

Primary Health Care Initiatives (PHCI) Project  
 Contract No. 278-C-00-99-00059-00  
 Abt. Associates Inc.

**NURSING PROCEDURES IN PRIMARY HEALTH CARE CENTERS**

**Topic:** Measuring the Blood Pressure of a Child or Adult

**Definition:** What the nurse needs to know and to do in order to measure the blood pressure.

**Purposes:**

1. To screen for hypertension
2. To monitor for hypotension or shock in cases of trauma, diarrhea, chest pain, etc.

**Materials and Equipment:**

1. Blood pressure cuff
2. Cuff size appropriate for the age and arm size of the patient
3. Stethoscope
4. Patient record to record result

**Procedures:**

Step	Action	Did Trainee Correctly Perform?	
		YES ✓	NO ✓
1	Client sitting and comfortable Arm resting at level of heart, supported by a table Sleeve removed completely for blood pressure cuff		
2	Position the sphygmomanometer so that it can be easily seen with the mercury level at your eye level		
3	Place the cuff on the arm at least 2 cm. above the elbow crease Cuff bladder should be centered over the brachial artery Make sure the cuff is proper size for the arm		
4	Be sure that the mercury level is at 0		
5	Stethoscope earpieces should be angled forward in the ears		
6	Place the stethoscope diaphragm over the brachial artery		
7	Close the valve on the bulb, and rapidly inflate to approximately 200, or until radial pulse disappears		
8	Open the valve, let the air slowly escape at approximately 4 mm per heartbeat		
9	Note the reading at which the first pulse beat is heard		
10	Continue letting the air escape, and note the reading at which the pulse beat disappears		
11	Allow all air to escape, with the mercury returning to "0"		

12	Remove the blood pressure cuff, and stethoscope. Clean stethoscope head		
13	Was blood pressure reading within 4 mm. of trainer's reading on both systolic and diastolic?		

## Nursing Procedures in Primary Health Care Centers

### Child Care Procedures

**Topic:** Weighing infants under the age of two years

**Definition:** What the nurse needs to know and do in order to measure an infant's weight in the correct manner.

**Purposes:**

- 1) To determine the precise weight of a newborn, nursing infant, or any other child under the age of two.
- 2) To assess the growth, health, and nutritional needs of infants and children under the age of two.
- 3) To make certain of the infant or child's precise weight in order to determine the proper dosages of particular treatments.

**Equipment:**

- 1) A scale with a tray covered by a protective layer of paper. It is possible to use various types of scales to assess infants' weights, and health centers frequently use scales with either a tray or other containers, such as baskets, in which to hold the infant. There are, in addition, portable scales which nurses may take to peoples' homes.
- 2) A protective layer of either paper or cloth to cover the tray before placing the infant on it.
- 3) Care should be taken to ensure that the examination room is at a suitable temperature before the infant's garments are removed.

## WEIGHING INFANT UNDER 2 YEARS OF AGE

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
1. Welcome the mother, ask her about the purpose of her visit, and inquire about the child's health and nutrition.		
2. Examine the child's card to make sure of his name, age, and previous vaccinations and recorded weights.		
3. Explain to the mother the importance of weighing her child in order to monitor his growth and development.		
4. Explain the procedure to the mother and request her assistance.		
5. Make sure the scale is ready and properly calibrated.		
6. Wash your hands thoroughly.		
7. Place a clean towel on the surface where the child will be weighed.		
8. Ask the mother to remove the infant's outer garments.		
9. Once his clothes have been removed, hold the child gently when placing him on the scale and removing him from it.		
10. Be attentive to the child while he is on the scale, and place one hand over him, without actually touching his body, as he is being weighed.		
11. Record the weight immediately on the child's card and on the weight register.		
12. Inform the mother of the child's weight and explain what this weight means in relation to the child's age and development; then answer any questions the mother may have.		
13. Inform the mother of when the next appointment will be, and record this in the child's file.		
14. Consult the physician if any of the measurements you obtain indicate abnormality.		
15. Ask the mother if she has any questions, and offer her written health education materials dealing with the child's nutrition, care, hygiene, vaccinations, and the importance of family planning.		

## Nursing Procedures in Primary Health Care Centers

### Child Care Procedures

**Topic:** Measuring the length/height of an infant or child under the age of two years while in a reclining position.

**Definition:** What the nurse needs to know and do in order to measure an infant's length or height in the proper manner.

#### **Purposes:**

- 1) To verify normal growth.
- 2) To correlate the infant's length or height with his weight.
- 3) To determine the infant's length or height, which is used together with weight in order to calculate a child's body surface area and, on this basis, to determine the proper dosages of certain medications.

