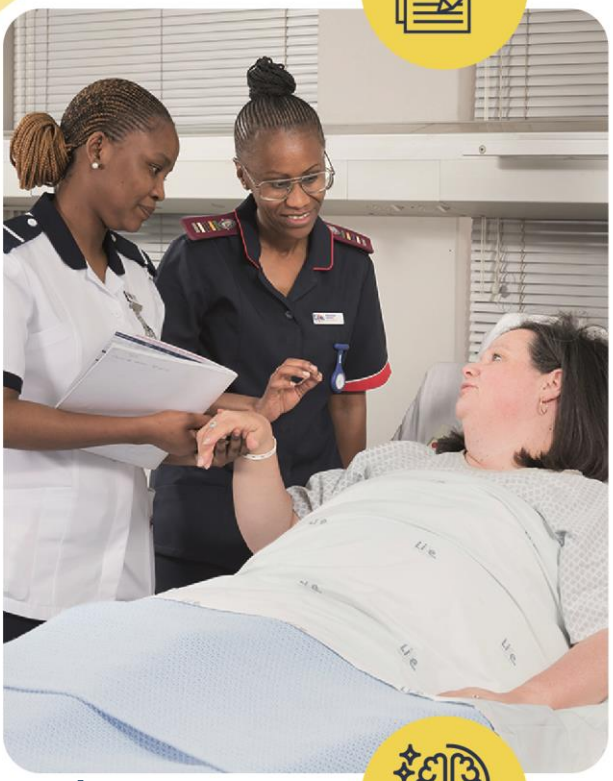
Life Healthcare
NURSING COLLEGE
Life Healthcare Group (Pty) Ltd
EDUCATION FOR SERVICE EXCELLENCE



Work Integrated Assessment Standard Guidelines

DIPLOMA IN NURSING 1st YEAR

Life Healthcare

Making life better

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1. Introduction

The College approach to Work Integrated learning (WIL) is based on the Novice- Expert learning Model of Patricia Benner (1982)

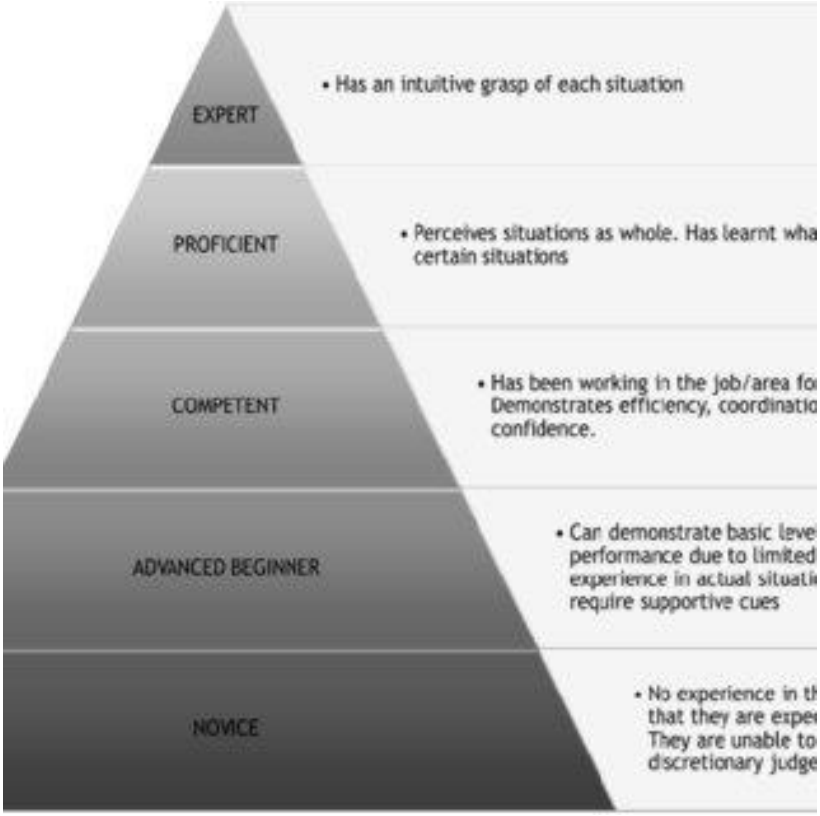


Figure 1 Benner – Novice to Expert

This means that students will have opportunities to develop their clinical skills, building up from novice status to competence status at the end of the programme. Undergraduate nurses will not exit the programme at an expert level but will be well prepared for the workforce in which they will gain further experience until they each expert level.

This is achieved through the development of basic competencies and skills and building the student's confidence and competence. Students will be taught essential competencies, basic skills and learn who to combine them into delivering safe and effective nursing care.

Further to the above, the College adopts a student-centred approach to education and training, which means that learning, is self-directed and you are expected to take responsibility for your learning. At the end of this academic year students are expected to have developed knowledge, skills and attributes to enable them to respond appropriately and effectively in all health care settings to the needs of an individual, family and the community. A student must be competent in managing an individual's health care problems with the relevant theoretical knowledge. At the same time, students must apply theory-practice integration skills to manage the health care problems effectively.

2. Definition of concepts

- **Work Integrated Learning (WIL):** refers to learning that takes place in the clinical environment i.e. hospitals and clinics. The aim of students working in the clinical environment is to ensure that they can apply the theory learnt in class in the actual real-world setting. Working with patients will help students develop their practical and attitude (soft) skills. There are 3 types of allocation when the student is placed in the units:
  - Clinical Learning: Students receive clinical outcomes that must be met and are allocated to observe, practice and assist with skills and procedures that meet the outcomes. This is done under the supervision of a registered nurse, professional nurse or allocated mentor in the nursing unit. The students work with patients but do not form part of any nursing team. The direct support of students is in the form of direct guidance by a clinical specialist or accompaniment by a clinical supervisor.
  - Role taking: After students are found competent through formal assessment and following adequate guided practice they are allowed to practice as part of the nursing team where they

are allocated tasks in the provision of daily patient care and practice as a team member under indirect supervision.
- Clinical accompaniment: A deliberate, planned and structured process to provide direct assistance and support to the students by a dedicated Clinical Training Specialist (CTS), to ensure the achievement of learning outcomes.
- Simulation refers to the acting out or mimicking of an actual or probable real-life condition, event, or situation to find a cause of a past occurrence (such as an accident), or to forecast future effects (outcomes) of assumed circumstances or factors (SANC, 2013).

3. General Rules

- Attendance of Work Integrated learning Activities are mandatory. Students need to comply to the Life Healthcare (LHC) Leave Policies as stipulated in their student contracts.
- Assessment of competencies and skills are only to be completed and signed off by designated individuals. Each tool in this book will indicate who will be allowed to declare the student competent. Any indication that a student allowed an assessment to be signed off by anyone other than the designated person, will be considered to have committed fraud and could be disciplined according to the LHC Disciplinary procedure.

4. Theory-Practice Integration

The College takes great care to plan your WIL experiences to develop and enhance your ability to deliver safe and effective nursing care. The WIL programme is designed to, as far as possible create opportunities in the clinical area, to practice what you have covered in theory. It is accepted that the clinical environment has many new and exciting experiences, and it is not reasonable to expect students to only experience what the WIL plan prescribes. It is thus accepted that students could be exposed to certain skills before a student has had a theoretical lesson or a clinical demonstration. However, students are encouraged to focus on developing their competencies and skills and be found competent in the prescribed procedures before embarking on more advance activities, when they are not yet ready.

5. Student Individual Development

At the commencement of the academic year and before a student starts WIL in the allocated clinical areas, each student will receive a Clinical Facilitation Plan (CFP). The CFP will direct the student as to which activities to participate in to develop competencies, skills and professional behaviour. Students use the CFP as a communication tool to the Unit Manager (UM) or Shift-Leader to inform and plan their learning activities. This discussion is supported by the CTS or Clinical Training Coordinator (CTC).
The CFP consists of activities related to competencies and skills required for the stage of the programme. The professional development goals are to guide the student's focus to the professional attributes they should aim to develop in a specific timeframe.
At the end of each placement period, the unit manager (UM)/Shift-Leader must give the student feedback as to their performance in the concluded period.

6. Guidelines for using the Work Integrated Assessment Standard Guidelines.

Use these Standard Guidelines together with the Work Integrated Assessment tools.
All competencies, skills and formative procedures will be demonstrated throughout the year either in simulation or in clinical practice. It is the student responsibility to ensure they attend these demonstrations and then engage in the opportunities to practice. There are due dates for assessments which will be communicated in the Assessment Schedule (formative assessments) and the Clinical Facilitation plan (CFP).
Plan your assessments in line with the CFP, ensure to plan time to practice a specific skill or competency before making appointments to be assessed.
There are certain check points during the WIL period where students WIL assessment workbook will be checked by the CTS/CTC/NED (nurse educator). This is done to ensure the students is on track to meet the requirements for programme completion/progression.
Each competency will identify who will be allowed to assess the student; these individuals can range from: CTS/CTC, The NED, UM, Shift-Leader, Peers/senior students and some will be self-evaluated.
As clinical competence is the responsibility of all education stakeholders including the student, the following processes apply:

- Competency assessments
  - These assessments generally relate to the student's demonstration of their critical thinking skills and involve the student to explain and demonstrate their thought processes.

- Students need to practice these competencies while in clinical practice under direct/indirect supervision or with a peer.
- Opportunities for practice is included in the CFP.
- Each competency has a Standard guideline and an assessment tool.
- Students should use the standard guideline and the assessment tool when they practice the competency.
- Once the student feels confident and ready for assessment they can arrange with the indicated assessor (see specific competency for who is allowed to assess) to assess them using the prescribed Competency assessment tool.
- The indicated assessor assessing the student should be familiar with the competency standard guideline.
- The assessment score used is a Competent/not yet competent scoring system.

- Skills assessments
  - These assessments relate to technical skills which require the student to comply to standards and procedure.
  - Students need to practice these skills until they can demonstrate confidence in performing the skills steps.
  - Skills should be demonstrated, practiced and assessed in the Simulation laboratory.
  - Students should use the standard guideline and the assessment tool when they practice the skill.
  - Once the student feels confident and ready for assessment, they can arrange with the indicated person (see specific competency for who is allowed to assess) to assess them using the prescribed Competency assessment tool.
  - The indicated person assessing the student should be familiar with the skill standard guideline.
  - The assessment score used is a Bondy scoring system.
- Procedure assessments
  - These assessments are focussed on determining competence for specific qualification related essential skills.
  - Once students have been found competent in certain competencies and skills, they can be assessed on their ability to apply it in one or two procedures.
  - Procedures will be assessed by the NED/CTS/CTC in clinical practice next to the patient's bedside.

Skill: Performing Hand Hygiene

OUTCOMES: The student will demonstrate competence in skills pertaining to:

- Hand wash technique
- Hand-rub techniques

RATIONALE

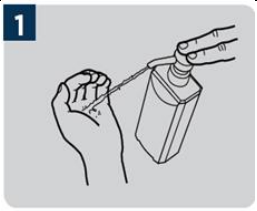
This skill is integrated in the following skills and procedures:

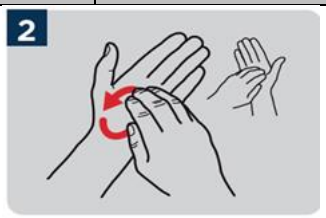
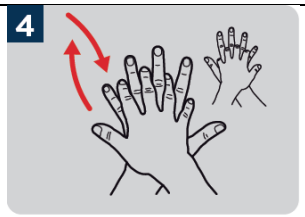
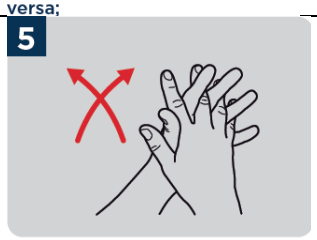
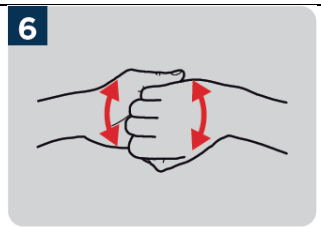
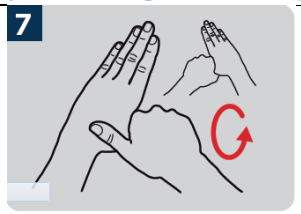
- All patient facing competencies, skills and or procedures

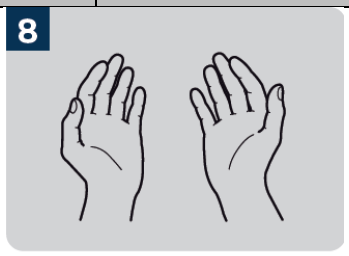
COMPETENCY REFERENCES:

1) Life Healthcare (LHC). 2023. *Procedure for Hand Hygiene* Doc. No: IPC-WP-S-201. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. *Practical Guide for General Nursing Science*. 2nd edition. Pearson: Cape Town. Pg 439 – 448.

COMPETENCY STEPS	RATIONALE
Hand wash	
Gather the relevant stock: 4% chlorohexidine gluconate liquid hand soap Clean running water Hand towels	Preparation to perform the skill prevents contamination of hands and ensure all relevant stock is available before starting the procedure.
Check expiry date	To ensure the soap is still safe and effective for use.
Open the tap/faucet and regulate the water to lukewarm.	Hot water can increase the risk for dermatitis or cause burns.
Wet hands with lukewarm running, holding hands lower than the elbows.	The water should flow from arms to the fingertips from the least contaminated to the most contaminated area. Hands are considered more contaminated than the lower arms.  Wet hands with water;
Use elbow to turn off tap/faucet.	The faucet is closed while washing hands to use water sparingly.
Apply 4% chlorohexidine gluconate liquid soap (4-5ml).	Liquid soap should cover all hand surfaces according to size of one's hand palm. 
Apply steps in hand washing correctly.	The continued and circular motions performed for about 20 seconds creates friction that helps remove microorganisms mechanically.
Rub hands palm to palm.	
Right palm over left dorsum with interlaced fingers and vice versa.	

COMPETENCY STEPS	RATIONALE
Palm to palm with fingers interlaced.	
Back of fingers to opposing palms with fingers interlocked.	
Rotational rubbing of left thumb clasped in right palm and vice versa.	
Rotational rubbing backwards and forwards with clasped fingers of right hand and left palm and vice versa.	The nails and fingertips are commonly missed during hand hygiene. 
Rinse hands with running cold water until all soap is removed without contamination.	Thoroughly rinse hands to remove soap. Any soap that remains on the hands can lead to dryness or breakdown in skin integrity. 
Dry hands thoroughly using a single-use disposable paper towel.	To prevent re-contamination of hands washed. 
Dispose of paper towel in the general waste bin.	Use the correct technique to dispose of the towel to prevent contamination.
Use elbow or a paper towel to turn off tap/faucet without contaminating the hands.	This prevents the nurse from picking up micro-organisms from the faucet handles. 
Duration of the entire procedure lasted for 40 - 60 seconds.	The procedure was performed thoroughly, removing harmful microorganisms and hands are now safe to use.
Hand rub	
Gather the relevant stock: Alcohol (70%) based hand rub.	Preparation to perform the skill prevents contamination of hands and ensure all relevant stock is available before starting the procedure.
Check expiry date	Ensure contents is still appropriate for use.
Apply enough hand disinfectant solution (3-5ml) in a cupped hand covering all hand surfaces. Dip fingers of one hand into the liquid. Pour liquid over into other palm and repeat the process.	 Apply a palmful of the product in a cupped hand, covering all surfaces;	Enough disinfectant gel should be applied to thoroughly wet hands and fingers for the entire procedure of 20 to 30 seconds before drying. Use an alcohol-based hand rub when your hands are **not** visibly soiled.

COMPETENCY STEPS		RATIONALE
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa (vigorous action).	 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;	Pressing the fingertips into opposing palms and rubbing ensures fingertips and nails are exposed to the cleaning product. Nails harbour more bacteria than do hands.
Rub hands palm to palm.	 Rub hands palm to palm;	Rubbing hands together ensures palmer surfaces are covered by the product.
Right palm over left dorsum with interlaced fingers and vice versa.	 Right palm over left dorsum with interlaced fingers and vice versa;	Rubbing between the fingers allows all surfaces of the hands to be exposed to the product.
Palm to palm with fingers interlaced.	 Palm to palm with fingers interlaced;	Rubbing hands together with fingers interlaced ensures palmer surfaces interdigital areas are covered by the product.
Back of fingers to opposing palms with fingers interlocked.	 Backs of fingers to opposing palms with fingers interlocked;	Interlacing the fingers to opposite palms with fingers interlocked cleans the interdigital spaces.
Rotational rubbing of left thumb clasped in right palm and vice versa.	 Rotational rubbing of left thumb clasped in right palm and vice versa;	Rubbing each thumb, from the base of the thumb to the top, provides complete coverage of the product on the thumb.

COMPETENCY STEPS		RATIONALE
Continue until the hands and fingernails are visible clean and dry. Duration of the entire procedure lasting for 20 - 30 seconds.	 Once dry, your hands are safe.	Hands must be completely dry prior to donning gloves, providing care, touching a client or their personal items, medical equipment, and environment.

Competency: Patient Identification

OUTCOMES
• Demonstrates competency in adhering to all principles and guidelines regarding correct patient identification.
• Confirm patient identity prior to the implementation of any nursing, medical or surgical treatments, interventions or procedures.

RATIONALE
This competency is integrated in all patient facing competencies, skills and procedures.

COMPETENCY REFERENCES:
This competency is based on:

1) Life Healthcare (LHC). 2022. Patient Identification*:* NUR-POL-GEN-001. Life Healthcare Intranet.
2) Life Healthcare (LHC). 2023. NUR-FORM-GEN002. Guidelines-Patient Documentation guidelines. Life Healthcare intranet.
3) Life Healthcare (LHC). 2023. NUR-WP-NEWBORN/003- Identification of a newborn baby. Life Healthcare intranet.
4) Mulder, M. Joubert, A & Olivier N. 2020. *Practical Guide for General Nursing Sciences. 2nd* edition. Cape Town. Pearson. p18.

COMPETENCY STEPS	RATIONALE
Obtain patient permission to perform the procedure.	• Involve patient in the procedure. • Ensure patient compliance.
Introduce self and the assessor.	The patient has a right to be treated by a named professional.
Explain the purpose of patient identification.	• Serves as a reliable method of identifying the individual as the person for whom the service or treatment is intended. • To match the service or treatment to that individual. • The primary responsibility for confirming the identity of all patients and affixing the white ID band to the patient's arm, lies with the admission staff. • Patients must not be accepted at ward level unless they have been identified.
Obtain patient file and identification bands.	• All patients must be identified prior to admission to the unit.
Identify patient related risks.	Elaborate on potential medico-legal risks related to negligent patient identification practices. • Identify high risks that could lead to medico-legal hazards. • Confused/disorientated patients • Patients with the same name or surname in the same clinical environment • Sedated patients • Communication challenges e.g. non-English speaking patients such as patients from foreign countries, impaired senses such as deaf or hard hearing patients • Patients being transferred from other units such as A & E unit
Identify work environment related risks.	High risk of patient misidentification due to time limits, unavailable staff, staff distractions, staff skills mix and unavailability of stock: • Patients being admitted in non-office working hours • Commencing with a new working shift • Agency nursing personnel working with rapid rotation work schedules • Increase in staff workload and time spent away from patient care
Obtain the appropriate coloured ID band: • **White** ID band are used for all patient identifications. • **Pink** ID band are used to identify a procedure/operation.	• ID bands worn around the arm or ankle denote the patient's name, hospital number, treating doctor's name, allergies, and procedures to be done. • Correct colour identification bands are essential to communicate high risk situations to the healthcare team.

COMPETENCY STEPS	RATIONALE
• **Yellow** ID band are used for allergies or comorbidities. • **Red** ID band are used for identifying a patient at risk for falling.	
Check appropriate placement of the identification bands.	• Ensure ID band is comfortable, not to lose nor to tight. Ensure a finger width between the ID band and patient's skin. • Select the most suitable body side for affixing the coloured ID bands. • Relate admission diagnosis and co-morbidities to the potential of interfering with ID band placement i.e. o peripheral oedema o latex allergies o most suitable site for peripheral IV line in view of environmental layout o planned surgery such as right/left shoulder replacement, carpal tunnel syndrome repair right/left hand. o take patient preferences into consideration
Placement of ID band for newborn, baby or child requires identification with 2 id bands – one around the leg and one around the arm). In instances where there is not sufficient space to place an ID band on 2 limbs, one can be placed securely on the IV line that is connected to the child	As they are usually moving around, an ID band can easily dislodge or fall off. With 2 bands, there is always at least one way to effectively identify the child/baby. Include the following information: • Mother's initials and surname • Date of birth • Attending doctor • Ward name/number
Check the ID band with the mother by comparing the mother's ID band, every time the baby is separated from the mother.	The patient must be correctly identified to ensure the correct child is returned to the mother after receiving the intended care.
Check for the presence of 2 ID bands with every nappy change and baby bath.	Before performing any procedure, the patient must be correctly identified to ensure the correct patient is receiving the intended care.
Check ID bands **verbally** and **confirm with documentation** and **patient admission letter** and **prescription chart.**	Before performing any procedure, the patient must be correctly identified to ensure the correct patient is receiving the intended care.
White Identification band contains all required information.	Include the following information: • Patient's initials and surname • Hospital number • Attending doctor • Ward name/number
Pink identification band contains all required information.	Include the following information: • Patient's initials and surname • Hospital number • Attending doctor • Procedure/operation
Yellow identification band contains all required information.	Include the following information: • Patient's initials and surname • Hospital number • Allergies • Correct co-morbidities that the patient suffers from
Red identification band is appropriate and contain all required information.	Perform a detailed risk of falling assessment. • Apply the band when patient's risk of falling score is 5 or greater. • Red ID band to be removed when the patient is no longer deemed to be at risk for falling.
Ensure all documentation in patient file correctly identified	These actions must be performed regularly to link the patient and patient records to the correct patient. Ensure all patient record has the correct patient sticker.

COMPETENCY STEPS	RATIONALE
	NB – when a patient is transferred from another ward e.g. ICU, order new stickers.
Provide relevant patient education.	• To ensure identification bands remains readable and secured onto the limb. • Not to remove the identification bands. • Report to the nursing staff when identification bands become loose or has been lost, writing has faded.

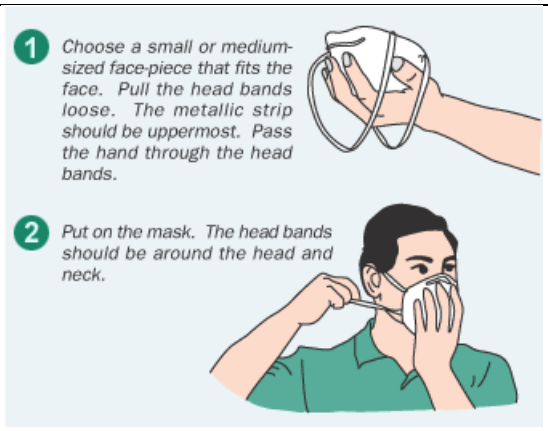
Skill: Donning and doffing of PPE

OUTCOMES: The student will demonstrate competence in:
• Donning and doffing of Personal Protective Equipment.

RATIONALE
This competency is integrated in the following skills and procedures:
- Isolation precautions

COMPETENCY REFERENCES:
1) Berman, A., Snyder, S.J. and Frandsen, G. 2022. *Kozier & Erb's fundamentals of nursing: concepts, process, and practice.* 10th ed. Boston: Pearson p 712.
2) Sequence for Donning Personal Protective Equipment (PPE) (cdc.gov).
3) Life Healthcare. 2022. Internal LHC policies: Management and control of Coronavirus disease (COVID-19) Doc. No: IPC-WP-PM-112. Life Healthcare Intranet.
4) Mulder, M, Joubert, A & Olivier, N. 2020 Practical guide for general nursing sciences second edition. Cape Town: Pearson p 410-418.

COMPETENCY STEPS	RATIONALE
Sequence for donning of PPE:	
Gown:	
Assess the patient's medical history for indications for isolation.	Ensure appropriate isolation precautions and barriers are identified.
Perform hand hygiene	Reduces the transmission of microorganisms.
Prior to applying PPE, step into the patient's room, but stay at the door. Introduce yourself and explain the care to be provided.	Allows patient to see you without PPE to ensure familiarity with the patient. Staying at the door prevents the risk of infection transmission.
Allow gown to unfold without touching any contaminated area.	Prevent contamination of clean gown.
Slip arms into sleeves and fully cover torso from neck to knees and pull sleeves down to the wrists.	Cover body completely to prevent contamination.
Fasten in back of neck and waist, overlapping the back.	• Prevent gown from falling away from the body. • Cover nurses' uniform to prevent contamination of uniform or environment. • To secure gown to prevent transmission of infection.
	
