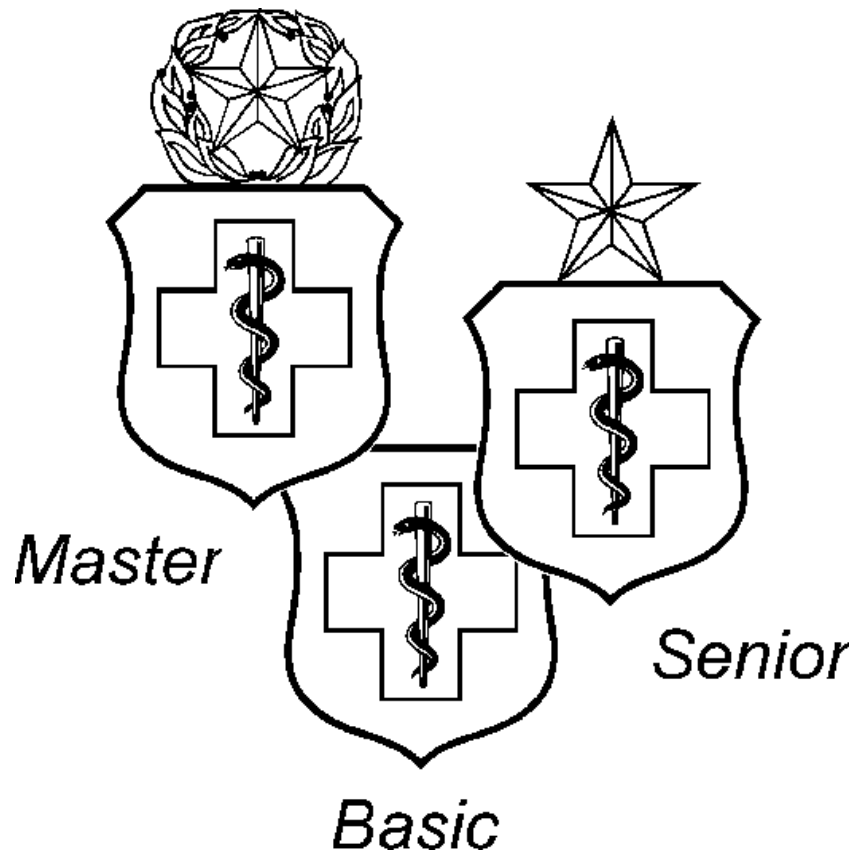


QTP 4N0X1-2
1 July 2014
Certify Current, 29 June 2022

**AEROSPACE MEDICAL SERVICE SPECIALTY
NURSING CARE OF PATIENTS WITH SPECIAL NEEDS**



TOTAL FORCE, TOTAL CARE – EVERYTIME, ANYWHERE

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

QTP 4N0X1-2

AEROSPACE MEDICAL SERVICE SPECIALTY

Volume 2: Nursing Care of Patients with Special Needs

TABLE OF CONTENTS

MODULE	OBJECTIVE	PAGES
1	<i>Assist with central venous line insertion and monitoring</i>	4 – 6
2	<i>Assist with chest tube insertion/monitor water seal drainage</i>	7 – 8
3	<i>Assist with arterial line insertion</i>	9 – 11
4	<i>Obtaining radial arterial blood gas sample percutaneously</i>	12 – 13
5	<i>Administering local anesthetic agents</i>	14 – 17
6	<i>Wound closure</i>	18 – 22
7	<i>Insert/irrigate/remove nasaogastric tube</i>	23 – 26
8	<i>Establish/maintain/remove closed urinary drainage system</i>	27 – 31

Supersedes QTP 4N0X1-2, 1 May 2005.

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 "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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***ASSIST WITH CENTRAL VENOUS LINE
INSERTION AND MONITORING***

SUBJECT AREA: Medical Examinations/Special Procedures--Cardiovascular Procedures

TASK(s): Assist with central venous line insertion

CFETP/STS REFERENCE(s): 2.13.9.5.

TRAINING REFERENCES: *Clinical Nursing Skills: Basic to Advanced Skills; Fundamental Concepts and Skills for Nursing, Mosby's Nursing Skills*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of assisting with central venous line insertion.

EQUIPMENT REQUIRED: 3-0 or 4-0 nylon suture with curved needle, 18-G needle, 1% lidocaine vial without epinephrine, Antiseptic solution, CVC insertion kit, CVC of choice (single-, dual-, or triple-lumen), usually supplied with insertion needle, dilator, syringe, and guide-wire, Dressing supplies, Large package of 4 × 4-inch (10.1 × 10.1-cm) gauze sponges, Large sterile drapes or towels, Moisture-proof under-pad (chux), No. 11 scalpel, Normal saline flushes or 0.9% sodium chloride, 10 to 30 ml, One 25-G 5/8-inch needle; two 22-G 1½-inch needles, PPE (face mask, head covering, eye protection [shield and mask combination may be used], sterile gloves, and sterile gown), Roll of 5-cm (2-in) tape, Syringes: One 10- to 12-ml syringe, two 3- to 5-ml syringes, Suture kit (hemostat, scissors, needle holder), Three-way stopcock

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in assisting with central venous line insertion.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order.		
2. Identify/verify patient using two identifiers.		
3. Gather Supplies/equipment.		
4. Perform hand hygiene.		
5. Assessed patient's vital signs and pulse oximetry.		
6. Assisted the patient into the appropriate position. Assisted with placing a towel posteriorly between the patient's shoulder blades if the selected site was the subclavian vein.		
7. Used a catheter checklist, standardized supply cart or kit, and standardized protocol for insertion.		
<p>8. Complied with Universal Protocol.</p> <div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> a) Used a standardized list to verify that all required items, including informed consent, were available. b) Marked the procedure site when required. c) Performed a time-out to verify correct patient, correct site, and correct procedure. </div>		
9. Performed Hand hygiene.		
10. Applied and maintained pressure in the pressure bag or device at 300 mm Hg.		
11. Placed a moisture-proof pad under the selected site of insertion.		
12. Placed the patient and the bed in the 15 - 25 degree Trendelenburg position, unless contraindicated.		
13. Use/maintain sterile barrier precautions during insertion.		
14. Perform hand hygiene and don sterile gloves, head covering, facemask and eye protection/face shield and assist physician if necessary.		
<p>15. Cleanse the area of insertion. For subclavian insertion, cleanse from the shoulder to the contralateral nipple line and from the neck to the nipple line. For a jugular vein insertion, cleanse from the mid-clavicle to the opposite border of the sternum, and from the ear to a few inches above the nipple line. For a femoral vein insertion, cleansed the entire arm.</p> <ul style="list-style-type: none"> a) If the skin needed cleansing, use soap and water first, then allow to dry b) Prepare the insertion site with one of the following antiseptic solutions <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <ul style="list-style-type: none"> i. Chlorhexidine--based antiseptic: Used a back and forth motion for at least 30 seconds ii. Tincture of iodine or 70% alcohol: Used a back and forth motion for at least 30 seconds iii. Povidone-iodine 1% to 2%: Using a single-use applicator, applied in a circle from the site of insertion moving outward </div> c) Allow site to dry completely, do not touch the cleansed site 		
16. Drape the patient using a large full-body drape.		
17. Monitor patient vital signs; respiratory distress due to possible pneumothorax, tracheal deviation and diminished breath sounds.		
18. Observe cardiac monitor during insertion and inform physician immediately of changes.		

