Federal State Budgetary Educational Institution of Higher Education «Kuban State Medical University" of the Ministry of Healthcare of the Russian Federation.

Department of Propaedeutics of Internal Diseases

General therapeutic care manipulation algorithms

Toolkit

Krasnodar, 2020

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Methodical manual “Algorithms of manipulations for therapeutic care”. - Krasnodar - 2020

The manual is intended for students of 1-2 courses of medical and medical and preventive faculties. It is called upon to systematize knowledge and optimize skills in the simplest medical manipulations.

Recommended for publication by the CMS KubSMU, protocol No. _____ of _____

Kuban State Medical University

TABLE OF CONTENTS:

Hygienic hand treatment (disinfection):

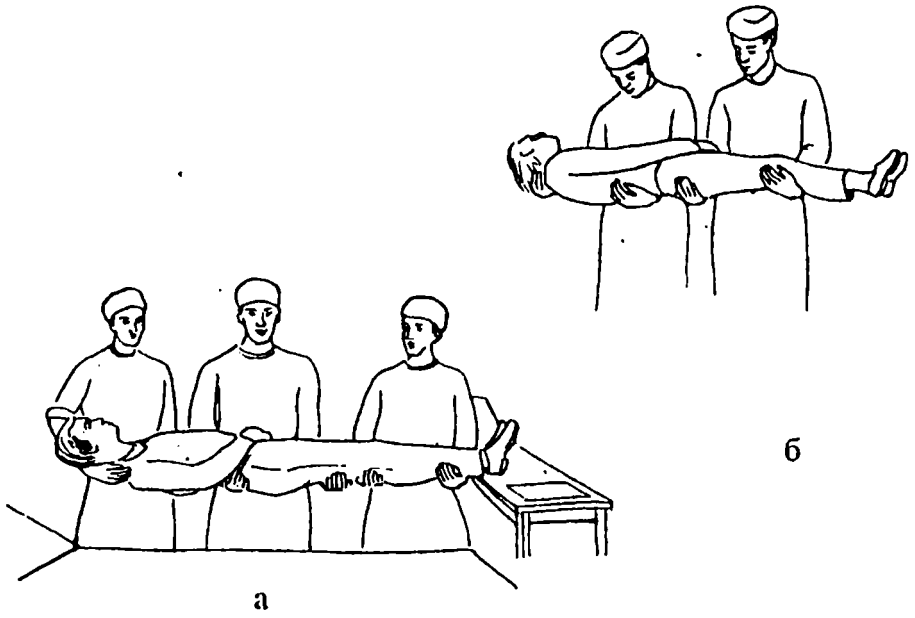
Indications: before performing invasive procedures, before caring for patients with weakened immunity, before putting on and after removing gloves. After wound care and work with a urinary catheter, after contact with body fluids, or after possible microbial contamination.
Prepare: toilet soap, a faucet with water, a cloth or paper towel, scissors and a nail file, sterile wipes, 70 ° ethanol, 0.5% alcohol chlorhexidine, 2.4% solution of first-moor, sterile surgical gloves.
Sequencing:
1. Perform a household level of hand processing.
2. Dry your hands with a sterile cloth.
3. Take a napkin moistened with 70 ° ethanol or 0.5% alcohol chlorhexidine, and treat your hands - sequentially, symmetrically, stepwise, punctually, that is:
- alternately process the fingers of the left and right hands,
- alternately process the palm and back surfaces of the left and right hands,
- alternately process the lower third of the forearm left and right,
- alternately process the middle third of the forearm left and right.
4. The treatment is carried out for 3 minutes for 1.5 minutes with two napkins.
3. Dry your hands with a sterile cloth.

Transportation and transfer of a therapeutic patient:

By transportation is meant both the transportation and transportation of the patient to the place of medical care.
The type of transportation is determined by the doctor, the manipulation is performed by two or three with or without the help of the patient.
Purpose: to create maximum peace for the patient when moving him.
Indications: the inability of patients to move independently, the delivery of patients to the operating room and from the operating room to the department.
Prepare: a gurney with a paralon mattress in an oilcloth cover, a clean sheet, a blanket and a pillow.
Before performing the manipulation:
1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation. Gain understanding and consent to its implementation.
3. Ensure confidentiality of manipulation. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.
Sequencing:
1. Prepare the wheelchair for transportation, check its serviceability.
2. Lay a sheet on a gurney and lay a pillow on it.
3. Place the gurney (stretcher) in relation to the couch (bed) at a right angle so that its head end fits the foot end of the couch.
4. Uncover the patient if he is covered.
5. Stand together on one side of the patient: one person puts his hands under the head and back of the patient, the second under the pelvis and knees.
6. Lift the patient and turn with him 90 ° towards the gurney (stretcher).
7. Lower the patient to a gurney (stretcher), give him a comfortable position, make sure he feels comfortable.
8. Cover, tell him a few kind words.
9. Transport it to the compartment with your head forward, and down the stairs (on a stretcher) with your feet forward, lifting the leg end of the stretcher.
10. During transportation, continuously monitor the patient's condition.
11. In the department, carefully transfer the patient to the bed (repeating the manipulation of shifting in the reverse order).

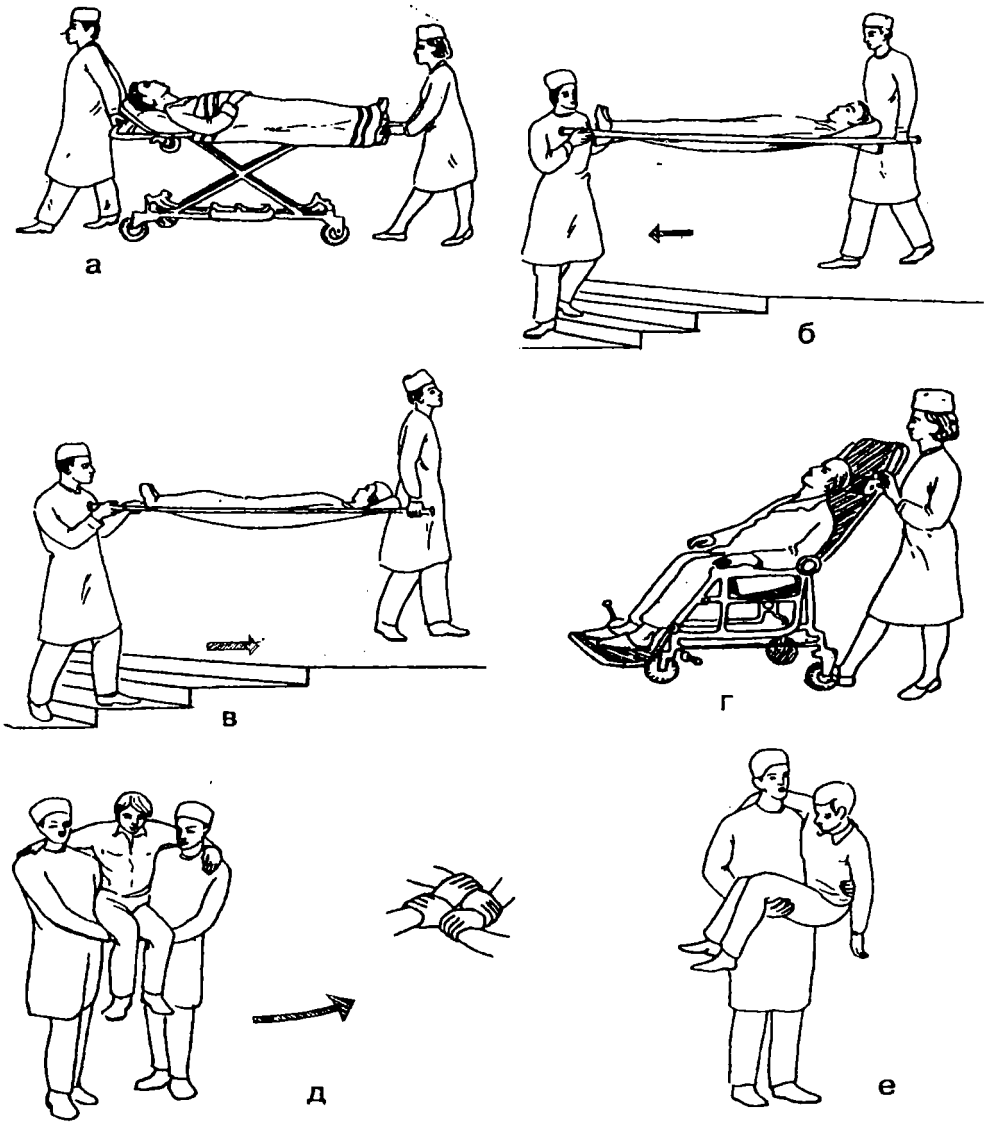
12. Help him lie down more conveniently.
13. Correct the bed.
14. Tell him a few kind words.

Transferring the patient to a stretcher with three (a) and two (b):



Transportation of the patient on a gurney (for two):

1. Check and prepare the gurney for transportation.
2. Lay on a gurney:
a) 1/2 part of the blanket;
b) cover with a sheet;
c) put a pillow;
d) oilcloth with a diaper (if necessary).
3. Place the gurney with the foot part at an angle to the head of the couch or in another way more convenient in this situation.
4. Lift the patient - one nurse puts her hands under the neck and torso, the other under the lower back and legs.
5. Put the patient on a gurney and make sure that he is comfortable lying down.
6. Cover the patient with the other half of the blanket and sheet.
7. Stand at the gurney - one nurse in front of the gurney, the other at the back, but facing the patient.
8. In this position, transport the patient head first to the ward.
9. Place the gurney to the bed as much as the room area allows.
10. Remove the blanket from the bed, unfold the patient and transfer him to the bed in an affordable way.
11. Take care of the patient and make sure that he is comfortable, that he has no requests.
Patient Transportation:

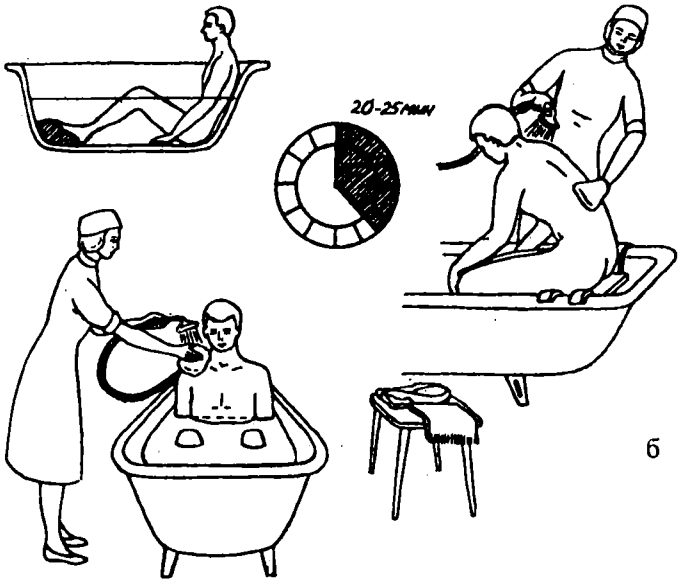


Sanitary treatment of the patient (hygienic bath):

Purpose: prevention of the introduction and spread of nosocomial infections.
Indications: upon receipt of the patient in the admission department and at least once within 7 days - the current hygienic treatment, patient care in violation of physiological functions.
Contraindications: serious condition of the patient, bleeding, trauma, high body temperature, skin diseases.
Prepare: individual disposable washcloth (for body), washcloth (for bath), soap, towel, sheets, thermometer for measuring water temperature, clean linen, containers for dirty linen, disinfectant solutions, pans with the inscription
M clean washcloths 'and рязdirty washcloths', ammonia bottle, bottle with heart drops (corvalol, valocordin).
Bath preparation:
1. Wash the bath with a washcloth and soap and treat with a disinfectant solution.
2. Pour cold water into the bathtub.
3. Add hot water to cold water to a temperature of 38-40 ° C (under the control of a thermometer).
4. Place a cloth napkin on the wooden floor near the bathtub.
5. Check the temperature of the bathroom (25 ° C).
6. Prepare an individual (disposable) washcloth.

Before performing the manipulation:
1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation. Gain understanding and get consent to carry it out.
3. Ensure confidentiality of manipulation.
4. Invite the patient to the bathroom.
5. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.
Sequencing:
1. Help the patient undress.
2. Help him enter the bath.
3. Help to sit comfortably in the bath. Water in the bath should reach the middle third of the patient's chest.
4. Place a wooden stand or bench under the patient's feet if he does not rest his feet on the opposite end of the bathtub or help him sit in a special bath seat.
5. Soap the washcloth with soap.
6. Wash the patient in the following sequence: head, trunk, arms, legs.
7. Help the patient get out of the bath.
8. Wipe it with a sheet or towel in the same sequence.
9. Help put on clean underwear.
10. Say a few kind words to the patient and take him to the ward.
Remember! The duration of the bath should not exceed 20-30 minutes. Particular attention should be paid to the treatment of inguinal areas, perineum, axillary cavities, in women - under the mammary glands. It is also necessary to monitor the color of the skin of the patient and the pulse.
Complications: blanching of the skin, dizziness, poor health, tachycardia.
Assistance for complications:
If the patient became ill while taking a bath, help him get out of the bath, wipe it with a sheet or a towel, put on a couch with a raised leg end, let it smell cotton wool moistened with ammonia. Put a towel dampened with cold water on the patient's forehead.
Depending on the patient's condition and complaints, call a doctor.

Complete sanitization of the patient in the bath (a) and in the shower (b):



Treatment of the patient with the identification of lice:

Purpose: preventing the spread of infection.
Indications: the presence of lice and nits.
Prepare (for yourself):
1. A bottle of shampoo.
2. Extra bathrobe.
3. The scarf.
4. The mask.
5. Gloves.

Prepare (for the patient):
1. The couch.
2. Oilcloth.
3. Rubberized bag for things (2 pcs.).
4. Normal shampoo for washing your hair.
5. Oilcloth pelerine.
6. Bathrobe.

Sequencing:
1. Place an oilcloth on the couch.
2. Put on an extra dressing gown, kerchief, mask, gloves.
3. Shake the shampoo bottle well.
4. Invite the patient to sit on the couch and explain his behavior during the manipulation.
5. Apply undiluted shampoo to the dry hair and skin of the patient, wait until they are completely wet.
6. Leave the shampoo on the surface for the period of time specified in the instructions.
7. Wash hair with warm water and regular shampoo or soap.
8. While the hair is still wet, comb all the knots with a regular comb, divide the hair into 4 strands.
9. Starting from the top of the head, lift one of the 4 strands 2-3 cm.
10. Take a special comb in the other hand and place the cloves as close as possible to the skin of the scalp.
11. Slowly comb from the roots to the ends of the hair, so as to completely comb the full length of the hair strand of 2-3 cm.
12. Pull back the strands that are already combed. continue combing and stabbing until all lice and nits have been combed out (often remove with a piece of gauze nits that accumulate on the comb).
13. When all hair is combed, rinse it with warm running water and ordinary shampoo.

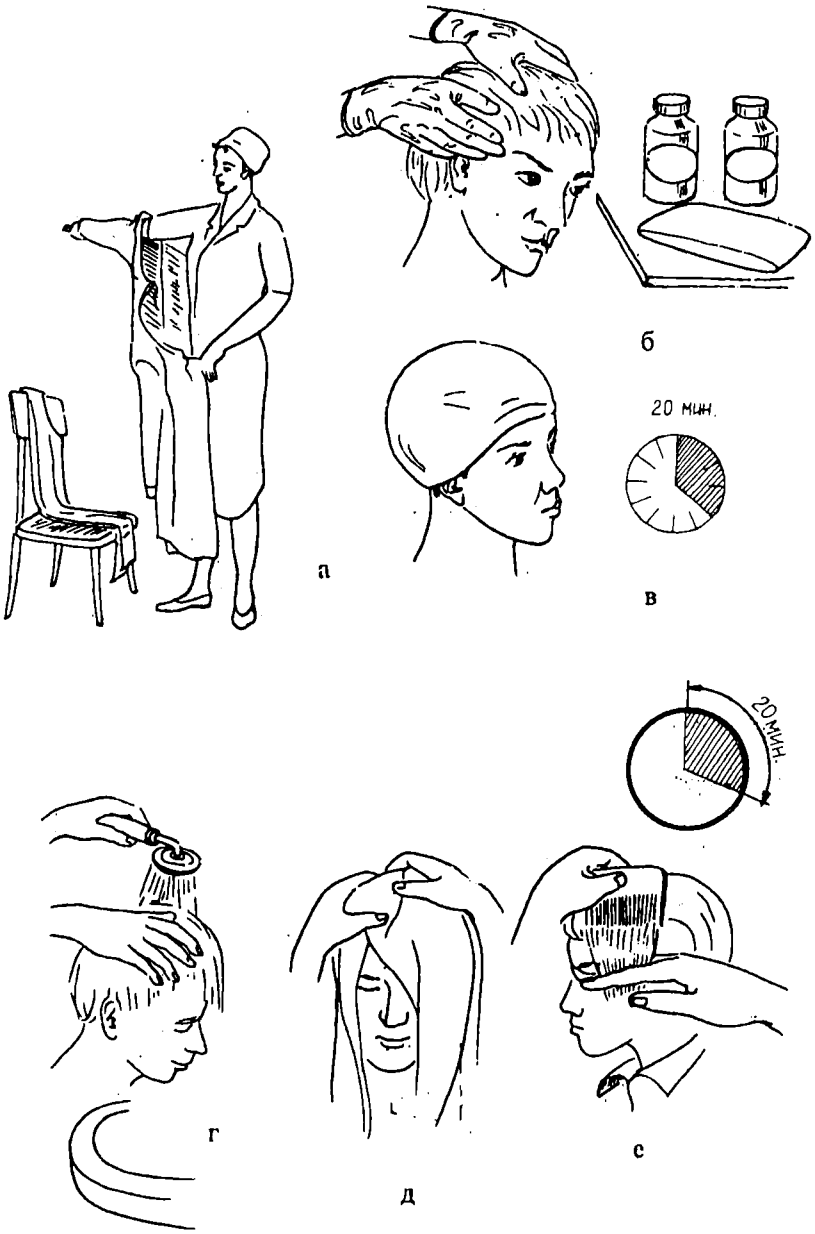
Additional Information:
1. If the hair dries during processing and combing, it must be moistened with water.
2. After drying the hair (after finishing the treatment), check it again, and if you find nits, comb the hair again carefully.
3. Repeat shampooing after 7-10 days.
4. Hand over the patient’s belongings to the descamer.
5. After use, comb and all other things and material soak in disinfectant. solution.
6. Acetic water - often used to combat nits.

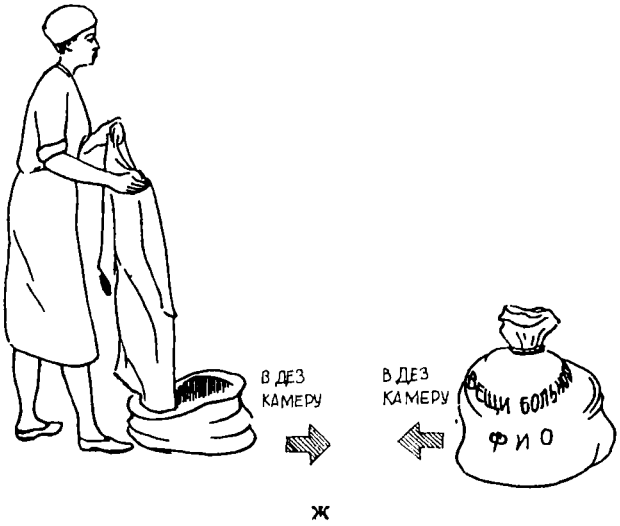
Ingredients: ordinary vinegar 5-9% (2-3 tbsp.spoons) + 1 cup ordinary warm water (27-35 degrees).
a) Apply the composition to the head.
b) Cover the head with a cotton scarf for 30 minutes.
c) To comb the head with a frequent comb (if it is not there, then stretch a thread between the cloves of the comb).
g) Rinse off with regular shampoo.

Remember!
Within a month, a 3-fold examination of the patient is required, every seven days, i.e. those who carried out the treatment should take a shower, and hand things over for decontamination.

After treatment of the patient with the presence of nits, lice, scabies in a hospital, all things of the patient and additional special. nurse clothes are sent to des. the camera.
If the patient was treated at home, then things must be boiled in any soda solution (2 tablespoons of soda in a bucket of water) 15 minutes from the moment of boiling.
After washing, be sure to iron the fabric with a hot iron!
The medical staff who conducted the des. treatment of the patient is required to conduct des. processing the premises, hand over your set of special clothes in des. chamber and undergo hygienic treatment.
Each medical institution, including clinics and hospitals, must have an anti-pediculosis kit in its equipment.

The sequence of actions of a nurse in the detection of pediculosis:





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Anthropometry:

Purpose: to obtain objective patient examination data.
Indications:
a) initial examination of the patient;
b) dynamic observation during treatment.
Contraindications: extremely serious condition of the patient.
Patient weighing:
Prepare:
a) medical scales;
b) a patient monitoring sheet;
c) gloves;
d) containers with disinfectant solutions;
d) a disposable napkin under the patient's feet (you can use a regular sheet of paper).
Prepare the patient:
a) warn about the manipulation in the morning on an empty stomach before eating;
b) offer to empty the bladder and intestines;
c) invite the patient to undress to underwear and be sure to take off his shoes.
Sequencing:
1. Check the health and accuracy of the medical balance.
2. Place a disposable napkin or plain paper on the scale pad.
3. Invite the patient to stand in the middle of the weighing pad with the shutter down.
4. Lift the bolt of the balance, establish the balance with the help of the weights located on the upper and lower levels of the balance - as a result, get the patient's body weight.
5. Obtained data must be entered in the appropriate column in the patient monitoring sheet.
6. Put on gloves and soak a used disposable napkin or plain sheet of paper in des. solution.

Remember!
Weighing is always carried out under the same conditions - on an empty stomach, in underwear, after emptying the bladder and intestines, without shoes.

Patient Growth Measurement:
Prepare:

a) stadiometer;
b) a disposable napkin (under the patient's feet) or a regular sheet of paper;
c) gloves;
d) containers with des. solution.
Sequencing:
1. Check the serviceability of the height meter.
2. Place a napkin on the height meter area.
3. Raise the bar of the height meter and invite the patient to stand on the platform of the height meter with his back to the scale so that his neck, shoulder blades, buttocks and heels fit snugly against it.
4. The head should be in such a position that the upper edge of the external auditory meatus and the corners of the eyes are on the same horizontal line.
5. Lower the bar on the crown of the patient and mark the length of his body along the lower edge of the bar.
6. Record the received data in the observation sheet.
7. Put on gloves and soak the diaper in a disinfectant solution.

Chest circumference measurement:
Prepare:
a) a centimeter tape;
b) a patient observation sheet;
c) gloves.
Sequencing:
1. Check the integrity of the centimeter tape, the clarity of the printed numbers.
2. Invite the patient to free the chest from clothing and slightly take his arms to the sides.
3. Put a centimeter tape at the back - at the lower corners of the shoulder blades, at the front - in the mizhchina by the level of the nipples, in women - by 4 ribs. the patient's hands are lowered, breathing is free. The measurement is carried out three times:
a) at rest;
b) at maximum inspiration;
c) at maximum exhalation;
4. Record the result in the observation sheet;
5. Put on gloves, dampen a rag in a disinfectant solution and treat the tape twice with a 5-minute break, then rinse under running water, dry it, and put it in a case.

Dynamometry:

It is usually carried out by a device with a metal spring connected to the dial arrow. Mercury, hydraulic, electric, pendulum dynamometers are also used. Recently, a polydynamic machine A.V. Korobkova and G.I. Chernyava, which allows you to achieve a separate action of certain muscle groups and measure their strength under equal conditions.
Abdominal circumference measurement:
Goal:
a) the detection of fluid accumulation in the abdominal cavity (ascites);
b) clarification of the volume of the abdomen to select the size of underwear.
Sequencing:
1. Warn the patient the day before that a measurement will be taken on an empty stomach in the morning.
2. Place the centimeter tape behind - at the level of the third lumbar vertebra, in front - at the level of the navel.
3. Record the obtained data in the observation sheet.

