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Procedure manual for student nurses.

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Service Paper

PROCEDURE MANUAL FOR STUDENT NURSES

Submitted by

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the Degree of Master of Education

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ADMISSION OF PATIENT

Purpose:

1. To orient patient to his new surroundings.
2. To place the patient in bed ready for examination by doctor.
3. To care for property of patient.

Procedure:

1. Speak to patient pleasantly. Conduct patient to unit which has been prepared and draw curtains.
2. Assist patient, if necessary, in removing clothes and getting into bed.
3. Take temperature, pulse, respiration and blood pressure. Record on clothes slip. If ambulatory patient, weigh in night clothes and bathrobe. Use paper towel for feet on scale. Record weight and height on clothes slip.
4. Observe general appearance of patient and note any unusual conditions as edema, eruptions, abrasions, discharges, etc.
5. Report to nurse in charge when patient has been completely admitted so that she may notify the doctor.
6. Urine specimens:
   a. Pre-operative patients: obtain specimen and take to the Urinalysis Laboratory immediately with tag labeled: "voided, admission, pre-operative."
   b. Routine admission specimens are to be obtained and sent to the Urinalysis Laboratory the following morning.
7. Care of clothes: see following directions "Care of Clothing."
8. If necessary an admission bath may be given.
9. Examine hair and scalp for cleanliness.
10. Demonstrate use of signal cord.
11. Do not give patient either fluid or food until ordered.

12. Introduce to nearby patients.

13. Prepare complete chart for patient; make initial entries.

14. Prepare Kardex Sheet; D.O.B. Sheet; Census Board Card.

15. When orders are received, transfer immediately to Kardex.

Care of Clothing:

1. Care for clothing immediately after admission.

2. Examine clothing thoroughly, in presence of patient or friend.

3. Where central lockers are used, make out clothes tag for every garment. Mark each tag with patient's name and locker number. Tags are unnecessary when patient is in private room.

4. Check each article in clothes book and sign your name in appropriate place.

5. Have patient check accuracy of list and sign name. If unable nurse must state reason on clothes slip.

6. Turn clothes slip and on reverse side, list glasses, dentures, wedding ring, watch, radio and any other articles which are to be kept at bedside. Both patient and nurse must sign this side also.

7. Place tagged clothing in proper locker. Hang or fold clothing carefully to preserve appearance.

8. Place original clothes slip with record.

9. Clothing or other property may be removed from hospital only when signed for by patient or friend and nurse in charge.
Care of Valuable Property on Admission:

1. Valuable property comprises all sums of money, jewelry, keys, bankbooks, glasses, teeth and any other articles which are of value to the individual. The Admitting Officer will care for valuables of patients admitted through the Admitting Office. The charge nurse and the admitting nurse of the ward to which the patient is admitted will take responsibility of collecting the valuables of any patient admitted by ambulance or by stretcher, not seen by the Admitting Officer.

2. A patient may keep one dollar in cash, watch, glasses, artificial teeth, engagement ring, wedding ring and radio if conscious and able to accept responsibility.

3. Place valuables, to be put in safe, in envelope provided for that purpose and list contents on outside of envelope. Nurse signs name. Also list these valuables on valuables slip in duplicate. Both slips must bear the signature of the patient and the nurse.

4. Contents of envelope and list must be checked by charge nurse.

5. Take valuables envelope and both valuables slips to the cashier. The cashier will sign both slips, keep the original and return the duplicate to the nurse. This duplicate is either given to the patient to keep as a receipt or, if the patient is not responsible, attached to his chart.

6. If during evening or night, give valuables to supervisor in charge.
Care of Dentures and Other Valuables kept at the Bedside:

When a patient is admitted to the hospital, the nurse on the ward or floor attending to the admission is to ascertain whether or not the patient has removable teeth, artificial eye, watch, rings, glasses, etc. Check these items with Form #43 (in duplicate) that the patient should have received from the Admitting Officer. If not, proceed as above.
If there are no valuables, note on clothes slip.

When teeth are removed because the patient is going to the operating room, or for any other reason, place them in jar for teeth at bedside.

Note on the Xardax when valuables are taken to the cashier's office and when they are returned. The head nurse is held responsible for seeing that this procedure is carried out. She must check on all patients in this respect.

Discharge of Patient:

Note: A discharge order must be in writing, with the doctor's signature.
If this is not given, the patient must sign an "against advice" slip.
If the patient is going to another hospital or nursing home, the nurse in charge prepares a written report of the patient's condition. From this report a letter is prepared to go with the patient regarding special reference to diet, abrasions, etc.
DISCHARGE OF PATIENT

Return of valuables:

When the patient is ready to reclaim his valuables, ask him to fill out the second section of his duplicate valuables form, make it payable to the person who will get them.

Take this slip to the cashier's office, obtain the valuables, sign the duplicate form for their receipt and take the original form, upon receipt of the valuables and return this promptly to the cashier.

The cashier will retain duplicate valuables form, with the signature of bearer as her receipt for having delivered the valuables, which means that the bearer is personally responsible for the valuables until the original form, with the patient's signature gets back to the cashier.

The head nurse should witness the return of valuables to the patient and should also sign the original form before it is returned to the cashier.

Dietary directions:

If any dietary discharge directions are needed, call the Diet Kitchen. A notice of at least twenty-four hours is needed for a diabetic patient.

Clothes:

Check all clothes with clothes slip. Get the patient's signature for their return.

Medications:

Special medications, which have been ordered for a patient and have been charged to him, are to be given to him at time of discharge.

Personal Property:

Prepare all personal property, plus flowers, fruit, etc., for the patient to take home.

Library books:

Return all Library Books to the head nurse.
Discharge of patient:

Obtain slip from relative or friend saying patient may be discharged.

Call the Main House Receptionist and say: "Patient is being discharged now." Ask for the official time.

Accompany patient to exit.

Discharge chart:

Notify kitchen of discharge if patient on special diet.

Remove all medicine tickets.

Record discharge on clinical chart, bedside notes, face sheet, and doctor's order book. If by death record: "Pronounced @ time" in red ink on clinical chart, bedside notes and face sheet.

Arrange record in order as follows:

1. Face sheet
2. History sheet
3. Progress notes
4. Consultation sheets
5. Clinical sheet
6. Laboratory sheet
7. Medication sheet
8. Pathological report
9. Anesthesia sheet
10. Bedside notes
11. Clothes slip
12. Admission sheet
CARE OF UNIT ON DISCHARGE OF PATIENT

Purpose:

1. To provide a clean unit for occupancy by a patient.

Note: A member of the Housekeeping Department will wash and clean the bedside table and bed.

Procedure: nurse’s responsibilities

1. Strip bed and place all soiled linen in laundry hamper or clothes chute.
2. Fold and place blankets on back of chair in unit.
3. Place both pillows on chair in unit.
4. Remove all equipment from bedside table. Wash enamelware with soap and water. Boil for ten minutes. Dry.
5. After the bed, bedside table and entire room have been cleaned by a member of the Housekeeping Department, make up bed as a "Closed Bed" and return cleaned equipment to table.
6. See procedure for "Temperature" for care of thermometer on discharge.
POST MORTEM CARE

Purpose:

1. To have the body clean, straight and in proper condition for delivery to the morgue.
2. To care for the patient's possessions so that their safety is assured.

Important Points:

1. Until a patient has been pronounced by a doctor and the discharge written in the order book, a nurse may not start preparation of the body.
2. It is the responsibility of the nurse, after the discharge has been written, to notify the supervisor and operator. State: ward, name of patient, time of discharge and by whom, whether relatives were present or not.
3. It is the responsibility of the doctor in charge to notify the immediate family.

CARE OF THE BODY

Equipment:

1. Bathing equipment
2. 1 smooth forcep
3. Adhesive
4. String
5. 1 shroud
6. 1 roll 1" bandage
7. 2 abdominal pads
8. 1 diaper
9. 6 safety pins
10. 3 tags for body
11. Sheet wadding
12. 6 applicators
13. Washed gauze
14. Cotton
15. Vaseline
16. Tongue blade
17. Brown paper
18. 2 tags for clothes

Procedure:

1. Take equipment to bedside. Screen unit.
2. Fill out three tags: name, date, ward, relatives present or not and time pronounced.
3. Straighten body, in horizontal position, with one pillow under head.
4. Fold bedding to foot of bed, cover body with bath blanket.
5. Comb hair. Tie with bandage if necessary.
6. Wash face. Use small wisp of cotton under eyelids if they do not remain closed.


8. Clean nostrils and ears with applicators if necessary.

9. Apply a thin coat of vaseline to entire face with tongue blade.

10. If necessary place piece of sheet wadding under chin and tie jaw in place with gauze bandage.

11. Bathe the entire body, except the back and perineum. Reduce surgical dressings to a minimum. Use washed gauze and adhesive tape for clean dressing.

12. Turn body on side. Wash back and buttocks thoroughly.

13. Use forceps to pack rectum with cotton. Place diaper under the buttocks and pad well with abdominal pads.

14. Turn body on back. Adjust diaper, pin securely.


16. Place feet together. Pad ankles with sheet wadding. Tie with bandage. Attach one identification tag to great toe.

17. Place shroud sheet on morgue truck. Move patient to truck.

18. Pin shroud in place. Attach third identification tag to outside of shroud. If shroud is not put on patient while on ward, pin third tag to shroud.

19. Cover patient with sheet.

20. Call orderly for assistance in transferring patient on truck to morgue.
Care of Clothes and Valuables:

The nurse must collect all personal property left in the unit, locker and room. Every article must be listed on a new clothes slip. Have this list checked by the charge nurse. Both nurses must sign the clothes slip.

Wrap the clothes in brown paper or pack in suitcase if available. Tag with patient's name, ward and date. Take to Admitting Office and Admitting Officer will sign clothes slip for receipt of clothes.

The Admitting Officer delivers the property to a relative, responsible friend or the undertaker, who must sign the clothes slip for receipt of the property.

The completed clothes slip must have four signatures:

1. Bedside nurse,
2. Charge nurse,
3. Admitting Officer, and
4. Relative or undertaker.

The clothes slip is sent to the Record Room from the Admitting Office and filed with the permanent record.

The clothes slip, made out on admission is sent to the Record Room with the chart from the ward.

Valuables:

Place all valuables, including the wedding band, in a valuables envelope and list on valuables slip attached to chart.

Enter disposition of dentures on record. (Usually are left with the patient. Note family's desire).
ASSISTING WITH GENERAL PHYSICAL EXAMINATIONS

Purpose:

1. To place the patient in correct position for examination.
2. To avoid unnecessary exposure of the patient by draping.
3. To protect the patient from mental and physical discomfort thus obtaining greater relaxation and cooperation.

Equipment:

1. Medical Tray

Procedure:


2. The nurse will stand on the opposite side of the bed while assisting the doctor. She will anticipate doctor's needs by having each item of equipment in readiness when needed.

3. Head and throat:
   a. Throat examination: have throat stick, flashlight and emesis basin ready for use. Break tongue depressor in half after use. Discard in paper towel.
   b. Eye examination: lower shades in room, place towel over patient's nose and mouth. The doctor provides his own ophthalmoscope. If necessary an ophthalmoscope may be obtained from the Pharmacy.
   c. Ear examination: doctor may use his own otoscope; if not provide aural speculum and flashlight. If head mirror used, provide a steady light behind the patient's head.
4. Chest:
   a. Have patient flat with one pillow under head. Remove arms from sleeves of bed gown.
   b. Have patient turn head away from doctor.

5. Back:
   a. Have patient sit up with arms folded over chest.
   b. Untie bed gown and expose back. Support lower back with pillow as necessary.
   c. If patient undressed, cover anterior chest with bath blanket and fasten at back of neck.

6. Abdomen:
   a. Have patient lying flat with one pillow. Turn bedding down to pubes.
   b. Turn bed gown back over chest.
   c. Cover abdomen with bath blanket. Fold blanket back during examination.

7. Lower extremities:
   a. Have patient lying flat completely covered with bath blanket.
   b. Adjust bath blanket between thighs as legs are examined.
   c. If patient to be examined in standing position, have patient stand on paper towels. Drape with bath blanket to prevent unnecessary exposure.

8. After examination completed make patient comfortable. Rearrange bedding and straighten unit.

9. Return equipment to proper place.
ASSISTING WITH VAGINAL EXAMINATION

Equipment:

1. 1 waste basin
2. 1 tube lubricant
3. Specula
   - 1 large size
   - 1 small size
4. 1 vaginal forcep
5. 2 glass slides
6. 1 pair sterile gloves
7. Sterile applicators
8. 1 vaginal probe

Procedure:

3. Cleanse patient before examination if necessary.
4. Stand on opposite side of bed from doctor.
5. Open sterile glove case for doctor. Check with doctor regarding size before examination.
6. When doctor is ready, drop small amount of surgical lubricant onto finger of glove.
7. Pass articles as needed.
8. If asked to hold flashlight, hold in a steady position. If asked to hold a speculum hold at the angle and tension received.
9. Discard soiled instruments and gloves into waste basin.
11. Care for equipment. Wash gloves and instruments thoroughly.
13. Leave tray completely re-equipped.
ASSISTING WITH RECTAL EXAMINATION

Equipment:

1. Waste basin
2. Rectal gloves
3. 1 tube lubricant
4. Powder

Procedure:

1. Follow the same procedure as for "Vaginal Examination" in the preparation of the patient.
2. The rectal gloves are not sterile. Wash thoroughly after use.
3. Leave tray clean and completely re-equipped.
POSITIONS

1. Dorsal Recumbent:

This position is used for a vaginal examination or for a digital examination of the rectum. The patient lies on his or her back with the thighs flexed upon the body and the legs upon the thighs, so that the soles of the feet rest flat upon the bed. Separate the legs. If the patient is on a table, bring the buttocks to the extreme edge of the table and place the feet on extensions of the table.

2. Horizontal:

The patient lies flat on her back with the arms at the sides.

3. Lithotomy:

This position is used in practically all perineal operations. Place the patient's arms across the chest.
Flex the legs and arrange in stirrups. Drop the foot of the table and pull the patient down so that the buttocks rest on the edge of the table. Have pad smooth under the buttocks; avoid pressure of the legs against any part of the stirrups.
Never allow ether to be poured over a patient's perineum.
It centers at the tip of the spine where the weight of the patient is resting and may cause a bad ether burn.

4. Prone:

The patient lies on her back with hands at the sides and head turned to one side.
5. Sims:
The patient lies on the left side, the cheek resting naturally on the pillow, the buttocks brought to the edge of the bed.
Bring the patient's left arm behind her back. Draw up her right knee at right angles to the body; the left knee may be extended or drawn up like the right one.

6. Trendelenburg Position:
The pelvis is raised higher than the head. This position is almost always used in operations on the pelvic organs. In this position, the abdominal viscera fall toward the floor of the chest and away from the pelvis, leaving pelvic organs more readily manipulated when the abdomen is opened. Always have the shoulder pieces in position on the operating table before operation begins. Shoulder pieces are used to prevent patient from sliding off the table as it is put into position.
TEMPERATURE, PULSE, RESPIRATION AND BLOOD PRESSURE

ORAL TEMPERATURE

Equipment:

<table>
<thead>
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<th>Tray Technique</th>
<th>Individual Technique</th>
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<tr>
<td>1. Tray</td>
<td>1. Thermometer tube with</td>
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<tr>
<td>2. Dry container for oral thermometers</td>
<td>pledget of cotton with Aqueous Zephiran 1:1000</td>
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<td>3. Container for Aqueous Zephiran 1:1000</td>
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<td></td>
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<tr>
<td>5. Container for used wipes</td>
<td></td>
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</table>

Procedure:

1. Fill solution cup for used thermometers with Aqueous Zephiran 1:1000.
2. Have patient lying down or sitting down.
3. Remove thermometer from dry container.
4. Shake mercury down to 96°F or below.
5. Place under tongue. Instruct patient to keep lips tightly closed and to breathe through nose.
6. Leave the thermometer in mouth for three minutes.
7. Remove from mouth, wipe and read. Return to container:
   a. Individual Technique: tube with Aqueous Zephiran in room.
   b. Tray Technique: container with Aqueous Zephiran on tray.
8. Record temperature on a slip of paper immediately.
9. When all temperatures have been taken, note time and let thermometers soak for thirty minutes.

Care of Thermometer Tray after each use:

Procedure:

1. Take tray to utility room.
2. Place soiled thermometers on paper towel. Discard Aqueous Zephiran solution.
3. Fill a small basin with soap and water solution at 105°F.
4. Wash each thermometer and all equipment with soap and water.
5. Dry each thermometer carefully with a clean medicine towel.
6. Reset tray. Place clean sponge in clean thermometer container.
   Shake down each thermometer to register 97°F. or below. Place in container.
7. Place clean sponge in bottom of solution cup.
8. Replenish supply of wipes.
9. Return tray to proper place.

Care of Thermometer Tube:

Procedure:

At least twice weekly each thermometer tube should be washed in hot soapy water, replenished with a fresh cotton pledget and Aqueous Zephiran Solution 1:1000.

Care of Thermometer Tube upon Discharge of Patient:

Procedure:

1. Wash thermometer with soap and water at 105°F.
2. Wash tube with soap and water. Boil tube ten minutes.
RECTAL TEMPERATURE

Equipment:

1. Hydrometer 4. Wipes
2. Rectal thermometer 5. Lubricant
3. Aqueous Zephiran

Procedure:

1. Obtain hydrometer, Aqueous Zephiran Solution 1:1000, lubricant wipes and rectal thermometer. Set up on bedside table in unit.
2. To take rectal temperature remove thermometer from hydrometer. Shake mercury down to 96°F.
3. Place a small amount of lubricant on a wipe. Lubricate bulb end of thermometer.
4. Screen patient. Explain procedure. Turn on side if possible.
5. Separate buttocks and insert thermometer carefully about two inches. Hold in place for five minutes.
6. Never allow patient to insert thermometer.
7. Expose patient as little as possible.
8. Remove thermometer, wipe, read. Return to hydrometer containing Aqueous Zephiran Solution 1:1000.
9. Record temperature on slip of paper.
10. Rearrange bedding and make patient comfortable.

