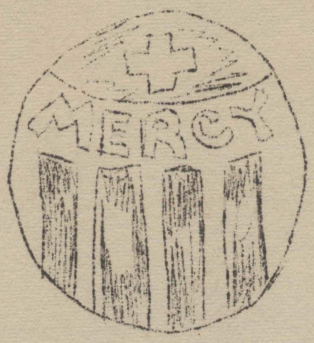
# MERCY HOSPITAL
# PROCEDURE MANUAL




NURSES' PLEDGE

I pledge myself to a life of personal purity and womanly dignity and to the maintenance of the high standards of my profession.

I pledge unswerving loyalty to the best traditions of my Alma Mater, Mercy Hospital School of Nursing, and I promise never to take or administer hramful drugs or to become a guilty party to any criminal attempt upon human life.

I pledge perfect fidelity and conscientous obedience to the directions and instructions of the physician or surgeon under whom I am serving, and I will devote myself conscientiously, painstakingly, and wholeheartedly to the care of the patients whose very lives are committed to my care

I pledge myself to keep sacred and inviolable whatever matters of an intimate nature may come to my knowledge where I am called to serve.

## Objectives in Pursuing the Profession of Nursing

It is one of man's highest privileges to administer to the needs of his fellow men. When we render help and solace to those who bear the burden of pain and sorrow, we not only benefit the immediate recipients of our solicitude, but we also enrich our own lives and furnish others with an inspiration to deeds of kindness and generosity. For this reason the profession of nursing is justly held in high esteem.

Those who embrace the profession of nursing should be actuated by lofty ideals. It would be unsuitable for anyone to be come a nurse for merely mercenary motives. Nursing calls for true sympathy for those in suffering, willingness to serve without thought of momentary consideration, interest in the mental and spiritual welfare of the sick as well as in their bodily health. These qualifications in addition to strictly technical ability must be found in those women who would adequately and successfully pursue the profession of nursing.

## Nursing Technique

Is the skilled handling of the patient with the least discomfort, the skillful handling of sterile apparatus without contamination, and the elimination of unnecessary movements so as to insure the maximum speed compatible with the highest efficiency.

## Objectives of the Course

1. To give a clear understanding of the fundamental principles which underlie all good nursing, to develop habits of observation, system, economy, manual dexterity and to establish a uniform and fine technique in nursing.
2. To create an interest in the whole patient, body, mind and soul, promoting his spiritual, mental and physical health by teaching and by example, stressing health education and health prevention.
3. To develop a love for nursing, a pride in good workmanship, and a keen interest in the human side of the nurse's work, as well as the scientific and practical side.
4. To prepare the students to meet the problems that will confront them in their daily work in the hospital.

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# Chapter I

## Admission of Patients

Purpose:

1. To admit patient to hospital with tact, sympathy and understanding and in this way contribute to the patients confidence in the hospital and nursing staff.
2. To show consideration to relatives and friends who may accompany the patient; so they may leave him reassured and satisfied that he is in capable hands.
3. To begin as soon as possible the efficient carrying out of doctor's orders regarding the treatment, tests, etc.

Procedure:

1. See that the room and bed are in readiness.
2. Greet the patient with courtesy and kindness by introducing yourself, calling him by name, and trying to put him at ease.
3. Provide the patient with gown and privacy, and instruct him to arrange his personal belongings and prepare for bed. Offer assistance as indicated. If patient is helpless and fully clothed, cover bedding with a bath blanket. Cover the patient as soon as he is placed on the bed and remove his clothing. In accident cases it may be necessary to cut some of the clothing. This should be done as close to the seam as possible Remove clothing from the affected side last.
4. By careful observation and tactful conversation, obtain helpful information regarding symptoms and complaints.
5. Add water to the themometer container, and take temperature, pulse, respiration and blood pressure.
6. Demonstrate the use of the signal light, and inform patient of hospital regulations and the routine of the ward.
7. The care of the patient's clothing is important. Valuables and money must be sent home or placed in hospital safe. The hospital is not responsible for the money or valuables left in the patient's room.
8. The nurse in charge will notify the doctor of the patient's admission having available information regarding the patient's room number, objective and subjective symptoms. Obtain the tentative diagnosis and orders.
9. Proceed with treatment ordered. Explain each procedure to the patient thus gaining his confidence and cooperation.
10. Admission urine specimen is sent to the laboratory in the morning unless ordered otherwise.

Admission Cont'

Procedure:

11. Send requisitions to special departments as soon as ordered.
12. Place a pitcher of fresh drinking water within easy reach of the patient, and urge him to drink freely unless contraindicated.
13. Do not give an admission bath unless indicated.
14. Assemble the chart and make admission notes.
15. Record patient's admission, time and manner, general condition, complaints, observations, temperature, pulse, respiration, blood pressure and signature of nurse.

## Discharge of Patient

1. Make sure the Doctor has ordered the patient's dismissal.
2. As soon as the order is writter, take dismissal slip to the office, and notify the relatives to call for the patient before 1:00 p.m. if possible.
3. Return all unused drugs and dressings to proper department for credit.
4. Assist the departing patient by having in readiness medicines and other supplies that he is to take home, giving him necessary instruction regarding their use, helping him pack and making sure he has all his belongings.
5. Accompany patient to business office and see that proper provision is made for his departure, treating the patient as a departing guest.
6. Complete the record; time and manner of departure, condition upon dismissal, signature of nurse. Chart is kept on ward and will be picked up by record room clerk.
7. If patient insists on leaving the hospital without being dismissed by the doctor, insist he sign his own release, thereby freeing the doctor and hospital of further responsibility. In order to validate the release, it should bear the signature of one or two witnesses.

## Transfer of Patient

Purpose:

To move patient from one unit to another to provide more complete nursing care in special cases.

Procedure:

1. Obtain permission from doctor and room clerk before transferring patient.

Transfer cont'

Procedure:

2. Notify supervisor or Head Nurse of the department to which patient is being transferred.
3. Transfer patient ambulatory, or via wheel chair or cart, as indicated.
4. Collect and transfer all of the patient belongings including dressings and medications.
5. Have chart up to date, remove from chart back and send with patient.
6. Acquaint the nurse in charge with patient and provide information pertinent to his nursing care.

# Chapter II

## Maintainence of A Wholesale Environment

### Care and Hygiene of the Ward

Purpose:

1. To provide the patient with a wholesome and healthful environment.
2. To promote economical use of hospital plans and equipment.
3. To provide working conditions conducive to efficiency.

A. Room or Ward Order

1. Adjust window shades to uniform height.
2. Keep beds and stands in alignment and away from the walls.
3. Keep bedside tables free of unnecessary articles.
4. Leave no soiled article on window sill, radiators or floor.
5. Remove all unnecessary articles or waste material.
6. Keep other furniture in a practical and attractive position.
7. Use lights as necessary for good lighting.

B. Room or Ward Hygiene

1. Keep room or ward well ventilated without allowing patient to be in a draft.
2. Keep temperature at constant comfortable level, and if regulation of humidity is possible use proper measures.
3. Whenever possible remove cause of unpleasant odors, airing room, thoroughly, using armospheric deodorant if necessary.
4. Prevent unnecessary noise, that is loud talking and laughing.
5. Report defective equipment.

### Cleaning a unit after the discharge of a patient

Purpose:

1. To promote cleanliness and prevent disease.
2. To learn the importance of hygienic housekeeping in the care of the sick.
3. To prepare a room for the new patient.

Requisites:

1. Basin with warm water

Environment cont'

Cleaning unit after discharge

Requisites:

2. Basin with small amount of Formalin 2%
3. Whisk broom
4. Yellow soap
5. Newspapers
6. Cleaning cloths

Procedure:

1. Carry necessary articles to bedside.
2. Strip and air the bed in the following manner: Place a chair at the foot or side of the bed as convenient. Remove the pillows and take off the cases. Place pillows on the seat of chair. Loosen clothes all around the bed by starting at the center of the head of the bed and raising the mattress with one hand and drawing out the clothes with the other. Place blankets to be aired on the back of the chair. The rubber sheet is hung over the foot of the bed. Remove all linen and place in linenchute.
3. Immerse the bedpan, urinal, washbasin, and emesis basin denture cup in a soap solution while bed and room are being cleaned.
4. Remove, clean, and return to its assigned place, all articles not belonging in room.
5. Wash bedside chair with a damp cloth and dry it. Clean pillows by brushing with a whisk broom wet in a 2% formalin solution.
6. Place rubber dray sheet over mattress and wash exposed surface with yellow soap, rinse and dry. Brush ticking on rubber draw sheet with 2% formalin. Place soiled side folded in over chair.
7. Brush upper side of mattress, being sure to get into all the crevices.
8. Place mattress crosswise on foot of bed and clean upper half bed and springs, then turn mattress over, clean side down on clean half of springs.
9. Wash remainder of spring and bed and brush the other side of mattress with formalin solution.
10. Place the rubber draw sheet, clean side down next to mattress, wash, rinse, and dry.
11. Let the bed and mattress air and dry while you are washing bedside utensils and cleaning the bedside table, dresser, etc.
12. Take drinking water articles to kitchen and clean thoroughly.
13. Wash and dry mirror, window sills, doorknobs, closet shelves and dresser drawers. Place clean newspapers in drawers and on shelves.
14. Be certain that entire equipment is in room and in working order.
15. If any equipment is missing or needs repairing,

Environment cont'

Cleaning unit after discharge

Procedure:

report at once to your supervisor. Ask the supervisor what to do with wool blankets that need washing or mending.

16. Be sure the signal light is in working condition.
17. If the room is not to be cleaned as soon as patient is dismissed, prepare the room by stripping the bed, opening drawers and windows so that it can air until such time as it will be cleaned. If at all possible, the bed should air several hours.
18. Make bed according to instructions for an unoccupied bed.

Care and Arrangement of Flowers

A. Importance of flowers to the patient

The nurse is to apt to consider that actual physical aid is all that is necessary to a patient. There are, however, values that may not be measured in terms of physical service. Mental and spiritual needs of the patient are as important as the physical needs in many instances. Flowers represent thoughtfulness and unselfishness on the part of someone, and they help the patient to feel that there are those who are interested and who hope for and expect a speedy recovery.

Remember then, such messages of hope, thoughtfulness and love, may be as much physical aid as medicine. In many instances, someone has paid for the flowers consigned to your care, who has made a sacrifice in order to cheer and comfort the patient. It is your duty to see that the sacrifice has not been in vain.

B. Reception and care of Flowers.

1. If possible, take the package of flowers to the patient's room before opening them and unwrap them in the presence of the patient. Unless instructed otherwise, keep the card with the bouquet.
2. Try to have the color of the vase harmonize with the flowers. The vases or bowls should be deep and roomy: the water should cover the stems a little more than half their length.
3. To avoid a stiff effect, the stems may be cut at unequal lengths, and assorted colors arranged harmoniously.
4. Water should be changed everyday. Cut stems slantwise under water as this keeps air from

Environment cont'

B. Reception and care of Flowers

entering the stem.

5. A little salt sprinkled in the water will help freshen wilted flowers. Sprinkling cool water over the bouquet will revive them.
6. Keep all flowers and plants away from drafts and radiators.
7. Special care is given to potted plants depending upon the species of the plant. Generally, potted plants should be watered daily, pouring the water at the rim of the pot or in the container which holds the pot. Do not pour water on the foliage.
8. Potted plants should be set on plates because moisture will ruin the furniture.
9. Do not discard flowers unless the patient is willing that you should do so.
10. Flowers may be taken from the sick room at night as some persons find the odor of flowers disagreeable.
11. When caring for flowers, lay them on a newspaper in the utility room. Wash the vase, wash flowers' stems, trim, and rearrange in a vase.
12. Leave the utility room in order after arranging flowers.
13. Flower arrangement lose their pleasing effect when crowded in the patient's room; therefore the nurse may tactfully suggest that some other useful gift be sent.

# Cleaning and Caring for Hospital Equipment

## A. Enamelware

General Instructions:

1. Train yourself to handle such articles gently as this will avoid unnecessary noise and damage to the article.
2. Do not place enamel ware directly over a gas flame.
3. Clean enamel with scouring powders that do not scratch.
4. Turpentine, which will usually be found in the medicine closet, will remove obstinate spots and itself be washed off with plenty of soap and hot water.
5. Do not allow enamel ware to accumulate in the utility room.
6. Be sure enamel is clean when returned to proper place.
7. Enamelware should not be dipped into hot water suddenly, nor cooled suddenly, the metal expands more than the glass surface and cracking and chipping occur.
8. Enamelware should be washed first in cold water to remove albuminous material, then with hot water and soap.
9. Enamel ware which is heavily chipped should not be used because of the danger to the patient and transferring of infections.
10. Strong acids and alkalies ruin enamel ware and stain less steel, therefore, do not use them.

### I. Bedpans

1. Add cold water to the contents of the pan and empty. (Cold water added first helps keep down offensive odors, and does not coagulate the albumin. Hot water added first coagulate albumin and combined with the grease clings to the sides of the pan, making it harder to clean the pan.
   If soiled, wash with brush and disinfectant provided.
2. Rinse with warm water. Dry and carry back to room.
3. After the dismissal of the patient, scrub the pan with soap and water and sterilize.

### II. Urinals

1. Rinse in cold water.
2. Use brush to clean inside, rinse after cleaning, dry the outside and return to room.
3. Clean with soap and water and sterilize after the dismissal of the patient

Equipment cont:

III. Face Basins and Foot Tubs

1. After use, wash basin well removing all deposit from the sides.
2. Rinse with warm water, dry and place on shelf or return to the patient's room.
3. After patient leaves, clean as demonstrated in cleaning a unit.

IV. Emesis Basin

1. Rinse with cold water and then clean with warm water and soap.
2. Denture cups are rinsed and cleansed as other articles. Boil after dismissal of the patient.

B. Glass Utensils

I. Drinking glass, pitchers, and drinking tubes: Wash in detergent solution, rinse in clear hot water, dry and return to proper place.

II. Thermometers:

1. Wash thermometer and container in green soap and water.
2. Place thermometer in Zephrian Chloride Solution 1:1000 for 7 minutes.
3. Rinse well and place in clean container, return to room as part of unit equipment.

# Chapter III

## Personal Hygiene and Correlated Procedures

### Baths

Do not allow patient to take their own bath unless directed to do so by Dr. or head nurse.

Purpose:

1. To refresh the patient mentally and physically
2. To afford comfort
3. To cleanse and stimulate

A. Bed Bath

Requisites:

1. At bedside unit
   a) Bath blanket
   b) Wash basin and pitcher
   c) Soap in soap dish
   d) Emesis basin and mouth wash cup
   e) Lotion and powder
   f) Tooth brush and comb (patient's own property. May be obtained at pharmacy)
2. Articles to be brought in:
   a) Hot water
   b) Linen as needed: usually large sheet, draw sheet, pillow case, bathtowel, wash cloth, gown.
   C) Newspaper, for protection of bedside stand

Procedure:

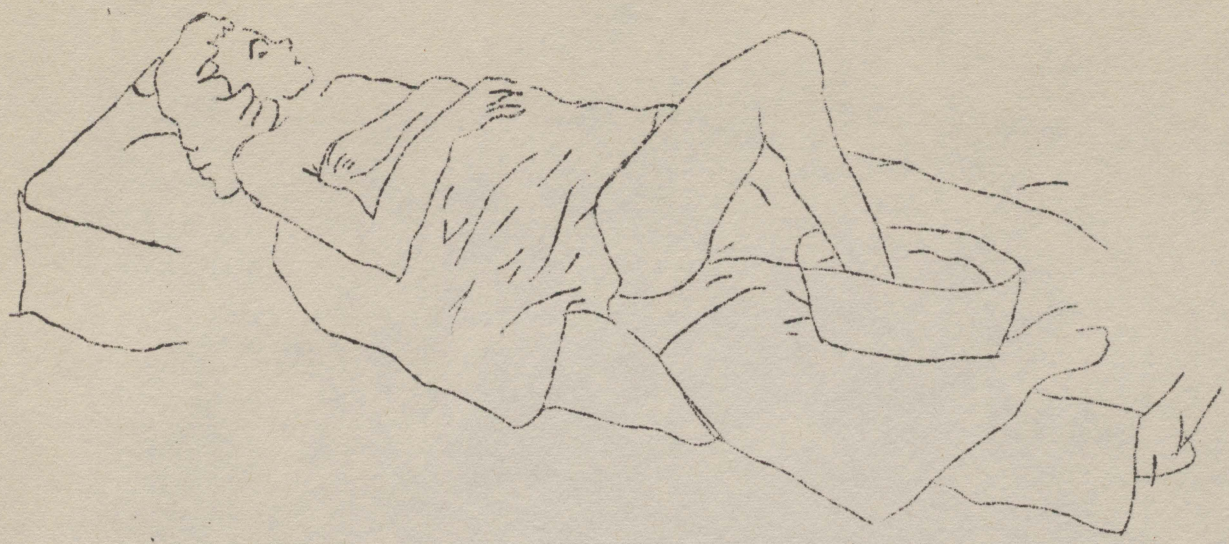
1. Approach the patient in a quiet, unassuming, seemingly unhurried manner, explaining the procedure, and inspiring in the patient confidence in the nurse and the hospital staff.
2. Prepare unit by:
   a) Providing adequate privacy
   b) Protecting from drafts and chilling
   c) Clearing the bedside table and removing all unnecessary articles from room.
3. Loosen top bedding all around the mattress. Fold the spread from top to bottom, then in half and hang over the back of a straight chair which has been conveniently placed at the foot of the bed. Fold blanket in similar manner and place on back of chair. Cover patient with bath blanket and remove the top sheet, fold and place on back of chair.

Personal Hygiene cont'

Bath

Procedure:

4. Offer bed pan to patient.
5. Give mouth care (If patient has brushed teeth in early A.M. care, this may be omitted.
6. Remove pillow and place on chair, unless the patient's comfort and condition necessitates having the pillow.
7. Remove all comfort appliances, that is , rubber ring, pillow, sandbags, cradles, etc.
8. Place bathing equipment on cleared bedside table. If painted or polished bedside tables, protect with newspaper.
9. Obtain water for bathing in pitcher provided (110-115) degrees.
10. Remove gown and binder. Place bath towel under patient's head to protect the under sheet.
11. Fold wash cloth firmly around the hand so that the ends do not dangle, wash face, neck, and ears, rinse and dry with face towel which has been placed over patient's chest. Some patient's prefer to wash their own face, no soap to be used, or neither soap or water to be used on their face.
12. Proceed in the following manner placing the bath towel lengthwise under extremities. Fold and drape bath blanket exposing only the area to be washed:
    a) Hand, arm, axilla furthest from you
    b) Hand, arm, axilla nearest to you
    c) Chest
    d) Abdomen
    e) Leg and thigh furthest from you
    f) Unless contraindicated foot is immersed in basin of water. (Place basin of water on the towel on bed. Wash, remove basin, and dry foot throughly especially between the toes)
    g) Leg and thigh nearest you
    h) Foot and ankle nearest you
    i) Genitalia..supply the necessary articles within the reach of the patient and leave the room while patient is finishing his bath. If patient is unable to perform this service, you will care for him as necessary. If an orderly is available, he may be called to care for the male patient.
    j) Change the water.
    k) Place patient in a lateral position. Spread bath towel on the bed lengthwise close to the patient's back back. Wash back, and buttocks, rinse and dry, rub with lotion and powder lightly.
13. Place upper arm in one sleeve of gown. Comb and brush the hair on this side.



Method of Proceeding with Bath Refer to p. 11 A - 12f.

Personal Hygiene cont'

Bath

Procedure:

14. Make the foundation bed changing the linen as follows:
    a) While patient is on side near the far edge of the bed, fan fold draw sheet close to the patient. Place rubber draw sheet over the patient's back while fan folding bottom sheet close to patient.
    b) Straighten out mattress pad and brush out crumbs. If mattress pad needs changing: fan fold to center of bed, and replace with clean mattress pad, fan folding surplus at center.
    c) Place clean sheet on mattress pad as for foundation bed, fan folding surplus to the center.
    d) Draw rubber sheet down over lower sheet. If necessary to raise rubber draw sheet, remove and replace or use a second rubber draw sheet.
    e) Place clean draw sheet on rubber sheet, fan folding surplus to center, straighten, and tuck the ends of both under the mattress. If binder is to be applied, fanfold the binder in such a way that the center of the binder will come to the center of the patient's back.
    f) Turn patient to opposite side allowing him to roll over the fanfolded linens.
    g) If patient was not turned sufficiently for complete back care, wash, dry, and powder back, shoulder, and hip.
    h) Loosen remainder of foundation bed, pull through clean and soiled linens so that the patient is not resting on the ridge.
    i) Tighten bottom sheet, rubber draw sheet, and draw sheet as for foundation bed. Pull binder into place and pin.
    j) Change pillow slip and replace pillow. Push mattress up to head of bed.
    k) Place upper arm in sleeve of gown.
    l) Complete combing and brushing hair.
    m) Place clean top sheet with unfinished side up and wide hem at top)over bath blanket and gently draw bath blanket from beneath it toward the foot of the bed, remove, and fold, and place in space provided.
    n) Replace blanket and spread and tuck in at foot of bed. Make toe pleats in sheet and blanket as necessary.
    o) Tuck spread under the blanket at the top and turn sheet back over blanket and spread, making a fold of approximately 9 inches.
    p) Clean bath equipment, remove linen and return to proper place.
    q) Replace bedside table. Get fresh drinking water and place within reach of patient.

## Prevention and Care of Pressure Sores (Decubitus)

Purpose:

1. To use all prophylactic measures possible to prevent the formation of ulcers.
2. To treat pressure areas so as to re-establish circulation and promote growth of new tissue.

Prevention:

1. Avoid pressure by:
   a) chinging position frequently
   b) cradles and Bradfor frames
   c) use of cotton rings and air cushions
   d) conditions which aggrevate: wrinkles in linen, crumbs, rough linen, mositure due to perspiration, urine, feces, drainage from surgical wounds, heat, friction, lack of cleanliness.
2. Stimulate the circulation through the parts:
   a) rub with circular motion towards the part
   b) when rubbing the back give special attention to areas at base of the spine, iliac crests, and shoulders.
   c) use of alcohol and powder
   d) exposure of part to electric light rays and warm air.
3. Absolute cleanliness:
   a) bathing after defecation and voiding
   b) washing or cleansing of area surrounding surgical wounds, from which there is drainage. Skin may be coated with vaseline.

Treatment (the best treatment is prevention)

1. Notify nurse in charge as soon as a break in the skin or other symptoms of a pressure sore are noticed.
2. Wash surrounding area thoroughly at least twice a day with warm water and soap. Cleanse area well and remove all sloughing material.
3. Consult the nurse in charge about the treatment, to be used when the doctor has not stated his preference. If the doctor orders "routine Decubitus care" one of the following may be used: Tincture of Benzoin, Balsam or Peru, Aristol Powder, etc.
4. With the use of pillows and air cushions, keep weight of patient of pressure areas until healed.
5. Use sterile dressing to cover area and absorb drainage if skin is broken. Do not allow dressing to become wrinkled. Change dressing often enough so that it does not become saturated. Do not use adhesive tape on skin.
6. Expose pressure areas to air and sunlight if possible.
7. Apply dry heat in the form of electric lights to promote healing if ordered by the doctor. If light bulbs are used provide protection for patient.
8. Avoid use of ointments and oils which tend to soften tissues.
9. Record: time, treatment, location, and observations. And signature of nurse.

Personal Hygiene cont'

Bath

Procedure:

r) Provide patient with personal articles desired, adjust signal light, care for flowers, and leave unit neat, clean, and attractive.

15. Record: Time, procedure, and observation of the patient.

B. Tub Bath

General Instructions:

1. Patients may take tub baths with the consent of the doctor or head nurse.
2. The amount of necessary assistance will depend on the condition of the patient.
3. Temperature of water should be 95-105 degrees. Temperature of room 70-78 degrees.
4. Do not permit patient to remain in the tub longer than 10 minutes without permission.
5. Impress upon the patient:
   a) The importance of leaving the door unlocked
   b) Of not turning on the hot water while in the tub.
   c) Of not touching any electric wires or fixtures
   d) Taking precautions against slipping
6. Remain within call to give assistance if needed.
7. Never permit patients who are weak, aged, mentally ill or a child to take a tub bath unassisted.
8. If the patient feels faint, drain out the water and do not try to move patient until revived.

Requisites

1. Bath thermometer
2. Bath blanket
3. Bath mat
4. Bath towel, face towel, wash cloth
5. Soap
6. Clean gown
7. Robe and slippers

Procedure:

1. Fill bath tub one half full at proper temperature.
2. Place chair at side of tub with bath blanket draped over it.
3. Place bath mat on floor.
4. Escort patient to bath room in robe and slippers.
5. Remove robe, gown, and slippers. Protect groin with towel to prevent exposure.
6. Assist patient into tub. A bath towel may be placed in the bottom of tub to prevent slipping.
7. Bathe in usual order, and observe any abnormalities.

Personal Hygiene cont'

Bath

Tub Bath

Procedure:

8. Allow patient to bathe public region.
9. Drain water out of tub.
10. Assist patient out of tub and seat in chair which has been draped with bath blanket.
11. Dry patient thoroughly using a bath blanket to prevent unnecessary exposure.
12. Put on gown, robe, and slippers.
13. Excort patient back to bed using a wheel chair if necessary.
14. Clean tub thoroughly and care for equipment leaving room in order.
15. Record: time, procedure, observation of patient and signature.

C.Partial Bath

When the bed bath is contraindicated because of the condition of the patient, or insufficient number of personnel, a partial bath is given. It includes Meticulous oval hygiene, combing the hair and bathing face, axillae, arms hands, neck and genitalia.

Beds

A. Making a Closed Bed

Purpoae:

1. To provide a comfortable bed for the patient
2. To develop skill in handling the bed linens
3. To insure economy of material, time, and energy of the nurse

Requisites:

1. Mattress pad
2. Two large sheets
3. One rubber draw sheet
4. One Draw sheet
5. Two Pillow cases
6. One Bed spread
7. One Blanket

Procedure:

1. Arrange the linen on a clean chair in order it is to be used.
2. Adjust the mattress and put mattress pad in place.
3. Place bottom sheet on bed straight with the center of the crease at center of the bed, wide hem at

Personal Hygiene cont'

Beds

Procedure:

4. Miter the corner as follows:
   a) Grasp the sheet so that it is in a straight line with the upper edge of the mattress.
   b) Raise this fold until the edge of the sheet forms a right angle to the top of the mattress.
   c) Tuck in the slack with the other hand.
   d) Bring diagnal fold down and then tuck the edge of the sheet under the mattress (this forms a diagonal corner)
   e) Tuck the remainder of the sheet in at the foot of the bed.
5. Arrange rubber draw sheet (this rubber sheet extends approximately the area of shoulders to bend of knees)
6. Place draw sheet over rubber draw sheet with the top edge a few inches higher. Tuck in both together.
7. Place top sheet with wrong side up with the wide hem even with the upper edge of the mattress.
8. Place blanket with open edge about 6 inches from the upper edge of mattress.
9. Place spread with right side up even with the upper edge of mattress.
10. Tuck sheet, blanket and spread together under at the foot and miter the corner.
11. Go to opposite side of bed, fold loose linens back, tighten and tuck linens from bottom sheet.
12. Put pillow slips on and pat pillows smoothly,
13. Arrange pillow flat one on top of the other with the open edge of their cases away from the door.

B. Making an Open Bed

1. Proceed as for 'Making a Closed Bed"
2. Turn the spread under the blankets at the head and fold the top sheet over it.
3. Grasp the uppermost corner of the top linen with one hand. Place other hand directly in center of bed. Fold uppermost corner of linen to center of bed forming a triangle. Repeat with other corner.
4. Grasp the point of the triangle folding linens back just beyond the base of the triangle. Then bring back point even with the center of the original triangle base with the point towards head of bed.

C. Modifications of Bed Making

1. To prevent foot drop, relieve pressure, and provide comfort in hot weather, draw the lower edge of the upper sheet over the foot of the bed to the level of lower edge of the mattress. Place blanket and spread the same as the upper sheet and miter the corners.

Personal Hygiene cont'

C. Modifications of Bed Making

2. To relieve pressure from the extremities or remainder of the body as circumstances require, select a cradle the approporiate size and place in desired position. Place upper linen over cradle and tuck under mattress and miter the corners. Additional bed linen may be necessary to prevent undue exposure.

## Personal Needs of the Patient

A. Oral Hygiene

Purpose:

1. To cleanse
2. To prevent formation of sordes
3. To avoid infection
4. To stimulate salivary secretion
5. To treat disease of mouth

I. Average Patient

Requisites:

1. Tooth brush
2. Dentifrice
3. Mouth wash or water
4. Emesis basin
5. Towel
6. Drinking tube, if necessary

Procedure:

1. Elevate backrest
2. Protect gown and pillow with towel.
3. If condition contraindicates an elevated position, turn patient on side with face along the edge of pillow. Place towel on pillow and emesis basin on towel close to patient's cheek.
4. Hold tooth brush over emesis basin and apply dentifrice, allowing patient to brush his own teeth.
5. Assist patient rinse mouth using drinking tube if necessary.
6. Care for the equipment.
7. Ambulatory patients may perform this procedure at the lavatory.

Personal Needs cont'

II. For the Helpless and Very Ill Patients

Requisites:

1. Tray containing:
   a) Requisites as for "average patient."
   b) Tongue depressor
   c) Applicators
   d) Gauze squares
   e) Mixture of equal parts of glycerin and lemon juice or ordered solution.
   f) Mineral oil
   g) Folded newspaper

Procedure:

1. Protect gown and pillow with towel.
2. Turn head to side over emesis basin.
3. Cleanse mouth with brush, gauze, or applicators depending on patient's condition. If patient is very ill, hold the cheek away from the teeth with a tongue depressor. Wash gums, teeth, and inside of cheeks with gauze wrapped about a second tongue depressor and dipped in solution. Discard used gauze in newspaper.
4. Cleanse tongue thoroughly and carefully.
5. Apply lubricant to mucous membrane and lips.
6. Care for the equipment and complete tray for succeeding treatments.
7. Wash your hands thoroughly.
8. Record: time, treatment, solution used and observation of patient.

B. Care of Dentures

1. If patient is able he may care for his own false teeth. Provide him with basin, soap, brush, and towel.
2. If patient is helpless, brush teeth twice daily and when necessary. Take to treatment room in denture cup and cleanse thoroughly with brush under cold running water.
3. After dentures have been cleansed, wet the dentures and replace in patient's mouth.
4. When dentures are not in patient mouth, keep false teeth in denture cup in cold water. Never leave teeth loosely on bedside table, under pillow, or anywhere except in patient's mouth or denture cup.
5. Remove dentures from the mouths of irrational, unconscious, convulsive patients and patients being prepared for surgery.

# Care of Hair and Scalp

## A. To comb the Hair

Purpose:

1. To give comfort and a neat appreance to patient
2. To stimulate circulation in the scalp
3. To inspect for pediculi

Requisites:

1. Comb
2. Towel
3. Bathing alcohol, if indicated

Procedure:

1. Protect pillow with a towel
2. Turn head on side
3. Part hair in middle from the forehead to the neck
4. If hair is tangled, wet with alcohol and then comb ends first gradually working toward the head. Grasp the hair a few inches from the head and remove tangles carefully with the comb.
5. Braid the long hair in one or two braids which ever is most comfortable for the patient. Short hair and men's hair is brushed to remove ling then combed and parted smoothly.
6. Do not cut hair without permission of the patient and the supervisor.
7. Report any unusual condition of the scalp.

## B. Bed Shampoo

Purpose:

1. Cleanliness and comfort
2. To prepare for certain types of operations about the head
3. To assist in removing perdiculi and nits

Requisites:

1. Tray containing:
   a. Large rubber sheet or Kelly Pad
2. Foot tub or basin
   b. Bath towels
   c. Pitchers of water 105 degrees F.
   d. Newspaper
   e. Soap solution in small measuring cup
   f. Rubber square
   g. Wash cloth

Procedure:

1. Comb patient's hair and wash the comb.
2. Bring all the equipment to the bedside and arrange conveniently.
3. Place newspaper on chair near the head of bed, then place foot tub on the paper.

Care of Hair and Scalp cont'
Bed Shampoo

Procedure:

4. Remove pillow; fold upper bedding back and place bath towel over patient's chest.
5. Untie gown at neck and fold under. Place rubber square and bath towel under patient's head.
6. Place Kelly pad slightly inflated on top of bath towel. Place free end of pad in the tub. (If a large rubber sheet is used, roll sides to form a drainage pad).
7. Place wash cloth over patient's eyes.
8. Moisten hair with clear water, apply soap solution and make a good lather by massaging the scalp with the tips of the fingers.
9. Lather and rinse until the hair is clean.
10. Squeeze water from hair and remove wash cloth.
11. Remove Kelly pad and place in tub, allowing rubber square and bath towel to remain under patient's head.
12. Wrap head in bath towel and rub partially dry. If this towel becomes too moist, continue with second towel.
13. Place clean towel under patient's head and spread hair out to finish drying.
14. Clean and care for equipment.
15. Return to unit, comb and arrange hair and leave unit neat.
16. Record: time, treatment, condition of hair and scalp, and patient's reaction.

C. Treatment of Pediculosis

General Instructions:

1. Avoid unnecessary embarrassment
2. Protect the eyes during the treatment.
3. Do not allow the patient to be up and about
4. Isolate patient and unit for duration of treatment.
5. Record: time, procedure, type of solution used, results on nurse's notes.

I. Pediculosis Capitis (Head lice)

Reqhisites:

Tray containing:

1. Ordered solution; cuprex, larkspur, equal parts of kerosene and oil
2. Rubber pillow
3. Triangular bandage
4. Cotton balls in small basin
5. Bath towel

Procedure:

1. Provide adequate privacy.
2. Carry equipment to bedside
3. Place towel on rubber pillow and place under patient's head.

Care of Hair and Scalp cont'

Pediculosis Capitis (Head lice)

Procedure:

4. Apply solution well to scalp with cotton balls and comb dipped in solution.
5. Roll the hair on top of patient's head.
6. Cover head with traingular bandage.
7. Remove bath towel and care for equipment.
8. Remove cap at end of time designated. If no time designated, leave cap 12-24 hrs if of larkspur type. When cuprex is used, leave 20-60 minutes.
9. Fine comb and examine scalp and hair, eyelashes, and eyebrows, minutely for pediculi and nits. Report findings to head nurse.
10. If no pediculi are present, shampoo hair.

II. Pediculosis Corporis and Pubis

1. Protect bed with towels. Apply prescribed solution to affected parts with cotton balls. Cover with towels and allow to remain the designated time. Bathe well with soap and water daily. A tub bath is most desirable.
2. Hair on public areas may be clipped with scissors, but should not be shaved unless ordered and patient's permission is obtained.
3. When undressing a patient with pediculi, place all clothing on newspapers, wrap well, and send clothing home with patient with instructions as to their care.
4. Upon completion of treatment, change under clothing and bed linens, and send to laundry as contaminated linen.

## Early P.M. Care

Purpose:

1. To refresh, relax, and comfort the patient.
2. As a prophylactic measure in the prevention of decubitus by stimulating local circulation and toughening the skin

Requisites:

1. Articles for washing hands and face
2. Oral hygiene equipment
3. Lotion and powder

Procedure:

1. Offer bedpan to patient.
2. Provide water and other articles for washing hands and face.
3. Offer oral hygiene and cleanse dentures.
4. Remove pillow and place on chair set near foot of bed. Roll down head of bed and pull up mattress.
5. Turn patient on side, rub back, shoulder, and hip well with lotion and powder. Brush crumbs from

Early P.M. Care cont'

Procedure:

6. bed. Straighten and tighten lower bed covers.
6. Repeat on other side.
7. Replace pillow; adjust, straighten, and neatly arrange upper linens and bedside equipment.
8. Supply fresh drinking water if condition warrants.
9. Make sure all patient's, wants are cared for before leaving the unit, that is refilling ice bags, hot water bottles, replacing comfort measures, etc.
10. Leave patient comfortable and unit in order.
11. Record: time, procedure, observation of patient.

