AOHS Health Careers Exploration

Lesson 10

Providing Patient Care

Student Resources

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| Resource | Description |
| Student Resource 10.1 | Ordering Procedural Steps: Changing a Wound Dressing |
| Student Resource 10.2 | Presentation Assignment Sheet: Training Patients in Wound Care |
| Student Resource 10.3 | Note Taking: Infection Control in a Hospital |
| Student Resource 10.4 | Reading: Infection Control in a Hospital |
| Student Resource 10.5 | Lab: Sterile Glove Procedure |
| Student Resource 10.6 | Reading: Nurse Charting |
| Student Resource 10.7 | Practice: Nurse Charting |
| Student Resource 10.8 | Lab: Dressing a Wound |
| Student Resource 10.9 | Culminating Project: Professional Profile Sheets |

Student Resource 10.1

Ordering Procedural Steps: Changing a Wound Dressing

Student Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: Below is a list of the various steps involved in removing the dressing, or bandage, on a wound; cleaning the wound; and applying a clean dressing. The steps are not in the right order. Read through them with a partner, and then predict the proper order using what you already know. Write a number 2 through 12 next to each instruction to indicate the correct order. The first step is numbered for you as an example.

\_\_\_Observe the exposed wound and make sure that it shows signs of healing. If you observe anything unusual, report it to your supervisor or the patient’s doctor when you have completed all steps in the procedure.

\_1\_ Begin by reading the doctor’s orders.

\_\_\_Screen the area the patient is in to create privacy for the patient. Expose the patient’s body part that has the wound dressing.

\_\_\_It’s time to clean the wound. Remove your gloves and discard them. Wash your hands. Then put on a new pair of disposable gloves. Pick up the gauze sponge. Cleanse the wound with it using a circular motion.

\_\_\_Tear off the tape you will need later to secure the clean dressing. Place the tape in an area where you will have easy access to it. Then put on disposable gloves.

\_\_\_Next, apply a clean dressing. Take the sterile dressing and place it lightly on the wound. The dressing should be centered on the wound. Place the tape over the dressing at the proper angle. Make sure that the dressing is secure and the ends are closed. Check to make sure the patient is comfortable.

\_\_\_Introduce yourself to the patient and explain the procedure.

\_\_\_After you have completed applying the clean dressing, remove your gloves and thoroughly wash your hands.

\_\_\_Finally, record on the patient’s chart the date, time, dressing change, amount and type of drainage, and any other important information.

\_\_\_Thoroughly wash your hands, and then on a sterile tray assemble the sterile equipment you will need to change the dressing.

\_\_\_Gently but firmly remove the tape from the soiled dressing. Discard it in the waste bag. Lift the dressing carefully. Note any drainage on the dressing, including the type, color, and amount.

\_\_\_Discard the soiled dressing in the waste bag.

Student Resource 10.2

Presentation Assignment Sheet: Training Patients in Wound Care

Directions: Imagine that you are a team of nurse educators who work in a hospital. You and your coworkers are preparing a presentation that you will deliver to a group of patients and caregivers. The patients all have minor pressure ulcer wounds that are in the process of healing, and they are being discharged from the hospital. At home, the patients or their caregivers will be responsible for dressing and cleaning their wounds.

Your teacher will assign your group one of the following parts of the presentation. (The parts will be presented to the audience in this order.)

* How infection spreads
* Preventing infection
* How to undress and clean a wound
* How to dress a wound
* Signs that your wound is healing
* When you should call your doctor

Before you begin work on your presentation, read through this entire resource, including the assessment criteria. Make sure you are clear on how your work will be assessed.

Step One

Collect information throughout the lesson that will help you develop your presentation. Use the chart below to make your notes.

|  |  |
| --- | --- |
| Group 1: How infection spreads | Notes |
| Common causes of infection at home |  |
| Reasons it’s important to prevent infection |  |

|  |  |
| --- | --- |
| Group 2: Preventing infection | Notes |
| Infection prevention techniques at home for the patient |  |
| Infection prevention techniques at home for the caregiver |  |
| Group 3: How to undress and clean a wound | Notes |
| Steps to undress a wound |  |
| Equipment and steps to clean a wound |  |
| Group 4: How to dress a wound | Notes |
| Steps and equipment to dress a wound |  |
| How often to change the dressing on a wound |  |

|  |  |
| --- | --- |
| Group 5: Signs that your wound is healing | Notes |
| What a healing wound might look like |  |
| What a healing wound might feel like |  |
| Group 6: When you should call your doctor | Notes |
| Signs that your wound may not be healing properly |  |
| Symptoms of infection |  |

Step Two

After you collect your information, follow the instructions below to create a PowerPoint presentation to present to patients and their caregivers. Read all of the instructions before you begin work, and review the assessment criteria.

1. The purpose of your presentation is to provide the patients and caregivers with information about wound care. With your group, review the notes that you have taken throughout the lesson. Discuss information that you think is important to include in your presentation.
2. Your target audience is patients with healing wounds and their caregivers. Make sure as you create your presentation that you keep your target audience in mind. Deliver information simply and clearly. Remember, you are educating your audience about caring for a wound, and if they don’t understand your instructions, it could result in them developing medical issues, such as an infection.
3. Create an outline for your PowerPoint presentation. You can use as many slides as your group thinks is necessary, but your presentation should not exceed four minutes. As you work on your outline, identify information that you might still need to research on the Internet.
4. Decide which member of your group will be responsible for researching, writing, designing, and presenting which slides in your presentation. Each group member must be responsible for at least one slide.
5. If you think it might strengthen your presentation, you can choose to demonstrate an activity as part of your presentation. If this is the case, decide what supplies you need and who will be responsible for each part of the demonstration.
6. Begin your research and writing. If you are unsure about the validity of a particular Internet site you are using for research, ask your teacher to verify it.
7. When you have finished writing and designing your slides, as a group review the slides in your presentation using the following checklist. Make sure that the information flows smoothly from one slide to the next. Then make any necessary edits to improve your group’s presentation.
   * The slide is simple and easy to read.
   * The information on the slide stays on topic.
   * This slide is visually interesting. Charts, diagrams, illustrations, or photographs that are appropriate for the topic are used and relevant source citations are included.
   * Information on the slide is organized with headings and bullet points.
   * The slide is clearly geared toward the target audience.
   * The information on the slide is accurate and factually correct.
8. As a group, practice presenting your slides and demonstration, if you chose to include one in your presentation. Give each other feedback about presentation issues, such as eye contact or the speed at which you deliver the information. Your presentation should not exceed four minutes.
9. Carefully review your presentation with your group to make sure that it meets the assessment criteria given below.

