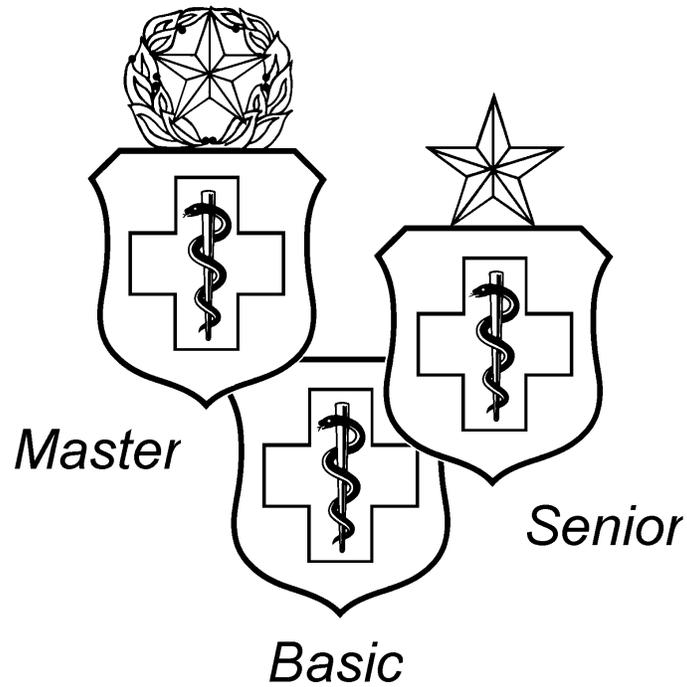


QTP 4N0X1-2
January 2004

AEROSPACE MEDICAL SERVICE SPECIALTY
NURSING CARE OF PATIENTS WITH SPECIAL NEEDS



**TRAINING THE BEST MEDICS FOR THE BEST
AIR FORCE IN THE WORLD**

**383 Training Squadron
Training Management Section
939 Missile Road STE 3
Sheppard Air Force Base, TX 76311-2262**

QTP 4N0X1-2

AEROSPACE MEDICAL SERVICE SPECIALTY

Volume 2: Nursing Care of Patients with Special Needs

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INTRODUCTION

1. These qualification training packages (QTPs) were developed to enhance on-the-job training for Aerospace Medical Service Specialty personnel. They provide for you, as a trainer, the breakdown of tasks into teachable elements. This will help you guide the trainee toward gaining enough proficiency to perform the tasks. They will also aid task certifiers when it becomes necessary to evaluate trainees for task certification.

2. As a trainer, go through each module and identify which QTPs are needed for the trainee's job position. Core task items (identified with an asterisk * in the STS) are mandatory skills for all trainees to be proficient in performing. You also have the flexibility to arrange training for each module in the order you decide. Review the different tasks related to the subject area in each module with the trainee. Direct the trainee to review the training references to better understand the objective of each module. If the trainee has any questions about the objective, clarify what is expected based on the objective of the module. Go through the performance checklist with the trainee and allow for enough time to learn each step (some objectives may take longer to teach). Remember, the objective of each QTP is to allow sufficient time for the trainee to learn each task thoroughly. When the trainee receives enough training and is ready to be evaluated on an objective, follow the evaluation instructions. Use the performance checklist as you evaluate each objective. If the trainee successfully accomplishes the objective, document appropriately in the OJT record. If the trainee does not accomplish the objective, go over the areas needing more training until the objective is met. Conduct a feedback with the trainee on each module. Once you, as the trainer, have ensured that the trainee is qualified to perform the task, he/she will then be evaluated by a certifier.

3. The goal of the developers of each QTP is to publish a usable document for trainers and trainees that will benefit the CFETP concept of training throughout your career. We value your expertise in meeting this goal. If you find discrepancies in a QTP, or if you have suggestions for improvement or additional QTP development, please let us know about them. We pledge to respond to all inquiries and will devote our resources to provide the best possible training material.

4. Direct all inquiries to:

383 TRAINING SQUADRON/TSOXB
c/o 4N051 CDC WRITER/MANAGER
939 MISSILE ROAD STE 3
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ASSIST WITH CENTRAL VENOUS LINE INSERTION AND MONITORING

SUBJECT AREA: Vital signs and assist with medical examinations/special procedures.

