**Ministry of Public Health Afghanistan**

**General Directorate of Curative Medicine**

**Directorate of Central Hospitals**

**Kabul Mental Health Hospital**

# General Psychiatric Nursing Procedure Manual

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# 1. Nursing Procedure Manual

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# MENTAL HEALTH AND PSYCHIATRIC NURSING.

## 1.1: Admission of a Psychiatric Patient.

**Definition:** This is the process of receiving and detaining a patient in a health care facility.
**Purpose:** To provide a safe environment for therapeutic interventions.

**Indications:**
All patients:
- Whose relatives are not able to provide adequate care at home.
- Who need close monitoring.
- Who are dangerous to themselves and to others.
- Suffering from substance related disorders requiring detoxification.

### A. ASSESSEMENT:
**Assess**:
- Mental status of the patient (rationale- to determine if the patient is violent, the type of room, emergency intervention and assistance required.)
- The physiological state of the patient. (To determine if the patient can tolerate the complete procedure of admission.).
- The number of patient's carers.(To determine if there is adequate space and the seating arrangements required for comfort).

### B. PLANNING:
**Self**:
- Review admission requirements for various admission orders.
- Reflect on own feelings of anxiety and how to control them.
- Wash hands to prevent transfer of microorganism to patient and relatives.

**Patient**:
- Offer the patient and his /her carer seats.
- Explain procedure to the patient and carers.

**Requirements**:
Assemble and arrange the following within comfortable reach but away from the patients reach. Table with;
- Pen, plain paper.
- Continuation sheets.
- Consent form.
- Admission record book.
- Report book.
- Psychiatric note Nursing notes.
- Assorted charts (vital signs, fluid charts, treatment).
- Emergency drugs including benzodiazepines, phenothiazines, (e.g. chlorpromazine) 50% dextrose.
- Hospital uniform.

**Environment**:

- A room that provides privacy. Well lit and ventilated with no dangerous equipment.
- Adequate seats.
- Sitting arrangement that allows for easy exit, movement and restraint.
- Strong room for restraining aggressive patients with a mattress and adequate linen.
- Examination couch.

## C. IMPLEMENTATION:

**Steps:**

1. Welcome the patient and his/her carer and offer them seats (To enhance comfort, relaxation and promote cooperation).
2. Check validity of the admission legal documents.(To ensure the patient is legally admitted in the hospital and to ensure patient's protection).
3. Take history from the patient and/or carer(See history taking procedure)(As part of assessment to establish data base, make psychiatric and nursing diagnosis).
4. Perform mental state assessment (see procedure) (As part of assessment to make psychiatric and nursing diagnoses and plan for interventions.
5. Perform physical examination (See procedure), and take vital signs-(see procedure) To detect other co morbid medical conditions.(To determine presence of any injuries sustained and establish baseline data).
6. Explain the possible modes of treatment.
7. Complete request forms for routine investigations such as Liver functioning. (Investigations are necessary to rule out other medical conditions that are commonly overlooked. These include Diabetes and dehydration.)
8. Inspect all the valuables and identify items to be taken home by relatives.(Ensure safety of patients property).
9. Label, make a list and appropriately store items that must be left in the ward.(To ease identification of patients property and avoid loss).
10. Introduce the patient to staff, other in –patients and ward annexes as appropriate. (To promote quick adjustment to hospital environment, relieve anxiety and promote security. Improve patients image and hygiene's status)
11. Ensure patient takes a bath (If necessary) and changes into hospital uniform.
12. Give due treatments.(To aid recovery).
13. Develop a nursing care plan.(For systematic, organised and quality care).
14. Keep the patients file in the file cabinet. (Ensure safe custody of legal documents for reference.).
15. Keep emergency trays in the respective cupboards.(Ensure safe custody and readiness for subsequent use.).
16. Store the vital signs observations equipment in the cupboard.
17. Dispose the used equipment and supply according to disposal procedure.(To prevent transfer of microorganism to patients and staff.

## D. EVALUATION:

**Evaluate**:

1. Patients interaction with other staff.
2. If patient can locate the various ward premises.
3. If the assessment done is adequate for diagnosis and plan of care.
4. The feeling of relatives about admission.

## E. DOCUMENT:

**Record:**

- The history obtained.
- Findings of physical and mental state examination.
- Any treatment given; dose, time, route and any adverse reactions.
- Priority interventions.
- Findings of evaluation.

### 1.2-1: PSYCHIATRIC HISTORY TAKING:

**Definition:**

This is a systemic procedure of gathering subjective and objective data or information about the patient's state of health.

**Purpose:**

To establish base line data to facilitate the psychiatric formulation, process of making psychiatric nursing diagnoses and planning for therapeutic interventions.

**Indications:**

- Any patient seeking mental health/psychiatric care.
- On first contact with a patient or informant.

### A. ASSESSEMENT:

**Assess**:

1. If the environment provides for safety (Psychiatric patients can turn violent and use equipment within the environment to injure themselves, staff, carer and other patients).
2. If environment provides for privacy.(Privacy ensures maintenance of patients dignity and comfort thereby promoting cooperation for patient and carer)
3. Client's general physical and mental state. (To determine the need to validate data from an alternative source (informant) or defer the procedure until history taking is possible).
4. Patients and carer/guardians understanding of the procedure. (To determine the explanation needed for allaying anxiety and promoting cooperation.)

5. Determine requirements.(To confirm availability and suitability)

**B. PLANNING**:

**Self**:

- Examine own ability to communicate effectively.
- Review history taking procedure and its contents.
- Determine own anxiety and put under control.
- Wash hands.

**Patient**:

- Greet patient and introduce self and offer a seat (create rapport).
- Explain procedure to patient and career.

**Environment**:

- Arrange seats to make provision for same height, a square setting of 90 degrees angle. Full view of the patient and carer with no barriers created between patient, carer and the nurse.
- Ensure easy access to the door by the nurse.
- Adequate space with adequate light.
- Adequate chairs and a table.

**Requirements**:

- Assemble and arrange the following items neatly on a trolley or table within easy access to the nurse but away from the patient:
- Plain papers
- Nursing notes
- Continuation sheets
- Pens

**C. IMPLEMENTATION**:

**Steps**:

**Introductory phase**:

1. Assume a relaxed sitting position that demonstrates availability and not in a hurry. (Makes patient and carer feel accepted, relaxed and promote disclosure).
2. Explain to patient the approximate time history taking is likely to take and what is required of them.(Prepare patient for concentrations).
3. Inquire from the carer(s) the relationship with patient.
4. Discuss general topics for about one minute.(Allow for relaxation and promote disclosure)

**Working phase**

5. Observe principles of interviewing techniques.
6. Observe patient for non verbal communication and validate them.
7. Ask open ended questions and use simple language.
8. Obtain, interpret and record complete information on the following;-

a) **Biodata**, - Reasons for referral: state in everyday language why the patient has been referred- chief complaint: (allegations and patient response)- mode of admission-
b) **History of past illness** (psychiatric, medical, surgical, obstetric for women-Prenatal history-
c) **Prenatal. Infancy, Childhood, adolescences, adulthood, education, religious, occupation/work record, and socio-cultural background;** -
d) **Psychosexual**: Begin sexual history by tactfully asking how the client acquired information about sexual matters. Ask whether the patient's sexual life is satisfying or not.
e) **Habits**: tobacco, and other substances of abuse;
f) **Pre-morbid personality**-Leisure activities, Mood, Character, Attitude and standards towards the body, health, illness, religious and moral standards.
g) **Early childhood signs of emotional disorders** (sleep walking, stammering)

**Terminal phase**

9. Explain to the patient that the information required for the time being has been obtained, however, if more information is required then he/she may be called. (Prepares patient and carer for end of history taking so that they don't feel rejected).
10. Ask patient and carer if they have questions to ask.(Encourages the patient/carer to clarify their issues of concern)
11. Thank patient and carer(s) and release them.(To signal the end of the working session while still maintaining a therapeutic relationship)
12. Keep patients' notes and files in respective cabinet.(For safe custody and confidentiality of patient's notes.)
13. Wash and dry hands. (Prevent transfer of microorganisms)

## D. EVALUATE:

**Evaluate**:

1. Quality of history obtained.(To determine if further history is required)
2. Adequacy of history in planning interventions. (Adequate history is required to help plan interventions.
3. Client's reaction during interview.(Reveals relationship between patient and carer helps evaluate effectiveness of patient preparation for the procedure)
4. Consistency of verbal and non verbal communication and diagnostic investigations.(Validity of data for accurate diagnosis)

## E. DOCUMENTATION

**Record:**

- Record full history obtained

- Specific issues of concern to patient and carer
- Any anxiety observed from patient or carer
- Areas of history that require further investigation
- Relationship between carer and patient during interaction

### 1.2-2 MENTAL STATE EXAMINATION/ASSESSMENT (MSE/A)

**Definition**

This is a formal and systematic assessment of client/patients cognitive functions, thought process, perception, speech, mood, appearance and behaviour.

**Purpose:**

To establish data base necessary for diagnostic formulation and therapeutic interventions.

**Indications:**

- Any patient seeking mental/psychiatric care
- On first contact with patient /client
- During routine monitoring progress of patients
- In –patient before discharge

### A. ASSEMENT

**Assess**

1. Environment for safety and quietness(Excessive stimuli may destruct patients concentration and interfere with assessment)
2. If environment provides for privacy(Privacy ensures maintenance of patients dignity and promotes cooperation)
3. Clients general state.(To determine if patient is likely to turn violent during the examination and assistance that maybe required)
4. Clients/patients understanding of the examination.(To determine explanation needed for allaying anxiety and promoting cooperation)

### B. PLANNING

**Self**

- Examine own ability to communicate effectively
- Review procedure for mental state examination
- Examine own anxieties and control them
- Wash and dry hands

**Patient**

- Greet patient, introduce self and offer a seat
- Explain procedure to patient and career

**Environment**

- Quite, safe room with relative privacy but within full view of other staff
- Arrange seats to make provision for same height, a square setting of 90 degrees, full view of the patient with no barrier created between patient and psychiatric/mental health nurse
- Easy access to the door by the nurse
- Adequate sitting space with adequate light

**Requirements:**

- Assemble and arrange the following items neatly on a trolley or table within easy access to the nurse but away from the patient:
- Nursing notes
- Continuation sheets
- Pen
- Patients file and previous mental state examination findings(where applicable)

## C. IMPLEMENTATION

**Steps**

1. Assume relaxed sitting position at an angle of 90(Makes the patient feel accepted and enhance patient's concentration)
2. Maintain adequate space as tolerated by patient(Patient may interpret being too close as intruding into his/her personal space and this can precipitate irritability)
3. Explain to patient the approximate duration of assessment and what is required of him/her.(Prepare patient for concentration and cooperation)
4. Discuss general topics for about one minute(Allows for relaxation and encourages patient to answer questions without feelings of interrogation)
5. Observe principles of interviewing techniques.(Promotes effectiveness in obtaining information)
6. Observe patient for non- verbal communication and validate them.(Reveals information and mental process that patient may not be able to express verbally)
7. Ask open ended questions and use simple language.(Facilitates understanding and enhance self expression)
8. Obtain, interpret and record complete information on the following;(Enables the nurse to identify and classify the mental disorder the patient is suffering from, mental capabilities and establish a data base for planning and evaluating effectiveness of interventions, rehabilitation and follow- up care.)

- Appearance: Physical handicaps, Dressing(whether appropriate, symbolic), grooming(kempt or unkempt), eye contact held, facial expression, posture and walk, body build, indication of recent weight loss
- Behaviour and psycho – motor activity: Restlessness, agitated, lethargic, mannerisms, tics, echopraxia (compulsive imitation of others' actions), Pakinson like symptoms including, akathisia and dyskinesia
- Rapport: Whether established and maintained or not.(friendliness, cooperation, or hostility and defensive)
- Speech: Normal flow rate, pressure of speech, spontaneous or non spontaneous, poverty of speech, mute, monosyllabic

- Mood: Depressed, irritable, anxious, angry, expensive, euphoric, elation. Diurnal/ daytime variation, labile etc
- Effect: Appropriate, constricted, flat, blunted, etc
- Form of thought/thought process:
  - Logical, coherent, understandable
  - Neologisms
  - Word salad
  - Circumstantialities and tangentiality (relevance)
  - Confabulation
  - Loosening of association
  - Flight of ideas
- Thought content: Contents of the patients thoughts including overvalued ides, delusions, obsessions, compulsions, phobia and suicidal ideas.
- Perception: Illusions, hallucinations, view of self (self concept)
- Sensorium and cognition: Including abstract reasoning, judgement, consciousness, orientation, memory, alertness, concentration and attention
- Insight: Whether present/complete or absent
- Vegetative symptoms:
  - Appetite increase or decrease
  - Insomnia or Hypersomnia
  - Loss of interest or energy in everyday activities

9. Explain that information required for the time being has been obtained.(Prepare patient for end of mental state examination so that patient does not feel is being rejected).
10. Ask patient if she/he has any questions to ask.(Encourage the patient to clarify his/her issues of concern)
11. Thank patient and release him/her.(Demonstrates appreciation and promotes cooperation)
12. Keep patients notes and files in respective cabinet. (For safe custody and confidentiality of Patient's notes)
13. Wash and dry hands.(Prevents transfer of microorganism)

## D. EVALAUTION

**Evaluate**

1. Quality of information obtained
2. Clients reaction during examination

## E. DOCUMENTATION

**Record:**

- Record full findings of mental state examination
- Time taken during examination
- Specific issues of concern to patient identified
- Any anxiety observed from patient
- Areas of examination that require further clarification
- Comparison of findings from previous mental state examination(if applicable)

## 1.2-3: PHYSCIAL EXAMINATION

**Definition:**

The systemic review of the body systems and structures by use of inspection, palpation, percussion and auscultation technique

**Purpose:**

- To establish database for the patient's normal abilities, determine risk factors for dysfunction and current pathology.
- To formulate clinical diagnosis on current health state and plan for appropriate interventions.

