Texas Curriculum for Nurse Aides in Long Term Care Facilities

(Third Edition 2000)

DEPARTMENT OF AGING AND DISABILITY SERVICES
REGULATORY
NURSE AIDE TRAINING PROGRAM
MAIL CODE E-420
PO BOX 149030
AUSTIN TX 78714-9030
(512) 438-2017

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COURSE OBJECTIVES

To prepare nurse aides with the knowledge, skills and abilities essential for the provision of basic care to residents in long term care facilities.

1. To provide basic care to residents of long term care facilities.

2. To communicate and interact effectively with residents and their families based on sensitivity to the psychosocial needs of residents.

3. To assist residents in attaining and maintain maximum functional independence.

4. To protect, support and promote the rights of residents.

5. To provide safety and preventive measures in the care of residents.

6. To demonstrate skill in observing and reporting.

7. To function effectively as a member of the health care team.

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PART 1

COURSE OUTLINE

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs

UNIT 1. INTRODUCTION

A. INTRODUCTION TO COURSE

1. Course content and student objectives
2. Class and clinical schedules
3. Textbooks/references
4. Course requirements and assignments

B. INTRODUCTION TO OBRA

1. The Omnibus Budget Reconciliation Act (OBRA) of 1987 is a federal law that regulates nursing facilities and nurse aide training in facilities.

2. The intent of OBRA is to improve the quality of life for residents in nursing facilities.

3. OBRA facility regulations focus on:
   a) Resident rights, restorative care, psychosocial care, and preventive care to maintain maximum physical and mental wellness of residents.
   b) State inspection of facilities for compliance with regulations, with penalties for noncompliance.

4. OBRA nurse aide training regulations include:
   a) The facility must assure that nurse aides complete an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) and be placed on the Nurse Aide Registry within 4 months of their date of hire by the facility.
      - the first 16 hours of training must be completed prior to any direct contact with a resident.
      - After the first 16 hours, nurse aides can perform only those skills for which they have been trained and found to be proficient by the instructor.
   b) An approved Nurse Aide Training Program must be at least 75 clock hours in length (including 51 class and 24 clinical training hours). The nurse aide must pass the training program to be eligible to take the state test.
   c) The state test (CEP) includes:
      - A written or oral exam consisting of 70 multiple choice items.
      - A skills test consisting of 5 randomly selected skills.
      - The nurse aide must pass the skills test and then the written test before being placed on the Registry. The nurse aide has 3 opportunities to pass each test.
   d) Benefits of course to residents, nurse aides and LTC facilities.
5. State registry requirements include:

SECTION I. Note to Instructor:

1. The first 16 hours of content (Section I "Introduction to LTC") must be completed prior to any direct contact with a resident.
2. The content of Section I should not be used as the orientation to a specific facility.
3. Distribute a copy of the Texas Nurse Aide Testing Program handbook to each student at this time or prior to the CEP. Obtain copies by calling Texas Nurse Aide Testing Program (Texas NACES) at (800) 444-5178.)

UNIT I. STUDENT OBJECTIVES

1. State the intent of OBRA.

2. Describe the OBRA requirements for nurse aide training and placement on the Texas Registry.
3. Discuss who can work as a nurse aide in a nursing facility.

4. Discuss the benefits of this course to residents, nurse aides and LTC facilities.

a) Each individual listed on the registry must keep the department informed of his or her current address and telephone number.
b) Nurse aide certification expires 24 months after being entered to registry. Nurse Aides must submit verification of paid employment prior to the expiration date to continue certification.
c) A finding of abuse, neglect or misappropriation of resident property may be entered to the registry. If a finding is entered, the nurse aide will not be employable as a nurse aide in Long Term Care facilities.
d) See Appendix C: Texas Administrative Code, Title 40, Part I, Chapter 94.11 and 94.12

C. INTRODUCTION TO RESIDENTS IN LTC FACILITIES

1. Purpose of LTC facilities

2. Types of residents of LTC facilities
   a) Geriatric
   b) Disabled
      - Physically
      - Mentally
   c) Other

3. Needs common to residents and ourselves
   a) Physical
   b) Psychosocial
   c) Privacy

4. Myths and feelings about aging

5. State the purpose of the LTC facility.

6. Describe the types of residents in LTC facilities.

7. Discuss common needs we all share.

8. Explain residents right to privacy of person and condition.

9. Describe a common belief or feeling about aging and discuss whether it is true.

UNIT 2. ROLE OF THE NURSE AIDE IN LONG TERM CARE

A. QUALITIES OF AN EFFECTIVE NURSE AIDE

1. Professional attitude

2. Responsible nature

B. RESPONSIBILITIES OF NURSE AIDES

1. To the resident - job description.

2. To the facility - commitment of professionalism.

3. To the staff – cooperation and dependability.

UNIT 2. STUDENT OBJECTIVES:

1. State the qualities of an effective nurse aide.

2. List the responsibilities of the nurse aide to the residents, the facility and other staff.

3. Discuss the role of the nurse aide in relation to the health care team. What should the nurse aide do if asked to perform a task which is beyond scope?

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs
C. RELATIONSHIP OF THE NURSE AIDE TO THE HEALTH CARE TEAM. D. RELATIONSHIP OF THE NURSE AIDE TO RESIDENTS. 1. Appropriate professional relationship. 2. Inappropriate relationships.	4. Discuss examples of how a nurse aide's relationship with a resident would be appropriate or inappropriate. 5. Discuss whether or not it is appropriate for a nurse aide to accept a gift from a resident/client.
UNIT 3. SAFETY MEASURES A. SAFETY IS EVERYONE'S CONCERN 1. The elderly may not realize that some activities may be harmful to them. 2. The most common causes of accidents in long term care residents are burns and falls. 3. Communicate with residents about safety. 4. The resident has the right to a safe environment. 5. Think safety first when you enter an area, and last when you leave the area. 6. Safety is integrated throughout this course.	**UNIT 3. Note to Instructor: Integrate the principles of safety throughout this course.** **UNIT 3. STUDENT OBJECTIVES:** 1. Discuss the importance of safety in the long term care facility.
B. PHYSICAL CHANGES IN THE ELDERLY THAT INCREASE THE RISK OF ACCIDENTS ARE: 1. Decreased vision. 2. Impaired hearing. 3. Tremors or shaking. 4. Changes in blood vessels that result in dizziness when position is changed. 5. Reflexes slower. 6. Mental changes such as forgetfulness or confusion.	2. Describe physical changes associated with aging that increase the risk of accidents.

7. Weakness due to illness or injury.

8. The nurse aide must understand that these changes are beyond the resident's control.

C. GUIDELINES FOR PROVIDING A ENVIRONMENT

3. Recognize safety hazards and describe how to maintain environmental safety in the long term care facility.

1. Report unsafe conditions that you are unable to correct yourself.

2. Keep hallways and resident rooms clean, dry and free of obstacles.
   (a) Keep equipment and supplies on one side of the hallway so that residents have an unobstructed path.
   (b) Pick up any objects on the floor.
   (c) Wipe spills immediately and place a wet floor sign.

3. Keep beds in low position.

4. Follow facility policy for use of siderails.

5. Maintain adequate lighting.

6. Keep all equipment in working order and use it only according to manufacturer's directions.

7. When transporting residents or equipment, always slow down and look around corners and at intersections.

8. Never run in the hall.

9. Instruct residents to use handrails.

10. Monitor soiled linen for sharp or misplaced articles.

11. Set brakes on wheelchairs during transfers or when parking the chair.

12. Keep all chemicals in their original container and be sure that the label is legible.

13. Keep all chemicals in a locked area. Do not store chemicals in the same area as food products.

14. Keep chemicals, sharp objects, and plants away from confused residents.

15. Both staff and residents should use only safe, sturdy shoes with non-slip soles.

16. Provide call signals to all residents (even if confused) and remind residents to call for help.

17. Always identify residents before beginning care.

18. Follow recommended safety precautions for all procedures

19. Follow recommended safety precautions for all procedures that you perform.

20. Keep resident belongings within easy reach.

21. Avoid the use of long clothing that could cause residents to trip.

22. Use shower chairs in showers. Do not leave residents unattended in tub or shower.

D. ACCIDENTS AND INCIDENTS

4. Describe the procedure to follow for reporting incidents and accidents.

1. "Incident"—An occurrence or event that interrupts normal procedures or precipitates a crisis.

2. "Accident"—An unexpected, undesirable event.

3. Role of the nurse aide in reporting incidents and accidents

5. Describe how to lock out unsafe or broken equipment.

E. UNSAFE OR BROKEN EQUIPMENT should be "locked out" so that it cannot be used. The person who discovers broken equipment should "tag" it following facility policy.

6. Describe where the Material Safety Data Sheets (MSDS) are located and how they are used in your facility.

F. THE HAZARDOUS COMMUNICATION EMPLOYEE RIGHT TO KNOW program is designed to make employees aware of the proper uses and hazards of chemicals in the workplace.

G. ROLE OF NURSE AIDE IN ANSWERING CALL SIGNALS

7. Demonstrate proper use and response to resident's call signal following facility policy.

1. Assure that all residents (even the confused) have access to call signal at all times and know how to use it.

2. The call signal may be the resident's only means of getting help in an emergency.

3. Know and follow facility policy for using call signals:
   a) In general, all staff are responsible for answering call signals, even if not their assigned residents.
   b) Know the various signals for resident rooms, bathrooms etc. in your facility.
   c) Know how to turn call signals off/on.
   d) Know time lines for answering call signals.
   e) Proper responses when answering call signals.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs
H. ROLE OF NURSE AIDE IN IDENTIFYING RESIDENTS 1. Resident identification systems a) Identification bands b) Name on door c) Pictures d) Sensor bracelets for wanderers. 2. Follow facility policy and procedure for identifying residents.	8. Demonstrate correct identification of residents prior to giving care following facility policy.
I. ROLE OF NURSE AIDE IN HEAT AND COLD APPLICATIONS 1. Examples of heat and cold applications. 2. Before applying heat or cold, always know: a) Type of application b) Exact location of application c) Length of application d) Correct temperature e) Safety precautions to follow f) Complications to watch for 3. Precautions for heat/cold application: a) May be applied <u>only</u> on specific directions of charge nurse and following facility policy. Some facilities do not allow nurse aides to apply heat or cold applications. b) Heat and cold can cause injuries especially in the young, elderly, confused and sensory impaired. c) <u>For heat application</u>, watch for and immediately report signs of burns, pain, blisters, red or white skin. d) For cold application, see Procedural Guideline #4.	9. Describe precautions to follow in the use of heat and cold applications.
J. ROLE OF NURSE AIDE IN OXYGEN SAFETY 1. Types of oxygen delivery systems and how they are used: a) Cannula b) Mask 2. Know the liter flow ordered by the doctor, monitor liter flow when in the room and notify charge nurse of incorrect liter flow. 3. Monitor and/or maintain humidifier bottles following facility policy. 4. Safety precautions when oxygen is used: a) Post oxygen signs on door and over bed or following facility policy. b) Check with charge nurse before using electrical equipment such as razors, fans, radios, televisions.	10. State safety precautions to take when oxygen is in use.

c) Never use flammable liquids such as nail polish remover.
d) Be sure that the oxygen cylinder is secured on base and/or chained to a carrier or wall.
e) Monitor smoking/smoking materials.
f) Use only cotton blankets – not wool or synthetic.

K. ROLE OF THE NURSE AIDE IN FIRE PREVENTION AND SAFETY

11. Identify measures to prevent fires.

1. Fire prevention
   a) Supervise smoking in designated areas/monitor for smoking materials in rooms.
   b) Allow no open flames near oxygen.
   c) Report frayed wiring or faulty electrical equipment.
   d) Avoid overloading electrical outlets.

12. In your facility, locate the emergency fire and disaster plans, emergency exits, alarm system and fire extinguishers.

2. Fire emergency rules
   a) Stay calm and do not panic, run or scream.
   b) Follow the steps of RACE:
      R= Remove all residents from the immediate vicinity of the fire.
      A = Activate the Alarm system.
      C = Contain the fire and smoke by closing all doors an and windows.
      E = Extinguish the fire, if it is small enough to contain.

3. Remove combustible supplies and equipment from hallways.

4. Remember that smoke kills. In a smoke-filled area, stay close to the floor because smoke rises.

L. ROLE OF THE NURSE AIDE IN OTHER NATURAL DISASTERS INHERENT TO THE AREA

13. Describe the role of the nurse aide in one natural disaster inherent to the area.

1. Tornado

2. Hurricane

3. Other natural disasters

M. THE SAFE MEDICAL DEVICE ACT OF 1991 requires that the FDA be notified of any death or serious injury caused by any type of medical device such as restraints and mechanical lifts.

14. Describe the requirements of:
   (a) The Safe Medical Device Act of 1991
   (b) The Texas Concealed Handgun Law
   (c) OSHA

N. THE TEXAS CONCEALED HANDGUN LAW prohibits carrying a concealed weapon in a hospital, nursing home or other health care facility.

O. THE OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) is mandated by the government to protect the employee.

1. OSHA inspects long term care facilities for compliance with personal protective equipment, Standard Precautions, MSDS's, and tuberculosis testing and exposure.

2. OSHA also requires each facility to have an eyewash station within a reasonable distance of where hazardous chemicals are used and a total body wash station. Facility shower rooms satisfy both requirements

UNIT 4. EMERGENCY MEASURES

A. GENERAL MEASURES FOR EMERGENCY CARE

1. Stay with the victim and call for help. Be sure charge nurse is notified.

2. Do not move the victim unless there is immediate danger.

3. Remain calm and reassure the resident.

4. Start emergency measures that you are trained to perform while waiting for help to arrive.

5. Assist the charge nurse as directed.

6. Know facility procedures and phone numbers for reporting emergencies.

7. Know where emergency equipment and supplies are located.

B. FAINTING AND SYNCOPE
(Procedural Guideline #1)

D. FALLS AND SUSPECTED FRACTURES
(Procedural Guideline #2)

D. SEIZURES
(Procedural Guideline #3)

E. APPLICATION OF COLD PACKS TO STRAINS AND BRUISES
(Procedural Guideline #4)

F. VOMITING AND ASPIRATION
(Procedural Guideline #5)

G. CLEARING THE OBSTRUCTED AIRWAY (HEIMLICH MANEUVER)
(Procedural Guideline #6)

UNIT 4. STUDENT OBJECTIVES:

1. State the general procedure to follow in an emergency in your facility.

2. Describe and/or demonstrate laboratory skill in emergency measures for:
   (a) Fainting and syncope
   (b) Falls and suspected fractures
   (c) Seizures
   (d) Application of cold packs to strains and bruises
   (e) Vomiting and aspiration
   (f) Clearing the obstructed airway (Heimlich Maneuver)
   NOTE: Do <u>not</u> practice forceful abdominal thrusts on human subjects as part of training.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs

UNIT 5. INFECTION CONTROL

A. DEFINITIONS

1. "Microorganisms" are living cells so small they can only be seen with a microscope. They are all around us in the air, water, food, plants and on our bodies.

2. "Pathogens" or "germs" are micro-organisms capable of causing disease.

3. "Infections" are conditions caused by the growth of pathogens in the body.

4. "Medical asepsis" means the absence of pathogens.

5. "Infection control" is the method used in health care facilities to prevent the spread of pathogens.

6. "Dis-infection" is a process which destroys most pathogens.

7. "Sterilization" is a process which kills all microorganisms.

B. CONSIDERATIONS FOR CARE

1. The elderly and ill have a weakened immune system and are more susceptible to infection than others.

2. Practice good infection control in all aspects of care.

3. Good infection control practices will protect residents, visitors, other employees, yourself and your family.

C. INFECTIONS ARE COMMONLY SPREAD BY:

1. Direct contact such as touching the source of infection.

2. Indirect contact such as touching contaminated objects.

3. Airborne route such as inhaling small pathogens floating in the air.

4. Droplet spread such as contacting drops of secretions placed in the air through sneezing, coughing or talking.

D. GENERAL MEASURES TO PREVENT INFECTIONS

1. Avoid "cross-contamination" through the separation of "clean" and "dirty."
   a) Do not share personal care items.
   b) Do not borrow supplies from others.

UNIT 5. Note to Instructor:

1. Integrate the principles of infection control throughout this course.
2. The Isolation Precautions listed at F and G of this unit are based on the Center for Disease Control (CDC) "Guidelines for Isolation Precautions in Hospitals," Infection Control and Hospital Epidemiology, Vol. 17, No. 1 (January 1996) pp 53-80. Copies can also be obtained as PB 96-138-102 from the National Technical Information Services, 5285 Port Royal Rd., Springfield, VA 22161, or by telephone at (703) 487-4650**.**

UNIT 5. STUDENT OBJECTIVES:

1. Define:
   (a) Microorganisms
   (b) Pathogens
   (c) Infections
   (f) Medical asepsis
   (g) Infection control

2. Discuss why infection control is important to both residents and the health care team.
3. Describe how infections are spread.
4. Define and discuss examples of "cross-contaminations", "clean" and "dirty."

2. Keep the environment and equipment clean following facility policy.
   a) Physical cleaning.
   b) Use of disinfectant/detergents.

3. Perform procedures the way you were taught to do them—avoid shortcuts that may spread germs.
4. Handwashing is the single, most important measure in the prevention and control of infection.
   a) Purpose of handwashing.
   b) Guidelines and precautions.
   c) Handwashing Procedure. (Procedural Guideline #7)

5. Identify general measures that should be followed by the nurse aide to reduce the spread of infection.

6. Describe the importance of handwashing.

7. State the times handwashing should be done.
8. Demonstrate the proper procedure for handwashing.

E. BASIC PROCEDURES FOR ISOLATION PRECAUTIONS

1. Again, handwashing is the single most important measure in the prevention and control of infection.

2. Personal Protective Equipment (PPE) is various apparel worn to protect the health care worker (Procedural Guideline #8):
   a) Gloves
   b) Gown
   c) Mask
3. Biohazardous waste is any waste product that has come into contact with blood, body fluids (except sweat) or known pathogens:
   a) Appearance and meaning of the biohazard emblem.
   b) Follow facility policy for bagging, transporting and disposing of biohazardous waste, linen, sharps.

9. Describe how to select the correct personal protective equipment for the task that you are performing.
10. Demonstrate proper application and removal of gloves, gown and mask.

11. Recognize the biohazard emblem and describe the proper procedure for handling biohazardous waste in your facility.

F. STANDARD PRECAUTIONS are recommended by the CDC to prevent the transmission of known and unknown infections through blood and body fluids.

1. Use Standard Precautions for the care of all residents when contact with blood or body fluids is likely.

2. Standard Precautions apply to, and "blood and body fluids" include all:
   a) Blood
   b) Body fluids, secretions, excretions (except sweat)
   c) Mucous membrane and non-intact skin (of resident or nurse aide)

3. Follow Standard Precautions and the isolation policies and procedures for your facility. (Your facility may use "Universal Precautions" and the OSHA "Blood-borne Pathogen Standards," which are similar to Standard Precautions).

12. State when Standard Precautions are to be used.

13. Define blood and body fluids.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs
4. Standard Precautions. (Procedural Guideline #9A) a) Purpose and guidelines. b) Rules • Handwashing • Gloves • Other PPE • Needle and sharp precautions • Other contaminated items	14. Describe the rules for Standard Precautions. 15. Demonstrate the use of Standard Precautions in the care of all residents.
G. TRANSMISSION-BASED PRECAUTIONS are also recommended by the CDC to prevent the spread of certain highly transmissible, known or suspected infections that cannot be controlled by Standard Precautions alone.	
1. Use Transmission-based Precautions (in addition to Standard Precautions) for the care of specified residents when ordered by the charge nurse.	16. State when transmission-based Precautions are to be used.
2. The three types of Transmission-based Isolation Precautions are: a) Airborne Precautions b) Contact Precautions c) Droplet Precautions	17. State the 3 types of transmission-based Precautions recommended by the CDC.
3. Follow the directions of charge nurse and facility policy for Transmission-based Precautions.	
4. Transmission-based Precautions. (Procedural Guideline #9B) a) Purpose and guidelines b) Rules	18. Describe the guidelines and rules for transmission-based Precautions.
5. Psychosocial aspects of isolation	19. Discuss how to “isolate” the pathogen without isolating the resident.
H. COMMON INFECTIOUS CONDITIONS	
1. Blood-borne diseases are caused by pathogens found in the blood and some body fluids. a) They are spread mainly by direct blood or sexual contact. b) Hepatitis B is a blood-borne disease caused by the Hepatitis Virus (HBV) that may lead to serious liver damage. c) Human Immunodeficiency Virus (HIV) is the blood-borne virus that leads to immune system damage. d) Acquired Immune Deficiency Syndrome (AIDS) is the final stage of HIV disease when the immune system fails. e) Standard Precautions are used for the care of all residents to prevent exposure to diseases spread by blood and body fluids.	20. Describe 2 blood-borne pathogens. 21. Describe the precautions to follow to prevent exposure to blood-borne pathogens.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs
2. Tuberculosis (TB) is an infection caused by the TB pathogen and spread by the airborne route. a) It usually affects the lungs but may occur anywhere in the body. b) TB was a problem many years ago. It has made a strong comeback, and it is now often drug resistant. c) Airborne Precautions (in addition to Standard Precautions) are used to prevent the transmission of TB during communicable stages.	22. Describe what TB is and how it is spread.
3. Drug Resistant Organisms are germs that cannot be killed with the usual antibiotics and are difficult to treat. They are spread by direct contact. a) Organisms became drug resistant due to prolonged exposure to low levels of antibiotics such as occurs when they are over-prescribed and misused. b) Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRA) are drug resistant organisms common in health care facilities. c) Contact Precautions (in addition to Standard Precautions) are used for certain MRSA infections following facility policy.	23. Describe the Isolation Precautions used for TB during the communicable stage. 24. Describe drug resistant organisms and how they are spread.
4. Head Lice (Pediculosis) are small parasites that infest the body. a) They affect all social-economic groups. b) Head lice are easily spread by close personal contact or by sharing personal items such as brushes, ribbons, caps, and combs. c) When giving hair care, check the hair and scalp for: • Nits – tiny white oval eggs firmly attached to the hair. • Lice – small brown parasites that move quickly. d) Report suspected nits or lice to charge nurse immediately. e) Treatment consists of medicated shampoo applied to hair and scalp, and left on for 24 hours. The hair must be combed to remove nits. f) Follow facility policy for infection control measures. g) Contact Precautions (in addition to Standard Precautions) are used until 24 hours after effective treatment, i.e. no lice or nits alive on resident or belongings.	25. Describe the Precautions used for drug resistant organisms in your facility. 26. Describe what head lice are and how they are spread. 27. State the signs and symptoms of head lice that you would report to the charge nurse. 28. Describe the infection control measures for head lice.
5. Scabies is caused by a parasite called an "itch mite." a) It is common in people who live in close, crowded conditions, or have weakened immune systems. b) Scabies is spread mainly by direct skin contact, less often by indirect contact. c) When giving skin care observe for: • Severe itching of skin	29. Describe what scabies is and how it is transmitted. 30. State the signs and symptoms of scabies that you would report to the charge nurse.

- Multiple scab-like lesions on finger-webs, wrists, elbows, underarms, waists, knees, buttocks, nipples, genitals. Report signs/symptoms of scabies to charge nurse immediately.

d) Report signs/symptons of scabies to charge nurse immediately.
e) Treatment consists of an anti-infective lotion applied to the entire body (except eyelids and lips) and left on for 24 hours.
f) Follow facility policy for infection control measures.
g) Contact Precautions (in addition to Standard Precautions) are used until 24 hours after treatment.

UNIT 6. RESIDENT RIGHTS AND INDEPENDENCE

A. CONSIDERATIONS FOR CARE

1. Effects of aging and institutionalization on resident rights and independence.

2. Empathy and how we all value our rights.

3. Respect resident rights and promote resident independence in all aspects of the care you give.

B. RIGHTS OF RESIDENTS

1. As citizens.

2. Resident rights as stated in the Long Term Care Nursing Facility Requirements, Texas Department of Human Services §19.201 - §19.219, October 1, 1995 as amended.

C. ROLE OF THE NURSE AIDE IN RESPECTING AND PROMOTING RESIDENT RIGHTS AND INDEPENDENCE.

1. Providing privacy.

2. Maintaining confidentiality.

3. Encouraging residents to make personal choices as able.

4. Accommodating individual needs and preferences.

5. Encouraging residents to participate in care as much as possible.

6. Providing care and security of residents' personal possessions.

7. Maintaining safety.

8. Assisting residents in resolving grievances and disputes.

9. Assisting residents to vote.
10. Assisting residents to attend and participate in activities within and outside of the facility.
11. Avoiding the need for restraints following current professional standards.
12. Providing care that is free from abuse, neglect and misappropriation of resident property.

31. Describe the infection control measures for scabies.

UNIT 6. Note to the Instructor: Stress the concept of resident rights and independence throughout this course.

UNIT 6. STUDENT OBJECTIVES

1. Discuss the effects of aging and institutionalization on resident rights and independence.
2. Describe the rights of residents in nursing facilities.

3. Describe an example of a behavior in each area that:
   (a) Promotes resident rights.
   (b) Violates resident rights.
4. Demonstrate respect for the rights of residents in your facility.

D. ROLE OF THE NURSE AIDE IN PROTECTING RESIDENTS FROM ABUSE, NEGLECT AND MISAPPROPRIATION OF RESIDENT PROPERTY.

1. Definitions (from 40 TAC Chapter 94)
   a) "Abuse—the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish."
   b) "Neglect – the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."
   c) Misappropriation of Resident Property – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

5. Define and describe one example of each term:
   (a) Abuse or "harming a resident."
   (b) Neglect or "failing to provide care to a resident.
   (c) Misappropriate or "stealing from a resident."

2. Avoiding abuse, neglect and/or misappropriation of resident property.
   a) Remain calm and don't take the resident's behavior personally.
   b) Remember there is no excuse for abusing a resident.
   c) Abuse often occurs when caregivers are tired, over-worked, experiencing personal problems, stressed and/or losing control.
   d) If you are feeling overwhelmed with your assigned duties or a certain resident discuss it with your charge nurse, get help from your co-worker and/or make arrangements to take a break and compose yourself.
   e) If you see a co-worker who is feeling overwhelmed offer support and assistance if possible, encourage co-worker to report the situation and/or report the situation to the charge nurse yourself.

6. Discuss how you would act to avoid abuse, neglect and misappropriation of resident property.

3. Recognizing signs of abuse:
   a) Bruising, swelling, pain or other injuries.
   b) Sudden changes in resident's personality or behavior.
   c) Fear and anxiety.

7. List 3 signs that might indicate that a resident has been abused.

4. Reporting abuse, neglect or misappropriation of resident property:
   a) As members of the health team, nurse aides are legally and ethically responsible for reporting actual or suspected abuse, neglect or misappropriation of resident property.
   b) Report suspected findings to the charge nurse and provide the factual information requested for filing reports.
   c) The Complaints Hotline at TDHS is (800) 458-9858.

8. Describe the responsibility of the nurse aide for reporting suspected abuse, neglect or misappropriation of resident property.

9. Locate the TDHS Hotline number posted in your facility.

UNIT 7. COMMUNICATION AND INTERPERSONAL SKILLS

A. "COMMUNICATION" is the way we exchange messages with others. Thus, it is the basis of our interpersonal relations.

UNIT 7. Notes to Instructor: Integrate communication skills throughout this course.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs
B. COMMUNICATION PROCESS 1. Sending messages. a) Verbal – what we say. b) Nonverbal/body language – the message we send without words such as facial expressions, gestures, nods, posture, personal appearance. 2. Receiving messages. a) Effective listening. b) Reading body language. 3. Feedback – acknowledging the message.	**UNIT 7. STUDENT OBJECTIVES** 1. Define verbal and nonverbal communication. 2. State two ways to send messages. 3. State two ways to receive messages.
C. IMPORTANCE OF COMMUNICATION 1. Communications and interpersonal relations are the most important part of life for most people. 2. The nurse aide may be the one person that the resident communicates with on a regular basis. 3. Communication is an important part of the care that you give. Effective communication can improve your relationships with residents, make your job easier and save wasted time. 4. Communication is also an important part of your personal life. Effective communication can improve your relationships with your family, friends and co-workers.	4. Imagine a day or a lifetime without commnication. 5. Describe a situation where you wasted much time and effort because of a miscommunication.
D. COMMUNICATING WITH FAMILY AND FRIENDS OF RESIDENTS 1. Remember that you are representing yourself and the facility to others. 2. Maintain an open, friendly and supportive relationship with residents' families and friends. 3. Protect resident privacy and confidentiality. 4. When asked, tell family and friends something about the resident's activities such as "He ate a good breakfast" or "She played Bingo last night." 5. Refer visitors to the charge nurse for problems, complaints or reports on a resident's condition.	6. Describe how to communicate with residents' families and friends.
E. ANSWERING THE TELEPHONE IN A LONG TERM CARE FACILITY 1. Identify the facility and your location if applicable.	7. Describe how to answer the telephone in a long term care facility.

2. Identify yourself by name and title.
3. Politely ask who is calling.
4. Speak clearly and courteously.
5. Determine what is requested and provide needed information, obtain information requested, transfer call to the appropriate person or take a clear message and relay it to the appropriate person.
6. Thank the person for calling.

F. COMMUNICATING WITH OTHER MEMBERS OF THE HEALTH CARE TEAM

8. Describe how to communicate with your peers and report to your supervisors.

G. CHANGES DUE TO AGING THAT AFFECT COMMUNICATIONS

9. State two age-related changes that may affect communication.

1. Sensory losses.
2. Memory losses.

H. COMMUNICATION STYLES AND GOALS

1. Communication should be goal-oriented. Think about what you are trying to accomplish and set your goal.
2. Select your communication style based on your goal.
   a. Social conversation – goal is to create a comfortable, relaxing atmosphere.
   b. Interviewing – goal is to conduct a question and answer period to determine resident needs.
   c. Teaching – goal is for the resident to learn and understand.
   d. Reporting – goal is to accurately communicate the facts.
   e. Problem solving – goal is to help meet resident's needs.
   f. Therapeutic communication – goal is to encourage resident to discuss feelings.

10. State one style of communication and identify the goal associated with it.
11. Give an example of how you plan to use one style of communication to reach a specific goal.

I. TECHNIQUES FOR EFFECTIVE (GOAL-ORIENTED) COMMUNICATION

1. Use every contact with resident as an opportunity to communicate.
   a) Talk courteously with residents during care, listening and responding appropriately.
   b) Smile and speak when you pass in the hall.
   c) Set aside time just to communicate with residents.
   d) Continue to communicate with residents who are unresponsive as they may still understand and benefit from your communication.

2. Assure that your verbal and nonverbal communication match and send the same message.
   a) Nonverbal messages tend to reflect your true feelings and are thought to be more powerful than what you say.
   b) If there is a difference between the verbal and nonverbal messages, people will likely believe the nonverbal message.

12. Discuss or role-play a situation in which the verbal and nonverbal message is different. Describe how this made you feel.

3. Plan your message ahead of time as needed to assure it is clear and correct.
   a) Arrange main points in logical order.
   b) Omit unrelated and non-essential information.
   c) Get feedback to determine if message is understood.

4. Select the most appropriate method for sending the message:
   (a) Verbal – most commonly used.
   (b) Nonverbal – most important
   (c) Written – may be useful for residents with hearing loss or memory loss. Also important in communication with health care team
   (d) Interpreter – may be required to communicate with a resident in a foreign language.
   (e) Communication assistive devices – (e.g picture boards, word boards) may be useful for residents with sensory loss.

5. Individualize your communications to the needs of the resident. The same communication techniques do not work for all residents or all nurse aides.
   (a) Be aware of what you are saying (verbally and non-verbally) and of the care you are giving.
   (b) Observe and evaluate the resident's response to what you are saying and doing.
   (c) Adjust your approach if you are not getting the desired response.
   (d) Then re-evaluate and re-adjust your approach as needed.
   (e) Report and discuss your observations and problems with communication to the charge nurse.

13. Discuss how you plan to individualize your communications by observing, evaluating and adjusting. Try out your plan with classmates or friends.

J. COMMUNICATION AND INTERPERSONAL SKILLS (Procedural Guideline #10)

1. Guidelines for Starting a Conversation.

2. Guidelines for Talking and Listening.

3. Guidelines for Encouraging Residents to Express Feelings.

4. Guidelines for Avoiding Barriers to Communication.

5. Guidelines for Ending a Conversation.

14. Demonstrate skill in communicating with residents:
   (a) Starting a conversation
   (b) Talking and listening
   (c) Encouraging residents to express feelings/concerns
   (d) Avoiding barriers to communication
   (e) Ending a conversation

6. Communicating with Residents who have Vision Loss.

7. Communicating with Residents who have Hearing Loss.

8. Communicating with Residents who have Problems with Speaking.

9. Communicating with Residents who have Problems with Understanding.

10. Guidelines for Effective Interpersonal Relations.

UNIT 8. TAKING CARE OF YOURSELF

A. MANAGING PHYSICAL ILLNESS

1. Preventing physical illness is very important.

2. Use the Standard Precautions and infection control practices taught in this class to help protect yourself as well as the residents, from infections and communicable diseases.

3. Practice the principles of good health, nutrition, and personal hygiene taught in this class.
   a) The principles taught are the same for all of us, whether resident or staff.
   b) Eat three well-balanced meals a day according to the food pyramid. Don't "crash diet" and minimize "junk food".
   c) Avoid using alcohol, tobacco and drugs. These substances endanger you and residents in your care.
   d) Do not come to work if you are under the influence of alcohol or drugs and do not bring these substances to work.

4. Get adequate rest and exercise.
   a) Get 8 hours of sleep a night.
   b) If you have many responsibilities, 30 minutes of relaxation may help you to feel refreshed.
   c) Exercise at least 30 minutes, 3 times per week. This keeps the body healthy and is a good stress-reliever.

5. See your doctor for regular checkups and other preventive health care and follow the doctor's advice.

6. Treat colds and other problems promptly – do not wait until they become worse.

7. Men should practice testicular self-examination monthly.

8. Women should practice breast self-examination monthly and have mammograms as recommended by their physicians.

15. Demonstrate skill in communicating with residents who have:
    (a) Vision loss
    (b) Hearing loss
    (c) Problems with speech
    (d) Problems with understanding

16. Demonstrate skill in promoting effective interpersonal relationships.

UNIT 8. TAKING CARE OF YOURSELF

UNIT 8. Note to Instructor: Integrate the principles of care of self throughout this course.

UNIT 8. STUDENT OBJECTIVES

1. Describe how to prevent physical illness.

COURSE CONTENT SECTION I INTRODUCTION TO LONG TERM CARE (LTC)	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION I Required Time = 16 Hrs

B. PREVENTING AND MANAGING INJURIES

1. The safety practices taught in this class will protect both the nurse aide and the resident from injury.

2. The most common causes of employee injury in long term care facilities are:
   a) Slips and falls.
   b) Back injuries caused by improper body mechanics.

3. Use good body mechanics for lifting and moving.
   a) Wear a back belt for lifting, if this is your preference or the policy of your facility.
   b) Back belts do not prevent injury. They do keep your spine straight and serve as a reminder to use good body mechanics.

4. Reporting injuries.
   a) Know and follow the facility policies for injuries and emergencies of residents and staff.
   b) All injuries should be reported and incident reports completed following facility policy.

C. MANAGING YOUR TIME

1. Report for duty on time.

2. Listen to report.

3. Set priorities to make the best use of your time.
   a) Rate each task in order of importance.
   b) Anything that must be done at a specific time is a high priority.
   c) Things that must be done by the end of the shift are next.
   d) Sometimes priorities change because of resident illness or new admissions. Be flexible.

4. The better organized you are, the more easily you will complete your tasks. Good organization also reduces stress.

5. Plan your work for efficient use of your time.
   a) Estimate the time that each task will take.
   b) Identify tasks that you can group together, e.g., while the resident is in bathroom, you can make the bed.
   c) Plan your schedule around meal times.
   d) Plan ahead for tasks in which you will need an assistant or special equipment.
   e) Check on your residents before you begin your assignment.
   e) Take care of resident's immediate needs as this reassures them and makes them less anxious.

2. Describe three ways to prevent work-related injury.

3. Describe how to manage your time and organize your work routine.

g) Make a list of procedures that must be done at scheduled times, such as turning and restraint release.
h) Check the activities calendar for events that residents might enjoy.

6. Anticipate and gather needed items before you go into a resident's room to avoid unnecessary trips.

7. Work while you are on duty. You are employed and paid to work entire shift.

8. Return from breaks and lunch on time.

9. Try to improve your performance.

D. PROTECTING YOURSELF LEGALLY

1. Follow all facility policies to protect your job and assure that you are functioning within the limits of the law. Check facility policy and procedure manuals if you are unsure of how to perform a procedure.

2. Do things the way you were taught.

3. Do not perform skills for which you have not been trained. Inform your supervisor if you don't know how to perform a procedure or are unable to get it done.

4. Protect residents' rights and meet residents' needs in a timely manner. These are both legal obligations and ethical standards (things that are morally right).

E. YOUR EMOTIONAL HEALTH

1. "Stress" is mental and physical tension or strain.
   a) Working in a LTC facility and dealing with sickness and death can be stressful.
   b) Your job is physically and emotionally demanding.
   c) Stress is unavoidable as you help others with their problems.
   d) Stress can leave you feeling overwhelmed and out of control.
   e) Your personal/family problems may also contribute to your stress.
   f) If you are not physically in good health, stress may seem to worsen.

2. "Burnout" is total mental, emotional and, sometimes, physical fatigue.

3. Use stress-reducing techniques to cope with stress or sadness.

4. Discuss ways to protect yourself legally.

5. Describe ways to stay emotionally healthy.

a) Sit with your feet up for a few minutes.
b) Shut your eyes and take deep breaths.
c) Close your eyes, picture a special/pleasant place in your mind and imagine that you are there.
d) Take a warm bath.
e) Listen to quiet music.
f) Use specific relaxation exercises and stress-reduction tapes.
g) Find a hobby that you like.
h) Talk with a friend to relieve frustration and help you feel less alone.
i) Get in touch with nature. Having contact with plants, wildlife or animals has been proven to reduce stress.
j) Watch a funny movie or do something that makes you laugh. This relieves tension.
k) Resolve to accept change, because change is inevitable in health care.
l) Be nice to yourself and be aware of your own needs.
m) Give yourself credit for the good things you do. Dwell on the good things and not on the mistakes you have made.
n) Do something that you enjoy. Have some fun.
o) Balance your personal life and work – offset with recreation.

4. Your feelings, anger and behavior are your responsibility and you must keep them under control.
   a) A sign of maturity is the ability to control your emotions.
   b) Ask yourself, "How will my actions affect my residents, my co-workers, my employer, and me?"
   c) Leave the area and practice "time out" if necessary.

5. Sometimes you may feel angry, frustrated, or impatient.
   a) Try to understand why you feel this way.
   b) Find acceptable ways of coping with these feelings – do not direct your anger towards residents.

6. Protect your self-esteem.
   a) Do not take negative resident behavior or remarks personally. The resident is reacting to a situation, not to you.
   b) Try to understand why the resident is acting or behaving this way.
   c) Regardless of how the resident reacts towards you, you must respond with courtesy and respect.
   d) Having high self-esteem helps you cope with stress.

F. PERSONAL AND VOCATIONAL ADJUSTMENTS

1. Health care rules and supervisors should be obeyed in a timely manner even if you do not agree with them. (See D. 1 – 4 of this unit).

2. Learn and profit from constructive criticism.

3. "Dependability" is one of the most important qualities of a nurse aide.
   a) Be dependable with your attendance by reporting for duty on time and when scheduled.
   b) Show others by your actions that you can be depended on in many ways.
   c) Keep absences to a minimum. Residents depend on you to be at work when you are scheduled.
   d) If you are unable to come to work, always notify the facility as far in advance as possible.
   e) Do not call in sick unless you are truly ill.
   f) Leave personal problems at home.

4. Complete your assignment carefully.

5. Respect your co-workers and try to get along with them.
   a) Be available to help others and accept help if you need it.
   b) Treat other staff members with the same courtesy and dignity that you would residents.
   c) Care is best delivered when everyone works as a team.
   d) Cooperate with your co-workers.

6. Understand human relations and needs.

7. Practice empathy, patience, courtesy, cooperation and emotional control.
   a) Everyone has a right to their own feelings.
   b) Don't judge people's feelings as right or wrong.
   c) You will become more aware of how to assist residents with their feelings as you learn more about emotional needs.
   d) Remember that behavior is influenced by factors such as personality, illness, emotions.
   e) Understanding why others respond as they do will help you to accept their behavior and deal with it appropriately.

8. "Attitude" is a very important trait that you bring to your job.
   a) Attitude is developed throughout your lifetime and is a reflection of your experiences.
   b) Attitude is an outer reflection of your inner feelings.
   c) Others can see your attitude through your behavior.
   d) Your tone of voice and body language can change the message that you are trying to convey.

6. Describe personal and vocational adjustments that the nurse aide must make.

e) Attitude is reflected in your work.
f) Be positive about your job, your contribution to resident care and believe that you will succeed.

9. "Tact" is the ability to say or do the right thing at the right time.
   a) Don't judge residents and co-workers or give advice.
   b) Always be cooperative and willing to learn.
   c) Be sensitive to the problems and needs of others.

10. Treat all residents and co-workers with courtesy and respect.
    a) Be polite and considerate.
    b) Don't argue, use abusive language, gossip about others or criticize your employer.

11. Continue to learn and grow.
    a) Your nurse aide class is just the beginning. Health care is always changing as new information and technology become available.
    b) You may learn much from charge nurses and other nurse aides.
    c) Attend 12 hours of in-service training per year that is offered by your facility. Attend other continuing education classes as possible.
    d) Read health-related books, journals.
    e) Review policy and procedure manuals if you are not sure about how to perform a procedure.
    f) You will have to be flexible and adjust to many new situations.

12. Networking and support groups:
    a) Support groups and publications are available to nurse aides.
    b) Participating in a professional organization or support group will help you deal with your feelings, learn and grow.

13. Practice guidelines from your instructor for presenting a neat appearance. Your appearance sends a message to others that says you have pride in yourself and your work.

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs

UNIT 9. BODY MECHANICS, POSITIONING AND MOVING RESIDENTS

A. BODY MECHANICS AND BODY ALIGNMENT

1. Principles

2. Importance to nurse aides/residents

3. Body Mechanics for Nurse Aides
(Procedural Guideline #11)

B. POSITIONING RESIDENTS IN GOOD BODY ALIGNMENT

1. Positioning and protective devices
   a) Pillows
   b) Foam wedges
   c) Handrolls/trochanter rolls
   d) Foot cradles/footboards
   e) Trapeze
   f) Other

2. Positioning Residents
(Procedural Guideline #12)
   a) Beginning steps
   b) Fowlers
   c) Supine
   d) Semi-supine
   e) Prone
   f) Semi-prone
   g) Lateral
   h) Closing steps

3. Beginning and Closing Steps
   a) Note the beginning and closing steps that appear for the first time in Procedural Guideline #12.
   b) These standard steps are repeated in most Procedural Guidelines that are done at the bedside.
   c) Follow the beginning and closing steps as appropriate.
   d) Start with the beginning steps and end with the closing steps for each applicable procedure.
   e) Review the steps with each procedural guideline, as slight differences occur mainly in the sub-points.

C. MOVING AND LIFTING RESIDENTS

1. Guidelines and precautions for all moving and lifting procedures.

2. Turning Resident on Side Toward You
(Procedural Guideline #13)

3. Moving Resident in Bed

UNIT 9. STUDENT OBJECTIVES:

1. State the benefits of using good body mechanics and alignment:
   (a) To the nurse aide
   (b) To the resident
2. Demonstrate proper body mechanics in moving and lifting.
3. Demonstrate skill in positioning and supporting residents in good body alignment in bed, chair and wheelchair.
4. Demonstrate ability to elevate head of bed to a 45° angle.
5. State the standard beginning and closing steps.
6. Demonstrate skill in performing the standard beginning and closing steps of the Procedural Guidelines.
7. State the guidelines and precautions for all of the moving and lifting procedures. Stress the significance of following precautions and to ensure safety of resident while moving or lifting.
8. Demonstrate skill in:
   (a) Turning resident on side toward you
   (b) Moving resident in bed

(Procedural Guideline #14)

4. Assisting Resident to Sit Up on Side of Bed (Procedural Guideline #15)

5. Assisting Resident to Transfer to Chair or Wheelchair (Procedural Guideline #16)

(c) Assisting resident to sit up on side of bed
(d) Assisting resident to transfer to chair or wheelchair

D. AMBULATION AND AMBULATION AIDS (Procedural Guideline #17)

1. Guidelines and Precautions for Ambulation

2. Gait Belts

3. Canes

4. Walkers

9. Demonstrate skill in assisting resident with ambulation using:
(a) Gait belt
(b) Cane
(c) Walker

UNIT 10. CARE OF THE RESIDENT'S ENVIRONMENT

UNIT 10. STUDENT OBJECTIVES:

A. CONSIDERATIONS FOR CARE

1. Respect resident's room as private space.

2. Respect resident's preferences and privacy.

3. Respect resident's personal belongings as irreplaceable.

4. Maintain a safe environment.

1. Discuss why the resident's personal belongings may be so important to the resident.

2. Demonstrate respect for the resident's room, privacy and belongings.

3. Discuss and/or demonstrate skill in maintaining a safe and comfortable environment for the resident while respecting the resident's personal preference.

B. ROLE OF THE NURSE AIDE IN USE AND CARE OF EQUIPMENT AND SUPPLIES IN RESIDENT'S ROOM

1. Bed

2. Siderails

3. Call signal

4. Privacy curtains/screens

5. Window curtains if applicable

6. Resident's belongings

7. Other items

4. Demonstrate skill in the proper use and care of equipment and supplies in resident's room.

C. ROLE OF THE NURSE AIDE IN ENVIRONMENTAL CONTROL

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs
1. Cleanliness—team effort 2. Control of odors 3. Safety 4. Comfort and convenience D. ROLE OF THE NURSE AIDE IN BEDMAKING 1. Making the Unoccupied Bed (Procedural Guideline #18) 2. Making the Occupied Bed (Procedural Guideline #19)	5. Demonstrate skill in correct handling of clean and dirty linen. 6. Demonstrate skill in bedmaking: (a) Unoccupied bed (b) Occupied bed
UNIT 11. ASSISTING RESIDENTS WITH BATHING A. CONSIDERATIONS FOR CARE 1. Consider how residents' personal care needs are like our own. 2. Use bath time to give all personal care, to communicate with residents and to make observations. 3. Do not get so busy with personal care procedures that you forget the other needs of the resident. 4. Promote residents' rights, privacy, independence and preferences in personal care. 5. Safety measures. 6. Organization of assignments 7. Observations and reporting associated with bathing B. ROLE OF THE NURSE AIDE IN ASSISTING RESIDENTS WITH BATHING 1. Tub or Shower Bath (Procedural Guideline #20) 2. Complete Bed Bath (Procedural Guideline #21) 3. Partial Bath (Procedural Guideline #22)	**UNIT 11. STUDENT OBJECTIVES:** 1. Discuss how difficult it would be to depend on someone else to perform your personal hygiene, and what would make it less difficult. 2. Describe the important role of the nurse aide in assisting residents with personal care on a daily basis. 3. Discuss how the nurse aide can use bath time to identify and meet the residents' needs. 4. Discuss how the nurse aide can protect resident's rights while assisting with personal care. 5. Demonstrate skill in safely assisting resident into and out of tub or shower. 6. Demonstrate skill in assisting residents with: (a) Tub bath (b) Shower bath (c) Complete bed bath
UNIT 12. TOILETING AND PERINEAL CARE A. ASSISTING RESIDENT WITH TOILETING	**UNIT 12. STUDENT OBJECTIVES:** 1. Discuss ways to promote privacy while assisting a resident with toileting. 2. Demonstrate skill in assisting residents with: (a) Bathroom or bedside commode (b) Bedpan and urinal

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs
1. Bathroom 2. Bedside commode 3. Bedpan and Urinal (Procedural Guideline #23)	
B. ASSISTING WITH PERINEAL CARE/INCONTINENT CARE 1. Perineal Care/Incontinent Care-Female (With or Without Catheter) (Procedural Guideline #24) 2. Perineal Care/Incontinent Care-Male (With or Without Catheter) (Procedural Guideline #25)	3. Describe the importance of perineal care/incontinent care. 4. Demonstrate skill in giving perineal care/incontinent care: (a) Female (b) Male
UNIT 13. SKIN CARE A. CONSIDERATIONS FOR CARE 1. Skin changes associated with aging 2. Importance of skin care 3. Common sites of pressure areas and skin breakdown 4. Early recognition of pressure areas and skin breakdown B. ROLE OF THE NURSE AIDE IN PREVENTING SKIN BREAKDOWN 1. Keep skin, bedding and clothing clean and dry 2. Use of lotions and powders 3. Encourage physical activity 4. Provide frequent change of position 5. Avoid trauma, friction or shearing 6. Encourage proper hydration and nutrition 7. Use of special devices to prevent skin breakdown a) Special mattresses b) Pads c) Sheepskins 8. Careful observation and early reporting	**UNIT 13. STUDENT OBJECTIVES:** 1. State changes in the skin, hair and nails associated with aging. 2. Identify common sites of skin breakdown. 3. Describe and/or demonstrate skill in observing, recognizing and reporting early signs of pressure areas and skin breakdown. 4. Describe and/or demonstrate skill in giving skin care for the prevention of pressure ulcers. 5. Define “friction” and “shearing” and describe measures for prevention. 6. State normal daily fluid requirements. 7. Describe how good nutrition affects the skin. 8. Describe the skin changes you would report to charge nurse. 9. Describe the care of resident with skin redness or breakdown. 10 Demonstrate skill in giving a back rub.

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs

9. Care of resident with skin redness or open areas

C. BACK RUB (Procedural Guideline #26)

UNIT 14. HYGIENE AND GROOMING

UNIT 14. STUDENT OBJECTIVES:

A. ASSISTING WITH ORAL CARE

1. Importance to residents

2. General Guidelines and Precautions

3. Brushing the Teeth
(Procedural Guideline #27)

4. Denture Care
(Procedural Guideline #28)

5. Special Mouth Care
(Procedural Guideline #29)

1. Demonstrate skill in assisting with oral care:
   (a) Brushing the teeth
   (b) Denture care
   (c) Special mouth care
2. Identify one precaution that should be followed when assisting with oral care.
3. Demonstrate skill in assisting residents with:
   (a) Hair care
   (b) Shampooing the hair
   (c) Shaving the resident
   (d) Hand, foot and nail care
   (e) Dressing and undressing the resident

B. HAIR CARE (Procedural Guideline #30)

C. SHAMPOOING THE HAIR (Procedural Guideline #31)

4. Read and describe the policy for hand, foot and nail care in your facility.

D. SHAVING THE RESIDENT (Procedural Guideline #32)

5. Identify one precaution that should be followed when cutting resident's toenails.

E. HAND, FOOT AND NAIL CARE (Procedural Guideline #33)

1. Most residents need assistance with hand, foot and nail care.

2. Nurse aides must not cut fingernails or toenails of resident with diabetes, circulatory impairment of the hands or feet, ingrown nails, infected nails, painful nails or nails that are too hard, thick or difficult to cut easily.

3. Nurse aides should always check and follow the facility policy for hand, foot and nail care. Some facilities do not allow nurse aides to cut nails or to clean nails with sharp objects such as nail files or orange sticks.

4. Nurse aides should always check the care plan and receive permission and instructions from the charge nurse prior to cutting fingernails and/or toenails.

6. Discuss ways to promote residents' independence and participation in personal grooming.
7. Explain why promoting independence is important to self-esteem

F. DRESSING AND UNDRESSING THE RESIDENT (PROCEDURAL GUIDELINE #34)

8. Describe the tasks required in performing A.M. and P.M. care.

G. ENCOURAGING AND ASSISTING RESIDENT WITH HANDWASHING

c) Non-slip plate holders
d) Utensils with built-up handles and other modifications
e) Food guards

H. OTHER GROOMING SUCH AS COSMETICS

I. A.M. CARE & P.M. CARE (Procedural Guideline #35)

UNIT 15. NUTRITION

UNIT 15. STUDENT OBJECTIVES:

A. CONSIDERATIONS FOR CARE

1. Basic nutritional needs
   a) Nutrients
   b) Food Guide Pyramid (USDA)

2. Importance of food to residents
   a) Nutritional
   b) Psychosocial

3. Changes in nutrition due to aging

4. Common problems related to nutrition
   a) Problems with appetite
   b) Mechanical problems in putting food into mouth, chewing and swallowing
   c) Diabetes

1. Define the six groups of foods in the food pyramid.
2. Select a well-balanced diet for one day using the food pyramid as a guide.
3. List two changes associated with aging that affect eating and drinking.
4. Discuss the importance of eating to residents.
5. Discuss one way a nurse aide could assist residents with each of the common eating problems.

B. ASSISTING RESIDENTS WITH NUTRITION

1. Setting the stage for pleasant mealtimes

2. Guidelines and Precautions in feeding residents

3. Assisting with Meals (Procedural Guideline #36)
   a) Preparing the eating area
   b) Preparing residents prior to mealtime
   c) Serving (passing) trays
   d) Assisting residents with eating
   e) Monitoring mealtime
   f) Removing trays
   g) Assisting residents after meals
   h) Observing and reporting

4. Use of assistive feeding devices to maintain independence in
   a) eating.
   b) Easy grip mugs

6. Demonstrate skill in assisting residents with meals.

7. Discuss the importance of the nurse aide in assisting residents with therapeutic diets and diet supplements.

8. Practice spoon feeding and being fed by a classmate and think about how the resident feels.

5. Importance of resident receiving and eating special therapeutic diets ordered by a physician as treatments:
   (a) Liquid, soft or easy-to-chew diets
   (b) High calorie or high protein diets
   (c) Low salt, fat or calorie diets
   (d) Diabetic diets

6. Feeding the Dependent Resident (Procedural Guideline #37)

7. Syringe Feeding the Resident (Procedural Guideline #38)

(a) Urinary retention

9. Demonstrate skill in feeding the dependent resident.
10. Describe and/or demonstrate skill in syringe feeding a resident.

UNIT 16. HYDRATION

UNIT 16. STUDENT OBJECTIVES:

A. CONSIDERATIONS FOR CARE

1. Amount of fluids needed by body

2. Normal daily range of I & O
   (a) Fluid intake = 2000 to 2500 cc
   (b) Urine output = 1500 to 2000 cc

3. Importance of fluid balance

4. Problems with hydration due to aging

5. How to recognize dehydration and fluid retention

B. ASSISTING RESIDENTS WITH HYDRATION

1. Role of nurse aide in offering and encouraging fluid intake

2. Measures to increase fluid intake

3. Serving Fresh Drinking Water
   (Procedural Guideline #39)

4. Measuring Intake and Output (I & O)
   (Procedural Guideline #40)

5. Fluid restrictions may be used in heart and kidney disease, dialysis

1. State the range of normal fluid intake and output.
2. Describe one observation you could make to recognize:
   (a) Insufficient fluid intake
   (b) Fluid retention
3. Discuss or demonstrate measures the nurse aide could use to increase fluid intake.
4. Describe and/or demonstrate skill in serving fresh water to residents using good infection control practices.
5. Describe and/or demonstrate skill in measuring and recording I & O, using the fluid containers in your facility.
6. Discuss the nurse aide's responsibilities when fluids are restricted.

UNIT 17. ELIMINATION

UNIT 17. STUDENT OBJECTIVES:

A. URINARY ELIMINATION

1. Normal function of urinary system

2. Changes in urinary function associated with aging

3. Common problems of the urinary system

1. Describe the changes in urinary function associated with aging.

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs
(b) Urinary incontinence (c) Urinary infection (d) Kidney failure	
4. Role of the nurse aide in preventing urinary problems (a) Encourage fluid intake. (b) Assist with toileting frequently, promptly and regularly as needed. (c) Provide privacy.	
5. Indwelling Urinary Catheter Care (Procedural Guideline #41) (a) Catheters must be ordered by physician. (b) Catheters must be inserted by licensed personnel. (c) Catheters must never be used for convenience of staff. (d) Catheters should always be secured with tape or leg strap.	2. Describe and/or demonstrate skill in the care of indwelling urinary catheters. 3. State observations about urinary elimination that should be reported to the charge nurse.
6. Observing and reporting urinary elimination	
B. BOWEL ELIMINATION	4. Describe the changes in bowel function associated with aging.
1. Normal bowel function	
2. Changes in bowel function associated with aging	
3. Common problems of bowel elimination (a) Constipation (b) Diarrhea (c) Incontinence	5. Discuss measures to help prevent constipation.
4. Role of the nurse aide in preventing constipation (a) Encouraging fluid intake (b) Encouraging high fiber foods (c) Encouraging exercise and activity (d) Assisting with toileting promptly and at regular times (e) Providing privacy	6. Discuss ways to identify fecal impaction.
5. Role of nurse aide in identifying fecal impaction	7. State observations about bowel elimination that should be reported to the charge nurse.
6. Role of nurse aide in managing diarrhea	
7. Observing and reporting bowel elimination	
C. BLADDER AND/OR BOWEL INCONTINENCE	8. Discuss the important role of the nurse aide in regular and prompt toileting of residents.
1. Definition and causes	
2. Avoiding incontinence (a) Incontinence is <u>not</u> a normal part of aging. (b) Regular and prompt toileting is an important measure in avoiding incontinence for all residents, including confused residents.	9. Discuss the important role of the nurse aide in the bowel and/or bladder retraining program in your facility.

COURSE CONTENT SECTION II PERSONAL CARE SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION II Required Time = 17 Hrs
3. Use of incontinent pads and briefs 4. Use of external catheters for males 5. Incontinent care (review Procedural Guidelines 24 & 25 as needed) 6. Bowel and bladder retraining programs (a) Description (b) Role of the nurse aide in bowel and/or bladder retraining program D. COLLECTING SPECIMENS 1. Urine Specimen Collection (Procedural Guideline #42) 2. Stool Specimen Collection (Procedural Guideline #43)	10. Describe and/or demonstrate skill in collecting: a) Routine or clean-catch urine specimens b) Routine stool specimens

COURSE CONTENT SECTION III BASIC NURSING SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION III Required Time = 8 Hrs

UNIT 18. PROMOTING A RESTRAINT-PROPER ENVIRONMENT

UNIT 18. STUDENT OBJECTIVES:

A. CONSIDERATIONS FOR CARE

1. OBRA defines "physical restraints" as any method or equipment used on or near the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body.

2. OBRA states that residents have the "right" to be free from restraints which are unnecessary, inappropriate or not required to treat the resident's medical symptoms.

3. Restraints (often called protective devices) are commonly used to promote safety when residents are agitated or at risk of falling.

1. Define physical restraints and list 2 types of restraints.
2. Discuss how you would feel if you were restrained in your chair.

B. REQUIREMENTS FOR USING RESTRAINTS

1. Restraints require written doctor's order that specifies the reason for the restraint.

2. Restraints may be used only to treat or protect the resident—not for discipline or staff convenience.

3. The least restrictive type of restraint must be used for the least amount of time.

4. Restraints must be used only as a last resort when all other methods have failed.

3. Discuss the meaning and importance of using restraints only as a last resort.

C. DANGERS OF USING RESTRAINTS

1. Physical effects such as skin damage, circulatory impairment, incontinence, nerve/muscle injury, pneumonia, serious injury and death.

2. Emotional effects such as depression, frustration, anger, agitation, disorientation and loss of self-esteem.

4. State 2 advantages of not using restraints:
   (a) To the resident
   (b) To the staff

D. ROLE OF THE NURSE AIDE IN AVOIDING THE NEED FOR RESTRAINTS

1. General measures
   a) Keep environment calm, restful.
   b) Eliminate multiple stimuli.
   c) Speak in a calm, gentle manner.
   d) Provide kind, respectful care.
   e) Treat residents as individuals.
   f) Meet residents' needs, e.g. elimination, positioning, activity.

5. State 3 general measures you could use to help avoid the need for restraints.

g) Adjust staff and environment to resident's needs—not vice versa.

2. Observation and problem-solving
   a) Make careful observations of resident to identify what:
      - Causes the problem behavior
      - Calms or distracts the resident
   b) Report your objective observations to charge nurse to assist nurse in care-planning.
   c) Provide care (that you are trained to provide) following instructions of charge nurse and care plan to:
      - Eliminate cause of behavior
      - Calm or distract resident
   d) Continue to report observations to the charge nurse to assist nurse with evaluating the plan of care.

6. Describe the observation and problem-solving measures you could use to help

7. Discuss the important role of the nurse aide in avoiding restraints.

E. ROLE OF THE NURSE AIDE IN THE CARE OF RESIDENTS WHEN RESTRAINTS ARE NEEDED

1. Soft Restraints (Mitt and Vest)
   (Procedural Guideline #44)
   a) Precautions
   b) Applying Soft Restraints (Mitt and Vest)
   c) Care of the Restrained Resident
   d) Observing and Reporting

8. State when a nurse aide can apply restraints.

9. Demonstrate laboratory skill in applying mitt or vest restraint.

10. Describe the care that must be given to a restrained resident every ½ hour and every 2 hours.

UNIT 19. VITAL SIGNS, HEIGHT AND WEIGHT

Unit 19. Note to Instructor: You must teach the temperature procedures using glass thermometers. Then you may also teach other methods e.g. digital or aural temperatures following facility policy.

A. TEMPERATURE ("T")

1. Definition: "Temperature" is the amount of heat in the body.

2. Normal "T" and range to be reported
   a) <u>Oral</u>
      Normal-98.6° (Report <97° & >99° F)
   b) <u>Axillary</u>
      Normal-97.6° (Report <96° & >98° F)
   c) <u>Rectal</u>
      Normal-99.6° Report <98° & >100° F)

UNIT 19. STUDENT OBJECTIVES:

1. State the normal temperature and the range to be reported for:
   (a) Oral Temperature
   (b) Axillary Temperature (Ax)
   (c) Rectal Temperature (R)

3. Factors that affect temperature.

4. How to read a glass thermometer.

5. Importance of accurate measurements.

6. Temperature
   (Procedural Guideline #45)
   a) Oral Temperature
   b) Axillary Temperature

COURSE CONTENT SECTION III BASIC NURSING SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION III Required Time = 8 Hrs
c) Rectal Temperature	
B. PULSE (P)	2. State the normal rate and the range to be reported for (a) Pulse (b) Respiration
1. Definition: The "pulse" is the rate of the heartbeat.	
2. Normal rate and range to be reported a) Normal rate - about 76/minute b) Report P <60 & >90/minute c) Normal rhythm – regular	
3. Pulse points	
4. Factors that affect pulse rate and rhythm	3. Discuss and/or demonstrate skill in recognizing and reporting irregular pulse and respiratory rates.
5. Importance of accurate rate and description of pulse (irregular, bounding, weak, thready)	
6. Pulse (Procedural Guideline #46A)	
C. Respiration (R)	4. Demonstrate skill in taking and recording TPR: a) Oral temperature b) Axillary temperature c) Rectal temperature d) Pulse e) Respiration
1. Definition-respiration is breathing.	
2. Normal rate and range to be reported a) Normal rate - about 16/minute b) Report R <12 & >22/minute	
3. Factors that affect respiratory rate, rhythm and character	
4. Importance of accurate rate and description (deep, shallow, noisy)	
5. Respiration (Procedural Guideline #46B)	5. State the normal blood pressure and the range to be reported.
D. Blood Pressure (BP)	
1. Definition-blood pressure is the force of the blood against the artery walls as the heart beats.	
2. Normal BP and range to be reported a) Recorded as systolic/diastolic b) Normal - about 120/80 mmHg c) Report <100/60 & >140/90 mmHg	6. Describe the importance of accurate measurement and reporting of TPR and BP.
3. Factors that affect blood pressure	7. Demonstrate skill in taking and recording blood pressure.
4. Importance of accurate BP readings	
5. Blood Pressure (Procedural Guideline #47)	8. Demonstrate skill in taking and recording height and weight.
E. Height and Weight	

1. Definition
2. Normal range of height to weight
3. Factors that affect height and weight
4. Importance of accurate measurements
5. Height and Weight
   (Procedural Guideline #48)
   a) Ambulatory Residents
   b) Non-ambulatory Residents

UNIT 20. OBSERVING, REPORTING AND CHARTING

A. IMPORTANCE OF OBSERVING, REPORTING AND CHARTING IN LTC

B. IMPORTANCE OF THE NURSE AIDE IN OBSERVING AND REPORTING

C. TYPES OF OBSERVATIONS

1. Objective observations

2. Subjective observations

D. GUIDELINES FOR EFFECTIVE OBSERVATIONS

1. Develop the habit of making systematic observations as you work. Go from head to toe or use your own system.

2. Use your senses (sight, touch, hearing, smell).

3. Learn the usual or stable baseline condition (both physical and mental) of the residents you take care of.

4. Then note any changes from the usual condition for that resident, such as: if a resident's usual BP is170/100, then a "normal" BP of 120/80 may be unusual for that resident.

5. Write down your observations on-the-spot and use for reporting and charting.

E. HOW TO REPORT

1. General reporting guidelines

2. Follow facility policy for reporting.
   a) Urgent reporting
   b) Routine reporting

F. HOW TO CHART

1. General charting guidelines

Unit 20. Note to Instructor: Procedural Guideline #49 is a summary of some important steps for observing and reporting covered in the Procedural Guidelines. It can be used as a review or a handout.

UNIT 20. STUDENT OBJECTIVES:

1. Explain the importance of recognizing and reporting changes in resident's condition.
2. Give two examples of how good observations and reporting by the nurse aide can lead to better care of residents.

3. Discuss observations that you would report immediately to the charge nurse and observations that you would report at the end of your shift.
4. Demonstrate skill in reporting and recording the care you give and/or observations you make.

5. Review and discuss what you would observe for and report to the charge nurse related to:
   (a) Vital sign changes
   (b) Infections
   (c) Respiratory problems
   (d) Cardiovascular problems
   (e) Skin problems
   (f) Bowel or abdominal problems
   (g) Urinary problems
   (h) Fluid balance problems
   (i) Nutritional problems
   (j) Mental status changes

2. Follow facility policy for charting.
   a) On worksheets
   b) In charts

F. OBSERVING AND REPORTING SUMMARY (Procedural Guideline #49)

UNIT 21. ADMISSION, TRANSFER AND DISCHARGE

UNIT 21. STUDENT OBJECTIVES:

A. TYPES OF ADMISSIONS/DISCHARGES/TRANSFERS

1. Describe the role of the nurse aide in admission, transfer and discharge of residents.

B. EFFECTS OF ADMISSIONS/DISCHARGES/ TRANSFERS ON RESIDENTS.

C. ROLE OF THE NURSE AIDE IN ADMITTING, DISCHARGING AND TRANSFERRING RESIDENTS

1. Follow the policies and procedures of your facility, as variations exist in methods, roles and responsibilities.

2. Request and follow instructions from charge nurse.

3. Set aside adequate time for the procedure and have the room and needed supplies available.

4. Transport the resident following facility policy.

5. Use effective Communication and Interpersonal Skills (Procedural Guideline #10). Be a good listener and develop supportive relationships with residents.

6. Provide assistance and support to reduce resident's stress and anxiety. Even under the best circumstances, these procedures represent changes that may result in increased stress and anxiety for the resident.

2. Discuss ways the nurse aide can help a new resident adjust to changes in surroundings.
3. Discuss signs of depression and when to report changed behavior.

7. Take baseline TPR, BP, Height and Weight following facility policy and Procedural Guideline #45 thru #48.

8. Care for resident's valuables and personal belongings following facility policy.

9. For newly admitted resident, make resident feel welcome and ask how resident prefers to be addressed.

UNIT 22. COPING WITH DEATH

UNIT 22. STUDENT OBJECTIVES:

A. ACCEPTING ONE'S OWN MORTALITY IS A DEVELOPMENTAL STAGE OF LIFE

1. Discuss ways residents cope with death.

COURSE CONTENT SECTION III BASIC NURSING SKILLS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION III Required Time = 8 Hrs
B. WAYS RESIDENTS COPE WITH IMPENDING DEATH 1. Denial 2. Anger 3. Bargaining 4. Depression 5. Acceptance	
C. SIGNS OF APPROACHING DEATH	2. State signs of approaching death, including loss of senses and body functions.
D. ROLE OF THE NURSE AIDE IN MEETING THE PHYSICAL NEEDS OF THE DYING RESIDENT 1. Personal care 2. Comfort	
E. ROLE OF THE NURSE AIDE IN MEETING THE EMOTIONAL NEEDS OF THE DYING RESIDENT 1. Preserving dignity 2. Providing privacy 3. Spiritual and cultural needs	3. Describe how you will manage your own feelings about death and how you can get support for yourself.
F. ROLE OF THE NURSE AIDE IN PROVIDING SUPPORT TO 1. Resident 2. Family and friends 3. Other concerned residents	4. Describe and/or demonstrate the role of the nurse aide in giving physical and emotional support to the dying resident. 5. Discuss how the nurse should respond to other resident's questions about a dying resident.
G. POSTMORTEM CARE (Procedural Guideline #50)	6. Discuss and/or demonstrate the procedure for postmortem care

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COURSE CONTENT SECTION IV RESTORATIVE SERVICES	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION IV Required Time = 4 Hrs

UNIT 23. INTRODUCTION TO RESTORATION

A. CONSIDERATION FOR CARE

1. Restoration is the care given to attain and maintain the highest possible level of independence and functional ability (physical and psychosocial).

2. OBRA focused on restoration to improve the quality of life for LTC facility residents by:
   a) Working as an interdisciplinary team to provide restorative care.
   b) Addressing risk factors in advance to prevent deterioration or declines in residents' conditions. Note that declines in condition are not normally due to the aging process alone.

3. The concept of restorative care is that optimal independence and function leads to optimal self-esteem and quality of life.

4. Use a restorative approach in all aspects of care.

5. Good care is restorative care.

B. THE INTERDISCIPLINARY RESTORATIVE TEAM

C. THE IMPORATNCE OF THE NURSE AIDE IN RESTORATIVE CARE

D. GUIDELINES FOR RESTORATION

1. Restoration is a resident's right

2. Restoration is a team effort

3. Promote optimal physical and psychosocial wellness.

4. Prevent complication through good care.

5. Maximize self-care within limitations.

6. Provide support, empathy, patience, encouragement, enthusiam, and praise.

7. Acknowledge success, however small.

8. Emphasize strengths and abilities—not weakness and disabilities.

9. Emphasize independence—not helplessness.

10. Convey a positive attitude of hope.

Unit 23. Note to Instructor: Restorative skills are integrated throughout this course.

UNIT 23. STUDENT OBJECTIVES:

1. Define restoration.

2. Discuss how restoration can improve self-esteem and the quality of life.

3. Discuss the importance of the nurse aide in restorative care.

4. Identify three guidelines for restorative care.

5. Describe how a problem in one area of your life has affected another area.

11. See the resident as a whole, complex person—a unique individual. Realize that problems in one area of life may affect other areas or overall functioning.

UNIT 24. ROLE OF THE NURSE AIDE IN RESTORATION

A. REVIEW OF GENERAL RESTORATIVE MEASURES

1. Restorative measures related to the Activities of Daily Living (ADL):
   a) Hygiene and grooming
   b) Activity
   c) Nutrition and hydration
   d) Elimination
   e) Communication

2. Role of the nurse aide in applying general restorative measures and promoting self-care
   a) Follow the Guidelines for Restoration.
   b) Use a restorative approach in the care of all residents, with a focus on independence and the quality of life.
   c) Prevent complications and promote wellness by:
      (1) Encouraging activity, exercise and good alignment
      (2) Offering adequate food and fluids
      (3) Providing good skin care
      (4) Practicing safety and infection control
   d) "Explain procedure and encourage resident's participation as appropriate" (standard beginning step of Procedural Guidelines).
   e) Allow adequate time for residents to complete self-care tasks.
   f) "Always replace call signal and needed items within resident's reach" (standard closing step of Procedural Guidelines).
   g) Encourage resident to use strengths to overcome weaknesses. Look for things the resident can do and build on the abilities.
   h) Encourage residents to function as independently as possible—but not beyond their capabilities.
      (1) Independence can be physical such as walking or mental such as decision-making.
      (2) Seek help from charge nurse in understanding residents' abilities and disabilities.
      (3) Find the right balance for each resident.
      (4) Generally stop short of resident becoming frustrated, discouraged or giving up.
   i) Make careful observations to prevent complications and to monitor resident's progress.
      (1) Be sensitive to residents' needs and responses.
      (2) Identify what works and what doesn't work for residents

UNIT 24. NOTE TO INSTRUCTOR:

This unit is a time to review the restorative skills already taught, stress the importance of restoration, and add new knowledge and skill in restorative care.

UNIT 24. STUDENT OBJECTIVES:

1. Discuss one way you can apply restoration in each area of ADLs.

2. Describe how the nurse aide could "encourage resident's participation" in a procedure.

3. Discuss how "replacing the call signal and needed items within resident's reach" can be a restorative measure.

4. Discuss how your observations relate to restorative measures.

COURSE CONTENT SECTION IV RESTORATIVE SERVICES	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION IV Required Time = 4 Hrs
(3) Report your observations to the charge nurse (standard closing step of Procedural Guidelines).	
B. SPECIFIC RESTORATIVE PROGRAMS	5. Describe and/or demonstrate skill in applying general restorative measures in the care of all residents.
1. Restorative care planning begins on the day of admission and is: a) Based on needs of individual residents b) Developed and implemented by the restorative team c) Written in the resident care plan	
2. Specific restorative programs a) Hygiene and grooming program b) Exercise program c) Ambulation program d) ROM program e) Pressure sore prevention program f) Dining program g) Bowel/bladder program h) "Alternatives to Restraints" program i) Communication program j) Behavior management program	6. State 3 types of specific restorative programs.
3. Role of the nurse aide in assisting with specific restorative programs a) Make initial observations of residents' problems and/or restorative needs. b) Report your objective observations to assist charge nurse in assessing and planning care. c) Review and become familiar with the specific restorative plan of care. d) Understand exactly what your role and responsibilities are. e) Request information and assistance from the charge nurse. f) Follow the restorative care plan and instructions of charge nurse. g) Continue careful observations and objective reporting to assist charge nurse in evaluating the plan of care. h) Work with the restorative team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.	7. Describe or demonstrate the role of the nurse aide in specific restorative programs. 8. Discuss and/or demonstrate skill in assisting residents with adaptive or assistive devices for: (a) Grooming (b) Ambulation (c) Feeding (d) Communication
C. ASSISTING RESIDENT WITH ADAPTIVE OR ASSISTIVE DEVICES 1. Grooming devices 2. Ambulation devices 3. Feeding devices 4. Communication devices	9. Discuss and/or demonstrate skills in assisting with: (a) Eye glasses (b) Hearing aids (c) Artificial eyes

COURSE CONTENT SECTION IV RESTORATIVE SERVICES	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION IV Required Time = 4 Hrs
E. ASSISTING RESIDENTS WITH PROSTHETIC DEVICES 1. Eye glasses 2. Hearing aids 3. Artificial eyes 4. Artificial limbs 5. Braces and splints 6. Dental devices	(d) Artificial limbs (e) Braces and splints (f) Dental devices
E. MAINTAINING RANGE OF MOTION (ROM) 1. Range of motion refers to the distance a joint will comfortably move. 2. Types of ROM a) Active b) Passive c) Assisted 3. Use of ROM during personal care a) Check with charge nurse to find out which joints should be exercised and the type of exercise needed. b) Plan ROM exercise as part of self-care or ADLs. c) Do not become discouraged if ROM is limited and/or progress is slow. 4. Range of Motion (ROM) Exercises (Procedural Guideline #51)	9. State the precautions and rules for ROM. 10. Demonstrate skill in performing ROM exercises.

COURSE CONTENT SECTION V MENTAL HEALTH AND SOCIAL SERVICE NEEDS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION V Required Time = 6 Hrs

UNIT 25. PSYCHOSOCIAL NEEDS OF RESIDENTS

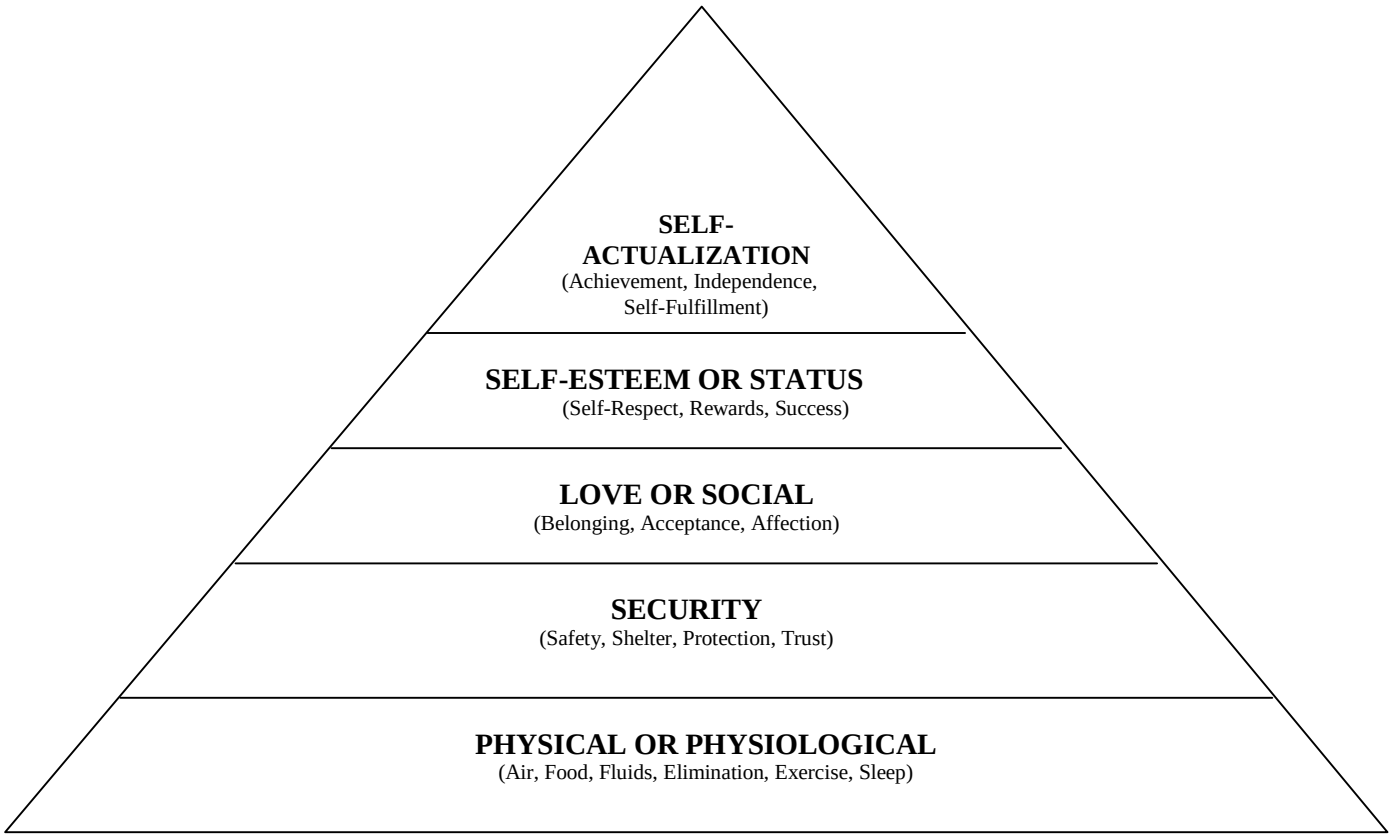
A. Basic human needs
   1. Abraham Maslow, a psychologist, studied the basic human needs that motivate people.
      a) He identified 5 basic human needs and arranged them in a pyramid to show their order from the most basic to the highest level needs. (See pyramid below)
      b) Maslow's theory is that people strive to meet their unmet needs, but the most basic needs must be met before the person is free to meet the needs at the next higher level.
      c) Individuals move up and down the pyramid of needs on an on-going basis, often meeting many needs with one activity.
      d) The needs are interactive, that is, changes in one need will cause changes in other needs.

SECTION V. NOTE TO INSTRUCTOR: Mental health and social service needs have been integrated throughout this course.

UNIT 25. STUDENT OBJECTIVES:

1. State the 5 basic human needs.

2. Think about how you meet your own basic human needs.



2. The resident is a person with basic human needs.

3. Physical or physiological needs of residents are the most basic needs related to body function.
   a) Meeting the physical needs of residents is covered in Sections I thru IV this course.
   b) If physical needs are not met, the higher needs cannot be met.

4. Security needs of residents are both physical and psychosocial.
   a) The physical aspects are related to the resident receiving care in a safe manner.
   b) The psychosocial aspects are related to the resident trusting the caregiver and "feeling" safe and secure.

5. Sexual needs of residents are both physical and psychosocial in nature.
   a) Sexuality includes physical sex, as well as sensual pleasures related to physical appearance, touch, intimacy, caring and love.
   b) Sexual needs and practices are highly individual.
   c) Sexual behavior of older adults
   (1) Myths
   (2) Facts
   d) Managing sexual behavior of residents
   (1) Appropriate sexual behavior
   (2) Inappropriate sexual behavior

6. Love or social needs of residents are met through interpersonal relations that result in a sense of belonging, acceptance, and affection.

7. Self-esteem or status needs of residents are the psychological (emotional) need to feel good about one's self.

8. Self-actualization is the highest level psychosocial need that can only be met if all of the other needs are met.
   a) It is the need to fulfill one's own unique potential.
   b) Being "the best that you can be" at whatever you strive to be (such as a student, caregiver, friend or parent) is a self-actualizing experience.

9. Spiritual needs are psychosocial in nature.
   a) Self-actualization is often attained through spiritual or religious activities.
   b) Spiritual needs include
      (1) Personal values
      (2) Religious beliefs

10. Cultural influence on residents' needs
    a) Culture is the customs, beliefs, social practices, and traits of a racial, religious or social group.

3. Discuss how the needs of residents are like our own.

4. Describe an example of an appropriate and inappropriate sexual behavior of residents and how you would respond.

5. Describe the basic human needs of residents.

6. State a specific religious activity or cultural practice and describe how the nurse aide could assist a resident to participate in the activity.

b) Culture is not a basic human need but has a strong influence on needs.

B. MAJOR LOSSES AND CHANGES ASSOCIATED WITH AGING.

1. Most older adults suffer at least some of these losses/changes. They tend to occur in rapid succession over a short period of time. The losses and changes (like the basic human needs) are interactive, that is one loss will be intensified by another loss.
   a) Loss of health and fitness may occur through the onset of sensory impairments, short-term memory loss and chronic disease.
   b) Loss of economic security may occur through loss of job, income, home, belongings and other losses.
   c) Loss of relationships may occur through death or loss of spouse, family, friends, and pets.
   d) Loss of independence and control over own life may occur as a result of other losses.
      (1) Admission to a nursing facility or other health care institution may be necessary due to one or more losses.
      (2) Relocating to an unfamiliar environment and giving up an established lifestyle represents the ultimate loss of independence to many.

2. Effects of losses and changes on basic human needs.
   a) The loss of health may decrease the person's ability to meet own needs, while
   b) increasing the complexity of physical care, medical care and the need for assistance. This will affect physical as well as self-esteem and independence needs.
   c) Then the loss of a spouse may occur, leaving the person alone (without a support system) to deal with health, as well as security problems. This will affect the need for security, love, self-esteem and Independence.
   d) If these events require relocation to a nursing facility, the resident's ability to adjust may be overwhelmed. This will affect all of the basic human needs (including independence) and the way in which all of the needs will be met.

C. DEVELOPMENTAL TASKS ASSOCIATED WITH AGING

1. Erik Erikson, another psychologist, studied the "developmental tasks" or tasks to be accomplished at the different stages of the life cycle. A brief summary of these developmental tasks follows (Eriksons' terms are identified by underlines and defined in parenthesis):
   a) Infant - Develops basic trust (security). Receives care.

7. Describe the major losses/changes associated with aging.

8. Discuss how you might respond to these losses/changes.

9. Discuss the interactive effects of losses and changes on basic human needs.

b) Toddler - Develops autonomy (self-identity). Learns self-control.
c) Preschool - Develops initiative (ambition/drive). Explores world.
d) School Age – Develops industry (work). Gains skills.
e) Teenage – Develops identity (individuality and sexuality).
f) Young Adult - Develops intimacy (close relationships). Starts family.
g) Middle Adult – Develops generativity (productivity). Pursues career.
h) Older Adult – Develops ego integrity mature identity). Reviews own life and accept own mortality.

10. Describe the developmental tasks of older adults.

2. The developmental task of older adults(age 65 and above) represents a major change in focus, and may include some or of the following tasks:
   a) Adjusting to the many losses and changes associated with aging
   b) Reviewing own life experiences(reminiscing)
   c) Accepting being old
   d) Resolving remaining life conflicts
   e) Realizing the continuity of life beyond own mortality
   f) Integrating life experiences into a meaningful whole
   g) Becoming comfortable with own life and own self
   h) Accepting own life and inevitable death (mortality) without despair or fear

D. NORMAL RESPONSES TO LOSSES AND CHANGES ASSOCIATED WITH AGING.

11. Describe 2 normal psychological responses to losses/changes.

1. Psychological responses of residents to losses/changes. These are normal responses commonly used by people adjusting to loss/change.
   a) Sadness and grief are normal and even psychologically necessary responses to losses and changes—not only loss of family/friends, but also losses such as mobility/independence/health.
   b) Fear and anxiety are normal responses that can become generalized as a result of past losses, fear of future losses and the feeling of vulnerability.
   c) Helplessness, uselessness, and hopelessness are normal responses that occur with the realization that past losses can't be reversed, and future losses can't be avoided.
   d) Frustration and anger are also normal responses. Anger may be internalized, but it is difficult to maintain self-esteem and be angry at one's self. Anger may be directed outward at family, friends or caregivers. This misplaced danger is difficult to deal with, but it is a better solution for the resident's mental health.

2. Coping or defense mechanisms used by residents adjusting to loss/change. These are normal methods commonly used by people to cope with stress and protect self-esteem. How a person copes with loss/change is largely determined by how well the person has mastered the developmental tasks.
   a) "Compensation" is using a strength to hide a weakness e.g. a person with hearing loss may attend a discussion group and do all of the talking to hide his/her inability to hear.
   b) "Rationalization" is providing an acceptable but untrue reason for one's own behavior e.g. "I'm too sick to go to the discussion".
   c) "Projection" is placing the blame for one's own problem on someone or something else e.g. "I can't hear you because you mumble"
   d) "Denial" is refusing to admit that a problem exists e.g. "I do not need a hearing aide".

12. Describe 2 normal defense mechanisms and give an example.

E. ASSISTING WITH PSYCHOSOCIAL NEEDS (PROCEDURAL GUIDELINE #52)

13. Describe and/or demonstrate skill in assisting residents with psychosocial needs:
    (a) Utilizing resident's family and friends for support
    (b) Security needs
    (c) Sexual needs
    (d) Love or social needs
    (e) Self-esteem or status needs
    (f) Self-actualization
    (g) Spiritual needs
    (h) Cultural practices
    (i) Adjusting to losses/changes
    (j) Developmental tasks of aging

UNIT 26. SPECIFIC BEHAVIOR PROBLEMS

UNIT 26. STUDENT OBJECTIVES:

A. CONSIDERATIONS FOR CARE

1. All behavior has a purpose.
2. Many experts believe that the purpose of behavior is to satisfy unmet needs.
3. Patterns of behavior are developed throughout a lifetime based on heredity and environment (life experiences).
4. Most older adults continue to use the same behavioral responses that they learned throughout their life.

1. Describe how an unmet need might cause you to behave in a certain way.

B. CAUSES OF BEHAVIORAL PROBLEMS

1. Remember that a resident's behavior may be a response to an unmet need.

2. Describe the unmet basic human needs that are most likely to cause behavioral problems in:
   (a) An alert, orientated resident
   (b) A confused resident

a) In an alert, orientated resident the unmet need is usually psychosocial.
b) In a confused resident, the unmet need is usually physical.

2. Behavioral problems occur when the stresses associated with aging exceed the resident's ability to cope with stress.

3. Behavioral problems vary widely. Those included here are some of the more common behavior problems seen in nursing facilities.

C. BEHAVIOR MANAGEMENT

1. ABCs of behavior management
   a) A is the Antecedent (cause) of the behavior.
   b) B is the Behavior.
   c) C is the Consequences (effect or results) of the behavior.

3. State the steps of behavior management.

2. Three steps of behavior management
   a) Step 1 – determine the cause of the behavior.
   b) Step 2 – eliminate the cause of the behavior. If the cause is eliminated, the behavior should stop or change.
   c) Step 3 – sometimes the consequences of the behavior may also have to be eliminated in order to eliminate the behavior, especially if the behavior has been rewarded over a period of time.

D. Role of the nurse aide in assisting with specific behavior management plans. These steps are the same as Unit 24 B 3 on Restorative Programs. Behavior management is restorative care.

4. Discuss how the nurse aide functions with the health care team for behavior management.

1. Make initial observations to describe the behavior problem and to identify possible causes of the behavior.

2. Report your objective observations to assist charge nurse in assessing and planning care.

3. Review and become familiar with the specific behavior management plan.

4. Understand exactly what your role and responsibilities are.

5. Request information and assistance from the charge nurse.

6. How the behavior management plan and instructions of charge nurse.

7. Continue careful observations and objective reporting to assist charge nurse in evaluating the plan of care.

1. Increase resident's appropriate behavior by reinforcement (rewards) as specified in the care plan. Rewards must be acceptable to the resident and sincere.
   a) Verbal reinforcement may include positive feedback such as approval, praise, compliments, congratulations.
   b) Nonverbal reinforcement may include touch that is acceptable to resident such as a pat, hug, kiss, handshake, or other rewards (a smile, snack, public recognition).

2. Reduce resident's inappropriate behavior by:
   a) Ignoring it, if you can safely do so
   b) Continuing to reinforce appropriate behavior
   c) Other non-punitive responses as specified in the plan of care

8. Work with the behavior management team as appropriate. Your participation can be valuable to the success of the program and can be a valuable learning experience for you.

5. Describe 1 step for increasing appropriate behavior and 1 step for reducing inappropriate behavior.

6. Give 2 examples of a verbal and nonverbal reinforcer.

E. THE BEHAVIOR MANAGEMENT PLAN MAY REQUIRE THAT YOU MODIFY YOUR BEHAVIOR IN RESPONSE TO RESIDENT'S BEHAVIOR.

F. ASSISTING WITH SPECIFIC BEHAVIOR PROBLEMS (PROCEDURAL GUIDELINE #53)

7. Describe and/or demonstrate skill in assisting residents with specific behavior problems
   (a) Sleep problems
   (b) Depression
   (c) Complaining or Demanding
   (d) Yelling or screaming
   (e) Verbal or physical aggression

UNIT 27. COGNITIVE IMPAIRMENT

UNIT 27. STUDENT OBJECTIVES:

A. DEFINITIONS

1. Cognitive impairment means impaired or damaged thinking.
   a) The main symptoms are memory loss and confusion.
   b) Cognitive impairment is not a normal part of aging.

1. Define cognitive impairment, dementia and Alzheimer's disease.

2. Dementia is a brain disorder that results in cognitive impairment.
   a) Acute dementia
   b) Chronic dementia

2. State the major difference between acute and chronic dementia.

3. Alzheimer's disease (AD) is a chronic, progressive brain disease that eventually destroys cognition.
   a) AD is the most common type of chronic dementia.
   b) There is no known cause or cure for AD.

B. THE DEVELOPMENTAL STAGES OF ALZHEIMER'S DISEASE:
   1. Early
   2. Middle
   3. Late

COURSE CONTENT SECTION V MENTAL HEALTH AND SOCIAL SERVICE NEEDS	STUDENT OBJECTIVES & INSTRUCTOR NOTES SECTION V Required Time = 6 Hrs
C. EFFECTS OF ALZHEIMER'S DISEASE 1. Progressive deterioration of behavior and personality 2. Impaired learning 3. Impaired thinking 4. Impaired judgement 5. Impaired memory 6. Impaired impulse control	3. Describe the effects of Alzheimer's disease.
D. ABILITIES THAT ARE SPARED (NOT LOST) IN ALZHEIMER'S DISEASE 1. Emotions and feelings 2. Physical strength 3. Senses such as vision, hearing, taste, smell, touch 4. Habits such as piano playing, cycling	
E. SOME BEHAVIORAL RESPONSES TO COGNITIVE IMPAIRMENT 1. Memory loss 2. Confusion and disorientation 3. Lack of self-control	4. Describe the behavioral responses to cognitive impairment.
F. SPECIAL NEEDS OF THE COGNITIVELY IMPAIRED RESIDENTS 1. Physical care 2. Safety needs 3. Supportive needs 4. Communication needs 5. Behavior management	5. Discuss the special needs of cognitively impaired residents (i.e as in early, middle and late stages of Alzheimers Disease). 6. Discuss importance of using verbal and non-verbal communication in working with cognitively impaired residents. Discuss pitfalls to avoid.
G. ASSISTING WITH COGNITIVE IMPAIRMENT (PROCEDURAL GUIDELINE #54)	7. Describe and/or demonstrate skill in assisting cognitively impaired residents: (a) By using communication (b) With memory loss/confusion (c) By using reality orientation (d) By using validation therapy (e) With wandering (f) With resistance to care (g) With self-control (h) With catastrophic reactions

PART 2

PROCEDURAL GUIDELINES

Texas
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PROCEDURAL GUIDELINE #1 – FAINTING AND SYNCOPE

A. Purpose

1. To prevent injury.

2. To restore blood supply to the brain.

B. Emergency Guidelines

1. Stay with resident and call for help. Be sure charge nurse is notified.

2. Lower the resident's head to increase blood supply to brain:
   a. If resident is standing, assist to lie down or to sit in chair.
   b. If resident is sitting, assist to lie down or assist to bend forward and put head down between knees if able.
   c. If resident is lying down, put head flat or slightly elevate legs if allowed.

3. Position resident on side if nauseated or vomiting.

4. Loosen tight or constrictive clothing.

5. Apply cool, wet towel to face or throat as indicated.

6. Check vital signs as requested by charge nurse.

7. Monitor pulse and respiration every 5 minutes.

8. Keep resident quiet with head lowered until recovery occurs or for at least 5 minutes as instructed by the charge nurse.

9. Assist resident to assume the upright position very gradually as instructed by the charge nurse. Be prepared to act quickly if fainting reoccurs.

10. Leave resident in a position of comfort and safety with call signal within easy reach.

11. Wash hands.

C. Observe For and Report to Charge Nurse:

1. Time, duration and description of fainting.

2. Measures taken and results.

3. Presence of vomiting, cool/clammy skin, changes in vital signs and/or loss of consciousness.

4. Other significant observations.

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PROCEDURAL GUIDELINE #2 – FALLS AND SUSPECTED FRACTURES

A. Purpose

1. To prevent injury due to falls.

2. To assist resident with a suspected fracture.

B. How to Break a Fall

1. Keep your back straight and your feet separated.

2. If the resident is wearing a gait belt, hold the belt firmly with an underhand grasp and ease the resident to the floor.

3. If the resident is not wearing a gait belt, quickly move close to and slightly behind the resident and:

   a. Wrap your arms around the resident's underarms or waist and pull the resident's weight against your body.
   b. Ease the resident and yourself to the floor, allowing the resident to slide down your body.

4. Protect the resident's head and body from injury, as you lower the resident to the floor.

C. How to Assist a Resident After a Fall

1. Stay with resident and call for help. Be sure charge nurse is notified.

2. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

3. Keep the resident as quiet as possible. Do <u>not</u> attempt to move the resident or to straighten the injured area.

4. Immobilize the area of suspected fracture in the position that you find it, if indicated or if requested by the charge nurse.

5. Do <u>not</u> attempt to move the resident until the charge nurse examines the resident, assesses the risk of fracture, and gives instructions.

   a. Then, follow the instructions of the charge nurse for moving resident.
   b. Check vital signs and provide other care as requested by charge nurse.

6. Leave the resident in a position of comfort and safety with call signal within easy reach.

7. If used, remove and discard gloves following facility policy. <u>Wash hands</u>.

D. Observe For and Report to Charge Nurse:

1. Time of the fall.
2. Cause of the fall such as wet floors, ill-fitting shoes or condition of resident. (Do not speculate on cause of fall. Report only what you know to be a fact).
3. Measures taken to break the fall and assist the resident.
4. Vital signs.
5. Results of the fall such as trauma, bruises, changes in level of consciousness or mental status, known head injury, bleeding.
6. If suspected fracture, appearance of the injured area and measures taken to immobilize the area.
7. Any witnesses to the fall.
8. Additional information needed by the charge nurse to complete the incident report.
9. Other significant observations.

PROCEDURAL GUIDELINE #3 – SEIZURES

A. Purpose: To prevent injury due to seizures.

B. Emergency Guidelines

1. Stay with resident and call for help. Be sure charge nurse is notified.

2. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

3. If resident is in bed, raise side-rails and remove pillow.

4. If resident is out of bed, gently lower resident to floor and protect head with pillow, padding or hold head in your lap.

5. Move hard objects out of the way as appropriate, or pad around bed and/or objects that might cause injury during seizure.

6. Turn head to side or place in side-lying position to open airway and promote drainage of secretions.

7. Loosen tight clothing.

8. Provide privacy by asking onlookers to leave and closing doors and/or curtains.

9. Do not attempt to restrain the resident.

10. Do not attempt to place any object into the resident's mouth during seizure.

11. Check vital signs and provide other care as requested by charge nurse.

12. The licensed nurse may provide suction, medications and/or oxygen.

13. When seizure passes, orient the resident to surroundings and allow to rest.

14. Leave resident in a position of comfort and safety with call signal within easy reach.

15. If used, remove and discard gloves following facility policy. Wash hands.

C. Observe For and Report to Charge Nurse:

1. Changes in resident before seizure such as visual or auditory aura, confusion, staggering or behavioral changes.

2. Time seizure started and stopped and duration of seizure.

3. Description of body parts involved and severity of convulsive movements.

4. Presence of an aura, incontinence, unconsciousness, eyes rolled upward, frothing of the mouth, biting of the tongue or injuries due to seizures.

5. Condition of resident after seizure such as disorientation or sleepiness.

6. Other significant observations.

PROCEDURAL GUIDELINE #4 – APPLICATION OF COLD PACKS TO STRAINS AND BRUISES

A. Purpose: To decrease the swelling and pain associated with strains and bruises.

B. Precautions

1. The nurse aide should apply cold packs only if instructed by the charge nurse and following facility policy.

2. Cold packs are generally left in place for 20 minutes and then removed to avoid tissue damage.

C. Emergency Guidelines

1. If the resident is on the floor, stay with the resident and call for help. Be sure the charge nurse is notified.

2. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluid is likely.

3. Do not move resident until examined by the charge nurse. Keep resident at rest and as comfortable as possible.

4. Elevate the injured area as instructed by charge nurse.

5. Apply a cold pack if directed by charge nurse and if allowed by facility policy.

   a. Wash your hands.
   b. Prepare cold pack as directed by charge nurse and following facility policy.
   c. Place a cloth cover over cold pack.
   d. Apply covered cold pack to affected area as soon as possible after injury.
   e. Secure loosely in place if needed.
   f. Check affected area every 10 minutes for unusual response such as numbness, pain or skin discoloration (white, gray, blue or red).
   g. Discontinue cold pack and notify charge nurse immediately if unusual responses occur.
   h. Remove cold pack after 20 minutes or as directed by charge nurse.
   i. Reapply cold pack as instructed by charge nurse.
   j. If used, remove and discard gloves following facility policy. Wash hands.

6. Leave resident in a position of comfort and safety, with call signal within easy reach.

D. Observe For and Report to Charge Nurse:

1. Time and description of injury, such as swelling, deformities or other abnormalities.

2. Cause of injury if known. (Report only what you know to be true. Do not speculate).

3. Time and type of cold pack applied.

4. Unusual responses to cold pack such as numbness pain or skin discoloration (white, gray, blue or red).

5. Other significant observations.

PROCEDURAL GUIDELINE #5 – VOMITING AND ASPIRATION

A. Purpose:

1. To prevent aspiration of food, fluids, secretions, blood or vomitus into the lungs.

B. Measures to be Followed for any Resident who has Vomiting, Bleeding Near the Mouth, Excess Secretions or Inability to Swallow:

1. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Keep resident's head elevated as allowed.

3. Keep resident turned on side or with head turned well to one side, if possible, to allow fluids to drain out of mouth.

4. Provide emesis basin for the resident who is vomiting.

5. Notify charge nurse immediately if:

   a. Resident is choking or is not able to swallow.
   b. Resident is not able to spit out vomitus, secretions or blood.

6. Nurse may provide suctioning and/or notify the physician.

7. If choking and obstructed airway occurs, follow Procedural Guideline #6 for Clearing the Obstructed Airway.

8. Assist the resident with oral hygiene as appropriate.

9. Leave resident in a position of comfort and safety with call signal within easy reach.

10. If used, remove and discard gloves following facility policy. Wash hands.

C. Observe For and Report to Charge Nurse:

1. Immediately report difficulty swallowing, bleeding, vomiting, and choking or aspiration.

2. Observe vomitus for color, odor, presence of undigested food, blood or partially digested blood (coffee-ground appearance).

3. Measure or estimate the amount of vomitus or blood, and record on the intake and output record.

4. Do not discard vomitus or blood until it is seen by nurse and a specimen is obtained if needed.

5. Other significant observations.

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PROCEDURAL GUIDELINE #6 – CLEARING THE OBSTRUCTED AIRWAY (HEIMLICH MANEUVER)

A. Purpose: To clear the obstructed airway of adults using the Heimlich Maneuver.

B. Guidelines and Precautions

1. Choking is a true life-threatening emergency that requires immediate action.

2. Choking is the sign of airway obstruction. The universal distress signal for choking is clutching the throat.

3. Choking usually occurs when eating large and poorly chewed pieces of meat or other foods. Associated factors are wearing dentures, laughing and talking while eating. The airway can also be obstructed by blood, vomitus, foreign bodies, the tongue.

4. Measures to help prevent choking:

   a. Assure that meat and other foods are cut into small pieces.
   b. Encourage residents to chew foods slowly and adequately.
   c. Discourage laughing and talking while chewing and swallowing.
   d. Assure residents receive correct diets that contain only allowed foods. Peanut butter, nuts, popcorn and beans can cause choking in some residents.

5. This procedure is limited to use of the Heimlich Maneuver on adults. Specialized and advanced procedures and training are available from the American Red Cross and the American Heart Association.

6. Do <u>not</u> practice forceful abdominal thrusts on human subjects as part of training.

C. Determine if resident can cough, breathe or speak.

1. Stay with the resident and call for help. Be sure charge nurse is notified immediately.

2. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluid is likely.

3. Observe resident for coughing, breathing and speech. Ask resident "Are you choking?"

   a. If resident is <u>able</u> to cough, breathe or speak (Partial Airway Obstruction), stand by and encourage coughing to clear the airway.
   b. If resident is <u>unable</u> or <u>becomes unable</u> to cough, breathe or speak (Complete Airway Obstruction), perform the Heimlich Maneuver following step D below as appropriate.

D. Perform the Heimlich Maneuver (Abdominal thrusts)

1. <u>With resident standing or sitting</u>:

   a. Stand behind the resident.
   b. Wrap your arms around the resident's waist.

c. Make a fist and place the thumb-side of the fist at the midline of abdomen, just above navel and well below breastbone.
d. Grasp fist with free hand and press inward with a quick upward thrust. Avoid pressure on ribs and breastbone.

2. With resident lying down:

    a. Place the resident in the supine position on the floor.
    b. Kneel down and straddle the residents' hips.
    c. Position the heel of one hand at the midline of abdomen, just above navel and well below breastbone.
    d. Place your free hand over other hand and press inward with a quick upward thrust. Avoid pressure on ribs and breastbone.

3. Repeat abdominal thrusts (as separate and distinct movements) until the airway is cleared (usually 5 to 10 thrusts).

4. Assist the charge nurse and/or EMS as appropriate.

5. If used, remove and discard gloves following facility policy. Wash hands.

E. Observe For and Report to Charge Nurse:

1. Exact time choking and unconsciousness started and stopped.

2. Procedures done and time procedure started and stopped.

3. Response to procedures.

4. Factors related to cause of choking.

5. Other significant observations.

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PROCEDURAL GUIDELINE #7 – HAND-WASHING

A. Purpose: To remove germs from hands and prevent the spread of infection.

B. Guidelines and Precautions

1. Hand-washing is the single most important method in the prevention and control of infection.

2. Hand-washing should be done at the following times:

   a. When coming on and going off duty.
   b. Before and after caring for each resident.
   c. Before applying gloves and after removing gloves.
   d. Before and after eating, drinking, smoking, using lip balm, touching contact lenses, wiping nose, using toilet.
   e. After contact with blood, body fluids and contaminated items (Procedural Guideline #9).
   f. Whenever hands are obviously soiled.

3. Precautions

   a. Always keep your fingertips pointed down while washing your hands.
   b. Avoid leaning against sink or splashing uniform during Hand-washing.
   c. Do not touch the inside of sink or faucet handles with clean hands.

C. Procedural Guidelines

1. Turn on warm water.

2. Wet hands.

3. Apply soap or skin cleanser to hands to produce lather.

4. Vigorously rub hands together in a circular motion for at least 10 seconds, washing all surfaces of the fingers and hands (up to the wrist).

5. Clean under nails if needed.

6. Rinse hands thoroughly from wrist to fingertips, keeping fingertips down.

7. Dry hands on clean paper towel.

8. Turn off faucet with paper towel.

9. Discard towel appropriately without contaminating hands.

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PROCEDURAL GUIDELINE #8 – PERSONAL PROTECTIVE EQUIPMENT (PPE)

A. Purpose: To protect the health care worker from occupational exposure to pathogens

B. Guidelines

1. Use PPE as required by Standard Precautions, Transmission-based Precautions and facility policy:

    a. Mask, gown and gloves are worn once and discarded after use.
    b. PPE is generally put on outside of the isolation room and taken off inside of the isolation room.
    c. Do not wear PPE outside of the isolation area unless allowed by facility policy.

2. Use other PPE (such as goggles, face shields) as required following facility policy. Note that a mask can be worn without eye protection, but eye protection should NEVER be worn without a mask.

3. Use of PPE is based on the separation of "clean" and "dirty".

4. When using PPE, hands should be washed:

    a. Before putting on PPE and entering the room.
    b. After removing gloves because they may develop holes too small to be seen.
    c. After removing PPE and leaving the room.

C. Putting on Disposable Isolation Mask, Gown and/or Gloves

1. Wash hands <u>first</u> before putting on mask, gown and/or gloves.

2. Put on mask <u>next</u> if required (hands are clean and mask is clean).

    a. Remove clean mask from container by strings.
    b. Adjust to cover both nose and mouth.
    c. Tie upper strings on top of head, then tie lower strings at neck.
    d. Note: mask should be changed when it becomes moist or after worn for 20 to 30 minutes.

3. Put on gown <u>next</u> if required (hands are clean and gown is clean).

    a. Hold clean gown by the neck in front of you and let it unfold.
    b. Put your arm through the sleeves.
    c. Tie strings at back of neck.
    d. Tie strings at back of waist, overlapping the back to cover your uniform.
    e. Note: gown should be changed if it becomes wet or torn.

4. Put on gloves <u>last</u> if required (hands are clean and gloves are clean).

    a. Remove clean gloves from container.
    b. Put hands into gloves.
    c. Adjust fingers for comfort.
    d. If gown is worn, pull cuffs of gloves over wrists of gown.

e. Note: gloves should be changed if torn or punctured.

D. Taking Off Disposable Isolation Gloves, Gown and/or Mask.

1. If gown is worn, untie waist ties of gown now (waist ties and gloves are considered dirty).

2. Take off gloves next if worn (used gloves are considered clean on inside and dirty on outside).

   a. Grasp outside of one glove below cuff and pull off with the clean side out. Continue to hold the removed glove in your gloved hand.
   b. Place fingers of ungloved hand inside cuff on gloved hand and pull off, turning glove inside out over other glove (clean to clean).
   c. Discard gloves as biohazardous waste following facility policy.

3. Wash hands next, before taking off mask and/or gown if worn.

4. Take off mask next if worn (ties on used mask are considered clean and mask is dirty).

   a. Untie at neck, then at head touching only clean ties with clean hands.
   b. Remove mask touching only the ties.
   c. Do not let outside of mask touch your face or hands.
   d. Discard mask as biohazardous waste following facility policy.

5. Take off gown next if worn (neck ties and inside of used gown are considered clean; waist ties and outside of gown dirty).

   a. Note that waist ties were untied at step D 1 (before removing gloves).
   b. Untie clean neck ties of gown with clean hands.
   c. Grasp neck ties at back of neck and pull gown off shoulders.
   d. Slip gown down arms and over hands touching only the clean inside.
   e. Roll the gown away from you with the clean side out.
   f. Discard gown as biohazardous waste following facility policy.

6. Wash hands.

E. Summary of Putting on PPE

   1. Wash hands.

   2. Put on mask if required.

   3. Put on gown if required.

   4. Put on gloves if required.

F. Summary of Taking off PPE

   1. If gown is worn, untie waist strings of gown now.

   2. Take off gloves if worn.

3. Wash hands.
4. Take off mask if worn.
5. Take off gown if worn.
6. Wash hands.

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PROCEDURAL GUIDELINE #9 – ISOLATION PRECAUTIONS

Standard Precautions

1. Purpose: To prevent the transmission of known and unknown infection through blood and body fluids.

2. Guidelines for Standard Precautions

   a. Use Standard Precautions for the care of all residents when contact with blood or body fluids are likely.
   b. Standard Precautions apply to, and "blood and body fluids" include all:
      (1) Blood
      (2) Body fluids, secretions and excretions (except sweat)
      (3) Mucous membrane and nonintact skin (of resident or nurse aide)
   c. Follow Standard Precautions and the facility isolation policies/procedures.

3. Rules for Standard Precautions

   a. **Hand-washing** (Procedural Guideline #7): Thoroughly wash your hands or any other skin surfaces that have come into contact with blood or body fluids. Wash hands before and after each resident contact and before applying and after removing gloves.
   b. **Gloves** (Procedural Guideline #8):

      (1) Wash hands. Wear clean, disposable examination gloves for anticipated contact with blood, body fluids or contaminated items/surfaces:
         (a) Put on clean gloves just before touching mucous membrane or nonintact skin.
         (b) Wear gloves if you have breaks in the skin of your hands.
         (c) Changes gloves if they develop holes or tears.
         (d) Change gloves between different procedures on the same resident to prevent cross-contamination of different body sites.
      (2) Remove and discard gloves (and wash hands) promptly after use:
         (a) After each resident contact
         (b) Before touching other residents, yourself or other people
         (c) Before touching noncontaminated environmental items/surfaces. This may require that you change gloves several times during the care of a single resident. Follow facility policy and the instructions of the charge nurse, as each situation is different.
      (3) Avoid wearing gloves when they are not necessary. Excessive use of gloves decreases direct contact by touch, and may cause residents to feel physically and psychologically rejected and "isolated."
   c. **Other Personal Protective Equipment** (Procedural Guideline #8):
      (1) Wear a clean gown only when indicated to protect your skin and clothing from splashes or sprays of blood or body fluids.
      (2) Wear a clean mask and goggles or a face shield only when indicated to protect your skin and the mucous membrane of your eyes, nose and mouth from splashes or sprays of blood or body fluids.
   d. **Needle and Sharp Precautions**: Follow facility policy for Needle and Sharp Precautions. Use extreme care in handling used needles, razors and other sharps to avoid puncture wounds and possible exposure to bloodborne pathogens. Needles are never bent, broken, or recapped by hand. Discard used sharps immediately after use into a puncture-resistant container.
   e. **Cleaning Blood Spills:** Promptly clean blood spills following facility policy.

f. **Contaminated Items:** Linen and equipment soiled with blood or body fluids should be handled carefully, contained in sturdy plastic bags (kept clean on the outside), labeled, and processed following facility policy. Contaminated environmental surfaces should be cleaned and disinfected following facility policy.
g. **Disposal of Biohazardous Waste:** Follow facility policy for the proper handling, labeling and disposal of items contaminated with blood or body fluids.
h. **Laboratory Specimens:** Consider laboratory specimens and specimen containers to be potentially infectious materials.

Transmission-based Precautions

1. Purpose: To prevent the spread of certain highly transmissible, known or suspected pathogens by airborne, contact or droplet spread.

2. Guidelines for Transmission-based Precautions

a. Use Airborne, Contact or Droplet Precautions (in addition to Standard Precautions) when ordered by the doctor and/or nurse for a specific resident. The charge nurse will determine the need for isolation, select the type of isolation and write directions for Isolation Precautions.
(1.) Always use Standard Precautions in addition to Transmission-based Precautions.
(2.) Follow the written directions and the facility policies/procedures.
(3.) Ask the charge nurse for instructions and assistance as needed.
b. Isolation Hand-washing should be performed following written directions and facility policy, which may include the following:
(1.) Remove watch and other jewelry on hands and arms
(2.) Roll sleeves to elbows
(3.) Wash hands and exposed areas of forearms (Procedural Guideline #7)
(4.) Use anti-microbial soap for isolation hand-washing

1. Rules for Transmission-based Precautions

a. **Airborne Precautions:** Use Airborne Precautions as ordered (in addition to Standard Precautions) to control infections spread by small pathogens that remain suspended in the air and travel over long distances. Examples include tuberculosis during the communicable period.
(1) Place resident in a private isolation room with special ventilation to keep the pathogen from spreading. Keep resident in room with door closed.
(2) Wear a special HEPA mask or N 95 or PFR 95 respirator inside the isolation room because the small pathogen will pass through a regular mask.
(3) Wash hands before entering and before leaving the room.
b. **Contact Precautions:** Use Contact Precautions as ordered (in addition to Standard Precautions) to control infections spread by direct or indirect contact with certain pathogens and parasites such as MRSA, head lice, scabies.
(1) Wash hands and put on gloves before entering the isolation room. Wear a gown if your skin or clothing will have substantial contact with the resident or the environment.
(2) Remove and discard gloves and gown and wash hands (usually with antimicrobial soap) before leaving the isolation room.
c. **Droplet Precautions:** Use Droplet Precautions as ordered (in addition to Standard Precautions) to control infections spread by large droplets that are placed in the air through coughing, sneezing and talking. The

droplets do not travel more than 3 feet and do not remain suspended in the air. Examples include some childhood communicable diseases and some pneumonias.

(1) Wear an isolation mask if working within 3 feet of the resident.

(2) Wash hands before entering and before leaving the room.

PROCEDURAL GUIDELINE #10 – COMMUNICATION AND INTERPERSONAL SKILLS

A. Guidelines for Starting a Conversation

1. Knock on the door before entering, identify yourself by name and title and greet resident by the preferred name.
2. Approach the resident in a calm and courteous manner.
3. Explain why you are there and what you are going to do.
4. If you are going to perform a procedure, explain the procedure to resident and encourage resident to participate as appropriate.

B. Guidelines for Talking and Listening

1. Get resident's attention before speaking.
2. Use courtesy when communicating. Talk courteously with resident during care, listening and responding appropriately.
3. Speak in a language that is familiar and appropriate for the resident--avoid slang or words with more than one meaning.
4. Use a normal tone of voice and adjust your volume to the resident's needs.
5. Speak slowly and adjust your rate to the individual resident's needs.
6. Speak clearly--avoid mumbling.
7. Keep your message brief and concise--avoid rambling.
8. Face the resident. Sit at resident's eye level and maintain frequent eye contact with resident as appropriate.
9. Send positive messages by use of encouragement, praise, smiles, gentle touch and other methods acceptable to resident.
10. Be sure your verbal and nonverbal message match.
11. Use open posture, leaning slightly toward resident while listening.
12. Pay attention and really listen to what the resident is saying.
13. Give, receive and/or request feedback as appropriate to assure that the communication is understood.

C. Guidelines For Encouraging Residents To Express Feelings

1. Use silence to allow resident to think and continue talking (this shows respect and acceptance).

2. Use broad opening statements like "You seem quiet today".

3. Use open-ended questions like "and then what happened?"

4. Use noncommittal responses like "Oh, I see", "Go on", "Hmm..."

5. Use responses that indicate you understand the resident's feelings such as "You really miss your son."

D. Guidelines for Avoiding Barriers to Conversation

1. Avoid interrupting or changing the subject.

2. Avoid expressing your opinion if it implies passing judgment.

3. Avoid talking about your own personal problems and the problems of other residents and co-workers.

4. Avoid pat answers such as "Don't worry" as this can make residents feel their concerns are not important.

5. Avoid questions that can be answered with "Yes" or "No" unless you want only direct answers.

6. Avoid questions that start with "Why" to avoid defensive responses.

E. Guidelines for Ending a Conversation

1. Tell resident that you are finished, that you have to leave and, if appropriate, when you will be back. Be sure to come back at designated time.

2. Tell the resident that you enjoyed the conversation.

3. Leave the resident in a position of comfort and safety, with call signal and other needed items within easy reach.

F. Communicating with Residents who have Vision Loss

1. Follow steps A thru E of this Procedural Guideline.

2. Identify self by name and title as you enter room to avoid startling resident.

3. Encourage and assist resident to keep glasses clean and to wear them.

4. Stand comfortably close to resident in a good light and face resident when you speak.

5. Speak in a normal tone of voice. Do not speak too loud.

6. Use talk and touch to communicate. Encourage resident to do the same.

7. Give ongoing, step by step explanations of what you are going to do and what is expected of the resident. Clarify resident's understanding as appropriate.

8. Do not rearrange the environment without the resident's knowledge and approval. Replace items to their original location in resident's room.

9. Tell resident when you are finished and when you are leaving.

G. Communicating with Residents who have Hearing Loss

1. Follow steps A thru E of this Procedural Guideline.

2. Alert the resident by approaching from the front or side and lightly touching resident's arm. Avoid startling the resident.

3. Eliminate distracting background noise and activity if possible.

4. Speak at a slightly lower pitch and at a normal or only slightly increased volume--avoid shouting.

5. Encourage and assist the resident to use a hearing aid as appropriate.

6. If the resident hears better in one ear, stand on the preferred side.

7. Stand comfortably close to resident in a good light and face resident while you speak.

8. Speak slowly, clearly and distinctly using your lips to emphasize sounds--do not chew gum or cover your face with your hands while talking.

9. Use short words and sentences, clarify resident's understanding then rephrase message if needed.

10. Keep conversations short and limited to a single topic.

11. Do not convey negative messages by your tone of voice or body language.

12. Write out key words, if needed, or use other communication assistive devices such as communication boards if available.

13. If the resident uses sign language, try to find someone who "signs" to interpret.

H. Communicating with Residents who have Problems with Speaking

1. Follow steps A thru E of this Procedural Guideline.

2. Keep conversation short, but frequent. Ask direct questions if resident can answer "Yes" or "No."

3. Allow the resident adequate time to respond.

4. Listen carefully. Don't pretend to understand the resident if you don't.

5. Emphasize the positive aspects such as the words you understand.
6. If you can't understand the words, validate what you think the resident is saying or feeling.
7. Take time to complete each conversation to avoid conveying impatience.
8. Monitor your body language to assure you are not sending negative messages.
9. Encourage and assist the resident to point, nod, write, or to use assistive devices for communication such as picture boards and word boards as appropriate.

I. Communicating with Residents who have Problems with Understanding

1. Follow steps A thru E of this Procedural Guideline.
2. Use simple sentences and words, and pronounce words clearly and slowly.
3. Keep conversation short, but frequent and focused on a single topic.
4. Give simple one-step instructions as appropriate.
5. Allow the resident adequate time to respond.
6. Monitor your body language to assure you are not sending negative messages.
7. Use gestures and expressions to enhance message.
8. Use clues to go with your verbal message, i.e., as you ask resident to brush teeth, put the toothbrush into resident's hand.
9. Take time to complete each conversation to avoid conveying impatience.

J. Guidelines for Effective Interpersonal Relations

1. Maintain open communication, be a good listener and encourage residents to express their feelings.
2. Be honest. Your best efforts will fail if you are not sincere.
3. Respect each resident as a unique individual with own behavior patterns.
4. Be courteous, patient and hopeful.
5. Develop supportive and trusting relationships with residents by being supportive and trustworthy.
6. Show residents that you care "about" them as well as caring "for" them.
7. Understand and accept residents – without judging.

8. Don't take resident's behavior personally.

9. Identify honest examples of residents' strengths and successes and provide positive feedback to resident.

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PROCEDURAL GUIDELINE #11 – BODY MECHANICS FOR NURSE AIDES

A. Purpose

1. To maximize strength

2. To avoid injury to the nurse aide and the resident

B. General Guidelines and Precautions for Lifting and Moving

1. Wear loose clothing and low heeled, comfortable, non-skid shoes to allow good body mechanics.

2. Always get help from co-workers when needed before lifting heavy objects or residents who are unable to stand.

   a. Plan the lift ahead of time.
   b. Lift on signal such as "on the count of three."

3. Elevate the bed to comfortable working height when working at the bedside. Remember to return the bed to the lowest horizontal position when finished for resident safety.

4. Maintain good posture and good body alignment while lifting.

   a. Keep your back straight.
   b. Keep your knees bent.
   c. Keep your weight evenly distributed on both feet.
   d. Keep your feet at shoulder width (about 12 inches apart) to provide a broad base of support.

5. Use the strongest and largest muscles to do the job. Leg and arm muscles are the strongest. Back and abdominal muscles are the weakest.

6. Bend from the hip and knees--not waist--when lifting objects.

7. Always squat down to lift heavy objects from the floor.

8. Keep objects close to your body when lifting and carrying.

9. Use both hands when lifting or moving heavy objects.

10. Slide, push or pull heavy objects rather than lifting them, when possible.

11. Use the weight of your body to help push or pull objects.

12. Work with smooth, even movements--not quick, jerky motions.

13. Face your work and avoid twisting your body.

14. To change the direction of your work, take short steps and turn your whole body without twisting your back and neck.

15. Avoid unnecessary bending and reaching.

16. Do not lift objects higher than your shoulders.

PROCEDURAL GUIDELINE #12 – POSITIONING RESIDENTS

A. Purpose: To maintain good body alignment and comfort, and to avoid contractures and pressure sores.

B. Guidelines

1. Proper positioning should always be done after moving or lifting residents.

2. Check with charge nurse and care plan for special instructions on positioning.

3. After positioning, always check that the resident is in good body alignment with spine straight and with head, arms, hands, legs, feet and lower back supported.

C. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
b. Gather needed supplies such as positioning devices, linen.
c. Knock on door and identify self by name and title.
d. Greet resident by preferred name and identify resident per facility policy.
e. Explain procedure and encourage resident's participation as appropriate.
f. Provide privacy as appropriate such as close door/curtains, drape resident.
g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
h. If siderails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Fowler's position is a sitting position. It is helpful in relieving respiratory distress, preventing aspiration and promoting activities such as eating and reading in bed. This position increases pressure on buttocks and coccyx and should not be used for more than 2 hours.

a. Position resident on back in center of bed and move resident up in bed if needed (Procedural Guideline #14).
b. Elevate the head of the bed to the desired angle (usually 45° or 30°) but may be higher or lower.
(1) For Semi-Fowlers--head of the bed is usually elevated to a 45° angle.
(2) For Low Fowlers--head of the bed is usually elevated to a 30° angle.
c. Reposition pillow under head and shoulder.
d. Slightly elevate foot of bed to prevent sliding down in bed if allowed.
e. Follow steps C3, d - g (below) as indicated.

3. Supine position is lying flat on back. It is often preferred for sleeping.

a. Place bed in flat position and remove pillow if tolerated.

b. Position resident on back in center of bed and move resident up in bed if needed (Procedural Guideline #14).
c. Replace pillow under head and shoulders.
d. Place pillows under arms with hand slightly elevated as indicated.
e. Place small pillows or rolled towels under hands to support them in good alignment as indicated.
f. Place pillows or rolled towels against outer thighs and footboard at foot of bed, as indicated, to keep legs straight and toes pointed upward.
g. Use other positioning methods and devices as indicated to maintain good body alignment.

4. Semi-Supine (Tilt) position is a variation of the supine position. It is not a lateral (side-lying) position. The benefits are reduced pressure on sacrum, coccyx and buttocks without added pressure to hip.

a. Turn resident on side toward you (Procedural Guideline #13).
b. Place a pillow behind the resident's back. Push resident slightly back against pillow to support back and relieve pressure on arm or shoulder.
c. Place another pillow under the resident's top leg, level with the hip joint.
d. Position the resident so that both legs are straight, with the top leg a little behind the bottom leg and supported by a pillow.
e. Position the resident's upper arm in a position of comfort with the wrist resting on the abdomen.

5. Prone position is lying on the abdomen. The benefit of this position is that it eliminates all pressure on the back. This position is uncomfortable for many residents. Do not put a resident into the prone position unless instructed to do so by the charge nurse.

a. Request assistant prior to positioning.
b. Using a lift sheet, turn resident on side toward you (Procedural Guideline #13).
c. Lower bed to flat position and remove pillow.
d. Place a small pillow against abdomen.
e. On signal, have assistant use lift sheet to slowly roll resident onto abdomen, as you guide the turn assuring that arm is safe and head is turned to side.
f. Adjust arm at side or flexed upward.
g. Move resident down in bed so toes hangs off edge of mattress, or place a pillow under lower legs so toes are off the bed.
h. Place small pillow under head.
i. Check resident every 15 minutes to assure that prone position is tolerated. Monitor for respiratory distress.

6. Semi-Prone position is the reverse of semi-supine. It is a comfortable position that reduces pressure and contractures.

a. Turn residents into prone position following steps C5, a - e (above).
b. Turn the resident's head to the side facing you.
c. Lift the shoulder near you and place a pillow under the chest and shoulder, with the resident's arm resting on (or extended on) the pillow. The other arm is positioned behind (not underneath) the resident.
d. Fold a second pillow in half and place under the top leg.
e. Extend both legs so that they are straight.
f. Check resident frequently to assure that semi-prone position is tolerated. Monitor for respiratory distress.

7. Lateral position is lying on either side. There are many variations of the lateral position. It is a comfortable position, which relieves pressure on the sacrum, coccyx and buttocks.

    a. Adjust bed flat, remove pillow, turn resident on side toward you (Procedural Guideline #13), and replace pillow under head.
    b. Raise siderail and go to other side of bed and lower siderail.
    c. Place hands under resident's shoulders and hips and pull resident toward the center of the bed. Resident should not be lying directly on shoulder.
    d. Place a pillow against back and push slightly under back to form a roll and maintain correct body alignment.
    e. Position upper leg slightly in front of lower leg and place a pillow between knees for support.
    f. Support hand and arm on pillow if indicated.

8. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

9. Observe for and report to charge nurse:

    a. Problems or complaints related to procedure.
    b. Changes in the resident's ability to participate in moving or positioning.
    c. Other significant observations.

PROCEDURAL GUIDELINE #13 – TURNING RESIDENT ON SIDE TOWARD YOU

A. Purpose: To turn resident on side without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.
2. Request special instruction from charge nurse as needed prior to the move.
3. Request assistance as needed prior to the move and use good body mechanics.
4. Encourage and assist resident to move as independently as possible.
5. Use assistive moving devices as indicated following facility policy.
6. Use a lift sheet when possible to avoid skin trauma.
7. Avoid trauma, injury and avoidable pain.

C. Beginning steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
2. Knock on door and identify self by name and title.
3. Greet resident by preferred name and identify resident per facility policy.
4. Explain procedure and encourage resident's participation as appropriate.
5. Provide privacy as appropriate such as close door/curtains, drape resident.
6. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   a. Lock wheels of bed and lower head of bed as flat as possible.
7. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

D. Assisting Resident to Turn on Side Toward You

1. Move resident to far side of bed as needed to allow enough space for the turn (Procedural Guideline #14).
2. Cross resident's far leg over near leg and cross resident's arms over chest as able.
3. Instruct resident to grasp side-rail and pull on signal to assist with turn as able.

4. Stand on side of the bed midway between resident's head and shoulders, with your feet separated and knees bent. Brace yourself against the side of the bed.

5. Place one hand behind resident's shoulder and other hand behind resident's hip.

6. Gently roll resident toward you, preventing trauma or avoidable pain.

7. Position resident as indicated following Procedural Guideline #12.

E. Turning Resident on Side Toward You With Assistant and Lift Sheet

1. Request assistance, give directions and coordinate move with your assistant.

2. Assure that a lift sheet/pad is in place under resident from neck to knees.

3. Stand on one side of bed with your assistant standing on opposite side.

4. Lower siderails on both sides.

5. Use lift sheet to move resident to far side of bed as needed to allow enough space for the turn (Procedural Guideline #14).

6. Cross resident’s far leg over near leg and cross resident’s arms over chest as able.

7. Stand on side of bed midway between resident’s head and shoulders with your feet separated and knees bent.

8. Place your hand behind resident's shoulder and your other hand behind resident's hip.

9. Your assistant rolls the lift sheet/pad close to resident's body and grasps lift sheet at resident's shoulders and hip.

10. On signal, your assistant uses lift sheet to roll resident onto side toward you, while you brace yourself against side of bed and assist the turn with your hands on resident.

11. Raise side-rail and position resident as indicated (Procedural Guideline #12).

F. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving such as straighten clothing/bedding, adjust bed/siderails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

G. Observe for and Report to Charge Nurse:

1. Problem or complaints related to procedure.
2. Changes in the resident's ability to participate in moving.
3. Other significant observation.

PROCEDURAL GUIDELINE #14 – MOVING RESIDENT IN BED

A. Purpose: To move the resident in bed without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.

2. Request special instruction from charge nurse as needed prior to the move.

3. Request assistance as needed prior to the move and use good body mechanics.

4. Encourage and assist resident to move as independently as possible.

5. Use assistive moving devices as indicated following facility policy.

6. Use a lift sheet when possible to avoid skin trauma.

7. Avoid trauma, injury and avoidable pain.

C. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Knock on door and identify self by name and title.

3. Greet resident by preferred name and identify resident per facility policy.

4. Explain procedure and encourage resident's participation as appropriate.

5. Provide privacy as appropriate such as close door/curtains, drape resident.

6. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

a. Lock wheels of bed and lower head of bed as flat as possible.

7. If siderails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

D. Assisting Resident to Move Up in Bed.

1. Remove pillow from under resident’s head and place pillow against headboard to protect head.

2. Instruct resident to bend knees, place feet flat on mattress and push down with feet against bed on signal to help lift the hips as able.

3. Place your arm under the resident's shoulders supporting the neck and your other arm under the resident's thighs supporting the hips.

4. On signal, lift the resident high enough to clear the bed and move the resident toward the head of bed, preventing trauma and avoidable pain.

5. Repeat as needed to reach desired position.

6. Replace pillow and position resident as indicated (Procedural Guideline #12).

E. Assisting Resident to Move to Side of Bed.

1. Determine the direction of the move and stand on that side of bed with feet separated and one foot forward.

2. Place your arms under resident’s neck and shoulders and assist resident to move upper section of body toward you.

3. Instruct resident to bend knees, place feet flat on mattress and push down with feet against bed on signal to help lift the hips as able.

4. Place your arms under resident’s waist and hips and, on signal, assist resident to move mid-section toward you.

5. Place your arms under resident’s legs and assist resident to move lower section of body toward you.

6. Repeat as needed to reach desired location.

7. Position resident as indicated (Procedural Guideline #12).

F. Moving Resident to Head or Side of Bed with Assistant and Lift Sheet.

1. Request assistance and give direction and coordinate the move with your assistant.

2. Assure that a lift sheet/pad is in place under resident from neck to knees.

3. Stand on one side of the bed with your assistant standing on the opposite side and performing the sameactions as you.

4. Lower siderails on both sides.

5. Use good body mechanics, with feet separated, knees flexed and one foot forward.

6. Cross resident's arms over chest if able.

7. If moving resident to head of bed, remove pillow and place against headboard to protect head.

8. If moving resident to side of bed, determine direction of move and clarify direction with assistant.

9. Roll the lift sheet/pad close to the resident on each side.

10. Grasp lift sheet/pad at thighs and shoulders on each side.

11. On signal, lift the resident high enough to clear the bed and move the resident to the desired position in bed, preventing trauma and avoidable pain.

12. Repeat, if needed, to reach desired position.

13. Replace pillow and position resident as indicated (Procedural Guideline #12).

G. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.
2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

H. Observe For and Report to Charge Nurse:

1. Problems or complaints related to procedure.

2. Changes in the resident's ability to participate in moving.

3. Other significant observations.

PROCEDURAL GUIDELINE #15 – ASSISTING RESIDENT TO SIT UP ON SIDE OF BED

A. Purpose: To assist resident to sit up on side of bed without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.

2. Request special instruction from charge nurse as needed prior to the move.

3. Request assistance as needed prior to the move and use good body mechanics.

4. Encourage and assist resident to move as independently as possible.

5. Use assistive moving devices as indicated following facility policy.

6. Avoid trauma, injury and avoidable pain.

C. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
b. Knock on door and identify self by name and title.
c. Greet resident by preferred name and identify resident per facility policy.
d. Explain procedure and encourage resident's participation as appropriate.
e. Provide privacy as appropriate such as close door/curtains, drape resident.
f. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
(1) Lock wheels of bed and raise head of bed as upright as tolerated.
g. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Move resident close to side of bed with feet off edge of mattress.

3. Face the head of bed and lean toward resident with your feet separated and one foot ahead of the other.

4. Put your arm under the resident's arm and around shoulders. Place your other arm under the resident's knees.

5. On signal, turn the resident about a quarter of a turn and allow the legs to go over the side of the bed, as the trunk becomes upright.

6. Instruct resident to support self with hands against mattress if able.

7. Stay with resident and provide support as needed, allowing resident to adjust to the upright position.

a. If resident feels faint or dizzy, assist to lie back in bed and notify charge nurse.

b. If resident is to dangle legs over side of bed, tell resident to slowly swing legs back and forth for the instructed time.
c. If resident is to get out of bed, put on gait belt and assist into desired position.
d. If resident is to return to bed, assist to lie back in bed.

8. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/siderails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

9. Observe for and report to charge nurse:

a. Problems or complaints related to procedure.
b. Changes in the resident's ability to participate in moving.
c. Other significant observations.

PROCEDURAL GUIDELINE #16 – ASSISTING RESIDENT TO TRANSFER TO CHAIR OR WHEELCHAIR

A. Purpose: To transfer resident to chair or wheelchair without trauma or avoidable pain.

B. Guidelines and Precautions for Moving and Lifting Residents

1. Know the abilities and limitations of the resident to participate in moving.
2. Request special instruction from charge nurse as needed prior to the move.
3. Request assistance as needed prior to the move and use good body mechanics.
4. Encourage and assist resident to move as independently as possible.
5. Use assistive moving devices as indicated following facility policy.
6. Avoid trauma, injury and avoidable pain.

C. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
2. Gather needed supplies such as gait belt, chair or wheelchair.
3. Knock on door and identify self by name and title.
4. Greet resident by preferred name and identify resident per facility policy.
5. Explain procedure and encourage resident's participation as appropriate.
6. Provide privacy as appropriate such as close door/curtains, drape resident.
7. Provide safety as appropriate such as use good body mechanics.
    a. Put bed in lowest position, lock wheels of bed and raise head of bed.
    b. Place chair or wheelchair parallel to the bed or at a 45° angle. Position chair so that resident's strongest leg moves towards the chair.
    c. Lock the brakes on wheelchair and/or put chair against wall if possible.
    d. Place the large part of the small front wheels of wheelchair forward to increase stability.
    e. Remove footrests whenever possible, or fold or raise footrests out of the way.
    f. Assist resident to wear non-skid footwear.

D. Assisting Resident to Transfer to Chair or Wheelchair using Gait Belt (Note this is the preferred method of transfer).

1. Direct and coordinate move with assistant if needed.

2. Assist resident to sit up on side of bed (Procedural Guideline #15). Allow resident to adjust to the sitting position before standing.

3. Show resident the gait belt and explain its use as a safety device.

4. Apply gait belt over the resident's clothing around the waist and check the fit by inserting your fingers under it.

5. Stand in front of resident with your knees bent, feet apart and back straight.

6. Grasp the gait belt with an under-hand grip and move resident forward so feet are close to or touching the floor.

7. Instruct resident to place hands on your shoulders, lean forward, and place feet on the floor on signal. Do not let resident put arms around your neck.

8. Place your hands on either side of gait belt, and on signal, gradually pull resident up into a standing position, supporting the knees and feet with your legs and feet as appropriate.

9. Assist resident to pivot until his/her legs are touching the seat of the chair. Move your feet and turn your body instead of twisting.

10. Ask resident to place hands on arms of chair and support self.

11. Bend your knees as you assist resident to safely lower self into chair.

12. Remove the gait belt from the resident's waist.

E. Assisting Resident to Transfer to Chair or Wheelchair without Gait Belt. (Note this method should be used only if the gait belt is contraindicated).

1. Direct and coordinate the move with the assistant if needed.

2. Assist resident to sit up on side of bed (Procedural Guideline #15). Allow resident to adjust to the sitting position before standing.

3. Stand in front of resident with your knees bent, feet apart and back straight.

4. Instruct resident to place hands on your shoulders, lean forward, and place feet on floor on signal. Do not let resident put arms around your neck.

5. Place your hands under resident's arms and around shoulder blades. Support the resident's knees and feet with your knees and feet as appropriate.

6. On signal, gradually pull the resident up into a standing position, continuing to support resident at the shoulders, knees and feet.

7. Assist resident to turn slowly until his/her legs are touching the seat of the chair. Move your feet and turn your body instead of twisting.

8. Ask resident to place hands on arms of chair and support self.

9. Bend your knees as you assist resident to safely lower self into chair.

F. Guidelines for Positioning the Resident Correctly in the Chair

1. Assure that the head and spine are erect.

2. Place arms on armrests.

3. Place pillows or pads as needed to maintain position.

4. Assure that hips are all the way back in the chair.

5. Assure the upper and lower leg form a 90° angle.

6. Support feet on floor or, if used, on footrest of wheelchair. Do not let feet dangle.

G. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed to proper working height.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

H. Observe for and Report to Charge Nurse:

1. Problem or complaints related to procedure.

2. Changes in the resident's ability to participate in moving.

3. Other significant observations.

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PROCEDURAL GUIDELINE #17 – AMBULATION AND AMBULATION AIDS

A. Purpose: To assist the resident to ambulate as independently as possible, without falls, trauma or avoidable pain.

B. Guidelines and Precautions

1. Know the abilities and limitations of the resident to ambulate.
2. Request special instruction from charge nurse as needed prior to ambulation.
3. Request assistance as needed prior to ambulation and use good body mechanics.
4. Encourage and assist resident to ambulate as independently as possible.
5. Use assistive ambulation devices as indicated following facility policy.
6. Avoid trauma and injury to the resident.

C. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
b. Gather needed supplies such as gait belt, cane or walker.
c. Knock on door and identify self by name and title.
d. Greet resident by preferred name and identify resident per facility policy.
e. Explain procedure and encourage resident's participation as appropriate.
f. Provide privacy as appropriate such as close doors/curtains, drape resident.
g. Provide safety as appropriate such as use good body mechanics.
    (1) Put bed in lowest position and lock wheels of bed.
    (2) Assist resident into safe and appropriate clothes and shoes.
    (3) Assist resident to sit up on side of bed and adjust to the upright position (Procedural Guideline #15).
h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. To Ambulate Resident Using Gait Belt (Note this is the preferred method):

a. Apply gait belt over the resident's clothing, around the waist and check fit by inserting your fingers under it.
b. Stand in front of resident with your knees bent, feet apart and back straight.
c. Move resident forward so feet are close to floor or touching the floor by grasping the belt with an underhand grip.
d. Instruct resident to place hands on your shoulders, lean forward, and place feet on the floor. Do not let resident put arms around your neck.
e. Place your hands on either side of gait belt, and on signal, gradually pull the resident up into a standing position, supporting the knees and feet with your legs and feet as appropriate.
f. Hold the gait belt firmly at the back and stand on resident's weak side if applicable.
g. Allow resident to stand until ready to ambulate.

h. Then ambulate resident, walking slightly behind and to one side of resident and supporting resident with gait belt.

3. To Ambulate Resident Without a Gait Belt (Note this method should be used only if gait belt is contraindicated and if needed assistance is available):
   a. Assist resident to standing position.
   b. Walk slightly behind and to one side of ambulatory resident, supporting resident as needed.
   c. Encourage ambulating resident to use hand rails for support as appropriate.

4. To Ambulate Resident Using a Walker:

   a. Check that walker is properly adjusted, with top of walker even with resident's hip joint.
   b. Place walker close to resident.
   c. Place gait belt on resident and assist to standing position.
   d. Hold gait belt firmly at the back and stand on resident's weak side if applicable.
   e. Assist resident to hold hand grips and move inside walker.
   f. Instruct resident to:
      (1) Lift and move walker about six inches ahead of body.
      (2) Walk forward into walker while leaning on walker for support.
      (3) Repeat step (1) and (2) to ambulate.
   g. Ambulate resident, walking slightly behind and to one side, and supporting resident with gait belt as needed.

5. To Ambulate Resident Using a Cane:

   a. Check that cane is proper height, with top of cane even with resident's hip joint.
   b. Place gait belts on resident and assist to standing position.
   c. Instruct resident to:
      (1) Hold cane on strongest side of body.
      (2) Place cane about 8 inches to the side of foot.
      (3) Move canes about twelve inches ahead of body.
      (4) Move weakest leg forward to cane.
      (5) Move strong leg forward to slightly beyond cane.
      (6) Repeat steps (1) through (5) to ambulate.

   d. Ambulate resident, walking slightly behind and to one side and supporting resident with gait belt as needed.

6. Encourage ambulating resident to:

   a. Walk the required time or distance.
   b. Rest as needed.
   c. Support self with guardrails as needed, if not using cane or walker.
   d. Stand with back straight and head up.
   e. Walk normally with the heel of foot touching the floor first.

7. Assist resident into chair or bed as indicated, after ambulation.

1. Closing steps

    a. Clean and store reusable item and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

2. Observe for and report to charge nurse:
    a. Problems or complaints related to procedure.
    b. Changes in the resident's ability to ambulate.
    c. Other significant observations.

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PROCEDURAL GUIDELINE #18 – MAKING THE UNOCCUPIED BED

A. Purpose: To provide a clean, comfortable bed for the resident who is able to get out of bed.

B. Procedural Guidelines

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Gather needed supplies at bedside on a clean, dry surface such as bedside or overbed table:

    a. Laundry bag, dirty linen container, or plastic bag for wet linen following facility policy
    b. 2 sheets – a top sheet and a bottom sheet
    c. Draw sheet or incontinent pads if used
    d. Blanket and/or bedspread if needed.
    e. Pillowcase(s)

3. Lower side-rails and remove call signal and resident's personal items.

4. Adjust bed flat, elevate bed to comfortable working height, lock wheels and use good body mechanics.

5. Remove soiled linen from bed.

    a. Check linen for misplaced items such as dentures, hearing aids, eyeglasses.
    b. Roll soiled linen away from you with dirty side inside.
    c. Avoid touching soiled linen against your uniform.
    d. Handle soiled linen as little as possible, and avoid shaking linen.
    e. Place soiled linen directly into soiled linen container following facility policy. Keep the outside of the container clean. Do not place soiled linen on clean surfaces or on the floor.
    f. Clean, dry and straighten mattress as needed. Observe for tears or holes in mattress and report them to the charge nurse.
    g. Wash hands.

6. Apply clean bottom linen, working on the side of bed near the clean linen. Do not allow clean linen to touch floor.

    a. For a fitted bottom sheet: Place the fitted sheet corners over the top and bottom mattress corners.
    b. For a straight sheet: Center and unfold lengthwise with bottom edge even with or just over the foot of mattress. Tuck top of sheet under head of mattress and miter top corner.
    c. If used, center drawsheet or pad on the bed.
    d. Tuck in the bottom linen on the side where you are working.

7. Apply top linen on same side of bed.

    a. Center and unfold top sheet lengthwise, with upper edge even with top of mattress.
    b. Center and unfold blanket and/or bedspread, with upper edge slightly below the edge of top sheet.
    c. Tuck in top linen at the foot of bed and make a smooth corner following facility policy.

8. Move to the opposite side of the bed to complete bedmaking.

9. Place corners of fitted sheet over mattress or miter top corner of bottom sheet.

10. Pull and tuck in bottom linen, keeping it straight and centered. Assure bottom linen is tight, smooth and free of wrinkles (unless waterbed, egg crate, gel or air mattress).

11. Tuck in top bedding at foot of bed, keeping it straight and centered. Make a smooth corner following facility policy.

12. Smooth top linen and fold top sheet over edge of blanket if used.

13. Apply clean pillowcase (with zippers and tags inside) and replace pillow on bed.

14. Replace call signal and any needed items within resident's reach.

15. Adjust height of bed and position of bed as appropriate.

16. If used, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

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PROCEDURAL GUIDELINE #19 – MAKING THE OCCUPIED BED

A. Purpose: To provide a clean, comfortable bed for the resident who is not able to get out of bed.

B. Procedural Guidelines

1. Beginning steps

    a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
    b. Gather needed supplies at bedside on a clean, dry surface such as bedside or overbed table:
        (1) Laundry bag, dirty linen container, or plastic bag for wet linen following facility policy
        (2) 2 Sheets -- a top sheet and a bottom sheet
        (3) Drawsheet or incontinent pad if used
        (4) Blanket and/or bedspread if needed
        (5) Pillowcase(s)
    c. Knock on door and identify self by name and title.
    d. Greet resident by preferred name and identify resident per facility policy.
    e. Explain procedure and encourage resident's participation as appropriate.
    f. Provide privacy as appropriate such as close doors/curtains, drape resident.
    g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
    h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Lock wheels of bed, put head of bed as flat as tolerated and assist resident to roll on side.

3. Check linen for misplaced items such as dentures, hearing aids, and eyeglasses.

4. Remove blanket and bedspread and set aside if they are to be reused. Leave resident covered with top sheet or bath blanket following facility policy.

5. Loosen bottom linen and roll or fanfold linen, soiled side inside, to center of bed.

6. Clean, dry and straighten mattress as needed.

7. Apply clean bottom linen, working on side of bed near clean linen. Do not allow clean lined to touch floor.

    a. For fitted bottom sheet: Place fitted corners over top and bottom mattress corners.
    b. For straight sheet: Center and unfold lengthwise with bottom edge even with or just over the foot of mattress. Tuck top of sheet under head of mattress and miter the top corner.
    c. If used, center the drawsheet or pad on the bed.
    d. Tuck in the bottom linen on the side you are working, keeping linen straight and centered.
    e. Roll or fanfold the clean bottom linen to the center of the bed. If soiled linen is wet, keep clean linen separated from soiled linen.

8. Raise siderail, assist resident to roll over linen toward you, and assure that resident is comfortable and safe.

9. Raise siderail, then go to opposite side of bed and lower siderail.

10. Remove soiled linen from bed.

    a. Roll soiled linen off of bed with dirty side inside.
    b. Avoid touching soiled linen against uniform.
    c. Handle soiled linen as little as possible and avoid shaking linen.
    d. Place soiled linen directly into soiled linen container following facility policy. Keep the outside of the container clean. Do not place soiled linen on clean surfaces or on the floor.
    e. Clean, dry and straighten mattress as needed. Report tears or holes in mattress to charge nurse.
    f. Remember to raise side-rail before you leave the bedside.
    g. Wash hands.

11. Pull clean bottom linen away from resident's back.

12. Pull and tuck in bottom linen, assuring bottom linen is tight, smooth, and free of wrinkles, (unless waterbed, egg crate, gel or air mattress).

13. Assist resident to roll back to the center of the bed.

14. Remove the pillow, change pillowcase (with zippers and tags inside), and replace pillow, providing support for resident's head if needed.

15. Remove the used top sheet or bath blanket as you apply the clean top sheet over the resident, avoiding unnecessary exposure.

16. Apply remaining top linen, keeping it straight and centered and tucking it in at foot of bed with smooth corners following facility policy.

17. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

18. Observe for and report to charge nurse:

    a. Problem or complaints related to procedure.
    b. Changes in the resident's ability to participate in moving.
    c. Other significant observations.

PROCEDURAL GUIDELINE #20 – TUB OR SHOWER BATH

A. Purpose: To bathe residents who are able to get in and out of tub or shower.

B. Precautions

1. Be sure water temperature is regulated to avoid burns.

2. NEVER leave the resident unattended in tub or shower.

3. Use emergency call signal to summon assistance if needed.

4. If resident becomes ill or uncooperative, call for help and turn off shower or open tub drain.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies on a clean dry surface in the bathing area:
      (1) Be sure tub or shower is available, clean and has a non-slip surface
      (2) Shower chair or tub chair if indicated
      (3) Washcloth and towel
      (4) Soap or skin cleanser
      (5) Lotion and other personal care items as preferred
      (6) Clean, disposable examination gloves
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close doors/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

2. Request assistance as needed prior to the bath.

3. Assist resident to bathing area as appropriate, providing needed support to prevent accidents and assuring resident is fully covered during transport.

4. Regulate temperature and flow of water before resident gets into water and as needed during bath.

   a. Water temperature should be comfortable warm (about 105?F). Before use, test water temperature for comfortable warmth on your wrist or forearm or use bath thermometer. Have resident test water for comfort before bathing.
   b. For tub bath, fill tub half-full with comfortably warm water.
   c. For shower, regulate temperature and flow for comfort and safety.

5. Assist resident with undressing and toileting as appropriate.

6. Assist resident into tub or shower, facing the controls.

    a. Provide adequate support to avoid falls and injuries.
    b. Encourage resident to use the safety grab bars.
    c. Use tub or shower chair as needed, locking wheels once chair is in position.

7. Stay with resident and assist/supervise with bathing as appropriate.
    a. Put on gloves for washing perineum.
    b. Wash (with soap) and rinse entire body, working from clean to dirty areas.
    c. Assure back, creases, skin folds, perineum, feet and between toes are thoroughly cleaned and rinsed.

8. When bathing is complete, turn off shower or open the tub drain.

9. Assist resident out of tub or shower, providing adequate support to avoid falls.

10. Assist resident to dry thoroughly, with special attention to back, creases, skin folds, perineum, feet and between toes.

11. Remove gloves and wash hands after perineal care is completed.

12. Assist with toiletries as desired. Apply lotion to dry skin. Avoiding area between toes. Remove excess lotion from hands and feet.

13. Supervise and/or assist resident with dressing as appropriate.

14. Assist resident to return to room and complete dressing and grooming as appropriate.

15. Return resident's belongings to room.

16. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
        (1) Place used linen and clothing in appropriate containers.
        (2) Wear gloves to clean tub/shower with approved cleanser. Leave areas clean and dry.
    b. Remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

17. Observe for and report to charge nurse:
    a. Problems or complaints related to the bath.
    b. Changes in the resident's ability to participate in bathing.
    c. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, foul odors.
    d. Skin complaints such as burning, itching, tingling, numbness, pain.
    e. Other significant observations.

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PROCEDURAL GUIDELINE #21 - COMPLETE BED BATH

A. Purpose: To bathe the resident who cannot get out of bed for bathing.

B. General Guidelines

1. Utilize bath time as a time to communicate with the resident, make observations and provide other needed care.

2. Follow resident's personal preferences for bathing as possible.

3. Change bath water at least prior to washing the perineum and as needed during bath to keep the water warm, clean and free of excess soap.

4. Wash, rinse and dry from clean to dirty areas.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9a) if contact with blood or body fluids is likely.
   b. Gather needed supplies at beside on a clean, dry surface such as bedside or overbed table:
      (1) Wash basins of comfortably warm water (about 105º F). Test water temperature for comfort on your wrist or forearm, or use bath thermometer.
      (2) Soap or skin cleanser as indicated
      (3) Towel and 2 washcloths
      (4) Lotion and other personal care items as preferred
      (5) Sheet of bath blanket
      (6) Clean, disposable examination gloves
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close doors/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Offer assistance with toileting and undressing before the bath as needed.

3. Lock wheels of bed, lower head of bed as tolerated and move resident to side of bed near you.

4. Remove upper bedding, leaving resident covered with top sheet or bath blanket to avoid unnecessary exposure.

5. Supervise/assist resident to wash, rinse and dry face, ears and neck, encouraging resident to do as much as able.

a. Fold washcloth into a mitt or gather corners together.
b. Wet washcloth in bath water and wash eyes (without soap), wiping from the inner to outer part of each eye and using a separate corner for each eye.
c. Wet washcloth and apply a minimum of soap. Wash, rinse, and dry the face, ears and neck.

6. Put towel under far arm. Supervise/assist residents to wash rinse and dry arm, axilla and shoulder. Then repeat procedure for near arm.

a. Allow resident to wash and soak hands directly in the wash basin.
b. Clean and trim fingernails if needed/allowed (Procedural Guideline #33).

7. Place bath towel over chest. Supervise/assist resident to wash, rinses and dry chest under towel.. Clean and dry area under breasts.

8. Cover chest and abdomen with lengthwise towel. Supervise/assist resident to wash, rinses and dries abdomen. Clean and dry skin folds and umbilicus.

a. Apply deodorant to underarms, lotion to dry skin, and powder sparingly under breasts and to skin folds as indicated.
b. Replace sheet or bath blanket over shoulders and remove towel.

9. Remove sheet or bath blanket from far leg, ask resident to flex far leg and place bath towel underneath. Wash, rinse and dry leg and foot. Replace sheet or bath blanket. Then repeat procedure for other leg.

a. Allow resident to wash and soak each foot directly in the wash basin.
b. Then dry feet, including area between toes.
c. Clean and trim toenails if needed/allowed (Procedural Guidelines #33).
d. Apply lotion as needed, avoiding area between toes. Wipe off excess lotion.
e. Replace sheet or bath blanket and raise side-rail.

10. Assist resident to turn on side. Place towel lengthwise under resident's back. Wash, rinse and dry the neck and back.

a. Apply lotion to skin as needed or a backrub may be given.

11. Change bath water and start with a clean washcloth.

12. Assist resident to turn onto back and supervise/assist resident with washing perineal area.

a. If no assistance is needed:
   (1) Instruct resident to wash, rinse and dry "between legs" or "privates".
   (2) Place washcloth, soap, basin, and towel and call signal within easy reach.
   (3) Instruct resident to signal when finished. Leave the room until signaled or check back as appropriate.
b. If assistance is needed:
   (1) Wash hands, wear gloves and provide perineal care following Procedural Guidelines #24 or #25 as appropriate.

(2) Note that the nurse aide must provide perineal care if the resident needs assistance. Residents may be reluctant to admit they need help.

c. Remove gloves and wash hands after perineal care is completed.

13. Cover resident and supervise/assist with dressing and other needed personal care.

14. Generally the bed will be changed after the bath (Procedural Guideline #18 or #19).

15. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

16. Observe for and report to charge nurse:

    a. Problems or complaints related to the bath.
    b. Changes in resident's ability to participate in bathing.
    c. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, and foul odors.
    d. Skin complaints such as burning, itching, tingling, numbness or pain.
    e. Other significant observations.

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PROCEDURAL GUIDELINE #22 – PARTIAL BATH

A. Purpose

1. To clean part of the body, when less than a full bath is needed or desired.

2. The partial bath is usually given on alternate days in between complete baths.

B. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies at bedside on clean, dry surface such as bedside or overbed table:
      (1) Wash basin or sink with comfortably warm water (about 105ºF). Test water temperature for comfort on your wrist or forearm or use bath thermometer.
      (2) Soap or skin cleanser
      (3) Towel and washcloth(s)
      (4) Lotion and other personal care items as preferred
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close doors/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Assist/supervise resident with toileting and undressing as needed.

3. For ambulatory resident:

   a. Encourage resident to stand or sit at sink or basin to wash self as able.
   b. Assist/supervise resident to wash, rinse and dry face, hands, axilla, back, perineum and other areas as needed.
   c. Wear gloves and follow Procedural Guideline #24 or #25 for Perineal Care as appropriate.

4. For bedfast resident:

   a. Assist/supervise resident to wash, rinse and dry face, hands, axilla, back, perineum and other areas as needed. Wear gloves and follow Procedural Guideline #24 or #25 for Perineal Care as appropriate.

5. Assist/supervise resident with dressing and other needed personal care.

6. Closing steps

   a. Clean and store reusable items and discard disposables per facility policy.
   b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/siderails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

7. Observe for and report to charge nurse:
   a. Problems or complaints related to procedure.
   b. Changes in the resident's ability to participate in bathing.
   c. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, and foul odors.
   d. Skin complaints such as burning, itching, tingling, numbness, pain.
   e. Other significant observations.

PROCEDURAL GUIDELINE #23 – BEDPAN AND URINAL

A. Purpose: To provide for elimination when resident is unable to get out of bed.

B. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
2. Gather needed supplies:

    a. Urinal, bedpan or fracture pan and cover
    b. Powder (optional)
    c. Tissue
    d. Washcloth and towel
    e. Soap and basin of comfortably warm water (about 105° F)
    f. Clean, disposable examination gloves

3. Knock on door and identify self by name and title.

4. Greet resident by preferred name and identify resident per facility policy.

5. Explain procedure and encourage resident's participation as appropriate.

6. Provide privacy as appropriate such as close doors/curtains, drape resident.

7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

8. If siderails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

C. Assisting Resident with Urinal:

1. Instruct resident in using urinal.

2. If resident is able to stand, assist to standing position. If needed provide support to resident while standing.

3. If resident is unable to stand, place head of bed as upright as tolerated.

4. Give urinal to resident or, if needed, position and hold urinal in place.

5. Remain in room while resident uses urinal, if necessary for safety.

6. Leave room while resident uses urinal, if you can safely do so.

    a. Place call signal in easy reach.
    b. Tell resident to call when finished or if help is needed.
    c. Leave room and close door for privacy. Wash hands.

d. Return to room promptly when resident calls, or check on resident as appropriate, knocking on door before entering.

7. Wash hands and put on gloves prior to contact with urine.

8. Remove urinal when resident is finished.

   a. Assist resident back to bed if standing.
   b. Provide perineal care if needed (Procedural Guideline #25).

D. Assisting Resident with Bedpan:

1. Request assistance as needed.

2. Warm bedpan with warm water if metal pan is used (optional).

3. Lower heads of bed as tolerated and adjust resident's clothing as appropriate.

4. Instruct resident in using bedpan. Ask resident to raise hips by bending knees and pushing with feet against mattress if able.

5. Assist resident to lift hips by supporting hips with arm.

6. Slide bedpan under resident's hips, avoiding friction and trauma.

7. If unable to lift hips, turn resident on side, hold bedpan securely in place against buttocks and help resident roll back onto bedpan.

8. Adjust the bedpan for comfort and position.

9. Raise siderails, if used, and elevate head of bed as upright as tolerated.

10. Remain in room while resident uses bedpan, if necessary for safety.

11. Leave room while resident uses bedpan, if you can safely do so.

    a. Place tissue and call signal in easy reach and raise siderails.
    b. Tell resident to call when finished or if help is needed.
    c. Leave room and close door for privacy. Wash hands.
    d. Return to room promptly when resident calls, or check on resident as appropriate, knocking on door before entering.

12. Wash hands and put on gloves prior to contact with stool and/or urine.

13. Remove bedpan when resident is finished.

    a. Lower head of bed, then lower siderail as appropriate.

b. Ask resident to raise hips while you remove bedpan, or hold bedpan securely while resident rolls to the side off bedpan. Avoid friction and trauma.
c. Assist resident to wipe perineum if needed.
d. Provide perineal care if needed (Procedural Guidelines #24 or #25 as appropriate).

E. Emptying urinal or bedpan.

1. Put on gloves for contact with urine or stool.

2. Measure and record urine if resident is on I and O.

3. Collect specimen if indicated.

4. Show unusual urine or stool to charge nurse, as a specimen may be needed.

5. Empty, rinse, clean and replace urinal or bedpan following facility policy.

F. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

G. Observe for and report to charge nurse:

1. Problems or complaints related to procedure.

2. Amount and appearance of urine such as dark, red, cloudy. Presence of unusual substances such as solid particles, blood, odor.

3. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.

4. Amount and appearance of stool. Presence of unusual substance such as blood, mucus.

5. Bowel complaints such as pain, constipation, diarrhea, bleeding.

6. Other significant observations.

PROCEDURAL GUIDELINE #24 – PERINEAL CARE/INCONTINENT CARE-FEMALE (WITH OR WITHOUT CATHETER)

A. Purpose: To clean the female perineum without contaminating the urethral area with germs from the rectal area.

B. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies:
      (1) Washcloth(s)
      (2) Towel(s)
      (3) Soap or other perineal cleanser following facility policy
      (4) Clean wash basin of comfortably warm water (about 105ºF). Test water temperature for comfort on your wrist or forearm or use bath thermometer.
      (5) Clean, disposable examination gloves
      (6) Additional supplies as needed if heavy soiling is present
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close doors/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Lower head of bed and position resident on back with legs flexed and separated as able and as appropriate.

3. If heavy soiling is present, wear gloves and use tissues or wipes to remove heavy soiling prior to perineal care. If necessary, use additional clean washcloths, towels, linen, basins, water, gloves. Then remove/discard gloves and wash hands.

4. Place protective or water proof pad under buttocks.

5. Cover resident with sheet or bath blanket and raise cover to expose perineum.

6. Wash hands and put on clean gloves for perineal care.

7. Gently wash, rinse and dry perineal area, wiping from "clean" urethral area toward "dirty" rectal area to avoid contaminating urethral area with germs from rectal area.

   a. Wet washcloth and apply soap or perineal cleaner sparingly to avoid irritation.
   b. First separate inner labia and wash down the center over the urethral area, wiping downward from front toward back and stopping at the base of labia.
   c. Continue to wash the rest of the perineal area, wiping from front to back, alternating from side to side and moving outward to the thighs.

d. Then rinse well and dry the urethral and perineal area, working in the same direction until entire area is clean, soap-free and dry.

8. If indwelling urinary catheter is present:

   a. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum. Keep drainage bag below level of bladder.
   b. When washing, rinsing and drying the urethral area:
      (1) Gently wash, rinse and dry around the juncture of the catheter and meatus.
      (2) Then wash the catheter from the meatus down the tube about 3 inches.

9. Assist resident to turn on side with top leg slightly bent if able.

10. Gently wash, rinse and dry the rectal area and buttocks, wiping from base of labia downward over rectal area until entire area is clean, soap-free and dry. Do not wipe back over urethral area.

11. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/siderails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

12. Observe for and report to charge nurse:

    a. Problems or complaints related to procedure.
    b. Skin changes such as rash, redness, irritation, bruising, swelling, discoloration, skin breakdown, drainage, foul odors.
    c. Skin complaints such as burning, itching, tingling, numbness, pain.
    d. Problems at catheter-meatal junction such as redness, irritation, swelling, crusting, drainage, bleeding, pain.
    e. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.
    f. Other significant observations.

PROCEDURAL GUIDELINE #25 – PERINEAL CARE/INCONTINENT CARE-MALE (WITH OR WITHOUT CATHETER)

A. Purpose: To clean the male perineum without contaminating the urethral area with germs from the rectal area.

B. Procedural Guidelines

1. Beginning steps

    a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
    b. Gather needed supplies:
        (1) Washcloth(s)
        (2) Towel(s)
        (3) Soap or other perineal cleanser following facility policy
        (4) Clean wash basin of comfortably warm water (about 105ºF). Test water temperature for comfort on your wrist or forearm or use bath thermometer.
        (5) Clean, disposable examination gloves.
        (6) Additional supplies as needed if heavy soiling is present
    c. Knock on door and identify self by name and title.
    d. Greet resident by preferred name and identify resident per facility policy.
    e. Explain procedure and encourage resident's participation as appropriate.
    f. Provide privacy as appropriate such as close door/curtains, drape resident.
    g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
    h. If siderails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Lower head of bed and position resident on back with legs flexed and separated as able and as appropriate.

3. If heavy soiling is present, wear gloves and use tissues or wipes to remove heavy soiling prior to perineal care. If necessary, use additional clean washcloths, towels, linen, basins, water, gloves. Then remove/discard gloves and wash hands.

4. Place protective or water proof pad under buttocks.

5. Cover resident with sheet or bath blanket and raise cover to expose perineum.

6. Wash hands and put on clean gloves prior to perineal care.

7. Retract foreskin of uncircumcised male.

8. Gently wash, rinse and dry perineal area, wiping from "clean" urethral area toward "dirty" rectal area to avoid contaminating urethral area with germs from rectal area.

    a. Wet washcloth and apply soap or perineal cleanser sparingly to avoid irritation.
    b. First wash the urethral area in a circular motion.
    c. Continue to wash down the penis and the rest of the perineal area including the scrotum, using downward strokes and working outward to the thighs.

d. Then rinse well and dry the urethral and perineal area, working in the same direction until entire area is clean, soap-free and dry.

9. If indwelling urinary catheter is present:

   a. Hold catheter tubing to one side and support against leg to avoid traction or unnecessary movement of the catheter while washing perineum. Keep drainage bag below level of bladder.
   b. When washing, rinsing and drying the urethral area:
      (1) Gently wash, rinse and dry around the juncture of the catheter and meatus.
      (2) Then wash the catheter from the meatus down the tube about 3 inches.

10. Reposition foreskin if retracted.

11. Assist resident to turn on side with top leg slightly bent if able.

12. Gently wash, rinse and dry the rectal area and buttocks, wiping from base of scrotum downward over rectal area until entire area is clean, soap-free and dry. Do not wipe back over urethral area.

13. Closing steps

   a. Clean and store reusable items and discard disposables per facility policy.
   b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
   c. Provide for resident's comfort and safety before leaving as appropriate such as straightenclothing/bedding, adjust bed/siderails.
   d. Always replace call signal and needed items within resident's reach.
   e. Inform resident when finished and ask if anything is needed before you go.

14. Observe for and report to charge nurse:

   a. Problems or complaints related to procedure. Skin changes such as rash, redness, irritation, bruising, swelling, discoloration, skin breakdown, drainage, and foul odors.
   b. Skin complaints such as burning, itching, tingling, numbness, pain.

   Problems at catheter-meatal junction such as redness, irritation, swelling, crusting, drainage, bleeding, pain.
   c. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.
   d. Other significant observations.
   e. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.
   f. Other significant observations.

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PROCEDURAL GUIDELINE #26 – BACK RUB

A. Purpose: To stimulate circulation, prevent skin breakdown and promote comfort and relaxation.

B. Precaution:

1. Check to be sure the resident may have a backrub, as some facilities require a physician's order for this procedure.

2. Avoid rubbing over bony prominence or red areas, as it may be harmful to tissue.

C. Procedural Guidelines

1. Beginning steps
    a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
    b. Gather needed supplies:
        (1) Lotion
        (2) Wash cloth and towel if needed
        (3) Basin of comfortably warm water (about 105ºF) if needed
    c. Knock on door and identify self by name and title.
    d. Greet resident by preferred name and identify resident per facility policy.
    e. Explain procedure and encourage resident's participation as appropriate.
    f. Provide privacy as appropriate such as close door/curtains, drape resident.
    g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
    h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Position resident prone or on side facing raised rail and with back toward you.

3. Uncover resident's back and (if acceptable to resident) buttocks. Keep remainder of body covered with top sheet or bath blanket.

4. Wash, rinse and dry skin of back if indicated.

5. Pour small amount of lotion into your hands and rub hands together to warm.

6. Rub back for 2 to 3 minutes, including neck, shoulders and (if acceptable to resident) buttocks. Do not rub over bony prominences or reddened areas.

    a. Spread lotion over back.
    b. Put hands at base of spine and move hands up back, around shoulders, down sides of back and (if acceptable to resident) around buttocks. Apply firmer pressure on upward strokes, use long smooth strokes, and keep your hands in contact with resident's skin.
    c. Rub in circular motions upward along the spine moving outward over the back.
    d. Repeat steps b to finish.
    e. Wipe off excess lotion if indicated.

7. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/siderails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

8. Observe for and report to charge nurse:

    a. Problems or complaints related to procedure.
    b. Skin changes such as rash, redness, irritation, bruising, discoloration, swelling, skin breakdown, drainage, foul odors.
    c. Skin complaints such as burning, itching, tingling, numbness, pain.
    d. Other significant observations.

PROCEDURAL GUIDELINE #27 – BRUSHING THE TEETH

A. Purpose: To maintain clean and healthy gums and teeth.

B. Procedural Guideline

1. Beginning Steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies:
      (1) Soft bristled toothbrush
      (2) Toothpaste
      (3) Glass of cool water or diluted mouthwash if permitted
      (4) Emesis basin
      (5) Towel
      (6) Clean, disposable examination gloves
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Assist resident into a safe and comfortable upright position as tolerated, or with head turned well to one side.

3. Place towel across resident's chest as needed.

4. Supervise/assist resident to perform procedure as able, such as applying toothpaste to toothbrush.

5. Wash hands and put on gloves prior to contact with oral secretions and mucous membrane.

6. Brush the teeth starting at upper back tooth and working in an orderly direction to brush the inner, outer and chewing surfaces of all upper and lower teeth.

7. Hold brush on gumline at 45° angle to teeth and gently brush at gumline, using a short circular motion. Then brush up the tooth surface from gum to top of tooth.

8. Brush the inner surfaces of front teeth by tilting brush vertically and using gentle up and down strokes.

9. Brush the chewing surface of upper and lower teeth using short back and forth strokes.

10. Repeat steps 7, 8 and 9 until all surfaces of upper and lower teeth are brushed.

11. Gently brush tongue as appropriate.

12. Have resident rinse mouth and spit into emesis basin or sink as needed and at the completion of brushing.

13. Wipe lips with tissues

14. Closing Steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

15. Observe for and Report to Charge Nurse:

    a. Problems or complaints related to procedure.
    b. Changes in the residents' ability to participate in procedure.
    c. Discoloration, irritation, bleeding or sores on mouth tongue or lips.
    d. Loose, broken, damaged or decaying teeth.
    e. Bad breath that does not improve after mouth care.
    f. Other significant observations.

PROCEDURAL GUIDELINE #28 – DENTURE CARE

A. Purpose: To maintain healthy gums and clean dentures.

B. Precaution

1. Take care to avoid damage or loss of dentures, as they are expensive and difficult to replace.

2. Hold dentures securely to avoid dropping but handle gently to avoid bending or breaking.

C. Procedural Guidelines

1. Beginning steps

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
b. Gather needed supplies:
(1) Denture brush or toothbrush
(2) Denture cleaner or toothpaste
(3) Clean denture cup--labeled as required by facility
(4) Glass of cool water or diluted mouthwash if permitted
(5) Tissues
(6) Clean, disposable examination gloves
c. Knock on door and identify self by name and title.
d. Greet resident by preferred name and identify resident per facility policy.
e. Explain procedure and encourage resident's participation as appropriate.
f. Provide privacy as appropriate such as close door/curtains, drape resident.
g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Assist resident into a safe and comfortable upright position as tolerated, or with head turned well to one side.

3. Wash hands and put on gloves prior to contact with oral secretions and mucous membranes.

4. Provide tissue and ask resident to remove dentures if able, or put tissue over your fingers and gently remove or assist with removal of dentures as needed.

5. Put dentures in labeled denture cup and take to appropriate area for cleaning. Dentures may be soaked in denture cleaner following facility policy.

6. Line sink with towel or fill sink half-full of water to prevent damage to dentures if dropped.

7. Thoroughly clean all surfaces of dentures (including inner, outer and chewing surfaces of upper and lower dentures) with denture cleanser and brush.

a. Remove dentures from container and rinse under cool (not hot) running water.

b. Brush up and down rather than across dentures, holding securely but gently, to avoid dropping and damage.
c. Rinse dentures in cool water and examine for broken or damaged areas.
d. Clean denture cup and place clean dentures in cup.

8. Return dentures to resident's bedside.

9. Assist residents to rinse mouth with mouthwash or water and wipe lips.

10. If dentures are to be replaced in mouth, assist as needed in replacing dentures.

11. If dentures are to be stored, follow facility policy for denture storage.

12. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

13. Observe for and report to charge nurse:

a. Problems or complaints related to procedure.
b. Changes in the resident's ability to participate in procedure.
c. Discoloration, irritation, bleeding or sores on mouth tongue or lips.
d. Damaged, broken, ill-fitting or lost dentures.
e. Bad breath that does not improve after mouth care.
f. Other significant observations.

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PROCEDURAL GUIDELINE #29 – SPECIAL MOUTH CARE

A. Purpose: To clean the mouth and teeth of the resident who is unconscious or has other special needs for gentle mouth care.

B. Precaution: Call charge nurse immediately for assistance if choking occurs.

C. Procedural Guidelines

1. Beginning steps

    a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
    b. Gather supplies below or follow facility policy for supplies:
        (1) Soft toothbrush, applicator sticks, toothettes or other cleaning device
        (2) Diluted mouthwash or other cleaning solution
        (3) Lubricant for lips
        (4) Emesis basin
        (5) Towel
        (6) Clean, disposable examination gloves
    c. Knock on door and identify self by name and title.
    d. Greet resident by preferred name and identify resident per facility policy.
    e. Explain procedure and encourage resident's participation as appropriate.
    f. Provide privacy as appropriate such as close door/curtains, drape resident.
    g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
    h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Position resident upright and/or on side with head turned well to one side as permitted to avoid choking and aspiration.

3. Cover chest or pillow with towel and place emesis basin under mouth to catch drainage.

4. Wash hands and put on gloves prior to contact with oral secretions and mucous membrane.

5. Lightly moisten cleaning device with cleaning solution used in facility, using a limited amount of cleaning fluid if resident is unable to spit or swallow.

6. Gently and thoroughly clean all surfaces of the mouth including gums, teeth, tongue, lips, roof, sides, base and back of mouth. Allow fluid to drain out of mouth.

7. Lubricate lips with product used in facility such as petroleum jelly, cold cream or glycerine. If oxygen is in use, use a water-soluble lubricant or check with the charge nurse for an acceptable alternative.

8. Closing steps.

    a. Clean and store reusable items and discard disposables per facility policy.

b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

9. Observe for and report to charge nurse:

a. Problems or complaints related to procedure.
b. Changes in resident's ability to tolerate procedure such as problems with opening mouth, spitting, swallowing, and choking.
c. Discoloration, irritation, bleeding or sores on mouth tongue or lips.
d. Loose, broken, damaged or decaying teeth.
e. Bad breath that does not improve after mouth care.
f. Other significant observations

PROCEDURAL GUIDELINE #30 – HAIR CARE

A. Purpose: To maintain grooming, appearance and self-esteem.

B. Precaution

1. Do not share brushes/combs between residents to avoid cross-contamination.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies:
      (1) Clean comb and/or brush
      (2) Hair dressing (optional)
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Position resident upright in bed or chair as permitted.

3. Supervise and/or assist resident to thoroughly brush and/or comb hair, following resident's preferences as possible.

   a. Have resident turn to comb or brush hair on back of head, beginning at ends and working toward scalp.
   b. Comb or brush hair on top and sides of head.
   c. If hair is tangled, part into sections and gently untangle with comb, beginning near ends and working toward scalp. Support hair between scalp and end of hair as you work.
   d. Apply hair dressing (optional).
   e. Arrange hair attractively following resident's preference. Avoid childish or inappropriate hairstyles.
   f. Long hair may be braided to prevent tangling if resident desires. Avoid tight braiding.

4. Encourage resident to examine results in mirror as appropriate.

5. Closing steps

   a. Clean and store reusable items and discard disposables per facility policy.
   b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
   c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
   d. Always replace call signal and needed items within resident's reach.

e. Inform resident when finished and ask if anything is needed before you go.

6. Observe for and report to charge nurse:

a. Problems or complaints related to procedure.
b. Changes in resident's ability to participate in procedure.
c. Unusual conditions of hair and/or scalp such as dandruff, sores, parasites.
d. Need or request for professional haircut or styling.
e. Other significant changes.

PROCEDURAL GUIDELINE #31 – SHAMPOOING THE HAIR

A. Purpose: To clean the hair and scalp.

B. General Guidelines

1. Check care plan to determine the schedule for shampoos, type of shampoo/cleanser and/or beauty shop appointments.

2. Shampoos are generally given once or twice a week during tub or shower bath.

3. Most residents need some assistance with shampooing.

C. Procedural Guidelines

1. Follow Procedural Guideline #20 for Tub or Shower Bath, gathering shampoo and extra towel with other bath supplies.

2. Shampoo the hair at any time during the tub or shower bath as preferred by resident or as appropriate.

3. If able, have resident hold folded washcloth over eyes and tip head backward or lean forward during shampoo.

4. Wet hair and scalp with stream of comfortably warm water (about 105° F) directed close to scalp and away from face. Use shower spray or pitcher of water as available.

5. Apply selected shampoo and work up lather, massaging into scalp using tips of fingers--not fingernails.

6. Rinse hair thoroughly.

7. Towel dry hair and wrap head with dry towel if resident desires.

8. Complete tub or shower bath as appropriate.

9. If allowed, dry hair with hair dryer following facility policy.

   a. Never use hair dryers in damp areas.
   b. Never place hair dryer in resident's lap.
   c. Be sure dryer is on low setting.
   d. Hold the dryer 8 to 10 inches from head.
   e. Keep the dryer moving and direct airflow to hair--not scalp.

10. Assist with combing the hair following Procedural Guidelines #30--Hair Care.

11. Wash hands.

12. Observe for and report to the charge nurse:

    a. Problems or complaints related to procedure.

b. Change in resident's ability to participate in shampooing.
c. Unusual conditions of hair and/or scalp such as dandruff, sores, parasites.
d. Need or request for professional haircut or styling.
e. Other significant observations

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PROCEDURAL GUIDELINE #32 – SHAVING THE RESIDENT

A. Purpose: To shave resident and maintain appearance and self-esteem.

B. Precautions

1. Do not share razors between residents to avoid spreading infections.

2. Immediately discard used blades and disposable razors following facility policy to prevent bloodborne infections.

3. Do not use electric shaver if oxygen is being used in room.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather the following supplies if using electric shaver:
      (1) Pre-shave and after-shave lotion (optional)
      (2) Towel
   c. Gather the following supplies if using safety or disposable razor:
      (1) Washcloth and towels
      (2) Basin of warm water
      (3) Shaving soap or cream
      (4) After-shave lotion (optional)
      (5) Clean, disposable examination gloves
   d. Knock on door and identify self by name and title.
   e. Greet resident by preferred name and identify resident per facility policy.
   f. Explain procedure and encourage resident's participation as appropriate.
   g. Provide privacy as appropriate such as close door/curtains, drape resident.
   h. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   i. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Provide adequate lighting and assist resident into comfortable position in bed or chair as allowed.

3. Follow resident's preferences as possible.

4. To shave resident using electric shaver:

   a. Follow manufacture's instructions for the safe use and care of shaver. Most electric shavers should not be used with or immersed in water.
   b. Apply pre-shave lotion if desired.
   c. Place towel over resident's chest to protect clothing as appropriate.
   d. Turn shaver “on.”
   e. Encourage resident to draw skin taut or pull skin taut with free hand.

f. For shaver with flat or flexible head, generally use short up-and-down motion with the grain of beard.
g. For shaver with circular head, generally use small circular motions.
h. Generally shave cheek areas first, around mouth and then the neck.
   (1) Have resident tilt head back while shaving neck if able.
   (2) Avoid shaving directly over a prominent Adam's apple by pulling skin to each side to shave area.

5. To shave resident using safety or disposable razor:

   a. Wash hands and put on gloves, as contact with blood is likely due to small cuts/nicks to skin.
   b. Place towel over resident's chest to protect clothing.
   c. Wet face with warm water to soften beard.
   d. Apply shaving soap or cream to bearded areas to be shaved.
   e. Encourage resident to make skin taut, or pull skin taut with free hand.
   f. Generally shave in the direction the beard grows, using short and even downward stokes.
   g. Follow step 4h above.
   h. Rinse razor in warm water as needed during use.
   i. Remove excess shaving cream or soap as appropriate.
   j. Rinse the razor in warm water as needed.
   k. Discard used blade or disposable razor immediately following facility policy.

6. Apply after-shave if resident desires.

7. Encourage resident to examine results in mirror or by touch as appropriate.

8. Closing steps

   a. Clean and store reusable items and discard disposables per facility policy.
   b. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
   c. Always replace call signal and needed items within resident's reach.
   d. Inform resident when finished and ask if anything is needed before you go.

9. Observe for and report to charge nurse:

   a. Problems or complaints related to procedure such as cuts nicks.
   b. Changes in resident's ability to participate in shaving.
   c. Skin problems such as cuts, rash, redness, and irritations, bleeding.
   d. Other significant changes.

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PROCEDURAL GUIDELINE #33 – HAND, FOOT AND NAIL CARE

A. Purpose:

1. To clean and groom hands and feet.

2. To safely trim fingernails and/or toenails if allowed by facility policy.

B. Precautions and Guidelines

1. Most residents need assistance with hand, foot and nail care. The nurse aide should provide the appropriate care, as needed, following facility policy.

2. Nurse aides must not cut fingernails or toenails of residents with diabetes, circulatory impairment of the hands or feet, ingrown nails, infected nails, painful nails, or nails that are too hard, thick or difficult to cut easily.

3. Nurse aides should always follow the facility policy for hand, foot and nail care. Some facilities do not allow nurse aides to cut nails or to clean nails with sharp objects such as nail files or orange sticks.

4. Nurse aides should always check the care plan and receive permission and instructions from the charge nurse prior to cutting fingernails or toenails.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed clean supplies:
      (1) Nail clippers
      (2) Nail file or emery board
      (3) Orange stick or nail brush (optional)
      (4) Basin of comfortably warm water (about 105°F)
      (5) Towel, washcloth and soap if needed
      (6) Lotion
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Provide adequate lighting, and assist resident into comfortable position in chair or bed as appropriate.

3. Hand and/or foot care

a. Perform hand and foot care after bath when possible; or wash, rinse and soak hands/feet for 5 to 10 minutes in basin of comfortably warm water.
b. If giving both hand and foot care, soak hands first and then feet, completing hand care while feet are soaking.
c. A soft nailbrush may be used to clean around nails while soaking.
d. Dry hands/feet thoroughly, being sure to dry between fingers and toes.
e. Gently push back cuticles of fingernails and toenails with towel or, if allowed orange stick.
f. Gently clean under nails with orange stick or nail file if allowed.
g. Smooth rough edges of nails with emery board or nail file if allowed. File toenails straight across. Fingernails may be slightly rounded.

4. Trimming fingernails and/or toenails

   a. Cut nails only if allowed by facility policy and only if you have permission and instructions from the charge nurse.
   b. Be sure the nails have been soaked for at least 5 minutes before trimming.
   c. Cut nails soon after soaking while they are still soft.
   d. Using clean nail clipper, cut fingernails/toenails straight across and slightly above the end of the fingers or toes.
   e. Do not cut the skin or trim nail below skin line.
   f. If trauma or pain occurs, stop immediately and ask for directions and/or assistance from charge nurse.
   g. Smooth rough edges of nails with emery board or nail file. File toenails straight across. Fingernails may be slightly rounded if preferred.

5. Apply lotion to hands and/or feet as indicated, avoiding lotion between toes. Wipe off excess lotion.

6. Remove old nail polish and apply new polish, if requested, and as time allows.

7. Assist resident to put on clean socks and shoes after foot care as appropriate.

8. Closing steps

   a. Clean and store reusable items and discard disposables per facility policy.
   b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
   c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
   d. Always replace call signal and needed items within resident's reach.
   e. Inform resident when finished and ask if anything is needed before you go.

9. Observe for and report to charge nurse:

   a. Problems or complaints related to procedure such as cuts, pain, bleeding or difficulties in cutting the nails.
   b. Problems such as corns, callouses, ingrown nails, swelling, redness, infection, discoloration, skin breakdown, drainage, foul odors.
   c. Other significant changes.

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PROCEDURAL GUIDELINE #34 – DRESSING AND UNDRESSING THE RESIDENT

A. Purpose: To maintain comfort, appearance, independence and self-esteem.

B. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids likely.
   b. Gather needed clothing
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Encourage and/or assist resident in selecting clothes as appropriate, or select clothes for the resident who is unable to participate in selecting.

3. Encourage residents to stand or sit to dress as able. Dependent residents are more easily dressed while in bed.

4. Supervise and/or assist resident in dressing as needed, or dress the dependent resident.

5. For residents with weakness or paralysis:

   a. Put clothing on the weak side first.
   b. Remove clothing from the strong side first.

6. To put on garments that go over feet (pants, underwear):

   a. Put one foot at a time into legs of pants, then pull up toward knees.
   b. If resident can stand, assist resident to stand, pull clothing up over hips, then sit back down.
   c. If resident is bedfast:
      (1) Assist resident to raise hips and pull clothing up over hips.
      (2) Or turn resident on side and pull clothing over hip on upper side. Then repeat for other side.
   d. Close fasteners after shirt is tucked in.

7. To put on garments that go over arms or head (shirts, dresses):

   a. To put arms into sleeves, put your hand through sleeve from wrist to shoulder. Then grasp resident's hand and guide resident's arm into sleeve.
   b. For garments that open in back: put one arm in sleeve, smooth garment across chest and insert other arm.
   c. For garments that open in front:

(1) Put one arm in sleeve. Assist resident to lean forward, if able, and smooth back of garment across resident's back.
(2) Or assist resident to turn on side. Put sleeve on upper arm, then smooth garment across back.
(3) Put remaining arm in other sleeve

d. For pullovers, assist resident to put garment over arms and then gently over head.
e. Close fasteners and tuck in shirt as appropriate.

8. Assist resident with undressing by reversing the steps above.

9. Assist resident with other dressing and grooming as needed.

10. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

11. Observe for and report to charge nurse:

a. Problems or complaints related to dressing.
b. Changes in resident's ability to participate in dressing.
c. Other significant changes.

PROCEDURAL GUIDELINE #35 – A.M. CARE/P.M. CARE

A. Purpose

1. To provide A.M. (morning) care and prepare resident for breakfast.

2. To provide P.M. (evening) care and prepare resident for sleep.

B. Beginning steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Gather supplies such as washcloth, towel and other needed items.

3. Knock on door and identify self by name and title.

4. Greet resident by preferred name and identify resident per facility policy.

5. Explain procedure and encourage resident's participation as appropriate.

6. Provide privacy as appropriate such as close door/curtains, drape resident.

7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

8. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

C. For A.M. (morning) care

1. Assist resident to get out of bed as appropriate.

2. Assist resident with toileting as needed.

3. Assist resident with washing hands and face as needed.

4. Assist resident with other needed personal care such as oral care, perineal care, dentures, eye glasses and dressing following appropriate Procedural Guidelines.

5. Assist resident into a safe and comfortable position for breakfast or other activity as appropriate.

D. For P.M. (evening) care

1. Assist resident with toileting as needed.

2. Assist resident with washing hands and face as needed.

3. Assist resident with other needed personal care such as oral care, perineal care, and dentures following appropriate Procedural Guidelines.

4. Store eyeglasses, hearing aids and dentures as appropriate.

5. As time permits, give back rub to residents (especially those who are bedfast, incontinent or in need of special attention) following Procedural Guideline #26.

6. Assist resident into a safe and comfortable position for sleep or other activity as appropriate.

E. Closing steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go

F. Observe for and report to charge nurse:

1. Problems or complaints related to procedure.

2. Changes in resident's ability to participate in procedure.

3. Other significant changes.

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PROCEDURAL GUIDELINE #36 – ASSISTING WITH MEALS

A. Purpose

1. To provide nutrition to residents.

2. To serve meals to residents in a pleasant environment.

B. Precautions

1. Take care when serving hot foods to avoid burns. Check temperature of food by dropping a small amount on your wrist or forearm.

2. Do not offer foods hot enough to burn to residents who drink from a straw or have visual problems, weakness, shakiness, inability to grasp objects or other problems that might lead to burns.

3. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 45° elevation; or whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to charge nurse for directions.

4. Follow Procedural Guidelines #6 if choking occurs.

C. Procedural Guidelines

1. Preparing the eating areas:

   a. Clean up dining area and rooms of residents who must eat in their rooms.
   b. Sanitize and dry tables following facility policy.
   c. Eliminate odors, control lighting, provide soft music and generally do whatever you can to create a pleasant, enjoyable atmosphere.

2. Preparing residents prior to mealtime:

   a. Assist with toileting, Hand-washing, oral hygiene and other care as indicated.
   b. Be sure resident has dentures and/or eyeglasses if needed.
   c. Assist resident to safe and comfortable seating in the eating area as able.
   d. Assure that resident is correctly positioned, sitting with head and body as straight upright as possible. Check with charge nurse for directions if resident cannot tolerate at least a 45° elevation.
   e. Provide clothing protectors as indicated.

3. Serving diet trays:

   a. Wash hands before handling food and serving trays.
   b. Identify diet tray by card.
   c. Check that tray contains the right food for the resident.
   d. Identify the resident and place tray within easy reach of resident.

e. Make sure every resident is served a tray, and that the right resident gets the right tray with the right food.
f. Remove food covers and assist with napkins as indicated.
g. Check that hot foods are hot (not too hot) and cold foods are cold.
h. Replace missing items following facility policy.

4. Assisting residents with eating:

a. Encourage resident to help self as much as possible.
b. Assist resident as needed to ensure adequate dietary intake.
c. Prepare food as needed such as open packets, cut meat, butter bread, offer condiments as preferred.
d. For residents with impaired vision, describe food and location of food as placed on plate in relation to the face of the clock if appropriate.
e. Observe for and/or inquire about problems with eating, and try to correct problem if possible:
   (1) Offer encouragement and/or assistance as indicated.
   (2) Offer appropriate food substitutes if needed.
   (3) Offer to replace or rewarm food that has become cold.
f. Provide encouragement and help with assistive eating devices as indicated.

5. Monitoring mealtime:

a. Allow resident ample time to eat.
b. Encourage socialization.
c. Remain pleasant and unhurried.
d. Try to avoid or control unpleasant situations.
e. Monitor and record dietary intake of all residents during mealtime and identify problems with eating.
f. Notify charge nurse of residents who are absent or who have eating problems.
g. For residents feeding self in own room, check frequently, offer assistance and visit briefly with resident as possible.

6. Removing trays:

a. Remove tray after resident has finished eating.
b. Determine and record fluid and food intake as required following facility policy.
c. Place used trays on cart after all clean trays have been served.
d. Wash hands.

7. Assisting resident after meals:

a. Assist residents with ambulation, oral hygiene, toileting, Hand-washing and other needs after eating as appropriate.
b. Assist resident to return to a position of comfort and safety.

8. Observe for and report to charge nurse:

a. Complaints about food. Obtain objective information from resident about the problem such as "too hard", "too cold".
b. Residents who eat poorly and possible causes such as inability to chew, difficulty in swallowing.

c. Changes in alertness, responsiveness, swallowing, ability to assume a safe upright position for eating.
d. Record and/or report the dietary and fluid intake of residents following facility policy.
e. Other significant problems or observations.

PROCEDURAL GUIDELINE #37 – FEEDING THE DEPENDENT RESIDENT

A. Purpose: To feed the resident who needs assistance with eating.

B. General Guidelines and Precautions

1. Take care when serving hot foods to avoid burns. Check temperature of food by dropping a small amount on your wrist or forearm.

2. Try to reduce the stress and frustration the resident may feel about being fed.

3. Do not attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 45° elevation; or whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to charge nurse for directions.

4. Follow Procedural Guidelines #6 if choking occurs.

C. Procedural Guidelines

1. Beginning steps:

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Knock on door and identify self by name and title.
   c. Greet resident by preferred name and identify resident per facility policy.
   d. Explain procedure and encourage resident's participation as appropriate.
   e. Provide privacy as appropriate such as close door/curtains, drape resident.
   f. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   g. f side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Prepare the eating area by straightening resident's room and sanitizing the table to be used for mealtime following facility policy.

3. Prepare the resident for mealtime by assisting with toileting, Hand-washing, oral hygiene and other needed care. Provide dentures, eyeglasses if needed.

4. Position resident with head and body supported as straight upright as possible in bed or chair. Check with charge nurse for directions if resident cannot tolerate at least a 45° elevation.

5. Wash hands and take correct diet tray and clothing protect to resident's room.

6. Check to assure that you have the right tray, with right foods for the right resident.

7. Place tray on clean table and adjust to appropriate level. Provide clothing protector.

8. Tell the resident what you are going to do, describe the foods and converse pleasantly with the resident during the meal.

9. Sit in a comfortable, relaxed position at eye level with resident.

10. Ask about resident's eating preference and follow them as possible.

11. Check that hot foods are hot (not too hot) and cold foods are cold.

12. Offer fluids first to moisten throat. Use straw or cup as indicated.

13. Encourage and assist resident to feed self as much as possible such as by making decisions, holding finger foods as appropriate.

14. Feed with a spoon filled no more than half-full. Use the tip of spoon to feed, placing gentle downward pressure on lips and center of tongue.

15. Feed the resident at a comfortable rate, allowing time for resident to taste, chew, swallow and rest between bites.

16. Offer fluids between every third or fourth spoon of solid food.

17. Wipe resident's mouth and hands with napkin/towel as necessary.

18. Continue feeding until resident has had enough or meal is finished.

19. Assure that resident remains with head elevated for at least 30 minutes after meal if able.

20. After resident has finished eating, remove tray, record food and/or fluid intake as required and place used tray on cart following facility policy.

21. Assist resident with toileting, oral hygiene, Hand-washing and other needs as appropriate.

22. Closing steps:

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
    c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
    d. Always replace call signal and needed items within resident's reach.
    e. Inform resident when finished and ask if anything is needed before you go.

23. Observe for and report to charge nurse:

    a. Complaints about food. Obtain objective information from resident about the problem such as "too hard, "too cold".
    b. Residents who eat poorly and possible causes such as inability to chew, difficulty in swallowing.

c. Changes in alertness, responsiveness, swallowing, ability to assume a safe upright position for eating.
d. Record and/or report the dietary intake and fluid intake of residents following facility policy.
e. Other significant problems or observations.

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PROCEDURAL GUIDELINE #38 – SYRINGE FEEDING THE RESIDENT

A. Purpose: To feed the resident who is able to swallow, but cannot be fed by spoon or cup.

B. Guidelines and Precautions

1. Syringe feeding should be ordered by a physician and performed with care.

2. Syringe feedings may be given by a nurse aide who has:

   a. Received training and demonstrated competency in performing syringe feeding.
   b. Been directed by the charge nurse to syringe feed a resident.

3. Syringe feeding should be avoided if possible. It should be used only for residents who can swallow, but who cannot be fed by spoon or spout cup.

4. Take care when giving hot foods to avoid burns. Check temperature of food by dropping a small amount on your wrist or forearm.

5. Try to reduce the stress and frustration the resident may feel about being fed.

6. Do <u>not</u> attempt to feed a resident who is asleep, unresponsive, choking, unable to swallow, unable to tolerate at least a 45° elevation; or whose head is tilted backward (airway is open), or whose head and chin are tilted downward and inward toward chest (airway is closed). Report promptly to charge nurse for directions.

7. Follow Procedural Guideline #6 if choking occurs.

C. Procedural Guidelines

1. Beginning steps

   a. <u>Wash hands</u>. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Knock on door and identify self by name and title.
   c. Greet resident by preferred name and identify resident per facility policy.
   d. Explain procedure and encourage resident's participation as appropriate.
   e. Provide privacy as appropriate such as close door/curtains, drape resident.
   f. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   g. If side-rails are in use, lower them on working side, keep them up on opposite side and <u>always</u> put them up before you step away from bedside.

2. Prepare eating area by straightening resident's room and sanitizing the table to be used for mealtime following facility policy.

3. Prepare the resident for mealtime by assisting with toileting, Hand-washing, oral hygiene and other needed care. Provide dentures, eyeglasses if needed.

4. Position resident with head and body supported as straight upright as possible in bed or chair. Check with charge nurse for directions if resident cannot tolerate at least a 45° elevation.

5. Wash hands and take prescribed liquid or pureed diet, syringe and clothing protector to resident's room. Place tray on table.

6. Check to assure that you have the right tray, with right foods for the right resident.

7. First give a small amount of clear water following steps 8 through 11 below to moisten mouth and to test resident's ability to swallow.

    a. If resident has difficulty swallowing or chokes; stop feeding, follow Procedural Guideline #6 for choking as appropriate, and report to charge nurse before continuing feeding.
    b. If resident swallows water without difficulty, go ahead with syringe feeding.

8. Draw a small amount of liquid or pureed food (1 or 2 teaspoons) into syringe.

9. Tell resident what you are going to do and encourage resident to swallow.

10. Place tip of syringe about one inch into unaffected side of the mouth.

11. Insert the liquid or puree slowly into the resident’s mouth against the cheek--not the throat--to avoid choking.

12. Alternate pureed foods with small amounts of fluids.

13. Feed at a comfortable rate, allowing enough time for resident to taste, chew, swallow and rest between bites.

14. If choking occurs, quickly turn resident's head to side and stop feeding until episode passes. If choking continues, follow Procedural Guidelines 5 & 6 and call charge nurse for help.

15. Wipe resident's mouth and hands with napkin or towel as necessary.

16. Continue feeding until resident has had enough or until meal is finished.

17. Assure that resident remains with head elevated for at least 30 minutes after meal as able.

18. After resident has finished, remove tray, record food and fluid intake and place used tray on cart following facility policy.

19. When feeding is completed, assist resident with toileting, oral care, washing face/hands and other needed care.

20. Closing steps:

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

21. Observe for and report to charge nurse:

a. Record and/or report the dietary intake and fluid intake following facility policy.
b. Response of resident to procedure.
c. Problems such as inability to swallow or choking.
d. Changes in alertness, responsiveness, swallowing, ability to assume a safe upright position for eating.
e. Other significant problems or observations.

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PROCEDURAL GUIDELINE #39 – SERVING FRESH DRINKING WATER

A. Purpose

1. To provide fresh drinking water and to encourage adequate fluid intake.

B. Precautions

1. Follow facility policy and good infection control to avoid cross-contamination.

2. Do not collect used pitchers in a common area for refilling.

3. Do not contaminate the ice machine, ice scoop or ice with soiled items such as hands, scoops, glasses, and pitchers.

4. Do not pour water from a used glass back into the water pitcher.

5. When refilling a used pitcher:

   a. Do not touch clean ice scoop to used pitcher.
   b. Do not fill used pitcher over the ice container or ice machine, as the ice and water that drops off the pitcher will contaminate the ice supply.

C. Serving Fresh Drinking Water in Clean Pitchers

1. Obtain a list from the charge nurse of residents who have special fluid orders such as no ice or nothing by mouth (NPO).

2. Collect all used pitchers and glasses and take them to the kitchen for washing following facility policy.

3. Record fluid intake on I & O Record as appropriate.

4. Wash hands. Gather needed clean supplies on a clean utility cart:

   a. Water pitchers with lids
   b. Drinking glasses
   c. Covered container of ice
   d. Ice scoop

5. Fill clean pitchers with clean ice and water, or plain water as indicated. Do not contaminate ice machine, ice scoop or ice.

6. Push cart down hallway and distribute a clean pitcher of fresh water and a clean glass to each resident's bedside as appropriate. Wash hands between residents when contaminated (your hands remain clean if you touch only clean items).

   a.Remember to knock on door, identify self, greet resident, identify resident and explain procedure.

b. Check and follow the list of special fluid orders and resident's preference for ice, straws.

7. Offer and pour a glass of water for each resident and encourage fluid intake as appropriate.

8. Record fluid intake on I and O Record as appropriate.

9. If hands are contaminated, wash hands before refilling next resident's pitcher.

D. Refilling Used Pitchers Individually in Each Resident's Room

1. Obtain a list from charge nurse of residents with special fluid orders such as no ice or nothing by mouth(NPO).

2. Wash hands. Gather needed supplies on clean utility cart.

   a. Container of clean ice
   b. Clean ice scoop in container
   c. Plastic bag attached to cart and hanging open to catch falling ice
   d. Pitcher of clean water (or fill pitchers at sink per facility policy)

3. Push cart down hallway and refill each resident's pitcher, one at a time, washing hands between each resident.

   a. Remember to knock on door, identify self, greet resident, identify resident and explain procedure.
   b. Check and follow the list of special fluid orders and resident's preference for ice, straws.

4. Empty and rinse one resident's pitcher.

5. Take pitcher to cart in hallway and fill with ice as indicated.

6. Hold pitcher over opened plastic bag while adding ice to avoid contaminating the ice or spilling ice on the floor.

7. Fill pitcher with clean water following facility policy.

8. Return filled pitcher to the same resident.

9. Offer and pour a glass of water for each resident and encourage fluid intake as appropriate.

10. Record fluid intake on I and O record as appropriate.

11. Wash hands before refilling next resident's pitcher.

E. Refilling a Used Water Pitcher Individually (without cart).

1. Carefully follow the facility policy and the precautions at B of this procedure to avoid cross-contamination.

PROCEDURAL GUIDELINE #40 – INTAKE AND OUTPUT (I & O)

A. Purpose: To provide an accurate record of the fluid balance.

B. General Guidelines and Precautions

1. Always check if resident is on I & O before giving fluids or discarding specimens.

2. Follow facility policy and procedures for Intake and Output

   a. Fluid intake includes all fluids taken in by mouth, tube feeding and IVs. Oral intake includes fluids given during medication passes and fluids on meal trays. Most facilities count semi-liquids foods as fluid intake such as ice creams, popsicles, gelatins and puddings.
   b. Fluid output includes all urine, vomitus, liquid stool and other measurable output such as drainage from wounds, tubes.

3. Normal daily range of I and O

   a. Fluid intake = about 2000 to 2500cc.
   b. Fluid output = about 1500 to 2000cc.

C. Procedural Guidelines

1. Initiating I & O:

   a. Check with care plan and charge nurse for instructions about I and O.
   b. Identify resident, explain procedure and encourage participation.
   c. Wash hands and gather needed supplies:
      (1) Graduate or measuring container
      (2) "Intake and Output" records
      (3) "Intake and Output" signs if used by facility
      (4) "Equivalent List of Liquid Measures" if used by facility
      (5) Receptacle for output such as a urinal, bedpan or specimen to be placed under toilet seat.
   d. Complete information on I & O record and place it in designated location.
   e. Place a clean graduate and receptacle for output in bathroom.

2. Measuring Intake:

   a. Estimate or measure and record all fluid intake.
   b. Check all serving containers for liquids.
   c. Determine the amount of the serving from the equivalent list.
   d. Accurately determine the amount of liquid remaining.
   e. Subtract amount remaining from amount of serving to determine intake.
   f. Record time and amount of intake on the I & O record.

3. Measuring Output:

a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) prior to contact with urine, blood or other body fluids.
b. Pour fluid output into the graduated container.
c. Measure the amount in the graduate at eye level and on a level surface.
d. Discard fluid into toilet, unless a specimen should be collected or an unusual output should be shown to charge nurse.
e. Clean and store graduate, urinal or bedpan following facility policy.
f. Remove and discard gloves following facility policy promptly after use to avoid environmental contamination. Wash hands.
g. Record the time and amount of output on the I & O Record.
h. Check with charge nurse if the output cannot be measured. You may be asked to estimate the number of times or the volume of the output. Indicate on I & O record if amount was estimated and why measurement was not done.

4. Observe for and report to charge nurse:

a. Problems or complaints related to procedure such as resident refusing fluids, lack of I & O records, incontinence, lost specimens.
b. Volume of I & O and changes in I & O such as decreases, increases or imbalances.
c. Abnormalities of urine or other output such as liquid stool, vomitus, blood or excessive perspiration.
d. Signs of dehydration such as low fluid intake, low output of dark urine with strong odor, weight loss, dry skin, dry mucous membrane (lips, tongue, eyes), drowsiness, confusion.
e. Signs of fluid retention such as edema, weight gain, respiratory problems, increased BP, changes in mental status.
f. Other significant observations.

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PROCEDURAL GUIDELINE #41– INDWELLING URINARY CATHETER CARE

A. Purpose

1. To maintain the indwelling urinary drainage system.

2. To help avoid urinary tract infections.

B. Guidelines for Maintaining the Urinary Drainage System

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Check that the catheter remains secured with tape or leg strap following facility policy, to reduce friction and movement at the insertion site.

3. Check that catheter is positioned over (not under) the leg.

4. Check that there is no disconnection or leaking of urine from the system (except into the drainage bag).

5. Check that urine is draining freely through the system.

6. Keep the catheter and drainage tubing free of kinks or obstructions.

7. Keep the urine-collecting bag below the level of the bladder at all times to prevent backflow of old urine into the bladder.

8. Keep the drainage tubing and bag off the floor at all times to prevent contamination and damage.

9. Never disconnect the catheter drainage system.

10. When the resident is in bed, attach the collection bag to the bed frame--never to the side-rail.

C. Procedure for Emptying the Urinary Drainage Bag

1. The catheter drainage bag is emptied at least every 8 hours or more often as needed to keep the bag from becoming full.

2. Empty one urinary drainage bag at a time using a clean and separate graduate for each resident, washing hands and changing gloves between residents.

3. Remember to knock on door, introduce self, greet resident, identify resident, explain procedure and provide privacy.

4. Obtain a clean graduate container. Use a separate container for each individual resident to prevent cross-contamination. The graduate may be labeled with resident's name to reserve it for a single resident.

5. Wash hands and put on gloves prior to contact with urine.

6. Position the graduate to collect the urine.

7. Open the clamp on the drain located at the bottom of the drainage bag.

8. Empty urine into graduate touching only the clamp and using aseptic technique.
   a. Note that the drain spout should not come in contact with the collecting graduate, hands or other objects.
   b. If accidental contamination occurs, wipe drain spout with antiseptic wipe.

9. Close clamp

10. Measures output and discard urine following facility policy.

11. Clean container and store for use for same resident following facility policy.

12. Remove and discard gloves following facility policy promptly after use to avoid environmental contamination. Wash hands.

13. Record urinary output.

D. Observe for and Report to Charge Nurse:

1. Catheters that are not secured with tape or straps.

2. Kinks in tubing that cannot be corrected by simple repositioning.

3. Accidental disconnection of tubing.

4. Leaking of urine from tubing.

5. No evidence of drainage of urine through tubing.

6. Accidental elevation of bag above level of bladder.

7. Amount of urine output at time of emptying drainage bag.

8. Appearance of urine such as dark, red, cloudy. Presence of unusual substances such as solid particles, blood, odor.

9. Problems at catheter-meatal junction such as redness, irritation, swelling, crusting, drainage, bleeding, pain.

10. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.

11. Other significant observations.

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PROCEDURAL GUIDELINE #42 – URINE SPECIMEN COLLECTION

A. Purpose: To collect a routine or clean-catch urine specimen for testing.

B. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Gather needed supplies:

   a. Clean bedpan, urinal, commode or specimen pan.
   b. Appropriate urine specimen container with lid and transport bag if used.
   c. Label--filled out following facility policy.
   d. Laboratory request form--to be completed by nurse
   e. Clean, disposable examination gloves
   f. For clean-catch specimen: clean-catch kit or follow facility policy

3. Knock on door and identify self by name and title.

4. Greet resident by preferred name and identify resident per facility policy.

5. Explain procedure and encourage resident's participation as appropriate.

   a. Explain that a urine specimen is needed. Offer a glass of water if allowed.
   b. Ask resident to notify you when ready to urinate.

6. Provide privacy as appropriate such as close door/curtains, drape resident.

7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

8. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

C. To Collect Routine Urine Specimen:

1. If perineum is heavily soiled, wear gloves and give perineal care (Procedural Guidelines #24 or #25 as appropriate).

2. Wash hands and put on gloves prior to contact with urine.

3. When resident is able to urinate, assist with toileting as appropriate. Remind resident not to put tissue or to have bowel movement in specimen.

4. Assist resident to clean and dry perineum.

5. Pour approximately 60cc of urine into the specimen container without contaminating the outside of the container.

6. If urine is accidently spilled on outside of container, wipe outside of container clean with disinfectant wipe.

7. Measure urine volume if resident is on I & O.

8. Empty, clean and replace bedpan or urinal following facility policy.

9. Remove gloves and wash hands after contact with urine.

10. Record urine output on I and O.

11. Place lid securely on container, attach label, and place in transport bag if used.

12. Take the specimen promptly to charge nurse or follow facility policy.

D. To Collect a Clean-Catch (Clean Voided/Midstream) Urine Specimen:

1. If perineum is heavily soiled, wear gloves and give perineal care (Procedural Guideline #24 or #25 as appropriate).

2. When resident is able to urinate, open the clean-catch kit or needed supplies following facility policy.

3. Position resident on bedpan, toilet or bedside commode as indicated.

4. Wash hands and put on gloves prior to contact with urine, other body fluids or mucous membrane.

5. Wipe the perineal area following instruction on kit or facility policy.

6. If resident is able to control stream of urine:

   a. Instruct resident to start urinating, then stop the stream.
   b. Place clean-catch container in position to catch urine and instruct resident to start urination.
   c. Collect the required amount of urine (about 60cc).
   d. Instruct resident to stop the stream when the needed amount is collected.

7. If resident is unable to control stream of urine:

   a. Ask resident to start urinating
   b. Place clean-catch container under the stream and collect the required amount of urine.

8. Remove specimen container and instruct resident to finish voiding.

9. Assist resident to clean and dry perineum.

10. Wipe outside of container with disinfectant wipe.

11. Follow steps C 7 thru 12 of this Procedural Guideline.

E. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

F. Observe For and Report to Charge Nurse:

1. Problems or complaints related to procedure.

2. Time and type of specimen collected.

3. Amount and appearance of urine such as dark, red, cloudy. Presence of unusual substances such as particles, blood, odor.

4. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain.

5. Other significant observations.

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PROCEDURAL GUIDELINE #43 – STOOL SPECIMEN COLLECTION

A. Purpose: To collect a routine stool specimen for testing.

B. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies:
      (1) Clean bedpan, commode or specimen pan
      (2) Appropriate stool specimen container with lid and transport bag if used
      (3) Tongue blade
      (4) Label--filled out following facility policy
      (5) Laboratory request form--to be completed by nurse
      (6) Clean, disposable examination gloves
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
      (1) Explain that a stool specimen is needed.
      (2) Ask resident to notify you when ready to have bowel movement, or make other arrangements as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Wash hands and put on gloves prior to contact with stool.

3. When resident is ready to have bowel movement, assist with toileting as appropriate.

4. When finished, assist resident to clean and dry the rectal area and buttocks.

5. Using tongue blade, place requested amount of feces (usually about 2 tablespoons) into specimen container without contaminating outside of container.

6. If outside of container is accidently contaminated with feces, wipe clean with disinfectant wipe.

7. Empty, clean and replace bedpan following facility policy.

8. Remove gloves and wash hands.

9. Place lid securely on container, attach label and place in transport bag.

10. Take specimen promptly to charge nurse or follow facility policy.

11. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

12. Observe for and report to charge nurse:

a. Problems or complaints related to procedure.
b. Time and type of specimen collected.
c. Amount and appearance of stool. Presence of unusual substances such as blood, mucus.
d. Bowel complaints such as pain, constipation, diarrhea, bleeding.
e. Other significant observations.

PROCEDURAL GUIDELINE #44 – SOFT RESTRAINTS (MITT AND VEST)

A. Purpose: To maintain body alignment and to protect residents from harming themselves or others.

B. Precautions

1. Restraints require a written doctor's order that states the reason for the restraint.
2. Nurse aides may apply restraints only under the directions of a licensed nurse.
3. Apply only restraints you have been trained to use. Ask for instructions and assistance if needed.
4. Follow manufacturer's instructions, nurse's directions and facility policy in applying restraints.
5. Use a restraint that is the correct size and is in good condition.
6. Use commercial restraints according to manufacturer's instructions. Do not use make shift restraints, sheets or locked restraints.
7. Use the least restrictive type of restraint for the least amount of time.
8. Use restraints as a last resort, when all other methods have failed.

C. Beginning Steps (move quickly through these steps in an urgent situation)

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
2. Gather needed supplies and restraints.
3. Knock on door and identify self by name and title.
4. Greet resident by preferred name and identify resident per facility policy.
5. Explain procedure and encourage resident's participation as appropriate.
6. Provide privacy as appropriate such as close door/curtains, drape resident.
7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
8. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

D. Applying Soft Mitt or Vest Restraint

1. Obtain adequate assistance to apply restraints quickly and safely.

2. Assist resident with elimination and other care before applying restraints.

3. Assure the resident and the part to be restrained is clean, dry and in a position of comfort and good body alignment.

4. Apply the type of restraint directed by the licensed nurse.

5. Apply restraints snug enough to be effective, while allowing maximum freedom.

6. Pad skin and bony areas under restraints to prevent injury.

7. To apply soft mitt restraint:

    a. Wash and dry residents' hands if needed.
    b. Pace hand roll in resident's hand or use padded mitt.
    c. Have resident rasp hand roll with hand in good alignment.
    d. Apply the mitt to the hand following manufacturer's instructions, nurse's directions and facility policy.
    e. Assure that the restraint is not too tight.
    f. Repeat for other hand if ordered.

8. To apply vest restraint:

    a. Apply vest restraint over resident's clothes or nightwear following manufacturer's instructions, nurses direction and facility policy.
    b. Slip resident's arms through the armholes of the restraint so that the vest crosses in front. Be sure the vest does not cross in back.
    c. Smooth out any wrinkles in the front and back of vest.
    d. Assure that the restraint is not too tight.
    e. Put ties through the slots.

9. Safely restrain resident in a position of comfort and good body alignment. Tie restraints following manufacturer's instructions and facility policy.

    a. Use a slipknot or bow so that restraints can be untied quickly in an emergency.
    b. In bed, tie straps to moveable part of bed frame as appropriate. Do not tie restraints to side-rails.
    c. In chair, tie straps to or around chair with straps placed between seat and armrest (not through the armrest). Do not tie restraints to wheels of wheelchair.

E. Care of the Restrained Resident.

1. The nursing team is responsible for meeting all of the basic needs of the restrained resident such as safety, nutrition, hydration, personal hygiene activity, elimination, comfort, alignment.

2. Every 30 minutes or following facility policy, the restrained resident must be visually checked.

3. Every two hours, the restraints must be released for at least 10 minutes. Provide ambulation, exercise, positioning, skin care, toileting, fluids and other needed care at this time.

4. Observe frequently for response of resident to restraints. Provide frequent reassurance and support.

F. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

G. Observe for and Report to Charge Nurse:

1. Type of restraints applied and time applied.

2. Response of the resident to restraints.

3. Times resident was visually checked.

4. Times restraints were removed care given, and time restraints were reapplied.

5. Problems related to the restraints such as circulatory problems, respiratory problems, skin damage, discoloration, swelling, and absence of pulse below the restraint, increased anxiety or agitation.

6. Other significant observations.

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PROCEDURAL GUIDELINE #45 – TEMPERATURE (ORAL, AXILLARY AND RECTAL)

A. Purpose: To measure the body temperature using a glass thermometer.

B. Guidelines

1. Temperatures are taken as ordered by the physician, as instructed by the charge nurse and following facility policy.

2. Elevated temperatures are generally taken every 4 hours following facility policy.

3. Recheck unusual high or low temperatures with another thermometer, and report rechecked unusual temperatures to the charge nurse immediately.

4. Keep rectal thermometers separate from oral thermometers.

C. Beginning Steps

1. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.

2. Gather needed supplies:

   a. For oral temperature: clean oral thermometer and clean, disposable gloves
   b. For axillary temperature: clean oral thermometer
   c. For rectal temperature:
      (1) Clean rectal thermometer
      (2) Water-soluble lubricant
      (3) Clean, disposable examination gloves
   d. Disposable plastic thermometer cover if used at facility
   e. Watch with second hand
   f. TPR worksheet or pad and pencil
   g. Tissues
   h. Container for used oral or rectal thermometers or follow facility policy

3. Knock on door and identify self by name and title.

4. Greet resident by preferred name and identify resident per facility policy.

5. Explain procedure and encourage resident's participation as appropriate.

6. Provide privacy as appropriate such as close door/curtains, drape resident.

7. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.

8. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

D. Procedural Guidelines for Oral Temperature

1. If resident has just finished eating, drinking or smoking, wait about 15 minutes before taking oral temperature.
2. Check with charge nurse to see if temperature should be taken at another site if resident is unresponsive, uncooperative, confused, short of breath, receiving oxygen or breathing through mouth.
3. Assist resident into position of comfort and safety in bed or chair.
4. Prepare clean oral glass thermometer for use following facility policy.
5. Read mercury column and shake down to below 95° F or follow manufacturer's instructions.
6. Place thermometer into plastic cover if used at facility.
7. Put bulb end of thermometer into one side of resident's mouth, well back under tongue.
8. Instruct resident to close lips and breathe through nose if able.
9. Leave thermometer in mouth for 3 to 5 minutes or following manufacturer's instructions. Remain with resident if indicated.
10. Take pulse and respirations (Procedural Guideline #46) while temperature registers.
11. Wash hands and put on gloves prior to contact with oral secretions.
12. Remove thermometer holding stem end. If used, remove and discard plastic cover following facility policy.
13. Wipe thermometer with tissue from stem to bulb or follow facility policy.
14. Read thermometer at the point where the mercury column ends.
15. Shake thermometer down and return to container for used oral thermometers.
16. Remove gloves and wash hands after contact with oral secretions.
17. Record the temperature reading.

E. Procedural Guidelines for Axillary Temperature

1. Assist resident into a position of comfort and safety in bed or chair.
2. Prepare clean oral glass thermometer for use following facility policy.
3. Read thermometer and shake down to below 95° F or follow manufacturer's instructions.
4. Place thermometer into plastic cover if used at facility.

5. Dry axilla and adjust or remove clothing away from axilla.
6. Place bulb end of thermometer in hollow of arm pit in contact with skin.
7. Draw arm over chest with hand resting on opposite shoulder.
8. Instruct and/or assist resident to hold arm snug against body if indicated.
9. Leave thermometer in place for 10 minutes or follow manufacturer's instructions. Remain with resident if indicated.
10. Take pulse and respiration (Procedural Guideline #46) while temperature registers.
11. Remove thermometer holding stem end. If used, remove and discard plastic cover following facility policy.
12. Wipe thermometer with tissue from stem to bulb or follow facility policy.
13. Read thermometer at the point where the mercury column ends.
14. Shake thermometer down and return to container for used oral thermometer.
15. Record the temperature reading followed by "AX" to indicate axillary.

F. Procedural Guidelines for Rectal Temperature

1. Check with charge nurse to see if temperature should be taken at another site if resident is uncooperative or combative, or has diarrhea, fecal impaction, rectal bleeding, hemorrhoids or certain heart conditions.
2. Prepare clean rectal glass thermometer for use following facility policy.
3. Read mercury column and shake down to below 95° F or follow manufacturer's instructions.
4. Place thermometer into plastic cover if used at facility.
5. Wash hands and put on gloves prior to contact with stool.
6. Assist resident into a comfortable side-lying position, if tolerated, and cover with sheet to expose rectal area only.
7. Apply small amount of water-soluble lubricant on bulb of rectal thermometer, if not prelubricated.
8. Separate buttocks with one hand.
9. Gently insert bulb end of thermometer into the rectum 1 to 1 1/2 inches.
10. Do not force thermometer. Check with charge nurse if resistance is met.

11. Replace cover over buttocks.

12. Hold thermometer in place for 3 to 5 minutes or follow manufacturer's instructions.

13. Gently remove thermometer holding stem end. If used, remove and discard plastic cover following facility policy.

14. Wipe rectal area with tissue.

15. Wipe thermometer with tissue from stem to bulb or follow facility policy.

16. Read thermometer at the point where the mercury column ends.

17. Shake thermometer down and return to container for used rectal thermometers.

18. Remove gloves and wash hands after contact with stool.

19. Record temperature reading followed by an "R" to indicate rectal.

G. Closing Steps

1. Clean and store reusable items and discard disposables per facility policy.

   a. Follow facility policy for cleaning and storing thermometers.

2. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

3. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.

4. Always replace call signal and needed items within resident's reach.

5. Inform resident when finished and ask if anything is needed before you go.

H. Observe for and Report to Charge Nurse:

1. Oral temperatures below 97° and above 99° F (normal is about 98.6° F).

2. Axillary temperatures below 96° and above 98° F (normal is about 97.6° F).

3. Rectal temperatures below 98° and above 100° F (normal is about 99.6° F).

4. Problems or complaints related to temperatures such as skin hot or cold, color flushed or blue, chilling or sweating.

5. Problems related to oral temperature such as inability to breathe through nose.

6. Problems related to axillary temperature such as difficulty in placing thermometer in contact with skin.
7. Problems related to rectal temperature such as pain or difficulty in inserting thermometer.
8. Other significant observations.

PROCEDURAL GUIDELINE #46 – PULSE AND RESPIRATION

A. Purpose: To determine the rate and quality of the pulse and respiration.

B. Guidelines: Pulse and respiration are usually counted while temperature is being taken (Procedural Guideline #45).

C. Procedural Guidelines for Counting Radial Pulse

1. Assist resident into position of comfort with arm and hand supported.

2. Locate the radial pulse by placing the tips of your first three fingers on the thumb side of the resident's wrist. Do not use your thumb.

3. Exert slight pressure until you can feel the pulse. Do not press hard.

4. Look at second hand on watch, count the pulse for 30 seconds and multiply by 2 to obtain pulse rate per minute.

5. Count pulse for 1 full minute if pulse is irregular, difficult to count or if instructed to do so by charge nurse or facility policy.

6. Note rate, rhythm and force of pulse.

7. Record pulse rate and character following facility policy.

8. Observe for and report to charge nurse:

    a. Pulse rate below 60 or above 90/minute (normal is about 76 and regular).
    b. Irregular, weak or bounding pulse.
    c. Problems or complaints related to pulse such as chest pain, pounding or skipping heart beat.
    d. Other significant observations.

D. Procedural Guidelines for Counting Respirations

1. Leave your fingers on the radial pulse after the pulse rate has been counted so that you can count the respiration without the resident being aware of what you are doing.

2. Count the number of respirations (each respiration includes one inhalation and one exhalation) for 30 seconds and multiply by 2 to obtain the respiratory rate per minute.

3. Count respirations for 1 full minute if respiration is irregular, difficult to count or if instructed to do so by charge nurse or facility policy.

4. Record rate and character of respiration following facility policy.

5. Observe for and report to charge nurse:

a. Respiratory rate below 12 or above 22/minute (normal is about 16).
b. Noisy, labored, irregular, shallow, deep or difficult respiration.
c. Problems or complaints related to respiration such as shortness of breath, (SOB), coughing, wheezing or pain.
d. Other significant observations.

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PROCEDURAL GUIDELINE #47 – BLOOD PRESSURE (BP)

A. Purpose: To measure systolic and diastolic arterial blood pressure.

B. Precautions and Guidelines

1. Report to charge nurse if blood pressure equipment is not in good working order or if cuff is not available in correct size for accurate reading. The cuff is the proper size when the length of the inflatable bladder is at least 80% of the circumference of the resident's arm.

2. Recheck a blood pressure no more than 3 times and wait at least 1 to 2 minutes before repeating the BP measurement on the same arm.

3. Report to the charge nurse for assistance if you cannot hear the BP or are unsure of what you are hearing after 3 tries. Don't guess at the BP reading.

C. Procedural Guidelines

1. Beginning Steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather needed supplies:
      (1) Sphygmomanometer with cuff of correct size
      (2) Stethoscope
      (3) Alcohol sponges
      (4) Pencil and paper
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Applying the cuff

   a. Assist resident into a comfortable sitting or supine position as allowed, with forearm flexed and supported at the level of the heart and with palm up (or as instructed by charge nurse).
   b. Remove or adjust resident's clothing so that 6 inches of upper arm is bare.
   c. Locate brachial artery pulse just above bend of elbow on inner side of arm.
   d. Place cuff firmly and securely around resident's bare upper arm, 1 inch above the brachial pulse. The center of the cuff's inflatable bladder should be centered above the brachial pulse.
   e. Provide adequate lighting and place mercury manometer at your eye level.

3. Estimating the systolic blood pressure

   a. Ask resident not to talk while you listen to BP.

b. Locate radial pulse and keep your fingers on the pulse.
c. Tighten valve attached to air bulb.
d. Quickly pump air into the cuff while feeling the radial pulse and watching for the point where you can no longer feel the radical pulse.
e. When you no longer feel the radial pulse, stop pumping and immediately read the level on the gauge. This is the estimated systolic pressure.
f. Quickly open the valve and deflate the cuff.
g. Write down your estimated systolic pressure and add 30 mmHg to it such as 150 + 30 = 180 mmHg.
h. Wait 30 seconds before inflating the cuff again.

4. Taking the blood pressure reading

a. Clean earpieces and bell or diaphragm of stethoscope with an alcohol sponge and place earpieces in your ears pointing forward.
b. Locate the brachial pulse
c. Place the bell or diaphragm of stethoscope over brachial pulse and hold it lightly but firmly in full contact with resident's skin. (Do not use your thumbs).
d. Tighten valve and rapidly inflate the cuff to 30 mmHg above the estimated systolic pressure.
e. Open valve on air bulb and let ear escape slowly and evenly (at 2 to 3 mmHg/second) while watching the gauge and listening for the pulse sounds.
f. When you hear the first of 2 consecutive beats, note and remember the reading on the gauge. This is the systolic blood pressure.
g. Continue to release the pressure slowly, watching gauge and listening to pulse.
h. When the sound stops, note and remember the reading on the gauge. This is the diastolic blood pressure.
i. Continue to listen for 10 to 20 mmHg to confirm the last sound.
j. Open the valve and deflate the cuff rapidly until pressure is at zero.
k. Follow facility policy for recording blood pressure (in even numbers) as systolic/diastolic. The time taken, position of resident, arm used and cuff size may also be recorded.
l. Remove cuff from resident's arm.
m. Remove stethoscope from ears and use alcohol wipe to clean earpieces, bell or diaphragm, and (if contaminated) tubing.

5. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

6. Observe for and report to charge nurse:

a. Time blood pressure taken, position (standing or sitting), cuff size and arm used.
b. Blood pressure readings below 100/60 or above 140/90 (normal BP is about 120/80 mmHg).
c. Problems related to procedure such as sore or discolored arm or unusual sounds.
d. Complaints related to blood pressure such as pounding pulse, headache, faintness, swelling.

e. Other significant observations.

PROCEDURAL GUIDELINE #48 – HEIGHT AND WEIGHT

A. Purpose: To determine a baseline record of body weight and height and to monitor nutrition and hydration.

B. General Guidelines

1. Height and weight are generally measured on admission, and weight is measured monthly.

2. To assure that weight measurement is accurate, measure weight at the same time of day, use same scale each time and have resident wear the same amount of clothing each time.

3. Follow facility policy and manufacturer's instructions on the proper use of specific scales such as standing, chair, platform and lift scale.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather weight record or pad and pencil and other needed items.
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close doors/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Measuring weight of ambulatory resident:

   a. Balance the scale by moving both weights to far left at zero and adjusting until balance beam is centered, or follow facility policy and manufacturer's instructions.
   b. Assist resident to adjust clothing to match the amount worn for previous weights or follow facility policy.
   c. Place clean paper towel on scale, if resident's shoes are to be removed.
   d. Assist resident to stand on scale.
   e. Check that resident is balanced and centered on scale with arms at sides and not holding onto anything.
   f. If resident cannot safely stand on scale, report to charge nurse and consider another type scale.
   g. Move larger bottom weight to right, just below estimated weight of resident. Be sure indicator is in the groove.
   h. Then move small top weight to right until scale is balanced.
   i. Read lower bar and upper bar and add numbers together for total weight.
   j. Record weight following facility policy.

3. Measuring height of ambulatory resident:

   a. Place clean paper towel on scale.
   b. Assist resident to remove shoes.

c. Assist resident to stand on scale.
d. Have resident stand straight and look straight ahead.
e. Raise height arm higher than the resident's head.
f. Gently lower height arm until level with top of resident's head.
g. Read and record height in feet and inches following facility policy.

4. Measuring weight of non-ambulatory resident using mechanical lift:

a. Carefully follow manufacturer's instructions and facility policy for using mechanical lift.
b. Request assistance as needed prior to this procedure.
c. Bring mechanical lift with slings and other needed items to bedside.
d. Lock wheels of bed.
e. Position and attach slings and straps following manufacturer's instructions.
f. Slowly lift resident free of the bed.
g. Adjust weights until scale is balanced.
h. Read and record the weight following facility policy.
i. Slowly return resident to bed.
j. Detach and remove slings and straps.

5. Measuring height of non-ambulatory resident:

a. Assist resident to lie flat in bed with legs extended as able.
b. Put a small pencil mark on sheet at top of head and at bottom of heels.
c. Measure the distance between the two marks with a tape measure.
d. If resident is contracted, use a tape measure and measure from top of head to base of heel, following curves of spine and legs.
e. Record height in feet and inches following facility policy.

6. Closing steps

a. Clean and store reusable items and discard disposables per facility policy.
b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.
c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

7. Observe for and report to charge nurse:

a. Procedure done and scale used.
b. Height and weight and changes in weight from previous measurement.
c. Problems or complaints related to the procedure.
d. Other significant observations.

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PROCEDURAL GUIDELINE #49 – OBSERVING AND REPORTING SUMMARY

A. Purpose: To review and summarize guidelines for observing and reporting.

B. Observing and Reporting Guidelines

1. Vital Sign Changes

		REPORT CHANGES	
	Normal	Below	Above
Temperature – Oral	98.6°	97°	99°
Temperature – Axillary	97.6°	96°	98°
Temperature – Rectal	99.6°	98°	100°
Pulse	76	60	90
Respiration	16	12	22
Blood Pressure	120/80	100/60	140/90

2. Signs of Infections

   a. Temperature elevation
   b. Chilling and sweating
   c. Skin hot or cold, color flushed or blue
   d. Inflammation (heat, pain, redness, swelling)

3. Respiratory Problems

   a. Respiratory below 12 or above 22, unusually irregular, shallow or deep
   b. Noisy, labored, difficult respiration (dyspnea) shortness of breath (SOB),wheezing
   c. Coughing - dry or productive. If productive, describe sputum
   d. Blue color of lips or nails

4. Cardiovascular Problems

   a. Pulse below 60 or above 90, irregular, weak or bounding
   b. Blood pressure below 100/60 or above 140/90
   c. Chest pain
   d. Headache, dizziness, vomiting, weakness, paralysis
   e. Cold, blue, numb or painful feet or hands

5. Skin Problems

   a. Skin changes such as rash, redness, irritation, bruising, discoloration,swelling, skin breakdown, drainage, foul odors.
   b. Skin complaints such as burning, itching, tingling, numbness, pain
   c. Skin infections
   d. Pressure areas
   e. Skin growths (benign and malignant)

6. Bowel or Abdominal Problems

    a. Unusual appearance of stool. Presence of unusual substances such as blood, mucus
    b. Bowel complaints such as pain, constipation, diarrhea, bleeding
    c. Indigestion
    d. Nausea and vomiting
    e. Abdominal pain
    f. Abdominal bleeding (digested blood causes vomitus and stool to look like "coffee-grounds")

7. Urinary Problems

    a. Urinary output which is unusually high or low
    b. Unusual appearance of urine -- such as dark, red, cloudy instead of yellow or straw colored. Presence of unusual substances such as solid particles, blood, odor
    c. Urinary complaints such as dysuria, burning, urgency, frequency, flank pain
    d. Changes in mental status

8. Fluid Balance Problems

    a. Fluid I & O too high, too low or imbalanced
    b. Signs of dehydration such as low fluid intake, low output of dark urine with strong odor, weight loss, dry skin, dry mucous membrane (lips, tongue, eyes), drowsiness, confusion
    c. Signs of fluid retention such as edema, weight gain, respiratory difficulties
    d. Changes in mental status

9. Nutritional problems

    a. Increase or decrease in food (caloric) intake
    b. Increase or decrease in body weight
    c. Diabetic residents who do not eat all of their diabetic diet or who eat more than their diabetic diet.

10. Mental status changes

    a. Changes in level of consciousness/alertness
    b. Changes in behavior or communication
    c. Changes in mood or emotional status
    d. Changes in memory of confusion
    e. Threats of suicide or threats of harm to others

PROCEDURAL GUIDELINES #50 – POSTMORTEM CARE

A. Purpose

1. To prepare the body for viewing by family and/or friends.
2. To prepare the body for transfer to the mortuary.

B. General Guidelines and Precautions

1. Postmortem care is done after the resident is pronounced dead.
2. Handle body gently to avoid bruising.
3. Respect the right to privacy and dignity after death, as well as during life.
4. Respect religious beliefs of deceased, such as Catholics may have last rites after death.

C. Procedural Guidelines

1. Identify resident following facility policy.
2. Assist the roommate to leave the room temporarily.
3. Provide privacy for the family until the body has been prepared for viewing.
4. Gather needed supplies:
    a. Bath supplies
    b. Linen
    c. Shroud if indicated by facility policy
    d. Bag for personal belongings
    e. Waste receptacle
    f. Clean, disposable examination gloves
5. Close the door, window curtains and privacy curtains.
6. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) for this procedure.
7. Raise height of bed to comfortable working level.
8. Position the body supine in proper alignment.
9. Place a pillow under the head and shoulders.
10. Close the eyelids by gently pulling lashes downward.

11. Follow facility policy for dentures. Either place in mouth or place in labeled denture cup to be sent to mortuary.

12. Close the mouth, using a rolled washcloth under the chin to support the closed position if needed.

13. The nurse will generally remove tubes, replace dressing and inventory valuables at this time.

14. Bathe soiled areas of body with water and comb hair if needed.

15. Place a pad at perineum or a bed protector under buttocks.

16. If body will be viewed by family or friends.

    a. Apply a clean gown and clean bed linen.
    b. Reposition the body in good alignment and cover the body to the shoulders.
    c. Arrange the room neatly.
    d. Provide privacy, support and physical presence for family/friends as appropriate.

17. Identify and assemble the resident's personal belongings and eyeglasses and place in labeled bags for the family. Notify the nurse if you find valuables or jewelry.

18. After the family/friend have gone, the nurse will release the body to the mortuary.

19. After the body has been removed, strip the unit following facility policy.

20. Perform other task following instructions of charge nurse and facility policy.

21. Remove and discard gloves following facility policy. Wash hands.

D. Observe For and Report to Charge Nurse:

1. What was done with resident's belongings including valuables, jewelry, dentures.

2. Unusual occurrences related to postmortem care.

3. Unusual responses of family, friends, or residents.

4. Other significant observations.

PROCEDURAL GUIDELINE #51 – RANGE OF MOTION (ROM) EXERCISES

A. Purpose: To maintain the function of joints and muscles without trauma or pain.

B. Precautions and Rules for ROM

1. ROM exercises may be ordered by the physician or the charge nurse.

2. Check with charge nurse for instruction about which joints to exercise, which joints not to exercise, what exercises to do and how many repetitions.

3. Perform each exercise 3 times or following facility policy or directions of charge nurse.

4. Hold the part above and below the joint being exercised so that the joint is supported.

5. Move each joint gently, smoothly and slowly through its ROM to the point of resistance. Do not force a joint to move beyond its free ROM.

6. Stop any ROM exercise immediately if pain occurs. Notify charge nurse immediately if pain is sharp or unexpected.

C. Procedural Guidelines

1. Beginning steps

   a. Wash hands. Wear gloves and follow Standard Precautions (Procedural Guideline #9A) if contact with blood or body fluids is likely.
   b. Gather any needed supplies.
   c. Knock on door and identify self by name and title.
   d. Greet resident by preferred name and identify resident per facility policy.
   e. Explain procedure and encourage resident's participation as appropriate.
   f. Provide privacy as appropriate such as close door/curtains, drape resident.
   g. Provide safety as appropriate such as use good body mechanics, adjust bed to proper working height.
   h. If side-rails are in use, lower them on working side, keep them up on opposite side and always put them up before you step away from bedside.

2. Lock wheels of bed, lower head of bed and assist resident to lie on back, without pillow and in good alignment as able.

3. Cover resident with bath blanket or top sheet and uncover only the part being exercised.

4. ROM exercise for right and left shoulders:

   a. Begin with arm straight at side. Support arm at elbow and wrist.
   b. Move straight arm out at a right angle to body, then return straight arm to side of body X 3.
   c. Flex elbow and bring arm over head, then return arm to side of body X 3.
   d. If resident is standing or sitting, move arm slightly behind body, then return arm to side X 3.

5. ROM exercise for right and left elbows:

    a. Begin with arm straight at side. Support arm at wrist and elbow.
    b. Bend the elbow moving hand toward shoulder, then straighten the arm X 3.

6. ROM exercise for right and left forearms:

    a. Begin with arm flat on bed. Support arm at wrist and elbow.
    b. Turn hand so palm is up, then turn hand so palm is down X 3.

7. ROM exercise for the right and left wrists:

    a. Begin with palm up. Support arm and hand.
    b. Bend hand down, then straighten hand X 3.
    c. Bend hand up, then straighten hand X 3.
    d. Turn hand toward thumb, then turn hand toward little finger X 3.

8. ROM exercise for fingers of right and left hands:

    a. Put your fingers over resident's fingers.
    b. Curl fingers to form fist with thumb on the outside, then straighten fingers out X 3.
    c. Touch resident's thumb to each finger X 3.
    d. Move each finger and thumb away from middle finger, then move each finger and thumb toward the middle finger X 3.

9. ROM exercise for right and left hips and knees:

    a. Begin with leg straight. Support leg with one hand under knee and one hand under ankle.
    b. Bend the knee and slowly raise the leg, then straighten the knee and lower the leg X 3.
    c. Move straight leg away from center of body, then move straight leg back toward center X 3.
    d. Turn the leg inward, then turn the leg outward X 3.

10. ROM exercise for right and left ankles and feet:

    a. Support foot with one hand under ankle and one hand holding forefoot.
    b. Move forefoot in a circle clockwise, then counter-clockwise X 3.

11. ROM exercise for toes of right and left feet:

    a. Place your fingers over the resident's toes.
    b. Gently curl toes down, then straighten toes X 3.
    c. Move each toe away from the middle toe, then move each toe toward the middle toe X 3.

12. Closing steps

    a. Clean and store reusable items and discard disposables per facility policy.
    b. If gloved, remove and discard gloves following facility policy at the appropriate time to avoid environmental contamination. Wash hands.

c. Provide for resident's comfort and safety before leaving as appropriate such as straighten clothing/bedding, adjust bed/side-rails.
d. Always replace call signal and needed items within resident's reach.
e. Inform resident when finished and ask if anything is needed before you go.

13. Observe for and report to charge nurse:

a. ROM exercise completed and time.
b. Problems or complaints related to ROM.
c. Changes in the resident's ability to participate in ROM.
d. Other significant observations.

PROCEDURAL GUDELINE #52 - - ASSISTING RESIDENTS WITH PSYCHOSOCIAL NEEDS

A. General Guidelines

1. Use effective Communication and Interpersonal Skills (Procedural Guideline #10). Be a good listener and develop supportive relationships with residents.

2. These guidelines are provided as suggestions and examples, because no single method will work for all individuals/situations.

3. Be constantly aware of how the resident is responding, and adjust your approach and methods to achieve the desired results.

4. Request help from charge nurse as needed for meeting psychosocial needs.

B. Guidelines for Utilizing Family and Friends of Resident for Support

1. Talk with residents about family and friends.

2. Encourage residents to recall pleasant family memories.

3. Assist residents to maintain contact with family/friends by visits, phone, and mail.

4. Assist residents to prepare for visits or outings with family/friends.

5. Help family/friends feel welcome at the facility and encourage visits.

C. Guidelines for Assisting with Security Needs

1. Develop trusting relationships with residents.

2. Provide safe care to residents as covered throughout this course.

3. Perform care in an organized, consistent and confident manner.

4. Answer calls signals promptly and be available to help residents who need help.

5. Check in on residents and offer assistance even before they ask for help.

6. Follow-through on any promises you make.

D. Guidelines for Assisting Residents with Sexual Needs.

1. Use praise and touch as appropriate to help meet needs for love and caring.

2. Assist residents to feel good about their physical appearance by:
   a. Providing care that includes occasional extras such as a new hairstyle.
   b. Compliment resident on best features such as “those beautiful blue eyes”.

3. Provide privacy for appropriate sexual behavior of residents such as closing doors and knocking before entering.

4. Manage inappropriate sexual behavior by calmly directing resident to private place following instructions of charge nurse and care plan.

E. Guideline for Assisting Residents with Love or Social Needs

1. For some residents, you may be the major social contact and/or the major source of assistance in making social contacts with others.

2. Listen carefully and express genuine interest in residents/activities.

3. Encourage and assist residents to maintain relationships with family/friends.

4. Identify residents' interest and find related social activities.

5. Work with charge nurse, social worker, activity director and/restorative team to meet social needs of residents as appropriate.

6. Support and assist residents with unplanned social contacts such as:
   a. Introduce resident to other people.
   b. Arrange activities and environment to promote socialization and avoid conflicts between residents.

7. Encourage and assist residents to participate in planned social contacts such as:
   a. Be creative in finding activities that are meaningful to individual residents.
   b. Inform residents of social activities that they may enjoy.
   c. Don't coerce residents to participate against their wishes.
   d. Assist residents to prepare for and arrive on time for social activities.

F. Guidelines for Assisting with Self-Esteem or Status Needs

1. Get to know and respect each resident as a unique individual.

2. Identify resident's strengths and successes and provide positive feedback.

3. Promote and reward independence, decision-making and assertiveness.

4. Know the resident's current goals and reward progress toward goals.

5. Use rewards appropriate to the residents' preference such as positive feedback, praise, compliments, congratulations, a handshake, a pat on the back, or a hug.

G. Guidelines for Supporting Self-Actualization

1. There are limitations to assisting other with self-actualization, as this process is highly personal, internal and unique to each individual.

2. Assure that basic needs are met, so that resident is free to pursue self-actualization.
3. Assist with meeting spiritual needs, as they are often closely related.
4. Encourage and support residents in achieving goals and independence.

H. Guidelines for Assisting with Spiritual Needs

1. Know and respect the spiritual beliefs of each resident.
2. Encourage residents to discuss spiritual beliefs and personal values.
3. Inform residents of available spiritual activities.
4. Assist residents to participate in spiritual activities of their choice.
5. Handle spiritual/religious items with care and respect.
6. If resident ask to see a clergy, report request to charge nurse promptly.
7. Provide privacy for religious visits and practices.

I. Guidelines for Assisting with Cultural Practices

1. Know and respect the cultural background of residents.
2. Talk to residents and/or family about their cultural background and practices.
3. Ask about dietary and other cultural practices. Report special needs to the charge nurse so they can be included in the care plan.
4. Support and assist with cultural practices of the resident as appropriate.

J. Guidelines for Supporting Adjustment to Losses and Changes.

1. Promote independence, decision-making, resident rights, self-esteem.
2. Respect the resident's individuality and dignity.
3. Assist residents to establish and maintain a daily schedule of activities as similar as possible to their prior life style.
4. For newly admitted residents, support and assist them to adjust to the facility.
5. For residents who are sad or grieving, encourage them to express feelings. Allow them to cry to express feelings. Avoid saying "Don't cry".

6. For residents who are fearful and anxious; meet security needs, encourage them to express feelings, provide appropriate information about fears, and provide examples of how the resident has successfully coped with change in the past.

7. For residents who feel helpless, useless, or hopeless; try to involve them in useful activities such as helping someone, reading, and folding linen.

8. For residents who are frustrated or angry, allow them to talk about their anger. Don't take the behavior personally, if the anger is directed at you.

K. Guidelines for Supporting the Development Tasks Associated with Aging

1. Like self-actualization, there are limitations to assisting with developmental task, as the process is highly personal, internal and unique to each individual.

2. Assist resident with meeting basic human needs, with special attention to spiritual and self-actualization needs which may be related.

3. Assure that resident has adequate time to recall and review life experiences (reminisce) as desired.

4. Encourage resident to discuss life experiences, listen carefully and point out resident's strengths, successes and positive experiences.

5. Assist resident to contact and interact with family/friends as desired.

6. Encourage and assist resident to review family pictures, records and other items.

L. Observe For and Report to Charge Nurse

1. Problem in assisting residents with basic human needs, adjustment to losses/changes, or the developmental tasks of aging.

2. Residents who are having problems with unmet needs, adjustment to losses/changes, or the developmental tasks of aging.

3. Other significant observations.

PROCEDURAL GUIDELINES #53 - - ASSISTING WITH SPECIFIC BEHAVIOR PROBLEMS

A. General Guidelines

1. Follow Procedural Guideline #10 - - Communication/Interpersonal Skills, #52 - - Psychosocial Needs and #54 - - Cognitive Impairment as appropriate

2. These guidelines are provided as suggestions and examples, because no single method will work for all individuals/situations.

3. Provide care that meets residents' needs and promotes residents' rights, dignity, privacy, independence and restoration.

4. Observe closely to learn the residents' likes and dislikes.

5. Know and understand the residents in your care. Know at least one effective measure to comfort and/or distract each resident such as:
   a. Objects such as a favorite pillow, doll, or something new and interesting.
   b. Activities such as a favorite topic, music, TV, rocking chair, holding hands.
   c. A favorite caregiver who is effective in calming the resident.

6. Use these measures at the first signs of distress to try to avoid more serious behavior problems.

7. Share your observations of comfort measures, likes and dislikes with the charge nurse to assist others in working with the resident.

B. Assisting Residents with Sleep Problems

1. If resident can't fall asleep at night:
   a. Promote sleep by offering P.M. care, backrub, controlling noise, dimming lights and other measures as appropriate.
   b. Allow resident to remain up and provide appropriate activity that won't disturb others. Don't set a specific bedtime.
2. If resident wakes up in middle of the night:
   a. If resident is frightened, provide reassurance and comfort measures.
   b. If resident is confused, provide orientation to time, place and person.
   c. If resident wants to get out of bed, assist to location close to nurse's station and provide diversional activities as appropriate.

3. Look for cause(s) of sleep problems, which may include environmental problems, anxiety, fear, pain, too much sleep or caffeine, too little exercise, unmet needs such as elimination of fluids.

4. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.

5. Follow instructions of charge nurse and behavior management plan as appropriate.

C. Assisting Residents who have Depression

1. Depression is a mental disorder
   a. It may occur following stress or losses such as death of a spouse, but it also occurs without a situational cause.
   b. The signs and symptoms are sadness, fatigue, decreased concentration, memory loss, sleep/eating disorders, crying, lack of interest, low self-esteem.

2. Develop an honest, caring and supportive relationship with the resident.

3. Be a good listener and encourage resident to express feelings.

4. Identify resident's strengths/successes and provide positive feedback.

5. Do not interrupt, change the subject or tell the resident "cheer up", "stop crying" or "things could be worse".

6. Provide care to meet basic needs and increase self-esteem.

7. Encourage physical activity as tolerated.

8. Encourage resident to participate in meaningful activities.

9. Encourage family/friends to provide support and activities.

10. Promptly report changes in behavior (both increased and decreased sadness) and threats of suicide to charge nurse.

11. Follow instructions of charge nurse and behavior management plan as appropriate.

D. Assisting Residents Who Are Complaining or Demanding

1. Talk with resident to determine the nature of the compliant/demand and report objective observations to charge nurse.

2. If complaint/demand is justified, correct or meet justified complaints or demands (that you are trained to do) as instructed by charge nurse.

3. If complaint/demand is unjustified or cannot be met immediately:
   a. Assure resident that complaint was heard and reported to charge nurse.
   b. Be a good listener and provide support.
   c. If complaints are related to the care, stay neutral and do not become defensive, take sides or argue with resident.
   d. Give resident as such control as possible over daily life and routines.
   e. Try to distract resident with a favorite object or activity as appropriate.
   f. Look for cause(s) of unjustified complaints such as boredom; need for attention, anger, long standing behavior patterns, or unmet needs.

4. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.

5. Follow instructions of charge nurse and behavior management plan as appropriate.

E. Assisting Residents Who Are Yelling or Screaming

1. Try to distract resident with a snack (hard candy or gum is best, if allowed) or discussing a favorite topic. If is difficult to yell while eating or talking.

2. Look for the cause(s) of the behavior such as over or under-stimulation, boredom, fear, pain, unmet needs (hunger, thirst, and need to toilet).

3. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.

4. Follow instructions of charge nurse and behavior management plan as appropriate.

F. Assisting Resident Who Are Verbally or Physically Aggressive

1. Verbal aggression is arguing, threatening or accusing, usually in a loud and angry voice. Physical aggression or combative behavior is fighting.
2. Remain calm, reassuring and use non-threatening body language.

3. Do not become defensive, argue or try to reason with resident.

4. Move resident into private space, or move other residents out of harms way.
   a. If attack is directed at you, leave if you can safely do so, or request assistance of a caregiver that can calm the resident.
   b. If attack is directed at another resident, request assistance and remove both the residents to separate quiet areas.

5. For physical aggression, use the following safety precautions as appropriate:
   a. Notify charge nurse quietly but promptly, and obtain needed assistance.
   b. Protect yourself with padding, as needed, following facility policy.
   c. Take threats seriously and keep your distance.
   d. Do not try to touch or turn your back on the combative resident.
   e. Don't back resident into a corner, especially if the fight is about space.

6. Try distraction or have resident's favorite caregiver calm resident.

7. Look for the cause(s), which may include fear, anger, stress, feeling helpless, lack of privacy, misunderstanding, personality conflicts, and unmet needs.

8. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.

9. Follow instruction of charge nurse and behavior management plan as appropriate.

10. If the charge nurse orders restraints, follow Procedural Guideline #44.

G. Observe for and Report to the Charge Nurse:

1. Changes in the behavior of resident that might indicate problems.
2. Possible cause(s) of the behavior.
3. Effective comfort/diversional measures
4. Residents who seem sad or depressed.
5. Any threats of suicide or threats of harm to other people or property.
6. Other significant observations.

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PROCEDURAL GUIDELINES #54 - - ASSISTING WITH COGNITIVE IMPAIRMENT

A. General Guidelines

1. Follow Procedural Guideline #10 - - Communication/Interpersonal Skills, #52 - - Psychosocial Needs and #53 - - Specific Behavior Problems as appropriate.

2. These guidelines are provided as suggestions and examples, because no single method will work for all individuals/situations.

3. Follow the safety measures at Unit 3 to prevent falls and other injuries.

4. Follow instructions of charge nurse and behavior management plan as appropriate.

B. Guidelines for Communicating with Cognitive Impaired Residents

1. Watch your body language, as it may be the only message the resident receives.

2. Watch resident's body language, as it may the only message he/she can send.

3. Speak slowly, calmly and in an unhurried manner - - don't rush.

4. Greet resident by preferred name and make eye contact when speaking.

5. Identify self by name, title and explain what you are going to do.

6. Reassure verbally and by touching, if resident responds well to touch.

7. Ask short simple questions, wait for a response, and then repeat if necessary.

8. Give simple instructions, one step at a time.

9. Use positive sentences. Avoid "don't" and "no".

10. Use cues or signals such as pointing, touching, smiling or placing a comb in resident's hand as you talk about combing the hair.

11. Recognize when the resident is becoming frustrated with trying to speak or remember, and offer help before resident becomes too frustrated.

12. Do not attempt to teach the resident to think or remember.

C. Guidelines for Assisting with Memory Loss and Confusion (Acute and Chronic)

1. Provide care to meet all of the resident's basic human needs.

2. Approach resident in a calm, patient and respectful manner.

3. Keep the resident's life as simple, stable and free of change as possible.
   a. Simplify tasks.
   b. Establish a routine and stick with it as possible, but be flexible if needed.
   c. Provide structure, consistency and direction in all activities.
   d. Maintain a soothing, stable environment with minimal change and stimuli

4. Limit decision-making to single choices, based on resident's abilities.

5. Recognize when resident is becoming frustrated and offer timely assistance.

6. Encourage resident to relate to people and memories that are familiar/pleasant.

D. Guidelines for Using Reality Orientation (as directed by charge nurse and care plan)

1. Use this method only if it is helpful to the resident who can learn and remember.

2. Provide orientation to residents with mild memory loss by inserting it into the normal course of conversation:
   a. Call resident by preferred name often and use full name occasionally.
   b. Tell resident your name, title, and what you are going to do.
   c. Tell residents the date, day and time.
   d. Tell residents where they are and how they are doing.

3. Use clues and reminders.
4. Encourage and assist the resident to use memory aides such as calendars, clocks, room numbers on the door and name on clothing as appropriate.

E. Guidelines for Using Validation Therapy (as directed by charge nurse and care plan)

1. Use the methods of Validation Therapy to encourage the confused resident to explore the emotions associated with false thinking.

2. Listen to what the resident is saying and read the body language to try and determine what the resident is feeling. For example a resident hugs a doll and says, "this is my baby".

3. To validate the emotions, respond to what you believe the resident is feeling. For example you might say "You must be thinking about your children" or "You must really love babies".

4. Do <u>not</u> validate false thinking as this may promote false thinking and confusion. For example, do <u>not</u> say, "May I hold your baby".

5. Do <u>not</u> correct false thinking as this gives a negative message and may cause the resident to withdraw. For example, do <u>not</u> say "that <u>is</u> <u>not</u> a baby – its a doll".

F. Guidelines for Assisting Residents Who Wander

1. Allow the resident to wander if it is not harmful to resident or others.

2. Assure that the resident who wanders wears appropriate identification.

3. Assure that appropriate doors and window are locked and alarms are turned on.

4. To interrupt the wandering, approach resident from side or front in a calm manner and gently guide resident back to the appropriate area.

5. If the resident is not willing to stop wandering, stay with the resident until it is possible to redirect the return. Do not argue or use force.

6. Try to distract the resident with an interesting object or favorite activity.

7. Look for the cause(s) of wandering which may include seeking an exit, restlessness, stress, boredom, or unmet needs.

8. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.

9. Follow instruction of charge nurse and behavior management plan as appropriate.

G. Guidelines for Assisting Residents Who Resist Care

1. Keep care simple and routine. Give care in a calm, patient manner. Don't rush.

2. Resisting care often occurs when the caregiver activities require skills that the cognitively impaired resident no longer has.

3. Match the demands of the care to the resident's abilities.

4. Always be aware of how your care is affecting the resident.

5. Observe for signs of anxiety which indicate early resistance to care such as restlessness, shifting position, clenching fists, wringing hands, or moaning.

6. At the first sign of distress, stop the care as soon as you can safely do so.

7. Look for the cause(s) of the resistance which may include:
   a. Resident may have unmet physical or psychosocial needs.
   b. The complexity or the care may exceed resident's ability.
   c. The caregiver (who has to get the job done) may be expecting too much of the resident, rushing the resident, communicating his/her own anxiety or impatience to resident, or sending mixed messages.

8. Provide care (that you are trained to provide) to eliminate the cause such as meet unmet needs, delay the care until later, simplify the task, provide additional assistance, slow down, adjust your approach.

9. Follow instructions of charge nurse and behavior management plan as appropriate.

H. Guidelines for Assisting Residents with Self-Control

1. Allow resident to do as much as possible, but assist before anxiety and frustration occurs (help, but don't do).
2. Know and avoid situations that lead to loss of self-control for the resident.
3. Redirect resident's thoughts and/or activities before they become agitated.
4. Use measures to comfort or distract the resident.
5. Remove resident to a private space before self-control is lost.
6. Look for cause(s) of the behavior, which may include unmet needs, frustration, and failure.
7. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.
8. Follow instructions of charge nurse and behavior management plan as appropriate.

I. Guidelines for Assisting Resident with Catastrophic Reaction

1. A catastrophic reaction is an emotional outburst which may include crying, screaming, agitation, or fighting – none of which the resident can control.
2. Try to avoid stressful situations and multiple distractions.
3. Approach resident from side or front in a calm, reassuring manner.
4. Guide resident to a quiet place or remove distractions.
5. Give verbal and non-verbal support. Do not scold, argue, teach or reason.
6. Try to comfort/distract resident with favorite object, activity or caregiver.
7. Leave resident alone to calm down if you can safely do so.
8. Look for cause(s) of the behavior, which may include unmet needs, failure, feeling overwhelmed, and loss of impulse control.
9. Provide care (that you are trained to do) to eliminate cause(s) of the behavior.
10. Follow instructions of charge nurse and behavior management plan as appropriate.

J. Observe For and Report to Charge Nurse:

1. Effective measures to comfort or distract the resident.
2. Changes in the behavior of residents that might indicate problems.
3. Possible causes of behavior problems.

4. Problems in managing the behavior, providing care or protecting safety.
5. Other significant problems.

PART 3

SKILLS CHECKLISTS

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August 1997 - Listing of 37 Skills

1. Handwashing
2. How To Start Conversations and Send Messages
3. Communicating With Residents Who Have Vision Loss
4. Communicating With Residents Who Have Hearing Loss
5. Communicating With Residents Who Have Problems With Speech
6. Assisting Residents Who Have Memory Loss, Confusion or Understanding Problems
7. Assisting Residents Who Are Demanding or Angry
8. Moving the Helpless Resident to the Head of the Bed With One Assistant (Using Draw Sheet or Incontinent Pad)
9. Assisting Resident to Sit Up on Side of Bed
10. Assisting the Resident to Transfer From Chair to Bed or Bed to Chair
11. Assisting the Resident With Ambulation
12. Making the Unoccupied Bed
13. Making the Occupied Bed
14. Tub or Shower Bath With Shampooing the Hair
15. Perineal Care/Incontinent Care--Female With or Without Catheter
16. Perineal Care/Incontinent Care--Male With or Without Catheter
17. Back Rub
18. Brushing the Teeth
19. Denture Care
20. Mouth Care of Dependent Resident
21. Shaving the Male Resident--Safety or Disposable Razor
22. Shaving the Male Resident--Electric Razor
23. Hand and Fingernail Care
24. Foot and Toenail Care
25. ---
26. Oral Temperature/Pulse/Respirations
27. Axillary Temperature/Pulse/Respirations
28. Rectal Temperature/Pulse/Respirations
29. Blood Pressure
30. Weight of Ambulatory Resident
31. Range of Motion (ROM) Exercise for Right or Left Upper Extremity
32. Range of Motion (ROM) Exercise for Right or Left Lower Extremity
33. Assisting the Totally Dependent Resident With Dressing, Hair Combing and Application of Prosthetic Devices
34. Complete Bed Bath
35. Feeding the Dependent Resident (Offering Food and Fluids)
36. Turning Resident on His Side Toward You
37. Assisting Resident with Use of Bedpan

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SKILL #1: HANDWASHING
Procedural Guideline #7

Turns on water.

Wets hands.

Applies skin cleanser or soap to hands.

RUBS HANDS TOGETHER FOR AT LEAST 10 SECONDS IN A CIRCULAR MOTION.

WASHES ALL SURFACES OF THE HANDS AT LEAST UP TO THE WRIST.

Rinses hands thoroughly from wrist to fingertips, clean under fingernails, if needed, fingers down, under running water.

Dries hands on clean towel/warm air dryer.

Turns off faucet with towel and/or avoids contact with sink or other dirty surfaces during rinsing and drying of the hands.

Discards wet towel appropriately.

SKILL #2: HOW TO START CONVERSATIONS AND SEND MESSAGES
Procedural Guideline #10

Greets resident by preferred name.

Identifies self to resident.

Focuses on the appropriate topic to be presented.

Faces the resident to speak and avoids talking off into space.

TALKS WITH RESIDENT WHILE GIVING CARE. USES APPROPRIATE INFECTION CONTROL PROCEDURE.

LISTENS AND RESPONDS APPROPRIATELY WHEN RESIDENT SPEAKS.

Uses social re-enforcers such as praise and smiles.

Encourages resident to interact with nurse aide and others.

USES COURTESY WHEN COMMUNICATING.

SKILL #3: COMMUNICATING WITH RESIDENTS WHO HAVE VISION LOSS
Procedural Guideline #10F

TO AVOID STARTLING THE RESIDENT, KNOCKS ON DOOR BEFORE ENTERING AND IDENTIFIES SELF UPON ENTERING THE ROOM.

Positions self in good light and faces resident when speaking.

Greets resident by preferred name using touch such as pat on the arm or holding hand as appropriate.

TALKS WITH RESIDENT WHILE GIVING CARE, GIVING STEP-BY-STEP EXPLANATION AS APPROPRIATE.

Explains what the resident is to do.

LISTENS ATTENTIVELY AND CLARIFIES RESIDENT'S UNDERSTANDING AS APPROPRIATE.

INFORMS RESIDENT BEFORE LEAVING THE ROOM.

USES COURTESY WHEN COMMUNICATING.

SKILL #4: COMMUNICATING WITH RESIDENTS WHO HAVE HEARING LOSS
Procedural Guideline #10G

Alerts resident to presence by approaching from the from or side.

Positions self in good light and faces resident while speaking.

Greets resident by preferred name.

Identifies self to resident.

TALKS WITH RESIDENT WHILE GIVING CARE.

SPEAKS IN A LOWER PITCHED VOICE AT A NORMAL OR ONLY SLIGHTLY INCREASED LOUDNESS - AVOID SHOUTING AS APPROPRIATE.

LISTENS ATTENTIVELY AND CLARIFIES RESIDENTS UNDERSTANDING AS APPROPRIATE.

USES COURTESY WHEN COMMUNICATING.

Informs resident before leaving room.

SKILL #5: COMMUNICATING WITH RESIDENTS WHO HAVE PROBLEMS WITH SPEECH
Procedural Guideline #10H

Greets resident by preferred name.

Identifies self to resident.

TALKS WITH RESIDENT WHILE GIVING CARE.

GIVES RESIDENT ADEQUATE TIME TO RESPOND, LISTENING ATTENTIVELY.

Encourages and assists resident with the use of assistive devices for communication such as picture board and word boards, if necessary.

Clarifies resident's understanding as appropriate.

USES COURTESY WHEN COMMUNICATING.

Informs resident before leaving the room.

SKILL #6: ASSISTING RESIDENTS WHO HAVE MEMORY LOSS, CONFUSION OR UNDERSTANDING PROBLEMS
Procedural Guideline #10I

Greets resident by preferred name.

Identifies self to resident.

TALKS WITH RESIDENT WHILE GIVING CARE, GIVING SIMPLE STEP-BY-STEP INSTRUCTION AS APPROPRIATE.

PRONOUNCES WORDS CLEARLY AND SLOWLY.

Promotes resident independence.

LISTENS AND RESPONDS APPROPRIATELY WHEN RESIDENT SPEAKS.

Provides some orientation to residents with mild memory loss as appropriate.

Continues to call resident by name during conversation.

USES COURTESY WHEN COMMUNICATING.

Informs resident before leaving room.

SKILL #7: ASSISTING RESIDENTS WHO ARE DEMANDING OR ANGRY
Procedural Guideline #10, & #52 - #54

Greets resident by preferred name.

Identifies self to resident.

TALKS WITH RESIDENT WHILE GIVING CARE AS APPROPRIATE.

REMAINS CALM.

Encourages resident to talk about concerns as appropriate.

LISTENS ATTENTIVELY AS RESIDENT SPEAKS.

USES COURTESY WHEN COMMUNICATING.

Informs resident before leaving room.

SKILL #8: MOVING THE HELPLESS RESIDENT TO THE HEAD OF THE BED WITH ONE ASSISTANT (USING DRAW SHEET OR INCONTINENT PAD)
Procedural Guideline #14

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

Lowers the head of the bed as flat as possible if tolerated by resident.

Places pillow against headboard before moving resident, to protect resident's head.

Exhibits proper body mechanics.

Gives directions and coordinates move with assistant.

USING DRAW SHEET OR INCONTINENT PAD, MOVES THE RESIDENT TO THE HEAD OF THE BED, PREVENTING TRAUMA AND AVOIDABLE PAIN.

Leaves resident in a position of comfort, replacing pillow under head, if appropriate.

SKILL #9: ASSISTING RESIDENT TO SIT UP ON SIDE OF BED
Procedural Guideline #15

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Rolls head of bed to upright position.

Exhibits proper body mechanics.

SAFELY SUPPORTS AND TURNS THE RESIDENT, ALLOWING THE LEGS TO GO OVER THE SIDE OF THE BED AS THE TRUNK BECOMES UPRIGHT.

PREVENTS TRAUMA AND AVOIDABLE PAIN TO THE RESIDENT DURING MOVE.

REMAINS WITH RESIDENT WHILE HE/SHE SITS ON SIDE OF BED AS APPROPRIATE.

Leaves resident in a position of comfort.

SKILL #10: ASSISTING THE RESIDENT TO TRANSFER FROM CHAIR TO BED OR BED TO CHAIR
Procedural Guideline #16

Properly cleans hands before procedure as appropriately.

Assembles appropriate equipment before procedure.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

Obtains assistance if needed and exhibits proper body mechanics.

Places chair or wheelchair near the bed if appropriate.

LOCKS WHEELS IF POSSIBLE OR STABILIZES BOTH BED AND WHEELCHAIR.

Assists resident into sitting position and allows resident to rest in sitting position before standing, in indicated.

SAFELY TRANSFERS RESIDENT, SUPPORTING RESIDENT DURING PROCEDURE.

PREVENTS TRAUMA AND AVOIDABLE PAIN TO RESIDENT DURING PROCEDURE.

Leaves resident in a position of comfort.

SKILL #11: ASSISTING THE RESIDENT WITH AMBULATION
Procedural Guideline #17

Note to Nurse Examiner: Select only residents who cannot ambulate independently.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

ASSEMBLES APPROPRIATE EQUIPMENT BEFORE PROCEDURE INCLUDING AMBULATION AIDS SUCH AS CANE, WALKER OR GAIT BELT IF USED BY RESIDENT.

Provides for resident's privacy as appropriate.

INSURES RESIDENTS SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Obtains assistance if needed and exhibits proper body mechanics.

SAFELY ASSISTS RESIDENT TO STANDING POSITION.

Walks slightly behind and to one side of ambulating resident.

SUPPORTS RESIDENT AS NEEDED DURING AMBULATION TO AVOID FALLS AND TRAUMA.

Leaves resident in a position of comfort.

SKILL #12: MAKING THE UNOCCUPIED BED
Procedural Guideline #18

Properly cleans hands before procedure as appropriate.

Assembles appropriate equipment and places it in the appropriate place.

Begins with bed in flat position and elevated to appropriate height if possible. Lowers bed when completed.

REMOVES SOILED LINEN AND PLACES IT IN APPROPRIATE PLACE. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

Avoids shaking and touching linen to uniform as much as possible.

Applies bottom sheet to clean mattress, keeping it straight and centered.

MAKES ALL CLEAN BOTTOM LINEN TIGHT AND FREE OF WRINKLES (UNLESS WATER BED, EGG CRATE OR AIR MATTRESS).

APPLIES TOP LINEN.

Applies clean pillowcase with zippers and/or tags to inside of pillowcase.

Leaves bed completely and neatly made according to facility policy.

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SKILL #13: MAKING THE OCCUPIED BED
Procedural Guideline #19

Note to Nurse Examiner: Select only residents who need side rails or simulate situation for demonstration of this skill.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure and places it in appropriate place.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Begins with the bed in flat position, if tolerated by resident, and elevated to appropriate height if possible.

RAISES SIDE RAIL AND ASSISTS RESIDENT TO ROLL ON SIDE FACING SIDE RAIL.

Rolls or fan folds soiled linen, soiled side inside, to the center of the bed.

Places clean bottom sheet along the center of the bed and rolls or fan folds linen against resident's back and unfolds remaining half.

RAISES THE OPPOSITE SIDE RAIL AND ASSISTS THE RESIDENT TO ROLL OVER THE BOTTOM LINEN, PREVENTING TRAUMA AND AVOIDABLE PAIN TO RESIDENT.

REMOVES SOILED LINEN AND PLACES IN APPROPRIATE PLACE.

Avoids shaking and touching linen to uniform as much as possible.

MAKES ALL CLEAN BOTTOM LINEN TIGHT AND FREE OF WRINKLES (UNLESS WATER BED, EGG CRATE OR AIR MATTRESS).

APPLIES UNSOILED TOP LINEN.

Applies clean pillow case with zippers and/or tags to inside, gently lifting resident's head to replace pillow.

Leaves resident in position of comfort in a neatly made bed.

SKILL #14: TUB OR SHOWER BATH WITH SHAMPOOING THE HAIR
Procedural Guideline #20 & #31

Note to Nurse Examiner: Must select a resident requiring assistance with bathing and, if possible, a shampoo. If shampoo is not given, score check points #8 through #11 "NA". Hair may be shampooed at any point during bath.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Assists resident to undress as needed.

REGULATES TEMPERATURE AND FLOW OF WATER PRIOR TO AND DURING SHOWER OR BATH AND SHAMPOO.

Positions resident to shampoo hair, offering washcloth to protect the eyes.

Directs warm water close to scalp and away from face.

Applies appropriate shampoo, works up lather, and massages into scalp using tips of fingers--not fingernails.

Rinses hair thoroughly and towel dries.

WASHES, RINSES AND DRIES BODY FROM CLEAN TO DIRTY AREAS, LEAVING RESIDENT CLEAN AND DRY.

Reports any deviations from the norm. (Nurse Examiner asks nurse aide for report).

Leaves resident in position of comfort.

SKILL #15: PERINEAL CARE/INCONTINENT CARE - FEMALE WITH OR WITHOUT CATHETER
Procedural Guideline #24

Properly cleans hands before procedure as appropriate.

Explains procedure to resident.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

If indwelling catheter present, holds and supports catheter tubing to one side to avoid traction or unnecessary movement during procedure.

If indwelling catheter present, when cleaning urethral area, gently washes, rinses, and dries the catheter tubing from urethra outward for about three inches of tubing.

If indwelling catheter present, keeps drainage bag below level of bladder.

First separates labia and gently washes, down the center over the urethral area, wiping downward from front to back and stopping at the base of labia.

Then washes, rinses and dries, as appropriate, the remaining perineal area, wiping from front to back and working outward to thighs.

Turns resident on side and appropriately and gently washes, rinses and dries the remaining area including the rectum and buttock without returning to the urethral area.

APPROPRIATELY AND GENTLY WASHES, RINSES AND DRIES FROM CLEAN TO DIRTY AREA LEAVING ENTIRE AREA CLEAN AND DRY.

Removes soiled linen and places in an appropriate place.

Leaves resident in position of comfort.

SKILL #16: PERINEAL CARE/INCONTINENT CARE--MALE WITH OR WITHOUT CATHETER
Procedural Guideline #25

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

If uncircumcised male, retracts foreskin before and replaces foreskin after procedure.

If indwelling catheter present, holds and supports catheter tubing to one side to avoid traction or unnecessary movement during procedure.

If indwelling catheter present, when cleaning urethral area, appropriately and gently washes, rinses and dries the catheter tubing from urethra outward for about 3 inches of tubing.

If indwelling catheter present, keeps drainage bag below level of bladder.

If indwelling catheter present, appropriately and gently washes, rinses and dries the tip of the penis, starting at urethra first and working outward in a circular motion.

Then washes, rinses and dries the entire perineal area including the penis, scrotum and outward to thighs.

Turns resident on side and appropriately and gently washes, rinses and dries the remaining area including the rectum and buttocks without returning to the urethra area.

APPROPRIATELY AND GENTLY WASHES, RINSES AND DRIES FROM CLEAN TO DIRTY AREA LEAVING ENTIRE AREA CLEAN AND DRY.

Removes soiled linen and places in an appropriate place.

Leaves resident in position of comfort.

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SKILL #17: BACK RUB
Procedural Guideline #23

Note to Nurse Examiner: Select only residents without stage I through Stage IV decubitus area on back and sacral area.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY.

Positions resident in bed for massage.

Exposes back and top of buttocks as appropriate.

Nurse aide pours a small amount of lubricant onto own hands and rubs together to warm.

RUBS ENTIRE BACK INCLUDING BUTTOCKS AND COCCYX, GIVING SPECIAL ATTENTION TO BONY PROMINENCES ON BACK, COCCYX AND BUTTOCKS.

Reports any deviation from the norm. (Nurse examiner asks for report).

Leaves resident in position of comfort.

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SKILL #18: BRUSHING THE TEETH
Procedural Guideline #27

Note to Nurse Examiner: Select a resident who uses a toothbrush for cleaning the teeth and needs assistance with this procedure.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

POSITIONS RESIDENT UPRIGHT OR ON SIDE WITH HEAD TURNED WELL TO ONE SIDE AS APPROPRIATE TO AVOID CHOKING OR ASPIRATION.

Drapes the chest as needed to prevent soiling.

Applies or assists/supervises resident in applying toothpaste to toothbrush.

GENTLY AND THOROUGHLY BRUSHES OR ASSISTS/SUPERVISES RESIDENT IN BRUSHING TEETH, INCLUDING THE INNER, OUTER AND CHEWING SURFACES OF ALL UPPER AND LOWER TEETH.

Cleans tongue if appropriate.

Assists or supervises resident in rinsing mouth.

Leaves resident in position of comfort.

Reports all deviations from the norm. (Nurse Examiner asks nurse aide for report)

SKILL #19: DENTURE CARE
Procedural Guideline #28

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL APPROPRIATELY.

Positions resident upright or on side with head turned well to one side as appropriate to avoid choking or aspiration.

Removes or assists/supervises resident in removing dentures from mouth or storage container.

Handles dentures carefully to avoid damage.

THOROUGHLY BRUSHES DENTURES, INCLUDING THE INNER, OUTER AND CHEWING SURFACES OF UPPER AND LOWER DENTURES.

RINSES DENTURES USING CLEAN WATER. (DOES NOT USE HOT WATER)

Assists or supervises resident in cleaning or rinsing mouth.

Replaces or assists/supervises in replacing dentures in resident's mouth or into clean denture cup.

Leaves resident in position of comfort.

Reports all deviations from the norm. (Nurse Examiner asks nurse aide for report)

SKILL #20: MOUTH CARE OF DEPENDENT RESIDENT
Procedural Guideline #29

Note to Nurse Examiner: Select resident who needs assistance with this procedure.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

POSITIONS RESIDENT UPRIGHT OR ON SIDE WITH HEAD TURNED WELL TO ONE SIDE AS APPROPRIATE TO AVOID CHOKING OR ASPIRATION.

Drapes chest/bed as needed to protect from soiling.

Uses applicators or soft toothbrush and cleaning solutions according to facility policy.

GENTLY AND THOROUGHLY CLEANS INSIDE OF MOUTH INCLUDING THE GUMS, TONGUE AND THE INNER, OUTER AND CHEWING SURFACES OF ALL UPPER AND LOWER TEETH.

Leaves resident in position of comfort.

Reports all deviations from the norm. (Nurse Examiner asks nurse aide for report)

SKILL #21: SHAVING THE MALE RESIDENT - SAFETY OR DISPOSABLE RAZOR
Procedural Guideline #32

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Provides adequate lighting.

Drapes chest appropriately to prevent soiling.

Wets face with warm water then appropriately applies shaving soap or cream to bearded area.

ENCOURAGES RESIDENT TO MAKE SKIN TAUT, OR PULLS SKIN TAUT WITH FREE HAND TO AVOID CUTTING FACE.

USES SHORT AND EVEN STROKES UNTIL SHAVED.

Removes excess shaving cream or soap as appropriate.

Leaves resident shaved and in a position of comfort.

SKILL #22: SHAVING THE MALE RESIDENT - ELECTRIC RAZOR
Procedural Guideline #32

Properly cleans hands before procedure, as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Provides adequate lighting.

Encourages resident to make skin taut or pulls skin taut with free hand.

SHAVES WHISKERS USING UP AND DOWN OR CIRCULAR MOTIONS UNTIL SHAVED.

Leaves resident shaved and in a position of comfort.

SKILL #23: HAND AND FINGERNAIL CARE
Procedural Guideline #33

Note to Nurse Examiner: Resident chosen for demonstration of this skill must be one who needs hand and fingernail care and whose care may be done by a nurse aide. Have nurse aide demonstrate skill on one hand only.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Provides adequate lighting.

Immerses nails in comfortably warm water and soaks for at least five (5) minutes. (If resident just completed shower or tub bath no additional soaking is necessary.)

Gently cleans under nails with file, orange stick or nail brush. (Nails may be cleaned as they soak.)

Dries hands thoroughly, being careful to dry between fingers.

Gently pushes cuticle back with towel or orange stick.

CUTS FINGERNAILS STRAIGHT ACROSS OR SLIGHTLY OVAL AND EVEN WITH OR SLIGHTLY ABOVE END OF FINGERS, WITHOUT CAUSING TRAUMA OR AVOIDABLE PAIN.

Smooths rough edges of nails with nail file or emery board, shaping as appropriate.

Leaves resident in position of comfort with fingernails smooth and clean.

SKILL #24: FOOT AND TOENAIL CARE
Procedural Guideline #33

Note to Nurse Examiner: Resident chosen for demonstration of this skill must be one who needs foot and toenail care and whose care may be done by a nurse aide. Have nurse aide demonstrate skill on one foot only.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Provides adequate lighting.

IMMERSES NAILS IN COMFORTABLE WARM WATER AND SOAKS FOR AT LEAST FIVE (5) MINUTES. (IF RESIDENT JUST COMPLETED SHOWER OR TUB BATH, NO ADDITIONAL SOAKING IS NECESSARY)

DRIES FEET THOROUGHLY, BEING CAREFUL TO DRY BETWEEN TOES.

Gently pushes cuticle back with towel or orange stick.

Gently cleans under nails with file, orange stick or nail brush.

CUT TOENAILS STRAIGHT ACROSS AND EVEN WITH OR SLIGHTLY ABOVE END OF TOES WITHOUT CAUSING TRAUMA OR AVOIDABLE PAIN.

Smooths rough edges of nails with nail file or emery board, leaving nails shaped straight across.

Leaves resident in position of comfort with feet and toenails clean and nails smooth.

SKILL #26: ORAL TEMPERATURE/PULSE/RESPIRATIONS
Procedural Guideline #45 & 46

Oral Temperature

Cleans hands appropriately before procedure.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY.

PREPARES THERMOMETER OR FOLLOWS MANUFACTURERS INSTRUCTIONS FOR USE APPROPRIATELY (IF GLASS THERMOMETER, SHAKES DOWN MERCURY TO 96 DEGREES OR BELOW) AND INSERTS CORRECT END OF THERMOMETER INTO RESIDENT'S MOUTH, UNDER TONGUE.

LEAVES THERMOMETER IN PLACE FOR APPROPRIATE LENGTH OF TIME WITH LIPS CLOSED (IF MERCURY THERMOMETER, 3 TO 5 MINUTES, OR FOLLOW MANUFACTURERS INSTRUCTIONS.)

Records the temperature reading. (Examiner should ask nurse aide to do this step.) (Instructions to Nurse Examiner: Read thermometer AFTER nurse aide does and record both readings in the spaces provided).

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS_____

NURSE AIDE'S RECORDED TEMPERATURE VARIES NO MORE THAN 0.2 DEGREES FROM EXAMINER'S RECORDED TEMPERATURE.

Radial Pulse

LOCATES THE RADIAL PULSE BY PLACING TIPS OF FINGERS ON THUMB SIDE OF THE RESIDENT'S WRIST.

COUNTS PULSE FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE (NURSE EXAMINER SHOULD ASK NURSE AIDE LENGTH OF TIME HE/SHE COUNTED).

Records pulse rate. (Nurse Examiner: Check resident's pulse rate, using same wrist, AFTER nurse aide does and record both rates in the spaces provided.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDED PULSE RATE IS WITHIN 10% OF NURSE EXAMINER'S RECORDED RATE.

Respirations

COUNTS AND RECORDS RESIDENT'S RESPIRATIONS FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE. (NURSE EXAMINER SHOULD ASK NURSE AIDE FOR LENGTH OF TIME HE/SHE WILL COUNT AND CHECK RESIDENT'S RESPIRATIONS WHILE NURSE AIDE DOES, RECORDING BOTH RATES IN THE SPACES PROVIDED.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDS RESPIRATORY RATE IS WITHIN 20% OF NURSE EXAMINER'S RECORDED RATE.

Leaves resident in position of comfort.

SKILL #27: AXILLARY TEMPERATURE/PULSE/RESPIRATIONS
Procedural Guideline #45 & #46

Axillary Temperature

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY.

PREPARES THERMOMETER OR FOLLOWS MANUFACTURERS INSTRUCTIONS FOR USE APPROPRIATELY (IF GLASS THERMOMETER, SHAKES DOWN MERCURY TO 96 DEGREES OR BELOW) AND PLACES CORRECT END OF THERMOMETER IN THE HOLLOW OF ARM PIT.

HOLDS THERMOMETER IN PLACE FOR APPROPRIATE LENGTH OF TIME; TEN (10) MINUTES IF MERCURY THERMOMETER OR FOLLOW MANUFACTURERS INSTRUCTIONS, HOLDING RESIDENT'S ARM CLOSE TO HIS/HER BODY.

Records the temperature reading, placing an "Ax" to indicate axillary temperature. (Examiner should ask nurse aide to do this step.) (Instructions to Nurse Examiner: Read thermometer AFTER nurse aide does and record both readings in the spaces provided.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDED TEMPERATURE VARIES NO MORE THAN 0.2 DEGREES FROM EXAMINER'S RECORDED TEMPERATURE.

Radial Pulse

LOCATES THE RADIAL PULSE BY PLACING TIPS OF FINGERS ON THUMB SIDE OF THE RESIDENT'S
WRIST.

COUNTS PULSE FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE (NURSE EXAMINER SHOULD ASK NURSE AIDE LENGTH OF TIME HE/SHE COUNTED).

Records pulse rate. (Nurse Examiner: Check resident's pulse rate, using same wrist, AFTER nurse aide does and record both rates in the spaces provided.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS_____

NURSE AIDE'S RECORDED PULSE RATE IS WITHIN 10% OF NURSE EXAMINER'S RECORDED RATE.

Respirations

COUNTS AND RECORDS RESIDENT'S RESPIRATIONS FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE. (NURSE EXAMINER SHOULD ASK NURSE AIDE FOR LENGTH OF TIME HE/SHE WILL COUNT AND CHECK RESIDENT'S RESPIRATIONS WHILE NURSE AIDE DOES, RECORDING BOTH RATES IN THE SPACES PROVIDED).

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDS RESPIRATORY RATE IS WITHIN 20% OF NURSE EXAMINER'S RECORDED RATE.

Leaves resident in position of comfort.

SKILL #28: RECTAL TEMPERATURE/PULSE/RESPIRATIONS
Procedural Guideline #45 & #46

Rectal Temperature

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY.

PREPARES THERMOMETER OR FOLLOWS MANUFACTURERS INSTRUCTIONS FOR USE APPROPRIATELY (IF GLASS THERMOMETER, SHAKES DOWN MERCURY TO 96 DEGREES OR BELOW). APPLIES SMALL AMOUNT OF LUBRICANT ON BULB OF RECTAL THERMOMETER IF NOT PRELUBRICATED AND GENTLY INSERTS CORRECT END OF THERMOMETER INTO RECTUM APPROXIMATELY 1 TO 1 1/2 INCHES.

HOLDS THERMOMETER IN PLACE FOR APPROPRIATE LENGTH OF TIME; THREE (3) TO FIVE (5) MINUTES IF MERCURY THERMOMETER OR FOLLOW MANUFACTURERS INSTRUCTIONS.

Records the temperature reading, placing an "R" to indicate rectal temperature. (Examiner should ask nurse aide to do this step.) (Instructions to Nurse Examiner: Read thermometer AFTER nurse aide does and record both readings in the spaces provided.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS_____

NURSE AIDE'S RECORDED TEMPERATURE VARIES NO MORE THAN 0.2 DEGREES FROM EXAMINER'S RECORDED TEMPERATURE.

Radial Pulse

LOCATES THE RADIAL PULSE BY PLACING TIPS OF FINGERS ON THUMB SIDE OF THE RESIDENT'S WRIST.

COUNTS PULSE FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE (NURSE EXAMINER SHOULD ASK NURSE AIDE LENGTH OF TIME HE/SHE COUNTED.)

Records pulse rate. (Nurse Examiner: Check resident's pulse rate, using same wrist, AFTER nurse aide does and record both rates in the spaces provided.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDED PULSE RATE IS WITHIN 10% OF NURSE EXAMINER'S RECORDED RATE.

Respirations

COUNTS AND RECORDS RESIDENT'S RESPIRATIONS FOR 30 SECONDS TIMES 2 OR FOR 60 SECONDS, USING A TIMEPIECE. (NURSE EXAMINER SHOULD ASK NURSE AIDE FOR LENGTH OF TIME HE/SHE WILL COUNT AND CHECK RESIDENT'S RESPIRATIONS WHILE NURSE AIDE DOES, RECORDING BOTH RATES IN THE SPACES PROVIDED.)

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE'S RECORDS RESPIRATORY RATE IS WITHIN 20% OF NURSE EXAMINER'S RECORDED RATE.

Leaves resident in position of comfort.

Texas
Nurse Aide Skills Exam

SKILL #29: BLOOD PRESSURE
Procedural Guideline #47

Note to Nurse Examiner: Instruct nurse aide to inflate cuff no more than 3 times to obtain reading. Wait 30 seconds before each reinflation. Use teaching stethoscope if available.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure such as correct sized cuff.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY.

Provides adequate lighting.

Assists resident into a comfortable sitting or recumbent position with forearm relaxed and supported in a palm-up position, approximately at the level of the heart.

Rolls resident's sleeve up about 6 inches above the elbow and applies the cuff around the upper arm just above the elbow.

Cleans earpiece of stethoscope appropriately and places in ears.

LOCATES BRACHIAL ARTERY, PLACES STETHOSCOPE OVER BRACHIAL ARTERY AND HOLDS SNUGLY IN PLACE WITHOUT TOUCHING CUFF, OR FEELS BRACHIAL PULSE WITH FINGERS WHILE INFLATING CUFF.

Tightens valve attached to air bulb.

Quickly pumps air into cuff to about 20mm to 30mm above the point where pulse ceased to be detected. (Places stethoscope over brachial artery now, if not done at step #11.)

Opens valve on air bulb, letting air escape slowly and evenly, while watching gauge and listening for pulse sounds. Notes the systolic pressure (when the first regular sound is heard) and the diastolic pressure (when the pulse changes from a loud beat to a faint murmur, or if no change is heard, until the sound disappears.)

Records the systolic and diastolic blood pressure. (Instructions to Examiner: Ask nurse aide to record blood pressure, then examiner checks blood pressure in same arm and records results. Use teaching stethoscope if available.

NURSE EXAMINER'S RESULTS _____ NURSE AIDE'S RESULTS _____

NURSE AIDE RECORDS BLOOD PRESSURE READING (BOTH SYSTOLIC AND DIASTOLIC) VARIES NO MORE THAN 10MM HG FROM NURSE EXAMINER'S BLOOD PRESSURE MEASUREMENT.

Removes blood pressure cuff and leaves resident in a position of comfort.

SKILL #30: WEIGHT OF AMBULATORY RESIDENT
Procedural Guideline #48

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

ASSURES THAT SCALE IS IN BALANCE BEFORE WEIGHING RESIDENT.

CHECKS THAT RESIDENT IS BALANCED AND CENTERED ON SCALE WITH ARMS AT SIDES AND NOT HOLDING ON TO ANYTHING THAT WOULD ALTER READING OF THE WEIGHT.

Properly adjusts weights until scale is in balance.

Reads weight and reports it to the nurse examiner. (Nurse Examiner: Read weight of resident WHILE the nurse aide does and record both weights in spaces provided.)

NURSE EXAMINER'S READING _____ NURSE AIDE'S READING _____

NURSE AIDE'S RECORDED WEIGHT VARIES NO MORE THAN 2 LBS. FROM NURSE EXAMINER'S READING.

NURSE EXAMINER'S READING _____ NURSE AIDE'S READING _____

Leaves resident in position of comfort.

Texas
Nurse Aide Skills Exam

SKILL #31: RANGE OF MOTION (ROM) EXERCISE FOR RIGHT OR LEFT UPPER EXTREMITY
Procedural Guideline #16

Note to Nurse Examiner: Instruct nurse aide to demonstrate only right or left upper extremity for testing purpose. If skill is discontinued due to pain or discomfort, select another resident to demonstrate this skill. Select only residents who receive preventive maintenance ROM as a part of their nursing plan care. For demonstration of this skill, ROM should be passive.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY, SUCH AS BY STOPPING EXERCISE IMMEDIATELY IF ANY PAIN OR DISCOMFORT OCCURS AND NOTIFYING CHARGE NURSE IF PAIN IS SHARP OR UNEXPECTED. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

Positions resident supine and in good body alignment.

MOVES JOINTS GENTLY, SMOOTHLY AND SLOWLY THROUGH THE RANGE OF MOTION TO THE POINT OF RESISTANCE AS TOLERATED.

(SHOULDER AND ELBOW)

GENTLY SUPPORTS ARM AT ELBOW AND WRIST.

Beginning with arm straight at side, flexes elbow and brings arm over head as far as possible, then returns arm to side of body x3.

Beginning with arm straight at side, moves straight arm out at a right angle to body, then returns straight arm to side x3.

(Optional step) With resident standing or sitting, moves arm slightly behind body, then returns arm to side x3. (If this step is not performed by nurse aide, score NA)

Beginning with arm at side, flexes elbow and moves hand toward shoulder, then straightens arm x3.

With arm flat on bed, turns hand so palm is up, then turns hand so palm is down x3.

(WRIST AND HAND)

GENTLY SUPPORTS WRIST AND HAND.

With palm up, flexes wrist toward shoulder, then extends wrist x3.

Moves hand side to side at wrist toward thumb then toward little finger x3.

Places fingers over resident's fingers and curls resident's fingers to form fist, then straightens resident's fingers out x3.

Touches resident's thumb to each finger x3.

Moves each finger and thumb away from middle finger, then moves each finger and thumb toward middle finger x3.

Leaves resident in a position of comfort.

SKILL #32: RANGE OF MOTION (ROM) EXERCISE FOR RIGHT OR LEFT LOWER EXTREMITY
Procedural Guideline #51

Note to Nurse Examiner: Instruct nurse aide to demonstrate only on right or left lower extremity for testing purposes. If skill is discontinued due to pain or discomfort, select another resident to demonstrate this skill. Select only residents who receive preventive maintenance ROM as part of their nursing plan of care. For demonstration of this skill, ROM should be passive.

Properly clean hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

ENSURES RESIDENT'S SAFETY, SUCH AS STOPPING EXERCISE IMMEDIATELY IF ANY PAIN OR DISCOMFORT OCCURS AND NOTIFYING CHARGE NURSE IF PAIN IS SHARP OR UNEXPECTED. USES INFECTION CONTROL PROCEDURES AS APPROPRIATE.

Positions resident supine and in good body alignment.

MOVES JOINTS GENTLY, SMOOTHLY AND SLOWLY THROUGH THE RANGE OF MOTION TO THE POINT OF RESISTANCE AS TOLERATED.

(HIP AND KNEE)

GENTLY SUPPORTS LEG AT KNEWW AND ANKLE.

Beginning with leg straight, flexes the knee and slowly raises the leg, then straightens the knee and lower the leg x3.

Beginning the leg straight, moves straight leg away from center of body, then moves straight leg back toward center x3.

With leg straight, turns leg inward, then turns leg outward x3.

(ANKLE AND FOOT)

GENTLY SUPPORTS ANKLE AND FOOT.

Moves forefoot in clockwise circles, and counterclockwise circles x3.

Places fingers over resident's toes and curls toes down, then straightens toes x3.

Moves each toe away from the middle toe, then moves each toe toward middle toe x3.

Leaves resident in position of comfort.

SKILL #33: ASSISTING THE TOTALLY DEPENDENT RESIDENT WITH DRESSING, HAIR COMBING AND APPLICATION OF PROSTHETIC DEVICES
Procedural Guideline #34 & 35

Note to Nurse Examiner: Prosthetic devices shall include eyeglasses, hearing aids and dental devices.

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Encourages resident to select his own clothing as appropriate.

GENTLY AND NATURALLY MOVES BODY PARTS, TO AVOID FORCING OR OVEREXTENDING LIMBS, JOINTS OR TO PREVENT TRAUMA AND AVOIDABLE PAIN.

Dresses resident in an organized manner to prevent undue exertion.

Combs resident's hair including back of head, and arranges it according to resident's preference.

Assist resident to put on desired prosthetic device(s) as needed, i.e., eyeglasses, hearing aids, dental devices.

Leaves resident in a position of comfort.

Texas
Nurse Aide Skills Exam

SKILL #34: COMPLETE BED BATH
Procedural Guideline #21

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure and places it in appropriate place.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Checks water for comfortable temperature.

Wets washcloth, applies soap (if resident desires) and supervises/assists resident in washing, rinsing (if soap is used) and drying face, ears and neck.

Supervises/assists resident in washing, rinsing and drying arms and hands, thoroughly drying between fingers.

Supervises/assists resident in washing, rinsing and drying chest and abdomen.

Supervises/assists resident in washing, rinsing and drying legs and feet, thoroughly drying between toes.

Washes, rinses and dries back of neck, back and buttocks.

Change bath water at least prior to washing the perineum and as needed during bath to keep the water warm, clean and free of excess soap.

Supervises/assists resident with properly washing, rinsing and drying perineal area or provides privacy if resident is able to wash perineum without assistance.

WASHES, RINSES AND DRIES FROM CLEAN TO DIRTY AREAS.

Reports all deviations from the norm. (Nurse Examiner asks nurse aide for report)

Leaves resident clean and in a position of comfort.

SKILL #35: FEEDING THE DEPENDENT RESIDENT (OFFERING FOOD AND FLUIDS)
Procedural Guideline #37

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Assembles appropriate equipment before procedure.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

POSITIONS RESIDENT UPRIGHT AT LEAST 45 DEGREES OR ON SIDE TO AVOID CHOKING OR ASPIRATION.

Protects clothing from soiling such as by using napkin or bib.

Washes resident's hands and face before feeding as needed.

Describes the foods being offered.

Assures the safe temperature of food to avoid burns.

Allows resident to feed self as much as possible to increase independence.

Offers fluids after every third or fourth bite.

OFFERS FOOD IN SMALL AMOUNTS AT A REASONABLE RATE, ALLOWING RESIDENT TO CHEW AND SWALLOW.

Wipes resident's hands and face during meal as needed.

Leaves resident clean and in position of comfort.

SKILL #36: TURNING RESIDENT ON HIS SIDE TOWARD YOU
Procedural Guideline #13

Properly cleans hands before procedure as appropriate.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

Exhibits proper body mechanics.

Positions resident to assist in turning.

GENTLY ROLLS RESIDENT ON TO SIDE TOWARD YOU WITHOUT TRAUMA OR AVOIDABLE PAIN.

Leaves resident in position of comfort and in good body alignment, using supports as needed to maintain the side-lying position.

SKILL #37: ASSISTING RESIDENT WITH USE OF BEDPAN
Procedural Guideline #23

Properly cleans hands before procedure as appropriate.

Assembles appropriate equipment.

Explains procedure to resident and encourages resident to participate as appropriate.

Provides for resident's privacy as appropriate.

INSURES RESIDENT'S SAFETY. USES INFECTION CONTROL PROCEDURES APPROPRIATELY.

ADJUSTS CLOTHING AS NECESSARY AND PLACES/ASSISTS RESIDENT ONTO BEDPAN WITHOUT TRAUMA OR AVOIDABLE PAIN.

Elevates head of bed, as appropriate.

Places call signal and tissue in each reach of resident.

Instructs resident to call when finished or if help is needed.

Washes hands and, if appropriate, leaves room.

Returns when needed and lowers head of bed if appropriate.

ASSISTS RESIDENT TO WIPE PERINEUM IF NEEDED, WIPING FROM CLEAN TO DIRTY, OR PROVIDES PERINEAL CARE IF NEEDED.

REMOVES BEDPAN WITHOUT TRAUMA OR AVOIDABLE PAIN.

Empties, cleans and replaces bedpan following facility policy.

Leaves resident in a position of comfort.

PART 4

APPENDIX

APPENDIX A

A. GUIDELINES FOR USING THE TEXAS CURRICULUM FOR NURSE AIDES IN LONG TERM CARE FACILITIES (CURRICULUM)

1. Introduction

The curriculum was first developed in 1988 and revised in 1997 in response to the Omnibus Budget Reconciliation Act of 1987 (OBRA) as amended, the federal regulations at 40 CFR Part 483, and the state rules at 40 TAC Chapter 94. It is important that you read chapter 94 in order to train nurse aides in compliance with the state and federal regulations.

The Curriculum is divided into 3 major parts:

a) Part 1 is the "Course Outline"
b) Part 2 is the "Procedural Guidelines"
c) Part 3 is the "Skills Checklists"

The nurse aide program (including the regulations, curriculum, training and testing) is based on the principle of competency-based education which requires that each graduate attain a minimal level of competency in performing the duties of an entry-level nurse aide.

2. Purpose

The purpose of the curriculum is to:

a) Establish the content to be taught in approved NATCEPs in Texas
b) Provide guidance to NATCEP directors and instructors
c) Promote standardization of NATCEPs in Texas
d) Establish the foundation for the CEP
e) Improve the quality of NATCEP training

To this purpose, the curriculum is written for the NATCEP staff--"to tell the teacher what to teach". All approved NATCEPs in Texas must teach the Texas Curriculum. To obtain NATCEP approval, see item 14 of these guidelines.

3. Authorization for NATCEPs to Reproduce the Curriculum

Although the curriculum is not written for use by nurse aides, instructors may want to use selected parts of the curriculum as instructional handouts. The Texas Department of Aging and Disability Services gives permission for approved NATCEPs in Texas to copy selected parts of the curriculum to distribute to their nurse aide trainees for educational purposes if:

a) The Texas Curriculum for Nurse Aides in Long Term Care Facilities is credited as the source of the material
b) No profit is made on the sale of curriculum materials
c) No charge is made to nurse aide trainees for curriculum materials pursuant to 42 CFR 483.152 (c)

4. Teaching Material (Textbooks, Workbooks, Instructor Guides, Audiovisual Materials)

The department no longer suggests or approves teaching materials for NATCEPs. It is the responsibility of the program to:

a) Select the teaching materials to be used in the NATCEP
b) Assure that the selected materials comply or are adjusted to comply with the Texas Curriculum

5. Course Length and Hours

Section 94.4(g) states that each NATCEP must teach a minimum of 75 clock hours of training, including at least:

a) 51 clock hours of classroom training (defined as classroom and skills training which does not involve direct care of residents by trainees)
b) 24 clock hours of clinical training (defined as hands-on care of residents in a facility by trainees under the direct supervision of a licensed nurse, or be exempt under §94.4(c) of the rules)
c) 75 clock hours of total training (1 clock hour equals 60 minutes and break time cannot be counted as training time)

Section 94.4(h) states that each NATCEP must teach the curriculum established by the department. The breakdown of class hours per Section of the Curriculum is listed below. (Note that the first 16 hours (Section I) are required hours and content that must be taught prior to any direct contact with a resident. The hours for the remaining Sections are suggested by the committee, and can be altered as needed, if the total 51 hours are met.):

Section I	–	Introduction to LTC	16 required hours*
Section II	–	Personal Care Skills	17 suggested hours
Section III	–	Basic Nursing Skills	8 suggested hours
Section IV	–	Restorative Services	4 suggested hours
Section V	–	Mental Health & Social Service Needs	6 suggested hours
		Total Class Hours	51

6. Course Schedules

NATCEP classes should be scheduled to meet the following requirements:

a) The minimum hours specified at item 5 MUST be met. A clock hour is 60 minutes.
b) Section I MUST be completed prior to any direct contact with a resident (see §94.4j).
c) The facility MUST not use an individual as a nurse aide for more than 4 months unless the individual has successfully completed a NATCEP or meets other specified requirements (see §94.3a).
d) Each NATCEP must primarily provide educational and training opportunities for the trainees rather than services to the facility (see §94.4r).

7. Part 1 "COURSE OUTLINE"

Part 1 is the "COURSE OUTLINE" which must be taught by approved NATCEPs in the51 hours of classroom training (defined as classroom and skills training which does not involve direct care of residents by trainees). The "COURSE OUTLINE" includes:

a) "Course Content" (in the left column) is the content which must be taught. Follow the content outline in preparing lesson plans and selecting teaching methods.
b) "Procedural Guidelines" are listed by name and number in the "Course Content" (left column) to indicate when they should be taught (see item #8).
c) "Instructor Notes" (in the right column) are special information and instructions for theteacher.
d) "Student Objectives" (in the right column) are behaviors or competencies that the student will be expected to exhibit by the end of the training. Thus, the objectives should guide the instructional process and student evaluation.

Some re-ordering and re-arranging of the Course Content may be done, starting in 1997with the 2nd Edition of the Curriculum. The first 16 hours of content (Section I) MUST be completed first, as written, prior to contact with a resident. Section II through V may be re-ordered and re-arranged. It is recommended that you keep the Sections or at least the Units intact, re-arranging only the order of Sections II through V and/or an occasional Unit. If you do re-order the content, be careful to assure that you have adequate time to re-order,

all the content is taught and the order of the content promotes effective learning and complies with state and federal requirements.

8. Part 2 "PROCEDURAL GUIDELINES"

Part 2 contains the 54 "PROCEDURAL GUIDELINES" that must be taught in approved NATCEPs. They are listed by name and number in the "Course Content" (left column) of the "COURSE OUTLINE" to indicate when they should be taught. They should be taught as close as possible to their related "Course Content". It is not educationally sound nor in compliance with the rules to teach all Skills Checklists (those not starred on the Performance Record) must be taught and checked off at least in the classroom and/or, as possible, in the skills lab and/or clinical training.

The Procedural Guidelines that are also Skills Checklists (those starred on the Performance Record) must also be taught and checked off in the skills lab and/or the clinical training to assure that trainees are competent to perform the skills and pass the CEP.

After the related course content is taught in the classroom, most Procedural Guidelines are best taught first in a pre-clinical skills lab (using demonstration by teacher and practice/return demonstration by trainee). The advantage is that it makes the most effective use of teaching time by providing an environment more realistic than the classroom and more controlled than the clinical. A pre-clinical skills lab can be as simple as an unoccupied resident unit or a bed and a sink in the classroom with needed supplies. If you cannot get a pre-clinical skills lab, find creative ways to make the best use of classroom nd clinical time for skills training.

After the pre-clinical skills training, ideally the Procedural Guidelines would then be performed in clinical training.

Some additional suggestions for teaching the Procedural Guidelines follow:

a) Use manikins (to protect the privacy and safety of volunteer subjects) when teaching skills e.g. perineal care and rectal temperature in the skills lab.
b) Some Procedural Guidelines are not really manual skills and may best be presented in the classroom and then re-enforced in clinical training e.g. communication, psychosocial skills, observing and reporting. These Procedural Guidelines may be useful as handouts.

Also see the requirements of §94.4(j) listed below at item #9, especially 9c.

9. CLINICAL TRAINING

Each NATCEP MUST teach at least 24 hours of clinical training (defined as hands-on care of residents in a nursing facility by trainees under the direct supervision of a licensed nurse or be exempt under §94.4c). The clinical training provides the opportunity for the trainee to learn to apply the classroom training to the care of residents with the assistance and direct supervision of the instructor.

Section 94.4(j) states that a NATCEP MUST ensure that trainees:

a) Complete at least the first 16 hours of training (Section I of the curriculum) prior to any direct contact with a resident.
b) Do not perform any services for which they have not been trained and found to be proficient by an instructor.
c) Who are performing skills on individuals as part of a NATCEP are under the direct supervision of a licensed nurse.
d) Who are providing services to a resident are under the general supervision of a licensed nurse.
e) Must be clearly identified as a trainee during the clinical training.

In a skills-based program, the clinical training is probably the most important part of the instructor's job, because if the trainee can not use the knowledge and skills, learning did not occur. Make the most of every minute of clinical time and, if possible, obtain additional assistants and/or hours for clinical training. Your job will be much easier if the students have already been checked off on the Procedural Guidelines in a pre-clinical skills lab.

Check the students off during clinical training on as many Procedural Guidelines as possible, focusing on those starred on the Nurse Aide Performance Record (see Appendix B).

Use the Skills Checklist (see item #13) as the criteria for checking the skills performance as Satisfactory (S) or Unsatisfactory (U) in both the skills lab and clinical. They will provide you with objective criteria for evaluating the students' ability to perform skills and pass the skills test and will provide the student with experience in taking a skills test. Use the Procedural Guidelines as the criteria for checking the performance of skills that are not Skills Checklist.

10. Nurse Aide Performance Record

    Section 94.4(l) requires NATCEPs to use the "Nurse Aide Performance Record" developed by the department. A copy of the "Performance Record" and instruction for its use are at Appendix B.

11. Course Grade for Training Programs

    Section 94.4(m)(4) requires that NATCEPs give a final course grade to each trainee indicating "pass" or "fail". For this competency-based training, pass should generally be defined as "competent to function as an entry-level nurse aide" and/or "competent to pass the CEP". A trainee must pass the course in order to be eligible to take the CEP. The course grade is to be part of the NATCEP records.

    Methods for determining the course grade are up to individual programs. Some general suggestions for course grading are:

    a) Determine your grading system ahead of time and put it in writing if possible
    b) Base the grade on performance in the classroom and clinical training
    c) Explain the grading system and the requirements for passing to the students at the start of the class
    d) Keep students informed on how they are doing and how they can improve during the course
    e) Apply the grading system to students without discrimination

12. Part 3 "SKILLS CHECKLISTS"

    Part 3 of the curriculum contains the "Skills Checklists" that were developed from the Procedural Guidelines. They are the checkpoints that will be scored by the Skills Examiner during the Skills Examination (see item #13).

    The Skills Checklists were developed to evaluate skills performance--not as teaching tools. Thus, they should not be used as the sole training material because they do not include some important information and procedures.

    Each trainee should be given a copy of the Skills Checklists to assist them in preparing for the Skills Exam. The Skills Checklists can be very beneficial during the NATCEP to:

    a) Assist the teacher in stressing important points
    b) Assist the students to gain competency in the 37 skills
    c) Prepare the students for the Skills Exam
    d) Evaluate students' performance on the 37 skills

13. Competency Evaluation Program (CEP)
    The NATCEP staff is responsible for scheduling trainees (who passed the course) for the state CEP. Contact NACES 3 to 4 weeks prior to the date you want to be tested by calling (800) 444-5178.

    For additional information on testing, refer to §94.5, the Texas Nurse Aide Testing Program handbook and the testing materials from NACES.
14. Reference Material for NATCEPs
    You may obtain the following program materials by calling (512) 231-5800:

    - Nurse Aide Rules at 40 TAC Chapter 94--Review these rules before starting a NATCEP
    - NATCEP Application--apply and receive program approval before starting a NATCEP
    - Nurse Aide Performance Record
    - Curriculum
    - Skills Checklists
    - Texas Nurse Aide Testing Program handbook

APPENDIX B

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES
REGULATORY SERVICES
NURSE AIDE TRAINING PROGRAM
PO BOX 149030; MAIL CODE E-420
AUSTIN, TX 78714-9030
512-438-20170

TEXAS NURSE AIDE PERFORMANCE RECORD

I. GUIDELINES FOR USE

A. The Texas Nurse Aide Performance Record is a list of the 54 Procedural Guidelines which MUST be taught in approved NATCEPs.

B. At the start of a NATCEP, the instructor must initiate a Nurse Aide Performance Record for each trainee as follows:

1. Copy blank forms as needed

2. Complete the identifying information at top of the form.

3. Explain the use of the Performance Record to trainees

C. During the training program the instructor must:

1. Teach all of the Procedural Guidelines and evaluate the competency of each trainee on each Procedural Guideline in the classroom, skills lab and/or clinical training.

2. Check off each trainee on each Procedural Guideline (on the appropriate column of the Performance Record) by entering "S" for Satisfactory or "U" for Unsatisfactory, the date, and the initials corresponding to the signature.
   a) The Procedural Guidelines that are not Skills Checklists (those not starred on the Performance Record) MUST be taught and checked off at least in the "Classroom" and/or, as possible, in the "Skills Lab" and/or "Clinical".
      (1) Use the Procedural Guidelines as the criteria to determine S or U performance.
   b) The Procedural Guidelines that are also Skills Checklists (those starred on the Performance Record) MUST also be taught and checked off in the "Skills Lab" and/or "Clinical" to assure trainees are competent to perform the skills & pass the test.
      (1) Use the Skills Checklists as the criteria to determine S or U performance

D. At the completion of the training program:

1. Each nurse aide should be checked off as "S" on all of the Procedural Guidelines listed on the Performance Record.

2. The nurse aide should receive a copy of his/her own completed Performance Record.

3. The employer should receive a copy or the trainee's Performance Record if applicable.

4. The NATCEP may wish to retain a copy of Performance Records.

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES
TEXAS NURSE AIDE PERFORMANCE RECORD

Nurse Aide Name (Last, First) _____ **Social Security Number** _____

NATCEP Name & Location _____

Date of Training: ____ | ____ | ____ To ____ | ____ | ____
mm dd yyyy mm dd yyyy

Program Code Number _____

S = Satisfactory Performance
U = Unsatisfactory Performance
***** = Is also a Skills Checklist
Ints = Initials

Place a full signature here to correspond with each set of initials on form.

INITIALS	CORRESPONDING SIGNATURE OF INSTRUCTOR	TITLE

No.	PROCEDURAL GUIDELINES	CLASSROOM			SKILLS LAB			CLINICAL		
		S/U	Date	Ints	S/U	Date	Ints	S/U	Date	Ints
Section I	**INTRODUCTION to LTC**									
	1. Fainting and Syncope									
	2. Falls and Suspected Fractures									
	3. Seizures									
	4. Cold packs to Strains/Bruises									
	5. Vomiting and Aspiration									
	6. Clearing Obstructed Airway									
*	7. Handwashing									
	8. Personal Protective Equipment									
*	9. Standard Precautions									
	Transmission-based Precautions									
*	10. Communication/Interpersonal Skills									
	11. Body Mechanics									
	12. Positioning Residents									

No. PROCEDURAL GUIDELINES	CLASSROOM			SKILLS LAB			CLINICAL		
	S/U	Date	Ints	S/U	Date	Ints	S/U	Date	Ints
Section I INTRODUCTION to LTC									
13. Turning Resident on Side									
* 14. Moving Resident in Bed									
* 15. Assisting to Sit Up on Side of Bed									
* 16. Assisting to Transfer Chair/Wheelchair									
* 17. Ambulation & Ambulation Aids									
* 18. Making the Unoccupied Bed									
* 19. Making the Occupied Bed									
* 20. Tub or Shower Bath									
* 21. Complete Bed Bath									
22. Partial Bath									
* 23. Bedpan and urinal									
* 24. Perineal/Incontinent Care – Female									
* 25. Perineal/Incontinent Care – Male									
* 26. Back Rub									
* 27. Brushing the Teeth									
* 28. Denture Care									
* 29. Special Mouth Care									
* 30. Hair Care									
* 31. Shampooing the Hair									
* 32. Shaving the Resident									
* 33. Hand, Foot & Nail Care									
* 34. Dressing/Undressing the Resident									
35. AM Care/PM Care									
36. Assisting with Meals									
* 37. Feeding the Dependent Resident									
38. Syringe Feeding the Resident									
39. Serving Fresh Drinking Water									
40. Intake and Output (I&O)									
41. Indwelling urinary Catheter									
42. Urine Specimen Collection									

No. PROCEDURAL GUIDELINES	CLASSROOM			SKILLS LAB			CLINICAL		
	S/U	Date	Ints	S/U	Date	Ints	S/U	Date	Ints
Section III BASIC NURSING SKILLS									
43. Stool Specimen Collection									
44. Soft Restraints (Mitt and Vest)									
* 45. Temperature (Oral, Axillary and Rectal)									
* 46. Pulse and Respiration									
* 47. Blood Pressure (BP)									
* 48. Height and Weight									
49. Observing & Reporting Summary									
50. Postmortem Care									
Section IV RESTORATIVE SERVICES									
* 51. Range of Motion (ROM) Exercises									
Section V MENTAL HEALTH/SOCIAL SERVICES NEEDS									
* 52. Assisting with Psychosocial Needs									
53. Assisting with Behavior Problems									
54. Assisting with Cognitive Impairment									

APPENDIX C
Texas Administrative Code

Title 40 **Texas Department of Aging and Disability Services**
Chapter 94 **Nurse Aides**
Rule §94.11 **Registry; Findings; Inquiries**

(a) The Texas Department of Aging and Disability Services (DADS) shall establish and maintain a registry of all individuals who qualify under §94.3(a)(2) of this title (relating to Facility Requirements). Each individual listed on the registry shall keep the department informed of his or her current address and telephone number.

(b) Nurse aide certification expires 24 months after being added to the Nurse Aide Registry or after the last date of verified employment. DADS will remove a Nurse Aide Registry entry for which appropriate employment verification has not been received prior to the expiration date, unless a finding of abuse, neglect, or misappropriation of resident property is on the registry for that individual. To maintain current Nurse Aide Registry status, the following requirements must be met:
(1) Facilities must submit a department form to DADS annually to document all nurse aides who are performing or have performed paid nursing or nursing-related services at the facility during the past year.
(2) A nurse aide must submit a department form to DADS prior to the expiration of his certification to document that the nurse aide has performed paid nursing or nursing-related services, unless the aide knows documentation was submitted by the facility or facilities at which he was employed.

(c) DADS reviews and investigates allegations of abuse, neglect, or misappropriation of resident property by a nurse aide employed in a facility. If there is a finding of an alleged act of abuse, neglect, or misappropriation of a resident property by a nurse aide, prior to entry of a finding on the Nurse Aide Registry, DADS will provide the nurse aide with an opportunity for an informal reconsideration and a hearing as provided in 42 Code of Federal Regulations §488.335.

(d) Informal reconsideration includes:

(1) notice of the facts or conduct alleged to warrant the proposed finding; and
(2) an opportunity to show compliance with all requirements of law for the retention of the certificate by sending the Credentialing Department a written request for an informal reconsideration. The request must:
(A) be received within ten calendar days of the date of receipt of DADS's notice; and
(B) contain specific documentation refuting DADS's allegations.

(e) DADS's review will be limited to a review of documentation submitted by the nurse aide and information DADS used as the basis for its proposed finding and will not be conducted as an adversary hearing. DADS shall give the nurse aide a written affirmation or reversal of the proposed finding. If DADS does not reverse the finding, a notice of adverse action is sent to the nurse aide.

(f) A nurse aide may request a hearing in accordance with Chapter 79, Subchapter Q of this title (relating to Formal Appeals), within 30 days from receipt of DADS's notice of adverse action.
(1) If the nurse aide fails to request a hearing, DADS will enter the finding on the registry.
(2) If the nurse aide or representative fails to appear at the scheduled hearing, the Administrative Law Judge may sustain DADS's finding.
(3) If a hearing is conducted regarding the finding of an alleged act of abuse, neglect, or misappropriation of resident property, the nurse aide will be informed of the final decision within 120 days from the date the request was received by DADS.

(g) If an alleged act of abuse, neglect, or misappropriation of resident property by a nurse aide, who also is a permitted medication aide under Chapter 95 of this title (relating to Medication Aides), violates the rules in this chapter and Chapter 95 of this title, DADS must comply with the(formal hearing procedures as required in subsection (f) of this section. Through the formal hearing, determinations are made on both the certificate of nurse aide practice and the permit for medication aide practice.

(h) DADS will not make a finding that an individual has neglected a resident if the individual demonstrates that the neglect was caused by factors beyond the individual's control.

(i) The registry, the nurse aide, the administrator of the facility where the event occurred, and the administrator of the facility that currently employs the nurse aide, if different from the facility in which the incident occurred, must be notified of the findings.

(j) The registry must include the documented findings involving an individual listed on the registry, as well as any brief statement of the individual disputing the findings.

(k) The information on the registry must be made available to the public.

(l) DADS, in the case of inquiries to the registry, must verify if the individual is listed on the registry and must disclose any information concerning a finding of neglect, abuse or misappropriation of resident property involving an individual listed on the registry. DADS must also disclose any statement by the individual related to the finding or a clear and accurate summary of such a statement.

Source Note: The provisions of this §94.11 adopted to be effective April 1, 1992, 17 TexReg 2262; amended to be effective May 17, 1993, 18 TexReg 2896; transferred effective September 1, 1993, as published in the Texas Register September 3, 1993, 18 TexReg 5885; amended to be effective May 1, 1995, 20 TexReg 2312; amended to be effective October 1, 1995, 20 TexReg 7380; amended to be effective July 1, 1996, 21 TexReg 5337; amended to be effective April 4, 1997, 22 TexReg 2513; amended to be effective August 1, 1998, 23 TexReg 7389.

Title 40 **Texas Department of Aging and Disability Services**
Chapter 94 **Nurse Aides**
Rule §94.12 **Requirements for Recertification**

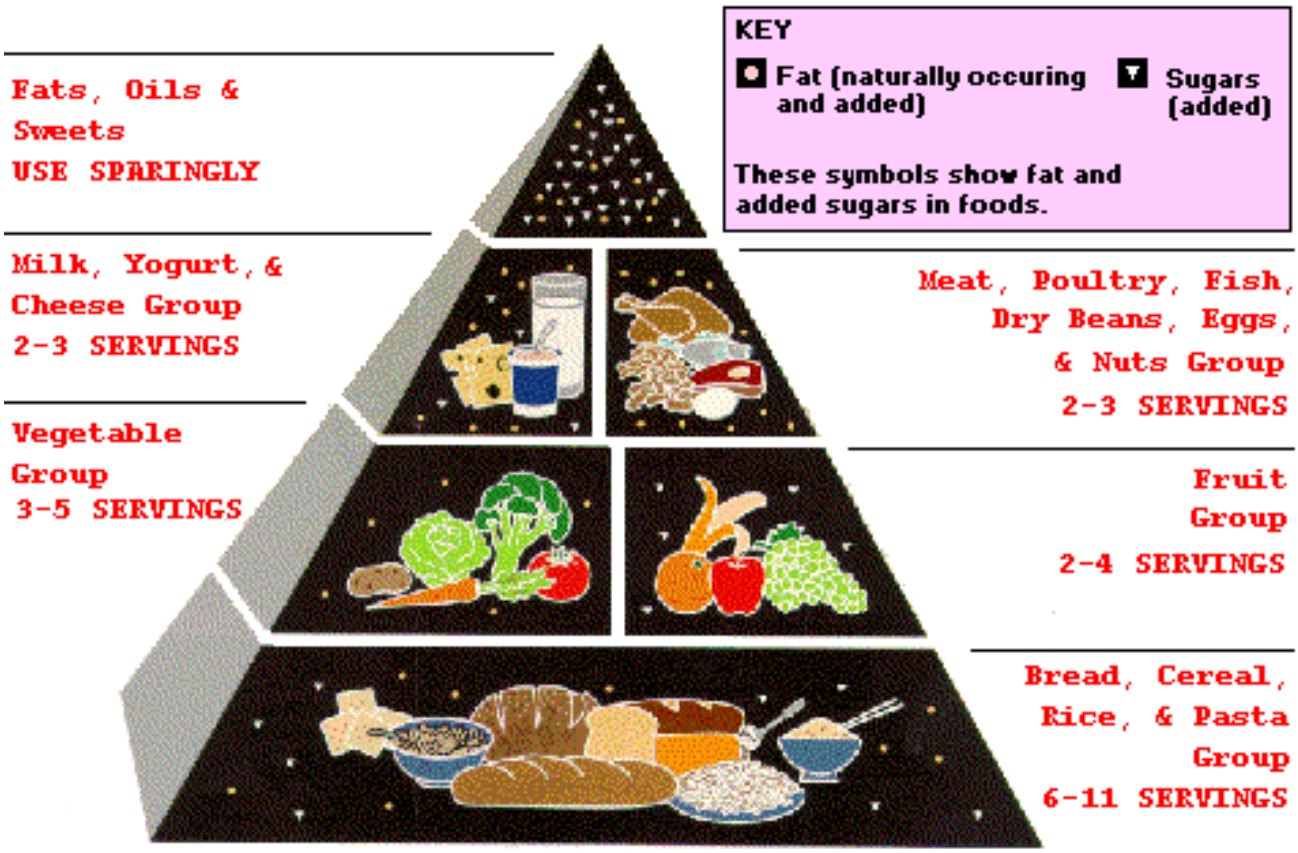
(a) A certified nurse aide who has had 24 consecutive months during which he or she has neither performed nursing or nursing-related services nor has acted as a nurse aide for monetary compensation loses his or her certification and is removed from active status on the Nurse Aide Registry as stated in §94.11(b) of this title (relating to Registry; Findings; Inquiries).

(b) A person for whom subsection (a) of this section applies:
(1) must successfully complete a new competency evaluation program (CEP); or
(2) may, at his or her option, successfully complete a new nurse aide training and competency evaluation program (NATCEP).

(c) A person for whom subsection (a) of this section applies and who complies with subsection (b) of this section will be recertified as a nurse aide and be placed back on the Nurse Aide Registry by the Texas Department of Aging and Disability Services.

Source Note: The provisions of this §94.12 adopted to be effective April 1, 1992, 17 TexReg 2262; transferred effective September 1, 1993, as published in the Texas Register September 3, 1993, 18 TexReg 5885; amended to be effective April 4, 1997, 22 TexReg 2513.

FOOD GUIDE PYRAMID



Source: U.S. Department of Agriculture/U.S. Department of Health and Human Services

GLOSSARY OF TERMS

A.M.	Morning
AD	*acronym:* Alzheimer's Disease
ADL	*acronym:* Activities of Daily Living
AIDS	*acronym:* Acquired Immune Deficiency Syndrome
b.i.d.	*abbreviation:* Latin *bis in die* meaning "twice a day"
BP	*acronym:* Blood Pressure
cc	*abbreviation:* cubic centimeter
CDC	*acronym:* Center for Disease Control
CEP	*acronym:* Competency Evaluation Program
CPR	*abbreviation:* cardiopulmonary resuscitation
CVA	*abbreviation:* cerebrovascular accident – a general term which encompasses such problems as stroke and cerebral hemorrhage.
EMS	*acronym:* Emergency Medical Service
mmHg	*abbreviation for:* millimeters of mercury to measure the partial pressure of a gas (as for measurement of blood pressure).
HIV	*abbreviation:* human immunodeficiency virus
I & O	*acronym:* Intake and Output
IV	*abbreviation:* Within or into a vein.
LTC	*acronym:* Long Term Care
ml	*abbreviation:* measures, milliliter
mm	*abbreviation:* measures, millimeter
MRSA	*acronym:* Methicillin Resistant Staphylococcus Aureus
MSDS	*acronym:* Material Safety Data Sheets
NATCEP	*acronym:* Nurse Aide Training and Competency Evaluation Program
NPO	Do not take anything by mouth.
OBRA	*acronym:* Omnibus Reconciliation Act of 1987
ºF	*abbreviation:* Degrees Fahrenheit
OSHA	*acronym:* Occupational Safety And Health Administration
oz	*abbreviation:* Italian *onza* meaning ounce or ounces (fluid measure)
P	*abbreviation:* Pulse
P.M.	Evening
PPE	*acronym:* Personal Protective Equipment worn by health care workers such as gloves, gowns, masks.
R	*abbreviation:* Respiration

SoB	*abbreviation:* Shortness of Breath
STAT	A common medical abbreviation derived from the latin word *statim* which means immediately. Used to imply "urgent" or "rush."
T	*abbreviation:* Temperature
- AX	*abbreviation:* Temperature taken at the axilla (underarm area).
- R	*abbreviation:* Temperature taken at the rectal area.
TAC	*acronym:* Texas Administrative Code
TB	*abbreviation:* commonly used for tuberculosis
TPR	*acronym:* Temperature/Pulse/Respiration
USDA	*abbreviation:* United States Department of Agriculture
VRE	*acronym:* Vancomycin Resistant Enterococcus