TASK(s): Assist with central venous monitoring set-up and central line insertion.

CFETP/STS REFERENCE(s): 9.1.15.1, 9.2.6.1.2, 19.6.3.

EQUIPMENT REQUIRED: Prep and dressing supplies, cardiac monitor, venous pressure tray (manometer and catheter, IV fluid and tubing prepared with heparin **saline**) flush, 3-way stopcock, Pressure bag, gowns, mask, cap, eye protection, and sterile gloves, and a carpenter’s level.

TRAINING REFERENCE(s): Lippincott Manual of Nursing Practice, current edition.

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

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

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order		
2. Identify patient/explain procedure a. Obtain informed consent b. Explain how and when to do Valsalva maneuver		
3. Gather supplies/equipment		
4. Wash hands		
5. Assist patient to supine position a. For brachial insertion: extend arm and secure to armboard b. For subclavian or neck insertion: place in Trendelenburg position		
6. Prepare monitoring set-up according to manufacturer's instructions		
7. Flush IV infusion set and manometer or prepare heparin flush for use with transducer		
8. Attach manometer to IV pole and ensure it is level with patient's right atrium		
9. Connect cardiac monitor leads to patient		
10. Assist physician in donning cap, gown, mask, gloves, and eye protection		
11. Assist physician in site preparation		
12. Assist physician in catheter insertion by keeping patient still and monitoring for dysrhythmias during insertion phase		
13. Connect IV tubing/heparin / saline) flush to catheter and adjust flow rate		
14. Dress site and secure catheter and tubing		
15. Record CVP (omit this step if not qualified to perform measurements)		
16. Continually assess insertion site for complications		
17. Change dressing as ordered		
18. Document procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

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

SUBJECT AREA: Assist with medical examinations/special procedures and special pulmonary procedures.

TASK(s): Assemble equipment and supplies for chest tube insertion and set-up and monitor water seal drainage.

CFETP/STS REFERENCE(s): 9.1.6.1.2.

EQUIPMENT REQUIRED: Chest tube insertion tray, suture material, chest tube connector, water seal drainage system, syringe/needle with local anesthetic.

TRAINING REFERENCE(s): Lippincott Manual of Nursing Practice, current edition, and water seal drainage system manufacturer’s operating instructions.

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

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of assisting with chest tube insertion and monitoring water seal drainage.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order		
2. Identify patient, explain procedure, and obtain written consent		
3. Gather supplies/equipment		
4. Wash hands and don gloves		
CHEST TUBE INSERTION		
1. Position patient according to physician's preference		
2. Set-up water seal drainage system per manufacturer's instructions		
3. Assist physician as needed during chest tube insertion procedure		
4. Connect chest tube to water seal drainage system		
5. Set suction to proper mm/Hg setting as ordered by physician		
6. Check system for leaks/proper function		
7. Observe drainage for blood or air. Check chest x-ray for placement.		
8. Document procedure		
MONITOR WATER SEAL DRAINAGE		
1. Attach chest drainage tube to tubing that leads to the long tube with the end submerged in sterile saline		
2. Ensure all tube connections are secure		
3. Monitor and mark output with tape (hourly and daily)		
4. "Milk" the tube as directed to maintain patency		
5. Monitor the patient for complications and report problems immediately: <ul style="list-style-type: none"> a. Rapid/shallow respirations b. Cyanosis c. Increased intrathoracic pressure d. Subcutaneous emphysema e. Signs and symptoms of hemorrhage 		
6. Assist patient with comfort measures as necessary		
7. Document observations and procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

ASSIST WITH ARTERIAL LINE INSERTION

SUBJECT AREA: Assist with medical examinations/special procedures.

TASK(s): Arterial line insertion.

CFETP/STS REFERENCE(s): 9.2.6.1.1, 18.14.4

EQUIPMENT REQUIRED: Over-the-needle catheter (size per physician’s request), ECG monitor, with arterial line readout capability and appropriate cables, pressure transducer, pressure tubing, sterile gloves, sterile towels/draping, anti-microbial preps, pressure bag, heparinized/ normal saline solution), IV pole, local anesthetic and syringe/needle, sterile dressing material, and tape.

