Tishk International University Faculty of Nursing



Paediatric Nursing
Clinical Nursing Skills
Checklists

Academic year: 2024-2025

Objectives

By the end of this course the student will be able to..

- 1. Apply physical assessment skills to infants, children, and adolescents.
- 2. Measure each type of paediatric vital signs (blood pressure, heart rate, respiratory rate, oral, axillary, and rectal temperatures)
- 3. Apply APGAR score assessment after birth.
- 4. Assess pain for children less than 1 year, for more than 1 year, more than 4 years, and assessing pain post operatively.
- 5. Perform PRE and POST operative care for children.
- 6. Assess gestational age for newborn after birth by chart.
- 7. Perform bulb sucking procedure.
- 8. Function capillary bloods draw in the clinical area for children.
- 9. Produce nasogastric tube feeding, gastrostomy feeding, and milk formula preparation and feeding.
- 10. Administer nebulizer medication for children.
- 11. Demonstrate phototherapy to newborn.
- 12. Produce nasopharyngeal suction skills to infants, children, and adolescents.
- 13. Succeed sponge bath to children and infant tub bath.
- 14. Perform enema administration and mummy restrain in paediatrics.

General guideline to students during clinical laboratory

- 1. Not leave dirty & used face mask in the lab.
- 2. Opening multiple doors and windows to bringing fresh outdoor air into a building which it is helps keep virus particles from concentrating inside.
- 3. Not eating and drinking inside of lab.
- 4. Students should return all clean equipment to its proper place after use.
- 5. Students are responsible to clean up and tidy up after complete of lab session.
- 6. Students are required to regulate bed linen after use.
- 7. Needles and syringes are not to be discarded in trash container.
- 8. Please save equipment obtained in labs for practice during open lab times

	PROCEDURE: Paediatric procedures –physical examination	Code	
No.	Skill steps	Not achie ved	Achie ved
1	Prepared procedure equipment:	700	
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the parent		
	or carer.		
	Provided privacy.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	*History Taking: <i>f</i>		
	Biographic data. f		
	Chief complaint. f		
	Present illness. f		
	Past health history. <i>f</i>		
	Family health history. <i>f</i>		
	Previous hospitalization. f		
	Immunization received. f		
	Feeding pattern		
	Allergies. f		
	Activity pattern.		
4	*Growth Measurement: f		
	Length / height. f		
	Weight. f		
	Head circumference. f		
	Chest circumference. f		
	Arm circumference		
5	*Physiological Measurement: f		
	Temperature. f		
	Pulse. f		
	Respiration. f		
	Blood pressure		
6	*General Appearance:		
	Inspect for: f		
	Posture. f		
	Facial expression. f		
	Hygiene. <i>f</i> Nutritional status. <i>f</i>		
	Level of child activity. f		
	Child's reaction to stress.		
7	*Skin: f	+	
'	Inspect color. f		
	Palpate texture. f		
	Palpate Turgor.		

	Lymph nodes.	
	Inspect & palpate. f	
	Size f	
	Temperature. f	
	Temperature. <i>f</i> Tenderness <i>f</i>	
7	Any abnormality. *Head: Inspect: f	
/		
	Shape. f	
	Control. <i>f</i> Posture.	
	Inspect and palpate: f	
	Fontanels Examine:	
0	range of motion	
8	*Scalp:	
	Inspect & palpate: f	
	Cleanliness. f	
	Trauma. f	
	Lesions f	
	Hair texture. f	
	Hair loss. f	
	Hair discoloration	
9	*Face:	
	Inspect	
	Symmetry.	
	Facial. f	
1.0	Expression	
10	*Neck: f	
	Inspect	
	Size	
	Trachea.	
	Thyroid	
	Carotid arteries f	
11	Palpate thyroid glands	
11	*Eyes: f	
	Test visual activity. f	
	Inspect	
	Placement.	
	Lids.	
	Conjunctiva.	
	Eyelashes.	
	Eye brows.	
	Cornea.	
	Pupils.	
	Iris.	
	Lens.	
	Examine	
	pupils f	
	Reaction to light	
12	*Ears: Inspect	
	Pinna	

	Evrtamal agnal	
10	External canal.	
13	*Nose & Sinuses: f	
	Inspect	
	External nose.	
	Nasal mucosa	
	Nasal septum.	
	Palpate	
4.4	Sinuses for tenderness.	
14	*Mouth and Tthroat:	
	Inspect	
	Lips - Tongue. Gums - Teeth	
	Roof of mouth Pharynx -color - exudate - tonsils	
15	*Chest: f	
	Inspect chest f	
	Palpate chest. f	
	Percuss chest. f	
	Ansultate the chest.	
16	*Nails: Finger nails and toes nails. <i>f</i>	
	Inspect for color and shape f	
	Palpate for lesions.	
17	*Heart: f	
	Inspect heart. f	
	Palpate for: Pulse	
	Tactile fremitus	
18	*Back:	
	Inspect back for:	
	Color	
	Symmetry. Lesions.	
	Palpate back for lesions.	
19		
	*Genitalia: Male:	
	Inspect and palpate: Penis f Scrotum f Tests	
	*Urethral meatus Female:	
	Inspect: f Labias	
	Vaginal orifice Urethral meatus	
20	*Anus:	
	Inspect: - Opening Skin condition	
21	*Extremities: f Range of motion f	
	Inspect: Upper and lower extremities for: - Color - Symmetry - Lesions - Bowlegs /	
	knock knee. f	
	Palpate: - Pulse - Oedema - Lesions	
22	*Neuromuscular system:	
	Test for: - Level of consciousness	
	Reflexes Activity – mobility Sensation	
23	Perform hand hinge by using correct techniques.	
24	Documented time, duration and child's response.	
25	Returned equipment to the dedicated area.	
26	Reported abnormal findings to the appropriate member of staff.	
	Reported authornial findings to the appropriate member of staff.	

					1.	SKIL	L EVA	LUAT	ION 6	0%			
Step	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill steps	
s						12	15	18	20	22	24	achieved	
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill points	
ts												achieved	
Lev			I	F			U	N S C I			I	Skill level	
el												achieved	
				2. P	ROCE	DURE	ASPE	CTS E	VALU.	ATION	V 40%		
Professional													
Rationale 10% Patient Focus 10% Manner 10%												Time 10%)
Failed	1		5	Failed			5	Failed			5	Failed+10	5
			6				6				6	Unsatisfactory	6
Unsati	isfactor	У		Unsat	isfactor	у		Unsati	isfactor	У		+8	
			7				7				7	Novice	7
Novic	ee			Novic	e			Novic	e			+6	
				Supervised	8								
Super	vised			Super	vised			Super	vised			+4	
Comp	etent		9	Comp	etent		9	Comp	etent		9	Competent +2	9
			10				10				10	Independent	10
_	endent			Indep	endent			Indepe	endent			TA	
Notes	:											Time allowed	
												(TA)	
												Time achieved	
												Aspects points	
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								OURE I					
< <u>≤</u> 5	50	51	-60	61	-70	71	-80	81-	.90	91-	100	Total points	
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Fai	Failed Unsatisfact Novice Su				Super	rvised	Comp	etent	Indep		Total level		
ory						_		- 1		n	t	achieved	
Studen						Signa							
						Signa	ture					Actual	
Clinic Area	Clinical Area											Mark/Out of	





