the same manner wipe the area with the dry swabs.

3. Discard forceps in the kidney tray.

**AFTER CARE OF EQUIPMENT:**

Empty the contents of the bed – pan into the flush. Rinse with cold water and clean with the bed – pan brush or mop. Rinse again in the cold water and immerse the bedpan into the tub containing disinfectant phenol 2% for 30 minutes wash the kidney tray and the forceps with soap and running water. Boil for 10 minutes and replace.

## **SITZ BATH**

### **PURPOSE:**

1. To relieve pain and congestion of the pelvic organs or areas.
2. To promote voiding following cystoscopy or circumcision.
3. To promote healing following perineal and anal area surgery.

### **EQUIPMENT OR REQUIREMENT:**

- Small tub [size to ensure that water covers the suprapubic area when the patient is sitting]
- Two bath towels.
- One rubber ring with cover.
- A pad.
- Sheet.
- Two safety pins.
- Lotion thermometer.
- Jug of solution at 150 F or 65.5 C.
- Patient's gown.
- Dressing set and kidney tray as needed.
- Solution as ordered by the Doctor.

### **SOLUTION:**

Commonly used.

Potassium permanganate 1: 10,000.

Magnesium Sulphate 2-5%.

Boric acid 4 gms or 1 gram per pint of water.

### **PROCEDURE OR ACTION:**

1. Explain the procedure to the patient.
2. Place the tub on the floor.
3. Prepare the solution in the tub [temperature 105 F to 115 F]  
40.6 C to 46.1 C.

4. Fill tub to half full.
5. Place the inflated rubber ring, in the tub.
6. Place bath towel over the edge of the tub to provide pad under the knees.
7. Assist the patient to dressing in the hospital gown and the slippers, remove dressing if it is there.
8. Pin the gown high around the chest, using the sheet to avoid exposure.
9. Assist the patient to sit in the tub.
10. Fasten the sheet about the shoulders.
11. During of the treatment 10-30 minutes.
12. Adjust the bath towels under the knees and a pad at the back.
14. If the water cools down, assist the patient to rinse and add water to bring temperature to 105 F or 40.6 C.
13. At completion of the treatment assist the patient to rise.
14. Dry well unpin the gown wrap the sheet about the shoulders and assist the patient to the bed.
15. Apply dressing if needed.
16. Clean and replace the equipment.

**RECORD:**

Time, treatment, solution used. In nursing notes duration and response to the treatment.

## **COLONIC IRRIGATION-ONE TUBE METHOD**

### **PROPOSE:**

1. to clean the colon of feces, gas and excess mucus in preparation for:
  - surgery
  - diagnostic procedure
  - to dilute poison
  - to wash out after rectal anesthesia

### **EQUIPMENT:**

Tray containing

- funnel with tubing, glass connector and rectal tube
- baseline for lubrication
- kidney tray
- pint measure or small pitcher
- jugs or irrigation solution as ordered
- bucket
- screen

### **PROCEDURE:**

- collect-check equipment carrying to bedside
- explain procedure to patient
- screen the bed .place patient in position
- place bucket to receive return flow
- take funnel and tubing in one hand lubricate rectal tube
- fill funnel with solution, expel air pinch tubing insert 4
- release tubing. elevate funnel allowing solution to enter rectum.
- Keep funnel full of solution until 3 to 4 funnels of solution run in.
- before funnel is completely, empty ,invert into bucket and off the fluid.
- Before return flow completely ceases, pinch tubing and hold funnel upright pour in more solution.
- repeat procedure until return flow is clean and amount ordered has run in.
- pinch tubing, withdraw rectal tube and place in kidney tray.

- leave patient comfortable.
- remove all articles to utility room.
- wash funnel tubing, glass connection and rectal tube, boil and replace
- wash and replace rest of the equipment.

| Date & time            | treatment and medication                     | nursing notes                       |
|------------------------|--|-------------------------------------|
| 29-5-1963<br>8:30 p.m. | Colonic irrigation with normal<br>saline 4.1 | give until return<br>glow was clean |
|                        |  | Madavi                              |

## **COLINIC IRRIGATION-TWO TUBE METHOD**

### **PURPOSE:**

1. To clean the colon of feces, gas and excess mucus in preparation for:
  - surgery
  - diagnostic procedure
  - to dilute poison
  - to wash out after rectal anesthesia
2. To supply heat or cold to colon and pelvic organs.

### **EQUIPMENT:**

- Kidney tray
- funnel
- rectal catheter
- jugs of solution as ordered
- Vaseline for lubrication
- bucket
- screen
- screw clamp
- irrigation solution as ordered

### **PROCEDURE:**

- Collect –check equipment carrying to beside
- explain procedure to patient
- Serene the bed
- Place bucket to receive return flow

- Take funnel and tubing in one hand lubricate rectal tube
- Fill funnel with solution, expel air, pinch tubing insert 4
- Release tubing. Elevate funnel allowing solution to enter rectum.
- Keep funnel full of solution until 3 to 4 funnels of solution run in.
- Before funnel is completely empty, invert into bucket and off the fluid.
- Before return flow completely ceases, pinch tubing and hold funnel upright pour in more solution
- Repeat procedure until return flow is clean and amount ordered has run in.
- Pinch tubing, withdraw rectal tube, disconnect and place in kidney tray.
- Leave patient comfortable.
- Remove all articles to utility room.
- Wash funnel tubing, glass connection and rectal tube, boil and replace.
- Wash and replace rest of the equipment.

| Date & time    | treatment & medication                    | nursing notes                     |
|----------------|---|-----------------------------------|
| 21-5-1963 8:30 | colonic irrigation with Normal saline 4.1 | give until return flows was clean |

Lalitha

## **ENEMATA**

### **METHOD OF ADMINISTERING LARGE ENEMA TO BE EXPELLED**

#### **PURPOSE :**

1. To cleanse the rectum for diagnostic or therapeutic procedures.
2. To relieve constipation.
3. To aid in expulsion of gas from the lower colon and rectum.
4. To aid in expelling residual Barium meal and Barium enema.

#### **EQUIPMENT :**

Screen  
Jug  
Litre measure  
Table spoon  
Lotion thermometer  
Bed pan and cover  
Duster  
Paper bag

#### **A TRAY CONTAINING :**

- Enema can with tubing approximately 18"-20" screw clamp, glass connector and a rectal tube.
- Vaseline and paper squares.
- Large kidney tray
- Draw mackintosh and draw sheet if necessary.
- Towel or toilet paper or cotton.

**PROCEDURE:**

1. Test the equipment for its proper functioning.
2. Prepare solution 750 ml to 1500 ml at 49°C or 120°F. Close screw clamp on tubing and pour solution into enema can
3. Rinse and replace articles used for making solutions
4. Carry tray to the bedside, Explain procedure to the patient.
5. Bring the screen and bed pan to the bedside.
6. Fan fold blanket to the foot end of the bed
7. Place mackintosh and draw sheet over the bed if there is none.
8. Turn the patient on the left lateral position bring the patients hips towards the edge of the bed and expose the part as little as possible.
9. Remove the pillow
10. Lubricate the rectal tube 2"-3" then place the paper in the paper bag.
11. Open the screw clamp and allow a little amount of the solution to pass into the kidney basin and clamp.
12. Place the enema can on bed and allow to rest against the patient's buttocks.
13. Insert the rectal tube 4"-5"
14. Open the screw clamp. Elevate the enema can 18"-24" about the level of anus  
"\*' and allow the solution to enter gradually into the rectum.

15. Encourage the patient to take deep breathing and instruct him/her to retain the solution.
16. Clamp the tubing before the whole of solution flow into the tube or when the patient is unable to retain more, withdraw rectal tube and replace the enema can on the tray. "
17. Disconnect the rectal tube. Wrap the soiled part of the rectal tube with the paper and place in the kidney basin.
18. Place the patient on the bed pan and raise the back of the patient so that the patient is in the sitting position if allowed, or assist the patient to go to the toilet, or let him/her use the commode.
19. Remove the tray to the cleaning area. Wash the enema can and the tubing with soap and water and rinse wipe the soiled part of the rectal tube with the paper starting from the distal and towards the tip of the rectal tube, and discard the paper. Rinse the rectal tube with cold water use brush to clean the tip of the rectal tube wash with soap and water necessary clean lumen of the tip with swab stick.
20. Boil the rectal tube and kidney basin for 5 minutes.

21. Wash the tray, replace the equipment and tray.
22. Return to the patient and clean her/him, observe result of the enema.
23. Remove the screen and leave the unit tidy.
24. Record time of giving enema, solution used and amount of solution.  
Result obtained
25. clean the bed pan.

**NOTE:**

1. Whenever the patient complains of discomfort stop the flow for one minute then continue the treatment.
2. If soap solution is used for the enema take 60 ml of soap solution per liter of water mix it well then remove the froth.

## **CHARTING**

### **PURPOSE :**

1. Important to patient for future reference.
2. Necessary for hospital to show quality and quantity of work done for patient.
3. Needed by physician as scientific record of diagnosis, treatment and progress.
4. Important in legal defence as witness.
5. Needed in Medical research for accurate scientific data
6. Aids in formal and informal education.

### **General Rules for Charting :**

1. All recording on the chart must be printed, except the written signature,
2. The written signature should consist of the initial of family names and name.
3. A nurse making a series of statements should sign only one for the series.
4. Record after a medication or treatment is given, not before,
5. Black ink should be used for recording between the hours of 7-00 a.m. and 7-00 p.m.
6. Red ink should be used for recording between the hours of 7 00 p.m. and 7-00 a.m.
7. Do not erase a mistake in printing, mark through the error indicating a mistake was made then copy the recorded notation correcting the error.

8. Printing the proper heading for all new pages to be added to the chart.
9. Record the attending Doctor's visit whenever the nurse sends a call or special visit done by the Doctor.
10. Record any unusual symptoms or any change in condition of the patient.
11. Arrange Pages of the chart in correct order when the patient is admitted and dismissed.
12. Place all recorded notations in the columns to which they belong according to the various column headings.
13. Do not word a recording in future tense, as "Backrest to be elevated"
14. Never printing the "patient" on the chart The chart itself is a record for each individual patient and all notations made are in regard to the person for whom the record is kept.
15. The time will be recorded for each entry.
16. Recording will be done by the nurse who cares for the patient, administers the medication or treatment.
17. If an error is made in recording, draw a Red line through the error, write the word "error" and your signature above the line.
18. At midnight a line is drawn horizontally across the page below the last recording and the date written in the proper column.
19. Only standard abbreviations should be used.

**IN. Charting should be :**

Pertinent  
Honest  
Neat  
Legible  
Clear and accurate  
Concise and complete  
Recorded in proper places  
Each entry should convey a complete thought

**IV. RECORDING SHOULD INCLUDE :**

Observation or reports subjective symptoms which indicate a change in the condition

of the patient, his behavior or mental attitude.

Medications, treatment and nursing care given, observable effects.

Notification of doctor, visits of doctor.

Treatments by or visits to other hospital departments

Specimens sent to the Laboratory.

Accidental or unusual happenings

Diet taken, amount of food taken if significant

## **HECTAL SUPPOSITORIES**

### **PURPOSE :**

1. To produce a bowel action. . -
2. To soften the feces<
3. To relieve pain
4. To soothe the bowel

### **REQUIREMENT :**

Screen

A tray containing

Suppository

Finger cot

Small container with water or oil

A covered container with cotton swabs

A paper bag and a kidney tray

Draw mackintosh and draw sheet necessary)

### **PROCEDURE:**

1. Explain the procedure to the patient
2. Carry tray to bedside and provide privacy
3. Fan fold blanket to the foot end of the bed
4. Put the patient in left lateral pasting
5. Place the mackintosh and draw sheet under the patient.
6. Expose the part . -
7. Put on finger cot
8. Lubricate the rectal suppository
9. Separate the buttocks with thumb and fore finger
10. Insert the tapered end of the suppository into the anal canal and push it upward swell beyond the internal spincter.

11.To retain the suppository. Encourage the patient take deep breathing and apply the 1pressure over the anus by holding the two buttocks together.

12.Record and report, the effect of the treatment

**N.B. :-**

Use cotton swabs while separating the buttocks to protect fingers from contamination.

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## **SIPHONAGE**

### **PURPOSE :**

To siphon off the solution after large enema if there is failure to expel.

### **REQUIREMENT :**

Screen

A tray containing

A small funnel with a rectal tube

Jug or bowl with warm water

Vaseline

Paper squar in a paper bag. Bed pan with cover kidney tray.

Draw mackintosh and draw sheet, if necessary

### **PROCEDURE:**

1. Explain the procedure to the patient
2. Carry tray to bedside and provide privacy
3. Fan fold blanket to the foot end of the bed
4. Place the bed pan on a stool at a lower level than the patient
5. Put the patient in left lateral position
6. Bring the patient's hips towards the edge of the bed and expose the part.
7. Take the funnel and the rectal tube in one hand. Lubricate the rectal tube. Fill the funnel with solution and allow the solution to flow in the tube.
8. Separate the buttocks with the thumb and fore finger.
9. Pinch the rectal tube and insert 4" to 6"
10. Pour a small amount of warm into the funnel.
11. When a small quantity of water is left in the funnel invert the funnel, over the bed pan.
12. Once the flow starts. If connect the Funnel from the tube.

13. Check for the amount of solution siphoned off.
14. Pinch the tube and with draw slowly.
15. Wrap the soiled part of the rectal tube with the paper and place it in the kidney basin.
16. Straighten bedding. Leave the patient comfortable.
17. Remove the screen and leave the unit tidy.
18. Remove the tray and bed pan to the cleaning area.
  
19. Boil the rectal tube funnel and kidney basin for 5 minutes and 20 minutes respectively after cleaning with soap and warm water.
20. Dry and replace the equipment.
21. Record the time of treatment amount of solution siphoned off and the patient reaction.

## **FLATUS TUBE**

### **PURPOSE :**

1. To relieve flatulence

### **REQUIREMENT :**

Screen  
 Flatus tube  
 Vaseline  
 paper squares in a paper bag  
 Kidney tray with water  
 Draw mackintosh and draw sheet if necessary

### **PROCEDURE:**

1. Screen the patient and explain the procedure.
2. Carry the tray to the bed side.
3. Fan fold blanket to the foot end of the bed.  
\*
4. Put the patient in left lateral position.
5. Expose the part.  
Lubricate the flatus tube and put the free end of the tube in the kidney tray under water.
7. Separate the buttocks with thumb and fore finger.
8. Insert the flatus tube 4"-6" and allow to remain in position for 20-30 minutes.
9. Observe the patient for amount of flatus passed.
10. Pinch and with draw the tube slowly.
11. Wrap the soiled part of the flatus tube with-the paper and place in the kidney tray
12. Strainghten the bedding. Leave the patient comfortable.

13. Remove the screen and leave the unit tidy.
14. Record and report the amount of flatus passed and the patient's reaction to the treatment.
15. Take tray to the clean up area, wash the flatus tube with soap and water. Rinse under running water. Boil for 5 minutes.
16. Dry and replace the equipment.

## **MEDICAL FOMENTATION**

### **PURPOSE :**

1. To relieve congestion
2. To promote resolution

### **EQUIPMENT :**

1. A tray containing :  
Hot water bottle with cover  
Treatment mackintosh and towel  
Abdominal binder - scultetus or wrapper or bandage  
Extra Sheet
2. Basin
3. Kettle with hot water
4. Wringer with hot water
5. Fomentation pad large enough to cover the area.
6. Plastic piece half to one inch bigger than the fomentation pad all round.

### **PROCEDURE:**

1. Screen the patient and explain the procedure.
2. In the utility room
  - i) Place the pad inside the wringer
  - ii) Put the wringer over the basin
  - iii) Adjust the rods.
  - iv) Pour sufficient boiling water over the wringer to immerse the pad and the wringer.
  - v) Wringe out the pad by twisting the rods in the opposite direction.
  - vi) Empty the basin.
  - vii) Remove the rods from the wringer
- viii) Place the wringer in the empty basin, cover with ten plastic piece.
- ix) Put hot water bottle over the plastic piece.

3. Take equipment to the bedside.
4. Fan fold the top bed linen. Expose the part, replacing with the extra sheet, if necessary.
5. Place treatment mackintosh, towel and wrapper or binder under the part.
6. Shake out the pad, test for tolerance of the heat over the part, if patient can endure, place the pad over the area, and cover with the plastic piece.
7. Secure the pad in place with the binder or wrapper.
8. Place hot water bottle over the part.
9. Keep the patient in a comfortable position.
10. Replace the top bed linen.
  
11. Fold the extra sheet and retain it for further use.
12. Clean and replace equipment.
13. Record treatment, time, observations, duration of the treatment and response of the patient to the treatment.

**NOTE :-**

1. Use lightly filled hot water bottle at 150°F, or 65.5°C
2. Refill the hot water bottle as required during the prolonged application.

## **COLD COMPRESS**

### **PURPOSE :**

1. To reduce temperature
2. To reduce congestion and inflammation
3. To check haemorrhage.

### **EQUIPMENT OR REQUIREMENT :**

1. A tray containing  
ice in a bowl  
Treatment mackintosh and towel  
Gauze squares

### **PROCEDURE OR ACTION :**

1. Bring equipment to the bed side.
2. Place treatment mackintosh and towel!
3. Put two compresses into the ice water until they are saturated.
4. Wring out excess water from one compress.
5. Apply the compress to the part.
6. Wring the other compress take off the first one and apply second.
7. Continue the treatment for 20 minutes, changing compresses frequently.
8. Dry the part. Remove mackintosh and towel Make the patient comfortable.
9. Clean and replace equipment.

### **NOTE :**

1. Cold compress should be applied on the forehead at 101 OF or 30.330C
2. Thickness of the compress should 1/2 to 1 cm. cut or fold layers of gauze,
3. Since on contact with cold may cause a skin burn therefore application should be on for 20 minutes and so on.
4. Temperature of the cold compress should be above the freezing point 0°C or 32°F.

