Module 9: Patient Care Procedures
Minimum Number of Theory Hours: 7
Recommended Clinical Hours: 20

Statement of Purpose:
The purpose of this unit is to provide learning experiences that will prepare the Nurse Assistant to safely carry out procedures that support the patient/resident in meeting physical care needs that cannot be performed independently.

Terminology:

1. Admission
2. Anti-embolic stockings
3. Bandage
4. Binders
5. Clean catch
6. Defecate
7. Discharge
8. Draw sheet
9. Edema
10. Elastic bandage
11. Electric bed
12. Evacuation
13. Excoriated
14. Expectorate
15. Fanfold
16. Fluid
17. Gastrostomy tube
18. Hives
19. Intake
20. Integumentary system
21. Intravenous (IV)
22. Lesions
23. Manual bed
24. Mitered corner
25. Mucous
26. Nasogastric tube (NGT)
27. Non-prescription
28. Occupied bed
29. Ointment
30. Output
31. Percutaneous Endoscopic Gastrostomy (PEG)
32. Pruritus
33. Reflux
34. Reverse Trendelenburg
35. Scaly
36. Semi-Fowler's position
37. Side rails
38. Specimen
39. Suppository
40. Transfer
41. Trendelenburg
42. Unoccupied bed

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

Performance Standards (Objectives):

Upon completion of seven (7) hours of class plus assignments and twenty (20) hours of clinical experience, the learner will be able to:

1. Define key terminology

COLLECTION of SPECIMENS

2. Describe the Nurse Assistant's role in collecting specimens (sputum, urine, and/or stool)

BED CARE

3. Discuss procedures for bed making and maintaining proper body mechanics
4. Discuss types of beds and bed positions
5. Discuss ways to maintain the patient's/resident's environment

BOWEL CARE

6. Describe the Nurse Assistant's role in administering an enema
7. Describe the Nurse Assistant's role in giving a suppository

TUBES

8. List the types and uses of gastrointestinal (GI) tubes
9. Describe major nursing care activities for patients/residents with feeding tube (nasogastric or gastrostomy)
10. Describe nursing care activities for a patient/resident receiving intravenous (I.V.) therapy

INTAKE AND OUTPUT

11. Describe the Nursing Assistant's role in assisting the patient/resident to maintain fluid balance
12. Describe the purpose and procedure for measuring the amount of fluid taken in and fluids excreted by the patient/resident

BANDAGES AND DRESSINGS

13. Discuss the Nursing's Assistant role in the use of bandages, binders and dressings
14. Describe the use and method of applying anti-embolic hose/elastic stockings

OINTMENTS, POWDERS, and LOTIONS

15. Identify the Nurse Assistant's role in the care of patients/residents' skin conditions and the use of non-prescription ointments, lotions, or powders

ADMISSION, TRANSFER and DISCHARGE

16. Explain the role of the Nurse Assistant in the admission of a patient/resident to the facility
17. Explain the role of the Nurse Assistant in transferring a patient/resident from one area to another within the facility
18. Explain the role of the Nurse Assistant in the discharge of a patient/resident

References:

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology.** A. Review the terms listed in the terminology section B. Spell the listed terms accurately C. Pronounce the terms correctly D. Use the terms in their proper context	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes	A. Ask students to select five words from the list of key terminology and write a sentence for each defining the term B. Administer vocabulary pre-test and post-test C. Uses appropriate terminology when charting and reporting to licensed personnel
Objective 2 **Describe the Nurse Assistant's role in collecting specimens (sputum, urine, and/or stool).** A. Sputum Specimens 1. Purpose a. Respiratory disorders cause the secretion of mucus from lungs, bronchi and trachea b. Mucous secretion is called sputum (not related to saliva) c. Expectorated from upper airways d. Sputum is studied for blood, microorganisms, and abnormal cells 2. Assisting the patient/resident in raising sputum for a specimen a. Secretions are more easily coughed up after the patient/resident wakes up in early a.m. b. Allow the patient/resident to rinse their mouth with water, as this reduces the amount of saliva in the mouth and removes food particles	A. Lecture/Discussion B. Ask students to role play what to tell patient/resident specifically. It is not enough to have them say "I'll explain it to the patient/resident". Each skill has requirement to "Explain procedure, speaking clearly, slowly, and directly. Maintain face to face contact whenever possible." They need to practice what to say	A. Written test B. Uses correct techniques to collect, label, and document obtaining a specimens

c. Do not use mouthwash, as this may destroy some of the organisms d. Coughing up sputum may be embarrassing to the patient/resident, and may nauseate others nearby e. The specimen itself may be perceived as unpleasant Keep container covered and place in bag f. Privacy is important g. Use standard precautions 3. Specimen needs to be labeled a. Patients/residents full name b. Room and bed number c. Time and date the specimen was collected 4. Observations a. Color b. Odor c. Consistency d. Blood 5. Document specimen obtained and where taken B. Urine Specimens 1. Purpose a. Urine is collected for a laboratory examination or testing in the unit to help the physician diagnose a problem or evaluate treatment 2. Methods for collecting urine specimens a. Mid-stream b. Clean catheter urine specimen c. 24-hour urine specimen 3. Rules to follow in collecting urine specimen a. Wash hands before and after collecting a specimen b. Use standard precautions c. Use the correct and clean container for each specimen	C. Demonstrate and return demonstration using vanilla pudding D. Manual Skills 9.2a-Collecting and Identifying Specimens-Sputum E. Demonstration and return demonstration of urine collection using colored water F. Manual Skills 9.2b-Collecting and Identifying Specimens-Urine G. Demonstration and return demonstration of stool specimen collection using “play dough” or clay H. Manual Skills 9.2c-Collecting and Identifying Specimens-Stool	

d. Label the container accurately 1) Patient's name 2) Room and bed number 3) Date and time specimen was collected e. Collect specimen directly into container at time specified f. Do not touch the inside of the container or lid g. Ask the patient/resident not to have a bowel movement while the specimen is being collected h. Ask the patient/resident to place toilet tissue in the toilet or wastebasket i. Take the specimen and the requisition slip to the designated lab pick-up station j. Document that the specimen was obtained and where it was taken in the patient/resident record 4. Observations a. Difficulty obtaining specimen b. Color, clarity and odor c. Particles d. Complaints of discomfort and/or urgency C. Stool Specimens 1. Stool is collected for a laboratory test to check for the presence of blood, fat, micro-organisms, worms (parasites), and any abnormal contents 2. General rules for collection a. Maintain patient's/resident's privacy b. Use standard precautions c. Use clean container d. Give the patient/resident clear instruction on how to defecate for the specimen; must not contaminate with urine or toilet tissue e. Label the container accurately 1) Patient's/resident's name 2) Room and bed number 3) Date 4) Time specimen was collected		

f. Clarify if the specimen must be kept at room temperature, or refrigerated (check on specific lab test) g. Take specimen and requisition slip to the designated area 3. Observations a. Difficulty in obtaining specimen b. Color, amount, consistency, and where taken c. Complaints of pain or discomfort 4. Document specimen obtained and where taken		
Objective 3 **Discuss procedures for bed making and maintaining proper body mechanics**. A. Bed making is an important part of the Nurse Assistant role 1. A clean, dry, neat bed makes the patient/resident more comfortable 2. The body exerts uneven points of pressure over bony prominences (elbow, sacrum), etc., when against the mattress for extended periods. Use a mattress pad, if ordered 3. Bed linen must be wrinkle-free to prevent it from becoming an irritant to skin 4. The state of mind of the patient/resident is affected by the condition of the bed. To create and maintain a positive attitude, the bed should be kept a. In good repair b. Clean bedframe by damp dusting daily c. Well-made, wrinkle-free d. Attractive with use of bedspread 5. Keep call bell in place, clipped to linen 6. Keep the patient/resident reality-oriented by use of patient's/resident's personal pillow, afghan, etc. (familiar objects)	A. Lecture/Discussion B. Demonstrate and return demonstration C. Manual Skills 9.3a-Occupied Bed Making D. Manual Skills 9.3b-Unoccupied Bed Making	A. Written test B. Demonstrates proper bed making in clinical setting C. Uses proper body mechanics during bed making in clinical setting

