Pediatric Nursing

For

Third Year Students

Checklist Part

By

Teaching Staff Members

of

Pediatric Nursing Department

Faculty of Nursing

Sohag University

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List of contents

Observation Checklist (Hand washing)

Satisfactory (S), unsatisfactory (U) and not performed (N)

	Steps	Performance score			
1	Inspect surface of hands for break or cuticles.	S	U	N	comment
2	Inspect hands for heavy soiling				
3	Inspect nails for length				
4	Push wrist watch and long uniform sleeves above wrist. Avoid wearing rings; if worn, remove during washing				
5	Stand in front of sink, keeping hands and uniform away from sink surface				
6	Turn on water & Avoid splashing water against uniform				
7	Regulate flow of water so that temperature remains warm.				
8	Wet hands and wrists thoroughly under running water. Keep hands and forearms lower than elbows during washing				
9	Apply adequate amount of soap or antiseptic lathering thoroughly				

10	Wash hands for at least 15 seconds or more : A. rub hands palm to palm B. rub back of each hand with palm of other hand with fingers interlaced C. rub palm to palm with finger interlaced D. rub with back of fingers to opposing palms with finger interlocked E. rub each thumb clasped in opposite hand washing using a rotational movement F. rub tips of fingers in opposite palm in a circular motion d. rub each wrist				
11	Rinse hands and wrists thoroughly, keeping hands down and elbows up				
12	Repeat steps and extend period of washing if hands are heavily soiled				
13	Dry hands thoroughly from fingers to wrists and forearm with towels, single use cloth or warm air dryer				
14	Turn off water with foot or knee pedals.				

Supervisor signature……..

Total Score:

……/14

Observation Checklist (Scrubbing)

Satisfactory (S), unsatisfactory (U) and not performed (N)

	steps	Performance score			
1	After medical hand washing, wear overhead and mask	S	U	N	Comment
2	Turn on water using knee/foot/elbow and adjust to comfortable temperature				
3	Wet hands and arms under running warm water and lather with soap/detergent to 5cm above the elbows				
4	Use firm circular movements to wash palms, back of hands, wrists, forearm and interdigital spaces of 20-25 seconds				
5	Rinse hands and arms thoroughly under running water				
6	Clean under nails of both hands with nail pick/nail brush				
7	Scrub nails of each hand with 15 strokes using antimicrobial agent				
8	Holding the brush perpendicular scrub palm, each side of thumb and fingers and posterior side of hand with 10 strokes each.				

9	Scrub from wrist to 5cm above each elbow that is lower arm, upper forearm and antecubital fossa to marginal area above				
10	Entire scrub should last for 5-10 minutes				
11	Discard brush and rinse hands from fingertips to elbows				
12	Take care not to touch the tap or sides of sink during the procedure				
13	Use a sterile towel to dry one hand moving from fingers to elbows.				
14	Repeat drying of the other hand using a different towel. Use one side to dry one hand and reverse side for other hand, if only one towel is available				
15	Discard towel				
16	Proceed with sterile gowning				

Supervisor signature:……

Total Score:
……/16

Observation Checklist (Physical Examination)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No	Skill Procedures steps	Performance Score			
		S	U	N	Comment
1 2 3	- Wash hands - Prepare the necessary equipment. -Explain procedure to mother and child.				
4	**HISTORY TAKING**				
a-	**Biosocial data:** name, age, sex, address, religion, educational level, eating and sleeping patterns				
b-	**Health History:**				
	• Birth history				
	• Immunization				
	• Previous childhood illnesses, accidents or injuries				
	• Previous hospitalization, - **if yes**: Obtain the following information - Reason for admission - Place of admission - Length of stay - Surgical procedure - Outcomes				
	• Presents of allergies				
c-	**Obtain history of current health(Present Complaints):** onset, duration, medication taken				
d-	**Family History:** ask about hereditary diseases, present of chronic illness in the family members				

5	**ASSESS ANTHROPOMETRIC MEASUREMENTS** • Length/ height				
	• Weight				
	• Head circumference				
	• Chest circumference				
	• Mid arm circumference				
6	**VITAL SIGNS**				
	• Temperature				
	• Pulse				
	• Respiration				
	• Blood pressure				
7	**GENERAL APPEARANCE**				
	• **Posture**, position				
	• **Facial expression**, clues for pain, frightened				
	• **Hygiene**: the appropriateness of dress for climatic condition, unusual odor, the condition of hair, nails, teeth and feet				
	• **Nutrition**: general state of nutrition				
	• **Behavior:** level of activity, interaction with others, response to stimuli, child overall personality as calm, anxious, tense aggressive, stable, talkative, or restless.				
	• **Development:** speech appropriately to his age, motor skills, degree of coordination and recent area of achievement				
8	**SKIN**				

	Skin is assessed for any lesions (macules, papules, vesicles, wounds).				
	• **Color**: abnormal colors as, cyanosis, pallor, presents of erythema, ecchymosis, petechiae or jaundice				
	• **Temperature**: comparing the temperature of the upper and the lower parts. In case of coarctation of the aorta the upper extremities are warm while lower ones are cool.				
	• **Turgor:** it is best determined by grasping the skin on the abdomen between the thumb and index finger.				
9	**HEAD**				
	• **Inspect:** shape and symmetry of the head, scalp for cleanliness, lesion, ecchymosis, masses, or scare				
	• **Evaluate** the range of motion, assess fontanels				
10	**NECK**				
	• **Inspect:** cleanliness of the neck				
	• **Palpate:** the thyroid gland				
11	**EYES**				
	Inspect: symmetry,				
	1. Lids for proper placement,				
	2. Blinking movement				
	3. Sclera				
	4. Cornea,				
	5. Iris and pupils				

12	**EARS**				
	Inspect: Placement and alignment				
	• Assess skin around the ear for small opening				
	• Hygiene, discharge, ear drum				
13	**NOSE**				
	Inspect: location of the nose				
	• Symmetry				
	• Internal structure for swelling of the mucosal lining, discharge, dryness, bleeding				
14	**MOUTH AND THROAT**				
	• Inspect**:** lips for color, moisture, cracking, or lesions				
	• Teeth; number, cavities, occlusion				
	• Gums for color, swelling or ulcer				
	• Tongue for normal motion, ulcer,				
	• Hard and soft palate for color, shape, or deformity				
	• Oropharynx using tongue depressor				
	• Tonsils for color, inflammation				
	CHEST				
14	• **Inspect:** movement of the chest wall, shape, pigeon chest, funnel chest				
	Rate and depth of respiration				
15	• **Palpate:** for breast tissues, tenderness, masses, lesions				

