

Level III Matching (II)

Column A

1. Painful menstruation
2. Absence of menstruation
3. Too little menstrual bleeding
4. Excessive menstrual bleeding
5. The onset of menstruation
6. Blood pressure above higher limit of normal
7. The difference between apical and radial pulse
8. Difference between systolic and diastolic blood pressure
9. The force or strength of blood with each beat
10. Pulse rate above higher limit of normal
11. More than 2 pregnancy
12. Total number of pregnancy
13. Total number of delivery

14. More than 5 deliveries

15. First time pregnancy

14. First time pregnancy

B

- A. Gravida
- B. .Oligomenorrhea
- C. PoraD..Pluse volume
- D. Multygravida
- M. Pulse rhythm
- E. Amenorrhea
- N. GrandPara
- F. Dysmenorrhea
- O. Brady cardia
- G. Purse depicit
- P. Hypotension
- H. Menororhogia
- Q. Primygravida
- I. Pulse pressure
- R. Menarche
- J. Tachycardia
- K. Hypertension

- A. Efficient contraceptive method
 - B. Stimulate uterine contraction
 - C. Increase the risk of hemorrhage
 - D. Stimulate bond bond between mother and baby
19. One of the activities is not true of taking pt's blood pressure
- A. Take the blood pressure over the radial artery
 - B. Make the pt comfortable during the procedure
 - C. Use the stethoscope to locate the strongest area of pulsation in the area
 - D. pump the monacle bulb until the mercury rises to about 20 mm /kg ----- systolic pressure.
20. The most common mode of transmission of HIV/AIDS in Ethiopia is
- A. Mother to child transmission
 - B. Hero sexual vaginal
 - C. Hero sexual rectal
 - D. Hero sexual oral
- Matching

Column A

1. Hospital acquired infection
2. Difficulty of brushing
3. Elevating body temperature
4. Swelling due abnormal accumulation of fluid in the tissue
5. Bullous discoloration of skin due to lack of oxygen
6. Prevent the spread of disease
7. Free from the presence of all living micro organisms
8. Restriction of activity of well person from the exposed one
9. Early detection and treatment
10. World wide epidemic disease
11. Artificially acquired passive immunity
12. Keeping and distributing vaccine in good condition
13. Given at birth
14. Referred to pregnant woman
15. To xeroderma

Column B

- A. Dyspnea
- B. Pandemic
- C. Cold chain system
- d. Gravid
- E. Nasocomial
- F. Hyperthermia
- G. Edema
- H. Quarantine
- I. Sterilization
- J. Cyanosis
- K Stage IV of HIV/ AIDS
- L. Prophylaxis
- M. Primary Prevention
- N. Secondary Prevention
- O. Pandemic Prevention
- P. Polio and BCG/ Polio / bcG
- Q. Tetanus Antitoxin
- R. Tetanus Toxoid

14. A child with gray hair, bilateral pitting edema, less of subcutaneous tissue and muscle and weight for age <60% of the standard is considered to be.

A. Marasmus

B. Kwashiorkor

C. Marasmic – Kwashiorkor

D. Under weight

15. Kebede is a four years old baby who comes to the health center where you are working with acute respiratory infection (ARI) for the first time. What is the dose of vitamin A you will give him?

A. 100,000 IU on the 1st, 2nd and 14th days

B. 200,000 IU on the 1st, 2nd and 14th days

C. 100,000 IU on the 1st day

D. 200,000 IU on the 1st day

16. It's acute bacterial disease characterized by rapid onset of profound vomiting, rapid pulse, dehydration, circulatory collapse & death.

A. Typhoid fever

B. Gastro enteritis

C. Cholera

D. food poisoning

17. The site of IM (intra muscular) that provides the absorption and present highest risk for injury to nerves and blood vessels.

A. Ventrogluteal

B. Dorsogluteal

C. Quadriceps femurs

D. Mid deltoid

1. The causative organism for cholera

A. E-coli

B. Staphylococcus

C. Klebsella

D. Vibrio cholera

2. A species that transmits malaria from one person to another person

A. Anopheles mosquito

B. Sand flies

C. Tsetse Flies

D. Culex

3. The best fluid used to resuscitate hypovolemic shock is

A. normal saline

B. Ringer lactate

C. Dextrose 5%

D. Sugar

4. One of the following is not important in drug administration

A. The right dose

B. The right patient

C. The right physical

D. The right time

5. The preferable position to administer IV therapy

A. outer part of the lower arm

B. inner part of the lower arm

C. inner part of the upper arm

D. outer part of the lower leg

6. The simple & most effective measure for infection prevention

A. isolation

B. Double Bagging

C. Sterilization

D. hand washing

7. The most important person in a hospital

A. physician

B. Nurse

C. Patient

D. Pharmacist

8. If 1000ml of normal saline is ordered for dehydration patient for 24hr how many drops / minutes should it run?

Give DF= 15 drop/min

A. 10

B. 20

C. 40

D.30

9. The emergency treatment of a back injury involves one basic rule
- A. Turn the victim by long – rolling
 - B. Do not move the victim until emergency medical assistance arrives
 - C. Move the victim's head so it is aligned with the back
 - D. Elevate the victim's head
10. The clinical act of identifying problems
- A. planning
 - B. implementation
 - C. Diagnosis
 - D. Assessment
11. Health is normally as the absence of signs and symptoms according to
- A. Holistic health model
 - B. high level wellness model
 - C. health believe model
 - D. Clinical model

Matching

Level -3

“A”

1. Bed bath Posn
2. Inflammation of liner cel
3. An emergency care
4. Total creaming of patients
5. Respiratory& contagious transmitted
6. Infant growth retardation
7. GI secretions that need control
8. A drug that relieves pain

“B”

- A. Hepatitis
- B. Cardio pulmonam resuaitati
- C. Supoheposn
- D. triage
- E. strict Isolation
- F. Down syndrome
- G. Enteric precautions
- H. analgesic

II. Matching

“A”

1. Amount of glucose in the blood
2. Amount of glucose in the blood
3. Cersation of cariae arrest
4. Difficult of breathing
5. Disinfeotant
6. Prpressure ulcer
7. Parity
8. Low Amount of Hgb
9. Anfaterials used tousle
10. Contageous
11. Social Acceptance after disabling apart
12. Study organ tissue body

“B”

- a. Hypoglycemia
- b. Hypoglycemia
- C. Spena
- D. Disable
- E. Neublizez
- F. Pathology
- G. Communi cable
- H. Loyspnea
- I bleach
- K. Rehabilitation
- L. Parity excditing abortion
- M. Anemip
- N. Neuro logic diug

1. Which problem should be managed first
- A. Bleeding
- B. Air way obstruction
- C. Fracture
- D. Vision problem
2. A local application of moist cold liquid to cool the scan

- A. Ice cap
 - B. Cold compress
 - C. Hot water bottle
 - D. Tepid sponge
3. The first emergency measure with flame burn
 - A. Rolling on the grassy ground
 - B. Pouring on the grassy ground
 - C. Removing the clothing
 - D. Stabbing with band
 4. Termination of pregnancy before 28 weeks is called
 - A. Abortion
 - B. Still birth
 - C. Live birth
 - D. New birth
 5. Immersion of the Genital and rectal area in warm water solution is called
 - A. Perinea care
 - B. Sitz bath
 - C. Shower
 - D. Bed bath
 6. With a tracheostomy cannot talk because
 - A. Air does not reach the vocal cords
 - B. He or she is too ill
 - C. There is swelling of the tracheal
 - D. Of the presence of secretion
 7. TORCH is an acronym for maternal infections associated with an increase in congenital manifestation and disorders which of the following disorders represents the letter H ?
 - A. Hemophilia
 - B. Hepatitis B virus
 - C. Herpes simplex virus
 - D. Human immunodeficiency virus
 8. Maria informs nurse Ana is aware that the success of breast feed is most dependent on the
 - A. Mothers educational level
 - B. Infants birth weight
 - C. Size of the mother breast
 - D. Mothers desire to breast feed
 9. What is the most common portal of entry for microorganisms associated with sepsis?
 - A. Skin
 - B. GI tract
 - C. Respiratory tract
 - D. Urinary tract
 10. Amoxicillin 500mg PO every 8 hours is prescribed for a child with an infection. The drug is available in suspension of 125 mg/5 ml how many ML should be the nurse administer with each dose
 - A. 20 ML
 - B. 4 ML
 - C. 100 ML
 - D. 10 ML
 11. After of the following injection techniques in massage indicate
 1. Intradermal
 2. Subcutaneous

3. Intramuscular
4. Z trat technique
 - A. 1 and 2
 - B. 1 and 4
 - C. 2 and 3
 - D. 3 and
12. _____ how are confined to bed should be provided with which accessory device to help prevent foot Arup
 - A. Cradle
 - B. Bed board
 - C. Foot board
 - D. Mattress pad
13. First thing you should do when admitting a pt is
 - A. Aren't the pt the unit
 - B. Ascertain and meet the pt's immediately need
 - C. Take TPR and BP
 - D. Make a base line assessment
14. Preferred position for birthing the PT-----
 - A. Prone
 - B. Supine
 - C. Semi fowler
 - D. Fowler's
15. The process of gathering information analyzing information and identifying problems is called
 - A. Assessment
 - B. Planning
 - C. Implementation
 - D. Evaluation
16. The patient begins to gag while you are tone feeding you should.
 - A. Stops the feeding for a time
 - B. Continue with the feeding as planned
 - C. Give additional in a feeding
 - D. Gives medication for nausea
17. When giving medication through a nasal gastric tube water is instilled after ward.
 - A. Provide the PT with additional fluid
 - B. Dissolve the medication
 - C. Flash the tube
 - D. Check the patency of the tube
18. Is important not to use medication at the bed side because
 - A. You will not be able to document that the Pt actually took the medication
 - B. It may fall on the floor
 - C. The patient may forget to take it
 - D. It take time to return and check with the Pt later
19. Effective it prevention and control of spread of immobieble should be strength skills and knowledge on
 - A. Data analysis
 - B. Communitdiagnousis
 - C. Rehabilitation of Pt
 - D. Health education
20. The ovum is fertilized normality at which of the following sites ?
 - A. Uterus
 - B. Fallopian tubes
 - C. Vagina
 - D. Cervix

21. The definition of sterile is
 - A. The absence of all germs
 - B. The absence of disease producing microorganisms
 - C. The absence of disease producing microorganism and their spores
 - D. The absence of all form of life
22. The vital signs to disappear at the time of death is usually the
 - A. Temperature
 - B. Respiration
 - C. Heart beat
 - D. Blood pressure
23. Sitz bath generally administered by
 - A. 5-10 mint
 - B. 15-20 mint
 - C. 30-40 mint
 - D. All hours
24. The head of A comatose Pt should be turned to the side after feeding prevent
 - A. Vomiting
 - B. Aspiration
 - C. Distention
 - D. Indigestion
25. Which of the follow site is the most accurate sate temperature measurement
 - A. Oral
 - B. Axillary
 - C. Rectal
 - D. Tympanic
26. Correct step of providing bed bath
 - A. Head , face, Trunk, Arm Leg ,Perineum
 - B. Head, Face Trunk ,Arm, ,perineum, Leg
 - C. Head ,Face ,Arm, Trunk ,Perineum ,Leg
 - D. Head ,Face ,Arm ,Trunk ,Leg, Perineum
27. Components of the chain of infection includes ,except
 - A. Infective agent
 - B. Portal of entry & portal of exit
 - C. Reservoir and susceptible host
 - D. Medication
28. Which of the following is not a measure used to prevent pressure sore
 - A. Back care
 - B. Avoiding wrinkles and hanging soiled bed
 - C. Restricting patient mobility
 - D. Applying cotton ring or air ring
29. Which type of communication is needed dis ring patient care
 - A. One way communication
 - B. Keep silent
 - C. Intra communication
 - D. Two way communication
7. which one of the following pandemic disease

A. Malaria	B. Cholera	C. HIV/AID	D. Tb
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8. The first & top during emergency nursing care

