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Hand Washing Procedure

Steps	Rational
Pre-Procedure:	
1. Prepare all needed equipment	1.To save time
2. Remove Jewelry.	2. To prevent transmission of infection.
3.Assess hands for hangnail, cuts, or breaks in the skin	3. breaks in skin are liable to infection and should be covered with a waterproof
4.Roll sleeves up to the elbow	4. To prevent transmission of infection.
5.Stand in front but away from the sink	5. To prevent clothes from getting wet
During Procedure:	
6. Turn on the water. Adjust the flow and temperature water (warm is preferable)	6. Running water wash out microorganisms.
7. Wet hands under running water, finger down, away from sink sides, avoid splashing water and touching the sides of the sink	7. Water should flow from clean to unclean. Splashing of water and touching any surface during washing may be a source of contamination.
8.Apply Sufficient soap rubbing hands together	8. Lather facilitates removal of microorganisms
9.Use firm, circular motions to wash the hands up to wrist	9. Friction remove microorganisms from the skin surface
10. Rub lather over all surfaces of the hands for 0 - 15) sec • Palm to palm, • Back of the hands, • Fingers, between fingers, • under fingers nails (all sides) • knuckles, wrists	
11.Rinse keeping hands in the lower position, rinse directly from fingers to wrist,	11.To prevent infection
12.Dry hands starting from fingers to wrist using clean paper towel	12.Dry hand to keep the fingers as the cleanest area
13.Turn tap off using elbow or using clean paper	To avoid recontamination of the hands
Post procedure:	
14.Discard the paper towels in appropriate bin, do not touch the bin	14.Prevent infection

Hand Washing Checklist

Please put (√) if the step is correct and put(x) if the step is wrong and give the student feedback

Student Name: ..... BUC ID: ..... Group: .....

Steps	1st trail	2nd trail	3rd trail
Pre-Procedure:			
1. Prepare all needed equipment			
2. Remove Jewelry.			
3.Check finger nails, cuts, or breaks in the skin			
4.Roll sleeves up to the elbow			
5.Stand in front of the sink without touching it			
During -Procedure:			
6. Turn on the water. Adjust the flow and temperature of water (warm is preferable)			
7. Wet hands under running water, finger down, away from sink sides, avoid splashing water and touching the sides of the sink			
8.Apply Sufficient soap rubbing hands together			
9.Use firm, circular motions to wash the hands and wrists			
10. Rub lather over all surfaces of the hands for (10 - 15) sec • Palm to palm , • Back of the hands, • Fingers, between fingers, • under fingers nails (all sides) • knuckles			
11. Rinse with hands in the down position, rinse straight in direction of fingers to wrist,			
12. Dry hands in the direction of fingers to wrist and forearm using clean paper towel			
13. Turn tap off using elbow or using clean paper			
Post-Procedure:			
14.Discard the paper towels in the in the appropriate bin, do not touch the bin			

Instructor Signature: ..... **Date:** .....

hand

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

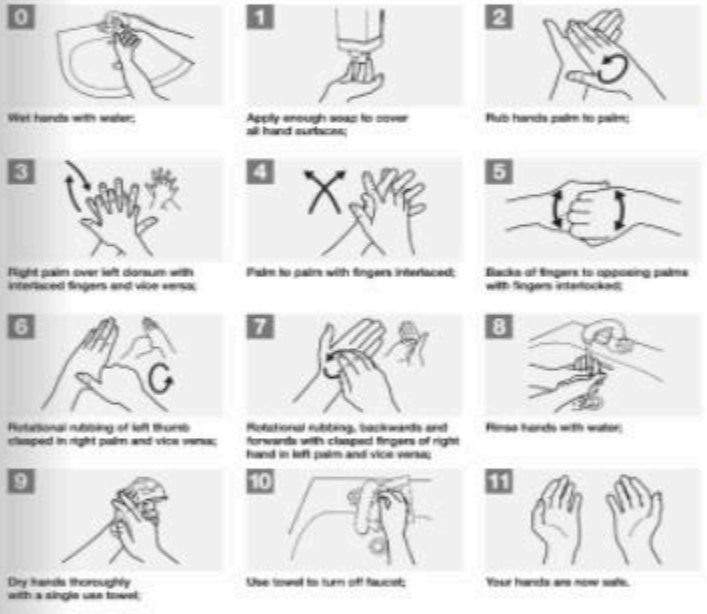
Duration of the entire procedure: 20-30 seconds

World Health Organization | Patient Safety | SAVE LIVES Clean Your Hands

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds



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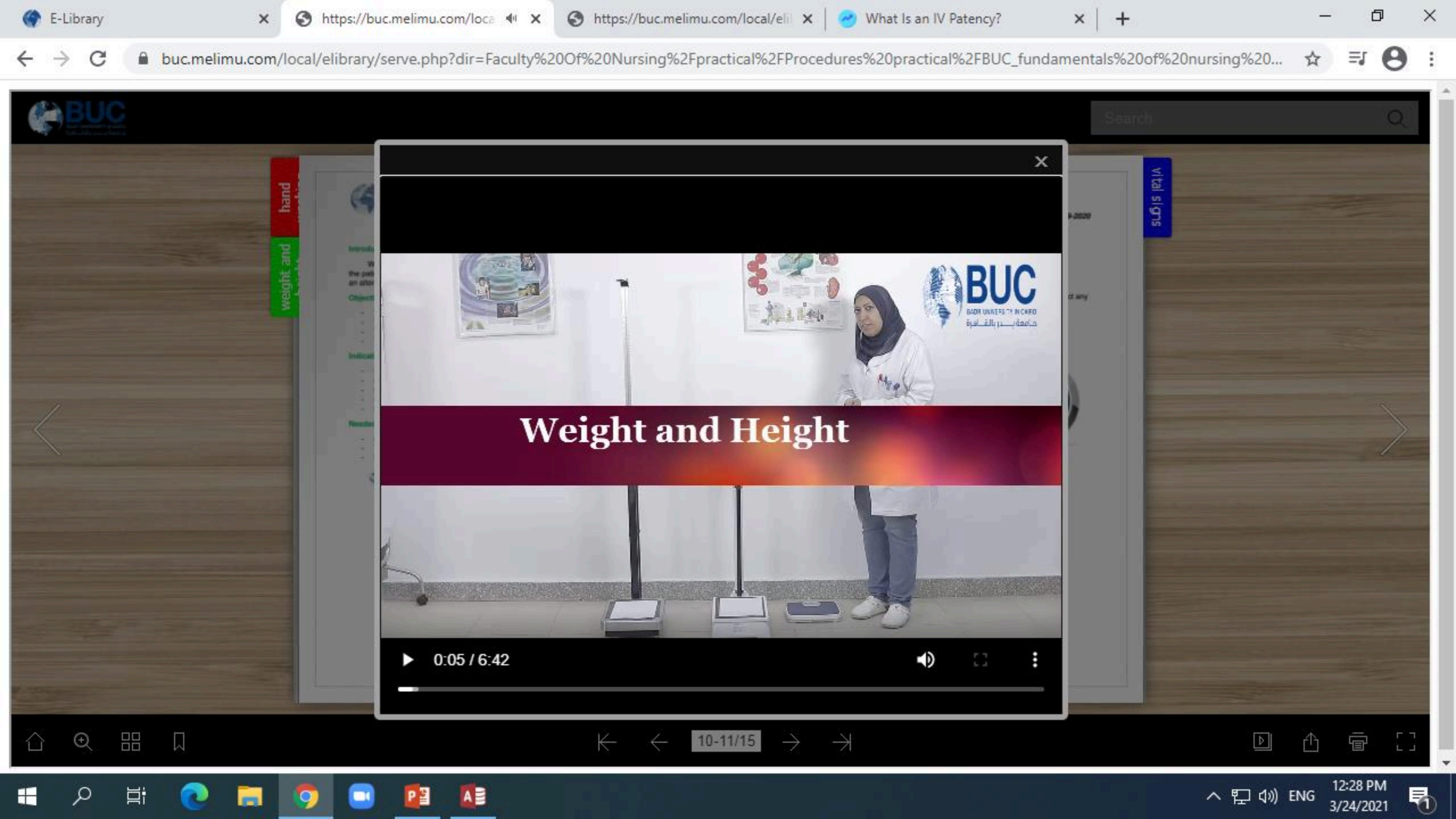
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Procedure Book level One 2019-2020