## **COLD SPONGE**

### **PURPOSE :**

1. To reduce temperature
2. To give comfort.

### **EQUIPMENT :**

1. one bed mackintosh with sheet.
2. Basin of water at 60°F or 15.5°C.
3. Bowl of ice
4. Bath thermometer.
5. Wash clothes
6. Ice cap and cold compress
7. Hot water bag
8. Thermometer Tray.
9. Tray containing  
Mixture Stimulant  
ounce glass  
feeding cup with water
10. Top sheet
11. Screen

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### ● **PROCEDURE :**

1. Collect equipment. Fill basin with cold water add ice and bring to desirecrature (60°F or 15.5°C) to patient's bed side.
2. Explain the procedure.
3. Screen the patient.
4. Fan fold top bed clothes having top sheet to cover' patient.

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5. Piece bed mackintosh and sheet over bed foundation.
6. Underess the patient
7. Expose one arm and one leg the same side.
8. Place wash clothes in the basin of water
9. Apply ice-cap to the head, compress to the fore-head and to the nape of the neck and hot water bag to feet.
10. Wring out four wash clothes and place one in each axlfla and groin.
11. Start to sponge patient by passing wash cloth well moistened with water, first starting at the back of the ear rest at the side of the neck, passing down over the shoulder and the outer aspect of the arm, turn the sponge bag and pass down over the inner aspect of the leg replace wash cloth in the basin.
12. Change the cold compress and the wash clothes at the axilla and the groin. Give sips of cold drinks to the patient.
13. Take up wash cloth well moistened with water, starting at the back of the ear, rest at the side of the neck passing down through the axilla along the inside of arm. hand and palm, turn the sponge bag and pass down over the outer aspect of the leg.
14. Continue to sponge for 4 to 8 minutes
15. Cover half of the body and expose the other half repeat step No.11, 12, 13 and 14
16. Repeat the procedure for both the side again following step No. 11, 12,13, 14 and 15.
17. Put the patient in side-lying position and sponge the back for 4 minutes place patient in dorsal position.
18. Remove wet sheets and mackintosh.
19. Place dry top sheet, leave hot water bag, ice cap and cold Compressor on the parts of the body depending upon patient's condition.
20. Help patient to dress and give a stimulant as per order.

21. Wash and replace equipment.
22. Check T.R.R. after 30 minutes and record
23. Record treatment time and result
23. Discontinue treatment if patients temperature come down to 2.3°C to 1.8°C and report.

**NOTE :**

1. Cold sponge is indicated over 103°F or (39.44°C)
2. Check T.R.R. of the patient after 20 minutes, the procedure has been started to see the patient's condition.
3. Fan is kept on to reduce the temperature by convection.
4. Maintain the water temperature at 60°F or 15.5°C by providing ice to the basin
5. Sponge the patient with slow and even strokes leaving tiny molecules of the water visible on the skin.
6. When patient is having heat stroke cold sponge may not effective for such patients we may have to put the patient in cold pack.

**PROCEDURE :**

1. Instead of wash clothes take 3 wet sheets along with other equipment as for cold sponge
2. Put one sheet under the patient, and with second cover the patient.
3. Keep Office sheet for changing
4. Put the patient under the fan
5. Change the top sheet every 5 minute's Maintaining the temperature of Water 60°F or 15.5°C. If required put the patient under fan.

6. Continue for 20 minutes.
7. Temperature range for cold therapy

|           |   |               |   |                   |
|-----------|---|---------------|---|-------------------|
| Tapid     | - | 80°F to 93°F  | - | 26.6°C - 33.88°C  |
| Cool      | - | -65°F to 80°F | - | -18.33°C - 26.6°C |
| Cold      | - | 55°F to 65°F  | - | 12.77°C - 18.3°C  |
| Very cold | - | below 55°F    | - | -12.77°C          |

## **ICE CAP**

### **PURPOSE :**

1. To reduce temperature
2. To reduce congestion and inflammation
3. To check haemorrhage.

### **EQUIPMENT OR REQUIREMENT :**

1. A tray containing
  - Ice in a bowl
  - Salt
  - Table spoon
  - Wooden hammer and canvas bag
  - Ice cap and cover
  - Treatment mackintosh and towel
  - Duster

### **PROCEDURE OR ACTION :**

1. Keep ice in the canvas bag and break into pieces with hammer
2. Wash ice pieces with water and put them into the ice cap
3. Add salt to the ice pieces.
4. Squeeze the ice cap to expel air and screw the cap
5. wipe the out side of the ice cap and put into the cover
6. Carry filled ice cap. treatment mackintosh and towel to the patient's bedside.
7. Explain the procedure to the patient.
8. Place treatment mackintosh arid towel under the area.
9. Apply the ice cap and secure.
10. Continue for 20 minutes or for the time specified Empty water and refill the ice cap as needed.

11. Record time, duration and effect.

**AFTER CARE OF EQUIPMENT :**

Empty water from the ice cap

Wash exterior of the ice cap with soap and water

Dry, powder, fill with air, screw cap and replace.

**NOTE :**

Application of the ice cap is indicated for the patient's have temperature 102°F or 38.9°C. Range varies for the application of the ice cap with the hospital policy.

## **HOT WATER BAG**

### **PURPOSE :**

1. To supply heat to an area.
2. To relieve pain
3. To hasten healing
4. To promote suppuration
5. To relieve retention of Urine

### **EQUIPMENT :**

1. Jug with hot water
2. A tray containing
  - Bath thermometer
  - Hot water bag with cover
  - Duster

### **PROCEDURE:**

1. Collect equipment. Pour hot water into jug and cold water until temperature of 120°F or 48°.8°C is obtained.
2. Fill hot water bag.
3. Expel air by putting the hot water bag flat on a hard surface and push the water level up to the mouth of the bag.
4. Screw in the stopper.
5. Turn the bag upside down and check for leakage.
6. Dry the bag thoroughly and put into the cover.
7. Take to patients' bedside.
8. Explain the procedure to the patient.
9. Apply the hot water bag over an affected area.
10. RECORD : Time of administration.  
In treatment column : Treatment.

In nursing notes column : Site of application, duration and effect.

**AFTER CARE OF EQUIPMENT :**

Empty, rins hot water bag wash exterior with soap and water, dry, inflate, tighten stopper, powder and replace.

**NOTE :**

1. Fill hot wet bag 1/3 full, when it is applied over a painful area.
2. For an unconscious patient the temperature of the water should not be more than 50°F or 10.6°C

## STEAM INHALATION

### **PURPOSE :**

1. To relive inflammation and congestion of the mucous membrane in acute cow and sinusitis.
2. To soften thick tenacious mucus to relieve coughing.
3. To warm and moisten air following operation such as tracheotomy.

### **EQUIPMENT :**

1. A tray containing
  - A bowl
  - Nelson's inhaler
  - A lint piece or towel (to wrap inhaler to retain heat)
- Medicine ordered

A cotton ball  
 Gauze square  
 One sheet  
 A Kettle of boiling water

### **PROCEDURE:**

1. Explain the procedure to the patient and position the patient.
2. Assemble equipment
3. Rinse the inhaler with hot water
4. Wrape the inhaler with the lint piece and place in the bowl
5. Measure medication and put in the inhaler close the spout with the cotton ball
6. Wrap the mouth piece with guaze square
7. Pour boiling water into the inhaler and fix the mouth piece
8. Take the wrapped inhaler in the bowl to the bedside.
9. Place mouth piece close to the patients mouth remove cotton ball from the spout
10. Cover the head and shoulders with the sheet, have, patient inhaler fumes through the mouth and exhale through the nose for 5-10 minutes.
11. Remove the sheet. Dry the patient's face and neck.

12. Wash, Rinse and replace equipment Boil the mouth piece for 5 minutes.

**RECORD:**

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| Time      | Diet | Medication                           | Nurses' Notes                            |
|-----------|------|--------------------------------------|--|
| 8-00 a.m. |      | Tr. Benzoin Co.<br>Inhalation 10 min | Nasal passage clean<br>voice less nasal. |
|           |      |                                      | Susheela                                 |

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**NOTE :**

1. If the mouth piece is bent to one side, keep it directing opposite to the air inlet.
2. If milk of magnesia is available coat the inhaler before (1 tea spoon-ful milk of magne-sain 200 ml or water)
3. To remove Tr. Benzoin co stains use acetone or methylated spirit.
4. If oil or eucalyptus or menthol (10 percent in alcohol) is used. Water should not be boiling. Since these are highly volatile.
5. If menthol is used, instruct the patient to keep eyes closed during the treatment, since it is irritation to the conjunctiva.
6. Tr. Benzoin Co usually is used 4 ml per pint of water.
7. Inhalations usually are given 4th hourly.

## **COLLECTION OF SPECIMENS FOR LABORATORY EXAMINATION**

### **PURPOSE :**

To collect specimens as ordered for laboratory examination in a manner so as to assist in the diagnosis of the patients disease.

### **GENERAL RULES FOR COLLECTION OF SPECIMEN :**

1. Specimens must be collected in clean or sterile receptacles and transferred into dean sterile containers for sending to the laboratory.
2. Each specimen container must be labeled so as to include :
  - Ward
  - Patent's name
  - Reni-ter Number
  - Bed Number
  - Nature of specimen
  - Date
  - Time
3. The external side of the container to be sent to the laboratory must be kept from contamination.
4. Specimens must be delivered for examination in a form consistent with the laboratory needs for example. Stools sent for amoeba must be examined within 1/2 hour of defecation or maintained without drying and at body temperature until examined.
5. Explaining the patient before hand of the need for collection of specimens to facilitate the correct diagnosis of disease and obtaining the laboratory reports as promptly as possible.
6. Specimens should not be contaminated with other bodily excretion.
7. Collect the required amount of specimen for the examination.

### **PROCEDURE :**

1. Explain the procedure to the patient.

2. Collect the specimen in a proper receptacle.
3. Transfer specimen to the container for sending to the laboratory.
4. Write the label as follows.

|                      |              |
|----------------------|--------------|
| Ward                 | Register No. |
| patient's Name       |              |
| Bed No               |              |
| Specimen             |              |
| Examination required |              |
| Time                 | Date         |

5. Affix label to the specimen container.
6. Send specimen with the requisition form to the Laboratory.
7. Chart the specimen Collected and sent to the Laboratory.  
The sputum specimen must be obtained from the bronchi and not of the aeliva from the mouth.
- 2 An order must be obtained for a catheterization to collect the urine specimen if a female patient is menstruating.
- 3, The stool specimen must be free of urine.

## **URINE TESTING**

**PURPOSE** : To test urine as an aid to diagnosis and or treatment.

**EQUIPMENT** : Urine glass or a cylindrical glass container.

Urinometer

Test tubes *and* holder

Support for test tubes

Spirit Lamp and matches

Red. litmus and blue litmus

Medicine dropper

Kidney Tray

Funnel and Filter paper

- Washing equipment

Soap and water

Brush or swab sticks

Chemicals as required :

Benedict's solution. for sugar test.

Nitric Aci Albumin test

Acetic Acid 3%

Sodium Nitroprusside (Crystas)

Ammonium Sulphate (crystals) Acetone Test

Liquor ammonia

Conistix Strip

CJinitest Tablet

Colour Chart

| Test                                   | Steps  | Interpretation  |
|--|--|---|
| 1 Reaction                             | <ul style="list-style-type: none"> <li>a) Dip a wet piece of blue litmus paper in the urine (if it does not change colour)</li> <li>b) Place a wet piece of red litmus paper in the urine.</li> <li>c) If neither the blue nor the red paper changes the colour.</li> <li>d) If the red litmus turns blue and the blue litmus turns red.</li> </ul>                                | <ul style="list-style-type: none"> <li>a) If it turns red, the Urine is acidic</li> <li>b) If it turns blue the urine is alkaline</li> <li>c) The Urine is neutral</li> <li>d) The reaction is amphoteric</li> </ul>  |
| 2. Specific gravity                    | <ul style="list-style-type: none"> <li>- Pour the urine into a container.</li> <li>- Place a urinometer into the specimen and suspend it to prevent sticking on the side of the container.</li> <li>- Take the reading - wash urinometer and the container.</li> </ul>   | 1.015 - 1.020 is normal   |
| 1. Albumin :<br>i) Boiling Test<br>x - | <ul style="list-style-type: none"> <li>- Filter urine if cloudy</li> <li>- Fill a test tube 2/3 full of urine</li> <li>- Boil top inch of urine</li> <li>- Compare top of urine column with lower portion in the test tube.</li> <li>- If cloudiness appears add a few drops of 3% acetic acid.</li> <li>- Wash and replace the equipment</li> <li>- Record and report.</li> </ul> | <ul style="list-style-type: none"> <li>e) If the urine is transparent and remains so, it is negative for albumin.</li> <li>f) If cloudiness disappears, phosphates are present.</li> <li>g) If cloudiness remains or increases albumin is present.</li> <li>. If the urine effervesces up on the addition of the acid either calcium carbonate or ammonium carbonate is present.</li> </ul> |
| ii) Heller's Test or Nitric acid test  | <ul style="list-style-type: none"> <li>- Pour 2 ml. of pure nitric acid in a test tube.</li> <li>- Using dropper, allow equal quantity of urine to trickle steadily down the side of the test tube.</li> <li>- If a white ring appears</li> <li>- Wash and replace equipment.</li> <li>- Record and report.</li> </ul>   | <ul style="list-style-type: none"> <li>- Pour pure nitric acid in the test tube it is heavier than urine</li> <li>- It is positive for albumin</li> <li>- If no white ring appears at junction of two liquids urine is negative for albumin</li> </ul>  |

|  |  |  |
|--|--|--|
| Sulfosalicylic acid test   | <ul style="list-style-type: none"> <li>- Place 4 or 5 ml. urine in a test tube and add 2 or 3 drops 20% aqueous solution of sulfo - salicylic acid and mix thoroughly.</li> <li>Wash and replace equipment.</li> <li>Record and report.</li> </ul>   | <ul style="list-style-type: none"> <li>- Opalescence occurs if small amounts of albumin are present,</li> <li>- If large quantities of albumin are present, a pronounced turbidity is noted.</li> </ul>  |
| Sugar<br>Benedicts<br>Tests  | <ul style="list-style-type: none"> <li>- Place 5 ml. Benedicts solution in a test tube.</li> <li>- Warm the solution</li> <li>- Add 8 drops of urine</li> <li>- Boil the solution for 2 minutes</li> <li>- Allow the mixture to stand till it attains room temperature</li> <li>- Wash and replace the equipment</li> <li>- Record.</li> </ul>   | <ul style="list-style-type: none"> <li>- To expel the dissolved impurities.</li> <li>- No change in colour - Negative for sugar</li> <li>ii) Greenish Liquid without deposit 0.1% or +</li> <li>iii) Yellow deposit with green liquid : 0.2% or + +</li> <li>iv) Orange deposit with colorless liquid 2% or + + +</li> <li>v) Brick red : above 2% or . + + + +</li> </ul>   |
| Clingiest<br>method  | <ul style="list-style-type: none"> <li>- Place 5 drops of urine in a test tube</li> <li>- Add 10 drops of distilled water.</li> <li>- Add 1 clinitest tablet and watch the reaction carefully.</li> <li>- (If the colour passes through orange to some shades of brown indicates a 'pass through<sup>1</sup> reaction and signifies more than 2% sugar)</li> <li>- Fifteen seconds after boiling steps, shake tube gently and compare with colour chart</li> </ul> | <ul style="list-style-type: none"> <li>• - If there is no glucose present, the solution will be blue</li> <li>- If glucose is present however the colour will vary from green to yellow to orange depending upon the amount of glucose present.</li> <li>- Normal colour (Nc)</li> <li>- Green - 0.25 - 0.5% and different</li> <li>- Yellow -0.75%</li> <li>- orange -1%</li> <li>- Brown - more than 2%</li> </ul> |
| <p>HINTS FOR GOOD USAGE :</p> <ol style="list-style-type: none"> <li>1 . Tables are Very Hygro scopic. Never leave tablets exposed to the air. If a tablet has absorbed moisture, dark spots will appear on the tablet and eventually it will turn black such tablets should not be used.</li> </ol> |  |  |

|                              |   |   |
|------------------------------|---|---|
| iii) Clinistix test          | <ul style="list-style-type: none"> <li>- Take clinistix test strip and dip in the urine.</li> <li>- Match with colour chart.</li> </ul>   | <ul style="list-style-type: none"> <li>- Colour blocks represent negative, light medium and dark colour development</li> <li>- At 10 Sec. a light colour generally indicates 0.25% or less.</li> <li>- A dark colour generally indicates 0.5% or more</li> <li>- A medium colour is obtained with large or small quantities of glucose depending greatly upon the specific gravity of urine.</li> </ul> <p>The test is more reactive in urines of low specific gravity than in concentrated urines.</p> |
| For Acetone Rothera's method | <ul style="list-style-type: none"> <li>- Take 5 ml. of urine</li> <li>- Add 2 gms of ammonium sulphate crystals to the urine fill the mixture reaches saturation level by shaking the mixture well.</li> <li>- Add a few crystals of nitroprusside in a ml water to prepare fresh nitroprusside solution</li> <li>- Add two drops of freshly prepared sodium nitroprusside solution to the mixture.</li> <li>- Allow the same quantity of concentrated ammonia to slowly trickle down the walls of the test tube.</li> <li>- Allow to stand 15-20 minutes</li> <li>- Wash and replace equipment</li> <li>- Record and report</li> </ul> | <ul style="list-style-type: none"> <li>- A purplish red or permanganate - coloured ring at the point of contact indicated the presence of acetone.</li> </ul>   |

## **INTAKE AND OUTPUT RECORD**

### **PURPOSE :**

To maintain an accurate record of fluid intake and out-put when ordered or when this information is important as a basis for therapeutic planning for the patient.

### **NECESSARY EQUIPMENT :**

Intake and out-put work sheet  
Pint measure for measuring urine, drainage etc.      ◀  
Patient's chart.

