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Excellence in clinical practice requires nurses to have a sophisticated knowledge level, highly developed technical and non-technical skills, a professional attitude and a person-centred approach. Quality and safety in health care is dependent upon the extent to which nurses are able to integrate these essential components into their care.

This first Australian edition of Skills in Clinical Nursing includes 95 of the most important skills performed by nursing students and graduates, organised from simple to complex and written to reflect current evidence-based practice guidelines. Skills in Clinical Nursing is intended to be a valuable textbook for nursing students and beginning nurses. Content was selected based on feedback from clinical reviewers, a market survey, and the extensive teaching and clinical experience of the authors. All content was critically reviewed for currency and accuracy by practising clinicians.

Format

Skills in Clinical Nursing has been designed as a practical and easy-to-navigate reference for both the classroom and clinical practice settings.

Each section contains concise introductory information with clear learning outcomes and key terms. Background information contextualises the skills and provides a brief overview of relevant anatomy, physiology and pathophysiology. The importance of and rationale for each skill is then outlined.

Each unit includes the following elements and features:

**CLINICAL SAFETY ALERTS** – highlight key patient safety issues relevant to the performance of particular skills.

**STANDARDS FOR PRACTICE** – link performance of the skills with the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (2016).

**CLINICAL SCENARIOS** – link what you are learning to a relevant clinical story. The scenarios are designed to promote person-centred care and clinical reasoning skills.

**CRITICAL THINKING QUESTIONS** – test your knowledge and application of learning at the end of each introductory section and following each Clinical Scenario.

**WHAT IF?** – explore unexpected outcomes in a concept map format.

**LIFESPAN CONSIDERATIONS** – present age-related content to alert you to differences in caring for people of different ages.

**3Ps TABLES** – Each clinical skill is organised with step-by-step instructions and using the 3P structure:

1. Preparation and planning
2. Performing the procedure
3. Priorities post procedure.

Explanations and rationales explain the reasons for particular nursing actions and decisions in the 3Ps Table.

Critical steps are visually represented with full colour photos and illustrations.

**FURTHER READINGS, WEBLINKS and REFERENCES** – provide evidence-based resources to extend your learning and can be found at the end of each unit.
We would like to express our sincere thanks to the clinicians and educators who revised or reviewed units of this text. Their insights, comments, suggestions, feedback and encouragement contributed to making this a more useful and relevant resource for students.

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FEATURES

CLINICAL SAFETY ALERTS - highlight key patient safety issues relevant to the performance of particular skills.

CLINICAL SAFETY ALERT
Prior to performing the skill, as with all clinical skills, the procedure needs to be fully explained to the person and consent obtained. People often report that knowing what is going to be done to them, helps minimise the embarrassment (Matiti & Torey, 2008). This is especially important when performing hygiene care. It is also critical to remember that the person is free to withdraw their consent at any time or only consent to certain aspects of hygiene care.

STANDARDS FOR PRACTICE
The Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (2016) specify that the registered nurse ‘coordinates resources effectively and efficiently for planned actions’ (NMBA, 2016, p. 4) and ‘appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse’s scope of practice or others’ clinical or non-clinical roles’ (NMBA, 2016, p. 5. © Nursing and Midwifery Board of Australia).

STANDARDS FOR PRACTICE BOXES - link performance of the skills with the Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice (2016).

CLINICAL SCENARIOS - link what you are learning to a relevant clinical story. They are designed to promote person-centered care and clinical reasoning skills.

CLINICAL SCENARIO
Back to Sam Neal, a 30-year-old male with a past history of contracting HBV. Sam has been diagnosed with appendicitis and is now being prepared for surgery.

Critical Thinking Questions
1. What precautions should both the emergency department and operating theatre staff take in relation to Sam?
2. How should body secretions, bed linen, equipment used for vital signs, one-use disposable equipment, sharps and laboratory specimens be handled?

CRITICAL THINKING QUESTIONS - test your knowledge and application of learning at the end of each introductory section and following each Clinical Scenario.

LIFESPAN CONSIDERATIONS - present age-related content to alert you to differences in caring for people of different ages.

LIFESPAN CONSIDERATIONS
When providing hygienic care for an older person be mindful of the developmental changes that occur with skin. The older person’s skin is more fragile and therefore care is needed with the amount of pressure and friction that is used when cleansing. Too much pressure or friction will put the person at risk of skin breakdown and injury. Recommendations for helping to maintain skin integrity include the use of protective moisturisers and not using ‘drying’ soaps.
WHAT IF FEATURES – explore unexpected outcomes in a concept map format.