A. Manage bleeding	C. Remove foreign body from the air wag
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- B. Check circulation D. Give OPR
9. which one of the following moist compress of liquid part
 A. ICE compress B. Cold compress C. Hot H2o bottle D. Tepid sponge
10. The following are prevention Bbed sore excepts
 A. Restricting the Pt mov't C. Reassure
 B. Using comfort device D. Remove wrinkle and crackles
11. What are prevent pregnancy and STL
 A. Condom B. IUCD C. Implantation D. Pills
12. During drug administration not necessary to tell to the Pt
 A. The Purpose of the drug
 B. The side effect of the drug
 C. The rout of administration
 D. Drug metabolism

Matching

A

1. Abnormal accumulation of fluid in blood stream
2. Under 60/min
3. An epidemic that is geo wide spread
4. wide spread
5. Leprosy
6. Hyper sensitivity disorder of the Immune system
7. On communicable disease
8. An Inflammation of uterine cervix
9. A state of violent mental ministration
10. Non-Transmitted disease
11. Absence of sign of life
12. Decreased amount of red blood cell
13. The state of functions as a phaycyte
14. The act of ending something

B

- A. Hansen's disease
- B. Brady cardiac
- C. HIV/AIDS
- D. Cancer
- E. Anemia
- F. Death
- G. Bed sore
- H. Edema
- I. Cerivitis
- J. Delirium
- K. Laxative
- L. allergy
- M. SIT
- N. Confidences
- O. Termination
- P. Phaasocytes
- Q. Diabetes mellitus

R. Pandemic

1. Which one of site of insulin

A. ID

B. SC

C. IM

D. IV

2. One is appropriate position for mouth care

A. Supine

B. semi flower

C. Lithotomy

D. prone

3. The first step for abdominal examination

A. Inspection

B. Palpation

C. Auscultation

D. Examination

4. Meaning of PRN

A. As necessarily

B. once per day

C. Give always

D. Intra dermal

5. The most appropriate site of temperature

A. Oral

B. Axillary

C. Rectum

D. Tympanic

6. The nurse report urine in what color

A. Red

B. Yellow

C. Odor less

D. None

7. Infection process Sequence

A. Agent → Reservior → Portal exit → Mode of Transmission → Portal of entry → Host

8. DM Pt medication
A. Amoxicillin B. Ampicilin C. Insulin D. Cefraxon
9. Wearing of glove recommended for
A. Mouth care B. Hair care C. Back care D. Nail care
10. Pt. Coming with vomiting and dehydration appropriate taking temperature Sick is
A. Oral B. Rectum C. Axillary D. For head

Matching

“A”

“B”

- | | |
|--------------------------|---------------------------|
| 1. Graves disease | A. IGA |
| 2. Hymphogranulome | B. Throod inflammation |
| 3. Anthropoide disease | C. Spinal biffed |
| 4. Cellular immunity | D. Cell mediates |
| 5. Measeal injection | E. Hyper thyrodism |
| 6. Natural Contraceptive | F. Eye innverion |
| 7. Taxic shock syndrome | G. STI |
| 8. Pharyngitis | H. Guni worm |
| 9. New borndises | I. Cotiusintrupts |
| 10. Weezing | J. Purdoxin |
| 11. Optalmus indication | K. Dopamix |
| 12. Drug | L. Loud during exhalation |
| 13. Communication | M. Thyroxin |
| 14. Goiter | N. Staphylococaus a urws |
| 15. Neurology drug | O. B/n doctor and pt |

1. The most accurate and suitable port for thermometer measurement.
A. Axillary B. Rectal C. Pral D. Anal
2. Total No. of pregnancy
A. Parity B. Gravida C. Nullipara D. Multrpara
3. Not ethical characteristics of nurses
A. Privacy B. Confidealality C. Empath
4. The drug prescribed 2 ml of syrup the normal dilution has 120 mg/5ml How Many me can gives?
A. 50mg B. 48mg C. 120mg D. 72 mg
5. Techniques of infected wound care cleaning
A. Cleaning inside to out side
B. Cleaning out side to inside
C. Clean up to down
6. All are a new born care except
A. Cord care B. Eye care C. Formula Feeding D. Immunization
7. During Pt care we use ----- Communication skill
A. Intra Communication skills
B. Group >>>>
C. One wag >>>>
D. Two wag >>>>
14. One of the following can cause of viral skin disease
A. Pediclasis C. Rolapsing fever
B. Herpes simplea D. Malaria

15. All are topical medication excepts
 - A. Nebulizer
 - B. Anti helmentic
 - C. Aye drop
 - D. Ear drop
16. All are management of fracture except
 - A. Immobilization
 - B. Cleasing&wondD.use splint
 - C. Manipulation binjerd part
17. Management &eldavgpt
 - A. Giratics
 - B. Obstraties
 - C. pedalities
 - D. aldoteew
18. Care B aped person
19. All are ANC care except

Maching (I)

Column A Column B

- | | |
|---|--------------------------------------|
| 1. Rectal /vaginal mgt | A. Gas gangren |
| 2. Clastlidiuimtetany | B. Lacuration |
| 3. Wound by surgical incision | C. Rehabilitation |
| 4. Nasocomal infection | D. shock |
| 5. Assessment & new born care | E. Trachoma |
| 6. Nursing care for disabled Pt | F. Gravida |
| 7. Eliminate moist include spore formG. Chocking | |
| 8. Mode of exite intestinal parasiteH. Partity | |
| 9. Give of vaccinel. Immunization | |
| 10. Cause of blindnessJ. Nebulizer or aerosal | |
| 11. Disease transmit person to personK. Feaces | |
| 12. Nasal medicationL. Disinfection | |
| 13. Unconscious due to decroapt blood flowM. Stralization the brain | |
| 14. Air wag abstraction by forign body N. APGAR score | |
| 15. No of skill birth and civil bulshO. Communicable disease | |
| | P. Suppositories |
| | Q. Decrease level of gruccg in Idood |
| | R. Hospital acquired infection |

Choose the best answer

1. The correct step for nursing process ?
 - A. Nursing assessment ,DX,planning,Implimentation and evaluation
 - B. NSG DX, planning, assessment,evaluation and implementation
 - C. NSG implementation, assessment,planning evaluation
 - D. NSG evaluation ,planning implementation and Diagnosis
2. All are factors of influencing medication action Excepts
 - A. Rate of observation
 - B. Metabolism
 - C. Rate of administration
 - D. Antiemetic's
3. Method of storage handling and using of medication include
 - A. Deylomist
 - B. Dumping
 - C.unlockedcapboayd
 - D. Dispasedtosome light
4. A common viral disease may not include
 - A. Herpex simplex 1 (cold sage)
 - B. Herpex simplex 2 (gental herpes)
 - C. Herpex simple 1 (gental herpes)

- D. Herpes zoster (common viral disease)
5. Commonly seen wound was a result of acute of chronic conditions may include
A. Stain B. C. Sprain D.
 6. Pregnant mother came to health center was complain of pushing down pain, when ancrat examination. What is her possible diagnoses.
A. 1st stage of labour B. 3rd stage of labour C. 2nd stage of labour D. 4th stage of labour
 7. A 35 weeks of pregnant mother come to your health center with complain of vaginal bleeding what do you suspect?
A. Abortion B. Ectopic pregnancy C. Placenta previa
 8. Emergency Nursing care may not include
A. Resuscitation
B. All evicition of respiratory distress
C. All aviation of cardiac distress
D. Septic wound care
 9. Which one of the following the sign of chronic malnutrition
A. Stant B. Very low wt for age C. Wasting D. sever wasting
 10. It is a type of shock caused by bleeding diarrhea vomiting burn and rstore by infusion
A. Hypovolemic shock B. Cardiogenic C. Septhic shock D. Anaphliactic
 11. The 3 cardinal sign which indicate the immediate condition
A. Pause, Respiration and peristalsis
B. B/P, PR and JO
C. RR,BP and largthmip
 12. The best solution of intravenous therapy for sever dohydration
A. Ringer lactate
B. As/S
C. DW
D. Aral rehydration therapy
 13. Priority given during resuscitation
A. Ventilation
B. Removing foreign body from air way
C. Cardiac compression
D. Central bleeding
 14. Validation strategy to relief distress and agitation ?
A. Acknowledgment
B. Alowing expression of distress
C. Providing verbal and physical examination
D. Showing the result
 15. Which of the following is not several contraceptive method .
A. Mubal ligation B. Implant C. IUCD D. Loop
 16. Infection controle policy and procedune may not related to
A. Personal protective equipment
B. Standard and addition precaution
C. Documentation
D. Standard of Hygien
 17. The point given for each vital sign during APGARSC care
A. O- 1 B. O - 3 C. O -2 D. O - 5
 18. The duration of TT4 Vac Cine preventable
A. 10 years
B. 5 years

- C. 2-3 years
D. Life long
19. In the infection prevention the disinfect trouns mission segancy
- A. Agent →Reserviour→ Portal of exite→ portal of entry → host
20. The inflammatory praccess except
- A. Red B. Strain C. Discharge D. abortion
21. The woment come to in your health center before 36 weeks she has started labour
- A. Post abortion B. Abortion C. Preterm labour

Matching

“A”

“B”

1. Expulsion of fetur be for 36 Weeks of gestations
2. Pareximal recurrent headach
3. Lack of o2 in the tissue
4. Bed sore
5. Intera dermal
6. Proprananol
7. Clean from inside to out side
8. Non toxic
9. Ring worm
10. Blister from with burn
11. Unable to suck
12. From birth up to 28 weeks
13. Edema , maonface abnormal wt rain
14. High grate fever
15. Congentiveinteuectual deterioration

- A. Neonate
- B. Parity
- C. TeniaCapitus
- D. Topical medication
- E. Asptic wound
- F. Pre term
- G. Hyper pyrexia
- H. Migrane
- I. detention
- J. Marasmus
- K. 2nd degree burn
- L. Beta blocker
- M.Kwashiker
- N. Asphaxia
- O. Danger sing of neonate
- P. Decuplitis
- Q. Normal flora
- R. Abortion

1. A type of shock dwring medication Administration
- A. Hypovolemic B. Anaphy/axis C. Nurogenic D. Cardiogenic
2. Wounds can be caused by in which of the following migolyanisms except
- A. StaphylocousaureusB. Costerdium C. proteus D. Manitol

3. Which one of the following is the cause of viral disease
 A. Mycobacterium B. Herpes Zoster C. Tetanus D. E. coli
4. Contraindication for PO (per mouth) medication
 A. Conscious patient B. Pneumonia patient C. HIV patient D. Continuous Vomiting
5. If you are a clinician and a 26 years lady comes to your clinic with LMP 30/07/06 E.C & Visiting day as to 19/12/06 E.C what is the G-A of the mother?
 A. 17 weeks & 4 days B. 18 weeks & 1 day C. 19 weeks & 4 days D. 17 weeks & 1 day
6. Client history may include
 A. Present history B. Behavioral C. Future History D. Admission diagnosis
7. Potential complication of blood transfusion include except
 A. Low back pain B. urticarial C. Nausea & Vomiting D. Bleeding
8. Solution used to clean septic wound is
 A. Hydrogen peroxide & normal saline
 B. Iodine
 C. Savlon
 D. Only normal saline
9. Which of the following are incorrect statements ?
 A. Medications are stored in a safe manner according to the legislative requirements & organization policy
 B. PRN medications are administered within the legislative requirements and organizational policy
 C. Client information & education related to the medication requirements are provided
 D. It is possible to administer medication without consent of patient & relatives
10. Post anesthetic & post operative management include all except
 A. Observing level of consciousness
 B. Vital signs
 C. Intravenous therapy
 D. Complete bed bath
11. If the neonate born with breathing well, which one is correct statement about his breathing pattern?
 A. Score is 2 B. It is abnormal breathing C. The Score is 0 (zero) D. He is birth asphyxiated
12. A mother comes to health center for attending ANC follow of part -1 , still birth -1 , abortion -1, what is the total number of pregnancies?
 A. 4 B. 1 C. 2 D. 3
13. Which one of the following statement is correct about infected wound care?
 A. If clean from outer to inner

- B. Clean to from inner to outer
 - C. It is septic wound
 - D. It is fresh wound
14. One of the following hormonal contrauptives
- A. Tubal higation B. Vasectomy C. Loop D. Esttogen&progestel on fill
15. All are post operative pain management strategies except
- A. Narcotic infection
 - B. Antibiotic
 - C. Oral analgesics
 - D. Topical antibiotics.

