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WRA HOSPITAL
AMACHE, COLORADO

M.O.

DUTIES OF WARD CLERKS

1. Report on duty 8:30 AM. Work until 4:30 PM. Daily*
2. Put chart desk in order and shelf under counter.
3. Make out Linen requisition - have signed.
   (list on hand material
   (list wanted materials
4. Make warehouse requisition - have signed.
5. Prepare pharmacy requisition - and have signed.
6. Take requisitions to Chief Nurse's Office.
7. Charting (as notified by Nurse and Nurse Aides or as seen)
   -Doctors' Visits
   -A.M. Cares
   -Dressings changed
   -10 AM temperatures - notify to be taken and put on Graphic sheet and Bedside Record.
   -Before noon - check off medications given (medications are charted by night nurses).
   -Preparation of charts for patients going to Surgery
8. Lunch - 12 to 1 PM.
9. Check Urine and Defecation sheet on Bedside record and Graphic sheet.
10. Chart 1 PM temperatures on Graphic Sheet and on Bedside Record.
11. At 4 PM check off medications which have been given.
12. Clinical charting as given by Nurses and Nurse Aides.

MISCELLANEOUS

1. Answer phone.
2. Keep want list sheet in Medicine room up to date.
3. Keep temperature book prepared for several days ahead.
   Narcotic book and Census Book
4. Complete Census book daily at 8:30 AM and 4 PM.
5. Prepare Urine and Defecation Sheets for the following day.
6. Keep bulletin board in order and up to date.
7. Make diet order lists (check with new diet orders from chart).
8. Make name cards for newly admitted patients and put on beds.
9. Set up charts for newly admitted patients.
10. Check on adequate chart pages made up in advance for patients on the Wards.
11. Upon discharge of patient, put chart in order for the Medical Historian.
12. Prepare night report sheets.
13. Prepare Laboratory requests and X-Ray requests from the Doctor's Orders.
14. Keep adequate chart supplies on hand.

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*Note: Saturday afternoon and all day Sunday off.

RULES & REGULATIONS OF THE HOSPITAL

1. No gum chewing while on duty.
2. Do not sing or whistle on duty.
3. Do not walk around with arms around each other.
4. Walk rapidly - do not run.
5. Do keep quiet - talk in a moderate tone of voice, but do not whisper either.
6. Try to keep visitors quiet too.
7. Do put hair up off shoulders and collar.
8. Keep clothes, hair, shoes clean and tidy. Clothes should be washable type.
9. Nails should be worn short and kept clean. Bright nail polishes are not good taste on duty.
10. No jewelry is to be worn with uniform, except hospital pins or wedding rings, (these should be removed when working in isolation), wrist watches are permitted.
11. In case of illness, do not consult a doctor on your own initiative, but notify the nursing office and a doctor will be referred to you.
12. If you are unable to be on duty for your appointed shift, please notify the nursing office in advance so that arrangements can be made for the care of the patients.
13. Be willing to take your turn at all shifts of duty assigned as it is unfair to keep the same people on the same shifts all of the time.
14. Be prompt. Pay will be docked for tardiness.
15. Do not visit with patients or with each other while on duty.
16. Keep busy - there is always cleaning to be done, and supplies to be made.
17. Stand up when a Doctor comes on the floor.
18. Stand up when your supervisor comes around or other nurses.
19. Do not stand around listening to conversations between doctors.
20. If the telephone rings and no nurse is available, do answer it and take the message.
21. If the nurse is at the desk, do not answer telephone.
22. If you should answer telephone and the message is about a patient, such as orders from Dr. etc - get a nurse to take orders.
23. When answering telephone, always state what floor and your name, such as - "Medical Floor, Mary speaking."
24. Do not talk about the private affairs of any patient that you happen to learn in the line of duty. This may be very important to the patient.
25. Do not talk of things that happen in hospital to outsiders. These things are so easily misunderstood and can start rumors that have no meaning - so please avoid all chances for misunderstandings.
26. Do not talk to patients about other patients or their affairs, or their disease. This is very unethical.
27. "Do unto others as you would have them do unto you."

Cleaning Utensils and Utility Room

Purpose: To insure clean, sanitary, and therefore safe equipment for use in nursing procedures.

Equipment: Warm soap and water, Cleaning cloths, Facility for sterilizing. Scrub brushes. Scouring soap. Antiseptic solutions.

Procedure: Remove articles from shelves. Wash shelves and racks with soap and water. Clean all articles before replacing. Basins, pitchers, irrigating cans, etc., to be cleaned with soap and water, scoured and sterilized for twenty minutes before being replaced in the cupboard. Where utensils are kept in solutions these should be emptied and fresh solutions made as needed.

Urinals and bed-pans may be placed in a deep sink or tub, soaked in an antiseptic solution and sterilized for twenty minutes.

Blood stained linen is soaked in cold water and the stains washed out before it is wrung out and sent to the laundry.

Cabinets in the utility room should be thoroughly cleaned twice a week. Sterilizers should be scoured at least every other day.

Waste and soiled dressings should be wrapped in a newspaper and put in the garbage can or sent to incinerator. Do not put down anywhere in utility room.

Hot water bottles and ice caps should be dried, the cap put in place (with bag inflated) and hung on rack for that use. Avoid letting rubber goods come in contact with oil, heat, acids, or pins.

Rubber gloves should be washed in cold water first then warm soapy water and boiled for one minute. Dry on both sides and return to operating room. Paper dressing wrappers should be returned daily to O.R.

All equipment belonging to operating room such as flasks, hypodermoclysis sets and needles must be returned to O.R. soon as used in order that they may be resterilized and ready for use. Besure needles are clean.

Leave folded papers and urine specimen bottles ready for use.
Clean sink and hopper and flush with hot water.
Empty bottles and medicine boxes are to be placed in the drug box.
Notify supervisor when supplies are needed such as ink, soap, etc.
Keep the door of the utility room closed when working there to avoid noise in the corridor.

Each nurse is responsible for the equipment used by her. It is not always possible to take care of it immediately, but should be done as soon as possible. Do not leave instruments in sterilizers or solutions longer than necessary as it ruins them very soon. Dressing trays should be replenished, the instruments sterilized and returned to their proper places as quickly as possible.
See that the utility room is well ventilated and free from odors as much as possible.

The utility room is a work room for all, and each nurse should be willing to do her share in keeping it tidy and in order. One alone cannot do this.

CARE AND USE OF HOT WATER BOTTLES.

Purpose: A convenient method of applying dry heat.
To relieve pain. To relieve congestion.
To relax muscles. (As a counterirritant).
To keep moist compresses hot.

Equipment. Hot water bottle and cover. Pitcher. Hot water.

Procedure: Test the temperature of the water in the pitcher; then pour it in the bottle, filling it 1/3 or 1/2 full. The amount depends on the purpose. Flatten the bottle (without twisting) until all the air is expelled and screw the top in firmly. Remove all moisture from the surface of the bottle and place in the cover. Do not use pins to fasten cover as a pin prick will ruin rubber. Apply to the area and see that it is kept hot by frequent changing of the water. The temperature is usually kept about 118 to 120 degrees.

Precautions: The careless use of a hot water bottle has resulted in serious burns to the patient. A leaking bottle may cause a scald even when the water is not intensely hot. This is particularly true of babies, old people, paralytics, and patients with a sensitive skin.

If a temperature higher than 120 degrees is required, great care must be taken that no burns result. Watch for undue redness of the skin. A cover should always be used. A hot water bottle should not be given without a doctor's order unless for warmth. Never for pain.

CARE OF HOT WATER BOTTLES

Do not put boiling water in a hot water bottle. When expelling air, do not twist the neck of the bottle. Be careful when screwing in the cork, not to spoil the threads. Screw in straight.

When putting away, empty the bottle, leave some air in it to keep the inner surfaces from adhering. Screw in the top and hang up the bottle.

Do not leave near extreme heat. Avoid letting the bottle come in contact with oils, acids, pins, or anything that will ruin the rubber. Do not fold rubber goods of any kind. This will cause breaks in the rubber.

CARE OF RUBBER GOODS

All rubber goods should be cleaned and dried before putting away.

Oil ruins rubber. Never bring in contact unless absolutely necessary. In this case, wash off as soon as possible with warm soapy water. Do not use scouring soap or powder as it ruins rubber too.

Heat ruins rubber. Do not place on or near a hot radiator to dry. Do not put boiling water in rubber. After drying inside of ice cap, leave a piece of wrinkled paper inside, or always leave air in it to prevent adhering of the sides when not in use.

Rubber rings should have air left in them to prevent sides from adhering when not in use. Do not fold rubber sheets as they will crack along the line of the fold. Hang over a round rod after the proper cleaning. Do not allow rubber tubing to remain bent as the rubber will soften and be useless at this point. The same thing happens if clamps are left on rubber tubing.

TO FILL ICE CAP

Purpose: To apply continuous cold to an area.
To reduce inflammation. To relieve swelling. To relieve pain. To check growth of bacteria. To arrest hemorrhage.

Procedure: Remove ice from refrigerator pan by running warm water over bottom of the pan. Never use an ice pick to get ice out of pan as this usually sticks holes in the pan. Break ice into small pieces and allow water to run over ice to remove the sharp edges. Fill ice bag, expell as much air from the bag as possible. Screw on the cap, remove the moisture from the surface of the bag. Apply cover. Do not use pins for the cover.

Precautions: Always watch for leakage. The rubber in bags is very thin and easily cut by sharp edges of ice. Never apply an ice cap without a cover. The intense cold next to the skin for any length of time is destructive to the tissues. Do not allow bag to become warm. Ice is to be applied, not a warm compress.

CLEANING A BED

Purpose: To provide clean, attractive, hygienic surroundings for the patient.

Equipment: Basin of 1% lysol solution (warm soapy water may be used).
Basin of clear water.
Cleaning cloths, brush, newspapers.

Procedure: Brush the mattress on both sides, and pillows also with a brush moistened with lysol solution. Brush well in all seams. Have janitor or orderly to take outside to be aired and sunned.

Wash the rubber sheet with lysol solution on both sides, sponge off with clear water, dry, and place to dry somewhere over a rod, or a place with no sharp edges. Change for clean solution. Place papers on the floor for protection. Clean the springs with lysol solution and brush. Go over frame of bed with cloths wet with lysol solution, then go over with clear water and dry. Clean bedside table and all furniture with the lysol solution.

Note: If it is suspected that the bed is vermin infested, the following procedure may be adopted and additional equipment will be required. This is to be done before the bed is cleaned.

Additional equipment: Wood alcohol, sheet, lighter, damp cloth, old rubber sheet.

Procedure: Spread sheet on floor under the bed. Tap the springs, going over them carefully. Remove the sheet, and if any vermin have fallen in it, fold carefully and place in an antiseptic solution.

Place old rubber sheet under head and foot of the bed. Put wood alcohol in all the cracks and light (one part at a time). Have a damp cloth ready in case burning alcohol falls on the floor. Clean the bed as in the previous demonstration.