## Bed Time Care

Purpose:

To remove causes of restlessness and discomfort to promote relaxation and sleep.

Procedure:

1. Start bedtime care as soon as the visiting hour is over.
2. Remove all heavily scented flowers from room and all others upon patient's request.
3. Offer bedpan or urinal.
4. If patient is uncomfortable, very ill, or newly operated, rub back.
5. Inspect dressings for bleeding or drainage and reinforce as necessary.
6. Replace soiled or wet bed garments with a clean one.
7. Refill ice bags, hot water bottles, and water pitchers.
8. Provide extra blankets if necessary.
9. Inspect special treatment equipment (oxygen, wangensteen, aspirator, etc).
10. Adjust patient's position. When patient is comfortable and unit neat, provide proper ventilation and darken room.
11. If diet allows, provide evening nourishment. A cup of hot milk or broth may help the patient to relax.
12. Complete all preparation for sleep before giving sedative.
13. Record: special care, nourishment, medication, and observation of patient.

## Personal Needs

### Giving and Removing the Bedpan

Requisites:

1. Bedpan and cover
2. Washcloth and towel
3. Toilet paper

Personal Needs cont'

Procedure:

1. Provide privacy for patient.
2. Bring covered bedpan to bedside, place on edge of bed.
3. Remove all comfort devices.
4. Lift bedclothes exposing patient as little as possible. Have patient flex knees. Place hand under coccyx, assist patient in raising hips, and with other hand slip bedpan in place. The upper end of the pan should comfortably support the buttocks. Tuck bedpan cover under mattress at foot of bed.
5. If condition warrants, raise the backrest to a comfortable position or place small rubber pillow under small of back for support.
6. Place signal cord and toilet paper within reach. Leave patient alone unless contra-indicated and take old dressings and perineal pad in a newspaper with you.
7. To remove the pan, support the patient as before, withdraw the pan gently, cover, and place on the bedside or chair.
8. Carry bedpan to utility room and observe contents carfully. Rinse with cold water, clean with a brush and soapy water, rinse with warm water.
9. If patient is emaciated or appears unable to sit on pan, place a pad or a towel folded on top of rim as a cushion.
10. Adjust bed clothes and provide patient with a towel and wash water or a damp wash cloth and ventilate the room.
11. If patient is helpless, roll patient on his side, cleanse rectum with several thicknesses of toilet paper and cleanse external genitalia depending on the circumstances encountered.
12. Wash your hands
13. Record: time, quantity, color, odor and general consistency of stool and urine.

## Offering the Urinal

Requisites:

1. Urinal and cover
2. Wash cloth and towel

Procedure:

1. Provide privacy
2. Place covered urinal within easy reach of patient's hand. If necessary, instruct the patient as to its use.
3. If the patient is helpless, place the urinal in position with as little exposure as possible.
4. Provide patient with requisites for washing hands.
5. Carry covered urinal to utility room, note color, odor, and quantity of urine. Cleanse urinal and return to

Personal Needs cont'

Offering the Urinal

Procedure:
bedside unit.
6. Wash your hands.
7. Record: time, quantity, and any abnormalities noted.

## Related Personal Procedure

## Application of Binders

Purpose:
1. To keep dressing and applications in place
2. To make compression
3. To afford support and comfort to the patient

Types of Binders and Procedure
A. Abdominal
1) Straight
a. With the patient in a dorsal position, fanfold binder and place it under the patient in such a way that the center of the binder will come to the center of the patient's back.
b. Draw the fanfolded half of the binder under the patient to the opposite side of the bed.
c. Fold ends of binder until it just meets over the largest part of the body.
d. Pin the binder in place. For best adjustment, first pin should secure center of the binder.
e. Pin a dart down each side of the binder for maximum comfort of the patient.

2) Sculteus or "many tailed"
a. Fanfold binder halfway. Place under patient so center of binder will come to center of patient's back and so lower edge of binder is at level of symphysis.
b. Draw the fanfolded half of the binder under the patient to the opposite side of the bed.
c. Draw "tailed ends" over abdomen, starting at the lowest portion of the binder, wrapping alternately and obliquely each strip of the binder smoothly and snugly around the patient.
d. Bring last two tails down obliquely to opposite side.
e. Use safety pins to secure binder in comfortable position.

B. Breast Binder
1. Place binder under the patient so that the center of the binder will come to the center of the patient's back.

Related Personal Procedure cont'

B. Breast Binder
   2. Hold breasts in normal position
      (Have patient place palms of her hands outside the binder on the axillary side of each breast, lifting the breasts toward the midline on the anterior chest wall, while the nurse pins the binder)
   3. Pin from the lower edge to the upper edge of the binder.
   4. Pin shoulder straps securely.

C. "T" Binders
   1. Single tail. Place binder around waist of patient. Bring the tail of binder over the perineal dressing. Pin binder in front being careful that the perineal dressing is smooth and secure.
   2. Double T Binder. Apply in same manner for male patients.

# Chapter IV

## Serving Food to the Sick

### Oral Method

A. Preparing the patient and his environment
   1) Protect the patient from unpleasant odors and sights by proper ventilation and the use of screens.
   2) Place patient in a comfortable position, offer bedpan, provide facilities for washing hands, elevate backrest, and arrange pillows.
   3) Adjust bedside table to correct position.
   4) If dentures are not in place, bring them to patient in denture cup of water.
   5) If patient is ambulatory place his chair in an inviting part of the room.
   6) Delay the tray of a patient having a treatment until after treatment is completed.
   7) Mealtime is important to most persons who are ill and everything should be done to make it a pleasant time.

B. Serving a tray
   1) Inspect tray before serving.
      a. To see that: it is clean, neatly and conveniently arranged.
      b. All necessary articles are on the tray
      c. That food is properly prepared. Hot foods hot and cold foods cold.
      d. Servings are of a moderate size
      e. Follow doctor's orders in choice of diet
   2) Serve first these patient who can eat with little or no assistance, and serve those who need help as the help can be given.
   3) Carry the tray balanced on palm of one hand above the shoulder at least six inches from the hair. The other hand may be used to support the tray.
   4) Always identify the tray before serving the tray by seeing that the number on the tray corresponds with the patient's room number.
   5) Place tray within convenient reach of the patiant
   6) Uncover the dishes and render any necessary assistance as pouring beverage, buttering bread, cutting meat, arranging napkin, etc.
   7) Encourage the patient to eat as much as possible.
   8) All nurses cooperate at meal time by distributing trays leaving routine duties to be done after the patients have been fed.
   9) Take the tray including all dishes away as soon as patient has finished eating. Observe the amount eaten and note special likes and dislikes.

Serving Food cont'

C. Feeding a Hepless Patient

1) Wash your hands before feeding patient.
2) Protect patient gown with a towel or napkin.
3) Place the tray so that it can be seen by patient, if possible and where it is convenient for the nurse. If patient is unable to see, describe the food before starting to feed him.
4) Both the patient and the nurse should be in a comfortable position and there should be no feeling of hurrying.
5) There can be no definite rule as to whether the nurse should sit or stand.
6) Give food in proper sequence and give food to patient as you would feed yourself.
7) Feed liquids from a spoon, drinking tube, or glass as patient desires.
8) Allow and encourage patients to help themselves as much as possible.
9) Wipe the patient's mouth occassionally and at the end of the meal.
10) If the nurse will keep in mind the general principles which guide one in eating, her task will be easier and the patient will be more comfortable.
11) Record: time, type of diet, amount of food and liquid taken, and the amount of assistance given.

Gastric Gavage

Purpose:

To introduce food into the stomach when patient is unable to take food in the normal manner.

Requisites:

1. Tray containing necessary requisites for insertion of the Levine tube.
2. Large asepto syringe
3. Graduate or glass containing prescribed food
4. Small basin of warm water
5. Adhesive strip and clamp (if tube is to remain in place)
6. Glass or cup of warm water

Procedure:

1. Assemble requisites.
2. Place graduate of prescribed food in basin of warm water.
3. Arrange all articles on tray, cover with clean towel, and carry to bedside.
4. Explain the procedure to patient and provide adequate privacy.
5. Insert levine tube in the usual manner (refer to page).

Serving Food cont'

Gastric Gavage

Procedure:

6. When normal breathing is established, attach barrel of asepto syringe to levine tube.
7. Pour small amount (30cc) of warm water into barrel. Follow with feeding, pouring slowly, never allowing the barrel to become empty.
8. Complete the gavage by pouring small amount of water into barrel (approximately 30cc) to cleanse tube.
9. If feeding is to be repeated at frequent intervals, fasten the tube to patient's cheek and clamp between feedings.
10. If tube remains in place always give small amount of water at beginning and completion of gavage. Never introduce food with force; it should flow in by gravity.
11. Clean and replace equipment on tray and leave in patient's room in preparation for next feeding.
12. Record: time, treatment, kind and amount of nourishment given, observation of patient, signature of nurse.

Gastrostomy

Purpose:

Creation of an artifical opening through the abdominal wall into the lumen of the stomach to that the patient may be fed.

Requisites:

1. Asepto syringe (barrel only)
2. Clamp
3. Graduate or glass containing food
4. Small basin of warm water
5. Glass of warm water
6. Gauze square and rubber band to cover tube between feedings
7. Emesis basin for waste

Procedure:

1. Assemble requisites.
2. Place graduate of prescribed food in basin of warm water
3. Arrange all articles neatly and attractively, on tray, cover with clean towel and carry to bedside.
4. Provide privacy and explain procedure to patient. Elevate backrest to semi-Fowler's position.
5. Lossen binder and dressings and expose gastrostomy tube.
6. Attach barrel of asepte syringe to tube.
7. Pour in asepto barrel approsimately an ounce of

Serving Food cont'

Gastrostomy

Procedure:

warm water followed with feeding as ordered.

8. Pour in water after feeding to cleanse tube.
9. Never force fluid into stomach. It should run in by gravity.
10. Clamp off tube between feedings to prevent the escape of gastric juice. Cover end of tube with 2" gauze square and hold securely with rubber band.
11. To avoid accidental removal of tube, examine the tube at each feeding, See that dressing is properly applied to abdomen with adhesive, and that dressing and tube are protected with a firm abdominal binder.
12. Clean and care for equipment.
13. Record: hour of feeding, kind and amount of fluid given and any significant observation.

# Chapter V

## General Comfort Measures

Purpose:
To afford comfort to the patient both mentally and physically by:
1) A knowledge of nursing technique
2) Keen psychological insight
3) An understanding of human nature
4) An appreciation of individual differences
5) An application of mechanical devices

A. To change the gown
1. Hospital gown
a. Loosen soiled gown.
b. Draw off one sleeve.
c. Put on the sleeve by crushing together so that patient's hand can be grasped through opening.
d. Draw over the arm and shoulder.
e. Remove the other sleeve.
f. Finish putting on the gown and tie strings.

2. The long closed gown
a. Remove the soiled gown by:
1) Loosening about the neck.
2) Flex the patient's knees and bring lower part of gown close to buttocks.
3) Slip hand underneath back just below the waist; raise the buttocks and at the same time with the other hand, slip gown to the waist.
4) Raise head and shoulders as in changing pillows, with the other hand draw gown above the shoulders
5) Remove one sleeve, then raise head and slip gown off over head, and remove other sleeve.
b. To put on the clean long gown:
1) Crush together the back of the gown.
2) Put the arm in the sleeve farthest from you.
3) Raise head and slip gown over head, slip other arm into gown.
4) Raise head and shoulders, draw gown down to waist.
5) With knees flexed raise body by placing hand under back.
6) With other hand draw gown below hips then down over legs and feet.

3. Pajamas
a. Tops: same procedure as for a closed gown
b. Pants:
1) Crush pant leg farthest from you and put

General Comfort cont'

on like a sleeve; slip foot nearest you into other leg.
2) Assist patient to raise hips and draw pants up over hips

B. To Replace Upper Bed Clothes with a Bath Blanket:
1. Fold down upper bed clothes about nine inches.
2. Place bath blanket on chest of patient with open edges toward head of bed.
3. Tuck lower edge of bath blanket securely around patient shoulders or have patient hold this edge of the bath blanket.
4. Fact foot of bed and grasp upper edge of bath blanket and draw to foot of bed.
5. Reach under bath blanket and draw covers to foot of bed, fanfold and adjust so that bed clothes do not rest directly on patient's feet.

C. To Remove Bath Blanket
1. Face the head of bed.
2. With one hand grasp the corner of the bath blanket at the foot of the bed and with the other hand grasp the bed covers pulling up the covers and bath blanket so that the bath blanket is now folded in half.
3. Grasp the bath blanket near the farthest shoulder of the patient and withdraw bath blanket.
4. Fold and place in space provided.

D. To Change Pillows:
1. Method 1
   a. Slip one arm under head, with hand under far shoulder blade; raise patient slightly.
   b. Reach around patient with other hand and remove pillow by drawing it out from opposite side of bed.
   c. Place pillow on side of bed and remove arm from under the patient's head.
2. Method 2
   a. Place arm on side nearest patient under axilla; with hand on patient's opposite shoulder blade
   b. Place other hand under patient's neck and farther shoulder
   c. After assisting the patient to sit up. remove pillows with the hand which supported the neck and shoulders.

E. To Replace the Pillows:
1. Place pillows at far side of bed
2. Support patient as above
3. With free hand draw pillow under head.
4. Adjust pillows to provide a comfortable position.

F. To change a patient's position:
1. To turn a patient on his side

General Comfort cont'

a. Move pillow towards you.
b. Place patient's hand nearest you, under the pillow.
c. Place the other arm across patient's chest.
d. Place one of your hands under shoulders and the other under hip farthest from you.
e. Gently but firmly pull patient toward you.
f. Flex upper leg and rest on bed, lower leg should be extended.
g. Move the hips back toward center of bed.
h. Place a pillow lengthwise at patient's back and one against abdomen if desired, tuck in close for support. Place a small pillow between the knees.
i. Reverse the process if you wish to turn the patient away from you.

2. To turn a patient on his back.
   a. Remove pillows and comfort devices
   b. Straighten flexed leg.
   c. Slip hands under hip and shoulder, gently drawing patient toward you
   d. Adjust pillows and comfort devices accordingly.

3. To turn a patient with a draw sheet.
   a. Move patient near center of slightly to farther side of bed.
   b. Place patient's arm on far side across chest.
   c. Grasp draw sheet on far side of bed and roll patient toward you.
   d. Support patient as previously instructed.

4. To lift a patient up in bed.
   a. Method 1
      1) Place pillows in upright position at head of bed
      2) Have patient flex knees.
      3) Have patient put arm across back and shoulders of nurse, or have patient grasp head of bed when able to help.
      4) Put one arm under back and shoulders of patient and have other under buttocks.
      5) Instruct patient to assist when you give signal
      6) Adjust pillow
   b. Method 2 (for a helpless patient)
      1) Nurses stand on opposite of bed
      2) Both nurses place hands under patient's shoulders and hips
      3) Lift and move patient
      4) Replace pillow under head

5. To lift an injured arm or leg
   a. When lifting an injured part, place hands beneath the injured limb on either side of the

General Comfort cont'

injury.
b. Raise slowly and gently.
c. Never grasp an injured limb along or change position of limb by grasping the fingers or toes.
d. In case a limb is fractured before the application of a splint, make slight tension with your hand when lifting so that the ends of the broken bones are kept apart.

6. Transferring a patient from stretcher to bed and from bed to stretcher:
   a. Method 1
      1) Apply bath blanket
      2) Move patient toward edge of bed
      3) Loosen draw sheet under patient
      4) Place stretcher or cart close to side of bed, if of the same height.
      5) Stand at side of stretcher and grasping the draw sheet with both hands, pull the patient over to the stretcher by means of the draw sheet.
      6) If a second nurse is present, she may brace against the opposite side of bed and by grasping the draw sheet, assist the patient on to the stretcher.
   b. Method 2
      1) Apply bath blanket
      2) Move patient to edge of bed
      3) Have stretcher ready to receive patient by placing head of stretcher at foot of bed at an angle of 135 degrees.
      4) Three nurses come to the same side of bed (inner angle).
      5) First nurse places her hands under the patient's head and shoulders.
      6) Second nurse places one arm under back and the other under buttocks.
      7) Third nurse places one arm under upper part of legs and the other under lower part of legs.
      8) Instruct patient to hold his body rigid and clasp his hands over first nurse's shoulders.
      9) Lift patient in unision, holding him forward and resting on nurse's chest.
      10) Together walk along bed and stretcher to proper place.
      11) Lower patient to stretcher gradually.
      12) Cover the patient and straighten the bed.

7. Sitting a patient up in bed.
   a. Elevate backrest to position ordered
   b. Purpose of backrest being:
      1) To change position
      2) To relieve dyspnea
      3) To afford postural drainage

General Comfort cont'

8. Dangling
   a. Move patient up in bed.
   b. Elevate backrest to a sitting position. Check pulse and respiration.
   c. Support the head and shoulders with one arm and moving the legs by placing the other hand under the knees, pivoting patient to a sitting position. This should be done slowly so that he adjusts to the sitting position without feeling faint and light headed.
   d. Protect patient's shoulders with bed jacket or bath blanket.
   e. Allow patient to rest feet on a straight chair, and cover feet with a bath blanket.
   f. It may be necessary to support the patient in position by placing your arms around patient's shoulders for a few moments.
   g. Check pulse and respiration and observe patient's reaction. Do not allow patient to become exhausted.
   h. If condition warrants, chair may be removed and patient allowed to swing legs several times.
   i. The length of time patient is allowed to dangle depends upon patient's condition and doctor's orders. Usually 5 minutes for first time and increasing each succeeding time.
   j. Record: pulse, and respiration before, during, and following procedure length of time dangled. patient's reaction, signature of nurse.

9. To get a patient up in a chair
   a. Method 1
      1) Place chair on convenient side of bed.
      2) Check pulse and respiration. Apply bath blanket.
      3) Elevate backrest and assist patient to a sitting position turning him so that his feet will be over the edge of the bed.
      4) Put on robe and slippers. Allow patient to sit on edge of bed a few minutes exercising his legs.
      5) Place the foot stool.
      6) Assist the patient as follows:
         a) Support patient by passing one arm firmly around his body under the arms with his nearest arm across the nurse's shoulders and held in position by the nurse's other hand. Lift patient slightly, standing him on his feet for a few moments and then rotating him into the chair. Leave patient comfortable by adjusting foot stool, arranging pillows, signal light, and covers.

General Comfort cont'

b) Stand directly in front of patient and place one hand under each axilla. Pull patient gently toward the edge of the bed, assist patient to his feet, and turning him around with his back to the chair. Seat him gently, at the same time steady the chair. Adjust comfort measures.

7) Observe patient for changes in color, pulse rate, dizziness, and signs of fatigue.

b. Method 2 (To move helpless patient requires two nurses)

1) Proceed as in method one to step 6.
2) One nurse stands on either side of patient.
3) Each nurse place one arm under the thighs, clasping hands under the thighs to give additional support.
4) Instruct patient to place one arm across the shoulder of each nurse for support.
5) In unison, lift and carry patient to chair.
6) Adjust comfort measures.
7) Record: pulse and respiration before, during, and following procedure, length of time up, observations and reactions of the patient.

10. Assisting patient back to bed:

a. Method 1 (one nurse)

1) Remove comfort devices.
2) Elevate backrest.
3) Assist patient to a standing position facing bed.
4) Place and brace the foot stool.
5) Support the patient as necessary and assist him.
6) Remove slippers and remove arms from robe.
7) Place one hand under patient's knees and swing legs into bed, with the other hand, pull up bed linens.
8) Remove robe, adjust comfort devices, and leave unit neat.

b. Method 2 (requires two nurses)

1) The procedure of getting a helpless patient back to bed is the reverse of "Assisting a helpless patient into a chair".
2) Note..when assisting a patient in or out of a wheel chair, make sure the foot rests are up, and the chair supported so the chair will not tip.

11. Helping a Patient to walk:

a. Instruct patient to place arms nearest you across your shoulders. Grasp the wrist of this arm with your arm farthest from patient.
b. Put your arm nearest patient around patient's waist.
c. Walk together slowly and observe patient's reaction.
d. Patient is to be adequately dressed in robe and slippers.

General Comfort cont'

G. Application of comfort devices:

1. Rubber ring

Purpose: to relieve pressure

a. Inflate ring only to about 1/3 capacity. This may be done by loosening valve, applying a paper straw, and blowing to desired capacity.
b. Cover with a pillow case
c. Place ring under patient, adjust to proper position, being sure the valve of the ring does not press against patient.

2. Small cotton ring or "Doughnut"

(To relieve pressure on ankles, heels, knees, etc.)

a. Obtain desired amount of cotton and one inch gauze bandage from Central Supply.
b. Roll and mould cotton into ring of desired size.
c. Wrap ring firmly with gauze bandage.
d. Place ring in position under bony prominence.

3. Sandbags

(Helps keep parts immbolized and supported and to form a foundation for special appliances)

a. Obtain sandbags and cover with pillow case or suitable piece of linen and place in position.
b. A written order is required if sandbags are used for more than support of a part.

4. Simple Bed Cradles

(To prevent bedclothes resting on tender areas)

a. Place the cradle over the required area.
b. Arrange bedding neatly over frame, using a second blanket crosswise if necessary.

5. Fracture Boards

(To keep mattress from sagging or moving)

a. Obtain boards and place under mattress as ordered.
b. Make bed in usual manner.

6. Foot Boards

(To support the soles of the feet and prevent "foot drop" to produce a feeling of support and to prepare the patient for wearing shoes and standing on the floor)

a. Cover board with draw sheet.
b. Place board (which is approximately 18 inches in height and the width of the bed in length) between the mattress and the foot of the bed.
c. Place feet against board keeping them in a normal position.
d. Arrange bedding neatly over the foot of the bed.
e. The foot rest may also be a covered box, or a firmly rolled pillow placed accordingly to maintain good posture.

General Comfort cont'

7. Knee Roll
   (To prevent patient from slipping down in bed and to relieve abdominal tension)
   a. Cover a rubber pillow with a pillow case, fold pillow in half lengthwise and place under patient's knees to relieve abdominal tension.
   b. To keep a patient from slipping down in bed place rubber pillow inside sheet and fold diagonally. Flex patient's knees and slip well under them arranging it to the patient's comfort. Bring ends of sheet through springs and tie to side of bed near head.

8. Pillows
   a. To use pillows as a backrest...
      Raise patient to semi-sitting position. Place one pillow obliquely on either side of patient and another on top of these to afford support to the back, arms, neck, and head. Support arms with two small pillows and prevent unnecessary pull on muscles and ligaments of arms.
   b. To relieve tension on muscles of back...
      Push a soft flat pillow under the small of the back.
   c. To support a patient on his side...
      Slip the edge of a large pillow well under the shoulder and back and double pillow over pushing pillow up close to the back. Place a small pillow between the knees. Use a small soft pillow for an arm rest.
   d. To elevate an extremity...
      Place extremity on rubber pillow with heels or fingers extending over pillow. A "doughnut" may be placed under the heels.
   e. To facilitate breathing and produce comfort for patients with marked dyspnea or orthopnea in cardiac conditions or asthma.
      1) Elevate backrest and support lower back with pillows
      2) Place the adjustable bedside table across the bed in front of the patient;
      3) Place a soft pillow on the table to support the patient's arms and head as he leans forward on the table.
   f. To relieve neck strain...
      A long narrow soft pillow at the back of the neck.

9. Restraints
   (To prevent patient from injuring themselves or other)
   a. Side Rails.
      1) Obtain side rails. If condition of patient permits, explain the purpose of the application of the rails.

General Comfort cont'

2) Fasten side rails securely to the side of the bed.
3) Side rails may be applied routinely on beds of all senile, unconscious, disoriented, convulsive patients and on all children's beds.

b. Sheet restraints.
1) Fold sheet diagonally. Place sheet across abdomen fastening each end securely (to bars of bed or mattress)
2) Additional sheets may be used; one over chest, one over thighs, fastening in the smae manner.

c. Cuff and Ankle
1) Must be ordered by doctor.
2) All anklet and wristlets must be padded to prevent irritation of flesh.
3) Watch for reddened areas and impairment of circulation.
4) Bring straps leading from restraints through and around side bars or foot of bed. Fasten securely.

d. Belt and side restraints.
(It is usually ordered to keep patient in bed, allowing him greater freedom of movement)
1) Apply strap around waist line of patient so that patient will not be able to slide over hips and shoulders.
2) Place second restraint strap through wast-line restraint, near left hip. Draw through spring and fasten on left side bar.
3) Repeat procedure by placing third strap near right hip.
4) Adjustable straps are locked with a key. The key must be kept in a definite place.
5) The presence of restraints necessitates careful watching of the patient. It is necessary to change position of patient frequently to prevent fatigue, impairment of circulation, chafing, and decubitus ulcers.

# Chapter VI

## Observation and Recording of Symptoms

### Temperatures

General Instructions:

1. Temperatures should be taken twice daily on all patients.
2. Temperatures every four hours on the following;
    a. 99 degrees or over
    b. Day of surgery and two days following.
    c. Critically ill
    d. When specifically ordered by doctor
3. Temperature at times not stated when observation of patient suggests elevation or fall of body temperature.
4. Do not take temperatures by mouth for 10 minutes when patient has had hot or cold foods or fluids.
5. Note and record pulse and respiratory rates at same intervals as temperatures.

A. Taking the temperature orally:

Requisites:

1. Oral thermometer kept at patient's unit in a container with cotton and clear water.
2. Jar of clean cotton at patient's unit.

Procedure:

1. Remove thermometer from container. Avoid touching bulb of thermometer. Shake mercury down to 96 degrees.
2. Without drying the thermometer, place the bulb of the thermometer under the tongue and instruct patient to keep mouth closed for three minutes.
3. Count pulse and respiration while thermometer is registering.
4. Remove thermometer, wipe from hand to mercury bulb, turn so that the column of mercury is seen, read, replace in container.
5. Record: time, temperature, pulse, and respiration on graphic sheet and nurses's notes.

General Instructions:

1. Indications for rectal temperatures:
    a. Temperature is above 100 degrees or below 97 degrees.
    b. If patient is coughing, delirious, extremely restless, disoriented, or comatose.
    c. In conditions necessitating mouth breathing:
        1) Eye, ear, nose, and throat surgery

Observation of Symptoms cont'

Temperatures

2) Neuro-sugery
3) Administration of oxygen

d. Post operatively for 2 days
e. All children under 10 years of age.

2. Do not take a rectal temperature if patient has had rectal surgery. Temperature may also be taken at colostomy or enterostomy opening if so ordered.
3. Do not allow patient to insert thermometer.
4. When taking the rectal temperature of a child who is uncooperative, place child flat on abdomen and have someone assist you and proceed.

B. Taking the temperature rectally:

Requisites:

1. Rectal thermometers
2. Mineral oil
3. Equipment for cleaning
   a. Glass of green soap solution with large piece of cotton.
   b. Glass of pink colored water with large piece of cotton.
   c. Glass of Zephrian Cloride solution (colored) with large piece of cotton.
   d. Glass of clear water with piece of cotton in glass.

Procedure:

1. Carry thermometer tray to room.
2. Screen patient and place patient on side, if possible. If not, flex one or both knees as indicated.
3. Shake down thermometer. Lubricate by dipping thermometer in bottle of mineral oil provided.
4. Separate buttocks and insert thermometer about 1½ to 2 inches.
5. Hold thermometer in rectum for 3-5 minutes. Do not expose unnecessarily.
6. Count pulse and respiration rate while thermometer is registering if possible; otherwise, obtain immediately following this procedure.
7. Remove thermometer and wipe from hand toward mercury tip with cotton.
8. Read and then place thermometer in soap solution. Rinse in colored water. Place in Zephrian Cloride for 7 minutes to disinfect. Then place in glass of clear water.
9. Record: time, how taken, pulse and respiration on graphic sheet and nurses's notes.

C. Taking the temperature Vaginally

Temperatures are taken vaginally only by specific order from doctor.

Requisites:

Complete rectal thermometer tray.

Observation of Symptoms cont'

Temperatures

Procedure:

1. Proceed according to directions for "Taking temperature rectally". Dorsal recumbent position preferred.
2. Insert thermometer into vagina about 1½ to 2 inches. Hold thermometer in place for required time.
3. Remove, clean and record.

D. Taking the temperature axillary or by groin.
An axillary or groin temperature should be taken on any patient who has injuries or conditions which contra-indicate the taking of a temperature by mouth or rectum.

Requisites:
Complete rectal thermometer tray.

Procedure:

1. Dry axilla so that it is free from moisture.
2. Remove thermometer, shake down and place the bulb in the hollow of the axilla so that the stem is pointing toward the patient's chest.
3. Bring the arm across the chest so that the bulb is in contact with the skin surfaces and there is no circulation of air over the thermometer.
4. Support the arm during the procedure which requires 10 minutes.
5. Count pulse and respiration rates.
6. Remove thermometer, read, and record.
7. Clean thermometer as directed.
8. In taking a temperature by groin, dry groin, place bulb of thermometer in hollow of groin. Have patient cross leg over other leg. Leave in place 10 minutes. Remove, read, and record.

Observation of Symptoms cont'

## Taking the Pulse

(The pulse is the alternate contraction and expansion of the artery corresponding to the heart beat).

The pulse may be counted and observed on any superficial artery that has a bone for a background. Example: the radial, the facial, the carotid, the temporal, the femoral, and the dorsalis pedis.

A. Radial

Procedure:

1. Before starting to take pulse, see that the patient is in a comfortable position and that the part is at rest and supported.
2. Place the index and middle fingers along the pathway of the radial artery. Exert slight pressure, feel the artery and get used to it before starting to count the rate and character of the pulse.
3. Count the pulse for ½ minute. (If pulse is dificult to count, irregular, or over 120 or below 60 per minute, count the pulse for one full minute.
4. Observe the general character of the pulse; the force, frequency, regularity, and abnormalities.
5. In patients with circulatory conditions check pulse at least every 2 hours and record source.

B. Apical Pulse

Purpose: to determine the pulse deficient

(The pulse deficient is the difference between a radial pulse and the pulse at the apex of the heart).

Procedure:

1. Place stethoscope over apex of heart and count pulse beats.
2. At same time have second nurse count simultaneously the radial pulse. The period of counting the two pulses must coincide exactly.
3. Record radial and apex pulses and note if pulse deficient is present.

## Counting the Breathing

Purpose: to determine normal or abnormal functioning of the lungs which in turn indicates the patient's condition.

Procedure:

1. Have the patient as comfortable as possible both physically and mentally.
2. Place the fingers on the pulse as though counting it, and watch the rise and fall of chest wall or abdomen. An inspiration and an expiration comprise one respiration. Respiratory rates are partly voluntary, and the consciousness of being watched may influence the rate and rhythm.
3. Count the respirations for ½ minute. (If respirations are difficult to count, irregular, or over 40 or less

Observation of Symptoms cont'

Counting the Breathing

than 12 per minute, count the respiration for one minute).
4. Observe the rate, rhythm, depth, and type of respirations
5. Record: time, rate and character of respiration on graphic sheet and nurses' notes.

## Taking the Blood Pressure

Purpose: to determine the pressure exerted by the blood as it is forced from the heart and pushed against the walls of the blood vessels as an indication of the patient's condition or symptom of disease.

Requisites:
1. Sphygomanometer
2. Stethoscope

General Instructions:
1. The patient should be physically and emotionally quiet as excitement or exercise will raise the blood pressure.
2. Either arm may be used in taking blood pressure, but in repeated readings it is important to use the same each time.
3. By subtracting the figures of the diastolic (expand) pressure from those of the systolic pressure, the pulse pressure is obtained. (contract)

Procedure:
1. Explain the procedure to the patient.
2. Place the patient in a comfortable sitting or recumbent position with the arm supported and the palm of the hand uppermost.
3. Wrap the cuff of the sphygomonometer evenly and securely around the arm, above the elbow and with the tubing toward the upper side.
4. Place the stethoscope to the ears ready for use.
5. Palpate the pulsations of the brachial artery and place the bell of the stethoscope on this site.
6. Compress the bulb and pump the mercury above the point of systolic pressure, that is, until no sound can be heard through the stethoscope. The screw clamp on the bulb must be tight before the bulb can be pumped.
7. Release the pressure slowly by means of the screw valves of the bulb, all the while listening for sounds.
8. The systolic pressure is that point at which the first regular sounds are heard.
9. Continue to release the pressure until the sounds become dull and muffled, this is the diastolic pressure.
10. Make two readings, if they are more than 10 mg. of mercury apart, recheck.
11. Remove cuff, fold carefully, and replace.
12. Record time, systolic pressure (above line $\frac{120}{60}$ diastolic pressure (below line on nurses' notes.

PLACES WHERE BLOOD PRESSURE MAY BE TAKEN:

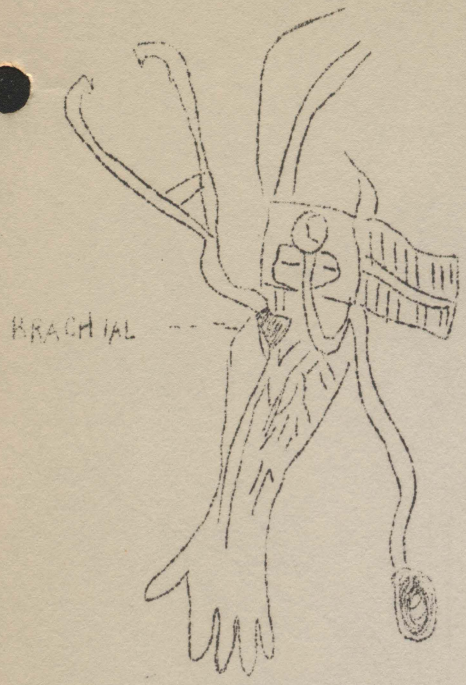



FIGURE 1.