Make sure your presentation meets or exceeds the following assessment criteria:

* The presentation uses language and graphics geared toward the target audience of patients and caregivers.
* The information presented is organized in a logical order.
* The presentation gives clear, accurate instructions, explanations, and demonstrations that will be easy for patients to follow.
* The presentation is visually engaging, with effective use of diagrams, charts, illustrations, photographs, and demonstrations.
* The presentation uses proper spelling and grammar.
* The presenters communicate the information clearly; they make eye contact with the audience and avoid reading the slides word for word.

Student Resource 10.3

Note Taking: Infection Control in a Hospital

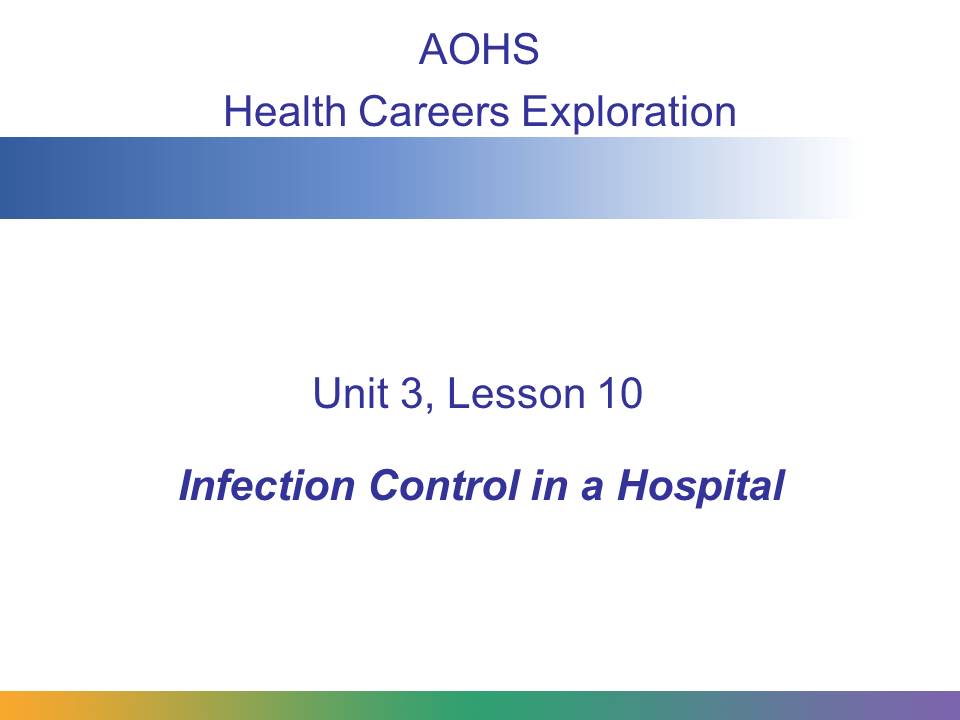
Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: During the presentation Infection Control in a Hospital, take notes on the chain of infection using the chart below. Then, in the space below the chart, take notes on ways that health care workers break the cycle of infection.

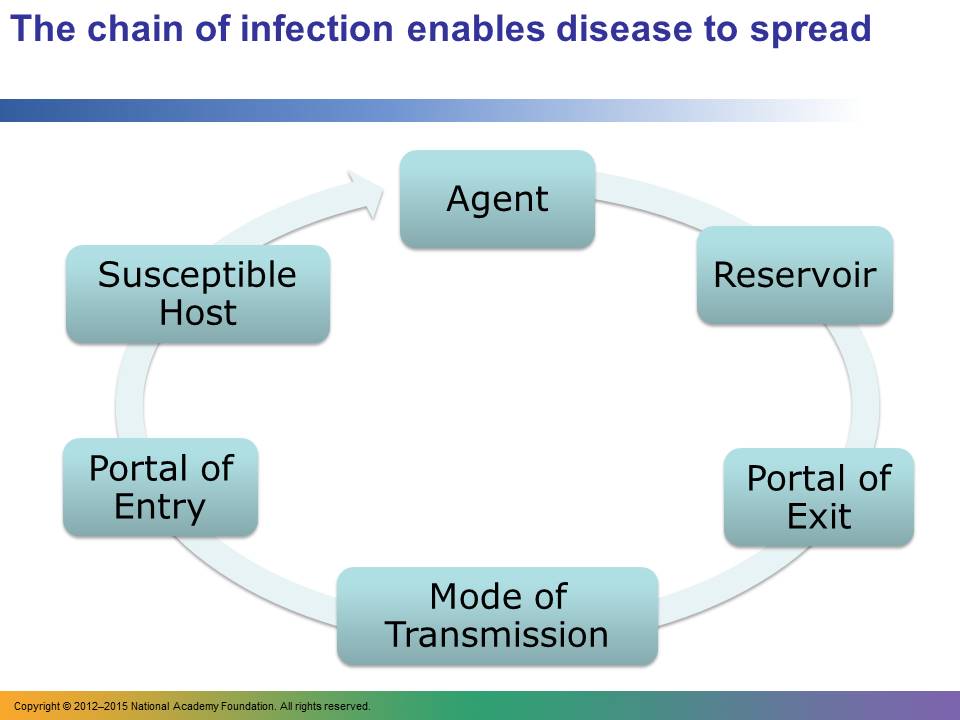
Ways that health care workers break the chain of infection:

Student Resource 10.4

Reading: Infection Control in a Hospital

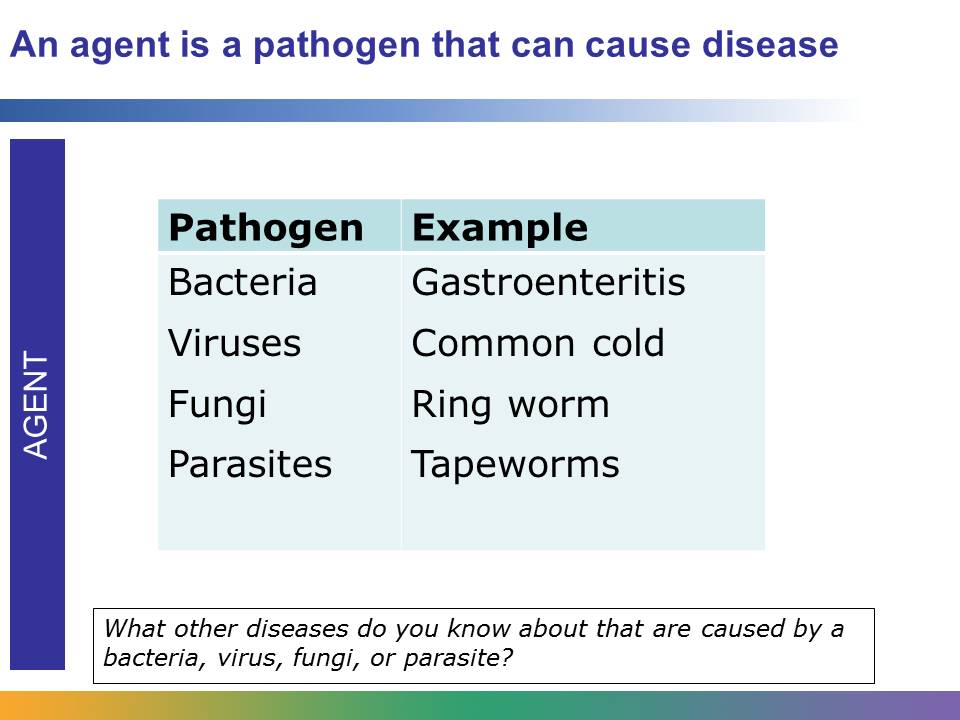


The chain of infection refers to the conditions that must be met for disease to spread from one person to another. In this presentation we’re going to look at the different parts of the chain of infection and explore the ways that health care professionals in a hospital setting work to break the chain.

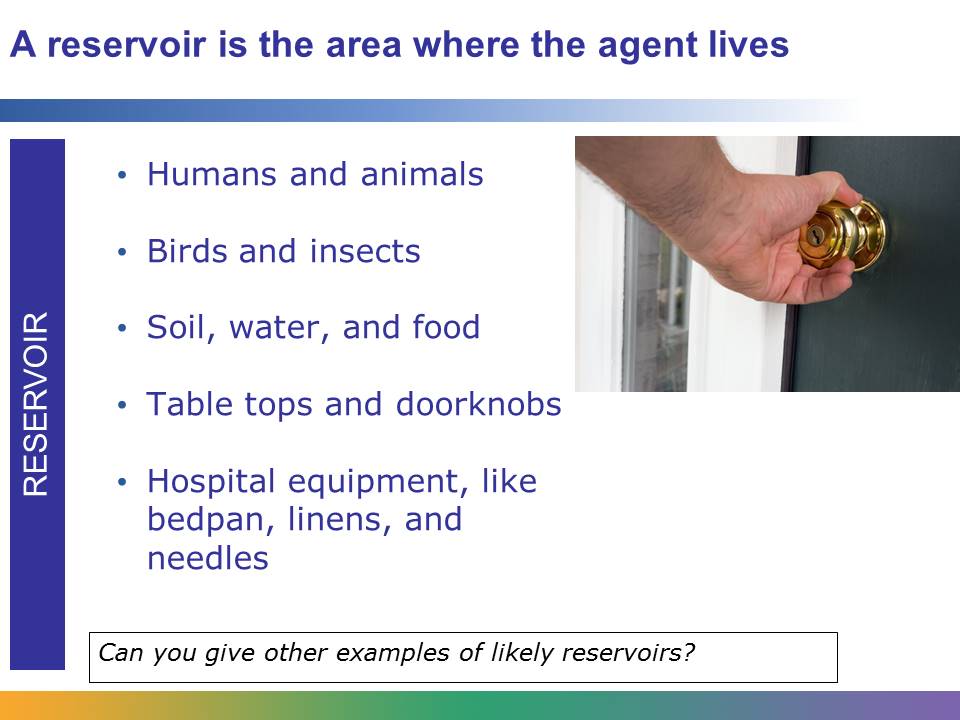


The spread of disease doesn’t just spontaneously happen. There is a process of events that enables infection to spread from one person to another. This process is called the chain of infection. There are six parts of the chain: an agent, a reservoir, a portal of exit, a mode of transmission, a portal of entry, and a susceptible host. If the chain is broken at any one of these links, infection will not occur.

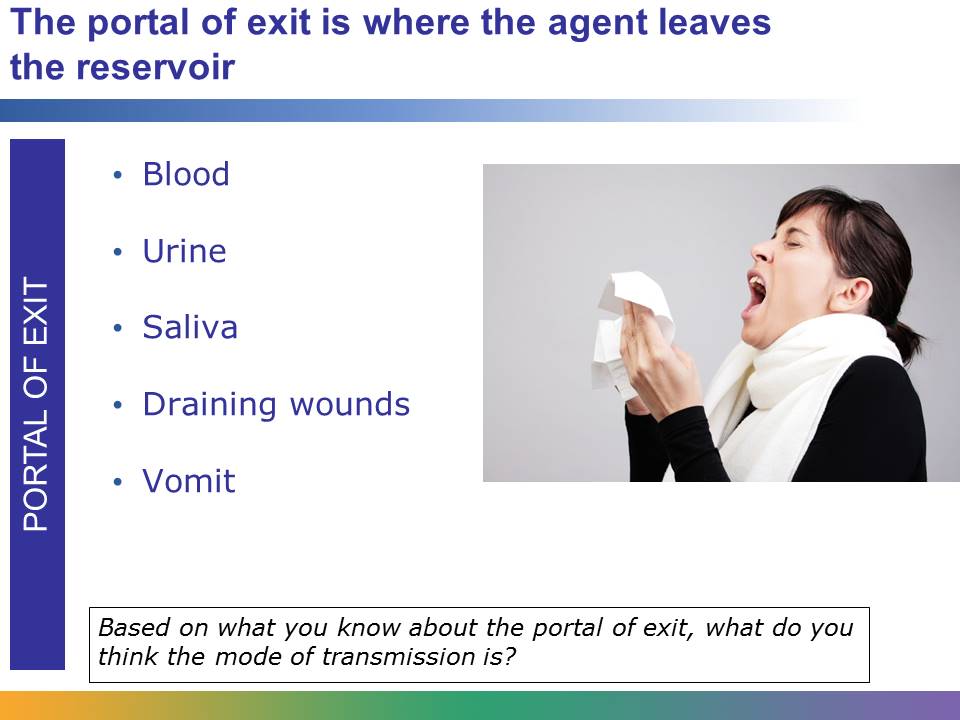
A very important responsibility of all health care workers in a hospital is to understand each link in the chain and to take measures to break the chain. Breaking the chain of infection protects hospital workers, patients, and visitors.