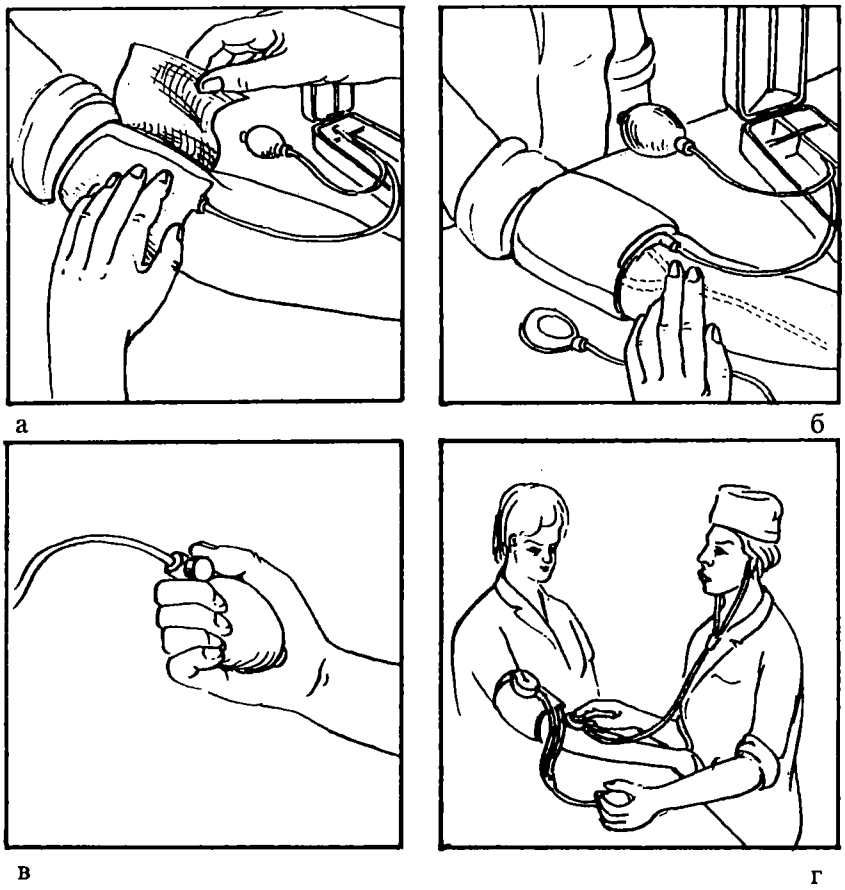
Blood pressure measurement:

Blood pressure is the pressure of blood on the walls of the arteries and the anterior column of blood in front of the systole and diastole. Normal blood pressure values are in the range of 120 / 70-140 / 90 mm Hg.
The value of blood pressure depends on many reasons:
a) age;
b) the state of the nervous and endocrine systems;
c) time of day;
d) physical activity, etc.
In the morning, blood pressure is 5-10 mm Hg lower. Art., but in patients suffering from high blood pressure (hypertension), on the contrary, there is a rise in blood pressure in the morning. Blood pressure should be measured at certain hours, preferably in the morning, before lunch, in the absence of fatigue and excitement, in a certain position of the body, if possible with the same average air temperature and normal atmospheric pressure.
Measurement of arterial pressure on the brachial artery:
Purpose: to obtain objective data on the patient's condition.

Indications are determined by the doctor. There are no contraindications.
Prepare:
a) tonometer;
b) a stethophonendoscope.
Prepare the patient:
a) report the manipulation;
b) seat or lay it so that there is no muscle tension, it should lie quietly, not talk;
c) warn that he should not monitor the progress of blood pressure measurement.
Sequencing:
1. Check the health of the tonometer and phonendoscope.
2. Check with the patient his usual pressure, pressure and his well-being at this moment; whether there were physical or psycho-emotional stress, smoking, taking any drugs for the next 30 minutes.
3. Release the shoulder from the clothes and put the cuff 2-3 cm above the elbow bend so that 1-2 fingers freely pass under it, fix it.
4. Flex the patient's arm as much as possible in the elbow joint, palm up. To make the veins more accessible, place a rubber pad under your elbow.
5. Locate the brachial artery in the elbow bend, put on a phonendoscope and firmly, but without pressure, attach it to the artery, pump air into it and into the manometer, record the moment of disappearance of tones auscultatory or palpation moment of disappearance of pulsation on the radial artery with a pressure excess of 20-30 mm Hg. Art. and gradually reduce the air pressure at a speed of 1-2 mm Hg. in sec .; when the first tone appears, mark this number in memory.
6. Continue to bleed the cuff until the tones disappear; note this number in your memory.
7. Remove the cuff from the patient’s hand, tell him the data obtained, enter the results on the patient’s dynamic observation sheet.

Additional Information:
1. The figure obtained when the first tone appears corresponds to systolic, that is, maximum pressure. The figure obtained with the disappearance of tones corresponds to the diastolic. that is, the minimum pressure.
2. The difference between the maximum and minimum pressure is called the pulse pressure, normally it is 30-40 mm RT. Art.
3. Before measuring blood pressure, it is necessary to check that the tonometer needle is strictly at zero. You can re-measure blood pressure after 1-2 minutes, after releasing all the air from the cuff!

Measurement of arterial pressure on the brachial artery:



calculation of the patient's pulse:

Pulse - jerky vibrations of the walls of blood vessels caused by the movement of blood pushed by the heart.

The most common places for determining the pulse:

a) radial artery;

b) temporal artery;

c) carotid artery;

d) an artery of the back of the foot.

Sequencing:

1. Using your hand, cover the patient's wrist joint so that the thumb is on the back of the forearm.

2. With the remaining fingers on the front surface of the joint, palpate the radial artery, pressing it to the radial bone.

Additional Information:

a) the pulse wave is felt as an expansion of the artery;

b) the study of the pulse should begin on both hands; in the absence of a pulse difference, they are further limited to its study on one arm;

c) in healthy people, the pulse rate corresponds to the heart rate and is 60-90 in one minute;

d) with a rhythmic pulse, the pulse wave frequency is calculated for 30 seconds. and multiply by 2; with arrhythmic pulse, the calculation should be carried out for 1 min;

d) an increase in heart rate of more than 90 in 1 min. called tachycardia, slowing heart rate less than 60 per min. - bradycardia;

e) during sleep, there is a decrease in the number of heart contractions by 10 in 1 minute;

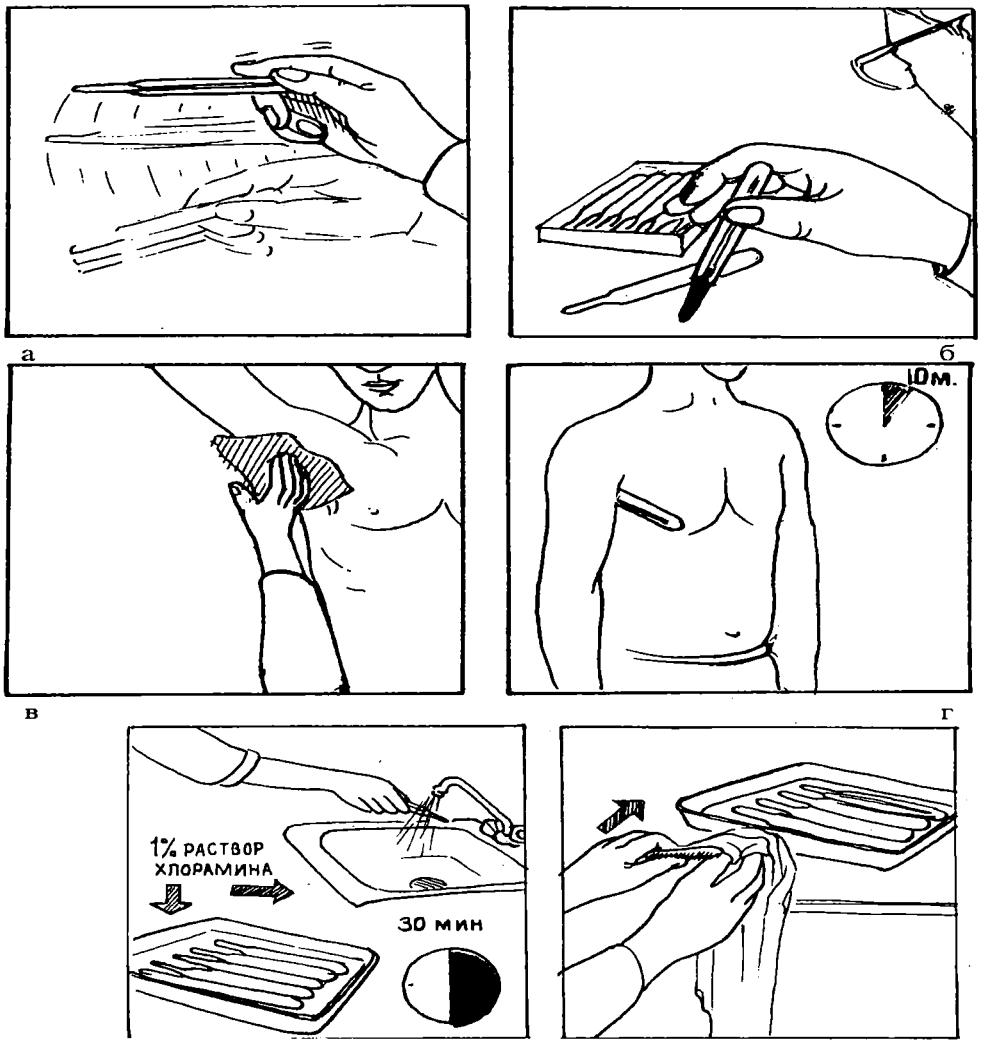
g) the nurse marks the result of the pulse count graphically with a colored pencil (usually black or blue) in the patient observation sheet;
g) an increase in body temperature by 1 degree most often increases the number of pulse beats by 10 in 1 min .;
h) a rare pulse (bradycardia) can be observed in athletes and trained people;
i) with arrhythmias, the pulse rate may be less than the heart rate. The difference between heart rate is called heart failure.
Remember a few rules:
a) you should not strongly press the artery, as under pressure the pulse wave can disappear;
b) it is not necessary to palpate the pulse with one finger, since a pulsating artery passes through it, this can mislead the researcher.

Measurement of the patient's body temperature:

Purpose: diagnostic.
Indications: monitoring the patient's condition.
There are no contraindications.
Prepare:
1. Gloves.
2. Maximum mercury medical thermometer.
3. Labeled container for disinfection of thermometers with:
a) 2% solution of chloramine (exposure 5 minutes);
b) 0.5% chloramine solution (30 minutes exposure);
c) 3% solution of hydrogen peroxide (exposure time 80 minutes).
4. Temperature sheets (individual and general).
Temperature measurement locations:
a) the oral cavity;
b) axillary region;
c) inguinal fold;
g) the rectum;
e) the vagina.
Patient preparation:
a) explain to the patient the rules for measuring temperature;
b) give the patient a comfortable position;
c) wipe the armpit or inguinal fold;
d) before measuring the temperature, the patient should not make active movements.
Sequencing:
Axillary temperature measurement:
1. Examine the axillary area.
2. In the thermometer, shake the mercury to the level of 35 degrees.
3. Position the thermometer in the armpit so that the mercury reservoir is in full contact with the body.
4. Note that there is no laundry between the body and the thermometer.
5. Remember 'Measure the temperature for at least 10 minutes! Put on your gloves!
6. Take out the thermometer, mark the result in memory.
7. Shake the mercury in the thermometer to 35 degrees.
8. Disinfect the thermometer in one of the indicated solutions.
9. Rinse it under running water, dry it.
10. Soak gloves, wash hands, and mark result.
11. Store the thermometers dry, with the mercury tank down in the case!
Additional Information:

The patient's temperature is usually measured 2 times a day: in the morning on an empty stomach (from 7 to 9 hours) and in the evening (from 17 to 19 hours). As directed by a doctor, temperature can be measured more often, as needed.

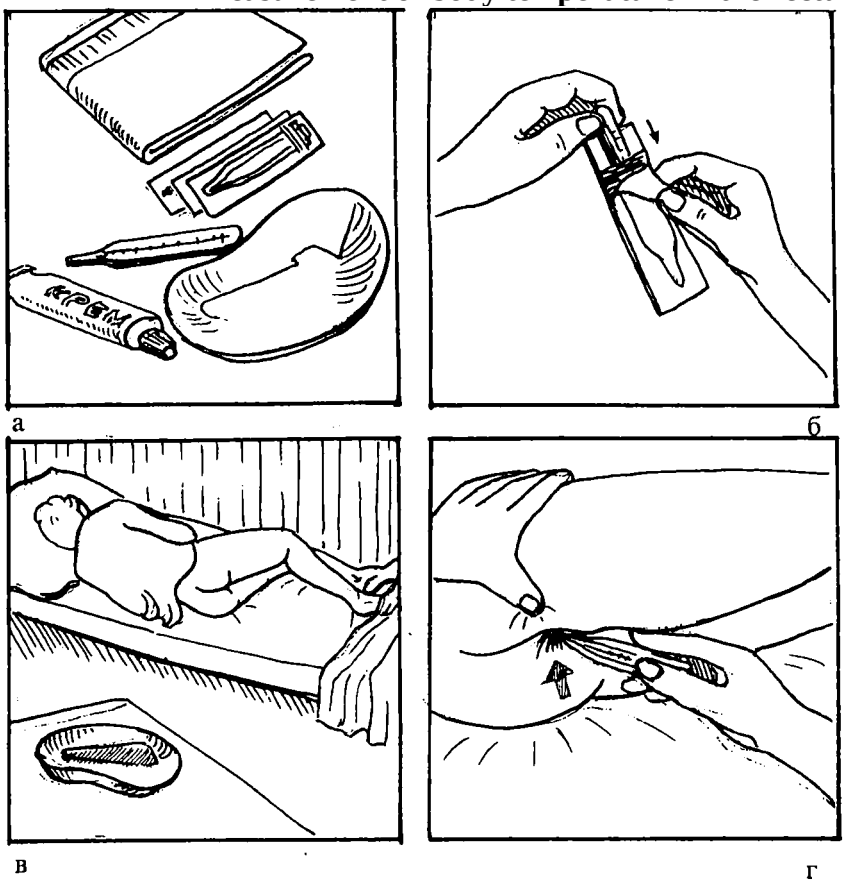
Measurement of body temperature in the armpit:



Rectal temperature measurement:
Purpose: diagnostic.
Indications: doctor's prescription.
Contraindications:
a) stool retention;
b) diarrhea;
c) diseases of the rectum.
Prepare:
a) gloves;
b) rectal thermometer (mercury tank - green);
c) petroleum jelly;
g) spatula;
e) a labeled container for disinfecting thermometers.
Prepare the patient:
a) psychologically;
b) explain his behavior during this manipulation;
c) inspect the injection site of the rectal thermometer for local inflammatory manifestations.

Sequencing:
1. Wash, dry your hands, put on gloves!
2. Offer the patient to lie on his left side (if you cannot lie on your side, you can measure the rectal temperature in the patient's supine position).
3. Invite the patient to bend the legs in the knee joints and press them to the stomach.
4. Put on the index finger or middle finger (with a glove!) A fingertip, dip it in a sterile, preferably liquid, petroleum jelly.
5. With 4 fingers of the left hand, part the buttocks of the patient and lubricate the anus with petroleum jelly, not very profusely, only to facilitate the insertion of a rectal thermometer.
6. Remove the fingertip and place in a container for used material.
7. With the four fingers of the left hand, spread the patient's buttocks and with the right hand, insert the rectal thermometer with the narrow part into the rectum half its length, press the buttocks to each other.
8. After 5 minutes, remove the rectal thermometer, mark the result in memory.
9. Soak the thermometer in one of the disinfecting solutions:
a) in a 2% solution of chloramine - exposure 5 minutes;
b) in a 0.5% solution of chloramine - exposure for 30 minutes;
c) in a 3% solution of hydrogen peroxide - exposure of 80 minutes.
10. Rinse the thermometer in a washing solution, rinse with running water, and dry (store dry, in a case, with the mercury end down).
11. Treat gloves in one of the disinfectant solutions, remove and soak in disinfectant. solution.
12. Wash your hands, dry, rub a softening cream.
13. The result obtained should be entered in:
a) a patient observation card, in the form of a curve drawn with a blue pencil or paste;
b) in the general temperature sheet, for the help desk, in Arabic numerals.

Measurement of body temperature in the rectum



Help with a fever:

Purpose: to assist the patient in various periods of fever.
Fever - a general adaptive reaction of an organism to exposure to an often infectious agent, is a change in thermal regulation with the accumulation of heat and an increase in body temperature.
During most fevers, three stages are distinguished, and the amount of patient care depends on one stage or another of the fever.
Stage 1 - temperature increase (short-term), characterized by the predominance of heat production over heat transfer.
Prepare:
a) a heating pad;
b) a towel;
c) one or two blankets;
d) a drinker;
e) ship;
f) mineral water (fruit drinks, juices) without gases.
Sequencing:
1. Create peace, put to bed, put a heating pad at your feet, cover well, drink strong freshly brewed tea.
2. Monitor physiological administration in bed.
3. Do not leave the patient alone!
4. Avoid drafts!
5. It is advisable to establish an individual post. If this is not possible, then the nurse must often approach the patient and monitor hemodynamic parameters (pulse, blood pressure, heart rate, NPV), and if there are changes in the direction of deterioration, she
should call a doctor immediately!
6. The higher the temperature and the more its fluctuations, the more the patient is depleted. To increase the body's resistance and make up for energy losses, it is necessary to feed the patient high-calorie and easily digestible food in liquid or semi-liquid form, 5-6 times a day, no more, in small portions. as a detoxification (decrease in concentration) and elimination of toxic substances from the body) a large amount of liquid is used in the form of mineral water, juices, fruit drinks.
Stage 2 - maximum temperature rise (peak period).
Prepare:
a) an ice pack;
b) a tonometer with a phonendoscope;
c) a drinker;
d) a ship.
Sequencing:
1. If possible, organize an individual post.
2. Tell your doctor about a change in patient condition.
3. Monitor hemodynamic parameters.
4. Remove the blankets and cover the patient with a sheet.
5. Use lotions to peripheral vessels and an ice pack to the head.
6. Ventilate the room, avoid drafts.
7. Care for other parts of the patient’s body.
8. Help the patient with physiological administration, prevent pressure sores.
Stage 3 - a period of temperature decrease.
It can occur in different ways, since the temperature can decrease critically, that is, sharply decrease from high numbers to low (for example, from 41 to 36 degrees), which is often accompanied by a rapid drop in vascular tone, which manifests itself in a sharp decrease in blood pressure to 60 / 20 mmHg Art. and lower, the appearance of a filiform pulse, increased sweating (hyperhidrosis), extreme weakness,

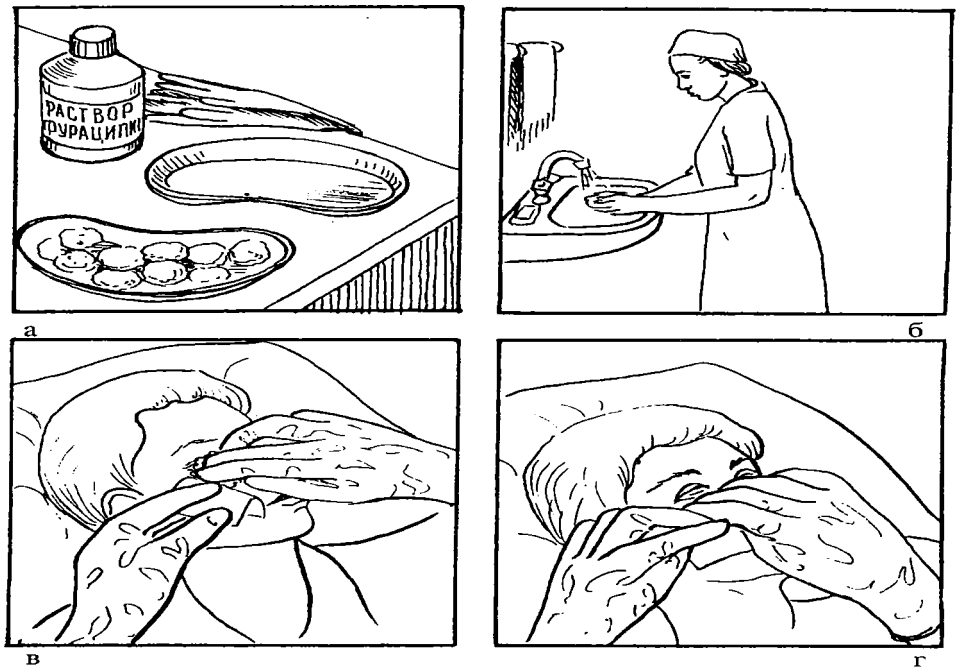
pallor of the skin. This condition of the patient is called collapse and requires urgent measures from medical personnel.
A gradual decrease in temperature from high numbers to normal (below normal) is called lytic temperature decrease (lysis).
The sequence of actions of a nurse at a critical decrease in temperature:
1. Urgently, by all available means, report the incident to the doctor, arrange care for the patient.
2. Never leave the patient alone.
3. quickly remove the pillow from under his head, raise the foot of the bed by 20 degrees or use improvised means (blankets, pillows, etc.).
4. The position of the patient should be horizontal, with raised legs.
5. Apply towel wrappers to the hands and feet of the patient.
6. Use oxygen moistened with water.
7. Monitor hemodynamic parameters.
8. Correctly report to the attending or on-call doctor about the patient's condition.
9. Follow your doctor's prescription.
10. After removing the patient from this condition, wipe it dry, change wet underwear and bedding.
11. Provide further care for the patient (hot sweet tea, etc.).
12. Monitor the patient's prescribed physical activity regimen.
13. Provide supervision of the honey on duty. staff during the day.
14. Create the patient conditions for a long deep sleep.
Remember!
1. As a rule, after the temperature drops, the patient falls asleep quickly, and wake him up for feeding, etc. not worth it!
2. The patient needs to be woken up only for taking medications, both by mouth and parenterally.

Eye Care:

Prepare:
1. Sterile gloves.
2. Gauze napkins (at least 8 pieces) or sterile balls of absorbent cotton (not leaving hairs).
3. Sterile tray for balls or napkins.
4. Tray for used material.
5.2 sterile beakers.
6.2 sterile pipettes.
7. Any aseptic solution or solution of chamomile, sage, tea, boiled water, etc.
8. Tanks with des. pipette treatment solution.
Morning toilet eyes:
Sequencing:
1. Warn the patient about the prescribed manipulation and get permission to perform it.
2. Help the patient to take a comfortable position in bed.
3. Wash, dry hands, put on gloves.
4. Pour aseptic solution into beakers.
5. Treat gloves with alcohol.
6. Gently squeeze the swab and wipe the patient’s eyelashes and eyelids in the direction from the outer corner of the eye to the inner; throw the swab.
4. Take another swab and repeat rubbing 4-5 times (with different swabs).
5. Blot the remaining solution in the corners of the eyes of the patient with a dry swab.
Remember!
In the presence of purulent discharge from one eye, it must be washed with an aseptic solution. it should be controlled so that the solution does not
rolled over the bridge of the nose from a sick eye to a healthy one.

12. Used material, beakers, pipettes, tray immerse in a container with des. solution.
13. Process gloves in des. solution and soak in it.