Mask or respirator:	
Locate top of mask.	Flexible strip needs to fit on bridge of the nose.
Hold mask by the top two strings or loop.	Prevents contamination of mask by hands.
Place the top of the mask over bridge of the nose and tie upper strings.	For comfort and prevention of contamination.
Secure ties or elastic bands at middle of head and neck.	To ensure a tight fit and prevent mask from slipping down.

COMPETENCY STEPS	RATIONALE
If glasses are worn, fit top of mask under the glasses.	Prevents glasses from fogging up and obscuring vision.
Fit snug to face and below chin.	To be effective the mask must cover the nose and mouth. It prevents the escape of microorganisms around the edges of the mask.
Wear mask only once and only for the time suggested by the manufacturer.	The moist from breathing makes the mask ineffective.
Never allow a mask to hang around your neck.	It is of no use and a source of cross contamination.
	
Goggles:	
Place over eyes and adjust to fit.	Prevention of bodily fluid spilling into eyes
	
Gloves:	
No special technique is required	
Extend to cover wrist of isolation gown	Covering of full body prevent contamination
	
Sequence for doffing of PPE:	
Gloves:	
Untie strings of the gown at the back.	Outside of gloves is contaminated.

COMPETENCY STEPS	RATIONALE
Grasp outside of glove with opposite gloved hand; peel off.	Prevent touching the contaminated part of the glove.
Hold removed glove in gloved hand.	Avoid touching contaminated gloves.
Slide fingers of un-gloved hand under remaining glove at wrist.	Avoid contamination of hands.
Peel the 2nd glove off over first glove.	Prevent contamination of hands.
Discard gloves in waste container.	Infection control and waste management principles.
Wash hands.	May have contaminated hand while removing gloves.

Goggles:	
To remove, handle by head band or earpieces.	Outside of goggles is contaminated.
Place in designated receptacle for cleaning.	

Gown:	
Pull away from neck and shoulders, touching inside of gown only.	Gown front and sleeves are contaminated.
Turn gown inside out.	Prevent contamination of environment.
Do not shake.	May spread microorganisms.
Fold or roll into a bundle and discard.	The gown will not stick out of the waste container.

COMPETENCY STEPS	RATIONALE
Mask or respirator	
Remove mask or respirator when leaving the room.	Prevent exposure to microorganisms.
Do not touch front of the mask.	Front of mask/respirator is contaminated.
Grasp bottom, then top ties or elastics and remove.	If you untie top string it may fall from your face and can contaminate.
Discard in waste container.	This is medical waste.
	
Perform proper hand hygiene.	May have contaminated oneself in process of doffing.

Competency: Creating a Therapeutic environment

OUTCOMES: The student will demonstrate competence to:
• Create and maintain a safe and clean environment.
• Manage unhygienic conditions appropriately to prevent infection.
• The room and direct patient environment are clutter free and neat.
• Ensure equipment is available and ready for an emergency at the bedside.

RATIONALE
The patient has the right to be nursed in an environment which will enhance their health and prevent harm. All patient care must take place in a safe and clean environment. The nurse and the patient can be harmed, should the environment not be safe and clean.

COMPETENCY REFERENCES:
This competency is based on:
1) Booysen, L. Erasmus, I. Van Zyl, M. 2015. The Auxiliary Nurse. 4th edition. Juta: Cape Town.
2) Mogotlane, S (Editor). 2022. Juta's complete textbook of Medical Surgical Nursing. Juta: Cape Town.

COMPETENCY STEPS	RATIONALE AND STANDARD
Check that floors are clean, dry and obstacle free (lines/cords).	To prevents slips, trips and falls for the patient and the nurse.
Check that cot sides up and working (if indicated).	To prevent falls and ensure patient safety.
Bed breaks checked and working.	To prevent injury to both nurse and patient.
Level of bed can be adjusted and at an appropriate height.	To prevent patient falls and back injuries for the nurse.
Oxygen connected and working.	Emergency Oxygen can be administered immediately. To ensure that the patient who are already on oxygen has no disruption in the oxygen supply.
Oxygen equipment clean and secure.	To prevent oxygen leaks or oxygen from not being delivered.
Suction working, connected and secured.	This must be available in case of an emergency and ready for use.
Suction equipment clean and available.	To prevent cross contamination.
Call bell and bed light functional and within reach.	To allow the patient to call when they are in need. Good lighting is necessary for safe performing of activities of daily living.
Bed accessories appropriately positioned and within reach of the patient.	To help the patient reach for these accessories when needed and to eliminate the risk of falling.
No urinals or bed pans on the bedside table the over bed trolley.	To prevent transmission of micro-organisms and eliminate bad odours.
Check that all monitors are plugged in and charging. Observe for any loose wires.	Patient monitoring equipment are in working order when required and all environmental risks are eliminated.
Emergency equipment should be checked according to the checklist provided at the start of each shift.	This must be available in case of an emergency and ready for use.

Skill: Oral Care

OUTCOMES: The student will demonstrate competence in:
• Conduct appropriate assessments on a patient receiving oral care
• Demonstrate correct psycho-motor skill execution when performing oral care

RATIONALE

This competency is integrated in the following skills and procedures:

- Brushing teeth
- Removal and cleaning of dentures
- Flossing of teeth

COMPETENCY REFERENCES:

This skill is based on

1) Life Healthcare (LHC). 2021. Fundamentals of care: Hygiene. Doc. NUR-W-GEN-028. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 324 – 350
3) Pictures from wikiHow //available @ How to Clean Dentures: 13 Steps (with Pictures) - wikiHow

COMPETENCY STEPS	RATIONALE
Planning and preparation prior to skill	
Identify at risk patients who may have special needs regarding oral hygiene	Initiate appropriate actions to avoid complications.
Assemble require stock and equipment: • Mug and kidney dish • 10 ml syringe • Toothbrush/ toothpaste • Receiver for dirty swabs • Receiver for contents after rinsing mouth • Glass with water • Chlorhexidine mouthwash • Unsterile gloves • Unsterile gauze • Spatula • Plastic forceps • Lip moisturiser • Floss • Linen saver or towel and face cloth	To easily ensure accessibility of the necessary stock and equipment.
General principles	
Identify the patient.	Ensures that the correct patient receives the care provided.
Explain the procedure to the patient/family member and obtain consent.	Ensures the patient understand, acknowledge and consent to the procedure.
Ensure privacy is always maintained.	To ensure patient dignity.
Wash hands and wear appropriate PPE (non-sterile gloves, apron).	The nurse eliminates the risk for infectious contamination and splash injuries.
Position the patient appropriately - semi fowlers/fowlers unless contraindicated.	To avoid risk for suffocation and aspiration.
Place linen saver or towel on the patient's chest.	To prevent contamination of patient linen.
• Assess the patient's mouth including the outer and the inner oral cavity. • Observe for any abnormalities including abscesses, thrush and ulcers, broken teeth, cracked lips. ○ Lips and buccal mucosa ○ Teeth and gums	Determine the specific needs in view of assessment outcomes.

COMPETENCY STEPS	RATIONALE
○ Tongue, floor of mouth and inner part of cheeks.	
Brushing teeth	
Apply toothpaste to the toothbrush and wet with a small amount of water.	Brushing removes accumulated materials and coatings.
Hold toothbrush at 45° angle in circular movements from furthest to nearest.	To obtain the correct angle to reach all aspects of the mouth. 
Brush the teeth for 3-4 minutes.	Ensure you reach all the angles of the teeth and reach areas frequently missed.
Brush over surface and sides of tongue, gums and hard palate.	Ensure you reach all the angles of the mouth to remove food particles and micro-organisms.
Allow the patient to rinse mouth with water.	To enhance oral hygiene and to prevent oral infections. To remove loose food particles.
Apply Vaseline or lip balm if available.	To prevent lips from drying out.
Record all the data accurately, chronologically and according to the scientific and legal criteria.	Recordkeeping reflects a comprehensive assessment approach to oral assessment findings, type of mouth care procedure performed, specific interventions taken, including the communications and actions taken to activate medical intervention if required.
Flossing of teeth	
Apply correct principles and techniques in flossing teeth. • Hold floss between thumb and forefinger. • Gently move the floss in between teeth. ○ To remove food particles stuck between teeth. ○ Ensure floss enters between teeth with ease ○ Do not force the floss in between teeth. • Repeat movement on lower teeth.	Prevent formation of plaque and removing food particles between the teeth. 
Allow the patient to rinse mouth with mouth wash.	To enhance oral hygiene and to prevent oral infections.
Apply Vaseline or lip balm if available.	To prevent lips from drying out.
Removal and cleaning of Dentures	
Gather all the needed equipment	Gather the needed equipment, from the list under “brushing of teeth”.
Ask the patient if they would prefer to clean their own teeth or if you can assist.	Independence is kept with assistance provided as required.
Ask patient to remove denture and place in a receiver/cup.	Safely remove the dentures, place in a receiver cup to avoid dentures from falling.
If the patient is unable to remove, don non-sterile gloves and grasp the upper plate with gauze at the level of front teeth and carefully move dentures up and down. Wiggle dentures until they are loose from the gums. Place dentures in a receiver cup.	Safely remove the dentures, place in a receiver cup to avoid dentures from falling.
Gently brush the dentures, performing the procedure over a kidney bowl containing water.	• Brush dentures using the same principles as brushing teeth. • Ensure brushing for 2 – 3 minutes. • Take care not to drop the dentures.

COMPETENCY STEPS	RATIONALE
	
Rinse dentures under running water.	To ensure all toothpaste residuals are removed. 
Allow patient to rinse the mouth with water.	• Rinsing loosens food particles and washes out loosened particles. • To enhance oral hygiene and to prevent oral infections.
Replace dentures in the patient's mouth.	Ask patient to place their own dentures back in their mouth, or gently place the dentures back into the mouth. Ensure correct alignment and secure dentures in place.
If patient is not able to receive dentures back into the mouth, place dentures in a receiving cup.	Could break or become misplaced or discarded if left on bed or wrapped in tissues.
Apply Vaseline or lip balm if available.	To prevent lips from drying out.
Record all the data accurately, chronologically and according to the scientific and legal criteria.	Recordkeeping reflects a comprehensive assessment approach to oral assessment findings, type of mouth care procedure performed, specific interventions taken, including the communications and actions taken to activate medical intervention if required.

Competency: Safe mobilisation and body mechanics

OUTCOMES: The student will demonstrate competence in:
• describe assessment of patient' prior to manual handling.
• explain observations to be done before and after moving the procedure.
• demonstrate techniques used to move and transfer patient out of bed.

COMPETENCY REFERENCES:

This competency is based on:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 121 – 150.
2) https://www.healthyworkinglives.scot/workplace-guidance/safety/manual-handling/Pages/manual-handling-risk-assessment [accessed on 19 April 2023].
3) The Scottish Manual Handling Passport Scheme. https://www.gov.scot/publications/scottish-manual-handling-passport-scheme. Part of Health and social care ISBN 9781784127053 [accessed on 24 April 2023].

COMPETENCY STEPS	RATIONALE
Identify the patient.	To ensure that the correct patient receives the treatment • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Provide patient privacy.	To ensure patient dignity is maintained.
Explain the purpose of manual handling of patients.	To apply correct lifting techniques. To utilise correct equipment. To encourage patient's involvement/ participation.
Perform manual handling risk assessment.	To be aware of any individual risks factors to be considered during manual handling task. Task, individual, load and environment.
Give a comprehensive history of the patient.	To ensure that the correct patient receives the treatment. To identify patient's capabilities as well as limitations in manual handling such as medical, allergies, surgical, family, occupational, social and cultural. This should include the patients name, age, marital status, employment status and reason for admission.
Perform vital signs, interpret and identify trends from previous vital signs.	Identify patient's response to treatment, then act accordingly. Analyse and motivate if it is safe to continue with the procedure.
Ensures safe environment by checking if equipment is in a good working condition.	Avoid injuries by removing clutter and obstacles and ensuring that there is adequate space for moving.
Identify the team leader for the manoeuvre	To provide directions and promote teamwork.
Ensure that the needs are met prior to the commencement of the skill.	To avoid disruptions during the procedure.
Determine the weight of the patient.	To assess the amount of assistance required to perform manual handling task. To determine the carrying capacity of the hoist.
Assemble all the necessary clothing and equipment.	To ensure fluidity of the task.
Wash/spray hands before and after procedure.	To prevent infection.
Stand as close to the patient as possible. Gather any assisting devices e.g. hoist, walking frame, crutches.	To prevent injuries to both staff and patient. Adhere to safe ergonomic principles by using assisting devices e.g. hoist.
Leader to give instructions and team must act on these instructions.	To ensure effective communication.
Allow the patient to rest after position change.	To prevent orthostatic hypotension.
Dress patient with appropriate clothing.	To maintain patient's dignity e.g. gown and slippers and cover with blanket.
Reassure and position patient comfortably in the chair and elevate legs on a footstool, if necessary.	To allay fear and anxiety. To ensure the patient is comfortable and to prevent the patient from sliding down.
Place locker and call bell within reach.	To ensure patient can call for help when needed.

COMPETENCY STEPS	RATIONALE
Re-assess vital signs after transfer.	To evaluate the client's tolerance, level of fatigue and comfort after transfer.
Record all data and any observations made.	To ensure effective communication to all staff involved in caring for the patient. Interpret, verbalise, report and findings, including any alterations or abnormalities to the professional nurse and medical practitioner.
Render and record relevant health education.	To keep patient informed and included in their care.
Ensure patient safety and a therapeutic environment before leaving the patient's bedside.	To ensure patient safety and eliminate any risks that could compromise patient safety.

Competency: Therapeutic use of self

OUTCOMES: The student will demonstrate competence in:
• Initiating and maintaining a supportive and caring therapeutic nurse-patient relationship during all patient encountered skills and procedures.
• Establishing and maintain a rapport with the patient.
• The ability to obtain informed consent from a patient during all patient encountered skills and procedures.

RATIONALE
This competency is integrated with all patient skills and procedures.

COMPETENCY REFERENCES:
This competency is based on:

1) Berman, A., Snyder, S. & Frandsen, G. 2022. *Kozier and Erb's Fundamentals of Nursing: Concepts, Process and Practice*. 11th ed. United Kingdom: Pearson Education Limited.
2) Brooker, C. Waugh, A., Van Rooyen, D. & Jordan, P.J. 2016. *Foundations of Nursing Practice: Fundamentals of Holistic Care*. 2nd ed. Johannesburg: Elsevier.
3) College of Nurses of Ontario. 2019. *Therapeutic Nurse-Client Relationship, Revised 2006.* https://www.cno.org/globalassets/docs/prac/41033_therapeutic.pdf Date of access: 23 June 2023.
4) Mogotlane, S., Mokoena, J., Chauke M., Mokgadi, M., Randa, A., 2022. Juta's Complete Textbook of Medical Surgical Nursing. 2nd ed. Cape Town: Juta and Company.
5) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 4 - 8

COMPETENCY STEPS	RATIONALE AND STANDARD
Non-verbal communication	• Shows empathy and awareness of the boundaries and limits of the professional role. • Traits such as empathy, respect and cultural appreciation are reflected through both non-verbal and verbal communication. • Non-verbal communication traits use appropriately. – touch – eye contact – body language
The student's appearance is neat, tidy and professional.	
The student wears the appropriate name badge.	
The student displays a caring and compassionate attitude according to the patients' needs.	
Interactions reflect a trusting nurse-patient relationship	
Verbal communication	• Verbal and non-verbal communication skills utilised should display a caring, compassionate and professional attitude towards the patient. o not loud, but audible o no jargon and communicates in patient's mother tongue. • The introduction interaction with patient displays professional conduct. • Traits such as empathy, respect and cultural appreciation reflected through both non-verbal and verbal communication.
The student uses the correct tone of voice	
The student uses the correct language.	
The student introduces himself/herself to the patient	
Introduce assessors to patient	
Explain the procedure to the patient before obtaining consent.	• Patient understands what to expect from nursing intervention. o Allow an opportunity for patient to ask questions. o To alleviate patient's anxiety due to a lack of understanding.
Consent	• Verbally re-confirm written informed legal consent before *continuing with a skill and/or procedure.* • Student-patient interactions reflect reassurance and compassionate care. • Patient aware of implications/potential risks related to procedure.
Confirm informed consent.	
Privacy and confidentiality	• To ensure patient privacy and confidentiality of information is maintained
Maintain patient privacy and confidentiality	

COMPETENCY STEPS	RATIONALE AND STANDARD
	• To apply knowledge of legislation & legal requirements Understand potential medico-legal risks related to privacy and confidentiality and prevent it from occurring
Patient Comfort Attend to patient's immediate needs: • Pain – ask and manage, if needed report to RN to administer analgesic. Provide nursing interventions to relive pain. • Position – is the patient in an appropriate and comfortable position. • Hungry or thirsty – ask the patient, provide with water or a snack if the patient is allowed to eat and drink. If the patient is NPO – provide education around the necessity of not eating and drinking. • Warm or cold – ask the patient and provide or remove blankets or switch the aircon off or on. • Elimination – ask patient and provide assistance to the bathroom or provide a bedpan where indicated.	To ensure patient is comfortable before commencing any procedure.

Competency: Fall Risk Assessment

OUTCOMES: The student will demonstrate competence in:
• Identifying potential factors that may cause a risk of falling to the patient.
• Scoring patients according to the Life Health Care Risk of Falling Assessment Tool.
• Interpreting the Risk of falling score.
• Describing precautionary measures to prevent falling incidents.

RATIONALE
Identify the patients at risk of falling and institute appropriate preventative measures

INDICATIONS:
This competency is integrated in the following skills and procedures:
- Admission of patients into the ward.
- Comprehensive patient assessment.
- Formulating daily nursing care plans for all in-patients.
- Re-assessment of the risk assessments for patients who have a change in their condition.
- Transfer of patients to or from a different unit or facility.

COMPETENCY REFERENCES:
This competency is based on:
1) Life Healthcare (LHC). 2023. *Risk of Falling Assessment Tool*. Doc. NUR-DOC-GEN-001. Life Healthcare Intranet.
2) M Cronje, J. J. (2022, June). *Preventing Slips and Falls: Hendrich II Fall Risk Assessment*. Retrieved from LHC Gate Way. (LHC WP: NUR-WP-SF-003)

COMPETENCY STEPS	RATIONALE AND STANDARD
Obtain relevant patient history.	*Assess the patient for relevant information:* • Previous falls at home/hospital in the last year. • Co-morbidities/medical conditions e.g. hypo/hypertension, epilepsy, stroke, diabetes • Any limb weakness/leg or foot problems/balance problems • The patient is day 1 post ICU/post operative/Post Normal delivery • Age 65 years and older • **Score as follows:** ○ No criteria – 0 ○ One criteria – 2 ○ Two or more criteria – 3
Determine the medication the patient is currently using.	*Ask the patient about medication or consult the prescription chart:* • Night sedation • Neurological/psychotropic medication • Analgesic (pain) medication • Cardiac medication • Bowel preparation/laxatives/diuretics • Any recent changes in medication • **Score as follows:** ○ No criteria – 0 ○ One criteria – 2 ○ Two or more criteria – 5
Perform an audiovisual assessment.	*Assess the patient for any of the following:* • Hearing loss/hearing aid present • Glasses/contact lenses • Blindness • **Score as follows:** ○ No criteria – 0 ○ One criteria – 1 ○ Two or more criteria – 2
Determine the patient's elimination needs.	*Ask the patient about their elimination habits:* • Any assistance required with elimination needs e.g. bedpan, urinal, commode? • Any urgency/frequency in elimination bowel/bladder?

COMPETENCY STEPS	RATIONALE AND STANDARD
	• **Score as follows:** ○ No criteria – 0 ○ One or more criteria – 2
Assess the patient's mobility and gait.	**Ask whether the patient themselves feel dizzy, or their environment is spinning.** • Unless previously diagnosed or recorded in the patient's history, the score must be based on the patient's report e.g., 'my head is spinning, 'I feel dizzy'. **Perform a 'get up and go test'** **Ask patient to independently rise from a chair or the bed.** • This is based on the patient's ability to get up from a seated position on a chair (or a bed at the correct height for the patient) with their hands placed on their thighs. Assessment criteria to observe for: • Dizziness/Vertigo/unsteady/needs assistance/muscle weakness • Patient needs walking aids/wheelchair • Equipment e.g. IV drip stand, Drains, catheters, monitors. • **Score as follows:** ○ No criteria – 0 ○ One criteria – 2 ○ Two or more criteria – 3
Determine the patient's mental state.	***Ask the patient for the time, date and place and observe:*** • Disorientation (time, place, person)/confused/restlessness/lack of sleep/ lethargy • Aggression/agitation • Tremors/Parkinsons disease/Dementia/Alzheimer's. • Elderly patient/fear of falling/uncooperative • Impulsive or unpredictable behaviour. • **Score as follows:** ○ Any criteria in this field – 3
Determine and assign the final score.	The total score will determine the risk classification.
Accurately interpret the risk score assigned.	Interventions implemented will be determined by the risk classification. • 11-18 – High Fall risk • 4-10 – Medium Fall risk • 0-3 – Low Fall risk.
Discuss the appropriate precautionary measures needed to manage the risk.	• Inform members of the team of the patients' risk • Patient education (teach back and falls leaflet) • Educate the family • Red project implementation (Red ID band, call bell functional) • Footwear appropriate for fall risk (no socks, non-slip shoes) • Personal items, assisting devices, bed locker and call bell in reach of patient • Drip stand wheels in working order and move freely • Bed close to nurses' station, cohort high risk patients • Bed in low position • Brakes on bed and equipment locked • Bedrail assessment complete and appropriately applied • Supervision/assistance with self-care • Accompany patient to bathroom and supervise • Clear pathway to bathroom/floors clean and dry • Chair and bathmats correctly placed in bathroom • Sufficient lighting in room/bathroom • Sufficient patient comfort rounds and clinical rounds performed.

ADDENDUM:

Addendum 1**: Life Health Care Risk of Falling Assessment Tool:**

PATIENT HISTORY															
Day ICU/Post-operative/Post Normal Vaginal Convulsive Therapy(ECT)															
SUBTOTAL No Criteria One criteria Two or more criteria score 3															
MEDICATION															
Two or more criteria score 5															
AUDIOVISUAL															
SUBTOTAL No Criteria score One criteria score Two or more criteria 2															
ELIMINATION															
MOBILITY/GAIT/EQUIPMEMT															
SUBTOTAL score															
ME STATE															
Any a															
TOTAL score															
HIGH RISK 11-18				MEDIUM RISK 4-10										LOW RISK 0-3	
(Tick appropriate patients															
Patient discussion education (Teach back/ Slips and falls leaflet)															
Caution against falling asleep with newborn															
Foot wea s															
Bed low position & call bell within patients reach															
Bed rail assessment completed appropriatly applied															
Accompany patient bathroom DO NOT clean															
Chair and bathmats correctly placed in bathroom with sufficient lighting															
Purposeful Comfort d Clinical															
Other:															

Competency: Skin Risk Assessment

OUTCOMES: The student will demonstrate competence in:
• Accurately completing a Skin Risk Assessment using the correct assessment tool.
• Correctly calculating the Skin Risk Assessment score.
• Effectively interpreting the Skin Risk Score.
• Accurately recording findings.

RATIONALE

This competency is integrated in the following skills and procedures:

- Planning Patient Care
- Postoperative Care
- Patient Handover
- Nursing diagnosis
- Patient Presentation.

