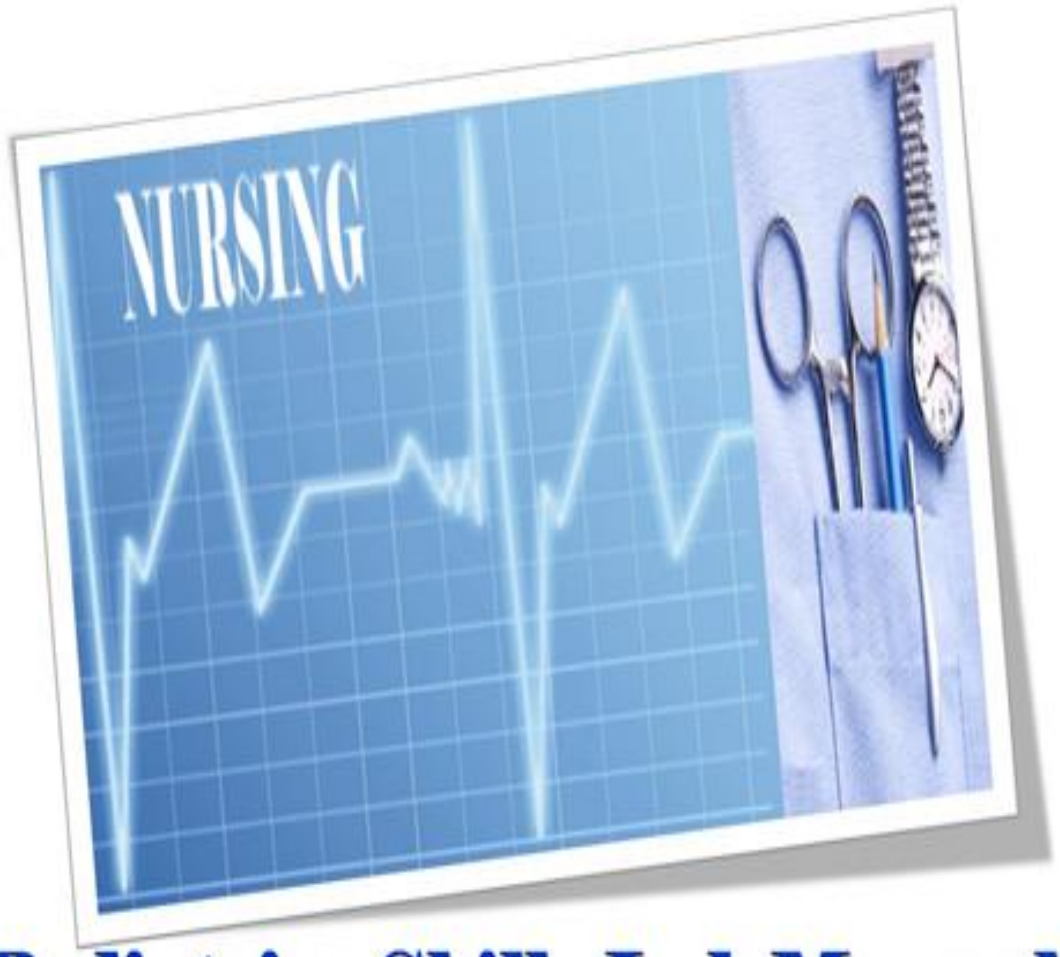

Pediatrics Skills Lab Manual

(NRS 364)

Pediatric Health Nursing Clinical skill manual

NRS 364

Index

Unit 6 **Oxygen Administration**	**Procedure 1: Nasal cannula, Nasopharyngeal Catheter, or Mask** **Procedure 2 Oxygen Hood**
Unit 7 **Suctioning**	**Procedure 1 Nasotracheal Suctioning**
Unit 9 **Collection of Specimens**	**Procedure 1: Urine Collection 24 hour specimen** **Procedure 2: Urine Collection Clean Catch or Midstream** **Procedure 3: Urine Collection Indwelling Catheter** **Procedure 4: Urine Collection Routine Voided Urine specimen** **Procedure 5: Blood drawing from peripheral sites: Performing heel and finger sticks.**
Unit 10 **Bathing the Infant**	**Procedure 1: Giving a Sponge Bath** **Procedure 2: Giving a Tub Bath**
Unit 11 **Feeding Infant**	**Procedure: 1 Breast-feeding** **Procedure: 2 Infant Formula-feeding**
Unit 12 **Diapering**	**Procedure 1: Diapering**
Unit 13 **Immunization**	**Procedure 1: Immunization**

Unit 1

Vital Signs

Procedure 1: Assessing Body Temperature

Procedure 2: Assessing an Apical Pulse

Procedure 3: Assessing a Peripheral Pulse

Procedure 4: Assessing Respirations

Procedure 5: Assessing Blood pressure

Purpose

1. To determine body temperature
2. To assist in diagnosis
3. To evaluate pediatric patient's recovery from illness
4. To determine if immediate measures should be implemented to reduce dangerously elevated body temperature or converse body heat when body temperature is dangerous low
5. To evaluate pediatric patient's response once heat conserving

Procedure:1 Measuring Body Temperature

Preparation

1. **Assess:**
   - Clinical signs of fever
   - Clinical signs of hypothermia
   - Site most appropriate for measurement
   - Factors that may alter core body temperature

2. **Assemble equipment and supplies:**

   - Thermometer
   - Thermometer sheath or cover
   - Disposable gloves
   - Water-soluble jelly.
   - Towel for axillary temperature
   - Tissues/wipes

Procedure

1. Explain procedure to the child & her parents.
2. Provide comfortable position and privacy.
3. Perform hand hygiene.
4. Check the working of thermometer by shaking it.
5. Clean the thermometer from bulb to tip.
6. Shake the level of mercury down to below 350C.
7. Apply a protective sheath or probe cover

Oral Temperature

8. Place thermometer in into the child's posterior sublingual pocket.
9. Tell the child to keep mouth closed, breath through the nose and to talk.
10. Hold thermometer in place for 3 minutes
11. Remove thermometer and wipe it from tip to bulb.
12. Perform hand hygiene.
13. Read and record the temperature of child.

.

Rectal temperature:

1. Perform hand hygiene.
2. Don examination gloves.
3. Gently spread the child's buttocks and insert probe 0.5 inches (1.3 cm.) for infant and 1 inch (2.5 cm.) for child and hold it for one minute.
4. Remove thermometer and wipe it tip to bulb.
5. Perform hand hygiene.

6. Read and record the temperature of child.

Axillary temperature

1. Place the thermometer in under arm with tip in center of axilla and keep it close to skin not clothing.
2. Hold child's arm firmly against side for 5 minutes.
3. Remove thermometer and wipe it tip to bulb.
4. Perform hand hygiene.
5. Read and record the temperature of child.

Procedure 2: Assessing an Apical Pulse

1. To count pulse rate per minute.
2. To assess pulse characteristic (rate, rhythm, strength).

Procedure 2-1: Measuring Heart Rate by Auscultation of Apical Pulse

Preparation

1. **Assess:**
   - Review child's record for baseline data on pulse rate know range for age
   - Clinical signs of cardiovascular alterations, other than pulse rate, rhythm, or volume
   - Factors that may alter pulse rate
   - Site most appropriate for assessment
   -
2. **Assemble equipment and supplies:**
   - Watch or clock with a second hand or digital readout
   - Statoscope
   - Alcohol swab

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Place the child in supine position on a flat table.
4. Clean statoscope chest piece and ear piece with alcohol wipe
5. Palpate the chest wall to determine the point of maximal impulse:
6. In children younger than 7 years-just left of the midclavicular line and fourth intercostal space.
7. In children older than 7 years – left midclavicular line and fifth intercostal space.
8. Listen to the heart sound and count for one full minute.

9. Cleanse statoscope chest piece and ear piece with alcohol wipe.
10. Put on child's clothes and make him / her comfortable.
11. Perform hand hygiene.
12. Record the apical pulse of child.

Procedure 3 : Assessing a Peripheral Pulse

Purpose :

1. To determine number of heart beats occurring per minute(rate)
2. To gather information about heart rhythm and pattern of beats
3. To evaluate strength of pulse.
4. To assess response of heart to cardiac medications ,activity, blood volume and gas exchange

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Identify site; radial and brachial are most frequently used.
4. Palpate the child's pulse and palpate with your first two or three fingers.
5. Note rhythm.
6. Count for 30 second and multiply by 2 if child's pulse is regular. If irregular, count for 1 full minute
7. Perform hand hygiene.
8. Record heart rate, site used to obtain, and child's activity level in patient record

Procedure 4: Assessing Respirations

Purpose

1- To count respiratory rate per minute.

2- To assess respiratory characteristics.

Preparation

1. **Assess:**
   - The child's color depth of respirations.
   - Presence of nasal flaring, grunting, retractions and types of accessory muscles.
   - Rhythm of respirations.
   - The position that child assume to breathe.
   - Fussiness and anxiety.
2. **Assemble equipment and supplies:**
   - Clock or watch with a second hand or digital readout

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Count the respiratory rate when the child is a wake and calm or when a sleepy:
4. Observe the abdomen for movement to infants and young children.
5. Observe thoracic movement in older children.
6. Count number of respirations for 30 seconds and multiply by 2, if respirations are regular.
7. Count number of respirations for 1 full minute, if respirations are irregular.
8. Note depth and pattern of respirations, presence of anxiety, restlessness. irritability and position of comfort.
9. Observe child's color, including extremities, noting cyanosis or pallor.
10. Perform hand hygiene.
11. Record results; respiratory rate is recorded in breaths per minutes

Procedure 5: Assessing Blood Pressure

Purpose:

1. To obtain base line data for diagnosis and treatment
2. To compare with subsequent changes that may occur during care of patient
3. To assist in evaluating status of patient's blood volume ,cardiac output and vascular system

Preparation

Assess:

- Signs of hypertension
- Signs of hypotension
- Factors affecting blood pressure

2. Assemble equipment and supplies:

- Stethoscope
- Measurement device:
  -Mercury gravity or android sphygmomanometer
  Or
  -Automated device that uses oscillometric or Doppler technique.
- Appropriately sized BP cuff

Procedure: 5-1 Auscultation Method

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene
3 Clean diagram of stethoscope
4. Select appropriate sized cuff
5. Center the bladder of the cuff to the extremity proximal to the pulse (eg. At the brachial site, position about 1-2 inches above the antecubital fossa) and snugly secure cuff
6. Locate the pulse at the site.
7. Place the bell of the statoscope where the pulse is felt, bellow the bottom edge of the cuff.
8. Close the sphygmomanometer valve, and inflate cuff to a pressure 30 mm Hg above the point at which artery pulsation is obliterated.
   Deflate cuff at a rate of 2 to 3 mm.Hg per second.
9. Note korotkoff sounds, beginning with the onset of tapping sound.
10 Note muffling of the sound, if applicable.

.

11. Note disappearance of sound.
12. Completely deflate cuff and remove from arm.
13. Perform hand hygiene.
14. Record the finding of the patient record.

Procedure: 5-2 Palpation Method

1. Follow steps1-5 in previous procedure. Auscultation method, for locating artery, cuff, selection and placement.
2. Inflate the cuff to palpate the artery.
3. Inflate the cuff to 30 mm.Hg higher than the point at which you last felt pulse
4. Slowly deflate cuff and note point at which pulse return is felt.
5. Completely deflate cuff and remove from extremity.
6. Perform hand hygiene.
7. Record measurement in patient record as palpated systolic reading.

Unit 2

Growth Parameter Assessment

Procedure 1: Assessing Weight of the Infant/toddler up to 24 Months of Age
Procedure 2: Assessing Weight of Older Ambulatory Child
Procedure 3: Assessing Length of Children Younger 2 Years of Age
Procedure 4: Assessing Height
Procedure 5: Assessing Head Circumference.
Procedure 6: Assessing Chest Circumference

Procedure 1: Assessing Weight of the Infant/toddler up to 24 Months of Age
Procedure 2: Assessing Weight of Older Ambulatory Child

Purpose :

1- To evaluate the child's health status.
2- To detect any marked loss or gain in weight.
3- To provide a basic idea for determining the infant status and medication dosage.

Procedure 3: Assessing Length of Children Younger 2 Years of Age
Procedure 4: Assessing Height

Purpose :

1. To plot on growth chart.
2. To compare value percentile for weight.

Procedure 5: Assessing Head Circumference.

Purpose :

To plot on growth chart

Growth Parameter Assessment

Preparation

1. **Assess:**
   - Child's previous growth pattern.
   - Most recent weight, height, and head circumference.

2. **Assemble equipment and supplies:**
   - Small sheet or paper drape to cover scale.
   - Infant/ toddler scale.
   - Adult scale.
   - Paper measuring tape
   - Flat surface or flat measuring board. Measuring device affixed to a wall (stadiometer), height assessment rod attached to scale, or an electronic length measurement device.
   - Growth chart.
   - Calculator.

Procedure 1: Assessing Weight of the Infant/toddler up to 24 Months of Age

Procedure steps

1. Explain procedure to the child & her parents.
2. Make the room warm.
3. Note the child's previous weight if available.
4. Perform hand hygiene.
5. Wipe the scale with alcohol swab.
6. Place light diaper or paper on scale pan
7. Calibrate scale to "0" position
8. Completely undress and safely place infant/ toddler on scale.
9. Hold hand slightly above infant while on scale.
10 Read the scale when child is still lying.
11 Carefully remove the infant from the scale.
12 Redress the infant
13 Return the infant to parent's arms or crib.
14 Dispose of paper on scale
15 Perform hand hygiene.
16 Document weight on child's growth chart and / or related specific to care location.

Procedure 2: Assessing Weight of Older Ambulatory Child

1 Demonstrate whether child is able to stand and balance on scale.
2 Note child's previous weight as available.
3 Place paper or drape on scale.
4 Calibrate scale to "0" position.
5 Ask child to remove shoes and heavy clothing.
6 Assist child to stand on scale.
7 Have child place hands at side of body or hold belly.
8 Note or record child's weight in kilograms on a notepad.
9 Assist the child to step down from scale.
10 Document weight on child's growth chart and / or related specific to care location.

Procedure 3: Assessing Length of Children Younger 2 Years of Age

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Place the child on center of proper covered hard surface in supine position.
4. Hold the head against headboard firmly.
5. Grasp the knee together gently until legs are fully extended and hold the legs firmly.
6. Make points of the top of the head and heel of the feet by a point.
7. Remove the child from his / her place.
8. Measure between the two points with measuring tape.
9. Place the child back to his/ her place.
10 Record the length of the child.