**Indications:**

- All new patients on first contact or admission
- Prerequisite to planning of care
- On routine monitoring of a patients progress
- After an incidence such as restraint, seclusion or escape
- All patients due for discharge

### A. ASSESSMNET

**Assess**

1. Environment for
   - Safety (Psychiatric patients can use dangerous equipment to harm staff and themselves)
   - Privacy (Ensure co-operation from the client and provision of information by the client)
2. Client's present general condition.(To determine if assistance from other members of staff is required)
3. Patients/carer understanding of the procedure. (To determine clients receptiveness to the physical examination process)
4. Client/patient's experience and data from previous physical assessment (To facilitate a complete and systemic examination by reducing the possibility of overlooking important findings and providing a base line for comparison.)
5. Determine the required equipment(To ensure availability and suitability)

### B. PLANNING

**Self**

Review procedure of physical examination (See Physical Examination chapter)

**Patient**

- Introduce self to the patient

- Explain procedure to the patient and obtain consent Re view procedure of physical examination)

## C. IMPLEMENTATION

**Steps**

1. Wash and dry hands.(Reduces transfer of microorganisms)
2. Place equipment and instrument within easy reach. (To promote efficiency)
3. Review clients history (See psychiatric history taking)-(The first step in holistic assessment. Provides important clues on areas of focus or follow-up during physical examination.
4. Take vital signs (To ascertain the haemostatic assessment. Provides important clues on areas of focus or follow-up during physical examination
5. Place patient in appropriate position. (To ensure patients comfort and easy accessibility of the areas to be examined)
6. Start systemic examination using a combination of head to toe and body systems approach; using the techniques of inspection, palpation, auscultation and percussion) (Ensure that no body system are overlooked and that time is used effectively)
7. Present any appropriate findings. Ask for additional information and discuss with client/patient issues of concern to him/her (Provides closure for examination and communicates feedback information)
8. Formulate a nursing care plan.(Facilitate provision of quality and evidence based individualized nursing care)
9. Clean, replace and discard equipment according to institutional waste disposal and decontamination protocol (Promotes safety for clients, patient and staff)
10. Wash and dry hands.(Reduces transfer of microorganism)

## D. EVALUATION

**Evaluate**

1. The quality of data obtained from the client(Determine if data is adequate for formulating accurate nursing diagnoses)
2. If the client's needs have been identified(Effective management depends on accurate identification of clients needs)
3. The client's behavior during the examination.(Determines if client was adequately prepared for examination)

## E. DOCUMENTATION

**Record:**

- Outcome of the evaluation.
- Date , time, and duration of assessment
- Chief concern of the patient and findings during examination abnormalities
- Interventions implemented

## 1.3: Establish a Therapeutic Nurses- Patient Relationship

**Definition:**

The process of establishing a goal oriented relationship that leads to positive change (growth and development) in the life of the parties (client and the psychiatric nurse) involved.

**Purpose:**

To assist clients/patients develop insight into their problems and develop effective problem solving abilities that enables them utilize their potentials and adapt to life situations.
**Indications:** All patients experiencing emotional problems or mental disorders

### A. ASSESSMNET

**Assess**

1. Presence of perceptual and thought disorders.(Determines communication strategy to apply as perceptual and thought disorder interfere with interpretation of facts)
2. Amount of physical space and sitting arrangement preferred by clients/patient.(Some clients/patients feel their space is intruded if they sit too close to nurse or intimidated if they sit at a lower level then the nurse)
3. Any speaking or communication disabilities. (To determine provision necessary to accommodate the disabilities)

### B. PLANNING

**Self**

- Review clients notes to obtain full information about the client/patient
- Plan for specific points and information gaps for clarification with clients/patient
- Reflect on own feelings and behavior that are likely to negatively influence clients/patients response
- Wash and dry hands

**Patient**

- Greet patient and introduce self
- Explain to patient the activity that he/she is to be involved in
- Set the time for the therapeutic sessions.

**Environment**

- Ensure a quite room or space free of disturbance and interruptions
- Plan sitting arrangements that allow for nurses easy exist if needed
- Organize sitting arrangement that allows the nurse to have full view of the client and yet not intimidating.

**Requirements**

- Stationary
- Seats

## C. IMPLEMENTATION

**Steps**

1. Welcome the client/patient to the seat.(Facilitate patient comfort and cooperation)
2. Sit squarely.( Allow for observations and eye contact without intimidation)
3. Maintain eye contact( conveys ones interest in the client/patient)
4. Speak with the client/patient on an appropriate (adult/child) level of development( Patient feels recognised and not intimidated thereby enhancing participation)
5. Give full concentration to the patient/client and avoid interruptions during interaction(Communicate respect for client/patient and builds trust that promotes concentration and disclosure)
6. Start the interaction with general topics which should not take more than two minutes(Puts patient/client at ease and allows for patient to give information)
7. Speak slowly and distinctly using appropriate tone variation(To maintain the client/patient interest and concentration)
8. Use open ended questions when asking client/patient what his/her concerns are. (Covey respect and gives client/patient a feeling of direct control over his/her issues. It also promotes self esteem).
9. Give the patient time to respond, exercise tolerance and patience( Allow patient/client to reflect on his thoughts and promote effective communication)
10. Observe facial expressions(To identify any conflicting messages conveyed)
11. Establish regular meeting times and observe punctuality.(For consistency and confidence that promotes a trusting relationship)

**Introductory phase**

12. For new patients, introduce a summary of the need or interaction session(To orientate client/patient and encourage participation)
13. For old client/patient (one with whom interaction session are already in progress), briefly review the previous discussion and then introduce the topic of today
14. Observe client/patient behaviour during this phase( To determine if client/patient is moving at expected pace and provides direction of interaction)
15. Help client/patient identify his/her needs and challenges(Promotes client/patient insight and perception which encourages his/her active participation)
16. Discuss the details of expectations and responsibilities of both nurses and client/patient(Encourage client/patient to take responsibility minimize his/her tendency of becoming dependent)
17. Gather more data from client/patient and identify patients strengths and limitations(To build strong data base and reduce possibility of client/patient being frustrated by too much expectation than he can perform
18. Formulate nursing diagnosis, set goals that are agreeable to both patient and nurse(Provides bases for evaluating effectiveness of the relationship)
19. Develop a plan of action that is realistic for meeting established goals.(Enhances motivation and minimizes frustrations)

20. Explore feelings for discomfort and anxiety(Interactions remain on a superficial level until anxiety subsides)

**Working Phase**

21. Guide the client/patient along topics of discussion. (To prevent deviation and circumstantialities)
22. Discuss client/patients problems and reality orientation.(Promote client/patient's insight and perception and helps client/patient learn problem solving technique)
23. Observe client/patient for signs of anxiety that may arise in response to discussion of painful experience(Provides data for planning interventions for reduction since high level of anxiety leads to client/patient resistance)
24. Continuously observe if clients/patient is ready for termination phase(Objectives of termination phase are not achieved if client patient is rushed)
25. Ask open ended questions(To allow client to elaborate details)
26. Offer silence and other appropriate therapeutic techniques of communication to obtain more information from client/patient( Communicate concerns, presence and promotes client's initiative to take lead on problem solving)
27. Deal with needs that require immediate attention(Facilitate forward movement in the therapeutic relationship)
28. Evaluate and set goals from time and change them where necessary(Ensure that goals are realised and client/patient benefits

**Termination phase**

29. Recognize and explore feelings of client/patient about termination(To detect signs of sadness and loss associated with termination phase)
30. Encourage client/patient to discuss the identified feelings (Helps the client/patient to learn that his/her feelings are normal experience which may promote growth process during termination)
31. Continuously evaluate the outcome of the set objectives during each session( Ensure that the activities undertaken are correct)
32. Summarize what has been discussed with the client/patient and allow him/her to ask questions(Clarify any factors that may hinder interaction)
33. Refer the client/patient depending on the outcome of the objectives.(Ensure maximum benefit to the patient/client)
34. Thank the patient for being tolerant and release as appropriate.(Covey appreciation and respect)
35. If the interaction sessions are to continue, then set the time and date of meetings with client/patient(For consistency and confidence)
36. Explain to client/patient that the meetings are over.(Allays client/patient's anxiety)
37. Give room for consultation as necessary.(Builds patients confidence in seeking further help if needed.

**NB:** When the client/patient experiences feelings of sadness and loss, behaviour to delay termination may become evident. If the nurse experiences the same feelings, he or she may allow the patients behaviour to delay termination. For therapeutic closure, the nurse must establish the reality of the separation and resist being manipulated into repeated delays by the patient by observing the following:

- Several interaction sessions from a therapeutic nurse- patient relationship

- Avoid a social type of relationship during any interaction session
- Avoid excessive writing during a interaction session as it may distract the patients attention and may prevent the therapist from eliciting important information from patient.
- Maintain confidentiality through the interaction sessions
- Keep to the set time(15-20 minutes per session)
  - A very short session may not enable time therapist to meet objective
  - Avery long session may be boring for client/patient
- If the client becomes restless during any phase of interaction session
  - Terminate immediately and thank him for his cooperation, then handle the immediate problem appropriately
  - Ask if the patient would like to have another session

## D. EVALUATION

**Evaluate**

1. If the patient was satisfied with the interactions. (Determine the effectiveness of the relationship)
2. The extent to which patients is able to solve or cope with similar situations in future(Confirm that patient growth was effective)
3. If the patient verbalized his /her problems. (Confirm that trust was achieved in orientation phase)
4. Whether the patient is comfortable with termination. (Determine the effectiveness of therapeutic closure)
5. 

## E. DOCUMENATATION

**Record:**

- Outcome of evaluation
- Any concerns verbalized by the patient
- Any concerns that need follow-up care by health care team or other professionals

## 1.4: Electroconvulsive Therapy (ECT) Care

### 1.4.1: Pre- ECT

**Definition:**

The care given to a patient from the time ECT is prescribed until a patient is taken to the ECT room.
It involves assessment and preparation (social, psychological, spiritual and physiological) of the patient

**Purpose:**

To identify risk factors, and potential problems and manage them in order to put patient in optimal condition before ECT and prevent complications during and after procedure

**Indications:**

All patients for whom ECT has been prescribed

## A. ASSESSMENT

**Assess**

1. Patient's attitude and values towards the ECT. (Facilitate identification of intervention that are necessary for the patient and relatives take the treatment positively)
2. Patient's perception of previous ECT experience (if applicable). (For appropriate planning of care)
3. Patient's knowledge about ECT. To identify information to share with the patient to correct any misconception and promote compliance)

## B. PLANNING

**Self;**

- Have full information about the patient
- Review full information about the patient
- Review ECT procedure and care
- Prepare information to be shared with the patient
- Wash and dry hands

**Patient**

- Ensure patient is ready for the procedure through nurse/patient therapeutic relationship
- Explain the purpose, process and effects of ECT
- Obtained informed consent

**Requirements**

- Vital signs observation equipment.
- Patients file containing notes and duly signed consent form
- Treatment chart
- Vital signs chart
- Pre – ECT checklist
- Container for denture and glasses if required
- Pre medication on a tray

## C.IMPLEMENTATION

**Steps**

1. Educate, patient on basic concepts of ECT. (Ensure patient gets factual information about ECT)
   - Benefits
   - Side effects
2. Take vital signs (To detect any physiological abnormalities and set a baseline data for comparison)
3. Establish base line memory for short and long time events( To detect any memory loss after the procedure)
4. Urinalysis (To detect any renal and or diabetic conditions that may complicate the procedure)
5. Nil by mouth (food) for six hours. (To prevent regurgitation during the procedure and reduce risk of aspiration pneumonia post the procedure)
6. Ensure a good night sleep. (To provide rest in readiness for ECT)
7. Ensure the patient has taken a bath. (To maintain hygiene and prevent infection)
8. Ensure the patient has emptied the bladder/bowel. (For patients comfort and prevention of release or urine/faeces during fits)
9. Check patient for denture, jewellery. (To prevent any interference of the procedure, reactions to the metals (jewellery) and for ease of manipulation during procedure)
10. Change patient into a theatre gown. (Minimize transfer of microorganism to the operating room)
11. Administer pre medication 30 minutes before the procedure. ( To calm down patients and dry secretions)
12. Assemble patient's documents (file, nursing notes, and treatment sheet)

**D. EVALAUTION**

1. The level of anxiety during pre ECT period. (To determine effectiveness of pre –ECT Preparation)
2. Interpret the vital signs. (Determine whether physical status of the patient can withstand the procedure)
3. Patient's readiness for ECT procedure. (Readiness will enhance the recovery process)

**E. DOCUMENTATION**

- Completed pre- ECT checklist
- Any adverse observations made
- Condition of patient during handing over to the ECT room nurse

**1.4-2: INTRA –ECT CARE**

**Definition:**

Psychiatric nursing care given to patient from the time he/she enters an ECT room to the time ECT is performed and the patient taken to recovery room

**Purpose:**

To facilitate effectiveness of ECT, promote patient safety and minimize its complications.