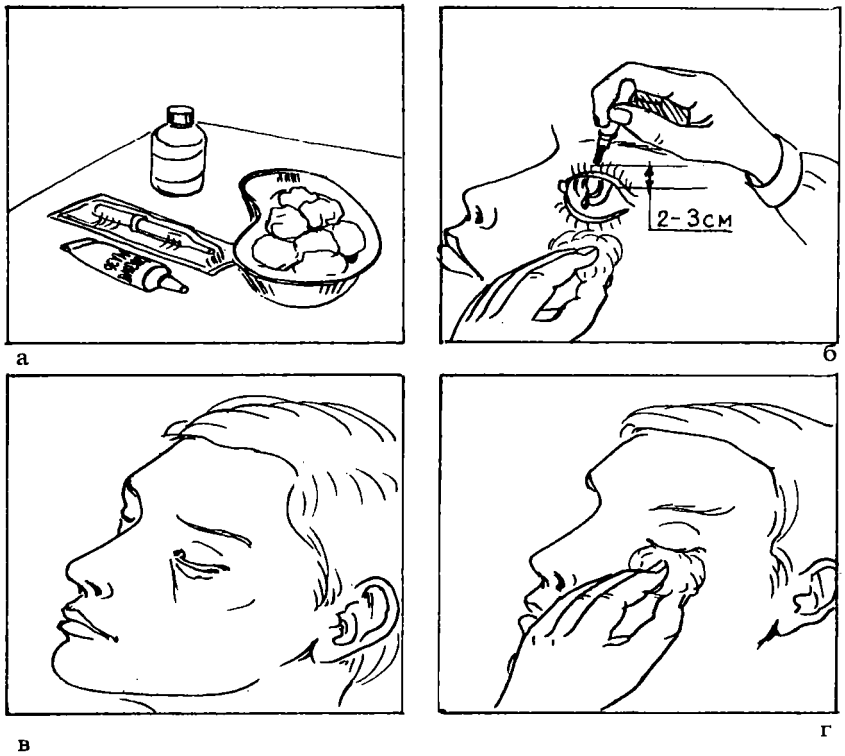
Morning toilet eyes:



Eye wash:
Prepare: a special glass cup on the leg, a medicinal solution.
Sequencing:
1. Pour a medicinal solution into a glass and place it on the table in front of the patient.
2. Ask the patient to take the glass by the leg with his hand, tilt his face
so that the eyelids were in the cup, pressed the cup to the skin and raised his head (while the liquid should not leak).
3. Ask the patient to often blink for 1 min without taking the glass from his face.
4. Ask the patient to put the glass on the table without taking the glass from his face.
5. Pour a fresh solution and ask the patient to repeat the procedure (8-10 times).
Drop instillation in the eyes:
Purpose: medical.
Indications: determined by the doctor.
Contraindications: determined by the doctor; individual intolerance.
Prepare:
a) sterile gloves;
b) a sterile tray;
c) sterile cotton balls made of absorbent cotton;
d) 2 pipettes (for each eye);
e) a tray for used material;
e) capacity with des. solution.
Patient preparation:
a) report the manipulation;
b) once again specify the allergological history;
c) explain the behavior during the manipulation.
Procedure:
1. Check the drug vial for:
a) tightness;

b) expiration date;
c) make sure the name, dose and concentration of the medicine are correct;
d) make sure that there are no signs of its unsuitability.
2. Seat the patient by pressing his back against the back of the chair.
3. Wear gloves.
4. Pipette the medicine from the vial onto ½ glass part, preventing the solution from entering the rubber part of the pipette.
5. Ask the patient to slightly tilt his head back, with the index finger of his left hand, slightly pull the lower eyelid down, suggest the patient to look up.
6. Bring the dropper to the middle of the lower eyelid at a distance equal to one drop (it is desirable that the dropper has a rounded end).
7. Tilt the pipette at an angle of 45 degrees to the lower eyelid and carefully enter the drug, not more than 2 drops.
8. Release the lower eyelid and ask the patient to tightly close his eyes (eyelids).
9. Blot up excess drug on the inner edge of the eye.
10. With the second eye, the actions are repeated.
Additional Information:
1. Before instillation into the eyes beforehand, at least two hours before, it is necessary to remove the vials of drugs from the refrigerator so that the temperature of the drug at the time of administration is at least 25 degrees.
2. If there is a purulent process in one eye, it must be controlled so that drops of the drug from the diseased eye do not fall into the healthy eye.
3. All used material, gloves, cotton balls are soaked in des. solution.

Drop instillation in the eyes:

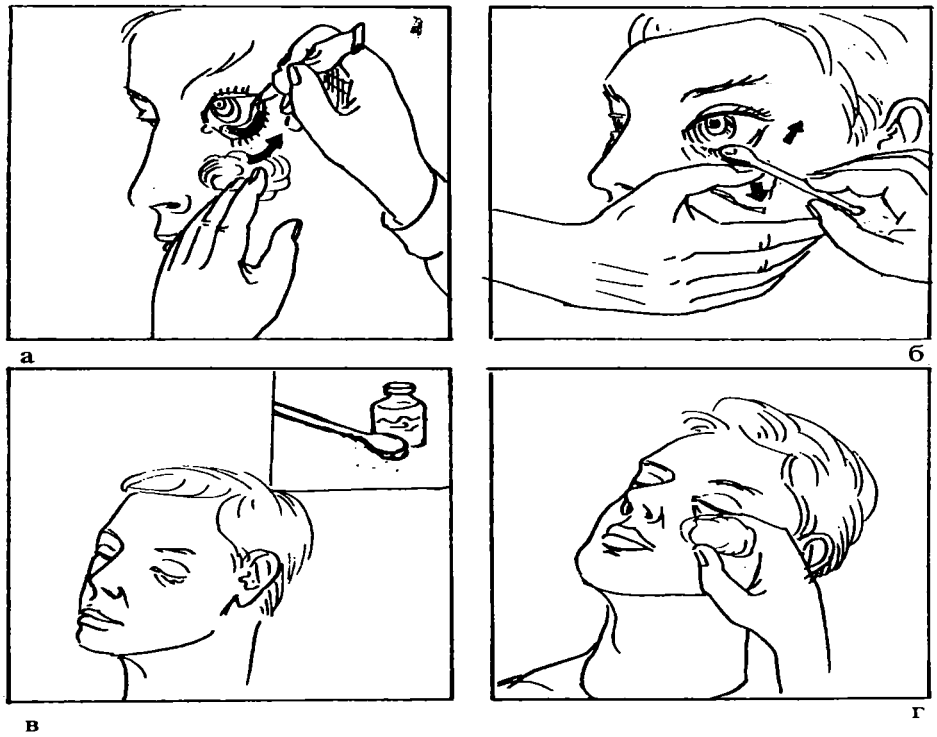


Plugging ointment in both eyes:
Purpose: medical.
Indications: determined by the doctor.
Contraindications: individual intolerance.
Prepare:

1. Sterile gloves.
2. Ophthalmic ointment (check name, concentration, shelf life, tightness of the package, signs of unsuitability).
3. 2 glass spatulas (for each eye).
4. Sterile tray for sterile wipes or absorbent cotton balls.
5. Tray for used material.
6. Tanks with des. solutions.
Patient preparation:
a) warn him of the appointed manipulation and get permission to carry it out;
b) explain how to behave during the manipulation;
c) specify the allergological history;
Sequencing:
1. Wash, dry your hands.
2. Check the integrity of the glass spatulas.
3. Invite the patient to take a position comfortable for carrying out the manipulation (on a chair or in bed).
4. Treat your hands with a ball moistened with alcohol. put on gloves.
5. Open a tube of ointment, squeeze an ointment from it, not more than 0.5-1 cm, on one side of the eye (glass) stick.
6. With the index finger of your left hand, pull the lower eyelid of the right eye down.
7. Middle finger hold the upper eyelid of the right eye and invite the patient to look up. Bring the eye stick to the middle of the lower eyelid and lay the ointment on it.
8. Invite the patient to close his eyelids tightly.
9. In a circular motion, carefully, in the direction from the ear to the nose, distribute the ointment in the conjunctival cavity. Remove the remnants of the ointment with a ball or napkin in the area of the inner eye angle.
10. If there is a need to lay the ointment in the other eye, repeat the steps in the same sequence with new balls or napkins. Soak all used material in des. solution.

The laying of an eye ointment from a tube:

Prepare: tube with eye ointment.
Sequencing:
1. Plant the patient in front of him and ask him to slightly tilt his head back and look up.
2. Pull the patient’s lower eyelid with the thumb.
3. Holding the tube at the inner corner of the eye and moving it so that the ointment is located along the entire eyelid and goes beyond the outer adhesion of the eyelids, squeeze the ointment from a tube to the conjunctiva of the lower eyelid along its border with the eyeball.
4. Release the lower eyelid: the ointment will be pressed against the eyeball.
5. Remove the tube from the eyelids.
The laying of an eye ointment for the lower eyelid:



Oral Care:

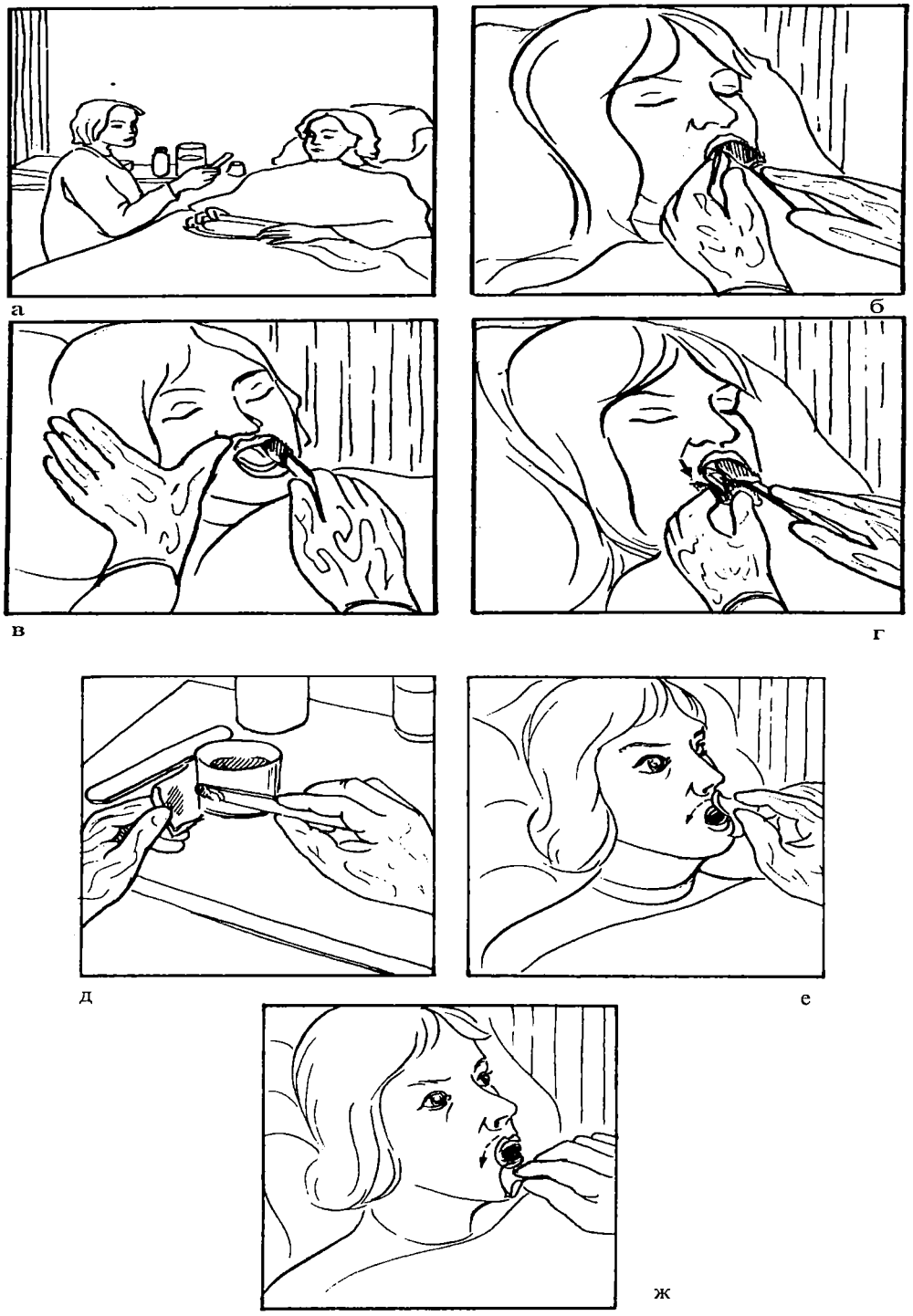
Prepare:
1. Sterile gloves.
2. Aseptic solution.
3. Boiled water (temperature 38-40 C. taking into account heat transfer).
4.Glycerin.
5. 2 kidney-shaped trays.
6. Sterile gauze wipes.
7. Iodine sticks -8-10 pieces.
8. 2 spatulas.
9. The beaker.
10. Rubber bottle or Janet syringe with rubber tip.
11. Towel.

Patient preparation:
1. Inform the patient about the prescribed manipulation and get permission to perform it.
2. Explain to the patient the course of the manipulation and its behavior during this manipulation.
3. Cover the patient’s chest with a towel or waterproof diaper.
4. Turn the patient’s torso sideways.
5. To the corner of the mouth on the diaper with oilcloth, put a tray to collect the wash water or solution.

Sequencing:
1. Wash your hands, dry them.
2. Wear gloves
3. Pour an antiseptic solution into the beaker.
4. Moisten an iodine stick with an antiseptic solution.
5. Swing the patient's cheek with a spatula.
6. Wrap the spatula with a sterile cloth, moisten it with an antiseptic solution.
7. Spat your teeth with a spatula on one side and the other.

8. With a sterile gauze cloth, grab the tip of your tongue with your left hand and pull the tongue out of your mouth.
9. Remove the plaque from the tongue with a spatula in the direction from the root of the tongue to the tip.
10. Irrigate the patient's mouth from a rubber bottle or Janet's syringe, first turn his head on its side and ask him to spit in the tray.
11. Tissues on the tongue, lips grease with glycerin.
12. Make sure that the patient does not ask you.

Oral care



Nose Care

Prepare:
a) gloves;
b) turunda;
c) beakers;
d) boiled vegetable oil, glycerin, etc.
Patient preparation:
a) psychological;
b) explain his behavior during the manipulation.
Sequencing:
1. Wash hands with soap, dry, put on gloves.
2. Pour oil into the beaker, moisten the turunda, squeeze out the remaining oil on the edge of the beaker.
3. Tilt the patient's head back slightly.
4. With your left hand, lift the tip of your nose.
5. With your right hand, rotate the turunda into the nasal passage to a sufficient depth.
6. Leave it there for 2-3 minutes to soften the crusts.
7. Remove turunda and soak in 3% chloramine.
8. In the same sequence, repeat manipulation with another nostril.

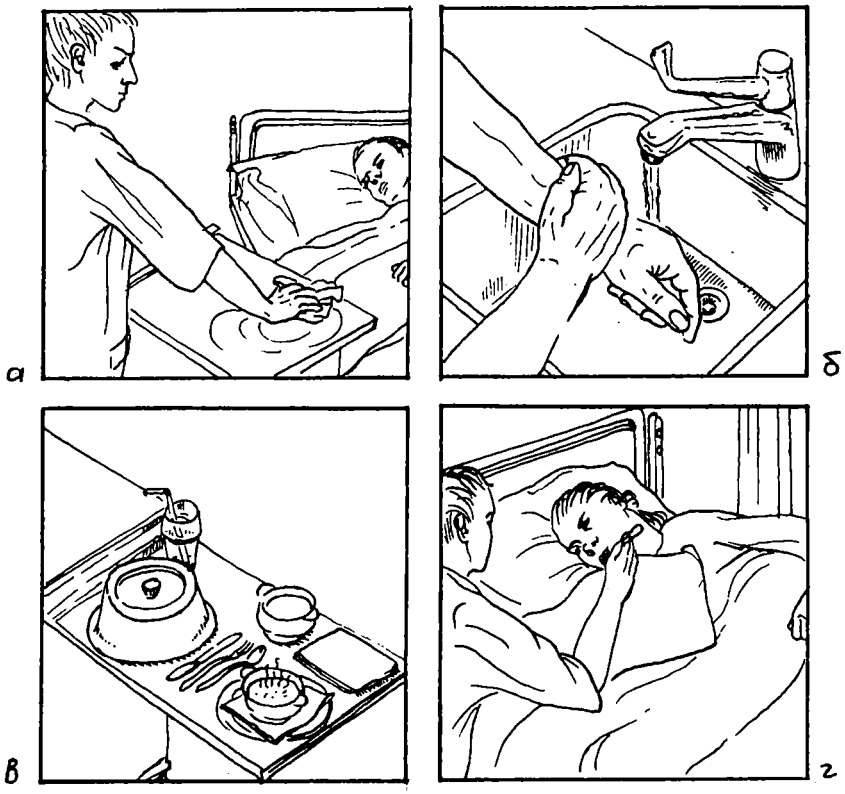
Ear Care:

Prepare:
a) gloves;
b) turunda;
c) pipettes;
d) beakers;
d) hydrogen peroxide go another means.
Prepare the patient:
a) psychologically;
b) explain his behavior.
Sequencing:
1. Wash, dry hands, put on gloves.
2. Pour a 3% hydrogen peroxide solution into the beaker.
3. Dip turundas in it.
4. Tilt the patient’s head away from the ear being treated.
5. With your left hand, pull the auricle up and back.
6. Rotate the turunda into the ear canal and remove earwax.
Additional Information:
a) If there is a small sulfuric plug as prescribed by a doctor, drop a few drops of hydrogen peroxide in your ear and after a few minutes remove the sulfuric plug with turunda (drip peroxide onto turunda);
b) check with the patient how he hears after the manipulation;
c) soak all used material and gloves in a 3% solution of chloramine.

Feeding a seriously ill patient in bed:

Purpose: to help the patient in meeting physiological needs (nutrition).
Indications: severe somatic condition, not allowing the patient to take food on his own.
Contraindications: no.
Prepare: a jug of warm water; basin; hand towel; napkin (bib); drinker; weak potassium permanganate solution or 2% solution of drinking soda; kidney-shaped coxa; tweezers; gauze balls; tableware and appliances; bedside table.

Patient preparation:
1. Kindly, politely greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation. Gain understanding and get consent to carry it out.
3. Make sure that the food prepared for the patient has a homogeneous consistency.
4. Tell the patient what dish is prepared for him (you can say that ≪ kasha in the hospital is medical ≫, thereby encouraging him).
5. If possible, help the patient take a half-sitting position in bed (using a headrest or pillows) or sitting with legs down.
6. Take a jug of water and, pouring onto the patient's hands over the basin, wash his hands and wipe them with a towel.
7. Set the bedside table on the bed in front of the patient.
Sequencing:
1. Wash your hands and put on a special bathrobe to distribute food and feed the sick.
2. Place cooked food on the table. Cover the patient's neck and chest with a napkin (bib).
4. Help the patient to install dentures (if any).
5. Politely wish him bon appetit.
6. Feed small amounts with a spoon and do not rush it (cheering and praising).
7. When feeding severe patients, show kindness, care, patience and tact (these patients are often deprived of appetite and refuse to eat).
8. Do not allow the patient to talk while eating (as food may enter the respiratory tract).
9. Do not insist that the patient ate the entire amount of food immediately (after a short break, heating food, you can continue feeding).
10. Let's drink to the patient on demand or every 3-5 tablespoons of food. Drink it from a drinker or spoon in small portions.
11. At the end of the meal, rinse the patient's mouth with boiled water from the drinker or treat the oral cavity.
12. Remove the tissue from the patient's chest.
13. Shake the crumbs out of bed.
14. If possible, leave the patient in a half-sitting position for 30 minutes after eating.
15. Then lay him in a comfortable position, straighten the bed and say a few kind words to him.
16. Take dirty dishes and a bedside table to the buffet.
Complications: ingestion of food into the respiratory tract of a patient with food.
Assisting with complication: ask the patient to cough. Tilt
the patient's head forward and downward and pat the patient on the back at the height of the inhale.
Feeding a patient from a spoon



Oxygen therapy:

Safety precautions:
a) avoid contact of oxygen with fats, oils, oil products;
b) prohibit smoking in the room where the cylinders are stored;
c) prohibit the storage of cylinders near sources of heat and light;
d) when filling the oxygen cushion (when opening the valve), stand to the side of it, as the oxygen stream, breaking free, can damage the eyes;
d) oxygen can be used under pressure not more than 2-3 atmospheres. For this purpose, a reducer is connected to the cylinder to reduce the pressure;
e) before using oxygen, make sure the airway is passable.
Oxygen supply from an oxygen cushion:
Prepare:
1. Oxygen pillow (rubberized bag with a capacity of 10-25l with a rubber tube, valve, mouthpiece).
2. Sterile gauze napkins - 4 pcs.
3. Alcohol 70%.
4. Water and tray.
5. Gloves.
Sequencing:
1. Wash, dry your hands, put on gloves!
2. Process the funnel (mouthpiece) with a cloth soaked in alcohol.
3. Wrap the mouthpiece with 2-4 layers of gauze moistened with water.
4. Place the funnel on the patient's mouth, open the valve on the rubber tube.
5. The oxygen supply rate can be adjusted not only by the valve, but also by pressing hands on the pillow. Usually it lasts for 5-7 minutes.
Additional Information:
The disadvantages of this method are:

a) the inability to establish the concentration of oxygen;
b) its uneven receipt;
c) large losses of oxygen;
d) insufficient moisture;
e) low efficiency;
e) during storage, part of the oxygen flows through the walls of the pillow.

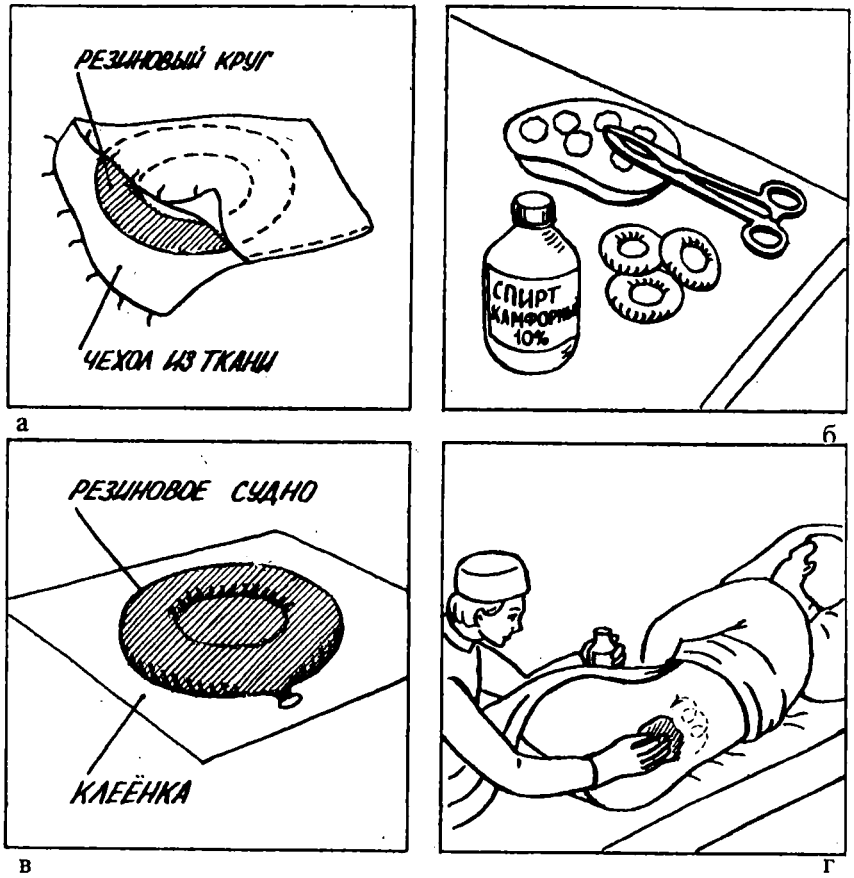
Oxygen through nasal catheters:
Provides more economical use and good hydration before inhalation. Use catheters No. 8-12, in which there should be several holes.
Prepare:
1. gloves.
2. The mask.
3. Sterile tray for sterile catheters.
4. Sterile catheters.
5. Vaseline.
6. Oxygen dosimeter.
Sequencing:
1. Wash, dry hands, put on gloves.
2. Lubricate the catheters with Vaseline.
3. Insert the catheter along the lower nasal passage to the posterior pharyngeal wall, which is approximately equal to the distance from the tip of the patient's nose to the earlobe.
4. If the patient is conscious, ask him to open his mouth, the nurse should see the inserted part of the catheter, and the outer part must be attached with a band-aid to the patient's cheek.
5. If you need a long introduction of the catheter, it should be changed 1-2 times a day and introduce a new one into another nostril. Now soft disposable catheters are used that can be in the nostril for up to 5-7 days.