16	• **Tactile fremitus**: the examiner instructs the child to repeat the ward (ninety- nine) with each movement of the examiner's hands. The vibrations are perceived by placing the palmer surfaces of fingers and hands on the thorax				
17	**Percussion**: percuss the anterior and the posterior chest from side to side, top to bottom, compare one side to the other looking for asymmetry				
18	**Auscultation:** breath sound, crackles, wheezes				
	• Bronchial breath sounds				
	• Bronchovesicular breath sounds				
	• Vesicular breath sound				
	HEART				
19	**Inspect:** size and observe chest wall for symmetry				
20	**Palpate**: • **point of maximum impulse**: lateral to the left mid clavicular line and fourth intercostals space in children younger than 7 years of age and at the left midclavicular line and fifth intercostals space in children 7 years and above				
21	• **Capillary filling time**: top of the hand to produce a slight blanching, calculate the time it will take for the blanched area to return to its original color				
22	**Percussion of the heart:** The left border of the				

	heart is located by percussion. It extends from the sternum to the midclavicular line in the third to fourth intercostals space				
23	**Auscultation of the heart:** listening for the heart sounds with stethoscope, two sounds S1 and S2 are heard (lub dub) Describe rate, rhythm and intensity **Auscultatory areas:** Aortic area (second right intercostal space close to sternum) Pulmonic area (second left intercostal space close to sternum) Tricuspid area (fifth right and left intercostal spaces close to sternum) Mitral or apical area (fifth intercostal space, left midclavicular line) (third to fourth intercostal space and lateral to left midclavicular line in infants)				
	ABDOMEN				
24	**Inspection:** assess counter, symmetry, characteristics of the umbilicus, skin				
25	**Auscultation:** listen for peristalsis movements and recorded per minute				
26	**Percussion:** hollow organs produce tympanic sounds and fluid filled tissue produce a dull sound				
27	**Palpation:** begin in the lower quadrants and proceed upward to avoid missing, the edge of				

	an enlarged liver or spleen. If the liver is 3cm below costal margin, it is considered enlarged				
	GENITALIA				
28	**a-Male: Inspect** • Location of scrotum				
	• Size of the penis				
	• Glans and urethral meatus				
	Palpate: scrotum for descended tests				
29	**b- Female: Inspect** • Valva				
	• Clitoris				
	• Labia majoras				
	• Labia minora				
	• Urethral meatus				
	• Vaginal orifice				
30	**Anus: Inspect:** opening, muscle tone and skin condition				
	BACK AND EXTREMITIES				
31	• **Back: Inspect** Curvature of the spine (normal or present of scoliosis)				
	• Color and symmetry of the back				
	• **Palpate back for:** lesions				
32	**Extremities:** • **Inspect** symmetry of length and size				
	• Color of arms				
	• Color of legs				

	• Shape of leg bones (present of bowlegs- knock knee)				
	• Count fingers				
	• Count toes				
	• **Palpate:** Pulse, Edema				
33	**Evaluate joints**, for range of motion, tenderness, swelling				
34	**Muscles:**				
	• Assess muscle tone: grasp the muscle and feel its firmness when it is relaxed and contracted				
	• Assess strength of the muscles: having the child use an extremity to push or pull against resistance (assess arms, hands and legs strength)				
	NEUROMUSCULAR SYSTEM				
35	**Assess mental status:** Observe the child's behavior, mood, affect, general orientation to surrounding and level of consciousness.				
36	**Test the vision and hearing.**				
37	**Assess sensory intactness and discrimination**				
	A- for sensory intactness, the examiner touch the child's skin lightly with a pin, then ask the child while he is closing his eyes to point to the stimulated area.				
	b- For sensory discrimination, the examiner touch the child's skin with pin and cotton and ask him/her to describe it was sharp or dull.				
	C- Touch the child's skin with warm and cold object and ask him/her to differentiate between				

	temperatures.				
38	**Assess reflexes for the newborn and infants**				
	AFTER THE PROCEDURE				
39	Record the findings &report for any abnormality.				
40	Clean the equipments and return it to their place				
41	Wash hands				

Supervisor signature……..

Total Score:

……/41

Observation Checklist (Weight)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No.	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1	Perform hand hygiene before patient contact.				
2	Verify the correct child using two identifiers				
3	Locate the appropriate measuring devices and growth charts based on the child's age and mobility.				
4	Explain the procedures to the child and his parents				
5	Place the scale horizontally on a firm surface.				
6	Check to see that the scale is balanced by setting it at zero, and noting if the balance registers exactly in the middle of the mark.				
7	Close windows & doors.				
	STEPS OF THE PRECEDURE				
8	Obtain the appropriate scale for the age and condition of the child. For children younger than 2 years of age, use a flat pan scale. For bedridden children more than 2				

	years of age, use a sling scale or special scale. For children who are able to stand, use a standing scale				
9	Wipe the scale using cotton with alcohol				
10	Remove the infant's shoes and clothes.				
11	Put a scale paper on the scale.				
12	Gently lift the infant from his bed and place him in the scale basket.				
13	For reason of the safety, hold one hand over the body of the infant.				
14	Adjust the weight to balance scale by the right hand.				
15	Read the scale when the infant is lying still.				
16	Return the infant to his bed.				
	AFTER THE PROCEDURE				
17	Record it in the infant's chart.				
18	Remove and dispose the scale paper.				
19	Wash hands				

Supervisor signature……..

Total Score:

……/19

Observation Checklist (Recumbent Length)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1-	Wash hands				
2-	Secure the help of an assistant, who may be a family member				
3-	Prepare the necessary equipments and supplies				
4-	Explain the procedures to the child's parents				
5-	Obtain a length board				
	STEPES OF THE PROCEDURE				
6-	Place the towel on the board.				
7-	Assist the child with removing shoes and clothes				
8-	Place the child supine on the length board				
9-	One assistant hold the head against the head of the board firmly				
10-	Grasp the knees together gently				
11-	Push down on the knees until the legs are fully extended and hold the legs firmly				
12-	Bring the headboard against the soles of the heels firmly.				

13-	Read and record the result				
	If such a measuring device is not available length is taken by using measuring tape:				
14	Place the infant on a proper-covered hard surface.				
15	Push down the knees and against a firm surface				
16	Make points of the top of the head and heel of the feet by a pen				
17	Remove the child from his place.				
18	Measure between these two points				
	AFTER THE PROCEDURE				
19	Return and clean the reused equipments				
20	Wash hands				
21	Record the findings				

Supervisor signature……..