**Indications:**

Patients undergoing ECT

**A. ASSESSMENT**

**Assess**

1. Patients preparation for ECT
2. Requirements for ECT procedure
3. Appropriateness of the room
4. Assistance required from other staff

**B. PLANNING**

**Self;**

- Review procedure of ECT and the role of the nurse
- Wash and dry hands

**Environment**

Clean room with all required requirement, instruments and supplies
The room that provides for;

- Privacy
- Adequate working space
- Adequate ventilation and light

**Requirements:**

- Oxygen delivery set
- Mouth gag
- Laryngoscope
- Endotracheal tubes and fittings
- Syringes in various sizes, IV infusion sets
- Adequate anaesthetics
- Needles of various sizes, cannula/branulas
- Suction machine
- Electrocardiogram (ECG) machines
- Vital signs observation machines and instruments
- EEG machine and pulse Oximeter
- Strappings, bandages, methylated spirit, swabs in a galipots, scissors, tray
- Cutdown tray
- Anaesthetic machine and ventilator
- Theatre table, urinalysis equipment
- ECT machine
- Resuscitation drugs in a tray including;
  - Adrenaline
  - Dextrose 50%

- Aminophylline, Hydrocortisone
- Sodium Bicarbonate
- Frusemide, calcium Gluconate
- Diazepam, potassium hydrochloride
- Intravenous fluids, e.g. Dextrose 5%.Normal saline

- Assorted stationery including;
  - Continuation sheets
  - Consent forms
  - Treatment sheets

**C.IMPLEMENTATION**

**Steps;**

1. Greet patient by name. (To identify patient positively)
2. Introduce self and other staff to the patient. (To allay patients anxiety and promote comfort)
3. Assist patient on to ECT table/surface. (Ensure safety and readiness of patient)
4. Place patient on supine position with hyperextension of the neck. (To allow for the intubation and fixing of ECT,EEG,ECG and oxygenations machines)
5. Explain to the patient in simple language steps of the procedure/activities being performed on him/her while still conscious. (Allays patients anxiety and promotes patients cooperation)
6. Ensure ECG machine and pulse Oximeter are accurately placed. (Allow for accurate measurements and readings of brain activity and oxygenation status of patient during ECT)
7. Provide suctioning if needed. (Maintain patent airway and adequate air entry to the lungs)
8. Monitor the vital signs, cardiac activity, oxygenation, electrical activity of the brain. (To detect signs of acidosis, and other abnormalities indicative of homeostatic imbalance in electrical activity of the brain and cardiovascular systems)
9. Provide gentle firm support to patient’s arms, legs and joints when Electroconvulsive current is commenced until seizure are over. (To prevent possible fractures and dislocations from the effect of induced seizures, prevents patient from falling off the bed)
10. Observe the nature and duration of seizures, body parts affected and intensity.(Determines success of procedure)
11. After the procedure place patient in the recovery position in bed and transfer patient to recovery room if $Sa0^2$ is ≥ 95%. (To ensure a patients safety and allow for post ECT observation as patient gains consciousness before transfer to the ward. Ensure patient doesn’t leave ECT table in acidosis state)

**E.EVALAUATION**

**Evaluate:**

1. If vital signs and pulse Oximeter level remain within normal levels during ECT procedure and before returning to the ward.(Indication that adequate perfusion was maintained during treatment)

2. Observe any crackling sounds and abnormal joints. (To determine if patient sustained fractures/dislocation during seizures.)
3. If EEG machine indicated expected Alteration in brain activity. (To determine if required seizures levels were observed)

## C. DOCUMENTATION

**Record:**

- The condition of the patient as received in ECT room
- Treatments given during the procedure
- The success of the procedure
- Vital signs, ECG and Sa02 readings
- Nature and duration of seizures during procedure
- Any adverse observations and intervention measures taken during the procedure

## 1.4-3: POST –ECT CARE

**Definition:**
Nursing care given to the patient in the recovery room and the subsequent 24 hours after ECT procedure

**Purpose:**

To minimize post- ECT complications and promote quick recovery from its effects

**Indications:**
All patients after ECT procedure

## A. ASSESSMENT

**Assess**

- Observation instruments and resuscitation equipment
- Seizure levels achieved
- Level of consciousness
- Signs of brain and musculoskeletal injury

## D. PLANNING

**Self;**

- Wash and dry hands
- Review the clients/patients notes to determine the type of anaesthesia and drugs administered during the procedure

**Patient**

- Explain to the patient the reason for various equipments used
- Inform patient of expected experiences and how to cope with them
- Explain reasons for frequent observations and need for his/her cooperation

**Requirements**
***A clean trolley***

- Vital signs observation equipment; stethoscope, sphygmomanometer, thermometer and pulse Oximeter
- Patients observation charts
- Patients file
- Clean hospital gown
- Receiver for dirty swabs

## E. IMPLEMENTATION

**Steps**

1. ¼ -1/2 hourly observations of respirations, pulse and blood pressure. (To determine adverse changes in the homodynamic state of the patient)
2. Maintain patient in recovery position. (To facilitate the flow of secretions, prevent tongue from falling back and ensuring patent airway)
3. When awake explain to patient his/her whereabouts. (Promotes orientation, allays anxiety and facilitates cooperation)
4. Assess the level of memory. (To determine memory loss associated with ECT)
5. Stay with the patient until he is fully awake and oriented. (Ensure patients safety)
6. Escort patient back to ward( Ensure patients safety and facilitates effective handing over patient for continuity of care)
7. Allow patient to verbalize experiences, fears and anxiety related to ECT. (Helps patient cope with ECT experiences and promotes recovery and compliance with care)
8. Assist patient to a quite place or low bed(Allows adequate rest and promoted comfort and safety)
9. Take vital signs observation every 4 hours and reduce to once a day where appropriate (To monitor progress on recovery from the effects of anaesthesia and ECT)
10. Provide patient with highly structured schedules of routine activities.(To promote recovery and minimize confusion)
11. Observe the patient for the following: (To detect signs of confusion and loss of memory which are common post ECT)
    - Ability to perform self care activities
    - Ability to remember ward routines
    - Ability to remember staff and other patients
12. Observe the gait of the client/patient when walking (To detect signs of fracture post ECT)
13. Perform mental state examination regularly. (To establish if patient has achieved full orientation and determine whether the patient benefited from ECT)

## F. EVALAUATION

**Evaluate**

1. Mental status of the client/patient. (To determine success of ECT)

2. If patients level of anxiety was maintained at manageable levels. (To determine if patient's psychological preparation was achieved pre- ECT)
3. If the patient/family can verbalize understanding of the procedure. (To determine if patient/family learning needs were met)
4. If patient recovered from effects of ECT within expected time and without/minimal complications. (Evaluate effectiveness of pre-, intra-, and post- ECT care)
5.

## G. DOCUMENTATION

**Record:**

- The general progress of the patient and memory status
- Treatment given pre- during and post –ECT
- Findings of all the vital observations taken
- Signs of fractures
- Concerns verbalized by the patient/family members

## 1.5-1: PATIENT WITH SUICIDAL BEHAVIOUR

**Definition:**

Nursing intervention for a client/patient who is at high risk of committing suicide or deliberate self harm

**Purpose:**
To prevent patient/client from performing self destructive acts (injury) that can lead to death by bringing him/her to self realization and assisting him/her to develop effective coping abilities.

**Indications:**

**Patients who/with;**

- Have verbalized desire to commit suicide
- Are suffering from depressive illness
- Are suffering from severe anxiety or agitation
- Are actively abusing alcohol or substances
- History of attempted suicide
- A family history of suicide
- Terminal/chronic illnesses

## A. ASSESSMENT

**Assess**
1. Own ability as a therapist to deal with the situation. (Determine if assistance is required)
2. Own knowledge of the condition/ patient (For effective plan of care)
3. The general condition of patient. (To determine the likely mode of suicide)

4. Physical, emotional/psychological needs of the patient. (To plan for appropriate interventions)
5. Appropriateness of the environment for therapy. (To determine if environment is safe and allows for quick response)
6. Understanding and willingness of the relatives to participate in the care of patient. (For continued care and social support that reduces suicidal risk)

**B. PLANNING**

**Self;**

- Review management of patients at risk of suicide
- Review clients/patients notes
- Reflect on own fears/feelings/anxiety and how to control them

**Patien**t

- Explain to client/patient his/her experiences and obtain informed consent for care
- Explain to the patient, the staffs concern about him/her that all interventions will be for his safety

**Requirements:**

- Clean tray containing emergency drugs
- Clean tray containing resuscitation equipment
- Assorted sizes of syringes, needles, cannula and intravenous sets
- Intravenous fluids such as dextrose (in different concentrations) sodium chloride
- Observation and fluid charts

**C. IMPLEMENTATION**

**Steps**

1) Allocate specific nurse (s) to attend client/patient during crisis period until the patient gains self control (For close monitoring, provision of security and support)
2) Search the patient's and his roommates belongings and relative and remove all items considered unsafe (Patients may use this items for self – harm/suicide)
3) Encourage clients/patient to verbalize and explore feelings (Promotes feelings of acceptance, improve self esteem with subsequent ability to evaluate options and develop problem solving skills)
4) Secure a "no suicide contract" from the patient (Demonstrates clients/patient's commitment to abide by therapeutic decision made by both client/patient and nurse)
5) Discuss with client/patient's and give a message of hope that life is worth living. (Allows clients/patients an opportunity to have a wider perspective on issues and helps him/her deal with ambivalent feelings of living/dying)
6) Assign client /patient recreational activities such as volley ball/ table tennis.. e.t.c. (Helps patient release tension/feelings of aggression and enhances healing process)
7) Ensure client/patient is always within view of the nurse at all times and the accompanying relative is also fully aware (Promotes close observation and assures client/patient safety)

8) Do not seclude or allow patient to sleep alone. (Staying with other people reduces the possibility of attempting suicide)
9) Maintain suicide precaution card observations and recordings including 20 – minute visual check on the client/patient; carefully observe and record mood and suicide indicators. (Signs and attempts of suicide are recognised early and appropriate interventions carried out promptly)
10) Physically hand over client/patient at end of each shift. (Evidence of close monitoring and assurance of client/patient safety/security)

## D. EVALUATION

**Evaluate:**

1. Patients self concept. (Positive self image is a sign of improvement and reduces contemplation of suicide)
2. Patients plan to cope with suicide and other challenges in future. (Determine if effective coping and problem solving skills have been successfully developed)
3. Patient's ability to interact with other people. (Indicates the patient/clients ability to integrate into the family and community)

## E. DOCUMENTATION

**Record:**

- Any suicidal attempts or verbal threats. Interventions and their outcome
- Summary of every 20 minutes recording on suicide precaution and no suicide contract
- Visitors received; relationship and nature of their interactions with the patient/client

## 1.5- 2: ALCOHOLIC WITHDRAWAL DELIRIUM (DELIRIUM TREMENS)

**Definition:**
Nursing intervention for a client/patient suffering from acute confusion states and autonomic nervous system hyperactivity occurring within 40 hours – 1 week after cessation of or reduction in long term heavy alcohol ingestion

**Purpose:**
Is to minimize and correct autonomic nervous system effects within the shortest duration and ensure client/patient safety

**Indications:**
Patient in acute confusion states and autonomic nervous system hyperactivity following alcohol withdrawal

## A. ASSESSMENT
**Assess**

1. Own feelings, fear and anxiety related to handling the situation.(Promotes readiness and enhances ability to carry out effective intervention)
2. Procedure on emergency management of acute alcoholic withdrawal delirium-delirium tremens- (Promotes efficiency and effectiveness)
3. Patients understanding of his/her current experiences (To identify and appropriately plan for client/patients needs)
4. Presenting physical psychological/emotional social and spiritual needs. (To plan for appropriate intervention and determine assistance required)
5. The safety of the environment. (A confused patient is at risk of injury)
6. The amount of light in the room. (Plan for adequate light that reduces risk of illusions common in alcoholic delirium)

## B. PLANNING

**Self;**

- Review institutional policy and emergency patient management
- Review care of patient experiencing alcoholic withdrawal syndrome
- Remove any accessories that may cause injury to patient during the care of such patient/clients
- Wash and dry hands

**Staff;**

- Explain to the members of staff that their assistance is required
- Explain to staff on their specific roles during the care of such patients/clients

**Patient/client**

- Explain to him/her what he/her is experiencing and the need to be calm

**Requirements:**

- Clean tray containing parental anxiolytics and antipsychotics, assorted sizes of syringes, needles, branules, IV sets, pack of sterile cotton wool, antiseptic such as methylated spirit and iodine
- Intravenous fluids including dextrose (indifferent concentrations) sodium chloride.
- Resuscitation tray
- Oxygen administration set

**Environment**

- Well ventilated room with minimal stimulation (no wall pictures) and interruptions
- A low bed with bed rails
- Restraints of different types according to hospital policy
- Adequate light but not too bright

## C. IMPLEMENTATION

**Steps**

1. Assist patient to the prepared room and settle him in bed. (Minimal stimulation ensures that patient's anxiety is controlled to minimal levels; Adequate light helps reduce illusions.)
2. Remove any dangerous objects with the patient or in the environment. (Patient experience episodes of hallucinations and may use objects to harm self or staff)
3. Administer prescribed anxiolytics/antipsychotics.(Anxiolytics have sedation and calming effects, Antipsychotic help to control hallucinations through their dopamine antagonistic effects.
4. Assign staff to stay with the patient. (Promotes patients safety)
5. Conduct and record mental status examination and vital signs observations four hourly. (Monitor mental functions to help evaluate progress for appropriate interventions for control; Monitors hyperactivity of the autonomic nervous system and plan)
6. Explain to patient the experience he had and the intervention carried out.(Knowledge of the condition promotes client participation in care and increases compliance)
7. Obtain an informed consent from the patient once they can understand what is expected of them. (Prevents feelings of self blame and facilitates compliance/cooperation; observe clients rights of autonomy)
8. Organize for individual/group counselling. (To ensure a therapeutic process aimed at assisting the clients to control/stop alcoholic ingestion habits)
9. Wash, dry and store equipment. (Ensure the equipment is ready for subsequent use)

## D. EVALUATION

**Evaluate**

1. Outcome of intervention: any injuries sustained during the management
2. Preparedness of the patient to continue with the care
3. Whether an informed consent was obtained

## E. DOCUMENTATION

- Duration of acute confusion, agitation and autonomic nervous system hyperactivity
- Intervention including drugs, restraints measures and their outcomes
- Summary of vital signs and mental state examination findings
- Outcome of evaluation
- Recommended plan for further action

## 1.5-3: ACUTE PANIC ATTACKS

Nursing intervention given to a patient in intense apprehension and severe fear or terror associated with feelings of impending doom.

**Purpose:**
To control the hyperactivity of autonomic nervous system associated with high levels of anxiety while promoting patients safety and enhancing effective coping mechanisms.