An agent is a pathogen that has the capability of causing disease or infection. Infectious agents (or pathogens) are bacteria, viruses, fungi, and parasites. Infectious agents can cause many types of disease and infection. For example, fungi can cause tinea, or ringworm, which is a skin infection. Bacteria can cause gastroenteritis, which causes inflammation of the stomach and intestines. Viruses are smaller than bacteria. Viruses can cause the common cold. Parasites can cause tapeworm infections.



A reservoir is the place where pathogens live. Agents thrive and reproduce in humans, animals, birds, and insects. For example, the influenza virus can live in humans, and typhus can live in the fleas of rodents. Agents can also live on inanimate objects, like water, food, table tops, linens, and doorknobs. Hospital equipment, like bedpans and needles, can also be a reservoir.



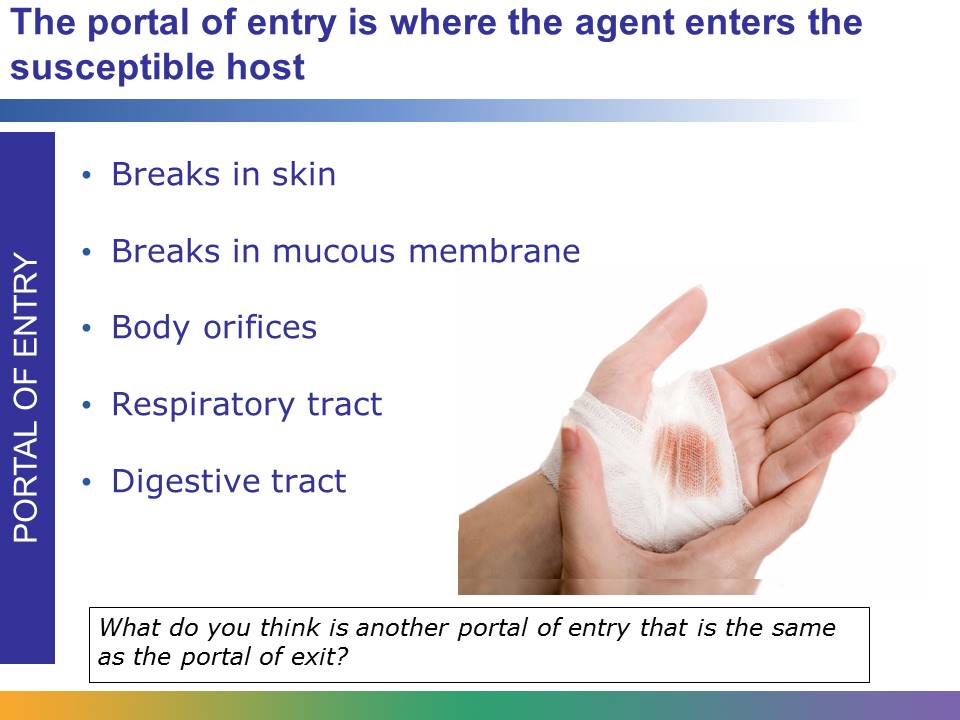
The portal of exit is where the agent leaves the reservoir. In the human body there are many ways for an agent to leave, including through blood, urine, vomit, saliva, and draining wounds. Pathogens frequently escape the human body through the nose or mouth when people sneeze or cough. This is called droplet transmission.



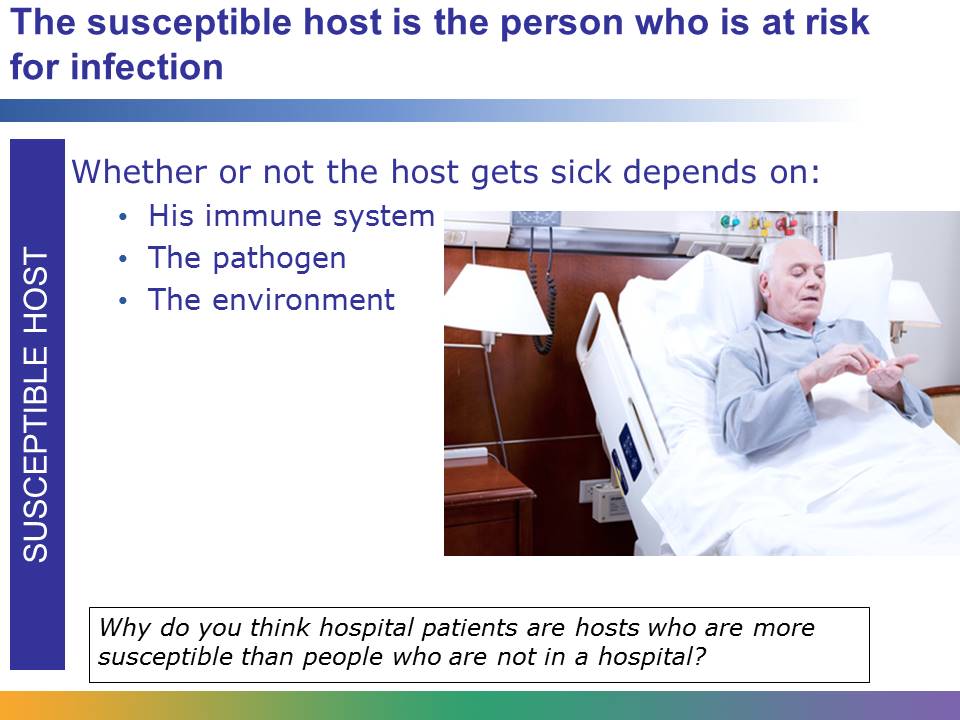
Once the agent has exited the reservoir, it needs a way to move. This is called the mode of transmission. The mode of transmission is the way that the pathogen is moved from one place to another.

Imagine another reservoir: a contained body of water. Water leaves the reservoir through canals. The mode of transmission is like the canals. It is the way that the pathogen leaves the reservoir and moves to another place.