TRAINING REFERENCE(s): Monitor and transducer manufacturer’s operating instructions, and local procedures as applicable.

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

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

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order		
2. Identify patient, explain procedure, and ensure appropriate consent is obtained		
3. Gather supplies/equipment		
4. Wash hands		
5. Connect transducer to monitor		
6. Connect heparinized or normal saline solution and tubing to transducer		
7. Pressurize solution with pressure bag to 300mm/Hg		
8. Place transducer level with patient's right atrium		
9. Zero the monitor		
10. Don sterile gloves and place sterile drape under patient's wrist		
11. Hand physician sterile gloves		
12. Hand physician anti-microbial prep		
13. Hand physician syringe with local anesthetic		
14. Hand physician arterial catheter/cannula		
15. Hand physician tubing once catheter/cannula is inserted in the artery and secure catheter/cannula with transparent tape material (Opsite).		
16. Monitor patient and monitor throughout procedure		
17. Report and record monitor readings		
18. Assist physician in applying sterile dressing after the procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

***ASSIST WITH PULMONARY ARTERY CATHETER INSERTION AND
MEASUREMENTS/CARDIAC OUTPUT MEASUREMENTS***

SUBJECT AREA:	Assist with medical examinations/special procedures and Cardiovascular procedures.
TASK(s):	Assemble equipment and supplies for pulmonary artery catheter; perform pulmonary artery pressure measurements; perform cardiac output measurements.
CFETP/STS REFERENCE(s):	9.2.6.1.3, 9.2.6.2.2, 9.2.6.2.3, 19.1.2.3, 19.6.2.
EQUIPMENT REQUIRED:	Sterile gloves, gowns, and drapes, pulmonary artery catheter, ECG monitor with pulmonary readout capability, defibrillator, pressure transducer, cutdown tray, sterile saline solution, pressure bag, heparinized / normal saline IV solution, local anesthetic and syringe, 3, 5, and 10cc syringes, cardiac output injectate kit, sterile dressing material, and tape.
TRAINING REFERENCE(s):	Lippincott Manual of Nursing Practice, current edition, catheter manufacturer's instructions, and AACN Procedure Manual for Critical Care, 3rd edition, 1993.
REMARKS/NOTES:	Review steps of the process one-on-one with Medical technician and/or nursing personnel skilled and verified in assisting with pulmonary catheter insertion/measurements and cardiac output measurements.
OBJECTIVE:	The trainee will successfully demonstrate without error the performance aspects of assisting with pulmonary catheter insertion/measurements and cardiac output measurements.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee's OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
ASSISTING WITH PULMONARY ARTERY CATHETER INSERTION		
1. Verify physician's order		
2. Identify patient, explain procedure, and ensure proper consent is obtained		
3. Gather supplies/equipment		
4. Wash hands and don gloves and mask		
5. Maintain sterility and open all packages		
6. Secure all connections and ensure stopcocks are appropriately adjusted		
7. Replace vented caps with non-vented caps		
8. Remove all air from 500cc bag of normal saline (with 1000U Heparin prepared by nurse unless contraindicated)		
9. Assemble IV administration set		
10. Hang bag inside pressure bag on IV pole		
11. Place transducer in holder		
12. Prime pressure tubing using intraflow fast flush device		
13. Inspect transducer for air bubbles and flush to remove		
14. Pressurize bag to 300mm/Hg		
15. Attach transducer to pressure cables		
16. Ensure transducer is level and set to zero per manufacturer's instructions		
17. Measure and record patient's vital signs		
18. Attach monitor to patient		
19. Assist physician with donning sterile attire		
20. Hand physician anti-microbial prep		
21. Hand physician syringe with local anesthetic		
22. Hand physician pulmonary artery catheter		
23. Observe the patient and the monitor during procedure for adverse signs		
24. Hand physician suture material		
25. Assist physician in dressing the site		
OBTAINING PULMONARY ARTERY WEDGE PRESSURE READING		
1. Wash hands and don gloves		
2. Locate PA menu and PA wedge		
3. Fill 1.5 cc syringe with 0.5-1.5cc of air		
4. Attach syringe to balloon lumen of catheter		
5. Align gate valve arrow to open position		
6. Select PA WEDGE (auto mode) and wait for INFLATE BALLOON prompt		
7. Slowly inflate balloon to minimal volume while watching waveform on monitor		
8. Record PAWP waveform, keeping balloon inflated for less than 15 seconds		