Matching

“A”

1. Blood urine
2. Cessation & heart function
3. Drugs commonly used during postoperative care
4. The feeling exposed by patients
5. Data that can be observed & measured
6. Low glucose level in the blood
7. The restoration of some one to useful place society
8. Acute corruption state
9. The code standard of conduct, performs & standard of ethics
10. Study of organ , tissue and body fluids
11. Pressure ulcer

“B”

12. A drug delivery device used to administer medication
 13. Unable to unfit
 14. Increase blood glucose level
 15. Low hemoglobin in level
- A. Subjective data
 - B. Analgesia
 - C. Confidentiality
 - D. Haerraturia
 - E. Nebulizer
 - F. Objective data
 - G. Pathology

H. Delirium

I. Disable

J. Relabilitation

K. Cardia arrest

O. Hyperglycemia

L. Dewbitus

M. Hypoglycemia

N. Anaerria

1. Important sign of pre eclampsia is
 - A. Albuminuria and raised blood pressure
 - B. Albuminuria and glycosuria
 - C. Albuminuria and fever
 - D. Convulsion
2. The common place where ectopic pregnancy is
 - A. Abdomen
 - B. Cervix
 - C. Fallopian tube
 - D. Every
3. At days old baby come with sign and symptom of sunken eyes skin pinprick goes back slowly turgor and dry mouth your possible diagnosis.
 - A. Severe dehydration
 - B. Some dehydration
 - C. No dehydration
 - D. Dehydration
4. Which one of the following preventive health care
 - A. Health screening
 - B. Cancer screening
 - C. diabetes mellitus
 - D. Vision or hearing
5. The appropriate place to take temperature for children is
 - A. Axilla
 - B. Rectum
 - C. Mouth
 - D. Axilla and rectum
6. A 3 year child who has cough and fever, PR is 50 bpm, temperature is 38.5 degree
 - A. Ceftriaxone 301
 - B. Tetracycline
 - C. Chloramphenicol
 - D. Ampicillin
7. The anterior fontanel is closed at age of
 - A. 18 month
 - B. 3 month
 - C. 4-6 week
 - D. 8-10 week
8. A correct statement about two way communication is
 - A. There is no feedback
 - B. Interaction between nursing and patient
 - C. there is no channel
 - D. It is one sided
9. From the following one that is not communicable disease
 - A. Typhus
 - B. Typhoid
 - C. Cancer
 - D. hepatitis B virus

10. The most effective mechanism for preventing the spread of infection.
 - A. Through hand washing
 - B. Wearing face mask
 - C. Using isolation precaution
 - D. Wearing disposable
11. The first action in management of epidemics
 - A. Treating cases
 - B. Immunization
 - C. Health education
 - D. Attacking source
12. Common fungi include
 - A. Trichophyton (athlete's foot)
 - B. Trichosporon
 - C. Trichosporon
 - D. Pediculosis
13. A 28 year old mother came to health center on 22-10-2008 with E.C.B Calculate gestational age
 - A. 30 week
 - B. 20 weeks and 1 day
 - C. 10 Week and 1 day
 - D. 18 Weeks
14. All are the cause of dehydration except
 - A. Diaphoresis
 - B. Bleeding
 - C. Vitamin
 - D.
15. Vaccine given earliest
 - A. BCG
 - B. Measles
 - C. Vitamin
 - D. DPT
16. Early Rupture of membrane can lead to
 - A. Bleeding and cord prolapse
 - B. Infection
 - C. Cord prolapse
 - D. Antepartum hemorrhage
17. Decubitus ulcer is seen on the patient of
 - A. Ambulatory patient
 - B. Bedridden patient
 - C. Nurse
 - D. Doctor
18. A mucosal ulceration of the stomach or duodenum
 - A. Gastritis
 - B. Oesophagitis
 - C. PVD
 - D. CHF
19. During administration of medication on the route of
 - A. Massive wound
 - B. Dizziness
 - C. Dehydration
 - D. Fluid overload
20. Neonatal respiration is
 - A. 18 -20BPM
 - B. 16- 18BPM
 - C. 20-22BPM
 - D. 30-60 BPM
21. Measles given in 9 month with
 - A. Vitamin D
 - B. Vitamin C
 - C. Vitamin A
 - D. Vitamin B
22. Breast milk contains except
 - A. Vitamin A

Crutch

Definitions

- **Crutch** is walking aids made of wood or metal in the form of a shaft which reaches from the ground to the client's axilla.
- **Crutch walking**; is one of the patient ambulation techniques which helps the client to stand and walk with the help of Crutch

Purpose

- ❖ Reduces anxiety and promotes client's autonomy
- ❖ To improve muscle strength

Types of Crutch

Axillary:

- ❖ Fits under the axilla with the weight being placed on the handgrips

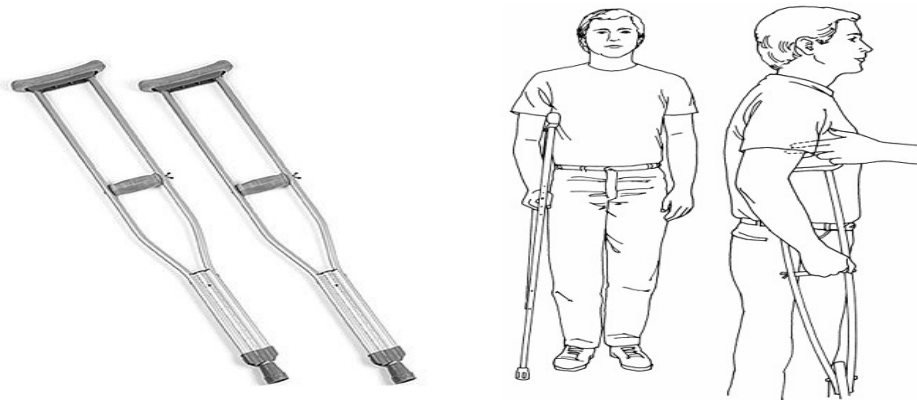


Figure 21: Axillary crutch

Forearm:

- ❖ It has a handgrip and a metal cuff that fits around the arm
- ❖ More convenient but provides less stability than the axillary crutch



Figure 22: Forearm crutch

Types of Crutch walking gaits

1. Two-point gait
2. Three point gait
3. Four point gait
4. Swing to gait
5. Swing through gait
6. Up and down stair gait

Two-point gait

Definition: Two-point gait is an assisted gait used for partial weight bearing on each leg which provides a strong base of support

Purpose

- ✓ To reduce anxiety and promote client's autonomy
- ✓ To improve muscle strength
- ✓ To help clients able to cope with disabilities
- ✓ To support patient during walking

Indication

- Weakness of the leg with partial ability to bear weight

Contraindication

- Patients unable to bear weight fully on each leg

Equipment

- Properly fitted crutches
- Regular, hard soled street shoes
- Gait /Safety belt, if needed

Procedure

1. Greet and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.
8. Instruct client on method to hold and walk with the crutches
 - o Move the left crutch and right leg forward 4 to 6 in then Move the right crutch and left leg forward 4 to 6 in.
9. Help the client practice the gait by repeating step 9 until the client independently practice it
10. Assess the client's progress, and correct any mistakes as they occur.
11. Observe the patient condition
12. Record the procedure

Three point gait

Definition: Assisted gait with weak/non weight bearing one leg supported with two Crutches

Purpose

- ✓ Reduces anxiety and promotes client's autonomy
- ✓ To assist weak or non weight bearing one leg
- ✓ Helps clients able to cope with disabilities

Indication

- Those patients having weakness in one leg or amputated one leg

Contraindication

- Patients having weakness in both legs

Equipment

- | | |
|-------------------------------------|-------------------------------|
| 1. Properly fitted crutches | 3. Safety belt, if needed |
| 2. Regular, hard soled street shoes | 4. Documentation chart/format |

Procedure

1. Greet and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.
8. Instruct client on method to hold the crutches to hold and walk with the crutches
 - o Advance both crutches and the weaker leg forward together 4 to 6 in then move the stronger leg forward, even with the crutches.

9. Help the client practice the gait by repeating step 8 until the client independently practice it
10. Assess the client's progress, and correct any mistakes as they occur.
11. Observe the patient condition
12. Record the procedure

Four point gait

Definition: Very stable but slow gait for weight bearing with both legs follows the pattern of right crutch forward, left foot forward, left crutch forward, then right foot forward

Purpose

- ✓ Reduces anxiety and promotes client's autonomy
- ✓ To improve muscle strength
- ✓ Helps clients able to cope with disabilities

Indication

- Weight bearing difficulties on both legs

Contraindication

- ❖ Patients unable to bear weight on both leg
- ❖ Bearing weight on axilla

Equipment needed

1. Properly fitted crutches
2. Regular, hard soled street shoes
3. Safety belt, if needed

Procedure

1. Great and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.
8. Instruct client on method to hold the crutches to hold and walk with the crutches
 - Position the crutches 4.5 to 6 in. to the side and in front of each foot then move the right crutch forward 4 to 6 in. and move the left foot forward, even with the left crutch.
 - Move the left crutch forward 4 to 6 in. and move the right foot forward, even with the right crutch.
9. Help the client practice the gait by repeating step 8 until the client independently practice it
10. Assess the client's progress, and correct any mistakes as they occur.
11. Observe the patient condition
12. Record the procedure

Swing to gait

Definition: Crutch walking gait in which both crutches move together then Lift body weight by the arms and swing to the crutches (at the level)

Purpose

- ❖ To relax and strengthen muscle
- ❖ To promote the client/autonomy
- ❖ To support the disability

Indication

- ❖ Weakness of both legs

Contraindication

- ❖ Improper body balance

Equipment

1. Properly fitted crutch
2. Regular, hard soled street shoes
3. Safety belt, if needed

Procedure

1. Great and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.
8. Instruct client on method to hold the crutches to hold and walk with the crutches
 - ❖ Move BOTH crutches together then Lift body weight by the arms and swing to the crutches (at the level)
9. Help the client practice the gait by repeating step 8 until the client independently practice it
10. Assess the client's progress, and correct any mistakes as they occur.
11. Observe the patient condition
12. Record the procedure

1.4.2.1. Swing through gait

Objectives: At the end of this lesson learner will be able to:

1. Define swing through gait
2. Identify the purpose of swing through gait
3. Indentify the indications and contraindications
4. Re -demonstrate Crutch walking using swing through gait appropriately

Definition: Crutch walking gait in which the pattern of crutches forward, then legs swing forward together through the crutch

Purpose

- To relax and strengthen muscle
- To promote the client/autonomy
- To support the disability
- To Speed up the walking

Indication

- ❖ Weakness of both legs

Contraindication

- ❖ Improper body balance

Equipment

1. Properly fitted crutch
2. Regular, hard soled street shoes
3. Safety belt, if needed

Procedure

1. Great and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.
8. Instruct client on method to hold the crutches to hold and walk with the crutches
 - o Move BOTH crutches together then Lift body weight by the arms and swing to the crutches **(beyond the level)**
9. Help the client practice the gait by repeating step 8 until the client independently practice it
10. Assess the client's progress, and correct any mistakes as they occur.
11. Observe the patient condition
12. Record the procedure

Up and down stair gait

Definition: Crutch walking gait helps to climb up and move down stair.

Purpose

- ❖ To promote clients level of activity in moving up and down stair
- ❖ Relax and strengthen muscle
- ❖ To promote the client/autonomy
- ❖ To support the disability

Indication

- ❖ Musculo-skeletal injury

Contraindication

- ❖ Improper body balance

Equipment

1. Properly fitted crutch
2. Regular, hard soled street shoes
3. Safety belt, if needed

Procedure

1. Great and explain the procedure.
2. Assess client for strength, mobility, range of motion, visual acuity, perceptual difficulties, and balance
3. Adjust crutches to fit the client.
4. Lower the height of the bed.
5. Dangle the client at the side of bed for several minutes.
6. Apply the gait belt around the client's waist if balance and stability are impaired.
7. Assist the client to a standing position with crutches. Support as needed.

8. Instruct client on method to hold the crutches to hold and walk with the crutches

Up stair

- a) Place unaffected leg on the stair
- b) Client transfer body weight to unaffected leg
- c) Client moves crutches and affected leg to stair

Down stair

- a) Start with weight on uninjured leg and crutches on the same level.
 - b) Put crutches on the first step
 - c) Put weight on the crutch handles and transfers unaffected extremity to the step where crutches are placed
9. Help the client practice the gait by repeating step 8 until the client independently practice it
 10. Assess the client's progress, and correct any mistakes as they occur.
 11. Observe the patient condition
 12. Record the procedure

Bed bath

Definition: Is a bath given to a patient who is unable to give care for him/her self.