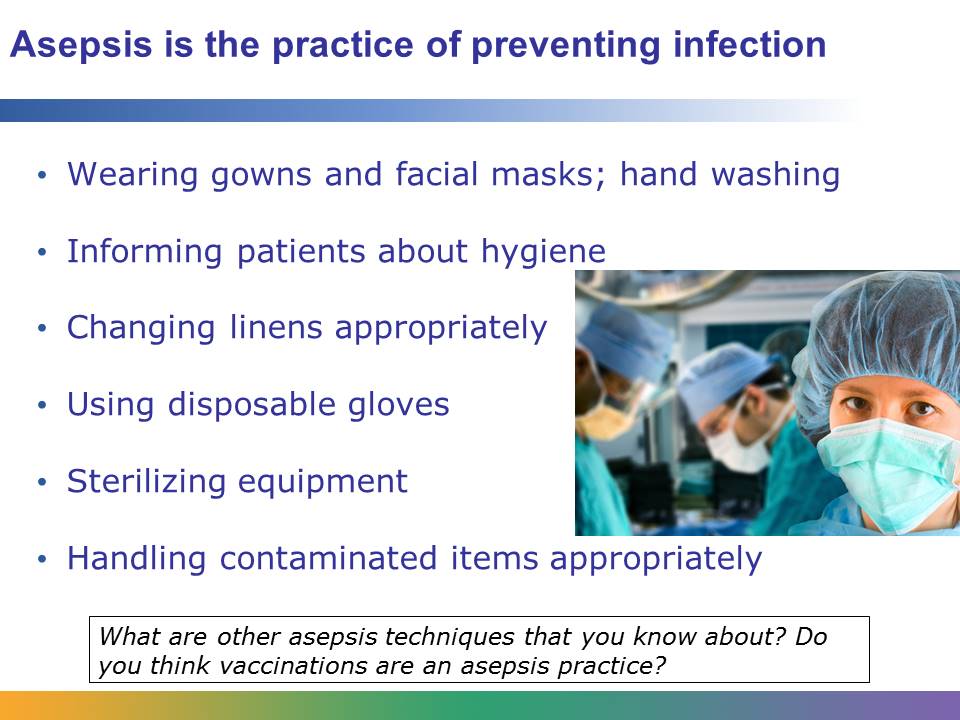
Contaminated hands are one of the most common means by which pathogens move. Air is another mode of transmission. If a person sneezes, air serves as the mode of transmission, carrying the contaminated droplets. Other modes of transmission include the clothing of health care workers, used tissues, and contaminated surgical equipment. Insects are also a mode of transmission. For example, mosquitoes can carry malaria and West Nile virus.



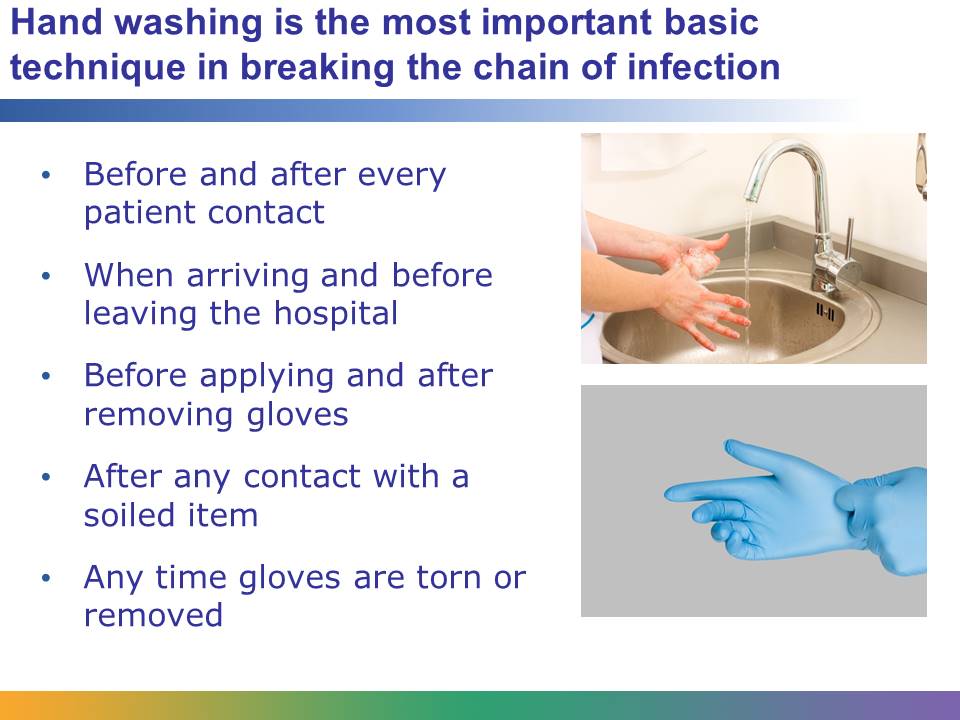
The portal of entry is where the agent enters the susceptible host. It is often the same place from which the agent exited the reservoir. For example, if a pathogen leaves one person’s body when he sneezes, it may enter another person’s body as she breathes through her nose. Portals include body orifices, or openings, like the nose and mouth; mucous membranes found at places like the nostrils, eyelids, and lips; breaks in the skin, such as through a needle; the respiratory tract; and the digestive tract.