Note: Keep at a little distance from the flame of alcohol, and if in ward, screen the bed.

TO STRIP A ROOM

Purpose: To prepare a room to be cleaned after the departure of a patient.

Procedure: Look carefully in the closet, bedside table, lavatory, etc. to be sure that the patient has not left any personal belongings. Should you find anything, wrap in a package, mark clearly with name and date and take to supervisor immediately. Should you find any money, jewelry, or valuables report to the supervisor immediately.

Remove linen from bed. Soiled old blankets are sent to the laundry with the linen. Soiled new blankets should be sent to the laundry by the orderly so that they will not be run thru the laundry with the rest of the linens. Blankets that are not soiled are to be aired, folded, and placed in the linen closet. Ventilate the room well. Take all utensils to the utility room to be cleaned and sterilized. Remove all extra equipment from the room.

Save time and steps by carrying a load from the room and not making unnecessary trips to and from the room. After a communicable disease, the walls of the room should be washed, all woodwork washed with soap and water, or a weak lysol solution. The bed and matress cleaned, sunned, and room aired to at least 24 hours or longer if possible before admitting a new patient.

TO PREPARE A ROOM FOR A NEW PATIENT.

Purpose: To have room ready for new patient; to avoid delay when patient arrives, and to save time in case of an emergency.

Procedure: Take clean linen for bed when going to room. Make closed bed. (This is done after the room has been thoroughly aired and cleaned.)

Be sure that the room is absolutely clean and dusted. Have furniture straight and placed to the best advantage. In every way, make the room as attractive as possible. Bed is to be placed straight and six inches from the wall to prevent scarring of the wall and allow a draft behind bed. Turn "feet" of bed inward and lock.

TO ADMIT A PATIENT

Purpose: To treat out patients at all times and under all circumstances as our guests. To be courteous and kind, remembering that sick people are not their normal selves.

Procedure: We are usually notified by the doctor or the ambulance driver that a patient is to be admitted. Any nurse or nurse-aid at the desk should feel responsible to meet the new patient and take him to the room, in case the supervisor is not there to do so, or to direct someone to do it. It is not very courteous, nor is it very business-like for the ambulance driver to have to hunt for a nurse or nurse-aid and ask her to receive the patient. The patient does not feel they are expected and it may leave a bad impression.

Escort the patient to his room, open the bed, be sure to see if the temperature and ventilation of the room is right. If needed, assist the patient to undress and perhaps unpack for him. Tell patient to save the specimen of urine as soon as possible if admitted before 5 PM. If after 5 PM and the case is not an emergency, wait until morning and save the first specimen voided in the morning. However it may be important to have this specimen immediately and unless you tell the patient, the specimen may be lost and a number of hours pass before one can be obtained. As soon as the specimen is obtained, take it to the laboratory with the slip for this purpose, and notify the supervisor that you have done so.

TO ADMIT A PATIENT
(Continued)

Take the patient's temperature, pulse, and respiration. Be sure you get the patient's full and correct name and address. Also ask him his religion, and the name of the town or city in California that was his former address. This information should all go on the front of the chart along with the name of the doctor in attendance. The nurse in charge will have the patient sign a slip, or consent for hospital care.

Make the patient comfortable and before leaving the room ask if there is anything you can do for him.

Do not change position of the furniture or remove the rubber sheet from the bed with out the permission of the supervisor. The bed is at all times to be left six inches from the wall. This is to protect the wall, and allow a draft to pass back of the bed.

This first contact with the hospital and the nurses and nurse-aides may decide the attitude the patient will have during his entire stay. Remember it may be the first time the patient has been in a hospital and everything is new, strange and often bewildering and they may be facing a serious operation. Your sympathetic understanding and kind treatment may make the stay here a pleasant memory in spite of the disagreeable experience and suffering. Mental comfort and relief from worry is an essential factor in the cure of any disease.

Report to the supervisor immediately any condition you think she should know, and all that you have done for the patient.

TO DISCHARGE A PATIENT

No patient is allowed to be discharged from the hospital without a written order from the Doctor on the case. Do not take the patient's word that the Doctor has given his permission.

When a patient insists on going out without permission, try to get in touch with the doctor immediately. The Doctor may give you permission to dismiss him. If you cannot reach the Doctor, then ask the patient or a near relative of the patient to sign a release slip. This slip may be obtained at the Supervisor's desk, if there isn't already one on the chart. Get the supervisor to witness the patient's signature.

The nurse, or nurse-aid who dismissed the patient should feel responsible to look carefully around the room, in the closet, bedside table, lavatory to be sure the patient is not leaving any personal belongings. This not only saves trouble for the hospital, but may avoid a return trip for the patient or relatives.

If the patient has not been out of bed very much, and is still weak - take him in the wheel-chair to the door. Assist him out of the chair and into the ambulance. If he is still to remain in bed, then the ambulance driver and orderly will take (lift) him into the ambulance.

When the patient is getting ready to leave, be cordial in bidding your farewell and tell him that you hope he continues to improve, etc. so that he remembers you and the hospital as having been among friends and that it was a pleasant experience.

METHOD OF SERVING CRACKED ICE

Purpose: When the mouth is dry and parched and the patient cannot take the amount of water desired, they will frequently derive comfort from allowing small pieces of ice to melt in the mouth.

In fevers and after surgical operations it may be particularly desirable though it is apt to increase thirst.

Equipment: Tray or plate. Tumbler or small bowl. Small pieces of ice. Teaspoon.

Procedure: Place bowl within convenient reach of the patient. Refill as needed.

SPECIAL CARE OF THE PATIENT'S MOUTH

Purpose: The mouth requires careful attention at all times, but in some diseases there is particularly great tendency to dryness and cracking of the mucous membrane of the tongue and lips, of infection, collection of sordes and foul breath. Cleanliness will prevent these conditions.

Equipment:

Small tray	Applicators	Ointment for the lips	Towel
Glass of mouth wash	Amesia basin	Tongue blades	
Tooth brush	Glass of fresh water	Paper bag for waste	

Procedure: Protect the pillow with a towel. Have patient's head turned toward you. Place basin so that he can expectorate into it without effort. Clean the teeth with tooth-brush or applicators. Many applicators may be needed to remove the film. Cleanse thoroughly between gums and cheeks. Clean the tongue and the roof of the mouth.

Allow the patient to rinse the mouth with the antiseptic solution and then clear water.

If the lips are dry or parched, apply a thin coating of cold cream, vaseline, or glycerin with lemon juice.

If the patient is unconscious, it will be necessary to hold the mouth open with a tongue blade or mouth-gag.

Work with great care and gentleness. It is very easy to injure the gums and thus leave a site for infection.

When a patient has a high temperature, the mouth should be cleaned at least 4 times a day. Always clean the mouth before offering the patient food. This will aid greatly in making the patient enjoy the food offered.

All milk drinks leave a film in the mouth. Allow the patient to rinse the mouth after all milk drinks.

Keep all equipment perfectly clean, and boil utensils after use. Keep the equipment in the room ready for use when using frequently.

Precautions: If the patient has a communicable disease, the tray and all the equipment must be isolated and used only for this patient. If possible, it is better to have separate equipment in all cases.

FEEDING A HELPLESS PATIENT

Purpose: Your aim should be to have the patient get the required nourishment with the least possible fatigue and discomfort and with as much enjoyment as possible.

Equipment: Extra pillow for patient. Glass drinking tube.
Tray arranged attractively. Napkin.

Procedure: Make the patient as comfortable as possible, having the head and shoulders slightly elevated if allowed.

Have surroundings clean (do not allow basins, soiled towels or anything unsightly on stand). Be sure your own hands and cuffs are clean. Arrange tray conveniently. Protect bed with napkin or towel. When everything is ready, sit down if convenient and take whatever time is necessary. Do not hurry the patient.

When feeding with a spoon, give small amounts only, giving the patient time to finish before offering more. Give the food in order in which he will enjoy it most. Do not forget to give a drink.

When giving tea, coffee, soup, or other hot liquids, be very careful not to burn the patient. This is apt to happen when giving hot liquids thru a tube, as the food is taken quickly without opportunity to test with the lips. Serve hot foods hot, and cold foods cold. Season the food to the patient's taste unless seasoning is to be eliminated from the diet.

Remember the patient needs nourishment in order to combat disease and often has no appetite. With patience and tact you may be able to persuade the patient to take the amount needed. Try to make the meal hour as restful and pleasant as possible.

TRAY SERVING

There are five kinds of diet. Liquid, soft, light, regular or full, and special.

Always serve exactly what is ordered and on time. Be sure to serve the tray to the right patient. Verify this by asking the patient's name if you aren't sure of it. Liquids are to be carried to the patient on a tray. Cover foods when possible. Be sure nothing is spilled on the tray.

If patient is unable to sit up, place the food within comfortable reach. If unable to help himself, feed him. Never place a tray or glass of liquid diet and leave it when you know the patient needs help. It will do him no good on the table out of reach. Patients are often timid about asking for help so it is your duty to ascertain whether help is needed or not. Many patients need help but do not need to be fed. You might spread bread, cut meat, open boiled eggs or pour coffee. This is saving strength and will encourage patient to eat.

In so far as possible try to remember the patient's likes and dislikes such as tea or coffee.

In removing tray, note the amount and contents taken, and report to supervisor so that it may be charted if appetite is good, or poor, or if food is refused altogether.

WHEN GIVING A BED-PAN

Warm pan by letting hot water run over it. Dry and carry covered to bed-side. Place under patient, aiding him to raise up by placing your hand under the small of his back and placing pan with the opposite hand. Screen the bed if in a ward. Watch for the patient's signal. Try not to make patient sit on pan longer than necessary. It is very uncomfortable and may be the cause of a bed-sore.

When removing pan, note contents carefully and record details and time immediately. Note amount (large, small or moderate amount), color (yellow, gray, brown, black, etc), consistency (constipated, hard-formed, soft formed, or liquid). If anything unusual in contents such as blood, or worms, or anything unusual in color or consistency, show it to the supervisor, and save in the lavatory for inspection.

If the patient is very ill or unable to help self, after removing the pan, turn on side and wash if necessary.

Besure to leave patient clean and dry, thus avoiding danger of great discomfort or pressure sores.

Always allow patient to wash hands.

Bed-pan must be kept clean. Rinse first in cold water, then in hot water each time it is used.

TO GIVE AN URINAL

In passing a bed-pan to male patients always take a urinal also.

Lift the bed clothes at the side of the bed and place urinal within reach of the patient's hand.

Place call bell within reach of the patient.

Cover urinal to remove to bathroom.

Record amount of urine in cc., also note if anything unusual in color.

BED BATH

Purpose: Cleanliness and comfort of the patient.

Equipment: Basin with warm water. Soap. Bathing alcohol. Bath blanket. Clean linen - bath towel, face towel, wash cloth. Gown or pajamas.