.

Procedure 4: Assessing Height

1. Explain procedure to the child & her parents.
2. Note the child's previous height if available.
3 Perform hand hygiene.
4 Ask the child to remove shoes.
5. Child should not be wearing a hat or hair ornaments.
6. Assist child to stand on scale with back to scale or place child with back to wall /stadiometer.
7. The child's heels, buttocks and shoulders should be in contact with the wall or height bar of the scale.
8. Any flexion of knees, lumping of shoulders or raising of heels of feet is checked and corrected.
9. The child should look straight ahead without tilting the head.
10 Raise the height road and extended height assessment bar over child's head.
11 Lower height rod to top of child's head.
12 Read the height measurement during the examiner eye to eye contact.
13 Perform hand hygiene.
14 Record the height of the child.

Procedure 5: Assessing Head Circumference

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Place light drape or paper on flat surface.
4. Place the child in supine position or seated on paper drape.
5. Place the tape measure over the most prominent point of the occiput, around the head just above the eyebrow and pinna.
6. Return the infant to the parent 's arms or crib

. 7. Perform hand hygiene.

8. Document the head circumference of the child.

Procedure 6: Assessing Chest Circumference

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Place the child in supine position on a flat table.
4. Remove child's clothes of upper half.
5. Place the measuring tape across the nipple line.
6. Measure midway between inspiration and expiration.
7. Remove the tape and put on child's clothes.
8. Perform hand hygiene.
9. Record the chest circumference of child.

Unit 3
Abdominal Girth

Purpose:

- To monitor progressive abdominal distention in children.

Procedures steps

Assess:

- Recently complained abdominal pain or injury or is at risk for abdominal distention.
- Risk factors of abdomen.

Assemble equipment and supplies:

- Paper measuring tape.
- Ballpoint pen.
- Stethoscope.

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Auscultate bowel sounds with stethoscope
4. Place the child in supine position on a flat table, with the child knees flexed or, for an infant, hold the legs flexed at the knee and hip. According to the condition of the child
5. Measure girth with the child in the same position each time
6. Remove or move aside clothing
7. Place tape snugly across the umbilicus.
8. Take measurements at the end of expiration
9. Remove the tape and put on child's clothes.
10. Perform hand hygiene.
11. Record the abdominal girth of child.

Unit 4

Restraints

Procedure 1 Using a Mummy Restraint

Procedure 2 Using an Elbow Restraint

Procedure 3 Using a Jacket Restraint

Procedure 4 Using Clove hitch restraint

Purpose:

1- To protect an infant from moving and possibly causing during special treatment or examination as in:

a. Scalp vein infusion.
b. Gastric lavage.
c. Eye or ear examination.

Procedures steps

Preparation

1. **Assess:**
   - Preexisting medical condition or physical disability and limitation
   - History of sexual or physical abuse
   -
2. **Assemble equipment and supplies:**
   - Receiving blanket.
   - Tape

Procedure 1 Using a Mummy Restraint

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Place the blanket on a or examination table on a diagonal.
4. Fold down one corner.
5. Place the child on the blanket with shoulders on line with the fold
6. Firmly pull one corner of the blanket over the infant's body and tuck under the opposite shoulder.
7. Pull the opposite side over and tuck it under the infant's back.

8. Pull the bottom up and secure ends of the blankets with tape to keep in place.
9. Do not cover the child's face.
10. Modify wrap to give access to chest and groin.
11. Roll the edges around the legs and secure with tape.
12. Ensure that the wrap does not obstruct circulation in the limb.
13. Perform hand hygiene.
14. Documentation

Procedure 2 Using an Elbow Restraint

Purpose :

1- To prevent infant or small children from flexing their elbows and hands, scratching surgical incision, skin lesion or removing I.V. line from the scalp.

Preparation

1 **Assemble equipment and supplies:**

- Commercial cuff
- Tongue depressors
- Tape

Procedure

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Obtain appropriately sized elbow restraint.
4. Pad the child's skin under restraint with towel or gauze padding.
5. Secure restraint using ties.
6. Ensure that there is adequate circulation to limb.
7. Remove restraints and check skin condition at least every 2 hours.
7. Provide range of motion.
8. Perform hand hygiene.
9. Documentation

Procedure 3 Using a Jacket Restraint

Purpose :

1- To prevent child from climbing out of the crib. i.e. prevent falling.

2- To keep patient lying on his back following chest surgery.

Preparation

Assemble equipment and supplies:

- Jacket or vest of appropriate size.

Procedure steps

1 Explain procedure to the child & her parents.
2 Perform hand hygiene.
3 Obtain a jacket appropriate size.
4 Place the child's arms through the armholes.
5 Secure the ties of the jacket to a non-movable part of the bed frame or wheelchair.
6 Use a quick-release kont or device that can be quickly released.
7. Reposition the child, release immobilizing restraints and perform range of motion exercise.
8. Perform hand hygiene.
9. Documentation

Procedure 4 Using Clove hitch restraint

Purpose :

To restraint movement of one limb or all four limbs as in the following cases:

a. Exposed burn of abdomen or chest.
b. Eczematous skin.
c. Patient with nasogastric tube.
d. To maintain I.V. infusion.

Preparation

1. ### Assemble equipment and supplies:

- Bandage with appropriate size.
- Cotton.

Procedure steps

1. Explain procedure to the child & her parents.
2 Perform hand hygiene.
3. Provide privacy.
4. Stay with distressed patient.

5. Ensure that the bony prominences of the wrist or ankle were padded.
6. Make two loops forming.
7. Pick up the two loops together.
8. Put the padded limb through it.
9. Attach the tie or straps of restraint to spring of the bed.
10 Put hand and limb in natural position slightly flexed position.
11 Knot the ties appropriately to the bed frame.
12 Check every 2 hours and readjust accordingly.
13 Perform hand hygiene.
14 Documentation

Unit 5

Medication Administration

Procedure 1: Administering Oral Medication.

Procedure 2: Administering Intramuscular Injections.

Procedure 3: Administering Intravenous medications.

Procedure 4: Administering Subcutaneous Injections.

Procedure 5: Administering Ophthalmic Medications.

Procedure 6: Administering Otic Medication.

Procedure 7: Administering Nasal Medication.

Procedure 1: Administering Oral Medication.

Purpose:

- To provide a safe, effective and economical route for administering medications.

Administering Oral Medication

Preparation

1. **Assess:**
   - The child previous experience with receiving IV medications.
   - Allergies.

2. **Assemble equipment and supplies:**
   - Nonsterile gloves
   - Correct medication
   - Oral syringe or medicine cup
   - Water or juice to drink or Popsicle
   - Flavored syrup, such as cherry or grape (optional)
   - Nipple (optional)
   - Applesauce (optional)

Procedure

1. Verify the order with the child's medical record.
2. Check for allergy to drug
3. Perform hand hygiene and don gloves.

4. Read the label of medication to verify with the order.
5. Check for expiration date.
6. Check medication from dispensed.
7. Prepare medication for administration
8. Measure all liquid medications using an oral syringe or medicine cup
9. Verify medication with electronic record or take the medication record and medication to child to administer.
10 Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
11 Elevate the child's head or pick up and hold an infant or small child before administering medication.
12 Administer the medication. Deliver liquids in small amounts, placing the syringe to the sides of the mouth and allow the child to swallow between amounts.
13 Stay with the child until the medication is taken.
14 Dispose of medicine cup, syringe, and other objects in appropriate receptacle.
15 Remove gloves and perform hand hygiene.
16 Documentation.

Procedure: 2 Administering Intramuscular Injections

Preparation

1. **Assess:**
   - The child's previous experience with receiving injection.
   - For allergies.
   - Child' age, muscle mass.
   - Other physical limitation that that will impact choice of site for IM injection

2. **Assemble equipment and supplies:**
   - Correct medication
   - Syringe, appropriate gauge and length
   - Nonsterile gloves
   - Alcohol swab
   - Cotton ball or gauze
   - Adhesive bandage
   - Fun bandage (optional)
   - Stickers (optional)

Procedure

1. Explain procedure to the child & her parents.
2. Verify the order with medical record
3. Perform hand hygiene.
4. Read the label of medication to verify with the order.
5. Check for expiration date.
6. Cheek the amount of medication to be administered.
7. Limit volume according to the age of the child and the of muscle used.
8. Use a low-dose 1-ml. syringe to give volumes <0.5 ml.
9. Choose appropriate length for the site and muscle size
10 Select gauge based on what available for the appropriate needle length for the child and medication viscosity.
11 Draw up the medication in the medication room
12 Draw up the correct amount of medication into the syringe.
13 Don gloves
14 Verify medication with electronic record or take the medication record and syringe with medication to the child to administer.
15 Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
16 Evaluate the child's mass muscle and choose the most appropriate site.
17 Position and restraint the child.
Cleanse the site with alcohol wipe and allow to dry.
18 Insert the needle quickly at 90 degree angle
19 Aspirate to check the blood
20 Rapidly inject the medication.
21 Withdraw the needle and apply pressure over the site with a dry cotton ball or gauze.
22 Do not recap the needle; dispose of syringe and needle in a sharp co

23 Place adhesive bandage over site
24 Remove gloves and perform hand hygiene.
25 Assess for signs of adverse reaction to medication.
26 Documentation.

.

Procedure 3 Administering Intravenous medications

Preparation

1. **Assess:**
   - Childs height, weight, age and hydration status.
   - Factors to consider when calculating medication dosage and fluid requirement.
   - The child previous experience with receiving IV medications.
   - The child' and parents' understanding of the need for the IV medications.

2. **Assemble equipment and supplies:**
   - Existing IV access
   - Correct medication
   - Syringe, as needed
   - Needleless access device
   - Alcohol pad or swab
   - Gloves
   - IV tubing with volume-control chamber pr piggyback setup
   - IV pump or syringe pump
   - IV tubing cap, as needed to maintain sterility of tubing

Procedure steps

2. Verify the order with medical record
3. Perform hand hygiene.
4. Read the label of medication to verify with the order.
5. Check for expiration date.
6. Draw up the medication in the medication room
7. Draw up the correct amount of medication into the syringe, reconstitute powder as indicated.
9. Determine the best method of IV administration for the medication and child.
10 Verify medication with electronic record or take the medication record and syringe with medication to the child to administered and other IV requirement needed to the child to administer.
11 Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
12 Explain to the child and the family that you are going to administer the medication
13 Verify that IV access is patent and without complications.
14 **If the child has intermittent lock:**
   a. Cleanse the needless injection cap with 70% alcohol.
   b. Insert the syringe with normal saline.
   c. Slowly infuse I ml. of normal saline.
   d. Connect the medication

15. **For the medication administered through IV push**

    a. Cleanse the top of the needless injection cap with 70% alcohol.
    b. Insert the syringe with medication.
    c. Inject the medication slowly over the time specified.

16. **For the medication administered through a volume control chamber:**

    a. Fill the container using fluid from hanging IV bag, with amount of fluid required for dilution.
    b. Calculate in the fluid volume of medication itself.
    c. Cleanse the diaphragm used for medication administration with 70% alcohol.
    d. Inject the medication into the chamber.
    e. Set the infusion rate to infuse medication volume and flush over directed time
    f. Start infusion.

17. **For medication administration through a small volume container:**

    a. Cleanse the container diaphragm used for medication insertion with alcohol.
    b. Inject the medication into the bag/bottle.
    c. Connect administration tubing to small-volume bag/bottle.
    d. Cleanse the port closest to the IV insertion site with 70% alcohol
    e. Connect medication administration tubing to main IV at Y connector closest to the IV site.
    f. Set the infusion rate to infuse medication volume and flush over the desired time.
    g. Start infusion.

18. **For medication administration through a syringe pump**

    a. Obtain a syringe of medication as dispensed from pharmacy.
    b. Prime infusion tubing and attach infusion tubing to the syringe.
    c. Attach the syringe to the IV-controlled infusion device.
    d. Cleanse the port closest to the IV insertion site with 70% alcohol.
    e. Connect medication administration tubing to main IV at Y connector closest to the IV site.
    f. Set the IV controlled infusion device to infuse medication volume and flush over the correct time.
    g. Start infusion

19. Dispose the equipment and waste in appropriate receptacle.
20. Perform hand hygiene.
21. Monitor the child initially and every 15 minutes.
22. Flush medication from tubing at the completion of administration
23. After infusion of medication and flush is complete, disconnect infusion tubing.
24. Attach sterile tubing cap at the end of infusion tubing.
25. Perform hand hygiene.
26. Documentation.

Procedure 5-4 Administering Subcutaneous Injections

Preparation

1. **Assess:**
   - The child previous experience with injections.
   - Allergies.

2. **Assemble equipment and supplies:**
   - Correct medication
   - Syringe appropriate size
   - Needle, appropriate size and length
   - Antiseptic swab or pledged (e , or 10% alcohol,2% chlorhexidine or 10% povidone-iodine)
   - Cotton ball
   - Nonsterile gloves
   - Adhesive bandage

Procedure steps

1. Verify the order with the child's medical record.
2. Check for allergy to drug
3. Perform hand hygiene and don gloves.
4. Read the label of medication to verify with the order.
5. Check for expiration date.
6. Check the amount of medication to be administered.
7. Choose appropriate needle gauge length for the medication.
8. Draw up correct correct amount of medication into syringe.
9. Verify medication with electronic record or take the medication record and medication to child to administer.
10. Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
11. Don gloves.
12. Evaluate the child's subcutaneous tissue.
13. Evaluate the use of biobehavioral interventions.
14. Restraint the child securely.
15. Cleanse the site with antiseptic and allow to dry
16. Grasp the site and elevate the tissue.
17. Insert the needle at appropriate degree angle
18. Rapidly inject the medication.
19. Withdraw the needle quickly
20. Apply pressure over the site with a dry cotton ball.
21. Do not recap the needle; dispose of syringe and needle in a sharp container.
22. Place adhesive bandage over site
23. Remove gloves and perform hand hygiene.
24. Assess for signs of adverse reaction to medication.
25. Documentation.

Procedure 5-5 Administering Ophthalmic Medications

Preparation

1. **Assess:**
   - The child previous experience with receiving ophthalmic medications
   - The drugs and latex allergies.

