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Introduction

The Nursing and Midwifery Council states Registered Nurses must have the knowledge and skills necessary for safe and effective practice when working. ‘Competence is a holistic concept. It is a combination of the skills, knowledge, attitudes, values and technical abilities that underpin safe, effective and autonomous nursing practice’ (NMC 2010)

Within the Nursing practice module the aim is to provide students with the opportunity to acquire essential nursing skills. It is important that students develop the cognitive, affective and psychomotor components of these skills.

This guide is intended to be a reference tool that will assist students in learning the psychomotor aspects of these skills while on clinical placements. It is not designed to be a comprehensive guide but should be used in conjunction with the core text.

References


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## Basic life Support

### Sequence of Action
- Check safety
- Check response
- If no response shout for help
- Open Airway with head tilt/ chin lift and check for breathing
  (up to 10secs)

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<th>Unconscious casualty Breathing</th>
<th>Unconscious casualty Not breathing</th>
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<td>Recovery position</td>
<td>Send (or go) for help. Dial 999(AED)</td>
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<td>Get help</td>
<td>Commence chest compressions</td>
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<td>Check for continued breathing</td>
<td>Combine chest compressions and rescue breathing at a ratio of 30:2</td>
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<td>Continue resuscitation until</td>
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<td>- the victim shows signs of life</td>
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<td>- qualified help arrives</td>
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<td>- you become exhausted</td>
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- Place the heel of one hand in the centre of the chest, place the heel of the other hand on top of the first hand.

- Interlock the fingers of hands and ensure that pressure is not applied over the ribs

- Do not apply pressure over the upper abdomen or the bottom end of the sternum

- Position yourself vertically above the chest and, keeping arms straight, press down on the sternum depressing it 5-6 cm.

- After each compression release all the pressure on the chest without losing contact between the hands and sternum.

- Use a compression rate of 100 -120 per minute.

- After 30 compressions – establish airway

- Give 2 rescue breaths checking for rise and fall of chest.

- Continue a ratio of 30:2
Unresponsive and not breathing normally

Call 999 and ask for an ambulance

30 Chest compressions

2 Rescue breaths

Continue CPR 30:2

As soon as AED arrives switch it on and follow instructions
Recovery Position

On finding the collapsed casualty:

- Check safety
- Check response
- If no response shout for help
- Open Airway with head tilt/ chin lift and check for breathing (up to 10secs)

Following assessment if the unconscious casualty is breathing, place in the recovery position and seek appropriate help:

- Remove the victim’s glasses, if present
- Kneel beside the victim and make sure that both legs are straight
- Place the arm nearest to you out at right angles to their body, elbow bent with the hand palm-up
- Bring the far arm across the chest, and hold the back of the hand against the victim’s cheek nearest to you.
- With your other hand, grasp the far leg just above the knee and pull it up, keeping the foot on the ground
- Keeping the victim’s hand pressed against their cheek, pull on the far leg to roll them towards you on to their side
- Adjust the upper leg so that both the hip and knee are bent at right angles
- Tilt the head back to make sure that the airway remains open
- If necessary, adjust the hand under the cheek to keep the head tilted and facing downwards to allow liquid material to drain from the mouth
- Check breathing regularly.
- If the victim has to be kept in the recovery position for more than 30 minutes turn them to their other side.
Temperatures

- Introduce yourself
- Explain to the patient the purpose of recording temperature to gain consent and co-operation
- Ensure patient is in a comfortable position
- Collect equipment and wash your hands
- Remove protective cap from thermometer and check the symbol on the display.
- Apply new probe cover
- lift the pinna of the ear and gently insert the probe into the auditory canal
- Keep the thermometer in position until an audible tone signals the correct temperature has been reached.
- Read the display.
- Discard the probe cover into a yellow clinical waste bag
- Replace the protective cap on the probe.
- Wash hands
- Record/report the temperature

Single-use Clinical Thermometers

- Place under the tongue as far back as possible
- have the patient press the tongue down on the thermometer and keep the mouth closed for 60 seconds.
- Remove the thermometer. Some blue dots may disappear as the device locks in for accuracy.
- Read the last blue dot; ignore any skipped dot.
- Discard thermometer and wash hands
- Record/Report temperature
For Axillary use:

- Position thermometer high in the armpit, vertical to the body, with dots against the torso.
- Lower the patient’s arm to hold the thermometer in place.
- Remove the thermometer after 3 minutes. Read and discard in yellow clinical waste bag
- Wash hands
- Record/Report
Location of pulses within the Body
Pulse and Respiration

- Introduce yourself
- Explain to the patient the purpose of measuring and recording the pulse to gain consent and co-operation.