**Indications:**
Patients with panic attack

## A. ASSESSMENT

**Assess**

1. The patient's mental state, (Determine the intervention required)
2. The environment. (Over stimulating environment is likely to worsen the panic attack; Dangerous equipment are a threat to patient and staff safety)
3. Availability of vital signs measuring equipment (Ensures efficiency in monitoring autonomic nervous system dysfunction)

## B. PLANNING

**Self;**

- Review institutional policy on handling of psychiatric emergency
- Review procedure of managing acute panic attacks
- Review patients treatment notes
- Reflect on own feelings and ability to handle the situation

**Patient**

- Explain to the patient their experiences
- Explain the planned intervention to patient

**Requirements**

Ensure cleanliness, assemble and organize the following:-
Tray(s) containing;

- Emergency drugs including anxiolytics and B- adrenergic receptor antagonists
- Intravenous drug administration equipment
- Vital signs observation equipment

A quite environment with minimum stimulation and adequate light

## C. IMPLEMENTATION

**Steps;**

1. Wash and dry hands. (Minimize spread of microorganism)
2. Take patient to a quite room with minimum stimulation and explain to patient all actions being taken. (Understanding of actions and a quite room minimize levels of anxiety)
3. Remove dangerous items within the environment. (To ensure safety to both patient and the nurse/staff)
4. Stay with the patient and encourage him/her to discuss his/her experiences. (Reduce feeling of abandonment; nurse's face may be the only contact with reality when overwhelmed with anxiety; Disturbing experiences allows patient to deal with unresolved issues likely to cause anxiety)
5. Maintain calmness and patience when attending to patient. (Nurse acting with anxiety and in a hurry can cause escalating of anxiety in the patient; Calmness promotes trust, a feeling of security and safety)
6. Take vital signs observation 2 hourly and reduce to 4 hourly as appropriate. (Provides for an objective measurement of anxiety levels and base line data for assessing progress of patient)

7. Administer the prescribed anxiolytics and B-adrenergic receptor antagonistic. (Anxiolytics have sedative effects; B – adrenergic receptor antagonistic reduce anxiety symptoms by reducing sympathetic stimulation)
8. Assess patient’s mental status every 4 hours. (To monitor the progress of the cognitive functions)
9. Use simple brief words and messages spoken calmly and clearly.
10. Reinforce reality if distortions occur. (High levels of anxiety obscure clients awareness of physical needs)
11. Attend to physical needs as necessary (Most anxiety states may manifest with severe physical needs)
12. When levels of anxiety are reduced, explore reasons of occurrence. (Recognition of precipitating factors helps in planning intervention for preventing future re-occurrences)
13. Teach patient signs of escalating anxiety and how to interrupt them. (Patient can recognize signs and interrupt progression to panic state)
14. Dispose syringes and used needles according to infection control measures. (Promotes patient and staff safety)

### D. EVALUATION

**Evaluate:**

1. Vital signs were maintained within the normal parameters. (Determine effectiveness of drugs given and other interventions)
2. Patient’s ability to control the anxiety levels. (Anxiety can be reduced by focusing on and validating happenings in the environment; Prevents future occurrence)
3. Patient’s feelings about his/her care. (Determine presence of quality of quality management.)

### E. DOCUMENTATION

**Record:**

- The range of vital signs during the panic attack
- Findings of the evaluation
- Current state of the patient in general

## 1.5-4: AGGRESSIVE AND VIOLENT PATIENTS

**Definition:**

Emergency nursing intervention aimed at controlling and providing safety to patients, staff and others due to patient’s inability to exercise effective coping patterns when overwhelmed by anxiety, disorder thoughts and perceptual process.

**Purpose:**

To control patients aggressive and violent behaviour while promoting effective coping mechanisms and providing safety to the patient, staff and relatives.

**Indications:**

- Patients presenting with range, aggression and poor impulse control
- Patients engaged in a fight
- Patients likely to harm other patients and staff if urgent measures are not taken to control them

## A. ASSESSEMENT

**Assess**

1. Previous violent and aggressive behaviours. (To predict outcome of current behaviour and plan for appropriate intervention)
2. The number, gender and level of preparation of staff to deal with such emergencies. (Determine need for more staff required to handle patient)
3. The environment for dangerous items that can be used by the patient. (To safe guard patient, other patients and staff from being injured)
4. The level of motor agitation and verbal aggression. (To determine when to exercise restraint measures and type of restraint technique to apply)
5. Psychiatric nursing intervention that may be antecedent to aggression. (To minimize further provocation)
6. Perform self assessment for the presence of accessories that can be destroyed or can cause harm to self and patient. Accessories may include staffs;
   - Long fingernails
   - Long hair left hanging
   - Pens, labels, bangles and ear rings

## B. PLANNING

**Self;**

- Review patient's current treatment and when it was last given
- Review facts on how to handle aggression and violence
- Reflect on own emotions and competence required to manage aggression and violence
- Remove any accessories that may cause injury to self, patient and others during restraint
- Stay in safe environment with clear exit

**Patient**

- Ensure short fingernails
- Remove any instruments and equipment that can be injurious to patient
- Explain to patient that he is not under punishment but that all intervention are necessary for his safety and that of others

**Staff**

- Ensure availability of staff and relative
- Explain to staff members the aggressive condition of the patient

- Explain to other staff members the strategic positions in readiness to restrain
- Requirements
- Adequate number of clean blankets
- Tray containing;
  - Injectable anxiolytics and antipsychotic drugs
  - Needles and syringes of assorted sizes
  - Pack of sterile cotton wool
  - Antiseptic lotion/solution such as methylated spirit
  - Kidney dish and galipot
- A clean tray containing first Aid:
  - Pack of cotton wool
  - Pack of sterile gauze
  - Bandages and adhesive tapes
  - Antiseptic lotion/solution
  - Sterile gloves
- Receiver for used items
- Sharps' safety box

**Environment**

- Remove all dangerous items such as chairs, utensils and stones
- Ensure a clear and easily accessible exit from the situation

**C. IMPELEMENTATION**

**Steps**

1. Approach patient carefully at arm's length. (Ensure safe margin and avoids encroaching upon patients personal space)
2. Address patient by name. (Help orientate patient and demonstrate respect and minimize provocation)
3. Request other patients to leave the room. (To maintain a safe environment for all patients and avoids aggravating the situation further)
4. Keep verbal communication briefs when talking with the patient; don't fold arms maintain an open posture. (Demonstrates acceptance and encourages verbalization)
5. Talk calmly, clearly and firmly keeping voice neutral; ask open questions using 'how' and 'where' to help clarify the problem. (Gives an opportunity to patient to express anger verbally by initiating conversation in a non over stimulating environment; 'why' questions are perceived as provocative)
6. Slowly show the patient that there is nothing in your hands. (Helps the patient to feel that he is not being pursued thus reducing tension)
7. Adopt an attentive expression but do not stare at the patient. (Enables the nurse to gauge the patients level of frustration; staring can be interpreted as an attempt to dominate the patient)
8. Call for assistance by shouting, using any signal system or request another patient relative to summon help. (It is unsafe to manage the situation alone)
9. Ask colleague to lead other patients away when the patient is being restrained. (Violent incidence may distress other patients (
10. Organize staff and identify a leader who gives direction on how to contain the situation. (Ensures coordination and efficiency)

11. One psychiatric nurse to prepare and administer prescribed parental antipsychotic or benzodiazepines. (Helps calms the patient)
12. Give clear instructions on how to restrain the patient. (Promotes coordination and efficiency)
13. Explain to each staff what part of the patient to hold and from where to approach the patient. (To facilitate efficiency in full immobilization of the patient)
14. Allocate one member of the group whom the patient is more familiar with to talk with him/her throughout the procedure. (For sustaining a therapeutic communication of the patient)
15. Minimize force used for restrain to be appropriate to the degree of resistance. (Avoid risk of injury to the patient)
16. Take the patient to a comfortable and isolated room. (Provides safe environment and facilitates recovery)
17. Ensure that the restrain is realized gradually by releasing one limb at a time. (To minimize the possibility of the patient striking the staff)
18. Observe patients respiratory rate half hourly and change gradually until the condition improves. (Determines progress of the patient by allowing for observation of mood and behaviour. It also monitors the effectiveness of sedatives/anxiolytics)
19. Withdraw staff from patient gradually. (To facilitate recovery and reduce anxiety)
20. Withdraw patient from isolation as soon as he is no longer violent.(Observe patients right of associations)
21. When patients calms down discuss the incident with the patient. (Allow the patient to verbalize experiences and identify provoking factors; promotes planning for interventions that prevent repeat of violence and aggression)

## D. EVALAUTION

**Evaluate**

1. Determine if the patient suffered any injuries during the restraint(Plan for appropriate intervention)
2. The feeling of the patient towards the restraint (To allow the for correction of any negative perception)
3. Feeling of the staff towards the management of the incident. (To determine effectiveness of the restraint methods used and to identify areas of future improvement)

## E. DOCUMENTATION

**Record**:

- The duration of restraint
- Drugs given during restraint and the effect
- Any adverse effects of the restraint on the patient
- Outcome of the evaluation

## 1.5-5: ACUTE DYSTONIA

**Definition:**

Emergency nursing intervention for patients experiencing life threatening muscles contractions/spasms of the neck, tongue, face, jaws, eyes and laryngeal/pharyngeal tract.

**Purpose:**
To control contractions/spasms, ensure patent airway and manage anxiety associated with the Dystonia experience

**Indications:**

Patients experiencing occulogyric crises, torticolis, trismus, tongue protrusions and extrapyramidal side effects of antipsychotic drugs

## A. ASSESSEMENT

**Assess**

1. The patency of airway and breathing pattern. (Determine the need for oxygen since spasms of the larynx and pharynx affect airway)
2. Level of pain. (To determine the type of analgesics needed)
3. Level of anxiety. (Experience of acute Dystonia may be frightening to patient)
4. Intensity of contractions/spasms. (Determine the type of muscle relaxant and anticholinergics required)
5. The presence of dangerous equipment in the patients surrounding. (Ensure patient and staff safety)

## B. PLANNING

**Self;**

- Review institutional policy on emergency patient management
- Review care of patient experiencing acute Dystonia
- Remove any accessories that may cause injury to the patient during care

**Staff**

- Explain to the staff that their assistance is required
- Explain to the staff their specify roles during care
- Patient
- Explain to patient his/her experience and need to remain calm

**Equipment**
- Clean and assemble the following equipment
- Intravenous injection tray containing anticholinergics such as
  - Benztropine
  - Trihexyphenidly
- Muscle relaxant such as benzodiazepines
- Oxygen administration set

## C. IMPLEMENTATION

**Steps**

1. Wash and dry hands. (Minimise the transfer of microorganisms)
2. Quickly and gently move the patient to the prepared room.(Life threatening situation must be managed urgently)
3. Quickly assess the airway patency and breathing patterns of the patient.(Delay in oxygen administration may lead to hypoxia)
4. Administer oxygen if necessary.(Ensure Sa02 level is maintained at ≥ 95%.)
5. Administer I.V benzodiazepine and anticholinergics as appropriate. (Facilitates muscle relaxation; counteract extrapyramidal effects of antipsychotic thus realising the acute Dystonia)
6. Perform vein puncture and administer IV fluids. (To rehydrate the patient since pharyngeal muscle spasms may interfere with feeding)
7. Take vital signs observations half hourly, gradually changing to one hourly until Dystonia is over and vital signs are normal. (To determine the degree of physiological functioning and plan for future intervention)
8. When patient recovers from the dystonic reaction, perform mental assessment status examination. (To monitor the psychological status of the patient. Helps to monitor the patients recovery from neuropsychiatric symptoms)
9. Discuss with the patient his/her experience. (Improve patients knowledge of the cause of his/her experience and enables the patient to seek help in future occurrences)
10. Explain to the patient that acute Dystonia is a side effect of antipsychotic drugs. (Improve the patients understanding of the cause of his/her experience and enables the patient to seek help in future occurrences)
11. Explain to the patient how to recognize its early signs, the need to notify the nurses and how to control it with anticholinergics and muscle relaxant. (Reduces patients anxiety and enhances compliance with treatment)
12. Clear all equipment used during the procedure:
    - Store the equipment in accordance with hospital policy
    - Dispose waste material according to the infection prevention and control procedure

## D. EVALAUTION

**Evaluate:**

1. Patients level of consciousness (To establish the seriousness of the side effects and the need for further neurological evaluation)
2. Effectiveness of the treatment given. (The intervention can be used in similar future experiences)
3. Patient feeling of the experience(Determine the effectiveness of the interventions)
4. Patient feeling of how he was managed during the experience.(For quality improvement in patient care to facilitate quick recovery)

## E. DOCUMENATATION

**Record:**

- The duration of the dystonic reaction
- Findings of the evaluation
- The vital signs taken during the dystonic reaction
- Treatments given and outcomes: For drugs indicate dosages
- Current physiological and psychological state of the patient

### 1.6: Conducting Nurses' Ward Round in a Psychiatric Unit

The process of reviewing all patients management plan and evaluating progress made or needs for change in the management

**Purpose**
To make a collective clinical judgement and conclusion regarding the patients management

**Indications:**

All patients

### A. ASSESSMENT

**Assess**

1. Information on the client/patients and their problems. (To anticipate the type of clients/patients being managed
2. Own level of knowledge in relation to the current management of the patients' condition.(To plan appropriate care)
3. The number, qualifications and experience of nurses on duty (To determine whether assistance is needed. To determine the learning needs and anticipated quality of contribution from the other psychiatric nurses,)
4. The number and type of patients to be reviewed. (Allows for adequate time allocation)
5. Preparedness of the patients for the procedure. (Encourages the patients cooperation and contribution to his/her care)
6. Patients needs. (Ensures individualized response)
   - Physical needs (Determines hemodynamic and personal hygiene state)
   - Emotional/psychological (To allay anxiety and enhance cooperation)
   - Social. (To gain support of family members in care)
   - Spiritual (To enhance the well being of the patient)
7. Patients understanding of his/her condition. (Determine teaching needs of the patient during the round.)
8. The state and quality of the environment. (A quite environment portrays privacy and encourages patient participation)
9. Required equipment and supplies. (To determine availability of equipment to ensure efficiency

