

Standard Nursing Operating Procedure for Merrygold Health Network

Participant's Manual
2008



Uttar Pradesh Social Franchising Project

A project supported by USAID & SIFPSA. Implemented by HLPPT



Preface

HLFPPT is an organization committed to work with various partners pioneering innovations for bettering health outcomes for the poor. Merrygold Health Network is one of such innovations in the field of Social Franchising.

Merrygold Health Network, aims towards achieving an objective of improving Maternal and Child Health through increased access to low cost – high quality healthcare services, for rural and urban working poor in Uttar Pradesh. In U.P. Social Franchising Project (supported by USAID and SIFPSA), HLPPT as an implementing agency, will be establishing 70 fully franchised Merrygold Hospitals at district level, 700 partially franchised Merrysilver Clinics at block level and will be working with more than 10,000 Tarang partners (ASHAs, Chemists, Fare price shop owners, Tarang health committee members, Opinion leaders, Anganwadi workers, Depot holders) and AYUSH practitioners at the village level by 2010. Two model hospitals are already established in Kanpur and Agra focusing on maternal and child health care.

In our endeavour to make this a successful model, it was felt that training of doctors, nurses and other team members will be a key component to improve the quality of service delivery and equip the staff with appropriate knowledge and skills.

This training manual on “*Standard Nursing Operating Procedures for Merrygold Health Network - 2008*” was designed to meet the above objectives. It has been pre-tested with Merrygold L0 hospital staff at Kanpur and Agra. The inputs and feedbacks from the hospital staff and comments of review committee members from SIFPSA and ITAP, has given this manual the present shape.

I am sure that this manual, when used by hospitals and clinics in the Social Franchising Project will as an enabling tool towards excellent service delivery.

HLFPPT

Acknowledgement

Nurses are considered to be the heart and soul of healthcare settings, offering their services to those in need. The care and concern they exhibit for patients is unparalleled and remarkable. I present this manual on “*Standard Nursing Operating Procedures for Merrygold health Network - 2008*”, as the first step towards sensitizing the nurses and other health care professionals, about importance and techniques of nursing care in any health care setting. This manual is the result of sincere intent, aspirations and hard work of all those who are an integral part of the network.

I am grateful to Mr. G. Manoj, (CEO, HLPPT) who has shown faith in my entire team to undertake the task of preparing this manual.

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I thank Ms. Shobhana Tewari from HLPPT for developing and designing this manual. I also thank Ms. Divya Babbar for providing secretarial assistance.

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The manual has been pre tested by UPSF training team at both L0 hospitals at Kanpur and Agra. Efforts made by Mr. Alok Tabelabux, Mr. B. K. Mishra from HLPPT, in organizing the trainings and involvement of entire Merrygold hospital staff in trainings was commendable.

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Abbreviations

ANC	Ante Natal Care
BP	Blood Pressure
EDD	Expected Date of Delivery
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IUD	Intra Uterine Device
I/V	Intra venous
LMP	Last Menstrual Period
OPD	Out Patient Department

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About the Manual –

This Manual has been tailored to the special needs of staff members of ‘Merrygold Hospital’, especially nurses. It contains the basic information regarding the procedures to be done for client care and issues like counseling, maintaining integrity of nursing profession, maintaining correct body posture while working etc. Special care has been taken while developing this manual to make it as simple as possible so that it can be used as a reference guide by nurses.

MODULE 1

Appearance and General Behaviour

- Unit 1.1 Appearance and General Behaviour
- Unit 1.2 Client Relationship Management
- Unit 1.3 Communication with Clients and Families
- Unit 1.4 Cultural Psychological and Spiritual care of client

About this Module

This module consists of four units explaining the Appearance and General Behaviour of hospital staff members, Client Relationship Management, Communication to Clients and their Families and Cultural Psychological and Spiritual Care of Client.

Unit 1.1 Appearance and General Behaviour

Learning Objectives:

- To understand and appreciate the dress code to be followed in a hospital setting

The staff working at Merry Gold network shall follow a code of conduct in their general and professional behaviour. This will inculcate discipline and proficient way of working among all the staff members. An individual should maintain a pleasant, professional appearance during their duty hours in the hospital.

1.1.1 If following a uniform in hospital, the dress code should be –

Uniform

- Uniform should be complete and spotlessly clean.
- The footwear worn should be according to the uniform and clean.

Hair

- Hair should be kept clean, combed, neatly tied and pinned, so that falling strands of hair is not the source of infection for the client and obstruction for the nurse while working.
- Coloured band or flashy hair pins should not be used on duty.
- Streaking of hair should be avoided.

Nails

- Finger and toe nails should be kept short and clean.
- No nail polish should be applied on fingernails.
- Rings should not be worn on duty as it can be a potential source of spreading infection from one client to another.

Jewellery and Makeup

- Makeup and jewellery should be subtle and should not draw extra-ordinary attention.
- Big ear rings, hair pins and bangles etc. can interfere in smooth working so should not be worn on duty.
- A thin chain can be worn, but it should be short and should not hangout.

1.1.2 For the staff following no uniform, the choice of clothes by hospital staff, requires consideration –

- The clothes should not have flashy colors and designs to attract attention from others.
- Comfortably loose/tight clothing, which is clean, subtle in colour and according to the climate will be the best option for any hospital staff.
- Shoes / sandals should not be high heeled and should be covered to protect the foot from accidental pricks and contamination from body fluids.
- Heavy make and flashy jewellery should not be worn, as it does not suit the professional environment.
- **An overcoat should always be worn during some procedure or dealing with client in close proximities.**

Unit 1.2 Client Relationship Management

Learning Objectives:

- Understand the intricacies of dealing with a client and maintaining a relationship.

The concept of customer relationship management is very significant in the practice of any business. Now is the time for Client Relationship Management in the Hospitals also.

There are very few relationships as important as one-to-one relationship between a client and his or her healthcare provider. Clients trust their providers to have accurate and complete information about their health. Health provider's availability, listening skills, responsiveness, reliability, etc. are all factored into a client's level of satisfaction and when client's expectations are not met, the tension arises. The fundamental lesson essential for maintaining long lasting relationship with clients is –

- **Understand a client's situation** – Hospital staff is expected to be considerate and thoughtful in understanding a client's situation. An empathetic behaviour with clients and their relatives will help them in calming down and reduce their anxiety.
- **To set realistic expectations** – Creating an image far away from reality might be fatal for hospital, as when the expectations are not met in the eyes of clients, they feel dissatisfied.
- **Inform** – Clients should be given complete information about the procedure, requirements and the outcomes. It is advisable for nurses that complete and prompt information about the client's condition should be given to his / her relatives after consulting with the doctor on duty.
- **Keep ready solutions** – The hospital staff is expected to have the solutions ready for clients when there are problems. Expecting them to tell us what to do, will be not correct.
- **Accepting client's ideas** – Collecting feedback from clients and accepting the reasonable ideas / suggestions will add value to the hospital's functioning and increase client satisfaction.

An excellent way of managing client's identity, health and information should be developed, which would increase the efficiency and popularity of the hospital.

Unit 1.3 Communication with Clients and Families

Learning Objectives:

- Understand and appreciate the different ways of communicating with clients in different situations.

Illness and hospitalization are stressful, often deeply frightening experiences for clients and their families. Good, clear and supportive communication is an important part of hospital staff's responsibility. Staff's caring attitude, smile and readiness to make contact will ease client's time in hospital. Few basic guidelines for communicating with client and families are:

1.3.1 Listening to client

- Begin your conversation using open ended questions like "How are you feeling today?"
- Concentrate attention on client, and do not get distracted by other things while he / she is speaking.
- Try not to interrupt and do not jump on conclusions without listening completely.
- Also try to observe the things which are not said, like client's gestures, facial expressions, way of speaking etc.

1.3.2 Maintaining Confidentiality

- If the information from the client needs to be given to another person, in order to help the client, inform the client that it will be told to the other person.
- If the information is not useful in helping the client, do not disclose it to anyone.

1.3.3 Being sensitive and respectful

- Put yourself in client's place and try to understand what he / she feels.
- Try to meet the client's needs and respond to his / her feelings.

1.3.4 Providing information to the client

- Be simple and clear in explaining things to clients.
- Do not pretend that you know things when you do not know.
- Never lie to the client.
- Keep in mind the timing of giving information. When a client is upset or frightened he / she might find it difficult to understand even simple things. If some information is really necessary to be given, ask client to repeat the

information that was given. If a client is not interested in listening do not force the information on him / her.

1.3.5 Communicating with difficult clients

- Understand that all clients are not same.
- If a client is angry, try to find out what they are angry about?
- Talk calmly, listen and respond with an understanding of pain and difficulties.
- If the client approaches with a legitimate complaint, take every action possible in your capacity, to solve it.

1.3.6 Giving the client a bad news

It is usually the doctor who tells the client a bad news. However sometimes, the client decides to talk to a nurse about it.

- Doctors and nurses should talk and agree on how and what to tell the client. The same message should go to the client, by any of the health personnel.
- Tell clients only as much as they want to know. Not all clients want to know everything.
- When clients are told some bad news, they usually do not want to believe it. This is called denial. It is useful as a first response, to help the client to cope.
- Doctors or nurses should slowly help the client to move on from the denial stage.
- Understand client's sadness and respond with compassion.
- Give hope to clients, but **do not give wrong information to make them feel better.**

1.3.7 Communication with families

- Find time to talk to the client's family as soon as the client is admitted; the sooner the better.
- Answer their question simply and clearly.
- If they want more information than you can give, arrange their meeting to a senior person who could make them understand about the condition.
- **Do not lie.**
- Offer support and encouragement.
- Involve them in client care and educate them about client care to make the care easier at home.

Unit 1.4 Cultural Psychological and Spiritual Care of Client

Learning Objectives:

- Understand the importance of cultural, psychological and spiritual care of client.

Culture is the sum of beliefs, practices, habits, likes and dislikes, norms, customs and rituals learned from the family during the years of socialization. The way that culture influences behaviour and attitude, is different in different individuals. It is vital that hospital staff should consider cultural background while interacting and planning care for individual clients.

During any sickness, the client might suffer with a sense of emotional isolation. She / he might lose self esteem and might feel frightened and anxious due to the condition. Their behaviour might also become aggressive due to the stress they are facing.

As psychological problems are often more difficult to assess and resolve than physical problems, the nurse and the doctor requires being extremely understanding, supportive, during this time with the client and her / his relatives. The client should be explained well about each process, to reduce anxiety and attain co-operation.

Spiritual belief can help clients to accept their condition well and it gives them some inner strength, which is closely intervening with emotional health and physical well being.

Health personnel should allow clients to continue with their spiritual and religious activities till the time they attain a stable physical and psychological balance.

MODULE 2

Assisting in Client Care

- Unit 2.1 Assisting in Outpatient Department
- Unit 2.2 Assisting during Normal Delivery
- Unit 2.3 Assisting during insertion of IUD
- Unit 2.4 Assisting during Ultrasonography

About this Module

This module consists of four units discussing and explaining about procedures of assisting in client care. The major procedures related to client care discussed in this module are - Assisting a client in OPD, during normal labour, during insertion of intrauterine device, during sonography.

Unit 2.1 Assisting in Out Patient Department (OPD)

Learning Objectives:

- Understand the procedure of assisting a physician and the client in OPD

Preparation

- Clean ventilated room
- Appropriate lighting
- Facilities of hand washing and toilet
- Examination table with mattress and clean bed sheet
- Piece of mackintosh and draw sheet on examination table
- Foot step
- Screen or curtain for privacy
- Light source
- Weighing machine
- Sphygmomanometer
- Tray containing sterile gloves
- Sterile cotton swabs
- Antiseptic solution
- Sterile speculum
- Chettle's forceps
- Clean and dry hand towel
- Waste Bin with plastic bag lining.
- A plastic basin with 0.5% bleaching powder solution.
- Prescription pad and pen.

- ❖ **Consider that every pregnancy is at risk**
- ❖ **Ensure that ANC is used as an opportunity to detect and treat existing problems**
- ❖ **Good record keeping assists in better case management and follow-up.**

Process

- The nurse on OPD duty should make sure that OPD room is clean and ready for consultation before arrival of doctor and clients. The room should be airy and free of unacceptable smells.
- The sterile articles and supply should be available in adequate quantity for the day.
- If there is more than one client, they should be given OPD numbers and they should be told about the sequence according to which they would be called in.
- General information about the client, such as name, age, address, number of visit, weight, height, blood pressure, temperature, pulse etc. should be recorded in ANC card / OPD card before she / he meets the doctor.

- If a client has come with some general complaints, personal and family history should be taken in detail from the client and recorded. She/ he should be asked about the present complaints, duration of complaint, previous encounter of similar complaint, family history of complaint, treatment taken, and result of the treatment.
- The antenatal cases should be asked about the previous pregnancies, births and abortions, mode of previous deliveries, twin pregnancy or any complication faced during last pregnancy, last menstruation period, present complaint, vaccines received, number of iron and calcium tablets consumed and ultra sounds done.
- Based on the date of last menstruation period, the expected date of delivery should be calculated. To calculate the expected date of delivery (EDD), the women should be asked to remember the date of last menstrual period (LMP). If she is unable to remember the exact date, she should be encouraged to remember some major event / festival etc. and then link that with her LMP.
- **Make sure, that the date, which she is telling, is the first day of her last menstrual period and not the last date of LMP or the date of first missed period. This will lead to miscalculation of the EDD.**
- Once the LMP date is known, EDD can be calculated by this simple formula –

$$\boxed{\text{EDD} = \text{LMP} + 9 \text{ Months} + 7 \text{ days} *}$$

* This formula is based on an assumption that the menstrual cycle of the women was regular before conception and it was 28 – 30 days cycle.

