Skills in Clinical Nursing

Ninth Edition

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Dedication

Audrey again dedicates this book to her child, Jordanna Elise MacIntyre, who has evolved and matured just as has the book itself. Also, like the book, Jordanna seeks to—and will—make the world a healthier and better place.

Shirlee again dedicates this book to her husband, Terry J. Schnitter, for his continual love and support; to the nurses, present and future, who contribute to the nursing profession; to her step-children (Kelly and Steven), grandchildren (Ashley, Brady, and Ryan), and first great-grandchild (Oliver); to her younger brother, Dan Snyder, and his wonderful family; and in memory of her older brother, Ted Snyder, who is missed by his loving and caring family.

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We would like to express our sincere thanks to the educators who reviewed chapters of this text. Their insights, comments, suggestions, criticisms, and encouragement contributed to making this a more useful and relevant tool for students.

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Preface

The skills performed by nurses exemplify the integration of the knowledge, psychomotor dexterity, attitude, and critical thinking necessary for effective clinical practice in the 21st century. The ninth edition of *Skills in Clinical Nursing* has been revised and updated to reflect the changes in practice that have occurred since the previous edition. It includes:

- The 161 most important skills performed by nurses, including all common variations, organized from the simple to the more complex. All skills have been revised to reflect current clinical practice.
- More than 800 illustrations. *Skills in Clinical Nursing* is intended as a primary textbook for nursing education programs and as a reference for practicing nurses. Content was selected based on feedback from reviewers of previous editions, market surveys, and the extensive teaching and practice experience of the authors.

All content was reviewed by practicing clinical nurses who provided invaluable firsthand knowledge of current practice.

FORMAT

Each chapter contains concise introductory material, placing the skills in perspective to client anatomy, physiology, and pathophysiology, and provides an overview of the rationale and purpose of the skills. The presentation of each skill follows the steps of the nursing process:

- A review of the **assessment** data required before performing the skill.
- During **diagnosing**, the second phase of the nursing process, the nurse uses critical thinking skills to interpret specific assessment data and identify the client's strengths and problems. The authors did not include this step of the nursing process for the skills in this book because the focus is on the skill and no specific client assessment data are included. Application of nursing diagnoses is reflected in each end-of-unit feature on the nursing process.
- As a component of the **planning** phase, information about when it is and is not appropriate to assign each skill to assistive personnel (AP).
- **Implementation** steps, including client teaching, observation of standard infection prevention precautions, and client record documentation. Rationales are indicated by italic type.
- Considerations in **evaluation** of the skill, focusing on steps indicated for follow-up and communication with other members of the healthcare team.

HIGHLIGHTS OF THE 9TH EDITION

- **Emphasis on QSEN!** The delivery of high-quality and safe nursing practice is imperative for every nurse. This edition has incorporated QSEN competencies and specified expectations into the narrative. This content highlights relevant information in patient-centered care, teamwork and collaboration, and safety.
- **Updated art!** Many new photos and drawings
- Current CDC and WHO definitions and guidelines
- 2019 National Patient Safety Goals (NPSGs) for hospitals and long-term care
- Current CMS guidelines for use of restraints
- *Healthy People 2020* objectives for cholesterol, hypertension, and diabetes
- Updated Infusion Nurses Society guidelines
- Updated nursing standards and references (ANA, NPSG, and so on)

Features of the Ninth Edition

Skills in Clinical Nursing

continues to be a definitive resource for the most commonly performed nursing skills. This skills book is designed as an easy reference for both the classroom and clinical practice!

Skills are organized in a nursing process framework and include step-by-step instructions.

SKILL 31.6

Removing Sutures and Staples

ASSESSMENT

Assess:

- Appearance of the suture line
- Factors contraindicating suture removal (e.g., nonuniformity of closure, inflammation, presence of drainage).

PLANNING

Before removing skin sutures, verify (a) the orders for suture removal (many times only *alternate* interrupted sutures or staples are removed one day and the remaining sutures or staples are removed a day or two later); (b) when the client may bathe or shower; and (c) whether a dressing is to be applied following the suture removal. Some primary care providers prefer no dressing; others prefer a small, light gauze dressing to prevent friction by clothing.