Pulse

- Wash your hands
- Ensure the patient’s arm is in a comfortable resting position
- Locate the radial artery at the base of the thumb.
- Place the 1st, 2nd or 3rd fingers of the dominant hand along the artery and press gently.
- Count the pulse for 60 seconds
- Note: Rate, Rhythm, Character, Volume

Respiration

- Continue to hold the patient’s wrist for a further 60 seconds while counting the respirations
- Count every rise and fall off the chest as one respiration
- Leave the patient comfortable
- Wash your hands
- Record / report the pulse and respiration rate, reporting any abnormality
- Note the rhythm or depth as appropriate.
Blood Pressure

- Introduce yourself
- Explain the procedure to gain the consent and co-operation of the patient
- Wash your hands
- Assist the patient into a comfortable position; ensure the arm is at heart level resting on a suitable firm surface
- Check the patient has been resting for 5 minutes and has not eaten for 30 minutes
- Ensure the arm is free from restrictive clothing
- Palpate the brachial/ radial artery
- Apply the cuff around the arm smoothly and firmly with the bladder centred over the brachial artery 2.5cm above the ante-cubital fossa
- Position the sphygmomanometer at heart level ensuring that the mercury level is at zero and can be easily read.
- Connect the cuff tubing and close the valve creating a sealed unit within the equipment
- Remind the patient of the feeling of tightness in the arm as the cuff is inflated- emphasising that this is temporary
- Palpate the radial artery and inflate the cuff until the pulse is no longer palpable, deflate the cuff rapidly and wait 15-30 seconds check the mercury level is at zero
- Clean the earpieces of the stethoscope
- Position the stethoscope over the brachial artery and inflate the cuff 2-3mmHg per second to 30mmHg above the previously determined pressure
- Deflate the cuff at a rate of 2-3mmHg per second, note when the first two consecutive beats are heard. This is the systolic pressure.
- Continue to deflate the cuff and note when the beats disappear. This is the diastolic pressure (listen for 10-20mmHg below the disappearance of the sound)
- Completely deflate the cuff, disconnect the tubing and remove the cuff from the patient's arm
- Clean the earpieces of the stethoscope
- Leave the patient comfortable
- Wash your hands
- Record and report measurement accurately to the nearest 2mmHg.
Hand Washing

- Turn on the water and adjust the temperature
- Wet your hands before applying a hand-washing agent
- Rub your palms together to create a lather
- Rub the right hand over the back of the left hand with fingers interlaced, change hands and continue.
- Rub your palms together again with fingers interlaced
- Clasp your fingers together and rub into the palms, change hands and repeat
- Rotate your right hand around your left thumb
- Rotate your left hand around your right thumb
- Use your fingertips to cleanse the centre of your palms
- Rotate your right hand around your left wrist
- Rotate your left hand around your right wrist
- Rinse your hands, shaking off any excess water
- Dry your hands thoroughly
- Turn off the taps using your elbows or paper towels
- Dispose of the paper towels in the household waste bag using the foot pedal.

Hands should be washed:

- Before and after patient contact
- After coming in contact with blood or other body fluids
- After removing protective gloves
- After using toilet
- On leaving the ward
- Before handling food
- Between clean and dirty tasks with the same patient
- Before and after invasive procedures/aseptic technique

Protective Clothing:

Disposable gloves should be used if you suspect you will come in contact with blood, body fluids or open wounds.

Disposable aprons should be worn when in direct contact with a patient with a known infection or when in contact with blood or other body fluids is likely
6 Step Hand Hygiene Technique

1. Palm to palm.

2. Right palm over left dorsum and left palm over right dorsum.

3. Palm to palm, fingers interlaced.

4. Backs of fingers to opposing palms with fingers interlocked.

5. Rotational rubbing of right thumb clasped in left palm, then vice versa.

6. Rotational rubbing, backwards and forwards with clasped fingers of hand in left palm then vice versa.
Application of Sterile Gloves

- Wash hands
- Clean trolley
- Check pack and open outer package emptying content onto trolley
- Wash hands
- Open sterile pack without contaminating inside the package
- Touch inside of cuff on one glove with finger to lift
- Pull first glove on without contaminating glove
- Insert first gloved fingers under cuff of second glove
- Pull on second glove without contaminating either glove
- Unfold the cuffs of both gloves without contaminating gloved hand
- Hold hands away from yourself
- Hold hands above waist after gloves are on.
- Remove one glove which should then be held in the other gloved hand
- Proceed to remove the second glove, being careful to remove it so that it covers the first glove.
- Grip both sides firmly to ensure that any contamination is held inside the gloves
- Dispose of both gloves (one glove being wrapped inside the other) in a yellow clinical waste bag.
- Wash hand and dry thoroughly
Wound Care (Simple Dressing)