### **INSTRUCTION :**

An intake and out-put record Ingl-axis will be maintained routinely for the following patients :

Those receiving diuretics, digitalis.  
Patients on intravenous fluid therapy  
Nothing by mouth patient  
Patients with uremia, nephritis, nephrosis  
Urinary retention  
Following surgery of the kidney or bladder  
Patients with hyperpyrexia, severe dehydration  
Persistent vomiting and diarrhoea cases  
Semi-conscious or unconscious patients  
As ordered by the Doctor

1. Intake and out-put will be recorded in ml. and totalled at 8-00 a.m. Totals are transferred to the appropriate columns in the patient's chart.
2. The work sheet for intake and out-put will be kept at the bedside affixed on the bedside chart back.

3. The nurse in-charge of the patient will be responsible for maintaining the record. However the patient and or his attendant if capable can be taught to do so.
4. For intake, measure the patient's own drinking glass and mark at 60 ml. 120ml.180 ml. with sticking plaster or with wax pencil.
5. Fluids will be recorded when given to the patient. If solution remains after dis-continuing I.V. that amount is to be subtracted from the original amount and recorded on the work sheet.
6. Food which will be recorded as fluid intake includes :  
Milk, Fruit Juice, Butter milk  
Conjee, Soup.
7. Patients receiving diuretics will be weighed daily.
8. For urine out-put, class IV employees will be instructed that the out-put records to be kept properly. The will report to the nurse incharge of the patient the amount of urinary out-put. The nurse will maintain the out-put record.
9. Vomitus, ryle's tube aspirations, drainages, bleedings should be measured and recorded as out-put and totalled up along with the 24 hours urine out-put.
10. For patients on forced fluids because of fever or dehydration, fluids will be given so as to minimum of 100 ml. urinary out-put in 24 hours.

## **USE OF KARDEX**

### **PURPOSE :**

1. To serve as a record of medical and nursing orders currently in effect for each patient in the ward cared for by the students of the College of Nursing.
2. To serve as a guide to nurses in giving and planning individualized nursing care

### **PERSON RESPONSIBLE FOR MAINTAINING KARDEX**

1. The clinical instructor will maintain the kardedex for patients assigned to 1st and 2nd Year students until they have been taught supervised and have demonstrated adequate accuracy to maintain the kardedex for those patients assigned.
2. Each 2nd yr. student will maintain the kardedex for those patients assigned to her care as soon as the instructor has indicated that she is capable of doing so without supervision.

### **MAINTENANCE OF KARDEX CARD**

1. A kardedex card will be maintained for all patients cared for by the college of nursing students will be filled out when a patient is first assigned to a student. It will be checked and revised as needed.
  - a) Daily after doctor's rounds
  - b) Maintains and checks for any new medical orders and Nursing Care Plan
  - c) Daily after completing the care to add or change Nursing Care Plan recording to the needs of the patient.
2. Ink will be used for all recording except:
  - a) Pencil will be used to record
    - Bed No
    - Diagnosis
    - Bath-type and frequency
    - T.PR.-frequency and method
    - Diet
    - Nursing Care Plan and
    - Treatments

- b) Red Ink will be use to indicate the time of Administration of medications, from 7-00 p.m. to 7-00 a.m. Black Ink will be used to indicate the time of administration of orders 7-00 a.m. to 7-00 p.m.
3. Only standard abbreviations will be used in writing orders on the kardex Do not abbreviate the name of the medications.
4. Cancellation of the orders will be done by drawing a Red line through the order and writing the date and writing the initials of person cancelling the order above line.
5. The medication orders should not be rubbed or over written

## **METHOD OF FILLING IN KARDEX CARD**

### **IDENTIFYING DATA :**

- a) Use capital letters to record
- b) Name - copy accurately and completely from the admission record
- c) Diagnosis : Record Provisional diagnosis  
Any change in the working diagnosis  
Surgical procedure done with date

### **MEDICATIONS :**

- a) write date, from and the name of the medication, frequency of administration. In 24 hours, route of administration of other than oral any specific instructions concerning administration in column marked "Medication"
- b) In column marked "Dosage" to write the amount to be administered at the time of each administration.
- c) in the column marked "Time" write the hours of Administration.
- d) Stat Prn and SOS medication orders should not be recorded in the Kardex card but the medicine card should be prepared and should be inserted in the kardex
- e) Alternate day, weekly and bi-weekly medications write with the pencil the due dates for three consecutive dosages.

**TREATMENTS:**

- a) In the column marked "treatment" write the date and name of the treatment eg., Vaginal tablets. I/V.S. irrigations diet - therapy external applications bakjng, frequency in 24 hours & if aplicible, site, duration temperature and or strength of solution and any , special instruction.
- b) In the "Time" column write the specific hours the treatment is to be done.

**NURSING CARE PLAN' :**

- a) Write orders relating to needed Nursing Care of the patient such as :
- Hygienic care           - Bath
  - Special Mouth care
  - Shampoo
  - Posture and position - Frequency in 24 hours
  - activity, rest and exercise.
  - Control of pain
  - Needs for health teaching of Nursing Care following discharge
  - Needs for support in relation to emotions or mental attitudes.
  - Food or Fluid
  - Intake
  - Type
  - Amount
  - Frequency
  - Elimination
  - Use of comfort devices and safety measures
  - Recreation and diversion
  - Plan to meet the spiritual needs.
- d) In the "Time" column indicate the specific hours for carrying out Nursing Care if applicable.

5. Bath - Record if bed bath or shower, frequency and, if not daily - the specific days of the week the bath is to be given.
6. T.P.R - Record the frequency of taking if other than the routine - Bic R.:J method of taking the temperature if other than by mouth.
7. Diet, Record the type of diet ordered supplementary, feedings if ordered, limitation of food or fluid if applicable.
8. Health teaching about :
  - Disease
  - General
  - Family Planning
  - Prevention of Disease

## **MEDICINE ADMINISTRATION BY MOUTH**

### **PURPOSE :**

To administer the correct medicine in the correct dosage in the correct way at the correct time of the right patient.

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### **EQUIPMENT OR REQUIREMENT :**

Kardex

Medicine cards

Tray with zinc rack and with the required number of medicine glasses

A container for drinking water Medications

GRADUATED MEASURES

Ounce glass

Minim glass

Tea spoon

Dropper - If needed

tow bowls - one with hot soapy water and another with hot water

Kidney tray - Paper bag

Towel

### **PROCEDURE OR ACTION :**

1. Obtain the medicine cards for the assigned patients-.
2. Check the medicine card against the Kardex.
3. Assemble necessary articles for the administration of the medicines.
4. Arrange the cards and the containers on the Zinc rack.
5. Check the drug label with the medication card.

6. Measure the medication according to the order on the individual medicine card.
8. Place the water container on the tray.
9. Carry the tray to the bed-side.
10. Identify the patient with the name and the Reg. No.
11. Administer the medicines followed with water (unless it is contra-indicated) and turn the medicine card.
12. Record
13. File the medicine card in the box.
14. Wash the medicine glasses in the hot soapy solution. Rinse in hot water, wipe it dry and replace in Tray.



- Routine hours for administration of medications e.g. at O.G.H.

|               |               |     |                  |
|---------------|---------------|-----|------------------|
| O.D.          | .....8        | ... | .....            |
| B.D.          | .....8        | ... | .....6           |
| <b>T.D.S.</b> | <b>.,.. 8</b> | ... | <b>2.....6</b>   |
| <b>H.S.</b>   | <b>....</b>   |     | <b>.. .....9</b> |

q4h I .

q 6 h I From the time the medicine is administered to the patient.

q8h I

I

III) For discontinuance of orders :

- Get the card checked by the instructor
- Strike off the discontinued medicine, order in the kardax and destroy the medicine cord

III) Medicine containers will be arranged alphabetical orders in the medicine cupboard.

IV) Un-identified and out dated medications are to be returned to the pharmacy.

## **ADMINISTRATION OF MEDICINE BY INTRAMUSCULAR INJECTION**

**PURPOSE :**

- To introduce drug in to the muscular tissue for
- a) Rapid absorption
  - b) Injecting fluids up to 10 ml.
  - c) Preventing irritation by certain Chemicals when administered by other routes

**EQUIPMENT :**

- Trolley or tray containing :
- Sterile mizur with syringes and needles of gauge No.24 and 1-1 1/2 in length.
  - Container with clean cotton swabs
  - Container with methylated spirit 70%
  - Distilled water ampules
  - The drug
  - Ampule file
  - Kidney tray
  - Abowl with pad and water
  - Towel

**PROCEDURE :**

1. Check the order for; injection and make a card
2. Assemble the equipment
3. Explain to the patient
4. Help patient to be in position
5. Select medication and check the order, dosage and expiry date,
- 6., Wash and dry hands
  
7. Moisten the cotton swab with spirit and wipe the rubber cap of the vial.
8. If the drug is in the ampule lightly tap the tip of the ampule and wipe the neck of the ampule and the ampule file with spirit swab. Break the tip from ampule holding with dry cotton.
9. Pick up the syringe from sterile mizur with out contaminating. Hold it at of lunge
10. Fix the needle of no 20 gauge firmly on to the syringe, by holding the hub of the needle.
11. Draw the required amount of medicine by pushing the air equal to the amount of the drug to be drawn.
12. Change the 20 gauge needle to a finer gauge.

13. Hold the syringe in horizontal position until ready to inject.
14. Check the name of the patient and the order
15. Locate the site and clean area of skin about one inch radius with spirit.
16. Expel air from the syringe but avoid accumulation of medicine at the tip of the needle
17. Stretch the skin and thrust the needle quickly at 90° angle to the site.
18. Hold the needle at the hub with left hand and with draw piston slightly with right hand and confirm that needle in the muscle.
19. Inject medicine slowly holding at the hub of the needle
20. With-draw the needle quickly lightly pressing the surrounding area with cotton swab
21. Massage the area gently, if not contra-indicated.
22. Place the patient in comfortable position.
23. Observe the patient for reaction.
24. Record in chart.

| Date     | Time | Medication                  | Nurses Notes | Signature |
|----------|------|-----------------------------|--------------|-----------|
| 19-11-76 |      | Inj. Decadron<br>4 mgs I.M. |              | Ms Ruben  |

25. Rinse the syringe and needle with water and place in the bowl.

N.B. :-

1. If blood is drawn into the syringe with draw the needle quickly. Discard the used needle and fix another and insert again at a different site.
2. Use a sterile cheatte forceps to pick up the syringes and needles from a sterile container.
3. Sensitivity test to be done for the drugs that may give reaction.
4. Zigzag technique is utilized for inferon injection.

# PROCEDURES FOR SECOND YEAR

**ABDOMINAL PARACENTESIS****PURPOSE :**

1. To remove fluid for diagnostic purposes.
2. To relieve pressure on abdominal and chest organs.

**REQUIREMENT :** Tray containing sterile

- 1 - 2 ml. syringe
- 2 - 25 G X 1 needle
- 1 - 23 GX1 1/4 needle
- 2 - small bowls
- 1 - 5" dissecting forceps or sponge holder
- 6 - cotton balls
- 2 - pad
- 1 - scalpel
- 1 - Trocar and cannula
- 1 - Pint measure
- 1 - Fenestrated towel
- 1 - 12" rubber tubing
- Screw clamp

**Skin preparation tray and in addition collect**

- I 1 - Pair of sterile gloves local anaesthetic 1-2% procain
- 3 - Sterile specimen bottles
- 1 - Many tailed binder
- 2 - Safety pins
- 1 - Draw mackintosh
- 1 - Back rest

**PROCEDURE :**

1. Assemble equipment and bring to bed side
2. Explain procedure to the patient and screen
3. Have patient empty the bladder
4. Fan fold the top linen down to the public area
5. Expose the area below the nipple upto the public area
6. Prepare the area as mentioned in the skin preparation.
7. Place the bucket in position to receive the fluid
8. Place the patient in fowler's position and bring the patient to

edge of the bed.

9. Place many tailed binder in position
10. Place draw mackintosh to protect the patient's linen
11. Place sterile tray, paper bag in a kidney tray at a convenient place.
12. Wash hands and open sterile tray.
13. Open draining dressing set and take forceps and hand over the surgical towel from the sterile tray to the doctor for wiping hands.
14. Open glove pack.
15. Assist in preparation of the skin (After skin preparation doctor drapes the area with fenestrated towel)
16. Assist doctor in drawing the local anaesthetic (after infiltration of the area with local anaesthetic) Doctor will insert trocar and cannula half way way between umbilicus and symphysis pubic. Trocar is removed by the doctor and rubber tubing is attached to the cannula to drain out the fluid. Place the rubber tubing in a sterile pint measure and adjust the rate of flow with a screw clamp.
17. If specimens are to be sent, collect the fluid in the specified number of bottles.
18. When desired amount of fluid is removed or procedure is to discontinued place the gauze piece and gamji pads after cleaning with sterile cotton swabs over the wound.
19. Secure it with many tailed binder.
20. Place patient in comfortable position in bed.

21. Remove equipment and keep the unit neat and tidy.
22. Remove fluid to the utility room, measure, note characteristic of the fluid and record.
23. Send specimens with requisition from to the lab.
24. Wash dry and replace the equipment.

## **PRE OPERATIVE SKIN PREPARATION**

### **1. OPERATIONS ON NECK :**

- a) Biopsy of neck glands.
- b) Excision of neck glands.
- c) Tracheostomy

Shave anterior surface of the neck starting from chin to the clavicle line.

- a) Thyroidectomy
- b) Laryngectomy

Shave anterior surface from the chin to the nippleline extended posteriorly from hair line behind the ear covering the hair line to bed line.

- a) Resection of sub maxillary gland.
- b) Resection of mandible.

Same as above and include area starting from maxillary line anteriorly.

N.B.: Obtain permission for female patients.

### **2. OPERATION ON CHEST :**

- a) Lobectomy
- b) Pneumone ctomy
- c) Operations on the Oesophagus
- d) Heart surgery
- e) Hiatus Hernia
- f) Oesophago Jejunostomy

Anteriorly shave the area starting from the neck upto superior iliac spine' extended posteriorly .  
to the affected side

### **3. OPERATION ON BREAST :**

- a) Simple mastectomy
- b) Redical mastectomy
- c) Excision of Lump in the breast

same as above & the corresponding side of the arm upto elbow.

### **4. OPERATION ON ABDOMEN**

- a) Laparotomy
- b) Gastrojejunostomy
- c) Gastrectomy (partial)
- d) Chole Cystectomy
- e) Caesarean
- f) Hysterectomy
- g) Hernia

N.B. : for males from nipple line upto mid thighs including pubic area,  
for females start from below the breasts.

**5. OPERATION ON THE KIDNEY**

- a) Nephrectomy
- b) Nephrectomy
- c) Pyelolithotomy

shave from the nipple line to anterior superior iliac spine & posteriorly, extending upto soine from top shave lower border of scapula upto the sacral line.

- a) Prostatectomy
- b) Suprapubic Cystostomy

Shave as for abdomen operation.

**6. OPERATIONS ON THE SPINE :**

- a) Haemorrhoidectomy
- b) Fistulectomy
- c) Amputation of the cervix
- d) Vaginal hysterectomy
- e) Manchester repair
- f) D&C
- g) Conisation
- h) Sterilization
- i) Periniorrhaphy
- j) Hydrocele

Shave anteriorly from Umbilical line to mid thighs including pubic area  
Post. from lumbar region to midthighs.

- b) Abdominoperineal resection same as for abdominal & rectal surgery

**7. OPERATION ON THE BONE ?**

- a) Amoutation of leg below hip joint and above knee joint shave the whole leg starting from hip joint totoes.
- b) Amputation of hand : shave whole had from the shoulder to the finger nail 187

**BLOOD TRANSFUSION****PURPOSE :**

To replace blood through the vein

- a) To prevent shock
- b) To treat shock
- c) To correct anaemia

**EQUIPMENT:**

Same as for Intravenous Infusion

except the following changes

1. Needle gauge No. 18 or 19 and 1<sup>1</sup>/<sub>2</sub>:-2" length.
2. A wrapper for the bottle
3. Anti histamin drug

**PROCEDURE :**

1. Check the order for transfusion.
2. Confirm blood group of the patient
3. Send the specimen of blood for cross-matching along with the requisition form to the blood bank
4. Collect the equipment.
5. Receive the blood.
6. Check along with the Doctor, for name, register number, ward, bed number and blood group of the patient.
7. Wrap the bottle with wrapper.
8. Follow the steps as per the I.V. infusion
9. Observe the reaction
10. Record :
  - i) The type of transfusion (whole blood or packed cells)  
Group of the blood amount time rate of flow Anti-histamin, if added name of the Dr., who started transfusion pulse and the respiration of the patient.
  - ii) Record on the temperature chart-the amount and group of the blood transfused.

N.B.: When the patient has the reaction.

- i) Stop the transfusion
- ii) Notify the Doctor,
- iii) Record the condition of the patient.
- iv) Send the entire blood and I.V. set with the form to the blood bank,
- v) Administer on emergency drug as per the order.
- vi) Send urine and blood specimen to the Laboratory and specify on the requisition form that the patient had blood transfusion.

2. A bottle of normal saline to be kept along with the equipment, if required.

3. i) Anti-histamin drug may be added to blood before starting.

OR

- ii) Before starting blood anti-histamin may be injected into the vein directly.

OR

- iii) May be given when the reaction occurs.

## **BLADDER INSTALLATION**

### **PURPOSE :**

To apply a medication locally to the bladder.

### **EQUIPMENT :**

In addition to equipment for catheterization or bladder irrigation which usually proceeds the procedure.

Medication as ordered by the doctor.

Sterile medicine glass.

If catheterization precedes this procedure.

Sterile funnel and, if necessary, a piece of tubing and adaptor which will fit into the end of the catheter.

### **PROCEDURE :**

Prepare medication in sterile glass following technique for administration of the any medication. -

When the bladder is empty either following catheterization or bladder irrigation allow the medication to slowly enter the bladder through the syringe or funnel.

Clamp or pinch the catheter before removing.

Record : In treatment and medication column : Name amount and strength of dication instilled.

In nursing column : Any reaction noted.

