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

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures –physical examination**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
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	*History Taking: *f* Biographic data. *f* Chief complaint. *f* Present illness. *f* Past health history. *f* Family health history. *f* 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. *f* Nutritional status. *f* 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* Tenderness *f* Any abnormality.		
7	*Head: Inspect: *f* Shape. *f* Control. *f* Posture. Inspect and palpate: *f* Fontanels Examine: 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* Expression		
10	*Neck: *f* Inspect Size Trachea. Thyroid Carotid arteries *f* 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		

	External canal.		
13	*Nose & Sinuses: *f* Inspect External nose. Nasal mucosa Nasal septum. Palpate 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. *f* 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.		

1. SKILL EVALUATION 60%													
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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)	
						Time achieved	
						Aspects points achieved	

3. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

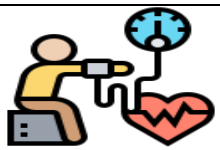
Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures – bulb suctioning**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Bulb syringe □ Normal saline drops □ Non-sterile gloves □ Paper towel □ Plastic tray		
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	Assessed respiratory status, including respiratory rate, colour, and effort.		
4	Positioned child with head flat or slightly elevated (someone can assist holding and comforting the child).		
5	Put on gloves.		
6	If secretions were very thick, dropped normal saline into nares before suctioning to loosen secretion.		
7	Deflected the bulb prior to inserting tip into infant's nares /mouth by squeezing bulb.		
8	Inserted tip into infant's nares /mouth.		
9	Allowed bulb to inflate and removed syringe from nares /mouth.		
10	Expelled secretions into paper towel.		
11	Repeated as necessary.		
12	Removed gloves.		
13	Repeated assessment of respiratory status.		
14	Documented respiratory status.		
15	Documented the colour, consistency and amount of secretions.		
16	Documented whether or not saline was used.		
17	Documented how well the child tolerated the procedure.		
18	Documented the frequency required to clear nares/ mouth of secretion.		
19	Returned equipment to the dedicated area.		
20	Reported abnormal findings to the appropriate member of staff.		

4. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	
5. 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)	
								Time achieved	
								Aspects points achieved	
6. COMPLETE PROCEDURE EVALUATION100%									
≤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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LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE:	**Paediatric procedures – Blood pressure Measurement**	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Patient medical record - Sphegmomanometer - Vital signs chart - Stethoscope - Watch - Cotton - Septic solusion - Plastic tray		
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	Select the appropriate cuff size.		
4	Attach the tube from the BP cuff.		
5	Expose the upper arm.		
6	Apply the cuff evenly over the upper arm with the lower edge about 1.5 cm above the antecubital space		
7	Position the sphygmomanometer on a level surface at approximately the level of heart.		
8	Palpate the radial artery and inflate the cuff until the palpated pulse is lost then pump for additional 20 mmhg.		
9	Position the bell of the stethoscope over the area where the brachial pulse is felt.		
10	Slowly deflate the cuff and listen to the sounds.		
11	Deflate the bp cuff & remove it		
12	Record the reading & report for any abnormality.		
13	Performed hand hygiene using correct technique.		
14	Documented time, duration and child's response.		
15	Returned equipment to the dedicated area.		

7. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	8-9	9-10	10-11	11-12	12-13	14-15	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	

8. 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)	
						Time achieved	
						Aspects points achieved	

9. COMPLETE PROCEDURE EVALUATION100%							
≤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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LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures – Heart rate Measurement**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Stethoscope □ Watch □ Cotton □ Septic solusion □ Plastic tray		
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	Expose the chest over the apex of the heart.		
4	Wipe earpieces and diaphragm of stethoscope with alcohol swab.		
5	Place the stethoscope between the fourth and the fifth intercostal spaces just below the left nipple.		
6	Listen to the heart sound and count for one full minute.		
7	Wipe the earpieces and the diaphragm with alcohol swab		
8	Performed hand hygiene using correct technique.		
9	Documented time, duration and child's response.		
10	Returned equipment to the dedicated area.		
11	Reported abnormal findings to the appropriate member of staff.		

10. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

11. 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)	
						Time achieved	
						Aspects points achieved	

12. COMPLETE PROCEDURE EVALUATION100%							
≤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**	

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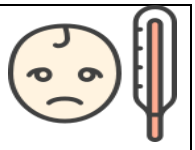
LABORATORY AND CLINICAL EDUCATION



Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures – Axillary Temperature**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Patient medical record - Vital signs chart - Thermometer - Cotton - Septic solusion - Plastic tray		
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.		
2	Check thermometer to see the reading.		
3	Clean thermometer from tip to the bulb.		
4	Shake the level of mercury down to below 35°C.		
3	Rinse and dry axilla.		
5	Place thermometer under arm with tip in centre of axilla and keep it close to skin not clothing.		
6	Hold child's arm firmly against side for 5 minutes.		
7	Remove thermometer and wipe it from up down to the bulb.		
8	Performed hand hygiene using correct technique.		
9	Documented time, duration and child's response.		
10	Returned equipment to the dedicated area.		
11	Reported abnormal findings to the appropriate member of staff.		

13. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

14. 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)	
						Time achieved	
						Aspects points achieved	

15. COMPLETE PROCEDURE EVALUATION100%							
≤50	51-60	61-70	71-80	81-90	91-100	Total points achieved	

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LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures – Oral Temperature**		Code	
No.	**Skill steps**	**Not Achieved**	**Achieved**
1	Prepared procedure equipment: - Patient medical record - Vital signs chart - Thermometer - Cotton - Septic solusion - Plastic tray		
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	Check thermometer to see the reading.		
4	Clean thermometer from tip to the bulb.		
5	Shake the level of mercury down to below 35°C.		
6	Place thermometer in the mouth far back under the tongue.		
7	Tell the child to keep mouth closed, breath through the nose and not to talk.		
8	Hold thermometer in place for 3 minutes		
9	Remove thermometer and wipe it from up down to the bulb		
10	Performed hand hygiene using correct technique.		
11	Documented time, duration and child's response.		
12	Returned equipment to the dedicated area.		
13	Reported abnormal findings to the appropriate member of staff.		

16. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

17. 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)	
						Time achieved	
						Aspects points achieved	

18. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures – Rectal Temperature**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Thermometer □ Cotton □ Septic solusion □ Plastic tray		
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	Check thermometer to see the reading.		
4	Clean thermometer from tip to the bulb.		
5	Shake the level of mercury down to below 35°C.		
6	Rinse and dry the anal area.		
7	Lubricate the bulb of the rectal thermometer.		
8	Place child in side-lying or prone position.		
9	Place infant prone across mother's lap or supine with knee flexed toward abdomen		
10	Insert the lubricated thermometer 2.5 cm in the rectum and hold it for one minute		
11	Remove the thermometer and wipe with swab from up down to the bulb.		
12	Take the reading.		
13	Wash thermometer with soap and water and disinfectant.		
14	Performed hand hygiene using correct technique.		
15	Documented time, duration and child's response.		
16	Returned equipment to the dedicated area.		
17	Reported abnormal findings to the appropriate member of staff.		

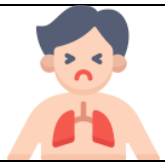
19. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

20. 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)	
						Time achieved	
						Aspects points	



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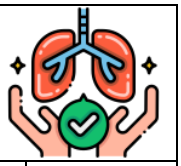
Procedure Evaluation Document (PED)



PROCEDURE:	**Paediatric procedures –Respiratory Rate**	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: □ Patient medical record □ Vital signs chart □ Stethoscope □ Watch □ Cotton □ Septic solusion □ Plastic tray		
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	Expose the chest.		
4	Observe abdominal movement in infants & young children		
5	Observe thoracic movement in older children.		
6	Count respiration for one full minute.		
7	Report any abnormality.		
8	Performed hand hygiene using correct technique.		
9	Documented time, duration and child's response.		
10	Returned equipment to the dedicated area.		

21. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

22. 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

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION
Procedure Evaluation Document (PED)

PROCEDURE: PROCEDURE: **Capillary Blood Draw**		**Code**	
No.	**Skill steps**	**Not achieved**	**Achieved**
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 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 using a quick, forceful motion (no slashing motion).		
13	Removed the lancet immediately.		