COMPETENCY REFERENCES:

This competency is based on:

1) NUR-WP-GEN-001: Assessment of patient health status and health needs. August 2022. Revision 4

COMPETENCY STEPS	RATIONALE AND STANDARD	
Obtain the correct Skin Risk Assessment tool currently in use in the organization. Complete a thorough skin assessment.		
Determine the patient's build/weight for height. Calculate the patient's Body Mass Index (BMI).	Consideration to the patient BMI scored from 0-3 Calculation of BMI= Wt.(kg) / Ht.(m) x 2 Wt.= Weight in kilograms (kg) Ht. = Height in meters (m) x 2	
Assigns the correct score.	• Average BMI (20-24.9) • Above average BMI (25-29.9) • Obese BMI (>30) • Below average BMI (<20)	0 1 2 3
Describes the patient's skin type visualising all skin areas.	Scored from 0-3. Dry, oedematous or clammy skin gets damaged more easily. Discolouration or spots are warnings of pressure damage already occurring. • Healthy: skin appears normal. • Tissue paper: skin appears thin and fragile, looks transparent. • Dry skin: skin is flaky. • Oedematous: skin appears puffy or swollen. • Clammy, pyrexia: increase temperature, skin is moist, cool to touch. • Discoloured: pressure injury stage 1, non-blanching erythema, dark skin will differ from surrounding skin. • Broken/spot: pressure injury 2,3,4 – unstageable suspected deep tissue injury.	
Assigns the correct score.	• Healthy • Tissue paper/dry skin/oedematous/ clammy/pyrexia • Discoloured • Broken/spot	0 1 2 3
Assigns correct score for Sex and age.	There is a higher incidence of pressure sores in women, possibly related to the shape of the pelvis. Gender gets scored 1-2 points.	
	• Male • Female	
	The risk of skin damage also increases with age due to loosing elasticity and plumpness. Age group gets scored 1-5 points.	
	• 14-49 • 50-64 • 65-74 • 75-80	1 2 3 4

COMPETENCY STEPS	RATIONALE AND STANDARD	
	• 81+	5
Describes patient's nutritional status.	Considers recent weight loss and the severity of weight reduction Scored from 0-4 Start with A: Has patient lost weight recently? Ask the patient "Have you lost weight recently without trying?" (In the last 6 months)	
Assign the correct score	• Yes • No • Unsure	go to section B go to section C go to section C and score.
	If the patient answered "Yes" to Question A, then go to B:	
	• 0.5 - 5kg • 5 - 10kg • 10 - 15kg • >15kg • Unsure	1 2 3 4 2
	If the patient answered "No" to Question A, then go to C:	
	Poor nutrition affects skin elasticity and subcutaneous tissue making it more prone to damage Ask the patient "Have you been eating poorly because of decreased appetite?"	
	No Yes	0 1
	If score is >2 refer the patient for nutrition assessment/intervention.	
Describes the patient's continence.	Incontinence brings excess moisture to the skin, casing softening and erosion of the epidermis. Score ranges from 0-3 • Nocturia/continence/catheterised = No risk • Incontinence of urine - risk of excoriation • Incontinence of faeces - risk of excoriation • Double incontinence (urinary faecal) - high risk of excoriation	
Assign the correct score.	• Complete/catheterized • Urine incontinence • Faecal incontinence • Urinary +faecal incontinence	0 1 2 3
Determine the patient's mobility.	Evaluates the ability to move and the level of restlessness The patient score can range from fully mobile with no restrictions 0 points to permanently chair bound 5 points • Fully - able to change position independently • Restless/fidgety - prone to shear and friction • Apathetic - sedated/depressed reluctant to move • Restricted - mobility restricted by disease, severe pain • Bedbound - unable to change position self/traction • Chair bound/wheelchair - unable to leave chair without assistance	
Assign the correct score.	• Fully • Restless/fidgety • Apathetic • Restricted • Bedbound e.g. traction • Chair bound e.g. Wheelchair	0 1 2 3 4 5
Describes any special risks relevant to the patient.	Point values are assigned based on specific or temporary conditions. A smoker will receive an additional point, while patients with multiple organ failure would get 8 points • Terminal cachexia - a wasting syndrome that leads to loss of skeletal muscle and fat. • Multiple organ failure - condition in which two or more organs undergo failure and show inappropriate functioning with altered physiology. • Single organ failure - means one or several organs is to do its job adequately for body needs.	

COMPETENCY STEPS	RATIONALE AND STANDARD
	• Peripheral vascular disease - is a slow and progressive circulation disorder. • Anaemia - a condition in which there is a deficiency of red cells or haemoglobin in the blood, resulting in pallor and weariness.
Assign the correct score.	<u>Tissue Malnutrition</u>: • Terminal cachexia — 8 • Multiple organ failure — 8 • Single organ failure (respiratory/renal/cardiac) — 5 • Peripheral vascular disease — 5 • Anaemia (Hb <8) — 2 • Smoking — 1
	<u>Neurological Deficit</u> • Diabetes, Multiple Sclerosis (MS), CVA — 4-6 • Motor/Sensory — 4-6 • Paraplegia (maximum of 6) — 4-6
	Score of 4 indicates Moderate affliction Score of 5 indicates moderate to severe affliction Score of 6 indicates sever affliction
	<u>Major Surgery or Trauma</u> • Orthopaedic/Spinal — 5 • On table >2 hours — 5* • On table >6 hours — 8*
	*Scores can be discounted after 48 hours provided patient is recovering normally
Evaluates prescription chart to identify high risk medication.	Some medication can contribute to skin breakdown and damage. Look at the prescription chart and identify any of the following classes of medication prescribed to this patient: ○ Cytotoxic medications, ○ Steroids prescribed for a long term or at a high dose, ○ Anti-inflammatory medications.
Assign the correct score.	• 1 drug — 1 • 2 drugs — 2 • 3 drugs — 3 • 4 or more drugs — 4
Correctly calculates the total Skin Risk score.	Add all the assigned scores for each aspect of the Skin Risk Assessment to get to a total. Ensure you added all the scores correctly to ensure the final score is accurate and represents the patient's risk
Records the Skin Risk Score in the relevant nursing documentation.	Accurate record keeping and communication is essential in preventing skin break down and pressure ulcer development. Records can include, but is not limited to: • Daily Nursing Assessment • Nursing Progress notes
Interprets the Skin Risk Score.	10 + Patient at risk 15 + Patient at high risk 20 + Patient at high risk How does this score influence your nursing management of this patient?

ADDENDUM:
Addendum 2: Waterlow Pressure Ulcer Assessment Tool and Prevention Guidelines

Life Group WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT	♦	SKIN TYPE VISUAL RISK AREAS	♦	SEX AGE	♦	MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 – Australia)	
Average BMI = 20-24.9	0	HEALTHY	0	MALE	1		
		TISSUE PAPER	1	FEMALE	2		
ABOVE AVERAGE BMI = 25-29.9	1	DRY	1	14 – 49	1	A - HAS PATIENT LOST WEIGHT RECENTLY • YES - GO TO B • NO - GO TO C • UNSURE - GO TO C AND SCORE2	B - WEIGHT LOSS SCORE • 0.5 – 5kg = 1 • 5 – 10kg = 2 • 10 – 15kg = 3 • > 15kg = 4 • Unsure = 2
		OEDEMATOUS	1	50 – 64	2		
OBESE BMI > 30	2	CLAMMY, PYREXIA	1	65 – 74	3		
		DISCOLOURED GRADE 1	2	45 – 80	4		
BELOW AVERAGE BMI < 20	3			81+	5	C - PATIENT EATING POORLY OR LACK OF APPETITE • "NO" = 0; "YES" SCORE = 1	NUTRITION SCORE If >2 refer for nutrition assessment/ intervention
BMI = Wt(Kg)/Ht(m)0/2		BROKEN/SPOTS GRADE 2-4	3				

CONTINENCE	♦	MOBILITY	♦
COMPLETE/CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g.TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SCORE
10+ AT RISK
15+ HIGH RISK
20+ VERY HIGH RISK

SPECIAL RISKS			
TISSUE MALNUTRITION	♦	NEUROLOGICAL DEFICIT	♦
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	MAJOR SURGERY or TRAUMA	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8
MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4			

Scores can be discounted after 48 hours provided patient is recovering normally

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REMEMBER TISSUE DAMAGE MAY START PRIOR TO ADMISSION, IN CASUALTY. A SEATED PATIENT IS AT RISK

ASSESSMENT (See Over) IF THE PATIENT FALLS INTO ANY OF THE RISK CATEGORIES, THEN PREVENTATIVE NURSING IS REQUIRED. A COMBINATION OF GOOD NURSING TECHNIQUES AND PREVENTATIVE AIDS WILL BE NECESSARY.

PREVENTION
PRESSURE REDUCING AIDS

Special mattress/beds — 10+ Overlays or specialist foam mattresses.
15+ Alternating pressure overlays, mattresses and bed systems.
20+ Bed systems: Fluidised bead, low air loss and alternating pressure mattresses.
Note: Preventative aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.

Cushions — No person should sit in a wheelchair without some form of cushioning. If nothing else is available — use the person's own pillow. (Consider infection risk).
10+ 100mm foam cushion
15+ Specialist Gel and/or foam cushion
20+ Specialised cushion, adjustable to individual person.

Bed clothing — Avoid plastic draw sheets, inco pads and tightly tucked in sheet/sheet covers, especially when using specialist bed and mattress overlay systems.
Use duvet — plus vapour permeable membrane.

NURSING

General — HAND WASHING, frequent changes of position, lying, sitting. Use of pillows.

Pain — Appropriate pain control

Nutrition — High protein, vitamins and minerals

Patient Handling — Correct lifting technique — hoists — monkey poles transfer devices

Patient Comfort Aids — Real sheepskin — bed cradle

Operating Table Theatre/A&E Trolley — 100mm(4 ins) cover plus adequate protection

Skin Care — General hygiene, NO rubbing, cover with an appropriate dressing

WOUND GUIDELINES

Assessment — Odour, exudate, measure/photograph position

WOUND CLASSIFICATION — EPUAP

GRADE 1 — Discolouration of intact skin not affected by light finger pressure (non-blanching erythema)
This may be difficult to identify in darkly pigmented skin

GRADE 2 — Partial thickness skin loss or damage involving epidermis and/or dermis
The pressure ulcer is superficial and presents clinically as an abrasion, blister or shallow crater

GRADE 3 — Full thickness skin loss involving damage of subcutaneous tissue but not extending to the underlying fascia
The pressure ulcer presents clinically as a deep crater with or without undermining of adjacent tissue

GRADE 4 — Full thickness skin loss with extensive destruction and necrosis extending to underlying tissue.

Dressing Guide — Use local dressings formulary and/or www.worldwidewounds.com

IF TREATMENT IS REQUIRED, FIRST REMOVE PRESSURE

Competency: Risk Management in a Paediatric Unit

OUTCOMES
• Demonstrates competency in evaluating and adhering to all principles and guidelines set for risk management of the paediatric ward.
• Confirm that the guidelines are followed and that the risk in the paediatric ward is reduced to the minimum.

RATIONALE
Evaluation of environment in paediatric ward to limit risks to the minimum

COMPETENCY REFERENCES:
This competency is based on:

1) Hockenberry, MJ. Wilson, D. Rodgers, CC. 2017. *Wong's Essentials of Paediatric Nursing*. Tenth edition. USA: Elsevier p590-593.
2) Brooker, C and Waugh, A. 2013. *Foundations of Nursing Practice*. *Fundamentals of Holistic Care.* 2nd ed. Great Britain: Elsevier p 268-276.
3) Berman, A; Snyder, S and Frandsen, G. 2022. *Kozier & Erb's Fundamentals of Nursing Concepts. Process and Practice*. 11th ed. Harlow: Pearson p729-753.
4) Heindrich II Fall Risk Assessment tool: Doc. No: NUR-WP-SF-002.

COMPETENCY STEPS	RATIONALE
Explain the reasons for specific emphasis on safety in pediatric wards.	• Purposeful, proactive initiative aiming at the prevention and mitigation of possible risks. • Safeguards the patients, employees and public against actual and potential harm. • Safeguards the health care institution against litigation and sustain service delivery productivity and functional capacity. • In pediatric wards, safety is of even bigger concern due to the absence of abstract thinking and reasoning. • Depending on the developmental age of children, they cannot respond to their names, needs, and therefore of utmost importance to identified at all times.
Define risks versus hazards.	• Risks are the probability that an injury or damage can occur. • A hazard is a source or exposure to danger.
Check and verify that clinical environment is safe	
Create a therapeutic environment.	• All measures taken in adult wards still apply (good lighting, clutter free, dry floors). • Poor lighting, clutter and wet floors are known risks for increasing the possibility of falls, even in paediatric wards. • Bells within reach. Older children must have a bell to call for help. They need to be taught to rather call than to try to help themselves and so increase the risk of falling.
Windows secured.	• Children tend to discover their environment and may fall out of an open window.
Entrance and exit doors controlled.	• It is important to control access to paediatric wards. It would be dangerous for children to wander outside of wards. • Proof of identification to enter a paediatric ward. Due to the possibility for kidnapping children. Family disputes may present situations where certain adults prohibited access to children.
Strangulation hazards managed.	• Children can easily get entangled in lose cords/tubing/wiring and strangle themselves. • Blinds, curtains and curtain cords are out of reach of children. • Ensure no electric cords, IV lines or oxygen tubing within reach of children. • No pacifiers tied around baby's necks
Electrocution/fire hazards managed	• Electric sockets are covered. • Children are curios by nature and might push their finger into the socket, exposing them to electric currents.

COMPETENCY STEPS	RATIONALE
	• Toys that generate sparks are not appropriate for children on oxygen.
Choking hazards managed.	• Disposal of all small objects. • Children tend to put objects into their mouth, noses and ears putting them at risk of choking or increased risk of infection. • E.g. needle cover, syringes. • Some toys may have small parts that children can choke on. • Latex balloon should not be allowed, if the balloon burst, the child might put small latex parts in its mouth. • Hold baby upright during feeding, no feeding lying down. Possibility of choking or aspiration is increased when child is left during feeding.
Poisoning hazards managed.	Medication trolley is not left unattended. • Children might take harmful substances and increase risk of injury. • Appropriate storage of cleaning solutions • Children are at risk of poisoning because they do not have the sense of risk and might drink cleaning solutions.
Drowning hazards managed.	• Children are never left alone in bathroom. • Children has an increased risk of falling, drowning and burning if left alone in a bathroom.
Falling hazards managed.	Furniture in working condition. • Furniture used in children's ward are sturdy and well-secured. • Children are prone to climb on furniture, play and move it around and if not secure, it might tip over or fall from it. • Children are safely strapped in feeding chair. • Cot/incubator sides are closed. – Never leave cot sides of close incubators – Prevent child from falling out of crib of incubator. • During procedures, never leave children unattended on treatment tables. • Beds are in the lowest position. – Decrease the risk of injury if the bed is set at its lowest. – Older children might play with electronic beds and set the beds to high. – Teach children not to play with electronic mechanisms of the beds
Risk of falling managed.	Baseline assessment of fall risk done on admission • To identify the increased risk of falling on admission and implement measures to prevent incidents. Written nursing care plan with measures to prevent falls. • cot sides, bells, environmental checks • Focused and individualised care in prevention of risks. Red identification belt to alert to the risk of falling. • Part of the identification of increased risk of falling to prevent falls from happening. Proof of health education to parents • Part of preventative measure to inform parents of increased risks. Good lighting in the wards during day and night • Poor lighting, clutter and wet floors are known risks for increasing the possibility of falls, even in paediatric wards.
Suffocation hazards managed.	• Sleeping conditions: – Firm sleep surface, – no pillows in cots, – supine position to sleep-in, – no-lose blankets or soft toys in cot (See Annexure 1) Increased risk of SIDS. Soft sleeping surfaces, pillows and soft toys increase the risk of smothering.
Burn injuries prevented.	Check water temperature before bathing baby. • Important to ensure that bath water is not too hot to prevent burns. Check temperature of formula feeding before feeding baby: • If infant feeding is to hot it can cause burns in mouth and throat • Do not let children in bathroom unattended.

COMPETENCY STEPS	RATIONALE
	• Small children are helpless, might open a faucet, and are burned. • Warmers and kitchen equipment should be out of reach, with no cords to pull which can cause hot fluid injuries.
Children are appropriately identified	• All children in paediatric ward must be fully identified at all times. • Small children do not have the ability to respond to their names and the possibility of medication and treatment errors are very high.
Infection risk is managed	Sharing of toys should not be allowed. • Infection spreads through toys being shared.
Child/parent teaching	Orientation to environment: • There is a decreased risk in falling if the parents and children know the environment. They are able to find their way and are more comfortable. Use call bell if assistance is needed: • It is always wise to ask for assistances especially in cases with increased risk of falling e.g. children with crutches or when they are just out of theatre. Wear non-skid footwear: • Decreases risks of falling Place bedside tables and over bed tables within reach of patient • Increased risk of falling if a child needs to stretch to get some water or reach for a toy. Keep hospital bed in low position: • Decrease the risk of injury if the bed is set at its lowest. • Never leave baby unattended on a bed. Always close cot sides: • Young children can easily fall out of cots or from a bed. Even small children can move and fall out of incubators. Evaluate suitability of toys to the situation and environment: • Help parent to bring suitable toys to hospital. Look for toys with small parts that can be removed or toys that can generate sparks and explain to the parents the dangers. Notify staff when family leaves the bedside: • Children should not be left unattended for long periods. Supervision at all times decrease risks because it can be identified and managed immediately.

Competency; Neurovascular observations

OUTCOMES
• Perform a neurovascular assessment on a patient.
• Obtain a base line to correlate future data against.
• Identify life-threatening situations and seek immediate help.

RATIONALE

This skill is integrated in the following skills and procedures:

- Admission of a patient.
- Assessment and monitoring of vital data.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

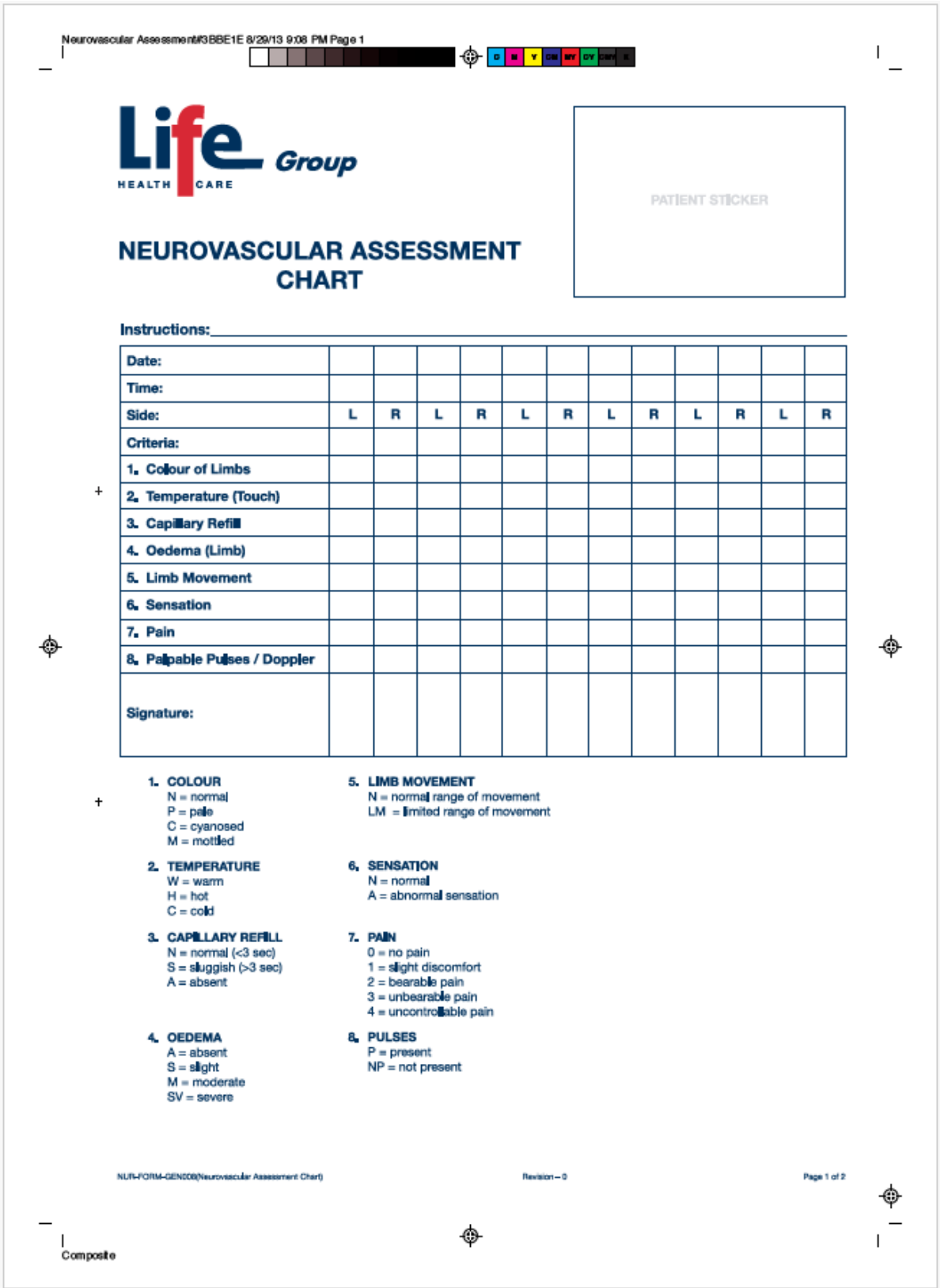
This competency is based on:

1) Life Healthcare (LHC). 2021. *Performing a Neurovascular Assessment*. Doc. No: NUR-WP-GEN-024. Life Healthcare Intranet.
2) Life Healthcare (LHC). 2022. *Patient identification*. Doc. No: NUR-POL-GEN-001. Life Healthcare Intranet.

COMPETENCY STEPS	RATIONALE/OBSERVATION
Prepare the environment and gather the needed documentation and equipment.	• Daily Assessment/Nursing Care Plan/Progress report NUR-FORM-GEN002 • Neurovascular assessment chart NUR-FORM-GEN008
Perform hand hygiene.	Adhere to Infection prevention protocols
Identify the need for performing a neurovascular assessment. • Limb injury/fractures • Vascular injuries • Trauma • Casts, splints, constrictive dressings • Limb oedema • Prolonged immobility	The need to perform the procedure and the frequency is determined by the patient's condition and or comorbidities.
Introduce yourself to the patient and explain the procedure.	Ensure the patient is familiar with the nurse and feels comfortable.
Identify the patient.	Ensure the correct patient is receiving nursing care.
Obtain informed consent to perform the procedure.	Adherence to legal obligation of obtaining informed consent before performing a procedure.
Ensure all nail polish and dirt is removed from the hands. Remove all jewellery.	Nail bed should be visible for the assessment. Jewellery could be constricting and could affect the outcome.
Perform a neurovascular assessment on the unaffected limb first.	This establishes a baseline on a normal or full function limb. Comparison between the limbs will determine any abnormalities.
Assess colour of the limbs.	• Compare with both right and left limbs. • Determine patient's skin tone – to identify possible deviation from the patient's natural skin colour. • Observe for any signs of cyanosis (bluish discoloration of the skin). • Observe for any pallor (paleness of the skin). • Dusky, cyanotic, mottled, or purple black coloration may indicate inadequate venous return. • Shiny and pale skin may indicate swelling.
Assess temperature of the limbs.	• Compare both right and left limbs. • Use the back of the hand to touch the patient's skin and determine the temperature of the limb. • Skin should be warm to touch. • Cold pale skin may indicate inadequate arterial blood supply. • Warm and cyanosed skin may indicate venous insufficiency.

COMPETENCY STEPS	RATIONALE/OBSERVATION
Assess capillary refill.	• Compare both right and left limbs, all fingers and all toes. • Apply pressure to the nailbeds. • Once blanching is visible, release and determine the time taken for blood flow back/ refill to the area. • Normal refill should take less than, or up to 3 seconds. • Longer than 3 seconds can indicate poor vascular perfusion.
Assess oedema of the limbs.	• Compare both left and right limbs. • Excessive swelling can cause neurovascular compromise.
Assess limb movement.	• Compare both left and right limbs. • Determine if the patient has had local anaesthesia to the affected limb. • Request the patient to move the limb, both affected and unaffected side. • Determine if the movement is limited or normal.
Assess sensation.	• Compare both left and right limbs. • As patient if they can feel the extremities. • Ask what sensation they feel when you touch both the proximal and distal ides of the limbs. • Is there a lack of feeling, numbness or a tingling sensation?
Assess pain.	• Compare both left and right limbs. • Use the pain assessment score as indicated on the assessment tool. • Assess pain specifically according to location, nature and intensity.
Assess pulses.	• Compare both left and right limbs. • Palpate upper extremity pulses (brachial, radial and ulnar). • Palpate lower extremity pulses (femoral, popliteal, posterior tibialis, and dorsalis pedis pulses). • Palpation of the pulses distal to the injured part and compare to the opposite side. • Document if measurement of pulse is hindered by a cast. • Document the strength of the pulse.
Keep clear accurate and legal documentations.	Part of the nurse's function is to keep clear and accurate records. This includes documenting all areas of neurological assessment and reporting a change in the patient's condition to the doctor and nursing team. Document on relevant forms and in the patients Daily Assessment /Nursing Care Plan /Progress Report NUR-FORM-GEN-002. • Ensure accurate recording of assessments, interventions, and outcomes are made. • Record health education that has been given to the patient and the family. • Ensure planned care is documented and interventions are recorded as they are implemented. • Clearly document your name, initials, surname, and designation in all records.