- Introduce yourself
- Explain the procedure to gain the patient’s consent
- Clean the dressing trolley and assemble sufficient quantity of required equipment
- Position the patient comfortably to allow access to the wound site.
- Wash your hands and put on an apron
- Check the pack and open it using non-touch technique
- Wash your hands and using the yellow bag arrange the contents.
- Remove the soiled dressing using this yellow bag and invert.
- Hang the bag on the side of the trolley
- Open any accessory material as required
- Wash your hands
- Put on sterile gloves
- Using gloved hand irrigate the wound and dry with a fresh swab.
- Apply suitable dressing with gloved hand
- Make the patient comfortable
- Discard disposable items, place soiled dressings etc. in the clinical waste bag
- Wash hands
- Record and report.
Safe Moving & handling

Risk Assessment:
- Task
- load
- Environment
- Individual capacity

Rules for safe handling:
- Never manually handle unless you have no other option. Always ask, “do I need to handle manually?”
- Carry out a risk assessment and always select the appropriate manoeuvre and handling equipment for the task in hand.
- Wear appropriate clothing and footwear.
- Keep your spine in line. Avoid static stooping.
- Identify a team leader prior to the manoeuvre. All instructions and explanations to both the client and any assisting carers should come from this leader. (see deleted)
- The leader must give clear, precise instructions (e.g. ready, steady, slide).
- Prepare the handling area.
- Where appropriate, apply the brakes on equipment. This is so easily forgotten.
- Use a broad base. Position your feet correctly to reduce spinal rotation
- Keep the person, or object, to be transferred as close to your body as possible. (where necessary, use protective personal equipment)
- Know your own handling capacity and do not exceed it.
- Bend the knees when transferring – not the back.

If in doubt seek advice
Bed making

- Wash hands and put on disposable apron
- Ensure bed flat and adjusted to a safe suitable working height
- Apply the brake on the bed
- Place new linen on the linen holder
- Remove used sheets, fold or bunch neatly
- Hold used linen away from own clothes and place in laundry bag
- Put on bottom sheet with sufficient to tuck under mattress
- Envelope bottom corner at both sides
- Envelope top corner and tuck in sheet at both sides
- Ensure sheet is wrinkle free
- Complete bed
- Readjust bed height for safety
- Wash hands
- Gather equipment required
- Preserve dignity
- Ensure privacy
- Wash your hands and put on a plastic apron (gloves only required if dealing with body fluids or the patient has an infectious disease)
- Ensure water is at the correct temperature
- With consent remove top clothes, ensuring the patient is not exposed unnecessarily and is covered with a blanket
- With consent, remove nightdress/pyjama top taking care if the patient has a weak arm to remove it from the clothing last to avoid tissue/joint damage.
- Face- can the patient wash his or her own face. If not wash and dry
- Ensuring dignity and privacy, wash arm farthest away from hand to axilla. Rinse off the soap, dry thoroughly. Repeat with nearest arm.
- With care and sensitivity, uncover chest and abdomen, wash and dry paying particular attention to skin folds; breasts; dressings in situ; patient’s body temperature; how the patient is responding.
- Cover the chest and abdomen; once the patient feels dry apply deodorant etc. according to the patient’s wishes
- Change water as necessary
- Sensitively remove lower body clothing
- Cover leg nearest and place towel under leg furthest away. Wash from toes to groin, rinse and dry thoroughly. Cover leg and repeat with other leg
- Observe skin, circulation etc.
- Using a disposable cloth, sensitively wash and dry the genitals and perineal area working from front to back to minimize risk of
Contamination of urethra/ vagina with faecal matter.

- Change water, use a clean cloth and ask the patient to roll over or seek help to roll the patient on to their side. Wash and dry back and buttocks, observing the skin especially along pressure points.
- Change sheets and assist with dressing patient in fresh nightclothes
- Attend to oral hygiene, hair care, spectacles and any other personal requirements.
Catheter care

- Introduce yourself to the patient
- Explain the procedure to allay anxiety and gain consent
- Collect and prepare equipment
- Assist the patient into a suitable position, maintaining dignity
- Wash your hands
- Put on an apron and gloves
- Gently cleanse the external urethral meatus using the wipe only once and in one direction, wiping from above downwards and away from the catheter-meatal junction
- Gently wipe the shaft of the catheter away from the catheter-meatal junction.
- Ensure that the area is dry using clean dry wipes
- Ensure you show concern for the patient’s feelings and dignity throughout.
- Dispose of the equipment safely and appropriately
- Remove gloves and dispose in clinical waste bag
- Wash hands
- Record and report appropriately
Positioning of Patients

Recumbent
- The patient lies flat on their back with one pillow under the head and arms by the side of their body
- Uses:
  - To examine the trunk
  - To nurse a patient on complete bed rest.