Care of Equipment on Discharge of Patient:

1. Remove all equipment from bedside.
2. Wash thermometer and hydrometer with soap and water. Rinse. Dry.
3. Return thermometer to charge nurse.
4. Return hydrometer to proper place in utility room.
PULSE AND RESPIRATION

Equipment:
1. Watch with second hand

Procedure:
1. Have patient lying down or sitting with arm at rest on abdomen or chest.
2. Place the first three fingers over the radial artery and observe the character of the pulse before beginning to count.
3. Count the pulse for one full minute.
4. After counting the pulse, maintain pressure on wrist while counting respirations. Note: the temperature is usually being taken while the pulse and respirations are being counted.
5. Record the pulse and respirations on a slip of paper.

APEX AND RADIAL PULSE

Equipment:
1. Stethoscope
2. Watch with second hand

Procedure:
1. Take equipment to bedside. Explain procedure to patient. Draw bedside curtains.
2. Two nurses count the heart beats during exactly the same interval, one listening with a stethoscope at the apex, the other counting the radial beat.
3. Record both apex and radial beats immediately.
BLOOD PRESSURE

Equipment:
1. Stethoscope
2. Sphygmomanometer

Procedure:
1. Have the patient lying down or sitting with arm well supported.
2. Apply completely deflated cuff smoothly and snugly above elbow approximately one inch about the antecubital space.
3. Locate brachial artery by palpation.
4. Place plate of stethoscope over the brachial artery.
5. Close valve in air bulb and pump air into cuff quickly until all sounds are obliterated.
6. Release valve slowly and allow pressure to fall two to four millimeters per second.
7. When the pressure in the cuff and that exerted during systole are the same, a sharp thumping sound is heard. Observe the point on the dial at which this sound is heard for the Systolic Reading.
8. The sounds become less distinct as the pressure allows blood to come through.
9. The point at which the loud thumping sound is last heard indicates the true Diastolic Pressure. The point at which the sounds cease is sometimes used, however this is not accurate.
BED MAKING

Purpose:

1. To prepare a safe, comfortable bed for the patient.
2. To prepare a neat, firm, uniform bed.

Essentials:

Firm, comfortable mattress; clean linen; tight, firm foundation; warmth without weight and a neat finished appearance.

Principles:

Economy of time, effort and materials; fine workmanship throughout, i.e. linen smooth and tight, pillows smooth and flat, wheels turned in and locked, cranks released and turned in, signal cord in place and neat arrangement of furniture in the unit.

CLOSED BED

Equipment:

1. 1 spread 6. plastic mattress cover
2. 3 sheets 7. rubber drawsheet
3. 1 bed blanket 8. 1 bath towel
4. 2 pillow cases 9. 1 face towel
5. 1 bath blanket 10. 1 bedpan cover

Procedure:

1. Take linen to bedside in order in which it is to be used.
2. Place chair beside bed allowing room to pass between chair and bed.
3. Place pillows on chair, place linen on pillows.
4. Drape blankets with drawsheet over back of chair.
5. Adjust mattress on spring close to head of bed.
6. Place plastic mattress cover over mattress evenly and secure at corners.
7. Place bottom sheet over mattress evenly with allowance of at least six inches at head of bed for tucking in.
8. Tuck sheet in at head of bed from center to nearest corner. Mitre upper corner and tuck in.
9. Pull sheet smoothly and firmly to foot of bed. Tuck in from center to corner and mitre lower corner.
10. Tuck sheet firmly under mattress along entire side.
11. Place rubber drawsheet on bed with upper edge approximately fifteen inches from head of bed. Tuck well under both sides.
12. Fold cotton sheet, with a twelve inch difference between hemmed edges. Fanfold in fourths.
13. Place on bed with fold four inches above upper edge of rubber drawsheet. Turn one-fourth fold down and tuck in. Be sure smooth side of hem is up.
15. Apply blanket nine inches from head of bed. Tuck in foot from center and mitre corner.
16. Place spread on bed five inches from head of bed, four inches above blanket. Tuck in foot from center and mitre corner.
17. Go to other side of bed. Fold back all linen separately.
18. Pull center of bottom sheet tightly with both hands. Tuck well under mattress. Mitre both corners. Tuck along entire side.
19. Pull center of rubber drawsheet tightly with both hands. Tuck well under mattress. Tuck remainder of drawsheet tightly.

20. Repeat procedure with cotton drawsheet tightly.

21. Pull top sheet over evenly, tuck in firmly at foot of bed, mitre corner.

22. Repeat procedure with blanket and spread.

23. Tighten all linen by pulling upper edge.

24. Fold spread under edge of blankets.

25. Turn sheet down over spread.

26. Apply cases to pillows. Push corners of pillows well into cases.

27. Place first pillow on bed with open end toward entrance; second pillow with closed end toward entrance. Leave both flattened and smooth.

28. Test signal cord and fasten to bed.

29. Place bedside table at head of bed, upper edge on line with center of pillow.

30. Place chair at end of bed, facing out, on same side with table.

31. Check bedside table equipment:

   1. Bath towel, face towel, wash cloth
   2. Bath basin, emesis basin
   3. Soap dish, soap
   4. Mouthwash cup
   5. Roll of toilet tissue
   6. Bedpan with cover
   7. Urinal with cover
OCCUPIED BED

Equipment:

1. 1 sheet
2. 1 pillow case
3. 1 spread
4. 1 bedgown
5. 1 bath towel
6. 1 face towel
7. 1 wash cloth
8. bedpan cover

Procedure:

1. Take clean linen to bedside.
2. Place clean linen on chair.
3. Screen the patient.
4. Lower bed to horizontal position if possible.
5. Loosen upper bedding around bed.
6. Remove spread. Fold if it is to be used again and hang over back of chair.
7. Remove blankets separately. Fold and hang over back of chair.
8. Place bath blanket over sheet.
9. Instruct patient to grasp edge of blanket or tuck blanket under shoulders if patient is unable to hold.
10. Stand at foot of bed and withdraw sheet.
11. Fold sheet to be used as drawsheet and place on chair.
12. Remove one pillow to chair. Change pillow case in usual manner.
13. Turn patient away from nurse. Loosen lower bedding.
14. Fold outside edges of cotton drawsheet to center of bed, make narrow folds close to patient.
15. Fold outer edge of rubber drawsheet to center. Lay over patient.
16. Fold lower sheet in same manner.
17. Reapply lower sheet in usual way.

18. Adjust rubber drawsheet and tuck in tightly.

19. Place cotton drawsheet on bed. Tuck in along side and gather half of it into narrow folds to the patient.

20. Turn patient toward nurse over ridge formed by bedding. Pull folds of sheet from under patient.

21. Remake under bedding as on other side.

22. Turn patient on back.

23. Replace pillows and arrange to provide support and comfort.

24. Place clean sheet, wrong side up, over patient. Fold under at top as much as will be needed to protect spread and blankets.

25. Withdraw bath blanket.


27. Tuck in and mitre corners of sheets and blankets separately.

28. Apply spread, tuck in at foot, make corners and fold under upper edge of blankets.

29. Fold upper sheet over spread.

30. Check appearance of entire unit.

31. Return chair to position.

32. Test signal cord and fasten within easy reach.

33. Check bedside table equipment. Place within easy reach.
CLOSED BED FOR AMBULATORY PATIENT

Procedure:
1. Remove pillows to chair.
2. Grasp edge of upper bedding with both hands, turn back and fanfold approximately two feet from top of drawsheet.
3. Return pillows to bed.

CLOSED BED FOR HELPLESS PATIENT

Procedure:
Follow procedure as for "Ambulatory Patient" except fanfold bedding to within twelve inches of the foot of the bed.
Tighten bedding.

TO STRIP AND REMAKE BED FOR AMBULATORY PATIENT

Equipment:
1. 1 sheet
2. 1 pillow case
3. 1 spread
4. 1 bath towel
5. 1 face towel
6. 1 wash cloth
7. bedgown

Procedure:
1. Take linen to bedside. Place on chair.
2. Place chair beside bed allowing room to pass between chair and bed.
4. Place both pillows on chair under clean linen.
5. Loosen bed linen around entire bed.
6. Remove and fold spread, place on back of chair. Discard if soiled.
7. Repeat procedure with blanket.
8. Remove and fold top sheet as drawsheet. Place over blanket.

9. Remove soiled drawsheet, discard.

10. Remove rubber drawsheet and place over blanket.

11. Remove bottom sheet entirely and place over blanket.

12. Turn mattress side to side and head to bottom.

13. Remake bed as for "Closed Bed Procedure;" open as for "Ambulatory Patient."

14. Leave bedgown on foot of bed for patient to change.

RECOVERY BED

Equipment:

| 1. 1 sheet          | 6. 1 mouth gag          |
| 2. 2 pillow cases   | 7. 1 box wipes/gauze    |
| 3. 1 spread         | 8. 1 medium size emesis basin from Utility Room |
| 4. 1 face towel     |                            |
| 5. 2 rubber pillow cases | 9. string            |
|                   | 10. piece scrap paper    |

Procedure:

1. Carry linen and equipment to bedside.

2. Strip bed as for ambulatory patient.

3. Apply bottom sheet, rubber drawsheet and cotton drawsheet in usual manner.

4. Apply upper sheet, blanket and spread in usual manner. DO NOT TUCK IN.

5. Arrange cuff of sheet, blanket and spread in usual manner.

6. Arrange cuff at foot of bed with fold of linen even with edge of mattress.
7. Roll upper bedding to opposite side of bed.
8. Apply rubber and cotton pillow case to one pillow and attach, open end away from door, to head of bed with string.
9. Apply cotton pillow case to second pillow and place on chair.
10. Place second rubber pillow case at head of bed and cover with clean cotton pillow case, open end away from door.
11. Attach signal cord to head of bed.
12. Arrange furniture; bedside table, cardiac table, chair for easy access to bed with stretcher.
13. Bedside table:
   a. Emesis basin
   b. Mouth gag  cover with face towel
   c. Box of wipes
   d. Scrap paper

NOTE: No other equipment or personal belongings are to be on top of the bedside table.
CARE OF BLANKETS

1. There are two bed blankets available for each bed. These are never to be used for any other purpose. If one is not needed on the bed it is to be put in the linen closet. Never place on bar of bed.

2. When in use a bed blanket must always have a sheet under it and a spread over it. It must never come in direct contact with a patient. It is never to be used outside the spread.

3. An overbed blanket is available for each bed. During the day it may be kept on the bar at the head of the bed. It is to be used for extra cover at night. When not in use in private rooms it is to be kept in a bureau drawer. This blanket is never to be used for other purposes.

4. Extra blankets for precaution patients may be obtained from the Linen Room.

5. For precaution patients on discharge, sun and air blankets. If this is inadequate, place in laundry bag marked precaution and take to the housekeeper for sterilization.

6. Whenever you have any type of blanket which needs cleaning, take to the Linen Room where you will receive a clean one in exchange.

7. Always use porch blankets for patients in chair, wheelchair and for use on stretchers.
CLEANSING BATHS

Purpose:
1. To cleanse skin and remove unpleasant odors.
2. To stimulate circulation.
3. To refresh patient and relieve discomfort.

BED BATH

Equipment:

2. Bath towel    7. Soap
3. Face towel    8. Scissors
5. Bathing lotion 10. Orangewood stick

Procedure:
1. Have room warm and free from drafts.
2. Take all equipment to bedside, include linen if bed to be changed. Place on chair.
3. Screen patient. Have patient flat in bed when possible.
4. Offer patient bedpan before starting bath.
5. Remove one pillow and place on top of clean linen.
7. Repeat procedure with blankets.
8. Place bath blanket over sheet. Instruct patient to hold bath blanket. Carefully remove sheet. Fold to be used as drawsheet and place on chair. Unfasten ties of bedgown. Remove.
9. Place face towel under head to protect pillow.
10. Wash face, neck and ears with or without soap as patient desired. Dry with face towel. Hang at head of bed.
12. Place bath towel under left arm. Wash hand and arm carefully. Pay attention to palm, nails, elbow and axilla. Rinse and dry thoroughly.

13. Use nail file or orangewood stick. Cut nails as necessary.

14. Repeat procedure with right arm.


16. Fold bath blanket down to waistline. Wash abdomen. Liquid petrolatum may be applied with a swab to clean umbilicus if it is necessary.

17. Place bath towel under left leg. Raise patient's knee, wash entire lower leg, thigh and groin. Dry.

18. Place bath towel at foot of bed, place basin of water on it. Wash foot by placing in basin. Use brush if necessary. Dry.

19. Repeat procedure with right leg.

20. Change bath water.

21. Turn patient on side. Place bath towel full length of back. Wash back going well up into hair line, down over sides and buttocks. Dry.


23. Patient then completes perineal bath. Help as indicated.

24. Discard bath water.


26. Remake occupied bed in usual manner.

27. Remove equipment from unit. Return clean and dry.
TUB BATH

Equipment:

1. Bedgown
2. 2 bath towels
3. Wash cloth
4. Soap

Procedure:

1. Prepare room at temperature of about seventy degrees.
2. Fill tub half full of water at 105 degrees, Fahrenheit.
3. Place equipment on chair near tub. Place bath towel for patient to stand upon.
4. When patient is able to carry out bathing procedure, allow to do so. Never allow patient to lock tub room door. Remain within call at all times.
5. When necessary assist patient from tub. Dry thoroughly.
6. Apply bedgown, bathrobe and slippers. Return to unit.
7. Drain tub. Scrub well with brush and soapy water. Rinse.
8. Discard all soiled linen. Return all equipment to proper place.
9. Chart procedure.

ALCOHOL SPONGE BATH

Purpose:

1. To stimulate circulation.
2. To stimulate elimination through the skin and kidneys.
3. To decrease restlessness.
4. To reduce temperature.

Equipment:

1. 1 bath blanket
2. 2 bath towels
3. 2 wash cloths
4. 1 ice cap and cover
5. 1 hot water bottle and cover
6. Treatment basin with
   a. 8 ounces bathing solution
   b. 8 ounces of water at 90°F
7. Basin of ice cubes
8. Bath thermometer
9. 1 rubber pillow case
Procedure:

1. Take equipment to bedside. Screen patient.


3. Cover with bath blanket and fold upper bedding in folds at foot of bed.

4. Remove bedgown.

5. Protect under bedding by placing bath towel under area to be sponged.

6. Note color, pulse and respirations.

7. Note temperature of solution. Bath should start at 80°F, and be dropped to 70°F if patient can tolerate this temperature.

8. Note temperature of solution. Bath should start at 80°F, and be dropped to 70°F if patient can tolerate this temperature.

9. Wring out wash cloth and sponge face and neck for two minutes. Dry.

10. Sponge one arm and half of chest with long firm upward strokes, pausing in bend of elbow and axilla where large blood vessels are near the surface. Sponge for three minutes. Dry skin if necessary.

11. Sponge other arm and half of chest in same manner.


13. Sponge abdomen for three minutes. Dry if necessary.

14. Note the pulse.

15. Sponge one leg and thigh for five minutes with long, firm, upward strokes. Pause under bend of knee and in groin. Dry.


17. Sponge other leg and thigh in same manner.

18. Note pulse.

19. Turn patient on side, protect bed and sponge back for six minutes. Dry if necessary.
20. Note pulse.


22. If at any time the condition of the pulse, color or shivering indicate an unfavorable reaction, stop the application, apply more friction and cover the patient.

23. Remove the ice cap and hot water bottle. Remove towels.

24. Return patient's bed gown.

25. Remove bath blanket and arrange upper bedding.


27. Care for equipment as indicated.

28. Replace hot water bottle at feet if patient desires it.

29. Take rectal temperature one-half hour later and record drop in temperature.

30. Chart procedure with temperature, pulse and respirations as recorded.

MEDICATED BATHS

Purpose:

1. To relieve skin irritation.

Bran or Oatmeal Bath:

Place approximately two cups of bran or oatmeal in a mesh bag. Cover with cold water and cook for twenty minutes. Use a utensil from kitchen. Prepare bath tub of water at 96°F., place mesh bag of bran or oatmeal as is, into tub of water. Do not open mesh bag. Keep patient in tube ten to fifteen minutes. Pat dry.
Cornstarch Bath:

1. Mix one-half pound of cornstarch with two quarts of cold water in a large container.
2. Add sufficient amount of boiling water, slowly until mixture is thick. It may be necessary to cook over a low flame for a few minutes.
3. Prepare a tub of cold water and slowly bring temperature up to 90°F.
4. Pour cooked cornstarch into bath water.
5. Keep patient in tub ten to fifteen minutes. Pat dry.

Soda Bath:

1. Measure one to three cups of soda bicarbonate.
2. Prepare tub of water at 98°F. Add soda bicarbonate and mix well.

After Care:

1. Wash all utensils carefully. Discard wastes into hopper. Discard mesh bag into waste barrel.
2. Clean tub thoroughly. Remove all soiled linen.
AFTERNOON AND EVENING CARE OF PATIENT

Purpose:

1. To refresh the patient.
2. To remove causes of restlessness and sleeplessness.
3. To judge the condition of the patient.