B. Bed linen can act as an irritant to patient/resident skin 1. Use sheets to separate the blanket from the patient's/resident's skin, thus preventing blanket fibers from causing irritation 2. Keep bottom linens tucked in and wrinkle-free 3. Cover plastic draw sheet with cotton draw sheet 4. Straighten and tighten loose sheets, blankets and bedspreads whenever necessary 5. Strong laundry soaps may cause skin irritation; observe for patient/resident skin problems and report C. Aseptic technique is important when handling bed linen; follow standard precautions 1. Wash hands. Germs spread by cross-contamination 2. Hold and carry linen away from uniform a. Dirty linen is dirtier than the uniform and could transfer micro-organisms to the uniform b. Clean linen is cleaner than the uniform 3. Shaking linens or fluffing them in the air is avoided during bed making since this practice will spread dust and germs 4. Keep linen off the floor or off the overbed table, as soiled linen can transfer germs to these areas 5. Soiled linen should be immediately placed in a linen hamper or rolled tightly and tucked at the foot of the bed between the mattress and frame until it can be carried to the linen hamper 6. Soiled-linen hampers should be kept covered to prevent spread of infection and odors D. Body Mechanics 1. Proper body mechanics is required to make a bed to prevent injury and fatigue 2. Know your limitations. Don't try to lift, turn, or move a patient alone if you have any doubts about your ability to do so 3. Get close to sides of bed; don't make beds from the head of bed or foot positions		

4. Keep back straight and knees bent 5. Keep feet apart to give a broader support base 6. Move feet to turn in the direction wanted and avoid twisting your back 7. Face in the direction you are working at the side of the bed 8. Raise bed to comfortable height 9. Make one side of bed before beginning other side		
Objective 4 **Discuss types of beds and bed positions** A. Functions and structures of a hospital bed 1. Manually operated beds have hand cranks at the foot of the bed which raise or lower the head, foot, or total bed. Cranks are to be kept down when not in use 2. Electric beds have electric controls located on the side or foot of the bed for the patient/resident and staff use 3. Side rails a. Uses 1) Prevent patient/resident from falling out of bed 2) Provide security 3) Give patient/resident support to hold or grasp when moving or turning while in bed b. Regulations regarding use 1) Considered restraints 2) Must have consent to use 3) Need for use must be noted in patient's/resident's record and care plan 4) Patient/resident must be checked frequently if side rails are ordered B. Bed Positions 1. High position encourages the staff to use good body mechanics when giving care to patients/residents, moving patients/residents to stretchers, or when making the bed	A. Lecture/Discussion B. Demonstrate and return demonstration of bed functions	A. Written test B. Demonstrates safe operation of beds in clinical setting C. Raises and lowers bed to accommodate patient's/resident's needs

2. Low position is used to encourage the ambulatory patient/resident to get in and out of bed with ease and safety 3. Fowler's position (backrest raised 45° to 90°) is used for patient/resident comfort to eat meals and to breathe more easily in certain respiratory and cardiac conditions 4. Semi-Fowler's position (backrest 45° with knees raised 15°) is used for comfort and to keep the patient/resident from sliding down in bed 5. Trendelenburg position is when the head of the bed is lowered and the foot of the bed is raised. This position requires a doctor's order 6. Reverse Trendelenburg position is when the head of the bed is raised and the foot of the bed is lowered. This position requires a doctor's order		
Objective 5 **Discuss ways to maintain the patient's/resident's environment.** A. Patients/residents spend a lot of time in their rooms 1. Rooms should be comfortable. Control temperature, ventilation, noise, light, and odor 2. Rooms should be safe a. Maintain furniture and equipment for communicating in a safe and effective manner b. Patient's/resident's rights to privacy should be considered when furnishing a room. Allow the patient/resident choices and selection of own furniture from home to the extent of facility policies c. Make sure bed wheels are locked when giving care or transferring patients/residents B. General rules for maintaining the patient's/resident's unit 1. Make sure patient/resident can reach bedside stand and overbed table 2. Arrange personal belongings the way the patient/resident prefers, with patient/resident safety in mind and within easy reach	A. Lecture/Discussion B. Ask students to think of creative ways to make the patient's/resident's room safe and comfortable as well as promote independence	A. Written test B. Maintains safe and comfortable room environment for patient/resident

3. Keep call bell within patient's/resident's reach 4. Make sure patient/resident can reach telephone, television controls, and light controls 5. Provide the patient/resident with tissues, toilet paper and a waste container 6. Adjust lighting and temperature for patient's/resident's comfort 7. Respect patient's/resident's belongings 8. Keep environment clean 9. Straighten bed linens as needed		
Objective 6 **Describe the Nurse Assistant role in administering an enema.** A. An enema is the introduction of fluids into the rectum and lower colon; ordered by a doctor B. The purpose of a enema is to 1. Stimulate a bowel movement 2. Relieve constipation or fecal impaction 3. Cleanse bowel of feces prior to surgery and diagnostic procedures 4. Remove flatus (gas) C. Types of enemas 1. Cleansing enemas to remove feces from colon and rectum a. Tap water b. Soap suds 2. Oil retention enema; given for constipation or fecal impaction for lubrication of feces 3. Commercial mixtures; given for constipation (i.e., Fleet's) D. General rules to follow when giving an enema 1. Before Nursing Assistant administers enema, make sure: a. State governing board allows Nursing Assistants to give enemas b. Procedure is in job description c. Have obtained the necessary education and training d. There is a nurse available to supervise the procedure	A. Lecture/Discussion B. Demonstrate and return demonstration on manikin C. Manual Skills 9.6a- Administering a Soap Suds Enema D. Manual Skills 9.6b- Administering the Commercially Prepared Enema and Cleansing Enema	A. Written test B. Administers enema according to policy

2. Temperature of solution should be 105° F. 3. Amount of solution is 500-1000 ml for adults 4. Patient/resident positioned in left Sim's position 5. Height of enema bag is no more than 18" above the mattress 6. Depth of tube insertion is about 2" to 4" into rectum and tube must be lubricated 7. Administer solution slowly over ten to fifteen minutes (Solution is usually held in rectum for a variable length of time until urge to defecate occurs) 8. Hold enema tube in place while administering 9. Make sure toilet facility is nearby and available 10. Observe the results of the enema 11. Use standard precautions		
Objective 7 **Describe the Nurse Assistant's role in giving a suppository.** A. A rectal suppository is used to 1. Stimulate to empty the bowel 2. Lubricate the stool to ease evacuation B. Nurse Assistant role 1. Facility policy dictates if the Nurse Assistant may insert a suppository 2. General rules to follow when inserting a suppository a. Nurse Assistants may not administer medicated suppositories b. Identify the patient/resident by checking the arm band c. Remove wrapper from the suppository (if wrapped) d. Place suppository 1 to 1-1/2 inches past anal sphincter using gloved hand and index finger f. Instruct the patient/resident to hold the suppository in the rectum as long as possible g. Observe for results of the suppository e. Report the results to the licensed nurse	A. Lecture/Discussion B. Demonstrate and return demonstration on manikin C. Manual Skills 9.7- Rectal Suppository-Laxative	A. Written test B. Administers suppository according to policy

Objective 8 **List types and uses of gastrointestinal (GI) tubes.** A. Nasogastric tube 1. Inserted through nose into stomach or intestine to a. Drain the GI tract by means of suction to prevent post-operative vomiting, obstruction, or gas formation b. Diagnose a disease c. Wash out stomach content d. Provide a route for feeding one who is unable to take food by mouth B. Gastrostomy tube/PEG 1. Surgically inserted through abdominal wall into the stomach 2. Purpose of tube is for feeding the patient/resident	A. Lecture/Discussion B. Show students examples of nasogastric and gastrostomy tubes or if unavailable, show pictures of tubes	A. Written test B. Correctly identifies types of GI tubes
Objective 9 **Describe major nursing care activities for patients/residents with feeding tubes (nasogastric or gastrostomy).** A. Care of patient/resident with nasogastric tube 1. Give frequent oral hygiene and keep the lips and mouth moist. The mouth becomes very dry and may have a bad taste 2. Nose and nostrils need to be cleaned frequently 3. Increase freedom of movement by securing tubing with clamp or tape to the patient's/resident's clothing to permit maximum activity 4. Check to see that the patient/resident does not sit or lie on tubing (tubing must be free of kinks) 5. Check to see if the suction machine is operating satisfactorily and reporting at once if it is not working (if suction is ordered) 6. Permitting the patient/resident (if allowed) to suck on ice chips, throat lozenges, or hard candy to keep throat slightly moist. Patient/resident is usually NPO (nothing by mouth) Positioning the patient/resident with head of bed elevated at 45 degrees during the feeding and for 30-60 minutes afterward, and then 30 degrees after the feeding	A. Lecture/Discussion B. Ask students to discuss what it would feel like to not be able to eat normal food	A. Written test B. Maintains patient NPO/ice chips as ordered C. Provides safe care for patient/resident with feeding tube D. Uses nursing measures to provide comfort to patient/resident with a feeding tube E. Reports unusual signs or symptoms to licensed nurse