Pressure sores prevention:

Purpose: preventing the formation of pressure sores.
Indications: prolonged immobility of the patient.
There are no contraindications.
Prepare:
1. Anti-decubitus mattress.
2. Cotton-gauze circles.
3. Rubber circle in a pillowcase.
4. Vaseline.
5. Divorced vinegar.
6. Portable device "Ultraviolet".
7. A clean, soft terry towel.
Sequencing:
1. Wash thoroughly, dry hands, put on gloves.
2. Turn the patient on his side and treat the skin with a soft gauze napkin (sponge) soaked in warm water, vinegar.
3. Thoroughly dry the skin, changing the towel to dry, massage the places where pressure sores are most often formed, lubricate the skin with petroleum jelly (sterile!) Or boiled oil.
4. Use quartz exposure to pressure sores.
5. Place cotton-gauze circles or rubber circles in the pillowcase under the bedsore.
6. Every 2 hours, change the position of the patient.
7. Inspect for frequent bedsores.
8. After feeding the patient, inspect his bed, shake off crumbs, change wet and soiled linen immediately.

9. When changing bedding and underwear, check that there are no seams, patches, or folds on them.
10. Treat red spots with a weak solution of potassium permanganate, camphor alcohol.
11. Constantly monitor the cleanliness of the patient's body!

Sores Prevention



Change of patient bedding and underwear:

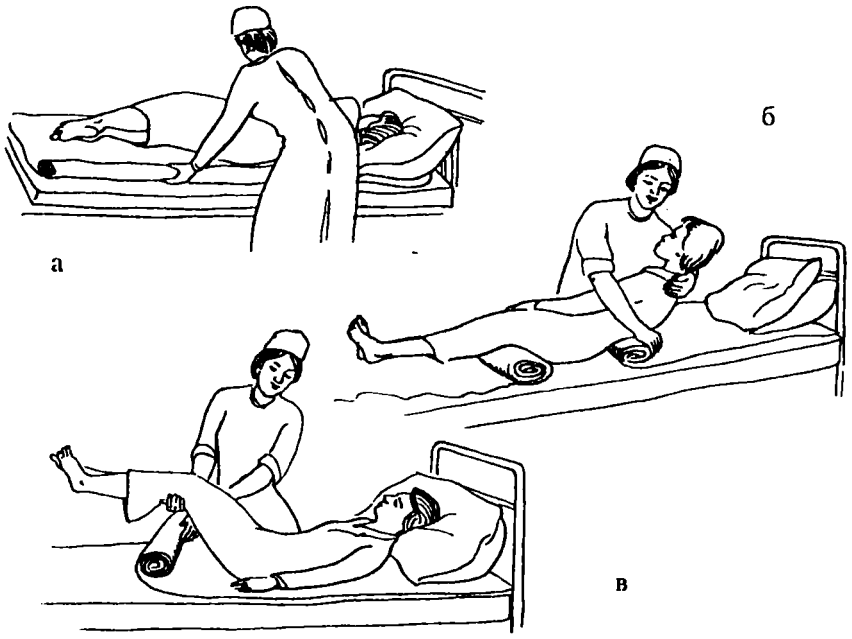
Purpose: creating a comfortable position in bed.
Indications:
1. Admission to the hospital.
2. Soiled laundry.
There are no contraindications.
Prepare:
1. A bed, preferably functional.
2. The mattress in the mattress pad.
3. Pillows - 2 pcs.
4. Pillowcases - 2 pcs.
5. The blanket.
6. Duvet cover.
7. Towels - 2 pcs. .
8. Oilcloth.
9. The diaper.
10. A bedside stool and an individual vessel, if the patient is in serious condition and is assigned a strict bed or bed regime of physical activity.
Making a bed for the patient:

Sequencing:
1. Check the bed.
2. Wash and dry your hands.
3. Wear gloves. a mask.
4. Tuck hair under the hood.
5. Lay the mattress on the bed in the mattress cover.
6. Lay a sheet, spread it out and tuck the edges under the mattress.
7. Put pillowcases on the pillows, whip them.
8. Position the pillows so that the bottom pillow
lay straight and protruded from under the top, and the top rested against the headboard.
9. Put a duvet cover over the bike blanket. If the room is cold, give a spare blanket.
10. Put the blanket on the bed, and the spare - at the foot edge of the bed, after folding it.
11. Hang both towels on the headboard.
12. Place oilcloth under the mattress.
13. Place a diaper under the pillows.

Change of bed linen for the patient:

There are two ways to change patient underwear:
a) transverse;
b) longitudinal.
It depends on the severity of the patient's condition and his ability to turn on his side.
Longitudinal change of linen:
It can be used when the patient is allowed to turn on his side.
Sequencing:
1. Wash, dry your hands, tuck your hair under the hood, put on a work dressing gown, apron, mask and household gloves.
2. Roll a clean sheet along 1/2 of its length.
3. Remove the blanket from the patient, change the duvet cover and lay it on a chair next to the patient’s bed.
4. Raise the patient’s head and take off the pillows one by one, change the pillowcases and put them back on the chair.
5. Help the patient turn on their side, to the opposite side of the bed from you.
6. Roll the dirty sheet all the way towards the patient’s back and spread a clean sheet on the freed half of the bed and place the pillows correctly.
7. Turn the patient first on his back, then on his side towards you so that he is in the clean half of the bed.
8. Remove the dirty sheet and carefully straighten the clean one so that there are no wrinkles.
9. Shelter the patient, make sure that he is comfortable lying.
10. Dirty laundry, trying not to shake, put in an oilcloth bag with the words "Dirty laundry", give it to the hostess sister.
11. Handle gloves in des. solution, rinse with water, dry, remove the apron, bathrobe, shake out the cap, remove the mask and gloves, soak everything in a des. solution.
12. Change the dressing gown.
Transverse way to change bedding:
It can be used when the patient is not allowed to turn sideways.
1. From steps 1 through 4, see the previous method.
2. The second nurse or nurse supports the patient's head. First, starting from the patient’s head, you remove the sheet and immediately place a pre-prepared clean sheet and pillows.
3. Gradually, lifting the patient from two sides, without changing his position, replace the dirty sheet, carefully straighten the clean sheet.
4. Further actions - see paragraphs 10-12 in the previous section.

Bed linen for seriously ill patients



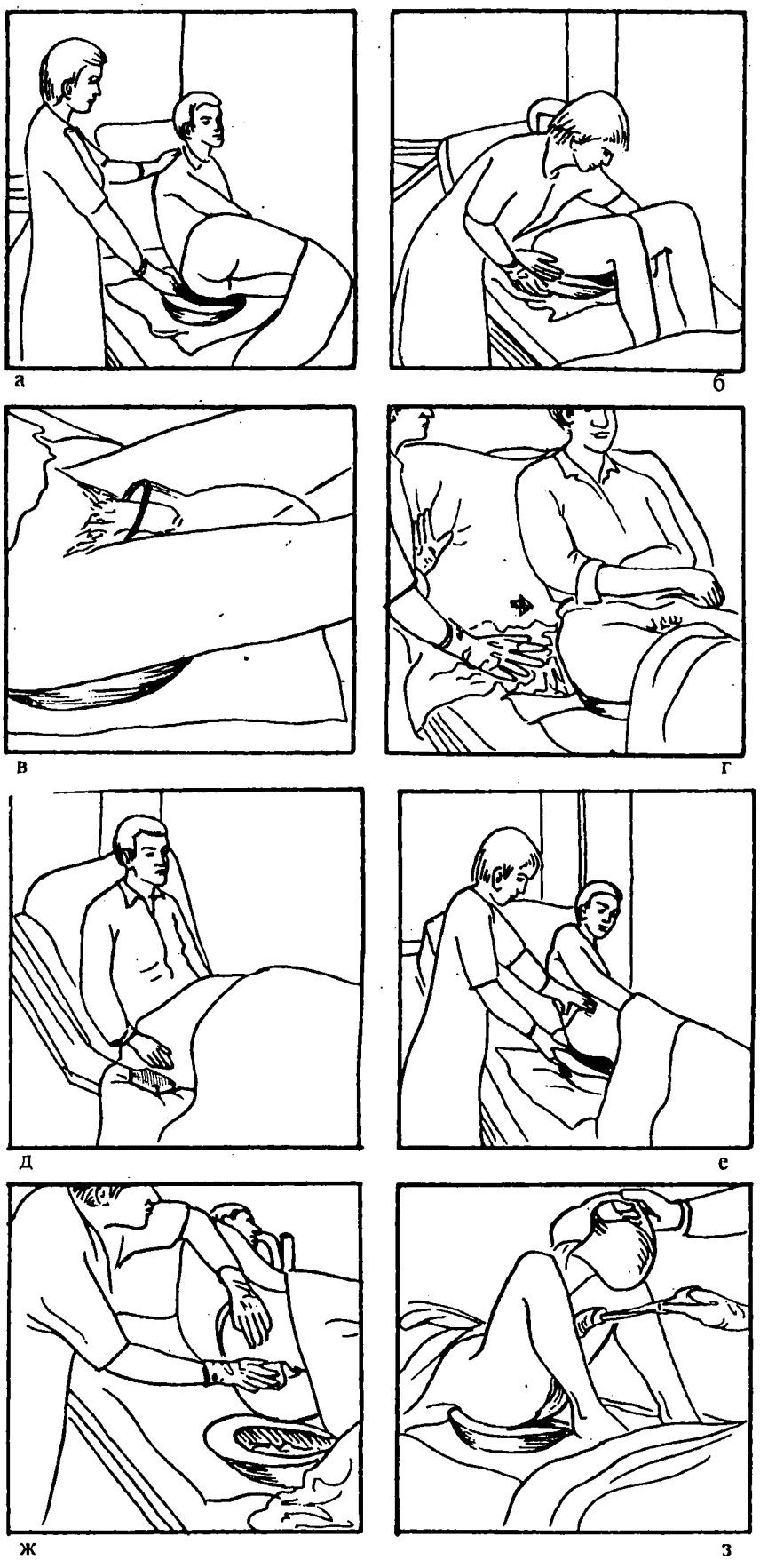
Change of underwear to the patient:
Prepare:
1. Clean, changeable clothing.
2. Bag for dirty laundry.
3. If necessary, all for partial patient sanitation.
Sequencing:
1. Remove the blanket from the patient.
2. Lift the upper half of the patient's torso.
3. Roll up the dirty shirt with a quick movement from the lower back to the back and back of the head, remove it over the head, free your hands.
4. Immediately put the removed shirt into the dirty laundry bag.
5. Throw the sleeves of a clean shirt over the patient's head, straighten it with a quick movement, lay the patient in a position convenient for him, cover him with a blanket.
Additional Information:
If the patient has a limb injury, then first remove the linen from a healthy limb, then from a damaged limb, and put it on - first on a damaged limb, and then on a healthy one.

Vessel Application:

Purpose: satisfaction of the physiological functions of the patient.
Indications: strictly bed and bed regimes of motor activity of the patient.
Prepare:
1. Screen (if the patient is in the common room).
2. Oilcloth with a diaper or a moisture-proof diaper.
3. The vessel (may be rubber, enameled, plastic, earthenware).
4. Capacity for water or aseptic solution.
5. Water or aseptic solution, t ° - 40C (taking into account heat transfer).
6. The apron.
7. The mask.
8. Gloves.
9. Everything necessary for the toilet of the genitourinary organs.
Manipulation can be carried out by 1-4 medical workers. It depends on the:

a) the severity of the patient's condition;
b) the mass of the patient.
The nurse can perform the manipulation both at the request of the patient and as prescribed by the doctor, in connection with the toilet of the genitourinary organs to perform other manipulations (catheterization of the bladder, etc.), after cleansing enemas in the patient's bed.
Prepare the patient:
a) psychologically, calm, create conditions for complete relaxation;
b) be sure to fence off the screen.
Sequencing:
1. Put on the apron, mask.
2. Wash, dry your hands.
3. Be sure to wear gloves. If necessary, invite assistants, explain their actions to them. Put oilcloth, diaper and on them in advance
put the ship!
4. Lift the shirt to the level of the shoulder blades, on both sides
the patient's left, and the assistant - the right, with the hands brought under the sacral region of the patient, previously bend the patient's legs in the knee joints.
5. With your right hand simultaneously bring the oilcloth with the diaper and the vessel, while noting that most of the diaper should be at the back of the patient!
6. Conveniently lay the patient on the wide part of the vessel with the sacral area so that the patient's crotch is above the vessel (the handle of the vessel should be between the patient's legs).
7. Roll up most of the diaper in the form of a tow and place it on the border of the vessel and the back so that liquids do not leak onto the back, since the wide part of the vessel bends even on a hard bed.
Attention!
If the patient is a man, then in addition you must also pass the urinal, since when urinating it can soak both the sheet and the blanket even with a sluggish stream.
8. Cover the patient and be nearby.
9. At the end of the act of defecation and urination, if there are two vessels, then change one to the other in the same order as they failed. If the ship is one, then
remove it from the patient, give it to the assistant or, if it is not, put it on the bedside stool (for an individual patient's vessel).
10. Spread the diaper under the patient and lay it on it. Take out the vessel, pour it into the toilet bowl, rinse, dry its outer surface and again bring it under the patient, after covering the part on which the patient was lying with the clean part of the diaper so that the bottom of the vessel does not stain with the remains of feces on the diaper.
11. Have a thorough toilet of the genitourinary organs. Take the boat away! Diaper! At the same time!
12. Check if there are any streaks on your back, if the bed is dry, straighten all the folds, and if necessary, process the places that cause you anxiety.
Attention!
After the vessel has been freed from feces for the toilet of the genitourinary organs, change gloves to sterile!
13. Shelter the patient, make sure that he is comfortable lying down and that he has no requests for you.
14. Open the window or window (depends on the season of the external air temperature).
15. Take out the vessel, empty it and disinfect, soak all used material in a des. solution for at least 60 minutes.
Additional Information:
Before delivering the vessel to the patient, be sure to pour a small amount of water on the bottom to:

a) odor reduction during an act of defecation;
b) easier departure of feces from the vessel.
Delivery of the vessel to the patient



The use of a warming compress:

Purpose: medical.
Indications as prescribed by the doctor.
Contraindications:
a) purulent skin diseases;
b) hyperthermia.
Prepare:
a) a napkin (linen - 4 layers or gauze - 6-8 layers);
b) waxed paper (polyethylene - in no case);
c) cotton wool;
g) bandage;
e) a kidney-shaped tray
f) solution: ethyl alcohol 40-45% or vodka, water 20-25 ° C.
Patient preparation:
1. Psychological.
2. Explain the meaning of manipulation and the rules of conduct for the patient.
Sequencing:
1. Prepare the first layer of a compress (napkin) so that its size is 3 cm larger than the site of the disease.
2. Each subsequent compress layer should be 3 cm larger than the previous one.
3. Moisten a napkin in a solution and squeeze it well.
4. Put it on the desired part of the body (if it is an ear, cut a hole to fit the ear).
5. Put waxed (compression) paper on the second layer (if on the ear, cut a hole).
6. On top of the paper, lay a layer of cotton wool that should completely cover the two previous layers.
7. Fasten the compress with a bandage so that it fits snugly against the body, but does not hamper the patient's movements.
8. Check with the patient his feelings after a while.
9. Leave the compress for 8-10 hours, and alcohol - for 4-6 hours (it is better to put them overnight).
10. After 2-3 hours, check the correct setting of the compress, put your finger under the first layer of the compress, if it is moist, warm, then the compress is correctly placed, if dry, then the compress must be put back in.
11. After removing the compress, apply a dry, warm bandage using cotton and a bandage.

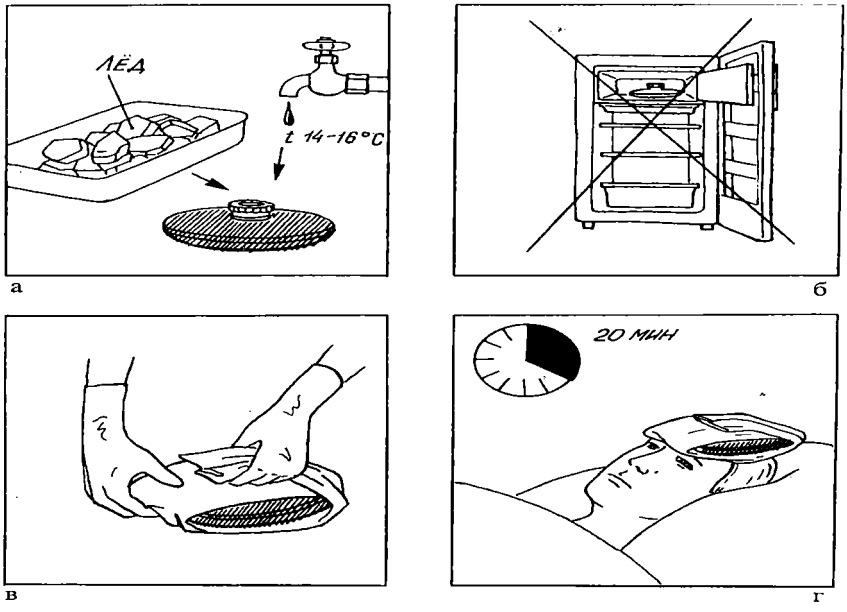
Serving a warmer for seriously ill patients:
Purpose: for warming the patient’s body, for resolving inflammatory infiltrates, for relieving pain with visceral colic.
Indications: the presence of focal inflammation in the infiltration stage, the state after surgery (post-anesthesia sleep - a violation of thermoregulation) and low ambient temperature, visceral colic.
Contraindications: acute inflammatory processes in the abdominal cavity (acute appendicitis, acute cholecystitis, acute pancreatitis), bleeding, malignant neoplasms, soft tissue bruises on the first day, high body temperature.
Prepare: a rubber heating pad with a stopper, a cloth or cloth, hot water (60-80 ° C), a water thermometer.
Patient preparation:
1. If the patient is conscious, politely, kindly greet him by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation. Gain understanding and get consent to carry it out.

3. Warn the patient that if there is an unpleasant pain after applying a heating pad, he will have to inform the medical staff about it.
Sequencing:
1. Take a rubber heating pad and fill it with 2/3 volumes of hot water (60-80 ° C), controlling the temperature of the water with a thermometer.
2. Displace air from the heating pad by squeezing the heating pad near the neck (the liquid level should rise to the neck of the heating pad).
3. Screw the cork into the heating pad.
4. Check the heater for leaks (turn the heater upside down).
5. Wrap a heating pad with a napkin.
6. Apply a heating pad to the patient's legs.
7. After 5 minutes, be sure to check for tissue overheating (vivid hyperemia).
8. Keep the heating pad on the patient's body until it cools.
Complications: in violation of the technique of preparation and application of a heating pad, weakened, severe patients and patients in a post-anesthetic sleep may have burns of various degrees.
Prevention of complications: it is necessary to strictly follow the rules for the preparation and application of a heating pad to patients with impaired skin sensitivity, severely ill patients in a coma, in an unconscious state (water temperature in the heating pad
should be 37-38 ° C).
Assistance in case of complications: it is urgent to inform the doctor about the complication arising from the use of a heating pad to the patient (burn). Apply an aseptic dressing. In the future, treat damage according to the laws of the wound process.

Preparation of a heating pad for use:

Serving an ice bladder for a seriously ill patient:
Purpose: to stop bleeding, both analgesic and anti-inflammatory
means to reduce elevated local and general body temperature.
Indications: acute inflammatory processes in the abdominal cavity (acute
appendicitis, acute cholecystitis, acute pancreatitis), bleeding, soft tissue bruises on the first day, high body temperature, condition after surgery (on the area of the postoperative wound with hemostatic purpose).
Contraindications: chronic diseases of the abdominal organs (gastritis, colitis, etc.).
Prepare: an ice bubble with a cork, pieces of ice, a cloth napkin or a diaper.
Patient preparation:
1. If the patient is conscious, politely and benevolently greet him by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation. Gain understanding and get consent to carry it out.
3. Warn the patient that if there is an unpleasant pain after applying an ice bladder, he will have to inform the medical staff about this.
Sequencing:
1. Take a bubble for ice and fill it with water, close the cork and turn over
down (leak test): if water does not flow through the cork, the bubble is airtight.
2. Pour water out of the bubble.
3. Fill the ice bubble with pieces of ice
4. Displace air from the bubble by placing it on the table (the level of pieces of ice should rise to the neck of the bubble).
5. Screw the plug into the bubble.
6. Wrap the bladder with a tissue and apply it to the patient in the area of the postoperative wound.
7. Hold the bladder for 15-20 minutes on the patient's body with a break of 15-20 minutes (to avoid local hypothermia).
8. As the ice melts, drain and add pieces of ice.
Complications: local hypothermia and frostbite of body parts on which an ice bladder was applied in severe patients.
Prevention of complications: an ice bubble must be removed every 20-30 minutes, in order to avoid hypothermia, they take a break for 10-15 minutes.

Preparation and use of an ice pack



Parenteral administration of drugs:
Venipuncture is the insertion of a needle into a vein through the skin to:
a) taking blood for research;
b) the introduction of medicinal substances for therapeutic and diagnostic purposes (contrast agents for x-ray examination);
c) for donor purposes.
Remember!
For the introduction of liquids of low density (saline solutions, glucose), thin needles are used, that is, with a narrow channel, and with the introduction of viscous liquids (blood, polyglucin, protein hydrolysates), larger needles are used.
Venesection - opening the lumen of a vein with the aim of inserting a needle, cannula or catheter into it for infusion therapy or diagnostic studies.
It is used for:
a) poor severity of saphenous veins;
b) conducting long-term infusion therapy.
For this, veins of the elbow bend, the middle and lower third of the forearm, or the superficial veins of the foot and lower leg are more often used.
A set of medicinal substance from an ampoule:
Purpose: medical, diagnostic.
Contraindications: allergic reactions to the drug.
Sequencing:
1. Specify the name and dosage of the prescribed medicinal substance (in the prescription journal).
2. Prepare the desired drug.
3. Check on the package:
a) the shelf life of the drug substance;
b) its dosage;
c) the method of its introduction.
4. Take the ampoules from the packaging and check:
a) tightness;
b) transparency;
c) color and other signs of suitability.
5. Shake the ampoule lightly so that the entire solution is in its wide part.
6. Take a sterile tweezers in your right hand and remove the ball from the sterile bin, soak it with 70% alcohol (or a ball from a container with 70% alcohol).
7. Treat the narrow part of the ampoule with a ball of alcohol in the direction away from the wide part.
8. Put the narrow part of the ampoule on the ball lying on the cushion of the index finger of the left hand.
9. File a narrow part of the ampoule with a file, break off its tip with a ball and put it in the kidney-shaped tray for used material.
10. Place the opened ampoule on the table, covering it with a sterile ball (you can not do this if bactericidal lamps have worked in the treatment room before).
11. Take the prepared syringe in your right hand, holding the needle sleeve with your second finger, the cylinder with your little finger and thumbs.
12. Remove the sterile ball from the ampoule.
13. Take the prepared ampoule in your left hand between the second and third fingers.
14. Without touching the edges of the ampoule, carefully insert the needle into it.
15. Hold the cylinder with the first and fifth fingers of the left hand, and the needle sleeve with the fourth.
16. Grasp the handle of the syringe with the first, second, third fingers of the right hand, or you can use only the thumb, pull the piston toward you.