### B. PLANNING
**Self;**

- Organize for more staff as necessary and accustom them on what is expected of them
- Review patients notes to familiarize yourself with the various mental disorders of the patients in the ward/unit

- Alert the nursing staff/students to join the ward round as necessary
- Wash and dry hands

**Patient**

- Explain to the patient groom him/herself prior to the ward round
- Explain to the patient that his/her presence will be required
- Explain to the patient that his/her condition and management will be discussed and will be free to contribute in the discussion

**Requirements**

- Prepare a quite room with adequate light
- Adequate clean seats and table for participating staff and relatives
- A clean Trolley or cabinet with stationary including;
  - Patients files, Psychiatric nursing care notes and Patients charts (observation, fluid)
  - Pen and Continuation sheets
  - Request forms for consultation, laboratory, radiological and other diagnostic Investigation

## C. IMPLEMENETATION

**Steps**

1. Prepare the room and welcome the patient, offer a seat, introduce self and staff and establish rapport.(Allays anxiety and promotes cooperation)
2. Explain to patient that a report about him will be given and discussed and that he/she is free to ask questions and give suggestions concerning his/her care
3. Allow the key nurse to give full report on the progress of the patient including:-
   - Psychiatric nursing assessment and findings
   - Both medical/nursing diagnosis
   - Objectives set for management
   - Interventions
   - Evaluations. (Provides information on current situation of the patient and guides discussion and planning further intervention)
4. Allow time for response from the rest of the staff and students while maintaining patient’s privacy and confidentiality. (Promoted discussion on management and evaluation of effectiveness of intervention implemented to date; Indentifies gaps and guides plans for appropriate interventions, Offers a learning opportunity for students and staff.
5. Allows the patient to verbalize any concerns about his/her care. (Encourages patient’s participations in care, Clarifies misconceptions and promotes compliance)
6. Explain to patient respectfully that his turn is over and release him from the room, (Allows the patient to attend to other duties and prepare the room for next patient
7. Clear the room and equipment and store them in accordance with the institutional protocol after all patients have been reviewed. (Reduces transfer of microorganism)

## D. EVALUATION

**Evaluate**

1. Feeling of patient during the ward round. (Determine if patient benefited from the rounds)
2. Any interventions that had been planned for but remained outstanding during the ward round. (To identify cause and prevent future repeats that delay recovery)
3. If staff benefited from the round. (Determine if clinical objectives of the round were met and subsequent adjustments required.)
4. Any areas of improvement identified during the round. (Promotes quality of patient care)

**E. DOCUMENTATION**

**Record**:

- Current mental status of the patient
- Physical examination results
- Any investigations ordered/done
- Evaluation outcome
- New plan of management

**1.7: Giving a Report about a Patient**

**Definition:**

It is the process of disseminating information about a patient/client to the staff reporting on duty, the institutional management and or during the psychiatric nurses round

**Purpose:**

To communicate logically organized information about a patient/client so as to plan for proper care and its continuity.

**Indications:**

- Changing over shifts
- Referrals/transfer of patients
- Ward rounds
- As a routine to the institutions management

**A. ASSESSMENT**

**Assess**

1. Own knowledge of the patients/clients diagnosis and current management. (an inclusion of current information on report)
2. Mental status of the patient. (To get the exact state of the patient during the report writing since this is likely to change as the client/patients continue with care)
3. The current and outstanding care to the patient. (To determine the nature of the report and continuity of care)

**B. PLANNING**

**Self**

- Wash and dry hands
- Meet with the coming staff and discuss the method of giving the report
- Review the patients notes, treatment charts and all other information about the patient
- Perform physical check to determine presence of patients in the respective beds

**Patient**

- Explain to the patient/client the importance of sharing his information with other members of staff
- Encourage patient/client to ask questions and make comments if he/she wishes

**Environment**

- Provide a quiet and safe environment free of interruptions
- Requirements
- Patient's Psychiatric Notes with all MDT section on.
- Treatment sheets
- Observation charts, and any relevant chart

## C. IMPELEMENTATION

**Steps**

1. Move to the first patient and ensure that information is given in a logical, organised and conscious manner. (Facilitate understanding of report and reduces chances of skipping other patients)
2. Give the following information about each patient:-(Identify information for accuracy)
   - The room number, the bed number, identification data
   - The psychiatric nursing and psychiatric/medical diagnoses, Key Psychiatric nurse and psychiatrist of the patient(For comparing the relevance of the interventions being implemented)
   - Investigations done and findings, investigations due and preparations required
   - Treatments given during the last 24 hours and patients response
3. Patient on special instructions and requirements including: (Enables the psychiatric nurses to plan for close monitoring for the specific patient)
   - Input/output measurements
   - Blood transfusions
   - Suicidal alert
   - Seclusion
4. Current needs for the patient:
   - Any severe pain
   - Assistance needed with activities of daily living(To enable the nurse prioritize care for these patients)
   - Mental status requiring immediate interventions (Ensures new treatment are not overlooked)
   - Scheduled treatment
   - Need for change of treatments. (Facilitates quick recovery)

- Any visitors for the patient and significant changes on patient's behaviour after the visit. (To evaluate effectiveness of intervention and if they can be continued)
- Significant changes in the client's condition during the shift, interventions measures taken and outcomes. (Facilitates planning for patient oriented goals and interventions)
- Current prescribed orders. (For continuity of care)

5. For newly admitted patients, give the following additional information:(Facilitates planning for quality nursing care)
   - Referring agent
   - Legal admission requirements
6. Give summary of discharge/transferred patients:
   - Reasons for discharge/ transferred patient. (Explains the reasons for patients' absence from the ward)
   - The destination. (Explains the additional patients in the ward
7. Do not elaborate on routine background data. (To avoid wasting time)
   - Give the report for each patient within 2-3 minutes. Ensure the report is given in low tones. (For effectiveness, efficiency and confidentiality)

**D. EVALUTION**

**Evaluate**

1. Completeness of information given. (Determine quality of the report and helps to identify gaps for inclusion)
2. Area of concern during the report giving, (To identify areas of improvement)
3. Duration of the report. (To improve efficiency in subsequent reports)

**E. DOCUMENTATION**

**Record:**

- Changes made in interventions
- New drugs
- Investigations scheduled and preparations required
- Concerns raised by patient during the round
- Progress made by patient
- Any other important information

**1.8: Discharging a Psychiatric Patient from a Psychiatric Unit/ Hospital**

**Definition:**

Psychiatric nursing intervention during the care of a patient released from an in – patient care environment

**Purpose:**

To facilitate integration of the patient/client in the family/society/community for optimal functioning with minimal ongoing professional support.

**Indications:**

- Patients who have recovered
- Patients who are ready to be rehabilitated in the environment of their choice (presumably home environment)

## A. ASSESSMENT

**Assess**

1. The type of admission. (To determine legal requirements of the discharge)
2. The level of readiness of the patient. (To determine mental health care needs of the patient and plan for follow- up care)
3. The level preparedness of patient's guardians. (To determine teaching needs for guardian and plan for clients follow- up)
4. The psychological, physical, spiritual and social needs of the patient. (To determine and plan for appropriate holistic interventions to reduce relapse)
5. The patient's perception of previous discharge experience. (To identify and apply positive experiences that facilitate recovery)
6. Resources availability. (Confirms availability and provide information of where to seek help)

## B. PLANNING

**Self**

- Ensure resolution to therapy
- Review patients notes
- Review discharge procedure and legal implications
- Prepare information to share with patient
- Assign adequate time for the procedure

**Patient**

- Greet the patient, guardian and confirm the patient's awareness of discharge details
- Prepare patients belongings
- Requirements
- Ensure the availability of a conducive room with furniture
- Assemble equipment/stationary required for patients discharge including:
  - Patients notes, charts and property
  - Nursing notes and discharge book
- Ensure long term prescriptions/drugs are available and appropriate legal forms for discharge

## C. IMPLEMENTATION

**Steps**

1. Provide the patient with a comfortable place to sit on. (Promotes concentration and readiness to receive information)

2. Explain the discharge procedure to the patient/guardian. (To allay anxiety and facilitate understandings of the patient's/guardians role in follow – up care)
3. Discuss with the patient his/her experiences from previous discharge. (Indentify strategies that were successful and can be reinforced and those that are likely to precipitate relapse)
4. Carry out physical and mental state examination. (To confirm that the patient's physiological and mental state is suitable for discharge)
5. Share information with the patient on his/her mental disorder including treatment and follow – up care. (Promotes compliance to treatment while promoting healthy behaviours)
6. Give instructions on how to take and store drugs. (Ensure compliance to safe drug use. Ensure the safe storage of drug to preserve drug potency and reduces incidences of drug poisoning by family members.)
7. Educate the patient on the expected side effects and how to manage them. (Helps patient to gain control of his care and promotes compliance)

## D. EVALAUATION

**Evaluate**

1. The patients understanding of his/her role in the treatment at home. (Determine if the patient requires further clarification concerning his/her treatment)
2. The extent to which the patient was ready for discharge. (Determine the need for immediate assessment of the home environment and plan intervention for prevention of relapse)
3. Content of discharge notes, medication and follow- up care schedules.(To determine if there was legal authority for discharge and quality of documentation and care given)

## E. DOCUMENTATION

**Record**:

- Physical and mental state of the patient on discharge
- Drugs on discharge
- Carer of the patient and relationship
- The follow up schedule
- The date/time of discharge
- The expected destination of the patient

## 1.9: Conducting Follow – up Care

**Definition:**

Follow- up care is the psychiatric nursing care provided to the client/patient and family members within their own familiar environment(s)/psychiatric rehabilitation centres.

**Purpose:**

To provide follow- up that aids family/community integration as well as socio – occupational functioning of the patient within the environment of their choice.

**Indication:**

**Patient with;**

- Indentified psychosocial problems
- Frequent relapse
- History of non – adherence to their medication regimen

## A. ASSESSMENT

**Assess**

1. Own knowledge about patient, his/her condition, fears and related anxiety. (To determine appropriate preparation)
2. The patients notes and identity his/her needs (Facilitates planning of care)
3. The community resources. (Indentify resources that enhance care of patient)
4. The type of equipment to be used. (To ascertain their status availability for use)
5. The scheduled time of the follow up visit. (To determine the availability of patient/family members)
6. Distance to be covered during the follow – up visit. (To organize for means of transport to plan for required time needed for the assignment)
7. Availability of the client's relatives. (Ensure members of the family and presence during visit)

## B. PLANNING

**Self**

- Review patients notes
- Formulate objectives for the visit
- Prepare information to be shared with patient and relatives
- Assign time/date for the follow – up visit
- Patient
- Discuss the purpose of the visit with the patient and the relatives and obtain consent
- Ensure that the patient and his/her relatives are aware and ready for the follow – up visit

**Requirements**

- Ensure availability of transport or realistic chance of the patient coming for a follow up due to distance.

## C. IMPLEMENTATION

1. Review the patient's records. (To determine appropriate intervention)
2. Attend to self indentified needs. (For effective therapeutic relationship)
3. As you meet the family introduce self and explain your agenda for the follow up. (To gain acceptance and recognition)

4. Observe the relationship between the client/patient and family members. (To determine the patients' acceptance or rejection in the family)
5. If it is second follow up session, give the health message and evaluate the outcome of the previous visit. (To determine the impact of the previous visit and the care to be given to patient/family)
6. Encourage the patient and family members to ask questions. (To correct misconceptions and allay fears)
7. Plan with patient/family the follow up session and leave them satisfied with the session. (For continued care)
8. Fill in the details of the visit in the card and file record in the register book and indicate the date/time of the next visit
9. Plan for any other necessary intervention that may need other expertise. (For further referral management)

**D. EVALUTION**

**Evaluate:**

1. If the objectives of the follow up were achieved. (Determine the effectiveness of the visit)
2. Readiness of the family for follow- up (Demonstrates appreciations for the services offered and understanding of the previous discussions on importance of follow – up visit)
3. Patient's compliance with medication. (Demonstrates participation in his/her care)
4. Strategies used in dealing with challenges. (Determines if effective coping skills are developed)

**E. DOCUMENTATION**

**Record:**

- Information obtained during the family interaction with therapist
- Non – verbal communication
- The interaction carried out
- The date/time of the next visit

**EVALUATION CHECKLIST**
**Evaluation of the Procedure manual from the Hospital Directorate**

| Psychiatric Nursing Guidelines | YES | NO | COMMENTS |
|---|---|---|---|
| **1.All procedures in Mental Health and Psychiatric nursing included in the chapter** | | | |
| **2.Procedures are placed under their relevant functionality pattern/system** | | | |
| **3.Procedures arranged from simple to complex within the respective functional pattern/systems** | | | |
| **4.Procedure correctly defined** | | | |
| **5.Purpose of the procedure stipulated clearly** | | | |
| **6.Indications for the procedure are correct** | | | |
| **7.Steps in procedure are accurate** | | | |

| 8.Nursing process correctly applied: | | | |
|---|---|---|---|
| Assessment | | | |
| Planning | | | |
| Implementation | | | |
| Evaluation | | | |
| Documentation | | | |

## 2. Protocols / Procedures for Bed Making

**PURPOSE**

To define the standard operating procedure for bed making.