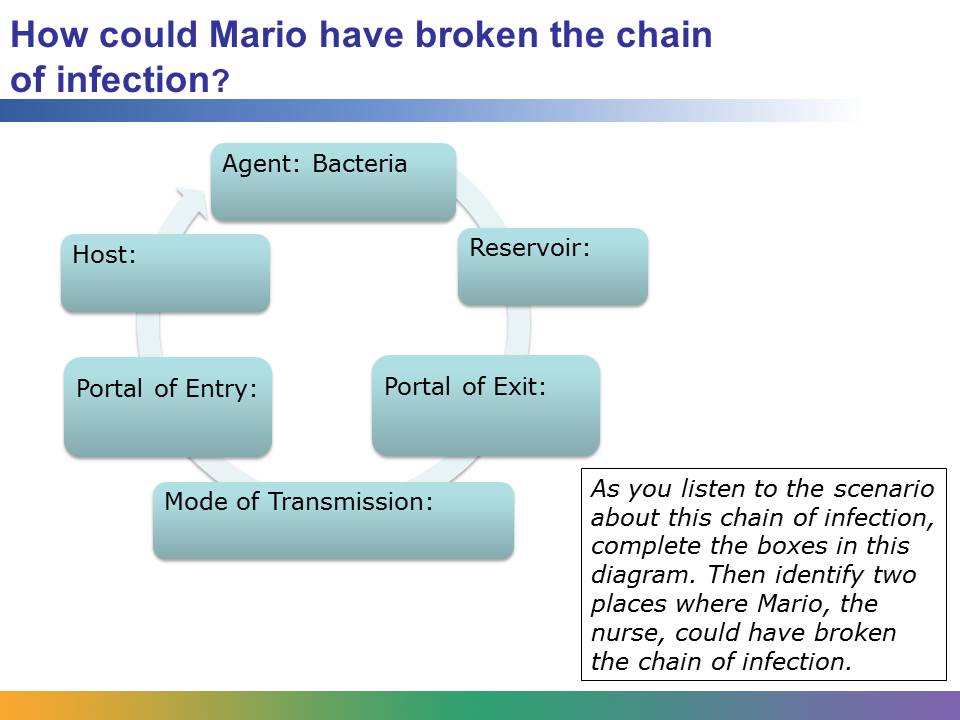
The susceptible host is the person who is at risk for getting infected by the agent. Just because an agent enters a new host doesn’t mean that person is going to get sick. If the person is healthy and has a strong immune system, he may be able to fight off the agent. Whether or not a person gets sick depends on his immune system and the pathogen. It also depends on the environment. For example, if the susceptible host is in an environment where he is breathing contaminated air and is exposed to more than one agent, his body may have a harder time fighting off the agent.



Health care workers in hospitals use a practice called asepsis to break the chain of infection. By practicing asepsis, health care workers protect both themselves and patients from getting infected. This practice includes techniques such as wearing gowns and facial masks, hand washing, and providing patients with information about basic hygiene. Techniques also include using a detailed process for changing linens on hospital beds, using disposable gloves when contacting body secretions, and properly cleaning and sterilizing equipment. Asepsis also involves appropriate handling and discarding of contaminated items.



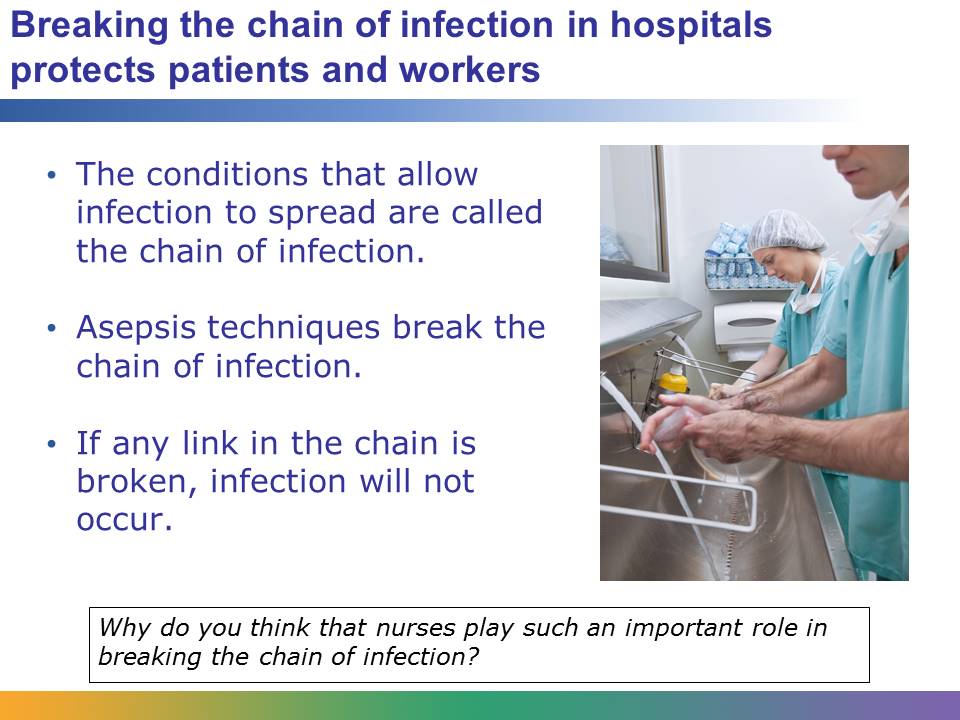
Hand washing by both health care workers and patients is the most important basic asepsis technique in preventing infections from spreading. Health care workers should wash their hands frequently. There are many times in the daily routine of a health care worker when hand washing is necessary, which include before and after every patient contact, when arriving and before leaving the hospital, before applying and after removing gloves, after any contact with a soiled item, and any time that gloves are torn or removed.



Mario, an LPN, was changing the dressing of a wound on Tara’s leg. He used the proper asepsis technique to change the dressing. After he was finished, he removed his gloves and then washed his hands. Then he noticed that he had left a piece of the soiled dressing outside of the waste bag. He picked it up and deposited it into the waste bag, and then he left to visit his next patient, Amanda. The RN asked Mario if he could help change Amanda’s catheter, a tube that drains urine from the bladder, and he got right to work.

In this scenario the agent is a bacteria living in Tara, who is the reservoir. The portal of exit for the agent is the wound on Tara’s arm. After Mario changed the dressing, he picked up the soiled dressing with his bare hands and didn’t clean them after. At that point, Mario’s hands became the mode of transmission. His hands became the way that that the bacteria would move from Tara to the host. In the scenario, Amanda is the susceptible host. The portal of entry for the pathogen entering Amanda’s body is the end of the catheter that Mario is handling with contaminated hands.

If Mario had washed his hands after touching the soiled dressing or used gloved hands to pick up the dressing, he could have broken the chain of infection. He had another opportunity to break the chain of infection. He could have washed his hands before he began the procedure in Amanda’s room.



All professionals who work in hospitals are trained to understand and break the chain of infection. It is one of the most important hospital procedures. By breaking the chain of infection they protect patients, their colleagues, and themselves.

Student Resource 10.5

Lab: Sterile Glove Procedure

Directions: Below is a set of instructions for putting on sterile gloves. Before beginning, read through all steps of the procedure. Then follow the steps in order.