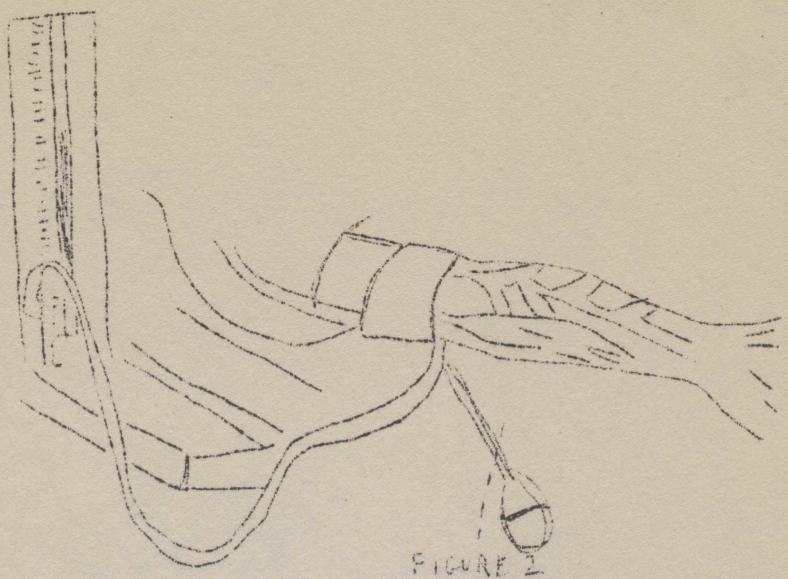


FIGURE 2

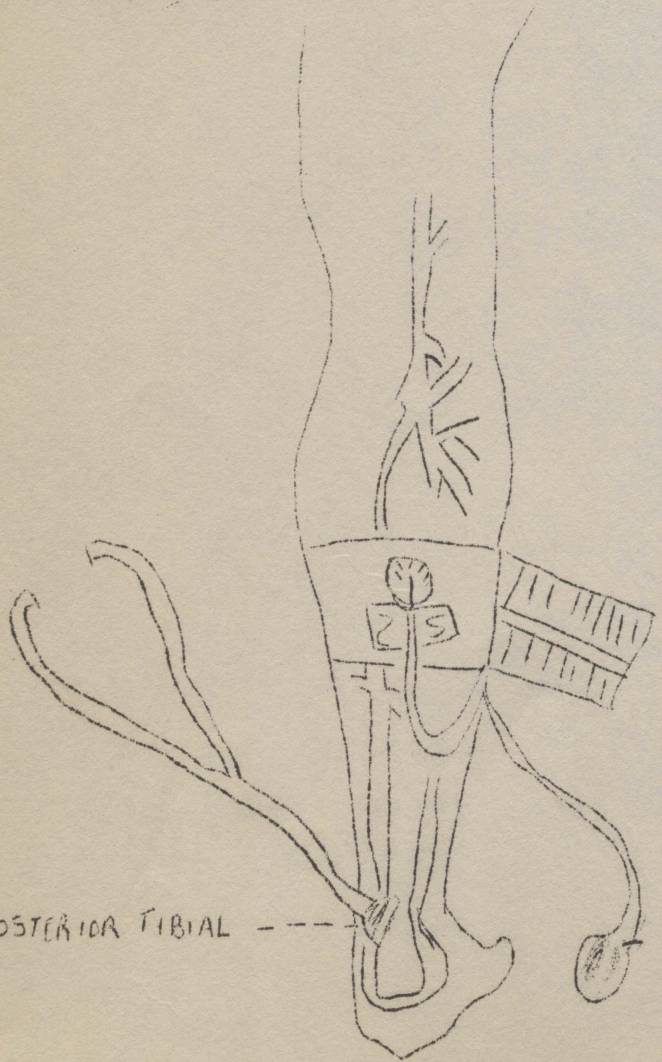



FIGURE 3

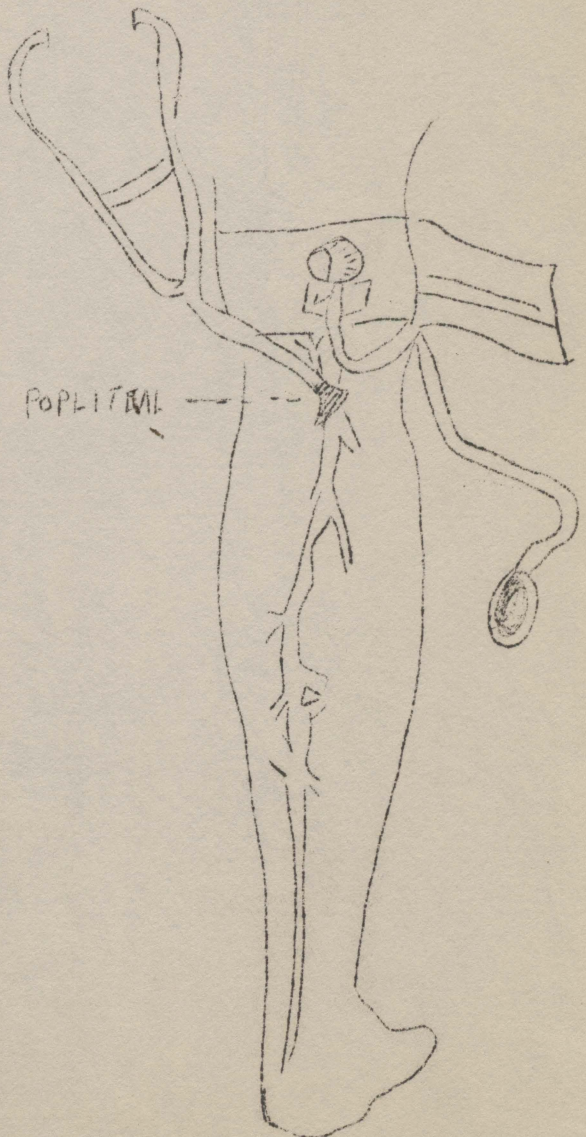
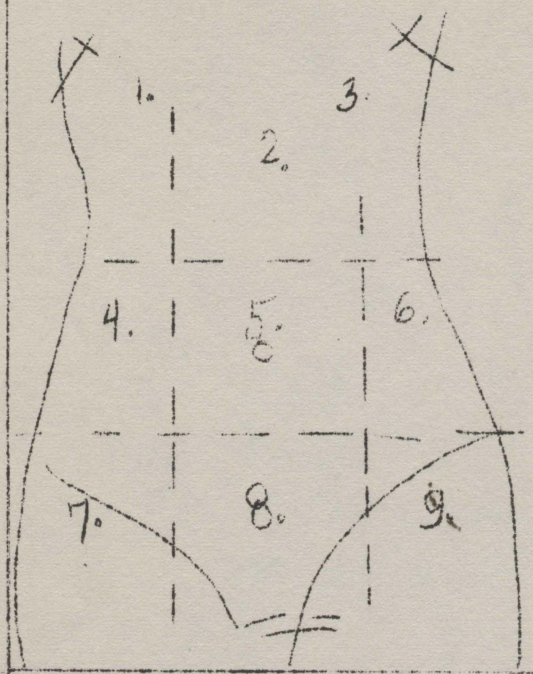



FIGURE 4

# Symptomology

| Concerning: | Suggested Terms to be used. |
|---|---|
| 1. Areas | 1. Right Hypochondriac Region<br>2. Epigastric Region<br>3. Left Hypochondriac Region<br>4. Right Lumbar Region<br>5. Umbilical Region<br>6. Left Lumbar Region<br>7. Right Iliac Region<br>8. Hypogastric Region<br>9. Left Iliac Region |




| Concerning: | Factors To Be Charted. | Suggested Terms To Use. |
|---|---|---|
| 2. Abdomen: | 1. Large & extends outward | Protuberant |
| | 2. Hard, Board-like | Hard, Rigid |
| | 3. Soft, Flabby | Relaxed, Flaccid |
| | 4. Hurts when Touched | Sensitive To Touch |
| | 5. Appears Swollen, Rounded | distended |
| 3. Amounts: (large amounts) | 1. of drainage | Profuse, copius, free |
| | 2. of urine | Polyuria (measured amount) |
| | 3. of Defecation | Copious amount |
| | 4. of Emesis | measured amount |
| (Medium amounts) | 1. of drainage | moderate, usual |
| | 2. of urine | measured amount |
| | 3. of Defecation | moderate amount |
| | 4. of Emesis | measured amount |

Symptomology cont'

| Concerning: | Factors to be Charted. | Suggested Terms To Use. |
|---|---|---|
| (small amount) | 1. of Drainage | 1. Small amount, Slight, Scanty, very little. |
| | 2. of Urine | 2. Scanty, measured amount. |
| | 3. of Defecation | 3. Small amount, Slight. |
| | 4. of Emesis | 4. Slight, measured amount. |
| 4. Appetite: | 1. Very fussy about food, Refuses to eat many foods. | 1. Has definite likes and dislikes concerning food. |
| | 2. Eats all food Served | 2. Appetite Good, Satisfactory. |
| | 3. Eats very little | 3. Appetite Poor. |
| | 4. Loss of appetite | 4. Anorexia |
| | 5. Craving for certain foods | 5. Parorexia |
| | 6. Refuses to eat | 6. Refuses food. (State Reason) |
| 5. Arm: (areas) | 1. Shoulder to Elbow | 1. Upper arm (Right or left) |
| | 2. Elbow to wrist | 2. Lower arm (Right or left) |
| 6. Back: (areas) | 1. Upper back | 1. Shoulder region |
| | 2. Small of back | 2. Lumbar region |
| | 3. End of spine | 3. Sacral region |
| | 4. Gluteal area | 4. Buttocks |
| 7. Baths: | 1. Given when patient is admitted | 1. Admission Bath. |
| | 2. All inclusive bath | 2. Complete Bath. |
| | 3. Including face, arms, back, axilla, genitals | 3. Partial bath. |
| | 4. Special Baths | 4. Name of Bath (Sitz Bath) |
| 8. Belch: | 1. Belching | 1. Eructation |
| 9. Bleeding: | 1. Spurting Blood | 1. In Spurts. |
| | 2. Very little | 2. Oozing |
| | 3. Nosebleed | 3. Epistaxis |
| | 4. Blood in vomitus | 4. Hematemesis |
| | 5. Blood in urine | 5. Hematuria |
| | 6. Spitting of Blood | 6. Hemoptysis |
| | 7. When Bleeding is stopped | 7. Hemorrhage controlled. |
| | 8. Fresh Blood | 8. Bright Red |
| | 9. Old Blood | 9. Dark Red (Black) |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use. |
|---|---|---|
| 11. Blister: | 1. Blister | 1. Vesicle |
| 12. Blood Pressure: | 1. Blood Pressure 120/74 | 1. B.P. 120/74 |
| 13. Breath: | 1. Unpleasant<br>2. Foul<br>3. With Sweet, fruit-like odor<br>4. Smell of alcohol | 1. Halitosis<br>2. Fetid<br>3. Fruity<br>4. Alcoholic |
| 14. Breathing: | 1. Breathing<br>2. Act of inhaling<br>3. Act of exhaling<br>4. Difficult breathing<br>5. Short periods when breathing has ceased.<br>6. Inability to breathe while lying down<br>7. Normal breathing<br>8. Rapid breathing<br>9. Increasing dyspnea with periods of Apnea.<br>10 Large volume of air inspired and expired.<br>11 Small volume of air inspired and expired.<br>12. Abnormal Variations in Rhythm.<br>13. Deep Snoring Sound on inspiration-cheeks puff out on expiration | 1. Respiration<br>2. Inspiration<br>3. Expiration<br>4. Dyspnea<br>5. Apnea<br>6. Orthopnea<br>7. Breathing normal or Respirations normal.<br>8. Breathing rapid or Respirations rapid or fast.<br>9. Cheyne-Stokes Respiration<br>10 Deep Respiration<br>11. Shallow Breathing<br>12. Irregular Respirations<br>13. Stertorus |
| 15. Care: | 1. Oral hygiene, face and hands sponged and back care.<br>2. Bath and oral hygiene<br>3. Preparation for bed, offering bedpan, giving medication<br>4. Special attention or treatment of back, mouth, etc., as ordered by the Doctor. | 1. P.M. care or evening care.<br>2. A.M. care<br>3. Bed-Time care.<br>4. Special care to Back, Mouth, etc. |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| 16. Chill: | 1. Blankets applied to warm the patient | 1. External heat |
| | 2. As to severity | 2. Severe, moderate, slight. |
| | 3. Type or kind | 3. Nervous, Reaction |
| | 4. As to length of chill | 4. Chill lasted number of minutes. |
| 17. Coma: | 1. Partly in coma | 1. Partially Comatose condition. |
| | 2. In deep coma | 2. Profound or deep comatose, unconscious. |
| 18. Convulsion: | 1. Continuous shaking | 1. Tonic Tremor. |
| | 2. Shaking intermittently | 2. Clonic Tremor. |
| | 3. Began without warning | 3. Sudden onset. |
| 19. Cough: | 1. Coughs all the time | 1. Continuous cough. |
| | 2. Coughing over long periods of time. | 2. Persistent cough. |
| | 3. Cough up material | 3. Productive cough, effective. |
| | 4. Dry, Hacking cough | 4. Dry cough. |
| 20. Decay: | 1. Of Teeth | 1. Dental Caries |
| | 2. Of Tissue | 2. Necrosis |
| 21. Defecation: | 1. Bowel movement (material) | 1. Feces, Stool. |
| | 2. Bowel movement (act of) | 2. Defecation |
| | 3. Excessive movement of liquid stool | 3. Diarrhea |
| | 4. Gray-Colored stool | 4. Clay-Colored stool. |
| | 5. Liquid stool | 5. Liquid stool, state color, and amount. |
| | 6. Formed, yet soft stool. | 6. Soft-formed stool, state color, and amount |
| | 7. Formed with hardened feces | 7. Hard-formed stool, state color, and amount. |
| | 8. Persistent desire to defecate with painful, involuntary, ineffective straining. | 8. Tenesmus |
| 22. Dizziness: | 1. Dizziness | 1. Vertigo |
| 23. Drainage: | 1. Watery, from nose | 1. Coryza |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms to Use. |
|---|---|---|
| 23. Drainage: | 2. Containing pus | 2. Purulent |
| | 3. Bloody | 3. Sanguineous. |
| | 4. Consists of feces | 4. Fecal. |
| | 5. Of Lymphatic fluid | 5. Serous |
| | 6. Contains mucus and pus | 6. Mucopurulent |
| | 7. Tough, Sticky | 7. Tenacious |
| | 8. From vagina (after delivery) | 8. Lochia |
| 24. Dressing: | 1. A second dressing added to the first | 1. Dressing reenforced. |
| | 2. Dressing removed another applied. | 2. Dressing changed. |
| | 3. Drain cut | 3. Drain shortened, approximate number of inches. |
| | 4. Sutures removed | 4. Sutures or skin clamps removed. |
| | 5. Area cleansed, disinfected, etc. | 5. Wound or area about wound cleansed with Boric Solution, or alcohol or tincture of merthiolate applied, etc. |
| 25. Drops: | 1. A drop | 1. gtt. |
| | 2. Drops | 2. gtts. |
| 26. Emesis: | 1. Produced by effort of the patient. | 1. Induced. |
| | 2. Without warning, ejected to a few feet distance. | 2. Projectile. |
| | 3. Containing only noticeable amount of blood. | 3. Blood Tinged. |
| | 4. Emesis of blood | 4. Hematemesis - state if bright red and fluid, Reddish brown, Clots or coffee ground appearance. |
| | 5. Of undigested food, watery mucus, etc. | 5. State measured amount and appearance. |
| 27. Enemata: | 1. To induce bowel movement | 1. Cleansing enema. |
| | 2. To supply nourishment | 2. Nutritive enema. |
| | 3. To relieve gas distention | 3. Carminative enema. |
| | 4. To expel Worms | 4. Anthelmintic enema. |

Symptomology cont'

| Concerning: | Factors to be Charted. | Suggested Terms To Use. |
|---|---|---|
| | 5. To be retained | 5. Rentention enema. |
| | 6. To stimulate | 6. Stimulation enema. |
| | 7. To facilitate Fluoroscopy. | 7. Barium enema. |
| 28. Eyes: | 1. Yellow in color | 1. Jaundiced |
| | 2. Puffy | 2. Edematous |
| | 3. Drooping eyelids | 3. Eyelids Ptosed |
| | 4. Motionless | 4. Fixed |
| | 5. Sensitive to light | 5. Photophobia |
| | 6. Double vision | 6. Diplopia |
| | 7. Squinting | 7. Strabismus |
| | 8. Abnormal Protrusion of eyeball | 8. Exophthalmos |
| | 9. Inflammation of conjunctiva | 9. Conjunctivitis |
| | 10. Dilitation of the pupil | 10. Mydriasis |
| | 11. Contraction of the pupil | 11. Myosis |
| | 12. Near-sightedness | 12. Myopia |
| 29. Faint: | 1. Fainting | 1. Syncope. |
| 30. Gas: | 1. Gas in the digestive tract | 1. Flatus. |
| | 2. Having gas in the digestive | 2. Flatulence. |
| 31. Hallucinations: | 1. Of hearing | 1. Auditory Hallucinations. |
| | 2. Of sight | 2. Visual Hallucinations. |
| | 3. Of smell | 3. Olfactory Hallucination |
| | 4. Of taste | 4. Gustatory Hallucination. |
| 32. Head: | 1. Forehead | 1. Forehead |
| | 2. Region over Temple | 2. Temporal region |
| | 3. Back of head | 3. Occipital region |
| | 4. Base of Skull | 4. Basilar region |
| 33. Hives: | 1. Hives | 1. Urticaria |
| | 2. Itching | 2. Pruritus |
| 34. Legs: (area) | 1. Thigh to knee | 1. Upper leg (Right or Left) |
| | 2. Knee to ankle | 2. Lower leg (Right or Left) |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| 35. Lice: | 1. Head, Body, Pubic<br>2. Condition of Lousiness | 1. Pediculi<br>2. Pediculosis |
| 36. Medicine: (administration) | 1. By mouth<br>2. By rectum<br>3. Breathing in<br>4. Rubbing into skin<br>5. Under the skin<br>6. Within the skin<br>7. Within the muscle<br>8. Within the Spinal Column<br>9. Within the Vein<br>10. Pouring into body cavity | 1. Orally<br>2. Rectally<br>3. Inhalation<br>4. Inunction<br>5. Subcutaneous<br>6. Intradermal<br>7. Intramuscular<br>8. Intraspinal<br>9. Intravenous<br>10. Instillation |
| 37. Menstruation: | 1. If present when admitted<br>2. If started admission<br>3. Painful<br>4. Excessive<br>5. Total abscence of<br>6. Occuring between periods | 1. Catamenia Present<br>2. Catamenia established.<br>3. Dysmenorrhea.<br>4. Menorrhagia<br>5. Amenorrhea<br>6. Metorrhagia |
| 38. Mental Atitude: | 1. Hard to please<br>2. Distrustful<br>3. Happy<br>4. Sad<br>5. Afraid<br>6. Lacks emotional control<br>7. Loss of memory<br>8. Not helpful, antagonistic<br>9. Inability to coordinate thought or speech | 1. Irritable, fault finding.<br>2. Distrustful, Suspicious<br>3. Optimistic, cheerful.<br>4. Depressed, Moody<br>5. Apprehensive, anxious.<br>6. Hysterical<br>7. Amnesia<br>8. Uncooperative.<br>9. Disorientated, incoherent. |
| 39. Nourishment: | 1. Very small amounts of water<br>2. Small piece of ice<br>3. Drink of water<br>4. Given thru tube into stomach<br>5. Given by enema | 1. Sips of water<br>2. Ice chips<br>3. Water No. of cc.<br>4. Per gavage<br>5. As nutritive enema. |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| 40. Odor: | 1. Like ammonia | 1. Ammonical |
| | 2. Like fruit | 2. Fruity |
| | 3. Very unpleasant | 3. Offensive |
| | 4. Belonging to a particular drug | 4. Characteristic |
| 41. Pain: | 1. Great pain | 1. Severe |
| | 2. Little | 2. Slight |
| | 3. Comes in Seizures | 3. Paroxysmal |
| | 4. Spreads to distant areas | 4. Radiating |
| | 5. Started all at once | 5. Sudden onset. |
| | 6. Hurts worse when moving | 6. Increased by movement. |
| 42. Paralysis: | 1. Of the muscles of the face | 1. Facial |
| | 2. Of the legs | 2. Paraplegia |
| | 3. Of one side of the body | 3. Hemiplegia |
| | 4. of a single limb | 4. Monoplegia (State limb) |
| | 5. Total loss of function | 5. Complete paralysis |
| | 6. Of the Arm | 6. Brachial (State Right or left) |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| 43. Patient: Admission of. | 1. Walking<br>2. By wheel chair<br>3. Carried (infant)<br>4. By stretcher<br>5. Had bed sore when admitted. | 1. Ambulatory<br>2. By wheel chair<br>3. In arms<br>4. By stretcher or Per cart.<br>5. Decubitus present on admission. |
| 44. Patient: Dismissal of. | 1. How dismissed<br>2. Condition<br>3. Was not dismissed by Doctor. | 1. Dismissed by wheel chair, by stretcher, or ambulatory.<br>2. Condition improved, same, unimproved etc.<br>3. Signed own release. |
| 45. Perspiration: | 1. Large amount<br>2. Small amount | 1. Profuse<br>2. Scanty, slight. |
| 46. Positions: | 1. Flat on back, arms straight at sides.<br>2. On side, knees flexed.<br>3. On left side, left arm behind back, left leg slightly flexed, right leg greatly flexed.<br>4. Semi-erect, head elevated knees flexed.<br>5. Semi-erect, head slightly elevated, knees slightly elevated.<br>6. On back, knees flexed and apart, feet on bed.<br>7. Resting on knees and chest.<br>8. On back, Pelvis higher than head.<br>9. On abdomen face turned to one side. | 1. Horizontal.<br>2. Lateral<br>3. Sims<br>4. Fowlers.<br>5. Semi-fowlers.<br>6. Dorsal Recumbent.<br>7. Knee chest or Genu-pectoral.<br>8. Trendelenburg.<br>9. Prone. |
| 47. Proctoclysis: | 1. Began- 40 gtts. Per minutes. | 1. Proctoclysis started flow regulated to gtts XL Per minute. |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| 48. Pulse: | 1. Number of beats per minute. | 1. Rate. |
| | 2. Rhythm | 2. Regular or irregular |
| | 3. Beats missed at intervals. | 3. Intermittent. |
| | 4. Over 100 beats per minute. | 4. Rapid |
| | 5. Very rapid, beats indistinct. | 5. Running |
| | 6. Slow in Rate | 6. Slow. |
| | 7. One scarcely perceptible | 7. Thready |
| | 8. Small, rapid and tense | 8. Wiry. |
| | 9. Seeming weak wave between the usual heart beats. | 9. Dicrotic |
| | 10. Short, powerful, jerky beat which suddenly collapses (usually visible.) | 10. Water-hammer. |
| | 11. Variation in strength of beats. | 11. Unequal. |
| | 12. The difference between The Systolic and diastolic Pressure. | 12. Pulse pressure |
| | 13. Pulseless | 13. Asphyctic. |
| 49. Reproductive Organs: | 1. External Reproductive organs | 1. Genitalia |
| 50. Respirations: | 1. Act of breathing | 1. Respiration |
| | 2. Above 25 respirations per minute. | 2. Accelerated |
| | 3. Induced by artificial means. | 3. Artificial respiration |
| | 4. Snoring | 4. Stertorous |
| | 5. Difficult | 5. Labored, dyspnea. |
| | 6. Slow | 6. Slow state rate. |
| | 7. Breathing moist, rattling sounds. | 7. Edematous. |
| | 8. Respirations increase in rapidity and volume to climax then gradually subside and cease entirely for few seconds. | 8. Cheyne-stokes. |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| | 9. When abdomen does not move--performed entirely by expansion of chest. | 9. Thoracic |
| | 10. Diaphragm chiefly exerts itself, walls of chest nearly at rest. | 10. Abdominal |
| | 11. Fast | 11. Rapid, frequent. |
| 51. RestraintsP | 1. Rails put on bed.<br>2. Tied down with sheet.<br>3. Fastened to bed with ankle straps.<br>4. Fastened to bed with wrist strap.<br>5. Strap around waist fastened to bed. | 1. Siderails applied.<br>2. Sheet restraint applied.<br>3. Right ankle strap applied.<br>4. Left wrist strap applied.<br>5. Restraining belt applied. |
| 52. Rings: | 1. Rubber ring to relieve pressure.<br>2. Cotton rings applied under heels. | 1. Placed on rubber ring.<br>2. Cotton ring or doughnut applied to each heel. |
| 53. Skin: | 1. Normal<br>2. Pink, hot<br>3. Bluish in color<br>4. Very white<br>5. Shines<br>6. Raw Surface<br>7. Yellow in color<br>8. Torn<br>9. Containing colored areas.<br>10. Wet<br>11. Small purplish hemorrhagic spots on the skin | 1. Healthy.<br>2. Flushed.<br>3. Cyanotic<br>4. Extreme Pallor.<br>5. Glossy<br>6. Excoriation<br>7. Jaundiced.<br>8. Lacerated.<br>9. Pigmented<br>10. Moist<br>11. Petechiae, Petechia |
| 54. Sleep: | 1. Slept very little<br>2. Moans while asleep<br>3. Inability to sleep<br>4. Sleepy, drowsy<br>5. Tired when wakens | 1. Slept very little.<br>2. Sleep disturbed, moaning.<br>3. Insomnia, agrypnia<br>4. Somnolent.<br>5. Awakens fatigued. |
| 55. Smoke: | 1. Smokes too much | 1. Smokes excessively |
| 56. Solution: | 1. Having the same tension as that of the blood. | 1. Isotonic |

Symptomology cont'

| Concerning: | Factors to be Charted | Suggested Terms To Use |
|---|---|---|
| | 2. Of greater tension<br>3. Of less tension | 2. Hypertonic<br>3. Hypotonic |
| 57. Specimen: | 1. Sent to laboratory | 1. Specimen to laboratory___ State Special examination requested. |
| 58. Symptoms: | 1. Observed only by the Patient.<br>2. Observed by someone else.<br>3. A group of Symptoms | 1. Subjective<br>2. Objective.<br>3. Syndrome. |
| 59. Teeth: | 1. False teeth<br>2. Decay of<br>3. Collection of food material. | 1. dentures<br>2. Dental caries.<br>3. Sordes. |
| 60. Unconsciousness: | 1. Complete unconsciousness.<br>2. Partial consciousness<br>3. Pretended unconsciousness. | 1. In comatose condition.<br>2. In Stuporous condition.<br>3. Feigned unconsciousness. |
| 61. Urination: | 1. To urinate<br>2. No control over urination.<br>3. Burning when voids<br>4. Large amounts of urine voided.<br>5. Frequent voiding at night.<br>6. Increased amounts voided<br>7. Painful Urination<br>8. Blood in the urine<br>9. Scantiness of urine<br>10. Color of urine | 1. Void, micturate. (State amount.)<br>2. Involuntary, incontinent.<br>3. Burning Sensation when voiding.<br>4. Diuresis<br>5. Nocturia<br>6. Polyuria<br>7. Dysuria<br>8. Hematuria<br>9. Oliguria<br>10. (Amber-normal<br>orange-red-<br>black-Melanuria<br>Bile colored<br>Blue<br>Colorless-<br>Achromaturia<br>Pale |

Symptomology cont'

| Concerning: | Factors to be Charted. | Suggested Terms To Use |
|---|---|---|
| 62. Vomit: | 1. Desire to<br>2. Contents<br>3. Nature of vomitus | 1. Nausea<br>2. Vomitus-Emesis<br>3. Green or greenish yellow-bilious. Fecal-Blood-hematemesis |
| 63. Weight: | 1. Overweight<br>2. Thin, underweight<br>3. Amount weighed | 1. Obese<br>2. emaciated<br>3. Wt. 130 lb. |
| 64. Wounds: | 1. Not infected<br>2. Infected<br>3. Discharging pus<br>4. Slight<br>5. Deep<br>6. Torn | 1. Clean<br>2. Infected<br>3. Suppurating<br>4. Superficial<br>5. Deep<br>6. Lacerated. |

# Chapter VII

## Assisting With Physical Examinations

### A. Routine Physical Examination

Requisites:
Examination tray containing:
1. Sterile tongue depressors
2. Flashlight
3. Stethoscope
4. Sphygomanometer
5. Percussion hammer
6. Tape measure
7. Small towel
8. Otoscope

Measures by which the doctor carries out his physical examination of the patient.

1. Inspection or observation of general appearance, with special attention to general nutrition, color and texture of skin and hair, and body build.
2. Manipulation to discover limitation of motion.
3. Palpation, or examination by touch, to discover tenderness, the presence of tumors, etc.
4. Percussion, or tapping, expecially of the chest wall.
5. Measuring, to discover inequalities or enlargements.
6. Ausculation, or listening, to discover abnormal sounds, expecially of the heart and lungs.

Procedure:
1. Give the patient some information as to what you are going to do. In some cases, a feeling of timidity and excessive modesty makes the physical examination a trying ordeal, and the nurse can do much to relieve fear and timidity by a friendly and understanding attitude.
2. Close the windows, put up the shades, loosen the bedclothing and gown, place towel over the patient's chest.
3. In examinations of the throat and mucous membranes, a flashlight and wooden tongue depressor are needed. If the doctor uses a head mirror, the light should be behind the patient.
4. In examination of the eyes, flashlight to determine reaction to light. If ophthalmoscope is to be used, to examine the retina, darken the room.
5. In examinations of the ears, patient is usually asked to turn his head first to one side and then to the other. The nurse is responsible for the cleaning and care of the otoscope and used speculum.
6. The neck is examined to determine any enlargements of the glands and rigidity of the muscles.

Physical Examinations cont'

Procedure:

7. In examination of the chest, doctor may want the patient to lie down or sit up. The chest is examined by means of the percussion with the fingers to reveal any areas of dullness, rales, changes of breath sounds or presence of fluid in the pleural cavity. When patient is asked to cough or breathe with mouth open, nurse should protect the examiner by holding a small towel in front of patient's mouth.
8. In examinations of the back, patient is usually asked to sit up in bed. If patient is in a weakened condition, the nurse may assist in supporting him by standing at the foot of the bed and hold his wrists, or turn patient on his side away from the doctor.
9. In examinations of the abdomen, the chest remains covered with the gown or towel folded back well above the waist line and sheet folded smoothly across the pubis.
10. Lower limbs; in examination, drape bed linen toward the middle of the bed, uncover legs from the sides, When both legs are being examined, drape sheet between the legs.

B. Special Examinations

In other than routine examination, drape patient for doctor's convenience and patient's protection.

1. Pelvic or Vagina

Requisites:

1. Rubber gloves
2. Lubricant
3. Vaginal speculum
4. Flashlight
5. If indicated, vaginal forceps cotton applicators, glass slides, culture tubes.

Procedure:

1. Explain procedure to patient and provide adequate privacy.
2. Have patient void cleanse external genitalia and rectum.
3. Drape patient and place in dorsal recumbent position, place small towel under patient's buttocks.
4. Assist doctor with glove and lubricant.
5. Reassure patient and instruct patient to relax.
6. Tidy the unit, clean and care for the equipment.

2. Rectal or Proctoscopic

Requisites:

1. Gloves
2. Powder
3. Lubricant
4. Anal speculum

For proctoscopic examinations, the doctor usually supplies own proctoscope.

Special Examinations cont'

Procedure:
1. Proceed as for "Vaginal Examination"
2. Place patient in position, desired by doctor usually dorsal, knee chest or sims.

3. Neurological Examination
Requisites:
1. Flashlight
2. Percussion hammer
3. Otoscope
4. Tuning fork

Procedure:
1. Place patient in desired position.
2. Assist doctor as indicated.

## Positions

Purpose:
1. To place patient in proper positon for special types of physical examniations.
2. To avoid unecessary exposure.

A. Dorsal (Generally preferred for vaginal and rectal exams)
On back, arms across chest or at side, a pillow under head.
1. Dorsal recumbent..on back with hips and knees flexed, knees apart, with the soles of the feet resting up on the bed.
2. Dorsal elevated..on back, head and shoulders are elevated at an angle of 30 degrees or more. Knees are flexed and apart as in dorsal recumbent.
3. Dorsal lithotomy..
   a. In bed...patient on back across bed, buttocks slightly beyond edge of mattress, hips slightly elevated with pillows; knees flexed on abdomen and held in position by strap or folded sheet passed upward over one shoulder, and pinned about flexed knees.
   b. On examining table...patient in dorsal position with knees flexed. The feet are placed in elevated stirrups at foot of table.

B. Fowlers (Generally preferred in abdominal and chest surgery.
To promote drainage and localize infection, relieve muscle strain, and to relieve dyspnea.
1. Elevate the head of bed so that the trunk of the body will be at angle of 45 degrees with normal level of the bed.
2. Flex the knees by adjusting knee gatch or use pillows if indicated.

Positions cont'

C. Knee-Chest (or Genupectoral) Generally preferred for vaginal, rectal, and post-partum examinations.
    1. Allow one small pillow for head
    2. Patient rests on chest and knees. Knees slightly separated; face turned one side resting on the pillow; thigh perpendicular; arms free at both sides.

D. Prone (Burns or injury to Back)
    Flat on abdomen with face turned to one side.

E. Sims or Left Lateral..rectal or vaginal examinations.
    1. Patient lies on left side right knee flexed and drawn up nearly to abdomen.
    2. Left knee slightly flexed; left arm drawn under the side to back.
    3. Right arm free in front.

F. Standing or erect (examination of feet, spine, and certain neurological abnormalities)
    1. Place covering on floor
    2. Provide a support such as a chair if necessary.

G. Trendelenburg (used in surgery during operations or pelvic organs)
    1. Patient lies on back on examining table which is tilted at one angle of 45 degrees; head is low and thighs high. The body on an inclined plane and the knees flexed over the adjustable lower section of the table.
    2. Shoulder supports are used to prevent patient from slipping.

H. Modified Trendelenburg ("Shock" position)
    Foot of bed is elevated.

# Chapter VIII

## Enemas

Types

A. Cleansing enema..to soften hardened fecal matter and to stimulate the contraction of the colon.

Solutions usually ordered:
1. Soap Suds... ½ ounce to one pint
2. Normal Saline solution... 1 dram to 1 pint
3. Tap water.

B. Carminative enema..to relieve abdominal distention.
1. 1-2-3 solution — 1 oz. magnesium sulfate, 2 oz. glycerin, 3 oz. water
2. Sugar and soda... — 2 oz. sugar, 1 oz. soda, 8 oz. water
3. Milk and molasses — 8 oz. milk, 8 oz. molasses

C. Retention enemas (temperature 105 degrees) to soften fecal material
1. To..soften
   a. oil..olive, cotton seed, mazola, or mineral oil.
2. Emollient..to soothe irritated mucous membrane. Dissolve 1 oz. of cornstarch in 1 oz. of cold water. Mix to a smooth paste and add 5 oz. of boiling water. Boil 1-2 minutes and cool to 100 degrees F. If drug (Tincture Opium, Laudanum) is prescribed, add to the enema just before giving.
3. Nutritive..rectal feeding. Solution as ordered.
4. Medicated:
   a. Sedative
      1) Chloral Hydrate..as ordered. Dissolve in 4 oz. water or milk.
      2) Paraldehyde..as ordered. Mix in 4 oz. warm oil or milk. Never water.
      3) Sodium Bromide..as ordered.. Dissolve in 4 oz. warm water or milk.
      4) Avertin..as ordered. Administered by anesthetist.
5. Stimulating
      1) Strong black coffee..120-180cc.
      2) Normal Saline 120cc plus 60cc brandy or whiskey.

D. Anthelmintic..to expel intestinal worms.
1. Quassia..500cc of hot water is poured over one ounce of quassia chips. When cooled to 105 degrees F. The

Enemas cont'

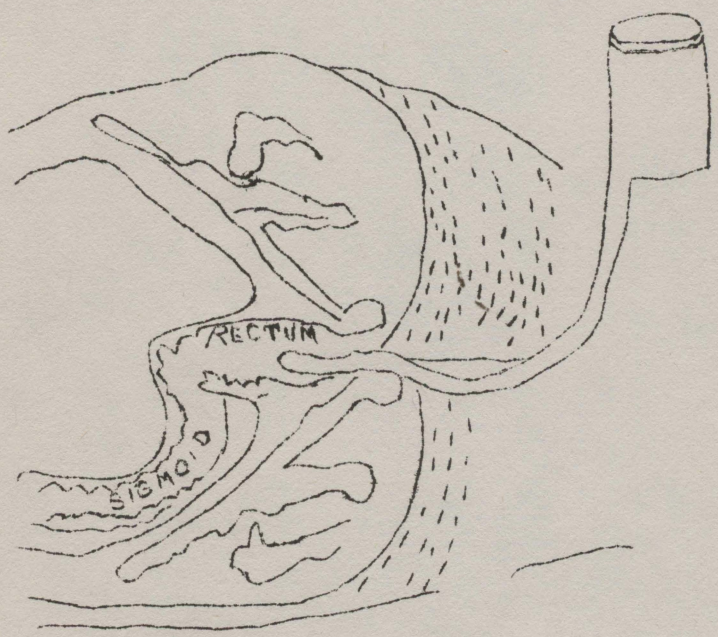
fluid is drained off. A purgative enema is given followed by an anthelmintic. If the solution is not expelled in 30 minutes, it is siphoned off.

2. Tannic Acid...one pint of hot water is poured over 30 grains of tannic acid. Solution is cooled to 105 degrees F.
3. Alum...one pint of hot water is poured over 30 grains of drug. Solution is cooled to 105 degrees F.

## Simple Enema

Requisites:

1. Tray containing:
   a) two quart irrigating can with 1000cc solution ordered, tubing, clamp, and connector.
   b) size 20-24 rectal tube
   c) lubricant
   d) folded newspaper
   e) toilet tissue
   f) bed pan cover
2. Bed pan




Procedure:

1. Assemble all equipment.
2. Prepare solution ordered.
   (Soap suds solution is prepared in a pitcher of warm water with a soap shaker containing a pure white mild toilet soap. The solution is tested with a bath thermometer, and water is added until the correct temperature (105 degrees F.) is obtained. The solution is poured into the irrigating can and the froth from the solution is removed.)

Enemas cont'

3. Carry tray containing requisites to bedside and place on cleared bedside table.
4. Place bedpan on chair..close to the foot of the bed.
5. Explain treatment to patient and provide adequate privacy.
6. Fan fold covers to foot of bed. Apply bath blanket.
7. Place folded newspapers under buttocks.
8. Instruct patient to lie on left side with knees flexed.
9. Attach rectal tube to rubber tubing, Release clamp on tubing. Expel air by running solution through tubing into bedpan. Reclamp tubing.
10. Put lubricant on folded toilet tissue and lubricate end of rectal tube four inches.
11. Separate the buttocks and insert tube into rectum with a slight boring motion.
12. Release clamp holding tube in place, pick up irrigating can and hold it about 18 inches above level of rectum.
13. Allow solution to flow slowly. Regulate flow by raising or lowering can in accordance to patient's ability to retain solution. (Rapid distention of the colon stimulates contraction and the desire to evacuate).
14. When the solution has been taken, close clamp on tubing, compress rectal tube, withdraw slowly and gently, wrap toilet tissue around tube, and place on tray.
15. Place patient on bedpan, elevate head of bed if allowed, have signal light, toilet paper in a convenient place.
16. Care for equipment.
17. Observe patient frequently..when signaled, remove bedpan and newspaper.
18. Provide patient with equipment to cleanse hands.
19. Ventilate room. Leave patient comfortable and unit neat.
20. Record: Time, procedure, type and amount of solution, character of results, observation of patient. Signature of nurse.

## Retention Enema Procedure

Requisites:

1. Tray containing
   a) Solution ordered
   b) Rectal tube
   c) Funnel
   d) Graduate
   e) Folded newspaper
   f) Toilet tissue with lubricant

Procedure:

1. Prepare solution ordered at correct temperature.
2. Carry covered tray with requisites to bedside.
3. Explain treatment to patient and provide adequate privacy.

Retention Enema cont'

Procedure:

4. Prepare patient as for a cleansing enema.
5. Attach rectal tube to funnel and lubricate end of tube.
6. Separate buttocks, insert tube gently and slowly for about 4 inches.
7. Pour solution in funnel. Solution must be given slowly in ordered to be retained.
8. When solution has been taken, clamp tube with fingers and withdraw slowly. Wrap toilet tissue around tube and place on tray.
9. Instruct patient to retain solution.
10. Care for equipment and leave unit neat.
11. Record: time, type and amount of solution used, and ability to retain. Signature of nurse.

General Instructions:

1. When giving small amount of solution (example 1-2-3 enema) as evacuating enema, use equipment as indicated under retention enema.
2. If the patient has difficulty in relaxing in order to take sufficient fluid to produce effective peristalis, direct him to breathe deeply through his mouth.
3. If abdominal cramping occurs before sufficient solution has been taken, clamp tubing until cramp has subsided, then release clamp.
4. If fluid does not flow freely into rectum, change position of rectal tube. If this does not facilitate the flow of fluid, the tube must be completely removed, cleaned, and reinserted.
5. If patient is not cooperative or cannot retain the fluid, it will be necessary to place him on the bedpan while instilling it.
6. If patient has a cardiac condition or is very ill, the nurse should remain with him or return frequently as the treatment may exhaust him.
7. All enemas are to be given by nurses with the patient lying down. Solution may be expelled in bedpan, commode, bathroom, in accordance with patient's condition and the doctor's orders.

## Siphoning Off an Enema

Purpose:

If patient is unable to expel or evacuate enema in ½ hour, it may be necessary to siphon it off to relieve abdominal distress.

Requisites:

(Same as retention enema using warm water as your solution)

Siphoning Off an Enema cont'

Procedure:

1. Carry tray with requisites to bedside.
2. Explain treatment to patient and instruct him to turn on left side.
3. Place bedpan on bedside beside patient.
4. Lubricate and insert the rectal tube.
5. Solution should drain freely into bedpan. If not attach funnel to rectal tube, and pour small amount of warm water into funnel.
6. Remove funnel and lower rectal tube into bedpan. This creates a siphon and solution should return. If not, repeat step number 5.
7. Record: Procedure, character and amount of solution returned and observation of patient. Signagure of the nurse.

## To Remove a Fecal Impaction

Requisites:

1. Glove
2. Lubricant
3. Folded newspaper

Procedure:

1. Place folded newspaper under patient's hips and place bedpan in bed.
2. Instruct patient to turn on left side. Explain treatment to patient and provide adequate privacy.
3. Put on glove, lubricate index finger well.
4. Gently insert finger into anus; work around the sides of the impacted mass to loosen it.
5. Break up mass, remove feces, using only gentle pressure.
6. Points to remember:
   a) never use force
   b) an oil retention enema will help to soften feces.
   c) after impaction has been removed or loosened, an evacuating enema may be given.
7. Record procedure and results, signature of the nurse.

# Chapter IX

## Local Application of Heat and Cold

### Sitz Baths

Purpose:

1. To relieve tenesmus in uterine and renal colic
2. To relieve pain, congestion, and inflammation in the organs of the pelvis.
3. To relieve pain and congestion caused by hemorrhoids and promote drainage of a rectal abcess.
4. To relax the sphincter of the bladder
5. To relieve sciatica.

Requisites:

1. Bath thermometer
2. Sitz tub or bath tub
3. Bath blanket (two)
4. 3 Bath towels
5. 2 Wash cloths
6. Rubber ring
7. Pitcher
8. Clean gown

Procedure:

1. Draw water to depth of 6 inches (100 degrees F.)
2. Bring patient to room in wheel chair.
3. Place folded bath towel over edge of sitz tub under knees, and at back to prevent contact with tub.
4. Place rubber ring (slightly inflated and covered) in bottom of sitz tub.
5. Assist patient into tub and drape bath blanket over shoulders.
6. Place cold wash cloth on forehead for comfort, if indicated.
7. From time to time add water 125 degrees from pitcher, pouring carefully away from the patient, to increase temperature of bath not to exceed 120 degrees.
8. Allow patient to remain in tub for the time ordered usually 10-20 minutes.
9. Do not leave patient alone and watch for signs of syncope and fatigue. If these symptoms appear, discontinue treatment and assist patient to bed.
10. Assist patient from tub, help dry, and return to bed per wheel chair, being careful to prevent chilling.
11. Clean tub and care for equipment.
12. Record: time, sitz bath, temperature and duration of treatment, observation of patient. Signature of nurse.

### Medicated Baths

(Consists in immersing the patient's body in a tub of water to which various substances have been added)

Medicated Baths cont'

Purpose:
1. To alleviate skin affections
2. As a nerve sedative, and circulatory stimulant.

A. Otmeal..to soothe and alleviate skin affections.
Obtain oatmeal (which is enclosed in a cheese cloth bag from Central Supply). Pour one quart of boiling water over bag and cook until thick (5-10 minutes). Fill bath tub about ½ full with water (100-105 degrees F.) Swish porridge bag about in the tub until the water is a milky white. This porridge bag may be used as a sponge to wipe over the patient's skin in removing old salve, lotion, and dried scales.

B. Starch..to produce an emollient effect.
One pound of cornstarch to a bath tub 2/3 full of water. Mix the starch into a smooth paste with cold water; add hot water; boil until thick; add to bath water. If the cornstarch or oatmeal is used in the raw state, the substance will sink to the bottom and the purpose will not be achieved.

C. Soda Bicarbonate..to relieve itching.
Prepare bathing solution by dissolving soda in a small amount of warm water then adding to bath water to the ratio of 8 ounces of soda Bicarbonate to 1 gallon of water.

D. Bran..to soothe, soften, and relax tissue.
Tie 2 pounds of bran in a loose muslin bag and place in a deep basin. Pour boiling water over bag and let soak 10-15 minutes. Press moisture from bag and add all the fluid to a 2/3 tub of water.

Procedure:
1. Prepare tub with bath solution ordered 100-105 degrees F.
2. Proceed in same manner as for general tub bath leaving the patient in tub for time ordered.
3. Pat the skin gently with towel to dry leaving the emollient to cover the skin.
4. Record: time, type of bath, temperature, duration, patient's reaction.

Note: If condition of patient contra-indicates tub bath, any-one of solutions listed may be applied as a sponge bath.

## Tepid-Sponge bath

Purpose:
1. To stimulate circulation

Tepid-Sponge Bath cont'

Purpose:
2. To increase elimination
3. To relieve restlessness and provide comfort
4. To reduce body temperature

Types of Solution
1. Alcohol..mixture of half water and half alcohol
2. Tepid water

Requisites:
1. Bath blanket
2. Icebag with cover
3. Hot water bottle with cover (120 degrees F.)
4. Two bath towels
5. Three wash cloths
6. Basin of bathing solution. (78-85 degrees F.) Temperature of solution depends upon age and condition of patient.
7. Bath thermometer.

General Instructions:
1. Cold baths should be given quickly to produce a marked effect on the circulatory system, through a rapid variation in temperature.
2. Friction is used to bring the blood to the surface and to increase the rate of circulation, thus hastening the cooling process.
3. Water is applied freely to regions where large blood vessels are near the surface of the body, such as the inner surfaces of the arms and thighs, the bend of the elbows and knees, the axilla and groins.
4. Chilling should be avoided by keeping the surroundings free from drafts, applying heat to the feet, exposing only the area to be treated and keeping the rest of the body covered, and avoiding the use of too large areas at any given time.

Procedure:
1. Prepare bathing solution, (75-85 degrees F.).
2. Check temperature, pulse and respiration especially noting the quality of the pulse.
3. Assemble requisites at bedside and explain treatment to patient .
4. Fanfold top bedding to foot of bed and cover patient with a bath blanket.
5. Remove gown.
6. Place hot water bottle (120 degrees F.) at feet and icebag on head.
7. Sponge face and neck and dry.
8. Wring a bath towel out of the bathing solution and drape lengthwise over the chest, abdomen, and groins. Renew this every three minutes.
9. Wring two wash cloths out of the solution and place in each axilla. Renew this every three minutes.

Sponge Bath cont'

Procedure

10. Sponge body with third wash cloth. Place remaining towel under extremity to be sponged and sponge in the following order:
    a) arms and hands
    b) chest
    c) thigh
    d) legs
    e) back
11. Check pulse frequently during treatment.
12. Check temperature and pulse following the treatment and ½ hour later.
13. The usual duration of the sponge should be approximately 20 minutes:
    a) 8 minutes for arms and chest
    b) 8 minutes for legs
    c) 4 minutes for back
14. Give complete warm alcohol rub at completion of treatment to open the pores which have been contracted by means of the cold sponge.
15. Record: time and duration of treatment, temperature, pulse, respiration, before and after the treatment, observation and reaction of the patient. Signature of nurse.

## Foot Bath

Purpose:
1. To promote circulation in legs and feet
2. To relieve congestion in head and pelvic viscera.

General Instructions:
1. If patient is able to sit in a chair, the tub of water may be placed on the floor or on foot stool.
2. The temperature is usually 105 degrees F., but it may be raised to 115-120 to relieve congestion in the pelvic viscera.
3. When hot water is added to tub, use caution in pouring in order to prevent burning the feet.
4. If mustard is to be added, tie 15 grams (4 teaspoons) mustard in a piece of gauze, immerse in tepid water to dissolve and add this solution to foot tub of water 100 degrees F.
5. Dreft soaks.. Use ½ cup dreft to half tub full of water.

Requisites:
1. Bath thermometer
2. Bath blanket
3. Rubber square
4. Foot tub half full of water at desired temperature
5. Bath towels
6. Pitcher of hot water
7. Medication, if ordered

Foot Bath cont'

Procedure:
1. Assemble requisites and explain the nature of procedure to patient.
2. Release upper bed linens at foot and fold back to knees.
3. Place rubber square covered with towel, under the patient's feet.
4. Place the foot tub of bathing solution on rubber square; flex the patient's knees, and place feet in the tub.
5. Drape the bath blanket around the legs and tuck under the foot tub to prevent its sagging into the water. Draw upper bed linens down over the bath blanket.
6. At intervals, turn bedding back, test the temperature of the water, and add warm water as necessary to maintain a constant temperature.
7. The duration of the bath is from 5-30 minutes, as ordered. Discontinue treatment, dry feet thoroughly, and wrap them in a dry blanket for 20-30 minutes.
8. Record: time and duration of treatment, type and temperature of solution used, observation and reaction of patient. Signature of nurse.

## Arm Bath

Purpose:
1. To localize infection
2. To relax muscles, tendons, and ligaments.

Types of solutions used:
1. Magnesium sulfate
2. Boric acid
3. Dreft
4. Mustard

General Instructions:
1. Sterile precautions must be maintained throughout the procedure if an open skin lesion is present.
2. The temperature of the solution 105-120 degrees F, according to the skin sensitivity of patient, the degrees of cellutitis present, or order of physician.
3. Prepare sufficient amount of solution in order that warm solution (125 degrees F.) may be added to maintain constant temperature.

Requisites:
1. Arm soak tub (obtain from Central Supply)
2. Solution as ordered
3. Sterile bath thermometer
4. Sterile towel-surgical dressings
5. Newspapers

Procedure:
1. Sterilze arm soak tub by filling it $\frac{1}{4}$ full of water, cover with lid, place a towel over arm opening, and boil for 10 minutes.

Arm Bath cont'

Procedure:

2. Prepare prescribed solution, fill arm soak half full and heat to 105 degrees F.
3. Place bedside table near the bed, lower to a convenient height, and cover top with several layers of newspapers.
4. Move patient as near the edge of the bed as possible. Roll sleeve of gown up over the elbow.
5. Place arm soak tub on bedside table.
6. Remove dressings using aseptic precautions, unless dressings are ordered to remain in place.
7. Immerse hand and arm in solution,
8. Leave arm immersed for time ordered, adding additional warm solution as necessary.
9. When treatment is discontinued, remove from solution, and wrap arm loosely in sterile towels.
10. Remove tub and equipment from bedside table and place arm in towel on bedside table. Apply necessary sterile dressings.
11. Care for equipment, disinfect tub and return to Central Supply.
12. Record: time, and duration of treatment, strength, type, and temperature of solution, condition of area immersed, patient's reaction, and signature of nurse.

## To Fill And Apply A Hot Water Bottle

Purpose:

1. To apply dry heat for comfort
2. For therapeutic effects
3. To maintain constant temperatures of moist applications

Requisites:

1. Hot water bottle
2. Water 120 F. for adults; lower temperature for children and aged.
3. Cover
4. Bath thermometer
5. Pitcher

Procedure:

1. Mix hot and cold water in pitcher, test with thermometer, until desired temperature is obtained.
2. Fill bottle ½ full of water.
3. Expell air and screw on cap.
4. Test for leaks by turning the bottle upside down. Dry, cover, and apply as ordered.
5. Refill as necessary if application is to be continuous.
6. Precautions. Apply only:
   a) when ordered by doctor
   b) when stated in a procedure
   c) in an emergency or advice of supervisor
7. Record: time, temperature of water, area and purpose of application.

## To Fill and Apply an Ice Cap and Ice Collar

Purpose:
1. To apply dry cold for comfort
2. Therapeutic effect such as:
   a) checking hemorrhage
   b) preventing or reducing swelling and inflammation
   c) reducing body temperature

Requisites:
1. Ice cap
2. Cover
3. Cracked ice
4. Ice scoop

Precedure:
1. Using scoop fill ice cap ½ full.
2. Expel air by gently compressing sides, replace screw top or close neck and test for leaks, dry.
3. Cover and apply as ordered. Be careful that ice cap does not press on bony prominences or sensitive areas.
4. Refill frequently if ice application is to accomplish its purpose.
5. Precautions:
   a) Apply only if ordered by doctor or stated in a procedure.
   b) Always cover to avoid frost bite or ice burn
   c) Do not force large pieces of ice into ice cap or collar.
6. Record: time of application and renewal, purpose and region to which applied. Signature of nurse.

## Sterile Hot Compresses

Purpose:
1. To relieve inflammation by dilating superficial blood vessels.
2. To relieve pain locally and in adjoining parts.
3. To reduce swelling by stimulating the absorption of effusion.
4. To help localize infections.

Requisites:
A. Tray containing:
1. Basin with prescribed solution
2. Two forceps in disinfecting solution
3. Oiled silk
4. Sterile compresses
B. Electric plate
C. Hot water bottle 120 degrees F.

Procedure:
1. Assemble requisites and carry to bedside.
2. Explain treatment to patient and provide privacy.
3. Heat solution on electric plate
4. Expose part to be treated, draping as necessary, and place towel (bath) or binder underneath part to be treated.

Sterile Hot compresses cont'

Procedure:

5. When solution is boiling, place compresses in solution and soak thoroughly. Wring out compresses with 2 straight forceps. Have compresses moist but not dripping.
6. Shake compresses and allow steam to escape.
7. Apply gradually to area.
8. Cover with oiled silk.
9. Place hot water bottle (120 degrees F.) on oiled silk and fold towel or binder over entire dressing to hold them in place. Refill hot water bottle frequently.
10. Precautions:
    a) Avoid burning the patient. Apply mineral oil or vaseline if skin is red and sensitive. Record and report condition to head nurse.
    b) Discard used compresses, they can not be reheated.
    c) Use fresh solution and fresh basin each day. Keep basin well covered with sterile towel.
    d) If necessary use bandage or adhesive to secure compresses in place. In any event take the necessary measures to keep patient comfortable and dry.
11. When treatment is discontinued, apply dry sterile dressing.
12. Clean and care for equipment.
13. Record: treatment, area to which applied, time began, renewed, and discontinued, amount and character of drainage, and effect of treatment. Signature of nurse.

For using a heat cradle and asepto syringe.

1. A tray containing:
    a) 5 yard roller (sterile)
    b) Covered sterile pitcher or basin with ordered solution
    c) Asepto syringe
    d) Oiled silk
    e) Bath towels and safety pins
    f) Sterile gloves
    g) Sterile dressing
2. Small heat cradle with bulb
3. Rubber pillows for elevation

Procedure:

1. Heat solution in treatment room and carry equipment to bedside. Explain procedure to patient and provide privacy.
2. Solution may be tested by dropping solution on front of wrist with the asepto syringe.
3. Drape patient as necessary and expose part. Place bath towel under area to be treated.
4. Open dressing and 5 yard roller. Drop in solution being careful not to contaminate.
5. Put on gloves, wring dressing and 5 yard roller and apply to area.
6. Enclose entire dressing in oiled silk. Fold bath towel over entire dressing, and pin securely.
7. Elevate part on rubber pillow if ordered.

Using Heat Cradle cont'

Procedure:

8. Place heat cradle in appropriate position being careful that the distance from bulb to area is at least 12".
9. Place bath blanket over cradle adjusting it to protect patient's eyes.
10. To moisten dressings as necessary, reheat solution and apply with asepto syringe quantity sufficient to make dressings moist.
11. Instruct the patient in the correct conduct during the use of the heat cradle.
12. Use a fresh solution, basin, and asepto syringe daily. Small compress may be discarded. Five yard roller is to be washed dried, and resterilized daily.
13. When treatment has been discontinued, apply dry sterile dressing.
14. Clean and care for equipment.
15. Record: treatment, time began, renewed, discontinued, kind and strength of solution used, drainage if any, effects, and signature of nurse.

## Cold Compresses

Purpose:

1. To relieve pain, congestion, and inflammation
2. To check hemorrhage
3. To prevent abcess formation and suppuration

Requisites:

1. A tray containing:
   a) Basin 3/4 full of large pieces of ice with small amount of water.
   b) Compress of suitable size
   c) Rubber square or oiled silk..depending upon area to be treated.
   d) Large gauze square

Procedure:

1. Carry requisites to bedside and explain treatment to patient.
2. Provide privacy and expose area to be treated.
3. Protect bedding with rubber square or oiled silk, and place patient in comfortable position.
4. Put compresses in ice water, wring with hands and apply as quickly as possible.
5. Change compress frequently, ordinarily every minute for 15-20 minutes. Cold compresses are usually applied for 15-20 minutes every2 hours.
6. Cold compresses are never sterile but the technique of application can be rendered fairly sterile by the use of sterile equipment and forceps for handling the compresses.
7. If cold compresses are applied to a large area, place a hot water bottle at the feet and take all necessary steps to prevent chilling.

Cold Compresses cont'

Procedure:

8. If area of skin is very sensitive, stretch a piece of gauze over the top of basin and hold in placewith a rubber band. Place compresses on the gauze allowing compresses to come in contact with ice but preventing chips of ice from sticking to gauze.
9. Observe area closely for evidence of ice burn, if application is of long duration.
10. When treatment is discontinued, discard compresses, clean and care for equipment.
11. Record: treatment, time began, renewed, and discontinued, type of solution used, effects, and signature of nurse.

## Abdominal Fomentations or Stupes

Purpose:

To relieve abdominal distention by stimulating peristalis.

Requisites:

Tray containing:

1. Large basin
2. Stupe ringer
3. Three flannel cloths
4. Oiled silk
5. Rectal tube and urinal
6. Binder and safety pins
7. Hot water bottle
8. Vaseline

Procedure:

1. Explain procedure to patient and provide privacy.
2. Insert rectal tube and direct opposite end into urinal.
3. Fill basin 2/3 full of water. Place stupe wringer containing flannel in basin, and heat in utility room.
4. Carry tray containing necessary requisites to bedside.
5. Fold back upper bed linens to the lower edge of the abdomen and draw gown up over chest. Place binder in position under the patient.
6. Apply vaseline to skin.
7. Wring out flannel by turning the sticks in the opposite direction.
8. Shake flannel to incorporate air, apply to abdomen accustoming patient to heat gradually.
9. Cover with oiled silk, followed by dry flannel.
10. Place hot water bottle (120 degrees ) on stupe and pin binder.
11. Cover the patient.
12. Prepare second fomentation placing on abdomen as the first one is removed.
13. Compresses are changed every hour, and treatment continued for the length of time ordered.
14. After removing the last compresses, cover the area with a dry piece of flannel and keep warm until the redness subsided.

Abdominal Fomentations cont'

Procedure:

15. Allow rectal tube to remain in place 20-30 minutes after completion of procedure.
16. When treatment is discontinued, clean and care for equipment.
17. Record: treatment, time of application, length and frequency of renewal, condition of skin, relief obtained, and signature of nurse.

## Turpentine Stupes

Requisites:

1. Same as for abdominal stupes plus
2. 1 dram of turpentine in 4-6 drams of olive oil
3. Gauze squares.

Procedure:

1. Proceed as for abdominal stupes.
2. Shake bottle containing oil and turpentine to mix well. Moisten gauze square with this mixture and apply to abdomen.
3. Apply hot wet flannels, oiled silk, hot water bottle, and binder.
4. Apply medication before every third application of flannel.
5. When treatment is discontinued, dry abdomen, gently and cover with warm flannel until redness subsides. If skin is very red, a thin layer of mineral oil or vaseline may be applied.
6. Record as above.

# Chapter X

## Catheterization and Related Procedures

### Catheterization of A Female Patient

Purpose:

1. To remove urine from bladder to relieve retention
2. To remove urine from bladder for diagnostic purposes
3. To measure residual urine in the bladder

Requisites:

1. Catheterization tray containing:
    a. Wide mouthed bottle of aqueous merthiolate
    b. Two folded newspapers
    c. Lubricant with water base
    d. A good light
    e. Catheter Set
        (1) Sterile pan with four cotton pledgets and warm sterile water
        (2) Sterile kidney basin
        (3) Sterile 500 c.c. graduate
        (4) Two sterile applicators
        (5) Two sterile rubber catheters. Size 14 and 12
        (6) Two sterile gauze squares
        (7) Two sterile finger cots
        (8) One sterile towel



Catheterization of Female cont'

Procedure:

1. Assemble requisites and carry to bedside.
2. Reassure patient and explain what is to be done.
3. Screen patient. Drape with bath blanket, and fan fold covers to foot of bed.
4. Place light so it will focus well on area.
5. Place tray in convenient place at foot of bed.
6. Place one folded newspaper well under buttocks and one in a convenient place at foot of bed.
7. Place catheter set in position and open cover so that one corner may be tucked under buttocks.
8. Express a small amount of lubricant on the sterile cover close to the sterile basin.
9. Pick up two sterile applicators with the sterile square, being careful not to contaminate the basin, and place them in the open merthiolate bottle.
10. Wash hands.
11. Dry hands with sterile towel, and place towel over thigh nearest you.
12. Put a finger cot on the first finger and thumb of left hand.
13. Separate the labia with these fingers. Cleanse the labia minora with pledgets squeezed out of the water, using one for each side. Use a third pledget to cleanse over meatus, using a downward stroke, and leave pledget over vagina.
14. Keep labia separated until after catheter is inserted into the bladder.
15. While meatus is thus exposed, pick up the applicator with the right hand and paint the meatus well. Discard the applicator on the newspaper.
16. Pick up sterile square with right hand thumb and first finger and with it grasp catheter about two inches from tip.
17. Lubricate the tip very carefully.
18. Insert catheter carefully (about two or three inches) and hold in place and direct flow of urine into the sterile kidney basin. When flow has stopped, withdraw catheter slightly and allow urine to drain.
19. Compress catheter and withdraw. Place catheter in cleansing basin.
20. Use graduate to measure urine.
21. Paint the meatus with remaining applicator.
22. Remove pledget from vagina and dry parts. Remove newspaper.
23. Remove and clean equipment. Leave patient comfortable and unit neat.
24. Record: time, amount, purpose, disposition of urine and signature of nurse.

Male Catheterization Tray.

1. a. Two to four sterile strips
   b. One sterile Coude Catheter. Hard Rubber Size 14.
   c. One sterile Coude Catheter. Soft Rubber Size 14.
   (a,b, and c wraped in sterile towel.)
2. Ky jelly
3. Sterile basin with Boric Solution covered with sterile

Male Catheterization Tray cont'

towel.
4. Kidney basin
5. Folded newspapers

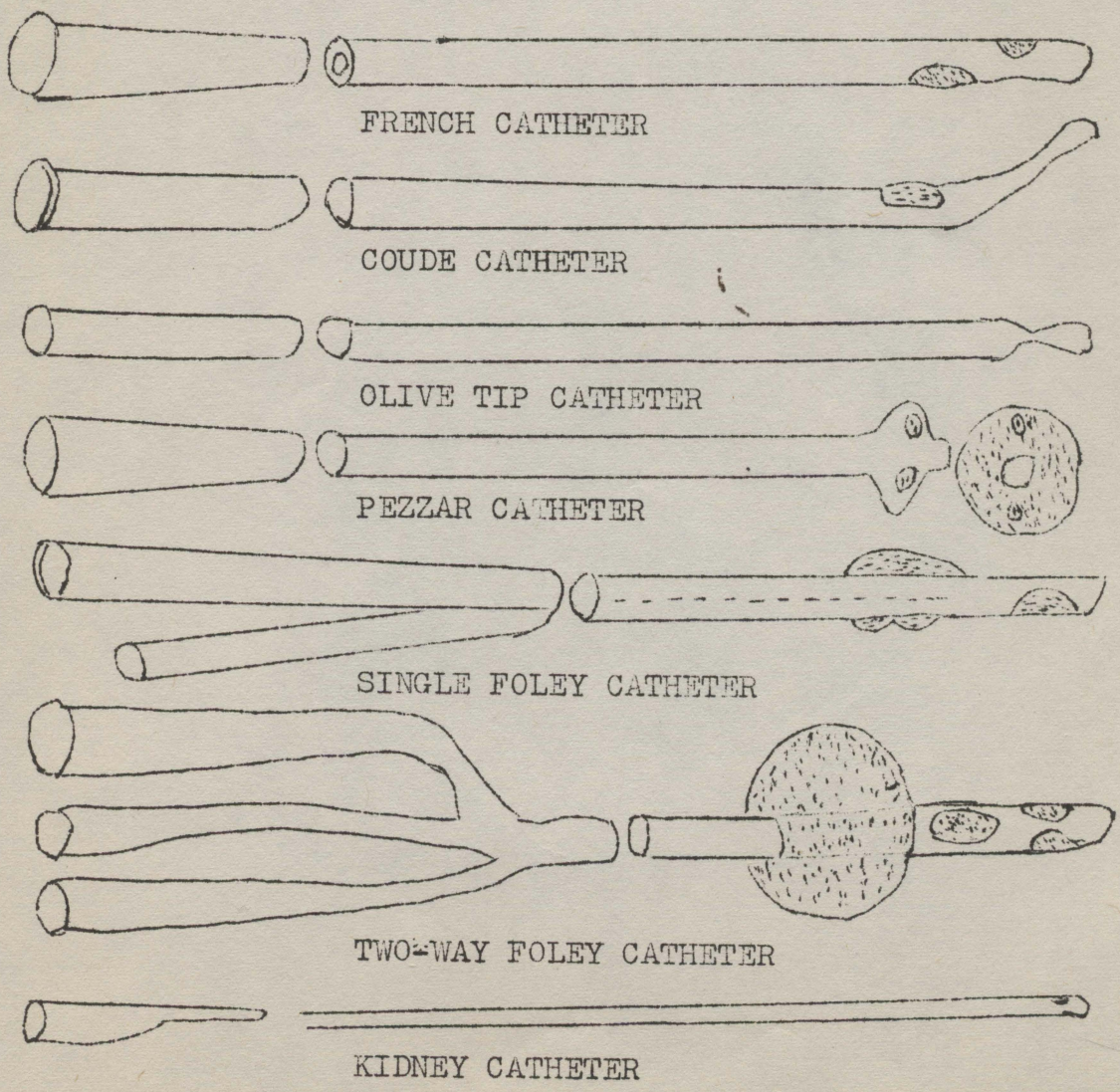
## Bladder Instillation

Purpose: to produce an anesthetic or antiseptic effect.

Requisites:
1. Usual catheter equipment
2. Medication as ordered
3. Sterile medicine glass
4. Asepto syringe (2 ounces) use barrel only

Procedure:
1. Catheterize patient in usual manner

TYPES OF CATHERS



Bladder Instillation cont'

Procedure:
2. When urine has ceased to flow connect barrel of syringe to catheter.
3. Pour medication into syringe (if correct amount in bottle, medicine glass need not be used).
4. Compress catheter, replace medicine glass or bottle on tray.
5. Disconnect barrel of syringe from catheter and place on tray.
6. Remove catheter, being careful to keep it compressed so that solution will not be withdrawn.
7. Complete procedure as in catheterization.
8. Record: Time, amount and description of urine obtained, amount and kind medication instilled, observation of patient, and signature of nurse.

## Bladder Irrigation

Purpose:
1. To cleanse bladder
2. To produce an anesthetic or antiseptic effect.

Requisites:
1. Complete catheterization tray plus:
   a) pitcher of solution ordered (500cc) temperature 105 degrees)
   b) asepto syringe
   c) extra sterile basin (pint size)

Procedure:
1. Explain procedure to patient.
2. Catheterize in the usual manner.
3. When urine has ceased to flow, connect barrel of syringe to catheter.
4. Pour 50 to 100cc of solution into barrel of syringe. Disconnect syringe, lower catheter and allow to drain.
5. Repeat until return flow is practically clear.
6. If medication is to be instilled, it may be poured into barrel of syringe at this time.
7. Compress and remove catheter. Complete procedure as in catheterization.
8. Record: Time, amount and description of urine obtained, amount, type, and temperature of irrigation solution, description of return flow, observation of patient, and signature of the nurse.

## Foley Retention Catheter

Purpose:
1. To maintain constant urinary bladder drainage
2. To aid in urinary bladder irrigation
3. To aid in control of hemorrhage by direct pressure on the bleeding area.

Foley Retention Catheter cont'

Equipment:
1. Complete catheterization tray.
2. Sterile Foley catheter (size 18-22)
3. Sterile 20 c.c. syringe
4. Sterile medicine glass containing sterile distilled water.
5. String or rubber band.
6. Sterile rubber tubing approximately 48 inches long with a glass adapter and attached safety pin.
7. Sterile drainage bottle
8. Screw clamp.

Procedure:
1. Catheterize patient in usual manner using a Foley catheter and inserting 2½ to 3 inches.
2. Inflate bulb of catheter with required amount of sterile water using a 20 cc syringe. (20 cc)
3. Tie end of lumen which connects to bulb securely.
4. Attach catheter to glass adapter. Place opposite end of tubing in drainage bottle. Fasten upper portion of tubing to bed with safety pin.
   (Note..At this time catheter may be attached to intermittent or tidal set up as ordered).
5. Leave unit in order, care for equipment.
6. Record: Time, type or catheter inserted with size of inflated bulb, disposal of urine as ordered, and signature of nurse.

## Decompression of Urinary Bladder

Purpose:
To relieve distention and avoid collapse of the urinary bladder.

Requisites:
Refer to Foley retention procedure.

Procedure:
1. Catheterize patient in usual manner using a Foley catheter.
2. Allow no more than 250cc of urine to drain into kidney basin (basin will be approximately ½ full).
3. Clamp catheter.
4. Release catheter every 30 minutes allowing no more than 100cc of urine to drain in measuring cup.
5. When less than 100cc of urine is obtained connect catheter to drainage tubing and bottle.
6. Care for equipment.
7. Record as for catheterization, state each time released amount of urine obtained and time it was connected to drainage bottle.

# Chapter XI

## Pre and Post Operative Care

### General Pre-Operative Nursing

Purpose:

1. To bring patient to surgery in best possible condition emotionally, physically, and mentally.
2. To avoid preventable complications

General Instructions:

1. Cleansing bath and good oral hygiene.
2. Local preparation done by surgical nurse
3. Dress for surgery:
   a) clean gown
   b) surgical stockings
   c) head towel with one safety pin
4. Remove dentures, hair pins, jewelry (a wedding ring may be worn but it must be well taped with adhesive).
5. Have patient empty bladder. Inability to void should be reported to head nurse.
6. Be sure operative permit is correctly signed and witnessed.
7. Give the pre-operative hypodermic as ordered. Avoid disturbing patient after this medication has been given.
8. Prepare the chart...note temperature, pulse, respiration and blood pressure on surgical sheet. The chart goes to surgery with the patient. Be sure laboratory findings are on the chart. Notify head nurse of any abnormal findings.
9. Observe and report any:
   A) anxiety, fear, or apprehensiveness
   b) symptoms of respiratory infection
   c) elevation of temperature
   d) allergies or idiosyncrasies
10. Have patient ready for operating room at least 20-30 minutes before the hour scheduled.

### Immediate Post-Operative Care

1. Make up operative bed, provide proper ventilation.
2. Assist with putting patient in bed and avoid undue exposure.
3. Place patient in appropriate position determined by type of surgery and anesthetic.
4. Connect drainage tubing.
5. Check pulse and respiration every 15 minutes until awake.
6. Check blood pressure upon return to room then every $\frac{1}{2}$ - 1 hour until stable.
7. Check temperature rectally (except on patients having rectal surgery every 4 hours for 48 hours).
8. Keep patient's head to one side to prevent aspiration of vomitus.

Post-Operative Care cont'

9. Note amount of perspiration and kind of perspiration and change linen accordingly.
10. Follow immediate post operative orders as to fluids, medications, etc.
11. Turn patient frequently at least every 2 hours. Encourage deep breathing and leg exercises.
12. Stay with patient until fully reacted. Never leave an unconscious patient along.
13. Observe, report, and record:
    a) external bleeding at surgical area
    b) change in quality and rate of pulse
    c) change in rate and quality of respirations
    d) raised or lowered blood pressure
    e) restlessness, apprehensiveness
    f) pain
    g) time and condition of patient when fully reacted
    h) amount and type of drainage
    i) nausea and vomiting

## Operative Bed

Requisites:
1. Same as for an open bed
2. 1 extra draw sheet
3. 1 rubber square
4. emesis basin
5. tongue blade
6. mouth wipes
7. paper bag with safety pin

Procedure:
1. Strip bed, turn the mattress
2. Make foundation bed on one side
3. Place rubber protector across head of bed; cover with cotton draw sheet and tuck in at side. Arrange upper bedding the same as for an open bed but do not tuck under mattress.
4. Complete foundation bed and upper bedding on the opposite side.
5. Fold back an 8" cuff at foot of bed level with the edge of mattress and at head of bed even with shoulder level.
6. On side of bed patient is to be admitted, fold back an 8" cuff even with edge of mattress. Allow the covers on the other side to hang.
7. Stand the pillow straight at the head of the bed with ends tucked between the rods of the bed frame. Pin with safety pins if necessary.
8. Pin a paper bag to the mattress near the head of the bed.
9. On the cleared bedside table place emesis basin, mouth wipes, and tongue depressor.
10. Close any window so located as to produce a draft over the patient and in warm weather screen the window.
11. Care for all unnecessary equipment, wash and dry drinking glass, pitcher and tray.
12. Leave unit neat.

Operative Bed cont'

13. Provide equipment indicated by Special surgical procedures such as: Sphygmomanometer, Stethoscope, oxygen, aspirating machine, wangensteen, drainage tubes and bottles, intermittent and tidal drainage etc.

## Aspirator (Suction) Machine

Purpose:
1. To aspirate mucus from an unconscious or critically ill patient.
2. To keep the inner cannula of a tracheotomy tube open.
3. To aspirate blood from the mouth or throat of a patient following surgery

Requisites:
1. Aspirating apparatus (Central Supply) with tubing, tracheal catheter and metal suction tip.
2. Basin with water
3. Mouth wipes

Procedure:
1. Connect electric cord to electrical outlet, being careful to keep cord dry.
2. Keep vacumm screw located at top of vacum bottle turned tight at all times.
3. Connect catheter or metal tip to tubing
4. Turn switch on.
5. Holding hand about 8" from end of catheter, place in patient's mouth 4-6 inches moving it back and forth to reach all parts and to get well back in oral Pharynx. Suction as necessary.
6. Rinse tubing by placing catheter in basin of tap water. Always wash out tubing with cold water after each use.
7. Do not allow vacum bottle to become more than half full.
8. When discontinuing use of aspirator, wash out well with soap and water and return to Central Supply.
9. Record: Time, procedure, nature of material aspirated, patient's reaction.

## Assisting With a Surgical Dressing

Requisites:
1. Dressing tray containing:
    a) Alcohol
    b) Merthiolate
    c) Sterile vaseline
    d) Sterile safety pins
    e) Jar of sterile cotton pledgets
    f) Jar of sterile tongue depressors
    g) Adhesive (1 inch and 2 inch)
    h) Sterile probe in glass tube
    i) Set of instruments wrapped in a sterile towel
        1) 1 scissors

Surgical Dressing cont'

Requisites
2) 1 tissue forceps
3) 1 curved hemostat
j) Forceps in antiseptic solution
k) Folded newspaper
2. The dressings are placed in each room early in A.M.

Procedure:
1. Bring dressing tray to the room and place on cleared bedside table.
2. Turn bed linen down or above surgical area as case may be. Remove binder, adhesive tape, and outer layer of dressings and place on newspaper.
3. Place sterile towel with instruments below or above wound (as case may be) turning edge of sterile towel down over bed linen.
4. Open dressings and be ready to provide alcohol, merthiolate, applicator or vaseline, etc., as needed. Be careful not to contaminate inside of containers.
5. Tear adhesive proper length, if drainage case make Montgomery tape dressing or match stick dressings.
6. Replace binder (pinning securely) and leave patient in a comfortable position.
7. Dispose of soiled dressings, carry contaminated instruments to utility room in towel, scrub throughly, being especially careful that all drainage or dried blood is removed from grooves of hemostat, or clip removers. Dry and place in germicide for 10 minutes. After sterilizing replace in a sterile towel.
8. Return dressing tray to place provided.
9. Record: Time, dressings changed by whom, wound clean or amount and character of drainage, drainage tube removed or shortened, kind of medication if used, sutures or clips removed and type of dressing reapplied.

## Irrigation of a Wound

Purpose:
1. To cleanse
2. To deodorize a wound or area

Solutions usually ordered:
1. Dakin's solution (solution should be less than 24 hours old)
2. Boric solution
3. Saline solution
4. Potassium Permanganate solution

Requisites:
1. Dressing tray
2. Rubber protector with cover
3. Irrigating tray with the following:
a) Sterile towel
b) Curved basin (kidney)
c) enamel bowl or pan with solution
d) asepto syringe

Irrigation of a Wound cont'

Procedure:

1. Place requisites on sterile towel which covers tray. After equipment is assembled cover tray with sterile towel.
2. Screen the patient and explain procedure.
3. Bring irrigating tray and dressing tray to room and place on cleared bedside table.
4. Move patient to a comfortable position.
5. Place rubber protector and curved basin in position to catch drainage.
6. Remove dressings with forceps and discard on newspaper. Fill syringe with solution. insert tip of syringe into wound and inject solution allowing it to drain into kidney basin.
7. When wound is clean and solution returns clear, dry the skin and dress the wound. (If Dakin's solution is used, protect the skin around the wound with vaseline or vaseline strips. Replace with fresh vaseline after each irrigation).
8. Remove all articles and leave the patient comfortable.
9. If capacity of the wound is to be measured, use a graduate syringe and measure the amount of fluid the wound will hold.
10. If tray is not contaminated, it may be used for several irrigations for the same patient. Sterilize all articles at least every 24 hours.
11. Record: Time, amount and kind of solution used, condition of wound, nature of drainage, and observation of patient. Signature of nurse.

## Perineal Irrigation

Purpose:

1. To cleanse
2. To relieve inflammation and irritation

Requisites:

1. A tray containing:
   a) Sterile covered pitcher with sterile water (105 degrees)
   b) Sterile covered enamel can containing cotton pledgets
   c) Sterile forceps in antiseptic solution
   d) Folded newspaper
   e) Atomizer with tincture of Merthiolate
2. Sterile perineal pads in patient's room
3. Bedpan

General Instructions:

1. Irrigations are given three times a day to patient's who have had rectal operations or perineal repair.
2. Irrigate following each micturition and defecation in above conditions.
3. Caution patient not to handle pad
4. Give special attention to stitches.

Perineal Irrigation cont'

Procedure:

1. Bring tray to bedside
2. Provide adequate privacy
3. Place patient on bedpan, remove soiled pad, and place in newspaper at foot of bed.
4. If urine is to be measured or specimen requested, remove bedpan, measure the amount, replace bedpan.
5. Hold pitcher of solution about 6 inches above patient and pour solution over perineum, rinsing well.
6. Dry labia and perineum with cotton pledgets held by forceps, using a downward stroke with each cotton ball. Discard soiled cotton balls in newspaper, not the bedpan.
7. If disinfecting spray is ordered, spray perineum.
8. Place perineal pad.
9. Remove bedpan, turn patient on side and dry buttocks with sterile cotton balls.
10. Turn patient on back and pin perineal pad in place.
11. Remove and clean equipment.
12. Record: Time, amount and description of urine or defecation, kind of solution used, condition of perineum, nurse's signature.

## Post Operative Carbon Dioxide Inhalations

Purpose:

1. To prevent atelectasis
2. To help the elimination of mucus
3. To promote increased respirations

Requisites:

1. Cyclinder of carbon dioxide and oxygen mixture
2. Mask and connecting tubing

Procedure:

1. Secure requisites from pharmacy and carry to patient's bedside.
2. Explain procedure to patient.
3. Place a "no smoking" sign in a conspicuous area as for oxygen therapy.
4. Open cyclinder valve, adjust the face mask over the patient's nose and mouth.
5. Continue inhalation for 5 or 10 minutes every hour or as ordered.
6. Encourage patient to breathe deeply and to follow your instructions.
7. Watch for signs of overdosage such as: labored or over vigorous breathing, breath holding. Discontinue the treatment.
8. Remove the mask and close the cyclinder.
9. Clean mask and return equipment to pharmacy as soon as treatment is discontinued.
10. Record: time, purpose and length of treatment, patient's reactions, signature of nurse.

# Vaginal Treatment

## Vaginal Irrigation

Purpose:

1. To cleanse (107 degrees)
2. To medicate (107 degrees)
3. To reduce congestion or inflammation (120 degrees)

Requisites:

1. A tray containing:
   a) Sterile irrigating can with rubber tubing and clamp
   b) Douche tip
   c) Kidney basin, perineal pad, cotton pledgets
   d) Prescribed solution measure in graduate
   e) Newspaper to protect bed
   f) Sterile rubber gloves
2. Bed pan and bath blanket in room

Procedure:

1. Assemble requisites in treatment room
2. Open sterile equipment. Place kidney basin with perineal pad, cotton pledgets, and douche tip on tray. Connect rubber tubing to irrigating can.
3. Prepare solution of correct amount, strength, and temperature in graduate. Pour in can.
4. Cover tray with sterile wrapper and carry tray to bedside.
5. Place patient in dorsal recumbent position. Drape. Place newspaper and bedpan under patient.
6. Have patient void.
7. Place kidney basin at foot of bed.
8. Put on rubber gloves and connect douche tip to rubber tubing.
9. Separate labia and cleanse external genitalia with flow of solution from tubing.
10. Insert douche tip gently, rotate and move douche point forward and backward along vaginal tract so that all parts will be cleansed.
11. When prescribed amount of solution has been used, disconnect douche tip and place in kidney basin.
12. Allow patient to remain on bedpan for a few minutes or sit erect to drain the vagina.
13. Dry labia with cotton pledgets, discard in kidney basin and remove bedpan.
14. Turn patient on side, dry buttocks well with cotton pledgets, apply perineal pad.
15. Remove newspaper and drape. Replace bed covers.
16. Remove and care for equipment in the usual manner.
17. Record: Time, kind and amount, temperature of solution used, description of the return flow, reaction of patient, and signature of the nurse.

# Chapter XII

## Administration of Medicines

### I. General Instructions

A. Ordering and Obtaining Medications

1. The attending physician or intern writes the original orders for drugs and medications on the blue order sheet.
2. Telephone or verbal orders may be taken when necessary by the nurse in charge who in turn is responsible for transferring the order on the blue sheet. It is to be signed with the name of the physician giving the order and initials of the individual receiving the order.
3. Refills may be obtained by requisitioning on the small white refill slip.
4. Prescription blanks are provided in each dept. for medications containing narcotics and medications that are to be sent home with the patient. These require signature of the physician.
5. "Stat" requisitions are taken immediately to pharmacy by nurse. These orders will be filled within 10 minutes.
6. Refill orders for all stock medicines should be in pharmacy by 9 A.M. with container provided.
7. Report idiosyncrasies or allergies of patient to physician and familiarize yourself with desired or undesired effects of the medication you are administering.

B. Medicine Cupboard

1. All medicines, with the exception of those that must be kept in the refrigerator, (oils, vaccines, insulin) are to be kept in the medicine cupboard.
2. All bottles, boxes, and other containers for drugs should be marked with a clear, legible label. Only the pharmacist may change labels and fill bottles.
3. Keep all bottles tightly corked.
4. Any change in color, odor, or consistency of medicine should be reported promptly and a fresh supply obtained.
5. All stock medicines are to be arranged on the shelves with drugs of a similar nature grouped together.
6. Each patient's medications are kept in individual corresponding numbered compartments in the medicine cupboard.
7. Permanently discontinued medications or medications upon discharge of patient are returned to the pharmacy promptly for credit. If this unused portion is to be taken home, it must first be sent

Medicine Cupboard cont'

to the pharmacy for relabeling.

C. Narcotics Box.

1. All narcotics or other drugs which are listed under the Harrison Act or are under other restrictive drug acts are kept in a locked drawer.
2. Narcotics must be recorded on special sheets, printed specifically for that purpose. This sheet requires the following data: Patient's name, date and time of administration, dosage taken from the supply, doctor's name, signature of the nurse.
3. Any prescription containing an opiate cannot be refilled. A new prescription must be written.
4. The charge nurse carries the key to the narcotic box. After obtaining the necessary drug, return the key to the charge nurse. Never give the key to a private duty nurse...go with her to the medicine press and dispense the drug to her.
5. To check narcotics..
   A) All narcotics are checked at 7 A.M., 3 P.M., 11 P.M., by the charge nurse leaving and the charge nurse coming on duty. No nurse is to go off duty until all narcotics are accounted for.
   b) At 7 A.M. the charge nurse rechecks narcotics used in the preceding 24 hours and orders refills for the next 24 hours on a special narcotic blank. In this hospital the order must be counter signed by the Sister Supervisor of the department.
   c) The narcotic box with refill orders is taken to the pharmacy by head nurse who waits for the order to be filled.

D. Sedative Box

1. The sedative box is kept in the same drawer as narcotic box under lock and key.
2. Sedatives are administered as ordered.
3. A separate refill medicine slip is filled out for each patient getting a sedative.
4. These sedatives are checked at 7, 3, 11, the same as for narcotics and refills obtained each A.M.

E. Emergency Box

1. Each floor is provided with an emergency tray which should contain the following equipment:
   a) Adrenalin Chloride
      Coramine
      Synkamin
      Caffeine Sodium Benzolate
      Digifoline
      Ergotrate gr. 1/320
      Calcium Gluconate 10%
      Novacaine 1%

Emergency Box cont'

Pitressin
Distilled Water
Aromatic Spirits of Ammonia
Nitroglycerine gr. 1/150
Strychnine Sulphate gr. 1/30
Sodium Luminal gr. 11
Surgical Pituitrin
Amyl Nitrate and gauze
Aminophyllin gr. 3 3/4 ampule
Atropine Sulphate gr. 1/150

b) syringes
10cc; 5cc; 2cc

c) needles
22 gauge Intra Muscular
25 gauge Hypodermic
20 gauge Intra Venous

2. Refills are obtained the same as for sedatives.

F. Medicine Card System

1. Order for medications to be given more than once are transferred from order sheet to medicine cards by the charge nurse.
2. Information on medicine cards should be accurate and legible and include the following:
   Patient's full name, room number, name and amount of drug to be given, hour of administration, and date.
3. The 7-3 charge nurse should check the cards daily at 7 A.M. and 3 P.M.
4. Rub card with paraffin to prevent staining.
5. When discontinuing a drug or patient has gone home, put the cards in box provided and return to dressing room.
6. Key to the color cards:

| | |
|---|---|
| Green... | Q A.M. every morning |
| White | Nights. 7 P.M.-7 A.M. (use red ink only) |
| Blue | A.C. before meals 7 A.M. (red ink)<br>10:30 A.M.<br>4:30 P.M. |
| Red | Q.I.D four times a day..9-12-3-6 |
| Buff | P.C. after meals 8-12-6 |
| Pink | B.I.D. twice a day 10-6 |
| Gray | Q 4 hrs. 10-2-6 Daytime.<br>Q 4 hrs. at night use white card with red ink 10-2-6 |
| Gray | T.I.D. three times a day 10-2-6 |
| Purple | Once daily |
| Salmon | Odd hours and q.o.d. (every other day)<br>If q. 12 hours, use a salmon colored card in day time |
| Orange | Q 3 hours every three hours 9-12-3-6 |

II Preparation of Drugs for Administration

A. Liquid drugs

1. Do not dilute cough syrups
2. Give oils as prepared or in fruit juice. Any effervescent drink should be mixed at bedside and be bubbling when offered to patient.
3. Hydrochloric acid and iron preparations should be well diluted and given through a drinking tube.
4. Always shake bottle well.
5. Never pour medicine back into bottle
6. Use accurate measuring glasses and droppers
7. When pouring liquids, hold bottle with label on upper side pouring away from label.
8. Concentrate all effort on task at hand and avoid interruption while pouring medications.
9. Read the label three times:
   a) Before taking bottle from shelf
   b) Before pouring from bottle
   c) After pouring from bottle
10. Never give two drugs together unless so ordered.
11. Hold medicine glass so that the most of the prescribed amount is on a level with the eye.

B. Dry Drugs

1. Never handle tablets, capsules, and pills with the fingers but drop into the pill tray or glass.
2. If patient has difficulty in swallowing the medicine, it may be crushed and given with water.
3. Nurses are not permitted to divide pills, capsules, etc. in order to make a correct dosage. This is done by the pharmacist.
4. Pills or capsules, with or without water, break one's fast.

III Administering Medications Orally

1. Wash your hands.
2. Remove medicine cards from "rack" at designated time.
3. Arrange cards in sequence..place stack of cards so that the top card only is visible when pouring the medicines.
4. As each medication is measured, the glass is placed on the medicine tray and marked at once by means of the medicine card.
5. Carry medicine tray to bedside.
6. The nurse who prepares the drug is the only one who should administer it to the patient.
7. Establish identity of patient before administering the medication. This is done by calling patient by complete name and receiving a positive response from conscious patient.
8. Supply fresh water to all patients when taking medications. A piece of ice may be held in the mouth to deaden the taste buds.
9. Remain with patient until medication has been swallowed. Never leave drugs to be taken later.

Medications Orally cont'

10. If the nurse is unable to administer the drug, it should be reported to the nurse in charge.
11. After administering the medications, return tray to medicine room, Clean and care for equipment.
12. Advance medicine cards accordingly to succeeding hours of administration.
13. Record: Time medication, amount, method of administration, observation and reactions of patient.
    Oral medications may be blocked; as each dose is given, the time is cancelled.
    Narcotics are recorded on narcotic sheet and nurses' notes with signature of nurse.

## Administration of Rectal and Vaginal Suppositories

Purpose:

To introduce drugs into the rectum or vagina for a direct local effect such as: checking hemorrhage, relieving pain, and stimulating defecation.

Requisites:

1. Prescribed suppository
2. Rubber glove
3. Lubricant
4. Gauge square or celluwipe

Procedure:

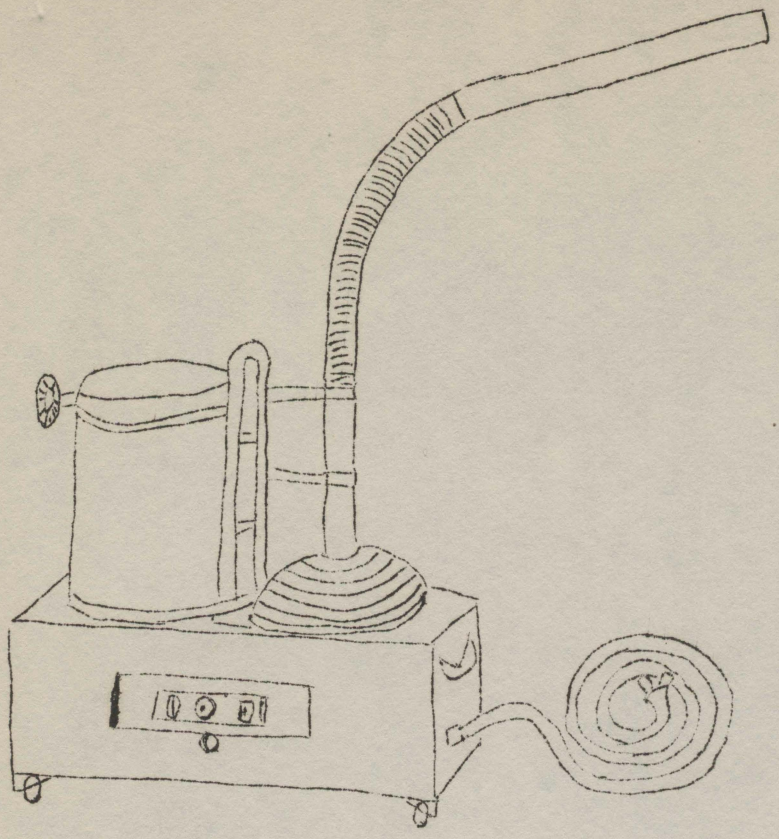
1. Place suppository on gauge square and lubricate the tip.
2. Carry requisites to bedside on a tray.
3. Explain procedure to patient and provide adequate privacy.
4. Turn patient on left side or dorsal recumbent position.
5. Put on rubber glove. Separate buttocks with other hand and insert the suppository tapered end first into the rectum beyond the spincter muscle. If the patient has difficulty in retaining the suppository, pressure may be applied to the anus for a few minutes by means of the gauge square.
6. Administer a vaginal suppository by separating the labia and inserting suppository as far into vagina as the finger can be introduced.
7. Rinse the glove under running water, remove, and place in soiled glove container.
8. Record: time, type of suppository administered, and patient's reaction.

## Inhalations

### (A) Steam Inhalation

Purpose:

1. To relieve inflammation, irritation, congestion, and edema of the upper respiratory tract.
2. To warm and moisten the air following operations (tracheotomy)



Colson Inhalator

Requires minimum of attention. Will operate from eight to sixteen hours on one filling, depending upon volume of steam vapor desired.

Water supply is always visible, therefore a glance tells if it needs replenishing. Should it become exhausted through oversight, an automatic thermal switch cuts off current and lights red signal light. To replenish water simply lift out glass bottle and refill. Water held in supply reservoir permits uninterrupted flow of vapor while bottle is being filled and replaced.

Medicine cup directly over rising steam assures complete volatilization. Medicine cup fully exposed by simply swinging tube assemble to one side.

Steam Inhalation cont'

Requisites:
1. Steam Inhalator (Central Supply)
2. Hot tap water
3. Medication ordered

Procedure:
1. Fill glass container to brim with hot tap water and apply cap.
2. Quickly invert container and replace in frame of inhalator.
3. If medication is ordered, place in medication cup which is exposed when tube assembly is swung to one side.
4. Carry inhalator to room. Attach to electric outlet and turn on.
5. Adjust assembly tube of inhalator in such a position that there is absolutely no danger of burning the patient.
6. Close doors and windows tightly to protect the patient from drafts and chilling and to maintain adequate vapor concentration.
7. Observe frequently and fill container as necessary.
8. Record: Time, treatment, duration, and observation of patient.
9. When treatment is discontinued, empty and clean throughly and return to Central Supply.

B. Atomizer:

Purpose:
Acts as an antispasmodic or cardiac stimulant

Requisites:
1. Glass vaporizer with rubber hand bulb
2. Solution ordered

Procedure:
1. Place ordered solution in atomizer.
2. Insert glass vaporizer into the mouth.
3. Instruct patient to inhale at the same time the bulb is pressed.
4. Caution the patient against swallowing the drug as it may cause epigastric distress.

C. Dry Inhalations

Purpose:..antispasmodic or cardiac effect

Procedure: Amyl Nitrate Pearl
1. Wrap a piece of gauge around a pearl of amyl nitrate, break it and allow patient to inhale the fumes. Do not hold medication too close to the nostrils. Observe patient closely for untoward effects.
2. Spirits of Ammonia
Pour a small amount of ammonia on a piece of gauge hold it to the patient's nose. Avoid prolonged administration

Dry Inhalations cont'

Procedure:

as the fumes are extremely irritating to the mucous membrane.

3. Record: time, treatment, effect. Signature of nurse.

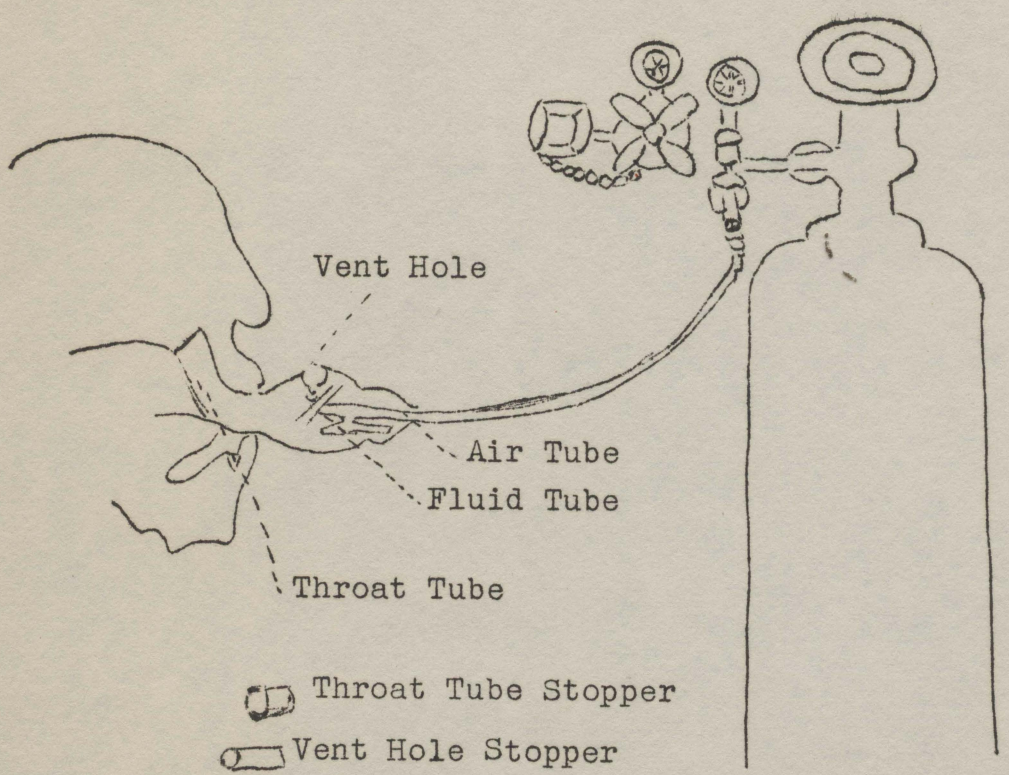
D. Penicillin Aersol Therapy

Purpose:

To apply penicillin directly to the mucous membrane in infections of the respiratory tract.

Requisites:

1. Cyclinder of oxygen and regulator
2. Penicillin nebulizer
3. Tubing with "Y" tube
4. Aqueous penicillin as ordered




ALL GLASS NEBULIZER

Penicillin Aersol Therapy cont'

Procedure:

1. Secure oxygen and regulator from pharmacy.
2. Secure nebulizer with "Y" tubing from Central Supply.
3. Explain procedure to patient.
4. Connect regulator to Cylinder, connect "Y" tubing and nebulizer to regulator.
5. Open Cylinder valve and allow oxygen to flow at rate of 4-6 liters.
6. Inject ordered penicillin into nebulizer.
7. Place the end of nebulizer into patient's mouth and instruct patient that upon inspiration the penicillin is felt on back of the throat.
8. When the thumb is placed over free end of "Y" tube, the penicillin is nebulized. The hole should be covered on inspiration and uncovered upon expiration. Continue treatment until penicillin is completely nebulized (approximately 20-30 minutes)
9. Turn off Cylinder valve.
10. Wash the nebulizer after each use.
11. The usual precautions in the use of oxygen apply here.
12. Patient may be taught to administer inhalation himself if he is physically able and understands the technique, otherwise, the nurse administers the medications.
13. Observe throat and tongue for redness, swelling and soreness.
14. Record: time, amount of penicillin administered, and by whom.

## Administration of Drugs to the Skin

Purpose:

1. To relieve pain and itching
2. To increase and stimulate absorption and circulation

Requisites:

1. Wash basin containing warm water and soap
2. Wash cloth and towel
3. Prescribed medication
4. Warm linseed or cotton seed oil, if soap and water is contra-indicated

Procedure:

1. Assemble requisites at bedside and explain procedure to patient.
2. Expose area, bathe with soap and water, and dry unless contra-indicated.
3. Rub prescribed medication on the designated areas with palm of the hand using a rotating motion.
4. When applying a mercurical ointment or if skin lesions are present, wear rubber gloves.
5. Clean and care for equipment.
6. Record: time, medication used, area applied, observation of patient. Signature of nurse.

# Administration of Hypodermic Injection

Purpose:

1. To obtain rapid action of drug
2. When it is inadvisable or impossible to give drug by mouth

Requisites:

1; Tray for articles
2. Autoclaved covered container with 12 (25) hypodermic needles and syringes (2cc) supported upright by screen.
3. Covered container of cotton balls
4. Bottle with rubber stopper containing sterile distilled water
5. Sterile forceps in solution of staphene
6. Box containing (12) intramuscular needles (22)
7. Ampoule file
8. Covered glass jar containing sterile 2" squares of paper.
9. Alcohol

Procedure:

1. Transfer from order sheet the name of patient, room number, medication and dosage to card.
2. With sterile forceps, remove one pledget from jar, saturate with alcohol, and place on the rubber cap of the sterile water bottle.
3. Remove one square of sterile paper and place it on hypo tray.
4. Place required medication on sterile square of paper.
5. Wipe off rubber cap of sterile water bottle with the alcohol pledget that was placed on it.
6. Uncover container of syringes and needles, with sterile forceps pick up the barrel of syringe, then the plunger, fit together.
7. Inject into sterile water bottle as much air as is equivalent to the amount of water to be withdrawn, then withdraw water.
8. Remove plunger from syringe, pick up tablet with wet end of plunger and replace plunger in syringe.
9. Shake syringe until tablet is dissolved completely.
10. Take hypodermic tray with requisites. Observe name, room number of patient. Repeat full name of patient. If conscious obtain full positive response, tell patient of treatment.
11. Disinfect skin with alcohol pledget using a rotary motion. Place pledget on tray or hold between 2nd and 3rd fingers of hand used for holding skin, or leave above disinfected skin area.
12. Expel air from syringe by holding syringe with needle point upward.
13. Make a cushion for the selected skin area.
14. Insert the needle into the cushioned area (sites of injection... front of thighs, outer surface of arm and forearm area) holding needle at a 45 degree angle. Insert the needle almost to the hilt with bevel uppermost.
15. Release hand on skin area, and with this hand pull back slightly on the plunger to make sure you are not giving

Hypodermic Injection cont'

Procedure:

the injection intravenously.

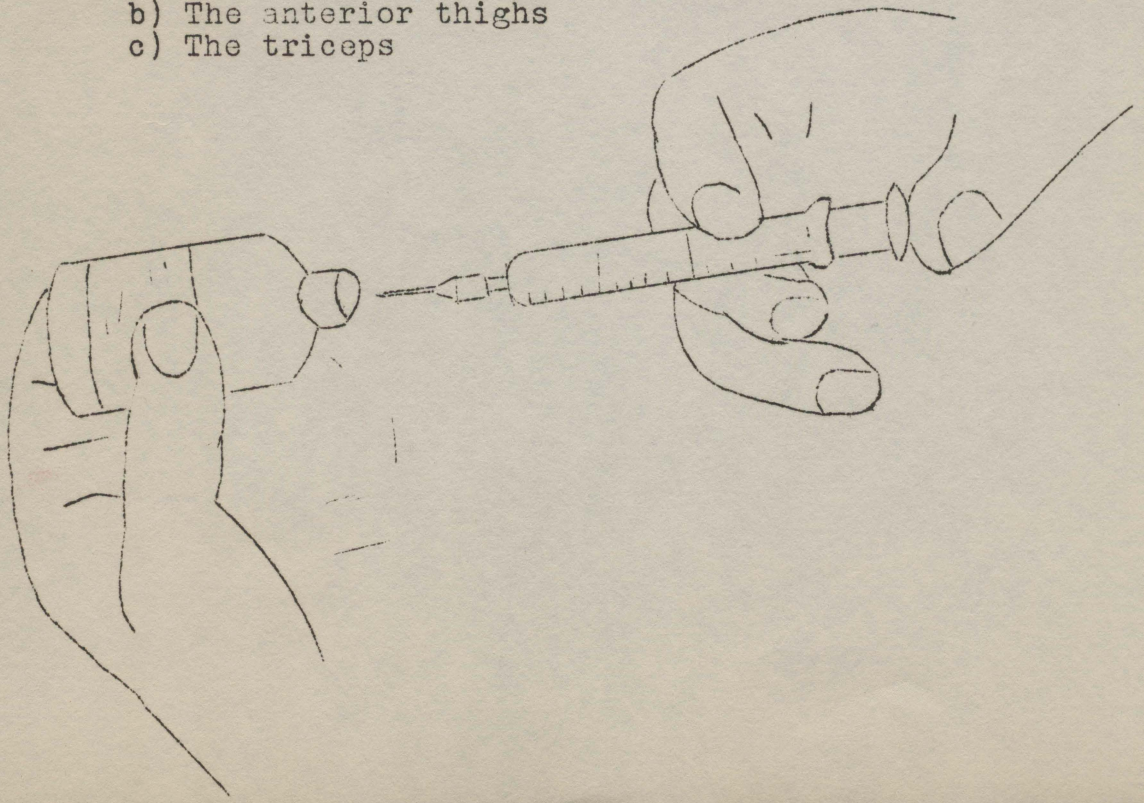
16. Pull back needle slightly and express solution slowly.
17. Remove the needle quickly and massage area lightly with pledget.
18. Clean the syringe and needle with cold tap water, separate and place in container provided.
19. Record on narcotic sheet. Wasted narcotic tablets are to be recorded as wasted.
20. Chart medication as given on the nurses' notes; if narcotic, chart on the narcotic sheet.

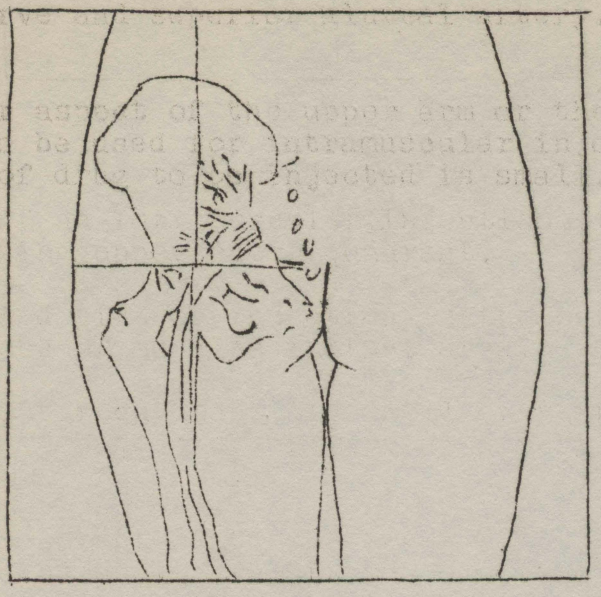
Variations for Ampoule and Rubber Stopper Vials

1. If drug is despensed in a vial, rubber stopper or vial is cleansed with alcohol pledget. Inject air into vial equivalent to the amount of solution to be withdrawn. Withdraw amount of solution ordered and proceed from step number 10.
2. If drug is dispensed in a ampoule, file off the tip of ampoule; insert needle and withdraw solution into syringe, inverting the ampoule as necessary.

Administrations of Medications Intramusculary

1. Obtain medication and check information on medicine card with label on medication.
2. Select desired syringe, attach intramuscular needle.
3. Proceed according to "Variations for Ampoule and Rubber Stopper Vials."
4. Insert needle at 90 degree angle
   a) Inner corner of upper outer quadrant of buttocks
   b) The anterior thighs
   c) The triceps





Preferred Site of an Intramuscular Injection, illustrating importance of using upper outer quadrant.

1. The preferred site of injection is the buttock because of the thickness of muscles in that area.

2. The upper outer quadrant lies well away from the great sciatic nerve and superior gluteal artery.

NOTE: The outer aspect of the upper arm or the anterior thigh may also be used for intramuscular injections when the amount of drug to be injected is small.

Medications Intramusculary cont'

5. Pull back slightly on plunger to effect positive aspiration. If blood appears at base of syringe, select a new injection sight.
6. If blood does not appear, complete the injection by exerting slow even pressure on plunger.
7. Remove needle, applying pressure with alcohol pledget and massage gently.
8. Record as given: Time, drug, dosage, method, nurse's signature.

## Administration of Medicine Intravenously

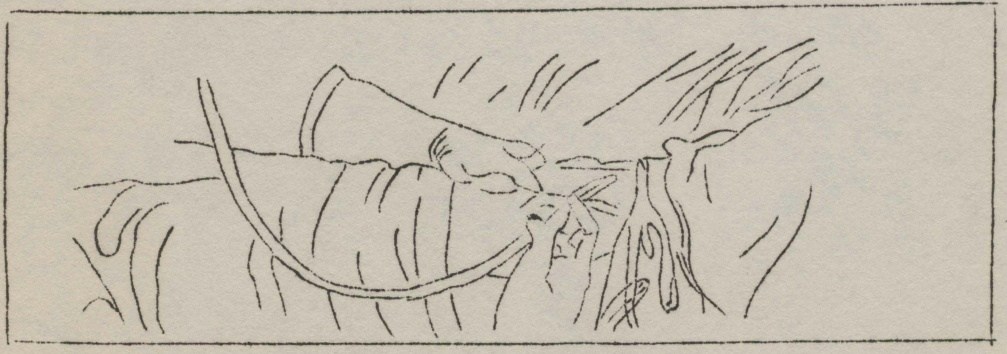
Requisites:

1. Medicine tray containing:
   a) Sterile syringe as desired
   b) 2 intravenous needles (20-22)
   c) Alcohol pledget
   d) Tourniquet
   e) Medication ordered

Procedure:

1. Obtain medication and check information on medicine card with label on medication.
2. Select desired syringe, attach Intravenous needle.
3. Proceed according to "Variations for Ampoule and Rubber Stopper Vials."
4. Provide patient with privacy and explain treatment.
5. Place tourniquet above elbow.
6. Cleanse skin area with alcohol pledget.
7. The usual site of injection is the median basilic or cephalic vein at the outer aspect of the elbow.

## Venipuncture



Needle is aimed parallel to long axis of vein, Note thumb of the left hand which is tensing skin back of needle. Vein should not be pierced in one motion.

Medicine Intravenously cont'

Procedure:

8. Tighten tourniquet.
9. With beveled side of needle pointing upward and almost parallel to the area the doctor or nurse will insert needle into vein.
10. The doctor or nurse will pull back slightly on plunger to effect positive entrance of needle in vein. Release tourniquet.
11. The doctor or nurse injects the medication slowly and then removes the needle.
12. Following the injection, pressure is applied over the wound with alcohol pledget.
13. Observe patient for effects of medication.
14. Wash syringe and needle in cold water.
15. Record as given: Time, drug, dosage, method, nurse's signature.

# Chapter XIII

## Administration of Fluids Parenterally

### A. Administration of Fluids Intravenously

Purpose:

1. To restore the blood volume in conditions such as hemorrhage.
2. To supply the body with fluids when the patient is unable to take adequate amounts by mouth.
3. To give nutrition in the form of glucose.
4. To remove toxins by stimulating the activity of the kidneys.

Requisites:

1. Intravenous tray containing:
   a) 70% alcohol
   b) Cotton pledgets
   c) Hemostat in disinfecting solution
   d) Tourniquet
   e) Roller bandage
   f) Scotch or adhesive tape
   g) Syringe (2cc or 5cc) not always used
   h) Intravenous needles (20-22 gauge)
2. Arm board
3. Fluid ordered
4. Intravenous set
5. Standard

Procedure:

1. Follow directions accompanying disposable Intravenous set.
2. Assemble requisites on a tray and take to patient's room.
3. Screen and prepare patient for the treatment.
4. Remove protecting cover from needle adaptor and attach needle securely.
5. Invert vacoliter, allowing solution to fill tubing, making sure all air bubbles are removed. (Bubbles are easily removed by holding needle at elbow level, and lowering solution container below the needle level and slowly raise container to height of standard).
6. Suspend vacoliter on standard and close clamp tightly.
7. Immobolize arm on arm board.
8. Refer to page.98-99., steps 5 through 9.
9. Release tourniquet and secure needle with tape.
10. Regulate flow of solution as directed.
11. Observe patient closely throughout the procedure;
12. When additional fluid is to be given, have solution at bedside. Do not wait until first bottle is completely empty before clamping the tubing and attaching to second bottle.

Fluids Intravenously cont'

Procedure:

13. When prescribed amount of solution has been given, remove needle and apply pressure over area with alcohol pledget.
14. Remove all equipment from unit. Clean needle and dispose of tubing and bottle as directed.
15. Record: Time, amount and kind of solution, by whom started, time discontinued, and signature of nurse.

B. Blood Transfusion

Purpose:

1. To restore blood constituents, which have been depleted by disease.
2. To supply a patient who has an infection with the blood of a person who has recovered from a similar disease and whose blood is therefore believed to contain agents which discourage the growth of the organism causing the disease.
3. To restore blood lost from hemorrhage
4. As a prophylaxsis previous to definite shock preceding operations.

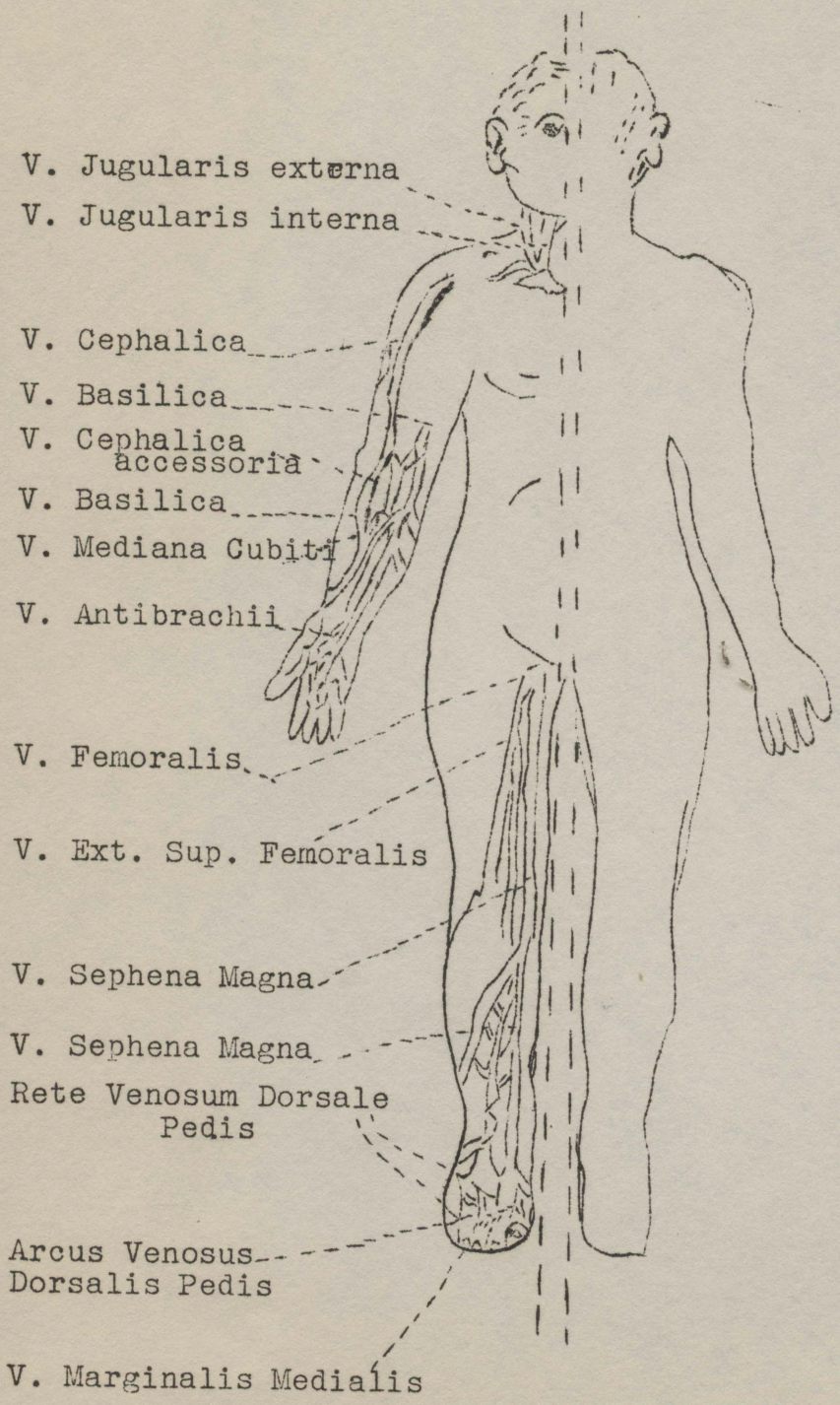
Requisites:

1. Same as for requisites for "Intravenous Infusion"
2. Recipient Set No. 19R
3. 500cc normal saline
4. Slotter and airway needle (18 gauge)
5. Size 18 needle for administration
6. Transfuse-Vac Blood

Procedure:

1. Assemble equipment
   a) Obtain blood from laboratory. Check label on bottle to ascertain if correct.
   b) Obtain normal saline and 19R set from pharmacy
   c) Obtain slotters and needles (Central Supply)
2. In treatment room:
   a) Prepare normal saline as for "Intravenous Infusion"
   b) Remove metal and rubber dises from blood bottle
   c) Insert airway needle into larger circle of indentation
   d) Remove needle and insert in smaller circle directly opposite
   e) Insert slotter into larger indented circle
   f) Attach plastic tubing to slotter with rubber connector
   g) Clamp off both bottles of solution with metal dises or screw clamps
3. Notify the doctor or intern who will start the transfusion.
4. Place the equipment, Intravenous tray, and arm board on a large tray and take to patient's room.
5. Explain procedure to patient and provide privacy.
6. Suspend bottles at the same level on a double standard.
7. Remove air bubbles by allowing saline solution to flow through tubing.
8. Upon intern's arrival, place arm board and tourniquet and prepare site of injection.

The superficial veins used in Blood Transfusion
Intravenous Injection



Blood Transfusion cont'

Procedure:

9. Attach No. 18 needle to glass adaptor.
10. Intern will insert needle, upon ascertaining if needle is in vein, release tourniquet and clamp on tubing from saline bottle.
11. Provide adhesive or scotch tape strips to anchor needle.
12. When intern directs, clamp saline tubing and release blood, regulating rate of flow to 60 drops per minute. Be sure flow is maintained.
13. Observe patient closely throughout entire procedure and for several hours afterward.
    If symptoms of reaction appear such as:
    a) Chills, rise in temperature
    b) Nausea and vomiting
    c) Increase in pulse and respiratory rates
    d) Apprehensiveness, restlessness
    e) Urticaria
    f) Pain in back
    g) Substernal oppression
    Close clamp and report condition immediately to Head Nurse.
14. If reaction occurs and transfusion is discontinued, return the remainder of blood together with identification card properly completed to laboratory. If another transfusion is to be given, obtain requisites 2,3,4,5, and 6 and proceed as outlined.
15. After all the blood has been given, unless specified otherwise, allow a small amount of normal saline to run thru tubing so that the entire amount of blood is given.
16. If additional blood is to be given, clamp off blood tubing, release normal saline. If slotter and airway have not been contaminated, insert in transfuse-vac and proceed according to step No. 2.
17. Discontinue infusion. Discard tubing and bottle. Clean slotter and needles.
18. Return completed blood identification card to laboratory.
19. Record: Time, kind and amount of solution, by whom started, observation of patient, time discontinued, and signature of nurse.

## Normal Human Blood Plasma

Purpose:

1. Restoration of circulating blood volume (Shock)
2. Restoration of blood proteins (Burns)
3. Emergency treatment in hemorrhage if whole blood is not immediately available.

Requisites:

1. Box containing:
    a) Dried normal human plasma
    b) 300cc pyrogen free distilled sterile water
    c) 1 double ended needle
    d) 1 intravenous needle
    e) 1 sterile airway and tubing

Normal Blood Plasma cont'

Requisites:
2. Complete Intravenous tray
3. Standard

Procedure:
1. Assemble equipment in treatment room. Obtain plasma from pharmacy.
2. Remove plasma and water bottles from box. Cleanse stoppers with alcohol pledget.
3. Remove wrapper from double-ended needle and remove glass tube from one end of needle.
4. With water bottle in upright position, insert uncovered end of double-ended needle through stopper into the WATER BOTTLE.
5. Remove wrapper and glass tube covering airway needle and insert needle of airway assembly through rubber stopper into the WATER BOTTLE.
6. Elevate free end of airway assembly to prevent water from wetting cotton filter in airway. If cotton in airway filter becomes wet, remove it.
7. Remove glass tube from other end of double-ended needle, invert water bottle and insert needle through stopper into plasma bottle.
8. Allow water to be drawn into plasma bottle. If vacumnin plasma bottle is lost, apply pressure in water bottle by forcing air into airway tube. If this method fails, remove stoppers and pour water into plasma. Replace stopper on plasma bottle and continue immediately. Be careful not to contaminate.
9. After water is added, double-ended needle is removed from plasma bottle.
10. Shake plasma bottle until plasma is completely dissolved.
11. Remove coverings from short needle attached to intravenous set and insert through stopper of plasma bottle.
12. Withdraw needle of airway assembly from water bottle and insert through stopper into plasma bottle.
13. Invert plasma bottle and suspend it for administration.
14. Fix glass end of the airway assembly with the suspension tape above the inverted bottle.
15. Remove wrapper from observation tube and intravenous needle.
16. Attach intravenous needle to tube and remove glass from needle.
17. Allow plasma to fill tubing.
18. Prepare the arm as for an "Intravenous Infusion".
19. Intern will insert needle into vein. If patient is to receive additional plasma, prepare second bottle as outlined. Pull out needle from first bottle and insert in second bottle, while pinching intravenous tubing to prevent it filling with air. Elevate end of airway and fix it in place with the suspension tape.
20. After the desired amount of plasma has been given, remove the needle and return the equipment to its proper place, discarding the tubing and disposable equipment.
21. Record: Time, amount of solution given, by whom started, time discontinued and observation of patient, and by whom.

## Administration of Amigen

Purpose:
To help correct protein deficiency and prevent further loss of body proteins.

Requisites:
1. Complete Intravenous tray
2. Amigen as ordered
3. Amiset (disposable infusion set)

Procedure:
1. Assemble equipment in treatment room:
   a) Remove outer metal cap from vacoliter, lift off metal disc, and remove rubber disc.
   b) Insert airway needle into larger circle of indentation.
   c) Remove needle and insert in smaller circle directly opposite.
   d) Insert dripmeter with attached plastic tubing into larger circle.
   e) Clamp off tubing with metal disc provided.
2. Place equipment on large tray and take to patient's room.
3. Proceed according to instructions for "Intravenous Administration of Fluids".
4. Regulate the rate of flow (40-50 drops per minute).
5. Do not inject medication into Amigen or Amiset unless specifically ordered.
6. Observe patient for symptoms of reaction:
   a) Nausea and vomiting
   b) Flushing
   c) Fainting and dizziness
   d) Perspiration (excessive)
   e) Headache
7. Record: Time, amount of solution given, by whom, observation of patient, time discontinued, and by whom.

## Administration of Fluids by Hypodermoclysis

Purpose:
To supply the body with a large amount of fluid when unable to administer fluids by mouth or intravenously.

Requisites:
1. Complete Intravenous tray
2. Solution ordered
3. Hypodermoclysis set (tubing and clamps)
4. Needled: gauge 18-19 (2"-2½") adult
   gauge 21-22 (1" - 1½") child

Procedure:
1. Assemble equipment in treatment room:
   a) Obtain solution from pharmacy, and tubing and clamps from Central Supply.
   b) Remove cover of vacoliter, adjust tubing and clamp.
2. Carry equipment on a tray to bedside and provide adequate privacy, and explain treatment to patient.
3. Fan fold covers above or below site of injection and place

Fluids by Hypodermoclysis cont'

Procedure:

bath blanket accordingly so that patient is not exposed. The sites of injection are:

a) Antero-lateral aspects of the thigh
b) Subpectoral region

4. Cleanse site of injection (an area about three inches in diameter) with a cotton pledget saturated with Tincture of Merthiolate, using a circular motion. Discard, Then use an alcohol pledget in the same manner.
5. Attach needles to adaptors. Invert bottle and suspend from standard. Allow solution to displace all air in tubing and needles.
6. Insert needle through a gauze square. Grasp tissue firmly with one hand, then introduce needle quickly at a slight angle for a length of approximately 1¼".
7. Secure needles in place with strips of adhesive.
8. Release screw clamps and regulate flow of solution.
9. See that the patient is adequately covered for warmth.
10. If additional fluid is to be given, secure second bottle of ordered solution before first bottle has completely emptied. Remove cap of new bottle. Close clamp on tubing. Quickly change from original bottle to new bottle, hang new bottle, release clamps, and regulate flow.
11. Observe patient frequently. Note rate of absorption and regulate flow accordingly. If site becomes very hard and distended, massage the area gently to aid in absorption. (Do not rub over point of needle). Regulate flow to a slow drip.
12. When the ordered amount of solution has been given, close clamps, loosen adhesive, and withdraw needles from gauze squares, leaving squares taped in place.
13. Leave unit neat and patient comfortable. Care for equipment.
14. Record: Time, kind and amount of solution, by whom, observation of patient, time and by whom discontinued.

# Chapter XIV

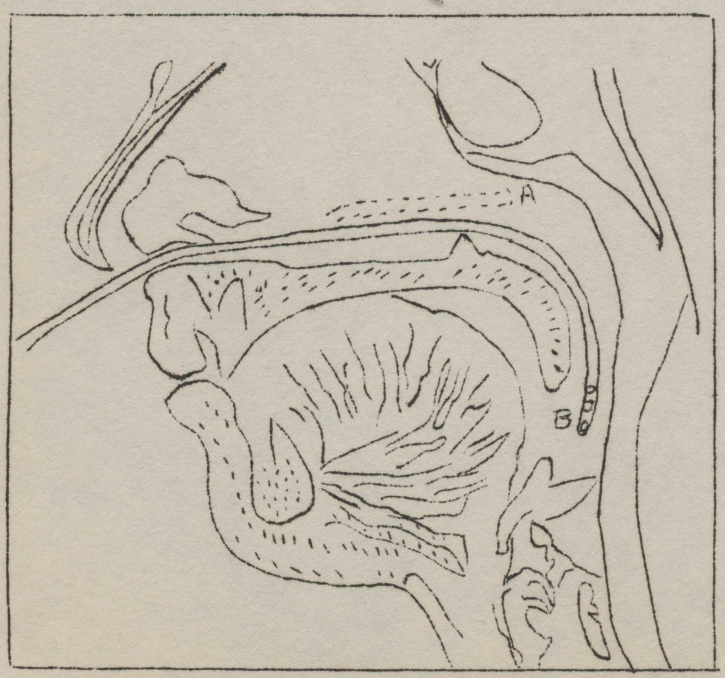
## Oxygen Therapy

Purpose:

1. To relieve anoxemia
2. Maintain adequate lung capacity
3. Maintain adequate supply of blood to the lungs.
4. Relieve cyanosis and dyspnea
5. Supply oxygen when respiratory passageways are obstructed.

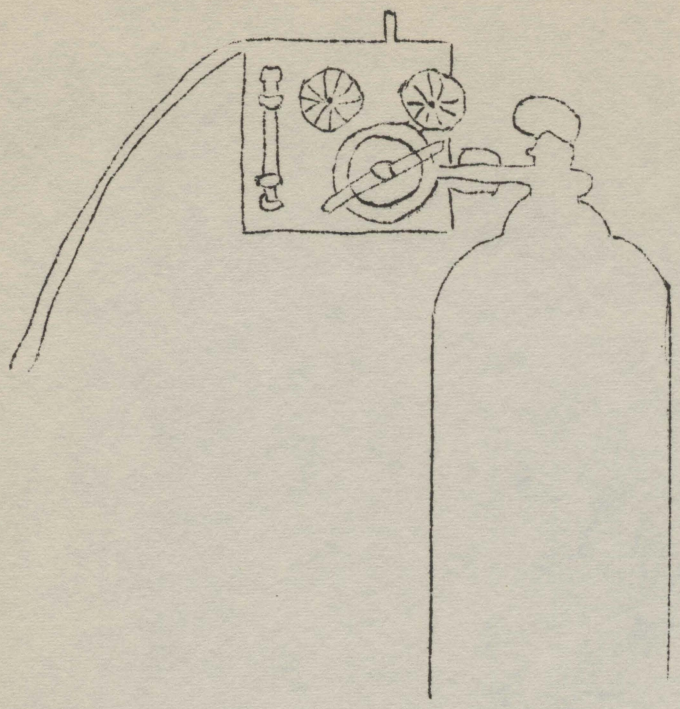
General Instructions:

1. Obtain tank of oxygen with regulator from Central Supply and crack the oxygen tank.
   a) Remove the cylinder valve cap
   b) Crack the valve (open cylinder valve slightly, and close it quickly - repeat)
2. Place tank on carrier and take to room.
3. Loosen regulator flow adjusting handle. (This is important and should be done before opening the cylinder valve).
4. Open cylinder valve very slowly----until needle on dial indicating the contents of cylinder stops moving.
5. Attach the administering apparatus to the regulator outlet.
6. Tighten flow adjusting handle by turning it to the right until the desired rate of flow liters per minute registers on the flow indicator gauge.
7. Keep a conspicuous warning (no smoking, use no oil or electrical appliances during oxygen therapy administration.
8. Record: Time method of administration, rate of flow, observation of patient, nurse's signature.



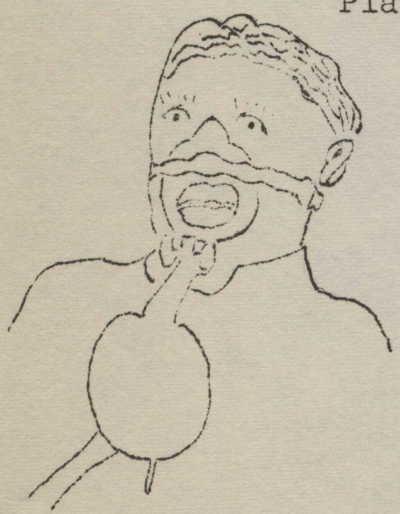

Showing position of rubber catheter in A. the nasopharynx
B. the oropharynx.

# Oxygen Therapy



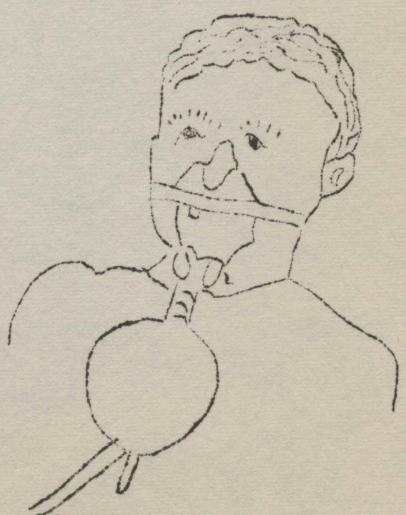
Puritan Safety, Pressure-reducing Regulator Catheter or face mask may be attached.

PER CATHETER
Plastic and Rubber 10-12-14



Nasal Mask

Per mask
The mask consists of three parts:
(1) the mask proper
(2) the connecting devise that joins the mask to
(3) a reservior-rebreathing bag.



Oronasal Mask

# METHODS OF ADMINISTRATION

A. Per Mask
1. Attach rubber tubing from mask to the outlet of the regulator.
2. Adjust the flow of oxygen to between 6-8 liters per minute. (always start with a flow of oxygen in excess of that required).
3. Apply the mask to the patient's face and adjust the head band so that the mask fits snugly but not to tight.
4. Wait several minutes until the initial abnormal breathing subsides, then reduce the flow of oxygen so that the breathing bag almost, but not quite collapses during inhalation. If the bag collapses completely the liter flow should be increased.

B. Nasal Catheter

Requisites:
1. Nasal Catheter (2)
2. Lubricant
3. Safety pin

Procedure:
1. Explain procedure to patient.
2. Attach glass connector with tubing to the outlet on the regulator.
3. Measure the distance from tip of the nose (external nares) to the lobe of the ear...this is the approximate distance the catheter is to be inserted.
4. Lubricate the catheter.
5. Insert catheter into the nose and push gently until it can be seen through the patient's mouth opposite the uvula.
6. Attach catheter to glass adapter on rubber tubing. Turn valve to required amount of oxygen liters (6-8).
7. Wrap $\frac{1}{4}$ inch tape around the catheter at the nostrils and fasten across the cheek bone and in front of the ear.
8. Fasten the tubing to the bedclothes or pillows with a large safety pin.
9. Remove catheter every 8-12 hours and replace with a freshly lubricated catheter in the alternate nostril.
10. Check equipment regularly for leaks, loose connections, humidifier.

C. Oxygen tent
1. Obtain oxygen tent and take to room.
2. Explain purpose of procedure to patient.
3. Plug into wall receptacle. Turn motor on.
4. "Set dial to temperature desired." (68 degrees winter; 10-12 degrees below room temperature in summer is recommended).
5. Turn oxygen liter flow up to 15 liters per minute for 20 min.
6. Turn liter flow back to 10 liters per minute.
7. Drape canopy over patient to cover entire bed tucking in under mattress on all sides.
8. Empty condensation pan twice daily pan (located on rear panel).
9. Change disposable filter after each case or when soiled.
10. Nursing care of the patient is permitted by reaching through the sleeve. Oxygen is lost every time the tent canopy is opened. Perform as many tasks inside the canopy at one time as possible.

# Chapter XV

## Special Procedures and Diagnostic Tests of Gastro-Intestinal Tract

### I. Gastric Expression and Irrigation

Gastric Lavage

Purposes:

1. To cleanse the stomach pre-operatively in preparation for gastric operations.
2. To remove poisons and irritating material.
3. To relieve gastric distention
4. To relieve nausea and vomiting

Solutions (95-105 degrees) Amount 1-4 quarts.

1. Plain water
2. Sodium bicarbonate 2½ per cent
3. Normal saline

Requisites:

1. A tray containing:
   a) Stomach tube in basin of chipped ice
   b) Bulb or evacuator
   c) Large pitcher for solution (graduate preferred)
   d) Funnel
   e) Large basin for return flow
   f) Rubber sheet
   g) Lubricant (mineral oil 2 oz. in medicine glass)

Procedure:

1. Wash hands, assemble requisites, and carry to patient's bedside.
2. Explain treatment to patient and provide adequate privacy.
3. Place patient comfortably in chair or semi-recumbent position in bed.
4. Fasten upper sheet around the patient's neck. Remove dentures, if any.
5. Place the emesis basin where it is handy, and give the patient paper tissues.
6. Lubricate the tip of the tube, grasp the tube about three inches from the end so that it curves slightly and will follow the curve of the mouth.
7. Reassure patient...pass the tube along the roof of the mouth, and when the pharynx is reached, instruct the patient to swallow continually and breathe deeply. When tube has been inserted into stomach (indicated by fact that 16" mark is at mouth), compress bulb and attach it to tube.
8. When stomach contents have been removed, replace bulb with funnel.
9. Pour solution, about 500cc at a time into funnel; siphoning off solution by lowering funnel and tubing

Gastric Expression and Irrigation cont'

Procedure:
so that solution will run into large basin.
10. Repeat until irrigating fluid is clear. (Discontinue treatment if blood appears in drainage).
11. Clamp tube with fingers when withdrawing it.
12. Return patient to comfortable position in bed. Give oral hygiene.
13. Care for equipment.
14. Record: Time, treatment, kind and amount of solution, by whom given, character and amount of return flow, and observation of patient.

## Retention of Stomach Contents

To determine the amount of stomach contents retained, measure the amount of solution used and the amount of solution returned, the difference of those two, is the amount of retention.

## II. Method of Inserting Levine Tube

Purposes:
1. To remove gastric contents for diagnostic purposes.
2. To prevent and relieve abdominal distention
3. To control nausea
4. To minimize peristalis
5. To introduce food into the stomach

Requisites:
1. Tray containing:
   a) Levine tube in basin of cracked ice
   b) Lubricant
   c) Clamp (screw)
   d) Adhesive
   e) Glass of water and drinking tube
   f) 20cc Syringe
2. Other requisites depending upon purposes of insertion.

Procedure:
1. Assemble requisites on tray and carry to bedside. Provide adequate privacy.
2. Explain to patient, what the treatment is to be and what relief he will obtain from it.
3. Place patient in sitting position if condition warrants. Remove dentures and glasses if any.
4. Lubricate the end of the tube and insert in patient's nostril to approximately 18" mark.
5. Instruct patient to breathe through mouth and swallow frequently. (Sips of tap water may be given to facilitate swallowing unless contra-indicated.
6. If no fluid drains off, test to see that the tube is correctly inserted by placing the end of the tube in water; if bubbles are seen, the tube should be withdrawn and reinserted.

Inserting Levine Tube cont'

Procedure:

7. Proceed with diagnostic test or treatment as ordered and record as such.

## III. Gastric Anaylsis

Method 1

Purpose:

To obtain specimens for determination of amount of free hydrochloric acid in gastric contents.

Requisites:

1. Ewald test meal (40 grams of white bread..2 slices of bread without crust) 200cc water..approximately 1 glass.
2. Tray containing:
   a) Levine tube in basin of chipped ice
   b) Topfler's Reagent
   c) 20cc Syringe
   d) Lubricant
   e) Rack containing test tubes (2-6)

Procedure:

1. Breakfast is withheld and an Ewald test meal is given, (noting time meal is finished)
2. Assemble requisites on a tray and carry to bedside.
3. Explain treatment to patient and provide privacy.
4. One hour after test meal is finished pass the levine tube.
5. Attach 20cc syringe to levine tube and aspirate small amount.
6. Test ½cc of the specimen with a drop of Topfler's reagent. If free hydrochloric acid is present a red color appears.
7. If free hydrochloric acid is present, extract 15cc of gastric contents, place in test tube and send to laboratory with requisition for gastric analysis.
8. Remove levine tube, leave unit in order, and care for equipment.
9. Serve meal as ordered.
10. If there is no free hydrochloric acid present in initial extraction, clamp tube. Histamine Acid Phosphate is administered by a doctor. (.0275mgm. in 1cc. ampules. The dosage is calculated in accordance with body weight).
11. Twenty minutes after administration of Histamine, withdraw 15cc of gastric contents, place in test tube, and send to laboratory with requisition of gastric analysis stating histamine was given.
12. Remove levine tube. Serve meal as ordered.
13. Record: Time, procedure, by whom done, difficulties encountered, character and amount of contents extracted, observation of patient, and disposition of specimens.
14. If histamine was administered note: time, amount of

Gastric Anaylsis cont'

Procedure:
histamine, Observe patient carefully noting following toxic symptoms:
1. Headache, (pounding type)
2. Increased pulse rate
3. Flushed face

Method II. Fractional Gastric Analysis
1. Follow prccedure under Method 1 to step 4.
2. Twenty minutes after test meal is finished, pass the levine tube. Extract first specimen (10-15cc) and place in test tube No. 1.
3. Clamp tube and fasten in place.
4. Aspirate 10cc of stomach contents every 15 min. until a total of 6 specimens are obtained. (If extractions are difficult..change position of patient and tubing. If further difficulty encountered instill 5cc of tap water. If unable to obtain specimen, notify supervisor).
5. Expel each specimen into properly numbered test tubes.
6. After the 6th specimen is obtained, withdraw the levine tube.
7. Send all specimens to laboratory with request for gastric analysis.
8. Record procedure as stated under Method 1.

## Gastric or Duodenal Suction (Wangensteen)

Purpose:
1. To prevent and relieve abdominal distention
2. To control nausea
3. To minimize peristalis

Requisites:
1. Tray containing requisites for the insertion of a levine tube.
2. Wangensteen Apparatus (Central Supply)

Procedure:
1. Follow procedure for insertion of levine tube.
2. When tube is in the stomach, connect levine tube to the tubing leading to the large gastric drainage bottle.
3. When electric suction is used, connect cord to outlet, and turn current on.
4. Close observation is necessary to determine if gastric suction is functioning adequately.
5. Irrigating the levine tube with warm water or normal saline solution at intervals will facilitate drainage and remove any obstructions in tubing.
6. Empty drainage bottle at half-way mark and every eight hours, and record amount and character of drainage.
7. Give only clear liquids by mouth as ordered.
8. Give special oral hygiene and apply mineral oil to nostrils and lips frequently.

Gastric Suction cont'

Procedure:

9. Adequate and correct measuring intake and output is essential in gastric suction.
10. When gastric suction is discontinued, clean apparatus throughly and return to Central Supply as soon as possible.
11. Record time and by whom levine tubewas inserted, color type and amount of gastric drainage, reaction of patient.

## "Miller Abbott Intestinal Intubation Tube"

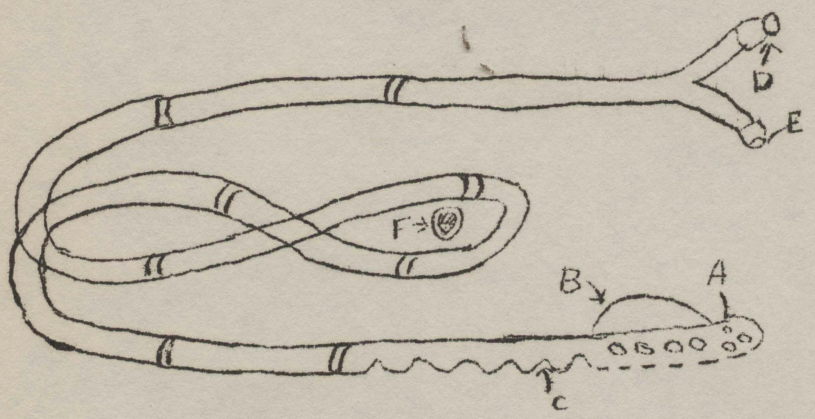
Purposes:

1. To reduce the distention in the portion of the intestine proximal to the lesion.
2. To locate and relieve obstruction.

Requisites:

Tray containing:

1. Basin with ice
2. Baloon and silk thread
3. Lubricant
4. Wangensteen suction apparatus
5. 20cc Syringe
6. Adhesive
7. Clamp
8. 5cc mercury (Air is sometimes used)




MILLER-ABBOTT TUBE

(A) Metal tip, (B) Balloon inflated, (C) Openings through which gas and fluids are aspirated, (D) Openings through which air is injected and withdrawn from balloon, (E) Point of attachment for suction, (F) Cross-section of tubing

Miller Abbott Intestinal Intubation tube cont'

Procedure:

1. Puncture center of closed end of rubber cover.
2. Draw cover over end of metal bulb "A".
3. Draw cover back over tied section and arrange folds.
4. If tied too tightly walls of channel "C" will be closely or partly closed. If tied too loosely the baloon "B" may leak.
   Before trimming excess rubber from balloon make the following tests:
   a. Test for inflation and suction.
   b. Immerse balloon section in water, inflate and apply moderate pressure by squeezing. If no leak appears, trim excess material.
5. The tube is passed in the same method as the levine tube. When the tube reaches the stomach, suction which is maintained constantly thereafter is begun.
6. Prop patient upon right side. Advance tube as ordered. Secure tube to face after each advance.
7. At this time the balloon is inflated with mercury 5cc. or air and clamp the lumen. (Never remove clamp).
8. Advance tube at rate directed (usually 2 tp 4 inches every hour.
9. Irrigate miller abbott tube in the same manner as irrigation of the nasal suction.
10. Record time of introduction of tube and by whom, method and time of each advancement, observation of patient, intake and output, which includes the fluid extracted through suction.
11. Withdraw tube slowly and gently when, treatment has been discontinued. Remove balloon from tube. The mercury is removed from balloon and return to the Pharmacy. Discard balloon. Wash tube well and return to Central Supply.
    Record time tube was removed.
    When treatment has been discontinued, withdraw tube slowly and gently, and record same.

