University of Malawi
KAMUZU COLLEGE OF NURSING

Bachelor of Science in Nursing and Midwifery

Module 12

NUR 203: Nursing Science 111: Adult Health Nursing Practice 11(ACUTE)

No of hours*:* 100 (240)
(10 Credits)

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(i) LEARNING CONTRACT

This clinical module offers me a chance to practice what I have learnt in the Acute adult nursing (NUR200). I have a minimum of 8 weeks to gain the Acute adult nursing knowledge, skills and attitudes in the Accident and emergency department, surgical ward, medical ward, Burn unit, orthopedic ward and clinical skills laboratory. I will also be required to gain a night duty experience during this semester.

I will be expected to do a group case study, undergo a clinical evaluation and go through an OSCE towards the end of the practical learning of the semester. I understand that I have to practice one skill at least a minimum of three times to achieve competency and the responsible clinical teacher, or qualified staff in the ward will supervise and sign as evidence that I have done the practice. I will take it upon my responsibility to master the learning experiences in this module and other experiences which I will come across in the clinical area.

Student Name……

Student signature……

Date……..

(ii) MODULE DESCRIPTOR

This module emphasizes on application of the nursing process during provision of nursing care, guided by the theoretical frameworks of Dorothea Orem's self care, Nancy Roper's Activities of Living, Madeleine Leninger's transcultural theories and Florence Nightingale's environmental model.

(iii) AIM OF MODULE

This module is designed to enable students to apply, analyze, synthesize and evaluate theoretical knowledge in the management of adult clients with acute conditions.

(iv) HOW TO USE THE MODULE

- Use the guidelines provided to complete all assignments
- Read and adhere to all policies outlined in clinical placement documents and the college clinical policy.
- Master and document attainment of all clinical competencies/skills which are outlined in this module.
- Meet deadlines for submission of all clinical assignments

(v) MODULE REQUIREMENTS

Students must have successfully completed module 12 –NUR 200 Nursing Science 11: Adult Health Nursing 11 (Acute) for them to be able to apply the theory into practice in the adult medical and surgical units.

1.0 MODULE OVERVIEW

1.1 Introduction

An acute illness is one caused by a disease that produces signs and symptoms soon after exposure to the etiological factors. The patients require critical care to facilitate quick recovery or assist to a peaceful death when recovery fails. In view of this, the student is expected to utilize this module in mastering the appropriate competencies at the end of the clinical placements.

1.2 Module Learning Outcomes

- Provide holistic nursing care, and apply the nursing process, guided by the selected theoretical frameworks to adult patients with acute conditions.
- Apply principles of pharmacodynamics in the administration of drugs to patients with acute conditions
- Carry out an assessment including subjective and objective data on patients/clients with various acute medical/surgical conditions.
- Identify actual or potential stressors that affect health/illness continuum.
- Recognize medical legal hazards and take appropriate precautions.
- Demonstrate competence in the performance of resuscitative measures in acute conditions.
- Demonstrate an understanding of pathophysiological factors underlying each client's alteration in health.
- Carry out a routine and emergency admission of patient using a prescribed format.
- Prepare patient physically and psychologically for medical/surgical procedures
- Assist the doctor during procedures and provide the appropriate care before /during and after the procedures.

- Apply principles of infection prevention by implementing universal precautions, isolation and barrier nursing
- Demonstrate competence in performance of nursing procedures related to acute medical/surgical problems as listed on the competence checklist.
- Accurately monitor fluid and electrolyte balance.

- Plan appropriate nursing care for patient/clients with acute medical /surgical problems.

- Provide appropriate health education to patients/clients/family during hospitalization and discharge.

- Report accurately verbally and in writing.

- Evaluate care given to patient s/ clients

- Provide compassionate and individualized care to patients/ clients and their families.

- Establish and maintain respectful, collaborative and appropriate interpersonal relationships with other health care team members.

- Demonstrate professional development through commitment; caring/compassion; consciousness; positive attitude, responsibility and accountability for own learning.

- Provide nursing care consistent with the professional code of ethics

1.3 Method of Assessment

Practical Examinations [OSCE]:	70%
Case study	20%
Clinical Evaluation	10%

2.0 G ENERAL APPROACH TO CLIENTS FOR PROCEDURES

These are the general principles that apply when you approach a patient for any procedure or intervention**:**

Establishing a rapport:

- Greet the client
- Introduce self
- Explain the procedure to client or significant other
- Obtain an informed consent from the client or significant others.

Provide privacy

Observe appropriate infection prevention measures such as hand washing and gloving.

Assemble appropriate equipment for the procedure.

Put client in a comfortable position.

Carry out the procedure in a humane manner.

Document all the proceedings accordingly.

Thank the client for the co-operation.

Report your observation to senior staff.

3.0 UTILIZING THE NURSING PROCESS

Conduct a nursing assessment:

- Subjective data
- Objective data
- Diagnostic findings

Formulate nursing diagnoses according to NANDA and in order of priority (ABCDE approach)

Plan patient care correctly

Implement planned patient care safely and comprehensively.

Evaluate the care given

Make appropriate changes according to evaluation findings (replan)

Document information on care plan, nursing Progress notes sheet, treatment chart and other documentation sheets according to unit Policy

4.0 PRE-OPERATIVE NURSING CARE

Prepare the client for the operation:

- Psychologically.
- Physically.
- Medications
- Laboratory investigations.
- Arrange for availability of blood where necessary.
- Use the pre-operative check list to ensure that the client has been adequately prepared for the operation.
- Ensure patient has signed informed consent form
- Clean client's body
- Inform theatre staff about the client.
- Teach necessary skills required in the post operative period such as:
  - Deep breathing, leg and ankle exercises
  - Coughing exercises
  - Incision splinting when coughing
  - Turning
  - Ambulation
- Prepare theatre bed for patient if coming to same ward
- Provide all equipment for patient's post operative care such as:
  - Absorbent linen saver on the bed
  - Emesis basin or receiver
  - Oxygen therapy equipment, suction machine

5.0 POST-OPERATIVE NURSING CARE

Provide immediate psychological/physical care for the first four hours:

- Assess briefly patency of airway, skin color and temperature, respiratory effort, breath sounds
  - Level of consciousness
  - Position and turning
  - Vital signs
  - Fluid and electrolyte balance
  - Pain management
  - Observe for hemorrhage
  - Medications
  - Note any prescriptions.