ADDENDUM:
Addendum 3: Neurovascular Assessment Chart



Neurovascular Assessment#3BBE1E 8/29/13 9:08 PM Page 1

Life Group HEALTH CARE

PATIENT STICKER

NEUROVASCULAR ASSESSMENT CHART

Instructions:_____

Date:												
Time:												
Side:	L	R	L	R	L	R	L	R	L	R	L	R
Criteria:												
1. Colour of Limbs												
2. Temperature (Touch)												
3. Capillary Refill												
4. Oedema (Limb)												
5. Limb Movement												
6. Sensation												
7. Pain												
8. Palpable Pulses / Doppler												
Signature:												

1. COLOUR
N = normal
P = pale
C = cyanosed
M = mottled

2. TEMPERATURE
W = warm
H = hot
C = cold

3. CAPILLARY REFILL
N = normal (<3 sec)
S = sluggish (>3 sec)
A = absent

4. OEDEMA
A = absent
S = slight
M = moderate
SV = severe

5. LIMB MOVEMENT
N = normal range of movement
LM = limited range of movement

6. SENSATION
N = normal
A = abnormal sensation

7. PAIN
0 = no pain
1 = slight discomfort
2 = bearable pain
3 = unbearable pain
4 = uncontrollable pain

8. PULSES
P = present
NP = not present

NUR-FORM-GEN008(Neurovascular Assessment Chart) Revision – 0 Page 1 of 2

Composite

SkillSampling of Urine for Urine Analysis from an Indwelling Catheter

OUTCOMES: The student will demonstrate competence in:

- Collecting urine from an indwelling catheter.

RATIONALE

This competency is integrated in the following skills and procedures:

- Midstream Urine collection in male patients.
- Midstream Urine collection in female patients.
- Therapeutic environment
- Patient identification
- Execution of a nursing care plan

COMPETENCY REFERENCES:

1) Life Healthcare (LHC). 2022. *The collection of clinical specimens for microbiological analysis*. Doc. No: IPC-WP-S-232. Life Healthcare Intranet.
2) Mogotlane, S. M, Manaka-Mkwanazi, I. M, Mokoena, JD, Chauke, M. E & Randa MB. 2015. *Juta's Manual of Nursing Volume 2. The Practical Manual.* 2nd ed. Lansdowne: Juta & Co.

PERFORMANCE CRITERIA	RATIONALE
Identify the patient and label the specimen bottle with patient details, date and time.	To ensure that the correct patient receives the treatment • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Check the prescription chart.	To determine the urine sampling method and rationale for sampling (sample type required e.g. midstream, closed drainage system, creatinine clearance, collecting from urostomy)
Explain the procedure and obtain informed consent.	To ensure the patient understands the procedure and is given the opportunity to ask any questions.
Ensure patient privacy.	To ensure patient dignity.
Collect appropriate equipment: • Sterile syringe to aspirate the urine from the catheter port. • PPE (apron, non-sterile gloves, goggles). • Urine specimen container.	Adequate preparation is necessary to save time and to ensure nurse and patient safety.
Perform hand hygiene through hand wash/hand rub.	Prevent the incidence of hospital associated infections.
Donn PPE: non-sterile gloves, apron, goggles (optional).	Refer to Donning and doffing PPE skill.
Disinfect the sampling port with an alcohol swab and allow it to dry.	Reduces the risk for infection through microorganisms entering the port.
Collect sample without contamination by attaching the syringe to the port. When fresh urine appears in the tubing, aspirate the specimen into the syringe. *Do not break the closed system or disconnect the tubing to collect the specimen.*	Application of correct psycho-motor skills for collecting a urine sample. Reduce the risk of infection and microorganisms entering the portal.
No clamping of catheter is advised.	Only use the clamping of tubing technique if urine sample is urgently required. Unclamp the tubing immediately after urine sample has been obtained.
Transfer urine to urine specimen container and secure the lid without contamination.	Transfer the specimen to the appropriate container without contamination of specimen. Securing the lid reduces the risk of spillage or contamination.
Ensure the urine specimen is labelled correctly.	To prevent medico-legal hazards. • patient details, • date and time.

Competency: Sampling of Urine for Urine Analysis - Midstream Urine collection

OUTCOMES: The student will demonstrate competence in:

- Collecting midstream urine from a male and female patient.

RATIONALE

This competency is integrated in the following skills and procedures:

- Midstream Urine collection in male and female patients.
- Collection of urine from an indwelling catheter.
- Therapeutic environment.
- Patient identification.
- Execution of a nursing care plan.

COMPETENCY REFERENCES:

1) https://geekymedics.com/urinalysis-osce-guide/ [Accessed 25 February 2020]
2) Life Healthcare (LHC). 2021. *Performing a Neurovascular Assessment*. Doc. No: NUR-WP-GEN-024. Life Healthcare Intranet.
3) Internal LHC policies: Sluice room management Doc. No: IPC-WP-S-231
4) Mogotlane, S. M, Manaka-Mkwanazi, I. M, Mokoena, JD, Chauke, M. E & Randa MB. 2015. *Juta's Manual of Nursing Volume 2. The Practical Manual.* 2nd ed. Lansdowne: Juta & Co.
5) Urine colour. https://www.mayoclinic.org/diseases-conditions/urine-color/symptoms-causes/syc-20367333?page=0&citems=10 [Accessed 25 February 2020]
6) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 646 - 664

COMPETENCY STEPS	RATIONALE
Gather all the relevant equipment/stock for the procedure: • Sterile urine specimen bottle (laboratory) • Clean urine container • Bedpan (if applicable) • Non-sterile gloves • Bowel, soap, water and washcloth	Planning for the procedure and having the appropriate equipment ensure adequate time management.
Introduce self and identify the patient. Label the specimen bottle with patient details, date and time.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Explain the procedure and obtain informed consent.	Ensure the patient understands the procedure and is given the opportunity to ask questions.
Check the prescription chart.	• To confirm sample collection method (sample type required e.g. midstream, closed drainage system, creatinine clearance, collecting from urostomy) • Identify correct procedure is carried out on the correct patient
Ensure patient privacy throughout the procedure.	Patient dignity is maintained.
Assist the patient to carry out the procedure if required. Assistant to wear non-sterile gloves.	To ensure patient safety.
Instruct the patient to perform hand hygiene with soap and water before the sample is obtained.	Factors that could contribute to contamination of urine analysis results have been identified and managed.
Give instructions to the patient on the appropriate position.	• In a female patient, instruct the patient to squat over the bedpan or toilet to allow easy access to urine. • In a male patient, the patient can stand if permitted or sit in the bed.
Allow the patient to independently clean the meatus area by separating	The urethral meatus and surrounding area are cleaned from any residue that could contaminate the specimen.

COMPETENCY STEPS	RATIONALE
the labia (female) or pulling back the foreskin (male). Use soapy water and rinse with clean water. If unable to perform the task independently, the nurse can assist using aseptic technique. In a male patient the foreskin must be returned to its original position.	Maintains patient dignity and comfort.
Instruct the patient to first pass urine into the bedpan/urinal/toilet. Stop mid-stream and pass the remainder of the urine into the urine container provided (clean catch). Any excess urine can be passed into the bedpan/urinal/toilet. Do not hand the patient the sterile specimen container.	Apply principles and correct techniques to obtain sample accurately. The outside of the container may be contaminated.
Transfer the urine into the urine specimen container without contamination.	Transfer the specimen to the appropriate container without contamination of specimen. Securing the lid reduces the risk of spillage or contamination.

Competency: Enteral Feeding

OUTCOMES: The student will demonstrate competence in:
• Maintaining the nutritional status of a patient who is receiving enteral feeds.
• Perform focused patient assessment to identify tube related health problems timeously.
• Implement efficient actions to prevent them from occurring.
• Understands potential risks and complications underlying the procedure.

RATIONALE

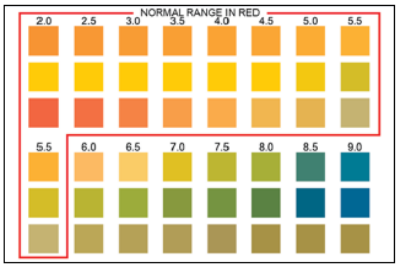
This competency is integrated in the following skills and procedures:

- Nurse a patient with an enteral feeding tube
- Feeding a patient with an enteral tube

COMPETENCY REFERENCES:

1) Life Healthcare (LHC). 2024. *Insertion and Management of a Nasogastric Tube and Enteral Feeding in an Adult*. Doc. No: NUR-WP-GEN-022. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 1025 – 1047
3) South African Department of Health. 2016. *National Enteral Nutrition Practices*. Phila. [Accessed on 20 November 2024]. https://criticalpoint.co.za/wp-content/uploads/2016/10/DOH-enteral-nutrition-guidelines.pdf
4) Perry, A.G., Potter, P.A., Ostendorf, W.R. 2024. Clinical Nursing Skills & Techniques. Elsevier: St. Louis. Pg 943 – 960
5) Aldughayfiq, B., Ashfaq, F., Jhanjhi, N.Z. and Humayun, M., 2023, April. Yolo-based deep learning model for pressure ulcer detection and classification. In *Healthcare* (Vol. 11, No. 9, p. 1222). MDPI.

COMPETENCY STEPS	**RATIONALE**
ENTERAL FEEDING:	
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Check the prescription chart for clinical orders and feeding instructions (doctor/dietician).	• To determine the indication for enteral tube insertion. • To ensure the patient receives the correct nutritional support.
Describe the indication for this patient to receive enteral support.	Enteral support (feeding) benefits nutritionally depleted patients or those at risk of becoming depleted. These individuals need to be identified. At its simplest, nutritional screening involves consideration of a patient's weight for height and recent history of weight loss. However, nutritional support should also be considered in all patients with excessive nutrient losses e.g., vomiting, diarrhoea, or fistulae, along with those who have high potential demands for nutrients including surgical stress, trauma, infection, metabolic disease, and bedsores. Further considerations would be: • Prolonged anorexia is related to chronic illness. • Severe protein-energy undernutrition. • Liver failure. • Inability to take oral feedings due to head or neck trauma. • Critical illnesses e.g., a patient with burns, causing metabolic stress. • Unable to consume adequate nutrients. • Impaired swallowing/ sucking. • Facial or oesophageal structural abnormalities. • Eating disorders. • Increased nutritional requirements. • Congenital anomalies. • Primary disease management

COMPETENCY STEPS	RATIONALE
Before administrating any feed, the enteral tube must be checked for correct placement/position. ○ Determine any change in length of the external portion of the tube by observing the exit site marked with a permanent marker (done on insertion). ○ Check nursing progress records for measurement comparison. ○ If no marking is observed, pH test strip testing with gastric aspirate can be used. ○ Use a 60 ml syringe to obtain a small amount of gastric aspirate. Use the pH stick to determine the pH.	• Misplaced tubes can occur in the oesophagus, duodenum or lungs. • Action is required to prevent aspiration. • Gastric aspirate pH should be more acidic.
<u>pH Indicator testing instructions:</u> ○ Aspirate the gastric fluid sample Remove a test strip from the bottle ○ Drop gastric fluid onto the test strip, keeping the strip horizontal until the reading. ○ Wait 15-60 seconds for the colour change (no more than 60 seconds) ○ Compare the colour change on the strip to the bottle.	 *<u>FIGURE 1: pH colour range indicating expected normal range (Outlined in red).</u>*
Obtain a baseline pulse oximetry reading and observe for any signs and symptoms of respiratory distress e.g. coughing, reduced saturation, cyanosis.	• Baseline is used to compare with oximetry changes in determining if the tube has been misplaced into the trachea.
Position the patient in high-Fowler's position or elevate the head of the bed at least 30-45 degrees. If the patient's condition permits supine position, the patient can be placed in Trendelenburg position to elevate the head.	• Elevating the head reduces the risk for gastric aspiration.
The correct method has been selected for administration of the nasogastric feed.	• Feeds can be administered via a *syringe*, *gravity feeding set*, or *feeding pump*. The method selected is dependent on the nature of the feed and the clinical status of the adult. There is limited evidence available to support one method of feeding over the other. • Feeds should be recommended and ordered by the doctor and/ or dietitian, considering the nutritional needs and clinical condition of the patient. • Do not administer feeds through enteral tubes that are being used for aspiration or are on free drainage.
Feeding pump method	
The student collects the correct administration set, consumables and feeding administration pump. Follow the feeding administration pump manufacturer's instructions.	• Patients must be provided with the most appropriate feeding pump. • Pumps should be kept clean and serviced to ensure functionality when needed.
Perform hand hygiene and don non-sterile gloves.	Appropriate infection control principles applied.
Verify the correct feeding formula and check the expiration date. The formula	• Integrity and condition of the formula is determined before administration to the patient to eliminate any medico-legal risks.

COMPETENCY STEPS	RATIONALE
must be administrated at room temperature.	• Administrating cold formula can cause discomfort and cramping.
The student uses aseptic technique when connecting the formula and administration set.	• Contamination of connections, tubing and formula bag introduces micro-organisms to the patient.
The student threads the administration set tubing through the infusion pump and titrates the rate/ volume of an enteral feed correctly as per the doctor or dietitian's prescription.	Check dieticians' prescription and program the volume of feed that should be administered per hour through the feeding pump.
After feeding the administration set must be: Rinsed with 30 ml warm water (tap or sterile) or every 4 hours for continuous feeding. Ensure the tip of the giving set is covered between uses.	Rinsing the tube with water clears the tubing of the feeding formula.
Syringe feeding method	
The students explain how they will check if the patient is tolerating feed the feed.	• Observe the patient's response during the tube feeding. • Assess for signs and symptoms of abdominal distress, which may indicate food intolerance: • Abdominal cramping & distension. • Nausea and vomiting. • Diarrhoea. • Dumping Syndrome. • Regurgitation of food and medicine. • Uncontrolled blood glucose levels. • Weight fluctuations. • Malabsorption/ maldigestion. • Aspiration. • Tube malposition. • Tube clogging. • Skin pressure injuries (around the site of the tube).
The student notifies the registered nurse in charge if, the patient is not able to tolerate the feed.	Early recognition of warning signs indicating intolerance would ensure early intervention to limit complications and risks to the patient.
If the tube is blocked, flush the tube in a pulsating manner (push/ pull) with 10-20ml of warm water. It may be appropriate to allow the warm water to soak, by clamping/ capping the tube to assist with unblocking the tube.	• Interaction between gastric acid, enteral feed, and medications. • Interactions between medications if the tube is not flushed between medications. • Inappropriately prepared medications e.g., inadequately crushed tablets. • The small internal diameter of the tubes and longer tubes. • Binding of medication to the tube. • The viscosity of some liquid preparation. • Poor flushing technique. • Bacterial colonization of the nasogastric tube.
After feeding is complete confirm tube placement.	• Movement and feeding can cause tube movement. Checking the placement after feeding, eliminates the risk to the patient for aspiration.
Complete the relevant documentation to record the procedure performed: ○ Type and volume of feed ○ Patient tolerance of feeding ○ Placement confirmed ○ Any abnormalities observed ○ Reporting	All relevant entries should be recorded in the nursing notes. Clear and accurate monitoring of intake and output is required.

Competency: Prevention and Management of Pressure complications and injuries.

OUTCOMES
• Apply effective measures to avoid or minimize the formation of pressure injuries in a patient.
• To be able to perform pressure part care on a patient.
• To be able to identify and plan for patients at risk of developing pressure injuries.

RATIONALE

This competency is integrated in the following skills and procedures:

- Admission of an adult patient
- Risk assessment – Skin integrity

COMPETENCY/ skills REFERENCES:

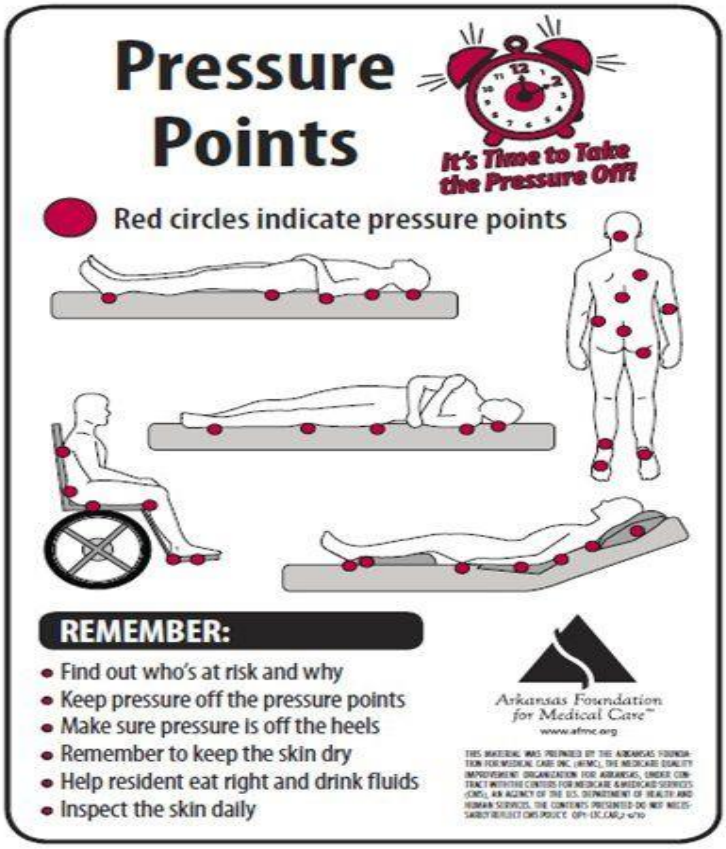
1) Life Healthcare (LHC). 2021. *Fundamentals of care: Prevention and management of pressure complication and injuries*. Doc. No: NUR-WP-GEN-029. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 103 - 119
3) Martin. P. 2023. 5 Pressure Injuries (bedsores): Nursing Care Plans. Available on Nurseslabs.com

COMPETENCY STEPS	RATIONALE
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Explain the procedure and obtain informed consent to do the procedure.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Ask permission to gain patient's cooperation's.
Review the patient's Waterlow risk assessment and interpret the patient's Waterlow score.	Assess the patient's risk to develop a pressure injury. Determine the patient risk score. **Low risk** – Waterlow Pressure Ulcer Risk assessment score of <10 **At risk** – Waterlow Pressure Ulcer Risk assessment of 10+ **High risk** – Waterlow Pressure Ulcer Risk assessment of 15+ **Very high risk** – Waterlow Pressure Ulcer Risk assessment 20+
Evaluate the nursing care plan.	Obtain the prescribed times that pressure care should be done.
Gather and prepare needed equipment.	Prepare a dressing trolley with the following: • Basin with warm water • Extra daily towel / face cloths • Soap • Towel to dry the skin Where applicable • Wet Wipes • Ointments /barrier creams • Linen savers • Nappies • Clean linen
Provide patient privacy.	Protect patients' privacy and maintain dignity by drawing the curtains.
Perform a head-to-toe skin assessment and compare findings to previous skin risk assessment.	Inspect the skin for: • discoloration, • swelling, • blisters, • dryness, • shiny areas, • cracks. • Assess areas on the patient's skin where medical devices are in prolonged contact with the patient's skin. • Pressure needs to be relieved in these areas through the implementation of specific interventions and protocols. Palpate the skin to feel for:

COMPETENCY STEPS	RATIONALE
	• hard areas, • warm areas • swollen areas over bony joints Note the areas at risk. **See Addendum A.**
Don appropriate PPE: ○ Plastic apron ○ Non-sterile gloves	• Place a plastic apron to prevent contamination to uniform. • Don non-sterile gloves to protect yourself against body fluid exposure
Explain the procedure to both the patient and your helper.	• Talk loud and clear by explaining which side the patient will be turning onto 1st. • To gain the patient's cooperation and to assist in the smooth running of the process.
Turn the patient on one side and pull up the cot side on the side the patient will face towards. Instruct the patient to hold onto the cot side.	Effective planning will allow the patient to assist as much as possible, which encourages independence, but also assist the nurses when turning.
○ Ensure the patient's skin is not pushed up against hard metal.	Eliminate any risks for injury or discomfort.
○ Work quickly and effectively. ○ Keep the patient covered, only expose the area that will be treated.	Unnecessary or prolonged exposure to the environment could cause loss of body heat and result in hypothermia.
Assess the patient's back.	Inspect the • back, • shoulder blades, and, • sacral area for • redness, • warmth of skin, • leathery appearing skin. **See Addendum C** for examples of pressure sore formation.
Wash the patient's buttock area if needed.	• Ensure the patient is cleaned in the presence of stool of leaked urine. • Wash the area with soap and water, as per bebathing procedure. • Dry the area well. • Note and report on urinary and or stool incontinence
Apply barrier cream as indicated.	• Apply barrier cream to back, shoulder blades and sacral area. • Ensure to concentrate on the areas at risk.
Ensure linen is changed where needed. If visibly soiled, change the soiled sheets. Push a new linen saver ½ way under the patient.	Moisture from body fluids exposes the skin to breakdown.
Assist the patient to gently roll over to the other side. Monitor the patient for cues of pain or discomfort and provide reassurance. Avoid dragging the patient over the sheet and remove all creases from the linen.	Dragging the skin over the linen can cause shaving resulting in broken skin.
Pull up the opposite cotside on the side the patient is facing.	Effective planning will allow the patient to assist as much as possible, which encourages independence, but also assist the nurses when turning.
Remove all dirty linen.	• The helper to remove all dirty linen and straighten new linen and reposition patient. • Do not touch uniform with soiled linen. • Place patient in a comfortable position on the identified side. **See Addendum B** for examples of a turning wheel.

COMPETENCY STEPS	RATIONALE
Dispose linen according to the linen management policy and waste management policy	• Effective infection control measures applied to prevent cross contamination.
Provide patient/family with advice on how to prevent a pressure sore injury.	Give health care advise to with the patient and or the family. See **Addendum D.**
Ensure all patients needs are met before leaving the room.	• Offer patient something to drink (if allowed). • Ensure call bell is within reach. • Ensure cot sides are pulled up (in needed). • Ensure patient is comfortable and all needs are met.
Maintain legal reporting structure	Report any areas noted of concern immediately to the UM/shift leader or RN.
Make suggestions towards the existing nursing care plan.	• Frequency • Use of pressure relieving devices • Mobility • Skin care products etc.
Record findings and actions	Maintain legal and accurate nursing notes. Complete all the relevant forms.

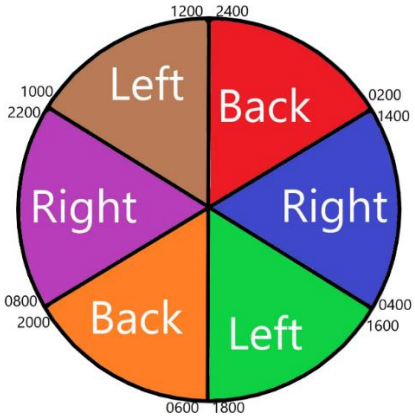
ADDEDNDUM
Addendum A:
Areas at risk to develop a pressure ulcer



Picture courteous of: Nursing Student Tips

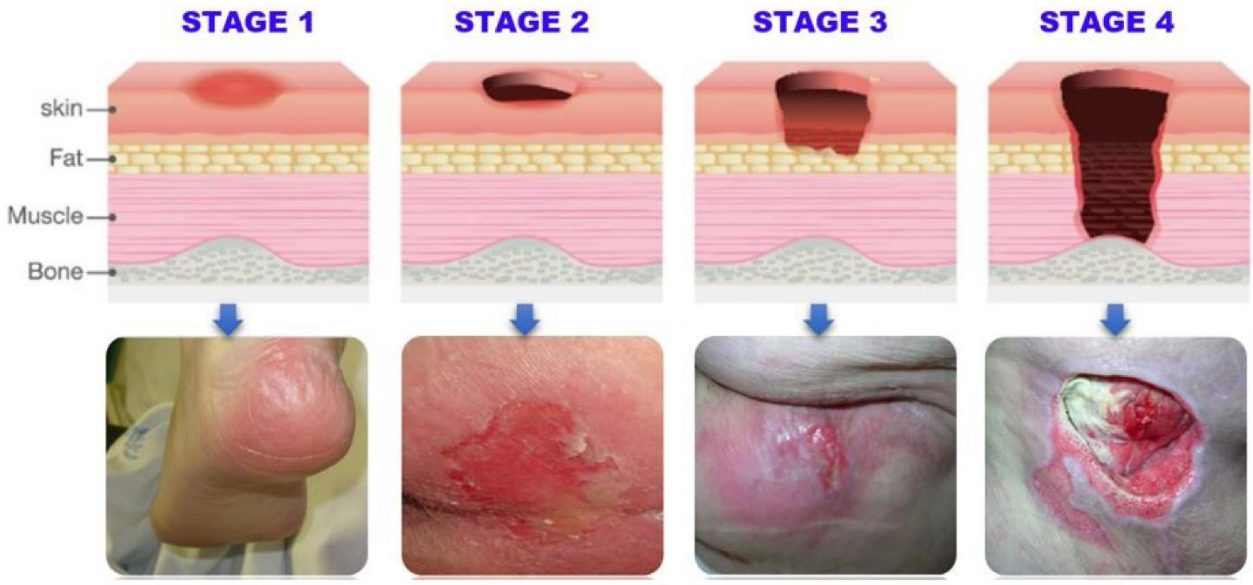
Addendum B
Example of a turning wheel.

