

**CLAY COUNTY PUBLIC SCHOOLS
CLAY COUNTY HEALTH DEPARTMENT**

GREEN COVE SPRINGS, FLORIDA

**HEALTH SERVICES MANUAL
FOR
MEDICALLY COMPLEX
STUDENTS**

2006-2008

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INTRODUCTION

This manual is intended as an informational source for school and nursing personnel dealing with medically complex students in an educational setting.

This manual consists of two major sections:

Section one includes general information concerning medically complex students, a matrix of recommended responsibilities concerning the delivery of health related services.

Section two includes information concerning the most common medical procedures seen in medically complex educational settings.

This manual is NOT intended to be an instructional instrument from which personnel will “learn” how to perform any medical procedures needed during school hours.

Only personnel specifically designated on physician’s orders and properly trained to perform a specific procedure with/on a specific child should be involved in any health procedure. It is the responsibility of the school administrator to assure that the orders from a child’s doctor are complete, contain information regarding personnel who should be allowed to perform the procedure(s) and note what type of training should take place. The individual student’s school Nursing Care Plan should reflect this information as well as note trained personnel. In most cases the school nurse or school health coordinator would be responsible for training designated personnel.

It is intended that this manual, coupled with appropriate inservice and specific training, will assist personnel in dealing with medically complex students in the school setting.

*Please note: If a school should register a student with special medical needs that cannot be adequately addressed by the present School Health Handbook, the principal should contact their assigned Community Health Nurse immediately.

SECTION I

*The following pages contain a “Matrix of Professional Responsibilities” for the delivery of special health care procedures in educational settings. The matrix contains many special health care procedures that some children may need performed in the educational setting. The procedures vary in the degree to which they require specialized knowledge and skill by persons conducting the procedure. Many are regulated by professional standards of practice. The matrix delineates the persons who are qualified to perform each procedure, who should preferably perform the procedure, and the circumstances under which these persons would be deemed qualified. It should be noted that the term “qualified” assumes that the individual has received appropriate training in the procedure. The matrix is based on the matrix contained in “Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting” published May 1, 1990 and developed by the Joint Task Force for the Management of Children with Special Health Needs which consists of The American Federation of Teachers, The Council for Exceptional Children, The National Association of School Nurses and The National Education Association.

These are simply recommendations as to personnel who should be considered, with appropriate training, as possible providers of specific health care procedures. It is the responsibility of the school administrator, based on specific doctor’s orders, to designate personnel to be trained in a health care procedure for a specific child.

SECTION II

COMMON PROCEDURES PROVIDED
IN EDUCATIONAL SETTINGS
FOR STUDENTS WITH MEDICALLY
COMPLEX NEEDS

CARE OF MENSTRUATING HANDICAPPED CHILD

A. General Information:

- 1) The established guidelines for growth and development/health curriculum will be followed in teaching handicapped students.
- 2) The exceptional child may require additional assistance or monitoring, depending upon her individual limitations, whether mental or physical.
- 3) The same consideration for privacy and hygiene apply to those reviewed in the discussion on hygiene and diaper changing.
- 4) Supplying feminine hygiene supplies is the responsibility of the parent. Only pads should be used at school. It remains the responsibility of the school staff to promote good skin care and hygiene while the student is at school. There are feminine hygiene supplies available at school for emergencies and accidents.
- 5) Procedures for handling bodily fluids should be followed when assisting students with the changing of pads. Proper procedures for disposal of pads, and/or contaminated items should be followed. See school health manual for further information.

B. Unique considerations:

Additional monitoring and education may be required for students who are mentally handicapped. More repetition of instructions in hygiene is required. Frequent viewing and reviewing of materials on menstruation is necessary.

The exceptional student may require additional assistance or monitoring, depending upon her individual limitations, whether mental or physical. Good hygiene must be taught and followed by school personnel. If any information or training materials are needed, the Health Services Coordinator can help the staff secure these. Identification of girls needing assistance with hygiene while maintaining their right to privacy is difficult. All adult caretakers should be made aware so that they can send the child for changing or remind the student to check herself. The staff at each school should develop a method of identifying these students requiring assistance during menstruation. One method is the use of a log, which easily tracks irregularities, heavy or light flows, or behavior problems. The staff can then anticipate menstrual time. Gloves should be worn when handling soiled hygiene supplies and clothing. Both gloves and soiled items should be placed in a plastic bag and tied before disposal. Soiled clothing should be placed in a plastic bag to be returned home.

DIAPERING

- Purpose:** To maintain the student's safety and comfort during diapering while safeguarding against infection.
- Note:** Changing diapers in a sanitary way is one of the most important things a school staff member can do to prevent the spread of infectious organisms present in stool. You can help prevent infection and illness among staff, students, and their families by remembering the following guidelines as you diaper students.
- Equipment:**
- A. Changing surface – If using an elevated changing table a restraining strap must be used. Keep students away from the changing surface. Cover it with a smooth, non-porous, moisture resistant, and easily cleanable material. For extra protection, use disposable examining table paper and change it between each changing.
 - B. Handwashing sink and towels – The sink should be in the same room as the changing surface. Soap and towels should be kept at the sink and single-service, disposable towels (i.e. paper towels) should be used.
 - C. Skin-care items – Keep changing supplies away from students. Keep skin care items nearby. Use cloths and towels only once, and discard. Many disposable diapering cloths are available.
 - D. Waste container – For disposable diapers use a tightly covered washable container with a foot operated lid. Line the container with a disposable trash bag. Keep it away from students. Remove soiled diapers daily, with double bagging technique.
 - E. Potty Chairs – Chair frames should be smooth and easily cleanable. The waste container should be removable. Sanitize the chair and frame after each use.
 - F. Cleaning Supplies –
 - 1) Disposable towels/cloths
 - 2) Sanitizing chemical solution made from 1 part household bleach per 10 parts tap water. Solution should be prepared daily or stored in an air-tight container. Leave the bleach solution on the surface for at least one minute (or for ten minutes at the end of the day or when the surface is soiled with body fluid). Keep solution out of reach of students.
 - G. Supplies Necessary -
 - 1) Clean diaper
 - 2) Disposable wipes
 - 3) Toilet paper
 - 4) Small plastic bag for disposal of feces

DIAPERING

(continued)

- Procedure:
- A. Assemble supplies and place clean paper on table or clean surface.
 - B. Wash hands; put on disposable latex gloves.
 - C. Assist or take students to changing area or bathroom.
 - D. Place student on clean changing table/surface.
 - E. Do NOT leave student unattended.
 - F. Talk cheerfully to the student during the procedure as some students may be uncomfortable with the height of the table or be embarrassed by the procedure.

 - G. Remove soiled or wet diaper, fold soiled portion inward, and immediately place in plastic bag or trash can.
 - H. Dispose of feces in the toilet. Place soiled diaper in small plastic bag before placing it in the trash can.
 - I. Do not place wet or soiled diaper on table, floor or sink.
 - J. Remove loose feces from skin with toilet paper. Wash the skin gently with antiseptic towelette.
 - K. Dry area well. Apply diaper creams and lotions only with written request by parent and approval of health services nurse. Powder will never be used unless it is by physician's order.
 - L. Apply clean diaper and secure outer clothing.
 - M. Assist student off changing table and return to classroom. Do not leave student unattended.
 - N. Clean and disinfect changing surface.
 - O. Wash hands.
 - P. Return all supplies to designated areas and put clean table paper in place.

Frequency of Diaper Changes:

- A. All diapers should be checked every two (2) hours and changed immediately if soiled to prevent skin irritations.
- B. There could be circumstances when the changing schedule should be altered due to field trips and other special activities. A reasonable alternative plan should be developed for these occasions.
- C. It is suggested that students in diapers have toileting logs kept on the bathroom door or other central location. Logs will be kept by the teacher and discarded at the end of summer school each year.