2. **Assemble equipment and supplies:**
   - Correct medication
   - Eyedropper
   - Cotton ball
   - Tissues
   - Non sterile gloves

Procedure steps

1. Verify the order with the child's medical record.
2. Check for allergy to drug
3. Read the label of medication to verify with the order.
4. Check for expiration date.
5. Verify medication with electronic record or take the medication record and medication to child to administer.
6. Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
7. Don gloves.
8. Cleanse the eye with cotton ball or gauze soaked with normal saline if necessary.
9. Position the child supine in bed or other flat surface, looking up.
10 Restraint the uncooperative child for administration.
11 Rest your dominant hand against the child's forehead. With the other hand, pull down the lower eyelid to expose the conjunctival sac.
12 Administer the medication
    a. Eye drops: if using a dropper, instill correct amount of drops into conjunctival sac
    b. Apply gentle pressure to the nasolacrimal dust for about 30 sec.
    c. Ointment: if using ointment, twist the ointment tube at the end to dislodge the ointment from the tube and place a thin ribbon of ointment along the entire conjunctival sac.
    d. Have the child keep his or her eyes closed for up to 1 minute after administration.
13 Wipe excess medication off with a cotton ball or tissue.
14 Remove gloves and perform hand hygiene.
15 Return medication to appropriate storage area.
16 Documentation.

Procedure: 6 Administering Otic Medication

Preparation

1. **Assess:**
   - The child's previous experience with receiving otic medications.
   - For the child's and parent's understanding of need for otic medication that will be administered.
   - For allergies.

2. **Assemble equipment and supplies:**
   - Nonsterile gloves
   - Otic medication
   - Dropper (if needed)

Procedure steps

1. Verify the order with medical record.
2. Check for allergy.
3. Perform hand hygiene and don gloves.
4. Read the label of medication to verify with the order is to be administered
5. Check for expiration date.
6. Verify medication with electronic record or take the medication record and bottle of medication to the child to administer
7. Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
8. Have the child in supine position with his/her head turned to the appropriate side.
9. Pull the earlobe down and back for children younger than 3 years.
   For older children, pull the pinna up and back.
10 Administer the ordered amount of drops into the ear canal, holding the dropper 0.5 inch above the ear canal
11 Gently massage tragus unless contraindicated due to pain.
12 Have the child remain in the supine position with the head turned for 3 to 5 minutes.
13 Distract and soothe the child.
14 Repeat with the other ear if prescribed.
15 Remove gloves and perform hand hygiene.
16 Return the medication to appropriate storage area.
17 Documentation.

Procedure: 5-7 Administering Nasal Medication

Preparation

1. **Assess:**
   - The child's previous experience with receiving nasal medications.
   - For the child's and parent's understanding of need for nasal medication that will be administered.
   - For allergies

2. **Assemble equipment and supplies:**
   - Non sterile gloves
   - Tissue
   - Bulb syringe (if needed)
   - Correct medication
   - Dropper (if medication bottle does not have one)

Procedure steps

1. Verify the order with medical record.
2. Check for allergy.
3. Perform hand hygiene and don gloves.
4. Read the label of medication to verify with the order Is to be administered.
5. Check for expiration date.
6. Identify the correct nostril in which to administer the medication.
7. Bring medication to the room temperature before administration.
8. Warm the solution by gentle rotating the bottle in your handsbefore administration.
9. Verify medication with electronic record or take the medication record and bottle of medication to the child to administer
10. Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.
9. Have the child blow his/her nose before administration.
10. **Nose drops:**
    a. Position the child in the supine position with head tilted back.
    b. Aim the tip of the dropper toward the nasal passage and instill the ordered number of the drops into each nostril.
    c. Have the child remain in that position for several minutes, if possible.
11. **Nasal spray**
    a. Position the child in a semi-fowler position with the head tilted slightly back.
    b. Instill the spray by holding one nostril closed while the medication is sprayed into the other nostril.
    c. Have the child take a deep breath the rough the nostril while the medication is being administered.
    d. If indicated, repeat the procedure on the other nostril.
12. Remove gloves and perform hand hygiene.
13. Recap the medication.

17. Return the medication to appropriate storage area.
18. Documentation.

Unit 6

Oxygen Administration

Purpose:

- To relieve hypoxemia results from respiratory or cardiac emergency.
- In respiratory emergency, oxygen administration helps the patient to reduce his ventilatory effort.
- In cardiac emergency, helps to meet increase myocardial work load as the heart tries to compensate hypoxemia.

Preparation

1. Assess:

- Child's history to determine rational for oxygen administration.
- Any contraindication related to particular method of oxygen delivery or level of oxygen concentration

2. Assemble equipment and supplies:

- Appropriate-size oxygen delivery device (nasal cannula, nasopharyngeal catheter or masks)
- "No smoking" sign
- Oxygen flowmeter
- Oxygen tubing
- Oxygen hood
- Pulse oximeter (if ordered)
- Paper tape
- Water soluble lubricant (for catheter insertion)
- Disposable gloves
- Goggle (if needed)
- Humidification attachment (if needed)
- Waterproof pad
- Extra baby blankets or bath blankets
- Warm sleepwear and hat for child
- Humidifier and sterile water
- Stimulating pictures to place on otside of the hood (optional)

Procedure 1: Nasal cannula, Nasopharyngeal Catheter, or Mask

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Select proper size for cannula catheter or mask
4. Remove all friction toys or open flames from the area and display "No smoking" signs.
5. Connect the flowmeter to either the oxygen wall unit or the freestanding tank.
6. Connect the humidifier to the oxygen setup.
7. Fill reservoir with sterile water.
8. Attach tubing to the oxygen source.
9. Check all electrical equipment in area to ensure that is grounded.
10. Connect the distal end of oxygen tubing to the delivery device (cannula, catheter or mask).
11. Turn on the flowmeter to the prescribed amount.
12. Don disposable gloves
13. Place the child on supine s
14. Place the infant's head in the midline "sniffing position".

For Nasal Cannula

15. Place the nasal prongs just inside the external meatus of the nares.
16. Secure the tubing to the face.
17. Instruct the child to breathe through nose.

For nasopharyngeal catheter

18. Lubricate the tip of the catheter with water soluble lubricant.
19. Gently insert the properly sized catheter to a depth equal to the distance from the nose to the front of the ear.
20. Do not use force to place the catheter. If resistance in placement is met do not proceed.
21. Secure the tubing to the child's face
22. Turn on flowmeter, providing humidified oxygen to the child.
23. Alternate the site of the catheter between nares every 8-12 hours and change the tube daily

For Mask

24. Place the oxygen mask over the mouth and the nose.
    Tighten the straps attached to the mask until you can fit one finger between the straps and the face of the child.

Procedure 2 Oxygen Hood

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Remove all friction toys or open flames from the area and display "no smoking" signs.
4. Line the area that the hood covers on the bed with a waterproof pad.
   Cover the same area with layers of bath or baby blanket.
5. Connect the humidifying unit to the hood.
6. Fill the reservoir with sterile water.
7. Connect the unit to the oxygen source.
8. Place the hood on the crib or bed so that the child's head is inside the unit.
9. Turn on the oxygen and humidifying unit to the prescribed setting.
10. Encourage family and other staff to limit the amount of time the child is outside the hood.

Unit 7

Suctioning

Procedure 7-1 Nasotracheal Suctioning

Purpose:

- To maintain patient airway.
- To facilitate exchange of gases.
- To stimulate a productive cough

Preparation

1. **Assess:**
   - The child's respiratory status.
   - The child's or family readiness to learn

2. **Assemble equipment and supplies:**
   - Portable or wall suction machine with tubing and collection container
   - Receiving blanket.
   - Towel or disposable waterproof pad
   - Appropriate-sized sterile suction catheter
   - Sterile container for sterile fluids used to lubricate and clear catheter
   - Water-soluble lubricant and/or normal saline
   - Sterile gloves
   - Protective eye shield/goggles as indicated
   - Sterile water

Procedure steps

1. Gather the necessary supplies and equipment.
2. Check for proper suctioning.
3 Turn-on the portable or wall suction apparatus
4. Set the pressure gauge to the appropriate range
5. Perform hand hygiene
6. Done protective gear
7. Assist the conscious child to assume the semi-fowler's position
8. Place the unconscious child in the lateral position.
9. Facing the person performing suctioning.

10 Place a towel or disposable waterproof pad on the child's chest.
11 Done sterile gloves
12 Check the equipment for proper functioning.
13 Make an appropriate measure of the depth for the insertion of the catheter.
14 Reassure the child before initiating the procedure.
15 Dip the catheter tip into the lubricant
16 Gently insert the catheter into either nares without applying suction,
17 Apply suction intermittently. Duration of suction should be limited no more than 15 seconds
18 Irrigate the catheter with sterile water or saline after each suction pass.
19 Lubricate the catheter and repeat suctioning as needed.
20 Assess the child's for color, respiratory rate, and effort and Sao2 levels (if monitored) during suctioning.
21 Gently cleanse around the child's nares once all suctioning has been completed.
22 Remove gloves inside out
23 Dispose the gloves, suction catheter and solution container in proper receptacle.
24 Perform hand hygiene.
25 Documentation

Unit 9

Collection of Specimens

Procedure 9-1: Urine Collection 24 hour specimen

Procedure 9-2: Urine Collection Clean Catch or Midstream

Procedure 9-3: Urine Collection Indwelling Catheter

Procedure 9-4: Urine Collection Routine Voided Urine specimen

Procedure 9-5: Blood drawing from peripheral sites: Performing heel and finger sticks.

Purpose

1- To determine the cause of an acute onset of illness.

2- To aid in diagnosis and treatment.

3- To determine the progress of patients condition.

Procedure 9-1: Urine Collection 24 hour specimen

Preparation

1. **Assess:**
   - Cognitive level, readiness and the ability to process information by the child and the family.
2. **Assemble equipment and supplies:**
   - Large-capped collection container (containing preservative, if necessary).
   - Clean bedpan or toilet specimen container, adhesive urine collection bag, or clean urinal, if indwelling catheter is not in place.
   - Large basin with ice (freshened with new ice, when the ice melts).
   - Adhesive label or marker
   - Signs: "24- Hour Urine Collection in progress".
   - Gloves

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Obtain a collection container from the laboratory to be kept in the bedside
4. Post signs on the door to the child's room, above the child's bed and in the bathroom saying that the 24-hour.

5. Don gloves to handle voided specimens.
6. If the child is able, have him or her voided to empty the bladder and discard the voided urine.
7. If indwelling catheter is in place, discard any urine already in the drainage bag.
8. Note the time that first urine was discarded.
9. Pour urine from each void into the collection container, and keep the collection container on ice
10 If indwelling catheter or urine collection bag is in place, empty and added to collection container on ice at least every 2 hours
11 Before the end of the 24 hour collection period, ask the child to void one last specimen.
12 Pour this fial specimen into the collection container.
13 Label the collection container and send it to the laboratory immediately after the 24-hour period.
14 Remove gloves
15 Hand hygiene after each contact with the urine specimen.
16 Documentation

.

Procedure 9-2: Urine Collection Clean Catch or Midstream

Preparation

1. **Assess:**
   - Cognitive level, readiness and the ability to process information by the child and the family.
   - The present history for toilet training if age appropriate.
   - Allergies to antimicrobial agent.

2. **Assemble equipment and supplies:**
   - Gloves
   - Basin with liquid soap and warm water, washcloth and towel
   - Sterile specimen container
   - Adhesive label or marker
   - Antimicrobial perineal wipes swabs or sponges
   - Biohazards bag for transporting the specimen to the laboratory
   - 4 X 4 gauze pads or tampon, if needed, for pubescent girls

Procedure

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Provide privacy.
4. Assist the child to the bathroom.
5. Done gloves.
6. Remove the lid of the sterile specimen container and place it with the inside of the

lid facing up, on a lean surface within easy reach.

7. If a parent is assisting or the child is performing self-care, he or she should perform hand hygiene and don gloves (optional).
8. Clean around the child urethral opening with liquid soap and water, antimicrobial wipes swabs or sponges.
9. Discard them in a nearby open waste receptacle.
10 Allow the area to dry.
11 For girls, using a separate antimicrobial swab for each stroke, open the child's labia and cleanse both the right and left side of the inner labia with one downward stroke.
12 For boys, retract the foreskin (if present). Cleanse the penis in an outgoing circular motion.
13 If possible, Instruct the child to void a small amount of urine into the toilet or urinal.
14 For infants and young children, use an adhesive urine collection bag or urine collection pad.
15 Have the child urinate 10-20-ml. directly into a sterile specimen container.
16 Place the lid back on the specimen container.
17 Wipe the outside of the container.
18 Assist the child with wiping/cleansing the perineal area after voiding is complete.
19 Assist the child to return to bed
20 Label the specimen, and place it in a biohazard bag.
21 Send the specimen to the laboratory immediately.
22 Dispose of equipment and waste in appropriate receptacle.
23 Remove gloves.
24 Perform hand hygiene.
25 Documentation.

Procedure 9-3: Urine Collection Indwelling Catheter

Preparation

1. **Assess:**
   - Cognitive level, readiness and the ability to process information by the child and the family.
   - The color and clarity of urine in the catheter drainage tubing.

2. **Assemble equipment and supplies:**
   - Clamp
   - Gloves
   - Sterile alcohol swab or institution- specific disinfectant swabs
   - Sterile 21-to 25-gauge needle or sterile needleless syringe adaptor.
   - Clean towel
   - Specimen container and label (if the specimen obtained is to be send to the laboratory for culture and sensitivity, the container for collection must be sterile).
   - Biohazard bag for transporting the specimen to the laboratory

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Provide privacy.
4. Clamp the indwelling catheter 4-6 inches below the needless sampling port in the urine catheter tubing.
5. Establish a clean working area, by using a clean towel spread open.
6. Using aseptic techniques.
7. Done gloves.
8. Withdraw urine from the sampling port by using a needleless adaptor with syringe (preferred) or a 23 or 25- gauge needle.
9. Withdraw needleless adaptor or needle syringe.
10 Inject the urine directly into the sterile specimen container.
11 To collect from the urine bag for a nonfresh urine, unclamp spigot and empty urine into the specimen container.
12 Put the lid on the container, label the specimen and place it in a biohazard bag.
13 Unclamp the indwelling catheter tubing.
14 Send the specimen to the laboratory immediately.
15 Dispose of used equipment and waste in appropriate receptacle.
16 Remove gloves.
17 Perform hand hygiene.
18 Documentation.