Procedure: Close window. Be sure heat is on. Screen patient if in ward. Clear off table, make room for basin of water. Cover table with a newspaper. Remove covers after applying bath blanket. Remove pillows. Get warm water and other equipment. Let alcohol stay in water to get warm. Do not put soiled linen on the floor, but get a chair to place it on. Have clean linen arranged in the manner in which it will be used.

Wash his face with clear water unless he wishes soap to be used. Wash neck and ears with soap and water. Rinse each part well, then dry. Be sure all soap is off well. Bathe arms, axilla, chest, and abdomen in order mentioned. Bathe thigh and leg. If patient wishes - place basin on towel and let foot soak in the warm water while bathing the leg and foot. Be careful to wash carefully between toes - dry carefully.

Change the water for hot water. Turn patient on side and wash back, rinse soap off well. Rub back with alcohol, and powder (if patient has it). Unless the patient is very ill he may bathe the perineal region, or finish his bath himself, the nurse seeing that he has wash cloth, soap water, and towel within easy reach. Leave the room while he does this. If he is too ill to complete bath ask the orderly to do it for you. If there is no orderly - then go ahead and finish for the patient.

During the bath, do not expose the patient unnecessarily. Uncover only the part you are bathing. Dry the skin thoroughly to avoid discomfort and danger of the pt. becoming chilled. If possible, do not leave patient during the bath. If you are called from the room, leave the patient well covered and return quickly as possible. It is very annoying to the patient to be left for any length of time.

Finger nails and toe nails must be kept clean and properly cut. Put on patient's gown, remove bath blanket and make up bed. Comb the patient's hair, protecting the bed with a towel. Leave the patient warm and comfortable. Note carefully any abnormalities such as burns, rashes, or bed sores. Leave room tidy and well ventilated. Carry out all unnecessary papers and magazines. Wash water glass and fill with fresh water. Leave tap bell within easy reach. Before leaving the room, ask the patient if there is anything else you can do before leaving.

TO ASSIST PATIENT OUT OF BED

Purpose: To aid patient in gaining strength.

Equipment: Comfortable chair. 2 blankets. Safety pins. Pillow. Patient's underclothing, stockings, slippers, bath robe.

Procedure: Dress the patient while he is lying down. If this is the first time the patient is getting up, strength must be conserved.

Arrange the chair with blankets and pillow and place near the bed. With one arm under his shoulders and one under his knees, help him to the edge of the bed, and into the chair. If he is to be lifted, this will require two nurses, or better call the orderly to do the lifting. Never try to lift a patient without help. You might drop the patient, or seriously injure yourself.

Arrange blankets comfortably around the patient and if cold pin one around his shoulders. See that his feet and ankles are well protected with blankets. Elevate his feet on a stool, or another chair.

Watch the patient carefully while you straighten the bed and the room. Do not leave patient up very long the first time. Ten minutes may be long enough. It is according to how sick the patient has been and how sick the patient has been and how long the patient has been in bed. Never leave him up longer than 20 minutes for the first time. It is so easy to overtire them and cause a setback.

Place the call bell within easy reach. Be sure the patient has water to drink and is comfortable. Go back after the first ten minutes to see that your patient is all right. Try to go back to put the patient in bed yourself. In that way it will not be forgotten.

P.M. CARE OF THE PATIENT

Purpose: To refresh and rest patient and make comfortable for the night.

Equipment: Basin of warm water, soap, wash cloth, towel, and bathing alcohol.

Procedure: Allow patient to clean teeth. Give bed-pan. Allow patient to wash his face and hands if able - otherwise, do it for him. Tidy up bed and surroundings for supper.

Serve supper trays. Feed if necessary.

P.M. CARE OF THE PATIENT
(CONT'D)

After supper, remove pillow. Turn patient on side-give warm alcohol back rub. Loosen draw sheet and rubber. Brush all crumbs out of bed. Tighten draw sheet and tuck in. Turn patient back, make other side of bed. Shake up pillows and replace. Ascertain patient's wishes for more bedding for night and ventilation of the papers and magazines. Leave furniture in order and out of way, or so that there is no chance of night nurse falling over it at night.

Follow the patient's wishes as much as possible as to time and order of giving the care outlined above. Make the patient feel that he is the one being considered, rather than the nurse. Ask if there is anything more you can do before leaving the room.

ENEMATA

An enema is an injection of fluid into the rectum.

Purpose: To cleanse the colon.
To provide a patient with nourishment while unable to take food or liquids by mouth.
To give medication.

There are a number of different kinds of enemata; such as:

Cleansing	Stimulating
Carminitive	Nutrient
Emollient	Saline
Sedative	Oil, etc.

Amounts: Adults: 1-2 quarts.
Children: 1-1½ pints.
Infants: ½ pint
Retention enema: 6-8 ounces.
Special enema: amount as ordered by doctor.

Temperature: Cleansing: 105 F
Stimulating: 110 F
Hemorrhage: 115-120 F, or very cold, as ordered.
Other enemata: 105 F.

Equipment: (For cleansing enema)
Bath blanket, newspapers, bedpan and cover, tray, enema can, rubber tubing, rectal or colon tube, small basin lubricant, and toilet paper.

Procedure: Screen the bed. Remove pillows. Protect bed with newspapers. Turn patient on left side if possible. Drape patient with the bath blanket. Lubricate the enema tube with vaseline. Allow some of the solution to flow out to expell air from tube and to warm tube. Insert enema tip very gently. Allow the fluid to flow slowly into the rectum, holding the can not more than 2 feet above the patient. If the patient complains of pain, clamp the tube, and allow patient to rest a few minutes--have her breathe thru her mouth while she has cramps. This will help her to relax. Then, ask her to tell you when she does not have pain, then allow more fluid to go in. When she is finished, clamp the tube, and withdraw tube carefully, avoid having water dripping on the patient. Place the soiled enema tube in the small basin for that purpose.

Place patient on the pan and remove the equipment. When the pan is removed, see that the patient is left clean and dry and comfortable, and that bed is clean and dry. Note contents of returns and record.

ENEMATA
(Cont'd)

Precautions: Do not leave patient on pan longer than necessary. It is uncomfortable and may cause bed-sore. Answer bell promptly. Have bed amply protected. Have patient comfortable as possible-watch for signs of faintness. After finishing, see that room is aired and all of equipment is removed and cleaned in the proper method. Allow patient to wash hands.

RETENTION ENEMA

A retention or small enema is a rectal injection given to be retained.

Different kinds: Nutrient, oil, and sedative.

Amount: Usually 6 to 8 ounces unless otherwise ordered by doctor.

Temperature: 105 F

Equipment: Small tray, small catheter, small funnel, newspapers, bath blanket, lubricant, pitcher containing the solution ordered, clamp, and small basin.

Procedure: Prepare solution at proper temperature. Carry equipment to bedside covered. Protect bed with newspapers. Have patient lying on left side if convenient. Fold covers down and place bath blanket. Lubricate catheter. Fill funnel with solution. Allow a very small amount to run thru the tube to expel the air. Insert the catheter in the rectum about 6 inches. Keep funnel filled with the solution so as not to introduce air into the tube. Hold funnel about the level of the bed so the solution will not run in too fast, thus causing the patient to want to expel it. When finished, remove equipment, make bed straight, and comfortable. Record immediately.

Precautions: Have solution the correct temperature. A cold solution is apt to stimulate the rectum to expel it. Always use a small catheter. A larger tube is uncomfortable and allows the solution to run in too fast which tends to stimulate the rectum to expel it. If the patient is unable to retain the solution, record the amount expelled and the time.

TEMPERATURE

The temperature is the degree of heat of the body measure by a given scale. It is the balance between the heat production and the heat loss.

Purpose: To aid in determining the condition of the patient.

When it should be taken: When normal: Twice a day 8:00am and 4:00 pm.
When over 99.4: Every 4 hours when awake.
Body heat is produced by oxidation of food substances.
Body heat is lost by:
1. Radiation from skin.
2. Evaporation from skin.
3. Air expelled from lungs.
4. Excretions of urine and feces.

Normal temperature of adult is:
1. 98.6 F by mouth.
2. 97.8 F by axilla.
3. 99.8 F by rectum.

TEMPERATURE
(Cont'd)

Subnormal temperature indicates a lowered vitality.
Temperature above normal indicates active process of disease.
A clinical thermometer is one in which the mercury remains at the degree which it registers until shaken down.
Fever is an abnormal condition due to a disturbance of the heat regulating centers. It is characterized by the temperature being elevated above normal.

Accuracy of temperature:
1. Most accurate - rectal
2. Next accurate - mouth
3. Least accurate - axilla

Equipment for taking temperatures: Tray, glass of bichloride of mercury solution (1-2000), glass of alcohol, glass of cotton pledgets, kleenex.

Procedure: Mouth temperature: Take thermometers out of Bich. solution, shake down the mercury, place in alcohol until you get to patient's bedside. Remove from alcohol. Wipe from bulb up to your hand. Place in the patient to keep lips closed and not talk. Leave thermometer in place for 3 minutes while taking the pulse and respiration. Remove and read carefully. If the mercury registered 96 or lower, repeat the process. Record immediately.

After use, wash the thermometers in running cold water before placing them in the Bichloride again.

Do not take a mouth temperature:

1. If a child is under 7 years old unless the mother tells you the child is accustomed to having it taken by mouth.
2. If a patient is delirious, insane, or unconscious.
3. When temperature is under 97 degrees.
4. For 10 minutes following a hot or cold drink.
5. When patient is a mouth breather.

Taking temperature by axilla: Wipe the axilla with a dry towel to remove moisture. Remove the thermometer from the solution, wipe dry and shake down if necessary. Place bulb of thermometer in the axilla. Hold the arm close to the body, with the hand resting on the opposite shoulder. The thermometer should remain there for 10 minutes to register correctly. It will register about 1 degree lower than if taken by mouth. Remove, read, and record immediately.

Taking temperature by rectum: A different type of thermometer is usually used to take rectal temperatures. The bulb end is shorter and thicker. They should be kept in separate containers. Remove thermometer from solution, wipe dry, and lubricate well with vaseline. Have patient on side with knees flexed, if convenient. Insert thermometer about 2 inches. Leave from 3 to 5 minutes. When removing, if there is any fecal material on the thermometer, wash, shake down, and repeat temperature. Read and record immediately.

Precautions: Do not take a rectal temperature following a rectal operation or when rectum is diseased or inflamed.
When taking a rectal temperature, always hold the thermometer until taken. Do not leave because it may be broken off or go up into the rectum and be difficult and dangerous to remove.
Report any sudden or unusual changes in temperature to the supervisor immediately after taking second time.

PULSE

Pulse is the expansion and retraction of an artery due to the wave of blood forced thru it by contraction (systole) of the heart. The pause is due to relaxation (diastole) of the heart.

Purpose: To aid in determining condition of the patient.

How often taken: Always with the temperature, and frequently when pulse is abnormal.

Pulse varies with:
1. Age
2. Position
3. Emotion
4. Personal peculiarity
5. Disease
6. Sex
7. Exercise

Quality of Pulse: Regularity, force, frequency, pressure.