POSITIONING

(LIFTING AND TRANSFERRING)

PURPOSE: To acquaint school personnel with basic techniques to follow when changing the position of a student who is unable to sit, stand, or walk without the assistance of an adult. Before lifting, carrying, or transferring a disabled student, it is recommended that the personnel involved participate in a practice session where a professional, such as a physical therapist, demonstrates the correct technique and procedure.

NOTES:

- A) Never attempt to lift a student who is difficult to manage without assistance.
- B) If two or more adults are moving a student, always discuss and plan the exact movements before beginning.
- C) The equipment involved must be positioned properly, securely, and as close to the student as possible. When a wheelchair is used, the brakes must be secured and the footrests lifted or removed.
- D) Avoid quick movements. This may cause the student's spastic muscles to tense and he/she may be frightened.
- E) Explain the procedure to the student and encourage him/her to assist as much as possible.
- F) Proper body mechanics are essential as follows:
 - Bend at the knees, not the waist
 - Be as close to the student as possible
 - Keep the back straight
 - Do not lift higher than the waist
 - Do not lift quickly or with jerky movements

PURPOSE:

- 1) To maintain shunting of cerebral spinal fluid from the ventricles to the peritoneum and atrium.
- 2) To prevent infection.
- 3) To prevent obstruction of the shunt.

EQUIPMENT:

- 1) Penlight
- 2) Measuring Tape
- 3) Protective Helmet, if ordered.

PROCEDURE:

- 1) Identify students with V-P or V-A shunts if possible. This should be listed on the student health card. Initiate a Nursing Care Plan.
- 2) Observe for signs of shunt obstruction. Signs can include vomiting, nausea, headache, lethargy, irritability, increased head circumference, vision problems, unequal or non-reactive pupils.
- 3) Observe for signs of shunt infection. Signs can include fever, irritability, restlessness, lethargy, poor feeding, redness or swelling along shunting system and seizures.
- 4) If signs of obstruction or infection are observed, notify student's parents and doctor.
- 5) Assist in protection of the student's shunt by encouraging the use of a protective helmet, if ordered; Advise the physical education teacher to exclude the student from contact sports (only if indicated by the student's physician); Advise teachers to keep the student from napping on the shunted side.

INTRODUCTION:

A child with complex medical needs has the same nutritional needs as any other child, as well as some additional demands. Depending on the child's medical problems, there may be greater susceptibility to nutritional disorders such as low intake of nutrients, inability to absorb certain nutrients, anemia, underweight, overweight, etc. Some of these disorders have been linked to mechanical feeding problems such as problems in sucking, swallowing, chewing, food acceptance, and self-feeding.

Note: A student should NEVER be force-fed by any school personnel. If the child demonstrates feeding problems, check doctor's orders and physical, occupational, speech and therapy recommendations. All personnel involved in feeding should be trained in the use of the Heimlich Maneuver.

ASSISTED FEEDINGS:

A: Factors Affecting Eating:

1. Atmosphere of the room (calm and organized)
2. Appropriateness of utensils
3. Child's muscle tone
4. Strong bite reflex
5. Mouth breathing
6. Texture, consistency, and temperature of food
7. Child's food preferences and feelings toward personnel

B: Feeding Positioning to provide correct body alignment:

1. Provide foot and trunk support
2. Keep back erect for good alignment and to provide for more independent activity
3. Provide head support using equipment or your shoulder or arm as needed
4. Keep the head slightly forward as a hyper-extended neck prevents proper swallowing and may cause choking
5. Keep the head facing to the front to provide a good midline position, better breathing and less chance for aspiration. Once the head is aligned, the jaw should be stabilized. You can use your own hand to cup the jaw while presenting food, or while the student swallows
6. Use an armrest or your hand to help stabilize the student's elbow

C: Feeding Technique:

1. There should be a small amount of food on the spoon
2. Feed the child slowly, hurrying and impatience will only lead to frustration
3. Insert the spoon on alternate sides of the mouth unless a side is indicated in the student's mealtime program
4. To encourage chewing close the child's mouth and gently press back on the chin while firmly rubbing the cheeks in a rotation motion
5. To encourage swallowing:
 - a) check positioning
 - b) place food between cheek and gum
 - c) try placing food between upper and lower back teeth
 - d) try pressing up and in at the base of the chin, under jaw, and quickly release.

6. To decrease tongue thrust, place a small amount of food inside of mouth, support the jaw with your hand and close lips with your fingers.
7. Provide lots of praise and socialization during mealtime.
8. If gagging occurs, check body alignment
9. If coughing or choking occurs, move the student's chin from side to side to dislodge any interference, such as mucus, then move the body and head forward.
10. If student should vomit, keep head in good alignment and lean student forward.
11. To encourage opening of mouth, check alignment first then tap lightly on student's lips or press firmly down on lower lip with spoon, or stroke down along the student's smile lines which begin at either side of the nose, pushing down slowly and firmly toward the corner of the mouth. Other techniques used are pressing in firmly and quickly on the student's chin, then releasing or gently massaging the gums from front to back with your fingers, starting at the center and moving slowly in one direction, until the student opens mouth.
12. When student clamps down on the feeding utensil first check positioning and head alignment. Press inward on utensil, quickly and firmly. If this does not work massage the smile lines then massage the gums from front to back.

D. Assisted Mouth Opening:

1. If you are sitting beside the child;
 - a. Put your middle finger under the chin
 - b. Place your index finger on the front of the chin
 - c. Use your thumb on the side of the cheek to control the head
2. If you are sitting in front of the child:
 - a. Place your middle finger under the chin to help control the jaw
 - b. Put your thumb on the front of the chin where it can help you close the lips and control the jaw
 - c. Place your index finger along the side of the cheek to control the head

SELF FEEDING

Care should be taken to ensure a child receives adequate nutrition. This may mean continuing to feed past the designated meal time in order to allow the child to complete the meal. Documentation should be available on the IEP and when determined necessary by the nurse (or nursing care plan) that the child has the physical and cognitive ability to self-feed. Procedures for monitoring the child's physical status will be included in the nursing care plan when appropriate.

A. Finger Feeding:

1. The child must have the ability to pick up objects with the fingers, move the hand to the mouth, chew and swallow.
2. Dip child's finger in desirable food such as applesauce or peanut butter.
3. Guide child's hand to mouth if necessary.
4. Place a small amount of finger food in front of the child. If the child doesn't reach for it, guide the child's hand to the food.
5. Guide the hand with the food to the mouth while standing behind the child and reaching around him/her.
6. Slowly decrease assistance and offer praise frequently as the child learns the skill.
7. Be prepared for messiness and ignore mistakes.

B. SPOON SELF FEEDING:

1. The child must have grasping ability, good hand-to-mouth motion and good mouth and lip control.
2. The foods served should be of thick consistency to stay on the spoon; i.e. mashed potatoes or vegetables, applesauce, cooked fruit or creamed meat dishes.
3. Tap spoon on table or tray and encourage child to reach for it.
4. If child does not reach for spoon, stand behind him/her and place your hand over child's hand and reach for the spoon.
5. Assist him/her with scooping the food and bring to child's mouth.
6. Gradually decrease assistance by placing your hand on child's elbow for guidance.
7. Offer praise continually as the child learns the skill.
8. Ignore mistakes and messiness.

NOTE: No child will be denied a meal because of an inability to feed. When learning to self-feed, care must be taken that a child is given ample time to eat and is fed if unable to complete the task. Under NO circumstances should a child not be fed.