**POLICY STATEMENTS**

1. Nurses / Nursing assistants will do the bed making.
2. Linens must be changed
   a. Daily at the time of morning care
   b. When soiled
   c. On discharge

**INDICATIONS**

1. To provide patient comfort, warmth or coolness
2. To provide access for treatment and nursing care
3. To prevent pressure area complications

### A. SIMPLE - Unoccupied Bed

**EQUIPMENT AND SUPPLIES**

1. 02 large bed sheets
2. 01 blanket
3. 01 pillow
4. 01 pillow cover
5. 01 hamper and laundry bag one per ward

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Wash hands | To reduce transmission of infection |
| 2. Remove over bed table to end of bed | For ease of access to bed. |
| 3. Loosen bedding all around bed | To aid ease of removal. |

| | |
|---|---|
| 4. Remove blanket and sheet separately, folding blanket in four and placing on over bed table. For sheet fold it into a bundle and place it in the hamper. | To facilitate replacement and prevent wrinkling. |
| 5. Remove pillow cover, folding it into a bundle and place it in the hamper. | To reduce transmission of micro-organisms. |
| 6. Remove bottom sheet, folding it into a bundle and place it in the hamper. | To reduce transmission of micro-organisms. |
| 7. Inspect mattress and bed for damage or soiling. | For patient comfort and to ensure prompt maintenance. |
| | |
| 8. Place top sheet on bed and unfold. Place centre fold of sheet along centre of bed. | Proper positioning of linen on bed ensures that adequate linen will be available to cover opposite side of bed. |
| 9. Tuck sheet over top of bed and fold corners before tucking sheet in along the side of the bed. | Correctly folded corners will not loosen easily. |
| 10. Move from head to foot of bed. Tuck sheet over fold corners. Complete tucking in of sheet along side of bed. | |
| 11. Move to opposite side of bed and tuck and fold sheet pulling the sheet tight. | Smooth linen prevents skin irritation by eliminating wrinkles. |
| 12. Place clean sheet on bed and unfold so that centre seam is along centre of mattress. | |
| 13. Ensure seams of sheet are upper most. | |
| 14. Place top seam of sheet level with top edge of mattress. | |
| 15. Tuck and fold corners at foot of bed. | |
| 16. Place blanket on bed, unfolding it so crease runs length wise along middle of bed. | |
| 17. Place top edge of blanket 15cm from top edge of mattress. | |
| 18. Tuck and fold corners at foot of bed. Tuck sheet and blanket in along both sides of bed. | |
| 19. Make a cuff by turning top edge of sheet down over edge of blanket. | |
| 20. Grasp clean pillow case and gather it, turning it inside out over hands. Pick up pillow and pull pillow case down over pillow. Tuck in end of pillow case. | This method makes it easy to slide case smoothly over pillow. |
| 21. Wash hands. | To reduce transmission of infection. |

**B. SIMPLE - Occupied Bed**

**EQUIPMENT AND SUPPLIES**

1. 01 large bed sheet
2. 01 pillow cover
3. 01 towel

4. 01 hamper and laundry bag
5. 01 draw sheet (if necessary)
6. 01 mackintosh (if necessary)

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Explain the procedure to the patient. | To obtain the patient's consent and co-operation. |
| 2. Wash hands. | To reduce transmission of infection. |
| 3. Ensure privacy by closing curtain around bed. | To ensure mental comfort of patient. |
| 4. Lower back rest if permitted. | To ensure position is therapeutic and comfortable for the patient. |
| 5. Loosen bedding all around the bed. | To aid ease of removal. |
| 6. Carefully draw top sheet out from underneath the blanket. | To ensure patient's privacy and warmth. |
| 7. Fold it into a bundle and place it in the hamper. | To ensure ease of replacement and prevent wrinkles. |
| 8. Position patient on side of far side of bed, facing away from you. Adjust pillow under patient's head. | To provide space for placement of clean linen. |
| 9. Fold bottom sheet and draw sheet towards patient. Touch edges of linen just under patient's buttocks back and shoulder. | |
| 10. Inspect mattress for moisture, crumbs or soiling. Wipe clean if present. | To reduce transmission of infection and prevent pressure areas. |
| 11. Place top sheet on exposed side of bed and unfold length wise, with seams down, so centre crease is along centre of bed. | |
| 12. Pull sheet over and under top of mattress, fold and tuck in at the corner. | Correct folding and tucking at corner of bed will ensure bedding is not loosened easily. |
| 13. Tuck overhang of sheet under along side of bed. | |
| 14. Fold sheet towards patient. | |
| 15. Straighten mackintosh. | |
| 16. Place centre fold of draw sheet along centre of bed, unfold, and tuck under. | |
| 17. Assist patient to roll over to face other side. | Exposes opposite side of bed for removal of soiled linen and placement of clean linen. |
| 18. Remove bottom sheet and draw sheet. | |
| 19. Straighten clean linen and mackintosh. Tuck in as for first side. | Smooth linen prevents skin irritation. |
| 20. Change pillow cover, then assist patient into position. | Patient comfort is maintained. |
| 21. With assistance pull mattress to top of bed. | To ensure patient comfort. |

| | |
|---|---|
| 22. Place clean sheet over patient and open it out so that centre seam is along centre of bed. Top edge of sheet should have seam facing up. | |
| 23. Draw blanket from under top sheet. Do not expose patient. Place blanket over top sheet ensuring even overhang. | |
| 24. Turn 15 cm of sheet down over blanket. | |
| 25. At foot of bed tuck and fold separately sheet and blanket. | |
| 26. Replace unit furniture | |
| 27. Replace towel. | |
| 28. Remove hamper to dirty utility room and wash hands. | To reduce transmission of infection |

## 3. Protocol / Procedures for Applying Sterile Gloves

**PURPOSE**

To define the standard operating procedure for putting on sterile gloves.

**POLICY STATEMENTS**

1. Nurses & Doctors must adhere to this procedure.
2. Aseptic technique must be observed & maintained during sterile procedure.

**EQUIPMENT AND SUPPLIES**

Sterile gloves: 01 pair appropriate size

**PROCEDURE**

1. Wash your hands
2. Open the outer wrap of the sterile glove pack and remove the inner wrap. Place the inner wrap on a clean, dry surface.
3. Carefully unfold the inner wrap touching only the outside edges.
4. If the inner wrap has numbered flaps, open them numerically. Be sure to touch only the folded tabs. If the wrap is unnumbered, open the gloves by following the steps for opening a sterile pack.
5. With your dominant hand, grasp the opposite glove at the inner edge of the folded cuff.
6. Carefully slip your hand into the glove.
7. While still grasping the inner edge of the folded cuff, pull the glove over your hand.
8. With your sterile gloved hand, slip your fingers into the folded cuff of the remaining glove.
9. Carefully slip the glove over your fingers.

10. Pull the glove over your hand.
11. Adjust each glove to ensure a snug fit over your hands and fingers. Carefully slide your fingers under each cuff and pull them up.

## 4. Protocols / Procedures Respiration Checking

**PURPOSE**

To define the standard operating procedure for checking respiration.

**POLICY STATEMENTS**

Following staff is allowed to check respiration

a. Nurses / Doctors

**DEFINITIONS**

**Respiration should be observed for:**

1. **Quality**:

   Normal relaxed breathing is effortless, automatic, regular and almost silent.

2. **Rate**:

Rate and depth to determine the type of respiration. .

3. **Depth**:

The depth of respiration is the volume of air moving in and out with each respiration.

**3. Pattern**:

Changes in the pattern of respiratory rate should be recorded, i.e., an increase, decrease, irregularity, or depth.

**EQUIPMENT AND SUPPLIES**

1. Watch with second needle
2. Lead Pencil

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Do not explain the procedure to the patient. Attempt to count the respiration when the patient is at rest. This may be done while you are still appearing to record the pulse. | Awareness of the patient regarding the procedure often produces changes in the respiration rate. |
| 2. Ensure that the patient is in a comfortable position. | To ensure accurate observation. |
| 3. Observe the movements of the chest wall. | To detect any respiratory obstruction, and to assess excessive use of the intercostals and accessory muscles of respiration. To observe for dyspnea. |
| 4. Evaluate the sound made when the patient breathes. | To detect respiratory obstruction and to assess whether suction or deep breathing exercises are required. |
| 5. Count the chest movement for 60 seconds. One inhalation and one exhalation together are counted as one respiration. | To count the number of respiration. |
| 6. Record the number of respiration. | To monitor differences and to detect trends. Irregularities should be brought to the attention of the Doctor on duty. |

## 5. Protocols / Procedures For Intra Muscular Injection

**PURPOSE**

To define the standard operating procedure for intra-muscular injections.

**POLICY STATEMENTS**

1. Nurse is allowed to give intra-muscular injection.
2. Doctor on duty/Consultant is responsible to calculate the dose for patients.
3. Assigned nurse must cross check the dose with doctor on duty before preparing the drug.
4. Ask patient's name and check with his/her medical notes before administering of any drugs.

**Sites :**

1. Gluteus maximums
2. Vastus lateralis
3. Deltoid Muscle
4. Elderly and emaciated people have little muscle mass. Site of choice is usually Vastus lateralis

## EQUIPMENT & SUPPLIES

1. Clean and dry kidney dish
2. 23 G needle (1.5 to 2") for administration
3. Syringe of appropriate size
4. Alcohol swab: 02
5. Drug to be administered

## PROCEDURE

| ACTION | RATIONALE |
|---|---|
| 1. Collect and check all equipment | To prevent delays and enable full concentration on the procedure. |
| 2. Check that the packaging of all equipment is intact. | To ensure sterility. If seal is damaged, discard. |
| 3. Wash hands. | To prevent contamination of medication and equipment. |
| 4. Prepare needle (s) and syringe (s) on clean dry kidney dish. | For infection control purposes |
| 5. Consult the patient's notes for<br>drug<br>dose<br>date and time of administration<br>route and method of administration<br>appropriate dilutent<br>signature of doctor | To ensure that the patient is given the correct drug in the ordered dose, in the appropriate solution and by the correct route. |
| 6. Select the drug in the appropriately sized container and check the expiry date. | To reduce wastage and prevent an ineffective or toxic compound being administered to patient. |

## SINGLE DOSE AMPOULE: SOLUTION

| ACTION | RATIONALE |
|---|---|
| 7. Inspect the solution for cloudiness or particulate matter. If this is present, return the drug to Pharmacy. | To prevent the patient from receiving an unstable or contaminated drug. |
| 8. Tap the neck of the ampoule gently. | To ensure that all the solution is in the bottom of the ampoule. |
| 9. Cover the neck of the ampoule with alcohol swab and snap it open, away from you. If there is any difficulty a file may be required. | To aid asepsis. To prevent aerosol formation or contact with the drug which could lead to a sensitivity reaction. To prevent injury to the nurse. |
| 10. Inspect the solution for glass fragments; if present, return drug to Pharmacy. | To prevent injection of foreign matter into the patient. |

| | |
|---|---|
| 11. Withdraw the required amount of solution tilting the ampule if necessary. | To avoid drawing in any air. |
| 12. Tap the syringe to dislodge any air bubbles. Expel air. | To prevent aerosol formation. To ensure the correct amount of drug is in the syringe. |

**SINGLE DOSE VIAL: POWDER**

| ACTION | RATIONALE |
|---|---|
| 13. Clean the rubber cap with alcohol swab and let it dry. | To prevent bacterial contamination of the drug. |
| 14. Insert needle into the cap to vent the bottle. | To prevent pressure differences separating the syringe and needle. |
| 15. Add the correct diluting solution carefully down the wall of the vial. | To ensure that the powder is thoroughly wet before it is shaken and is not released into the atmosphere. |
| 16. Stir up the vial and inspect the contents. | To dissolve the drug. |
| 17. When the solution is clear, withdraw the prescribed amount, tilting the vial if necessary, and keeping the level of the needle under the level of the solution. | To avoid drawing in air. |
| 18. Remove the needle from the cap and inspect the solution for pieces of rubber, which may have come out of the cap. | To prevent the injection of foreign matter into the patient. |
| 19. Expel the air. | To prevent aerosol formation. To ensure the correct amount of drug is in the syringe. |

**ADMINISTRATION**

| ACTION | RATIONALE |
|---|---|
| 20. Explain the procedure to the patient. | To obtain the patient's consent and co-operation. |
| 21. Assist the patient into the required position, ensuring privacy, expanding the chosen site. | |
| 22. Clean the chosen site with alcohol swab and allow it to dry. | To reduce the number of pathogens introduced into the skin by the needle at the time of injection. |
| 23. Stretch the skin around the chosen site with thumb and index finger. | To facilitate the insertion of the needle and to displace the subcutaneous tissue. |
| 24. Holding the needle at an angle of 90, quickly plunge it into skin. Leave one third of the shaft of the needle exposed. | To ensure that the needle penetrates the muscle. |
| 25. Pull back the plunger. If no blood is aspirated, depress the plunger and inject the drug slowly. If blood appears withdraw the needle, change it and begin again. Explain to the patient what has occurred. | To confirm that the needle is in the correct position. To prevent pain and ensure even distribution of the drug. |

| | |
|---|---|
| 26. Withdraw the needle rapidly. Apply pressure to any bleeding point with alcohol swab. | To prevent haematoma formation. |
| 27. DO NOT RECAP NEEDLE | To prevent needle stick injuries and inoculation with infectious diseases. |
| 28. Record in the patient notes and if appropriate, in the Nurses Notes that the injection has been given. | To ensure an accurate and legal record is maintained. |
| 29. The needle and syringe are discarded into sharp container. Wash and dry kidney dish. | To ensure safe disposal and to avoid laceration or other injury to staff. |
| 30. Wash and dry hands. | To avoid cross infection. |

## 6. Protocols / Procedures For Removing Isolation Gown.

**PURPOSE**

To define the standard operating procedure for removing isolation gown in order to minimize the potential of hands and garments contamination.

**POLICY STATEMENTS**

Nurse / Medical staff must follow the proper steps and adhere to this procedure.

**EQUIPMENT AND SUPPLIES**

1. Isolation gown: appropriate size
1. Hamper with red laundry bag
2. Dust bin with bin liner

**PROCEDURE**:

1. Untie the waist strings of isolation gown.

1. **Remove your gloves:** With your dominant hand, make a cuff by hooking gloved fingers into the lower outside edge of the other glove. Pull the glove inside out as you remove it and then hold the glove in your gloved hand.

2. Tuck your un-gloved fingers into the inside edge of the remaining glove. Remove that glove by pulling it inside out and encase the other glove as you do. Discard the gloves into the designated dust bin. Next untie the neck strings of isolation gown.