Turning Wheel
A turning wheel is a guidance tool that can be utilised in all units to act as a visual reminder of turning times and position changes, as well as correct tracking and monitoring of patient position. During the time indicated the patient should be positioned according to the wheel (if not contra-indicated).
• 00:00 – 3:00 (12:00 – 15:00): Patient nursed lying on back
• 03:00 – 6:00 (15:00 – 18:00): Patient nursed on left side
• 06:00 – 9:00 (18:00 – 21:00): Patient nursed lying on back
• 09:00 – 12:00 (21:00 – 00:00): Patient nursed on right side



Ref: Preventing Pressure Ulcers Turn Clock tool

Addendum C
The Stages of Pressure Ulcer



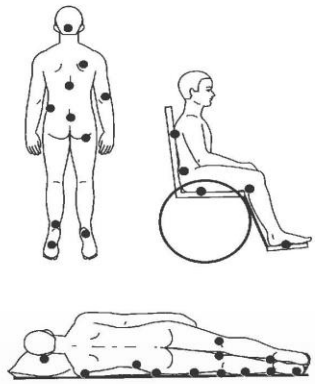
Picture courteous of: (Aldughayfiq *et al*, 2023).

Addendum D
Information to the patient.

WHERE CAN YOU GET A PRESSURE ULCER?

Pressure ulcers can happen anywhere on the body that there is pressure or rubbing.

Usually, they occur over the bony areas shown in the diagrams below.



HOW DO I KEEP MY SKIN HEALTHY?

- Move your body every 15 minutes when you are sitting and when you are in bed.
- Turn your body every 2–4 hours when you lie in a bed.
- Avoid positions that press on red or purple areas.
- Keep your heels from rubbing or resting on the bed.
- Eat healthy meals.
- Drink lots of water.
- Keep your skin clean and dry.
- Wash your skin every day with water, unscented soap and a soft cloth. Pat your skin dry.
- Moisten your skin with unscented lotions twice a day.
- Be active.
- Exercise and move as much as you are able.
- If you smoke, try to quit or cut down.

If you have any questions, contact your nurse, occupational therapist, physical therapist or dietitian.

826219 Feb 27-15

Interior Health
For your whole life

Preventing Pressure Ulcers

Preventing Pressure Ulcers pamphlet for patients and families: Courteous of BCPSLSCentral.

Competency: Urine analysis

OUTCOMES: The student will demonstrate competence in:
• Explaining the indications for testing and reasons for ongoing monitoring of urine at the bedside.
• Demonstrating knowledge of the ranges for normal blood glucose levels.
• Using the correct technique to obtain a urine sample.
• Initiating and executing appropriate and correct interventions on interpreted findings.

RATIONALE

This competency is integrated in the following skills and procedures:

- Admission of a patient.
- Assessment and monitoring of vital data.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

This competency is based on:

1) Berman, A., Snyder, S.J. and Frandsen, G. 2016. Kozier & Erb's fundamentals of nursing: concepts, process, and practice. 10th ed. Boston: Pearson.
2) https://geekymedics.com/urinalysis-osce-guide/ [Accessed 25 February 2020].
3) Urine colour. https://www.mayoclinic.org/diseases-conditions/urine-color/symptoms-causes/syc-20367333?page=0&citems=10 [Accessed 25 February 2020].
4) Internal LHC policies: Sluice room management Doc. No: IPC-WP-S-231.
5) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 673 – 688.

For this competency, obtain a urine sample from a patient before doing the assessment in the sluice room. Identify the specimen appropriately.

COMPETENCY STEPS	RATIONALE AND STANDARD
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Explain the procedure and obtain informed consent.	Ensure the patient understands the procedure and is given the opportunity to ask questions.
Describe the indication for performing urine analysis.	• Explain patient-specific indications for collecting and testing the urine specimen. • Evaluate the applicability of current nursing care plan against the patient context and indications to test urine.
Assemble all necessary equipment and stock. ○ Second-hand watch ○ Pen & paper ○ Clean disposable paper towel ○ Clean disposable gloves ○ Check that the dipstick bottle is well sealed to keep organisms and moisture out ○ Ensure that the drying agent is still in the container ○ Check expiry dates (urine dipsticks) ○ Chemical analysis - urine dipsticks	Adequate planning for the procedure allows for prerequisites for urine collection to be met.
Prepare a clean area in the sluice room.	Ensure no contamination of urine sample occurs.

COMPETENCY STEPS	RATIONALE AND STANDARD
Apply Personal Protective Equipment (PPE). ○ Clean non-sterile gloves	Appropriate infection control measures in place to minimalise cross-infection.
Assess physical properties of the urine specimen.	**Physical urine properties:** Colour: normal **urine** is clear and has a straw-yellow colour Pigments and other compounds in certain foods can change your urine **colour** such as: • Pink and red - berries, beetroot • Reddish orange - medications such as Rifampin (Rifadin, Rimactane), Phenazopyridine (Pyridium), and laxatives containing senna. • Orange - sulfasalazine (Azulfidine); phenazopyridine (Pyridium); some laxatives; and certain chemotherapy drugs. • Bue or green - amitriptyline, indomethacin (Indocin, Tivorbex) and propofol (Diprivan). • Dark brown or cola-coloured urine - eating large amounts of fava beans, rhubarb or aloe, antimalarial drugs chloroquine and primaquine, antibiotics metronidazole (Flagyl) and nitrofurantoin (Furadantin), laxatives containing cascara or senna, and methocarbamol, Extreme exercise because muscle injury from extreme exercise can result in pink or cola-coloured urine and kidney damage. **Medical conditions** causing changes in urine colour: • Red or pink urine – haematuria related to urinary tract infections, an enlarged prostate, cancerous and noncancerous tumours, kidney cysts, long-distance running, and kidney or bladder stones. • Orange - can indicate a liver or bile duct conditions, especially if you also have light-coloured stools, dehydration. • Blue or green - Familial benign hypercalcemia, a rare inherited disorder. Green urine caused by pseudomonas bacteria. Dyes used in endoscopic procedures. • Dark brown or cola-coloured urine - liver and kidney disorders, extreme exercise, pyelonephritis. • Cloudy urine - urinary tract infections and kidney stones. **Odour**: urine usually has a distinct odour, and the **odou**r is relatively mild and not too noticeable. Medical conditions causing changes in urine odour • Ammonia odour - if urine becomes highly concentrated. Dehydration causes a high level of waste products with little water. • Some foods and medications, such as asparagus or certain vitamins, can cause a noticeable urine odour, even in low concentrations. • Offensive urine odours caused by medical conditions such as a fishy-smell due to urinary tract infections, urethritis, liver failure, or a pungent smell due to existence of gastro-intestinal-bladder fistulas. • Metabolic disorders such as uncontrolled Diabetes type II, Diabetic ketoacidosis cause an abnormally sweet urine odour. **Sediments and transparency** - normal healthy urine has no sediments and should be transparent. • Medical conditions causing changes in transparency of urine. • Foamy urine – needs further investigation for medical conditions especially if associated with other manifestations such as albuminuria/proteinuria, oedema of limbs, changes in urine

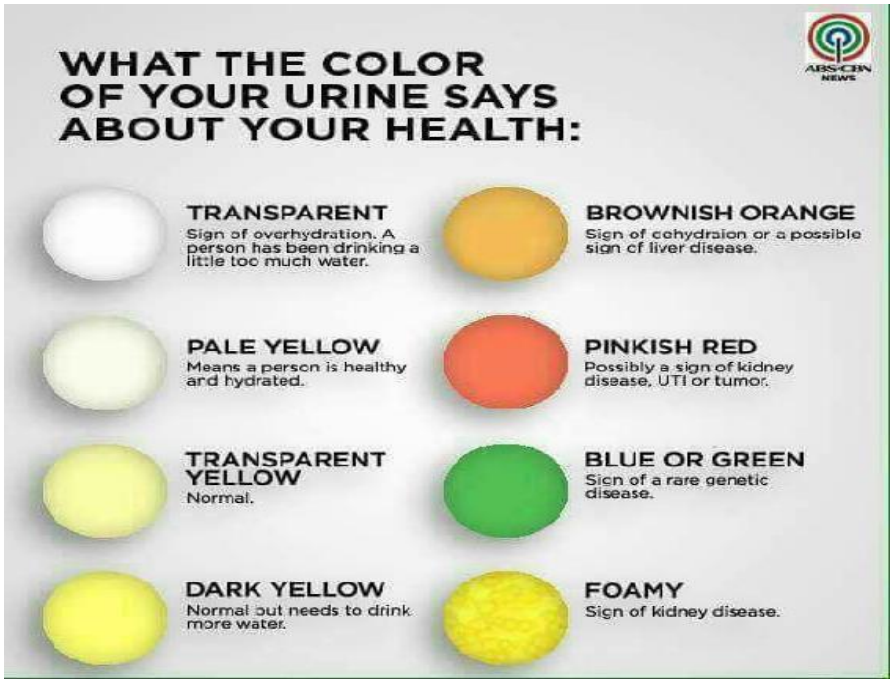
COMPETENCY STEPS	RATIONALE AND STANDARD
	volume output, cloudy urine, concentrated urine, fatigue, nausea, vomiting, male sexual dysfunction and infertility. • Sediment in urine can be made up of a variety of substances, including sloughing of tissue (debris), crystals, casts, small stones, or cells. The most common cause of sediment in the urine is urinary tract infections when urine contains white blood cells or pus • Cloudiness in urine –urinary tract infections, vaginitis and STI's such as gonorrhoea may contaminate the urine sample, making the urine to appear cloudy. Other conditions associated with cloudy urine include bladder stones, Calcium Pyrophosphate, Crystals, Glomerulonephritis, Nephrotic syndrome, retrograde ejaculation, urethritis, uric acid crystals, (hyperuricemia) **See annexure A for chemical urine properties** **See annexure C for physical urine properties.**
Remove reagent strip from container. Remove one testing strip from the container (avoid touching the testing zones).	To prevent contamination of the urine sample, which will affect the results.
Close the container immediately.	Close container tightly without contaminating the inside of the lid. To protect left over strips from direct sun light.
Immerse the test strip urine specimen.	Immerse test strip into urine sample for a duration of __ seconds or remove immediately (ensuring all test zones are immersed)
Remove excess urine: ○ Remove the strip, ensuring to turn the strip to allow residual urine to flow onto the paper towel. ○ Do not touch bottle with the urine strip (contamination). ○ Dab the strip horizontally on its side on the paper towel to prevent mixing of chemical agents.	Residual urine will cause the test strip colours to mix cross contamination of the testing zones, resulting in an inaccurate reading.
Wait the required time.	A time limit is allocated to each test area (as per manufacturer guidelines). This time limit allows the test strip colour change to occur. If the test strip is read to early or too late it will affect the reading.
Read the results. Keeping the test strip horizontally, use the dipstick analysis guide on the side of the testing strip container to interpret the findings. Do not allow the test strip to touch the bottle and read the strip after the exact time has expired.	Contamination of the bottle will result in wastage if the test strips if the bottle would need to be discarded. **See annexure B for test strip reading**
Interpret test results to the assessors. State the readings clearly. Link the reading to patient's current condition.	**See annexure A for interpretation.**
Dispose waste correctly.	Effective waste management limits cross contamination.
Document findings in the appropriate documentation and document on the output chart.	Effective documentation of continuous nursing care provided.
Report any abnormal findings to the RN.	Timeous reporting results in early recognition of early warning signs.

Annexure A
Chemical urine properties

CHARACTERISTICS	NORMAL FINDINGS	POSSIBLE SIGNIFICANCE OF ABNORMAL FINDINGS
Colour	Pale straw colour to deep amber	• Dark urine indicates dehydration. • Blood in the urine is bright red. • Bilirubin in the urine gives a brown/green colour. • Certain foods or drugs may influence the colour. • Beetroot colour urine pink. • Rifampicin cause orange/red urine.
Clarity	Usually clear	• Cloudiness or debris can indicate presence of pus, protein or white blood cells. • Need further investigation.
Odour	Freshly voided urine has a slight aromatic odour but does not smell. Stale urine might smell of ammonia	• A fishy smell would indicate infection. • Pear-drop smell indicate ketones in the urine. • Certain foods can produce a characteristic odour.
Specific gravity	Normal range is: 1.000 – 1.025	• Anything above 1.025 the urine is concentrated – patient is then dehydrated. • Anything below 1.000 the urine is diluted – patient is over hydrated.
pH	The pH is normally acidic 5 – 8	• Very acidic urine may suggest urinary stone formation. • Alkaline urine suggests an infection with certain bacteria.
Protein	Negative	• Glomerular/renal damage. • Urinary tract infection.
Blood	Negative	• Problems in urinary tract. • Kidney stones. • Cancers of the Urinary tract. • Menstruation in female patients.
Glucose	Negative	• Diabetes mellitus. • Corticosteroids. • Gestational Diabetes. • Excessive glucose intake.
Ketones	Negative	• Prolonged vomiting, fasting, starvation and poorly controlled diabetes mellitus.
Urobilinogen	Small amounts can be found in urine	• Liver damage, abnormal breakdown of red blood cells • Decreased bilirubin indicates biliary tract obstruction.
Bilirubin	Negative	• The presence of bilirubin can indicate liver disease or biliary obstruction.
White blood cells	None	• Associated with UTI but can also indicate severe renal problems.
Nitrates	Negative	• A positive test for nitrite is associated with bacteria.

Annexure B
Test strip reading

Annexure C
Physical urine properties



Skill: Changing (replacing) an IV Solution

OUTCOMES: The student will demonstrate competence in:

- Demonstrate efficient execution of psychomotor skills, using the correct principles and techniques to replace an empty IV bag (vaculitre) with a new one.

RATIONALE

This competency is integrated in the following skills and procedures:

- Assessment of a patient.
- Calculation of intake and output.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

1) Joubert, A, Olivier, N. 2020. Practical Guide for general Nursing Sciences. 2nd Edition. Pearson South Africa.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 956 - 1023

SKILLS STEPS	RATIONALE
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address. Correct specimen obtained to prevent medico-legal risks.
Explain the procedure to the patient.	Ensure the patient understands the procedure and is given the opportunity to ask questions
Perform an IV site check: ○ Redness ○ Swelling ○ Pain ○ Soiled dressing	IV site check ensures early recognition of signs of IV fluid infiltration and allow for early intervention to prevent complications.
Verify medical and nursing prescription.	Ensure correct patient is getting the correct treatment.
Complete the IV label correctly, verifying the patient details and prescription with the Registered nurse.	Ensures the correct patient gets the correct treatment.
Gather the appropriate IV solution bag (vaculitre).	Ensures the patient receives the correct treatment.
Perform appropriate hand hygiene technique.	Proper infection control practices prevent transmission of harmful microorganisms.
○ Open new IV solution bag. ○ Remove outer plastic packaging and squeeze bag to test for leak. ○ Ensure the protective coverings over the infusion spike and distal adapter are intact and contents are not damaged.	Protective coverings reduces the risk micro-organism entry.
Check IV solution for precipitates, cloudiness, and expiry date.	Expired or damaged stock compromises patient safety.
○ Hang new IV solution on IV pole.	Ensures the vaculitre does not get contaminated by lying on any other surface.
Pause the electronic IV pump or close the roller clamp on a gravity infusion set.	Prevents air from entering the line from an empty vaculitre.
Remove protective plastic cover from the new IV solution tubing port. Avoid contamination of the port through contact.	Apply infection prevention principles to ensure no contamination of new vaculitre.

SKILLS STEPS	RATIONALE
Connect IV-Line to new IV solution without contamination. o Turn IV bag upside down, grasping the tubing port. o Remove IV tubing spike from old IV solution bag with a twisting motion. o Firmly insert the spike into the new IV bag. o Remove the empty/previous IV solution bag from the pole.	Connect new IV solution using infection prevention principles to ensure no contamination.
o Compress and fill the fluid chamber of tubing by gently pressing the chamber between the forefinger and the thumb. o Ensure that the chamber is 1/3 – 1/2 full.	Ensures no air bubbles enter the line when infusing the IV solution.
Check IV tubing for any air bubbles.	Ensures patient safety and mitigate medico-legal risks.
Open clamp and restart the IV pump.	Ensure IV solution is infusing well.
If IV fluid is not connected to an IV pump, inform the RN to assist with drop-regulation (do not open the roller clamp to free flow).	Eliminate the risk to the patient for fluid overloading.
Inform the Registered Nurse of the IV bag change.	Eliminates the risk of infusion error.
Record the IV fluid change in the relevant documentation: o Intake and Output chart o Continuous progress record.	Adherence to documentation legality.

Skill: Changing an IV administration set

OUTCOMES: The student will demonstrate competence in:

- Demonstrate efficient execution of psychomotor skills, using the correct principles and techniques to replace an intravenous administration set.

RATIONALE

This competency is integrated in the following skills and procedures:

- Assessment of a patient.
- Calculation of intake and output.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

1) Joubert, A, Olivier, N. 2020. Practical Guide for general Nursing Sciences. 2nd Edition. Pearson South Africa.
2) Mulder, M. 2011. Practical guide for general nursing science Part 1. 11th impression. Cape Town: CTP Printers Cape Town.

SKILLS STEPS	RATIONALE
Collect the required equipment/stock: o Prescribed IV solution, o IV administration set	
Remove the IV solution from outer packaging and gently squeeze to check for leakages.	Ensure vaculitre is intact and contents are not compromised.
Check IV solution for precipitates, cloudiness, and expiry date.	Ensure the vaculitre is safe for use on a patient and not compromised in any way.
Open new IV tubing from packaging. Ensure no contamination occurs at the tip.	Using infection prevention principles to ensure no contamination.
Close new IV tubing with roller clamp.	Ensures easy access of roller clamp and prevents air entering the tubing when roller clamp is closed. Move the roller clamp about 3cm below the drip chamber and close the clamp.
Remove the protective cover on the IV solution port and keep sterile. o Open IV solution port without contamination.	Ensures no contamination of IV solution.
Open IV tubing spike by removing the protective cover, without contamination.	Using aseptic technique to ensure no contamination.
Without touching the tip, insert spike into new container using a twisting motion.	Ensures sterility of the IV solution and tubing spike.
Hang IV fluid bag on IV pole. The IV bag should be approximately 1 metre above the IV insertion site.	The pull of gravity ensures the IV solution infuses well and prevents pooling of the solution in the tubing.
Prepare the drip chamber. o Fill the drip chamber to 1/3 – 1 /2 full by gently squeezing the chamber to remove protective cover on the end of the tubing.	To prevent air from entering the IV tubing.
Prime the IV tubing: o With distal end of tubing over basin, slowly open roller clamp to prime the IV tubing o Close roller clamp. o Cover end with sterile protective cover.	Removes all air from the tubing. Adhere to infection control principles to prevent contamination.
Clamp old IV administration set.	Stop the flow of infusion during the tubing and solution change.

SKILLS STEPS	RATIONALE
Clean connection site: ○ Clean the connection between the distal end of old IV tubing and the positive pressure cap. ○ Scrub the connection area with a alcohol swab for 15 seconds and let it dry for 30 seconds to reduce bacterial load.	Ensures no contamination of tubing and IV solution by preventing transmission of harmful microorganisms.
Apply hand rub	Prevent contamination of the connector port
Don gloves	
Disconnect old IV line and connect new IV line without contamination. ○ Remove the protective cap on the distal end of the new IV administration set. ○ Carefully disconnect the old tubing from the positive pressure cap (IV hub). ○ Insert the new IV tubing into the positive pressure cap attached to the extension tubing.	Apply infection control principles to prevent contamination.
Open roller clamp and start the IV pump. In the case where an IV pump is not used, the RN must assist to regulate flow rate as prescribed.	Ensure IV solution is infusing well.

Competency: Caring for patients with an indwelling catheter

OUTCOME: The student will demonstrate competence in:

- Demonstrate efficient execution of psychomotor skills, using the correct principles and techniques to: Care for a patient with an indwelling catheter.

RATIONALE:
This skill will be displayed when conducting the following procedures:

- Hand hygiene
- Donning and doffing of PPE

SKILL REFERENCES:
This skill is based on:

1) Mulder, M. & Olivier, N. 2020. Practical Guide for General Nursing Sciences. 2nd edition. Pearson: Cape Town. pg. 278 – 285.
2) Life Healthcare (LHC). 2019. *Management of indwelling urinary catheters.* Doc. No: NUR-WP-CCU-014 - 2019. Life Healthcare Intranet.

COMPETENCY STEPS	RATIONALE
General pre-procedure preparation	
Collect correct equipment and check the expiry dates:	To prevent using expired stock. ○ Medium wash basin ○ **4% chlorhexidine (CHG) – 1 squirt** ○ 1000 ml lukewarm water in the basin ○ Non-sterile gloves ○ Bedpan if necessary ○ Urinal if necessary ○ Disposable cloth ○ Linen saver (optional) ○ Gauze
Introduce self to the patient.	Patient rights to be treated by a named healthcare provider.
Identify the patient correctly.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the procedure to the patient and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
Perform hand hygiene and Donn PPE	• Implement appropriate patient-specific precautionary measures to prevent infections. ○ Gloves and Apron
Confirm the amount of catheter days (see CAUTI bundle).	CAUTI (Catheter Associated Urinary Tract Infection) Evaluate the relevance of continued catheterisation.
Confirm if the catheter is secured to the thigh.	• Implement appropriate patient-specific precautionary measures to prevent infections.
Confirm if the catheter was inserted aseptically.	• Recognise early signs and symptoms of UTI (with reference to clinical condition and urine analysis) • Perform focused assessments for signs of systemic infection i.e. altered vital observations, changes in fluid and electrolyte status, altered mental status. • Correct measures to prevent backflow of urine in catheter pipe.
Ensure that patient privacy is maintained at all times.	Patient privacy, dignity and confidentiality of information.
Assist the patient in the correct position:	Allow visualisation of the genital and ureteral areas. • Ask patient to lie on her back. • Pull up knees. • Place heels together • Open the knees apart, keeping the heels together.
Observe for any abnormalities:	Recognise early signs and symptoms of UTI (with reference to clinical condition and urine analysis).

COMPETENCY STEPS	RATIONALE
	• Redness • Discharges • Bleeding • Tissue trauma and if the patient reports • Itching • Burning
The student must either perform catheter care on a female/male patient	
Female Catheter Care	
Apply principles of cleaning:	To prevent contamination of the genito-urinary tract. ○ Pour 100 ml lukewarm water into the basin. ○ One squirt 4% chlorhexidine (CHG) into the wash basin with water (1000ml).
○ Use the disposable cloth to wash the genital area. Clean from top to bottom	• To prevent contamination of the vagina with faeces and to remove smegma, a thick discharge of the sebaceous gland of the clitoris and labia minora. • To limit the spread of microorganisms to other areas.
○ Clean from inside to outside	
○ From furthest to closest – first the vestibule – labia minora – labia majora – groin	
○ Wipe the catheter away from the genitals.	• To prevent contamination of the Genito-urinary tract. ○ Use gentle but thorough circular movements to clean the insertion point of the urethral meatus downwards, away from the meatus. ○ Avoid pulling of the catheter to prevent pulling and injury to the bladder.
Dry the patient with gauze.	Excessive moisture can lead to skin breakdown.
Clean environment.	See therapeutic environment
Dispose of waste appropriately.	Follow policy on waste disposal
Male Catheter Care	
Apply principles of cleaning:	To prevent contamination of the genito-urinary tract. ○ Pour 100 ml lukewarm water into the basin. ○ One squirt 4% chlorhexidine (CHG) into the wash basin with water (1000ml).
Clean from top to bottom by gently lifting the penis up.	• Lift the penis up. • To wash the glans penis and to remove smegma secreted by the sebaceous glands situated on the inside of the foreskin. ○ In the uncircumcised patient retract the foreskin ○ Return the foreskin back in position over the tip of the penis.
Wash the scrotum.	To prevent contamination of the genito-urinary tract. ○ Include posterior and other areas of the scrotum.
Wash and rinse the other skin areas between the legs.	• To limit the spread of microorganisms to other areas. • To minimise cross-infection
Wash and rinse the anal area.	• To prevent skin irritation and tissue breakdown.
Clean the catheter.	• Use gentle but thorough circular movements to clean the insertion point of the urethral meatus downwards, away from the meatus. • Avoid pulling of the catheter to prevent pulling and injury to the bladder.
Clean environment.	See therapeutic environment
Dispose of waste appropriately.	Follow policy on waste disposal
Throughout the procedure	
Keep the catheter bag below the level of the bladder to prevent backflow of urine into the bladder.	
Avoid kinking the catheter to prevent obstruction in urine flow.	
Documentation	
Record all observations using legal recordkeeping principles.	• Document the abnormal findings appropriately to provide a written record of the activity and interventions. • Record observations such as odours, swelling inflammation, haematoma, tissue damage and haemorrhoids. • Report anything unusual to the registered nurse of physician.

Skill: Blood Glucose Monitoring at the Bedside

OUTCOMES: The student will demonstrate competence in:
• Demonstrating knowledge of the ranges for normal blood glucose levels.
• Using the correct technique to obtain a blood sample.
• Initiating and executing appropriate and correct interventions on interpreted findings.

RATIONALE

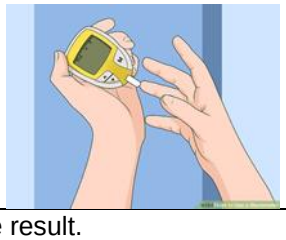
This skill is integrated in the following skills and procedures:

- Admission of a patient.
- Assessment and monitoring of vital data.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 738 – 745.
2) Life Healthcare (LHC). 2023.*Nursing Clinical Practice Workflow: Blood Glucose Monitoring in the General Ward.* Doc. No. 9. Life Healthcare Intranet.
3) Images from Wiki How available @ https://wikihow.com

SKILLS STEPS	RATIONALE
Perform hand wash / spray before the procedure.	Prevents transmission of harmful microorganisms, reducing the risk of infection.
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, Make sure all record has same name and address.
Explain the procedure and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. Alleviate feelings of anxiety and fear and encourage participation.
Check the prescription chart and documents for indication for performing the procedure. Also determine the frequency of measurement.	• Blood glucose monitoring related to patients' medical history. • Frequency is determined by the patient's risk for imbalance.
Place all equipment close to patient on a stable surface: ○ Glucometer ○ Reagent strips in container ○ Non-sterile gloves ○ Cotton balls	Ensures equipment is easily accessible and reduces the risk of contamination. 
Check functionality of equipment.	Ensure understanding of how equipment works to ensure a smooth sequence of events when obtaining a reading.
Check the expiry date of the reagent strips.	Eliminate the risk to the patient when using expired stock.
Wash/sanitize hands and Don non-sterile gloves.	Prevents transmission of harmful microorganisms through adherence to infection control principles.
○ Assist the patient to wash hands with soap and warm water and dry well or clean site with a cotton ball.	• Prevents contamination and inaccurate results. • Clean with water only, alcohol-based disinfectant, wait for area to dry completely to prevent inaccurate results.

SKILLS STEPS	RATIONALE
Observe the skin for any cuts, bruises and sores.	The puncture site should be free from wounds and infection, using these areas to puncture can increase the risk for bleeding and infection.
Remove reagent strip from the container.	Store test strip container as per manufacturer's instruction. Tight closure of the container keeps strips from damage due to environmental factors. Prevent contamination of reagent strip.
Re-seal the container cap.	
Insert reagent strip into the glucometer. Do not bend the strip.	Check the manufacturer's instructions to ensure correct handling and calibration.
Wait for the machine to indicate that it can receive a drop of blood.	
Place a linen saver or paper towel beneath the patient hand.	Protect the linen from spillage.
○ Choose a vascular site. ○ The finger must be pricked at the correct depth, typically at the side of a finger. ○ Avoid pricking the tips of fingers. ○ Avoid pricking in the same area.	The sides of the fingers have less nerve endings, which reduces the incidence of soreness on the most frequently used surfaces of the fingers.
Stimulate blood flow correctly.	Hold finger and gently massage toward the tip. Increases blood flow.
Remove the cover of the lancet aseptically.	Prevents contamination.
Warn the patient to a sharp prick.	Psychologically prepares the patient.
○ Puncture the site to produce an adequate drop of blood. ○ Turn the hand palm upwards. ○ Gently massage the length of the finger to increase blood flow. (do not 'milk' or squeeze the blood out).	The finger must be pricked at an adequate depth to produce enough blood. 
Place lancet in sharps container or neutral zone.	Prevents incidents of needle stick injuries.
Wipe away the first drop of blood.	Reduces incidents of contaminated blood producing false results.
Gently massage the length of the finger to increase blood flow until a large drop occurs (do not 'milk' or squeeze the blood out).	The blood should flow freely. It is acceptable to apply light, intermittent pressure to the puncture site to encourage blood flow, but do not milk the site which can cause the red blood cells to haemolyse and result in the sample having a disproportionate percentage of interstitial fluid.
Correctly collect blood on reagent strip.	The second droplet of blood needs to be large enough to cover the test pad on the reagent strip.  
Apply pressure to the puncture site.	Stops the bleeding whilst waiting for the result.

SKILLS STEPS	RATIONALE
	
Obtaining reading Review it with the patient.	Identify correct ranges for HGT and any abnormalities. Supports patient-centred care by involving the patient in their treatment. 
Dispose waste according to company policy.	Correct disposal of health care waste for control of Infection prevention.
Record all data.	Accurate documentation is crucial for patient safety, legal and regulatory compliance, and continuity of care. See Legal Recordkeeping Competency

Competency: Caring for patients with an IV Line

OUTCOMES: The student will demonstrate competence in:

- Demonstrate competency in the application of theory-practice integration to nurse a patient with an intravenous peripheral line safely.

RATIONALE

This competency is integrated in the following skills and procedures:

- Assessment of a patient.
- Calculation of intake and output.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 991 - 992
2) Life Healthcare (LHC). 2023. *Monitoring and management of venous vascular access devises.* Doc. No. NUR-WP-GEN-002. Life Healthcare Intranet.
3) Life Healthcare (LHC). 2023. *Bundle compliance checklist.* Doc. No. IPC-FORM-403.Life Healthcare Intranet

SKILLS STEPS	RATIONALE
Checking and maintaining intravenous infusion lines (peripheral)	
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the procedure and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
Explain the therapeutic purposes of peripheral IV catheters.	Peripheral venous cannulation is indicated for short-term use mainly for the administration of: • IV fluids and medication e.g. water-soluble vitamins, to replace blood and blood products • To replace or maintain electrolytes • To administer contrast media for diagnostic investigations • To secure intravenous access - 'to keep vein open' • To supply fluids and nutrients to NPO patients or patients unable to ingest oral liquids due to prolonged nausea, vomiting, diarrhea, peritonitis, paralytic ileus, fistulas • To restore fluid volume that is lost from the body due to diarrhoea, vomiting, haemorrhage • To dilute toxins in case of toxemia or septicemia
Identify the type of intravenous fluid prescribed	Types of fluids for intravenous fluid therapy • Isotonic solutions • Hypotonic solutions • Hypertonic solutions • Crystalloids and colloids • Nutrient solutions • Electrolyte solutions • Alkalising and acidifying solutions • Blood volume expanders
○ Explain the current specific indications for current patient's IV therapy.	• Argue the need for IV-line placement to continue.

SKILLS STEPS	RATIONALE
○ Elaborate on the medical prescription: fluid type and/or medication prescribed. ○ Relate the patient condition to the indications for PIVC.	
Identify potential medico-legal risks pertaining to the procedure.	• Wrong patient identification can lead to wrong treatment to the wrong patient. • Incorrect assessment findings can lead to a delay in appropriate treatment, contributing to ineffective treatment of infection and deterioration in patient condition. • Infection due to inaccurate application of hand hygiene procedure leading to prolonged hospitalisation/death. • Injury to the skin due to wrong procedure execution techniques.
State the frequency of IV checks.	• IV systems must be assessed every 1 to 2 hours or more frequently if required e.g. if a patient complains of pain, tenderness, or discomfort at the IV site/IV limb. • Early detection of potential phlebitis.
Assessment of IV Site	
○ Expose the limb containing the IV cannula.	• Observe for any signs of infiltration of IV fluid and identify the risk for phlebitis.
Assess skin around IV cannula for signs of: ○ signs of phlebitis, infiltration or extravasation e.g. pain, erythema, ○ tenderness, ○ swelling, ○ warmness of skin area, ○ skin discolouration Compare findings to opposite limb.	• Early detection of phlebitis.
○ Do a neuro-vascular observation on the limbs involved (see procedure). ○ Compare to the opposite limb.	• Check the blood circulation on the limb.
Assess dressing and or splint where applicable.	Functionality and cleanliness of IV site covering • dressing and splint securement, • cleanliness and dryness of dressing, • splint tapes not too tight, restrictive or loose, • efficiency of securing method
Assess patency of IV cannula.	• Patency of the I.V. tubing and presence of kinks in the tubing (Sometimes the patient may lie on the tube and block the flow of fluid). • Leaks from IV ports, causing dampness on dressings • Signs and symptoms of occlusion (with and without volumetric pump). • Flow rate, securement /dislodgement of cannula.
Evaluate intake and output balance	• Evaluate the fluid intake balance against the fluid output balance of the past 72 hours • Analyse BMI (including calculation) and relate it to an acceptable calculation for fluid intake and expected fluid output in a healthy body. • Interpret assessment findings and vital signs in terms of current I & O status.
Maintain complete and legal documentation	• Evaluate the completeness and correctness of documentation on the relevant patient documentation – fluid balance flowsheets – patient progress reports – doctor's orders – nursing care plan prescriptions

Skill: Obtaining a Blood Pressure Reading

OUTCOMES: The student will demonstrate competence in:
• conducting appropriate and correct assessments on a patient from whom vital observations are obtained.
• applying appropriate principles and correct psycho-motor techniques to obtain accurate blood pressure readings.

RATIONALE

This competency is integrated in the following skills and procedures:

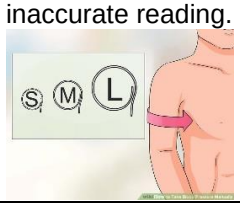
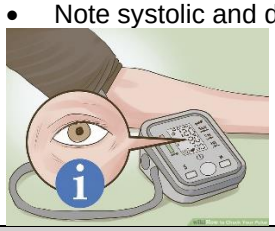
- Vital data collection
- Vital data interpretation
- Admission of a patient
- Pre and post operative care of a patient

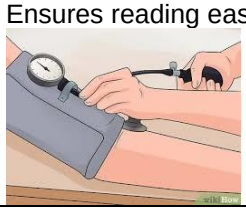
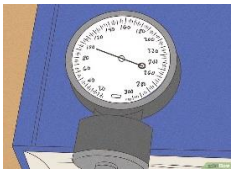
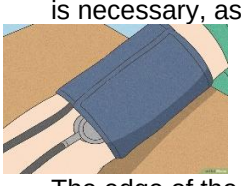
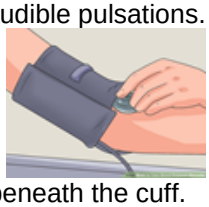
COMPETENCY REFERENCES:

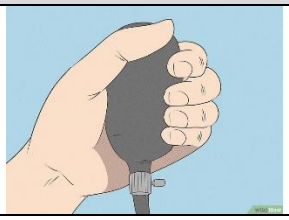
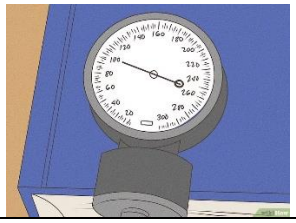
This skill is based on:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 74 – 89.

SKILL STEPS	RATIONALE AND STANDARD
Obtaining a blood pressure reading	
Determine the need to assess the patient's blood pressure.	Certain conditions place patient at an increased risk for blood pressure alterations. ○ History of cardiovascular disease ○ Renal disease ○ Diabetes ○ Circulatory shock ○ Acute and chronic pain ○ Postoperative status ○ Age and gender
Eliminate all factors for obtaining the reading:	Allows the nurse to anticipate factors that influence the reading. ○ Eating ○ Drinking fluids ○ Smoking ○ Exercise
Determine the correct time to obtain a blood pressure.	A blood pressure should be measured under controlled circumstances to get a truly accurate reading.
Determine the previous baseline blood pressure from documentation.	Early detection of abnormal trends.
Check the functionality of the equipment.	Faulty equipment can lead to inaccurate readings and cause patient harm.
Position patient in semi-fowlers position/ seated position (if permitted).	Consider the patient's condition. 
Choose the appropriate site for obtaining the blood pressure reading.	• Inappropriate site selection may result in reduced quality of sound causing inaccurate readings • Injury to the patient if injured site is chosen. **DO NOT** – apply the cuff on and arm when: • The patient has in IV insitu in the same arm. • Surgery (current or previous) • The patient has a wound or injury on the arm. • Arteriovenous shunt or fistula.

SKILL STEPS	RATIONALE AND STANDARD
	If both arms are not ideal to use to obtain a blood pressure – lower extremities can be utilised.
Remove restricted clothing or roll up a loose sleeve.	Excessive clothing will influence the pressure and the reading. 
Choose the correct size cuff.	Using a cuff that is too small or too big can result in an inaccurate reading. 
Palpate brachial artery using the index and middle finger.	The tips of the index and middle finger is most sensitive and the thumb has its own pulse which will affect the sensation.  Assess the strength of the radial (manual) and brachial pulse (manual and electronic)
Electronic blood pressure machine (N.I.B.P)	
Apply the cuff:	A loosely fitted cuff will affect the pressure and the reading. ○ Position the cuff 2.5 cm above the site of pulsation. Centering the arrows marked on the cuff over the artery. ○ Wrap the cuff snugly around the arm, not too tight. ○ The tubing should be over the area where the brachial artery was palpable. 
Switch machine on by pressing "On/OFF" button.	
Press "auto" start button.	• Machine should make an inflation sound. • Keep patient's arm still for the duration of the process.
Observe patients' reaction to the inflation of the cuff.	• Reassure patient during the process, as an inflating cuff can be painful. • Assist patient to keep still with a gentle touch on the arm.
Obtain the reading displayed on the screen.	• Immediately write down the reading. • Note systolic and diastolic readings. 
Manual technique	
Check the functionality of equipment: ○	Faulty equipment will influence the reading. ○ Ensure the sound is audible and clear. ○ Turn the stethoscope's bell into the correct position. ○ Large for all humans over the age of five. ○ Small for all humans under the age of five.

SKILL STEPS	RATIONALE AND STANDARD
Ensure the cuff is fully deflated using the roller valve.	Inflating the cuff from the deflated position will ensure a more accurate reading. 
Apply the cuff:	A loosely fitted cuff will affect the pressure and the reading.   ○ Position the cuff 2.5 cm above the site of pulsation. Centering the arrows marked on the cuff over the artery. ○ Wrap the deflated cuff snugly around upper arm.
Position the manometer gauge vertically at eye level.	Ensures reading ease when hands are occupied. 
Keep your hand on the patient's radial pulse and inflate the cuff until the radial pulse is no longer felt. (ensure the valve is closed). Lock the inflation bulb and read the number on the regulator. Remember this number and deflate the cuff by opening the valve. Determine the baseline for cuff inflation by adding 30 mmHg to the above number.	The point that the pulse disappear indicates the baseline for inflation when obtaining the reading. 
After 30 seconds, place bell (flat surface) of stethoscope in the correct position, against the skin over the brachial pulse.	• By ensuring you do not hear a thumping sound until you have begun to deflate the cuff – accuracy of results is ensured. • To be able to hear the rhythmic pulsations, complete silence is necessary, as some patients less audible pulsations.    ○ The edge of the diaphragm must be beneath the cuff. ○ Gently insert the stethoscope earpieces in your ears. ○ Hold the head of the stethoscope in place with your index and middle fingers. ○ Do not hold the stethoscope with your thumb (the thumb has its own pulse and will confuse the reading). ○ To obtain an accurate reading, ask the patient and people around to not talk during this process. ○ Ensure you have a clear view of the gauge, to be able to read the blood pressure determinants.
Ensure the roller valve is closed (not over-tight) and rapidly pump the rubber bulb to inflate the cuff.	• Ensures that no air escapes while pumping the rubber bulb to inflate the cuff. • The pressure from the cuff will occlude the artery temporarily cutting off blood flow.

SKILL STEPS	RATIONALE AND STANDARD
	
Gently turn the roller valve counterclockwise to release the cuff pressure at a very slow pace.	The blood pressure will be determined by the audible sound from the artery when blood flow returns. If the cuff is released too quickly, you will miss the reading on the gauge.
Determine blood pressure, systolic and diastolic, whilst slowly deflating the cuff. ○ Listen carefully for the 1st rhythmic sound of a heartbeat. ○ Note this as the systole. ○ Listen where the heartbeat stops being audible. ○ Note this as the diastole.	• The systolic number is generated from the pressure that blood flow exerts on the artery walls after the heart contracts. • The systolic number is written as the top number. • The diastolic number is generated from the pressure that bloodflow exerts on the artery when your heart relaxes between contractions. • The diastolic number is written down as the lower number. 
If a reading was missed, a repeat attempt can be made – not more than twice, thereafter use the alternative arm.	Bloodflow in that arm could take a while to return to normal, and this may affect the reading or cause injury to the patient.
Document the reading	• Ensure accurate and legal documentation is done. • Note and describe any abnormalities found as well as patient's reaction during the procedure.

Skill: Obtaining a patient's breath rate/respiration

OUTCOMES: The student will demonstrate competence in:
• conducting appropriate and correct assessments on a patient from whom vital observations are obtained
• applying appropriate principles and correct psycho-motor techniques to obtain accurate repertory rate

RATIONALE
This competency is integrated in the following skills and procedures:
- Vital data collection
- Vital data analysis
- Patient admission
- Pre-and-post operative care

COMPETENCY REFERENCES:
This competency is based on:
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 65 – 72.

SKILL STEPS	RATIONALE AND STANDARD
Eliminate all contra-indications.	Consider the following factors that may influence respiration: • Age • Gender • Illness and disease • Exercise • Emotions • Positioning • Medication • Pain • Smoking • Elevated temperature • Previous respiratory count (baseline data)
Explain procedure to patient.	• This will help allay anxiety. • The patient's awareness that you are counting respiration could cause an alteration in breathing pattern, creating false measurement.
Symmetrical chest movement.	• Help patients assume a comfortable position, sitting or supine, fold down the bed linen, if necessary, this will make the chest more visible. • Observe the chest movement for symmetrical movement. • Asymmetrical expansion invariably implies decreased ventilation to one side.
Chest and abdominal movement.	• Chest and abdominal movement – the chest and abdomen should move in the same direction during a normal tidal breath.
Accessory Muscle use.	• Accessory muscle use – observe the patient from the front and note whether there is increased work of breathing at rest, which includes the use of the sternocleidomastoid (neck), scalene (shoulder), pectoral and abdominal.
Listen for audible Adventitious sounds.	Listen for: • Fine crackles (rales) may indicate asthma and chronic obstructive pulmonary disease (COPD). • Coarse crackles may indicate pulmonary oedema. • Wheezing may indicate asthma, bronchitis, or emphysema. • Low-pitched wheezing (rhonchi) may indicate pneumonia.
Count patient's chest movement whilst keeping time on your device.	• Count respiration whilst supposedly taking the radial pulse • One minute allows sufficient time to accurately evaluate any abnormalities • Observe or palpate the breaths, one inspiration and expiration equal one breath, only count inspirations or expirations. • For regular breath rate you can count over 30 seconds for irregular breath rate count over 1 minute • Take caution not to count the seconds on your watch

SKILL STEPS	RATIONALE AND STANDARD
Determine the breath rate per minute	• After having counted for 1 minute, consider the number you have as the total number of breaths per minute. • If you counted for 30 seconds, multiply your findings by two and regard that the total number of breaths per minute.
Make patient comfortable and clean up the environment.	• Straighten the patient's clothes and bed linen, and re-position him or her after the assessment
Document the reading	• Record findings, compare with pre-recorded trends. Report all abnormalities to the registered nurse
Report abnormalities.	• Report your findings to the registered nurse

Skills: Obtaining a pulse

OUTCOMES: The student will demonstrate competence in:
• conducting appropriate and correct assessments on a patient from whom vital observations are obtained
• applying appropriate principles and correct psycho-motor techniques to obtain accurate pulse.

RATIONALE

This competency is integrated in the following skills and procedures:

- Vital data collection
- Vital data interpretation
- Admission of a patient
- Pre and post operative care of a patient

COMPETENCY REFERENCES:

This competency is based on:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 55 – 64.

SKILL STEPS	RATIONALE AND STANDARD
Eliminate any contra-indications for taking a pulse.	A resting pulse must be taken unless it is specified that a resting pulse must be compared with a non-resting pulse.
Check the functionality of the equipment.	Watch with a 2nd hand. A watch with a second hand must be used or a watch that has a countdown setting.
Identify the factors that will influence a pulse.	The following are examples of factors that will influence a pulse: • Conditions such as Atrial fibrillation and Atrial flutter. (A rapid and irregular pulse) • Anxiety (An increase in heart rate) • Exercise (An increase in heart rate) • Chest pain
Assess and expose the area you would use to obtain the pulse.	Obtaining a pulse required bare skin to skin contact.   Select the correct site: ○ Radial ○ Brachial ○ Femoral ○ Popliteal ○ Dorsalis Pedis ○ Carotid Place 2 fingers horizontal over the chosen pulse
Comment on the characteristics of the pulse:	The pulse rate is the measurement of the heartrate in beats per minute. <u>Characteristics:</u> • Rate: number of beats per minute measured. • Rhythm/regularity: measures the interval between beats measured as equal/regular or irregular. • Strength/volume: Force of the blood against the artery wall measured as strong/full or weak/thready • Number of beats felt against your fingers. ○ Count the beats for 30 seconds (count while keeping your eye on your watch) ○ After 30 seconds, calculate the HR/Min by multiplying the beats counted in 30 sec with 2. ○ If the patient has an irregular beat, count for full 60 second (1 min).
Document the findings	Legal requirement

Skill: Assessing Oxygen Saturation

OUTCOMES: The student will demonstrate competence in:

- Applying appropriate principles and correct psycho-motor techniques to obtain accurate oxygen saturation.

RATIONALE

This competency is integrated in the following skills and procedures:

- Vital data collection
- Vital data interpretation
- Admission of a patient
- Pre and post operative care of a patient

COMPETENCY REFERENCES:

This competency is based on:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 68.

SKILL STEPS	RATIONALE AND STANDARD
Eliminate factors that can influence the saturation reading.	Identify and act upon factors which may affect the accuracy of the pulse oximetry reading: • Physiologic conditions e.g. severe anaemia caused by hypovolemic shock, hypotension, cardiac failure, atrial fibrillation, vasoconstriction, hypothermia, carbon monoxide poisoning. • Movement disturbances caused by shivering, rigors, grand mal epilepsy. • Physical barriers caused by nail polish, artificial & gel manicured nails, dirt, foreign objects. • Environmental factors i.e. cold room temperatures, fluorescent room lighting, intravenous dyes. • Eliminate any activities that would increase oxygen saturation reading, leading to misinterpretation of resting saturation reading.
Place patient in appropriate position.	• Position to optimise lung capacity e.g. fowler position. • Select the peripheral access that is accessible. • Assess neurovascular status, compared to opposite limb.
Select the suitable area to affix the probe.	• Select the most suitable extremity. • Clean the extremity using a wet wipe/ water or a sanitizer. • Probe size for adult as directed by manufacturer's instructions.
Switch on the machine.	• Allow the machine to calibrate. • Ensure that the probe sensor is detecting the pulse.
Verify accuracy of heart rate.	• Check the accuracy of the heart rate reading. • Compare accurately to the number on the pulse oximeter display, counting the true heartbeat. • Correlate with patient's respiratory pattern, rate, depth.
Obtain the saturation reading.	• Apply the machine for the correct time duration as indicated by the manufacturer's instructions. • Interpret the meaning of the reading. • Relate to patient's condition and normal values.
Remove the probe.	Remove the probe carefully from the patient's extremity.
Record the findings.	• Record findings, compare with pre-recorded trends. • Report all abnormalities to the registered nurse.
Clean the probe.	• Clean probe and remove the equipment from the room. • Follow institutional disinfecting guidelines to clean probe in between patients.

Skill: Taking a Tympanic Temperature

OUTCOMES: The student will demonstrate competence in:
• conducting appropriate and correct assessments on a patient from whom vital observations are obtained.
• applying appropriate principles and correct psycho-motor techniques to obtain accurate temperature.

RATIONALE

This competency is integrated in the following skills and procedures:

- Vital data collection
- Vital data interpretation
- Admission of a patient

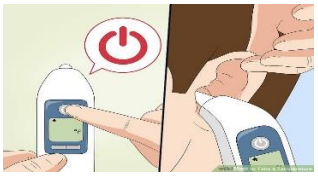
Pre and post operative care of a patient

COMPETENCY REFERENCES:

This competency is based on:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 35 – 54.

SKILL STEPS	RATIONALE AND STANDARD
Eliminate all contra-indications.	• Explain patient-specific indications. • Evaluate the applicability of current nursing care plan prescriptions to existing trends in vital data. • To wait at least 30 minutes after exposure to environmental changes. 
Check functionality of equipment.	• Ensure compliance with manufacturer's guidelines for device maintenance schedules. Check service schedule sticker on electronic apparatus. • Follow manufacture guidelines. • Ensure thermometer is set to °Celsius. • Fit with a disposable plastic cover. 
Assess skin.	Assess patient's skin via physical palpation and observation. • Identify associated symptoms e.g. cough, dysuria, diarrhea and headache. • Identify a history/risk of immunosuppression duration of pyrexia • Assess for current clinical signs of pyrexia or hypothermia by touching the patient's skin (forehead).