Provide Subsequent care as follows:

- Continue with immediate post operative care
- Conduct systematic and comprehensive physical assessment on
    - Level of consciousness
    - Papillary size and reactivity
    - Spontaneous movement of extremities
    - Heart sounds, rate and rhythm
    - Peripheral circulation skin temperature, color
    - Capillary refill and jugular vein distention
    - Respiratory rate, depth and pattern
    - Bilateral chest expansion
    - Breath sounds
- Ambulation, range of motion exercises
- Nutrition
    - Laboratory investigations.
    - Arrange for blood where necessary

6.0 COMPETENCIES

By the end of the practical allocation the student should be able to demonstrate the following competencies/skills:

Competency	**Supervisor signature and title**		
	1	2	3
Communication and Interpersonal Skills			
Utilize the Nursing Process			
Patient Admission			
Conducting a primary survey			
Conducting a secondary survey			
Beginning Skills In Basic Life Support/ CPR			
Oxygen administration			
Management of Convulsions			
Advanced Skills In Intravenous Insertion			
Maintenance of Fluid and Electrolyte Balance			
Patient Teaching			
Drug Administration			
Inserting a Nasal /oral Gastric Tube			
Tube feeding			
Obtaining specimens			
Blood transfusion.			
Suturing			
Oral rehydration therapy			
Reducing elevated temperature			
Urinary Catheterization			
Pre-operative nursing care.			
Post-operative nursing care.			
Glasgow Coma Scale (GCS)			
Oral/ nasal suctioning			
Tracheotomy care and suction			
Care of underwater seal chest drainage			
Changing chest drain			
Glucose Monitoring			

Competency	**Supervisor signature and title**		
	1	2	3
Placement of hard collar			
Spinal immobilization using back board (including log rolling)			
Maintenance of airway			
Manual ventilation			
Relief of chocking (Hemlich maneuver)			
Dressing a sucking chest wound			
Gastric lavage			
Removal of foreign body from eye			
Eye swabbing and instillation of Eye drops or ointment			
Removal of foreign body from ear			
Discharging the client.			

7.0 PROCEDURE CHECK LISTS

7.1 Routine Patient Admission

Step	Yes	No	Comments
Offer seats for patient and relatives			
Receive report from person who escorted patient			
Explain the admission process			
Take vital signs			
Take personal data			
Take history of present illness			
Past medical and surgical history			
Social and family history			
Give appropriate orientation of ward surroundings			
Conduct appropriate physical assessment			
Carry out laboratory Investigation and interpret the findings			
Inform seniors / Doctor about the patient			
Document the procedure and report accordingly.			

Supervisor's comments

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Signature……..

7.2 Primary survey:

Step	Yes	No	Comment
AIRWAY			
Looks for breathing (rise and fall of chest)			

Listens for breathing (sounds of obstruction -noisy breathing)			
Feels for breathing (air escaping from mouth and nose)			
If airway compromised, opens airway through chin lift or jaw thrust if trauma patient			
Inserts oro /nasal pharyngeal (Guedel) airway			
Stabilises the neck with rigid collar, head support, sand bags			
Administers oxygen			
BREATHING			
Looks for bilateral chest movements, paradoxical movement, ability to talk, very fast breathing, Use of accessory muscles, Jugular vein distension and trachea position –central or displaced			
Listens for breath sounds (normal, stridor, grunting, bubbling/ snoring ,wheeze)			
Feels for air escaping from mouth and nose			
Places breathing patient in recovery position			
For non breathing patient, ventilates with bag and mask			
Inserts oro-pharyngeal (Guedel) airway Suctions the patient Administers oxygen In chest trauma, assists with needle thoracentesis, chest tube insertion, artificial ventilation and applies 3 sided non porous dressing			
CIRCULATION			
Looks for obvious bleeding in case of trauma Feels hands for warmth **,** if hands are warm assesses coma Assesses capillary refill time if hands are cold Checks radial or carotid pulse Treats patient for shock if the pulse is weak and fast Stops any bleeding by applying firm direct pressure Gives oxygen Keeps patient warm Establishes IV line using 2 large bore needle Takes blood samples for emergency laboratory tests Infuses appropriate fluids Transfuses blood as required If circulation is absent, commences Cardiopulmonary Resuscitation (CPR)			
DISABILITY			
Assesses level of consciousness by calling patient's			

name, gentle shake, If no response, applies pain on nail bed or sternum Scores the patient according to Glassgow Comma scale Assesses pupil for size and reaction to light Assesses for abnormal postures (decorticate and decerebrate) Assesses movement ofl limbs Places patient in recovery position if awake Opens airway by chin lift or jaw thrust, suctioning, guedel airway and oxygen Checks blood sugar and intervenes accordingly Feeds patient as soon as conscious Gives anticonvulsants if patient convulsing Documents assessment findings and interventions done on each step			
Reassesses ABCD for any compromise before moving to secondary survey			

Supervisor's comments

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Signature……..

7.3 Secondary Survey

Step	**yes**	**No**	**Comment**
Immobilizes neck until injury has been excluded.			
Undresses the patient for examination whilst providing privacy and warmth			

Checks vital signs (TPR Bp)			
Obtains history relating mechanism of injury using mnemonic **MIST**			
Obtains patient related history using **AMPLE**			
Conducts a head to toe physical examination:			
Head: Examines and palpate scalp for swelling, depression and lacerations, ears mouth and nose for leakage of CSF			
Face: Checks lacerations, faciomaxillary fractures, broken teeth, contact lenses, eye vision and pupils, eccymosis.			
Neck: Inspects and palpates for tenderness, penetrating wound, subcutaneous emphysema, tracheal deviation, laryngeal fracture and observes appearance of neck veins.			
Chest: palpates clavicle and ribs, auscultates breath and heart sounds			
Abdomen: Inspects, auscultates and palpate for presence of free intraperitoneal fluid, bowel sounds, guarding; Looks for bruising/pain/tenderness, flank pain,hematuria			
Extremities: Inspects all limbs: bruising, wounds, deformities, pain/tenderness, vascular/neuro deficits, and pelvic mobility to rule out fractures.			
Neuro: Assesses Motor and sensory function of extremities, pupil size and response, does a full GCS			
Genitalia: Inspects for hematoma/bleeding, contusion/lacerations, pregnancy test			
Does the ordered investigations			
Gives all medications such as TTV,Analgesia Antibiotics			
Prepares patient for definitive care			

Supervisor's comments

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Signature……..