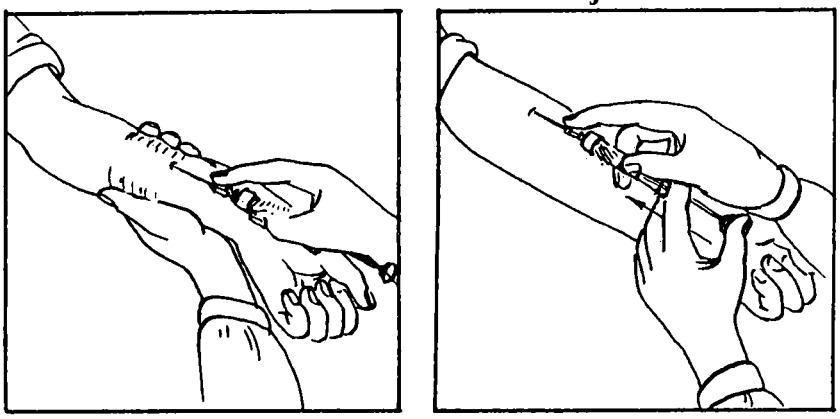
17. Enter the required amount of medicinal substance, put the ampoule in the tray for the used material.
18. Change the needle to the injection needle.
19. With your right hand, rub the needle against the cone with tweezers.
20. A syringe in the left hand. Holding the needle sleeve with the 2nd finger,
cylinder - with 1st and 5th fingers, lift the syringe vertically and release air bubbles from it.
21. Put the syringe on the sterile tray and cover it with a sterile cloth or leave it on the sterile part of the inner packaging of the calico and cover it with the sterile part.
Remember!
Before picking up a syringe for an injection, you must carefully treat the gloves with a cotton ball (sterile) dipped in alcohol.

Technique of an intradermal allergological test:

Purpose: diagnostic and anesthetic.
Indications: as prescribed by the doctor.
Contraindications determined by the doctor.
Prepare:
a) ampoules with allergens, serums, toxoids;
b) a syringe of 1.0 ml (specially graduated);
c) needles for dialing and / or injection;
d) gloves;
d) a transparent ruler;
e) sterile balls;
g) alcohol 70%;
g) sterile tweezers in des. a solution;
h) tonometer, phonendoscope;
i) anti-shock set;
g) the first-aid kit "Antispeed".
Places of intradermal injection: middle third of the front surface of the forearm.
Patient preparation:
1. Psychological.
2. Explain the meaning of manipulation and how the patient behave after it.
3. Check the individual tolerance of the drug.
Sequencing:
1. Invite the patient.
2. Free up the injection site (the patient can do this himself).
3. Determine the immediate injection site.
4. Wear gloves.
5. Treat the injection site with alcohol twice, wait until it dries.
6. Take the syringe with the needle into your right hand.
7. Grasp the patient’s forearm with your left hand and fix the skin (do not stretch!).
8. Insert the needle from the bottom up at an angle of 15 degrees to the length of the cut so that it shines through the skin.
9. Raise your skin with a “tent” shaped needle.
10. In this needle position, enter the prescribed dose of the drug.
11. Remove the needle with a quick motion.
Remember:
Do not apply a sterile ball!
Attention!
1. The sample is interpreted by a doctor or a specially trained nurse.
2. The criterion for the correctness of the injection is the formation at the injection site of the "papule" or the so-called symptom of "lemon peel",

3. Soak the balls in a 3% solution of chloramine.
The sequence of actions after each injection:
a) ask the patient about his health;
b) in the absence of complaints and requests, release him;
c) rinse the used reusable syringe with a needle for half a minute in the rinse tank, finish rinsing on an empty cylinder;
d) rinse the syringe with the needle for half a minute in the container for soaking the needles, finish the washing on the full cylinder, carefully remove the needle and soak in the container for at least 60 minutes;
d) soak the disassembled syringe and piston in a 3% chloramine solution for at least 60 minutes;
f) treat with a clean rag soaked in a 3% solution of chloramine, the workplace after each patient;
g) if used: rubber pad, tourniquet, diapers and other materials and tools, they must also be soaked in a 3% solution of chloramine.

Intradermal injection:



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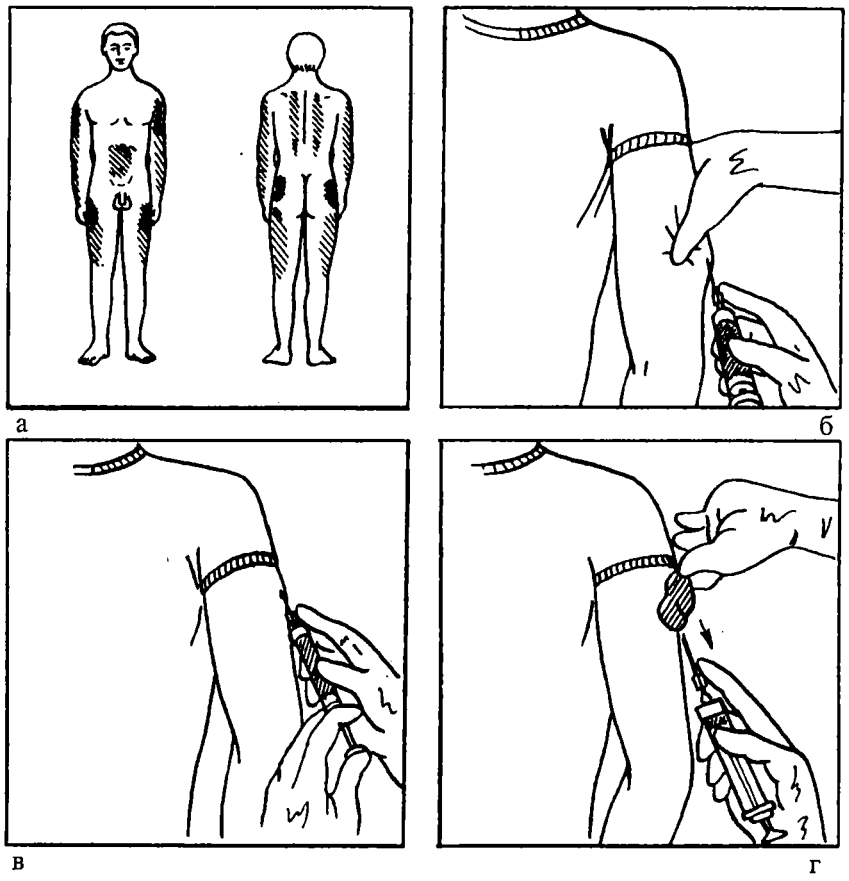
Subcutaneous Injection Technique:

Purpose: medical.
Indications: administration of the drug subcutaneously.
Contraindications: individual intolerance to the drug substance by the patient.
Note: when introducing the oil solution, before putting it into the syringe, place the ampoule in a dry beaker and lower it in a container with hot water (temperature 90 ° C).
Places for subcutaneous injection:
a) the middle third of the rear surface of the shoulder;
b) the middle third of the front surface of the thigh,
c) subscapular region,
d) anterior abdominal wall.
Prepare:
1. Sterile syringe tray.
2. A sterile syringe with a medicinal substance.
3. Sterile needles for subcutaneous administration.
4. Sterile balls.
5. Alcohol 70%.
6. Gloves.
7. Tray for used material.
8. Tonometer, phonendoscope.
9. Anti-shock set.
10. First-aid kit "Antispeed".
Patient preparation:
1. Psychological.

2. Check the tolerance of the drug.
3. Explain to the patient the meaning of manipulation.
4. Place or seat the patient.
Sequencing:
1. Free up the injection site (this can be done by the patient).
2. Determine the injection site.
3. Put on gloves, treat them with a ball moistened with alcohol.
4. Treat the injection site with a sterile ball moistened with alcohol in one direction wide, then the second - directly at the injection site, leave the ball nearby.
5. Take the syringe in your right hand, hold the second finger
the needle coupling, with the thumb and the rest of your fingers - the cylinder (before doing this, remove the remaining air bubbles).
6. Fold the skin at the injection site with the 1st and 2nd fingers of the left hand.
7. Quickly insert the needle at an angle of 30–40 ° into the base of the fold 2/3 of the length of the needle, holding it upside down (usually the needle is inserted from the bottom up, but if the patient is short or insulin is injected, the needle is directed from top to bottom).
8. Release the crease.
9. With the fingers of your left hand, slightly pull the piston toward you, make sure that the needle does not enter the vessel (lack of blood in the syringe).
10. Inject the drug slowly.
11. Press the injection site with a dry, sterile ball and remove the needle with a quick movement.
12. Do not forget to ask about the well-being of the patient, if the injection is painful, warn him about this in advance.
13. Handle the syringe, needle, balls, gloves in accordance with the above rules.

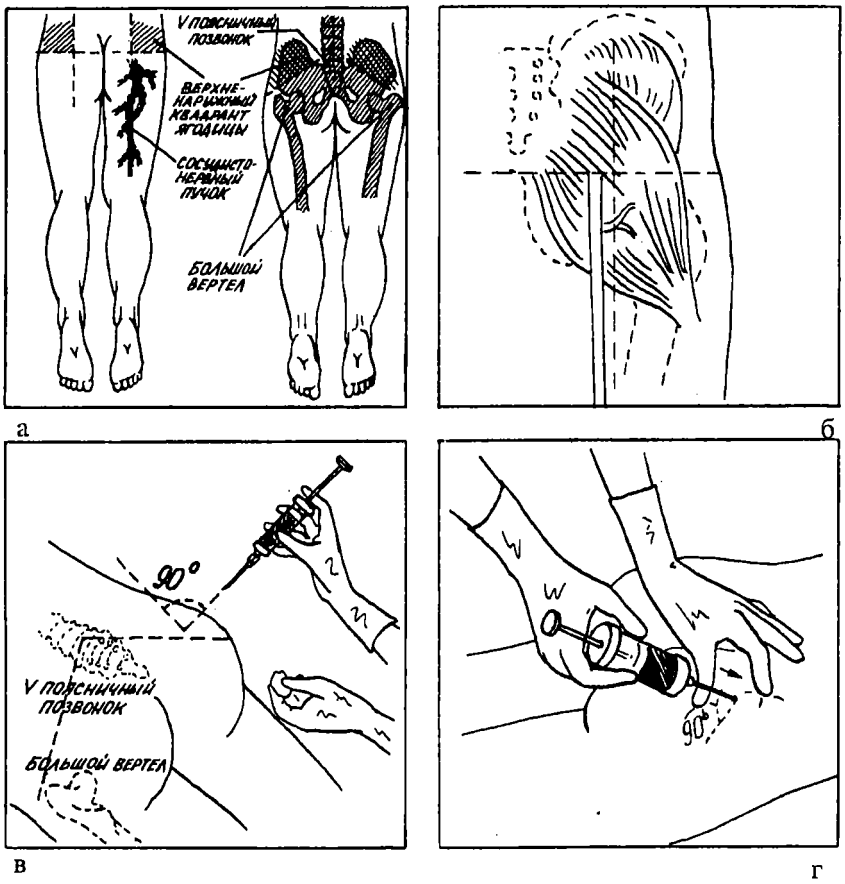
Subcutaneous injection:



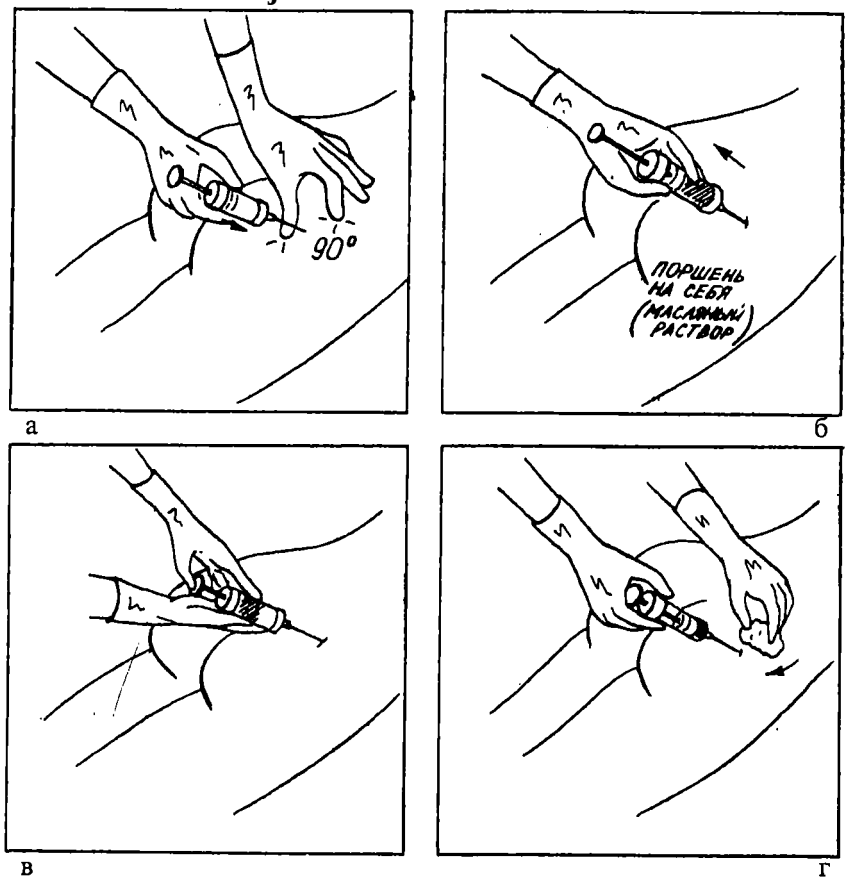
Technique for intramuscular injection:

Purpose: medical.
Indications: administration of the drug intramuscularly.
Contraindications: individual intolerance to the drug substance by the patient.
Intramuscular injection sites:
a) buttock muscles (middle and small gluteus muscle);
b) thigh muscles (lateral broad muscle);
c) much less often the deltoid muscle of the shoulder.
Prepare:
a) a disposable syringe with a needle 5 cm long;
b) a sterile syringe tray;
c) an ampoule (vial) with a solution of a medicinal substance;
d) 70% alcohol solution, Bix with sterile material (cotton balls, tampons);
e) sterile tweezers, a tray for used syringes;
e) sterile mask, gloves;
g) anti-shock set;
g) a container with a disinfectant solution.
Patient preparation:
1. Psychological.
2. Check the tolerance of the drug.
3. Explain to the patient the meaning of manipulation.
Sequencing:
1. Offer the patient to take a comfortable position (lying on his stomach or on his side, with this leg, which is on top, should be unbent in the hip and knee joints).
2. Wash hands thoroughly with soap and warm running water; without wiping with a towel in order not to violate the relative sterility, wipe them well with alcohol; put on sterile gloves and also treat them with a sterile cotton ball soaked in a 70% alcohol solution.
3. Prepare a syringe with a drug, remove air from the syringe.
4. To treat the injection area with two sterile cotton balls soaked in alcohol, widely, from top to bottom: first, large
surface, then the second ball directly to the injection site.
5. Take the syringe in the right hand, fixing the needle sleeve with the little finger, with the rest of the fingers
holding the cylinder; position the syringe perpendicular to the injection site.
6. With the thumb and forefinger of the left hand, stretch the skin of the patient at the injection site; if the patient is exhausted, the skin, on the contrary, should be folded.
7. With a quick movement of the hand, insert the needle at an angle of 90 ° to the injection site at 2/3 of its length.
8. Without intercepting the syringe, pull the piston towards you with your left hand to make sure that the needle doesn't enter the blood vessel (there should be no blood in the syringe barrel); if there is blood in the syringe, repeat the needle injection.
9. Continuing to hold the syringe with your right hand, slowly inject the drug solution with your left hand.
10. Press a sterile cotton ball moistened with alcohol to the injection site and withdraw the needle with a quick movement.
11. Fold the used syringe, needles into the tray; the used cotton balls should be placed in a container with a disinfectant solution.
12. Remove gloves, wash hands.
Additional Information:
When injecting the medicine into the thigh, the syringe must be held like a writing pen at an angle of 45 °, so as not to damage the periosteum.

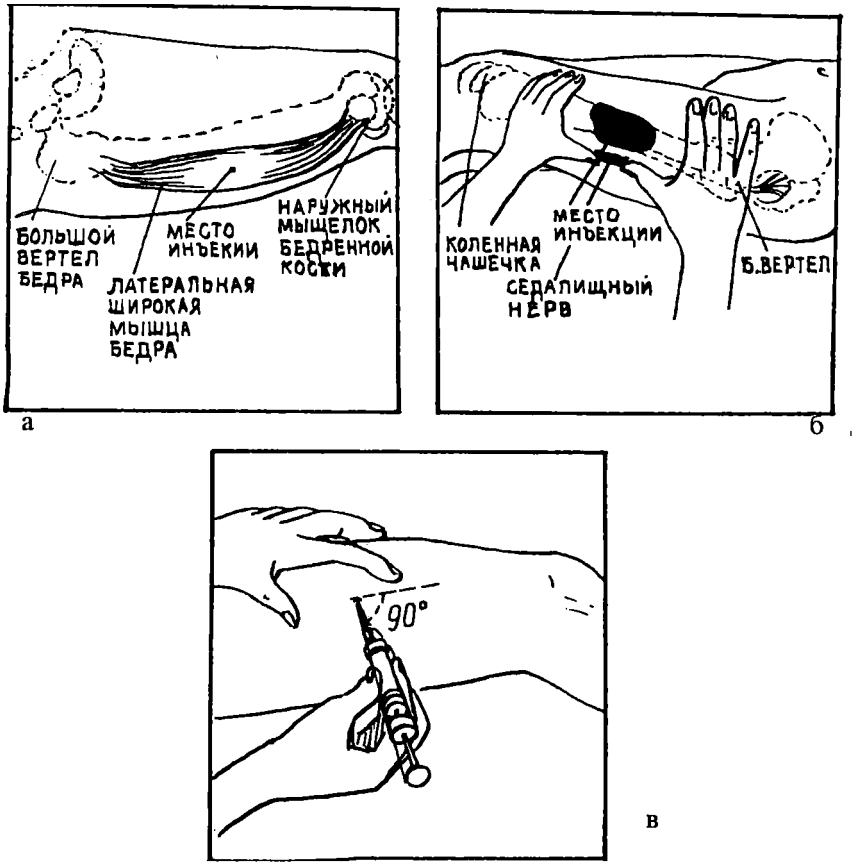
Intramuscular injection in the buttock



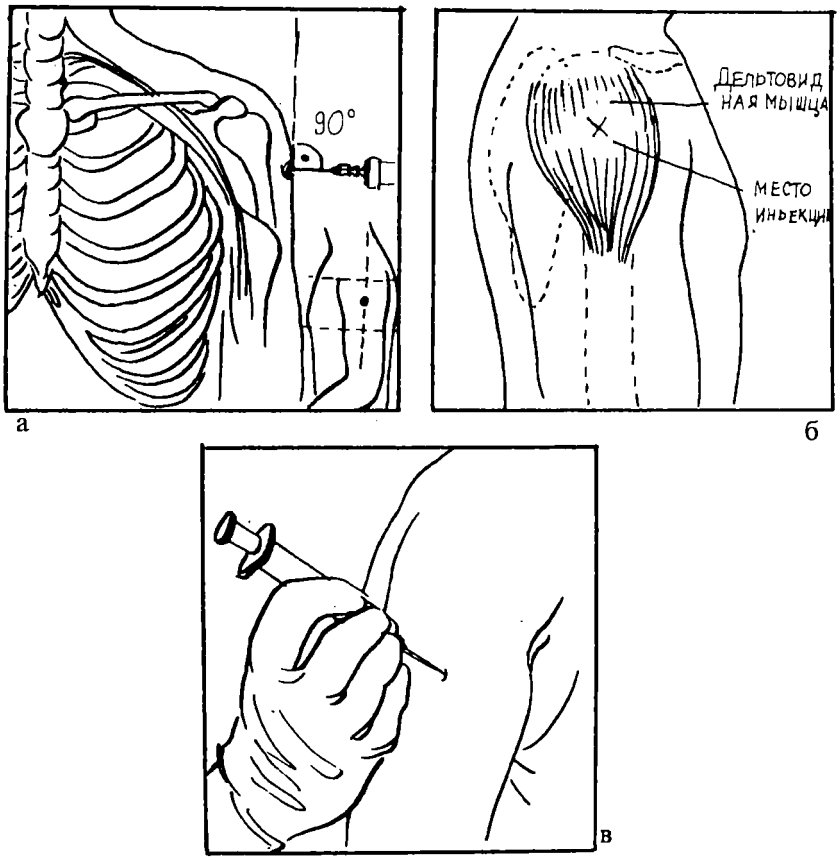
Intramuscular injection into the buttock of an oil solution



Intramuscular injection in the thigh



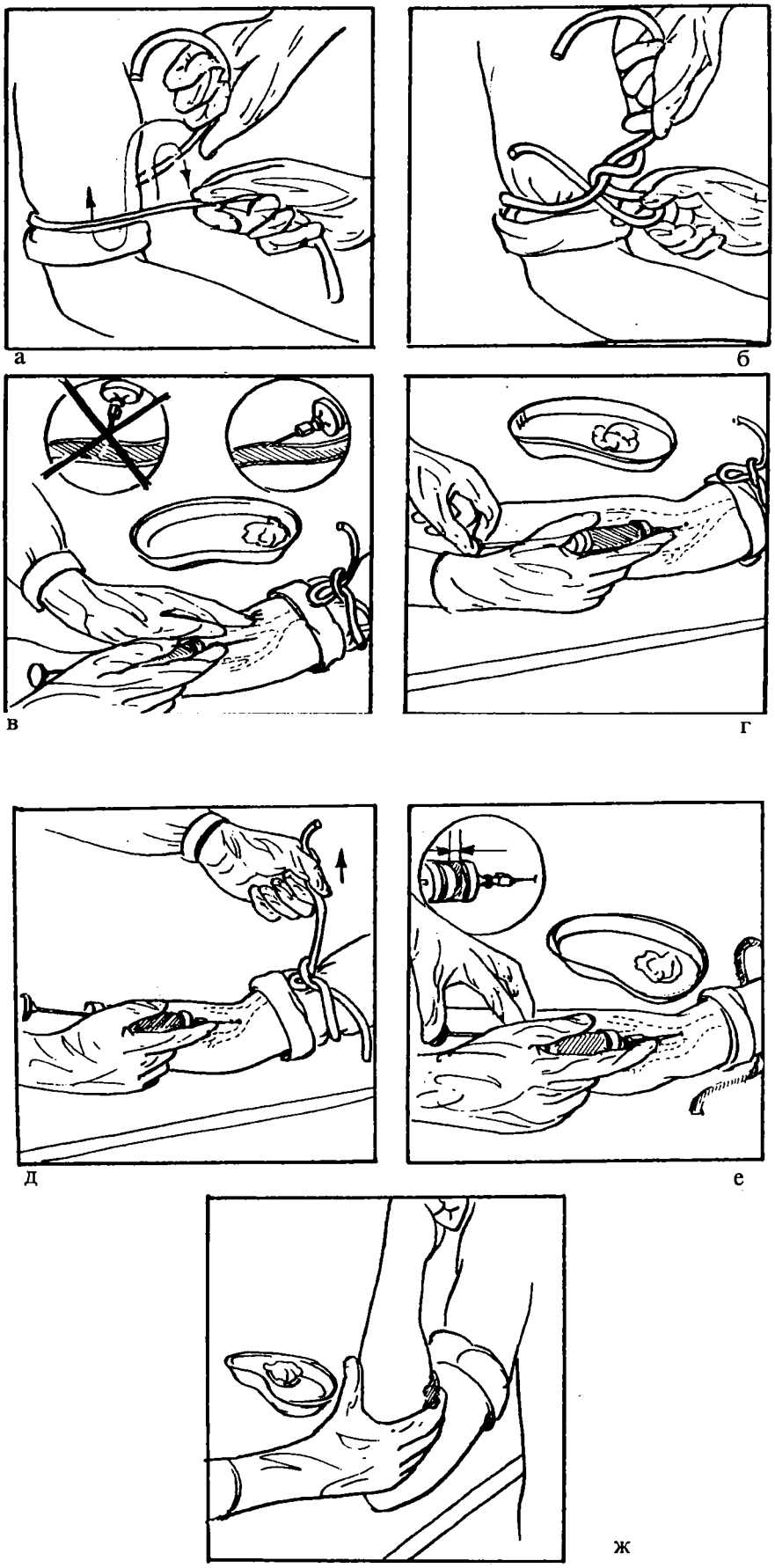
Intramuscular injection into the shoulder



Technique for performing intravenous injection:

Purpose: medical.
Indications: doctor's prescription.
Contraindications determined by the doctor.
Prepare:
a) first-aid kit "Anti-AIDS" on the mucous membranes and skin;
b) an antishock set with a disposable syringe;
c) tonometer, phonendoscope;
d) a container with a ground stopper for alcohol;
d) containers with des. solutions;
e) a container for used material not in contact with the patient (bucket with a pedal);
g) a rubberized pad (roller), venous tourniquet, diaper;
h) Bix with sterile material and tools;
i) a sterile tray for syringe, needles, sterile wipes;
g) sterile gloves, a mask (if suspected of HIV infection - glasses!);
Patient preparation:
a) psychological - specify whether the patient is afraid of the prescribed manipulation and type of blood;
b) specify the individual sensitivity to the drug;
c) designate the time and place of the manipulation (ward, treatment room).
d) explain that for some time before the injection he should eat.
Sequencing:
1. Wash your hands, dry, change your dressing gown, put on a mask, treat your hands with a cloth soaked in alcohol and prepare for injection all sterile material, including collect the syringe from a sterile table, tray.
2. Assemble the syringe for the drug kit, put it into the syringe, change the needle to the injection needle, expel air bubbles from the cylinder, put the syringe in the sterile tray.
3. Seat or lay down the patient, examine both hands, revealing the presence of accessible veins. After specifying the injection site, lay the patient's hand so that it is not strained.
4. Wear sterile gloves. Under the elbow bend, put a roller, palpate the pulse.
5. Above the elbow, on the middle third of the shoulder, not on the naked body, apply a venous tourniquet, and the pulse should be determined.
6. Ask the patient to squeeze and unclench his fist several times, meanwhile palpate the most filled vein and ask the patient to clench his fist and DO NOT unclench until your permission.
7. Treat the injection field with gauze napkins dipped in alcohol, first widely, then directly to the puncture site, last
work gloves (the direction of processing is from the bottom up).
8. Make sure that the puncture site is dry, take the syringe in your right hand, fixing the needle sleeve with your left hand. With your thumb, pull the skin over the punctured vein, thereby fixing it, for convenience, 4 fingers bring under the elbow.
9. Punctate the vein in one of the ways (simultaneously or simultaneously) until the sensation of "failure". Without intercepting the syringe in the other hand, pull the piston toward you with your left hand, if blood appears in the cylinder, then you are in a vein.
10. Ask the patient to unclench a fist and remove a plait.
11. Slowly inject the drug (note that if blood in the cylinder has formed clots, then the drug must be administered before the blood clots, if it has dissolved and stained the drug evenly, you can enter it to the end.
12. With a quick movement, remove the needle from the vein, press a sterile gauze napkin to the puncture site and ask the patient to bend his elbow bend until the bleeding stops.
13. Ask the patient about his health, take away a napkin from him, schedule the next injection and let him go.
14. Spend dis. processing of all used material.

