HAWLER MEDICAL UNIVERSITY
COLLEGE OF NURSING
LABORATORY AND CLINICAL EDUCATION
Procedure Evaluation Document (PED)

PROCEDURE:	**Pressure ulcers – risk assessment**	**Code**	**14-10**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared the equipment: - Patient medical record - Norton Scale for pressure ulcer risk assessment - Non-sterile gloves - Hand rub gel		
2	Performed hand hygiene using correct technique.		
3	Identified the patient using two identifiers.		
4	Performed Greeting, Introduction and Permission procedure (GIP).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Adjusted the height of the bed to elbow height.		
8	Assisted the patient to supine position.		
9	Performed hand hygiene using correct technique, put on gloves if needed.		
10	Identified any patient characteristics that might be risk factors for pressure ulcer formation. - Paralysis, or immobilization caused by restrictive devices - Sensory loss (e.g., hemiplegia, spinal cord injury) - Circulatory disorders (e.g., diabetes mellitus) - Fever - Anaemia - Malnutrition - Incontinence - Heavy sedation and anaesthesia - Age - Dehydration - Oedema - Existing pressure ulcers - History of pressure ulcer		
11	Performed the risk assessment using Norton Scale.		
12	Assessed physical condition correctly.		
13	Assessed mental condition correctly.		
14	Assessed activity correctly.		
15	Assessed mobility correctly.		
16	Assessed incontinence correctly.		
17	Obtained risk score, and evaluate its meaning based on patient's unique characteristics (verbal report).		
18	Assessed condition of patient's skin over regions of pressure. - Inspected for: -skin discoloration (redness in light-tone skin; purplish or bluish colour in darkly pigmented skin) -tissue consistency (firm or boggy feel) -abnormal sensations - Palpated discoloured area for blanching. - Inspected for pallor and mottling. - Inspected for absence of superficial skin layers		
19	Assess patient for additional areas of potential pressure. - Nares: nasogastric (NG) tube, oxygen cannula - Tongue and lips: oral airway, endotracheal tube - Ears: oxygen cannula, pillow - Drainage tubes - Wound drainage		

	☐ Indwelling urinary drainage (Foley) catheter ☐ Orthopaedic and positioning devices		
20	Observed patient for preferred positions when in bed or chair (verbal report).		
21	Encouraged the patient to change position frequently to relieve pressure areas.		
22	Observed ability of patient to initiate and assist with position changes.		
23	Assessed patient/caregiver understanding of risks for the development of pressure ulcers.		
24	Restored the patient to a comfortable position.		
25	Performed hand hygiene using correct technique.		
26	Documented the procedure and the results (including the length of exposed tube).		
27	Returned the equipment to the dedicated area.		

NORTON SCALE

Name	Date	Physical condition	Mental condition	Activity	Mobility	Incontinent	Total score
		Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk/help 3 Chair-bound 2 Stupor 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasionally 3 Usually/urine 2 Doubly 1	

Norton Scale Interpretation

>18 - low risk

14-17 - medium risk

10-13 - high risk

<10 - very high risk

1. SKILL EVALUATION 60%

Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-25	26-27	Skill steps achieved
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved
Level	F						U	N	S	C	I	Skill level achieved

2. PROCEDURE ASPECTS EVALUATION 40%

Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**Time** 10%	
Failed	5	Failed	5	Failed	5	Failed +10	5
Unsatisfactory	6	Unsatisfactory	6	Unsatisfactory	6	Unsatisfactory +8	6
Novice	7	Novice	7	Novice	7	Novice +6	7
Supervised	8	Supervised	8	Supervised	8	Supervised +4	8
Competent	9	Competent	9	Competent	9	Competent +2	9
Independent	10	Independent	10	Independent	10	Independent TA	10

Notes:

Time allowed (TA)	**30**
Time achieved	
Aspects points achieved	

3. COMPLETE PROCEDURE EVALUATION 100%

≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	**Unsatisfactory**	**Novice**	**Supervised**	**Competent**	**Independent**	Total level achieved	

Student		Signature		**Actual Mark/Out of**	
Teacher		Signature			
Clinical Area		Date			

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PROCEDURE: **Pressure ulcers – care**		**Code**	**14-11**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared the equipment: □ Patient medical record □ Non-sterile gloves □ Plastic apron □ Sterile gloves □ Sterile pack – gauze, container, forceps □ Sterile cotton tip applicator □ Sterile Normal saline □ Antiseptic cleaning solution □ Prescribed topical medication or dressing □ Measuring tape or ruler □ Towel □ Plastic bag □ Hand rub gel		
2	Performed hand hygiene using correct technique.		
3	Identified the patient using two identifiers.		
4	Performed Greeting, Introduction and Permission procedure (GIP).		
5	Provided privacy.		
6	Explained the procedure to the patient and answered any questions.		
7	Assessed the patient's level of comfort and need for pain medication.		
8	Determined if the patient is allergic to topical agents, especially silver products, or to latex.		
9	Adjusted the height of the bed to elbow height.		
10	Assisted the patient to a position that will allow dressing to be performed.		
11	Exposed the pressure ulcer area keeping the remaining body parts draped.		
12	Put on non-sterile gloves.		
13	Removed the dressing and dispose in plastic bag.		
14	Removed gloves and disposed in aplastic bag.		
15	Performed hand hygiene using correct technique.		
16	Put on non-sterile gloves.		
17	Assessed the pressure ulcer according to the stage. **Stage 1**: A reddened area on the skin that, when pressed, does not turn white. This is a sign that a pressure ulcer is starting to develop. **Stage 2**: The skin blisters or forms an open sore. The area around the sore may be red and irritated. **Stage 3**: The skin now develops an open, sunken hole called a crater. There is damage to the tissue below the skin. **Stage 4**: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints.		
18	Noted the condition of the skin around the pressure ulcer: □ colour □ temperature □ level of oedema □ amount of moisture □ drainage		
19	Measured the pressure ulcer's: □ length □ width □ depth		
20	Performed hand hygiene using correct technique.		

21	Put on plastic apron.		
22	Opened sterile pack without contaminating the sterile field.		
23	Poured cleansing solution into the container.		
24	Donned sterile gloves correctly.		
25	Cleansed the area around pressure ulcer thoroughly with normal saline or a prescribed wound-cleansing agent.		
26	Cleansed the pressure ulcer thoroughly with normal saline or a prescribed wound-cleansing agent.		
27	Applied topical medication (hydrogel) or special dressings (calcium alginate dressing) if prescribed.		
28	Placed a gauze dressing directly over the pressure ulcer, and taped it in place.		
29	Removed gloves.		
30	Performed hand hygiene using correct technique.		
31	Encouraged the patient to change position frequently to relieve pressure areas.		
32	Observed ability of patient to initiate and assist with position changes.		
33	Assessed patient/caregiver understanding of risks for the development of pressure ulcers.		
34	Restored the patient to a comfortable position.		
35	Documented the procedure and the results (including the length of exposed tube).		
36	Returned the equipment to the dedicated area.		

1. SKILL EVALUATION 60%

Steps	0	1-4	5-8	9-12	13-16	17-18	19-22	23-26	27-30	31-34	35-36	Skill steps achieved
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved
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Rationale 10%		**Patient Focus** 10%		**Professional Manner** 10%		**Time** 10%	
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Independent	10	Independent	10	Independent	10	Independent TA	10
Notes:						Time allowed (TA)	**20**
						Time achieved	
						Aspects points achieved	

3. COMPLETE PROCEDURE EVALUATION 100%

≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	
Failed	**Unsatisfactory**	**Novice**	**Supervised**	**Competent**	**Independent**	Total level achieved	
Student			Signature			**Actual Mark/Out of**	
Teacher			Signature				
Clinical Area			Date				

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PROCEDURE:	**Medication - administering oral medications**	**Code**	**15-01**
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient's medical record □ Medication chart □ Hand rub gel □ Disposable or plastic cups for medications □ Plastic tray		