Total Score:

……/21

Observation Checklist (Height)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1	Wash hands				
2	Prepare the necessary equipments and supplies (stadiometer or measuring tape)				
3	Explain the procedures to the child and/ or his parents				
4	Obtain a stadiometer to measure standing height				
	DURING THE PROCEDURE				
5	Remove the child's shoes and socks				
6	Have the child stand erect with feet flat on the floor, looking straight ahead, with the heels, buttocks, shoulders, and head against the measuring board. Ensure the heels are touching, the knees are fully extended, and the heels are flat				
7	Lower the horizontal ruler of the stadiometer firmly onto the crown of the child's head, so it is at a right angle to the vertical ruler. Ensure enough pressure to compress the hair.				
8	Read the measurement at eye level.				

9	Record the child's stature measurement to the nearest 0.1 cm.				
	AFTER THE PROCEDURE				
10	Return and clean the reused equipments				
11	Wash hands				
12	Recording				

Supervisor signature……..

Total Score:

……/12

Observation Checklist (Head Circumference)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No.	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1	Wash hands				
2	Verify the correct newborn using two identifiers				
3	Prepare the necessary equipment and supplies (a tape measure)				
4	Explain the procedures to the child and /or his parents				
	DURING OF THE PROCEDURE				
5	Position the newborn supine				
6	Place a flexible tape measure around the occipitofrontal circumference (the widest diameter) of the newborn's head, positioning it above the ears and just above the eyebrows. Adjust the tape measure at the occipital bone to obtain the largest measurement, and read the tape in centimeters				
7	A second measurement if the first was abnormal for the newborn's gestational age or overall size.				
8	Remove the tape measure by gently				

	lifting it or rolling the newborn off the tape.				
9	Document the procedure in the newborn's record.				
	AFTER THE PROCEDURE				
10	Return and clean the reused equipments				
11	Wash hands				
12	Recording				

Supervisor signature……..

Total Score:

……/12

Observation Checklist (Chest Circumference)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No.	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1	Wash hands				
2	Prepare the necessary equipments and supplies (A tape measure)				
3	Explain the procedures to the child and/ or his parents				
	DURING THE PROCEDURE				
4	Remove the child's clothing of upper half.				
5	Place on the flat table in a supine position for infant, stand alone for children				
6	Place the tape across the nipple line.				
7	Take measurement during inhalation and expiration.				
8	Record the average of the two values.				
9	**AFTER THE PROCEDURE**				
10	Return and clean the reused equipments				
11	Wash hands				
12	Recording				

Supervisor signature……..

Total Score:

……/12

Observation Checklist (Mid-Arm Circumference)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No	Skill Procedures steps	Performance score			
		S	U	N	Comment
	GETTING READY				
1	Wash hands				
2	Prepare the equipment needed (Measuring tape)				
3	Explain procedure to the child and parent				
	DURING THE PROCEDURE				
4	Let the child's right arm flexed 90º at the elbow				
5	Mark the Midpoint between the acromion and the olecranon on the posterior aspect of the arm				
6	Wrap a paper or steel measuring tape around upper arm at midpoint				
7	Measure to nearest 1 cm				
8	Read the result				
9	**AFTER THE PROCEDURE**				
10	Record the result				
11	Clean and return the used equipment				
12	Wash hands				

Supervisor signature……..

Total Score:

……/12

Observation Checklist (infant bath)

Satisfactory (S), unsatisfactory (U) and not performed (N)

	Steps	**Performance score**			
1	Wash hands	S	U	N	Comment
2	Prepare necessary equipment (wash basin with water about 100 F (37.8C), wash cloth, cotton ball, towel, bath blanket, baby comb, infant cloths, mild soap, bag to dispose cotton balls, crib linen.				
3	Explain procedure to the mother				
4	Close window and doors				
5	Count apical pulse, measure temperature and respiration before				
6	Fill the bath basin one-half full of warm water				
7	Test temperature of water by your wrist or elbow				
8	Place the rubber sheet on bed				
9	Undress the infant, and wrap him in bath towel				
10	Clean the eye using wash cloth with water only from the inner to outer aspect of the lid				
11	Wash the infant face with water only then dry				
12	Wash infant's ears and neck giving particular attention to skin fold of the neck, behind the ears and the external part of the ears				
13	Place the infant again on his back, wash, rinse and dry each arm and hand , pay attention to the axilla, dry it thoroughly				

14	Wash, rinse and dry the infant's chest and abdomen. Keep him covered with bath blanket or towel between washing and rinsing				
15	Turn the infant on his stomach or side, wash, rinse and dry the back				
16	Wash, rinse and dry the infant legs and feet, pay attention to areas between the toes				
17	Place the infant on his back, clean and dry the genital areas from front to back, the rectal area is cleansed last since it is the most contaminated				
18	Pick the infant up using football hold position the baby's head over the wash basin. Lather the scalp using mild soap and message the scalp using your finger tips				
19	Rinse and dry the scalp				
20	Dress the infant				
21	Clean the finger nails with , cutting toe nails, comb the hair				
22	Clean the equipment				
23	Wash hands thoroughly with soap and water, dry with clean and dry cloth				
24	Record the following : time, observation, reaction of infant				

Supervisor signature……..

Total Score:

……/24

Observation Checklist (Essential newborn care)

Satisfactory (S), unsatisfactory (U) and not performed (N)

steps		Performance score			
		S	U	N	Comme
	Immediate newborn care				
1	1. When the head is delivered, wipe the mouth and nose with gauze.				
2	2. When the baby is fully born, place the baby on a clean, dry towel or blanket on the mother's abdomen.				
3	3. Note the time of birth and sex of the baby.				
4	4. Wipe the eyes and face and thoroughly dry the baby.				
5	5. Stimulate mildly depressed baby for breathing while drying by rubbing up and down along the baby's back with warm and clean cloth.				
6	6. Assess the baby's breathing while drying and stimulating. □ If the baby is not crying or breathing well within 30 seconds of birth, clamp and cut the cord and begin resuscitation. □ If the baby is breathing normally, continue with the other components of essential newborn care.				
7	7. Remove the wet cloth and place the baby skin-to-skin on the mother's chest.				

8	8. Cover the baby with a clean, dry cloth including the head. Use a hat if available.				
	Clamp and cut the cord				
9	1. Wait for 2-3 minutes after birth or until the cord ceases to pulsate before clamping and cutting the cord.				
10	2. Tie the cord two fingers' length from the baby's abdomen and make another tie two fingers from the first one. Cut the cord between the two clamps using a sterile scissor.				
	Care of the umbilical cord.				
11	1. Tie the cord with a cord clamp (2-3 cm) from the abdomen, making sure. Check for bleeding; if present, retie the cord.				
12	2. Apply alcohol on the cord, taking care to apply it on the base of the cord.				
	Initiating immediate breastfeeding				
13	1. If everything is normal, the mother should immediately start breastfeeding.				
14	2. Help the mother begin breastfeeding within the first hour of birth.				
15	3. Help the mother at the first feed. Make sure the baby has a good position, attachment, and is sucking well.				

