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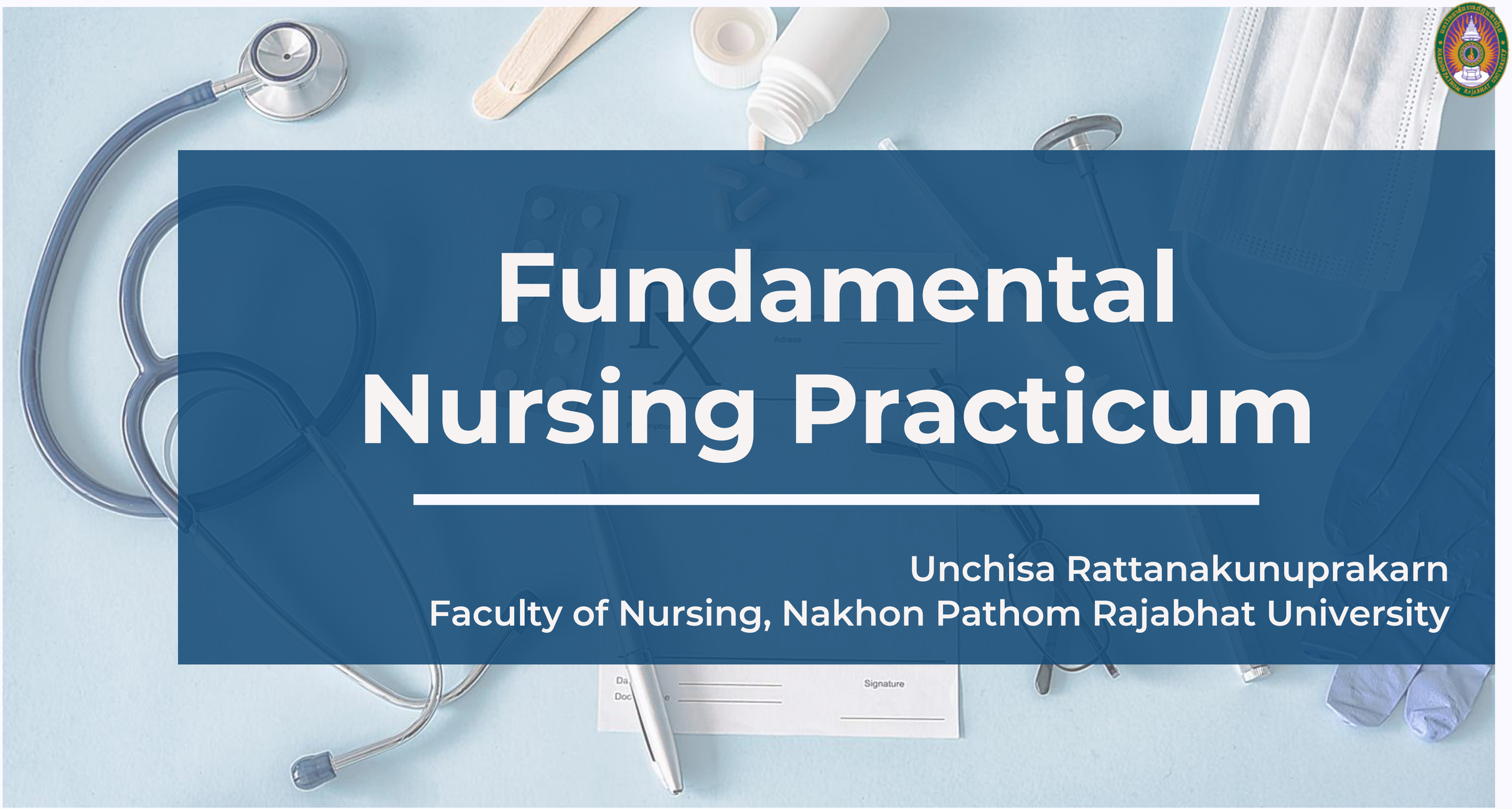

Fundamental Nursing Practicum

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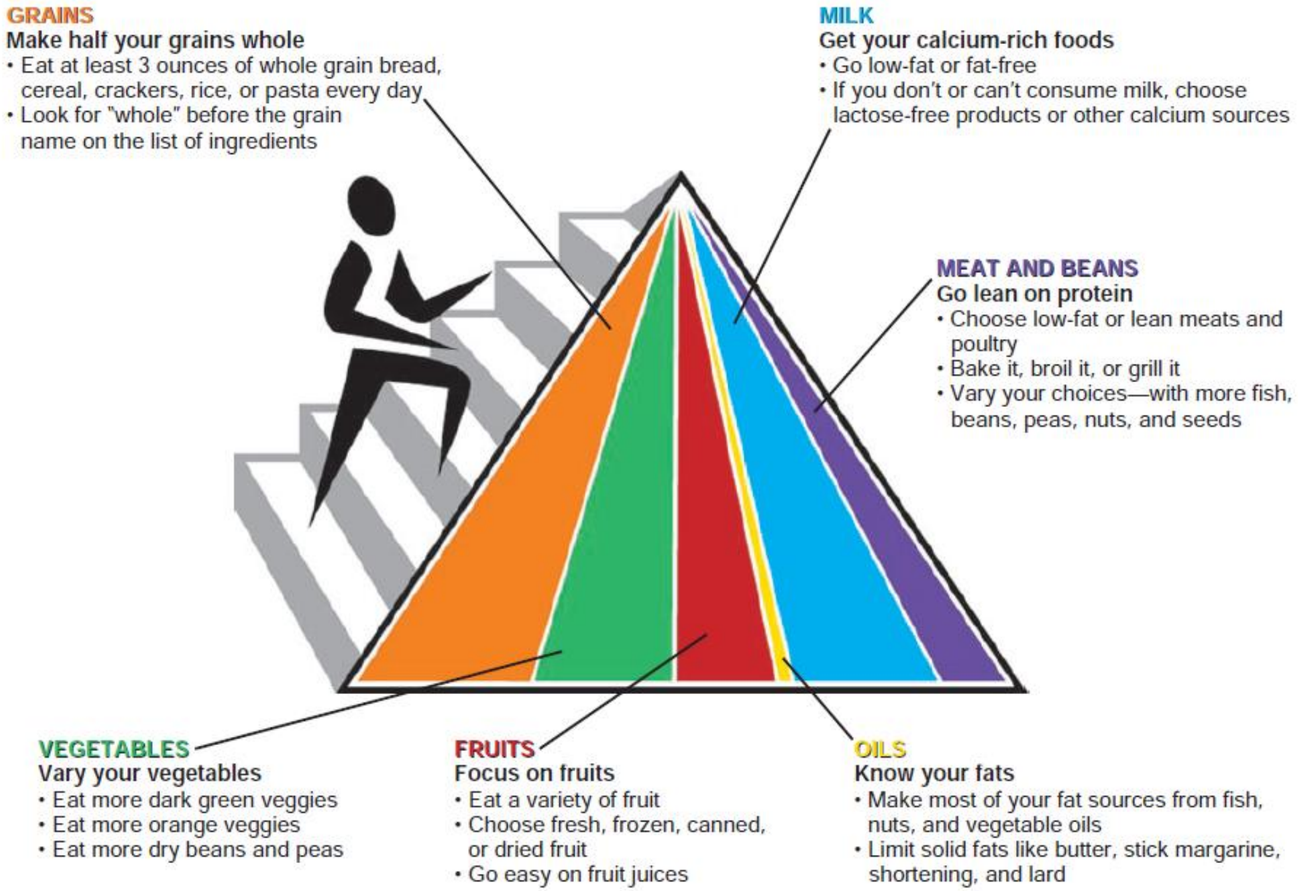
CHAPTER 7

BASIC NURSING PROCEDURES

Enteral tube feeding

Enteral tube feeding



THE FOOD GUIDE PYRAMID

(Sue & Patricia, 2011; Ernstmeyer & Christma, 2021)

Objectives

Identify common nursing interventions for clients experiencing nutritional deficits.

Enteral tube feeding

Inserting a Nasointestinal Tube

EQUIPMENT

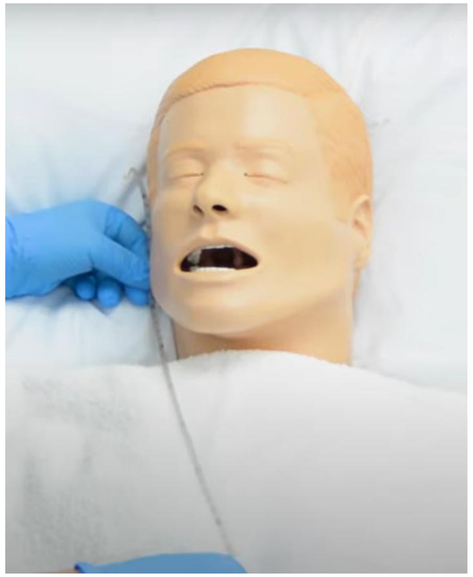
- Nonsterile gloves
- Cup of ice or water and straw
- Towel and tissues
- Hypoallergenic tape, rubber band
- 20-mL syringe or Asepto syringe
- Water-soluble lubricant

From Mosby's Nursing video skill-intermediate. https://www.ndsu.edu/pubweb/bismarcknursing/intermediate/skill/M006.html

Enteral tube feeding

Steps for Inserting a Nasointestinal Tube

1. Review client's medical record.
2. Gather equipment. Wash hands.
3. Place client in Fowler's position, at least a 45 degree angle or higher
4. Examine nostrils and assess as client breathes through each nostril.
5. Lubricate first 4 inches of tube with water soluble lubricant.
6. Insert tube
7. Secure tube with tape



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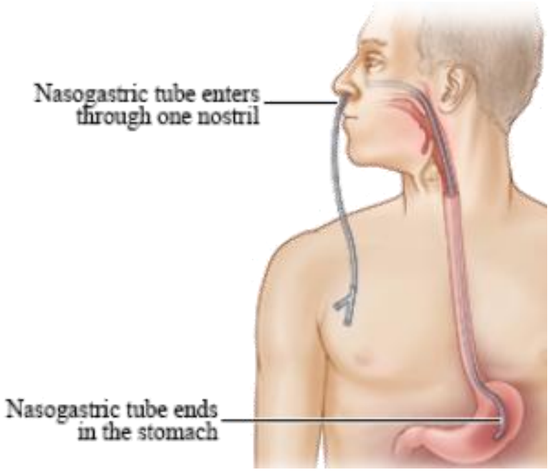
Enteral tube feeding

Steps for Inserting a Nasointestinal Tube

8. Gastric decompression:

• Remove syringe from free end of tube, and connect tube to suction tubing; set machine on type of suction and pressure as prescribed.

9. Provide oral hygiene and cleanse nares with a tissue.



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Enteral tube feeding

Administering Enteral Tube Feedings

EQUIPMENT

- Asepto syringe or 20- to 50-mL syringe
- Emesis basin
- Clean towel
- Disposable gavage bag and tubing
- Formula
- Water to follow feeding
- Nonsterile gloves

From Mosby's Nursing video skill-intermediate.
https://www.ndsu.edu/pubweb/bismarcknursing/intermediate/skill/M006.html

Enteral tube feeding

Steps for Administering Enteral Tube Feedings

1. Identify client and review medical record for formula, amount, and time.
2. Wash hands/hand hygiene.
3. Place client in high Fowler's position.
4. Observe for abdominal distention; auscultate for bowel sounds.
5. Check feeding tube
6. Administer tube feeding.

Wound dressing

Wound dressing

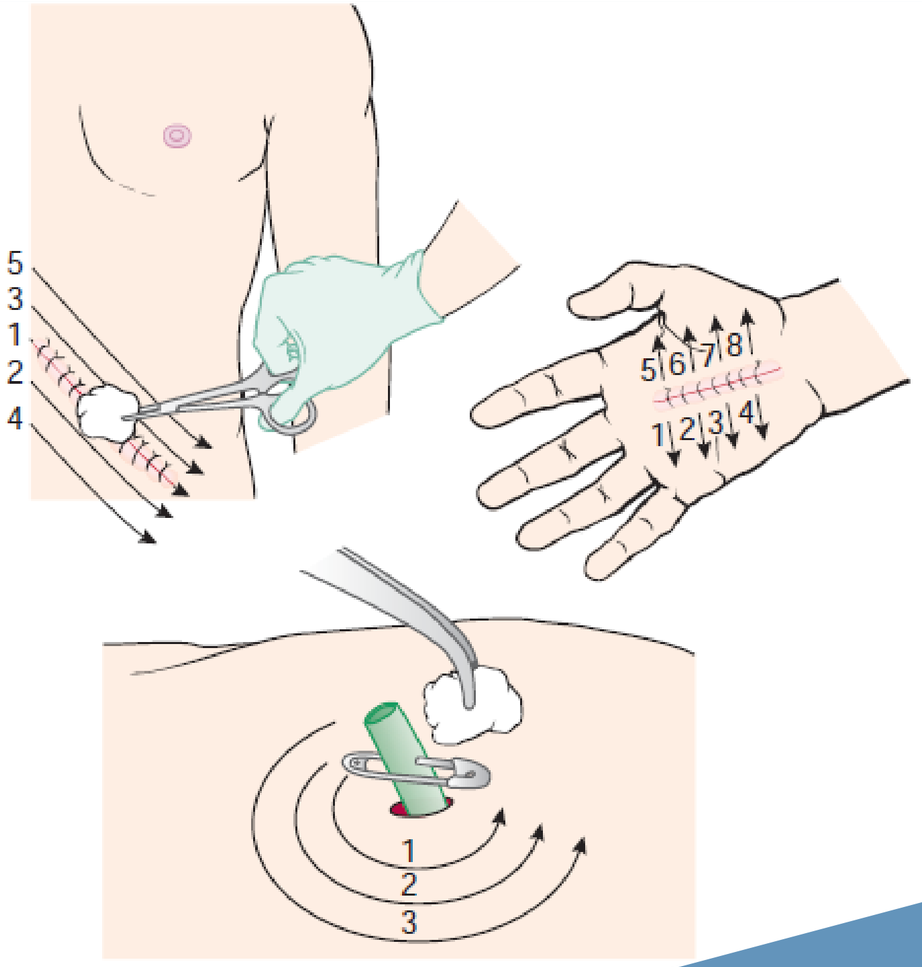
Objectives

1. Describe the principles of wound assessment and care.
2. Outline dressing products used to treat wounds.

Dressing the Wound

The three purposes of a wound dressing are to:

1. Keep the wound moist and therefore enhance epithelialization
2. Clean the wound or keep it clean
3. Protect the wound from physical trauma or bacterial invasion



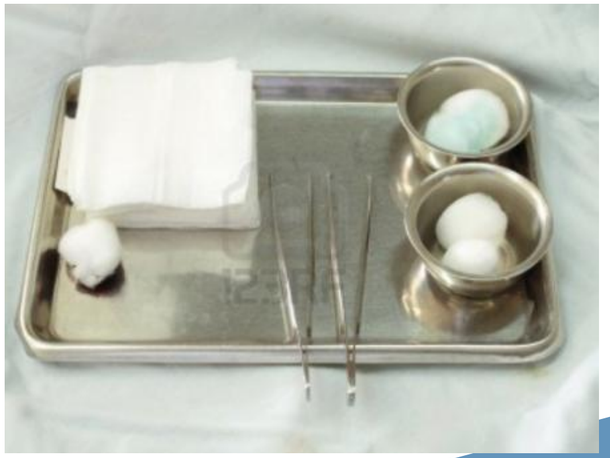
(Sue & Patricia, 2011; Ernstmeyer & Christma, 2021)

Wound dressing

Applying a Dry Dressing

EQUIPMENT

- Clean exam gloves
- Container for proper disposal of soiled dressing
- Sterile 4 x 4 gauze pads
- 2-inch tape



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Wound dressing

Steps for Applying a Dry Dressing

1. Gather supplies
2. Provide privacy; draw curtains; close door.
3. Wash hands/hand hygiene.
4. Apply clean exam gloves.
5. Remove dressing and place in appropriate receptacle.

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https://www.ndsu.edu/pubweb/bismarcknursing/intermediate/skill/M006.html

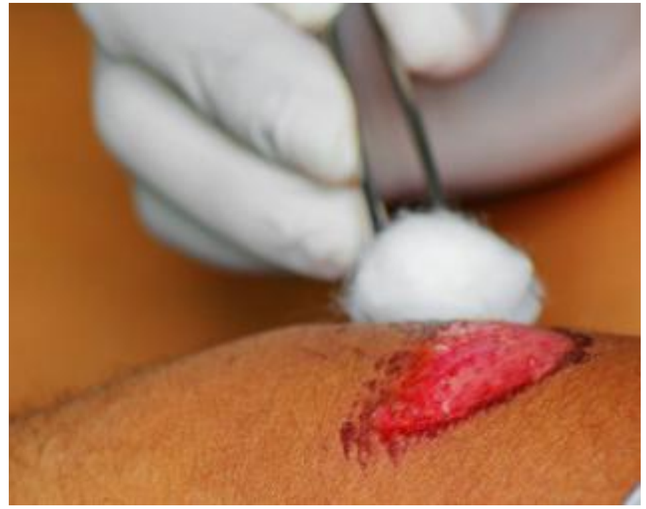
Wound dressing

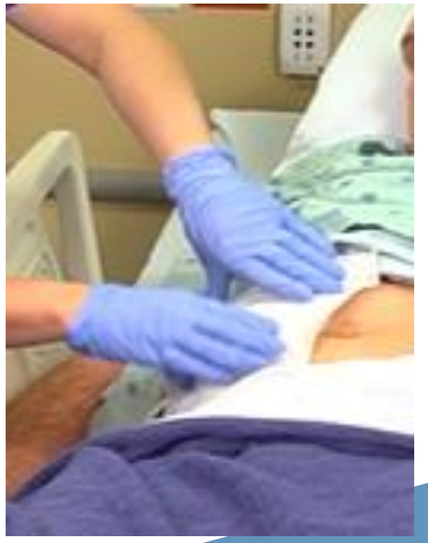
6. Assess the appearance of the undressed wound bed for healing.

7. Cleanse the skin around the incision. Use normal saline, half-strength hydrogen peroxide, or Betadine swab (consult orders of health care provider and/or institution policy regarding antiseptic agents) and cotton-tip applicators using a rolling motion.

8. Grasping just the edges, apply a new dressing using 4 x 4 gauze pads folded in half to the 2 x 4 size.

9. Remove used exam gloves.





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Urinary Elimination

Urinary Elimination

Objectives

Discuss nursing interventions for promote normal elimination.

Equipment for Urinary elimination

Three-Way Foley Catheter with Balloon Inflated

Bed pan

Urinal male

Foley Catheter

Urinary Elimination

1. Assisting with a Bedpan or Urinal

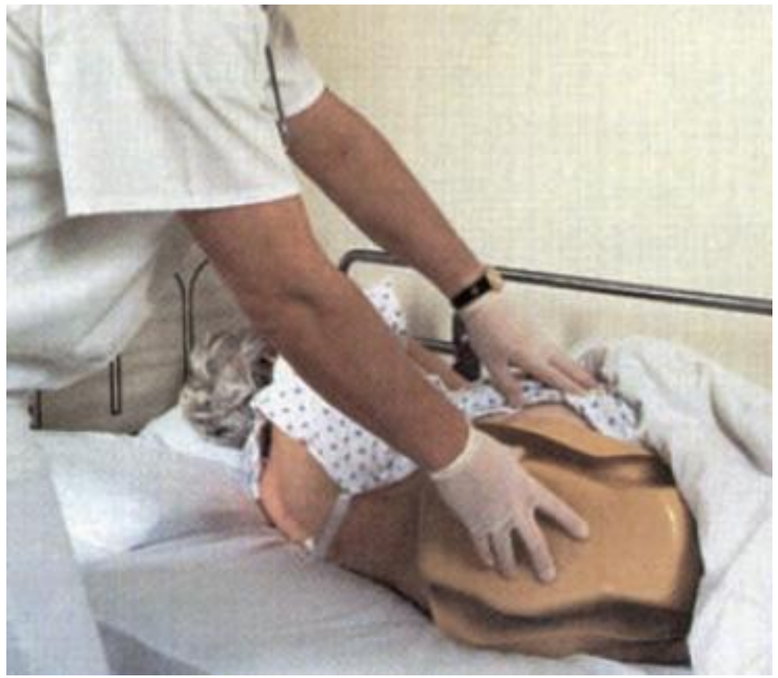
EQUIPMENT

- Bedpan (regular or fracture) or urinal
- Disposable gloves
- Bedpan cover
- Toilet paper
- Washcloth and towel

Urinary Elimination

Steps for Assisting with a Bedpan

1. Wash hands/hand hygiene; apply gloves.
2. Lower head of bed so client is in supine position.
3. Assist client to side-lying position using side rail for support.
4. Place bedpan under buttocks.
5. If indicated, elevate head of bed to 45 degree angle or higher for comfort
6. Remove gloves; wash hands/hand hygiene.



(Sue & Patricia, 2011; Ernstmeyer & Christma, 2021)

Urinary Elimination

Steps for Assisting with a Urinal

1. Wash hands/hand hygiene; apply gloves.
2. Lift the covers and place the urinal so the client may grasp the handle and position it. If the client cannot do this, you must position the urinal and place the penis into the opening
3. Remove gloves; wash hands/hand hygiene.

Urinary Elimination

2. Inserting an Indwelling Catheter: Male

EQUIPMENT

- Indwelling or straight catheter
- Adequate lighting source
- Disposable gloves
- Blanket or drape
- Soap and washcloth
- Forceps

From Mosby's Nursing video skill-intermediate. https://www.ndsu.edu/pubweb/bismarcknursing/intermediate/skill/M006.html

Urinary Elimination

Steps for Inserting an Indwelling Catheter: Male

1. Gather the equipment needed
2. Provide for privacy and explain procedure to client.
3. Assist the client to a supine position
4. Drape the client's abdomen and thighs if needed.
5. Wash hands/hand hygiene
6. Open the catheterization kit, using sterlie technique.
7. If the catheter is not included in the kit, carefully drop the sterile catheter onto the field using aseptic technique. Add any other items needed.
8. Apply sterile gloves.

(Sue & Patricia, 2011; Ernstmeyer & Christma, 2021)

Urinary Elimination

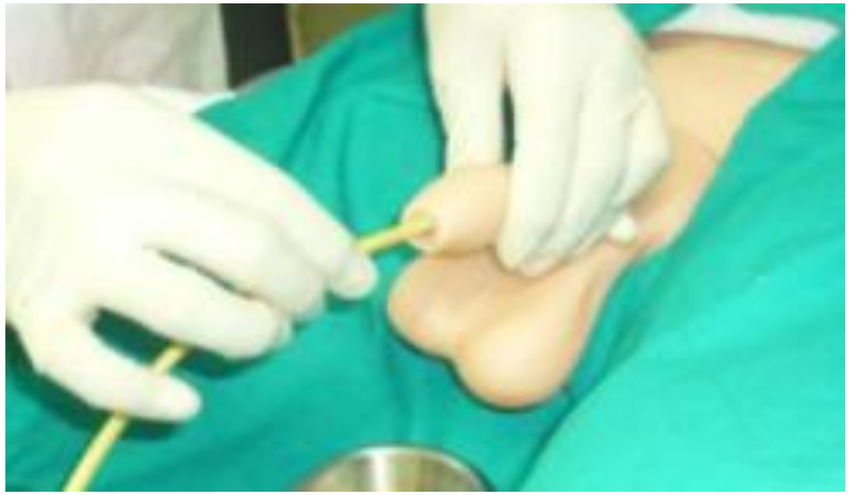
9. If inserting a retention catheter, attach the syringe filled with sterile water to the tail of the catheter.

10. Attach the catheter to the urine drainage bag if it is not preconnected.

11. Coat the distal portion of the catheter with water-soluble

12. Gently grasp the penis and retract the foreskin. With your dominant hand, cleanse the glans penis with a povidone-iodine solution or other antimicrobial cleanser

13. Holding the catheter in the dominant hand, steadily insert the catheter about 8 inches, until urine is noted in the drainage bag or tubing



Urinary Elimination

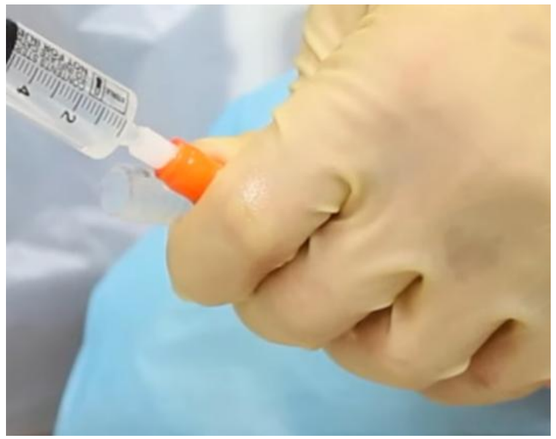
14. Reattach the water-filled syringe to the inflation port.

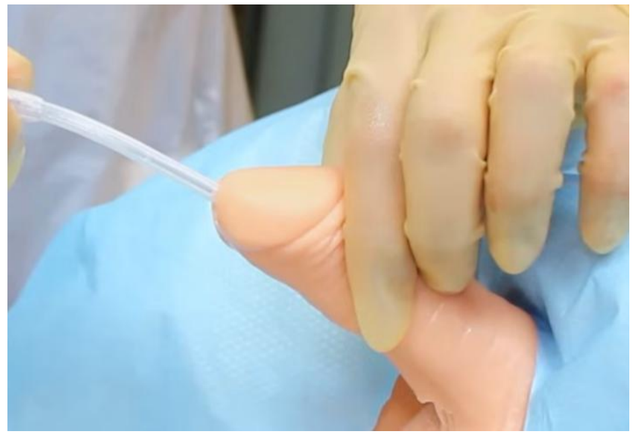
15. Inflate the retention balloon with sterile water

16. Once the balloon has been inflated, gently pull the catheter until the retention balloon is resting snug.

17. Place the drainage bag below the level of the bladder.

18. Remove gloves; dispose of equipment. Wash hands.





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Urinary Elimination

3. Inserting an Indwelling Catheter: Female

EQUIPMENT

- Indwelling or straight catheter
- Sterile catheterization kit
- Adequate lighting source
- Disposable gloves
- Blanket or drape
- Soap and washcloth
- Warm water
- Towel

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Urinary Elimination

Steps for Inserting an Indwelling Catheter: Female

1. Gather the equipment needed
2. Assist the client to a supine position or to a side-lying position with upper leg flexed
3. Drape the client's abdomen and thighs.
4. Wash hands/hand hygiene; apply disposable gloves.
5. Clean perineal area.
6. Remove gloves and wash hands.
7. Open the catheterization kit
8. Apply sterile gloves.

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Urinary Elimination

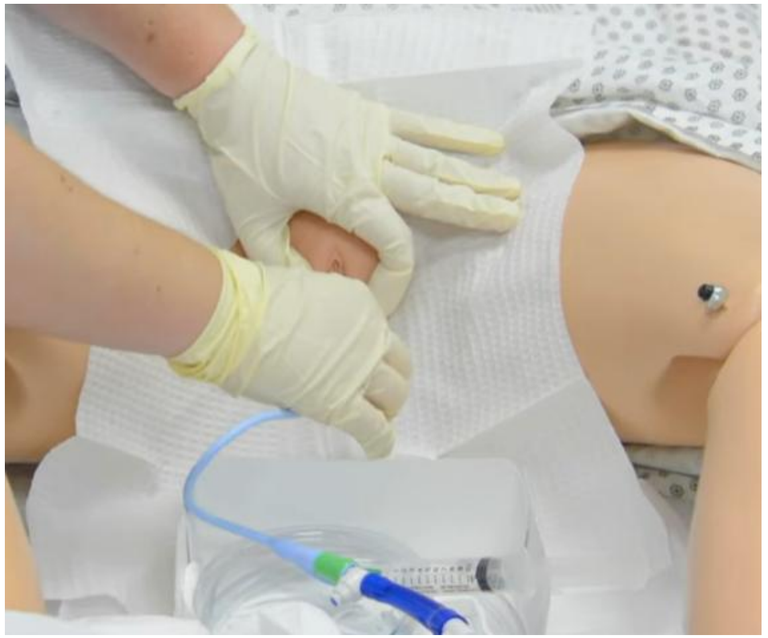
9. Attach the catheter to the urine drainage bag.

10. Coat the distal portion of the catheter with water-soluble

11. Gently spread the labia minora with the fingers of your nondominant hand.

12. Holding the labia apart with your nondominant hand, and cleanse the periurethral mucosa.

13. Holding the catheter in the dominant hand, steadily insert the catheter into the meatus until urine is noted in the drainage bag.



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Urinary Elimination

14. Reattach the water-filled syringe to the inflation port.

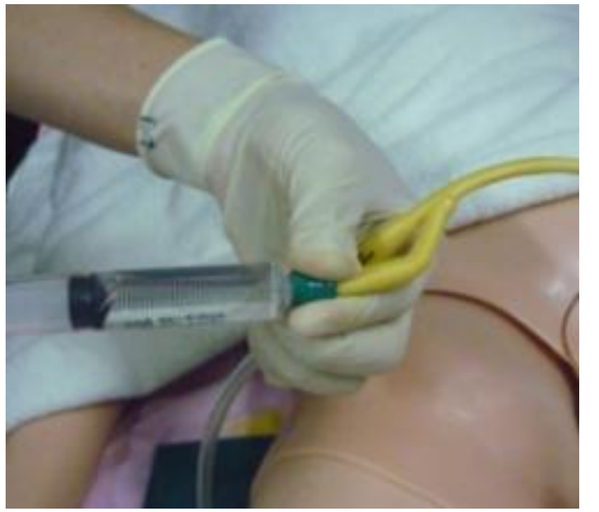
15. Inflate the retention balloon

16. Gently pull the catheter until the retention balloon is resting snugly against the bladder neck

17. Tape the catheter to the abdomen or thigh snugly.

18. Place the drainage bag below the level of the bladder. Do not let it rest on the floor.

19. Remove gloves, dispose of equipment, and wash hands.



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Bowel Elimination

Bowel Elimination

Administering an Enema

EQUIPMENT : LARGE or SMALL-VOLUME CLEANSING ENEMA

- Absorbent pad for the bed
- Disposable gloves
- Bedside commode or bedpan
- Prescribed solution
- Lubricant
- Enema container
- Tubing with clamp and nozzle
- Toilet tissue

From Mosby's Nursing video skill-intermediate. https://www.ndsu.edu/pubweb/bismarcknursing/intermediate/skill/M006.html

Bowel Elimination

Steps for Administering an Enema

1. Wash hands/hand hygiene.

2. Apply gloves.

3. Place position the client in the left lateral position

4. Pour solution into the bag or bucket, open clamp, and allow solution to prime tubing. Clamp tubing when primed.

5. Lubricate 5 cm (2 in) of the rectal tube unless the tube is part of a pre-lubricated enema set.

6. Holding the enema container level with the rectum, have the client take a deep breath. insert rectal tube into rectum approximately 7 to 10 cm in an adult.

From Mosby's Nursing video skill-intermediate.
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Bowel Elimination

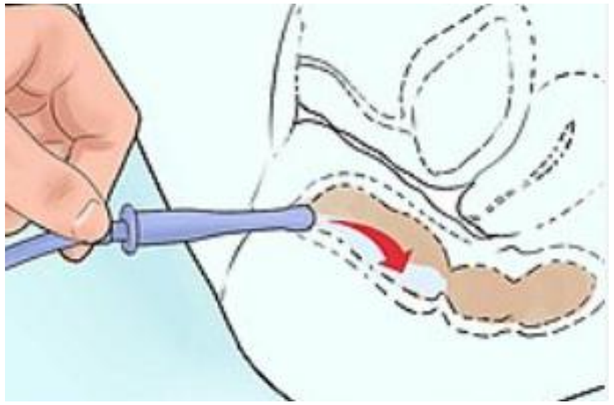
7. Raise the container holding the solution and open clamp. The solution should be 30 to 45 cm (12 to 18 in) above the rectum for an adult and 7.5 cm (3 in) above the rectum for an infant

8. Slowly administer approximately 200 cc of solution.

9. Assist onto the bedpan or up to the bathroom or commode.

10. Return client to a comfortable position. Place a clean, dry protective pad under the client to catch any solution or feces that may continue to be expelled.

11. Remove gloves; wash hands/hand hygiene.



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