SKILLS BOOK 2018-19

SKILL PROFICIENCY PERFORMANCE LIST GUIDE

UNIT 1 CERTIFICATION

TMU—TEST MASTER UNIVERSE

The TMU is a website provided by the Utah Nursing Assistant Registry. We (ccCNA) will enter your name, phone number, e-mail address, and beginning and ending class dates into the TMU website when you pass our final exam. You will receive a user name and password and can schedule your State Skills and Written tests on the TMU. You can also get the results of your testing and print a certificate.

UNIT 2 INTRODUCTION TO HEALTHCARE

*Demonstrate Beginning and Ending Procedures

*Before each skill tested on:

Greet resident by name
Introduce self by name and title
Perform hand hygiene
Explains procedure to resident

*After each skill tested on:

Performs hand hygiene
Places call light, water and phone within reach

Additional Beginning and Ending Procedures:

BEGINNING PROCEDURES—(WAGIAPEAR)

A. Wash hands thoroughly prior to entering room or when in room
Hand washing: Demonstrating hand washing is necessary and is evaluated as part of the critical criteria
B. Assemble needed equipment
C. Go to the resident's room, knock and pause before entering
D. Introduce self by name and title and identify the resident by facility policies and address them by name.
E. Ask visitors to leave the room and inform them where they may wait
F. Provide privacy throughout procedure; pull curtains, shut door, properly cover patient as needed
G. Explain procedure to resident; speak clearly, slowly and directly to resident, maintaining face to face contact whenever possible and answer resident's questions about the procedure.

H. Allow president to assist as much as possible
I. Raise the bed to a comfortable working height.

ENDING PROCEDURES—(PRLPOCWLRD or PRLSOCWLRD)

A. Position resident comfortably
B. Return bed to lowest position
C. Leave signal cord, telephone and water within reach
D. Perform a general safety check
E. Open curtains
F. Care for equipment following policy
G. Wash hands
H. Let visitors know they may return
I. Report completion of task and observation of any abnormalities
J. Record or document actions and observations.

CRITICAL CRITERIA
Critical criteria include behaviors that are part of EVERY skill you perform
They include:

A. Infection control and standard precautions (following all rules of medical asepsis)
B. Safety (Protecting resident and self from physical harm)
C. Residents' rights (Taking action to prevent or minimize emotional stress to resident)
D. Communication (Explaining procedure to resident prior to initiating it)
E. Recognizing and reporting changes (Observing and reporting abnormalities)

UNIT 3 COMMUNICATION

Demonstrate ability to converse with residents (roll play)

A. Introduce yourself.
B. Call the resident by name.
C. Think about what you want to say. Present the information in a logical, organized way.
D. Speak at a normal pace, and avoid mumbling. Unless the person is hearing impaired, there is no reason to raise your voice.
E. Use words that the person you are speaking to understands.
F. Use simple, non-medical terms.
G. Face the person you are speaking to.
H. Make sure that the person you are speaking to is able to hear. For example, make sure the hearing aid is turned on.
I. LISTEN

Give verbal report (roll play)

CNAs report information to the nurse throughout the shift.

A. Observations that suggest a change in the resident's condition
B. Observations regarding the resident's response to a new treatment or therapy.
C. Resident's Complaints of pain or discomfort
D. Resident's refusal of treatment.
E. A resident's request for clergy
F. Reporting is also done at shift change.
G. The staff members who are just arriving at work are made aware of all the information necessary to ensure a smooth continuation of care for the resident.
H. Be brief and accurate.

Call light positioning

A. The call light must be within the patient's reach when you leave the room
B. It may be attached to the patient's gown or bed linens
C. In the hospital it may be found built into the bed rail.

Hearing aid/eyeglass care

A. Wash hands
B. Inspect ear for excessive wax build up
C. Inspect hearing aid, making sure it is clean and batteries are in place
D. Gently insert tapered ends into ear canal rotating until it fits the curve of the ear
E. Turn on control switch and adjust the volume talking to the person as you increase the volume
F. Stop when the person hears you. Level 2 is usually good.
G. To store hearing aids, remove batteries before putting them in the case
H. clean hearing aids according to manufacturer's instructions (usually with a dry cloth)
I. Do not get the hearing aid wet
J. A spare set of batteries should be available
K. Keep the hearing aid away from heat and moisture
J. Many different types of hearing aids.
K. Remember hearing aids are very expensive. Take good care of them.

A. Keep glasses in case on resident's bed side stand
B. Never use paper towels to clean glasses. Always use a soft cloth or special eye glass wipes.

UNIT 4 INFECTION PREVENTION

Handwashing

***SKILL #1 P. 3 HANDWASHING**

Wet hands thoroughly with warm water
Apply soap to hands
Wash hands for at least **20 seconds**
Rub hands together lathering all surfaces of hands/fingers
Lather surfaces of wrists
Clean fingernails by rubbing them in the palm of the other hand
Rinses hands/wrists with fingers pointing downward
Dry hands/wrists with clean paper towel
Do not touch clean hands to sink or faucet
Immediately discard paper towel into trash can without touching the other hand

Hand Sanitizer

Washing hands with soap and water is the best way to reduce the number of microbes on them in most situations. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol.
When using hand sanitizer, apply the product to the palm of one hand (read the label to learn the correct amount) and rub the product all over the surfaces of your hands until your hands are dry.
Alcohol-based hand sanitizers can quickly reduce the number of microbes on hands in some situations, but sanitizers do not eliminate all types of pathogens
Hand sanitizers may not be as effective when hands are visibly dirty or greasy.

Gloving (don, doff)

Don gloves-put them on

Remove gloves

A. Grasp the other glove at the palm and pull the glove off the hand with one gloved hand. Keep the removed glove in the gloved hand.
B. Slip two fingers from the ungloved hand underneath the cuff of the remaining glove at the wrist. Remove that glove from your hand, turning it inside-out as you pull it off
C. Dispose of the soiled gloves in a facility-approved waste container
D. Wash your hands

Putting on and removing personal protective equipment (gown, gloves, mask)

***SKILL #10 P. 7 CONTACT PRECAUTIONS, GOWN AND GLOVE**

Don gown, mask, (goggles if necessary) then gloves

Unfold gown
Don gown
Secure neck opening
Secure back opening
Put on mask then goggles
Don gloves overlapping gown sleeves

Remove gloves, goggles if worn, gown, then mask
Removes gloves before removing gown
Grasp one glove at palm of one hand then pull off
With ungloved hand slip two fingers or thumb underneath cuff of remaining glove at wrist
Pull down and turn glove inside out
Dispose of gloves in trash can
Remove goggles if worn
Unfasten gown at neck
Unfasten gown at waist
Remove gown by rolling dirty side in
Dispose of gown in trash can
Remove mask
Perform hand hygiene

UNIT 5 BASIC SAFETY & EMERGENCIES

Abdominal thrust/Heimlich Maneuver

1. ASK THE RESIDENT, "ARE YOU CHOKING?"
2. "CALL FOR HELP."
3. STAND BEHIND THE RESIDENT AND WRAPS ARMS AROUND THE RESIDENT'S WAIST
4. PLACE THE THUMB SIDE OF THE FIST AGAINST THE RESIDENT'S ABDOMEN
5. POSITIONSFIRST SLIGHTLY ABOVE NAVEL
6. GRASP FIST WITH OTHER HAND, SIMULATES PRESSING FIST AND HAND INTO RESIDENT'S ABDOMEN
7. USE AN INWARD, UPWARD THRUST
8. CONTINUE UNTIL SUCCESSFUL OR UNTIL THE VICTIM LOSES CONSCIOUSNESS OR UNTIL SOMEONE TAKES OVER.

UNIT 6 POSITIONING & AMBULATION

Moving and Positioning

*SKILL #21 p. 11 POSITION LATERAL

A. Lateral

a. Lying on side. The lower leg is straight, and the upper leg is bent at the knee. Pillows are placed under the head, lengthwise between the legs, and under the upper arm

i. Left lateral—left side

ii. Right lateral—right

iii. Semi-side lying—pillows are placed along the person's back and hip or along the front of the body so that the person lies either a little more forward or a little more toward the back.

B. Supine

a. Lying on back. The bed is flat with a pillow under the head. Pillows may also be placed under the arms and hands, under the knees, or under the lower back

C. Prone

a. Lying on abdomen with the head turned to one side. The arms are bent at the elbows, and the hands are placed on either side of the head palms facing down. Small pillows are placed under the head, under the lower abdomen and pelvis and/or under the person's lower legs

D. Semi prone/Sims/Enema

a. Lying on the side, almost prone. The head is turned to one side. The knee on that side is bent sharply and supported by a pillow. The corresponding arm is bent at the elbow with the hand in front of the face. The lower leg is straight and the lower arm extends out from the side with the palm turning upward.

D. Fowlers (this is a sitting position)

a. Lying on back, head elevated. A pillow is placed under the head. Pillows may also be placed under the arms and hands, and under the knees (or the knee gatch may be bent.)

Semi-Fowlers

b. Lying on back. Head elevated to 30-45 degrees

High-Fowlers

c. Lying on back. Head elevated 60-90 degrees

Assisting to move to the head of the bed

Up in bed

A. If the resident is able to assist with the move, encourage him or her to do so.
B. Place the resident's pillow upright on the headboard to protect the resident's head from injury
C. Stand next to the bed with your feet about 12 inches apart. The foot that is closer to the head of the bed should be pointed in that direction
D. Place a hand under the resident's shoulders and one under the buttocks
E. Ask the resident to bend the knees and brace his or her feet firmly against the mattress
F. On the count of "three" have the resident move toward the head of the bed with feet as you support and move the resident. Remember to keep your back straight and knees bent.

Assisting to move to the head of bed using draw sheet/lift/transfer sheet

Draw Sheet

1. Lays bed flat
2. Uses 2 people
3. Rolls draw sheet for gripping
4. Grasps the rolled draw sheet near resident's shoulders and hips
5. On the count of "3" lifts and moves resident up toward top of bed
6. Maintains proper alignment of resident's body

Moving a resident to one side of the bed

SKILL #21 P. 11 POSITION LATERAL

Assist to the edge of bed

A. Stand at the side of the bed with your feet spread about 12 inches apart
B. Gently slide your hands under the person's head and shoulders and move the person's upper body toward you
C. Gently slide your hands under the person's torso and move the person's torso toward you
D. Gently slide your hands under the person's hips and legs and move the person's lower body toward you
E. A turn sheet or draw sheet may be used

Turning a resident away from you

Turning a resident toward you

To the side of the bed, away and toward

A. Assist patient to the side of the bed nearest you (in segments starting at the upper body or you may use a draw or turn sheet)
B. Cross the person's arm that is nearest you over the person's chest
C. Bend the person's leg that is nearest you, placing the foot on the bed, or cross the person's leg that is nearest to you over his or her other leg

a. To roll away from you: Place one of your hands on the person's shoulder that is nearest you, and place your other hand on the person's hip that is nearest you. Gently roll the person away from you, toward the opposite side of the bed.
b. To roll toward you: Place one hand on the person's shoulder that is farthest away from you, and place your other hand on the person's hip that is farthest away from you. Gently roll toward you.
c. A draw sheet or turn sheet may be used.

Logrolling a Resident

***SKILL #17 P. 9 POSITION: LOG ROLL USING DRAW SHEET**

LOG ROLLING RESIDENT WITH HIP FRACTURE PRECAUTIONS

1. Lower the head of the bed to the flattest possible position
2. Raise side rail on the non-working side
3. Place the abduction splint or pillows between the legs
4. Use at least 2 people to perform the log roll (***on same side of the bed***)
5. Rolls on the count of "3"
6. Roll the resident in one single movement
7. The residents head, spine and legs must remain aligned during the turn
8. Do not roll the resident onto the injured side

Assist to edge of bed to dangle

Help patient to sit on the edge of the bed until they do not feel dizzy.

Proper use of the gait belt (used whenever assisting to ambulate or transfer)

***SKILL #5 P. 4 AMBULATE USING GAIT BELT**

Put the belt around the resident's waist over clothing with the buckle in the front. Be sur the belt is snug with just enough room to get your fingers under it. Use an underhand grasp.

Assist to ambulate, including resident with an affected side

ASSISTING TO AMBULATE

1. Check that the bed wheels are locked
2. Lower the bed until resident's feet touch the ground
3. Make sure resident has footwear with non-skid soles
4. Sit resident up on the side of the bed allowing resident to adjust to the upright position
5. Apply the gait belt properly around the resident's waist
6. Assist the resident to stand while holding the gait belt
7. Grasp the gait belt at each side, not the front
8. Do not allow the resident to hold onto their neck while transferring
9. Maintain own body mechanics while assisting the resident to stand
10. Walk slightly behind the resident on the resident's weak side
11. Remove the gait belt

Assist to ambulate a visually impaired resident

Allow the blind person to hold onto your arm or elbow

Assist to ambulate with a cane

ASSISTING TO AMBULATE WITH A CANE

1. Check that bed wheels are locked
2. Lower the bed until resident's feet touch the ground
3. Make sure resident has footwear with non-skid soles
4. Sit resident up on the side of the bed allowing resident to adjust to the upright position
5. Apply the gait belt properly around the resident's waist
6. Give resident cane to use on his/her strong side before ambulating (cane can be given before or after assisting resident to stand)
7. Assist the resident to stand while holding the gait belt
8. Grasp the gait belt at each side, not the front
9. Do not allow the resident to hold onto their neck while transferring
10. Maintain own body mechanics while assisting the resident to stand
11. Walk at the residents weak side or slightly behind on the weak side
12. Make sure that resident uses the cane on the strong side
13. Remove the gait belt without harming the resident

Assist to ambulate with a walker

***SKILL #6 P. 5 AMBULATE WITH WALKER USING GAIT BELT**

ASSISTING TO AMBULATE WITH A WALKER

1. Check that bed wheels are locked
2. Lower the bed until resident's feet touch the ground
3. Makes sure resident has footwear with non-skid soles
4. Sits resident up on the side of the bed allowing resident to adjust to the upright position
5. Apply the gait belt properly around the resident's waist
6. Assist the resident to stand while holding the gait belt
7. Grasp the gait belt at each side, not the front
8. Do not allow the resident to hold onto their neck while transferring
9. Maintain your own body mechanics while assisting the resident to stand
10. Place the walker in front of the resident
11. Walk slightly behind the resident on the resident's weak side
12. Removes the gait belt

Pivot transfer from bed to wheelchair and wheelchair to bed (including resident with an affected side)

***SKILL #22 P. 11 PIVOT TRANSFER: BED TO WHEELCHAIR USING GAIT BELT**

PIVOT TRANSFER FROM A BED TO A WHEELCHAIR/Demonstrating proper use of a gait belt

1. Check that the bed wheels are locked.
2. Lower the bed until resident's feet touch the ground
3. Assist the resident to sit up on the side of the bed, allowing the resident to adjust to the upright position
4. Make sure resident has footwear with non-skid soles
5. Position the wheelchair close to the side of the bed on the resident's strong side
6. Lock the wheelchair brakes
7. Apply a gait belt properly around the resident's waist
8. Assist the resident to stand while holding the gait belt at each side, not in the front
9. Do not allow the resident to hold around their neck while transferring
10. Maintain your own body mechanics while assisting the resident to standing
11. Transfer resident to the chair by pivoting toward the strong side and into the wheelchair
12. "How do you properly position the resident in the wheelchair?" Answer: Back erect with the back and buttocks against the back of the chair and feet flat on the floor and hips against the back of the seat."
13. Remove the gait belt

Proper wheelchair/geriatric chair positioning

Resident should be positioned in chair with hips against the back of seat

Pressure ulcer prevention

A. Four ways to prevent pressure ulcers.
    a. Proper use of bed cradle
    Footboards are padded boards placed against the resident's feet to keep them properly aligned and to prevent foot drop.
    Bed Cradles are devices used to keep the bed covers from pushing down on a resident's feet.

    b. Elbow/heel protector

    c. Using pillows to reduce skin to skin contact
        i. Use pillows to float heels off of the bed
        ii. Place pillow under arm to cushion elbow
        iii. Place pillow between the legs to prevent skin to skin contact

    d. Making sure sheets are wrinkle free

B. Ways to prevent pressure ulcers.
   a. Changing position frequently—every 2 hours
   b. Good nutrition and hydration
   c. Provide good perineal care (keep resident clean and dry)
   d. Be careful of the resident's skin (no shearing or friction)
   e. Check resident's skin carefully, provide good skin care
   f. Assist your resident to the bathroom frequently
   g. Encourage mobility
   h. Use pressure reducing devices

Assisting a falling resident

A. If the person complains of dizziness or seems unsteady; help him to sit in a chair. If a chair is not close by, help the person to sit on the floor. Stay with the person and call for assistance. This action can prevent a fall completely.
B. If a fall cannot be avoided, place your body behind the person and place your arms around his torso, pulling him close to your body. Do not grab the person's arms in an attempt to stop the fall
C. With the person's body pulled close to yours, widen your base of support by placing one foot behind the other, and allow the person to slide down your body toward the floor
D. As the person slides down, squat while still supporting his body and gently lower him to the floor. Lower yourself to the floor and assume a sitting position with the person's head in your lap.

UNIT 7 RESIDENT ENVIRONMENT

Bed making

Occupied bed making

a. Place clean linen on clean surface within reach (chair or over the bed table)
b. Provide privacy throughout the procedure
c. Lower head of bed, placing patient in supine position
d. Loosen top linen from end of bed or working side. Unfold bath blanket over the top sheet to cover resident. Remove top sheet.
e. You will make the bed on one side of the bed at a time. After raising side rail on far side of the bed, assist resident to turn onto side, moving toward raised side rail
f. Loosen bottom sheet and other soiled linen on working side
g. Roll soiled bottom linens toward patient. Tuck it in snugly against the resident's back. Rolling puts dirtiest surface of linen inward, lessening contamination. The closer the linen is rolled to resident, the easier it is to remove from the other side.
h. Place and tuck in clean, bottom linen (fitted sheet and draw sheet). Make sure the linen is wrinkle free.
i. Raise side rail nearest you and assist resident to turn onto clean bottom sheet

j. Remove soiled bottom linen rolling from head to foot of bed, avoiding contact with clothes, and place in appropriate location within room—never on the floor
k. Pull and tuck in bottom linens, just like the other side with the sheets free of wrinkles
l. Ask resident to turn onto back. Help as needed. Keep resident covered and comfortable, with a pillow under the head.
m. Unfold the top sheet. Place it over the resident. Ask the resident to hold the tope sheet. Slip the bath blanket out from underneath. Put it in a hamper.
n. Place a blank over the top sheet. March the top edges. Tuck the bottom edges of top sheet and blanket under the bottom of the mattress. Make hospital corners on each side. (Mitered corners). Loosen the top linens over the resident's feet (toe tuck). At the top of the bed, fold the top sheet over the blanket about 6 inches.
o. Remove pillow and change the soiled pillowcase. Replace pillow.
p. Make sure bed is in the lowest level.

Occupied draw sheet change

***SKILL # 20 P. 10 OCCUPIED DRAW SHEET CHANGE**

1. Put on gloves
2. Places clean draw sheet on clean surface within reach (chair, over-the-bed table)
3. Raises side rail on non-working side
4. Raises bed to a comfortable working height
5. Lowers the head of the bed and places the resident in a supine position
6. Assists the resident to their side moving them toward the raised bed rail
7. Loosens draw sheet and rolls the soiled draw sheet toward the resident
8. Places the clean draw sheet on the working side (this must be done before turning the resident)
9. Turns the resident onto the clean draw sheet
10. Removes the soiled linens and draw sheet
11. Places soiled linen in the linen basket
12. Does not put soiled linen on the floor
13. Pulls and tucks in the clean draw sheet on both sides
14. Finishes with a sheet that is free of wrinkles
15. Side rail on whichever side the student is not working is up when the bed is elevated
16. Removes gloves
17. Performs hand hygiene

Call light placement

A. The call light must be within the patient's reach when you leave the room
B. It may be attached to the patient's gown or bed linens
C. In the hospital it may be found built into the bed rail.

Height: standing and supine

HEIGHT STANDING

A. Assist resident to stand on scale
B. Resident is balanced and centered on the scale with arms at side
C. Raise folded measuring bar above resident's head, open and lower gently until bar rests on the top of the head (not hair)
D. Accurately record height

Height Supine

A. Body extended, bed flat, and pillow removed
B. Mark sheet at top of head and bottom of foot (not toes) - then measure the distance between the marks on the sheet, not over patient body

Weight: standing and wheelchair

A. Move weights to zero before assisting resident on to scale
B. Assist resident to stand on scale if needed
C. Ensure resident is balanced and centered on the scale with arms at side

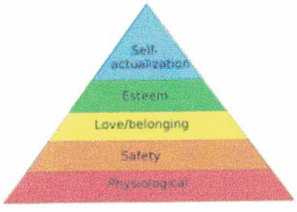
Accurately record weight within+/-0.25 lbs. of nurse's measurement

Wheelchair Scale

You must subtract the weight of the wheelchair

UNIT 8 BASIC HUMAN NEEDS

Maslow Hierarchy of Needs



1. Physiological needs must be met first 2. Safety Needs 3. Love/belonging needs 4. Self esteem needs 5. Self-actualization needs

UNIT 9 VITAL SIGNS

Reading electronic and digital thermometers

Tympanic: (97-99.6)

1. Place tympanic thermometer cover on
2. Ask person to turn his head so ear is in front of you, put new probe cover on
3. Pull back on the ear (gentle, firm) to straighten the ear canal and insert probe gently into ear canal directed toward nose
4. Start thermometer
5. Wait until you hear a beep or flashing light and remove
6. **Read the temperature and record accurately.**

B. Oral (97-99.6)/Axillary (96-98.6) using the electronic thermometer

Don gloves

1. Ask the person if they have eaten or consumed a beverage, cold or hot or smoked within the last 15 minutes.
2. Place a sheath on the probe
3. Correct placement for obtaining oral reading or axillary reading
4. If necessary, hold the probe in place for oral
5. Leave the probe in place until the instrument beeps
6. Remove the probe sheath from the probe and dispose of properly
7. Replace the probe
8. Read the temperature and record accurately.

A. Temporal Thermometer
   a. Slide straight across forehead. Place probe on center of forehead, depress button and keep depressed until temp is complete. Slide probe in a straight line across forehead to the hairline. Touch the soft depression behind the ear.

B. Rectal temperature (98-100.6 R) you will not be tested on rectal temperatures
   a. Use specific thermometer for rectal use (red cord for electronic)
   b. Place cover on thermometer
   c. Lubricate thermometer
   d. Wear gloves
   e. Ask patient to lie on his side away from you (Sim's or lateral)
   f. Expose buttocks
   g. Raise upper buttock to expose the anus
   h. Gently insert the lubricated end of the thermometer into the person's rectum not more than 1 inch for adults, or ½ inch for children. Never force the thermometer into the rectum
   i. Remove the thermometer from the person's rectum
   j. Wipe the person's anal area with a tissue to remove the lubricant and adjust the person's gown or pajama bottoms to cover the buttocks
   k. Read the thermometer
   l. Remove your gloves

Measuring and documenting oral, temporal and tympanic temperatures

Measuring and documenting radial and apical pulses (within 4)

***SKILL #3 P. 4 PULSE**

Radial pulse

A. Supplies needed: Watch with a second hand
B. Locate pulse at the radial site
C. Use 2 or 3 fingers not the thumb
D. Count pulse for 30 seconds and double or count for 1 full minute.
E. Note strength and regularity
F. If irregular count for one full minute
G. Document accurately

Apical pulse

A. Supplies needed: Stethoscope and a watch with a second hand
B. Clean the earpieces and diaphragm of the stethoscope with an alcohol wipe
C. Listen over the apex (lower tip) of the heart with a stethoscope 2-3 inches left of the sternum at the nipple line under the clothing (clothing will distort sound).
D. Use two fingers to hold the stethoscope firmly against the skin
E. Count heartbeat for 0 seconds. Each time the heart beats, you will hear two sounds "lubb" and a "dubb". Both sounds make a heartbeat.
F. Document accurately

Measuring and documenting respirations

***SKILL #3 P. 4 RESPIRATION**

A. Count respirations for 30 seconds and double or count for 1 full minute Accuracy with + or – 2 breaths
B. Look at the patient's chest or abdomen, or place hand on shoulder
C. Do not tell the patient you are counting the respirations
D. Records the respirations on the recording form

Measuring and documenting blood pressure 1 step method

***SKILL #2 P. 3 VITAL SIGN: BLOOD PRESSURE**

Learning blood pressure takes time and practice. First learn to operate the equipment and control rate. Then learn to be familiar with the sounds, recognizing beginning and ending sounds.

1. Clean ear pieces and diaphragm with antiseptic wipe

2. Position resident's arm resting on firm surface with palm up
3. Wrap cuff around arm with bladder over artery 1" above antecubital space—cuff even and snug
4. Place ear pieces in ears (directed forward towards eardrum) and place the diaphragm over artery
5. Inflate cuff to no more than 180mm/Hg or may use pulse obliteration method, candidate choice
6. Deflate cuff, note systolic reading, and note point of diastolic reading
7. Accurate reading within 10 mmHg window on both systolic & diastolic
8. **Accurately record blood pressure on recording form**

Measuring and documenting blood pressure 2 step method or pulse obliteration method

A. Locate Brachial artery

B. Place B/P cuff over upper arm with arrow pointing toward brachial artery 1-2 inches above inside of elbow. Patient's palm should be up.

C. Determine palpated systolic pressure by feeling the radial artery and pumping cuff until the pulse is no longer felt. This is an estimate of the systolic B/P.

D. Release the valve to 0.

E. Pump cuff to 30 mm Hg above the last felt pulse

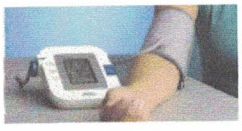
F. Place stethoscope over the brachial artery

G. Slowly release valve until pulse is heard (this is the systolic B/P)

H. Listen to the pulse until you no longer hear a pulse (this is the diastolic B/P)

I. Open valve to release air in cuff

Measuring and documenting blood pressure with electronic BP machine

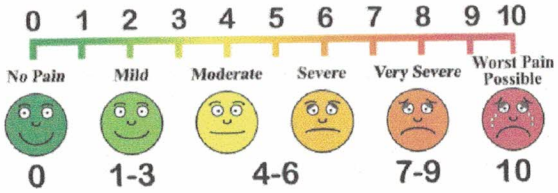


Place cuff correctly on the upper arm. Push start button.

Measuring and documenting oxygen saturation and pulse using a pulse oximeter

Place oximeter on finger. Read O2 saturation and pulse. Should be above 90%

Observing resident for signs of pain and asking questions when a resident reports pain; numerical and faces pain scale



Cold pack application and monitoring

1. Cover cold compress with towel or other protective cover (compress should not be placed on bare skin without covering)
2. Properly place on correct site as directed by skills examiner (left knee)
3. "When would you check resident's skin after placing the compress?" Answer: After 5 minutes.
4. "What would you be looking for? Answer: Redness, swelling irritation or pain.

Application of anti-embolism stockings

***SKILL #4 P. 4 ANTI-EMBOLISM STOCKINGS**

1. "What position should the resident be in when applying the stocking?" Answer: "When the resident is in bed or the leg is elevated."
2. Smooths the stocking up and over the leg so the hose is even, snug, and not twisted or wrinkled
3. Assures that the heel and toe are in the proper location
4. The toe hole may be on the top, or bottom of toes depending on the design

UNIT 10 HYGIENE AND GROOMING

Complete Bed Bath/Partial Bed Bath

A. Assist resident in removing clothing, only as necessary, exposing only the area being washed. Provide privacy and remember dignity
   a. Partial: face, hands, axilla (underarms), back, buttocks and perineal area
   b. Complete: Partial, plus trunk and extremities
   c. Using washcloth, wash front to back/ clean to dirty
   d. Rinse and gently dry each area thoroughly after washing

Tub Bath/Shower (demo and discussion)

A. Patients who are able to get out of bed to bathe will take a shower or a tub bath
B. Non-skid mats should be used
C. Use a shower chair if the resident is weak or unsteady. Lock the wheels on the shower chair
D. Check water temperature and keep the patient warm
E. Facility bath tubs often have special modifications that make it easier for the person to get into and out of the tub safely
F. Assist clean to dirty areas
G. Rinse the skin thoroughly
H. Gently pat the skin dry

Back rub

1. Place the resident into a sitting, lateral, or prone position
2. Pour lotion into hands. Pretends to rub hands together to warm lotion
3. Use gentle pressure using both hands
4. Use long firm strokes
5. Performs backrub 3 to 5 minutes
6. Assesses condition of skin while preforming backrub
7. "What would you do if redness or skin breakdown is observed? Answer: "Do not rub the reddened area."
8. Reports any redness or breakdown immediately to the nurse

Perineal care; male and female

MALE PERI-CARE

A. Don gloves
B. Assist the resident in removing their clothing, only as necessary and exposing only the area being washed
C. Obtain no-rinse perineal wipes
D. Cleanse the penis from tip to base (clean to dirty)
E. Repeat until the area is clean using a different part of the wipe for each stroke. Obtain clean wipes as they become soiled
F. If the male resident is uncircumcised retract the foreskin bny gently pushing the skin toward the base of the penis and clean as directed above. Replace the foreskin after drying the area as needed
G. Turn the resident onto their side
H. Clean the anal area from front to back
I. Apply moisturizers or moisture barrier products as ordered

FEMALE PERI-CARE

A. Don gloves
B. Assist the resident in removing their clothing, only as necessary and exposing only the area being washed
C. Place waterproof pad under the resident

D. Obtain no-rinse perineal wipes
E. Separate the labia and clean inside the labia in a downward motion from front to back (clean to dirty)
F. Wash the outside of the labia from front to back starting outside the labia and then going to the inside of the thighs
G. Repeat until the area is clean using a different part of the wipe for each stroke. Obtain clean wipes as they become soiled.
H. Turn the resident onto their side
I. Clean the anal area from front to back
J. Apply moisturizers or moisture barrier products as ordered
K. Remove gloves and wash hands
L. Re-dress the resident

Haircare/shampoo; bed, sink, dry shampoo, shower cap

Combing—should be performed daily
a. Long tangled hair should be combed from the ends up, holding onto the roots to prevent pulling
B. Shampooing
a. Hair should be shampooed at least once a week
b. May be done in the shower, or in bed.
c. There are also disposable shampoo caps with no rinse shampoo in some facilities.

Oral Care

Dentures

***SKILL #11 P. 7 DENTURE CARE**

1. Put on gloves
2. Line the bottom of the sink with a towel or washcloth or fills sink with water
3. "What temperature of water should be used for cleaning the dentures?" Answer: "Warm or luke-warm is acceptable."
4. Brushe the dentures under running water with a toothbrush and paste that has been provided
5. Place the dentures in denture cup with water, adding a cleaning tabling tablet if available and covers with a lid and allows them to soak
6. Remove gloves
7. Perform hand hygiene.

Natural teeth

Conscious resident

***SKILL #18 P. 10 MOUTH CARE CONSCIOUS, BRUSHING TEETH**

A. Conscious Patient—Teeth should be brushed twice a day. In the morning and at bedtime.

a. Prepare toothbrush with toothpaste
b. Clean all tooth surfaces in an up and down/circular motion paying special attention to gum lines
c. Allow resident to expectorate into appropriate container
d. Assist resident to rinse mouth, wiping lips and mouth
e. Moisturize lips
f. Report abnormalities such as bleeding gums

Unconscious resident-aspiration precautions

SKILL #19 P. 10 MOUTH CARE, UNCONSCIOUS

1. Don gloves
2. Places a towel under the resident's head
3. Positions resident supine with head to the side or side lying or with HOB elevated and head turned to the side
4. Wets sponge gently into resident's mouth
5. Rotates sponge against all surfaces of mouth
6. Does not use toothbrush or toothpaste
7. Removes gloves
8. Performs hand hygiene
9. "How often is oral care performed on an unconscious resident? Answer: "Every 2 hours."
10. "What would you do if you found any abnormalities?" Answer: "Tell the nurse.

Shaving/electric and safety razor

SHAVING WITH RAZOR BLADE

1. Puts on gloves
2. Place a towel to protect the residents clothing
3. Soften the beard with a warm washcloth
4. Applies shaving cream liberally
5. Uses short razor strokes in the direction the hair is growing
6. "What would you do if your resident has many wrinkles on his face?" Answer: Student indicates they would pull the skin taut while shaving
7. Rinse the razor often
8. Rinse and dry the residents face
9. Removes gloves
10. Performs hand hygiene
11. "What would you do if the skin is cut?" Answer: "Apply direct pressure and tell the nurse."
12. "What would you do with the razor when you are finished shaving?" Answer: Put it in the sharps container.

ELECTRIC RAZOR

Do not use electric razor on a resident receiving oxygen
Resident's are not to share electric razors

AM and PM or HS care

A. A.M. care is given after a person wakes up in the morning
    a. Toileting
    b. Partial bath (washing face, hands, axilla, back and peri-care)
    c. Oral care –brushing teeth or inserting dentures
    d. Dressing
    e. Grooming
        i. Shaving
        ii. Make-up
B. H.S. (hour of sleep) or P.M. care is given before a person goes to bed at night
    a. Toileting
    b. Washing faces and hands
    c. Oral care—brushing teeth or removing and cleaning dentures
    d. Changing into pajamas or nightgowns
    e. Straightening linens
    f. Back Rubs and foot rubs

Nailcare/footcare, including trimming nails and toenails

A. Inspect nails to determine care needed
B. Smooth any rough or sharp edges with an emery board
C. Check facility policy before using nail clippers

Foot care

A. Don gloves
B. When asked by examiner, verbalize the need to inspect the feet and toes. Identify cuts, sores, redness or swelling
C. When asked by the examiner, verbalize that you may clip toenails if approved at your facility
D. Wash the residents feet in warm water, do not soak them
E. Dry the residents feet completely, including between the toes
F. Apply lotion if desired but do not put lotion between the toes
G. Apply socks and shoes if desired by the resident
H. Remove gloves and wash hands
I. Report any abnormalities

Dressing/undressing, including resident with an affected side

***SKILL #12 P.7 DRESSING RESIDENT, AFFECTED ARM**

A. Don gloves
B. Allow the resident to choose clothing
C. Demonstrate how to properly dress and undress resident with hemiplegia

D. When undressing, be sure to undress the strong side and then the weak side
E. When dressing, be sure to dress the weak side then the strong side
F. Removes gloves
G. Performs hand hygiene

UNIT 11 NUTRITION

Position resident and serve a meal tray

Serving a meal tray
A. Check diet order card
B. Clothing protector may be used if necessary to protect clothing from spilled food. Do not refer to the clothing protector as a bib
C. Help the person with opening milk cartons, removing silverware from its wrapper, buttering bread, or cutting up meat
D. Help with seasoning according to the resident's taste
E. If eating in bed, HOB should be elevated 69--90 degrees

Assist resident at mealtimes

Feed resident a complete meal

***SKILL #14 P. 8 FEEDING RESIDENT, WHILE IN BED**

1. Verify that the name and diet on the meal tray matches the name of resident receiving it
2. Position the resident in an upright position (a minimum of 60 degrees)
3. Wash and dries the resident's hands before feeding them
4. Offer resident a clothing protector
5. Place clothing protector on resident
6. Describe the food being offered to the resident
7. Maintain eye level contact while feeding the resident
8. Allow the resident to choose food as they are able
9. Offers fluid frequently
10. "What complications could occur that would suggest the need to stop feeding the resident?" The answer could include:
    a. Choking
    b. Persistent coughing
    c. Mouth sores
    d. Drooling
    e. Cyanosis
    f. Difficulty swallowing
    g. Resident refusing food
    h. The resident falls asleep
    i. Verbalize the need to stop feeding when complications occur and report them to the nurse
    g. Leave the resident clean and in a position of comfort.

Feed a resident with swallowing difficulties

Feeding the patient with swallowing difficulties
A. Observe closely
B. Encourage resident/patient to chew thoroughly and swallow
C. May require thickened liquids

Estimate the amount of solid food eaten

A. All facilities keep track of how much food and liquid a resident consumes. The method varies.
B. Some facilities use a percentage method. For example: "R" Refused=0% No food eaten; "P" Poor=25% Very little food eaten; "G" Good=75% Most of the food is eaten; and "A" All=100% Entire meal is eaten
C. Other facilities may document the percentage of specific foods eaten—protein, carbohydrates, fats, etc.

Convert ounces to ml/cc

30 ml = 1 ounce

UNIT 12 BODY SYSTEMS; GI & GU, MS

Provide assist to nurse with resident care pre and post enema

A. Place resident in a left Sim's or side lying position
B. Drape or cover appropriately

Ostomy care; skin care, empty bag, bag change

A. An ostomy is an artificial opening, called a stoma, to eliminate stool
B. Feces passes through the stoma into a pouch called an ostomy appliance
C. Always wear gloves when caring for an ostomy
D. Drain the bag by emptying the contents into a bedpan. Clean the inside of the bag with a large bulb syringe full of water
E. Burp the bag prn by removing excess air to prevent the bag from exploding

Assisting with a bedpan/fracture pan

***SKILL #7 P. 5 ASSIST WITH BEDPAN**

ASSISTING WITH A BEDPAN/FRACTURE PAN

1. Put on gloves
2. Position the bedpan under the resident correctly
3. Raise the HOB to a comfortable level
4. Place tissue within reach of the resident

5. Gently removes the bedpan
6. Provide or assists with peri care as needed
7. Empty the bedpan into the toilet, rinse, dry and store in a proper place
8. Remove gloves
9. Perform hand hygiene
10. Wash or assist to wash resident's hands

Assisting resident with bedside commode/to bathroom

A. A portable commode is a chair with a toilet seat and a removable container underneath
B. Empty in toilet and rinse container after use
C. Make sure brakes are on when the patient/resident is sitting on the commode

Brief change including pericare; male and female

***SKILL #8 AND 9 P. 6 BRIEF CHANGE WITH PERI/ANAL CARE**

BRIEF CHANGE (BEDBOUND) FEMALE **SKILL #8 FEMALE**

1. Put on gloves
2. Place the resident in the spine position with the bed flat
3. Undo the front tabs of the brief and rolls the brief down between residents legs
4. Wipe front genital area with a disposable wipe, wiping front to back
5. Use a different part of the wipe for each stroke
6. Discard soiled wipes in a plastic bag or trash can
7. Raise side rail on non-working side of bed
8. Roll the resident onto their side
9. Wipe the anal area with a disposable wipe, wiping front to back
10. Remove the soiled brief being careful not to tear the brief or drop the contents
11. Tuck the clean brief under the resident
12. Roll the resident onto their back
13. Secure the brief in place
14. Remove gloves
15. Performs hand hygiene
16. "Where would the brief need to be disposed of when you leave the resident's room?" Answer: "Outside the resident's room
17. "How often do you need to check the resident's brief?" Answer: "Every 2 hours."

BRIEF CHANGE (BEDBOUND) MALE **SKILL #9 MALE**

1. Put on gloves
2. Place resident in the supine position with the bed flat
3. Undo the front tabs of the brief and rolls the brief down between residents legs
4. Clean penis from tip to base
5. Use a different part of the wipe for each stroke
6. Discard soiled wipes in a plastic bag or trash can
7. Roll the resident onto their side
8. Wipe the anal area with a disposable wipe, wiping front to back
9. Remove the soiled brief being careful not to tear the brief or drop it's contents

10. Tuck the clean brief under the resident
11. Roll the resident onto their back
12. Secure brief in place
13. Remove gloves
14. Perform hand hygiene

"Where would the brief need to be disposed of when you leave the residents room?" Answer: Outside of the resident's room

15. "How often do you need to check the resident's brief?" Answer: "Every 2 hours."

Assist a male resident with a urinal

A. A urinal is a device used for urination when a man is unable to get out of bed. The urinal fits between the man's legs
B. The man puts his penis into the opening of the urinal
C. If a man is weak or disabled you may need to do this for him.
D. The urinal is stored in the man's bedside table or may be hung on the side rail.
E. There are also urinals made specifically for women.

Indwelling catheter care; including tubing and bag positioning

***SKILLS # 15 AND 16 P. 9 INDWELLING CATHETER CARE MALE AND FEMALE**

1. Performs hand hygiene
2. Puts on gloves
3. Washes the catheter tubing 4 inches starting at the urinary meatus and working away from the body with the cleansing wipe provided
4. Secures the tubing to the resident's inner thigh or abdomen
5. Places the tubing over the leg
6. Attaches tubing to the bed from and below the level of the bladder (not on the side rail)
7. Prevents the catheter bag from touching the ground
8. Provides privacy cover for the bag
9. Removes gloves
10. Performs hand hygiene
11. "How often is catheter care performed and what do you clean with?" Answer: "At least twice a day with cleansing wipe not alcohol or according to facility policy."
12. "How often do you empty a catheter bag?" Answer: "According to facility policy or when the bag is over ½ full."

Empty down drain bag and measure urine output using a graduate

***SKILL #13 P. 8 EMPTY DOWN DRAIN BAG AND RECORD URINE OUTPUT**

1. Put on gloves
2. Collect paper towel/measuring container
3. Place paper towel, then measuring container on floor under drainage bag

4. Remove drainage tube from storage sheath
5. Unclamp while directed toward the container and facilitate the gravity flow
6. Ensures that drainage tube does not touch the side of the measuring container
7. Cleans the tip of the drainage tube with an alcohol swab
8. Re-clamps tube
9. Reinserts tube into storage sheath
10. Places graduate on a flat surface
11. Reads at eye level
12. Record the output accurately
13. Remove gloves
14. Perform hand hygiene

Applying an abduction pillow for hip fracture

Used for resident's with hip fractures to keep the legs from touching or crossing

UNIT 13 MENTAL HEALTH & MENTAL ILLNESS

UNIT 14 COGNITIVE IMPAIRMENT & DEMENTIA

UNIT 15 REHABILITATION AND RESTORATIVE CARE

Range of Motion exercises; passive and active

Active ROM/lower and upper extremities
A. In active range-of-motion exercises, the patient or resident performs the exercises independently. You may only need to provide encouragement and direction

Passive ROM exercises
A. You will perform the Range of Motion exercises for the patient/resident.
B. Never exercise past the point of pain or resistance
C. Provide support for joint
D. Avoid fast jerky movements using flexion, extension, adduction, abduction and rotation if applicable
E. Repeat exercise at least 3 times or as ordered by the physician

UNIT 16 END OF LIFE CARE

Post mortem care is care is performed on a resident's body after they pass away, so the family can view the body prior to transporting to the mortuary. It should be done before soon before rigor mortis occurs (2-4 hours after patient passes away).

Post mortem care is performed after the Dr. pronounces the patient dead.

A. Position the body supine in proper body alignment
B. Bathe soiled areas and dry thoroughly
C. Place a clean gown on the body
D. Gently pull eyelids over the eyes
E. Insert dentures if needed
F. Close mouth and place a rolled towel under the chin to support the mouth if necessary
G. Remove any jewelry
H. List all jewelry removed and secure according to facility policy
I. Brush and comb hair as necessary
J. Cover the body to the shoulders with a clean sheet if the family will view the body
K. Make sure the room is neat
L. *Allow family to view the body, provide privacy*
M. Give the person's belongings to the family