#### **Materials and equipment:**

1. A measuring board or tape divided into centimeter units (measuring instruments based on centimeters yield greater accuracy).
2. If no measuring board is available, a foot band [?] or similar object may be used.
3. An ordinary ruler.

## MEASURING THE LENGTH/HEIGHT OF A CHILD UNDER 2 YEARS OF AGE

Procedures	Yes	No
1. Welcome the mother, ask her about the purpose of her visit, and inquire about the child's health and nutrition.		
2. Explain the procedure to the mother and request her assistance.		
3. Wash your hands thoroughly.		
4. Place a clean paper or cloth towel on the surface of the measuring board.		
5. Place the infant, parallel with the measuring stick, on the surface of the board; do not leave the infant alone on the board lest he roll off.		
6. Place the soles of the infant's feet against the surface of a flat object which is perpendicular to his body at point "zero" on the measuring stick.		
7. Make sure that the infant's knees are extended.		
8. Position the infant's head so that he is facing the ceiling.		
9. Place the regular ruler against the infant's head at a right angle to the measuring stick.		
10. Note the point at which the edge of the ruler touches the measuring board.		
11. Record the child's length/height directly on the child's card, and on the length/height register.		
12. Inform the mother of the child's length/height, and explain to her what this means with respect to his age and development; then answer any questions that she may have.		

## Nursing Procedures in Primary Health Care Centers

### Child Care Procedures

**Topic:** Measuring the circumference of an infant's head.

**Definition:** What the nurse needs to know and do in order to correctly measure the circumference of an infant's head.

**Purpose:** To determine the average growth of the skull and its components, as well as the absolute growth of the head during the phases of lactation and early childhood.

**Equipment:**

- 1) Disposable paper measuring tapes.
- 2) An ink pen and the infant's record.

### MEASURING THE HEAD CIRCUMFERENCE OF AN INFANT

Procedures	Yes	No
1. Welcome the mother and ask about the reason for her visit to the center.		
2. Review the child's card to make certain of his name, age, and previously recorded vaccinations and weights.		
3. Wash your hands.		
4. Place the infant on a level table on a clean sheet.		
5. Place the measuring tape around the back of the head and the most prominent part of the forehead.		
6. Remove the measuring tape.		
7. Read the measurement on the tape in centimeters.		
8. Record the reading which you obtained.		
9. Inform the mother of the measurement and explain its significance to her, then answer any questions she may have.		

## Nursing Procedures in Primary Health Care Centers

### Child Care Procedures

**Topic:** Taking a rectal measurement of an infant's temperature.

**Definition:** What the nurse needs to know and do in order to take an infant's temperature rectally in the correct manner.

**Purposes:**

- 1) To assess the patient's state of health, and to compare this with previous and future readings.
- 2) To monitor any increase in temperature and to intervene at the appropriate time with fever-reducing measures.

**Equipment:** A tray containing the following items: 1) a rectal thermometer, 2) a container holding cotton in an antiseptic solution, 3) a container of antiseptic solution in which to place the thermometer, 4) a container holding cotton in a mixture of soap and water, 5) a container holding cotton and water, 6) an empty, kidney-shaped dish, 7) pieces of dry cotton or gauze, and 8) a lubricating substance, such as Vaseline.

Procedures	Yes	No
<ol style="list-style-type: none"> <li>1. Wash hands thoroughly.</li> <li>2. Explain to the patient what he is to do, or to the mother if the patient is an infant or young child.</li> <li>3. Preserve the patient's privacy by drawing a curtain around him.</li> <li>4. Remove the thermometer from the antiseptic solution and, using a piece of cotton which has been placed in soap and water, wipe the thermometer with a circular motion; repeat this process with cotton and plain water. Then dry the thermometer beginning at the end containing the mercury and working toward the glass end.</li> <li>5. Take firm hold of the thermometer with your forefinger, thumb and middle finger.</li> <li>6. Shake the thermometer until the mercury level is below the 35-degree Centigrade mark.</li> <li>7. Place the Vaseline on a piece of gauze, then wipe the thermometer with it to a distance of at least 2.5 centimeters for children, and to a distance of at least 4 centimeters for adults.</li> <li>8. Place the infant on his left side, with his right leg bent at a right angle.</li> <li>9. Position the infant on his back, then grasp his legs by the ankles and raise them up with one hand.</li> <li>10. Make sure the anus is clean by wiping it with a piece of dry cotton or gauze.</li> <li>11. Insert the thermometer slowly and gently into the rectum and leave it for 2-3 minutes; for infants up to one year old, it should be inserted 1.5 centimeters, for children older than one year, 2.5 centimeters, and for adults, 4 centimeters.</li> <li>12. Remove the thermometer and wipe the lubricant off the anus.</li> <li>13. Make sure the child is in a comfortable position.</li> <li>14. Grasp the thermometer between the thumb and forefinger and hold it horizontally at eye level and read the temperature.</li> <li>15. Employing a circular motion and moving from the glass end toward the end where the mercury is collected, wipe the thermometer with cotton soaked in soap and water; then repeat the same action with cotton and plain water.</li> <li>16. Shake the thermometer until the mercury moves below the 35-degree Centigrade mark.</li> <li>17. Return the thermometer to the container holding the antiseptic solution.</li> <li>18. Record the temperature on a vital signs form.</li> <li>19. Put away the equipment.</li> <li>20. Inform the mother of the child's temperature.</li> <li>21. If the temperature is high, commence with fever-reducing measures.</li> </ol>		

## Nursing Procedures in Primary Health Care Centers

### **Child Care Procedures**

**Topic:** The physical assessment of newborns between 1-28 days old.

**Definition:** What the nurse needs to know and do in order to conduct a physical assessment of a newborn.

**Purposes:**

- 1) To assess a newborn's overall condition.
- 2) To form a nursing diagnosis of the young child.

**Materials and Equipment:** a) containers, b) a lamp, c) a weight-measuring device, d) a table, e) a measuring tape, f) gloves, g) a stethoscope, and h) a thermometer.

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
<ol style="list-style-type: none"> <li>1. Have all equipment ready near the child's bed.</li> <li>2. Explain the procedure.</li> <li>3. Wash hands.</li> <li>4. Review the mother's file as it relates to the following: a) number of pregnancies, b) dates of deliveries, c) whether there have been any instances of premature labor or complications during pregnancy, d) still-births or abortions, e) mother's health during pregnancy, and f) treatments received during pregnancy.</li> <li>5. Review labor and delivery file as it relates to: a) duration of labor, b) type of delivery, c) place of delivery, and d) treatment.</li> <li>6. Review the initial assessment of the newborn based on the APGAR assessment scale, by rating the child's physical condition on a scale of zero to two (0-2) in each of the following areas: a) heartbeat, b) respiratory system, c) muscular strength, d) responses to stimuli, and e) skin color.</li> <li>7. Review the following information pertaining to the newborn: a) date of birth, b) birth weight and length, c) type of delivery, d) weeks of pregnancy, e) health, f) the presence of any congenital defects.</li> <li>8. Note the newborn's overall appearance and activity.</li> <li>9. Take measurements of the child's vital signs.</li> <li>10. Measure the child's weight, head circumference, and length.</li> <li>11. Examine the skin with respect to the following: color, texture, puffiness or lack thereof, temperature, suppleness, and blood vessels.</li> <li>12. Check the shape of the head. Is it symmetrical? Are the fontanelles sunken or do they protrude? Are the junctures between the skull bones wide? Is there softness to the skull?</li> <li>13. Examine the eyes as to the following: the eyelids, eye color, tears, the eyes' location, size and movement, the pupils and whites, the conjunctiva and its responsiveness to light.</li> <li>14. Check the ears with respect to their location and shape, cartilaginous growth, the canal of the outer ear, and hearing (does the child "start" at sounds, for example?).</li> <li>15. Examine the mouth, throat, lips, gums, palate, tongue, and mucous membrane.</li> <li>16. Check the nose with respect to its size, shape, location, and inner capacity.</li> <li>17. Examine the neck with respect to its location, size, range of movement, and the pulse in the carotid artery.</li> <li>18. Examine the chest for symmetry, the average number of breaths [per minute], and rhythm or regularity [of breathing].</li> <li>19. Check and feel the nipples for their degree of protrusion, milk-like secretions, firmness of the surrounding area and redness in this area.</li> <li>20. Listen for the average heart rate; take the pulse in the wrist, upper arm, thigh and head, and check for the position of the heart.</li> </ol>		

<ol style="list-style-type: none"> <li>21. Examine the abdomen for skin rashes, umbilical hernia, flatulence, enlargement of the veins, absence of sounds from the intestines, enlargement of the liver or spleen, and absence of a pulse in the thigh.</li> <li>22. Examine the navel for the number of blood vessels observable there.</li> <li>23. Examine the penis, checking for the following: the urethra, coverage by the foreskin, inability to retract the foreskin, the retraction of the testicles with respect to the hernia [if one should be found], and urination over a period of 24 hours.</li> <li>24. Check the female genitalia for excretions of blood, enlargement of the clitoris, the vaginal labia, the lack of a vaginal opening, and urination over a period of 24 hours.</li> <li>25. Examine and feel the spinal column for the straightness of the medial line, signs, the bladder, grooves, and cracks.</li> <li>26. Check the anus for its width, and elimination for a period of 24 hours.</li> <li>27. Examine the limbs for excessive pliability, flexion of the joints, displacement of the hip, asymmetry of the buttocks, asymmetry in the length of the legs, an audible “popping” sound, range of motion, overall symmetry of the right and left sides of the body, and the pulse in the thigh.</li> <li>28. Note nervous activity, crying, paralysis, and the activity and strength of the muscles.</li> <li>29. Check reflexes: a) the Moro reflex, that is, the child’s involuntary response of contracting his limbs and neck when he is allowed to fall a short distance through the air, or when he is startled by a noise or a sudden shock; b) grasping objects; c) sucking; d) constant neck motion; e) the Babinski phenomenon, that is, the extension, rather than the usual involuntary flexion, of the big toe when the sole of the foot is stimulated; f) stepping/walking; and g) elimination by pushing.</li> </ol>		
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## Nursing Procedures in Primary Health Care Centers

### Procedures for the Prevention of Infection

**Topic:** Putting on and removing surgical gloves.

**Definition:** [none found]

**Purpose:** To put on and remove surgical gloves in the appropriate manner.

**Time required:** One-two minutes.

**Instruments required:** Sterilized surgical gloves in a sealed package of a size appropriate for the nurse concerned.

Procedures	Yes	No
1) Open the outer wrapping of the bag of gloves, taking care not to touch the gloves themselves.		
2) Wash hands well.		
3) Place the gloves, together with their inner wrapping, on a smooth, clean surface.		
4) Open both ends of the inner wrapping while touching the outside of the wrapping only.		
5) Using your thumb and forefinger, grasp the cuff of one of the gloves, taking care not to touch the outside of the glove.		
6) Remove the glove from the package and lift it up with care.		
7) Place your other hand inside the glove, making sure to touch only its inside surface, then pull it up toward your wrist while keeping your thumb pointed toward your palm.		
8) Leave the end of the glove folded back as it is.		
9) Remove the other glove from the package by placing the fingertips of the hand now wearing a glove inside the cuff of the second glove, all the while keeping your thumb toward your palm and lifted back.		
10) Carefully pull on the second glove, keeping the thumb of the hand now wearing a glove far away from the palm of the other hand.		
11) Arrange the gloves in such a way that their folds are straightened out and unfold the cuff by placing your fingertips beneath the folded portion on the outside of the gloves.		
12) Raise your hand to eye level, not allowing it to make contact with any non-sterilized surface.		

## Nursing Procedures in Primary Health Care Centers

### Procedures for the Prevention of Infection

**Topic:** Putting on and removing clean, non-sterilized disposable gloves.

**Definition:** [none found]

**Purpose:** To properly put on and take off clean, non-sterilized gloves.

**Time required:** One-two minutes.

**Equipment needed:** a) clean, disposable gloves, b) running water, c) soap, d) a paper or cloth towel.

Procedures	Yes	No
1) First wash and dry your hands.		
2) Grasp one of the gloves in the cuff region with one hand and insert your other hand; repeat the same process for the second hand.		
3) Pull the cuff of the glove up to cover your wrist; if you are wearing a garment with sleeves, cover your sleeve with the glove.		
<i>Removing disposable gloves</i>		
1) Before taking off the gloves, wash your hands in an antiseptic .5 % chlorine solution in order to kill any bacteria which may be clinging to the gloves.		
2) With your left hand, grasp the end of the right glove from the outside of the wrist area.		
3) Pull the glove off in such a way that the inside of the glove is turned outside.		
4) Grasp the glove that has been removed and turned inside out with the fingers of your [left] hand which is still wearing the glove.		
5) Place the fingers of your right hand inside your left glove at the wrist; then [reverse] this glove over the first one.		
6) Throw the gloves in the wastebasket.		
7) Wash your hands properly.		

## Nursing Procedures in Primary Health Care Centers

### **Procedures for Preventing Infection**

**Topic:** The procedure for changing a surgical dressing.

**Purpose:** To change a surgical dressing in the proper manner.

**Time required:** Between 53-55 minutes.

**Equipment needed:** A changing cart with the following articles on it:

- 1) A sterilized package for changing surgical dressings which contains: a) a kidney-shaped dish, b) surgical forceps, c) artery forceps, d) 2 small containers, e) cotton balls, and e) 5 x 5 cm gauze.
- 2) Adhesive tape.
- 3) Antiseptic liquid.
- 4) Disposable gloves + sterilized gloves.
- 5) A pair of scissors.
- 6) A waste basket.
- 7) A plastic bag.

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
<ol style="list-style-type: none"> <li>1) Explain to the patient what you wish to do.</li> <li>2) Safeguard the patient's privacy by drawing a curtain around him.</li> <li>3) Place the patient in a position in which the wound can be comfortably exposed.</li> <li>4) Expose the area of the wound only, and cover all other areas of the body.</li> <li>5) Situate the changing cart near the patient.</li> <li>6) Open the outer wrapping of the package [containing the disposable gloves], touching only the outside of the package.</li> <li>7) Attach the package to the edge of the cart with a piece of adhesive tape if a plastic bag is not available.</li> <li>8) Put on the disposable gloves in the proper manner.</li> <li>9) Remove the adhesive tape over the wound as follows: a) Pull the skin taut while pulling the adhesive tape back; b) remove the adhesive tape nearest the wound first, then work your way outward; c) if the tape is firmly attached to the wound, a small amount of normal saline solution may be placed on the area.</li> <li>10) Remove the old dressing and place it in the plastic bag, noting the color and amount of the secretions present and the condition of the wound.</li> <li>11) Fold the old dressing by closing the edges over one another.</li> <li>12) Remove the gloves and dispose of them in the same bag.</li> <li>13) Assess the wound by noting its size, odor, the secretions it has produced, and the degree to which it has healed over.</li> <li>14) Wash your hands.</li> <li>15) Open the package containing the new dressing by touching the sterilized portion as per the priority governing the use of equipment.</li> <li>16) Pour the antiseptic liquid into one of the small containers.</li> <li>17) Open the packages of gauze or additional cotton, employing the same method which you used in opening the sterilized package.</li> <li>18) Put on the sterilized gloves in the proper manner.</li> <li>19) Place the piece of gauze or cotton around the artery forceps.</li> <li>20) Dip the gauze or cotton in the antiseptic liquid, then submerge it completely by pressing on the edge of the container or by using the surgical forceps.</li> <li>21) Clean the wound from the less contaminated area to the more contaminated area and from the higher area to the lower area; moreover, if the wound runs up and down, it should be cleaned by means of a single stroke and not be wiped again with the same piece of gauze.</li> <li>22) Throw the piece of gauze or cotton in the wastebasket, then dip another piece in the antiseptic and submerge it completely. Clean around the wound, making sure each time to use a fresh piece which has been dipped in the antiseptic.</li> </ol>		

<p>23) Continue in the same manner until the wound and the surrounding area are completely clean. If the wound is irregular, as in the case of bed sores, for example, clean it from the center outward in a circular motion and change the gauze each time. Moreover, if the wound is infected, first clean the area surrounding the wound, then the wound itself.</p> <p>24) Dry the wound in the same way in which you cleaned it; if there is an abscess beside the wound, clean around it with a circular motion using a clean piece of gauze or cotton. Then wipe the abscess from bottom to top.</p> <p>25) Cover the wound with an amount of gauze appropriate to the size of the wound, and cover the abscess as well.</p> <p>26) Remove the gloves in the proper manner and dispose of them in the wastebasket.</p> <p>27) Place the adhesive tape over the gauze.</p> <p>28) Clean and sterilize the instruments and return them to their proper places.</p>		
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## Nursing Procedures in Primary Health Care Centers

### **Mother Care Procedures**

**Topic:** Post-partum care.

**Definition:** The post-partum period extends from delivery to six weeks thereafter.

**Purpose:** To protect the mother and her child from any complications.

**Equipment:** A thermometer, a blood pressure measuring device, a stethoscope, a scale for adults, and the mother's file.

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
1) Wash hands.		
2) Prepare instruments to be used.		
3) Explain the procedure to the mother.		
4) Take vital signs.		
5) Note the mother's overall appearance.		
6) Note any problems which the mother faced during pregnancy.		
7) Ask the mother about any problems she faced during and/or following delivery.		
8) Perform an overall physical examination of the mother.		
9) Perform laboratory tests such as PCV and a urine analysis.		
10) Weigh the mother.		
11) Provide the mother with a thorough explanation of natural breastfeeding.		
12) Offer counsel and guidance concerning nutrition for the mother and her child.		
13) Explain about general hygiene, particularly of the breasts and the genital area.		
14) Instruct the mother in how to do certain physical exercises.		
15) Instruct the mother concerning the basic vaccinations required by the child.		
16) Note the strength of the bond between mother and child.		
17) Record all observations in the mother's file.		
18) Give the mother a follow-up appointment date.		
19) Provide information about methods of family planning.		

**Note:** With respect to health education, it takes place through procedures such as those described above.

## Nursing Procedures in Primary Health Care Centers

### **Mother Care Procedures**

#### **Procedure 3**

**Topic:** Home visits—family evaluation.

**Purposes:** Family evaluation is done in order to:

- One) assess the family as a single unit,
- Two) observe the family in its actual environment and find out how its various members relate to each other,
- Three) provide health-related education and guidance in the same environment in which the family lives, which also allows the use of familiar materials and instruments,
- Four) give each family member the opportunity to ask questions,
- Five) allow sufficient time to identify the needs of every member of the family,
- Six) note the nursing care provided for sick members of the household and offer whatever guidance might be needed in this regard,
- Seven) identify the dangers and health problems which could not be dealt with through a visit to the clinic, such as how to prepare an infant's bath or a bottle of infant formula, and
- Eight) identify those family members with particularly acute needs and make the appropriate referrals.

#### **Materials required:**

- 1) all the equipment in the family visit satchel needed to assess newborns, nursing infants, toddlers, pregnant mothers, and other adults. This includes a device for measuring blood pressure, a stethoscope, a thermometer, soap, a towel, a tape measure, an ink pen, an observation notebook, and a scale.
- 2) All documents and records required for home visits and family assessments,
- 3) a source of transportation when needed depending on one's time table.

Procedures	Yes	No
<p>1) <i>Before leaving the health center</i>, the health worker (nurse or midwife) due to make the visit must: a) define the purpose of the visit, b) write a brief description of her work plan for the visit, c) obtain the family's file and records, d) make sure she has all the materials and equipment needed for family assessments and home visits, e) verify the addresses of all the women to be visited.</p> <p>2) <i>During the home visit</i>, the health worker should greet the patient graciously and mention the purpose for her visit (using the instructions page); b) render the service which conforms to the purpose of the visit (review the various types of visits in the Guide to Primary Health Care Procedures). If the case is serious or high priority, she should discuss the situation with the mother, taking care not to reprimand her or be critical of her; c) the worker should record any anomalous facts she may have noticed and the procedure which she followed in response to it in the space designated for this purpose on the family assessment form.</p> <p>3) <i>Family assessment</i>: During the initial visit, the health worker should do the following:</p> <p>One) inquire about all of the health services which the family has received from the health center, such as vaccinations, prenatal care, post-partum care, child care, and so on,</p> <p>Two) examine every member of the family, giving special attention to children under the age of five years and, in particular, to any child who is ill or who has just been weaned,</p> <p>Three) provide health education related to the importance of following up on any health-related measures,</p> <p>Four) refer any family members with health complains to the health center and give them appointments for follow-up visits, using the referral form designated for this purpose,</p> <p>Five) record all measures taken and services provided, as well as the date of the scheduled follow-up,</p> <p>Six) record any significant information and facts relating to any of the family members in the family files,</p> <p>Seven) sit with the mother after the service has been rendered, explaining to her the services which she has received and telling her about the other nurses at the center.</p> <p>4) <i>The home environment</i>:</p> <p>One) Note any harmful practices in the family setting and discuss these with the mother, explaining how and why such practices are detrimental to the family's health.</p> <p>Two) Suggest steps which the family can take to correct the situation.</p> <p>Three) Record your observations and the measures which were taken.</p>		

**Performance Checklist:  
Standards for Home Visit Procedures**

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
1) After defining the purpose for the upcoming visit, make plans for it.		
2) Prepare all documents needed (the family file, records, nursing care plan) for the upcoming visits.		
3) Prepare all materials and equipment which will be needed.		
4) Review the map of the area to be visited.		
5) In accordance with the rules of etiquette for home visits, greet the mother and explain the purpose for your visit.		
6) Carry out the procedure included in the purpose for the visit without reprimanding or criticizing the mother in any way.		
7) Record all information and facts which you observe on the assessment form and the nursing care plan.		
8) Obtain answers to all questions pertaining to the health services which the family has received.		
9) Record the visit in the visits register at the center.		

## Nursing Procedures in Primary Health Care Centers

### Vaccination Procedures

**Topic:** Monitoring the refrigeration chain.

**Definition:** What the nurse needs to do in order to ensure the soundness and usability of vaccines by monitoring the “refrigeration chain” at the health center.

**Purpose:** To monitor the chain of refrigeration on a daily basis and to ensure that each type of vaccine is being stored at the proper temperature, thereby ensuring that it is fit to be given to the recipients of the center’s services.

**Equipment:** a) vaccines, b) a vaccine refrigerator, c) bags of ice, d) a thermometer, e) a device for indicating when substances have reached freezing point, f) a small thermos in which to store vaccines, g) a refrigeration chain monitor (ABC), and h) vaccination monitoring card.

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
<ol style="list-style-type: none"> <li>1) Open the refrigerator door and quickly make certain that the temperature is between 2-8 degrees Centigrade.</li> <li>2) Make sure that the freezer is being reserved for polio, measles, and MMR vaccines.</li> <li>3) Make sure that the middle shelf is being set aside for the tripartite vaccine (whooping cough, diphtheria, tetanus), tuberculosis and tetanus vaccines, and solution.</li> <li>4) Leave spaces between the various vaccines.</li> <li>5) Place a bottle of colored water on the bottom shelf to preserve the cold.</li> <li>6) Be sure that no food or drink is placed in the refrigerator where the vaccines are being stored.</li> <li>7) Make certain that the vaccines are in their places and not on the shelves of the refrigerator door.</li> <li>8) Make sure that the bags of ice are in the freezing room.</li> <li>9) Examine vaccines in search of those whose expiry date has passed.</li> <li>10) Dispose of expired vaccines and inform the responsible officials that they are no longer valid.</li> <li>11) On the paper designated for this purpose on the refrigerator door, record the temperature of the refrigerator at the beginning of the shift, and again at the end of the shift.</li> <li>12) Request maintenance work for the refrigerator if it is not functioning properly.</li> <li>13) Keep the thermos and the ice ready at all times in order to use them as a substitute for the refrigerator in the event that it breaks down, and as a place to keep the daily vaccines.</li> <li>14) Be sure to change the refrigeration chain monitor (ABC) every month when new vaccines are brought in.</li> </ol>		

## Nursing Procedures in Primary Health Care Centers

### **Vaccination Procedures**

**Topic:** What the nurse needs to do in order to administer the tripartite vaccine.

**Purpose:** To protect nursing infants from whooping cough, diphtheria, and tetanus.

**Equipment:** a) a thermometer, b) pieces of dry cotton, c) a bottle of vaccine, d) vaccination and registration card, e) a tray, f) a syringe, g) a thermos in which to store daily vaccines, and h) a container in which to store used syringes.

<b>Procedures</b>	<b>Yes</b>	<b>No</b>
1) Refer to the child's vaccination card to verify what vaccinations have already been given, and their dates.		
2) Ask the mother to specify the vaccine needed, then prepare the vaccination card for the child.		
3) Ask the mother about her child's health.		
4) Note and measure the child's temperature; if the child's temperature is higher than 38 degrees Centigrade, notify the physician.		
5) Explain the tripartite vaccination to the mother: how it helps to protect the child and the importance of giving it at the scheduled times. Then answer any questions the mother may have.		
6) Ask the mother to place her child on the bed and to expose the site of the injection.		
7) Wash your hands well.		
8) Clean the injection site.		
9) Administer the proper dose of the vaccine (one-half millimeter), noting that for nursing infants and other young children, the injection is given in the front of the thigh, whereas for older children, it is preferable to give it in the front of the upper arm.		
10) Place the bottles of the vaccine back in the thermos.		
11) Record the relevant information about the vaccination given: the child's name, the child's date of birth, the date on which the vaccination was given, and the date on which the next dose is to be taken.		
12) Inform the mother of the complications that may result from the vaccination and instruct her in how to care for the child at home in the event that any such complications occur.		
13) On the vaccination card, record the type of vaccine administered, the dose, and the date on which the next dose is to be taken.		
14) Inform the mother of the date of the next appointment, make certain that she understands what you have said, and ask her if she has any questions.		
15) The nurse may also take this opportunity to present important health information to the mother concerning how to care for her child, the importance of natural breastfeeding, and the importance of family planning as a means of preserving her own health and that of her family.		

## Nursing Procedures in Primary Health Care Centers

### Vaccination procedures

**Topic:** Procedures for administering the polio vaccine.

**Purpose:** To protect nursing infants and young children from polio.

**Equipment:** a) a thermometer, b) a bottle of vaccine, c) vaccination and registration card, and d) a tray.

Procedures	Yes	No
1) Refer to the child's vaccination card to determine what vaccinations he or she has already received, and on what dates.		
2) Ask the mother to specify the vaccine needed.		
3) Ask the mother about her child's health.		
4) Take the child's temperature, and if it is higher than 38 degrees Centigrade, notify the physician.		
5) Explain the polio vaccination to the mother, stressing the importance of taking its doses at their scheduled times; then answer the mother's questions about the vaccination.		
6) Prepare the vaccine and whatever instruments are needed to administer it, taking care not to expose it to heat.		
7) Ask the mother to hold her child in the correct manner.		
8) Wash your hands thoroughly.		
9) Administer the proper dose of the vaccine (two drops orally).		
10) Record the information pertaining to the vaccine and the dosage on the child's vaccination card.		
11) Tell the mother when to bring the child in for the next dose.		
12) Tell the mother how to administer the required home care and when to bring her child to the doctor, making certain that she understands what you have said.		
13) Present the mother with the appropriate health education literature pertaining to child care and the importance of family planning.		

## Nursing Procedures in Primary Health Care Centers

### Vaccination Procedures

**Topic:** Procedures for administering the measles or MMR vaccine.

**Definition:** What the nurse needs to know and do in order to administer the measles vaccine.

**Purpose:** To protect nursing infants and young children from contracting measles.

**Equipment:** a) a thermometer, b) pieces of dry cotton, c) a bottle of vaccine containing one injection, d) vaccination and registration card, e) pieces of cotton soaked in normal saline solution, f) a tray, g) a syringe, h) a small thermos in which to store the vaccines, and I) a container in which to place the used syringe.

Procedures	Yes	No
1) Review the child's vaccination card to determine what vaccines he has already received and on what dates.		
2) Ask the mother to specify the vaccine needed.		
3) Ask the mother about her child's health.		
4) Take the child's temperature, and if it is higher than 38 degrees Centigrade, inform the physician.		
5) Explain to the mother about the measles vaccine, including the importance of taking its doses at the scheduled times; then answer the mother's questions about the vaccine.		
6) Prepare the vaccine and whatever instruments are needed to administer it, taking care not to expose it to the light.		
7) Ask the mother to hold the child in the proper manner.		
8) Wash your hands thoroughly.		
9) Administer the proper dose of the vaccine (one-half millimeter under the skin).		
10) Return the vaccine to its place and avoid exposing it to the light.		
11) Record the necessary information on the child's vaccination card and in the vaccinations register.		
12) Inform the mother when to bring her child to be vaccinated again and record the appointment date on the child's vaccination card.		
13) Present the mother with the suitable health education literature concerning child care, nutrition, and the importance of family planning.		

## Nursing Procedures in Primary Health Care Centers

### Vaccination Procedures

**Topic:** Procedures for administering the bipartite vaccine (tetanus and diphtheria).

**Definition:** What the nurse needs to know and do in order to administer the bipartite vaccine.

**Purpose:** [none found]

**Equipment:** a) a thermometer, b) pieces of dry cotton, c) a bottle of vaccine containing one injection, d) vaccination and registration card, e) pieces of cotton soaked in normal saline solution, f) a tray, and g) a syringe.

Procedures	Yes	No
1) Ask the mother if the child has taken this vaccine this before, and whether he or she is suffering from a fever or cold.		
2) Prepare the vaccine and the materials required for its administration.		
3) Wash your hands.		
4) Expose the injection site (the shoulder muscles).		
5) Ask if the child has ever had a violent reaction to an injection or vaccination.		
6) Ask one of your colleagues or the mother to hold the child in the proper manner.		
7) Administer the proper dose of the vaccine (.5 millimeters) in the upper arm		
8) Return the vaccine to its place and avoid allowing it to freeze.		
9) Record the following information pertaining to the vaccines given: a) the child's name and date of birth, b) the date on which the vaccine was given, and c) the dosage. Note: Encourage and educate the parents concerning the importance of the vaccination, the possible side-effects of the injection, and how to administer the proper home care.		
10) Inform the mother when to bring her child in for the next vaccination, and write down the appointment date on the child's vaccination card.		
11) Ask the mother to repeat back to you when she is to bring her child in for the next vaccination.		
12) Ask the mother if she has any questions.		
13) Wash your hands.		

## Nursing Procedures in Primary Health Care Centers

### Vaccination Procedures

**Topic:** Procedures for administering the tetanus vaccine to pregnant women and other women of child-bearing age (between 15 and 45 years of age).

**Definition:** What the nurse needs to know and do in order to administer the tetanus vaccine to pregnant women and other women of child-bearing age.

**Purpose:** To protect newborns from contracting tetanus before, during, or after delivery.

**Equipment:** a) the tetanus vaccine, b) a vaccine refrigerator or thermos, c) syringes and needles, d) pieces of cotton soaked in normal saline solution, and e) a container for waste disposal.

Procedures	Yes	No
1) Wash your hands.		
2) Prepare the required materials.		
3) Explain the procedure to the woman and obtain her consent.		
4) Make certain that the vaccine is not damaged or expired.		
5) Prepare the recommended dosage of the tetanus vaccine, namely, one-half millimeter.		
6) Clean the injection site: the outer section of the upper left arm.		
7) Use the left hand to pull the arm muscle taut.		
8) Insert the needle through the skin inside the muscles.		
9) Press the vaccine into the muscles.		
10) Remove the needle and press on the injection site with a piece of dry cotton.		
11) Educate the woman concerning the importance of protection against tetanus and the doses which she should receive.		
12) Tell the mother (woman) about her next appointment, at which she will receive the next dose.		
13) Record the date on which the dose was given on the register and on the woman's vaccination card; specify the date of her next appointment and write it down on her vaccination card.		