		PROC	EDURI	Ξ:	Paedi	atric p	rocedu	res – b	ulb suc	tioning	5		Code	
No.						Skill	steps						Not achie ved	Achie ved
1	Prepar	red prod	cedure (equipm	ent:									
		-	nt medi											
		Vital	signs cl	nart										
			syringe											
			al salin											
			sterile g											
			towel											
		Plasti												
2	Identi			tusing	two ide	ntifiers	_							
_					ction a			procedi	ıre (G.I	.P) wit	h the p	arent		
	or care	_	6,			- F		1		,	r			
	Provid	ded priv	acy.											
				dure to	the pare	ent or c	arer and	d answe	red any	questi	ons.			
	Perfor	med ha	nd hyg	iene us	ing corr	ect tecl	hnique.		•					
3					includi				lour, aı	nd effor	rt.			
4	Position	oned ch	ild witl	h head t	flat or s	lightly	elevate	d (some	one car	n assist	holdir	ng and		
	comfo	orting th	ne child).										
5	Put or	gloves	S.											
6	If secr	etions	were ve	ry thicl	k, dropp	ed nor	mal sali	ine into	nares b	efore s	uction	ing to		
		i secreti												
7	Defle	cted the	bulb p	rior to i	nserting	g tip int	to infan	t's nare	s /mout	th by so	queezii	ng bulb.		
8					es /mou									
9					remove		ige fron	n nares	/mouth	•				
10					per towe	el.								
11			necessa	ry.										
12		ved glo												
13					piratory									
14					tus.									
15					nsistenc			of secre	etions.					
16					tsaline									
17					child tol									
18					require			s/ mout	h of sec	retion.				
19					dedicate				0 . 00					
20	Repor	ted abn	ormal f	indings	to the					201				
C4	•	1.2	2.4				L EVA		1		22	C1 '11		
Step	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill ste	-	
S Doin	0		10	10	24	12	15	18	20	22	24	achieve		
Poin to	0	6	12	18	24	30	36	42	48	54	60	Skill po		
ts		l	l	1	1		l	1			I	achieve	u	

Lev el]	F		U	N	S	С	I	Skill level achieved	
ei			5. PROCE	DURE	A SPE	CTS E	VALII	A TION	J 40%	acineved	
			J. TROCE	DURE			Profes		1 70/0		
]	Rationa	ale 10%	Patient I	Focus 10						Time 10%)
Failed		5	Failed		5	Failed 5			5	Failed+10	5
		6			6	6			6	Unsatisfactory	6
Unsati	isfactor	y	Unsatisfactor	ry		Unsatisfactory				+8	
		7		7			•	7	Novice	7	
Novic	ee		Novice		Novic	e			+6		
		8			8				8	Supervised	8
Super	vised		Supervised		Super	vised			+4		
Comp	etent	9	Competent	9	Comp	etent		9	Competent +2	9	
		10			10				10	Independent	10
Indepe	endent		Independent			Indepe	endent			TA	
Notes	:									Time allowed	
										(TA)	
										Time achieved	
										Aspects points	
										achieved	
			6. COMPLI								
≤5	50	51-60	61-70	71-	-80	81-	.90	91-1	100	Total points	
										achieved	
Fai	iled	Unsatisfact	Novice	Super	vised	Comp	etent	Indep		Total level	
		ory	1101166			Comp		n	t	achieved	
Stude				Signat							
					Signature					Actual	
Clinic Area	al			Date	ate				Mark/Out of		





P	ROCE	DURE:		Paedia	tric pro	ocedur	es – Blo	ood pre	essure	Measu	remen	nt	Code	
No.						Skill	steps						Not achieve d	Achieve d
1	Prepai	-	cedure e											
			it medic											
			gmomai		r									
			signs cl	nart										
			oscope											
		Watch												
		Cotto												
		_	solusi	on										
		Plasti												
2			patient					1	(0	1D) .	.1 .1			
		_	eeting,	ıntrodu	iction a	nd peri	mission	proced	ure (G.	I.P) W1	th the	parent		
	or care	er. led priv	10.0XI											
				lure to	the nare	ent or c	arer and	l ancwe	red any	z anesti	ons			
							hnique.	answe	icu any	y questi	ons.			
3			oropriat				mique.							
4			be from											
5			oper arı											
6			_		the upp	oer arm	with th	ne lowe	r edge	about 1	.5 cm	above		
			al space	•										
7	Positio	on the	sphygm	omano	meter o	on a le	vel surf	ace at	approxi	imately	the le	evel of		
	heart.													
8					inflate	the cuf	f until tl	he palpa	ated pul	lse is lo	st then	pump		
	for ad	ditional	20 mm	nhg.										
9							ne area	where t	he brac	hial pu	lse is f	elt.		
10			e the cu			o the so	ounds.							
11			cuff 8											
12							rmality.							
13							hnique.							
14			-				sponse.							
15	Returi	<u>1ea equ</u>	ipment	to the c				ATTIA	TION	<i>6</i> 00/				
Step	0	1-2	3-4	5-6	7-8	8-9	LL EV 9-10	10-	11 0N	12-	14-	Skill s	tens	
siep	U	1-2	3-4	5-0	7-0	0-9	9-10	11	12	13	15	achiev	-	
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill p		
ts	3	3		10				.2				achiev		
Lev		1	F	7	1	1	U	N	S	С	I			
el														
												Skill l		
												achiev	red	
]		

		8. PROC	EDURI	E ASP	ECTS EVAL	UATIO	N 40%	6		
					Profes	sional				
Ration	ale 10%	Patient I	Focus 10	%	Manne	er10%		Time10%		
Failed	5	Failed		5	Failed		5	Failed+10	5	
	6			6			6	Unsatisfactory	6	
Unsatisfacto	ory	Unsatisfactor	ry		Unsatisfactor	У		+8		
	7		•	7			7	Novice	7	
Novice		Novice			Novice			+6		
	8			8			8	Supervised	8	
Supervised		Supervised			Supervised			+4		
Competent	9	Competent		9	Competent		9	Competent +2	9	
	10			10	•		10	Independent	10	
Independent		Independent			Independent			TA		
Notes:	·							Time allowed		
								(TA)		
								Time achieved		
								Aspects points		
								achieved		
		9. COMPI	LETE P	ROCE	DURE EVAI	UATI	ON100)%		
≤50	51-60	61-70	71-	80	81-90	91-1	100	Total points		
								achieved		
Failed	Unsatisfact	Novice	C		Commissions	Indep	ende	Total level		
raneu	ory	Novice	Super	viseu	Competent	n	t	achieved		
Student			Signat	ure						
Teacher			Signat	ure				Actual		
Clinical								Mark/Out of		
Area			Date							



	PROCE	EDUKE	<i>i</i> :	Paedia	atric pr	oceaui	res – H	eart ra	te Mea	surem	ent		Code	
No.						Skill s	teps						Not achieve d	Achi eved
1	Prepar	red prod	cedure (equipm	ent:									
		Patier	it medic	cal reco	rd									
		Vital	signs cl	nart										
			scope											
		Watch	-											
		Cotto	n											
		Septio	solusi	on										
		Plasti												
2	Identi			using	two ide	ntifiers								
	Perfor	med gr	eeting,	introdu	ction ar	nd perm	nission	procedu	ıre (G.I	.P) witl	the p	arent		
	or care	_				1		•	•	,	•			
	Provid	led priv	acy.											
								d answe	ered any	questi	ons.			
					ing corr									
3				1	pex of the									
4								th alcoh						
5				e betwe	en the f	ourth a	nd the	fifth int	ercostal	spaces	i just b	elow		
		t nipple					2.11	•						
6					d count									
7						_		ol swat)					
8					ing corr									
9					and chi		-							
10			-		dedicate			1	C + CC					
11	Repor	ted abn	ormal 1	indings				ember o		,				
Ctoma	0	1-2	3-4	5 7	8-10. S	11-	13-	UATIO			22	C1-:11	-4	T
Steps	U	1-2	3-4	5-7	8-10	11-	15-	16- 18	19- 20	21- 22	23- 24	achie	steps	
Points	0	6	12	18	24	30	36	42	48	54	60		points	
1 Ullits	U	U	12	10	24	30	30	42	40	34	00	achie	-	
Level			I	7			U	N	S	С	I		level	
Level			•					11	5	C	•	achie		
				11. PR	OCEDI	URE A	SPEC'	TS EV	ALUAT	TION 4	0%		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				-					Profes					
R	ational	le 10%		Pa	tient F	ocus10)%		Manne	er10%			Time 10%	,)
Failed			5	Failed			5	Failed	<u> </u>		5	Faile	ed+10	5
			6				6				6	Unsa	tisfactory	6
Unsatisf	actory			Unsati	isfactor	y		Unsat	isfactor	y		+8		
			7				7				7	Novi	ice	7
Novice				Novic	e			Novic	e			+6		

	8		8				8	Supervised	8
Supervised		Supervised			Supervised			+4	
Competent	9	Competent	9		Competent		9	Competent +2	9
	10		10)			10	Independent	10
Independent		Independent			Independent			TA	
Notes:								Time allowed	
								(TA)	
								Time achieved	
								Aspects points	
								achieved	
	12	2. COMPLET	E PROCEI	DU	RE EVALUA	TION	100%		
≤50	51-60	61-70	71-80		81-90	91-1	100	Total points	
								achieved	
Failed	Unsatisfact	Novice	Cunomico	7	Competent	Indep	ende	Total level	
ralled	ory	Novice	Supervise	u	Competent	n	t	achieved	
Student			Signature					Actual	



	PROC	CEDUR	E:	Paed	liatric _J	procedi	ures – A	<u>Axillar</u>	y Temp	<u>eratur</u>	·e		Code	
No.						Skill s	teps						Not achieve d	Achieve d
1	Prepar	red prod	cedure (equipm	ent:									
		Patier	nt medi	cal reco	ord									
		Vital	signs cl	hart										
		Thern	nomete	r										
		Cotto	n											
		Septio	solusi	on										
		Plasti	c tray											
2		fied the												
		_	eeting,	introdu	ction a	nd perm	nission	procedi	ıre (G.I	.P) with	n the p	arent		
	or car													
		ded priv												
									ered any	questi	ons.			
		med ha					hnique.							
2	Check	thermo	ometer	to see t	he read	ing.								
3		thermo												
4		the lev			down to	below	√ 35°C.							
3		and dry												
5			meter u	ınder aı	m with	tip in	centre o	of axilla	a and ke	ep it c	lose to	skin		
		othing.	~	1		C 7	• ,							
6		child's							11.					
7		ve ther							ulb.					
8 9		med ha												
10		ned equ												
11		ted abn						ember (of staff					
11	Ксроі	tca aon	Official	manigs					10N 60)%				
Steps	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill	steps	
~ TTP						12	15	18	20	22	24	achie	-	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill	points	
												achie		
Level			I	F			U	N	S	C	I		level	
							. ~					achie	eved	
				14. P	KOCE!	DURE	ASPE	CTS E	VALUA		40%			
R	ational	le 10%		Pa	tient F	ocus10)%		Profes Manne				Time10	%
Failed			5	Failed			5	Failed	1		5		ed+10	5
			6				6				6		ntisfactory	6
Unsatisf	actory			Unsat	isfactor	У		Unsat	isfactor	У		+8		

	7		7		7	Novice	7
Novice		Novice		Novice		+6	
	8		8		8	Supervised	8
Supervised		Supervised		Supervised		+4	
Competent	9	Competent	9	Competent	9	Competent +2	9
	10		10		10	Independent	10
Independent		Independent		Independent		TA	
Notes:						Time allowed	
						(TA)	
						Time achieved	
						Aspects points	
						achieved	
		15. COMPLE	TE PROCEI	OURE EVALU	J ATION 1009	6	
≤50	51-60	61-70	71-80	81-90	91-100	Total points	
						achieved	





Procedure Evaluation Document (PED)

Paediatric procedures – Oral Temperature

	PR	OCEDU	JRE:	Pa	ediatri	c proce	edures -	- Oral	Tempe	rature			Code	
No.						Skill st	eps						Not Achieve d	Achieve d
1	Prepar	red prod	cedure	equipm	ent:									
		Patier	nt medi	cal reco	ord									
		Vital	signs cl	hart										
		Thern	nomete	r										
		Cotto	n											
		Septio	c solusi	on										
		Plasti	c tray											
2		fied the												
	Perfor	Performed greeting, introduction and permission procedure (G.I.P) with the												
	parent	parent or carer.												
		ded priv												
		ined the							red any	questi que	ons.			
		med ha					hnique.							
3		thermo												
4		thermo												
5		the lev												
6		thermo												
7		ne child					n throug	gh the n	ose and	l not to	talk.			
8		thermor												
9		ve ther			-			o the b	ulb					
10		med ha												
11		mented						•						
12		ned equ	-						C + CC					
13	Repor	ted abn	ormal 1	indings						· O O /				
Cton	0	1-2	2.4	5.7	8-10		LL EV				22	Clri	11 atoma	
Step	0	1-2	3-4	5-7	8-10	11- 12	13- 15	16- 18	19- 20	21- 22	23- 24		ll steps ieved	
S Poin	0	6	12	18	24	30	36	42	48	54	60		ll points	
ts	U	U	12	10	24	30	30	42	40	J -1	00		ieved	
Lev			l	<u>. </u>			U	N	S	С	I		ll level	
el			-	L				11	S	C	1		ieved	
<u> </u>				17. I	PROCE	EDURI	E ASPE	ECTS E	VALU	ATIO	N 40%		20,00	
	Professi													
]	Rationa	ale 10%)	Pa	itient F	ocus10)%		Manne	er10%			Time 10	%
Failed			5	Failed			5						led+10	5
			6				6				6	Un	satisfactory	6
Unsati	sfactor	y		Unsat	isfactor	у		<u> </u>				+8		
			7				7	.			No	vice	7	
Novic	e			Novic	e						+6			
			8				8				8	_	pervised	8
Super											+4			

Competent		9	Competent		9	Competent		9	Competent +2	9
		10			10			10	Independent	10
Independent			Independent			Independent			TA	
Notes:									Time allowed	
									(TA)	
									Time achieved	
									Aspects points	
									achieved	
			18. COMPL	ETE PI	ROCE	DURE EVAL	UATIO	N100	%	
≤50	51-	-60	61-70	71-	80	81-90	91-1	100	Total points	
									achieved	
Failed	Unsat	isfact	Novice	Cumon	rriand	Competent	Indep	ende	Total level	
raneu	01	ry	Novice	Super	viseu	Competent	n	t	achieved	
Student				Signat	ure					
Teacher		•		Signat	ure				Actual	
Clinical				Doto					Mark/Out of	
Area				Date						



PROCEDURE: Paediatric procedures – Rectal Temperature											Code				
No.						Skill	steps						Not achieve d	Ac	hieve d
1	Prepar	red prod	cedure	equipm	ent:										
		Patier	nt medi	cal reco	ord										
		Vital	signs c	hart											
			nomete												
		Cotto	n												
		Septio	c solusi	on											
		Plasti	c tray												
2	Identi	Identified the patient using two identifiers.													
	Perfor	Performed greeting, introduction and permission procedure (G.I.P) with the parer													
		or carer.													
		ded priv													
	-		-		-			d answe	ered any	/ questi	ons.				
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4				from tip											
5				ercury		below	⁷ 35°C.								
6				al area.											
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12		the read					ما ما ما	fectant.							
13 14					1				•						
15				iene us uration											
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17			_					ember o	of ctaff						
1 /	Керог	ica aon	Office	imamg				ALUA		60%					
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S						12	15	18	20	22	24	achiev			
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill p	oints		
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Lev]	F			U	N	S	C	I	Skill l			
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Failed												Failed	+10		5

	6		6		6	Unsatisfactory	6
Unsatisfactory		Unsatisfactory		Unsatisfactory		+8	
	7		7		7	Novice	7
Novice		Novice		Novice		+6	
	8		8		8	Supervised	8
Supervised		Supervised		Supervised		+4	
Competent	9	Competent	9	Competent	9	Competent +2	9
	10		10		10	Independent	10
Independent		Independent		Independent		TA	
Notes:						Time allowed	
						(TA)	
						Time achieved	
						Aspects points	

	F	ROCE	DURE:	· ·	Paedia	tric pro	ocedur	es –Res	pirato	ry Rate	;		Code	
No.						Skill	steps						Not achieve d	Achieve d
1	Prepar	red prod	cedure	equipm	ent:									
		Patien	it medi	cal reco	rd									
		Vital	signs cl	hart										
			scope											
		Watch	_											
		Cotto	n											
		Septio	solusi	on										
		Plastic												
2	Identi	fied the		t using	two ide	ntifiers								
								procedi	ıre (G.I	.P) witl	h the p	arent		
		erformed greeting, introduction and permission procedure (G.I.P) with the parcarer.												
	Provid	ded priv	acy.											
	Expla	ined the	proce	dure to	the pare	ent or c	arer and	d answe	red any	questi	ons.			
	Perfor	med ha	nd hyg	iene us	ing corr	ect tecl	hnique.							
3	Performed hand hygiene using correct technique. Expose the chest.													
4	Obser	ve abdo	minal	movem	ent in ii	nfants &	& young	g childr	en					
5	Obser	ve thora	acic mo	ovemen	t in olde	er child	ren.							
6	Count	respira	tion fo	r one fu	ll minu	te.								
7		t any al												
8		med ha												
9		nented					-							
10	Returi	ned equ	ipment	to the										
		1		1				ALUA						
Step	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill s	-	
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Poin	0	6	12	18	24	30	36	42	48	54	60	Skill p		
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Super	vised			Super	vised			Super	vised			+4		
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FACULTY OF NURSING LABORATORY AND CLINICAL EDUCATION Procedure Evaluation Document (PED)



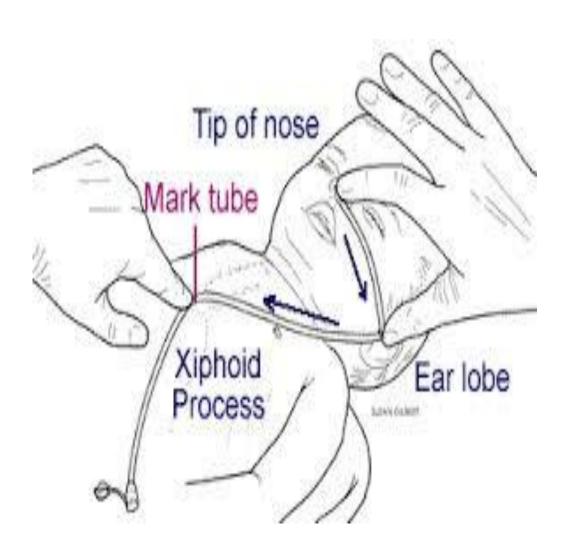
	PROCEDURE: PROCEDURE: Capillary Blood Draw	Code	
No.	Skill steps	Not achieved	Achieve d
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Lancet		
	☐ Cleansing solution or soap and water		
	☐ Sterile cotton balls or gauze		
	□ Non-sterile gloves		
	☐ Adhesive bandage		
	☐ Appropriate sample container or closable plastic bag		
	□ Labels		
	☐ Completed laboratory request forms		
	☐ Hand rub gel		
	□ Tray		
	□ Clay		
2	Checked physician's order.		
3	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P).		
	Provided privacy.		
	Explained the procedure to the caregiver and answered any questions.		
	Performed hand hygiene using correct technique.		
4	Assessed the child for allergies to any materials used, e.g., povidone-iodine		
	(asked the caregiver if appropriate).		
5	Selected site.		
	a . Heel: (Infants younger than 1 year of age): Plantarsurface beyond lateral and		
	medial calcaneus.		
	b .Great toe: (children older than 1 year of age).		
	c. Finger: Side of ball of finger (3rd or 4th finger)across the fingerprint		
6	Applied moist warm compress to area for 5–15 minutes.		
7	Put on non-sterile gloves.		
8	Removed compress and cleaned the selected site with cleansing solution.		
9	Let area dry completely before puncture.		
10	Gently massaged base of finger or heel, stroking toward selected puncture site		
11	without touching the puncture site.		
11	Isolated the puncture site using the non-dominant hand to hold the hand or foot		
	holding the selected site in a dependent position.		
	a. Heel: Support dorsum of foot with thumb and ankle with other fingers.		
	b. Toe: Grasp foot across dorsum, support toe with thumb on plantar surface.		
	c. Finger: Keep finger to be used extended and pointed downward.		
12	Using the dominant hand, punctured the site at a 90° angle to the skin with lancet		
13	using a quick, forceful motion (no slashing motion).		
13	Removed the lancet immediately.		

Unsatisfactory6Unsatisfactory6Unsatisfactory+86Novice7Novice7Novice +67Supervised8Supervised8Supervised +48Competent9Competent9Competent +29Independent10Independent10Independent TA10	4.4	****	1	.1 0	. 1	C1 -	•	•	. •1		11				
Collected specimen allowing blood to flow into the collecting tube. Wiped the site with sterile cotton ball or gauze and applied pressure for 2 3 minutes.		_							terile co	otton b	all or gau	ıze.			
Wiped the site with sterile cotton ball or gauze and applied pressure for 2-3 minutes. 18 Applied bandage if appropriate. 19 Discarded equipment in appropriate container. 20 Removed gloves. 21 Labelled specimen. Placed the specimen in appropriate bag or container along with laboratory request slips. Documented the time, source/site, specimen sent to lab (specify for what test) in patients notes. 23 Applied bandage if appropriate bag or container along with laboratory request slips. Documented the time, source/site, specimen sent to lab (specify for what test) in patients notes. 24 Restored patient to a comfortable position. 25 Performed hand hygiene using correct technique. 16 Informed the patient or relative if appropriate of the result. 27 Returned equipment to the dedicated area. 28 Sent specimens to the laboratory. 23 SKILL EVALUATION 60% Steps 0 1-3 4-6 7- 11 15- 17- 21- 25- 28-30 31- Skill steps achieved 10 - 16 20 24 27 33- 33- Skill steps achieved 10 - 16 20 24 27 18- 33- 33- Skill steps achieved 10 - 16 20 24 27 18- 33- Skill steps achieved 11 V N S C I Skill steps achieved achieved achieved 12 Point 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved 12 Procedure Aspects EVALUATION 40% 13 Professional Manner 10% Rationale 10% Patient Focus 10% Professional Manner 10% Failed S Failed 5 Failed 10 Independent 1 To Total level achieved 2 Signature 1 Signa															
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Placed the specimen in appropriate bag or container along with laboratory request slips. Documented the time, source/site, specimen sent to lab (specify for what test) in patients notes. 24 Restored patient to a comfortable position. 25 Performed hand hygiene using correct technique. 26 Informed the patient or relative if appropriate of the result. 27 Returned equipment to the dedicated area. 28 Sent specimens to the laboratory. 23. SKILL EVALUATION 60% Steps 0 1-3 4-6 7- 11 15- 17- 21- 25- 28-30 31- 32 achieved 10 - 16 20 24 27 32 achieved Point 0 6 12 18 24 30 36 42 48 54 60 Skill points achieved Level F U N S C I Skill level achieved 24. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 7 Novice 7 Novice 6 7 Novice 6 7 Novice 6 7 Novice 6 7 Novice 7 Novice 7 Novice 7 Novice 6 7 Time allowed (TA) Time achieved Aspects points achieved Aspects points achieved Failed Unsatisfactor Novice Gompeten Independen Total level achieved 7 Total level achieved 8 Signature 8 Signature 8 Total level achieved 7 Total Level 8 Signature 8 Signature 8 Total Revel Park (Patr of Patr of Pat															
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24 Restored patient to a comfortable position. 25 Performed hand hygiene using correct technique.	22				e, sou	arce/si	ite, spe	ecimen	sent to	lab (sp	ecity for	what t	est) in		
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Level F U N S C I Skill level achieved 24. PROCEDURE ASPECTS EVALUATION 40% Rationale 10% Patient Focus 10% Professional Manner 10% Time 10% Failed 5 Failed 5 Failed+10 5 Unsatisfactory 6 Unsatisfactory 6 Unsatisfactory 7 6 Unsatisfactory 8 6 Novice 7 Novice 7 Novice 46 7 Supervised 8 Supervised 8 8 Supervised 4 8 Competent 9 Competent 9 Competent +2 9 Independent 10 Independent 10 Independent TA 10 Notes: Time allowed (TA) Time allowed (TA) Time allowed (TA) Time achieved Aspects points achieved Student Novice Supervise Supervise Competen Independen t Total level achieved Student Signature		U	U	12	10	27	50	30	72	10	54	00			
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Date	Teacher	r						iture							
							Date								



	PROCEDURE: Nasogastric tube Feeding Checklist	Code	
No.	Skill steps	Not achieved	Achieved
1	Prepared procedure equipment:		
	Tray for equipment		
	Nasogastric tube size		
	Lubricant jell		
	o Stethoscope		
	o Gloves		
	o Feeding pump		
	 Appropriate size syringes 		
	o Prepared feed		
	 Cooled boiled water 		
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the		
	parent or carer.		
	Provided privacy.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	Wear gloves.		
4	Position the child conceding the developmental approach		
5	Measure the tube for approximate length of insertion and mark the point with a		
	small piece of tape.		
6	Place a towel over child's gown		
7	Lubricate the catheter with sterile water or water soluble lubricant.		
8	Insert the tube gently and firmly through either the mouth or one of the nares to		
	the predetermined mark		
9	Check the placement of the tube		
10	Tape the tube securely & closed it by clamp.		
11	Elevate head of the bed up 30 degrees		
12	Measure prescribed amount of enteral formula in graduated measuring cup or		
	catheter tip syringe.		
13	Place a towel under the child's chin &chest		
14	Connect catheter tip syringe to the tube push gently with the plunger to start		
	flow of food, then remove the plunger and allow the food to flow by gravity.		
15	After finishing, gently clear tubing &catheter –tip syringe by warm water flush then Clamping it.		
16	Hold, cuddle and burp the child		
17	Dispose of equipment and waste in appropriate receptacle.		

18	Remo	Remove gloves and wash hands.												
19	Recor	d: time,	type, a	amount	of fed,	amoun	t of gas	tric resi	dual ar	d colo	ur, chil	d's		
	tolera	nce of t	he proc	edure a	and pres	sence of	f bowel	sounds	١.					
			_		2	26. SKI	LL EV	ALUA	TION	60%				
Step	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	22-	24-	Skill steps		
s						12	15	18	21	23	25	achieved		
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill points		
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Marria			7	Marria			7	Novice			7	Novice	7	
Novic	e		8	Novic	e		8	Novic	e		8	+6	8	
Super	rvisad		0	Super	wicod		0	Super	visad		0	Supervised +4	0	
Comp			9	Comp			9	Supervised Competent 9			9	Competent +2	9	
Comp	CtCIIt		10	Comp	CtCIIt		10	Comp	CtCIIt		10	Independent	10	
Inden	endent		10	Inden	endent		10	Inden	endent		10	TA	10	
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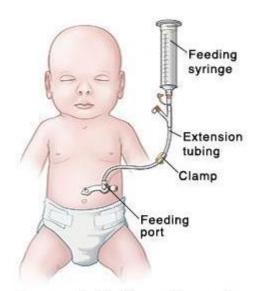


	PROCEDURE: Gastrostomy Feeding Checklist	Code	
No.	Skill steps	Not achieved	Achieve d
1	Prepared procedure equipment:		
	 Tray for equipment 		
	o Gastrostomy tube		
	o Gloves		
	 Feeding pump 		
	 Appropriate size syringes 		
	o Prepared feed		
	Cooled boiled water		
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the		
	parent or carer.		
	Provided privacy.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	Wear gloves.		
4	Measure prescribed amount of formula into clean graduated cup or catheter tip		
	syringe.		
5	Inspect and palpate abdomen for distension.		
6	Place child in a supine position with the head of bed up 30 degree.		
7	Check residual stomach contents by attaching syringe to the tube and aspirating.		
8	Attach 60mL catheter-tip syringe with plunger removed to the end of the feeding		
	tube.		
9	Elevate catheter-tip syringe to a level to deliver the feeding Allow feeding to flow		
	slowly by gravity.		
10	Allow feeding to flow slowly by gravity.		
11	After feeding is complete, gently clear tubing and catheter-tip syringe with warm		
	water flush.		
12	Withdraw the tubing with a slow, smooth, steady movement.		
13	Dispose of equipment and waste in appropriate receptacle.		
14	Remove gloves and wash hands.		
15	Record: time, type, amount of fed, amount of gastric residual and color, child's	_	
	tolerance of the procedure and presence of bowel sounds.		
	29. SKILL EVALUATION 60%		
Step		steps	
S	12 15 18 21 23 25 achie	eved	

Poin ts	S			18	24	30	36	42	48	54	60	Skill points achieved	
Lev el]	F			U	N	S	С	I	Skill level achieved	
CI				30.	PROC	EDUR	E ASP	ECTS	EVAL	UATIO	N 409		
Rationale 10% Patient						ocus1()%		Manne	er10%		Time10	%
Failed			5	Failed			5	Failed	l		5	Failed+10	5
			6				6				6	Unsatisfactory	6
Unsati	isfactoı	y		Unsati	sfactor	У		Unsat	isfactor	У		+8	
			7				7				7	Novice	7
Novic	e			Novic	e			Novic	ee			+6	
			8				8				8	Supervised	8
Superv	vised			Super	vised			Super	vised			+4	
Comp	etent		9	Comp	etent		9	Competent 9			9	Competent +2	9
			10				10				10	Independent	10
Indepe	endent			Indepe	endent			Indep	endent			TA	
Notes	:											Time allowed	
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≤5	50	51	-60	61-	70	71	-80	81	-90	91-	100	Total points	
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Teach						Signa	ture					Actual	
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Area	Area				Date								



Before feeding your child, connect the extension tubing to the G-tube or G-J tube.



Connect the feeding syringe to the extension tubing.





PR	OCEDURE: Paediatric procedures - Nebulized Medication Administration	Code	
No.	Skill steps	Not achie ved	Achie ved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	☐ Nebulizer and nebulizer connecting tubes		
	☐ Compressor oxygen tank		
	☐ Mouthpiece/mask		
	☐ Respiratory medication to be administered		
	□ Normal saline solution		
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the parent		
	or carer.		
	Provided privacy.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	Verify the correct child		
4	Assess baseline - Vital signs, lung sounds, respiratory effort, pulse oximetry reading,		
	and, peak flow meter reading.		
5	Determine the appropriate delivery device - a mouthpiece between the lips, - a face		
	mask.		
6	Assess the child for specific contraindications to receiving the nebulized medication		
7	Check accuracy and completeness of the MAR with the practitioner's original order.	-	
9	Ensure the six rights of medication.		
	Use a bar code system or compared the MAR to the child's armband.		
10	Label all medications, medication containers, and other solutions		
11	Assemble the nebulizer equipment according to the manufacturer's recommendations.		
12	Assist the child into a comfortable sitting or semi-Fowler position		
13	Add the prescribed medication and diluent if needed to the medication chamber of		
13	the nebulizer.		
14	Checked the required fill volume for the device used.		
15	Turn on the small-volume nebulizer via the flow meter.		
16	- If a mouthpiece was used, instruct the child to hold it with the lips, using gentle		
	pressure to form a seal around the tip.		
	- If the infant or child unable to hold the mouthpiece, use a face mask. Make sure		
	the face mask fit tightly and instruct the child to breathe through an open mouth.		
17	Instruct the child to take a deep breath slowly and exhale passively.		
18	Monitor the child's heart rate periodically during treatment Discontinued		
	treatment if his or her heart rate is rising.		
19	Tap the sides of the chamber to drop medication to the bottom of the chamber.		
	When the medication dose has been delivered		

1					check h		_	_		_		_		
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22	Praise	the chi	ild for r	ositive	behavi	our.								
23					nfortab		ion							
24					reaction									
25							erforme	d hand	hvgiene	e.				
26	Discard supplies, and remove PPE, and performed hand hygiene. Wash hands													
27	Document the procedure in the child's record.													
	32. SKILL EVALUATION 60%													
Step	0 1-2 3-4 5-7 8-10 11- 13- 16- 19- 21- 23- Skill steps													
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	PROCEDURE: Newborn care - phototherapy	Code	
No.	Skill steps	Not achie ved	Achie ved
1	Prepared procedure equipment:		
	□ Newborn medical record		
	☐ Phototherapy chart		
	☐ Phototherapy unit		
	☐ Eye protection shield or patches		
2	Checked patient record for medical order for phototherapy		
3	Checked the latest serum bilirubin blood test result.		
4	Identified the patient using two identifiers.		
5	Performed greeting, introduction and permission procedure (G.I.P) with the parent or carer.		
6	Provided privacy.		
7	Explained the procedure to the parent or carer and answered any questions.		
8	Performed hand hygiene using correct technique.		
9	Checked the last day of cleaning of the unit (should be done once a week).		
10	Plugged in the phototherapy unit.		
11	Checked the light indicator is on.		
12	Moved the unit above the cot or incubator.		
13	Undressed the baby.		
14	Opened their nappy to ensure treatment is applied to the maximum area of skin.		
15	Gave the baby eye protection ensuring it does not occlude the nares, as asphyxia and		
	apnoea can result		
16	Placed the baby in the supine position.		
17	Checked that unit is about 40-50cm above the baby (according to manufacturer's		
	instructions). If an incubator is used, there should be a 5- to 8 cm space between it		
	and the lamp cover to prevent overheating.		
18	Turned the phototherapy unit on by pressing the on/off button or switch.		
19	Checked the intensity of the light is set to prescribed intensity: low, medium, high.		
20	Reported following nursing interventions during treatment:		
	☐ Changing position every 2 hours		
	☐ Removing eye shields and checking eyes regularly		
	□ Not applying any cream or oil to the exposed area of skin		
	☐ Monitoring the baby's temperature three hourly		
	☐ Ensure the baby is kept in a thermo-neutral environment (eg. temperature per axilla 36.8 - 37.2oC)		
	☐ Monitoring hydration by daily weighing of the baby and assessing wet		
	nappies		
	☐ Monitor bilirubin as per doctor's order		
	☐ Observing the baby for potential signs of bilirubin encephalopathy (eg		
	lethargy, poor feeding, hypotonia, arching of the head and neck, and		
	seizures)		
	☐ Gave parents opportunity to interact with the baby.		
21	Reported potential complications of phototherapy:		
	□ diarrhoea	1	

		skin r	ash											
		'bronz	ing' of	baby's	skin									
					aration									
		overh		•										
		water	_											
		retina	l damag	ge										
22	Suppo			_	s and e	ncoura	ged the	m to int	teract w	ith the	baby.			
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		te's rec					1			1.7				
24	Docur	nent tin	ne of co	ommen	cement	and co	mpletio	n of ph	otother	apy in	the			
		herapy					•	•						
25	Perfor	med ha	nd hyg	iene us	ing cor	ect tecl	hnique.							
					35	. SKIL	L EVA	LUAT	ION 6	0%				
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I	PROCEDURE: Paediatric procedures Nasopharyngeal (NP) suctioning	Code	
		Not	Achie
No.	Skill steps	achie	
		ved	ved
1	Prepared procedure equipment:		
	☐ Patient medical record		
	□ soft and/or rigid suction catheter		
	☐ Suction source with a receptacle		
	□ Lubricant		
	☐ Clean gloves		
	☐ Mask with a shield		
	□ Personal protective equipment		
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the parent		
	or carer.		
	Provided privacy.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	Wearing gloves		
4	Assess the child's developmental level and ability to interact.		
5	Monitor the child's vital signs before, during, and after suctioning.		
6	Assess the child's last intake of any food or liquids.		
7	Ensure that a handheld, appropriate-size resuscitation bag with mask is available.		
8	Wash hands and wear gloves.		
9	Assess for the presence of airway secretions.		
10	Determine the appropriate-size suction catheter.		
11	Place the child in the semi-Fowler position.		
12	Turn the suction device on and set the suction regulator pressure.		
	a. Neonate: 60 to 80 mm Hg		
	b. Infant: 80 to 100 mm Hg		
	c. Child 1 to 8 years of age: 100 to 120 mm Hg		
	d. Adult: 100 to 150 mm Hg		
13	Determine the appropriate insertion length of catheter by measuring from the tip of		
13	the nose to the tragus of the ear.		
14	Apply water-soluble lubricant to the suction catheter.		
15	Pour a small amount of sterile water or normal saline in a sterile basin.		
16	Wash hands wear gloves, mask, and eye protection		
17	Pick up the suction catheter with the dominant hand.		
18	Pick up connecting tube with the non-dominant hand and secure it to the suction		
=	catheter.		
19	Place the non-dominant thumb over the control vent of the suction catheter and		
	suction a small amount of fluid from the sterile solution in the basin.		
20	Dip the end of the catheter in the water-soluble lubricant.		
21	Instruct the child to cough before the procedure, if developmentally appropriate.		
	Consider administering oxygen before, during, and after the procedure.		

23	Roll t	he cath	eter bet	ween th	ne finge			er lengtl th advar		rough t	he tur	binate		
24				to cou		41	4	vent of	1		1 4	4		
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26						ion fro	m the b	asin an	d rinse	off anv	secret	tions on		
		terior o								<i>y</i>				
27	Asses	s the ch	nild's re	esponse	to sucti	ioning.								
	Assess the child's response to suctioning. - If coughing or gagging with evidence of pallor was present, ceased the procedure													
	until the coughing or gagging subsided.													
	- Instruct the child to take several deep breaths during this rest period before the													
20	next suctioning pass, if developmentally appropriate. Repeat the procedure, alternating nares unless contraindicated, until the airway was													
28	Repea	it the pi	ocedur	e, aiteri	iating n	ares un	ness co	ntraind	cated,	untii th	e airwa	ay was		
29		the cat	heter or	ound th	e domi	nant ha	nd and	pull the	glove	off inci	de out			
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31		ganizat			Conten	its and v	cicaii o	Теріас	e the st	criic sa	iiiic ot	isiii pei		
32					v pertir	nent cha	anges a	fter suc	tioning					
33		tor the									nd ver	itilation		
34	Docu	ment th	e proce	dure in	the chil	ld's rec	ord.							
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			7				7				7	Novice		7
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~			8	_			8				8	Superv	ised	8
	vised		0	Super			0	Super			0	+4	44	
Comp	etent		9	Comp	etent		9	Comp	etent		9	Compe		9
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Teacher			Signature			Actual	
Clinical			Doto			Mark/Out of	
Area			Date				





P	ROCEDURE: Feeding – bottle – milk formula preparation and feeding	Code	
No.	Skill steps	Not achie ved	Achie ved
1	Prepared procedure equipment:		
	☐ Feeding bottles		
	\Box Teats		
	☐ Bottle brush		
	☐ Teat brush		
	□ Washing up liquid		
	☐ Clean dry knive or plastic leveller included in sterilizer		
	☐ Kettle for boiling water		
	☐ Formula milk		
	☐ Cleaning solution		
	☐ Cloth or paper towel		
	□ Plastic tray		
2	Performed hand hygiene using correct technique.		
3	Filled the kettle with at least 1 litre of fresh tap water from the cold tap.		
4	Boiled the water and let it to cool for no more than 30 minutes.		
5	Cleaned and disinfected the working surface and a plastic tray.		
6	Washed the bottles and teats carefully with warm water, brushes and washing up		
	liquid and placed on a plastic tray.		
7	Put the bottles and teats in the sterilizer according the manufacturer's instructions.		
8	Poured required amount of water into the sterilizer.		
9	Turned on the sterilizer.		
10	When the bottles and teats are sterilized, removed them from the sterilizer without		
	touching the necks of the bottles and tops of the teats (plastic prongs can be used)		
4.4	and placed them on the upturned lid of the sterilizer.		
11	Assembled the bottles Without touching the teats and placed them on the plastic tray.		
12	Filled one of the bottles with required amount of water from the kettle depending on		
	how much milk is to be prepared (usually multiplies of 30mls).		
13	Checked the manufacturer's instructions for number of scoops of milk formula are		
	required for the prepared amount of water (usually I scoop for 30ml of water).		
14	Loosely filled the scoops one by one with formula levelling them off using either the		
	flat edge of a clean, dry knife or the leveller provided.		
15	Covered the bottle with the teat and cap.		
16	Shook the bottle well until all powder dissolved.		
17	Tested the temperature of the infant formula on the inside of the wrist. If it was too		
	hot held the bottom half of the bottle under cold running water moving the bottle		
10	about to ensure even cooling.		
18	Put the baby in comfortable, position with head raised to prevent aspiration.		

19	Fed th	e baby	with as	much	milk as	desired	l holdin	g bottle	e with t	he teat	full to	prevent		
	Fed the baby with as much milk as desired holding bottle with the teat full to prevent swallowing air. Held baby upright for to release the swallowed air.													
20	Held l	oaby up	right fo	or to rel	ease the	e swallo	wed ai	r.						
21		e baby												
22	Check	ed the	amount	of mill	k drank	by the	baby.							
23		rded un												
24	Docui	nented	the tim	e of fee	ding ar	ıd amoı	ınt of n	nilk giv	en to th	e baby				
25	Retur	ned equ	ipment	to the	dedicate	ed area.								
26	Perfor	med ha	nd hyg	iene usi	ing con	ect tecl	nnique.							
					41	. SKIL	L EVA	LUAT	ION 6	0%				
Step	0	1-2	3-5	6-8	9-11	12-	14-	17-	20-	23-	25-	Skill steps		
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Novic	e			Novic	e			Novic	e			+6		
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		Ungot	isfact							Indep	ondo	Total level		
Fai	led			Nov	vice	Super	rvised	Comp	oetent	n		achieved		
Stude	nt	Ol	y y			Signat	ure			11	ı	acmeveu		
Teach						Signat						Actual	1	
Clinic							iuic					Mark/Ou		
Area	uı					Date						IVIAI IS/ O'U	01	
111Ca						l .		l .						



			PRO	CEDU	RE:	Hyg	giene –	sponge	bath				Code	
													Not	Achie
No.						Skill	steps						achie	ved
													ved	veu
1	Prepar	red prod	cedure	equipm	ent:									
		Patier	nt medi	cal reco	rd									
		Vital	signs cl	hart										
		Wash	basin o	r bathtu	b									
		Tepid	water(body te	mperat	ure, sho	ould be	not feel	warm	or cold	to tou	ch		
		_		small to	-									
				r bath b		U	1							
		-		to prote										
		Plasti		to prote										
2				ord for i	nanage	ement o	f fever							
3				t using										
4			_	introdu				nrocedi	ire (G I	P) wit	h the n	arent		
	or care	_	ceting,	muoda	ction a	na pern		procedi	ne (3.1	/ **10.	ii tiio p	urent		
5		ded priv	acv											
6				dure to	the pare	ent or c	arer and	l answe	red any	anesti	ons			
7				iene usi				a uns we	rea arry	questi	ons.			
8			<u>, , , , , , , , , , , , , , , , , , , </u>	before				port).						
9				or expo					ge supe	rficial l	plood s	vessels		
				and ingi					5F.					
10				th a pla			red wit	h a batl	ı blanke	et.				
11				ith tepi							oke the	wet		
				for 12										
12				a towe										
13	Remo	ved the	plastic	sheet.										
14	Redre	ssed the	e child	in light	weight	clothing	g.							
15	Reass	essed cl	hild's to	emperat	ure and	dother	vital sig	ns imn	nediatel	y after	discon	tinuing		
				30 minu			_			-				
16	Returi	ned the	child to	a com	fortable	e positio	on.							
17				iene usi										
18	Docur	nented	time ar	nd durat	ion of s	spongin	g and c	hild's r	esponse	e.				
19	Returi	ned equ	ipment	to the	dedicate	ed area.			-					
20	Repor	ted abn	ormal f	findings	to the	approp	riate me	ember c	f staff.					
					44	. SKIL	L EVA	LUAT	ION 60)%				
Step	0	1-2	3-4	5-6	7-8	9-10	11-	13-	15-	17-	19-	Skill ste	eps	
S							12	14	16	18	20	achieve	d	
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill po	ints	
ts												achieve		
Lev]	F			U	N	S	C	I	Skill lev		
el												achieve	d	
				45. P	ROCE	DURE	ASPE				140%			
_				_					Profess			=	T1 4 2 2 2	
		ale 10%				ocus10			Manne	<u>er10%</u>			<u>Γime10%</u>	
Failed			5	Failed			5	Failed			5	Failed+	10	5

	6			6			6	Unsatisfactory	6
Unsatisfactor	y	Unsatisfactor	ry		Unsatisfactor	y		+8	
	7			7			7	Novice	7
Novice		Novice			Novice			+6	
	8			8			8	Supervised	8
Supervised		Supervised			Supervised			+4	
Competent	9	Competent		9	Competent		9	Competent +2	9
	10			10			10	Independent	10
Independent		Independent			Independent			TA	
Notes:								Time allowed	
								(TA)	
								Time achieved	
								Aspects points	
								achieved	
		46. COMPLI	ETE PR	OCEI	OURE EVALU	J ATIO	N1009	%	
≤50	51-60	61-70	71-	80	81-90	91-1	.00	Total points	
								achieved	
Failed	Unsatisfact	Novice	Super	rziand	Competent	Indep	ende	Total level	
raneu	ory	Novice	Super	viseu	Competent	nt	t	achieved	
Student			Signat	ure					
Teacher			Signat	ure				Actual	
Clinical			Date			·		Mark/Out of	
Area			Date						



Procedure Evaluation Document (PED)

DURE: Infants Tub Bath

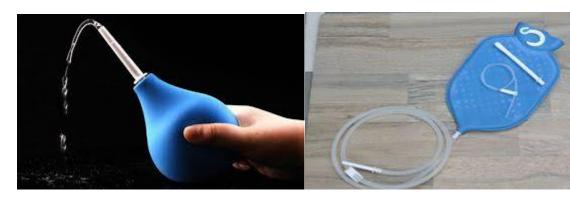
			P	ROCE	DURE:			n Docur Tub Ba		LD)			Code	
No.						Ski	ill steps	3					Not achie ved	Achie ved
1	Pre	pared p	procedu	re equi	pment:									
			Baby bat											
			otton ba											
			ild soap	-	00									
			veral to											
			omb or l											
			by toys											
			nsing co	_										
			veral w		h									
			aper su											
			il clipp											
2			the pati							<u> </u>				
			l greetii	ng, intro	oductio	n and p	ermissi	on proc	edure ((G.I.P)	with th	ne		
		ent or o											<u> </u>	
			privacy		1			1						
			the pro						swered	any qu	estions	S		
	-		l hand l	nygiene	using o	correct	techniq	ue.						
3		ear glov			•••									
<u>4</u> 5			osite sic				.h.o.v.o. tl	ha infar	tla bad	h 0	5 am	4.Fill		
3			ne warn ab with		-	-								
			ps when				mperau	ire 57.0	1 10 3 /	o °C in	at reac	in the		
6	_		ne infan		ing pos	HUOH								
7			slip the		into the	a tub xx	hilo our	nortine	tha na	alz Prh	and a			
8	-											.or		
8			infant v s with c				_	g by sn	outaers	s, arms,	to low	er		
9								a wooh	loth					
			infant t							font w	mon hir	n in a		
10			he uncle			•	-				-	a a &door		
		sed	et ,cove	i tile lie	ad by C	ap, use	man Ci	ippei ,k	eep bec	i side i	ans up	&u001		
11			&rinse	the bee	in or tul	h Dotu	rn oll o	auinma	nt's to	thoir n	laga di	e n oco		
11		waste	XIIIISC	uic Das.	ııı oı tu		ın an e	quipilit	AIL S 10	men pi	act, ul	spose		
12			loves &	nerfor	m hand	hygian	Α							-
13			t the fol	-				normal	finding	r Brtun	a of bot	th)		
13	טען	Cullicili	t uie 101	TOWING				LUAT			or ba	ш <i>)</i>		
Steps	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	22-	24-	Skill st	ens	
Steps		1 4				12	15	18	21	23	25	achieve	-	
Points	0	6	12	18	24	30	36	42	48	54	60	Skill po	oints	

Level			F		U	N	S	С	I	Skill level achieved	
			48. PROCI	TOUDE	A SDE	CTS EV		ATION	I 400/	acmeved	
			40. PROCI	DUKE	ASPL		VALUA Profes		1 40%		
Rat	ionale 10)%	Patient 1	Focus 10	10%		r rotes Manne			Time10%	
Failed	ionaic 10	5	Failed	rocusio	5	Failed	wann	110/0	5	Failed+10	5
Tanca		6	Tanca		6	1 anca			6	Unsatisfactory	6
Unsatisfa	ctory	0	Unsatisfacto	rv	U	Unsati	sfactor	V	U	+8	U
Chiatisia	ctory	7	Chausiacto	ı y	7	Chath	Stactor	<i>y</i>	7	Novice	7
Novice	Novice		Novice		,	Novice			,	+6	,
		8			8				8	Supervised	8
Supervise	Supervised		Supervised			Superv	vised			+4	
-	Competent 9		Competent		9	Compo	etent		9	Competent +2	9
•		10	•		10	•			10	Independent	10
Independe	ent		Independent			Independent				TA	
Notes:										Time allowed	
										(TA)	
										Time achieved	
										Aspects points	
										achieved	
			49. COMPL			1					
≤50	5	51-60	61-70	71-	-80	81-	90	91-1	100	Total points	
										achieved	
Failed	Uns	satisfact	Novice	Super	rvised	Comp	etent	Indep		Total level	
		ory	1,0,120	_		0 0 222 P		n	<u>t</u>	achieved	
Student				Signat							
Teacher				Signat	ture					Actual	
	Clinical			Date						Mark/Out of	
Area			Date								



	PRC	CEDU	RE:	Pac	ediatric	proce	dures -	Enema	Admi	nistrati	ion		Code	
						~							Not	Achi
No.						Skill	steps						achie	eved
	_												ved	0,002
1	Prepai	red proc		equipm	ent:									
		Enem	_											
				e lubric	ante									
	□ Syringe													
	□ Gloves													
	☐ Catheter													
2	Identified the patient using two identifiers.													
	Performed greeting, introduction and permission procedure (G.I.P) with the parent													
	or care													
	_					ent or c		d answe	red any	y questi	ons.			
					ing cor	rect tecl	nnique.							
3		k medic												
4		-		draping	the chi	ild with	his anı	ıs expo	sed and	l closed	curta	ins		
	around the bed.													
5						l be kep	t at bec	lside						
6		the wat		pad ur	der the	child.								
7	Position the child:													
			-			nd legs			-	e anal o	orifice	•		
				; semi's	s positio	on or kr	nee-che	st posit	ion.					
8		n glove												
9		cate the												
10						anal spł								
4.4						rom 2.5								
11	_		n contai	iner on	a bedsi	de stan	d elevat	ted 30 -	45 cm	above t	he chi	ld's		
10	abdon			. • •	1	1 0	.1 (1	C1 · 1	• • •			1		
12									•	• •	ms of	distress		
10					ain, sno	ortness	or breat	n or ch	est pair	1.				
13		he butte			14	1	4 - C 4	1	1.	. 1	1	1'		
14			derecat	es and o	expers t	ne cont	ent of t	ne enen	na on b	eapan c	or ciea	n diaper		
1.5	for inf													
15		the per			-:4:	£ £								
16	_					f comfo								
17							er –							
18		hands					on D:	. D :			. d ·			
19		ment L espons				ieaicati	on, Dos	se, Koui	ie, preso	ents of a	aavers	se effect,		
	Cillu I	capons	c, and k	orginatu.		SKILL	EVAI	ΠΑΤΙ	ON 600	Vo.				
Steps	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill ste	ens	
Steps		1 -2	J - T	5-1	0 10	12	15	18	20	22	24	achieve	-	

Points	0	6	12	18	24	30	36	42	48	54	60	Skill points	
												achieved	
Level		•]	F	·	•	U	N	S	С	I	Skill level	
								achieved					
51. PROCEDURE ASPECTS EVALUATION 40%													
Professional													
	ational	le 10%		Patient Focus 10%				Manne	er10%	,	Time10%		
Failed			5	Failed			5	Failed			5	Failed+10	5
			6				6				6	Unsatisfactory	6
Unsatisf	actory			Unsat	isfactor	y		Unsat	isfactor	У		+8	
			7				7				7	Novice	7
Novice				Novice				Novice				+6	
8						8				8	Supervised	8	
Supervised			Supervised				Supervised				+4		
Competent 9			Competent			9	Competent			9	Competent +2	9	
10						10				10	Independent	10	
Independ	Independent			Independent			Independent				TA		
Notes:	Notes:											Time allowed	
												(TA)	
												Time achieved	
												Aspects points	
											achieved		
			5	2. CON	IPLET	E PRO	OCEDU	JRE EV	VALUA	ATION	100%		
≤50 51-60		-60	61-70 71		-80	80 81-90		91-100		Total points			
									achieved				
Faile	ad	Unsat	tisfact	No	vica	Supar	rvicad	Comr	natant	Indep	ende	Total level	
rall	r aneu		ry	Novice		Super	Supervised		Competent		t	achieved	
Student				Signature		ture					Actual		
Teacher						Signa	ture					Mark/Out of	
Clinical Area					Date						Maik/Out 01		





]	PROCE	DURE		Paedia	tric pr	ocedui	es -Mu	mmy R	estrain	ts		Code	
No.	Skill steps													Achie ved
1	Prepared procedure equipment:													
2	Identified the patient using two identifiers.													
	Performed greeting, introduction and permission procedure (G.I.P) with the parent													
	or carer.													
	Provided privacy.													
	Explained the procedure to the parent or carer and answered any questions.													
_	Performed hand hygiene using correct technique.													
3	Describe to the mother what is going to be done and encourage her to ask questions													
4	Stay with distressed child													
5	Place opened sheet or blanket on flat surface with one corner folded to the center													
6	Place infant on blanket with shoulders at blanket fold and feet toward opposite													
7	corner Place infant's right arm straight against side of the body													
8	Place infant's right arm straight against side of the body Pull side of the blanket on right side firmly across right shoulder and chest													
9	Pull side of the blanket on right side firmly across right shoulder and chest Secure beneath left side of body													
10	Place left arm straight against side													
11	Bring remaining side of blanket across left shoulder and chest													
12	Secure beneath body													
13	Fold lower corner and bring up to shoulders and secure ends beneath body													
14	Fasten in place with safety pins or tape													
15				rvation										
						. SKIL	L EVA	LUAT	TON 6	0%			1	
Step	0	1-2	3-4	5-7	8-10	11-	13-	16-	19-	21-	23-	Skill ste	eps	
S						12	15	18	20	22	24	achieve		
Poin	0	6	12	18	24	30	36	42	48	54	60	Skill po	oints	
ts												achieve		
Lev]	F			U	N	S	C	I	Skill le		
el				= 4 =	D 0 07		4 6777			1 mro 1	7. 40.54	achieve	ed	
				54. P	ROCE	DURE	ASPE	CTS E			40%	1		
,	Dation	- l - 100/		D.	4: a-4 T	Fo o a 1 C	10 /		Profes			,	Time a 1 00/	,
Failed										Time10%	5			
raneu			5 6	raneo	L		6	Failed	<u> </u>		5 6	Failed+ Unsatis		6
Uncati	isfactor	3 7	U	Uncat	isfactor	.	U	Uncat	isfactor	3 7	0	+8	ractory	U
Onsat	israci01	J	7	Ciisat	15140101	J	7	Onsat	israci01	J	7	+8 Novice		7
Novic	e		,	Novic	e		,	Novice			,	+6		,
- 10 110	-		8	_ , 5 , 10			8	-,5,10	1101100			Supervised		8
Super	vised		-	Super	vised			8 Supervised 8 Supervi						
Comp	etent		9	Comp			9	Comp			9	Compe	tent +2	9

	10		10			10	Independent	10			
Independent		Independent		Independent			TA				
Notes:							Time allowed				
							(TA)				
							Time achieved				
	Aspects points										
							achieved				
	55. COMPLETE PROCEDURE EVALUATION 100%										
≤50	51-60	61-70	71-80	81-90	91-1	100	Total points				
							achieved				
Failed	Unsatisfact	Novice	Supervised	Compotent	Indep	ende	Total level				
raned	ory	Novice	Supervised	Competent	n	t	achieved				
Student			Signature								
Teacher			Signature				Actual				
Clinical			Doto				Mark/Out of				
Area			Date								