Weight and Height Procedure

#	Steps	Rational
Pre procedure		
1	Check physician prescription	To avoid any mistake.
2	Wash hands	To reduce transmission of microorganisms
3	Prepare equipment	To save time
4	Check the weighing scale at zero balance and is functioning.	To have accurate readings
5	Introduce yourself to patient	To build trust and break the ice
6	Identify patient	To be sure that it is the correct patient
7	Explain procedure to patient	To avoid anxiety
8	Utilize a quiet room	To keep patient privacy
During procedure		
9	Ask the patient to void before weighing	To obtain accurate body weight
10	Place the scale near the patient	To reduce the risk of fall or injury
11	Turn on the scale and calibrate it to zero	To ensure accurate reading
12	Place a clean tissue paper on the scale	To reduce transmission of microorganisms
13	Ask patient to remove footwear	To obtain accurate reading
14	Assist patient to stand on the scale.	To avoid patient's imbalance and fall
15	Ask the patient to stand erect, and check that patient is not carrying any objects e.g. mobile, keys	To obtain accurate reading
16	Read patient's weight after the arrow has stopped fluctuating.	To obtain accurate body weight reading
17	Place L-shaped sliding height bar on top of patient's head without pressure	To obtain accurate reading
18	Read patient's height as measured.	
Post procedure		
19	Assist the patient to get down from scale surface	To avoid patient's imbalance and fall
20	Discard the tissue paper	To avoid its re-usage and reduce transmission of microorganisms
21	Wash hands	To reduce transmission of microorganisms
22	Documentation (record weight and height measurement and calculate BMI).	To keep reading for evaluation and monitoring patient's health status.
23	Return used equipment	To keep environment organized
24	Report if any abnormalities	To maintain patient safety

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Procedure Book level One 2019-2020

Measuring Weight and Height Checklist

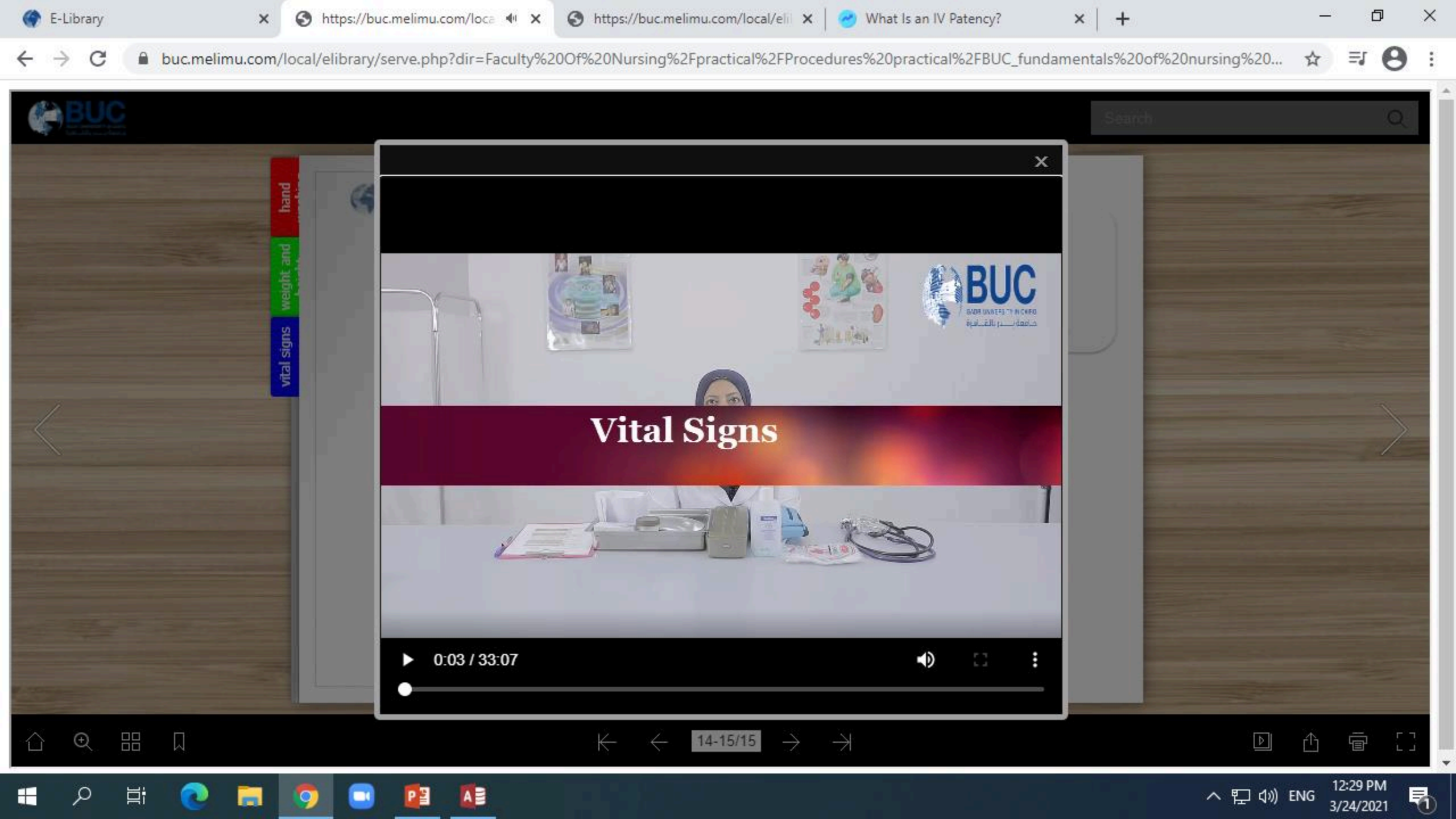
Student's name: ..... BUC ID: ..... Group: .....

#	Steps	Trial 1	Trial 2	Trial 3
Pre procedure				
1	Check physician prescription			
2	Wash hands			
3	Prepare equipment			
4	Check the weighing scale at zero balance and functioning.			
5	Introduce yourself to patient			
6	Identify patient			
7	Explain procedure to patient			
8	Use a quiet room			
During procedure				
9	Ask the patient to void before measuring the weight			
10	Place the scale near the patient			
11	Turn on the scale and calibrate it to zero			
12	Place a clean tissue paper on the scale			
13	Ask patient to remove footwear			
14	Assist patient to stand on the scale.			
15	Ask the patient to stand erect, and check that patient is not carrying any objects e.g. mobile, keys			
16	Read patient's weight after the arrow has stopped fluctuating.			
17	Place L-shaped sliding height bar on top of patient's head without pressure			
18	Read patient's height as measured.			
Post procedure				
19	Assist the patient to get down from scale surface			
20	Discard the tissue paper			
21	Wash hands			
22	Return equipment and keep environment clean and tidy			
23	Documentation (record weight and height measurements and calculate BMI).			
24	Report any abnormalities			

Documentation:

Patient's name:	
Hospital No: Medical Record Number (MRN):	Weight: Height:
Date:	BMI:
Time:	Comment:

Instructor Signature: .....**Date:** .....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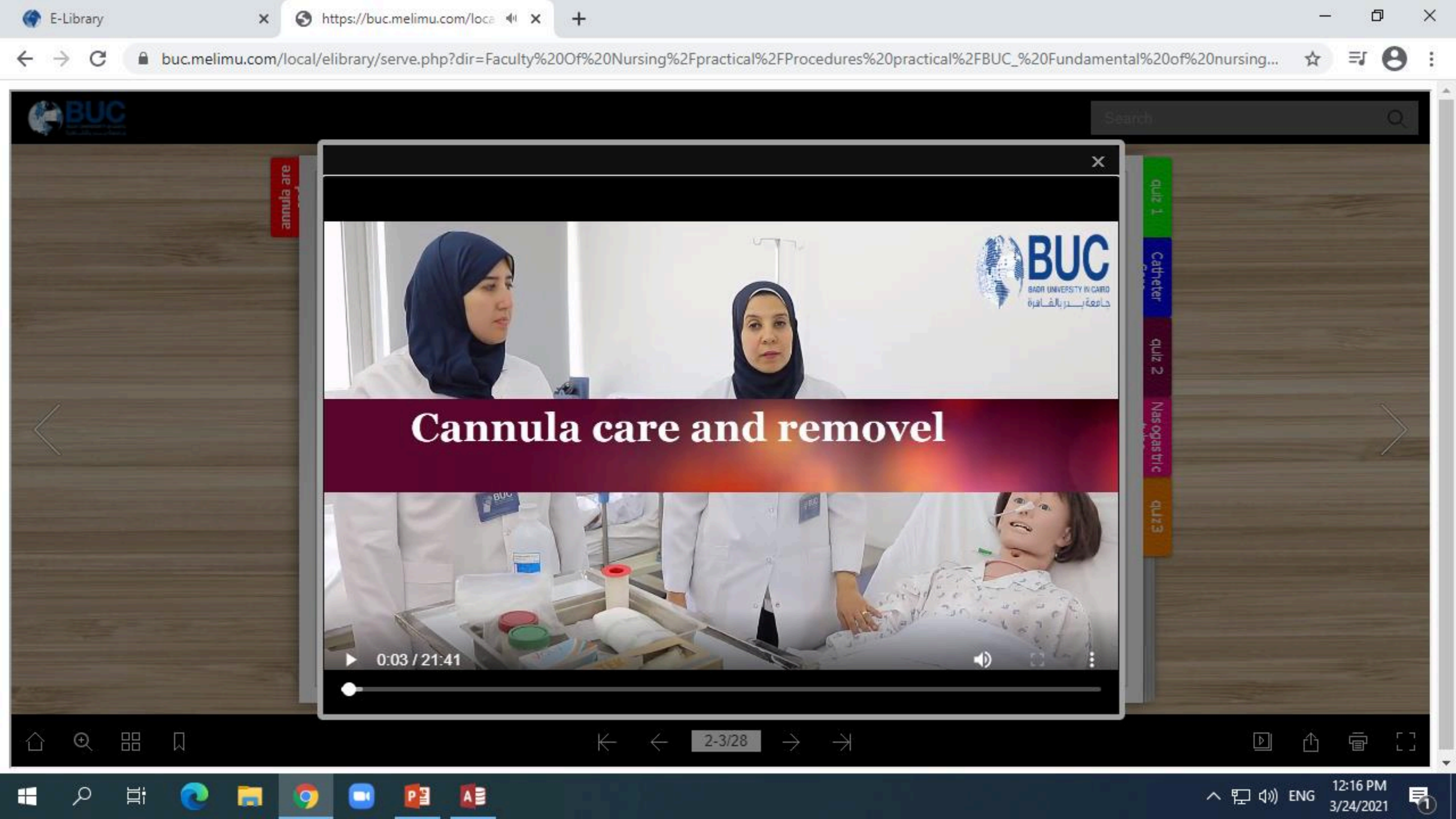
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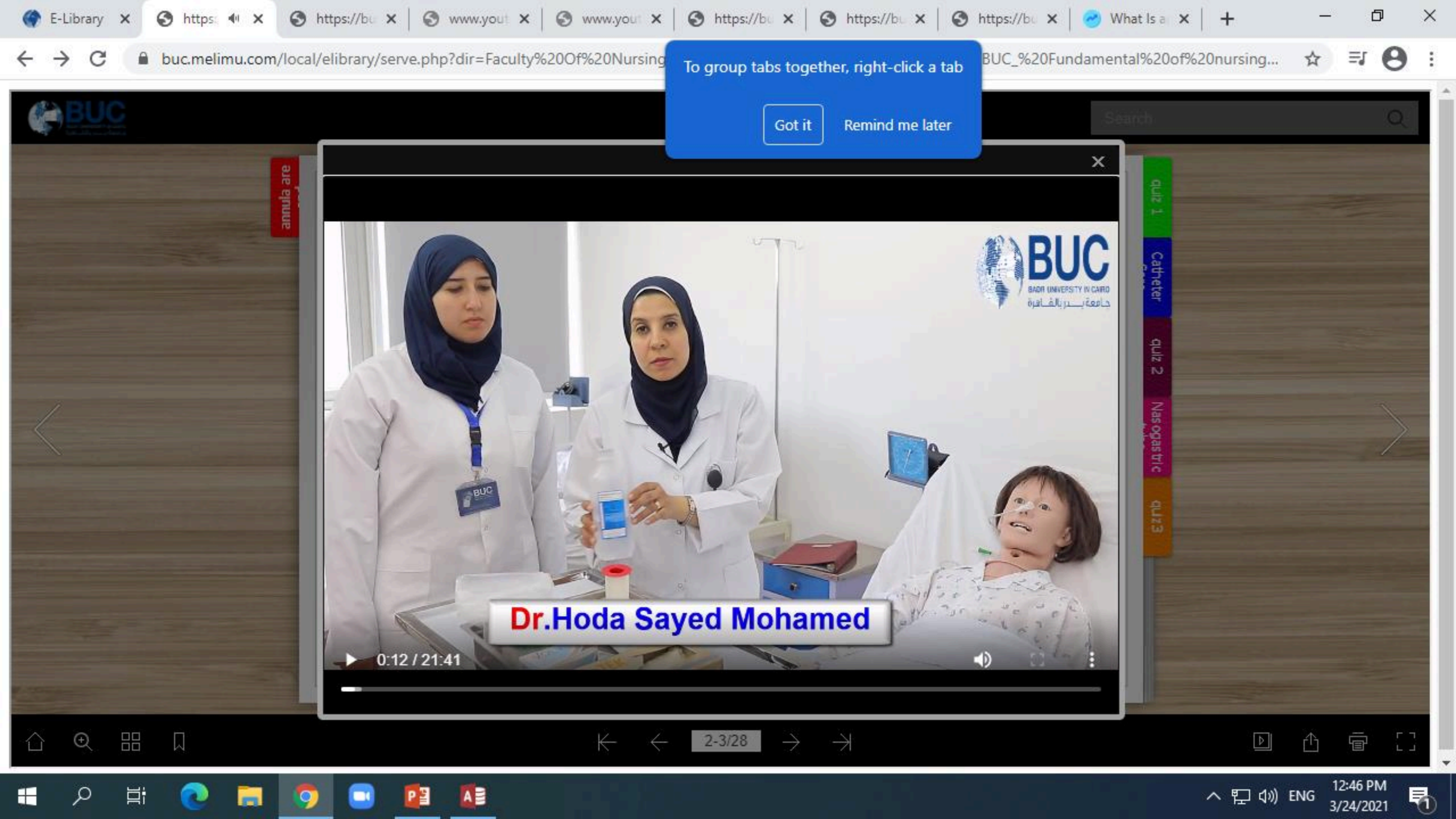
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Cannula Care and Removal Checklist

Student name: .....**BUC ID:**.....

Steps	1st trial	2nd trial	3rd trial
Pre procedure:			
1.Check physician prescription			
2.Wash hands			
3.Prepare equipment			
4.Introduce yourself to patient			
5. Identify the patient			
6.Explain procedure to the patient			
7.Keep patient privacy			
8.Put patient in comfortable position			
9.Put Disposable pad under the arm with venous access			
10.Disinfectant your hands			
11.Wear clean gloves			
During procedure :			
12. **Check if cannula is function or not by:** - Fill syring with 2cc normal saline then connect tip of syringe into cannula & aspirate amount of saline slowly. - If blood not appear not in the syringe, inject normal slne slowly, observe the insertion site. (swelling during inject STOP if No swelling inject slowely) .			
13. Support the cannula with nondominant hand and carefully remove old dressing by use gauze with sterial water or saline.			
14. Observe skin condition (if there is any inflamation, redness , swelling, pain, discharge) signs of **phelibtis**.			
15.Change gloves			
16. Disinfect insertion site with alcohol swab in one direction,start from insertion site outward.(repeat by new swab if needed)			
17. Leave Alcohol to evaporate.			
18. Fix cannula by adhesive tap			
19.Lable dressing with data,time of change,date of insertion,nurse name.			
Post procedure:			
20.Dispose any used material			
21. Remove gloves			
22.Wash hands			
23. Record the procedure(patency, skin around the insertion site, date of insertion, date of care)			
24.Report any abnormalitis			
Cannula Removal			
Pre procedure:			
1-Follow steps 1 to 11			
During procedure:			
12-Observe skin condition (if there is any inflamation, redness , swelling ,pain)			
13- Remove cannula (after 3days from insertion or if necessary)			

14- Use gauze with water or saline over old tape.			
15.Remove old tape which attached to cannula gently (support the cannula) .			
16. Remove IV cannula &quickly press with dry cotton over puncture site until bleeding is stopped.			
17. Assess vein puncture site (for redness, swelling or formation of hematoma) press on the site of removal for 5 minutes at least.			
18.Put band aid over puncture site			
Post procedure:			
19.Dispose any used material			
20.Remove gloves.			
21. wash hands.			
22.Record the procedure			
23.Report any abnormalities			

Instructor signature:.....**Student signature:**.....

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Qaiz

BUC Book Level One 2018-20109 Procedure

Urinary Catheter Care and Removal Procedure

Introduction:

Urinary catheterization is a procedure used to drain and collect urine, through a flexible tube called a catheter. Insertion of urinary catheter is an invasive procedure that should inserted by qualified competent health care professional using strict aseptic technique ongoing care of catheter is crucial time to prevent infection, injury, discomfort and complications. Continuous care is the main goal of nurses to prevent further problem **(NHS.2015).**

Objective:

- ✓ To assess and reduce the risk of urinary tract infection (UTI).
- ✓ To remove discharges at the urinary catheter site.
- ✓ Maintain patient comfort

VIDEO

Purposes for urinary catheter care and removal:-

For care	For removal
✓ To avoid transmission of microorganism. ✓ To check urinary catheter patency. ✓ To observe signs of infection. ✓ To observe characteristics of urine.	✓ Improvement of patient's condition. ✓ (improvement of urinary incontinence) ✓ patient able to void urine. ✓ to make culture from tip of catheter and then replace it again

Indications for urinary catheter:

1. Certain medical conditions, such as an enlarged prostate.
2- Cases with inability to control the release of urine, (urinary incontinence)
3- Before and after surgery.
4- Immobilized patients
5- Patient with blocked flow of urine due to bladder stones, blood clots in the urine.
7- Patient with injury to the nerves of the bladder.
8- A condition that impairs your mental function, such as dementia
9- Medications that impair the ability of bladder muscles to squeeze, which causes urine to remain stuck in the bladder.

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quiz 3

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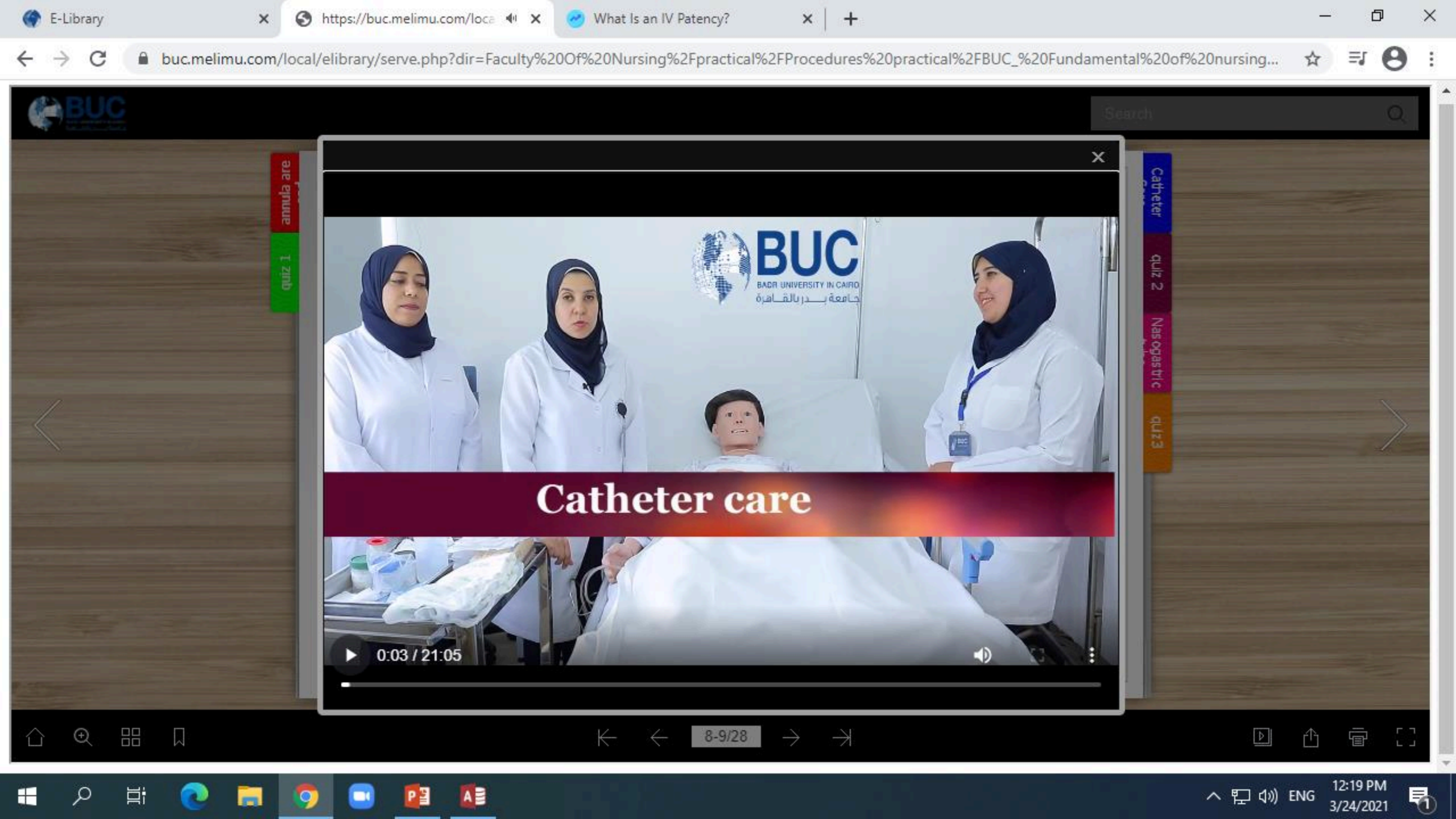
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22. Turn patient in one side with the side rail up and remove the absorbed sheet (do the same thing in the other side (be sure to raise the side rail when turning the patient to other side)	To maintain patient safety
23. Place a paper on the floor below the urinary bag	To prevent the spread of infection
24. Carefully emptied the urine from urine bag using urinal by opening the clamp.	To prevent spread of infection
25. Clamp the bag and disinfect the clamp end using Alcohol swab.	To prevent spread of infection
26. Hang the tube to proper place.	To prevent spread of infection
27. Fix the external part of the Urinary bag on the patient thigh using plaster	To maintain patient comfort
28.Open urinary catheter clamp (**artery**)	To facilitate drainage
29. Place the side rail up and return the bed into proper height	To maintain patient safety
Post procedure:	
30.Dispose any used materials	To reduce infection
31. Keep and clean equipment	To reduce infection
32. Remove gloves	To reduce infection.
33. Wash hands	To reduce infection.
34. Record the procedure	Documentation provides ongoing data collection
35.Report any abnormalities(redness, inflammation, discharge, odor)	To ensure patient safety

Instructor Name: ..... **Date:**.....

Urinary Catheter Care Checklist

Student name:..... **BUC ID:**.....

Steps	1st trial	2nd trial	3rd trial
Pre procedure:			
1.Check physician prescription			
2. Wash hands			
3. Prepare equipment			
4. Introduce yourself to patient			
5.Identify patient			
6. Explain procedure to the patient			
7. Keep patient privacy			
8. Adjust the height of the bed			
9.Disinfect hands with alcohol hand gel			
10.Wear clean gloves			
During procedure:			
11. Clamp urinary catheter at first by (**artery**). Unhooked the Urinary bag and place it between patient legs.			
12. Lower side rails in your side			
14. Fold the patient gown until waist (keep patient covered by linen at all times)			
14. Turn patient to one side (in side rail up part)			
15. Put absorbed sheet under the patient **(use bedpan if necessary)**			
16. Reposition the patient in his/her back			
17. Expose the perineal area			
18. Assess presence of discomfort from the catheter, and assess perineal area for redness, discharge, odor or inflammation			
19. Wash the urinary meatus -using dressing or gauze with warm water, OR non perfumed soap(if needed) and dry it gently.			
For female patient: gently separate the labia and clean it **in one direction from up to down (Repeat the action if necessary).start from far to near.**			
For male patient: gently support the penile while cleaning and retract foreskin (if uncircumcised). **In one direction from up to down (Repeat the action if necessary).start from far to near.**			
20. Disinfect the external catheter tube by antiseptic solution in one direction (from up to down)			
21. Remove and discard gloves and wear another pair			
22. Turn patient in one side with the side rail up and remove the absorbed sheet (do the same thing in the other side (be sure to raise the side rail when turning the patient to other side)			
23. Place a paper on the floor below the urinary bag			

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Quiz

Nasogastric

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Procedure Book Level One 2018-2019

Nasogastric Tube Feeding, Care and removal Procedure

Introduction:

Nasogastric tube is a medical process involving insertion of a plastic tube through the nose or mouth, passed through the throat, and down into the stomach. It intubation most often used to deliver food and medicine to a patient when they are unable to eat or swallow (Lynn 2015).

Objective:

- NGT is most often use in special cases as:
  - ✓ Unconscious patient.
  - ✓ Patient breathing with assistance of mechanical ventilator.
  - ✓ Patient who had oral surgeries.

VIDEO

Another purpose for NGT:

- ✓ Decompress or to drain unwanted fluid or air from the stomach.
- ✓ To allow intestinal tract to rest and promote healing after bowel surgery.
- ✓ To monitor bleeding in GIT (gastrointestinal tract).
- ✓ To remove undesirable substance (lavage) such as poisons.

Indications:

1- **(Decompression)** removal of secretion and gaseous substances from Gastrointestinal (GIT) tract prevention or relief of abdominal distention
2- **(Feeding)** (gavages') instillation of liquid nutritional supplements or feeding into stomach for client unable to swallow fluid
3- **(Compression)** internal application of pressure by means of an inflated balloon to prevent internal gastrointestinal hemorrhage
4- **(Lavage)** irrigation of stomach in cases of active bleeding, poisoning

Equipment :(NGT for feeding)

- Large syringe, 60ml
- Stethoscope
- Clean gloves
- Towel or disposable pad
- Cup of water
- Feeding (formula)

Equipment for (NGT care):
Adhesive tab
Clean gloves
Gauze or cotton (wet with normal saline)
Notes: Mouth care equipment & Lubricant, lips lotion

Remember to :

- Put patient in high fowler/sitting position.
- Do not push the liquid forcefully.
- Do not move patient after feeding and keep head of bed elevated for **one hour**

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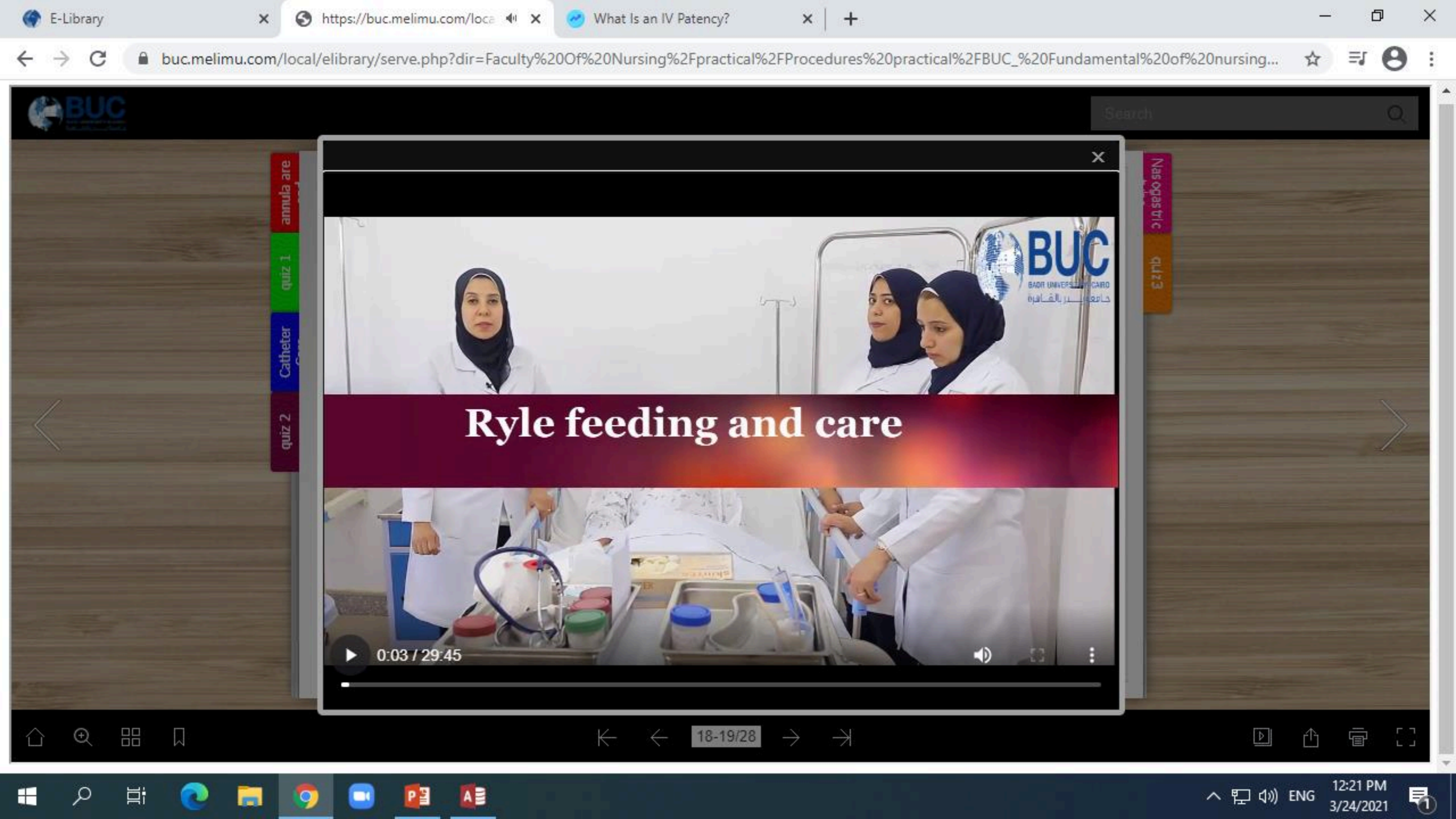
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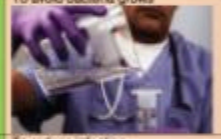
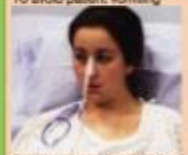
17. Elevate of syringe with tube no more than 45 cm.	To help formula enter by gravity
18. Allow syringe to empty gradually until prescribed ordered amount has been administered. **(DO NOT PUSH THE LIQUID FORCEFULLY)**	
19. Flush tube with amount of water (30 -60 ML) after finishing feeding.	To avoid bacteria grows
20. Recap tube.	To reduce infection
21. **Don't move patient after feeding for One hour.**	To avoid patient vomiting
22. perform mouth care for patient	To avoid bad odor and infection
Post procedure	
23. Dispose any used material.	To maintain organization
24.Return equipment to its place	To organize work
25. Remove gloves	To reduce infection
26- Wash hand.	To reduce infection
27. Record amount, contain, time, type of food, and report any abnormalities.	Documentation provides ongoing data
28.Report any abnormalities	To ensure patient safety





Checklist of Nasogastric Tube Feeding

Student's Name: ..... **BUC ID:**.....

Steps	1st trials	2nd trials	3rd trials
Pre procedure			
1-Check physician prescription			
2- Wash hands.			
3- Prepare all equipment needed.			
4. Introduce yourself to patient			
5-Identify patient			
6- Explain procedure to patient.			
7-Keep patient privacy			
8-Place patient in high fowler position			
9- Check physician prescription for appropriate formula. (check amount, concentration, type, frequency, check formula expiration date)			
10-Disinfectant your hands			
11. Wear clean gloves.			
During procedure			
12- Put towel over patient's chest and kidney basin.			
13.Check placement of feeding tube by: - Auscultation with stethoscope. (30 ml air) - Aspirate gastric content (residual volume) - if less than 20% of the previous meal, minimize this amount from next meal and give the meal. - If less than 20% of the previous meal, give the meal completely - if greater than 20% of the previous meal undigested food, don't give meal and report to doctor -Check pH of gastric content (less than 7) acidic - Do X. Ray			
Ryle Feeding:			
14. Remove cap of end of tube and pinch it to prevent leakage of air.			
15. Attach syringe to end of feeding tube.			
16. Fill syringe with formula.			
17. Elevate of syringe with tube no more than 45 cm.			
18. Allow syringe to empty gradually until prescribed ordered amount has been administered. **(DO NOT PUSH THE LIQUID FORCEFULLY)**			

Checklist of Nasogastric Tube Removal

Student's Name: ..... **BUC ID:**.....

Steps	1st trail	2nd trial	3rd trial
Pre-Procedure:			
Repeat steps (1-11)			
12.check written doctor order .			
During procduer			
13. Remove tube in ruling way gently.			
Post proceduer:			
14. Remove gloves.			
15.Hand washing			
15.Clean patient face			
16.Offer oral hygiene.			
16.Put patient in comfortable position.			
17. Replace equipment after clean it.			
18.Record the proceduer			
19.Report if any abnormalities			

Observer signature :.....**Date** .....

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Quiz

E-Library | https://buc.melimu.com | https://buc.melimu.com/loc | https://buc.melimu.com/lo | What Is an IV Patency?

buc.melimu.com/local/elibrary/serve.php?dir=Faculty%20Of%20Nursing%2Fpractical%2Flab_maternal%20newborn%20ebook%2Findex.html

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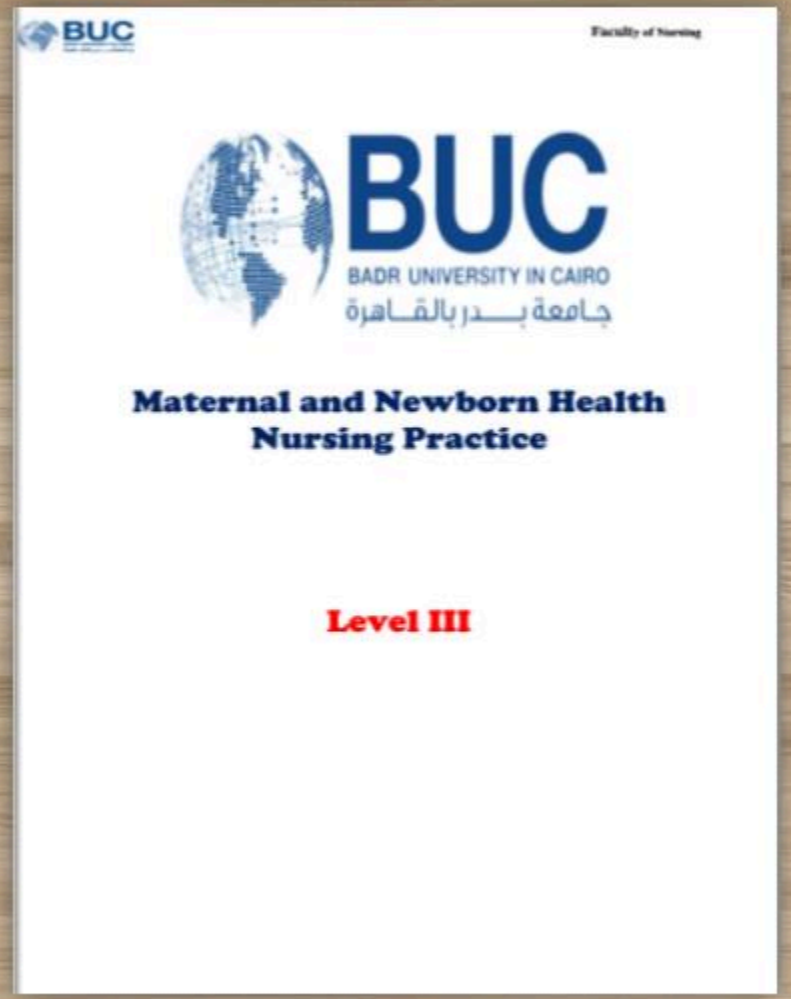
Double click to zoom in.



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A. Ante-natal Area

Cited in: www.google.com

Leopold's Maneuvers Procedure

Learning Objectives:

By the end of this procedure the learner will be able to:

- **Observe the signs of pregnancy.**
- Determine the:
  - Fetal part lying in the fundus.
  - Fetal presentation.
  - Fetus position.
  - Location of fetal back.
  - Engagement of the presenting part.
  - Degree of flexion of fetal head.
  - Gestational age (GA) of the fetus.
- Auscultation the fetal heart rate (FHR).

Third maneuver (Pawlick's Grip)

- Standing at the side of the bed facing the client.
- Gently grasp the lower portion of the abdomen just above the symphysis pubis, between the thumb and the two fingers of one hand and pressing together.

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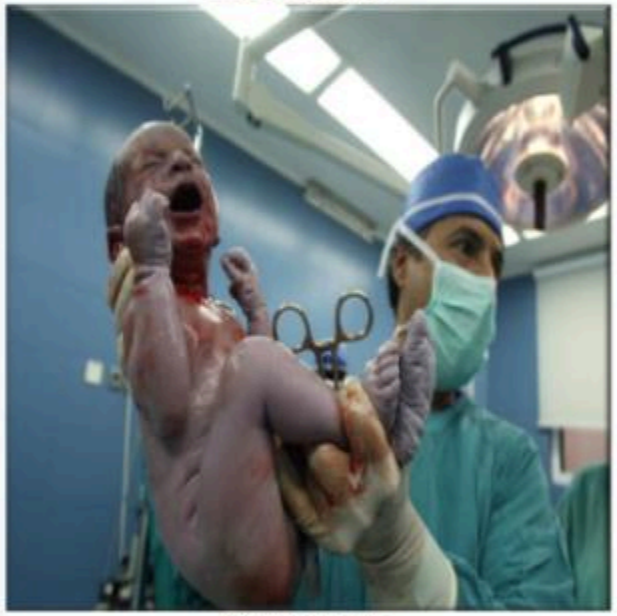
B. Labor



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11. Apply Measures of Infection Control:

- Follow aseptic techniques.
- Keep dry and clean clothes and bed linen.
- Change pads frequently.

12. Care of bladder:

- Encourage the expecting mother to pass urine every 2-3 hours.

13. Observe signs of maternal distress:

- Increased pulse rate over 100b/min.
- Elevated temperature more than 38C.
- Decreased blood pressure.
- Sweating and pale face.
- Signs of dehydration.
- Dark vomitus.
- Ketone bodies in urine.
- Irritability and restlessness.

14. Observe for complication:

- Power: hypotonic or hypertonic uterine contraction.
- Passengers: big fetus, mal-position, and mal-presentation.
- Passages: cephalopelvic disproportion.

Part (3):Post-Procedure Steps:

1. Blot all the results and findings of each procedure utilizing partograph.
2. Equipment processing (decontamination, cleaning, preparing for sterilization).
3. Transfer parturient (pregnant woman in labor) to the delivery room.

- Primiparous: During crowning of fetal head (the cervix is 10 cm dilated).
- Multiparous: When the cervix is 8-9cm dilated.

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Observation Checklist for Nursing Management of the 1st Stage of Labor

The Procedure Consists of Three Parts:	Done (1)	Not done (2)
Part (1): Preparation for the Procedure:		
1. Welcome and greet the expected mother.		
2. Fill the admission card information.		
3. Explain all procedures.		
4. Ensure privacy.		
5. Hand hygiene before each procedure.		
Part (2): Steps of the Procedure:		
1. Obtain the history.		
2. Differentiate between true and false labor pain.		
3. Record time, color, odor and consistency of membranes if ruptured.		
4. Measure vital signs.		
5. Perform Leopold's maneuver.		
6. Assess and record FHR.		
7. Assess uterine contraction.		
8. Obtain blood sample for lab investigation.		
9. Encourage the woman to empty her bladder every 2hrs.		
10. Administer IV fluids, drugs, oxytocin as ordered.		
11. Apply measures of non-pharmacological pain relief.		
12. Identify deviations from normal through partograph.		
Part (3):Post-Procedure Steps:		
1. Record & report during the progress of labor with the partograph findings.		

Date of Assessment:

Comments:.....

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Observation Checklist for the Immediate Nursing Care of the Neonate

Steps The Procedure Consists of Three Parts:	Done (1)	Not done (2)
Part (1): Preparation for the Procedure:		
1. Prepare the equipment needed.		
Part (2): Steps of the Procedure:		
1. Do suction for the neonate.		
2. Put the neonate on suitable oxygen source.		
3. Dry the neonate thoroughly.		
4. Evaluate the neonate's condition using Apgar Score at 1st and 5th minutes.		
5. Perform cord care.		
6. Apply ID band.		
7. Weigh the neonate.		
Part (3): Post Procedure Steps:		
1. Hands hygiene.		
2. Equipment processing.		
3. Assist mother in carrying her neonate and enhance immediate suckling.		

Date of Assessment:

Comments:.....
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C. Post-partum

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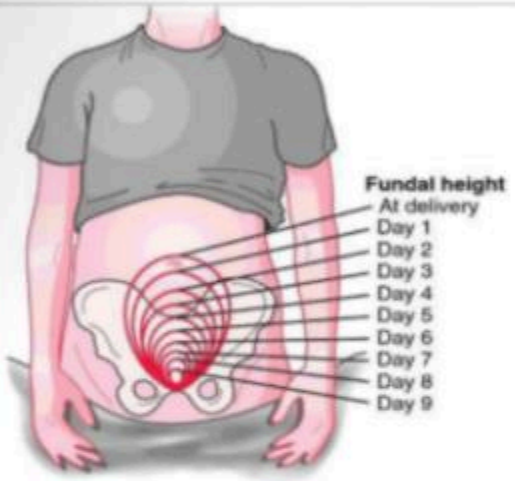

Fig. (22): Assessment of the Fundal Level after Delivery

N.B.: All figures cited in www.google.com

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Observation Checklist for the Fundus and Lochia Assessment

Steps	Done (1)	Not done (2)
The Procedure Consists of Three Parts:		
Part (1): Preparation for the Procedure:		
1. Prepare the necessary equipment and take to the bedside table.		
2. Greet the mother and explain the procedure.		
3. Instruct the mother to empty her bladder before the procedure.		
4. Provide privacy throughout the procedure.		
5. Assess mother's fundus and lochia in correspondence with the period of postpartum.		
Part (2) : Steps of Procedure:		
1. Hand hygiene and wear gloves.		
2. Help the mother to lie on her back with her knees slightly bent.		
3. Massage the fundus using one hand and the other gloved hand lower the perineal pad to assess the lochia flow in the pad.		
4. Ask the mother when she changed her perineal pad.		
5. Assess the fundal level, position, and size and consistency then massage as needed.		
6. Support the uterus by cupping one hand against the lower uterine segment (just above the symphysis pubis).		
7. Use gently the side of the other cupped hand to determine the location of fundus between umbilicus and symphysis pubis		
8. Measure by fingers how far the fundus is from the umbilicus.		
9. Determine size, position, and consistency of the uterus by hand.		

10. Massage the lax uterus using the flat part of the fingers to gently massage toward the lower uterine segment till it becomes contracted and firm.		
11. Use a new perineal pad to cover the perineum after perineal care.		
Part (3): Post Procedure steps:		
1. Remove and dispose gloves.		
2. Help the mother adjust her clothes.		
3. Inform the mother about the findings		
4. Equipment processing.		

Date of Assessment:

Comments:.....
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Perineal Assessment &Care

Learning Objectives:

By the end of the postpartum clinical area the student nurse will be able to:

- Clean the vulva and perineal.
- Avoid odor & infection.
- Promote healing of episiotomy.
- Examine the condition of premium.