Assignment

Removal of sutures or staples requires application of knowledge and problem-solving and is not assigned to AP.

Equipment

- Waterproof bag
- Sterile gloves
- Sterile dressing equipment including:
- Sterile suture scissors or staple remover
- Gauze squares
- Sterile hemostat or forceps
- Sterile butterfly tape or Steri-Strips (optional)
- Tape, if a dressing is to be applied

IMPLEMENTATION

Performance

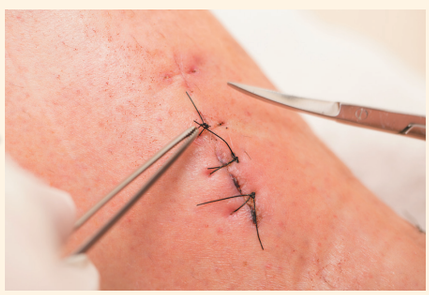
1. Prior to performing the procedure, introduce yourself and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how to participate. Inform the client that suture removal may produce slight discomfort, such as a pulling or stinging sensation, but should not be painful.
2. Perform hand hygiene and observe other appropriate infection prevention procedures.
3. Provide for client privacy.
4. Apply clean gloves, remove any dressings, and clean the incision (see Skill 31.4).
   - Clean the suture line with an antimicrobial solution before and after suture or staple removal. **Rationale:** This is generally done as a prophylactic measure to prevent infection.
5. Remove the sutures or staples.
   - Apply sterile gloves.

Plain Interrupted Sutures

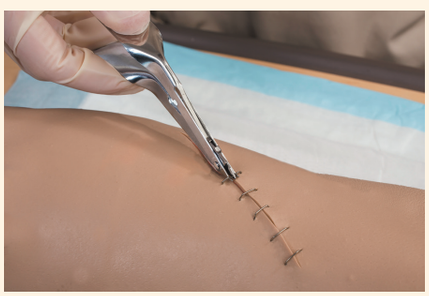
- Grasp the suture at the knot with a pair of forceps.
- Place the curved tip of the suture scissors under the suture as close to the skin as possible, either on the side opposite the knot ❶ or directly under the knot. Cut the suture. **Rationale:** *Sutures are cut as close to the skin as possible on one side of the visible part because the visible suture material is contaminated with skin bacteria and must not be pulled beneath the skin during removal. Suture material that is beneath the skin is considered free from bacteria.*
- With the forceps or hemostat, pull the suture out in one piece. Inspect carefully to make sure that all suture material is removed. **Rationale:** *Suture material left beneath the skin acts as a foreign body and causes inflammation.*
- Discard the suture onto a piece of sterile gauze or into the moisture-resistant bag, being careful not to contaminate the forceps tips. Sometimes, the suture sticks to the forceps and needs to be removed by wiping the tips on a sterile gauze.

Staples

- Place the lower tips of the sterile staple remover under the staple.
- Squeeze the handles together until they are completely closed. ❷ **Rationale:** *Pressing the handles together causes the staple to bend in the middle and pulls the edges of the staple out of the skin.* Do not lift the staple remover when squeezing the handles.



❶ Removing a skin suture.
Bojan Fatur/Getty Images.



❷ Removing surgical clips or staples.

Easy-to-find **RATIONALES** provide a better understanding of why critical steps are performed.

CRITICAL STEPS are visually represented with full-color photos and illustrations.

VARIATIONS present alternative methods of performing certain skills.

SKILL 17.8

Administering Intermittent Intravenous Medications—*continued*

9. After infusion of the secondary IV medication bag, regulate the rate of the primary solution by adjusting the clamp or IV pump infusion rate. Some infusion pumps will do this automatically.
10. Leave the secondary piggyback bag and tubing in place for future administration or discard as appropriate.
11. Document relevant data.
    - Record the date, time, medication, dose, route, and solution; assessment of the IV site, if appropriate; and the client's response.
    - Record the volume of fluid of the medication infusion bag on the client's intake and output record.