Equipment:

1. Face basin
2. Face towel
3. Wash cloth
4. Soap
5. Tooth brush
6. Mouth wash cup
7. Mouth wash basin
8. Bathing lotion

Procedure: carried out before evening meal

1. Prepare equipment. Screen patient.
2. Offer patient bedpan.
3. Wash patient's face and hands.
5. Comb hair.
6. Remove binder if one worn. Remove upper pillow.
7. Turn patient on side.
8. Unfasten gown and rub back with lotion. Rub other bony prominences as necessary.
9. Brush crumbs from bed.
10. Loosen lower bedding, tighten and tuck in.
11. Replace binder if one worn. Return pillow.
13. Check bedside table equipment.
15. Care for equipment in usual way.
Procedure: carried out following evening meal

1. Offer patient bedpan.
2. Give mouth care.
3. Fill bedside carafe with fresh water.
5. Place extra blanket at foot of bed as necessary.
6. Provide ventilation.
7. Remove flowers from room or ward.
8. Remove nourishment glasses and tidy unit or room.
PROVISION FOR ELIMINATION

Purpose:

1. To place the bedpan in the proper position.
2. To leave patient and bed clean and dry after removal.

Equipment:

1. Bedpan
2. Bedpan cover
3. Toilet tissue

Procedure:

1. When necessary, warm bedpan by running hot water over it.
   Dry well.
2. Screen patient.
3. Fold upper bedding back at sides. Draw gown from under patient.
4. Place bedpan cover on chair or at foot of bed.
5. Have patient flex knees.
6. Place one hand under coccyx, raise patient and place pan.
7. Place signal cord and toilet tissue within easy reach.
8. If patient unable to care for self, remove pan, have patient turn on side, cover hand with several thicknesses of paper and cleanse anal region. If necessary wash with soap and water. Dry.
9. Place bedpan on chair and cover.
10. Arrange bed gown and bedding. Return toilet paper to bedside table.
11. Allow patient to wash hands.
12. Remove screen.
14. Note, if contents to be saved for specimen, record properly.
16. Place bedpan in hopper and flush. Rinse and dry.
16. If necessary use hopper brush to clean bedpan. Rinse well.
17. Return to bedside table well dried.

Procedure: to give a urinal
1. Remove urinal and cover from bedside table.
2. Raise bedding at side and place urinal within reach of patient.
3. After use, cover and remove to utility room.
4. Make a similar report as when caring for bedpan.
5. Wash and rinse well with cool water. Drain and dry outside.
6. Return to bedside table with cover and place inside.
CARE OF THE HAIR

To Comb the Hair:

Purpose:

1. To note cleanliness of hair.
2. To preserve the hair.
3. To add to comfort of patient.

Equipment:

1. Comb
2. Face towel
3. Ribbon or bandage

Procedure:

1. Cover the pillow with towel.
2. Part hair in center from brow to neck. Divide into small strands.
3. Comb tangles from ends first. If necessary alcohol may be applied to remove tangles.
4. Arrange hair becomingly about face. Braid according to position patient assumes most of the time. Fasten braid with bandage or ribbon.
5. Remove towel, shake clean and hang on rod. Brush any loose hair from bed.
7. Note condition of scalp and hair.

Hair Shampoo in Bed:

Purpose:

1. To improve cleanliness.
2. To assist in removing pediculi
Equipment:

1. 1 rubber cape
2. 1 rubber pillow case
3. 1 treatment sheet
4. 1 treatment rubber
5. 1 bath towel
6. 3 face towels
7. Absorbent cotton
8. Small safety pins
9. 1 bath basin
10. Newspaper
11. Pitcher of soapy water
12. Pitcher of clear water

Procedure:

1. Take all equipment to bedside. Screen patient.
2. Remove cotton pillow case and replace with rubber pillow case.
3. Fold treatment sheet to cover pillow. Arrange pillow so that it slants down toward right side of bed.
4. Pin face towel around patient's neck.
5. Place small amount of absorbent cotton in each ear.
6. Turn patient on left side, close to edge of bed.
7. Protect chair with newspaper, move to head of bed and place basin on it.
8. Fasten rubber cape close to patient's neck. Arrange to form trough from head to basin.
9. Place treatment rubber over patient's shoulder and tuck under edge of trough.
10. Place one face towel beside patient's face. Hang remaining towels on head of bed.
11. Bring pitchers of soapy water and clear water to bedside.
12. Pour soapy water over hair, protecting face and eyes.
13. Wash hair and scalp thoroughly, using both hands.
14. Rinse thoroughly with clear water.
15. Repeat several times until hair thoroughly clean and free of soap.
16. Squeeze out water and wrap hair in bath towel.
17. Remove wet cape. Drop into basin.
18. Remove treatment rubber and face towel. Place on table.
19. Dry face, ears and neck thoroughly.
20. Turn patient on back in comfortable position.
21. Spread hair over sheet. If sheet has become wet, remove and cover pillow with face towel.
22. Dry well with towel or dryer. Comb.
23. Remove covering on pillow. Replace cotton pillow case.
24. Remove equipment to utility room.
25. Wash and dry rubber cape and pillow case. Care for remaining equipment in usual manner.

TREATMENT FOR PEDICULOSIS CAPITIS, CORPORIS AND PUBIS

Purpose:

1. To destroy pediculi

Equipment:

1. 1 rubber pillow case or rubber sheet
2. 1 face towel
3. 1 precaution gown
4. 1 precaution cap
5. 1 laundry bag
6. cotton balls
7. 1 solution bowl
8. 1 waste basin
9. 1 fine comb
10. solution: A-200 Pyrinate
Procedure:

2. Put on precaution gown and cap.
3. For head treatment cover pillow with rubber pillow case. Other infected areas protect mattress with rubber sheet.
4. Place towel under patient's head or infected areas other than head.
5. Using cotton balls, thoroughly saturated with solution, apply to the entire area.
6. Rub area briskly with saturated cotton balls for one minute to insure thorough distribution of solution.
7. Rinse entire area with warm water using cotton balls.
8. Comb hair with fine comb.
9. Removal of equipment from unit: place in laundry bag all soiled linen.
10. Take all equipment and laundry bag to utility room.
11. Wrap all cotton balls in newspaper and discard into waste barrel.
12. Wash solution and waste basin thoroughly. Boil ten minutes.
13. Wash fine tooth comb with soap and water using brush. Boil metal comb for ten minutes; soak plastic comb in aqueous zephiran for thirty minutes.
14. Wash hands thoroughly.
15. Tag laundry bag and send to laundry.
16. Record treatment and results.

Note: This treatment may be repeated as often as necessary, using A-200 Pyrinate without danger of irritation.
CARE OF THE MOUTH

Purpose:

1. To keep the mouth in good condition.
2. To keep the mouth clean and moist.
3. To prevent disease.
4. To make the patient comfortable.

Mouth Care using Toothbrush:

Equipment:

1. Toothbrush
2. Mouthwash cup with solution
3. Tooth paste
4. Emesis basin
5. Face towel

Procedure:

1. Provide necessary equipment within easy reach of the patient if he is able to carry out this procedure.
2. Place patient's face towel in position to protect bed and bed gown.
3. If patient needs assistance, turn him on one side.
4. Hold toothbrush over emesis basin, pour some solution over it.
5. Apply tooth paste to brush.
6. Allow patient to brush teeth and rinse mouth with solution or water.
7. Hold basin or adjust in convenient position for expectoration.
8. Dry patient's face. Replace articles on table.
9. Wash and dry cup and basin thoroughly before replacing in table.

To Give Mouth Care to very Ill Patient:

Solutions commonly used:

1. Mouth wash:

   (a) Antiseptic mouth wash: 1:3 parts of water
   (b) Saline mouth wash: \( \frac{1}{2} \) teaspoon salt to 1 cup water
2. For coated tongue:

(a) Equal parts: hydrogen peroxide and water
(b) Equal parts: hydrogen peroxide and milk of magnesia
(c) Equal parts: lemon juice and liquid petrolatum
(d) Liquid petrolatum

Equipment:

1. Tray
2. Solution to be used
3. Small container with cold cream
4. Waste container
5. Mouth wash cup
6. Emesis basin
7. Cotton applicators
8. Tongue depressors
9. Drinking tube
10. Mouth wash solution

Procedure:

1. Wash hands thoroughly. Place tray on bedside table.
2. Prepare mouth wash solution in cup.
3. Screen patient. Protect bed and bedgown with face towel.
4. Use tongue depressor to hold cheeks away from gums and tongue while cleaning the mouth.
5. Dip clean applicator in solution and wash teeth, gums and inside of cheeks. Use applicator once and then discard.
6. Clean tongue with firm strokes. If badly coated use specially prepared solution. A tongue depressor covered on one end by a gauze sponge may be more effective than an applicator. Gently remove coating.
7. Turn patient's head to one side.
8. Place mouth wash basin close to lower corner of patient's mouth.
9. Instruct patient to rinse mouth and expectorate into mouth wash basin. Use drinking tube if possible.
10. Dry face thoroughly.
11. Apply thin layer of cold cream to dry, cracked lips.
12. Remove screen. Remove tray to utility room.
13. Clean and re-equip tray. Return to patient's table.
14. Wash hands thoroughly.

Care of Dentures:

Equipment:

1. Mouth wash cup  
2. Toothbrush  
3. Tooth paste  
4. Antiseptic solution

Procedure:

1. If patient can clean own teeth, follow usual procedure. Screen patient to avoid embarrassment.

2. When dentures must be cleansed by nurse, a gauze sponge may be used to hold teeth and to prevent dropping them.

3. Place teeth in mouth wash cup. Take to utility room with brush, paste or powder.

4. Grasp teeth firmly and clean with brush. If necessary a solution of equal parts of hydrogen peroxide and water may be used to soak dentures to cleanse thoroughly. Rinse well and return to patient.

5. Provide means for patient to cleanse gums and rinse mouth before replacing teeth.
SPECIAL FOOT CARE

Purpose:

1. To stimulate and maintain circulation daily in diabetic and circulatory cases, so that amputation may not be necessary.
2. To lubricate dry feet to prevent cracking and infection.

Equipment:

1. Foot tub basin
2. Bath towel
3. Face cloth
4. Soap
5. Liquid petrolatum
6. Cotton ball

Procedure:

1. Soak feet in tub of water at 100 - 105°F for twenty minutes.
2. Wash well with soap and water. Pat until thoroughly dry. Use special care between toes.
3. Apply oil and massage feet until it is absorbed.
4. If feet become too soft, rub occasionally with alcohol.
5. Cut nails straight across as needed.
6. Stress to patient the importance of such care, teach him to do it himself as condition permits.

Note: Notify head nurse whenever you notice break in skin or evidence of infection.

Lanolin Ointment may be substituted for liquid petrolatum.

To apply Lanolin use a throat stick and sponges.
APPLIANCES TO INCREASE THE SAFETY AND COMFORT OF THE PATIENT

BALKAN FRAME

Purpose:

1. To provide an attachment for traction and pulleys.
2. To provide a trapeze by which a patient may raise himself.

This is a wooden frame which is fastened to the head and foot of the bed, with adjustable cross-pieces. This frame is frequently used in combination with a Bradford Frame.

Note: The Balkan Frame is set up by and removed by an orderly.

BED BLOCKS - BED JACK

Purpose:

1. To elevate the head of a bed as ordered.
2. To elevate the foot of a bed as ordered.

1. Bed blocks: Wooden blocks grooved to accommodate the wheels of the bed. Obtain from the Orthopedic Supply Room.

2. Bed jack: Hand jack, designed to fit bar at foot or head of bed to raise to the desired height.

Note: One hand jack is standard equipment on every ward with the exception of the Pediatric Department.

Maximum height hand jack will elevate bed is sixteen inches.

BRADFORD FRAME

Purpose:

1. To aid in the care of fracture cases.
2. To aid in other cases where special care is needed and the patient is difficult to move.
Equipment:

1. Iron frame
2. 2 sheets
3. 4 single favorable size fracture boards
4. 2 canvas covers
5. Wooden blocks
6. Safety pins (large)

Procedure:

1. Place two fracture boards (correct size for bed) at level of frame; one over and one under mattress. Repeat procedure at level of foot of frame. Place wooden blocks on fracture boards.
2. Cover iron frame with canvas covers, then with smoothly folded sheets.
3. Place patient on frame, elevate on wooden blocks.
4. Arrange upper bedding to provide sufficient warmth.
5. To obtain a Bradford Frame call Orthopedic Supply Room. Designate size desired, child or adult.

CARDIAC OR OVERBED TABLE

Purpose:

1. To bring tray and other articles within easy reach of the patient sitting in bed.
2. To provide relief from dyspnea by enabling patient or the nurse to adjust in reclining forward position.

Procedure:

This is a movable table which fits over the bed. One or more pillows placed on the table will support and rest a patient who cannot lie down. Support pillows at back and at sides as necessary. Pin bath blanket around shoulders for warmth.
CRADLE BED

Purpose:
1. To keep the weight of bedding from a sensitive part.
2. To keep the weight of bedding from an injured part.

Procedure:
These frames are made of wood or iron in the shape of a half hoop which is placed in position on the bed before applying top linen. In applying upper bedding, allow ample to cover shoulders. A bath blanket may be placed over the injured or sensitive part of the body, or over the entire body, for extra warmth. When applying bottom bedding, place the cradle on a newspaper under the bed. A sheet may be placed lengthwise across the top bedding, just under the spread, to hold the bedding and cradle in place. Use straight folds for sheets and blankets, even with the cradle.

DOUGHNUT PADS

Purpose:
1. To remove pressure from small, bony prominences.

Equipment:
1. Sheet wadding
2. Roll of bandage

Procedure:
1. Fold sheet wadding into fourths, edges inside.
2. Wrap around fingers and make a ring, size according to use.
3. Hold firmly. Cover with two layers of bandage.
4. Turn under edge of bandage. Cover ring third time to make neat edge.
5. Slip under bony prominence and fasten in place with bandage.
FOWLER'S POSITION

Purpose:

1. To elevate the patient's body to form angle of sixty to seventy degrees with the horizontal to:

(a) to promote drainage in surgical and obstetrical conditions,
(b) to relieve dyspnea in cardiac or lung conditions,
(c) to lessen strain on abdominal muscles and surgical incisions following surgery, and
(d) to gradually accustom the patient to a sitting position.

Procedure:

1. Have patient well up toward the head of the bed.
2. Raise foot section to flex knees. Raise head section until the patient is in a semi-sitting position.
3. Support the small of the back, head and arms with pillows as necessary. Avoid a too acute angle.
4. Readjust position as often as necessary to maintain good position.

FRACTURE BOARD

Purpose:

1. To provide a firm support for a patient with a fracture.
2. To provide a firm support for a patient with other types of orthopedic trauma.

Procedure:

1. Type A: fracture board is made of two pieces of plywood hinged together to make one board, the full size of the hospital bed. This is placed between the spring and mattress to prevent the latter from sagging when motion must be reduced to a minimum, as in fracture of the pelvis or hip.
2. Type B fracture boards are approximately six inches wide and thirty-six inches long. Several, as desired, are used at one time.

3. In conjunction with a fracture board, either type A or B it is always necessary to use a hair mattress, which is obtained by calling the Housekeeping Department.

Both types of fracture boards are stored in the orthopedic supply room.

INCONTINENT PADS

Purpose:
   1. To absorb excretions from the bladder and rectum when they are discharged involuntarily.

   Note: Incontinent pads are obtained from the storeroom.

KNEE ROLL

Purpose:
   1. To prevent patient from slipping down in bed, when backrest is used.
   2. To support knees thus relieving strain on abdominal muscles.

Equipment:
   1. Feather pillow
   2. Sheet
   3. Rubber pillow case

Procedure:
   1. Cover pillow with rubber pillow case. Apply cotton pillow case.
   2. Fold pillow through the center. Expel air from pillow case.
4. Twist ends of sheet tightly. Loop until ready to use.
5. Slip roll under knees of patient. Bring it well up against the buttocks for support.
6. Place twisted ends of sheet through the spring, higher than the level of the patient. Tie securely on both sides of the bed.

RUBBER RING - AIR FOAM RING

Purpose:

1. To eliminate pressure from spine or bony prominence.

Procedure:

1. Inflate rubber ring to pliable stage.
2. Air foam, obtain desired size.
3. Cover either type with pillow case.
4. Place ring under patient with weight removed from portion of body that is tender. Adequately cover valve on inflated type to protect patient.

SAND BAGS

Purpose:

1. To limit motion.
2. To afford support to an injured part.

Procedure:

1. Before use cover, gauze for small size, pillow case for larger size.
2. These bags are made of heavy ticking, filled with sand. Always designate size and weight desired when ordering.
BINDERS

Purpose:

1. To hold applications, i.e. surgical dressings, splints, and poultices in place.
2. To afford support, limit motion and apply pressure.

Important Points to Remember:

1. Select correct type and size: straight, soultetus or T binder.
2. Have patient flat while binder is being applied.
3. Place binder in correct position: pin to fit, keep smooth and right in place.
4. Hold binder in place with straps when necessary. Adjust binder at least twice daily.
5. Use small pins for tucks and straps.

STRAIGHT BINDER: May be used for breast or for an abdominal binder

Procedure: Abdominal

2. Fanfold half of binder; place close to patient. Have patient raise hips, pull through with center of binder at mid-line of back. Be sure it is well down under hips.
3. Bring both ends of binder to median line in front. Pin tightly in center, then pin at lower edge and work up.
4. Place pins horizontally, pin length apart, to top in a straight line.
5. Fit binder to patient using small pins fastened vertically at sides.
6. Apply perineal straps to lower edges of binder at center front. Slip under thighs, fasten to lower edge on both sides.

Procedure: Breast

1. Prepare patient and binder as in previous procedure. Ask the patient to support breasts.
2. Pin at center first, then toward top and from center down to bottom in a straight line.