Purposes

- To promote comfort relaxation and cleanliness
- To stimulate circulation
- To prevent bad body odors
- To prevent pressure sores
- To relax and refresh the patient
- Maintain muscle tone & joint mobility
- To improve self image
- To give an opportunity for the nurse to assess patients
- To prevent multiplication of pathogenic micro organisms on the skin surface.

Indication:

- Patients who are weak
- seriously ill and for pt that has certain heart conditions
- unconscious, paralyzed or confused patient

Precautions

- Avoid scratching the skin with jeweler or long sharp fingernails.
- Avoid harsh scrubbing, use of rough towel or wash clothes.
- Assess the status & level of mobility.
- Maintain adequate privacy and warmth throughout the procedure and drape appropriately.
- Identify if there are limitation of movements or position for pt.
- Bath water must be warm enough and change throughout the procedure when it becomes cool, too soapy, dirty or after washing the genital area
- Always wash from clean to dirty.
- Determine allergies to soap and other cream lotion.
- Clean the eyes with water from the inner to the outer cantus.

Equipment

- Washcloth (2)
- Washbasin (2)
- Bath towels (2)
- Basin and jug with warm water
- Pajama
- Oil, cream, lotion/powder
- Soap with soap dish
- Nail cutter
- Bath blanket
- Trays for nail care or mouth care if necessary
- Bed making materials
- air freshener
- Face towel
- Lotion thermometer
- Bed pan or urinal
- Comb and brush
- Gloves disposable
- Screen
- Deodorant
- Humber for soiled cloths
- Trolley

Procedure

1. Assess the patient condition and Explain procedure to pt.
2. Wash your hands
3. Assemble the necessary equipment for bed bath.
4. Before starting bath, offer bedpan or urinal, remove bedpan or urinal; find out what linen is needed.
5. If the patient is in the ward, screen patient and remove unnecessary articles from bed side table, place linen on chair in order of use and bring bath basin with hot water. and adjust the bed at the level of you to prevent back strain
6. Remove top bedding, fold and place over back of chair. If there is no chair, it should be placed on foot of bed. Cover the patient with bath blanket. Have patient move to near side of bed and remove gown. Remove pillow unless this is uncomfortable for patient.
7. Use pillow for turning patient if necessary; otherwise, remove soiled pillowcase; place soiled gown in it and place it on chair or foot of bed between matters and foot of bed.
8. Wash eyes with clean water only and face of patient before the other parts of the body.
9. Do not expose patient unnecessary.
10. Work quickly and smoothly. Watch for signs of fatigue during bath; report and chart any reddened spots, rash, sores or swelling. Change water as often as necessary. Never use dirty or soapy water.
11. Remember to protect the bed from dampness by placing bath towel each part of body during bath.
12. Place one hand under each part to support it while washing and drying the extremities.
13. Using long, firm, even strokes, wash from wrist to shoulder. Place basin on towel on side of bed and allow patient to put hands in water. Wash, take basin away, dry thoroughly.
14. Bath chest, dry and cover with towel, then bath abdomen.
15. Flex knee on far side, uncover leg and thigh and drape to protect bed. Wash and dry leg. Do the same for the other leg.
16. Get clean, warm water and turn patient on side. Spread towel close to body, wash back

and hips well. Rinse and dry carefully.

17. Rub back with alcohol and talcum powder or soapy water using whole flat of hand and long smooth strokes. Use a circular movement around the reddened areas or over bony prominences. If soap is used, clean it off after the rub.
18. Place towel under hips. Put basin and soap within easy reach of the patient. Give him the washcloth if he is able to wash the genital area so that he may finish his bath. If the patient is unable to do so, the nurse should finish the bath by cleaning the genital area of the patient by wearing the glove.
19. Put on clean gown protect the pillow or bed with face towel and comb patient's hair. Cut and clean finger nails and toe nails.
20. Make the bed and leave patient comfortable.
21. Wash bedside table and take dirty linen, bath basins, soap and alcohol to utility room. Wash basin well, dry and return to cupboard. Return other equipment to proper place.
22. Before you leave patient, ask patient if there is anything else you may do for him within reach and chart procedure, time and observation.

Giving tub bath

Definition: Type of bath that allow direct washing and rinsing by using shower

Shower: - The pt is assisted to the bathroom, sits or stands and spray of water is usually directed on to the body.

Purpose

- To promote comfort relaxation and cleanliness
- To stimulate circulation
- To prevent bad body odors
- To relax and refresh the patient
- Maintain muscle tone & joint mobility
- To prevent multiplication of pathogenic micro organisms on the skin surface.

Precautions

- o Adjust temperature and flow of the water
- o Avoid chilling
- o Always keep bath room un locked
- o Check pt frequently for sign of exhaustion.
- o Make sure that the tub shower clean and functioning
- o Place disposable rubber or plastic materials on the floor of the shower
- o Instruct patient not to use oil during bath
- o If sensation is normal, ask client to test water, and adjust temperature if water is too warm

Equipment

- | | |
|-----------------------|------------|
| a. Soap and soap dish | d. Gown |
| b. Washcloth | e. Sleeper |
| c. Bath towel | |

- | | |
|----------------------------|---------------------|
| f. Chair | 4. Bed pan/Urinal |
| 2. Comb & Brush | 5. Nail cutter |
| 3. Wheel chair (optional) | 6. Oil/cream/lotion |
| | 7. Pajama |

Procedure

2. Check the bath room temperature, which should be warmer than the normal room temperature
3. Make sure the tub is clean. Scour it carefully with disinfectant. Unless using a long-handled swab, wear glove when cleaning the tub.
4. Rinse the tub well
5. Place a chair near the tub, with a bath blanket opened over it
6. Place towels, washcloth and soap where the client can reach them easily
7. Fill the tub about halfway(less for a child)
8. Test the water with a bath thermometer. Water temperature should be warm to very warm, but never over 40.6°C (105°F).
9. Bringing the client to the bathroom and assist patient to undress
10. Assist patient into the tub and avoid falling.
11. Allow patient to bath himself or assist as necessary.
12. Assist patient out of tub and dry his body and put on gown.
13. Return patient to room and put to bed.
14. Clean bathtub and leave room in order.
15. Discard soiled linen.

Giving back care

Definition: Is purpose full manipulation (massage) of the muscle and tissues. It is also known as back message, back rub.

Purpose

- Provide psychological & physical comfort (reduce tension, anxiety stress, stimulate and relax muscles)
- Increase general and local circulation
- Improves muscle and skin functioning
- Prevent bed sore.
- To relieve insomnia(inability to sleep)
- It provides opportunity for the nurse to assess the patient condition.

Precautions

1. Massage pressure areas gently massage the back by using appropriate technique.-duration of massage should not exceed 20 minutes
2. Apply the all four patterns of stroke at least three times
 - **Pertissage (kneading):** press on muscle groups or single muscle, picking them up and squeezing them gently. Use the palms of the hand for the large muscle; use finger and thumbs for single muscle. Use this for outer aspect of back.

- **Effleurage (stroking):** massaging upward and down ward from vertebral column, and back again in the direction of heart.
 - **Friction:** rub around the bony prominence of the clients bony, such as at the end of the spine and along each shoulder blade.
 - Tapping (tapotement): use light tapping with the edge of the hands (the edge farthest from the thumb) at times to stimulate circulation.
- 3 Repeated back massage may possibly cause subcutaneous tissue degeneration.
 - 4 Frequent positioning is preferable to back massage
 - 5 Inspect skin areas of pressure points for whitened or reddened areas that do not disappear after rubbing.
 - 6 Covering areas not being massaged & prevent unnecessary exposure
 - 7 Lubricating palms to decreases friction on skin during massage.
 - 8 Identify location of bony prominences to avoid direct pressure

Equipment

- | | |
|-----------------------|--|
| 1. Soap and soap dish | 8. Screen |
| 2. Draw sheet | 9. Basin with water |
| 3. Wash cloth | |
| 4. Lotion | 10. Rubber sheet with its cover |
| 5. Bath towel | 11. Other medication as ordered |
| 6. Powder | 12. Air ring, cotton ring as necessary |
| 7. Alcohol | 13. Pillow |

Procedure

1. Assess and explain procedure to patient
2. Wash your hands
3. Assemble the equipment
4. Assist the client to assume either a prone, Sim's, supine, or sitting position, depending on client's condition
5. Place towel under patient's side
6. Wash with soap and water
7. Apply powder or lotion and rub back. pay special attention to bony Prominences
8. Choose stroke technique based on desired effects

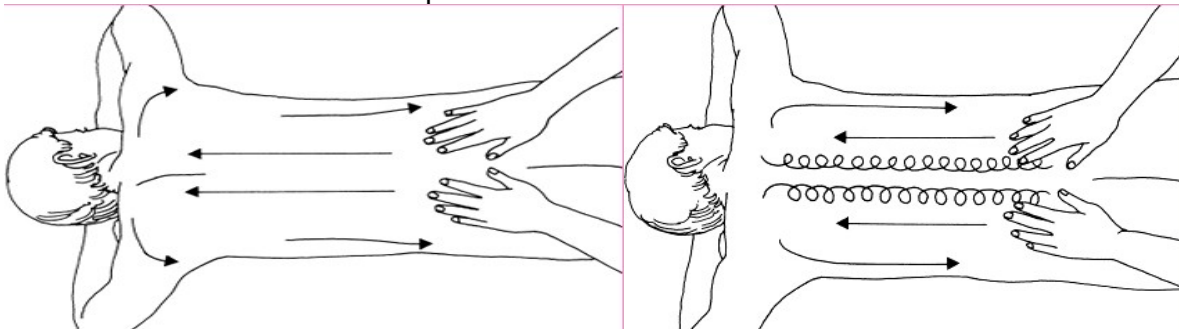


Figure 25: Effleurage (left) and Petrissage(right)

9. Circular movement should be used on bony prominences.
10. Begin with light to medium effleurage at lower back and continue upward

following muscle groups, being careful to avoid the spine and spinal processes.

11. Move hands up toward the base of the neck and continue outward over the trapezius muscles with circular motions, over and around shoulders and upper arms, and return with lighter downward strokes laterally over the latissimusdorsi to the upper gluteals
12. Use lotion to avoid friction and to give lubrication & prevent from dry.
13. Dry back and apply powder.
14. Turn patient on back and put pillow as necessary.
15. Report reddened area on the back.
16. If there is pressure sore (breakage of the skin) sterile dressing should be applied using whatever solution or ointment is ordered.
17. Clean and return the used equipments in to their proper place.
18. Wash your hands and charting.

Mouth care

Definition

- **Mouth care:** -Care of the mouth which includes brushing the teeth, mouth and tongue with mouth wash solution and rinse it with water
- **Routine mouth care:** -is providing oral care at least three times a day for hygienic purpose.
- **Special mouth care:** - Is a care given to entire mouth, teeth, tongue and gum in an increased frequency using mouthwash solution for helpless patient.

Purpose

- Keep the mouth clean and fresh, which provide the pt sense of well being.
- Stimulate appetite
- Prevent dental decays & halitosis (bad breath)
- Remove food particles, dead epithelial cells, microorganisms from around and b/n the teeth tongue & lips.
- Prevent inflammation of tongue gums & oral mucous.
- Prevent spread of infection to other parts of the body

Indications for special mouth care

- Is un conscious
- Is not taking oral food or fluid
- Has mouth infection or inflammation e.t.c.

Equipment

- **Solutions**
 - Sodium bicarbonate solution ½ Tsp in 250 ml, of water
 - Hydrogen per oxide solution
 - Glass of Clean water
 - Normal saline solution
 - Lemon juice
 - Other mouth wash solution if a specially ordered.
- Mouth gag
 - Emesis basin

- Glycerin/petrolatum
- Cotton tipped application
- Receiver
- Towel
- Tissue paper or piece of gauze
- Denture care cup
- Toothbrush and paste
- Forceps
- Sputum mug
- Tongue depressor wrapped with gauze bandage
- Lubricate (liquid paraffin or mineral oil, cold cream, glycerin , Vaseline)
- Drinking tube (straw)

Procedure

1. Explain procedure to the patient and wash your hands
2. Have all equipment read on the bed side table
3. Set on the semi sitting position and up the head of the bed
4. Place towel under patient's chin across his/her chest
5. Turn patient's head to the side and arrange basin at corner of the mouth.
6. Dip applicator in mouth washes solution and cleans the inside of the mouth, the tongue, and the teeth gently and carefully.
7. Discard the swab.
8. If the teeth are difficult to clean, a larger swab can be used. This is done by Wrapping several turns of cotton around a tongue depressor.
9. If the tongue or lips are dry and cracked, moisten an applicator with lubricant and gently wipe them with mineral oil, liquid paraffin, Vaseline or any suitable cream. A mixture of lemon and glycerin is also good.
10. If he/she is unconscious, hold the mouth open with a tongue depressor padded with gauze.
11. This care should be done in the morning, at night and after each meal if possible.
12. Wait at least ten minutes after patient has eaten to prevent nausea. Do not go far back on the patient's tongue as it may gag him.
13. Chart – procedure, time and observation.

Care of dentures

Definition:-it is a care for artificial teeth.

Purpose

- To Freshens mouth and facilitates intake of solid food.
- To remove microorganisms

Equipment:

- Denture brush
- Denture cleaner
- Emesis basin
- Towel
- Cup of water
- Non sterile gloves
- Denture cup
- Tissue paper

Procedures

1. Assemble articles for denture cleaning.
2. Provide privacy.

3. Assist client to a high-Fowler's position.
4. Wash hands and don gloves.
5. Assist client with denture removal:

Top denture:

- With tissue, grasp the denture with thumb and forefinger and pull downward.
- Place in denture cup.

Bottom denture:

- Place thumbs on the gums and release the denture. Grasp denture with thumb and forefingers and pull upward.
- Place in denture cup

6. Apply toothpaste to brush and brush dentures either with cool water in the emesis basin or under running water in the sink.
7. Rinse thoroughly.
8. Assist client with rinsing mouth and replacing dentures.
9. Reposition client, with side rails up and call button within reach
10. Rinse, dry, and return articles to proper place

Giving bedpan and urinals

Definition: -Giving bedpan and urinals is the process of giving bedpan or urinal for pts in bed.

Purpose

- To provide receptacle for elimination of waste material for clients confined to bed.
- To obtain specimen of urine or stool for laboratory examination.
- To obtain an accurate measurement or assessment of the client's urine or stool.

Indication

- Bed ridden patients
- Patient with problem of the spine
- Patient with cast or fracture
- For critically ill patients
- Post operative patients

Type of bed pans

- **Regular bed pans**-made of metal or hard plastic ,has a curved smooth upper end and tapered lower end
- **A fractured pan**- designed for clients with body or legs casts or clients restricted from raising their hips



Figure 26: Type of urinals: Males, Females

Time

- Early morning, after each meal and at bed time-PRN (when required).
- For maternity patients four hourly during

the day.

- For patients with diarrhea or dysentery-PRN (when ever necessary).
- In case of frequency of urine-PRN.

Equipment

1. Bedpan or urinal and cover
2. Toilet paper(toilet tissue)
3. Disposable gloves
4. Specimen container as necessary
5. Basin in which soap and water, may or may not be necessary
6. Air fresher (optional)

Procedure

1. explain the procedure
2. wash hand
3. assemble equipment
4. keep privacy
5. Obtain a bedpan, if one is not available in the bed side cabinet
6. Put on glove
7. Raise the bed to a comfortable height. Lower the near side rail
8. Fold the bed linen away from the client, exposing as little of his or her body as possible.
9. Place an incontinence pad on the bed if the client is confused or if using a fracture pan
10. Warm and dry the outer of the bedpan and carry to bed side and place in on a chair
11. Assist the client on to pan. If the client is able to help, encourage him/her to flex the knee and lift the hips:
 - ➔ Place the bedpan under the buttocks, with the round curved end toward the clients back and the narrower opened end toward the feet.
 - ➔ Turn back covers at the side. Place free hand under patient's buttocks and have him flex knees and help in lifting his body. With the other hand adjust bedpan under him.
 - ➔ If the patient unable to use regular bed pan use a fracture bedpan. Place it under the buttocks with the flat end toward the client's back.
12. If the client is immobile, roll the client onto his or her side away from you. Position the bedpan against the client's buttocks, hold it firmly in place and turn the client onto his or her back. Check the pans location
13. Replace the bed linen over the client
14. Elevate the head of the bed to semi-fowler's position if the client can tolerate it. Raise the side rail again.
15. Place the call light and toilet tissue within the client's reach and leave him or her alone if possible. Tell the client to call if he or she needs help and also when finished. If leaving the bedside, remove gloves and wash hands.
16. To remove the bedpan:
 - A. Wash hands and put on gloves
 - B. Lower the side rail and the head of the bed
 - C. Uncover the client

- D. Fold the toilet tissue and wipe from the front(pubic area) to the back (anus) if the clients is unable to do so independently
 - E. Steady the bedpan as the client either lift the hips or is assisted to turn away from you.
 - F. Place the bed pan on the chair cover it.
 - G. Cleanse the area with soap and water if necessary. Shaving-cream lather works well and is soothing. Dry carefully.
17. Offer hand washing supplies to the client
 18. Return the client to a comfortable position. Lower the bed and raise the side rail. Use air freshener if necessary.
 19. Empty the pan into the toilet and rise. Measure output or obtain stool sample if ordered .remove gloves and wash hands.
 20. Document results according to agency policy on flow sheet, intake and output summary or chart.

Perineal care

Definition

- **Perineal care:-**is a cleaning procedure prescribed for cleansing the perineum and genitalia of male or female patient. It can be clean or sterile procedure.
- **Routine Perineal care:** - Is done for hygienic purposes routinely twice a day and more frequently during menstruation and excess vaginal discharge.
- **Special Perineal care:** - Is a care given after various procedures for therapeutic and preventive purpose using strict aseptic technique.

Purpose

- To remove normal perinea secretions and odors
- To prevent infection
- To promote client comfort
- To facilitate healing
- To prevent irritation and ulceration of the genitalia.

Indication

- Infection on the genital and perineum
- Surgery of the genitalia and perineum
- Post delivery
- Incontinent patients
- pts with indwelling catheter
- Abnormal or un pleasant discharge from the genitalia.

Equipment

- | | |
|---|-------------------------|
| 1. Pitcher or container with warm water | 6. Sterile Perineal pad |
| 2. Prescribed solution | 7. Bowl or kidney basin |
| 3. Sterile forceps or glove | 8. Bed pan/urinals |
| 4. Protecting materials ,draw sheet | 9. Screen |
| 5. Gauze swabs | |

Procedure

1. Prepare tray or trolley with the above equipment, cover & take to patient's room.
2. Explain procedure to patient.
3. Assist patient to use bedpan.
4. Remove soiled pad and place in bowel or kidney basin.
5. Move tray or trolley near bed.
6. Fold the blanket to foot of the bed
7. Flex patient's knees and cover with top sheet.
8. Take the sterile cotton swabs with forceps, pour solution on the cotton and clean perineum using downward strokes. Use only one cotton swab for each strokes.
9. Repeat cleansing the perineum pouring the solution over the genitalia.
10. Avoid hurting the perineum with the forceps. Be careful with episiotomies stitches
11. Dry perineum and genitalia thoroughly using cotton swabs. If patient has episiotomy observed for any signs of infection – swelling, discharge etc. medicated powder or solution may be applied according to the orders.
12. Remove bedpan
13. Turn patient on one side and dry anal area.
14. Place perineal pad across perineum.
15. Avoid contaminating the inner side of pad
16. Apply T – Binder (as needed)
17. Straighten bed and leave patient comfortable
18. Remove soiled article, clean and return to their proper places. Perinea swabbing should be done at least three times daily and each time following bowl movement

Administering oral medication (Per Os) (Po)

Objective: - At the end of this lesson, the learner will be able to

1. Identify drugs given by mouth
2. Identify the 8 rights of medication administration
3. List indications and contraindications of oral route administration
4. Collect necessary equipment's needed for oral administration
5. Provide oral drug to the patient

Definition is an administration of medication through the mouth and ensuring that patient swallows the medicine.

Purpose

- To provide local effects
- To prolong systemic action
- To prevent the disease
- To give palliative treatment
- To give symptomatic treatment

Contraindication

- Vomiting.
- Patient with gastric or intestinal suction.
- Patient who are unable to swallow.
- Patient on NPO.
- Unconscious patient.

Equipment

A trolley containing

1. A bowl of water for used medication cup.
2. Towel
3. Measuring spoon.
4. A jug of water (bed side water).
5. Mortar and pestle to crush and powder the tablet if necessary
6. Kidney dish and paper bag to discard the waste
7. Chart and medication card.
8. Ordered medication.
9. Straw if necessary.
10. Glass

Producer

1. Explain the procedure to the patient
2. Wash hands
3. Prepare your tray and take it to the patients room
4. Begin by checking the order.(Read the label 3 times)
5. If the patient is allowed to sit assist him to sit
6. Place solution and tablets in a separate container
7. If suspension, shake the bottle well before pouring.
8. Take it to the patient's bed side.
9. Keep the medication insight at all times.
10. Identify the patient carefully using all precautions (patient's name, bed number...).
11. First give little water to moisten the mouth and then give the medicine one at a time.
12. Remain with the patient until each medicine is swallowed.
13. Offer additional fluid as necessary unless contra-indicated.
14. Remove the towel and wipe the face with it
15. Position the patient for good body alignment
16. Take all articles to the utility room. /wash dry all articles and put them in their proper place.
17. Wash hands
18. Recode the medication given, reaction observed, refused or omitted immediately

Administering sublingual medication

Definition: - Is a medication that is placed under the tongue and allowed to dissolve completely

Purpose

- To provide local effects
- To prolong systemic action
- To prevent the disease
- To give palliative treatment
- To give symptomatic treatment

Indication

- Patient with gastric and intestinal problems
- Patients with gastric and intestinal surgery

Contraindication

- Patients with nausea and vomiting
- Oral surgery
- Patients with
- Unconscious patient.
- Patients with gastric and intestinal suctioning

Precaution

- Tell the patient not to drink liquid and smoke for an hour because some tablets take up to an hour to dissolve.
- Tell the patient to keep the medication in place until it dissolves completely to insure absorption
- Tell the patient to avoid chewing the tablet or touching the tablet with the tongue to prevent accidental swallowing.
- When the client is receiving repeated doses of a buccal medication, the nurse should indicate the site, such as right buccal cavity, to prevent irritation of the same site.

Equipments

A trolley containing

1. A bowl of water for used medication cup.
2. Towel
3. Kidney dish and paper bag to discard the waste
4. Chart and medication card.
5. Ordered medication.

Procedure

1. Explain the procedure to the patient and assess the client's knowledge of the drug and its action
2. Wash hands
3. Prepare your tray and take it to the patients room
4. Begin by checking the order.(Read the label 3 times)
5. If the patient is allowed to sit assist him to sit
6. Take it to the patient's bed side.
7. Keep the medication insight at all times.
8. Identify the patient carefully using all precautions (patient's name, bed number...).
9. Don non-sterile gloves.
10. To give a drug sublingually, ask the client to open the mouth and lift the tongue; place the drug under the client's tongue.
11. To give a drug buccally, instruct the client to open the mouth wide, and place the tablet between the client's cheek and teeth.
12. Remove the towel and wipe the face with it if necessary
13. Position the patient for good body alignment
14. Take all articles to the utility room. /wash dry all articles and put them in their proper place.
15. Wash hands
16. Recode the medication given, reaction observed, refused or omitted immediately

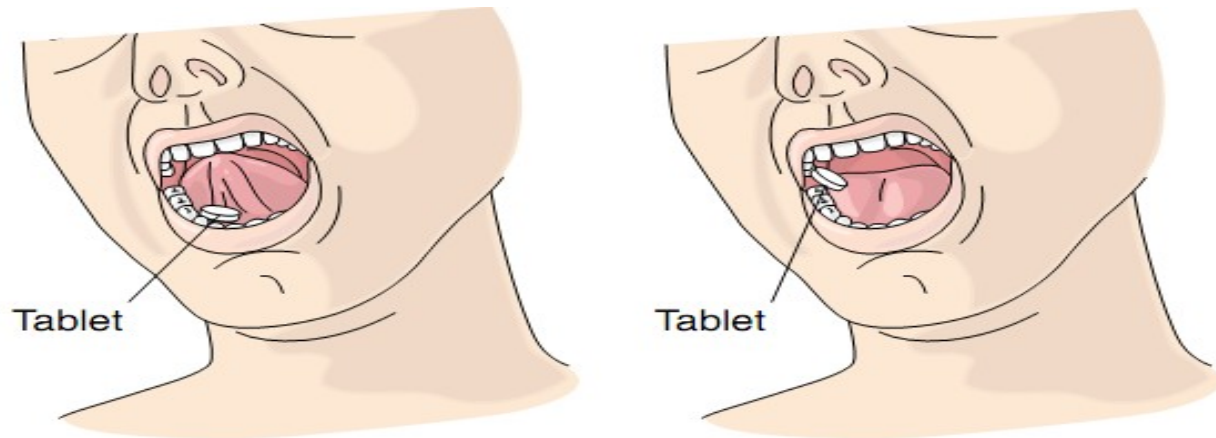


Figure 29: Sublingual and buccal areas for medication administration.
Instillation of nasal drops

Definition: installation of medication in to the nose in the form of nasal drop

Purpose

- To relive nasal congestion
- To treat pain and inflammation of the nasal cavity
- To prevent and control bleeding

Precaution

- Avoid touching the tip of the nose with dropper since it may contaminate
- Avoid touching the inner surface of the nose with dropper since it cause the patient to sneeze
- Do not use oily solutions as nasal drops since it interferes with the normal ciliary's action
- Do not use decongestants excessively or frequently as they became ineffective and may actually worsen the patients nasal congestion

Equipment

Small tray containing

- Medication with rubber tipped dropper
- Cotton balls / handkerchief
- Receiver
- Cotton tipped applicator

Procedure

1. Explain the procedure to the patient and assess the client's knowledge of the drug and its action
2. Wash hands
3. Prepare the equipments
4. Begin by checking the order.(Read the label 3 times)
5. Position the pt with the head tilted back ward

6. Clean the nostrils with cotton applicator
7. Apply prescribed amount of medication directly in to the nostrils.
8. Keep patient's head tilted back for a few minutes/five minutes to ensure that the drops run in to the back of the nose and to allow the medicine to act on mucus membrane and avoid blowing the nose.
9. Clean and return used equipments to its proper place
10. Make the patient to the comfortable position
11. Wash your hands very carefully and chart procedure and observations

Administering rectal medications

Rectal suppository – a conical mass to be introduced in to the rectum usually containing medication (easily melted at body temperature).

Purpose:

- To produce laxative effect (bowel movement).
- To produce local sedative in the treatment of hemorrhoids or rectal abscess.
- To produce general sedative effects when medications cannot be taken by mouth.
- To stop rectal bleeding and to relieve pain and soothe tissue irritated by diarrhea.

Equipment –

1. Suppository (as ordered)
2. Water soluble lubricant/k-y jelly
3. Gauze square
4. Glove or finger cot
5. Toilet paper
6. Receiver for soiled swabs
7. Bed pan, if the Rx is in order to produce defecation
8. Screen
9. Mackintosh and towel

Procedure

1. Explain the procedure to the patient and assess the client's knowledge of the drug and its action
2. Wash hands
3. Prepare the equipments
4. Begin by checking the order.(Read the label 3 times)
5. Screen the patient and put on gloves
6. Assist the client to the sim's position or the left lateral position with the upper leg flexed
7. Fold back the bed linen to expose the rectum
8. Apply small amount of lubricant to the smooth rounded end of the suppository to reduce mucosal irritation. Lubricate the gloved index finger
9. Instruct the client to breathe through the mouth.
10. Insert the suppository in to the client's anal canal at least 4 inches (10 cm) for an adult and 5cm (2 inches)for a child. This position ensures placement of the suppository above the client's internal sphincter and maximizes medication absorption (lubrication makes the insertion easier)

11. Ask the client to maintain the position for 15-20 minutes to resist urge to defecate and maintaining the position allows time for the medication to melt.
12. Press the folded tissue against anus for a few minutes until the pt's urge to expel the suppository has passed.
13. Clean the anus with a toilet paper
14. Dispose of gloves and wash hands
15. Document the time, type, or given medication. Indicate the strength or dosage of the drug

Follow up phase

Check on the client 20-30 minutes and document client's response or result of the Rx and the reaction of the pt to the Rx.

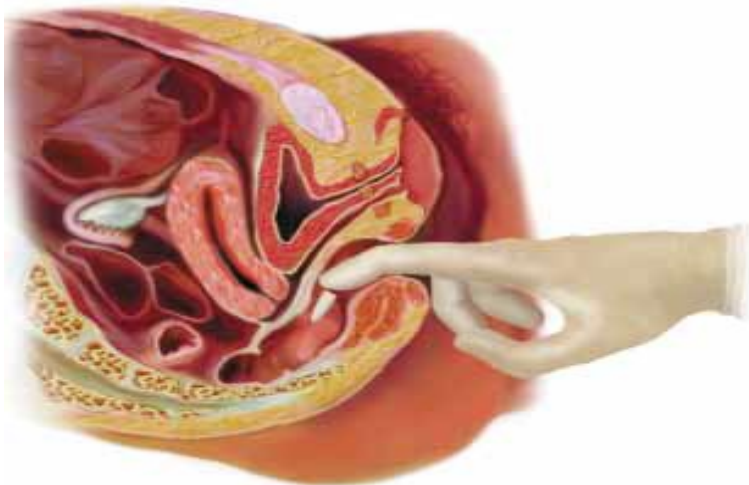


Figure 30: Administering a Rectal Suppository
Administering Vaginal Medications

Definition: is an insertion of suppositories into the vagina canal

Purpose

- To treat or prevent infection
- To remove an offensive or irritating discharge
- To reduce inflammation
- To relieve vaginal discomfort

Equipment

1. Medication administration record (MAR)
2. Non-sterile gloves
3. Prescribed vaginal suppository
4. Water-soluble lubricant/k-y jelly
5. Disposable applicator
6. Tissue

WOUND CARE

Definitions: Wound is a disruption in the integrity of body tissue which may be intentional or unintentional

Wound dressing

Definitions:Dressing: Any of various materials used for covering and protecting a wound

Wound dressing is process of covering wound or applying sterile protective covering using aseptic technique

Types of wound dressing

1. Clean wound dressing
2. Septic wound dressing
3. Wound dressing with drainage tube

Purpose of wound dressing

- | | |
|---|---|
| ❖ To Keep the wound moist and therefore enhance epithelialization | ❖ Maintain a moist wound environment |
| ❖ To Keep the wound clean | ❖ Protect wound from further injury |
| ❖ To keep locally applied drugs in position | ❖ Protect skin surrounding wound |
| ❖ To keep edges of the wound together by immobilization | ❖ To protect the wound from mechanical injury. |
| ❖ To relief pain and comfort the patient | ❖ To protect the wound from microbial contamination. |
| ❖ Provide physical, psychological, and aesthetic comfort | ❖ To absorb drainage |
| ❖ Remove necrotic tissue | ❖ To prevent hemorrhage. |
| ❖ Prevent, eliminate, or control infection | ❖ To splint or immobilize the wound site and there by facilitate healing and prevent injury |

General Precautions in wound dressing

1. Wash hands thoroughly before, after and between several dressings.
2. Dressing should be done after the wards have been cleaned
3. Clean wounds should be dressed before wounds with drainage.
4. Never do a dressing when the air is dusty from sweeping, bed making or in dust.
5. Wear gloves when touching blood, body fluids, mucous membrane and handling soiled items with blood or body fluids.
6. Do talk , cough and sneeze over wound
7. Wear mask and protective eye wear as necessary
8. Practice strict aseptic techniques to reduce transmission of micro organism
9. Soaked wound with frequent drainage should be changed frequently.
10. Clean wound from the cleanest area to the less clean area
11. Separate instruments should be used for each dressing.
12. Keep forceps lower than the handles at all times
13. Saline should be used to remove adherent dressings.
14. Medicines are given and applied if necessary.
15. Be economical on using gauze , sponges' applicators, adhesive or medication.
16. Adhesive marks on skin can be removed with solvent such as ether alcohol or benzene.

Dressing clean wound

Definition:

- ❖ Clean wound dressing is aseptic technique of covering clean wound after cleaning

Purpose

- To keep wound clean
- To prevent the wound from injury & contamination
- To keep in position drugs applied locally
- To keep edges of the wound together by immobilization
- To enhance wound healing
- To relief pain and comfort the patient
- To apply pressure

Equipment:-

Sterile dressing set

1. One kidney dish
2. Sterile gloves
3. Cotton balls in a galipot
4. Sterile gauze (4×4 inch) or squares
5. Sterile Dressing forceps (3)
6. Sterile Scissor
7. Sterile galipot
8. Sterile fenestrated towel (drape)
9. Spatula if ointment

Clean try

1. Clean glove
2. Cleaning solution (Normal Saline, Sterile 0.9% sodium chloride), chlorhexidine, povidone-iodine, and hydrogen peroxide
3. Adhesive tape (Plaster)
4. Bath Blanket: (if needed)
5. Rubber and draw sheet
6. Bandage scissors or surgical blade
7. Anti microbial Ointment: if prescribed
8. Bath Blanket: (if needed)
9. Screen
10. Adhesive remover
11. Protective apron: as the condition of the wound
12. Waste Receiver(disposable plastic container)
13. Chart

Procedure

1. Check order for dressing change
2. Explain the procedure to the patient
3. Hand washing
4. Assemble the supplies at a convenient work area
5. Apply screen, close door and curtain.
6. Assist the patient to a comfortable position to expose the wound.
7. Place a rubber sheet under the patient to prevent soiling the linen.
8. Place opened, cuffed plastic bag near working area.
9. Loosen tape on dressing. Use adhesive remover if necessarily. If tape is soiled don gloves
10. Wear a protective apron when caring for a patient with a draining wound. Don non sterile gloves.
11. Gently remove and discard the old tape and soiled dressing in a plastic trash bag.
 - Roll or lift an edge of the dressing, then gently remove it while supporting the surrounding skin. When possible, remove the dressing in the direction of hair growth.
 - If the dressing sticks to the wound, moisten with sterile normal saline and then remove.

- Sterile saline provides for easier removal of dressing. Assess amount, type and odor of draining if present
12. Remove and discard non sterile gloves.
 13. Using aseptic technique open the packed sterile instruments, sterile dressings, the irrigation and cleaning solution, and the instrument set to provide a sterile field,
 14. Pour cleaning solution to galipot, gauze and cotton from a drum.
 15. Don sterile gloves
 16. Gently remove and discard the old tape and soiled dressing in a plastic trash bag. Roll or lift an edge of the dressing, then gently remove it while supporting the surrounding skin. When possible, remove the dressing in the direction of hair growth. If the dressing sticks to the wound, moisten with sterile normal saline and then remove. Sterile saline provides for easier removal of dressing. Assess amount, type and odor of draining if present
 17. Remove and discard the soiled gloves.
 18. Using aseptic technique open the packed sterile instruments, sterile dressings, the irrigation and cleaning solution, and the instrument set to provide a sterile field, Pour cleaning solution to galipot, gauze and cotton from a drum.
 19. Don sterile gloves.
 20. Apply fenestrated towel to the wound to increase the sterile field
 21. If sample is needed, take the sample first then clean.
 22. Take the second sterile forceps, and clean wound with cotton balls soaked in antiseptic solution starting from inside to the outside.
 23. Use one gauze square for each wipe, discard each square by dropping in to plastic bag, do not touch bag with forceps.
 24. Again use the second forceps to dry wound using gauze sponge and same motion by another new forceps then discard.
 25. Apply medication if any and dress the wound with sterile gauze with sterile another dressing forceps
 - o Ointment and paste must be smeared with spatula on gauze and then applied on the wound.
 - o Solutions or powder can be applied direct on the wound.
 26. Make sure that the wound is properly covered
 27. Fix dressing in place using adhesive tape or bandage.
 28. Remove fenestrated towel, rubber and draw sheet.
 29. Remove gloves from inside out, and discard them in plastic waste bag.
 30. Provide patient comfort measures.
 31. Clean and return equipment to proper place.
 32. Wash your hands
 33. Document the procedure

Dressing septic wound

Definition: Dressing septic wound is method of covering infected wound that generally contain purulent material (pus) draining from the wound site .

Purposes:-

- Absorb materials being discharged from the wound.
- Apply pressure to the area.
- Apply local medication.
- Prevent pain, swelling & injury.

Percussions

- ✓ If sterile forceps are not available use sterile gloves.
- ✓ Immerse used forceps, scissors and other instrument in strong antiseptic solution before cleansing and discard soiled dressing properly.
- ✓ In a big ward it is best to give priorities to clean wounds and then to septic wounds when changing dressings as this might lessen the risk of cross infection.
- ✓ Wounds should not be too tightly packed in effort to absorb discharge as this may delay healing.

Equipment

Sterile Dressing set

- | | |
|--|--|
| 1. Sterile galipot | 5. Sterile cotton tipped application |
| 2. Sterile kidney dish | 6. Sterile pair of gloves if needed in case of gas gangrene rabies etc |
| 3. Sterile gauze | |
| 4. Sterile forceps (3) Sterile test tube or slide if necessary | |

Clean try

- | | |
|--|---|
| 1. Clean glove | 8. Rubber and cotton draw sheet /Mackintosh with its cover |
| 2. Surgical glove | 9. Spatula if ointment |
| 3. Cleaning solution (normal saline, H ₂ O ₂) | 10. Receiver with strong disinfectant to immerse used instrument |
| 4. Ordered medication | 11. Probe and director if required |
| 5. Plaster | 12. Benzene or ether |
| 6. Bandage scissors or surgical blade | 13. Bandage or adhesive tape and Bucket to put in soiled dressing |
| 7. Bucket to put in soiled dressing/water proof disposable bag | |

Procedure

1. Check order for changing dressings/dressing
2. Great the patient and explain procedure to the patient.
3. Wash your hands
4. Clean trolley or tray, assemble sterile equipment on one side & clean items on the other side and make sure that the sterile equipments are properly covered.
5. Put on single use examination glove
6. Apply screen (close door and curtain), drape, & put patient in comfortable position
7. Place rubber sheet and its cover under the patient to prevent soiling the linen.
8. Place a clean towel or draw sheet underneath the working area to minimize contamination.
9. First remove the outer layer of the dressing.
10. Remove the outer layer of dressing and dispose with glove
11. Wear sterile gloves
12. Use forceps to remove the inner layer of the dressing smoothly & discard forceps
13. Observe wound and check if there is drainage rubber or tube.
14. Take specimen for culture or slide if ordered (do not cleanse wound with antiseptic before you obtain the specimen).
15. Take the sterile cleaning forceps
16. Start cleaning wound from the cleanest part of the wound to the most contaminated part using antiseptic solution (Hydrogen per oxide 3% is commonly used for septic wound).

17. Debride dead tissue as needed
18. Discard cotton ball used for cleaning after each stroke over the wound.
19. Cleanse the skin around the wound to remove the plaster gum with benzene
20. Use gauze for drying the skin around properly.
21. Use third forceps for dressing the wound
22. Dress the wound and make sure that the wound is covered completely.
23. Make sure that the wound is properly covered
24. Fix dressing in place with adhesive tape or bandages.
25. Remove gloves from inside out, and discard them in plastic waste bag.
26. Leave patient comfortable and tidy.
27. Clean and return equipment to proper place.
28. Wash your hands
29. Document the procedure
30. Send the specimen to laboratory

Suturing

Definitions

- **Suturing** is the technique of uniting parts of the body by stitching them together.
- **Sutures** are threads used to sew body tissue together which can be **absorbable** (**Chromic Cat gut**) and **non absorbable** (silk, cotton, linen, clips and wire nylon).

Purpose

- ❖ To approximate wound edges until healing occurs.
- ❖ To speed up healing of wound.
- ❖ To minimize the chance of infection
- ❖ For aesthetic purpose

Indication

- Open intentional and unintentional wound

Contraindication

- | | |
|-------------------------------|--|
| 1. Edema of the wound margins | 5. Tendon, nerve, or vessel involvement |
| 2. Infection | |
| 3. Puncture wounds | 6. Wound more than 12 hours old (body) and 24 hrs (face) |
| 4. Animal bites | |

Precautions

1. Check that the patient gets TAT before he leaves the hospital.
2. Do not suture puncture (deep) wound.
3. Before you suture any wounds make sure it is free of any foreign body.
4. The completed knot must be tight, firm, and tied
5. To avoid wicking of bacteria, knot should not be placed in incision lines
6. Knots should be small and the ends cut short (2-3mm)
7. Avoid excessive tension to finer gauge materials as breakage may occur
8. Avoid using a jerking motion, which may break the suture
9. Do not tie suture too tightly as tissue ischemia may occur.

Equipments

Sterile field set

1. Tray or trolley covered with a sterile towel
2. Sterile needle holder

3. Sterile suture scissors
4. Sterile round needle (2)
5. Sterile cutting needle (2)
6. Sterile hole towel (fenestrated towel)
7. Sterile kidney dish(2)
8. Sterile needle and syringe
9. Sterile gloves
10. Sterile tissue forceps(2)
11. Sterile cotton swabs in gallipots
12. Sterile gauze
13. Sterile artery forceps(3)
14. Sterile needle holder (2)

Clean tray

1. Silk and catgut
2. Antiseptic solution with its container
3. Adhesive plaster
4. Local anesthesia
5. Light bulb

Procedure

1. Check the order for suturing
2. Greet the patient, introduce yourself and explain the purpose of the procedure to the patient.
3. Wash your hands
4. Clean trolley or tray, assemble sterile equipment on one side & clean items on the other side and make sure that the sterile equipments are properly covered.
5. Adjust light
6. Put on sterile gloves.
7. Clean the wound thoroughly.
8. Drape the wound with the hold sheet
9. Infiltrate the edge of the wound to be sutured with local anesthesia.
10. Approximate the edge of fascia with the help of the tissue forceps and using the round needle and catgut.
11. Suture the facial layer first followed by muscles. Suture the facial layer and muscle with chromic catgut and.
12. Using cutting needle and silk suture the outer layer of skin approximating the edges with the help of the tissue forceps
13. Clean wound area with iodine
14. Dress the wound with sterile gauze.
15. Remove the whole sheet.
16. Make the patient comfortable.
17. Remove all equipment wash and return to its proper place or send for sterilization.
18. Wash your hands
19. Record the state of the wound.

Feeding a helpless patient(NGT feeding)

Definition: Feeding a helpless patient is providing nutritional intake for a pt that is unable to feed him/her self.

Purpose

- To assist the patient to eat meal
- To meet the nutritional need
- To promote healthy
- To prevent dehydration
- To improve appetite

Indication

- General weakness or critically ill patient
- Paralysis or limitation of movement E.g. Presence of arm splints casts and traction.
- Small children.

Feeding the Helpless Patient General Instruction

- Check the diet ordered
- Make surrounding neat and clean.
- Prepare pt and over – bed table
- Hot food should be served hot and cold food cold.
- The tray should be complete, clean and neat. The food, no matter how simple, should be attractive and appetizing.

Precaution

- Control odors noise and unpleasant sights at meal equipment.
- Remove solid equipments& linens

Patient - Provide oral hygiene

- Hand washing
- Position comfortable preferable sitting up position

Meal tray: - Ensure correct tray for correct pt

- Arrange tray on table to be accessible to pt
- Adjust the bed table at appropriate height
- Assist in removing cover, cutting and preparing food.
- Present the food in attractive manner
- The meal should be placed near the pt where it can be seen & smelt to help in stimulating appetite.

Equipment

- 1.Extra – pillow, if not a patch bedNap kin
- 2.Food on a clean tray
- 3.Towel
- 4.Glass of water
- 5.Meal tray
- 6.Drinking tube or feeding cup
- 7.Over bed table
- 8.Oral hygiene equipment
- 9.Feeding spoon

Gastric lavage(Eg. If the pt's drinking poisionig)

Definition: Gastric lavage is the introduction of solution into the stomach and removing gastric contents through nasogastric tube for washing out the stomach.

Purpose

- ❖ To remove inserted poison, other than corrosive substances like ammonia and mineral substances.
- ❖ To introduce ice water or normal saline solution in tackling bleeding.
- ❖ To cleanse the stomach before operation.
- ❖ For diagnostic purposes.
- ❖ To relief congestion, nausea and vomiting .

Indication

- ❖ Pyloric stenosis
- ❖ Poisoning
- ❖ Preoperative care

Equipments

1. Equipments for NG tube insertion
2. Measuring jug

3. 2-3 liters prescribed solution.
4. IV stand
5. Tap water or ice if ordered
6. 50ml syringe
7. Funnel
8. Gloves
9. Rubber and cotton sheet
10. Towel
11. Litmus paper
12. Suction machine (optional)
13. Labelled specimen container
14. Laboratory request form
15. Charcoal tablets (universal antidote)
16. Emesis basin
17. Tissue paper
18. Drainage container
19. Vital sign instruments
20. Chart

Procedure

1. Explain the procedure to the patient
2. Wash your hand
3. Assemble the necessary equipments.
4. Keep patient privacy and position the patient
 - Position in left lateral position for conscious patient but **if unconscious**, place in prone position with head over the edge of the bed or head lower than the body (**semi prone position**)
5. Protect client and bed linen with towel and rubber sheet
6. Done single use examination glove
7. Select the appropriate distances mark on the tube by measuring the distance on the tube from the client's bridge of the nose to ear lobe plus the distance from ear lobe to the bottom of the xiphistemu(xyphoid process).
8. Lubricate the tube.
9. Gently insert and pass the tube, the tongue, the mouth forward the posterior pharynx (If the client is unconscious, mouth gag may be used)
 - If air bubbles, cough and cyanosis are noticed withdraw the tube and recommence the procedure.
10. Advance the tube slowly to prevent injury until the pre measured mark,
11. Assess the correct placement by aspirating stomach contents, or by listening gosh of air while the client exhales.
12. After the NG tube is in place, allow the stomach contents to empty in to the drainage container before instilling any irrigating solutions. This confirms proper placement of the tube and decreases the risk of over filling of the stomach and inducing of vomiting.
13. Once you confirm proper placement of the tube, begin gastric lavage by instilling about 250ml of irrigating solution to assess the patient's tolerance and prevent vomiting.
 - **If you are using simple rubber tube for the lavage**

- a. Fill the small jug with water/ solution, measure and pour gently until the funnel is empty, then invert over the pail (the funnel is connected with the funnel end of the oesophageal tube)
- b. Take specimen, if required, and continue the process until the returned fluid becomes clear and the prescribed solution had been used.
- **If you are using a tube with a bulb**
 - a) Clamp the tube below the bulb,
 - b) With right hand, squeeze the bulb thus forcing the air out through the funnel.
 - c) With left hand, pinch tubing above the bulb/proximal to you/ and at the same time with right hand, release the clamp. This creates a suction which will draw the stomach contents into the bulb.
 - d) Lower funnel and allow excess gastric contents to drain into the pail.
 - e) Pour 200-300 cc of solution/water into funnel. Before funnel is empty allow solution to drain.
 - f) Before a solution stops running. Turn up funnel and add another quantity of solution
 - g) Repeat this procedure until returns are clean.
14. Instruct the client to take deep breath and hold it to close epiglottis
15. Monitor patient's vital signs, urine output, and level of consciousness every 15 minutes and notify the physician for any changes.
16. Give mouth wash
17. If ordered, gently remove the tube, feel the client's tube, and watch the respiration
18. Remove glove, hand wash, Clean or discard used equipments.
19. Comfort the patient
20. Record the procedure, including the time, date, type of irrigating solution and the amount of gastric contents drained.

Cardiopulmonary resuscitation (CPR)

Definition

Cardio-Pulmonary Resuscitation is an emergency procedure consisting of external cardiac massage and artificial respiration

Purpose

- To squeeze blood manually out of the heart for victim's with cardiac arrest
- To provide oxygenated blood to the brain and heart
- To restore blood circulation

Indications

- Respiratory Arrest: - Respiratory arrest refers to the absence of breathing.
- Cardiac Arrest: When the heart stops, there is no pulse.

Precaution

- The CPR Must begins within 4-6 minutes of collapse if not; the brain is sensitive to hypoxia and will sustain irreversible damage after 4-6 minutes of no oxygen.
- The cause of cardiac arrest is important **BUT** do not delay CPR to obtain history

Relative Contraindications

- Ribs fractured
- Burn of sternum(full thickness)

Equipments

- No special equipments are needed at emergency situation- just hands and mouth & step by step procedure.
- At hospital level (Ambu bag , firm board, stethoscope , spatula , air way

Adult CPR procedure

1. Check the Scene or Assessment of the Situation (Always Present if it is out of Health Centers)

- Make sure it is safe for you to help.
- Don't become another victim and assess the environment to know the cause of the problem

2. Check the Victim or Assessment of unresponsiveness

- Tap or gently shake the victim and shout “Are you ok”.
- To elicit a response a painful stimulus can be applied such as:
 - Pinching the earlobe,
 - Pressing over the eyelid and observing for grimacing.
 - Other associations recommend rubbing on the sternum using the knuckles of the fingers.

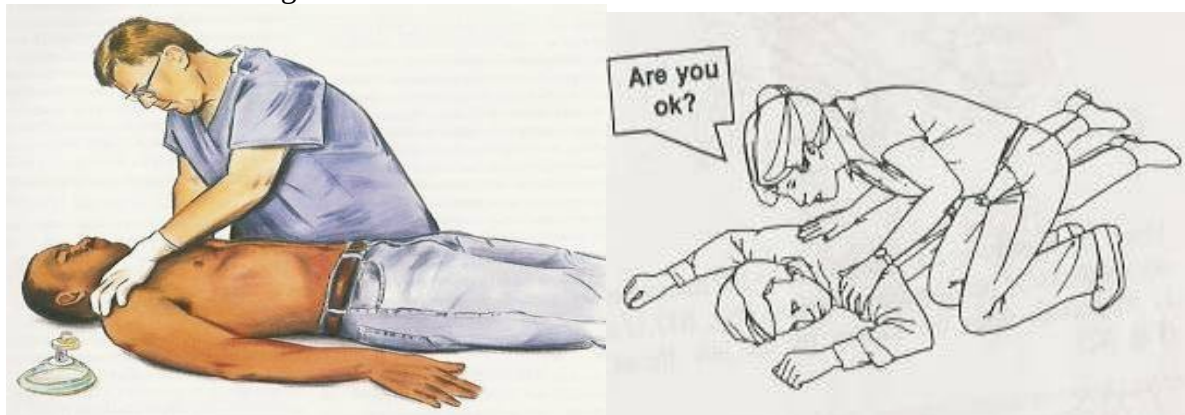


Figure 45: Checking client responsiveness in CPR

3. Call for Help or Activate EMS

- Rescuer who is alone should alter sequence of rescue based on most likely cause.
- Sudden witnessed collapse (likely VF) arrest activates EMS (Emergency medical service), do CPR.
- Hypoxic arrest (i.e., suffocation give 5 cycles of CPR (about 2 minutes) before alerting EMS. If there is no response, **Call ******* and return to the victim. In most locations the emergency dispatcher can assist you with CPR instructions



Figure 46: Calling 911

4. Positioning the victim

- Place the victim first on His/ Her back on hard surface. If the victim is lying face down, turn or roll the victim as unit, supporting the head and neck

5. Airway

- Open the airway by the head tilt / chin lift maneuver for all victims and Remove **foreign body**. We might also assess the breathing status of the victim
- Health care personnel use:
 - Head tilt- chin lift
 - Jaw thrust in trauma patient



Figure 47: Positioning the client for giving rescue breathing

6. Breathing

- Assessment of breathlessness and carotid pulse (5-10 seconds)

- Place your ear just one inch above the mouth and the nose of the victim and perform the following simultaneously: Use **LLF** methods
 - o **LOOK**: for the chest to rise and fall
 - o **LISTEN**: for air escaping during exhalation, and
 - o **FEEL**: for the flow of air on your cheek

NB: Count the number 1001,1002,1003,1004,1005,1006,1007,1008,1009,1010 to be sure you are checking for 10 seconds because 1001 represents 1 second, and 1002 represents 2, and continue others like this.

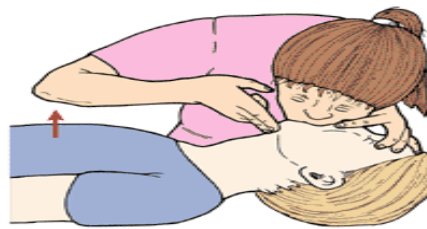


Figure 48: Listening (left) and giving resc

- **Simultaneously assess the presence of pulses**
 - o Assessment of pulselessness (5-10 secs.): check pulse at carotid artery which is the most common and most reliable.
 - o While maintaining the head tilt with one hand, locate the victim's Adams apple (thyroid cartilage) with two or three fingers of the other hand. Slide your fingers into the groove between the Adam's apple and the muscle on the side nearest you where the carotid pulse can be felt.

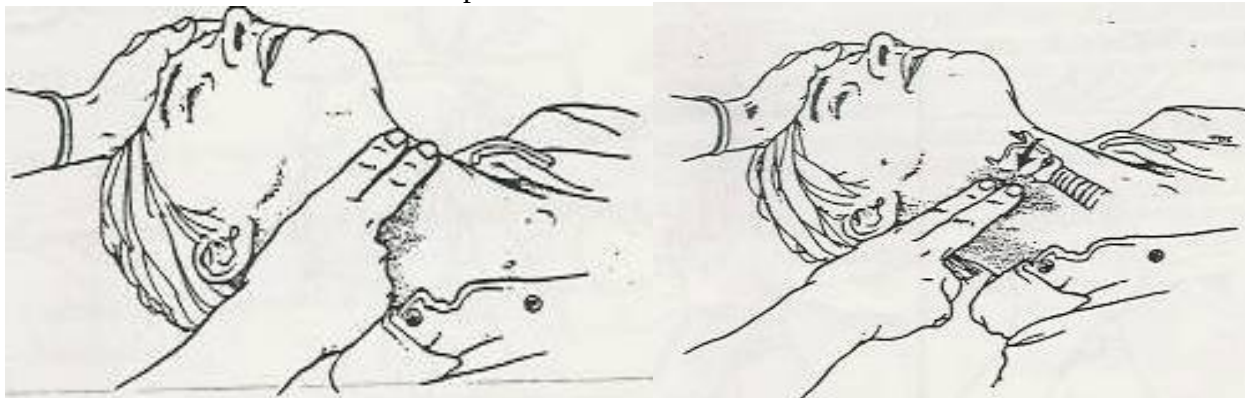


Figure 49: checking returning of pulse in CPR

- If breathing is not present, begin rescue breathing by giving **two** slow breaths: pinch nose and cover the mouth with yours and blow until you see the chest rise. Give 2 breaths.
- **Time:**
- Each breath should take 1.5 sec to 2 sec and watch for chest rise and allow time for exhalation (3-3.5 sec).
- **Volume:**

- o Sufficient volume
- o No large volume or forceful breathing.

7. Circulation

- If pulse is not definitely felt within 10 seconds, proceed with chest compression
- Provides 30% (or less) of normal circulation

To locate the landmark for external chest compression

- The technique of costal margin that is as follows:
A. Run your index and middle fingers up the lower margin of the rib cage and locate the sternal notch with your middle finger. The index finger is place next to the middle finger on the lower end of the sternum.

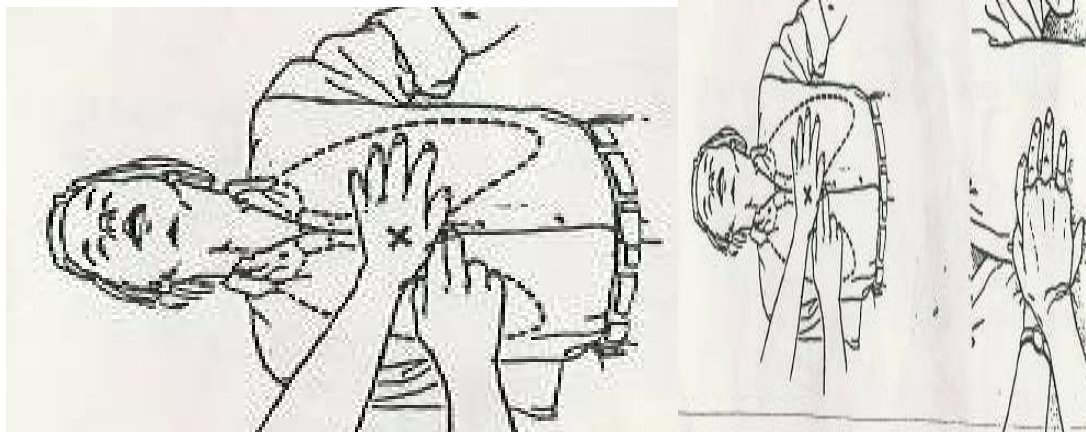


Figure 50: Selecting proper site for chest compress in CPR

- B. The heel of the other hand (the one nearest the victim's head) is placed on the lower half of the sternum, and the other hand is placed on the top of the hand on the sternum so that the hands are parallel.
- C. Your fingers may be either extended or interlaced but must be kept off the chest.

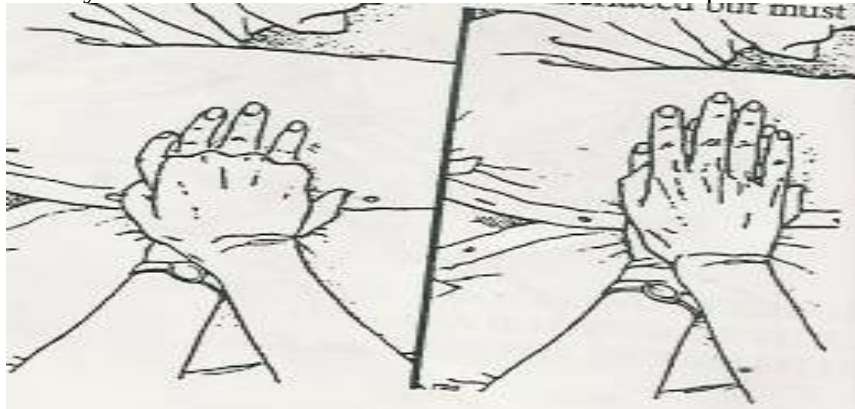


Figure 51: Selecting proper site for chest compress in CPR

- D. Lock your elbows into position, the arms are straightened and shoulders directly over the victim's sternum. Keep the heel of your hand lightly in contact with the chest during the relaxation phase of chest compression to maintain correct hand position.
- Push hard- push fast: equal compression and relaxation allowing recoil of chest wall.
- Chest compression – ventilation **30: 2**, for 5 cycles (2 minutes rate of 100 per minute.
- Depth of 1.5 to 2 inches for adults

- Count compression in English in the sequence of:
 - o 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20, and 1,2,3,4,5,6,7,8,9,1= **for 1st cycle**
 - o 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20, and 1,2,3,4,5,6,7,8,9,2= **for 2nd cycle**
 - o 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20, and 1,2,3,4,5,6,7,8,9,3= **for 3rd cycle**
 - o 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20, and 1,2,3,4,5,6,7,8,9,4= **for 4th cycle**
 - o 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20, and 1,2,3,4,5,6,7,8,9,5= **for 5th cycle**

8. Reassessment

- After 5 cycles of compressions and 6 cycle of ventilations (30:2), check for return of carotid pulse/ and spontaneous breathing
- According to the findings (after 2 minutes):
 - o There is pulse – place in the recovery position, monitor vital signs until EMS arrives.
 - o There is pulse but no breathing: continue rescue breathing every 5- 6 seconds (10-12 breaths). Recheck pulse every 2 minutes.
 - o No pulse or breathing continues CPR 30:2. Until provider arrives

Repeat A – B- C to 5 cycle of compression and 6 cycles of breathing. (150:12)

When to Stop CPR

1. if another trained person takes over CPR for you
2. if more advanced medical personnel take over
3. if you are exhausted and unable to continue
4. if the scene becomes unsafe
5. if the victim's heart starts beating

Procedure

1. Make patient comfortable. Elevate head and shoulder if permissible.
2. Protect patient's gown and bed with a towel.
3. Arrange tray conventionally. Place tray where it can be reached easily.
4. Feed patient as indicated.