3. After untying the neck strings, remove the gown by turning it inside out during the process.

4. Hold the gown away from your body and roll it up so that the contaminated side is inner most.

5. Place the gown in an impermeable bag that has been designated for contaminated laundry.

6. Finally remove the mask by grasping it by the elastic strap and pulling it off. Dispose off in the dust bin and wash your hands with scrub before leaving the room.

## 7. Protocol / Procedures for Temperature Checking

**PURPOSE**

To define the standard operating procedure for taking the temperature.

**POLICY STATEMENTS**

1. A clean thermometer should be used for all the patients each time the temperature is taken.
2. Only following staff is allowed to take the temperature:
   Nurses & Doctors

**DEFINITIONS**

Oral temperature is affected by:

Temperature of food, excitement, anxiety, smoking & disease process.
The patient should be resting quietly before the temperature is taken.

Normal body temperature: 98.6 F
A state of pyrexia: greater than 99 F
Subnormal temperature below: 98 F

The most reliable time, of the day, to record a daily observation of body temperature is between 1600 and 2000 hrs. The same site should be used consistently when taking temperature to ensure an accurate record. Any change of site must be recorded on the Graphic chart.

**Oral**
Place the thermometer in the sublingual pocket for two minutes.

**Axillary**
Only for patients who cannot tolerate oral thermometer e.g. after sedation. Place the thermometer in the centre of axilla with the patient's arm firmly against the side of the chest for 3 minutes.

**Rectal**
The rectal thermometer should be inserted at least 4cm in an adult to obtain the most accurate reading.

**EQUIPMENT AND SUPPLIES**
1. Thermometer and plastic container
2. Alcohol swab
3. Black ball point

**INDICATIONS**

1. To establish a base line temperature
2. To monitor fluctuations in the temperature

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Wash hands. | To prevent contamination and cross infection. |
| 2. Explain the procedure to the patient. | To obtain the patient's consent and co-operation. |
| 3. Remove the thermometer from its plastic container. | |
| 4. Shake the mercury to bring it to the lowest reading by using a flicking movement of the wrist. | To ensure an accurate reading. |
| 5. Ask the patient to open his/her mouth and insert the thermometer under the tongue into the "heat pocket" at the posterior base of the tongue. | The highest oral temperature reading is at the posterior base of the tongue, which is least affected by environmental condition. |
| 6. Ask the patient to close his/her mouth. | To increase the patent's comfort<br>To minimize the risk of temperature lowering by the external environment. |
| 7. Hold the thermometer in place for two minutes. | Tissue contact must be maintained for an accurate reading to be obtained |
| 8. Remove the thermometer from the patient's mouth and note the level of mercury. | To record the temperature |
| 9. Wipe the thermometer with an alcohol swab and allow to dry. | To remove mucous and saliva and ensure that the thermometer is dry before storage. |
| 10. Replace the thermometer in its plastic container. | To prevent loss of equipment and cross infection. |
| 11. Record the temperature on the Graphic chart using black pen. | To maintain accurate record and monitor fluctuation. |
| 12. Explain the result to the patient. | To reassure the patient and keep him/her informed. |

## 8. Protocols / Procedures for Death Handling

**PURPOSE**

To define the standard operating procedure for handling an inpatient who has died during hospitalization.

**POLICY STATEMENTS**

1. The doctor on duty will complete the Death Certificate.
2. The doctor on duty/nurse will inform the next of kin.
3. The assigned nurse will prepare the dead body after the doctor has formally pronounced that the patient is dead.
4. The assigned nurse will ensure identification with patient's name, and medical record number before the body is moved from the hospital.

**PROCEDURE**

1. Closes the patient's eyes by gently pulling down the eyelashes. The nurse may place
   a. Moistened cotton ball on the eyelids if they do not remain shut by themselves.
   b. Secures the jaw with light bandaging
   c. Pack all orifices such as ears, nostrils, anus and vagina with cotton balls.
   d. Dresses the dead body with his/her own dress, and wraps in morgue sheet.
   e. Ensures identification with patient's name and Medical Record Number.
   f. Packs the patient's belongings and handovers to attendant.
2. The assigned nurse handovers the "Death Certificate" to the patient's attendant.
   a. The assigned nurse and transporter escort the dead body to the ambulance.

## 9. Protocol / Procedures for Narcotic control and Administration

**PURPOSE**

To define the standard operating procedure and governing of the administration, storing and monitoring of the narcotics in the nursing units to:

1. Prevent the misuse of narcotics
2. Provide prompt and safe supply of the medication to the patient
3. Maintain an accurate record of narcotics consumption in the hospital
4. Comply with legal requirement of the controlled drugs
5. Administration of narcotics by the doctor’s prescription and storing its empty ampoules until the emerging of their reactions.

**POLICY STATEMENTS**

1. All narcotics will be issued against unit/ward par-level.
2. Only Psychiatrists are allowed to write the prescription for narcotics. In case of emergency the doctor on duty may take telephonic order from the Psychiatrist but counter signed by concerned Psychiatrist within 24 hours.
3. Only unit nurse is permitted to receive the narcotics from pharmacy upon submitting the empty ampule along with the completed narcotic sheet.
4. The par level of narcotics will be determined by the Director of Nursing and approved by the Director of the MHH.
5. The narcotic drug will be administered and witnessed by:
   i. A nurse and a Physician or
   ii. Two nurses
6. All narcotics must be witnessed for administration (based on five rights) and

discarding of residual drug in the ampule.

**EQUIPMENT & SUPPLIES**

1. 01 Syringe 3 cc
2. Alcohol swab

**PROCEDURE**

| PROCEDURE | RATIONALE |
|---|---|
| 1. The nurse along with Team leader (senior nurse) checks the Physician's order/notes. | To ensure the correct order and prevent irreversible damage to the patient. |
| 2. Prepare the narcotic according to the five principles. | To ensure the right drug, right dose, right route, right time and right patient |
| 3. Explain the procedure to the patient & make him comfortable. | Helps to reduce patient's anxiety. |
| 4. The prepared narcotics must be counter checked by the Team leader or a Physician. | This action will avoid any error. |
| 5. After preparation of the drug, the extra amount must be discarded by the nurse who prepared the medication. | Avoids misuse of the drug. |
| 6. Before administering each dose of narcotic, assess neurological status of the patient. | To ensure the patient's safety and getting base-line data. |

**DOCUMENTATION:**

1. Two nurses, one medication nurse and the Team leader must sign the narcotic sheet.
2. Team leader ensures that narcotic count is congruent with the number of narcotic entered in the narcotic control sheet.

## 10. Protocol / Procedures for Hand Washing

**PURPOSE**

To define standard operating procedure for hand washing.

**POLICY STATEMENTS**

All nursing and medical staff are adhered to this procedure.

**EQUIPMENT & SUPPLIES**

1. Mini soap
2. Kitchen roll/Disposable Towel

**PROCEDURE**

1. Before washing your hands, remove the rings from your fingers to facilitate thorough cleansing and drying. If your watch has an expansion band, slide it above your wrist. Adjust the water to a warm temperature, and rinse your hands.
2. Lather your hands thoroughly. Remember that it is the friction from rubbing your hands together that removes potentially infectious organisms from the skin. A 10-second vigorous hand washing will adequately remove most transient flora.
3. Wash each wrist by vigorously sliding the opposite hand around its surface area.
4. Interlace your fingers and thumbs, and slide them back and forth. Clean under your nails and around the nail beds with the fingertips and nails of the opposite hand.
5. Thoroughly rinse each hand from the wrist down. If your hands were grossly soiled, repeat steps 2-4.
6. Dry your hands with kitchen roll/disposable towel.
7. To protect your hands from contaminated surface of the faucet handle, turn off the faucet by placing a dry section of your used towel over the handle.

## 11. Protocol/ Procedure for Disposal of Needles and Syringes

**PURPOSE**

To define the standard operating procedure for the safe disposal of needles and syringes.

**POLICY STATEMENT**

All Nursing / Phlebotomists / Laboratory Staff must dispose off needles and syringes in proper manner.

**APPLICATION:**

All Nursing / Phlebotomists / Laboratory Staff

**EQUIPMENT AND SUPPLIES**

1. Needle cutter
2. Sharp container

**PROCEDURE**

- After the usage of a needle and syringe, the needle is cut with needle cutter, by inserting the needle into the hole provided for this purpose, with sharp movement of the blade.
- Similarly the syringe is inserted into the bigger hole for its cutting with a quick movement of the respective blade.
- At the end of a day, the needle and syringe holes and their respective blades are to be wiped with alcohol swab and later with water (TAKING CARE NOT TO INJURE ONESELF) simply by detaching the lid of the syringe and needle cutter.
- The stuff cut so far accumulated in the provided container is transferred into a bigger container / box.
- The containers / boxes when they get filled are closed and tapped.
- Place a hazardous sticker for autoclaving / incineration / burial, as per the arrangement made by the management.

**PRECAUTION**

Never re-sheath or bend a needle for the purpose of disposing off.

## 12. Protocol/Procedure for Oxygen Administration by Simple face mask

**PURPOSE**

To define the standard operating procedure for oxygen administration.

**POLICY STATEMENTS**

Nurses / Medical officers / Consultants may administer oxygen to the patient.

**EQUIPMENT AND SUPPLIES**

1. Oxygen source
2. Humidifying bottle with distilled water and flow meter.
3. Oxygen mask with tubing
4. Nebulizer

**ASSESSMENT:**

| ACTION | RATIONALE |
|---|---|
| 1. Determine current vital signs, level of consciousness, and SaO2 ABG, if patient is at risk for $CO_2$ retention. | To have a baseline data |
| 2. Assess viscosity and volume of sputum produced. | 2. Humidification is provided to mobilize retained secretions. |

**PROCEDURE:**

| ACTION | RATIONALE |
|---|---|
| i. -Show the oxygen mask to the patient and explain the procedure. | |
| ii. -Make sure the humidification bottle is filled to the appropriate mark. | If the humidification bottle is not sufficiently full, less moisture will be delivered. |
| iii. -Attach the oxygen tubing from mask to the humidifying outlet. | |
| iv. -Set desired oxygen concentration on flow meter. ( 2 Manometer ) | The inspired oxygen concentration is determined by the flow meter. |
| v. -If the patient is tachypneic and greater concentration of oxygen is desired, use venti ( Provide information about venti mask) mask of required percent. | The face mask is a low flow system. |
| vi. -Adjust the flow rate (usually 10 -12 liters / as per physician's orders). | This ensures that the patient is receiving flow sufficient to meet inspiratory demands and maintains constant accurate concentration of oxygen. |
| vii. -Apply the mask to the patient's face and adjust the straps so that the mask fits securely. | |

**EVALUATION / OUTCOME:**

| ACTION | RATIONALE |
|---|---|
| 1. -Record inspired oxygen concentration<br>1. and immediate patient response. | Note the patient's tolerance to treatment. Notify the physician if intolerance occurs. & should be noticed in Nursing Progress Note. |
| 2. -Assess the patient's condition and the functioning of equipment at regular intervals. | Assess the patient for change in mental status, diaphoresis, changes in blood pressure, and increasing heart and respiratory rates. |

| | |
|---|---|
| 3. If the patient's condition changes, assess<br>4. $SaO_2$ or ABG. ( Please Provide information about $SaO_2$ or ABG) | If the patient has high minute ventilation, flow from the mask may not be sufficient to meet inspiratory needs without pulling in room air. Room air will dilute the oxygen provided and lower the inspired oxygen concentration, resulting in hypoxemia. A change in mask or delivery system may be indicated. |
| 5. Record changes in volume and tenacity of sputum produced. | Indicates effectiveness of therapy. |

## 13. Protocol / Procedures for Eye Irrigation

**PURPOSE:**
To define the standard operating procedure for the irrigation of eye.

**EQUIPMENT & SUPPLIES**

1. Sterile Gauze 4 x 4 cm
2. Eye pad if necessary
3. I.V. giving set.
4. I.V. pole
5. Solution - sterile water or ringers (as ordered) 1000 ml flask
6. Clean kidney dish/bowl.
7. Mackintosh
8. Kitchen roll (paper towel)

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Explain procedure to the patient. | To gain the patient's consent and co-operation |
| 2. Prepare the irrigation fluid to the appropriate temperature. | Tepid fluid will be more comfortable for the patient.<br>The solution should be poured across the inner aspect of the nurse’s wrist to test the temperature. |
| 3. Assist the patient into the appropriate position.<br>a. Head comfortably supported with chin almost horizontal.<br>b. Head inclined to the side to be treated. | To avoid the solution running either over the cheek into the eye or out of the eye and down the side of the nose. |
| 4. Wash and dry hands. | To prevent cross infection |
| 5. Pierce the flask of the solution with giving set, hang the flask and prime the line. | To expel any air from the tubing. |

| | |
|---|---|
| 6. Perform an eye toilet to remove any discharge from the eye. | To prevent washing the discharge down the lacrimal duct or across the cheek. |
| 7. Ask the patient to hold the receiver dish against his/her cheek below the eye being treated. | To collect irrigation fluid as it runs away from the eye. |
| 8. Document in nurse's notes. | |

## 14. Protocol/Procedure for Subcutaneous Injection.

**PURPOSE:**

To define the standard operating procedure for giving subcutaneous injection.

**POLICY STATEMENTS**:

Only nurse/doctor is allowed to give subcutaneous injection.

**APPLICATION:**

All nursing staff.

**Sites :**

1. Lateral aspects of upper arms.
2. Lateral aspects of thighs.
3. Abdomen (Epigastric region).
4. Back and lower loins.

These sites are poorly supplied with sensory nerves.
Sites should be rotated in long term use to ensure improved absorption.