- Post natal cases should be asked about the date, time and place of delivery. If she is a case of Merrygold hospital, her previous records should be retrieved and made available for the consultation. If the case is a non- Merrygold case, she should be enquired about the mode of delivery, any complications faced during pregnancy and delivery, use of episiotomy, vacuum or forceps assistance and complications faced in immediate post partum period. All the details should be recorded and given to the doctor as the client enters the consultation room.
- Nurse should be able to make the client comfortable and should assist her / him in obtaining positions for physical examination as instructed by the doctor. The nurse should also make special efforts to maintain auditory and visual privacy of the client during examination and consultation.
- After the examination, the nurse should accomplish the procedures instructed by doctor like guiding the client to laboratory if some tests are to be done or giving injections if advised.
- She should guide the client to pharmacy if medicines are to be purchased and should ask her / him to confirm about the timing of medicines if has any confusion. She should take the client to Ultrasonography room if ultrasound is advised.
- Counsel the client and attendant accompanying her / him about the situation and steps to be taken further. An antenatal mother should be given information about her immunization, nutrition, rest, sleep and danger signs and should be provided with the **first information booklet** for antenatal mothers.
- The nurse should also keep replenishing sterile supply / articles in OPD. She should remove the used articles or instrument for cleaning after proper treatment with bleaching power solution.

- Antenatal and OPD cards should be duly completed for every patient and similar information should simultaneously go in registers to be maintained.

Unit 2.2 Assisting during Normal Delivery

Learning Objectives:

- Understand the procedure of assisting a client during her normal delivery.
- Gather knowledge about different stages of labour.
- Differentiate between normal signs of labour and risk signs.
- Appreciate the important points for counseling during labour.

Preparation

- A clean spacious labour room
- Appropriate lighting facility
- A spot lamp
- Toilet facility
- Sink and running water facility
- Hand washing articles
- Wall clock
- Examination table with mattress and clean sheet
- Clean separate slippers for labour room
- Sterile supply (sterile gloves, gown, cap, mask, plastic apron, gauze pieces, cotton)
- Kelly's pad
- Suction apparatus
- Sterile suction catheter
- Urinary catheter
- Oxygen cylinder, tubing and oxygen mask
- Sterile pads
- Antiseptic solution
- Sterile needles and syringes
- Injections (Oxytocin, Methergin / Tab. Misoprost, Injection Prostodin, 2 % Xylocaine, I/V fluids – Ringer lactate, 5% Dextrose)
- A set of woman's clothes
- Freshly washed and sun dried cotton cloths for baby
- Pediatric weighing machine
- Foot rests.
- Waste Bin with plastic bag lining.
- A plastic basin with 0.5% bleaching powder solution.

Sterile instrument needed for normal labour:

- Sterile instrument tray with sterile cloth lining – 1
- Sterile big plastic tray for receiving baby – 1
- Sponge holding forceps – 2
- Artery clamps – 2
- Tissue cutting scissors – 1
- Thread cutting scissors – 1
- Needle holder – 1
- Cutting needle – 1
- Round body needle – 1
- Suture material – 1
- Bowl – 1
- Cord clamp – 1

Process

There are three stages of labour:

- **First stage of labour** is when the contractions get painful and regular, pushing the baby down and opening up the cervix.
- **Second stage of labour** is when the cervix is completely open (dilated) and the baby is coming out. The second stage ends when the baby is born.
- **Third stage of labour** is the time after baby is born, when placenta separates from the uterus and comes out. The third stage ends when the placenta is out.

I. First stage of labour –

When a woman in labour comes to the hospital, first decide if she is in normal labour or if she has any risk signs (see below).

a) **Signs of normal labour (first stage of labour)**

- Contractions get longer, stronger and closer.
- Labour pains exist for 12 hours or less, for a woman who has had a baby before; 24 hours or less for the first baby.
- Small amounts of blood-stained mucus “show” may come two to three days before labour starts and continue throughout labour.
- If the bag of water (“the waters”) breaks, the colour should be checked. If colour of water is clear like ordinary water, it is normal
- The mother’s temperature stays below 37.8 °C.
- The mother’s blood pressure remains normal and stays below 140 / 90 mm of Hg.
- The mother’s blood pressure does not suddenly drop.
- The mother’s pulse is between 60 and 100 beats a minute.

b) **Risk signs in the first stage of labour**

If the mother has any of the following risk signs, she will need special attention and the physician should be informed immediately –

- Labour begins before the eighth month of pregnancy.
- The mother has a fever of over 37.8 °C.
- The mother’s pulse is more than 100 beat a minute.
- The mother has a serious condition called pre-eclampsia where her blood pressure is greater than 140/90 mm of Hg, with swollen face, hands, and headaches.
- The mother has fits (convulsions).
- The bag of waters breaks but labour does not start within eight hours.
- In spite of strong contractions, the labour lasts more than 12 hours for women with previous pregnancies, or 24 hours for the first baby.

- The mother has an unusual amount of bleeding. This includes blood clots, fresh blood or more than “show”.
- The mother feels pain between contractions and the womb stays hard.
- The baby’s heartbeat is more than 160 beats a minute or less than 110 beats a minute.
- The cord comes out before the baby is born.
- If a woman comes to the hospital with any of these signs or if she develops them during labour, she needs emergency obstetric care.

c) Examination of mother in labour

When a woman arrives at hospital in labour, check condition of the mother and baby. If there are any risk signs of abnormal labour, arrange for the mother to have an expert obstetrical help immediately.

Check baby’s position - Most babies lie with the head down. If mother is in active labour and the baby’s head is up or if the baby is lying sidewise, arrange to meet emergency obstetric condition/ surgery and inform the physician.

Check baby’s heartbeat - A healthy baby’s heartbeat is between 120 and 160 beats a minute during labour. Continue to check the baby’s heartbeat with a stethoscope every half hour during labour. Do not check baby’s heart beat during contractions.

Check mother’s temperature - Take mother’s temperature when she comes to hospital. Continue to take her temperature at least every four hours while she is in hospital. If she has a temperature above 37.8 °C (100°F), she may have an infection. Give her plenty of fluids and inform the physician

Check mother’s blood pressure - Take mother’s blood pressure when she comes to hospital. Check it every hour. If her blood pressure is going up, check it every 15 to 30 minutes. Blood pressure going up, is a risk sign, inform physician immediately.

Check mother’s pulse - In early labour, the mother’s pulse should be between 60 and 100 beats a minute between contractions. If her pulse is above 100 between two contractions, she may have an infection, bleeding inside or dehydration.

Ask the mother if her bag of waters is broken - Once the bag of water is broken, the observer should also check for colour of the fluid. Normally the water should be clear and transparent. Meconium stained water is greenish / yellowish in colour. Meconium staining should be immediately informed to the consultant or doctor on duty.

If bag of water has broken, germs can move into the womb. To prevent infection to the mother and the baby:

- Do not do vaginal examinations.
- Do not put anything into the mother’s vagina.

d) Maintaining five cleans to prevent infection

Five cleans are the best way to prevent infection. These are -

- Clean hands.
- Clean perineum.
- Clean delivery surface
- Cleanness in cutting the umbilical cord.
- Cleanness in caring for the newborn baby's cord.

To maintain five cleans and make the mother comfortable –

- Wash hands frequently.
- Clean the perineum as soon as the client arrives and whenever required.
- Change the bedding under the mother when it gets wet or soiled.
- Change cloths and pads when they get soaked. While changing bedding, check if the mother is bleeding too much, passing blood clots, or passing water which is brown, yellow or green. If notice any of these risk signs, take action immediately.
- Make sure the mother drinks or take sips of, at least one cup of liquid each hour. Drinks like tea with honey or sugar, and fruit juices mixed with water will give her strength for labour.
- Make sure the mother urinates at least once every two hours. Full bladder can make the labour last much longer. **If necessary catheterize the client.**
- Make sure the mother changes her position every hour. The mother should not lie flat on her back. This position squeezes the blood vessels and makes blood circulation more difficult.

- ❖ **Enemas are not necessary and should not be given unless prescribed.**
- ❖ **Do not shave pubic hair. Shaving can cause infection.**
- ❖ **If labour last longer than 12 hours for a woman with previous deliveries or 24 hours for the first baby, consider it a risk sign and get help.**

II. Second stage of labour –

- Protects mother's privacy.
- Maintain room temperature at least 25°C, so that baby does not get too cold.
- Make sure to use sterile equipments.
- Clean mother's genitals carefully and gently, using clean or boiled water and a disinfectant.
- Keep a clean cloth under the mother and clean cloths close by in case they are needed during the birth. If any stool comes out when the mother is pushing, remove the stool with a clean cloth or cotton.
- Check mother's blood pressure every 30 minutes.
- Make sure that mother continues to drink fluid and continues to urinate. If the genitals are not bulging after strong pushing, this means that the head is not coming down which can be a sign of problem.

- ❖ **Do not scold or threaten the mother. Upsetting or frightening the mother can slow the birth.**
- ❖ **It is dangerous to push mother's abdomen to make the baby come out.**

III. Third stage of labour –

- Stage three begins when the baby is born and ends when placenta comes out.
- Watch for signs that placenta has separated from the womb. The placenta usually separates in a few minutes after birth, but it may take up to half an hour. Signs that the placenta has separated include:
 - A small gush of blood comes from the vagina
 - The cord gets longer
 - The uterus rises to the navel or above. The top of the uterus (the fundus) may feel rounder and harder.
- Once the placenta has separated, mother should be able to push it out when she has a contraction.
- Sometimes it is needed to pull the placenta out gently by controlled cord traction. This is done only after the placenta has separated.

- ❖ **Pulling on the cord can be dangerous. Pulling strongly on the cord can break it off from the placenta or can even pull the womb inside out. This can kill the mother.**

- Watch for heavy bleeding. If blood is gushing out or if the woman bleeds more than two cups of blood, consider it as a danger sign.
- Watch for fits (convulsions). If the woman had pre-eclampsia (swelling and high blood pressure) during pregnancy or labour, she may still have fits (convulsions) in the first 24 to 48 hours after giving birth.
- After placenta comes out, check top and bottom of the placenta and membranes to make sure that everything has come out.

Counseling

- Be gentle with the client and do not speak rudely.
- Teach her to take deep breaths during the first stage of labour.
- In second stage, ask the mother to take deep breaths during relaxation and push as done while passing stool, when contractions come.
- Encourage the client to pass urine time to time.
- Ask the client to roam around a bit.
- Encourage her to take sips of water, juice or glucose water for energy.
- Make sure that baby is covered properly from head to toe and is put to breast feed with in half an hour of delivery.

Unit 2.3 Assisting during insertion of Intrauterine device

Learning Objectives:

- Understand the procedure of assisting a physician while insertion of an intrauterine device.
- Know about the preparation and articles needed for insertion of IUD

Preparation

- An examination table with mattress lined with clean bed sheet
- Mackintosh with draw sheet spread at the lower end of table
- Foot step
- Screen or separate room for privacy
- Light source
- Tray containing 2 sets of sterile rubber gloves
- Sterile cotton swabs
- Antiseptic solution
- Sterile Uterine sound
- Sterile sim's/ cusco's speculum
- Sterile Sponge holding forceps
- Sterile Intra uterine device
- Pair of sterile scissors
- Waste Bin with plastic bag lining.
- A plastic basin containing bleaching powder solution
- Hand washing facility
- Soap and towel.

Process

- Collect all the articles and equipments required for the procedure beforehand.
- Maintain privacy.
- Counsel client and explain the procedure completely to her.
- Answer her queries about the procedure to reduce her anxiety and fear.
- Ask her to pass urine and direct her towards toilet.
- Wash hands and prepare a tray, maintaining aseptic technique, with few sterile cotton swabs/ gauze pieces in a bowl and pour antiseptic solution like dettol over it. Cover the tray and keep it ready.
- If required, ask client to loosen / remove her lower clothing,
- Help her lie down on the examination table and give her lithotomy position.
- Adjust light source to ensure correct and enough lighting on the vagina.
- Offer correct sized gloves to the physician after he/ she has washed hands.
- Maintain aseptic techniques during the entire procedure and make sure physician also follow aseptic techniques.
- Assist the physician during the procedure, with equipments or other help.
- Support the client and be in the room until the procedure ends.
- After the procedure help the client in climbing down the examination table and dressing up.
- Utilize her presence to education and reinforce on the special precautions to be taken after insertion of contraceptive device and when to come next for the check-up.
- Dismantle the articles and get the area clean and ready for the other client.
- Throw the sterile supply, if left unused in the tray.

- Ensure correct segregation of waste and usage of waste bins by the physician, self and other staff members.
- Wash hands and record the procedure.

Counseling

- The client should be clearly told about side effects, the device would have and her consent should be obtained before starting the procedure.
- She should be told about the total duration for which the contraceptive device would be effective.
- She should be told how to check if the device is in place.
- She should be encouraged to ask questions and clear her misconceptions if any.

Unit 2.4 Assisting during Ultrasonography

Learning Objectives:

- Understand the procedure of assisting a physician during Ultrasonography
- Understand about the preparations to be made prior to procedure.

Preparation

- An examination table with mattress lined with clean bed sheet
- Footstep
- Ultrasound machine and gel
- Clean soft cotton cloth to clean the probe after use
- Small towel
- Hand washing facility
- Soap, and water

Process

- Make sure that all the articles required for the procedure are available near the ultrasound machine.
- Make sure, privacy is maintained.
- Explain the procedure to client.
- Ask her to pass urine and wash hands.
- After she comes back from the toilet, ask her to loosen her lower clothing and help her in lying down on examination table.
- Position her according to the requirement of procedure and physician.
- Be by her side to make her feel comfortable.
- Provide help required by the physician.
- After the procedure, properly clean the client's skin with soft cotton cloth and help her to get dressed again.
- Clean the probe of ultrasound machine and replace other items and wash hands.
- Leave the place clean and tidy for other client.
- Record procedure in client's record and ultrasound register.

Counseling

- Client should be counseled about necessity of ultrasound during antenatal period if the client is a pregnant woman.
- She should be encouraged to see her fetus in womb, on ultrasound machine's screen so she develops bonding and love for her baby.
- Her queries should be dealt properly, in detail.

MODULE 3

Clinical Procedures

Unit 3.1 Clinical Procedures related to an Adult

About this Module

This module discusses about various procedures to be done in the hospital for an adult client and it's correct method.

Unit 3.1 Clinical Procedures related to an Adult

Learning Objectives:

- Appreciate the importance of each procedure being performed and its contribution in client's comfort.
- Recognize significance of each article being used for the procedure.
- Understand correct use of articles in client care.
- Understand ways of communicating with clients and importance of counseling during the procedure to obtain full cooperation from client.

3.1.1 Pre requisites of the procedure

Before starting with any procedure, some basic pre-requisite should be kept in mind. These are –

- **DO NO HARM!!!** Ask for help if you've never done this before.
- Verify physician's order
- Identify the client
- Explain the procedure to client
- Wash hands
- Wear necessary protective attire (gloves, gown, goggles, etc.)
- Provide for client's privacy and draping as necessary
- Perform procedure according to protocol
- Utilize proper body mechanics
- Position client for comfort and explain each step to the client
- Clean and position client for comfort. Protect client by adjusting side rails.
- Remove all equipments and clean or dispose as per protocols
- Document findings and outcomes
- Notify physicians of any unusual findings or change in condition

3.1.2 Vital signs measurement

Vital signs include temperature, pulse, respiration and blood pressure. Changes in any of the vital signs indicate change in patient's condition.

- ❖ Vital signs should always be checked when a patient complains of light-headedness, dizziness, being suddenly hot or when patient's condition changes for worse.

a) Measuring Temperature:

The body temperature is the heat of body measured in degrees. Normal temperature of an adult is between 36.7 – 37°C.

The temperature higher than the usual average is called a fever or hyperthermia.

- ❖ Fever is a sign of infection. Extremely high fever can cause convulsions; can damage liver, kidneys and other organs and even cause death.

The body temperature, which is lower than the average, is called hypothermia. It induces severe shivering, pale cool skin, low blood pressure and disorientation.

The body temperature can be measured at oral, rectal and axillaries (under the arm) site. **Rectal temperature is not recommended now-a-day.**

Oral temperature:

Preparation:

- Oral thermometer
- Cotton balls
- Soap and water facility.

Process:

A person's temperature is usually measured in the mouth, or orally. If the patient is under five years old or is confused, temperature must be taken in some other way, in case he or she bites the thermometer and breaks it.

If a patient has had cold or hot fluids or has been smoking, a nurse should wait for 15 to 30 minutes before taking an oral temperature to avoid getting false readings.

- Wash hands and take the thermometer out of its cover. The thermometer should have a long slender tip. The round tip thermometer is for rectal temperature measurement.
- Make the client sit on a chair or if the client is in bed, make her / him sit or lie straight.
- Carefully shake the thermometer down to below 35°C. While shaking, it should not slip out of hands or hit the coat button, watch / bangle of the other hand to prevent breakage of thermometer.
- Ask the patient to open mouth and put the thermometer under the patient's tongue, to the right or left of the pocket at the base of the tongue.
- Tell the patient to close her or his lips, but not teeth, around the thermometer. Leave the thermometer in place for at least **three minutes**.
- Take out the thermometer and read temperature holding the thermometer at eye level.
- Wash thermometer in soapy water, rinse it, wipe it and store it dry. Do not store it in a bottle filled with antiseptic solution. This may give rise to bacterial growth.
- Wash hands and record the temperature.

Axillary temperature:

To take an axillary temperature, the thermometer is put under the patient's arm (in the axilla). This is not the most accurate way to take a temperature, but it is done for adults who have inflammation of the mouth, patients who are confused and for children. An axillary temperature is usually a half degree lower than an oral temperature.

Preparation:

- Oral thermometer
- Cotton balls
- Soap and water facility.

Process:

- Wash hands and explain the procedure to the client.
- Prepare the thermometer just as is done to take an oral temperature.
- Put the thermometer in axilla under the client's arm.
- Ask the client to hold the arm tight against the chest and leave the thermometer in place for five minutes.
- Take out the thermometer, read the temperature, wipe it with cotton balls and store the thermometer.
- Wash your hands and record the temperature.

b) Measuring Pulse:

The pulse therefore reflects the heartbeat. A normal adult pulse usually is from 60 to 80 beats a minute, but the range is 60 to 100.

The pulse is faster in women and children than in men. **The pulse increases with exercise, with stress, and fever or when patient is losing blood.**

A pulse can also be felt at several places in the body but most of the times pulse is taken on the thumb side of the inner wrist; this is called the radial pulse. If radial pulse is not palpable, due to some reasons, another site can be used.

❖ Never use thumb to feel pulse because thumb has a pulse in itself that could be mistaken for the client's pulse.

Preparation: A wrist watch.

Process:

- Wash hands.
- Ask client to sit down comfortably and relax. If the client has come walking let her / him rest for 10 – 15 minutes before measuring the pulse.
- Rest client's right or left hand on a flat surface in a comfortable position.

- Place the index and middle fingertips or all three middle fingertips on the inner wrist, on the thumb side and apply moderate pressure to press the artery against bone, until the pulsation is felt.
- With very less or too much pressure, one will not feel the pulsation.
- Count the number of beats for a full minute.
- Note whether the pulse is regular or not.
- If the pulse is faster or slower than usual for the patient, or if pulse is irregular, bounding or weak, report this to the doctor.
- Record the pulse in nurse's note.

c) Measuring respiration:

The normal rate of breathing or respiration, in a resting adult is 12 (or more commonly 15) to 20 breaths a minute. The rate is higher in infants. It is also higher in a person who is exercising or under stress, and when the outside temperature is higher. It's best to count pulse when client is not aware about it because If carefully observed, client can become conscious and start controlling his/her breathing pattern.

Count the respiration/ breath while the fingers are on the client's pulse, as if their pulse is being checked. So the client will not notice that the nurse is checking the breathing.

Preparation: A wrist watch

Process:

- Wash hands.
- Ask the client to sit down comfortably and relax. If the client has come walking let her rest / him for 10 – 15 minutes before measuring the respiration.
- After counting pulse, while the fingers are still on the wrist, start counting breaths by observing chest movement.
- Count the respiration for full one minute.
- Observe if the respiration is irregular, shallow or difficult. Listen for wheezing, which is a whistling or sighing sound.
- Record whatever was noticed about client's respiration and number of respiration, in nurse's note and inform the doctor about any abnormalities.

d) Measuring Blood pressure

Blood pressure is a measure of the pressure that blood creates in arteries as it moves through the body. There are two kinds of blood pressure: Systolic pressure and Diastolic pressure. Systolic pressure is the highest pressure produced when heart contracts. Diastolic pressure is the lowest pressure produced when the heart relaxes. It is the pressure that is always within the arteries. Blood pressure is measured in millimeters of mercury (mm Hg).

The normal blood pressure of an adult ranges from 110/60 to 140/90 mm Hg, and the average is 120/80 mm Hg.

Preparation:

- Sphygmomanometer
- Stethoscope
- Chair and table.

Process:

- Ask the client to sit down comfortably and relax. If the client has come walking let her / him rest for 10 – 15 minutes before measuring the BP.
- Wash hands.
- BP apparatus should be placed on a flat surface, in level with client's heart.
- Rest client's elbow on the flat surface/ table and tie the inflatable cuff on the middle of upper part of arm, after removing all the clothes from arm.
- The dial or the manometer of BP apparatus is placed at the same level as health personnel's eye level.
- Feel the brachial artery over the cubital fossa with fingertips and start inflating the cuff with other hand. Make sure that the valve on the bulb is closed.
- Inflate the cuff until the mercury in mercury column, reaches 30 mm above the point where brachial pulse disappears.
- Now, put the diaphragm of the stethoscope over the brachial artery and release the valve on the bulb slowly.
- Listen for the sounds carefully and note the reading, where the first tap sound is heard. This is **systolic pressure**.
- Keep resealing the air through the valve and again, note the reading where the last sound is heard. This is **diastolic pressure**.
- Release the valve completely and remove the cuff from client's hand.
- Record the readings in nurse's record and if there are any significant changes in blood pressure from the last time it was measured, report it immediately to the physician.

3.1.3 Bed making

Preparation:

- Two clean bed-sheets
- One pillow cover
- Mackintosh
- One draw sheet
- Blanket if required
- Dry and wet dusters.

General Instructions:

- Wash hands before and after the procedure and collect all the articles needed in bed-making prior to starting of procedure.
- Do not mix clean and dirty linen
- Do not let the linen touch your body or uniform
- Do not shake the linen forcefully in air to let the bacteria spread in the atmosphere.
- Always get extra help while making bed for bed bound client
- Maintain good body mechanics.

Process:

- If the bed is already occupied, check the client's ability to move and do self-care.
- Wash hands and assemble all articles needed for making the bed.
- If the client can easily move, ask her / him to get down from the bed for bed making and make her /him sit comfortably on a chair.
- Remove the pillow and place it on a chair after removing the cover.
- Loosen and remove the sheets starting from the head end to the foot end and send them for washing. Blood stained sheets should be treated with the bleaching power before being washed.
- Do not forcefully shake the sheets in the environment, to avoid the spread of microorganism in the environment.
- Wipe the mattress with the help of dry duster, from farther end to the nearer one. Turn the mattress (if cotton) to air them.
- Wet duster should be used to remove stains, only if the mattress is lined with mackintosh. Pull the mattress to the top of the bed.
- Dust the furniture in patient unit, like side table, chair etc. using a damp duster dipped in antiseptic solution.
- After dusting of mattress, a clean sheet should be spread on the bed and should be tucked under the mattress from one side.
- Place the mackintosh on the lower half of the bed and the draw sheet over it and tuck them both together.
- Go to the other side and tuck the bottom sheet, mackintosh and draw sheet after pulling and tightening the sheet from all the sides.
- All four corners should be neatly made and there should be no creases on the bed.
- Top sheet with the blanket should be spread over the bed and tucked at the lower end after making a small pleat. The upper end of top sheet and blanket should be folder back, so as to keep the edges away from the client's face.
- Change the pillowcase and replace the pillow back on the head end.
- Make the patient comfortable on the bed.
- Dismantle all the other articles and wash hands.

3.1.4 Hair care

Hair care is not only washing hair: simple combing and neatly tying client's hair is also a part of hair care. When needed, hair wash can be given to clean the scalp. This small activity makes the client feel fresh and healthy.

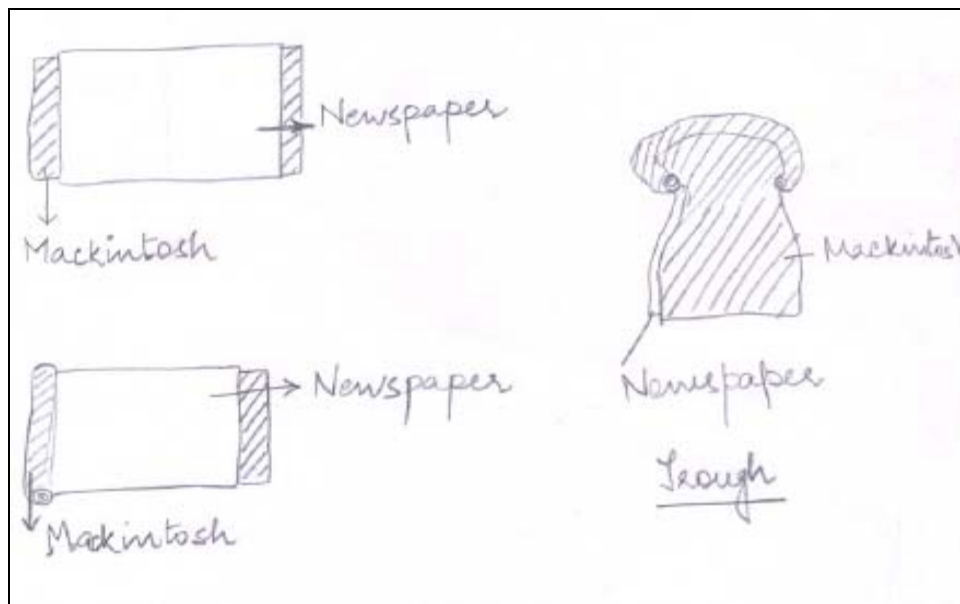
Preparation:

- A small piece of mackintosh
- Sheet of newspaper
- Empty bucket
- Mug
- Shampoo
- 2 towels
- Comb
- Gloves
- Lukewarm water
- Cotton balls

Process:

- Before starting the procedure, client should be informed about the procedure and consent should be obtained from her/ him for procedure.
- Client's privacy should be maintained by drawing curtains or closing doors.
- Wash hands and collect all the articles, in a tray before starting the procedure and check temperature of the water to suit the environment and client's need.
- Remove pins, rubber band, and open client's hair if platted. Comb them carefully to remove tangles.
- Give the client supine position, remove pillow and bringing her/ his head to the edge of bed.
- Prepare 'trough' by rolling one end of a long piece of mackintosh lined with newspaper and turning it into 'U' shape as shown in the picture. This rolled U shaped portion will go under patient's head.

Fig 1: Making trough with mackintosh and newspaper



- Ask the client to lift her/ his head and support client's neck with one hand. Spread a towel under his/her head and place the trough over it keeping the mackintosh side up.
- Wear gloves and tuck another towel around client's neck to prevent his/ her clothes from getting wet. Plug the ears by inserting cotton buds into it.
- Place a bucket at the head end with the lower end of trough falling into it. This arrangement will navigate the flow of dirty water into the bucket.
- Wet client's hair and ensure that her /his clothes are not getting wet. Start applying shampoo on hair and massage the head gently.
- Keep talking to the client during the procedure, to make her / him comfortable.

- Pour water with the help of mug from client's forehead to wash of the shampoo in hair but be careful, so the drops of water should not enter into his/her eyes or ears.
- After washing off the shampoo properly, lift his/her head by supporting from neck and pull out the trough carefully without spilling water on the bed sheet or floor. Put the trough in the bucket.
- Wrap and dry hair with the towel lying below client's head and make her / him sit with support if possible. Remove ear plugs and the other towel.
- Dismantle articles after the procedure by throwing water in bathroom and newspaper into dustbin. Wash mackintosh with soap and dry in shade.
- Remove gloves and wash hands. Comb hair after drying and plate them if required
- Wash hands after the procedure is complete and record procedure in nurse's note.

3.1.5 Mouth care

Some clients in hospital may be able to get up and brush their teeth and wash out their mouth. If the nurse brings a toothbrush and basin of water, patients can sit up in bed and brush their teeth there.

Preparation:

- Toothbrush
- Paste
- Kidney tray
- Water
- Glycerin or Vaseline.

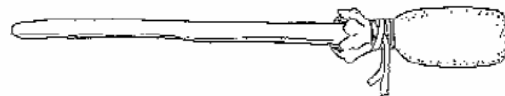
Process: Mouth care for a conscious client

- Inform the client about the procedure and convince her / him to receive mouth care.
- Ask for the toothbrush and paste, if the client has one. If toothbrush and paste is not available with the client, ask if it could be purchased from the market.
- If toothbrush is not available, a small 'Neem' twig can be used and if none of these are available a small stick with gauze piece tied on one end could be used.

Fig 2: Neem Twig and stick for mouth cleaning



Neem Twig



A stick with gauze at an end

- If nothing is available, help the client to rinse his/ her mouth with saline or salt water.
- Collect all required articles in a tray and wash hands.
- Make the client sit up in bed or prop up bed to 45 degree level with pillows behind him/ her for comfort.
- Remove dentures or other prosthesis from mouth, if any.
- Cover client's neck and chest with towel to avoid spillage of water.
- Hand over her / him the brush and assist in brushing teeth.

- Assist in rinsing the mouth with water and receive the dirty water in kidney tray; instruct the client to be careful while spitting to avoid spillage.
- Remove kidney tray, wipe mouth with towel and apply Vaseline or glycerin on client's lips to avoid chipping of lips.
- Dismantle articles and wash kidney tray with soap and water before replacing.
- Record the procedure in nurse's note.

Mouth care for an unconscious client

Mouth care is especially important for an unconscious patient. Special precautions need to be taken.

- If possible, position client on his or her side, near the edge of the bed.
- Collect articles required and wash hands.
- Tilt patient's head to one side. Put a kidney tray under client's chin with a towel under it to catch any water that drips.
- Open his/her mouth very gently with a tongue blade or other object, such as a spoon supporting with hand. Avoid putting finger in patient's mouth.
- Clean teeth and membranes with help of toothbrush/ 'Neem' twig, then rinse the mouth by injecting a little amount of water into mouth with a syringe; or use a moistened gauze or cloth wrapped in an artery clamp, to clean the mouth.
- If water is injected into patient's mouth, make sure that it runs out of the side of the mouth or suction the mouth to get it out. Fluid left in the mouth might choke the patient. It could be breathed into the lungs and cause pneumonia.
- After cleaning patient's mouth, apply glycerin or Vaseline to prevent dryness.
- Wash hands and record the procedure in nurse's note.

3.1.6 Sponge bath

Bathing removes microorganisms as well as body secretions from skin, gets rid of unpleasant smells, improves blood circulation to skin and makes the client feel more relaxed and refreshed. Bathing the client gives the nurse a good opportunity to look at condition of the patient's skin and to see how well the patient can move.

Preparation:

- | | |
|-----------------------|---------------------------------|
| • Two Steel basins | • Betadine sticks or bowl |
| • Lukewarm water | containing gauze pieces and |
| • 2 sponge cloths | betadine solution |
| • 2 towels | • Two cotton balls for plugging |
| • Soap | ears. |
| • Fresh clean clothes | |

Process:

- Choose a right time for giving bath like in the morning. Inform the patient about the procedure and encourage clients to take bath by them selves in bath room.

- If client has gone to take bath, assist her / him with soap, towel and the things which are required.
- If bath has to be given in bed, be preparing with a set of bed sheets to change, as sheets might become wet after sponging. Involve the client or relatives in the process as much as possible and comfortable for them.
- For bed sponging, make the client lie in bed in supine position. If supine position is not comfortable, give the position, which is comfortable for the client and remove the pillow, blanket etc.
- Cover the bed with the help of screens, to maintain privacy of the client.
- Wash hands and wear gloves.
- Cover the client till neck, with a top sheet and undress him/ her under the sheet. Check clothes, for blood and other type of stains. If not stained send the clothes for washing; if stained, treat them with bleaching powder first and then send for a wash.
- Put cotton balls in client's ears to prevent any water from going in ears.
- Start wrapping sponge cloth around the fingers and fold the hanging part of the sponge cloth over the palm to tuck inside the fold as shown in the picture below.

Fig 3: Wrapping and folding a sponge cloth



- Dip the cloth in a basin of lukewarm water and start sponging from the face.
- Clean the eyes first, twice and ensure to remove all extra water from eyes.
- Wet the body parts using one cloth and apply soap using another cloth simultaneously on the areas. The sequence followed of cleaning should be face, neck, shoulders, chest, arms, hands, fingers, legs, foot and back. Back should be massaged gently using circular strokes. Keep on dipping and washing the sponge cloth in the basin in between the process. Change water whenever dirty.
- Check nails and cut them if they are too long.
- During the whole process, do not expose body parts, which are not being wiped.
- At the end, clean perineum using betadine gauze and apply principles of asepsis. Penis should be cleaned from tip to shaft using singular firm strokes. Vagina and vulva should be cleaned from inside to out, top to bottom, using singular firm strokes and one gauze piece to be use only once.

- Dry the body with towel after cleaning and dress the client in fresh clothes.
- Change sheets as sheet become wet while sponging.
- Dismantle articles, dispose waste as per guidelines, wash hands and record the procedure in nurse's note.

3.1.7 Back care

Back rub is one of the most comforting things for clients. It relieves tension, provides relaxation and improves circulation. The back rub is particularly useful in preventing pressure sores in those clients on bed rest for long times, as it improves the circulation. It also allows the nurse to check the client's skin and look for red areas that may later develop pressure sores.

Preparation:

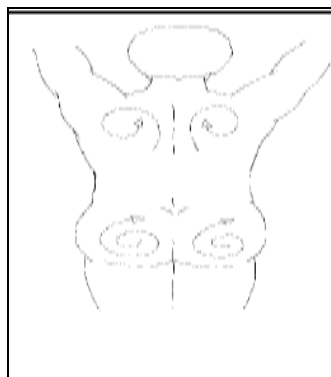
- Lotion for back rub
- Powder.

Process:

- A lotion may be used to soften the skin during the massage. Alcohol is refreshing, but it is not usually recommended because it dries out the skin.
- Wash hands and dry them. Rub them together to make them warm.
- Wear plastic or clean gloves and pour a little lotion in hands.
- Now, using circular motions, massage the middle of the patient's lower back.
- Next, stroke upward and massage the areas over the right and left shoulder blades, again using circular motions.
- Then stroke downward and end by massaging the iliac crests, the large muscles of the right and left buttocks.
- Repeat this process for three to five minutes, and then take off any lotion left on the skin with a towel.
- Dismantle the articles, wash hands and record procedure in nurse's note.

The figure below will give some idea about the motions or strokes to be used during back rub –

Fig 4: Stroke of Back Rub



While massaging back, check the skin for redness that does not go away even after being rubbed. These are areas to be watched, since they may develop into pressure sores. Immediate measures should be taken to relieve pressure from these areas by giving position and supporting by pillows or by using air rings.

❖ Do not rub over reddened areas of the skin since rubbing skin can cause peeling or damage.

Ways to avoid pressure sores:

- Help the patient change position every one to two hours.
- Keep the patient well nourished: See that he or she gets enough calories, protein and vitamin C.
- Keep the patient clean: If the skin is not clean, bacteria will collect and make pressure sores develop more quickly.
- Keep the patient dry: Moisture from urine and perspiration helps pressure sores to form.
- Keep bedding clean and free of wrinkles: This will reduce friction, which also leads to pressure sores.
- If necessary, use a foam rubber pad or soft mattress: This will reduce the pressure on bony parts of the body such as the back of the pelvis (sacrum). Raising the heels makes them less likely to develop sores.

3.1.8 Surgical Dressing of stitches

Surgical dressing is a protection with a sterile covering of gauze or other materials, applied over a wound after cleaning it with all aseptic precautions.

Preparation:

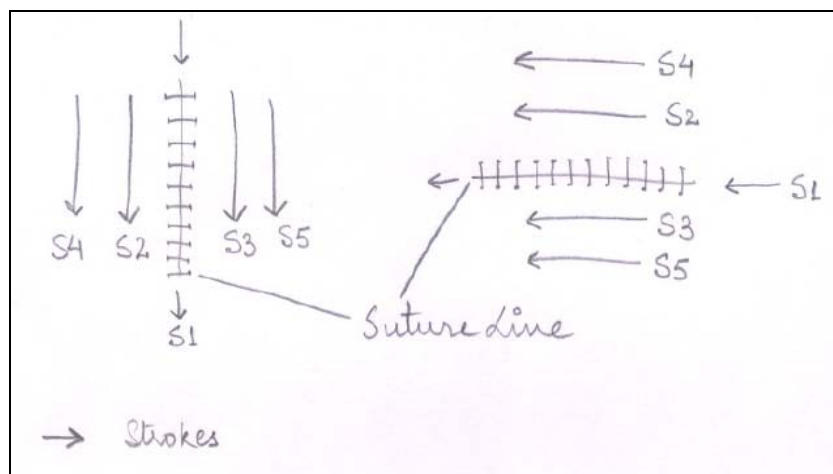
- A sterile tray containing sterile gloves
- Pair of sterile thumb forceps and artery forceps
- Sterile gauze pieces
- Normal saline
- Betadine solution or ointment
- Adhesive plaster
- Scissors.

Process:

- Inform client about the procedure and make sure she / he has had food/ breakfast/ lunch etc, as after dressing client in pain, might refuse the feed.
- Collect all articles near bed-side and cover the client with curtain to maintain privacy.
- Wear mask, wash hands and expose the area to be dressed and loosen the old dressing but do not remove it.
- Maintaining complete aseptic techniques open dressing set (Artery clamp and thumb forceps), open sterile bowl and pour some betadine solution in it.

- Drop some sterile gauze pieces into the bowl of betadine with the help of artery forceps and let the gauze get soaked in betadine.
- Cut appropriately long pieces of adhesive plaster and keep them ready.
- Remove the old dressing with first two fingers and throw it into the dust bin.
- Wash hands as done before surgical procedures and air-dry them.
- Observe the suture line, if that is clean or infectious with pus.
- Now, wear sterile and well fitting gloves, hold the artery forceps in right hand. Pick up one betadine soaked gauzes with artery and make sure there is no extra solution dripping from gauze.
- Wrap the gauze piece around the tip of artery clamp with the help of thumb forceps and make sure that the tip of artery clamp is properly secured.
- Clean the middle suture line of wound from top to bottom, with singular firm strokes. Discard gauze pieces after singular stroke.
- Clean farther end of the periphery of wound with betadine gauze, discard and take another one to clean the nearer end. Repeat the process until the suture line and periphery is completely clean.
- Squeeze some betadine ointment on a piece of sterile gauze and place it over the sutures, if advised by doctor.
- Cover the suture line with more gauze and wash hands with gloves on in 0.5 % bleaching powder solution. Remove gloves in 0.5% bleaching solution.
- Fix the dressing neatly with the help of adhesive plaster. Make the client comfortable and remove the curtains.
- Wash hands again and record the procedure in nurse's note. It is necessary to note the findings clearly and if the wound seems to be infectious, inform the physician about it.

Fig 5: Strokes of surgical dressing



Counseling:

- Inform client to keep the wound neat and dry.
- Ask her / him to support the suture line while coughing or stretching / bending, if suture line is on abdomen.

- Instruct client, not to wet the sutures and dressing. If dressing had got wet by mistake, it should be informed to the nurse and changed.
- Inform the client that changing of dressing is necessary everyday, till the wound is dry enough.

Nurses Note should describe about:

- Size of the wound in cm (length, width, depth) and presence of sutures or staples.
- Note if wound is free of dressing which is noted as open to air.
- If any type of drainage apparatus.
- Amount of drainage as minimum, moderate, or copious.
- Color of the drainage (describe if it bright thick red blood, pale red and watery, clear with a yellow cast, yellow and thick)
- Odor coming from the wound
- Level of pain before and after dressing.

3.1.9 Oral medication

It is the nurse's responsibility to prepare and give the drugs safely ordered by the doctor. If not given properly, medicines can be harmful or even fatal. Before giving any medication the nurse needs to know:

- doses of the drug which are safe to administer
- dose of the drug which has been prescribed for the patient
- method of administration
- drug's actions and expected effects
- possible side effects (unintended effects).

It is also important to know if a patient is allergic to a drug. Ask your patients about any bad reactions they have had to drugs in the past.

The five rights of drug administration are –

- **Right dose**
- **Right drug**
- **Right patient**
- **Right route**
- **Right time**

Preparation:

- A tray
- Prescribed medicine
- A glass of fresh water
- Spoon or measurement cup if the medicine is liquid.

Process:

- If the medicine is difficult for the patient to swallow, tablet can be crushed into powder; then mixed with some soft food or water so that the patient can swallow it
- Calculate the amount needed and wash hands.
- Take liquid or solid medicine to the patient in medicine tray.
- Make sure that five rights are maintained and double check them to prevent any mistake.
- If a medicine requires checking patient's vital signs, check vitals first. If vital signs indicate problems, check with the doctor before giving any drug.

Drugs that require checking vital signs include:

- ❖ **Digoxin** - check pulse
- ❖ **Hypotensive drugs** (drugs that reduce blood pressure) - check blood pressure
- ❖ **Narcotics** - check breathing.

- Explain what the drug is for and what are its expected side effects.
- Help the client to sit up or lie on one side for swallowing the drug.
- If the patient says that this medicine is not the same as he or she was given before, do not force the client to take medicine but check the order again to make sure that it is correct.
- Give liquid medicine in a cup to the patient to swallow. If patient cannot hold the cup, bring it to his or her mouth. If medicine has an unpleasant taste, give the patient some water after medicine to cover its taste.
- Give a glass of water to patient with the pills. This will help the patient to swallow.
- Always go back and check the patient for any adverse reactions or side effects from medication.
- Record down the medication patient has taken in nurse's record.

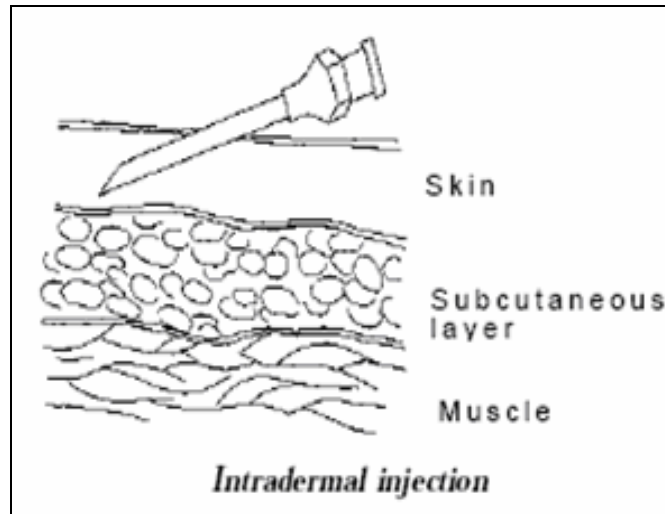
3.1.10 Injections

Medicine may be injected (given parenterally) under the skin, into fatty tissues, into a muscle, or into a vein. Drugs given in any of these ways are absorbed more quickly than drugs given by mouth. Therefore it is especially important to be sure that right drug is given to right person in the right amount.

a) Injections under the skin –

An intradermal injection is given in the dermal layer of skin, just below the top layer, which is visible. Intradermal injections are used for allergy tests, tuberculin tests, and many immunizations. The most common site for this type of injection is the lower arm. BCG vaccination is also given intradermally. For BCG injection most common sites are the upper arm, forearm and buttocks or upper thigh. To give a BCG injection or other intradermal injection:

Fig 6: Intradermal Injection



Preparation:

- Prescribed injection
- Needle of correct number (26 G)
- Syringe and spirit swabs.

Process:

- Wash hands before beginning and collect the required articles.
- Check the name of patient and name of drug to be injected.
- Inform client about the injection been given and that injection will cause a small lump, like a mosquito bite or small blister, but will disappear quickly. If client is a child, ask his/ her mother to hold the child firmly to prevent any jerky movements.
- Attach the needle on syringe, withdraw the correct amount of drug (which is generally not more than 0.1 ml) and keep the injection.
- Get rid of any air bubbles in the syringe by tipping the syringe upside down and slowly pushing the plunger until a drop of solution comes in the needle's bevel or end.
- Select a site that has no discoloration or rash or broken skin.
- Clean the site with spirit swab, using it in a singular circular motion.
- Pull the patient's skin flat. Hold the syringe at about a 15° C angle, and insert the needle through the epidermis into the dermis.
- Inject the fluid slowly until a lump appears. This indicates that the fluid is in the dermis.
- Take the needle out quickly and lightly wipe the site with the swab.
- Dismantle the articles, wash hands and record the procedure with time, name of the drug, amount given and site of the injection.

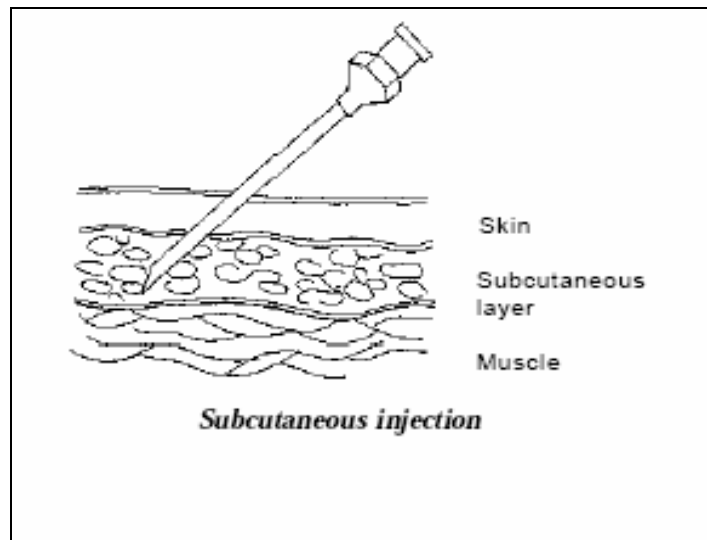
❖ Do not massage and instruct the client not to massage the injection site because that might make the medication go into the tissue or out of the injection site.

b) Injections in subcutaneous layer –

Subcutaneous injections go into the fatty tissue just below the skin. Many drugs are injected subcutaneously, including vaccines, preoperative medications, narcotics, insulin and heparin.

Common sites for subcutaneous injections are: the backs of the upper arms and the fronts of the thighs, the upper back, and the fat pads on the abdomen.

Fig 7: Subcutaneous Injection



Preparation:

- The prescribed injection ampoule or vial
- Needle of correct number (24 G)
- Syringe and spirit swabs.

Process:

- Wash hands and collect the required articles.
- Before giving medicine, check the patient's name and the prescription twice.
- Inform client about the injection been given.
- Draw medication into the syringe.
- Get rid of any air bubbles in the syringe by tipping the syringe upside down and slowly pushing the plunger until a drop of solution comes in the needle's bevel or end.
- Grasp the patient's skin with the thumb and forefinger of non dominant hand to rise up the subcutaneous tissue and form a fat fold.
- With another hand, insert the needle in at a 45 ° or 90 ° angles and pull slowly back on the plunger to confirm that the needle is not in blood vessel. Keep the hand firm and make sure the needle does not shake when inside the skin.
- If no blood comes into the syringe, give the injection by slowly and steadily pushing the plunger.
- Quickly take the needle out and press down on the skin.

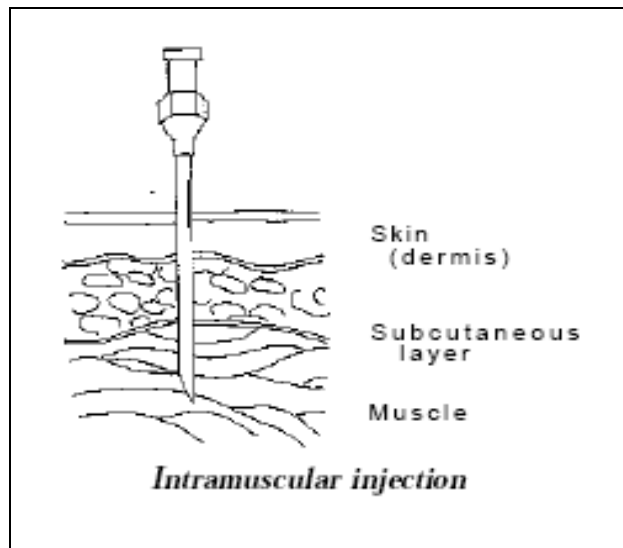
- There is usually no bleeding from subcutaneous injections. However, if there is bleeding, press gently until it stops.
- Dismantle articles, wash hands and record the procedure with time, name of the drug, amount given and site of the injection.

❖ If blood comes into the syringe when plunger is pulled back, it is understood that needle has hit a vein. Withdraw the needle, discard the syringe and prepare a new injection. That is because subcutaneous injections can be dangerous if they go directly into the bloodstream, where they are absorbed more quickly than from the fatty tissue.

c) Injections in Muscle –

Intramuscular injections (that is, injections into the muscle) are absorbed faster than subcutaneous injections. Large injections (up to 1-2 ml for a child and 3 ml for an adult) can be given this way because muscle can absorb more fluid than fatty tissues.

Fig 8: Intramuscular Injection

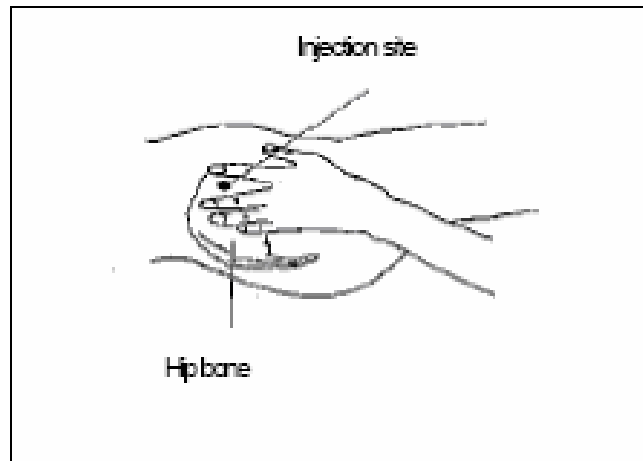


The preferred sites for intramuscular injections are the dorsogluteal site in gluteus muscle in the posterior hip or ventrogluteal site in gluteus muscle in the lateral hip.

Ventrogluteal site

Ventrogluteal injection site is easy to identify and safe to use. It avoids major nerves and blood vessels.

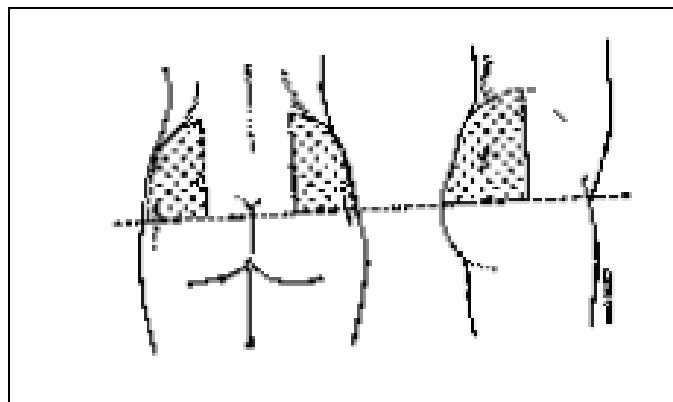
Fig 9: Ventrogluteal site for intramuscular Injections



Dorsogluteal site

One must be careful while using dorsogluteal site, to avoid the sciatic nerve injury, because accidental injection into this nerve can cause permanent or partial paralysis of the leg.

Fig 10: Dorsogluteal site for intramuscular Injections



- ❖ Never use dorsogluteal site in posterior hip for infants or children who have not yet begun to walk. Give the injection in rectus femoris muscle or vastus lateralis site in middle third of the thigh.

Deltoid muscle

The muscle of the upper arm, deltoid muscle, can also be used for an older child or an adult. However, remember that you cannot inject as much fluid into the arm as into the muscles of the hip.

Preparation:

- The prescribed injection ampoule or vial
- Needle of correct number (23 G)
- Syringe and spirit swabs.

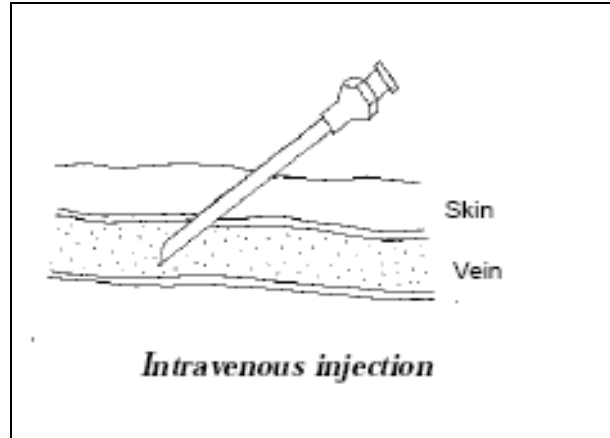
Process:

- Wash hands and arrange the required articles.
- Protect the patient's privacy by putting a sheet over body parts that do not need to be exposed.
- Explain the procedure to the client.
- If injection is being given to a child, show the mother how to hold the child.
- Before giving medicine, check the patient's name and the prescription twice.
- Draw the medication into the syringe.
- Get rid of any air bubbles in the syringe by tipping the syringe upside down and slowly pushing the plunger until a drop of solution comes in the needle's bevel or end.
- Choose a site for injection that has no broken skin, swelling, hardness, tenderness, redness or warmth.
- Locate the exact site and clean it with an antiseptic swab or cotton ball using singular circular motion and extending outward about 5 cm on each side.
- Using the non dominant hand, stretch the skin at the site. This makes it firmer so that it is easier to insert the needle.
- Insert the needle straight at a 90° angle through the skin and into the muscle.
- Make sure that the needle should not shake when inside. This will cause injury to the tissues.
- Aspirate by pulling back on the plunger. If blood appears in the syringe, pull out the needle, throw away the syringe and prepare a new injection.
- If blood does not appear, then slowly, steadily push the plunger to inject the medication.
- Quickly remove the needle and apply firm pressure to the site using an antiseptic swab.
- Dismantle the articles, wash hands and record the procedure with time, name of the drug, amount given and site of the injection.

d) Injection into veins –

The site for giving intravenous injection is usually one of the veins of the forearm. Patients needing faster running infusions or blood transfusions require larger needles and therefore larger veins. Sometimes some drugs are given directly into I/V route for immediate effect and faster results.

Fig 11: Intravenous Injection



Preparation:

- The prescribed injection ampoule or vial
- Needle of correct number (22 - 23 G)
- Syringe
- Spirit swabs.

Process:

- Wash hands and arrange the required articles.
- Explain the procedure to the client.
- Before giving medicine, check the patient's name and the prescription twice.
- Draw the medication into the syringe.
- Get rid of any air bubbles in the syringe by tipping the syringe upside down and slowly pushing the plunger until a drop of solution comes in the needle's bevel or end
- Pick a vein that is easy to feel and that is fairly straight. The vein should be full, soft, and easy to feel. It should not feel hard or rubbery.
- Avoid veins that are inflamed (red and warm), irritated or painful. Try not to use a vein that has been used before, because it may be damaged.
- Choose the vein and clean the site with an antiseptic swab using singular circular motion and extending outward about 5 cm on each side.
- Using the non dominant hand, stretch the skin at the site. This makes it firmer so that it is easier to insert the needle.
- Insert the needle slowly at 15° angle and keep aspirating lightly to check if the needle has reached and punctured a vein or not.
- As soon as blood aspirates in the needle, stop pushing the needle further and slowly push the medicine into the vein.
- After injecting the whole amount, put the swab over the needle and quickly pull the needle out.
- Firmly keep pressing the site for a minute. See if the bleeding has stopped, dispose the swab, needle and syringe as per waste management policy and wash hands.

- Record the procedure with time, name and amount of the drug and site of injection.

e) Intra venous therapy –

Intravenous therapy is putting a sterile fluid through a needle directly into the patient's vein. Usually the sterile fluid contains electrolytes (sodium, calcium, and potassium), nutrients (usually glucose), vitamins or drugs. Intravenous (IV) therapy is used to give fluids when the patient cannot swallow, is unconscious, is dehydrated or is in shock.

Drugs given intravenously enter the bloodstream directly and are absorbed faster than any other kind of medication. Therefore, drugs are given in this way when a rapid effect is needed, or when the drug is too irritating to body tissues to be given any other way.

Preparation:

- IV fluid or blood / blood products
- IV tubing or Blood transfusion tubing
- A syringe containing 1 ml. normal saline.

Process:

- Collect the articles and check twice the fluid/ drug/ blood or blood product to be infused, for name, quantity, expiration date.
- Flush I/V line with normal saline or sterile water slowly to cause the least pain.
- If facing difficulty in flushing canula, observe the site for swelling, redness, pain and hardness.
- Get the canula changed to the other site.
- Start I/V fluid or blood product with the calculated drop per minutes.
- Dispose off the waste as per waste management policy in hospital and wash hands.
- Record the procedure in nurse's note.

- ❖ Only one antibiotic is given at a time intravenously. The IV line is washed out (flushed) between antibiotics.
- ❖ Never give medications, sterile water, or dextrose water with blood or blood products.
- ❖ Watch all the patients on IV therapy for any signs of an adverse reaction, including a rash, trouble with breathing, increased pulse rate, vomiting,
- ❖ If insertion site shows swelling, redness, hardness, pain or warmth, change IV canula
- ❖ Check the IV flow rate to make sure it is correct.
- ❖ Do not pierce the plastic bottles with needle, or leave the needle pinned inside the bottle while fluid is being infused.

How to determine how fast the IV fluid should be going in:

- First work out the drop rate of the IV tubing. A blood set can deliver 10 drops per milliliter, regular I/V tubing delivers 15 drops per 1 ml and micro drip tube can deliver 60 drops per 1 ml. The number of drops required for 1 ml is called the drop factor.

- To find out the number of millilitres of fluid to be administered in an hour; divide the total amount of solution to be delivered by the number of hours the infusion will last. Then multiply that figure by the drop factor.
- To determine how many drops to administer per minute, divide by 60.
- Count the number of drops per minute that are being infused. If that is not the correct flow rate, adjust the drip rate.
- The formula for rate calculation is –

$$\frac{\text{volume (ml)} \times \text{drop factor (gtts / ml)}}{\text{time (min)}} = \text{gtts / min (flow rate)}$$

3.1.11 Per vaginal cleaning

Perineal and per vaginal cleaning is necessary after delivery of the mother, to keep vagina infection free and to promote healing.

Preparation: A tray containing

- | | |
|--|-----------------------|
| • A sterile bowl of boiled and cooled to be lukewarm water | • Fresh pad |
| • Pair of gloves | • Bed pan |
| • Sterile gauze pieces | • Sheet of news paper |
| • Antiseptic solution (savlon/ dettol) | • Artery clamps |
| • Betadine ointment | • Thumb forceps. |

Process:

- Wash hands and collect the articles required.
- Maintain privacy by drawing curtains or screen.
- Remove the top sheets and blankets and leave just a single sheet on the client.
- Fold this sheet up, till the knees and help client to loosen her lower clothing.
- Remove the lower cloths, or lift them to expose the perineum, with a sheet on patient's thigh.
- Ask client to flex her knees and help her lift her hips; slide the bedpan under her buttocks.
- Add little quantity of antiseptic solution into the bowl of lukewarm water and soak some sterile gauze piece into it.
- Wear gloves and approach the patient from her left side.
- Ask the mother to open her legs wide and hold a piece of soaked gauze piece from artery clamp.
- Squeeze the extra amount of solution in the bowl by pressing the gauze onto the walls of the bowl.

- Clean the middle of the perineum from top to bottom with one single stroke and drop the gauze piece in the bedpan.
- Take gauze and clean labia minora on the farther side with a singular, top to bottom stroke.
- Using the same technique, clean labia minora on the nearer side, followed by the labia majora of the farther side and then labia majora of the nearer side.
- Use more gauze pieces, if perineum is still dirty. Remember that each gauze piece should be used just once and all the strokes should be from top to bottom.
- After cleaning, observe the perineum and sutures, if any, for pus, fowl smell or redness.
- If any signs of infection are present, note it and inform to physician.
- Apply betadine ointment on suture line with the help of a gauze piece if advised by physician.
- Provide fresh pad to the women.
- Support and lift her hips and remove bedpan slowly.
- Make the patient comfortable and cover her properly.
- Remove screen.
- Remove bedpan after covering it with a sheet of newspaper.
- Throw the liquid in pan in latrine and flush it. Be careful not to drop gauze pieces into the latrine.
- Throw gauze pieces in the solid infectious waste and wash and disinfect the bed pan by pouring antiseptic solution into it.
- Place them in direct sunlight for few hours to deodorize and disinfect.
- Remove and disinfect gloves and record the procedure with findings in nurse's record.

Counseling:

- Explain mother the benefits of maintaining perinial cleanliness and ask her to clean and change pad at least twice daily.
- Ask her to inform about any severe pain, discharge and fowl smell from vagina.

3.1.12 Offering bed-pan

Preparation:

- Bedpan
- Plastic gloves/ clean gloves
- Sheet of newspaper.

Process:

- Wear plastic gloves and take a clean bed-pan to bedside
- Maintain privacy by using screen.
- Make the client lie down flat on bed.
- Fold back the sheet/ blanket, leaving just one sheet over the client.
- Help client to loosen the lower clothing.
- Ask her / him to flex knees, press heels against the bed and try lifting his/her buttocks.

- Slip left hand under the client's pelvis to help her / him raise hips and slip bedpan with the open pouring side towards the client's head and handle of bedpan towards the foot of the bed.
- Lower the client gently and cover with sheet.
- Raise back rest or place pillow under the back if necessary.
- Leave client alone and inform her / him to call when they finish.
- Give plenty of time but be around to listen to patient's call.
- If the client has finished and can not clean him/ herself, clean the perineum and buttocks with the help of cotton or toilet paper.
- Lift the client up, pull-out the bedpan and change the pad in case of female clients.
- Make the client comfortable and put the sheet of the newspaper over the bedpan to cover it.
- Take bedpan to toilet, throw the faeces or urine in pot and flush it.
- Clean bed pan in free flowing water and pour some antiseptic in it to make it disinfected.
- Wash hands and make a record of colour, consistency and amount of stool or urine, if found unusual and inform to the doctor.

3.1.13 Assisting in breast feeding

The baby should breast-feed as soon as possible after birth. Breast milk is all the baby needs for the first four to six months of life. The first fluid that comes out of mother's breast after delivery (colostrum) is most beneficial for the baby. Colostrum protects the baby against infections. There is no need to give water or other fluids such as sugared water to baby, while waiting for the breast milk to come in.

- ❖ Keep the baby with mother and allow sucking as often as he or she wants, day and night.
- ❖ While feeding let the child suckle from one breast till it is empty, then the next breast should be used. Next time feeding should be started from the other breast.
- ❖ Breast-feeding should continue even if the baby is sick.

Preparation: A tray containing

- Bowl with lukewarm water
- Cotton
- Soap
- Towel.

Process:

- Wash hands and collect all the required articles.
- Draw curtains to maintain privacy.
- Explain the procedure to mother.
- If mother is feeding for the first time after delivery, clean the breasts before starting the feed.
- Wet a cotton swab in lukewarm water and apply some soap on the swab.

- Expose the one breast and clean it with soapy cotton swab, then with wet swab and dry it using towel.
- Repeat the process with the other breast.
- Encourage the mother to wash her hands every time before feeding the baby.
- Let her assume a comfortable position, such as sitting with back rest or lying on her lateral side. Pillow support behind the back, under the thighs adds on to the comfort.
- Let mother hold the baby so that baby faces his/her mother, with baby's head and body supported against mother's arm and buttocks resting in her hand. If mother is lying on her side, she can have baby lying on her side, facing her.
- Make sure that mother is in a position to bring the baby to nipple with out straining her back, shoulders or arm.
- Ask mother to touch baby's lips gently with her breasts and when baby opens mouth, guide the nipple and areola into the mouth.
- Encourage the women to feed the baby from both breasts at each feeding, to ensure emptying and stimulation for milk supply in both breasts.
- Begin with approximately 7 -10 minutes on each breast, then increase the time at each breast.
- To take off the baby from breasts, ask mother to put a tip of her finger, in the corner of baby's mouth to break suction, and then slowly remove the breast.

Counseling:

- Instruct the mother to always wash hands before feeding baby.
- Never start feeding without assuming comfortable position.
- Never apply pressure on baby's cheeks to open his/her mouth.
- Feed the baby from one breast, go on to the other breast if baby is still suckling and start from the other side, the next time.
- Make sure that baby's mouth covers the nipple and the brownish coloured skin (the areola) around the nipple. The baby's chin should touch the breast.
- Breast feed every 2 – 4 hours or as per baby's demand.
- Exclusively breast feed the baby for 6 months. Do not give water, sugar water, honey, ghutti, to the baby during first six months.

3.1.14 Movement of the client

It is in the best interest of clients that they start walking and performing their daily activities as soon as their body permits.

The benefits of early movement include:

- Feeling of wellness
- Faster tissue healing
- Improved circulation
- Improved digestion
- Improved bowel and bladder movement
- Less dependency on hospital staff for physical care.

Clients should be encourage to perform any of these activities which they can perform comfortably without much straining, from the first or second day of their surgery and from few hours after their delivery, for better healing like -

Sitting up, standing, walking with support / without support, going to toilet and strolling around.

The relatives and husbands/ wives should be involved in these activities as it require least medical skills and the involvement of family members will make the client happy.

MODULE 4

Counseling

- Unit 4.1 Process of Counseling clients
- 4.1.1 Antenatal Counseling
- 4.1.2 Exclusive and early breast feeding
- 4.1.3 Post partum care
- 4.1.4 Family Planning
- 4.1.5 Menstrual Hygiene

About this Module

This module describes the importance of counseling and the process of counseling for nurses. Dealing with various issues where counseling can be done, this module also provides information on major RCH issues.

Unit 4.1 Process of Counseling Clients

Learning Objectives:

- Understand the process of counseling clients.
- Appreciate and learn the important points for good counseling.

This unit is important for nurses as clients and their attendants come in contact of nurses for the maximum time. By the virtue of being the prime care takers, nurses are aware of and understand the problems faced by client due to diseased condition or hospitalization. If a nurse is a good counselor, she can not only listen and comprehend client's problem but also can give her / him the best option/ solution available. Counseling is not a measure to be used just for the solution of a problem, instead counseling can be done for every client at every step, focusing on the prevention of a problem or a situation.

Counseling is a skill in which counselor helps the client to make informed and voluntary decision about an issue. It is a two-way process of exchanging information that involves, listening to client and providing them accurate information, options available and understanding of the matter.

Process of Counseling

Counseling has six basic elements, it is commonly known as **GATHER** steps. Each letter in the word stands for one-steps.

G - Greet Clients

A - Ask Clients about Themselves

T - Tell Clients about Their Choices

H - Help Clients to Choose

E - Explain what to do

R - Return for Follow-Up

How to do good counseling?

A good counselor should understand client's feeling and needs. With this the counselor adapts counseling to suit each client. Client will be benefited if a counselor:

- Understands and cares about the client. Builds Rapport.
- Give clients useful, accurate information. Help them understand what is necessary for them.
- Create a two-way interaction with clients by listening attentively and encouraging clients to ask questions and express concerns.
- Help clients to make their own choices, based on clear information and their own feelings, situation, and needs. The decision should not be forced.
- Help them remember key information.

Client Rights: A Client has the right to

- Accurate information
- Access to service
- Informed choice
- Safe service
- Privacy & confidentiality
- Dignity, comfort and expression of opinion

4.1.1 Antenatal Counseling

Antenatal women should be advised –

- To bring ANC card at each visit.
- To have at least 100 tablets of Iron & folic acid (IFA) supplementation during her pregnancy.
- Get 2 doses of Injection Tetanus Toxoid (Inj. TT).
- Continuing her usual activities throughout pregnancy if not tired.
- Hard and strenuous work should be avoided, especially in Ist and III trimester.
- Pregnant woman should sleep for about 8-10 hours at night and 2 hours in the daytime.
- Should take daily bath but be careful against slipping in the bathroom due to imbalance.
- Clean, loose comfortable, preferably cotton cloths to be worn.
- Retracted nipples to be corrected manually during the last months to avoid problems during breast-feeding.
- Avoid supine position especially during late pregnancy. Left lateral position with support of pillows is advised.
- Coitus to be avoided during the first trimester and during the last 6 weeks.
- Travel by vehicles having jerks to be avoided.
- Walk in morning or evening makes the women feel fit and cheerful

- Pregnant women and her attendant to be told about symptoms and signs of complications like pain in abdomen, watery discharge per vaginam, bleeding per vaginam, severe headache with blurring of vision, vomiting, swelling all over the body or feet, diminished foetal movements, undue breathlessness, palpitations, decreased urine output. Tell them to bring the pregnant woman immediately to hospital whenever any of these occur.

Dietary advice during pregnancy:

The woman should be advised to eat more than her normal diet throughout her pregnancy. Remember, a pregnant woman needs about 300 extra kcal per day compared to her usual diet. The woman's food intake should be especially rich in proteins, iron, vitamin A and other essential micronutrients. Nurses should give examples of food beneficial during pregnancy like green leafy vegetables, milk and milk products, groundnuts, soyabean, pulses, fruits, jaggary, eggs, fish and chicken if the woman is a non-vegetarian.

Danger signs during pregnancy:

Woman and her family members must be told about these danger signs that are to be noted and appropriately reported to the hospital immediately:

- a. Any bleeding per vaginum any time
- b. Any discharge of water per vaginum
- c. Severe continuous headache
- d. Disturbance of vision
- e. Convulsions
- f. High fever and prolonged Malaise
- g. Unusual abdominal pain
- h. Difficulty in breathing

Birth Preparedness & Complication readiness:

All pregnant women and accompanying relative (husband, parent or in-laws) should be well informed about:

- The Expected Date of Delivery (EDD)
- The various danger signs during antenatal, natal and post natal period. In case of any of the danger signs, they should report to the hospital at once.
- The total cost of a normal delivery and a caesarean section. Tell the family to keep aside small savings that will come in handy in any emergency

They should also be counseled about

- Reaching a decision regarding conducting the delivery by a Skilled Birth Attendant in hospital and not by any unskilled one at home.
- Identifying a person who will be able to arrange transport when the woman goes into labour.
- Make prior arrangements for support at home, in case they have older children who need to be looked after for the period when the woman is in hospital.

- To keep ready two sets of soft clothing (washed, sun-dried, and neatly packed) for themselves and the baby. Clean sanitary pads would be required during her post natal period
- Care of the breast and exclusive breast feeding
- Family planning methods.

4.1.2 Early and Exclusive Breast Feeding

Counseling for exclusive and early breast feeding should start from the antenatal period only. The mother should be informed about all the benefits of exclusive and early breastfeeding, so that she has a reason to follow the advice. She should be informed about the benefits like –

- Early breastfeeding of colostrum is very important because it helps to protect against diseases and enhances the immunity of baby.
- It also helps to increase the flow of milk to mother’s milk.
- It helps in evolution of the uterus and reduces post partum pain.
- Enhances the emotional bonding between mother and child.

Mother should be explained that the breast feeding should always be done in a calm and relaxed mood and in comfortable position. She should be told that child should be fed every 2 hourly or on demand and at least 8 – 10 times per day. Nurses should know about the good attachment and good position during breast feeding so that they can inform and assist mother in breast feeding her child.

Signs of Good Attachment are -

1. Baby’s mouth is wide open
2. Lower lip is turned outwards
3. Baby’s chin touches mother’s breast
4. More areola visible above than below.

Fig 12: Attachment of baby while breast feeding

Good Attachment



Poor Attachment



Signs of Good Position are –

1. Baby's body is well supported.
2. The head, neck and the body of the baby are kept in the same plane.
3. Entire body of the baby faces the mother.
4. Baby's abdomen touches mother's abdomen

Fig 13: Position of baby while breast feeding

Good Position



Poor Position



Mothers should also be told to burp the baby after every feed. They should be informed and motivated about exclusive breast feeding at least for six months and should be explained that breast milk fulfils the need of baby's nutrition and water, so there is no need of feeding her / him water or other liquids.

All the myths related to colostrum and exclusive breast feeding should be discussed with mother and her family members and cleared in a convincing manner, by stating facts.

4.1.3 Post partum Care and Exercises

Counsel the women and families about the need for –

Diet and Rest

- Food rich in calories (550 kcal extra per day for initial 6 months and then 400 kcal during next 6 months), proteins, iron, vitamins and other micronutrients should be advocated. An extra meal consisting of 2 chapattis or 1 cup rice, 1 cup dhal, 1 cup cooked vegetables, 1 glass milk and 1 cup tea is equivalent to taking 550 K Calories.
- Taking of more water and oral liquids should be encouraged as it helps clear the bowel and bladder.
- She should be advised against food taboos, if they are harming woman and / or baby.

- The woman needs sufficient rest during the postpartum period to be able to regain her strength. She, her husband and other family members should be advised that she should not be allowed to do any heavy work during the postpartum period, except for looking after herself and her baby.

Home Care and feeding of Newborn

- Advise the mother for Exclusive Breast Feeding for 6 months, Kangaroo Mother Care, when to return immediately to clinic (important signs to watch for), to attend immunization clinic for timely and complete immunization of infant.
The following points about feeding the child should be discussed -
 - Breastfeeding should be initiated early.
 - Pre-lacteal feeds should not be given.
 - Colostrum should be fed to the baby.
 - Exclusive breastfeeding is mandatory for 6 months.
 - Breast feeding should be done every 2 hourly or on demand.
 - Rooming in should be encouraged.
 - Weaning should start at 6 months of age.
- The baby should be kept warm to prevent from hypothermia and should not be given a bath till 24 hours after birth. In winter season, bath can be postponed till 7 days. The baby should just be wiped with soft cotton cloth with warm water.
- The parents and family of the newborn should be informed about danger signs like lethargy in baby, not accepting feed, yellowish discoloration of body, face and limbs, fever, diarrhea etc. They should be instructed to bring the child immediately to Merrygold hospital if any of the symptoms occur in child.
- The family should be informed about applying nothing on the cord of baby. No medicine or bandage should be applied and the cord should be left dry.
- The nurses should also inform the parents about immunization of the baby, its current status and the further immunization schedule to be followed.
- In child's care, father should also participate equally. This increases father's bond with the baby and makes him realize his responsibilities towards the new family.

Contraception

Remind the mother that strictly exclusive breast feeding for first three months with no menstruation, till that time may protect most women against pregnancy. But some women, who are not exclusively breastfeeding and also are not menstruating, might conceive even after a single act of unprotected sex even before three months. So, various choices of contraceptives available should be timely told to the couple to help them make an informed choice.

Resumption of Sex

- The couple should be advised to abstain from having sex during the first 6 weeks following delivery, or till the perineal /episiotomy wound heals (if present), whichever is later.

Exercises

- The women should keep herself active by at least going for a walk or doing some simple movements at home. Nurse should inform the client that these exercises are good for regaining the tone of her body.

4.1.4 Family Planning

Family planning counseling can be divided into three phases

General family planning counseling- based on information on a range of methods and to assist in choosing a method that is appropriate for her.

Method specific counseling- the client is provided more information about the method, as well as instructions on how to use it safely and effectively.

Follow- up counseling (during each visit) - The client's satisfaction with the product is assessed, and any problems or concerns are discussed.

G - Greet clients

A - Ask clients about their needs and desires

T - Tell clients about their options to make an informed choice

H - Help clients choose a method in terms of her needs and circumstances

E - Explain how to use the method

R - Return for follow- up

- A Nurse should always keep in mind, the social biases and cultural values of the client and provide proper privacy to her.
- If the client is not comfortable talking about some issue, nurse should be sensitive about handling it.
- Before starting a session, client's history should be taken and background knowledge should be checked by asking questions about her previous experience with some family planning method or product.
- Models and charts should be used to explain about the products and various family planning methods.
- Nurse should be patient enough to answer client's questions and satisfy their anxieties.
- Nurse should also keep herself updated with new methods and product in order to guide clients appropriately.

4.1.5 Menstrual Hygiene

Counseling for menstrual hygiene and care can be done to all females who are in the child bearing age; still nurses should not lose the opportunity to specially counsel an adolescent girl, who visits Merrygold Hospital with her mother or any other relative. As girls feel shy talking about such topics, the session with adolescent girls should be brief and informative. They can be told about few general facts and special care, diet and hygiene to be maintained during menstruation.

General facts about menstruation

- The bleeding period usually lasts 4-5 days.
- A woman loses 120-150 ml. of blood on an average, during one period.
- Period gets repeated every 28 – 30 days or once a month in most cases.
- Ovulation occurs on the 14th day prior to the expected menstrual period.
- During menstruation, slight pain in lower abdomen and thighs is common.

Menstruation Hygiene and Care

- Sanitary Napkin (*Sakhi*) should be used to absorb menstrual flow. It is economical and helps maintaining menstrual hygiene by preventing rashes and infections.
- Sanitary napkins should be changed at least once a day or more often depending on the menstrual flow.
- If using cloth to absorb the menstrual blood, instead of napkin, it should be old, cotton cloth which should be washed and sun dried as sunlight kills all bacteria.
- Other clothes and panties should be properly washed with soap and water and dried in the sun.
- Bathing daily is recommended as it keeps the body clean and fresh.
- The diet during menstruation should consist of vegetables and fruits that give nourishment and helps clear bowel system.
- Used napkins (pads) or cloth should be wrapped in a paper bag and disposed in waste. The pads should never be flushed in toilet.

MODULE 5

Article Management

Unit 5.1 Article Management

About this Module

This Module discusses the maintenance and management of a few selected articles. These articles include rubber goods, linen, laundry and instruments.

Unit 5.1 Article Management

Learning Objectives:

- Understand the specific method of managing and storing different types of articles.
- Realize the need to treat different articles differently.
- Use the knowledge in maintaining articles in a better manner and prolonging their lives.

5.1.1 Rubber Goods Management

The rubber goods commonly in use are mackintosh, air cushions, ice caps, rubber tubes, catheters, gloves etc. To prolong the life of rubber goods proper cleaning and storage is required. Few common precautions to be taken, for protection of rubber items are as follows –

- It should not be creased or folded.
- Never use any pins to fix rubber goods in any place.
- Never expose it to direct sunlight.
- Boiling water ruins rubber.
- It should be kept free from grease and acids and contact with stove or artificial heat.
- Any fluid spilt on them should be wiped off immediately.
- It should not be tied in knots, hanged on hooks or nails.
- Two rubber surfaces should not come together but must be separated. In the case of hot water bottle, the surfaces are separated by air.
- Mackintoshes should be rolled with a lining of newspaper in between layers and then stored in dark.

a) Mackintosh:

- Spread the mackintosh on a table or flat surface and wet it with cold water.
- Rub the upper surface with soap and water with cloth or towel then turn and repeat the process
- Wash both surfaces in running water and disinfect using carbolic solution (1:20)
- Store at cold place, by putting newspaper in between the layers and rolling the mackintosh.

b) Tubing:

- The tubing used in procedures like urinary catheter, flatus tube etc. should be washed after being decontaminated, under the stream of running water.
- Hold the eye end upwards; allow the water to run through the tube.

- Use swab stick to remove the small particles of organic matter which usually get stuck at the eye.
- Fine brushes can be used to clean inside the tubing.
- Boil the tubes for 5 -10 minutes by putting them in boiling water and then dry them by hanging.
- When dried, powder and store them in air tight containers lengthwise.
- Maximum efforts should be made to keep the tubing either straight or curved should not be knotted.
- Should not be exposed to excessive heat.

c) Gloves:

- After use, gloves should be removed directly in bleaching powder solution for decontamination.
- After decontamination, the gloves should be washed with soap and cold water and should be rinsed from both sides.
- Holes and tears should be discovered by submerging an air filled glove in the water. If there are holes, the bubbles will pass up through the water. Discard torn gloves.
- Hang gloves to dry in air, when outside is dried, turn the glove inside out and dry.
- When both sides are dried, powder them inside and make pairs of similar sizes, right and left gloves. Autoclave after making pairs in glove wrapper.
- While autoclaving, gloves should not be tightly packed because of which the movement of steam is restricted.

5.1.2 Laundry and Linen Management

- All linen must be properly stamped with the Merrygold names so that it is not lost in the laundry or in the ward.
- New linen should be washed once before use.
- Torn linen should be put aside for repair and should be repaired promptly.
- Soiled linen is sorted and account is written when sending to laundry.
- Stains from soiled linen should be removed at once before they become fixed or it should be send to the laundry soon.
- Wet linen must not be left in the dirty linen bin.
- Linen is carefully sorted, on its return from the laundry and discrepancies reported.
- Stock-taking must be accurate and frequent so that track is kept on lost linen.

5.1.3 Instrument and Equipment Management

- All the instruments and equipments available in the hospital should be listed and entered systematically in registers under different headings and sub headings.
- All the instruments & equipments which are in stock or issued to different departments should be checked monthly to keep a track of missing and non-functional/ poorly functional instruments.

- The nonfunctional or poorly functional instruments or equipments should be replaced with the functional once from the stock immediately and should be send for repair.
- After use, the instruments should be immediately dipped in antiseptic solution (0.5% bleaching solution), for at least 10 minutes for decontamination.
- They should not be left in the antiseptic solution for long as this will cause corrosion.
- Cleaning of the instruments should take place vigorously, to remove any infected material from its surface and to reduce the number of bacterial endospores from the surface of instrument. The teeth, grooves and screws should be carefully cleaned. Brushes can be used for cleaning but very hard brushes should be avoided to prevent the instrument from getting scratches.
- Boiling or sterilization of instruments through autoclaving/ chemicals should be done carefully to achieve the purpose.
- All the instruments should be used only for the purpose they are made e.g. the sharp tissue cutting scissors should never be used for cutting gauze or threads.
- The instruments, not in use should be stored at a dry and clean place. The area should be kept free of leakage or moisture to prevent rusting of the instruments.
- Flush out the instrument at least once a month with a mild soapy solution and luke-warm water. Then rinse with cold water and dry thoroughly. Don't use hot water as it may damage the finish.
- Cleaning and regular check of other equipments should be performed regularly and records should be maintained about their functioning or non-functioning status.
- To ensure the correct use of the equipments, the nurse in-charge should take the responsibility to read instructions about new equipment and take a small session for all staff nurses or people using that equipment.
- Main instructions and precautions of equipment should be printed out and pasted near the equipment.

MODULE 6

Record Keeping

Unit 6.1 Maintaining Records

About this Module

This module discusses about maintaining records for all clients visiting the hospital.

Unit 6.1 Maintaining Records

Learning Objectives:

- Understand and appreciate the importance of maintaining records and registers.
- Know the correct method of maintaining records and using them for referring back in the case of emergency.

Documentation and record keeping is an integral part of nursing practice. Correct and prompt records not only save patient's life but help the nurse to give skilled and safe care and produce written document at the time of need. There must be a list of records and registers being maintained in a hospital.

All patient records should –

- Be factual consistent and accurate.
- Be written in terms others can easily understand.
- Not include abbreviations, jargon, meaningless phrases or irrelevant speculation.
- Be written clearly, accurately and be dated, timed and signed.
- Be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient.
- All the details should be mentioned about event including patient's objective and subjective expression.
- The records should be compiled and stored in a way that they are easily traceable whenever required.
- Be kept confidential and should be shared only with the medical team for diagnostic and treatment purposes.
- All the procedures performed on the client by a nurse or physician and decisions taken by the medical team should certainly be recorded to keep a track of the treatment.

MODULE 7

Maintaining Correct Posture

Unit 7.1 Correct Posture during Caring for Clients

About this Module

This module discusses about maintaining correct posture while working in Merrygold. This is especially written for nurses because if they are unaware of correct posture to be maintained while working, they might face severe physical stress and land up having complications.

Unit 7.1 Correct Posture during Caring for Clients

Learning Objectives:

By the end of this module the participants will be able to –

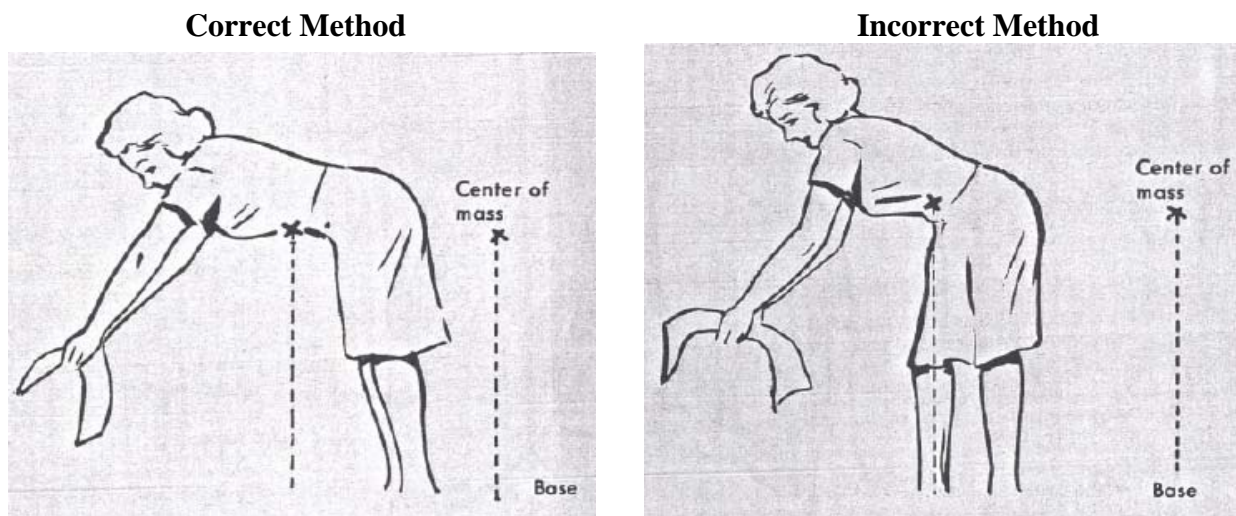
- Understand the importance of maintaining correct posture while caring for client.
- Know about extremely important tips related to health care.

Nurses' give and give until they have nothing left. Many nurses good at their work, don't even realize when they have started putting themselves in trouble.

Few tips if followed can keep nurses, comfortable at work, increase their efficiency and avoiding back aches and body aches. These are –

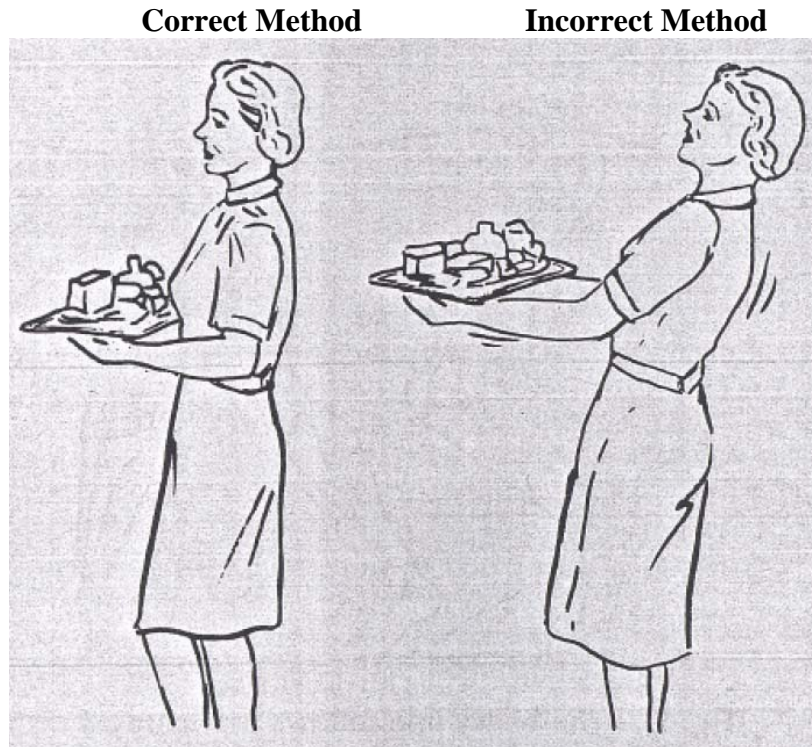
- Always stand with both the legs slightly apart, which helps maintaining balance while standing and balances the weight of the body equally on both legs.
- Avoid continuously long standing position.
- While bending down, flex knees while keeping the backbone straight. While picking up something from ground, extend one foot in front for support.

Fig 14: Method of picking up things from ground



- While carrying any article or tray, keep the article, close to the body and walk straight but not too close to touch the body and clothes.

Fig 15: Method of carrying tray/ articles while walking



- Take help of nurse's aid, ward boy or other nurse, while shifting, lifting or turning the client.
- Involve the client in their care as it makes physical care easier and effortless. Assistance from few family members can also be taken.
- Wear extremely comfortable shoes.
- Avoid heels while on duty and wear shoes with good grip. This will reduce the effort in walking.
- Sit straight while writing notes or working on computer.
- Perform foot exercise in between whenever get free time by flexing and extending the foot and moving it forward and backward.

Apart from maintaining correct posture, there are few more things to be kept in mind to avoid health hazards –

- Try to have food on time and relax while eating.
- Drink lot of water.
- Empty bladder and do not retain urine, due to work pressure.
- Consciously blink eyes while working long on computers.
- Maintain universal precautions with all clients to avoid infectious diseases.

MODULE 8

Maintaining Integrity

Unit 8.1 Maintaining Integrity

About this Module

This module discusses about maintaining integrity in a professional environment as a hospital's. This is an important module for all the staff members of Merrygold Hospital, as through this module, health professionals can become role models for the people joining Merrygold network.

Unit 8.1 Maintaining Integrity

Learning Objectives:

- Understand the basic pre - requisites for maintaining professional integrity.
- Able to relate with the examples written in the module and would be encouraged to take the issue positively.

"True Integrity is doing something right, even when no one is looking."

- Oprah Winfrey

Maintaining integrity of any profession is as important as being in the profession. Nurses are responsible for nursing decisions that are not only clinically and technically sound but also morally appropriate and suitable for the specific problem of the patient undergoing treatment.

The basic pre - requisites for maintaining professional integrity are –

- **Update knowledge** – Nurses are hard working and sincere but many a times face difficulties in managing a client due to the lack in updated knowledge. Up to date and correct knowledge can make any nurse, efficient in handling emergencies and also confident in accomplishing routine tasks with competency. Such nurses will not only perform their activities with full competence but also will keep a check on the activities of other health professionals and will make proficiency, a culture in the hospital.
- **Do not misuse or disrespect uniform** – A uniform is not just a piece of stitched cloth but it signifies a lot for a health professional. A nurse's uniform earns her the respect, trust and consent from patients, to perform any procedures on them, so nurses should understand the value of their uniform.
The uniform should only be worn during duty hours only and special attention should be given on its cleanliness. A properly ironed, complete uniform is the one to be worn on duty and inappropriate jewelry, sandals, shoes should not be worn with it. The uniform should never be used to get some work done which breaks rules.
- **Do not be rude to the client physically, mentally or socially** – Uniform does not give anyone a right to behave impolitely with clients. Every health professional in uniform is bound to help and assist patients and should not behave rudely to clients in any way. Nurses should

understand the ignorance, pain and anxiety of clients, which can sometimes lead to their irritating and uncooperative behaviour. Understanding clients, reassuring them and explaining them is the only solution for making them comfortable.

- **Do not accept or demand gift/ money/ reward for caring** – Accepting or demanding money/ gifts etc. from patients is equal to taking money for doing ones basic job, for which one is already being paid from the organization. A sense of happiness and satisfaction of providing excellent care to clients and saving lives will only sustain till the time, work is done as the part of the job and not for receiving gifts from clients.
- **Do not discriminate between clients** – Discriminating among clients on the basis of caste, class, nationality, personal liking and acquaintance is totally unacceptable in medical profession and against the integrity of the profession.
- **Respect for individual needs, beliefs and values, psychological and spiritual needs** – Clients in hospital come from different backgrounds and possess different values and beliefs. The nurses should accept them all, with a non-judgmental attitude and should provided care according to their needs. A nurse can obtain full cooperation of clients, if she keeps in mind, their physical, psychological as well as spiritual needs.
- **Provide as much comfort, dignity, privacy, alleviation of pain and anxiety as possible** – Maintenance of client's dignity and privacy should be the prime necessity, for a nurse during any procedure. Proper explanation should be given to clients, to reduce anxiety and immediate steps should be taken to alleviate client's pain.

Nurses have a right to refuse to participate in procedures, which would violate their reasoned moral conscience

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