16	4. Do not limit the length of time the baby feeds; early and unlimited breast feeding gives the newborn energy to stay warm, nutrition to grow, and antibodies to fight infection.				
	Maintain the baby's body temperature/ thermal protection				
17	1. Keep the baby warm, ideally by keeping him/her in skin-to-skin contact on the mother's chest, with the body and head covered by a cloth or hat. If the baby cannot be placed in skin-to-skin contact in case of a Cesarean section or if the mother is ill, wrap the baby well and cover the head.				
18	2. Check the baby's axillary temperature with a thermometer.				
	Care of the eyes (while the baby is held by mother)				
19	1. Instill eye drops (tetracycline or erythromycin), one drop in each eye. When using an ointment, depress the lower eyelid and place a length/strip of the ointment inside the lid from the inner to the outer edge of the eye. Do the same for the other eye.				
20	2. Make sure that the tip of the bottle or the tube does not touch the eye of the baby or other objects.				

	Administer vitamin K1(while the baby is held by mother)				
21	1. Explain to the mother that an injection will be required to prevent hemorrhage in the baby.				
22	2. Collect all the necessary supplies: disposable syringe (preferably 1 mL) with needle, vitamin K, alcohol, pieces of gauze/cotton, preferably sterile.				
23	3. Wipe the injection site with alcohol soaked cotton or gauze.				
24	4. Inject the drug intramuscularly in the antero-lateral part of the thigh: 1 mg for a normal weight baby and 0.5 for a baby weighing less than 1500 grams.				
25	5. Dispose of the needle and syringe in an appropriate and safe manner (in a container for sharp instruments).				
	Identification of the baby				
26	1. Place an identification band, preferably two—one on the wrist and the other on the ankle of the baby—noting the name of the mother and that of the father (where available), the sex of the baby, and date and time of the delivery.				
	Weigh the baby after the first breast fed				
27	Delay taking the weight of the baby until he/she is stable and warm and after first breast feeding.				

	Decontamination, cleaning, and sterilization				
28	Ensure the proper disposal of waste and decontamination of the equipment and supplies that can be reused.				

Supervisor signature……..

Total Score:

……/28

APGAR scoring check list

	steps	Score of performance			
		S	U	N	Comment
	1- Color:				
1	a. Pale or blue = 0				
2	b. Normal color body, but blue extremities (arms and/or legs) = 1				
3	c. Normal color = 2 – completely pink				
	2- Respiration:				
4	a. Not breathing = 0				
5	b. Weak cry, irregular breathing = 1				
6	c. Strong cry = 2				
	3- Heart Rate:				
7	a. Absent heartbeat = 0				
8	b. Slow heartbeat (less than 100 beats/minute) = 1				
9	c. Adequate heartbeat (more than 100 beats/minute) = 2				
	4- Muscle Tone:				
10	a. Limp, flaccid = 0				
11	b. Some flexing or bending = 1				

12	c. Active motion = 2				
	5- Response to Stimulation (also called Reflex Irritability):				
13	a. No response = 0				
14	b. Grimace (facial expression) = 1				
15	c. Vigorous cry or withdrawal = 2				
16	***Results:**				
	*10 out of 10 is a perfect score.				
	*A score over 7 indicates good condition				
	*A score from (4 -6) moderately depressed and need more extensive clearing airway and supplementary oxygen.				

Supervisor signature……..

Total Score:

……/16

Observation Checklist (Restraining)

1-Mummy Restrain

Procedure	**Performance score**			
	S	U	N	**comment**
1 – wash hand				
2 – wear the gloves				
3 – prepare the equipment				
4 - explain the procedure to the mother				
5-Put The blanket (or sheet) on the bed or examination table. fold down one corner until reaches the middle of the blanket				
6- place infant in diagonal position with his or her neck on the folded of edge				
7-bring one side of the blanket over the infant ‘s arm and then under the back .tuck the edge under and over the other arm and around the back				
8- Bring the other side of the blanket around the body and tuck underneath the body				
9- bring the bottom corner of the blanket up and over the abdomen				
10 – fasten in place with safety pins or tape				
After procedure				
11 – wash hand				
12 – put the enfant in comfortable position				

Supervisor signature……..

Total Score:

……/12

2—The Elbow restrains

Procedure	**Performance score**		
	S	U	N
1 – wash hand			
2 – wear the gloves			
3 – prepare the equipment			
4 - explain the procedure to the mother			
5-wrap the elbow immobilizer around the arm from axilla to wrist snug enough to prevent bending of the elbow			
6-the device may be secure with pins or tape to the bedding or the child's clothing if needed. this type of restrain more restrictive than just using the immobilizers, should be used only if needed , and requires a written medical order			
7-remove the elbow immobilizer at least every 2 hours (or the interval specified in the institution's guidelines)			
After procedure			
8 – wash hand			
9 – put the enfant in comfortable position			

Supervisor signature……..

Total Score:

……/9

3 – Jacket restraint

Procedure	**Score of performance**		
	S	**U**	**N**
1 – wash hand			
2 – wear the gloves			
3 – prepare the equipment			
4 - explain the procedure to the mother			
5 - Place jacket on the child with ties positioned in the back			
6 – secure each tie on unmovable portion on the bed , secure the shoulder straps to the head of the bed			
7 – secure the straps over the abdomen to the spring underneath the mattress on either side of the bed			
After procedure			
8– wash hand			
9– put the enfant in comfortable position			

Supervisor signature……..

Total Score:

……/9

4- Crib Net restrain

Procedure	**Score of performance**		
1 – wash hand	**S**	**U**	**N**
2 – wear the gloves			
3 – prepare the equipment			
4 - explain the procedure to the mother			
5-Apply the crib –Net snugly over the top and sides of crib and secure its tips to the mattress spring			
6 - Tie all knots in a manner that permits quick release			
After procedure			
7 – wash hand			
8 – put the infant in comfortable position			
9 – record and report any abnormality			

Supervisor signature……..

Total Score:

……/9

Observation Checklist (Formula feeding)

Satisfactory (S), unsatisfactory (U) and not performed (N)

Procedure	**Score of performance**		
1 – wash hand	S	U	N
2 – wear the gloves			
3 – prepare the equipment			
4 - explain the procedure to the mother			
5- Clean any surface thoroughly where the feed is prepared.			
6 - Wash hands with soap and water and then dry.			
7 - Boil fresh tap water in a kettle. Alternatively bottled water that is suitable for infants can be used for making up feeds and should be boiled in the same way as tap water.			
8 - Allow the boiled water to cool to no less than 70^{o}C. This means in practice using water that has been left covered for less than 30 minutes after boiling.			
9 - Pour the amount of boiled water required into the sterilized bottle.			
10- Add the exact amount of formula as instructed on the label always using the scoop provided with the powered formula by the manufacturer. Don't add any extra powder than instructed as this could make the baby ill.			
11 - Re-assemble the bottle following manufacturer's instruction.			
12 - Shake the bottle well to mix the contents.			
13 - Cool quickly to feeding temperature by holding under a running tap, or placing in a container of water.			
14 - Check the temperature by shaking a few drops onto the			

inside of the wrist – it should feel lukewarm, not hot.			
15- Any feed that has been used within 2 hours should be discarded.			
After procedure			
16– wash hands			
17 – put the enfant in comfortable position			

Supervisor signature……..

Total Score: ……/17

RYLE'S TUBE INSERTION

Procedure	**Score of performance**		
1 – wash hand	**S**	**U**	**N**
2 – wear the gloves			
3 – prepare the equipment			
4 - explain the procedure to the mother			
5 - Assemble the required articles at the patient's bedside.			
6 - Explain the procedure to the child if possible, or to the care givers.			
7 - Give comfortable position to the client.			
8 - Wash hands with soap and water			
9 Place the child in supine position with head slightly hyper flexed.			
10 - Measure the tube for approximate length of insertion (from the nose to the bottom of the ear lobe and then to the end of xiphoid processes) and mark it.			
11 - Lubricate the tip of the tube with saline or water.			
12 - Insert the lubricated tube through mouth or nares to the predetermined mark.			
13 - When inserting through nasal route, slip the tube along the base of the nose and direct it back towards the occiput			
14 - When entering through the mouth direct the tube towards the back of the throat...			
15 - Check the placement of the tube by aspirating the contents or with help of syringe or inject a small amount of air (0.5 – 1 ml in preterm or small infants to 5 ml in larger children) into the tube and listening with			

stethoscope over stomach..			
16 - Secure the tube with the help of tape if in correct position.			
After procedure			
17 – wash hands			
18 – put the infant in comfortable position			

Supervisor signature……..

Total Score:

……/18

Observation Checklist (Incubator care)

Satisfactory (S), unsatisfactory (U) and not performed (N)

Steps		Performance score			
		S	U	N	comment
	Preparation of incubator:				
1	1.Wash hands				
2	2. Cover the mattress with a sheet and tuck it under the sides				
3	3. Make sure that the porthole of the clean incubator is remained close				
4	4. Fill the humidity reservoir with distilled water only till the level indicated by a black line				
5	5. Attach the incubator plug to electricity (wall socket)& switch it on				
6	6. Turn the temperature control dial between 28 –32 °c				
7	7. Connect a tube between $\mathbf{O_2}$ inlet and oxygen source				
8	8. Set prescribed $\mathbf{O_2}$ flow between 20% – 40%				
9	9. Adjust humidity knob between 55%-65%				
10	10. Keep incubator away from sunlight or warm radiant				
	Daily care of incubator :				
11	1. Wash hand				
12	2. Replenish humidity tank up to the black line with distillated water.				

13	3. Wipe down the inside wall with disinfectant (Savlon) or according to hospital policy while changing sheet and having infant on scale				
14	4. Wipe the outside wall every 8 hours with disinfectant (Savlon)				
15	5. Wipe plastic cover mattress with disinfectant				
16	6. Change bed sheet daily and whenever needed				
17	7. Monitor O_2 flow rate and concentration as prescribed				
18	8. Check that temperature is between 28-32°c				
19	9. Check that humidity is between 55-65%				
20	10. Replace incubator every 7 days. (Date of replacement should be indicated clearly on incubator)				
21	11. Wash hands following completion of procedure				
	Terminal care of incubator :				
22	1. Wash hands before initiating procedure				
23	2. Switch electricity off from incubator and wall socket				
24	3. Invert humidity tank to drain and dry it .				
25	4. Remove all detachable parts				
23	5. Wash it with hot soapy water , rinse and dry				
24	6. Inspect the mattress cover carefully for signs of tear or loss of impermeability				

25	7. Wash mattress with soap and water & dry it well				
26	8. Wash the floor of incubator with water ,and dry it				
27	9. Expose the whole unit to adequate fresh air and sunshine				
28	10. Change the air filters according to manufacturer instructions.				
29	11. If disinfection's required , wipe the inside and outside wall , floor and mattress of the incubator with a dilute hypo- chloride solution but Should be reined off				
30	12. If the incubator has integral humidifier (can't be removed) to disinfect it , raise the temperature of water at least 70 °c for 10 minutes				
31	13. If the humidifier is removable , detach it and send it to autoclave				
32 33	**<u>After the procedure(Terminal care):</u>** **-Wash hands** **-Documentation**: date of disinfection ,name of personnel who has performed care on a tape and place it on the outer surface of incubator				

Supervisor signature……..

Total Score:

……/33

Observation Checklist (neonatal resuscitation)

Satisfactory (S), unsatisfactory (U) and not performed (N)

Steps of Procedure	S	U	N
1- Wash hand			
2- Wear gloves.			
3- Prepare the necessary equipments and supplies.			
4- Anticipating the need for resuscitation (risk factors for neonatal resuscitation)			
5- Explain the procedures to the child's parents.			
6-Assessment of the newborn at birth: A. assessing the need to initiate and continue resuscitation B. If there is meconium-stained amniotic fluid so there may be associated with asphyxia, tracheal suction is needed			
7-Provide initial steps: Thermal management ,Dryness, Positioning			
A. Airway			
8-Provide dryness and stimulate the baby to breathe (tactile stimulation).			
9-Position the head is slightly extended .			
10-Clear the airway by suctioning the mouth first and then the nose.			
B. Ventilation			
11-Evaluate respirations, heart rate and color; give oxygen as needed.			
12-If the baby is apneic, or heart rate is less than 100 b/m provide positive pressure ventilation with a			

resuscitation bag and 100% oxygen.			
13-The resuscitation mask should be chosen based on the size of the infant.			
14-If breathing is normal (30-60 b/m) and there is **no indrawing** of the chest and **no grunting**: a. Put skin- to- skin contact with mother. b. Observe breathing at frequent intervals. c-Measure the newborn's axillary temperature and re-warm D-Encourage mother to begin breastfeeding. E-Assess for hypoglycaemia. F-Observe suckling			
15-C. Circulation:			
-If the heart rate is less than 60 b/m: – Give chest compressions with positive pressure ventilation at a rate of 3:1 compressions to every breath			
16-D.Drugs as prescribed			
-If the heart rate remains slower than 60 b/m after ventilation and chest compressions,administer epinephrine, volume expanders, or both.			
<u>17-Discontinuation of resuscitation</u> -If there is no heart rate after 10 minutes and there is no evidence of other causes of newborn compromise, discontinue efforts.			
18-Dispose suction catheters & other equipments			
19-For reusable catheters and other equipment - Wash in water and detergent. - Boil or disinfect in an appropriate chemical solution			

and check for damage.			
20-Wash hands			
21-Test the functioning of all equipment & return it to their place			
22-Written documentation of: Personal involved , All procedures including drugs and Timing			