1. Remove rings and watch, and then wash and dry your hands thoroughly.
2. Place the package of gloves on a clean, dry surface. Have the cuffed end of the gloves face you.
3. Open the gloves package by peeling the outer envelope wrap. Do not touch the inside of the wrapper.
4. From the sides, reach in to open the inner package. This will expose the sterile gloves. The right-hand glove will be on the right side. The left-hand glove will be on the left side.
5. Carefully pick up the first glove by grasping it on the top edge of the folded-down cuff.
6. Hold the glove by the cuff. Then slip the opposite hand into the glove with your fingers pointed downward. Wiggle your fingers until they fit firmly into the finger holes. If the glove rips or tears, start the procedure over with a new pair of gloves.
7. Once the first hand is gloved, slip the gloved fingers under the cuff of the second glove. Lift it from the package.
8. Insert the other hand into the glove while holding the gloved hand under the cuff. Wiggle your fingers until they fit firmly into the finger holes. Now both hands should be gloved.
9. To position the gloves correctly, interlace the fingers of your hands. Make sure not to touch your gloved hands with the skin of your wrist or forearm, or with anything that is not sterile. If the gloves become contaminated, begin the process again with a new pair of gloves.
10. Once your gloves are on properly, do not touch anything that is not sterile.
11. If you are using Glo Germ to check for contamination, follow your teacher’s instructions to find out if your gloves are sterile or contaminated.

Student Resource 10.6

Reading: Nurse Charting

One of a nurse’s most important responsibilities is to thoroughly chart, or document and record, every interaction a nurse has with a patient. Hospitals, long-term care facilities, and medical offices have different policies and procedures that nurses follow when charting. However, all charting done by nurses must be an accurate account of a nurse’s observations, decisions, actions, and the results of the actions. Charting is a complex subject that nurses receive training in, both in college and at the facility where they work. Nurses use different tools when they chart. These tools include worksheets, checklists, and care plans, which may be paper or electronic.

More and more health care facilities are using electronic medical records, or EMRs. Experts believe that having a patient’s medical information in one centralized digital location that is accessible by the patient’s interdisciplinary team improves both the quality of care the patient receives and the convenience for the nurses and other health care providers. They think EMRs decrease the likelihood for error caused by ineligible handwritten charting and other human mistakes. This image shows one screen from a patient’s EMR.

|  |
| --- |
| ::::Untitled.png |

The Importance of Charting

Charting is important because it helps nurses meet legal standards. It is also important because it allows nurses to communicate with each other and with doctors. It ensures that patients receive continuous care, or uninterrupted care.

Imagine this scenario: a nurse administers a dose of a strong pain medication to a patient but she fails to document it on the patient’s paper chart. Her shift ends and she goes home. The next nurse on duty reviews the patient’s chart. This new nurse sees that the physician ordered that the patient be given the pain medication. But there is no note that the patient ever received the medication. So the new nurse administers the medication again. The consequences of a patient receiving an unnecessary dose of medication are serious. It could harm the patient, and the hospital and nurse responsible could face legal action or penalty.

The Patient’s Record

The information that a nurse charts is usually part of the patient’s record. The hospital, clinic, or doctor’s office owns the record. But patients have the right to access any information in their records.

The information in patient records is confidential, or private. Legally medical records must be maintained and kept for a required amount of time, which is usually between 6 and 10 years depending on state law. When that time has expired, the records must be destroyed completely so that no one can access them. Paper records should be shredded, not deposited into a recycling bin.

Information to Chart

The information that nurses chart is varied and depends on the patient’s condition, the facility, and the type of interaction the nurse has with the patient. For example, when a patient is first admitted to a hospital, the nurse will likely document information that includes the following:

* A history of the patient’s problem
* All injuries and illnesses the patient has
* The patient’s allergies, including allergies to medications
* Current medications that the patient takes
* The last time the patient ate food or drank fluids
* Details about the patient’s emergency contact
* The patient’s vital signs

A nurse who is providing care to a patient who has been hospitalized for several days will likely document the following:

* The patient’s current symptoms, often using the patient’s own words
* Any new symptoms or conditions, such as if the patient has an elevated temperature or is refusing to eat
* The patient’s vital signs
* Actions the nurse takes to respond to one of the patient’s problems, such as readjusting the patient so that he or she is more comfortable
* What the patient has eaten
* When the doctor examined the patient and what happened
* The nurse’s observations

Subjective and Objective Observations

The nurse will record both subjective and objective observations. A subjective observation cannot be seen or measured by a nurse. It is often a statement that the patient makes about the way that he or she feels. For example, if a patient says, “I feel warm and my eyes are burning,” the nurse will record that subjective information.

Objective observations can be seen or measured by the nurse. For example, temperature can be measured. Swelling, rashes, bruises, or wounds can be seen.

Imagine that a patient tells a nurse that he feels itchy and uncomfortable. The nurse then examines the patient and observes rashes on his stomach. The rash is an objective observation. An appropriate note in his record might say, “Mr. L is complaining of ‘feeling itchy and uncomfortable.’ The skin on his abdomen is red and swollen.”

Narrative Documentation

Nurses use different methods for charting information. One method is called narrative documentation. Using this method, nurses record events relating to a patient in chronological order over a period of time. Nurses create a narrative, or the whole story, of the care given to a patient. Narrative documentation can be used to assess a client before and after medication, to report information given to a physician, or to indicate instructions given to a patient’s family. Narrative documentation can stand alone or it can accompany another tool like a flow sheet or checklist.

Below is an example of narrative documentation. Notice that the date is given. The time for each entry is also given, and the entries are written in chronological order. Also notice that each entry gives a brief summary of what occurred with the patient at that time and that the nurse signed his or her name after each entry.

**Nurse’s Progress Record**

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
| 3/5/12 | 1230 | Physical Therapist at bedside with Mrs. K. for ordered PT. Mrs. K. says she feels “comfortable” at this time.  –P. Smith, RN- |
|  | 1245 | After PT session, Mrs. K denies pain. Rates pain 0/10.  –P. Smith, RN- |

Abbreviations

In the first entry above, the nurse uses the abbreviation PT, which stands for physical therapy. Nurses are required to use abbreviations when they chart. Each medical facility uses different abbreviations, but here are some common ones.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Abbreviation** | **Meaning** |  | **Abbreviation** | **Meaning** |
| BID | twice a day |  | MN | midnight |
| CBR | complete bed rest |  | oint | ointment |
| DOB | date of birth |  | P | pulse |
| DX | diagnosis |  | QD | every day |
| Ex | examination |  | q3h | every 3 hours  ("q" for *quaque*, which means "every" in Latin) |
| FBW | fasting blood work |  | R/O | rule out |
| FH | family history |  | tab | tablet |
| HOH | hard of hearing |  | TID | three times a day |
| HS | at bedtime |  | VS | vital signs |
| inj | injection |  | w/c | wheelchair |

Charting Checklist

Here is a list of general guidelines that nurses follow when they chart using paper records. (A different set of guidelines applies for electronic charting.)