3. Make darts with small pins so that binder fits smoothly.

4. Apply shoulder straps from center back to front.

SCULTETUS BINDER

Procedure:
1. Select binder that is large enough to allow tails to overlap sufficiently.

2. Place binder under patient in same manner as for straight binder.

3. Arrange strips or tails flat on bed.

4. Fold tails snugly across the abdomen, alternating from side to side. Begin at bottom and work to top overlapping each tail about half its width over the preceding one.

5. Pin ends of the last two straps at the center.

T BINDER

Procedure:
1. Place belt around patient's waist, with wide strap of binder at back.

2. Bring between thighs over perineum to hold dressing securely in place.

3. Pin to belt.

Note: The T Binder is shaped like the letter "T" and is used to retain perineal dressings. Divided "T" binders are for the male patient.
BANDAGES

Purpose:
1. To hold applications, surgical dressings or splints in place.
2. To afford support.
3. To control bleeding.
4. To reduce swelling.
5. To immobilize a part.

Materials used:
1. Gauze
2. Muslin
3. Flannel
4. Rubber
5. Rubber and wool
6. Elastic-ace bandage
7. Rubber and silk
8. Crinoline
9. Plaster of Paris
10. Crepe bandage

Widths and Lengths:
1. Finger 1 inch 1-3 yards
2. Hand 1-2 inches 3 yards
3. Head 3 inches 3 yards
4. Extremities 2-3 inches 3-9 yards
5. Foot 2-3 inches 3 yards
6. Body 3-6 inches 9-12 yards

Fundamental Bandages:
1. Circular
2. Oblique
3. Spiral
4. Spiral-reverse
5. Figure of eight
6. Spica
7. Recurrent

Important Points to Remember:
1. Stand directly in front of the patient.
2. The part to be bandaged should be well supported.
3. Hold the roll uppermost when applying a bandage.
4. Hold bandage firmly to avoid dropping it.
5. Make all turns in the same direction.
6. Anchor bandage with two circular turns at the start.
7. Apply each turn of bandage with even pressure or tension.
8. Fasten by pinning with small safety pin, adhesive tape, clip or tying.

9. The form of bandage used will be dependent upon the part of the body bandaged and the purpose the bandage is being applied for.

SLING

Purpose:

1. A sling is a triangular bandage used to support the hand, forearm and elbow.

Equipment:

1. Sling
2. Safety pins

Procedure:

1. Flex the forearm and place in the center of the sling.

2. Carry the outer end of the sling over the arm and tie it at the back of the neck or on the shoulder to the inner end, after drawing this up between the arm and the chest.

3. Fold the third point neatly at the elbow and pin.
LIFTING AND MOVING PATIENTS

Important points to remember:

1. Before preparing patient have object to which patient is to be lifted ready and in position.
2. Be sure bed is secure. Lock wheels or have held by another person.
3. Be sure patient is warmly covered.
4. Have enough assistance to avoid accidents.
5. When working with a team, have leader direct procedure.
6. Bend, keeping back straight, to avoid back strain.

TO ASSIST FROM BED TO CHAIR

Equipment:

1. Rubber pillow case  3. Bathrobe
2. Porch blanket  4. Slippers

Procedure: one nurse - patient able to stand

1. Place porch blanket crosswise over chair so it may be used to envelop patient.
2. Protect pillow with rubber pillow case. Place in chair. Place second pillow against back of chair with open end downward.
3. Place chair facing head of bed.
5. If patient getting up for first time, take pulse. Allow to sit on edge of bed for a few minutes before moving to chair.
6. Place left arm under patient's arm and across back; right arm of patient across nurse's shoulder.
7. Support patient while he steps to floor. Make a half turn. Lower into chair.
8. Wrap patient with blanket. Place chair as desired by patient.


10. Observe patient's reaction. Do not permit to be come overtired. As a general rule, if the first time out of bed, allow to stay up no longer than twenty minutes.

11. To return patient to bed place chair facing head of bed.


13. Support patient while he regains a standing position. Make a half turn to side of bed.

14. Help patient well up over edge of mattress on to bed. Remove slippers.

15. Return pillows to bed. Remove rubber pillow case.


17. Return patient's clothing and equipment to proper place.

Procedure: two nurses - lifting patient

1. Prepare patient and chair as in previous procedure; plus leaving a space between bed and chair for standing room.

2. Standing on either side of the patient:
   a. First Nurse: place one arm across patient's back to farther axilla, the other arm under the patient's knees.
   b. Second Nurse: place one arm around patient's waist, other arm under knees grasping hand of first nurse.

3. Instruct patient to place one arm over shoulder of each nurse.

4. The nurse near the chair steps backward, to farther side, as other
nurse moves forward into the space between chair and bed.

5. Lower patient carefully into chair. Cover with blanket.

6. Make same observations and give same care as in previous procedure.

Procedure: wheelchair

1. Prepare chair as in procedure "To Assist from Bed to Chair," also patient. Arrange footrest close to chair.

2. Place patient in chair as described in previous procedure. HAVE THIRD PERSON HOLD CHAIR.

3. Instruct patient to sit well back in chair. Arrange footrest comfortably. Warm patient that bending too far forward will cause chair to tip.

4. Have chair held before moving patient back to bed.

5. Never allow patient to step on footrest, always have turned up.

TO LIFT FROM BED TO STRETCHER

Procedure:

1. Place head of stretcher at right angle opposite foot of bed. Leave three feet between stretcher and bed.

2. Cover patient with bath blanket, folded double, lengthwise. Turn upper bedding to foot of bed.


4. Instruct patient to place arms around neck of nurse; nurse places her arms well under the patient's shoulders and back. Support head. Assisting nurse places arms under buttocks and legs.
5. Lift together. Turn toward food of bed. Place patient on stretcher gently.


Note: Stretcher may be placed parallel with side of bed if patient able to get over onto stretcher unassisted.

**TO MOVE FROM BED TO BED**

Procedure:

1. Prepare clean bed as for helpless patient.

2. Cover patient with bath blanket. Entirely remove upper bedding from bed number one.

3. Fold both edges of drasheet close to patient.

4. Place beds side by side.

5. Together, two nurses, reaching across grasp the drasheet with both hands. A third nurse guides the patient from the opposite side.

6. Pull the patient, on drasheet, to clean bed. Cover with bedding and remove bath blanket.
BUERGER-ALLEN EXERCISE

Purpose:
1. To increase circulation in the legs and feet.

Equipment:
1. Inclined plane at an angle of 45° to 60° (straight-backed chair or specially constructed board). Latter is obtained from the central supply.
2. Bath blanket to pad inclined plane.
3. Watch
4. Woolen blanket, approximately one by one yard square.

Procedure:
1. Pad inclined plane with several thicknesses of the bath blanket.
2. Place the inclined plane at the foot of the bed so that its lowest point will reach the patient's mid thigh.
3. Keep watch in sight at all times.
4. Instruct the patient to exercise his legs and feet as follows:
   Position I:
   a. Instruct patient to lie on his back with his legs resting upon the inclined plane.
   b. Maintain position for one minute, or until feet thoroughly blanched.
   Position II:
   a. Have patient sit on edge of bed with legs hanging over side.
   b. Exercise the feet and toes as follows in this position:
      (1) Flex ankles downward, then upward.
      (2) Rock feet inward, then outward.
      (3) Spread toes apart, then close.
   c. Continue these exercises in this order for one minute, or until the feet become flushed.
Position III:

a. Return patient to recumbent position lying flat on his back. Place the legs horizontally on the bed and wrap in a woolen blanket. If ordered by the physician, a hot water bottle may be used with the blanket.

b. Maintain this position for one minute.

Note: These three position, holding each for two or three minutes, depending on fatigue, one promptly following the other, constitute one cycle of the Buerger-Allen Exercise.

5. Repeat this cycle three to six times at each session. Determine the number of repetitions by the degree of fatigue caused and by the general condition of the patient.

6. The number of sessions to be repeated daily is specified by the physician.

7. Record the procedure. Note carefully the changes which occurred in the color of the toes and feet during the following exercises and the patient's reactions to the exercises.
TOURNIQUET THERAPY FOR ACUTE PULMONARY EDEMA

Purpose:

1. To slow venous return to the heart.

Important Points:

1. Tourniquets should not be applied too tightly, otherwise arterial circulation may be obliterated.
2. When fastening tourniquet avoid bruising skin by pinching.
3. On arm blood pressure cuff may be substituted.
4. Release one tourniquet at a time. More than one tourniquet released at a time defeats the purpose of the procedure.

Procedure:

1. Place one twenty-four inch tourniquet midway under each upper arm.
2. Place one thirty inch tourniquet under mid portion of each thigh.
3. Apply tourniquets, by single loop method, in position indicated in quarter-hour diagram, nearest the time treatment is started, as follows:

<table>
<thead>
<tr>
<th>Position I</th>
<th>Position II</th>
<th>Position III</th>
<th>Position IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="https://via.placeholder.com/150" alt="Diagram" /></td>
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<td><img src="https://via.placeholder.com/150" alt="Diagram" /></td>
</tr>
</tbody>
</table>

4. Check arterial pulse at wrists and popliteal space.
5. Time procedure:
   a. Release one tourniquet every fifteen minutes, rotate clockwise.
   b. After releasing tourniquet, leave in place.

6. To discontinue procedure:
   a. Release one tourniquet every fifteen minutes until all tourniquets are released.
   b. Check pulse after removal of each tourniquet and record.

7. Record procedure and include psychological effect on the patient.
CHARTING

Important Points:

1. All nurses are responsible for records until they are delivered to the Record Room.
2. A record may never be taken from a ward without permission of the Director of the Hospital.

General Directions:

1. Print or write plainly all entries IN INK. No erasures.
2. Keep all records up to date, neat, accurate and complete.
3. Spell correctly.
4. Enter dates completely: month, day, year.
5. Pay particular attention to names, always use full name.
6. Complete chart headings on all sheets when making out admission chart.
7. Chart covers are made by entering only the patient's full name, doctor's name and hospital number.

Order of Record as Kept on Ward:

1. Chart cover
2. Clinical Sheet
3. Laboratory report
4. Bedside notes
5. History sheet; progress sheet
6. Anesthesia sheet
7. Clothes slip
8. Admission slip
9. Face sheet
10. Special sheets
DIRECTIONS FOR THE USE OF THE MEDICATION SHEET

1. Every doctor's order is to be written on the medication sheet and is to be signed by the doctor. Every telephone order temporarily entered by a nurse must be signed for by the doctor on his next visit.

2. All nurses' entries on the medication sheet are in red ink.

3. When a standing order for a medication is written, the head nurse or charge nurse will enter in the column at the left of the order the letter "T" with the time and her initials. This indicates a medicine ticket has been made to start the routine to assure regular administration.

4. The nurse who administers the first dose of a medication makes a note in the right hand column to show that administration has been started.

5. Record in the right hand column of the medication sheet every administration of a stat medication and every administration of a narcotic on a by the clock order at the time you give it.

6. When a number of orders have been written for a patient, it will not be possible to make all nurses' entries for administration of p.r.n. narcotics opposite the order. In this case record administration under date when it is given. P.r.n. orders hold for seventy-two hours.

7. The nurse who accompanies a doctor when he writes an order will enter the name of the patient on a sheet kept for this purpose on the outside cover of the Doctor's Order Book. This indicates to the other nurses that a new order has been written.
8. When an order is omitted the date is to be entered opposite the original order and must be signed by the doctor.

9. When an order, other than for medication is written, transfer the order to the Kardex, if it is to be carried out by the nurses. If it is an order for Laboratory work or for Xray, make out the requisitions and on the medication sheet check in the right hand column, opposite the order, ordered, requisitioned, booked or done.
DIRECTIONS FOR USE OF KARDEX

Equipment:
1. Kardex form
2. Kardex sheets
3. Xray film cover
4. Glass pencil

Procedure:
1. There must be a sheet for each patient. Assign spaces to correspond with census board.
2. The nurse who admits a new patient starts a new Kardex sheet with identifying data.
3. Write day orders in black, night orders in red. State specific time for each order to be carried out.
4. Use a separate line for each order, write date ordered at the beginning of the line.
5. As soon as you have carried out an order, indicate with a check mark and your initials beside the hour. Use glass pencil and mark on Xray film cover.
6. When you carry out a p.r.n. order, enter time with the check mark and your initials.
7. When an order is discontinued, rule one line through it.
8. Stat orders are not transferred to the Kardex Sheet.
9. The charge nurse will check the Kardex at frequent intervals to keep it up to date and to enter new orders. She will check each student as she reports of duty in regard to treatments and medications given.
10. At eight a.m. the charge nurse will make final check for the previous twenty-four hours, dry wipe all covers to remove checks and start new day.
11. When many cancelled orders have accumulated on one sheet, the charge nurse should start a new sheet for the patient.

12. When a patient is discharged make two or three vertical lines through the sheet to cancel it. Use reverse side for another patient. Discard after use.

SYMBOLS TO BE USED ON KARDEX

1. When a patient may need bedside notes occasionally but not constantly, write "B.N. p.r.n." on upper left side of card.

2. When a patient is placed on the danger list, write "D.L." in red after his name. When he is taken off the danger list rule one black line through these letters.

3. Write the dosage of every medication except narcotics on the Kardex.

4. When a medicine is ordered every other day, write the specific dates for a week in advance. After this time has expired rewrite the item.
ADMINISTRATION OF MEDICINES

Purpose:

1. To insure the accurate, prompt, efficient administration of a medication and, in the best way, to obtain the desired results.

General Rules:

1. Medicines are kept in a medicine closet which is kept locked at all times.
2. Oils should be kept in a cool place. Refrigeration increases the palatability and prevents decomposition.
3. Contents of medicine closet checked daily to maintain supply of stock drugs.
4. All poisons should be clearly labeled.
5. Narcotics are kept in a separate, locked, compartment within the medicine closet.
6. Drug labels must never be changed except by the Pharmacist.
7. Medicine closet cleaned completely daily.
8. No nurse may administer any medication poured or prepared by another.
9. Do not talk or become distracted while pouring medications.
10. All medications must be accurately measured with the proper utensils.
11. All medications must be accurately measured with the proper graduates (liquid).
12. Medications should never be mixed unless specifically ordered.
13. No medication, dry or liquid, may be returned to its container.
14. The label on all medications should be read three times.
15. A medication never may be left at a bedside.

16. All medications are to be given by mouth, unless otherwise ordered.

17. Check name on medicine card with patient, before giving medication.

18. All liquid medications should be well shaken before pouring.

19. Telephone and verbal medication orders may be taken only by the charge nurse. The nurse will sign the name of the doctor giving the order and her own initials below the order.
METHODS OF ADMINISTRATION

By Mouth

Procedure: (includes oral medications excluding narcotics)

1. Go to the medicine closet, select card for medication which is to be administered. Check with order.

2. Return to medicine closet; place card on shelf in front of you. Wash hands. Prepare tray.

3. To prepare medication:
   a. Read patient's name; name of medication and dosage on medicine card.
   b. Find correct container.
   c. Read the label.
   d. Check name of drug and dosage with medicine card.

Liquid:

1. Read label.

2. Remove cover.

3. Pour medication into medicine glass from side opposite label.

4. Re-check label.

5. Wipe bottle if necessary.

6. Replace cap.

7. Return to shelf.

8. Place medicine card in standing position in medicine glass cover.
Tablet:
1. Read label.
2. Remove cover.
3. Pour tablet or tablets into medicine glass cover.
4. Re-check label.
5. Replace cover.
6. Return to shelf.
7. Place medicine card in standing position in medicine glass cover.
4. Repeat this procedure until all medications are poured.
5. Fill pitcher on medicine tray with water.
7. At bedside:
   a. Repeat name of patient for whom medication is intended.
   b. Watch patient take medication.
   c. Place medicine card in horizontal position on medication tray.
   d. Repeat this procedure with all medications.
   e. Never leave a medication at a bedside.
8. Return medicine tray to medicine closet. Wash and set up tray ready for use.
9. Record time administered; name of medication and dosage; method of administration; reason for medication and signature.
Narcotics by mouth

Procedure:
1. Obtain permission to give medication.
2. Check time of previous dose and time elapsed.
3. Check original order for:
   a. date order written; (must be renewed every 72 hours).
   b. dosage, frequency and channel of administration.
   c. time previous dose administered.
4. Obtain bottle of narcotic.
5. Check bottle with order, name and dosage.
6. Check bottle and order with charge nurse.
7. Prepare medication.
8. Before returning bottle to narcotic closet, recheck dosage of bottle with charge nurse.
9. At bedside: repeat name of patient before administering medication.
10. Record: time administered; name of medication; dosage; method of administration; reason for administration and name.
HYPODERMIC INJECTION

Purpose:

1. To obtain prompt action of a drug.
2. To administer a drug when it may not be taken by mouth.

Equipment:

Tray with:

1. Container with Zephiran sponges
2. Container with dry sterile sponges
3. Vial of sterile water (50 cc)
4. Syringe and needle
5. Sterile spoon
6. Waste container

Procedure:

1. Read order and obtain stock bottle of medication, carry to tray.
2. Open package containing sterile spoon. Place spoon, ready for use on tray.
3. Open syringe and assemble.
4. Remove cotton plug from sterile needle container. Insert syringe into needle container, fit syringe into hilt of needle. Leave in needle container.
5. Place one dry sponge on tray.
7. With assembled syringe and needle, withdraw desired amount of sterile water. Slowly expel into spoon.
8. Carefully detach needle from syringe and place on dry sponge with tip of needle in center of sponge.
9. Place tip of syringe into glass needle container.
10. Read label of medication. Pour tablet into cap of bottle, drop into spoon.

