

Module 8: Patient Care Skills**Minimum Number of Theory Hours: 14****Recommended Clinical Hours: 44****Statement of Purpose:**

The purpose of this unit is to teach the students skills needed to support and/or assist the 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 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 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 |

Performance Standards (Objectives):

Upon completion of fourteen (14) hours of class plus homework assignments and forty-four (44) hours of clinical experience, the learner will be able to:

1. Define key terminology.
2. Identify and assist 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 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 resident needing assistance, and for the unconscious individual.

NAIL CARE, HAIR CARE, SHAVING

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

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

MEASURING HEIGHT AND WEIGHT

22. Describe the procedures for weighing and measuring height of the 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.

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
<p>Objective 1 Define Key Terminology</p> <p>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- Resident Care Skills Crossword-1. E. Handout 8.1b- Resident Care Skills Crossword-1-KEY. F. Handout 8.1c- Resident Care Skills Crossword-2. G. Handout 8.1d- Resident Care Skills Crossword-2-KEY.</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>Objective 2 Identify and assist residents with daily routine care, promoting independence and dignity.</p> <p>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. D. Specific manual skills are listed under each</p>	<p>A. Written test B. Assists residents with daily routine care.</p>

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

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

<p>Objective 6 Describe procedure of oral hygiene and denture care for a resident needing assistance, and for the unconscious individual.</p> <p>A. Carry out procedure using standard precautions</p> <ol style="list-style-type: none"> 1. Contact with mucous membranes. 2. Gums may bleed. 3. Pathogens may exist in the mouth. <p>B. Examine oral cavity and report findings</p> <ol style="list-style-type: none"> 1. Dry, cracked, swollen or blistered lips. 2. Redness, swelling, sores or white patches in the mouth or on the tongue. 3. Redness, swelling or bleeding of gums. 4. Loose broken or chipped teeth. 5. Resident complaints. <p>C. Dentures</p> <ol style="list-style-type: none"> 1. Dentures are very costly and fragile. 2. Handle with care at all times. 3. Any observed damage to dentures. 	<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 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>Objective 7 Identify the Nurse Assistant's role and responsibility for resident nail care and foot care.</p> <p>A. Performed to prevent infection, injury and odors. Guidelines:</p> <ol style="list-style-type: none"> 1. Nails are easier to clean after soaking in warm, soapy water. 2. Cut fingernails with clippers, not scissors (if facility allows). 3. File fingernails with emery board. 4. When trimming fingernails, be cautious to prevent damage to tissues. 5. Do not trim nails on resident with diabetes or if on medication that affects blood clotting and circulatory problems. 6. Do not cut or trim toenails. 	<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</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"> 7. Report unusual conditions to licensed nurse such as redness or tenderness of finger tips, cuticles or toes. 8. Follow facility procedure. 	Care.	
<p>Objective 8 Identify the Nurse Assistant's role and responsibility for caring for hair or residents.</p> <ul style="list-style-type: none"> A. Hair care <ul style="list-style-type: none"> 1. Part of daily care. 2. Important for identity and self-esteem. 3. Accommodate resident preferences for style, hair products. 4. Shampoo Types <ul style="list-style-type: none"> a. Shower/tub. b. Sink. c. Bed. 5. Medicinal shampoos are performed per facility policy. B. Report observations <ul style="list-style-type: none"> 1. Scalp sores. 2. Flaking. 3. Presence of lice. 4. Patches of hair loss. 5. Very dry or oily hair. 6. How procedure was tolerated. 	<ul style="list-style-type: none"> A. Lecture/Discussion B. Demonstration/return demonstration. C. Role play. D. Refer to Manual Skill Procedure 8.8a - Combing the Resident's Hair. E. Refer to Manual Skill procedure 8.8b- Shampoo with Shower/Tub Bath. F. Refer to Manual Skill procedure 8.8c- Shampoo of Bedridden Resident. 	<ul style="list-style-type: none"> A. Written test B. Cares for resident's hair daily.
<p>Objective 9 Describe procedure for shaving a resident.</p> <ul style="list-style-type: none"> A. Important for feelings of comfort and self-esteem B. Guidelines <ul style="list-style-type: none"> 1. Use either electric razor or safety razor (resident choice/facility policy). 2. If using an electric razor use appropriate safety precautions for electrical equipment. 3. Safety razors can cause nicks or cuts; use standard precautions to prevent contact with blood. 	<ul style="list-style-type: none"> A. Lecture/Discussion B. Demonstration/return demonstration. C. Role play. D. Refer to Manual Skill Procedure 8.9- Shaving the Resident. 	<ul style="list-style-type: none"> A. Written test B. Follows guidelines for shaving residents.

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

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

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

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

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

<ol style="list-style-type: none"> 1. Complete loss of bladder control. 2. Urinary retention (inability to urinate). 3. Before, during, and after surgical procedures. 4. Too weak or disabled to use commode, bedpan or bathroom. 5. Prevention of urine contamination on wounds and pressure ulcers. 6. Not for convenience. <p>D. Complication resulting from catheters</p> <ol style="list-style-type: none"> 1. Bladder infection. 2. Blockage. 3. General rules of catheter care <ol style="list-style-type: none"> a. Tubing should not be kinked or compressed (urine should flow without obstruction). Coil tubing on the bed. b. Do not pull on catheter tubing. c. Keep drainage bag below level of the bladder. d. Drainage bag should be attached to the bed frame, not the side rail. e. Never allow bag to touch the floor. f. Catheter should be secured to the inner thigh. g. Clean the perineal area and around the catheter, soapy water is adequate (use the procedure for catheter care preferred by facility). h. Drainage bag should be emptied and measured each shift (or more often if ordered/required). i. Report resident complaints promptly to the licensed nurse. j. Follow the rules of asepsis at all times, keep drainage systems closed. k. Check for leaks and report status. l. Use separate measuring containers for each resident. m. Encourage fluids. <p>E. Report observations</p> <ol style="list-style-type: none"> 1. Complaints of pain, burning, need to urinate, or irritation 		
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2. Color, clarity, odor, presence of particles.		
<p>Objective 19 Describe the goals and methods for bowel and bladder training.</p> <p>A. General Guidelines</p> <ol style="list-style-type: none"> 1. Goal is to regain voluntary control of bowels and bladder. 2. Follow standard precautions. 3. Follow bowel and bladder training schedule. 4. Offer toileting per facility protocol. 5. Explain schedule to resident. 6. Encourage proper diet. 7. Answer call light immediately. 8. Provide for privacy. 9. Assist with perineal care to prevent skin breakdown. 10. Keep accurate record of elimination pattern following facility protocol. <p>B. Bladder training</p> <ol style="list-style-type: none"> 1. If having difficulty voiding <ol style="list-style-type: none"> a. Have resident lean forward slightly. b. Run water. c. Never rush resident. 2. Follow facility policy for clamping of urinary catheter. <p>C. Bowel training</p> <ol style="list-style-type: none"> 1. Suppository at a regular time. 2. Increase fluids. 3. Diet will affect regularity. 	<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>Objective 20 Describe the normal pattern of bowel movements and reportable observations.</p> <p>A. Each person is different and has own pattern.</p> <ol style="list-style-type: none"> 1. Frequency – daily to every 2 to 3 days. 2. Time of day – morning or evening. 3. The Nurse Assistant should note and report stool shape, size, 	<p>A. Lecture/Discussion</p> <p>B. Refer to Manual Skill Procedure 8.20- Assisting Resident to</p>	<p>A. Written test</p> <p>B. Assists 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"> 1. Stool shape. 2. Size. 3. Frequency. 4. Color. 5. Consistency. 6. Amount. 7. Complaints of pain with defecation. <p>C. Factors influencing bowel movements</p> <ol style="list-style-type: none"> 1. Privacy – fear of others, hearing and/or smelling. 2. Age – as resident ages, more problems. 3. Diet – need balanced diet with regular meals, food stimulates bowel movement. 4. Fluids – need adequate fluid. 5. Activity – stimulates. 6. Medications – most tend to constipate. 7. Personal habits. 8. Disabilities. <p>D. General rules for maintaining normal elimination patterns</p> <ol style="list-style-type: none"> 1. Promptly provide the bedpan, urinal, or commode, or help the resident to the bathroom when the request is made. 2. Assist the resident to get into normal position (as much as is possible or safe). 3. Cover the resident for privacy and warmth. 4. Remain nearby if the person is weak or frail. 5. Place the signal light and toilet tissue nearby. 6. Allow the person time to carry out the elimination process. 7. If 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. 	Commode/Toilet.	
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8. Provide perineal care if needed. 9. Offer the opportunity to eliminate at regular intervals.		
<p>Objective 21 Explain the purpose of an ostomy and the care of residents with an ostomy.</p> <p>A. Definition of ostomy</p> <ol style="list-style-type: none"> 1. Surgical creation of an artificial opening most commonly into colon or small intestine. 2. Some ostomies are for urinary drainage, i.e. nephrostomy, ureterostomy. 3. Urine or feces and flatus pass through opening. 4. Allow for healing of intestine after surgery or disease. 5. Can be temporary or permanent. <p>B. Terms used with ostomy residents</p> <ol style="list-style-type: none"> 1. Stoma – a portion of the intestine brought to the surface of the abdomen to allow for drainage. <ol style="list-style-type: none"> a. Pink and moist/red like mucous membrane. b. Size and shape are different depending on area of intestine and resident. c. Can bleed when cleaned. 2. Peristomal skin – the skin around the stoma; it should be clean, intact and dry. 3. Appliance – the wafer and pouch or bag that protects the resident's skin and collects the drainage. <p>C. Ostomy types</p> <ol style="list-style-type: none"> 1. Location depends on the disease or injury. 2. Names according to location <ol style="list-style-type: none"> a. Colostomy <ol style="list-style-type: none"> 1) Ascending and transverse <ol style="list-style-type: none"> a) Stool is consistency of pureed liquid with slightly acidic content. b) Must wear pouch all the time. 	<p>A. Lecture/Discussion</p> <p>B. Show supplies for colostomy care.</p> <p>C. Demonstrate/return demonstration on manikin for colostomy care.</p> <p>D. Refer to Manual Skill procedure 8.21- Colostomy Care.</p>	<p>A. Written test</p> <p>B. Follows guidelines when providing care for resident's with colostomy.</p> <p>C. Follows guidelines when changing ostomy appliance.</p> <p>D. Follows guidelines when emptying ostomy bag.</p> <p>E. Provides skin care to resident with an ostomy.</p>

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

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

<p>5. Cord- connects the amplifier to the earmold.</p> <p>6. On/off switch-turns hearing aid on/off and may control volume.</p> <p>C. Care of Hearing aids</p> <ol style="list-style-type: none"> 1. Caution: Never wash a hearing aid or immerse in water, as it will be ruined. 2. Report to licensed nurse when the hearing aid needs cleaning or appears damaged. 3. Check the battery periodically. 4. Never drop the hearing aid. 5. Do not attempt to repair hearing aids. 6. Do not expose the hearing aid to heat. 7. Do not let moisture get into the hearing aid. 8. Do not use any kind of hair spray or medical spray on residents while their hearing aids are in place the spray can clog the microphone opening. 9. Check food trays and bed linens for misplaced hearing aids. <p>D. Storage of a hearing aid</p> <ol style="list-style-type: none"> 1. Turn the hearing aid off when it is not in use. 2. Store a hearing aid in a well-marked container labeled with resident's name and room number. 3. Label hearing aids with resident's name. <p>E. Placement of the hearing aid</p> <ol style="list-style-type: none"> 1. Turn down the volume before placing the hearing aid in the external ear canal. It should fit tightly but comfortably. 2. After the hearing aid is in place, turn it on and adjust the volume so that resident can hear in a normal tone. The resident will tell you when he or she can hear comfortably. 3. If the 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. <p>F. Checking the batteries</p> <ol style="list-style-type: none"> 1. Before applying a hearing aid, check the batteries. 		
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<ol style="list-style-type: none">2. Be sure they are the right size for the hearing aid.3. The battery case must close easily or something is wrong.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.5. If the resident complains that he or she cannot hear any sound,<ol style="list-style-type: none">a. First check if hearing aid is turned on.b. Remove the hearing aid and check the batteries for freshness.c. Check to see if the hearing aid is broken.d. Clean ear mold if necessary.6. If the resident complains of hearing only intermittent sound, remove and check the batteries.		
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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 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 resident. Which of the following observations should be reported immediately to the nurse?
 - A. Dry skin on the 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 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 resident not to ambulate without assistance.
5. In preparing the bath for the dependent 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 resident in the tub before adding water.

6. When bathing a dependent resident, the Nurse Assistant should:
 - A. Leave the room at intervals to encourage the 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 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 resident, into a bathtub, the Nurse Assistant should:
 - A. Stand at the side of the tub and have the resident hold on to your shoulder as she steps into the tub.
 - B. Place a chair next to the tub and have the resident hold on to the chair as she steps into the tub.
 - C. Have the resident hold on to the grab bar in the tub enclosure as she steps into the tub.
 - D. Have the 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 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 resident with oral hygiene:
- A. Offer a cup of mouthwash to the 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 resident's chin when he/she needs to spit.
 - D. Let the resident rinse his/her mouth with orange juice after brushing teeth.
13. When the 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 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 resident, it is important for the Nurse Assistant to:
- A. Prevent the resident from aspirating (breathing in) any fluid.
 - B. Hold the resident's mouth open with your fingers.
 - C. Use large amounts of mouthwash for rinsing the 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 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 resident a nail clipper so that he may cut his nails himself.
 - D. Use a sharp scissors to trim the excess nail after a bath.
18. To clean under the fingernails of the 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 resident, the Nurse Assistant should:
- A. Comb it into a new style each day.
 - B. Style it according to the resident's wishes.
 - C. Apply hair oil to reduce static.
 - D. Wait until family comes in.
20. Before combing or brushing a 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 resident's shoulders.
 - D. Soak the resident's comb and brush in a disinfectant solution.

21. The purpose of shampooing the hair of residents is to:
- A. Remove tangles.
 - B. Lower body temperature.
 - C. Maintain cleanliness and well-being.
 - D. Be part of daily care of 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 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 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 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 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 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 resident flat on his back.
 - D. Assist the 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 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 resident, a general rule to follow is to:
- A. Weigh the resident at different times each day.
 - B. Have the resident be NPO before weighing.
 - C. Balance the scale before the resident steps on it.
 - D. Weigh the resident fully dressed.
29. If a resident is unable to stand up while being measured it is best to:
- A. Estimate the resident's height.
 - B. Measure the resident's height while lying in bed.
 - C. Ask the resident how tall he was when ambulatory.
 - D. Chart that the measurement was not done because the resident could not stand.
30. A resident was admitted to the nursing unit several days after surgery. To prevent problems, the Nurse Assistant should:
- A. Leave the resident in bed at all times.
 - B. Tell the resident to remain in the same position at all times.
 - C. Tell the resident to cough and deep breathe every two hours.
 - D. Leave the resident alone to rest all day.

31. The Nurse Assistant is caring for a resident who wants to shave with a safety razor. The resident should not use the razor if the 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 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 resident who does not like to bathe. The Nurse Assistant should NOT:
- A. Prepare the resident before bathing.
 - B. Give a sponge bath if resident resists tub or shower.
 - C. Force the resident into the shower or tub.
 - D. Schedule bathing when resident is agitated.
35. A resident is to be weighed daily. The Nurse Assistant should:
- A. Weigh the resident at the same time of day.
 - B. Hold the resident on the scale, if unable to stand.
 - C. Not weigh the resident who is unable to stand on scale.
 - D. Not allow the resident to urinate before being weighed.

36. When preparing to bathe a resident, the Nurse Assistant should provide privacy curtains:

- A. Immediately after entering the room.
- B. Before beginning the bath.
- C. After washing the resident's face.
- D. After completing the bath.

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

46. When preparing to shave a resident, the Nurse Assistant should soften the 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 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 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 resident must make.
 - B. Denying the resident the ability to make a personal choice about when her care would be done.
 - C. Showing the resident who was the boss was on the unit.
 - D. Performing job duties as expected.

50. When bathing a resident, a Nurse Assistant should observe:

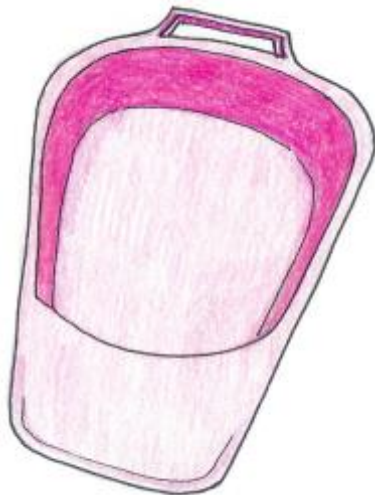
- A. Body size.
- B. Body tone.
- C. Skin condition.
- D. Amount of body fat.

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 resident's room.
3. Introduce self.
4. Identify 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 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 resident.

SKILL STEPS:

1. Offer resident bedpan or urinal.
2. Cover 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 resident to check water for comfort.
7. Assist resident to move closer to you.
8. Lay towel across 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 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 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 resident's abdomen keeping towel across chest.
17. Wash, rinse, and dry resident's chest. For female 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 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 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 resident can bend knee easily, place basin on towel and place the resident's foot in the basin to wash.
24. Cover the 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 resident to turn on side so his/her back is toward you.
28. Place towel lengthwise on bed along resident's back.
29. Wash, rinse, and dry resident's back and buttocks.
30. Remove towel and assist resident to turn onto back.
31. If 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 resident is unable to wash own perineal area, assist by washing perineal area front to back to avoid infection. For female 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 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 resident comfortably
4. Place call light within reach
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 resident to check water for comfort.
2. Place towel or bath mat on floor beside tub.
3. Assist resident to Tub Room.
4. Provide for privacy.
5. Assist resident to remove clothing.
6. Assist resident into tub.
7. Give resident soap and washcloth and encourage to wash and rinse themselves as much as possible. Assist as necessary.
**NEVER LEAVE RESIDENT ALONE IN THE TUB.
8. Assist resident out of the tub encouraging use of grab bars.
9. Assist resident in drying themselves thoroughly and dressing.
10. Return resident to room.
11. Position resident comfortably.

12. Place call light within reach.
13. Lower bed to safe position for the 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 resident to verify comfort of water.
3. Apply clean gloves prior to bathing 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
4. Introduce self.
5. Identify 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 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 resident's room.
3. Introduce self.
4. Identify 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 resident sitting up comfortably (in bed or chair).
2. Place towel over 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 resident to brush own teeth if able. If unable, brush 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 resident requests, so that resident can rinse mouth. Hold basin under resident's chin to catch water and give 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Mouth Care of the Unconscious 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 resident's room.
3. Introduce self.
4. Identify 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 resident in side-lying position on the side towards you. Turn his/her head well to the side.
3. Place towel under 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 resident's hand) over overbed table.
2. Place basin on towel with water in a comfortable position for resident.
3. Before immersing fingernails, checks water temperature for safety and comfort and asks resident to verify comfort of water.
4. Assist 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
4. Introduce self.
5. Identify 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 resident comfortably.
2. Lower bed to safe position for the resident.
3. Leave room neat.
4. Document.
5. Report abnormal findings to licensed nurse.

MANUAL SKILL: Combing the Resident's Hair

EQUIPMENT:

Comb or hairbrush

Towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 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 resident's hair into style resident requests.
6. Remove towel and loose hair from the 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Shampoo of Bedridden Resident

EQUIPMENT:

Bath blanket
Bed protectors
Brush
Chair
Conditioner (optional)
Electric blow dryer (if allowed)
Large basin or pail
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 resident's room.
3. Introduce self.
4. Identify 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 resident to edge of bed close to where you are standing.
4. Place bed protector on mattress under resident's head and shoulders.
5. Place trough under 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 resident and set aside.
11. Dry hair by rubbing with towel, blow-dry if allowed.
12. Comb or brush hair in style agreeable to 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 resident dry washcloth and/or assist resident to hold over the eyes. Encourage resident to tilt head backward, if possible.
4. Wet 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Dressing and Undressing the Resident**EQUIPMENT:**

Encourage resident to select clean clothing of choice

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident to a comfortable sitting position while assisting. Be gentle and pay attention to how you hold the resident.
3. Avoid overexposure and assist resident with clothing on upper body first (if 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 resident to roll side to side while adjusting clothing).
9. Assist resident in buttoning, fastening garments if 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 resident is able, ask that he/she raise the hips while you pull the pants up to the waist. If resident cannot assist, turn onto the weak side, pulling the clothing up the stronger side.
12. Turn 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Dresses Resident with Affected (Weak) Right Arm

EQUIPMENT:

Clean clothing of resident's choice

BEGINNING STEPS:

1. Knock and pause before entering the resident's room.
2. Introduce self.
3. Identify 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 resident which shirt he/she would like to wear and dresses them in their shirt of choice.
2. While avoiding overexposure of resident, removes gown from the unaffected side first, then removes gown from affected side and disposes of gown into soiled linen container.
3. Assist 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 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 resident's room.
3. Introduce self.
4. Identify 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 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 resident's gown, but keep the lower part of the body covered.
3. Ask the resident to assist by bending the knees and placing the feet flat on the mattress. Ask 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 resident's lower back; handle should point toward foot of bed
5. If the resident is unable to assist, turn the resident to one side and place the bedpan against the buttocks, push downward on the bedpan into the mattress as you carefully turn the resident back onto the bedpan.
6. Replace the sheet over the 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 resident, raise side rail.
9. Ask the resident to signal when finished, leave resident alone unless contraindicated in the nursing care plan. Check on resident every 2-5 minutes.
10. Discard gloves, wash hands.
11. When the resident signals, return to the room. If the resident is unable to signal, check frequently. Never leave a 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 resident's signal immediately.
13. Fill the basin with warm water; assemble soap, washcloth, and towel.
14. To remove bedpan from under resident, ask the 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 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

EQUIPMENT:

Disposable gloves
Graduate

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 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 resident on back, cover with drape, sheet or bath blanket and have resident hold top of drape or sheet while you pull out top sheet.
5. Instruct resident to raise hips while bed protector is placed underneath resident.
6. Offer bedpan to resident.
7. Position drape, sheet or bath blanket so only the area between the legs is exposed.
8. Female perineal care:
 - a. Ask 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 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 resident to bend and separate knees. Help resident if required. Wash scrotum carefully. Rinse and pat dry.
- 14. Turn resident away from you. Use a new washcloth and wash around anus. Rinse area and dry.
- 15. Help position resident onto back.
- 16. Remove protective pad under buttocks and remove gloves.
- 17. Put top sheet over resident and have 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

EQUIPMENT:

Antiseptic wipe
Disposable gloves
Graduate
Paper towel

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 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 resident comfortably.
3. Place call light within reach.
4. Lower bed to safe position for the resident.
5. Leave room neat.
6. Wash hands.
7. Document.
8. Report abnormal findings to licensed nurse.

MANUAL SKILL: Assisting 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 resident's room.
3. Introduce self.
4. Identify 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 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 resident to sitting position on side of bed with feet flat on floor.
4. Before assisting to stand, resident is wearing non-skid footwear.
5. Assist resident to standing position.
6. For commode, pivot resident and lower to commode. For toilet, assist 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 resident unattended.
9. When resident signals, return promptly.
10. Put on gloves and assist resident to clean anus and perineum.
11. Allow resident to wash and dry hands.
12. Assist resident back to bed.

ENDING STEPS:

1. Position resident comfortably.
2. Place call light within reach.
3. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 Resident

EQUIPMENT:

Paper towel
Portable upright scale

BEGINNING STEPS:

1. Gather equipment, if applicable.
2. Wash hands.
3. Knock and pause before entering the resident's room.
4. Introduce self.
5. Identify 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 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Weighing the Resident in Bed**EQUIPMENT:**

Overbed scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident's bedside.
3. Set scale to zero.
4. Balance scale to include weight of sling, straps, and linen prior to positioning resident in sling.
5. Provide for privacy.
6. Assist the 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 resident away from the Nurse Assistant.
11. Place the sling folded lengthwise under the resident.
12. Turn the resident toward Nurse Assistant and position sling so that the resident rests centered within the sling.
13. Turn and position 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 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 resident's arms inside straps.
19. Slowly raise sling so 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 resident onto the bed.
24. Take off hooks and straps.
25. Turn 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Weighing the Resident in a Wheelchair

EQUIPMENT:

Wheelchair scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident and assist resident into wheel chair.
3. Take resident to scale with wheel chair platform.
4. Provide for privacy.
5. Roll wheel chair with resident onto platform.
6. Lock wheels of wheel chair.
7. Adjust weights to balance scale.
8. Record weight.
9. Return 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measuring the Height of Resident Using an Upright Scale

EQUIPMENT:

Portable upright scale

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident has shoes/nonskid slippers on before walking to scale
2. Take the resident to the scale or bring the scale to the resident's room.
3. Provide for privacy.
4. Place a paper towel on the platform of the scale.
5. Assist the resident to remove their slippers.
6. Raise the height rod.
7. Assist the resident to stand on the scale platform, arms at side.
8. Have the resident turn around and face away from the scale.
9. Lower the height measurement rod until it rests on the resident's head.
10. Record the height. The reading is made at the movable point of the ruler.
11. Assist the resident off the platform.
12. Assist the 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

MANUAL SKILL: Measuring the Height of a Resident in Bed

EQUIPMENT:

Pencil
Tape measure

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the resident's room.
3. Introduce self.
4. Identify 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 resident on his or her back (supine position).
3. Draw a small pencil mark at the top of the resident's head on the sheet. If the resident is stooped over or contracted, measure the resident's body in segments and total the measurements. (See below).
4. Make a second pencil mark even with the resident's heels.
5. Position the 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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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 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 resident so that you can assist the 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 resident. Stop when the 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the 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 resident's room.
3. Introduce self.
4. Identify 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).

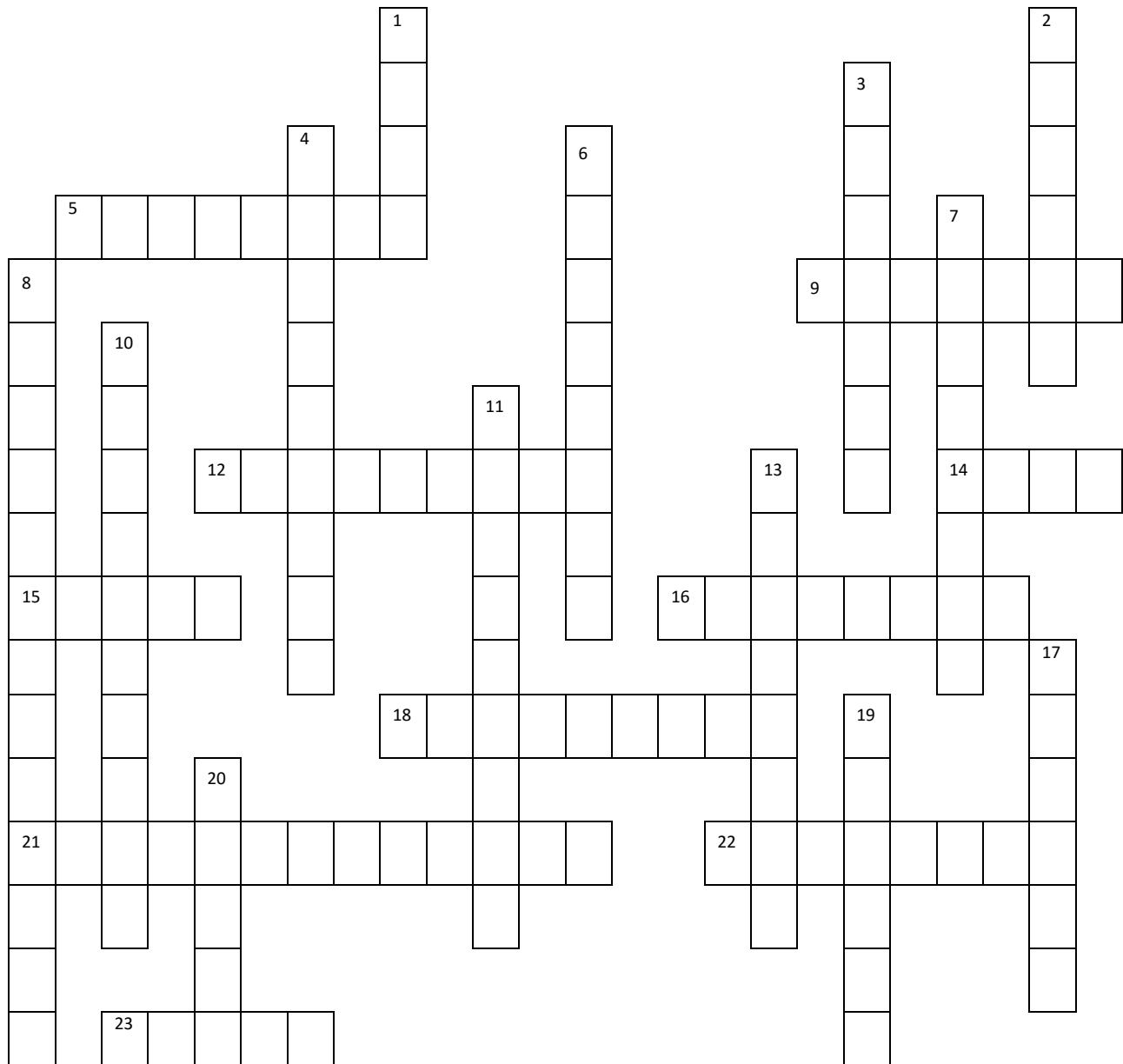
SKILL STEPS:

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 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 resident comfortably.
4. Place call light within reach.
5. Lower bed to safe position for the resident.
6. Leave room neat.
7. Wash hands.
8. Document.
9. Report abnormal findings to licensed nurse.

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.

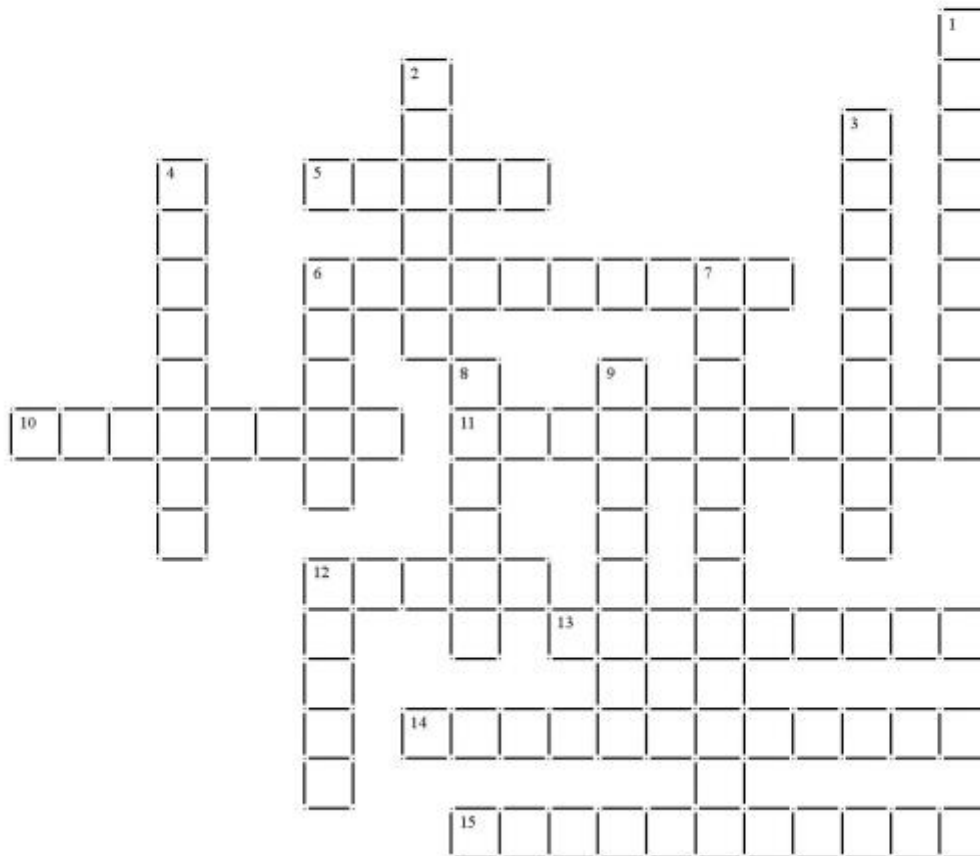
Down

- 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 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 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.

[illegible]

Module 8: Resident Care Skills[Type text] Handout 8.1c- Crossword #2

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: Resident Care Skills Handout 8.1Cc-Crossword #2

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

[illegible]

High Risk Factors for Skin Breakdown and Interventions to Prevent

<u>High Risk Factors</u>	<u>Interventions</u>
1. Mobility/Sensory: Paraplegic Quadriplegic CVA Peripheral Vascular Disease Bed rest Diabetic COPD Decreased sensation	Control pressure-egg crate; air bed ROM at least every 4 hours. Turn every two hours, even air bed. Proper position with pillows. Avoid friction, or shear by using draw sheet, trapeze. Specific pressure relief devices-booties, elbow, wheel chair pad. Assesses skin every 8 hours. Keep HOB below 30 degrees as much as possible.
2. Elimination: Incontinence stool/urine Diaphoresis Dehydrated Leaking tubes	Keep dry-fecal incontinence bag, rectal tube, Foley cath, texas cath. Caution with "diapers". Use briefs. Check diaphoretic patient. Change diet or stool routine. R/O UTI and other causes. Adjust meds-watch for yeast. No plastic near skin-watch "Attends". Cleanse-do not "scrub" pat dry well.
3. Edema/Fluid status: Edema/swelling Dehydration	Elevate limb and change position. Use compression devices-TEDS. Ace wrap <u>BUT</u> remove every 8 hours and check skin; check that device does not cut in on the edges.

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

	Force fluids 2000 day if low. Check skin every 8 hours. Lotion skin frequently-especially dry skin.
4. Nutrition/Body structure: Obese Thin Poor appetite Nutritional lab values low	Dietary consult. Medicate for N&V (nausea & vomiting); diarrhea Supplement diet-need protein, vitamins, and minerals. Use semi-fowlers position for tube feeders
5. Other Predisposing Factors: COPD Diabetes Medications-Prednisone Cancer Splints/casts Prosthetic devices Anemic	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. Realize some patients will break down no matter what. Close watch on high risk areas of feet and coccyx.

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 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 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																					
2 pm																					
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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