

**Module 8: Patient Care Skills**

**Minimum Number of Theory Hours: 14**

**Recommended Clinical Hours: 40**

**Statement of Purpose:**

The purpose of this unit is to teach the students skills needed to support and/or assist the patient/resident in the areas of personal hygiene, an area of activities of daily living, and elimination. Personal hygiene or personal care is generally performed independently. The Nurse Assistant should assist with or perform personal care only when patients/residents are unable to perform a skill for themselves. Other activities included in this module are use of prosthetic devices, bowel and bladder retraining, and weighing and measuring height of the patient/resident.

**Terminology:**

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|--------------------|--------------------------|
| 1. Abrasion        | 20. Hour of sleep (h.s.) |
| 2. Aspiration      | 21. Ileostomy            |
| 3. Axilla          | 22. Impaction            |
| 4. Catheter        | 23. Incontinence         |
| 5. Colostomy       | 24. Jejunostomy          |
| 6. Constipation    | 25. Neuropathy           |
| 7. Cyanosis        | 26. Nits                 |
| 8. Decubitus ulcer | 27. Oral hygiene         |
| 9. Defecation      | 28. Osteomyelitis        |
| 10. Dermis         | 29. Ostomy               |
| 11. Diarrhea       | 30. Perineum/Perineal    |
| 12. Elimination    | 31. Pressure sore        |
| 13. Epidermis      | 32. Prosthesis           |
| 14. Erythema       | 33. Stoma                |
| 15. Eschar         | 34. Stool                |
| 16. Excoriation    | 35. Urinal               |
| 17. Fecal          | 36. Urinary incontinence |
| 18. Feces          | 37. Urination            |
| 19. Flatulence     | 38. Urine                |

Patient, resident, and client are synonymous terms referring to the person receiving care

**Performance Standards (Objectives):**

Upon completion of fourteen (14) hours of class plus homework assignments and forty (40) hours of clinical experience, the learner will be able to:

1. Define key terminology
2. Identify and assist patients/residents with daily routine care, promoting independence and dignity

BATHING and FOOT CARE

3. Identify benefits of bathing and list five areas of body that require bathing daily
4. Describe the procedure for bathing patients/residents and safety guidelines

ORAL HYGIENE

5. List purposes and schedule for oral hygiene
6. Describe procedure of oral hygiene and denture care for a patient/resident needing assistance, and for the unconscious individual

NAIL CARE, HAIR CARE, SHAVING

7. Identify the Nurse Assistant role and responsibility for patient/resident nail care
8. Identify Nurse Assistant role and responsibility for caring for hair of patients/residents
9. Describe procedure for shaving a patient/resident

SKIN CARE

10. List ways to maintain healthy skin and identify at risk patients.
11. Describe causes, signs and symptoms, and staging of pressure sores.
12. Describe general nursing measures to prevent and treat pressure sores

DRESSING THE PATIENT/RESIDENT

13. Describe general guidelines for selecting and caring for patient's/resident's clothing
14. Discuss rationale for use of street clothes and guidelines for dressing or undressing a patient/resident

URINARY AND BOWEL ELIMINATION

15. Describe the usual frequency pattern for urination
16. List the observations to be made about urine
17. Describe urinary incontinence and the need for immediate care
18. Describe the purpose and general rules of care for urinary catheters
19. Describe the goals and methods for bowel and bladder training
20. Describe the normal pattern of bowel movements and reportable observations
21. Explain the purpose of an ostomy and the care of patients/residents with an ostomy

MEASURING HEIGHT AND WEIGHT

22. Describe the procedures for weighing and measuring height of the patient/resident

PROSTHETIC DEVICES

23. Describe common prosthetic devices and their care (artificial limbs, contact lenses, dentures, eyeglasses and hearing aids)
24. Describe the application, removal and care for "behind the ear" hearing aids

**References:**

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3. Carter, P. J. (2017). *Lippincott Essentials for Nursing Assistants: a Humanistic Approach to Caregiving*. (4th ed.) Philadelphia, PA. Lippincott Williams & Wilkins
4. Deck, M. L. (2004). *Instant Teaching Tools for the New Millennium*. St Louis, MO. Mosby
5. Hedman, S. A., Fuzy, J., & Rymer, S. (2018). *Hartman's Nursing Assistant Care: Long-Term Care* (4th ed.). Albuquerque, NM. Hartman Publishing, Inc.
6. Hartman Publishing. (2018). *Workbook for Hartman's Nursing Assistant Care: Long-Term Care* (4th ed.). Albuquerque, NM. Hartman Publishing, Inc.
7. Haroun, L. & Royce, S. (2004). *Teaching Ideas and Activities for Health Care*. Albany, NY. Delmar Publishers
8. Pearson Vue (2018) *California Nurse Assistant Candidate Handbook for National Nurse Aide Assessment Program*. Philadelphia, PA. Pearson Education, Inc.
9. Sorrentino, S. A., Remmert, L., & Kelly, R. (2018) *Workbook and Competency Evaluation Review for Moby's Textbook for Nursing Assistants* (9th ed.) St. Louis, MO. Mosby Company
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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
<p><b>Objective 1</b>  <b>Define Key Terminology</b>                      A. Review the terms listed in the terminology section                      B. Spell the listed terms accurately                      C. Pronounce the terms correctly                      D. Use the terms in their proper context</p>	<p>A. Lecture/Discussion                      B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration                      C. Encourage use of internet, medical dictionary, and textbooks                      D. Handout 8.1a- Patient/resident Care Skills Crossword-1.                      E. Handout 8.1b- Patient/resident Care Skills Crossword-1- KEY                      F. Handout 8.1c- Patient/resident Care Skills Crossword-2                      G. Handout 8.1d-</p>	<p>A. Have students select five words from the list of key terminology and write a sentence for each defining the term                      B. Administer vocabulary pre-test and post-test                      C. Uses appropriate terminology when charting and reporting to licensed personnel</p>
<p><b>Objective 2</b>  <b>Identify and assist patients/residents with daily routine care, promoting independence and dignity.</b>                      A. Each facility has specific policies and procedures related to AM care, PM care and h.s. care                      B. Early morning (AM) care                          1. Offer bedpan/urinal or assist to bathroom, incontinence care, linen change</p>	<p>A. Lecture/Discussion                      B. Demonstration/return demonstration                      C. Role play                      Specific manual skills are listed under each objective</p>	<p>A. Written test                      B. Assists patients/residents with daily routine care</p>

<ul style="list-style-type: none"> <li>2. Wash face and hands</li> <li>3. Offer oral hygiene</li> <li>4. Assist with grooming</li> <li>5. Straighten bed and unit</li> <li>6. Position patient/resident for breakfast</li> <li>C. Morning care after breakfast             <ul style="list-style-type: none"> <li>1. Oral hygiene</li> <li>2. Offer bedpan/urinal or assist to bathroom</li> <li>3. Bathing (includes foot care)</li> <li>4. Shaving</li> <li>5. Hair care</li> <li>6. Dressing</li> <li>7. Skin care</li> <li>8. Assisting with activity (ROM, ambulation)</li> <li>9. Linen change</li> <li>10. Unit maintenance</li> </ul> </li> <li>D. Afternoon care (prepare for meals - lunch and dinner)             <ul style="list-style-type: none"> <li>1. Offer bedpan/urinal or assist to bathroom</li> <li>2. Incontinence care/linen change</li> <li>3. Wash hands/face</li> <li>4. Straighten bed/unit</li> <li>5. Position for meal/take to dining area</li> </ul> </li> <li>E. Evening care (PM care, h.s. care)             <ul style="list-style-type: none"> <li>1. Offer snack when applicable</li> <li>2. Offer bedpan/urinal or assist to bathroom</li> <li>3. Incontinence care/linen change</li> <li>4. Wash hands/face</li> <li>5. Oral hygiene</li> <li>6. Back rub</li> <li>7. Assist into sleepwear</li> <li>8. Straighten bed/unit</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>E. Refer to Manual Skills procedure 8.2- Back rub</li> </ul>	
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<p><b>Objective 3</b>  <b>Identify benefits of bathing and list five areas of body that requires bathing daily.</b></p> <p>A. Benefits of bathing</p> <ol style="list-style-type: none"> <li>1. Cleanliness</li> <li>2. Reduce bacteria and germs</li> <li>3. Promote skin integrity</li> <li>4. Stimulate circulation</li> <li>5. Provide movement and exercise</li> <li>6. Relaxation</li> <li>7. Sense of well-being</li> <li>8. Opportunity for communication and observation</li> </ol> <p>B. Body areas that require bathing</p> <ol style="list-style-type: none"> <li>1. Face</li> <li>2. Arms/underarms (axilla)</li> <li>3. Hands</li> <li>4. Legs/feet</li> <li>5. Perineal area             <ol style="list-style-type: none"> <li>a. Genitals</li> <li>b. Anal area</li> </ol> </li> <li>6. Back</li> <li>7. Any area where skin folds or creases, e.g., under breasts</li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Specific manual skills listed under each objective</p>	<p>A. Written test</p> <p>B. Assists in bathing for patients/residents according to guidelines and facility policy</p>
<p><b>Objective 4</b>  <b>Describe the procedure for bathing patients/residents and safety guidelines.</b></p> <p>A. General steps for bed bath</p> <ol style="list-style-type: none"> <li>1. Check with licensed nurse regarding type of bath             <ol style="list-style-type: none"> <li>a. Complete bed bath</li> <li>b. Partial bed bath                 <ol style="list-style-type: none"> <li>1) Done on days when complete bed bath not given</li> <li>2) The partial bath consists of washing the patient's/resident's face, hands, axilla, back, buttocks, and genital area (perineal care)</li> </ol> </li> </ol> </li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Demonstration/return demonstration</p> <p>C. Role play</p> <p>D. Refer to Manual Skills procedure 8.4a- Bed Bath</p> <p>E. Refer to Manual Skills</p>	<p>A. Written test</p> <p>B. Assists in bathing for patients/residents according to guidelines and facility policy</p>

<ol style="list-style-type: none"> <li>2. Gather equipment (bath blanket, basin, soap, water thermometer, wash cloths, bath towels)</li> <li>3. Wash hands</li> <li>4. Check patient's/resident's personal choices (water temperature, soap etc.)</li> <li>5. Identify patient/resident</li> <li>6. Identify yourself to patient/resident</li> <li>7. Provide privacy             <ol style="list-style-type: none"> <li>a. Close door</li> <li>b. Pull curtain around patient/resident</li> <li>c. Only uncover area being washed</li> <li>d. Facility policy may vary</li> </ol> </li> <li>8. Follow standard precautions and blood borne pathogen standards</li> <li>9. Assure adequate comfort, such as room temperature, freedom from drafts and adequately covered</li> <li>10. Use comfortably warm water, change it when it becomes soapy, dirty or cold</li> <li>11. Bathe areas soiled by fecal material or urine with soap and water</li> <li>12. Wash from cleanest to dirtiest area</li> <li>13. Rinse off all soap</li> <li>14. Pat skin dry</li> <li>15. Encourage patient/resident to help as much as possible</li> </ol> <p>B. Safety guidelines</p> <ol style="list-style-type: none"> <li>1. Monitor correct water temperature</li> <li>2. Use safety equipment, such as grab bars, nonskid surfaces, emergency call buttons and safety belts</li> <li>3. Stay with patient/resident</li> <li>4. Use correct body mechanics</li> </ol> <p>C. Reportable observations during bathing</p> <ol style="list-style-type: none"> <li>1. Color of skin, whites of eyes, lips, nail beds</li> <li>2. Rashes; locations and description</li> </ol>	<p>procedure 8.4b- Tub Bath</p> <p>F. Refer to Manual Skills Procedure 8.4c- Modified Bed Bath-For Testing</p> <p>G. Refer to Objective 17 for Perineal Care</p>	
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<ul style="list-style-type: none"> <li>3. Dry skin, bruising or open areas</li> <li>4. Pale or reddened areas</li> <li>5. Drainage or bleeding</li> <li>6. Swollen legs or feet</li> <li>7. Complaints of pain or discomfort</li> <li>8. Skin temperature</li> </ul>		
<p><b>Objective 5</b>  <b>List purposes and schedule for oral hygiene.</b></p> <ul style="list-style-type: none"> <li>A. Purpose             <ul style="list-style-type: none"> <li>1. Cleanliness of mouth and teeth</li> <li>2. Prevent mouth odor and infection</li> <li>3. Prevent dental disease and tooth loss</li> <li>4. Comfort</li> <li>5. Pleasant taste</li> <li>6. Improve taste of food</li> </ul> </li> <li>B. When to perform oral hygiene             <ul style="list-style-type: none"> <li>1. On awakening</li> <li>2. After each meal</li> <li>3. At bed time</li> </ul> </li> <li>C. Special circumstances; when the patient/resident needs more frequent care             <ul style="list-style-type: none"> <li>1. Unconscious – patient/resident should be side-lying to avoid choking and aspiration</li> <li>2. Mouth breather</li> <li>3. O2</li> <li>4. NG tube or NPO</li> <li>5. Elevated temperature</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture</li> <li>B. Discussion</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Performs or assists with oral hygiene and reports significant findings</li> </ul>



<p><b>Objective 6</b>  <b>Describe procedure of oral hygiene and denture care for a patient/resident needing assistance, and for the unconscious individual.</b></p> <p>A. Carry out procedure using standard precautions</p> <ol style="list-style-type: none"> <li>1. Contact with mucous membranes</li> <li>2. Gums may bleed</li> <li>3. Pathogens may exist in the mouth</li> </ol> <p>B. Examine oral cavity and report findings</p> <ol style="list-style-type: none"> <li>1. Dry, cracked, swollen or blistered lips</li> <li>2. Redness, swelling, sores or white patches in the mouth or on the tongue</li> <li>3. Redness, swelling or bleeding of gums</li> <li>4. Loose broken or chipped teeth</li> <li>5. Patient/resident complaints</li> </ol> <p>C. Dentures</p> <ol style="list-style-type: none"> <li>1. Dentures are very costly and fragile</li> <li>2. Handle with care at all times</li> <li>3. Any observed damage to dentures</li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Demonstration/return demonstration</p> <p>C. Role play</p> <p>D. Refer to Manual Skill procedure 8.6a- Providing Mouth Care</p> <p>E. Refer to Manual Skill procedure 8.6b- Assisting with Mouth Care</p> <p>F. Refer to Manual Skill procedure 8.6c- Mouth Care of the Unconscious Patient/resident</p> <p>G. Refer to Manual Skill procedure 8.6d- Providing Denture Care</p>	<p>A. Written test</p> <p>B. Performs or assists with oral hygiene and reports significant findings</p>
<p><b>Objective 7</b>  <b>Identify the Nurse Assistant’s role and responsibility for patient/resident nail care and foot care.</b></p> <p>A. Performed to prevent infection, injury and odors. Guidelines:</p> <ol style="list-style-type: none"> <li>1. Nails are easier to clean after soaking in warm, soapy water</li> <li>2. Cut fingernails with clippers, not scissors (if facility allows)</li> <li>3. File fingernails with emery board</li> <li>4. When trimming fingernails, be cautious to prevent damage to tissues</li> <li>5. Do not trim nails on patient/resident with diabetes or if on medication that affects blood clotting and circulatory problems</li> <li>6. Do not cut or trim toenails</li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Demonstration/return demonstration</p> <p>C. Role play</p> <p>D. Refer to Manual Skill procedure 8.7a- Fingernail Care</p> <p>E. Refer to Manual Skill Procedure 8.7b- Foot Care</p>	<p>A. Written test</p> <p>B. Performs nail care according to guidelines and reports observations as required</p>

<ul style="list-style-type: none"> <li>7. Report unusual conditions to licensed nurse such as redness or tenderness of finger tips, cuticles or toes</li> <li>8. Follow facility procedure</li> </ul>		
<p><b>Objective 8</b>  <b>Identify the Nurse Assistant’s role and responsibility for caring for hair or patients/residents.</b></p> <ul style="list-style-type: none"> <li>A. Hair care             <ul style="list-style-type: none"> <li>1. Part of daily care</li> <li>2. Important for identity and self-esteem</li> <li>3. Accommodate patient/resident preferences for style, hair products</li> <li>4. Shampoo Types                 <ul style="list-style-type: none"> <li>a. Shower/tub</li> <li>b. Sink</li> <li>c. Bed</li> </ul> </li> <li>5. Medicinal shampoos are performed per facility policy</li> </ul> </li> <li>B. Report observations             <ul style="list-style-type: none"> <li>1. Scalp sores</li> <li>2. Flaking</li> <li>3. Presence of lice</li> <li>4. Patches of hair loss</li> <li>5. Very dry or oily hair</li> <li>6. How procedure was tolerated</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Demonstration/return demonstration</li> <li>C. Role play</li> <li>D. Refer to Manual Skill Procedure 8.8a - Combing the Patient’s/resident’s Hair</li> <li>E. Refer to Manual Skill procedure 8.8b- Shampoo with Shower/Tub Bath</li> <li>F. Refer to Manual Skill procedure 8.8c- Shampoo of Bedridden Patient/resident</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Cares for patient’s/resident’s hair daily</li> </ul>
<p><b>Objective 9</b>  <b>Describe procedure for shaving a patient/resident.</b></p> <ul style="list-style-type: none"> <li>A. Important for feelings of comfort and self-esteem</li> <li>B. Guidelines             <ul style="list-style-type: none"> <li>1. Use either electric razor or safety razor (patient/resident choice/facility policy)</li> <li>2. If using an electric razor use appropriate safety precautions for electrical equipment</li> <li>3. Safety razors can cause nicks or cuts; use standard precautions to prevent contact with blood</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Demonstration/return demonstration</li> <li>C. Role play</li> <li>D. Refer to Manual Skill Procedure 8.9- Shaving the Patient/resident</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Follows guidelines for shaving patients/residents</li> </ul>

<p><b>Objective 10</b>  <b>List ways to maintain healthy skin and identify at risk patients.</b></p> <p>A. Maintain skin health</p> <ol style="list-style-type: none"> <li>1. Encourage well-balanced diet and fluids</li> <li>2. Provide skin care             <ol style="list-style-type: none"> <li>a. Bathe as necessary</li> <li>b. Rinse off soap thoroughly</li> <li>c. Apply lotion as necessary</li> <li>d. Massage healthy skin</li> <li>e. Keep skin clean and dry</li> </ol> </li> <li>3. Observe high-risk patients/residents for potential problems</li> <li>4. Give special attention to bony prominences             <ol style="list-style-type: none"> <li>a. Turn and position the patient/resident correctly</li> <li>b. Keep pressure off of reddened or irritated areas</li> </ol> </li> <li>5. Do not massage red, purple, or irritated areas</li> <li>6. Only massage healthy tissue around the area</li> <li>7. Keep bed free of small objects and linen free of wrinkles</li> <li>8. Keep patient/resident clean &amp; dry</li> <li>9. Prevent shearing and friction</li> <li>10. Report and record observations</li> </ol> <p>B. Factors that place patients/residents at high risk for skin breakdown</p> <ol style="list-style-type: none"> <li>1. Mobility/sensory problems             <ol style="list-style-type: none"> <li>a. Paraplegic or quadriplegic</li> <li>b. CVA</li> <li>c. Peripheral vascular disease</li> <li>d. Bed rest or decreased mobility</li> <li>e. Decreased sensation</li> <li>f. COPD                 <ol style="list-style-type: none"> <li>1) Low oxygen level</li> <li>2) Continuous high Fowlers</li> <li>3) Medications</li> </ol> </li> <li>g. Circulatory problems</li> </ol> </li> </ol>	<p>A. Lecture          B. Discussion          C. Handout 8.10- High Risk Factors for Skin Breakdown and Interventions to Prevent</p>	<p>A. Written test          B. Provides care to maintain skin health and prevent skin breakdown</p>
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<ul style="list-style-type: none"> <li>1) Diabetes</li> <li>2) Arterial disease with decreased sensation (neuropathy)</li> <li>3) Poor circulation and healing</li> <li>2. Elimination             <ul style="list-style-type: none"> <li>a. Incontinent of stool or urine</li> <li>b. Diarrhea</li> <li>c. Diaphoresis</li> <li>d. Dehydrated</li> <li>e. Leaking tubes or drainage</li> </ul> </li> <li>3. Fluid status             <ul style="list-style-type: none"> <li>a. Edema (swelling)</li> <li>b. Dehydration</li> </ul> </li> <li>4. Nutrition/body structure             <ul style="list-style-type: none"> <li>a. Obese</li> <li>b. Thin</li> <li>c. Poor appetite</li> <li>d. Nutritional lab values are low</li> <li>e. Poor fluid balance</li> <li>f. Poor nail care</li> </ul> </li> <li>5. Other predisposing factors             <ul style="list-style-type: none"> <li>a. Medications like Prednisone make the skin fragile and heal slower</li> <li>b. Cancer</li> <li>c. Splints/casts/prosthetic devices</li> <li>d. Anemia</li> <li>e. Age</li> </ul> </li> </ul>		
<p><b>Objective 11</b>  <b>Describe causes, signs and symptoms, and staging of pressure sores.</b></p> <ul style="list-style-type: none"> <li>A. Common conditions which can lead to pressure sores             <ul style="list-style-type: none"> <li>1. Pressure leads to decreased blood flow and nutrition of an area resulting in tissue loss</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture</li> <li>B. Discussion</li> <li>C. Handout 8.11- Staging for pressure sores</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> </ul>

<p>2. Excessively wet or dry skin</p> <p>3. Moving patients/residents causing shearing force</p> <p>B. Stages; signs and symptoms</p> <p>1. Stage 1</p> <ul style="list-style-type: none"> <li>a. Skin is not broken. The epidermis and dermis are intact</li> <li>b. Erythema (redness) that does not resolve within 15-30 minutes</li> </ul> <p>2. Stage 2</p> <ul style="list-style-type: none"> <li>a. Skin not intact</li> <li>b. Partial skin loss of the inner and/or outer skin layer (epidermis is damaged and part of the dermis can be involved)</li> <li>c. Skin can be blistered, cracked, and open with erythema or appear as a shallow crater</li> <li>d. No necrotic or dead tissue is present</li> <li>e. Wound bed is moist, pink and painful</li> </ul> <p>3. Stage 3</p> <ul style="list-style-type: none"> <li>a. Full-thickness skin loss with both epidermis and dermis gone</li> <li>b. Damage extends to, but not through the tissue that covers the muscle</li> <li>c. Can have part of dermis left with necrotic tissue</li> <li>d. Possible drainage</li> </ul> <p>4. Stage 4</p> <ul style="list-style-type: none"> <li>a. Full skin loss with major destruction and tissue death</li> <li>b. Involves subcutaneous tissues – possible fatty tissue, muscle and/or bone</li> <li>c. Can see pink healthy cells, necrotic tissue and eschar</li> <li>d. Wound can tunnel or have undermining in skin surrounding wound</li> <li>e. Risk that bone may become infected (osteomyelitis)</li> </ul>		
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<p><b>Objective 12</b>  <b>Describe general nursing measures to prevent and treat pressure sores.</b></p> <p>A. Nursing measures to prevent and treat pressure sores</p> <ol style="list-style-type: none"> <li>1. Mobility/sensory             <ol style="list-style-type: none"> <li>a. Control pressure by pressure-reducing devices or special beds</li> <li>b. Turn every two hours at least</li> <li>c. Position with proper support of the body and limbs</li> <li>d. Promote active range of motion exercises or assist patient/resident with them</li> <li>e. Teach or assist patient/resident using a wheel chair to change position frequently</li> <li>f. Prevent shearing and friction during lifting, moving, transferring and repositioning procedures</li> <li>g. Keep bed linens clean, crumb free, and avoid wrinkles</li> <li>h. Watch tubing (like Foley Catheter) does not cause pressure</li> <li>i. Remove patients/residents from toilets and bedpans promptly</li> <li>j. Encourage circulation by gentle massage around red area; not over red area</li> <li>k. Check skin every eight hours</li> <li>l. Keep head of bed (H.O.B.) at 30 degrees as much as possible to avoid sacral pressure</li> </ol> </li> <li>2. Elimination             <ol style="list-style-type: none"> <li>a. Keep skin clean and dry; apply powder where skin touches skin. Watch diaphoretic (sweaty) patient/resident</li> <li>b. Check incontinent patient/resident every two hours and ensure dry and clean (even when using adult incontinence garment)</li> <li>c. Monitor incontinence garment– plastic edges near skin can cause irritation</li> <li>d. Avoid scrubbing or rubbing when bathing and drying</li> <li>e. Use blankets and pillows to prevent skin from being in contact with skin</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Show pictures of wounds in various stages</li> <li>C. Handout 8.12- Sitting on hand exercise: Sit on hands for 5 minutes Observe changes in color, sensation, etc.</li> <li>D. Share examples of how nursing assistants can be involved in QA/PI activities</li> </ol>	<ol style="list-style-type: none"> <li>A. Written test</li> <li>B. Uses techniques to prevent pressure sores</li> <li>C. Reports signs and symptoms of pressure sore formation to licensed nurse</li> </ol>
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<ul style="list-style-type: none"> <li>3. Fluid status             <ul style="list-style-type: none"> <li>a. Elevate limb that has edema</li> <li>b. Monitor compression devices, such as anti-embolic stockings and ace bandages. Remove every eight hours, check skin and watch edges do not cut into skin</li> <li>c. Encourage fluids to 1500-2000ml/day or as per care plan</li> </ul> </li> <li>4. Nutrition status/body structure             <ul style="list-style-type: none"> <li>a. Encourage and assist with balanced diet</li> <li>b. Obese patient/resident; check skin folds</li> <li>c. Monitor bony prominences on thin patients/residents</li> </ul> </li> <li>5. Others; monitor casts, braces, and clothing items that may cause pressure against skin</li> <li>B. Use of pressure-reducing devices             <ul style="list-style-type: none"> <li>1. Nothing replaces basic nursing care</li> <li>2. Still must turn position and keep patient/resident clean and dry</li> <li>3. Types of pressure reducing devices                 <ul style="list-style-type: none"> <li>a. Bed cradle; keeps pressure off feet and lower legs</li> <li>b. Sheepskin</li> <li>c. Heel and elbow protectors – shearing effect</li> <li>d. Egg crate type pads/gel cushions</li> <li>e. Alternating pressure mattress</li> <li>f. Air fluidization bed (for example Clinitron or KinAir)</li> <li>g. Trochanter rolls</li> <li>h. Flotation pads or cushions</li> </ul> </li> </ul> </li> <li>C. Legal, Quality Assurance (QA) and Performance Improvement(PI) issues             <ul style="list-style-type: none"> <li>1. Duty to keep patient/resident from harm and prevent sores</li> <li>2. There are increased legal risks associated with patients/residents developing pressure sores when there are no preventive measures implemented</li> <li>3. Utilization Review (UR) issues – huge increase cost to facility</li> </ul> </li> </ul>		
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<p><b>Objective 13</b>  <b>Describe general guidelines for selecting and caring for patient's/resident's clothing.</b></p> <p>A. Selecting clothing for the patient/resident</p> <ol style="list-style-type: none"> <li>1. Fits well</li> <li>2. Comfortable – including finding out whether the patient/resident is warm enough, but not too warm</li> <li>3. Easy to get on and off</li> <li>4. Neat - looks nice and attractive – respect the patient's/resident's own individual taste and choice of what clothing to wear</li> <li>5. In good condition – has no wrinkles or holes, has snaps, fasteners, buckles and buttons, which function as they should</li> </ol> <p>B. Clothing is personal property</p> <ol style="list-style-type: none"> <li>1. Label clothes with patient's/resident's name and write on personal belongings list</li> <li>2. Avoid cutting or tearing</li> <li>3. Do not discard</li> <li>4. Store in the patient's/resident's unit</li> <li>5. Fold neatly or hang on hangers in closet</li> <li>6. Find out whether family or facility will clean soiled clothing and put into dirty clothes container</li> <li>7. Assist patient/resident or family to choose clothing that meets physical needs and looks good</li> <li>8. Do not use patient's/resident's clothing or personal items for another patient/resident</li> </ol>	<p>A. Lecture                  B. Discussion</p>	<p>A. Written test</p>
<p><b>Objective 14</b>  <b>Discuss rationale for use of street clothes and guidelines for dressing or undressing a patient/resident.</b></p> <p>A. Purpose of dressing in street clothes</p> <ol style="list-style-type: none"> <li>1. How a patient/resident looks has an effect and influences their feelings of dignity and self-esteem as well as how others perceive them</li> <li>2. It encourages patients/residents to be more independent about their activities in daily living (ADL's)</li> </ol>	<p>A. Lecture/Discussion                  B. Demonstration/return demonstration                  C. Role play</p>	<p>A. Written test                  B. Follows guidelines in dressing a dependent patient/resident and in assistant</p>



<p>B. Factors that limit a patient's/resident's ability to dress self</p> <ol style="list-style-type: none"> <li>1. Limitation of body movement             <ol style="list-style-type: none"> <li>a. Brain impairment, as in dementia, mental retardation, injury, or coma</li> <li>b. Weakness</li> <li>c. Pain</li> <li>d. Fractures</li> <li>e. Contractures</li> <li>f. Amputation</li> <li>g. Paralysis</li> </ol> </li> <li>2. Other factors             <ol style="list-style-type: none"> <li>a. Special equipment, such as IV's, casts or braces</li> <li>b. Blindness</li> <li>c. Psychological factors, such as depression, fear of pain</li> </ol> </li> </ol> <p>C. Guidelines for dressing/undressing patient/resident</p> <ol style="list-style-type: none"> <li>1. Provide for privacy</li> <li>2. Encourage the patient/resident to do as much as possible</li> <li>3. Allow patients/residents to choose what to wear</li> <li>4. While assisting the patient/resident, be gentle, while supporting all extremities</li> <li>5. Follow patient's/resident's individual choices in use of makeup, jewelry, perfume, etc.</li> </ol> <p>D. Reportable observations</p> <ol style="list-style-type: none"> <li>1. How much help is provided</li> <li>2. How patient/resident tolerated procedure</li> <li>3. Any complaint from patient/resident</li> </ol>	<p>D. Refer to Manual Skill Procedure 8.14a- Dressing and Undressing a Patient/resident</p> <p>E. Refer to Manual Skill Procedure 8.14b- Dressing a Patient/resident with an Affected (Weak) Right Arm</p>	<p>a partially dependent patient/resident</p>
<p><b>Objective 15</b>  <b>Describe the usual frequency pattern for urination.</b></p> <p>A. Frequency of urination depends on</p> <ol style="list-style-type: none"> <li>1. Amount of fluid ingested</li> <li>2. Personal habits</li> <li>3. Availability of toilet facilities</li> </ol>	<p>A. Lecture/Discussion            B. Demonstrate and return</p>	<p>A. Written test            B. Assists patient/resident with</p>

<ul style="list-style-type: none"> <li>4. Physical activities</li> <li>5. Illness/infection</li> </ul> <p>B. Frequency ranges from every 2-3 hours to every 8-12 hours</p> <ul style="list-style-type: none"> <li>1. Each patient/resident has different urination needs</li> <li>2. It is important to keep the patient's/resident's routine as normal as possible</li> </ul>	<p>demonstration of positioning bedpan</p> <ul style="list-style-type: none"> <li>C. Role Play</li> <li>D. Refer to Manual Skill Procedure 8.15- Assist with Use of Bedpan/Urinal</li> </ul>	<p>bedpan as needed</p> <p>C. Follows facility policy for bladder training</p>
<p><b>Objective 16</b>  <b>List the observations to be made about urine.</b></p> <p>A. Observations made about urine:</p> <ul style="list-style-type: none"> <li>1. Color</li> <li>2. Clarity</li> <li>3. Odor</li> <li>4. Amount</li> </ul> <p>B. Information that should be reported to the licensed nurse</p> <ul style="list-style-type: none"> <li>1. Urine that appears abnormal             <ul style="list-style-type: none"> <li>a. Cloudy, stones, gravel, sediment</li> <li>b. Pinkish or reddish tint</li> <li>c. Dark color/concentration</li> </ul> </li> <li>2. Patient/resident complaints             <ul style="list-style-type: none"> <li>a. Urgency</li> <li>b. Burning on urination</li> <li>c. Difficulty in urinating</li> <li>d. Feeling of pressure in area of bladder</li> <li>e. Frequency</li> <li>f. Strong odor</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Refer to Manual Skill Procedure 8.16- Measures and Records Urinary Output</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Reports observations and patient/resident complaints according to policy</li> </ul>
<p><b>Objective 17</b>  <b>Describe urinary incontinence and the need for immediate care.</b></p> <p>A. Urinary incontinence</p> <ul style="list-style-type: none"> <li>1. Inability to control the passage of urine from the bladder             <ul style="list-style-type: none"> <li>a. Constant leakage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Demonstrate and return demonstration on manikin</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Performs hygiene measures in a safe manner while avoiding</li> </ul>

<ul style="list-style-type: none"> <li>b. Occasional leakage when laughs, coughs or sneezes</li> <li>c. No control</li> <li>2. Causes             <ul style="list-style-type: none"> <li>a. Central nervous system problems</li> <li>b. Spinal cord injury</li> <li>c. Aging</li> <li>d. Confusion/disorientation</li> <li>e. Medications</li> <li>f. Weak pelvic muscles</li> <li>g. Urinary tract infection</li> <li>h. Prostate problems (male)</li> <li>i. Prolapse of uterus and bladder (female)</li> <li>j. Restraints</li> <li>k. Immobility</li> <li>l. Unanswered call lights</li> <li>m. Not having signal light within reach</li> <li>n. Urinary frequency/urgency</li> <li>o. Failure to toilet frequently</li> </ul> </li> <li>3. Signs of possible need to go to the bathroom             <ul style="list-style-type: none"> <li>a. Restlessness</li> <li>b. Fidgeting</li> <li>c. Pulling at clothes/undressing</li> <li>d. Holding or pointing at genitals</li> <li>e. Crying</li> </ul> </li> <li>4. Nursing measures             <ul style="list-style-type: none"> <li>a. Record incontinent episodes</li> <li>b. Answer call lights promptly</li> <li>c. Promote normal elimination</li> </ul> </li> <li>B. Immediate care is important to prevent             <ul style="list-style-type: none"> <li>1. Embarrassment, shame, anger, frustration, and depression</li> <li>2. Development of odors</li> <li>3. Patient/resident is uncomfortable</li> </ul> </li> </ul>	<p>C. Refer to Manual Skill procedure 8.17- Perineal Care</p>	<p>embarrassment of the patient/resident</p>
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<ul style="list-style-type: none"> <li>4. Skin breakdown             <ul style="list-style-type: none"> <li>a. Infection</li> <li>b. Irritation, redness or rashes</li> </ul> </li> <li>5. Disposable briefs are to be avoided as it may cause low self-esteem and skin irritation, and may encourage incontinence</li> <li>C. Nursing measures             <ul style="list-style-type: none"> <li>1. Record voiding</li> <li>2. Promote normal elimination</li> <li>3. Follow elimination training programs</li> <li>4. Encourage easy to remove clothing</li> <li>5. Provide good skin care &amp; perineal care</li> <li>6. Dry garments and linens</li> <li>7. Observe for skin breakdown</li> <li>8. Use incontinent products as directed</li> <li>9. Maintain clean, pleasant environment</li> </ul> </li> </ul>		
<p><b>Objective 18</b>  <b>Describe the purpose and general rules of care for urinary catheters.</b></p> <ul style="list-style-type: none"> <li>A. Definition of urinary catheter             <ul style="list-style-type: none"> <li>1. Plastic or rubber tube used to drain or inject fluid through a body opening</li> <li>2. Most commonly used to drain the bladder</li> <li>3. One end is placed in the bladder and the other end is attached by tubing to a drainage bag</li> <li>4. Catheters are inserted by licensed personnel using sterile technique</li> </ul> </li> <li>B. Types of indwelling catheters             <ul style="list-style-type: none"> <li>a. "Foley"</li> <li>b. Retention</li> <li>c. Suprapubic</li> <li>d. Straight catheter</li> </ul> </li> <li>C. Purpose of urinary catheter</li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Show equipment-urinary catheter and drainage system</li> <li>C. Demonstrate and return demonstration for emptying drainage bag</li> <li>D. Refer to Manual Skill Procedure 8.18a- Empty Urinary Drainage Bags</li> <li>E. Refer to Manual Skill Procedure 8.18b- Catheter Care for Female</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Follows guidelines when caring for urinary catheters and drainage systems</li> </ul>

<ul style="list-style-type: none"> <li>1. Complete loss of bladder control</li> <li>2. Urinary retention (inability to urinate)</li> <li>3. Before, during, and after surgical procedures</li> <li>4. Too weak or disabled to use commode, bedpan or bathroom</li> <li>5. Prevention of urine contamination on wounds and pressure ulcers</li> <li>6. Not for convenience</li> <li>D. Complication resulting from catheters             <ul style="list-style-type: none"> <li>1. Bladder infection</li> <li>2. Blockage</li> <li>3. General rules of catheter care                 <ul style="list-style-type: none"> <li>a. Tubing should not be kinked or compressed (urine should flow without obstruction). Coil tubing on the bed</li> <li>b. Do not pull on catheter tubing</li> <li>c. Keep drainage bag below level of the bladder</li> <li>d. Drainage bag should be attached to the bed frame, not the side rail</li> <li>e. Never allow bag to touch the floor</li> <li>f. Catheter should be secured to the inner thigh</li> <li>g. Clean the perineal area and around the catheter, soapy water is adequate (use the procedure for catheter care preferred by facility)</li> <li>h. Drainage bag should be emptied and measured each shift (or more often if ordered/required)</li> <li>i. Report patient/resident complaints promptly to the licensed nurse</li> <li>j. Follow the rules of asepsis at all times, keep drainage systems closed</li> <li>k. Check for leaks and report status</li> <li>l. Use separate measuring containers for each patient/resident</li> <li>m. Encourage fluids</li> </ul> </li> </ul> </li> <li>E. Report observations</li> </ul>		
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<p>2. Color, clarity, odor, presence of particles</p>		
<p><b>Objective 19</b>  <b>Describe the goals and methods for bowel and bladder training.</b></p> <p>A. General Guidelines</p> <ol style="list-style-type: none"> <li>1. Goal is to regain voluntary control of bowels and bladder</li> <li>2. Follow standard precautions</li> <li>3. Follow bowel and bladder training schedule</li> <li>4. Offer toileting per facility protocol</li> <li>5. Explain schedule to patient/resident</li> <li>6. Encourage proper diet</li> <li>7. Answer call light immediately</li> <li>8. Provide for privacy</li> <li>9. Assist with perineal care to prevent skin breakdown</li> <li>10. Keep accurate record of elimination pattern following facility protocol</li> </ol> <p>B. Bladder training</p> <ol style="list-style-type: none"> <li>1. If having difficulty voiding             <ol style="list-style-type: none"> <li>a. Have patient/resident lean forward slightly</li> <li>b. Run water</li> <li>c. Never rush patient/resident</li> </ol> </li> <li>2. Follow facility policy for clamping of urinary catheter</li> </ol> <p>C. Bowel training</p> <ol style="list-style-type: none"> <li>1. Suppository at a regular time</li> <li>2. Increase fluids</li> <li>3. Diet will affect regularity</li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Share sample policy for bowel and bladder training</p> <p>C. Handout 8.19- Bowel and Bladder Assessment Program</p>	<p>A. Written test</p> <p>B. Follows facility policy for bowel and bladder training</p>
<p><b>Objective 20</b>  <b>Describe the normal pattern of bowel movements and reportable observations.</b></p> <p>A. Each person is different and has own pattern</p> <ol style="list-style-type: none"> <li>1. Frequency – daily to every 2 to 3 days</li> <li>2. Time of day – morning or evening</li> <li>3. The Nurse Assistant should note and report stool shape, size,</li> </ol>	<p>A. Lecture/Discussion</p> <p>B. Refer to Manual Skill Procedure 8.20- Assisting Patient/resident to</p>	<p>A. Written test</p> <p>B. Assists patients/residents with elimination as needed</p>

<p>frequency, color, consistency, complaints of pain with defecation, etc.</p> <p>B. Notable observations</p> <ol style="list-style-type: none"> <li>1. Stool shape</li> <li>2. Size</li> <li>3. Frequency</li> <li>4. Color</li> <li>5. Consistency</li> <li>6. Amount</li> <li>7. Complaints of pain with defecation</li> </ol> <p>C. Factors influencing bowel movements</p> <ol style="list-style-type: none"> <li>1. Privacy – fear of others, hearing and/or smelling</li> <li>2. Age – as patient/resident ages, more problems</li> <li>3. Diet – need balanced diet with regular meals, food stimulates bowel movement</li> <li>4. Fluids – need adequate fluid</li> <li>5. Activity – stimulates</li> <li>6. Medications – most tend to constipate</li> <li>7. Personal habits</li> <li>8. Disabilities</li> </ol> <p>D. General rules for maintaining normal elimination patterns</p> <ol style="list-style-type: none"> <li>1. Promptly provide the bedpan, urinal, or commode, or help the patient/resident to the bathroom when the request is made</li> <li>2. Assist the patient/resident to get into normal position (as much as is possible or safe)</li> <li>3. Cover the patient/resident for privacy and warmth</li> <li>4. Remain nearby if the person is weak or frail</li> <li>5. Place the signal light and toilet tissue nearby</li> <li>6. Allow the person time to carry out the elimination process</li> <li>7. If patient/resident has difficulty, ask them what kinds of things they did at home to assist them, i.e., running water, reading or looking at a magazine</li> </ol>	<p>Commode/Toilet</p>	
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<ul style="list-style-type: none"> <li>8. Provide perineal care if needed</li> <li>9. Offer the opportunity to eliminate at regular intervals</li> </ul>		
<p><b>Objective 21</b>  <b>Explain the purpose of an ostomy and the care of patients/residents with an ostomy.</b></p> <ul style="list-style-type: none"> <li>A. Definition of ostomy             <ul style="list-style-type: none"> <li>1. Surgical creation of an artificial opening most commonly into colon or small intestine</li> <li>2. Some ostomies are for urinary drainage, i.e. nephrostomy, ureterostomy</li> <li>3. Urine or feces and flatus pass through opening</li> <li>4. Allow for healing of intestine after surgery or disease</li> <li>5. Can be temporary or permanent</li> </ul> </li> <li>B. Terms used with ostomy patients/residents             <ul style="list-style-type: none"> <li>1. Stoma – a portion of the intestine brought to the surface of the abdomen to allow for drainage                 <ul style="list-style-type: none"> <li>a. Pink and moist/red like mucous membrane</li> <li>b. Size and shape are different depending on area of intestine and patient/resident</li> <li>c. Can bleed when cleaned</li> </ul> </li> <li>2. Peristomal skin – the skin around the stoma; it should be clean, intact and dry</li> <li>3. Appliance – the wafer and pouch or bag that protects the patient’s/resident’s skin and collects the drainage</li> </ul> </li> <li>C. Ostomy types             <ul style="list-style-type: none"> <li>1. Location depends on the disease or injury</li> <li>2. Names according to location                 <ul style="list-style-type: none"> <li>a. Colostomy                     <ul style="list-style-type: none"> <li>1) Ascending and transverse                         <ul style="list-style-type: none"> <li>a) Stool is consistency of pureed liquid with slightly acidic content</li> <li>b) Must wear pouch all the time</li> </ul> </li> </ul> </li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Show supplies for colostomy care</li> <li>C. Demonstrate/return demonstration on manikin for colostomy care</li> <li>D. Refer to Manual Skill procedure 8.21- Colostomy Care</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Follows guidelines when providing care for patient’s/resident’s with colostomy</li> <li>C. Follows guidelines when changing ostomy appliance</li> <li>D. Follows guidelines when emptying ostomy bag</li> <li>E. Provides skin care to patient/resident with an ostomy</li> </ul>



<ul style="list-style-type: none"> <li>c) Chew food well with a lot of fluids</li> <li>2) Descending and sigmoid             <ul style="list-style-type: none"> <li>a) Stool formed and looks “normal”</li> <li>b) Pattern of stool drainage - every day or every other day</li> <li>c) May irrigate (enema)</li> <li>d) Regular diet</li> <li>e) May wear small patch, not pouch</li> </ul> </li> <li>b. Ileostomy, small intestine (ileum)             <ul style="list-style-type: none"> <li>1) Continuous liquid stool with large acidic content</li> <li>2) About 1000-1500 ml output every day</li> <li>3) Empty pouch every 2-4 hours or when one-third full</li> <li>4) Watch skin for irritation if there is leakage</li> <li>5) Very special diet</li> <li>6) Fluid and electrolyte problems</li> </ul> </li> <li>c. Jejunostomy, small intestine (jejunum)             <ul style="list-style-type: none"> <li>1) Similar to ileostomy</li> <li>2) Liquid output that drains 2000-3000 ml/ day</li> <li>3) May attach to a Foley catheter bag to help drainage</li> <li>4) Need IV nutrition to meet nutritional needs, as very little absorption takes place</li> </ul> </li> <li>D. Ostomy care             <ul style="list-style-type: none"> <li>1. Equipment                 <ul style="list-style-type: none"> <li>a. Soap and water</li> <li>b. Bag or pouch</li> <li>c. Wafer</li> <li>d. Wash cloth or paper towels</li> <li>e. Gloves</li> <li>f. Many different types of appliances                     <ul style="list-style-type: none"> <li>1) One piece is a wafer and pouch together and cannot be reused</li> <li>2) Two piece</li> </ul> </li> </ul> </li> </ul> </li> </ul>		
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<ul style="list-style-type: none"> <li>a) Wafer that lasts 5-7 days and cannot be reused</li> <li>b) Pouch can be taken off and emptied and cleansed and reused multiple times</li> </ul> <ol style="list-style-type: none"> <li>2. Emptying of pouch             <ul style="list-style-type: none"> <li>a. Check pouch every 2-4 hours and do not let the pouch get more than one-third full</li> <li>b. If the pouch is reusable; empty and rinse over toilet with water, dry and reapply</li> <li>c. Make sure “seal” is tight</li> <li>d. Observe contents of bag - color, amount, consistency, and odor</li> <li>e. Report complaints of discomfort</li> </ul> </li> <li>3. Skin care             <ul style="list-style-type: none"> <li>a. Wash skin well with soap and water, and dry well</li> <li>b. Shave hair</li> <li>c. Observe skin around stoma for redness and irritation</li> </ul> </li> <li>4. Odor management             <ul style="list-style-type: none"> <li>a. Everyone’s stool smells; ostomy patients/residents are no different</li> <li>b. There are sprays, tablets, etc. to reduce the odor</li> </ul> </li> </ol> <p>E. Nurse Assistant’s role</p> <ol style="list-style-type: none"> <li>1. Assist with personal hygiene</li> <li>2. Provide for privacy</li> <li>3. Change appliances</li> <li>4. Emptying ostomy bag</li> <li>5. Provide skin care</li> <li>6. Use standard precautions</li> <li>7. Encourage patient/resident to assist in the care</li> <li>8. Reinforce the teaching plan and material shared by the licensed nurse</li> <li>9. Be aware of cultural differences in attitude about ostomies and their care             <ul style="list-style-type: none"> <li>a. Privacy</li> </ul> </li> </ol>		
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<ul style="list-style-type: none"> <li>b. Shame</li> <li>c. Body image</li> </ul>		
<p><b>Objective 22</b>  <b>Describe the procedures for weighing and measuring height of the patient/resident (see module 7).</b></p> <ul style="list-style-type: none"> <li>A. Measure height and weight on admission and as ordered</li> <li>B. Patient/resident wears gown or pajamas</li> <li>C. Should urinate before being weighed</li> <li>D. Do routine weights at the same time each day if physician ordered</li> <li>E. Most accurate weights completed during early morning care</li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Refer to Manual Skill Procedures               <ul style="list-style-type: none"> <li>a. 8.22a- Measures and Records Weight of Ambulatory Patient/resident</li> <li>b. 8.22b- Weighing the Patient/resident in Bed</li> <li>c. 8.22c- Measuring Weight of Patient/resident in Wheel Chair</li> <li>d. 8.22d- Measuring the Patient's/resident's Height Using an Upright Scale</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Accurately measures patient/resident height and weight according to guidelines and facility policy, using standing scale, bed scale or wheel chair scale as appropriate</li> </ul>
<p><b>Objective 23</b>  <b>Describe common prosthetic devices and their care (artificial limbs, hearing aids, contact lenses, eye glasses and dentures).</b></p> <ul style="list-style-type: none"> <li>A. Types of prosthetic devices – cosmetic, adaptive and restorative           <ul style="list-style-type: none"> <li>1. Artificial limbs; arms and legs               <ul style="list-style-type: none"> <li>a. Specially fitted to the individual patient/resident</li> <li>b. Nursing considerations                   <ul style="list-style-type: none"> <li>1) Ask charge nurse for guidelines</li> <li>2) Observe patient's/resident's ability and/or assist</li> </ul> </li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>A. Lecture/Discussion</li> <li>B. Show pictures of various prosthetic devices</li> <li>C. Use internet resources</li> </ul>	<ul style="list-style-type: none"> <li>A. Written test</li> <li>B. Assists patients/residents with prosthetic devices</li> </ul>

<p>participate in ADLs and ambulation</p> <ol style="list-style-type: none"> <li>3) Assist patient/resident to apply brace as ordered</li> <li>4) Maintain body alignment when in chair or bed</li> <li>5) Keep call bell and personal items within reach</li> <li>6) Assist patient/resident with ROM to affected muscles</li> <li>7) Assist patient/resident with aids to foster ADL and independence</li> <li>8) Use pad brace, if necessary</li> <li>9) Use stump sock to reduce swelling</li> <li>10) Give constant praise for rehabilitative efforts</li> <li>11) Provide skin care at pressure points of device to prevent skin breakdown</li> <li>12) Observe for complaint of arm/leg pain or numbness, or weakness with use of prosthetic device</li> <li>13) Encourage physical strengthening exercises for involved and non-involved extremities</li> </ol> <p>2. Contact lenses</p> <ol style="list-style-type: none"> <li>a. Cleanse contact lenses as directed</li> <li>b. Special caution due to fragile nature of contact lenses</li> <li>c. Store according to package directions</li> <li>d. Easily lost</li> <li>e. Report the following             <ol style="list-style-type: none"> <li>1) Redness or drainage from eyes</li> <li>2) Complaints of eye pain or blurred vision</li> </ol> </li> </ol> <p>3. Eyeglasses</p> <ol style="list-style-type: none"> <li>a. Clean daily or as needed             <ol style="list-style-type: none"> <li>1) Wash glass lenses with warm water, dry with soft tissue</li> <li>2) Use special cleansing solution tissue and cloths on plastic lenses</li> </ol> </li> <li>b. Check for intact parts, such as temples and screws</li> <li>c. Encourage patient/resident to wear eyeglasses as needed</li> <li>d. Store glasses carefully to protect from breakage and</li> </ol>		
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<p>damage</p> <ul style="list-style-type: none"> <li>e. Check food trays and bed linens for misplaced eyeglasses</li> <li>f. Label eyeglasses with patient's/resident's name and room number</li> </ul> <p>4. Dentures</p> <ul style="list-style-type: none"> <li>a. Refer to Mouth Care Objective 6</li> <li>b. Label denture storage container with patient's/resident's name</li> <li>c. Label dentures with patient's/resident's identification</li> <li>d. Encourage patient/resident to wear dentures</li> <li>e. Examine dentures for rough surfaces, breaks or cracks</li> <li>f. Report findings to charge nurse</li> <li>g. Handle with care and clean thoroughly before storing</li> <li>h. Check food trays, bed linens, and wrapped up tissues or napkins for misplaced dentures</li> </ul> <p>B. Prosthetic devices help maintain independent functioning and patient/resident self-esteem</p>		
<p><b>Objective 24</b>  <b>Explain the purpose of a hearing aid and the procedures for maintenance and care of the hearing aid.</b></p> <p>A. Purposes of a hearing aid</p> <ul style="list-style-type: none"> <li>1. Makes sound louder</li> <li>2. Even the best hearing aid cannot restore full, normal hearing ability             <ul style="list-style-type: none"> <li>a. The patient/resident may still have trouble hearing</li> <li>b. Always face the patient/resident when talking to him/her and speak clearly</li> </ul> </li> </ul> <p>B. Parts of a hearing aid</p> <ul style="list-style-type: none"> <li>1. Microphone- changes sound waves into electric signals and transmits sound</li> <li>2. Battery and Battery compartment</li> <li>3. Amplifier uses battery energy to make the sound signals strong</li> <li>4. Earmold channels the sound through the external ear canal to the ear drum (tympanic membrane)</li> </ul>	<p>A. Lecture/Discussion</p> <p>B. Refer to Manual Skill Procedure 8.24a- Applying a Behind-the-Ear Hearing Aid</p> <p>C. Refer to Manual Skill procedure 8.24b- Removing a Behind-the-Ear Hearing Aid</p>	<p>A. Written test</p> <p>B. Demonstrates proper care and storage of hearing aid</p>

<ul style="list-style-type: none"> <li>5. Cord- connects the amplifier to the earmold</li> <li>6. On/off switch-turns hearing aid on/off and may control volume</li> <li>C. Care of Hearing aids             <ul style="list-style-type: none"> <li>1. Caution: Never wash a hearing aid or immerse in water, as it will be ruined</li> <li>2. Report to licensed nurse when the hearing aid needs cleaning or appears damaged</li> <li>3. Check the battery periodically</li> <li>4. Never drop the hearing aid</li> <li>5. Do not attempt to repair hearing aids</li> <li>6. Do not expose the hearing aid to heat</li> <li>7. Do not let moisture get into the hearing aid</li> <li>8. Do not use any kind of hair spray or medical spray on patients/residents while their hearing aids are in place the spray can clog the microphone opening</li> <li>9. Check food trays and bed linens for misplaced hearing aids</li> </ul> </li> <li>D. Storage of a hearing aid             <ul style="list-style-type: none"> <li>1. Turn the hearing aid off when it is not in use</li> <li>2. Store a hearing aid in a well-marked container labeled with patient's/resident's name and room number</li> <li>3. Label hearing aids with patient's/resident's name</li> </ul> </li> <li>E. Placement of the hearing aid             <ul style="list-style-type: none"> <li>1. Turn down the volume before placing the hearing aid in the external ear canal. It should fit tightly but comfortably</li> <li>2. After the hearing aid is in place, turn it on and adjust the volume so that patient/resident can hear in a normal tone. The patient/resident will tell you when he or she can hear comfortably</li> <li>3. If the patient/resident complains of an unpleasant whistle or squeal, check the placement in the ear and for a crack or break in the earmold or wire</li> </ul> </li> <li>F. Checking the batteries             <ul style="list-style-type: none"> <li>1. Before applying a hearing aid, check the batteries</li> </ul> </li> </ul>		
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<ol style="list-style-type: none"> <li>2. Be sure they are the right size for the hearing aid</li> <li>3. The battery case must close easily or something is wrong</li> <li>4. To test the batteries, place the control switch to on and turn up the volume control. Cup your hand over the hearing aid and you should hear a whistle. If you do not hear the whistle, change the batteries</li> <li>5. If the patient/resident complains that he or she cannot hear any sound,             <ol style="list-style-type: none"> <li>a. First check if hearing aid is turned on</li> <li>b. Remove the hearing aid and check the batteries for freshness</li> <li>c. Check to see if the hearing aid is broken</li> <li>d. Clean ear mold if necessary</li> </ol> </li> <li>6. If the patient/resident complains of hearing only intermittent</li> </ol>		
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**Sample Test- Module 8: Patient Care Skills**

1. A partial bath would include bathing the following body areas:
  - A. Face, hands, underarms, back, buttocks and genital area
  - B. Face, neck, chest, and arms
  - C. Face, feet and legs
  - D. Hands, feet, chest and back
  
2. A complete bed bath would be given to a patient/resident who:
  - A. Has difficulty using his right hand
  - B. Cannot step into a bath tub
  - C. Is paralyzed on one side
  - D. Is unconscious
  
3. A Nurse Assistant is bathing a patient/resident. Which of the following observations should be reported immediately to the nurse?
  - A. Dry skin on the patient's/resident's legs
  - B. A vein that curves and stands out
  - C. An old bruise is turning yellow
  - D. A bleeding skin tear
  
4. When bathing a patient/resident, the Nurse Assistant sees a swelling around the knee that is tender to touch. The Nurse Assistant should:
  - A. Avoid washing the sensitive area during the bath
  - B. Apply a warm wet washcloth to the knee
  - C. Report this observation to the nurse
  - D. Remind the patient/resident not to ambulate without assistance
  
5. In preparing the bath for the dependent patient/resident, the Nurse Assistant should:
  - A. Fill the tub with no more than two inches of water
  - B. Make sure that the water temperature is at least 120° F.
  - C. Adjust the water temperature to 105° F.
  - D. Position the patient/resident in the tub before adding water



6. When bathing a dependent patient/resident, the Nurse Assistant should:
  - A. Leave the room at intervals to encourage the patient/resident to bathe on his own
  - B. Rinse off all soap completely and dry the skin thoroughly
  - C. Rub the skin vigorously to stimulate circulation
  - D. Apply soap to all areas before rinsing with fresh water
  
7. When washing the face of a dependent patient/resident, the Nurse Assistant should:
  - A. Use a separate washcloth for washing each eye
  - B. Wipe the eyes from the outer edge to the center
  - C. Use different corners of the washcloth when washing each eye
  - D. Rinse the eyes by pouring a small amount of water on the forehead
  
8. In a complete bed bath, the water is changed:
  - A. At the completion of the bath
  - B. After each body area is washed
  - C. After the front surfaces of the body are washed
  - D. Whenever the water becomes soapy or cool
  
9. To assist Mrs. B a patient/resident, into a bathtub, the Nurse Assistant should:
  - A. Stand at the side of the tub and have the patient/resident hold on to your shoulder as she steps into the tub
  - B. Place a chair next to the tub and have the patient/resident hold on to the chair as she steps into the tub
  - C. Have the patient/resident hold on to the grab bar in the tub enclosure as she steps into the tub
  - D. Have the patient/resident sit on the side of the tub, pick up both legs and pivot them over the side and into the tub
  
10. Oral hygiene should be done:
  - A. After each meal and at bedtime
  - B. After breakfast and after last meal or snack of the day
  - C. Before and after each meal
  - D. Before and after meals or snacks

11. In what position should an unconscious patient/resident be placed when performing oral care?
  - A. Lateral (side-lying, head to side) position
  - B. Prone (on the stomach) position
  - C. Supine (on the back) position
  - D. Standing position
  
12. In assisting a patient/resident with oral hygiene:
  - A. Offer a cup of mouthwash to the patient/resident before the toothbrush
  - B. Warm the mouthwash in a basin of warm water before it is used
  - C. Hold the emesis basin under the patient's/resident's chin when he/she needs to spit
  - D. Let the patient/resident rinse his/her mouth with orange juice after brushing teeth
  
13. When the patient/resident takes his/her dentures out for the evening, the Nurse Assistant should:
  - A. Send the dentures home with the family
  - B. Store them in a labeled container filled with cool water inside the bedside table drawer
  - C. Dry them and store in a plastic bag under the patient's/resident's pillow
  - D. Store them in a clean container in the clean utility room
  
14. When cleaning dentures, the Nurse Assistant should:
  - A. Use dental floss to clean between the teeth
  - B. Soak the dentures in Lysol type disinfectant solution
  - C. Brush only the teeth portion of the dentures
  - D. Brush all surfaces of the dentures
  
15. When giving oral hygiene to an unconscious patient/resident, it is important for the Nurse Assistant to:
  - A. Prevent the patient/resident from aspirating (breathing in) any fluid
  - B. Hold the patient's/resident's mouth open with your fingers
  - C. Use large amounts of mouthwash for rinsing the patient's/resident's mouth
  - D. Wait at least 5 hours between each cleaning

16. As you brush Mrs. K's teeth, you notice that her gums are bleeding. The Nurse Assistant should:
- A. Brush harder to toughen up the gums
  - B. Notify the charge nurse
  - C. Stop brushing the teeth
  - D. Increase fluids, because of the loss
17. A patient/resident asks a Nurse Assistant to cut his toenails because they are very thick and hurt when he wears shoes. The Nurse Assistant should:
- A. Soak his feet and then cut the nails using nail clippers
  - B. Report his request to the nurse
  - C. Give the patient/resident a nail clipper so that he may cut his nails himself
  - D. Use a sharp scissor to trim the excess nail after a bath
18. To clean under the fingernails of the patient/resident, the Nurse Assistant should:
- A. Use an orange stick
  - B. Use the blunt blade of a bandage scissors
  - C. Use the point of fingernail scissors
  - D. Trim and file the nails first
19. When performing hair care for a patient/resident, the Nurse Assistant should:
- A. Comb it into a new style each day
  - B. Style it according to the patient's/resident's wishes
  - C. Apply hair oil to reduce static
  - D. Wait until family comes in
20. Before combing or brushing a patient's/resident's hair, the Nurse Assistant should:
- A. Put on gloves
  - B. Wet the hair with a spray bottle
  - C. Place a towel over the patient's/resident's shoulders
  - D. Soak the patient's/resident's comb and brush in a disinfectant solution

21. The purpose of shampooing the hair of patients/residents is to:
- A. Remove tangles
  - B. Lower body temperature
  - C. Maintain cleanliness and well-being
  - D. Be part of daily care of patient/resident
22. A bed shampoo will require:
- A. Shampoo tray, plastic sheet or bag, pitcher and basin
  - B. Extra sheet, pillow, and pitcher
  - C. Thermometer, graduate, bath basin, and several towels
  - D. Spray bottle, emesis basin and washcloth
23. A medicinal shampoo generally requires:
- A. That the shampoo is left in the hair for a period of time before rinsing it out
  - B. That the medicinal solution is left in the hair without rinsing it out
  - C. Rinsing the hair with disinfectant solution
  - D. That the nurse perform the procedure rather than a Nurse Assistant
24. To safely shave a patient/resident with a safety razor, the Nurse Assistant should:
- A. Apply an alcohol pre-shave solution
  - B. Keep the skin taut in the area being shaved
  - C. Move the razor in the opposite direction as the hair growth
  - D. Rinse the razor in a disinfectant solution during shave
25. After shaving a patient/resident with his own electric razor, the Nurse Assistant should:
- A. Apply an oil based lotion to the skin
  - B. Clean the blades of the razor with a cleaning brush
  - C. Soak the razor in a disinfectant solution
  - D. Report the action to the charge nurse

26. The Nurse Assistant is putting a pair of pants on a patient/resident who cannot sit up because of weakness. The Nurse Assistant should slip both feet into the legs of the pants and then:
- A. Ask the patient/resident to bend his knees and raise his buttocks as the Nurse Assistant pulls the pants up to his waist
  - B. Attempt to sit the patient/resident on the side of the bed and pull pants up toward the waist
  - C. Pull the top of the pants under the buttocks up the waist with the patient/resident flat on his back
  - D. Assist the patient/resident to roll from side to side as the Nurse Assistant pulls the pants up to the waist
27. A general rule for dressing a patient/resident who is paralyzed or injured is:
- A. Dress the affected side first and undress it last
  - B. Dress the affected side last and undress it first
  - C. Have clothing split and snaps applied for easy dressing
  - D. Avoid dressing the affected side
28. To accurately weigh the patient/resident, a general rule to follow is to:
- A. Weigh the patient/resident at different times each day
  - B. Have the patient/resident be NPO before weighing
  - C. Balance the scale before the patient/resident steps on it
  - D. Weigh the patient/resident fully dressed
29. If a patient/resident is unable to stand up while being measured it is best to:
- A. Estimate the patient's/resident's height
  - B. Measure the patient's/resident's height while lying in bed
  - C. Ask the patient/resident how tall he was when ambulatory
  - D. Chart that the measurement was not done because the patient/resident could not stand
30. A patient/resident was admitted to the nursing unit several days after surgery. To prevent problems, the Nurse Assistant should:
- A. Leave the patient/resident in bed at all times
  - B. Tell the patient/resident to remain in the same position at all times
  - C. Tell the patient/resident to cough and deep breathe every two hours
  - D. Leave the patient/resident alone to rest all day

31. The Nurse Assistant is caring for a patient/resident who wants to shave with a safety razor. The patient/resident should not use the razor if the patient/resident is:
- A. Receiving oxygen
  - B. Confused and disoriented
  - C. Unable to ambulate to the bathroom
  - D. Visiting with family
32. The Nurse Assistant is collecting supplies for colostomy care. Which of the following is NOT needed?
- A. A bedpan
  - B. Toilet tissue
  - C. Alcohol wipes
  - D. Gloves
33. When changing a colostomy bag, the Nurse Assistant should know:
- A. The colostomy bag must be changed every two hours
  - B. All colostomy patients/residents have liquid stools
  - C. The colostomy bag needs to be changed when the bag is leaking
  - D. A skin barrier will hold the bag in place without a belt
34. The Nurse Assistant is caring for a confused patient/resident who does not like to bathe. The Nurse Assistant should NOT:
- A. Prepare the patient/resident before bathing
  - B. Give a sponge bath if patient/resident resists tub or shower
  - C. Force the patient/resident into the shower or tub
  - D. Schedule bathing when patient/resident is agitated
35. A patient/resident is to be weighed daily. The Nurse Assistant should:
- A. Weigh the patient/resident at the same time of day
  - B. Hold the patient/resident on the scale, if unable to stand
  - C. Not weigh the patient/resident who is unable to stand on scale
  - D. Not allow the patient/resident to urinate before being weighed

36. When preparing to bathe a patient/resident, the Nurse Assistant should provide privacy curtains:
- A. Immediately after entering the room
  - B. Before beginning the bath
  - C. After washing the patient's/resident's face
  - D. After completing the bath
37. The Nurse Assistant is checking the patient's/resident's body for signs of pressure sores. Which of the following areas are more likely to be affected?
- A. Bony areas such as shoulder blades, elbows, heels, and knees
  - B. Thicker areas such as thighs and upper arms
  - C. The abdomen and breasts
  - D. The genital area
38. Which of the following foot care procedures is required for the patient/resident who is paralyzed from the waist down?
- A. Soak the feet in hot water after bathing
  - B. Wrap the feet in hot towels, trim toenails if needed, and lubricate feet
  - C. Wash and dry feet carefully and thoroughly, and check for any pressure signs
  - D. Wash feet carefully, trim toenails and apply lubricant to keep area between toes moist
39. The Nurse Assistant should know that incontinent patients/residents:
- A. Cannot control their bladder or bowels
  - B. Are lazy
  - C. Are able to control the bladder or bowels
  - D. Are confused
40. When putting in dentures, it is important to:
- A. Dry the dentures
  - B. Wet the dentures
  - C. Rinse with alcohol
  - D. Dry the mouth

41. The Nurse Assistant should clean the patient's/resident's genital and anal areas:
- A. Every time the patient/resident uses the bathroom
  - B. Only when the patient/resident is soiled
  - C. Once a day and when the patient/resident is soiled
  - D. Once during each shift
42. If the patient/resident is unable to clean up properly after using a bedside commode, the Nurse Assistant should:
- A. Assist the patient/resident to bed and return later to clean the patient/resident
  - B. Give the patient/resident a washcloth and instruct him in proper cleaning techniques
  - C. Provide the patient/resident with privacy and clean him gently and thoroughly
  - D. Tell the patient/resident that he will be cleaned at bath time
43. Which of the following might the Nurse Assistant do to keep a patient/resident from being incontinent of urine?
- A. Offer the patient/resident the toilet, bedpan or urinal at regular intervals
  - B. Tell the patient/resident that he will be assisted to the bathroom every four hours
  - C. Leave a bedpan under the patient/resident
  - D. Tell the patient/resident not to drink as much water
44. When caring for a patient/resident with dry skin, the Nurse Assistant should use:
- A. Soap
  - B. Lotion
  - C. Hot water
  - D. Talcum powder
45. When providing a bedpan for a patient/resident, the Nurse Assistant should always:
- A. Use the same size bedpan for all patients/residents
  - B. Wait until the patient/resident asks for a bedpan before giving one
  - C. Place the open end of the bedpan toward the patient's/resident's back
  - D. Allow privacy while the patient/resident is using the bedpan



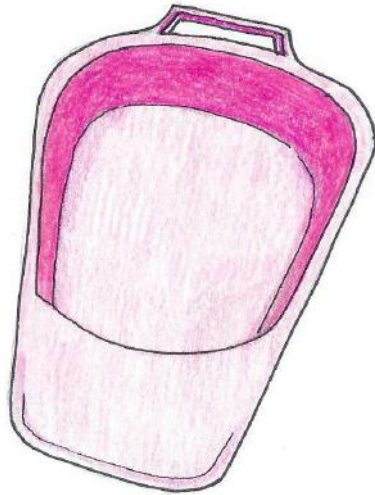
46. When preparing to shave a patient/resident, the Nurse Assistant should soften the patient's/resident's facial hair by using:
- A. A cold towel
  - B. A warm towel
  - C. Lotion
  - D. Alcohol
47. Which bathing method should the Nurse Assistant select for a patient/resident on bed rest who needs total assistance?
- A. A tub bath
  - B. A shower
  - C. A complete bed bath
  - D. A partial bed bath
48. The Nurse Assistant should know that dentures should be cleaned at which of the following times?
- A. Before breakfast and at bedtime
  - B. After breakfast and at bedtime
  - C. After breakfast, lunch and supper
  - D. Before breakfast, lunch, supper, and at bedtime
49. A patient/resident asks the Nurse Assistant to help her to the bathroom. The Nurse Assistant responds, "OK, but I'm really busy today. Bring your things with you so you can brush your teeth and fix your hair, too." By making these requests, the Nurse Assistant was:
- A. Lessening the number of decisions the patient/resident must make
  - B. Denying the patient/resident the ability to make a personal choice about when her care would be done
  - C. Showing the patient/resident who was the boss was on the unit
  - D. Performing job duties as expected
50. When bathing a patient/resident, a Nurse Assistant should observe:
- A. Body size
  - B. Body tone
  - C. Skin condition
  - D. Amount of body fat

51. The Nurse Assistant is caring for a resident who just received a new pair of glasses. The Nurse Assistant should:

- A. Tell the resident to wear the glasses only at mealtimes
- B. Clean the glasses with a disinfectant solution
- C. Put the glasses on the resident's bedside table when not in use
- D. Put the glasses in a labeled case when not in use

52. The bedpan shown below is a:

- A. Standard pan
- B. Fracture pan
- C. Curved pan
- D. Flat pan



**Sample Test Answers: Module 8**

- |       |       |
|-------|-------|
| 1. A  | 27. A |
| 2. D  | 28. C |
| 3. D  | 29. B |
| 4. C  | 30. C |
| 5. C  | 31. B |
| 6. B  | 32. C |
| 7. C  | 33. C |
| 8. D  | 34. C |
| 9. C  | 35. A |
| 10. A | 36. B |
| 11. A | 37. A |
| 12. C | 38. C |
| 13. B | 39. A |
| 14. D | 40. B |
| 15. A | 41. C |
| 16. B | 42. C |
| 17. B | 43. A |
| 18. A | 44. B |
| 19. B | 45. D |
| 20. C | 46. B |
| 21. C | 47. C |
| 22. A | 48. D |
| 23. A | 49. B |
| 24. B | 50. C |
| 25. B | 51. D |
| 26. D | 52. B |

**MANUAL SKILL: Back Rub**

**EQUIPMENT:**

Bath blanket  
Bath towel  
Lotion

**BEGINNING STEPS:**

1. Wash hands
2. Knock and pause before entering the patient's/resident's room
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

**SKILL STEPS:**

1. Raise side rail on opposite side of work area.
2. Raise bed to a comfortable position.
3. Position patient/resident in a prone or side-lying position with his or her back toward you.
4. Expose back, shoulders, upper arms, and buttocks. Cover rest of body with linens or bath blanket.
5. Lay towel on bed and tuck under edge of back.
6. Apply warm lotion to back (rub moderate amount of lotion in hands to warm it before applying to back or place lotion container in hot water).
7. Use long strokes; rub from buttocks to shoulders. Then stroke from shoulders over to upper arms and back down to buttocks. Use firm, gentle strokes. Keep hands in contact with patient's/resident's skin.
8. Repeat the process for at least three minutes.
9. Massage bony areas with a circular motion. (Do not massage bony areas that are reddened.)
10. Dry the patient's/resident's back by patting gently with the towel.
11. Close and retie the gown.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse

**Manual Skill: Bed Bath**

**EQUIPMENT:**

Basin  
Blanket or sheet  
Soap  
Washcloth and towel

**BEGINNING STEPS:**

1. Wash hands
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, and directly maintaining face to face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with curtain, screen or door.
8. Apply clean gloves prior to bathing patient/resident.

**SKILL STEPS:**

1. Offer patient/resident bedpan or urinal.
2. Cover patient/resident with bath blanket or sheet and fold top linen to bottom of bed.
3. Remove gown or pajamas.
4. Raise the bed to a level convenient for good body mechanics. Lower side rail on side where nurse will be working. Be sure opposite side rail is up and secure.
5. Lower head of bed to flat position.
6. Fill wash basin 2/3 full of warm water (105 degrees F). Check water for safe temperature and ask patient/resident to check water for comfort.
7. Assist patient/resident to move closer to you.
8. Lay towel across patient's/resident's chest and make a mitt with the washcloth.
9. Wash eyes without soap from nose to outside of face and use separate area of cloth for each eye. Wash inner aspect to outer aspect then proceed to wash face.
10. Wash face, ears, and neck, being careful to keep soap out of patient's/resident's eye.

11. Rinse and dry face by patting gently with towel.
12. Place towel lengthwise under arm farthest from you. Support arm with your hand under patient's/resident's elbow. Apply soap to wet washcloth. Wash shoulder, arm, underarm, and hand keeping rest of body covered. Use long, firm but gentle strokes. Move body gently and naturally avoiding force and over-extension of limbs and joints.
13. Rinse and dry well.
14. Place arm and hand under cover.
15. Repeat steps 12-14 with arm nearest you.
16. Fold sheet down to patient's/resident's abdomen keeping towel across chest.
17. Wash, rinse, and dry patient's/resident's chest. For female patients/residents, gently lift breasts to wash, rinse, and pat dry thoroughly.
18. Keeping chest covered with towel, fold sheet down to pubic area.
19. Wash, rinse, and dry patient's/resident's abdomen being careful to clean umbilicus and skin folds.
20. Pull sheet up over abdomen and chest and remove towel.
21. Empty wash basin and refill with clean water of proper temperature.
22. Fold sheet back from patient's/resident's leg farthest from you and place towel lengthwise under leg.
23. Bend the knee and wash, rinse, and dry the leg and foot. If patient/resident can bend knee easily, place basin on towel and place the patient's/resident's foot in the basin to wash.
24. Cover the patient's/resident's leg with sheet and remove towel.
25. Repeat steps 21-23 with leg nearest you.
26. Empty basin, rinse, and refill with water of proper temperature.
27. Assist patient/resident to turn on side so his/her back is toward you.
28. Place towel lengthwise on bed along patient's/resident's back.
29. Wash, rinse, and dry patient's/resident's back and buttocks.
30. Remove towel and assist patient/resident to turn onto back.
31. If patient/resident is able to wash own perineal area give him/her a soapy washcloth, then a clean, wet cloth to rinse, and a towel to dry.
32. Disposes linens without contaminating self.
33. If patient/resident is unable to wash own perineal area, assist by washing perineal area front to back to avoid infection. For female patients/residents, separate labia and wash from front to back. For uncircumcised males, retract foreskin and wash tip of penis and replace foreskin. Wear gloves when washing genital area.
34. Assist patient/resident into clean clothing.
35. Remove and remake bed with clean linen when necessary.
36. Lower bed, place side rails in up position, if applicable.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable
2. Remove gloves without contaminating self
3. Position patient/resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the patient/resident
6. Leave room neat
7. Wash hands
8. Document
9. Report abnormal findings to licensed nurse



**MANUAL SKILL: Tub Bath**

**EQUIPMENT:**

Clean clothing  
Soap  
Towel  
Washcloth

**BEGINNING STEPS:**

1. Wash hands
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self
4. Identify patient/resident
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

**SKILL STEPS:**

1. Fill tub half full of warm water (105 degrees F). Check water for safe temperature and ask patient/resident to check water for comfort.
2. Place towel or bath mat on floor beside tub.
3. Assist patient/resident to Tub Room.
4. Provide for privacy.
5. Assist patient/resident to remove clothing.
6. Assist patient/resident into tub.
7. Give patient/resident soap and washcloth and encourage to wash and rinse themselves as much as possible. Assist as necessary.  
\*\*NEVER LEAVE PATIENT/RESIDENT ALONE IN THE TUB.
8. Assist patient/resident out of the tub encouraging use of grab bars.
9. Assist patient/resident in drying themselves thoroughly and dressing.
10. Return patient/resident to room.
11. Position patient/resident comfortably.

12. Place call light within reach.
13. Lower bed to safe position for the patient/resident.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**Manual Skill: Modified Bed Bath (Face, One, Arm, Hand, and Underarm)-Testing Purposes Only**

**EQUIPMENT:**

Basin  
Blanket or sheet  
Soap  
Washcloth and towel

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, and directly maintaining face to face contact whenever possible.
6. Provide for privacy with curtain, screen or door.
7. Wash hands.
8. Lay towel across patient's/resident's chest and make a mitt with the washcloth.

**SKILL STEPS:**

1. Removes gown and places in soiled linen container, while avoiding over exposure of the client.
2. Before washing, check water temperature for safety and comfort and ask patient/resident to verify comfort of water.
3. Apply clean gloves prior to bathing patient/resident.
4. Beginning with eyes, washes eyes with wet washcloth (no soap) using a different area of the washcloth for each stroke, washing inner aspect to outer aspect then proceeds to wash face.
5. Dry face with towel.
6. Expose one arm and places towel underneath arm.
7. Applies soap to wet washcloth.
8. Wash arm, hand and underarm, keeping rest of body covered.
9. Rinse and dry arm, hand and underarm.
10. Moves body gently and naturally avoiding force and over-extension of limbs and joints.
11. Puts clean gown on client.
12. Empties, rinses, and dries basin.

13. After rinsing basin, place basin in designated dirty supply area.
14. Disposes of linen into soiled linen container.
15. Avoids contact between Nurse Assistant clothing and used linens.
16. After placing basin in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Provides Mouth Care**

**EQUIPMENT:**

Cup with water  
Emesis basin  
Gloves  
Mouthwash (if desired)  
Toothbrush  
Toothpaste  
Towel

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explain procedure, speaking clearly, slowly, and directly, and maintaining face to face contact whenever possible.
7. Privacy is provided with curtain, screen or door.

**SKILL STEPS:**

1. Before providing mouth care, client is in upright, sitting position (75-90 degrees).
2. Puts on clean gloves before cleaning mouth.
3. Place clothing protector across chest before providing mouth care.
4. Secures cup of water and moistens toothbrush.
5. Before cleaning mouth, applies toothpaste to moistened toothbrush.
6. Clean mouth (including tongue and surfaces of teeth) using gentle motions.
7. Maintains clean technique with placement of toothbrush.
8. Candidate holds emesis basin to chin while client rinses mouth.
9. Candidate wipes mouth and removes clothing protector.
10. After rinsing toothbrush, empty, rinse and dry the basin and place used toothbrush in designated basin/container.

11. Places basin and toothbrush in designated dirty supply area.
12. Disposes of used linen into soiled linen container.
13. After placing basin and toothbrush in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.
14. Signaling device is within reach and bed is in low position.

**ENDING STEPS:**

1. Position patient/resident comfortably.
2. Leave room neat.
3. Wash hands.
4. Document.
5. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Assisting with Mouth Care**

**EQUIPMENT:**

Cup with water  
Emesis basin  
Gloves  
Mouthwash (if desired)  
Toothbrush  
Toothpaste  
Towel

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Position patient/resident sitting up comfortably (in bed or chair).
2. Place towel over patient's/resident's chest and under chin.
3. Place overbed table in front of the person. Adjust table height for the person.
4. Allow person to perform mouth care.
5. Rinse toothbrush and apply toothpaste.
6. Encourage patient/resident to brush own teeth if able. If unable, brush patient's/resident's teeth, using gentle massaging pressure, being sure to clean all tooth surfaces, including tongue.
7. Provide water, when finished or at any other time patient/resident requests, so that patient/resident can rinse mouth. Hold basin under patient's/resident's chin to catch water and give patient/resident tissue or cloth to wipe the mouth.

8. Clean and return equipment; placing toothbrush in a container that will avoid contamination and allow toothbrush to air dry.
9. Dispose of soiled linen in soiled linen container.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.



**MANUAL SKILL: Mouth Care of the Unconscious Patient/resident**

**EQUIPMENT:**

Gloves  
Lemon and glycerin swabs (if ordered)  
Solutions for cleansing and lubricating mouth  
Sponge swabs (toothettes)  
Tissues  
Tongue blade, padded with gauze  
Towel

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Raise bed to working height, lower side rail closest to Nurse Assistant.
2. Position patient/resident in side-lying position on the side towards you. Turn his/her head well to the side.
3. Place towel under patient's/resident's head and face and place kidney basin under the chin.
4. Position overbed table so you can reach it. Adjust height as needed.
5. Moisten toothettes with solution ordered.
6. Gently open mouth. If patient/resident resists, use padded tongue blade to hold mouth open. Separate upper and lower teeth with padded tongue blade. **DO NOT USE TONGUE BLADE TO FORCE LIPS OR MOUTH OPEN.**
7. Press excess solution from toothette and cleanse teeth, tongue, gums, roof of mouth, inside cheeks and lips with toothette.
8. Repeat process using lemon and glycerin swabs if needed.

9. Apply lubricant to lips if necessary.
10. Dry area around the mouth.
11. Remove the towel under the patient's/resident's head.
12. Repeat procedure every two hours or more often as needed.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Cleans Upper or Lower Denture**

**EQUIPMENT:**

Denture cleanser/toothpaste  
Denture cup  
Emesis basin  
Gloves  
Mouthwash  
Towel  
Washcloth

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Bottom of sink is lined and/or sink is partially filled with water before denture is held over sink.
2. Rinses denture in moderate temperature running water before brushing them.
3. Applies toothpaste to toothbrush.
4. Brushes surface of denture.
5. Rinses surface of denture under moderate temperature running water.
6. Before placing denture into cup, rinses denture cup and lid.
7. Places denture in denture cup with moderate temperature water/solution and places lid on cup.
8. Rinses toothbrush and places in designated toothbrush basin/container.
9. Maintains clean technique with placement of toothbrush and denture.
10. Sink liner is removed and disposed of appropriately and/or sink is drained.

11. After rinsing equipment and disposing of sink liner, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Fingernail Care**

**EQUIPMENT:**

Bath basin 1/3 full of water (105 degree F)  
Bath towel  
Emery board  
Kidney basin  
Orangewood sticks  
Lotion  
Nail clippers  
Paper towels

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Place towel (under patient's/resident's hand) over overbed table.
2. Place basin on towel with water in a comfortable position for patient/resident.
3. Before immersing fingernails, checks water temperature for safety and comfort and asks patient/resident to verify comfort of water.
4. Assist patient/resident to immerse fingertips in basin of water.
5. Clean under each fingernail with orangewood stick.
6. Wipe orangewood stick on towel after each nail.
7. Dry fingernail area.
8. Nurse Assistant feels each nail and files as needed (should be smooth).

9. Repeat steps on other hand.
10. Dispose of orangewood stick and emery board when finished.
11. Empty, rinse, and dry basin.
12. Place basin in designated dirty supply area.
13. Disposes of used linen into soiled linen container.
14. After cleaning nails and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container.
15. Wash hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Foot Care**

**EQUIPMENT:**

2 Towels  
Basin  
Bath Mat  
Gloves  
Lotion  
Soap  
Wash Cloth

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Before washing, check water temperature for safety and comfort and asks client to verify comfort of water.
2. Basin is in a comfortable position for client and on protective barrier.
3. Put on clean gloves before washing foot.
4. Client's bare foot is placed into the water.
5. Applies soap to wet washcloth.
6. Lifts foot from water and washes foot (including between the toes).
7. Foot is rinsed (including between the toes).
8. Dries foot (including between the toes).
9. Applies lotion to top and bottom of foot, removing excess (if any) with a towel.
10. Support foot and ankle during procedure.

11. Repeat steps 6-12 for other foot.
12. Empties, rinses, and dries basin then place basin in designated dirty supply area.
13. Disposes of used linen into soiled linen container.
14. After cleaning foot and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.



**MANUAL SKILL: Provides Foot Care on One Foot (For Testing Purposes Only)**

**EQUIPMENT:**

2 Towels  
Basin  
Bath Mat  
Gloves  
Lotion  
Soap  
Wash Cloth

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Wash hands
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.

**SKILL STEPS:**

1. Explains procedure, speaking clearly, slowly, and directly, and maintaining face-to-face contact whenever possible.
2. Privacy is provided with a curtain, screen, or door.
3. Before washing, check water temperature for safety and comfort and asks client to verify comfort of water.
4. Basin is in a comfortable position for client and on protective barrier.
5. Put on clean gloves before washing foot.
6. Client's bare foot is placed into the water.
7. Applies soap to wet washcloth.
8. Lifts foot from water and washes foot (including between the toes).
9. Foot is rinsed (including between the toes).
10. Dries foot (including between the toes).
11. Applies lotion to top and bottom of foot, removing excess (if any) with a towel.
12. Support foot and ankle during procedure.
13. Empties, rinses, and dries basin then place basin in designated dirty supply area.

14. Disposes of used linen into soiled linen container.
15. After cleaning foot and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands.
16. Signaling device is within reach.

**ENDING STEPS:**

1. Position patient/resident comfortably.
2. Lower bed to safe position for the patient/resident.
3. Leave room neat.
4. Document.
5. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Combing the Patient's/resident's Hair**

**EQUIPMENT:**

Comb or hairbrush  
Towel

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Raise head of bed to comfortable sitting position.
2. Place towel around patient's/resident's shoulders if sitting, or on pillow, if lying in bed.
3. Put hair into two sections, and then divide one side into two more sections.
4. Brush the hair. Start at scalp and brush little by little with downward motion moving towards the ends.
5. Comb or brush patient's/resident's hair into style patient/resident requests.
6. Remove towel and loose hair from the patient's/resident's shoulder.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Shampoo of Bedridden Patient/resident**

**EQUIPMENT:**

Bath blanket  
Bed protectors  
Brush  
Chair  
Conditioner (optional)  
Electric blow dryer (if allowed)  
Large basin or pail  
Patient's/resident's comb  
Several containers of warm water  
Several large bath towels  
Shampoo  
Shampoo tray  
Tough or extra-large plastic garbage bag  
Washcloth

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Lower side rail, raise bed to working position.
2. Place chair at bedside with basin or pail on chair.
3. Position patient/resident to edge of bed close to where you are standing.
4. Place bed protector on mattress under patient's/resident's head and shoulders.
5. Place trough under patient's/resident's head with open end in basin or pail and washcloth over eyes.
6. Wet hair by pouring warm water from pitcher over scalp.
7. Apply shampoo and lather hair well, massage scalp while shampooing.
8. Rinse hair well.
9. Repeat shampoo as necessary.
10. Remove trough from under patient/resident and set aside.
11. Dry hair by rubbing with towel, blow-dry if allowed.
12. Comb or brush hair in style agreeable to patient/resident.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Shampoo with Shower or Tub Bath**

**EQUIPMENT:**

Conditioner  
Shampoo  
Supplies for tub bath or shower

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Follow steps for bathing procedure to place patient/resident in tub or shower.
2. Test temperature of water by running it over the inside of your wrist – should be 105° F (40-45°C) warm but not hot.
3. Give patient/resident dry washcloth and/or assist patient/resident to hold over the eyes. Encourage patient/resident to tilt head backward, if possible.
4. Wet patient's/resident's hair.
5. Apply shampoo, rubbing into scalp with fingertips. Start at hairline and work toward the back.
6. Massage the scalp with your fingertips. Do not scratch the scalp.
7. Rinse with water until all shampoo is gone. Avoid getting water in patient's/resident's face, ears.
8. If conditioner is used, pour into palm of your hand, work through the hair, and allow to remain 2-3 minutes. Rinse with clear warm water.
9. Wrap towel around patient's/resident's head and complete bath according to bath procedure.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Shaving**

**EQUIPMENT:**

Aftershave lotion (if desired)  
Basin of warm water (105 degree F)  
Gloves  
Safety razor  
Shaving cream  
Tissues  
Towel & wash cloth

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Raise head of bed to comfortable sitting position. Semi-fowler's position, if allowed.
2. Position overbed table within easy reach and at a comfortable height.
3. Place towel under patient's/resident's chin and across chest.
4. Hold wash cloth, wrung out of warm water for a minute on facial area to be shaved.
5. Check for safe water temperature and ask patient/resident to verify water for comfort.

*Safety Razor:*

6. Rub shaving cream into beard to soften.
7. Pull skin tight above area to be shaved; shave gently using short, even strokes and rinsing razor frequently.



8. Shave in the direction of hair growth.
9. Lather neck area and stroke upward in a similar manner.
10. Dispose of safety razor in sharps container

*Electric Razor:*

11. Check equipment for damaged cord or mechanisms.
12. Pull the skin tight above area to be shaved.
13. Shave in the direction of hair growth when shaving male face and female underarms.
14. Shave upward, starting at the ankle, when shaving legs.
15. Apply direct pressure to any nicks and cuts.
16. Wash shaved area with clean cool water and dry gently.
17. Apply aftershave lotion to male face if desired.
18. Remove towel.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Dressing and Undressing the Patient/resident****EQUIPMENT:**

Encourage patient/resident to select clean clothing of choice

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen
8. Apply gloves (standard precautions)

**SKILL STEPS:**

1. After asking what clothing items he/she would like to wear, arrange clothing items in the order of dressing and open buttons, zippers, and fasteners.
2. Assist patient/resident to a comfortable sitting position while assisting. Be gentle and pay attention to how you hold the patient/resident.
3. Avoid overexposure and assist patient/resident with clothing on upper body first (if patient/resident has a weak side, apply clothing to weak side first).
4. While putting on clothing items, move body gently and naturally avoiding force and over-extension of limbs and joints.
5. Place arm in sleeve. (Do not pull on arm).
6. Gather shirt, blouse, or dress to neck opening and slip over head or around shoulders as appropriate to garment and place other arm in sleeve.
7. Position sleeves comfortably at shoulders. Adjust clothing to cover upper body.
8. Smooth and ease clothing over body by pulling it down. (If unable to sit up, assist patient/resident to roll side to side while adjusting clothing).
9. Assist patient/resident in buttoning, fastening garments if patient/resident is unable.
10. To apply clothing to lower extremities put weaker foot into pants first followed by stronger foot, working them up the legs by pulling one side then the other.

11. If patient/resident is able, ask that he/she raise the hips while you pull the pants up to the waist. If patient/resident cannot assist, turn onto the weak side, pulling the clothing up the stronger side.
12. Turn patient/resident onto stronger side and finish pulling up the pants.
13. Assist with buttons or zippers as necessary.
14. To undress, reverse steps of the procedure.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Dresses Patient/resident with Affected (Weak) Right Arm**

**EQUIPMENT:**

Clean clothing of patient's/resident's choice

**BEGINNING STEPS:**

1. Knock and pause before entering the patient's/resident's room.
2. Introduce self.
3. Identify patient/resident.
4. Gather equipment, if applicable.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Privacy is provided with a curtain, screen, or door.

**SKILL STEPS:**

1. Ask patient/resident which shirt he/she would like to wear and dresses them in their shirt of choice.
2. While avoiding overexposure of patient/resident, removes gown from the unaffected side first, then removes gown from affected side and disposes of gown into soiled linen container.
3. Assist patient/resident to put the right (affected/weak) arm through the right sleeve of the top before placing garment on the left (unaffected) arm.
4. While putting on shirt, moves body gently and naturally avoiding force and over-extension of limbs and joints.
5. Finish with clothing in place.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Signaling device is within reach and bed is in low position.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Assist in the Use of Bedpan**

**EQUIPMENT:**

Basin of warm water  
Bedpan and cover, or fracture bedpan and cover  
Disposable gloves (two pairs)  
Toilet tissue  
Urinal  
Washcloth, soap, towel  
Hand wipes

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Wash hands.
6. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
7. Privacy is provided with a curtain, screen or door.

**SKILL STEPS:**

1. Lower head of the bed.
2. Puts on clean gloves before handling bedpan.
3. Places bedpan correctly under client's buttocks.
4. Removes and disposes of gloves (without contaminating self) into waste container and washes hands.
5. After positioning client on bedpan and removing gloves, raises head of bed.
6. Toilet tissue is within reach.
7. Hand wipe is within reach and client is instructed to clean hands with hand wipe when finished.
8. Signaling device within reach and client is asked to signal when finished.
9. Puts on clean gloves before removing bedpan.
10. Head of bed is lowered before bedpan is removed.
11. Avoids overexposure of client.
12. Empties and rinses bedpan and pours rinse into toilet.

13. After rinsing bedpan, place bedpan in designated dirty supply area.
14. After placing bedpan in designated dirty supply area, removes and disposes of gloves (without contaminating self) into waste container and wash hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Signaling device is within reach and bed is in low position.
4. Leave room neat.
5. Wash hands.
6. Document.
7. Report abnormal findings to licensed nurse.

**NOTE:** The above information lists the required performance steps in testing the skill.

The following provides additional helpful information regarding Assisting with Bedpan or Urinal.

1. Before placing bedpan or urinal, fold back the top sheets so that they are out of the way.
2. Raise the patient's/resident's gown, but keep the lower part of the body covered.
3. Ask the patient/resident to assist by bending the knees and placing the feet flat on the mattress. Ask patient/resident to raise hips. Assist as necessary by slipping your hand under the lower back and lifting slightly. Place the bedpan in position evenly under the buttocks. The narrow end of pan should point toward the foot of the bed.
4. Fracture pan: narrow end of pan points toward head of bed, under patient's/resident's lower back; handle should point toward foot of bed
5. If the patient/resident is unable to assist, turn the patient/resident to one side and place the bedpan against the buttocks, push downward on the bedpan into the mattress as you carefully turn the patient/resident back onto the bedpan.
6. Replace the sheet over the patient/resident.
7. Elevate the head of the bed and the knees slightly to a modified sitting position.
8. Put the call light or signal, warm, wet washcloth or hand wipe and toilet paper within easy reach of the patient/resident, raise side rail.
9. Ask the patient/resident to signal when finished, leave patient/resident alone unless contraindicated in the nursing care plan. Check on patient/resident every 2-5 minutes.
10. Discard gloves, wash hands.
11. When the patient/resident signals, return to the room. If the patient/resident is unable to signal, check frequently. Never leave a patient/resident sitting on a bedpan for a prolonged period, or with the urinal positioned where skin pressure can be created.
12. Put on your gloves and answer the patient's/resident's signal immediately.

13. Fill the basin with warm water; assemble soap, washcloth, and towel.
14. To remove bedpan from under patient/resident, ask the patient/resident to flex knees and rest weight on heels.
15. Place one hand under the small of the back and lift gently to help raise the buttocks or roll the patient/resident off the bedpan to the side and remove the pan (be sure to hold bedpan from tipping while rolling the resident). Lift and move carefully. Hold pan firmly with one hand. Cover bedpan after removing.
16. Many residents have difficulty cleaning adequately after using the bedpan. Assist the resident to clean and wipe as necessary. Check the anal area, clean with soap and warm water while resident is on his or her side (always clean from front to back).
17. Remove bedpan or urinal to bathroom.
18. If specimen is required, collect it at this time. Measure urine if resident is on Intake and Output.
19. Check the stool or urine for abnormal appearance.
20. Empty the bedpan or urinal into the toilet and flush.
21. Rinse bedpan/urinal in cold water and disinfect; rinse and dry or follow facility procedure for cleaning equipment.
22. Discard gloves, wash hands.
23. Put clean bedpan or urinal inside resident's bedside table.
24. Assist resident with hand washing.

**MANUAL SKILL: Measures and Records Urinary Output**  
(see module 7)

**EQUIPMENT:**

Disposable gloves  
Graduate

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Provide for privacy with a curtain, door, or screen.
7. Wash hands.

**SKILL STEPS:**

1. Puts on clean gloves before handling bedpan.
2. Pours contents of the bedpan into measuring container without spilling or splashing urine outside of container.
3. Measures amount of urine at eye level with container on flat surface.
4. After measuring urine, empties contents of measuring container into toilet.
5. Rinses measuring container and pours rinse into toilet.
6. After rinsing equipment, and before recording output, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
7. Records contents of container within plus or minus 25 ml of evaluator's reading.



**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse

**MANUAL SKILL: Perineal Care for Female**

**EQUIPMENT:**

Basin of warm water and soap or perineal wash  
Bath blanket  
Bedpan  
Gloves  
Towels  
Washcloths  
Waterproof protector for bed

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Privacy is provided with a curtain, screen or door.

**SKILL STEPS:**

1. Before washing checks water temperature for safety and comfort and asks patient/resident to verify comfort of water.
2. Puts on clean gloves.
3. Place pad/linen protector under perineal area before washing.
4. Exposes perineal area while avoiding overexposure of client.
5. Applies soap to wet washcloth.
6. Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke.
7. Using a clean washcloth, rinses soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke.
8. Dries genital area moving from front to back with towel.
9. After washing genital area, turns to side, then washed and rinses rectal area moving from front to back using a clean area of the washcloth with each stroke. Dries with towel.
10. Reposition client.
11. Empties, rinses, and dries basin.
12. After rinsing basin, places basin in designated dirty supply area.

13. Disposes of used linen into soiled linen container and disposes of linen protector appropriately.
14. Avoids contact between nurse candidates clothing and used linen.
15. After disposing of used linen, and placing used equipment in designated dirty supply area, remove and dispose of gloves(without contaminating self) into waste container and wash hands.

**ENDING STEPS:**

1. Position patient/resident comfortably.
2. Signaling device is within reach and bed is in low position.
3. Leave room neat.
4. Wash hands.
5. Document.
6. Report abnormal findings to licensed nurse.

NOTE: The above information lists the required performance steps in testing the skill.

The following provides additional helpful information regarding Perineal Care.

1. Raise the bed to a level convenient for good body mechanics.
2. Lower side rail on side where Nurse Assistant will be working. Be sure opposite side rail is up and secure.
3. Remove bedspread and blanket. Fold and place on back of chair.
4. Turn patient/resident on back, cover with drape, sheet or bath blanket and have patient/resident hold top of drape or sheet while you pull out top sheet.
5. Instruct patient/resident to raise hips while bed protector is placed underneath patient/resident.
6. Offer bedpan to patient/resident.
7. Position drape, sheet or bath blanket so only the area between the legs is exposed.
8. Female perineal care:
  - a. Ask patient/resident to separate her legs and flex knees.
  - b. If she is unable to spread legs and flex knees, the perineal area can be washed with the patient/resident on the side with legs flexed.
9. Put on disposable gloves.
10. Wet washcloth, make mitt and apply soap or periwash.
11. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back.
12. Rinse and pat dry with towel.
13. Male perineal care:
  - a. Form a mitten with washcloth and apply soap.
  - b. Gently wash pubis and penis. If uncircumcised, pull back foreskin and wash.

- c. Carefully dry and return foreskin to normal position. Make sure shaft of penis is dry.
  - d. Ask patient/resident to bend and separate knees. Help patient/resident if required. Wash scrotum carefully. Rinse and pat dry.
14. Turn patient/resident away from you. Use a new washcloth and wash around anus. Rinse area and dry.
  15. Help position patient/resident onto back.
  16. Remove protective pad under buttocks and remove gloves.
  17. Put top sheet over patient/resident and have patient/resident hold it at top while you remove the drape, sheet or bath blanket.
  18. Replace blanket and spread.

**MANUAL SKILL: Empty Urinary Drainage Bags**

(see module 7)

**EQUIPMENT:**

Antiseptic wipe  
Disposable gloves  
Graduate  
Paper towel

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Place paper towel on floor with graduate on it so that urine can be collected when drain is open.
2. Open the clamp on the bottom of the drainage bag.
3. Let all urine drain into the graduate. Do not let the drain touch the graduate.
4. Close the clamp and clean with antiseptic wipe, then replace the clamped drain in the holder bag.
5. Measure the amount of urinary output. See Manual Skill 8.16 Records and Measures Urinary Output.
6. Discard paper towel and antiseptic wipe.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. After placing used equipment in designated dirty supply area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Catheter Care for Female (not Tested in California)**

**EQUIPMENT:**

Basin of warm water and soap or perineal wash  
Bath blanket or sheet for privacy  
Bedpan  
Gloves  
Towels  
Washcloths  
Waterproof protector for bed

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Before washing check water temperature for safety and comfort and ask patient/resident to verify comfort of water.
2. Place pad/linen protector under perineal area before washing and cover with bath blanket.
3. Expose area surrounding catheter while avoiding over exposure of patient/resident.
4. Apply soap or perineal wash to wet washcloth.
5. While holding catheter near meatus without tugging, clean at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.
6. While holding catheter near meatus without tugging, rinse at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.

7. While holding catheter near meatus without tugging, dry at least four inches of catheter nearest meatus, moving in only one direction, away from meatus, using a clean area of the cloth for each stroke.
8. Empty, rinse, and dry basin.
9. After rinsing basin, place basin in designated dirty supply area.
10. Dispose of used linen into soiled linen container and dispose of linen protector appropriately.
11. Avoid contact between Nurse Assistant's clothing and used linen.
12. After disposing of used linen and placing used equipment in designated dirty supply area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Position patient/resident comfortably.
3. Place call light within reach.
4. Lower bed to safe position for the patient/resident.
5. Leave room neat.
6. Wash hands.
7. Document.
8. Report abnormal findings to licensed nurse.



**MANUAL SKILL: Assisting Patient/resident to Commode/Toilet**

**EQUIPMENT:**

Basin  
Commode/toilet  
Disposable gloves  
Toilet paper  
Towel, water and soap (or hand wipe)

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. For commode:
  - a. Place next to bed.
  - b. Position for patient's/resident's convenience.
  - c. Lock wheels.
  - d. Remove cover, be sure bedpan or other receptacle is present in commode.
2. Position bed at lowest point, lower side rails nearest commode.
3. Assist patient/resident to sitting position on side of bed with feet flat on floor.
4. Before assisting to stand, patient/resident is wearing non-skid footwear.
5. Assist patient/resident to standing position.
6. For commode, pivot patient/resident and lower to commode. For toilet, assist patient/resident to ambulate to bathroom, and lower to toilet. Use of gait belt is per facility protocol.
7. Leave call bell and toilet tissue within reach.

8. Maintain privacy, but do not leave patient/resident unattended.
9. When patient/resident signals, return promptly.
10. Put on gloves and assist patient/resident to clean anus and perineum.
11. Allow patient/resident to wash and dry hands.
12. Assist patient/resident back to bed.

**ENDING STEPS:**

1. Position patient/resident comfortably.
2. Place call light within reach.
3. Lower bed to safe position for the patient/resident.
4. Put cover on commode and remove to bathroom, noting contents and measuring if required.
5. Empty and clean per facility policy.
6. Measure output. See Manual Skill 8.16 Measures and Records Urinary Output.
7. Return clean commode to proper place.
8. After cleaning equipment and placing used equipment in designated area, remove and dispose of gloves (without contaminating self) into waste container and wash hands.
9. Leave room neat.
10. Wash hands.
11. Document output.
12. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Colostomy Care**

**EQUIPMENT:**

Bedpan  
Clean colostomy appliance prepared to fit stoma  
Cleansing agent or soap (cleansing agent is ordered by team leader)  
Disposable bed protector  
Gloves  
Skin barrier as ordered by team leader  
Toilet tissue  
Washbasin  
Washcloth and towel

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Raise bed to working position.
2. Lower side rails.
3. Place disposable bed protector under patient/resident.
4. Fill washbasin half full of warm water.
5. Gently remove soiled stoma bag and place in bedpan.
6. Wipe area around stoma with toilet tissue to remove feces or mucus.
7. Place dirty tissue in bedpan.

8. Clean skin around stoma with water or prescribed cleaning agent.
  - a. If medicated agent is used, must be applied by licensed nurse.
  - b. Note any evidence of skin breakdown or redness.
9. Rinse entire area well to remove any residue.
10. Pat area dry with towel gently but thoroughly.
11. Apply skin barrier if ordered.
12. Remove adhesive backing on appliance.
13. Center appliance over stoma; apply gentle pressure to adhesive surface from stoma outward.
14. If used, connect belt to appliance.
15. Cover bedpan and take it to the bathroom, maintain patient/resident safety and privacy.
16. Measure as directed; empty pouch and bedpan; note color, amount, consistency, and odor.
17. Put pouch in disposable bag.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Measures and Records Weight of Ambulatory Patient/resident**

**EQUIPMENT:**

Paper towel  
Portable upright scale

**BEGINNING STEPS:**

1. Gather equipment, if applicable.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explains procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
7. Provide for privacy with a curtain, door, or screen.

**SKILL STEPS:**

1. Make sure client has shoes on before walking to scale.
2. Before patient/resident steps onto scale, candidate sets scale to zero then obtains client's weight.
3. While client steps onto scale, candidate stands next to scale and assists client, if needed, onto center of scale.
4. While client steps off scale, candidate stands next to scale and assists patient/resident, if needed, off the scale before recording weight.
5. Before recording, washes hands.
6. Records weight based on indicator on scale. Weight is within plus or minus 2 lbs. of evaluator's reading. If weight recorded in kg weight is within plus or minus 0.9 kg of evaluator's reading.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Weighing the Patient/resident in Bed**

(see module 7)

**EQUIPMENT:**

Overbed scale

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Check scale sling for frayed area or poorly closing straps.
2. Take scale and mechanical lift to patient's/resident's bedside.
3. Set scale to zero.
4. Balance scale to include weight of sling, straps, and linen prior to positioning patient/resident in sling.
5. Provide for privacy.
6. Assist the patient/resident to use the bedpan.
7. Lock bed wheels.
8. Raise bed to comfortable working level for Nurse Assistant.
9. Lower side rail on Nurse Assistant's side. Make sure side rail on other side is up and locked.
10. Turn patient/resident away from the Nurse Assistant.
11. Place the sling folded lengthwise under the patient/resident.
12. Turn the patient/resident toward Nurse Assistant and position sling so that the patient/resident rests centered within the sling.
13. Turn and position patient/resident onto his or her back (supine position).
14. Attach suspension straps to sling. Check that all attachments are securely in place and hook points facing outward, away from patient's/resident's body.
15. Position frame over bed with base legs in the maximum open position.

16. Lock frame.
17. Attach suspension straps to frame.
18. Position patient's/resident's arms inside straps.
19. Slowly raise sling so patient's/resident's body is not touching the bed.
20. Adjust weights to balance scale.
21. Record weight.
22. Reposition sling over center of bed.
23. Slowly lower the patient/resident onto the bed.
24. Take off hooks and straps.
25. Turn patient/resident toward Nurse Assistant and remove sling.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.



**MANUAL SKILL: Weighing the Patient/resident in a Wheelchair**

(see module 7)

**EQUIPMENT:**

Wheelchair scale

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Weigh empty wheelchair and all miscellaneous linens and clothing.
2. Take wheel chair to patient/resident and assist patient/resident into wheel chair.
3. Take patient/resident to scale with wheel chair platform.
4. Provide for privacy.
5. Roll wheel chair with patient/resident onto platform.
6. Lock wheels of wheel chair.
7. Adjust weights to balance scale.
8. Record weight.
9. Return patient/resident to bed as necessary.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Measuring the Height of Patient/resident Using an Upright Scale**

(see module 7)

**EQUIPMENT:**

Portable upright scale

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Assures patient/resident has shoes/nonskid slippers on before walking to scale
2. Take the patient/resident to the scale or bring the scale to the patient's/resident's room.
3. Provide for privacy.
4. Place a paper towel on the platform of the scale.
5. Assist the patient/resident to remove their slippers.
6. Raise the height rod.
7. Assist the patient/resident to stand on the scale platform, arms at side.
8. Have the patient/resident turn around and face away from the scale.
9. Lower the height measurement rod until it rests on the patient's/resident's head.
10. Record the height. The reading is made at the movable point of the ruler.
11. Assist the patient/resident off the platform.
12. Assist the patient/resident to put on their slippers.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Measuring the Height of a Patient/resident in Bed**

(see module 7)

**EQUIPMENT:**

Pencil  
Tape measure

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

**SUPINE POSITION**

1. Lower side rail on your side.
2. Position patient/resident on his or her back (supine position).
3. Draw a small pencil mark at the top of the patient's/resident's head on the sheet. If the patient/resident is stooped over or contracted, measure the patient's/resident's body in segments and total the measurements. (See below).
4. Make a second pencil mark even with the patient's/resident's heels.
5. Position the patient/resident on his/her side with his/her back toward the Nurse Assistant.
6. Using the tape measure, measure the distance between the two marks.

**CONTRACTED PATIENT/RESIDENT**

1. Measure from crown to hip.
2. Measure from hip to knee.
3. Measure from knee to heel.
4. Add total of three measurements.
5. Record and report.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

**MANUAL SKILL: Applying a Behind-the Ear Hearing Aid**

**EQUIPMENT:**

Fresh battery (if required)  
Hearing aid

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

**SKILL STEPS:**

1. Check the hearing aid to be sure batteries are working and tubing is not cracked.
2. Check to be sure hearing aid is turned off or volume is turned to lowest level.
3. Look into the patient's/resident's ear to check for wax buildup or other problems such as sores.
4. Handle the hearing aid carefully. Do not drop it nor get it wet.
5. Hand the hearing aid to the patient/resident so that you can assist the patient/resident if necessary as he/she inserts the hearing aid ear mold into the ear canal.

**Alternative actions:**

1. Grasp the ear mold and gently insert the tapered end into the ear canal.
2. Gently twist the ear mold into the curve of the ear while gently pulling the earlobe with the other hand. The hearing aid should fit snugly, but comfortably, flush with the ear.
3. Turn on the control switch.
4. Adjust the volume while talking to the patient/resident. Stop when the patient/resident can hear you.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.



**MANUAL SKILL: Removing a Behind-the Ear Hearing Aid**

**EQUIPMENT:**

Hearing aid  
Hearing aid storage container

**BEGINNING STEPS:**

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy with a curtain, door, or screen.
8. Apply gloves (standard precautions).

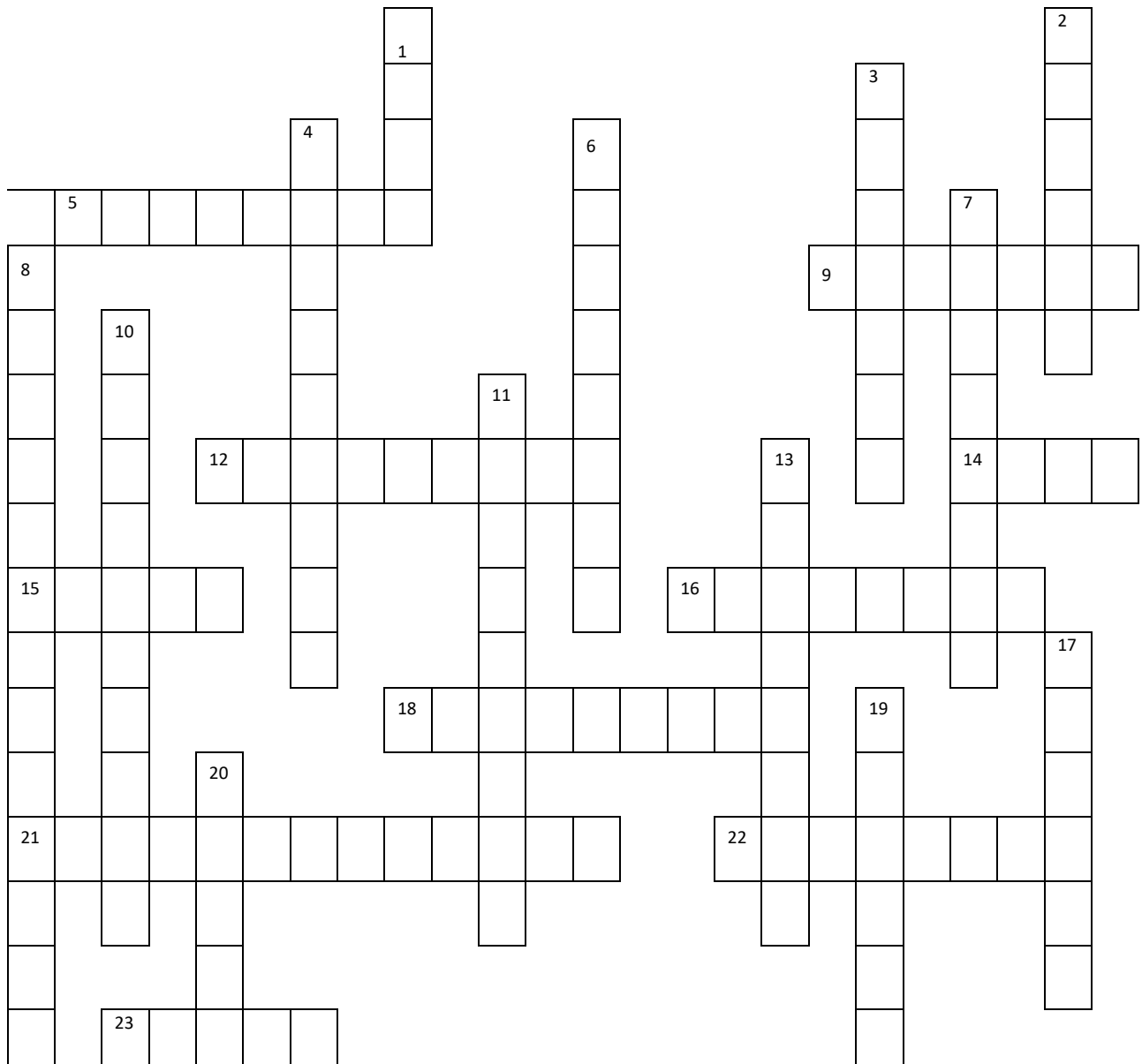
**SKILL STEPS:**

1. Turn off the hearing aid.
2. Loosen the outer portion of the hearing aid mold by GENTLY pulling on the upper part of the ear.
3. Lift the ear mold upward and outward.
4. Make sure on-off switch is in off position.
5. Remove battery if necessary.
6. Store hearing aid in a container marked with the patient's/resident's name.
7. Place it in the bedside stand or other safe place as facility policy states.

**ENDING STEPS:**

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container and wash hands.
3. Position patient/resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

# Patient/resident Care Skills Crossword #1



**Across**

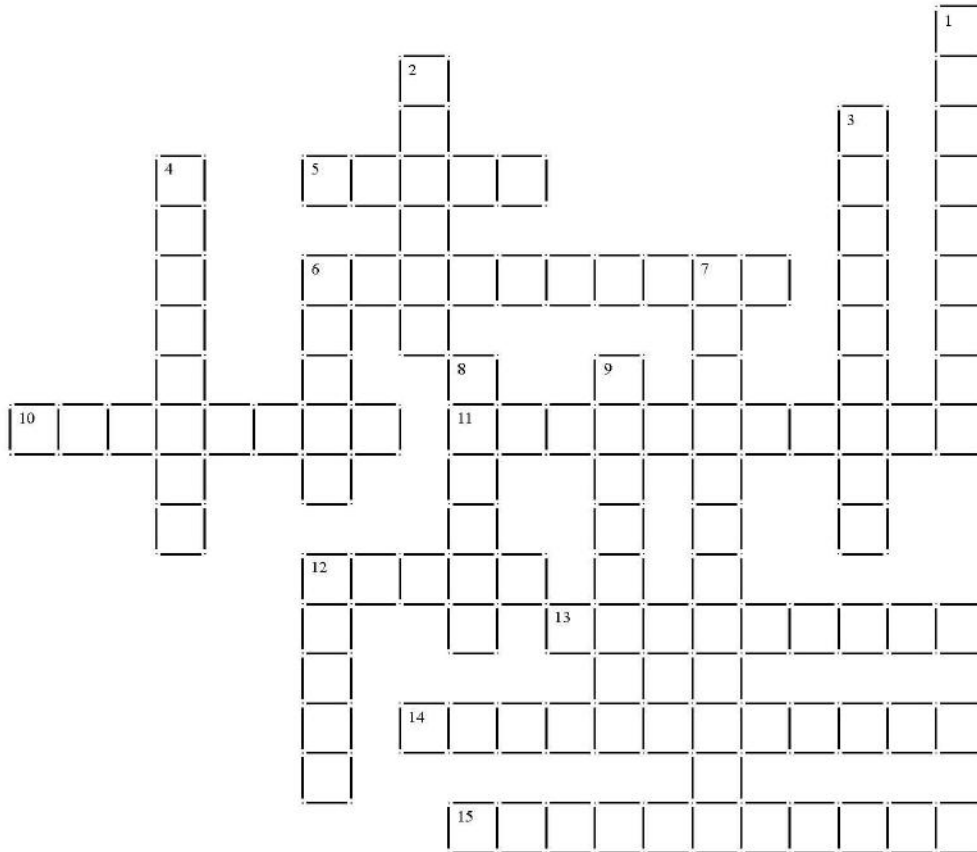
- 5** A spot where skin or mucous membrane has been scraped off.
- 9** A way of tucking linens under the mattress to keep the linens straight and smooth at the corner.
- 12** A small sheet placed over the middle of the bottom sheet.
- 14** Mouth.
- 15** An open sore.
- 16** Bluish discoloration of the skin.
- 18** Outer layer of the skin.
- 21** The head of the bed is lowered and the foot of the bed is raised.
- 22** Area of the genitalia and anus.
- 23** Part on the bed that allows the head or foot of the bed to be raised or lowered.

**Down**

- 1** A bed where the top linens are folded to the foot of the bed indicates that it is\_\_\_\_\_.
- 2** A bed where the top linens are not folded back indicates that it is\_\_\_\_\_.
- 3** Referring to health and cleanliness.
- 4** Official departure of a patient/resident from a facility or nursing unit.
- 6** Itching.
- 7** The death of a group of cells.
- 8** Skin.
- 10** A bed with no one in it.
- 11** Referring to a particular type of skin breakdown, and a recumbent position.
- 13** Moving a patient/resident from one room, nursing unit, or facility to another.
- 17** Inner layer of skin.
- 19** Space under the upper arm.
- 20** Official entry of a person into a facility or nursing unit.



## Resident Care Skills Crossword #2



### Across

- 5 Fluid excreted by the kidneys.
- 6 Excessive gas in the stomach and intestines.
- 10 A tube used to drain or inject fluid through a body opening.

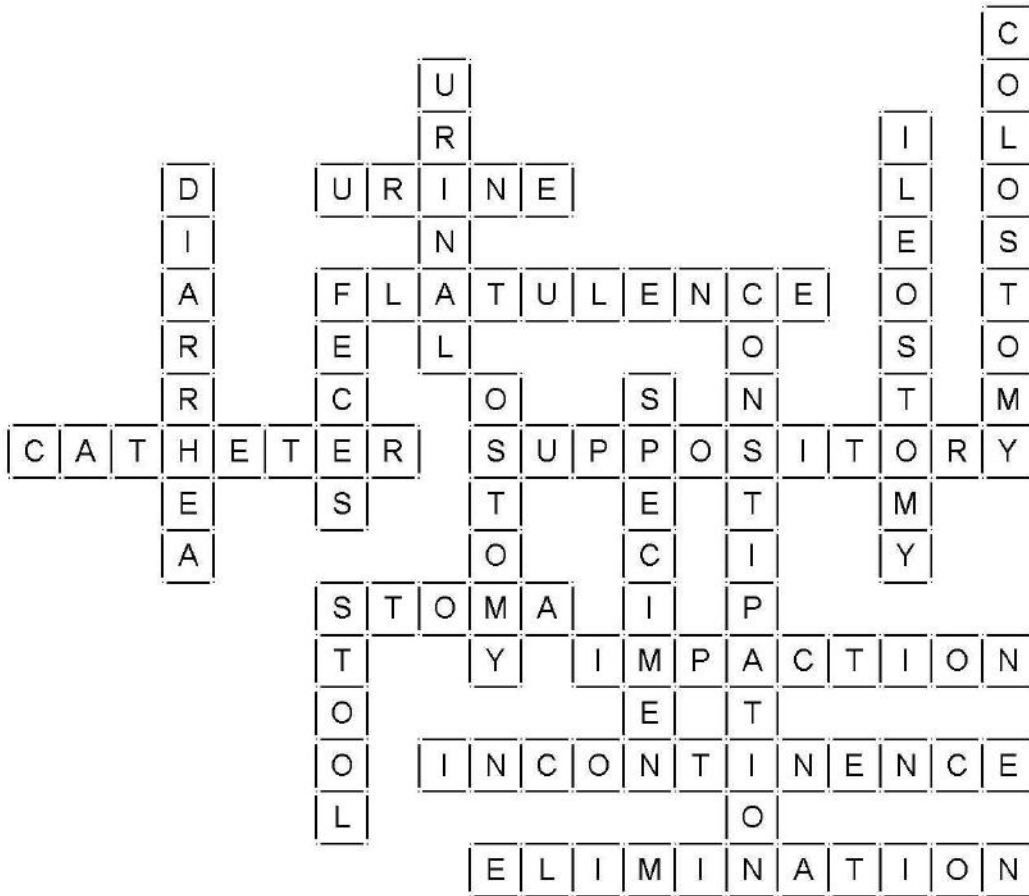
### Down

- 1 An artificial opening between the large intestine and the abdominal surface.
- 2 Used by men for urination.
- 3 The surgical creation of an opening between the ileum (small intestine) and the abdomen.

Module 8: Patient/resident Care Skills Handout 8.1Cc-Crossword #2

- |  |  |
|--|--|
| <b>11</b> A cone-shaped solid medication that is inserted into a body opening. | <b>4</b> The frequent passage of liquid stools.          |
| <b>12</b> An opening.  | <b>6</b> The excretions of the bowels.                   |
| <b>13</b> A buildup of hard feces in the rectum.                               | <b>7</b> Passage of a hard, dry stool.                   |
| <b>14</b> The inability to control the passage of urine or feces.              | <b>8</b> The surgical creation of an artificial opening. |
| <b>15</b> Excretion of wastes.   | <b>9</b> A sample of something.                          |
|  | <b>12</b> Feces that have been excreted.                 |

## Resident Care Skills Crossword #2





**High Risk Factors for Skin Breakdown and Interventions to Prevent**

<b><u>High Risk Factors</u></b>	<b><u>Interventions</u></b>
<p>1. Mobility/Sensory:</p> <ul style="list-style-type: none"> <li>Paraplegic</li> <li>Quadriplegic</li> <li>CVA</li> <li>Peripheral Vascular Disease</li> <li>Bed rest</li> <li>Diabetic</li> <li>COPD</li> <li>Decreased sensation</li> </ul>	<p>Control pressure-egg crate; air bed ROM at least every 4 hours.</p> <p>Turn every two hours, even air bed.</p> <p>Proper position with pillows.</p> <p>Avoid friction, or shear by using draw sheet, trapeze.</p> <p>Specific pressure relief devices-booties, elbow, wheel chair pad.</p> <p>Assesses skin every 8 hours.</p> <p>Keep HOB below 30 degrees as much as possible.</p>
<p>2. Elimination:</p> <ul style="list-style-type: none"> <li>Incontinence stool/urine</li> <li>Diaphoresis</li> <li>Dehydrated</li> <li>Leaking tubes</li> </ul>	<p>Keep dry-fecal incontinence bag, rectal tube, Foley cath, texas cath.</p> <p>Caution with “diapers”. Use briefs.</p> <p>Check diaphoretic patient.</p> <p>Change diet or stool routine.</p> <p>R/O UTI and other causes.</p> <p>Adjust meds-watch for yeast.</p> <p>No plastic near skin-watch “Attends”.</p> <p>Cleanse-do not “scrub” pat dry well.</p>
<p>3. Edema/Fluid status:</p> <ul style="list-style-type: none"> <li>Edema/swelling</li> <li>Dehydration</li> </ul>	<p>Elevate limb and change position.</p> <p>Use compression devices-TEDS.</p> <p>Ace wrap <u>BUT</u> remove every 8 hours and check skin; check that device does not cut in on the edges.</p>

***High Risk Factors for Skin Breakdown and Interventions to Prevent***

**High Risk Factors**

**Interventions**

	<p>Force fluids 2000 day if low.                  Check skin every 8 hours.                  Lotion skin frequently-especially dry skin.</p>
<p>4. Nutrition/Body structure:</p> <ul style="list-style-type: none"> <li>Obese</li> <li>Thin</li> <li>Poor appetite</li> <li>Nutritional lab values low</li> </ul>	<p>Dietary consult.                  Medicate for N&amp;V (nausea &amp; vomiting); diarrhea                  Supplement diet-need protein, vitamins, and minerals.                  Use semi-fowlers position for tube feeders</p>
<p>5. Other Predisposing Factors:</p> <ul style="list-style-type: none"> <li>COPD</li> <li>Diabetes</li> <li>Medications-Prednisone</li> <li>Cancer</li> <li>Splints/casts</li> <li>Prosthetic devices</li> <li>Anemic</li> </ul>	<p>Licensed nurse check labs-anemia, protein, oxygen saturation, albumin                  Steroids-slow healing, mask infection, fragile skin.                  Check oxygen sat. Possible oxygen.                  Keep track of patient's blood sugars.</p> <p>Realize some patients will break down no matter what.                  Close watch on high risk areas of feet and coccyx.</p>

### Staging of Pressure Sores

#### **Stage I**

- The skin has not been broken.
- The epidermis and dermis are intact.
- Has erythema that does not resolve within 30 minutes.

#### **Goal:**

- Prevent skin breakdown
- Heal in 48 hours with pressure relief.

#### **Stage II**

- The skin is open.
- There is damage to the epidermis and PART of the dermis can be involved.
- The skin can be cracked, blistered, broken open, and reddened.
- No necrotic tissue is present.
- Wound bed is moist, pink and painful.

#### **Goal:**

- Re-epithelialization
- Heal in 5-7 days

#### **Stage III**

- Have a full thickness loss (epidermis and dermis gone) or partial dermis left but has necrotic tissue is present in wound.
- May or may not have necrotic tissue in deeper full lose wounds.
- May not be painful.

#### **Goal:**

- Granulation, contraction, re-epithelialization.
- Takes weeks to months to heal.

**Stage IV**

- Involves deep tissue including possible fat, muscle, and bone.
- Can have granulated tissue, necrotic tissue, and eschar.
- Some wounds have tunneling or undermining.
- Osteomyelitis of the bone is a threat.

**Goal:**

- Granulation, contraction, and re-epithelialization.
- Long term healing process – months.
- May need skin graft or flap to heal.

A licensed nurse assesses and “Stages” wounds. A wound is not “staged” until the eschar is gone and wound bed can be visualized and assessed. Wounds are reassessed at every dressing change or every eight hours if possible. Wounds may continue to deteriorate within the first 5-7 days of treatment and may even look worse. The wound care is not to blame; it is just the wound declaring the true amount of damage that was done, now that it is in a “good” environment.

**“Sitting on Hand” Activity**

**Purpose** - To help student understand the principles of pressure on the skin and how their patient/resident may feel this pressure

**Timing** - At beginning of skin lecture

1. Ask students to take their non-dominant hand and place entirely under their buttocks while sitting.
2. Instruct student that they may not move/shift positions or remove hand until you tell them they can in five minutes.
3. Observe students while lecturing and note shifting and moving – remind them not to do so.
4. After five minutes have students remove hand from under buttock and note: red, pain and numbness.
5. Reinforce patients/residents may not be able to move and they only get moved every two hours.

**Bowel & Bladder Assessment Program**

Date																					
Date Started	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM	Incontinent	Voided	BM
7 am																					
8 am																					
9 am																					
10 am																					
11 am																					
12 noon																					
1 pm																					
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11 pm																					
12 Midnight																					
1 am																					
2 am																					
3 am																					
4 am																					
5 am																					
6 am																					
Signature																					
7-3																					
3-11																					
11-7																					

S- Suppository Inserted  
BM-Bowel Movement

Licensed Nurses Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name- Last	First	Middle	Room No.	Attending Physician	Hosp. No.

**Bowel & Bladder Retraining Program**  
Form 609 Briggs, Des Moines, Iowa 50306