**EQUIPMENT:**

5. Clean, dry kidney dish
6. 1 ml syringe (insulin syringe) with 26 G needle
7. Alcohol swab
8. Drug to be administered

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| Collect and check all equipments | To prevent delays and for full concentration on the procedure. |
| Check that the packaging of all equipment is intact. | To ensure sterility. If seal is damaged, discard. |

| Wash hands | To prevent contamination of medication and equipment. |
|---|---|
| Prepare needle and syringe on clean dry kidney dish. | |
| Consult the patient's notes for :<br>a) Right Patient<br>b) Right Medication<br>c) Right Dose<br>d) Right Route<br>e) Right Time<br>f) Right Administration | To ensure that the patient is given the correct drug, in the ordered dose, in the appropriate solution and by the correct route. & 6 rights should be considered. |
| Select the drug in the appropriately sized container and check the expiry date. | To reduce waste. |

**ADMINISTRATION**

| ACTION | RATIONALE |
|---|---|
| 1. Explain procedure to the patient. | To obtain the patient's consent and co-operation. |
| 2. Assist patient into the required position. | |
| 3. Ensuring privacy, expose the chosen site. | |
| 4. Choose the correct sized needle. | To minimize the risk. |
| 5. Clean the chosen site with alcohol swab in a circular fashion to cover an area 5 cm in diameter. Allow the alcohol to evaporate. | To reduce the number of pathogens introduced into the skin by the needle at the time of insertion. |
| 6. Grasp the skin firmly. | To elevate the subcutaneous tissue. |
| 7. Insert the needle into the skin at an angle of 45° or at 90° if insulin syringe is used<br><br>8. Release the grasped skin. | Thin patients use an angle of 15° - 45°, obese patient may require a 90° angle to be effective. |
| 9. Pull back the plunger. If no blood is aspirated, depress the plunger and inject the drug slowly. If blood appears withdraw the needle, change it and begin again. Explain to the patient. | To confirm that the needle is in the correct position. To prevent pain and ensure even distribution of the drug. |
| 10. Withdraw the needle rapidly.<br>11. Apply pressure to any bleeding point with alcohol swab. | |
| 12. DO NOT RECAP NEEDLES | To prevent needle stick injuries and inoculation with infectious diseases. |
| 13. Record on the medication chart that the drug has been given. | |

| 14. Dispose off the needle and syringe into the sharp container and swabs into the waste disposal bag.<br>15. Wash and dry kidney dish.<br>16. Wash and dry your hands. | To ensure safe disposal and to avoid laceration or other injury to staff. |
|---|---|

## 15. Protocol / Procedures for Putting on Sterile gown

**PURPOSE:**
To define the standard operating procedure for putting on a sterile gown.

**EQUIPMENT AND SUPPLIES**

Sterile gloves: appropriate size
Sterile gown

**PROCEDURE**

1. Wash hands, put on a hair cover and face mask and then open the sterile pack containing the sterile gown.
2. Remove the sterile gloves from outer wrap and drop the inner wrap onto the sterile pack.
3. Wash hands with an antimicrobial soap and dry thoroughly with towel provided in the gown pack.
4. Grasp the sterile gown by its uppermost folded crease near the neckline.
5. Step into an area which you will have space to open the gown without contaminating it and hold it away from you to allow the gown to unfold. Place your hands inside the gown and work your arms through the shoulders, making certain to touch the inside of the gown only.
6. If you perform the closed-glove technique, advance your hands only as far as the proximal edge of the cuff. However, if you apply sterile gloves using the usual aseptic (Open-glove) technique, extend your hands through the cuff but do not touch the outside of the gown. (Regardless of the gloving technique you use, a co-worker will be needed for assistance). The co-worker should first put on a mask and a hair cover and then grasp the ties at the neckline area at the back of your gown and pull the gown up to cover the neckline of the front of your uniform and then ties the strings without touching the exterior of your gown.
7. Unfold the inner wrap of the sterile gloves. If you are using the closed-glove technique, do this with your covered hands.
8. Grasp the first glove by manipulating your thumb and index finger through the fabric of the sleeve or cuff.
9. Place the glove palm down onto the cuff of your sterile gown. The fingers of the glove should point toward your elbow.
10. Manipulate your fingers within the cuff to firmly anchor the glove. Stretch the glove over the entire cuff with your other covered hand.
11. When the glove has been successfully pulled over the cuff, close cuff and extend your fingers into the glove.
12. Place your gloved fingers within the folded cuff of the remaining glove.
13. Position the glove over the closed cuff.
14. Pull the glove up over the gown's cuff as you extend your fingers through the glove.

15. Adjust the glove to fit your fingers. Make sure both gloves cover the cuffs of the gown.

## 16. Protocol / Procedure for Vital Signs Checking

**PURPOSE**

To define the standard operating procedure for checking Vital Signs.

**POLICY STATEMENTS**

1. Only following staff is allowed to take the vital signs
    a. Nurse/ Physician
2. A clean thermometer must be used for all patients each time the temperature is taken according to the clinical procedure.
3. Vital signs timing will be followed for all In-patients areas upon physician's order
4. Team Leader / Assigned Nurse can also determine vital signs frequency.

**DEFINITIONS**

Vital Signs: Checking Temperature, Pulse, Respiration and Blood Pressure
Blood pressure is measured for one of two reasons
1. To establish a baseline in blood pressure
2. To monitor fluctuations in blood pressure

Normal blood pressure: 100/60 to 140 / 90

**APPLICATION:**

All Nursing / Medical Staff

**EQUIPMENT AND SUPPLIES**

1. Sphygmomanometer
1. Stethoscope
2. Alcohol Swab

**PROCEDURE**

| | ACTION | RATIONALE |
|---|---|---|
| **1** | Explain procedure to the patient | To obtain the consent and co-operation of the patient. |
| **2** | Check vital signs under the same condition each time. | To ensure continuity and consistency in recording. |
| **3** | Wash hands. | To reduce transmission of micro-organisms. |

| | | |
|---|---|---|
| **4** | Ensure the patient is in the desired comfortable position - lying, standing or sitting. | To obtain the required readings. |
| **5** | Place all the equipments near the patient's bed side /over bed table. | |
| **6** | Check temperature first. | |
| **7** | Remove the thermometer from it's plastic container. | |
| **8** | Shake the mercury to below the lowest reading by using a flicking movement of the wrist. | To ensure an accurate reading. |
| **9** | Ask the patient to open his/her mouth and insert the thermometer under the tongue into the "heat pocket" at the posterior base of the tongue. | The highest oral temperature reading is at the posterior base of the tongue, which is least affected by environmental condition. |
| **10** | Ask the patient to close his/her mouth. | To increase the patent's comfort<br>To minimize the risk of temperature lowering by the external environment. |
| **11** | Hold the thermometer in place for two minutes. | Tissue contact must be maintained for an accurate reading to be obtained. |
| **12** | Apply the correct size of blood pressure cuff. | To obtain the correct amount of pressure over an artery |
| **13** | Fully deflate and apply the cuff of sphygmomanometer to slightly flexed arm, 2.5cm above the cubital fossa or to the leg above the popliteal fossa. The extremity should be positioned at heart level, with palm turned up. There should be maximum patient comfort and examiner accessibility. The leg should only be used if both arms are inaccessible. | To ensure that proper pressure will be applied over artery. The brachial and popliteal arteries are superficial in the cubital and popliteal fossae. |
| **14** | Position the manometer at eye level. | Ensures accurate reading of mercury level. |
| **15** | If the patient's normal systolic pressure is not known inflate the cuff whilst palpating the radial artery on the lower medial side of the biceps muscle. When the beat can no longer be felt, note the pressure reading on the sphygmomanometer and release the cuff. | To determine the maximum level to which the mercury should be pumped, without causing extra discomfort to the patient. |
| **16** | After 30 secs place the stethoscope ear pieces in ears, and bell of stethoscope over the brachial artery inflate cuff to a point approximately 20-30 mmHg above the first reading. | When the bell/diaphragm of the stethoscope is placed over an artery, the sound will be heard with little distortion. The artery must be located by palpating with the finger tips |

| | | |
|---|---|---|
| **17** | Release pressure valve on the cuff slowly. All mercury to fall at a rate of 2-3 mmHg/sec. | Pressure exerted by the inflated cuff prevents blood from flowing through the artery. The point at which the first clear beat is heard is the systolic reading. The point at which the last beat is heard is the diastolic reading. |
| **18** | Deflate cuff rapidly and remove from patient's arm. | Continuous inflation causes arterial occlusion, resulting in numbness and tingling of patient's arm. |
| **19** | Record the systolic and diastolic pressures on the graphic chart, and compare the present reading with previous readings. If repeating the procedure, wait for 30 seconds. | To monitor differences and detect trends. Irregularities should be brought to the attention of Team Leader / Physician.<br>Prevent venous congestion and falsely high readings. |
| **20** | Remove the equipment and clean the bell / diaphragm and ear pieces of the stethoscope with the alcohol swab. Fold cuff and store it properly. | To prevent the spread of infection |
| **21** | Assist the patient to a position he prefers. | To maintain patient's comfort. |

**VITAL SIGNS TIMINGS**

| Abbreviation | Meaning | Timing |
|---|---|---|
| **Routine (B.D)** | Twice a day | 0600<br>1800 |
| **Q Shift (8h)** | Every shift | 0600<br>1400<br>2200 |
| **Q 6 h** | Every six hourly | 0600<br>1200<br>1800<br>0000 |
| **q 4 h** | Every four hourly | 0200<br>0600<br>1000<br>1400<br>1800<br>2200 |

| q 2 h | Every two hourly | 0200<br>0400<br>0600<br>0800<br>1000<br>1200<br>1400<br>1600<br>1800<br>2000<br>2200<br>0000 |
|---|---|---|

## 17. protocol/Procedure Assisting a Patient from a wheel chair to the bed

**PURPOSE**

To define the standard operating procedure for assisting the patient from the wheel chair to the bed / bed to wheel chair.

**POLICY STATEMENTS**

Assigned nurse/ Transporter will help moving the patient from wheel chair to bed or bed to wheel chair.

**EQUIPMENT AND SUPPLIES**

1. Wheel Chair
2. Bed sheet = 01

**PROCEDURE**

1. Patient's who have enough mobility to help support themselves during the transfer may be assisted from the wheelchair or chair to the bed with the standing-pivot techniques. Position the wheel chair at a 45 ° angle to the bed and lock both the wheel chair and bed to ensure their stability. If the patient will be transferred from a chair, make sure it is stable and will not slide on the floor. It is important to either remove the wheelchair's leg rests or swing them out of the way so that they will not obstruct the move. Explain the procedure to the patient and ensure that he/she understands each step and his/her role during the transfer. Encourage him/her to assume as much of the lifting and weight bearing as he/she can comfortably handle, using his/her stronger leg, if this is appropriate. Before starting, however, you must ensure that his/her belt is securely fastened round his/her waist.

| |
|---|
| 2. Flex your knees and position your feet into a wide base of support with one foot slightly in front of the other. Grasp the patient's belt, and instruct him/her to position his/her arms around your waist. On the cue to stand, the patient will prepare to stand on his/her stronger leg as you assist him/her into the standing position by pulling his/her trunk forward and up. As you pull him/her forward, transfer your weight from your forward leg to your back leg. |
| 3. To ensure the stability of your patient's stronger leg, position the side of your knee against the side of his/her knee to maintain it in extension. Pivot the patient and guide him/her until the backs of his/her legs are positioned against the bed. Keep your knees flexed and your back straight. |
| 4. Assist the patient in lowering himself / herself to the sitting position by using a slow bending of your knees to control the rate of descent. |
| 5. Support him/her until he/she is stable and comfortable. Then remove the belt and robe and assist him/her into bed. Reverse the procedure to move him/her from the bed to the chair. |

## 18. Protocol / Procedure for Moving Patient from Stretcher to the bed

**PURPOSE**

To define the standard operating procedure for moving the patient from the stretcher to the bed or bed to stretcher.

**POLICY STATEMENTS**

Assigned Nurse/Transporter will help moving the patient from the stretcher to bed or bed to stretcher.

**EQUIPMENT AND SUPPLIES**

1. Stretcher
2. 02 bed sheets
3. 01 pillow with cover

**PROCEDURE**

1. If your patient can assist in the transfer, you can instruct her to move onto the bed from the stretcher by employing the segmental transfer technique. Before she begins the move, ensure that both the bed and the stretcher are locked in place to prevent them from separating during the move; adjust the bed to a height as close to that of the stretcher as possible. Explain to the patient that he/she will move his/her head, trunk, and feet in stages.
2. Ask him/her to flex his/her hips and knees so that his/her feet are flat on the stretcher.
3. He/she should press down on his/her feet and slide his/her trunk, buttocks, and then his/her head over to the side of stretcher.
4. He/she should move his/her trunk and then his/her head as close to the edge of the stretcher as possible.
5. Tell him/her to place his/her feet on the side of the bed.

6. Instruct him / her to make a bridge of his/ her trunk by lifting his / her pelvis off the stretcher.
7. Once the transfer is completed, remove the stretcher.
8. To transfer the patient from bed to stretcher-reverse procedure is followed.

## 19. Protocol/ Procedure for Electrocardiogram (ECG)

**PURPOSE**

To define the standard operating procedure for performing E.C.G.

**POLICY STATEMENTS**

1. Cardiac Technician/ Trained Nurse is only allowed to perform E.C.G.
2. Female patient requires female staff.

**EQUIPMENT AND SUPPLIES**

1. ECG machine
2. ECG Jelly
3. Tissue Paper (Kitchen Roll)
4. ECG recording paper

**INDICATIONS**

To detect any abnormalities of the heart.

**PROCEDURE**

| ACTION | RATIONALE |
|---|---|
| 1. Explain the procedure to patient | To obtain the co-operation of patient and reduce anxiety |
| 2. Lock the door, ensure privacy. | |
| 3. Let patient lie down in comfortable position, exposure the chest area | To apply electrodes on the chest. |
| 4. Apply ECG jelly | |
| 5. Place the electrodes | |
| 6. Attach ECG leads | To obtain ECG recording |
| 7. Remove the leads and electrodes after completing the ECG | |
| 8. Clean the patient chest with tissue paper (kitchen roll). | To keep patient clean and comfortable. |
| 9. Assist patient to dress up. | |