EATING AND DRINKING DEVICES:

- A. Squeeze bottles: These are useful when the amount of liquid offered needs to be controlled.
- B. Cups: There are cups of various sizes and handle shapes that can be used for students with limited hand and arm function and impaired coordination. Cups with a lid and mouthpiece or a weighted bottom help stabilize the cup and prevent spills. Cups with cut-outs help children with limited neck mobility drink. Straws of various lengths can be used to teach sucking and swallowing.
- C. Plate Guards: These can help to keep food on the plate and provide a surface against which to push food.
- D. Rubber Mats: These can be placed under the student's plate to prevent it from slipping while the student is learning to self-feed. A weighted plate with suction grips may also be used.
- E. Utensils: There are many types available for students with physical handicaps. Adapted handles are helpful for students with a poor grasp or limited joint movement in the hand or arm. Some can be bought commercially but they can easily be made by using rubber tubing, foam rubber or wrapping a handle with a wash cloth and securing with tape. For specific feeding problems, consult the Occupational Therapist.

PURPOSE: To minimize waste of formula while providing safe nutritional support.

NOTES:

- A. The guardian will supply all special formulas.
- B. Formulas will be administered only with a written physician's order.
- C. All formula received at the school must be in unopened containers.
- D. As formula is received at the school it will be immediately marked with the student's name.

PROCEDURE:

- A. Identify the formula by checking the physician's order. Check the expiration date.
- B. For liquid or concentrated liquid formulas:
 - 1) Wash the top of the can prior to opening with tap water, or if obviously soiled, with soap and water.
 - 2) Mix and administer according to physician's order and tube feeding procedures.
 - 3) Label the can with a marker and/or tape specifying the student's name, the date and time of opening, and the initials of the person opening the can.
 - 4) Store the unused formula in a refrigerator, preferably with a cap on the can.
 - 5) Never return poured formula to the can. Any portion which has been poured and/or mixed should be discarded.
 - 6) Discard unused formula which has not been refrigerated or which has been refrigerated but is over 24 hours old.
 - 7) When using an already opened can, check the label for the student's name and the date and time it was opened. Discard if improperly labeled, opened more than 24 hours, or if anything seems questionable.
- C. Powdered Formula:
 - 1) If opening for the first time, wash the can lid with tap water or soapy water if soiled.
 - 2) Mix and administer according to physician's order and tube feeding procedure.
 - 3) Label the can with a marker and/or tape specifying the student's name, date of opening, and initials of person opening the can.
 - 4) Store according to package specification in a secured area making certain that the lid has been tightly replaced.
 - 5) IF the package specifies a length of time after which the opened powder should be discarded, mark the projected discard date clearly on the label.

PURPOSE: Safe and clean nutritional support for a student with impaired swallowing abilities.

EQUIPMENT:

- a. Catheter-tip syringe. (Provided by the guardian)
- b. Formula (Provided by the guardian)
- c. Clamp (if specified for individual student).
- d. Stethoscope (for nasogastric tube).
- e. Cup with measurements.
- f. Cup with fresh tap water.
- g. If tube comes out, cover with sterile gauze and notify parent.

NOTES:

- a. If vomiting occurs at any point during procedure, stop and send for the nurse while at least one staff member continues to observe the student for possible aspiration/respiratory difficulties.
- b. The procedure must be initiated by doctor's order.
- c. See "Storage of Nutritional Formulas" procedure.

TERMS: *G Tube* Gastrostomy Tube (a tube inserted through a surgical opening in the abdominal wall and emptying directly into the stomach).

Aspiration: Inhalation of a liquid, such as formula into the lungs.

PROCEDURE:

- A. Position the student with his/her head elevated at least 30 degrees to prevent aspiration.
- B. Make certain that:
 1. Work area is clean.
 2. Equipment is handy.
 3. Formula is at room temperature.
 4. Staff member's hands are washed.
- C. Tell the student what you are doing to minimize surprise and to enhance student's comprehension and communication skills.
- D. Pull back on the syringe to see if the previous feeding has been digested. (Note: undigested feeding is called "residual")
 1. If more than one half of the previous feeding is undigested, notify the parent before proceeding with feeding.
 2. If less than half of the previous feeding is undigested, discard undigested portion and proceed with new feeding.

- E. Remove syringe plunger and connect syringe tip to tube.
- F. Allow formula to flow by gravity; do not push in with plunger as this can cause vomiting or aspiration.
- G. After feeding is complete, flush the tube with 30 cc of water (more if ordered for hydration purposes). This prevents clogging of the tube.
- H. Clamp the tube if ordered.
- I. If possible and/or indicated, keep the student's head elevated for at least 30 minutes following a feeding.
- J. Wash your hands.
- K. Wash syringes and cups following each feeding and store in a clean, labeled container.
- L. Document each feeding (See attached form).

PURPOSE:

To provide feedings for the child who is unable to receive adequate nourishment by mouth.

EQUIPMENT:

1. Formula, juice or water
2. 60cc syringe
3. Feeding Catheter
4. Adapter
5. Water

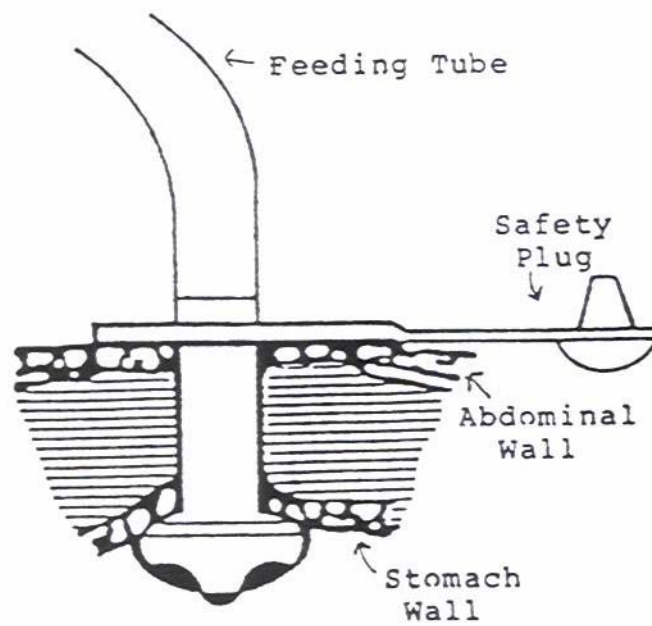
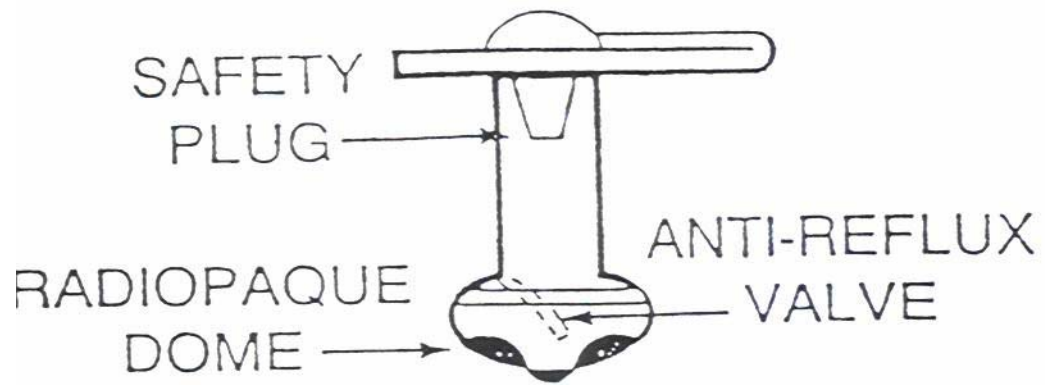
NURSING ACTION:

1. Identify need
2. Wash hands
3. Obtain equipment
4. Explain procedure to child
5. Position the child in an upright or semi-reclining position.
6. Attach the adapter and feeding catheter to the syringe
7. Fill the syringe and catheter with the feeding
8. Open the safety plug and attach feeding catheter
9. Elevate syringe about level with stomach
10. Do not let syringe run dry
11. Flush with water to clear tube
12. After flushing, lower the syringe below stomach level to facilitate burping
13. Remove the adapter and catheter and close safety valve
14. Rinse equipment with water after use and wash with soap and water daily
15. Wash hands
16. Document procedure

POINTS OF EMPHASIS:

1. Check doctor's orders
2. Follow handwashing procedures
3. Arrange on clean surface
4. Use appropriate developmental approach
5. Occupy child's hands if necessary
6. Clamp off the lower portion with clamp/fingers
7. This prevents large amounts of air from entering the stomach and causing abdominal distention
8. Adapter has serrated end to retrofit button
9. Feeding will take 15-30 minutes to flow by gravity
10. Prevent excess air from entering stomach
11. 10cc tap water should be sufficient
12. Formula will not flow out if anti-reflux valve is working. Eructation sounds like a release of air
13. Safety plug will keep the lumen clean
14. Return equipment to designated area
15. Follow handwashing procedure
16. Chart date, time, type and amount of feeding and child's response

GASTROSTOMY FEEDING BUTTON



INSTALLATION OF MEDICATION THROUGH FEEDING TUBE

PURPOSE: To ensure proper medication administration through a gastrostomy or jejunostomy tube.

EQUIPMENT:

- a) Medication, properly identified according to procedure outlined in the district's School Health Services Handbook
 - B. Small container with tap water to follow medication
 - C. Catheter tip syringe (provided by the guardian)
 - D. Clamp if needed

NOTES: The procedure must be initiated by a doctor's order

PROCEDURE:

- A. Assemble equipment and ensure a clean work area
- B. Wash hands thoroughly with liquid soap and running water, put on gloves
- C. Prepare medication for administration through feeding tube according to physician's order and if available, manufacturer package insert
- D. Explain the procedure to the student to minimize fear and enhance student comprehension and communication skills
- E. Position the student with head elevated at least 30 degrees
- F. Disconnect the tube from continuous feeding, pinching the tube to keep large amounts of air from entering the stomach
- G. Insert the appropriate syringe, pour medication into syringe and un-pinch the tube, allowing gravity to drain the medication into the tube
- H. As soon as the medication has been instilled, and before air is absorbed through the tube, flush with at least 30cc (1 oz.) of tap water, or amount specified in plan
- I. As the last of the water drains reconnect or clamp the feeding tube
- J. Remove gloves and dispose of gloves and any other soiled materials in a plastic bag
- K. Wash hands
- L. Document on Tube Feeding Documentation form.

TUBE FEEDING DOCUMENTATION LOG

Student Name: _____

Physician Ordering Procedure: _____

Date of Order: _____

Type of Formula: _____

Frequency or Rate: _____

Amount of Water to follow*: _____

Other Specifications: _____

FEEDING LOG						
DATE & TIME	AMOUNT OF FORMULA GIVEN	AMOUNT OF WATER GIVEN	SETTING ON PUMP	RESIDUAL	COMMENTS	SIGNATURE

TUBE SITE CARE*			
DATE	TIME	DRAINAGE (COLOR, AMOUNT, CONSISTENCY, ETC.)	SIGNATURE

Additional Comments: _____

TUBE SITE CARE

(Gastrostomy / Jejunostomy)

PURPOSE:

To prevent skin breakdown and infection around tube insertion site and to keep tube from becoming clogged.

TERMS:

G Tube = Gastrostomy Tube; a tube inserted through a surgical opening in the abdominal wall which empties the stomach.

J Tube = Jejunostomy Tube; a tube inserted through a surgical opening in the abdominal wall which empties directly into the jejunum.

NOTES: Students with jejunostomy / gastrostomy tubes will receive tube care at the discretion of the nurse. Routine tube care should be scheduled outside of school hours.

EQUIPMENT:

- a) Cotton tipped swabs
- b) Sterile saline or water
- c) 2x2 gauze pads
- d) Paper tape

PROCEDURE:

- i) Assemble equipment can use a clean work area
- ii) Talk to student to minimize surprise and to enhance student's comprehension and communication skills
- iii) Position the student on his/her back or right side
- iv) Wash hands. Put on latex gloves ****DO NOT use latex gloves when working with Spina Bifida children**
- v) Remove the old dressing and discard in a lined waste container
- vi) Dampen the tips of the swabs with sterile saline or water
- vii) Clean around the tube in circles, moving outward from the opening. All drainage, wet or dried, must be removed
- viii) Observe the site for signs of infection such as redness, swelling, heat, tenderness, oozing and report such signs to the guardian
- ix) Dry the area well with 2x2 gauze
- x) Apply sterile gauze around the tube site to absorb leakage if ordered by Dr.
- xi) Remove gloves and dispose of gloves and other soiled disposable items in a plastic bag or lined waste can
- xii) Wash hands
- xiii) Staff will note date and time of tube care; color, amount, consistency and odor of drainage; other pertinent information on Tube Feeding Documentation form.

PERCUSSION AND POSTURAL DRAINAGE

PURPOSE:

To prevent respiratory complications by loosening bronchial secretions for easier and more effective deep breathing, coughing, and expectoration.

Contraindications: Percussion and postural drainage can be done at the discretion of the R.N. There are many contraindications to this procedure. A physician's order is always needed for this procedure.

EQUIPMENT:

- (1) A wedge, pillow or folded blanket
- (2) Tissues
- (3) Emesis Basin
- (4) Suction machine if ordered by physician

IMPLEMENTATION / NURSING ACTION

1. Identify need
2. Consider timing in relation to other activities such as eating or therapy
3. Wash hands thoroughly, remove all rings
4. Explain procedure to child and use measures to relax him/her
5. Position as directed by physician (usually prone, with head down on wedge) with tissue available
6. Observe color and respiratory rate
7. Have the child take a few deep breaths. Percuss indicated area. Hand position: cup the hand with fingers close together and wrist loose. Use enough force to make a firm air-cushioned impact (hollow sound) to help dislodge secretions without causing discomfort. A light shirt or diaper may be worn to make the procedure more comfortable. Do not "slap" the skin. Discontinue if reddening occurs. Vibrate the indicated area for three breaths. Tell the child to cough if able.
8. Leave in position for 10-15 minutes. Child should be attended during this time. Provide tissues and emesis basin as necessary
9. Suction if ordered and necessary
10. Assist child slowly to normal position
11. Do mouth care
12. Wash hands thoroughly
13. Stop the procedure immediately if color changes or respiratory distress is observed.
14. Document procedure