Procedure 9-4: Urine Collection Routine Voided Urine specimen

Preparation

1. **Assemble equipment and supplies:**
   - Gloves
   - Basin with liquid soap and warm water, waser cloth and towel or perineal wipe.
   - Waterproof pad
   - Age appropriate urine collection device:
     - Bedpan
     - Urinal
     - Toilet specimen container
     - Sterile foil bowel
     - Adhesive urine collection bag
     - Urine collection pad
     - Cotton balls
   - Urine specimen container
   - Adhesive label or marker
   - Biohazards bag for transporting the specimen to the laboratory
   - 4 X 4 gauze pads or tampon, if needed, for pubescent girls

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Provide privacy.
4. Don gloves
5. As age appropriate, have the child urinate in a clean bedpan, urinal, or toilet specimen container or use a urine collection device to collect urine from the child who is not yet toilet trained.
6. **For specimen collected in a bedpan or urinal**:
   a. Position the child on the back with the head of the bed slightly elevated.
   b. Place waterproof pad under the child's buttocks.
   c. Wash the child genital area with warm water and soap.
   d. Rinse and dry the area.
   e. Place the bedpan under the child or place the urinal such that the penis is inserted in the opening.
   f. Once the child has voided, remove the bedpan or urinal.
   g. Offer toilet paper an
   h. Assist the child to place underwear back on
   i. Assist the child to perform hand hygiene.

7. **For the child using a toilet specimen container:**
    a. Explain to the child and family how to clean the genitalia area
    b. Give a container to the child and explain how to hold the container while voiding.
    c. Ask the child to leave the sample in the bathroom after the specimen is obtained.
    d. Don gloves.
    e. Pour fresh urine in in the specimen container and put lid on the container.
8. **For the specimen collected by using a urine collected bag:**
    a. Position the child on the back with the legs in the frog-like position.
    b. Remove the diaper and clean the premium prepuce of the child.
    c. Apply chemical adhesive (eg. tincture of benzoin).
    d. Attach a urine collection bag to the child
    e. For boys. Insert the pines and the scrotum into the bag opening: the adhesive adhere to the premium and the symphysis**.**
    f. For girls, position the lower half of the adhesive on the bag on the premium first and press on the adhesive up toward the symphysis**.**
9. Cut a hole in the diaper, pulling the urine bag through the opening.
10 Replace the diaper and wait for the child to void
11 Removes the gloves
12 Perform hand hygiene.
13 After the child has voided, don gloves.
14 Remove the bag from the child.
15 Transfer the urine to specimen container.
16 Remove gloves.
17 Perform hand hygiene.
18 Documentation.
19 For specimen collected by using a urine collection pad:
    a. Explain procedure to the child & her parents.
    b. Perform hand hygiene.
    c. Don gloves.
    d. Remove the diaper and clean the premium prepuce of the child.
    e. Place urine collection pad across the urethra or the pines in lengthwise fashion.
    f. Remove the adhesive backing from the pad and replace the diaper.
    g. Once the child has voided, done gloves.
    h. Remove the diaper with the absorbent pad in from the infant.
    i. Place clean diaper on the child.
    j. With gloved hands, squeeze out urine from the absorbent pad into an appropriate urine container or onto urine testing strips.
    k. Dispose of the absorbent pad and the diaper in the appropriate receptacle.
    l. Remove gloves.
    m. Perform hand hygiene

Procedure 9-5: Performing heel and finger sticks

Preparation

1. **Assess:**
   - Child for signs of poor perfusion, local edema, infection at the site and impaired blood coagulation.

2. **Assemble equipment and supplies:**
   - Mechanical (automated) lancing device or lancet sized appropriately for infant/child weight (Follow manufacture's recommendation)
   - Antiseptic wipes(75% isopropanol)
   - 2 X2 sterile wipes
   - Gloves
   - Specimen catheter
   - Warming supplies (i.e. chemical warmer, cloth)

Procedure steps

1. Explain procedure to his/her parents.
2. Apply warming device in area for before puncture
3. Perform hand hygiene.
4. Don gloves
5. Remove warming device.
6. Select and identify puncture site
   a. Heel outer aspects (infants younger than 18 months).
   b. Finger (older than 18 months of age).
7. Cleanse puncture site with antiseptic allow to dry for 30 seconds.
8. Dry with sterile gauze.
9. Place extremity in a depended position.
10 For heel stick. Apply mild pressure between thumb and fingers to hold ankle in dorsiflexion.
11 Briskly puncture skin with selected lancing device
12 Wipe away the first drop of blood with sterile gauze
13 Continue to hold puncture site in dependent position while gently intermittent pressure to surrounding area.
14 Collect blood in appropriate container.
15 Gently press dry sterile gauze to puncture site until bleeding stop.
16 Do not use bandages.
17 Properly dispose of contaminated equipment.
18 Placing lancing device in sharp container and blood soaked guaze in biohazard bag.
19 Remove gloves and perform hand hygiene.
20 Documentation

Unit 10

Bathing the Infant

Procedure 10-1: Giving a Sponge Bath

Procedure 10-2: Giving a Tub Bath

Purpose

1- To keep skin clean.

2- To stimulate the circulation.

3- To give an opportunity for the nurse to observe infant's behavior, state of arousal, alertness and muscular activity.

4- To provide a wonderful opportunity for parent-infant social interaction.

5- To lower the body temperature.

Procedure 10-1: Giving a Sponge Bath

Preparation

1. **Assess:**
   - Special needs of the child before starting the bath
   - Some restrictions may apply to children with surgical incision, traction, intravenous catheter, casts, urinary catheters and artificial airway
   - The premature infant's physiological state (vagal tone, heart rate, oxygen saturation)**.**

2. **Assemble equipment and supplies:**
   - Warming lamp
   - Dry blanket or waterproof pad
   - Basin with warm water: 98.6 to 99.5 F (37.0 to 37.5 C)
   - Non sterile gloves
   - Mild liquid cleanser approved for infant use
   - Towels (at least two)
   - Washcloth
   - Cotton swabs or gauze wipes
   - Perfume free lotion or ointment
   - Petroleum jelly
   - Emollient

- Soft – bristle brush or comb
- Clean clothing and diaper
- Bedding
- Bulb syringe (if needed)

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Ensure that the opposite side rail of a crib is raised. Keep isolette doors closed until equipment is ready for the bath.
4. Turn on warming lamp and ensure that it is at appropriate distance from the infant.
5. Place a dry bath blanket or waterproof pad on the bed surface of the crib or isolette.
6. Fill basin or small tub with warm water. Water temperature should be about (37.0-37.5°C).
7. Perform hand hygiene and don gloves.
8. Position the infant in a supine position. Loosely cover the infant at all times with a dry towel or blanket.
9. Begin bath by bathing the face using cotton balls or a soft washcloth and water.
10 Cleansing orbital area wash from inner canthus to outer canthus, using a fresh cotton ball.
11 Pat bathed area dry with a clean, dry towel.
12 Cleanse nose with corner of cloth or cotton ball.
13 Gentle suctioning of the nares with a bulb syringe may help clear the nares of nasal secretion.
14 Wash the external ears and behind the ear by winding a damp washcloth around the index finger.
15 Using a mild liquid cleansing agent, work from the shoulders to the feet in a systematic manner to wash one section of the body at a time. Pay special attention to the folds of the neck, thighs, and underarms.
16 Excess vernix can be removed from the newborn's skin; however, removal of all vernix is not necessary.
17 Rinse and pat dry each area after washing with a towel. Do not rub the skin surfaces.
18 Clean the umbilical area with a cleansing agent and water.
19 Observe the umbilicus for redness and drainage. Lift cord and clean base.
20 Do not wet the umbilical cord. Rinse and dry the area. Leave the site open to air.
21 Place the infant on his or her stomach. Wash rinse and dry the infant's back. Cover the infant with dry towel.
22 Apply a small amount of perfume-free lotion or emollient to any dry area.
23 Clean the genital area. For females, gently wash the area from front to back, from vagina to rectum.
24 For male, squeeze clean water over head of the pines. In the uncircumcised male, gently move the foreskin as far as it will go, cleanse the head and the penis, and return the foreskin to the normal position.

25 In the circumcised infant, a petroleum-coated gauze bandage or petroleum jelly should be applied to the tip of the penis if the circumcision was the Gomco type.
26 Raise the infant lower body by the ankles to expose the buttocks wash rinse and dry the infant's buttocks.
27 Apply protective ointment on the buttock area and crease areas if indicated by redness
28 Apply a clean diaper. If the umbilical cord is still in place, adjust the top of the diaper so that it is below the umbilical area.
29 Apply emollient to the infant's skin as needed
30 If washing hair, rap the infant in a warm blanket, securing the arms close to the body. Place the infant in a football hold position,
31 Position the infant's head over the wash basin. lather the infant's scalp with a mild liquid cleansing agent or shampoo
32 Using a damp, soapy cloth, wash the infant's hair and rinse thoroughly, massage the entire scalp including the fontanels. Dry with towel.
33 Comb the infant's hair with a Fine-toothed comb or a soft-bristle brush
34 Remove the blankets from infant after hair washing
35 Cover the head with cap or bonnet.
36 Position for comfort and safety.
37 Disinfect and rinse the basin or tube
38 Return all equipment.
39 Dispose of waste in appropriate receptacle.
40 Remove gloves and perform hand hygiene

Procedure 10-2: Giving a Tub Bath

Procedure steps

1. Ensure that the opposite side rail of a crib is raised.
2. Turn on warming lamp and ensure that it is at appropriate distance from the infant
3. Fill basin or tub with enough water to reach the infant's hips when in sitting position. Water temperature should be about (37.0-37.5 ^{o}C)
4. Perform hand hygiene and don gloves.
5. Undress the infant
6. Gradually slip the infant into the tub while supporting the neck and head
7. Wash the infant with the soapy cloth beginning at the shoulders and arms, continuing to lower extremities.
8. Cleanse the skin fold thoroughly
9. Rinse the infant thoroughly with a clean, damp washcloth
10 If washing hair, rap the infant in a warm blanket, securing the arms close to the body. Place the infant in a football hold position.
11 Position the infant's head over the wash basin. lather the infant's scalp with a mild liquid cleansing agent or shampoo
12 Using a damp, soapy cloth, wash the infant's hair and rinse thoroughly, massage

the entire scalp including the fontanels.

13 Dry with towel.

14 Comb the infant's hair with a Fine-toothed comb or a soft-bristle brush

15 Remove the blankets from infant after hair washing

16 Proceed to dress the infant in dry clothing and wrap him or her in a dry blanket. Cover the head with cap or bonnet

17 Dry the infant by patting the skin with a towel

18 Dress the infant in dry clothing.

19 Disinfect and rinse the basin or tub

20 Return all equipment.

.

21 Dispose of waste in appropriate receptacle.

22 Remove gloves and perform hand hygiene.

Unit 11
Feeding Infant

Procedure 1 Breast-feeding

Procedure 2 Infant Formula-feeding

Assess:

- Infant's general health status
- Infant's oral motor development
- Parent preference to breast feed or bottle feed
- Parent's level of comfort with feeding, knowledge about positioning the infant
- Financial resources of the family to purchase formula and equipment

Assemble equipment and supplies:

- Non sterile gloves
- Washcloth and soap (if needed)
- Pillow or blanket roll
- Drinking water for the mother

Procedure steps

1. Perform hand hygiene.
2. Don gloves.
3. Assist nursing mother as needed to perform hand hygiene before feeding and wash and dry breasts.
4. Position the infant close to the mother with head slightly elevated and abdomen turned in contact with mother’s body direct skin to skin contact.
5. The mother should rotate which breast the infant starts on which each
6. feeding.
7. Encourage mother to have infant nurse 10-15 minutes per side.
8. Burping the infant in between breasts and at the end if feeding.
9. Instruct mother to insert the tip of her little finger between the breast and the corner of the infant's mouth and pull slightly downward.
10. Offer mother water to drink during breast-feeding.
11. When done breast-feeding, assist the mother to place the infant safe in the crib (with side rails up) or bassinet.
12. Assist mother as needed to re-dress and assume position of comfort.
13. Perform hand hygiene.

Procedure 2 Infant Formula-feeding

Purpose

1- To provide the infant with adequate fluid and caloric intake for appropriate growth feeding.

2- To supplement breast-feeding with formula feeding.

3- T provide additional fluid intake between feeding.

Assemble equipment and supplies:

- Measuring cup (1 quart)
- Appropriate formula, either stored breast milk, powdered concentrated liquid or ready-to-feed formula
- Scoop
- Bottled water
- Additives as prescribed-by-the healthcare prescriber (e.g., oil, polycose)
- Long-handled spoon
- Bottles with appropriate nipples and rings or disposable bottle liners with nipple, rings, and support form

Procedure steps

1. Perform hand hygiene
2. Gather the necessary supplies.
3. Prepare concentrated or powdered formula exactly as recommended:
   a. Review directions for preparation listed on the label as specific for each type and brand of formula.
   b. Use boiled, nursery," or distilled water.
   c. Concentrated formula is usually a-1:1dilution and powdered is usually 2 oz of water to one level scoop of powder.
   d. Using the quart measuring cup, measure the concentrate formula into the cup
   e. Add the appropriate amount of bottled water; mix well with a long handled spoon.
   f. Ready-to feed formulas need only be lightly shaken before use.
4. Warm formula slowly to comfortable temperature.
5. Position supplies so that they are readily accessible to the feeder.
6. Hold infant on the Lap with head elevated and close to the parent's /
7. caregiver's body.
8. Tilt bottle to keep the nipple full at all times.
9. Stimulate rooting reflex by rubbing nipple along lower lip or tickling side of cheek. Place nipple on top of tongue.
10. After 5 minutes or 1-2 oz, stop and burp infant.
11. Burp again at end of feeding

12. When feeding is to be discontinued , assist the parent / caregiver to place assist the mother to place the infant safe in the crib (with side rails up) or bassinet.
13. Discard bottle and formula remaining in bottle at end of feeding.
14. Perform hand hygiene.
15. Documentation.

Unit 12
Diapering

Procedure 1: Diapering

Preparation

- **Assemble equipment and supplies:**
  - Diaper
  - Non sterile gloves
  - Washcloth or diaper wipes (non-allergic and non-scented).
  - Mild soap
  - Towel
  - Cotton-tipped swab (for umbilical cord care).
    Petroleum jelly or Petroleum jelly gauze (for newly circumcised infant with Gomoco-type device).
  - Barriers cream (such as Petroleum or zinc oxide paste) if needed
    Topical anticandidal agent (Nystatin, Lotrimin, Micatin, Nzorol) if ordered for diaper dermatitis
    Low-potency, nonflurinated, 1% hydrocortisone cream if ordered for severe inflammation due to diaper dermatitis

Procedure steps

1. Explain procedure to the child & her parents.
2. Perform hand hygiene.
3. Don gloves
4. Place the infant /child or on firm clean surface, such as changing table or crib/bed mattress
5. Keep your hand on infant and do not turn away from infant during the procedure.
6. Remove the soiled diaper and assess contents of diaper for unusual appearance or odor of urine or stool
7. Assess infant/child perineal area for redness, rash, or excoriation.
8. Cleanse the skin with disposable or a wet, warm washcloth. Clean from the front toward the anus for a female and from the tip of the penis toward the scrotum for a male.
9. Dry perineal area.
10 Apply a simple barriers cream (such as petroleum or zinc oxide paste) to the noninfected diaper rash
11 Apply new diaper securely, folding front of diaper to avoid irritation of umbilical cord. Fold plastic away from skin.
12 Dispose of diaper and waste in appropriately receptacle.
13 Remove gloves and perform hand hygiene.

14 Wrap the infant in blanket
15 Place infant in a secure crib with side rails up.

Unit 13
Immunization

Procedure 1: Immunization

Preparation

1. **Assess:**
   - Previous vaccine history
   - The child's allergy history, including latex allergy
   - Prescience of fever and post illness symptoms.
   - The immune compromised status of child and family

   Assemble equipment and supplies:
   - Vaccine information statement
   - Health department or institution-specific documentation records
   - Child's immunization record
   - Correct medication
   - Syringe, appropriate gauge and length
   - Nonsterile gloves
   - Alcohol swab
   - Cotton ball or gauze
   - Adhesive bandage
   - Fun bandage (optional)
   - Stickers (optional)
   - Needle, appropriate size and length
   - Antiseptic swab or pledged (e , or 10% alcohol,2% chlorhexidine or 10% povidone-iodine)

Procedure steps

1. Explain procedure to the child & her parents.
2. Encourage the parent to comfort child before and after immunization administration.
3. Institute age-appropriate pain and distress relief measures.
4. Perform hand hygiene.
5. Gather and prepare all needed supplies before entering the child's room.
6. Don gloves.
7. Administer vaccine via rout indicated on immunization schedule.
8. If the child requires multiple injections, administer the injections in different extremities.
9. Apply adhesive bandage to immunization site as needed.
10 Evaluate necessity of adhesive bandage use in young children
11 Dispose the equipment and waste in appropriate receptacles
12 Remove gloves and perform hand hygiene.

13 Documentation.
14 Provide parent with information about time frame for child's next scheduled immunizations

TEMPERATURE

Procedure:1-1 Measuring Body Temperature		Performed		Mastered	Comments
Preparation		Yes	No		
1.	**Assess:** • Clinical signs of fever • Clinical signs of hypothermia • Site most appropriate for measurement • Factors that may alter core body temperature				
2.	**Assemble equipment and supplies:** • Thermometer • Thermometer sheath or cover • Disposable gloves • Water-soluble jelly. • Towel for axillary temperature • Tissues/wipes				
	Procedure				
1.	Explain procedure to the child & her parents.				
2.	Provide comfortable position and privacy.				
3.	Perform hand hygiene.				
4.	Check the working of thermometer by shaking it.				
5.	Clean the thermometer from bulb to tip.				
6.	Shake the level of mercury down to below 350C.				
7.	Apply a protective sheath or probe cover				
Oral Temperature					
8.	Place thermometer in into the child's posterior sublingual pocket.				
9.	Tell the child to keep mouth closed, breath through the nose and to talk.				
10.	Hold thermometer in place for 3 minutes.				
11.	Remove thermometer and wipe it from tip to bulb.				
12.	Perform hand hygiene.				
13.	Read and record the temperature of child.				
Rectal temperature:					
1	Perform hand hygiene.				
2	Don examination gloves.				
3	Gently spread the child's buttocks and insert probe 0.5 inches (1.3 cm.) for infant and 1 inch (2.5 cm.) for child and hold it for one minute.				
4.	Remove thermometer and wipe it tip to bulb.				
5.	Perform hand hygiene.				
6.	Read and record the temperature of child.				
Axillary temperature					
1	Place the thermometer in under arm with tip in center of axilla and keep it close to skin not clothing.				
2	Hold child’s arm firmly against side for 5 minutes.				
3	Remove thermometer and wipe it tip to bulb.				
4	Perform hand hygiene.				
5	Read and record the temperature of child.				

Procedure 1-2: Assessing an Apical Pulse

Procedures Checklist

HEART RATE

Procedure 1-2: Measuring Heart Rate by Auscultation of Apical Pulse		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • Review child's record for baseline data on pulse rate know range for age • Clinical signs of cardiovascular alterations, other than pulse rate, rhythm, or volume • Factors that may alter pulse rate • Site most appropriate for assessment				
2.	**Assemble equipment and supplies:** • Watch or clock with a second hand or digital readout • Statoscope • Alcohol swab				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Place the child in supine position on a flat table.				
4.	Clean statoscope chest piece and ear piece with alcohol wipe				
5.	Palpate the chest wall to determine the point of maximal impulse: -In children younger than 7 years-just left of the midclavicular line and fourth intercostal space. -In children older than 7 years – left midclavicular line and fifth intercostal space.				
6.	Listen to the heart sound and count for one full minute.				
7.	Cleanse statoscope chest piece and ear piece with alcohol wipe.				
8.	Put on child's clothes and make him / her comfortable.				
9.	Perform hand hygiene.				
10.	Record the apical pulse of child.				

Procedure 1-3: Assessing a Peripheral Pulse

Objectives:

5. To determine number of heart beats occurring per minute(rate)
6. To gather information about heart rhythm and pattern of beats
7. To evaluate strength of pulse.
8. To assess response of heart to cardiac medications ,activity, blood volume and gas exchange

Procedure 1-3: Measuring Heart Rate by palpation of peripheral Sites		**Performed**		**Mastered**	**Comments**
Procedure		**Yes**	**No**		
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Identify site; radial and brachial are most frequently used.				
4.	Palpate the child's pulse and palpate with your first two or three fingers.				
5.	Note rhythm.				
6.	Count for 30 second and multiply by 2 if child's pulse is regular. If irregular, count for 1 full minute				
7.	Perform hand hygiene.				
8.	Record heart rate, site used to obtain, and child's activity level in patient record				

Procedure 1-4: Assessing Respirations

Procedure :1-4 Assessing Respiratory Rate		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child's color depth of respirations. • Presence of nasal flaring, grunting, retractions and types of accessory muscles. • Rhythm of respirations. • The position that child assume to breathe. • Fussiness and anxiety.				
2.	**Assemble equipment and supplies:** • Clock or watch with a second hand or digital readout				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Count the respiratory rate when the child is a wake and calm or when a sleepy:				
4.	Observe the abdomen for movement to infants and young children.				
5.	Observe thoracic movement in older children.				
6.	Count number of respirations for 30 seconds and multiply by 2, if respirations are regular.				
7.	Count number of respirations for 1 full minute, if respirations are irregular.				
8.	Note depth and pattern of respirations, presence of anxiety, restlessness. irritability and position of comfort.				
9.	Observe child's color, including extremities, noting cyanosis or pallor.				
10.	Perform hand hygiene.				
11.	Record results; respiratory rate is recorded in breaths per minutes				

Procedure 1-5: Assessing Blood Pressure

Procedure: 1-5: Assessing Blood Pressure		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
	Assess: • Signs of hypertension • Signs of hypotension • Factors affecting blood pressure				
2.	**Assemble equipment and supplies:** • Stethoscope • Measurement device: -Mercury gravity or android sphygmomanometer Or -Automated device that uses oscillometric or Doppler technique. • Appropriately sized BP cuff				
Procedure: 1-5-1 Auscultation Method					
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene				
3	Clean diagram of stethoscope				
4.	Select appropriate sized cuff				
5.	Center the bladder of the cuff to the extremity proximal to the pulse (eg. At the brachial site, position about 1-2 inches above the antecubital fossa) and snugly secure cuff				
6.	Locate the pulse at the site.				
7.	Place the bell of the statoscope where the pulse is felt, bellow the bottom edge of the cuff.				
8.	Close the sphygmomanometer valve, and inflate cuff to a pressure 30 mm Hg above the point at which artery pulsation is obliterated.				
	Deflate cuff at a rate of 2 to 3 mm.Hg per second.				
9.	Note korotkoff sounds, beginning with the onset of tapping sound.				
10.	Note muffling of the sound, if applicable.				
11.	Note disappearance of sound.				
12.	Completely deflate cuff and remove from arm.				
13.	Perform hand hygiene.				
14.	Record the finding of the patient record.				
Procedure: 1-5-2 Palpation Method					
1.	Follow steps1-5 in previous procedure. Auscultation method, for locating artery, cuff, selection and placement.				
2.	Inflate the cuff to palpate the artery.				
3.	Inflate the cuff to 30 mm.Hg higher than the point at which you last felt pulse				
4.	Slowly deflate cuff and note point at which pulse return is felt.				
5.	Completely deflate cuff and remove from extremity.				
6.	Perform hand hygiene.				
7.	Record measurement in patient record as palpated systolic reading.				

Chapter 2

Growth Parameter Assessment

Procedures Checklist

GROWTH PARAMETER ASSESSMENT

		Performed			
Preparation		**Yes**	**No**	**Mastered**	**Comments**
1.	**Assess:** • Child's previous growth pattern. • Most recent weight, height, and head circumference.				
2.	**Assemble equipment and supplies:** • Small sheet or paper drape to cover scale. • Infant/ toddler scale. • Adult scale. • Paper measuring tape • Flat surface or flat measuring board. Measuring device affixed to a wall (stadiometer), height assessment rod attached to scale, or an electronic length measurement device. • Growth chart. • Calculator.				
Procedure 2-1: Assessing Weight of the Infant/toddler up to 24 Months of Age					
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Make the room warm.				
3.	Note the child's previous weight if available.				
4.	Perform hand hygiene.				
5.	Wipe the scale with alcohol swab.				
6.	Place light diaper or paper on scale pan				
7.	Calibrate scale to "0" position				
8.	Completely undress and safely place infant/ toddler on scale.				
9.	Hold hand slightly above infant while on scale.				
10.	Read the scale when child is still lying.				
11	Carefully remove the infant from the scale.				
12	Redress the infant				
13	Return the infant to parent's arms or crib.				
14	Dispose of paper on scale				
15	Perform hand hygiene.				

16	Document weight on child's growth chart and / or related specific to care location.				
Procedure 2-2: Assessing Weight of Older Ambulatory Child					
1	Demonstrate whether child is able to stand and balance on scale.				
2	Note child's previous weight as available.				
3	Place paper or drape on scale.				
4	Calibrate scale to "0" position.				
5	Ask child to remove shoes and heavy clothing.				
6	Assist child to stand on scale.				
7	Have child place hands at side of body or hold belly.				
8	Note or record child's weight in kilograms on a notepad.				
9	Assist the child to step down from scale.				
10	Document weight on child's growth chart and / or related specific to care location.				
Procedure 2-3: Assessing Length of Children Younger 2 Years of Age					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Place the child on center of proper covered hard surface in supine position.				
4.	Hold the head against headboard firmly.				
5.	Grasp the knee together gently until legs are fully extended and hold the legs firmly.				
6.	Make points of the top of the head and heel of the feet by a point.				
7.	Remove the child from his / her place.				
8.	Measure between the two points with measuring tape.				
9.	Place the child back to his/ her place.				
10.	Record the length of the child.				
Procedure 2-4: Assessing Height					
1.	Explain procedure to the child & her parents.				
2.	Note the child's previous height if available.				
3	Perform hand hygiene.				
4	Ask the child to remove shoes.				
5.	Child should not be wearing a hat or hair ornaments.				
6.	Assist child to stand on scale with back to scale or place child with back to wall /stadiometer.				
7.	The child's heels, buttocks and shoulders should be in contact with the wall or height bar of the scale.				
8.	Any flexion of knees, lumping of shoulders or raising of heels of feet is checked and corrected.				
9.	The child should look straight ahead without tilting the head.				
10.	Raise the height road and extended height assessment bar over child's head.				
11.	Lower height rod to top of child's head.				
12.	Read the height measurement during the examiner eye to eye contact.				
13.	Perform hand hygiene.				
14.	Record the height of the child.				
Procedure 2-5: Assessing Head Circumference					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				

3.	Place light drape or paper on flat surface.				
4.	Place the child in supine position or seated on paper drape.				
5.	Place the tape measure over the most prominent point of the occiput, around the head just above the eyebrow and pinna.				
6.	Return the infant to the parent 's arms or crib				
7.	Perform hand hygiene.				
8.	Document the head circumference of the child.				
Procedure 2-6: Assessing Chest Circumference					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Place the child in supine position on a flat table.				
4.	Remove child’s clothes of upper half.				
5.	Place the measuring tape across the nipple line.				
6.	Measure midway between inspiration and expiration.				
7.	Remove the tape and put on child’s clothes.				
8.	Perform hand hygiene.				
9.	Record the chest circumference of child.				

Chapter 3

Abdominal Girth

Procedures Checklist

ABDOMINAL GIRTH

Procedure 3-1 Measuring Abdominal Girth		**Performed**		**Mastered**	**Comments**
Preparation		**Yes**	**No**		
1.	**Assess:** • Recently complained abdominal pain or injury or is at risk for abdominal distention. • Risk factors of abdomen.				
2.	**Assemble equipment and supplies:** • Paper measuring tape. • Ballpoint pen. • Stethoscope.				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3	Auscultate bowel sounds with stethoscope				
4.	Place the child in supine position on a flat table, with the child knees flexed or, for an infant, hold the legs flexed at the knee and hip. According to the condition of the child				
5.	Measure girth with the child in the same position each time				
6.	Remove or move aside clothing				
7.	Place tape snugly across the umbilicus.				
8.	Take measurements at the end of expiration				
9.	Remove the tape and put on child's clothes.				
10.	Perform hand hygiene.				
11.	Record the abdominal girth of child.				

Chapter 4

Restraints

Procedure 4-1 Using a Mummy Restraint

Procedures Checklist

		Performed			
Preparation		**Yes**	**No**	**Mastered**	**Comments**
1.	**Assess:** • Preexisting medical condition or physical disability and limitation • History of sexual or physical abuse.				
2.	**Assemble equipment and supplies:** • Receiving blanket. • Tape				
Procedure 4-1 Using a Mummy Restraint					
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Place the blanket on a or examination table on a diagonal.				
4.	Fold down one corner.				
5.	Place the child on the blanket with shoulders on line with the fold				
6.	Firmly pull one corner of the blanket over the infant's body and tuck under the opposite shoulder.				
7.	Pull the opposite side over and tuck it under the infant's back.				
8.	Pull the bottom up and secure ends of the blankets with tape to keep in place.				
9.	Do not cover the child's face.				
10.	Modify wrap to give access to chest and groin.				
11.	Roll the edges around the legs and secure with tape.				
12.	Ensure that the wrap does not obstruct circulation in the limb.				
13.	Perform hand hygiene.				
14.	Documentation				

Procedure 4-2 Using an Elbow Restraint

		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1	**Assemble equipment and supplies:** • Commercial cuff • Tongue depressors • Tape				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Obtain appropriately sized elbow restraint.				
4.	Pad the child's skin under restraint with towel or gauze padding.				
5.	Secure restraint using ties.				
6.	Ensure that there is adequate circulation to limb.				
7.	Remove restraints and check skin condition at least every 2 hours.				
7.	Provide range of motion.				
8.	Perform hand hygiene.				
9.	Documentation				

Procedure 4-3 Using a Jacket Restraint

		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1	**Assemble equipment and supplies:** • Jacket or vest of appropriate size.				
Procedure					
1	Explain procedure to the child & her parents.				
2	Perform hand hygiene.				
3	Obtain a jacket appropriate size.				
4	Place the child's arms through the armholes.				
5	Secure the ties of the jacket to a non-movable part of the bed frame or wheelchair.				
6	Use a quick-release kont or device that can be quickly released.				
7.	Reposition the child, release immobilizing restraints and perform range of motion exercise.				
8.	Perform hand hygiene.				
9.	Documentation				

Procedure 4-4 Using Clove hitch restraint

Procedures Checklist

		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assemble equipment and supplies:** • Bandage with appropriate size. • Cotton.				
Procedure					
1.	Explain procedure to the child & her parents.				
2	Perform hand hygiene.				
3.	Provide privacy.				
4.	Stay with distressed patient.				
5.	Ensure that the bony prominences of the wrist or ankle were padded.				
6.	Make two loops forming.				
7.	Pick up the two loops together.				
8.	Put the padded limb through it.				
9.	Attach the tie or straps of restraint to spring of the bed.				
10.	Put hand and limb in natural position slightly flexed position.				
11.	Knot the ties appropriately to the bed frame.				
12.	Check every 2 hours and readjust accordingly.				
13.	Perform hand hygiene.				
14.	Documentation				

Chapter 5

Medication Administration

Procedure 5-1: Administering Oral Medication.

Procedures Checklist

ADMINISTERING ORAL MEDICATION

		Performed			
	Preparation	**Yes**	**No**	**Mastered**	**Comments**
1.	**Assess:** • The child previous experience with receiving IV medications. • Allergies.				
2.	**Assemble equipment and supplies:** • Nonsterile gloves • Correct medication • Oral syringe or medicine cup • Water or juice to drink or Popsicle • Flavored syrup, such as cherry or grape (optional) • Nipple (optional) • Applesauce (optional)				
	Procedure				
1.	Verify the order with the child's medical record.				
2.	Check for allergy to drug				
3.	Perform hand hygiene and don gloves.				
4.	Read the label of medication to verify with the order.				
5.	Check for expiration date.				
6.	Check medication from dispensed.				
7.	Prepare medication for administration				
8.	Measure all liquid medications using an oral syringe or medicine cup				
9.	Verify medication with electronic record or take the medication record and medication to child to administer.				
10.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
11.	Elevate the child's head or pick up and hold an infant or small child before administering medication.				
12.	Administer the medication. Deliver liquids in small amounts, placing the syringe to the sides of the mouth and allow the child to swallow between amounts.				
13.	Stay with the child until the medication is taken.				
14.	Dispose of medicine cup, syringe, and other objects in appropriate receptacle.				
15.	Remove gloves and perform hand hygiene.				
16.	Documentation.				

Procedure: 5-2 Administering Intramuscular Injections		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child's previous experience with receiving injection. • For allergies. • Child' age, muscle mass. • Other physical limitation that that will impact choice of site for IM injection				
2.	**Assemble equipment and supplies:** • Correct medication • Syringe, appropriate gauge and length • Nonsterile gloves • Alcohol swab • Cotton ball or gauze • Adhesive bandage • Fun bandage (optional) • Stickers (optional)				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Verify the order with medical record				
3.	Perform hand hygiene.				
4.	Read the label of medication to verify with the order.				
5.	Check for expiration date.				
6.	Cheek the amount of medication to be administered.				
7.	Limit volume according to the age of the child and the of muscle used.				
8.	Use a low-dose 1-ml. syringe to give volumes <0.5 ml.				
9.	Choose appropriate length for the site and muscle size				
10.	Select gauge based on what available for the appropriate needle length for the child and medication viscosity.				
11.	Draw up the medication in the medication room				
12.	Draw up the correct amount of medication into the syringe.				
13.	Don gloves				
14.	Verify medication with electronic record or take the medication record and syringe with medication to the child to administer.				
15.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
16.	Evaluate the child's mass muscle and choose the most appropriate site.				
17.	Position and restraint the child.				
	Cleanse the site with alcohol wipe and allow to dry.				
18.	Insert the needle quickly at 90 degree angle				
19.	Aspirate to check the blood				
20.	Rapidly inject the medication.				
21.	Withdraw the needle and apply pressure over the site with a dry cotton ball or gauze.				
22.	Do not recap the needle; dispose of syringe and needle in a sharp co				
23.	Place adhesive bandage over site				
24.	Remove gloves and perform hand hygiene.				
25.	Assess for signs of adverse reaction to medication.				
26.	Documentation.				

Procedure 5-3 Administering Intravenous medications		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • Childs height, weight, age and hydration status. • Factors to consider when calculating medication dosage and fluid requirement. • The child previous experience with receiving IV medications. • The child' and parents' understanding of the need for the IV medications.				
2.	**Assemble equipment and supplies:** • Existing IV access • Correct medication • Syringe, as needed • Needleless access device • Alcohol pad or swab • Gloves • IV tubing with volume-control chamber pr piggyback setup • IV pump or syringe pump • IV tubing cap, as needed to maintain sterility of tubing				
Procedure					
2.	Verify the order with medical record				
3.	Perform hand hygiene.				
4.	Read the label of medication to verify with the order.				
5.	Check for expiration date.				
6.	Draw up the medication in the medication room				
7.	Draw up the correct amount of medication into the syringe, reconstitute powder as indicated.				
9.	Determine the best method of IV administration for the medication and child.				
10.	Verify medication with electronic record or take the medication record and syringe with medication to the child to administered and other IV requirement needed to the child to administer.				
11.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
12.	Explain to the child and the family that you are going to administer the medication				
13.	Verify that IV access is patent and without complications.				
14.	**If the child has intermittent lock:**				
	e. Cleanse the needless injection cap with 70% alcohol.				
	f. Insert the syringe with normal saline.				
	g. Slowly infuse I ml. of normal saline.				
	h. Connect the medication				
15.	**For the medication administered through IV push**				

	d. Cleanse the top of the needless injection cap with 70% alcohol.				
	e. Insert the syringe with medication.				
	f. Inject the medication slowly over the time specified.				
16.	**For the medication administered through a volume control chamber:**				
	g. Fill the container using fluid from hanging IV bag, with amount of fluid required for dilution.				
	h. Calculate in the fluid volume of medication itself.				
	i. Cleanse the diaphragm used for medication administration with 70% alcohol.				
	j. Inject the medication into the chamber.				
	k. Set the infusion rate to infuse medication volume and flush over directed time				
	l. Start infusion.				
17.	**For medication administration through a small volume container:**				
	h. Cleanse the container diaphragm used for medication insertion with alcohol.				
	i. Inject the medication into the bag/bottle.				
	j. Connect administration tubing to small-volume bag/bottle.				
	k. Cleanse the port closest to the IV insertion site with 70% alcohol				
	l. Connect medication administration tubing to main IV at Y connector closest to the IV site.				
	m. Set the infusion rate to infuse medication volume and flush over the desired time.				
	n. Start infusion.				
18.	**For medication administration through a syringe pump**				
	h. Obtain a syringe of medication as dispensed from pharmacy.				
	i. Prime infusion tubing and attach infusion tubing to the syringe.				
	j. Attach the syringe to the IV-controlled infusion device.				
	k. Cleanse the port closest to the IV insertion site with 70% alcohol.				
	l. Connect medication administration tubing to main IV at Y connector closest to the IV site.				
	m. Set the IV controlled infusion device to infuse medication volume and flush over the correct time.				
	n. Start infusion				
19.	Dispose the equipment and waste in appropriate receptacle.				
20.	Perform hand hygiene.				
21.	Monitor the child initially and every 15 minutes.				
22.	Flush medication from tubing at the completion of administration				
23.	After infusion of medication and flush is complete, disconnect infusion tubing.				
24.	Attach sterile tubing cap at the end of infusion tubing.				
25.	Perform hand hygiene.				
26.	Documentation.				

Procedure 5-4 Administering Subcutaneous Injections		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child previous experience with injections. • Allergies.				
2.	**Assemble equipment and supplies:** • Correct medication • Syringe appropriate size • Needle, appropriate size and length • Antiseptic swab or pledged (e , or 10% alcohol,2% chlorhexidine or 10% povidone-iodine) • Cotton ball • Nonsterile gloves • Adhesive bandage				
Procedure					
1.	Verify the order with the child's medical record.				
2.	Check for allergy to drug				
3.	Perform hand hygiene and don gloves.				
4.	Read the label of medication to verify with the order.				
5.	Check for expiration date.				
6.	Check the amount of medication to be administered.				
7.	Choose appropriate needle gauge length for the medication.				
8.	Draw up correct correct amount of medication into syringe.				
9.	Verify medication with electronic record or take the medication record and medication to child to administer.				
10.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
11.	Don gloves.				
12.	Evaluate the child's subcutaneous tissue.				
13.	Evaluate the use of biobehavioral interventions.				
14.	Restraint the child securely.				
15.	Cleanse the site with antiseptic and allow to dry				
16.	Grasp the site and elevate the tissue.				
17.	Insert the needle at appropriate degree angle				
18.	Rapidly inject the medication.				
19.	Withdraw the needle quickly				
20.	Apply pressure over the site with a dry cotton ball.				
21.	Do not recap the needle; dispose of syringe and needle in a sharp container.				
22.	Place adhesive bandage over site				
23.	Remove gloves and perform hand hygiene.				
24.	Assess for signs of adverse reaction to medication.				
25.	Documentation.				

Procedure 5-5 Administering Ophthalmic Medications		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child previous experience with receiving ophthalmic medications • The drugs and latex allergies.				
2.	**Assemble equipment and supplies:** • Correct medication • Eyedropper • Cotton ball • Tissues • Nonsterile gloves				
Procedure					
1.	Verify the order with the child's medical record.				
2.	Check for allergy to drug				
3.	Read the label of medication to verify with the order.				
4.	Check for expiration date.				
5.	Verify medication with electronic record or take the medication record and medication to child to administer.				
6.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
7.	Don gloves.				
8.	Cleanse the eye with cotton ball or gauze soaked with normal saline if necessary.				
9.	Position the child supine in bed or other flat surface, looking up.				
10.	Restraint the uncooperative child for administration.				
11.	Rest your dominant hand against the child's forehead. With the other hand, pull down the lower eyelid to expose the conjunctival sac.				
12.	Administer the medication				
	e. Eye drops: if using a dropper, instill correct amount of drops into conjunctival sac				
	f. Apply gentle pressure to the nasolacrimal dust for about 30 sec.				
	g. Ointment: if using ointment, twist the ointment tube at the end to dislodge the ointment from the tube and place a thin ribbon of ointment along the entire conjunctival sac.				
	h. Have the child keep his or her eyes closed for up to 1 minute after administration.				
13.	Wipe excess medication off with a cotton ball or tissue.				
14.	Remove gloves and perform hand hygiene.				
15.	Return medication to appropriate storage area.				
16.	Documentation.				

Procedure: 5-6 Administering Otic Medication		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child's previous experience with receiving otic medications. • For the child's and parent's understanding of need for otic medication that will be administered. • For allergies.				
2.	**Assemble equipment and supplies:** • Nonsterile gloves • Otic medication • Dropper (if needed)				
Procedure					
1.	Verify the order with medical record.				
2.	Check for allergy.				
3.	Perform hand hygiene and don gloves.				
4.	Read the label of medication to verify with the order is to be administered				
5.	Check for expiration date.				
6.	Verify medication with electronic record or take the medication record and bottle of medication to the child to administer				
7.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
8.	Have the child in supine position with his/her head turned to the appropriate side.				
9.	Pull the earlobe down and back for children younger than 3 years. For older children, pull the pinna up and back.				
10.	Administer the ordered amount of drops into the ear canal, holding the dropper 0.5 inch above the ear canal				
11.	Gently massage tragus unless contraindicated due to pain.				
12.	Have the child remain in the supine position with the head turned for 3 to 5 minutes.				
13.	Distract and soothe the child.				
14.	Repeat with the other ear if prescribed.				
15.	Remove gloves and perform hand hygiene.				
16.	Return the medication to appropriate storage area.				
17.	Documentation.				

Procedure: 5-7 Administering Nasal Medication		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child's previous experience with receiving nasal medications. • For the child's and parent's understanding of need for nasal medication that will be administered. • For allergies.				
2.	**Assemble equipment and supplies:** • Nonsterile gloves • Tissue • Bulb syringe (if needed) • Correct medication • Dropper (if medication bottle does not have one)				
Procedure					
1.	Verify the order with medical record.				
2.	Check for allergy.				
3.	Perform hand hygiene and don gloves.				
4.	Read the label of medication to verify with the order Is to be administered.				
5.	Check for expiration date.				
6.	Identify the correct nostril in which to administer the medication.				
7.	Bring medication to the room temperature before administration.				
8.	Warm the solution by gentle rotating the bottle in your handsbefore administration.				
9.	Verify medication with electronic record or take the medication record and bottle of medication to the child to administer				
10.	Verify the child's identity by comparing name on medication (if verified electronically) or on medication record with child's identification band.				
9.	Have the child blow his/her nose before administration.				
10.	**Nose drops:**				
	d. Position the child in the supine position with head tilted back.				
	e. Aim the tip of the dropper toward the nasal passage and instill the ordered number of the drops into each nostril.				
	f. Have the child remain in that position for several minutes, if possible.				
11.	**Nasal spray**				
	e. Position the child in a semi-fowler position with the head tilted slightly back.				
	f. Instill the spray by holding one nostril closed while the medication is sprayed into the other nostril.				

	g. Have the child take a deep breath the rough the nostril while the medication is being administered.				
	h. If indicated, repeat the procedure on the other nostril.				
12.	Remove gloves and perform hand hygiene.				
13.	Recap the medication.				
17.	Return the medication to appropriate storage area.				
18.	Documentation.				

Chapter 6

Oxygen Administration

Procedures Checklist

		Performed			
Preparation		**Yes**	**No**	**Mastered**	**Comments**
1.	**Assess:** • Child's history to determine rational for oxygen administration. • Any contraindication related to particular method of oxygen delivery or level of oxygen concentration				
2.	**Assemble equipment and supplies:** • Appropriate-size oxygen delivery device (nasal cannula, nasopharyngeal catheter or masks) • "No smoking" sign • Oxygen flowmeter • Oxygen tubing • Oxygen hood • Pulse oximeter (if ordered) • Paper tape • Water soluble lubricant (for catheter insertion) • Disposable gloves • Goggle (if needed) • Humidification attachment (if needed) • Waterproof pad • Extra baby blankets or bath blankets • Warm sleepwear and hat for child • Humidifier and sterile water • Stimulating pictures to place on otside of the hood (optional)				
Procedure 6-1: Nasal cannula, Nasopharyngeal Catheter, or Mask					
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Select proper size for cannula catheter or mask				
4.	Remove all friction toys or open flames from the area and display "No smoking" signs.				

5.	Connect the flowmeter to either the oxygen wall unit or the freestanding tank.				
6.	Connect the humidifier to the oxygen setup.				
7.	Fill reservoir with sterile water.				
8.	Attach tubing to the oxygen source.				
9.	Check all electrical equipment in area to ensure that is grounded.				
10.	Connect the distal end of oxygen tubing to the delivery device (cannula, catheter or mask).				
11.	Turn on the flowmeter to the prescribed amount.				
12.	Don disposable gloves				
13.	Place the child on supine s				
14.	Place the infant's head in the midline "sniffing position".				
For Nasal Cannula					
15.	Place the nasal prongs just inside the external meatus of the nares.				
16.	Secure the tubing to the face.				
17.	Instruct the child to breathe through nose.				
For nasopharyngeal catheter					
18.	Lubricate the tip of the catheter with water soluble lubricant.				
19.	Gently insert the properly sized catheter to a depth equal to the distance from the nose to the front of the ear.				
20.	Do not use force to place the catheter. If resistance in placement is met do not proceed.				
21.	Secure the tubing to the child's face				
22.	Turn on flowmeter, providing humidified oxygen to the child.				
23.	Alternate the site of the catheter between nares every 8-12 hours and change the tube daily				
For Mask					
24.	Place the oxygen mask over the mouth and the nose.				
	Tighten the straps attached to the mask until you can fit one finger between the straps and the face of the child.				
Procedure 6-2 Oxygen Hood					
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Remove all friction toys or open flames from the area and display "no smoking" signs.				
4.	Line the area that the hood covers on the bed with a waterproof pad. Cover the same area with layers of bath or baby blanket.				
5.	Connect the humidifying unit to the hood.				
6.	Fill the reservoir with sterile water.				
7.	Connect the unit to the oxygen source.				
8.	Place the hood on the crib or bed so that the child's head is inside the unit.				
9.	Turn on the oxygen and humidifying unit to the prescribed setting.				
10.	Encourage family and other staff to limit the amount of time the child is outside the hood.				

Chapter 7

Suctioning

Procedures Checklist

		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • The child's respiratory status. • The child's or family readiness to learn				
2.	**Assemble equipment and supplies:** • Portable or wall suction machine with tubing and collection container • Receiving blanket. • Towel or disposable waterproof pad • Appropriate-sized sterile suction catheter • Sterile container for sterile fluids used to lubricate and clear catheter • Water-soluble lubricant and/or normal saline • Sterile gloves • Protective eye shield/goggles as indicated • Sterile water				
Procedure					
1.	Gather the necessary supplies and equipment.				
2.	Check for proper suctioning.				
3	Turn-on the portable or wall suction apparatus				
4.	Set the pressure gauge to the appropriate range				
5.	Perform hand hygiene				
6.	Done protective gear				
7.	Assist the conscious child to assume the semi-fowler's position				
8.	Place the unconscious child in the lateral position.				
9.	Facing the person performing suctioning.				
10.	Place a towel or disposable waterproof pad on the child's chest.				
11.	Done sterile gloves				
12.	Check the equipment for proper functioning.				

13.	Make an appropriate measure of the depth for the insertion of the catheter.				
14.	Reassure the child before initiating the procedure.				
15.	Dip the catheter tip into the lubricant				
16.	Gently insert the catheter into either nares without applying suction,				
17.	Apply suction intermittently. Duration of suction should be limited no more than 15 seconds				
18.	Irrigate the catheter with sterile water or saline after each suction pass.				
19.	Lubricate the catheter and repeat suctioning as needed.				
20.	Assess the child's for color, respiratory rate, and effort and Sao2 levels (if monitored) during suctioning.				
21.	Gently cleanse around the child's nares once all suctioning has been completed.				
22.	Remove gloves inside out				
23.	Dispose the gloves, suction catheter and solution container in proper receptacle.				
24.	Perform hand hygiene.				
25.	Documentation				

Chapter 9

Collection of Specimens

Procedures Checklist

Procedure 9-1: Urine Collection 24 hour specimen		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • Cognitive level, readiness and the ability to process information by the child and the family.				
2.	**Assemble equipment and supplies:** • Large-capped collection container (containing preservative, if necessary). • Clean bedpan or toilet specimen container, adhesive urine collection bag, or clean urinal, if indwelling catheter is not in place. • Large basin with ice (freshened with new ice, when the ice melts). • Adhesive label or marker • Signs: "24- Hour Urine Collection in progress". • Gloves				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Obtain a collection container from the laboratory to be kept in the bedside				
4.	Post signs on the door to the child's room, above the child's bed and in the bathroom saying that the 24-hour.				
5.	Don gloves to handle voided specimens.				
6.	If the child is able, have him or her voided to empty the bladder and discard the voided urine.				
7.	If indwelling catheter is in place, discard any urine already in the drainage bag.				
8.	Note the time that first urine was discarded.				
9.	Pour urine from each void into the collection container, and keep the collection container on ice				
10.	If indwelling catheter or urine collection bag is in place, empty and added to collection container on ice at least every 2 hours				
11.	Before the end of the 24 hour collection period, ask the child to void one last specimen.				

12.	Pour this fial specimen into the collection container.				
13.	Label the collection container and send it to the laboratory immediately after the 24-hour period.				
14.	Remove gloves				
15.	Hand hygiene after each contact with the urine specimen.				
16.	Documentation				

Procedure 9-2: Urine Collection Clean Catch or Midstream		**Performed**		**Mastered**	**Comments**
Preparation		**Yes**	**No**		
1.	**Assess:** • Cognitive level, readiness and the ability to process information by the child and the family. • The present history for toilet training if age appropriate. • Allergies to antimicrobial agent.				
2.	**Assemble equipment and supplies:** • Gloves • Basin with liquid soap and warm water, washcloth and towel • Sterile specimen container • Adhesive label or marker • Antimicrobial perineal wipes swabs or sponges • Biohazards bag for transporting the specimen to the laboratory • 4 X 4 gauze pads or tampon, if needed, for pubescent girls				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Provide privacy.				
4.	Assist the child to the bathroom.				
5.	Done gloves.				
6.	Remove the lid of the sterile specimen container and place it with the inside of the lid facing up, on a lean surface within easy reach.				
7.	If a parent is assisting or the child is performing self-care, he or she should perform hand hygiene and don gloves (optional).				
8.	Clean around the child urethral opening with liquid soap and water, antimicrobial wipes swabs or sponges.				
9.	Discard them in a nearby open waste receptacle.				
10.	Allow the area to dry.				
11.	For girls, using a separate antimicrobial swab for each stroke, open the child's labia and cleanse both the right and left side of the inner labia with one downward stroke.				
12.	For boys, retract the foreskin (if present). Cleanse the penis in an outgoing circular motion.				
13.	If possible, Instruct the child to void a small amount of urine into the toilet or urinal.				
14.	For infants and young children, use an adhesive urine collection bag or urine collection pad.				

15.	Have the child urinate 10-20-ml. directly into a sterile specimen container.				
16.	Place the lid back on the specimen container.				
17.	Wipe the outside of the container.				
18.	Assist the child with wiping/cleansing the perineal area after voiding is complete.				
19.	Assist the child to return to bed				
20.	Label the specimen, and place it in a biohazard bag.				
21.	Send the specimen to the laboratory immediately.				
22.	Dispose of equipment and waste in appropriate receptacle.				
23.	Remove gloves.				
24.	Perform hand hygiene.				
25.	Documentation.				

Procedure 9-3: Urine Collection Indwelling Catheter		**Performed**		**Mastered**	**Comments**
Preparation		**Yes**	**No**		
1.	**Assess:** • Cognitive level, readiness and the ability to process information by the child and the family. • The color and clarity of urine in the catheter drainage tubing.				
2.	**Assemble equipment and supplies:** • Clamp • Gloves • Sterile alcohol swab or institution- specific disinfectant swabs • Sterile 21-to 25-gauge needle or sterile needleless syringe adaptor. • Clean towel • Specimen container and label (if the specimen obtained is to be send to the laboratory for culture and sensitivity, the container for collection must be sterile). • Biohazard bag for transporting the specimen to the laboratory				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Provide privacy.				
4.	Clamp the indwelling catheter 4-6 inches below the needless sampling port in the urine catheter tubing.				
5.	Establish a clean working area, by using a clean towel spread open.				
6.	Using aseptic techniques.				
7.	Done gloves.				
8.	Withdraw urine from the sampling port by using a needleless adaptor with syringe (preferred) or a 23 or 25-gauge needle.				

9.	Withdraw needleless adaptor or needle syringe.				
10.	Inject the urine directly into the sterile specimen container.				
11.	To collect from the urine bag for a nonfresh urine, unclamp spigot and empty urine into the specimen container.				
12.	Put the lid on the container, label the specimen and place it in a biohazard bag.				
13.	Unclamp the indwelling catheter tubing.				
14.	Send the specimen to the laboratory immediately.				
15.	Dispose of used equipment and waste in appropriate receptacle.				
16.	Remove gloves.				
17.	Perform hand hygiene.				
18.	Documentation.				

Procedure 9-4: Urine Collection Routine Voided Urine specimen		**Performed**		**Mastered**	**Comments**
Preparation		**Yes**	**No**		

1.	**Assemble equipment and supplies:**
	• Gloves
	• Basin with liquid soap and warm water, waser cloth and towel or perineal wipe.
	• Waterproof pad
	• Age appropriate urine collection device:
	  • Bedpan
	  • Urinal
	  • Toilet specimen container
	  • Sterile foil bowel
	  • Adhesive urine collection bag
	  • Urine collection pad
	  • Cotton balls
	• Urine specimen container
	• Adhesive label or marker
	• Biohazards bag for transporting the specimen to the laboratory
	• 4 X 4 gauze pads or tampon, if needed, for pubescent girls				

Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Provide privacy.				
4.	Don gloves				
5.	As age appropriate, have the child urinate in a clean bedpan, urinal, or toilet specimen container or use a urine collection device to collect urine from the child who is not yet toilet trained.				

6.	**For specimen collected in a bedpan or urinal**: j. Position the child on the back with the head of the bed slightly elevated. k. Place waterproof pad under the child's buttocks. l. Wash the child genital area with warm water and soap. m. Rinse and dry the area. n. Place the bedpan under the child or place the urinal such that the penis is inserted in the opening. o. Once the child has voided, remove the bedpan or urinal. p. Offer toilet paper an q. Assist the child to place underwear back on r. Assist the child to perform hand hygiene.				
7.	**For the child using a toilet specimen container:** f. Explain to the child and family how to clean the genitalia area g. Give a container to the child and explain how to hold the container while voiding. h. Ask the child to leave the sample in the bathroom after the specimen is obtained. i. Don gloves. j. Pour fresh urine in in the specimen container and put lid on the container.				
8.	**For the specimen collected by using a urine collected bag:** g. Position the child on the back with the legs in the frog-like position. h. Remove the diaper and clean the premium prepuce of the child. i. Apply chemical adhesive (eg. tincture of benzoin). j. Attach a urine collection bag to the child k. For boys. Insert the pines and the scrotum into the bag opening: the adhesive adhere to the premium and the symphysis**.** l. For girls, position the lower half of the adhesive on the bag on the premium first and press on the adhesive up toward the symphysis**.**				
9.	Cut a hole in the diaper, pulling the urine bag through the opening.				
10.	Replace the diaper and wait for the child to void				
11.	Removes the gloves				
12.	Perform hand hygiene.				
13.	After the child has voided, don gloves.				
14.	Remove the bag from the child.				
15.	Transfer the urine to specimen container.				
16.	Remove gloves.				
17.	Perform hand hygiene.				
18.	Documentation.				

19	For specimen collected by using a urine collection pad: n. Explain procedure to the child & her parents. o. Perform hand hygiene. p. Don gloves. q. Remove the diaper and clean the premium prepuce of the child. r. Place urine collection pad across the urethra or the pines in lengthwise fashion. s. Remove the adhesive backing from the pad and replace the diaper. t. Once the child has voided, done gloves. u. Remove the diaper with the absorbent pad in from the infant. v. Place clean diaper on the child. w. With gloved hands, squeeze out urine from the absorbent pad into an appropriate urine container or onto urine testing strips. x. Dispose of the absorbent pad and the diaper in the appropriate receptacle. y. Remove gloves. z. Perform hand hygiene				

Blood drawing from peripheral sites

Procedure 9-5: Performing heel and finger sticks		**Performed**		**Mastered**	**Comments**
Preparation		**Yes**	**No**		
1.	**Assess:** • Child for signs of poor perfusion, local edema, infection at the site and impaired blood coagulation.				
2.	**Assemble equipment and supplies:** • Mechanical (automated) lancing device or lancet sized appropriately for infant/child weight (Follow manufacture's recommendation) • Antiseptic wipes(75% isopropanol) • 2 X2 sterile wipes • Gloves • Specimen catheter • Warming supplies (i.e. chemical warmer, cloth)				
Procedure					
1.	Explain procedure to his/her parents.				
2.	Apply warming device in area for before puncture				
3.	Perform hand hygiene.				
4.	Don gloves				
5.	Remove warming device.				
6.	Select and identify puncture site c. Heel outer aspects (infants younger than 18 months). d. Finger (older than 18 months of age).				
7.	Cleanse puncture site with antiseptic allow to dry for 30 seconds.				
8.	Dry with sterile gauze.				

9.	Place extremity in a depended position.				
10.	For heel stick. Apply mild pressure between thumb and fingers to hold ankle in dorsiflexion.				
11.	Briskly puncture skin with selected lancing device				
12.	Wipe away the first drop of blood with sterile gauze				
13.	Continue to hold puncture site in dependent position while gently intermittent pressure to surrounding area.				
14.	Collect blood in appropriate container.				
15.	Gently press dry sterile gauze to puncture site until bleeding stop.				
16.	Do not use bandages.				
17.	Properly dispose of contaminated equipment.				
18.	Placing lancing device in sharp container and blood soaked guaze in biohazard bag.				
19.	Remove gloves and perform hand hygiene.				
20.	Documentation				

Chapter 10

Bathing the Infant

Procedures Checklist

	Procedure 10-1: Giving a Sponge Bath	Performed		Mastered	Comments
	Preparation	**Yes**	**No**		
1.	**Assess:** • Special needs of the child before starting the bath • Some restrictions may apply to children with surgical incision, traction, intravenous catheter, casts, urinary catheters and artificial airway • The premature infant's physiological state (vagal tone, heart rate, oxygen saturation)**.**				
2.	**Assemble equipment and supplies:** • Warming lamp • Dry blanket or waterproof pad • Basin with warm water: 98.6 to 99.5 F (37.0 to 37.5 C) • Nonsterile gloves • Mild liquid cleanser approved for infant use • Towels (at least two) • Washcloth • Cotton swabs or gauze wipes • Perfume free lotion or ointment • Petroleum jelly • Emollient • Soft – bristle brush or comb • Clean clothing and diaper • Bedding • Bulb syringe (if needed)				
	Procedure				
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Ensure that the opposite side rail of a crib is raised. Keep isolette doors closed until equipment is ready for the bath.				
4.	Turn on warming lamp and ensure that it is at appropriate distance from the infant.				

5.	Place a dry bath blanket or waterproof pad on the bed surface of the crib or isolette.				
6.	Fill basin or small tub with warm water. Water temperature should be about (37.0-37.5°C).				
7.	Perform hand hygiene and don gloves.				
8.	Position the infant in a supine position. Loosely cover the infant at all times with a dry towel or blanket.				
9.	Begin bath by bathing the face using cotton balls or a soft washcloth and water.				
10.	Cleansing orbital area wash from inner canthus to outer canthus, using a fresh cotton ball.				
11.	Pat bathed area dry with a clean, dry towel.				
12.	Cleanse nose with corner of cloth or cotton ball.				
13.	Gentle suctioning of the nares with a bulb syringe may help clear the nares of nasal secretion.				
14.	Wash the external ears and behind the ear by winding a damp washcloth around the index finger.				
15.	Using a mild liquid cleansing agent, work from the shoulders to the feet in a systematic manner to wash one section of the body at a time. Pay special attention to the folds of the neck, thighs, and underarms.				
16.	Excess vernix can be removed from the newborn's skin; however, removal of all vernix is not necessary.				
17.	Rinse and pat dry each area after washing with a towel. Do not rub the skin surfaces.				
18.	Clean the umbilical area with a cleansing agent and water.				
19.	Observe the umbilicus for redness and drainage. Lift cord and clean base.				
20.	Do not wet the umbilical cord. Rinse and dry the area. Leave the site open to air.				
21.	Place the infant on his or her stomach. Wash rinse and dry the infant's back. Cover the infant with dry towel.				
22.	Apply a small amount of perfume-free lotion or emollient to any dry area.				
23.	Clean the genital area. For females, gently wash the area from front to back, from vagina to rectum.				
24.	For male, squeeze clean water over head of the pines. In the uncircumcised male, gently move the foreskin as far as it will go, cleanse the head and the penis, and return the foreskin to the normal position.				
25.	In the circumcised infant, a petroleum-coated gauze bandage or petroleum jelly should be applied to the tip of the penis if the circumcision was the Gomco type.				
26.	Raise the infant lower body by the ankles to expose the buttocks wash rinse and dry the infant's buttocks.				
27.	Apply protective ointment on the buttock area and crease areas if indicated by redness				
28.	Apply a clean diaper. If the umbilical cord is still in place, adjust the top of the diaper so that it is below the umbilical area.				
29.	Apply emollient to the infant's skin as needed				
30.	If washing hair, rap the infant in a warm blanket, securing the arms close to the body. Place the infant in a football hold position,				

31.	Position the infant's head over the wash basin. lather the infant's scalp with a mild liquid cleansing agent or shampoo				
32.	Using a damp, soapy cloth, wash the infant's hair and rinse thoroughly, massage the entire scalp including the fontanels. Dry with towel.				
33.	Comb the infant's hair with a Fine-toothed comb or a soft-bristle brush				
34.	Remove the blankets from infant after hair washing				
35.	Cover the head with cap or bonnet.				
36.	Position for comfort and safety.				
37.	Disinfect and rinse the basin or tube				
38.	Return all equipment.				
39.	Dispose of waste in appropriate receptacle.				
40.	Remove gloves and perform hand hygiene				

Procedure 10-2: Giving a Tub Bath		**Performed**		**Mastered**	**Comments**
Procedure		**Yes**	**No**		
1.	Ensure that the opposite side rail of a crib is raised.				
2.	Turn on warming lamp and ensure that it is at appropriate distance from the infant				
3.	Fill basin or tub with enough water to reach the infant's hips when in sitting position. Water temperature should be about (37.0-37.5 °C)				
4.	Perform hand hygiene and don gloves.				
5.	Undress the infant				
6.	Gradually slip the infant into the tub while supporting the neck and head				
7.	Wash the infant with the soapy cloth beginning at the shoulders and arms, continuing to lower extremities.				
8.	Cleanse the skin fold thoroughly				
9.	Rinse the infant thoroughly with a clean, damp washcloth				
10.	If washing hair, rap the infant in a warm blanket, securing the arms close to the body. Place the infant in a football hold position.				
11.	Position the infant's head over the wash basin. lather the infant's scalp with a mild liquid cleansing agent or shampoo				
12.	Using a damp, soapy cloth, wash the infant's hair and rinse thoroughly, massage the entire scalp including the fontanels.				
13.	Dry with towel.				
14.	Comb the infant's hair with a Fine-toothed comb or a soft-bristle brush				
15.	Remove the blankets from infant after hair washing				
16.	Proceed to dress the infant in dry clothing and wrap him or her in a dry blanket. Cover the head with cap or bonnet				
17.	Dry the infant by patting the skin with a towel				
18.	Dress the infant in dry clothing.				
19.	Disinfect and rinse the basin or tub				
20.	Return all equipment.				

21.	Dispose of waste in appropriate receptacle.				
22.	Remove gloves and perform hand hygiene.				

Chapter 11

Feeding Infant

BREAST FEEDING:

Procedure: 11-1 Breast feeding		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
1.	**Assess:** • Infant's general health status • Infant's oral motor development • Parent preference to breast feed or bottle feed • Parent's level of comfort with feeding, knowledge about positioning the infant • Financial resources of the family to purchase formula and equipment				
2.	**Assemble equipment and supplies:** • Nonsterile gloves • Washcloth and soap (if needed) • Pillow or blanket roll • Drinking water for the mother				
Procedure					
3.	Perform hand hygiene.				
4.	Don gloves.				
5.	Assist nursing mother as needed to perform hand hygiene before feeding and wash and dry breasts.				
6.	Position the infant close to the mother with head slightly elevated and abdomen turned in contact with mother's body direct skin to skin contact.				
7.	The mother should rotate which breast the infant starts on which each feeding.				
8.	Encourage mother to have infant nurse 10-15 minutes per side.				
9.	Burping the infant in between breasts and at the end if feeding.				
10.	Instruct mother to insert the tip of her little finger between the breast and the corner of the infant's mouth and pull slightly downward.				
11.	Offer mother water to drink during breast-feeding.				
12.	When done breast-feeding, assist the mother to place the infant safe in the crib (with side rails up) or bassinet.				
13.	Assist mother as needed to re-dress and assume position of comfort.				
14.	Perform hand hygiene.				

Procedure: 11-2 Infant Formula-feeding

		Performed		Mastered	Comments
	Preparation	**Yes**	**No**		
1.	**Assemble equipment and supplies:** • Measuring cup (1 quart) • Appropriate formula, either stored breast milk, powdered concentrated liquid or ready-to-feed formula • Scoop • Bottled water • Additives as prescribed-by-the healthcare prescriber (e.g., oil, polycose) • Long-handled spoon • Bottles with appropriate nipples and rings or disposable bottle liners with nipple, rings, and support form				
	Procedure				
2.	Perform hand hygiene				
3.	Gather the necessary supplies.				
4.	Prepare concentrated or powdered formula exactly as recommended:				
	g. Review directions for preparation listed on the label as specific for each type and brand of formula.				
	h. Use boiled, nursery," or distilled water.				
	i. Concentrated formula is usually a-1:1dilution and powdered is usually 2 oz of water to one level scoop of powder.				
	j. Using the quart measuring cup, measure the concentrate formula into the cup				
	k. Add the appropriate amount of bottled water; mix well with a long handled spoon.				
	l. Ready-to feed formulas need only be lightly shaken before use.				
5.	Warm formula slowly to comfortable temperature.				
6.	Position supplies so that they are readily accessible to the feeder.				
7.	Hold infant on the Lap with head elevated and close to the parent's / caregiver's body.				
8.	Tilt bottle to keep the nipple full at all times.				
9.	Stimulate rooting reflex by rubbing nipple along lower lip or tickling side of cheek. Place nipple on top of tongue.				
10.	After 5 minutes or 1-2 oz, stop and burp infant.				
11.	Burp again at end of feeding				

12	When feeding is to be discontinued , assist the parent / caregiver to place assist the mother to place the infant safe in the crib (with side rails up) or bassinet.				
13.	Discard bottle and formula remaining in bottle at end of feeding.				
14.	Perform hand hygiene.				
15.	Documentation.				

Chapter 12

Diapering

Procedures Checklist

Procedure 13-1: Diapering		Performed		Mastered	Comments
Preparation		**Yes**	**No**		
2.	**Assemble equipment and supplies:** • Diaper • Nonsterile gloves • Washcloth or diaper wipes (nonallergic and nonscented). • Mild soap • Towel • Cotton-tipped swab (for umbilical cord care). Petroleum jelly or Petroleum jelly gauze (for newly circumcised infant with Gomoco-type device). • Barriers cream (such as Petroleum or zinc oxide paste) if needed Topical anticandidal agent (Nystatin, Lotrimin, Micatin, Nzorol) if ordered for diaper dermatitis Low-potency, nonflurinated, 1% hydrocortisone cream if ordered for severe inflammation due to diaper dermatitis				
Procedure					
1.	Explain procedure to the child & her parents.				
2.	Perform hand hygiene.				
3.	Don gloves				
4.	Place the infant /child or on firm clean surface, such as changing table or crib/bed mattress				
5.	Keep your hand on infant and do not turn away from infant during the procedure.				
6.	Remove the soiled diaper and assess contents of diaper for unusual appearance or odor of urine or stool				
7.	Assess infant/child perineal area for redness, rash, or excoriation.				
8.	Cleanse the skin with disposable or a wet, warm washcloth. Clean from the front toward the anus for a female and from the tip of the penis toward the scrotum for a male.				
9.	Dry perineal area.				
10.	Apply a simple barriers cream (such as petroleum or zinc oxide paste) to the noninfected diaper rash				

11.	Apply new diaper securely, folding front of diaper to avoid irritation of umbilical cord. Fold plastic away from skin.				
12.	Dispose of diaper and waste in appropriately receptacle.				
13.	Remove gloves and perform hand hygiene.				
14.	Wrap the infant in blanket				
15.	Place infant in a secure crib with side rails up.				

Chapter 13

Immunization

Procedures Checklist

IMMUNIZATION

	Procedure 13-1: Immunization	Performed		Comments
	Preparation	**Yes**	**No**	
1.	**Assess:** • Previous vaccine history • The child's allergy history, including latex allergy • Prescience of fever and post illness symptoms. • The immunecompromised status of child and family			
	Assemble equipment and supplies: • Vaccine information statement • Health department or institution-specific documentation records • Child's immunization record • Correct medication • Syringe, appropriate gauge and length • Nonsterile gloves • Alcohol swab • Cotton ball or gauze • Adhesive bandage • Fun bandage (optional) • Stickers (optional) • Needle, appropriate size and length • Antiseptic swab or pledged (e , or 10% alcohol,2% chlorhexidine or 10% povidone-iodine)			
	Procedure			
1.	Explain procedure to the child & her parents.			
2.	Encourage the parent to comfort child before and after immunization administration.			
3.	Institute age-appropriate pain and distress relief measures.			
4.	Perform hand hygiene.			
5.	Gather and prepare all needed supplies before entering the child's room.			
6.	Don gloves.			
7.	Administer vaccine via rout indicated on immunization schedule.			
8.	If the child requires multiple injections, administer the injections in different extremities.			
9.	Apply adhesive bandage to immunization site as needed.			
10.	Evaluate necessity of adhesive bandage use in young children			
11.	Dispose the equipment and waste in appropriate receptacles			
12.	Remove gloves and perform hand hygiene.			
13.	Documentation.			
14.	Provide parent with information about time frame for child's next scheduled immunizations			