## **CARE OF GRAVITY DRAINAGE FROM BODY CAVITY**

**PURPOSE** : To prevent ascending infection to the body cavity to which drainage is applied.

I

### **EQUIPMENT :**

Sterile drainage bottle  
Sterile drainage tube  
Sterile glass connection

### **PROCEDURE:**

1. Wash bottle with soap water, and rinse.  
If salt deposits are present, clean with any as before washing with soap and water.
2. Prepare paper cover and prepare for autoclaving if autoclaving not possible, use savion.
  - a) Cover bottle and drainage tube with 3% saviod for 15 minutes OR
  - b) Boil bottle and tube for 20 minutes.
3. Take the bottle and drainage tube to bed aide and connect to the catheter. Cover mouth of the bottle with paper cover or four of steril gauze
4. Suspend bottle from the side of the bed or place in bottle stand.
5. Fix the tube with pin at the edge of the bed.
6. When the bottle is full bring the measure to the bedside, remove drainage tube from the bottle and pour drainage into the measure. Replace the end of tube the bottle and cover Measure drainage and record.

**AFTER CARE OF EQUIPMENT :**

Drainage should be continuous

If urethral catheter has been inserted, record drainage from each urethral catheter separately

Prevent excoriation of skin by keeping skin dry,

Drainage tube, glass connection and bottle should be changed daily.

If there is any sandy material in the tube, irrigate the tube with any acid wash with soap and water.

Drainage tube should be long enough to enable the patient to move freely in bed but should not coil.

Drainage bottle should be below the level of symphysis pubis.

Nurse taking care of the patient should empty drainage, measure and record before going off from duty.

## **BLADDER IRRIGATION**

### **PURPOSE :**

To cleanse the bladder of irrigating substances  
To relieve pain and congestion

### **EQUIPMENT :**

To equipment for catheterization add  
Container with sterile as ordered by doctor  
Sterile 20 cc. syringe (with adaptor if needed to facilitate attachment to catheter)

OR

Sterile funnel with rubber tubing and glass connection  
Large kidney basin.

solutions commonly used

Normal saline

Acridine, 1 : 5000

Potassium permanganate. 1:6000

Bismuth of mercury, 1 : 8000

Temperature of solutions for treatment of inflammation 100 to 110°F

### **PROCEDURE OR ACTION :**

Prepare solution at room temperature unless ordered specifically.

Catheterize the patient.

When the urine flow has ceased, attach the barrel of the syringe to the catheter (or the funnel and rubber tubing)

Replace small kidney basin with the large one.

introduce 2 to 4 ounces of the solution into the barrel of the syringe or the funnel and allow to flow into the bladder.

Lower syringe or funnel and allow solution to return into the kidney basin.

Continue introducing solution and allowing it to flow out of bladder until return flow is clear or the amount of solution ordered has been used.

Complete the procedure as for catheterization.

**RECORD :**

As for catheterization

In the treatment column indicate treatment, kind Strength, amount (and if measured-temperature) of solution used.

In nursing notes, record character of return flow and any important reaction to treatment.

**FOR INTERMITTENT IRRIGATION OVER  
A PERIOD OF TIME**

Prepare solution in a standard intravenous set-up  
(label: Bladder irrigating solution kind amount and strength)  
Attach the set the catheter by means of a Y connect Attach other  
outlet of Y connect to a length of rubber tubing leading to a drainage  
bottle. Fasten stop cocks  
A      on tubing leading to catheter  
B      on tubing leading to drainage  
Loosen stopcock A and allow 2 - 4 ounces of solution to flow into the  
bladder slowly.  
Tighten stopcock  
Open stopcock B and allow return flow into drainage bottom  
Continue until amount of solution ordered for the irrigation is used.  
Repeat irrigation at intervals as ordered.

## **GASTRIC ANALYSIS**

### **PURPOSE :**

To obtain gastric contents for laboratory test.

### **EQUIPMENT :**

As for gastric intubations :

. 10 or 20 cc. syringe. 6 labelled specimen bottles.

### **GENERAL INSTRUCTIONS :**

1. Patient to have light meal the night before the test and nothing by mouth after midnight.
2. Instruct patient to avoid swallowing saliva during period that specimens are being drawn.

### **METHOD:**

1. After passing Rhyle's tube aspirate all stomach contents. Place 10cc in specimen bottle labelled "Tasting fluid" Measure total amount aspirated and indicate on label of specimen. Clamp tube.
2. Give 13 Oz. of Congee.
3. Hax 1/2 hour after administration of Congee take 1st specimen. Aspirate 5cc of stomach contents and place in specimen bottle labelled "NO. 1<sup>s</sup> Aspirate b cc of stomach contents every 15 minutes and place in consecutively numbered specimen bottle until a total of 5 specimens have been obtained.
4. Remove Rhyle's tube if no further treatment needed.
5. Send specimen with laboratory request to laboratory.

After Care of equipment: As for gastric intubation Record :

| TIME      | Diet   | Treatment & Medication | Nursing Notes   |
|-----------|--------|------------------------|---|
| 7-30 a.m. | congee | Rhyle's tube passed    | Fasting Stomach   |
| 7-45 a.m. | 13 oz  |                        | Contents aspirated  |
| 8-15 a.m. |        |                        | 30 cc.  |
| 9-30 a.m. |        | Rhyle's tube removed   | Aspiration of<br>5 specimens 5 cc. each<br>gastic analysis. |

**GASTRIC UAWAGE OR GASTROSTOMY TUBE FEEDING****PURPOSE :**

To introduce liquid food or medication directly into the stomach.

**EQUIPMENT :**

In addition to equipment needed for naso-gastric intubation  
Feeding or medication as ordered.

Feeding cup with water

Funnel (if gastrostomy feeding)

**PROCEDURE :**

1. Prepare or obtain feeding. If cold, place In basin of warm water,
2. If tube is not already in place insert following procedure for naso-gastric intubation
3. If gastrostomy feeding, attach funnel if feeding is to be given through naso gastric tube, replace syringe with funnel if desired
4. Introduce a small amount of water through tube.
5. Slowly introduce feeding or medication Keep funnel or syringe barrel full until total amount has been introduced.
6. Clear tube by introducing a small amount of water.
7. Disconnect funnel or syringe barrel.
8. Clamp tube if it is to be left in place-otherwise, remove tube, Place in kidney basin.

**RECORD:**

| <u>Time</u><br><u>Noted</u> | <u>Diet</u>                                       | <u>Medication &amp; treatment</u> | <u>Nursing</u>   |
|-----------------------------|---|-----------------------------------|--|
| 10A.M.                      | Milk<br>150cc.<br>Egg. 1<br>Sugar<br>2 tea sponns |                                   | Feeding through<br>gastrostomy tube<br>Complains of<br>Slight nausea<br>K. Lalitha |

## After care equipment:

1. Rinse equipment in cold water.
2. Wash in soap and water. Dry.  
Replace ready for next feeding.

## **GASTRIC LAVAGE**

### **PURPOSE :**

To cleanse and / or decompress stomach :  
to wash out poisons or irritating substances  
from the stomach.

### **EQUIPMENT :**

In addition to equipment for naso-gastric intubation  
Stomach tube  
Jug with solution as ordered  
Small mug or graduate  
Bucket

### **PROCEDURE :**

1. Assemble equipment
2. Screen patient
3. Explain procedure
4. Bring equipment to bedside
5. Place bucket at side of bed (on stool if necessary)
6. If possible place patient in Fowler's position with head and neck well supported in position of hyperextension.
7. Place covered treatment mackintosh on patients class.
8. Instruct patient to hold kidney basin or place convenient to use.
9. Remove tube from basin of cold water. Place tip of tube for pack into mouth and ask patient to swallow- As patient swallows, advance tube quickly to mark.
10. Hold funnel upright at level lower than stomach. Introduce solution slowly-elevating funnel so that solution flows at rate desired Allow 300 to 500 cc.. of solution to enter stomach.
11. Pinch tube. Invent funnel over bucket and allow solution to return.
12. Continue alternate Introduction and supporting of fluid until quantity ordered doctor has been given or return flow is clear.
13. Pinch and remove tube and place in kidney basin.

14. Remove mackintosh and towel Leave patient comfortable and unit tidy
15. Remove bucket, empty, rinse, wipe, dry and replace.
16. Remove tray with used Equipment to utility room, Rinse tube with cold water, wash with soap and place in boiling water and bottle for 5 minutes. Dry and replace ready for use. Rinse wash and remaining equipment and replace ready for use.

**RECORD:**

| Time   | Diet | Treatment and medication                          | Nursing Noted   |
|--------|------|---|---|
| 2 p.m. |      | Gastric lavage. Sodium bicarbonate 2%, 2, 500 oc. | Solution greenish brown containing particles of food indigested continued until flow clear Patient very comfortable.<br>K. Lalita |

## **ADMINISTRATION OF MEDICINE BY INTRADERMAL INJECTION**

### **PURPOSE :**

To introduce drug, vaccine, sera or toxoid in to the dermis.

1. To test for allergic manifestation
2. To develop immunity
3. To diagnose disease condition

### **EQUIPMENT :**

Tray containing :

- Sterile mizur with 2 cc syringe or tuberculin syringe and needles of guage No, 25 or 26 and 3/8 of an inch *in* container with clean cotton swabs.  
Container with methy, Spirit 70%  
distilled water ampules  
ampule file drug  
Kidney
- a bowl with pad and water
- towel

### **PROCEDURE :**

1. Check the order.
2. Assemble the equipment
3. Explain to the patient
4. Make the patient sit up or lie down
5. Select the medication and check for expiry date
6. Moisten the cotton swab with spirit and wipe the rubber cap of the vial
7. Pick up the syringe from sterile, Mizur holding the flange
8. Fix the wide bore needle firmly on to the syringe holding the hub of the needle

9. Draw 01-02 ml of the drug
10. Change to finer gauge needle
11. Select the site and clean with spirit swab
12. Expel air from syringe
13. Stretch the skin taut with left thumb and index finger
14. Introduce the needle level side up at 45° angle until the level is completely covered.
15. Inject the drug to raise 5 mm of wheal
16. Withdraw the needle.
17. Observe the patient for reaction
18. Record in the chart
19. Rinse the syringe and needle with water and place in the bowl.

N.B. : If the drug has to be taken from the ampule, refer to step 8 under.

1. IM injection
  2. If intradermal injections are given on a level keep the following articles for sterilizing the needles
    - 1) Spirit lamp
    - 2) Matchbox
    - 3) Syringe stand
    - 4) Small metal screen to protect the flame
- Give specific instructions accordingly the type of drug administered.



## **INTRAVENOUS INFUSION**

### **PROCEDURE:**

1. Check order
2. Explain to patient and carry out any Nursing procedures eg., offering bed pan, care changing linen etc.
3. Assemble equipment and table the bottle.
4. Place dressing mackintosh and towel under the selected site where I.V. is to be started.
5. Place tourniquet.
6. Place the hanger as the I.V. bottle and place the kidney tray near to the site.
7. Wash and dry hands
8. Open the I.V. set
9. Connect it to the solution bottle and hang the bottle about 2-3 feet above the level of bed.
10. Expel air by allowing the fluid to run through the tube into the kidney tray and pinch the tube then raise the tube above the level of fluid in the bottle, release the tubing until all the air is expelled from tubing, link the tube and clamp the tubing tight.
11. Cover the adapter with sterile cover until it is fixed.
12. Apply tourniquet when doctor is ready with the syringe and needle.
13. After the insertion of the needle into the vein fix the adapter to the needle, loosen screw clamp and fix the adhesive plaster.
14. Adjust the Infusion rate to desired speed.
15. Secure the needle to tubing in place with adhesive plaster on the hub of the needle.

16. Apply bandage to the arm.
17. Observe the flow of solution and placement of needle in vein.
18. Record :

| <u>Dt. and time</u>     | <u>Medication</u>     | <u>Nurses</u> | <u>Notes</u> | <u>Signature</u> |
|-------------------------|-----------------------|---------------|--------------|------------------|
| 27.11.1976<br>11.00a.m. | 1. 5% glucose 500 ml. |               | 40 drops     |                  |
| 2.00 p.m.               | 2. N. Saline 500 ml   |               |              |                  |
| 6.00p.m.                | 3. 5% Glucose.        |               |              |                  |

19. Glean and dry the used articles and replace
20. To discontinue I.V. Infusion, bring J.V. preparation tray to bed side. (Kidney tray cotton balls and spirit bottle)
21. Close the screw clamp, remove adhesive strips from the tubing and needle.
22. Apply pressure with sponge for a few minutes until no danger of bleeding.
23. Flush water through I.V. Tubing and needle.
24. Replace equipment.

- N.B: 1. Observe the patient continuously as long as the solution is following.
2. Instruct the attendant to report pain, swelling rigor, leakage.
  3. When positive pressure is used to run the I.V. infusion keep the B.P. Apparatus bulb. At such time precaution to be taken to prevent entry of air.

## **NASO GASTRIC INTUBATION**

### **PURPOSE :**

To introduce a naso gastric (Rhylics tube) so as to produce a minimum of discomfort to the patient

### **EQUIPMENT :**

Tray containing:  
Naso-gastric tube in bowl containing cold water  
Adhesive strip  
Kidney tray  
Gauze pieces  
Treatment mackintosh  
Screen 10 cc. syringe.

### **PROCEDURE :**

1. Assemble equipment and bring to bedside
2. Explain procedure, screen patient
3. If possible, place patient in Fowler's position with shoulders and head well supported in hyper extension.
4. Place covered treatment mackintosh over chest.
5. Measure distance for insertion of tube from tip of sternum to nares and mark with adhesive.
6. Insert tube through nostrile to pharynx.
7. Have patient I.P. head forward and swallow. Each time patient swallow, advance tube into egophagus as far as possible continue until adhesive mark is reached.
8. Attach barrel of syringe to end of tube. Invert barrel into water to check that tube is not in respiratory passage. Aspirate to see that tube is in stomach.

9. Continue with aspiration, lavage or gavage as indicated (See specific procedures).
10. Quickly withdraw tube and place in kidney basin. Leave patient comfortable, Unit clean and neat remove equipment to utility room. •

**RECORD :**

| <u>Time</u> | <u>Diet</u> | <u>Medication &amp; treatment</u> | <u>Nursing Noted</u>                  |
|-------------|-------------|-----------------------------------|---------------------------------------|
| 2p.m.       |             | Rhyles tube inserted              | Distention -relieved<br><br>K Lalitha |

## After care equipment:

1. Rinse tube with cold water. Wash with soap and water. Place in boil water and boil for 5 minutes.
2. Rinse, wash and dry remaining equipment and replace.

## **OXYGEN THERAPY**

**PURPOSE** : To administer Oxygen

**EQUIPMENT** : Oxygen cylinder stand

Oxygen cylinder

Key to open and close cylinder.

Flow meter

Gauge

Woulfo's bottle

Rubber tubing's 2 (one short and one long)

Glass connection

Nasal catheter

Cotton bag tied to stand

A tray containing : Small bowl of water Adhesive plaster

Safety pin Torch.

**PROCEDURE** :

Check set up and bring to bedside. Explain Procedure to patient

Take adhesive strips

On catheter, measure distance from nares to ear lobe

Open the fine valve

Lubricate tip of nasal catheter in bowl of water Insert the nasal catheter, to mark on catheter. Secure with adhesive strips. Fix the tubing firmly by pinning it on to the Bottom sheet.

Check location of catheter - tip in pharynx Clean and dry articles and replace.

**RECORD :**

| Date & Time | Diet      | Medication & Treatment             | Nursing Noted                      |
|-------------|-----------|------------------------------------|------------------------------------|
| 6-5-1963    | 8-30 a.m. | Oxygen by nasal catheter @ 4 L/min | Resp. 48/m                         |
|             | 8-45 a.m. |                                    | Susheela<br>Resp. 30/m.<br>Sheela. |

**After care equipment:**

When the treatment is discontinued, remove adhesive strips disconnect nasal catheter, clean with soap and water, put in boiling water for 3 minutes. Replace Catheter in the bag tied to cylinder ready for use.

If no oxygen guage is available, adjust flow by frequent taking of pulse and respiration rate. Increase oxygen flow-if pulse, and respiration decrease following adjustment. Maintain flow at adjusted rate when pulse and respiration rates are stabilized.

## **POST - OPERATIVE BED**

### **PURPOSE :**

To facilitate reception of the patient after surgery and the giving of care from the time patient returns from the theatre until he has fully recovered from anesthesia.

### **EQUIPMENT:**

Linens as for an open bed  
Rubber and cotton draw sheet  
Treatment mackintosh and towel  
Blanket if weather is cold  
Kidney basin  
Bowl with gauze  
Paper for recording observations of condition  
Additional equipment according to the kind of surgery and anesthesia and anticipated orders of the doctor.

### **PROCEDURE:**

- Assemble equipment and take to bedside.
- Strip bed turn the mattress and dust bed and mattress.
- Make foundation of bed using clean linen if possible.
- Apply rubber and cotton draw sheets.
- Place treatment mackintosh covered with towel at head of bed.
- Place top covers as for an open bed but do not tuck at foot of bed.
- When bed is completed or opposite side, fanfold top bedding to edge of mattress on side opposite to which the stretcher will be brought.
- Place pillow upright against the bed rails at the head of the bed.
- Place kidney basin and bowl with gauze on locker.
- Clip paper to chart board.

## **Preparation of Patients for RADIOLOGICAL INVESTIGATIONS**

### **BARIUM MEAL SERIES :**

Patient is given a light diet (Bread and milk) in the evening, the day before, and starved till next morning. At 8-00 a.m. on the day posted Antrenyl 10 mg tablet is given if pyloric stenosis is suspected stomach wash should be given followed by Antrenyl. Send the patient to X-Ray department at 8-30 a.m. on empty stomach.

### **BARIUM ENEMA :**

Patient is given a purgative (Preferably Castor oil 1 Oz.) the previous evening on the day of posting in the morning, soap and water enema is given. Patient is sent to X-ray department at 8-30 a.m.