EXPLANATION / POINTS OF EMPHASIS

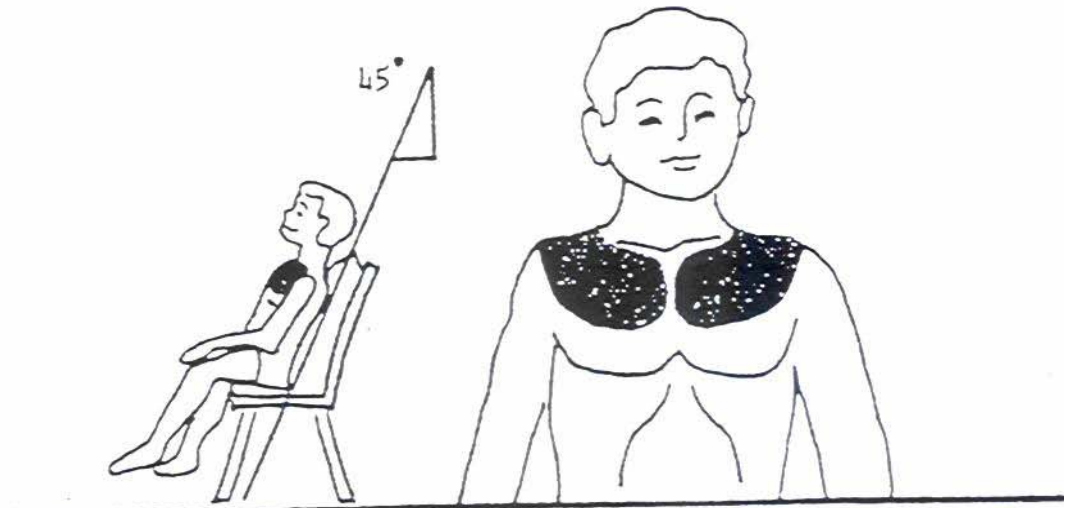
1. Check physician's order
2. Should not be done immediately after eating. should have time for relaxation afterward.
3. Follow handwashing procedure
4. Procedure will be more effective if child is not anxious
5. Wipe up secretions immediately. The spine should be as straight as possible. Use wedges or pillows to position
6. If indicated, auscultate before and after the procedure
7. Do not percuss over the spinal column or soft tissue. Allow for intervals of rest every 2-3 minutes
Vibrate only on exhalation. Helping the child into a sitting position may facilitate coughing.
Observe for respiratory status and drainage.

8. Secretions may be expelled with gravity

9. Refer to suctioning and doctor's orders
10. Total procedure should be 20-30 minutes.
11. XXXXXXXXXXXXXXXXXXXX
12. Follow handwashing procedure
13. XXXXXXXXXXXXXXXXXXXX
14. Chart date, time, why done, type and amount of drainage and child's response.

UPPER LOBES

#1



anterior aspects

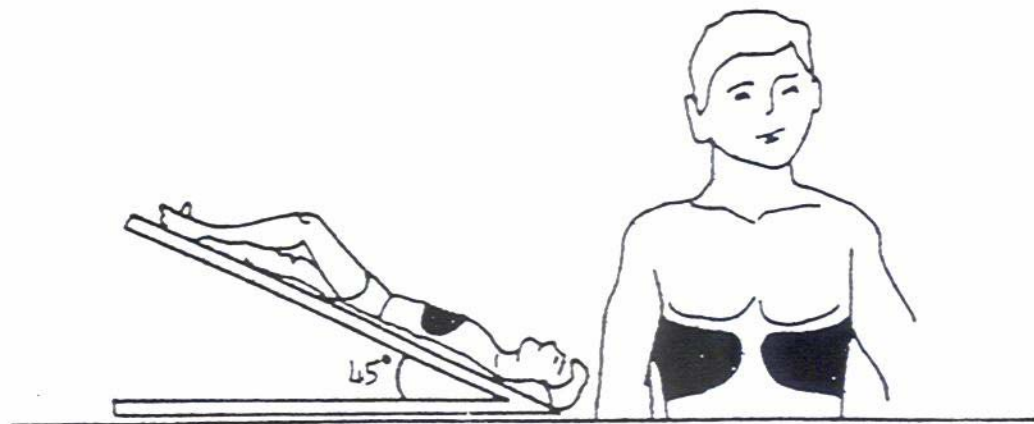
#2



posterior aspects

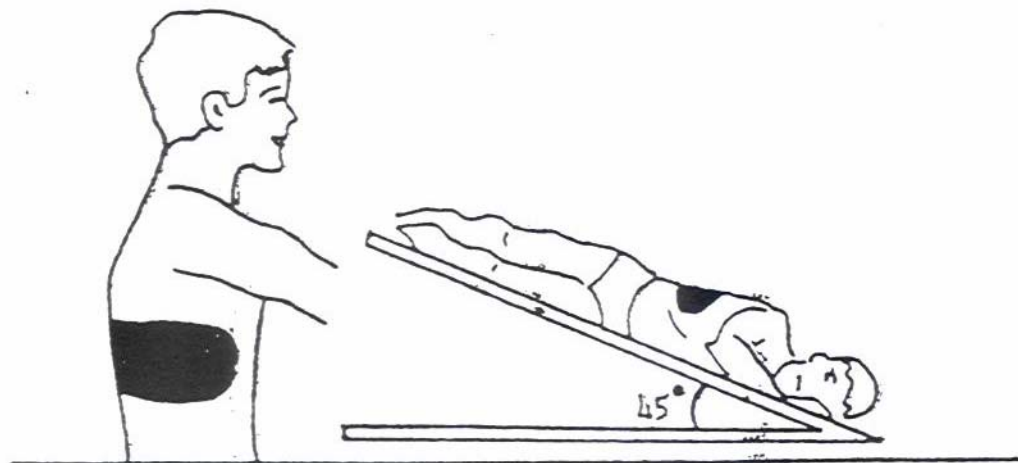
LOWER LOBES

#3



anterior aspects

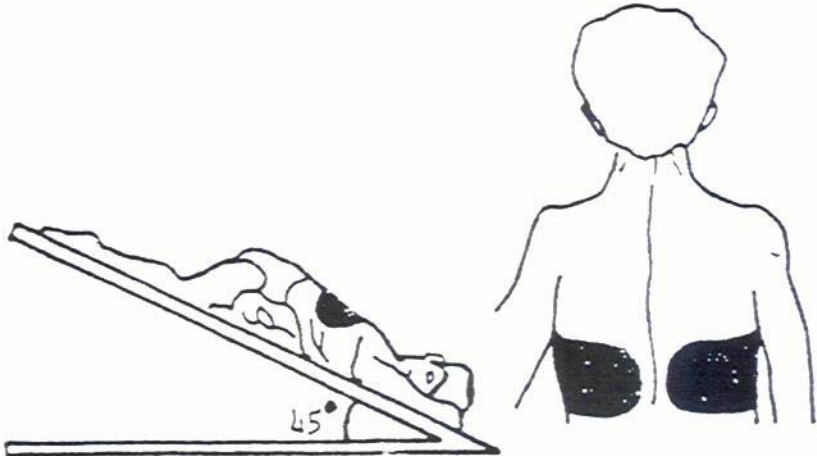
#4



right lateral aspect

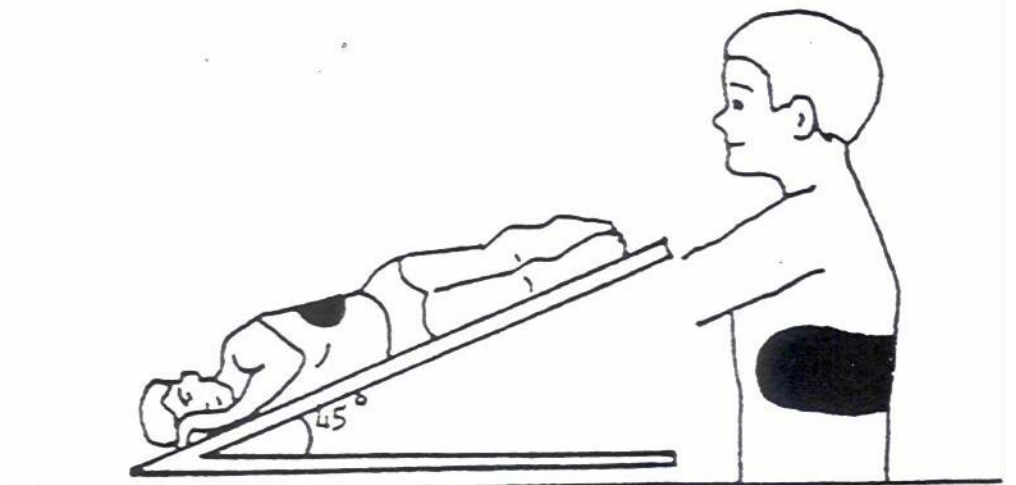
LOWER LOBES

#5



posterior aspects

#6



left lateral aspect

NASAL SUCTIONING

PURPOSE: (MUST HAVE PHYSICIAN'S ORDER)