continued on next page

PERFORMANCE ITEM	SAT	UNSAT
9. Allow balloon to passively deflate		
10. Disconnect syringe to passively deflate		
11. Close gate valve to “off” position		
12. Move cursor if you disagree with placement for PA wedge pressure valve		
13. Keep number of PAWP readings to a minimum		
14. If resistance is met during balloon inflation, stop procedure and notify nurse or physician		
15. If air goes into balloon freely or if blood return is noted from balloon lumen, close gate valve, label it “DO NOT INJECT AIR,” and notify physician		
16. Do not flush catheter when it is wedged		
17. Recognize PAWP waveform and notify physician if catheter spontaneously wedges		
18. Document value in ICU/CCU flowsheet or hemodynamic worksheet		
OBTAINING PULMONARY ARTERY PRESSURE READING		
1. Read PA systolic at uppermost portion of waveform and document reading		
2. Read PA diastolic at lowermost portion of waveform and document reading		
PERFORMING CARDIAC OUTPUT MEASUREMENT		
1. Wash hands		
2. Set-up cardiac output injectate kit <ul style="list-style-type: none"> a. Connect syringe to two-way valve assembly b. Remove air from 500cc bag of normal saline or D5W c. Insert injectate tubing into bag d. Fill tubing by repeatedly pulling back and pushing forward on syringe until system is free of air e. Close roller clamp f. Connect syringe assembly to the proximal (cardiac output) port of the PAC g. Connect appropriate CO temperature sensor cables to the injectate syringe assembly and PAC thermistor connector 		
3. Access cardiac output program on monitor		
4. Fill 10cc syringe with injectate solution		
5. Turn stopcock to open syringe to proximal port		
6. Deliver injectate smoothly within 4 seconds		
7. Obtain 3 to 5 values, edit if necessary, and average the values		
8. Use cardiac calculations program and save calculations		
9. Document values on flow sheet and amount of fluid used on I&O sheet		
10. Notify physician as necessary of any abnormal values or changes		
PULMONARY ARTERY CATHETER MAINTENANCE		
1. Wash hands and don personal protective attire		
2. Maintain patency of PA catheter with pressurized flush solution by infusing at a rate of 3cc/hr		

continued on next page

PERFORMANCE ITEM	SAT	UNSAT
3. Change pressure transducer tubing every 48-72 hours		
4. Document amount of flush solution used on I&O sheet		
5. Monitor system for presence of air or clots and ensure connections are secure		
6. Inspect insertion site every shift and prn (Document findings)		
7. Change dressing every 72 hours if transparent materials are used, or every 24 hours if gauze is used. Catheter replacement or site rotation every seven (7) days.		
8. Document all observations and procedures		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

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

- SUBJECT AREA:** Special pulmonary procedures.
- TASK(s):** Drawing radial arterial blood gas sample percutaneously
- CFETP/STS REFERENCE(s):** 9.1.6.2.3 and 19.5.5.
- EQUIPMENT REQUIRED:** Sterile gloves, sterile drape, 23 or 25ga. needle/2-3ml syringe, Heparin .5cc (1000u/cc), skin prep antiseptic solution, ABG specimen collection kit, and container with ice.
- TRAINING REFERENCE(s):** Lippincott Manual of Nursing Practice, current edition.
- REMARKS/NOTES:** Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in drawing a radial arterial blood gas sample percutaneously.
- OBJECTIVE:** The trainee will successfully demonstrate without error the performance aspects of assisting drawing a radial arterial blood gas sample percutaneously.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee's OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
PREPARATION		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Wash hands		
5. Perform Allen test: a. Firmly press radial and ulnar pulses simultaneously at the wrist b. Ask patient to clench and unclench fist until blanching of the skin is noted c. Release pressure on ulnar artery while maintaining pressure on radial artery d. Watch for return of skin color within 15 seconds (Note: Perform test on the other wrist if skin color does not return within 15 seconds)		
6. Don sterile gloves		
7. Place drape under patient's wrist		
8. Prepare ABG syringe: a. Lubricate barrel of syringe with heparin solution b. Follow instructions with kit and expel all air from needle and syringe		
DRAWING ARTERIAL BLOOD PERCUTANEOUSLY		
1. Assist physician as directed during procedure		
2. Ensure needle is capped or placed in rubber stopper after specimen is obtained (Use caution when recapping needle. Use one-handed "scoop method to recap needle)		
3. Place syringe in ice container and send specimen to laboratory or civilian agency immediately		
4. Maintain pressure on site for at least 5 minutes. If on anticoagulants, 10-15 minutes.		
5. Apply a firm pressure bandage over the dressing		
6. Wash hands, dispose of supplies properly, and document the procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

***OBTAINING ARTERIAL BLOOD
GAS SAMPLE VIA MANIFOLD***

SUBJECT AREA: Special pulmonary procedures.

TASK(s): Obtain arterial blood gas sample from arterial line manifold.

CFETP/STS REFERENCE(s): 9.2.5.4.

EQUIPMENT REQUIRED: Sterile gloves, sterile drape, 23 or 25ga. needle/2-3cc syringe, 5cc waste syringe, Heparin .5cc (1000u/cc), skin prep antiseptic solution, ABG specimen collection kit, and container with ice.

TRAINING REFERENCE(s): Lippincott Manual of Nursing Practice, current edition.

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in obtaining arterial blood gas sample via a manifold.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of obtaining an arterial blood gas sample via a manifold.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
PREPARATION		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Wash hands		
5. Don sterile gloves		
6. Prepare ABG syringe: <ul style="list-style-type: none"> a. Lubricate barrel of syringe with heparin solution b. Follow instructions with kit and expel all air from needle and syringe 		
COLLECTION OF ARTERIAL BLOOD GAS SAMPLE VIA ARTERIAL LINE MANIFOLD		
1. Uncap appropriate port on arterial line and connect waste syringe to port		
2. Open stopcock to permit 5cc of blood to enter syringe		
3. Close stopcock, remove syringe, and discard in appropriate biological waste container.		
4. Connect prepared ABG syringe to port on manifold and permit appropriate amount of blood to enter syringe		
5. Place syringe in ice container and send specimen to laboratory or civilian agency immediately		
6. Flush arterial line with appropriate amount of saline/heparin solution		
7. Wash hands, dispose of supplies properly, and document the procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

ADMINISTERING LOCAL ANESTHETIC AGENTS

- SUBJECT AREA:** Wound management.
- TASK(s):** Administer local anesthetic agents: topical, local infiltration, and digital block.
- CFETP/STS REFERENCE(s):** 9.1.4.1.3.7, 9.1.7.2.8.1, 9.1.7.2.8.2, 9.1.7.2.8.3, 18.8.1, 20.1.3.2.
- EQUIPMENT REQUIRED:** Gloves, topical anesthetic, Lidocaine per physician’s orders, syringe, and 25, 26, or 27ga.needles .
- TRAINING REFERENCE(s):** Medical-Surgical Nursing, current edition.
- REMARKS/NOTES:** Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in administering local anesthetic agents.
- OBJECTIVE:** The trainee will successfully demonstrate without error the performance aspects of administering local anesthetic agents.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
1. Verify physician's order		
2. Identify patient, explain procedure, and obtain written consent		
3. Gather supplies/equipment, wash hands, and don gloves		
TOPICAL ANESTHETIC		
1. Position patient in position of comfort with affected site exposed		
2. Verify the order using the five rights		
3. Ensure patient is not allergic to anesthetic agent. Identify whether lidocaine with or without epinephrine should be used for specific area per physician and/or local guidance.		
4. Clean the site with anti-microbial soap, water and allow to air-dry		
5. Assess patient's sensory awareness at site before administering the anesthetic		
6. Apply topical anesthetic to site		
7. Assess patient's sensory awareness at site after administering the anesthetic		
8. Dispose of supplies properly and wash hands		
9. Document procedure		
LOCAL INFILTRATION		
1. Position patient in position of comfort with affected site exposed		
2. Verify the order using the five rights		
3. Ensure patient is not allergic to anesthetic agent		
4. Clean site with anti-microbial soap, water and allow to air-dry		
5. Assess patient's sensory awareness at site before administering the anesthetic		
6. Inject anesthetic into superficial tissue at site		
7. Test site with needle to ensure anesthesia after 2-3 minutes (administer additional anesthetic if necessary)		
8. Dispose of supplies properly and wash hands		
9. Document procedure		
DIGITAL BLOCK		
1. Position patient in position of comfort with affected site exposed		
2. Verify the order using the five rights		
3. Ensure patient is not allergic to anesthetic agent		
4. Clean site with soap and water and allow to air-dry		
5. Assess patient's sensory awareness at site before administering the anesthetic		
6. Inject no more than 3cc of the anesthetic along nerve pathway		
7. Massage site to ensure equal distribution of the anesthetic		
8. Test area of block with needle to ensure anesthesia after 2-3 minutes (administer additional anesthetic if necessary)		
9. Dispose of supplies properly and wash hands		
10. Document procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

WOUND CLOSURE

- SUBJECT AREA:** Wound management.
- TASK(s):** Wound closure: suture laceration, care of clips and staples in wound management, and removal of sutures, clips, or staples.
- CFETP/STS REFERENCE(s):** 9.1.7.2.9.2, 9.1.7.2.9.3, 18.8.2.
- EQUIPMENT REQUIRED:** Sterile and non-sterile gloves, mask, eye protection, gown, sterile saline, antiseptic soap solution, anti-microbial swabs, syringe for irrigation, 18 ga. flexible catheter tip, Lidocaine per physician’s orders, syringe for injection, 25,26,or 27ga. needles, minor suture kit, suture removal kit, staple removal kit, sutures per physician’s orders, hydrogen peroxide, sterile dressings and bandages, and tape.
- TRAINING REFERENCE(s):** Medical-Surgical Nursing, current edition, and Lippincott Manual of Nursing Practice, current edition.
- REMARKS/NOTES:** Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in wound closure and follow-up care.
- OBJECTIVE:** The trainee will successfully demonstrate without error the performance aspects of wound closure and follow-up care.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
SUTURE LACERATION		
1. Identify patient, explain procedure, and obtain written consent		
2. Verify the order using the five rights		
3. Ensure patient is not allergic to anesthetic agent or anti-microbial		
4. Position patient in position of comfort with affected site exposed		
5. Gather supplies/equipment, wash hands, don non-sterile gloves, mask, eye protection, and gown		
6. Anesthetize the site (per QTP Vol.2 Module 6)		
7. Clean the site using deep irrigation with syringe, flexible catheter tip, and antiseptic soap and sterile saline solution. Irrigate wound with 500cc of normal saline for each cm of laceration. If wound is grossly contaminated, additional irrigation should be performed.		
8. Debride the site as necessary		
9. Prep the site with locally approved disinfectant in a circular motion, from the center outward		
10. Set-up sterile field and don sterile gloves		
11. Suture the site: a. Alternate from end-to-end of the wound, working toward the center (to make the wound smaller as each new suture is applied) b. Pass needle and suture through epidermal and dermal tissue layers c. Wrap suture around hemostat twice d. Pull free end through the loop and draw wound edges together e. Wrap suture around hemostat in opposite direction once f. Pull free end tight against the knot g. Repeat by alternating direction of single wraps 2 more times h. Cut the suture leaving a 1/2 inch tail on each end i. Continue applying sutures approx. 1/8 inch apart until wound is closed j. Ensure knots are not directly over laceration.		
12. Clean site with ½ hydrogen peroxide and ½ normal saline		
13. Dress and bandage site		
14. Instruct patient to follow-up per physician's orders for suture check(s) and removal and provide patient with suture care instructions		
15. Document procedure		
CARE OF CLIPS AND STAPLES		
1. Identify patient and explain procedure		
2. Wash hands and gather supplies and equipment		
3. Position patient in position of comfort with affected site exposed		
4. Don non-sterile gloves, remove dressing, and observe for signs of infection		
5. Ensure clips/staples are adequately holding wound edges together		
6. Don gloves and clean wound using antimicrobial solution		
7. Allow site to air-dry		
8. Apply new dressing and bandage		
9. Dispose of supplies properly		
10. Instruct patient to follow-up per physician's orders		
11. Wash hands and document observations and procedure		

