NURSING FOUNDATIONS II (N11)
STUDY GUIDE

BASIC NURSING SKILLS IN THE CARE OF CLIENTS WITH PHYSIOLOGIC NEEDS

SKIN INTEGRITY

Introduction

Hello students!

In some of your earlier courses in nursing you were made to understand that the **intact skin** is the body's first line of defense against the invasion of microorganisms. In addition, it has a vital role in maintaining homeostasis of the body, it provides a protective barrier from numerous environmental threats, and it facilitates retention of moisture. One of your nursing goals is to ensure that your client maintains an intact, healthy, and moisturized skin. However, there are many routine client-care activities which may have a detrimental effect on the skin, including external factors resulting from the client's health condition, or even surgical procedures, which consequently, if not properly attended to may develop into significant problems (Bryant and Rolstad, 2001; WoundSource, 2019).

This session looks into the introduction of competencies that will equip you with the essential knowledge, skills and attitudes in providing basic nursing care for clients with mild to moderate health problems related to skin integrity. You will review basic concepts in skin integrity, factors that can influence skin integrity, as well as common health problems and your role as nurses in addressing these problems.

Just like the previous sessions, nursing process will be our primary approach in understanding the concepts of maintaining skin integrity and addressing problems related to it. A focus on the basic nursing skills will be expected as we are honing your skills to take care of clients with such alterations. We will look at both independent and dependent nursing interventions in client care.

Learning Outcomes

After studying this topic, you should be able to:

1. Describe basic concepts on skin integrity and wound management.
2. Identify the factors affecting skin integrity.
3. Describe the common conditions that can alter or affect skin integrity.
4. Identify assessment data pertinent to skin integrity, pressure sites, and wounds.
5. Determine assessment data pertinent to skin integrity, pressure sites, and wounds.
6. Identify significant findings from data based on nursing assessment.
7. Identify common nursing diagnosis based on identified assessment findings.
8. State outcome criteria for evaluating client responses to measures that promote skin integrity.
9. Describe common nursing interventions to manage pressure ulcers, promote wound healing, and prevent complications in wound management.
10. Discuss roles and responsibilities of nurses in procedures involving promoting skin integrity and wound management.
11. Describe the steps in common wound management procedures.
12. Discuss basic nursing skills procedures and responsibilities in perioperative care.
13. Evaluate outcomes of care and client's response to interventions.
14. Develop a care plan for clients experiencing mild to moderate problems affecting skin integrity using the NANDA-I, NOC and NIC taxonomies.
15. Demonstrate appropriate documentation and reporting of nursing care.

Concept Outline

On Patrol: Skin Integrity

Review of the basic concepts in promoting and maintaining skin integrity. From your previous classes in Anatomy and Physiology, the skin is a three-layered structure that functions to maintain skin integrity consistently. These are the: epidermis, dermis, and the subcutaneous layer or hypodermis. We have been mentioning about the importance of the skin's functions. It is not only for the body but also for the skin to keep it in its optimum healthy state. It must perform a list of vital functions, which include: thermoregulation, vitamin D synthesis, sensation, protection, body image, water retention, and electrolyte balance. The skin, if you remember, is also the protector of regulation, sensation, protection, immunological surveillance, and biochemical functions. If the skin is damaged or impaired, it affects all skin functions, resulting in poor skin integrity, and of course eventually affecting the entire body (Berman, Snyder, and Frandsen, 2016; WoundSource, 2019; Lawton, 2019).

Factors affecting skin integrity.

Skin – the body's first line of defense can become vulnerable to injury, damaged, or the inability to heal. This can be considered a skin integrity issue. As an important independent function of the nurse, promoting and maintaining skin integrity starts with the knowledge of what intrinsic and extrinsic factors could affect skin integrity. Between these types of factors, prolonged exposure to extrinsic factors can increase the vulnerability of the skin for injury or impairment. When this particular defense is down i.e., altered skin structure or function, the chance of infection, limb loss, and even death increases.

The skin's barrier function can be jeopardized or threatened by several events: aging, dryness, bathing technique, activities of daily living, and soaps. Intrinsic factors could include diabetes, skin diseases, poor nutrition, or vascular diseases, among others. Extrinsic factors could include pressure, friction, shearing, falls, immobility, surgical procedures, etc. (Berman, Snyder, and Frandsen, 2016; WoundSource, 2019).

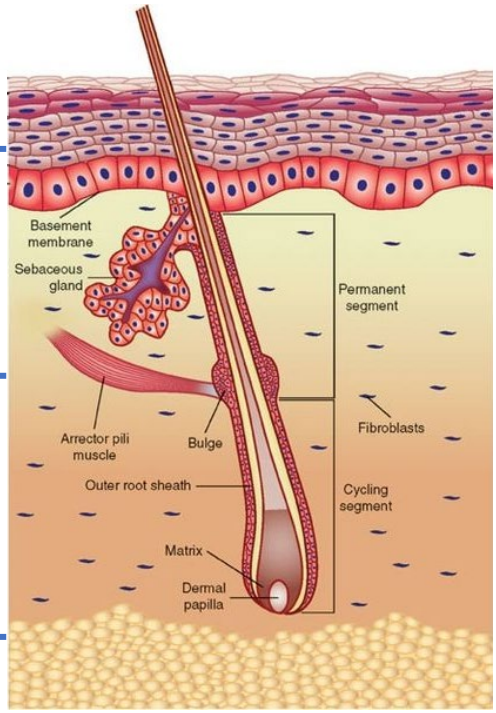
Deepening Your Understanding

The article of Lawton (2019), provides a summary of the skin's basic structure and function.

Lawton S (2019) Skin 1: the structure and functions of the skin. Nursing Times [online]; 115, 12, 30-33. Accessed from: https://www.msdmanuals.com/home/skin-disorders/biology-of-the-skin/structure-and-function-of-the-skin

Activity 1: The Skin Layers

Identify the Layers of the Skin and their Function/s



Wong & Chang, 2009)
(CC BY 3.0)

See the N11 – Key to Exercises for the Answers

Common conditions affecting skin integrity

The two most common skin problems affecting skin integrity are wounds and in chronic skin conditions, pressure ulcers. **Wounds** are described as intentional or unintentional, closed or open, and clean, clean contaminated, contaminated, or dirty (infected). A wound is usually caused by the disruption of the integrity of body skin as a result of environmental or medical factors. The goal of care is to return the disrupted body skins to its optimum integrity. But wound healing involves a complex cascade of events in order to restore the skin's integrity. This takes place by replacing damaged cells and tissues which consists of four phases: hemostasis, inflammation, proliferation, and remodeling. *You should be able to determine the different characteristics of the wound as it goes through these stages.* Various factors can influence the quality of wound healing including nutrition, vitamin deficiencies, smoking, sex hormones, oxygenation, age, stress, diabetes, alcoholism, and medications such as glucocorticoid steroids, chemotherapeutic agents, and nonsteroidal anti-inflammatory drugs. *Some factors are modifiable following some changes in lifestyle. Could you identify which factors are these?*

The types of wound healing are distinguished by the amount of tissue loss: primary intention healing and secondary intention healing. The main complications of wound healing include: hemorrhage, infection, dehiscence, and evisceration. Each of these are identifiable by specific clinical signs and symptoms. *Be able to distinguish or differentiate these types of complications.* There are a number of conventional and newer varieties of treatment modalities used to enhance wound healing such as different medicines, surgical procedures, physical therapy, hyperbaric oxygen therapy, and physical modalities (Feily, Moeineddin, & Mehrab, 2016; Berman, Snyder, and Frandsen, 2016).

Pressure ulcers are also referred to as decubitus ulcers, pressure sores or bed sores and as pressure injures**. A pressure ulcer** is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or force, or pressure in combination with shear

(Monfre, 2016). It is a problem that impacts not only the client but the family and the health care providers as well. Two other factors that act in conjunction with pressure to produce a pressure ulcer are friction and shearing forces. Some agencies removed friction as a causative factor, since based on studies, friction, although an important factor as it leads to shear stress and strain, yet does not alone lead to the development of a pressure ulcer (Monfre, 2016). In addition to these, several other factors increase the risk for the development of pressure ulcers: immobility and inactivity, inadequate nutrition, fecal and urinary incontinence, decreased mental status, diminished sensation, excessive body heat, advanced age, and certain chronic medical conditions. Some of these conditions that present both in the home and in the health care facility. *What assessment indicators and parameters will you use to determine the presence or absence of these risks?*

There are stages of pressure ulcers, which vary according to the degree of tissue damage or tissue loss. Depth of tissue loss is important, as it determines the treatment plan of care. Knowledge of these stages is important to complete the assessment. Several risk assessment tools are available to identify clients at risk for pressure ulcer development. These include scoring systems to evaluate a person's degree of risk.

Deepening Your Understanding

Read Chapter 36, pp. 829 – 837 on *Skin Integrity and Wound Care*

Berman, A., Snyder, S., & Frandsen, G. (2016). Skin Integrity and Wound Care. Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice. 10th ed. Upper Saddle River, New Jersey: Pearson Education, Inc.

You can also refer to the PowerPoint slide ***On Patrol: Skin Integrity*** uploaded in the course site.

Nursing Care of Clients with Mild to Moderate Health Problems Affecting Skin Integrity

Nursing assessment. Nursing care begins with good assessment of the skin regardless of the presence of wounds in order to determine possible risks for altered skin integrity. Nursing history can include additional questions focused on the risk factors. The nurse can also use evidence-based and validated pressure ulcer risk assessment instruments following the institutions protocol. The most common include: The Braden scale and Norton scale.

Essential data for assessing wounds include wound appearance, size, drainage, swelling, pain, and the presence of tubes and drains. Major types of wound exudate are serous, purulent, and sanguineous. Exudate can be a combination of two or three of these types (e.g., serosanguineous). The process of pus formation is referred to as suppuration. When a pressure ulcer is present, the nurse describes the ulcer in terms of location, size, depth, stage, color, condition of the wound bed and surrounding skin, and clinical signs of infection, if present. Laboratory data that may be used to assess the progress of wound healing include leukocyte count, hemoglobin, blood coagulation studies, serum protein analysis, and wound cultures. Depending on hospital policies, nurses are usually responsible for obtaining specimens of wound drainage for culture.

The **NANDA International nursing diagnoses** *Risk for Pressure Ulcer, Risk for Impaired Skin Integrity, Impaired Skin Integrity*, and *Impaired Tissue Integrity* apply to clients at risk for developing and to those with pressure ulcers. Nursing diagnoses related to clients with wounds may include

Risk for Infection and *Pain*. In addition to these, the nurse could also use nursing diagnoses on the psychological and social impact of the wounds on the client (Berman, Snyder, and Frandsen, 2016; Vera, 2019).

Major goals or outcomes of care for clients at *Risk for Impaired Skin Integrity* (pressure ulcer development) are to maintain skin integrity and to avoid potential associated risks. Clients with *Impaired Skin Integrity* need goals to demonstrate progressive wound healing and regain intact skin within a specified time frame. The nurse should also consider preparation of the client and family for home care through home/community assessment and related health teachings.

Major nursing responsibilities related to providing support for wound care and wound healing include assisting the client in maintaining moist wound healing, obtaining sufficient nutrition and fluids, preventing wound infections, and proper positioning. **Nursing interventions** to prevent the formation of pressure ulcers include conducting ongoing assessment of risk factors and skin status, providing skin care to maintain skin integrity, ensuring adequate nutrition and hydration, implementing measures to avoid skin trauma, providing supportive devices, and client teaching. Treatment for pressure ulcers varies according to the stage of the ulcer and agency protocol. The **RYB color code of wounds** can assist nurses to provide appropriate nursing interventions for wounds that heal by secondary intention. In this scheme, the nurse protects red, cleanses yellow, and debrides black wounds.

Wound care may involve cleaning/irrigating, protecting, hydrating, and covering wounds; applying heat and cold; and applying bandages and binders. Various types of dressing materials are available to protect wounds, absorb exudate, and keep the wound bed moist, thus facilitating healing.

Evaluation of care includes the results of the nurse's continuous monitoring or assessment of the wounds, the client's response to the plan of care and wound treatment modality. The client's achievement of the short term or long-term goals or specific outcomes of care, whether these are met/partially met or requires re-assessment. The nurse uses data collected during care, such as skin status over bony prominences, nutritional and fluid intake, mental status, signs of healing if an ulcer is present, and so on. If outcomes are not achieved, the nurse should explore the reasons why, specifically on the risk factor areas earlier identified.

Deepening Your Understanding

Read Chapter 36, pp. 837 – 861 on *Nursing Management* for skin integrity-related problems.

Berman, A., Snyder, S., & Frandsen, G. (2016). Chapter 36 Skin Integrity. Kozier's & Erb's Fundamentals of Nursing: Concepts, Process, and Practice. 10th ed. Upper Saddle River, New Jersey: Pearson Education, Inc. pp 828-863.

Read the following article for an example of capsule nursing care plan.

Vera, M. (2019, April 12). Nurseslabs.com. Retrieved from Dermatitis Nursing Care Plans: https://nurseslabs.com/dermatitis-nursing-care-plans/

Case Application – Skin Integrity and Wound Care

Read and work on the case application for this module on Skin Integrity. Submit or post your answers to the case application in the Assignment bin following the prescribed format. In addition to this submission, answer the question: ***What is your most relevant learning from the case? Why?*** - post your answers and comment on the posts of your group mates in the discussion forum.

Basic nursing principles, skills and responsibilities in perioperative care

The nature of perioperative care

Surgery is a unique experience that creates stress and necessitates physical and psychological changes, and therefore, preparation for the nurse (the entire surgical team in actuality) and the client and family. The perioperative period begins when the client is informed of the need for surgery, includes the surgical procedure and recovery, and continues until the client resumes his or her usual activities (e.g. ADLs or IADLs) at an optimal level. The perioperative period includes **three phases: preoperative, intraoperative, and postoperative**. *Try to differentiate these three phases in terms of nursing activities or responsibilities and what patients are likely to experience in each of these stages.* Surgical procedures are categorized by purpose, degree of urgency, and degree of risk. Given these, there are several factors that influence a client's risk for surgery and these should be considered particularly during the planning stage of surgery (Berman, Snyder, and Frandsen, 2016).

The nursing process is used as the framework or approach by the nurse in providing care in every phase of the perioperative period. The activities and functions of the nurse involve independent, dependent and collaborative functions.

Activity 2: Peri-Operative Phases

Determine the different functions or responsibilities of the nurse across the perioperative phases. *You can fill-in your answers using the table below.*

Pre-Operative Phase	Intra-Operative Phase	Post-Operative Phase

In addition to knowing your roles and responsibilities as nurses, you should also be cognizant of the different members of the surgical team and their specific responsibilities. This will facilitate collaboration and effective, quality client care.

These are just introductory concepts. In-depth discussions and applications will be tackled in your nursing interventions classes. The main focus in this topic is discussed below.

Surgical Asepsis and the Principles of Sterile Technique

Within the set of roles and responsibilities, perioperative nursing involves technical expertise, including responsibility for equipment, instrumentation, and surgical technique. An important set of concepts and principles the perioperative nurse should observe include strict compliance with surgical **aseptic technique** (**sterile technique**) in performing or assisting in the different surgical procedures, changing dressings on surgical wounds to promote healing and reduce the risk of infection, care of clients with drainage systems, sutures, wire clips or staples.

Briefly **asepsis** or **aseptic technique** is a process or procedure used to achieve asepsis to prevent the transfer of potentially pathogenic micro-organisms to a susceptible site that may result in the development of infection (Wilson, 2019 as cited in Denton and Hallam, 2020). There are basically two types: medical asepsis and surgical sepsis. So, what's the difference? **Medical asepsis** sometimes referred to as standard aseptic technique (Association of Safe Aseptic Practice, 2015), or simply clean technique – aims to reduce the number of organisms and prevents their spread by use of standard principles of infection prevention. While **surgical asepsis** includes procedures to eliminate, rather than reduce, micro-organisms from an area and is practiced by surgical teams and nurses in operating rooms and procedure areas, including interventional radiology (NICE, 2012, as cited in Denton and Hallam, 2020).

Activity 3: "To Scrub or Not to Scrub…Which phase are you?"

Determine in which perioperative phase the given items belong by ticking the check box:

	PRE-Op	INTRA-Op	POST-Op
Obtaining informed consent	☐	☐	☐
Surgical handwashing	☐	☐	☐
Donning surgical PPEs	☐	☐	☐
Vital-signs taking	☐	☐	☐
Changing dressings and binders	☐	☐	☐

See the N11 – Key to Exercises for the Answers

Principles of Basic Nursing Skills and Interventions

For this course, the focus of the nursing skills, procedures and interventions will be on:

- Establishing and Maintaining a Sterile Field
- Wound management (cleaning and dressing wounds)
- Use and application of bandages on wounds and binders
- Surgical handwashing or surgical scrub
- Donning and removal of surgical Personal Protective Equipment

For the specific procedures of some of these skills, refer to the N-11 Skills Performance Checklist or e-Manual.

Principles on infection control techniques were already discussed in N – 10 and some of your other courses. You will need to **review** these principles since they form the very foundation in providing and ensuring safety and quality in client care across all health settings and client care levels.

Establishing and Maintaining a Sterile Field

The purpose of creating a sterile field is to reduce the number of microbes present to as few as possible. The sterile field is used in many situations outside the operating room as well as inside the operating room when performing surgical cases. Sterile fields should be used outside the operating room when performing any procedure that could introduce microbes into a patient (Tennant, 2021). Such procedures include wound dressing, insertion of foley catheter, etc.

Anyone that is performing an invasive procedure should use sterile technique.

Deepening Your Understanding

Read Surgical Asepsis and the Principles of Sterile Technique on important principles, steps and rationale behind these principles.

As you go through the article, try answering these Critical Thinking Exercises:

When should a sterile field be opened (under normal circumstances)?

What part of the sterile field is considered non-sterile?

Wound dressing and bandages.

When planning for the type of dressing to be used consider: (a) location, size, and type of the wound; (b) amount of exudate; (c) whether or not the wound requires debridement, is infected, or has sinus tracts; and (d) such considerations as frequency of dressing change, ease or difficulty of dressing applications, and cost.

There are many types of wound dressings, and a number of considerations *(see above)* as to which to choose and use. Recently a good number of **synthetic dressings** have been developed for use with specific types of wounds. These include transparent adhesive films, impregnated nonadherent dressings, hydrocolloids, hydrogels, polyurethane foams, clear acrylic dressings, and alginates. The nurse must be aware of the specific purposes of each and their indications for use (Berman, Snyder, and Frandsen, 2016; WoundSource editors, 2019)

Bandages and binders.

These are basically applied over or around the dressings to hold dressings in place, provide extra protection, apply pressure to wounds, support circulation, and immobilize joints, and several other therapeutic benefits. Bandages and binders come in different materials, sizes depending on the specific purpose and the body part on which it will be used. Assessment of the client's affected part for bandaging is very important before and after application of either the bandage or binder. You will need to learn the different techniques in applying bandages and binders (Unbound Medicine, 2020)

Heat and cold applications. Heat and cold produce specific local physiological and systemic responses that account for their therapeutic effects. Various parts of the body differ in tolerance to heat and cold. The physiological tolerance of individuals also varies. Specific conditions such as neurosensory and circulatory impairments necessitate precautions when applying heat or cold. When applying heat or cold, clients and nurses need to be aware of the effects of thermal receptor adaptation and the rebound phenomenon, including the amount or length of time required for the application. Depending on hospital protocol, heat and cold applications require a physician's valid order (Berman, Snyder, and Frandsen, 2016).

Activity 4: Heat and Cold Application

Using the table below list when Heat and Cold Applications are used:

HEAT APPLICATION	COLD APPLICATION

You can place your answers here in this study guide. Submission is not required.

Surgical handwashing. Surgical hand scrub is one of the most important principles in preventing the surgical site infections. The aim of surgical hand washing is to clean up microorganisms, prevent their transfer or to reduce the amount of permanent flora of the hands, which would ultimately prevent surgical wound contamination from microorganisms found on the hands of the surgical team. As to the technique, a recent study revealed that, in contrast to the traditional scrubbing with soap or povidone iodine, it is sufficient to scrub until the hand dries and the most efficient alcohol-based hand washing product is chlorhexidine gluconate (Gök, Kabu, and Özbayir, 2016). Given current debates on what technique and product to use, it is of utmost importance to the nurse to ensure asepsis in these procedures based on hospital protocol.

Donning (Putting on) and Doffing (Taking off) Procedure for Surgical Personal Protective Equipment. This process which involves scrubbing, gowning, and gloving is one that all members of the surgical team must complete before each operation or surgical procedure. The **surgical scrub** involves first decontaminating the hands, then donning a sterile surgical gown and a pair of sterile gloves, creating an aseptic environment. This procedure strictly follows one after the other and cannot be interchanged (TeachMe Series, 2019). Please note that there are differences between donning/doffing sterile surgical attire and donning/doffing personal protective equipment (PPEs).

Deepening Your Understanding

Read Chapter 37, pp 883 - 898 on Nursing Management related to Perioperative Nursing functions.

Berman, A., Snyder, S., & Frandsen, G. (2016). Perioperative Nursing. Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice. 10th ed. Upper Saddle River, New Jersey: Pearson Education, Inc.

Each hospital protocol follows a minimum standard for surgical asepsis based on existing guidelines; however, in the light of covid-19, a stricter protocol has been established based on guidelines from the WHO and the CDC.

Read the article below on some of these enhanced procedures to ensure added measures of safety to the surgical team and quality surgical care to clients who may be positive or suspected covid-19 patients.

Equipment Donning and Doffing Procedure to Protect Surgical Teams from SARS-CoV-2 Exposure during the COVID-19 Pandemic

> Heather L. Evans, Christopher S. Thomas, L. Hannah Bell, Ashley B. Hink, Stephanie O'Driscoll, Catherine D. Tobin, and Cassandra D. Salgado. Surgical Infections. Published Online: 6 Jul 2020 https://doi.org/10.1089/sur.2020.140

Assignment – The Wound Wardrobe: Types of Wound Dressing

Read the Assignment Guide:

There are 8 Main Categories for Wound Dressing: Gauze, Films, Hydrogels, Foams, Alginates, Composites, Hydrocolloids, Interactive Dressings *(some agencies may have added to this list).* This can make choosing from among several types of dressing often times confusing for the novice nurse.

This activity aims to help you become familiar with all these types (both conventional and the newer or synthetic types) as well as prepare you when you have to actually perform a wound dressing on an actual client.

*Instruction: Construct or create an INFOGRAPHIC on the different **Types of Wound Dressing**. Provide the different information or data to guide users in the choice and use of wound dressing. The output should be useful and practical that can later on be printed or stored online.*
Layout: Minimum size is 8.5" x 13"; maximum size is 11" x 17"; any orientation; printable format (PDF)

Preferably in PDF format so it can later be printed. Indicate the members who worked on the specific output. Use the following file format:

LastName_FirstName_Group_Infograph1.pdf (Ex. Cruz_Juan_GroupA_Infograph1.pdf)

The output or product for this assignment should facilitate information, data, or knowledge on wound dressings (e.g. types, uses, materials, etc.) intended to present information quickly and clearly. Think that you can actually use this later to aid you in your clinical duty.

This is a GROUP ASSIGNMENT meaning you can work within your Group. As a group, you will submit no less than **two (2) outputs of different designs or presentations.** You can divide yourselves into subgroups, so each subgroup will work on one output.

This is a **graded assignment.** Upload your assignment in the **designated submission bin** in the N11 course site.

Pre-Lab

Nursing Skills Video: "Must Watch"

Read the skills procedure in the N11 e-Manual. You can refer back to the references on the skills listed in this study guide.

- Setting Up a Sterile Field *(scroll down to Checklist 13)*
- Wound Care Management
- Bandaging and Application of Binders

Watch the following videos: *(You can also go directly to the N11 Nursing Skills Video Resources Collection)*

Wound Management and Application of Bandages

- Establishing a Sterile Field
- Preparing and Maintaining a Sterile Field
- Pouring Sterile Solution
- Wound Cleaning and Dressing *(note the direction when cleaning the wound)*
- Dry Dressing; Wet-to-Dry Dressing
- Cleaning a Sutured Wound and Changing a Dressing on a Wound Drain (Image)

Bandaging

- Circular Bandage Turn
- Spiral Bandage Turn
- Spiral Reverse Bandage Turn
- Figure-of-8 Turn

Surgical Aseptic Technique

- Surgical Hand Scrub
- Open Gloving Technique (review)
- Closed Cuff Gloving (with double gloving)

From Brookside Associates. (2016, July 28). Nursing 411. Retrieved from Nursing Training and Education

- Surgical cap, mask, eye protection, shoe covers
- Surgical gowning (solo) and closed cuff gloving
- Two Person Surgical Gowning
- Final Tie of Gown
- Removing Gowns and Gloves

Refer to the N – 11 Skills Procedure Checklist or e-Manual for the step-by-step method and rationale of specific skills above. You will have the actual demo and return demo of these skills during the Skills Lab session next semester.

Self-Assessment Activity 5: Practice Makes Perfect

Do the **Preparing a Sterile Field** activity. You can also try doing this in the course site.

You have the following materials/supplies available for your use. Your task is to choose from among these materials what you will use to prepare a sterile field which you will use for dressing the surgical wound on the gastric region. Mark with **X** the squares of those materials you will use for this procedure. *Each item is labeled to help you identify these.* X

See the N11 – Key to Exercises for the Answers

Self-Assessment Activity 6: Practice Makes Perfect

Do the **Preparing a Sterile Field** activity. You can also try doing this in the course site.

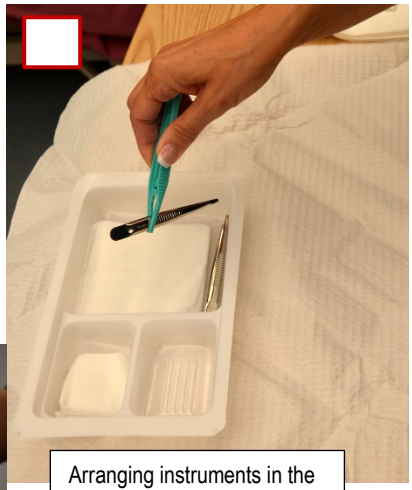
Arrange the images below to show the chronological order in the procedure *Preparing a Sterile Field* by assigning the numbers 1 – 7 on each image. *Each image is labelled with description.*

1

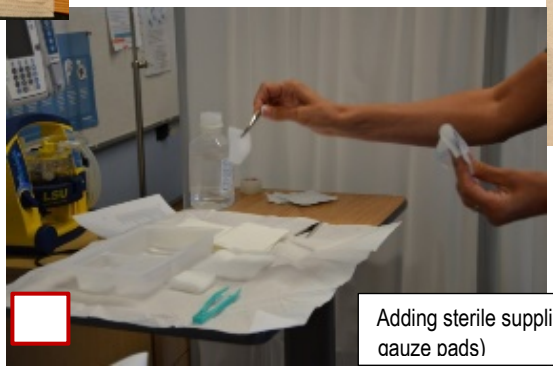
Pouring sterile water into a sterile

Inspecting the sterile gloves

Ready sterile field



Arranging instruments in the sterile area/field



Adding sterile supplies (cotton balls and gauze pads)

Opening the sterile pack

Handwashing

See the N11 – Key to Exercises for the Answers

References

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Feily, A., Moeineddin, F. and Mehraban, S. (2016, October 12). Physical Modalities in the Management of Wound(s), Wound Healing - New insights into Ancient Challenges, Vlad Adrian Alexandrescu, IntechOpen, DOI: 10.5772/64340. Available from: https://www.intechopen.com/books/wound-healing-new-insights-into-ancient-challenges/physical-modalities-in-the-management-of-wound-s-

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