1. To clean the nasal passages of mucus and discharge
2. To prevent complications of mucus remaining in the upper respiratory tract

EQUIPMENT:

1. Bulb Syringe
2. Normal Saline Solution
3. Eye Dropper
4. A second person may be needed to help hold the head/hands

NURSING ACTION

1. Identify Need
2. Wash hands
3. Obtain equipment
4. Explain procedure to child
5. Insert 1-2 drops of saline into one nostril
6. Depress syringe bulb with thumb and insert into nostril, release to suction
7. Repeat steps 5&6 on other nostril
8. Evacuate bulb syringe and clean
9. Wash hands
10. Document procedure

POINTS OF EMPHASIS

1. Note sounds of nasal congestion
2. Follow handwashing procedure
3. Arrange on clean surface
4. Use appropriate developmental approach
5. Prepare to suction saline and mucus once the saline causes some thinning of mucus
6. Do not place suction tip directly against wall of nasal passages after bulb is depressed
7. Continue to suction alternate nostrils until nasal passages sound clear
8. Wash bulb syringe in warm soapy water and place in an open area to dry
9. Follow handwashing procedure
10. Chart date, time, type and amount of mucus, and child's response

ORAL SUCTIONING

PURPOSE: (MUST HAVE PHYSICIAN'S ORDER)

1. To remove secretions from the mouth and throat
2. To stimulate the cough reflex
3. To promote optimal respiratory function

EQUIPMENT:

1. Suctioning unit
2. Disposable connecting tube
3. Disposable catheter and glove or clean Yankauer Catheter
4. Bottle of Saline
5. Clean rinsing container
6. Tissues
7. Paper bag
8. A second person may be needed to help hold the head/hands

NURSING ACTION:

1. Identify Need
2. Obtain equipment
3. Connect machine

4. Wash hands
5. Explain procedure to student
6. Arrange equipment

7. Place glove on dominant hand
8. Attach suction tube to catheter

9. Turn on suction machine
10. Moisten tip of catheter
11. Put catheter into mouth
12. Apply suction pressure

13. Rotate suction catheter around mouth
14. Rinse Catheter

15. Repeat suctioning

16. Allow student to cough and/or expectorate mucus
17. Clear all tubes
18. Turn suction machine off
19. Remove glove and discard
20. Cover end of connection tube
21. Wash hands
22. Document procedure

METHODS OF CARE:

- Disposable plastic for oral use: discard at the end of the day or sooner as necessary
- Yankauer Suction Catheter: wash in soapy water daily, every 2 days after washing in soapy water, soak in 50% vinegar solution for 20 minutes and rinse well.

POINTS OF EMPHASIS:

1. Check MD orders, observe for respiratory congestion
2. Use a clean table at a convenient height
3. Put adapter into wall outlet if vacuum type is used. Check functioning of machine by turning to "on" position
4. Follow handwashing procedure
5. Use appropriate developmental approach
6. Open catheter and have gloves ready. Open and fill rinsing container with normal saline. Open connecting tube to suction outlet. Place end that will be connected to catheter to avoid contamination.
7. This hand will hold the catheter
8. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing/twisting gently.
9. Use ungloved hand
10. Dip end into saline.
11. Pinch tube during insertion
12. Occlude lumen of catheter near the connection to suction tube with ungloved hand during insertion; release to apply suction.
13. Alternately apply/release suction pressure
14. Dip into saline basin intermittently and apply pressure. Rinse frequently.
15. Repeat until the entire area is cleared of mucus. Stop periodically and observe respiratory effort. Repeat as necessary
16. Repeat as necessary
17. Rinse with intermittent suction applied
18. Use ungloved dominant hand.
19. Discard glove in covered trash can
20. Disconnect from suction machine
21. Follow handwashing procedure
22. Chart date, time and amount of secretions, and child's response.

TRACHEOSTOMY MACHINE SUCTIONING

PURPOSE:

1. To aspirate retained or excessive secretions
2. To maintain open airway
3. To aid in the respiratory efforts of the student

EQUIPMENT:

1. Portable suction
2. Disposable connecting tube
3. Sterile disposable catheter. (size determined by M.D.), sterile or clean gloves (bases on M.D. order)
4. Sterile saline, preferably in single use packets, at room temperature or a jar of sterile saline with eye dropper dispenser
5. Clean rinsing container
6. Tissues or paper towels
7. Bandage scissors

NURSING ACTION:

1. Identify need

2. Assemble equipment
3. Connect machine

4. Explain procedure to child
5. Wash hands

6. Arrange equipment for use

7. Put sterile glove on dominant hand
8. Attach suction tube to sterile catheter

9. Turn on suction machine
10. Tell the child to take several deep breaths
11. Moisten tip of catheter
12. If secretions are thick, place 2-3 drops of saline directly into tracheostomy
13. Insert catheter into trach being careful not to cover catheter vent opening

14. Apply suction pressure
15. Slowly pull catheter out with a rotating action, alternating on and off suction pressure

16. Rinse Catheter

17. Repeat suctioning

18. Clear tubes
19. Turn suction machine off
20. Discard disposable equipment
21. Clean rinsing container and return equipment to proper place
22. Wash hands
23. Document procedure

POINTS OF EMPHASIS:

1. Check doctor's orders. Observe for respiratory congestion and cyanosis. Example: Agitation, restlessness, hard/fast breathing, bluish color around lips, nail beds, nostrils flaring.
2. Use a clean table at a convenient height
3. Check functioning capacity of machine by turning to "on" position.
4. Use appropriate developmental approach
5. Follow handwashing procedure (use disposable wipes if water is not available.)
6. Open sterile catheter and glove packet on table. Open and fill rinsing container with sterile normal saline. Open sterile connecting tube already connected to portable suctioning machine. Connect connecting tube to suction outlet.
7. This hand will hold the sterile catheter
8. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing and twisting gently.
9. Use ungloved hand
10. This increases oxygen reserve
11. Dip end of catheter in sterile saline
12. Allow saline to dilute mucus to facilitate removal.

13. Leave inner cannula in place. Insert to depth of 3 inches (7.5 cm) to cleanse cannula or until resistance is met. DO NOT insert further than needed to stimulate coughing
14. Occlude catheter vent opening with ungloved thumb
15. Intervals of continuous suction should not last longer than 5 seconds. Use suction only when removing catheter to prevent damage to mucus membrane
16. Dip into sterile saline basin, intermittently apply pressure, rinse frequently
17. Repeat as necessary until desired results are obtained. Allow student to rest 15-20 seconds and catch breath. If catheter becomes blocked rinse with sterile saline. If airway blockage is not relieved contact RN or dial 911. Suspect a mucus plug if the student continues to be in distress, cut ties and remove trach tube. Reinsert a clean tracheostomy tube according to procedure
18. Rinse with intermittent suction applied
19. Use ungloved hand
20. Use covered trash receptacle
21. Store in assigned area
22. Follow handwashing procedure
23. Chart date, time, why done, type and amount of secretions and child's response

Note: It is recommended that two knowledgeable adults be present when performing this procedure on a child. In some cases, non-sterile techniques are used. Verify with the physician regarding the use of non-sterile tracheostomy care and adapt procedure accordingly.