**What If... Bed bathing a dependent person**

**ACTION**

- Perform hand hygiene.
- Determine the indication and the type of bath that the person needs. Determine if the hygiene care can be delegated to an Assistant in Nursing or appropriate caregiver.
- Assess the person’s physiological and psychological comfort levels and determine if there are cultural, religious, environmental or any other factors that need to be considered prior to commencing the procedure.
- Determine the person’s self-care ability.

**EXPLANATION AND RATIONALE**

- Hand hygiene is an essential skill to remove microorganisms and prevent cross contamination.
- A person-centred approach to care is essential. Nurses need to be considerate of a person’s normal hygiene practices and individual preferences. Whenever possible, individual preferences should be accommodated and the person should be made to feel as comfortable as possible. A person-centred approach will also help determine if there are any specific precautions or considerations needed for that person – i.e. movement issues, intravenous therapy, plaster casts.
- Encouraging the person to perform self-care if they are physically and psychologically able to do so. Self-care helps to promote independence, exercise and self-esteem. Often people prefer to clean their own face and genital area if able.

**PERFORMANCE**

- Gather the necessary equipment and supplies to complete the procedure. The equipment needed includes:
  - Non-sterile clean gloves (if appropriate)
  - Washcloth x 2
  - Soap/cleansing agent
  - Bath towels x 2
  - Extra towel/Bath blanket
  - Basin (or sink) with warm water (43°C-46°C)
  - Tub/Urinal items as requested by the person (i.e. lotions, deodorant, shaving equipment)
  - Clean linen and linen carrier (linen skip)
  - Pyjamas, gown or clothes
  - Table for bathing equipment.

- Perform hand hygiene and put gloves on if body fluids or open lesions are present.
- Introduce yourself to the person using full name and designation. Verify the person’s identity and ask how they would like you to address them, i.e. their preferred name.

**RATIONALE**

- Hand hygiene is an essential skill to remove microorganisms and prevent cross contamination. Gloves are required if body fluids or open lesions are present or if you are providing perineal-genital hygiene care.

This is a professional expectation and helps to promote rapport with the person. Verifying the person’s identity ensures that you have the right person. Checking how the person prefers to be addressed also helps to promote rapport and demonstrates respect.

---

**THE 3Ps TABLE**  
**BED BATHING A DEPENDENT PERSON**

**PREPARATION AND PLANNING**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>EXPLANATION AND RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform hand hygiene.</td>
<td>Hand hygiene is an essential skill to remove microorganisms and prevent cross contamination.</td>
</tr>
</tbody>
</table>

**PERFORING THE PROCEDURE**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>EXPLANATION AND RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform hand hygiene and put gloves on if body fluids or open lesions are present.</td>
<td>Hand hygiene is an essential skill to remove microorganisms and prevent cross contamination. Gloves are required if body fluids or open lesions are present or if you are providing perineal-genital hygiene care.</td>
</tr>
</tbody>
</table>

This is a professional expectation and helps to promote rapport with the person. Verifying the person’s identity ensures that you have the right person. Checking how the person prefers to be addressed also helps to promote rapport and demonstrates respect.

---

**3Ps TABLE** – Each clinical skill is organised with step-by-step instructions and using the 3P structure:

1. Preparing and planning
2. Performing the procedure
3. Priorities post procedure
**Section 1.3 Clinical Skills Appraisal Form**

**USING PERSONAL PROTECTIVE EQUIPMENT (PPE)**

<table>
<thead>
<tr>
<th>Category</th>
<th>U</th>
<th>D</th>
<th>S</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREPARATION AND PLANNING FOR THE PROCEDURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines infection control precaution level</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Collects equipment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gown, mask, eyewear, gloves</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>PERFORMING THE PROCEDURE</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Removes/Secures all loose personal items</td>
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</tr>
<tr>
<td>Explains to the individual why PPE is necessary</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Performs hand hygiene and observes appropriate infection control procedures</td>
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<td></td>
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</tr>
<tr>
<td>Applies a clean gown</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Applies the face mask</td>
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</tr>
<tr>
<td>Applies protective eyewear if it is not combined with the face mask</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applies clean gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To remove soiled PPE, removes the gloves first since they are the most soiled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs hand hygiene</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Removes protective eyewear and dispose of properly or place in the appropriate receptacle for cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes the gown when preparing to leave the room</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes the mask</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PRIORITIES POST PROCEDURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposes of used equipment appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs hand hygiene</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ensures that area is stocked with necessary equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student: ____________________________
Assessor name and signature: ____________________________