Intravenous injection

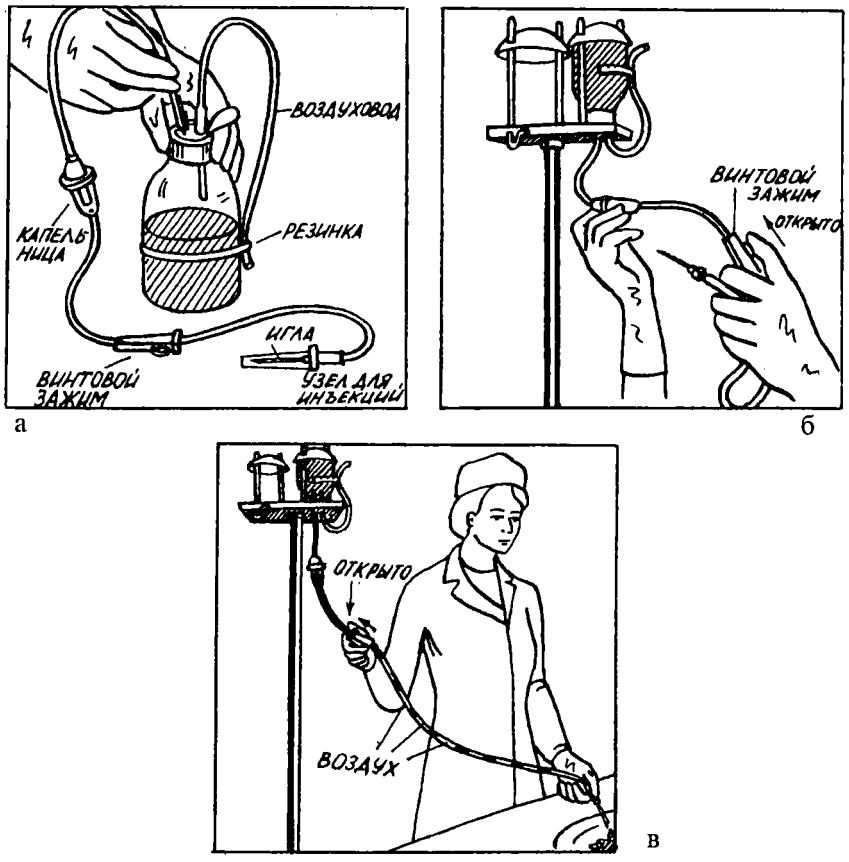


Technique for intravenous drip infusion:

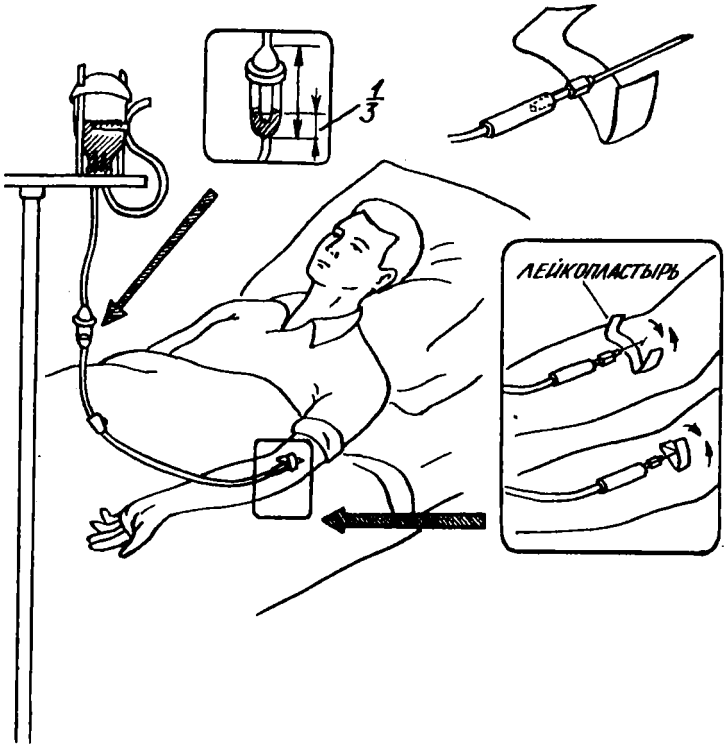
Purpose: medical.
Indications: doctor's prescription.
Contraindications determined by the doctor.
Prepare:
a) first-aid kit "Anti-AIDS";
b) an antishock set with a disposable syringe;
c) tonometer, phonendoscope;
d) a container with a ground stopper for alcohol;
d) capacity with des. means;
e) a container for material not in contact with the patient, a bucket with a pedal;
g) a rubberized pad or cushion, venous tourniquet, diaper, adhesive plaster, scissors;
g) bixes with sterile material, tools,
h) a sterile syringe tray, which is used to rinse the drip system and sterile wipes des. solution;
i) a disposable system for transfusion;
g) sterile gloves, mask;
j) medicine vials.
Patient preparation:
1. Psychological.
2. Tell the patient how much time will be approximately spent on the manipulation.
3. Depending on the patient's physical activity, provide him with the possibility of physiological administration.
4. Check to see if the patient has any requests.
5. Explain to the patient what his position in bed should be during manipulation (if the patient is conscious and perceives everything adequately).
Sequencing:
1. Before handling, check that the patient is properly prepared.
2. Help the patient lie on the opposite edge of the bed so that his arm rests without tension. not hanging down.
3. Wash, dry hands, change a dressing gown, put on a mask.
4. Check the drip system packaging for:
a) tightness;
b) expiration date,
c) the presence of visible defects (cracks, breaks, the absence of safety caps on the needles).
5. Check the vials with the prescribed drugs for leaks,
specify the expiration date or date of manufacture, if the drug is prepared by a hospital pharmacy, name, dose, absence of signs of unsuitability according to the list of medical appointments.
6. Treat the metal disk of the bottle with a ball soaked in alcohol, remove it with sterile tweezers, treat the rubber stopper: alcohol - iodine - alcohol. If there is no alcohol, then you can treat it with an alcohol solution of chlorhexidine.
7. Before opening the package with the drip system through the package, secure the safety caps on all needles.
8. Use scissors to open the package with the drip system from 3 sides and you can work as if on a sterile diaper.
9. Remove the safety cap from the duct and insert the needle into the rubber stopper of the bottle until it stops.
10. Close the clamp of the drip system, remove the safety cap from the drug transfusion needle and insert it into the vial until it stops.
11. Position the duct pipe along the bottle so that its end is at the bottom of the bottle.
12. Turn the bottle upside down with the stopper and in this position secure it to the tripod stand.

13. Remove the safety cap from the injection needle (punctured patient vein).
14. Take the dropper in your right hand and give it a horizontal position, open the clamp, but not completely, slowly fill the dropper to 1/2 of its volume.
15. Close the clamp and return the dropper to a vertical position.
Remember! The dropper filter must be completely covered by the solution.
16. Open the clamp and slowly fill the entire system until air is completely displaced in the duct,
17. Check for air bubbles in the drip tube system.
18. Place 2 sterile wipes on the injection unit with sterile tweezers, apply a sterile clip to them and fasten it to the hook of the tripod stand.
19. Cut 2-3 strips of adhesive tape and attach to a tripod. Lower the system clamp to the level of the injection unit. The system is ready for the prescribed drip of drugs.
20. Wash your hands (in the ward), treat them with alcohol, put on gloves, remove the system and put in the tray.
21. Under the elbow and the patient's wrist joint, place a roller.
22. On the middle part of the shoulder (not on the naked body), apply the tourniquet in the direction from top to bottom so that the loop of the tourniquet is located on the outside of the shoulder.
23. Ask the patient to squeeze and unclench his fist several times, palpate the most filled vein, and ask the patient not to unclench his fist.
24. With rapid movements, treat the injection field with a sterile cloth moistened with alcohol or another antiseptic, first broadly, then directly at the injection site.
25. Treat gloves with alcohol.
26. Separate the needle from the drip system (if the injection unit is made of opaque rubber), remove the safety cap from it, place the needle sleeve on 2 sterile wipes and puncture it with a vein. If blood appears, do not fully open the clamp and attach a system to the needle on a full drop of solution from the cannula.
27. Palpate the area around the puncture to determine if the solution has got under the skin. if there is no swelling around the puncture site, then the needle remains in the vein.
As directed by your doctor, adjust the rate of infusion.
28. Remove the blood-soaked gauze, fix the needle over the sleeve to the patient's skin
Additional Information:
a) if the injection unit is made of transparent material, then you can puncture the vein without separating the needle from the system, since you can see the incoming blood;
b) enter additional drugs only through the injection unit after it has been treated with alcohol, use needles with a diameter of not more than 0.8 mm;
c) when changing the bottle, close the clamp, do not allow the system to empty out of the drug. first remove the drug needle from the cork of the vial, then insert the airway needle into the vial filled with the medicine, open the clamp and adjust the rate of drug intake;
29. After the end of the manipulation:
a) remove the napkin, adhesive tape, put it in the tray for used material;
b) carefully place the index and middle fingers under the napkin with the needle, put your thumb on the needle sleeve and put the needle on the napkin, attach a sterile napkin to the puncture site;
c) ask the patient to bend the arm in the elbow joint until the bleeding stops from the puncture site;
d) all used material must be decontaminated in des. solutions, including a napkin taken from the patient after stopping bleeding from the puncture site.

Filling system for intravenous drip



Intravenous drip



Gastric lavage:

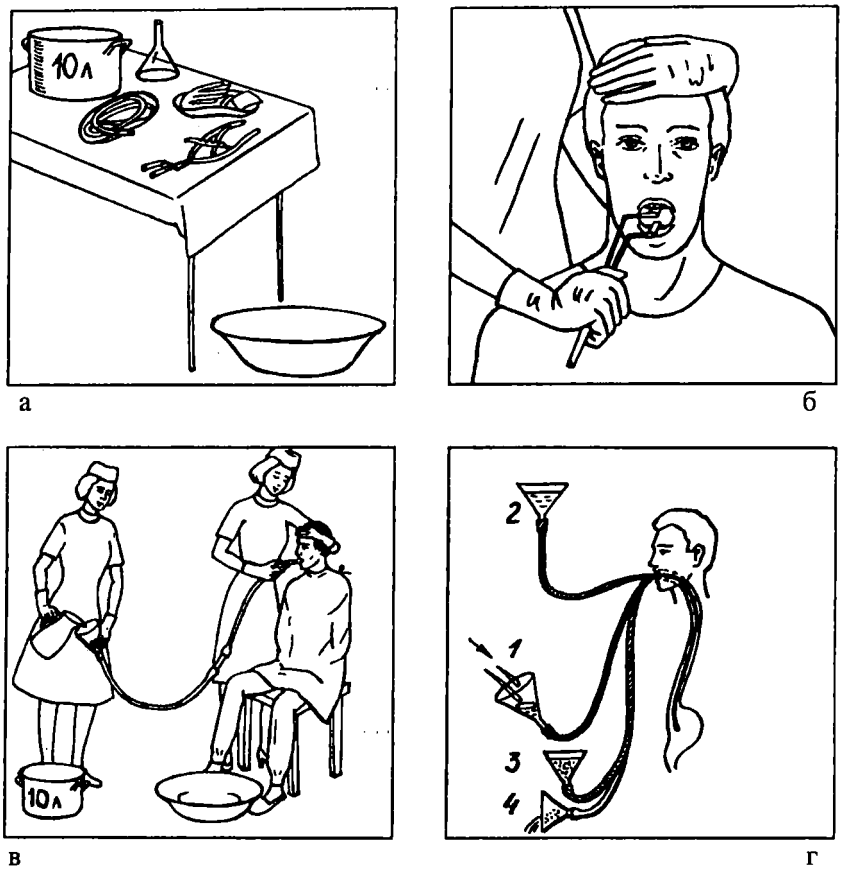
Active release of the stomach from toxic substances. The method is available, does not require large equipment and a set of medicines.
To wash the stomach, you can use various methods:
a) "restaurant" method;
b) washing with a thick gastric tube;
c) washing with a thin gastric tube;
g) washing with the use of the drug apomorphine, which has a strong emetic effect.
Remember!
Emergency (urgent) gastric lavage is necessary for the patient, regardless of the time elapsed since the moment of toxic substances intake.
The "restaurant" method of gastric lavage is used when the patient's condition allows this.
Sequencing:
1. Depending on the conditions in which you find yourself, seat the patient or lay him on his side so that the body is above the patient's head.
2. If possible, fix the patient in the position necessary for the manipulation.
3. Use improvised means to ensure the collection of flushing water (for examination by an ambulance doctor).
4. Protect your skin integuments and mucous membranes as much as possible from the contact with the washings.
5. In portions, not more than 500 ml, water the patient at room temperature (in total he needs to drink from 5 to 10 liters, and sometimes more).
6. After each portion of the water taken, incline the patient over the rinse water tank, fixing his head and body (this manipulation is best performed by two or three).
7. Ask the patient to open his mouth wide and, if able, insert 2 fingers of his right hand into the oral cavity and move along the root of the tongue, causing a gag reflex. After the vomiting is over, free the oral cavity from the remaining vomit.
8. Rinse the stomach to "clean" wash water so that they do not have food debris, mucus; clean the mucus from the nasopharynx.
9. After the gastric lavage is completed, the patient can be offered an activated carbon tablet.
Remember!
If gastric lavage was carried out according to the behavior of an accidental or deliberate use of toxic agents, you first need to call an ambulance team.
If there are no dishes for rinsing water at hand, you can use plastic bags (they can also be used instead of gloves).
The use of apomorphine (0.5-1.0 p / c - only as prescribed by the doctor) - if necessary, the rapid removal of poisons and substandard foods from the stomach, especially when it is impossible to rinse the stomach. The action comes in a few minutes. After vomiting, the patient is in bed for several hours. The nurse is obliged to monitor the patient's compliance with the prescribed physical activity regimen by the doctor.

Gastric lavage with a gastric tube:

Goal:
a) medical;
b) diagnostic.
Indications are determined by the doctor.
Contraindications determined by the doctor.
Prepare:
1. Gastric tube, rubber tube, glass adapter.
2. Transparent funnel with a capacity of 1 liter.
3. Sterile tray.
4. A sterile tube with a stopper.

5. The syringe of Janet.
6. Jug with a capacity of 1 liter.
7. Gloves.
8. Oilcloth apron - 2 pcs.
9. Towel.
10. Capacity with water for 8-10 l, t ° 20 C.
11. Wash water tank.
12. Tanks with des. solution.
13. Tripod.
14. Referral to the laboratory.
Patient preparation:
a) reassure the patient;
b) explain to him how to behave during the manipulation;
c) measure blood pressure and count the pulse.
The procedure for the ward nurse:
1. Sit on a chair so that its back is firmly pressed against the back of the chair.
2. Cover the patient's chest with an oilcloth apron.
3. Remove the removable dentures and place them in a glass of water at room temperature.
4. Check the patient's height to determine the length of the probe inserted into the stomach (growth minus 100 cm or from the wing of the nose to the earlobe and then to the patient's xiphoid process). Make a mark on the probe (if the patient's height is standard, from 160 to 180 cm, you can work on the standard marks on the probe).
5. Wash your hands with soap.
6. Put on an apron, mask, gloves.
7. Stand to the right of the patient, place a container of clean water on the right, and for flushing water, on the left.
8. Instruct patient to open mouth wide and breathe deeply through nose. At the expense of 1, 2, 3, 4 - the patient takes a breath, and you quickly enter the blind end of the probe at the root of the tongue, smeared with liquid oil or moistened with saline or oil, and ask the patient to swallow. At the expense of 1, 2, 3, 4, 5, 6 - exhale, the patient is resting.
7. Ask the patient to make several swallowing movements. Pass the probe through the esophagus and into the stomach in the same way.
8. Attach a funnel to the probe at the level of the patient's knees, tilting it slightly towards you so as not to introduce additional air into the stomach. Pour water over the wall of the funnel, thereby displacing air from the tube system.
9. Filling the tube system, raise the funnel up to the level of an outstretched arm, water will immediately begin to flow into the stomach.
10. Having waited until the water reaches the narrowing of the funnel, quickly lower it down, the gastric lavage quickly fill the funnel.
11. Pour the contents of the funnel into the wash tank, being careful not to spray.
12. Repeat the steps described in p. 8-11.
Additional Information:
1. The manipulation is repeated until the washings are "clean", that is, they will not contain food debris, mucus, etc.
2. In case of poisoning, if the patient is taken to the intensive care unit, the nurse must immediately, without waiting for the doctor's prescription, insert a disposable probe into the stomach.

Gastric lavage with a gastric tube:



Washing of a seriously ill patient:

Purpose: personal hygiene.
Indications: after each act of defecation and urination.
Prepare: a jug with a warm (37–38 ° C) solution of furatsilin or a weak solution of potassium permanganate; surgical clamp (forceps); gauze napkins; oilcloth; vessel; gloves screen, thermometer.
Before performing the manipulation:
1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation, gain understanding and get consent to carry it out.
3. Ensure the confidentiality of the manipulation (fence off the patient with a screen in the room).
4. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.
Sequencing:
1. Wear rubber gloves.
2. Put oilcloth on the bed under the patient, put the vessel on it and help him lie on the vessel on his back, legs should be slightly bent at the knees and divorced in the hips.
3. Stand to the right of the patient.
Performing manipulations to a woman:
Sequencing:
1. Take a jug with a warm solution of furatsilin in the left hand, and the clip with a napkin to the right.

2. When pouring from a jug, treat the external genitals sequentially
towards the anus (front to back): pubic area, external (large) labia, inguinal folds, crotch, anal area, intergluteal fold.

Manipulation of a man:

Sequencing:

1. Carefully move the foreskin with the fingers of your left hand, exposing the glans penis, and treat it with a sterile cloth moistened with furacilin.
2. Take a jug with a warm solution of furatsilin in the left hand, and clamp
with a napkin to the right. When pouring from a jug, sequentially treat the skin of the penis, scrotum, inguinal folds, the anus, and the intergluteal fold.
3. Change wipes as they become dirty.
4. Dry the crotch with a dry cloth in the same sequence (front to back).
5. Remove the boat and oilcloth, straighten the bed.
6. Help the patient lie comfortably, cover him, tell him a few kind words.
7. Treat the vessel and oilcloth with disinfectant according to the applicable instructions.
8. Remove gloves and place them in disinfectant.
9. Wash your hands.

Remember! With the wrong sequence of the procedure, infection can be introduced into the urinary tract.

The staging of a vent pipe for a seriously ill patient:

Purpose: removing gases from the intestines.
Indications: flatulence (accumulation of gases in the intestine).
Prepare: a sterile vent pipe (disposable), petroleum jelly; oilcloth, a vessel with a small amount of water; gloves gauze napkins; spatula, screen, furatsilina solution.
Before performing the manipulation:

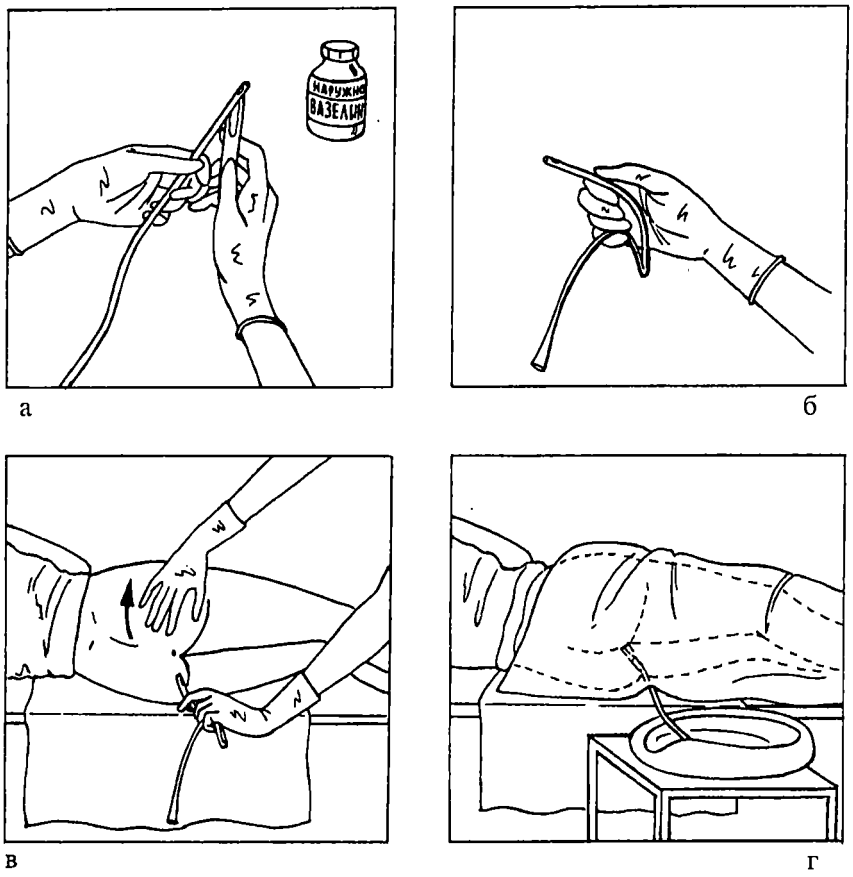
1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation, gain understanding and get consent to carry it out.
3. Ensure the confidentiality of the manipulation (fence off the patient with a screen in the room).
4. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.

Sequencing:

1. Wear gloves.
2. Put oilcloth on the bed under the patient, help him lie on his back, on the oilcloth.
3. Ask him to bend his knees and spread them apart.
4. Place a vessel near the patient (with a small amount of water).
5. Take the vent pipe and grease the rounded end of the tube with Vaseline.
6. Spread the buttocks to the patient.
7. Insert a 20-30 cm vent tube into the rectum, carefully, using rotational movements.
8. Lower the outer end of the tube into the vessel with water, cover the patient with a blanket or sheet.
9. Monitor gas discharge and patient well-being every
15 minutes, since clogging of the tube with feces is possible.
10. After an hour, carefully remove the tube through a tissue moistened with disinfectant.
11. Treat the anus first with a damp cloth moistened with furatsilin, then dry or wash the patient.
12. Remove the boat and oilcloth, straighten the bed.
13. Help the patient lie comfortably, cover him, tell him a few kind words.
14. Treat the flue pipe, vessel, oilcloth in a disinfectant according to current instructions.

15. Remove gloves and place them in a disinfectant solution.
16. Wash your hands.
Complications: with prolonged staging of the vent tube for more than 2 hours, the patient may experience pressure sores on the mucous membrane of the rectum.
Remember! The vent pipe can be removed after 20-30 minutes, if the patient has passed the gases. If the manipulation is ineffective, repeat it after 30-60 minutes using another sterile gas vent tube.

The staging of a vent pipe for a seriously ill patient:

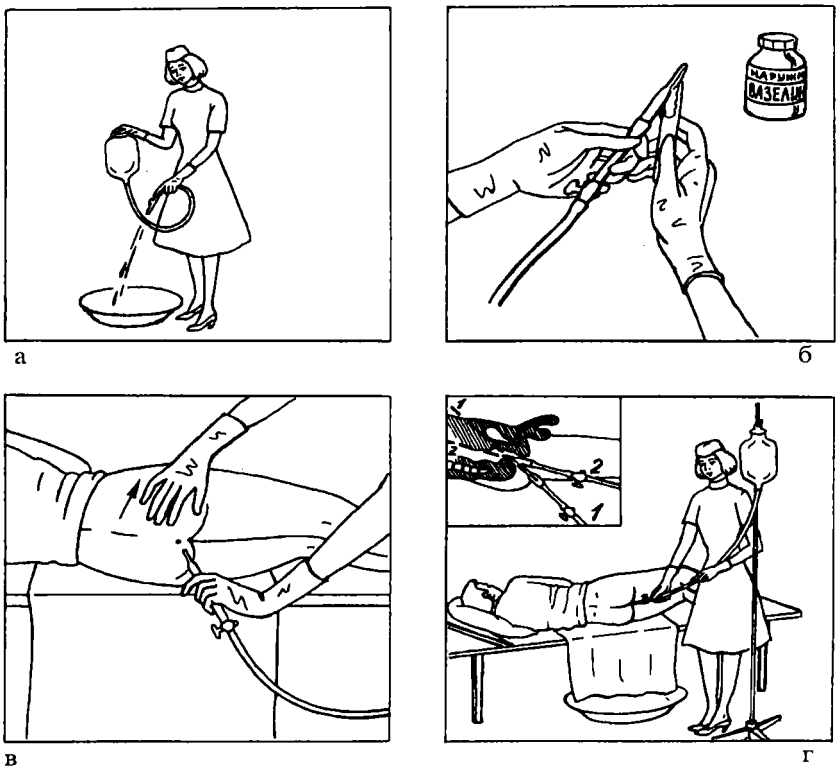


Setting a cleansing enema for the patient:

Purpose: bowel cleansing (medical and diagnostic).
Indications: bowel cleansing before radiological and endoscopic
studies of the colon, with constipation, before surgery, childbirth, before setting a medicinal enema.
Contraindications: bleeding from the lower digestive tract, acute inflammatory or ulcerative processes in the colon and anus, malignant colon, the first days after surgery on the digestive tract, prolapse of the rectum.
Prepare: an Esmarch mug with a hose, a sterile tip, petroleum jelly, oilcloth, a vessel, boiled water 1-1.5 l (20 ° C), gloves, an apron, a thermometer (for measuring the temperature of the injected liquid), a tripod for hanging an Esmarch mug, enameled pelvis, spatula, jug with a warm (37–38 ° C) solution of furatsilin or a weak solution of manganese, a surgical clamp (forceps), gauze napkins, a screen.
Before performing the manipulation:

1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation, gain understanding and get consent to carry it out.
3. Ensure the confidentiality of the manipulation by inviting the patient to the enema, and if the manipulation is carried out in the ward, then fencing it with a screen from the rest of the patients.
4. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.
Sequencing:
1. Wear rubber gloves.
2. Put on the apron.
3. Assemble the system by connecting the tip to it.
4. Pour 1-1.5 l of water with a temperature of 20-22 ° C into Esmarch's mug.
5. Hang the mug on a rack 1 m above the patient.
6. Close the valve.
7. Fill the system with water.
8. Bleed the system by opening the valve and letting water through
through the tip.
9. Lubricate the tip with Vaseline using a spatula.
10. On the couch (bed) under the patient, put an oilcloth, the end of which hangs in the pelvis (in case the patient does not hold water in the intestine).
11. Help the patient lie on his left side with his knees bent and legs slightly raised to his stomach.
12. Using your fingers of your left hand, spread the buttocks of the patient, and with your right hand carefully insert the tip into the anus, moving it into the rectum towards the navel (3-4 cm), then parallel to the spine (8-10 cm).
13. Open the valve so that water slowly enters the intestines. Ask the patient to breathe deeply in the stomach.
14. If it is difficult for the patient to hold water, then introduce water in separate portions, closing the valve after each portion, giving him a break.
15. After introducing water into the intestine, close the valve and carefully remove the tip, leaving a little water at the bottom of the mug so that air does not enter the intestine.
16. Help the patient get up from the couch and reach the toilet bowl when there is a urge to defecate.
17. Offer him toilet paper.
18. After emptying the patient, take the patient to the ward.
19. When performing manipulations in the ward, place the vessel under the patient.
20. After defecation, take the vessel with feces to the toilet and
pour out.
21. Bring a clean vessel and substitute under the patient, his legs should be slightly bent at the knees and divorced in the hips.
22. Stand to the right of the patient and, holding a jug with a warm solution of furatsilin in your left hand, and a clip with a napkin in your right hand, pouring the patient's external genitals from the jug, while treating the perineum with a napkin in the clip towards the anus (front to back).
23. Dry the crotch with a dry cloth (front to back).
24. Remove the boat and oilcloth.
25. Correct the bed and cover the patient, tell him a few kind words.
26. Disassemble the system, disinfect the tip according to the current instructions.
27. Disinfect the vessel in accordance with current regulations.
28. Remove the apron and treat with disinfectant according to the instructions.
29. Remove gloves and lower them into a container for disinfection.
30. Wash and drain your hands.
31. Ventilate the room and remove the screen.

Setting a cleansing enema for the patient

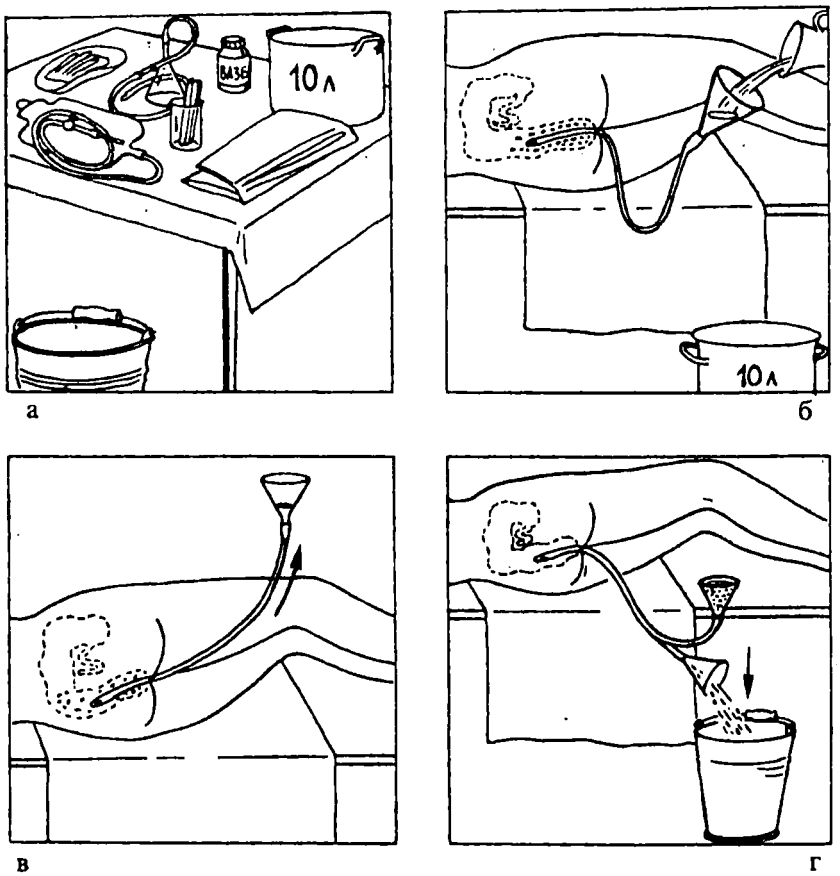


Siphon enema setting:

Purpose: cleansing.
Indications are determined by the doctor.
Contraindications determined by the doctor.
Prepare:
a) rubber probe, rubber tube;
b) glass adapter;
c) a transparent funnel with a capacity of 1 l;
d) a sterile tray for the above kit;
d) a jug with a capacity of 1 liter;
e) oilcloth apron;
g) a diaper, oilcloth;
g) a container of water for 8-10 l, t ° 18-20'C;
h) capacity for washing water;
i) a tripod with a container for shipment to the laboratory;
g) referral to the laboratory;
j) containers with des. solution.
Patient preparation:
a) psychological;
b) specify the purpose of the enema;
c) explain to the patient how to behave during the manipulation;
d) measure blood pressure and count the pulse.
The procedure for the ward nurse:
1. Prepare for the procedure: wash your hands thoroughly with soap and warm running water, put on a mask, apron and gloves.

2. Put a basin on the floor near the couch; put oilcloth on the couch (the free end of which is lowered into the basin) and a diaper on top of it.
3. Ask the patient to lie on the edge of the couch, on the left side, bending his knees and bringing them to his stomach to relax the abdominal press.
4. Prepare the system, draw a small amount of Vaseline with a spatula and grease the end of the probe with it.
5. Slide the buttocks with the thumb and forefinger of the left hand, and with the right hand gently rotate the probe carefully into the anus to a depth of 30-40 cm.
6. Place the funnel in an inclined position just above the level of the patient's body and fill it with a bucket in the amount of 1 liter.
7. Slowly raise the funnel 0.5 m above the patient's body level.
8. As soon as the level of the decreasing water reaches the mouth of the funnel, lower the funnel below the patient's body level and wait for the funnel to fill with the reverse fluid flow (water with particles of intestinal contents).
9. Drain the contents of the funnel into the basin.
10. Repeat washing (paragraphs 6-9) until clean wash water appears in the funnel. 11. Slowly remove the probe and immerse it together with the funnel in a container with a disinfectant solution.
12. Hold the toilet of the anus.
13. Remove apron, mask, gloves, wash hands.
Additional Information:
1. The criterion for the correctness of the siphon enema (as well as for gastric lavage) is the amount of wash water obtained, it must be greater than the entered volume.

Siphon enema



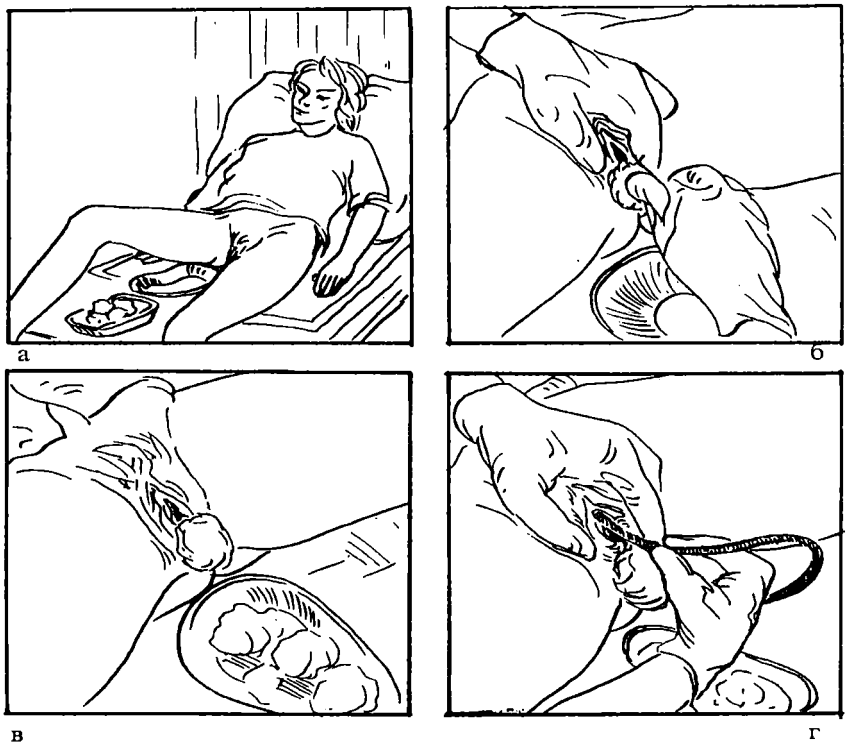
Bladder catheterization in women and men:

Purpose: urine excretion (for medical or diagnostic purposes) and injection of drugs (for medical or diagnostic purposes) into the bladder.
Indications: for acute urinary retention, for washing the bladder,
for the introduction of drugs into it, taking urine for analysis.
Prepare: a sterile elastic plastic or rubber catheter, sterile tweezers, a sterile tray, 0.02% sterile furatsilin solution, sterile liquid paraffin or urogel, sterile wipes, urinal, gloves, a screen.
Before catheterization, the elastic catheter must be held in hot, sterile, distilled water - it will become less rigid.
Before performing the manipulation:
1. Polite, benevolently greet the patient by contacting him by name and patronymic.
2. Explain to him the meaning of manipulation, gain understanding and get consent to carry it out.
3. Ensure confidentiality of the manipulation by inviting the patient to the manipulation room, and if the manipulation is carried out in the ward, then he fenced it with a screen from the rest of the patients.
4. During the manipulation, politely communicate with the patient, explaining to him your actions. Show kindness and mercy to him.

Performing manipulations in women:

Sequencing:
1. Wear gloves.
2. Politely ask the patient to lie on his back, bend his knees and spread his hips.
3. Place the urinal between the patient's legs.
4. Take a sterile cloth and moisten it with furatsilina solution.
5. Open the patient's labia majora with the first and second fingers of the left hand, exposing the external opening of the urethra.
6. Treat the entrance to the urethra with a cloth moistened with a solution of furatsilina.
7. With your right hand, take sterile forceps with a sterile rubber catheter near its tip at a distance of 5-6 cm from the side hole, and hold the tail of the catheter between 4 and 5 fingers of the same hand and grease the tip with sterile paraffin oil or urogel.
8. Insert the catheter into the urethra until urine appears and
lower the tail of the catheter into the urinal.
9. Remove the catheter from the urethra at the end of the urine output.
10. Dry the perineum with a sterile cloth.
11. Correct the bed and cover the patient, tell her a few kind words.
12. The catheter after catheterization and the urinal should be treated in a disinfectant according to current instructions.
13. Remove gloves and lower them into a disinfection container.
14. Wash and dry your hands.

Bladder catheterization in women:

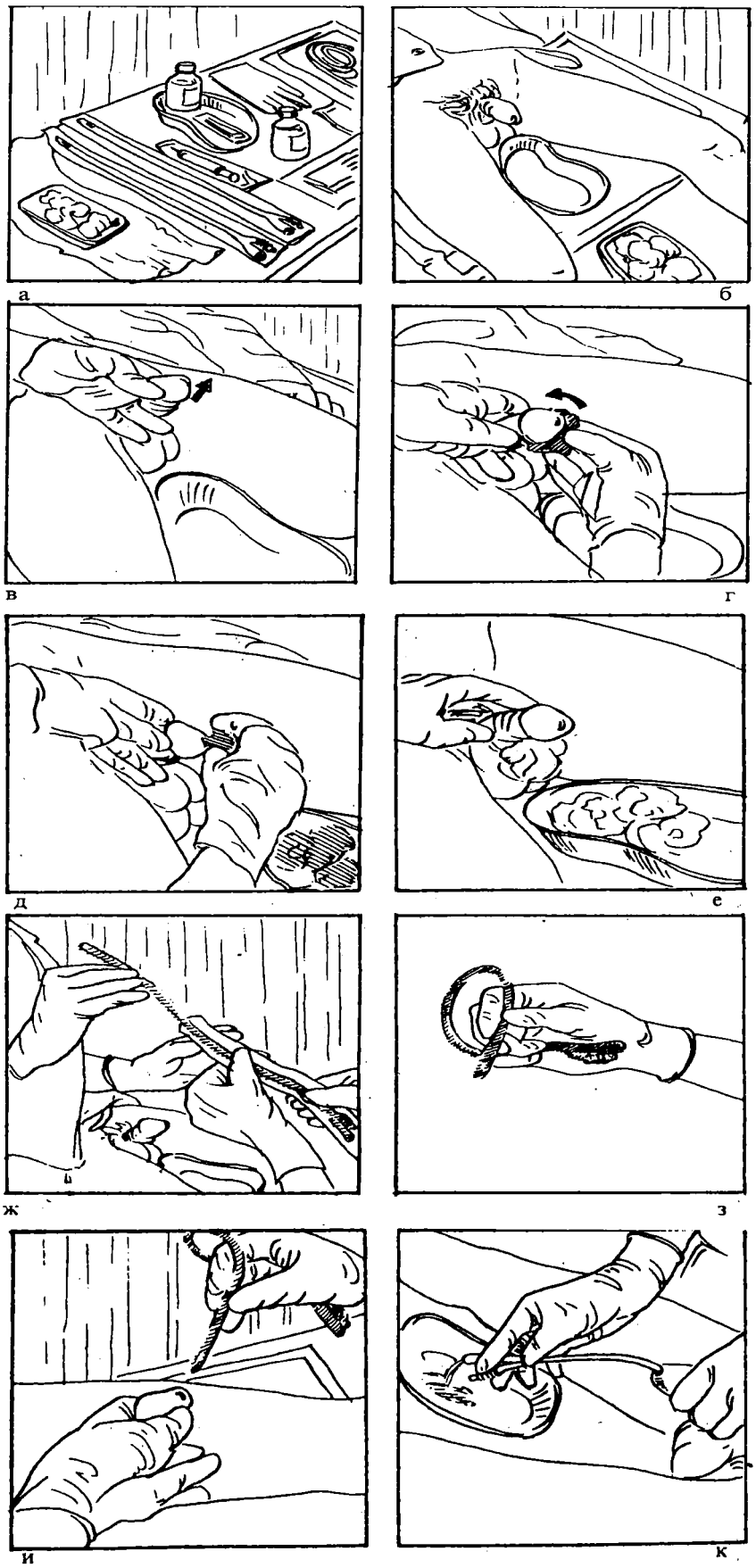


Performing manipulations in men:

Sequencing:

1. Wear gloves.
2. Politely ask the patient to lie on his back, bend his knees and spread his hips.
3. Place the urinal between your legs.
4. Take a sterile cloth and moisten it with furatsilina solution.
5. Grip between the 3rd and 4th fingers of the left hand the head of the penis of the patient, and with the first and second fingers, open the external opening of the urethra.
6. With your right hand, treat the entrance to the urethra with a cloth soaked in a solution of furatsilina.
7. With your right hand, take sterile forceps with a sterile rubber catheter (moistened with pre-sterile liquid paraffin or urogel) near its tip at a distance of 5-6 cm from the side hole, and hold the tail of the catheter between 4 and 5 fingers of the same hand.
8. Insert the end of the catheter into the external opening of the urethra of the patient and, gradually grabbing the catheter, push it deeper into the canal, and pull the penis upward, as if pulling it on the catheter until urine appears. If there is an obstacle when moving the catheter, advise the patient to calm down, relax.
9. If urine appears, lower the tail of the catheter into the urinal.
10. Remove the catheter from the urethra by tightly clamping its outer end at the end of urine output.
11. Dry the head of the penis with a sterile cloth.
12. Correct the bed and cover the patient, tell him a few kind words.
13. The catheter after catheterization and the urinal should be treated in a disinfectant according to current instructions.
14. Remove gloves and lower them into a container for disinfection.
15. Wash and dry your hands.

Catheterization of the bladder in men

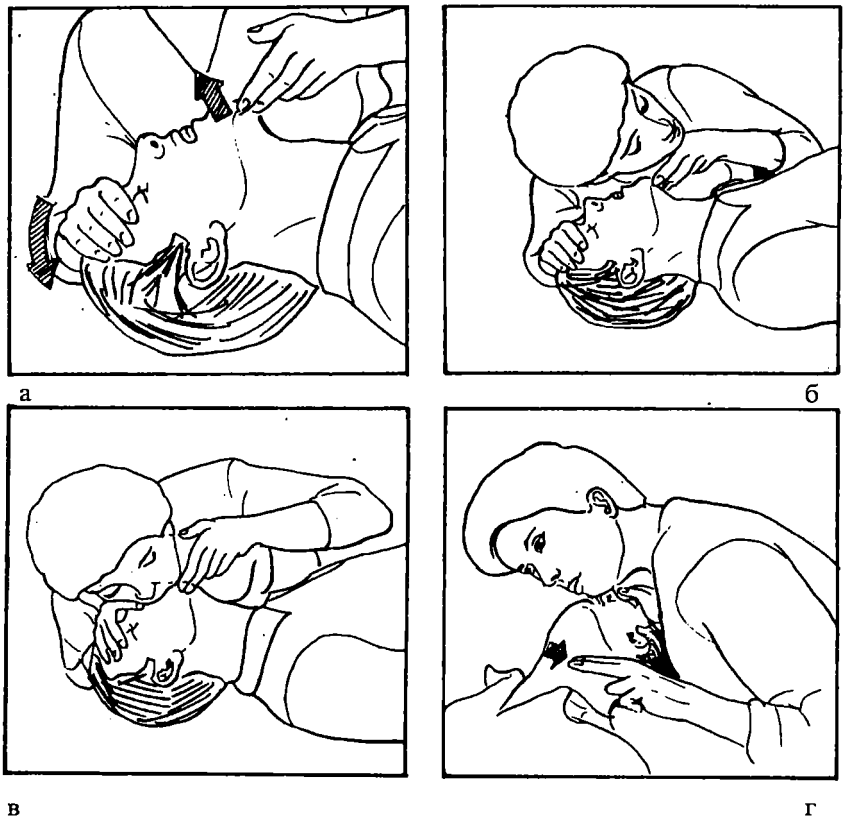


Cardiopulmonary resuscitation:

Purpose: revitalizing the body.
Indications: respiratory arrest and palpitations.
Contraindications: signs of biological death, trauma incompatible with life (tearing off the head, crushing of the chest, etc.) in incurable patients (cancer patients, severe stroke, etc.), if more than 25 minutes have passed since the cardiac arrest at an ambient temperature of 20-25 ° C.
Equipment: not required.
Sequencing:
1. Seeing the victim lying motionless with his eyes closed, approach him.
2. Touch and ask him “What is the matter with you?”, If he does not answer, check his heartbeat.
3. With your right hand, grasp the wrist of the victim so that the first finger is located on the ulnar side of the forearm, and the rest palpates the radial artery, pressing it to the radius.
4. If peripheral pulsation is absent, palpate the pulse on the carotid arteries. Grab the victim’s neck with his right hand so that the first finger is located on the back of the neck, and the others, slipping from the front edge of the sternocleidomastoid muscle, palpate the carotid artery, pressing it to the side surface of the cervical spine. If there is no pulse on the carotid arteries, then there is no heartbeat.
5. Bring a mirror to the victim’s nose, if it does not fog up, then there is no breathing. In the absence of a mirror, you can bring it to the victim’s nose
thread, if there is no rhythmic deviation of the thread brought to the nose, then breathing is absent.
6. With the first and second fingers of the brush, part the eyelids of the victim, if, when light enters the pupil, it does not narrow, which means that the pupil does not react to light.
7. Check if the victim has signs of biological death (cadaveric
spots and rigor mortis) - examine his subject areas of the body. Making sure that the victim is in a state of clinical death,
try to call for help - shout: "Help!" or use
mobile phone (if available) and quickly proceed to cardiopulmonary resuscitation.
9. Lay the victim on his back on a hard surface.
10. Release his chest from tight clothing.
11. Make a pericardial stroke - with a fist from a height of 20 cm, double-hit the chest in the compression point, in the absence of effect, continue resuscitation (mechanical ventilation, closed massage).
12. Stand at the head of the side of the victim.
13. Open the victim’s mouth with the index finger of his right hand wrapped in a handkerchief, revise the victim’s mouth and clean his mouth of mucus and foreign bodies.
14. Using a triple dose, ensure airway:
a) put the left hand on the victim’s forehead, the right one under the back of the head - throw the victim’s head back and put a roller from clothes under his shoulders.
b) cover with your index fingers the corners of the lower jaw of the victim and, resting your thumbs on the upper jaw, try to push the lower jaw forward.
c) by clicking on the chin with your right hand open the victim’s mouth.
15. Place a handkerchief with a small hole in the center on the victim’s mouth.
16. First and second fingers of the left hand, pinch the openings of the nose of the victim.
17. Inhale deeply and exhale vigorously into the respiratory tract of the victim through the mouth (the exhalation of the victim occurs passively), while exhaling the victim, take your head to the side.
18. Proceed to a closed heart massage:
a) place your hands with one palm surface crossed on top of the other, in the center of the lower third of the sternum of the victim two transverse fingers above the xiphoid process, while the fingers are raised and the arms are extended and locked at the elbows.

b) make a strong, energetic, quick pressure with the entire weight of the body at a speed of about 100 per minute, while displacing the sternum of the victim by 4-5 cm.
c) with one resuscitator, alternate 2 breaths with 30 presses on the chest; with two resuscitators, alternate 1 breath with 5 clicks on the chest
19. During resuscitation measures monitor their effectiveness,
if the measures are effective, then with mechanical ventilation at the time of inhalation, an increase in the chest of the victim is noted, with external massage in
the moment of pressing the victim's chest is determined
pulse wave in the central and peripheral arteries.
20. If the resuscitation measures are effective, continue them for half an hour. If during this time the victim does not have spontaneous heartbeat and breathing, resuscitation should be stopped.

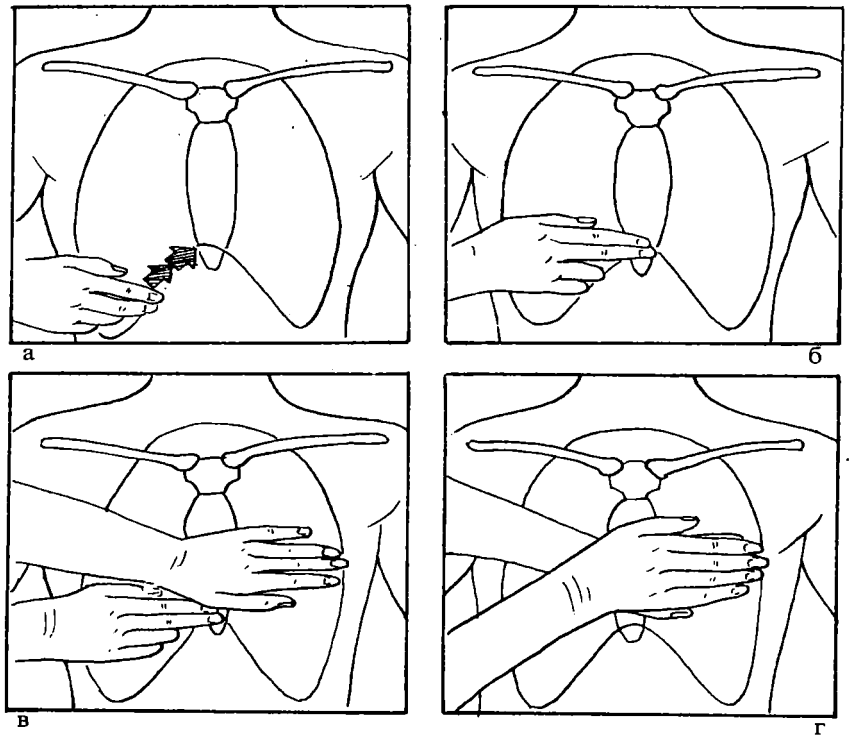
Creating airway patency with mechanical ventilation



Cardiopulmonary resuscitation using an air duct (Safar tube):
Purpose: revitalizing the body.
Indications: respiratory arrest and palpitations.
Contraindications: signs of biological death, trauma incompatible with life (tearing off the head, crushing of the chest, etc.) in incurable patients (cancer patients, severe stroke, etc.), if more than 25 minutes have passed since the cardiac arrest at room temperature.
Prepare: Safar tube, rotary expander, tongue holder.
Sequencing:
1. Seeing the victim lying motionless with his eyes closed, approach him.
2. Touch the victim and ask him "What is the matter with you?", If he does not answer, check his heartbeat.
3. Grip the victim's wrist with his right hand so that the first finger is located on the ulnar side of the forearm, and the rest palpated the radial artery, pressing it to the radius. If peripheral pulsation is absent, palpate the pulse on the carotid arteries.

4. Grasp the victim’s neck with his right hand so that the first finger is located on the back of the neck, and the others, slipping from the front edge of the sternocleidomastoid muscle, palpate the carotid artery, pressing it to the side surface of the cervical spine. If the pulse on the carotid arteries
absent, then there is no heartbeat.
5. Bring a mirror to the victim’s nose, if it does not fog up, then there is no breathing. If there is no mirror, you can bring a thread to the nose of the victim, if there is no rhythmic deviation of the thread brought to the nose, then there is no breathing.
6. With the first and second fingers of the brush, part the eyelids of the victim, if, when light enters the pupil, it does not narrow, which means that the pupil does not react to light.
7. Having ascertained that the victim is in a state of clinical death, try to call for help - shout: “Help!” or use a mobile phone (if available) and quickly proceed to cardiopulmonary resuscitation.
8. Place the victim on his back on a hard surface.
9. Release his chest from tight clothing.
10. Make a pericardial stroke - with a fist from a height of 20 cm, hit the chest twice at the compression point, in the absence of effect, continue resuscitation (mechanical ventilation, closed massage).
11. Stand at the head of the side of the victim.
12.Use the mouth of the expander to open the victim’s mouth: insert the mouth of the mouth of the mouth between the victim’s lips and, moving the cheek away, move the branches of the mouth into the mouth behind the molars, push the jaws of the mouth of the mouth to open the mouth of the victim.
13. Give him a toilet of the oral cavity.
14. With the jaws of the tongue holder, grab the tongue and remove it from the victim's mouth.
15. Insert the Safar tube between the victim’s teeth, with the convex side down, and then turn this side up and advance along the tongue all the way to its root.
16. Clamp the openings of the victim’s nose with two thumbs, and with your index fingers slide the rubber shield to your mouth. With the other three fingers of both hands, pull the chin forward for the corners of the lower jaw.
17. Take a deep breath and exhale forcefully into the mouthpiece of the duct, the victim is exhaled passively (while exhaling the victim, take your head to the side).
18. Proceed to a closed heart massage:
a) place your hands with one palm surface crossed on top of the other, in the center of the lower third of the sternum of the victim two transverse fingers above the xiphoid process, while the fingers are raised and the arms are extended and locked at the elbows.
b) make a strong, energetic, quick pressure with the entire weight of the body at a speed of about 100 per minute, while displacing the sternum of the victim by 4-5 cm.
c) with one resuscitator, alternate 2 breaths with 30 presses on the chest; with two resuscitators, alternate 1 breath with 5 clicks on the chest
19. During resuscitation measures monitor their effectiveness,
if the measures are effective, then with mechanical ventilation at the time of inhalation, an increase in the chest of the victim is noted, with external massage in
the moment of pressing the victim’s chest is determined
pulse wave in the central and peripheral arteries.
20. If the resuscitation measures are effective, continue them for half an hour. If during this time the victim does not have spontaneous heartbeat and breathing, resuscitation should be stopped.

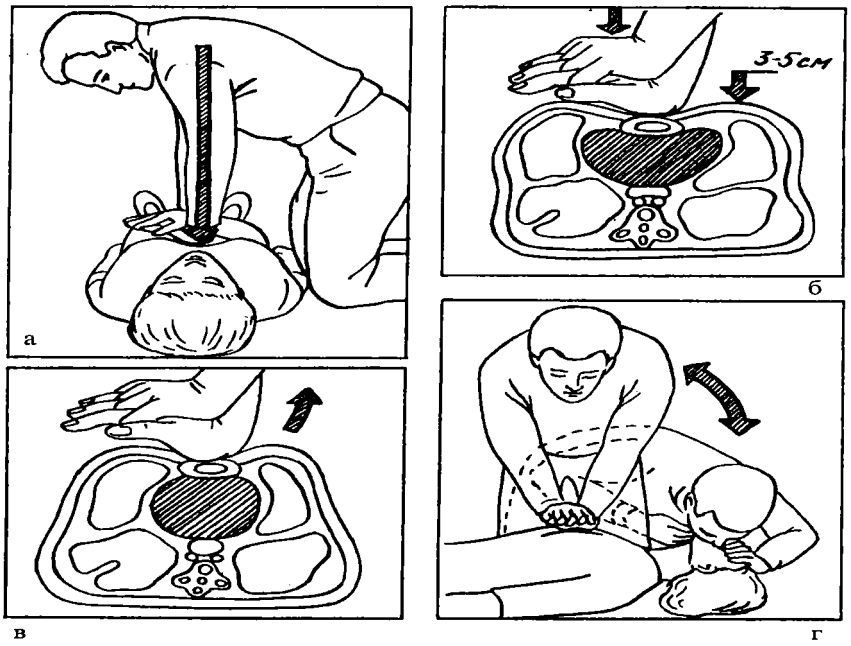
Arrangement of hands with indirect heart massage



Hardware cardiopulmonary resuscitation using an AMBU bag:
Purpose: revitalizing the body.
Indications: respiratory arrest and palpitations.
Contraindications: signs of biological death, trauma incompatible with life (tearing off the head, crushing of the chest, etc.) in incurable patients (cancer patients, severe stroke, etc.), if more than 25 minutes have passed since the cardiac arrest at room temperature.
Prepare: air duct, rotary expander, tongue holder, AMBU bag.
Sequencing:
1. Seeing the victim lying motionless with his eyes closed, approach him.
2. Touch the victim and ask him “What is the matter with you?”, If he does not answer, check his heartbeat.
3. Grip the victim’s wrist with his right hand so that the first finger is located on the ulnar side of the forearm, and the rest palpated the radial artery, pressing it to the radius.
4. If peripheral pulsation is absent, palpate the pulse on the carotid arteries.
5. Cover the victim’s neck with his right hand so that the first finger is located on the back of the neck, and the others, slipping from the front edge of the sternocleidomastoid muscle, palpate the carotid artery, pressing it to the side surface of the cervical spine. If the pulse on the carotid arteries
absent, then there is no heartbeat.
6. Bring a mirror to the victim’s nose, if it does not fog up, then there is no breathing. If there is no mirror, you can bring a thread to the nose of the victim, if there is no rhythmic deviation of the thread brought to the nose, then there is no breathing.
7. With the first and second fingers of the brush, part the eyelids of the victim, if, when light enters the pupil, it does not narrow, which means that the pupil does not react to light.
8. After making sure that the victim is in a state of clinical death, try to call for help - shout: “Help!” or use a mobile phone (if available) and quickly proceed to cardiopulmonary resuscitation.
9. Lay the victim on his back on a hard surface.
10. Release his chest from tight clothing.

11. Make a pericardial stroke - with a fist from a height of 20 cm, double-hit the chest in the compression point, in the absence of effect, continue resuscitation (mechanical ventilation, closed massage).
12. Stand at the head of the side of the victim.
13.Use the mouth of the expander to open the victim's mouth: insert the mouth of the mouth of the mouth between the lips of the victim and, moving the cheek away, move the branches of the mouth into the mouth behind the molars, open the mouth of the mouth with the handles of the mouth and open the victim's mouth.
14. Give him a toilet of the oral cavity.
15. With the jaws of the tongue holder, grab the tongue and remove it from the victim's mouth.
16. Insert the duct between the victim's teeth with the convex side down, and then turn it with this side up and slide it along the tongue all the way to its root.
17. Take the AMBU bag and firmly press the mask connected to the bag of the AMBU device to your face, placing it on the victim's mouth and nose (you can fix the mask with a mask holder).
I 8. With one hand holding the mask on the victim's face, with the other hand, squeeze the bag of the AMBU apparatus, blowing air into the victim's lungs (exhale passively into the atmosphere).
19. Relax your hands and the bag will be filled with air by stretching. Adjust your breathing rhythm - inhale should be half as long as exhale.
20. Proceed to a closed heart massage:
a) place your hands with one palm surface crossed on top of the other, in the center of the lower third of the sternum of the victim two transverse fingers above the xiphoid process, while the fingers are raised and the arms are extended and locked at the elbows.
b) make a strong, energetic, quick pressure with the entire weight of the body at a speed of about 100 per minute, while displacing the sternum of the victim by 4-5 cm.
c) with one resuscitator, alternate 2 breaths with 30 presses on the chest; with two resuscitators, alternate 1 breath with 5 clicks on the chest
21. During resuscitation measures monitor their effectiveness,
if the measures are effective, then with mechanical ventilation at the time of inspiration raising the chest of the victim, with external massage in
the moment of pressing the victim's chest is determined
pulse wave in the central and peripheral arteries.
22. If the resuscitation measures are effective, continue them for half an hour. If during this time the victim does not have spontaneous heartbeat and breathing, resuscitation should be stopped.

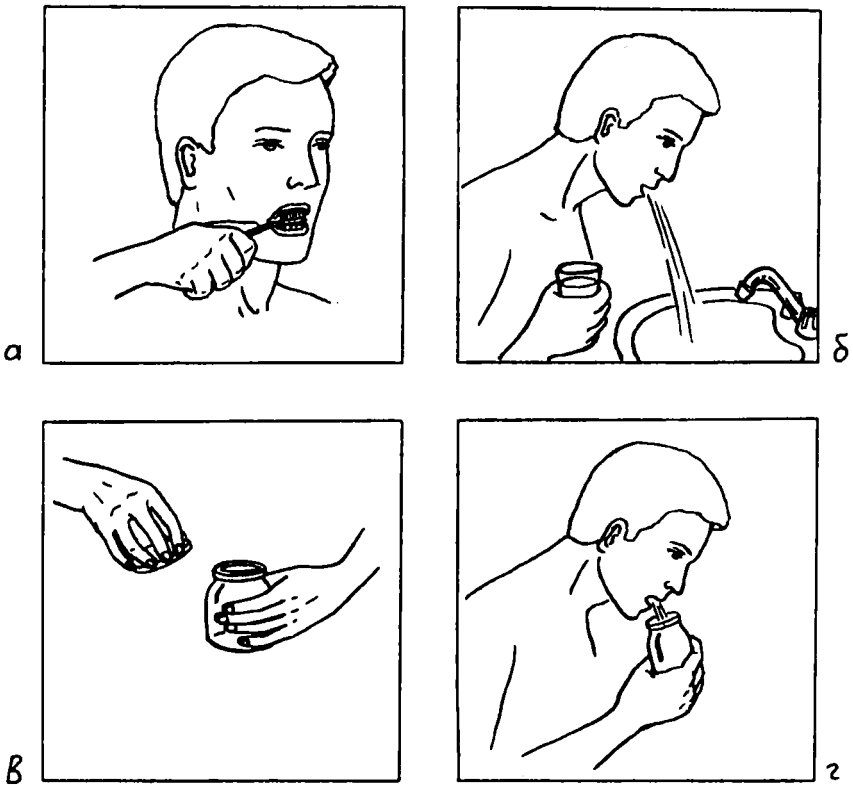
Indirect Heart Massage Technique



Sputum collection for general analysis:

Sputum is a pathological secret of the bronchi, lungs, trachea, and larynx. secreted by coughing and expectoration. sputum may be:
a) the mucosa;
b) serous;
c) purulent;
d) mucopurulent;
e) serous-purulent;
e) bloody.
Purpose: diagnostic.
Indications are determined by the doctor.
Contraindications determined by the doctor.
Patient preparation:
1. Warn about the day and time of delivery of sputum.
2. Inform on sputum collection techniques.
3. Bring a cuspidor.
Sequencing:
a) in the morning he brushes his teeth expectorants sputum in the spittoon, not touching its edges (5 ml is enough);
b) tightly tightens the lid and puts it in a cool place;
c) the nurse draws up a referral to the laboratory and ensures its delivery.
Additional Information:
1. When collecting sputum on atypical cells, the nurse should immediately deliver the material to the laboratory, as the tumor cells are rapidly destroyed.
2. The collection of sputum for tuberculosis can last 2-3 days,

Sputum collection



Urine collection for general analysis:

Purpose: diagnostic.
Indications are determined by the doctor.
There are no contraindications.
Prepare:
1. A clean dry container with a volume of 200-250 ml.
2. Gloves.
3. Diuresis.
4. The funnel.
5. Capacity with disinfectant.
Patient preparation:
a) psychological;
b) the technical preparation of the patient for the collection of this urinalysis.
c) Pay special attention to the careful toilet of the genitourinary organs in women (a swab is inserted into the vagina).
Sequencing:
1. After a thorough toilet of the genitourinary organs and drying, the patient pours the first drops of urine into the vessel or into the toilet, and the remaining portion into the diuresis; in men, the 1st and last servings merge into the toilet bowl, and the middle portion - into the diuresis.
2. On the funnel wall (so that the urine does not foam), the patient pours the urine into a container (at least 100 ml) and closes it tightly with a lid.
3. Puts a container of urine in the sanitary room.
4. The nurse draws up a referral to the laboratory, puts on gloves and glues it to the container.
5. Organizes the delivery of urine to the laboratory no later than an hour after collection.
6. The funnel, diuresis is soaked in a 3% solution of chloramine.
7. Handles gloves in des. solution, removes them and soaks in a 3% solution of chloramine.
Additional Information:
The patient is temporarily canceled by diuretics a day before the study (if he takes them).

Daily urine collection for glucose:

Purpose: diagnostic.
Indications are determined by the doctor.
Contraindications determined by the doctor.
Prepare:
a) a clean dry container (from 3 to 10 liters);
b) a clean dry container with a volume of 300 ml;
c) a glass rod;
d) referral to the laboratory;
d) diuresis registration sheet;
e) diuresis;
g) a funnel;
g) hours;
h) gloves;
i) capacity with des. solution.
Patient preparation:
1. Psychological.
2. Report the assigned study.
3. Brief urine collection techniques.
Sequencing:
1. The morning portion of urine is poured into the toilet bowl and the time of urine output is detected, it is recorded in the diuresis registration sheet.

2. The next portion of urine - into the diuresis, the patient notes the amount in the diuresis sheet, pours it into a common vessel and so on until the next morning.
3. The morning portion is taken into account, its quantity is measured and poured into the total capacity.
4. The nurse puts on gloves, carefully stirs urine with a glass rod, paying attention to the precipitate (the specific gravity of sugar is higher than the specific gravity of water).
5. On the wall of the funnel, 200 ml of urine are poured out of the total amount, closed with a lid, the rest of the urine is poured into the toilet.
6. The total capacity, a glass rod, a funnel is placed in a disinfectant solution.
7. Gloves handles in des. solution, removes and soaks them in it.
8. Draws up a referral to the laboratory.
9. A nurse delivers urine to the laboratory.
Additional Information:
a) normal glucose in the urine is absent;
b) the diet remains normal;
c) the toilet of the genitourinary organs before each portion of urine is not required;
g) a container with a daily amount of urine is stored in a cool place and
covered with a lid

Collection, examination of urine according to Nechiporenko:

Purpose: diagnostic.
Indications are determined by the doctor.
Contraindications: menstruation (if absolutely necessary, after a thorough toilet of the genitourinary organs, the vagina is closed with a swab and urine is taken with a catheter).
Prepare:
1. A clean, dry container of at least 250 ml.
2. Diuresis.
3. The funnel.
4. Referral to the laboratory.
5. Disinfectant solutions.
Patient preparation:
1. Psychological.
2. Briefing on a thorough toilet of the genitourinary organs and collecting urine only in the middle portion, explain what the “middle portion” is.
Sequencing:
1. The day before, give the patient a clean, dry container with a lid, a diuretic bowl and a funnel.
2. Explain to the patient that in the morning he should collect an average portion of urine into the container (the first and last in the toilet).
3. Explain that the urine container must be put in the sanitary room no later than 7.30 in the morning.
4. Ensure that the direction to the laboratory is correctly registered and urine is delivered there no later than an hour after its collection.

Urine collection for research on Zimnitsky:

Purpose: determination of the concentration and excretory functions of the kidneys.
Indications: doctor's prescription.
There are no contraindications.
Patient preparation:
1. Explain to the patient that the drinking, food and motor regimen should remain the same.
2. It is necessary to collect urine per day, for every 3 hours.
3. The doctor cancels the diuretics the day before the study.
The sequence of actions of the patient:

1. Give the patient 8 numbered containers with time and 9th spare. At 6 a.m., the patient urinates in the toilet.
2. Then, every 3 hours, the patient urinates in an appropriate container until 6 am the next day, the morning portion is included in the study.
3. The resulting containers must be tightly closed with lids with glued labels on which are written:
a) full name the patient;
b) branch number;
c) chamber number;
d) the time interval (6-9; 9-12; 12-15; 15-18; 18-21; 21-24; 24-3; 3-6).
4. Ensure the delivery of urine to the laboratory.
5. Use the gloves, funnel, diuresis, vessel (urinal) treated in a disinfectant, solution, then soak in it — for at least 60 minutes, separately.
Additional Information:
1. The nurse must remember that at night every three hours she must wake the patient.
2. Urine collected at 6 a.m. the day before is not examined, as it is excreted from the previous day.
3. If the patient has polyuria and does not have enough volume of one capacity, the nurse gives him an additional capacity, which indicates the appropriate period of time. If the patient does not have urine at a certain time interval, this container should remain empty.

Fecal collection for general analysis:

Purpose: diagnostic.
Indications are determined by the doctor.
There are no contraindications.
Patient preparation:
a) to warn about the assigned study;
b) explain the technique of collecting feces;
c) give out a container and a spatula for collecting feces;
d) issue a referral to the laboratory and glue;
e) if the patient is on bed rest, then all this is done by the nurse.
Prepare:
1. A clean, dry glass container.
2. Wooden spatula, matches.
3. Referral to the laboratory, glue.
4. Tanks with des. solution.
5. gloves.
Sequencing:
1. Wear gloves.
2. Feces immediately after the act of defecation, preferably in a warm form, put with a spatula in a container (small amount), without touching its edges; burn the spatula
handle the gloves and remove them.
3. Close the cover securely.
4. Make a direction to the laboratory, glue it.
5. Ensure delivery of material to the laboratory.
Additional Information:
For the study of feces, it is better to take after an independent act of defecation in the form in which it stood out

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