Semi-recumbent
- The patient lies on their back, half propped up well supported.
- Uses:
  - Widely used in medical and surgical nursing.
  - For convalescent patients where no specific position is required.

Prone:
The patient lies flat on their front with the head to one side resting on a pillow. A small pillow is placed under the ankles to prevent the toes pressing on the bed. A second pillow may be placed under the chest.

Uses:
- To relieve pressure
- Following back surgery
- Extensive back injuries.

Semi-prone
The patient lies on one side, but more towards the prone position

Uses:
- The unconscious patient

Left lateral
The patient lies on the left side, buttocks towards the edge of the bed
with the head forward resting on one pillow. The thighs and knees bent.

Uses:
- For administering enema and suppositories
- Rectal, vaginal and perineal examinations

Dorsal
The patient lies on their back, one pillow under their head, thighs are flexed and knees abducted.

Uses:
- Catherisation
- Abdominal and vaginal examinations

Upright
A bed table with a pillow on it may be used to assist the comfort of a breathless patient

Uses:
- Chronic cardiac and respiratory conditions
Eye care

- Introduce yourself
- Explain the procedure to gain the consent
- Wash your hands
- Clean the trolley and collect the equipment you require
- Assist the patient into the correct position (either lying or seated with head tilted back)
- Ensure adequate light
- Wash hands and arrange equipment
- Wash hands and apply gloves
- Using a slightly moistened swab, ask the patient to look up and swab the lower eyelid from lower corner outwards
- Using a new swab each time, repeat until the discharge is removed
- Repeat the procedure for the upper lid asking the patient to look down
- Dry the lids with a dry swab
- Assess the patient’s comfort
- Remove and dispose of the equipment in clinical waste bag
- Wash your hands and dry thoroughly
- Record and report accordingly
Mouth Care

- Introduce yourself
- Explain the procedure to gain consent and co-operation
- Collect necessary equipment
- Wash your hands and put on an apron and gloves
- Place tissues under the patient’s chin
- Ask the patient to open their mouth wide
- Inspect the patient’s mouth especially the buccal mucosa with the aid of a torch and spatula
- Using a toothbrush and toothpaste/teledont brush the patient’s teeth and gums
- Keep the brush positioned over only two or three teeth at a time. Use small rotating movements to cover the outside surfaces of all teeth.
- Clean the inner surfaces of all back teeth and buccal cavity the same way
- Examine the condition of the teeth and gums and mucus membranes
- If the patient is unable to rinse use a rinsed toothbrush to clean the teeth and moistened foam sticks to wipe gums and oral mucosa
- Lubricate the patient’s lips with petroleum jelly
- Remove gloves and apron
- Dispose of all equipment correctly
- Wash hands
- Record and report accordingly
Urinalysis

- Wash your hands
- Collect urinalysis test strips
- Apply gloves and apron
- Observe the colour of the urine
- Observe if there is sediment present
- Observe and note the odour of the urine
- Check the expiry date of the reagent strips
- Remove a reagent strip without touching the test square on the strip
- Recap the container.
- Dip the reagent strip fully into the urine, accurately note the time
- Tap the reagent strip against the top of the container to remove any excess urine
- Wait the recommended time keeping the strip horizontal, ensuring the strip does not touch the container.
- Read the strip comparing the colour on the reagent strip to the colour code on the container at the appropriate times.
- Discard the reagent strip into the yellow clinical waste disposal bag using the foot pedal
- Remove and discard gloves and apron into the clinical waste bag
- Wash your hands
- Record the result and report any abnormality
Administration of oxygen