Supervisor signature:……

Total Score:
……/22

Observation check list (collection of specimen)

A-Performing a capillary puncture

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands			
2	Wear gloves			
3	**Finger stick:** Hold the child's hand with your non dominant hand or have an assistant hold it, keeping the finger to be used extended and pointed down			
4	**Heel stick:** Hold the child's foot in your non dominant hand, supporting the dorsum of the foot with your thumb and the ankle with your fingers			
5	**Toe stick:** Grasp the child's foot across the dorsum with your non dominant hand, supporting the toe with your thumb on the planter surface			
6	Clean the site with Chlorhexidine-based preparation			
7	Using your dominant hand, pierce the skin quickly with the lancet			
8	Wipe the first drop of blood away with the dry gauze			
9	Gently squeeze the site, hold the punctured site downward, and direct the blood into the appropriate tube by covering one end of the capillary tube with a finger and inserting other end into sealant			

10	When collection is complete, have an assistant hold the gauze on the site until the bleeding has stopped. Apply an adhesive bandage			
11	Label the specimen and send to the laboratory Document the specimen collected and time sent to the laboratory			
12	Dispose of lancet ,gloves, and any solid equipment in proper container			

Supervisor signature:……

Total Score:
……/12

B-Performing a venipuncture

No	Steps of the procedure	Score of performance		
1	Wash hands	**S**	**U**	**N**
2	Raise or lower bed to comfortable working height			
3	Assist client to supine or semi fowler's position with arms extended to form straight line from shoulder to wrist			
4	Ask parent or staff member to restrain child so that venipuncture site is immobilized			
5	Apply disposable gloves			
6	Apply tourniquet 5-15 cm above venipuncture site selected			
7	Palpate distal pulse below tourniquet. If pulse not palpable, reapply tourniquet more loosely			
8	Keep tourniquet for no longer than 1-2 minutes			
9	Ask client to open and close fist several times, finally leaving fist clenched			
10	Quickly inspect extremity for venipuncture site, looking for straight, prominent vein without swelling or hematoma			
11	Palpate selected vein with index finger. Note if vein is firm and rebound when palpated or if vein feels rigid and cord like when palpated			
12	Select venipuncture site			
13	Cleanse venipuncture site with alcohol swab in circular motion. Allow to dry			
14	Have a syringe with appropriate needle securely			

	attached			
15	Remove needle cover and inform client ' stick' lasting for few seconds felt			
16	Place thumb or forefinger of non-dominant hand 2.5 cm above or below site and pull skin taut			
17	Hold syringe and needle at 15-30 degree angel from client arm with bevel up			
18	Hold syringe gently and pull back gently on plunger			
19	Look for blood return			
20	Obtained desired amount of blood keeping needle stabilized			
21	After specimen is obtained release tourniquet			
22	Apply gauze pad over puncture site without applying pressure and quickly withdraw needle from vein			
23	Immediately apply pressure over venipuncture site with gauze pad for 2-3 minutes or until bleeding stops. Apply pressure over site and tape gauze dressing securely			
24	Insert needle through stopper of blood tubes and allow vacuum to fill tube. Don't force blood into tube			
25	Take blood tubes containing additives and gently rotate back and force 8-10 times			
26	Check tubes for any signs of external contamination with blood			
27	Remove disposable gloves after specimen			

28	Attach properly completed identification label to each tube			
29	Dispose of needles, syringe, and any soiled equipment in proper container			
30	Sent specimens immediately to laboratory			

Supervisor signature:……

Total Score:

……/30

2-Urine sample

Applying a urine collecting bag (infants)

No	Steps of the procedure	Score of performance		
		S	U	N
1	wash hands and wear gloves			
2	Remove the diaper and clean the skin well with soap water, ensuring any skin folds are opened for access to cleaning			
3 4	For female: Spread the labia apart with non-dominant hand. Pick up a cleansing swab and clean the meatus, using one ball for each wipe, in a front to back direction, then along the sides of the urinary meatus, then labia minora and majora For male: Old the penis and spread the meatus with your thumb and forefinger. Clean the tissue surrounding the meatus using one cotton ball for each wipe			
5	Avoid touching the inside of the bag as you handle it			
6	Remove the covering from the adhesive strips, attach the bag with adhesive tape for girls: around the labia For the boys: around the penis			
7	Make sure the seal is tight			
8	Reapply diaper and check the bag frequently for urine			

9	To remove bag container: 1. . wear gloves **2.** . Gently pull the bag away from the skin. Fold the opening over and place the urine bag into specimen container			
10	Cap the container tightly			
11	Label specimen and sent to laboratory			
12	Dispose of gloves and wash hand			

Supervisor signature:……

Total Score:

……/12

Collecting a clean-catch midstream urine specimen

No	Steps of the procedure	Score of performance		
		S	U	N
1	The parent or nurse should instruct the older child to wash his hands well. For male: Clean the head of the penis three times, each time using a different towelette, and moving from the urethral meatus outward. All ridges and skin folds should be cleaned For female: The girl should sit back on the toilet as far as possible with her legs apart. After spreading the labia, wipe each side with a separate towelette using a front to back stroke. A third wipe is used to clean the meatus, repeating the front to back motion			
2	Wear gloves			
3	Have the child urinate a small amount into the toilet and then catch the flow in the sterile container			
4	Cap the container tightly			

5	Label specimen and send to laboratory			
6	Remove glove and wash hands			

Supervisor signature……..

Total Score:
……/6

3-Stool culture

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands, wear gloves			
2	Check the child's frequency			
3	Remove soiled diaper from child. Clean perineal area, apply clean diaper			
4	Remove small amount of stool from diaper with tongue blade and place in the specimen container			
5	Label specimen and send to the laboratory immediately			
6	Dispose waste materials according hospital policy			
7	Wash hands			

Total Score:

……/7

Supervisor signature:……

4-Throat specimen

No	Steps of the procedure	Score of performance		
		S	**U**	**N**
1	Wash hands and put on gloves			
2	Ask the child to sit erect in the bed. Young child may lie back against bed with head of the bed raised to 45 degree angel			
3	Have swab in tube ready for use			
4	While collecting throat swab: 1. instruct child to tilt head backward 2. ask the child to open mouth and say 'aaah' 3. if pharynx not visualized, depress tongue with tongue blade, anterior 1/3 of tongue only 4. Insert swab without touching lips, teeth, tongue, and cheeks 5. gently but quickly swab tonsiller area **6.** Carefully withdraws swabs without striking oral structures. Immediately place swab in culture			
5	Discard tongue blade and gloves			
6	Send specimen immediately to laboratory			
7	Wash hands			

Supervisor signature:……

Total Score:

……/7

5-Respiratory secretions

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands wear gloves			
2	Instruct child to take three breaths and force cough into sterile container			
3	Label specimen container and sent to the laboratory			
4	Remove gloves and wash hands			

Supervisor signature……..