SUTURE REMOVAL		
1. Verify physician's orders		
2. Wash hands and gather supplies and equipment		
3. Identify patient and explain procedure		
4. Position patient in position of comfort with affected site exposed		
5. Don gloves and remove dressing		
6. Clean site gently using soap and warm water		
7. Remove sutures: a. Grasp knot with forceps and gently pull upward b. Cut one side of suture below the knot c. Pull the suture out of the wound d. Continue until all sutures are removed e. Ensure all sutures that were placed in the wound are accounted for		
8. Clean the site again		
9. Apply steri-strips if indicated		
10. Dress and bandage site		
11. Instruct patient on proper care of the site		
12. Dispose of supplies properly		
13. Wash hands and document observations and procedure		
REMOVAL OF CLIPS AND STAPLES		
1. Verify physician's orders		
2. Wash hands and gather supplies and equipment		
3. Identify patient and explain procedure		
4. Position patient in position of comfort with affected site exposed		
5. Don gloves and remove dressing		
6. Clean site gently using soap and warm water		
7. Remove clips/staples: a. Place staple remover under staple b. Squeeze handle down and pull staple upward c. Continue until all staples are removed d. Ensure all staples that were placed in the wound are accounted for		
8. Clean the site again		
9. Apply steri-strips if indicated		
10. Dress and bandage site		
11. Instruct patient on proper care of the site		
12. Dispose of supplies properly		
13. Wash hands and document observations and procedure		
14. Document procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

INSERT/IRRIGATE/REMOVE NASOGASTRIC TUBE

SUBJECT AREA: Nutrition and elimination-related procedures.

TASK(s): Insert/irrigate/remove nasogastric (NG) tube.

CFETP/STS REFERENCE(s): 9.1.13.2.1, 9.1.12.2.2, 9.1.13.2.3

EQUIPMENT REQUIRED: Gloves, emesis basin, tape, normal saline, syringe, water soluble lubricant, towels, stethoscope, NG tube, cup, and straw.

TRAINING REFERENCE(s): Lippincott Manual of Nursing Practice, current edition.

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in nasogastric tube insertion, irrigation, and removal.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of nasogastric tube insertion, irrigation, and removal.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.

2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.

3. Use the performance checklist to ensure all steps of the task are accomplished.

4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
INSERT NG TUBE PROCEDURES		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Position patient in high Fowler's position and drape appropriately		
5. Measure for proper NG tube: a. Tip of nose to tip of earlobe to tip of xiphoid b. Mark point on tube with tape c. Diameter of tube approximately same as diameter of patient's little finger		
6. Evaluate nose for patency: a. Close off one nostril to evaluate patency b. Ask patient if their nose has ever been broken c. Evaluate patient for facial trauma prior to insertion		
7. Don gloves		
8. Lubricate first 4-6 inches of tube with water soluble lubricant		
9. Insert tube: a. Insert through nostril aiming downward and toward back of throat b. Flex patient's head toward their chest c. Encourage patient to sip water through straw d. Advance tube as patient swallows until tape mark reaches nostril		
10. Assess tube placement: a. Inject 10-20cc of air and listen for "whoosh" sound in the stomach with stethoscope b. Aspirate gastric contents with syringe		
11. Anchor tube by taping to nose and pinning to gown		
12. Connect tube to intermittent or continuous suction		
13. Document procedure		
IRRIGATE NG TUBE PROCEDURES		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Don gloves		
5. Disconnect tube from suction		
6. Assess tube placement		
7. Fill an Asepto or irrigation syringe with 30-60cc of normal saline		
8. Gently instill saline. DO NOT USE FORCE		
9. Withdraw amount equal to amount instilled		
10. Document procedure		
REMOVE NG TUBE PROCEDURES		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Don gloves		

continued on next page

PERFORMANCE ITEM	SAT	UNSAT
5. Disconnect tube from suction		
6. Assess tube placement		
7. Inject 10cc of saline to clear tube of contents, then clamp tube		
8. Instruct patient to take a deep breath and hold		
9. Slowly and steadily remove tube		
10. Assist patient with oral hygiene		
11. Dispose of supplies properly		
12. Document procedure		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

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

SUBJECT AREA: Nutrition and elimination-related procedures.

TASK(s): Establish and maintain closed urinary drainage systems and remove closed urinary drainage system.

CFETP/STS REFERENCE(s): 9.1.13.6.2, 9.1.13.7

EQUIPMENT REQUIRED: Gloves, closed urinary drainage system, catheter tray with catheter, solution for cleansing, gauze pads, tape, drape or waterproof barrier, lubricant and 10cc syringe.

TRAINING REFERENCE(s): Lippincott Manual of Nursing Practice, current edition.

REMARKS/NOTES: Review steps of the process one-on-one with medical technician and/or nursing personnel skilled and verified in urinary catheter insertion, maintenance, and removal.

OBJECTIVE: The trainee will successfully demonstrate without error the performance aspects of urinary catheter insertion, maintenance, and removal.

EVALUATION INSTRUCTIONS:

1. After the trainee has received instruction, allow sufficient practice on each part of the task.
2. The evaluator will **STOP** the procedure immediately and correct the trainee if performance could become detrimental to patient safety at any time.
3. Use the performance checklist to ensure all steps of the task are accomplished.
4. Document task competency upon completion of the evaluation in the trainee’s OJT record. Initial evaluation should be documented in the CFETP. All recurring evaluations should be documented on AF Form 1098.

PERFORMANCE ITEM	SAT	UNSAT
ESTABLISH CLOSED URINARY DRAINAGE SYSTEM		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Identify patient/explain procedure		
4. Position patient appropriately: a. Males: Supine with legs extended b. Females: Supine with knees bent and apart		
5. Wash hands		
6. Open catheter tray using aseptic technique		
7. Don sterile gloves		
8. Drape patient		
9. Perform test on catheter balloon		
10. Cleanse urinary meatus using anti-bacterial solution		
11. Lubricate catheter		
12. Insert catheter: <i>(Note: Do not force catheter if resistance is met)</i> Do not inflate balloon without observing urine return. a. Males: Retract foreskin if necessary, raise penis to 90 degree angle, and insert catheter approximately 6-10 inches until urine return is noted b. Females: Insert catheter approximately 2-3 inches until urine flow is noted NOTE: Remove no more that 750-1000 cc at any one time		
13. Inflate indwelling catheter balloon per manufacturer's instructions		
14. Anchor tubing: a. Males: Tape catheter to lower abdomen and tubing to thigh b. Females: Tape catheter and tubing to thigh		
15. Dry area and ensure patient comfort		
16. Document procedure, to include urine color, sediment, and output measurement		
MAINTENANCE OF CLOSED URINARY DRAINAGE SYSTEM		
1. Wash hands		
2. Don gloves		
3. Identify patient/explain procedure		
4. Clean area around insertion point with soap and water		
5. Avoid pulling on catheter		
6. Ensure urine flow is unobstructed		
7. Empty bag: a. Disinfect spigot b. Empty contents into measuring container and disinfect spigot again		
8. Ensure bag is secured and off of floor		
9. Document procedure, to include urinary color, sediment, and output measurement		
REMOVE CLOSED URINARY DRAINAGE SYSTEM		
1. Verify physician's order		
2. Gather supplies/equipment		
3. Wash hands and don gloves		
4. Identify patient and explain procedure		

Vol.2 Module 9 (continued) Establish/Maintain/Remove Closed Urinary Drainage System

PERFORMANCE ITEM	SAT	UNSAT
5. Position patient appropriately: a. Males: Supine with legs extended b. Females: Supine with knees bent and apart		
6. Drape patient appropriately		
7. Remove catheter: a. Insert barrel of syringe into inflation port and withdraw fluid to empty balloon-tipped catheter b. Hold catheter near the insertion point and pull it out gently c. Inspect catheter to ensure it is intact		
8. Assist patient in cleaning the perineum		
9. Dispose of supplies properly and wash hands		
10. Document procedure		
11. Document procedure, amount of urine in bag, and time of first voiding after catheter removal		
FINAL RESULT:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.