# Instructions For Use of Cantor Tube

Purpose:

1. To relieve abdominal distention in obstructive or Paralytic Ileus allowing the walls of the intestine to contract thus retaining normal Blood Supply, innervation and motility.
2. To aid in diagnosis of intestinal obstruction.
3. To relieve the effects of obstruction until the patient is in condition for Surgery.

Requisites:

1. Cantor Tube (Obtained from Central Supply).
2. Lubricant
3. 5 to 10 c.c. of Mercury (Obtained from Drug Room).
4. 10 c.c. syringe
5. Water and drinking ture.
6. Black silk string (Obtained from Central Supply).
7. Stylet of a 21 or 22 gauge Needle (Obtained from Central Supply).

Procedure:

1. Give the patient morphine sulphate gr. 1/6 and atropine sulphate gr. 1/150 (by hypo) about one half hour before attempting to pass the tube.
2. Apply pontocaine 2 percent to the side of the nose through which the tube is to pass.
3. Lubricate end of tube.
4. Have the patient lie flat on his back with his head hyperextended or sit patient up with the head hyper-extended. Bear in mind that the bag is to pass downhill so put the patient in such a position that the nasal passage will be downhill from the external nares to the internal.
   With the head hyper-extended, feed the bag into the external nares. First grasp the bag at the tip to allow the mercury to run toward the tie. Now fold the bag to form a spur, and insert the spur into the nose. In patients with a very narrow passageway it is sometimes necessary to push the balloon back with a cotton tipped applicator. If the patient has a perforated septum the ballon may be inserted with a bayonet forcep.
5. After the bag drops into the naso-pharynx, sit the patient up and give him a drink of water. When he swallows once, the bag containing the mercury will drop down the esophagus and into the stomach. Pass in sufficient tubing to bring the letter "S" to the external nares. This indicates the tube is in the stomach. Connect up with the suction.
6. Now have the patient lie on his right side (without a pillow) and elevate the foot of the bed twelve inches. At this time pass sufficient tubing to bring the letter "P" to the External nares. This will bring the bag to the pylorus. Permit the patient to remain in this position for two hours.
7. Now turn the patient on his back, lower the foot of the

Instructions For Use of Cantor Tube cont'

bed, and put the patient on a back-rest. At this time pass in sufficient tubing to bring the letter "D" to the external nares. This should bring the tube into and down the duodenum. Permit the patient to remain in this position for two hours.

8. Now leave the patient lie flat in bed, and turn him on his left side. After this period permit the patient to move about freely. Motion of the patient greatly aids in the downward passage of the tube.
9. Check-up roentgen ray to determine the position of the tube in six hours.
10. Do not fasten the tube to the side of the face with adhesive. Permit the tube to lie free. Peristalsis often carries it down unaided.

Caution: Do not push the tube down. Do not advance the tube faster than four inches every two hours.

Recording:

1. Time of inserting, rate of progress of the downward passage of the tube, Characteristics of drainage.

Cleaning the Tube:

The tube is washed in plain water, rinsed in soap and water, soaked for ten minutes in lysol two percent. Wash in clean water and hang up to dry.

Caution: Do not permit organic solvents such as alcohol, benzine, etc. to come in contact with the tube.

# Chapter XVI

## Specimens

### Preparation of Specimens for Laboratory

Purpose:
1. To aid in making a diagnosis
2. To aid in determining progress of disease

General Instructions:
1. Secure proper receptacles for each kind of specimen.
2. Avoid contamination of specimen by having all receptacles clean. Avoid contamination of the outside of specimen receptacle.
3. Collect quantity sufficient for examination.
4. Collect specimens at the exact time ordered and take to laboratory promptly.
5. Label the laboratory requisition and the specimen clearly and completely.
6. Be sure container is sterile if specimen is requested sterile for culture.
7. Explain the procedure to the patient so that his cooperation may be secured.
8. Record: time collected, kind of specimen, signature of nurse.

A. Urine
1. Single voided
   a) Have patient void in clean bedpan or urinal.
   b) Transfer a sufficient quantity (100-150cc) to clean specimen bottle and label correctly.
   c) For routine urine specimen lnless time is specified, the early morning urine is sent to lab.
2. Single catheterized
   a) Catheterize patient in usual manner (see page 76)
   b) Collect specimen in sterile container, label, and send to laboratory.
3. Urine Culture
   a) Obtain culture tube from laboratory.
   b) Catheterize patient in usuall manner by allowing urine to flow directly from catheter into culture tube. (Do not allow cotton plug to become contaminated).
   c) Replace cotton plug, label, and send to laboratory.
4. 24 Hour
   a) Secure large glass container, label clearly, and collect all urine voided in that 24 hour period including that voided at 7 A.M. the following morning.
   b) Have patient void at 7 A.M. discard urine.
   c) Save all urine during 24 hour period including that voided at 7A.M. the next morning.
   d) 24 Hour specimen is kept in utility room, it may be necessary to use a preservative.

Preparation of Specimens cont'

E) Measure each voiding and record on chart.
f) At end of 24 hours, measure entire amount and send 4-6 oz. to laboratory.
g) If a quantitative test is ordered, send all urine collected in 24 hours to laboratory and label accordingly.

5. Fractional Diabetic 24 hour.
   a) The 24 hour period is divided into 4 parts....
      7-11 A.M.
      11 A.M.-4 P.M.
      4 P.M. - 10 P.M.
      10 P.M.-7 A.M.
   b) Secure a glass container, label accordingly, and leave in utility room. Collect all urine for the stated interval, put together in container. At end of period, measure entire amount and clinitest If negative, discard urine, and cleanse glass container. If sugar is present, (2%) send all of urine for that period to laboratory for a quantitative Bendict's test. (With appropriate requisition).
   c) The other specimens should be collected and disposed of likewise.
   d) Record on special diabetic sheet: time, total amount of urine, result of clinitest, disposition of urine.
   e) Be sure to cleanse glass container thoroughly after each period.

B. Feces
1. Obtain waxed cardboard container with cover.
2. Collect stool in clean bedpan which is free of contamination by urine.
3. Transfer small quantity of fecal material (about size of large walnut) from bedpan to specimen container with tongue blade and cover securely. Be sure that any unusual material such as mucus, blood, etc. is included.
4. Label and take to laboratory immediately with proper requisition.
5. Collect stools in which amoeba are thought to be present, in bedpan and transfer quickly to waxed container and take immediately to laboratory.
6. Record: time, how obtained (natural bowel movement or enema) disposition of specimen, signature of nurse.

C. Sputum
1. Obtain a small wax-lined pasteboard container and place at patient's bedside.
2. Instruct patient to cough up material from the lungs or bronchi and expectorate directly into container.
3. Cover well, label and take directly to laboratory with proper requisition.
4. Wash your hands.
5. The best specimen is obtained in the early morning. But in the same instances all sputum in a 24 hour period may be saved. Record: time, disposition of spec. signature of nurse.

CLINICO-PATHOLOGY
LABORATORY

MERCY HOSPITAL

DIRECTIONS FOR NURSES

TIMES LABORATORY IS OPEN:

The laboratory is open on weekdays from 7:00 A.M. to 6:00 P.M.; on Saturdays from 7:00 A.M. to 4:00 P.M. and on Sundays from 7:00 A.M. to 12:00 Noon.

EMERGENCY OR STAT WORK WHEN LABORATORY IS NOT OPEN:

All stat blood counts and urine examinations from 6:00 P.M. to 7:00 A.M. on weekdays and from 12:00 Noon on Sunday to 7:00 A.M. Monday are done by the intern on call. Other emergency or stat laboratory work such as blood matchings and blood sugars is done by the technician on call. Requests for the technician to be called should be made by the Visiting Staff Doctor or by the intern to the telephone operator.

Nurses should not make this request.

STAT WORK DURING LABORATORY HOURS:

Stat work during laboratory hours should be ordered as stat only by the Visiting Staff Doctor. Request slips for this work should be brought immediately to the laboratory with the word "STAT" on them and they should be handed to one of the technicians.

CHARTING:

Laboratory reports are charted at 10:30 A.M. and 1:30 P.M. and 5:45 P.M. All reports are charted on the first charting around after they are completed. It is requested that telephone request for reports be kept to a minimun.

REQUESTS FOR LABORATORY WORK:

NOTE: ALWAYS FILL OUT LABORATORY REQUEST SLIPS COMPLETELY INCLUDING FIRST AND LAST NAMES OF PATIENTS, ROOM NUMBER, DOCTOR, DATE, TIME SLIP WAS FILLED OUT. ALL SLIPS SHOULD BE SIGNED BY THE NURSE FILLING THEM OUT.

All requests except for urinalysis should be made on the standard laboratory Form 52-A. These requests should state exactly what procedure is required instead of reading "sputum examinations" or "stool examination". Urinalysis slips

Clinico-Pathology Laboratory cont'

No. 252-A in duplicate should accompany each specimen of urine sent to the laboratory except those for pregnancy tests and urine for culture. These specimens should be accompanied by the standard Form 52-A. All request slips except stat requests and those around urine specimens should be placed in the request box in the hall by the laboratory.

AGGLUTINATIONS:

Request slips for agglutinations should be made on Form 52-A and should indicate the type of agglutination desired.

BACTERIOLOGY:

(1) Smears and cultures of exudate such as draining wounds, should be collected by the interns or residents using sterile applicators and slides secured from the laboratory. The specimens are then sent to the laboratory.

(2) Urine cultures. These specimens are collected in sterile test tubes secured from the laboratory. Female patients must be catheterized. Male patients need not be catheterized but the penis must be washed with green soap and water and the bladder partially emptied before the specimen is collected. The tubes should never by filled more than halfway and the cotton plugs should be handled only on the outer end.

(3) Stool cultures. This specimen should be collected in sputum cups with lids and sent to the laboratory as soon as possible after collection.

(4) Blood cultures. Request slips for blood cultures should come to the labbratory before medication is begun if possible and if the history of the case indicates when a spike in temperature might be expected this information should be placed on the request slip.

(5) Sputum. Collect specimen in sputum cup (with cover) and send to laboratory with name of procedure desired indicated.

(6) Bacteriology. Nasopharyngeal and throat cultures are collected by the intern. These are run routinely on patients admitted to pediatrics with upper respiratory infections. The sterile applicator stick swab is used for the throat and the sterile copper wire swab for the nasopharyngeal cavity. However, slow growth of the bacteria may require up to 40 hours. Collection of a heavy swab inoculum from the inflamed area will aid in a rendering a more rapid report.

(7) Sensitivity tests or antibiotic sensitivity tests can be performed on any organism cultured from any source. This should be requested at the time the culture request is made.

(8) Gastric washing for tuberculosis. The stomach should be washed with about 25 cc. of sterile saline and the contents of the stomach place in one or more test tubes.

Clinico-Pathology Laboratory cont'

SPINAL FLUIDS:

Spinal fluids should be collected in three sterile test tubes and the tubes numbered with the first portion of the specimen in tube "1", et cetera. All of the procedures desired should be indicated on the slip. If no list of determinations desired is given, a cell count, protein, Wassermann, and colloidal gold will be done. The specimens should be sent to the laboratory immediately after collection. Lumbar punctures should be done before 2:00 p.m. whenever possible.

BLEEDING AND COAGULATION TIME:

Bleeding and coagulation time should be done on all surgical cases before operation and on all male infants before circumcision. Requests should be sent down for these procedures as soon as the patient is admitted (or delivered).

BLOOD CHEMISTRIES:

All requests for blood chemistries should be in by 7:30 A.M. Requests for glucose tolerance tests should come down the afternoon before whenever possible. Breakfast should be held on patients who are to have any of the following tests:

(1) Non-Protiin Nitrogen.
(2) Urea Nitrogen.
(3) Blood sugar (dextrose).
(4) Blood chlorides.
(5) Phosphatase
(6) Cholesterol.
(7) Calcium.
(8) Phosphorus.
(9) Serum proteins.
(10) Blood potassium.
(11) Creatinine.
(12) Icterus Index.
(13) Van den Bergh.
(14) Thiocyanate level.
(15) Glucose tolerance.
(16) Basal Metabolic Rate.
(17) A. G. Ratio.
(18) Cephalin flocculation.
(19) Thymol turbidity test.
(20) Amylase.
(21) Bromsulfalein.

Collection of the chemistry specimens is begun at 7:30 A.M. and is completed as soon as possible so that the patients may have their breakfast.

GLUCOSE TOLERANCE TEST:

A. Exton-Rose Test.
1. Collect fasting urine and blood specimens.
2. Give glucose (50 Gm in 325 cc of water) intravenously.

Clinico-Pathology Laboratory cont'

3. Collect urine specimens 30 minutes later.
4. Give glucose intravenously again.
5. Collect urine specimen 30 minutes later.
6. Collect another urine specimen one hour later.

B. Regular Test.
1. Conduct test in morning after fasting night and no breakfast.
2. Collect fasting blood and urine specimens for sugar determinations.
3. Give 1.75 Gm glucose per kilo of body weight dissolved in 500 cc of water orally.
4. Urine and blood specimens every hour for four to five hours for sugar determinations.

P. S. P. TEST:

Give the patient two glass of water. Twenty minutes later have him void and discard the urine. Inject 1 cc phenolsulfonphthalein intravenously or intramuscularly. Collect urine specimens one hour and ten minutes later and two hours and ten minutes later. Send both specimens to the laboratory.

BLOOD COUNTS:

Request slips (on Form 52-A) should be sent to the laboratory as soon as ordered by the doctor and should indicate whether a complete blood count is desired or whether a hemoglobin and red blood count, total white count, or total white count and differential count is to be done.

EOSINOPHILE COUNTS (THORN TEST)

No food after 8:00 P.M. On the following day 200 cc of water at 6:00 A.M., 8:00 A.M. and 10:00 A.M. Urine is collected from 6:00 A.M. to 8:00 A.M. and an eosinophile count is done at 8:00 A.M. Immediately thereafter 25 mg of A.T.C.H. (Armour standard) is injected intramuscularly. Urine is collected from 9:00 A.M. to 12 noon and an eosinophile count is repeated at 12:00 noon. Send the two urines to the Laboratory for uric acid and creatinine determinations.

BASAL METABOLIC RATE:

Requests for B.M. R's should be sent down the evening before whenever possible and the patient should receive no breakfast until the procedure is done. The patient should be kept quiet and not allowed to smoke prior to the test. A very small amount of water to rinse the mouth is permissible.
A. B. M. R. should not be run on a patient having a fever.

BLOOD DONORS:

Requests for typing and crossmatching should be sent to the laboratory as soon as ordered. The request slip for cross-

Clinico-Pathology Laboratory cont'

matching should indicate how many 500 cc units of blood if the patient is an adult or number of cc if patient is a baby. Each patient receiving a transfusion will be notified of the number of replacement donors needed. Donors are taken each afternoon with the exception of Sunday from 12:00 to 3:00. Donors should be fasting for four hours.

DIABETIC URINES:

Routine diabetic urines are tested for sugar on the ward using clinitest. Those sent to the laboratory for quantitative testing should consist of the entire specimen voided and should indicate the time the specimen was passed.

E. K. G. 'S:

Requests for E. K. G. 'S should come to the laboratory in the morning if possible as they are taken each afternoon at 12:30 P.M.

PREGANACY TESTS:

The first morning specimen should be collected and sent to the laboratory in a urine specimen bottle accompanied by a Form 52-A which indicates the type test desired.

FROZEN SECTION:

Frozen sections should be scheduled in the Pathology office as soon as the case is booked in the operating room.

GASTRIC ANALYSIS:

Breakfast is with-held and Ewald test meal is given (2 slices of white bread and a glass of water). A specimen is aspirated one hour later and if no free acid is present histamine diphosphate is given. Free acid is detected by adding a drop of Topfer's reagent to 5 cc of gastric contents. If free hydrochloric acid is present a red color appears. Histamine diphosphate is to be administered by the intern. Histamine should not be administered in cases of Pregnancy, migraine headache, or hypertension (over 150/100). At no time should more than .5 cc be given. Another specimen of gastric contents is collected 30 minutes after administration of the histamine.

Subcutaneous injection for gastric analysis:

| Weight | Mg. Histamine Di Phosphate (Lilly--2.75 mg. histamine base per cc) |
|---|---|
| 150 lb or over | 0.5cc |
| 140 | 0.4cc |
| 130 | 0.3cc |
| 120 | 0.25cc |
| 110 | 0.20cc |
| 100 | 0.20cc |

Clinico-Pathology Laboratory cont'

PREOPERATIVE LABORATORY WORK:

Requests for preoperative blood counts and bleeding and coagulation time should be sent to the laboratory as soon as ordered if the patient has been in for several days. Work on surgical patients admitted the night before is picked up and charted by the hour scheduled. It is requested that patients scheduled at 8:00 A.M. be taken to surgery no earlier than 7:30 A.M. so the specimens may be collected.

SEROLOGY:

All admissions receive a V.D.R.L. and Kline. Request slips are not necessary unless a recheck is desired as the names are taken from the admit slip. All positive serologies are sent to Iowa City for checking by the complement fixation technique.

URINALYSIS:

Urine specimens for routine urinalysis should be sent to the laboratory on the first morning after admission unless ordered STAT and should be in the laboratory by 7:15 A.M. Please see that all patients have a urine specimen sent to the laboratory.

NOTE

Any suggestions as to how the laboratory service may be improved will be greatly appreciated. If you are not sure what to do about any laboratory work call the laboratory. If at night, call either the technician on call, the resident in Pathology, or Doctor Coleman.

January 12, 1951

# Lumbar Puncture

Purpose:

1. To relieve pressure
2. To remove fluid for examination
3. To remove fluid when a liquid is to be injected to prevent an increase in pressure

Requisites:

1. Spinal tray and novacaine from Central Supply
    a) Sterile towel
    b) 3 Applicators
    c) Spinal sheet
    d) 2 cc luer lock syringe (for anesthesia) with 1 25 gauge needle
       1 23 gauge needle
       1 ampoule file
    e) 1 10cc syringe
    f) 2 lumbar needles (18-20) gauge
    g) spinal manometer
    h) 3 sterile test tubes with stoppers (2 cork, 1 cotton) in medicine glass.
    i) 2 gauze squares for dressing
    j) ampoule of 1% novacaine 2 cc in sterile towel
    k) hemostat (for emergency use)
2. Tincture of Merthiolate to disinfect skin
3. Rubber gloves (sterile)
4. Folded newspaper
5. Adhesive tape
6. Sterile gown at doctor's request

Procedure:

1. Have all requisites in room on cleared bedside table.
2. Upon arrival of doctor open spinal tray and sterile towel containing the novacaine. Place sterile gloves on this towel.
3. Put folded newspaper in a convenient place on bed.
4. Open merthiolate bottle.
5. Put patient in proper position.
    a) Place on his side with back close to edge of bed.
    b) Flex knees up to abdomen and draw the head down.
    c) Have the shoulders and hips as near perpendicular to the bed as possible.
    d) Hold the patient by placing one arm under the knees and the other around the neck.
6. Be prepared to locate the iliac crest and compress the jugular vein, if the physician requests, to also hold the manometer if requested.
7. When the doctor has finished, place a small gauze square over the area and fasten with adhesive tape.
8. It is well and wise for the patient to remain flat for 4-6 hours.

Lumbar Puncture cont'

Procedure:

9. Take specimen to laboratory with necessary data as ordered. If specimen is to remain in room for doctor's observation, a corked stopped test tube is used and dated.
10. Clean equipment, check itemized list and return to Central Supply immediately.
11. Record: time, spinal puncture, by whom and disposition of fluid.

## Abdominal Paracentesis
(Withdrawal of fluid from the abdominal cavity)

Purpose:

1. For diagnostic purposes
2. For the relief of pressure
3. To permit drainage of an exudate

Requisites:

1. Dressing tray plus:
   a) pointed scapel
   b) trocar and cannula
   c) 5 cc syringe with a hypodermic needle and 1 # 22..1½"
   d) ampoule novacaine 1%
   e) ampoule file
   f) sterile gloves
   g) sterile towels
   h) 2 sterile culture tubes
   i) sterile dressing
   j) 3 way stopcock
   k) needle holder, needle, and sutures if ordered
2. Sterile gown
3. Rubber sheet
4. Bath blanket (2)
5. Rubber tubing with glass connector
6. Large non sterile pail for fluid
7. 50 cc. syringe
8. Aspirating machine, if desired

Procedure:

1. Explain procedure to patient and provide adequate privacy. Assemble requisites and arrange conveniently at bedside.
2. Have patient void or report failure to void.
3. Prepare the area as ordered. Shave if necessary.
4. Place patient in position requested by doctor:
   a) on a straight chair
   b) on the edge of the bed with feet on a chair
   c) in bed with backrest elevated
5. Drape with bath blanket, one over shoulders and one over the knees if the patient sits up.
6. Place rubber sheet over lap well against lower abdomen below prepared skin surface.
7. Assist physician as necessary with gown, gloves and other equipment.
8. The doctor will prepare the skin, give the local anesthetic, make the incision and insert the trocar and cannula.

Abdominal Paracentesis cont'

Procedure:

9. After a specimen has been collected connect long rubber tubing to arm of cannula and allow fluid to collect in pail.
10. If aspirating machine is used, connect rubber tubing from aspirator to the arm of cannula and turn on switch.
11. While fluid is being withdrawn, observe patient closely for symptoms of collapse.
12. As the flow lessens, gentle pressure on the abdomen may increase the drainage.
13. When the cannula is removed, apply thick sterile dressing and snug abdominal binder.
14. Remove drapes and equipment and leave patient comfortable.
15. Measure entire amount of fluid and send ordered specimen to lab.
16. Clean and care for equipment.
17. Observe patient for chills, headache, abdominal pain, dizziness, cardiac or respiratory difficulty. Keep patient quiet in bed for at least six hours or as long as there is pain or drainage.
18. Record: time, procedure, by whom, amount and character of fluid, specimen sent to laboratory, observation and reaction of patient.

## Thoracentesis
## (Withdrawal of Fluid From Pleural Cavity)

Purpose:

1. Diagnostic measures
2. Relief of intrathoracic pressure

Requisites:

1. Dressing tray same as for "Abdominal Paracentesis".
2. Remove trocar and cannula, pointed scapel, sutures, needle holder.
3. Add two aspirating needles gauge 16 and 18.
4. Sterile gown
5. Bath blanket
6. Rubber sheet
7. Sterile dressing
8. 1000 cc. sterile graduate

Procedure:

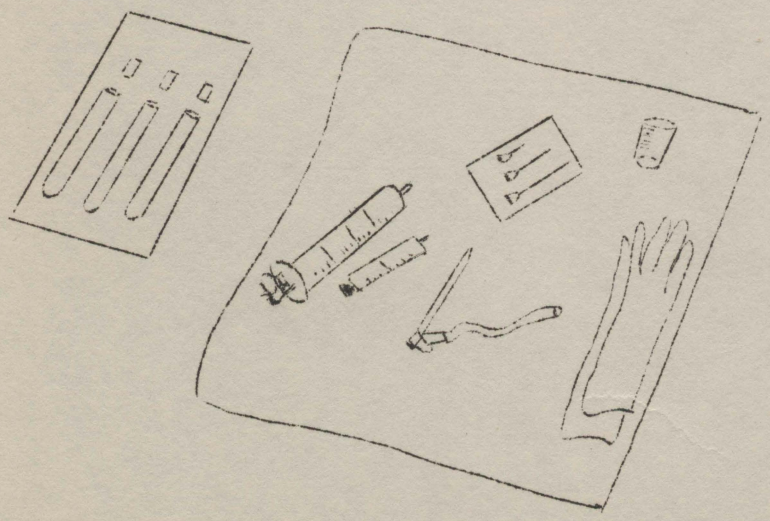
1. Explain procedure and provide privacy.
2. Assemble requisites and arrange conveniently at bedside.
3. Place patient in position requested by doctor:
   a) In a sitting position with the arm on the affected side raised to afford widening of the intercostal spaces. A bedside table padded with 2 pillows is placed in front of the patient to afford firm support and offset fatigue. Another pillow is pressed closely to the base of the spine.
   b) If patient is unable to sit up, place patient in semi-recumbent position with affected side uppermost with

Thoracentesis cont'

Procedure:

back near edge of bed. Remove sleeve of gown on affected side, place the arm across the chest on opposite shoulder.

4. Protect patient with bath blanket.
5. Protect bed with rubber sheet.
6. Prepare area as ordered.
7. Assist doctor with gown, gloves, and other equipment.
8. The doctor anesthetizes the area and inserts the aspirating needles. The stopcock is connected and fluid is alternately withdrawn and then expressed into the graduate pitcher. It is important that the stopcock be closed when expressing fluid from the syringe in order to prevent air from entering the pleural cavity.
9. Observe patient closely during the procedure and several hours following treatment for dyspnea, cyanosis, pallor, weak pulse, and collapse.
10. When the needle is withdrawn, apply sterile dressing, replace gown and leave patient comfortable.
11. Clean and care for equipment.
12. Record: time, procedure, by whom, amount and character of fluid, specimen sent to lab, and patient's reaction.



# Chapter XVII

## Special Procedures Related to the Care of The Eye, Ear, Nose and Throat.

I. The Eye.

A. Hot Compresses to the Eye

Purpose:

1. To relieve pain
2. To increase circulation
3. To promote absorption..and reduce tension

Requisites:

1. Electric hot plate
2. Tray containing:
   a) Basin with prescribed solution (boric and water)
   b) Compresses (strips)
   c) 2 Large towels
   d) Vaseline or cold cream

Procedure:

1. Hot plate is plugged in and prescribed solution in basin is heated.
2. Cut strips to size needed, put compresses in a towel with ends of towel hanging over pan. Heat.
3. Rub surrounding skin around lids with vaseline or cold cream.
4. Put towel over patient's chest.
5. Express solution from pads by twisting towel in opposite direction.
6. Test pads on back of hand (compresses as a rule are not considered sterile.)
7. Place gently over closed lid.
8. Change the compress every 30-60 sec., for 10-15 minute intervals. Repeat in 2-3 hours as ordered.
9. Dry lids after treatment.
10. New pads are used after each application if eye has a purulent secretion. If both eyes are affected, treat one eye, change compress solution and equipment and apply to other eye for stated time. Use of shield is sometimes indicated.
11. Record: time, treatment, duration, kind and amount of drainage, patient's reactions.

B. Ice Compresses to the Eye

Purpose:

1. To cause constriction
2. To reduce amount of secretion and relieve pain
3. To reduce swelling
4. To retard bacterial growth

Ice Compresses to Eye continued

Requisites:
1. Strips cut to size needed
2. Crushed ice in basin
3. Towel

Procedure:
1. Carry articles to bedside and explain the procedure.
2. Have patient move to side of bed in dorsal recumbent position. Remove all but one pillow under the head.
3. Clean eye lids and dry.
4. Place patient's face towel well up under chin.
5. Place pads in sling suspended in ice.
6. When thoroughly chilled, place one over eye and change every 15-30 sec., for 10-15 minutes each hour or as ordered.
7. As you change the pads use the next succeeding pad that is next in order on the ice.
8. Carry out treatment for duration of time ordered.
9. Dry the eye and area about the eye with a clean sponge. Remove chest towel.
10. Record: time, treatment, duration, condition of eye and signature of nurse.

C. Eye Irrigation

Purpose:
1. To cleanse the eyes.
2. To control infection and relieve inflammation.

Requisites:
1. Asepto syringe (small) or medicine dropper.
2. Bottle or warm boric solution.
3. Kidney basin for catching secretions and fluid.

Procedure:
1. Carry equipment to bedside and explain procedure to patient.
2. Place patient in a dorsal recumbent position with head tilting slightly back and turned on affected side or up in chair with head tilted.
3. If only one eye is to be treated, protect the other by using a pad or dressing or shield.
4. Wash off discharge from lids with moist sponge, using each sponge only once, and wiping from the inner to the outer canthus. Discard sponge into waste basin.
5. Instruct patient to hold basin. Stand directly in front of patient so you may see what you are doing.
6. With your thumb and finger hold lids open (thumb for lower lid and index finger for upper lid). Press firmly against molar bone. Have the patient look up.
7. Direct stream of solution away from the nose. Enough solution must be used to insure thorough removal

Eye Irrigation cont'

of any discharge. No part of the dropper should touch the eye, lids, or lashes.
8. Dry the face.
9. Clean and care for the equipment.
10. Record: time, treatment, solution used, condition of eye. Signature of nurse.

D. Instillation of eye drops

Purpose:
1. To alter the size of the pupil.
2. To produce local anesthesia.
3. To relieve discomfort of the patient.
4. To treat certain eye conditions.

Requisites:
1. Medication ordered
2. Sterile eye dropper
3. Sponge

Procedure:
1. Carry requisites to bedside and explain procedure to patient.
2. Place patient in dorsal recumbent position with head tilting slightly back and toward affected eye.
3. Draw up required amount of medication into dropper. Hold dropper so that solution will not run into rubber bulb.
4. Evert the lower lid and have the patient look up.
5. Steady the hand holding the dropper by resting the little finger on the patient's forehead. The dropper should never touch the eye.
6. Allow the drop of medication to fall into the lower conjunctival sac, never on the cornea.
7. Have the patient close his eyes gently and look down. Catch the overflow of the medication with the compress (if it is impossible to gain the cooperation of the patient in opening his eyes, hold the head in position and allow a drop of medication to fall on the inner canthus. When the eyelids are opened the medication will run into the eye).
8. If it is necessary to prevent the absorption of the medication through the lacrimo-nasal duct, apply pressure with the compress at the inner canthus for a moment.
9. Care for the eye dropper.
10. Record: time, medication, strength, amount and the eye in which medication has been instilled. Signature of nurse.

E. Administration of Eye Ointments

Purpose:
1. To treat certain eye conditions

Administration of Eye Ointments cont'

2. To lubricate and soothe eyelids and eyes.

Requisites:
1. Medicated ointment as ordered
2. Compress

Procedure:
1. For eyelids.
   a) Squeeze a small amount of ointment on lids and spread gently with the little finger.
2. For eye.
   a) lower lid
      (1) Evert lower lid.
      (2) Press tube and apply a thin layer of ointment into the lower conjunctival sac. To break off ointment from tube, turn sharply in opposite direction. Do not touch the eye or lids with the tube.
      (3) Have the patient close his eyes.
   b) upper lid
      (1) Instruct patient to look down.
      (2) Evert upper lid.
      (3) Apply ointment in same manner as for lower lid.
3. Record: time, name, strength and amount of medication, eye in which medication applied, condition of eye. Signature of nurse.

II. The Nose.

A. Instillations of nose drops.

Purpose:
1. To relieve congestion.
2. As an astringent to shrink the mucous membranes.
3. As an antiseptic to retard bacterial growth.

Requisites:
1. Prescribed medications
2. Medicine dropper
3. Gauze or kleenex
4. Folder newspaper or paper bag.

Procedure:
1. Assemble equipment at patient's bedside.
2. Explain procedure to the patient and encourage him to cooperate.
3. Place patient in desired position.
   a) Lying so that head drops backward over the side of the bed.
   b) With pillows removed and head tilted backward. (Pillows may be placed under shoulders).
4. Turn the patient's head to one side.
5. Insert the medicine dropper in the lower nostril

Instillations of Nose Drops cont'

about ½ inch and instill the number of drops ordered.
6. Avoid touching the nostril with dropper.
7. After the medication has been instilled keep patient in same position about 5 minutes.
8. Turn the patient's head to the opposite side and repeat the procedure.
9. Offer kleenex as some medication may run into the mouth and need be expectorated.
10. Leave patient comfortable and care for the equipment.
11. Record: time, medication, amount used, reaction of the patient and nurse's signature.

III. Throat Irrigations.

Purpose:
1. To relieve congestion and inflammation.
2. To cleanse the mouth and throat of accumulated secretion and discharge.
3. To promote suppuration before incision of an abscess.

Requisites:
1. Prescribed solution (1000 cc). 110 degrees F.
   a) Physiological Salt Solution
   b) Tap water
   c) Sodium Bicarbonate Solution (2%).
2. Sterile irrigating can with tubing, clamp and glass irrigator.
3. Large basin for return flow.
4. Rubber protector
5. Graduate (1000 cc) for Solution
6. Towels
7. Standard

Procedure:
1. Assemble equipment and arrange conveniently at patient's bedside.
2. Explain procedure to patient and provide adequate privacy.
3. Place patient in sitting position or semi-recumbent with head turned to one side.
4. Apply rubber protector and towel over shoulders and chest of patient.
5. Instruct the patient to hold the large basin under chin, to breathe thru his nose during treatment and to open his mouth wide.
6. Pour solution in irrigating can and hang on standard.
7. Open the clamp on the tubing and allow a little of the solution to run into the basin.
8. Clamp off tubing and place the irrigating tip as far inside the patient's mouth as you can without touching the Pharynx.
9. Unclamp tubing and control the flow with pressure of your fingers.

Throat Irrigations cont'

10. Let the solution run move the tip about so that all parts of the upper mouth are irrigated.
11. Remove and care for equipment leaving unit in order and patient comfortable.
12. Record: time, treatment, amount and kind of solution used and reaction of the patient. Signature of the nurse.

# Routine Tracheotomy Care

Purpose:
To keep tube free from mucus and promote easier breathing

Requisites:
1. Electric suction with rubber catheter
2. Tray (at bedside containing:
   a) tracheotomy tube (sterile) the correct size for Pt.
   b) basin of water to cleanse suction catheter
   c) basin of hydrogen peroxide to cleanse inner tube
   d) basin of lime water or boric acid to wet dressing
   e) pipe cleaners
   f) forceps in solution
   g) scissors (sterile)
   h) sterile 4x4's or 12 x8's
   i) tracheotomy tape to be used when re-inserting a new outer tube
3. Pencil and paper at bedside
4. Steam inhalator

Procedure
1. Suction pt. as often as necessary to keep free from mucus (usually every hour for the first 24 hours.) Introduce catheter into tube at end of inspiration.
2. After each suctioning cleanse catheter by drawing water through it.
3. Suction, remove inner tube, suction, clean tube with pipe cleaners saturated in hydrogen peroxide.
4. To ascertain if tube is clean, hold it up to light. Be sure it is thoroughly clean and unobstructed before inserting. Never leave inner tube out longer than five minutes. Never leave patient alone if you are cleaning the inner tube.
5. Change dressings around tracheotomy tube as frequently as they become soiled. Take care that dressing does not obstruct tracheotomy opening.
6. Moisten a dressing with lime water or boric. Pin over opening of tube (this moistens the inspired air and filters out dust).
7. Only the Dr. will change the outer tube. Clean tracheotomy tape is applied at this time.
8. Clean, boil, and keep sterile (at bedside) the tube (all three parts) which were removed.
9. Oxygen may be administered through tracheotomy tube if necessary.
10. Nursing Care:
    a) place pt. in a semi-sitting position
    b) keep signal light handy
    c) keep pencil and paper handy...these patients cannot talk and make their desired wants and wishes known.
    d) do not until the tapes holding the outer tube
    e) give good oral hygiene
    f) keep room moist with steam inhalator...adds to patient's comfort.

g) if tracheotomy tube is expelled or accidently removed...Remember that a hemostat may be used to spread the tracheal wound apart and allow patient to breathe until a duplicate tube can be reinserted.

h) all tracheotomy patients need careful observing

11. Record: time, removal of inner tube, suction, amount of secreation obtained, patient's respirations and reactions, Nurse's signature.

# Chapter XVIII

## Care Of The Dying

A. Physical care of dying.

General Instructions:

1. If possible, patients in a critical condition should be placed in a private room. When left in a semi-private room, they should be well screened.
2. When a change of condition is noted, it is reported to the day or night supervisor. The priest ( if the patient is a Catholic) the physician, and Patient's relatives are notified by the supervisor.
3. A nurse should be in constant attendance at the bedside of the dying patient. Any distressing symptoms which may arise should be alleviated insofar as is possible.
4. Incontinence should be anticipated and a pad made of soft, absorbent material placed under the buttocks to save linen and make the cleaning of the bed less an ordeal for the patient.
5. If the patient is able to swallow, thirst may be alleviated by cool drinks in small quantities given by a teaspoon or medicine dropper, carefully watching that the patient swallows before giving more..
6. When the patient is no longer able to swallow, the mouth and lips may be moistened with a gauge swab dipped in ice water. Oil may be used also to keep the lips and mouth moist.
7. Raising the head of the bed helps the patient to breathe more freely. Turning him on his side, the head and shoulders supported by pillows will prevent the tongue from rolling back and obstructing the passage of air to the lungs. Since the patient cannot move himself, his position will have to be changed for him.
8. The skin should be kept dry of perspiration, and the gown and linen changed as necessary.
9. Bathing the eyes with boric acid solution will relieve irritation or dryness and remove the exudate which gathers because of weakened reflexes.
10. Every dying man or woman has the right to know that he is going to die, if he wants to know it; and when all hope for his recovery is lost, difficult though it may be to tell him, most physicians feel that it is their duty to tell them.
11. Although hospital activities cannot be stopped because a patient is dying, the air of bustle and the preoccupation of nurses in their own duties are likely to make the distressed family feel that the hospital staff is indifferent to suffering. Every effort should be made to show genuine concern and sympathy for them.

Care Of The Dying cont'

12. As the end draws near, the dying patient often develops his own anesthesia. His sense of hearing becomes less and less acute. His senses, are gradually dulled, his vision fails. It is usually necessary by this time to speak in a clear loud voice near the ear of the patient to have him understand directions. Talking, however, must always be guarded in the presence of a patient who seems insensitive to what is happening around him.

Care of the body after death.

Requisites:

1. Mortuary bundle (to be obtained from the Central Supply) unless an autopsy is performed.
2. Mortuary Box on each floor.

Procedure:

1. Note the exact time the patient ceases to breathe.
2. Unless already present, call the House Physician or intern to pronounce death.
3. Notify the admittance office, who will notify the physician in charge. Complete the form provided leave in main office.
4. Notify the relatives, leave the family alone with the body for a few minutes, then showing them sympathy and kindness, escort them to the reception room, where they maywait until they are ready to go home.
5. Return to the room and begin preparation of the body. There should be no loud talking or laughing when caring for the body. Do work quietly, quickly, and respectfully.
6. Straighten the body as soon as death is pronounced.
7. If the patient has dentures, replace at once and close the mouth.
8. Remove all pillows from under the head, except one; remove all upper bedclothes except the top sheet.
9. Close the eyes.
10. Give a complete or partial bath as necessary.
11. Pack the rectum with cotton, also the vagina, if necessary.
12. Remove all jewelry, relics, etc. and place with patient valuables. Give these to the relatives. If they are not present, take them to the office for safe keeping.
13. Remove all soiled dressings and replace with clean ones.
14. Remove drainage tubes, clamps, trachetomy tube, etc.
15. Remove adhesive marks from the body with benzine or adhesive remover.
16. Put a paper shroud or mortuary gown on the patient. Comb the hair, clean the fingernails.
17. Fill in identification tags found with the mortuary gown with the patient's, name, room number, Doctor's name and time of death. Place one tag on opposite

Care of the Dying cont'

wrist and ankle.
18. Take the body to the morgue if an autopsy is to be done, or if another patient occupies the room.
19. If the patient's relatives do not take the clothes, wrap them and send them with the mortician.
20. If autopsy is performed, chart goes with the corpse. If no autopsy, chart is completed, and placed in discharge basket.
21. Record: hour of death and who pronounced death, notification of Doctor, anything unusual connected with the death, nurses's signature.

B. Spiritual Care of the Dying

Notify the Priest on Each of These Occassions:
1. Persons critically ill,
2. Again when dying, or
3. found recently dead.
4. Before major surgery.

(In cases 2,3, and 4 notify the priest even at night unless you are sure the person has been completely taken care of by him within the last few hours.

Preparation for the Administration of the Last Sacraments to a Catholic Patient.

I. Holy Communinn

Requisites:
1. Bedside table
2. Table cover
3. A Corporal or small square of linen (folded)
4. Two blessed candles and two candle sticks
5. A Crucifix
6. A small glass with water and a dessert spoon
7. A bottle with shaker top containing Holy Water.
8. A finger cloth (this may be omitted where the Priest returns to the Chapel.
9. A Communion card.

Preparation of Table:
1. The table should be placed where it can be easily seen by the patient. The linen table co cover is placed on the table.
2. The Crucifix is placed at the center back of the table with a Blessed Candle in the holder at each side.
3. The Corporal is unfolded and placed at the center front.
4. The Bottle of Holy Water is placed to the left of the Corporal, and a finger cloth and a small glass of water to the right.
5. The Candles are lighted unless there is an oxygen tent or a highly inflammable substance in the room.

Spiritual Care of the Dying cont'

Preparation of the Patient:

1. See that the patient, his bed, and surroundings are perfectly clean.
2. A Communion Card is placed under the patient's chin.
3. If Holy Communion is given at the regular time, the table is set up at the east end of the hall in Pediatrics. If not given at the regular time, the table is set up in the patient's room.
4. The nurse kneels beside the bed during the administration of the Sacrament, and attends the patient as necessary.
5. When the patient finds it difficult to swallow, the nurse should stay in the room. Kneel down while the patient receives Holy Communion, and then give him a drink of water to help him swallow the Sacred Host. This is a grave responsibility.
6. After the priest leaves, the nurse puts the articles away. If the water in the small glass is used to purify the Priest's fingers, it should be poured on a growing plant, or taken to the Sacristy and poured into a sink which empties directly into the ground. (If there is time, the nurse should recite prayers before and after Holy Communion with the patient, especially when he is too sick to recite them himself.

Procedure for aiding the Catholic Patient:

1. Encourage him to pray. (My Daily Prayer Card, and the Rosary). A card is kept in the Kardex on which is listed the room numbers of the patients who are to receive Holy Communion of the following morning.
2. Any knowledge acquired with regard to the patient's spiritual condition should be made known to the supervisor in charge.
3. Surgical patients admitted after 7 P.M.
   a. Ask if he wishes to receive Holy Communion before going to surgery. If he does, place his room and bed number on a card in the Kardex.
   b. Ask if he wishes to go to Confession. If he does notify the supervisor in charge.
4. Any patient may receive Holy Communion--laboratory tests and x-rays are not affected.
5. The Chaplain should be notified if any patient is unable to swallow the Host.
6. Water may be given to a patient to aid him in swallowing the Host.
7. If the Host is vomited, notify the Chaplain.

Spiritual Care of the Dying cont'

II. Last Sacraments

Procedure for aiding the dying patient:

1. Notify the nurse in charge.
2. Prepare the patient mentally to receive the sacrament of Extreme Unction.
3. Obtain the anointing set from the ward. Place contents of the box on the table. Light the candles if there is no oxygen or highly inflammable substance present.
4. Kneel during the first part of the Ritual.
5. When the Priest begins to anoint the senses, rise and assist him. Order of anointing the senses: EYES, NOSTRILS, MOUTH, HANDS, FEET.
6. Kneel until the end of the prayers.
7. If the patient has not received Holy Communion and is able to do so notify the Chaplain. Fasting is not necessary.

III. Baptism

1. Formula for Baptizing Absolutely. While pouring the water say audibly: "I baptize thee in the name of the Father, and of the Son and of the Holy Ghost".

Note: Use clear water if Baptismal Water is not available.

2. Formula for baptizing Conditionally. While pouring the water say audibly: "If thou art capable of being baptizing, I baptize thee in the name of the Father, and of the Son and of the Holy Ghost."

Procedure for aiding the non-Catholic:

1. Encourage patient to pray. (My Daily Prayer Card).
2. Notify the supervisor.
3. For patients critically ill but not conscious;
   a. Help the patient make an Act of Faith in the four basic truths.
      1. The existence of God.
      2. God rewards the good and punishes the wicked.
      3. There are three persons in God.
      4. The second person became man and died to redeem us.
   b. Help the patient to make an Act of Sorrow for sin.
   c. Inquire whether or not the patient has been baptized. If not, and the patient expresses the intention or desire to be baptized; baptize him.
   d. Baptize the patient conditionally if there is any question as to the validity of his Baptism.

Spiritual Care of the Dying cont'

4. A patient apparently unconscious or dead may still be able to hear. (Before baptizing such a person conditionally recite clearly into his ear an Act of Faith in God and sorrow for sin).
5. Any child below the age of reason must be baptized.
6. If patient or relatives wish to have the minister called, notify supervisor.

## Care of the Body of the Fetus after Death

A miscarried fetur or embryo, no matter how small, must be baptized -- absolutely if certainly alive, conditionally if doubtfully alive. Maceration (putrefaction or advanced general decomposition) in this case, is the only certain sign of real death. Break the membranes, or open the blood clot of mole, surrounding the embryo. Immerse it in a pan of water making sure the water contacts the fetus itself. Then, while moving it about in the water so that there will be a washing or flowing or "baptizing" say the words, usually those for conditional baptism: "If you are capable, I baptize you in the name of the Father, and of the Son, and of the Holy Ghost". Finally, remove it from the water.

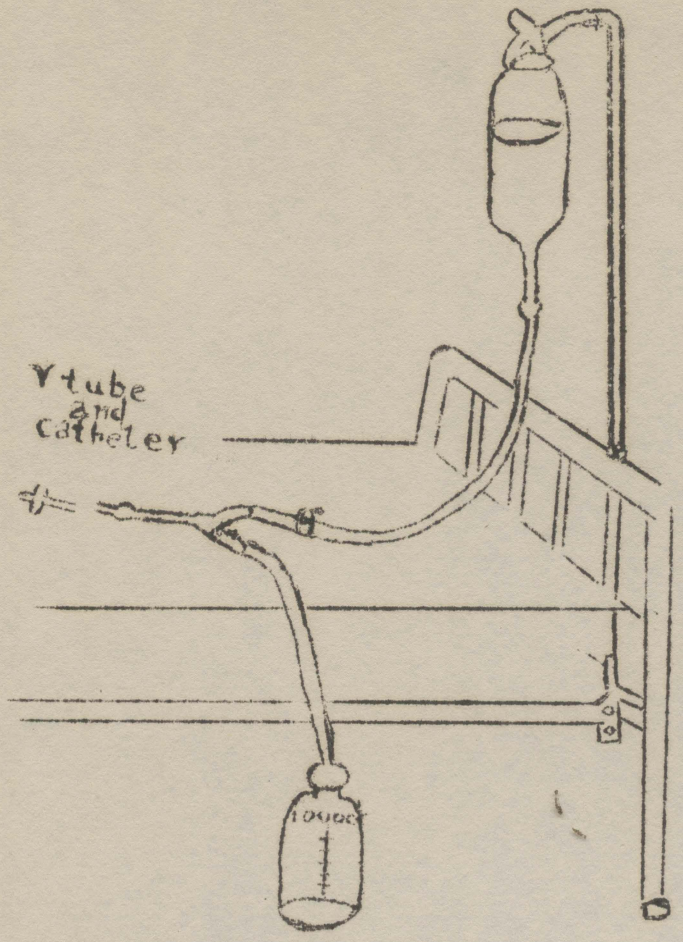
Never fail to follow this procedure even though told in a hospital to take the clot, etc. intact to the medical laboratory. The water must contact and flow on the fetus or embryo itself. Baptism on the covering membrane is no baptism. Those in a medical laboratory are not in fact interested in the "intactness" of the membranes. Hense break membranes, baptize, and if necessary explain afterwards.

# Chapter XIX

## Special Procedures Relating to the Urological and Neurological Patient

### The Urological Patient

### I. Intermittent Bladder Irrigation




Purpose:

1. To cleanse the bladder frequently.
2. To help control bleeding and clot formation.
3. To relieve inflammation and congestion.

Requisites:

1. Foley catheter.
2. Irrigating tubing with glass "Y" and clamp. (Obtained in Urological Department).
3. Graduated bottle.
4. Drainage bottles.
5. Standard.
6. Solution as ordered.

Procedure:

1. Take equipment to bedside, provide privacy and explain procedure to patient.
2. Insert foley catheter as directed and clamp with forceps.

Intermittent Bladder Irrigation cont'

3. Open bladder Irrigation Set.
4. Fill graduated irrigating bottle with solution ordered.
5. Attach irrigating tubing to bottles and hang on standard.
6. Connect straight end of glass "Y" tube with catheter.
7. Place end of other rubber tubing in drainage bottle.
8. Release the clamp controlling inflow of solution, and allow solution to flow through tubing until all air is expelled.
9. Clamp off inflow tubing and release clamp on foley catheter.
10. At intervals every (15 to 20 minutes) as ordered compress outflow tubing with hand; release clamp on inflow and allow 25 to 50 cc. of solution to flow into bladder. Release compression on out flow tubing.
11. Observe the amount and character of return flow solution.
12. Allow about 50c.c. of irrigating solution to remain in the bladder between irrigations.
13. Pin inflow and outflow tubing to sheet with provided pins.
14. Compute the urinary output and record every 12 to 24 hours.
    (The difference between the amount of irrigating solution and the output in drainage bottle represents the urinary output).
15. When treatment has been discontinued clean equipment with soap and water and return to supply.
16. Record as intermittent bladder drainage, time of irrigations, amount and kind of solutions used and return flow.

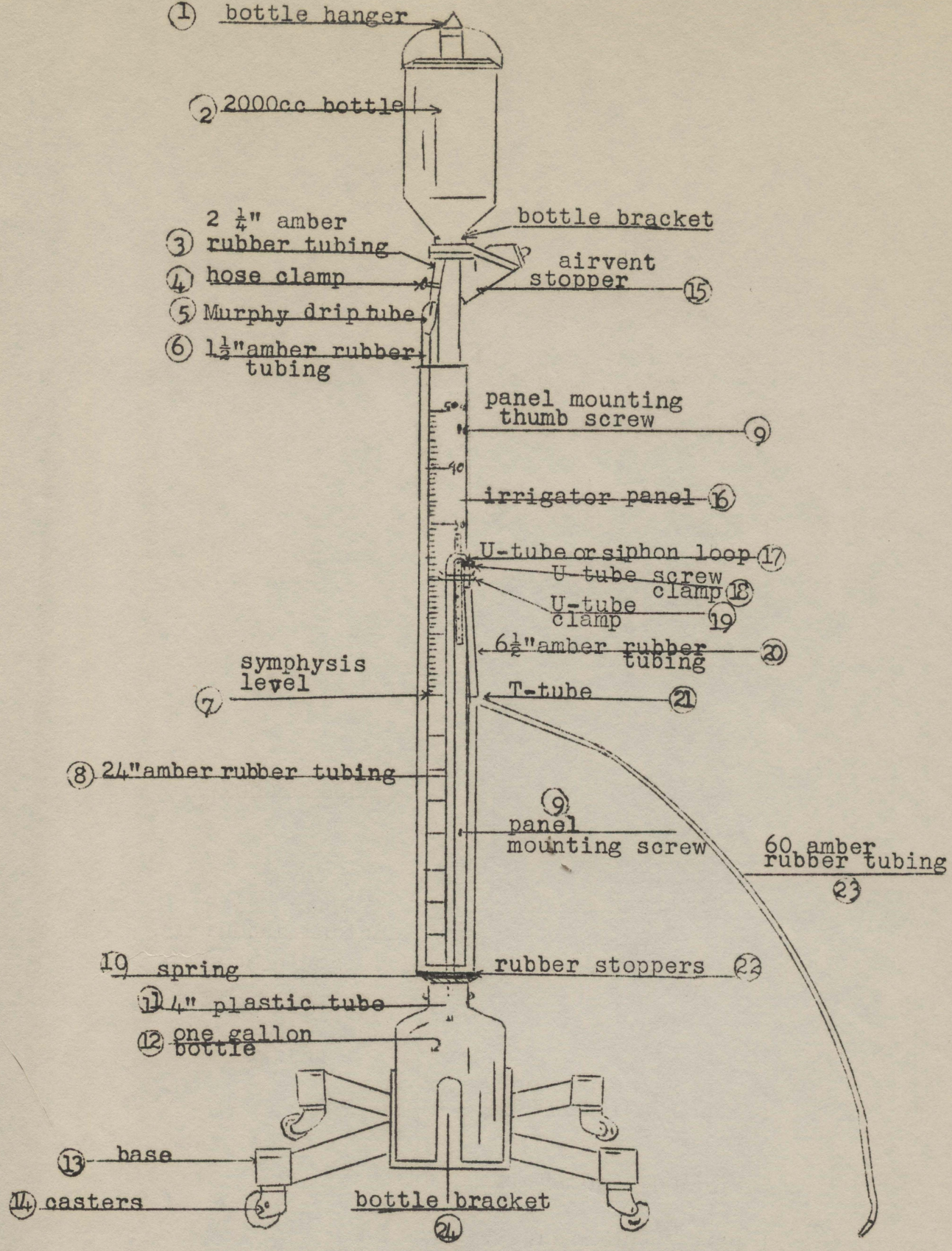
II. Tidal Drainage

Requisites:

1. Tidal Irrigator
2. Solution as ordered
3. Foley catheter
4. Catheterization Tray.

Purpose:

1. Aiding in prevention of infection.
2. Establishing automatic function of the bladder until normal function has been restored.
3. Helping to promote resumption of normal bladder tone.
   (a) By increasing the capacity of the contracted hypertonic bladder, by progressively raising the height of the siphon curve.
4. Providing mental and physical comfort of the patient with a dry bed therefore lessening the danger of developing decubitus ulcers.




# TIDAL IRRIGATOR

A. Gomco Tidal Irrigator

Procedure:

1. Assemble equipment and take to bedside.
2. Explain procedure to patient, and inform him of the importance of regulated intake.
3. Aseptic technic should be observed at all times in the operation of this treatment.
4. Insert catheter in the usual manner.
5. Bladder is thoroughly washed out by hand irrigation with an asepto syringe to insure freedom from mucoid material and particles. All fluid and air is evacuated from the bladder and the catheter is clamped.
6. The reservoir bottle is filled with irrigating solution.
7. The symphysis level marked on the panel is adjusted to the level of the patients symphysis by raising the standard and tightening the knob screw at the lower end of the sliding pole.
8. The cock screw is opened and the solution is allowed to fill the "L" system of plastic tubes. When the column of fluid reaches the horizontal line of the "T" tube it will flow into the rubber tubing to which the catheter will be connected.
9. Allow to flow until all air bubbles are washed out of the system, when this occurs connect to catheter and remove clamp from catheter.
10. Adjust the stop cock to a rate of from 30 to 60 drops per minute.
11. Refill the reservoir bottle and empty the waste bottle as necessary.

Note: To check the circuit for obstruction, notice the presence or absence of up and down excursions of the fluid column in the tube on the left of the panel.

12. The catheter and complete tidal drainage should be changed and resterilized at least once a week.

B. Tidal Irrigator--Improvised

Requisites:

1. Infusion Standard
2. Catheterization Tray
3. Foley Catheter
4. Solution as ordered.

Procedure:

The equipment is prepared as follows:

1. Take tidal drainage tray, catheterization tray, sterile solution and extra equipment (on movable table) to the patient's room. Carry in the infusion standard.
2. Adjust the gauge on the standard to the level of the patient's symphysis pubis.
3. Open the sterile tray.
4. Hang the Kelly flask on the superior hook of the standard.

Tidal Irrigator -- Improvised cont'

5. Adjust the apparatus so that the quadruple outlet drain will be eight inches below symphysis pubis level.
6. Secure the quadruple outlet drain with a metal clamp with rubber adjustments.
7. Secure the air vent to the standard with the metal clamp with rubber adjustments at the needle hub and lower end of the glass connection.
8. Adjust the metal curve of the siphon loop to the metal hook on the standard at the level determined by the doctor.
9. Place the drainage bottle on the adjustable shelf and attach the rubber stopper to the bottle.
10. Pour the solution into the Kelly flask, allow it to circulate through apparatus, eliminate all air.
11. Clamp off with kelly Clamp.
12. Atach a toy balloon, with stretched elastic band, to illustrate the action in the bladder.
13. Open the Kelly Clamp to permit the alternate flow of fluid content into and out of the balloon, to demonstrate to the patient the purpose of the treatment.
14. Close the Kelly clamp above the connector to the balloon. To prepare the patient, secure her cooperation and confidence by explaining the treatment. Draw curtains around the unit. Place the patient flat in bed and drape for catheterization. Place an unsterile pad under her buttocks. Adjust light.

    The treatment is administered as follows:

    Catheterize the patient as directed. Clamp off the catheter with the Kelly clamp, being careful that no air is retained in the catheter.

    With the Luer syringe, inflate the bulb with 5 cubic centimeters of sterile water, tie off the tip of the tube and fasten securely with a stretched elastic band. Take the sterile tip of the connecting tube off the tidal drainage apparatus and secure to the catheter, removing the Kelly clamps.

    The doctor regulates intravesical pressure by adjusting the apex of the siphon curve, and also the flow per minute of the drip bulb.

    Attach the tubing to bedding by means of metal paper clip, with excess of tubing in bed, allowing for free movement of the patient.

    Remove all extra equipment and make the patient comfortable.

    Place the apparatus at the head of the bed and screen it from the view of patient.

    During the period that the tidal drainage is being maintained, measure and empty the drainage in the waste bottle at twelve-hour intervals and when necessary. Add sterile solution to Kelly flask at twelve hour intervals or when necessary. Keep the tubing free from pressure or kinks. Change the

Tidal Irrigator -- Improvised cont'

catheter and sterilize the equipment once a week, or more frequently if indicated. Maintain an air-tight system to assure proper function of siphonage.

When the tidal drainage is discontinued, rinse all equipment with cold running water, wash it with soap and warm water, rinse, and dry. Check the equipment, reassemble it, and return it to the Central Supply room for autoclaving.

To record the treatment, record the time it was started and by whom (doctor). Record the amount of urine obtained at the time of catheterization. Record the type of solution used, number of drops per minute and height of apex of siphon curve. Record the twelve-hour fluid intake by mouth and sterile solution intake, and the twenty-four hour urine output minus the fluid intake.

## Procedure for Intravenous Injection of Phenolsulphonphthalein Test (Combined Function Test).

I. (Used in G. U. Dept)

Purpose: To test kidney function

Requisites:
1. Sterile 2cc. syringe containing 1cc. phenolsulphonphthalein.
2. Small amount (½ oz.) Sodium Hydroxide 10%.
3. Complete Catheterization Tray.
4. Specimen bottles (2).

Procedure:
1. Explain procedure to patient and provide adequate privacy.
2. Catheterize patient, and discard this specimen.
3. Give patient <u>one</u> glass of water to drink (200 c.c.).
4. Inject 1c.c. phenolsulphonphthalein intravenously, and note exact time of injection. (Dye may be given intramuscularly if ordered).
5. Collect specimens as follows:
   a. Appearance time.
      Note: Place a little sodium hydroxide 10 percent in bottom of basin, and allow catheter to drain into the kidney basin and note when urine appears pinkish.
   b. 1 Hour after appearance of dye give patient 1 glass (200 c.c.) of water.
   c. 2 Hours after appearance time.
6. Save all specimens for doctor to see and send to Laboratory if directed to do so.
7. Remove catheter and care for equipment.
8. Record as P.S.P. test, appearance time degree of concentration, and disposition of specimens.

## Procedure for Phenolsulphonphthalein Test

II. (Divided Test)
(Bilatual Function Test)

Purpose: To test function of each kidney.

Requisites:
1. Phenolsulphonphthalein 1 c.c. in 2 c.c. syringe with I.V. needle.
2. Rack with clean test tubes.
3. Emesis basin with gauze or cotton in bottom on which test tubes may be supported.
4. Sodium Hydroxide 10% (½ oz.)

Procedure for Phenolsulphonphthalein cont'

Procedure:

1. Have patient empty bladder.
2. Give 400 c.c. water.
3. Send patient to cystoscopy room where cystoscopy is done and ureteral catheter inserted.
4. Upon return to room 1 c.c. of Phenolsulphonphthalein is injected intravenously, and exact time noted.
5. A test tube marked appearance time and containing a little Sodium Hydroxide 10% is attached to each catheter and the appearance time noted. (Reddish urine).
6. Collect another specimen by placing catheter in 2nd test tube immediately after appearance time is noted and leave in place 15 minutes. Collect two 15 minute specimens.
7. Place test tubes in rack for Doctor to see unless otherwise ordered. Care for other Equipment.
8. Record as PSP. test, appearance time, Rt. and Left, reaction of patient, disposition of urine.

Note: Specimen maybe sent to the Laboratory for quantitive test.

## Water Excretion Test

Purpose: To determine the status of the adrenal glands.

Procedure:

The day before the test the patient takes his regular meals, without added salt. He is instructed not to eat or drink after 6 P.M. At 10:30 P.M. he voids, the urine being discarded. All urine voided from 10:30 P.M. to 7:30 A.M. is collected, measured and saved for chemical analysis, if this proves to be necessary (night specimen). At 8:30 A.M. the bladder is emptied, if possible and the urine is discarded. Immediately thereafter the patient is given 30 c.c. of water per kilogram of body weight in the course of forty-five minutes. The bladder is emptied at 9:30, 10:30 and 11:30 A.M. and 12:30 P.M., the volume of each specimen being recorded. At 11:30 or 12:30 a specimen of blood is taken for urea and Cl determinations if these should prove to be necessary. Label and send all specimens to laboratory.

## Mosenthal Test

Purpose: For renal function

1. On the day of test, and preferably also the day before, prescribe a full diet, such as the following: breakfast of fruit, cereal, bread, butter, and tea, coffee, cocoa or water at 8 A.M.; dinner of soup, meat, vegetables, bread, butter, dessert and tea, coffee, of water at noon, and supper of eggs, bread, butter, fruit and tea or water at 5 P.M. Much latitude is allowed in the choice of foods and in many cases the ordinary diet to which the patient is accustomed to is used. At least a pint of fluid must be taken at each meal, and no other fluid or liquid of any sort may be taken until after 8 o'clock on the following morning.

2. Instruct the patient to empty his bladder immediately before breakfast. Collect specimens of urine at 10 AM, 12 noon, 2 PM., 4 P.M., 6 PM., 8 PM., and finally at 8 o'clock the following morning. It is essential that the intervals be exact, and that the bladder is emptied completely each time.

   Should the hour for the meal be changed, the times for collecting the urine should be changed accordingly. The last of the two hour specimens must be collected less than three hours after the beginning of the evening meal.

3. Measure the night urine 8 P.M. to 8 A.M. and take its specific gravity with an accurate urinometer.

Mosenthal Test cont'

4. Measure each of the six hour specimens, and take the specific gravity, first making sure that they are all at the same temperature, since misleading figures may be be obtained if some have been kept on ice and some at room temperature.

# Neurological Nursing

Outline of nursing care in:

A. Head Injuries:

1. Stop hemorrhage if there be one.
2. Treat patient for shock.
   a. Lower head
   b. Heat to body. (Place hot water bottle between blankets and note temperature of water)
3. Watch state of consciousness. Note if patient becomes drowsy or irritable. Observe & report inequality of pupils.
4. Frequent check on blood pressure and temperature, pulse, and respiration.
5. Apply sterile dressings. When shock is controlled lacerations may be cleaned up and sutured by the doctor.
6. In case of bleeding or drainage from nose or ears, do not swab or spray. Caution patient not to blow his nose. Try to prevent sneezing by placing patients fingers against nose.
7. Carefully record intake and output. Fluid may be limited.
8. Do not restrain patient without an order from the doctor. Side rails may be applied.
9. Do not give morphine. Sedatives that are prescribed by doctor may be given.
10. Keep patient clean and dry. Secure order for indwelling catheter if necessary.
11. Ice bags three to head will keep patient quiet and alleviate some pain and swelling.
12. Observe carefully for twitching for convulsive movements. Note portion of body involved, frequency and duration.
13. Reassure relatives. Ask relatives to stay so information regarding history of the accident or cause of injury may be obtained.
14. Provide material for complete neurological examination by intern or doctor including ophthalmoscope, percussion hammer, spinal puncture set, flash light and etc.
15. If there is respiratory difficulty or patient is vomiting place in prone-lateral position with head lowered to drain bronchial tree.

B. Brain Surgery:

1. Pre-Operative care.
   a. Obtain permission for surgery from patient or nearest relative.
   b. Have patient typed and cross-matched in addition to routine laboratory work.
   c. Enema evening before surgery only if ordered.
   d. Shave head completely. (This is now being done in Surgery immediately preceding the surgery).
   e. No food after 12 midnight unless patient is scheduled, for P.M. Surgery then withhold food on doctor's orders.

f. Pre-operative medication as ordered by anesthetist.
   1. Obtain weight or approximate weight of patient and record on chart.

2. Post-operative care:
   a. Place patient in clean warm bed in the following position:
      1. Head rest slightly elevated 12-18 inches.
      2. Turn head and body if possible to unoperative side to prevent aspiration of emesis and mucus.
   b. Check B.P., Pulse and Respiration every 15 min. for the first 2 hours.
      Check B.P., Temperature, Pulse and Respiration every 30 min. for next 4 hours.
      Check B.P., Temperature, Pulse and Respiration every 2 hours for 24 hours.
      Then check Blood Pressure tid.
   c. Notify house doctor of unusual rise or fall in cardinal symptoms.
   d. Water post nausea. Diet as tolerated.
   3. Record intake and output.
   f. Change position at least every 2 hours. Keep Clean and Dry.
   g. Observe for convulsions, part of body involved, frequency and duration.
   h. Note degree of consciousness, drowsiness or irritability. May record as comatose, semi-comatose, confused, dizziness, etc.
   i. Note paralysis, degree and location.
   j. Note mental disturbances and personality changes
   k. Restrain patients only by order of the doctor. Side rails may be used if indicated.
   l. Note symptoms of Hyperthenia. Notify house doctor who will designate the method to be used in "cooling off" the patient--such as ice bags, cold water enemas, cool sponges, cold packs, etc.
   m. For pain give Codeine Sulphate gr.i hypodermically. Special Rx capsules containing Codeine Sulphate gr. i, Caffeine gr. i, and Aspirin gr. x may be given orally post
   n. Report to house doctor if dressings become wet with cerebro spinal fluid or are blood-tinged.
   o. Watch closely. Encourage patient to help himself and provide occupational therapy when possible. Above all be watchful, calm, and tolerant.

C. Spinal Cord Injuries

1. Keep patient in hyper-extension until treatments is instigate.
2. Treat for shock.
3. Note paresis and paralysis.
4. Note decrease or absence of sensations.
5. Keep patients clean and dry.
   a. Keep weight off bony prominences
   b. Change position frequently
   c. Change linens prn.
   d. Keep sheets free from wrinkles.
   e. Toughen skin with alcohol rubs.

6. Watch for retention or overflow of urine
   a. Get order for catheterization and retention catheter
   b. Instigate tidal drainage if ordered.
7. Watch for incontinence and retention of feces
   a. Break up fecal impaction
8. Record intake and output
9. Give fluids freely
10. Boards under mattress
11. Turn patient as a unit
12. Make use of comfort measures to prevent foot drop, decubitus etc.

D. Surgery of Spinal Cord
   I. Pre-operative Care-same as for other surgery
   II. Post-operative Care
      a. Supine position (flat) and turned on side frequently for back care
      b. Check Blood Pressure, Pulse, and Respiration frequently
      c. Fluids freely post nausea
      d. Rectal tube prn.
      e. Watch urinary output. Catheterize, insert retention catheter or instigate tidal drainage as ordered
      f. Report loss of motion or change in sensation
      g. Keep patient clean and dry
      h. Turn as unit--boards under mattress

E. Diagnostic Tests:
   1. Spinal Puncture -- see page 122
   2. Cisternal Puncture
      a. Purpose: To remove cerebre-spinal fluid for diagnostic purposes and to relieve pressure
      b. Requisites: Same as for spinal puncture - page 122
      c. Procedure:
         1. Assemble equipment
         2. Place patient in position -- horizontal position on side with head flexed sharply on chest
         3. Shave back and neck
         4. Doctor proceeds with puncture
         5. Dispose of specimen as directed
         6. Care for equipment
         7. Chart time, amount and disposition of fluid obtained, reaction of patient, by whom done.

Disorders of the Cranial Nerves

I. Pre-operative care
   1. Note characteristics of attack of pain. Describe area involved, precipating factors, frequency and duration
   2. Emotional attitude of patient
   3. Difficulty in eating or oral hygiene
   4. Eye affected - Report any evidence of irritation immediately.
   5. Give nourishing diet, easily eaten and of room temperature
   6. Note and requisition laboratory tests
   7. Pre-operative medication as ordered

II. Post-operative care
1. Position -- in bed with head elevated 12 inches or more
2. Liquids and food as tolerated
3. Oral hygiene and mouth lubrication 4-5 times daily
4. Change position frequently -- encourage to move freely
5. Note if cornea is anesthetized and keep eye protected with shield--give special eye care. Note irritation of eye and report immediately.
   a. Irrigation with NaCl.
   b. Mineral oil 1-2 gtts
6. Note paresis or paralysis of facial muscles
7. Give good Geriatric nursing care.

Electroencephalogram - record of electrical activity of the brain.

Purpose: Localized abnormal electrical action which may indicate the situation of a tumor, hemorrage, injury or infection of the brain. Will also indicate the existence and type of epilepsy.

Examination must be conducted in a specially constructed room shielded to eliminate interference from outside electrical activity.

No special preparation is necessary. Patient is taken by car or ambulance to "The Retreat" where such a room is available.

Patient may have breakfast or lunch.

Ventriculograms: Done when patients have increased intra-cranial Pressure and Pneumoencephalograms are Contraindicated.

1. Operative procedure and permit must be signed. Patient or relative understand that a craniotomy will follow if a lesion is found. (Craniotomy follows stat because air in the ventricle is irritating and if not absorbed causes marked intra-cranial pressure.)
2. Post-operative care as outlined for brain surgery.

Myelogram - Spinogram

Purpose: To locate spinal block or to determine degree of obstruction.

Method: Injection of some radio-opaque substance in spinal canal and subsequent X-Ray. Care as following spinal puncture.

Encephalogram: Cerebro-spinal fluid spaces in and around brain and spinal cord are filled with air or gas, so the spaces may be visualized by X-Ray. Localizes lesion of central nervous system.

Preparation of patient: (Per it must be signed)
1. Spinal puncture usually done to relieve spinal fluid pressure
2. Record weight of patient
3. Cleansing enema at bedtime
4. Omit breakfast
5. Pre-operative Medication as ordered

Post-operative care:

1. Position - flat, head down at all times until cerebro-spinal fluid pressure back to normal.
2. Turn to side until awake so that mucus and emesis will drain from mouth
3. Blood pressure, pulse and respiration as for brain surgery
4. Ice bags to head iii
5. For headache give Codeine Sulphate gr. i hypodermically or Rx Capsule
6. Fluids and food as tolerated--force fluids post nausea
7. Patient may be up when headache has disappeared (usually 3rd day)
8. Oxygen per mask may be ordered

Arteriogram (Carotid): Injection of a radio-opaque substances into the com on carotid artery in connection with special X-Ray studies.

Purpose: To diagnose and localize intracranial vascular lesions such as aneurysms and angiomas.

Method: Dye is injected in carotid area allowing the arterial system of one side of the brain to be visualized.

1. Permit must be signed as patient will be given an anesthetic
2. Observe patient P.O. for homatoma in the neck
   a. Swelling, stridor and dysphagia
3. Ice bag to area may afford comfort
4. Observe and treat as any P.O. Neurological patient