19. Once the catheter is placed, blood return ensured and the lumens flushed, assist as needed with applying a sterile dressing. Use a transparent semipermeable dressing alone or a gauze dressing with tape. Gauze dressing would be recommended if the patient is diaphoretic or if the site is bleeding or oozing.		
20. Reposition the patient into a comfortable position.		
21. Assist with obtaining chest x-ray.		
22. Continue to assess, treat, and reassess pain level.		
23. Discard supplies as appropriate IAW local guidelines.		
24. Remove and dispose of PPE and perform hand hygiene.		
25. Document procedure in patient's medical record.		
FINAL RESULTS:		

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 record.

***ASSIST WITH CHEST TUBE INSERTION
/MONITOR WATER SEAL DRAINAGE***

SUBJECT AREA: Medical Examinations/Special Procedures—Assemble supplies & Equipment/Assist Those Authorized/Licensed to Perform the Task.

TASK(s): Assemble Supplies/Assist With Inserting a Chest Tube with Water Seal Drainage.

CFETP/STS REFERENCE(s): 2.13.1.2.

TRAINING REFERENCES: *Clinical Nursing Skills: Basic to Advanced Skills; Fundamental Concepts and Skills for Nursing, Mosby's Nursing Skills/Kx Current Edition.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of assembling supplies & assisting with inserting a chest tube with water seal drainage.

EQUIPMENT REQUIRED: Antiseptic solution (e.g., chlorhexidine or povidone-iodine) or swab packet(s), PPE (caps, masks, sterile gloves, protective eyewear [goggles], gowns, and drapes), Local anesthetic: 1% lidocaine solution, without epinephrine, Tube thoracotomy insertion tray, Sterile towels, 4 × 4-in (10.1 × 10.1-cm) sterile gauze, Scalpel with No. 10 blade, Two Kelly clamps, curved clamps, Needle holder, Monofilament or silk suture with cutting needle, Sterile basin or medicine cup, Suture scissors, Two hemostats, 10-ml syringe with 20-G, 1½ -inch needle, 5-ml syringe with 25-G, 1-inch needle, Thoracotomy tube(s) (12 to 40 Fr) as appropriate, Closed chest-drainage system, Suction source as appropriate, Suction connector and connecting tubing (usually 6 feet for each tube), ½-inch and 1-inch adhesive tape, Dressing materials, 4 × 4-in (10.1 × 10.1-cm) gauze pads, Slit drain sponges, Tape or commercial securing device.

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in assisting with inserting a chest tube with water seal drainage.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order.		
2. Identify patient using 2 identifiers, explain procedure and assist with obtaining consent if necessary.		
3. Gather supplies. (check with physician for "special request" items)		
4. Perform hand hygiene.		
5. Assess for significant medical history or injury.		
6. Assess baseline cardiopulmonary status for signs and symptoms requiring chest tube insertion.		
7. Assist with Marking the procedure site when required.		
8. Perform a time-out to verify correct patient, correct site, and correct procedure.		
9. Position the patient per the physician's direction.		
10. Place an absorbent pad under the patient on the side of the procedure.		
11. Ensure a clean, flat surface is available for setup of sterile equipment and within physician's reach.		
12. Set up closed chest drainage system per manufacturer's instructions.		
13. Open the chest tube insertion tray using sterile technique.		
14. Assist with preparation of equipment.		
15. Assist the physician with preparation of the insertion site and tube placement.		
16. After tube insertion, connect the chest tube to the closed chest-drainage system, and check for leaks per instruction manual, and apply ordered amount of suction.		
17. Assist with application of an occlusive dressing.		
18. Secure connection sites.		
19. Assist as needed with taping the chest tube to the tube of the drainage system.		
20. Secure the tube to the patient's skin below the dressing.		
21. Assist with obtaining chest x-ray confirm tube placement.		
22. Assess, treat, and reassess pain.		
23. Discard supplies IAW local policy, perform hand hygiene and Document site location size of chest tube, amount of initial output and any complications during procedure, medical record.		
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 record.

ASSIST WITH ARTERIAL LINE INSERTION

SUBJECT AREA: Medical Examinations/Special Procedures--Cardiovascular Procedures.

TASK(s): Assist with arterial line insertion.

CFETP/STS REFERENCE(s): 2.13.9.4.

TRAINING REFERENCES: *Clinical Nursing Skills: Basic to Advanced Skills; Fundamental Concepts and Skills for Nursing, Mosby's Nursing Skills/Kx, Current Edition.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of assisting with arterial line insertion.

EQUIPMENT REQUIRED: 1% lidocaine solution without epinephrine, 1 to 2 ml 1- to 2-in (2.5- to 5-cm) over-the-needle catheter (14- to 20-G for adults) or prepackaged kit with catheter, introducer, and guide-wire, 2-in tape, 3-ml syringe with a 25-G needle, Antiseptic solution, Chlorhexidine-impregnated sponge, Disposable pad, PPE (face-shield mask or eye protection, gown, head covering, gloves, sterile gloves, and gown), Full sterile drape, Non-vented caps for stopcock, Single-pressure transducer system, including the following: flush solution recommended according to organization standard, pressure bag or device, pressure tubing with flush device, transducer, and monitor cable, Sterile 4 × 4-in (10.1 × 10.1-cm) gauze pads, Sterile towels, Standardized supply cart or kit.

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

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician’s order.		
2. Identify patient using 2 identifiers, explain procedure and assist with obtaining consent if necessary.		
3. Gather supplies. (check with physician for “special request” items)		
4. Perform hand hygiene.		
5. Prepare a single-pressure transducer system, IAW manufacturer’s instructions.		
6. Prepare the flush solution, using your organization’s standard for adding heparin to the IV bag, IF heparin was NOT contraindicated.		
<p>7. Position the patient appropriately for the insertion, depending on the site to be used. Pad pressure points.</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <ul style="list-style-type: none"> a. If using the radial artery, place a towel under the back of the wrist to hyperextend the wrist, and tape it in place or have someone hold it b. If using the brachial artery, elevate and hyperextend the patient’s arm. Support the arm with a pillow c. If using the femoral artery, position the patient in a supine position with the head of the bed at a comfortable angle. The patient’s leg should be straight, with the femoral area easily accessible </div>		
8. Perform hand hygiene and don sterile gloves, head covering, gown, and face-shield mask or eye protection.		
9. Use sterile barrier precautions during insertion.		
10. Once the catheter is in position, connect the primed tubing with the Luer-Lok adapter to the arterial catheter.		
11. Connect the pressure cable from the arterial transducer to the bedside monitor.		
12. Set the scale.		
13. Level the arterial air-fluid interface (zeroing stopcock) to the phlebostatic axis if trained or have the practitioner perform this step.		
14. Zero the system connected to the arterial catheter by turning the stopcock off to the patient, opening the stopcock to air, and zeroing the monitoring system.		
15. Close the top stopcock. Place an occlusive sterile cap or a needleless cap on the top port of the stopcock.		
16. Observe the waveform and perform a dynamic response test.		
17. Assist with securing the catheter in place.		
<p>18. Cleans the area of insertion.</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <ul style="list-style-type: none"> a. If the skin needed cleansing, used soap and water first, then allowed to dry. </div>		
19. Apply a sterile dressing to the site.		
20. Document the date, time and initials external dressing.		

21. Apply joint stabilization devices as needed to minimize complications and maintain patency.		
22. Set the alarm parameters according to the patient's current blood pressure and organization policy.		
23. Run a waveform strip and record the patient's baseline arterial pressure.		
24. Obtain a manual blood pressure and compare it to the arterial blood pressure; document/report findings.		
25. Assess the neurovascular and peripheral vascular status.		
26. Document procedure in patient's medical record.		
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 record.

***OBTAINING RADIAL ARTERIAL BLOOD GAS SAMPLE
PERCUTANEOUSLY***

SUBJECT AREA: Medical Examinations/Special Procedures—Assemble supplies & Equipment/Assist those authorized/licensed to perform the task.

TASK(s): Assemble Supplies & Assist With Obtaining a Radial Arterial Blood Gas (ABG) Sample Percutaneously.

CFETP/STS REFERENCE(s): 2.13.1.13.

TRAINING REFERENCES: *Clinical Nursing Skills: Basic to Advanced Skills; Fundamental Concepts and Skills for Nursing, Mosby's Nursing Skills/KX, Current Edition.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of assembling supplies & assisting with acquiring an ABG percutaneously.

EQUIPMENT REQUIRED: 20- to 25-G, 5/8- to 1½-inch-long hypodermic needle with safety device (*Note:* longer needles are required for brachial and femoral artery puncture), 1- to 5-ml pre-heparinized (if available) syringe with a cap or blood- air filter cap, 2 × 2-in (5 × 5-cm) gauze pads, Antiseptic solution, Occlusive plastic bags for transport of sample to laboratory, Ice slurry in a sealed, occlusive plastic bag, if required, One adhesive bandage, Laboratory forms, Specimen label, gloves, Topical anesthetic and application or injection materials, Small rolled towel to support patient's wrist or pillow to support the elbow.

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in assembling supplies and assisting with obtaining a radial arterial blood gas percutaneously.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician’s order.		
2. Identify patient using 2 identifiers, explain procedure, and assist with obtaining consent if necessary.		
3. Gather supplies. (check with physician for “special request” items)		
4. Perform hand hygiene.		
5. Assess for factors that influence ABG measurements.		
6. Review the patient's history for and inquire about signs of adverse responses to previous arterial puncture, including vagal or seizure response.		
<p>7. Assess the radial arteries.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Perform Allen’s Test.</p> <ul style="list-style-type: none"> a. Firmly press radial and ulnar pulses simultaneously at the wrist b. Ask the patient to clench and unclench fist until blanching of the skin is noted c. Release pressure on ulnar artery while maintaining pressure on the radial artery d. Watch for return of skin color within 15 seconds (repeat on other wrist if necessary) </div>		
8. If the patient is receiving oxygen and/or mechanical ventilation, ensure that the current therapy has been underway for at least 20 to 30 minutes before obtaining ABG samples.		
<p>9. Assemble equipment, including specimen labels, syringes, needles, and ultrasound machine, if required, to the patient's side and organize on a clean surface.</p> <div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> a. Beveled 20- to 25-gauge, 5/8- to 1-inch needle b. Specialized 1-, 3-, or 5-ml disposable syringes, prefilled with a laboratory approved anticoagulant, manufactured ABG kits maybe available with all needed supplies </div>		
11. Position the patient appropriately based on the site being utilized.		
12. At the patient's side, prepare or compare laboratory requisitions and computer-generated labels with the patient's identification band by reading at least two identifiers.		
13. Prepare the puncture site by applying an antiseptic and allowing it to dry completely.		
14. Assist the physician/nurse in performing the percutaneous puncture. Elevate and hyperextend the wrist using a small, rolled towel under the wrist for support.		
15. Once sample is obtained, apply and press a sterile 2x2 over the puncture site until hemostasis is established, (could take between 5 and 10 minutes) and cover with an adhesive bandage.		
16. Express air bubbles from the syringe. Remove the needle and dispose of it in a sharps container, seal the tip of the syringe immediately with a cap or blood-air filter.		
17. Gently roll the syringe, annotate collection time on specimen label, and place it in the bag with the ice slurry, keeping the label dry and deliver to lab per local protocol.		
18. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient’s medical record.		

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 record.

Final Result

SUBJECT AREA: Wound Management—Administer Local Anesthetic Agents.

TASK(s): Perform/Administer Topical, Local Infiltration and Digital Block.

CFETP/STS REFERENCE(s): 2.13.3.3.1, 2.13.3.3.2, 2.13.3.3.3.

TRAINING REFERENCES: *Mosby's Nursing Skills/Kx, Current Edition, Fundamental Concepts and Skills for Nursing.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of applying a topical anesthetic and performing a local infiltration and digital block.

EQUIPMENT REQUIRED: Gloves (clean or sterile, depending on local or topical anesthetic prescribed), Antiseptic wipes, Syringes for infiltration: 3, 5, 10 ml, Needles for infiltration: 18, 25, 27 gauges, Local or topical anesthetic as prescribed: 1% lidocaine without epinephrine, 1% lidocaine with epinephrine, 2% lidocaine without epinephrine, 2% lidocaine with epinephrine, 0.25% to 0.5% bupivacaine, LET solution or gel, EMLA (2.5% lidocaine and 2.5% prilocaine), Clear bioocclusive dressing (optional), Elastic bandage (optional)

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in applying a topical anesthetic and performing a local infiltration and digital block.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order.		
2. Identify patient using 2 identifiers, explain procedure.		
3. Gather supplies.		
4. Perform hand hygiene, don gloves, eye protection, mask.		
5. Irrigate, cleanse, debride the wound/site as necessary.		
6. Assess the 7 P's. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. Pain b. Pulses c. Pallor (i.e., color, temperature, and moisture of skin) d. Paralysis (i.e., motor function) e. Paresthesia (i.e., sensory function) f. Pressure (i.e., tenseness, as in compartment syndrome) g. Puffiness (i.e., swelling, edema) </div>		
7. Determine the appropriate type and route of anesthetic agent.		
8. Apply the six rights of medication safety: medication, dose, time, route, patient, documentation.		
9. Assess patient's sensory awareness before administering anesthetic.		
APPLYING A TOPICAL ANESTHETIC AGENT		
EMLA		
1. Apply a thick layer (1 to 2 gm/10 cm ²) of EMLA to intact skin and cover with an occlusive dressing for approximately 30 minutes to 1 hour before procedure.		
2. When more painful procedures, apply 2 gm of EMLA per 10 cm ² for at least 2 hours.		
3. Assess patient's sensory awareness after administering anesthetic.		
LIDOCAINE		
1. Apply lidocaine topically as a liquid, ointment, jelly, or viscous fluid (2% to 10%).		
2. The maximum safe dose for adults is 250 to 300 mg. Do not exceed the recommended dose, because total absorption is rapid and cannot be calculated.		
3. Assess patient's sensory awareness after administering anesthetic.		
BENZOCAINE AND TETRACAINE		
1. Use sprays containing benzocaine and tetracaine (Cetacaine, Hurracaine) for oral procedures.		
2. Spray application should not exceed 2 seconds.		
3. If anesthetizing the nose, mouth, or pharynx, instruct the patient to remain n.p.o. for 1 hour.		

<p>Topical anesthesia of the nose, mouth, or pharynx may create an inadvertent suppression of the gag reflex, which may cause aspiration when combined with difficulty in swallowing.</p>		
<p>4. Assess patient’s sensory awareness after administering anesthetic.</p>		
<p style="text-align: center;">LET (LIDOCAINE 4% Epinephrine 0.1% Tetracaine 0.5%)</p>		
<p>1. Use LET primarily for minor facial and scalp lacerations in lieu of injectable anesthetic, especially in children. Because it contains epinephrine, LET should not be used on mucous membranes, the nose, the pinnae of the ears, the fingers, the toes, or the penis.</p>		
<p>2. Apply LET by saturating sterile gauze and applying it to the wound with firm pressure for 15 to 20 minutes. LET may also be applied by dripping it into a wound with a syringe or by applying it to a wound with sterile cotton swabs. In gel form, LET is spread directly into the wound. A gel or solution-soaked gauze may be held in place with a clear bio-occlusive dressing or elastic bandage.</p>		
<p>3. Ensure LET does not run or drip into the eyes, nasal passages, or mouth. Observe the patient carefully during and after administration.</p>		
<p>4. If the first dose of LET is not effective, infiltrate the laceration with a local anesthetic; do not repeat a dose of LET.</p>		
<p>5. Assess patient’s sensory awareness after administering anesthetic.</p>		
<p style="text-align: center;">PERFORM LOCAL INFILTRATION</p>		
<p>1. Use appropriate techniques to decrease the patient’s pain during wound infiltration. Options include but are not limited to the following. ALWAYS follow the physician’s orders.</p> <div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> a. Use buffered lidocaine, which may reduce pain with injection. Lidocaine is buffered by adding 1 ml of sodium bicarbonate (8.4%) to every 10 ml of lidocaine solution. It remains effective after mixing for 1 week. b. Using a longer-acting local anesthetic (e.g., bupivacaine), which may prevent the wound from having to be re-infiltrated. Lidocaine has a more rapid onset, but it has a short duration of action. If prolonged post anesthesia pain is anticipated, bupivacaine is useful. c. Use appropriate size needle for infiltration. d. Slowly administer anesthetic intradermally through the inside margins of wound edges and not through the skin. As the needle passes through the dermis, continue injecting. e. Reentering through areas already infiltrated with anesthetic to lessen the pain of infiltration when additional needle entry is needed, multiple injections may be necessary to ensure maximum anesthetic effect. </div>		
<p>2. Assess patient’s sensory awareness after administering anesthetic.</p>		
<p>3. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient’s medical record.</p>		

PERFORM DIGITAL BLOCK		
1. Assess CSM distal to the wound before and after administering anesthetic. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>a. Assess vascular status by noting the capillary refill response at the distal end of the affected digit.</p> <p>b. Evaluate sensation, using closed hemostats; sharp vs pressure.</p> <p>c. Assess mobility by testing grip, opposition of thumb and finger.</p> </div>		
2. Determine anesthetic of choice. The amount required varies with each patient. For adults, an effective block can be accomplished with 3 to 4 ml in the digits, 4 to 5 ml in the thumb, and 4 to 6 ml in the great toe.		
3. Position the needle adjacent to the nerve. The patient may complain of tingling or feeling a shock if the nerve is touched. Reposition the needle to avoid nerve injury.		
4. Attempt to aspirate to avoid injecting into blood vessels that are adjacent to digital nerves.		
5. Insert the needle down to the periosteum and infiltrate close to the bone.		
6. Administer separate injections on either side of the digit as indicated.		
7. After infiltration of local anesthetic, gently massage the tissue.		
8. Assess patient's sensory awareness after administering anesthetic.		
9. Discard supplies IAW local policy, perform hand hygiene and document the procedure in the patient's medical record.		
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 record.

WOUND CLOSURE

SUBJECT AREA: Wound Management—Wound Closure and Care.

TASK(s): Perform Stapling & Suturing, Remove Sutures & Staples, Apply Surgical Glue.

CFETP/STS REFERENCE(s): 2.13.3.4.2, 2.13.3.4.3, 2.13.3.4.4, 2.13.3.4.5.

TRAINING REFERENCES: *Mosby's Nursing Skills/Kx, Current Edition, Fundamental Concepts and Skills for Nursing*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of stapling & suturing, removing staples & sutures, and applying surgical glue.

EQUIPMENT REQUIRED: 8 to 10 4 × 4-inch (10.1 × 10.1-cm) gauze pads, 30 or 60-ml syringe and 18-G needle, Chlorhexidine solution and sterile normal saline, Fenestrated drape, Gloves, Electric clippers (only if hair removal is necessary), Local anesthetic, Sterile drape, Sterile gloves, mask, eye protection.

For suturing: 6-inch needle holder, Curved dissecting scissors, Suture material and needle, Suture scissors, Tissue forceps, Two mosquito hemostats—one curved, one straight

For other wound closures: Staple gun, Steri-Strips, Skin adhesive

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in performing stapling & suturing, removing staples & sutures and applying surgical glue.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

Vol. 2 Module 6	<i>Wound Closure</i>	
PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order.		
2. Identify patient using 2 identifiers, explain procedure.		
3. Gather supplies.		
4. Perform hand hygiene, don sterile gloves, mask and eye protection		
SUTURING		
1. Anesthetize the site. --Consider applying LET topically. Use a 27- to 30-G needle to infiltrate the area with a local anesthetic with or without epinephrine. Immobilize the site, if necessary, to aid in decreasing pain.		
2. Thoroughly examine the wound for foreign bodies.		
3. Irrigate, Cleanse and debride the wound as necessary. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>a. Mechanical cleanse: Wipe, brush, and irrigate with copious amounts of high-pressure saline using a 30 or 60-ml syringe with a 18-G needle. Properly clean and irrigate with high pressure. Use caution to avoid damaging tissue.</p> <p>b. Chemical cleanse: Use an antiseptic solution such as chlorhexidine. Apply in concentric circles, moving toward the periphery. Use a cleansing solution that is nontoxic to tissues.</p> </div>		
4. Remove hair if necessary.		
5. Perform hand hygiene and don sterile gloves.		
6. Apply Sterile drapes over and under the area as necessary.		
7. Select needle and suture material according to the type of wound/physician's order.		
8. Arm the needle between the jaws of the needle holder.		
9. Position the free end of the suture away from self.		
10. Pass the needle through the tissue until the tip of the needle is visible.		
11. Using tissue forceps to grasp the tip of the needle, unclamp the needle holder jaws.		
12. Re-grasp the needle between the needle holder jaws and pull the desired length of suture through the wound.		

<p>13. Tie the suture knot, ensuring that the edges are slightly everted. Secure the precise approximation of the wound edges without strangulating the tissue; tie the suture snugly but gently.</p> <p>a. Form a suture loop by wrapping the fixed suture end over and around the needle holder twice. Keep the length of free suture end less than 2 cm.</p> <p>b. Pass the free end of the suture through the loop to create a throw.</p> <p>c. Advance the throw to the wound surface by applying tension perpendicular to the wound.</p> <p>d. Repeat four or five times. With each throw, ensure that the hands reverse positions and apply equal and opposing tension to the suture ends in the same plane.</p>		
<p>14. Cut the suture by holding the scissor blades perpendicular to the suture, keeping the knot in view between the blades, allowing a 3-mm tail to remain.</p>		
<p>15. Position the knot on one side of the wound, keeping all knots on the same side.</p>		
<p>16. Repeat steps for suturing until the wound is appropriately closed.</p>		
<p>17. Assess, treat, and reassess pain.</p>		
<p>18. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient's medical record.</p>		
PERFORM STAPLING		
<p>1. Perform steps 1-9 of Suturing procedures.</p>		
<p>2. Use fingers or forceps to approximate the edges.</p>		
<p>3. Apply firm pressure with a stapler and dispense staples as directed.</p>		
<p>4. Place staples 0.5 to 1 cm apart.</p>		
<p>5. Have an assistant help evert the wound edges while using the stapler.</p>		
<p>6. Apply dressing as needed</p>		
<p>7. Assess, treat and reassess pain</p>		
<p>8. Discard supplies IAW local policy, perform hand hygiene and document the procedure in the patient's medical record.</p>		
REMOVE SUTURES		
<p>1. Assess the integrity of the wound edges; looking at color, drainage, and inflammation.</p>		
<p>2. Assess, treat, and re-assess pain level.</p>		
<p>3. Place sterile gauze a few inches from the suture line. Grasp the scissors in the dominant hand and the forceps in the non-dominant hand.</p>		
<p>4. Grasp a knot of suture with the forceps, and gently pull it up while slipping the tip of the scissors under the suture near the skin. Avoid pinching the skin around the wound when lifting</p>		

the suture.		
5. Snip the suture as close to the skin as possible at the end distal to the knot. Avoid cutting the skin around the wound when snipping the suture.		
6. Grasp the knotted end with the forceps and pull the suture through one continuous smooth action. Place the removed suture on the gauze, continuing the process for remaining sutures.		
7. Inspect the incision site making sure all sutures have been removed. Gently wipe the incision line with a sterile antiseptic swab to remove debris and clean the wound.		
8. If a separation is apparent, consult with physician, apply wound closure strips if necessary.		
9. Apply a light dressing as needed.		
10. Assess, treat, and reassess pain.		
11. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient's medical record.		
REMOVE STAPLES		
1. Follow steps 1-6 from Suture removal procedure.		
2. Place lower tip of staple extractor under staple and close the handles.		
3. As soon as both ends of the staple are visible, move the staple away from the skin surface and drop staple in sharps container.		
4. Repeat process until all staples are removed.		
5. Inspect the incision site to make sure all intended staples or sutures have been removed and identify any trouble areas. Gently wipe the incision line with a sterile antiseptic swab to remove debris and clean the wound.		
6. If a separation is apparent, consult with physician, apply wound closure strips if necessary,		
7. Apply a light dressing as needed.		
8. Assess, treat, and reassess pain.		
9. Discard supplies IAW local policy, perform hand hygiene and document the procedure in the patient's medical record.		
APPLY SURGICAL GLUE		
1. Use fingers or forceps to approximate the wound edges.		
2. Open the product, saturate the porous applicator tip, and paint the edges of the wound using short strokes in a multi-layering process. Obtain an even, controlled flow to minimize drips and prevent complications. Do not place the adhesive in the wound.		
3. Apply the skin adhesive to dry, well-opposed wound edges.		

4. Apply multiple layers (follow manufacturer's instructions).		
5. Hold the edges together for 30 to 60 seconds. Apply dressing as needed.		
6. Assess, treat, and reassess pain.		
7. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient's medical record.		
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 record.

INSERT, IRRIGATE & REMOVE A NASOGASTRIC TUBE

SUBJECT AREA: Medical Examinations--Nasogastric Tube.

TASK(s): Insert, Irrigate and Remove a Nasogastric Tube.

CFETP/STS REFERENCE(s): 2.13.7.1, 2.13.7.2, 2.13.7.3.

TRAINING REFERENCES: *Mosby's Nursing Skills/Kx, Current Edition, Fundamental Concepts and Skills for Nursing, Clinical Nursing Skills: Basic to Advanced Skills.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of inserting, irrigating and removing a nasogastric tube.

EQUIPMENT REQUIRED: Bulb syringe or catheter-tipped syringe, Clamp, Suction machine with pressure gauge (if using wall suction), Emesis basin, Facial tissues, Pen light, Glass of water with straw, Gloves, Tape 1 inch wide or commercial fixation device, Lidocaine gel or spray to numb naris if deemed necessary--per physician order, NG tube, pH test strips, Sterile water for irrigation or saline or clean, Suction equipment including oral suction device, Tincture of benzoin or skin preparation agent (optional), Tongue blade, Towel, Transparent dressing (optional), Water-soluble lubricating jelly, Waterproof absorbent pad (chux).

REMARKS/NOTES: Review steps of the process one-on-one with the medical technician and/or nursing personnel skilled and verified in inserting, irrigating and removing a nasogastric tube.

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
INSERT NASOGASTRIC (NG) TUBE		
1. Verify physician's order.		
2. Identify patient using 2 identifiers, and explain procedure.		
3. Gather supplies.		
4. Perform hand hygiene and don gloves.		
5. Place the patient in a high Fowler's position as tolerated. Place pillows behind head and shoulders. Raised the bed to a horizontal level that was comfortable for the tech/nurse.		
6. Cleaned the bridge of the patient's nose with soap and water or an alcohol swab.		
7. Instruct the patient to relax and breathe normally while occluding one nostril. Select the nostril with greater airflow, if bilateral airflow was equal, asked for patient preference.		
8. Estimate the length of tube to be inserted. Measure the distance from the tip of the nose to the earlobe, then to the xiphoid process and mark with a piece of tape.		
9. Lubricate 7.5 to 10 cm (3 to 4 inches) of the end of the tube with water-soluble lubricating gel.		
10. Alert the patient when the procedure is about to begin.		
11. Instruct the patient to extend the neck back against a pillow; insert the NG tube gently through the naris at an angle parallel to the floor of the nasal canal, not upright.		
12. Continue to pass the tube along the floor of the nasal passage, aiming down toward the patient's ear. If resistance is felt, apply gentle downward pressure to advance the tube.		
13. If resistance continues, try to rotate and then advanced the tube. If resistance persists, withdraw the tube, allow the patient to rest, lubricate the tube again, and insert the tube into the other naris. Do not force past resistance.		
<p>14. Continue inserting the tube until it is just past the nasopharynx by gently rotating the tube toward the opposite naris.</p> <div style="border: 1px solid black; padding: 5px;"> <p>a. Once past the nasopharynx, stop tube advancement, (unless the patient prefers to avoid delay) and allow the patient to relax, provide tissues if necessary.</p> <p>b. Explain to the patient that swallowing may facilitate tube advancement. If drinking water is not contraindicated, and the patient prefers to sip water to facilitate insertion, had water available for the next step.</p> </div>		
15. Instruct the patient to flex his or her head forward and take a small sip of water (if safe and the patient is able to cooperate), and swallow. Advanced the tube with swallowing. If the patient is not allowed fluids, instruct the patient to dry swallow and advanced the tube during the swallowing motion. If the patient is unable to cooperate with swallowing motions, watch for signs (e.g., cough or other discomfort) that the tube is entering the trachea.		
16. If the patient begins to cough, gag, or choke, stop advancement and withdraw the tube to the nasopharyngeal area. Instruct the patient to breathe easily and take sips of water if able to swallow. If vomiting occurs, assist the patient to clear his or her airway, suctioning as needed. If gagging and coughing continue or the patient complain that the tube feels as though it is coiling in the throat, check the back of the oropharynx using a pen light and tongue blade. Withdraw any coiled tube until the tip is in the oropharynx again and reinserted as the patient swallowed.		

17. After the patient relaxes, continue to advance the tube while the patient swallows. Advancing until reaching the tape on the tube signifying that the tube is inserted the desired distance. Anchor the tube to the patient's cheek with tape until tube placement was verified.		
18. Verify NG Tube Placement by instilling 20 to 30 ml of air into the tube with a large syringe and auscultating the upper left abdominal quadrant for sound of air bolus, and/or attaching a syringe to the end of the tube and aspirating gastric contents observing color, volume and checking with pH indicator strips. A chest x-ray should be considered prior to instilling fluid or medications.		
19. Don new gloves if needed and secure the NG tube to the patient.		
20. Ensure the tube is capped or clamped or connected to drainage.		
21. Secure tube to patient's face using one of the following methods <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <ul style="list-style-type: none"> a. Tape the tube to the patient's nose in a way that avoids placing pressure on the internal or external aspect of the naris. Apply prepared tape to the nose, leaving split ends free. Be sure the tape over the nose is secure. Carefully wrap two split ends of tape around the tube. NG tubes can be inadvertently removed; ensure that the tube is well secured and as innocuous as possible. b. Apply a tube securement device using adhesive patch. c. Small, soft NG tubes may be fastened to the cheek with transparent dressings from the tube exit site and across the cheek instead of tape to naris if adequate securement can be obtained in this manner. If this is not possible, try securing the tube to the cheek after securing to the naris. Apply tincture of benzoin or skin preparation agent to the cheek and wait until it is dry and tacky before placing a securement device to help keep the dressing in place. </div>		
22. Fasten the end of the NG tube to the patient's neck with tape, ensuring adequate head rotation is possible.		
25. Connect tubing to drainage bag or suction per the physician's order.		
26. Elevate the head of the bed 30 degrees (unless contraindicated)		
27. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient's medical record.		
IRRIGATING THE NG TUBE		
1. Verify physician's order.		
2. Identify patient using 2 identifiers, and explain procedure.		
3. Gather supplies.		
4. Perform hand hygiene and don gloves.		
5. Place a waterproof absorbent pad (chux) under the NG tube and tubing connection.		
6. Verify tube placement, using same techniques for inserting NG tube.		
7. Draw up 30 ml of normal saline or sterile water (or amount and type of irrigant prescribed by the physician) into a 60 ml catheter-tip syringe.		
6. Clamp the NG tube and disconnect it from the connecting tubing, lay the connecting tubing on the chux.		

7. Insert the tip of the syringe into the end of the NG tube and remove the clamp. Hold the syringe with the tip securely fitted into the NG and pointing downward. Inject fluid slowly and evenly. Do not force the solution.		
8. If resistance is met, try turning the patient on to his/her left side and reattempt irrigation, if resistance continues report findings to the physician.		
9. After instilling fluid, immediately aspirate, or pull back slowly on the syringe to withdraw the fluid. If the amount aspirated is greater than the amount instilled, record the difference as output. If the amount aspirated is less than the amount instilled, record the difference as intake.		
10. Fill a 10 ml syringe with air and flush the blue pigtail.		
11. Reconnect the NG tube to drainage or suction. Repeat as needed.		
12. Discard supplies IAW local policy, perform hand hygiene, and document the procedure in the patient's medical record.		
DISCONTINUING THE NG TUBE		
1. Verify physician's order.		
2. Identify patient using 2 identifiers, and explain procedure.		
3. Gather supplies.		
4. Perform hand hygiene and don gloves.		
5. Turn off suction and disconnect the NG from the connecting tube.		
6. Instill 20 ml of air into the lumen of the NG tube and remove any tape or securement device.		
7. Give the patient tissues and place a chux on the patient's chest.		
8. Instruct the patient to take and hold their breath.		
9. Clamp or kink the tubing securely and then pull the tube out steadily and smoothly into a chux held in the non-dominant hand as the patient holds his/her breath.		
10. After tube is out, instruct patient to relax and resume breathing.		
11. Inspect the tube to ensure it is intact.		
12. Discard the tube and drainage equipment IAW local policy.		
13. Position the patient in a position of comfort, clean the naris and provide mouth care.		
14. Discard supplies IAW local policy, perform hand hygiene and document the procedure in the patient's medical record.		
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 record.

***ESTABLISH/MAINTAIN/REMOVE CLOSED URINARY DRAINAGE
SYSTEM***

SUBJECT AREA: Medical Examinations/Special Procedures—Apply/Insert and Remove.

TASK(s): Establish/Maintain/Remove Closed Urinary Drainage System, Pediatric Urine Collection bag.

CFETP/STS REFERENCE(s): 2.13.8.2, 2.13.8.4, 2.13.8.5.

TRAINING REFERENCES: *Mosby's Nursing Skills/Kx, Current Edition, Fundamental Concepts and Skills for Nursing.*

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of inserting and removing a Foley catheter, establish, maintain and remove a closed urinary drainage system and apply and remove a pediatric urine collection bag.

EQUIPMENT REQUIRED: Additional light source as needed (e.g., flashlight or procedure light), Bath blanket, Bladder scanner (if available), Catheter kit containing the following sterile items: Antiseptic cleansing agent (e.g., povidone-iodine), Appropriate specimen container, Cotton balls or antiseptic swabs, Forceps or tweezers, Gloves (extra pair optional), Lubricant, Prefilled syringe with sterile water (to inflate balloon of indwelling catheter only), Proper-size urinary catheter with preassembled drainage tubing and collection bag (indwelling catheter only), Urine collection system, Waterproof drapes (one fenestrated), Clean gloves, warm water, soap, washcloth, and towel for perineal care, Multipurpose securement device, Waterproof absorbent pad (chux).

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

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 record. Initial evaluation should be documented in the CFETP; all recurring evaluations should be documented on the 1098.

PERFORMANCE ITEM	SAT	UNSAT
Establish Closed Urinary Drainage System		
1. Verify physician's order.		
2. Identify patient using 2 identifiers, and explain procedure		
3. Gather supplies.		
4. Perform hand hygiene and don gloves.		
5. Raise the bed to an appropriate working height. Facing the patient, stand on the left side of the bed if right-handed and on the right side if left-handed. If side rails are in use, raise the side rail on the opposite side of the bed and lower the side rail on the working side.		
6. Assist the patient to a supine position.		
a. Males: Supine with legs extended. b. Females: Supine with knees bent and apart		
7. Place a waterproof pad under the patient.		
8. Drape the patient only exposing the genitalia.		
9. Clean the perineal area with soap and water as needed and dry.		
10. Remove gloves and perform hand hygiene.		
11. Open the catheter kit; place inner wrapped box on easily accessible, clean bed side table or set it between the patient's legs.		
12. Open the sterile wrap covering the box containing catheter supplies. Use sterile technique, and fold back each flap of the sterile package one at a time, with the last flap opened toward the nurse/tech.		
13. Don Sterile gloves.		
14. Apply sterile fenestrated drape over patient's genitalia creating a sterile field.		
15. Prepare items for catheter insertion.		
a. Checked for a secure connection at the tubing and catheter connection site. b. test catheter balloon by injecting fluid from prefilled sterile water syringe into the balloon port (follow manufacturer's instructions)		
16. Loosen the lid on the sterile specimen container if a urine specimen was required.		
17. Open the package of sterile antiseptic solution and pour the solution over sterile cotton balls. If the kit contained sterile antiseptic swabs instead of solution, opened the package with "stick" ends up for access.		
18. Open the packet containing lubricant, and squeeze the lubricant onto the sterile field. If the lubricant is provided in a prefilled syringe, remove the protective cap and spread lubricant into the sterile tray.		
19. Place the catheter tip into the lubricant.		
20. Using non dominant hand gently spread the urethral meatus so the opening is visible.		

21. Using dominant hand cleanse urethral meatus.		
22. Use sterile dominant hand to pick up the catheter, hold the distal end of the catheter loosely coiled in the palm of the dominant hand.		
23. Insert the catheter (<i>Do Not force the catheter if resistance is met</i>) <div style="border: 1px solid black; padding: 5px;"> <p>a. Males: Retract foreskin if necessary, raise penis to a 90 degree angle, and insert catheter approximately 6-10 inches until urine return is noted.</p> <p>b. Females: Insert catheter approximately 2-3 inches until urine flow is noted.</p> <p>Note: Remove no more the 750-1000 ml of urine at any one time</p> </div>		
24. Inflate catheter balloon with the provided prefilled syringe with sterile water per the manufacturer's instructions. Gently pull back on the catheter until resistance is met.		
25. Secure the tubing. <div style="border: 1px solid black; padding: 5px;"> <p>a. Males: Anchor catheter to lower abdomen and tubing to the thigh.</p> <p>b. Females: Anchor catheter and tubing to the thigh.</p> <p><i>In both cases ensure slack in the catheter so movement does not create tension on the catheter.</i></p> </div>		
26. Place the drainage bag below the level of the bladder. Do not place the bag on the side rails of the bed, and ensure there were no dependent loops in the tubing.		
27. Obtained a sterile specimen as needed from the most proximal port using aseptic technique.		
28. Discard supplies, perform hand hygiene		
39. Observe characteristics and amount of urine in the drainage system and document in the patients chart.		
Maintenance of closed Urinary Drainage System		
1. Perform hand hygiene.		
2. Identify patient using 2 identifiers, and explain procedure.		
3. Gather supplies needed for routine perineal care.		
4. Perform hand hygiene and don gloves.		
5. Raise bed to appropriate working height, lower side rails on working side.		
6. Inspect urine for color, clarity and amount.		
7. Ensure tubing is intact and is not kinked.		
6. Position the patient and cover with a blanket only exposing the perineal area and place a water proof pad under the patient. <div style="border: 1px solid black; padding: 5px;"> <p>a. Male: Supine position</p> <p>b. Female: Dorsal Recumbent position</p> </div>		
7. Remove Catheter anchor device.		
8. Expose urethral meatus with non-dominant hand. <div style="border: 1px solid black; padding: 5px;"> <p>a. Males: Retract foreskin if patient is not circumcised. Hold penis at shaft just below glans, maintaining hand position throughout procedure.</p> <p>b. Female: Gently retract labia to fully expose urethral meatus and catheter insertion site, maintain position of hand throughout procedure.</p> </div>		
9. Assess the perineal area for redness, swelling and discharge, as well as assessing the patient's		

pain level.		
10. Provide routine perineal care with soap and water.		
<ul style="list-style-type: none"> a. Stabilize catheter using non-dominant hand. Use clean washcloth or prepackaged, approved wipes to clean the area around and where the catheter comes in contact with the perineum or meatus. b. Remove all traces of soap and pat dry with a clean towel. For males, reduce or reposition the foreskin after care. c. Replace, as necessary, the anchor device. d. Avoid pulling on or placing tension on the catheter. 		
11. Discard supplies, remove gloves, and perform hand hygiene.		
12. Lower the level of the bed, and position side rails accordingly.		
13. Document procedure in patient's medical record.		
Remove Closed Urinary Drainage System		
1. Verify physician's order.		
2. Identify correct patient using 2 identifiers and explain the procedure.		
3. Perform hand hygiene and don gloves.		
4. Raise the bed to an appropriate working height and position the patient.		
5. Place a waterproof pad (chux) under the patient.		
6. Obtain a sample if needed.		
7. Remove the catheter anchoring device.		
8. Assess for discharge or redness around the urethral meatus.		
9. Insert the hub of a syringe into the catheter's inflation valve. Allow sterile water from the balloon to return to the syringe by gravity until the plunger stops moving and the amount originally instilled is removed. Set the syringe aside for later discard.		
10. Pull out the catheter slowly and gently while wrapping the now-contaminated catheter in a waterproof pad. The catheter should slide out very easily. Do not use force. If any resistance is met, use the syringe again to remove any remaining fluid in the inflation port, and notify the practitioner. Notify the practitioner if unable to remove the catheter.		
11. Inspect the condition of the urethra and surrounding tissue, and ask the patient if he or she is comfortable.		
12. Reposition the patient as necessary. Cleanse the perineum. Lower the level of the bed, and position side rails accordingly.		
13. Unhook the collection bag and drainage tubing from the bed. Empty, measure, and record the urine present in the drainage bag. Send the urine specimen to the lab, if applicable.		
14. Discard supplies, remove gloves, and perform hand hygiene.		
15. Document the procedure in the patient's record.		

Apply and Remove a Pediatric Urine Collection Bag

1. Verify physician's order.		
2. Identify correct patient using 2 identifiers and explain the procedure.		
3. Perform hand hygiene and don gloves.		
4. Clean the perineal area with soap and water if needed.		
5. Using antiseptic cleansing agent clean the genital area and allow to dry.		
6. Remove adhesive backing from the collection bag.		
7. Apply the collection bag with opening positioned to collect urine. <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>a. Female: adhere bag to perineal area first and secure adhesive tabs in an upward motion to symphysis, ensuring the bag is positioned to catch urine.</p> <p>b. Males: place penis inside of bag and secure adhesive tabs ensuring the bag is in position to catch urine.</p> </div>		
8. Straighten the bag.		
9. Apply a diaper, comfort the child and consider giving clear liquids to promote urination.		
10. Elevate the head of bed or place in an infant seat if appropriate.		
11. Check the patient/collection bag every 5-10 minutes to see if the patient has voided.		
12. To remove the bag, gently pull to release the adhesive from the skin, then cleanse the area to remove residual adhesive from the skin and a clean diaper.		
13. Pour the collected urine into specimen collection cup, correctly label and take the specimen to the lab for testing.		
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 record.