B. Care of patient/resident with gastrostomy tube 1. Give frequent oral hygiene and keep the lips and mouth moist The mouth becomes very dry and may have a bad taste 2. Increase freedom of movement by securing the gastrostomy tube with clamp or tape to the patient's/resident's clothing to permit maximum activity 3. Check to see that the patient/resident does not sit or lie on tubing (tubing must be free of kinks) 4. Permit the patient/resident (if allowed) to suck on ice chips, throat lozenges, or hard candy to keep throat, as well as tube, slightly moist 5. Position the patient/resident with head of bed elevated at all times 20 degrees to 30 degrees, to prevent reflux 6. Removing dressing from G-tube; clean and dry area; replace according to care plan 7. Reporting any unusual conditions observed during procedure a. Same as nasogastric tube b. Redness, swelling, drainage, odor or pain at the ostomy site C. Nursing care is provided to maintain a patient's/resident's mental and emotional comfort by: 1. Keeping the environment clean, tidy, and well-ventilated, as the patient/resident is often very sensitive to odors which can cause nausea and vomiting 2. Answering call lights promptly 3. Checking frequently and giving emotional support 4. Giving an extra back rub 5. Straightening or changing bed linen prn 6. Asking patient/resident to express concerns about the tube 7. Encouraging the patient/resident to be up, dress in day clothes, and join in activities as tolerated 8. Assist patient/resident to attend family and group activities		

D. Observe, report, and record routine care and any unusual events 1. Nausea, vomiting, diarrhea 2. Discomfort 3. Distended abdomen 4. Coughing 5. Care of indigestion or heartburn 6. Elevated temperature 7. Signs and symptoms of respiratory distress 8. Increased pulse rate 9. Care of flatulence		
Objective 10 **Describe nursing care activities for a patient/resident receiving intravenous (I.V.) therapy.** A. Reasons for using I.V. therapy 1. I.V. therapy provides the body with needed elements that can't be given as rapidly or efficiently by other means 2. I.V. may contain a. Blood, plasma b. Nutritional requirements for water, salt, sugar, etc. c. Medications 3. Rate of I.V. flow is often controlled by an infusion pump B. Nursing Assistant responsibilities include observing for flow from I.V. 1. Keeping tubing free of twisting or kinking 2. Observing position of tubing and condition of injection site for any infiltration a. An infiltrated I.V. is one in which the needle has come out of the vein and the I.V. leaks into the tissue, causing swelling b. Report this condition immediately to the charge nurse	A. Lecture/Discussion B. Manual Skills 9.10- Changing Clothing of Patient/resident with an I.V.	A. Written test B. Uses proper procedures for bathing and dressing patient/resident with an I.V. C. Uses nursing measures to provide comfort to patient/resident with an I.V.

3. Checking restraints or soft protective devices to be sure that they are not blocking the vein. Follow your agency's policy regarding restraints and soft protective measure C. Nursing Assistant responsibilities 1. Maintain a patient's/resident's physical comfort 2. Bathe the patient/resident according to daily routine a. Wash gently around the area where needle is inserted b. Do not loosen the tape that holds needle in place c. When drying, do not rub over area, pat gently to avoid dislodging the needle 3. Assist the patient/resident with eating by cutting food, preparing liquids, and arranging utensils conveniently 4. Assist the patient/resident with feeding as little as possible to encourage self-care 5. Assist the patient/resident to ambulate a. Provide a portable I.V. stand b. Assist out of bed c. Observe closely for weakness d. Support the I.V. arm to ensure continuous flow; a sling may be used to rest the arm e. Patients/residents may grasp the I.V. pole for support (with I.V. hand). This provides support for the arm and lets them move at their own pace, leaving other hand free for balance by holding onto railings		
Objective 11 **Describe the Nursing Assistant role in assisting the patient/resident to maintain fluid balance.** A. Importance of maintaining fluid balance 1. Next to oxygen, water is the most important physical need 2. Death can result from taking in inadequate fluids, from losing too much fluid or too much fluid intake a. Water enters body through food and fluid b. Water is lost through urine, sweat, feces, and lungs	A. Lecture B. Discuss creative ways to encourage increase in fluid intake	A. Written test B. Follows instructions for patient/resident fluid intake

3. Balance between amount of fluid taken in and the amount of fluid lost is necessary to maintain health a. Amount of fluid taken in and the amount of fluid lost must be equal b. An adult needs about 2000 ml of fluid a day c. Edema; fluid intake exceeds fluid output, tissues swell with water d. Dehydration; fluid output exceeds fluid intake, decrease in the amount of fluid in tissues 4. Patients/residents depend on nursing personnel to meet part or all of their food and fluid needs B. Encouraging increase in fluid intake 1. Forcing Fluids a. When physician orders “force fluids” it means to have the patient/resident drink an increased amount of fluid b. May order specific amount of fluid for 24-hour period c. Maintains fluid balance d. May be for general or specific amount of fluid 2. Nurse Assistant’s responsibility to encourage fluid intake a. Keep record of amount taken in b. Provide variety of fluids c. Place within patient’s/resident’s reach d. Offer fluids frequently to patients/residents who cannot feed themselves C. Restricting fluid intake 1. When physician orders “restrict fluids” it means fluids are restricted to a specific amount 2. Nurse Assistant’s responsibility a. A sign posted above the bed b. Water is offered in small amounts c. Keep water pitcher out of sight, or removed from room d. Keep accurate intake and output record e. Be aware of shift fluid requirements f. Provide patient/resident with frequent oral hygiene		

g. Explain to the patient/resident and family the reason for limiting fluid, removing water pitcher, etc. D. Nothing by mouth (NPO) 1. Ordered a. Before and after surgery b. Before certain lab tests and x-rays c. In the treatment of some illnesses 2. Nurse Assistant's responsibility for NPO patient/resident a. NPO sign above bed b. Remove water pitcher and glass c. Offer frequent oral hygiene d. No swallowing of any fluid		
Objective 12 **Describe the purpose and procedure for measuring the amount of fluid taken in and fluids excreted by the patient/resident (see module 7).** A. Purpose of "intake and output" (I & O) measurement 1. The doctor or nurse may want to keep track of a patient's/resident's fluid intake and output to evaluate a. Fluid balance b. Kidney function c. Response to medical treatment 2. Accurate measurement is needed and documented on the I & O record B. Measurement of patient's/resident's intake 1. Measured in milliliters (ml) 2. Determine the fluid capacity of bowls, dishes, cups, pitchers, glasses, and other containers used to serve fluids 3. Count as intake a. Water, milk, coffee, juice, soup, etc. b. All food in liquid form when eaten or those that later revert to liquid, i.e., Jell-O, ice cream 4. A conversion table is provided on the intake and output record used to chart intake	A. Lecture/Discussion B. Review metric and household systems of measurement in Module 15- Fluid Measurement Handout 15.5 C. Provide exercises for students to practice intake and output measurement D. Manual Skills 9.12- Measuring Oral Intake E. Refer to Module 8 Manual Skill: 8.16- Measuring Urinary Output	A. Written test B. Records accurate intake and output according to facility policy

5. A container called a graduated cylinder is used to measure fluid C. Measurement of patient's/resident's output 1. Measure all fluids excreted by patient/resident done in ml. 2. All liquid output will be measured including urine, vomitus, liquid stool, drains and suctions 3. Plastic urinals and emesis basins may be calibrated 4. Use standard precautions when measuring output D. Recording intake and output 1. I & O record at bedside, document amounts when fluid is taken in or excreted 2. Amounts are totaled at end of shift and entered in the patient's record 3. Other special forms as required by facility E. Reporting intake and output: 1. Report any unusual occurrences 2. Refusing to drink fluid, special fluid likes or dislikes, and blood in urine		
Objective 13 **Discuss the Nursing Assistant role in the use of bandages, binders and dressings.** A. Purpose of bandages and binders 1. Apply pressure (compression) in order to stop bleeding or swelling, and to assist in absorbing tissue fluids 2. Provide for immobilization of an injured part; a fractured (broken) arm 3. Hold dressings in place 4. Protect open wounds from contaminants	A. Lecture/Discussion B. Demonstrate and return demonstration of dressing and bandage application	A. Written test B. Follows instructions of licensed nurse for application and removal of bandages and dressings

5. Apply warmth to a joint, as for persons suffering from painful joints due to arthritis 6. Provide support and aid in venous (return blood flow) circulation, as when bandaging the leg of a patient/resident suffering from varicose veins or limited circulation in the extremities (arms or legs) B. Dressings are ordered by the physician and initially applied by the licensed nurse C. Nurse Assistant role 1. Apply simple, dry, non-sterile dressings to uncomplicated wounds 2. Assist the licensed nurse with complex wounds D. The licensed nurse will inform the Nurse Assistant when to change a dressing and what supplies to use E. Materials used for dressings and bandages 1. Dressings are made from a variety of materials, mainly gauze which comes in 2 inch, 3 inch, and 4 inch squares. The size depends on the area of the body involved and the purpose of the dressing 2. Bandages and binders are made from muslin, gauze, flannel, rubber, and elastic fiber 3. Dressings are held in place with hypoallergenic tape, plastic tape, elastic tape, paper tape, silk tape, adhesive tape, and binders or bandages. The type depends on the purpose and the patient/resident F. Principles of bandaging 1. Apply bandage so pressure is evenly distributed to area a. If joint is involved in bandaging, support it in a comfortable position with a slight flexion of the joint b. Attach bandage securely to avoid friction and rubbing of underlying tissue which could cause irritation c. Start at the lower (distal) part of extremity d. Work upward to the top (proximal) part		

G. Rationale for removing elastic bandages 1. Elastic bandages should be removed every eight hours, unless ordered more frequently, to allow for inspection of underlying skin 2. Replace a moist or soiled bandage 3. Reapply a loose or wrinkled bandage H. Observation and reporting to licensed nurse 1. Swelling 2. Pain 3. Change in color 4. Decrease or increase of temperature 5. Drainage: color, consistency, amount 6. Odor		
Objective 14 **Describe the use and method of applying anti-embolic hose/elastic stockings.** A. Anti-embolic hose/elastic stockings are used to increase circulation by improving venous return from the legs to the heart B. Key points when applying elastic stockings 1. Always apply before patient/resident gets out of bed 2. Check for wrinkles 3. Check skin color and temperature 4. Check popliteal pulse **C.** Anti-embolic hose/elastic stockings are to be removed every 8 hrs. or according to facility policy	A. Lecture/Discussion B. Demonstrate and return demonstration in applying anti-embolic hose/elastic stockings C. Manual Skill 9.14- Anti-embolic Hose/Elastic Stockings	A. Written test B. Applies Anti-embolic hose/elastic stockings according to procedure C. Removes Anti-embolic hose/elastic stockings according to facility policy
Objective 15 **Identify the Nurse Assistant's role in the care of patient's/resident's skin conditions and the use of non-prescription ointments, lotions, or powders.** A. The Nurse Assistant can provide care to patients/residents with the following intact skin conditions 1. Foot care 2. Dandruff 3. Dry Skin	A. Lecture/Discussion B. Demonstrate and return demonstration of foot care with lotion application	A. Written test B. Applies non-prescription ointments, lotions and

B. The Nurse Assistant must reports the following existing skin conditions to the licensed nurse 1. Acne 2. Minor burn 3. Rash 4. Excoriation, abrasions, skin tears 5. Eczema or psoriasis 6. Poison ivy or poison oak 7. Minor wounds 8. Insect bites or stings C. The Nurse Assistant can apply over-the-counter ointments, lotions, or powders to intact skin surface only D. The Nurse Assistant does not apply ointments, lotions, or powders to irritated skin surfaces OR open lesions E. Over-the-counter ointments, lotions, or powders that the Nurse Assistant may apply to intact skin 1. Zinc oxide 2. A and D ointment 3. Clearasil 4. Stri-dex medicated pads 5. Selsun Blue 6. Keri Lotion 7. Corn Huskers 8. Johnson's Medicated Powder 9. Tinactin Foot Powder F. General rules for application of ointment, lotion, or powder 1. Prepare the patient/resident 2. Position the patient/resident 3. Cleanse the skin 4. Protect the surrounding skin	C. Refer to Module 8 Manual Skill 8.7b- Foot Care	powders according to facility policy

4. Applying ointments, lotions, or powders a. Apply as directed, wear gloves b. Creams or liniments are rubbed in by hand c. Lotions are patted on with a cotton ball d. Ointments are applied with a wooden tongue blade or a cotton swab e. Sprinkle powder onto hand or cloth, and then apply to patient/resident 5. Chart and report observations a. Make a note of the appearance of the skin b. Describe any changes in the appearance c. Identify any signs of irritation		
Objective 16 **Explain the role of the Nurse Assistant in the admission of a patient/resident to the facility.** A. Admission to a long-term facility is stressful to both the patient/resident and family 1. First impressions of the facility are important for the adjustment of the patient/resident to the facility 2. The new patient/resident may have many feelings of loss a. Home b. Possessions c. Independence d. Family e. Freedom f. Privacy g. Control over one's life B. Welcome the patient/resident 1. Greet patient/resident by name 2. Introduce yourself 3. Explain what you will be doing	A. Lecture B. Discussion	A. Written test B. Follows admission procedures of facility

4. Convey a warm welcome through tone of voice and facial expression C. Collect base line information about the patient/resident 1. Measure patient's/resident's height and weight 2. Measure patient's/resident's vital signs 3. Observe the patient's/resident's a. Grooming b. Condition of hair and nails c. Condition of skin d. Mental alertness e. Sight and hearing f. Presence of any prosthesis g. Ability to move around D. Report all questions and concerns of the patient/resident or family to the licensed nurse E. Orient the patient/resident and family to the facility 1. Review facility routine 2. Introduce patient/resident to roommate and staff 3. Tour the facility 4. Explain the operation of bed controls, TV controls, and nurse call system F. Care for personal belongings 1. Patients/residents must know they have control over their possessions and can decide where to put item 2. Fill out the facility list of possessions a. Encourage patient/resident to send valuables home with family b. Objectively describe valuables kept at facility 3. Label items with patients/residents' name		
Objective 17 **Explain the role of the Nurse Assistant in transferring a patient/resident from one area to another within the facility.** A. Tell the patient/resident in advance about the transfer, and explain	A. Lecture	A. Written test

the reason for moving B. Collect all the patient's/resident's belongings and take them to the new room 1. Be careful not to lose any items 2. Check all drawers and closets for personal items C. Introduce patient/resident to new roommates 1. New surroundings may cause confusion; orient patient/resident to new room 2. Continue to remind patient/resident of new room	B. Discussion	B. Follows transfer procedures of facility
Objective 18 **Explain the role of the Nurse Assistant in the discharge of a patient/resident.** A. Collect base line information about the patient/resident: 1. Measure patient's/resident's height and weight 2. Measure patient's/resident's vital signs 3. Observe the patient's/resident's: a. Grooming b. Condition of hair and nails c. Condition of skin d. Mental alertness e. Sight and hearing f. Presence of any prosthesis g. Ability to move around B. Collect all personal belongings of the patient/resident: 1. Check all drawers and closets for personal items 2. Review facility list of possessions for items that might be in the safe or locked cabinet or the laundry C. Assist the patient/resident to his or her vehicle or designated mode of transportation after checking with licensed nurse. Patient/resident usually leaves by wheelchair	A. Lecture B. Discussion	A. Written test B. Follows discharge procedures of facility

Sample Test: Module 9- Patient Care Procedures

1. A patient/resident has diarrhea. You know that liquid feces and frequent wiping can lead to?
    A. Skin breakdown
    B. Dehydration
    C. Oliguria
    D. Death

2. What is the preferred position for giving an enema?
    A. Fowler's or semi-fowlers position
    B. Sims' or left side lying position
    C. Prone or supine position
    D. Supine or right side-lying position

3. Water temperature for an enema solution for adults usually is
    A. 100^{o}
    B. 105^{o}
    C. 110^{o}
    D. Body temperature

4. A patient/resident finished urinating. The person cannot clean her genital area. You need to do the following **EXCEPT**
    A. Wipe her from back to front
    B. Use fresh tissue for each wipe
    C. Provide perineal care if necessary
    D. Wear gloves

5. A male patient/resident is not circumcised. When giving perineal care, which is correct?
    A. Retract the foreskin
    B. Separate the labia
    C. Start at the rectum
    D. Use firm, upward strokes

6. Which linens must be tight and wrinkle-free?
    A. Bottom linens
    B. The blanket
    C. The bedspread
    D. The pillowcase

7. The nurse asks you to collect a random urine specimen. Which is correct?
    A. No special measures are needed
    B. The perineal area is cleaned before collecting the specimen
    C. The first voiding is discarded
    D. The person voids twice

8. The nurse asks you to strain a person's urine. To do this, you need
    A. A midstream urine specimen
    B. A 24-hour urine specimen
    C. A strainer or gauze
    D. Elastic tape

9. Mucus from the respiratory system that is expelled through the mouth is
    A. Phlegm
    B. Saliva
    C. Sputum
    D. Ketone

10. Oral care before collecting a sputum specimen involves
    A. Brushing the teeth
    B. Using mouthwash
    C. Flossing
    D. Rinsing with clear water

11. The nurse asks you to collect a stool specimen from a patient/resident. Which is **INCORRECT**?
    A. Explain what the person needs to do
    B. Explain what you will do
    C. Ask if the person understands what to do
    D. Stay with the person until the person has a bowel movement

12. When collecting a sputum specimen, the person coughs up sputum from the
    A. Mouth
    B. Throat
    C. Upper airway
    D. Bronchi and trachea

13. Normal urine has
    A. A faint odor
    B. A strong odor
    C. A sweet odor
    D. An ammonia odor

14. Which of the following is a characteristic of normal urine?
    A. Pale-yellow urine
    B. Straw-colored urine
    C. Red-colored urine
    D. Clear urine

15. A clean, neat, wrinkle-free bed does the following except
    A. Increase the person's comfort
    B. Help prevent skin breakdown
    C. Help prevent pressure ulcers
    D. Prevent incontinence

16. A patient/resident is up all day. What kind of bed should you make?
    A. Closed bed
    B. Open bed
    C. Occupied bed
    D. Surgical bed

17. Which is **not** a safety measure for making beds?
    A. Raise the bed for body mechanics
    B. Wear gloves when removing linen from the person's bed
    C. After making a bed, lower the bed to its lowest position
    D. After making an occupied bed, always raise the bed rails

18. Linens are held
    A. With forceps
    B. Close to your body and uniform
    C. Away from your body and uniform
    D. With gloves on

19. A patient/resident brought a pillow from home. Which statement is correct?
    A. The person needs to bring a pillowcase, too
    B. The person must use a pillow provided by the nursing center
    C. The person has the right to use the pillow
    D. The pillow must have a safety check by the maintenance department

20. You brought 2 pillowcases into a patient's/resident's room. The person uses 1 pillow. What should you do with the other pillowcase?
    A. Return it to the linen supply
    B. Leave it in the person's room for another time
    C. Take it to another patient's/resident's room
    D. Put it with the dirty laundry

21. You are going to make a bed. For good body mechanics, the bed is
    A. Fowler's position
    B. Raised
    C. Locked into position
    D. Moved so you can reach it with ease

22. Your patient/resident is right-handed. The bedside stand and call signal should be:
    A. On her right side
    B. On her left side
    C. Wherever the facility wants it
    D. Where it will be convenient for you

23. Wet, damp, or soiled linens are changed
    A. Right away
    B. After meals
    C. After the shower or bath
    D. Each shift

24. The bottom sheet is placed on the bed correctly if
    A. The hem-stitching is down
    B. The hem-stitching faces outward
    C. The top edge is even with bottom of the mattress
    D. It completely covers the plastic draw sheet

25. You are removing dirty linens from a person's bed. Which is correct?
    A. Remove all dirty linens at once
    B. Roll each piece away from you
    C. Keep the side that touched the person outside the roll
    D. Place dirty linen on the floor

26. Which is **not** a rule for collecting specimens?
    A. Use a clean container for each specimen
    B. Use the correct container
    C. Label the container accurately
    D. Collect the specimen as soon as you have time

27. A patient/resident has fecal incontinence. You know that
    A. Good skin care is required
    B. A bowel training program will cure the person's incontinence
    C. The condition is permanent
    D. The person has dementia

28. Keeping the person's room clean, neat, safe, and comfortable is the responsibility of
    A. Housekeeping staff
    B. Everyone involved in the person's care
    C. Maintenance staff
    D. The person and family

29. The loss of urine in response to a sudden need to void is called:
    A. Overflow incontinence
    B. Mixed incontinence
    C. Functional incontinence
    D. Urge incontinence

30. You are admitting a new patient/resident. Which is **incorrect**?
    A. Discuss the person's diagnoses and medical history
    B. Complete the clothing list
    C. Orient the person to the room
    D. Orient the person to the nursing unit and the facility

31. The nurse asks you to assist with the admission of a new patient/resident. What can the nurse delegate to you?
    A. Transporting the person to his or her room
    B. Having the person sign admitting papers
    C. Having the person sign a general consent for treatment
    D. Explaining patients/residents rights to the person

32. An infected wound is
    A. A contaminated wound
    B. An open wound
    C. A dirty wound
    D. A full-thickness wound

33. These statements are about skin tears. Which is **incorrect?**
    A. Skin tears can occur during bathing, dressing, repositioning, or transfers
    B. Skin tears are painful
    C. Infection can develop in a skin tear
    D. Skin tears usually occur over a bony area

34. Drainage that is thick green, yellow, or brown is
    A. Purulent drainage
    B. Serosanguineous drainage
    C. Serous drainage
    D. Sanguineous drainage

35. Which will help prevent skin tears?
    A. Keep your fingernails short and smoothly filed
    B. Wear simple earrings
    C. Wear gloves
    D. Practice hand hygiene before and after giving care

36. A patient/resident is going to be discharged. What must occur before the person can leave?
    A. Give the person prescriptions written by the doctor
    B. The person must be transported to the exit area by wheelchair or stretcher
    C. The person must pay the bill
    D. The person must sign a consent form

37. Which is not a guideline for measuring weight and height?
    A. No footwear is worn
    B. The person voids after being weighed
    C. Weigh the person at the same time of day
    D. Use the same scale for daily, weekly, and monthly weights

38. An elastic bandage is applied from the
    A. Lower part to the top part
    B. Top part to the lower part
    C. Back to front
    D. Front to back

39. Elastic stockings also are called
    A. Anti-embolism stockings
    B. Support Hose
    C. Elastic bandages
    D. Montgomery bandages

40. A patient/resident objects to a transfer or a discharge. An ombudsman makes sure that the person's best interests are considered.
    A. True
    B. False

41. When removing dirty linens, roll each piece toward you.
    A. True
    B. False

42. Wet, damp and soiled linens are changed at the end of your shift.
    A. True
    B. False

43. When using a fracture pan, the larger end is placed under the buttocks.
    A. True
    B. False

44. When collecting specimens, you must not touch the inside of the container lid.
    A. True
    B. False

45. Linen can be transferred from one patient's/resident's room to another patient's/resident's room.
    A. True
    B. False

Matching

A. Oliguria
B. Enema
C. Open bed
D. Pressure Ulcer
E. Constipation

46. The passage of a hard, dry stool
47. A type of bed ready for a patient/resident arriving on a stretcher.
48. Scant amount of urine.
49. Open wound on the heel of a patient/resident.
50. The introduction of fluid into the rectum.

Sample Test Answers: Module 9

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

MANUAL SKILL: Collecting and Identifying Specimens: Sputum

EQUIPMENT:

Completed label
Completed laboratory requisition
Emesis basin
Gloves
Mask
Paper or plastic bag
Sputum specimen container with cover
Tissue

BEGINNING STEPS:

1. Gather equipment .
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce yourself (name and title).
5. Identify patient/resident. Use two identifiers (name, DOB).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Put on mask and gloves. (If patient/resident has known or suspected TB, wear the proper mask).

SKILL STEPS:

1. If the patient/resident has eaten recently, ask the patient/resident to rinse her mouth with water. Assist as necessary. Use emesis basin to spit water out.
2. Ask the patient/resident to cough deeply, so that sputum comes up from the lungs. To prevent the spread of infection ask the patient/resident to cover the nose and mouth with a tissue while coughing.
3. Have the patient/resident spit the sputum directly into the specimen container. (Collect 1-2 teaspoons).
4. Wipe any sputum of the outside of the container with tissues (only the outside of the container should be touched) cover the container tightly.
5. Discard the tissues.

ENDING STEPS:

1. Place container into bag.
2. Remove and dispose of gloves and mask properly (without contaminating self).
3. Leave call light within patient's/resident's reach.
4. Wash hands.
5. Report any changes in the patient/resident to nurse.
6. Document procedure using facility guidelines.
7. Take specimen container and lab slip to designated place promptly.

MANUAL SKILL: Collecting and Identifying Specimens: Urine

EQUIPMENT:

Bedpan
Bedside commode
Completed lab requisition
Gloves
Graduate measure
Labeled specimen container and lid
Paper or plastic bag
Specimen pan for toilet
Urinal

BEGINNING STEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self (name and title).
5. Identify patient/resident. (Name and DOB).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Provide privacy (curtain and/or door).
8. Apply clean gloves.

SKILL STEPS:

1. Under optimal conditions the specimen should be collected directly into the container or use clean/unused bedpan urinal or specimen pan.
2. Assist the patient/resident to a comfortable position to urinate.
3. Ask the patient/resident to urinate into a clean bedpan, urinal or specimen pan.
4. Instruct the patient/resident not to put toilet tissue in bedpan, urinal or specimen pan, put in plastic bag or wastebasket.
5. Cover the bedpan or urinal and take it to the bathroom.
6. If patient/resident is on intake and output. Pour urine into new or unused graduate and measure.

7. Pour the urine into specimen container, filling it three fourths full if possible.
8. Place lid on container. Put container in plastic bag.
9. Pour leftover urine into toilet and flush.

ENDING STEPS:

1. Clean and return equipment and supplies, if applicable.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Assist patient/resident to wash hands, if applicable.
5. Position patient/resident comfortably.
6. Place call light within reach.
7. Lower bed to safe position, if applicable.
8. Wash hands.
9. Report any abnormal findings to licensed nurse.
10. Document.
11. Take the labeled specimen and lab requisition to the appropriate storage or pick-up station.

MANUAL SKILL: Collecting and Identifying Specimens: Stool

EQUIPMENT:

Bedpan
Bedside commode
Completed lab requisition
Gloves
Labeled specimen container and lid
Paper or plastic bag
Specimen pan for toilet
Toilet tissue
Tongue blade
Urinal

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self (name and title).
4. Identify patient/resident. (Name and DOB).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment, if applicable.
7. Provide for privacy.
8. Wash hands.

SKILL STEPS:

1. Practice good body mechanics. Adjust bed to safe working level, (waist high) if using a bedpan. Lock the wheels.
2. Lower the side rail (if it is not already lowered) on the side nearest you.
3. Apply clean gloves.
4. Assist the patient/resident with toileting. Use a clean or unused bedpan, bedside commode or specimen pan.
5. Ask the patient/resident not to urinate at the same time.

6. Ask the patient/resident not to put the toilet paper in with the sample. Provide a plastic bag or wastebasket.
7. Provide privacy; make sure call light is within reach.
8. After the bowel movement, help as necessary with perineal care. Help the patient/resident wash hands.
9. Make patient/resident comfortable.
10. Using the tongue blades, take about two tablespoons of stool and put it in the container.
11. Cover the container tightly and bag the specimen.
12. Wrap the tongue blades in toilet paper and throw them away in proper container.
13. Empty bedpan or container into the toilet and flush.

ENDING STEPS:

1. Clean equipment and store in proper place.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Return bed to low position if raised. Ensure patient's/resident's safety. Return side rails as ordered.
5. Leave call light within reach.
6. Wash hands.
7. Report any changes in the patient/resident to the licensed nurse.
8. Document procedure using facility guidelines.
9. Take specimen to designated place promptly.

MANUAL SKILL: Occupied Bed Making

EQUIPMENT:

Bedspread
Blanket
Bottom Sheet
Drawsheet or plastic pad
Mattress Pad (if used)
Pillow case
Top Sheet

BEGINNING STEPS:

1. Wash Hands.
2. Collect clean linens (always carry away from uniform).
3. Knock and pause before entering, identify self by name and title.
4. Identify patient/resident. (Name and DOB).
5. Place linen on a clean surface (may use overbed table, bed side dresser, may cover with towel).
6. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
7. Provide Privacy, draw curtain and/or close door.

SKILLS STEPS:

1. Lower head of bed before moving patient/resident.
2. Keep patient/resident covered while linens are changed.
3. Loosens top linen from end of the bed.
4. Raise side rail on side to which patient/resident will move and patient/resident moves toward raised side rail.
5. Raise the bed to comfortable working height.
6. Loosens bottom used linen on working side and moves bottom linen toward center of bed.
7. Places and tucks in clean bottom linen or fitted bottom sheet on working side and tucks under patient/resident.
8. Before going to other side, client moves back onto clean bottom linen.
9. Raise side rail then goes to other side of bed.
10. Remove used bottom sheet.
11. Pulls and tucks in clean bottom linen, finishing with bottom sheet free of wrinkles.

12. Patient/resident is covered with clean top sheet and bath blanket/used top sheet has been removed.
13. Change pillowcase.
14. Linen is centered and tucked in at foot of bed.
15. Avoid contact between Nurse Assistant's clothing and used linen.
16. Dispose of used linen into soiled linen container and avoid putting linen on floor.

ENDING STEPS:

1. Return bed to the lowest position.
2. Make sure call light is within reach.
3. Wash hands.

Note: Above steps are minimal requirements for testing purposes. See below for additional steps that may be useful for this skill.

Additional Skill Steps

1. If bedspread and blanket are to be reused, remove from bed and fanfold on back of chair or foot board of bed.
2. Lower the side rail on the side of the bed nearest you and raise side rail on side where patient/resident will turn.
3. Loosen the top and bottom linen at the foot of the bed.
4. Drape patient/resident with a bath blanket
    a. Unfold the bath blanket over the top sheet.
    b. Ask patient/resident to hold top of the bath blanket.
    c. Roll the top sheet under bath blanket to the foot of the bed.
5. Assist patient/resident to roll away from you towards the side rail (adjust pillow for patient/resident comfort).
6. Roll the bottom linen toward the patient/resident and tuck under the patients/residents body.
7. Put the mattress pad on the bed (if used).
8. Place the bottom sheet on the bed.
    a. If using a fitted sheet, pull the fitted corner over the top and bottom of the mattress.
    b. If using a flat sheet, put narrow hem at the bottom of the bed, tuck the sheet under the top of the mattress, and make a mitered corner, then tuck the sheet under the mattress along the side.
9. If using a draw sheet, place it on top of the sheet about 12" to 14" from head of bed.
10. Fold the clean linen toward the patient/resident next to the used linen; this will create a "hump" of linen next to the patient/resident.
11. Assist patient/resident to roll towards you over the hump of linen and immediately raise the side rail for support (adjust pillow for patient/resident comfort).

12. Go to the opposite side of bed and lower the side rail.
13. Remove soiled linen by rolling edges towards side with soiled side inward and place in linen hamper, or plastic bag. AVOID HOLDING SOILED LINEN AGAINST UNIFORM.
14. Unfold clean bottom linen from beneath the patient/resident, pulling it snug and removing wrinkles.
15. Assist the patient/resident to a comfortable position, making sure bath blanket does not get caught under patient/resident.
16. Place top sheet with wide hem toward head of bed with centerfold at center of bed, over bath blanket and unfold with as little movement as possible.
17. Place blanket (if used) over top sheet with centerfold at center of bed, about 6-8" below the top edge of top sheet and fold top sheet over to form a cuff.
18. Ask patient/resident to hold the top linen. Roll bath blanket from head to foot of bed and remove.
19. Tuck top linen under bottom of the mattress and make a mitered corner.
    a. With hand closest to foot of bed, pick up edge of sheet at side of bed about 18" from foot of bed.
    b. Place this section of sheet and blanket on bed.
    c. Tuck the hanging part of the sheet under the mattress.
    d. Pick up the part of the linens resting on the bed at the point, fold back over side of the bed.
20. Make a toe pleat.
21. Remove pillow and replace pillowcase.
    a. Grasp the clean pillowcase at the center of the seamed end.
    b. Turn the pillowcase back over your hand.
    c. Grasp the pillow at the center with the hand that is inside the pillowcase.
    d. Pull the pillowcase down over the pillow with your free hand.
    e. Line up seam of the pillowcase with the edges of pillow making sure corners of the pillow are in the corners of the pillowcase.
    f. Fold extra material of the pillowcase over and under the pillow.
22. Place pillow under the patients/residents head with the open edge facing away from the door.
23. Make sure patient/resident is comfortable in proper body alignment, bedside table is within reach.
24. Return side rails per care plan.
25. Open curtains, window drapes and door (per patients/residents preference).
26. Dispose of soiled linens.
27. Document.
28. Report any abnormal findings to the licensed nurse.

MANUAL SKILL: Unoccupied Bed Making

EQUIPMENT:

Bed Spread
Blanket
Bottom Sheet
Draw Sheet (chuck)
Mattress pad (if used)
Pillowcase
Top sheet

SKILLSTEPS:

1. Wash hands.
2. Collect clean linens.
3. Carry linens away from uniform.
4. Place linen on clean surface (bedside table, overbed table; a towel may be used to create a clean surface).
5. Lower the head of bed to flat position, raise bed to comfortable working height, lower side rails.
6. Remove pillowcase and set pillow aside on clean surface.
7. Remove soiled linen, loosen all linen, and roll from edges to center with soiled side inward, place directly into linen hamper. **NEVER PLACE LINEN ON FLOOR.**
8. Wash Hands.
9. If used, place mattress pad on the mattress.
10. Place bottom sheet on mattress in the center, with the center fold at the center from head to foot. **DO NOT SHAKE.**
    a. If using a fitted sheet pull the fitted corners over the top and bottom of the mattress on one side.
    b. If using a flat sheet
        1) Put narrow hem at bottom of bed.
        2) Tuck the sheet under the mattress at the top.
        3) Make a mitered corner.
        4) Tuck sheet under mattress along side.
11. Place draw sheet on top of bottom sheet about 12 – 14” from top edge of mattress.
12. Place top sheet with centerfold at center of bed from head to foot.
13. Center the top sheet with the wide hem even with the top of the mattress and the stitched side or seemed side up.
14. Unfold the sheet so that it hangs evenly on both sides of the mattress. **DO NOT SHAKE.**
15. Place the blanket over the top sheet.
    a. The top edge of the blanket should be 6 – 8” below the top edge of the top sheet.

   b. Fold the top sheet down over the top of the blanket to make a cuff.
16. Tuck the top sheet and blanket under the foot of the mattress. Make a mitered corner.
17. Move to the other side of the bed.
18. *Complete one side of bed before going to the other side of bed to save time and energy (*Repeat step 10 – 16).
19. Loosen end of linens or make a toe pleat for comfort.
20. Place pillowcase on pillow.
    a. Grasp the clean pillowcase at the center of the seamed end.
    b. Turn the pillow case back over hand.
    c. Grasp the pillow at the center with the hand that is inside the pillowcase.
    d. Pull the pillowcase down over the pillow with your free hand.
    e. Line up the seams of the pillowcase with the edges of the pillow making sure that the corners of the pillow are in the corners of the pillowcase.
    f. Tuck the extra material of the pillowcase inside and under pillow.
21. Place the Pillow on the bed so that the open edge is facing away from the door.
22. Lower the bed.
23. Ensure room is neat and clean, call light on bed, bedside table straightened and placed by bed.
24. Wash hands.

Closed Bed- Place the bed spread over the blanket and the pillow.

Open Bed- Fanfold the top linen toward the foot of the bed. Be certain that the cuff edge is closest to the head of the bed.

MANUAL SKILL: Administrating a Soap Suds Enema:

EQUIPMENT:

Bed protector
Bedpan or commode
Enema bag/bucket, tubing with clamp
Enema solution (soapsuds, tap water, or normal saline as ordered by physician)
Gloves
Toilet tissue
Water-soluble lubricant

BEGINNINGSTEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room, introduce self by name and title.
4. Identify patient/resident (use name band and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide for privacy (close privacy curtains, window shades and/or door).
7. Apply clean gloves.

Skill Steps:

1. In the bathroom or utility room prepare enema.
    a. Make sure that the tubing is connected to bag/bucket.
    b. Close clamp on tubing and fill bag/bucket with accurate amount of solution.
    c. Test temperature of solution to ensure that it is not neither too hot or too cold.
    d. Open clamp and allow solution to fill the tubing to remove air and then close clamp.
2. Raise side rails, and raise bed to a comfortable working height.
3. Lower the side rail nearest you.
4. Assist patient/resident to left Sims' position.
5. Place bed protector under the patient's/resident's buttocks.
6. Have a bedpan within reach.

7. Keep patient/resident covered and expose only the buttocks.
8. Apply lubricant to tip of tubing 2-4“.
9. Raise right buttocks so you can visualize the anus.
10. Gently and slowly insert tip of tubing 2-4” using a gentle rotating movement. ***Never push against resistance because you may injure your patient/resident, stop procedure and call supervising nurse.***
11. Open clamp and raise enema bag/bucket 18 inches above the mattress.
12. Allow the solution to flow slowly into anus.
13. If patient/resident complains of discomfort clamp tubing and wait a minute or so before continuing the flow.
14. When the solution is almost gone, clamp tube and slowly remove the tubing.
15. Place tubing into the enema bag/bucket and do not allow the tip to come in contact with the bed, floor or uniform (may wrap tip of tubing in a paper towel).
16. Encourage patient/resident to hold solution as long as possible.
17. When patient/resident is ready to expel enema, assist patient/resident onto bedpan. If allowed raise head of bed.
18. If patient/resident is allowed bathroom privileges, assist to bathroom and stay near in case patient/resident needs help.
19. Place toilet tissue and signal cord within reach.
20. Check on patient/resident every few minutes.
21. Discard disposable equipment.
22. Remove bedpan, remove bed protector and any soiled linens and replace, cleanse patient/resident as necessary or cleanse patient/resident and assist back to bed.
23. Assist patient/resident to wash hands.
24. Check contents of bedpan or toilet for color, consistency, amount, unusual material then empty and flush.

ENDING STEPS:

1. Remove and dispose of gloves (without contaminating self) into waste container.
2. Wash hands.
3. Position patient/resident comfortably.
4. Lower the bed to a safe position.
5. Ensure call light is within reach.
6. Wash hands.
7. Document.
8. Report any abnormal findings to licensed nurse.

MANUAL SKILL: Administering the Commercially Prepared Enema (Cleansing and/or Oil Retention)

EQUIPMENT:

Bed protector
Bedpan
Commercially prepared enema (cleansing and/or Oil Retention)
Lubricating jelly
Toilet tissue

BEGINNING STEPS:

1. Gather Equipment.
2. Knock on door and pause before entering, introduce self by name and title.
3. Wash hands.
4. Identify patient/resident (name band and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide privacy, close privacy curtains, window shades and/or door.
7. Raise the bed to a comfortable working height.
8. Lower the side rail nearest you.
9. Apply clean gloves.

SKILL STEPS:

1. Cover patient/resident with a blanket or sheet, fold remaining linen to the foot of the bed.
2. Position the patient/resident in the left Sims' position.
3. Place bed protector under buttocks.
4. Have bedpan within reach.
5. Expose buttocks by raising edge of blanket, keep patient/resident covered.
6. Raise right buttocks to visualize the anus.
7. Remove cap from enema.
8. Lubricate the tip 2 to 4 inches with lubricating jelly.
9. Gently insert tip of enema 2" through anus into rectum.
10. Squeeze and roll the plastic bottle gently until all the solution enters the rectum. Stop if patient/resident complains of pain or if you feel resistance, or if bleeding occurs.
11. Remove tube from patient's/resident's anus and place bottle in box for disposal.

   a. For oil retention – encourage patient/resident to hold solution for 20 minutes (or time ordered) before placing on bedpan or assisting patient/resident to toilet.
   b. For cleansing enema – assist patient/resident onto bedpan or to toilet. Encourage patient/resident to retain enema until urge to defecate is felt.
12. Remove gloves.
13. Wash hands.
14. Provide toilet tissue and make sure call bell is within reach, provide privacy.
15. Discard disposable enema equipment.
16. Monitor patient/resident every few minutes or when patient/resident signals.
17. Apply gloves.
18. Remove bedpan.
19. Assist patient/resident to clean perineal area.
20. Remove bed protector.
21. Check contents of bedpan or toilet for color, consistency, amount, unusual material then empty.

ENDING STEPS:

1. Remove and replace any soiled linen.
2. Remove and dispose of gloves (without contaminating self) into waste container. Wash hands.
3. Provide material for patient/resident to wash hands.
4. Position patient/resident for comfort.
5. Lower bed to safe position.
6. Ensure call light is within reach.
7. Wash hands.
8. Document.
9. Report any abnormal findings to licensed nurse.

MANUAL SKILL: Rectal Suppository-Laxative

EQUIPMENT:

Bedpan with cover
Disposable gloves
Suppository as ordered for bowel evacuation
Toilet tissue
Water-soluble lubricant

BEGINNING STEPS:

1. Wash hands.
2. Gather equipment.
3. Knock on door and pause, introduces self by name and title.
4. Identify patient/resident (use name and date of birth).
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Provide privacy, close privacy current and/or door.

SKILL STEPS:

1. Raise bed to a comfortable working level.
2. Position the patient/resident or ask the patient/resident to turn on left side and raise one knee toward the chest. Assist as necessary.
3. Apply clean gloves.
4. Lift the sheet and expose the buttocks.
5. Unwrap the suppository.
6. Lubricate suppository as needed.
7. Spread buttocks to expose anal area.
8. Insert the suppository, using index finger. Ask the patient/resident to take deep breaths, as this will help relax the patient and retain the suppository Place the suppository past the rectal sphincter against the wall of the colon.
9. Withdraw the finger and hold toilet tissues against the anus briefly.
10. Remove the gloves by turning them inside out; dispose according to facility policy.
11. Wash hands.
12. Reposition the patient/resident in a comfortable position, and ask patient/resident to retain the suppository as long as possible (15-20 minutes).

13. Provide a bedpan for use, if necessary, or assist to the bathroom.
14. Adjust bedding, helping patient to assume a comfortable position.
15. Place a call bell near the patient's/resident's hand, but check every few minutes.
16. Provide privacy.
17. Once patient/resident is finished, assist with hygiene if necessary.

ENDING STEPS:

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

MANUAL SKILL: Changing Clothing of Patient/resident with an I.V.

I.V. without pump

EQUIPMENT:

Gown or clothing of patient's/resident's choice, non-skid footwear

BEGINNING STEPS:

1. Wash hands.
2. Knock and pause before entering the patient's/resident's room.
3. Introduce self.
4. Identify patient/resident.
5. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
6. Gather equipment.
7. Provide for privacy.
8. Apply gloves, if necessary.

SKILL STEPS:

1. Ask patient/resident what she/he would like to wear.
2. Raise bed to a comfortable working level.
3. Lower the side rail near you.
4. Cover the patient/resident with a bath blanket. Fanfold linens to the foot of the bed.
5. Untie the gown and free parts of the gown that the person is lying on.
6. Remove gown/shirt/blouse from arm without I.V. first.
7. Gather up the sleeve of the arm with the I.V. Slide it over the I.V. site and tubing. Remove the arm and hand from the sleeve.
8. Keep the sleeve gathered. Slide your arm along the tubing to the bag.
9. Remove the I.V. bag from the pole. Slide the bag and tubing through the sleeve. Do not pull on the tubing. **DO NOT LOWER THE BOTTLE OR BAG BELOW THE LEVEL OF THE PATIENT'S/RESIDENT'S ARM.**
10. Replace the I.V. bag on the pole.
11. Gather the sleeve of the clean gown that will go on the arm with the I.V. bag.
12. Remove the I.V. bag from the pole. Slip the sleeve over the bag at the shoulder part of the gown. Replace the bag on the pole.

13. Slide the gathered sleeve over the tubing, arm, hand, and I.V. site and over the arm.
14. Replace IV bag on pole.
15. Put the other side of the gown on. Fasten the back.
16. Cover the person. Remove bath blanket.

ENDING STEPS:

1. Clean and return equipment and supplies.
2. Remove gloves, if wearing.
3. Position the patient/resident comfortable.
4. Place call light within reach.
5. Lower bed to safe position for the patient/resident.
6. Thank the patient/resident, leave room neat.
7. Wash hands.
8. Document.
9. Report any abnormal findings to licensed nurse.

I.V. INFUSING VIA PUMP

EQUIPMENT:

I.V. Gown or patients/residents clothing choice (gown with snaps at shoulder)

BEGINNING STEPS:

1. Wash hands.
2. Gather equipment.
3. Knock and pause at door before entering the patient's/resident's room.
4. Introduce self, using name and title.
5. Identify patient/resident using name and date of birth.
6. Explain procedure.
7. Provide privacy.
8. Apply gloves if necessary.

SKILL STEPS:

1. Raise bed to comfortable working level.
2. Lower side rail nearest you.
3. Cover patient/resident with a bath blanket, fanfold top linens to foot of bed.
4. Untie gown and free any part of the gown patient/resident is lying on. (If in personnel clothes STOP and get licensed nurse to disconnect I.V.)
5. Remove the sleeve from the arm without the I.V. first.
6. Unsnap the closure at the shoulder of the gown with the I.V. and remove.
7. With the new gown unsnap the closure on the side with the I.V.
8. Put on the gown on the side without the I.V. first, and then snap the closure at the shoulder on the I.V. side fasten back.
9. Cover the patient/resident, remove the bath blanket.

ENDING STEPS:

1. Clean and remove equipment.
2. Remove and dispose of gloves (without contaminating self) into waste container.
3. Wash hands.
4. Position the patient/resident comfortably.
5. Place call light within reach.
6. Lower bed to safe position for the patient/resident.
7. Thank the patient/resident, leave room neat.
8. Wash hands.
9. Document.
10. Report any abnormal findings, if patient/resident was disconnected from the pump inform licensed nurse to restart.

MANUAL SKILL: Measuring Oral Intake
(see module 7)

EQUIPMENT:

Graduated measuring container (graduate)
Intake and output record
Pen/pencil

BEGINNING STEPS:

9. Wash hands.
10. Knock and pause before entering the patient's/resident's room.
11. Introduce self.
12. Identify patient/resident.
13. Explain procedure speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
14. Gather equipment, if applicable.
15. Provide for privacy with a curtain, door, or screen.
16. Apply gloves (standard precautions).

SKILL STEPS:

1. Gather equipment.
2. Wash hands.
3. Knock and pause before entering the patient's/resident's room.
4. Introduce self.
5. Identify patient/resident.
6. Explain procedure.
7. Provide for privacy.
8. Apply gloves, if necessary.
9. Pour the liquid remaining in the container into the graduate.
10. Measure the amount at eye level. Keep the container level.
11. Check the amount of the serving on the I & O record.
12. Subtract the remaining amount from the full serving amount. Note the amount.
13. Repeat steps 9 – 12 for each liquid.
14. Add the amounts from each liquid together.

15. Immediately record the time and amount on the I & O record.
16. Clean and return equipment and supplies.
17. Remove gloves, if wearing.
18. Position patient/resident comfortably.
19. Place call light within reach.
20. Lower bed to safe position for the patient/resident.
21. Leave room neat.
22. Wash hands.
23. Report abnormal findings to licensed nurse.

ENDING STEPS:

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

MANUAL SKILL: **Applies One Knee-High Elastic Stocking**

EQUIPMENT:

Anti-embolic/elastic stockings

BEGINNING STEPS:

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

SKILL STEPS:

1. Client is in supine position (lying down in bed) while stocking is applied.
2. Turns stocking inside out, at least to the heel.
3. Places foot of the stocking over the toes, foot and heel.
4. Pulls top of stocking over foot, heel, and leg (It turns right side out as it is pulled up).
5. Moves foot and leg gently and naturally, avoiding force and over-extension of limb and joints.
6. Finishes procedure with no twists or wrinkles and heel of stocking, if present, is over heel and opening in toe area (if present) is either over or under toe area.

ENDING STEPS:

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