SKILL STEPS	RATIONALE AND STANDARD
Position patient.	• Consider the patients diagnosis - is the patient able to sit up in fowlers? • Is the patient allowed to sit up in fowlers? • Initiate appropriate actions to avoid risk and promote patient safety and comfort.
Perform a gross ear inspection.	• Observe for ear wax and take appropriate action to remove it prior to procedure. • Avoid taking tympanic membrane readings on ear with identified lesions, wounds, drainage and ear canals with structural abnormalities.
Insert the thermometer in ear gently. ○ Gently pull the top of the earlobe up and back to avoid injury. ○ Gently insert the tip of the thermometer into the ear canal towards the eardrum and switch the thermometer on. ○ Wait for it to signal that the reading is complete ○ Wait for the duration of time, until thermometer signals that a reading has been obtained.	• To be able to position device at the correct angle as to obtain an accurate reading.  • To be able to position devise at the correct angle as to obtain an accurate reading.  • To be able to position devise at the correct angle as to obtain an accurate reading. 
Remove the thermometer and read the temperature.	• Read the temperature. • Interpret the meaning of the reading. • Relate to patient's condition and normal values.
Apply correct documentation and reporting skills.	• To adhere to correct, legal documentation guidelines. • Follow lines of reporting.
Clean the environment and return patient into a comfortable position.	• Provide dignity and comfort to the patient.

Competency: Patient Education

OUTCOMES: The student will demonstrate competence in skills pertaining to
• Providing health education to meet specific needs of a patient.
• Assess understanding of the health education by the patient.
• Identification and clarification of misunderstanding of health education by the patient.

COMPETENCY REFERENCES:
This competency is based on:
1) Booysen, L. Erasmus, I. Van Zyl, M. 2015. The Auxiliary Nurse. 4th edition. Juta: Cape Town p 203-206.

COMPETENCY STEPS	RATIONALE
Select health education topic relevant to patient current condition.	• To ensure that the correct information is given to the patient. • Ensure teaching is relevant and related to the immediate need of the patient.
Provide clear and understandable health information. Explain terminology that may be difficult to understand.	
Engage the patient during the discussion.	• Patients who understand their condition and take responsibility for care and strive for independence have a lower risk of complication and a decreased risk for re-admission in hospital. • Stimulate interest in patient by answering questions, addressing specific concern so that patient will understand the necessity of the teaching. • Patients that play an active role in the teaching process will retain information after discharge.
Tailor health education to suit the patient's needs.	• Display competency in the health information topic. • Ensures information is correct and trustworthy. • Include the references in your notes.
Consideration of cultural differences.	• Display a respectful attitude and have an ability to communicate effectively across all diverse populations. • Consider ethical practices when providing health education and advice.
Use open-ended questions to confirm understanding.	• Determines if there is additional information required and if the education outcomes have been met.
Assess the patients understanding.	
Identify possible misunderstandings and clarify the information if needed.	
Record all data accurately according to legal prescriptions.	• Recordkeeping reflects adherence to all principles of recordkeeping. • Recorded the relevant health education given.

Skill: Physical assessment

OUTCOMES: The student will demonstrate competence in:

- Performing physical examination of an adult patient.

RATIONALE

This skill is integrated in the following procedures:

- Admission of a patient.
- Daily assessment of the patient.

COMPETENCY REFERENCES:

1) Booyens, L., Erasmus, I. and Van Zyl, M.2015. The Auxiliary Nurse. 4th editions. Juta: Cape Town. Pg 331 – 333.
2) Mogotlane, S., Mokoena, J., Chauke M., Mokgadi, M. and Randa, A., 2022. Juta's Complete Textbook of Medical Surgical Nursing. 2nd edition. Juta: Cape Town. Pg258 – 261.

SKILL STEPS	RATIONALE AND STANDARD
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the procedure and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
○ Ensure safe patient positioning and cover patient with a blanket with only the area of assessment being exposed. ○ Privacy ensured at all times.	• Patient comfort is important during the assessment. • Overexposure can lead to hypothermia and the patient's dignity is affected.
Perform hand hygiene.	• Infection control principles followed to prevent cross infection of microorganisms.
Nervous System and Special Senses	
Determine patient's responsiveness (AVPU).	To measure and record a patient's responsiveness, indicating their level of consciousness. The AVPU scale: ***A-Alert*** ***V- Voice*** ***P- Pain*** ***U- Unresponsive***
Assess mental status and orientation.	Identify patient-specific age-related changes in the nervous system. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Determining the patient's orientation and awareness of time, place and person. • Assess for comfort, presence of pain, including duration, location and type of pain. • Current emotional status e.g. reaction to hospitalization or mood. • Assess for anxiety and confusion. • Assess indicators of stress and general coping strategies.
Determine gross motor and fine motor function.	• Identify patient-specific age-related changes in the nervous system. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Assess the patient's balance and gait. • Conduct finger to nose test.

SKILL STEPS	RATIONALE AND STANDARD
Inspect the ears and nose.	Identify patient-specific age-related changes in the special senses. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Auricles for colour, symmetry and position. • Colour same as facial skin, eye symmetry. • Determine gross hearing problems by assessing patient's response to normal voice tones. • Inspect the external nose for size or colour, nose flaring, lesions, asymmetry or inflammation. • Inspect internal any deviation in shape and discharges
Inspect the eyes.	Identify patient-specific age-related changes in the special senses. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Peripheral visual fields, ocular movements, location of light reflex (PEARL). • External eye structures: eyebrows for hair distribution, alignment, skin quality and movement, eye lashes for direction of curl. • Bulbar conjunctiva: colour, texture, presence of lesions, drainage and discharges. • Observe for any abnormal eye movement. • Investigate and report on subjective visual problem experiences.
Respiratory System	
Inspection.	Identify patient-specific age-related changes in the respiratory system. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Determine the best position for patient comfort and promotion of effective respiration. • Assess for previous & current scars/lesions on chest area. • Determine the position of trachea (should be mid-line). • Observe for signs of airway obstruction, including breath sounds, central cyanosis and absence of chest movements. • Observe for tachypnoea, bradypnea, dyspnoea, asymmetrical chest movements with decreased or absent air entry. • Assess for chest deformities such as barrel chest, pigeon chest (pectus carinatum), funnel chest (pectus excavatum), kyphoscoliosis. • Assess for complaints of shortness of breaths, orthopnoea. • Observe for signs of respiratory distress e.g. sweating, central cyanosis, use of accessory muscles, abdominal breathing and inability to talk in long sentences. • Make accurate cough assessments: duration, frequency of occurrence. If cough is productive, assess colour, consistency and amount of sputum. • Assess patient's adherence to appropriate cough etiquette and sputum disposal (include in care plan –health education). • Inspect mucus membranes and skin colour, determine level of cyanosis. • Determine patient's reaction to O2 therapy if applicable
Palpation	• Palpate thorax for tenderness, masses, lesions, surgical emphysema. • Assess for symmetry on respiratory excursion.
Cardiovascular System	
Inspection	Identify patient-specific age-related changes in the cardiovascular system. Utilize assessment findings to develop a holistic patient-specific nursing care plan. • Assess for previous & current scars/lesions on chest, varicose veins. • Assess for jugular vein distension.

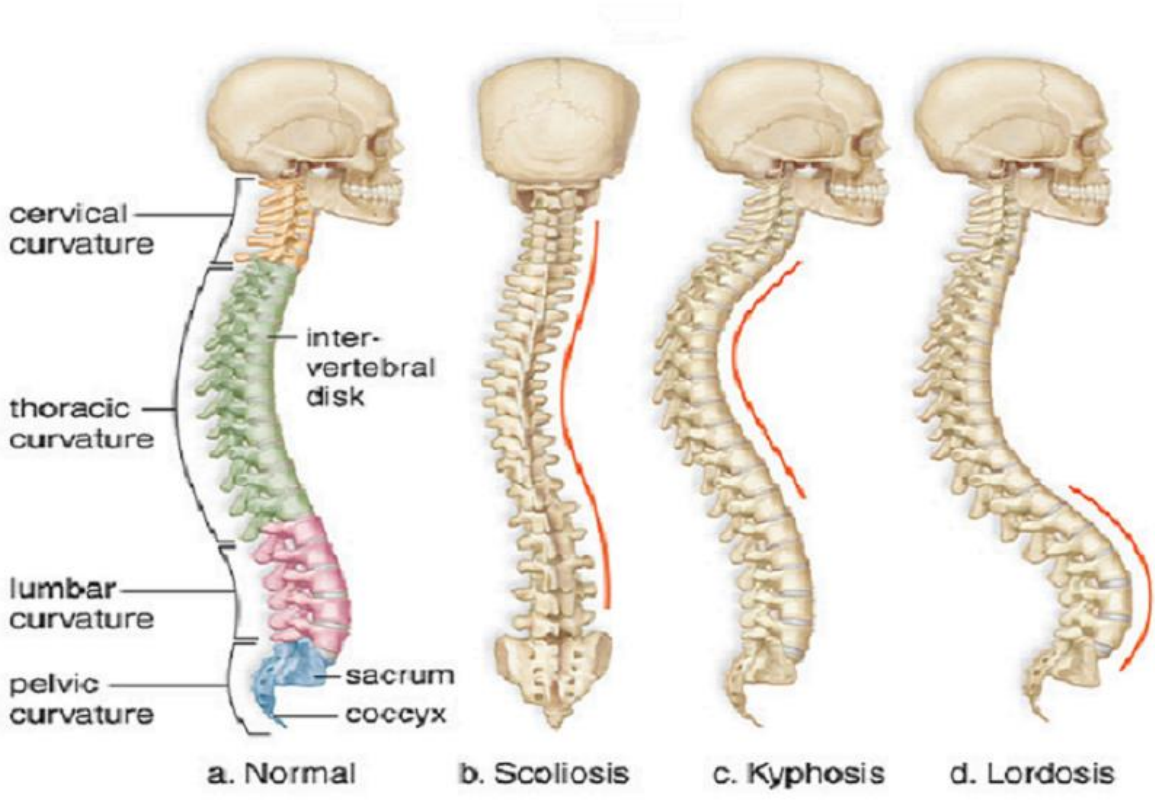
SKILL STEPS	RATIONALE AND STANDARD
	• Assess skin temperature and skin colour i.e. lips, earlobes, fingertips & extremities to identify abnormalities in blood circulation. • Inspect the mucus membranes and skin colour for signs of cyanosis or flushing, skin turgor, xanthelasma, pallor. • Inspect nail beds for clubbing. • Inspect and palpate digits for capillary refill. • Assess for evidence of bleeding (nose bleeds, GI bleed, vascular abscess, incisions, eyes, bruising on skin). • Measure capillary refill time on nail beds • Identify and grade oedema. • Obtain vital signs and interpret the findings.
Palpation	• Assess peripheral, radial and pedal pulse for rate, rhythm, volume and presence of arrhythmia. • Palpate apical impulse over the apex of the heart.
Gastrointestinal System	

Inspection	Identify patient-specific age-related changes in the gastrointestinal system. Utilize assessment findings to develop a holistic patient-specific nursing care plan.
	• Determine the best position for patient comfort to promote comfort.
	• Assess for previous & current scars/lesions.
	• Inspect the appearance of the abdomen and note the size, contour, colour and venous pattern.
	• Lips for cracks/cyanosis, symmetry, and oedema.
	• Teeth: shape/dental caries.
	• Tongue and mucous membrane: colour of buccal mucous membranes (pink and moist) and tongue indicating perfusion, signs of infection and inflammation.
	• Throat and neck for abnormal swelling and masses and muscle strength.
	• Abdomen: girth measurements, visible masses.
	• Assess the diet to determine the type, amount dietary restrictions and tolerance.
	• Determine nutritional needs and special diet preferences e.g. cultural dietary habits.
	• Assess for changes in appetite or taste alterations or swallowing ability.
	• Assess for recent weight gain or weight loss.
	• Normal bowel habits & last time stool passed (including colour, shape, consistency of stool).
	• Presence of nasogastric tube/PEG feeding, parenteral nutrition, Intestinal stoma(s).
	• Presence of hematemesis, constipation, melena.
	• Enquire about recurring vomiting, unrelieved abdominal discomfort/pain.
	• Presence of nausea & vomiting – amount, physical appearance.
	• Assess bowel habits as well as other signs and symptoms in terms of:
	  ○ Regular bowel habit pattern (including shape, normal colour, consistency, associated problems/experiences)
	  ○ Bowel related problems
	  ○ amount
	  ○ specific description (e.g. odour, colour)
	  ○ when last observed
	  ○ relieving and aggravating factors
	  ○ previous medical and self-treatment

Palpation	Palpate the abdomen to determine: if it is soft, hard, distended, or the presence of pain, presence of nausea and /or vomiting.

SKILL STEPS	RATIONALE AND STANDARD
Urinary System	
Inspection	• Assess for previous & current scar or lesions. • Assess for peripheral and/or systemic oedema. • Assess for urinary dysfunction such as nocturia, dysuria, oliguria, polyuria, enuresis, urinary incontinence, haematuria, use of indwelling catheter.
Integumentary System	
Inspection	• Determine the general condition including hygiene, skin thickness, skin elasticity, existence of petechiae, ecchymosis, bruises. Investigate and inquire about usage of blood thinning medications (prescribed, home-meds and homeopathic, herbal). • Assess for previous & current scars/lesions (head-to-toe approach). • Observe for colour, rashes, skin breakdown, tubes and drains, scars, bruising, temperature changes, turgor and oedema. • Use appropriate terminology e.g. pallor, cyanosis, jaundice, erythema, flushing, etc. • Assess skin integrity with focus on presence of surgical wounds, tubes and drains, and pressure ulcers. • Assess whether nails are translucent, shiny and firm in texture, presence of nail biting, nail infections, nail polish. • Assess scalp for balding/alopecia, scarring, scalp infections & infestations e.g. ringworm, head lice, Itching and excessive flaking i.e. dandruff (seborrheic dermatitis) and psoriasis. • Assess hair for hair loss – pattern, texture e.g. thin, coarse, smooth, brittle, dry, oily, distribution, colour changes.

Addendum 1:
Deformities of the chest



Competency: Managing a patient with restraints

OUTCOMES
• Demonstrates competency in evaluating and adhering to all principles and guidelines set for risk management.
• Confirm that the guidelines are followed and that the risks area reduced to a minimum in a general ward.

RATIONALE
Evaluation of environment in a general ward to limit risks to the minimum.

COMPETENCY REFERENCES:
This competency is based on:

1) Life Healthcare (LHC). 2021. The Use of Mechanical Restraints. Doc. No. NUR-PO-CP-001. Life Healthcare Intranet.
2) Life Healthcare (LHC). 2021. Performing a Neurovascular Assessment. Doc. No. NUR-WP-GEN-024. Life Healthcare Intranet.
3) Life Healthcare (LHC). 2021. Neurovascular Assessment Chart. Doc. No. NUR-FORM-GEN-008. Life Healthcare Intranet.
4) Life Healthcare (LHC). 2021. Mechanical Restraints. Doc. No. NUR-FORM-CP-001. Life Healthcare Intranet.
5) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 197 - 220

Competency steps	Guidelines
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the reason for restraint application and reassure the patient and family members.	• Ensure the patient understands the reason for restraint application and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
Define concepts of mechanical and chemical restraint.	• Mechanical restraints involve the use of a physical device to restrict a patient's movements or mobility. Examples are mittens or limb restraints. • Chemical restraints involve the use of medication to manage the patient's behaviour, usually to sedate or calm the patient such as sedatives.
Indications for using restraints.	Student can indicate the indication for using constraints for the presenting patient. Any one of the following can be applied: • Imminent Risk of Harm to Self or Others: ○ When a patient's behaviour poses an immediate threat to their safety or the safety of others. ○ This could include situations where the patient is exhibiting violent or aggressive behaviour, self-harm tendencies, or attempts to remove medical devices necessary for their well-being. ○ Can help prevent injuries and provide a temporary means of ensuring the safety of the patient and those around them. • Delirium or Altered Mental Status: ○ May exhibit agitation, confusion, disorientation, and impulsivity, which can increase the risk of falls, self-injury, or disruption of medical treatments. ○ A short-term measure to ensure their safety and prevent them from engaging in harmful or disruptive behaviours until the underlying condition can be addressed and managed appropriately. • Protection during Medical Procedures: ○ Ensure the patient's safety during medical procedures that require minimal movement or the need to maintain a specific position.

Competency steps	Guidelines
	○ This can include situations such as surgery, radiological procedures, or other interventions where patient cooperation and immobility are crucial for successful outcomes. • Prevention of Dislodging Life-Sustaining Devices: ○ In cases where patients have life-sustaining devices, such as endotracheal tubes, feeding tubes, or intravenous lines, to prevent inadvertent removal or manipulation of these devices. ○ It is essential to balance the need for restraint with the patient's comfort and the potential for complications associated with immobilization.
Describe the legal implications when using restraints.	• Potential patient's rights violation: ○ can restrict the patient's freedom to move and so may infringe on the autonomy and dignity. ○ There is always a balance between not to harm but also to benefit the care of the patient. ○ Only use as a last option and only done for the shortest period. • Prescribed use of restraints by treating doctor: ○ Must be prescribed by the treating doctor and communicated to the family. ○ The Use of Mechanical Restraints Doc. No: NUR-POL-CP-001 • Possibility of neglect: ○ Due to the restraint of the patient and the inability of the patient to do anything for him or herself, it is of utmost importance that activities of daily living must be monitored and patient assisted to ensure that patient is cared for. • Decision for restraint based on staff shortage and not in protection of patient: ○ The use of restraints is subject to legal and regulatory guidelines that vary across jurisdictions. ○ Healthcare providers must be aware of and adhere to these guidelines to ensure that restraint use is ethically and legally justified.
Assess for contraindications for using mechanical restraints.	• Any limb with an injury prior restraint application. • Skin integrity is compromised, or skin breakdown is noted.
Confirm the medical prescription for restraints.	• Prescription available for restraining patient and reviewed every 24 hours. • The decision to restrain a patient must be re-evaluated within 24 hours to determine the necessity. • The restrains must be used for the shortest time possible to minimise the possible risks.
Perform hand hygiene.	• Infection control principles followed to prevent cross infection of microorganisms.
Using the Neurovascular assessment chart NUR-FORM-GEN008, record 1-2 hourly observations.	• Perform a neurovascular assessment and compare both limbs to recognise signs of vascular compromise (refer to neurovascular assessment). • Also assess for proper placement of the restraints, skin integrity and vital signs. • Restrains should be released to allow for proper assessment of the skin and allow more movement to increase comfort and relieve strain on muscles. • Restricted movement due to restraints can lead to muscle weakness and joint stiffness.
Additional points to remember.	• Restraints can cause discomfort and restrict the patient's ability to move freely. Regular repositioning and assistance with personal hygiene can help prevent skin breakdown, maintain dignity, and improve overall comfort. • The airway must not be obstructed, elevate the head of the bed or position patient lateral or semi-prone position.

Competency steps	Guidelines
	• Nurses should ensure that the patient is nutritional, and hydration needs are met. This may involve offering regular meals, assisting with feeding if necessary, and providing adequate hydration to prevent dehydration and malnutrition. • Restraints should be used for as short a period as possible. • Due to the impact of restrains on the patient's dignity, the high possibility of harm and negative impact on psychological health, it is important to remove restrains as soon as possible. • Patients restrained need to be sedated to prevent exhaustion. • If a patient is responding to the restrains with violence or aggression and is fighting against the restrains, it may be necessary to make use of chemical restraint.
Check and verify accurate and complete documentation.	Accurate and detailed documentation is essential when a patient is restrained: • Reason for restraint use, • Type of restraints used, • Ongoing assessments, • Patient responses, • Complications or adverse effects, and the plan for restraint discontinuation or modification. • Documentation helps maintain continuity of care, ensures accountability, and facilitates communication among the healthcare team. • Completion of Mechanical restraint form NUR-FORM-CP-001. • Neurovascular assessment chart NUR-FORM-GEN008, must be completed and checked by the RN.

Competency: Admission of an adult patient

OUTCOMES
• Demonstrates competency in using applicable data collection techniques to obtain complete subjective and objective patient data.
• Apply correct skills and techniques to obtain accurate patient data.
• Initiate and execute correct and appropriate interventions on interpreted data findings.
• Demonstrate complete and accurate record keeping, reporting and patient interaction in view of the findings.

RATIONALE

This competency is integrated in the following skills and procedures:

- Therapeutic environment
- Patient identification
- History collection
- Vital data assessment
- Risk assessment

COMPETENCY REFERENCES:

This competency is based on:

1) Life Healthcare (LHC). 2021. *Admission and Discharge*. Doc. No. NUR-CP-CP-GEN. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 17.

COMPETENCY STEPS	RATIONALE
Prepare the environment to admit a patient.	• See Therapeutic Environment competency. • Ensure a Standard patient file with relevant documentation.
Collect all the relevant documents to complete the admission process.	As per admission requirements.
Introduce yourself and other staff to the patient.	Establish a therapeutic relationship. See Therapeutic use of self, competency.
○ Assist the patient to dress into a hospital gown. ○ Make the patient comfortable in bed.	The patient should be as comfortable as possible for the admission process.
Orientate the patient to environment.	• Orientate the patient to the room/ward, visiting times and visitor's policies, emergency exits, bathrooms, call bell, TV and radio availability and other relevant detail. • Record all information accurately.
Identify the patient correctly.	Identify patient correctly according to the policy. See Patient identification competency.
Complete the Admission document correctly.	• Obtain relevant biographical data from the patient. • Document any allergies, risks and co-morbidities (for example asthma, hypertension etc.). • Apply an allergy sticker to all areas on the documentation if applicable. • If no risks are present, document under "nil known." • Obtain contact details of relatives, religion and home language. • Document the admission diagnosis on the Patient Record and the prescription chart. • Describe the patient's primary reason for admission (state what the current problem is). Obtain the following information: • The commencement of symptoms • The nature and frequency of the problem

COMPETENCY STEPS	RATIONALE
	• Activity the patient was performing when the problem occurred. • Factors that aggravate or alleviate the problem. Obtain information of the patient's previous illness and current treatment. • childhood illnesses, • chronic conditions, • previous injuries and hospitalisation, • medication taken. • Obtain information regarding family illnesses e.g. heart disease, diabetes, back problems, etc. • Obtain information on personal habits – alcohol use, smoking habits and religious/cultural considerations. • Obtain information regarding previous surgery and record any anaesthetic problems which occurred.
Obtain chronic medication history and management.	• If medication is brought into the hospital, the medication must be listed on the prescription chart, as well as the dose and the quantity brought in. • Indicate by ticking in the appropriate block if patient has prosthesis.
Identify any risk factors.	• Complete the risk tools (Waterlow pressure sore prevention score and risk of falling). • If necessary, apply safety measures such as cot sides and ensure that necessary steps are taken to prevent pressure sores.
Take care of patient's valuables.	• Explain to the patient that valuables brought into hospital, are kept at the patients' own risk – the patient is required to sign the patient record. • Follow the policy to ensure safeguarding of valuable should the patient be unable to send them home. • Follow the policy for safeguarding of firearms – it must either be sent home or kept in the hospital safe. • Complete this section by ticking in the appropriate block.
Document legality and signature verified.	• The patient or guardian is required to sign the patient document after completion of the admission which confirms that the information is correct. • The admitting nurse must sign the patient document once completed. • The registered nurse must check and verify that a complete admission is recorded on the admission documentation and sign the document.
Assess physical dependency/ functional activities.	Establish the patient's physical dependency needs: • Hygienic needs • Mobility needs • Nutritional needs • Elimination needs • Report any abnormalities to the RN
Obtain Vital data.	• Assess vital signs in order to establish a base line for reference and to manage risks (Temperature, pulse, respiration and blood pressure). • Oxygen maintenance (assess if patient needs active intervention to maintain oxygen –O2 saturation level monitored). • Neurological status (complete the Glasgow coma scale if necessary). • Complete the fluid and electrolyte balance chart. • Do a urine analysis (dipstick).

COMPETENCY STEPS	RATIONALE
	○ A specimen of urine is obtained as soon as possible – assessed, charted and abnormalities reported. ○ If abnormalities are found on dipstick, a sample should be sent for MC&S for testing. • Perform a blood glucose test if necessary. • Record and report any abnormality.
Commence the prescribed treatment.	• Wound care: Assess if the patient has any wounds and what type of wound care is required. (Assess the condition of the wound and wound drainage). • Establish if the patient has brought in a doctor's letter for admission. • If so, conduct the admission prescription. • Pain management: complete the pain scale and assess the need for intervention – aim to keep the patient pain free. • Assess the need for intravenous therapy according to the doctor's prescription. • Establish whether the patient requires any diagnostic or therapeutic interventions and ensure that the necessary referral is done and arrangements are made. • In the event that no letter has been sent, contact the relevant doctor and inform him of the admission and status of the patient. • Use the ISBAR principles when communication with the doctor.
Provide psycho-social support.	Assess the patient's and family's need for psycho-social support and do appropriate reference where needed.
Record on all relevant documentation	• Apply legal record keeping principles.
Enter information into the admission book.	• Attach a sticker in the ward admission book and update bed list in order to ensure that case managers are aware of patient and that census reports are correct. • Ensure the correct admission diagnosis. • Update the diagnosis when necessary.

Skill: Obtaining neurological observations

OUTCOMES
• Perform a neurological assessment on a patient.
• Obtain a base line to correlate future data against.
• Identify life-threatening situations and seek immediate help.

RATIONALE

This skill is integrated in the following skills and procedures:

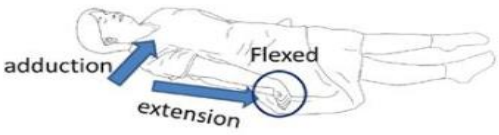
- Admission of a patient.
- Assessment and monitoring of vital data.
- Execution of a nursing care plan.
- Pre- and post-operative care.

COMPETENCY REFERENCES:

This competency is based on:

1) Life Healthcare (LHC). 2022. *Performing neurological observations*. Doc. No. NUR-WP-GEN-027. Life Healthcare Intranet.
2) Life Healthcare (LHC). 2022. *Patient identification*. Doc. No. NUR-WP-GEN-001. Life Healthcare Intranet.
3) Pictures curtesy of: Reproduced from: Critical Care Services Ontario. *Guidelines for Basic Adult Neurological Observation*. Ontario. CCSO: Ontario, 2018.

SKILL STEPS	RATIONALE
Prepare the environment and gather the needed documentation and equipment.	• Glasgow coma scale flow chart NUR-FORM-GEN007. • Vital signs flow chart NUR-FORM-GEN004. • Prepare a penlight torch or ophthalmoscope to assess pupil reaction.
Perform hand hygiene.	Adhere to Infection prevention protocols.
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the procedure and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
Assess eye-opening response	• The eye-opening response is scored out of four. • Approach the patient's bedside without speaking. This allows the nurse to assess for a **spontaneous** eye opening. If the patient opens their eyes, a score of 4 is given. • If the nurse needs to stimulate eye opening with **speech**, a three is awarded. • If eye opening is prompted with **pain**ful stimuli, for example by performing a trapezius squeeze or applying supraorbital pressure, a score of two is given. Sometimes assessment of a peripheral pain response can be performed by applying ***interphalangeal joint pressure*** **-** squeezing the side of the patient's fingernail. • If there is **no response**, a 1 is scored.
Assess best verbal response	• The best verbal response is scored out of five. • If the patient has a tracheostomy or endotracheal tube, the letter "T" is documented. The 5 is then **removed** from the overall score. The score will then be out of 10. • Should the patient not be able to appropriately respond due to a **language barrier**, this must be indicated and elaborated on in the daily nursing records. A score should not be given until the language barrier is resolved. • Ask patient questions to determine orientation to time, place, and person.

SKILL STEPS	RATIONALE
	• The sequence of questions should be changed to ensure the patient has not memorised the answers. • The patient might be orientated but appear to be behaving inappropriately. You will score the patient as orientated but document the displayed behaviour in the daily nursing records. If the patient is **orientated** a score of **5** is given. • If the patient is disorientated and **confused**, ***the answer 1 or more questions incorrectly*** to time, place, and person, a score of **four** is given. • If the patient uses **inappropriate words** that have no connection to the conversation of time, place, and person, a three is awarded. • If the patient offers **incomprehensible sounds**, such as moaning, the patient is scored a **2**. • If there is **no verbal response**, the patient is scored a **1**.
Assess best motor response	• The best motor response is scored out of six. • Assess to ascertain whether the patient can **obey** a simple **command** such as requesting them to lift their arm or stick out their tongue. If they can, they are scored a **6**. • If the patient does not respond to the simple command, place the patient in the supine position and assess. If the patient **localises to pain** produced either by using the trapezius squeeze or by applying supraorbital pressure (localising is when the patient moves a hand in an attempt to remove the source of the pain, moving towards the chin or the midline of the body), then a score of **five** is given. • Localising to pain: ○ Assess if the patient withdraws to pain (normal flexion) in that the limb bends at the elbow or knee and moves away from the midline with no direct attempt to remove the painful stimulus. If this occurs, a score of 4 is given. (Do not confuse this with abnormal flexion)  • Abnormal Flexion: ○ If abnormal flexion (decorticate) is displayed, a score of 3 is given.  • Abnormal extension: ○ Abnormal extension (decerebrate) is scored a 2.  • If there is no response, then a score of 1 is given.
Using above three (3) parameters accurately calculate the patients GCS.	• Add the score of each parameter together to obtain a score out of 15. • Interpret and discuss the results. • Note how the score will influence nursing care of the patient. • Check and correlate with trends and discuss any concerns.

SKILL STEPS	RATIONALE
Assessment of the pupils	Assess the pupil **size** once it has adjusted to the natural room light first. Record this size. • Ask the patient to look directly ahead. If the patient is unconscious, or the eyelids are oedematous, the nurse may gently open the patient's eyelids. If not, indicate, using the letter "C", that the eyes are closed. • In a dim room, with lights turned off and using your light, assess the **size**, **reaction** and **equality** of the left and right pupil. Do this by moving the light from the outer aspect of the eye towards the pupil. Constriction should be evident. Check to see that the pupils are equal by shining the light in one pupil and checking the other eye for constriction at the same time. This must be repeated for both right and left eyes. • Document your findings using the symbol guide on the Glasgow coma scale tool. • If there is a change from the baseline assessment, alert the emergency team and notify the treating doctor of this change.
Performing a limb movement and strength assessment	Performing a limb movement and strength assessment alerts the assessor to possible neurological changes which need immediate intervention. In order to acquire further information about the potential anatomical location of intracranial pathological processes or dysfunction, limb muscle strength is tested. On occasion, the patient might not be able to move these limbs due to restrictive aids or conditions such as traction or a cast. • Limb **movement** ○ Assessed on both **arms** and **legs**, **left** and **right** sides. These are assessed separately. Start with the arms first. ○ To assess limb **strength**, the nurse can ask the patient to push the nurse's hands away which are placed at the sole of the foot. To further test, the nurse can place his/her hands on the tops of each foot whilst requesting the patient to pull their foot away. ○ The scale of assessment involves 6 areas of varying power levels ranging from normal power to no response. Document findings accordingly. ○ Limb strength is determined using the scale for muscle strength which is located on the Glasgow coma scale flow chart NUR-FORM-GEN007. ○ Using this scale, which offers a score ranging from 5 – 0, the assessor is able to award a score ranging from normal strength, 5, to no contraction, 0. ○ Each limb's strength is recorded: Arms – Left and Right, and Legs – Left and Right. ○ When assessing arm strength, the nurse asks the patient to squeeze the nurse's hands, or the patient can be asked to raise their arms. The nurse assesses whether the patient can hold this position, or whether the arm falls.
Keep clear accurate and legal documentations	• Clear and accurate recordkeeping monitor for changes in the patient's condition. Document on relevant forms and in the patients Daily Assessment /Nursing Care Plan /Progress Report NUR-FORM-GEN-002. • Ensure accurate recording of assessments, interventions, and outcomes are made. • Record health education that has been given to the patient and the family. • Ensure planned care is documented and interventions are recorded as they are implemented. • Clearly document your name, initials, surname, and designation in all records.

Competency: Discharge of a patient

OUTCOMES: The student will demonstrate competence in skills pertaining to
• Demonstrate safe transfer / discharge of a stable uncomplicated adult patient through:

COMPETENCY REFERENCES:

1) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 17.
2) Life Healthcare (LHC). 2011. *Nursing Care Plan – Admission and Discharge*. Doc. No. NUR-CP-CP-GEN. Life Healthcare Intranet.
3) Mogotlane, S., Mokoena, J., Chauke M., Mokgadi, M., Randa, A., 2022. Juta's Complete Textbook of Medical Surgical Nursing. 2nd ed. Cape Town: Juta and Company.

COMPETENCY STEPS	RATIONALE
Indicate the reason(s) for the discharge of the patient.	To ensure that a comprehensive final assessment prior to discharge is completed and recorded.
Explain the discharge process to the patient.	To ensure that the main aspects and implications of the transfer have been addressed and explained on the patient's level of understanding. To acknowledge and manage any of the patient's responses and concerns in discharge planning process. Address the following where applicable. • Final doctor's consultation. • Scheduling and conducting a discharge health information /teaching session. • Administrative discharge process. • Medication prescription management. • Transport arrangements. • Physical discharge assessment. • Wound care & dressings. • Continuation of nursing care and hospital routine until discharge.
Confirm medical prescription.	To prevent any medico-legal risks and ensure patient is prepared prior to discharge event: • Check and verify discharge from unit notice, confirm specific treating doctor instructions. • Confirm patient consent and maintain professional and transparent communication with patient and family.
Complete discharge documentation and any documentation for the patient to take home (sick notes, referral notes).	To ensure all discharge instructions and documentation are systematically completed.
Prepare the patient for discharge.	• To ensure patient and environment is presentable prior to discharge. • Ensure all patient valuables are locked out and handed the patient. • All patient clothes, toiletries etc. are collected and packed. • Inform the family of the patient's discharge.
Conduct a general patient survey.	A comment card will enable one to determine what is effective and what was ineffective within the Life Health care business.
Obtain the vital observations accurately.	To ensure an overview vital observation chart and evaluate vital data ranges and trends prior to discharge
Perform additional ward tests.	To ensure an overview of the additional ward tests and evaluate trends of tests prior to discharge.
Complete a full physical body-system assessment.	Performing a full physical body-system assessment on the patient is to verify the health condition before discharge & establish any physical progress during hospitalisation period. • Nervous system • Respiratory system

COMPETENCY STEPS	RATIONALE
	• Cardiovascular system • Gastrointestinal system • Urinary system • Integumentary system • Musculoskeletal system • Metabolic and endocrine system • Immune system
Provide 'To take out' (TTO) medication to the patient and sick certificate. (if applicable). Clarify medication instructions.	• To ensure continued and accurate medication usage after discharge.
Provide patient with follow up appointment or direction according to doctor's preference.	To assist the patient in maintaining health through follow-up visits with the doctor.
Conduct health education and provide educational pamphlet.	The purpose of the health education is to optimise patient understanding related to the patient's specific condition prior to discharge.
Record all data accurately according to legal prescriptions.	Recordkeeping reflects adherence to all principles of recordkeeping.
Ensure patient is discharged off Impilo system and file is given to stock controller for final billing and case management intervention.	To ensure effective billing of hospital costs, updates sent to the medical aid timeously and digitally capturing of file.

Competency: Transfer of an Adult Patient

OUTCOMES: The student will demonstrate competence in:
• Demonstrating knowledge of the underpinning principles related to the transfer of an adult patient.
• Demonstrating complete and accurate recordkeeping and reporting. and patient interaction regarding the findings.

RATIONALE

This skill integrates skills and competencies including –

- Patient identification
- observing a patient's vital signs and other ward tests,
- patient physical assessment,
- legal recordkeeping
- health education.

COMPETENCY REFERENCES:

1) Life Healthcare (LHC). 2023. *Internal and External Patient Transfer.* Doc. No. NUR-WP-GEN 035. Life Healthcare Intranet.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 17.

COMPETENCY STEPS	RATIONALE
Provide the indication for patient transfer.	• Internal transfer (between wards/units/departments). • External transfer (transfer from or to another hospital or facility).
Outline transfer risks.	To ensure patient safety and prevent medico-legal risks. • Transport risks e.g. unnecessary exposure to ill weather conditions, privacy violations Integrity of patient identification bands are legible, especially when patients are mentally compromised. • Inter-healthcare transferral risks e.g. compromised continuity in patient care due to inadequate communications and role and responsibility clarification (ensure clear verbal and written communications about all invasive lines etc.) • Risks related to insufficient support and referral systems to sustain optimal rehabilitation/recovery.
Outline the criteria for the transfer of a patient.	To ensure the patient's physical safety and prevent medico-legal risks: • A legal doctor's order with transferral instructions. • The patient must be identified as medically stable for transfer with evidence of recordkeeping to secure a safe transfer. • Only skilled and experienced nurses (2 staff members of one being a RN) should manage patient transfers. • Vital signs and risk score assessments scores must be stable on final assessment and at the point of verbal handover. • The unit manager should be aware of changes in vital observations and engage in immediate consultation with the treating physician if deterioration in patient condition is identified before or at transfer. To ensure sufficient staff are available to transfer the patient and to prevent unnecessary disruption to other patients: • Planned transferrals must be done during normal office working hours. To ensure safety of the patient's property and medico-legal risks: • Care must be taken to ensure that all personal belongings of the patient including dentures, hearing-and walking aids, spectacles and medication are transferred with the patient To ensure the receiving ward / facility is adequately prepared for the patient's arrival and have the necessary equipment and facilities. • The transferring ward receiving the patient must be informed about the patient's individual needs before transfer.

COMPETENCY STEPS	RATIONALE
	• This includes patient co-morbidities, risks and alerts, skin condition, disabilities, mental condition, communication abilities and emotional support required, infection and isolation status (current and previous treatments received). To ensure the receiving unit / facility have treatment instructions at hand on arrival ensuring continuity of care: • The transfer documentation and relevant health records must accompany the patient as per Institutional policy (i.e. medical records, multidisciplinary notes and copies of the medical prescription chart. To maintain a therapeutic relationship and prevent unnecessary anxiety for the patient and family: • The patient and his/her relatives must be informed that the patient is leaving the unit and advised of where the patient is going. To protect the patients physical and emotional safety. • The patient should be moved with the minimum disruption. Privacy, dignity and patient comfort should be maintained throughout the transfer process. To ensure continuity of care and prevent medico-legal risks: • All information must be recorded in the patient's records.
Prepare relevant documentation required for transfer.	To ensure all patient information reaches the receiving facility / unit allowing for continuity of care: • Patient records. • Standard internal transfer form. • Report on Transfer to another Hospital / facility. • Blood results, diagnostic tests e.g. x-rays and copies of diagnostic test results.
Prepare the patient.	Ensures patient's dignity and self-esteem needs are met: • Patient is clean and neat -haircare, mouth care, nails, wound dressings, nightgown. • Incontinence & sanitary napkins must be changed shortly before the actual discharge. • Assist the patient with any special requests i.e. grooming hair. Ensures protection of the patient's property and avoids possible litigation: • Pack/assist the patient to collect and pack all their personal belongings, including valuables that have been locked away. • Manage medication, clothes, belongings, valuables according to institutional policy.
Explain the transfer process to the patient.	Ensures patient's right to informed consent.
Confirm transfer instructions/ prescription.	Ensures that doctor's orders are correctly carried out and prevents litigation: • Check and verify transfer from the unit - confirm specific physician instructions
Perform a general patient survey.	Ensures emotional, self-esteem, mobilisation and independence needs are met: • Prevents patient injury. • Prevents litigation. Assess general healthcare related patient-specific aspects with a needs-and risk-based focus: • General appearance e.g. hygiene • Mobilisation capabilities • Level of independence • Cognitive understanding and mental readiness to leave hospital. • Determine the mode of transportation and need for physical comfort during transportation. • Overview patient records to verify existing clinical presentation.

COMPETENCY STEPS	RATIONALE
	• Action priority problems and needs appropriately and record accurately in patient documentation.
Accurately obtain and evaluate vital observations. Obtain and evaluate relevant additional ward tests. Perform a physical examination.	• Ensures the patient is medically stable for transfer. • Ensures problems are addressed, thus avoiding patient injury/ litigation. • Previous recorded ranges and trends monitored and compared. • Identify deviations in vital data ranges and act immediately and appropriately on identified concerns e.g. lowered saturation levels, pyrexia. ○ *See collection of Vital data skill.* ○ *See Urine analysis skill.* ○ *See blood glucose skill.* ○ *See Physical assessment skill.*
Provide relevant health education.	Ensures patient is knowledgeable about their medical condition and how to manage it thus relieving anxiety and promoting independence. • Consider the unique patient context to enhance health education. • Involve patient in discussion. • Provide information brochures where possible to reinforce knowledge. • Demonstrate clinical skills/techniques. • Motivate the patient with empathy and respect.
Preform final care responsibilities.	To prevent litigation: • Legible, intact identity bands and allergy bands. To maintain patient dignity: • The patient is properly dressed and covered. To prevent falls: • Appropriate transport arrangements – accompanied, wheelchair / stretcher. To ensure continuity of care and confidentiality: • Referral letter is complete and sealed in an envelope. To stabilise invasive devices during transport: • Appropriate devices: ○ Drip stands ○ Catheter stands ○ Oxygen carriers To ensure patient comfort • Immediate needs are met: ○ Pain management ○ Elimination needs
Record data legally and accurately.	To ensure continuity of patient care: • Accurate use of medical terminology. • Accurate descriptions of nursing interventions. • Adherence to all principles of recordkeeping. To prevent litigation:

Competency: Bed Bath

OUTCOMES: The student will demonstrate competence in:
• Effective planning to provide a bed bath procedure to a bedridden patient.
• Effective execution of the procedure.
• Maintaining patient safety and dignity through the procedure.

RATIONALE
This competency is integrated in the following skills and procedures:
- All patient who may require receiving a full bed bath.

COMPETENCY REFERENCES:
This competency is based on:
1) Fundamentals of care: Hygiene Doc. No: NUR-WP-GEN-028 and all references contained therein.
2) Mulder, M., Joubert, A. and Olivier, N. 2020. Practical Guide for General Nursing Science. 2nd edition. Pearson: Cape Town. Pg 257 - 269

COMPETENCY STEPS	RATIONALE AND STANDARD
Introduce self and identify the patient.	To ensure that the correct patient receives the treatment: • Check the identity band, • Ask patient name and address, • Make sure all record has same name and address.
Explain the procedure and obtain informed consent.	• Ensure the patient understands the procedure and is given the opportunity to ask questions. • Alleviate feelings of anxiety and fear and encourage participation.
Perform handhygiene.	Infection control principles applied to prevent cross-infection.
Conduct a physical assessment.	• Assess the patients need for a bed bath. • Review the nursing care plan prescription. • Validate the type of bed wash indicated for the patient in view of his general health status and level of independence. • Identify and appropriately address limitations in patient's emotional preparation. • Assess for any breaks in skin. **NB**. After hand hygiene is performed any breaks in skin are covered with waterproof dressing.
Gather all the equipment to be used.	Determine the patient's diagnosis and prepare equipment relevant to the hygiene procedure being performed: • Toiletries • Towels • Washcloths (preferable two if available) • Brush/comb • Toothbrush & toothpaste • Mug/glass of water for mouth rinse • Denture cap • Deodorant • Razor & shaving cream • Clean clothing • Clean bedlinen • Disposable gloves & linen saver • Obtain water for washing in the appropriate washing basin as per unit standard
Offer the patient a bedpan or urinal before commencing with the procedure.	Ensure patient comfort before, during and after the procedure, and that all needs have been met, this includes: • Elimination needs. • Nutritional needs • Pain management

COMPETENCY STEPS	RATIONALE AND STANDARD
Position the patient comfortably.	Position patient in a semi-fowlers/ supine position, diagnosis permitting.
Ensure privacy throughout the procedure.	Maintain the patient's dignity throughout the procedure. • Close the curtains. • Do not overexpose the patient, only expose the part of the body that is being washed. • Where possible, allow the patient to wash certain areas themselves, e.g. face and genitals.
Wash hands and put on gloves, and other personal protective equipment (apron and non-sterile gloves).	• Understand the purpose and medico-legal risks related to contamination and spread of infection. • See hand hygiene competency.
Prepare the patient.	• Place a sheet over the patient to maintain their modesty and keep them warm. • Remove the top linen.
Undress the patient without exposing him/her.	Remove dirty clothing, keep patient covered to maintain dignity and keep patient warm.
Throughout the procedure, observe the skin for any breakdown, redness or bruising.	Early detection of loss of skin integrity.
Start with the head, neck and shoulders.	Systematic approach followed.
Place the towel under this area of the patient;	Protect the matrass from getting wet.
Wash the patients face. Wash the back and front of the neck. Wash the ears. Wash the shoulder area.	• Use a clean cloth, ensure water is warm. • Lather the face cloth with soap. • Apply evenly and rinse off. NB. Consider patient preferences for products to be used to wash the face. If possible, allow the patient to wash their own face – this gives some dignity to the patient
Dry the patient Rinse the cloth.	• Wipe the soap off with a clean face cloth and dry the area softly, by using patting motions. • Inspect skin and general appearance of special senses (eyes, ears)
Remove the bath towel.	Remove the wet towel quickly and dispose the towel as per waste management policy.
Wash the arms one at a time:	
Place the towel lengthways under one of the patient's arms.	Start with one arm, wash, and rinse and dry the arm before moving to the next arm.
Clean the patient's hands and fingernails	• By placing them into the basin. • Ensure fingernails are washed, and hands dried.
Wash the abdomen and sides of the chest and breasts:	
Do not overexpose the patient. Dry the patient. Cover the patient.	Lather the face cloth with soap and wash the abdominal area. Rinse the face cloth and wipe away the soap. Lightly dry the abdominal area.
Wash the lower extremities one at a time:	
Place the towel under the leg Do not overexpose the patient Dry each leg	• Lather face cloth with soap. • Wash one leg at a time, rinse and dry the leg before moving to the other leg. • When washing the patient's legs, expose each leg and wash starting with the one furthest from you, wash carefully bending the leg as needed, dry, repeat on the other side. • Wash the feet and toes and dry carefully, • Ensure the patient's genitalia are not exposed.
Cover the patient with the sheet when finished.	Maintain body temperature and ensure patient dignity.
Wash the patient's back:	

COMPETENCY STEPS	RATIONALE AND STANDARD
Assist the patient onto their side facing away from you.	Turn the patient into a lateral position. Keep cut side up. Let patient hold onto the cot side for support.
Tuck the towel under the full length of the patient. Wash the patients back downwards from the neck.	• Place towel under the patient's back, to protect the matrass from getting wet. • Lather face cloth with soap and wash in a downward motion, starting at the patient's neck towards his/her buttocks. • Rub the patients back with the soapy water, rinse with clean water and dry with the towel.
Wash the patient's buttocks. Wash the perineal to anal area.	• Use a different cloth for the buttocks. Wash the buttocks area, rinse and dry the area. • Inspect the area for redness, skin breakage or pressure sore formation. • Push dirty linen through and remove wet towels.
Roll the patient onto their back.	Keep patient covered, ensure patient is coping with the movement. Can place patient in a semi-fowlers position.
Wash the genitalia	
Place the towel under the patient's hips.	• If catheterized perform catheter care as per institutional policy • Work fast and efficiently and make use of a colleague's presence if possible. • Identify and act upon health problems/concerns
Cover the genitalia with another towel.	• To maintain dignity **NB.** Ask the patient if they would prefer to wash their own genitalia. Give them the prepared cloth. Rinse giving them the towel to dry the area.
Wash or direct patient to wash correctly.	For a **female patient** wash the groin area then clean the vulval area and labia majora, then the labia minora. Ensure the area is well rinsed and dried completely. For the **male patient** wash the groin area, and then clean the penis towards the scrotum. Washing a **male patient who is uncircumcised** includes the need to retract the foreskin, and clean from the glans penis towards the scrotum, replace the foreskin, ensure the area is dried. • Do not wash genital area with water and soap, use water only. • Dry the area through patting. Do not rub dry. • To avoid infections and trauma to delicate and sensitive areas.
Do not wash genital area with water and soap, use water only; dry the area through patting – do not rub dry.	To avoid infections and trauma to delicate and sensitive areas.
Apply sprays, talc's and lotions depending on patient preference.	Avoid these getting onto catheters and wound areas.
Assist patient to dress.	• Assist patient to dress with clean pyjamas or hospital gown. • Comb patient's hair, assist with application of make-up.
Clean the working environment.	• Replace bed accessories. • Deal with used items; hand up used towels or replace with clean ones, thoroughly rinse the washcloths in clean water
Remove personal protective equipment and perform hand hygiene.	• Discard all waste and clean up the environment. ○ Healthcare Risk Waste Policy (QMS-WP-RM-002) • Infection control measures to prevent cross infection.
Promote patient safety and comfort.	• Ensure patient safety and comfort before leaving the patient's direct site. • Replace call bell and personal belongings within reach.
Record the procedure.	Record all relevant information to ensure continuation of nursing care.