11. Carefully dissolve pill by using tip of syringe. Dissolve the medication completely.

12. Draw solution into syringe.

13. Attach needle to syringe and lay syringe, down with tip of needle in the center of the dry sponge.

14. Cover needle with aqueous zephiran sponge ready to carry to bedside.

15. Reread label on medication bottle, re-check doctor's order and return bottle to cabinet. Lock cabinet.

16. Take medication to bedside. Identify patient by name.

17. Select site for injection. Wipe area with moist sponge.

18. Expel air from syringe by holding vertically and by advancing plunger until fluid comes to point of needle.

19. Grasp flesh firmly on the site selected. Insert needle through the skin quickly at a forty-five degree angle. Withdraw needle slightly and inject solution slowly, at the same time relaxing pressure on part.

20. Remove needle quickly, massage area with circular motion to facilitate entrance of drug to circulation.

21. Rinse syringe thoroughly in cleansing solution; remove needle from syringe, leave plunger halfway in barrel. Place syringe and needle in pan to soak in solution prepared for needles and syringes.

22. Chart medication administered.
HYPODERMIC INJECTION

Drugs in Solution in Sterile Ampule
1. Obtain needle and syringe as in procedure.
2. Wash off top of ampule with a sponge, file neck, wipe again with sponge and break off at neck.
3. Attach needle to syringe and insert into ampule carefully.
4. Draw solution into syringe and proceed.

Drugs in Solution in Rubber Stoppered Vial
1. Obtain syringe and needle as in procedure.
2. Wash off stopper thoroughly with sponge.
3. Fill syringe with amount of air equal to amount of medication desired.
4. Insert needle through stopper and invert bottle. Force air into vial.
5. Draw required amount of solution into syringe and proceed.
INTRAMUSCULAR INJECTION

Important Points to Remember:

1. Safety depends upon:
   a. Maintaining aseptic technique.
   b. Selecting suitable site for injection.
   c. Testing to make certain that needle is not in a blood vessel before injecting medication.
   d. Accuracy of dosage.

2. Effectiveness depends upon:
   a. Introduction of all medication.
   b. Site of injection.

3. Comfort for the patient depends upon:
   a. Position permitting relaxation of the muscle.
   b. Quick and skillful introduction and withdrawal of the needle.

4. Site of injection depends upon:
   a. Nature of medication to be administered.
   b. Amount of medication to be administered.

INTRAMUSCULAR ADMINISTRATION OF MEDICATION

Purpose:

1. To inject a large amount of fluid or drug.
2. To inject a drug that is irritating.
3. To inject a drug not easily absorbed otherwise.
Equipment:

1. Sterile syringe
2. 20-22 gauge needle
3. Aqueous Zephiran sponge
4. Medication
   - 1½ inches long

Procedure:

1. Obtain medicine card. Check information in proper way.
2. Check medicine card with medication.
3. Prepare syringe and needle. Cleanse ampule or rubber stoppered vial with sponge.
4. Fill syringe with slightly more medication than required dose.
5. Holding syringe in a vertical position, eject air and excess medication.
6. Cover needle with sponge.
7. At approach to bedside, repeat name of patient for whom medication is intended before administration.
9. Standing at patient's side, draw two imaginary lines over the buttoc to be injected:
   a. Horizontal, from the top of the gluteal fold to crest of ileum.
   b. Longitudinal, midway between gluteal fold and iliac crest.
10. Cleanse area in upper outer quadrant. Eject air from syringe.
11. Place the left hand flat upon the buttoc and with firm pressure draw the superficial tissue downward toward the thigh. Ask patient to take deep breath.
12. While patient inhaling, insert the needle into the upper and outer quadrant with a quick plunge at a ninety degree angle.
13. Steady syringe with left hand and pull plunger upward with the right hand to determine presence of needle in a blood vessel. If blood appears in syringe, withdraw and repeat procedure one centimeter or more from first site.

14. If needle is in muscle tissue, inject slowly.

15. Remove needle, apply pressure with sponge. Massage area gently to aid in absorption.


17. Chart time, medication, amount, method of administration, site and your signature.

18. Note: alternate injections between the right and left buttock. The deltoid muscle may be used if the gluteal muscle is notably irritated or inaccessible.
MEDICATION ADMINISTERED RECTALLY

Note: Medication by rectum is administered by retention enema and by suppositories.

Equipment: (for administration of suppository)

1. Rectal tray
2. Suppository in sponge

Procedure:

1. Take equipment to bedside.
2. Screen patient.
3. Turn patient on side, if possible.
4. Put on rubber glove.
5. Lubricate suppository and index finger of glove.
6. Insert suppository as far as finger will reach. Tapered end of suppository is introduced first.
7. Instruct patient to remain quiet until the desire to expel the suppository has passed.
8. Chart medication and time administered.
USE OF NEBULIZER FOR INHALATION

Purpose:

1. To provide medicated "mist" for inhalation and lung-to-blood-stream penetration and absorption.

Equipment:

1. Nebulizer
2. Rubber tubing
3. Tank of oxygen
4. Syringe
5. Medication
6. Glass "Y" tube

Procedure:

1. Assemble equipment at bedside.

2. Place medicated solution in vaporizer. Level of medication should not reach the glass tube. Use care not to tip the vaporizer to prevent fluid from running into tubing.

3. Attach nebulizer in patient's mouth. If patient able to support nebulizer, allow to do so. Instruct patient to keep lips closed over nebulizer.

4. Connect the rubber tubing to oxygen tank.

5. Turn on gauge at seven or eight liters.

6. Instruct patient to hold gingerly and place finger over open end of glass "Y" tube when inhaling and release it when exhaling.


8. At completion of treatment turn off oxygen and remove nebulizer by disconnecting rubber tube at tank.


10. Label remaining solution concentration and mark for use in nebulizer.
PODTS TO OBSERVE IN MAINTAINING ASEPTIC TECHNIQUE

1. Use sterile transfer forceps to remove sterile articles from containers.

2. Immerse sterile transfer forceps as far as possible in Zephiran Solution in transfer forceps holders.

3. Fasten clamp on transfer forceps when removing or returning them to the holder to avoid contact with the rim. If the transfer forceps becomes contaminated, it must be boiled ten minutes before returning to the holder.

4. Always hold transfer forceps with the points downward.

5. Invert covers of sterile containers only when necessary to lay them down while removing articles from containers. Otherwise, hold above container with sterile side downward. Replace immediately.

6. Do not attempt to remove or to put a large number of sponges through the mouth of the jar at one time, as some of them will become contaminated by contact with the rim.

7. If there is any question of contamination, consider the article unsterile and discard it. Never take a chance.

8. Avoid reaching over a sterile field or surface.

9. Instruct patient to keep his hands away from the field or equipment.

10. Use sponge for only one stroke in washing an area and then discard.

11. To open dry sterile goods:
   a. Hold the package in left hand, fastening uppermost.
   b. Remove the pin and place in tray provided.
c. Fold back the corners of the cover without contaminating the contents by touching the inside of the wrapping.

d. Remove the dressing with a sterile instrument or drop onto a sterile field.

12. When an antiseptic or sterile solution is being used in a dressing, pour a small portion of solution from the container into the dressing basin. This is done to cleanse the rim of the bottle or flask before using.

CARE GIVEN WOUND AND SURROUNDING AREA

1. If dressing is adherent to wound, moisten with wet saline sponge until it comes away from the wound easily and without damage to new tissue.

2. Remove adhesive tape by holding skin taut with one hand and pulling adhesive quickly and firmly toward the wound. Remove remnant of adhesive with benzene.

3. Wash the area from the wound outward with alcohol or zephiran.

4. Apply sufficient dressing to care for drainage at the lowest area to which it will gravitate.

5. Use Montgomery straps when area requires frequent dressing to prevent skin irritation due to repeated removal of adhesive tape.
HAND SCRUB FOR STERILE PROCEDURE ON THE CLINICAL UNITS

Equipment:
1. Clean brushes
2. Watch
3. Soap - Gll

Procedure:
1. Boil one hand brush for ten minutes. Drain off water and take to scrub sink in container in which boiled.
2. Clean nails and cuticle with orangewood stick.
3. Insert ends of nails into soap bar to force soap under ends of fingernails.
4. Wash hands and arms thoroughly with soap under running water and rinse.
5. Soap the brush. Place the soap on the back of the brush.
6. Scrub both hands. Starting at the finger tips, work systematically between the fingers up the wrist and to the elbow, concentrating on the hands. Rinse frequently. Scrub for one and one-half minutes on each hand.
7. Drop soap into the soap dish.
8. Rinse hands and brush thoroughly.
9. Turn faucet with brush or with dry sterile towel.
10. Point hands upwards while going to the bedside.
THE DRESSING OF WOUNDS

Purpose:
1. To cleanse wounds.
2. To protect wounds.
3. To absorb discharges.
4. To apply medication.
5. To provide pressure.

Equipment:
1. Surgical cart fully equipped

Procedure:
1. Take surgical cart to bedside.
2. Screen the patient.
3. Place the patient in comfortable position with hands away from field of dressing.
4. The arrangement of bedding will depend upon the area to be dressed. Fold bedding neatly away from this area, exposing patient as little as possible.
5. Open binder.
6. Provide a sterile field, either on the bed or on the shelf of the dressing cart, by opening and placing a sterile towel.
7. Using transfer forceps, place the instrument to be used on the sterile field with handles toward the edge, pointing toward the doctor. Do not let transfer forceps touch the towel.
8. Place sponges on the field.
9. When soiled dressings are removed, place in dressing basin.
10. To moisten sponges with alcohol or any other solution, hold with instrument over basin and pour solution over them.
11. As the dressing proceeds, provide all instruments and materials as needed, lifting with transfer forceps and placing on sterile field.

12. Place discarded instruments in basin.

13. Apply binder or bandage to hold dressing in place.

14. Remove used equipment to utility room.
   a. Place soiled gauze in gauze pail.
   b. Wrap other dressings in newspaper and discard in waste pail.
   c. Clean instruments, boil ten minutes and return to sterile instrument tray on surgical cart.
   d. Wash dressing basin and instrument basin thoroughly.
   e. Discard soiled towels in laundry.
   f. Replenish supplies.
CARE OF SURGICAL CART

1. Daily care of the surgical cart should be done at night.
2. Scrub all instruments, boil ten minutes, dry with a sterile towel, double thickness and place in freshly boiled covered instrument tray.
3. Damp dust shelves of cart daily and change covers as necessary.
4. Replenish cans of sterile towels, sponges, abdominal pads on the cart every morning.
5. Replenish boric strips at least every two weeks.
6. Check and replenish supplies on all shelves.
7. Wash, scrub and boil ten minutes basins for dressings and soiled instruments.

CARE OF SCISSORS

Equipment:

1. Covered pan with Zephiran Chloride Solution 1:1000
2. Scissors

Procedure:

1. Wash scissors after use, with soap and water. Dry thoroughly.
2. Submerge scissors in Zephiran Chloride Solution, with blades open for a minimum of thirty minutes.
3. Handle scissors with sterile transfer forceps. Use directly from solution. Exposure to air makes sterilization ineffective.
4. Every Sunday: discard Zephiran Solution, wash pan in warm soap and water, dry. Line pan with a folded gauze sponge and provide fresh solution. Use enough to cover scissors entirely.
CARE OF SYRINGES AND NEEDLES

Equipment:

1. 1 square enamel pan
2. 1 bottle cleaning powder
   (use 1/2 teaspoon to 1 pint water)

Procedure:

1. Open a 4x4 sponge and spread on bottom of pan.
2. Fill pan with warm water and add correct amount of cleaning powder.
3. As needles and syringes are used, flush cleaning solution through them thoroughly.
4. Remove needle from syringe and leave to soak in solution.
5. Leave plunger halfway in barrel of syringe and leave to soak in the solution.
6. Always allow syringes and needles to soak at least three to ten minutes.
7. Change cleaning solution at least once daily and thoroughly wash pan.
8. Before returning needles and syringes rinse well and dry.
Routine Pre-operative orders:

1. Follow general directions for admission of patient.
2. Keep in bed, unless ordered up by physician.
3. Record four-hourly temperature until discontinued by physician.
4. Check to make sure that urinalysis is completed before time of operation.
5. Diet: unless otherwise ordered by surgeon or by anesthetist, force fluids and carbohydrates on evening before operation. During the six hours immediately preceding the scheduled time of operation, give nothing by mouth, except small amount of water with pre-operative oral medications.
6. All treatments, enemata, pre-operative medications must be on written order by surgeon or anesthetist. Report any signs of blood, mucus or clay colored stools occurring before or after operation. Save specimen. Watch for untoward reactions to pre-operative sedation and report immediately.
7. Prepare anesthesia sheet the night before operation. Record all pre-operative medications there when given, indicating exact drug, dosage, exact time of administration and avenue of administration.
8. Prepare skin night before operation.
9. One hour before scheduled time of operation, prepare the patient for operating room:
   a. Remove jewelry, dentures, glasses, artificial eyes and extremities.
b. Apply laparotomy stockings and anesthesia cap.

c. Apply pediculosis cap to any patient with pediculi.

d. Cover patient with sheet, folded once crosswise.

e. Have patient void.

f. Give pre-operative medications according to specific orders and record carefully.

g. Check anesthesia sheet ready to go with patient. It must indicate ward, full name, temperature, pulse, respirations, blood pressure, height, weight, pre-operative medications with times of administration, time and amount of last voiding.

10. Transport every patient to and from operating room by truck. Knee strap must be fastened during transport.

11. Send with the patient the complete record. This includes the history chart, anesthesia sheet, medication sheets and charge slip.

12. The nurse, aide or orderly, who accompanies the patient to the operating room must transfer the care of the patient directly to an operating room nurse before leaving.

For Patients under General Anesthesia:

1. Turn patient on side unless otherwise ordered.

2. Take pulse, respirations and blood pressure immediately on return from operating room.

3. Count pulse and respirations and take blood pressure every ten minutes.
4. When patient is conscious, pulse and respirations are to be counted every thirty minutes for three hours. Notify charge nurse, is very important, if any changes occur.

5. If patient vomits while still unconscious, elevate foot of bed and use suction apparatus. Notify anesthetist.

For Patients under Spinal Anesthesia:

1. Place patient flat in bed. Elevate foot of bed. Patient may turn head, but should not raise head from bed for twenty-four hours.

2. Take pulse, respirations and blood pressure immediately on return from operating room. Repeat every fifteen minutes for the first hours, then every half hour for the next two hours. Record all readings. Notify anesthetist of falling blood pressure or of any unusual change in blood pressure.

3. A small pillow may be placed under the small of the back.

4. Record rate and depth of respirations. Call anesthetist if they tend to be shallow.
NURSING CARE OF POST-OPERATIVE PATIENT

1. Remove ether stockings and tuck in bedclothes as in occupied bed.

2. Keep head turned to the side if the patient has mucus or is vomiting.

3. If choking occurs, hold mouth open with mouth gag and swab with gauze wrapped around finger. If due to relaxation of tongue, cover tongue with gauze and grasp, pull forward. Turn patient on side if possible.

4. Keep patient warm and dry.

5. Record all observations in concise, definite terms, state time.

6. Make patient as comfortable as possible.
   a. Raise knees to relieve strain on abdominal muscles.
   b. Turn patient frequently from side to side unless in shock, otherwise if ordered by surgeon. If patient is in shock avoid change of position.
   c. Pillow may be placed under curve of back.
   d. Cleanse mouth after vomiting to lessen nausea. Remove all signs of vomitus immediately.
   e. Lessen thirst by moistening mouth and lips with applicators, or by allowing patient to rinse his mouth, if taking fluids by mouth is contraindicated.
   f. Provide as much quiet as possible.
   g. Provide good ventilation without chilling the patient.
   h. Bathe face and hands to refresh patient.
   i. When fluid is allowed give either hot or cold, never iced.
7. Carry out all post-operative orders.
8. Watch for distention and discomfort due to retention of urine.
9. Watch for distention due to gas. Turn patient frequently.
10. See that binder does not become uncomfortably tight as patient becomes distended.
12. Discontinue all pre-operative orders automatically with the operation.
13. Special every patient until he can state name and where he is.
14. Use low head rest as soon as conscious unless otherwise ordered.
15. Report any untoward signs immediately.
16. Give water in small amounts as soon as nausea ceases.
17. Give special mouth care every four hours or oftener as necessary.
18. Notify surgeon if patient does not void within twelve hours after operation.
19. During the first forty-eight hours give narcotics as ordered for pain, discomfort or restlessness.
20. Measure and record all fluid intake and output carefully.
21. The first surgical dressing is done by the surgeon.
22. If an ointment is ordered for a dressing, apply on sterile fine-mesh gauze.
SKIN PREPARATION FOR OPERATION

Areas to be prepared:

1. Abdominal:

High: from mid-portion of chest to and including pubic hair visible with legs together and to mid-axillary line on both sides.

Low: from xiphoid process to and including pubic hair visible with legs together and to mid-axillary line on both sides.

2. Breast:

From the clavicle to level of umbilicus, from nipple line of other side to mid-line posteriorly, including shoulder, axilla and arm to elbow on side designated.

3. Chest:

For right chest prepare from mid-sternal line to middle of left scapula, include right shoulder and axilla, to umbilical level front and back. For left chest reverse procedure.

4. Inguinal:

From level of umbilicus down to middle of thigh. Include entire area between mid-axillary lines.

5. Kidney:

From mid-point of chest to pubes, mid-line in front to mid-line posteriorly.

6. Rectal:

Shave area four inches in diameter about anus. Do not shave pubes.