### **PLAIN X-Ray ABDOMEN : (Kidney, Ureter, Bladder and Gall Bladder)**

1st Day - Charcoal tablets 2 (gr. v each) tds and Take diastase 2 tds in the evening with water  
Pulv Glycerhizaco 2 grams at bed time

2nd Day : Repeat as above. Give light diet in the evening (Bread & Milk) stave patient after 10-00 p.m. patient can have water during the night.

3rd Day - Send the patient to X-ray department at 8-00 a.m. on empty stomach.

### **INTRAVENOUS PYELOGRAPHY :**

**1st Day** - Charcoal tablets 2 (each 5 grains) t.d.s. take diastase 2 tablets t.d.s. Pulv Glycerihizaco 2 drams at bed time.

**2nd Day-** Charcoal tablets 2 t.d.s. Take diastase 2 tablets at 8-00 a.m. 2 tablets at 12-00 noon. Light fat free diet at 5-00 p.m. Telepaque 6 tablets 6-00 p.m. to be indented from x-ray department), all to be taken at same time. Tablets

should not be chewed or crushed. Nothing to be eaten after 6-00 p.m.

**3rd Day** - Send to x-ray department at 8-00 a.m. an empty stomach.

**CHOLECYSTOGRAPHY :**

**1st Day** - Charcoal tablets 2 (each 5 grains) t.d.s. take diastase 2 tablets t.d.s. Pulv Glyechrizace 2 grams at bed time,

**2nd Day** -Charcoal tablets 2 t.d.s. Take diastase 2 tablets at 8-00 a.m. 2 tablets at 12-00 p.m. Light fat free dinner diet at 5-00 p.m. Telepaque 6 tablets at 6-00 p.m. (to be indented from x-ray department), all to be taken at same time. Tablets should not be chewed. Nothing to be cater after 6-00 p.m.

**3rd Day** - Send to X-ray department at 9-00 a.m. on empty stomach. Send along with the patient 2 slices of bread. 1 oz. of butter and glass of milk (If non-vegetarian-two eggs in any form)

**Note** - The diet should be indented for the evening before, and obtained from the kitchen department.

Take diastase and charcoal tablets are indented from in-patient pharmacy.

**SKIN - PREPARATION**

**PURPOSE** : To prepare the skin for surgery / surgical procedures.

**EQUIPMENT :**

- |  |   |
|--|---|
| 1) A tray containing : <ol style="list-style-type: none"> <li>1. Sterile Surgical towel</li> <li>2. Dressing set</li> <li>3. Bowl of warm water-</li> <li>4. Razor set with blade-</li> <li>5. Bowl with 6 cotton balls</li> <li>6. 6-gauze squares</li> <li>7. Soap dish with soap</li> <li>8. Bottle of Savion 1:30</li> <li>9. Bottle of ether</li> <li>10. Bottle of spirit.</li> <li>11. Torch</li> <li>12. Kidney tray</li> <li>13. Draw mackintosh</li> <li>14. Treatment bowl</li> <li>15. Paper bag</li> <li>16. Bandage or binder safety pins/plaster and pair of scissor</li> </ol> | 2) Articles for cleaning : <ul style="list-style-type: none"> <li>- Basin</li> <li>Sponge cloth</li> <li>Jugs</li> <li>Bucket.</li> </ul> |
|  | 3) Screen.  |

**PROCEDURE:**

1. Check pre-operative instructions and consent of the patient for option.
2. Explain the procedure to the patient.
3. Assemble the equipment.
4. Expose the operative area to good light.
5. Screen the patient.
6. Wash hands
7. Place the draw mackintosh area to good Sight towel under the part to be prepared
8. Expose the part to be prepared
9. Arrange the equipment.
10. Apply soap to the area to be shaved with cotton swabs/sponge cloth.

11. Stretch the skin to be shaved by holding the cotton ball in between the forefinger.
12. Loosen the screw of the razor and rinse it in the water as often as required to remove loose hair.
13. Remove all the soap and loose hair from the skin with sponge cloth.
14. Inspect the area carefully under good light for missed hair, chest and cuts. Shave and clean if necessary.
15. Scrub the area thoroughly with soap and water using sponge cloth and remove the soap completely.
16. Scrub the area with other using gauze squares.
17. Wash hands.
18. Open dressing set.
19. Clean with savlon using sterile forceps and gauze squares and dry the skin with cotton
20. Apply spirit using sterile forceps and cotton swabs.
21. Place sterile towel over the prepared part.
22. Apply binder or bandage
23. make binder or bandage.
24. Replace screen
25. Record

---

| Date    | Time Medication & treatment | Nurses Notes        | Signature |
|---------|-----------------------------|---------------------|-----------|
| 14-7-78 | 8AM                         | Skin prepare forGJ. | D.Reuben  |

26. Remove the blade and discard / disinfect
27. Boil / Disinfect the razor set.
28. Wash dry and replace

**Note:**

1. All patients oaving surgery must have thorough bath.
2. For male patients shave the beard.
3. For orthopedic operation three days preparation is required before surgery.
4. Application of antiseptics and cleaning with binder or bandage, are done on final I preparation.

## **SUBCUTANEOUS INJECTION**

### **PURPOSE :**

To introduce the drug in to subcutaneous tissue for slow absorption.

### **PROCEDURE:**

Same as for I.M. Injection, except the following:

- Introduce the needle gauge No. 25 and ½ in length, at 45° angle in the subcutaneous tissue.

**VENE- SECTION****PURPOSE :**

Same as for I.V. infusion except incision is made the skin.

1. To identify the vein to Introduce the canvula or polyethene tube when the veins are collapse.
2. When continuous infusion is needed.

**EQUIPMENT :**

- |    |                                |    |
|----|--------------------------------|----|
| I. | A Sterile tray containing :    |    |
|    | B.P handle with blade          | 10 |
|    | Small curved scissors          | 1  |
|    | Toothed dessecting forceps     | 1  |
|    | Mosquito curved artery forceps | 2  |
|    | Ameurysm needle                |    |
|    | Needle holder                  |    |
|    | Straight cutting needle        |    |
|    | curved cutting needle          |    |
|    | cotton thread                  |    |
|    | Suture scissors                | 1  |
|    | Fenestrated Towel              | 1  |
|    | Small bowl                     | 1  |
|    | Syringe 2 cc                   |    |
|    | Needle gauze No. 23-24         |    |
|    | Cotton balls                   |    |
|    | Gauze sponge.                  |    |
|    | II                             |    |
|    | Sterile glove                  |    |
|    | pack 6 V <sub>2</sub> or 7     |    |
|    | III.                           |    |
|    | Sterile                        |    |
|    | vene section                   |    |
|    | Canula or polyethylene         |    |
|    | Tube in a small bottle         |    |
|    | Sterile Pressing set-1         | .  |
|    | Suture removal set-1           |    |

- IV. A Tray containing:  
Zylocaine  
Toreily  
Bandage  
I.V. Preparation tray.

**PROCEDURE :**

1. Prepare the skin where vene section is to be done.
2. Doctor prepares the skin and drapes the patient and incises the skin and exposes the vein for insertion of canula.
3. When canula is introduced into the vein, fix the adapter of the infusion set to the canula.
4. Fix the sterile asesings with adhesive plaster.
5. The meaning procedure is same as I.V. Infusion.

N.B.: 1. Observe for the local irritation of the vein a placement of the canula in vein.



**PROCEDURE:**

- Assemble equipment in utility room.
  - Screen patient and explain procedure.
  - Bring equipment and explain procedure.
  - Catheterize patient with Foley's catheter and clamp.
  - Open tidal drainage pack and assemble equipment.
  - Fill irrigating bottle with about 100 cc of solution. and hang it with rubber tubing on I.V. stand.
  - Connect tubing to the catheter and adjust murphy and tubing so that a measured amount of fluid flow from irrigating bottle into to bladder.
  - Secure tubing to bed clothes with safety pin.
  - Attach a card to irrigating flask with date, time, started amount, kind and strength of solution used.
  - Make patient comfortable and remove extra equipment.

**RECORD:**

Time started, amount of solution used and condition of patient.

**After care of equipment:**

Wash with soap water rinse under running water and send for autoclaving.

## **CATHETERIZATION (Female)**

### **PURPOSE :**

To remove urine from the bladder under aseptic conditions and without trauma to the mucosa.

This treatment might be ordered :

To relieve urinary retention.

To obtain a sterile urine specimen.

To empty the bladder before certain operations

To determine urinary residual.

### **EQUIPMENT :**

Sterile:

Covered tray containing :

Small bowl with 3 cotton swab moistened with 2% dettol.,

Small bowl containing sterile water

8 dry cotton swabs

2 artery forceps

2 catheters (six according to need. 12, 13, 16 French)

Treatment towel

Kidney basin

Gloves

Specimen bottle

### **UN-STERILE :**

Large tray

Treatment rubber and cover

500 cc. measure

Kidney basin

Sheet

Treatment lamp or torch as needed

### **PROCEDURE :**

- Assemble and take equipment to bedside
- Screen patient and explain treatment
- Fanfold bedding to foot of bed replacing with sheet
- Place treatment rubber and cover under erinens

- Put patient in lithotomy position and cape
- Wash hands
- Remove cover from sterile tray
- Loosen cover of specimen bottle if, specimen is to be collected.
- Turn back corner of drape to expose Perineum
- Place tray with equipment convenient to use
- Put on sterile gloves
- Place sterile towel with edge slightly under buttocks.
- Place kidney basin containing one catheter on sterile towel.
- Separate labia with thumb and forefinger
- hand using two dry cotton swabs to help separate labia apart.
- Cleanse over urethral orifice and perineum with dettol swabs hold in artery for downward strokes discarding each of time after reaching rectum. Discard cotton unsterile kidney basin.
- Discard artery forceps unsterile kidney.
- Keep labia separated with fingers of left hand with right hand pick up to catheter 3 inches from holding rest of catheter coiled in hand. More tip of catheter with sterile water. (If gloves not available - use sterile artery forceps to catheter).

Drop end of catheter into sterile kidney basin and move basin close to perineum to receive urine.

Gently insert catheter through urinary meatus until flow of urine starts.

Hold catheter in place with right hand until flow of urine stops.

If a sterile specimen is to be collected remove cover from specimen bottle, place bottle against cup of kidney basin, lift end of catheter and direct flow of urine into bottle. When sufficient urine has collected for a specimen bottle on tray  
Cover.

**NOTE :**

- Second catheter is on tray in case of contamination of the first.
- If necessary discontinue flow of urine by pinching end of catheter and emptying kidney basin into measures.
- When flow of urine stops emptying urine into measure remove catheter and place into kidney basin, replace latter on tray.
- Using artery forceps and swabs dipped into sterile water, cleanse over urinary meatus and perineum, Use 3 swabs and downward strokes only - discharging each swab after cleansing perineum.
- Use remaining 3 swabs to day area Discard swabs and artery forceps into unsterile kidney basin.
- Turn patient to side and dry buttocks with treatment towel.
- Remove, treatment rubber and cover. Replace bidding and remove crape.
- Remove equipment to clean up area Secure cover of specimen bottle, label and send to laboratory.
- Clean and replace equipment.

**RECORD**

In treatment column : Treatment time

In nurses notes column Amount and appearance on if abnormal, Specimen, to laboratory. Any other reaction to treatment.

Catheterization for residual Have patient void completely immediately from catheterizing.

Self retaining catheters are usually inserted by doctor.

In addition to the above equipment add a metal sound for insertion of a male cot or mushroom catheter and a 20 cc syringe for insertion of a Foley's catheter.

**CATHERIZATION [MALE PATIENT]**  
**(USUALLY DONE BY DOCTOR)**

**PURPOSE :**

Same as for female

**EQUIPMENT :**

As female add :

STERILE

4X4 gauze sponge

Cotton swab moistened with liquid paraffin, dry cotton swabs only 3 needed.

**PROCEDURE :**

Assemble and take equipment to bedside.

Screen the patient and explain the treatment. Fanfold bedding to mid-thighs replacing with sheet.

Place treatment rubber and cover under buttocks.

Place tray convenient for reach.

Wash hands.

Turn back sheet to expose the part.

Uncover small sterile tray.

Loosen cover of specimen bottle if specimen is to be collected.

Put on gloves.

Place sterile towel over thighs and under penis.

Lubricate catheter and place in sterile kidney basin.

Using gauze sponge, grasp penis with left hand, hold in position at right angle to body and with foreskin retracted

Using forceps and dettol swabs (3) clean the glands

penis Discard swabs and for keeps into un sterile kidney tray.  
Pick up the catheter, 3 inches from the tip.

Insert gently through the meatus until flow of urine (second catheter available if the first becomes contaminated)

Remainder of procedure as desired in catheterization female patient (only two cotton swabs moistened with water are needed for cleaning after removal of catheter and one drying cotton swab for drying).

6. To discontinue keep sterile tooth dissecting for sterile gesture removal set, bandage, skin tray, mackintosh and removal,
7. Dress the wound.

\*/- Mosquito straight artery forceps – 2

**FEMORAL RETROGRADE ANGIOGRAPHY****[Open method]**

**PURPOSE** : To expose and open an artery to inject radio-opaque dye to outline the systemic circulation.

**NOTE** : Site chosen commonly is femoral artery, as the basilica artery goes into spasms, and made pass of gum elastic catheter difficult.

**PREPARATION & PROCEDURE:**

- Prepare patient as for general anesthesia.
- Local skin preparation as indicated by doctor.
- Administer premeditation ordered 1/2 hour before sending to theatre.
- Under general anesthesia surgeon exposes the femoral artery and passes gum elastic cardiac catheter or
- polyethylene tube into the far artery.
- Intravenous normal saline or 5% glucose / water ordered amount of Heparin slow drip through or end of the bifurcated cardiac catheter.
- Patient is taken to the X-ray Department by the scrubbed up team and equipment and drugs need for combating cardiac arrest.
- Under the fluorescent screen the surgeon passes the cardiac catheter as needed.
- Clamp the heparin drips.
- Through the free end of bifurcated tube "Urographin " 65%, 50 cc. injected and X-ray are taken as dye circulates.

- Resume Heparin drip and wait for wet films.
- Procedure is repeated if unsuccessful.
- Patient is taken back to the theatre after completion of procedure for ligation of artery and closure of wound.

**AFTER CARE OF PATIENT :**

As for any patient under general anesthesia.

## **LUMBAR PUNCTURE**

### **PURPOSE :**

1. To with draw Cerebrospinal fluid to relieve pressure
2. To secure specimen of fluid for diagnostic purposes
3. To inject sera or drugs in the treatment of a disease
4. To inject a spinal anesthetic
5. To introduce an opaque liquid before x-ray for diagnosis of card and brain lesions R. To measure the pressure of the spinal fluid under varying conditions.

### **Equipment:** Tray containing sterile

- 1 - 2 ml. Syringe
- 1 -25 GX1" needle
- 1 -23 GX 1 1/4" needle
- 1 - 18, 19, or 20 G X 3" spinal needle
- 2 - Small bowels
- 1 - 5" toothed thumb forceps
- 1 - fenestrated drape
- 6 - cotton balls
- 1 - Gauze sponge
- 1 - surgical towel

### Skin preparation tray and in addition collect

- 1 - pair of sterile gloves local anesthetic 1-2% procaine
- 3 - sterile specimen bottles
- 1 - sterile dressing set. Adhesive, screen, stool.

Water manometer  
Foot Blocks

|  
if required

**PROCEDURE :**

1. Assemble equipment and bring to bed side
2. Explain procedure to the patient and screen ;
3. Shave the lumbar region if needed
4. Wash the area thoroughly with soap and water
5. Cleanse the skin with savlon and spirit
6. Fan fold the top linen down to the foot end of the bed
7. Position the patient on his side and bring near to the edge of the bed. Ask the patient to flex his knees and bring his head and shoulders down as close possible o his knees. Place small pillow under the patient's head and between his knees for comfort.
8. Place mackintosh and towel under his lumbar region to protect the linen.
9. Place paper bag in a kidney tray at convenient place
10. Open sterile tray.
11. Open dressing set and take, the forceps, Hand over the surgical towel from the sterile tray to the doctor
12. Open sterile glove pack
13. Assist doctor as needed
14. Collect C.S.I, into the labeled specimen bottles if needed
15. Atere the lumbar puncture needle is removed cover the wound with gauze piece and secure it with adhesive plaster
16. Place the patient in dorsal equipment position and raise the foot end of the bed.  
Remove equipment and leave unit orderly.

17. Send the specimen with requisition form to the lab.
18. Wash, dry and replace equipment:

**NOTE :**

1. If patient is lying on spring cot use fracture board under the mattress.
2. The usual site for insertion of the needle is in between the 4th and 5th lumbar vertebrae
3. Instruct the patient not to move about while inserting the needle.
4. Observe the patient's reaction, pulse, and respiration carefully. Report to the doctor immediately, if anything unusual is observed.
5. Record Pulse and respiration Q 1/2 H for at least 4 hrs.
6. Remove the blocks used to. raise the foot and of the bed after 6 hours.

## **MYELOGRAM**

**PURPOSE** : To inject a radio-opaque substance into spinal canal to detect any space occupying lesion or obstruction in the canal. ]

### **PREPARATION & PROCEDURE :**

Lumbar puncture is done in the ward and 3 cc. of "Myodil" injected and patient sent to X-ray Department.

In the dark room "Myodil" is observed by radiology under fluorescent screen. The table is tilted up and down to allow "Myodil" run along the canal and radiographs taken at different point.

### **AFTER CARE OF PATIENT :**

Patient is made to lie flat in bed with head raised one pillow to prevent "Myodil" from entering into ventricles.

## **(CEREBRAL ANGIOGRAPHY (CLOSED METHOD))**

**PURPOSE** : Injection of radio-opaque dye into the common carotid artery so as to outline the cerebral circulation and diagnose any vascular lesion of the brain.

### **PREPARATION & PROCEDURE :**

- Patient is taken to the X-ray Department on empty stomach.
- Premeditation is given as ordered half an hour before sending the patient to **X-ray** Department.
- Patient is made to lie on the table with neck extended.
- Neck is cleaned with spirit and local anesthetic injected at the site.
- Doctor's orders the amount and concentration of dye (urografen 65% or Pyelocil 50%).