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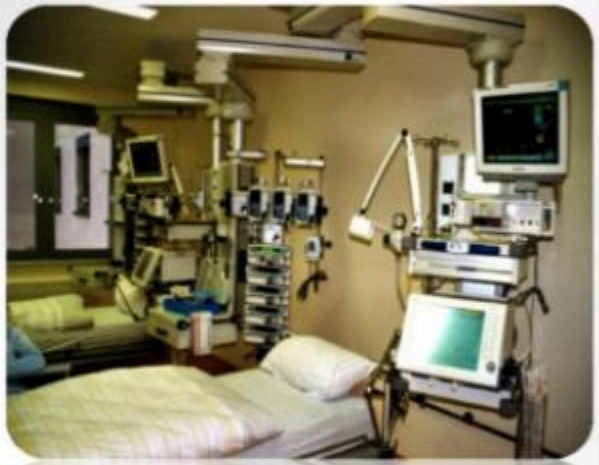
D. High Risk Area



Cited in:www.google.com

Assessment of Deep Tendon Reflex

Learning Objectives:

By the end of high risk area the student nurse will be able to:

- Determine the site of the tendons correctly.
- Assess the deep tendon reflex (DTR) in upper and lower extremities.
- Determine and adverse effect from medications likes Mgso4.

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Got it | Remind me later

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Manual of Child Health Nursing Practice

Adapted and compiled by Dr. Hoda Ahmed Mahmoud
Lecturer in Child Health Nursing
Faculty of Nursing, Cairo University secondment at Badr University in Cairo

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Vital Signs | ulse | ration | ood | owth | ange | per | ttle | amuscu | enous | ygen

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Vital Signs

General Considerations

1. Vital sign values provide the nurse with only rough estimates of physiological activity. It is important to identify trends, sudden discrepancies and wide deviations from normal.
2. Vital signs should be taken as often as the nurse thinks necessary. They should not be delayed until the next scheduled time if it is suspected that a trend is developing.

https://www.youtube.com/watch?v=Da24hzGTH5U

Temperature

- Body temperature is a regulated function of the hypothalamus , and is the balance between heat gain (metabolism) and heat loss (respiration). Heat loss depending on varies condition (gender- recent activity- food and fluid consumption and illness (Hoehn, 2010).
- Heat is gained through metabolic activity of the body especially of the muscles and liver and heat loss is achieved through the skin by the process of radiation, convection, conduction and evaporation (Hoehn, 2010).
- Core temperature, also called core body temperature, is the operating temperature of an organism, specifically in deep structures of the body such as the liver, in comparison to temperatures of peripheral tissues.
- It ranges between (36.4 – 37.4 ^{0}C).
- If the rate of heat generated equates to the rate of heat lost, the core body temperature will be stable (Tortora and Derrickson, 2011).

Indication

- To determine the child's temperature on admission as a base for comparing future measurements.
- To monitor fluctuation in temperature

N.B.: Never leave the child alone when taking his temperature.

Equipment

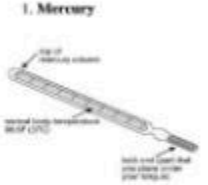
- Alcohol swab and dry cotton
- Waste disposal
- Water – soluble lubricant.
- Thermometer

https://www.youtube.com/watch?v=K0N-Jah4imI

https://www.youtube.com/watch?v=7Uc9MY2pGa8

Fig. 1: Types of thermometer

1. Mercury



2. Digital

3.Thermometer nipple type

4.Tympanic membrane

https://www.youtube.com/watch?v=GOp7o-01ehY

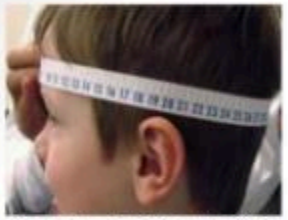


Fig. 9: Measuring HC for young children

https://www.youtube.com/watch?v=YTYtCC7Ofo0

https://www.youtube.com/watch?v=e35TkmcXLRw

Chest circumference (CC)

Equipment

- Measuring tape
- alcohol swab

NB.

- At birth: H. C. > C.C
- 12–14month H. C. = C.C
- At 24 months H. C. < C.C

Procedure for chest circumference

Action	Rational
1. Remove all clothing from the child's Chest.	To place the measuring tape well fitted.
2. Place the infant in flat position.	
3. Wrap the tape around the chest just under the axilla at the nipple line.	
4. Cover the child immediately	To maintain infant's safety.
6. Read and record immediately.	To avoid forgetting

Abdominal girth

Abdominal girth is measured routinely in high risk neonates usually before each feeding, while measured occasionally in children with certain conditions such as edema from cardiac disease, renal disease, liver disease, hepato renal disease and abdominal distention.

Equipment:

- Measuring tape
- Cotton with alcohol

Procedure for measuring the abdominal girth

Action	Rational
1. Remove all clothing from the child's abdomen	To gain accurate measurement
2.Wrap the tape around the abdomen at the level of umbilicus, or above the umbilical cord	
3. If the measurement is taken at another location, place mark at the location of measurement.	To enable you or another nurse to make future measurement at the same location
4. Record immediately	To avoid forgetting
5. Compare reading to those taken previously.	To determine change in size

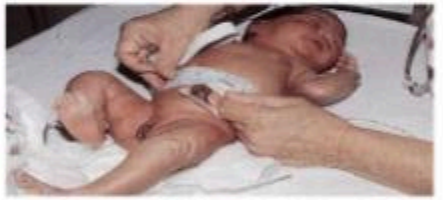


Fig. 10: Measuring Abdominal girth for newborn

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Cord care

1- Hand wash.
2- Position infant supine.
3- Inspect the cord closely during the first 24 hrs (2 artery & 1 big vein
4- Observe for bleeding, signs of infection as redness, bad odor, discharge and inflammation.
5- Place the infant on the back (supine position).
6- Clean area at base in circular motion with alcohol cotton ball
7- Put dry gauze around base of cord.
8- Wipe the top of the cord with cotton with alcohol.
8- Squeeze cotton with alcohol over the tip of the cord.
9- Remove circular gauze.
10- Hand wash
11-Remove all equipment.
12-Time and record for any observation.

N.B: For premature infants sterile water alone should be used for bathing.

Bowden,V.R&Greenberg,C.S.2008.Pediatric Nursing Procedure,2nd edition ,Lippincott Williams & Wilkins.

https://www.youtube.com/watch?v=CFRBb2BF3ec

https://www.youtube.com/watch?v=Z9WXdvYDeg8

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Sponge Bath Performance Checklist

Student's Name : ***Area :***
Instructor's Name : ***Group :***
Date :

Actions	Yes	No	Comments
1. Explain procedure to the mother.			
2. Assemble the equipment at the child bedside.			
3.Provide safe environment (Free from drafts).			
4.Check the water temperature either with a thermometer or by the wrist .			
5.Proceed by bathing from top to bottom.			
6.Wipe each eye with moist sponge from the inner to the outer aspect then dry gently each one and put eye drop.			
7.Clean the baby face, wipe around mouth and nose then go over cheeks and forehead, dry with sponge.			
8.Clean each ear over and behind only.			
9.Wipe the scalp & dry it.			
10.Wipe the neck thoroughly pay attention to creases.			
11. Clean hands from fingers then hands and dry well totally.			
12.Wipe under the axilla from front to back and dry well.			
13.Clean the chest, abdomen.			
14. Turn infant to nearest side to clean back then dry well in one direction.			
15.Clean the lower extremities from bottom to top then dry well.			
16.Clean diaper area.			
17. Remove equipment.			
18. Hand wash.			
Cord care			
16 . Hand wash.			
17. Place the infant on the back (supine position) .			
18. Observe for bleeding, signs of infection as redness, bad odor, discharge and inflammation.			
19. Clean area at base in circular motion with alcohol and put dry gauze around base of cord.			
17. Wipe the top of the cord with cotton with alcohol.			
18. Squeeze cotton with alcohol over the tip of the cord.			
19. Remove the dry gauze around base of cord.			
21. Wash hands.			
22. Record.			
23. Dress the child clean clothes.			

Total grade:

Instructor's signature: