

## **ESSENTIAL SKILLS - CRITICAL CRITERIA**

### **NURSING 198**

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student's performance:

\*Denotes individual faculty check-off.

#### General Principles

1. Standard precautions must be utilized and appropriate asepsis must be maintained.
2. Correct supplies/equipment must be assembled and organized.
3. The nursing process must be used.
4. Client instruction must be provided.
5. The client must not be placed in physical jeopardy.
6. The client must not be placed in emotional jeopardy.
7. Pertinent information must be reported and/or documented.

#### \*Safety Practices

1. Verifies care/order for client.
2. Washes hands before and after performing any client care or gathering supplies.
3. Assembles appropriate equipment or supplies.
4. Identifies client and assesses overall condition.
5. Explains procedure to client.
6. Elevates bed to appropriate working level.
7. Practices body substance isolation precautions.
8. Lowers bed, raises side rails and places call system within reach.
9. Reassesses any abnormal reading and if still abnormal, reports and records immediately.

#### Protective Barriers:

##### Gloves

- Dons gloves so that wrists or cuffs of gown are covered.
- Removes gloves following client care by touching only outside surface of first glove.
- Gathers contaminated glove in other hand.
- Utilizing skin-to-skin contact, removes second glove and disposes of both gloves in designated receptacle.
- Washes hands.

##### Gowns

- Covers clothing with clean gown and secures.
- Removes gloves following client care.
- Removes gown without contaminating hands or clothing.
- Turns gown inside out and places in designated receptacle.

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### Masks

- Dons masks covering nose and mouth.
- Removes mask by undoing fastener(s).
- Disposes of mask without contaminating hands or clothing.

### Eye Protective Devices

- Dons protective device to cover eyes and surrounding area.
- Removes without contaminating hands or clothing.
- Places in designated receptacle.

### \*Physical Assessment

- Collects data in a systematic manner utilizing inspection, auscultation, palpation, percussion.
- Documents data utilizing assessment form.

#### 1. General Survey

- Mental Status
- Appearance
- Communication
- Developmental Stage

#### 2. Skin (Inspection, Palpation)

- Turgor
- Color
- Temperature
- Moisture
- Integrity
- Nails
- Hair (Body)
- Edema

#### 3. Head (Inspection, Palpation)

- Hair
- Scalp
- Shape
- Symmetry
- Control
- Anterior-Posterior Fontanelle
- Features (Abnormal)
- Size

#### 4. Ears (Inspection, Palpation)

- External
- Hearing (in response to speech)

NOTE: Demonstration of otoscope and tuning fork will be provided in campus laboratory.

5. Eye (Inspection)
  - Sclera
  - Conjunctiva
  - Cornea
  - Pupils
  - Vision
  
6. Nose (Inspection)
  - Mucosa
  - Patency of Nares
  
7. Mouth and Pharynx (Inspection)
  - Teeth
  - Oral Mucosa
  - Gums
  - Breath Odor
  - Tongue
  - Palate
  - Tonsils
  
8. Neck (Inspection, Palpation)
  - Appearance
  - Lymph nodes
  - Movement
  
9. Thorax and Lungs - Anterior and Posterior (Inspection, Palpation, Percussion, Auscultation).
  - Shape
  - Symmetry
  - Breath Sounds
  
10. Breasts and Axillae (Inspection, Palpation)
  - Symmetry
  - Condition of Nipples
  - Masses
  
11. Heart and Peripheral Vascular (Inspection, Palpation, Auscultation)
  - Cardiac Landmarks (Aortic, Pulmonic, Erb's Point, Tricuspid, Apical/Mitral Areas)
  - Rate
  - Rhythm
  - Quality
  - Heart Sounds (S1 and S2)
  - Locate peripheral pulses by palpation or doppler as indicated: carotid, temporal, brachial, femoral, popliteal, dorsalis pedis, or posterior tibial

12. Abdomen (Inspection, Auscultation, Percussion, Palpation)
  - Contour
  - Bowel sounds
  - Auscultation for bruit
  - Response to Palpation
  
13. Musculoskeletal (Inspection, Palpation)
  - Symmetry
  - Posture
  - Gait
  - Joints
  - Strength
  
14. Neurological Evaluation (Inspection, Palpation)
  - Determines level of consciousness according to the Glasgow Coma Scale.
  - Assesses:
    - Eye opening
    - Motor response
    - Verbal response
  - Evaluates pupils for size, equality and reaction to light.
  - Assesses vital signs.
  - Determines sensory response to tactile stimuli.
  - Measures head circumference if client is less than 2 years of age.
  - Assesses deep tendon reflexes as appropriate.
  
15. Genitourinary and Anus (Inspection)
  - External Genitalia
  - Scrotal Size/Symmetry/Masses
  - Urethral Meatus
  - Appearance and Patency of Anus
  - Appearance of stool and urine

### **Documentation: Physical Assessment**

#### **Client's Chart**

- All assessments and procedures must be completely documented according to institutional policy.
- Record under objective portion of assessment.
- Record in order of the category groupings used in the assessment.
- Record date and time of assessment.
- Identify information and historian.
- Indicate ability of client to assist with assessment.
- Record chief concern.
- List positive findings first followed by significant negative findings for each body system or body part examined.
- Record detailed description of assessment related to chief concern (need for visit).

- Record detailed description of abnormalities (positive findings).
- Record description of negative findings.

\*Administration of Medications

1. Verifies order for medication.
2. Prepares medication based on five rights:
  - a. Right drug.
  - b. Right dose.
  - c. Right time.
  - d. Right route.
  - e. Right client.
3. Provides adjunctive assessment and interventions as indicated.
4. Administers medication according to five rights.
5. Documents time, medication, dose and route.
6. Evaluates effectiveness of drug.

Oral

- a. Remains with client until medication is taken.

Topical

- a. Prepares area for medication.
- b. Applies with applicator or with gloved finger as indicated.
- c. Covers with dressing as indicated.
- d. Maintains anatomical position to allow absorption or distribution.

Injections

1. Uses sterile technique.
2. Positions or restrains as indicated.
3. Using anatomical landmarks, locates and names acceptable sites for injection.

Intramuscular

- a. Ventrogluteal.
- b. Dorsogluteal.
- c. Vastus lateralis.
- d. Deltoid.

Subcutaneous

- a. Outer aspect of upper arm.
- b. Anterior thigh.
- c. Lower abdomen.

Intradermal

- a. Inner forearm.
4. Selects and cleanses site for injection.
5. Maintains skin contact with selected site with non-dominant hand.

6. Insert needle with bevel up at:
  - a. 90 degree angle for intramuscular.
  - b. 45 to 90 degree angle as indicated for subcutaneous.
  - c. 15 degree angle for intradermal.
7. Stabilizes syringe.
8. Aspirates if indicated.
9. Injects medication slowly and at an even rate of speed.
10. Withdraws needle quickly.
11. Applies pressure to injection site as indicated.

### **Documentation: Administration of Medications**

#### **Oral**

##### **Medication Administration Record**

- Date and time each drug was administered including initials and signature.
- If drug is withheld, circle the time the drug was scheduled on the MAR.

##### **Nurses' Notes**

- Date, time, and reason a drug was withheld.
- Response to drug administered.

#### **Topical**

##### **Medication Administration Record**

- Record the date, time, and site of application of the topical medication.

##### **Nurses' Notes**

- Document any changes in the client's skin integrity, coloration, or sensation.
- If medication was for irritation, itching, or rash, document any improvement or change.
- Note any unusual findings or client complaints.

#### **Injections**

##### **Intramuscular**

##### **Medication Administration Record**

- Name of medication.
- Dosage.
- Route of administration.
- Location of injection.
- Time administered.
- Initials and signature of nurse administering medication.

##### **Nurses' Notes**

- Time and type of client complaints.
- Medication administered.
- Outcome of treatment (client response).

- Nurse's signature.

### Subcutaneous

#### **Medication Administration Record**

- Document the date, drug, dose, route, site of injection, and signature or initials.

### Intradermal

#### **Medication Administration Record**

- Document the date, drug, dose, route, site of injection, and signature or initials.

#### **Nurses' Notes**

- Date and time of skin reaction.
- Date and time of any systemic side effects of the medication. Report to physician.

### \*Teaching - Learning

1. Assesses client's knowledge of subject and readiness to learn.
2. Reviews goals of session with client.
3. Assembles materials and prepares the environment.
4. Implements teaching plan, using appropriate content.
5. Obtains evaluative feedback from client.
6. Summarizes content taught.
7. Evaluates effectiveness of session and documents.

#### Breast Self-Examination

1. Explains best time to perform breast self-exam.
2. Demonstrates visual inspection of breast before mirror.
3. Demonstrates breast examination
  - a. Standing
  - b. Lying down
  - c. Checking nipples
  - d. Circular method
4. Gives instructions to client with abnormal findings.

#### Testicular Examination

1. States time for examination.
2. Demonstrates palpation technique.
3. Identifies testes and epididymis.
4. Gives instructions for anyone with abnormal findings.

#### Chronic Disease Self Care

1. Recognizes strengths and weaknesses.
2. Ventilation of anxiety and concerns.

3. Identifies support systems.
4. Identifies community resources.
5. Verbalizes importance of adherence to medical regime.

#### Perioperative Concepts

1. Documents client's understanding of surgical procedure and expected outcome.
2. Explains legal forms and procedures to be completed prior to surgery.
3. States reasons for and demonstrates to client how to move, perform leg exercises, and coughing/deep breathing exercises.
4. Clarifies clients' concerns related to postoperative pain and its control.
5. Explains and completes preoperative assessment.
6. Explains and conducts postoperative assessment.
7. Evaluates achievement of identified outcomes.

#### Maintenance of Traction

1. Assesses neurovascular status of affected limbs.
2. Identifies skin irritation and breakdown.
3. Maintains client in appropriate traction position.
4. Ensures maintenance of effective traction.

#### Cast Care

1. Assesses neurovascular status of affected extremity daily.
2. Evaluates casted extremity for underlying skin problems daily.
3. Maintains integrity of cast.
4. Identifies self-care, comfort and safety measures.

#### Crutch/Walker Ambulation

1. Utilizes proper equipment for ambulation.
2. Demonstrates proper stance for crutch/walker foot sequence.
3. Practices safe crutch/walker maneuvering techniques.
4. Identifies comfort and safety measures.

### **Documentation: Teaching/Learning**

#### **Nurses' Notes**

- Record the date and time.
- Summarize content taught.
- Record the client's response to teaching.
- Document the client's return demonstration (if applicable).
- Record a follow-up plan, if necessary.

#### **\*Surgical Asepsis**

1. Prevents anything that is not sterile from coming in contact with that which is sterile.
2. Prepares a sterile field maintaining visual contact at all times.

3. Avoids reaching across the sterile field with unsterile objects.
4. Dons sterile gloves avoiding contamination.

#### Dressings

1. Uses clean gloves to remove and discard soiled dressing.
2. Assesses wound and/or dressing for appearance, drains, and drainage.
3. Uses sterile technique, cleanses wound from area of least to most contamination, using one swab for each stroke.
4. Applies and secures dry sterile dressing.

#### Catheterization

1. Cleanses perineal area.
2. Positions and drapes for exposure.
3. Opens catheter kit and applies sterile drape if appropriate.
4. Organizes supplies using sterile technique.
5. Cleanses urinary meatus:
  - a. Female
    - Maintains exposure
    - Uses anterior/posterior strokes
    - Uses each swab once
  - b. Male
    - Exposes meatus and straightens urethra
    - Cleanses using circular motion from meatus downward
    - Uses each swab once, repeats as needed
6. Uses the uncontaminated hand, inserts lubricated catheter into the urethra and obtains urine.
  - Replaces foreskin over glans for the male client.

### **Documentation: Surgical Asepsis**

#### Dressings

##### **Nurses' Notes**

Documentation should include the following:

- Date and time dressing changed.
- Brief description of the wound site.
- Brief description of the site care and dressing applied.
- Client comfort before and after dressing change.
- Client/family education done and evaluation of the teaching.

#### Catheterization

##### **Nurses' Notes**

- Record the time and date the catheter was inserted.
- Note the size and type of catheter used, including the size of the retention balloon and the amount of sterile water used to inflate the balloon.

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- Record the client's response to the procedure and the amount, color, and quality of urine returned.

### **Intake and Output Record**

- Record the amount of urine returned.

### Heat Application

1. Gathers specific equipment for type of dry/moist heat application as ordered.
2. Selects proper temperature (100-115 F) or use appropriate distance above area exposed (18-24 inches).
3. Provides protective covering when applicable.
4. Applies to specific area and checks frequently.

NOTE: If using commercial devices, follow the manufacturer's instructions for use.

### Cold Application

1. Fills container 1/2 to 2/3 capacity with chipped or cracked ice.
2. Expels air and closes securely.
3. Dries bag and tests for leakage.
4. Provides protective covering.
5. Applies to specified area and checks frequently.

NOTE: If using commercial devices, follow the manufacturer's instruction for use.

### Oxygen Administration

1. Removes articles which can produce a spark or open flame.
2. Places caution signs in view.
3. Provides for humidification of oxygen.
4. Sets, adjusts and maintains oxygen flow at designated rate.
5. Secures and maintains integrity of devices used for flow of oxygen.

### Glucose Monitoring

1. Assembles equipment and supplies.
2. Selects and prepares puncture site.
3. Obtains blood specimen on reagent strip.
4. Times according to manufacturer's instructions.
5. Measures and documents blood glucose.

### \*Intravenous Therapy - IV (Blood, Fluids and Medications)

#### Initiation and Maintenance

1. Correctly assembles intravenous system.
2. Expels air from tubing.
3. Applies tourniquet when appropriate.
4. Selects appropriate vein.
5. Releases tourniquet.
6. Prepares site.
7. Reapplies tourniquet when appropriate and distends vein.
8. Inserts needle/catheter in vein.

9. Releases tourniquet.
10. Connects tubing to intravenous device.
11. Initiates IV flow to maintain patency of line.
12. Secures intravenous device to skin.
13. Applies sterile dressing.
14. Regulates and maintains intravenous flow at prescribed rate.
15. Monitors.

#### \*I.V. Maintenance

##### Assessment

1. Verifies order for I.V. fluids and rate.
2. Assess site for patency and complications reporting abnormalities.
3. Documents findings.

##### Termination

1. Stops flow.
2. Removes intravenous device.
3. Applies pressure and applicable dressing.

#### Intravenous Medication

1. Prepares medication based on five rights.
2. Verifies pharmacological compatibility.
3. Verifies patency and placement of intravenous device.
4. Administers intravenous medication at appropriate rate.
  - a. I.V. Piggyback/Additives
  - b. I.V. Push Medications.
5. Provides adjunctive assessment and interventions as indicated.
6. Maintains patency of intravenous device.

#### Infusion Devices

1. Set up infusion.
2. Inserts IV tubing into infusion device.
3. Sets required rate.
4. Initiates infusion.
5. Monitors infusion hourly as needed.

#### Central Line Dressing

1. Wears mask and instructs client on head position (or places a mask on the client).
2. Uses clean gloves to remove the soiled dressing toward catheter insertion.
3. Discards soiled dressing.
4. Assesses site and/or dressing for appearance and drainage.
5. Cleans site in circular motion from catheter site to outer areas.
6. Applies and secures air occlusive sterile dressing.

NOTE: Follow the manufacturer's instructions for use.

## **Documentation: Intravenous Therapy**

### **Initiation**

#### **Nurses' Notes and/or IV Flow Sheet**

- Note date and time the IV was inserted.
- Document type and gauge of catheter.
- Document site of insertion.
- Document IV solution and rate.
- Record date of dressing placement.
- Describe client's reaction to the procedure.

### **Maintenance**

#### **IV Flow Sheet**

- Name of IV solution with additives.
- Hourly rate of fluids.
- IV site condition.
- Time checked.
- Initials/signature of nurse.

### **Termination**

#### **Nurses' Notes**

- Date and time IV was discontinued.
- Any unusual findings at insertion site.

#### **Medication Record/IV Flow Sheet**

- Date and time IV was discontinued.

#### **Intake and Output Record**

- Record the amount of IV solution left in the bag when the IV was terminated.

### **Intravenous Medication**

#### **Medication Administration Record**

- Document the date, time, drug, dose, and route of medication.

#### **Intravenous Flow Sheet (if policy)**

- Document the date, time, and volume of fluid infused IV piggyback or IV push medication.

#### **Nurses' Notes**

- Document the client's response to the medication.
- Record any serious side effects and report them to the physician or qualified practitioner immediately.

#### **Intake and Output Record**

- Note the amount of fluid infused.

### Central Line Dressing Change

#### **Nurses' Notes**

- The date and time the dressing was changed.
- The type of dressing applied.
- The condition of the skin at the site.
- The presence of any exudate or bleeding at the site.

#### \*Tracheostomy Care

1. Maintains patency of airway.
2. Removes, cleans, and replaces inner cannula, when applicable using sterile technique.
3. Cleans stomal area.
4. Applies sterile dressing.
5. Replaces tracheostomy ties.

#### **Documentation: Tracheostomy Care**

#### **Nurses' Notes**

- Record date and time of procedure.
- Document assessment of respirations and breath sounds.
- Describe client's tolerance of the procedure.
- Record amount and consistency of any secretions.
- Document condition of the client's skin.

#### Basic Electrocardiograph (EKG) Strip Interpretation

1. Determines heart rate, regularity and rhythm.
2. Identifies each wave from of cardiac cycle.
3. Checks configuration and placement of P wave, QRS complex, ST segment and T wave.
4. Measure PR interval, QRS duration.
5. Analyzes the ST segment.
6. Identifies normal sinus rhythm.
7. Recognizes the following dysrhythmias.
  - a. sinus tachycardia
  - b. sinus bradycardia
  - c. PVC's
  - d. V-tachycardia
  - e. V-fibrillation
  - f. 3rd degree heart block
  - g. asystole

\*Suctioning (oropharyngeal, nasotracheal, nasopharyngeal and tracheobronchial)

1. Positions patient appropriately (semi-Fowler's).
2. Assesses respirations and auscultates breath sounds.
3. Selects correct vacuum setting (low: 80-120 mmHg).
4. Uses appropriate aseptic technique.
5. Administers oxygen or uses Ambu bag.
6. Inserts lubricated catheter to correct depth.
7. Applies intermittent suction and rotates catheter as it is withdrawn.
8. Reoxygenates client when appropriate.
9. Rinses catheter and tubing.

**Documentation: Suctioning**

**Nurses' Notes**

- Note date and time of suctioning procedure.
- Describe client's tolerance of the suctioning procedure.
- Note amount, consistency, color, and odor of secretions.

\*Gastrointestinal Intubation

1. Positions client appropriately.
2. Measures tube for placement in stomach.
3. Inserts lubricated tube into oral or nasal orifice.
4. Advances tube to pre-determine distance and stabilizes.
5. Verifies placement of tube in stomach.
6. Secures tube.

Gavage

1. Positions client appropriately.
2. Verifies placement of tube.
3. Assesses gastric residual.
4. Instills prescribed feeding and flushes with water.
5. Clamps tube appropriately.

Lavage

1. Positions client appropriately.
2. Verifies placement of tube.
3. Instills solution.
4. Aspirates fluid.
5. Measures and assesses return.

Suctioning (Gastric)

1. Connects tubing to appropriate suctioning device.
2. Selects correct vacuum setting.
3. Measures and assesses return.

## **Documentation: Gastrointestinal Intubation**

### **Nurses' Notes**

- Document the type and size of NG tube inserted, the naris used, how the client tolerated the procedure, and the methods used to verify placement.
- Document care provided to the client to increase comfort of the NG insertion naris.
- Note any unusual findings.

### **Intake and Output Record**

- Note the amount of fluid the client drank to aid insertion of the NG tube.
- Note the amount of gastric contents removed for testing.

### **\*Management of Care**

1. Applies the nursing process to clinical decision-making and the management of care for a minimum of two clients.
2. Documents assessment of individual needs and establishes nursing care priorities based on the individual needs of a minimum of two clients.
3. Constructs a plan and implements nursing care to meet individual needs of the assigned clients.
4. Communicates appropriately with team members in the clinical setting.
5. Evaluates effectiveness of nursing care of assigned clients.