7.4 Assisting with CPR

Procedure	**Yes**	**No**	**Comment**
Approaches the patient after checking it is safe to do so, check for danger- Hazards			

Checks the patient for response and signs of life- Hallo			
If the patient is unresponsive, shout for help- Help			
Opens the patient's mouth to assess for foreign material.			
Opens the airway by tilting the head back and lifting the jaw with four fingertips. Assesses for normal respirations by looking for chest movement, listening for breath sounds and feeling for exhaled air on your cheek. Simultaneously assesses for a carotid pulse.			
Places the patient in supine on a firm flat surface.			
Places the heal of one hand on the centre of the patient's chest. Puts the other hand on top, keeping fingers clear of the ribs.			
Positions self so that shoulders are over the patient's chest.			
Pushes down about 4-5cm without lifting hands off chest.			
Repeats, giving 30 compressions at a rate of 100/min (should take approximately 18 seconds).			
Gives two rescue breaths. Attaches to the pocket mask at a rate of 15L/min.			
Repeats the chest compressions and rescue breaths at a ratio of 30:2 until further help arrives or you become exhausted.			

Supervisor's comments

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Signature……..

7.5 Oxygen administration

Step	Yes	No	Comment
Assesses the need for oxygen therapy. (respiratory rate, oxygen therapy, etc)			
Checks that the cylinder has enough oxygen or			

the concentrator is working			
Checks humidifier is connected and has enough sterile water			
Places the "oxygen in use- no smoking'' sign near patient's bedside			
Explains the indication, and anticipated experience with the oxygen and obtain an informed consent from the client, guardian.			
Washes hands.			
Attaches cannula tubing securely to oxygen source			
Sets flow rate on the flow meter as prescribed			
Checks cannula prongs to make sure air is coming out			
Loops tubing over each ear and then under chin, secures by sliding the clasp up under the chin or loops tubing behind the head			
Assesses response to oxygen therapy			
Thanks the client for the co-operation.			
Documents oxygen administration and any observation			

Supervisor's comments

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Signature……..

7.6 Gastric Lavage

Step	**Yes**	**No**	**Comments**
Follows general approach to clients for Procedures.			
Places patient in high fowlers position if conscious or lateral position if unconscious			
Assembles appropriate supplies,			

equipment for gastric lavage e.g. bucket for collecting aspirate, appropriate antidote			
Performs the procedure accurately as follows: Inserts nasal gastric tube instills 150 to 200 mL of solution in the gastric tube Connects nasal gastric tube to the drainage tube and places it under patient's chest to drain the contents by gravitational force			
Thanks the client / significant others for the co-operation			
Documents the procedure and report accordingly.			

Supervisor's overall comments

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Signature……..

7.7 Care of Patient with under water seal chest drainage

Intervention	**Yes**	**No**	**Comment**
Follows general approach to client for Procedures.			
Positions the patient in high fowlers			
Assesses for pain and gives pain relief to promote comfort			
Keeps two pairs of forceps at bedside in case of			

accidental disconnection			
Puts the drainage bottle below the patient's chest			
Notes presence of bubbling or tidaling (fluctuations).			
Supports the chest drain on the chest wall with adhesive tape			
Loops the tubing to avoid kinking it.			
Secures the tubing to bed linen taking care not to pierce the tube to avoid leakage of air.			
Houses the bottle in a special cradle on the side of the bed or floor.			
Maintains patency of the chest tube by gently lifting sections of the tubing at a regular interval to facilitate gravitational drainage of blood and viscous fluid.			
Observes the color, rate, consistency and amount of the drainage hourly			
Records the amount, color, and consistency of drainage and reports findings			

Supervisor's overall comments

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Signature……..

7.8 Female Catheterization

Intervention	**Yes**	**No**	**comments**
Follows general approach to client for procedures.			
Stands on left side of bed (if right handed) or right side of bed (if left handed)			
Assists patient assume the dorsal recumbent position *(supine with knees flexed and externally rotated)*			
Places waterproof pad / mackingtosh and draw sheets under patient's buttocks			
Removes gloves, washes and dries hands			
Opens the dressing pack			
Opens the outer cover of the catheter and places catheter on			

the sterile area of the dressing pack.			
Dons clean gloves			
Places sterile drape between the thighs			
Places sterile receiver on the sterile drape between the thighs and place the base/tail of the catheter in the receiver			
Cleans the perineum using the five swab technique			
Lubricates the catheter about 2-3 inches			
Inserts the catheter about 2 – 3 inches into the urethral meatus until urine flows out of the catheter.			
Inflates the catheter balloon with saline / sterile water			
Secures catheter with plaster against inner thigh			
Connects catheter to drainage bag and ties bag on the edge of bed frame			
Places the drainage bag under the patient's chest			
Assists patient to a comfortable position			
Provides patient education on caution against pulling of catheter			
Disposes off used equipment and materials			
Replaces the equipment			
Removes gloves and washes hands			
Documents the procedure			

Supervisor's overall comments

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Signature……..

7.9 Blood glucose testing

Step	**Yes**	**No**	**Comments**
Follows general approach to clients for Procedures.			
Checks if glucose monitoring device is functioning			
Bleeds the patient correctly onto a test strip.			
Evaluates the reading on the glucose monitoring device			
Interprets and report the reading			
Intervenes accordingly			

Supervisor's overall comments

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Signature……..

7.10 Spinal immobilization *using back board* (including log rolling)

Step	**Yes**	**No**	**Comments**
Follows general approach to clients for Procedures.			
The leader ensures continuous alignment of the patient throughout			
The leader instructs the team 'on the count of three' to roll the patient on to his or her side as a unit			
Positions the backboard under patient and holds it in place			
The leader directs the team 'on the count of three' to			

roll the patient back on to backboard as a unit			
Documents the procedure and reports accordingly.			
Thanks the client for the co-operation.			

Supervisor's overall comments

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Signature……..

7.11 Insertion of Oropharyngeal (Guedel) Airway

Step	**Yes**	**No**	**Comments**
Follows general approach to clients for Procedures.			
Checks airway opening by looking, listening and feeling for breathing			
Performs the procedure appropriately by selecting right size–from centre of teeth to angle of jaw with convex side down			
Reassesses patients airway patency by looking, listening and feeling for breathing			

Gives Oxygen			
Thanks the client / significant others for the co-operation.			
Documents the procedure and report accordingly.			

Supervisor's overall comments

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Signature……..

7.12 Patient Teaching

Step	**yes**	**no**	**comment**
Follow general approach to clients for Procedures			
Establish effective communication skills			
Assemble the necessary equipment/teaching aids			
Checks with patient what they already know about the topic			
Conducts patient teaching from known to unknown			
Demonstrates good questioning technique			
Demonstrates empathy, caring, compassion,			

consciousness, supporting attitude			
Evaluates level of understanding after teaching			

Supervisor's overall comments

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Signature……..

7.13Inserting a Nasal /oral Gastric Tube

Step	Yes	No	Comment
Follows general approach to clients for Procedures.			
Assists client to high fowler position with pillows behind head and shoulders			
Places towel over chest. Keep tissues within reach			
Stands on right side of bed if right handed and other side if left handed			
Instructs client to relax and breathe normally while occluding one naris. Selects one with			

greater airflow for easy tube passage			
Estimates the distance by placing tip of tube at client's nose to tip of earlobe and to xiphoid process(base of sternum)			
Curves 10-15 cm of tube tightly around index finger and release to aid tube insertion			
Lubricates 7-10cm of tube with water soluble jelly			
Instructs client to initially extend neck. Inserts tube slowly through naris with curved end pointing downward. pass along floor of nasal passage			
When resistance is felt applies gentle downward pressure to advance tube *Don't force tube past resistance			
Stops tube advancement , allows to relax			
Explains that next step requires to swallow or suck in air through a straw			
Passes the tube down the esophagus up to the marked level while observing patients response to tube insertion			
Secures tubing to the cheek			
Aspirates gastric contents and tests them using the Ph indicator strip			
Puts the patient in a comfortable position			

Supervisor's overall comments

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Signature

7.14 Administering of blood (Blood transfusion)

Step	**Yes**	**No**	**comments**
Checks if transfusion is prescribed to the patient			
With qualified staff: Checks that patient details are identical to information on the blood unit.			
Checks blood unit for damage (hemolysis, clot, leakage, discoloration			
Checks expiry date of blood and tissue time *Do not proceed with transfusion if any discrepancies			
Administers pre transfusion medication i.e. furosemide if indicated			
Hangs normal saline solution and allows it to fill up			

chamber half way			
Prime the administration set with normal saline			
Hangs the blood and slowly opens the roller clamp closest to the blood product			
Does pretransfusion observation: general condition, respirations, pulse, temperature and blood pressure			
Attaches the distal end of administration set to the IV catheter using aseptic technique			
Adjusts the drip rate as prescribed keeping in mind that blood administration set have a drip factor of 10 drops per minute			
Remains with patient the first 5 minutes and then obtain vital signs			
Tells patient/ guardian to alert nurse immediately of any reaction such as back pain,chills,itching or shortness of breath			
Observes general condition and vital signs after 15 minutes, then again 30 minutes and then hourly during infusion			
Closes blood roller clamp and attaches the normal saline to flush it after infusion			
Keeps the blood bag and discards it in proper receptacle if patient shows no reactions (assessor to probe)			
Continue vital signs frequently depending on policy			

Supervisor's overall comments

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……Signature……..

7.15 Glasgow Coma Scale (GCS) assessment

Step	Yes	No	Comments
Follows general approach to clients for procedures.			
Assesses eye response and gives a score			
Assesses verbal response and gives a score			
Assesses motor response and gives a scores			
Totals and interprets scores			
Reports findings and intervenes accordingly			
Thanks the client/patient/ relatives for cooperation			

Supervisor's overall comments

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Signature……..

7.16 Discharging the client

Procedure	**yes**	**No**	**Comment**
Assembles appropriate medications, supplies and equipment for the discharge.			
Health education: Disease prevention Drug storage, compliance and side effects			
Home care on: Nutrition and fluids Rest and sleep and exercise Hygiene			
Follow-up date or refer			

Provides discharge slip and review dates.			
Documents and reports to health care provider			
Thank the client/guardian for the co-operation.			

Supervisor's overall comments

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Signature……..

7.17 Oral/ nasal suctioning

Procedure	**yes**	**No**	**Comment**
Position client If conscious semi fowler with head turned on side, hyperextend neck for nasal suctioning ,If unconscious lateral position			
Place towel on pillow or under patient chin			
Select proper suction pressure and type of suction unit, wall unit 120-150 mmHg			
Pour sterile water or saline in bowl			
Wear sterile gloves on dominant hand			
With gloved hand attach catheter to suction machine			
Approximate distance between earlobe and tip of nose and place thumb and forefinger at that point			
Moisten catheter tip with sterile solution. Apply suction with tip in solution			
Oral suctioning: gently insert catheter into side of			

mouth and guide it to oropharynx.			
Nasal suctioning: gently insert catheter into one naris. Guide in medially along floor of nasocavity. Don't force catheter. *Do not apply suction during insertion			
Occlude insertion port with thumb. Gently rotate catheter as you withdraw it. *Should not take longer than 15 seconds			
Flush catheter with sterile solution by applying suction			
Allow to rest for 20-30 seconds before reinserting			
Give oxygen			
If Resuscitation is needed repeat the steps			
Suction in mouth and under tongue after oro and nasopharynx			
Discard catheter by wrapping around gloved hand and pulling glove off around catheter			
Prepare equipment for next suctioning			
Record amount, consistency, color and odor and client response to procedure			

Supervisor's overall comments

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Signature……..

7.18 Tracheotomy Care

Step	Yes	No	Comments
Opens the tracheostomy kit or sterile basins. Pours hydrogen peroxide and sterile normal saline into separate containers			
Puts on mask, apron,and gloves			
Opens suction kit			
Drape the chest			
Suctions the full length of the tracheotomy			
Rinses the suction catheter and discards inside the glove of one hand			
Unlocks the inner cannula and removes it by gently pulling it outward in line with its curvature.			
Places inner cannula in hydrogen peroxide solution.			
Removes soiled tracheostomy dressing and discards the gloves and dressing			
Don sterile gloves			
Cleans the incision site using sterile applicators or gauze moistened			

with normal saline. Uses each applicator only once and discard.			
Cleans the flange of the tube in the same manner as above			
Dries the client's skin and tube flange with dry gauze squares			
Cleans the lumen and entire inner cannula using the brush or pipe cleaners moistened with normal saline.			
Rinses the inner cannula in normal saline.			
Shakes the cannula to remove excess saline Use a pipe cleaner to dry only the inside of the cannula (not outside)			
suctions the outer cannula			
Inserts the inner cannula by grasping the outer flange and inserting the cannula in the direction of its curvature			
Locks the cannula in place by turning the lock into position to secure the flange of the inner cannula to outer cannula			

Applying Tracheostomy Dressing

Uses prepared V-shape tracheostomy dressing of non raveling material			
Places the dressing under the flange of the tracheostomy while securing the outer tube			
Cut two unequal strips of twill tape on approximately 25 cm long and 50cm long			
Cut a 1cm length slit approximately 2.5cm from one end of each strip			
Leaves the old ties in place, threads slit end of one clean tape through the eye of the tracheostomy flange from the bottom side, then threads the long end of the tape through the slit pulling it out until it is securely fastened to the flange			
Repeats for the second tie			
Asks client to flex the neck. Slip the longer tape under the client's neck, place 2 fingers between the tape and the clients neck and tie tapes together at the side of the neck			
Ties end of the tapes using square knots. Cut off only long ends leaving approximately 1-2cm.			

Removes the soiled ties once the clean ties are secured.			

Supervisor's overall comments

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Signature……..

7.19 Instillation of Eye drops or ointment

Step	Yes	NO	Comment
Washes hands and dons surgically clean gloves			
Places patient in a supine position with head slightly hyperextented and cleans eye gently along margins of inner canthus to outer canthus using warm swabs			
Removes cap from eye bottle and places it on its side			
Puts gauze below the lower lid			
Holds eyedropper ½ to ¾ inch above the eyeball with dominant hand			
Places non dominant hand on cheekbone and expose lower conjunctival sac by pulling the lower eyelid downward while applying slight pressure to the inner canthus			
Instruct the patient to look up and instill 1-2 drops of the intended medication into centre of inner lower lid			
If the patient blinks and the drops land on the outer lid or eyelash, repeat the procedure			
Instruct patients to close and move eyes gently			
Puts gentle pressure over the opening of the tear duct at the inner corner of the eye with a finger			
Replaces the bottle cap without touching the dropper tip on any surface			
Disposes off wastes a appropriate			
Removes gloves and washes hands			
Records the following on the treatment			

chart:Date,Time,Dose,Site			

Supervisor's overall comments

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Signature……..

7.20 Suturing

step	Yes	No	comments
Nurse and assistant to wear apron and mask			
Scrub hands to reduce microorganisms			
Dry hands with own sterile towel or air dry			
Don sterile gloves for infection prevention			
Ask assistant to put antiseptic solution			
Clean cut area thoroughly from inside out with antiseptic solution to reduce microbes			
Drape the patient appropriately			
Infiltrate the surrounding skin with anesthesia as required for pain			
Test for pain			
Suture the area starting with inner layer and finish with the superficial layer			
Use absorbable catgut when suturing inner layers (continuous stitch) and silk for the skin (interrupted stitch) or as necessary			
Give analgesics and antibiotics as per prescription			
Immobilize the limb if necessary			
Give instruction on how to take care of the wound			
Give return date for stitch removal			
Remove the screen			
Wheel trolley to treatment room			
Discard soiled swabs according to infection prevention protocols			
Decontaminate instrument in 0.5% chlorine solution			
Clean, rinse and dry them and return for sterilization			

Supervisor's overall comments

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Signature……..

7.21 Heimlich maneuver

Step	Yes	No	Comments

Calls for help			
Stands behind the victim			
Passes arms around client's waist			
Forms a fist with one hand			
Places the thumb side of fist against the victim's abdomen in the midline slightly above navel and well below breast bone			
Grasps your fist other hand and presss fist into victims abdomen with a quick upward thrust			

Supervisor's overall comments

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Signature……..

7.22 Collecting subjective data from a malaria patient

step	Yes	No	Comment
Greets, introduces self and identifies the patient			
Explains the procedure and patient expectations			
Provides privacy and confidentiality			
Puts patient in a comfortable position: facing each other and close to each other.			
Obtains and reviews health passport			
Obtains history of present illness:			
When did the symptoms start			
How the symptoms started			
Any treatment taken			
Obtains family history: Asks about malaria attacks in the family			
Obtains environmental history:			
Asks about environmental history eg swampy, lighting, bushes			
Asks about use of mosquito net			
Obtains past health history:			
use of anti malarial drugs			
Asks about previous attacks of malaria			
Asks about history of blood of transfusion			
Asks about history of drug allergies			
Documents findings			

Supervisor's overall comments

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Signature……..

7.23 Counselling session

Step	Yes	No	Comments
Greets client, introduces self and makes client comfortable			
Sits with an open posture at same level with client			
Maintains eye contact			
Provides privacy and assures client of confidentiality			
Prompts the client to ventilate his concerns			
Shows unconditional and positive regard to the client			
Together with the client identifies the priority needs/problems for client			
Helps client to identify possible solutions to his needs/problems			
Actively listens to the client			
Asks client open ended questions			
Summarises what client is saying			
Paraphrases what client is saying			
Shows empathy			
Focuses on client concerns rather than the self			
Allows the client to ask questions			
Prepares client for termination of the relationship			
Share tasks with client to accomplish before next session			
Agrees with client date and time for next session			
Thank the client for cooperation			
Documents the notes about the session			

Supervisor's overall comments

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Signature……..

7.24 Insulin administration checklist

Step	Yes	No	Comments
Greets, introduces self and identifies the patient			
Explains the procedure and patient expectations			
Provides privacy			
Washes hands			
Organizes appropriate equipment: *(insulin syringe, soluble insulin, sliding scale chart, cotton swabs, surgical spirit, receiver, sharp container, gloves,)*			
Analyses sugar level and refers to sliding scale			
Identifies soluble insulin from the cooler box			
Checks expiry date on vial			
Identifies correct insulin syringe			
Washes hands			
Draws correct insulin dose according to sliding scale			
Closes drip			
Injects IV insulin aseptically			
Opens normal saline drip			
Removes gloves			
Washes hands			
Documents the intervention			
Clears away used equipment and materials			
Communicates with client throughout			

Supervisor's overall comments

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Signature……..

7.25 Commencing an intravenous infusion

Step	Yes	No	Comments
Preparation			
Greets, introduces self and identifies the patient			
Explains the procedure and patient expectations			
Provides privacy			
Washes hands			
Organizes appropriate equipment: (giving set, tourniquet, spirit, cotton swabs in a bowl, intravenous canulla, adhesive tape, sterile gloves, a Litre of Ringers Lactate, Drip stand, fluid balance chart, razor)			
Implementation			
Washes hands			
Positions patient appropriately			
Close clamp of the regulator of fluid administration set just below the drip chamber			
Hang solution container on drip stand one meter above patient's head			
Remove the cover from the plastic spike of the administration set and insert the spike into the connector port of the bag of fluid until it perforates the seal.			
Maintains sterility of the spike as it enters the bag of fluid			
Gently squeezes drip chamber until it is half full with the solution			
Releases regulator to allow fluid to run through the tubing to expel all air, then turn off the fluid			
Prepares strips of adhesive tape to stabilize			

cannula			
Selects position of comfort for self			
Applies the tourniquet firmly above the site to be used and request that the fist is opened and closed a few times to engorge the veins with blood			
Cleans the insertion site with spirit swabs			
Dons clean gloves			
Palpates the vein and pull the skin taut below entry site			
Cleans the skin around the vein and swab the area with a spirit swab			
Opens the cannula in a sterile manner			
Holds needle pointed in direction of blood flow at 30 degrees angle to the skin with the bevel uppermost			
Warns the patient of the needle prick			
Pierces the skin, once the needle puncture the vein, lower the needle parallel to the skin			
Advances the canulla along the vein while withdrawing the needle pressing on the upper part of the vein			
Releases tourniquet			
Attaches infusion giving set tubing to the canulla			
Opens the regulator and ensures free flow of fluid. If fluid not flowing freely, withdraw canulla slightly as it may be lying against vein wall			
Inspects the insertion site for signs of infiltration.			
Secures the cannula			

Calculates the drip drop rate			
Sets the drop rate			
Labels the Iv infusion (date, time, drop rate)			
Advises the patient move limb carefully to avoid dislodging the canulla, report any discomfort and not to alter rate of flow of fluid			
Ensures patient is comfortable in bed			
Disposes off equipment and places back all reusable equipment			
Washes hands			
Documents the procedure in nurses notes and fluid balance chart (date, time, type of intravenous infusion, drop rate, signature)			
Communicates with patient throughout procedure			

Supervisor's overall comments

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Signature……..

7.26 Prevention of pressure sores

step	0	1	Remarks

Greets patient, Introduces self, Identifies patient			
Explains procedure to patient and guardian			
Organizes appropriate materials: ***(four pillows, sand bags and gloves, massaging oil/Vaseline and talcum powder, extra beddings)***			
Provides privacy			
Washes hands			

Implementation

Removes top beddings except one			
Rolls patient onto his side.			
Places patient in semi-prone position in center of bed			
Ensures that patient does not lie on the catheter and its tubings			
Massages occiput area			
Massages Shoulder blades,			
Massages sacrum,			
Massages hips,			
Massages ankles,			
Massages heels.			
Straightens the bottom sheet			
Supports upper arm with a pillow under the forearm			
Slightly flexes both arms			
Straightens lower leg and flexes upper leg			
Places a pillow under patient's upper leg evenly from groin to foot			
Supports feet with sand bags			
Places heel support			
Places rolled pillow parallel with back			
Makes the bed			
Documents care provided			
Communicates with client throughout the procedure			
Thanks client and guardian for their co-operation			

Supervisor's overall comments

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Signature……..

7.27 Commencing blood transfusion checklist

	I T E M	Yes	No	Comments
	Greets Patient, introduces self and identifies the patient			
1.	Explains the procedure			
2.	explains patient expectations			
3.	**Provides privacy and confidentiality**			
Obtains patient's base line data before the transfusion				
4.	Checks and documents: Temp			
5.	Pulse			
6.	Respiration			
7.	Blood Pressure.			
8.	Determines any known allergies or previous adverse reaction to blood			
Obtains the correct blood component for the patient.				
9.	Checks the physician's prescription with the requisition.			
10.	Checks the requisition form and the blood bag label for: Patient name,			
11.	Identification number			
12.	Blood type and Rh group			
13.	The expiration date of blood			
14.	Counterchecks with a senior nurse, the laboratory blood label with: Patient's name (asking the patient to state the full name as a double check)			
15	The identification number on the blood bag			

	label			
16.	Patient's blood group			
17.	Amount of blood			
18.	Checks blood for any abnormalities, gas bubbles, dark color or cloudiness, clots and excess air			
Commences blood transfusion				
19.	Washes and dries hands			
20.	Identifies the patient and explains: The procedure			
	Its purpose			
22.	Approximate length of time			
23.	Desired outcome of transfusion.			
24.	Assembles the equipment and brings to the patient			
25.	Wears gloves			
26.	Positions the patient comfortably			
27.	Inverts the blood bag gently several times to mix the cell within the plasma			
28.	Connects the blood giving set to the blood bag			
29.	Disconnects the normal saline giving set and connects the blood giving set to the cannula on the patient			
30.	Start infusion slowly at 2 ml/mnt. Remain at bed side for 5-30 minutes. (10 drops per			

	minute for first 15 minutes)			
31.	Increases the infusion rate if there are no signs of circulatory overloading (20 drops per minute)			
32.	Observes the patient closely for chilling, nausea, vomiting, skin rashes, tachycardia as they indicate early sign and symptom reaction			
33.	Checks vital signs after every 5 minutes for the first 15 minutes after the transfusion begins and then every hour until the transfusion is completed.			
34.	Stays with the patient for the first 15 minutes of the transfusion to detect transfusion reaction. (asks patient to report signs of transfusion reaction such as shortness of breath, hives, itching, or chest pain. (Assess for fever, and tachycardia.)			

Supervisor's overall comments

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Signature……..

7.27 Administering oxygen

Step	Yes	No	Comments
Check physician's order			
Explain procedure,safety precautions to patient and family			
Assemble equipment: cylinder/concentrator, cannula			
Check that the cylinder has enough oxygen			
Ensure humidifier is on			
Post an "oxygen is use" sign on the patient's door			
Wash hands			
Position patient in semifowler			
Assess immediate respiratory status			
Assess condition of nose and mouth and provide l care if needed			
Attach cannula tubing securely to oxygen source			
Set liter flow on the flow meter as prescribed			
Check the cannula prongs to make sure that air is coming out			

Insert prongs gently into nose.Make sure both prongs are in the nose			
Loop tubing over each ear and then under the chin ; secure by sliding the clasp up under the chin			
Wash hands			
Document oxygen administration and any observations			
on the patient's chart:			
(a) Date and time oxygen started			
(b) Method of delivery			
(c) Specific oxygen concentration or flow rate in liters per minute			

Supervisor's overall comments

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Signature……..

7.28 Post operative assessment

Preparation

Action	Yes	No	Remarks
Greets, introduces self and identifies the patient			
Explains the procedure and patient expectations			
Provides privacy			
Washes hands			
Organizes appropriate equipment: *(BP machine, thermometer, pulse meter, etc)*			

Implementation

Action	Yes	No	Comments
Assesses level of consciousness			
Checks vital signs (Temperature, Pulse, Respirations, and Blood Pressure)			
Assesses skin color for pallor and cyanosis			
Assesses dressing site for bleeding or oozing			
Checks IV infusion (Site, type of solution, amount left in			

bottle, and flow)			
Checks Bladder catheter for connections, kinks, drainage bag, free drainage, colour and amount of urine			
Checks proper position of urinary bag			
Checks nasogastric tube for connections, kinks, drainage amount consistency and colour.			
Check for safety and comfort (appropriate position, pain)			
Documents findings on appropriate charts			

Supervisor's overall comments

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Signature……..

7.29 Semi prone positioning

Preparation

Action	Yes	No	Comments
Greets, introduces self and identifies the patient			
Explains the procedure and patient expectations			
Provides privacy			
Organizes appropriate materials: ***(four pillows, sand bags and gloves)***			
Washes hands			

Implementation

Action	Yes	No	Comments
Remove some beddings and leave the top sheet			
Place patient supine in center of bed			
Roll patient onto his side			
Place pillow under patient's head and neck			
Slightly flex both arms			
Support upper arm with a pillow under the forearm			

Place a pillow under patient upper leg evenly from groin to foot			
Support feet with sand bags			
Place rolled pillow parallel with back			
Make the bed and tight in the beddings			
Record in nurses notes the patient new position			
Communicates with client throughout			

Supervisor's overall comments

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Signature……..

8.0 LEARNING/TEACHING APPROACHES

- Case study
- Demonstrations
- Reflective practice log
- Simulation of cases
- Conference/ presentations
- Supervision
- Coaching
- Practice checklist
- Role play

University of Malawi
Kamuzu College of Nursing
Clinical Department

Clinical Evaluation Form

Student's Name _____Dates _____
No of weeks_____Level_____
Semester_____Clinical Area/Unit (s)_____
Hospital_____

GRADING CRITERIA

Evaluation Criteria for Section A: Nursing Process

LEVEL OF MASTERY

1= KNOWLEDGE UNSATISFACTORY =0-34%
Student can recall or recognize patient information in approximate form. (K)

2= COMPREHENSION UNSATISFACTORY = 35--49%
Student can grasp and interpret prior learning about patient situation (C)

3= APPLICATION SATISFACTORY =50-59%
Student can transfer selected information and apply it to clinical situation with minimal direction (AP)

4= ANALYSIS ABOVE SATISFACTORY =60-69%
Student can examine, classify, predict and draw conclusions regarding patient information (AN)

5= SYNTHESIS OUTSTANDING =70-85%
Student can originate, combine, and integrate parts of prior knowledge to plan and propose management (S)

6= EVALUATION OUTSTANDING = 86-100%)
Student can appraise, assess, or criticise the care and management of clients based on specific standards and
Criteria (E)

	K	**C**	**AP**	**AN**	**S**	**E**
	1	**2**	**3**	**4**	**5**	**6**

A: NURSING PROCESS

SUBJECTIVE 1 2 3 4 5 6

Obtains history specific to patient's chief complaint
Obtains history of present illness
Obtains relevant past medical history/Review of systems
Obtains relevant family history/social history
Demonstrates psychological support during history
TOTAL /6

OBJECTIVE 1 2 3 4 5 6

Reviews patient record
Performs appropriate physical examination
Protects patient privacy/modesty
Provides psychological support during examination

TOTAL /6

NURSING DIAGNOSIS 1 2 3 4 5 6

Identifies client problems
Prioritises client problems
Phrase problems according to NANDA

TOTAL /6

PLANNING 1 2 3 4 5 6

Formulates objectives/goals
Individualizes care plan
Short-term plan
Comprehensive long-term plan
Promotes patient involvement in care plan
Appropriate patient education is provided

TOTAL /6

IMPLEMENTATION 1 2 3 4 5 6

Documents information using SOAPIE format
Carries out planned interventions
Modifies plan as needed

TOTAL /6

EVALUATION 1 2 3 4 5 6

Identifies how plan will be evaluated
Evaluate patient for response to plan
Evaluates client's perception of plan's effectiveness

TOTAL /6

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TOTAL/Section A /36

Evaluation Criteria for Section B: Professional Development

1=UNSATISFACTORY =0-49%
Student fails to demonstrate professional behaviour less than 50% of clinical time (US)

2=SATISFACTORY =50-75%
Student demonstrates professional behaviour more than 50% of clinical time (S)

3=OUTSTANDING =76-100%)
Student demonstrates professional behaviour greater than 76% of clinical time (O)

B: PROFESSIONAL DEVELOPMENT	US	S	O
COMMITMENT	1	2	3

Attire: appropriate uniform, hair, shoes
Attendance/punctuality
Effective utilization of time
Report to supervisor before tea/lunch breaks
Accountable/responsible for own learning

TOTAL /3

CARING/COMPASSION 1 2 3

Responds to immediate need/s of patient
Recognizes own feelings in the nurse/patient/family relationship
Approaches patients and families with compassion
Provides comfort to patients and families
Recognizes the importance of therapeutic relationships
Individualizes care of patient and family

TOTAL /3

CONSCIOUSNESS 1 2 3

Collaborates with health team members
Performs duties consistent with Code of Ethics
Respects hospital policies
Respectful to clinical team
Able to critically evaluate own performance

TOTAL /3

TOTAL/Section B /9

Evaluation criteria for section C: Attitude

5 =Excellent:= 75-100%

Confident student that knows how to handle fears and deals with problems effectively takes initiative and has good attitude towards self and others.

4 =**Very good=**60-74%

Optimistic and enthusiastic. Has self confidence and takes obstacles as learning opportunities, has self respect and positive attitude towards self and others

3 =Good = 50-59%

Good attitude about self and others but allows fear and insecurity to get in his/her way.

2 =Poor =35-49%

Lacks confidence and positive attitude towards self and others, fears rejection.

1 =Very poor = 0-34%

Lacks self respect, self awareness, gets upset easily, very defensive and lacks respect towards clients, colleagues and other members of the health care team

C. ATTITUDE 1 2 3 4 5

VP P G VG E

Able to recognize personal strengths weakness, talents and attributes

Able to overcome anticipated obstacles (e.g. change in roster and break time)

Approaches colleagues, Lecturers, senior members of staff or motivation, guidance and advice

Shares experience with colleagues and other health care team members

Handles obstacles, disappointments in a mature manner

Utilizes learning opportunities (Doctor's rounds, case presentation and procedures)

TOTAL/Section C /5

GRAND TOTAL

/50

Comments :

NURSE IN CHARGE/ PRECEPTOR

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Nurse Incharge's Signature ----------Date……..

LECTURER'S COMMENTS

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Lecturer's signature……..Date……

STUDENT'S COMMENTS

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Student ‘s signature.....

Record of Clinical hours

Name of student----------

Hospital---------- Unit- Female Medical ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit- Male Medical ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit----Male Surgical ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit--Female Surgical ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit- Eye ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit- Skin Clinic

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Unit- Orthopedic Ward

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

Record of Clinical hours

Name of student----------

Hospital---------- Burns Unit

Date	Time started	Time finished	Patients nursed or procedures exposed to	Name of preceptor	Signature o Preceptor

Total hours worked----------

REFERNCES

Required Reading

Bache, J: Armitt, C. & Gadd, C. (1998). Practical Procedures in the Emergency Department

Carpenito, L.J. (2004). Nursing Diagnosis: Application to Clinical Practice. Philadelphia, Lippincott Williams and Wilkins.

Dolan, J.T. (1990). Critical Care Nursing Clinical Management Through The Nursing Process. F.A. Davis Company. Philadelphia

Clark, J B E, Queener S F and karb V B (2000): Pharmacologic basis of Nursing Practice. St. Louis: Mosby.

Phipps, Wilma J (2007): Phipps' Medical-surgical nursing: health and illness perspective. Elsevier: Mosby.

Linton, A Maebius and Nancy K (2003): Introduction to medical surgical nursing. Philadelphia: Saundres.

Urden, L. D; Stancy, K. M. & Lough, M.E. (2006). Thelan's Critical Care Nursing *Diagnosis and Management* 5th edition Elsecier st Loius

Supplementary Reading:

Dirsen, Shannon (2004): *Medical surgical nursing: Assessment and management of clinical problems*. St. Louis: Mosby.

Malawi Ministry of Health and World Health organization (2005): *Technical Guidelines for integrated Disease Surveillance and Response in Malawi*. Lilongwe: Ministry of Health.

Brunner S L and Suddarth D S (2004): *Medical Surgical Nursing*. Philadelphia: J B Lippincott.

Lewis S M, Heitkemper M M and Dirksen S R (2004): *Medical Surgical Nursing*. Mexico. Mosby.

Smeltzer S C and Bare B G (2004): *Brunner and Suddarth's Textbook of Medical Surgical Nursing.* Philadelphia. J B Lippincptt.

Goskens V and Chalira L (1981): *Common Skin Diseases in Malawi and Their Treatment*: Limbe: Montfort Press.

Lemone P and burke K M (2000): *Medical Surgical nursing: Critical Thinking in Client care*. New York: Addisons Wesley.

Phipps W J (2007): *Phipps`Medical Surgical Nursing: Health and Illness perspective*. Elcevier: Mosby.

Supporting Websites

Websites References (please use KCN-e-journal web page as access)
Blackwell: (http://www.blackwell-synergy.com)
Ebsco host:(http://search.epnet.com)
HINARI: (http://www.healthinternetwork.org)
WHO: (http://who.int)
Wiley: (http://www.interscience.wiley.com)

Supporting Resources

IT infrastructure
Lecture/clinical teachers