3. Report missing resident immediately.

D. Hallucinations/Delusions – may be caused by acute illness or psychiatric diagnosis/condition.

1. Ignore harmless hallucinations or delusions. A new onset of hallucinations should be reported to M.D. to make sure there is not a medical cause (illness).

2. Provide reassurance.

3. Do not argue.

4. Stay calm.

5. Validate feelings then redirect to activities or to another discussion.

6. Notify nurse of hallucination(s)/delusion(s).

E. Sundowning – as this occurs in the evening, consider need for increased activities and/or staffing in the evening.

1. Remove trigger(s).

2. Avoid stress in environment.

3. Keep environment calm and quiet.

4. Reduce/remove caffeine from evening fluids/diet, if possible.

5. Validate feelings then Redirect; offer activity or favorite food.

F. Catastrophic Reaction – may be caused by fatigue or over stimulation.

1. Remove trigger(s), if possible.

2. Offer food or quiet activity.

3. Validate feelings then Redirect.

4. May be the result of abuse or neglect and it is reportable according to law and regulations.

G. Repetitive Phrasing – may be caused by habit, sense of insecurity or cognitive impairment. May be caused by the person trying to express a specific concern, ask for help, or cope with frustration (self–soothing), anxiety and insecurity or a habit.

1. Be patient and calm.

2. Look for reason behind repetitive phrase/question.

3. Answer question.

4. Do not try to silence or stop.

5. Validate feelings then Redirect.

H. Violence – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort, etc.

1. Step out of reach.

2. Block blows with open hand or forearm.

3. Do not strike back or grab resident.

4. Call for help.

5. Stay calm.

6. Identify triggers and remove, if possible.

7. Give the resident space.

8. Do not take resident's actions personal.

I. Disruptive actions – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort etc.

1. Remain calm.

2. Avoid treating like a child.

3. Gently direct to a private area, provide distraction or activity.

4. Explain procedure(s) or change in normal pattern.

5. Be reassuring.

J. Challenging Social Acts – may be caused by delusion, hallucination, acute illness, cognitive impairment, provocation by another resident, physical discomfort etc.

1. Remain calm.

2. Identify trigger, if possible.

3. Gently redirect to private area.

4. Report physical or verbal abuse to the nurse.

K. Challenging Sexual Acts – may be provoked by a thought, visual, etc.

1. Do not over–react.

2. Be sensitive.

3. Try to redirect or relocate to a private area.

4. Ensure the safety of other residents, if potentially involved.

5. Report to nurse.

L. Pillaging/Hoarding – note that either activity is not stealing, rather, a behavior often associated with a psychiatric diagnosis.

1. Label personal belongings of all residents.

2. Regularly check rooms for items which might belong to others.

3. Provide direction to resident's own room (a visual cue could be helpful).

4. Mark other residents' room with symbols or labels to avoid residents from entering.

III. Methods/Therapies to Reduce Behaviors

A. Validation Therapy – allowing the resident to express feelings and emotions. Caregiver not only listens but acknowledges and respects the resident's thoughts/concerns.

B. Reminiscence Therapy – encouraging the resident to remember; to talk about the past. Can be accomplished through communication, pictures, music, smells, etc.

C. Activity Therapy – using activities that the resident enjoys to prevent boredom and frustration.

D. Music Therapy – form of sensory stimulation; hearing familiar songs can cause a response in residents that do not respond to other therapies.

E. Re–direction – gently and calmly encouraging the resident to do a different action; change focus of attention.

IV. Tips to Remember when Dealing with Cognitively Impaired Residents

A. Not personal – residents do not have control over words or actions.

B. Talk with family – learn about the resident's life, names of family members, occupation, hobbies, pets, foods, favorites.

C. Team work – report changes or observations; be flexible and patient.

D. Handle behaviors/situations as they occur – remember that the resident has lost the ability to remember prior directions given.

E. Know your limits – watch for signs of stress, frustration and burnout.

V. Communication Strategies

A. Always identify yourself.

B. Speak slowly, calmly in a low tone.

C. Avoid loud, noisy environments.

D. Avoid startling or scaring; approach from the front, remain visible to the resident.

E. Allow the resident to determine how close you should be.

F. Listen to resident; Validate feelings.

G. Avoid arguing.

H. Give visual clues.

I. Ensure your body language and facial expressions are appropriate.

VI. Techniques to Handle Difficult Behaviors

A. Anxiety/Fear

1. Stay calm, speak slowly.

2. Reduce noise or distractions.

3. Explain what you are doing.

4. Use simple words and short sentences.

5. Watch your body language and ensure it is not threatening.

B. Forgetful/ Memory Loss

1. Repeat, using same words.

2. Give short simple instructions.

3. Answer questions with brief answers.

4. Watch tone, facial expressions and body language.

C. Unable to express needs

1. Ask to point or gesture.

2. Use pictures or written words.

3. Offer comfort if resident is becoming frustrated.

D. Unsafe or abusive language or activities

1. Avoid saying "don't" or "no".

2. Validate feeling then Redirect to another activity or discussion.

3. Remove hazard, if possible.

4. Don't take the residents actions/words personally.

E. Depressed, lonely or crying.

1. Take time with resident; do not rush.

2. Really listen and provide comfort.

3. Try to involve in activities to redirect resident focus.

4. If continues or repeats, report to nurse.

VII. Behavior Interventions

A. Bathing

1. Schedule at time that resident is agreeable.

2. Be organized.

3. Explain what you are going to do in simple steps.

4. Allow resident to assist as much as possible.

5. Take your time.

6. Provide privacy.

7. Make sure resident is not afraid of tub/shower.

8. Have resident assist, as able.

9. Maintain safety; do not leave alone.

10. Do not argue with resident; if upset, try again at another time.

B. Dressing

1. Encourage to choose what to wear.

2. Do not rush.

3. Provide privacy.

4. Use simple steps; short step–by–step directions.

5. Allow resident to assist.

6. Take time and be calm.

C. Toileting

1. Encourage fluids – lack of fluids can cause dehydration and constipation.

2. Establish a toileting schedule; for example, take to bathroom every 2 hours.

3. Toilet before and after meals.

4. If incontinent – watch for patterns to determine resident routine for a 2–3-day period (this is also effective for night time incontinence).

5. Identify bathroom with sign or picture.

6. Avoid dark or unlit bathrooms or hallways.

7. Check briefs frequently; change when soiled and observe skin.

8. Document/track bowel movements (constipation may cause increase in behaviors).

9. Document and report any changes in bowel/bladder patterns as it could be a sign of infection/illness.

D. Eating/Meals

Helping with Nutrition:

Many people with Alzheimer's have challenges with eating. An individual might lose his/her appetite or the ability to evaluate if food is too hot or cold. In addition, an individual might forget that he/she has eaten and ask you for another meal.

The individual may be experiencing physical difficulties that are causing the changes in eating habits. Sores in the mouth, poor–fitting dentures, gum disease or dry mouth may make eating difficult. Individuals will lose the ability to recognize and use utensils appropriately.

To ensure the individual with dementia is receiving the proper nutrition, you must work to prevent eating and nutrition problems. Consult with the individual's physician and/or dietician for guidance.

1. Schedule meals at regular times.

2. Provide adequate lighting and space.

3. Avoid delays – have meal ready, i.e., pre–cut, opened cartons or packages.

4. Watch temperatures – avoid very hot foods.

5. Simple (white) dishes, no extra items which could confuse resident.

6. Avoid overwhelming with too many different foods.

7. Give simple instructions.

8. If the resident needs to be fed, use slow, calm, relaxed approach.

9. Watch for chewing, swallowing or pocketing issues and report to nurse. (Pocketing refers to holding food in the mouth, especially in the cheeks.)

10. Ensure adequate fluid intake during meal.

E. Recreational Activities: Recreational activities are an important part of a healthy life with dementia. The benefits include:

1. Improves eating and sleeping patterns.

2. Lessens wandering, restlessness, anxiety.

3. Reduces complications with sun downing.

4. Improved socialization and cooperation.

5. Delays deterioration of skills.

6. Eases behavior management.

7. Source of pleasure and rewards.

*** It is important to find activities that are meaningful and provide success. Meaningful activities create a sense of usefulness and accomplishment and promote self–esteem. To promote this, match activities to the abilities and interests of the individual. Focus on enjoyment, not achievement. Be sure to observe the individual's behavior during the activity to watch for signs of boredom or tiring. Keep activities adult–like but you may have to use children's materials. Do a variety of activities to hold their interest. Alternate active and passive activities.**

1. Card games or board games

2. Reminiscing and memory stimulation

3. Music

4. Crafts and art projects

5. Outings

6. Gardening

7. Pets

8. Visits from others

9. Spiritual activities

VIII. Activity Chart

A. Waking Hours (low key)

1. Personal cares

2. Reading paper

3. Discussing day ahead

4. Having a cup of coffee

5. Engaging in conversation

B. Early Morning (quiet)

1. Clipping coupons

2. Folding laundry

3. Winding yarn balls

4. Craft projects

C. Late Morning

1. Group exercises

2. Board Games

3. Meal prep– set table, pour milk

4. Outside Walks

5. Individual projects

D. Lunchtime/early afternoon

1. Eating and sharing

2. Resting/napping

3. Helping with serving and clean up

E. Midafternoon (active)

1. Physical game skills

2. Exercising/walking

3. Music: singing along, dancing, exercising

4. Crafts

5. Memory stimulation games

6. Cleaning house

F. Late afternoon (quiet)

1. Reminiscing

2. Helping with meal prep

3. Checkers

4. Watering plants

G. Dinnertime

1. Meal prep, serve, clean up

2. Eating and sharing

H. Early evening (quiet)

1. Soothing music

2. Walking through neighborhood

3. Reminiscing

4. Evening cares– washing and dressing for bed

I. Other examples of useful activities

1. Polishing silverware

2. Sorting buttons

3. Putting coins into rolls

4. Shelling nuts

5. Folding and stuffing envelopes, stapling, applying labels

6. Dusting furniture, sweeping floor

7. Organizing closet/drawers

8. Washing and drying dishes

IX. Safety Checklist

A. Kitchen precautions. Proper storage of:

1. Knives, utensils, gadgets; toaster, grill, etc.

2. Remove controls for stove, cover burners

3. Locks on fridge and cupboards

4. Cover for garbage disposal

B. Bathroom precautions. Proper storage of:

1. Shavers, blow dryers, cosmetics, medicines, etc.

2. Non–skid mats in tub/shower and on floor

3. Safety rails

4. Use shower chair

5. Monitor water temperature

C. Fall precautions:

1. Remove scatter rugs

2. Keep pathways clear of clutter

3. Adequate lighting, non–glare

4. Don't move furniture around

5. Safety rails in halls, bathrooms, and stairways

6. Gates or locks to keep person out of unsafe areas

D. Visual aids:

1. Nightlights placed throughout home.

2. Cover doorknobs with cloth same color as the door; use childproof knobs (personal home only).

3. Camouflage doors by painting them same color as the walls (personal home only).

4. Use black tape or paint to create a two–foot black threshold in front of the door (personal home only).

5. Place STOP sign on door to prevent entrance into restricted area.

E. General:

1. Post emergency numbers by phone (numbers should be 1–5).

2. Lock doors and windows.

3. Cover outlets.

4. Working smoke detectors.

5. Hot water heater secured.

F. General. Proper storage of:

1. Chemicals: cleansers, pesticides, paint

2. Medications– childproof caps

3. Sharps: scissors, glass, knives

4. First aid supplies

5. Yard tools

X. Sleep Changes

A. Common sleep changes

Many people with Alzheimer's experience changes in their sleep patterns. Scientists do not completely understand why this happens. As with changes in memory and behavior, sleep changes somehow result from the impact of Alzheimer's on the brain. Many older adults without dementia also notice changes in their sleep, but these disturbances occur more frequently and tend to be more severe in Alzheimer's. There is evidence that sleep changes are more common in later stages of the disease, but some studies have also found them in early stages.

Sleep changes in Alzheimer's may include:

1. Difficulty sleeping. Many people with Alzheimer's wake up more often and stay awake longer during the night. Brain wave studies show decreases in both dreaming and non–dreaming sleep stages. Those who cannot sleep may wander, be unable to lie still, or yell or call out, disrupting the sleep of their caregivers.

2. Daytime napping and other shifts in the sleep–wake cycle. Individuals may feel very drowsy during the day and then be unable to sleep at night. They may become restless or agitated in the late afternoon or early evening, an experience often called "sun–

downing." Experts estimate that in late stages of Alzheimer's, individuals spend about 40 percent of their time in bed at night awake and a significant part of their daytime sleeping. In extreme cases, people may have a complete reversal of the usual daytime wakefulness–nighttime sleep pattern.

B. Contributing medical factors

A person experiencing sleep disturbances should have a thorough medical exam to identify any treatable illnesses that may be contributing to the problem. Examples of conditions that can make sleep problems worse include:

1. Depression

2. Restless legs syndrome, a disorder in which unpleasant "crawling" or "tingling" sensations in the legs cause an overwhelming urge to move them.

3. Sleep apnea, an abnormal breathing pattern in which people briefly stop breathing many times a night, resulting in poor sleep quality.

* For sleep changes due primarily to Alzheimer's disease, there are non–drug and drug approaches to treatment. Most experts and the National Institutes of Health (NIH) strongly encourage use of non–drug measures rather than medication.

* Studies have found that sleep medications generally do not improve overall sleep quality for older adults. Use of sleep medications is associated with a greater chance of falls and other risks that may outweigh the benefits of treatment.

C. Non–drug treatments for sleep changes

Non–drug treatments aim to improve sleep routine and the sleeping environment and reduce daytime napping. Non–drug coping strategies should always be tried before medications, since some sleep medications can cause serious side effects. To create an inviting sleeping environment and promote rest for a person with Alzheimer's:

1. Maintain regular times for meals and for going to bed and getting up.

2. Seek morning sunlight exposure.

3. Encourage regular daily exercise, but no later than four hours before bedtime.

4. Avoid caffeine and nicotine.

5. Treat any pain. Be alert to verbal and non–verbal cues for pain.

6. Make sure the bedroom temperature is comfortable.

7. Provide nightlights and security objects.

8. If the person awakens, discourage staying in bed while awake; use the bed only for sleep.

9. Discourage watching television during periods of wakefulness.

10. 12 Tips to promote Regular Sleep Patterns

    a. Try keeping bedtime rituals consistent.

    b. Go to bed at similar times each night.

    c. Close blinds to demonstrate differences in light levels.

    d. Keep lighting dim. Use night lights if there is a safety problem or the dark promotes anxiety.

    e. Relaxing in a bathtub or having a warm shower can promote sleep.

    f. A peaceful evening with less stimulation may encourage sleep. Play any music softly, choose relaxing music, T.V. programs.

    g. A snack before bed may help. Hunger can wake and make a person restless.

    h. Restrict caffeine and excess intake of fluids before bedtime.

    i. Use the bathroom before going to bed.

    j. Restlessness during the night may be due to hunger, the need to go to the bathroom, heat or cold, discomfort.

    k. Discourage naps in the day. If a nap is important try to limit the time.

    l. Encourage exercise and stimulating activities in the day.

Review Questions --- Lesson #25

1. Believing something that is not true, for example, that you are the President, is considered a hallucination or a delusion?

2. Should a cognitively impaired resident leave the facility unattended and that resident's whereabouts is unknown to staff, it is called _____.

3. Allowing the resident to believe what he or she believes to be true, without correcting or trying to bring the resident back to current reality is called _____.

4. Behavioral change that occurs in the evening which may result in challenging behavior that improves or disappears during the day is called _____.

Lesson #26 (1 hour, 15 minutes)

Title: Mental Health, Depression and Social Needs

Lesson Objectives:

I. The student will be able to describe interventions to use in response to challenging or problematic resident behavior.

II. The student will be able to describe the difference between mental illness and intellectual disability (mental retardation).

III. The student will be able to explain the importance of immediately reporting challenging or problematic behavior to the nurse.

Key Terms:

Anxiety – uneasiness or fear of a situation or condition.

Apathy – lack of interest.

Bipolar Disorder – a psychiatric diagnosis that describes mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes. The resident experiences extreme highs and lows.

Claustrophobia – fear of having no escape and being closed in small spaces or rooms.

Defense Mechanisms – unconscious behaviors used to release tension or cope with stress or uncomfortable, threatening situations or feelings.

Depression – a persistent feeling of sadness and loss of interest.

Intellectual Disability – a developmental disability that causes below average mental functioning.

Manic Depression – fluctuation between deep depression to extreme activity, including high energy, little sleep, big speeches, rapid mood changes, high self–esteem, overspending and/or poor judgment.

Mental Health – level of cognitive or emotional well–being or an absence of a mental disorder.

Mental Illness – disruption in a person's ability to function at a normal level in a family, home, or community, often producing inappropriate behaviors.

Obsessive Compulsive Disorder (OCD) – uncontrollable need to repeat or perform actions in a repetitive or sequential manner.

Panic Disorder – fearful, scared or terrified for no specific reason.

Paranoid Schizophrenia – a schizophrenic disorder in which the person has false beliefs that somebody (or some people) are plotting against them.

Phobias – an extreme form of anxiety/fears.

Post–Traumatic Stress Disorder (PTSD) – anxiety related to a disorder caused by a traumatic experience or event.

Psychotherapy – sessions with mental health professionals during which the resident discusses problems or issues.

Psychotropic Medication – drugs taken which affect the mental state and are used to treat mental disorders.

Schizophrenia – a complex mental disorder that makes it difficult to tell the difference between real and unreal experiences, to think logically, and to behave normally in social situations.

Content:

I. Causes of Mental Illness

- A. Physical factors – illness, disability, aging, substance abuse or chemical imbalance.
- B. Environmental factors – weak interpersonal skills, weak family support, traumatic experiences.
- C. Heredity – possible inherited traits.
- D. Stress – inability to handle or cope with stress.

II. Response to Behaviors

- A. Remain calm.
- B. Do not treat as a child.
- C. Be aware of body language and facial expression.
- D. Maintain a normal distance.
- E. Use simple, clear language.
- F. Avoid arguments.

G. Maintain eye contact.

H. Listen carefully.

I. Show respect and concern.

III. Use of Defense Mechanisms – unconscious behaviors used to release tension or cope with stress or uncomfortable, threatening situations or feelings.

A. Denial – rejection of a thought or feeling.

B. Projection – seeing feelings in others that are really one's own.

C. Displacement – transferring a strong negative feeling to something or someone else.

D. Rationalization – making excuses to justify a situation.

E. Repression – blocking painful thoughts or feelings from the mind.

F. Regression – going back to an old immature behavior.

IV. Types of Mental Illness

A. Anxiety related disorders

1. Anxiety – uneasiness or fear about a situation or condition that cannot be controlled or relieved when the cause has been removed.

2. Panic Disorders – fearful, scared or terrified for no specific reason.

3. Obsessive Compulsive Disorders – OCD – uncontrollable need to repeat or perform actions in a repetitive or sequential manner.

4. Post–traumatic Stress Disorder – PTSD – anxiety related to a traumatic experience.

5. Phobias – intense fear of certain things or situations.

6. Symptoms – sweating, dizziness, choking, dry mouth, racing heart, fatigue, shakiness, muscle aches, cold or clammy feeling, shortness of breath or difficulty breathing.

B. Depression

1. Clinical depression – depression ranges in seriousness from mild, temporary episodes of sadness to severe, persistent depression. The term "clinical depression" is used to describe the more severe

form of depression also known as "major depression" or "major depressive disorder".

a. Clinical depression symptoms may include:

i. Depressed mood most of the day, nearly every day.

ii. Loss of interest or pleasure in most activities.

iii. Significant weight loss or gain.

iv. Sleeping too much or not being able to sleep nearly every day.

v. Slowed thinking or movement that others can see.

vi. Fatigue or low energy nearly every day.

vii. Feelings of worthlessness or inappropriate guilt.

viii. Loss of concentration or indecisiveness.

ix. Recurring thoughts of death or suicide.

2. Bipolar Disorder – sometimes called manic–depressive disorder – is associated with mood swings that range from the lows of depression to the highs of mania. When the resident becomes depressed, he/she may feel sad or hopeless and lose interest or pleasure in most activities. When the resident's mood shifts in the other direction, he/she may feel euphoric and full of energy. Mood shifts may occur only a few times a year, or as often as several times a day.

3. Schizophrenia – brain disorder that affects a person's ability to think and communicate. It affects the way a person acts, thinks, and sees the world.

a. Does not mean "split personality".

b. Symptoms – delusions, hallucinations, thought disorder, disorganized behavior, loss of interest in everyday activities, appearing to lack emotion, reduced ability to plan or carry out activities, neglect of personal hygiene, social withdrawal, and loss of motivation.

V. Behaviors Associated with Mental Disorders – actions and interventions

A. Combative

1. Actions – hitting, kicking, spitting, pinching, pushing, pulling hair, and cursing.

2. Interventions – remain calm, don't take personal, step out of way, remove other residents, never strike back or respond verbally, leave resident alone to de–escalate (calm)– but only if safe, report to nurse.

B. Anger

1. Actions – shouting, yelling, threatening, throwing things, pacing, withdrawal, sulking.

2. Interventions – remain calm, do not argue, try to understand what triggered anger, empathize with resident, listen, stay at a safe distance, explain what you are doing.

C. Sexual Behaviors

1. Actions – sexual advances, comments, sexual words or gestures, removing clothing, inappropriate touching of self or others, exposing body parts or masturbation.

2. Interventions – do not overreact; be "matter–of–fact" and try to redirect; gently direct to private area, report to nurse, and maintain safety of other residents.

3. Special consideration – check for possible explanation for behavior, such as clothing not fitting, skin irritation, need for toileting, remember to report all inappropriate sexual behavior to the nurse.

VI. Treatment for Mental Illness

A. Medications – numerous medications are available. Physician orders the medication dependent on diagnosis and conditions that need to be addressed. The nursing staff is responsible for monitoring and administration of these medications.

B. Psychotherapy –sessions during which the residents discuss problems or issues with mental health professionals in order to identify and address problems and develop interventions for staff to follow when caring for the resident.

VII. Special Considerations

A. Talk of suicide or death – any verbalization of suicide, "death wish" or self–inflicted injury, **REPORT IMMEDIATELY**.

B. Changes in conditions – any changes in mood, activity, eating, extreme behaviors or reactions, more upset or excitable, withdrawn, hallucinations or delusions. Report to nurse immediately.

VIII. Mental Illness and Intellectual Disability

A. Intellectual Disability– a developmental disability that causes below–average mental functioning.

1. Intellectual Disability vs. Mental Illness:

a. Intellectual Disability is a permanent condition; mental illness can be temporary.

b. Intellectual Disability is present at birth or early childhood; mental illness can develop at any age.

c. Intellectual Disability affects mental ability; mental illness may or may not affect mental function.

d. No cure for Intellectual Disability. Some mental illnesses can be cured or controlled with treatment, such as medication or therapy.

Review Questions --- Lesson #26

1. If a resident verbalizes thoughts of suicide or an intention to cause harm to self, when should this be reported to the nurse?

2. If a resident starts kicking or hitting you, what actions should you take?

Lesson #27 (1 hour, 15 minutes)

Title: Admission/Transfer/Discharge

Lesson Objectives:

I. The student will be able to explain the role of the direct caregiver in familiarizing the newly-admitted resident to their new home.

II. The student will be able to explain the role of the direct caregiver in preparing a resident for transfer to an appointment or to the hospital.

III. The student will be able to explain the role of the direct caregiver in assisting a resident to discharge to home or to another health care facility.

Key Terms:

Admission – resident arrival to reside at the facility.

Discharge – resident departure from the facility; no longer a resident of the facility.

Personal Inventory Record – record of personal items brought to the facility and belonging to the resident.

Transfer – resident relocates to another location or to another area of the facility (e.g., Medicaid to Medicare unit).

Room Change – resident moves to another room in the same facility with the same status.

Content:

I. Admitting a New Resident to the Facility (See CARE SKILLS #77)

A. Role of the Nurse Aide

1. Prepare the room for the resident's arrival.

2. Introduce self to resident and family/responsible party and explain role.

3. Explain surroundings to resident, including the use of the call light to communicate with staff, if needed.

4. Create a trusting relationship.

5. Be available to family.

6. Become a resource and support for the family.

7. Refer family members requesting information about a resident to the nurse.

II. Assisting to Transfer a Resident to a Hospital (i.e., Care Transition)

A. Role of the Nurse Aide

1. Follow any instructions given by the nurse to prepare the resident for transfer, particularly if the transfer is for an emergent condition.

2. If resident is leaving for a non–emergent appointment, ensure that the resident has received appropriate care, assistance with grooming, toileting and is appropriately dressed for the weather conditions during transport.

3. Assist emergency medical personnel, as requested, to ensure safe transfer of the resident.

III. Assisting a Resident to Discharge Home or to Another Facility (see CARE SKILL #78)

A. Role of the Nurse Aide

1. Follow instructions given by the nurse to prepare the resident for discharge.

2. Assist to gather personal belongings, as requested, in preparation for transfer/discharge, using the personal inventory as reference to personal items on site.

CARE SKILLS:

- Admission of a Resident – #77
- Transfer/discharge of the Resident – #78

Review Questions --- Lesson #27

1. Describe ways to welcome a new resident to his/her new environment.

2. The list used to describe the resident's belongings brought to the facility is called the _____.

Lesson #28 (1 hour, 15 minutes)

Title: End of Life

Lesson Objectives:

I. The student will be able to explain the resident's right to formulate an advance directive which must be honored by staff.

II. The student will be able to describe interventions to make the dying resident as comfortable as possible.

III. The student will be able to demonstrate the steps to be taken to provide post mortem care to the deceased resident and prepare belongings for disposition.

Key Terms:

Advance Directive – the resident's spoken and/or written instruction about future medical care and treatment.

Cheyne–Stokes – a pattern of breathing with gradual increase in depth and sometimes in rate, followed by a decrease resulting in apnea (no breathing); the cycles ordinarily are 30 seconds to 2 minutes in duration, with 5–30 seconds of apnea (no breathing).

Cyanotic – bluish discoloration of the skin, mucous membranes, lips or nails due to lack of sufficient oxygen in the blood.

DNR (Do not resuscitate) – no heroic measures are to be taken should the resident's respirations cease.

Hospice – support services provided to a resident with a terminal illness who is anticipated to have six months or less to live.

Mottling – the skin, especially on the hands and feet, appear blue and blotchy; caused by slow blood circulation. The underside of the body may become darker. There may be a bluish gray color around the mouth or paleness in the face.

Content:

I. Advance Directives

A. Purpose – by stating health care choices in an advance directive, the resident helps his/her family and physician understand their wishes about the resident's medical care.

B. Advance directives are normally one or more documents that list the resident's health care instructions. An advance directive may name a

person of choice to make health care choices when the resident cannot make the choices for themselves. If desired, the resident may use an advance directive to prevent certain people from making health care decisions on their behalf.

C. An advance directive will not take away the resident's right to decide his/her current health care. As long as the resident is able to decide and express their own decisions, the resident's advance directive will not be used. This is true even under the most serious medical conditions. An advance directive will only be used when the resident is unable to communicate or when the physician decides that the resident no longer has the mental competence to make their own choices.

* Arkansas recognizes the following types of advance directives:

1. Talking directly to your physician and family.
2. Organ and tissue donation.
3. Health Care Representative.
4. Living Will Declaration or Life–Prolonging Procedures Declaration.
5. Psychiatric Advance Directive.
6. Out of Hospital Do Not Resuscitate Declaration and Order.
7. Power of Attorney.

II. Role of Hospice

A. Participation – Resident is not expected to live more than six months.

B. Licensed nurse, clergy, social service and primary caregiver services may be provided.

C. Focus is on comfort measures and pain management.

D. Preserves dignity, respect and choice.

E. Plan of care is to be coordinated between facility staff and hospice staff.

F. Offers empathy and support for the resident and the family.

III. Care of the Dying Resident

A. Place resident in most comfortable position for breathing and avoiding pain. Maintain body alignment as much as possible.

B. Bathe and groom resident as desired by the resident/family to promote self-esteem, yet do not be disruptive.

C. Keep resident's environment as normal as possible, as desired by the resident.

D. Provide skin care, including back rubs/comfort measures, frequently.

E. Provide frequent oral care as needed. Keep dry/cracked lips lubricated for comfort.

F. Offer fluids frequently.

G. Keep the resident's skin/linens clean.

H. Offer resident's favorite foods.

I. Communicate with the resident, even if he is not responsive, by identifying self and explaining everything you are doing.

J. Be guided by the resident's attitude.

K. Respect each resident's idea of death and spiritual beliefs.

L. Give the resident and the family privacy, but do not isolate them.

IV. Signs/Symptoms of Impending Death

A. Circulation – slows as heart fails; extremities become cool; pulse becomes rapid and weak.

B. Respiration – irregular, rapid and shallow or slow and heavy; Cheyne Stokes.

C. Muscle tone – jaw may sag; body becomes limp; bodily functions slow and become involuntary.

D. Senses – sensory perception declines; the resident may stare yet not respond; hearing is believed to be the last sense to be lost.

V. Post Mortem Care (See CARE SKILLS #79)

A. Respect the family's religious restrictions regarding care of the body, if applicable.

B. Provide privacy and assist a roommate to leave the area until the body is prepared and removed.

C. Place the body in the supine position with one pillow under the head to prevent facial discoloration.

D. Put in dentures. Notify nurse to remove any tubes or dressings.

E. Wash the body, as necessary, and comb hair.

F. Put on a clean gown and cover perineal area with a pad.

VI. Disposition of Personal Belongings

A. Assist the family/responsible party to gather personal belongings and compare to the personal inventory record to ensure the personal belongings of the resident are accounted for and returned to the family/responsible party.

B. Send dentures, eyeglasses and prosthetic devices with the body to the mortuary.

VII. Stages of Reaction to Dying:

A. DENIAL – denying that death will occur

1. Behaviors:

a. Unrealistically cheerful.

b. Ask lots of questions.

c. Disregard medical orders.

2. Response to this behavior:

a. Listen and be accepting.

b. Do not probe.

B. ANGER – anger that this is happening to me, and anger at others because it is not happening to them

1. Behaviors:

a. Complaining.

b. Unreasonable requests.

c. Anger at family, doctor, and nursing staff.

2. Response to this behavior:

a. Listen.

b. Remain open and calm.

c. Don't try to place blame.

C. BARGAINING – trying to make an agreement for postponing death

1. Behaviors:

a. May be difficult to observe this stage.

b. Person vacillates between doubt and hope.

2. Response to this behavior:

a. Listen.

b. Do not contradict plans.

c. Promote a sense of hope.

D. DEPRESSION – reality of death is unavoidable; is a reaction to getting sicker; and is grieving for the losses they will experience

1. Behaviors:

a. Turn face away from people.

b. Not speak or speaks in expressionless voice.

c. Separating self from the world.

2. Response to behaviors:

a. Stay with the person as much as is possible.

b. Avoid cheery phrases and behavior.

c. Encourage the person to express feelings.

E. ACCEPTANCE– realizes that death is inevitable.

CARE SKILLS:

- Post Mortem Care – #79

Review Questions --- Lesson #28

1. Blue discoloration of the skin and mucous membranes is called what?

2. Hospice services are intended to provide support to the resident who is anticipated to have six months or less to live. *(True or False)*

Lesson #29 (45 minutes)

Title: Daily Responsibilities

Lesson Objectives:

I. The student will be able to explain the importance of prioritization, organization and time management when providing daily care.

II. The student will be able to describe the importance of the interdisciplinary team and the ongoing revision of the care plan based upon the resident's changing condition/needs.

Key Terms:

Abbreviation – a shortened form of a word.

Assignment sheet – a document which lists the residents assigned to a caregiver and the specifics regarding care to be provided.

Care plan – a plan developed for each resident by the interdisciplinary team to achieve certain goals.

Care team – people with different education and experience who help care for residents. It is often called the "interdisciplinary team" or "IDT".

Chronological order – the sequence in which events occur.

Content:

I. Day-to-day Time Management/Resident Care

A. Beginning of Shift Report.

B. Use of assignment sheets/communication of resident needs.

C. Ancillary duties/assignments (e.g., cleaning, stocking supplies, etc.).

D. Documentation/Flow Records.

1. Resident's name on each page.

2. All entries in ink, neat and legible.

3. Entries are accurate and in chronological order as they occurred.

4. Never document before a procedure is completed.

5. Use facility–approved abbreviations.

6. No ditto marks or copycat documentation.

7. Time and date entries; sign with name and title, unless initials are acceptable per facility policy.

8. Never document for someone else.

9. If correcting an error, draw a single line through the error, print word "error" above entry and initial and date the correction.

10. Some facilities may use military time. In this case, for the hours between 1:00 p.m.to 11:59 p.m., add 12 to the regular time. For example, to change 2:00 p.m. to military time, add 2 + 12. The time would be 1400 hours.

11. Some facilities use computers/electronic medical records. When using, make certain information seen on the screen remains private. Do not share confidential information with anyone except other caregivers on the team.

12. Be sure you are documenting on the correct resident.

E. Reporting

1. Routine reporting.

2. Immediate reporting of resident change in condition, unusual occurrence, accident, etc. Failure to do so may be neglect under the law.

F. End of Shift Report

1. Report pertinent concerns regarding resident status.

2. Communicate any duties unable to be completed on your shift.

3. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.).

II. Interdisciplinary Care Plan Meetings

A. Revisions of the plan of care/communication to direct caregivers

1. The Care Plan Team reviews the plan at least quarterly and with any significant change in condition.

2. The care plan is reviewed and revised to reflect the current condition(s) and needs of the resident.

3. The care plan must be accessible for review by all caregivers.

4. When revisions are made to the care plan, the assignment sheet used by direct care staff should also be updated accordingly.

Review Questions – Lesson #29

1. Explain the procedure for correcting an error in documentation.

2. Describe information that should be communicated to the oncoming shift during report.

Lesson #30 (45 minutes)

Title: Protecting Your Profession

Lesson Objectives:

I. The student will be able to describe the common causes of stress/burnout in the healthcare industry.

II. The student will be able to describe abuse/neglect/misappropriation of resident property and will be able to explain his/her responsibility to respond and report any allegations of abuse/neglect/misappropriation of resident property.

III. The student will be able to explain the requirements for certification and renewal to maintain professional status.

Key Terms:

Abuse – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse can be verbal (something said–oral, written or gestured), physical (something done to the resident–rough handling, hitting, slapping, pinching, etc.), emotional/mental (humiliation, harassment, threats of punishment or deprivation) or sexual (harassment, coercion or sexual assault). Any sexual relationship with a resident is considered to be abuse.

Burnout – a condition of feeling stressed and/or overworked to the point that the care provided to residents is negatively affected.

Catastrophic Event – are extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care.

Consensual – agreed to by the people involved; done with the consent of the people involved.

Involuntary Seclusion – a separation of a resident from other residents or from their room or confinement against the resident's will, or the will of the legal representative.

Neglect – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; failure to follow a prescribed order of treatment or the care plan; Negligently failing to provide necessary treatment, rehabilitation, care, food clothing, shelter, supervision , or medical services; Negligently failing to report health problems or changes in health problems or changes in health condition of a resident to the appropriate medical personnel, and failing to carry out a prescribed treatment plan developed or implemented by the facility.

Misappropriation – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

Stress – the state of being frightened, excited, confused, in danger, or irritated, which can result in an emotional and/or physical response.

Stressor – something that causes stress (divorce, marriage, new baby, new job, losing a job, etc.).

Content:

I. Reducing Stress/Burnout

A. Manage stress

1. Develop healthy habits of diet and exercise.
2. Get sufficient rest/sleep.
3. Drink alcohol in moderation.
4. Do not smoke.
5. Find time for relaxing activities such as taking walks, reading books, etc.

B. Signs that you are not managing stress

1. Exhibiting anger toward co–workers and/or residents.
2. Arguing with a supervisor or co–workers about assignments.
3. Complaining about responsibilities.
4. Feeling tired, even when you are well-rested.
5. Difficulty focusing on residents and job duties.

C. Develop a plan to manage stress.

1. Identify the sources of stress in your life.
2. Identify when you most often feel stress.
3. Identify what effects of stress are evident in your life.
4. Identify what can be changed to decrease the stress that you are feeling.

5. Identify the things in your life that you will have to learn to cope with due to an inability to change them.

II. Abuse/Neglect/Misappropriation

A. Responsibility to immediately protect the resident should a staff member witness abuse/neglect.

1. You must stay with the resident and call for assistance.

2. Ask a caregiver to leave the room if he/she is witnessed to be abusive to the resident

B. Know the Arkansas state law and regulation regarding reporting abuse. Failure to report is against the law in Arkansas.

1. To whom should the Nurse Aide report? His/her immediate/direct supervisor

2. How should you report?

a. Verbally – to your immediate/direct supervisor.

b. In writing – if requested by your immediate/direct supervisor.

c. Form used – be familiar with the facility form to report concerns voiced by staff, family or residents.

3. When should a Nurse Aide report?

a. Immediately!

4. The Nurse Aide Must Report When He/She…

a. Receives any "allegation", witnessed event, or reason to suspect abuse, neglect or theft.

b. Observe signs that "suggest" abuse or neglect may have happened, including a change in the resident's behavior/demeanor (e.g., a resident becomes quiet, withdrawn, or flinches as if fearful when touched), or suspicious injuries such as teeth marks, belt buckle or strap marks, old and new bruises, dislocation, burns of unusual shape and in unusual locations, scratches, etc. If the aide hears of an alleged incident from a resident or co–worker then it must be reported according to the law.

5. The nurse aide doesn't make a determination that abuse or neglect "has" or "has not" occurred and then decide whether to report. If the

resident makes an allegation (even if it doesn't seem that it can't be true) it must be reported to the direct supervisor immediately. If the nurse aide hears of an alleged incident from a resident or co–worker, it must be reported to the direct supervisor immediately.

6. NA Investigation

a. Conducted by the administrator or the designated representative according to state regulations using the investigative packet provided the Arkansas Office of Long Term Care.

b. May result in revocation of certification.

III. Nurse Aide Testing/Certification

A. To Maintain Certification

1. The CNA must renew certification with the AR CNA Registry according to the current regulations.

2. To be eligible for renewal, the CNA must work at least one 8-hour shift as a CNA for pay during their certification period.

3. The CNA must not have a verified complaint against them on the registry. If a complaint of abuse or misappropriation of resident's property/funds is found to be valid, the CNA will lose certification in all 50 states permanently.

4. The CNA must not be disqualified to work based on DPSQA Criminal Record Check guidelines.

5. The nurse aide must exhibit professional behavior.

a. Be responsible, calling the facility if unable to work the scheduled shift.

b. Be on time for your scheduled shift.

c. Arrive to work clean and neatly dressed and groomed.

d. Maintain a positive attitude.

e. Follow facility policies and procedures.

f. Document and report carefully and correctly.

g. Always ask questions, if uncertain.

h. Report anything that keeps you from completing your duties/assignment.

i. Offer suggestions for improving the living and working environment.

IV. Certification Renewal

A. The CNA must renew certification with the AR CNA Registry every other year.

1. Renewals can be processed online by the CNA, or by submitting the renewal application to the AR Registry through the mail.

2. Renewals can be submitted and processed up to 60 days prior to the expiration of the certificate.

3. CNAs who do not renew within the 24-month grace period, or those who do not work during their certification period, are required to take the State competency exam in order to have their certification reinstated.

V. Course Review

A. Brief overview of each lesson.

B. Review of CARE SKILLS.

Review Questions – Lesson #30

1. Name common signs of stress and burnout in the healthcare industry.

2. What is the minimum work requirement for a CNA to maintain certification?

Works Cited

Alzheimer's Association. (c2018). *Wandering*. Retrieved from https://www.alz.org/help-support/caregiving/stages-behaviors/wandering.

Alzheimer's Association. (c2018). *Stages and behaviors*. Retrieved from https://www.alz.org/help-support/caregiving/stages-behaviors.

Alzheimer's Foundation of America. (c2018). *About Dementia*. Retrieved from https://alzfdn.org/about-dementia/.

Arkansas State Board of Nursing. (2018). *Nurse practice act of the state of Arkansas*. Little Rock, AR: ARSBN. Retrieved from https://www.arsbn.org/Websites/arsbn/images/NURSEPRACTICEACT_2018.February2018.pdf.

Frank Broyles and the University of Arkansas Board of Trustees. (2006). *Coach broyles' playbook for alzheimer's caregivers: A practical tips guide*. Fayetteville, AR: Broyles Foundation.

Centers for Medicare & Medicaid Services. (2017). *Guidance to surveyors for long term care facilities*. State Operations Manual, Appendix PP. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). Alzheimer's Association Dementia Care Practice Recommendations. *The Gerontologist, 58*(S1), S1–S9. doi: 10.1093/geront/gnx182

Fazio, S., Pace, D., Maslow, K., Zimmerman, S., & Kallmyer, B. (2018). The Fundamentals of Person-Centered Care for Individuals With Dementia. *The Gerontologist, 58*(S1), S10–S19. doi: 10.1093/geront/gnx122

Kandelman, N. (2017). Risk factors for burnout among caregivers working in nursing homes. *Journal of Clinical Nursing, 27*(1-2), e147-e153. doi: 10.1111/jocn.13891

Mangar Health. (2016, October 20). *The prevention of pressure ulcers*. Retrieved from https://mangarhealth.com/us/news/prevention-pressure-ulcers.

Manthorpe, J., & Samsi, K. (2016). Person-centered dementia care: current perspectives. *Clinical Interventions in Aging, 11*, 1733–1740. doi: 10.2147/CIA.S104618

Power, A. (2010). *Dementia Beyond Drugs: Changing the Culture of Care*. Baltimore, MD: Health Professions Press.

Power, A. (2014). *Dementia Beyond Disease: Enhancing Well-Being*. Baltimore, MD: Health Professions Press.

Sorrentino, S. A. & Gorek, B. (2014). *Mosby's Essentials for Nursing Assistants* (5th ed.). St. Louis, MO: Elsevier, Inc.

United States Health and Human Services, Food and Drug Administration, Center for Devices and Radiological Health. (2006). *Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment*. Rockville, MD: Division of Dockets Management, Food and Drug Administration. Retrieved from https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf.

University of Arkansas for Medical Sciences, Donald W. Reynolds Department of Geriatrics. (2005). *Dementia Care Manual.* Little Rock, AR: UAMS.

University of Arkansas for Medical Sciences, Department of Psychiatry. (2001). *Behavioral Interventions Pocket Reference.* Little Rock, AR: UAMS.

Woodhead, E. L., Northrop, L., & Edelstein, B. (2016). Stress, social support, and burnout among long-term care nursing staff. *Journal of Applied Gerontology, 35*(1), 84-105. doi: 10.1177/0733464814542465.

Appendix A
Supplemental Materials

ZONES/AREAS OF POTENTIAL BED ENTRAPMENT

The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below.

Zone 1: Within the Rail

Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support

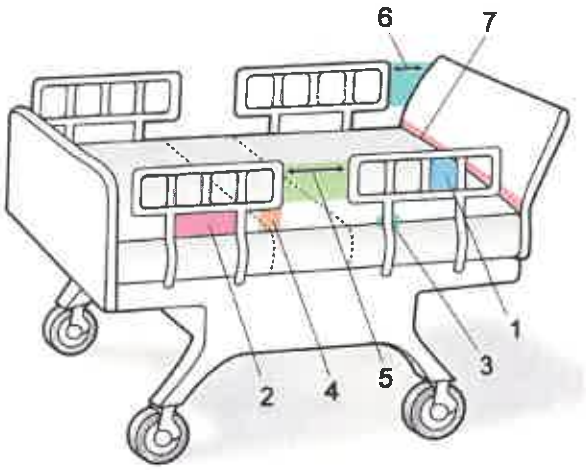
Zone 3: Between the Rail and the Mattress

Zone 4: Under the Rail, at the Ends of the Rail

Zone 5: Between Split Bed Rails

Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board

Zone 7: Between the Head or Foot Board and the Mattress End



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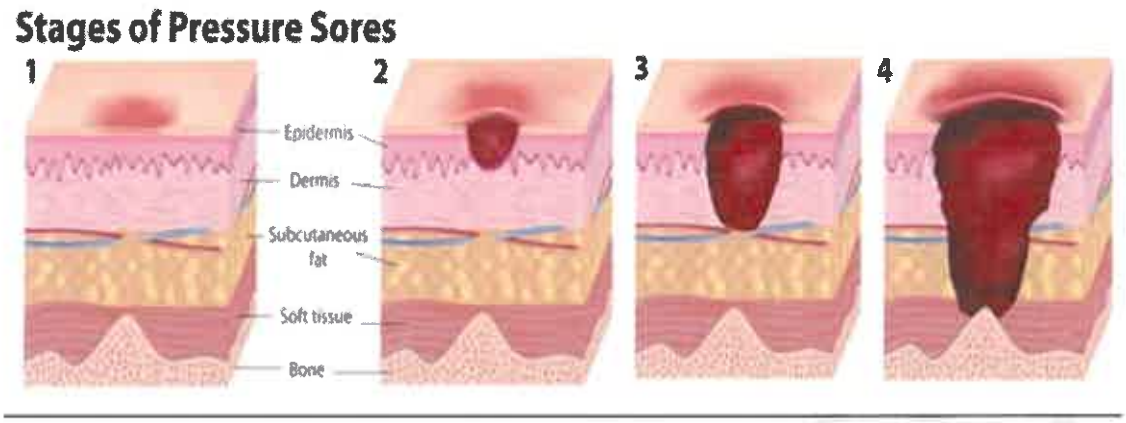
https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm072729.pdf



Stage 1:
The skin is not broken. Redness that is not relieved within 15-30 minutes of pressure being removed. Skin can be warmer than in other areas.

Stage 2:
Top layer of skin is broken. Blister or shallow sore can be seen. Second layer of skin can be affected. Affected area is usually painful.

Stage 3:
Wound is deeper and may extend into the subcutaneous layer.

Stage 4:
Wound extends to muscle or bone, causing severe damage to the affected areas.

https://mangarhealth.com/us/news/prevention-pressure-ulcers

COMMON MEDICAL ABBREVIATIONS

Time Abbreviations

a.m.	-morning	stat	-immediately
p.m.	-afternoon or evening	noc	-night
a.c.	-before meals	P.R.N.	-whenever necessary
p.c.	-after meals	q.d.	-every day
B.I.D.	-twice a day	q.h.	-every hour
T.I.D.	-three times a day	q.o.d.	-every other day
Q.I.D.	-four times a day	q3h	-every three hours
H.S.	-bedtime (hour of sleep)	q4h	-every four hours

Resident Orders

amt	-amount	NPO	-Nothing by mouth (sometimes NBM)
ax	-axilla		
BM	-bowel movement	P.T.	-physical therapy
BRP	-bathroom privileges	R	-rectal or right
c	-with	ROM	-range of motion
s	-without	spec.	-specimen
ad lib	-as desired	DC	-discontinued
ht	-height	w/c	-wheelchair
wt	-weight	TPR	-temperature, pulse, respiration
I&O	-Intake and Output		
ADL	-activities of daily living	BP	-blood pressure
V.S.	-vital signs (TPR & BP)		

Diagnostic Terms

MI	-Myocardial Infarction (heart attack) or Mental Illness	GI	-gastro intestinal
		GU	-genito-urinary
CVA	-cerebrovascular accident or stroke	CHF	-congestive heart failure
H.O.H.	-hard of hearing	Ca	-cancer
S.O.B.	-short of breath	CV	-cardiovascular
fx	-fracture		

Appendix B
Answers to Review Questions

Lesson #1

1. The licensed nurse.

2. An objective observation is factually seen, heard, felt or smelled by the person reporting; a subjective observation is what one "thinks" or "heard" happened from someone else.

3. Time to get dressed in the morning; whether to shower or bathe in a tub; what time to go to bed in the evening.

Lesson #2

1. Examine survey results, voice grievances, self–administer medications.

2. The caregiver must immediately report signs/symptoms of abuse, neglect or misappropriation.

3. Verbal, physical, emotional/ mental, sexual, neglect, involuntary seclusion, misappropriation.

4. Leaving a resident in bed soiled. Leaving the call light or water out of resident reach.

5. Using a resident's personal telephone to make calls. Taking a resident's money or personal belongings.

6. Report it immediately. Follow your facility's policies and procedures for reporting abuse.

Lesson #3

1. Causative Agent, Reservoir, Portal of Exit, Mode of Transmission, Portal of Entry, Susceptible Host.

2. Handwashing.

3. Before resident/patient contact, before aseptic task, after exposure to blood/body fluids, after resident/patient contact, after contact with resident/patient surroundings.

4. Proper usage will provide a barrier between the caregiver and the pathogen, thus, preventing the spread of infection.

5. Touching an infected person and then proceeding to touch another person without washing one's hands.

6. Touching a contaminated object and then proceeding to touch a person without washing one's hands.

7. No.

Lesson #4

1. Remove residents from area of immediate danger; Activate the fire alarm; Contain the fire, if possible (close doors); Extinguish, if possible.

2. Pull the pin; Aim at the base of the fire; Squeeze the handle; Sweep back and forth at the base of the fire.

3. Stop, drop and roll to smother the flames.

Lesson #5

1. Clutching throat (hands around throat).

2. Material Safety Data Sheet.

3. Call/notify nurse; stay with resident; position resident on side; move furniture away from resident; place padding under head; loosen clothing; check for injury; note duration and areas involved; do NOT place anything in mouth; do NOT restrain resident.

Lesson #6

1. True.

2. True.

3. Water.

4. Nectar thick, honey thick, and pudding thick.

Lesson #7

1. True.

2. True.

Lesson #8

1. False.

2. True.

3. True.

Lesson #9

1. True.

2. False.

Lesson #10

1. Cold/clammy skin, double or blurry vision, shaking/trembling, hunger, tingling or numbness of skin.

2. True.

Lesson #11

1. True.

2. True.

Lesson #12

1. Female: Separate labia; wash urethral area first; wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use a different part of washcloth for each stroke.

   Male: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of the penis using circular motion beginning with urethra. Continue washing down the penis to the scrotum and inner thighs.

   Rationale/Importance: Prevents the spread of infection by washing pathogens away from the urethra and not toward the urethra where pathogens could enter.

Lesson #13

1. Irritation, raised areas, coated or swollen tongue, sores, complaint of mouth pain, white spots, loose/chipped or decayed teeth.

2. Due to poor circulation, even a small sore on the foot can become a large wound.

Lesson #14

1. A clean catch mid–stream requires that genitalia be cleansed prior to collecting the urine specimen.

2. True.

Lesson #15

1. The resident's shoulders are directly above their hips; their head and neck are straight; their arms and legs are in a natural position.

2. Supine, Lateral, Fowler's and Semi–Fowler's.

3. Semi–Fowler's.

4. Less.

5. False.

Lesson #16

1. False.

Lesson #17

1. Dry mouth, weight loss, foul smelling urine, dark urine, cracked lips and sunken eyes.

2. True.

Lesson #18

1. True.

2. True.

3. True.

Lesson #19

1. False.

2. On the side she will be facing – her left.

Lesson #20

1. 60 – 100 beats per minute.

2. The average BP range for adults is systolic blood pressure: 90–139; Normal range for Diastolic blood pressure is 60–89. However, baseline ranges vary from person to person.

3. Place your hand on the resident's chest and feel the chest rise and fall during breathing.

Lesson #21

1. True.

2. At least once every hour and more frequently if the resident's condition requires.

3. At least every two hours, or more often if necessary except when the resident is asleep.

Lesson #22

1. Active range of motion exercises are done by the resident himself; Passive range of motion exercises are done by caregivers providing support and moving the resident's joints through the range of motion when the resident cannot move on their own.

2. Contractures.

3. Restorative Services.

Lesson #23

1. Redness, warmth, tenderness, open area.

2. True.

3. True.

Lesson #24

1. Change in vital signs – B/P, pulse, respiration, nausea, vomiting, sweating, tearful or frowning, sighing, moaning or groaning, breathing heavy or shortness of breath, restless or having difficulty moving, holding or rubbing a body part, tightening jaw or grinding teeth.

2. Medication administration, such as antibiotics, nutrition administration, hydration, blood products, solutions are administered by gravity or through a portable pump.

3. Fear of addiction to pain medication, feeling caregivers are too busy to deal with pain, fear pain medication will cause other problems, i.e., drowsiness, sleepiness, constipation.

Lesson #25

1. A delusion – a fixed, false belief.

2. An elopement.

3. Validation Therapy.

4. Sundowning.

Lesson #26

1. Immediately.

2. Remain calm, step out of the way, remove other residents, never strike back or respond verbally, leave the resident alone to calm down (if safe) and report the behaviors to the nurse immediately.

Lesson #27

1. Prepare the room for the resident's arrival; introduce self to resident and family/responsible party and explain role; explain surroundings to resident, including use of call light to summon help, if needed; create a trusting

relationship; be available to family; become a resource and support for the family; refer family members requesting information about a resident to the nurse.

2. Personal inventory record.

Lesson #28

1. Cyanosis.

2. True.

Lesson #29

1. Draw a single line through the error, print word "error" above entry and initial and date the correction.

2. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.)

Lesson #30

1. Exhibiting anger toward co–workers and/or residents; arguing with a supervisor or co-workers about assignments; complaining about responsibilities; feeling tired, even when you are well rested; difficulty focusing on residents and job duties.

2. The CNA must work at least one 8-hour shift as a CNA for pay during their certification period

Appendix C

Care Skills

1. Initial Steps
2. Final Steps
3. Handwashing/Hand rub
4. Gloves
5. Gown (PPE)
6. Mask
7. Fire
8. Fire Extinguisher
9. Falling or Fainting
10. Choking
11. Seizures
12. Unoccupied Bed
13. Thickened Liquids
14. Measure and Record Fluid Intake/Urinary Output
15. Passing Fresh Ice Water
16. Serving Meal Tray
17. Nasal Cannula Care
18. Shower/Shampoo
19. Bed Bath/Catheter Care/Perineal Care
20. Back Rub
21. Shampoo Hair in Bed
22. Whirlpool
23. Oral Care
24. Oral Care for the Unconscious Resident
25. Denture Care
26. Shaving with an Electric Razor
27. Shaving with a Safety Razor
28. Comb/Brush Hair
29. Fingernail Care
30. Foot Care
31. Change a Resident's Gown
32. Dressing a Dependent Resident
33. Assist to Bathroom

34. Bedside Commode
35. Bedpan/Fracture Bedpan
36. Urinal
37. Empty Urinary Drainage Bag
38. Urine Specimen Collection
39. Stool Specimen Collection
40. Application of Incontinent Brief
41. Assist Resident to Move to Head of Bed
42. Supine Position
43. Lateral Position & Side to Side
44. Fowler's Position
45. Semi-Fowler's Position
46. Use of Wheelchair/Geriatric Chair
47. Transfer to Chair
48. Sit on Edge of Bed
49. Using a Gait Belt to Assist with Ambulation
50. Walking
51. Assist with Walker
52. Assist with Cane
53. Using a Portable Mechanical Resident Lift
54. Transfer to Stretcher/Shower Bed
55. Transfer: Two Person Lift
56. Occupied Bed
57. Inspecting Skin
58. Float Heels
59. Bed Cradle
60. Feeding
61. Oral Temperature (Electronic)
62. Axillary Temperature
63. Pulse and Respiration
64. Practical Use of the Pulse Oximeter
65. Blood Pressure
66. Height

67. Weight
68. Application of Physical Restraints
69. Passive Range of Motion
70. Splint Application
71. Abdominal Binder
72. Abduction Pillow
73. Knee Immobilizer
74. Palm Cones
75. Assisting with Hearing Aids
76. Elastic/Compression Stocking Application or Ted Hose
77. Admission of a Resident
78. Transfer/Discharge of the Resident
79. Postmortem Care

CARE SKILLS #1: INITIAL STEPS (Lesson #2)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Ask nurse about resident's needs, abilities and limitations, if necessary and gather necessary supplies.	1. Prepares you to provide best possible care to resident.
2. Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room.	2. Maintains resident's right to privacy.
3. Greet resident by name per resident's preference.	3. Shows respect for resident.
4. Identify yourself by name and title.	4. Resident has right to know identity and qualifications of their caregiver.
5. Explain what you will be doing; encourage resident to help as able.	5. Promotes understanding and independence.
6. Gather supplies and check equipment.	6. Organizes work and provides for safety.
7. Close curtains, drapes and doors. Keep resident covered, expose only area of resident's body necessary to complete procedure.	7. Maintains resident's right to privacy and dignity.
8. Wash your hands.	8. Provides for Infection Control.
9. Wear gloves as indicated by Standard Precautions.	9. Protects you from contamination by bodily fluids.
10. Use proper body mechanics. Raise bed to appropriate height and lower side rails (if raised).	10. Protects yourself and the resident from injury.

CARE SKILLS #2: FINAL STEPS (Lesson #2)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Remove gloves, if applicable, and wash your hands.	1. Provides for Infection Control.
2. Be certain resident is comfortable and in good body alignment. Use proper body mechanics.	2. Reduces stress and improves resident's comfort and sense of well–being.
3. Lower bed height and position side rails (if used) as appropriate.	3. Provides for safety.
4. Place call light and water within resident's reach.	4. Allows resident to communicate with staff as necessary and encourages hydration.
5. Ask resident if anything else is needed.	5. Encourages resident to express needs.
6. Thank resident.	6. Shows your respect toward resident.
7. Remove supplies and clean equipment according to facility procedure.	7. Facilities have different methods of disposal and sanitation. You will carry out the policies of your facility.
8. Open curtains, drapes and door according to resident's wishes.	8. Provides resident with right to choose.
9. Perform a visual safety check of resident and environment.	9. Prevents injury to you and resident.
10. Report unexpected findings to nurse.	10. Provides nurse with necessary information to properly assess resident's condition and needs.
11. Document procedures according to facility procedure.	11. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.

CARE SKILLS #3: HANDWASHING/HAND RUB (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
Wash hands when visibly soiled or prior to giving care.	1. Handwashing is the single most effective barrier to transmission of bacteria.
1. Turn on faucet.	
2. Adjust water to acceptable temperature.	3. Hot water opens pores which may cause irritation.
3. Angle arms down holding hands lower than elbows. Wet hands and wrists.	4. Water should run from most clean to most soiled.
4. Apply enough soap to cover all hand and wrist surfaces. Work up a lather.	
NOTE: Direct caregivers must rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands, fingers and wrists.	
5. Use friction to distribute soap and create lather cleansing front and back of hands, between fingers, around cuticles, under nails, and on wrists.	5. Lather and friction will loosen pathogens to be rinsed away.
6. Rinse hands with water down from wrists to fingertips.	6. Soap left on the skin may cause irritation and rashes.
7. Dry thoroughly with single use towels.	
8. Use towel to turn off faucet and discard towel.	8. Prevents contamination of clean hands.
How to Use Hand Rub:	
9. Apply a quarter size amount of the product in a cupped hand.	9. Refer to label for estimated amount of product to be placed in palm.
10. Rub hands together to distribute product on front and back of hands, between fingers, around cuticles, under nails, and on wrists.	10. Thorough application will reach all surfaces of concern.
11. Allows hands to dry. Waterless hand rubs must be rubbed for at least 10 seconds or until dry to be effective.	11. The product must be dry to be effective.

CARE SKILLS #4: GLOVES (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Wash hands.	
2. Put gloves on, one hand at a time.	
3. Interlace fingers to secure gloves for a comfortable fit.	
4. Check for tears/holes and replace glove, if necessary.	4. Damaged gloves do not protect you or the resident.
5. If wearing a gown, pull the cuff of the gloves over the sleeves of the gown.	5. Covers exposed skin of wrists.
6. Perform procedure.	
7. Remove first glove by grasping outer surface of other glove, just below cuff and pulling down.	7. Both gloves are contaminated and should not touch unprotected skin.
8. Pull glove off so that it is inside out.	8. The soiled part of the glove is then concealed.
9. Hold the removed glove in a ball of the palm of your gloved hand. Do not dangle the glove downward.	9. To ensure the first glove goes into the second glove.
10. Place two fingers of ungloved hand under cuff of other glove and pull down so first glove is inside second glove.	10. Touching the outside of the glove with an ungloved hand causes contamination.
11. Dispose of gloves without touching outside of gloves and contaminating hands.	11. Hands may be contaminated if gloves are rolled or moved from hand to hand.
12. Wash hands.	

CARE SKILLS #5: GOWN [Personal Protective Equipment] (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Wash your hands.	
2. Open gown and hold out in front of you. Let the clean gown unfold without touching any surface.	2. Prevents contamination of the gown.
3. Slip your hands and arms through the sleeves and pull the gown on.	
4. Tie neck ties in a bow.	4. They can easily be un–tied later.
5. Overlap back of the gown and tie waist ties.	5. Ensures that your uniform is completely covered.
6. If gloves are required, put them on last.	
7. Perform procedure.	
8. Remove gloves.	
9. Remove goggles and/or face shield.	
10. Untie or break the waist ties.	
11. Untie or break the neck ties.	
12. Pull the sleeve off by grasping each shoulder at the neckline and turn the sleeves inside out as you remove them from your arms.	12. Not touching the outside surface of the gown with your bare hands prevents contamination. The back of the gown should not be soiled.
13. Fold gown with clean side out and place in laundry or discard if disposable.	13. Gowns are for one use only. They must be either discarded or laundered after each use.
14. Wash your hands.	

CARE SKILLS #6: MASK (Lesson #3)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Wash your hands.	
2. Place upper edge of the mask over the bridge of your nose and tie the upper ties. If mask has elastic bands, wrap the bands around the back of your head and ensure they are secure.	2. Your nose should be completely covered.
3. Place the lower edge of the mask under your chin and tie the lower ties at the nape of your neck.	3. Your mouth should be completely covered.
4. If the mask has a metal strip in the upper edge, form it to your nose.	4. This will prevent droplets from entering the area beneath the mask.
5. Perform procedure.	
6. If the mask becomes damp or if the procedure takes more than 30 minutes, you must change your mask.	6. Dampness of the mask will reduce its ability to protect you from pathogens. The effectiveness of the mask as a barrier is greatly diminished after 30 minutes.
7. If wearing gloves, remove them first.	7. This will prevent contamination of the areas you will touch when untying the mask.
8. Wash your hands.	
9. Untie each set of ties and discard the mask by touching only the ties. Masks are appropriate for one use only.	9. Hands may be contaminated if you touch an area other than the ties. Masks must be discarded after each use.
10. Wash your hands.	

CARE SKILLS #7: FIRE (Lesson #4)	
STEP	**RATIONALE**
1. Remove residents from area of immediate danger.	1. Residents may be confused, frightened or unable to help themselves.
2. Activate fire alarm.	2. Alerts entire facility of danger.
3. Close doors and windows to contain fire.	3. Prevents drafts that could spread fire.
4. Extinguish fire with fire extinguisher, if possible.	4. Prevents fire from spreading.
5. Follow all facility policies.	5. Facilities have different methods of responding to emergencies. You need to follow the procedures for your facility.

CARE SKILLS #8: FIRE EXTINGUISHER (Lesson #4)	
STEP	**RATIONALE**
1. Pull the pin.	1. Allows the extinguisher to be functional.
2. Aim at the base of the fire.	2. Targets the source of the flames, which should be found at the base.
3. Squeeze the handle.	3. Releases the chemical(s) to extinguish the fire.
4. Sweep back and forth at the base of the fire.	4. Fully extinguishes the source of the fire.

CARE SKILLS #9: FALLING OR FAINTING (Lesson #5)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Check if resident is breathing.	2. Provides you with information necessary to proceed with procedure.
3. Do not move resident. Leave in same position until the nurse examines the resident.	3. Prevents further damage if resident is injured.
4. Talk to resident in calm and supportive manner.	4. Reassures resident.
5. Apply direct pressure to any bleeding area with a clean piece of linen.	5. Slows or stops bleeding.
6. Take pulse and respiration.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Assist nurse as directed. Check resident frequently according to facility policy and procedures. Assist in documentation.	

CARE SKILLS #10: CHOKING (Lesson #5)	
STEP	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Ask if resident can speak or cough.	2. Identifies sign of blocked airway (not being able to speak or cough).
3. If not able to speak or cough, move behind resident and slide arms under resident's armpits.	3. Puts you in correct position to perform procedure.
4. Place your fist with thumb side against abdomen midway between waist and ribcage.	4. Positions fist for maximum pressure with least chance of injury to resident.
5. Grasp your fist with your other hand.	5. Allows you to stabilize resident and apply balanced pressure.
6. Press your fist into abdomen with quick inward and upward thrust.	6. Forces air from lungs to dislodge object.
7. Repeat until object is expelled.	
8. Assist with documentation.	

* **Note:** Discuss and demonstrate administering abdominal thrust for an unconscious resident or for someone who is lying down.

CARE SKILLS #11: SEIZURES (Lesson #5)	
STEP	**RATIONALE**
1. Call for nurse and stay with resident.	1. Allows you to get help, yet continuously provide for resident's safety and comfort.
2. Place padding under head and move furniture away from resident.	2. Protects resident from injury.
3. Do not restrain resident or place anything in mouth. Assist nurse with placing resident on his/her side.	3. Any restriction may injure resident during seizure. Positioning resident on his/her side prevents choking if the resident should vomit.
4. Loosen resident's clothing especially around neck.	4. Prevents injury or choking.
5. Note duration of seizure and areas involved.	5. Provides nurse with necessary information to properly assess resident's condition and needs.

CARE SKILLS #12: UNOCCUPIED BED (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Collect clean linen in order of use.	2. Organizing linen allows procedure to be completed faster.
3. Carry linen away from your uniform.	3. If linen touches your uniform, it becomes contaminated.
4. Place linen on clean surface (bedside stand, over bed table or back of chair).	4. Prevents contamination of linen.
5. Place bed in flat position.	5. Allows you to make a neat, wrinkle free bed.
6. Loosen soiled linen. Roll linen from head to foot of bed and place in barrel at door of room or in bag or pillow case and place at foot of bed or chair.	6. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.
7. Fanfold bottom sheet to center of bed and fit corners.	
8. Fanfold top sheet to center of bed.	
9. Fanfold blanket over top sheet.	
10. Tuck top linen under foot of mattress and miter corner.	10. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in or out of bed.
11. Move to other side of bed.	11. Completing one side of bed at a time allows procedure to be completed faster and reduces strain on the caregiver.
12. Fit corners of bottom sheet, unfold top linen, tuck it under foot of mattress, and miter corner.	
13. Fold top of sheet over blanket to make cuff.	
14. With one hand, grasp the clean pillow case at the closed end, turning it inside out over your wrist.	

15. Using the same hand that has the pillow case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.	
16. Place the pillow at head of bed with open edge away from the door.	16. Creates a neater, more uniform look to rooms and beds.
17. For open bed: make toe pleat and fanfold top linen to foot of bed with top edge closest to center of bed.	17. Top edge of top linen must be closest to head of bed so resident can easily reach covers.
18. For closed bed: pull bedspread over pillow and tuck bedspread under lower edge of pillow.	18. Toe pleat automatically reduces pressure of top linen on feet when resident returns to bed.
19. Removed soiled linens.	19. Prevents contamination.
20. Do final steps.	

CARE SKILLS #13: THICKENED LIQUIDS (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Obtain thickener and measuring spoon.	2. Measuring spoon is required to ensure proper amount of thickener is utilized to obtain ordered thickness. Follow your facility policy for thickening liquids.
3. Thicken liquids to desired consistency following manufacturer's instructions.	3. Physician will specify thickness. Various brands of thickener require different amounts of product to be added.
4. Offer thickened fluid to resident. Encourage resident to consume thickened fluids.	4. Decreases risk of resident becoming dehydrated.
5. Ensure the water pitcher has been removed from the bedside unless facility policy states otherwise.	5. Resident may attempt to drink liquids that have not been thickened which will increase risk of choking.
6. Do final steps.	

CARE SKILLS #14: MEASURE & RECORD FLUID INTAKE & URINARY OUTPUT (Lessons #6 & #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves, if necessary.	2. Gloves are not generally required for measuring fluid intake, but they are required for measuring urinary output.
Fluid Intake:	
3. Note the amount of fluids in the container before serving it to the resident. If necessary, document the amount.	3. Different containers hold different amounts of fluids. Check labels to determine how much fluid each container holds.
4. Once the resident is finished with the meal/snack, note the amount of fluid remaining in the container. (If necessary, pour the remaining fluid into a graduated container and read it at eye level to measure.)	4. Measuring the remaining fluid is more accurate, but this technique is not always necessary. Reading at eye level ensures accuracy.
5. Subtract the remaining amount of fluid from the total amount that was in the container. The difference is the amount of fluid consumed by the resident. Document the amount according to the facility's policy.	
6. Dispose of food/drinks accordingly. (If used, be sure to rinse, sanitize, and store the graduated cylinder according to the facility's policy.)	6. Leaving unconsumed food/drinks in the room could lead to pest concerns and can also result in amounts being documented multiple times. Fluids that were measured in cylinder are now considered contaminated and should not be consumed by the resident.
7. Wash hands.	
8. Do final steps.	
Urinary output:	
1. Empty urine into a graduated cylinder.	

2. Place container on a flat, level surface. Be sure to use a protective barrier between the container and the surface, including the floor.	1. If the surface is not level, the liquid will tilt, resulting in inaccurate readings. A barrier should be used to avoid cross-contamination.
3. Measure the amount of urine inside of the container at eye level.	2. Ensures accuracy.
4. Dispose of urine accordingly. Rinse, sanitize, and store the graduated cylinder according to the facility's policy.	
5. Remove gloves.	
6. Document the amount according to the facility's policy.	
7. Do final steps.	

CARE SKILLS #15: PASSING FRESH ICE WATER (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Obtain cart, ice container, ice scoop and go to ice machine. Keep ice scoop covered.	
3. Fill container with ice using ice scoop.	
4. Replace ice scoop in proper covered container or cover it with a clean towel or plastic bag to prevent contamination.	4. Keeping the ice scoop covered maintains infection control practices.
5. Proceed to resident rooms, noting any fluid restriction(s) prior to pass and any residents who require thickened liquids.	5. Residents who require a fluid restriction or thickened liquids should not have a water pitcher placed at the bedside unless facility policy states differently.
6. Empty water from pitcher and bedside glass into the sink. If resident is on I&O's – record intake of water.	6. Emptying the pitcher of old water will allow you to fill it with ice and fresh water. Emptying the glass will allow you to fill it with fresh water.
7. Take pitcher into hall and fill it with ice. NOTE: Do not touch the pitcher with the ice scoop.	7. The ice scoop is utilized for all residents thus should not be contaminated by touching a water pitcher.
8. Replace the scoop in covered container or cover with a fresh, clean towel or plastic bag between rooms to prevent contamination.	8. Maintains infection control practices.
9. Return to resident's room and fill pitcher with water at bathroom sink, not allowing pitcher to touch faucet.	9. Ensures that resident has fresh ice water in pitcher.
10. Pour fresh water into bedside glass and leave a straw with the glass, if needed.	10. Ensures that water is available and ready for resident when he/she desires it.
11. Offer the resident a drink of fresh water if resident is present.	11. Resident may be unable to independently obtain a drink of water.
12. Repeat procedure until all residents have been provided with fresh ice water.	12. Ensures that all residents receive fresh ice water.
13. Do final steps.	

CARE SKILLS #16: SERVING MEAL TRAY (Lesson #6)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Confirm diet card/tray. Check name, diet, utensils and condiments.	2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.
3. Confirm any adaptive equipment is present, if indicated.	3. Provision of adaptive equipment will encourage resident participation.
4. Assist to protect the resident's clothing, if desired.	4. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.
5. Assist to open carton(s), arrange food items within reach, season foods per resident preference, etc.	5. The resident may have limited hand dexterity and/or weakness, making it difficult to open cartons/containers.
6. Contact the nurse if the resident appears to be having difficulty during meal, and you are not trained on how to feed a resident If properly trained, then offer assistance.	6. Residents may refrain from "asking" for assistance, thus, staff should be pro–active in observing the need for assistance and offer the same.
7. Offer to assist in cleansing resident's hands/face following the meal.	7. Promotes good hygiene.
8. Assist resident to room or location of choice.	
9. Do final steps. Measure and record I&O's if required.	

CARE SKILLS #17: NASAL CANNULA CARE (Lesson #8)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Adjust and lift nasal cannula tubing enough to observe the skin underneath and to clean and dry nostrils as needed. Use a soft cloth or tissue for cleaning area once each shift or as needed. Do not remove cannula from nostrils.	3. Removes any accumulation of dried drainage that may be present. Removing the cannula from the nostrils is considered stopping/discontinuing the treatment/therapy, which cannot be performed by nursing assistants.
4. Note any redness or irritation of the nares or behind the ears and notify nurse if present. Continue procedure only if instructed.	4. Provides nurse with necessary information to properly assess resident's condition and needs.
5. Readjust nasal cannula so that it fits comfortably for resident. Ensure that sides are not too tight.	5. Nasal cannula too tight can cause discomfort. Incorrect placement could result in decrease flow of oxygen to resident and/or discomfort.
6. Remove gloves.	
7. Do final steps.	

CARE SKILLS #18: SHOWER/SHAMPOO (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Clean/disinfect shower area and shower chair as per facility policy. Prep the bathing area per facility policy. Gather supplies and take them into the shower area.	2. Reduces pathogens and prevents spread of infection. Have the supplies ready when you bring the resident in the shower room to ensure resident safety.
3. Help resident remove clothing. Provide resident privacy—ensure door is shut, curtains pulled, blinds closed.	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Turn on water and check temperature. Also allow resident to check water temperature for comfort, if able.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature.
5. Assist resident into shower via wheelchair. Lock wheels of shower chair and wheelchair. Transfer resident to shower chair. Use safety belt to secure resident stability, if indicated. Never take your eyes off the resident or turn your back to the resident while in the shower.	5. Chair may slide if resident attempts to get up. Ensure resident safety at all times. Never transport resident through the facility in shower chair. Keep eyes on resident at all times in shower room to ensure safety (i.e., prevent falls, ingestion of chemicals, etc.).
Shampoo:	
6. Give resident a washcloth to cover his/her eyes during the shampoo, if he/she desires. Place cotton balls in resident's ears if desired.	6. Prevents soap and water from entering the resident's eyes and ears.
7. Wet the resident's hair.	
8. Put a small amount of shampoo into the palm of your hand and work it into the resident's hair and scalp using your fingertips.	8. Using fingertips instead of fingernails to massage the scalp decreases the risk of scratching the resident.
9. Rinse the resident's hair thoroughly.	9. Leaving soap in the hair can cause dry scalp.
10. Use a conditioner if the resident desires you to do so. Rinse.	
Shower continued:	
11. Let resident wash as much as possible.	11. Encourages resident to be independent.

starting with face. Assist as needed to wash and rinse the entire body going from head to toe. Use a separate washcloth to cleanse the perineal area last.	
12. Turn off the water. Cover resident with bath blanket or towel.	12. Prevents resident from getting cold.
13. Remove cotton balls from the resident's ears, if utilized.	
14. Give resident towel and assist to pat dry. Ensure that hair, neck, and ears are dried. Thoroughly dry under breasts, between skinfolds, in the perineal area, and between toes.	14. Patting dry prevents skin tears and reduces chaffing. Water left in areas, especially in skin folds, can cause pathogens to grow, leading to irritation and skin breakdown.
15. Apply lotion to skin and assist resident with dressing and combing hair. Blow dry hair if necessary.	
16. Be sure that floor is dry before assisting resident out of shower chair. Apply non-slip device to floor if available. Ensure shoes are on and fit properly. Assist resident out of shower room.	16. Wet floors and transferring resident without shoes or nonskid socks on
17. Do final steps. Report skin abnormalities to the nurse.	

CARE SKILLS #19: BED BATH/CATHETER CARE/PERINEAL CARE (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Offer resident urinal or bedpan.	2. Reduces chance of urination during procedure which may cause discomfort and embarrassment.
3. Provide Resident privacy—including closing doors, windows and curtains.	3. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
4. Fill bath basin with warm water and have resident check water temperature for comfort, if able.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature.
5. Put on gloves.	5. Protects you from contamination by body fluids.
6. Fold washcloth and wet.	
7. Gently wash eye from inner corner to outer corner, using a different part of cloth to wash other eye. Be sure to use a different part of the cloth with each wipe throughout procedure/bed bath.	7. Helps prevent eye infection. Always wash from clean to dirty. Using separate area of cloth reduces contamination.
8. Wet washcloth and apply soap, if requested. Wash, rinse and pat dry face, neck, ears and behind ears.	8. Patting dry prevents skin tears and reduces chaffing.
9. Remove resident's gown.	
10. Place towel under far arm.	10. Prevents linen from getting wet.
11. Wash, rinse and pat dry hand, arm, shoulders and underarm.	11. Soap left on the skin may cause itching and irritation.
12. Repeat steps with other arm.	
13. Place towel over chest and abdomen. Lower bath blanket to waist.	13. Maintains resident's right to privacy.
14. Lift towel and wash, rinse and pat dry chest and abdomen.	14. Exposing only the area of the body necessary to do the procedure maintains resident's dignity and right to privacy.

15. Pull up bath blanket and remove towel.	
16. Uncover and place towel under far leg.	16. Prevents linen from getting wet.
17. Wash, rinse and pat dry leg and foot. Be sure to wash, rinse and dry well between the toes.	17. Soap left on the skin may cause itching and irritation.
18. Repeat with other leg and foot.	
19. Change bath water and gloves, wash hands and use clean gloves and towel.	19. Water is contaminated after washing feet. Clean water should be used for neck and back.
20. Assist resident to spread legs and lift knees, if possible.	20. Exposes perineal area.
21. Wet and soap folded washcloth.	21. Folding creates separate areas on cloth to reduce contamination.
Catheter Care:	
22. If resident has catheter, check for leakage, secretions or irritation. Secure tubing, then gently wipe four inches of catheter from meatus out.	22. Washes pathogens away from the meatus.
Perineal Care:	
23 Wipe from front to back and from center of perineum to thighs. If washcloth is visibly soiled, change cloths. For Females: Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. For Males: Pull back foreskin if male is uncircumcised. Wash and rinse the tip of penis using circular motion beginning with urethra. Continue washing down the penis in a circular motion to the scrotum and inner thighs. Rinse off soap and dry. Return foreskin over the tip of the penis.	23. Prevents spread of infection. Females: Removes secretions in skin folds which may cause infection or odor. Males: Removes secretions from beneath foreskin which may cause infection and odor.

24. Change water in basin. Wash hands and change gloves. With a clean washcloth, rinse area thoroughly in the same direction as when washing.	24. Water used during washing contains soap and pathogens. Soap left on the body can cause irritation and discomfort.
25. Gently pat area dry with towel in same direction as when washing.	25. If area is left wet, pathogens can grow more quickly. Patting dry prevents skin tears and reduces chaffing.
26. Assist resident to lateral position, facing away from you.	
27. Wet and soap washcloth.	
28. Clean anal area from front to back. Rinse and pat dry thoroughly.	28. Prevents spread of infection.
29. Change bath water and gloves. Use clean washcloth and towel.	29. Water and linen are contaminated after washing anal area.
30. Wash, rinse and pat dry from neck to buttocks.	30. Always wash from clean to dirty.
31. Return to supine position.	
32. Wash hands and change gloves.	
33. Help resident put on clean gown, undergarments or clothing of choice.	
34. Do Final Steps.	
35. Report any reddened areas, abrasions or bruises to the nurse.	

CARE SKILLS #20: BACK RUB (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place lotion in warm water. Shake occasionally if necessary to ensure lotion is warm all the way through. If hands are cold, hold them under warm water.	2. Warm water will help warm the lotion and hands. May need to remain in water several minutes.

3. Assist resident with turning on side or lying on abdomen.	
4. Expose the resident's back to the top of the buttocks.	
5. Pour small amount of lotion into palm of hand. If not warm enough, rub lotion between hands. Do not pour lotion directly onto resident's skin.	5. The friction of rubbing hands together will help warm the lotion. Pouring lotion directly onto the skin is cold and uncomfortable for most individuals.
6. Use the palm of both hands to apply the lotion to the back using long firm strokes, beginning at the base of the back on both sides. (Let the resident know that the lotion may feel cool at first.) Continue strokes from the buttocks to the back of the neck and shoulders, exerting firm upward pressure.	
7. Use gentle downward pressure rubbing in small circular motions with palm of hands. Do not lift hands. Alternate method – Circle hands outward at shoulders, then use gentle pressure to rub down the outer edges of the back. Circle hands again when you reach the top of the buttocks, and firmly massage in long strokes in the center of the back until you reach the shoulders again. Circle out and back down again. Repeat.	7. Regardless of the technique used, massaging will help relieve tension and relax resident. Whichever method the resident prefers is what should be used.
8. Give special attention to all bony prominences using circular motion.	8. Helps stimulate circulation and prevent skin damage. If areas are discolored, massage around them and be sure to report areas to nurse.
9. Continue rhythmic rubbing for one (1) to three (3) minutes. Let resident know when you are almost done.	
10. Dry resident's back by patting with a towel.	10. Helps to remove excess lotion.
11. Assist resident with getting dressed.	
12. Perform final steps.	

CARE SKILLS #21: SHAMPOO HAIR IN BED (Lesson #12)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Gently comb and brush resident's hair.	2. Reduces hair breakage, scalp pain, and irritation.
3. Place a towel around resident's neck and shoulders. Lower head of bed.	3. Decreases the chance of resident getting wet.

4. Have resident check temperature of water, if able.	4. Resident's sense of touch may be different than yours, therefore, resident is best able to identify a comfortable water temperature.
5. Place bed shampoo basin under resident's head according to manufacturer's instructions. If available, place protective covering such as a pad, on the bed before adding basin.	5. Pad will protect linens and mattress from getting wet. If equipment is not applied according to manufacturer's instruction, discomfort or injury could result.
6. Place wash basin or other receptacle on chair to catch water flowing from shampoo basin.	
7. Pour water carefully over resident's hair.	
8. Lather hair with shampoo using fingertips. Rinse thoroughly. Apply conditioner to resident's hair if requested. Rinse thoroughly.	8. Utilizing fingertips massages the scalp and decreases the risk of scratching resident.
9. Squeeze excess water from hair. Towel dry hair.	
10. Replace gown or pajama top if necessary.	
11. Comb and brush resident's hair. Dry hair with dryer if resident wishes.	11. Helps maintain resident's dignity and self–esteem.
12. Do final steps.	

CARE SKILLS #22: WHIRLPOOL (Lesson #12)	
STEP – Type of whirlpool, trolley, etc., may alter actions. Always refer to facility policy and/or manufacturer's instructions.	**RATIONALE**
1. If possible, fill tub with water before bringing resident to bathing area.	1. Having water ready saves time.
2. Transport resident to whirlpool.	

3. If tub is already filling, have resident check water temperature for comfort. Adjust if necessary.	3. Water should be at the resident's desirable temperature vs. the temperature that suits the staff.
4. Assist resident into lift bath trolley or into the tub per facility policy and manufacturer's instructions. Remove clothing and secure straps around resident, if applicable. Lower lift bath trolley and resident into the tub. If tub is not already filled with water, do so now, adjusting the temperature to the resident's comfort. When tub is filled, turn the system on.	4. Secure straps for resident's safety. Some tubs/whirlpools are made to be pre-filled. Others cannot be filled until the resident is inside. Some whirlpools/tubs require the use of a lift to lower resident inside tub. Others have a door, allowing resident to step inside tub. Follow manufacturer's instructions and the facility's policy on when to fill tub with water and how to get resident in/out of tub.
5. Let resident wash as much as possible, starting with face.	5. Encourages independence.
6. You may shower the resident by using the shower handle to gently spray over the resident's body. Stay with resident during procedure.	6. Leaving resident unattended can result in serious injury or death.
7. Turn system off after completion of bath and return shower handle to hook, if used. Drain water from tub.	
8. Raise trolley out of tub. Assist resident to pat dry as needed. Be sure to dry areas that are touching the trolley, skinfolds, underneath breasts, and the perineal area.	8. Leaving areas wet can cause irritation and skin breakdown.
9. Assist resident with dressing and getting out of trolley/tub. Comb hair.	
10. Help resident return to room or desired location. If necessary, leave indicator for others to know that tub has not been sanitized.	10. Tub should be cleaned between use. Leaving indicator for others ensures that tub will not be used before being cleaned.
11. Sanitize tub per manufacturer's instructions.	11. Tub should be properly cleaned after use.
12. Do final steps.	

CARE SKILLS #23: ORAL CARE FOR THE ALERT AND ORIENTED RESIDENT (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check with nurse if the resident is on swallowing precautions.	
2. Raise head of bed so resident is sitting up.	2. Prevents fluids from running down resident's throat, causing choking.
3. Put on gloves.	3. Brushing may cause gums to bleed. Protects you from potential contamination.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Wet toothbrush and apply small amount of toothpaste.	5. Water helps distribute toothpaste.
6. First brush upper teeth and then lower teeth. Gently brush inner, outer, and chewing surfaces of teeth. Clean entire mouth, including the tongue and the gum line.	6. Brushing upper teeth minimizes production of saliva in lower part of mouth.
7. Hold emesis basin under resident's chin.	
8. Ask resident to rinse mouth with water and spit into emesis basin.	8. Removes food particles and toothpaste.
9. If requested, give resident mouthwash diluted with half water.	9. Full strength mouthwash may irritate resident's mouth.
10. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	10. Provides nurse with necessary information to properly assess resident's condition and needs.
11. Remove towel and wipe resident's mouth.	
12. Remove gloves.	
13. Do final steps.	

CARE SKILLS #24: ORAL CARE FOR AN UNCONSCIOUS RESIDENT (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Drape towel over pillow and a towel under resident's chin.	2. Protects linen.
3. Turn resident onto unaffected side.	3. Prevents fluids from running down resident's throat, causing choking.
4. Put on gloves.	4. Protects you from contamination by bodily fluids.
5. Place an emesis basin under resident's chin.	5. Protects resident's clothing and bed linen.
6. Dip swab in cleaning solution of ½ mouthwash and ½ water and wipe teeth, gums, tongue and inside surfaces of mouth, changing swab frequently.	6. Stimulates gums and removes mucous.
7. Rinse with clean swab dipped in water.	7. Removes solution from mouth.
8. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	8. Provides nurse with necessary information to properly assess resident's condition and needs.
9. Cover lips with thin layer of lip moisturizer.	9. Prevents lips from drying and cracking. Improves resident's comfort.
10. Remove gloves.	
11. Do final steps.	

CARE SKILLS #25: DENTURE CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Prevents fluids from running down resident's throat, causing choking.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Remind resident that you are going to remove their dentures. Remove upper dentures by placing your index finger at the ridge on top of the right upper denture and gently moving them up and down to release suction. Turn lower denture slightly to lift out of mouth. If able, have resident to remove their dentures.	5. Prevents injury or discomfort to resident and reduces chance of resident biting staff. Removing upper dentures first is more comfortable for the resident and placing your finger at the ridge decreases the chance of stimulating the gag reflex. Allowing resident to remove their own dentures encourages independence.
6. Put dentures in denture cup marked with resident's name and take to sink.	
7. Line sink with towel and fill halfway with water.	7. Prevents dentures from breaking if dropped.
8. Apply denture cleaner to toothbrush.	
9. Hold dentures over sink and brush all surfaces.	9. If dropped, the dentures will fall into the sink. The towel and water in sink will prevent dentures from breaking.
10. Rinse dentures under warm water. Place in a clean cup and fill with cool water.	10. Hot water may damage dentures.
11. Clean resident's mouth with swab if necessary. Help resident rinse mouth with water or mouthwash diluted with half water, if requested.	11. Removes food particles. Full strength mouthwash may irritate resident's mouth.
12. Check teeth, mouth, tongue and lips for odor, cracking, sores, bleeding and discoloration. Check for loose teeth. Report unusual findings to nurse.	12. Provides nurse with necessary information to properly assess resident's condition and needs.

13. Help resident place dentures in mouth, if requested. Moisturize the lips.	13. Restores resident's dignity and keeps lips from drying and cracking. Improves resident comfort.
14. Remove gloves.	
15. Do final steps.	

CARE SKILLS #26: SHAVING WITH AN ELECTRIC RAZOR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in more natural position.
3. Do not use electric razor near any water source, when oxygen is in use or if resident has pacemaker.	3. Electricity near water may cause electrocution. Electricity near oxygen may cause explosion. Electricity near some pacemakers may cause an irregular heartbeat.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Put on gloves.	5. Shaving may cause bleeding. Protects you from potential contamination.
6. Apply pre–shave lotion as resident requests.	
7. Hold skin taut and shave resident's face and neck according to manufacturer's guidelines.	7. Smooth out skin. Shave beard with back and forth motion in direction of beard growth with foil (oscillating blades) shaver. Shave beard in circular motion with three head (rotary, circular blades) shaver.
8. Check for any breaks in the skin. Apply aftershave lotion as resident requests.	8. Decreases risk of pain from aftershave getting into any breaks in the skin. Improves resident's self–esteem.
9. Remove towel from resident.	9. Restores resident's dignity.
10. Remove gloves.	
11. Do final steps.	

CARE SKILLS #27: SHAVING WITH A SAFETY RAZOR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in more natural position.
3. Fill bath basin halfway with warm water.	3. Hot water opens pores and causes irritation.
4. Drape towel under resident's chin.	4. Protects resident's clothing and bed linen.
5. Put on gloves.	5. Shaving may cause bleeding. Protects you from potential contamination.
6. Moisten beard with washcloth and spread shaving cream over area.	6. Softens skin and hair.
7. Hold skin taut and shave beard in downward strokes on face and upward strokes on neck.	7. Maximizes hair removal by shaving in the direction of hair growth.
8. Rinse resident's face and neck with washcloth.	8. Removes soap which may cause irritation.
9. Pat dry with towel.	
10. Apply after–shave lotion, as requested.	10. May decrease skin irritation, especially with sensitive skin. Improves resident's self–esteem.
11. Remove towel.	
12. Remove gloves.	
13. Do final steps.	

CARE SKILLS #28: COMB/BRUSH HAIR (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed so resident is sitting up.	2. Places resident in position to access hair.
3. Drape towel over pillow.	3. Protects resident's clothing and bed linen.
4. Remove resident's glasses and any hairpins or clips.	
5. Remove tangles by dividing hair into small sections and gently combing out from the ends of hair to scalp.	
6. Use hair products, as resident requests.	
7. Style hair as resident requests.	7. Improves resident's self–esteem.
8. Offer mirror.	
9. Do final steps.	

CARE SKILLS #29: FINGERNAIL CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check fingers and nails for color, swelling, cuts or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure.	2. Provides nurse with information to properly assess resident's condition and needs.
3. Raise head of bed so resident is sitting up.	3. Places resident in more natural position.
4. Fill bath basin halfway with warm water and have resident check water temperature for comfort. Add soap to water. If possible use non–rinse soap, being sure to follow manufacturer's instructions for dilution. If no–rinse solution is not available, and regular soap is used, then aide must rinse hands by using a pitcher of water, or by taking resident to sink, or by emptying and refilling basin.	4. Resident's sense of touch may be different than yours; therefore, resident is best able to identify a comfortable water temperature. Adding soap helps to clean resident's hands.
5. Soak resident's hands and pat dry.	5. Nail care is easier if nails are softened.
6. Put on gloves.	6. Nail care may cause bleeding. Protects you from potential contamination.
7. Clean under nails with orange stick.	7. Pathogens can be harbored beneath the nails.
8. Clip fingernails straight across, then file in a curve.	8. Clipping nails straight across prevents damage to skin. Filing in a curve creates smooth nails and eliminates edge which may catch on clothes or cause skin tear.
9. Remove gloves.	
10. Do final steps.	

CARE SKILLS #30: FOOT CARE (Lesson #13)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Fill the basin halfway with warm water. Have resident check the water temperature.	2. To prevent resident from scalding or burning his/her feet.
3. Place basin on towel or bathmat.	
4. Remove resident's socks. Completely submerge resident's feet in water and soak for five to ten minutes.	4. Soaking allows for softening skin depending on thickness of calluses, etc.
5. Put on gloves.	
6. Remove one foot from water. Wash entire foot, including between the toes and around the nail beds using a soapy washcloth.	
7. Rinse entire foot, including between the toes.	7. Soap left on the skin may cause itching and irritation.
8. Dry entire foot, including between the toes. Inspect the feet and in between all toes for condition of skin, presence of corns or callouses or other foot problems.	8. Thoroughly drying skin reduces irritation and chaffing.
9. Check with the charge nurse before trimming the resident's toenails. If trimming is allowed, trim the toenails straight across to prevent the edges from becoming ingrown.	9. Facility may not allow nurse aides to trim toenails and/or fingernails. Certain residents may require licensed staff (nurses, doctors, podiatrist, etc.) to trim their toenails, especially if they are diabetic or have poor circulation.
10. Repeat steps with the other foot.	
11. Place lotion in hand, warm lotion by rubbing hands together, and then massage lotion into entire foot (top and bottom) except between toes, removing excess with a towel.	
12. Assist resident to replace socks and shoes, as desired.	
13. Do final steps.	

14. Report any cuts, sores, or other findings to the nurse.	

CARE SKILLS #31: CHANGING RESIDENT'S GOWN (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Untie and/or unbutton soiled gown as needed.	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
3. Raise top sheet over resident's chest.	
4. Remove resident's arms from gown, unaffected arm first.	4. Undressing unaffected arm first requires less movement.
5. Roll soiled gown from neck down and remove from beneath top sheet. Place soiled gown in dirty linen bag.	5. Rolling reduces spread of infection.
6. Slide resident's arms into clean gown, affected arm first.	6. Dressing affected side first requires less movement and reduces stress to joints.
7. Tie or button gown as needed.	
8. Remove top sheet from beneath clean gown and cover resident.	8. Maintains resident's dignity and right to privacy.
9. Do final steps.	

CARE SKILLS #32: DRESSING A DEPENDENT RESIDENT (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check care plan to see if resident is a one person or two-person assist.	
2. Assist resident to choose clothing.	2. Allows resident as much choice as possible to improve self–esteem.
3. Move resident onto back.	
4. Provide privacy.	4. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
5. Guide feet through leg openings of underwear and pants, affected leg first. Pull garments up legs to buttocks.	5. Dressing affected side first requires less movement and reduces stress to joints.
6. Slide arm into shirt sleeve, affected side first.	6. Dressing lower and upper body together reduces number of times resident needs to be turned.
7. Turn resident onto unaffected side. Pull lower garments over buttocks and hip. Tuck shirt under resident.	
8. Turn resident onto affected side. Pull lower garments over buttocks and hip and straighten shirt.	
9. Turn resident onto back and slide arm into shirt sleeve, align and fasten garments.	
10. Do final steps.	

CARE SKILLS #33: ASSIST TO BATHROOM (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Check care plan to see if resident is a one person or two-person assist.	
2. Assist resident to put on non–skid socks/ footwear.	
3. Walk with resident into bathroom.	
4. Assist resident to lower garments and sit.	4. Allows resident to do as much as possible to help promote independence.
5. Provide resident with call light and toilet tissue if resident has been identified as safe to be provided privacy. Remain with the resident if required to do so.	5. Ensures ability to communicate need for assistance. Provides for resident's right to privacy.
6. Put on gloves.	6. Protects you from contamination by bodily fluids.
7. Assist resident to wipe area from front to back.	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
8. Remove gloves. Wash hands.	
9. Assist resident to raise garments.	
10. Assist resident to wash hands.	10. Handwashing is the best way to prevent the spread of infection.
11. Walk with resident back to bed or chair.	
12. Do final steps.	

CARE SKILLS #34: BEDSIDE COMMODE (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to put on non–skid socks/ footwear.	
3. Place commode next to bed on resident's unaffected side.	3. Helps stabilize commode and is the shortest distance for resident to turn.
4. Assist resident to transfer to commode by transferring the safest way the resident is able. Check care plan to see if resident is a one person or two person assist.	
5. Give resident call light and toilet tissue if resident has been identified as safe to be provided privacy and not attended by staff.	5. Ensure ability to communicate need for assistance. Provides resident's right to privacy.
6. Put on gloves.	6. Protects you from contamination by bodily fluids.
7. Assist resident to wipe from front to back.	7. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
8. Assist resident to bed or chair.	
9. Remove and cover pan and take to bathroom.	9. Pan should be covered to prevent the spread of infection.
10. Prior to disposal, observe urine and/or feces for color, odor, amount & characteristics and report unusual findings to nurse.	10. Changes may be the first sign of a medical problem. By alerting the nurse, you ensure that the resident receives prompt attention.
11. Dispose of urine and/or feces, sanitize pan and return pan according to facility policy.	11. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
12. Remove gloves. Wash hands.	
13. Assist resident to wash hands.	13. Handwashing is the best way to prevent the spread of infection.
14. Do final steps.	

CARE SKILLS #35: BEDPAN/FRACTURE BEDPAN (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved without working against gravity.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Turn resident away from you.	
5. Place bedpan or fracture pan under buttocks according to manufacturer directions.	5. Equipment used incorrectly may cause discomfort and injury to resident.
6. Gently roll resident back onto pan and check for correct placement.	6. Prevents linen from being soiled.
7. Cover resident with sheet/blanket.	7. Provides for resident's privacy.
8. Raise head of bed to comfortable position for resident.	8. Increases pressure on bladder to encourage with elimination.
9. Give resident call light and toilet paper.	9. Ensures ability to communicate need for assistance.
10. Leave resident and return when called.	10. Provides for resident's privacy.
11. Lower head of bed.	11. Places resident in proper position to remove pan.
12. Press bedpan flat on bed and turn resident.	12. Prevents bedpan from spilling.
13. Wipe resident from front to back. Wash hands and change gloves.	13. Prevents spread of pathogens toward meatus which may cause urinary tract infection.
14. Provide perineal care, if necessary.	
15. Cover bedpan and take to bathroom.	15. Pan should be covered to prevent the spread of infection.
16. Check urine and/or feces for color, odor, amount and characteristics and report unusual findings to nurse.	16. Changes may be first sign of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.

17. Dispose of urine and/or feces, sanitize pan and return pan according to facility policies.	17. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
18. Remove gloves. Wash hands.	
19. Assist resident to wash hands.	19. Handwashing is the best way to prevent the spread of infection.
20. Do final steps.	

CARE SKILLS #36: URINAL (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Raise head of bed to sitting position.	2. Increases gravity on top of bladder to encourage urination.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Offer urinal to resident or place urinal between his legs and insert penis into opening. Remove gloves.	4. Allows resident to do as much as possible to help promote independence.
5. Cover resident.	5. Maintains resident's right to privacy.
6. Give resident call light and toilet paper.	6. Ensures ability to communicate need for assistance.
7. Leave resident and return when called.	7. Provides for resident's privacy.
8. Put on gloves. Remove and cover urinal.	8. Urinal should be covered to prevent the spread of infection.
9. Take urinal to bathroom, check urine for color, odor, amount and characteristics and report unusual findings to nurse.	9. Changes may be first sign of medical problems. By alerting the nurse you ensure that the resident receives prompt attention.
10. Dispose of urine, rinse urinal, sanitize and return urinal according to facility policies.	10. Facilities have different methods of disposal and sanitation. You need to carry out the policies of your facility.
11. Remove gloves. Wash hands.	
12. Assist resident to wash hands.	12. Handwashing is the best way to prevent the spread of infection.
13. Do final steps.	

CARE SKILLS #37: EMPTY URINARY DRAINAGE BAG (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Place paper towel on floor beneath bag and place graduated cylinder on paper towel.	3. Reduces contamination of graduate cylinder and protects floor from spillage.
4. Detach spout (if bag has one) and point the drainage tube into center of graduated cylinder without letting tube touch sides.	4. Prevents contamination of tubing.
5. Unclamp spout and drain urine.	
6. Clamp spout. Clean using alcohol wipe.	6. Removes contaminates from spout.
7. Replace spout in holder.	
8. Check urine for color, odor, amount and characteristics and report unusual findings to nurse.	8. Changes may be first signs of medical problem. By alerting the nurse you ensure that the resident receives prompt attention.
9. Measure and accurately record amount of urine.	9. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally it didn't happen.
10. Dispose of urine, rinse, sanitize and return graduated cylinder according to facility policies.	10. Facilities have different methods of disposal and sanitation. Follow facility policy and procedures.
11. Remove gloves.	
12. Do final steps.	

CARE SKILLS #38: URINE SPECIMEN COLLECTION (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	2. Label contains resident's identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. Assist resident to bathroom or commode, or offer bedpan or urinal.	
5. Provide perineal care to the resident.	5. To ensure area is clean and free of possible contamination of the specimen.
6. Ask resident to void into the urine hat placed on the toilet, or to urinate in the bedpan. Ask the resident not to put toilet paper with the sample.	6. A clean collection device is necessary for accurate lab evaluation. Toilet paper will contaminate the urine and produce an inaccurate result.
7. After urination, assist the resident as necessary with perineal care and to wash the resident's hands. Change your gloves and wash your hands.	
8. Take bedpan, urinal, and commode pail to bathroom and pour urine in to the specimen container. The container should be at least half full.	
9. Cover the urine container with its lid. Do not touch the inside of the container. Wipe off the outside with a paper towel.	9. Touching the inside can contaminate the specimen, causing inaccurate results.
10. Place the specimen container in the bag supplied by the lab for transport.	
11. Discard excess urine in bedpan or urinal; clean and disinfect equipment as per facility policy.	
12. Do final steps.	

CARE SKILLS #39: STOOL SPECIMEN COLLECTION (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare label for specimen with appropriate information and place it on specimen container, not the lid.	2. Label contains resident's identifying information which is essential for the laboratory. Label should be placed on the specimen container in the event the lid is misplaced or thrown away.
3. Put on gloves.	3. Protects you from contamination by bodily fluids.
4. When the resident is ready to move bowels, ask him/her not to urinate at the same time. Ask the resident not to put toilet paper in with the sample.	4. A clean collection device is necessary for accurate lab evaluation. Urine contaminated stool will produce an inaccurate result.
5. Provide the resident with a bedpan, assisting if needed.	
6. After the bowel movement, assist as needed with perineal care.	
7. Remove gloves, wash hands and put on clean gloves.	
8. Using two tongue blades, take about two tablespoons of stool and put in the container. Try to collect material from different areas of the stool.	8. In order to ensure adequate amount of stool for test ordered. Obtaining material from different areas ensures that all possible contents will be identified.
9. Cover the container with lid. Label as directed per facility policy and procedure and place in the plastic bag supplied by the lab for transport. Dispose of remaining stool; clean and disinfect equipment as per facility policy. Notify nurse of collection.	
10. Do final steps.	

CARE SKILLS #40: APPLICATION OF INCONTINENT BRIEF (Lesson #14)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	
3. Provide the resident privacy.	
4. Unfasten and remove brief resident is currently wearing and place in small plastic trash bag for disposal in soiled utility bag.	4. Residents should have soiled briefs removed promptly to decrease risk of skin breakdown.
5. Provide perineal care as indicated.	5. Prevents infection, odor, and skin breakdown; improves resident's comfort.
6. Wash hands and change gloves.	
7. Place back of brief under resident's hips, plastic side of disposable brief away from resident's skin.	7. Plastic may cause irritation of the resident's skin.
8. Bring front of brief between resident's legs and up to his/her waist.	
9. Fasten each side of brief and adjust fit.	9. Adjusting brief to a snug fit will prevent leakage.
10. Apply resident's clothing.	
11. Do final steps.	

CARE SKILLS #41: ASSIST RESIDENT TO MOVE TO HEAD OF BED (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Ask another CNA to assist you if needed.	
2. Lower head of bed and lean pillow against head board. Adjust bed height as needed.	2. When bed is flat, resident can be moved without working against gravity. Pillow prevents injury should resident hit the head of bed. Adjusting the bed height decreases risk of injury.
3. Ask resident to bend knees, put feet flat on mattress.	3. Gives resident leverage to help with move.
4. Place one arm under resident's shoulder blades and the other arm under resident's thighs. If a draw sheet or pad is under resident, two caregivers should grasp the sheet or pad firmly, with trunk centered between hands.	4. Putting your arm under resident's neck could cause injury. Use of a draw sheet/pad causes less stress on caregiver and reduces risk of injury.
5. Ask resident to push with feet on count of three.	5. Enables resident to help as much as possible and reduces strain on you.
6. Place pillow under resident's head.	6. Provides for resident's comfort.
7. Do final steps.	

CARE SKILLS #42: SUPINE POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Lower head of bed.	2. When bed is flat, resident can be moved without working against gravity.
3. Move resident to head of bed if necessary.	3. Places resident in proper position in bed.
4. Position resident flat on back with legs slightly apart.	4. Prevents friction in thigh area.
5. Align resident's shoulder and hips.	5. Reduces stress to spine.
6. Use supportive padding and/or float heels, if necessary.	6. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
7. Do final steps.	

CARE SKILLS #43: LATERAL POSITION & SIDE TO SIDE (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place resident in supine position.	2. Places resident in proper position and alignment.
3. Move resident to side of bed closest to you.	3. Allows resident to be positioned in center of bed when turned.
4. Cross resident's arms over chest.	4. Reduces stress on shoulders during move.
5. Slightly bend knee of nearest leg to you or cross nearest leg over farthest leg at ankle.	5. Reduces stress on hip joint during turn.
6. Place your hands under resident's shoulder blade and buttock. Turn resident away from you onto side.	6. Prevents stress on shoulder and hip joints.
7. Place supportive padding behind back, between knees and ankles and under top arm.	7. Maintains position, prevents friction and reduces pressure on bony prominences.
8. Do final steps.	
Moving a Resident in Bed from Side to Side:	
1. Do initial steps. Ask another CNA to assist you if needed.	
2. Put the side rail in the up position on the far side of the bed.	
3. Loosen the top sheets but do not expose the resident.	
4. Place your feet in a good position – one in close to the bed – one back. Slide both of your arms under the resident's back to his far shoulder and then slide the resident's shoulders toward you by rocking your weight to your back foot. If a second aide is present, use the draw sheet to move the resident in bed.	
5. Keep your knees bent and your back straight as you slide the resident.	

6. Slide both your arms as far as you can under the resident's buttocks and slide his/her buttocks toward you in the same way. Use a draw sheet whenever possible for helpless residents.	
7. Place both your arms under the resident's feet and slide them toward you.	
8. Place pillows under resident accordingly to ensure spine is in proper alignment.	
9. Do final steps.	

CARE SKILLS #44: FOWLER'S POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Move resident to supine position.	2. Places resident in proper position and alignment.
3. Elevate head of bed 45 to 60 degrees.	3. Improves breathing, allows resident to see room and visitors.
4. Use supportive padding if necessary.	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
5. Do final steps.	

CARE SKILLS #45: SEMI–FOWLER'S POSITION (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Move resident to supine position.	2. Places resident in proper position and alignment.
3. Elevate head of bed 30 to 45 degrees.	3. Improves breathing, allows resident to see room and visitors.
4. Use supportive padding if necessary.	4. Maintains position, prevents friction and reduces pressure on bony prominences. Padding may be used under neck, shoulders, arms, hands, ankles, lower back. Never use padding under knees, unless directed by nurse, as it may restrict blood flow to lower legs.
5. Do final steps.	

CARE SKILLS #46: USE OF WHEELCHAIR/GERIATRIC CHAIR (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Be sure you know how to properly operate chair before transferring resident into it. Reading manufacturer's instructions may be necessary.	2. Not all wheelchairs are made alike. Electronic vs manual chairs differ in use. Improper use can result in damage to chair and injury to resident and staff.
3. Inspect the chair to ensure that it is clean and works properly. Most wheelchairs can be opened by pressing down on the bars on either side of the seat. To fold, lift the center edges of the seat.	3. Decreases spread of pathogens and likelihood of injury.
4. Engage and disengage the wheel lock by moving the braking device towards and away from the wheel.	4. Locking wheels helps to ensure chair will not move during transfers.
5. To move the footrests, press or pull the release lever and swing it out towards the side of the wheelchair. To remove the footrest, lift it off when it is at the side of the chair. To replace it, put the footrest back onto the pins at the side of the wheelchair. Swing footrest back to the front of the chair to lock it into place.	5. Leaving footrest in front of chair can cause injury and/or falls for the aide and/or the resident during transfers.
6. Remove armrests by releasing lock and pulling armrest straight up. Not all armrests are detachable from chair.	6. Removing armrests can help prevent injury during transfer.
7. To adjust footrest up or down, activate the release mechanism before pulling or pushing the footrest into desired position. Always support the leg/foot when moving footrest.	7. Decreases injury and adds comfort for resident.
8. Follow manufacturer's instructions on how to properly recline and engage locks for geri-chair.	8. Process varies depending on brand of chair.
9. Do final steps.	

CARE SKILLS #47: TRANSFER TO CHAIR/WHEELCHAIR (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place chair on resident's unaffected side. Brace firmly against side of bed.	2. Unaffected side supports weight. Helps stabilize chair and is shortest distance for resident to turn.
3. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.	3. Allows resident to adjust to position change. A significant change in position may cause dizziness due to a drop in blood pressure.
4. Stand in front of resident and apply gait belt around resident's abdomen. (Refer to Using a Gait Belt to Assist with Ambulation for instructions on applying gait belt.)	4. Gait belts reduce strain on your back and provides for security for the resident.
5. Grasp the gait belt securely on both sides of the resident.	5. Provides security for the resident and enables them to turn.
6. Ask resident to place his hands on your upper arms or shoulders.	6. You may be injured if resident grabs around your neck.
7. On the count of three, help resident into standing position by straightening your knees.	7. Allows you and resident to work together. Minimizes strain on your back.
8. Allow resident to gain balance, check for dizziness.	8. Change of position may cause dizziness due to drop in blood pressure.
9. Move your feet to shoulder's width apart and slowly turn resident.	9. Improves your base of support and allows space for resident to turn.
10. Lower resident into chair by bending your knees and leaning forward.	10. Minimizes strain on your back.
11. Align resident's body. Remove gait belt.	11. Shoulders and hips should be in straight line to reduce stress on spine and joints.
12. Place feet on footrests and reattach armrest if necessary.	
13. Unlock wheels and transport resident to desired location, as needed.	
14. Do final steps.	

CARE SKILLS #48: SIT ON EDGE OF BED (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Adjust bed height to lowest position.	2. Allows resident's feet to touch floor when sitting. Reduces chance of injury if resident falls.
3. Move resident to side of bed closest to you.	3. Resident will be close to edge of bed when sitting up.
4. Raise head of bed to sitting position, if necessary.	4. Resident can move without working against gravity.
5. Place one arm under resident's shoulder blades and the other arm under resident's thighs.	5. Placing your arm under the resident's neck may cause injury.
6. On count of three, slowly turn resident into sitting position with legs dangling over side of bed.	
7. Allow time for resident to become steady. Check for dizziness.	7. Change of position may cause dizziness due to a drop in blood pressure.
8. Assist resident to put on shoes or slippers.	8. Prevents sliding on floor and protects resident's feet from contamination.
9. Move resident to edge of bed so feet are flat on floor.	9. Allows resident to be in stable position.
10. Do final steps.	

CARE SKILLS #49: USING A GAIT BELT TO ASSIST WITH AMBULATION (LESSON #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.	2. Allows resident to adjust to position change. A change in position may cause dizziness due to drop in blood pressure.
3. Place belt around resident's waist with the buckle in front (on top of resident's clothes) and adjust to a snug fit ensuring that you can get your hands under the belt. Position one hand on the belt at the resident's side and the other hand at the resident's back.	3. Buckle is difficult to release if in back and may cause injury to ribcage if on side. Placing the belt on top of resident's clothes maintains proper infection control procedures. The belt must be snug enough that it doesn't slip when you are assisting resident to move. Ensure a female resident's breasts are not under the belt.
4. Assist the resident to stand on count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance. Ask the resident if dizzy.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Stand to side and slightly behind resident while continuing to hold onto belt.	6. Allows clear path for the resident and puts you in a position to assist resident if needed.
7. Walk at resident's pace.	7. Reduces risk of falling.
8. Return resident to chair or bed and remove belt.	
9. Do final steps.	

CARE SKILLS #50: WALKING (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed. Encourage resident to sit for a few seconds to become steady. Check for dizziness.	2. Allows resident to adjust to position change.
3. Assist resident to stand on count of three.	3. Allows you and resident to work together.
4. Allow resident to gain balance, check for dizziness.	4. Change in position may cause dizziness due to a drop in blood pressure.
5. Stand to side and slightly behind resident.	5. Allows clear path for the resident and puts you in a position to assist resident if needed.
6. Walk at resident's pace.	6. Reduces risk of resident falling.
7. Do final steps.	

CARE SKILLS #51: ASSIST WITH WALKER (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Assist resident to sit on edge of bed.	2. Allows resident to adjust to position change.
3. Place walker in front of resident as close to the bed as possible.	
4. Have resident grasp both arms of walker.	4. Helps steady resident.
5. Brace leg of walker with your foot and place your hand on top of walker.	5. Prevents walker from moving.
6. Assist resident to stand on count of three. Check for balance and dizziness.	6. Allows you and resident to work together.
7. Stand to side and slightly behind resident.	7. Puts you in a position to assist resident if needed.
8. Have resident move walker ahead 6 to 10 inches, then step up to walker moving the weak or injured leg forward to the middle of the walker while pushing down on the handles of the walker, and then bringing the unaffected leg forward even with the weak/injured leg. Continue sequence until desired destination is reached.	8. Resident may fall forward if he steps too far into walker.
9. Do final steps.	

CARE SKILLS #52: ASSIST WITH CANE (Lesson #15)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check the cane for presence of rubber tip(s).	2. Presence of intact rubber tips decreases the risk of falls by improving traction and preventing slipping.
3. Assist resident to sit on edge of bed.	3. Allows resident to adjust to position change.
4. Assist resident to stand on count of three.	4. Allows you and resident to work together.
5. Allow resident to gain balance. Check for dizziness.	5. Change in position may cause dizziness due to a drop in blood pressure.
6. Have resident place cane approximately 4 inches to the side of his/her stronger/ unaffected foot. The height of the cane should be level with resident's hip.	
7. Stand to the affected side and slightly behind resident.	7. Allows clear path for the resident and puts you in a position to assist resident if needed.
8. Have resident move cane forward about 4–6 inches, step forward with weak (affected) leg to a position even with the cane. Then have resident move strong leg forward and beyond the weak leg and cane. Repeat the sequence.	8. Reduces risk of resident falls.
9. Do final steps.	

CARE SKILLS #53: USING A PORTABLE MECHANICAL RESIDENT LIFT (Lesson #16)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Never use a lift that you have not been properly trained to use. Facility should ensure that each aide is properly trained over facility policy and manufacturer's instructions for use.	1. Misuse could result in serious injury to resident. Different manufacturers provide different instructions for equipment. Aide must know how to properly work the equipment they are responsible for using.
2. Never use a lift alone. There should always be two aides present to transfer resident with lift.	2. One aide should guide the lift, while the other aide guides the resident and ensures resident is not injured during transfer.
3. Before transferring resident, ensure that battery for lift is charged. Also check other equipment (i.e., lift pad, sling, straps, etc.) to ensure it works properly and is not in need of repair.	3. If battery is not charged, lift could shut down during transfer. Fraying, holes, tears, etc. on lift pad could result in resident falling.
4. Do initial steps.	
5. Follow manufacturer's instructions and facility's policy on transfers using the lift.	
6. Be sure all locks and straps are fastened securely. Lock brakes on lift once it is in position. Brakes on wheelchair should be locked before transferring resident.	6. Brakes should be locked to ensure equipment does not move during transfer, which could result in serious injury to resident and/or staff.
7. Reassure and talk to resident during transfer.	7. Helps calm anxiety and fear of falling.
8. After transfer is complete, ensure resident is comfortable. Remove sling/lift pad if indicated.	
9. Perform final steps.	

CARE SKILLS #54: TRANSFER: TO STRETCHER/SHOWER BED (Lesson #16)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Loosen sheet directly under resident and roll edges close to resident.	2. This sheet will be utilized to slide resident from bed to stretcher.
3. Place stretcher/shower bed at bedside. NOTE: Make certain wheels are locked. After locking wheels, ensure bed and stretcher/shower bed are at the same height. Then lower side rails.	3. Wheels must be locked to prevent stretcher from moving.
4. Staff should be present at the bedside as well as on the opposite side of the stretcher/shower bed. (Requires a minimum of two staff members, except when use of additional staff is specified in care plan and/or facility policy.)	4. To prevent resident from falling/rolling off the bed or stretcher.
5. Grasp sheet on each side of resident. On the count of three, slide resident laterally onto stretcher/shower bed.	5. Counting to three enables staff members to work together to distribute weight evenly and prevent injury to resident and/or staff.
6. Center and align resident. Place pillow under his/her head, cover with a blanket, and raise the rails of stretcher/shower bed.	6. Place resident in proper position and alignment. Pillow provides comfort; blanket maintains dignity, provides privacy, and keeps resident warm; raising the rails prevents resident injury.
7. Do final steps.	

CARE SKILLS #55: TRANSFER - TWO PERSON LIFT (Lesson #16) ***ONLY TO BE USED IN AN EMERGENCY***	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place chair at bedside. Brace it firmly against side of bed. Lock wheels of wheelchair or Geri chair.	2. Helps stabilize chair and is the shortest distance for staff to turn. Wheel locks prevent chair from moving.
3. Assist resident to sit on edge of bed. Ensure there is staff on each side of the resident.	3. Allows resident to adjust to position change.
4. Reach around resident's back and grasp other assistant's forearm above wrist. Have resident place arms around your shoulders (not your neck) or on your upper arms.	4. Having resident place arms on your shoulders or upper arms reduces the chance of injury to your neck.
5. Each NA should reach under resident's knees and grasp other assistant's forearm above wrist.	5. Grasping your partner's forearm provides for support and prevents resident from slipping out of your grasp.
6. On the count of three lift resident.	6. Allows you to work together and allows weight to be distributed evenly to prevent injury to resident or staff.
7. Pivot and lower resident into chair.	
8. Align resident in chair.	8. Shoulders and hips should be in a straight line to reduce stress on spine and joints.
9. Do final steps.	

CARE SKILLS #56: OCCUPIED BED (Lesson #17)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Collect clean linen in order of use.	2. Organizing linen allows procedure to be completed faster.
3. Carry linen away from your uniform.	3. If linen touches your uniform, it becomes contaminated.
4. Place linen on clean surface (bedside stand, over bed table or back of chair).	4. Prevents contamination of linen.
5. Lower head of bed and adjust bed to a safe working level, usually waist high. Lock bed wheels.	5. When bed is flat, resident can be moved without working against gravity.
6. Drape the resident.	
7. The caregiver will make the bed one side at a time. The caregiver will raise the side rail on far side of bed (if rail not in use, ensure there is a second caregiver on the opposite side of the bed to ensure that the resident does not roll over the side of bed). Assist resident to turn onto side, moving away from you toward raised side rail (or second caregiver).	
8. Loosen bottom soiled linen on the side of bed on which you are working. Put on gloves.	
9. Roll bottom soiled linen toward resident and tuck it snuggly against the resident's back. Change gloves to avoid cross–contamination after working with soiled/dirty linens.	9. Rolling puts dirtiest surface of linen inward, lessening contamination. The closer the linen is rolled to resident, the easier it is to remove from the other side.
10. Place clean bottom linen on unoccupied side of bed and roll remaining clean linen under resident in the center of the bed.	
11. Smooth bottom sheet out and ensure there are no wrinkles. Roll all extra material toward resident and tuck it under the resident's body.	

12. Raise the side rail nearest you (or remain in place if a second caregiver is being utilized) and assist the resident to turn onto clean bottom sheet. Inform resident that he/she may feel hump due to the covers being rolled up. Move to opposite side of bed, as resident will now be facing away from you.	
13. While resident is lying on side, loosen soiled linen and roll linen from head to foot of bed, avoiding contact with your skin or clothing.	13. Always work from cleanest (head of bed) to dirtiest (foot of bed) to prevent spread of infection. Rolling dirtiest surface of linen inward, lessening contamination.
14. Place soiled linen in barrel or bag at foot of bed or in chair. Change gloves to prevent possible cross contamination.	
15. Pull clean bottom linen as was done on the opposite side.	
16. Assist resident to roll onto back, keeping resident covered and comfortable.	
17. Unfold the top sheet placing it over the resident. Request the resident to hold the clean top sheet, slip the bath blanket or previous sheet out from underneath the clean sheet.	17. Maintains resident's dignity and right to privacy by not exposing body.
18. Assist resident with blanket over the top sheet and tuck the bottom edges of the top sheet and blanket under the bottom of the mattress. Miter the corners and loosen the top linens over the resident's feet.	18. Mitering prevents resident's feet from being restricted by or tangled in linen when getting in or out of bed. Prevents pressure on feet which can cause pressure sores.
19. Remove pillow and remove the soiled pillow case by turning it inside out.	
20. With one hand, grasp the clean pillow case at the closed end, turning it inside out over your wrist.	
21. Using the same hand that has the pillow case over it, grasp one narrow edge of the pillow and pull the pillow case over it with your free hand.	21. Prevents contamination.
22. Place the pillow under resident's head with open edge away from the door.	22. Creates a neater, more uniform look to rooms and beds.

23. Assist resident to comfortable position and return the bed to the appropriate position.	
24. Remove soiled linens from room – carrying away from uniform.	
25. Do final steps.	

CARE SKILLS #57: INSPECTING SKIN (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Provide the resident privacy.	2. Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm.
3. Check bony areas including ears, shoulder blades, elbows, coccyx, hips, knees, ankles and heels for redness and warmth.	3. Redness and warmth indicates that the skin is under pressure and position should be changed more frequently.
4. Check friction areas including under breasts and arms, between buttocks, groin, thighs, skin folds, contracted areas, and around any tubing for redness, irritation, moisture and odor.	4. Pressure, rubbing and perspiration will cause skin to break down.
5. Remove drape from resident, if one was used, and assist resident with getting comfortable and changing position if necessary.	
6. Report any unusual findings to the nurse immediately.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Do final steps.	

CARE SKILLS #58: FLOAT HEELS (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Lift resident's lower extremity.	
3. Inspect the skin, especially the heels.	3. To identify any potential skin problems/breakdown.
4. Place a full pillow under calves, leaving heels in the air and free from pressure. (Do not use rolled pillows or blankets.)	4. Placing the pillow directly under the heels can increase pressure on heels.
5. Do final steps.	

CARE SKILLS #59: BED CRADLE (Lesson #18)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place bed cradle on bed according to manufacturer's instructions.	2. If equipment is not applied according to manufacturer's instructions, discomfort or injury could result.
3. Cover bed cradle with top sheet and bedspread/blanket.	3. Keeps the top linens from applying pressure/weight to toes, feet and lower legs.
4. Do final steps.	

CARE SKILLS #60: FEEDING (Lesson #19)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps. Assist resident with toileting if needed, change brief if soiled.	
2. Confirm diet card/tray. Check name, diet, utensils and condiments.	2. This will ensure that the resident is being served the diet as ordered; at the appropriate consistency.
3. Explain procedure.	
4. Have resident wash hands, help the resident if needed.	4. Provides good hygiene in preparation for meal consumption.
5. Sit on unaffected side eye level with resident and facing them.	5. Encourages interaction with the resident and placement of spoon at an appropriate angle.
6. Resident's head should be elevated at least 45 degrees, if in bed.	6. Places resident at an angle to promote swallowing and reduce risk of choking.
7. Protect the resident's clothing with a clothing protector or per facility policy and procedures.	7. Use of a napkin or clothing protector (if resident desires) preserves dignity by keeping clothing clean and free of spillage.
8. Offer different foods; ask resident's preference.	8. Involving the resident encourages consumption.
9. Food should be in bite sized pieces or with the spoon half full. Food should be fed to the unaffected side of the mouth.	9. Reduces risk of choking.
10. Allow time for resident to chew and empty mouth between bites. Notify nurse immediately should choking occur.	10. Reduces risk of choking.
11. Frequently offer beverage.	11. Encourages swallowing.
12. Make conversation with the resident; atmosphere should be pleasant.	12. Enhances meal experience, thus encourages consumption.
13. Cleanse the resident's hands/face as needed during the meal and after.	13. Promotes good hygiene.
14. Do final steps. If required, measure and record I&O's and percentage of food eaten.	

CARE SKILLS #61: ORAL TEMPERATURE [ELECTRONIC] (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
Do not take oral temperature for a resident who is unconscious, uses oxygen, or who is confused/disoriented.	
1. Remove thermometer from storage/ battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath and place thermometer under the tongue and to one side, press button to activate the thermometer.	4. The thermometer measures heat from blood vessels under the tongue.
5. The resident should be directed to breathe through their nose.	
6. Instruct resident to hold thermometer in mouth with lips closed. Assist as necessary.	6. The lips hold the thermometer in position.
7. Leave thermometer in place until signal is heard, indicating the temperature has been obtained.	
8. Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.	8. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.
9. Do final steps.	
10. Return thermometer to storage/battery charger.	
11. Report unusual reading to nurse.	11. Provides nurse with necessary information to properly assess resident's condition and needs.

CARE SKILLS #62: AXILLARY TEMPERATURE (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
Often taken when inappropriate to take an oral temperature; particularly if resident is confused or combative	
1. Remove thermometer from storage/ battery charger.	
2. Do initial steps.	
3. Position resident comfortably in bed or chair.	
4. Put on disposable sheath, remove resident's arm from sleeve of gown, wipe armpit and ensure it is dry. Hold thermometer in place with end in center of armpit and fold resident's arm over chest.	4. Places thermometer against blood vessels to get reading.
5. Press button to activate the thermometer.	
6. Hold thermometer in place until signal is heard, indicating the temperature has been obtained.	
7. Read the temperature reading on the face of the electronic device, remove the thermometer, discard the sheath, and record the reading.	7. Record temperature immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you document is a legal record of what you did. If you don't document it, legally, it didn't happen.
8. Assist the resident to return arm through sleeve of clothing/gown.	
9. Do final steps.	
10. Return thermometer to storage/battery charger.	
11. Report unusual reading to nurse.	11. Provides nurse with necessary information to properly assess resident's condition and needs.

CARE SKILLS #63: PULSE AND RESPIRATION (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Place resident's hand on comfortable surface.	
2. Feel for pulse above wrist on thumb side with tips of first three fingers.	2. Because of artery in your thumb, pulse would not be accurate if you use your thumb.
3. Count beats for 60 seconds, noting rate, rhythm and force.	3. Ensures accurate count. Rate is number of beats. Rhythm is regularity of beats. Force is strength of beats.
4. Continue position as if feeling for pulse. Count each rise and fall of chest as one respiration.	4. Resident could alter breathing pattern if aware that respirations are being taken.
5. Count respirations for 60 seconds noting rate, regularity and sound.	5. Ensure accurate count. Rate is number of breaths. Regularity is pattern of breathing. Sound is type of auditory breaths heard.
6. Record pulse and respiration rates.	6. Record pulse and respirations immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
7. Report unusual findings to nurse.	7. Provides nurse with information to assess resident's condition and needs.
8. Do final steps.	

CARE SKILLS #64: PRACTICAL USE OF THE PULSE OXIMETER (Lesson #20)	
STEP – Initial Steps: Turn the pulse oximeter on: it will go through internal calibration and checks.	**RATIONALE**
1. Select the appropriate probe with particular attention to correct sizing and where it will go (usually finger, toe or ear).	1. If used on a finger or toe, make sure the area is clean. Remove any nail varnish.
2. Connect the probe to the pulse oximeter.	
3. Position the probe carefully; make sure it fits easily without being too loose or too tight.	3. If possible, avoid the arm being used for blood pressure monitoring as cuff inflation will interrupt the pulse oximeter signal.
4. Allow several seconds for the pulse oximeter to detect the pulse and calculate the oxygen saturation.	
5. Look for the displayed pulse indicator that shows that the machine has detected a pulse. Without a pulse signal, any readings are meaningless.	
6. Once the unit has detected a good pulse, the oxygen saturation and pulse rate will be displayed.	
7. Like all machines, oximeters may occasionally give a false reading – if in doubt, rely on your clinical judgment, rather than the machine.	7. The function of the oximeter probe can be checked by placing it on your own finger. Aide is to record pulse ox % (as in other vital signs).
9. Adjust the volume of the audible pulse beep to a comfortable level for your theatre – ever use on silent.	9. Always make sure the alarms are on.
10. Record measurements as displayed on monitor, per facility policy, and report to charge nurse accordingly.	10. Further treatment may be needed, depending on values that are reported. If the numbers are not documented, then the skill cannot be considered performed.

CARE SKILLS #65: BLOOD PRESSURE (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Clean earpieces and diaphragm of stethoscope with antiseptic wipe.	1. Reduces pathogens; prevents spread of infection.
2. Uncover resident's arm to shoulder.	
3. Rest resident's arm, level with heart, palm upward on comfortable surface.	3. A false low reading is possible, if arm is above heart level.
4. Wrap proper sized sphygmomanometer cuff around upper unaffected arm approximately 1–2 inches above elbow.	4. Cuff must be proper size and placed on arm correctly so amount of pressure on artery is correct. If not, reading will be falsely high or low.
5. Put earpieces of stethoscope in ears.	5. Earpieces should fit into ears snugly to make hearing easier.
6. Place diaphragm of stethoscope over brachial artery at elbow.	
7. Close valve on bulb. If blood pressure is known, inflate cuff to 20 mm/hg above the usual reading. If blood pressure is unknown, inflate cuff to 30 mm/hg past the point of occlusion.	7. Inflating cuff too high is painful and may damage small blood vessels.
8. Slowly open valve on bulb.	8. Releasing valve slowly allows you to hear beats accurately.
9. Watch gauge and listen for sound of pulse.	
10. Note gauge reading at first pulse sound.	10. First sound is systolic pressure.
11. Note gauge reading when pulse sound disappears or changes.	11. Last sound is diastolic pressure.
12. Completely deflate and remove cuff.	12. An inflated cuff left on resident's arm can cause numbness and tingling. If you must take blood pressure again, completely deflate cuff and wait 30 seconds. Never partially deflate a cuff and then pump it up again. Blood vessels will be damaged and reading will be falsely high or low.

13. Accurately record systolic and diastolic readings.	13. Record readings immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
14. Do final steps.	
15. Report unusual readings to nurse.	15. Provides nurse with information to properly assess resident's condition.

CARE SKILLS #66: HEIGHT (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Using standing balance scale: Assist the resident onto the scale, facing away from the scale. Ask the resident to stand straight. Raise the rod to a level above the resident's head. Lower the height measurement device until it rests flat on the resident's head.	1. Measurements are written on the rod in inches.
2. When a resident is unable to stand: Flatten the bed and place resident in supine position. Place a mark on the sheet at the top of the head and another at the bottom of the feet. Measure the distance.	2. Places resident in proper position and alignment; allows you to measure resident accurately.
3. If the resident is unable to lay flat due to contractures: Utilize a tape measure and beginning at the top of the head, follow the curves of the spine and legs, measuring to the base of the heel.	3. Allows you to obtain an accurate measurement for the resident who cannot fully extend body.
4. Accurately record resident's height. Assist resident off the scale.	4. Record height immediately so you won't forget. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
5. Do final steps.	

CARE SKILLS #67: WEIGHT (Lesson #20)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Balance scale.	1. Scale must be balanced on zero for weight to be accurate.
2. Depending on scale used, assist resident to stand on platform or sit in chair with feet on footrest or transport wheelchair onto scale and lock brakes.	2. When using chair scale, if resident has feet on floor, weight will not be accurate. Wheel locks prevent chair from moving when using a wheelchair scale.
3. When using a standard scale –lower weight to fifty-pound mark that causes arm to drop. Move it back to previous mark. Move upper weight to pound mark that balances pointer in middle of square. Add lower and upper marks. When using a digital scale – press weigh button. Wait until numbers remain constant.	3. When arm drops, weight is too high. When pointer is suspended, weight is accurate. Total gives accurate weight.
4. Subtract weight of wheelchair from total weight, if applicable.	
5. Accurately record resident's weight.	5. Record weight immediately so you won't forget. Weight changes are an indicator of resident's condition. Accuracy is necessary because decisions regarding resident's care may be based on your report. What you write is a legal record of what you did. If you don't document it, legally, it didn't happen.
6. Do final steps.	
7. Report unusual reading to nurse.	7. Provides nurse with information to assess resident's condition and needs.

CARE SKILLS #68: APPLICATION OF PHYSICAL RESTRAINTS (Lesson #21)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Check with the nurse before gathering supplies. Verify the type of restraint that was ordered for the resident. The NA should ensure that he/she was properly trained by the facility on how to use the restraint per the manufacturer's instructions and facility's policy.	1. NA/CNA can only use/apply restraints when instructed to do so by the charge nurse. Ensures that the correct restraint will be used, as ordered by the physician. NA/CNA should not apply a restraint that he/she has not received training for. Although restraints appear the same, manufacturers can provide different instructions/guidance for use and application. Improper application can result in serious harm and/or death for the resident.
2. Do initial steps.	
3. Follow manufacturer's instructions and facility's policy on applying the restraint.	3. Same as previously stated.
4. If resident is in bed, be sure to tie restraint to the part of the bed that moves with the resident. Never tie restraints to side rails or the fixed part of the bed frame (that does not move with the resident when repositioning).	4. Tying restraints to the fixed portion of the frame or to side rails will cause the restraint to tighten as the bed is moved for positioning. This can cause discomfort, pain, and problems with circulation and lead to more serious concerns.
5. Make sure that the restraint is not too tight. Check pulse in the affected areas to ensure circulation is not occluded (cut off). Make sure that breasts and skin are not caught in the restraint.	5. Occlusion can lead to serious consequences for the resident, including nerve damage, loss of use, etc.
6. Place call light in easy reach.	
7. Check resident and restraint every 15 minutes, or more frequently if necessary or instructed.	7. Constant monitoring helps to ensure that the resident is not in distress or experiencing discomfort due to the restraint.
8. Release the restraint at least every two hours or more frequently as needed or instructed. Assist the resident with toileting, ambulating, changing position, and other ADLs as needed.	
9. Document according to facility policy.	
10. Perform initial/final steps as needed when checking on the resident.	

CARE SKILLS #69: PASSIVE RANGE OF MOTION (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Position resident in good body alignment.	2. Reduces stress to joints.
3. Observe joints. If swelling, redness or warmth is present, or if resident complains of pain, notify nurse. Continue procedure only if instructed.	3. Indicates inflammation in joint which can be worsened if procedure is continued.
4. Support limb above and below joint.	
5. Begin range of motion at shoulders and include the shoulders, elbows, wrists, thumbs, fingers, hips, knees, ankles and toes.	5. Allows you to control joint movement and minimize resident's discomfort.
6. Slowly move joint in all directions it normally moves.	6. Rapid movement may cause injury.
7. Repeat movement per facility policy or care plan.	7. Ensures benefit from procedure.
8. Encourage resident to participate as much as possible.	8. Promotes resident's independence and self–esteem.
9. Stop procedure at any sign of pain and report to nurse immediately.	9. Pain is a warning sign for injury.
10. Do final steps.	

CARE SKILLS #70: SPLINT APPLICATION (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Observe affected joints. If swelling, redness, or warmth is present or if resident complains of pain, notify nurse. Continue procedure only if instructed.	2. Indicates inflammation in joint which can be worsened if splint is applied.
3. Apply splint according to therapy recommendation and physician's order.	3. Application of splint not in accordance with therapy recommendation could cause injury or discomfort to resident.
4. Remove splint after designated period of time. Cleanse the skin, dry thoroughly and again observe for swelling, redness, warmth, complaint of pain or open area. Notify the nurse if present.	4. Indicates inflammation in joint. Notifying nurse provides him/her with information to assess resident's condition and needs.
5. Do final steps.	

CARE SKILLS #71: ABDOMINAL BINDER (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Check the skin for redness, open areas, or needed incontinence care.	2. Allows you to identify early signs of skin breakdown and the need for cleansing prior to binder application.
3. Place binder flat on the bed and ask resident to lie down with upper border at the upper waist and lower border at the level of the gluteal fold. If resident is in bed, assist him/her to roll side–to–side while placing binder underneath him/her in the same position.	3. A binder placed above the waist interferes with breathing; one placed too low interferes with elimination and walking.
4. Bring the ends of binder around the resident, and overlap them. Beginning at the bottom of the binder, secure the Velcro fastener strip so that the binder fits snugly.	4. A snug fit provides maximum support. If the binder is too loose, efficacy is impaired. If it is too tight, resident may be uncomfortable.
5. Ensure that there are no wrinkles or creases in the binder.	5. Wrinkles and creases put pressure on the skin increasing the risk for excoriation.
6. Do final steps.	

CARE SKILLS #72: ABDUCTION PILLOW (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Place the pillow between the supine resident's legs. Slide it with the narrow end pointing toward the groin until it touches the legs all along its length.	
3. Place the upper part of both legs in the pillow's indentations. Raise each leg slightly by lifting under the knee and ankle to bring straps under and around leg and then secure the straps to the pillow.	3. Securing the straps prevents the pillow from slipping out of place.
4. Do final steps.	
5. Report resident intolerance or complaint of pain upon application to the nurse.	5. Provides nurse with information to assess resident's condition and needs.

CARE SKILLS #73: KNEE IMMOBILIZER (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. With resident lying supine in bed, one caregiver will support the leg above the knee and at the ankle and lift the leg in one motion, providing enough height for a second caregiver to place the immobilizer under the affected leg. Check skin prior to applying the immobilizer.	2. It is important to maintain the leg in a straight position while placing the immobilizer and to monitor for any skin problems/breakdown.
3. The caregiver will lower the leg into the open immobilizer, keeping the leg straight.	
4. Pull both sides of the immobilizer to center of front of leg and wrap one side over the other, securing the Velcro strip holding the immobilizer in place. Make sure the Velcro stabilizer bar strips are attached to opposite sides of the immobilizer to prevent any motion of the knee medially or laterally.	
5. Bring straps around each side and secure to stabilize the immobilizer.	
6. When removing the immobilizer for bathing/care, support the leg in the same manner, keeping the leg straight at all times. Observe for any reddened areas, particularly at the upper and lower edge of the immobilizer, which is in contact with the resident's skin.	6. Constant contact with the edge of the immobilizer can place the skin at risk of breakdown. Early detection of any concern can prevent further breakdown.
7. Report to the nurse any skin irritation, open area, or complaint of pain.	7. Reporting to the nurse will ensure that treatment is obtained, if needed.
8. Do final steps.	

CARE SKILLS #74: PALM CONES (Lesson #22)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Cleanse and thoroughly dry resident's hand.	2. Cleansing and drying of hands prevents odor and infection.
3. Place cone with clean cover in resident's palm.	
4. Observe hand(s) every shift; cleanse and thoroughly dry hands. Observe for areas of redness, swelling or open areas and report to the nurse, if noted.	4. Allows you to identify early signs of skin breakdown.
5. Note covering of palm cone and send to laundry when soiled, re–covering cone with a clean covering, as needed.	5. Maintaining cleanliness enhances resident's dignity.
6. Do final steps.	

CARE SKILLS #75: ASSISTING WITH HEARING AIDS (Lesson #23)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Gently clean resident's ear with a damp washcloth. Clean hearing aid of wax and dirt when needed according to manufacturer's instructions.	2. To ensure ears are clean prior to insertion of hearing aids, thus ensuring maximum acuity.
3. Insert hearing aid into resident's ear.	
4. Assist to adjust the volume control to a desired level.	4. To ensure that aid is turned up high enough for resident to hear, but not so high that noises will hurt resident's ear(s).
5. Do final steps.	
6. Report any abnormalities to nurse.	6. Provides nurse with necessary information to properly assess resident's condition and needs.
7. Keep hearing aid in safe place when not in use.	7. Helps reduce risk of damage to device.

CARE SKILLS #76: ELASTIC/COMPRESSION STOCKING APPLICATION OR TED HOSE (Lesson #23)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Observe skin prior to applying the stockings for any redness, warmth, swelling, excessive dryness, or open area. Notify nurse if abnormalities present. Continue procedure only if instructed.	2. Provides nurse with information to assess resident's condition and needs.
3. Apply the hose before resident gets out of bed.	3. Hose should be applied before veins become distended and edema (swelling) occurs.
4. Hold heel of stocking and gather the rest in your hand turning hose inside out to mid foot area.	
5. Support foot at the heel and slip the front of the stocking over the toes, foot and heel.	
6. Pull the stocking up until it is fully extended.	
7. Smooth away any wrinkles or twisted areas.	7. Wrinkles, creases, or twisted areas can irritate the skin and interfere with circulation.
8. Remove the hose at least twice daily for skin care unless otherwise indicated by physician.	8. Allows you to identify early signs of skin break down.
9. Do final steps.	

CARE SKILLS #77: ADMISSION OF A RESIDENT (Lesson #27)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Prepare the room for the resident by making sure that all necessary equipment and furniture are in its proper place, in good working condition and clean. Make sure bed is made with clean linen and all space is clean. Check for adequate lighting and provide ventilation. Apply resident's name label on door, etc. as needed.	2. Preparing the room in advance can help the resident feel more welcomed and at ease upon arrival, and it allows more time to focus on the resident.
3. Identify the new resident by asking his/her name and by checking the identification. Identify yourself. Greet the resident and family courteously. Call resident by proper or preferred name. Introduce yourself and state your position.	3. Greeting the resident and family and showing kindness helps ease anxiety. Identifying them by proper name shows respect and allows the resident the opportunity to establish how they prefer to be addressed.
4. Take the resident and family to the room. If semi-private room, be sure to introduce resident to roommate.	4. Resident should be introduced to other residents and employees. Helps establish bonds and ease anxiety.
5. Assist resident with getting comfortable in the room. Provide privacy and assistance as needed with transferring to bed/chair, dressing/undressing, or any other task as requested by resident and/or nurse.	
6. Place call light within reach of resident and explain how and why it is used.	6. Gets the resident familiar with how they will contact the staff if assistance is needed.
7. Care for clothing and personal articles according to facility policy. Assist with unpacking and labeling clothing. Label all personal articles and store in bedside table (or appropriate place). Be certain that resident and/or family member(s) know where to place these articles.	7. Labeling articles helps the staff to identify what items belongs to which resident. Ensures that items will be returned to appropriate person. Establishing placement of articles alleviates confusion, especially when room is being shared with another resident.

8. Follow and explain to the resident and family the facility policy for inventory and safekeeping of valuables.	8. Same rationale as above.
9. Give instructions to resident and/or family as to time and place of meals and, as appropriate, provide other orientation such as facility premises, introduction to other staff, etc.	9. Orienting resident and family to facility and staff helps them learn the daily routine, addresses questions/concerns they may have, and helps get them familiar with their new home and caregivers. Alleviates confusion regarding their new surroundings.
10. Obtain vital signs, including temperature, pulse, respiration, and blood pressure. Also obtain weight and height. Record according to facility policy. Follow guidelines for performing each skill accordingly.	10. Establishes baseline levels for nurses to compare to later.
11. Ensure resident is comfortable and has call light available. If permitted, leave fresh ice water within reach.	
12. Record/report completion of procedure. Report to charge nurse: resident's vital signs; any bruises, sores, etc. on the resident's body; any special observations made about the resident. Perform any additional final steps accordingly.	

CARE SKILLS #78: TRANSFER/DISCHARGE OF THE RESIDENT (Lesson #27)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Inform the resident of the move and let them know you are there to assist. Questions or concerns that arise should be addressed by the nurse, unless informed otherwise.	2. Some information may be different from what you were previously told. It is best for the nurse to provide updates and address any concerns/questions.
3. Collect all personal items that are to be moved with the resident and assist with packing as needed. Secure valuables per facility policy. Ensure that all items on the inventory list are there. Report to the nurse if items are missing. Take items to designated pick-up area.	3. Nurse should be aware of missing items so that attempts can be made to locate them. If possible, take belongings to designated area first to make transporting the resident easier.
4. Assist the resident with getting dressed if necessary.	
5. Before the resident leaves the unit, confirm with the nurse that all discharge procedures have been completed.	5. Helps to ensure that steps are not being missed.
6. Speak with the nurse to determine how the resident is to be transported (in his/her own bed, wheelchair, or stretcher). Transport accordingly.	
7. Allow and assist the resident to say goodbye to the staff and other residents while being transported to the designated pick-up area.	
8. Assist resident with getting into the vehicle and ensure that their belongings are also loaded.	
9. Wash hands. Document and report. Perform any additional final steps accordingly.	

CARE SKILLS #79: POSTMORTEM CARE (Lesson #28)	
STEP – Initial Steps: Check the resident's care plan/closet care plan first.	**RATIONALE**
1. Do initial steps.	
2. Put on gloves.	2. Protects you from contamination by bodily fluids.
3. Respect the family's religious restrictions regarding the care of body, if applicable.	3. Residents/families have the right to freedom of religion.
4. Assist roommate to leave the area until body is prepared and removed, if applicable.	4. Reduces the roommate's stress.
5. Place body in supine position.	5. Prepares body for procedure.
6. Place one pillow beneath resident's head.	6. Prevents blood from discoloring the face by settling in it.
7. Close the eyes.	
8. Insert dentures, if this is the facility policy, and close the mouth.	8. It is easier to put dentures in the mouth right away and gives the face a natural appearance.
9. Cleanse body as necessary. Comb hair.	9. Prepares the body for viewing by family and friends.
10. Place a pad under the buttocks to collect any drainage.	10. Due to total loss of muscle tone, urine and/or stool may drain from the body even after death.
11. Put a clean hospital gown on resident and place body in a comfortable looking position to allow family and friends to view the body.	
12. Remove gloves.	
13. Do final steps.	
14. After the mortuary has removed the body, strip the bed and clean the room according to facility policy.	

Appendix D
Task Performance Record

Trainee's Name		**SS#**	
Primary Instructor's Name			
Program Name			
Program's Address		**Telephone**	

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Initial Steps			
Final Steps			
Handwashing/Hand Rub			
Gloves			
Gown (PPE)			
Mask			
Fire			
Fire Extinguisher			
Falling or Fainting			
Choking			
Seizures			
Unoccupied Bed			
Thickened Liquids			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Measure & Record Fluid Intake/Urinary Output			
Passing Fresh Ice Water			
Serving Meal Tray			
Nasal Cannula Care			
Shower/Shampoo			
Bed Bath/Catheter Care/Perineal Care			
Back Rub			
Shampoo Hair in Bed			
Whirlpool			
Oral Care			
Oral Care for the Unconscious Resident			
Denture Care			
Shaving with an Electric Razor			
Shaving with a Safety Razor			
Comb/Brush Hair			
Fingernail Care			
Foot Care			
Change a Resident's Gown			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Dressing a Dependent Resident			
Assist to Bathroom			
Bedside Commode			
Bedpan/Fracture Bedpan			
Urinal			
Empty Urinary Drainage Bag			
Urine Specimen Collection			
Stool Specimen Collection			
Application of Incontinent Brief			
Assist Resident to Move to Head of Bed			
Supine Position			
Lateral Position & Side to Side			
Fowler's Position			
Semi-Fowler's Position			
Use of Wheelchair/Geriatric Chair			
Transfer to Chair			
Sit on Edge of Bed			
Using a Gait Belt to Assist with Ambulation			

TASK PERFORMANCE	Satisfactory Performance Date	Supervising Instructor's Initials	Clinical Performance Date
Walking			
Assist with Walker			
Assist with Cane			
Using a Portable Mechanical Resident Lift			
Transfer to Stretcher/Shower Bed			
Transfer: Two Person Lift			
Occupied Bed			
Inspecting Skin			
Float Heels			
Bed Cradle			
Feeding			
Oral Temperature (Electronic)			
Axillary Temperature			
Pulse and Respiration			
Practical Use of the Pulse Oximeter			
Blood Pressure			

Height			
Weight			
TASK PERFORMANCE	**Satisfactory Performance Date**	**Supervising Instructor's Initials**	**Clinical Performance Date**
Application of Physical Restraints			
Passive Range of Motion			
Splint Application			
Abdominal Binder			
Abduction Pillow			
Knee Immobilizer			
Palm Cones			
Assisting with Hearing Aids			
Elastic/Compression Stocking Application or Ted Hose			
Admission of a Resident			
Transfer/Discharge of the Resident			
Postmortem Care			

I, as Primary Instructor, attest to the competency/skills observations shown on this Task Performance Record, whether performed by me or designated to another training instructor.

_____

Primary Instructor's Signature _____ Date

DMS-741 (Revised 01-19)