QTP 4N0X1-1 20 March 2015 Certified Current on, 13 July 2022

AEROSPACE MEDICAL SERVICE SPECIALTY FUNDAMENTALS OF NURSING CARE



TOTAL FORCE, TOTAL CARE - EVERYTIME, ANYWHERE

383 Training Squadron Training Management Section 2931 Harney Rd, BLDG 903 Fort Sam Houston, TX 78234

QTP 4N0X1-1

AEROSPACE MEDICAL SERVICE SPECIALTY

Volume 1: Fundamentals of Nursing Care

TABLE OF CONTENTS

MODULE	OBJECTIVE	PAGES
1	Surgical Instrument Sterilization Preparation & Decontamination Procedures	4 - 8
2	Postural vital signs measurement	9–11
3	Cardiac monitor setup and lead placement	12 - 15
4	Electrocardiogram: 12 Lead	16 – 18
5	Recognize normal sinus rhythm/arrhythmias	19–22
6	Pulse oximetry/oxygen saturation	23 – 25
7	Blood specimen collection: Vacutainer method	26 – 29
8	Perform urine reagent stick testing	30 – 31
9	Perform capillary stick for blood sampling	32 -33
10	Use blood glucose meter	34 -35
11	Medication administration	36 - 44
12	Parenteral fluid therapy	45 - 48
13	Blood administration	49 – 51
14	Tympanometry	52 – 53
15	Measure and record intake & output	54 - 55

Supersedes QTP 4N0X1-1, 24 Oct 2014.

INTRODUCTION

1. These Qualification Training Packages (QTPs) were developed to enhance on-the-job training for *Aerospace Medical Service Specialty* personnel. As a trainer, the QTPs provide you with the breakdown of tasks into teachable elements. The teachable elements will help you to guide the trainee toward sufficient proficiency for task performance *without assistance*. QTPs are also used by the task certifiers/certification official to evaluate trainees concerning tasks which need third-party certification.

2. Review each volume and identify which modules of QTPs are needed for the trainee's job position. Core task items are identified with the number "5" on the STS Column 2; these items are the minimum mandatory skills which are required for all 4N0X1 personnel to be proficient in performing. You have the flexibility to arrange training for each module in the order that you decide.

3. Review the subject-area tasks in each module with the trainee. Direct the trainee to review the training references to gain a better understanding of the objective for each module. If the trainee has any questions about the objective, clarify the behavior that is expected in the objective. Review the performance checklist with the trainee, and allow him/her sufficient time to learn each step (some objectives may take longer to teach). Remember--the objective of each QTP is to standardize training and to allow sufficient time for the trainee to learn each task thoroughly in order to perform the task *without assistance*.

4. When the trainee receives sufficient training and is ready to be evaluated on an objective, follow the evaluation instructions. The performance checklist must be used as you evaluate each task objective. When the trainee successfully accomplishes the objective, document task completion appropriately in AFTR.

5. The QTP task completion is to be annotated on AF Form 1098, *Special Task Certification and Recurring Training*, filed in Part 3, Section B in AFTR. **NOTE:** The individual checklists are **not** filed in each member's AFTR. A master checklist is filed in Part 3, Section B of the hardcopy Master Training Plan (MTP) folder.

6. If the trainee does not accomplish the objective, review the areas which need remediation. Conduct a feedback concerning each module with the trainee, and document appropriately in AFTR. As the trainer, when you are satisfied that the trainee is qualified to perform the task, he/she will be re-evaluated until the objective is met.

7. If the task which is being trained requires third-party certification by a task certifier/certifying official, the trainer first must ensure that the trainee is qualified to perform the task *without assistance*. Then the trainee will be evaluated by a task certifier/certifying official. The tasks which require third-party certification are denoted with a "^" in Column 3E of the Career Field Education and Training Plan (CFETP). After third-party certification, training qualification is documented appropriately in AFTR.

8. The QTPs are a necessary tool for standardizing refresher/sustainment training. Such standardization will benefit the CFETP training concept throughout each member's career. These documents also will be utilized for assessing/certifying the Aerospace Medical Service Specialist each time that he/she is assigned to a new duty position. The QTP developers' goal is to publish a usable document for certifying officials, trainers, and trainees for the purpose of enhancing on-the-job training for *Aerospace Medical Service Specialty* personnel. We value your first-hand expertise, and we encourage your feedback. Direct all inquiries to:

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Module 1

SURGICAL INSTRUMENT STERILIZATION PREPARATION & DECONTAMINATION PROCEDURES

SUBJECT AREA: Patient Care Skills

TASK NAMES: Perform Sterilization Procedures Perform Disinfection Procedures

CFETP/STS REFERENCE(s): 2.12.5.8. 2.12.5.9.

EQUIPMENT REQUIRED: PPE (face shield, face mask, fluid-resistant gown, and heavy-duty gloves), transport cart, containers, including puncture-proof containers, enzymatic cleaner, soft-bristle brushes, cleaning cloths, mechanical cleaner and lubricant.

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, current edition, *Surgical Instruments: Decontamination (Perioperative). Sterilization: Preparation of Instruments (Perioperative).*

REMARKS/NOTES: This task involves the handling of *contaminated* items (including sharps and delicate instruments) ensure that the trainee understands the disinfection procedures, knows the inherent risk factors, and is closely supervised during the evaluation. Ensure that the trainee dons all personal protective equipment (PPE) which is required by current standards/precautions. **NOTE: The evaluator will STOP the procedure immediately and correct the trainee if performance compromises safety or damages resources.**

OBJECTIVE: Given training resources and trainer demonstration, prepare instruments for sterilization and disinfection IAW the attached *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 1, *Surgical Instrument Sterilization Preparation & Decontamination Procedure.*

EVALUATION INSTRUCTIONS:

1. After the trainee has received the applicable instruction and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task *without assistance*.

2. Use the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 1, *Surgical Instrument Sterilization Preparation & Decontamination Procedures,* when evaluating the task to ensure that all steps of the task are accomplished correctly.

3. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation should be documented in the Specialty Training Standard (STS) of the trainee's CFETP. All

recurring evaluation should be documented by using AF Form 1098, *Special Task Certification and Recurring Training*.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 1, Surgical Instrument Sterilization Preparation & Decontamination Procedures.

FEEDBACK: Using the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 1 *Surgical Instrument Sterilization Preparation & Decontamination Procedures,* as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

PERFORMANCE ITEM		UNSAT
Discussion		
1. Explain the differences between decontamination and sterilization.		
2. Explain why mechanical cleaning methods are preferred over manual cleaning methods. Cite examples of items that must be manually cleaned and decontaminated, and explain why.		
Instrument Preparation		
1. Perform hand hygiene		
2. Don personal protective equipment (PPE) that is required for decontamination; explain why this PPE is needed.		
3. Identify sharp instruments, such as scissors, towel clips, and retractors with sharp ends.		
4. Separate sharp instruments from other instruments by placing them into a puncture-proof container for transport.		
5. Place the sharp ends of instruments downward in a puncture-proof container.		
6. Identify instruments with box locks and open box locks.		
7. Identify instruments that are to be disassembled; disassemble them and place the pieces into a container or basin for transport. Flush any lumens.		
8. Identify lightweight instruments and place them on top of heavier instruments or in a separate container for transport.		
9. Identify fragile instruments and put them in a separate container.		
10. Place the camera, scope, and light cord, if used, in their original containers for transport.		
11. Presoak instruments with enzymatic solution according to the manufacturer's instructions and local policy.		
12. Transport the contaminated instruments to the central service department or sterile processing department in a contained, leak-proof transport cart.		
13. Perform hand hygiene		
Manual Cleaning		
1. Perform hand hygiene		
2. Don personal protective equipment (PPE) that is required for cleaining; explain why this PPE is needed.		
3. Identify, based on the instrument manufacturer's instructions, which instruments can be manually and mechanically cleaned or only manually cleaned.		
4. Prepare the sink with an organization-approved enzymatic cleaner and clean warm water. Follow the instrument manufacturer's instructions for appropriate enzymatic cleaner usage. Use a proteolytic enzymatic agent.		

Vol. 1 Module 1 Surgical Instrument Sterilization Preparation & Decontamination Procedures

Vol 1 Module 1 Surgical Instrument Sterilization Preparation & Decontamination Procedures (cont)

5. Manually clean the instruments by using a soft-bristle brush to clean	
serrations and box locks and a soft cloth to wipe surfaces. Keep instruments submerged while cleaning.	
6. Air blow the instruments that have lumens and fill them with cleaning solution and then rinse. Brush the lumen as needed to remove debris.	
7. Rinse instruments and place them in a perforated or mesh-bottom tray for the mechanical cleaner.	
Mechanical Cleaning	
1. Describe the function and explain the proper use for each of the following types of equipment:	
a. Washer-sterilizer	
b. Washer-decontaminator	
c. Ultrasonic cleaner	
2. Identify the appropriate mechanical cleaner for instruments based on the instrument manufacturer's instructions.	
3. Ensure all instruments have been manually cleaned IAW procedures above and local policy	
4. Place the instrument tray into the mechanical cleaner and operate the cleaner per the mechanical cleaner manufacturer's instructions.	
a. Combine only similar metal instruments in an ultrasonic cleaner.	
b. Do not place chrome-plated instruments; power instruments; air hoses; rubber, silicone, or plastic instruments; and endoscopic lenses into an ultrasonic cleaner	
c. Do not place powered instruments in a washer decontaminator or washer sterilizer	
5. Remove PPE, perform hand hygiene, and don gloves.	
6. At end of the cycle, ensure instruments have made completed a full cycle to include rinsing and remove them from the mechanical cleaner.	
7. Dry the instruments.	
8. Inspect instruments for cleanliness and proper functioning. A current leakage test should be performed. Remove any damaged instrument and label it with Needs Repair and then send instrument for repair. Inspection includes assessing the following:	
a. Cleanliness	
b. Alignment	
c. Corrosion or pitting	
d. Burrs, nicks, or cracks	
e. Sharpness of cutting instruments	

Vol 1 Module 1 Surgical Instrument Sterilization Preparation & Decontamination Procedures (cont)

f. Loose set pins		
g. Wear and chipping of instruments that have inserts or are plated		
h. Missing parts		
i. Proper functioning		
9. Have the sterile processing department conduct testing on electrosurgical instruments before sterilization to protect the patient from injury.		
10. Lubricate any instruments with moving parts per the instrument manufacturer's instructions. Lubricate instruments with organization-approved water-soluble lubricant that is steam penetrable, and use per the manufacturer's instructions.		
11. Remove gloves and perform hand hygiene.		
FINAL RESULT:		
NOTE: The evaluator will STOP the procedure immediately and correct the trainee could become detrimental to personnel safety at any time.	if performa	ance

Module 2

POSTURAL VITAL SIGNS MEASUREMENT

SUBJECT AREA: Patient Care Skills

TASK NAMES: Perform orthostatic vital signs

CFETP/STS REFERENCE(s): 2.12.6.8.

EQUIPMENT REQUIRED: Blood pressure cuff (appropriate size), Noninvasive blood pressure monitor (optional), Stethoscope (if blood pressure will be taken manually), Clock with second hand (if pulse will be taken manually)

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, current edition, Postural Vital Signs

REMARKS/NOTES: Vital signs must be taken in the same extremity for each of the three readings. A difference of 5 to 10 mmHg is common with blood pressure readings between arms. Normal range for blood pressure: Systolic – 95-140 mmHg Diastolic – 60-90 mmHg The systolic pressure is expected to fall 10 to 15 mmHg and the diastolic pressure is expected to rise slightly (by 5 mmHg) when changing between positions for orthostatic vital signs.

OBJECTIVE: Given the training resources and trainer demonstration, perform orthostatic vital signs measurement IAW the attached *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care*, Module 2, *Postural Vital Signs Measurement*.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task *without assistance*.

2. Use the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care*, Module 2, *Postural Vital Signs Measurement*, when evaluating the task to ensure that all steps of the task are accomplished correctly.

3. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation should be documented in the Specialty Training Standard (STS) of the trainee's CFETP. All recurring evaluation should be documented by using AF Form 1098, *Special Task Certification and Recurring Training*

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 2, Postural Vital Signs Measurement.

FEEDBACK: Using the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 2, *Postural Vital Signs Measurement,* as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

PERFORMANCE ITEM	SAT	UNSAT
ORTHOSTATIC VITAL SIGNS		
1. Verify physician's order.		
2. Gather supplies/equipment.		
3. Perform hand hygiene.		
4. Verify the correct patient using two identifiers per institution policy.		
5. Determine the patient's medication history, because certain medications—such as sympatholytic drugs, diuretics, nitrates, narcotics, antihistamines, psychotropic agents, barbiturates, antihypertensive, and anticholinergics—can predispose a patient to orthostatic hypotension in the absence of hypovolemia.		
6. Have the patient lie in a supine position for 5 to 10 minutes before taking the initial measurements. Prevent unreliable results by avoiding invasive or painful procedures during the measurement of postural		
vital signs.		
7. Measure blood pressure and heart rate after the patient has been in a supine position for 5 to 10 minutes. Be sure to use the appropriate size of blood pressure cuff. The correct cuff size is determined by arm circumference.		
8. Have the patient move from the supine to the standing position. If the patient is unable to stand for a blood pressure measurement, try either the high Fowler or the sitting position, although the results may be less credible. A supine-to-standing measurement is more accurate than a supine-to-sitting measurement.		
 9. Question the patient about weakness, dizziness, or visual dimming associated with a change of position. Note any pallor or diaphoresis. These symptoms are as important as the measurement of vital signs. Terminate the measurement if the patient becomes extremely dizzy and needs to lie down or experiences syncope. 		
10. Take the standing or sitting blood pressure (in the same arm as the initial readings), and determine the heart rate at 1 and 3 minutes after the position change. Support the patient's forearm at heart level when taking the blood pressure to prevent an inaccurate measurement. When measuring orthostatic vital signs, one or more of the following findings may indicate intravascular volume loss in adults:		
a. Decrease in systolic blood pressure of 20 mm Hg or more.b. Decrease in diastolic blood pressure of 10 mm Hg or more.		
c. Increase in heart rate of 20 bpm or more.		

Vol.1 Module 2 (cont)

Postural Vital Signs Measurement

11. If an intermediate sitting measurement was taken, have the patient move into the standing position and repeat the two previous steps.	
12. Return the patient to a supine or sitting position.	
13. Monitor for the resolution of symptoms such as dizziness, visual changes, or hypotension if any occurred during the measurement of postural vital signs.	
14. Perform hand hygiene.	
15. Document the results in the patient's record.	
FINAL RESULT:	

NOTE: The evaluator will STOP the procedure immediately and correct the trainee if performance could become detrimental to personnel safety at any time.

CARDIAC MONITOR SETUP AND LEAD PLACEMENT

SUBJECT AREA: Medical Examinations/Special Procedures

TASK NAMES: Set-up cardiac monitor/defibrillator. CFETP/STS REFERENCE(s): 2.13.10.1.

EQUIPMENT REQUIRED: ECG monitor (central and bedside monitor) or battery pack (telemetry monitoring only), Electrodes, pregelled and disposable, Dry gauze pads or terry cloth washcloth, Cleansing pads or nonemollient soap and water in a basin, Lead wires (no longer than 18 inches), Patient cable (should be compatible with the monitor and the lead wires), ECG calipers (may be available electronically via the central monitoring functions), Alcohol pads. Additional equipment to have available as needed includes the following: Skin preparation solution, such as skin barrier wipe or tincture of benzoin, if needed; Pouch or pocket gown to hold telemetry unit (telemetry monitoring only), Clippers or scissors to clip hair from the chest as needed.

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, *current edition, Cardiac Monitor Setup and Lead Placement.*

REMARKS/NOTES: Review steps of the process one-on-one with skilled medical technician and/or nursing personnel who are certified to set-up cardiac monitor/defibrillator.

OBJECTIVE: Given the training references and trainer demonstration, perform proper cardiac patient procedures IAW *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 3, *Cardiac Monitor Setup and Lead Placement.*

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task *without assistance*.

2. Use the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care*, Module 3, *Cardiac Monitor Setup and Lead Placement* when evaluating the task to ensure that all steps of the task are accomplished correctly.

3. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation should be documented in the Specialty Training Standard (STS) of the trainee's CFETP. All recurring evaluation should be documented by using AF Form 1098, *Special Task Certification and Recurring Training*.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 3, *Cardiac Monitor Setup and Lead Placement.*

FEEDBACK: Using the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 3, *Cardiac Monitor Setup and Lead Placement,* as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

Cardiac Monitor Set up and Lead Placement

PERFORMANCE ITEM	SAT	UNSAT
SETUP CARDIAC MONITOR AND LEAD PLACEMENT		
1. Verify physician's order.		
2. Perform hand hygiene.		
3. Verify correct patient using two identifiers.		
4. Turn on the monitoring system.		
5. Identify whether a three-lead or a five-lead wire system.		
6. Check the cable and lead wires for fraying, broken wires, or discoloration.		
7. Plug the patient cable into the monitoring system.		
8. Check that the lead wires are plugged into the patient cable correctly and securely:		
9. Three-lead system:		
a. The negative wire plugs into the opening marked N, (-), RA		
b. The positive wire plugs into the opening marked P, (+), LL, or LA		
c. The ground wire plugs into the opening marked G, Neutral, or RL		
10. Five-lead system:		
a. The right arm wire plugs into the opening marked RA		
b. The left arm wire plugs into the opening marked LA		
c. The left leg wire plugs into the opening marked LL		
d. The right leg wire plugs into the opening marked RL		
e. The chest wire plugs into the opening marked C or V		
11. Connect the electrodes to the lead wires before placing the electrodes on the patient.		
12. Choose electrode placement:		
a. Three-lead system:		
i. Lead I		
ii. Lead II		
iii. Lead III		
iv. MCL ₁		
v. MCL ₆		
b. Five-lead system:		
i. First choice: Select V_1 and the limb lead appropriate for the clinical		
situation.		
ii Second choice: Substitute V_6 for V_1 when the patient cannot have an electrode at the sternal border or when the QRS complex amplitude is not adequate for optimized computerized monitoring.		
13. Identify the sternal notch or angle of Louis.		
14. Clean the area for the application of electrodes with cleansing pads or soap and water and dry thoroughly.		

Vol.1 Module 3	Cardiac Monitor Set up and Lead	<u> Placement (cont)</u>
15. Clean the intended sites with alcohol pa solutions.	ds. Consider using skin preparation	
16. Abrade the skin using a washcloth or ga	auze pad.	
17. Remove the backing from the pregelled the pads for moistness.	electrodes and test the centers of	
18. Apply electrodes to the sites, ensuring a pads.	a seal. Avoid pushing on the gel	
19. Place electrodes as follows:		
a. Three-lead system: MCL ₁ and MCL ₆ :		
i. Apply right arm (RA) electrode to the	e patient's left shoulder	
ii. Apply left arm (LA) electrode at four	rth ICS right sternal border	
iii. Apply left leg (LL) electrode to the	fifth ICS at midaxillary line	
iv. Select lead I to obtain MCL ₁ and lea	d II to MCL ₆	
b. Lewis lead:		
i. Apply right arm (RA) electrode at first	st ICS right sternal border	
ii. Apply left arm (LA) electrode to four	rth ICS right sternal border	
iii. Apply left leg (LL) electrode to four	th ICS left sternal border	
iv. Apply left leg (LL) electrode to four	th ICS left sternal border	
v. Set the lead selector to lead I		
c. Five-lead system:		
i. Apply right arm (RA) to the right sh right arm and torso	oulder close to the junction of the	
ii. Apply left arm (LA) to the left shou arm torso	lder close to the junction of the left	
iii. Apply right leg (RL) electrode at th right abdominal region or on the hip	ne level of the lowest rib, on the	
iv. Apply left leg (LL) electrode at the abdominal region, or on the hip	level of the lowest rib, on the left	
v. Apply the chest lead electrode on th sternal border or V_6 fifth ICS left midaxilla	e	
vi. Set the lead selector or monitor the	appropriate leads.	
20. Reduce tension on the lead wires and ca		
21. Examine the ECG tracing on the monitor	or for the size of the R and T waves.	
22. Obtain an ECG strip and interpret it for configuration of P waves, length of P-R interpretent presence and configuration of T waves, lenger extra waves (e.g., U waves), and presence of	rhythm, rate, presence and erval, width of QRS complexes, gth of Q-T intervals, presence of	
23. Set the alarms. Upper and lower alarm patient's current clinical status and heart rat	limits are set on the basis of the	
24. Set ST segment parameters.		

Cardiac Monitor Set up and Lead Placement (cont)

25. Discard used supplies in appropriate receptacles and perform hand hygiene.		
26. Document the procedure in the patient's record.		
FINAL RESULT:		
NOTE: The evaluator will STOP the procedure immediately and correct the train	nee if perfo	ormance
could become detrimental to personnel safety at any time.		

Electrocardiogram: 12 Lead

Module 4

SUBJECT AREA: Patient Care Skills

TASK(s): Perform Electrocardiogram: 12 Lead.

CFETP/STS REFERENCE(s): 2.12.6.14.

EQUIPMENT REQUIRED: 12-lead ECG machine and recorder, Alcohol pads, Cleansing pads or non-emollient soap and water in a basin, Electrodes, Gauze pads or terrycloth washcloth, Patient cable and lead wires. Additional equipment to have available as needed includes the following: Clippers or scissors to clip hair from chest if needed, indelible marker and skin preparation solution (e.g., skin barrier wipe or tincture of benzoin)

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, current edition, *Electrocardiogram: 12 Lead*.

REMARKS/NOTES: Review steps of the process one-on-one with skilled medical technician and/or nursing personnel who are certified to perform a Electrocardiogram: 12 Lead.

OBJECTIVE: Given the training references and trainer demonstration, perform Electrocardiogram: 12 Lead IAW *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 4, *Electrocardiogram: 12 Lead.*

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task *without assistance*.

2. Use the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 4, *Electrocardiogram: 12 Lead* when evaluating the task to ensure that all steps of the task are accomplished correctly

3. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation should be documented in the Specialty Training Standard (STS) of the trainee's CFETP. All recurring evaluation should be documented by using AF Form 1098, *Special Task Certification and Recurring Training*.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 4, Electrocardiogram: 12 Lead

FEEDBACK: Using the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 4, *Electrocardiogram: 12 Lead,* as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, etc.. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

Electrocardiogram: 12 Lead

Vol.1 Module 4Electrocardiogram: 12 Lead		
PERFORMANCE ITEM	SAT	UNSAT
ELECTROCARDIOGRAM: 12 LEAD		
1. Verify physician's order.		
3. Verify the correct patient using two identifiers per institution policy.		
4. Assist the patient to a supine position.		
5. Assist the patient with removing clothing that covers the chest while		
providing the patient privacy.		
6. Perform hand hygiene and don gloves.		
7. Check the cables and lead wires for fraying, broken wires, or discoloration. If equipment is damaged, obtain alternative equipment and notify the biomedical engineer for repair.		
8. Plug the ECG machine into a grounded AC wall outlet or ensure that the battery-operated machine is functioning.		
9. Turn the ECG machine on and input the information required. Follow the manufacturer's recommendations and requirements for inputting information and warm-up time.		
10. Ensure that the patient is in the supine position and is not touching the bedrails or footboard. Ensure that subsequent ECGs are recorded in the same position. If another position is clinically required, note the position on the tracing or in the comment space of the machine input.		
11. Expose only the necessary parts of the patient's legs, arms, and chest to provide privacy and warmth.		
12. Identify the lead sites before placement. Mark the sites with an indelible marker if serial ECGs are anticipated.		
13. Prepare the patient's skin, if time permits.		
a. Cleanse the area with cleansing pads or soap and water to prepare for the application of electrodes and dry thoroughly. If necessary, clip the patient's hair to ensure good skin contact with the electrode		
b. Clean the intended sites with alcohol pads. Consider using a skin preparation solution. Apply skin preparation solutions to the area of the skin in direct contact with the electrode gel because transmission of impulses may be decreased		
c. Abrade the skin using a washcloth or gauze pad		
14. Prepare the electrodes.		
a. For pregelled electrodes, remove the backing and test for moistness. Ensure that the gel is moist. Replace the electrodes if they are not moist		
b. For adhesive electrodes, remove the backing and ensure that the adhesive pad is sticky or moist. Replace adhesive electrodes if they are not sticky		
15. Place the limb leads in fleshy areas, equidistant from the heart, and in approximately the same place on each limb. Avoid bony prominences.		

Vol.1 Module 4	Electrocardiogram: 12 Lead (Cont
16. Place the chest leads, ensuring accurate placeme accurately placed, clearly document the actual lo placement on the 12-lead ECG. Placing electrode breasts can be problematic. Place precordial lead women who have large breasts.	ocation of the lead es on a woman with large
a. Identify the angle of Louis or the sternal notch	
b. Palpate the upper sternum to identify where the Slide fingers down the center of the sternum to the This is the sternal notch, which identifies the second landmark for noting the fourth ICS	obvious bony prominence.
c. When the fourth ICS is located, place the V lear	ds in the appropriate
locations.	
i. V_1 at the fourth ICS, right sternal border	
ii. V_2 at the fourth ICS, left sternal border	
iii. V_3 equidistant between V_2 and V_4	
iv. V ₄ at the fifth ICS, midclavicular line	
v. V_5 horizontal level to V_4 at the anterior axilla	
vi. V_6 horizontal level to V_4 at the midaxillary l	line
17. Attach the lead wires to the electrodes.	
18. Turn the ECG machine on and program the mac	hine.
a. Paper speed: 25 mm/sec	
b. Calibration: 10 mm/mV	
c. Filter settings: 0.05 to 100 Hz	
19. Obtain a 12-lead ECG recording.	
a. Instruct the patient to remain still while the mac the electrical activity of the heart to electrical wave	
b. Obtain a rhythm strip if needed. Refer to the n instructions on obtaining a rhythm strip.	nanufacturer's manual for
20. Examine the 12-lead ECG tracing to ensure that if it is not clear. Obtain approval from provider for determine whether the recording must be repeat connected to the machine.	or adequacy of strip to
21. Disconnect the equipment, clean the gel off of the equipment for future use. Follow the manufacture institution policy for electrode use and removal.	
22. Discard supplies, remove gloves, and perform h	and hygiene.
23. Document the procedure in the patient's record.	
FINAL RESULT:	
NOTE: The evaluator will STOP the procedure imm could become detrimental to personnel safety at any	· · ·

Volume 1 RECOGNIZE NORMAL SINUS RHYTHM/ARRHYTHMIAS

SUBJECT AREA: Medical Examinations/Special Procedures

TASK(s): Recognize/Report Normal Sinus Rhythm; Recognize/Report Ventricular Tachycardia Recognize/Report Ventricular Fibrillation

CFETP/STS REFERENCE(s): 2.13.10.3.; 2.13.10.4.; 2.13.10.5.

EQUIPMENT REQUIRED: EKG strips or EKG simulator.

TRAINING REFERENCE(s): *Clinical Nursing Skills: Basic to Advanced Skills*, eighth edition.

REMARKS/NOTES: Review steps of the process one-on-one with skilled medical technician and/or nursing personnel who are certified to identify cardiac arrhythmias. Prior to identifying cardiac arrhythmia, the trainer is to review each aspects of a normal sinus rhythm with the trainee *NOTE: This skill should not be evaluated during a real-life emergency situation.*

OBJECTIVE: Given the training resources and trainer demonstration, identify the following arrhythmias of ventricular tachycardia (VTach) and ventricular fibrillation (VFib), IAW the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 5, *Recognize Normal Sinus Rhythm/Arrhythmias*.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task *without assistance*.

2. If an EKG simulator is not used, use the EKG strips on the attached checklist for the purpose of identifying the four arrhythmias listed on the performance checklist.

3. Use the *Aerospace Medical Service Specialty* Performance Checklist Volume 1, *Fundamentals of Nursing Care,* Module 5, *Recognize Normal Sinus Rhythm/Arrhythmias* when evaluating the task to ensure that all steps of the task are accomplished correctly.

4. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation should be documented in the Specialty Training Standard (STS) of the trainee's CFETP. All recurring evaluation should be documented by using AF Form 1098, *Special Task Certification and Recurring Training*.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 5, Recognize Normal Sinus Rhythm/Arrhythmias. **FEEDBACK:** Using the Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 5, Recognize Normal Sinus Rhythm/Arrhythmias as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's Air Force Training Record.



PERFORMANCE ITEM	SAT	UNSAT
RECOGNIZE NORMAL SINUS RHYTHM		
Ventricular Tachycardia		
1. Identify Normal Sinus Rhythm by noting the following		
a. Rate – usually 60-100 beats per minute (bpm)		
b. Rhythm – regular		
c. P wave – present		
d. P-R interval1220 seconds		
e. QRS complex – <.12 seconds		
f. T wave – present		
FINAL RESULT:		



Check the patients pulse to determine the proper interventions needed.

PERFORMANCE ITEM	SAT	UNSAT
RECOGNIZE VENTRICULAR TACHYCARDIA		
1. Identify Ventricular Tachycardia (VTach) by noting the following		
a. Rate – usually 140-220 beats per minute (bpm). Because a normal heart rate can be 40 bpm or lower, 100 bpm may be considered tachycardia		
b. Rhythm – may be regular or irregular		
c. P wave – not present		
d. P-R interval- immeasurable		
e. QRS complex – broad, bizarre configuration, greater than 0.12 seconds wide		
f. T wave – deflected opposite to the QRS complex		
FINAL RESULT:		



PERFORMANCE ITEM	SAT	UNSAT
RECOGNIZE VENTRICULAR FIBRILLATION		
1. Identify Ventricular Fibrillation (VFib) by noting the		
following		
a. Rate – immeasurable because of the absence of QRS		
complexes		
b. Rhythm – chaotic		
c. P wave – not present		
d. QRS complex – bizarre, chaotic, not well defined		
e. T wave – not apparent		
FINAL RESULT:		

Module 6

PULSE OXIMETRY/OXYGEN SATURATION

SUBJECT AREA: Patient Care Skills

TASK(s): Perform pulse oximetry/oxygen saturation.

CFETP/STS REFERENCE(s): 2.12.6.10.

EQUIPMENT REQUIRED: Pulse Oximeter, Oximeter probe, Acetone or nail polish remover and cotton swabs, if needed and Disinfectant (for cleaning monitoring probe between patients)

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, current edition

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in measuring oxygen saturation with a pulse oximeter.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of measuring oxygen saturation with a pulse oximeter.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 6, Pulse Oximetry/Oxygen Saturation.

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

Pulse Oximetry Oxygen Saturation

DI.1 Module 6 Pulse Oximetry C PERFORMANCE ITEM	SAT	UNSAT
PULSE OXIMETRY/OXYGEN SATURATION		
1. Perform hand hygiene.		
2. Verify the correct patient using two identifiers per organization policy.		
3. Determine the most appropriate patient-specific site (e.g., finger, earlobe, bridge of nose, or forehead) for sensor placement by measuring capillary refill. If capillary refill is greater than 3 seconds, select an alternative site.		
a. Select the sensor site based on peripheral circulation and extremity temperature		
b. The site must have adequate local circulation and be free of moisture		
c. A finger free of polish or acrylic nail is preferred		
d. If the patient has tremors or is likely to move, use earlobe or forehead		
e. If the patient is obese, a clip-on probe may not fit properly; obtain a disposable (tape-on) probe		
4. If using the patient's finger, remove any nail polish with acetone or polish remover.		
5. Position the patient comfortably. If using a finger as the monitoring site, position the hand so that the finger is clear of obstructions, such as blankets and straps.		
6. Instruct the patient to breathe normally.		
7. Attach the sensor to the selected monitoring site. Inform the patient that the clip-on probe feels like a clothespin on the finger but does not hurt.		
8. Once the sensor is in place, turn on the oximeter.		
a. Observe the pulse waveform or intensity display and note the audible beep, if available		
b. Correlate oximeter pulse rate with the patient's radial pulse. If simultaneously measuring oximeter pulse rate, radial pulse, and apical pulse and they are different, reevaluate the oximeter probe placement and reassess pulse rates. If necessary, reposition probe and reassess rates		
9. Leave the sensor in place until the oximeter readout reaches constant value and pulse display reaches full strength during each cardiac cycle.		
a. Inform the patient that the oximeter alarm will sound if the sensor falls off or if the patient moves the sensor		
b. Read the SpO_2 on the digital display. Reading usually takes 10 to 30 seconds, depending on site selected		
10. If continuously monitoring oxygen saturation, verify that the SpO_2 alarm limits preset by the manufacturer are at a low of 85% and a high of 100%.		

Vol.1 Module 6	Pulse Oximetry Oxyge	n Saturati	on (Cont)
a. Determine limits for SpO ₂ and pulse rate as indic	ated by the patient's		

a. Determine limits for SpO_2 and pulse rate as indicated by the patient's		
condition		
b. To ensure alarms are heard and responded to, set their limits and volumes according to organization's patient safety guidelines		
c. Verify that alarms are on		
d. Assess skin integrity under the sensor; relocate the sensor if skin integrity is altered or tissue perfusion is compromised		
11. If performing intermittent or spot-checking of SpO ₂ , remove the probe and turn off the oximeter power. Store the probe in an appropriate location.		
12. Discuss findings with the patient as needed, and record findings.		
13. Assist the patient in returning to a comfortable position.		
14. Assess, treat, and reassess pain according to institution standard.		
15. Perform hand hygiene.		
16. Document the procedure in the patient's record.		
FINAL RESULT:		
NOTE: The evaluator will STOP the procedure immediately and correct the traperformance could become detrimental to personnel safety at any time.	ainee if	

BLOOD SPECIMEN COLLECTION: VACUTAINER METHOD

SUBJECT AREA: Patient Care Skills

TASK(s): Perform and label venipuncture.

CFETP/STS REFERENCE(s): 2.12.7.3.2.1.

EQUIPMENT REQUIRED: 70% alcohol swab, Clean gloves, Small pillow or folded towel or chair with special arm extension, Sterile 2 × 2-inch gauze pads, Tourniquet, Adhesive bandage or adhesive tape, Appropriate blood tubes, **completed identification labels with proper patient** identifiers, Completed laboratory requisition (appropriate patient identification, date, time, name of test, and source of culture), Small plastic biohazard bag or approved container for delivery of specimen to laboratory, Vacutainer and safety access device, Vacutainer blood tubes with Luer-Lok adapter (for Luer-Lok syringe), Sterile double-ended needles (20- to 21-gauge for adults; 23- to 25-gauge for children)

TRAINING REFERENCE(s): Mosby's Nursing Skills/Kx, current edition

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in venipuncture.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of venipuncture.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

ATTACHMENT: Aerospace Medical Service Specialty Performance Checklist Volume 1, Fundamentals of Nursing Care, Module 7, Blood Specimen Collection: Vacutainer Method

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

Blood Specimen Collection: Vacutainer Method

PERFORMANCE ITEM	SAT	UNSAT
BLOOD SPECIMEN COLLECTION: VACUTAINER METHOD		
1. Perform hand hygiene.	1	
2. Verify correct patient using two identifiers.		
3. Determine if special conditions need to be met before specimen		
collection.		
4. Assess the patient for risks associated with venipuncture. Review medication history.		
5. Assess the patient for contraindicated sites for venipuncture.		
6. Verify the practitioner's orders for tests required.		
7. Identify appropriate laboratory tubes and order in which specimens should be collected (if multiple specimens are required).		
8. Bring equipment, including specimen labels, to the patient and organize.		
9. Raise or lower bed to a comfortable working height (if supine.)		
10. Assist the patient to position with his or her arms extended to form a straight line from shoulders to wrists. Place a small pillow or towel under the patient's upper arm. If in a clinic or health care provider's office, use a chair with a special arm extension.		
11. Apply a tourniquet 5 to 10 cm (2 to 4 inches) above selected venipuncture site (antecubital fossa site is most often used). Encircle the extremity, and pull one end of the tourniquet tightly over the other, looping one end under the other. Apply the tourniquet so that it can be removed by pulling an end with a single motion. If the tourniquet is too tight, pressure will impede		
arterial blood flow. Do not keep the tourniquet on the patient		
longer than 1 minute. Do not obtain blood samples from an		
extremity with a peripheral access device in place. If		
unavoidable, obtain the sample below the peripheral access device.		
12. Ask the patient to make a fist. Instruct the patient to avoid vigorous opening and closing of fist.		
13. Quickly inspect the extremity distal to the tourniquet for the best venipuncture site, looking for a straight, prominent vein without swelling or hematoma.		
14. Palpate selected vein with fingers. Palpate for a firm vein that rebounds. Do not use a vein that feels rigid or cordlike, or that rolls when palpated.		
15. Select venipuncture site. Release the tourniquet. (If the vein cannot be palpated or viewed easily, remove the tourniquet and apply a warm, wet compress over the extremity for several minutes.)		

Vol.1 Module 7 Blood Specimen Collection: Vacuta	iner Method (cont)
16. Perform hand hygiene and don clean gloves.	
17. Obtain blood sample.	
a. Reapply the tourniquet and relocate the vein. Attach a double- ended needle to the Vacutainer tube	
b. Have proper blood specimen tube resting inside the Vacutainer, but do not puncture the rubber stopper	
c. Cleanse the venipuncture site with an antiseptic swab moving in a circular motion out from the site approximately 5 cm (2 inches). Allow it to dry completely, about 30 seconds. Do not touch the venipuncture site after cleansing	
d. Remove the needle cover and maintain sterility of the needle. Inform the patient that he or she will feel a stick. If contamination occurs, dispose of the needle and Vacutainer in a designated sharps receptacle and use a new Vacutainer with safety access device	
e. Place the thumb or forefinger of your non-dominant hand 2.5 cm (1 inch) below the site, and gently pull and stretch the patient's skin distal to the patient until it is taut and the vein is stabilized	
f. Hold Vacutainer needle at a 15- to 30-degree angle from arm with the bevel up	
g. Slowly insert the needle into the vein	
h. Grasp Vacutainer securely, and advance the specimen tube into the needle of the holder (do not advance the needle in the vein)	
i. Note the flow of blood into the tube (should be fairly rapid).	
j. After the specimen tube is filled to the correct level, grasp Vacutainer firmly and remove specimen tube. Insert additional specimen tubes as needed. If tubes contain additives, gently invert back and forth immediately. Do not shake.	
k. Just before filling the last specimen tube, release the tourniquet. Fill the last tube and remove it from Vacutainer.	
18. Apply a 2×2 -inch gauze pad over the puncture site without applying pressure, and quickly but carefully withdraw the needle with Vacutainer from the vein.	
19. Immediately apply pressure over venipuncture site with gauze or an antiseptic pad until bleeding stops. Observe for hematoma.	
20. Inspect puncture site for bleeding, and apply adhesive tape with gauze.	
21. Check collection tubes for any sign of external contamination with blood. Decontaminate with 70% alcohol if necessary.	
22. Assist the patient to a comfortable position.	

Vol.1 Module 7 Blood Spectrum	cimen Collection: Vacutainer Method (cont)
23. At the bedside, complete tube identific patient identifiers, name, date, time of coll collector. Attach appropriate label securely proper requisition.	ection, and initials of
24. Discard Vacutainer, needle, and tubing Do not recap needles or attempt to remove Vacutainer.	
25. Following institution guidelines for sp transport requirements, place labeled spect to the laboratory.	ę
26. Send specimens immediately to the lab	boratory.
27. After any spillage has been cleaned, di nonsharp supplies, remove gloves, and per	e e
28. Document the procedure in the patient	's record.
FINAL RESULT:	
NOTE: The evaluator will STOP the proce performance could become detrimental to	edure immediately and correct the trainee if personnel safety at any time.

PERFORM URINE REAGENT STICK TESTING

SUBJECT AREA: Patient Care Skills

TASK(s): Perform urine reagent stick testing

CFETP/STS REFERENCE(s): 2.12.7.3.2.4.

EQUIPMENT REQUIRED: Gloves, paper towel, reagent strips with color strip code, specimen containers, bedpan if necessary, and a watch with capacity to count seconds

TRAINING REFERENCE(s): Fundamental Concepts and Skills, current edition; Clinical Nursing Skills: Basic to Advanced Skills, current edition

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in urine testing procedures.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of testing urine for glucose, ketones, protein, blood, pH, and specific gravity.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Perform Urine Reagent Stick Testing

PERFORMANCE ITEM	SAT	UNSAT
Perform Urine Reagent Stick Testing		
1. Verify physician's order.		
2. Gather supplies/equipment.		
3. Identify patient/explain procedure.		
4. Don gloves.		
5. Obtain urine sample from patient and place container on clean paper towel.		
6. Observe and note color and appearance of urine.		
7. Gently swirl urine container to mix urine thoroughly.		
8. Remove one strip from the test strip bottle and replace cap immediately.		
9. Dip strip into specimen ensuring all reagent pads are immersed; remove		
Immediately.		
10. Run edge of strip against rim of specimen container to remove excess		
urine.		
11. After required waiting period(s) specified on stick container, match reagent		
pads with color key on label; compare carefully.		
12. Observe for presence of blood, protein, glucose, or ketones in urine.		
13. Discard urine.		
14. Remove gloves and perform hand hygiene.		
15. Document results and report results as needed.		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's Air Force Training Record.

PERFORM CAPILLARY STICK FOR BLOOD SAMPLING

SUBJECT AREA: Patient Care Skills

TASK(s): Perform capillary stick for blood sampling

CFETP/STS REFERENCE(s): 2.12.7.3.2.5.

EQUIPMENT REQUIRED: Gloves, disposable lancet, laboratory specimen collection tubes, alcohol pads, betadine pads, 2x2 gauze pads, warm pack, and band-aids

TRAINING REFERENCE(s): Fundamental Concepts and Skills, current edition; Clinical Nursing Skills: Basic to Advanced Skills, current edition

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in collecting capillary blood via skin puncture.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of collecting capillary blood via skin puncture.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
Perform Capillary Stick for Blood Sampling		
1. Verify physician's order.		
2. Identify patient/explain procedure.		
3. Gather supplies/equipment.		
4. Wash hands and don gloves.		
PERFORM FINGER STICK (for children older than 1 year of age)		
1. Select finger for sample collection (2nd or 3rd digit. Ensure no callouses)		
2. Cleanse site with betadine and/or alcohol preps and allow to dry.		
3. Position and immobilize child as appropriate.		
4. Hold arm in a dependent position.		
5. Hold the distal phalanx of the digit using one hand.		
6. Using lancet, puncture skin on side of ball of finger perpendicular to the lines of the fingerprint.		
7. Wipe away first drop of blood with gauze.		
8. Obtain specimen by touching tip of capillary tube or collector end of container to the drop of blood.		
9. Remove capillary collection piece of collection tube and cap specimen.		
10. Apply pressure to puncture site with 2x2 gauze pad until bleeding stops.		
11. Apply band-aid.		
12. Label specimen at bedside.		
13. Dispose of supplies properly.		
14. Document procedure.		
PERFORM HEEL STICK (for infants younger than 1 year of age)		
1. Warm the site with warm compress for 3 to 5 minutes.		
2. Cleanse site with betadine and alcohol preps and allow to dry.		
3. Position and immobilize child as appropriate.		
4. Hold heel at 90-degree angle using one hand.		
5. Using lancet, puncture skin on the most medial or lateral plantar surface		
portion of the heel.		
6. Wipe away first drop of blood with gauze.		
 Obtain specimen by touching tip of capillary tube or collector end of container to the drop of blood. 		
8. Remove capillary collection piece of collection tube and cap specimen.		
9. Apply pressure to puncture site with 2x2 gauze pad until bleeding stops.		
10. Apply band-aid.		
11. Label specimen at bedside.		
12. Dispose of supplies properly.		
13. Document procedure.		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's AFTR.

USE BLOOD GLUCOSE METER

SUBJECT AREA: Patient Care Skills

TASK(s): Use blood glucose meter

CFETP/STS REFERENCE(s): 2.12.7.3.2.6.

EQUIPMENT REQUIRED: Gloves, antiseptic swab, cotton ball or gauze, sterile single-use auto-disabling lancet or bloodletting device, blood glucose meter and reagent strips, tape, and band-aid

TRAINING REFERENCE(s): Blood glucose meter manufacturer's operating instructions. (NOTE: Due to the many types of glucose meters available for use, this QTP has been developed as generically as possible. The evaluator can make changes as needed to reflect proper use of the glucose meter on hand for the evaluation).

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in use of the glucose meter.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of blood glucose testing using a glucose meter.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Use Blood Glucose Meter

	Г	
PERFORMANCE ITEM	SAT	UNSAT
Use Blood Glucose Meter		
1. Verify physician's order.		
2. Identify patient/explain procedure.		
3. Gather supplies/equipment.		
4. Wash hands and don gloves.		
5. Remove reagent strip from container and tightly seal cap.		
6. Turn on glucose meter.		
7. Ensure correct calibration of meter per manufacturer's		
instructions.		
8. Perform finger stick to obtain blood sample (per QTP Vol.1		
Module 9)		
9. Wipe away first drop of blood with cotton ball or gauze.		
10. Gently squeeze finger until sufficient droplet of blood has formed.		
11. Apply blood sample to strip per manufacturer's directions.		
12. Obtain and record test results.		
13. Control bleeding with gauze or band-aid as needed.		
14. Turn meter off.		
15. Dispose of supplies properly.		
16. Document procedure.		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's Air Force Training Record.

MEDICATION ADMINISTRATION

SUBJECT AREA: Patient Care Skills

TASK(s): Prepare and administer oral medications, subcutaneous injections, intramuscular injections, intradermal injections, agents in prefilled or Tubex syringes, autoinjector, rectal suppository, vaginal suppository, ophthalmic ointments/drops, otic drops, topical medications, inhaled medications via updraft nebulize, sublingual medications

CFETP/STS REFERENCE(s): 2.12.8.3.1.2; 2.12.8.3.1.3; 2.12.8.3.1.4; 2.12.8.3.1.5; 2.12.8.3.1.6; 2.12.8.3.1.7; 2.12.8.3.1.8; 2.12.8.3.1.9; 2.12.8.3.1.10; 2.12.8.3.1.11; 2.12.8.3.1.12; 2.12.8.3.1.13; 2.12.8.3.1.17.

EQUIPMENT REQUIRED:

<u>Oral/Sublingual Medication:</u> Gloves, oral administration cup, glass of approved liquid, drinking straw

<u>Subcutaneous or Intramuscular Injections</u>: Gloves, adhesive bandage, alcohol swab, gauze, needle and syringe appropriate for type of injection

Intradermal Injection: Gloves, alcohol swab, gauze, 1-mL TB syringe with preattached 25- or 27-G needle

Prefilled or Tubex Syringes: Gloves, adhesive bandage, alcohol swab, gauze, Tubex

Rectal Suppository: Gloves, water-soluble lubricating jelly, tissue, drape

Vaginal Suppository: Gloves, tissue, perineal pad, drape, water-soluble lubricating jelly, bedpan

Ophthalmic Ointments and Drops: Gloves, tissue, cotton balls, eye patch

Otic Drops: Gloves, cotton-tipped applicator

Topical Medication: Gloves

Inhaled Medication Via Updraft Nebulizer: Gloves, nebulizer and tubing, pulse oximeter, stethoscope

TRAINING REFERENCE(s): Mosby's Nursing Skills Online; Nebulizer User Manual

REMARKS/NOTES:

1. Prior to performing tasks, medical technicians must successfully pass the Mosby's Nursing Skills On-Line skills and tests.

2. Demonstrate step of medication administration process one-on-one in a patient care setting under direct supervision (preceptorship) of a registered nurse preceptor, qualified 4N071 (MSgt
or above) or 4N091. A qualified 4N071 (MSgt or above) or 4N091 are those who are trained and signed off in the tasks in which they are providing training or preceptorship for.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of medication administration.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Medication Administration

PERFORMANCE ITEM	1	LINICA T
	SAT	UNSAT
Medication Administration		
ORAL MEDICATIONS		
1. Verify physician's order.		
2. Obtain supplies and medication, check medication expiration		
date, and calculate dosage.		
3. Identify patient/ensure 6 rights/explain procedure.		
4. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
5. Wash hands and don gloves.		
6. Pour tablet/capsule into cap of container and then into administration.		
7. Position patient and assist patient in taking medication.		
8. Observe patient for effectiveness/adverse reactions to medication.		
9. Dispose of supplies properly and wash hands.		
10. Document procedure.		
SUBCUTANEOUS INJECTIONS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
4. Wash hands and don gloves.		
5. Select site for injection.		
6. Withdraw medication from ampule/vial into syringe.		
7. Expel all air from syringe.		
8. Position patient for administration.		
9. Clean site with alcohol pad in a circular motion, from the center-		
outward.		
10. Stabilize site properly with non-dominant hand.		
11. Insert needle bevel up at a 45-degree angle in a steady manner.		
12. Inject all medication slowly and steadily.		
13. Withdraw needle and apply gentle pressure to the site with a $2x2$.		
14. Observe patient for effectiveness/adverse reactions to medication.		
15. Dispose of supplies properly and wash hands.		
16. Document procedure.		
INTRAMUSCULAR INJECTIONS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure		

Medication Administration (continued)

PERFORMANCE ITEM	SAT	UNSAT
INTRAMUSCULAR INJECTIONS (continued)		
3. Confirm patient is not allergic to medication nor has specific contraindications.		
4. Wash hands and don gloves.		
5. Select site for injection.		
6. Withdraw medication from ampule/vial into syringe.		
7. Expel all air from syringe.		
8. Position patient for administration.		
9. Clean site with alcohol pad in a circular motion, from the center- outward.		
10. Stabilize site properly with non-dominant hand.		
11. Insert needle bevel up at a 90-degree angle in a steady manner.		
12. Aspirate and ensure no blood return is noted (select new site if necessary)		
13. Inject all medication slowly and steadily.		
14. Withdraw needle and apply gentle pressure to the site with a 2x2.		
15. Observe patient for effectiveness/adverse reactions to medication.		
16. Dispose of supplies properly and wash hands.		
17. Document procedure.		
INTRADERMAL INJECTIONS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific contraindications to medication.		
4. Wash hands and don gloves.		
5. Select site for injection.		
6. Withdraw medication from ampule/vial into syringe.		
7. Expel all air from syringe.		
9. Clean site with alcohol pad in a circular motion, from the center- outward.		
10. Stabilize site properly with non-dominant hand.		
11. With needle almost against skin, insert slowly at 5- to 15-		
degree angle until resistance is felt. Advance needle approximately 3mm below skin surface.		
12. Inject slowly. If resistance is not felt, needle is too deep; remove and begin again.		
13. While injecting, observe for expected bleb to appear on skin surface.		
 Withdraw needle and apply light pressure to the site with a 2x2. 		
15. Observe patient for effectiveness/adverse reactions to medication.16. Dispose of supplies properly and wash hands.		
17. Document procedure.		

Medication Administration (continued)

PERFORMANCE ITEM	SAT	UNSAT
AGENTS IN PREFILLED/TUBEX SYRINES		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
4. Wash hands and don gloves.		
5. Select site for injection.		
6. Follow manufacturer's instructions for inserting medication		
cartridge.		
7. Clean site with alcohol pad in a circular motion, from the center-		
outward.		
8. Stabilize site properly with non-dominant hand.		
9. Insert needle bevel up at a 90-degree angle in a steady		
manner.		
10. Aspirate and ensure no blood return is noted (select new site if		
necessary)		
11. Inject all medication slowly and steadily.		
12. Withdraw needle and apply gentle pressure to the site with a		
2x2.		
13. Observe patient for effectiveness/adverse reactions to medication.		
14. Dispose of supplies properly and wash hands.		
15. Document procedure.		
RECTAL SUPPOSITORIES		
1. Verify physician's order.		
2. Ensure patient privacy.		
3. Identify patient/ensure 6 rights/explain procedure.		
4. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
5. Wash hands and don gloves.		
6. Position patient on his/her side and drape appropriately.		
7. Examine anus externally for any conditions that may impede		
medication.		
8. Remove suppository from foil wrapper and lubricate rounded end and		
gloved index finger of dominant hand.		
9. Instruct patient to take several slow deep breaths and relax anal.		
10. Retract buttocks and insert suppository past internal sphincter and		
against rectal wall.		
11. Withdraw finger and wipe patient's anal area.		
12. Dispose of supplies properly and wash hands.		
13. Document procedure.		

Vol. 1 Module 11

Medication Administration (continued)

PERFORMANCE ITEM	SAT	UNSAT
VAGINAL SUPPOSITORIES		
1. Verify physician's order.		
2. Ensure patient privacy.		
3. Identify patient/ensure 6 rights/explain procedure.		
4. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
5. Wash hands and don gloves.		
6. Position patient lying in dorsal recumbent position.		
7. Inspect condition of external genitalia and vaginal canal.		
8. Remove suppository from foil wrapper and lubricate rounded end and gloved index finger of dominant hand.		
9. Gently separate labial folds in the front-to-back direction.		
10. Insert suppository along posterior wall of vaginal canal entire length of finger.		
11. Withdraw finger and wipe away lubricant from around orifice and labia.		
12. Instruct patient to remain on back for at least 10 minutes.		
13. Offer perineal pad when patient resumes ambulation.		
14. Dispose of supplies properly and wash hands.		
15. Document procedure.		
SET-UP FOR OPHTHALMIC OINTMENTS AND DROPS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
4. Wash hands and don gloves.		
5. Position patient supine or sitting back in chair with head slightly.		
6. Gently wash away drainage or crusts, wiping from inner to outer canthus.		
ADMINISTER OPHTHALMIC OINTMENTS		
1. Ask patient to look at ceiling.		
2. Hold applicator over lower lid margin and apply thin ribbon of		
ointment evenly along inner edge of lower eyelid on conjunctiva from		
the inner to outer canthus.		
3. Have patient close eye and rub lid lightly in circular motion with		
cotton.		
4. Wipe away excess medication from inner to outer canthus.		
5. Apply eye patch as ordered.		
6. Assist patient to comfortable position.		
7. Dispose of supplies properly and wash hands.		
8. Document procedure		

PERFORMANCE ITEM	SAT	UNSAT
ADMINISTER OPHTHALMIC DROPS		
1. Ensure eye drops are at room temperature.		
2. Ask patient to look at ceiling.		
3. Hold tissue on patient's cheekbone just below lower eyelid.		
4. Gently press downward with thumb or forefinger against bony orbit.		
5. Rest hand against patient's forehead and hold filled eye dropper		
approximately 1 to 2 cm above conjunctival sac.		
6. Instill prescribed number of drops into conjunctival sac.		
7. After instilling drops, ask patient to close eye gently.		
8. Wipe away excess medication from inner to outer canthus.		
9. Apply eye patch as ordered.		
10. Assist patient to comfortable position.		
11. Dispose of supplies properly and wash hands.		
12. Document procedure.		
OTIC DROPS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
4. Wash hands and don gloves.		
5. Warm medication by running warm water over bottle.		
6. Position patient side-lying with ear to be treated facing up.		
7. Remove excess cerumen or drainage as ordered.		
8. Instill prescribed drops holding dropper 1 cm above ear canal.		
a. Adults: Pull ear upward and backward		
b. Children: Pull ear downward and backward		
9. Have patient remain in side-lying position for a few minutes.		
10. Apply gentle massage or pressure to tragus of ear.		
11. If ordered, insert cotton ball into outermost part of canal and remove		
after 15 minutes.		
12. Assist patient to comfortable position.		
13. Dispose of supplies properly and wash hands.		
14. Document procedure.		

Medication Administration (continued)

Vol. 1 Module 11 Medication A PERFORMANCE ITEM	SAT	UNSAT
TOPICAL MEDICATIONS		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
Contraindications to medication.		
4. Wash hands and don gloves.		
5. Place required amount of medication in palm of hand and		
soften.		
6. Spread medication evenly over skin surface, using long even strokes		
that follow direction of hair growth. Apply to the thickness specified by		
manufacturer's instructions. Do not vigorously rub skin.		
7. Assist patient to comfortable position.		
8. Dispose of supplies properly and wash hands.		
9. Document procedure.		
INHALED MEDICATION VIA UPDRAFT NEBULIZER		
1. Verify physician's order.		
2. Identify patient/ensure 6 rights/explain procedure.		
3. Confirm patient is not allergic to medication nor has specific		
contraindications to medication.		
4. Assemble nebulizer per manufacturer's instructions.		
5. Wash hands and don gloves.		
6. Auscultate lungs and document pre-nebulizer pulse oximeter reading.		
7. Add prescribed medication and diluent to nebulizer cup.		
8. Have patient hold mouthpiece between lips with gentle		
pressure.		
9. Turn on machine and ensure that sufficient mist is formed.		
10. Have patient take a deep breath, encourage brief end-inspiratory		
pause.		
11. When medication is gone, turn off machine.		
12. If steroids were used, instruct patient to rinse mouth and gargle with		
warm water after treatment.		
13. Observe patient for adverse reactions, auscultate lungs, and		
document.		
14. Assist patient to comfortable position.15. Dispose of supplies properly and wash hands.		
16. Document procedure.		
ro. Document procedure.		

Medication Administration (continued)

PERFORMANCE ITEM	SAT	UNSAT
SUBLINGUAL MEDICATIONS		
1. Verify physician's order.		
2. Obtain supplies and medication, check medication expiration date, and calculate dosage.		
3. Identify patient/ensure 6 rights/explain procedure.		
4. Confirm patient is not allergic to medication nor has specific contraindications to medication.		
5. Wash hands and don gloves.		
6. Pour tablet/capsule into cap of container and then into administration.		
7. Position patient and assist patient in taking medication. Have patient place medication under tongue and allow it to dissolve completely.		
8. Observe patient for effectiveness/adverse reactions to medication.		
9. Dispose of supplies properly and wash hands.		
10. Document procedure.		
FINAL RESULT:		

Volume 1

PARENTERAL FLUID THERAPY

SUBJECT AREA: Patient Care Skills

TASK(s): Set up/regulate/monitor intravenous and intraosseous (IO) fluid administration and saline locks, initiate peripheral intravenous (IV) infusion, apply armboard or restraints to secure infusion, set up and regulate infusion pumps/controllers, set up and regulate infusion pressure bags, change intravenous fluid bags/bottles, discontinue intravenous infusion

CFETP/STS REFERENCE(s): 2.12.8.5.1; 2.12.8.5.1.1; 2.12.8.5.1.2; 2.12.8.5.1.3; 2.12.8.5.2; 2.12.8.5.2.1; 2.12.8.5.2.7; 2.12.8.5.2.8; 2.12.8.5.3; 2.12.8.5.3.1.

EQUIPMENT REQUIRED:

IV and/or Saline Lock Initiation: Gloves, tourniquet, cleansing and antiseptic swabs (i.e. alcohol pads), 2x2 and 4x4 gauze pads, Op-site or similar sterile transparent dressing, tape, IV catheter of appropriate type and length, saline lock, syringe with 1 to 3 mL of 0.9% sodium chloride for saline lock

IV Fluid Infusion: IV solution, IV tubing, 3-way stopcock, infusion pressure bag, armboard, roller gauze, IV pump/controller with appropriate administration set

Intraosseous Initiation: Gloves, antiseptic solution, IO needle of appropriate type and length, syringe for aspiration, normal saline for irrigation, tape, armboard or legboard, dressing supplies, IV tubing, IV solution, infusion pressure bag

TRAINING REFERENCE(s): Mosby's Nursing Skills Online; Infusion Pump/Controller User Manual

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in parenteral fluid therapy.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of parenteral fluid therapy.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
Parenteral Fluid Therapy		
SET-UP FOR IV INITIATION & INFUSION		
1. Verify orders using the 6 rights.		
2. Ocather of the state of the	teral Fluid	Therapy
3. Identify patient/explain procedure.		
4. Wash hands.		
5. Position patient in comfortable position.		
INITIATE IV INFUSION		
1. Select insertion site.		
2. Clean and prep site.		
3. Apply tourniquet.		
4. Don gloves.		
5. Insert catheter at 10 to 30 degree angle with the bevel up.		
6. Monitor for blood return and lower catheter until almost flush with skin.		
7. Advance catheter into vein while withdrawing needle.		
8. Attach tubing or saline lock.		
9. Release tourniquet.		
10. Open clamp and ensure flow is unobstructed.		
SECURE INFUSION SITE		
1. Secure catheter hub with Op-site or sterile transparent dressing.		
2. Secure tubing at site in a loop to prevent accidental pulling.		
3. Apply armboard using roller gauze and tape.		
REGULATE IV INFUSION		
1. Calculate drip rate per physician's order.		
2. Adjust flow.		
3. Time-tape IV bag if necessary.		
SET-UP AND REGULATE INFUSION PUMP/CONTROLLER		
1. Assemble appropriate infusion set and attach to pump/controller.		
2. Connect to 3-way stopcock.		
3. Switch IV flow from initial IV infusion line to pump/controller line.		
4. Ensure settings are properly set with alarm feature on.		
CHANGE IV FLUID BAGS/BOTTLES		
1. Verify orders.		
2. Wash hands.		
3. Obtain new solution bag/bottle.		
4. Close tubing clamp.		
5. Lower empty bag/bottle.		
6. Remove spike without contaminating.		
7. Spike new bag/bottle.		
8. Hang new bag/bottle on IV pole.		
9. Ensure no air is in line.		
10.Initiate IV fluid flow.		
11.Document procedure		