Comments: ____________________________

Date: ____________________________
### MAPPING TO THE NMBA REGISTERED NURSE STANDARDS FOR PRACTICE

<table>
<thead>
<tr>
<th>UNIT NUMBER</th>
<th>STANDARD</th>
<th>CRITERIA</th>
<th>EVIDENCE-BASED EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Failure to implement basic infection control principles will increase the risk of health care-associated infections, in Section 1.1 Clinical Safety Alert, p. 4.</td>
</tr>
<tr>
<td>1</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>The strategies of hand hygiene, the application of standard precautions, where required transmission-based precautions, cleaning and disinfection reduces the spread of infection, in Section 1.1, p. 4.</td>
</tr>
<tr>
<td>1</td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Personal protective equipment is a major consideration in preventing and controlling infection, in Section 1.3, p. 11.</td>
</tr>
<tr>
<td>2</td>
<td>3. Maintains the capability for practice</td>
<td>Considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice</td>
<td>'Pause-break-stretches' assists health care workers to relax their muscles after performing manual handling activities, in Section 2.1, p. 45.</td>
</tr>
<tr>
<td>2</td>
<td>4. Comprehensively conducts assessments</td>
<td>Conducts assessments that are holistic as well as culturally appropriate</td>
<td>A person who has had a fall, whether there is an injury or not, may develop a loss of confidence in walking. Through assessment, nurses are able to assist the person in identifying strategies to increase their confidence to walk, in Section 2.2, p. 50.</td>
</tr>
<tr>
<td>2</td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Cushions that distribute a person's weight evenly are essential to prevent skin breakdown when they are confined to a wheelchair, in Section 2.3 Clinical Safety Alert, p. 58.</td>
</tr>
<tr>
<td>2</td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Frequent position changes assist in the prevention of pressure ulcers, superficial nerve damage and contractures, in Section 2.5 Clinical Safety Alert, p. 74.</td>
</tr>
<tr>
<td>2</td>
<td>3. Maintains the capability for practice</td>
<td>Considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice</td>
<td>The use of lifting devices reduces musculoskeletal pain and injuries to both the nurse and the person, in Section 2.6 Clinical Safety Alert, p. 83.</td>
</tr>
<tr>
<td>UNIT NUMBER</td>
<td>STANDARD</td>
<td>CRITERIA</td>
<td>EVIDENCE-BASED EXAMPLE</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Taking a temperature via the rectal route is contraindicated for persons with rectal surgery, diseases, or have diarrhoea, haemorrhoids or immunosuppression, in Section 3.3 Clinical Safety Alert, p. 101.</td>
</tr>
<tr>
<td></td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>Do not press both carotid arteries at the same time as there can a reflex decrease in blood pressure or pulse , in Section 3.3 Clinical Safety Alert, p. 109.</td>
</tr>
<tr>
<td>3</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>When a sleeping adult has a respiratory rate less than 10 breaths per minute, use other vital signs to validate status, in Section 3.3 Clinical Safety Alert, p. 117.</td>
</tr>
<tr>
<td></td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>A systolic blood pressure greater than 180 mmHg or less than 80 mmHg requires an immediate nursing response, in Section 3.3 Clinical Safety Alert, p. 127.</td>
</tr>
<tr>
<td>4</td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Regular hygiene promotes healthy skin, control of odours, circulation, gentle musculoskeletal movement and skin assessment, in Section 4.1, p. 158.</td>
</tr>
<tr>
<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Cleansing creams do not dry the skin like soap or detergents, and should be used in conjunction with a moisturiser, in Section 4.3 Clinical Safety Alert, p. 174.</td>
</tr>
<tr>
<td>4</td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>People in long-term care settings are at high risk of oral health problems and respiratory diseases, in Section 4.4 Clinical Safety Alert, p. 179.</td>
</tr>
<tr>
<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>To reduce the risk of pressure injuries, requires ongoing assessment, positioning, nutrition, hygiene and pressure relieving devices, in Section 5.2, p. 195.</td>
</tr>
<tr>
<td>5</td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>Minor wounds in children should be cleansed with warm soapy water and covered with a sterile bandage, in Section 5.3 Lifespan Considerations, p. 201.</td>
</tr>
<tr>
<td></td>
<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
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<td>5</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Wound packing facilitates granulation tissue formation, removal of necrotic material and healing by secondary intention, in Section 5.6, p. 217.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>The medication label must be compared to the medication three times before administration, in Section 6.1 Box 6-2, p. 248.</td>
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<td>6</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Enteric coated, slow release, sublingual and buccal medications are not be crushed as the rate of absorption will change and efficacy will be effected, in Section 6.2 Clinical Safety Alert, p. 251.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Gloves are worn when applying a transdermal patch to prevent skin contamination, in Section 6.3 Clinical Safety Alert, p. 256.</td>
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<td>6</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Subcutaneous injection sites are rotated to minimise tissue damage, facilitate absorption, and avoid discomfort, in Section 6.4, p. 278.</td>
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<td>5. Develops a plan for nursing practice</td>
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<td>6</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Check for signs of phlebitis, thrombophlebitis, infection, inflammation and infiltration before administering an intravenous route medication, in Section 6.4, p. 290.</td>
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<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
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<td>2. Engages in therapeutic and professional relationships</td>
<td>Actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care</td>
<td>Two registered nurses are required to prepare intravenous medication and set patient controlled analgesia pump settings, in Section 7.3 Clinical Safety Alert, p. 332.</td>
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<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people</td>
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<td>7</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>To mitigate the risks of patient controlled analgesia of sedation, respiratory depression and hypotension, observations are recorded at regular intervals, in Section 7.3, p. 333.</td>
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<td>4. Comprehensively conducts assessments</td>
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<td>7</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Contraindications to massage therapy are fractures, recent surgery and poor skin integrity, in Section 7.4, p. 336.</td>
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<td>4. Comprehensive conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
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<td>5. Develops a plan for nursing practice</td>
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<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Adequate hydration and fluids promotes healing, so fasting should be within the guidelines, in Section 8.2, p. 347.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
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<td>8</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Preoperative teaching reduces anxiety, increases pain control and the person’s satisfaction with the surgical experience, in Section 8.2, p. 349.</td>
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<td>5. Develops a plan for nursing practice</td>
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<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Anti-emboli stockings reduce help prevent venous stasis, in Section 8.2, p. 354.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
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<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Nasogastric tube insertion is more challenging when a person is critically ill, has a neurological deficit, a tracheostomy tube is in situ and clotting profile is impaired, in Section 9.4 Clinical Safety Alert, p. 382.</td>
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<td>4. Comprehensive conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
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<td>9</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Each nurse is responsible for checking the position of an enteral feeding tube at least once per shift, in Section 9.5, p. 389.</td>
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<td>4. Comprehensive conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
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<td>5. Develops a plan for nursing practice</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Feeding tubes are flushed with 30 mL of water before, between and after each medication is administered, in Section 9.5, p. 390.</td>
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<td>10</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Older adults who have urinary problems, including incontinence are at greater risk of falling, and require a falls strategy, in Section 10.1 Clinical Safety Alert, p. 414.</td>
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<td></td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>A urine output of below 1 mL/kg/hr is a reportable observation and is an indicator of cardiac or renal dysfunction, in Section 10.2 Clinical Safety Alert, p. 418.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Urinary sheaths reduce skin irritation due to urinary incontinence, in Section 10.3, p. 432.</td>
</tr>
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<td>10</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Initial venipuncture occurs in the distal part of the arm so as subsequent venipunctures move up the arm, in Section 11.7, p. 490.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Normal saline and Hartmann’s Solution restore vascular volume and electrolyte imbalance, whilst plasma and albumin increase blood volume, in Section 11.8, p. 502.</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Intravenous fluid administration requires a flow rate control device for children and older adults to reduce the risk of fluid overload, in Section 11.8 Clinical Safety Alert, p. 504.</td>
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<td>11</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>All intravenous bags are changed every 24 hours to reduce contamination, in Section 11.9, p. 510.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
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<td>12</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>People who shallow breathe due to pain are at risk of atelectasis, so sufficient pain relief is required for deep breathing, in Section 12.3 Clinical Safety Alert, p. 561.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>A humidifying device is required for long term oxygen therapy to reduce drying of the respiratory membranes, in Section 12.5 Clinical Safety Alert, p. 571.</td>
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<tr>
<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Nebulisers require cleaning after each use to reduce contamination, in Section 12.6 Clinical Safety Alert, p. 585.</td>
</tr>
<tr>
<td>12</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Oropharyngeal suctioning cause less trauma for the person, in Section 12.7 Clinical Safety Alert, p. 590.</td>
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<td>5. Develops a plan for nursing practice</td>
<td>Uses assessment data and best available evidence to develop a plan</td>
<td>Tracheal suctioning is limited to 10–15 seconds per attempt, to reduce hypoxia, in Section 12.7 Clinical Safety Alert, p. 590.</td>
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<tr>
<td></td>
<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>Hyperinflation, hyperoxygenation and hyperventilation are techniques which reduce hypoxaemia for tracheostomy and endotracheal suctioning, in Section 12.8, p. 600.</td>
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<td>13</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Always test both sides in cranial nerve testing, in Section 13.2 Clinical Safety Alert, p. 632.</td>
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<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>Neurovascular assessment is performed in the first 72 hours after injury, surgery or application of a cast, in Section 13.3, p. 639.</td>
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<td>13</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>Disproportionate levels of pain in relation to injury and analgesia indicate compartment syndrome, in 13.3 Clinical Safety Alert, p. 644.</td>
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<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
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<td>13</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td></td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>Antipsychotic medication can be administered orally or by intramuscular injection (ventrogluteal site), in Section 14.3 Clinical Safety Alert, p. 666.</td>
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<tr>
<td>14</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td></td>
<td>4. Comprehensively conducts assessments</td>
<td>Uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice</td>
<td>Antipsychotic medication can be administered orally or by intramuscular injection (ventrogluteal site), in Section 14.3 Clinical Safety Alert, p. 666.</td>
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<td>14</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td>14</td>
<td>1. Thinks critically and analyses nursing practice</td>
<td>Complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td>6. Provides safe, appropriate and responsive quality nursing practice</td>
<td>Practises in accordance with relevant policies, guidelines, standards, regulations and legislation</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td>7. Evaluates outcomes to inform nursing practice</td>
<td>Evaluates and monitors progress towards the expected goals and outcomes</td>
<td>思 safety, assessment and confirm when caring for a person with a mental illness, in Section 14.2 Clinical Safety Alert, p. 661.</td>
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<td>SECTION 1.2: Hand Hygiene</td>
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<td>SECTION 1.3: Using Personal Protective Equipment (PPE)</td>
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<td>SECTION 1.6: Establishing a Critical Aseptic Field</td>
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<td>SECTION 2.2: Mobility and Falls Risk Assessment</td>
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<td>SECTION 2.3: Helping a Person out of Bed</td>
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<td>SECTION 2.4: Assisting with Mobilisation</td>
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<td>SECTION 2.5: Turning or Moving a Dependent Person: Moving up in Bed: One-Person Assist with or without Slide Sheet</td>
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<td>SECTION 2.5: Turning or Moving a Dependent Person: Moving up in Bed: Two-Person Assist with Slide Sheet</td>
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<td>SECTION 2.5: Turning or Moving a Dependent Person: Turning a Person: Two-Person Assist with Slide Sheet</td>
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<td>SECTION 2.6: Using a Lifting Device: Two-Person Assist Using a Hoist/Sling</td>
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<td>SECTION 3.3: Oral Temperature, Peripheral Pulse and Respirations</td>
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<td>SECTION 3.3: Blood Pressure</td>
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<td>SECTION 3.6: Diagnostic Testing: Blood Glucose</td>
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<td>SECTION 4.2: Bed Bathing a Dependent Person</td>
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<td>SECTION 4.2: Providing Perineal-Genital Care</td>
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<td>SECTION 4.3: Assisting with Showering</td>
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<td>SECTION 4.4: Assisting a Person with Oral Care</td>
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<td>SECTION 5.2: Pressure Injury Assessment</td>
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<td>SECTION 5.3: Wound Assessment</td>
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<td>SECTION 5.4: Simple Wound Dressing</td>
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<td>SECTION 5.5: Wound Irrigation</td>
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<td>SECTION 5.6: Packing a Wound</td>
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<td>SECTION 5.7: Closed Wound Drainage Care</td>
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<td>SECTION 6.2: Oral Medication Administration</td>
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EDUCATOR RESOURCES

A suite of resources is provided to assist with the delivery of the text, as well as to support teaching and learning. These resources are downloadable from the Pearson website <www.pearson.com.au/9781486011971>.

Clinical Skills Appraisal Forms
All Clinical Skills Appraisal Forms are available in a zip file for download which can be shared with students.

Solutions Manual
The Solutions Manual provides educators with answers to all the Critical Thinking Questions from the textbook.

Test Bank
The Test Bank provides a wealth of multiple-choice, true/false and short answer questions based on key concepts in the textbook, to be used as homework or tests. Each question is ranked according to level of difficulty and is aligned to the Nursing and Midwifery Board of Australia’s Registered Nurse Standards for Practice (2016).

Digital Image Powerpoint Slides
All the figures, tables and photos from the textbook are available for lecturer use.
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