TRACHEOSTOMY SKIN CARE

PURPOSE:

1. To prevent skin irritation and breakdown
2. To remove secretions from skin

EQUIPMENT:

1. Cotton tip applicators
2. Normal saline or Hydrogen Peroxide
3. Sterile 2x2 pre-cut trach dressing or I.V. Sponge

NURSING ACTION

1. Identify need

2. Wash hands
3. Obtain equipment
4. Explain procedure to child
5. Remove old trach dressing

6. Clean skin around and under tracheostomy tube area, using sterile technique if ordered.
7. Gently pat dry
8. Insert clean dressing around stoma, under tracheostomy tube
9. Wash hands
10. Documents procedure

POINTS OF EMPHASIS

1. Check doctor's orders. Observe for skin irritation or breakdown
2. Follow handwashing procedure
3. Arrange on clean surface
4. Use appropriate developmental approach
5. Observe for skin irritation or breakdown. Check with MD if area is irritated
6. Use cotton tip applicator moistened with normal saline or half strength hydrogen peroxide
7. Use 2x2's
8. Use one hand to stabilize tracheostomy tube

9. Follow handwashing procedure
10. Chart date, time reason for procedure, problems, and child's response

PURPOSE:

1. To maintain an open airway
2. To prevent skin irritation and breakdown

EQUIPMENT:

1. Two people must be present
2. Twill tape or bias seam tape
3. Bandage scissors
4. Gloves

NURSING ACTION

1. Identify need

2. Wash hands
3. Obtain equipment
4. Explain procedure to child
5. Position child
6. First person holds the trach tube in place
7. Second person cuts and removes ties
8. Second person follows listed steps to put on new ties
 - a) fold the end of the tie and cut a small slit
 - b) Tread the tie through the flange hole
 - c) Pull the other end of the tie through the slit
9. Repeat steps for other side
10. First person bends the child's head forward while holding the tube in place
11. Second person ties a knot in the tie on the side of the child's neck
12. Wash hands
13. Documents procedure

POINTS OF EMPHASIS

1. Check doctor's orders. Observe for skin irritation or breakdown
2. Follow handwashing procedure
3. Arrange on clean / sterile surface
4. Use appropriate developmental approach
5. Place on back with neck extended
6. Use tips of fingers and avoid occluding the opening
7. Carefully use scissors to cut ties
8. Use ties prepared as described:
 - a) Make cut ½ " from the end of the tie
 - b) Use the hemostat to pull through, from bottom to top
- 9 First person should continue to hold tube in place
10. This technique tightens the tie

11. The tie should be tight enough to get only one small finger between the tie and the child's neck
12. Follow handwashing procedure
13. Chart date, time, reason for procedure, problems, and child's response

PURPOSE:

To replace the tracheostomy tube which provides an open airway. This is an EMERGENCY procedure and should never be done at school unless suction is unsuccessful after at least three attempts

EQUIPMENT:

1. Sterile tracheostomy tube of type and size prescribed or clean tube if properly labeled for that particular child. (Extra should be on hand at all times)
2. Sterile tracheostomy tube of next smaller size. (Extra should be on hand at all times)
3. Pair of bandage scissors
4. Roll to prop shoulders (optional)
5. Trach ties (twill tape)

NURSING ACTION

1. Identify need

2. Put roll under child's shoulders, if time permits

3. Open sterile package
4. Cut old ties and gently remove tube
5. Remove the sterile tracheostomy from package, holding the tube by phalanges, not by the piece which fits into the stoma
6. Insert the obturator (guide) into the trach tube

7. Spreading the stoma open with the index and middle fingers of one hand, gently insert new tube.
8. Hold the tube in place with slight pressure until a second person can assist in placing new ties.
9. Suction if necessary
10. Tie the ties on the side of the neck using a square knot (R over L, L over R)
11. If you are unable to insert the trach tube:
 - a) Reposition the head and try again
 - b) If new tube will not enter, try to insert trach tube of next smaller size
 - c) If smaller tube will not enter, reposition head and try again. If still not successful, CALL 911
 - d) Observe child for respiratory distress: cyanosis, anxiety, poor inspiratory effort

12. Observe until child's condition is stable and there is no further danger or until paramedics arrive.
13. Wash hands
14. Document Procedure

15. Notify parents and physician immediately

POINTS OF EMPHASIS

1. Use when child is unable to provide open airway after three attempts at suctioning; child exhibits signs of respiratory distress, i.e.: anxiety, pale, bluish or dusky color around mouth or lips, flaring nostrils, rapid or labored breathing
2. Use to visualize the stoma optimally. In an emergency, it is possible to change a tracheostomy in almost any position.
3. Equipment should be ready to use as needed
4. Use an outward and downward motion when removing tube
5. Avoid contaminating the tube

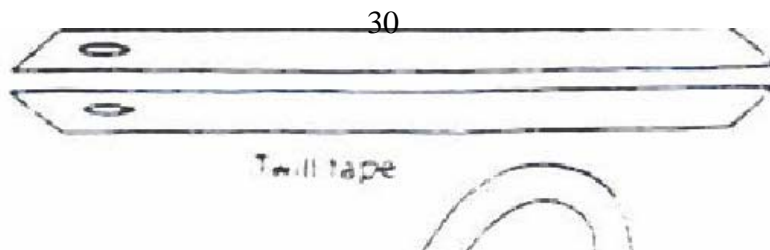
6. The obturator makes insertion easier, but is not left in place after insertion because it blocks the airway. Some brands do not have an obturator
7. Tube should be directed back, then down. Remove obturator as soon as tube is in place
8. Two people are needed to change tracheostomy ties safely

9. See suctioning procedure
10. Knot should be loose enough to permit one finger to be placed between knot and neck
11. -----
a)-----
b)-----

c)-----

d) If necessary, start rescue breathing using mouth to stoma technique. If too much resistance is felt, cover stoma with gauze and do mouth to mouth. Sometimes, after several breaths, child will relax enough and stoma will open and the trach tube may be inserted and mouth to stoma rescue breathing can resume.
12. -----

13. Follow handwashing procedure
14. Chart date, time, reason action was indicated, action taken, and child's response
15. -----



TWILL TAPE

APPLYING TIES

SQUARE KNOT

30 a

Pediatric plastic trach tubes are usually
2 mm above the larynx and 10 cm below

Pediatric plastic trach tubes are usually a one piece item and do not have an inner cannula. In larger sizes for older children there are some plastic trach tubes available with inner cannulas

OUTER CANNULA

OBTURATOR (GUIDE)

PLASTIC TRACHEOSTOMY TUBE

30 b

RESPIRATORY LOG

(Tracheostomy Care, Suctioning, Nebulizer)

Student Name: _____ DOB: _____ Room #: _____

Date Ordered: _____ Physician's Order: _____

Date	Time	Assessment of Student Pre-Treatment	Type of Treatment	Assessment of Student Post-Treatment	Performed By

OXYGEN ADMINISTRATION

PURPOSE:

Maintenance of student oxygen needs in a safe manner

EQUIPMENT:

1. Oxygen tank and delivery system
2. Back up oxygen tank and delivery system, if ordered by physician

NURSING ACTION:

A. Prior to student's arrival:

1. Obtain physician order for oxygen administration. Order needs to include method of delivery (mask, cannula, tracheostomy, etc.), the flow rate, time to be given and if oxygen is to be self administered.
2. Write a care plan to include responsibilities of parents, school and outside agencies involved, and a plan for failure of the system.
3. Inservice staff regarding oxygen administration and designate, in writing, at least two staff members other than the school nurse, who can be responsible for the operation of the equipment and identify empty or nonfunctional apparatus.
4. Notify the risk management office, if requested by school principal, that oxygen will be used on campus. Assist with any safety inspection or measures they feel are necessary.
5. Make necessary arrangements with the Transportation Department who will be transporting the student. Inservice this staff as needed.
6. School nurse can request a home visit by the Health Services Coordinator or request the family bring the child to school for an assessment and planning time.

B. When student arrives at school:

1. Complete the oxygen administration log.
2. If school is to administer oxygen, the system must be checked every morning upon student's arrival.
3. Obtain new physician's order every three (3) months and contact family and doctor as needed.

OXYGEN SAFETY PRECAUTIONS

- Do not smoke or allow open flames, heaters, or radiators near oxygen
- Never permit oil, grease or any highly flammable material to come in contact with oxygen cylinders, liquid oxygen, valves, regulators or fittings. Do not lubricate with oil or other flammable substances. Do not handle equipment with greasy hands or rags.
- Never put anything over gas cylinder.
- Know who the home oxygen supply company contact person is and have phone number posted in an obvious place.
- Return any defective equipment to the authorized company for replacement.
- Have spare oxygen readily accessible, based on the student's needs. This should be stored safely in a secure place.
- Extra tubing and tank equipment (wrenches, etc.) must be kept in an easily accessible place.
- If using oxygen gas be sure that the tank is securely placed in its stand and cannot fall or be knocked over.
- Be careful that the oxygen tubing does not become kinked, blocked or disconnected.
- Use only the flow meter setting prescribed by the child's doctor.
- The local fire department should be notified that oxygen is in use in the school.

Student Name: _____ Room #: _____ Date Ordered: _____

Physician's Order: (Include method of delivery, rate of flow, time to be given, permission for self administration, and need for backup system)

Signature & Initials of Person(s) Authorized to Administer Oxygen

Date	Time	Initials of Responsible Party	Comments

A. General Information:

The Mediport is a subcutaneously implanted device designed for access ease to the vascular system. It provides an easily located needle insertion port for administration of fluids or medications. The Mediport is usually located subcutaneously in the upper left quadrant of the chest, just below the clavicle. The circular reservoir body is 1.3 inches in diameter and is easily palpable. The center contains the self sealing rubber septum, which is the puncture site for injections or infusions.

B. Criteria for Usage in School Age Children:

- 1) The child with a disease (such as sickle cell anemia) who requires frequent blood products and/or medications.
- 2) The child receiving intravenous chemotherapy.

C. Considerations and Precautions:

- 1) Since Mediport is sutured in place it is unlikely to become dislodged.
- 2) Trauma to the area would probably result in minimal bruising.
- 3) Prompt reporting to the parent and physician are necessary for generalized fever, redness, swelling, hematomas, fluid accumulations, clot formations, occlusions, erosions, or extrusion of the device.
- 4) There are usually no activity limitations on the child.
- 5) Request information from the physician from the manufacturer of the device.
- 6) Request from the physician in writing any precautions or restrictions for the specific unit.

PURPOSE:

Clean intermittent catheterization is the periodic drainage, by catheter, of urine from the bladder. Use of this procedure ensures that the bladder is emptied at regular intervals in order to decrease the morbidity associated with residual urine and to avoid the permanent placement of a catheter in the bladder. The major reason for CIC is the student's kidney function. When the bladder is continually full, pressure forces urine into the ureters (tubes leading from the kidneys to the bladder). This in turn puts damaging pressure on the kidneys. Catheterization helps prevent such damaging pressure by regularly emptying the bladder of urine. Another reason for catheterization is the prevention of urinary tract infections and incontinence which requires the use of diapers or a permanently placed catheter into the bladder.

Under the Education for All Handicapped Children Act (P. L. 94.142), schools are required to provide catheterization to those students needing such services during the hours when they attend school. CIC has been designated as a School Health Services subcategory of related services and is neither a medical service nor a service that requires a physician or a nurse. Students should be assessed for their ability to assist or perform self-catheterization. School personnel designated to assist students in CIC should be trained in the proper procedures by a registered nurse or a physician.

PROCEDURE:

CIC is a procedure for which some students may need assistance while attending school. The person designated to provide assistance does not necessarily have to be licensed. A clinic aide, clerk, volunteer, teacher, etc. trained by a physician or a registered nurse can perform this procedure.

Written parental permission must be obtained prior to assisting with or performing a CIC during school hours. In addition, procedures for CIC must be in accordance with written instructions received from the student's physician. Both the parental permission form and the physician's instructions should be kept in the student's cumulative health record. Doctor's orders must note the frequency with which catheters must be changed.

EQUIPMENT:

1. Catheter (size to be determined by physician via written order)
2. Shallow pan
3. Soap & water
4. Sealable plastic bag or clean towel for catheter storage
5. Clean towels to place under student, if indicated
6. Cotton balls (16-20)
7. Water soluble lubricant

GENERAL POINTS REGARDING CATHETERIZATIONS:

1. Do not increase student's fluid intake beyond what is considered normal for the student's age.
2. Tell the student the importance of reasonable fluid intake. Reasonable fluid intake ensures good urine flow, which encourages elimination of bacteria.
3. Do not put hard pressure on the bladder by placing your hand on the abdomen and pressing downward unless specifically instructed to do so by the physician.
4. After each use clean (not sterile) procedures are used in storing the catheter. Place the clean catheter in a sealable plastic bag or clean, dry towel.
5. The suggested frequency for catheterization is twice during the school day. Catheterization is carried out on a regular schedule throughout the day and schedules should be individualized depending on student.
6. The catheter may be reused if washed with soap and rinsed thoroughly. For aftercare of equipment, lather hands and wash catheter in warm soapy water, rinse thoroughly both inside and out. Store the catheter in a plastic bag or clean towel until it is ready to be sterilized. Catheters should be sent home daily for complete sterilization. If they are maintained at school, they should be sterilized by boiling them in water for at least 30 minutes at the end of each day and placed in a clean container.

CATHETERIZATION LOG

Student Name: _____ DOB: _____ Room #: _____

Date Ordered: _____ Physician's Order: _____

DATE	TIME	AMT. OF URINE	COLOR & CONSISTENCY	COMMENTS	SIGNATURE

How to perform C.I.C. (female)

1. Assemble all equipment: catheter, lubricant, drainage receptacle.
2. Wash your hands thoroughly with soap and water and clean the vulva and urethral opening.
3. Lubricate the catheter.
4. Locate the urethral opening (meatus). The opening is located below the clitoris and above the vagina.
5. Spread the labia (vaginal lips) with the second and fourth finger, while using the middle finger to feel for the opening.
6. Begin to gently insert the catheter into the opening, guiding it upward as if toward the belly button.
7. Once the catheter has been inserted about 2 to 3 inches past the opening, urine will begin to flow.
8. Once the urine flow starts, continue to advance the catheter another 1 inch and hold it in place until the urine flow stops and the bladder is empty.
9. Withdraw the catheter in small increments to make sure the entire bladder empties.
10. Wash the catheter with soap and water. If the catheter is disposable, discard it right away. If it is reusable, rinse the catheter completely and dry the outside. Store the catheter in a clean, dry, secure location.
11. Record the amount of urine obtained, as instructed by your health care provider.

How to perform C.I.C. (male)

1. Assemble all equipment: catheter, lubricant, drainage receptacle.
2. Wash your hands thoroughly with soap and water and clean the penis and urethral opening.
3. Lubricate the catheter.
4. Hold the penis on the sides, perpendicular to the body.
5. Begin to gently insert and advance the catheter.
6. You will meet resistance when you reach the level of the prostate. Try to relax by deep breathing, and continue to advance the catheter.
7. Once the urine flow starts, continue to advance the catheter another 1 inch and hold it in place until the urine flow stops and the bladder is empty.
8. Withdraw the catheter in small increments to make sure the entire bladder empties.
9. Wash the catheter with soap and water. If the catheter is disposable, discard it right away. If it is reusable, rinse the catheter completely and dry the outside. Store the catheter in a clean, dry, secure location.
10. Record the amount of urine obtained, as instructed by your health care provider