Parenteral Fluid Therapy (continued)

PERFORMANCE ITEM	SAT	UNSAT
SET-UP AND REGULATE INFUSION PRESSURE BAG		
1. Verify the order.		
2. Wash hands.		
3. Ensure new IV bag is used.		
4. Set-up tubing and fill drip chamber completely.		
5. Place IV bag inside pressure bag.		
6. Remove excess air from bag port using needle and syringe.		
7. Ensure no air is in line.		
8. Initiate flow at pressure ordered by physician.		
9. Monitor procedure continuously.		
SET-UP AND MAINTAIN INTERMITTENT INFUSION DEVICE		
1. Verify the order.		
2. Wash hands and don gloves.		
3. Prepare intermittent infusion device without contamination.		
4. Attach device cap to IV cannula.		
5. Flush device with solution per local protocol.		
6. Secure device with tape and dressing.		
7. Maintain patency by flushing (frequency of flushing varies		
depending on type of IV)		-
8. Clean injection port with alcohol.		
9. Slowly inject heparin or saline solution per local protocol.		
10. Document procedure.		-
DISCONTINUE IV INFUSION		
1. Verify the order.		
2. Wash hands and don gloves.		
3. Turn off infusion.		
4. Remove IV site dressing and assess site for complications.		-
5. Place 2x2 over site and remove catheter (ensure catheter is intact)		
6. Apply pressure to site until hemostasis is achieved.		
7. Dress site.		
8. Document procedure.		
INITIATE IO ACCESS		
1. Verify the order.		
2. Wash hands and don gloves.		-
3. Select site and a needle of the proper type and length for infusion.		-
4. Position patient and locate site using anatomic landmarks.		
5. Cleanse area with antiseptic solution.		-
6. Anesthetize area as ordered.		
7. Insert IO needle as directed by type of needle used.		
8. Remove stylet and confirm placement by aspiration of bone marrow.		
9. Irrigate with a rapid 10-mL normal saline flush.		
10. Connect IV tubing and administer fluids under pressure or with IV		
pump for maximum flow rate		

11. Apply sterile dressing and stabilize needed and tubing.	
12. Monitor patency of IO device.	
DISCONTINUE IO INFUSION	
1. Verify the order.	
2. Wash hands and don gloves.	
3. Disconnect IV tubing.	
4. Remove IO needle as directed by the type of needle used.	
5. Apply dressing to the site.	
6. Monitor site for extravasation and/or infiltration; edema; expanding hematoma; dependent edema on the posterior aspect of an extremity.	
7. Assess for pain.	
8. Discard supplies.	
9. Document procedure.	
FINAL RESULT:	

Volume 1

BLOOD ADMINISTRATION

Module 13

SUBJECT AREA: Medical Examinations/Special Procedures

TASK(s): Obtain blood/blood products from blood bank; Set-up blood warmer and pump; Monitor patient for adverse reactions during blood transfusion

CFETP/STS REFERENCE(s): 2.12.8.4.5.1.1; 2.12.8.4.5.1.2; 2.12.8.4.5.1.3.

EQUIPMENT REQUIRED: Gloves, blood administration set appropriate for blood component being administered, normal saline IV fluid, blood warmer and/or pump, blood pressure cuff, stethoscope, thermometer

TRAINING REFERENCE(s): Mosby's Nursing Skills Online, Local procedures as applicable, Blood warmer and pump user guide

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in blood administration.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of blood administration.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

- 3. Use the performance checklist to ensure all steps of the task are accomplished.
- 4. Document task competency upon completion of the evaluation in the trainee's AFTR. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Blood Administration

PERFORMANCE ITEM	SAT	UNSAT
PRE-TRANSFUSION PROCEDURES		
1. Verify physician's order.		
2. Gather supplies/equipment.		
3. Wash hands.		
4. Identify patient/explain procedure.		
5. Ensure all paperwork is complete and informed consent has been		
documented per local protocol.		
6. Assess and record baseline blood pressure, pulse, respirations, and temperature.		
7. Assess for existing back pain, flank pain, and/or hematuria.		
8. Establish vascular access and obtain any ordered blood specimens to include type and crossmatch.		
9. Ensure IV of .09% normal saline has been initiated.		
BLOOD ADMINISTRATION PROCEDURES		
1. Verify physician's order.		
2. Complete appropriate paperwork per local protocols.		
3. Explain procedure to patient.		
4. Obtain blood/blood component from laboratory per local protocols		
5. Verify correct patient, correct blood component, and correct unit with another qualified person per local protocols.		
6. Measure and record baseline vital signs.		
7. Wash hands and don gloves.		
8. Assemble necessary blood administration equipment:		
a. "Y"-type blood administration set		
b. Blood warmer if ordered		
c. Pressure device if ordered		
9. Nurse will hang blood.		

Blood Administration (continued)

PERFORMANCE ITEM	SAT	UNSAT
10. If blood warmer is used:		
a. Turn on warmer per manufacturer's instructions		
b. Open door and insert tubing into tubing insets		
c. Close door and regulate flow rate		
11. Instruct patient to report any unusual signs or symptoms.		
12. Monitor patient closely during first 15 minutes of transfusion.		
13. Measure and record vital signs after 15 minutes.		
14. Continue to monitor patient and measure and record vital signs every		
30 minutes until transfusion is complete.		
15. If adverse signs/symptoms are noted, immediately stop transfusion,		
treat for life-threatening conditions, and notify nurse or physician.		
POST-TRANSFUSION PROCEDURES		
1. Measure and record post-transfusion vital signs.		
2. Stop transfusion and flush blood tubing with normal saline.		
3. Monitor for adverse signs/symptoms and notify nurse or physician.		
4. Obtain any ordered specimens.		
5. Properly dispose of contaminated tubing and blood component bag per local.		
6. Wash hands.		
7. Continue to monitor patient for delayed reactions.		
8. Document procedure.	1	
FINAL RESULT:		

Volume 1

Module 14

TYMPANOMETRY

SUBJECT AREA: Medical Examinations/Special Procedures

TASK(s): Tympanometry

CFETP/STS REFERENCE(s): 2.13.1.7.

EQUIPMENT REQUIRED: Tympanometry meter

TRAINING REFERENCE(s): Tympanometry meter manufacturer's operating instructions.

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in tympanometry.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of tympanometry.

EVALUATION INSTRUCTIONS:

- 1. After the trainee has received instruction, allow sufficient practice on each part of the task.
- 2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
- 3. Use the performance checklist to ensure all steps of the task are accomplished.
- 4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Tympanometry

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order.		
2. Gather supplies/equipment.		
3. Identify patient/explain procedure.		
4. Position patient in position of comfort.		
5. Select proper size ear tip.		
6. Place tip on probe.		
7. Obtain adequate seal.		
8. Attach printout result to chart.		
9. Clean tip per local protocol.		
10. Store equipment properly.		
FINAL RESULT:		

Module 15

Volume 1

MEASURE AND RECORD INTAKE & OUTPUT

SUBJECT AREA: Measure and record patient parameters

TASK(s): Measure and record intake and output (I&O)

CFETP/STS REFERENCE(s): 2.12.6.11.

EQUIPMENT REQUIRED: Bed pan, urinal, bedside commode or urine "hat", daily I&O record, gloves, mask, gown, eye protection, graduated measuring container

TRAINING REFERENCE(s): Mosby's Nursing Skills on-line

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in measuring and recording I&O

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of measuring and recording I&O

EVALUATION INSTRUCTIONS:

- 1. After the trainee has received instruction, allow sufficient practice on each part of the task.
- 2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
- 3. Use the performance checklist to ensure all steps of the task are accomplished.
- 4. Document task competency upon completion of the evaluation in the trainee's Air Force Training Record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

Measure and Record Intake and Output

PERFORMANCE ITEM	SAT	UNSAT
PREPARATION		
1. Verify physician's order.		
2. Gather supplies/equipment.		
3. Identify patient/explain procedure.		
4. Wash hands and don gloves.		
MEASURE AND RECORD INTAKE		
1. Measure and record all fluid intake.		
2. Measure how much fluid has infused from intravenous (IV) bag/bottle.		
3. Remove PPE and wash hands.		
4. Document in appropriate blocks on the I&O record.		
MEASURE AND RECORD OUTPUT		
1. Measure urine drainage and observe color and characteristics of urine.		
2. Measure urine amount at eye level.		
3. Determine output from vomit, stool, and any drainage.		
4. Clean area and equipment.		
5. Remove PPE and wash hands.		
6. Document in appropriate blocks on the I&O record.		
FINAL RESULT:		