7. Thyroid and Neck:

From point of chin to mid-point of chest to hair line on side. Do not include hair line. Shave one-third of neck posteriorly on either side.
8. Varicose Veins and Amputations:

From level of umbilicus down to ankle. Include entire area between mid-axillary lines and perineal preparation. In amputations for circulatory conditions, i.e. gangrene, preparation should be stopped well above the area of discoloration and this area should be completely isolated in a separate dressing.
SKIN PREPARATION FOR OPERATION

Purpose:

1. To increase cleanliness of skin pre-operatively.

Equipment:

1. Tray: 3 basins
   - soap solution
   - warm water
   - zephiran solution
2. Sponges
3. Applicators
4. Container with wipes
5. Razor
6. Waste basin
7. Treatment sheet
8. Drop light
9. Treatment rubber

Procedure:

1. Take equipment to bedside.
2. Arrange bedclothes so that area to be cleansed is exposed.
   Place treatment sheet and rubber beneath area to be shaved, to protect bedding. Use bath blanket as needed to protect patient during procedure.
3. Shave area designated by order.
5. Scrub shaved area with sponges and soap and water for three minutes immediately following shaving procedure. Use circular motion. Start at center of area and work outward.
6. Scrub with sponge and clear water in the small areas and in the same order.
7. Scrub again with zephiran solution.
9. Wash and boil all equipment for ten minutes.
10. Set up tray and leave fully equipped and in order.
OXYGEN THERAPY

Purpose:

1. To relieve respiratory distress.

Important Points:

1. When ordering oxygen therapy designate type to be employed:
   a. Nasal catheter,
   b. Mask or
   c. Tent.

2. Be sure no open flame or faulty electrical equipment is in or near the unit.

3. Nasal catheters are changed every six hours, more often if necessary. Rinse used catheter thoroughly in cold water and then warm soapy water. Soak in Aqueous Zephiran for thirty minutes.

4. Check carefully that catheter does not become clogged with mucus.

5. Patients receiving nasal oxygen must receive special mouth care every four hours.

6. Check rate of flow and contents of oxygen tank regularly. A second, full tank of oxygen should always be on hand.

7. A charge slip is made out for every tank of oxygen received. Always note on charge slip amount of oxygen in tank.

8. A credit slip is made out for every tank of oxygen returned which has not been completely used. Always specify, on credit slip, amount of oxygen used: i.e. credit one-half tank or amount remaining.
OXYGEN THERAPY - NASAL CATHETER

Equipment:

1. Oxygen tank with gauge
2. Bottle $\frac{1}{2}$ full of water
3. 2-hole stopper with glass tubing
4. Rubber tubing
5. Glass connecting tube
6. Rubber nasal catheter or two prong metal catheter
7. Lubricant
8. Adhesive tape or scotch tape
9. Straps (secure tank to bed)

Procedure:

1. Take equipment to bedside. Explain entire procedure to patient.
2. Test equipment:
   a. Crack tank of oxygen
   b. Apply gauge - test
3. Assemble remaining equipment and attach to tank. Test again.

RUBBER NASAL CATHETER

4. Measure catheter from tip of nose to ear, approximately four to six inches for length to be inserted.
5. Lubricate tip of catheter with lubricant. Insert slowly and carefully.
6. Nasal catheters may be introduced by any nurse who has had instruction in technique.
7. Fasten catheter securely in place with small strips of adhesive or scotch tape. Check flow of oxygen. Usual rate five to seven liters.
8. Check flow of oxygen frequently.

TWO PRONG METAL CATHETER

1. Gently place prongs in nose. Adjust head band to fit snugly.
2. Check rate of flow of oxygen frequently.
FACE MASK

Equipment:

1. Face mask plus equipment in procedure for Nasal Catheter with exception of #6, #7 and #8.

Procedure:

1. Proceed as for nasal catheter therapy.
3. Check flow of oxygen frequently. Usual rate of flow five to seven liters.
4. Mask may be removed and oxygen discontinued while patient is eating. All other nursing measures may be done without removal of the mask.
5. Chart procedure. Include psychological effect on patient when writing bedside notes.

After Care:

2. Return all equipment to storage.

OXYGEN BY MEANS OF TENT

Equipment:

1. Adequate supply of oxygen and oxygen tent.
2. Adequate supply of ice if necessary.

Important Points:

1. Assist orderly to set up oxygen tent.
2. Read directions always on all equipment carefully.
3. Keep tent tucked in around mattress. Avoid tearing canopy by pulling tightly. Loosen only when absolutely necessary.
4. Check temperature of tent hourly. Temperature should never rise above 70°F.

5. Patients in an oxygen tent should be protected from chilling by use of shoulder covering if necessary.

6. Patients should receive special mouth and back care every four hours at least.

7. Fire hazard is the greatest danger in using oxygen. Do not use any electrical apparatus or allow smoking or use of matches in unit. Do not allow patient to use electric signal cord. Provide other means for calling nurse. Nurses caring for patients receiving oxygen are not allowed to wear nylon uniforms.

8. Request orderly to remove equipment when not in use.
PARENTERAL THERAPY

Parenteral therapy is the administration of fluids and medication other than through the gastro-intestinal tract. Commonly, needles are inserted into the veins or into the loose areolar subcutaneous tissues.

Purpose:

1. To substitute food which the patient is temporarily unable to assimilate through the gastro-intestinal tract, and
2. To substitute fluids and electrolytes which the patient is unable to assimilate through the gastro-intestinal tract, thus:
   a. To supply fluid, to combat dehydration and to restore the blood volume; thus improve circulation in shock and hemorrhage.
   b. To supply electrolytes in cases of acidosis or alkalosis, and to aid in the retention of fluid in the tissues.
   c. To supply calories in the form of dextrose or alcohol in saline or distilled water.
   d. To stimulate diuresis and thus to eliminate toxins and to relieve toxemia.
   e. To introduce medication.
VENEOLYSIS: INTRAVENOUS INFUSION

Equipment:

1. Instrument (snap)
2. Intravenous set
3. Arm board
4. Sheet wadding
5. Bandage
6. Adhesive tape
7. Tourniquet
8. Dry sterile sponges
9. Aqueous Zephiran 1:1000
10. Needle
11. Gravity pole
12. Solution ordered

Procedure:

1. Take equipment to bed, cart or tray.
2. Explain procedure to patient. Reassure.
3. Prepare arm for application of arm board and tourniquet by rolling sleeve of gown as high as possible. Be sure that the arm is well supported and in a comfortable position. Use sheet wadding under gauze when applying arm board.
4. Assemble equipment. Place bottle on hook. Do not remove rubber covering sterile tip until doctor or nurse is ready to insert needle.
5. When directed, apply tourniquet to upper arm. Preferably tourniquet is not applied more than two inches above point of insertion.
6. Cleanse designated area with sponge moistened with aqueous zephiran. The needle is then inserted and secured with a strip of adhesive tape.
7. Release tourniquet as directed.
8. The person starting infusion will regulate the rate of flow.
9. Instruct patient not to move arm. Do not leave children, restless or unconscious patients alone.
10. Leave signal cord within easy reach of patient.
11. Return all equipment to proper place. Replenish any supplies necessary.

12. Record:
   a. Time infusion started on bedside notes in time column.
   b. Solution and amount infusion started on bedside notes in note column.
   c. Name of individual who started infusion on bedside notes in note column and site of insertion of needle.

13. Observe rate of flow frequently. Observe site of infusion for edema. Observe the color, pulse and respirations of patient. Watch patient for symptoms of chill. Any change of condition or rate of flow of solution should be reported immediately to head nurse or doctor.

14. If more than one flask of solution is to be administered, clamp off tubing before first flask empties to the level of the vent tube. Remove flask from hook, place on table, have second bottle of solution ready. Remove plastic adaptor from bottle number one and insert into bottle number two. Invert second bottle and place on hook of gravity pole. Release clamp and continue infusion. Never place bottle below level of needle. At this time record:
   a. Hour
   b. Amount and type of solution administered and the addition of bottle number two, plus information in step number twelve.

15. When infusion is complete, remove all adhesive tape and apply a dry sterile sponge over the point of insertion of the needle. Remove needle carefully. Hold sponge over site of insertion exerting slight pressure to check oozing.
16. Remove arm board. Patient may bend arm as desired.


18. Remove all equipment to utility room. Detach needle and put in needle solution to soak.

Record:

a. Time ended on Kardex.

b. Bedside notes:

1. Time column: time completed

2. Intake column: amount of solution; type; how administered.

3. Note column: solution completed and needle removed by, name.
HYPODERMOCLYSIS

Equipment:

1. Hypodermoclysis set
2. Solution
3. Sterile sponges
4. Adhesive tape
5. Gravity pole
6. Waste basin
7. Aqueous Zephiran
8. Needles

Procedure:

1. Take equipment to bedside, cart or tray. Screen patient.
2. Explain procedure to patient, reassure.
3. Arrange bedding so that area of insertion of needles is exposed, but patient is warmly covered otherwise. The usual site of insertion is made in the outer aspect of the thigh.
4. Prepare the skin with aqueous zephiran.
5. Assemble equipment. Place bottle on hook. Do not remove the rubber covering sterile tips until the doctor or nurse is ready to insert the needles.
6. The doctor or nurse will run the needles through sterile sponges and insert them into the loose areola tissue, overlying the deep fascia and fasten in place by strips of adhesive tape.
7. The rate of flow is adjusted by the doctor or nurse.
8. Make the patient as comfortable as possible. Be sure the patient is well covered. Remove screen.
9. Record:
   a. Time infusion started on bedside notes in time column.
   b. Solution and amount of infusion started in note column.
   c. Name of individual who started infusion and site of insertion in note column.
10. The nurse must watch the condition of the patient closely and the areas for swelling, hardening of the tissue, blanching of the skin or pain. This indicates a too superficial placing of the needles. Clamp off the tubing and notify the doctor or nurse who will reinsert the needles. Gentle massage may be ordered when the rate of absorption is too slow.

11. A child or restless patient should never be left alone.

12. When infusion is completed apply a dry sterile sponge to the point of skin puncture with moderate pressure and carefully remove the needles.

13. Make the patient comfortable by changing position and rearranging pillows and bedding.

14. Remove equipment to the utility room. Detach needles and put in needle solution to soak.

15. Follow directions in the previous procedure for recording.
PROCEDURES FOR WITHDRAWAL OF BODY FLUIDS

Purpose:

1. To obtain fluid from the body for diagnostic or therapeutic purposes.
2. To relieve the patient of distressing symptoms as pain, pressure and dyspnea.
3. To allow for administration of a drug.

ABDOMINAL PARACENTESIS

Equipment:

1. 1 50 cc syringe
2. 1 2 cc syringe
3. 1 #3 knife handle
4. 1 #10 knife blade
5. 1 #11 knife blade
6. 2 3-way stop cocks
7. 1 2-way stop cocks
8. 2 trocars with cannuli (Double abdominal)
9. 1 suction tip, suction pump
10. 4 feet rubber tubing
11. 1 file
12. 1 #17 needle (spinal)
13. 4 #16 needles
14. 2 #18 needles
15. 2 #20 needles
16. 2 #22 needles
17. 2 #25 needles
18. 1 tube Dermalon 4-0
19. 1 medicine glass
20. test tube with cork
21. sterile:
   sponges
   towels
   gloves
22. Tray
23. Iodine
24. Alcohol
25. Aqueous Zephiran
26. Novocaine 1% or 2%
27. Pail
28. Newspaper
29. Stool
30. Bath blanket
31. Treatment sheet and rubber

Procedure:

1. Take equipment to utility room. Use tray to work on.
2. Open set. Use cover as sterile field. Arrange equipment with sterile transfer forceps.
3. Add additional equipment necessary from surgical cart.
4. Cover tray with sterile towel.
5. Take equipment to bedside. Explain procedure to patient.

7. Have patient void.

8. Fold upper bedding to foot of bed. Cover patient with doubled bath blanket.

9. Place treatment sheet and rubber over edge of bed for patient to sit on.

10. Bring patient to a sitting position close to the edge of the bed. Separate legs and rest feet on chairs. Arrange bath blankets about legs.


12. Place pail on newspaper on floor in front of patient.

13. Place stool in front of patient for doctor.

14. Move bedside table to within easy reach of doctor.

15. Place waste basin on overbed table.

16. Remove sterile towel covering tray. Pour novocaine into medicine glass.

17. After the doctor has scrubbed his hands, supply with antiseptic solution desired for cleansing the skin.

18. The doctor will then arrange the towels to provide a sterile field, anesthetize the area with novocain, make a small incision and insert the trocar through the abdominal wall into the abdominal cavity.

19. If requested, as the doctor withdraws the trocar, hold sterile test tube in position to collect a sterile specimen of fluid.
20. The doctor will then attach the long piece of rubber tubing to the cannula and allow the remaining fluid to flow into the pail. Direct the end of tubing so that the sound of running fluid will not distress the patient.

21. Throughout the procedure the nurse must carefully observe the pulse, respirations and color of the patient.

22. When the fluid ceases to flow, the doctor will withdraw the cannula.

23. Cover puncture wound with a sterile dressing, large enough to absorb subsequent drainage. Hold in place with adhesive tape.

24. Return patient to a recumbent position in bed. Apply an abdominal binder tightly.

25. Rearrange bedding and raise the patient to a comfortable position.

26. Measure the fluid and record the amount and character on bedside notes. Check treatment on kardex. Note psychological effect on the patient.

27. Watch the patient carefully for several hours for change in pulse, respirations, color and abdominal distention due to change in intra-abdominal pressure.

28. Label specimen carefully. Send to Bacteriology Laboratory.

29. After care:
   a. Remove all equipment to utility room.
   b. Measure and record fluid.
   c. Wash all equipment with soap and water. Rinse.

       Dry thoroughly.
LUMBAR OR SPINAL PUNCTURE

Equipment:

1. 1 medicine glass  
2. 1 2 cc syringes  
3. 2 lumbar puncture needles  
   with 3-way stop cock  
4. 1 pressure indicator  
5. 1 # 25 needle  
6. 1 # 22 needle  
7. 1 # 20 needle  
8. 1 file  
9. Waste basin  
10. Sterile:  
    sponges  
    towels  
11. Tray  
12. Iodine  
13. Alcohol  
14. Aqueous Zephiran  
15. Novocaine 1% or 2%  
16. Collodion  
17. Adhesive tape  
18. Bath blanket  
19. Treatment sheet  
20. 3 test tubes  
    with corks  
21. Treatment rubber  
22. Sterile gloves

Procedure:

1. Take equipment to utility room. Use tray to work on.

2. Open set. Use cover as sterile field. Arrange equipment with sterile transfer forceps.

3. Add additional equipment necessary from surgical cart.

4. Cover tray with sterile towel.

5. Take equipment to bedside. Explain procedure to patient.


7. Place patient on side close to edge of bed or treatment table with head bent forward and knees drawn up as near as possible to chin, knees gripped by arms if patient can do so. Attempt to keep the upper as well as the lower shoulder and hips parallel to the edge of the bed. Instruct patient to remain in this position.

8. Turn bedding down. Drape patient with bath blanket with back exposed.

9. Place treatment sheet and rubber under patient. Extend over edge of bed.
10. Place chair for doctor and move bedside table to position within easy reach.

11. Remove sterile towel covering tray. Place waste basin on overbed table.

12. Pour novocain into medicine glass.

13. After the doctor has scrubbed his hands and put on rubber gloves, supply with antiseptic solution desired for cleansing the skin.

14. The doctor will then arrange the towels to provide a sterile field, anesthetize the area with novocain.

15. If the patient is uncooperative it will be necessary for a third person to hold him in position from the other side of the bed. A child is always held by a third person.

16. When the fluid flows into the needle, a specimen may be collected in a sterile test tube.

17. A stop-cock is then attached to the needle and the manometer arranged to measure the amount of pressure. The doctor will instruct the nurse if he wishes jugular pressure applied.

18. When the needle is removed the puncture wound may be covered with a dry sterile dressing or with an application of collodion.


20. Unless otherwise ordered, keep the patient flat in bed for three to six hours.

21. Record the number of specimens obtained on the bedside notes. Include the psychological effect on the patient.

22. Label and number specimens according to order obtained.
23. After care:

a. Remove all equipment to utility room.

b. Rinse all equipment with cold water immediately.

c. Wash all equipment with soap and water. Rinse. Dry.

d. Care for remaining equipment in usual manner.
THORACENTESIS

Equipment:

1. 1 50 cc syringe
2. 1 10 cc syringe
3. 1 2 cc syringe
4. 2 # 18 needles
5. 2 # 18 needles
6. 1 # 25 needle
7. 1 # 22 needle
8. 2 5-way stop cocks
9. 1 piece rubber tubing
   two feet long
10. 1 medicine glass
11. 1 file
12. 1 test tube
    with cork
13. Sterile:
    sponges
towels
gloves
14. Alcohol
15. Aqueous Zephran
16. Iodine
17. Novocain 1% or 2%
18. Adhesive tape
19. Tray
20. Bath blanket
21. Overbed table
22. Treatment sheet
23. Treatment rubber

Procedure:

1. Take set to utility room. Use tray to work on.
2. Wash hands thoroughly.
3. Open set. Use cover as sterile field. Arrange equipment with
   sterile transfer forceps.
4. Add additional equipment necessary from surgical cart.
5. Cover tray with sterile towel.
6. Take equipment to bedside and explain procedure to patient.
   Screen patient.
7. Place patient in sitting position in bed, leaning forward on an
   overbed table or on pillows. Support lower back.
8. Open gown at back. Drape with bath blanket. Leave area for
   treatment exposed.
9. Place treatment sheet and rubber under patient.
10. Move bedside table to within easy reach. Place waste basin in
    convenient place.
11. Remove sterile towel covering tray. Pour novocain into medicine glass.

12. After the doctor has scrubbed his hands, supply him with antiseptic solution desired for cleansing the skin.

13. The doctor will arrange the field with sterile towels, anesthetize the area with novocain and insert the aspirating needle into the thoracic cavity.

14. The doctor will then attach the fifty cc. syringe to the needle, withdraw the amount of fluid desired for a specimen; detach the syringe and place the fluid in the sterile test tube.

15. Have waste basin ready to receive drainage.

16. When no more fluid can be obtained, the doctor will remove the needle. Apply a sterile dressing to the site of puncture. Fasten with adhesive tape.

17. Return patient to comfortable position. Apply chest binder if ordered.

18. For several hours following this treatment the nurse must observe the patient closely.

19. Measure fluid and record amount and character. Record psychological effect on patient.

20. After care:
   a. Remove all equipment to utility room.
   b. Rinse all equipment with cold water immediately.
   c. Wash all equipment with soap and water. Rinse. Dry.
   d. Care for remaining equipment in usual manner.
PROCEDURES WHICH REQUIRE INTRODUCTION OF TUBE INTO THE STOMACH

Purpose:

1. To remove poisons and irritating matter from the stomach.
2. To relieve nausea.
3. To aid diagnosis by determining amount and character of stomach contents.
4. To introduce fluid food into the stomach.

Gastric Lavage:

Procedure:

1. Explain procedure to patient. Assemble equipment and prepare a large pitcher of solution as ordered at 100°F.
2. Drape rubber and cotton treatment sheet around neck of patient.
3. Place a pail with a newspaper on a chair at bedside.
4. Have wipes and emesis basin on hand.
5. The doctor will introduce the lubricated tube into the stomach via the mouth. To check location of tube test by placing end in container of water.
6. As directed by doctor pour solution slowly into funnel.
7. To siphon contents of stomach lower tube to pail.
8. Repeat process until return flow is clear.
9. The doctor will pinch off tube and remove carefully.
10. Remove drapes and make patient comfortable.
11. Wash stomach tube and funnel with cold water, warm soapy water and rinse thoroughly. Soak in Aqueous Zephiran 1:1000 for thirty minutes.
Gastric Aspiration:
Purpose:
1. Withdrawal of stomach contents

Procedure:
1. Follow procedure as for lavage until tube is introduced.
2. Expel air from syringe, attach to tube and apply suction.
3. Aspirate contents of stomach and place in specimen bottle.
4. Send to laboratory properly labeled.

Gastric Gavage:
Purpose:
1. Introduction of fluid food by a tube through the mouth, via a tube, into the stomach.

Procedure:
1. Proceed as for lavage until tube is introduced. Test to see that tube is in the stomach and not in the trachea.
2. Allow patient to rest a few minutes after the introduction of the tube.
3. The doctor will administer the fluid slowly.
4. Upon completion of feeding, remove tube.
5. Make patient comfortable and instruct him to remain quiet.
6. Record intake of fluid given.

Nasal Feeding:
Purpose:
1. The introduction of food into the stomach by a tube through the nasal trach and esophagus.
Procedure:

1. The same as for gavage except that a tube in this procedure is introduced through the nose. This will be done by the physician.

2. The fluid is administered slowly with the syringe.

3. In case more than one feeding is to be administered, the tube may be left in place and clamped off and fastened with adhesive tape.

4. Care for equipment in usual way.
CATHETERIZATION

1. To withdraw urine from the bladder in retention.
2. To withdraw urine from the bladder to aid in diagnosis.
3. To withdraw urine from the bladder to prevent wound infection.
4. To withdraw urine from the bladder in retention with overflow.

Equipment:

1. 2 solution cups
2. 1 test tube
3. 9 cotton balls
4. Newspaper
5. 1 2x2 sponge
6. Catheter
7. Tray
8. Drop light
9. Emesis basin
10. Treatment sheet
11. Treatment rubber
12. Bath blanket

Procedure:

1. Take equipment to utility room.
2. Use tray to work on. Open catheterization set. Use cover as sterile field. Arrange equipment with sterile transfer forceps. Put two cotton balls in one solution cup; four in second; leave three on sterile field.
3. Open catheter set. Place catheter on sterile field with sterile transfer forceps.
4. Pour green soap solution in cup containing two cotton balls.
5. Pour saline in cup containing four cotton balls.
6. Take equipment to bedside. Screen patient.
8. Place table in position.
9. Use bath blanket or sheet to cover patient. Fold upper bedding to foot of bed.
11. Place waste basin in position. Place newspaper and light conveniently.
12. Scrub hands for three minutes.
13. Wash vulva with green soap using both cotton balls. Direct all strokes toward rectum. Use each cotton ball for one stroke only.
15. Hold labia apart with a 2x2 sponge, wash with remaining cotton balls in saline solution. Start at meatus and work down.
16. Pick up catheter, approximately three inches from the tip. Use other hand, with 2x2 sponge, to separate labia. Insert catheter slowly and gently approximately two inches, until urine flows.
17. Collect sterile specimen in test tube if ordered. Let remaining urine flow into waste basin.
18. When urine ceases to flow, turn catheter over slowly, then withdraw slowly and gently.
19. Clean and dry vulva with remaining cotton balls.
20. Rearrange bedding and see that patient is comfortable.
21. Remove all equipment to utility room.
BLADDER IRRIGATION

Purpose:

1. To cleanse the bladder.
2. To check inflammation.

Equipment:

1. Catheterization equipment
2. Asepto syringe
3. Measured graduate
4. Catheter
5. Tray
6. Droplight
7. Waste basin
8. Treatment sheet
9. Treatment rubber

Procedure:

1. Take equipment to utility room. Use tray to work on.
2. Open set. Use cover as sterile field. Arrange equipment with sterile transfer forcep.
3. Prepare catheterization equipment as for catheterization.
4. Prepare sterile solution at 110°F. in sterile measured graduate.
5. Take equipment to bedside. Screen patient.
7. Proceed as for catheterization.
8. After urine ceases to flow, draw fluid from graduate into syringe.
9. Test temperature of solution on back of hand.
10. Attach syringe to catheter with care.
11. Introduce fluid slowly, use as much as possible without causing discomfort. To refill asepto syringe, pinch catheter to prevent escape of fluid or entrance of air.
12. Drain bladder. Continue irrigation until return flow is clear.
13. Complete procedure as for catheterization.
IRRIGATION OF RETENTION CATHETER

Purpose:
1. To cleanse the bladder.
2. To cleanse the catheter.
3. To relieve congestion.

Equipment:
1. Towel
2. Solution basin
3. Asepto syringe
4. Sponge
5. Tray
6. Waste basin
7. Treatment rubber
8. Treatment sheet
9. Warmed solution for treatment

Procedure:
1. Take equipment to utility room. Use tray to work on.
2. Open set. Use cover as sterile field. Arrange equipment with sterile transfer forcep.
3. Pour solution, heated, into basin. Cover tray with towel.
5. Turn back bedding so that the patient is not exposed.
6. Place treatment sheet and rubber under catheter. Place waste basin in position.
7. Disconnect catheter from glass connecting tube. Cover latter with sterile sponge.
8. With asepto syringe, inject two to three ounces of solution slowly and with moderate force. Allow solution to flow back into waste basin.
9. Note character of return flow. Repeat step number eight until return flow is clear.
10. When irrigation is completed re-attach catheter to connecting tube.
11. Remove all equipment to utility room.
BLADDER INSTILLATION

Purpose:

1. To inhibit the development of bacteria.
2. To inhibit the decomposition of urine.

Equipment:

1. Catheterization equipment
2. Asepto syringe
3. Medicine glass
4. Catheter
5. Trey
6. Drop light
7. Emesis basin
8. Treatment sheet
9. Treatment rubber

Procedure:

1. Take equipment to utility room. Use tray to work on.
2. Open set. Use cover as sterile field. Arrange equipment with sterile transfer forceps.
3. Proceed as for catheterization.
4. Warm medication in medicine glass, in treatment basin filled with hot water.
5. Into catheter introduce fluid slowly. Do not drain the bladder.
6. Instruct the patient that solution is to be retained one to two hours.
7. Complete procedure as for catheterization.
8. Remove all equipment to utility room.
ENEMATA

Purpose:

1. To stimulate peristalsis, to clean or evacuate the rectum.
2. To treat a local condition.
3. To supply fluid or medication for systemic effect.

Types of Cleansing Enema:

1. Simple: (a) Soap solution: 1 ounce to 1 pint of water at 105°F.
   Give 1 - 2 quarts
(b) Saline: 2 teaspoons of salt in 1 quart of water at 105°F.

2. Purgative: (to hasten evacuation in obstinate constipation)
   (a) Magnesium sulfate; Glycerine; Water: two ounces of each at 105°F.
   (b) Glycerine: 3 - 8 drams diluted in 1 - 3 ounces of water at 105°F.

3. Carminative: (to relieve distension caused by flatus)
   (a) Turpentine: 1 dram added to soap solution enema 1 quart at 105°F.
   Mix soap solution and turpentine and then add water.
   (b) Milk and Molasses: use equal parts of each give one-half to one pint at 105°F.
   Follow in one hour with one quart of water.

4. Laxative: (to soften feces)
   (a) Cottonseed Oil: 6 - 8 ounces at 105°F.
   Follow with soap solution enema 1 - 8 hours later as ordered.
Types of Retention Enema:

1. For systemic effect:
   a. To supply fluid: 100°F.
      (1) Tap water: 250 cc
      (2) Saline: 250 cc
   b. To supply medication: 100°F.
      (1) Medication dissolved or diluted in saline. Not more than total volume of six ounces should be used.
      (2) Paraldehyde: dissolve in cotton-seed oil or boiled starch according to order.
   c. To supply stimulation: 110°F.
      (1) Saline 3 ounces; coffee 3 ounces
      (2) Saline 8 ounces

Types of Enema for Local Effect:

1. Emollient: to soothe irritated mucous membrane; 100°F.
   to be retained
   a. Starch: dissolve 1 teaspoon of starch in a small amount of cold water. Add 6 ounces of boiling water; boil for one to two minutes. Stir constantly. Cool to the desired temperature.
   b. Mineral oil: 6-8 ounces
   c. Cottonseed oil: 6-8 ounces

2. Anthelmintic: to destroy or expel worms. Give six ounces of quassia 105°F. Retain fifteen minutes.

3. Astringent: to contract tissues and blood vessels; 105°F.
   to be taken and retained for fifteen minutes.
   a. Alum: one-half teaspoon to 1 pint of water
   b. Tannic Acid: one-half teaspoon to 1 pint of water
EYE TREATMENTS

Eye Irrigation

Purpose:

1. To cleanse the conjunctiva.
2. To relieve congestion and inflammation.
3. To remove foreign bodies.

Equipment:

1. Tray
2. Sterile medicine glass
3. Sterile cotton balls
4. Sterile medicine dropper
5. Treatment sheet
6. Treatment rubber
7. Waste basin
8. Sterile rubber ear syringe

Procedure:

1. Take equipment to bedside and arrange within easy reach.
2. Screen patient.
3. Place treatment rubber and sheet over pillow and across shoulder to protect bed and patient.
4. Wash hands thoroughly.
5. If patient sitting up, stand behind patient. If patient is in bed bring head close to edge of bed and stand above patient's head.
6. Turn patient's head to one side with the eye to be irrigated downward.
7. Test the temperature of solution to be used on the wrist.
8. If discharge has dried on eyelid or lashes, remove by careful washing with cotton ball moistened with solution.
9. Hold two or three dry cotton balls close to the outer canthus of the eye to absorb solution flowing from draining eye during irrigation.
10. Instruct patient to look upward.

11. Separate lids with thumb and first finger of one hand, being careful to avoid any pressure on eyeball.

12. After drawing up solution, rest medicine dropper or rubber ear syringe on bridge of nose and allow solution to fall gently on the inner surface of the lower lid. Irrigate always from inner to outer canthus.

13. Allow patient to rest a moment. Dry lid with cotton ball.

14. Repeat procedure until eye is completely clean.

15. Dry lid and cheek.

16. Care for equipment in usual manner.

Iced Compresses to the Eyes

Purpose:

1. To relieve pain.
2. To relieve congestion and inflammation.

Equipment:

1. Tray
2. 12 2x2 sponges in sterile towel
3. Ice - chip or cube
4. Paper bag
5. Safety pin
6. Two throat sticks
7. Solution basin, over top of which two thicknesses of washed gauze have been stretched and held in place with an elastic band; this allows water from melting ice to drain into the bottom of basin.
8. Treatment sheet and rubber

Procedure:

1. Take equipment to bedside.

2. Place treatment sheet and rubber under the patient's head.

3. Place several 2x2 sponges, moistened with water, on the ice.

   Allow these to remain on the ice for several minutes to chill.
4. Squeeze excess moisture from chilled sponges between throat sticks.

5. Apply compresses to eye and hold in place with one of the throat sticks. Change every two minutes.

6. Discard used compresses into paper bag pinned to bed.

7. Cold compresses should be used for a period of at least ten to fifteen minutes and as often as ordered.

8. Dry patient's face very gently by wiping with dry sponge.

9. Care for equipment in usual manner.
INSTILLATION OF EYE DROPS

Purpose:

1. To dilate or contract the pupil.
2. To relieve inflammation.
3. To produce local anesthesia.

Equipment:

1. Drug
2. Sterile cotton balls
3. Sterile medicine dropper

Note: any dropper which has been used for a myotic drug or atropine must be discarded after use. Even after sterilization there is a danger of some of the drug being left in the dropper.

Procedure:

1. Proceed as for eye irrigation.
2. Place cotton ball close to the outer canthus of the eye and hold against side of face.
3. Steady dropper on bridge of nose.
4. Evert lower lid gently, instructing patient to look upward.
5. Allow one or two drops, as ordered, to fall on center of inner surface of the lower lid.
6. Catch excess solution in the cotton ball as patient closes eye and rotates eye ball.
7. Exert slight pressure over the puncta at the inner canthus to prevent escape of medication into the tear duct. This is very important when giving atropine to prevent generalized toxic effects from the drug.
8. Discard eye dropper if not to be used for same solution and on the same patient again.
HOT FOMENTATIONS TO THE EYE

Purpose:

1. To relieve pain.
2. To relieve congestion.
3. To relieve inflammation.

Equipment:

1. Tray
2. Sterile cotton balls
3. Sterile forceps
4. 2 throat sticks
5. Saline at 125°F.
6. Sterile cotton tipped applicators
7. Sterile vaseline
8. Paper bag for waste
9. Treatment sheet
10. Treatment rubber

Procedure:

1. Take equipment to bedside.
2. Lubricate lid, using vaseline and sterile applicator.
3. Place a few cotton balls in saline solution with sterile forceps.
4. Saturate cotton balls with solution and squeeze out excessive saline with the two sterile throat sticks.
5. Apply hot cotton pads to eyelid and hold in place with throat stick.
6. Change cotton pad as it becomes cool. Discard into paper bag, pinned to bed.
7. These fomentations should be continued for at least ten to fifteen minutes and as often as ordered.
8. When procedure is finished, dry lid gently with sterile cotton ball.
9. Care for equipment in usual way.
10. The patient may be instructed to do this treatment himself depending upon condition.
CARE OF ARTIFICIAL EYE (PROTESIS) AND SOCKET

Equipment:

1. Tray
2. Small basin or container for sterile cotton balls
3. Small basin or container for sterile saline, at the bottom of which is a sterile square of folded gauze. This is used to place prothesis when not in use.
4. Tooth pick sterile swabs, applicators
5. Large sterile medicine dropper or rubber ear syringe
6. Small basin for sterile solution for irrigation
7. Paper bag or container for waste

Procedure: Removal of prothesis

1. Place patient in dorsal position.
2. Press down the lower lid with thumb of left hand.
3. Gently push tooth pick swab or applicator under lower edge of prothesis at external canthus. Air, as it gets underneath shell assists in releasing vacuum of air. Slightest pressure on upper lid with index finger causes shell to slide out easily.
4. Place shell in warm sterile saline.
5. Irrigate socket frequently, each time shell is removed, with saline, boric or whatever special solution has been ordered.

Procedure: Replacement of prothesis

1. Pick up wet prothesis between thumb and index finger, with widest portion nearest to external canthus.
2. Gently place the upper edge of prothesis under upper eyelid.
3. Depress lower lid. Prothesis then becomes fixed.
4. Release the lid and the shell slips into the socket without difficulty.
EYE PREPARATION FOR SURGERY

Important Points:

Eye preparation orders must be seen on the order sheet by the nurse while doing the preparation. The order sheet is checked before starting the procedure, during procedure and after the procedure is completed. A red cross is placed on the cheek of the patient being prepared for surgery, after the entire preparation is completed, to signify that the order sheet has been checked for the final time. No verbal orders are to be taken except in an absolute emergency.

Equipment:

1. Sterile boric ointment or vaseline
2. Sterile cotton balls
3. Fine bladed plastic scissors
4. Basin for waste
5. Tissue paper
6. Small basin of soap solution
7. Small basin of sterile water
8. Aqueous Zephiran 1:1000
9. Eye dressing and cotton bandage
10. Drop light

Procedure:

1. Screen bed. Take preparation tray, patient's record and drop light (protected with wire frame) to bedside.

2. Attend to hair, braid in two braids. If necessary put in cap (female patient).

3. Wash hands.

4. Lubricate blade of scissors with boric ointment or vaseline.

5. Instruct patient to close eyes gently; then clip lashes on upper lid, directing points of scissors away from patient. To clip the lower lashes, instruct patient to open eyes and look upward.
6. After clipping, head nurse or assistant must check preparation.
7. Irrigate prepared eye with saline solution and follow with any medication that may be ordered.
8. Do soap solution scrub, if ordered, beginning at inner canthus, across the lid margin back over upper lid, down on lower lid, over brow using a rotary motion, then reverse cotton ball. Scrub over bridge of nose to tip, over superior maxillary bone and up above brow, over cheek and ending at external canthus.
9. Follow with sterile water twice. Be sure that all soap removed.
10. Use aqueous zephiran 1:1000 twice over the same area with cotton balls.
11. Apply sterile eye pad, bandage if ordered.
12. After checking order sheet, place red "X" on cheek of prepared eye or on bandage if one used.
13. Tell patient not to touch eye.
CATARACT NURSING CARE

Note: These patients are usually elderly; it is important that they have security and that they be fully oriented to their surroundings. They should be transferred to another ward only before operation, never afterward.