- Introduce yourself
- Explain to the patient the purpose of oxygen therapy to gain consent and co-operation
- Wash your hands
- Check the prescription on the medicine kardex to identify the percentage of oxygen to be administered
- Collect the appropriate mask and attach the tubing to the mask and oxygen supply
- Check the patient’s identification with the prescription sheet prior to commencement of the therapy
- Assist the patient into an upright position ensuring comfort
- Explain the dangers of smoking; ensure a no smoking sign is placed above the patient’s bed
- Turn on the oxygen, ensure there is no leakage
- Set the flow rate according to the prescription to ensure the correct percentage of oxygen is administered.
- Check the oxygen is flowing by listening or feeling. Allow the patient to feel the oxygen against their cheek or hand prior to administration via the facemask.
- When the patient is ready secure the mask ensuring this is comfortable.
- Stay with the patient for a few moments to ensure compliance
- Leave the patient comfortable
- Wash your hands
- Record that oxygen therapy has commenced stating the percentage and rate of flow and noting patient compliance. Report accordingly.
Peak flow

- Introduce yourself
- Explain the purpose of peak flow to gain the patient’s consent and co-operation
- Wash your hands
- Ensure the patient is in the correct position, standing if possible or sitting fully upright
- Fit a clean disposable mouthpiece to the peak flow meter and ensure that the flow indicator is at zero
- Instruct the patient to take a deep breath, clamp lips around the mouthpiece and blow out as hard as possible in a short, sharp manner
- Note the number on the scale indicated by the pointer, return the pointer to zero
- Repeat the procedure twice more to obtain three readings
- Monitor the patient for fatigue and technique. Encourage patient effort
- Leave the patient comfortable
- Dispose of the mouthpiece in the yellow clinical waste bag
- Wash your hands
- Report and record accurately the best of the three readings
Always maintain Sharps awareness. Dispose of needles and other sharps safely.

Action to be taken in the event of a Needlestick injury

- Encourage bleeding from the affected site
- Wash the injured area/irrigate
- Cover with a waterproof dressing
- Report to line manager
- Attempt to identify source patient and assess risk
- Complete an accident/incident form
- Seek medical help as soon as possible go to Occupational health/ A&E or GP
Administration of Medicines

When administering medication the prescription should:

- Be based on the patient’s informed consent and awareness of the purpose of the treatment
- Be clearly written and indelible
- Clearly identify the patient for whom the medication is intended
- Record the weight of the patient where the dose is related to weight
- Clearly specify the substance to be administered, its generic name, its stated form, the strength, dosage, timing, and frequency of administration, start and finish dates and route of administration
- Be signed and dated by the authorised prescriber
- Not be for a substance to which the patient is allergic or unable to tolerate
- In the case of controlled drugs, specify the dosage and number of dosage units or total course.

You must:

- Know the therapeutic uses of the medicine, its dosage, side effects, precautions and contra-indications.
- Be certain of the identity of the patient
- Be aware of the patient’s care plan
- Check the prescription, and the label on the medicine is clearly written and unambiguous
- have considered the dosage, method, route and timing in the context of the condition of the patient and co-existing therapies
- Check the patient is not allergic to the medicine
- Contact the prescriber without delay where contra-indications to the prescribed medication are discovered, where a patient develops a reaction to the medicine or where assessment of the patient indicates
that the medicine is no longer suitable
- Make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring that written entries and the signature are clear and legible
- Make sure that a record is made when delegating the task of administering medicine
- The supervising registered nurse should countersign student’s signatures.

Drug Calculations

Prescribed dose x Vol

\[
\frac{\text{Prescribed dose} \times \text{Vol}}{\text{Stock dose}}
\]
Interacting with patients and clients

The initial consultation with a patient/client is vital in developing an effective relationship.

Identification

Verbal skills: hello, Mr/Mrs (surname) my name is nursing student (name). It is nice to meet you. how are you?

Non verbal skills: Smile/handshake/eye contact/appropriate facial expression/appropriate tone of voice/active; listening/open posture

Introduction

Verbal skills: Examples: It is a lovely day today, isn't it?/Did anyone come with you for your admission today?

Non verbal skills: Smile/eye contact/appropriate facial expression/demonstrate a caring approach/demonstrate; genuineness/warmth/appropriate tone of voice/active listening

Clarification

Verbal skills: I would like to ask you some questions to gather some information related to your admission.

This will take about 30 minutes.

Non verbal skills: Eye contact/appropriate facial expression/sit at similar level to patient/appropriate; proximity/demonstrate concern/appropriate tone of voice/active listening

Consent

Verbal skills: Does it suit if I ask you those questions now?

Non verbal skills: Eye contact/appropriate facial expression/appropriate tone of voice/active; listening/demonstrate respect/
Privacy

Verbal skills: Examples: Do you mind if I pull the curtains around for some privacy when I am asking you the questions?/Does it suit if we go to another room for some privacy when I am asking you the questions?

Non verbal skills: Appropriate facial expression/eye contact/head nodding/appropriate tone of voice/active; listening