- which the nurse should prepare and keep in a syringe.
- Common carotid is palpated and dye injected rapidly.
- A 30 cc. syringe with saline is kept ready and handed over after dye is injected. Saline is injected slowly as X-rays are being taken.
- Saline injection is maintained while films are developed in case the procedure has to be repeated.
- When the procedure is complete remove needle and apply firm pressure over the artery with a swab. Dressing applied and patient returned to the ward.

**AFTER CARE OF PATIENT :**

Patient lies flat in bed for 24 hours.

There may be vascular spasms of the cerebral arteries or oedema giving rise to increased intracranial pressure, pulse and blood pressure chart is maintained.

Observe patient for any projectile vomit and report immediately if any.

Cold compress at the site of injection to prevent.

formation of hematoma and decrease local irritation

Mouth wash and gargles, as patients are afraid to swallow due to soreness of the neck.

**STERNAL PUNCTURE (Bone-Marrow Biopsy)****PURPOSE :**

To assist doctor in carrying out procedure

SITE [a] Sternum [b] Iliac Crest

**EQUIPMENT:**

Tray containing sterile -  
 Sternal puncture needle  
 syringe with hypodermic needle.

Preparation tray containing :

Cheatele forceps in 5% dettol  
 Sterile cotton ball in covered container  
 Spirit  
 Local anesthetic  
 Tr. Benzoin  
 Kidney basin  
 Clean watch glass with 2 cc. of solution made of  
 Potassium oxalate 0.8 Gm.  
 Ammonium oxalate 1.2 Gm.  
 made in 100 cc of Dist water.

|                       |           |
|-----------------------|-----------|
| Basin of water & soap | if needed |
| Razor and Blade       |           |

**PROCEDURE:**

Requisition is sent to pathology laboratory to fix up date time procedure is to be done.

1. Explain procedure to patient.
2. Shave area if needed, and clean with soap and water.
3. Send patient to pathology laboratory or assemble and prepare equipment or wards
4. Put patient in position.
5. Pass sterile forceps and spirited cotton ball to doctor for preparation of skin.
6. Pass syringe and needle and local anaesthetic to doctor for preparation of skin.
7. Pass bone-marrow biopsy needle.
8. Receive specimen into the watch glass
9. Seal site with Tr. Benzoin
10. Observe patient for bleeding from the area take and record pulse and respiration Q 1/2 it for 2 hours.
11. Wash rinse and replace equipment.

**RECORD :**

| Diet | Treatment & Medications | Nurses Notes   |
|------|-------------------------|--|
| •    | Sternal puncture        | Done by Dr. Rao<br>Specimen sent to laboratory. No bleeding from puncture<br>Susheela. |

## **POSTURAL DRAINAGE**

### **PURPOSE :**

1. To drain excessive secretions and pus from the lungs.
2. To remove Radiopaque substances used in X-ray examination.

### **EQUIPMENT :**

Stool of suitable height  
Pillows  
Kidney Basin  
Rag pieces  
Paper bag  
pint measure  
Warm solution for gargle ( $Kmno_4$ )

### **PROCEDURE:**

1. Explain the procedure to the patient and screen.
2. Assemble equipment and bring to bed side.
3. Arrange stool at side of the bed with pillows on top.
4. Place rag pieces within the reach of the patient.
5. Place kidney basin over the paper on floor.
6. Ask patient to lie across the bed on his abdomen with head and chest extending over the edge of the bed, have patient support himself on elbow place stool of convenient height.
7. Encourage patient to cough and to take deep breathings with diaphragm.
8. Collect drainage into the Kidney basin.
9. Watch patients need for rest and degree of fatigue (pulse, respiration and colour)
10. Have patient maintain position for 5-10 mts.
11. Return patients to normal position.
12. Give mouth gargle.

13. Measure Drainage.
14. Discard paper bag with dirty rag, piece wash, rinse and dry kidney basin and replace.

**RECORD :**

- Position :
1. a) When the patient is in position see that the mouth of the patient to approximately 20 lower than the base of the lung.
    - b) Make the patient to lie in fowlers position if the upper lobes are affected.
      - If the Rt. middle lobe or inferior segment left upper lobe is affected, the patient should lie on his back with his body turned to the unaffected side, approximately a 45 degree angle, Raise the foot end of bed about 12".
  2. Clapping and vibrating the chest wall over the involved area helps to loosen mucous plugs and move that into the bronchi where they may be drained out cleaned out. This is not applied when there is a danger of hemorrhage or patient c/o pain.

## **THORACENTESIS**

### **PURPOSE :**

1. To aspirate fluid from the pleural cavity for diagnostic and therapeutic purposes.
2. To relieve pain and dyspnea.

### **EQUIPMENT:**

Equipment is same as abdominal paracentesis except the following

Potain aspiration set or  
1 - 50 ml. syringe  
,1 - 15 6X2-3" needle  
1 - 3 way stop cock  
1 heart table

(Trocar and cannula, back rest bucket, many tailed binder, safety pins are used only, in abdominal paracentesis)

### **PROCEDURE:**

1. Assemble equipment and bring to bed side.
2. Explain procedure to the patient and screen.
3. Fan fold the top linen depending upon the position of the patient - for sitting up  
position fan fold the top linen down to the foot end of the bed.
4. Fold the jacket up and pin at the nape of the neck.
5. Shave if necessary and wash the area where the physician indicates with soap and water.
6. Again clean the area with savion and spirit.
7. Place the heart table over the bed and make the patient to sit up and lean forward  
over a heart table with both arms forward and relaxed.
8. Place mackintosh and towel to protect the patient's linen. ,
9. Place paper bag in a kidney tray at convenient place.
10. Open sterile tray.

11. Open dressing set and take the forceps Hand over the surgical from the sterile tray to the doctor.
12. Open glove pack.
13. Assist in preparation of the skin (doctor will drape the area with fenestrated towel)
14. Assist doctor in drawing the local anesthetic.

(after infiltrating the area, doctor fixes the needle to the 3 way stop cock and syringe and inserts the needle about the 6th and 7th inter space just in front of the angle of the scapula)

15. Whenever the syringe gets filled up he operates the 3 way stop cock to empty the syringe.
16. If specimens are to be sent, collect fluid in the specified No. of bottles.
17. After the procedure, cover the wound with sterile gauze piece and secure it with adhesive.
18. Make the patient lie down quietly without exertion or sudden movement. Remove equipment. Leave unit orderly.
19. Remove fluid to utility room, measure, note characteristics.
20. Send specimen with requisition form to the lab.
21. Wash, dry and replace equipment.

**NOTE :**

1. Keep ready syrup coione 1 GM
2. Instruct patient not to move or to cough during the Treatment.
3. Place flannel over the patient shoulder in cold weather and cover the lower portion of the body with a blanket to prevent shock.
4. Watch for dyspnoea, rapid pulse, syncops, hemorrhage.
5. Watch the sputum for blood after the treatment.

**WATER SEAL DRAINAGE****PURPOSE :**

To set up and maintain equipment needed for chest drainage.

**A. One Bottle Method****EQUIPMENT:**

Sterile articles :

Sterile water, Glass connection.

Polyethelene tube (roughly 1 - 1 / 2 meter), Drainage bottle)

Two holed rubber stopper with

- a) short glass tubing
- b) glass tubing enough to reach below water level.

**PROCEDURE :**

1. Polyethelene tube connected to catheter

from patients chest wall.

2. Two holed stopper.
3. Long glass tubing that reaches below level of water
4. Measured amount of sterile water - holed

5. Air vent.

**IN UTILITY ROOM :**

1. Mark on drainage bottle

level to which water is to reach.

2. Wash hands.
3. Pour sterile water upto the mark
4. Close bottle with the two

stopper which is filed with glass connection.

5. Fix one end of polyethelene tube to the longer glass tubing and the other end to glass connection.
6. Protect glass connection from contamination.
7. Bring equipment to bedside.

8. Explain procedure
9. Connect drainage set to the catheter from chest.
10. Open clamps on catheter.

**NOTE :**

1. Before removing drainage bottle for measuring content and cleaning, always clamp catheter with two clamps
2. Drainage tubes should be well soured and tube leading from chest should be attached to glass tube which passes under water.
3. Keep drainage bottle below the level of the top of the matteress.
4. The drainage bottle should be emptied as the level of drainage reaches safety mark for the particular drainage bottle.

- B. Two Bottle Method :
1. Polyethylene tube connected to catheter from chest wall.
  2. Short glass tubing
  3. Two-holed stopper of drainage bottle.
  4. Drainage bottle
  5. Drainage.
  6. Short glass tubing.
  7. Rubber tubing that connects drainage bottle to suction bottle.
  8. Three-holed stopper.
  9. Glass tubing from drainage bottle that reaches under water level.
  10. Measured amount of water that acts as water seal.
  11. Glass tubing that acts as the vacuum control.
  12. Short glass-tubing connected to section.

- C. Three Bottle Method : CONNECTIONS SAME UPTO NO.7

8. Two-holed stopper.
9. Long glass tubing that reaches under water level.
10. Sterile water up to mark which acts as water seal.
11. Short glass tubing Rubber tubing that connects water seal and vacuum control bottles.
13. Bottle with water to act as water seal.
14. Three-holed rubber stopper.
15. Short glass tubing.
16. Long glass tube acts as vacuum control.
17. Water that determines amount of suction.
18. Short tube connecting suction.

**Add two other bottles :**

1. A two-holed rubber stopper fitted with one long enough tube to reach under water level and another short glass tubing.
2. A three-holed rubber stopper fitted with two short glass tubings and one long glass tubing which acts as vacuum control.

NOTE : The level of water in the third bottle determines the amount of suction.  
Clamp tubing connects the second and third bottle when suction is not in use.

**After Care of equipment :**

Measure and empty drainage, wash under running water, Fill drainage bottles with 2% dettol lotion and soak the other equipment in a container in the lotion of same strength and Keep for 24 hours. At the end of the time, wash equipment using soap and brush, rinse, dry and send for autoclaving if needed.

## **Principles and Rules to Follow While Practicing Sterile Technique**

1. All articles used in operation should be sterilized prior to Surgery. Instruments may be sterilized immediately preceding operation and remove directly from the stylization to the sterile table.
  - Linen, packs sponges, dressings can be considered sterile for 7 to 14 days after autoclaving
2. if in doubt about sterility of any object consider it not
  - If a sterile appearing package is found in a non sterile work-room-consider unsterile.
  - If you are unsure about the actual timing of the sterility.
  - If a non sterile person close to a sterile table.
3. Tables are sterile only at table level.
  - Linen or sutures falling over table edge are discarded.
  - Sterile nurse does not touch the part hanging below table.
4. Arms are considered sterile only from waist to shoulder level in front sleeves.
  - Sterile person keeps hand in front and above waist level.
  - Hands should be kept away from face and elbows close to side
  - Arms are never folded there is apt to de perspiration in auxiliary region
  - Articles draped below waist level are discarded.
5. Edge of anything that encloses sterile container is not considered sterile.
  - Edges of .wrappers on sterile packages the caps on solution flasks, test tube covers.
  - While closing and removing the edge of flask cover does not touch the lip of the flask.
  - While instruments, trays etc., are boiled in a sterilizer the equipment must not touch the edge of sterilizer when lifting it out.
  - 6. Moisture may cause contamination
  - when moisture soaks through a sterile area to a non sterile area or vice-versa it provides a means of transporting bacteria to the sterile area.
  - Sterile packages are laid on dry area.
  - If a sterile package becomes damp or wet it is sterilized or discarded.
  - Drapers are placed in dry field.
  - If a solution soaks through a sterile area to a non-sterile one, the wet area is covered, with another sterile diaper. :

- Towel is placed in the bottom of an instrument tray before placing instruments and it is to absorb and keep tray dry to permit the tray to be set on a sterile table.
  - Linen packages etc. from autoclave are permitted to cool and dry before being put in shelves to prevent their becoming damp from sterile steam condensation when in contact with cold shell
7. Persons who are sterile touch only sterile articles - persons who are non-sterile touch only unsterile articles.
  8. Sterile person keeps well within the sterile area.
    - Sterile person stands back at a safe distance from the operating table when diapering the patient.
    - Sterile persons pass each other back to back.
    - Sterile person turns the back to a non-sterile person or non-sterile area while passing.
    - Sterile person faces sterile area when passing it.
    - Sterile person asks a non-sterile person to slip aside while passing rather than going around.
  9. Sterile persons keep contact with sterile areas to a minimum.
    - Do not lean on sterile tables and on the draped patient.
    - Keep the Nurses and Doctors Table far enough from each other so that their gowns do not touch the tables.:
  10. Non-sterile Persons avoid reaching over a sterile field sterile persons avoid leaning over an un-sterile area.
    - Scrub nurse sets basins or classes to be filled at the far edge of the sterile table, the circulating nurse stands near the edge of the table to fill them.
    - The circulating nurse stands at a distance from the sterile field to adjust the light over it.
    - Surgeon turns away from the sterile field to have perspiration dropped from his brow.
    - Sterile nurse drapes a non-sterile table towards her first.
    - If circulating nurse, using sterile forceps drapes a table, drapes away from her first.

- 1 1 Non-sterile persons keep away from sterile areas.
  - Non sterile persons face sterile area when passing it so that they can be sure they have no touched it.
  
12. When bacteria cannot be eliminated from a field, they must kept to an irreducible minimum.
  - Skin cannot be sterilized-skin of the patient is a source of potential contamination in every operation.
  - Patient's skin if operation area is given preliminary shave and scrub on the ward and is scrubbed again in surgery.
  - In draping all the skin area is covered except the area of incision.
  - All operators scrub their hands and arms.
  - Doctors and Nurses use sterile, caps, mask, gowns and gloves to keep sterile all the possible parts of the body that are in contact with the sterile fields.
    - Dry hands after scrubbing with sterile material before putting on gloves.
    - Knife used for skin incision is discarded from sterile field.
    - After skin incision is made, skin towels are used to covered all skin area wherever possible.
    - During operation, gloves are changed at once if they are punctured, from or loose elasticity.
    - If a glove is pricked by a needle or instrument, the gloves should be changed at once and the needle or instrument is discarded from the sterile field.

## **STERILE HOT COMPRESSES**

### **PURPOSE :**

To increase circulation to the part  
To relieve congestion  
To hasten suppuration  
To promote resolution

### **EQUIPMENT :**

Tray containing.

Sterile :

Covered basin  
3 forceps -  
small container moist cotton swabs  
dry cotton swabs, compresses  
Covered bowl with boiling water

Unsterile :

Kidney tray  
bandage  
treatment rubber and cover  
If indicated extra sheet to cover patient while exposing the part.

### **PROCEDURE :**

Take equipment to the bedside  
Screen the patient and explain procedure  
Exposing the part (fan folding bedding and using extra sheet for cover as indicated)  
Place treatment rubber and cover  
Cleanse the area, using artery forceps and moist cotton swabs  
Discard into kidney tray  
Using artery forceps, wet a compress in hot water and rinse thoroughly  
Shake out and apply gently, avoid burning  
As compress cools, replace with another  
[if there is drainage from lesion, compresses must be discarded as they are removed]  
Continue treatment for 20-30 minutes or as ordered  
Apply dry, sterile compress and bandage  
Clean and replace equipment  
Record time in treatment column, treatment in Nursing notes duration and condition of area.

**STERILE COLD COMPRESSES****NOTE :**

To relieve congestion

To relieve pain

Equipment and procedure as above except  
bowl of sterile solution for compresses is kept in a larger bowl  
of chipped ice.

**NAMES AND FUNCTIONS OF INSTRUMENTS**

1. Curved artery forceps - to hold the bleeding points
2. Straight artery forceps - to separate the muscles and rectus sheath. To hold the peritoneum while cutting.  
To hold the ends of the sutures.  
To hold the varicose veins in case of hemorrhoids.
3. Toothed dissecting forceps - To hold the skin or muscles during cutting and suturing
4. Non - toothed dissecting forceps - To hold the soft tissues during cutting or suturing
5. Towel clip - To hold the towels in place.
6. Tetra clamp or skin towel clip - To hold the skin and towels together.
7. Sponge holder - To hold the swab for cleansing of the skin.
8. Laine tissue forceps - To hold the muscles - e.g. in simple mastectomy, amputation and piles.  
To hold the tissues together during suturing.
9. Allis forceps - To hold certain tissues such as the bladder..
10. Babcock's - To hold the soft tissues - e.g. stomach, intestines and appendix.
11. Morris retractor - To retract the deeper muscles used in G.J. and appendectomy.
12. Landenberg retractor - To retract the superficial muscles used in hernia repair also used for all Laparoscopy procedures before cutting of the peritoneum.
13. Deverse retractor - To retract the deeper muscles used in nephrectomy and gastrectomy.
14. Probe - To see the depth of the injured part - e.g. used in fistula.

15. Sinus forceps - To remove purulent material. The part is exposed to drain the area.
16. Scooper or curette - To scoop out purulent material and necrotic tissue.
17. Beaker handle or scalpel blade handle - Facilitate the use of the scalpel blade.
18. Needle holder - To hold the needle.
19. Curved scissors - To cut the rectus sheath, muscles and peritoneum.
20. Straight scissors - To cut the sutures and ligatures.
21. Groove director - To direct the cutting of the knife.
22. Aneurysm needle - To ligate or suture the vessels used in Thyroidectomy.
23. Curved straight mosquitoes - To clamp the delicate blood vessels.

## **PRE-OPERATIVE PREPARATION AND DRAPING IN OPERATING ROOM**

Skin preparation is done to render the operative site as free as possible from bacteria, so the incision can be made through it with a minimum danger of infection from the source.

After shaving, final skin preparation is done, then draping is done with sterile towels leaving only the operative site to create and maintain a sterile field during the operation.