Total Score: ……/4

Observation check list (Vital signs)

A-Oral method

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands and wear gloves			
2	Remove the thermometer from the disinfectant solution and rinse it in plain water			
3	Wipe the thermometer with swab from the bulb to stem in a circular motion and discard the swab			
4	Read the level of the mercury in good light			
5	Shake the thermometer if the mercury level is above 35 degree C or 95 F.			
6	Ask the patient to open the mouth and place the thermometer under the tongue.			
7	Have the thermometer in place for 2-3 minutes			
8	Remove the thermometer after 2-3 minutes. Wipe the thermometer from the stem to the bulb with a clean cotton swab, using rotating movements.			
9	Read the level of mercury then Shake it			

	down			
10	Place the thermometer in container with plain water and clean it then wipe the thermometer from stem to bulb in a circular motion			
11	Put the thermometer in disinfectant solution			
12	Remove gloves and wash hands			
13	Record the temperature			

Supervisor signature:……

Total Score:
……/13

B-Axillary method

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands and wear gloves			
2	Remove the thermometer from the disinfectant solution and rinse it in plain water			
3	Wipe the thermometer with swab from the bulb to stem in a circular motion and discard the swab			
4	Read the level of the mercury in good light			
5	Shake the thermometer if the mercury level is above 35 degree C or 95 F.			
6	Place the bulb of the thermometer in the axilla so that the bulb is in touch with the two skin folds of axilla			
7	Keep the bulb of the thermometer high in axilla and then hold the young infant's arm against his body for 5 minutes			
8	Remove the thermometer after 5minutes. Wipe the thermometer from the stem to the bulb			

9	Read the level of mercury then Shake it down			
10	Place the thermometer in container with plain water and clean it then wipe the thermometer from stem to bulb in a circular motion			
11	Put the thermometer in disinfectant solution			
12	Remove gloves and wash hands			
13	Record the temperature			

Supervisor signature:……

Total Score:
……/13

C-Rectal method

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands and wear gloves			
2	Place the child in side laying or prone position			
3	Read the thermometer and be sure that mercury is below 35C			
4	Lubricate the bulb with lubricant			
5	Take two soft tissues in left hand and separate the skin folds around the anus			
6	Gently introduce the thermometer 2 cm in term babies and 1.5 cm in preterm babies with right hand and ask the patient to take deep breath			
7	If resistance is felt during inserting, withdraw thermometer immediately			
8	Hold the thermometer in place			
9	After one minute remove the thermometer			
10	Wipe it from stem to bulb			
11	Read the thermometer at eye level			

12	Soak the thermometer in disinfectant solution and wipe the thermometer from stem to bulb with swab			
13	Wipe client's anal area with soft tissues to remove lubricant			
14	Remove and dispose of gloves			
15	Wash hands			
16	Record the temperature			

Supervisor signature:……

Total Score:
……/16

D-Tympanic method

Child younger than 3 year:

No	Steps of the procedure	Score of performance		
		S	U	N
1	If using the child's right ear, hold the thermometer in your right hand. For the child's left ear, hold the thermometer in your left hand			
2	Pull the pinna of the ear straight back and downward. Approach the ear from behind to direct the tip anteriorly to make sure the thermometer tip is aimed toward the tympanic membrane			
3	Place the probe in the ear canal according to the manufacture's recommendation. It will sound a tone or beep when finished			
4	Remove the probe, read and record the temperature			

Supervisor signature:……

Total Score:
……/4

Child older than 3 year:

No	Steps of the procedure	Score of performance		
		S	U	N
1	Pull the pinna back and upward in children beginning at about age 3 years			
2	Place the probe in the ear canal according to the manufacture's recommendation. It will sound a tone or beep when finished			
3	Read and record the temperature			

Supervisor signature:……

Total Score:
……/3

2-Heart Rate

Infants (Apical pulse):

No	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands			
2	Wipe earpieces and diaphragm with alcohol swab.Warm the diaphragm with hands			
3	Place the stethoscope on the anterior chest at the left fifth intercostal space in a midclavicular position			
4	Count heart beats, if the pulse is regular, count the number of pulsation for half minute and multiply it by two. If the pulse is irregular, count the rate for one full minute.			
5	While auscultating the heart rate, note rhythm and strength			
6	Place the infant in a comfortable position			
7	Record your findings			

Supervisor signature:……

Total Score:
……/7

Children (radial pulse):

	Steps of the procedure	Score of performance		
		S	U	N
1	Wash hands			
2	Place the finger tips over the pulse point			
3	Count heart beats, if the pulse is regular, count the number of pulsation for half minute and multiply it by two. If the pulse is irregular, count the rate for one full minute.			
4	While palpation, note rhythm, strength and amplitude			
5	Compare the distal and proximal pulses in an extremity for strength			
6	Record your findings			

Supervisor signature……..

Total Score:

……/6

3-Respiratory Rate

		Score of performance		
		S	**U**	**N**
1	**For infants and young children:** Observe the abdomen rather than the chest **For older child:** Count rise and fall of the chest			
2	Count the respiratory rate for one minute without the knowledge of the child			
3	If the rhythm is regular, count the number of respiration for half minute and multiply it by two. If the rhythm is irregular, count the rate for one full minute.			
4	Note the respiration for rate, rhythm and depth			
5	Record the findings			

Supervisor signature……..

Total Score:

……/5

4-Blood pressure

	Steps	Score of performance		
		S	U	N
1	Wash hands			
2	Position the child. sitting down or lying in bed			
3	Support the child's forearm at heart level with the palm turned up			
4	Be sure manometer is positioned vertically at eye level			
5	Place stethoscope earpieces in ears and be sure sounds are clear not muffled			
6	Locate brachial artery and place stethoscope over it. Rotate the cuff around the arm			
7	Close valve of pressure bulb until tight			
8	Palpate radial artery with fingertips of one hand while inflating cuff rapidly to pressure 30 mm Hg above point at which pulse disappears			
9	Slowly release valve and allow Hg to fall at rate of 2-3 mm of Hg per second			
10	Note point on manometer when first clear sound is heard			
11	Continue to deflate cuff gradually, noting point at which sound disappears			

12	Deflate cuff rapidly and completely remove from child's arm unless you plan to repeat measurement			
13	If this is first assessment of patient, repeat procedure on other arm			
14	Assist child in returning to comfortable position and cover upper arm if previously clothed			
15	Wash hands			
16	Record your finding			

Supervisor signature……..