14	Wiped away the first drop of blood using a sterile cotton ball or gauze.		
15	Allowed blood to collect at puncture site.		
16	Collected specimen allowing blood to flow into the collecting tube.		
17	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.		
22	Placed the specimen in appropriate bag or container along with laboratory request slips.		
23	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**	**7-10**	**11-14**	**15-16**	**17-20**	**21-24**	**25-27**	**28-30**	**31-32**	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

24. 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)	
						Time achieved	
						Aspects points achieved	

25. COMPLETE PROCEDURE EVALUATION100%

≤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				
			Date				

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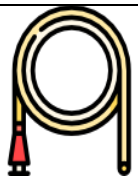


Procedure Evaluation Document (PED)

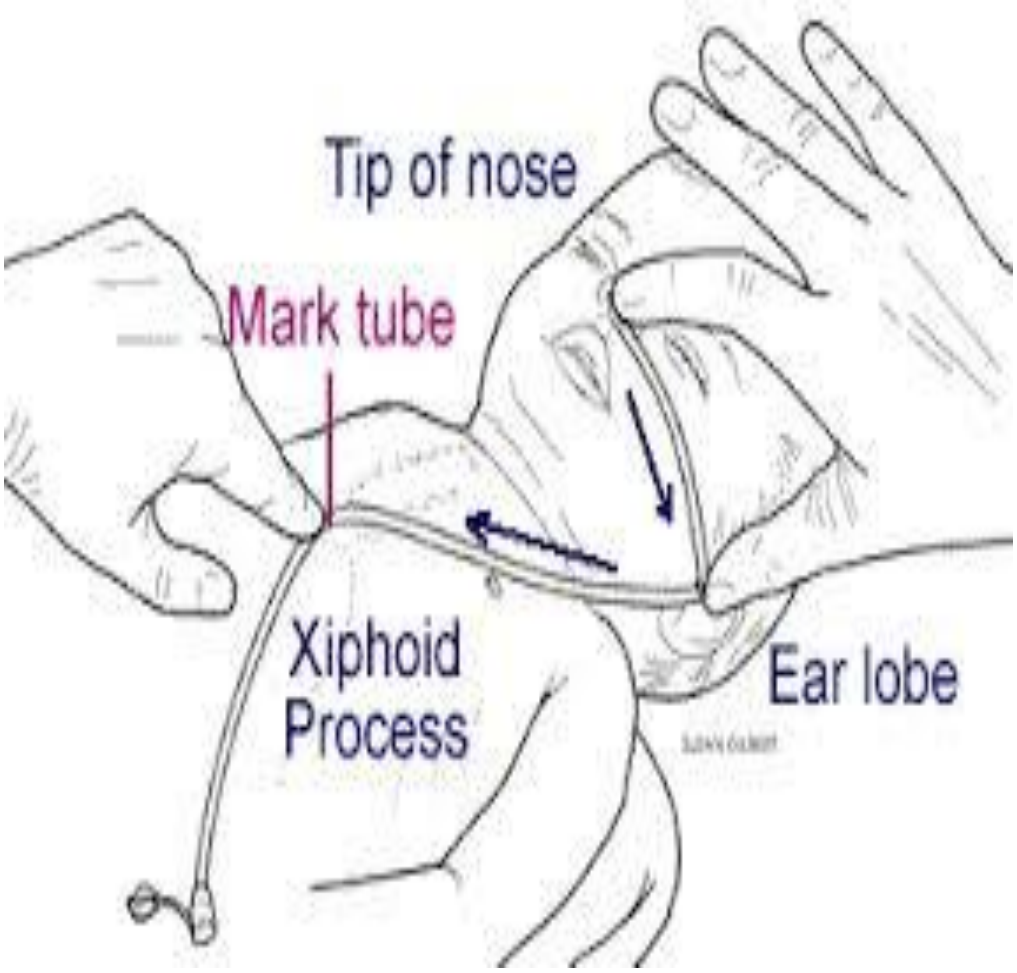
PROCEDURE: Nasogastric tube Feeding Checklist		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: o Tray for equipment o Nasogastric tube size o Lubricant jell o Stethoscope o Gloves o Feeding pump o Appropriate size syringes o Prepared feed o Cooled boiled water		
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	Remove gloves and wash hands.		
19	Record: time, type, amount of fed, amount of gastric residual and colour, child's tolerance of the procedure and presence of bowel sounds.		

26. SKILL EVALUATION 60%													
Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	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	

27. 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)	
						Time achieved	
						Aspects points achieved	

28. COMPLETE PROCEDURE EVALUATION100%							
≤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				


Tip of nose
Mark tube
Xiphoid
Process
Ear lobe

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LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: Gastrostomy Feeding Checklist		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ○ Tray for equipment ○ Gastrostomy tube ○ Gloves ○ Feeding pump ○ Appropriate size syringes ○ 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.		

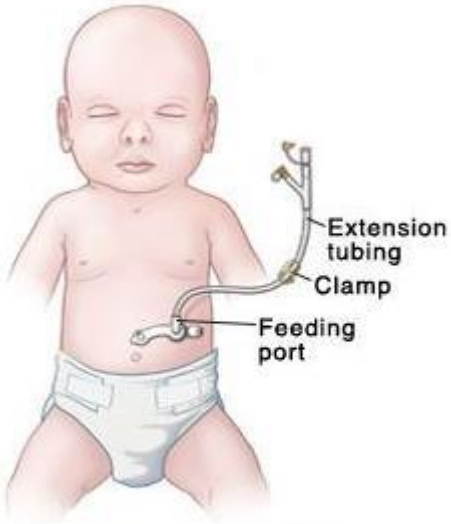
29. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	Skill steps achieved	

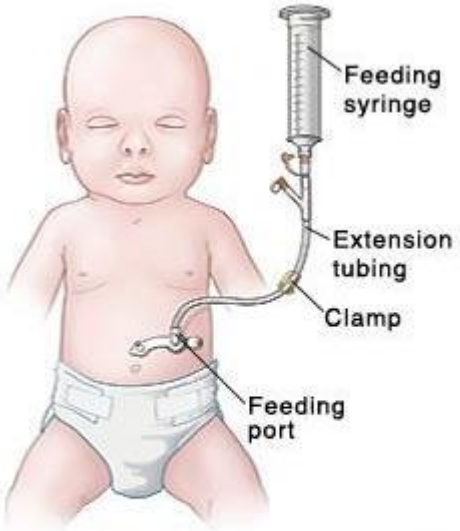
Points	0	6	12	18	24	30	36	42	48	54	60	Skill points achieved	
Level	F						U	N	S	C	I	Skill level achieved	

30. 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)	
						Time achieved	
						Aspects points achieved	

31. COMPLETE PROCEDURE EVALUATION100%							
≤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				



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



Connect the feeding syringe to the extension tubing.

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Procedure Evaluation Document (PED)

PROCEDURE:	**Paediatric procedures** -Nebulized Medication Administration	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
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.		
8	Ensure the six rights of medication.		
9	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 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		

20	Turn off the flowmeter and check heart rate, respiratory rate, lung sounds, oxygen saturation values, and, if ordered, peak flow readings. When treatment is completed		
21	Disassemble all parts of the nebulizer, - shake the nebulizer cup, - remove all the remaining solution - rinse each part in sterile or distilled water, - shake off excess water, and - allow to air dry completely. - Store the nebulizer cup and tubing assembly in a clean bag until its next use.		
22	Praise the child for positive behaviour.		
23	Help the child back to a comfortable position		
24	Assess the child for adverse reactions		
25	Discard supplies, and remove PPE, and performed hand hygiene.		
26	Wash hands		
27	Document the procedure in the child's record.		

32. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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

33. 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)	
						Time achieved	
						Aspects points achieved	

34. COMPLETE PROCEDURE EVALUATION100%

≤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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ABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Newborn care - phototherapy**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
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		

	□ skin rash □ 'bronzing' of baby's skin □ parental anxiety/separation □ overheating □ water loss □ retinal damage		
22	Supported parents and carers and encouraged them to interact with the baby.		
23	Documented time of commencement and completion of phototherapy in the neonate's record.		
24	Document time of commencement and completion of phototherapy in the phototherapy chart.		
25	Performed hand hygiene using correct technique.		

35. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	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

36. 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)	
						Time achieved	
						Aspects points achieved	

37. COMPLETE PROCEDURE EVALUATION100%

≤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 Evaluation Document (PED)

PROCEDURE:	**Paediatric procedures Nasopharyngeal (NP) suctioning**	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
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 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.		

22	Insert the catheter into the nose next to the septum without applying suction and advanced it caudally to the predetermined catheter length.		
23	Roll the catheter between the fingers to assist with advancing through the turbinate until the child began to cough.		
24	Place the non-dominant thumb over the control vent of the suction catheter and apply continuous suction while withdrawing the catheter from the nares.		
25	Rotate the catheter between the thumb and forefinger during withdrawal, limiting suctioning to less than 5 seconds.		
26	Flush the catheter with sterile solution from the basin and rinse off any secretions on the exterior of the catheter.		
27	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 next suctioning pass, if developmentally appropriate.		
28	Repeat the procedure, alternating nares unless contraindicated, until the airway was clear.		
29	Wrap the catheter around the dominant hand and pull the glove off inside out.		
30	Flush the connecting tubing with sterile water or normal saline solution.		
31	Discard the collection basin contents and clean or replace the sterile saline basin per the organization's practice.		
32	Assess breath sounds for any pertinent changes after suctioning.		
33	Monitor the child's vital signs and assess for changes in oxygenation and ventilation indices.		
34	Document the procedure in the child's record.		

38. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

39. 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)	
						Time achieved	

						Aspects points achieved	
40. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE:	**Feeding – bottle – milk formula preparation and feeding**	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Feeding bottles - Teats - Bottle brush - Teat brush - Washing up liquid - Sterilizer - 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) 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 about to ensure even cooling.		
18	Put the baby in comfortable, position with head raised to prevent aspiration.		

19	Fed the baby with as much milk as desired holding bottle with the teat full to prevent swallowing air.		
20	Held baby upright for to release the swallowed air.		
21	Put the baby back in the cot safely.		
22	Checked the amount of milk drank by the baby.		
23	Discarded unused milk.		
24	Documented the time of feeding and amount of milk given to the baby.		
25	Returned equipment to the dedicated area.		
26	Performed hand hygiene using correct technique.		

41. SKILL EVALUATION 60%

Steps	0	1-2	3-5	6-8	9-11	12-13	14-16	17-19	20-22	23-24	25-26	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

42. 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)	
						Time achieved	
						Aspects points achieved	

43. COMPLETE PROCEDURE EVALUATION100%

≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Hygiene – sponge bath**		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Patient medical record - Vital signs chart - Washbasin or bathtub - Tepid water(body temperature, should be not feel warm or cold to touch - Washcloths, small towels, or gauze squares - Dry towels or bath blanket - Plastic sheet to protect bed - Plastic tray		
2	Checked patient record for management of fever.		
3	Identified the patient using two identifiers.		
4	Performed greeting, introduction and permission procedure (G.I.P) with the parent or carer.		
5	Provided privacy.		
6	Explained the procedure to the parent or carer and answered any questions.		
7	Performed hand hygiene using correct technique.		
8	Assessed vital signs before proceeding (verbal report).		
9	Undressed the child or exposed areas where there are large superficial blood vessels such as the axillary and inguinal regions.		
10	Protected the bed with a plastic sheet covered with a bath blanket.		
11	Sponged the child with tepid water using gentle friction and slowly stroke the wet washcloth over body for 12-30 minutes unless child becomes chilled.		
12	Patted child dry with a towel.		
13	Removed the plastic sheet.		
14	Redressed the child in lightweight clothing.		
15	Reassessed child's temperature and other vital signs immediately after discontinuing sponging and again 30 minutes later.		
16	Returned the child to a comfortable position.		
17	Performed hand hygiene using correct technique.		
18	Documented time and duration of sponging and child's response.		
19	Returned equipment to the dedicated area.		
20	Reported abnormal findings to the appropriate member of staff.		

44. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	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	

45. 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)	
						Time achieved	
						Aspects points achieved	

46. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: Infants Tub Bath		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: ○ Baby bathtub ○ Cotton balls ○ Mild soap/shampo ○ Several towels ○ Comb or brush ○ Baby toys ○ Rinsing cup ○ Several washcloth ○ Diaper supplie ○ Nail clippers or scissors		
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	Keep opposite side rails or crib raised .		
5	Turn on the warmer lamp and keep it above the infant's body by 0.5 cm 4.Fill basin or tub with enough water with temperature 37.0 to 37.5 ◦C that reach the infant's hips when in setting position		
6	Undress the infant		
7	Gradually slip the infant into the tub while supporting the neck &head		
8	Wash the infant with the soapy cloth beginning by shoulders, arms, to lower extremities with cleansing of the skinfolds.		
9	Rinse the infant thoroughly with a clean ,damp washcloth		
10	Remove the unclean blanket , dry, wear diaper &dress the infant ,wrap him in a dry blanket ,cover the head by cap, use nail clipper ,keep bed side rails up &door closed		
11	Disinfect &rinse the basin or tub .Return all equipment's to their place ,dispose of waste		
12	Remove gloves &perform hand hygiene		
13	Document the following (infant's response ,abnormal finding &type of bath)		

47. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-21	22-23	24-25	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	

48. 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)	
							Time achieved	
							Aspects points achieved	

49. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

	PROCEDURE: **Paediatric procedures -Enema Administration**	Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
1	Prepared procedure equipment: - Enema bag - Water soluble lubricante - Syringe - Gloves - Towele - Catheter		
2	Identified the patient using two identifiers.		
	Performed greeting, introduction and permission procedure (G.I.P) with the parent or carer.		
	Explained the procedure to the parent or carer and answered any questions.		
	Performed hand hygiene using correct technique.		
3	Check medication order.		
4	Provide privacy by draping the child with his anus exposed and closed curtains around the bed.		
5	Assure the child that a bed pan will be kept at bedside		
6	Place the waterproof pad under the child.		
7	Position the child: a-For infants; placed on his back and legs are lifted to expose the anal orifice. b-For older children; semi's position or knee-chest position.		
8	Put on gloves.		
9	Lubricate the catheter.		
10	Introduce the catheter through the anal sphincter into the anal canal and the lower rectum. Insertion distance ranges from 2.5 to 10 cm according to the child's age.		
11	Hang solution container on a bedside stand elevated 30 -45 cm above the child's abdomen.		
12	Allow solution to flow until finished. Stop the flow fluid if any symptoms of distress appear such as abdominal pain, shortness of breath or chest pain.		
13	Hold the buttocks together.		
14	Let the child defecates and expels the content of the enema on bedpan or clean diaper for infants.		
15	Clean the perineum		
16	Help the child resume a position of comfort		
17	Assess the return for amount and character		
18	Wash hands and dispose equipment's.		
19	Document Date, Time, Name of medication, Dose, Route, presents of adverse effect, child response, and Signature		

50. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

51. 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)	
						Time achieved	
						Aspects points achieved	

52. COMPLETE PROCEDURE EVALUATION100%							
≤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				

FACULTY OF NURSING
LABORATORY AND CLINICAL EDUCATION

Procedure Evaluation Document (PED)

PROCEDURE: **Paediatric procedures -**Mummy Restraints		Code	
No.	**Skill steps**	**Not achieved**	**Achieved**
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 corner		
7	Place infant's right arm straight against side of the body		
8	Pull side of the blanket on right side firmly across right shoulder and chest		
9	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	Recording any observation		

53. SKILL EVALUATION 60%

Steps	0	1-2	3-4	5-7	8-10	11-12	13-15	16-18	19-20	21-22	23-24	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	

54. 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)	
						Time achieved	
						Aspects points achieved	
55. COMPLETE PROCEDURE EVALUATION100%							
≤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				