Variation: Using a Saline Lock

Intermittent infusion devices 5 may be attached to an IV catheter to allow medications to be administered intravenously without requiring a continuous IV infusion. The device may also have a port at one end of the lock and a needleless injection cap at the other end, with the extension tubing between the two ends. 6

- Prepare two normal saline prefilled syringes (10 mL each).
- Spike the medication bag with minidrip (60 gtt/mL) IV tubing.
- Attach the needleless adapter to the tubing, prime the tubing, and close the clamp.
- Clean the needleless injection port of the saline lock with an antiseptic swab. Open the saline lock clamp, if appropriate.

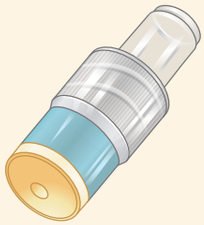
Insert the first saline syringe into the port, flush 1 to 2 mL, and then gently aspirate to check for patency. Flush the remaining volume slowly, noting any resistance, swelling, pain, or burning. **Rationale:** *This ensures placement of the IV in the vein*.

After connecting the IV tubing to the injection port of the lock, administer the medication, regulating the drip rate to allow medication to infuse for the appropriate time period. Macrodrip (10 to 20 gtt/mL) tubing may also be used if using an IV pump to regulate the flow.

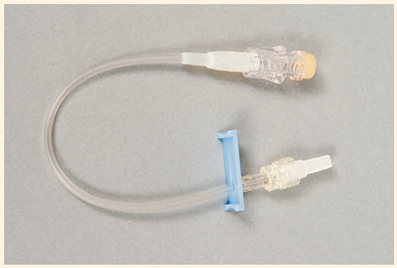
- When the medication has been infused, disconnect the IV tubing, maintaining sterility of the end of the IV tubing.
- Insert the second saline syringe into the port and flush at the same rate that the drug was injected until the entire drug dose has been cleared from the infusion system and vascular access device lumen. **Rationale:** *This clears the tubing and maintains patency*. Clamp the saline lock after flushing, if appropriate.
- Dispose of syringes in the appropriate container.

Variation: Adding a Medication to a Volume-Control Infusion

- Withdraw the required dose of the medication into a syringe.
- Ensure that there is sufficient fluid in the volume-control fluid chamber to dilute the medication. Generally, at least 50 mL of fluid is used. Check the directions from the drug manufacturer or consult the pharmacist.
- Close the inflow to the fluid chamber by adjusting the upper roller or slide clamp above the fluid chamber; also ensure that the clamp on the air vent of the chamber is open.
- Clean the medication port on the volume-control fluid chamber with an antiseptic swab.
- Inject the medication into the port of the appropriately filled volume-control set (i.e., the ordered amount of solution).
- Gently rotate the fluid chamber until the fluid is well mixed.
- Regulate the flow by adjusting the lower roller clamp below the fluid chamber.
- Attach a medication label to the volume-control fluid chamber.
- Document relevant data and monitor the client and the infusion.



5 Intermittent infusion device with an injection port.



6 Intermittent infusion device with an injection port and extension tubing.

EVALUATION

- Conduct appropriate follow-up such as desired effect of medication, any adverse reactions or side effects, or change in vital signs.
- Reassess status of the IV lock site and patency of the IV infusion.
- Compare to previous findings, if available.
- Report significant deviations from normal to the primary care provider.

ASSIGNMENT highlights guidelines for when it is appropriate and how to assign skills to assistive personnel (AP).

PLANNING

Assignment

The administration of intermittent IV medications involves the application of nursing knowledge and critical thinking. Check the state's nurse practice act to verify the scope of practice for the LPN/LVN as it relates to IV medication administration. Agency policy also must be checked and followed. This skill is not assigned to AP. The nurse, however, can inform the AP of the intended therapeutic effects and specific side effects of the medication and direct the AP to report specific client observations to the nurse for follow-up.

Equipment

- Client's MAR or computer printout
- Pharmacy-prepared medication-infused bag with correct label
- Short secondary administration set
- Antiseptic swabs for disinfection of needleless connector or injection port
- Needleless adapter, syringe, and saline if medication is incompatible with the primary infusion

SAFETY ALERTS correlate to the National Patient Safety Goals and identify other crucial safety information.

Safety Alert! SAFETY

Encourage the prescribing care provider to provide correct spelling of a drug, using aids such as "B as in boy." It is also important for the provider to pronounce numbers separately. For example, the number 16 should be stated as "one six" to avoid confusion with the number 60.

PRACTICE GUIDELINES provide instant access summaries of common procedures and clinical practice.

PRACTICE GUIDELINES **Strategies for Colleague Accountability in Pain Management**

What do we do if the healthcare team does not respond positively to a client's report of pain?

- Speak up! Inappropriate professional behavior will persist if not challenged. If necessary, file an "incident" or "variance" report for persistent patterns or unacceptable violations of standards of care. These types of behaviors (ignoring reports of pain, failing to treat or mistreating people with pain) are not only unethical, but legally indefensible because a standard of care is not being met.
- Clarify that the sensation of pain is subjective and that professionals have a duty to believe clients' reports of their symptoms.
- Cite recommendations from evidence-based clinical practice guidelines (e.g., American Pain Society, Agency for Health Care Policy and Research), The Joint Commission standards, organization-specific documents (e.g., mission statement, patient bill of rights, practice standards), or relevant research and quality reports. As necessary, distribute or post with key passages highlighted.
- Involve key committees, managers, and administrators in studying and addressing the problem from a cost, quality, competency, and credentialing perspective.

CLIENT TEACHING CONSIDERATIONS give tips and tools to help clients facilitate self-care and wellness.

CLIENT TEACHING CONSIDERATIONS

Client Self-Management of Pain

Choose a time to teach the client about pain management when the pain is controlled so that the client is able to focus on the teaching.

Teaching the client about self-management of pain can include the following:

- Demonstrate the operation of the PCA pump and explain that the client can safely push the button without fear of overmedicating. Sometimes it helps clients who are reluctant to repeatedly push the button to know that they must dose themselves (i.e., push the button) 5 to 10 times to receive the same amount of medication (10 mg morphine equivalent) they would receive in a standard "shot."
- Describe the use of the pain scale and encourage the client to respond in order to demonstrate understanding.
- Explore a variety of nonpharmacologic pain relief techniques that the client is willing to learn and use to promote pain relief and optimize functioning.
- Explain to the client the need to notify staff when ambulation is desired (e.g., for bathroom use), if applicable.

LIFESPAN CONSIDERATIONS present age-related content to alert you to differences in caring for clients.

LIFESPAN CONSIDERATIONS **PCA Pump**

CHILDREN

- Include the parents in teaching.
- Assess the child's ability to understand and use the client control button. Pasero and McCaffery (2011) report that "PCA has been used effectively and safely in developmentally normal children as young as 4 years old" (p. 314).
- Use distraction techniques to avoid dislodging or disconnection by the child.
- Use pediatric elbow immobilizers (no-nos, Snuggle Wraps) if distraction is not effective in keeping the child from playing with tubing and ports.

OLDER ADULTS

- Carefully monitor for drug side effects.
- Use cautiously for individuals with impaired pulmonary or renal function.
- Assess the client's cognitive and physical ability to use the client control button.

CLINICAL ALERTS highlight important information such as high-risk situations.

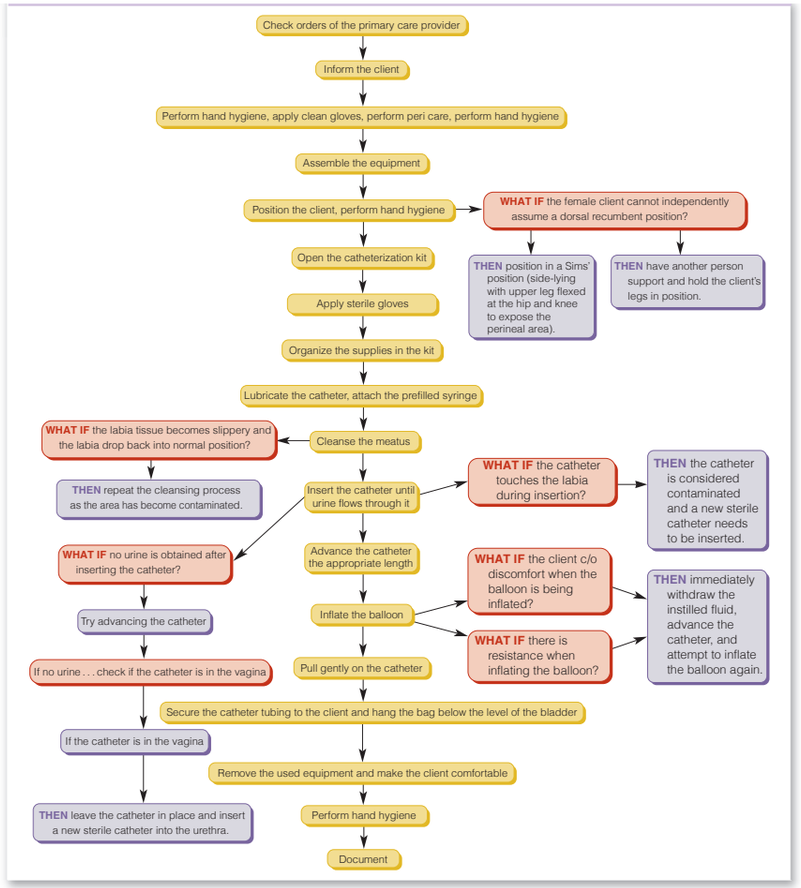
Clinical Alert!

Emphasize to the client that, at times, treatment may need to balance the demands of providing pain reduction with functional improvement. Too much pain medicine might impair alertness or gait; too much pain impairs alertness and ability to move. Thus, a client may have to tolerate mild pain in order to do what is necessary to maximize functioning and recovery (e.g., cough, deep-breathe, walk).

FOCUS ON CLINICAL THINKING!

UNIQUE! What If . . . concept maps visually represent the flow of a skill and present options for unexpected outcomes.

WHAT IF Urinary Catheterization Using an Indwelling Catheter



FOCUSING ON CLINICAL THINKING
at the end of every chapter promotes critical thinking with application-oriented scenarios and questions.

FOCUSING ON CLINICAL THINKING

Consider This

1. An older male client requests that the urinal be left in place between his legs at all times. How would you respond, and why?
2. Needing to use the urinal every 30–60 minutes around the clock has exhausted an 85-year-old man. However, he voids only 15–30 mL each time. Is an external urinary device an appropriate solution?
3. While removing an indwelling catheter, only about 75% of the amount of balloon fluid indicated on the catheter is retrieved. How would you proceed?
4. Following a transurethral resection of the prostate gland (TURP), significant bleeding may occur. The primary care provider may order "irrigate catheter prn." How would you determine if the catheter requires irrigating?
5. The hospitalized client's urostomy bag was last emptied 4 hours ago at 4:00 a.m. It now contains 100 mL. Is this acceptable? If not, what steps would you take?

Answers to Focusing on Clinical Thinking questions are available on the faculty resources site. Please consult with your instructor.

TEST YOUR KNOWLEDGE helps you prepare for the NCLEX-RN® exam. Alternate-style questions are included.

TEST YOUR KNOWLEDGE

1. Which terms are acceptable for use in documenting the process of emptying the urinary bladder? Select all that apply.
   1. Urination
   2. Voiding
   3. Maturation
   4. Micturition
   5. Incontinence
2. The nurse is obtaining a urinary elimination history. Which should be emphasized due to likely influence on urinary elimination?
   1. Cardiovascular system disease
   2. Integumentary system disease
   3. Immune system disease
   4. Respiratory system disease
3. The nurse is preparing to assist a male client with using a urinal. In what order would the nurse perform this procedure? Place the following steps of the procedure in the proper order.
   1. Place the urinal between the client's legs.
   2. Pull the curtain around the bed or close the door to the room.
   3. Apply clean gloves.
   4. Rinse the urinal and return it to the client's bedside.
   5. Remove the urinal.
4. The nurse is caring for a client with benign prostatic hyperplasia and urinary retention. Which catheter would be the *best* choice for this client?
   1. Foley catheter
   2. Robinson catheter
   3. Condom catheter
   4. Coudé catheter
5. While preparing a client for thoracic surgery, the nurse prepares to insert an indwelling urinary catheter. Which is the *least* appropriate indication for inserting a retention catheter?
   1. Accurate measurement of intake and output
   2. Avoidance of soiling of the surgical incision and dressing
   3. Avoidance of urine retention and bladder distention
   4. Client's inability to void normally postoperatively secondary to anesthesia
6. When inserting a Foley catheter as opposed to a straight catheter, the nurse must complete which action?
   1. Perform hand hygiene.
   2. Obtain a collection bag and tubing.
   3. Apply sterile gloves.
   4. Lubricate the tip of the catheter prior to insertion.
7. The nurse is caring for a client with an indwelling urinary catheter in place. What is the nurse's primary concern when caring for this client?
   1. Maintain the client on bed rest to prevent backflow of urine from the drainage bag back into the bladder.
   2. Encourage fluids to produce urine output.
   3. Reduce the risk of infection.
   4. Reduce the risk of skin breakdown.
8. The nurse is teaching a client with a urinary diversion how to reduce the odor of urine. The nurse recognizes that the client needs further teaching when the client says:
   1. "I will soak my reusable pouch in diluted vinegar solution to reduce the smell of urine."
   2. "If I drink plenty of fluids, that will help to reduce the urine smell."
   3. "I can put some baking soda in the pouch to make my urine less acidic."
   4. "I can buy deodorant drops to put in the pouch and that will lessen the smell of urine."

UNIT 3

Applying the Nursing Process

This unit looks at comfort and hygiene skills including bathing, bedmaking, infection control, heat and cold applications, and pain management. Comfort and hygiene needs are highly personal, and the nurse must consider the client's wishes, culture, and unique requirements when planning and providing care. The client should be involved as much as possible in both decision making and care delivery to increase his or her well-being and autonomy.

END-OF-UNIT Applying the Nursing Process activities provide the opportunity to think through themes and competencies presented across chapters in a unit and think critically to link theory to nursing practice.

CLIENT: John AGE: 42 Years
CURRENT MEDICAL DIAGNOSIS: Fractured Left Femur and Left Ulna

Medical History: John fell asleep while driving home from his night shift job and was involved in a collision with another vehicle. He fractured his left femur, requiring placement of pins and traction. He also fractured his left ulna, which was casted with a synthetic cast following closed reduction surgery. He has multiple abrasions and lacerations. A laceration above his left ear required sutures and has become infected with a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. He was placed on contact precautions. John has an infusing IV with a patient-controlled analgesia (PCA) pump for pain management in his right arm via a percutaneous intravenous central catheter (PICC).

Personal and Social History: John lives with his wife in a three-story townhouse in the suburbs of a major city. He works the night shift in a department store. His wife is a high school chemistry teacher. She is 18 weeks pregnant with their first child. The parents and siblings of both John and his wife live within a 30-mile radius of their home. As a result, John has many visitors including family, friends, and coworkers.

Questions

Assessment

1. The nurse is assessing John for pain, which he ranks as a 6 on a 0–10 scale. What other information will the nurse assess?
2. The nurse offers John a back massage to help him relax as a nonpharmacologic pain management technique. What assessments will the nurse perform while providing the back massage?

Analysis

3. List two possible nursing diagnoses that can be identified from the medical-personal history and assessment data above.

Planning

4. The nurse plans care for John to include applications of ice to his fractured left arm to manage pain and edema. What expected outcomes would the nurse include in the plan of care related to this intervention?
5. John tells the nurse he usually showers every day and washes his hair in the shower. The nurse, developing his plan of care, includes interventions to shampoo his hair three times a week. For what outcomes would the nurse have associated this intervention?

Implementation

6. The nurse initiates contact isolation for John to reduce the risk of spreading MRSA. Describe the components of contact isolation to be used for this client.
7. What type of client hygiene interventions would the nurse include in John's plan of care?

Evaluation

8. Describe the steps to take if the outcomes have not been met or have been only partially met.

Applying the Nursing Process suggested answers are available on the faculty resources site. Please consult with your instructor.

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