**NURSE OBSERVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EVALUATOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| **OBSERVATION** | **YES** | **NO** | **COMMENTS** |
| HCW performed hand washing prior to handling clean contents of treatment cart |  |  |  |
| Treatment cart left outside of the room, locked when nurse not present |  |  |  |
| Physician order for treatment reviewed |  |  |  |
| All supplies collected before leaving cart and entering resident’s room |  |  |  |
| Solutions dated and discarded after 24 hours (i.e., normal saline) |  |  |  |
| Privacy provided before beginning treatment |  |  |  |
| Nurse informed resident of treatment she/he intends to perform |  |  |  |
| Nurse changed gloves when appropriate/Proper use of gloves |  |  |  |
| Clean field set up at bedside |  |  |  |
| Hand hygiene performed with each removal and application of gloves at appropriate times |  |  |  |
| Treatment performed with appropriate “no touch” techniques to avoid cross- contamination. Always cleanse wd. from area of least contamination to most contamination |  |  |  |
| Observe wound for size, color drainage and appearance  (measure wound before application of medication) |  |  |  |
| Discard soiled materials appropriately |  |  |  |
| Were items used at bedside returned to the treatment cart before sanitizing item  (like scissors) |  |  |  |

CONCLUSION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_