Total Score:

……/16

Observation Checklist- drug administration

Intra-muscular Injection Administration

Satisfactory (S), unsatisfactory (U) and not performed (N)

No	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1.	Check the medication's order accuracy (medication's card) it should contains : the child name, drug name, time for administration, route of administration, and dose to be administered				
2.	Wash hands				
3.	Prepare the needed equipments as tray, appropriate syringe and needle size, alcohol swap, prescription sheet, medications, sterile saline bottle or ampoule of sterile distilled water				
4.	Prepare the medication away from the child's sight				
5.	Verify the correct child using two identifiers				
6.	Bring the injection tray to the child's bedside.				
7.	Explain to parent or to the child what you plan to do.				
8.	Review the child's history for drug allergies				
9.	Assess the child for contraindications to the				

	prescribed medication and advise the practitioner accordingly				
	DURING THE PROCEDURE				
10	Assess the child's muscle mass and skin condition				
11	Provide privacy.				
12	Position the child with area well exposed.				
13	Select an appropriate site. the recommended injection sites of intra muscular injection for children are: ▪ Vastus lateralis muscles for infant and young child ▪ Rectus femorus muscles for infant and young child ▪ Gluteal region for children who have been walking				
14	Maintain firm restraint of the child through the injection.				
15	Cleanse the skin with an alcohol sponge and keep the sponge in hand to cleanse the site after wards.				
16	Expel air bubbles				
17	Remove the needle cover				
18	The muscle mass of the thigh to be injected in firmly grasped in one hand to stabilize the limb and compress the muscle mass for injection with other hand				
19	Insert the needle at 90 degree angle using				

	quick darting motion. 2 mm of the needle length must be deepen on the muscle				
20	Spread the skin taut between thumb and forefinger				
21	Fix the syringe with left hand and aspirate before injecting if blood is revealed, the needle must be withdrawn				
22	Inject the medication slowly.				
23	Press the alcohol cotton against the injection site and pull the needle quickly				
24	Move the limb or massage the site with alcohol sponge, if bleeding occurs, apply pressure with dry cotton for a few seconds.				
	AFTER THE PROCEDURE				
25	Don't recap the needle, discard it in a disposable needle box				
26	Wash hands.				
27	Chart site selection, rotate site at next injection.				
28	Record date, time, name of the medication, dose, route site, any given complaint or observation and signature.				

Supervisor signature……..

Total Score:

……/28

Observation Checklist (Intravenous Infusion Administration for Children)

Satisfactory (S), unsatisfactory (U) and not performed (N)

No.	Skill Procedures steps	Performance Score			
		S	U	N	Comment
	GETTING READY				
1.	Check the medication order accuracy (medication's card) it should contain: the child's name, drug name, time and route of administration, and dose to be administered.				
2.	Wash hands				
3.	Prepare the needed equipments as Tray, bottle of solution, medication, infusion set, normal saline, butterfly needle, 21 G - 25 G, syringe 5 ml , 10 ml, I.V pole, tourniquet, arm board or footboard, surgical tape, gauze, cotton with alcohol & jar, kidney basin, label and measured label.				
4.	Prepare the medication away from the child's sight				
5.	Bring the injection tray to the child's bedside.				
6.	Verify the correct child using two identifiers.				
7.	Explain to parent or to the child what you				

	plan to do.				
8.	Review the child's medical history, including venous access history, before placing a peripheral IV catheter.				
9.	Perform a clinical assessment of the child, including vital signs, height and weight, fluid volume status, depth of subcutaneous tissue, and skin pigmentation, and determine the potential sites for vascular access.				
10.	Assess the child's ability to cooperate with the procedure.				
	DURING THE PROCEDURE				
11.	Select the venipuncture site: Perform a vascular assessment and select a site. **Avoid the following sites in an infants and children**: 1) Areas of flexion, such as the wrist or the bend at the antecubital space, which can lead to mechanical phlebitis. 2) The ventral surface of the wrist, which can lead to pain and damage to the radial nerve. 3) The feet of a child of walking age. 4) The dominant hand and fingers. 5) Areas of planned procedures.				

	6) Areas those are painful or compromised.				
12.	Place the child in a comfortable position. Use positioning for comfort techniques to restrain the child**.**				
13.	Use appropriate cognitive or behavioral interventions before and during the procedure.				
14.	Don gloves				
15.	Tighten tourniquet above the vein that will be punctured.				
16.	Cleanse an area of needle insertion with alcohol swab				
17.	Insert the needle & check for blood return				
18.	Advance the catheter into the vein. Ensure that at least three quarters of the catheter is in the vein to prevent accidental dislodgment.				
19.	Remove the tourniquet.				
20.	Secure all connections and initiate therapy as prescribed.				
21	Start to drop & set the I.V. flow rate according to prescribed.				
	After The Procedure				
2	Don't recap the needle, discard it in a disposable needle box				

2					
23	Wash hands.				
24	Chart selected site, rotate site at next injection.				

Supervisor signature……..

Total Score:
……/24

Care of newborn under radiant warmer checklist

Procedure	U	S	N
Getting ready			
1 – Wash hand			
2 – Wear the gloves			
3 – Prepare the equipment			
4 - Explain the procedure to the mother			
During the procedure			
5 - Clean the radiant warmer/ incubator properly before use.			
6 - Switch on the main electrical supply.			
7 - Put the baby sheet on the bed. Arrange all necessary items near the bed.			
8 - Put the radiant warmer on the manual mode with 100% heater output so that the temperature of all items likely to come in contact with the baby, are warm.			
9- Once for radiant warmer is ready. Switch to skin mode with desired setting.			
10 -Read temperature on display. Abdominal skin temperature should be 95.9% to 97.7 F (35.5o to 36.5o)			
11-Tape the probe onto the infant's abdomen b/w the umbilicus and xiphoid process in supine position and groin area in prone position.			
12 -Note the length of time of the radiant waves.			

13- Maintain the fluid and electrolyte balance with 30% extra fluid.			
14 - Place only one baby under each radiant warmer.			
15-Check the temperature of the warmer and of the room every hour and adjust the temperature setting accordingly. Record the heater output in each shift (every 6 hours).			
16 - Move the baby with the mother as soon as the baby no longer requires frequent procedures and treatment.			
After procedure			
17 – Wash hand			
18 – Put the enfant in comfortable position			
19 – Record and report any abnormality			

Supervisor signature……..

Total Score:

……/19