Pre-operative Care:

As for any operative case, a sedative the night before and a cleansing enema are important. The patient goes to the operating room in his own bed.

Post-operative Care:

1. On return from operating room, turn on unoperative side for four to five hours after operation. Rub back. Prop patient on side with pillows, he may have low head rest.

2. Diet: nothing but liquids without milk for first twenty-four hours, followed by soft solids and regular diet, unless ordered to the contrary.

3. Any indication of nausea or cough must be reported at once to doctor so that medication for relief of such symptoms may be ordered.

4. Every patient must wear a mask, or have hands tied at night until discharged.

5. All cataract patients should have sides on the bed at night and during the day as need indicated.
EAR TREATMENT

Ear Irrigation

Purpose:
1. To cleanse auditory canal.
2. To relieve inflammation and congestion.
3. To remove impacted wax.

Equipment:
1. Tray
2. Large emesis basin
3. Bottle of saline
   Heat to 110°F.
4. Sterile ear wipes
5. Sterile ear forceps
6. Rubber cape
7. Cotton treatment sheet
8. Small basin for waste

Procedure:
1. Take equipment to bedside.
2. Have patient in sitting position and place the rubber cape, covered with treatment sheet, over the patient's shoulders.
3. Place emesis basin close against patient's neck and under ear lobe. Patient may hold it in position.
4. Fill syringe about two-thirds full of solution.
5. Straighten the auditory canal by grasping the tip of the auricle and pulling upward and backward for an adult; downward and backward for a child.
6. Insert rubber tip of the syringe into canal about one-fourth inch. Direct flow of solution against the floor of the canal, never back toward the tympanic membrane.
7. Refill the syringe and continue treatment as long as necessary depending upon the reason for irrigation.
8. Dry auricle and outer part of auditory canal with ear forceps and wipe.
NASAL TREATMENT

Nasal Irrigation

Purpose:
1. To relieve pain and congestion.
2. To soften crusts in atrophic rhinitis.
3. To cleanse nasal membrane.

Equipment:
1. Sterile irrigating can with rubber tubing and glass irrigating tip covered with rubber protector
2. Bath basin
3. Rubber cape
4. Cotton treatment sheet
5. One pint of solution at 110°F.
6. Gravity pole
7. Tissue wipes
8. Gauze

Procedure:
1. Take equipment to bedside.
2. Have patient in sitting position with head forward.
3. Arrange cape, covered with treatment sheet, around patient's neck.
4. Place bath basin in patient's lap and gauze in his hand.
5. Irrigate slowly and gently from unaffected nostril toward affected side to avoid the spread of infection.
6. Instruct patient to breathe through his mouth and warn him not to cough or sneeze.
7. Regulate the flow of solution by pressure exerted upon tubing by thumb and forefinger.
8. At end of treatment, wipe nose but warn patient not to blow it.
9. If patient is able he may be taught to do this treatment himself.
STEAM INHALATIONS

Purpose:

1. To relieve inflammation and congestion of the mucous membranes of the throat.
2. To supply moisture to the air in the room of the tracheotomy patient.

Equipment:

1. Two quart metal pitcher
2. Treatment basin
3. Face towel and elastic band
4. Glass drinking tube
5. Gauze square

Procedure:

1. Bring water to boiling point in tea kettle and turn about one quart into pitcher.
2. Place face towel folded in fourths over the top of the pitcher and hold in place with elastic band around the top of pitcher.
3. Place pitcher in treatment basin and carry to bedside with drinking tube and gauze square.
4. Have patient in sitting position bending forward.
5. Lift the folded towel covering the top of the pitcher a little and insert one end of the drinking tube about two inches. Wrap the gauze near the top of the protruding end of the drinking tube so that the patient may grasp it easily. Place this end of the tube into the patient’s mouth. Steam should be tested by the nurse allowing the steam to flow out against her own wrist to be sure it will not burn before giving it to the patient.
6. Instruct the patient to breathe through the mouth.
7. Treatment should continue for about fifteen minutes and should be repeated as ordered.

8. Care for equipment in usual manner.

9. The Colson Electric Inhalator, which is obtained from the Central Sterile Supply Room, may be used for the patient in a single room where the air needs to be moistened. However, because of damage which may occur to plaster, its use is prohibited in some rooms. Permission for its use should be obtained from the Director's Office.

Warnings:

1. Never use compound Tincture of Benzoin in the Colson Inhalator.

2. Never allow water bottle to become empty while Colson Inhalator is in use.

3. Always direct the flow of steam from the Colson Inhalator far enough away from the patient to prevent burning.

4. Extreme caution is always necessary in using all types of inhalations in order to prevent burning the patient.
THROAT IRRIGATION

Purpose:

1. To relieve congestion and pain.
2. To cleanse mucous membrane.

Equipment:

1. 1 quart of solution
2. Sterile irrigating can with glass tip and rubber
3. Rubber cape
4. Cotton treatment sheet
5. Gravity pole
6. Tissue wipes
7. Gauze

Procedure:

1. Take equipment to bedside.
2. Place patient in sitting position.
3. Put rubber cape, covered with treatment sheet, around the patient's neck.
4. Place bath basin in patient's lap.
5. Give patient gauze tell to hold in hand.
6. Hang irrigating can on gravity pole one foot above level of patient's head.
7. Expel air from tubing.
8. Instruct patient to bend at the waist with head forward.
9. Insert irrigating tip into mouth and direct flow of solution against pharynx, moving it from side to side so that all parts may be reached.
10. Instruct patient not to cough or sneeze during the treatment.
11. Control force of the solution flowing through the tubing by exerting pressure with thumb and forefinger.
12. At the end of treatment dry patient's mouth.
13. Care for equipment in usual manner.
TRACHEOTOMY

Note:

A. Tracheotomy Set is to be at the bedside of every thyroidectomy patient or patient where laryngeal edema is present or apt to occur.

Location of Sets:

1. Central Supply: two sets for ward use
2. Accident Room: one set must not be removed
3. Operating Room: one set must not be removed

Equipment:

1. 1 #3 knife handle
2. 1 #11 knife blade
3. 1 #15 knife blade
4. 1 plain tissue forcep
5. 1 fine tooth forcep
6. 4 mosquito snaps
7. 2 Kellys
8. 2 Allis forceps
9. 1 needle holder
10. 1 skin needle
11. 1 curved needle
12. 2 small rake retractors
13. 1 tracheal dilator
14. Silver tracheotomy tubes: 
   #1, #2, #3, #4, #5, #6
15. Neck tape: 60" long
16. 8 4x4 sponges
17. 4 strands black silk 12" long

POST OPERATIVE CARE OF THE PATIENT WITH A TRACHEOTOMY

Important Points:

1. The room must be humidified in some way, either by using the Colson Inhalator or in some other manner if at all possible.
2. The temperature of the room should be between 70°F and 80°F.
3. Suction apparatus must be complete and always in excellent working condition and kept near the patient.
4. Oxygen equipment must be conveniently near for immediate use.
Equipment:

1. Sterile towel with two suction tips. These tips must be cleansed and sterilized frequently. Catheters may be used for this purpose if regular suction tips are not available.
2. Basin with sterile saline for flushing through suction tip.
3. Emesis basin and tissue wipes.
4. Pencil, scratch pad for patient to write requests or answers to questions.
5. Mirror for patient who cares for own tracheotomy tube.
6. Paper bag attached to side of bed.
7. If ordered, sterile gauze to place warm moist sponge over the opening of the tracheotomy tube, two thicknesses only. This helps when there is a tendency for crusting and when means for humidifying the room are unavailable.
8. Keep ready at all times a sterile, duplicate tracheotomy tube and dilator. The duplicate may be obtained from Central Sterile Supply in sizes #1, #2, #3, #4, #5 and #6.

Equipment on treatment tray:

1. Transfer forceps in sterilizing solution.
2. Sterile gauze for tracheotomy dressings.
3. Sterile toothpick swabs.
5. Tracheotomy tape and small safety pins.
6. Two small solution bowls for alcohol and hydrogen peroxide.
Procedure for caring of the tracheotomy tube:

1. Take tray with equipment to bedside.

2. Suction tracheotomy tube if necessary, always standing at one side of the patient.

3. Remove dressing. Place in paper bag for waste.

4. Remove inner tube carefully and place in basin of hydrogen peroxide.

5. Suction outer tracheotomy tube if necessary.

6. Instill alcohol, if ordered, very carefully and suction again.

7. With a toothpick swab, twisted and tested, clean outer tube, steadying the tube with the index finger of the left hand. The surrounding skin should also be cleaned at this time.

8. Gently apply Boric Ointment, or ointment specifically ordered, on skin near tube.

9. Apply sterile dressing.

10. Insert sterile, duplicate tracheotomy inner tube of the same size which is being used for the patient. This should be in the room ready for use before beginning procedure.

11. Take soiled tube, in the bowl of hydrogen peroxide to the utility room. Wash tube first with cold water and then hot soapy water. Thread a piece of two inch bandage onto a piece of wire and upper part is pulled through the tube to assure thorough cleansing. Polish tube with detergent. Wrap tube in gauze and place in pan which has enough water to cover tube. Add a small amount of soda bicarbonate. Boil in sterilizer for three to five minutes.
12. Return to patient and note condition, color, breathing and other upper respiratory symptoms.

13. Suction if necessary. Remove tip and turn off suction. Disconnect bottle and carry to utility room to be thoroughly cleansed.

14. Return to patient with clean bottle and the now sterile tracheotomy inner tube wrapped in sterile towel.

15. Leave all equipment set up and ready for immediate use.

16. The inner tube should be changed and cleansed at least every twenty-four hours and more often if indicated.

Important Points:

1. Never disturb the larger outer tube or tape. This is the responsibility of the doctor. If the outer tube should by accident come out, try to replace it. If unsuccessful, use tracheal dilator until doctor arrives.

2. The patient, depending upon condition may be taught within twenty-four hours after operation to suction, to change the moist sponge if used and to change the clean inner tube. This is done with the aid of a mirror.

3. Watch children closely. Use handcuffs or other types of restraints to prevent them from removing the tube.

4. Reassurance at night is important. These patients are apt to be extremely apprehensive. Observe mental attitude closely. Report anything unusual immediately.
APPLICATIONS FOR TREATMENT OF INFLAMMATION

Purpose:

Applications of Cold:
1. To relieve pain
2. To relieve congestion and inflammation
3. To prevent and reduce swelling

Application of Heat:
1. To increase warmth
2. To produce hyperemia
3. To relieve congestion and inflammation
4. To hasten suppuration
5. To relieve tympanites
6. To relieve pain

Important Points to Remember: Dry Heat and Dry Cold
1. Continuous application may result in tissue injury.
2. A blue, mottled appearance of skin indicates poor circulation.
3. Avoid point of anesthesia by testing sensation in area of application frequently.
4. Lubricate area to reduce or prevent irritation.
5. A hot water bottle or heating pad may only be used with a doctor's order.

Important Points to Remember: Moist Heat and Moist Cold
1. Always examine skin for redness from previous applications.
2. Lubricate skin with thin, even coat of oil.
3. Wring flannels as dry as possible. Always test on own forearm before applying to patient.
4. Lift application several times to accustom patient to temperature and to provide layer of air between skin and application to allow steam to escape.
5. Consult patient before pinning in place and leaving the bedside.

6. If a hot water bottle is used with a moist application, to maintain heat, place it outside of the wrapping, never next to application.

7. Report any redness or tenderness of skin to charge nurse immediately.

LOCAL APPLICATIONS OF COLD: DRY

Ice Cap

Equipment:

1. Ice cap
2. Ice cap cover
3. spoon
4. chipped ice

Procedure:

1. Fill ice cap full of ice. Be sure to expel all air.

2. Screw top on securely. Hold neck of cap firmly to avoid tearing rubber.

3. Distribute ice evenly in cap. Dry. Apply cover.

4. Chart procedure.

5. After care:

   a. When finished, empty and dry inside.

   b. Place dry gauze in ice cap. Inflate with air and replace cap. Treat with care when not in use by keeping in cool place.
Ice Cap

Procedure:

Follow procedure for "Ice Cap" and use flannel ice cap cover. Always apply with metal cap away from patient.

LOCAL APPLICATIONS OF COLD: MOIST

Iced Compresses to Head

Equipment:

1. Treatment basin
2. Washed gauze
3. Treatment rubber
4. Treatment sheet

Procedure:

1. Place ice cubes in treatment basin. Fold compresses and moisten with water.
2. Place compresses on ice. Carry equipment to bedside.
3. Place treatment rubber and sheet under head. Brush hair back from forehead.
4. Apply compress to forehead. Be sure it does not extend over eyes.
5. Replace compress every three to five minutes for period of time ordered.
6. When treatment completed, dry forehead gently; remove equipment.
7. Return equipment to proper place.
8. Note: chipped ice may be used, however it is not as satisfactory as the cubes.
LOCAL APPLICATIONS OF HEAT: DRY

Hot Water Bottle

Equipment:

1. Hot water bottle with cover
2. Bath thermometer
3. Large pitcher

Procedure:

1. Fill pitcher with water at 125°F for adults; 115°F for children, unconscious or paralyzed patients. Test with thermometer.
2. Fill bottle two-thirds full, unless weight objectionable.
3. Expel air by placing bag on side, force water into mouth of bottle.
4. Fasten top securely. Invert to check for leakage.
5. Cover. Apply to affected area with top away from patient.
6. When finished treatment or use, empty bottle. Dry.
7. Fill with air to spread sides. Hang in proper place.

Heating Pad

Procedure:

1. Apply heating pad to area desired. Adjust comfortably.
2. Do not use safety pins on heating pad. Do not fold heating pad.
3. The use of a heating pad must be under a physician's order.
4. Carefully instruct patient how to use. Check temperature after starting.
LOCAL APPLICATIONS OF HEAT: MOIST

Flaxseed Poultice

Equipment:
1. Treatment basin
2. Safety pins
3. Binder
4. Lubricant
5. Throat stick
6. Wrapping paper
7. Flaxseed
8. Flaxseed pan and spoon
9. Soda bicarbonate
10. Washed gauze

Procedure:
1. Place safety pins, binder and lubricant with throat stick, in treatment basin.
2. Cut piece of wrapping paper a little larger than four times the size of poultice desired. Fold in half.
3. To make flaxseed:
   a. Put required amount of water on to boil.
   b. Remove boiling water from stove. Add flaxseed. Stir constantly, until cohesive and comes away from pan.
   c. Add one teaspoon of soda bicarbonate and beat smooth.
4. Turn mixture onto one half of folded piece of brown paper. Spread evenly using spoon, to within two inches of edge. Poultice should be one inch thick.
5. Cover flaxseed with other half of sheet. Fold in edges to prevent leakage.
7. Wash flaxseed pan and spoon immediately. Return to proper place.
8. Carry treatment basin to bedside. Explain procedure to patient.
10. Place binder in place if to be used. Lubricate area with lubricant using throat stick.
11. Test poultice on wrist and when able to tolerate, apply to patient.
12. Allow steam to escape by lifting from side to side.
13. Fasten in place securely.
15. Repeat treatment as ordered.
16. To avoid chilling, leave binder in place until circulation has returned to normal.
17. Discard poultice, well wrapped in newspaper in waste barrel.

LOCAL APPLICATIONS OF HEAT: MOIST

Hot Soaks

Equipment:
1. Soak tub or basin
2. Solution
3. Bath towel
4. Bath blanket
5. Bath thermometer
6. Treatment sheet
7. Treatment rubber

Procedure:
1. Take equipment to bedside. Screen patient. Explain procedure.
2. Make patient comfortable with part to be soaked well supported.
3. Protect bed with treatment rubber and sheet.
4. Fill container with solution at 105°F as tolerated. Completely immerse part.
5. Cover exposed part with bath blanket.
6. Keep solution at correct temperature by adding hot solution.
Mustard Paste

Equipment:

1. Bowl
2. Mustard
3. Flour
4. Spoon
5. Knife
6. Two pieces of compress
7. Sheet wadding
8. Dressing towel
9. Water
10. Mineral oil

Strengths:

1. For adult: 2 tablespoons mustard to 4 tablespoons flour
2. For child: 1 tablespoon mustard to 6 tablespoons flour

Procedure:

1. Collect equipment on a tray. Prepare two pieces of compress, one size desired, other one inch larger.
3. Spread mixture on large piece of compress, one-eighth thick. Cover with second compress. Turn edges over.
4. Put compress on hot water bottle only while carrying to bedside. Apply compress to area as ordered. Cover with sheet wadding and dressing towel.
5. Leave in place fifteen minutes, until skin red and warm. Check every five minutes.
6. When paste is removed, sponge area with warm soap and water to remove irritating particles of mustard.
7. Pat skin dry and leave covered with towel until skin is normal.
8. Chart procedure and results.
LOCAL APPLICATIONS OF HEAT: MOIST

Sitz Bath

Procedure:

1. Fill tub with sufficient water to cover patient's hips. Temperature of water should start at 105°F.

2. If available, place rubber ring under patient. Do not use foam rubber type.

3. Gradually increase temperature of water, as tolerated, by adding water from a large pitcher.

4. Maintain this temperature for ten to twenty minutes.

5. Be sure patient is thoroughly dry and warmly covered before leaving tub room.

6. Chart procedure.