* Write the date and time for each entry. The time should be given in military time. For example, 9:23 a.m. should be written as 0923, and 2:04 p.m. should be written as 1404.
* Entries should be legible.
* The nurse should sign each entry with his or her first initial, last name, and title. The signature should be on its own line at the end of each entry.
* Entries should always be in black ink because this is best for copying.
* A single line should be drawn through errors. The reason for the deletion must be noted, and deletions must always be initialed and dated. White out should never be used.
* Only abbreviations and symbols that have been approved by the facility should be used.
* No slang should be used, unless it is part of a patient’s quote.
* Information in entries should be clear and concise.
* Vague terms, like “good” or “normal,” should not be used.
* There should be no spelling or grammar errors.
* Something that has not happened yet should not be documented. For example, a nurse who is going to administer Tylenol, should not document it until the patient is given the medication.

Student Resource 10.7

Practice: Nurse Charting

Student Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: After you have completed reading Student Resource 10.6, Reading: Nurse Charting, complete this resource based on the information in the reading. You may look back to the reading while you work.

Explain one reason why charting is important.

Who owns a patient's health records? What rights do patients have regarding their records?

Read the following scenario. Then, take on the role of the nurse. Fill in the line of the patient’s chart below with the pieces of information from the scenario that are necessary to chart. When possible, use the correct abbreviations.

On March 6, 2010, at 3:45 p.m. a mother and her child interacted with a nurse. The mother told the nurse, “My son is refusing milk and food.” The nurse asked the mother if the child had any allergies that she knew about. The mother said no. The nurse saw that the child’s face looked flushed. She took his temperature. It was 102°.

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
|  |  |  |

Decide if each observation given in the chart is subjective or objective.

|  |  |
| --- | --- |
|  | Subjective or Objective |
| There is a blue bruise under the patient’s eye. |  |
| The patient complains of a stomach ache. |  |
| The patient’s temperature is 100°. |  |

Use what you have learned to guess the meaning of the following abbreviations.

q2h:

DOD:

Review the following narrative documentation. Then in the space below explain six problems with the report.

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
|  | 3:00 p.m. | Mr. P appears well, but he says that he feels worse than last time. |
|  | 2:45 p.m. | Will give meal to Mr. P in one hour. –Martin Roth, RN- |

1.

2.

3.

4.

5.

6.

Student Resource 10.8

Lab: Dressing a Wound

Student Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: In your group, decide who will play the following roles: nurse, patient, and observer. Then read through the scenario below and the instructions for cleaning and dressing a wound. After you have reviewed the steps, do the procedure. As the nurse works, the observer should offer the nurse verbal feedback about misinterpretations, errors, or steps done out of order. Then switch roles and complete the procedure again. Continue until each member of your group has played each role.

**Scenario:** The patient has a wound on his or her inner arm from a piece of broken glass. The nurse follows the steps below to properly clean the wound, dress it, and then chart the interaction.

1. Assemble the necessary equipment on a tray: normal saline solution in a small dish, two pairs of gloves, tape, a sterile dressing, a gauze sponge, and an infectious waste bag.
2. Wash your hands using the proper procedure.
3. Introduce yourself to the patient and explain the procedure for dressing a wound.
4. Tear off the tape you will need later to secure the clean dressing. Place the tape in an area where you will have easy access to it.
5. Put on gloves using the proper procedure (see Student Resource 10.5, Lab: Sterile Gloves Procedure).
6. Observe the wound. This type of wound is called an incision. The edges of the skin should look smooth and neat. Report unusual observations to the patient’s physician. Unusual observations include bright red blood, swelling, pus, or patient complaints of dizziness.
7. Place the gauze sponge in the saline solution, and then squeeze to remove any excess solution. Clean the wound using a circular motion. Begin near the center of the wound and move outward. Do not clean directly over the wound. When you’re done, discard the gauze sponge.
8. Discard your gloves. Wash your hands. Put on a new pair of gloves using the proper procedure.
9. Lift the sterile dressing and place it lightly on the wound. The dressing should be centered on the wound. Place the tape over the dressing along the sides. The tape should be long enough to hold the dressing in place but not so long that it will irritate the patient’s skin. Make sure that the dressing is secure and the ends are closed.
10. Make sure the patient is comfortable. Remove and discard your gloves. Wash your hands.
11. Chart the interaction by indicating what you used to clean the wound, that a sterile dressing was applied, and any observations you made about the wound. Remember to sign the entry properly.

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| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
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Student Resource 10.9

Culminating Project: Professional Profile Sheets

Directions: Follow the steps below to organize your group work on professional profile sheets and determine which sheet you will submit for assessment. If you need a blank form to start a new professional profile sheet, refer to Student Resource 6.5, Culminating Project: Professional Profile Sheet, from Lesson 6.

1. In your group, review the professional profile sheets that you have already completed:
   * Identify any sheets that are incomplete or need revisions
   * Identify professional profile sheets that still need to be written.
2. Review the interviews, notes from guest speakers, readings, and presentations from this unit, and determine what information needs to go into the professional profile sheets.
3. Decide as a group which of your professional profile sheets you would like to submit for assessment, and determine what work needs to be done to complete that sheet and meet the assessment criteria given below.
4. Decide which group member is going to do what work to complete the sheets, and write down the work assigned to each group member.

Make sure your assignment meets or exceeds the following assessment criteria:

* The information on the professional profile sheet reflects an in-depth understanding of the professional’s roles, responsibilities, skills, education, and training.
* The interactions the patient will have with this professional are clearly described.
* The information is accurate and comes from reliable sources.
* The information has been compiled from multiple sources, such as interviews, readings, reliable Internet sites, and guest speakers.
* The professional profile sheet is neat and uses proper spelling and grammar.