### **POINTS TO REMEMBER IN DRAPING**

| <u>ACTIVITY</u>  | <u>SAFEGUARDS</u>   |
|--|---|
| 1) Handle drapes as little as possible<br><br>avoid shaking of line.   | Air currents are capable of carrying<br><br>contaminants.   |
| 2) Making a cuff or turning the corners of the drape over the gloved hand toward the head end or foot and will afford Protection as the sterile person places the drape in position. | Contact with an un sterile surface -<br>contaminates a sterile<br>object  |
| 3) A scrubbed person places drapes on a table or a patient in such a way the side closest to her is covered.   | Contact with an un sterile contaminates a<br>sterile object.  |
| 4) The part of the drape which falls below the top level of the table is considered<br><br>unsafe as a sterile area.   | When a question exists regarding sterility of the object or field is considered as<br>it<br><br>being un sterile. |
| 5) Drapes that have holes, tears or worn spots should not be used.   |   |
| 6) Drapes should not be held so high that they touch the lights or low that they touch the floor.  | Contact with an un sterile object<br>Contaminates a sterile Object  |

**STATEMENTS PERTAINING TO SURGICAL ASEPSIS TO BE  
USED AS GUIDES IN NURSING**

CANVAS SHOES ARE TO BE WORN IN THE OPERATING ROOM

SHORT SKIRTS ARE TO BE WORN IN THE OPERATING ROOM

SURGICAL ATTIRE : The person is clothed in operating room dress, cap & mask.

OPERATIVE ATTIRE : The person is clothed in surgical attire plus sterile gown and sterile gloves.

A PERSON IN OPERATIVE ATTIRE IS CONSIDERED AS SCRUBBED PERSON.

In order to maintain his scrubbed statue, a scrubbed person will observe the following:

- a) The sleeves and the front of the gown from the waist to shoulder level only, are considered sterile.
  - b) Keep hands in sight and at, or above, waist level.
  - c) When passing another scrubbed person, always pass back to back.
  - d) Turn his back to a non-scrubbed person to non-sterile area when passing.
  - e) Always face sterile areas.
  - f) Keep well within the sterile area.
  - g) Avoid unnecessary contact with sterile areas.
  - h) Avoid leaning over a non-sterile field
- When handling sterile equipment, the following pertain:
- a) If in doubt about the sterility of on item, consider it not possible.
  - b) The edge of anything that encloses sterile content is not considered sterile.
  - c) When opening sterile package, open the wrapper away from you.
  - d) All sterile articles are to be held above waist level.
  - e) Tables are sterile only at table level.
  - f) Moister transports organisms by capillary action.

- g) Avoid reaching over a sterile field.
- h) Chattel or transfer forceps are to be held with the points facing downward and above waist level.
- i) When pouring sterile solutions keep the flask high and away from the sterile field. I
- i) Unused sterile objects are not be returned to the sterile multiple container.

All articles used in an operative procedure have been sterilized within a 24 hour period and must remain sterile for the duration of this procedure.

All sterile articles are sterile only for that patient and may not be used for another operation.

All scrubbed persons in contact with the patient are considered sterile for that patient only. Since bacteria cannot be removed completely from the patient's environment, they must be kept to an irreducible minimum. The following measures would be taken to provide this :

- a) masks must be changed with each operation.
- b) conversation in the operating room should be kept to a minimum.
- c) turn head away from sterile field to cough or sneeze.

Whenever open sterile supplies are present everyone in the room is obliged to wear I surgical attire.

Upon entering a room set up with open sterile materials, avoid contamination by immediately identifying sterile & non-sterile area.

Persons who are scrubbed touch only sterile articles.

Persons who are not scrubbed touch only unsterile articles.

If necessary to pass in front of a sterile area, face the area following for a wide margin of safety.

## **SCRUBBING**

### **PURPOSE :**

- 1) To prevent possibility of contamination of the operative wound by bacteria on the hands and arms.
  - The finger nails should be clean be clean before entering surgery.

### **EQUIPMENT :**

Sterile bowl with brushes  
 Bowl for used brushes  
 Soap

### **PROCEDURE:**

Adjust turban and mask.  
 Roll sleeves of scrub dress 3" above the elbows. ,  
 Open the tap and regulate the flow. '  
 Check time in clock before starting scrubbing. ,  
 Apply soap and wash hands  
 Take a sterile brush from the container, apply soap to the brush Scrub nails, fingers in between fingers, hands, fore arms and up to the elbow by circular motion.  
 After completion of *one* arm and start scrubbing for other hand, throw used brush in I container.  
 Rinse hands and arms.  
 Keep the hands higher than elbow.

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## **SAVLON HOSPITAL CONCENTRATE**

### **GENERAL ANTISEPTIC PURPOSE**

|                                      |       |
|--------------------------------------|-------|
| Washing Hospital Equipment, floor    | 1/4%  |
| Disinfection of solid Hospital linen | 1-200 |

### **CASUALTY WORK, MIDWIFERY, etc.,**

|  |       |
|--|-------|
| Preliminary treatment of wounds bathing abscesses,<br>rising hands | 1-100 |
|--|-------|

VAGINAL DOUCHE 1-800

INFANTS NAPKING - 15 minutes 1-800

### **INSTRUMENT**

Emergency disinfection (3 minutes) Pure

Sterile storage (Prolonged immersion)I

### **RUBBER APPLIANCES**

|   |                  |
|---|------------------|
| Catheters, drainage tubing etc.,'(15 minutes) | 3%               |
| I/v set, Polyethylene tub                     | 3%               |
| (to destroy spares) - 18 hours                | 3%               |
| Emergency disinfection (1-2 min)              | 1-20 (in spirit) |

PRE-OPERATIVE SKIN DISINFECTION 1-30

DISINEFCTION OF CLINICAL THERMOMETER 3%

DRAINAGE BOTTLES (15 minutes) 1-30

**INSTRUCTIONS :**

Syringes and Needles which have been immersed in the solution should be rinsed very carefully with sterile water before use for any injections.

Soap should not be used with Savlon as it counter-acts the action of Savlon.

Repeated rinsing of hands in Savlon causes slight dermatitis. Sodium Nitrite 4 gm. per liter should be added to prevent rusting.

**ACTIVE CONSTITUENTS**

|                                  |        |
|----------------------------------|--------|
| Hibitane (chlorhexide gluconate) | 15%w/v |
| Cetavlon (celnmid)               | 15%w/v |
| Absolute Alcohol                 | 20%v/w |

## **DRAPING A MAYO STAND**

### **PURPOSE:**

To provide a sterile surface in which to keep items close to the Operative area. I

### **SUGGESTED STEPS REASON**

1. The person who is in operative attire holds the slip cover in one hand facing the free end of the stand
2. Place the hands beneath the up perm-In the preparation 2/3 of the cover has lost fold at each side of the cover. Ex- been turned back on itself, uppermost tend the arms, slightly flex the elbowsfold provides a protective cuff u and slip the folded cover over the topwhich the scrubbed nurse can place of the stand.the gloved hands.
3. The folds of the drape are supported onTo prevent their falling below the waist her arms in the bend of the elbowslevel
4. The nurse places her foot on the baseStabilizes mayo stand The scrubbed of the hand.person can drape the mayo stand withfree movement.
5. She inserts her gloved hands under the Any article below the waist considered fold Brings top end of the cover off as contaminated the tray, shakes the portion of .the cover thereby forcing it to fall over the,, end of the tray.
6. Nurse places in top of the covered st Double thickness of material in ensures and a second layer material, using sterility of objects by acting as barrier either a sterile towel or small sheet for to unsterile objects this purpose.

### **REFER TO :**

- 1) Alexander "The care of the patient in surgery including techniques" - 3rd edition  
-pp: 12-123. fig. 102&103.
- 2) Berry and Kiln "Introduction to Operating room Techniques"  
2nd adition - pp : 65  
fig. 9-3, 9-4.

## **GOWNING**

### **PURPOSE :**

- 1) To prevent bacteria present on the uniform from being transferred to the patient's wound during surgery.
- 2) To permit the wearer to come close to the sterile field.

### **EQUIPMENT :**

Sterile gown

### **PROCEDURE:**

Grasp the back of the gown in one hand, lifting it directly from the package.

Holding the neck band with both hands, gently shake the folds from the gown.

Slip the hands into the .arm holes, holding the hands upward.  
Tapes are given to circulating nurse by means of sleever of the gown.

## **GLOVING**

### **PURPOSE :**

- 1) To prevent bacteria present on the hands from being transferred to the patient's wound.
- 2) To permit the wearer to handle sterile equipment.

### **EQUIPMENT :**

Sterile gloves in a bag  
French chalk powder  
Basin for used bag and powder

### **PROCEDURE:**

Have the sleeve of the gown approximately 3" below the tips of the fingers.  
Remove the sterile gloves from the bag with your fingers inside the sleeve of the gown.  
Unfold the glove put powder inside the glove.  
Take glove of the right hand, fold the cuff of the gown upon itself so that it is small enough to place into the glove.  
Hold the glove by means of the fingers of the left hand which are inside the gown sleeve.  
Insert the folded cuff of the right sleeve inside the glove.  
Manipulate the fingers of the right hand so that the hand is inside the glove.  
The cuff of the gown at the wrist is now covered by the cuff of the glove.  
Pick up the left hand glove with the right gloved hand apply left hand glove in same manner.  
Discard the glove bag in a basin.

## **KINDS OF SUTURES**

Sutures are classified into absorbable and non-absorbable.

**ABSORBABLE SUTURES** : are those which can be absorbed during the healing process by the tissues in which they are embedded.

**PLAIN CATGUT : has No. 2, 1, 0, 2/0, 3/0.**

No. 2/0 or 0 plain catgut used for ligation of the bleeding points, plain catgut is used for subcutaneous tissues.

**CHROMIC CATGUT :**

with resist absorption for longer time No. 2, 1, 0, 2/0.

0 or 1 chrome catgut is used for the muscles and peritoneum suturing.

2/0 or 3/0 is used for the soft tissues such as intestines and stomach.

1 or 2 is used for the repair of the hernial sac.

**NON-ABSORBABLE SUTURES :**

These suture materials are not absorbed in tissues during the process of wound healing and generally the material remains encapsulated or walled off by the tissue around it Eg. Surgical cotton.

Surgical nylon - used for skin suturing surgical line - used for skin and used for ligation of blood vessels in gastrectomy.

Black silk thread - used for skin sutures in plastic surgery. Stainless steel mesh - used for the repair of hernia Michel clips - used for the skin.

**SUTURE NEEDLE :**

Classified into    Eye needle  
                          Eyeless needle  
Eyeless needle    Non-cutting  
                          Cutting

1. **NON-CUTTING NEEDLES** : are round bodied and are used on tissue that offers small amount of resistance to needle as it pass through  
2 types - curved - straight. Curved needle is use for peritoneum,

appendix and suturing of bleeding points.

Straight needle is used for anatomizing of stomach and Jejunum (soft tissue)

2. **CUTTING NEEDLES** : These make a slight tear in tissues while suturing, used for tough tissue such as skin, fascia and muscles. Straight cutting needle - used for the skin.
3. **ANEURYSM NEEDLE** - blunt needle with an eye at the end of it. Needle form a right or oblique angle to the handle, which is one continuous unit with the needle. It is used to ligate the blood vessels in Thyroideectomy and chest surgery.

**EYELESS OR ATRAUMATIC NEEDLE :**

There is only one thickness of suture to pull through the tissue. '

- 1) Need not be threaded
- 2) Produce a minimum of tissue trauma used for soft tissues such as intestines and stomach.

**REFER TO :**

Eliasurs "Surgical Nursing" - pp : 168-169. Fig, 78 and 79.

**BASIC SET OF INSTRUMENTS**

**ALSO CALLED :** (a) Laparotomy set (b) General set. I

4 towel clips - to hold drapes in place

2 sponge holders to prepare patient's skin.

2 scalpels one to cut the skin and fascia., another one used for tissues.

2 dissecting or thumb forceps with teeth to hold the tissues while cutting or suturing

1 plain dissecting forceps to hold the soft tissues while cutting or suturing

18 artery forceps or haemostates : 6 straight 12 curved to clamp the blood vessels stop

haemorrhage

4 allis clamps or tissue forceps to hold the tissues without injuring them

1 Landenberg retractor

1 moris retractor

2 needle holders to hold the needle while suturing

3

**NEEDLES :** 1 round needle for peritoneum

1 cutting curved needle for tissue (mu\*les)

cutting or straight needle for skin

**SUTURES AND LIGATURES :**

plain catgut No. 20/0 for ligation

chromic catgut No. 1 for muscles and peritoneum.

## **APPENDECTOMY**

### **INSTRUMENTS :**

Lapartotomy

1 extra suture scissors suction apparatus

### **SPECIAL POINTS :**

All instruments which touch the stump are contaminated and should be discarded in a kidney tray and removed from the table.

### **Dr. RAMAIAH :**

No. 10 thread with non cutting needle for ligation of appendicular vessels and stump.

### **Dr. RAMESH PAI :**

chromic catgut No. 0 for stump

chromic catgut No. 2/0 with curved intestinal needle for pursestring sutures.

## **GASTRO - JEJUNOSTOMY)**

### **DEFINITION**

The making of an opening between the stomach and the intestines. This is done so that the food may pass directly from the stomach to the small intestines, without passing over the ulcer. This helps the ulcer to heal,

### **INSTRUMENTS :**

- 2 Stomach clamps straight twin clamps used in clamping the stomach and intestines Cautery suction apparatus

### **SPECIAL POINTS :**

- a) Special small swabs are used for wiping away stomach and intestines contents.
- b) all instruments touching the inside of the stomach are considered contaminated and are discarded.
- c) plenty of strife towels should be on hand for keeping exposed abdominal contents wet and protected.

### **Dr. RAMESH PAI :**

A traumatic straight needle with No 2/0 chromic catgut used for anastomosis.  
Curve for mesocolon.

### **Dr. RAM I AH :**

3/0 chromic catgut with straight ordinary needle for anastomosis  
3/0 chromic catgut with curved needle for mesocolon

## **HAEMORRHOIDECTOMY**

**DEFINITION :** Removal of haemorrhoids or piles

**POSITION OF THE PATIENT :** Lithotomy

**INSTRUMENTS :**

4 towel clips

1 scalpel

2 scissors ..... a) curved    b) straight

6 curved artery forceps

12 straight artery forceps

1 proctoscope

1 needle holder

Drainage tube

Cautery

Vaseline gauze

**NEEDLES :**

3 non cutting curved needles with No 2 linen No 10 thread for ligation.

## **OPERATION FOR RECTAL FISTULA**

The excision of rectal fistula Lithotomy position.

### **INSTRUMENTS :**

4 towel clips

1 scalpel

2 scissors    a)    1    straight for suture  
                  b)    1    curved for tissues

2 dissecting forceps

1 probe director artery forceps straight

12 curved artery forceps

2 Kocher clamps

4 lain tissue forceps

Vaseline gauze

No 10 thread for ligation

After the probe is inserted, the tract is excised completely, if possible failing this the tract maybe laid open and curetted. Then the cavity is packed with Vaseline gauze and encored he from within.

## **SUPRAPUBIC CYSTOTOMY**

**DEFINITION** : Incision of the bladder above the tubes. This is done to remove the stony & tumors, as a first in prostatectomy & in obstruction of the urethra Position of the patient Dorsal recumbent, or trendlenberg.

### **INSTRUMENT :**

Laparotomp set plus

1 stone forceps (for lithotomy)

1 Urethral sound

suction apparatus

A sterile bowl of solution to irrigate bladder. I catheter plain and retention.

rubber tubing to be stitched in the wound to drain the bladder

### **Dr. RAMAIAH :**

small non cutting needle with No 1 plain catgut

Muscle - - O chromic with curved cutting needle

Skin - - No 10 thread with straight cutting needle

### **Dr. RAMESH PAI :**

Nylon for the skin

## **ISOLATION PROCEDURES IN COMMUNICABLE DISEASES**

### **PURPOSE :**

1. To separate the infectious person from others for the period of communicability.
2. To protect the personnel caring for the patients.
3. To prevent the spread of communicable diseases.

### **1. SETTING UP OF ISOLATION UNIT**

Clean area - Nurses Office

Contaminated area - Unit room and ward

- lavatory bath room

- Treatment

- a) Clean area :**
1. facilities for hand washing
  2. facilities for hot water.
  3. facilities for disinfection
  4. Waste receptacle with pedal operator
  5. Basic equipment including - Gowns  
Gloves  
Masks

Turbans/ caps

Laundry bags

receptacle for clean masks

patients chart

large table to place the diet

before serving

- b) Patient's Unit** - Facilities for hand washing (mentioned article required for the above procedure in the hand washing technique)
- Facilities for disinfection

1. Large tub for disinfection of IV sets
2. Large sinks for disinfection of bed pans and Urinals and all linen.

3. Large containers with lid, stove for boiling patient's utensils.

**- OTHER FACILITIES -**

1. Clean laundry bags to receive used equipment
2. Container with disinfectant for used masker
3. Individual containers for storing drinking water plates and glasses.

It is ideal to keep individual articles required for each patient care eg feeding cups, basins, kidney trays sputum mug thermometers etc.

Waste receptach with pedal operator.

Container with disinfectant for used masks.

**II) HAND WASHING TECHNIQUE** : same procedure as in the procedure manual except after caring the patients, open the top, wash the hands thoroughly and wash the tap head before closing the tap.

Equipment - as mentioned in the procedure.

**PROCEDURE:**

1. Wash hands.
2. Put on the gown, Tie taps of the neck, grasp both edges of the gown at the back and cover the back portion completely by over taping the flaps.
3. Tie the tapes of the gown at the back side.
4. To remove gown un-fasten the tapes at waist, slightly away from uniform.
5. Wash hands.
6. Unfasten tapes at neck and remove the gown by holding at the neck seam from inside taking care that the clean hands do not contaminated side of the gown.
7. Discard in the laundry bag.

N.B. : - For reuse of gown :-

1. Hang the used gown by the arm holes of the peg, folded with contaminated side put at the entrance in the patients Units.
2. To reuse - remove gown from the peg by grasping the shoulder seams, put on the right sleeve by pulling the sleeve seem well up on the shoulder and follow same to left sleeve. The tapes at the neck and waist'back.

## **COLLOID OR EMOLLIENT BATHS**

### **PURPOSE :**

To relieve skin irritation.

**EQUIPMENT :** Tub of warm water  
Muslin bag  
Towel

Solutions which may be ordered include :

- Oalmial      I 2 cups to 2 quarts boiling water, boil for 5 minutes
- Bran      |    pour into gauze bag and stir bag in bath.

Boiled starch bath - 2 quarts boiling water over a cupful of cornstarch.

Cold uncooked starch -1 cupful starch with sodium bicarbonate  
-**1 1/4** to 1/2 cup.

### **PROCEDURE:**

Ordered mixture in muslin bag is stirred in bath.  
Pat or mop gently the skin with bag.  
Allow patient to sit in bath for 30 minutes to 1 hour  
Pat himself dry with dry muslin.  
Clean, dry and replace articles.  
Apply medication ordered.

### **DERMATITS PACKS :**

**Purpose :** To apply medication and for a soothing effect on the skin.

**Equipment:** Solution ordered  
Gauze packs  
Container for waster  
Basin or large bowls  
Plastic

**PROCEDURE:**

Prepare solution as ordered at room temperature.  
 Carry equipment to bedside.  
 Remove clothing from affected part.  
 Protect bed under affected part using plastic material.  
 Dip packing into solution, squeeze out excess.  
 Apply to affected part  
 At intervals prior to drying of outer layers of the pack-remove layer of gauze next to skin.  
 Add another layer or gauze to outside skins, remoister and apply.

***Application of Lotions? Ointments and Salves and Powder***

**PURPOSE** : To apply lotion and ointment ordered for the patient for cooling, refreshing and pruritic effect.

**EQUIPMENT** : Required lotion or ointment  
 Spatula  
 Gauze on artery forceps  
 Bandage

| <b>LOTION :</b>              | <b>OINTMENT :</b>   |
|------------------------------|---|
| Shake lotion                 | - Cut muslin piece sufficiently affected area.                                    |
| large to cover               | - Using spatula smooth on ointment on to muslin piece and apply to affected area. |
| Pour lotion                  | - Secure loosely with a bandage.  |
| Put lotion to affected area. |   |

**POWDER** : Shake powder into palm  
 Dab areas gauze dipped into powder till whole of affected area is covered.

## **Procedure Involving Medical Aseptic Techniques** **Caring for Patient With Communicable Diseases**

### **PURPOSE :**

1. To confine the disease to the patient.
2. To protect the worker and other patients from the infection.
3. To protect the patient from new infection or re-infection.

### **IN A COMMUNICABLE DISEASE WARD :**

1. Establish zones as clean areas  
sometimes contaminated areas.  
contaminated area.

### **CLEAN AREAS :**

Doctor's table  
Nurse's duty from Telephones.

### **SOMETIMES CONTAMINATED AREAS :**

Examining rooms

**I**

### **CONTAMINATED AREA :**

**I**

Immediate surroundings of the patient cubicle  
Lavatory, bath-room  
Floors, sinks

- II. Be sure all personnel and patients know the limits of these zones.
- III. Each cubicle or ward should have facilities at the entrance so that hand washing or gown wearing techniques are followed.

### **HAND WASHING TECHNIQUE**

Wash hands before and after removing :

masks  
gowns medications and treatments  
serving diet, water

before leaving the ward  
before and after each task

**EQUIPMENT :**

Sink with running water or water container with hopper  
Soap in a container.  
Clean paper squares hang to a wall  
Waste receptacle.

**PROCEDURE:**

Wash hands under running water making certain, there is good friction with soap lather. Making lather twice, rub vigorously around fingers and nails up to elbow.  
Rinse thoroughly under running water allowing the water to flow down over the fingers tips and not up to the elbow.  
After hand washing, turn off faucets with clean paper;

Discard paper squares in waste receptacle.

**MASK TECHNIQUE :**

Medicated : When caring for a patient whose disease is spread by droplets or discharges from the nose and throat.

Masks worn should always cover mouth and nose.

They should be changed after they become moist or after 30 minutes.

Change always between patients.

Do not touch mask after it has put on.

**EQUIPMENT:**

Covered receptacle labelled containing clean masks.  
Covered receptacle labelled for dirty masks

**PROCEDURE TO PUT ON MASK :**

Wash hands  
Pick masks from clean mask receptacle

Place mask over mouth and nose and tie strings around at the back hand.

**REMOVE MASK :**

Wash hands

Untie strings and hold mask by strings only, place in used mask receptacle.

Wash hands

Place used mask receptacle in mask bag, autoclave the bag.

Wash masks, dry, roll and place in clean mask receptacle.

**TECHNIQUE :**

Medicated : Caring patients whose disease is spread by droplet discharges from the nose, throat, gastro-intestinal tract or skin lesions.

**NORMAL INSTRUCTIONS :**

In a disease Unit, same gown can be used between patients.

in a patient Unit, a separate gown must be used for each patient.

Gowns worn-giving patient care-handling contaminated article or equipment.

**EQUIPMENT:**

Gown

Hook for gown

Linda bag (if gown to be sent to laundry)

**A CONTAMINATED AREA :**

The gown is kept in the patient's unit hanging by the arm on hook folded with contaminated side cut.

**A CLEAN AREA :**

The gown is folded with area of gown coming into contact with the uniform in clean area.

**PROCEDURE**

*If gown is hung in a contaminated area :*

Wash hands

With palms together slip, in both hands.

Without touching the outside of the gown, remove gown from hook by grasping the shoulder seams.

Hold the two seems together at the shoulder seam

Put on the right sleeve by pulling the sleeve seam well up on the shoulder.

Put on left sleeve, pulling it will up on the left shoulder.

Tie tape of neck.

**TO REMOVE GOWN :**

Unfasten tapes at waist, pulling gown slightly away from uniform.

Wash hands, unfasten tapes at neck.

- Return to the area where gowns are hung.

Remove gown by twisting forward fist one shoulder and then the other, taking care that the clean hands do not touch the contaminated outside of the gown

> does not to touch the floor.

When hands reach the sleeve seams bring both hands with thumbs together at

the shoulder seams.

Grasp the neck line on the Inner side with right hands.

Remove the left hand to the outer side of the gown and grasp the back of the

neck line at the bottom.

With the right hand push out the front of the neck hand. Hang gown for reuse with shoulder seams together so that they can be fitted over the hook leaving the neck hand standing upright and the open edge of the gown towards the entrance of the Unit.

Wash hands up to elbow.

**TO DISCARD GOWN :**

- Repeat procedure for removing gown."

Slip out of gown rolling clean side out over hands and fore-arms as it falls Forward while wash hands Sterilize or boil gowns in laundry bag.

Dis infectating.

Equipment

**TO PUT ON GOWN IF GOWN IS HUNG IN A CLEAN AREA**

Wash hands

With palms together, slip in both hands into the two sleeves' taking care gown

does not touch the floor.

Tie tapes at neck

Clasp both edges of the gown at the back, fold inwards.

Tie tapes of the gown by crossing ties at the back and then tie tapes at front.

***TO HUNG GOWN IN A CLEAN AREA :***

*Follow procedure for removing gown.*

Hang gown with the contaminated side inside *and clean side outside*

## **Principles and Rules to Follow While Practicing Sterile Technique**

1. All articles used in operation should be sterilized prior to Surgery.  
Instruments may be sterilized immediately preceding operation and remove directly from the sterilization to the sterile table.  
Linen, packs sponges, dressings can be considered sterile for 7 to 14 days after autoclaving.
  
2. If in doubt about sterility of any object consider it not.  
If a sterile appearing package is found in a non - sterile work-room – consider unsterile.  
If you are unsure about the actual timing of the sterility.  
If a non-sterile person close to a sterile table.
  
3. Tables are sterile only at table level.  
Linen or sutures falling over table edge are discarded.  
Sterile nurse does not touch the part hanging below table.
  
4. Arms are considered sterile only from waist to shoulder level in front sleeves.  
Sterile person keeps hand in front and above waist level.  
Hands should be kept away from face and elbows close to side.  
Arms are never folded there is apt to be perspiration in auxiliary region.  
Articles draped below waist level are discarded.

## **EAR DROPS INSTILLATION**

### **PURPOSE :**

To administer medication locally to external ear canal.  
To soften wax. To Relieve pain. To apply local Anesthesia,  
To destroy Organisms  
& insects.

### **EQUIPMENT :**

- 1) Sod bicarbonate solution, 1/2%
- 2) Oil to soften cerument
- 3) H O<sub>E</sub> to remove wax
- 4) Burrows sol. Aluminum acetate 5% 8%
- 5) Medicine dropper.
- 6) Prescribed medication (warmed to body temperature)
- 7) Cotton swabs in container
- 8) Kidney basin
- 9) Paper bag

### **PROCEDURE:**

- 1) Assemble equipment Bring to patient.
- 2) Have patient sit or lie with ear to be treated uppermost.
- 3) If discharge is present, cleanse outer ear and entrance to canal with cotton swab.  
Moistened with Sod bicarbonate solution. Discard cotton into paper bag.
- 4) Draw medication into dropper.
- 5) Straighten ear canal as follows :  
For adult : draw pinna up and back.  
For child : draw pinna down and back.
- 6) Insert loose cotton swab. Do not push when the ear is draining.
- 7) Instill prescribed amount of medicine, Discard medicine dropper into kidney basin.
- 8) If possible, have patient remain in same position for 10 minutes.

**AFTER CARE EQUIPMENT :**

Wash, rinse, dry and replace all equipment

**RECORD:**

- 1) In treatment and medication column :  
Medication, strength, amount instilled, ear treated, time, initial of person doing treatment.
- 2) In Nursing Notes column :  
Nature and amount of discharge subjective symptoms of patient reaction to treatment.

| Time |        | Medication & treatment                 | Nursing Notes                                   |
|------|--------|--|---|
| K.L. | 12-4-8 | Glycerin drops instilled into left ear | Discharge and pain decreased.<br><br>K. Lalitha |

## **EAR DRY WIPING**

### **PURPOSE :**

To keep external ear canal dry to limit growth of organisms.

### **EQUIPMENT:**

Swab sticks  
Paper bag.

### **PROCEDURE :**

1. Assemble equipment and bring to patient
2. Straighten ear canal as described in Ear Drop Administration.
3. Gently introduce swap stick into external panel.  
Rotate swab, remove and discard into paper bag.
4. Repeat until there is no discharge on cotton.

### **RECORD:**

- 1) In treatment and medication column :  
Treatment, time initials of person doing treatment.
- 2) In Nursing Notes column :  
Any observations made or affect of treatment.

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| Time               | Date | Medication & treatment                       | Nursing Notes                             |
|--------------------|------|--|---|
| 8-00<br>green foul |      | Right dry wipe q. 2 h.<br><br>KL. 0-12 2-4-6 | Small amount of<br><br>smelling discharge |
|                    |      |  | <u>K. Lalitha</u>                         |

## **EYE DROPS, INSTILLATION**

**PURPOSE** : To administer medication locally to the eye.

**EQUIPMENT :**

Covered container with saline cotton swabs  
Forceps in jar containing sterile water.

**PROCEDURE:**

- 1) Wash hands Assemble equipment.
- 2) Make solution if necessary and label with name, strength date and initials of person preparing [Do not use solution more than 24 hours old]
- 3) Bring equipment to patient Explain procedure wash hands. To look upward during instillation. The medicine may change the vision or the appearance of eye for a short time.
- 4) Remove cotton swab with handling forceps.
- 5) Wipe effected eye with cotton swab from inner to outer cathus. Discard swab.
- 6) Draw medication into dropper
- 7) Steady the hand in which the Dropper is held by placing the little finger against the forehead in the temporal region.

Ask the patient to look up, place the thumb. If the other hand below the margin of the lower lid and gently press downward.

- 8) Bring the end of- the dropper close to the outer contuse of the lower lid and express the drop or the medicine.
- 9) Have patient close eye slowly. Hold cotton swab at inner can thus over lacrimal duct for a couple of seconds. Discard cotton swab.

**RECORD:**

- 1) In treatment and medication column :  
medication, strength, amount instilled, eye treated, time initials of person admitting
- 2) In Nursing Notes column :  
Symptoms, objectives subjective change of condition

| <u>Time</u> | <u>Diet</u> | <u>Medication &amp; treatment</u>   | <u>Nursing Notes</u>   |
|-------------|-------------|---|--|
|             |             | Penicillin 2 500 units in 1 cc<br>drops iri in left eye<br>at KL 12-3-6<br>present. | Conjunctive inflamed.<br>Eyelids swollen Small<br>amount of thick<br>white discharge |
| <hr/>       |             |   | <u>K. Lalitha</u>  |

## **EYE IRRIGATION**

### **PURPOSE :**

- To cleanse the eye prior to instillation of medication.
- To remove irritating material or. foreign bodies from the eye
- To apply heat to inflamed mucous membrane.
- To relieve pain and congestion.

### **EQUIPMENT :**

- Sterile :
- Undine or medicine dropper
  - Bottle of sterile solution as ordered (luke warm)
  - Cotton swabs in covered container
  - Ounce glass
  - Kidney basin
  - Handling forceps in sterile container Mackintosh and towel paper bag.

### **PROCEDURE:**

- 1) Wash hands
- 2) Assemble equipment and bring to bedside.
- 3) Explain procedure
- 4) Position patient lying down or sitting up with head tilted toward affected eye to be irrigated.
- 5) Place mackintosh and towel over shoulders, kidney basin at side of face.
- 6) Full undine with solution ordered.
- 7) If eyelids are adhered together, cleanse with moist cotton.
- 8) Separate eye lids, direct flow of solution from inner to outer canthus a continuous flow until eye is clean or of discharge foreign object removed.
- 9) Dry eyelid with cotton swab.

**AFTER CARE EQUIPMENT :**

Wash, rinse, dry and replace equipment

**RECORD:**

- y In treatment and medication column :  
 Solution, strength, amount used, time, initials of person doing treatment.

In Nursing Notes column :

Condition of eye according to purpose

| <u>Time</u> | <u>Diet</u> | <u>Medication &amp; treatment</u>       | <u>Nursing Notes</u>               |
|-------------|-------------|---|------------------------------------|
|             |             | Left ove irrigated With N Saline 40 cc. | Small grit<br>particle<br>Removed. |

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**EYE OINTMENT****PURPOSE** :To lubricate eye

1. To treat infection
2. To dilator or contract pupil

**EQUIPMENT :**

1. Container with ointment
2. Sterile applicators
3. Sterile cotton swabs
4. Paper bag
5. Sterile water in cup

**PROCEDURE:**

1. Wash hands
2. Assemble equipment and bring to bedside
3. Explain procedure to patient
4. If discharge is present cleanse eye with moist cotton as indicated for procedure for administration of Eye drops.
5. Apply ointment onto, applicator
6. Depress lower lid and apply ointment on to culde sac of lower lid. Discard applicator.

**RECORD :** In treatment column :  
Ointment, strength, time, initials of person doing treatment.  
In Nursing Notes column :  
Condition of eye.

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| Time   | Diet | Medication & treatment                  | Nursing Notes              |
|--------|------|---|----------------------------|
| 6-3-93 |      | Achromycin ointment applied to left eye | Conjunctive stey inflammed |

## **NASAL SPRAY**

PURPOSE : To relieve nasal congestion

EQUIPMENT : Atomizer with medicine ordered  
A chair

### **PROCEDURE:**

1. Keep patient sitting upright with his head tilted slightly backward.
2. Explain to patient to inhale, while spray is being applied and to apply finger pressure against the opposite nostril while the atomizer is being used.
3. Remove air from atomizer by squeezing bulb until spray is seen. Hold atomizer so that the nasal tip is at nostril.

### **BERNOULLI'S EFFECT**

As the Atomizer is squeezed in a nose, air is forced out of the bulb and move along to the outlet, heating a low pressure area on either side of rapidly moving air, atmospheric pressure on the solution in the bottle forceps the solution in to the low pressure area, and the solution is carried out with the next squeeze on the bulb in the form of fine spray.

4. Spray each nostril by tilting the head to the side as needed.
5. Keep patient in position till he tastes medicine at the back of the mouth
6. Remove nasal tip, wash with soap and warm water and fix on to the atomizer.

| Time              | Diet                 | Medication & | Nursing Notes  |
|-------------------|----------------------|--------------|--|
| 8.00 a.m.         | Bread & tea          |              | C/o. blocking of nose.<br>Seen by  |
| 9.00a.m.          |                      |              | Dr. S.R. Rao, referred to<br>E.N.T. Dept.<br>Seen by Dr. S.R. Raiu,<br>spray ordered. Sprayed<br>nostrils. |
| S-6<br>12.00 noon | Rice, vegs.<br>curds | drops        | Nasal passage more<br><br>Suseela.   |

## **NOSE DROPS INSTILLATION**

### **PURPOSE :**

- To relieve nasal congestion.
- To administer medication to the nasal passages.

### **EQUIPMENT :**

- Tray
- Medicine dropper in clean container
- Medication ordered
- Kidney basin.
- Paper wipe or tissue.

### **PROCEDURE:**

1. Assemble equipment and bring to bedside.
2. Explain procedure.
3. place patient in position so that head is lower than shoulders or head is well tipped back and tipped to side Parkinson.
- a) Proetzposition: To treat ethmoid and sphenoid sinuses.
- b) Parkinson Position: to treat frontal and maxillary sinuses and nasal passages. Draw the solution into the dropper 1/3 to fill passages or more.
4. Hold the medicine dropper in a slanted position and place the dropper inside the nose near approximately 1/3 and instill the prescribed medication.
5. Discard medicine dropper into kidney basin.
6. Have patient remain in position for 5 minutes or until medication is felt or tasted at back of throat.

After care of equipment:

Wash, rinse, boil, dry and replace equipment.

**RECORDS:**

In treatment column:

Medicine, strength amount instilled, time, initials of person doing treatment.

In nursing Notes column.

Any reaction to treatment.

| Time   | Diet | Medication & Treatment                    | Nursing Notes.                                  |
|--------|------|---|---|
| 12-3-6 |      | Ephedrine in saline 1%<br>drops 5 in both | Nasal Congestion<br>Relieved<br><br>K. Lalitha. |

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