Force or Volume is the strength of the pulse.
Regularity or Rhythm means the pulsations having equal strength and the interval between pulsations being equal length.
Frequency or Rate means the number of pulsations in a given time, usually a minute.
The Pressure is the force with which the heart sends the blood against the walls of the blood vessels. This is found with the sphygmomanometer.
A thready pulse is one that the pulsations are double. The second half being weaker than the first.
A running pulse is one which has more than 120 pulsations per minute.
An intermittant pulse is where there is an intermission of pulsations at regular or irregular intervals.

Normal pulse:		
	For women	72 - 84
	men	64 - 72
	children under 5 yrs.	80 - 96
	infants	Around 120

Procedure: Place 2 or 3 fingers over the artery, making a slight pressure. Note the general character of the pulse, then count the number of pulsations in one minute.

Precautions: Do not make too great pressure on the artery.
Do not use the thumb to feel pulse.
A watch with a second hand is essential.
Allow the arm of the patient to be at rest and not strained when taking pulse at the radial artery.
If pulse cannot be taken in the radial artery on one wrist, try other wrist.
Unusually slow or rapid pulse should always be repeated.
Report to supervisor any unusual change in pulse.
Record time and rate.

RESPIRATION

Respiration is the sum total of the process by which the body obtains oxygen and gets rid of carbon dioxide. This process includes inspiration and expiration.

Purpose: To aid in determining patient's condition.

How often taken: With temperature and pulse, and more frequently when abnormal.

Variations in respirations may be caused by:

1. Emotion
2. Position
3. Exercise
4. Control of will
5. Disease
6. Drugs

Normal respirations:

Men	15 - 18	per minute
Women	18 - 20	" "
Children	20 - 25	" "
Infants	30 - 35	" "

Quality of respirations may be described as:

Deep or shallow.
Regular or irregular.
Smooth or intermittent.
Noisy or quiet.
Easy or difficult.
Cheyne-Stokes
Dyspnea (difficult or labored breathing).
Apnea (absence of or a complete cessation of breathing).

Cheyne-Stokes respiration (called after two Doctors who first described them) consist of periods of dyspnea preceded and followed by periods of apnea and occuring in a rhythmical cycle, each paroxysm lasting from 30 to 60 sec.

Procedure: Watch the rise and fall of the chest or upper abdomen.
Count each inspiration and expiration as one breath, and count for 1 min.

Precautions: The respirations should be counted without the patient's knowledge.
Counting respirations with the finger on the pulse will usually divert the patient's attention.
Respiration should be counted always when the temperature and pulse are taken.
Notify supervisor if unusually slow or rapid.
Record time, frequency, and any abnormal condition.

CARE OF BACK - - PRESSURE SORES

The prevention of pressure sores is one of the most important duties of a nurse. With the right kind of nursing care, a patient will rarely develop them. Except in unusual cases a nurse should feel that she is responsible for the condition and that she has not put forth the effort necessary to prevent them.

Report to the supervisor at once the first symptom of a pressure sore so that active measures may be used to prevent it.

A pressure or bed-sore (decubitus) consists of an ulceration and sloughing of a localized area of tissue due to death of its cells as the result of pressure.

Causes:
1. Wrinkles in bed-clothing or patient's clothing.
2. Crumbs in bed.
3. Chafing.
4. Pressure from splints and casts.

This may be aggravated by:
1. Moisture.
2. Breaking the skin.
3. Poor circulation.

Pressure sores are likely to develop:

1. On bony prominences.
2. The back of the head and ears in infants.
3. Between the folds of the abdomen under the breasts and on the buttocks in obese patients.

Patients in danger of developing pressure sores:

1. Emaciated and obese patients.
2. Those whose vitality is low, due to old age or long illness.
3. Those who have involuntary micturition and defecation.
4. Those whose condition is such that the circulation is impaired, due to certain kinds of heart disease, and paralysis.
5. Those suffering from faulty metabolism.

Preventive measures:

1. Keep bed clothing free from wrinkles and crumbs.
2. Change the patient's position frequently.
3. Relieve pressure by use of rubber and cotton rings.
4. Exercise care when giving and removing bed-pan to prevent breaking of skin.
5. Keep patient clean and dry to prevent chafing.
6. Bathe reddened areas frequently and massage with alcohol.
7. Keep skin dry by use of powder.
8. Watch splints and casts so that padding is adequate.

Symptoms of pressure sores:

1. Redness which does not disappear when pressure is removed.
2. Smarting.

CARE OF PRESSURE SORES (Continued)

Care of area which has appearance of pressure sore:

1. When predisposing causes exist, or in other cases, on the appearance of the first symptom, wash the part and a large area surrounding the part every 4 hours with hot water and soap. Dry by patting.
2. Massage toward the center of area with cocoa butter or with alcohol and apply zinc oxide ointment or dust with stearate of zinc.
3. Report immediately to supervisor before applying the ointment so that she may ask the doctor for orders. He may order something different.
4. Repeat this treatment every 4 hours.
5. Relieve pressure, change positions frequently.
6. When chafing is present about the genitals from involuntary micturition, cleanse area frequently and apply olive oil.

Care when pressure sore exists: As soon as the skin breaks, a pressure sore is formed and the treatment will be prescribed by the doctor.

1. Keep the wound surgically clean and observe aseptic precautions.
2. Cleanse the area twice a day thoroughly with either 2% Boric Acid solution or equal parts Hydrogen Peroxide and sterile water.
3. Cleanse the area around the sore as outlined in preventive measures and massage every 4 hours.
4. Cover sore with sterile dressing and an application of medication as ordered by physician.
5. Have dressing cover entire reddened area, so that the adhesive straps will not be placed on it. (Ask the supervisor to see it once each day.)
6. Avoid pressure by use of air ring and change position frequently.

Treatment commonly prescribed:

1. Stearate of zinc powder.
2. Castor oil and bismuth.
3. Boracic acid powder.
4. Balsam of Peru.
5. Scarlet red ointment.
6. Ichthyol ointment.
7. Zinc ointment.
8. Tr. Benzoin.
9. Gentian Violet.

WRA HOSPITAL
AMACHE, COLORADO

m.d.

CARE OF PATIENT AFTER DEATH

When a patient has apparently expired, do not begin the post-mortem care until the physician has pronounced the patient dead.

Notify Miss Oliver or in her absence the Nurse in-charge so she can promptly notify the necessary authorities.

Should death occur suddenly while the patient is in a ward with other patients, the bed should be moved to a private room. This must be handled in a quiet manner to avoid upsetting the other patients. DO NO UNNECESSARY TALKING AT THIS TIME.

Straighten the body and place it in the dorsal recumbent position so that it will look as natural as possible. This can be done immediately without waiting for orders.

The care of the patient's belongings is as important after death as when the patient is admitted to the hospital. If the immediate family is present when the patient expires, give them all the personal articles including the jewelry, if they prefer to have it removed. If they are not present, wrap in one bundle or put in their suitcase and give to the mortician.

Too much attention cannot be given to the handling of personal effects of a patient just expired as some very inexpensive article may have a deep sentiment attached to it.

Leave head and shoulders on one pillow to prevent congestion of the blood vessels of the face.

Remove rubber rings, hot water bottles and extra equipment from the bed.

Remove spread, blankets, and gown - leaving a sheet over the body.

If the patient has dentures, these should be placed in the mouth at once as the jaw sets and it is impossible to do this later.

Bathe the body as needed.

Comb the hair and arrange neatly.

In surgical cases, remove the dressings and apply clean unsterile dressings if there is drainage. If no drainage see that the incision is clean.

Do not bind the patient in any way. Close the eyes but apply no pressure. Morticians do not like to have bandages used as they often cause congestion, the marks of which are difficult to remove.

All work should be done quietly, quickly and respectfully. Consider the wishes and feelings of the family whether or not they are present. Your composure and kindness will be a source of comfort to the family.

N.O

WRA HOSPITAL
AMACHE, COLORADO

PREPARATION FOR SURGERY

Whenever possible, the patient must be surgically prepared the evening preceding the operation.

In the morning the patient must be given general care before pre-operative medication is given. This includes bath (if able to take tub bath, otherwise A.M. care), oral hygiene, removal of dentures or removable bridge and care of hair.

Place a strip of adhesive over rings worn to prevent loss of same.

The hair must be brushed or combed and if long must be braided.

Have patient wear short surgical gown if available - otherwise clean pajamas.

Following medication have patient rest quietly.

Immediately preceding surgery have patient void. It is important that the bladder be empty before an operation. If the patient cannot void, the Surgical Supervisor must be notified in order that there be time for catheterization to be done if ordered by the doctor, without having unnecessary loss of time. Chart accurately the time and amount voided or catheterized.

Have patient wear OR socks and a triangular bandage around head. Wrap patient well before entering corridor.

Take the chart with you to Surgery, having recorded the time the patient left the Ward.

Have relatives wait in the Ward as no one is given permission to enter the operating room except those needed to do their work.

Be sure the anaesthetic bed is made immediately after the patient leaves it.

November 23, 1943

Nurses

EMERGENCY TREATMENT OF HEMOPTYSIS

1. Albolute bed rest in single room.
2. Put patient in semi-recumbent position.
3. Give ms. 1/6 to 1/4 grain Hypo. (Nurses)
4. Ice Cap on chest, affected side.
5. Vitamin K. Hypo - PRN
6. Cold Liquid diet
7. Report to doctor in charge.

January 25, 1964

LAUNDRY SERVICE

Laundry from wards will be picked up as follows:

Isolation -- Monday and Thursday

Obstetrics
Medical
Surgical
Out Patient
Operating Room — Daily

Nurse's Uniforms:
Pinafores, Blouses, etc. — Daily

Linen from:

Doctor's Quarters
Nurse's Quarters — Tues. and Sat.

N.O.

WAR RELOCATION AUTHORITY
WRA HOSPITAL
AMACHE, COLORADO

Health Division — Effective April 19, 1943

RULES AND REGULATIONS

GENERAL CLINIC HOURS:

Monday through Friday: 2:00-4:00PM (AFTERNOONS ONLY)
Saturday morning: 9:30-11:00AM

Registration with Receptionists:
Patients for GENERAL CLINIC will be registered for the day's treatment between 1:30 & 2:30PM Monday through Friday and between 9 & 10AM on Saturday mornings. Patients will be called to see doctors during the scheduled general clinic hours in the order in which they sign up.

It must be understood, however, that although registration time is not fully up, receptionists may sometimes be forced to stop receiving further patients if the clinic is particularly full and it is certain doctors will not be able to see on that day more than those who have already signed up.

SPECIAL CLINICS:

Patients for Special Clinics are seen by appointments only.
Time: 9:30AM - 11:00AM.

SCHEDULE:
Monday.....Venereal Disease
Tuesday.....Chest
Wednesday.....Well Baby
Thursday.....Gynecology
Friday.....Prenatal

NO CLINIC ON SATURDAY AFTERNOONS AND ALL DAY SUNDAYS.

IMMUNIZATION PROGRAM:

PERTUSSIS (WHOOPING COUGH) - Wednesday mornings between 9:30 & 10AM.
DIPTHERIA & SMALL POX - Starting Wednesday April 21, 1943 from 9:30-10AM and every 3 weeks thereafter. Please come on time.

REFILLS ON MEDICINES:

All requests for medicines, including REFILLS, must be accompanied by a doctor's prescription before they will be honored by the pharmicists. This is a safeguard for the patient.

Those requiring refills must register with the receptionists first.
Do NOT go directly to a doctor or pharmicist.
Original bottles or containers should be cleaned & brought for refill.

OPTOMETRY CLINIC APPOINTMENTS:

Patients desiring eye examinations must register through the GENERAL CLINIC first and receive an appointment to the Optometry Clinic. The Optometry Department is very busy and it is therefore imperative that appointment hours be strictly observed once they are made.

HOME CALLS - EMERGENCIES:

Home calls are for EMERGENCIES ONLY. Please notify the Out-Patient Department in such cases. Do NOT go to the doctor's home.

Telephones are for emergency use only. Such cases should be reported by an immediate member of the family with complete information concerning the patient.

OUT-PATIENT DEPARTMENT OFFICE:

This department is open 24 hours a day for the various clinics as scheduled, for emergency cases, and for treatment.

NOTE: PLEASE KEEP THESE MIMEOGRAPHED RULES & REGULATIONS FOR FUTURE REFERENCE!

RECEPTIONIST IN HOSPITAL ADMINISTRATION OFFICE:
There is a receptionist on duty until 10PM daily, Mondays through Fridays, and from 2 to 10PM on Sundays.

VISITING HOURS: (These rules will be strictly enforced!)

MEDICAL WARD.....2:30PM-3:30PM daily
7:00PM-8:00PM daily

OBSTETRICS WARD.....2:30PM-3:30PM daily
7:00PM-8:00PM daily

ISOLATION WARD.....7:00PM-8:00PM Wednesdays and Sundays ONLY.
Note: These patients must sleep in afternoons so it is important that they are not disturbed during this time.

CHILDREN UNDER 12 YEARS OF AGE WILL NOT BE ALLOWED TO VISIT PATIENTS.

BABY FOOD STATION SCHEDULE:

MESS HALL	TIME
6E	10:15 to 11:15AM
6F	10:00 to 11:00AM
6G	10:00 to 11:00AM
6H	9:00 to 10:00AM
7E	9:00 to 10:00AM
7F	9:00 to 10:00AM
7G	10:00 to 11:00AM
7H	9:00 to 10:00AM
8E	2:00 to 4:00PM
8G	9:30 to 10:30AM
8F	10:00 to 11:00AM
8K	9:00 to 11:00AM
9E	2:00 to 4:00PM
9H	9:00 to 11:00AM
9K	9:00 to 10:00AM
9L	10:15 to 11:15AM
10E	9:00 to 11:00AM
10H	9:00 to 11:00AM
11E	10:30 to 11:00AM
11F	10:00 to 11:00AM
11G	9:30 to 10:30AM
11H	10:00 to 11:00AM
11K	9:00 to 10:00AM
12E	10:00 to 11:00AM
12F	9:00 to 10:00AM
12G	8:30 to 9:30AM
12H	8:30 to 9:00AM
12K	10:00 to 11:00AM

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Medical

WRA HOSPITAL
AMACHE, COLORADO

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Straighten the body and place it in the dorsal recumbent position so that it will look as natural as possible. This can be done immediately without waiting for orders.

The care of the patient's belongings is as important after death as when the patient is admitted to the hospital. If the immediate family is present when the patient expires, give them all the personal articles including the jewelry, if they prefer to have it removed. If they are not present, wrap in one bundle or put in their suitcase and give to the mortician.

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Remove spread, blankets, and gown - leaving a sheet over the body.

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Bathe the body as needed.

Comb the hair and arrange neatly.

In surgical cases, remove the dressings and apply clean unsterile dressings if there is drainage. If no drainage see that the incision is clean.

Do not bind the patient in any way. Close the eyes but apply no pressure. Morticians do not like to have bandages used as they often cause congestion, the marks of which are difficult to remove.

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Obst

WRA HOSPITAL
AMACHE, COLORADO

PREPARATION FOR SURGERY

Whenever possible, the patient must be surgically prepared the evening preceding the operation.

In the morning the patient must be given general care before pre-operative medication is given. This includes bath (if able to take tub bath, otherwise A.M. care), oral hygiene, removal of dentures or removable bridge and care of hair.

Place a strip of adhesive over rings worn to prevent loss of same.

The hair must be brushed or combed and if long must be braided.

Have patient wear short surgical gown if available - otherwise clean pajamas.

Following medication have patient rest quietly.

Immediately preceding surgery have patient void. It is important that the bladder be empty before an operation. If the patient cannot void, the Surgical Supervisor must be notified in order that there be time for catheterization to be done if ordered by the doctor, without having unnecessary loss of time. Chart accurately the time and amount voided or catheterized.

Have patient wear OR socks and a triangular bandage around head. Wrap patient well before entering corridor.

Take the chart with you to Surgery, having recorded the time the patient left the Ward.

Have relatives wait in the Ward as no one is given permission to enter the operating room except those needed to do their work.

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WRA HOSPITAL
AMACHE, COLORADO

ROUTINE O.B. ORDERS

1. Admitting an O.B. Patient
   A. Put to bed
   B. Ask the patient her name, address, religion, former address, husband's name, birthplace, day month and year she was born.
   C. Ask her what time labor began; if she is full term; if the membranes have ruptured; how often her pains are; if there is any bloody show; if she is a multiparae or primiparae; if she has had more than one baby; if she has a history of fast delivery.
   D. If the patient is not doing much go ahead and prepare the patient - get a catheterized urine specimen and give s.s. emena. If the pains seems very hard and the patient is a multipara do not give enema. If rectal examination reveals patient is progressing rapidly and head well engaged do not give enema.
   E. Call the doctor and notify him what the patient is doing and if you want him to come or not.
   F. Give synkamin cap'T soon after patient is admitted and give every four hours for four doses.
2. File admission report in Card index box on admission of patients and babies.
3. Write name of patient, date, time, address of each patient or baby admitted or discharged in Census Book.
4. After patient is dismissed and chart completed, leave chart at the chart desk and the Historian will pick up same each morning.
5. Have Doctors sign each chart complete before patient is dismissed.
6. Order of chart:
   1st page -white sheet with name, address, doctor's name, identification number, religion, former address
   2nd page -Doctors Orders
   3rd page -Temperature sheet
   4th page -Nurses bed side record
   5th page -Labor and Post Partum Record
   6th page -New Born
   7th page -Consent to care in Hospital. Be sure to get patient's signature - if too ill, have some responsible relative sign it.
   8th page -In Patient admission and discharge
   9th page -Ante Partum Record. This record can be obtained from the Out Patient Clinic. Return same to Out Patient Clinic when patient is dismissed.
7. If the doctor does not write up delivery, the Nurse in-charge of the shift is to write up the delivery.
8. Nurse is to keep up daily summary on patients.
9. Nursery Nurse who is in the nursery in the mornings is to chart for the babies' weight, temperature, feedings, stools, etc.
10. Each shift is to see that there is enough formula made up for the next shift.
11. Use one measure of SMA to every ounce of sterile H_2O.

12. Sterilize baby bottles, nipples, eye droppers, breast shields, etc. in large pan provided for that purpose in Nursery or kitchen.
13. Wash breast pump well in soap and water and rinse well. "Boiling pump will soon wear it out and looses its suction."
14. Only instruments and catheterization trays are to be boiled in sterilizer in Delivery Room.
15. Large sterilizer can be used for forceps and things too large to put in small sterilizer.
16. Between 8 AM and 10 AM make a requisition for next day's linen supply after checking linen room. The boy in-charge will pick up requisition every morning. The linen will arrive about 2 PM same day.
17. Requisition necessary for drugs and supplies are to be signed in the Office first.
18. Keep bathrooms, kitchen, linen room, utility room in order, and each shift is to clean up dirty pans, dishes, glasses, and drinking tubes that were used on that shift.
19. Each shift is to wash their own masks (and be sure to get the "lip-stick washed off") and put away.
20. Notify Miss Oliver if there is a death during the night or any emergency.
    Notify the front Office or Miss Oliver as soon as possible when a birth or death occurs during the day.
    If a birth occurs during the night, notify Miss Oliver or the front Office as soon as Nurse -in-charge gets off duty in the morning.
21. Have a rubber sheet on all beds.
22. Nursery:
    --Oil bath for baby daily.
    --Weigh daily.
    --Temperature to be taken every morning; if elevated, take every four hours or P.R.N.
    --Bands to be kept on all babies until cord comes off.
    --Cord to be kept dry and wiped off with alcohol daily or when necessary.
    --Report to doctor if cord seems infected or not drying as it should.
    --Wash eyes c̄ boric acid solution if there is any discharge.
    --Babies to breast every four hours -6-19-2-6 at night if mother has breast milk.
    --Premature are fed every 3 hours -6-9-12-3-6 etc.
    --Mark babies with adhesive bands c̄ marking ink and put on wrist.
    --Mark the crib with baby's name and doctor.
    --Mark the baby blankets with small adhesive marker and pin on corner of blanket.
    --$AgNO_3$ followed with normal saline is used in baby's eyes after birth; if a discharge is noted a few hours later wash out eyes frequently with boric acid solution.
23. Delivery Room:
    --Packs, sterile pan set, sterile gloves, applicators, towels, gowns, drape sheets - will be on the shelves in the work room next to the delivery room.
    --Also extra cans of ether, green soap, brushes, masks, and caps will be in the work room.
    --The catheterization tray is in the work room. Every

nurse that uses the tray is responsible to have it sterilized and ready for use. Also have enough specimen bottles on hand from the laboratory.

--Before patient is ready to be draped, cleanse patient w/ cotton balls that have been in solution of water and green soap. Spray below either with mercurochrome or Tr. of Merthiolate, whichever the doctor prefers.

--Ask the doctor on the case if he wishes either to be given.

--Ask the doctor on the case when he wants the pituitrin and ergonovine given.

--Extra cord tie is on the table in the delivery room.

--Chromic Sutures in a glass jar in delivery room.

--Ask the doctor if he wants stirrups used or not.

--Blood pressure apparatus and stethoscope to be kept in delivery room.

--Instruments are put up sterile after each delivery by the Nurse -in charge at that time. Boil instruments in small sterilizer, and dry each instrument on a sterile towel before putting in a sterile towel. Catheter and needles are also put up w/ instruments.

--Hypodermics and hypo. needles are to be kept.sterile and put in sterile jar on the table in the delivery room.

HOW TO PUT UP A O.B. PACK

1. First have two large bundle wrappers.
2. On top of the bundle wrappers, put two diapers.
3. Eight sterile towels folded.
   T binder with 4 kotex pads and safety pins.
   About 25 sponges or flats.
   Put cord tie in a piece of gauze and put underneath diapers with tie sticking out so that it can be seen.
4. Large Drape sheet
5. Chest cover
6. OB socks
7. Drape sheet
8. Doctors gown
9. Sterile towel - for doctor to dry his hands
10. Hip pad - or Bath towel - to be put underneath patient as soon after she is cleansed.

All bloody linen to be washed out with cold water and dried in bath room before putting in clothes hamper.
Nurse in charge of floor at time of delivery is responsible in getting the delivery room in order.
Have floor swept and scrubbed after each delivery.
Wash gloves, and powder, and have ready to be put up for sterilizing.
Have pan set put up and ready for sterilizing.
Note: There are three pans..1 for sterile lysol water
1 to receive placenta
1 with sterile cotton balls
"Be sure and have cotton balls in the one pan"
After delivery boil a pitcher of water and cover with sterile towel so it will be ready for next delivery.

RULES ON CHARTING

Each nurse is responsible for writing the patients' name and identification number on the sheets that are put new into a chart.

On first page of the Nurses Record be sure and write on the first line the date and time of admittance.

On the day the patient enters the Hospital, chart as admission day. The following day is 1st medical day, etc.

On the midnight line write in red ink the day-month-year, and either if it is 1st p.p. or 1st p.d. or 1st hospital day, etc.

Temperature must be taken at 6 AM; elevated, at 10 AM. All temperatures at 2 PM; and elevated, at 6 PM and 10 PM - unless otherwise ordered every four hours.

When a nurse gives a hypodermic, initial same in small signature.

Measure urine the first 24 hours on all O.B. cases.

When the nurse or nurse-aide takes 2 PM temperature, ask patient if she has had a bowel movement. This is to be charted on graphic and bed side record.

> Mothers will have routine time for using the bed pan - at 5:30 AM before babies go to breast; when patient is having her AM care before bath between 8:30 and 9:30 AM; just after dinner; at 4 PM before patient washes for supper; in the evening when they are having their PM care; after the babies nurse at 10 PM.

In regard to the New Born record, use only one line daily. Night nurse charts in red ink and uses one half of the line and day nurse charts in blue ink the other half of the line. If the baby's condition is not normal, use Nurses record and chart in blue during the day, 8 AM to 8 PM, and red at night, 8 PM to 8 AM.

On outside sheet use first name first as: Mrs. Helen Brown.

****

ROUTINE ADMISSION FOR O.B. PATIENTS

Put patient to bed immediately and notify supervisor.
Take T. P. R.
Have patient sign consent sheet.
Fill out "In patient admission and discharge" page for chart.
Perineal preparation. (see page 12 - preparing the patient for delivery.) This is done by the nurse in charge except when permission is given by R.N.
Proklot 2 mg. (1 tab.) is given upon admission and every 4 hours for 4 doses. (N.A. may give this with permission)
Get urine specimen after patient has been prepared. (label spec. bottle with name-ward voided or catheterized)
Time pains.
Inquire if membranes have ruptured.
Note any discharge
Enema to all primiparae.
Inquire before giving enema to multiparae.
Report to nurse in charge.

ROUTINE FOR THE DAY

8 A.M.	On duty. Check charts to fine out how many enemas are to be given. Verify your count with the nurse in chart. All enemas given. Bed pans to patients who do not get enemas. Take off all bedpans. Any badly soiled bedpans and all enema cans are left to soak in square sink in utility room while ward work is being done. Baths All patients who are able to, take their own baths. N.A. washes the back and straightens bed. Fresh linen is used as needed. Draw sheets are usually left 2 days or more unless badly soiled. Change sheets and pillow cases every other day. T binders and breast binders P. R. N. Bottom sheets are changed only if they become too soiled. Change sheets and pillow cases every other day. On first P.P. day if patient is too uncomfortable because of stitches or packs, N.A. may give complete bath. Fresh water to all patients.
9:40	Babies to breast Tray girls pass nourishment. Clean nursery and utility room.
10:25	All babies back in nursery. Give babies complimentary feeding of SMA as necessary. See that they are comfortable and dry. Chart feeding.

11:00	Check ward
11:15	Tray passed by tray girls
12:00-12:30	Bed pans
12:40	Babies to breast.
1:15	Babies back to nursery
1:30	T. P. R.
2:00	Medications - Nourishment (tray girls)
2:30	Visiting hours. No bells.
3:30	Wash water
33:40	Babies to breast
4:15	Babies back to nursery
44:00-4:15	Bed pans
4:30	Trays
5:00	Supper
6:40-7:15	Babies to breast
7:00-8:00	Visiting hours
8:00	Give medications - Nourishment will be found in refrigerator. Back rubs
9:20	Bed pans
9:40	Babies to breast
10:30	Lights our
12:40	Babies to breast
1:15	Babies back to nursery
3:40-4:15	Babies to breast
6:00	Bed pans Wash water
6:40	Babies to breast
7:00	Back to nursery - feed Trays, Charts
8:00	Medications Report to nurse coming on duty before you leave ward.

WARD - CARE OF MOTHERS

A. Immediately after delivery:
Massage fundus with rotary motion abour every 15 min. for 1 hour.
To lie flat on back in bed with knees together for 2 hours.
Watch for excessive bleeding; if noted.
1. Try to massage fundus until hard.
2. Pin pads on very tightly.
3. Call nurse in charge.
4. If unable to get doctor immediately, put baby to breast or use breast pump. This sucking stimulates uterus to contract.
5. If no excessive bleeding: Patient may turn on side after 2 hours.

B. Routine daily care.
1. Daily bath
On first P.P. day N.A. should give patient complete bed bath.
In normal cases patient bathes herself after 1st day N.A. washes back and makes her bed. Cleans off bedside tables. Washing off any staines or spots. If patient has discomfort from stitches N.A. may help patient more with bath.
2. Bed Pan.
a. All patients are to be cared for with utmost cleanliness.
b. All patients are to have bed pans between 8:00 am and 9:30 am. Please inform patients of bed pan schedule.
c. Perineal Care
Unpin T of binder. Stick pin into mattress of pillow. Remove pads - Never let part of pad over anus touch perineum of vulva. Push T up under patient and slip bedpan in place. To remove patient from pan: Separate thighs widely. Pour warm germicide solution over vulva. With sterile forceep - pick up a cotton ball and dry vulva, starting at symphosos, wiping down, avoiding vaginal opening. Also avoid rough wiping on stitches. If patient has stitches spray with mercurochrome. Apply 1 perineal pad. Do not touch the side that goes next to the patient with your fingers.

Now have the patient raise up off the pan and turn on her side - back toward you. With more cotton balls, or the back of used pad, dry around anus and buttocks. Place another pad if needed, and bring T down. Turn patient and pin binder in place. Wrap soild pads and cotton in paper and place in bucket or cart. Bedpans are passed every day 5:30am; 8:00-9:30 am; 12 noon; 3:30 pm; 6:30 pm; 9:20 pm.

3. Breast
Until breasts begin to fill: No binder.
On about 3rd P.P? day milk begins to enter breasts.
Breast binder is then applied.
Lay binder under patient's back and bring up over breast. As patient to support breasts with hands outside or binder on each side. Lay sterile 2 x 2 on each nipple. Pin binder to fit snugly over ribs just below breast. Use 2 pins if necessary to support. Pin binder up from over nipples and full part of breast just snug enough to be comfortable, but never binding. Bring s straps down over shoulder and either cross or leave straight and pin firmly to binder for added support.

4. Enemas:
All patients without stitches or complications may have enemas on 2nd P.P. day.
If stitches are present, give enema on 3rd P.P.
All patients are to have a B.M. or enema every other day.
Perineal care after an enema is the same as at any other time, but great care must be used, not to bring fecel material into contact with stitches.

5. Baths - see routine for day.

6. Babies to Breast: Pour rubbing alcohol in mothers hands first.
Unpin binder and cleanse nipples well with boric acid. Help baby to find and grasp nipple if necessary. If first baby, instruct mother how to nurse baby. Call nurse in charge to help you in this.
Allow babies to nurse 15-20 minutes. Carry baby in upright position--head on your shoulder and pat gently on his back on the way back to nursery. This aids in expelling air bubbles.
Fresh water frequently
   1. During am care
   2. Meals
   3. After T. P. R.
   4. After visiting hours.
   5. During pm care.
   6. During am care.
   7. Any time patient's glass is empty.

SPECIAL DUTIES FOR EACH SHIFT

8 A.M. - 4 P.M.
- Make SMA for 24 hours
- Put linen away
- Wash all masks at end of shift
- All baths and enemas
- Leave all jars, etc. filled
- See that linen room, kitchen, utility room, bathrooms, etc. are in order.

4 P.M. - 12 Midnight
- Daily census book - Write name, date, address, time and each patient admitted or dismissed.
- Check SMA to be sure of an adequate supply for your shift and next.
- Make supplies as time allows.

12 Midnight - 8 A.M.
- Keep diet list in order
- Keep med. list in order
- Clean temp. tray as needed
- Clean ink stands and pens.
- Keep charts up to date and pages filled out.
- See that diet kitchen is clean
- Make supplies

DUTIES OF NURSES AIDES DURING LABOR AND DELIVERY

- Admit O.B. patient.
- To bed immediately.
- T. P. R.
- Fill in Patient admission and discharge sheet.
- Have consent signed.
- Urine specimen.
- Enema - inquire of nurse in charge
- As patient progresses toward delivery, be near so nurse can call you if needed.
- In delivery room be close to help nurse

SUPPLIES USED IN O.B. WARD

2 x 2 flats - for mother's nipples.
4 x 4 flats - for babies cords.
sponges during delivery.
Cotton balls - for perineal care, for oiling baby, cleaning baby's eyes.
for pan set.
Dressing papers - for wrapping soiled pads and cotton balls for disposal.
Toothpick applicators - small-tightly twisted cotton on flat end of tooth pick.

ROUTINE DAILY CARE OF BABY

8:00 - 9:30 A.M.

Weigh, take rectal temperature.
Measure any baby who hasn't been measured before.
Cleanse eyes with boric acid, using clean piece of cotton for each eye and wiping from nose out (never attempt to clean inside of lids.)
Examine nose for secretions. If present, use cotton applicator dipped in oil and gently insert into nostril.
Oil scalp with pads of fingers.
Wipe face, ears and neck well with oil. Get into each crease with oil. Note any skin eruptions and report to nurse.
Oil entire body, avoiding cord.
Wash buttocks with soap and water
Dry well and oil.
On male babies push foreskin of penis back as far as possible and oil, removing white substance each morning.
If cord is still on - apply alcohol dressing and band.
If cord has dropped off - examine navel for moisture apply Tr. Merthiolate, gauze and band. If dry, no band.
Dress baby and put in clean bassinett. If before 9 A.M. offer 2 oz of water.
Examine baby's wrist marker if illegible or loose- replace it with a new one.

9:40 A.M.

Babies to breast. All babies except those under 8 hrs. old. See that each baby is dry. Then wrap in blanket.
Put boric solution on sterile cotton ball and carry with baby to mother. First cleanse mother's nipple with cotton and boric , then put baby to breast.
Babies should be nursed 10-20 minutes.
Impressmmothers to keep baby awake.

9:50

Nursery is cleaned by janitresses after nurse has taken care of shelves and bathtable.

10:00

Bring babies back to nursery
Change and offer SMA. Most babies take $\frac{1}{2}$ to $2\frac{1}{2}$ oz.
They should have taken all the feeding necessary in 15 - 20 minutes. Bottles are propped so watch them. Carefully.
If mother has adequate breast milk - do not give SMA.

ROUTINE ORDERS:

I. Care of Babies
   A. Immediately after birth
      1. Put 1 drop of 1% Silver nitrate ($AgNO_3$)

ROUTINE ORDERS:

I. Care of Babies

A. Immediately after birth.

1. Put 1 drop of 1% Silver nitrate (AgNo3) (wax ampule) in each eye. Turn baby's head so that solution runs away from the other eye.
2. Weigh baby without clothes. First balance scale with 2 diapers on it. Lay one diaper on scale and cover baby with the other.
3. Clean the baby
   Head. Warm water may be used first to remove dried blood. Then use oil on cotton to remove vernix from hair.
   Body. Oil well to remove vernix from entire body.
4. Cord....See that cord is not bleeding. Then put alcohol on a sterile foat and wrap around cord.
5. Dress. Pin band in place high enough in back to prevent soiling by bowel movements. Place pins in front on either side of cord. Never in back. Pin diaper in place and put shirt on. Be sure all safety pins are fastened securely.
6. Put marker on baby's wrist. Be sure name is correctly spilled.
7. Place on left side in bassinet, the foot of which is elevated.
8. Cover wrmly with diapers of blanket. If necessay place well protected hot water bottle at feet.
9. Watch carefully for signs of choking, blueness of bleeding from cord.
10. Chart. Eye care, wt. meconim stool, if any - urine, cord, general condition.

11 Preparation of Formulg

10:15 Fill large pitcher with water and boil 20 minutes on kitchen stove.
In nursery - Place 32 level measures of SMA into small graduated pitcher. Add filtered boiled water - just enough to dissolve SmA - about ½ pint. Pour boiled water though cotton in funnel into pitcher containing powdered SMA. Mix well - Pour into previously sterilized quart bottly. Fill Bottle with filtered water to make 1 quart. Leave in nursery until it has cooled to room temperature.

111 Care of Bottles -- Nipples and othe Utensils
Wash all utensils used in makin SM A; bottles. nipples, breast shields, thoroughly in warm water and soap. Rinse twice. Drain. Boil 15 minutes. (Use stove in kitchen). Replaced on shelves where taken from. Do not boil breast pump, as it will lose it's suction.

1V Routine for day

A. Warm water may be given to any baby who is hungry

between feedings. Do not give less than 1 hour previous to the feeding time..

After 9 A.M. - 12 P.M. - 3 Pm. - 6 P.M.
9 P.M. - 12 A.M. - 3 AM. - 6 A. M.

B. After baby has had a stool - cleanse buttocks with soap and water or oil very well.
If buttocks become irritated, dust frequently with cornstarch.

C. Take babies to breast at 20 minutes. before scheduled feeding time..
As.....9:40 - 12:40 - 3:40 - 6:40 ect.

D/ Babies are shown during visiting hours, and at no other time, except on special occasions, as to new fathers or visitors touring the hospital.

FEEDING THE NEWBORN

After baby is 3-6 hrs. old, boiled water may be given. This will frequently be regurgitated with a lot of mucus at first.
When baby is 8-10 hrs. old, SMA diluted with $\frac{1}{2}$ water is given. Select the nearest feeding on the schedule.
If mucus is not bothering baby, give full strenght SMA 10- 16 hours after birth.
Example:

Born - 2 a.m.
H_2O - 7 a.m.
$\frac{1}{2}$ st. SMA - 10 a.m.
Full st. SMA - 1 p.m.

ROUTINE FOR DISMISSING O.B. PATIENTS

Take patient into Nursery on day before dismissal and give instruction in bathing and handling of newborn baby.

If baby's cord is still on at time of dismissal from hospital:

1. Show mother how to dress cord and how to apply band.
2. Send two packages of sterile 4x4 flats home with patient. Be sure patient has alcohol or suitable antiseptic at home for care of cord until it drops off.

If baby has been circumcised:

1. Show mother how to apply sterile vaseline to circumcision.
2. Send home with mother one can of sterile vaseline and two packages of 4x4 flats.

Advise mother of the way in which baby has been fed in the hospital. If the baby needs SMA, tell her how to go about getting it at her own mess hall.
Also explain the care of all formula utensils and feeding equipment.
Fill out Referral slip and Clinic appointment slip, making the appointment 6 weeks from the day of delivery. Send these to the nusing office.

Clean and remake bed. It is not necessary to brush mattress with germicide solution if there is a mattress cover on bed. Change this cover each time a patient is discharged.
Be sure there is a rubber sheet on bed. Do not remove any rubber sheets without permission from Head Nurse.

Wash baby's crib with soap and water and rinse well. Put clean case on mattress and clean lining around head of bassinet.

CARE OF PREMATURE INFANTS

Indication of prematurity: Birth weight less than 2500 grams (5.5 pounds) and a lenght under 45 centimeters (17.7").

Temperature: 80 - 85 degrees F. Relative humidity of 60-85. Incubator.

Carbogen inhalation: As often as required for cyanosis.

Feeding: Caloric requirements of 110-130 calories per kilograms. Feed with Breck feeder if necessary. Pump breast milk, or may use diluted SMA. Gavage if necessary.

First 24 hours - no feeding. Second 24 hours - one-third to two-thirds ounces breast milk per pound per day (20-40 cc per kilogram). Increase 8-15 cc per kilogram per day, until the 20th day when two to two and a half ounces per pound are fed every three hours.

Isolation precautions: Wear cap and mask, also gown. Scrub hands with soap and water before touching the baby.

Medications: Cevitamic acid 25 miligrams daily. May be given in water.

Ferric ammonium citrate - ¼ grain (.016 gram) per day dissolved in syrup or orange juice.

Cod liver oil - concentrate 1 to 2 drops daily.

Vitamin K in jaundic. One ampule intra- muscular.

RULES ON CHARTING

For examples — refer to Sample Chart.

1. Each nurse aide is responsible for writing the patient's name and identification number on the sheets that are put new into a chart. Night aides should chedk charts to be sure there is enough space for day's charting.

2. On first page of the Nurse's Record, be sure to write on the first line the date and time of admittance.

3. On the day the patient enters the hospital, cart as admission day. The following day is 1st Medical day, etc.

4. On the midnight line, write in red ink the day-month-year, and either if it is 1st P.P. or 1st P.O. or 1st Hospital Day, etc.

5. Temperature must be taken at 6 a.m.; elevated, at 10 a.m. All temperatures at 2 p.m.; and elevated, at 6 p.m. and 10 p.m. - unless other wise ordered every four hours.

6. When a nurse gives a hypodermic, initial sme in small signature.

7. When a nurse or nurse aide takes 2 p.m. temperatures, ask patient if she has had a bowel movement. This is to be charted on graphic and bedside record.

8. On outside sheet use first name first as: Mrs. Helen Brown.

9. Measure intake and output for three days on all P.O. cases.

10. In regard to "newborn" records use only 1 line daily. Night nurse uses $\frac{1}{2}$ of the line and charts in red ink and day nurses use blue ink and chart in lower half of line, If baby's condition is not normal, use a bedside Note and Chart, same as any other patient.

11. After patient is dismissed and chart completed, leave chart in Chartback, marked "Discharged Charts".

12. For order of the chart refer to sample chart.

13. If the doctor does not write up the delivery, the nurse in charge is to write it up.

14. Nurses to keep up daily summary on patients; Nursery nurse is to chart for the baby's (wt. tiny feedings, stools etc.)

PREPARING THE PATIENT FOR DILIVERY

"Prep" tray is to be found in Sterilizing Room (upper cupboard* next to window on the bottom shelf).

Take to patient's room -- Fill empty basin with warm H_2O and add greensoap. Place newspaper under patient -- have piece of toilet tissue handy to clean razor.

Soap pubic hair well. Start shaving from top, removing long hair with toilet paper as often as necessary. Continue shaving until all hair is removed. Use soap as needed and change blade if necessary to get close shave. Rinse skin with water and dry well. Use unsterile gauze flats to hold patient's skin tight while shaving. Do not neglect to shave around anus.

ROUTINE ORDERS ON ALL NORMAL OB CASES

ANTEPARTUM INSTRUCTIONS:

1. Give vitamin K 2 mg at the beginning of laabor (immediately upon entry to hospital) every four hours for four doses unless patient delivers before that.

POSTPARTUM INSTRUCTIONS:

1. Liquid diet for first 24 hours; soft diet for second day; regular diet from third day on.
2. Postpartum pains - Aspirin, grains 10, P.R. N., unless other orders are given.
3. Ergonovine - gr. 1/320 (mouth) Q.I.D. for first 24 hours; T.I.D. for next three days.
4. Dram 1 aromatic fluid extract cascara to ½ o z. mineral oil.
5. Lysol - external perineal care.
6. Routine blood count - red count and hemoglobin. (Second postpartum day).
7. Abdominal binders.

WRA HOSPITAL
AMACHE, COLORADO

OBSTETRICAL TERMS

1. Amnion: The innermost fetal membrane, forming the bag of water; the sac that encloses the fetus and forms a sheath for the umbilical cord.

2. Cervix: The neck of the uterus, the part which dilates during first stage of labor.

3. Embryo: Fetus in early stages of development expecially before end of 3rd month.

4. Fetus: The unborn child after end of 3rd month.

5. Fundus: The top part of the uterus.

6. Labia majora; The hairy fold of skin on either outer side of the slit of the vulva.

7. Labia minora: Fold of mucus membrane within labia majora.

8. Liquor amnii: Amniotic fluid; fluid surrounding embryo in the uterus. The fluid which escapes when the amniotic membrane (amnion) ruptures.

9. Meconium: The first intestinal discharge of new born.

10. Obstetrics: The science of the care of women pregnancy, childbirth and the puerperium.

11. Perineum: Space between anus and genitalita.

12. Placenta: The round, flat organ within the uterus which establishes communication between the mother and child by means of the umbilical cord.

13. Umbilical Cord: The navel string.

14. Vernix Caseosa: A sebaceous deposit covering the skin of fetus.

15. Vulva: The external female genitalia.

16. Breech: Buttocks

17. Colostrum: The first milk secreted by breasts.

18. Fontanel: The membraneous space at the junction of the cranial bones (the soft spot.)

19. Purulent: Containing pus.

20. Cephalic: Pertaining to the head.

21. Circumcision: Removal of all or part of the prepuce or foreskin.

22. Contraction: A shortening as of a muscle in the normal responses to a nervous stimulus.

23. Delivery: Expulsion or extraction of the child at birth.

24. Dilation: The condition of being stretched beyond normal dimensions.

25. Engorgement: Local congestion; excessive fullness of an organ or passage.

26. Episiotomy: Surgical incision of the vulvar orifice.

27. Labor: Child birth.

28. Lactation: The secretion of milk.

29. Lochio: The vaginal discharge after delivery.
    a. Rubra: 1st bight red, mostly blood
    b. Serusa: Brownish
    c. Alba: Last stage, pale, white

30. Mastitis: Inflammation of breast.

31. Post-partum: Occurring after delivery.

32. Ante-partum: Occurring before delivery.

33. Puerperium: The period from delivery to return of uterus to normal.

34. Stillbirth: The birth of a dead fetus.

35. Caput Succedanum: A swelling formed on the presenting part during labor.

November 24, 1943

ROUTINE ORDERS FOR TUBERCULAR PATIENTS

1. Routine Wassermann; Sedimentation Rate; CBC; Sputum; and Urinalysis on entry.

2. CBC; Sedimentation Rate; Urinalysis - repeat every three months or oftener if ordered.

3. Repeat sputum examination every one month (or oftener if ordered). If sputum is negative, collect three to seven days sputum spicimen for concentration test for Acid Fast.

4. Routine P. A. of Chest every three months and followed by a Physica l Examination.

5. Please take temperature three times a day at:

   8:00 A.M. 3:00 to 4;00 P.M. 8:00 P.M.

November 24, 1943

CLASSIFICATION SCHEDULE OF PATIENTS
(A Manual of Pulmonary Tuberculosis)
-Lindberg-

I INFIRMARY

Tray service
Full time rest
Bed making and baths with patient recumbant
Bedside shampoo when prescribed only
Occupational therapy 6 to 15 minutes

For those showing exudative extension of disease of fulminating type with temperature elevation and severe tuberculo-toxemia.

II INFIRMARY A

Tray service
Full time rest - wheel chair - toilet privilege (stool)
Bed baths - shampoo monthly
Occupational therapy 15 to 45 minutes

Used for reclassification of patients from a higher classification when necessary because of acute manifestations of tbc or intercurrent disease. For those with exudative lesion of progressive type with or without cavitations. Slowly progressive lesion of any type. Temperature elevation to 100^0 or more (except for sporadic temperature elevation.)

III SEMI-INFIRMARY B

Tray service
Full time rest. Bathroom privilege
Shampoo not oftener than once monthly
Occupational therapy 45 min. to 1½ hour.

For those with minimal or moderately advanced lesion with or without cavitations though otherwise non exudative - and advanced cases whose lesions show retrogression on serial film.

IV SEMI-INFIRMARY A

Meals in room - Bathrobe
Rest hours 8:20 to 11:30 A. M.
1:00 to 4:30 P. M.
6:00 to 8:30 P. M.
Occupational therapy 2 hours

Asymptomatic. Sputum negative for tbc bacilli. Cavities if any spontaneously or mechanically closed and with lesions showing x-ray evidence of only small residual parenchymal lesion with fibrotic element predominating.

V SEMI-AMBULANT

Dress for meals
Morning and afternoon rest periods
9 to 11 A. M. 1 to 3 P. M.
May have pass once a week during afternoon visiting hours
Occupational therapy 3 hours

1. All symptoms should be absent
2. Sputum negative for the bacillis by 3 to 7 day concentration technique.
3. X-ray comparable with those of healed lesions.

This classification usually of a month's duration and is used as a step to pull ambulant regime which continues for the succeeding two months period.

VI AMBULANT

Dress for meals
Rest hours 1 to 3 P. M.
May have visiting hour passes
Permission to go home for the day not more often than once in 2 weeks. May be given by the Medical Director.
Additional special absences may be granted not more often than once monthly provided that such total time does not exceed six hours.
Occupational therapy 4 hours.

For two months

VII PREDISCHARGE

Dress for meals
Observation exercise try out with no rest period
Permission to go home for the day not more often than once a week
Special absences not to exceed 10 hours monthly
Occupational therapy 5 hours

This is an exercise tryout period preliminary to return to an existence on outside. The walking exercise is gradually increased to an hour a day and at a rate more active than a casual stroll and more nearly that of the rout step of the Army. This is followed by a 20 minutes rest and temperature and pulse should return to normal within this period. One of the supervision requirements for this group is to prevent their unprescribed rest and to otherwise regulate and supervise carefully the exercise regime. Or, patients may feel that they could carry out this exercise regime in their own home while reassuming household or other duties. Our own statistic show that when patient left Sanitarium against medical advice during this period 35% were reactivated within 5 years whereas in this group remaining for full completion of treatment 89% showed indurance of their rest.

The qualification for discharge should be strictly adhered to ithout regard for unrelated circumstances.

VIII OBSERVATION STATUS

Full time rest with toilet privilege for 15 days
Observation exercise-try out remainder of 30 days period (with no rest periods unless otherwise prescrived)
Permission to go home may be granted after the first 15 days on the same basis as predischarge group.

FOLLOW-UP FOR DISCHARGED PATIENTS

1. Leucocytic monocytic ration and sedimentation rate every 3 months for first year.

2. Chest x-ray every 6 months for 3 years and each year thereafter and whenever deemed necessary.

OCCUPATIONAL THERAPY DEFINED

"Occupational therapy is any occupation of mind or body prescribed as an adjunct to treatment without any vocational training, ambition or purposes."

November 29, 1943

ADMISSION OF PATIENTS

1. T. B. patients are weighed on admission.
2. Sign Consent Sheet on chart and complete History Sheet, and remainder of chart.
3. Specimen to laboratory:
   (a) Sputum in A.M.
   (b) Urinalysis on admission
4. Diet
5. Name in Census Book on admission and discharge.
6. Fill out name plate card and place in same on foot of bed.
7. Check Doctor's orders, make out medication card, record medication ordered on Nurses notes, also treatments.
8. Enter name on temperature list.

SPINAL PUNCTURE TRAY

1. Sterile Towels (3)
2. Spinal Needle
3. 2 c.c. syringe -- skin (Hypo) needle.
4. Novocain
5. Spinal manometer.
6. 3 sterile test tubes
7. Merthiolate (
8. Alcohol (- For skin
9. Applicators (
10. Sterile Gloves

THORANCENTESIS

1. Put patient on table with affected side down.
2. Paint with merthiolate.
3. Put on Pneumo sheet and fasten with towel clips.
4. Novocain 1% in 2 c.c. syringe, rubber tubing.
5. Trocar, 3 way stop-cock, 30 c.c. syringe, rubber tubing.
6. Newspaper on floor, basin, also measuring graduate.
7. N.S. Sol. and I. V. set for irrigating.
8. Sterile Gloves -- size $7\frac{1}{2}$ for Dr. Yamada.
   Gown (
   Mask (- Not Sterile

November 29, 1943

PNEUMOTHORAX

1. Gloves - Sterile
   Gown) - Not Sterile
   Mask)
2. Patient on table with affected side up.
3. Paint with merthiolate
4. Put on pneumo sheet
5. Novocain 1% in 2-cc syringe
6. Trocar or large needle, adapter with rubber and glass tubing, attach to pneumo machine
7. After Refill, paint site with merthiolate, colladian Band aid dressing.

EXTRA CLEANING

1. Soak and clean bedpans and urinals weekly.
2. Side Tables weekly.
3. Thermometer tray daily.

Night Nurse Aid or Orderly -- 12 - 8 a.m.

1. Wash both desks every a.m. before going off duty.
2. Collect specimens (if any) before 8 a. m.

THERMOMETER TECHNIQUE

1. Wash thermometer in soap solution.
2. Wash thermometer in cool water.
3. Soak in alcohol 15 minutes. (Save alcohol)
4. Then wash in cool water and shake down, place in clean glass.
5. Thermometers are placed in glass of Bichloride Solution after being used.
6. Wash and boil emesis basins and used glasses.
7. Place clean thermometer and glasses on tray.

1/14/44

ISOLATION TECHNIQUE

D O N O T T O U C H O W N F A C E

WHILE IN PATIENT'S RÐOM

Cover hair completely with cap while on floor.

Wear isolation gown always when caring for patient.

Scrub hands - running water and s oap:

Before removing gown
After removing gown
After handling anything contaminated

Wear mask while in patient's room.

Hang gown with contaminated side out - on or near door.

Keep Nurses' Station, diet kitchen, linen closet, and Utility rooms clean (not contaminated).

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November 24, 1943

ROUTINE ---- ISOLATION

8:00 AM - Clean drinking glasses and fill with fresh water.
Janitor - Pass out clean sputum cups and sacks.
Janitor - Collect used sputum cups and sacks and send with garbage from diet kitchen to be burned.

8:30 AM - A. M. Care
Baths
Make Beds
Back rubs

10:00 AM - Nourishment

11:30 AM - Trays

12:00 N - Medications

1:00 to 3:00 PM - Rest Hour - Patients to sleep
No talking or reading.

3:00 PM - T. P. R. and Charting Nourishment
Wash - H_2O

4:00 PM - Medications
Pour 6 p.m. and 8 p.m. Medications for Nurse Aide or Orderly

4:45 PM - Trays

8:00 PM - Nourishment
P. M. Cares with Back rubs
Medications, Charting.

9:00 PM - Lights Out

LINEN AND BATH SCHEDULE

Linen will be given according to the following schedule:

Pediatric Patients.....Tuesdays
Thursdays
Sundays

Private Room Patients, exclusive of Tuberculous Patients.....Tuesdays
Thursdays
Sundays

Tuberculous Patients.....Mondays
Fridays

Mens and Womens Medical & Surgical Ward:
Bedfast patients.....Mondays
Fridays
Ambulatory patients.....Wednesdays only

A set of Linen will include:
1 sheet
1 pillow
1 hand towel
1 bath towel
1 wash cloth

Please use the upper sheet for a draw sheet and the clean sheet over the patient.

When coming on duty at 8 AM make rounds to your patients and make an inventory of your linen needs. Take the slip to the nurse in-charge and get the entire amount needed at one time. It will save many steps for everyone. If necessary to obtain more linen later, contact the nurse in-charge and explain the situation to her.

When possible, please give the patient a bath on the day the linen is changed.

2/11/43

November 24, 1943

REQUIREMENTS FOR DISCHARGE

DEFINITE ARREST

1. Constitutional Symptoms absent 6 Months:

2. Sputum Negative for TBC Bacilli by Concentration and Culture Methods:

3. X-Ray films reveal No Infiltration except such density as suggest Fibrosis or Calcifications:

4. Rales may be present or absent:

5. Exercise tryouts without change in reaction for 3 Months prior to Discharge:

6. Lymphocytic — Monocytic ratio and sedimentation curves without abrupt adverse changes: